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: **November 17, 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
Presentation of Los Angeles County Board of Supervisors' Scroll to Dr. Marc Eckstein, Medical Director, Los Angeles City Fire-Retired

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**
   September 15, 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. 227: Dispatch Pre-Arrival Instructions
   - 3.2 Reference No. 302: 9-1-1 Receiving Hospital Standards
   - 3.3 Reference No. 517: Private Provider Agency Transport/Response Guidelines
   - 3.4 Reference No. 620: EMS Quality Improvement Program
   - 3.5 Reference No. 703: ALS Unit Inventory
   - 3.6 Reference No. 834.1: Patient Refusal of Treatment/Transport and Treat and Release at Scene Quick Reference Guide
   - 3.7 Reference No. 838: Application of Patient Restraints
   - 3.8 Reference No. 1208: Agitated Delirium
   - 3.9 Reference No. 1208-P: Agitated Delirium – Pediatric
   - 3.10 Reference No. 1209: Behavioral/Psychiatric Crisis
   - 3.11 Reference No. 1209-P: Behavioral/Psychiatric Crisis – Pediatric
   - 3.12 Reference No. 1307: Medical Control Guideline: Care of the Patient with Agitation
   - 3.13 Reference No. 1307.1: Medical Control Guideline: Flowchart for Initial Approach to Scene Safety
   - 3.14 Reference No. 1307.2: Medical Control Guideline: Verbal De-escalation (Eraser Mnemonic)
   - 3.15 Reference No. 1307.3: Medical Control Guideline: Common Etiologies of Agitation, Field Presentation, Likelihood Verbal De-escalation
   - 3.16 Reference No. 1317.32: Medical Control Guideline: Drug Reference - Olanzapine

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
- 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)
- 4.5 EMS Commission Ordinance and Composition Review – Vote Required (Attachment)
- 4.6 Data Advisory Committee (DAC) Meeting Frequency

BUSINESS (NEW)

- 4.7 Data Report (Attachment)
- 4.8 EMSC Workplan (Goals/Objectives) for Fiscal Year 2021-22 Annual Report (Attachment)
- 4.9 Nominating Committee for 2022 Chair and Vice Chair
- 4.10 EMS Agency Meeting Schedule 2022 (Attachment)

V. LEGISLATION

- 5.1 AB 389 (Grayson D) Ambulance Services (Attachment)

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

CORRESPONDENCE – Highlighted items left over from September 15, 2021 meeting

- 6.1 (07-14-2021) Police Chief Michael Ishii, Hawthorne PD: Officer Commendations
- 6.2 (07-30-2021) Bryan Webb, LACoFD: Implementation of Systemwide Dispatch Center Annual Program Reviews

6.3 (08-22-2021) Stephen Albrecht, Star Behavioral Health Urgent Care: Psychiatric Urgent Care Center Designation (Lancaster)

6.4 (08-24-2021) Distribution: Notification of Fatal or Non-Fatal Submersion Incidents by EMS to Public Health

6.5 (08-25-2021) Distribution: Standard Guidance for First Responders Entering Hospital/Health Facilities

6.6 (09-30-2021) From Board of Supervisors Executive Office: Commission Meetings and County Vaccination Mandate (Attachment)

VII. COMMISSIONERS' COMMENTS / REQUESTS

VIII. ADJOURNMENT

To the meeting of January 19, 2022

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
SEPTEMBER 15, 2021
Zoom Meeting

☐ *Captain Brian S. Bixler	Peace Officers' Assn. of LAC	Cathy Chidester	Executive Director
☒ Diego Caivano, M.D.	L.A. County Medical Assn.	Richard Tadeo	EMS Asst. Director
☒ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Marianne Gausche-Hill	EMS Medical Director
☒ Carl Povilaitis	LAC Police Chiefs' Assn.	Kay Fruhwirth	EMS Nursing Director
☒ John Hisserich, Dr.PH	Public Member, 3rd District	Roel Amara	EMS Asst. Director
☒ Lydia Lam, M.D.	So. CA Chapter American College of Surgeons	Vanessa Gonzalez	EMS Staff
☒ James Lott, PsyD, MBA	Public Member, 2nd District	Nichole Bosson	EMS Asst Med Direct
☐ *Carol Meyer, RN	Public Member, 4th District	Christine Clare	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.	Natalie Greco	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	Andrea Solorio	EMS Staff
☐ *Jason Tarpley, M.D.	American Heart Association	Christine Zaiser	EMS Staff
☒ Carole A, Snyder, RN	Emergency Nurses Assn.	Adrian Romero	EMS Staff
☒ Atilla Uner, M.D., MPH	American College of Emergency Physicians CAL-ACEP	Kelsey Wilhelm	EMS Staff
		John Telmos	EMS Staff
		Angelica Maldonado	EMS Staff
☒ Gary Washburn	Public Member, 5th District	Gary Watson	EMS Staff
		Jacqui Rifenburg	EMS Staff
		Jennifer Calderon	EMS Staff

GUESTS

Laurie Donegan	LBM APCC	Shelly Trites	Jenn Nulty
Rex Pritchard	LB-Fire CPF	Kelly Vitt	Brit Alton
Adam VanGerpen	LA Fire Department	Andy Reno	Catherine Borman
David Gillotte	LA County Fire Local 1014	Cassandra Lane	
Puneet Gupta, MD	LA County Fire	Caroline Jack	

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

I. CALL TO ORDER

The Emergency Medical Services Commission (EMSC) meeting was held via Zoom Video Communications Conference Call due to the California Statewide Safer at Home Order related to the Coronavirus (COVID) pandemic. The meeting was called to order at 1:02 p.m. by Chairman Paul Rodriguez. A quorum was present with 15 Commissioners on the call.

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

Chairman Rodriguez welcomed meeting participants and provided instructions for public comments and using Zoom.

Richard Tadeo, EMS Agency Assistant Director, did roll call of the Commissioners.

III. CONSENT AGENDA

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

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

1. MINUTES

July 21, 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

3.1 Reference No. 834.1: Patient Refusal of Treatment/Transport and Treat and Release at Scene Quick Reference Guide
3.2 Reference No. 1124: Disaster Preparedness Exercise/Drills

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

Dr. Marianne Gausche-Hill, EMS Agency Medical Director, gave an update on:

Restraint Policies:
1) Agitated Delirium
2) Behavioral Health Emergency Psychiatric Crisis

Medical Control Guidelines:
1) Care of Agitated Patient, including information on de-escalation
2) Suicidal Risk Assessment.

These draft policies and Medical Control Guidelines (MCG) have been evaluated by Base, Providers, Pediatric Advisory Council, and Medical Advisory Council. Providers and Medical Directors felt that moving to a Suicidal Risk Assessment system is too complex to fully operationalize and integrate at this time. Therefore, the MCG for Suicidal Risk Assessment is withdrawn for now with potential for a pilot program prior to moving it forward.

These policies and guidelines will be modified to remove the MCG on Suicidal Risk Assessment and brought back to the Commission in November.

4.1.2 Press Release: First Responders Work Together to Reduce Use of Force Through Integrated Medical Intervention Response Pilot Program
Cathy Chidester, EMSC Executive Director, provided background on the Integrated Medical Intervention Response Pilot Program collaboration with Long Beach Police, Long Beach Fire and EMS on identifying signs and symptoms of agitated delirium patients and determining if dispatch requires medical care versus incarceration.

Richard Tadeo, EMS Agency Assistant Director, provided an updated report on transports to sobering centers and psychiatric urgent care centers, noting that Star began receiving patients on April 1, 2021. This report will be emailed to the Commission.

4.2 Ambulance Patient Offload Time (APOT)
Mr. Tadeo reported on first quarter APOT and noted the East Region times were lower than the prior quarter. Facility and equipment time was not included because facility updates to ePCR caused information to not flow through to the EMS Agency.

The EMS Agency is exploring the use of FirstWatch to provide real-time data on ambulances enroute to the hospitals and those that are waiting to offload their patients at the hospitals. The dashboard display will also include each hospital's average and the longest time ambulances are waiting to offload and transfer care to hospital personnel. Hospital Association of Southern California (HASC) has endorsed this product. The EMS Agency has been approved for a grant for CARES Provider Relief Funds to subscribe to FirstWatch. Provider agency dispatch centers have been provided demonstrations and have given feedback.

FirstWatch is utilized by the three Exclusive Operating Area (EOA) emergency ambulance providers (Care Ambulance, McCormick Ambulance and American Medical Response) for Los Angeles County Fire Department.

There was further discussion on problematic APOT resulting from COVID-19 surge, vaccine mandates, and staff shortages significantly impacting nursing, respiratory therapists, EDs, as well as hospital engineering. Registries are offering healthcare professionals huge compensation to travel for work in other states that do not have mandatory vaccination policies, and this is an unintentional consequence to the vaccine mandate but very problematic as some employees are leaving and unwilling to be vaccinated.

4.3 LA County COVID Update – EMS Agency
Dr. Gausche-Hill reported on the COVID Daily Tracking Report for LA County, covering prehospital data for provider impressions including fever, flu-like symptoms, respiratory distress and cardiac arrest. Data were also abstracted from the California Hospital Association/California Department of Public Health, which demonstrate a drop in hospitalizations in the medical/surgical wards and ICUs due to COVID-19. At this point, only 4-5% of all hospital admissions are secondary to COVID-19.

At least 70% of all LA County residents eligible for the vaccine have received at least one dose of vaccine.

The stress to the system at this time is due the number of healthcare workers, as well as supporting personnel, who are unvaccinated. LA County and Los Angeles City Fire Departments are the two largest providers that have a large number of unvaccinated personnel.

There are plans to set up a town hall style meeting to dispel the myths related to the vaccine which is creating great vaccine hesitancy. At the Paramedic Training Institute, we will require vaccine. Very few will be able to get exemption because you must be allergic to the components of the vaccine or have a religious exemption and we are not seeing that. We will see workforce leaving both for EMS and hospital-based personnel until there is an overall leveling, and hopefully we can continue to encourage vaccination as it is safe and effective.

There was discussion about the Commission making a statement that the vaccination mandate might need to be rethought due to staffing shortages and potential impacts. It was agreed that the Commission would not make any recommendations at this time, but if specific entities need more time, an extension of the deadline may be requested from Public Health.

4.4 EMS Commission Membership – Vote Required

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

Public Comment:
Rex Pritchard, President of Long Beach Firefighters Local 372 and Second District Vice President for California Professional Firefighters (CPF), requested the Ordinance change through Supervisor Janice Hahn's office for CPF to become the nominating organization for paramedic representation on the EMSC replacing CSFA.

CPF feels they are the appropriate body to have appointing authority, as they represent 99% of firefighters and EMTs in LA County. Los Angeles Area Fire Chiefs are in collaboration with and supportive of this Ordinance change from CSFA to CPF. Mr. Pritchard was unable to attend the July 21st EMSC meeting due to wild fires and being an active duty firefighter.

Adam VanGerpen, Second Vice President for United Fire Fighters of Los Angeles City Local 112, Fire Captain and active paramedic, spoke in support of Rex Pritchard, and would like to see future nominations made by CPF. Los Angeles Fire Department members recently withdrew from CSFA, and their Local felt CPF provides the legislation and represents the large majority of their members, over 1250 medics and 3500 firefighters.

David Gillotte, President of LA County Fire Department labor union, spoke in support as an urgent aye for CPF to be the nominating entity for paramedic representation on the EMSC, stating that he is the longest standing member in CPF.

Director Chidester responded to questions from the Commission that CSFA has one seat on the State EMSC, and CPF has 2 seats on the State EMSC.

Motion/Second by Commissioners Salas/Powell to approve the Ordinance change for nominations for Paramedic Representation from California State Firefighter's Association (CSFA) to California Professional Firefighters (CPF) was a failed motion:

Aye (3): Hisserich, Powell, Salas

No (9): Cheung, Lott, Olney, Ower, Povilaitis, Rollman, Snyder, Uner, Washburn

Abstain (3): Caivano, Lam, Rodriguez

At the July 21, 2021 EMSC meeting, CSFA provided public comment and requested to continue being the nominating organization for paramedic representation on the EMSC. CSFA was not present for this September meeting, and CPF was not available for the July meeting.

Motion/Second by Commissioners Lott/Ower to table the previous Motion and discussion on 4.4.1 until representatives from both CSFA and CPF are present at the November 17, 2021 meeting was approved and carried unanimously.

Agenda item 4.4.1 will be put back on the agenda for the November 17, 2021 EMSC meeting to allow public comments from CSFA and CPF. Meeting invites will be sent to both organizations.

4.5 EMS Commission Ordinance and Composition Review
Kay Fruhwirth, EMS Agency Nursing Director, provided an overview of the following proposed changes to clean up the language in the LA County Ordinance 3.20.040 – Composition:

1) Include in all representations that the individual works in and practices in Los Angeles County, and to include the following changes:
   adding emergency physician that works at an LA County paramedic base hospital; the physician for the American Heart Association works in LA County; the Mobile Intensive Care Nurse is nominated by the Greater Los Angeles Chapter; and an administrator from a hospital in LA County nominated by the Hospital Association of Southern California.

   Ms. Fruhwirth also clarified that the Composition handed out in July had incorrect information on the trauma surgeon item "G", and that the current Composition is correct and reflects "A trauma surgeon who practices in Los Angeles County at a designated trauma center nominated by the Southern California Chapter American College of Surgeons".

Commissioners were asked to review their items and let Denise Watson, EMSC Liaison, know if any additional changes are needed.

The EMS Commission Ordinance will be brought back to the November meeting. Once all Composition changes are decided, this will be moved as a package to the Board of Supervisors.

BUSINESS (NEW)

4.6 Data Advisory Committee Meeting Frequency

Commissioner Jeff Rollman opened the discussion on keeping the Data Advisory Committee (DAC) intact as is, or possibly repurposing this committee since approximately half of these meetings are cancelled due to lack of agenda items and usually are information only. A lot of information discussed in DAC is discussed in PAAC and other meetings. The DAC is not seeking any motion nor decision, simply soliciting feedback to initiate any potential processes.

Mr. Tadeo provided background on DAC, noting that when DAC was put together there were no standards for data collection for EMS, base hospitals and trauma centers. Since the National Trauma Data Bank was established for trauma centers, it removed the necessity for the DAC to establish trauma center data collection standards. The EMS Agency has developed various data collection work groups that address specific needs and issues of the EMS providers, base hospitals, and specialty care centers such as trauma, stroke and STEMI.

A list of activities between February 2017 to 2021 was provided to the Commission. The list identified the few actions taken by the DAC. Most of the meetings were canceled because there were no agenda items. A lot of data is brought to the other committees, Medical Council, Pediatric Advisory, Trauma Hospital Advisory Committee, Stroke and STEMI Advisory Committees.

The biggest challenge with DAC is its membership consists of non-decision-makers. They provide reports on challenges but do not have authority to make changes in their own departments. Every year the annual report is presented to the DAC, and when asked for agenda items and what would be a good start to have dashboard reports from the EMS Agency, no recommendations are made. There is an avenue for establishing and revising standards and a process for requesting data reports from the agency.

When the Education Advisory Committee ((EAC) was abolished, we reviewed the membership of that committee and identified that EMT and paramedic training programs were not represented in the other sub-committees of the Commission. The Commission approved the addition of EMT and paramedic training program representation to the Provider Agency Advisory Committee and EAC was dissolved. In DAC, all members are already represented in other sub-committees. I would suggest to make it an ad hoc committee to address critical issues. Currently this meeting meets six times a year.

Director Chidester noted that since DAC is part of the Commission and there is a policy, maybe the representation should be corrected. Data are a critical aspect along with quality improvement. Maybe an ad hoc from the Commission to review the makeup of the committee would be appropriate. The data report we publish is excellent but could be better if hospital and pre-hospital providers give feedback on what is important on the dashboard. Maybe we can put together an ad hoc committee of the Commissioners to see what you want to see from the data. The membership is in policy, but we could repurpose it as recommended by Commissioner Carole Snyder.

Commissioner Erick Cheung questioned if quality improvement (QI), quality data and performance data is already an existing part of the DAC and there is no material to review? Or, has there not been the historical purpose and that would be a potential future purpose?

Mr. Tadeo reported since data is mostly confidential information and protected by HIPAA, and the DAC is a Brown Act public meeting, that precludes DAC from discussing provider or hospital or patient-specific data. We do have QI data and activities in all subject matter expert advisory committees. We have QI committees for both provider agency public and providers. There is a defined trauma QI program divided into regions. STEMI also has a QI component on it.

Chairman Rodriguez expressed the importance of data, and noted the discussion should be what that format looks like in the future in terms of available data.

Commissioner Caivano questioned as far as DAC falling under the Brown Act, what data can be made to come forward?

Director Chidester noted that for the next meeting, Dr. Gausche-Hill will talk about data and overall data that can be looked at versus what is protected health information.

Commissioner Rollman requested an ad hoc group to discuss further, and will arrange with Director Chidester and other Commissioners who may be interested.

4.7 Annual Report to the Board of Supervisors
Director Chidester discussed the components of the EMSC Annual Report which informs the Board of Supervisors the activities of the EMSC over the past year. Since it also includes a workplan, at the November meeting we should put on the agenda to identify additional items to work on for next year, such as looking at data in a different way to be on next year's report and driven by the Commission rather than by the agency or COVID and things that come up. If we get approval on the Annual Report, we can submit to the Board unless there are any changes you would like.

Motion/Second by Commissioners Ower/Hisserich to approve the Annual Report to the Board of Supervisors was approved and carried unanimously.

V. LEGISLATION

Tabled to the next meeting due to time.

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

Dr. Gausche-Hill reported that Dr. Marc Eckstein retired. She also reported that the National Pediatric Readiness Project was a huge success, as 100% of all hospitals in LA County responded to that assessment. She thanked Commissioner Rollman and EMS Agency staff, Dr. Nichole Bosson and Christine Clare, for preparing this report and noted she was also a contributor.

CORRESPONDENCE:

Moved to the next meeting.

6.1 (07-14-2021) Police Chief Michael Ishii, Hawthorne PD: Officer Commendations
6.2 (07-30-2021) Bryan Webb, LACoFD: Implementation of Systemwide Dispatch Center Annual Program Reviews
6.3 (08-22-2021) Stephen Albrecht, Star Behavioral Health Urgent Care: Psychiatric Urgent Care Center Designation (Lancaster)
6.4 (08-24-2021) Distribution: Notification of Fatal or Non-Fatal Submersion Incidents by EMS to Public Health
6.5 (08-25-2021) Distribution: Standard Guidance for First Responders Entering Hospital/Health Facilities

VII. COMMISSIONERS' COMMENTS / REQUESTS

None.

VIII. ADJOURNMENT:

Adjournment by Chairman Rodriguez at 3:06 p.m. to the meeting of November 17, 2021. Meetings are continuing by Zoom, and we are still following guidelines as mandated by the State and the County until further notice.

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

Next Meeting: Wednesday, November 17, 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

October 16, 2021

MEMBERSHIP / ATTENDANCE
VIA ZOOM

	REPRESENTATIVES		EMS AGENCY STAFF
☐	Carol Meyer., Chair	EMS Commission	Dr. Nichole Bosson
☐	Carole Snyder, RN., Vice Chair	EMS Commission	Christine Clare
☐	Atilla Uner, MD, MPH	EMS Commission	Jackie Rifenburg
☒	Lydia, Lam, MD	EMS Commission	John Telmos
☐	Diego Caivano, MD	EMS Commission	Susan Mori
☒	Erick Cheung, MD	EMS Commission	Karen Rodgers
☒	Garry Olney	EMS Commission	Gary Watson
☒	Rachel Caffey	Northern Region	David Wells
☒	Melissa Carter	Northern Region	Dr. Kelsey Wilhelm
☐	Charlene Tamparong	Northern Region, Alternate	Natalie Greco
☒	Samantha Verga-Gates	Southern Region	Andrea Solano
☒	Laurie Donegan	Southern Region	Natalie Greco
☒	Shelly Trites	Southern Region	Laura Leyman
☒	Christine Farnham, APCC President	Southern Region, Alternate	Lily Choi
☒	Paula Rosenfield	Western Region	
☒	Ryan Burgess	Western Region	
☒	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. Ashley Sanello, Compton Fire
☒	Lila Mier	County Hospital Region	Gloria Molleda, Commissioner DAC
☒	Emerson Martell	County Hospital Region	Robert Ower, Commissioner LACAA
☒	Yvonne Elizarraz	County Hospital Region, Alternate	John Hisserich, Commissioner PAAC
☒	Antoinette Salas	County Hospital Region, Alternate	Tina Crews, LACoFD
☒	Shira Schlesinger, MD	Medical Council Representative	J. Curry
☐	Roger Yang, MD	Medical Council Representative, Alt.	
☒	Alec Miller	Provider Agency Advisory Committee	
☒	Jennifer Nulty	Provider Agency Advisory Committee, Alt.	
☐	Laarni Abdenoja	MICN Representative	
☐	Naomi Leland	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 Christine Farnham, Chair Pro Tem.

2. **APPROVAL OF MINUTES**: The meeting minutes for August 11, 2021, were approved as submitted.

   M/S/C (Burgess/Caffey)

3. **INTRODUCTIONS/ANNOUNCEMENTS:**

   3.1 National Pediatric Readiness Project (NPRP)

   The NPRP is complete. Thank you to all participating Los Angeles hospitals. Los Angeles County had 100% response rate, California 88%, and national response rate was 71%. Once the data has been complied and the gap reports have been distributed, the EMS Agency will request that these reports be shared so that we can aggregate data and share with system stakeholders.

4. **REPORTS & UPDATES:**

   4.1 EMS Update 2022

   An EMS Update 2022 work group will convene soon. Topic for next year's update include, Behavioral Health Emergencies, administration of Olanzapine, and ventilation/ airway management in adults and pediatrics. More to come.

   4.2 Emergi-Press

   Next Emergi-Press highlights ECMO and will be available late October, early November.

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

   4.3 ECMO Pilot

   The ECMO Pilot is ongoing, participating hospitals include Ronald Regan UCLA Medical Center (UCL), Cedars Sinai Medical Center (CSM), and LAC+USC Medical Center (USC). Participating providers include Beverley Hills Fire, Culver City Fire, specific Los Angeles County Fire Stations near UCL and USC, and Los Angeles City Fire Stations near USC.

   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. The *ECMO Candidate Radio Report Checklist* will be distributed as a guide for the Non-ECMO Base hospitals.

   4.4 i-gel Pilot

   The i-gel Pilot has concluded, there were a total of 102 patients enrolled over a four-month period. Data is being collected, once complete we will present the findings and discuss the plan moving forward. More to come.

4.5 Data Collaboratives

Overview of each of the collaboratives was provided by Dr. Bosson. Collaboratives meet on a quarterly basis to discuss and explore research opportunities, data collection, and opportunities for system improvement.

SRC Collaborative:
- Recently accepted publication: EMS Agency in collaboration with Stryker – Atypical presentation of potential STEMI and broad screening, taking into account the ECG reading, patient presentation, and provider impression.
- Publication Submission: Examination of hyperglycemia in out of hospital cardiac arrest (CA) and the effect of hyperglycemia on post resuscitation outcomes for out of hospital CA.
- Ongoing projects: Impact of COVID on STEMI and cardiac arrest, Impact of protocol implementation and post resuscitation care, and CPR training for minority populations.

Stroke Data Collaborative: Projects have been on hold until data system issues have been resolved. Recent publications: *Prospective, Multicenter, Controlled Trial of Mobile Stroke Units.*

Trauma Consortium: Nothing to report

Pediatrics (Ad Hoc):
- Children's Hospital Los Angeles, Harbor-UCLA, LAC+USC Medical Center, MemorialCare Long Beach, and Ronald Reagan UCLA are collaborating on the BRUE Project which looks at Paramedic recognition of BRUE, identification of low risk BRUE and routing to EDAP.
- PediDose Study, by Dr. M. Shah, is a multi-center study comparing paramedic-administered conventional dosing and standardized dosing of Midazolam for the management of pediatric seizure, anticipated enrollment to begin in May 2022. Harbor-UCLA and Ronald Reagan UCLA will be the participating pediatric receiving centers, and the EMS Agency will be contributing data.

Dr. Shah will be presenting, *Optimizing Pediatric Prehospital Seizure Management*, on Tuesday, November 30, 2021, from 11:45-12:45. Additional information can be found on the EMS website.

Two volunteers have been appointed from the BHAC, Lorna Mendoza (SFM) and Coleen Harkins (AVH), to participate in the PediDose workgroup.

5. OLD BUSINESS:

All policies in old business were previously reviewed and approved during the BHAC meeting on August 11, 2021. Returned to this committee for review of previously recommended changes, review of additional changes, and discussion.

All policies were reviewed and discussed.

5.1 Ref. No. 838, Application of Patient Restraints

5.2 Ref. No. 1208, Agitated Delirium

5.3 Ref. No. 1208-P, Agitated Delirium (Pediatric)

5.4 Ref. No. 1209, Behavioral / Psychiatric Crisis

5.5 Ref. No. 1209-P, Behavioral / Psychiatric Crisis (Pediatric)

5.6 Ref. No. 1307, MCG: Care of the Patient with Agitation

5.7 Ref. No. 1307.1, MCG: Flowchart for Initial Approach to Scene Safety

5.8 Ref. No. 1307.2, MCG: Verbal De-Escalation

5.9 Ref. No. 1307.3, MCG: Table of Common Etiologies of Agitation, Field Presentation, Likelihood Verbal De-Escalation

5.10 Ref. No. 1317.32, MCG: Drug Reference – Olanzapine

5.11 Ref. No. 1318, MCG: Evaluation and Care of Patients At Risk of Suicide
[HOLD to Pilot based on Medical Council Feedback]

5.12 Ref. No. 1318.1, MCG: Suicide Risk Screening (C-SSRS) EMT/Firefighter
[HOLD to Pilot based on Medical Council Feedback]

6. NEW BUSINESS:

6.1 Ref. No. 227.1, Dispatch Prearrival Instructions

Approved as presented.

M/S/C (Burgess/Caffey)

6.2 Ref. No. 302, 9-1-1 Receiving Hospital Requirements

Approved as presented.

M/S/C (Burgess/Trites)

6.3 Ref. No. 517, Private Provider Agency Transport Guidelines

Approved as presented.

M/S/C (Sepke/Caffey)

7. OPEN DISCUSSION:

None

8. NEXT MEETING: BHAC's next meeting is scheduled for **December 8**, **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 1:55 P.M.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Holly J. Mitchell
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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Fax: (562) 941-5835

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

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

EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE

MEETING NOTICE

Date & Time: Wednesday, October 13, 2021 10:00 A.M.
Location: Zoom Meeting

DATA ADVISORY COMMITTEE
DARK FOR OCTOBER 2021

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

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, October 20, 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
☑ Jeffrey Rollman	EMSC, Commissioner
☐ Paul Rodriguez	EMSC, Commissioner
☐ Brian Bixler	EMSC, Commissioner
☑ John Hisserich	EMSC, Commissioner
☐ James Lott	EMSC, Commissioner
☐ Carl Povilaitis	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. *(Alt. Rep to Medical Council)*
☑ 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)	
Cathy Chidester	Marianne Gausche-Hill, MD
Richard Tadeo	Nicole Bosson, MD
Kay Fruhwirth	Denise Whitfield, MD
Roel Amara	Kelsey Wilhelm, MD
Jennifer Calderon	Lily Choi
Christine Clare	Elaine Forsyth
Greg Klein	Laurie Lee-Brown
Laura Leyman	Susan Mori
Jacqui Riffenburg	Karen Rogers
Andrea Solorio	John Telmos
Gary Watson	David Wells
Christine Zaiser	

PUBLIC ATTENDEES (Virtual)	
Christina Eclarino	LA County Public Health
Kelsey OYong	LA County Public Health
Angelica Loza-Gomez, MD	Glendale/Montebello FD
Roger Yang, MD	Pasadena FD
Joe Nakagama, MD	Hawthorne PD
Paula LaFarge	LACoFD
Luis Manjarrez	Glendale FD
Jennifer Breeher	Alhambra FD
Ryan Jorgensen	La Habra Heights FD
Adrienne Roel	Culver City FD
Richard Oishi	Arcadia FD
Daniel Dunn	So. Pasadena FD
Catherine Borman	Santa Monica FD
Nanci Medina	LAFD
Alex Wilkie	MedCoast Ambulance
David Konieczny	McCormick Ambulance
Kristina Crews	LACoFD/Compton FD
Sheryl Gradney	LACoFD
Scott Atkinson	Mtn San Antonio College
Craig Hammond	Glendale FD
Jacob Wagoner	Lynch Ambulance
Paul Voorhees	Culver City FD
Erich Ekstedt	Downey FD
Drew Bernard	Emergency Ambulance Svs
Elena Giardino	Ambulnz Ambulance
Benjamin Esparza	

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

2. **INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS**

2.1 Area E Representative

- Ivan Orloff [Downey FD] has stepped down as Area E Representative.
- Kurt Buckwalter [Area E Alternate] will move up to primary Area E Representative.
- Los Angeles Area Fire Chiefs Association (LAAFCA) will be selecting a replacement for Area E Alternate during their next meeting in December 2021.

2.2 Alternate to Medical Advisory Council, Representing PAAC

- Committee approved Clayton Kazan, MD [Area B Alternate], to fill the vacant position as Alternate PAAC representative to Medical Advisory Council.

2.3 FirstWatch® - Realtime Data Analysis *(Richard Tadeo)*

- The EMS Agency applied for a grant to implement a countywide program called FirstWatch®.
- Funds from this grant must be utilized before December 31, 2021.
- The FirstWatch® program provides real-time data on a hospital's status, as it relates to APOT (Ambulance Patient Offload Time). The program will provide the Agency with the ability to see how many ambulances are holding the wall at any particular facility and the length of time they have been waiting to offload. Currently, this is being done via telephone, which at times may take 15-30 minute to process, before a decision can be made to place a hospital on diversion.
- This program is already in place by Los Angeles Fire Department, McCormick Ambulance, Falck (Care) Ambulance and AMR Ambulance.
- The EMS Agency is working with all dispatch centers in Los Angeles County to implement FirstWatch®.
- The EMS Agency will continue to provide updates to this Committee.

3. **APPROVAL OF MINUTES (Zabilski/Hernandez)** August 18, 2021 minutes were approved as written.

4. **REPORTS & UPDATES**

4.1 Disaster Services Update

4.1.1 EMS COVID-19 Vaccination Survey
(Kelsey Oyong, Los Angeles County Department of Public Health)

- There will be a 6-question survey on the COVID-19 vaccination poll going out this week to all providers. The survey is to assist Public Health with tracking the vaccination rates amongst frontline workers and target their outreach.
- Please complete and return this survey by November 15, 2021.
- Questions regarding this survey may be directed to either Kelsey OYong at koyong@ph.lacounty.gov or Jennifer Calderon at jrcalderon@dhs.lacounty.gov

4.1.2 COVID After Action Review – Save the Date *(Elaine Forsyth)*

- EMS providers are invited to attend an after-action review of the County's response to the COVID-19 pandemic on December 1, 2021 at the EMS Agency.
- Registration information will be emailed to all providers next week. Please RSVP to Elaine Forsyth at eforsyth@dhs.lacounty.gov.

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

- Los Angeles County COVID-19 data graphs were presented and reviewed. The number of COVID-19 cases and COVID-19 related deaths continue to decline. There has been no pediatric surge.
- 70% of the general public has received the COVID-19 vaccine and 92% of the elderly have received at least the first vaccine dose.
- Currently, the biggest concern relates to the workforce:
  - All healthcare training schools were impacted by the COVID-19 pandemic. COVID constraints made it nearly impossible to secure on-site clinical hours, making it very difficult to train EMTs and paramedics.
  - As EMS personnel begin to retire or leave the workforce, it's been very problematic to hire replacements.
  - The EMS Agency will continue working to resolve this problem.

4.3 EMS Update 2022 *(Denise Whitfield, MD)*

- EMS Update 2022 is in the planning phase. Possible topics include: behavioral health policies; medication – olanzapine; and use of the I-Gel® device.
- The EMS Agency will be reaching out to the planning Committee members from the previous year. Twice-a-month meetings will begin at the end of November 2021.
- Those interested in participating with the EMS Update 2022 planning Committee, may contact Dr. Whitfield at dwhitfield@dhs.lacounty.gov.

4.4 ITAC Update *(Denise Whitfield, MD)*

- Last meeting was held on August 2, 2021. The following products were reviewed:
  - Reeves Heavy Duty Flexible Stretcher – optional use; approved
  - Talon 90c Quad (as backboard device) – Insufficient data; not approved
  - Dechoker Suction Airway Clearance Device – Insufficient data; not approved
  - BD-IO Intraosseous Needle Device – optional use; approved
- A full list of products reviewed by this Committee is in Reference No. 205.1, ITAC Recommendations.
- Next meeting is scheduled for November 1, 2021 and will be reviewing a video laryngoscope.

4.5 EmergiPress *(Denise Whitfield, MD)*

Next edition will be posted at the end of October 2021 and will include a video module on the ECMO pilot that is being conducting throughout Los Angeles County.

4.6 Data Collaboratives (*Marianne Gausche-Hill, MD)*

- Collaborative groups are working on several projects and publications.
- Tiffany Abramson, MD (Long Beach FD) has a recent publication on hypoglycemia in cardiac arrests.
- Pediatric Collaboratives are working on a BRUE project; tracking of the cardiac arrests data that's being entered into CARES; and a Pedi-Dose trial.
  - The Pedi-Dose trial is called "Pediatric Dose Optimization for Seizures in EMS Update". Funded by the NIH (National Institution of Health), that's looking at standardized dosing, based on age for children.
  - The Los Angeles County EMS system will be able to participate in this trial by having this pilot implemented into Reference No. 1309, Color Code Drug Doses.

- The EMS Agency is developing a steering committee for Pedi-Dose, that will meet quarterly. Several names were submitted to participate in this committee. Thank you to Adrienne Roel, Angelina Loza-Gomez, MD, Caroline Jack, Jenny Van Slyke and Rachel Caffey, for volunteering.
- Others interested in participating in the Pedi-Dose steering committee may contact Dr. Gausche-Hill at MGausche-Hill@dhs.lacounty.gov

4.7 ECMO Pilot *(Nicole Bosson, MD)*

- ECMO Pilot is ongoing. Inclusion criteria for the pilot study was reviewed.
- COVID-19 caused a reduction in the number of enrollments; however, enrollments are now beginning to increase.
- Participating providers include: Santa Monica FD, Culver City FD, Los Angeles County FD, Los Angeles (City) FD and Beverly Hills FD.
- Providers are reminded that only providers who have received EMS Agency approval may participate in this pilot.
- Education regarding this ECMO Pilot will be part of the next Emergi-Press.

4.8 I-Gel® Pilot *(Nicole Bosson, MD)*

- This 4-month pilot concluded with favorable outcome.
- Feedback from participating providers stating the I-Gel® device was easy to place and easy to ventilate.
- Thank you to the participating providers: Pasadena FD, Torrance FD, Culver City FD and Los Angeles County FD.
- The EMS Agency's plan is to implement this device during EMS Update 2022. Providers' input on operational ideas to implement were received.

5. UNFINISHED BUSINESS

5.1 Reference No. 620, EMS Quality Improvement Program *(Susan Mori)*

Policy reviewed and approved as written.

M/S/C (Lara/Dobbs) Approved Reference No. 620, EMS Quality Improvement Program.

5.2 Reference No. 703, ALS Unit Inventory *(John Telmos)*

Policy reviewed and the following changes were approved:

- Replace the Bag-Mask-Ventilation (BMV) sizes to read:
  - "Adult" replaced with "Bag Volume 650-1000 mL"
  - "Pediatric" replaced with "Bag Volume 400-700 mL"
  - "Infant" replaced with "Bag Volume 200-450 mL"
- Add "Thermometer (Oral or axillary)"
- Once approved, changes will be incorporated into all inventory policies.

M/S/C (Miller/Kaduce) Approved Reference No. 703, ALS Unit Inventory; All current inventory policies will reflect these approved changes.

The following policies were presented by Marianne Gausche-Hill, MD; Committee recommendations are listed:

5.3 Reference No. 838, Application of Patient Restraints

Policy reviewed and approved as written.

5.4 Reference No. 1208, Agitated Delirium

Policy reviewed and approved with the following recommendation:

- Special Considerations, No. 3: underline the word “should”

5.5 Reference No. 1208-P, Agitated Delirium (Pediatric)

Policy reviewed and approved with the following recommendation:

- Special Considerations, No. 3: underline the word “should”

5.6 Reference No. 1209, Behavioral / Psychiatric Crisis

Policy reviewed and approved as written.

5.7 Reference No. 1209-P, Behavioral / Psychiatric Crisis (Pediatric)

Policy reviewed and approved with the following recommendation:

- Page 1, No. 8, under “If the patient is cooperative”: remove the word “pediatric”. To read “Olanzapine 10mg ODT for patients longer than the length-based resuscitation tape.”

5.8 Reference No. 1307, MCG: Care of the Patient with Agitation

Policy reviewed and approved as written.

5.9 Reference No. 1307.1, MCG: Flowchart for Initial Approach to Scene Safety

Policy reviewed and approved as written.

5.10 Reference No. 1307.2, MCG: Verbal De-Escalation

Policy reviewed and approved as written.

5.11 Reference No. 1307.3, MCG: Table of Common Etiologies of Agitation, Field Presentation, Likelihood Verbal De-Escalation

Policy reviewed and approved as written.

M/S/C (Miller/Dobbs) Policies were reviewed and approved with recommendations.

- **Approve Reference No. 838, Application of Patient Restraints**
- **Approve Reference No. 1208, Treatment Protocol: Agitated Delirium, with recommendation.**
- **Approve Reference No. 1208-P, Treatment Protocol: Agitated Delirium [Pediatric], with recommendation.**
- **Approve Reference No. 1209, Treatment Protocol: Behavioral / Psychiatric Crisis**
- **Approve Reference No. 1209-P, Treatment Protocol: Behavioral / Psychiatric Crisis [Pediatric], with recommendation.**

- **Approve Reference No. 1307, MCG: Care of the Patient with Agitation.**
- **Approve Reference No. 1307.1, MCG: Flowchart for Initial Approach to Scene Safety.**
- **Approve Reference No. 1307.2, MCG: Verbal De-Escalation (ERASER Mnemonic).**
- **Approve Reference No. 1307.3, MCG: Common Etiologies of Agitation, Field Presentation, Likelihood Verbal De-Escalation.**
- **Approve Reference No. 1317.32, MCG: Drug Reference – Olanzapine, with recommendation.**

5.12 Reference No. 1318, MCG: Evaluation and Care of Patients at Risk of Suicide *(Info Only) (Marianne Gausche-Hill, MD)*

- Policy placed on hold until a pilot study can be conducted.
- Providers interested in piloting policy may contact Dr. Gausche-Hill at MGausche-Hill@dhs.lacounty.gov

5.13 Reference No. 1318.1, MCG: Suicide Risk Screening (C-SSRS) EMT/Firefighter *(Info Only) (Marianne Gausche-Hill, MD)*

- Policy placed on hold until a pilot study can be conducted.
- Providers interested in piloting policy may contact Dr. Gausche-Hill at MGausche-Hill@dhs.lacounty.gov

6. NEW BUSINESS

6.1 Reference No. 1317.32, MCG: Drug Reference – Olanzapine *(Marianne Gausche-Hill, MD)*

Policy reviewed and approved as written.

M/S/C (Zabilski/Van Slyke) Approve Reference No. 1317.32, MCG: Drug Reference - Olanzapine

6.2 Reference No. 227.1, Dispatch Pre-Arrival Instructions *(John Telmos)*

Policy reviewed and approved as written.

M/S/C (Dobbs/Lara) Approve Reference No. 227.1, Dispatch Pre-Arrival Instructions

6.3 Reference No. 302, 9-1-1 Receiving Hospital Requirements *(Richard Tadeo)*

Policy reviewed and approved as written.

M/S/C (Hernandez/Dobbs) Approve Reference No. 302, 9-1-1 Receiving Hospital Requirements

6.4 Reference No. 517, Private Provider Transport Guidelines *(John Telmos)*

Policy reviewed and approved as written.

M/S/C (Lara/Hernandez) Approve Reference No. 517, Private Provider Transport Guidelines

6.5 Reference No. 621, Personnel Change Notification *(Jacqui Rifenburg)*

Policy reviewed and approved as written.

M/S/C (Zabilski/Lara) Approve Reference No. 621, Personnel Change Notification

7. OPEN DISCUSSION

7.1 Clarification – Against Medical Advice (AMA) Policy and Reference Guide *(Richard Tadeo)*

Discussion on two policies:
1. Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene.
2. Reference No. 834.1, Patient Refusal of Treatment/Transport and Treat and Release at Scene – Quick Reference Guide.

To alleviate contradiction between the two policies above, Committee suggested EMS Agency to remove the words "has a medical complaint and" from the heading found in Reference No. 834.1.

EMS Agency will review this request.

7.2 Summary of Policy Changes *(Richard Tadeo)*

- Committee member requests EMS Agency provide annual notifications of all policy changes that were made throughout the year.
- EMS Agency advised Committee that this request will be under review and a response will be presented to Committee.

7.3 Thermometers on Inventory Policies *(John Telmos, Denise Whitfield, MD)*

- Concern was voiced by provider agencies that have proactively purchased no contact thermometers and are currently stocking these on their units and the need to dispose of these and purchase oral or axillary thermometers.
- It was approved by the EMS Agency to replace the no contact thermometers as they malfunction or require replacement, with either an oral or axillary monitor.

8. NEXT MEETING: December 15, 2021

9. ADJOURNMENT: Meeting adjourned at 3:05 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DISPATCH PREARRIVAL INSTRUCTIONS** REFERENCE NO. 227.1

DISPATCH PREARRIVAL INSTRUCTIONS

TABLE OF CONTENTS

This document is a result of review of submitted dispatch protocols to the Los Angeles County EMS Agency. EMS Agency staff have updated these templates for pre-arrival instructions based on the latest available evidence and published guidelines. These templates may be used by Dispatch Centers' administrators in the development of pre-arrival instructions.

BASIC MEDICAL INSTRUCTIONS PROCEDURE

Initial Screening: Evaluate all calls for severity of complaint and possible cardiac arrest

1. **Determine whether the caller is calling for himself/herself or someone else. If the caller is calling for someone else, immediately after confirming location ask the following screening questions:**
    a. **Is the person alert?**
        i. **Check for response to verbal or other stimuli**
    b. **Is the person breathing normally?**

2. **If the answer to both is 'No' proceed to the age-appropriate cardiac arrest instructions and instruct the caller in CPR. (see below)**

GENERAL MEDICAL for such chief complaints such as:
Abdominal Pain
Back Pain
Chest Pain
Headache
Sick Person (including fainting)
Stroke

1. If alert, allow the patient to rest in a position of comfort.
2. If not alert, rest the patient with the left side down and assess breathing.
3. Do not give the patient anything to eat or drink.
4. Gather the patient's medications.
5. If the patient begins to vomit, turn onto their left side.
6. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

AED INSTRUCTIONS

1. Place the patient on their back.
2. Turn the AED on.
    a. The AED will verbally instruct you of all the steps. Follow prompts spoken by the machine
3. Remove clothing and undergarments to expose the patient's bare chest.
4. If wet, wipe the chest dry.
5. If excessively hairy, consider shaving the chest (some AEDs come with razors).
6. Place the pads adhesive-side down onto the patient's chest as illustrated (on the non-adhesive sides of the pads).

- For adults, place one pad just below the patient's right collar bone (above the nipple) and the other pad below and outside to the left nipple (for women, place the left pad just below the intra-mammary fold).
- For children, place one pad in the middle of the chest (between the nipples) and the other pad in the middle of the back (between the shoulder blades).

7. Assure that the two pads are plugged into the AED.
8. Once pads are placed, allow the machine to analyze the patient. Do not touch the patient during this time.
9. If shock is advised, yell "clear" and assure that no one is touching the patient. Once clear, press the shock button. If shock is not advised or the patient does not improve after 1st shock, resume 2 minutes of chest compressions before analyzing again.

ALLERGIC REACTION/ANAPHYLAXIS

1. If alert, allow the patient to rest a position of comfort.
2. If not alert, rest the patient on their left side and assess breathing.
3. Refer to BREATHING PROBLEMS instructions as needed.
4. If the patient has a history of severe allergic reaction to the same allergen and is prescribed an epinephrine auto-injector (e.g., Epi-Pen), assist with administration. Refer to the epinephrine auto-injector instructions as needed.
    a. Remove cap but do not press on the top of the cap; this will release the needle); place on outer thigh about 6 inches above the knee cap; press down firmly (the needle can puncture clothing); count to "three" before removal; do not throw away but place to the side.
    b. If another form of auto-injector is available, refer to those instructions for administration.
5. If the patient was stung by an insect such as a bee or wasp, remove the stinger by scraping the stinger away with a finger nail or with the edge of a credit card.
6. Once the stinger is removed, rinse the area with soap and water as able and apply a cold pack to affected part.
7. Do not give the patient anything to eat or drink.
8. Gather the patient's medications.
9. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

BEHAVIORAL PROBLEMS

1. Observe the patient from a safe distance. If safety is in doubt, leave the scene.
2. Be calm and reassuring and avoid sudden movements.
3. Do not attempt to restrain the patient.
4. If hanging, cut the patient down immediately.
5. Refer to BLEEDING, BREATHING PROBLEMS or INGESTION/OVERDOSE/POISONING instructions as needed.
6. Tell the patient to rest in the most comfortable position.
7. Do not give the patient anything to eat or drink.
8. Gather the patient's medications if safe to do so.
9. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

BITES/STINGS

1. If alert, allow the patient to rest in a position of comfort.
2. If not alert, rest the patient on their left side and assess breathing.
3. Refer to BREATHING PROBLEMS instructions as needed.
4. If the patient has a history of severe allergic reaction to the same allergen and is prescribed an epinephrine auto-injector (e.g., Epi-Pen), assist with administration. Refer to the EPI-PEN or other epinephrine auto-injector as needed; refer to ALLERGIC REACTION.
5. Provide local wound care:
    - **Hymenoptera (ants, bees, wasps):** remove the stinger by scraping with fingernail or edge of a credit card. Once the stinger is removed, apply a cold pack to the affected part.
    - **Mammalian bites (cats, dogs, humans):** immobilize affected part below heart level. If bleeding, apply direct pressure.
    - **Marine envenomation and toxins**: if the stingray spine is deeply embedded into the skin do not remove it. For other marine envenomations, remove the barb/stinger and immerse affected part in warm water (stingray); apply vinegar and immerse affected part in warm water (jellyfish).
    - **Snake and spider bites:** immobilize affected part below heart level. Do NOT apply ice, a tourniquet. Do NOT attempt to “suck” venom out of affected part.
6. Do not give the patient anything to eat or drink.
7. Gather the patient’s medications.
8. Monitor the patient’s level of consciousness and breathing; call back if the patient’s condition worsens.

BREATHING PROBLEMS

1. If alert, allow the patient to rest in a position of comfort.
2. If not alert, rest the patient on their left side and assess breathing.
3. If unresponsive and not breathing (or breathing abnormally), refer to CARDIAC ARREST instructions.
4. Refer to the ALLERGIC REACTION or CHOKING instructions as needed.
5. Calmly reassure the patient to take slow, deep breaths.
6. If the patient takes medication for a known breathing problems (asthma, COPD), assist with administration of inhaler.
7. Do NOT encourage the patient to breathe into a paper bag.
8. If a pediatric patient is conscious without signs of choking, allow the patient to sit on parent’s lap and do not attempt to look into the child’s mouth.
9. Do not give the patient anything to eat or drink.
10. Gather the patient’s medications.
11. Monitor the patient’s level of consciousness and breathing; call back if the patient’s condition worsens.

BURNS

1. Confirm scene safety and evacuate the area.
2. If the patient is on fire, STOP-DROP-ROLL (with or without a blanket) or douse with water.
3. Provide local wound care:
    - **Chemical burn:**
        - dry chemical- gently brush off with something other than bare hand
        - wet chemical- flush with large amounts of water.
    - **Electrical burn:** if the patient is still in contact with the electrical source, **do not touch the patient.** If appliance can be unplugged or electrical switch turned off safely then do so.
    - **Thermal burn:** cool with water, but stop cooling if patient begins shivering, and remove jewelry in affected area.
4. Do not give the patient anything to eat or drink.
5. Gather the patient's medications.
6. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

CARDIAC ARREST: ADULT AND CHILD

1. Verify that the patient is unresponsive and not breathing (or is breathing abnormally).
2. Place the patient on a flat, hard surface backside down.
3. Place the heel of one hand in the middle of patient's chest (on the breastbone) and place your other hand on top of the first hand.
4. Interlock your fingers.
5. Begin compressions at a rate of at least 100-120 compressions/minute at a depth of 2 inches and allow for complete recoil; rate can be estimated by singing the song "Stayin' Alive".
6. Continue compression-only CPR until AED or help arrives.
7. Once available, set-up the AED. Refer to the AED instructions as needed.
8. If shock is not advised or the patient does not improve after 1st shock, resume 2 minutes of CPR before analyzing again.

CARDIAC ARREST: PEDIATRIC (infant from birth to 1 year)

1. Verify that the patient is unresponsive and not breathing (or is breathing abnormally).
2. Place the patient on a flat, hard surface backside down.
    - Infants: Hands encircle the chest with thumbs between the nipples in the center of the chest; compress at a depth of 1.5 inches.
3. Begin compressions at a rate of at least 100 to 120 compressions/minute and allow for complete recoil.
4. Optional to give rescue breaths if dispatch operator feels rescuer able to understand and follow instructions - 30 chest compressions followed by 2 breaths (30:2).
    - Begin with head-tilt, or chin-lift.
    - Cover the patient's mouth and nose while providing breaths.
    - Blow until rescuer observes chest rise, allow for exhalation and repeat the breath.

5. Continue 30:2 for 2 minutes (about 5 cycles) before switching rescuer roles (if available).
6. If unable or unwilling to provide breaths, continue compression-only CPR until AED or help arrives.

CARDIAC ARREST: NEWBORN

1. After drying and stimulating the newborn, verify that the baby is unresponsive and not breathing (or is breathing abnormally).
2. Place the patient on a flat, hard surface backside down.
3. Encircled hands around chest and supporting the back, and place 2 thumbs in the middle of the patient's chest (on the breastbone)
4. Optional to begin 3 compressions followed by 1 breath (3:1) and allow for complete recoil.
    - Head-tilt, chin-lift.
    - Cover both the patient's nose and mouth with your mouth while providing small breaths.
    - Observe chest rise.
5. Continue for 2 minutes before switching rescuer roles (if available)
6. If unable or unwilling to provide breaths, continue compression-only CPR until help arrives.

CHILDBIRTH

1. Is the baby already born?
    - Yes: Dry and stimulate the baby. Is the baby breathing?
        - Yes: Proceed to Step 6.
        - No: Refer to the CARDIAC ARREST: NEWBORN instructions.
    - No: Proceed to Step 2.
2. Have the mother remove all clothing from waist-down.
3. Assist the mother onto a clean, safe surface such as a bed or floor, backside down.
    - If the woman states she is ready to push, or if the head is visible in the vaginal opening birth is imminent (about to occur)
    - If possible, place a plastic sheet with a bed sheet or newspaper down to absorb the liquid and obtain towels to dry the baby once delivered.
    - Help the woman lie down with her legs apart and back supported by a rolled towel or pillow.
    - Use plastic disposable gloves if available. If gloves not available, wash your hands.
    - Often women grab their knees, squat or lie on the left side. Allow her to do as she prefers.
4. Look for a presenting part of the baby:
    - Nothing: encourage the mother not to push. Continue to monitor for a presenting part.
    - Head (normal): Proceed to Step 5.
    - Arm, foot (breech): Proceed to Step 7.
    - Cord (prolapsed cord): Proceed to Step 8.
5. Normal delivery (head first)
    - If the baby's head is visible in the vaginal opening, the birth is about to occur.

- Encourage the mother to exhale and push with each contraction. Several contractions may be required to deliver the baby.
- Gently place one hand on the top of the baby's head to prevent the baby from delivering too quickly.
- Do not try to hurry the birth by pulling on the baby's head. Let the woman push the baby out.
- When the head is outside of the vagina, put two fingers along the top side of the head and feel around the neck area for a loop of the umbilical cord. It will be about the thickness of your little finger. If you can feel it, hook the loop of cord with your two fingers and slide it gently over the baby's head.
- Assist the delivery by supporting the baby's head and shoulder. The baby may turn as it exits the vagina but do not pull or yank on the baby.
- Be careful during delivery as the baby is slippery; have a dry towel available to quickly dry the baby removing membranes from the birth sac around the nose and mouth.
- Dry and stimulate the baby. Is the baby breathing?
    - Yes: Proceed to Step 6.
    - No: Refer to the CARDIAC ARREST: NEONATE instructions.

6. Post-delivery
    - Dry the baby, wrap the baby (excluding the face) in a clean, dry blanket or towel, and place the baby on the mother's chest or abdomen for warmth. You do not need to remove the whitish sticky substance on the baby's skin. Discard wet towels.
    - Do not cut the umbilical cord keep the baby at the level of the mother's stomach and lower chest and await EMS providers to clamp and cut the cord.
    - The placenta may deliver if so do not pull on the cord but allow the placenta to deliver naturally. Save the placenta for the EMS personnel when they arrive. Place the placenta in a plastic trash bag and set on the bed next to the mother or place on a table at the level of the baby being held by mother until EMS arrives;
    - If the mother continues to bleed after the placenta (afterbirth) delivers, firmly massage the mother's lower abdomen.
    - Continue to re-assess the baby and mother until help arrives.
7. Breech delivery:
    - If the presenting part is not the head, assist the mother into 1 of 2 positions:
        - While still laying backside down, elevate/prop up the mother's hips up high.
        - Roll the mother onto her hands/elbows and knees.
    - Encourage the mother to breathe deeply and not to push with each contraction.
    - Continue to re-assess the mother until help arrives.
8. Cord Prolapse:
    - Elevate the presenting part of the cord; don't push the cord back inside the mother.
    - Continue elevating the presenting part until help arrives.

CHOKING: ADULT and CHILD (1-8 years old)

1. Patient is conscious:
    - **Partial obstruction (able to breath, cough, cry, speak)**: calmly reassure the patient and encourage continued coughing to expel the object. Continue to carefully monitor for decompensation to complete obstruction.
    - **Complete obstruction (unable to breath, cough, cry, speak)**:
        - Perform abdominal thrusts only if the patient is able to stand and is conscious
            - From behind, wrap your arms around the patient's abdomen.
            - Make a fist just above the patient's belly button. Wrap one hand over the other.
            - Quickly and forcefully, jerk inward and upward on the patient's stomach.
            - Repeat until the object is expelled or the patient becomes unconscious (see below).
        - Chest thrusts:
            - If the patient is pregnant or obese, chest thrusts can be done in lieu of abdominal thrusts.
            - From behind, wrap your arms around the patient's chest.
            - Make a fist in the middle of the patient's chest (breastbone).
            - Quickly and forcefully, jerk into the patient's chest.
            - Repeat until the object is expelled or the patient becomes unconscious (see below).
2. Patient is not conscious:
    - Adult:
        - Refer to the CARDIAC ARREST: ADULT instructions.
        - Caveat: prior to breaths, look in the patient's mouth for expelled object and, if visible in the mouth, carefully remove with your fingers – do not attend blind finger sweeps as the foreign body could be pushed deeper in the throat.
    - Child:
        - Refer to the CARDIAC ARREST: PEDIATRIC instructions.
        - Caveat: prior to breaths, look in the patient's mouth for expelled object and, if visible in the mouth, carefully remove with your fingers– do not attend blind finger sweeps as the foreign body could be pushed deeper in the throat.

CHOKING: INFANT (<1 years old)

1. Patient is conscious:
    - **Partial obstruction (able to breath, cough, cry, speak)**: calmly reassure the patient and encourage continued coughing to expel the object. Continue to carefully monitor for decompensation to complete obstruction.
    - Complete obstruction **(unable to breath, cough, cry, speak)**:
        - From a seated position, place the infant on your forearm facedown, keeping the head lower than the body.
        - With the heel of your hand, deliver 5 back blows between the shoulder blades.

    - Turn the infant over and place 2 fingers in the middle of the patient's chest (on the breastbone) and deliver 5 chest compressions at a depth of 1.5 inches each.
    - Repeat until the object is expelled, is visible in the mouth and can be removed, or the patient becomes unconscious (see below).
2. Patient is not conscious:
    - Refer to the CARDIAC ARREST: PEDIATRIC instructions.
        - Caveat: prior to breaths, look in the patient's mouth for expelled object and, if visible in the mouth, carefully remove with your fingers– do not attend blind finger sweeps as the foreign body could be pushed deeper in the throat.

COLD EXPOSURE

1. If possible, move the patient to a warm, sheltered area out of cold air, wind, or water spray.
2. If hypothermia is suspected:
    - Remove wet clothing and wrap the patient in dry clothing and/or blankets.
    - Do not give the patient alcohol or caffeine (may worsen hypothermia).
3. If frostbite is suspected:
    - Wrap or cover affected part with something dry and warm.
    - Elevate affected part.
    - Do not rub or place affected part in hot water.
4. Do not give the patient anything to eat or drink.
5. Gather the patient's medications.
6. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

CONVULSIONS/SEIZURES

1. Still seizing:
    - Do not attempt to restrain or hold the patient down.
    - Do not place anything in the patient's mouth.
    - Move objects away from the patient.
    - Stay on the phone until the seizure stops and then verify that the patient is breathing.
    - Saliva from the mouth can be wiped away with a dry towel.
2. Stopped seizing:
    - Rest the patient on their left side with right knee forward in recovery position.
    - Do not give the patient anything to eat or drink.
    - Gather the patient's medications.
    - Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

DIABETIC PROBLEMS

1. If alert, allow the patient to rest in the most comfortable position.
    - If low blood sugar is suspected (hypoglycemia), give the patient candy, juice, non-diet soda, or any other form of sugar.
2. If not alert, rest the patient on their left side and assess breathing.
    - Do not give the person anything to eat or drink.
3. If the patient begins to vomit, turn onto their left side.
4. Gather the patient's medications.
5. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

EMERGING INFECTIONS (e.g. Ebola)

1. Confirm that the patient has travelled to the affected area of the world and is presenting with concerning signs or symptoms, such as fever and bleeding.
2. Ask other individuals in the area to remove themselves from the immediate area, but not to leave the scene/ property.
3. Responding EMS units may contact the Public Health Officer for additional instruction 24/7 at 213-974-1234.

EYE INJURIES

1. If **chemical injury**, flush the affected eye with tap water continuously. Take care to flush from nose to ear, avoiding the unaffected eye.
2. If there is an **impaled or penetrating object** in the affected eye, do not remove the object. If possible, attempt to stabilize object in place.
3. If **blunt injury**, sit the patient upright and calmly reassure them.
4. Do not put pressure on the affected eye.
5. Do not put drops or ointment into the affected eye.
6. Do not give the patient anything to eat or drink.
7. Gather the patient's medications.
8. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

HEAT EXPOSURE

1. If possible, move the patient to a cool, well-vented area out of direct sunlight or away from other source(s) of heat.
2. If the patient is trapped in an automobile and is conscious, call police. If unconscious, attempt to safely break the window. Refer to the UNCONSCIOUS instructions as needed.
3. Remove outer clothing.
4. If very hot, apply room-temperature to cool (not cold nor iced) water to the patient's skin. Use fans if available.
5. If available, apply cold packs (indirectly) to the armpits or groin.
6. If alert, allow the patient to rest in a position of comfort.
7. If not alert, rest the patient on their L-side and assess breathing.

INGESTION/OVERDOSE/POISONING

1. Refer to the BREATHING PROBLEMS and CONVULSIONS/SEIZURES instructions as needed.
2. If alert, allow the patient to rest in a position of comfort.
3. If not alert, rest the patient on their left side and assess breathing.
4. Do not give the patient anything to eat or drink.
5. Gather the patient's medications, including empty pill bottles.
6. If the patient begins to vomit, turn onto their left side.
7. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

UNCONSCIOUS (including "MAN DOWN")

1. If the patient is not breathing, refer to the CARDIAC ARREST instructions.
2. If the patient is having difficulty breathing, refer to the BREATHING PROBLEMS instructions.
3. If alert, allow the patient to rest in the most comfortable position.
4. If not alert, rest the patient on their left side and assess breathing.
5. Look for a medical alert bracelet/necklace.
6. Do not give the patient anything to eat or drink.
7. Gather the patient's medications.
8. If the patient begins to vomit, turn onto their left side.
9. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

TRAUMA INSTRUCTIONS

GENERAL TRAUMA for such chief complaints such as:
Falls – Injury - Motor Vehicle Collisions (MVCs)

1. Do not move an injured patient unless they are in immediate risk of danger/injury.
2. If an injured patient must be moved, stabilize the neck and log-roll the body as a unit.
3. If an **amputation** or **severe bleeding** is present, apply continuous, firm, direct pressure and refer to the BLEEDING instructions as needed.
4. If a **fracture** is suspected, do not move the affected part; stabilize in the position found.
5. If an **impaled object** is present, do not pull or remove the object. If possible, attempt to stabilize object in place.
6. Do not give the patient anything to eat or drink.
7. Gather the patient's medications.
8. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.
9. If time and scene safety allow, ask potential witnesses to remain on scene until responders arrive.

ASSAULT

1. Confirm scene safety and advise putting a barrier between the patient and the assailant (door, wall).
2. Do not move an injured patient unless they are in immediate risk of danger/injury.
3. Reassure the patient that help is on the way.
4. Encourage the patient not to change, bathe, shower, or go to the bathroom.
5. Encourage the patient not to disturb the scene or move weapons.
6. Refer to BLEEDING instructions as needed.
7. Do not give the patient anything to eat or drink.
8. Gather the patient's medications.
9. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

BLEEDING

1. Control bleeding with continuous, firm, direct pressure. If more pressure is needed for bigger wounds, use the heel of your hand or knee.
2. For extremity wounds where bleeding is not controlled with direct pressure, place a commercial tourniquet per manufacturer instructions, if available, secured tightly until the bleeding stops completely. For tourniquet with windlass, apply at least three turns or more Place amputated part(s) into a clean, dry bag. Do not place in liquid or on ice.
3. Do not remove impaled objects, attempt to stabilize object in place.
4. For a nosebleed, have the patient sit up straight, lean forward slightly, and pinch just below the nasal bridge between their index finger and thumb.
5. Do not give the patient anything to eat or drink.
6. Gather the patient's medications.
7. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

DIVING/DROWNING

1. Patient in water:
    - **Deep water:** throw a flotation device or rope to the patient. Do not go into water unless safe to do so.
    - **Shallow water:** consider neck or spinal injury.
        - If neck injury is suspected and the patient is **breathing**, stabilize the neck and support the patient's body until the patient can safely be removed from water.
        - If neck injury is suspected and the patient **not breathing**, stabilize the neck, remove the patient from water, and begin CPR. Refer to the CARDIAC ARREST instructions.
2. Patient out of water:
    - **Not breathing:** begin CPR. Refer to the CARDIAC ARREST instructions.
    - **Breathing:** rest the patient on their left side.
    - Do not give the patient anything to eat or drink.
    - Gather the patient's medications.
    - Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

ELECTROCUTION

1. Confirm scene safety and advise caller of continued risks such as electrified water (standing water which may conduct electricity).
2. Check to see if the patient is free from current: if no or unsure, do not touch the patient or source of current.
3. If safe to do so, turn power off: disconnect from the wall (appliance) or turn off the main breaker (home). If near downed utility pole, obtain number of adjacent pole only if visible and safe to do so. *(Dispatcher: contact utility company with pole number).*
4. Only touch the patient if the power has been confirmed off.
5. If alert, allow the patient to rest in the most comfortable position.
6. If not alert, rest the patient on their left side and assess breathing.
7. If unresponsive and not breathing (or breathing abnormally), refer to the CARDIAC ARREST instructions.
8. Refer to the BURNS and GENERAL TRAUMA instructions as needed.
9. Do not give the patient anything to eat or drink.
10. Gather the patient's medications.
11. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

PENETRATING INJURY (including GUNSHOT and STAB injuries)

1. Confirm scene safety. If safety is in doubt, leave the scene.
2. Avoid disrupting the scene— do not touch or move weapons.
3. Do not pull or remove impaled object. If possible, attempt to stabilize object in place.
4. Control bleeding. Refer to the BLEEDING instructions as needed.
5. If internal organs are exposed, cover with a clean dry cloth.
6. Do not give the patient anything to eat or drink.
7. Gather the patient's medications.
8. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

ADDITIONAL INSTRUCTIONS

CARBON MONOXIDE INHALATION

1. Confirm scene safety and evacuate the area to the outside.
2. If the patient cannot be evacuated, ventilate the area by opening doors and windows (as long as patient is not trapped in a structure fire).
3. Refer to the BURNS instructions as needed.
4. If alert, allow the patient to rest in a position of comfort.
5. If not alert, rest the patient on their left side and assess breathing.
6. Do not give the patient anything to eat or drink.
7. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

TRAPPED IN CONFINED SPACE (including INDUSTRIAL ACCIDENT)

1. Confirm scene safety and advise caller of continued risks such as running machinery.
2. If safe to do so, shut off running machinery.
3. Do not remove a trapped patient.
4. Refer to the GENERAL TRAUMA instructions as needed.
5. Determine a location to meet rescuers and assign someone to meet them.
6. Assign someone to gather maintenance/mechanical staff to assist rescuers with machinery.
7. Monitor the patient's level of consciousness and breathing; call back if the patient's condition worsens.

TRAPPED IN STRUCTURE FIRE

1. Re-confirm caller location (address, floor, room number/type, location within room).
2. Close the door (do not lock).
3. Cover nose and mouth with thin material such as a shirt.
4. Cover crack between door and floor with a towel, rug, or anything else that is readily available.
5. Do not open or break windows.
6. Hang an object such as a white sheet from the window to signal help.
7. Do not jump from great heights (> 2 stories or 20 feet).

TRAPPED IN SUBMERGED VEHICLE

1. Unbuckle your seat belt.*
2. Unlock but do not open the door.
3. Roll down the window— break it if necessary. (Reassure caller that this may feel counterintuitive but that this is their best chance of survival).
4. Exit through the window.
5. If unable to exit through the window, breathe within the vehicle's air pocket until the vehicle has filled with water.
6. Once the vehicle has completely filled with water the door will open easier.
7. Take a deep breath, exit through the door, and swim toward the surface.*

*If children are present, unbuckle their seatbelt(s) after releasing your own. Help propel/push them out of the submerged vehicle prior to your exit.

Reference No. 227.1 Dispatch Prearrival Instructions

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/21/20	10/21	N
	Base Hospital Advisory Committee	10/13/21	10/13/21	N
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITAL)

SUBJECT: **9-1-1 RECEIVING HOSPITAL STANDARDS**

REFERENCE NO. 302

PURPOSE: To outline the guidelines to be approved as a 9-1-1 receiving hospital.

AUTHORITY: Health & Safety Code 1797.88, 1798.175(a)(1)(2)

DEFINITIONS:

9-1-1 Receiving Hospital: A licensed, general acute care hospital with a permit for basic or comprehensive emergency medical service and approved by the Los Angeles County Emergency Medical Services (EMS) Agency to receive patients with emergency medical conditions from the 9-1-1 system.

Advanced Cardiovascular Life Support (ACLS): Resuscitation course that is recognized by the EMS Agency (e.g., American Heart Association, American Red Cross).

Ambulance Arrival at the Emergency Department: The time the ambulance stops (actual wheel stop) at the location outside the hospital emergency department where the patient is unloaded from the ambulance.

Ambulance Patient Offload Time (APOT): The time the patient is physically transferred from the ambulance equipment on to the hospital equipment and hospital staff assume care of the patient. The Standard for Los Angeles County is 90% of all ambulance transports have an APOT of 30 minutes or less.

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

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

Emergency Department (ED) Nurse Leader: A Registered Nurse currently licensed to practice in the State of California.

Emergency Department (ED) Medical Director: A physician licensed in the State of California, Board Certified in Emergency Medicine (EM) or Pediatric Emergency Medicine (PEM) and privileged by the hospital in EM.

Pediatric Advanced Life Support (PALS): Pediatric Resuscitation course that is recognized by the EMS Agency (e.g., American Heart Association, American Red Cross).

VMED28: Formerly known as HEAR (Hospital Emergency Administrative Radio). This is an interoperable radio voice communication system (155.340.156.7) utilized by hospital administrative staff during emergencies. This provides communication redundancy in the event

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

of multiple casualty incidents and disaster situations when normal channels of communication are not available.

PRINCIPLES:

1. Patients who call 9-1-1 receive optimal care when transported to a facility that is staffed, equipped and prepared to administer emergency medical care appropriate to their needs.

2. Emergency departments (ED) equipped with the communications required of 9-1-1 receiving facilities drill regularly with other system participants and can communicate effectively during multi-casualty incidents (MCI) and disasters.

3. Data collection and evaluation is critical to assess system performance and evaluate for educational and improvement needs.

POLICY:

I. General Requirements

9-1-1 Receiving Hospital shall:

A. Be accredited by a Centers for Medicare and Medicaid Services (CMS) recognized Hospital Accreditation Organization within six (6) months of designation

B. Have an Emergency Department open and caring for walk-in patients for a minimum of one (1) month prior to requested date for receiving 9-1-1 patients.

C. Appoint a physician on staff to function as the ED Medical Director.

D. Appoint an administrative manager to function as the ED Nurse Leader.

E. Ensure that at least 60% of the ED attending physicians are BC or BE in Emergency Medicine (EM) or Pediatric Emergency Medicine (PEM). For ED physicians who are not EM or PEM BC or BE, they shall have current ACLS and PALS provider or instructor certification and an affidavit signed by the ED Medical Director and Chief Medical Officer verifying competency in caring for adult and pediatric patients needing all levels of emergency care.

F. Have an operational ReddiNet® terminal with redundant connectivity via satellite and internet.

G. Collaborate with EMS provider agencies to provide and maintain a means of obtaining prehospital electronic patient care records through designated web portal(s) with ability to print records. Paramedic providers are required to document patient care on electronic medical record system. Although, BLS providers are not required by regulations to utilize electronic records, most BLS providers have transitioned from paper-based EMS records to electronic medical record systems.

H. Have VMED28 radio for communication with paramedic providers and the Medical Alert Center during multiple casualty incidents.

I. Maintain a dedicated telephone line to facilitate direct communication with the paramedic base hospitals, 9-1-1 personnel, and the Medical Alert Center.

J. Have an interfacility transfer policy, approved by the EMS Agency, that addresses the following:

1. For hospitals that are not designated Trauma, STEMI, Stroke, EDAP, PMC or SART centers, transfer policies shall address higher level of care transfers to Specialty Care Centers.

2. For designated Specialty Care Centers, transfer policies shall be established with surrounding referral facilities.

3. Compliance with Title XXII transfer requirements and Emergency Medical Treatment and Active Labor Act (EMTALA) to include: accepting physician and confirmation that the receiving facility has capacity, capability and qualified personnel to treat the condition.

4. Mechanisms to obtain appropriate transportation for the effective interfacility transfer of patients which should include written agreements with private ambulance companies.

5. Utilization of 9-1-1 for interfacility transfer is only for patients who meet specific Trauma Re-Triage criteria (Ref. No. 506 and 506.2) or confirmed STEMI patients (Ref. No. 513.1)

a. A mechanism shall be implemented to ensure that each transfer for which 9-1-1 was used is tracked reviewed for appropriateness, with corrective measures taken when indicated to ensure proper use of resources.

b. All transfers utilizing the 9-1-1 system should be logged, with documentation of the results of the review

J. Execute and maintain a Specialty Care Center Designation Master Agreement – Exhibit A-5, 9-1-1 Receiving Facility, with the EMS Agency.

K. Provide updated contact information to the base hospital(s) and the EMS Agency whenever there is a change in key personnel as per Ref. No. 621.

L. Maintain an accurate list of hospital services and contact information in the ReddiNet® for disaster and MCI purposes.

M. When implemented, collect and submit data to the EMS Agency on all patients transported via the 9-1-1 system. Data submission requirements are defined in Ref. No. 610, 9-1-1 Receiving Hospital Data Dictionary.

N. Have a process to ensure that all patients transported via ambulance are offloaded in a timely manner and transfer of care to hospital staff meets the current Ambulance Patient Offload Time (APOT).

O. Have a mechanism in place to ensure physician consultation is available for medical services provided.

P. Respond timely and participate in all EMS requested drills/surveys including, but not limited to: MCI drills, annual Hospital Impact Survey, National Pediatric Readiness Project.

II. ED Leadership Requirements

A. ED Medical Director responsibilities:
1. Acts as a liaison to the EMS Agency as it relates to EMS practices and policies
2. Collaborates with the ED Nurse Leader to ensure on-going compliance with these Standards
3. Stays current on LA County EMS policies
4. Ensures on-going education of ED physician staff in the care of adult and pediatric patients as well as current EMS policy

B. ED Nurse Leader responsibilities:
1. Collaborates with the ED Medical Director to ensure on-going compliance with these Standards.
2. Act as a liaison to the EMS Agency.
3. Stays current on LA County EMS policies
4. Ensures on-going education of ED staff in current EMS policy

III. Procedure for Approval to be a 9-1-1 Receiving Hospital

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

1. The rationale for the request to be a 9-1-1 receiving hospital.

2. A document verifying the hospital has a permit for basic or comprehensive emergency medical service.

3. Proof of accreditation by a CMS-approved accrediting organization within six (6) months of designation.

4. Most recent two (2) months, (current and previous months) of ED physician schedules, along with proof of BC or BE in EM or PEM. For those ED physicians who are not BC or BE, provide copies of current ACLS certification and signed affidavit.

5. Number of patients treated during the previous month in the following categories:
a. Total ED visits
b. Total admitted to the ICU (not just from the ED)
c. Cardiac arrests (hospital-wide)

d. Total surgical cases requiring general anesthesia
e. Total interfacility transfers for higher level of care

6. Interfacility transfer policy and all transfer and transport agreements.

7. The proposed date the emergency department (ED) would open to 9-1-1 traffic.

B. Site Visit

1. Once all required communication systems are installed and hospital staff training on the equipment is complete, the EMS Agency will coordinate a site visit.

2. Administrative and field personnel from local EMS provider agencies will be invited to exchange contact information, participate in the VMED28 and the ReddiNet® system tests, and become familiar with the physical layout of the facility.

3. Representatives from the nearest paramedic base hospital (Administrative, Medical Director and/or Prehospital Care Coordinator) will provide contact information, explain the role and function of the paramedic base, and discuss how patient information is communicated to the surrounding 9-1-1 receiving hospitals.

4. EMS Agency role at the site visit:

a. Conduct ReddiNet® drill and VMED28 test

b. Explain the role of the Medical Alert Center and provide contact information

c. Discuss disaster preparedness activities

d. Review the Prehospital Care Policy Manual, Treatment Protocols and other relevant materials:
i. Ref. No. 502, Patient Destination
ii. Ref. No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients
iii. Ref. No. 503.1, Hospital Diversion Request Requirements for Emergency Department Saturation
iv. Ref. No. 506.2, 9-1-1 Trauma Re-Triage
v. Ref. No. 513.1, Interfacility Transport of Patients with ST-Elevation Myocardial Infarction
vi. Ref. No. 620.2, Notification of Personnel Change
vii. EMS Agency staff contacts
viii. Paramedic Base hospital/receiving hospital contacts
ix. EMS Agency meeting calendar
x. Situation Report/Problem resolution
xi. EmergiPress

e. Conduct an exit interview to include outstanding items needed and timeline as to when hospital can expect to be designated as 9-1-1 receiving.

IV. Receipt of Ambulance Transports

A. All 9-1-1 Receiving Hospitals shall have a process to ensure that all patients transported via ambulance are offloaded in a timely manner and transfer of care to hospital staff meets the current Ambulance Patient Offload Time (APOT).

1. An ambulance crew that has been waiting in excess of 60 mins shall notify their immediate supervisor and the department charge nurse.

2. The ambulance provider shall notify their dispatch center of the extended wall time and to begin tracking.

CROSS REFERENCES:

Prehospital Care Manual:
Reference No. 304, **Role of the Base Hospital**
Reference No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**
Reference No. 503.1, **Hospital Diversion Request Requirements for Emergency Department Saturation**
Reference No. 506, **Trauma Triage**
Reference No. 506.2, **9-1-1 Trauma Re-Triage**
Reference No. 610, **9-1-1 Receiving Hospital Data Dictionary**
Reference No. 621, **Notification of Personnel Change**
Reference No. 621.1, **Notification of Personnel Change Form**
Reference No. 513.1, **Emergency Department Interfacility Transport of Patients with ST-Elevation Myocardial Infarction**

Reference No. 302, 9-1-1 Receiving Hospital Standards

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/20/2021		
	Base Hospital Advisory Committee	10/13/2021	10/13/2021	
	Data Advisory Committee			
	Medical Council			
OTHER COMMITTEES/RESOURCES	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Pediatric Advisory Committee			
	County Counsel			
	Other:			
	HASC – Emergency Health Services Committee	7/19/21	9/29/21	Y

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

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

Reference No. 302, 9-1-1 Receiving Hospital Standards

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definition	HASC – EHS Committee	Replace ED Clinical Manager with ED Nurse Leader	Adopted
Definition	HASC – EHS Committee	Add definition for VMED 28 radio	Adopted
Policy I.G.	HASC – EHS Committee	Elaborate on the requirement for electronic documentation for paramedics and EMTs	Adopted
Policy I.J.	HASC – EHS Committee	Clarify the requirement for interfacility transfer policy to delineate between specialty care centers and referral facilities	Adopted
Policy I.M.	HASC – EHS Committee	Add “When implemented” at the beginning of the sentence	Adopted
Policy I.O.	HASC – EHS Committee	Replace the phrase “capabilities for all patients needing care, including but not limited to, psychiatric, orthopedic and general surgery. This can be met with call panels or telemedicine agreement.” with “is available for medical services provided.”	Adopted
Policy III.A.5.	HASC – EHS Committee	Add “e. Total interfacility transfers for higher level of care”	Adopted
Policy IV.	HASC – EHS Committee	Delete the statement “All 9-1-1 Receiving Hospitals shall have a mechanism to reimburse Ambulance Providers for extended APOT”	Adopted

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **PRIVATE PROVIDER AGENCY TRANSPORT/RESPONSE GUIDELINES** REFERENCE NO. 517

PURPOSE: To provide guidelines for private ambulance providers handling requests for emergency and non-emergency transports.

AUTHORITY: Los Angeles County Code, Title 7, Business License, Division 2, Chapter 7.16
Health & Safety Code, Division 2, Section 1250,
Health & Safety Code, Division 2.5, Sections 1797.52 - 1797.84, California Code of Regulations Section 100174
California Code of Regulations, Title 13, Division 2, Chapter 5. Special Vehicles, Article 1. Ambulances
Emergency Medical Treatment and Labor Act of 2006 (EMTALA)

DEFINITIONS:

Emergency Medical Condition: A condition or situation in which an individual has an immediate need for medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure – except in isolated asymptomatic hypertension, oxygen saturation) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification (as listed in Ref. No. 1200.1 Treatment Protocols General Instructions) are also considered to have an emergency medical condition. These conditions include, but is not limited to, the following:

- Anaphylaxis
- Cardiopulmonary arrest
- Bradydysrhythmias and Tachydysrhythmias
- Patients in labor
- Persistent altered level of consciousness (new onset)
- Respiratory distress and/or failure
- Signs or symptoms of shock
- Signs and symptoms of stroke
- Status epilepticus
- Suspected cardiac chest pain or discomfort
- Severe traumatic injuries

Extremis: A life-threatening, time critical situation (e.g., unmanageable airway, uncontrollable hemorrhage) that, without immediate stabilization, could result in serious and immediate jeopardy to the health of an individual (in the case of a pregnant woman, the health of the woman or her unborn child), such that the patient's life would be jeopardized by transportation to any destination but the most accessible receiving (MAR) facility.

Health Facility: A health facility may include, but not limited to, any of the following:

General Acute Care Hospital
Skilled Nursing Facility

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

Clinic/Urgent Care Center
Physician Office
Dialysis Center
Intermediate Care Facility
Acute Psychiatric Facility

Interfacility Transport (IFT): The transport of a patient from one health facility to another health facility as defined above.

Response Time: The time from initial dispatch to arrival at the physical location/address of incident

9-1-1 Response: An emergency response by the primary emergency transportation provider or its designee for that geographic area in which the response is requested. Requests for a 9-1-1 response are generally made by the public but may include requests from health facilities.

PRINCIPLES:

1. A private provider agency must be licensed by the County of Los Angeles as a Basic Life Support provider. Each of the company's ambulance vehicles that operate within the County of Los Angeles shall also be licensed by the County.

2. Private provider agencies are prohibited from dispatching an ambulance to any call that would normally be considered an emergency 9-1-1 call for the authorized emergency transportation provider for that geographical area. A private provider agency may only dispatch an ambulance to such a call if the request is from either the 9-1-1 jurisdictional provider or the primary emergency transportation provider requesting backup services.

3. Any ambulance personnel observing the scene of a traffic collision or other emergency should:

    a. Contact their respective dispatch center and request that the jurisdictional 9-1-1 provider agency be notified

    b. Follow the internal policy developed by their employer in regard to stopping at the scene of an observed emergency

4. It is the responsibility of the requested transport provider, in consultation with the facility requesting the transport, to provide the appropriate level of transport (Basic Life Support, Advanced Life Support or Specialty Care Transport) based on the transferring physician's determination of the medical needs of the patient (Refer to Ref. No. 517.1, Guidelines for Determining Level of Interfacility Transport). At minimum, one (1) transport personnel must accompany the patient and occupy the patient compartment at all times.

5. Health facilities shall provide the transport personnel with appropriate transfer documents in compliance with Title 22 and EMTALA transfer requirements.

6. A health facility may not have the staffing and equipment available to assess, treat and/or monitor a patient for extended time frames. Therefore, 9-1-1 emergency responses may be necessary for those patients whose condition may deteriorate while waiting for a private provider response.

7. If it is known that transfer arrangements were not made, the transporting unit shall make every possible effort to contact the receiving facility and advise them of the patient's imminent arrival. This may be done through the provider's dispatch center.

8. Patients with a valid Do-Not-Resuscitate (DNR) form or order shall be transported as outlined in Reference No. 815, Honoring Prehospital Do-Not-Resuscitate Orders.

9. The transferring physician, in consultation with the receiving physician, assumes responsibility for determining the appropriateness of the transfer. It is not the responsibility of the base hospital or the transport personnel to determine whether the transfer is appropriate.

10. Private provider agencies shall ensure that a patient care record (PCR) is completed for each patient transport performed including, but not limited to, critical care transports. The PCR shall include documentation regarding patient monitoring and care during transport, from the time of the patient contact at the sending facility until transfer of care at the receiving health facility or other patient destination. For patients transported to a health facility, each private provider agency shall ensure there is a mechanism in place to provide the receiving facility with a copy of the transport PCR at the time of transfer of care.

POLICY:

I. Transport Modalities

A. Basic Life Support (BLS) Transport

1. Unit is staffed with two EMTs

2. Requests may be for emergency or non-emergency response

3. Patient requires care which does not exceed the Los Angeles County EMT scope of practice

4. Patient does not have an emergency medical condition (as defined above) at the time of transport

5. Patients who develops an extremis condition enroute shall be diverted to the most accessible facility appropriate to the needs of the patient.

B. Advanced Life Support (ALS) Transport

1. Unit is staffed with two paramedics unless the ambulance provider has been given approval by the EMS Agency to staff ALS IFT units with one paramedic and one EMT.

2. Requests may be for emergency or non-emergency response.

3. Patient requires skills or treatment modalities which do not exceed the Los Angeles County paramedic scope of practice.

4. Base hospital contact is not required to monitor therapies established by the sending facility prior to transport if such therapies fall within the Los Angeles County paramedic scope of practice.

5. If the patient's condition deteriorates or warrants additional therapies enroute, paramedics shall treat the patient in accordance with Ref. No. 1200, Treatment Protocols, et al. and make Base contact. The base hospital will determine if the patient may be transported to the original destination requested by the sending facility, which should occur whenever possible, or if the patient requires diversion to the most accessible receiving facility appropriate to the needs of the patient.

6. Paramedics may not accept standing orders or medical orders from the transferring physician or provider medical director.

C. Nurse and/or Respiratory Care Practitioner (RCP) Specialty Care Transport (SCT)

1. Unit is staffed by a qualified registered nurse and/or RCP and two EMTs or paramedics. Other medical personnel (e.g., physician, perfusionist, etc.) may be added to meet the needs of the patient.

2. Requests may be for emergency or non-emergency response.

3. Patient requires, or may require, skills or treatment modalities that are within the nurse's and/or RCP's scope of practice.

4. Registered nurses and RCPs are not required to make base hospital contact. Nurses and RCPs may follow medical orders of the transferring physician and/or orders approved by their SCT Medical Director within their applicable scope of practice for patient care enroute. However, if paramedic(s) are part of the SCT transport team, they can only perform medical orders received from a base hospital.

5. Patient destination requested by the sending facility will be honored; however, if the patient's condition deteriorates enroute, the registered nurse or RCP may determine it is in the patient's best interest to divert the patient to the most accessible facility appropriate to the needs of the patient.

II. Transport Requests and Response Levels

A. If a transport request is received under the following circumstances and it is determined that the patient has an emergency medical condition, the dispatcher shall immediately refer the request to the jurisdictional 9-1-1 provider.

1. A private citizen requesting ambulance transportation

2. If the patient is at a health facility but has not been evaluated and stabilized to the extent possible by a physician prior to the facility requesting transport

B. If upon arrival at a health facility or private residence and EMTs or paramedics find that the patient has an emergency medical condition, the EMS personnel shall determine whether it is in the best interest of the patient to request the jurisdictional 9-1-1 provider to respond or to provide treatment and rapid transport to the most accessible receiving facility. If on-scene personnel

determine that immediate transport is indicated, the jurisdictional 9-1-1 provider shall be notified and justification shall be documented on the patient care record.

C. Emergency Response Requests

1. Request by a 9-1-1 Provider Agency

Ambulance providers shall dispatch an ambulance within the maximum response times for emergency calls specified in the County Code in response to an emergency call from a public safety agency or authorized emergency transportation provider for that geographical area, unless the caller is immediately advised of a delay in responding to the call. Response times for emergency and non-emergent request are as follows:

a. For an emergent response (code 3) maximum response times are:
Urban area – 8 min and 59 seconds (five hundred thirty-nine (539) seconds)
Rural area – 20 min and 59 seconds (twelve hundred fifty-nine (1259) seconds)
Wilderness area – as soon as possible

b. For a non-emergent (code 2) the maximum response times are:
Urban area – 15 minutes and 59 seconds (nine hundred fifty-nine (959) seconds)
Rural area – 25 minutes (one thousand five hundred (1,500) seconds)
Wilderness area – as soon as possible

2. Request by a Health Facility

a. If a physician in the emergency department at the health facility has evaluated and stabilized the patient to the extent possible and arranged an interfacility transfer, a private ground (or air) ambulance transport may be arranged and the jurisdictional 9-1-1 provider is not ordinarily contacted.

b. **The jurisdictional 9-1-1 provider may only be contacted if the ETA of the private provider is delayed and the condition of the patient warrants a rapid response and transport suggests that there is an acute threat to life or limb that warrants immediate response and transport. Patient destination will then be determined as outlined in the applicable patient destination policy.**

D. Non-Emergency Response Requests - Request by a Health Facility or Private Citizen

1. A request for transport of a patient who has, or is perceived to have a stabilized medical condition that requires transport, and the patient does not have an emergency medical condition

2. Transports are handled by a private ambulance provider with BLS, ALS, or SCT staffed units, depending upon the medical requirements of the patient and the EMS personnel's scope of practice

III. Role of the Base Hospital in ALS Interfacility Transports

A. Provide immediate medical direction to paramedics if the patient's condition deteriorates or warrants additional therapies during transport.

B. Determine if the patient may be transported to the original destination requested by the sending facility, which should occur whenever possible, or if the patient requires diversion to the most accessible receiving facility appropriate to the needs of the patient if the patient's condition changes while enroute to the pre-designated facility. If diverted, the base hospital shall:

1. Contact the new receiving hospital and communicate all appropriate patient information.

2. Advise the original receiving hospital that a diversion has occurred.

C. Clarify the scope of practice of EMS personnel when requested to do so by a sending facility.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 304, **Role of the Base Hospital**
Ref. No. 414, **Specialty Care Transport (SCT) Provider**
Ref. No. 502, **Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 511, **Perinatal Patient Destination**
Ref. No. 513, **ST Elevation Myocardial Infarction Patient Destination**
Ref. No. 513.1, **Interfacility Transport of Patients with St-Elevation Myocardial Infarction**
Ref. No. 514, **Prehospital EMS Aircraft Operations**
Ref. No. 516, **Return of Spontaneous Circulation (ROSC) Patient Destination**
Ref. No. 517.1, **Guidelines for Determining Level of Interfacility Transport**
Ref. No. 802, **EMT Scope of Practice**
Ref. No. 802.1, **EMT Scope of Practice, Field Reference**
Ref. No. 803, **Paramedic Scope of Practice**
Ref. No. 803.1, **Paramedic Scope of Practice, Field Reference**
Ref. No. 815, **Honoring Prehospital Do-Not-Resuscitate (DNR) Orders, Physician Orders for Life Sustaining Treatment and End of Life Option (Aid-in-Dying Drug)**

Reference No. 517 Private Provider Agency Transport/Response Guidelines

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/20/20	10/20/21	N
	Base Hospital Advisory Committee	10/13/21	10/13/21	N
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMS QUALITY IMPROVEMENT PROGRAM** REFERENCE NO. 620

PURPOSE: To establish a process for the Los Angeles County Emergency Medical Services (EMS) Agency and system participants to evaluate the EMS system to ensure safety and continued improvement in prehospital patient care delivery.

AUTHORITY: California Code of Regulations, Title 22, Chapter 12
Health and Safety Code Division 2.5
California Evidence Code, Section 1157.7
California Civil Code Part 2.6, Section 56

DEFINITIONS:

Adverse Event: A preventable or non-preventable unintended event that results or has the potential to result in harm to the patient.

Indicator: A well-defined, objective, measurable, and important aspect of care. Other terms for indicators include: key performance indicator, metric and quality indicator or measure.

Important Aspects of Care: Patient care activities that are of greatest significance to the quality of patient care. These include activities that are high in volume, high risk, and/or problem prone for patients and/or healthcare providers.

Near Miss Event: An incident or unsafe condition with the potential for injury, damage or harm that is resolved before reaching the patient. Also referred to as a “close call” or “good catch”.

Periodic Review: A re-evaluation of a discontinued indicator within a predetermined time frame after achievement of threshold to ensure ongoing compliance.

Quality Improvement (QI): The continuous and systematic analysis of performance in an effort to improve it.

System Participant: For the purposes of this policy, a system participant is any prehospital care agency or entity required by law, regulation, agreement, or policy to develop and maintain a QI program consistent with state and local requirements.

Threshold: A pre-established level of performance related to a specific indicator.

PRINCIPLES:

1. An EMS QI program is an essential component of an effective EMS system capable of providing quality patient care and achieving system performance goals.

2. Key components of an EMS QI program include:
   a. Personnel
   b. Equipment and Supplies

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

c. Documentation
d. Data Collection and Analysis
e. Clinical Care/Patient Outcome
f. Skills Maintenance/Competency
g. Transportation/Facilities
h. Risk Management
i. Public Education/Prevention

3. EMS organizations become valuable stakeholders in the State QI program by participating in the local EMS Agency QI program.

4. Data sampling may be utilized to measure an indicator or monitor performance. However, to obtain meaningful data that are representative of the study population, factors such as the population affected, the frequency of the activity, and the severity of consequence when thresholds are not met, must all be considered when determining the size and population of data samples.

POLICY:

I. EMS Agency Responsibilities:

A. Implement a state-approved EMS QI plan consistent with ~~all~~ regulatory requirements.

B. Review QI programs and approve QI plans of local EMS system participants.

C. Maintain a systemwide QI program.

II. System Participant Responsibilities:

A. Implement and maintain a QI program approved by the EMS Agency that reflects the organization's current QI process(es).

B. Demonstrate how EMS QI is integrated within the organization.

C. Designate a representative to attend the relevant EMS Agency QI Committee meeting(s).

D. Participate in systemwide QI studies, to include timely submission of requested data to the EMS Agency.

E. Provide education, training, or other methods utilized to disseminate information specific to findings identified in the QI process.

F. Establish and maintain relationships with stakeholders and, as needed, convene meetings to facilitate the QI process.

G. Review the QI plan annually and update as needed. If there are no revisions, a signed copy of the QI plan signature page (signed by the Medical Director) or written statement to that effect, along with a copy of the current QI indicators, may be submitted in lieu of the entire plan.

H. Describe method(s) utilized to ensure accurate and reliable documentation of patient care delivered.

III. Other Specified Specialty Care Center Responsibilities:

A. Participate in the EMS Systemwide QI Program

B. Collect and submit requested data to the EMS Agency.

IV. QI Plan Requirements:

Each QI plan shall include a description, at a minimum, of the following components:

A. Organizational Structure

1. Mission statement and/or philosophy of the organization.

2. Goals and objectives.

3. Organizational chart or narrative description of how the QI program is integrated within the organization's EMS Agency QI Program, and State EMS QI Program.

4. Organizational chart or narrative description of how the organization's QI program is integrated with local and State QI programs

B. Methodology, processes and tools used to facilitate the QI Process (i.e., FOCUS-PDSA)

F Find a process to improve
O Organize an effort to work on improvement
C Clarify current knowledge of the process
U Understand process variation and capability
S Select a strategy for further improvement

P Plan a change or test aimed at improvement
D Do – carry out the change or the test
S Study the results, what was learned, what went wrong
A Act – adopt the change, or abandon it, or run through the cycle again

C. Approach to identifying and evaluating QI indicators

D. Data Collection and Reporting

1. All reliable sources of information utilized in the QI plan; including EMS databases, patient care records, checklists, customer input, direct observations, and skills simulation.

2. Flow of information.

3. Methods used to document QI findings.

4. Process used to submit data to the EMS Agency.

E. Training or educational methods that will be used to communicate relevant information among stakeholders.

V. QI Program Requirements:

Each QI Program shall include, at minimum, the following:

A. An approved QI Plan

B. Develop QI indicators that relate to important aspects of care, to include the following:

1. Well-defined description of the important aspect of care being measured.

2. Threshold for compliance.

3. Timeline for tracking indicator once the threshold has been achieved.

4. Data source.

C. Methods for tracking compliance and identifying trends.

D. Written analysis that summarizes the QI findings.

E. Corrective actions utilized to improve processes.

F. Written trending report that includes effectiveness of performance improvement action plans.

G. Education and training specific to findings identified in the QI process.

H. Methods utilized for dissemination of the QI findings to stakeholders.

I. Recognition and acknowledgment of performance improvement.

J. Periodic review or a re-evaluation of a discontinued indicator within a predetermined time frame after achievement of threshold to ensure ongoing compliance.

K. Methods for identifying, tracking, documenting and addressing near miss events.

L. Record Keeping

1. All QI records shall be maintained in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations.

2. The following records shall be maintained and available for review until the EMS Agency Program Review is concluded:

a. QI meeting minutes and attendance rosters/sign-in sheets.

b. Attendance rosters/sign-in sheets for activities where QI findings and/or actions are discussed.

c. QI indicator(s) data collection tools.

d. Written summaries of the trending/analysis.

e. Documentation of dissemination of QI findings within the organization and to stakeholders.

f. Dates and times of continuing education and skill training based on QI findings.

g. Dates and times of remedial education or skills training, when provided.

h. A tracking tool for monitoring performance excellence, adverse events, near misses or issues regarding non-compliance with current policies and procedures outside of QI activities.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 618, **EMS Quality Improvement Program Committees**

California EMS Authority, Quality Improvement Program Model Guidelines, 2005
Los Angeles County EMS Agency Quality Improvement Plan

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

REFERENCE NO. 620, EMS Quality Improvement Program

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	08-11-2021	08-11-2021	N
	Data Advisory Committee			
	Education Advisory Committee			
	Provider Agency Advisory Committee	10-20-2021	10-20-2021	N
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	09-07-2021	09-07-2021	N
	Ambulance Advisory Board			
	EMS QI Committee	0812-2021	0812-2021	N
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other: Private Provider Agency QI Committee	08-05-2021	08-05-2021	N

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **ALS UNIT INVENTORY** REFERENCE NO. 703

PURPOSE: To provide a standardized minimum inventory on all Advanced Life Support (ALS) Units.

PRINCIPLE: Any equipment or supplies carried for use in providing emergency medical care must be maintained in good working order.

POLICY:

I. Providers may only carry one narcotic analgesic on the ALS units. Provider Agency Medical Directors may request approval from the Emergency Medical Services (EMS) Agency's Medical Director to carry Fentanyl.

II. ALS Units shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied according to the Department of the California Highway Patrol, California Administrative Code, Title 13.

III. All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.

MEDICATIONS			
Adenosine	**24mgs**	Glucagon	**1mg**
Albuterol (pre-mixed w/ NS)	**20mgs**	Ketorolac 15mg/mL	**4**
Albuterol / Metered Dose Inhaler (MDI) [11]	**2**	**OR** Ketorolac 30mg/2mLs	**2**
Amiodarone	**900mgs**	Lidocaine 2% [4]	**200mg**
Aspirin (chewable 81mg)	**648mgs**	Midazolam [5]	**20mgs**
Atropine sulfate (1mg/10mL)	**3mgs**	Morphine sulfate [6]	**20mgs**
Calcium chloride	**1gm**	Naloxone	**4mgs**
Dextrose 10% / Water 250mL	**3 bags**	Normal saline (for injection)	**2 vials**
Dextrose solution (glucose paste may be substituted)	**45gms**	Nitroglycerin (SL) spray, tablets, or single dose powder packets	**1 pump/ bottle/ or 36 packets**
Diphenhydramine	**100mgs**	Ondansetron 4mg ODT	**16mgs**
Epinephrine (1mg/mL)	**5mgs**	Ondansetron 4mg IV	**16mgs**
Epinephrine (0.1mg/mL)	**7mgs**	Sodium bicarbonate	**50mLs**
Fentanyl [2, 3]	**500mcgs**	Disaster Cache (**mandatory for 9-1-1 responders**) [1]	**1**
INTRAVENOUS FLUIDS			
Normal saline 1000 mL	**6 bags**	Normal saline 250 or 500 mL	**2 bags**

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

SUPPLIES			
Adhesive dressing (Band-Aids®)	**1 box**	Color Code Drug Doses, Ref. No. 1309	**1**
Airways – Nasopharyngeal:		Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5" 14G	**2**
Large (34-36)	**1**	Contaminated needle container	**1**
Medium (26-28)	**1**	Continuous Positive Airway Pressure (CPAP) device: [3, 7,]	
Small (20-22)	**1**	**9-1-1 paramedic provider agencies only**	
Airways – Oropharyngeal:		Small	**1**
Large	**1**	Medium	**1**
Medium	**1**	Large	**1**
Small Adult/Child	**1**	Endotracheal tubes w/ stylets Sizes 6.0-8.0	**2 each**
Infant	**1**	Tube introducer	**2**
Neonate	**1**	End Tidal CO2 Detector or Aspirator (Adult)	**1**
Alcohol prep pads	**1 box**	Extrication device or short board	**1**
Backboards	**2**	Filter, viral HEPA [11]	**2**
Bag-Mask-Ventilation (BMV) device w/ O_2 inlet & reservoir:		Flashlight or penlight	**1**
~~Adult~~ Bag Volume 650-1000 mL	**1**	Gauze bandages	**6**
~~Pediatric~~ Bag Volume 400-700 mL	**1**	Gauze sponges 4x4 (sterile)	**12**
~~Infant~~ Bag Volume 200-450 mL	**1**	Gloves, sterile	**2 pair**
Bag-Mask-Ventilation (BMV) Masks:		Gloves, unsterile	**1 box**
Large	**1**	Glucometer w/ strips	**1**
Medium	**1**	Lancets (automatic retractable)	**5**
Small Adult/Child	**1**	Hand-held nebulizer pack	**2**
Toddler	**1**	Hemostats, padded	**1**
Infant	**1**	Intraosseous device: [3, 7]	
Neonate	**1**	**9-1-1 paramedic provider agencies only**	
Burn pack or burn sheet	**1**	Adult	**1**
Cervical collars (rigid):		Pediatric	**1**
Adult (adjustable)	**4**	Intravenous catheters: Sizes 16G - 22G	**5 each**
Pediatric	**2**	Intravenous tubing - Macrodrip	**12**
Cardiac Monitor-Defibrillator w/ oscilloscope	**1**	King LTS-D (Disposable Supraglottic Airway w/ 60mL syringe):	
Defibrillator pads or paste (including pediatric)	**2 each**	Small Adult (Size 3)	**1**
ECG electrodes:		Adult (Size 4)	**1**
Adult	**6**	Large Adult (Size 5)	**1**
Pediatric	**6**	Laryngoscope blades:	
ECG, 12-lead & transmission capable	**1**	Adult: curved & straight	**1 each**
9-1-1 paramedic provider agencies only		Pediatric: Miller #1 & #2	**1 each**
Pulse oximeter	**1**	Laryngoscope handle:	
Transcutaneous pacing	**1**	Adult (compatible w/ pediatric blades)	**1**
Waveform capnography	**1**		

SUPPLIES (continued)			
Magill forceps:		Scissors	**1**
Adult	**1**	Sphygmomanometer:	
Pediatric	**1**	Thigh	**1**
Metered-Dose-Inhaler (MDI) Mask [11]	**2**	Adult	**1**
Metered-Dose-Inhaler (MDI) Spacer [11]	**2**	Pediatric	**1**
Mucosal Atomization Device (MAD)	**3**	Infant	**1**
Needle, filtered-5micron [8]	**2**	Splints:	
Normal saline for irrigation	**1 bottle**	Long	**2**
OB pack & bulb syringe [9]	**1**	Short	**2**
Oxygen cannulas:		Splints – traction:	
Adult	**3**	Adult	**1**
Pediatric	**3**	Pediatric	**1**
Oxygen masks – (non-rebreather):		Stethoscope	**1**
Adult	**3**	Suction unit (portable) w/adapter	**1**
Pediatric	**3**	Suction instruments:	
Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	**1**	Catheters sizes 8Fr. - 12Fr.	**1 each**
Personal Protective Equipment:		Tonsillar tip	**1**
Mask	**1 per provider**	Syringes sizes: 1mL – 60mL w/ luer adapter	**assorted**
Gown	**1 per provider**	Tape (various types, must include cloth)	**1**
Eye protection	**1 per provider**	Thermometer (Oral or axillary)	**1**
Radio transmitter receiver (Hand-Held) [10]	**1**	Tourniquets	2
Saline locks	**4**	Tourniquets (commercial for bleeding control)	2
		Vaseline gauze	2

APPROVED OPTIONAL EQUIPMENT	
Hemostatic dressings [3]	Pediatric laryngoscope handle FDA-Approved
Intravenous tubing, blood	Resuscitator w/ positive pressure demand valve (flow rate not to exceed 40L/min)
Mechanical CPR device [3]	

[1] Disaster Cache minimum contents include: (9) DuoDote kits or equivalent;
And when available: (6) AtroPen Auto Injector 1.0mg
(6 AtroPen Auto Injector 0.5mg – Pediatric Use
[2] Fentanyl carried on ALS Unit is not to exceed 1500mcgs.
[3] Requires EMS Agency approval, which includes an approved training program & QI method prior to implementation.
[4] Utilized w/ infusions through IO access.
[5] Midazolam carried on ALS Unit is not to exceed 40mgs.
[6] Morphine sulfate carried on ALS Unit is not to exceed 60mgs.
[7] Mandatory for providers that respond to medical emergencies via the 9-1-1 system.
[8] Optional, if not utilizing glass ampules.
[9] OB kits w/ clamps / scissors (no scalpels).
[10] Los Angeles County Department of Communications, Spec. No. 2029/2031/2033.
[11] As supply allows.

This policy is intended as an ALS Unit inventory only. Supply and resupply shall be in accordance with Ref. No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**
Ref. No. 710, **Basic Life Support Ambulance Equipment**
Ref. No. 712, **Nurse Staffed Critical Care Transport (CCT) Unit Inventory**
Ref. No. 1104 **Disaster Pharmaceutical Caches Carried by First Responders**

Reference No. 703 – ALS Unit Inventory

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/20/21	10/20/21	N
	Base Hospital Advisory Committee			
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PATIENT REFUSAL OF TREATMENT/TRANSPORT AND TREAT AND RELEASE AT SCENE QUICK REFERENCE GUIDE**

REFERENCE NO. 834.1

If EMS has assessed a patient who ~~has a medical complaint and~~ DOES NOT want transport to the hospital, this guide may be used to assist in determining the need for AMA; Assess, Treat and Release; or Treatment in Place

STEP 1 - Does the patient have Decision-Making Capacity?

The patient understands and can verbalize the risks/consequences of not receiving treatment / transport ideally in their own words – as EMS has described and EMS believes the patient has decision-making capacity

- Yes → Is there an Authorized Health Care Provider (HCP) on scene?
  - No → **STEP 2 - Does the patient have an emergency medical condition?**
    - *Abnormal vital signs (except isolated asymptomatic HTN)*
    - *Meets Base Contact Requirements (Ref. 1200.2)*
    - *In the PM/EMT judgment, patient has an immediate need for medical attention*
    - No → **STEP 3 - Does the patient have a High-Risk Chief Complaint / Features OR Social Risk Factors?**
      - ***High-Risk Chief Complaints:*** *Chest Pain, Abdominal Pain, GI Bleeding, Pregnancy, Syncope Neurologic symptoms (including dizziness/vertigo, weakness, visual changes), and ALOC*
      - ***High-Risk Features:***
        - *Age <12 months or >70 years old*
        - *Patient with complicating co-morbidities: active cardiac, respiratory, liver or kidney disease, cancer, neurologic disease, or immunocompromised*
      - ***Social Risk Factors:*** *Homelessness, Congregate Living, Skilled Nursing Facility, Long Term Care Facility*
      - No → Assess, Treat & Release
      - Yes → Against Medical Advice (AMA)
    - Yes → Against Medical Advice (AMA)
  - Yes → Meets "Treatment in Place"
    - *Patient may be treated in place or medically cleared by authorized HCP*
    - *AMA required if patient meets Base Contact Requirements*
- No → Treat / Transport
- Uncertain → Base Contact

Against Medical Advice (AMA) → Does the patient meet Base Contact Requirement or is EMS concerned?

- No → Base Contact not required
- Yes → Base Contact required for AMA

Make every attempt to contact Base before patient leaves the scene. Base may want to speak with the patient

Reference No. 834.1, Patient Refusal of Treatment/Transport and Treat and Release at Scene Quick Reference Guide

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/20/2021	10/20/2021	Y
	Base Hospital Advisory Committee			
	Data Advisory Committee			
	Medical Council			
OTHER COMMITTEES/RESOURCES	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Pediatric Advisory Committee			
	County Counsel			
	Other:			

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

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

Reference No. 834.1, Patient Refusal of Treatment/Transport and Treat and Release at Scene Quick Reference Guide

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
First Text Box	PAAC 10/20/21	Delete the phrase “has a medical complaint and” to be consistent with the main policy Ref. No. 834	Adopted

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/ PARAMEDIC/MICN)

SUBJECT: **APPLICATION OF PATIENT RESTRAINTS** REFERENCE NO. 838

PURPOSE: To provide guidelines for emergency procedures and use of restraints in the field or during transport of patients who are violent or potentially violent, or who may harm self or others.

AUTHORITY: California Code of Regulations, Title 22, Sections 100063, 100145, 100169(a)(1,2) and (c)(1)
Welfare and Institutions Code, 5150
California Code of Regulations, Title 13, Section 1103.2
Health and Safety Code, Section 1798(a)

PRINCIPLES:

1. The safety of the patient, community, and responding personnel is of paramount concern when considering the use of restraints.

2. Staff should be properly trained in the appropriate use and application of restraints and in the monitoring of patients in restraints.

3. The application of restraints is a high-risk procedure due to the possibility of injury to both the patient and EMS personnel; therefore, the least restrictive method that protects the patient and emergency medical services (EMS) personnel from harm should be utilized.

4. Restraints should be used in situations where the patient is potentially violent or is exhibiting behavior that is dangerous to self or others, only as necessary, when all lesser restrictive measures (e.g., verbal de-escalation) have failed.

5. EMS personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol, substance abuse, metabolic disorders, emotional stress and, behavioral and psychiatric disorders. Base contact criteria shall be strictly adhered to for those conditions that require it.

6. Authority for scene management (e.g., controlling the activities that occur in the environment or space around the patient; ensuring bystanders are kept away; and EMS personnel are provided with a safe environment to treat the patient) shall be coordinated by law enforcement (LE), where applicable.

7. The responsibility for patient health care management rests with the highest medical authority on scene. Therefore, medical intervention and patient destination shall be determined by EMS personnel according to applicable policies.

    a. The preferred restraint modality should be coordinated with LE, when applicable.
    b. The method of restraint used should allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise neurological or vascular status.

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

8. This policy is not intended to negate the need for LE personnel to use appropriate restraint equipment approved by their respective agency to establish scene management control.

POLICY

I. Forms of Restraining Devices

A. Restraint devices applied by EMS personnel (including for the purpose of interfacility transport of psychiatric patients) must be either padded hard restraints or soft restraints (i.e., vest with ties, Velcro or seatbelt type). Both methods must be keyless and allow for quick release. Restraints shall be applied as four point padded wrist and ankle restraints, or a two-point padded wrist and belt restraint.

B. The following methods of restraint shall NOT be utilized by EMS personnel:

1. Applying hard plastic ties or any restraint device requiring a key to remove.

2. Restraining a patient's hands and feet behind their back.

3. Restraining patients in prone position.

4. Placing a patient on a gurney and then placing a device (e.g., backboard, scoop stretcher or flats) on top of the patient, referred to as "Sandwich" method.

5. Applying materials in a manner that could cause vascular, neurological or respiratory compromise (e.g., restriction of limbs, the neck or chest using gauze bandage or tape).

C. In some situations, it may be necessary for LE to apply restraints (e.g., handcuffs, flex-cuffs, herein referred to as LE-restraint), which are not approved by EMS protocols. When appropriate, patients requiring ongoing patient care or EMS transported patients should have LE-restraints discontinued in favor of an EMS approved restraint intervention.

II. Application and Monitoring of Restraints

A. A restrained patient shall never be left unattended.

B. Any restraint device used must allow for rapid removal if the patient's airway, breathing, or circulation becomes compromised.

C. Restrained extremities should be evaluated for pulse quality, capillary refill, color, temperature, nerve and motor function immediately following application and at a minimum of every 15 minutes thereafter (or more often if clinically indicated). Any abnormal findings require adjustment, removal and reapplication of restraints if necessary.

D. Restraint methods must allow the patient to straighten the abdomen and chest such that they can take full breaths.

E. Under no circumstances are patients to be transported in the prone position regardless of who applies the restraint.

F. EMS personnel must ensure that the patient's position allows for adequate monitoring of vital signs, does not compromise respiratory, circulatory, or neurological status, and does not preclude any necessary medical intervention to protect or manage the airway should vomiting occur.

G. Restraints shall not be attached to movable side rails of a gurney.

H. Restraint devices applied by LE require the officer's continued presence to ensure patient and scene management safety.

1. The LE officer should accompany the patient in the ambulance.
2. In the unusual event that this is not possible, the LE officer should follow by driving in tandem with the ambulance on a pre-determined route.
3. A method to alert the LE officer of any problems that may develop during transport should be discussed prior to leaving the scene.
4. If the patient is handcuffed by LE officers, consideration should be made to transition to the least restrictive restraints that are safe for the patient and responders, including consideration of transfer to EMS restraints.

III. Pharmacologic Management of the Patient in Restraints

A. A patient who has undergone physical restraint should not be allowed to continue to struggle against the restraints as this may lead to injury (i.e., rhabdomyolysis, strains, sprains, severe acidosis, cardiac ischemia).

B. Patients who are agitated while in physical restraint may receive administration of medication by EMS personnel to reduce agitation with continued monitoring for respiratory depression, in accordance with (*TP 1209, Psychiatric/Behavioral Emergencies*) and/or (*TP 1208, Agitated Delirium*).

a. If the patient remains agitated in BLS care and there is an ongoing concern for patient safety, ALS upgrade shall be initiated.

IV. Required Documentation on the Patient Care/EMS Report Form

A. Reason restraints were applied.

B. Type of restraints applied.

C. Identity of agency/medical facility applying restraints.

D. Assessment of the overall cardiac and respiratory status of the patient; and the circulatory, motor and neurological status of the restrained extremities at a minimum of every 15 minutes.

E. Reason for removing or reapplying the restraints or any abnormal findings.

V. Quality Assurance:

A. Develop a process for review of selected cases where physical restraint or medication management by EMS personnel are used, with attention to the appropriateness of restraint for the patient, the type of restraint(s) used, the quality and frequency of physiologic monitoring, protocol compliance, and documentation compliance.

B. Agencies shall track the use of medications for the purpose of management of agitated patients.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 502, **Patient Destination**
Ref. No. 703, **ALS Unit Inventory**
Ref. No. 1200.2, **Base Contact Requirements**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: AGITATED DELIRIUM **Ref. No. 1208**

Base Hospital Contact Required.

1. Assess situation for safety; approach patient with caution and attempt verbal de-escalation (*MCG 1307*)

2. Attain law enforcement (LE) assistance prior to approaching a patient if a weapon is visualized or the patient threatens violence (*MCG 1307*)

3. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*
   Continually assess patient's airway and ventilation status ❶

4. Administer **Oxygen** prn *(MCG 1302)*

5. Patients with agitated delirium have confusion and extreme agitation along with any of the following: ❶
   - Diaphoresis
   - Elevated temperature, hot or flushed skin
   - Tachycardia
   - Rapid breathing

   Agitated and/or combative patients without these signs/symptoms are not suffering agitated delirium, treat per the appropriate treatment protocol

6. Apply physical restraints when indicated *(Ref. No. 838, Application of Patient Restraints)* ❷

7. For patients requiring medical management for agitated delirium, including patients requiring physical restraint for patient or EMS personnel safety:
   Administer **Midazolam 5mg (1mL) IM/IN/IV**
   Repeat x1 in 5 min prn, maximum total dose prior to Base contact 10 mg ❸ ❹

   CONTACT BASE for additional sedation
   With Base Contact may repeat as above up to a maximum total dose of 20mg ❹

8. Evaluate for physical trauma, if present treat in conjunction with *TP 1244, Traumatic Injury*

9. Establish vascular access prn *(MCG 1375)*

10. Check blood glucose prn ❺
    If glucose < 60 mg/dL or > 400 mg/dL treat in conjunction with *TP 1203, Diabetic Emergencies*

11. Initiate cardiac monitoring after pharmacologic intervention *(MCG 1308)*
    Assess for dysrhythmia or interval widening
    CONTACT BASE for QRS > 0.12 sec, QT > 500ms, or heart rate > 150 or < 50 to discuss need to administer **Sodium Bicarbonate 50mEq IV** ❻

12. For suspected ingestions, treat in conjunction with *TP 1241, Overdose / Poisoning / Ingestion*

13. **Normal saline 1L IV rapid infusion**
    Reassess after each 250mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

14. If patient's skin is hot to touch or has a measured fever with suspected hyperthermia (i.e., measured temperature greater than 39°C or 102°F), initiate cooling measures

SPECIAL CONSIDERATIONS

❶ Patients with Agitated/Excited Delirium often are impervious to pain and have a lack of response to verbal commands by EMS. They are at risk for sudden cardiac arrest, often preceded by a brief, abrupt period of lethargy and decreased respirations. Careful observation of patient's activity level, vital signs, and airway are essential to patient safety. If patient develops cardiac arrest, treat in conjunction with *TP 1210, Cardiac Arrest – Non-traumatic*

❷ Use of restraints in patients with Agitated Delirium is associated with an increased risk of sudden death. Avoid using restraints in patients who do not present a threat to self or to EMS personnel. Never transport a patient in restraints in prone position.

❸ Patients who are agitated while in physical restraint and have the potential for injury due to the degree of agitation, should receive administration of medication by EMS personnel to reduce agitation with continued monitoring for respiratory depression, in accordance with *Ref 838, Application of Patient Restraints*.

❹ Midazolam onset is 2 minutes with maximum effect at 5 minutes (IM/IN route is preferred, unless an IV has been previously established).

❺ Agitation may be present after a seizure, or in the setting of hypo/hyperglycemia. Consider checking glucose early if the patient is a known diabetic or demonstrates clinical evidence of hypoglycemia, but only if safe to do so.

❻ Several drugs may cause life threatening cardiac arrhythmias after intentional or accidental overdose. These arrhythmias are often preceded by prolonged ECG intervals (particularly QRS > 0.12 sec or QT interval > 500ms). Cocaine intoxication is strongly associated with Agitated Delirium and may also produce cardiac effects similar to Tricyclic antidepressant (TCA) overdose (widened QRS progressing to malignant arrhythmia). These patients may require a large dose of sodium bicarbonate to prevent sudden cardiac death. Consult Base Physician immediately to discuss administration of Sodium Bicarbonate; may repeat x1 if QRS remains > 0.12 sec after initial sodium bicarbonate. Treat in conjunction with *TP 1241, Overdose / Poisoning / Ingestion.*

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: AGITATED DELIRIUM **Ref. No. 1208-P**

Base Hospital Contact Required prior to transport.

1. Assess situation for safety; approach patient with caution and attempt verbal de-escalation *(MCG 1307)*

2. Attain law enforcement (LE) assistance for physical restraint prior to approaching a patient if a weapon is visualized or the patient threatens violence. *(MCG 1307)*

3. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*
   Continually assess patient's airway and ventilation status ❶

4. Administer **Oxygen** prn *(MCG 1302)*

5. Patients with agitated delirium have confusion and extreme agitation along with any of the following: ❶
   - Diaphoresis
   - Elevated temperature, hot or flushed skin
   - Tachycardia
   - Rapid breathing

   Agitated and/or combative patients without these sign/symptoms are not suffering agitated delirium, treat per the appropriate treatment protocol.

6. Apply physical restraints when indicated *(Ref. No. 838, Application of Patient Restraints)* ❷

7. For patients requiring medical management for agitated delirium including patients requiring physical restraint for patient or EMS personnel safety:
   Administer **Midazolam** (5mg/mL) 0.2 mg/kg IM/IN, dose per *MCG 1309*
   Repeat x1 in 5 min prn, up to a total dose of 10mg prior to Base contact. ❸❹

   CONTACT BASE for additional sedation:
   With Base contact may repeat as above up to a maximum total dose of 20mg❹

8. Evaluate for physical trauma; if present treat in conjunction with *TP-1244-P, Traumatic Injury*

9. Establish vascular access prn *(MCG 1375)*

10. Check blood glucose prn ❺
    If glucose < 60 mg/dL or > 250mg/dL treat in conjunction with *TP 1203-P, Diabetic Emergencies*

11. Initiate cardiac monitoring after sedation *(MCG 1308)*
    Assess for dysrhythmia or interval widening
    CONTACT BASE for QRS > 0.12 sec, QT > 500ms, or heart rate > 150 or < 50 to discuss need to administer **Sodium Bicarbonate 1mEq/kg IV** per *MCG 1309* ❻

12. For suspected ingestions, treat in conjunction with *TP 1241-P, Overdose / Poisoning / Ingestion*

13. **Normal saline 20mL/kg IV rapid infusion** *MCG 1309*
    Reassess after each 250mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

14. If patient's skin is hot to touch or has a measured fever with suspected hyperthermia (i.e., measured temperature greater than 39°C or 102°F), initiate cooling measures

SPECIAL CONSIDERATIONS

1. Pediatric patients with Agitated Delirium / Excited Delirium are infrequently encountered by EMS personnel. These patients often are impervious to pain and have a lack response to verbal commands by EMS are at risk for sudden cardiac arrest, often preceded by a brief, abrupt period of lethargy and decreased respirations. Careful observation of patient's activity level, vital signs, and airway are essential to patient safety. If patient develops cardiac arrest, treat in conjunction with *TP 1210-P, Cardiac Arrest – Non-traumatic.*

2. Use of restraints in patients with Agitated Delirium is associated with an increased risk of sudden death. Avoid using restraints in patients who do not present a threat to self or to EMS personnel. Never transport a patient in restraints in prone position.

3. Patients who are agitated while in physical restraint and have the potential for injury due to the degree of agitation, should receive administration of medication by EMS personnel to reduce risk of self-injury. These patients should be continually monitored for respiratory depression, in accordance with *Ref. 838, Application of Patient Restraints.*

4. Midazolam onset is 2 minutes with maximum effect at 5 minutes. The IM or IN route is preferred, unless an IV has been previously established.

5. Agitation may be present after a seizure, or in the setting of hypo/hyperglycemia. Consider checking glucose early if the patient is a known diabetic, but only if safe to do so.

6. Several drugs may cause life threatening cardiac arrhythmias after intentional or accidental overdose. These arrhythmias are often preceded by prolonged ECG intervals (particularly QRS > 0.12 sec or QT interval > 500ms). Cocaine intoxication is strongly associated with Agitated Delirium and may also produce cardiac effects similar to Tricyclic antidepressant (TCA) overdose (widened QRS progressing to malignant arrhythmia). These patients may require a large dose of sodium bicarbonate to prevent sudden cardiac death. Consult Base Physician immediately to discuss administration of Sodium Bicarbonate; may repeat x1 if QRS remains > 0.12 sec after initial sodium bicarbonate. Treat in conjunction with *TP 1241-P, Overdose / Poisoning / Ingestion*

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: BEHAVIORAL / PSYCHIATRIC CRISIS **Ref. No. 1209**

1. Perform initial assessment of scene and patient situation for safety

2. Attain law enforcement (LE) assistance prior to approaching a patient if a weapon is visualized or the patient threatens violence or for potential assistance with application of an involuntary psychiatric hold ❶❷

3. Approach patient with caution, assess for agitation and treat accordingly including use of verbal de-escalation as needed *(MCG 1307, Care of the Psychiatric Patient with Agitation)*❸

4. Assess airway and initiate basic and/or advanced airway maneuvers prn

5. Administer Oxygen prn *(MCG 1302)*

6. Assess for agitated delirium; treat per *TP 1208, Agitated Delirium*

7. Evaluate for medical conditions, including those that may present with psychiatric features ❹

8. If ongoing agitation with safety risk to patient or EMS personnel, initiate medication management **CONTACT BASE** for orders for treatment of agitation

   If the patient is cooperative
   Olanzapine 10mg Oral Disintegrating Tablet (ODT); given once *(MCG 1317.32)* ❺❻

   If the patient is uncooperative
   Midazolam 5mg (1mL) IM/IN/IV, repeat every 5 min prn; maximum total dose 20mg ❻❼

9. Evaluate for physical trauma; if present treat in conjunction with *TP 1244, Traumatic Injury*

10. Establish vascular access prn *(MCG 1375)*

    Check blood glucose prn ❽
    If glucose < 60 mg/dL or > 400 mg/dL treat in conjunction with *TP 1203, Diabetic Emergencies*

11. Initiate cardiac monitoring prn *(MCG 1308)*
    Assess for dysrhythmia or interval widening
    CONTACT BASE for QRS > 0.12 sec, QT > 500 ms, or heart rate > 150 or < 50 to discuss need to administer **Sodium Bicarbonate 50mEq (50mL) IV** ❾

12. Evaluate for possible suicide attempt ❿
    For potential overdose, obtain patient and bystanders information about ingestions and treat in conjunction with *TP 1241, Overdose/Poisoning/Ingestion*

13. Evaluate for acute mental health and/or substance abuse crises
    Obtain relevant clinical history regarding patient's current psychiatric diagnoses, psychiatric and other medications, and any recent alcohol or recreational drug ingestions
    Obtain and document relevant third party or collateral data ⓫

14. Patients who respond to verbal de-escalation, are cooperative without medications by EMS, and

have no acute medical conditions may be transported by EMS or LE to the Emergency Department, Psychiatric Urgent Care Center as per *Ref. No. 526, Behavioral/Psychiatric Crisis Patient Destination.*

SPECIAL CONSIDERATIONS

❶ Scene safety includes the assessment for the presence of firearms or weapons, including observations and direct inquiry with the patient and any available/relevant third parties (e.g., family, caregivers, or witnesses). If a weapon is found on the scene, EMS personnel should notify all members on the scene, and contact law enforcement (LE) immediately.

❷ Psychiatric, including mental health and substance abuse, emergencies are medical emergencies, and as such are best treated by EMS personnel. Those patients with psychiatric emergencies presenting with agitation, violence, threats of harm to self or others, or criminal activity are best managed by an EMS and LE co-response.

❸ Always attempt verbal de-escalation first and avoid applying restraints to patients who do not present a threat to self or EMS personnel (*Ref. No. 838, Application of Patient Restraints)*

❹ Many medical causes of psychiatric symptoms exist:

- Agitation *(see MCG 1307)*
  - Acute pain
  - Head trauma
  - Infection
  - Encephalitis or Encephalopathy
  - Exposure to environmental toxins
  - Metabolic derangement
  - Hypoxia
  - Thyroid disease or other hormone irregularity
  - Neurological disease
  - Toxic levels of medications
  - Alcohol or recreational drugs: intoxication or withdrawal
  - Exacerbation of a primary psychiatric illness
  - Autism Spectrum Disorder
- Psychosis
  - Delirium
  - Chronic neurological disease (dementia, seizures, parkinsonism, brain tumor)
  - Steroid use, other medication reactions
  - Alcohol or recreational drugs: intoxication or withdrawal
- Mania
  - Delirium
  - Thyrotoxicosis
  - Alcohol or recreational drugs: intoxication or withdrawal
- Anxiety
  - Respiratory disease
  - Cardiac disease
  - Thyroid disease
  - Toxic levels of medications
  - Alcohol or recreational drugs: intoxication or withdrawal
- Depression
  - Reaction to medication
  - Chronic disease or chronic pain

Hormonal variations
Subclinical / clinical hypothyroidism
Alcohol or recreational drugs: intoxication or withdrawal

❺ Olanzapine onset is 5-15 minutes with maximum effect at 45-60 minutes

❻ Medications used for pharmacologic management of agitation may cause respiratory depression, and every individual who receives pharmacologic management should be continuously monitored and transported for additional clinical assessment and treatment.

❼ Midazolam onset is 2 minutes with maximum effect at 5 minutes. The IM or IN route is preferred unless an IV has been previously established.

❽ Agitation may be present after a seizure, or in the setting of hypo/hyperglycemia. Consider checking glucose early if the patient is a known diabetic or demonstrates clinical evidence of hypoglycemia, but only if safe to do so.

❾ Several drugs that may cause agitation and present similarly to a psychiatric crisis may also cause life threatening cardiac arrhythmias after intentional or accidental overdose. These arrhythmias are often preceded by prolonged ECG intervals (particularly QRS > 0.12 sec or QT interval > 500 ms). Cocaine intoxication is strongly associated with Agitated Delirium and may also produce cardiac effects similar to Tricyclic antidepressant (TCA) overdose (widened QRS progressing to malignant arrhythmia). These patients may require a large dose of sodium bicarbonate to prevent sudden cardiac death. Consult Base Physician immediately to discussion administration of Sodium Bicarbonate; may repeat x1 if QRS remains > 0.12 sec after initial sodium bicarbonate. Treat in conjunction with *TP 1241, Overdose / Poisoning / Ingestion*

❿ It is important to assess for any evidence of suicide attempt. If there is concern for overdose, ask the patient or bystanders to provide information on agents used (specifically what, when, and how much). Collect and transport any medication vials, or additional pills). This will assist in determining necessary antidote treatment and monitoring at the hospital. This information is often lost, if not obtained immediately on scene.

⓫ Patients with acute mental health or substance abuse crises may not be capable or willing to provide reliable information; therefore, it is important to obtain third party collateral information about the patient's condition (e.g., from family, caregivers, witnesses), including names and contact information for persons knowledgeable about the patient's illness, treatment and medications

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: BEHAVIORAL / PSYCHIATRIC CRISIS **Ref. No. 1209-P**

1. Perform initial assessment of scene and patient situation for safety

2. Attain law enforcement assistance for assistance prior to approaching a patient if a weapon is visualized or the patient threatens violence or for potential assistance with application of an involuntary psychiatric hold ❶❷

3. Approach patient with caution, assess or agitation and treat accordingly including use of verbal de-escalation as needed *(MCG 1307 Care of the Psychiatric Patient with Agitation)* ❸

4. Assess airway and initiate basic and/or advanced airway maneuvers prn

5. Administer Oxygen prn (MCG 1302)

6. Assess for agitated delirium; treat per *TP 1208-P, Agitated Delirium*

7. Evaluate for acute medical conditions, including those that may present with psychiatric features❹

8. If ongoing agitation with safety risk to patient or EMS personnel, initiate medication management **CONTACT BASE** for orders for treatment of agitation

   If the patient is cooperative:
   Olanzapine 10mg ODT for pediatric patients longer than the length-based resuscitation tape per *MCG 1309; MCG 1317.32*; **given once**❺❻

   If the patient is uncooperative and/or olanzapine contraindicated:
   Midazolam (5mg/mL) 0.2 mg/kg IM/IN, dose per *MCG 1309*
   Repeat every 5 min prn; maximum single dose 10 mg; total dose 20mg❻❼

9. Evaluate for physical trauma; if present treat in conjunction with *TP-1244-P, Traumatic Injury*

10. Establish vascular access prn *(MCG 1375)*

    Check blood glucose prn ❽
    If glucose < 60 mg/dL or > 250 mg/dL treat in conjunction with *TP 1203-P, Diabetic Emergencies*

11. Initiate cardiac monitoring prn *(MCG 1308)*
    Assess for dysrhythmia or interval widening
    CONTACT BASE for QRS > 0.12 sec, QT > 500 ms, or heart rate > 150 or < 50 to discuss need to administer **Sodium Bicarbonate 1 meq/kg** per *MCG 1309*❾

12. Evaluate for a possible suicide attempt ❿
    For potential overdose, obtain patient and bystanders information about ingestions and treat in conjunction with *TP 1241-P, Overdose/Poisoning/Ingestion*

13. Evaluate for acute mental health and/or substance abuse crises
    Obtain relevant clinical history regarding patient's current psychiatric diagnoses, psychiatric and

other medications, and any recent alcohol or recreational drug ingestions
Obtain and document relevant third party or collateral data⓫

14. Patients who respond to verbal de-escalation, are cooperative without medications by EMS, and have no acute medical conditions may be transported by EMS or LE to the Emergency Department, Psychiatric Urgent Care as per *Ref. No. 526 Behavioral Psychiatric Destination*

SPECIAL CONSIDERATIONS

❶ Scene safety includes the assessment for the presence of firearms or weapons, including observations and direct inquiry with the patient and any available/relevant third parties (e.g., family, caregivers, or witnesses). If a weapon is found on the scene, EMS personnel should notify all members on the scene, and contact law enforcement (LE) immediately.

❷ Psychiatric, including mental health and substance abuse, emergencies are medical emergencies, and as such are best treated by EMS personnel. Those patients with psychiatric emergencies presenting with agitation, violence, threats of harm to self or others, or criminal activity are best managed by an EMS and LE co-response.

❸ Always attempt verbal de-escalation first and avoid applying restraints to patients who do not present a threat to self or EMS personnel *(Ref. 838, Application of Patients Restraints)*

❹ Many medical causes of psychiatric symptoms exist:

- Agitation (see *MCG 1307*)
  - Acute pain
  - Head trauma
  - Infection
  - Encephalitis or Encephalopathy
  - Exposure to environmental toxins
  - Metabolic derangement
  - Hypoxia
  - Thyroid disease or other hormone irregularity
  - Neurological disease
  - Toxic levels of medications
  - Alcohol or recreational drugs: intoxication or withdrawal
  - Exacerbation of a primary psychiatric illness
  - Autism Spectrum Disorder
- Psychosis
  - Delirium
  - Chronic neurological disease (dementia, seizures, parkinsonism, brain tumor)
  - Steroid use, other medication reactions
  - Alcohol or recreational drugs: intoxication or withdrawal
- Mania
  - Delirium
  - Thyrotoxicosis
  - Alcohol or recreational drugs: intoxication or withdrawal
- Anxiety
  - Respiratory disease
  - Cardiac disease
  - Thyroid disease
  - Toxic levels of medications
  - Alcohol or recreational drugs: intoxication or withdrawal
- Depression
  - Reaction to medication
  - Chronic disease or chronic pain
  - Hormonal variations

Subclinical / clinical hypothyroidism
Alcohol or recreational drugs: intoxication or withdrawal

❺ Olanzapine onset is 5-15 minutes with maximum effect at 45-60 minutes.

❻ Medications used for pharmacologic management of agitation may cause respiratory depression, and every individual who receives pharmacologic management should be continuously monitored and transported for additional clinical assessment and treatment.

❼ Midazolam onset is 2 minutes with maximum effect at 5 minutes. The IM or IN route is preferred unless an IV has been previously established.

❽ Agitation may be present after a seizure, or in the setting of hypo/hyperglycemia. Consider checking glucose early if the patient is a known diabetic or demonstrates clinical evidence of hypoglycemia, but only if safe to do so.

❾ Several drugs that may cause agitation and present similarly to a psychiatric crisis may also cause life threatening cardiac arrhythmias after intentional or accidental overdose. These arrhythmias are often preceded by prolonged ECG intervals (particularly QRS > 0.12 sec or QT interval > 500 ms). Cocaine intoxication is strongly associated with Agitated Delirium and may also produce cardiac effects similar to Tricyclic antidepressant (TCA) overdose (widened QRS progressing to malignant arrhythmia). These patients may require a large dose of sodium bicarbonate to prevent sudden cardiac death. Consult Base Physician immediately to discussion administration of Sodium Bicarbonate; may repeat x1 if QRS remains > 0.12 sec after initial sodium bicarbonate. Treat in conjunction with *TP 1241-P, Overdose / Poisoning / Ingestion*

❿ It is important to assess for any evidence of suicide attempt. If there is concern for overdose, ask the patient or bystanders to provide information on agents used (specifically what, when, and how much). Collect and transport any medication vials, or additional pills). This will assist in determining necessary antidote treatment and monitoring at the hospital. This information is often lost, if not obtained immediately on scene.

⓫ Patients with acute mental health or substance abuse crises may not be capable or willing to provide reliable information, therefore, it is important to obtain third party collateral information about the patient's condition (e.g., from family, caregivers, witnesses), including names and contact information for persons knowledgeable about the patient's illness, treatment and medications.

Medical Control Guideline: Care of the Patient with Agitation

DEFINITIONS:

Agitation: A hyper-aroused state (ranging in severity from anxious and cooperative to violent and combative) in which the individual exhibits excessive, repeated, and purposeless motor or verbal behaviors (e.g., pacing, fidgeting, clenching fists or teeth, prolonged staring, picking at clothing or skin, responding to internal stimuli such as hallucinations, threatening or carrying out violent acts).

Agitated Delirium: A state of agitation, excitability, and aggression associated with stimulant abuse, substance abuse and/or psychiatric disorders which leads to physiologic changes, such as hypertension, hyperthermia, diaphoresis, and cardiovascular instability. Also commonly referred to as “Excited Delirium”.

Delirium: An acute change in mental state due to an underlying medical condition characterized by confusion, disorientation, reduced awareness of the environment, and disordered thinking.

Autism Spectrum Disorder: A disorder diagnosed in childhood, but continuing into adulthood, with a wide range of severity involving difficulty with social communication and interaction, repetitive patterns of behavior, and narrowed interests or activities. Some patients have very little ability to communicate, or comprehend verbal and nonverbal communication, while others may communicate and are intelligent. Individuals are often sensitive (fearful/reactive) to environmental stimulation and depend on routines.

Bipolar Disorder: An episodic illness in which patients experience periods of elation or “high” mood (mania or hypomania), and periods of depression. Manic episodes are characterized by decreased sleep, lots of energy, rapid speech and ideas, impulsive and reckless decision-making (e.g., buying expensive objects, quitting a job, going on sudden unplanned trips) and an inflated view of oneself (grandiosity).

Delusion: A false belief that is firmly held despite objective and obvious contradictory proof or evidence. Delusions can be dangerous when the patient has a fixed idea that causes them to act violently.

Dementia: An illness generally diagnosed in older adults, associated with progressive cognitive decline including memory loss and an inability to carry out tasks or basic functions (i.e., driving, using a phone, dressing/grooming). The condition ranges in severity with some patients having little ability to speak, communicate, to those with less severe forms may be able to communicate well and manage their own care needs.

Major Depressive Disorder: An episodic illness in which a person feels profound sadness, a lack of enjoyment, and other symptoms that may include impairments in sleep, energy, appetite, motivation, concentration, and socialization. These patients often feel hopeless and are especially likely to think about or try to commit suicide.

Disorganized behaviors: A set of behaviors or actions that do not appear to accomplish anything meaningful (e.g., laughing to self, lying motionless and unresponsive to people around them, pacing or repeatedly sitting/standing without any clear reason, staring at the wall, or

object with a blank expression). They can be seen with a variety of conditions including psychosis, autism, dementia, and mania.

Disorganized Speech: A speech pattern that is extremely difficult to follow, such as garbled or non-sense speech, telling a story that jumps illogically from one topic to the next, making up new words, or highly repetitive speech (e.g., muttering to self with repetitive phrases).

Hallucinations: Patients experience sensing things that other people cannot hear, see, or smell (infrequent). Most commonly this means a patient is “hearing voices” or “seeing things”. This can be dangerous if the patient is experiencing hallucinations that command them to harm themselves, other people, or carry out dangerous acts. Hallucinations can be a symptom of psychosis or drug intoxication, but can be associated with other conditions like mania, depression, dementia and delirium.

Iatrogenic escalation: Escalation of a patient’s agitated state caused by EMS / healthcare personnel either inadvertently, or deliberately, by acting in ways that the patient does not expect or desire (e.g., restricting a patient’s freedom to move (cornering the patient), taking away patient belongings or invalidating, confronting, arguing with, or intimidating a patient).

Intellectual Disability: A range of disability from mild to severe, characterized by significant limitations in intellectual functioning (learning, reasoning, problem solving, planning) and adaptive behavior (everyday social skills like communication, and practical skills like living independently).

Paranoia: A state of suspicion or mistrust of people or institutions, such as hospitals/healthcare personnel, law enforcement or security.

Psychosis: A state where a person loses contact with reality. Common diagnoses or terms of psychotic illness include: “Schizophrenia”, “Psychotic disorder”, “Acute psychotic episode”, “Schizoaffective disorder” (a combination of schizophrenia and bipolar disorder), “delusional disorder”. The symptoms of a psychotic illness are commonly: hallucinations, delusions, paranoia and/or disorganized behaviors and speech.

Self-injurious behaviors: Behaviors or violent acts directed at oneself, occurring in many psychiatric disorders which may include depression or bipolar disorder, psychosis, drug abuse, and personality disorder (patients are often trying to distract themselves from extreme emotional pain they feel). (Also referred to as: Non-suicidal self-injury)

PRINCIPLES:

1. Psychiatric emergencies, including those related to mental health and substance abuse, are medical emergencies, and as such are best treated by EMS personnel who are trained, equipped, and experienced to evaluate and manage medical patients.

2. A proportion of prehospital psychiatric emergencies involve acute behavioral agitation, violence, threats of harm to self or others, or criminal activity. Such patients are best managed by an EMS and law enforcement (LE) co-response.

3. The overarching goal in management of acute behavioral agitation is to help the patient regain control over their behaviors so that they can participate in their evaluation and treatment.

4. EMS personnel should maintain the patient’s dignity to the extent possible, including use of the least restrictive method of restraint or intervention to facilitate clinical patient assessment, medically indicated treatment, and safe transport to a hospital.

5. Agitation has varying presentations on a spectrum, ranging in severity from anxious and cooperative to violent and combative. The patient may not have the ability to understand the situation or the dangers of their behavior or comply with directions because they lack insight and/or self-awareness.

6. The potential causes of agitation are numerous and varied and can include medical and/or psychiatric and/or substance abuse conditions. Agitation can also be unrelated to a medical/psychiatric condition, in such cases agitation may be used by a person "instrumentally" as a means of achieving a goal.

7. Physical restraint and pharmacologic management of agitation when providing EMS care are primarily indicated to protect a patient, the public, and other EMS personnel from injury.

8. The decision for EMS personnel to utilize medication management to treat agitation is a critical health care decision. (Note: "chemical sedation" or "chemical restraints" are not preferred terms)

9. Persons who lack decision-making capacity, or unaccompanied minors, are assessed and treated with implied consent (Ref. No. 834 – *Patient Refusal of Treatment/Transport and Treat and Release at Scene*).

10. LE officers, whenever available, should be involved in cases in which a patient poses a threat to themselves, the public, and/or EMS personnel.

GUIDELINES:

1. Initial Approach to Scene Safety:
   A. Evaluation of the agitated patient should start from a safe and sensible distance *(See MCGs 1307.1 and 1307.2)*.

   B. If EMS personnel are in danger of harm, they should retreat to a safe location and await the arrival of LE.
      i. Safety is paramount and at no time should EMS personnel jeopardize their safety by engaging with an agitated patient unless they feel that they have the knowledge, tools, and skills to do so.

   C. The first EMS and/or LE responders should organize their approach by identifying a lead who is responsible for communicating with the patient and coordinating the actions of the rest of the team.

   D. If there is no safe option for retreat, EMS personnel who are being physically attacked may defend themselves as permitted by local law. EMS personnel should not show aggression or retaliate against the patient.

   E. The goals of EMS care are to determine whether the patient is a candidate for verbal de-escalation (the preferred first step in managing agitation), if physical restraint is indicated, if pharmacologic intervention is indicated, and ultimately to provide an assessment for acute medical and psychiatric conditions.

   F. The flowchart in *MCG 1307.1* describes the initial approach to the scene of an agitated patient.

2. Verbal De-escalation:

   A. All EMS personnel shall be trained, capable, and competent in verbal de-escalation techniques, (e.g., using the "ERASER" mnemonic, see *MCG 1307.2*).

   B. The use of appropriate de-escalation techniques should take precedence and be attempted prior to physical restraint and/or administration of pharmacologic management, whenever possible and clinically appropriate.

   C. EMS personnel should not directly question or confront a patient's psychotic symptoms (e.g., hallucinations, delusions, paranoia, or behaviors) as it may worsen the patient's agitation.

   D. EMS personnel should remain self-aware and not allow themselves to react to provocative patients because this can lead to iatrogenic escalation of agitation.

3. Assessment of Agitation:

   A. EMS personnel shall attempt to perform an appropriate patient assessment to identify and manage clinical conditions that may be contributing to a patient's agitated, combative, or violent behavior. The table in *MCG 1307.3* describes potential clinical scenarios where a patient presents with agitation and provides guidance on use of verbal de-escalation.

4. Pharmacologic intervention may be required for the safety of the patient, EMS personnel and/or public when verbal de-escalation techniques are ineffective (*TP 1209 or 1209-P,*
5. *Behavioral/Psychiatric Crisis*).

6. Use of Restraints:

   A. If determined that the patient is not an appropriate candidate for verbal de-escalation (i.e., after failed attempts at verbal de-escalation, or acute medical situation requires immediate intervention) or when managing a patient who re-escalates to agitated behavior after verbal de-escalation, physical restraint may be required in conjunction with pharmacologic management (*Ref. No. 838, Application of Patient Restraints*).

7. Co-Response with Law Enforcement:

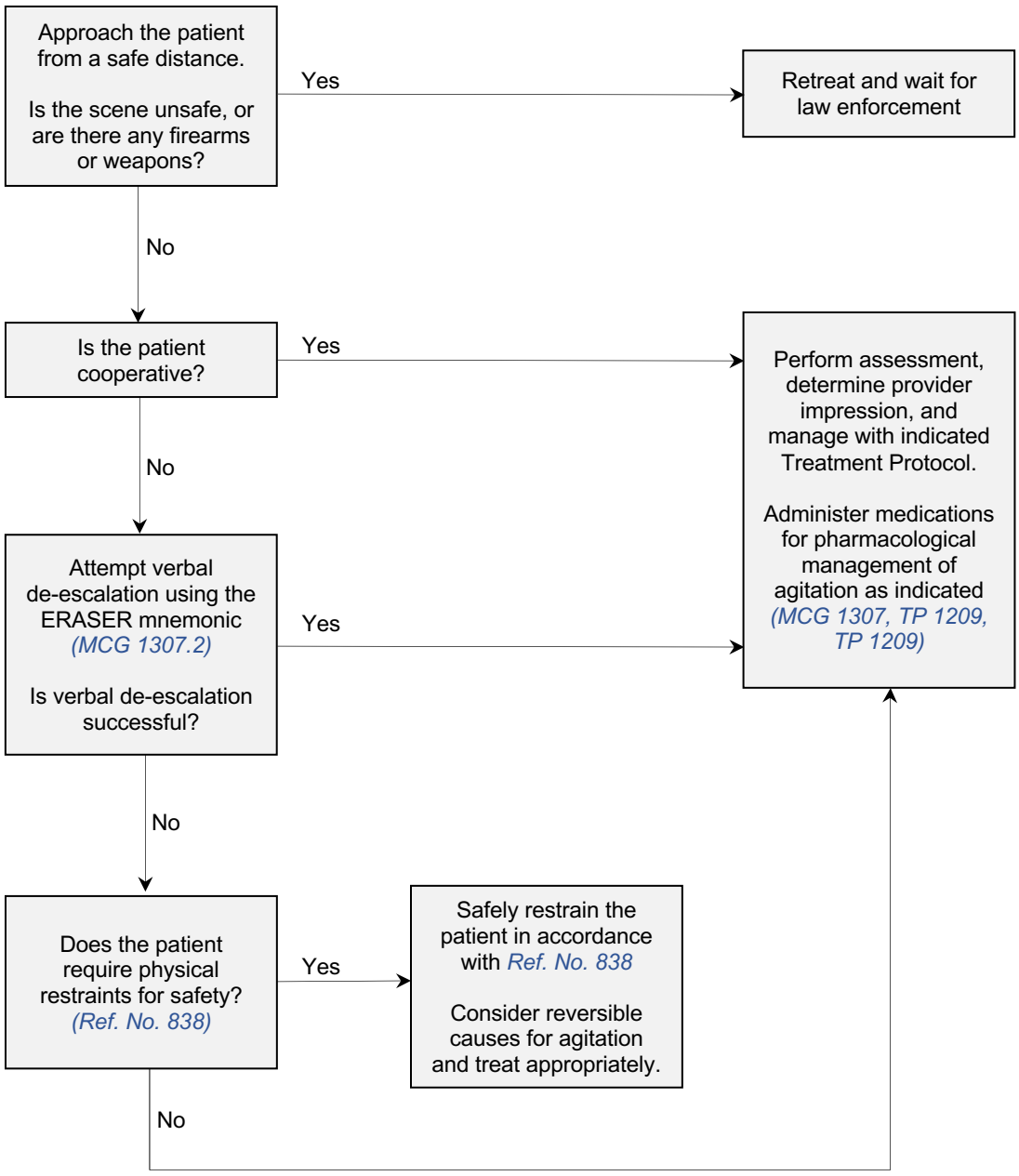
   A. At all times, EMS personnel should act as an advocate for the safety, medical monitoring, and clinical care of the patient.

   B. In some situations, it may be necessary for LE to apply restraint techniques or interventions (e.g., handcuffs or flex cuffs, herein referred to as LE restraint).
      a. Patients requiring ongoing care and/or EMS transport that are in LE restraints shall be managed in accordance with *Ref. No. 838, Application of Patient Restraints*, with preference for discontinuing LE restraint in favor of EMS approved restraint interventions when appropriate.

   C. Patients who are in LE custody or who are under arrest must always have a LE officer present or immediately available during EMS transport.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Medical Control Guideline: FLOWCHART FOR INITIAL APPROACH TO SCENE SAFETY Ref. No. 1307.1



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COUNTY OF LOS ANGELES

Medical Control Guideline: VERBAL DE-ESCALATION (ERASER MNEMONIC) Ref. No. 1307.2

E	**Eyeball the patient**	Evaluate the patient from a safe distance. Survey the scene and ask about weapons or other features that make the scene unsafe. Decide if Law Enforcement (LE) is necessary (if in doubt err on the side of caution). Are there signs that the patient will not respond to verbal de-escalation?
R	**Respect the Patient's Space**	Patients may escalate when there is intrusion into the personal space. EMS personnel should maintain a respectful distance while being aware of escape routes should the patient become violent.
A	**A single member of EMS personnel does the talking and builds rapport**	Establishing rapport is critical. With multiple EMS personnel on the scene, a single individual should be charged with talking to the patient. The EMS personnel charged with this task must remain neutral, and not become "emotionally involved" in the patient (such as becoming angry, irritated, or frightened of the patient). • State your name and position, offer your help. • Be genuine and honest. • Use a calm, reassuring, and helpful voice, and a neutral expression. Be concise in your questions, statements, or instructions. • Give the patient time to respond.
S	**Sensible Listening**	Often patients want to be heard, and people who are upset or confused generally want a way to resolve the issue. Help them find a "way out" if it is reasonable. Try to understand what the patient wants. Show a willingness to calmly listen to the patient, without necessarily reacting to demands. This step can result in re-escalation of agitation if EMS personnel becomes emotionally reactive, angry, frightened, or frustrated. Other EMS personnel may need to step in and continue if this happens.
E	**Establish expectations and set boundaries**	Boundaries should be set with the patient about behavior that will not be tolerated, consequences of actions, and what the patient is likely to expect. It is important to be clear but avoid using language that can sound intimidating or threatening. • For example, "You may not threaten people, it is our job to make sure everyone stays safe." "We need to make sure that you are ok, can we check your vitals and ask you some questions." "Unfortunately, we are worried that you cannot make informed medical decisions because you are intoxicated. We are going to take you to the hospital so you can be treated for your injuries." • Give specific instructions such as "can you please sit down so we can talk", "can you put down your bag". Avoid generic directives like "calm down" or "relax". • Provide a clear warning to the patient about the need to ensure the safety of both the patient and EMS personnel and public. Warn that restraint, or medications will be given as necessary, but as a last resort.
R	**Reasonable choices are given to the patient**	By retaining some degree of control, many patients will comply with direction if given reasonable choices. For example, EMS personnel could say, "would you like to walk over to the ambulance and sit on the bed inside, or do you prefer we bring the bed over here for you to sit on?"

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Medical Control Guideline: COMMON ETIOLOGIES OF AGITATION, FIELD PRESENTATION, LIKELIHOOD VERBAL DE-ESCALATION **Ref. No. 1307.3**

	Etiology / Cause	General Description or Examples*	Candidate for Verbal De-escalation?
1	Autism spectrum disorder*	History of such provided by bystanders/collaterals; repetitive behaviors, odd or highly limited or immature speech, awkward social interaction / communication, inflexibility of being out of a routine, hypersensitive to external stimulation.	Yes. High likelihood of success; use extensively
2	Intellectual disability*	Varied presentation, may have childlike speech and demeanor, may have caretakers despite being an adult, some intellectual disabilities co-occur with reliable physical findings / stigmata (e.g., Down syndrome).	Yes. High likelihood of success; use extensively
3	Emotional dysregulation	Can occur with many conditions such as bipolar disorder, depression, dementia, autism, or acute stress or trauma. Free from altered mental status; highly emotional, potentially angry, frightened, or stressed beyond ability to cope.	Yes. High likelihood of success; use extensively
4	Intoxication - Alcohol	Odor of alcoholic beverage, unstable gait / balance, slurred speech, family/bystander report of alcohol ingestion, emotional swings, relatively acute onset	Consider a short trial
5	Intoxication - stimulants / amphetamines	Tachycardia, mydriasis, hypertension, psychosis, delusions or paranoia, hallucinations, sleeplessness, hyperactivity, or drug paraphernalia found on scene	Consider a short trial
6	Traumatic brain injury	Physical findings or history consistent with trauma, other findings of injury, repetitive questions, grogginess or confusion.	Consider a short trial
7	Seizure / post-ictus	Oral trauma, bladder or bowel incontinence, altered mental status, may improve over time without intervention	Consider a short trial
8	Cerebral Vascular Accident (CVA)	Acute onset, loss of speech, pupillary changes, hemiparesis, confusion, known risk factors for CVA, hypertension	Consider a short trial
9	Dementia*	Typically found in older age patients, impaired memory (especially short-term memory), impaired ability to make plans or carry out tasks.	Consider a short trial
10	Psychosis*	Paranoia, delusions, hallucinations, disorganized speech or behaviors, typically free from altered mental status	Consider, may be highly effective in certain cases
11	Acute Mania (Bipolar Disorder)*	Exhibiting euphoric mood or irritability, elevated sense of oneself / grandiosity, rapid speech, impulsive and risky behaviors or decision making	Consider, may be highly effective in certain cases
12	Instrumental Violence	Agitation used as a tool for achieving a goal; no confusion or underlying medical or psychiatric cause, be aware of persons engaged in potential criminal behavior or in police custody	Consider a short trial; involve law enforcement
13	Delirium*	Altered mental status and agitation with waxing and waning course; confusion; poor attention; may be disoriented	Consider potential causes, refer to protocol (TP 1229); if verbal de-escalation ineffective, consider medication administration (*TP 1209*)
14	Agitated Delirium*	Highly agitated, impervious to pain, unresponsive to verbal commands, unusual superhuman strength / lack of fatiguing, often sheds clothing due to hyperthermia, diaphoretic, combative	No, pharmacologic management and early intervention important. See *TP 1208*
15	Hypoxia	Altered mental status, changes in skin color, low pulse oximetry readings, respiratory distress	No, treat underlying cause
16	Hypoglycemia	Diaphoresis, pale pallor, confusion, ataxia, declining mental status	No, treat underlying cause

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Medical Control Guideline: DRUG REFERENCE – OLANZAPINE **Ref. No. 1317.32**

Classification
Atypical anti-psychotic

Prehospital Indications
Agitation in a cooperative patient (able to self-administer medication)

Other Common Indications
None

Adult Dose
10 mg ODT given ONCE

Pediatric Dose
10mg ODT given ONCE for pediatric patients longer than the length-based resuscitation tape

Mechanism of Action
2nd generation anti-psychotic. Antagonizes serotonin 5-HT, dopamine, histamine and alpha-1 receptors. The precise mechanism is unknown but thought to be mediated through serotonin 5-HT and dopamine receptor sites.

Pharmacokinetics
Onset is 10-15 min; duration is hours

Contraindications
Pregnancy
Not indicated for dementia related psychosis
Patients ≤14 years AND on the length-based resuscitation tape

Interactions
CNS Depressants
Blood pressure lowering agents (enhances hypotensive effect)
QT prolonging drugs (additive prolongation of QT may produce torsade depointes/polymorphic ventricular tachycardia)

Adverse Effects
Dry mouth
Dystonic reaction
Drowsiness
GI upset
Headache
Orthostatic hypotension
Sedation

Prehospital Considerations
- Caution in use of patients >70 years of age.
- May cause prolonged QT interval. Caution in patients with known prolonged QT syndrome or recent/simultaneous use of other QT-prolonging drugs.
- Should not be administered in patients known to be pregnant, regardless of gestational age.
- Patients with known schizophrenia or bipolar disorder that are symptomatic (i.e. hearing voices, paranoid thoughts) may benefit most for symptom management. May be administered safely for undifferentiated agitation.
- Monitor airway and sedation, especially if concomitant CNS depressant use is suspected as depressant effects may be enhanced.

3.20.040 - Composition.

The commission shall be composed as follows:

A. An emergency physician practicing in a Los Angeles County paramedic base hospital nominated by the California Chapter of the American College of Emergency Physicians;

B. A physician practicing in Los Angeles County nominated by the American Heart Association, Western States Affiliate;

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

D. An administrator from a hospital in Los Angeles County nominated by the Healthcare Association of Southern California;

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

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

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

H. A psychiatrist practicing in Los Angeles County nominated by the Southern California Psychiatric Society;

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

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

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

DATA FACTS

LOS ANGELES COUNTY EMS SYSTEM REPORT

MAY 1, 2021

ISSUE 9

Message from the Director and Medical Director

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

Cathy Chidester
Director

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

Dr. Marianne Gausche-Hill
Medical Director

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

INSIDE THIS ISSUE:

SPECIAL POINTS OF INTEREST:

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

2020 System Demographics

70 9-1-1 Receiving Hospitals

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

EMS Provider Agencies

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

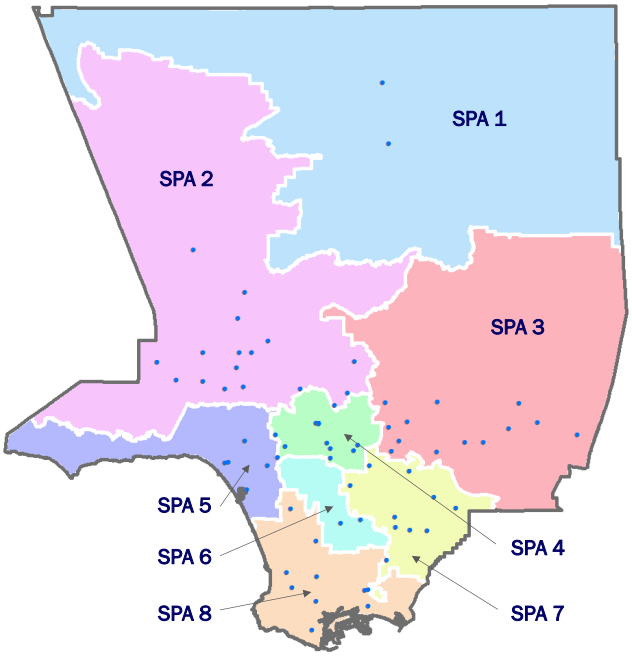
EMS Practitioners

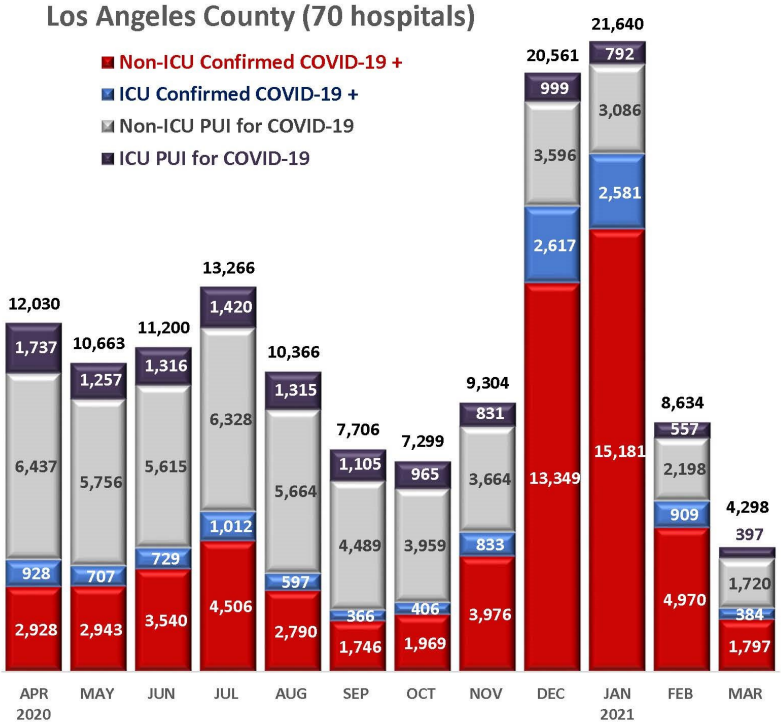
- 4,512 Accredited Paramedics
- 8,123 Certified EMTs by LA Co EMS Agency
- 883 Certified Mobile Intensive Care Nurses

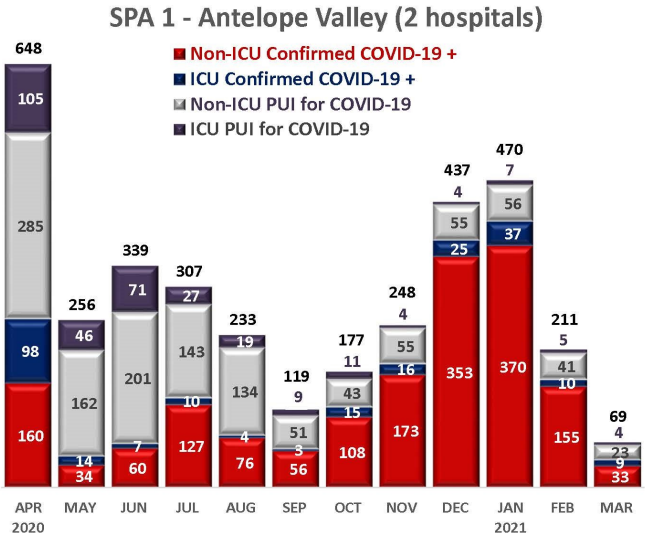
COVID-19 Hospitalizations by Month and by Service Planning Area (SPA)

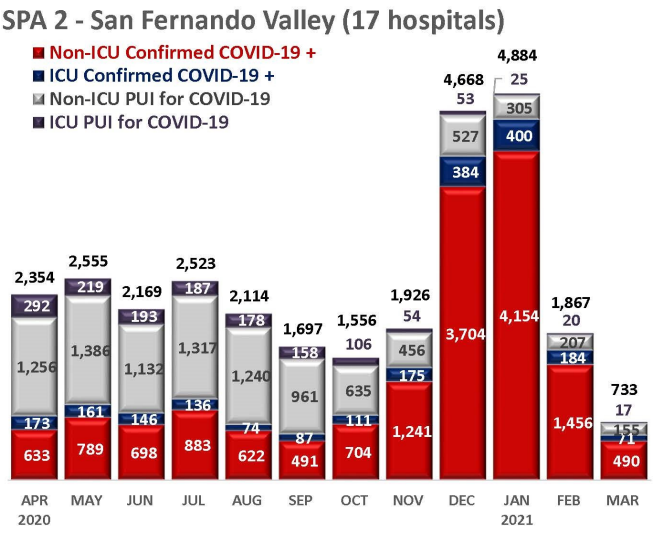
Confirmed and Person Under Investigation (PUI)

(Age 15 years and older)

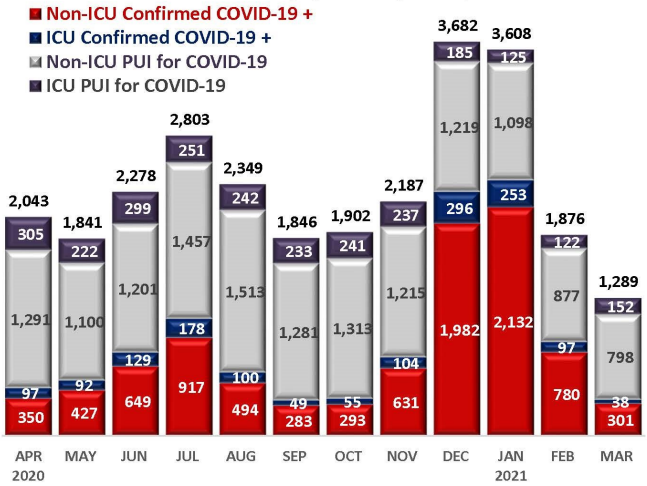




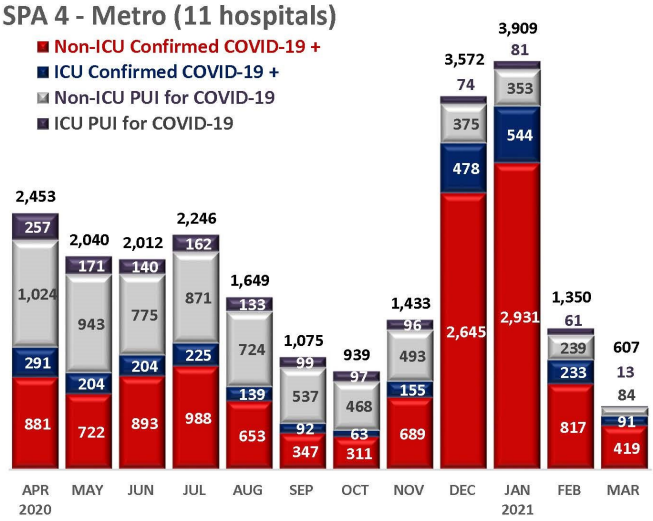




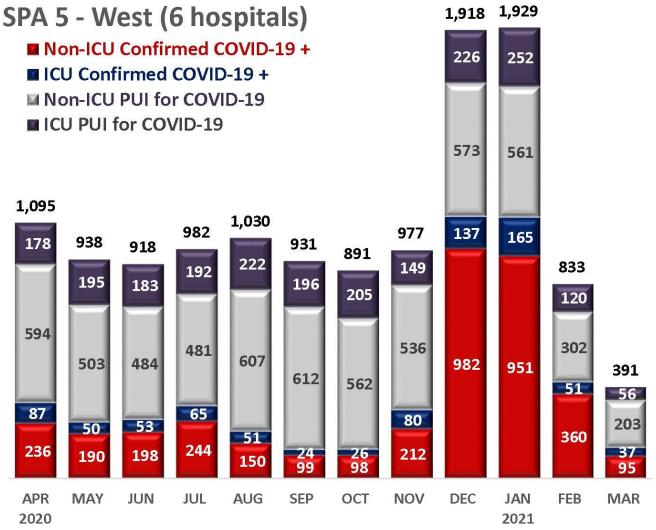
SPA 3 - San Gabriel Valley (13 hospitals)



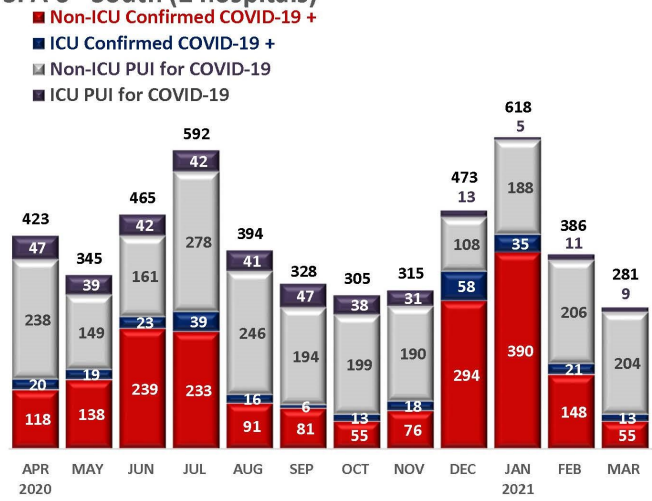
SPA 4 - Metro (11 hospitals)



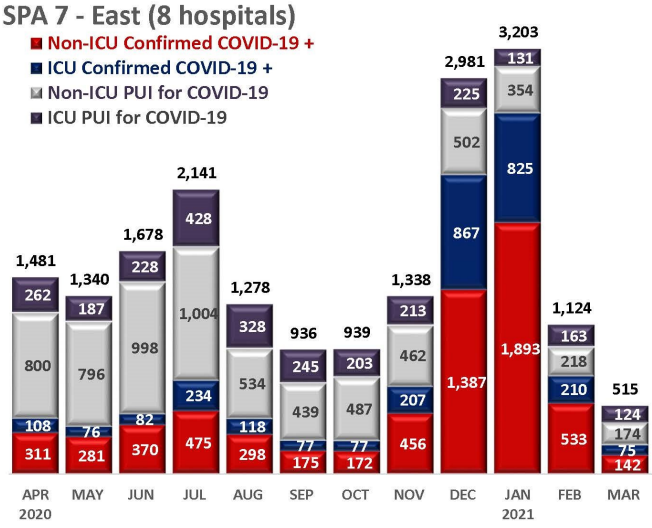
SPA 5 - West (6 hospitals)



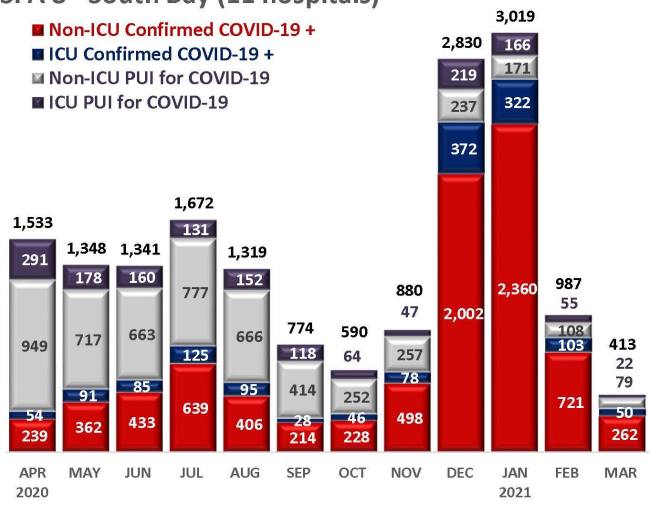
SPA 6 - South (2 hospitals)



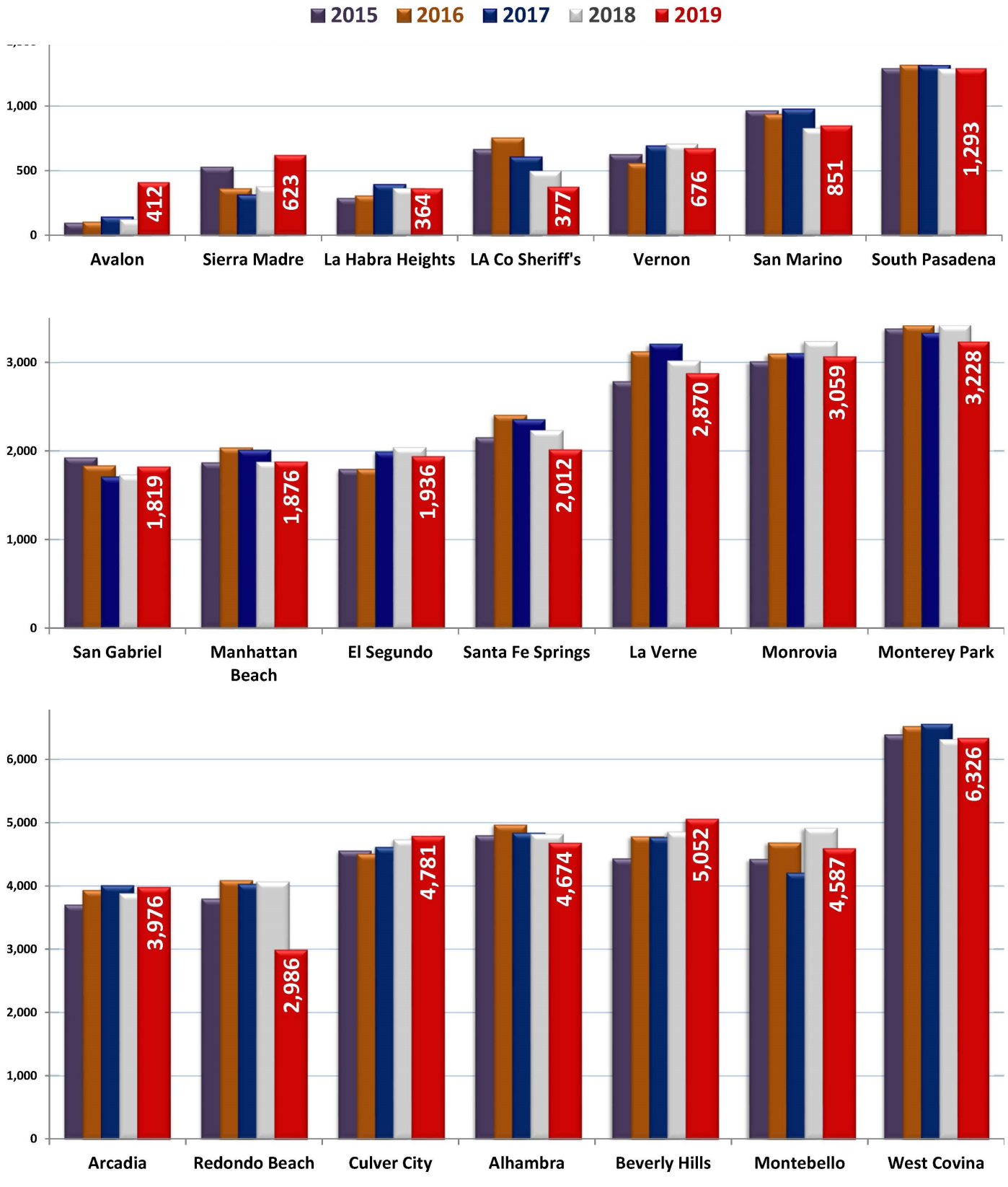
SPA 7 - East (8 hospitals)



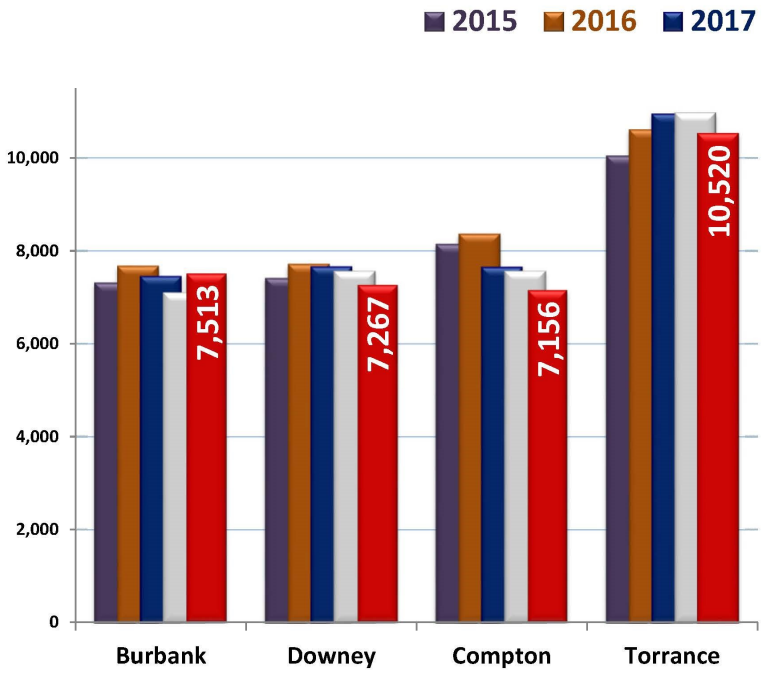
SPA 8 - South Bay (11 hospitals)

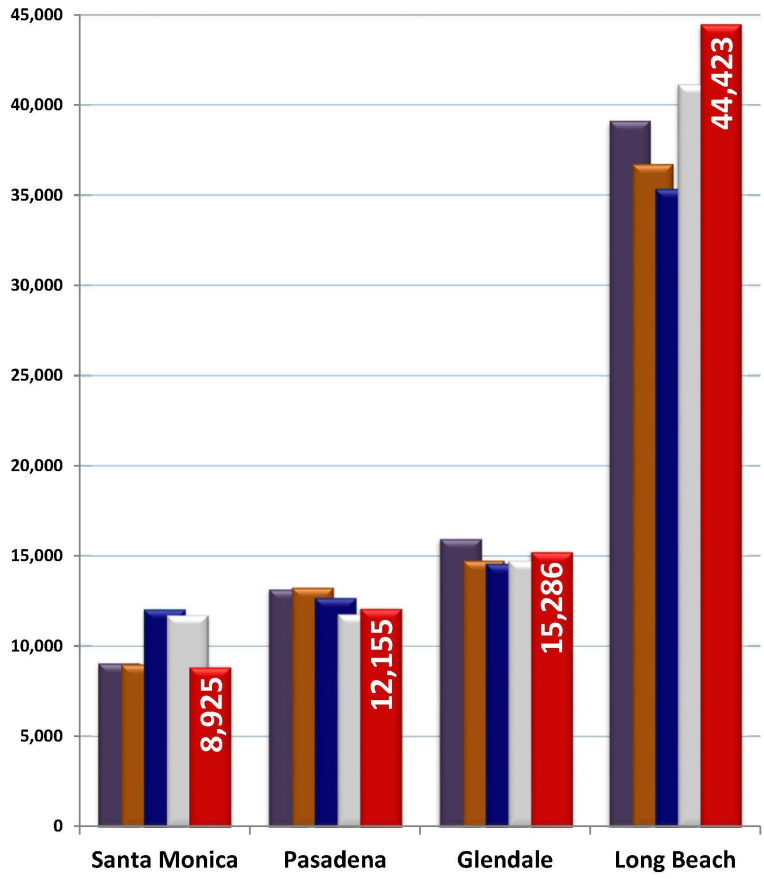


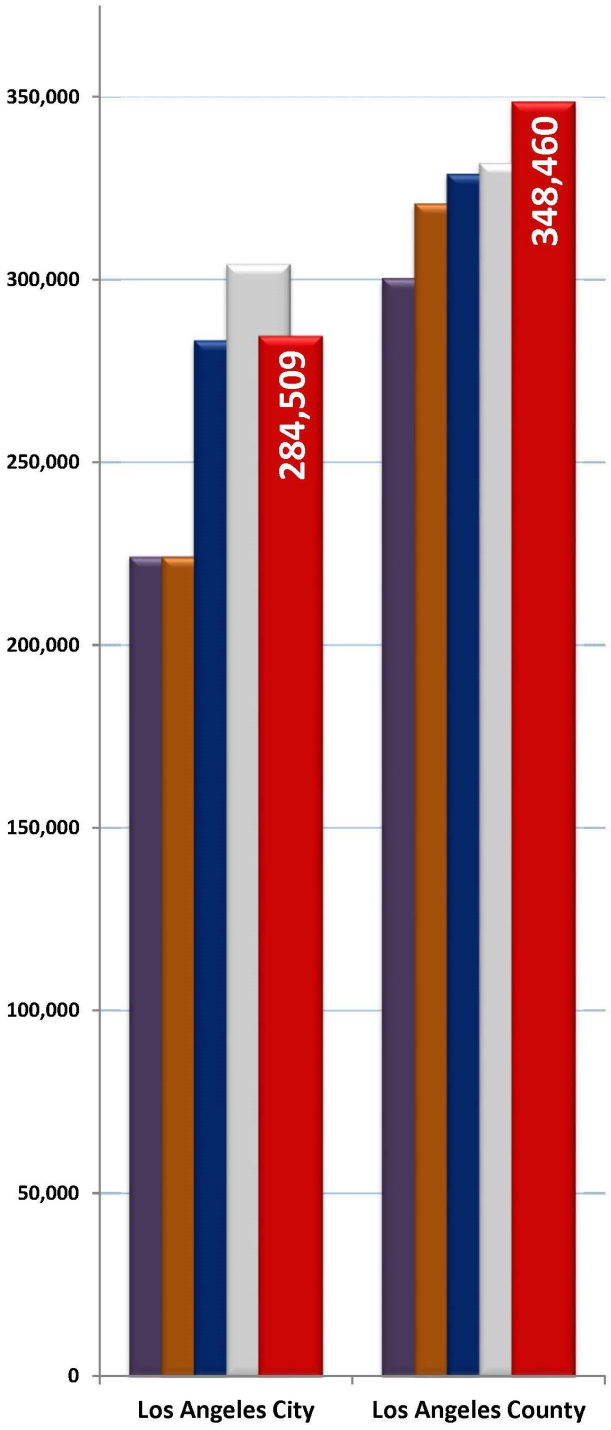
EMS Responses by 9-1-1 Jurisdictional Provider Agency



EMS Responses by 9-1-1 Jurisdictional Provider Agency







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

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

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

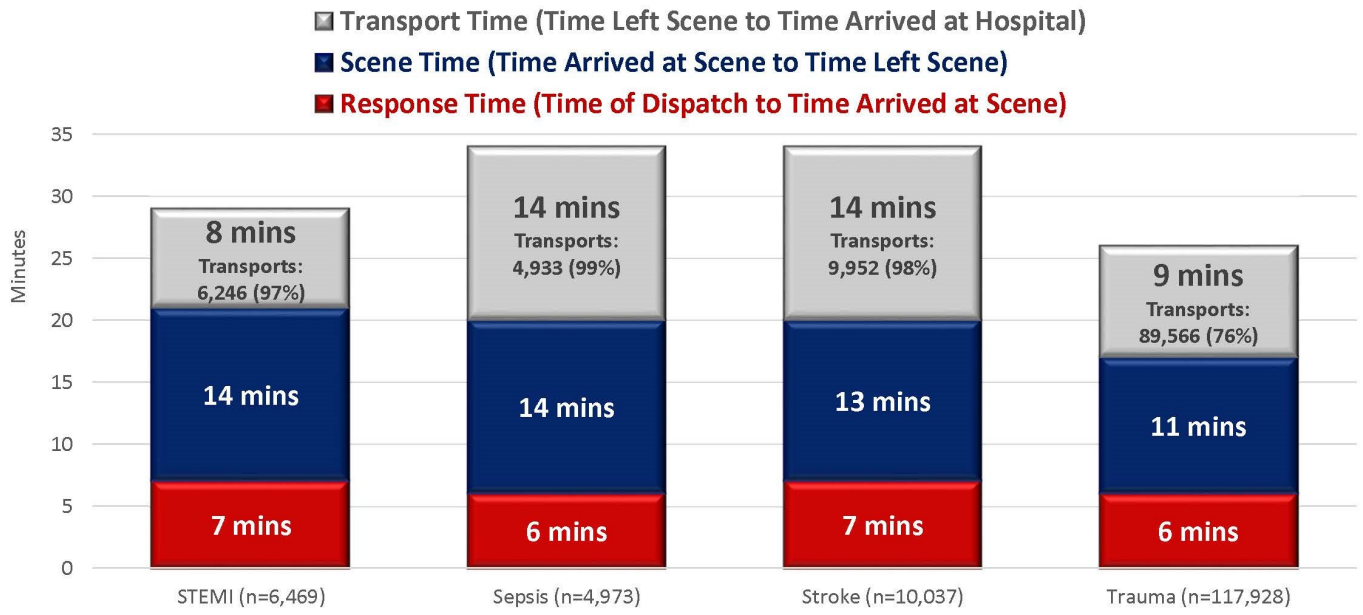
PEDIATRIC PROVIDER IMPRESSIONS (TOP 10)	2018	%	2019	%
Traumatic Injury	8,559	23%	8,234	23%
No Medical Complaint	5,377	15%	4,709	13%
Seizure - Postictal	4,533	12%	4,988	14%
Behavioral / Psychiatric Crisis	1,860	5%	1,827	5%
Cold / Flu	1,690	5%	1,771	5%
Fever	1,531	4%	1,467	4%
Respiratory Distress - Other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

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

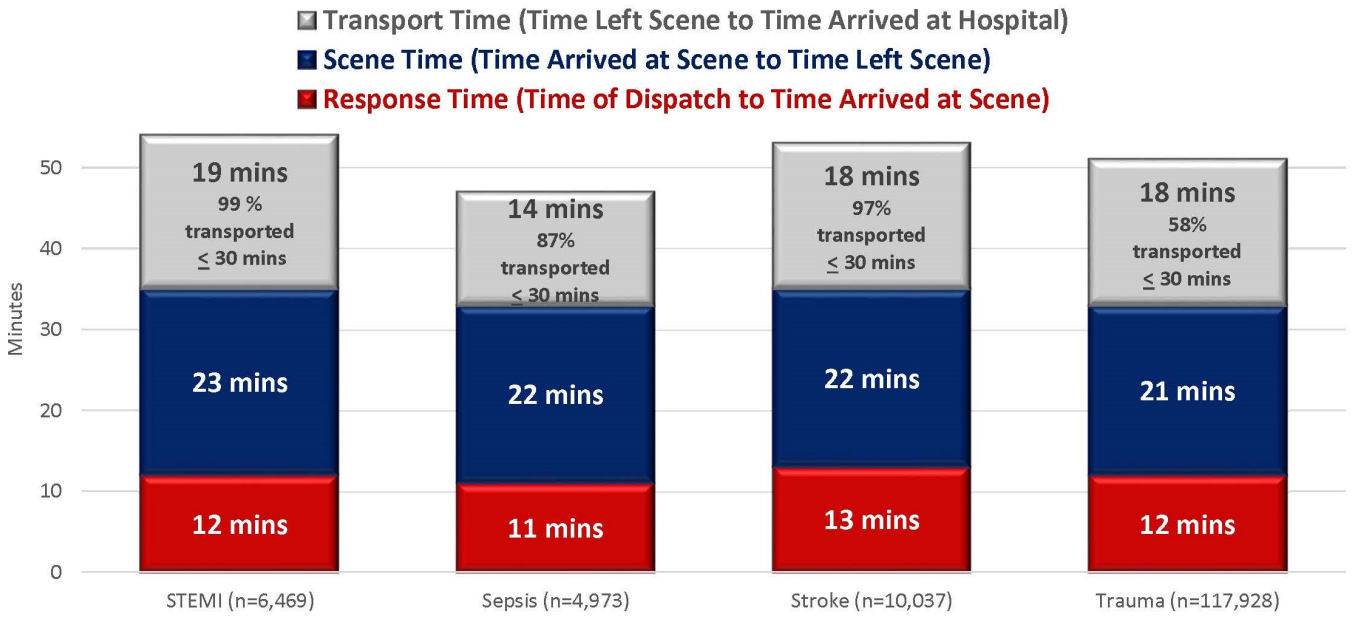
PEDIATRIC MECHANISMS OF INJURY (TOP 10)	2018	%	2019	%
Fall	3,215	31%	2,859	28%
Motor Vehicle Accident	2,503	24%	2,882	28%
Sports / Recreational	789	8%	758	7%
Pedestrian/Bicycle struck by Motor Vehicle	728	7%	778	8%
Animal Bite	328	3%	452	4%
Assault	475	5%	449	4%
Accidental Self-Inflicted Injury	133	1%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

2019 EMS Times: Adult (Median)

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

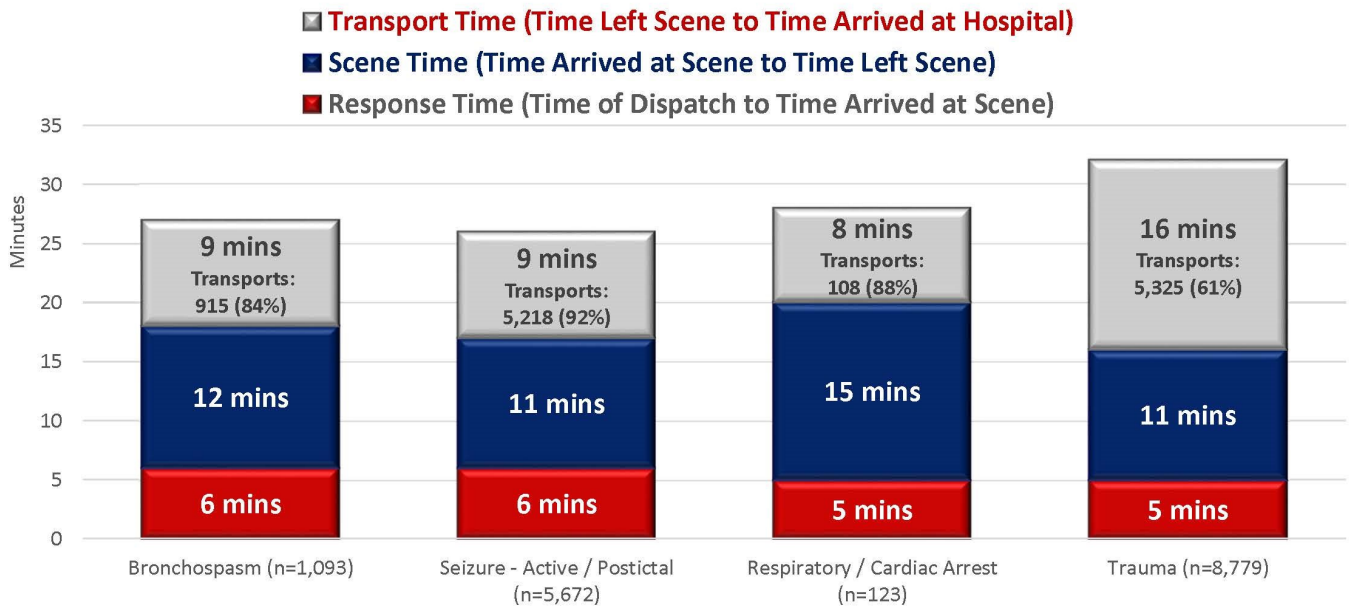


2019 EMS Times (90th Percentile)

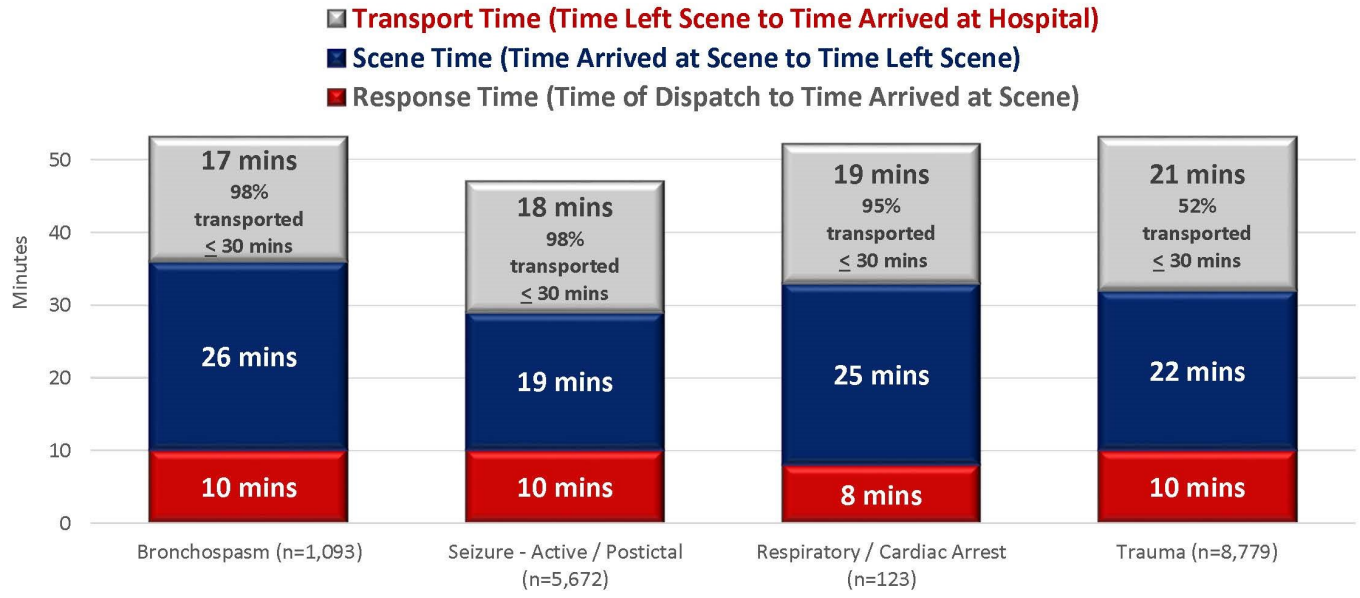


2019 EMS Times: Pediatric (Median)

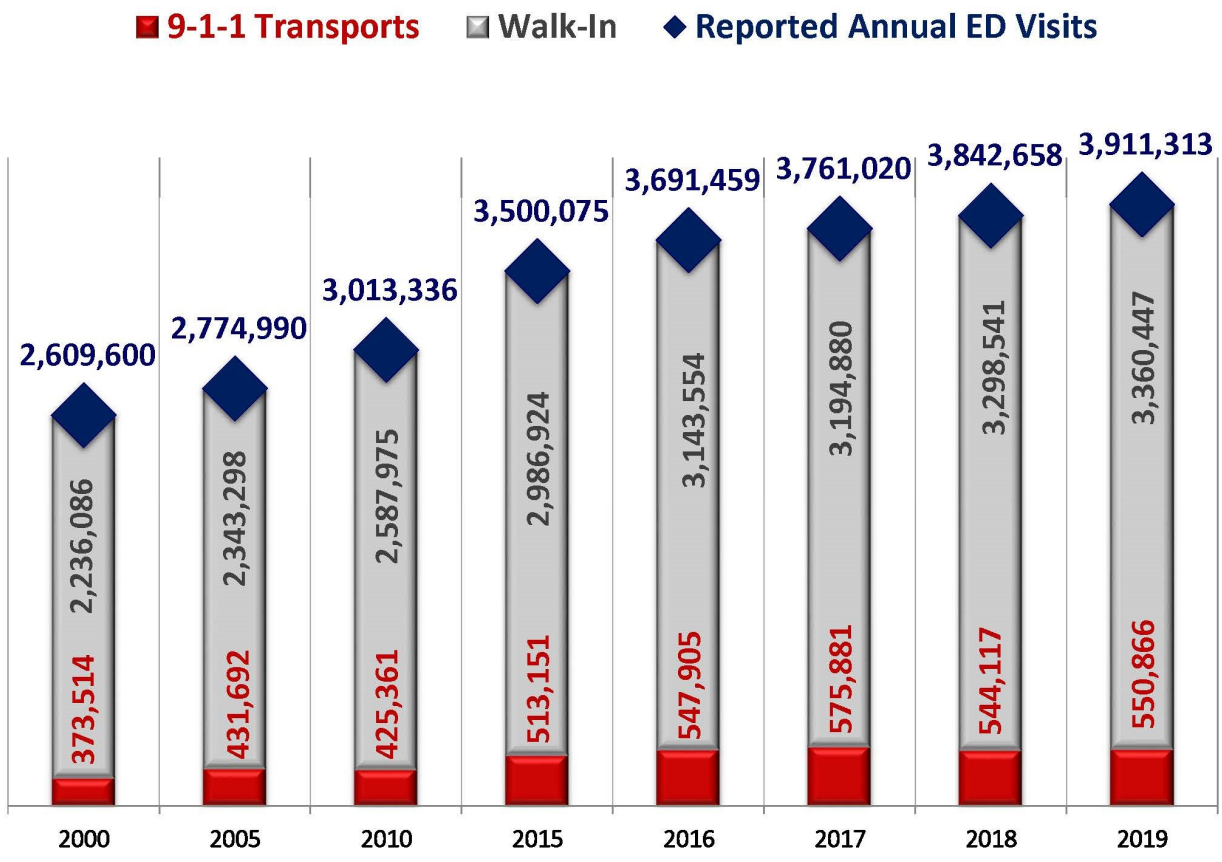
LA County EMS Transport Time PEDIATRIC Patients with Provider Impressions Bronchospasm, Seizure, Respiratory/Cardiac Arrest and Traumatic Injuries



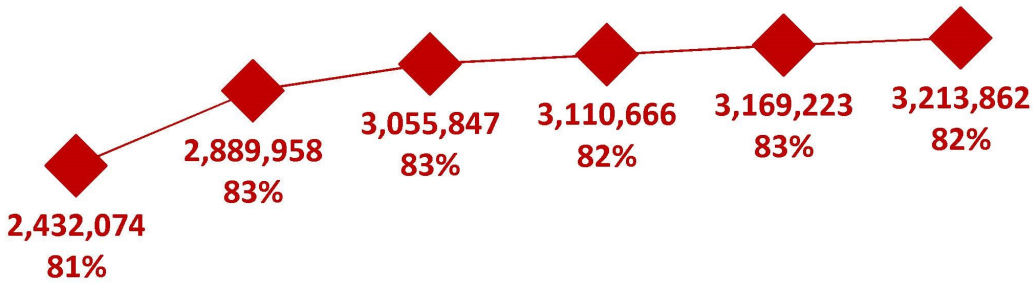
2019 EMS Times: Pediatric (90th Percentile)



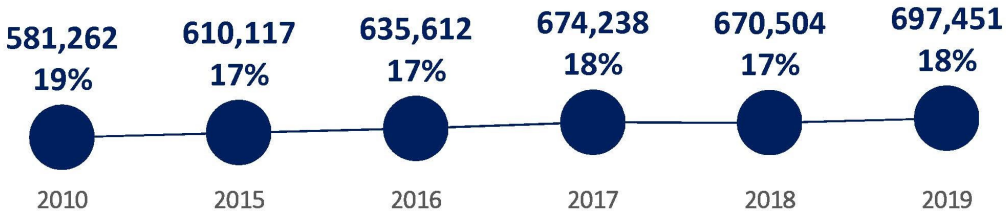
Emergency Department Volume



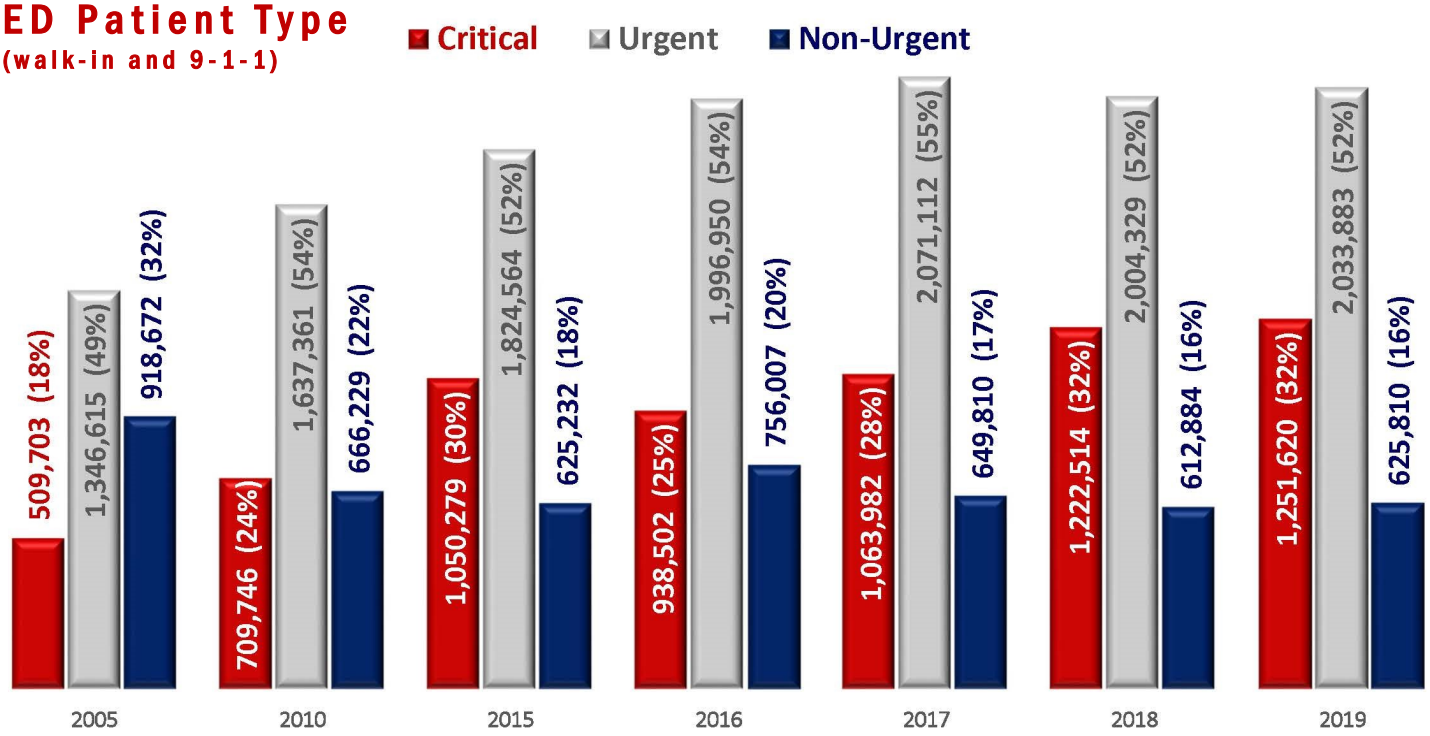
Adult:
15 years and older



Pediatric:
14 years and younger

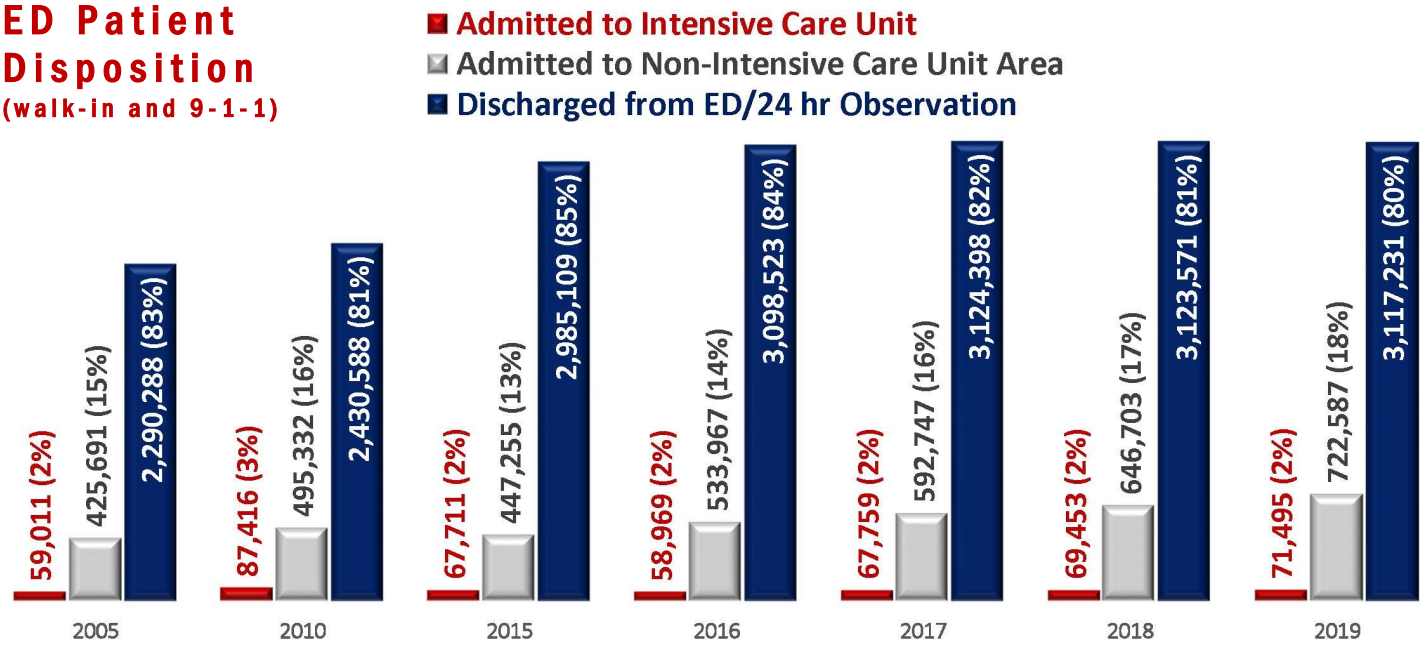


ED Patient Type
(walk-in and 9-1-1)

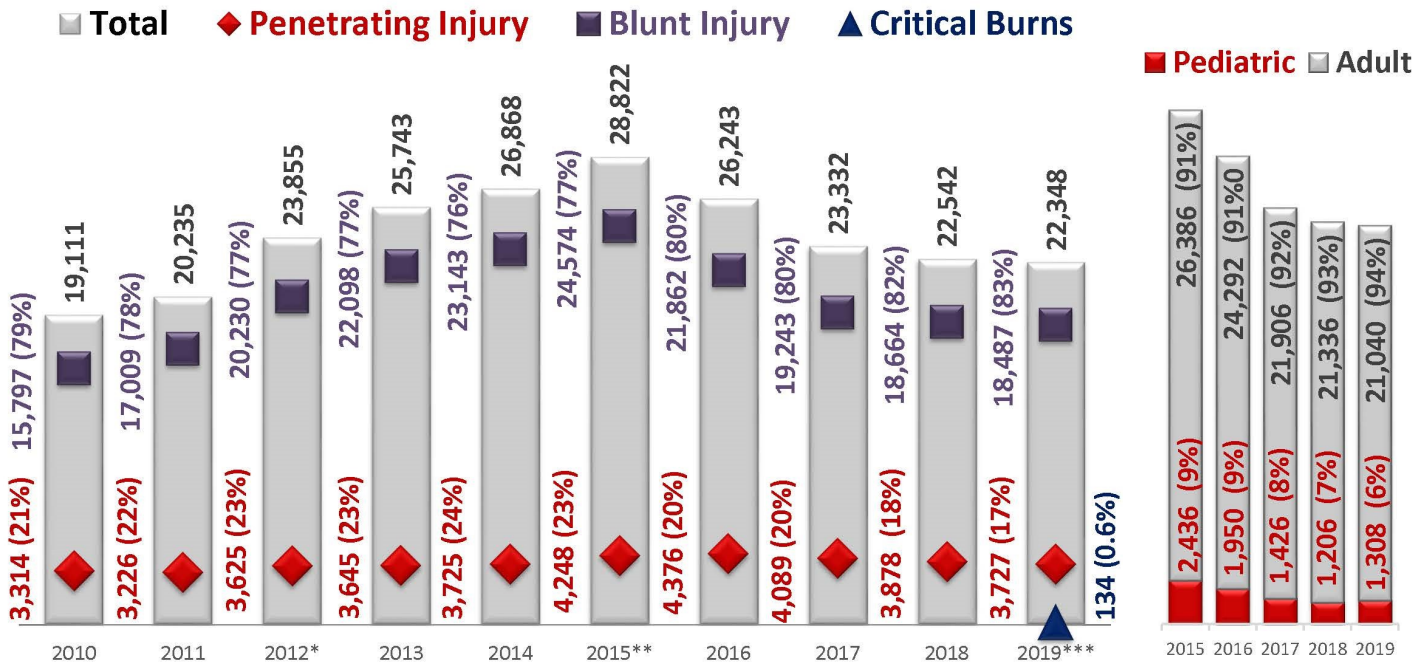


Critical—a patient presents an acute injury or illness that could result in permanent damage, injury or death (head injury, vehicular accident, shooting). Applicable Current Procedural Terminology (CPT) codes for this level of service would be 99284 (detailed history, detailed physical, and medical decision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

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

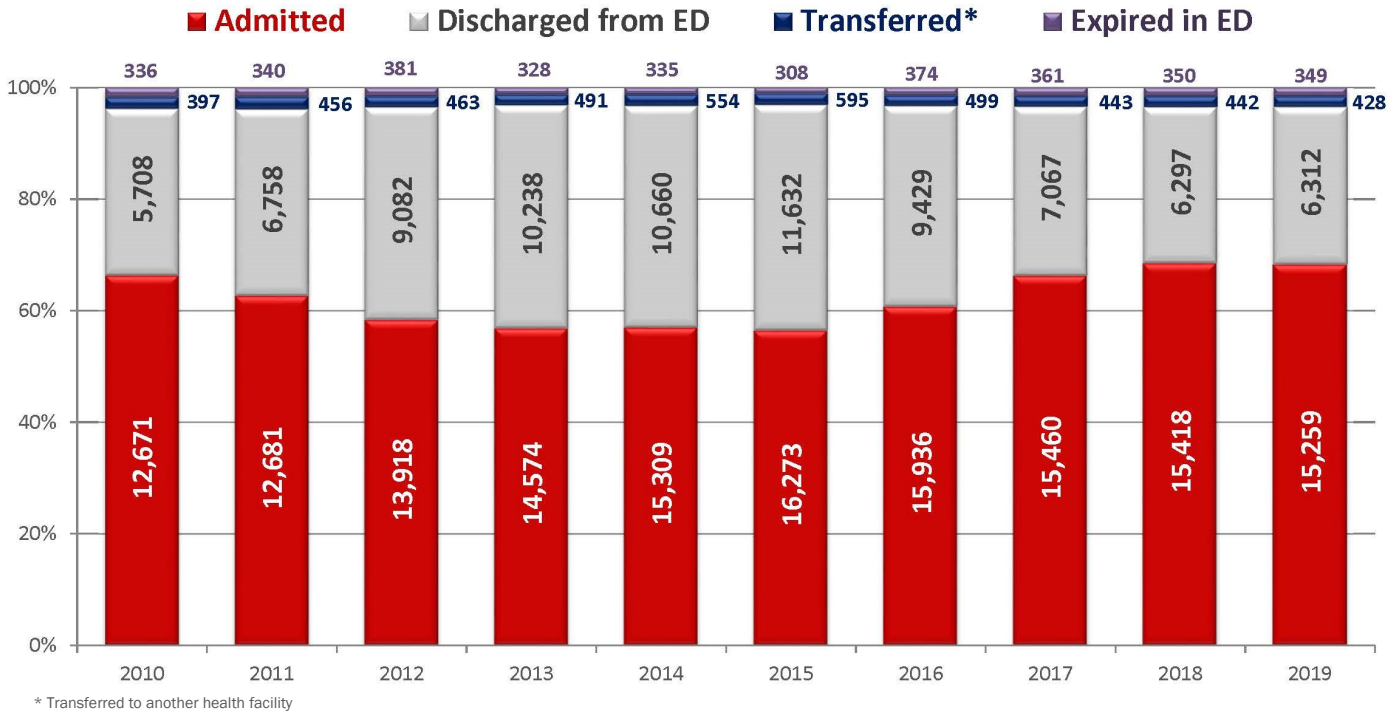


Trauma Center Volume



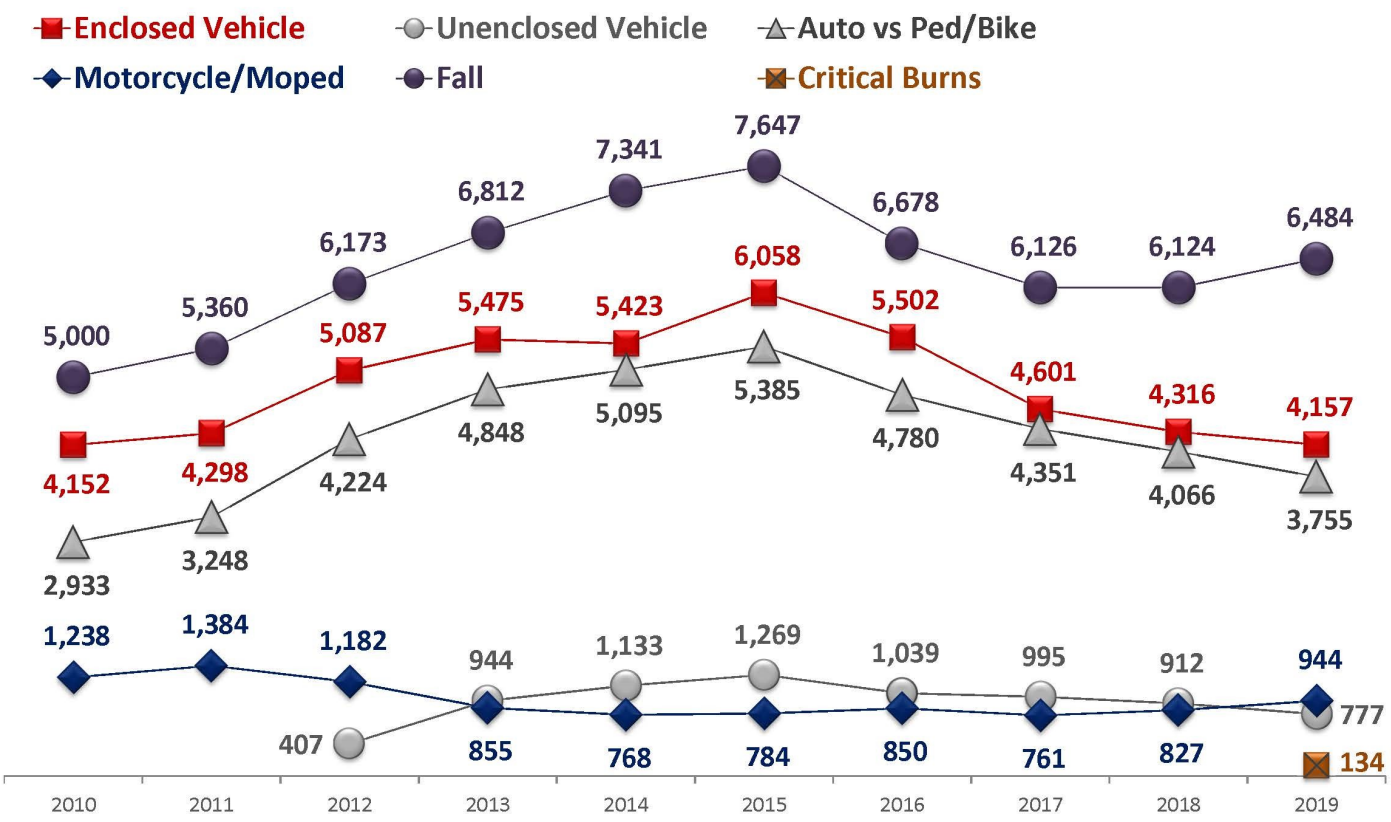
*2012: LA County adopted the Centers for Disease Control and Prevention Guidelines for Field Triage of Injured Patients
**2015 : Trauma Center Registry inclusion criteria was reduced.
***2019: Critical Burns added as a Trauma Center Criteria

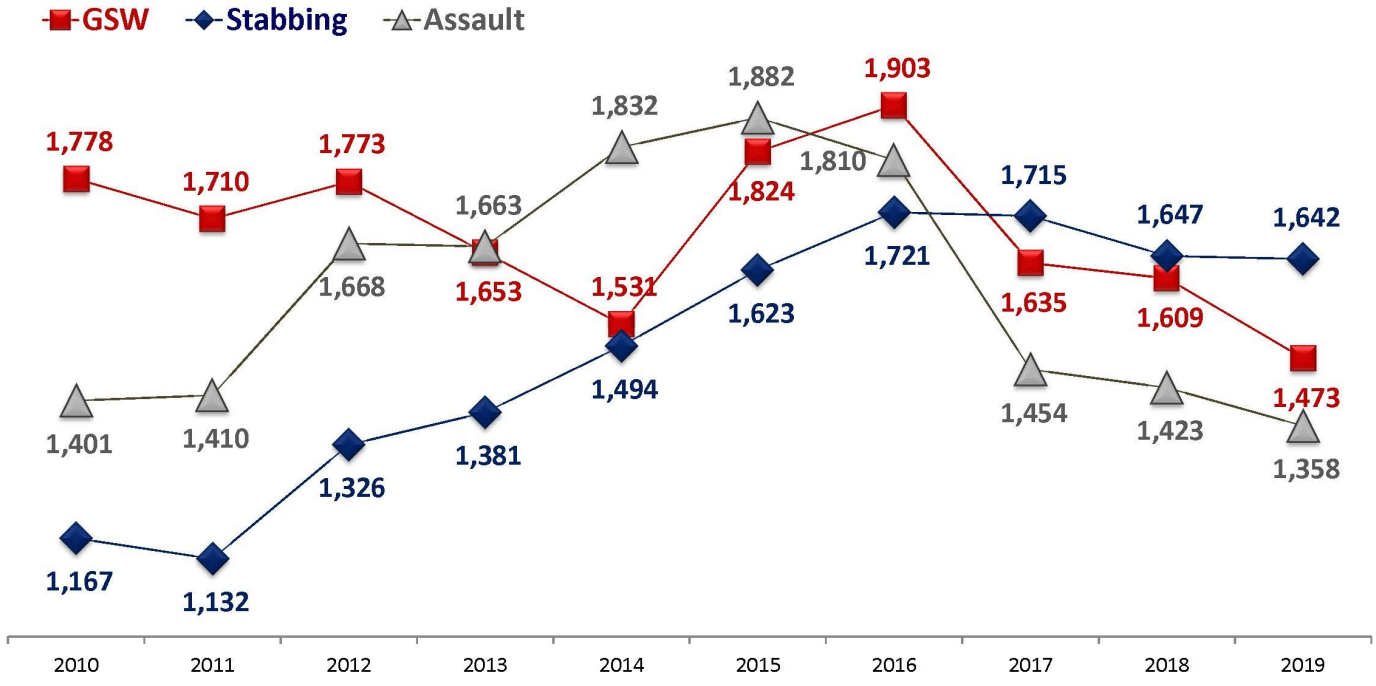
Patient Disposition of Trauma Center Patients



* Transferred to another health facility

Mechanism of Injury: Patients Transported to Trauma Centers

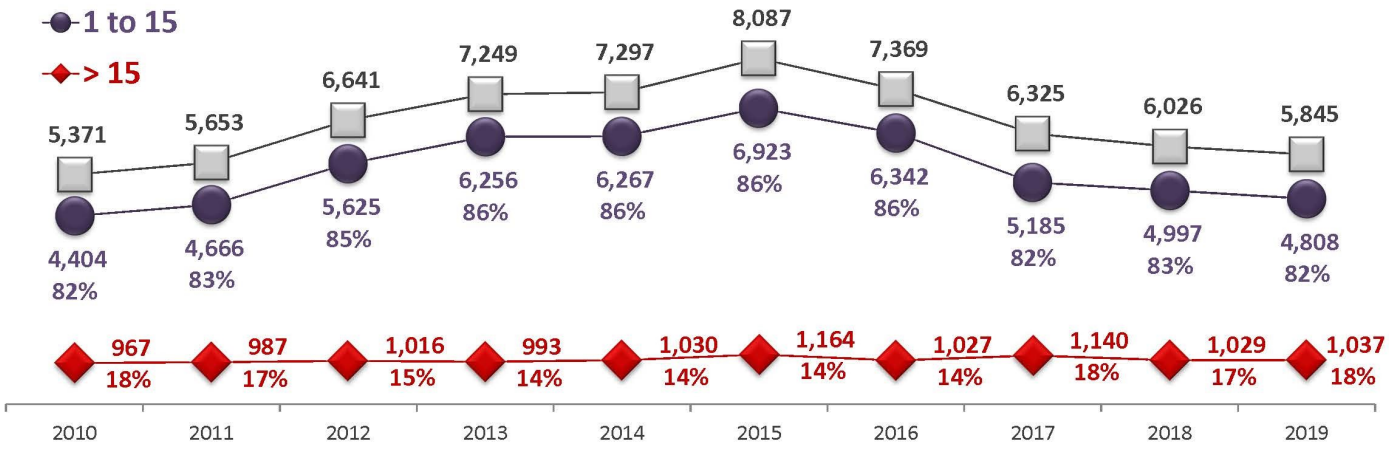




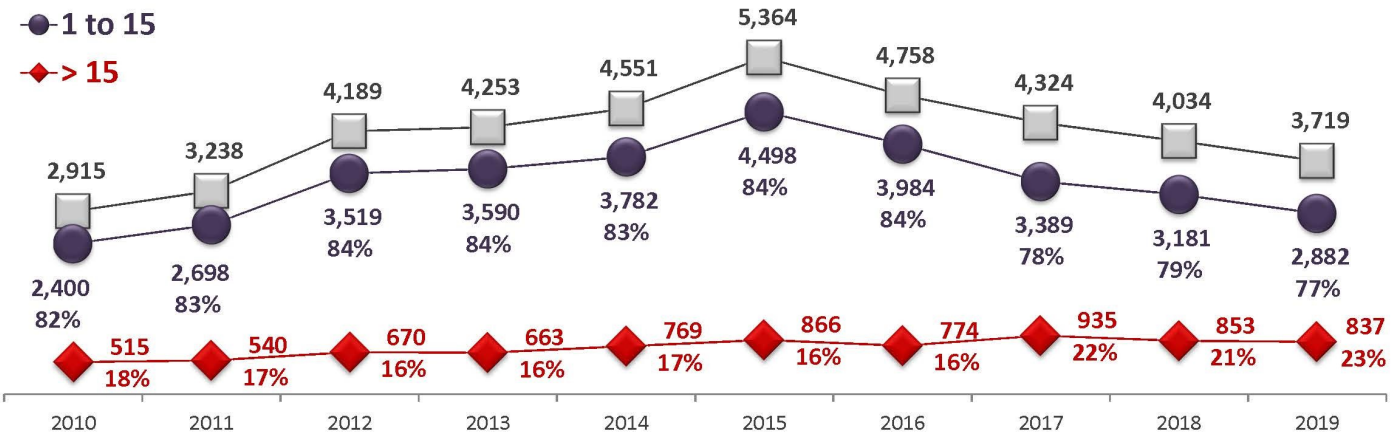
Injury Severity Score by Mechanism of Injury

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

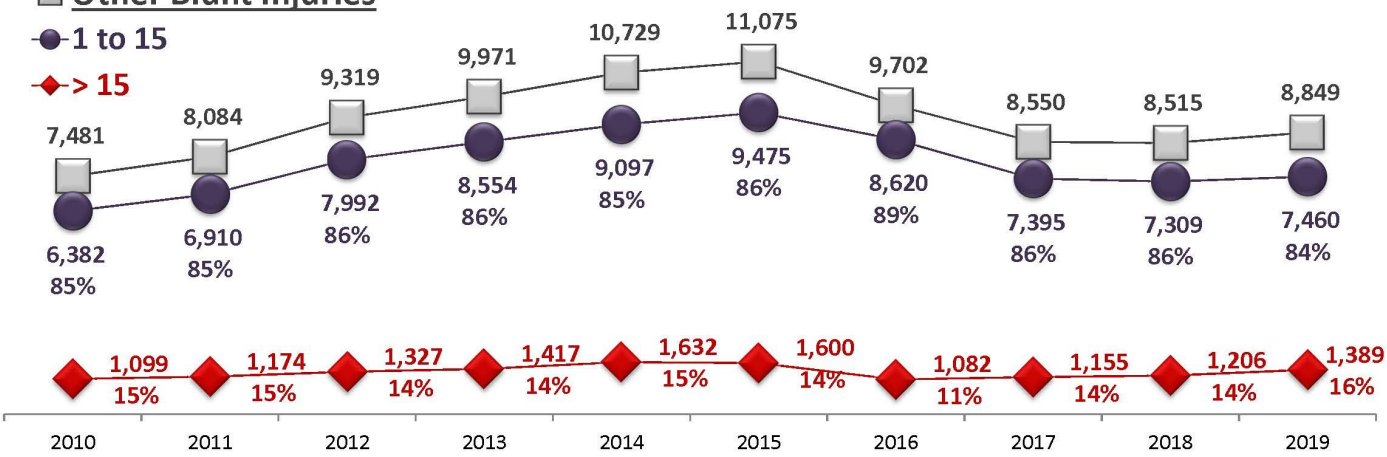
Motor Vehicle Accident



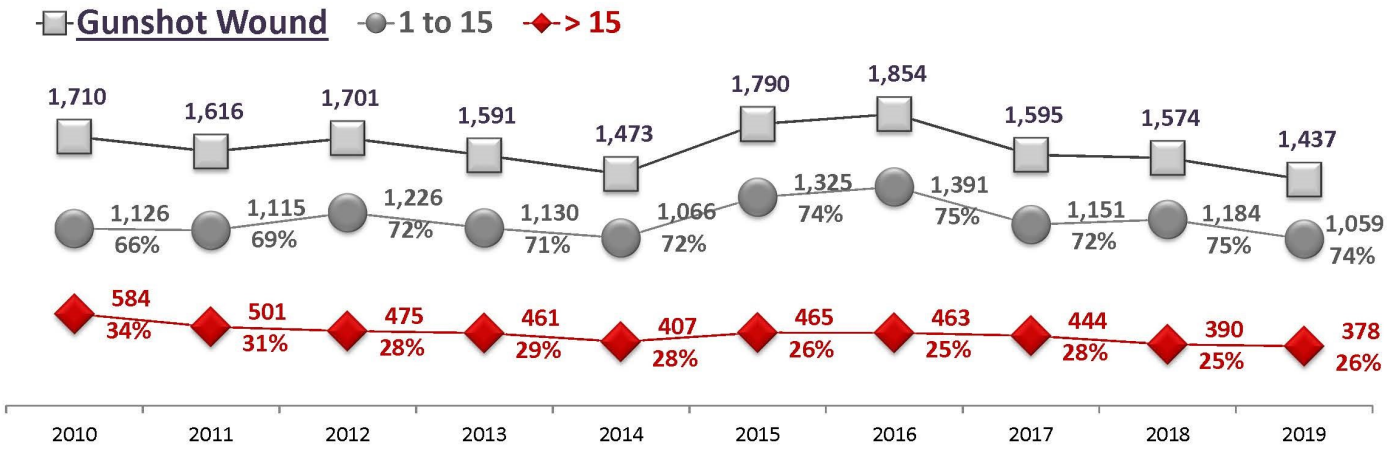
Automobile vs Pedestrian/Bicycle

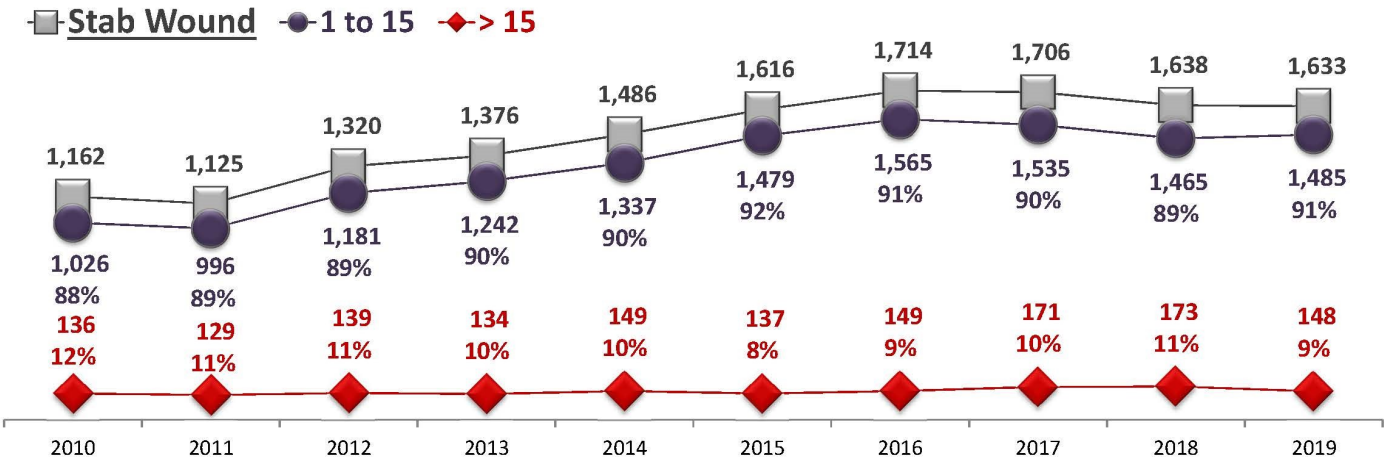


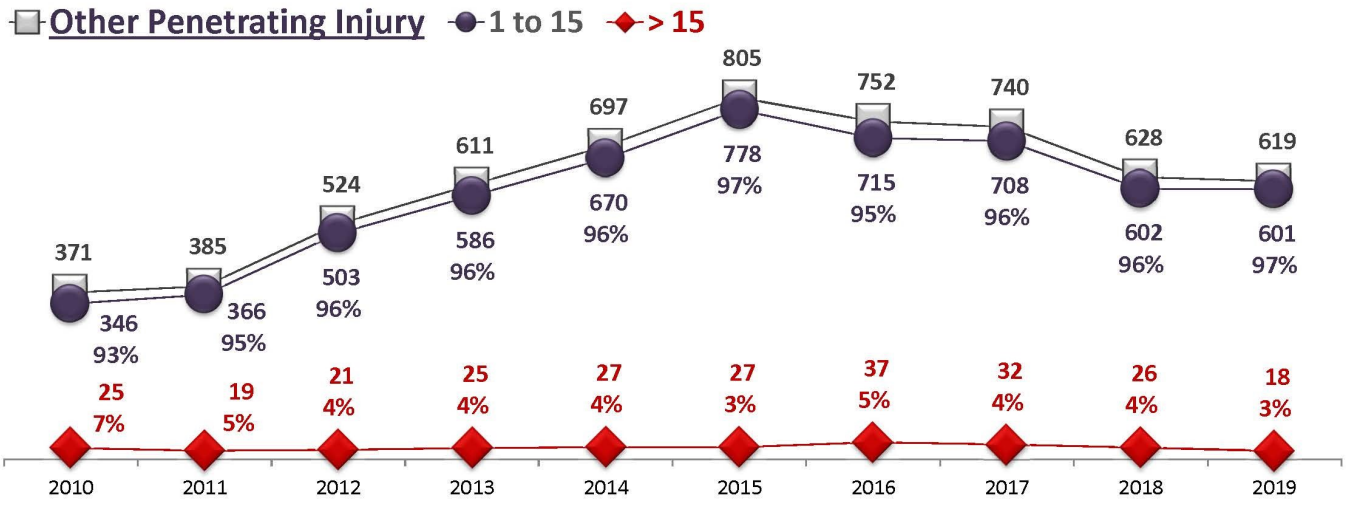
Other Blunt Injuries



Injury Severity Score by Mechanism of Injury



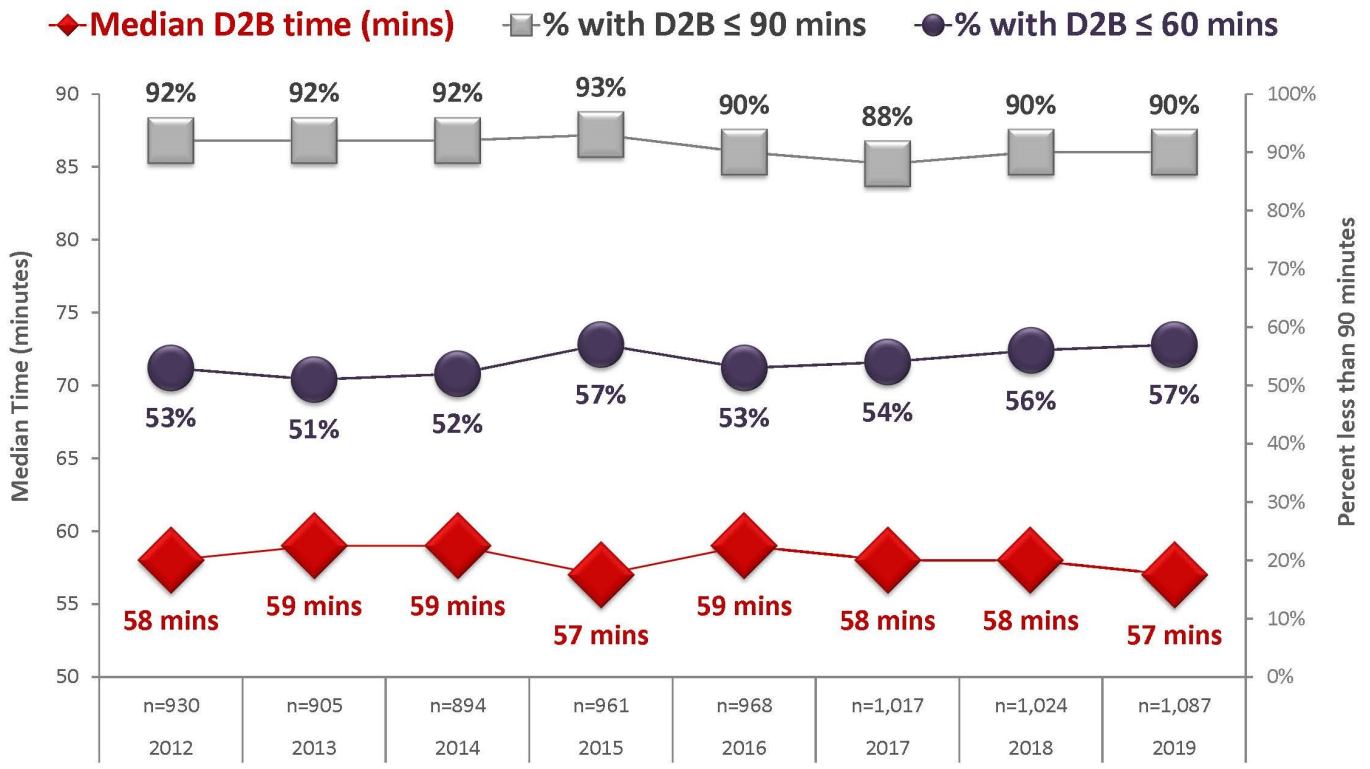




ST-Elevation Myocardial Infarction (STEMI)

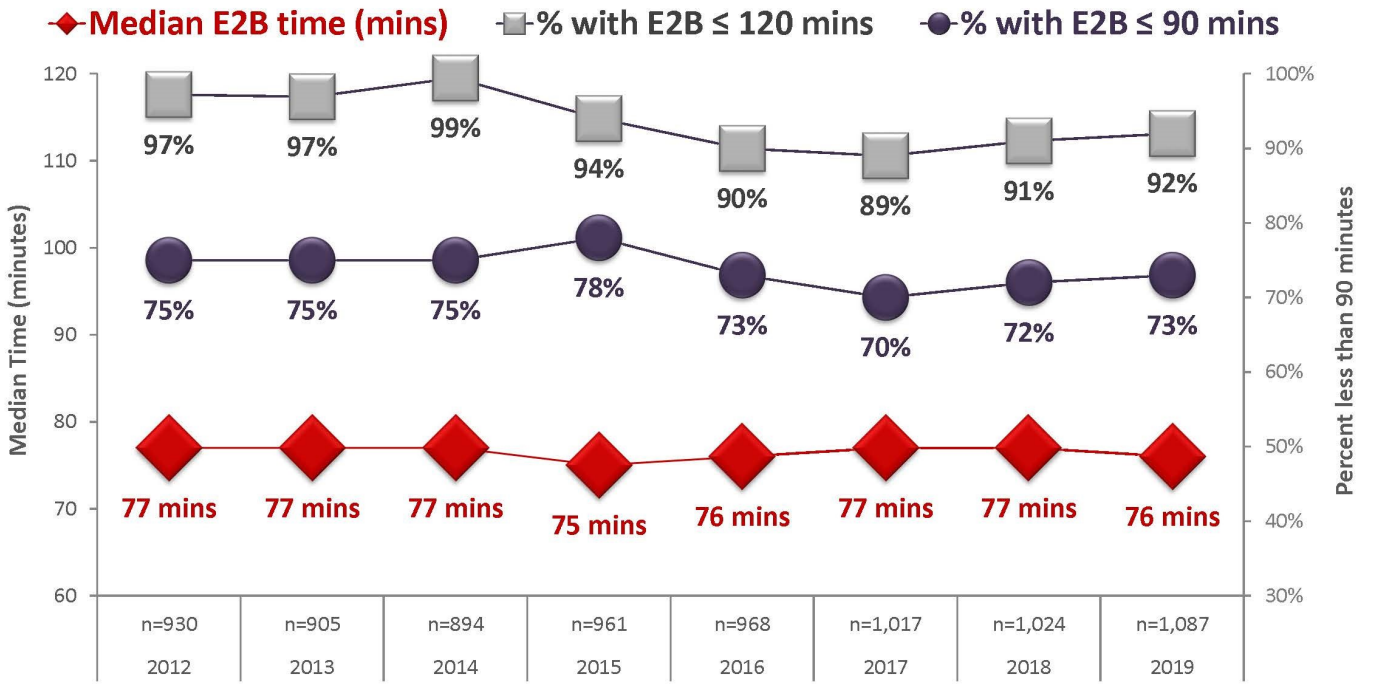
STEMI Receiving Center: Door-to-Device (D2B) Time

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



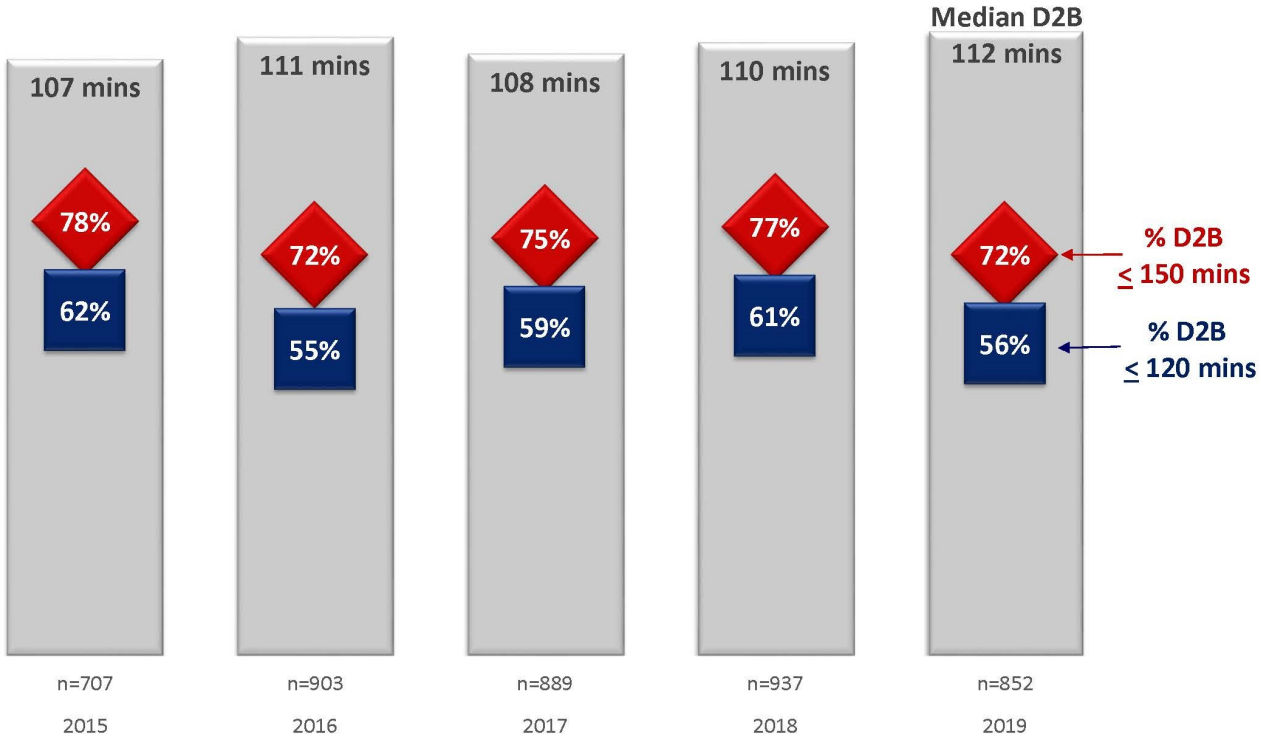
STEMI Receiving Center: EMS Medical Contact-to-Device (E2B) Time

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



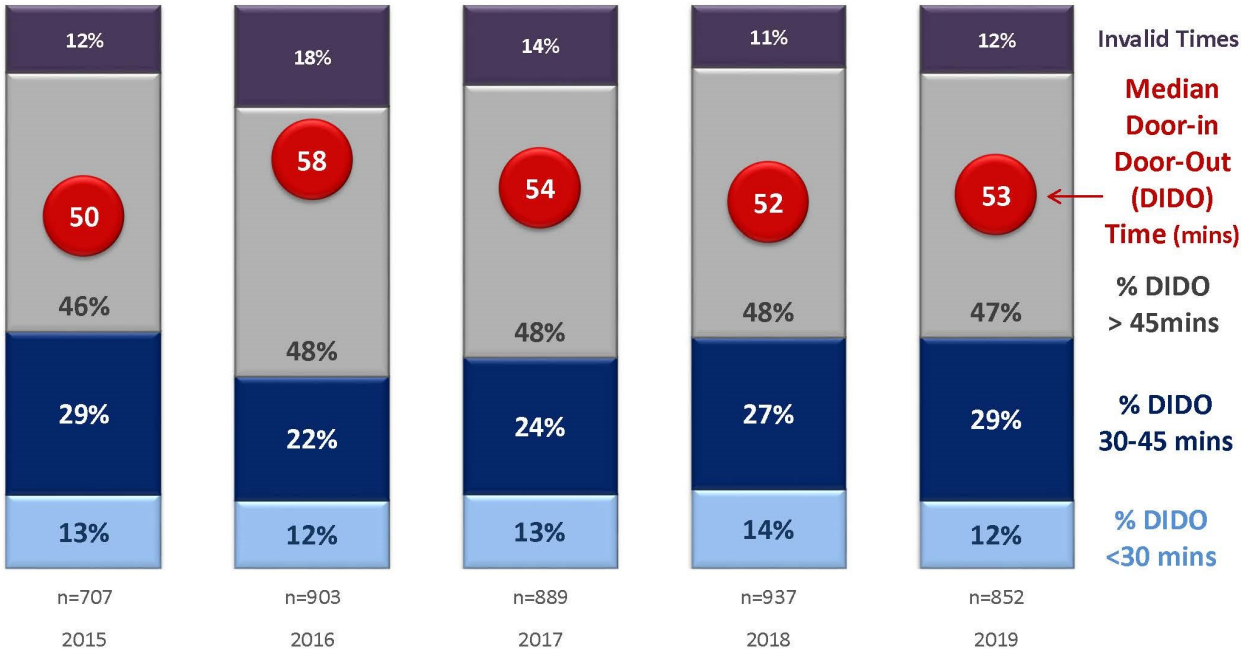
STEMI Referral Facility: Door-to-Device (D2B) Time

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

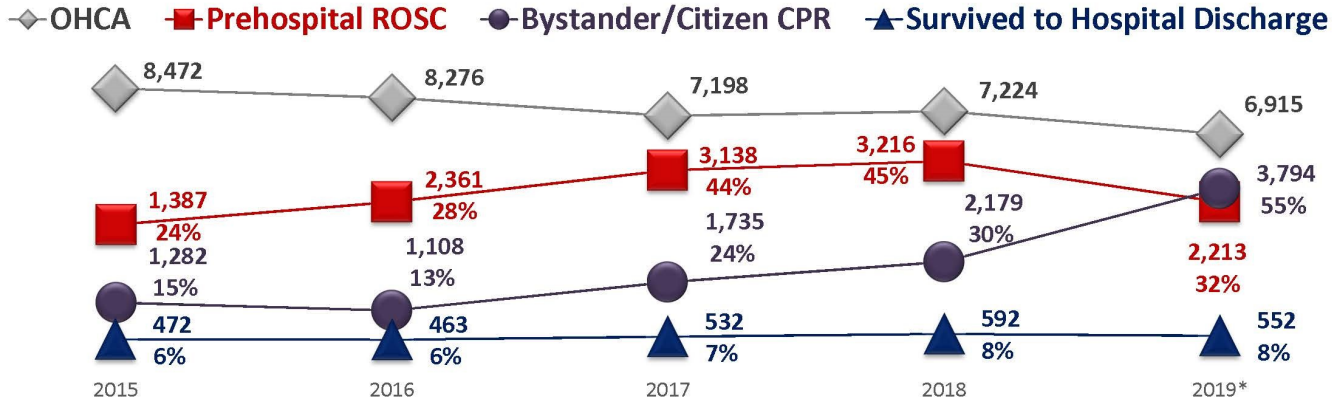


STEMI Referral Facility: Door-in Door-out (DIDO) Time

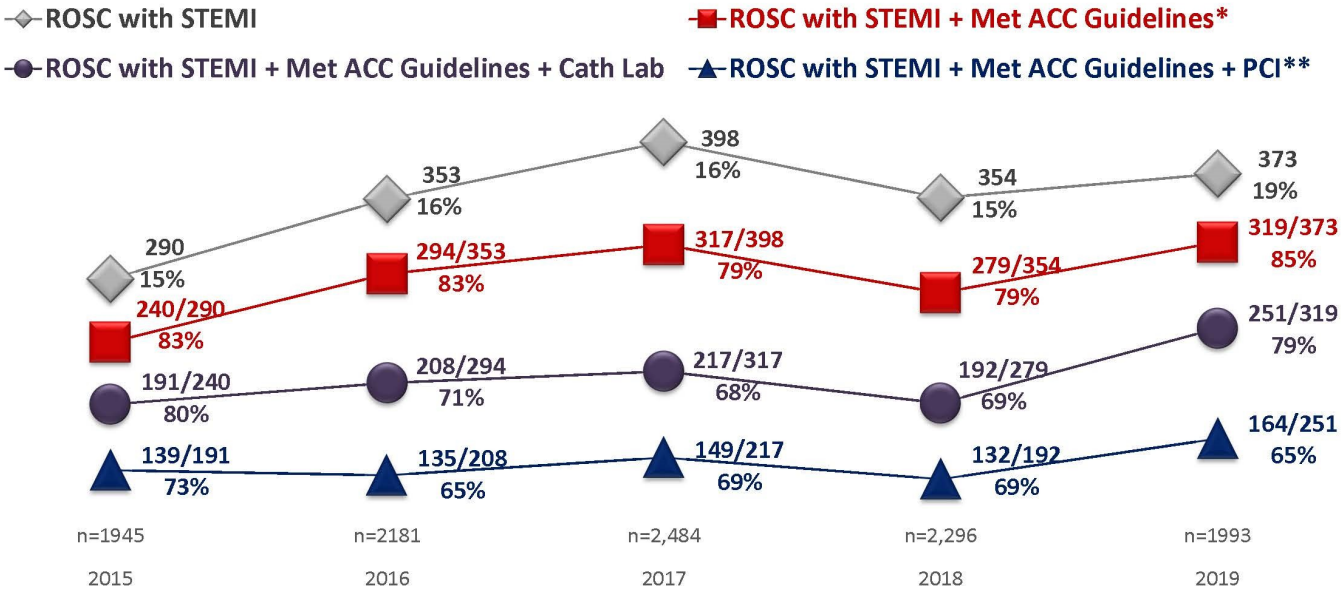
LA County Target: < 30 minutes



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

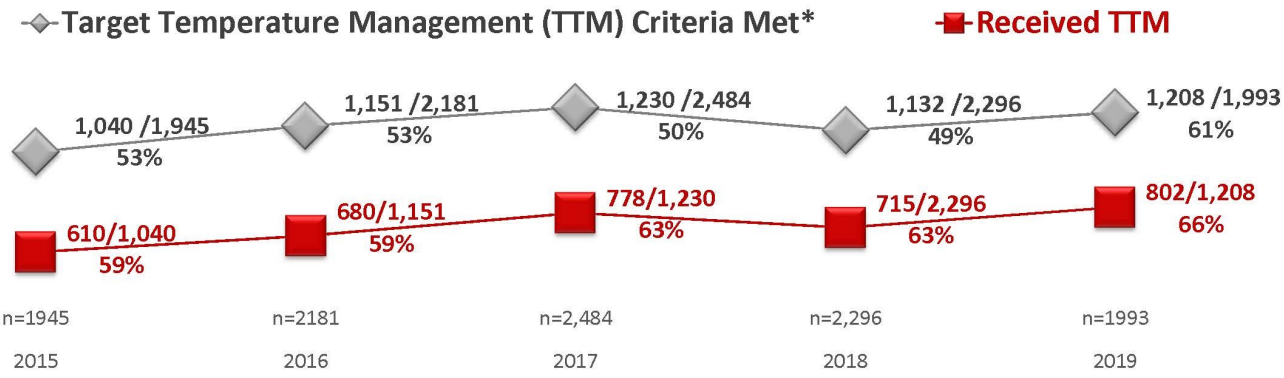


*2019 OHCA population is based on Provider Impression Cardiac Arrest Non-Traumatic, which was fully implemented April 1, 2019. DOAs were excluded. 2015-2018 OHCA population was based on Chief Complaint of Cardiac Arrest.



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

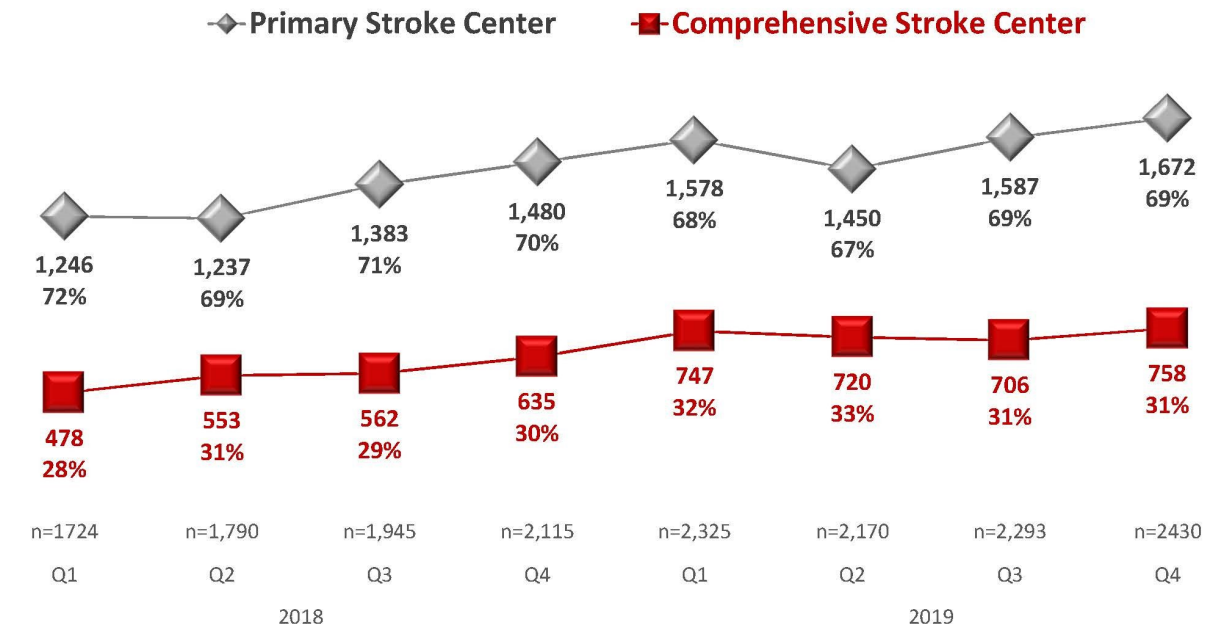
**PCI - Percutaneous Coronary Intervention is a procedure used to open or widen a narrowed or blocked coronary artery to restore blood flow supplying the heart.



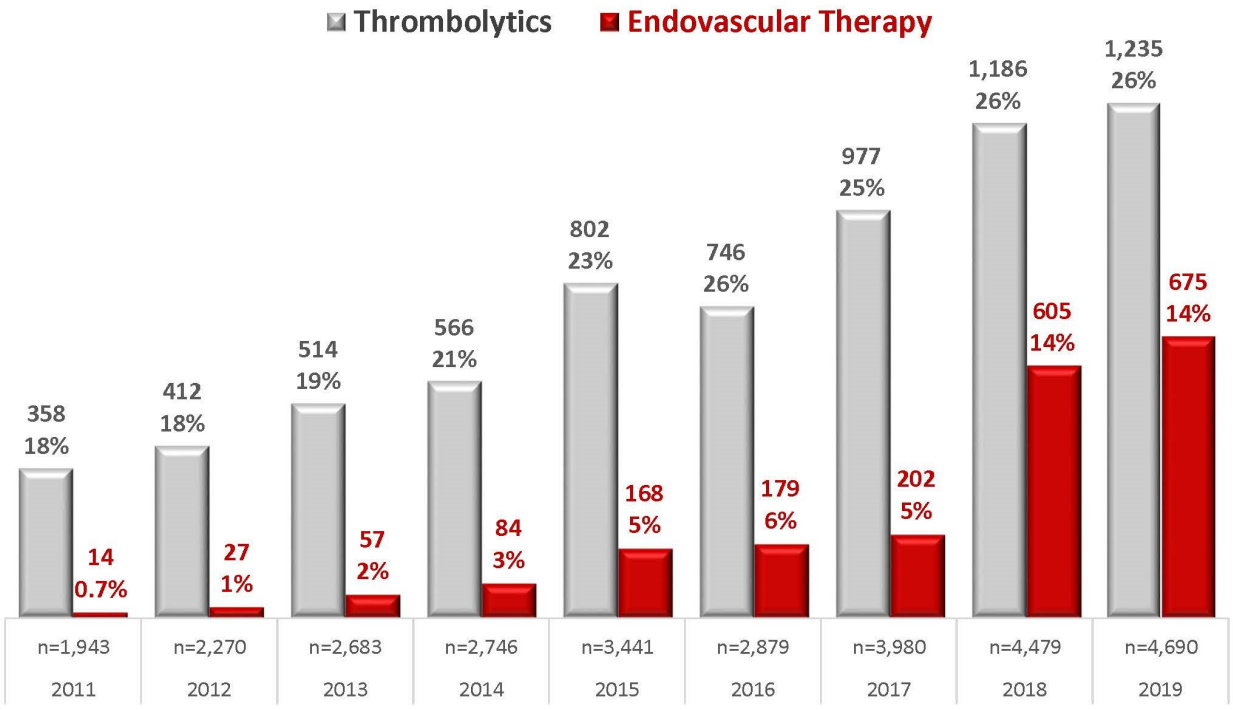
*TTM criteria excludes: died in ED, age <18, awake/responsive, end stage terminal illness, core temp <35 and pre-exiting DNR

Suspected Stroke Patient Destination

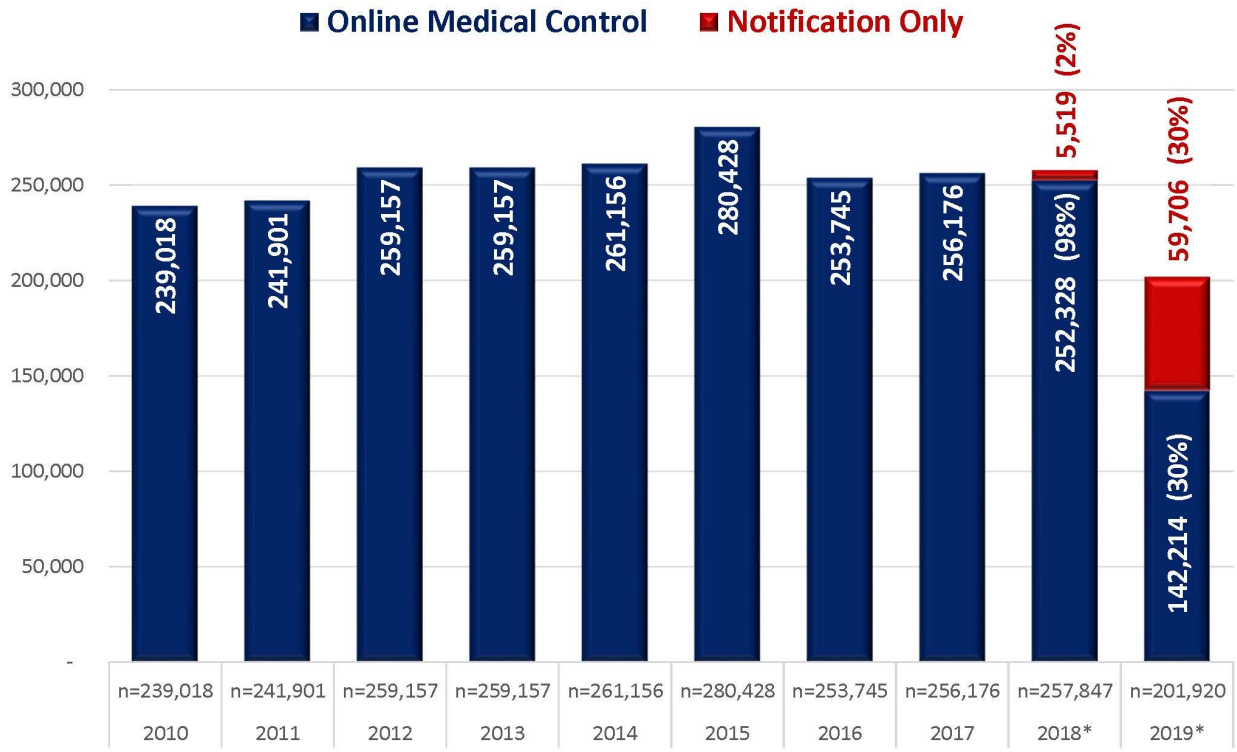
The routing of suspected stroke patients with large vessel occlusions based on a Los Angeles Motor Scale (LAMS) score of 4 or 5 to designated Comprehensive Stroke Centers began on January 8, 2018.



Treatment—All Ischemic Stroke



Paramedic Base Hospital Contact Volume



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

EMS AGENCY

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

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

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

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

ANNUAL WORKPLAN

The EMS Commission's goals and objectives for the upcoming year support the County's mission, vision, and strategic priorities through continuing to make recommendations on policies that support the health of residents and visitors to Los Angeles County. The EMS Commissions' membership ensures input and understanding of the various organizations and communities served by the EMS system.

Goals and Objectives:

- Review and recommend policies and directives for adoption by the EMS Agency
- Provide input on proposed policies and suggested changes
- Review criteria for 9-1-1 Receiving Center Designation
- Review Los Angeles County Ordinance, Chapter 3.20: *Emergency Medical Services Commission* Section 3.20.040: Composition: to update the nominating entity of the member and any other member requirements such as working in Los Angeles County
- Advice on the impact of emergency medical care policies related to paramedic and EMT services and training
- Monitor State and Federal legislation affecting the EMS system
- Through the established committee process, advise and recommend topics for education
- Conduct public hearings, as required
- Continue moving forward and implement recommendations from the September 2016 Ad Hoc committee report on the *Prehospital Care of Mental Health and Substance Use Emergencies* through:
  - Development of protocols for management of agitated patients – pharmacologic and non-pharmacologic
  - Monitor, support, and make policy recommendations to standardize criteria for dispatching fire and law to behavioral health calls
  - Revise Prehospital Care Policy Reference No. 838: *Application of Restraints*
  - Ensure collaboration and awareness of Department of Mental Health and similar groups work to establish a system to triage mental health emergency calls and deploy the appropriate resources to these calls
- Continue to engage with law enforcement to support similar or overlapping response protocols, i.e., tactical EMS, use of Narcan in the field, and dispatch and triage of 9-1-1 behavioral calls
- Continue to monitor ambulance patient offload times (APOT) data and work with transportation providers, including ambulance companies and fire departments, and hospitals to reduce ambulance patient offload times and recommend best practices to address offload delays
- Support the EMS Agency's efforts to ensure timely and accurate data submission from all EMS providers and specialty care centers
- Participate as a voting member on the Measure B Advisory Board and ensure constituent groups are aware of the Measure B allocation process
- Maintain awareness of the EMS Agency's COVID-19 response activities related to supporting the hospitals and EMS providers and data collection/analysis

4.10 BUSINESS (NEW)

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES

EMS AGENCY MEETING SCHEDULE

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

2022

Note: Meeting dates and times are subject to change

Revised: October 12, 2021

COMMITTEE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
EMS Commission *(3rd Wednesday - ODD months)* ***1:00 pm***	19		16		18		20		21		16	
Base Hospital Advisory Committee *(2nd Wednesday - EVEN months)* ***1:00 pm***		9		13		8		10		12		7
Data Advisory Committee *(2nd Wednesday - EVEN months)* ***10:00 am***		9		13		8		10		12		7
Provider Agency Advisory Committee *(3rd Wednesday - EVEN months)* ***1:00 pm***		16		20		22		17		19		21
Pediatric Advisory Committee *(Tuesday – Quarterly)* ***10:00 am***			1			7			6			6
Medical Council *(Tuesday – Quarterly)* ***1:00 pm***			1			7			6			6
Trauma Hospital Advisory Committee *(4th Wednesday – ODD months)* ***1:00 pm***	26		23		25		27		28		30	
EMS Orientation *(Last Tuesday - Quarterly)* ***8:00 am***	25			26			26			25		
Innovation, Technology and Advancement Committee *(1st Monday- Quarterly)* ***10:00 am***		7			2			1			7	
EMS QI Committee Base Hospital and Public Provider *(2nd Thursday – Quarterly)* ***1:00 pm***		10			12			11			10	
EMS Private Provider QI Committee *(1st Thursday – every 4th month)* ***1:00 pm***				7				4				1
ACN-Building Emergency Coordinators Meeting *(4th Wednesday– Quarterly)* ***9:00 am***	26			27			27			26		
Disaster Coalition Advisory Committee *(1st Thursday – Every 4th month)* ***9:30 am***		3				2				6		

AB 389 (Grayson D) Ambulance services.

Status

9/17/2021 - Enrolled and presented to the Governor at 3 p.m.

Summary

The Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, among other things, authorizes a county to develop an emergency medical services program, and requires a county developing such a program to designate a local EMS agency that is required to be the county health department, an agency established and operated by the county, an entity with which the county contracts for the purposes of local emergency medical services administration, or a particular type of joint powers agency. The act authorizes a local EMS agency to create one or more exclusive operating areas in the development of a local plan, if a competitive process is utilized to select the provider of the services pursuant to the plan, except as specified.This bill would specify that a county is authorized to contract for emergency ambulance services with a fire agency, as defined, that will provide those services, in whole or in part, through a written subcontract with a private ambulance service. The bill would further specify that a fire agency is authorized to enter into a written subcontract with a private ambulance service for these purposes. The bill would prohibit, on and after January 1, 2022, a county from entering into or renewing these contracts unless the county board of supervisors has adopted, by ordinance or resolution, a written policy setting forth issues to be considered for inclusion in the county contract for emergency ambulance services and the fire agency adopts a written policy that requires the written subcontract to be awarded pursuant to a competitive bidding process, as specified. The bill would specify certain issues that may be included in those written policies, including, for the county contract with the fire agency, employment retention requirements for the employees of the incumbent ambulance service, and, for the fire agency subcontract, whether the written request for proposals or other similar written request for bids adequately describes criteria to evaluate a bidder's demonstrated ability and commitment to providing cost-efficient and high-quality services. The bill would also require the county contract to demonstrate how the county contract will provide for the payment of comparable wages and benefits to all ambulance service employees that are generally consistent with those provided to ambulance service employees in the same geographic region and to demonstrate that the staffing levels for ambulance service employees will be comparable to the staffing levels under the county's previous contract. The bill would require a contracting fire agency to provide the ambulance service provider with reasonable advance written notice of any operational changes under the written subcontract and to use best efforts to address concerns raised by the ambulance service provider employees regarding those operational changes. (Based on text date 9/13/2021)

Bill Text

09/13/2021	Enrolled	pdf	htm
09/03/2021	Amended	pdf	htm
08/16/2021	Amended	pdf	htm
07/05/2021	Amended	pdf	htm
02/02/2021	Introduced	pdf	htm

Analysis

09/09/2021	Assembly - Floor Analysis
09/07/2021	Senate - Floor Analyses
08/18/2021	Senate - Floor Analyses
08/18/2021	Senate - Floor Analyses

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

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

July 14, 2021

Police Chief Michael Ishii
Hawthorne Police Department
12501 Hawthorne Boulevard
Hawthorne CA 90250

Dear Chief Ishii:

OFFICER COMMENDATIONS

The Emergency Medical Services (EMS) Agency would like to congratulate officers Bearet Luttenbacher, Samantha Naghaway, and John Yoshida on the recognition award from the California Emergency Medical Services Authority (EMSA).

The officers were recognized during the 2020 California EMS Services Award Ceremony on July 1, 2021 and received the EMSA Inter-Service EMS Service Recognition for their quick actions/treatment provided to a gunshot victim.

The officers responded to a scene of shots fired and found a female victim that sustained a gunshot wound to her left thigh and was hemorrhaging from the wound. The officers applied a tourniquet to her left upper thigh, controlling the hemorrhaging and was transported to a local trauma center where she underwent surgical intervention to repair her femoral artery.

There are many instances where law enforcement is first on scene of a medical or traumatic injury where officers are ready and capable of rendering initial (in many cases life saving) care to the victim(s).

This is reflective of Hawthorne Police Department's commitment to first responder education and the community. It also exemplifies the teamwork and close bond there is in our communities between EMS and law enforcement in providing Prehospital life-sustaining care.

Sincerely,

Cathy Chidester
Director

CC:jt
07-09

c. Officer Bearet Luttenbacher, Hawthorne Police Department
Officer Samantha Naghaway, Hawthorne Police Department
Officer John Yoshida, Hawthorne Police Department

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

July 30, 2021

Bryan Webb, Dispatch Center Manager
Los Angeles County Fire Dispatch
1320 N Eastern Avenue
Los Angeles, CA. 90063

CERTIFIED

IMPLEMENTATION OF SYSTEMWIDE DISPATCH CENTER ANNUAL PROGRAM REVIEWS

This letter is to notify you that the Emergency Medical Services (EMS) Agency will begin systemwide implementation of annual program reviews of dispatch centers responsible for public provider 9-1-1 emergency medical dispatch beginning September 2021.

In order to be consistent with the California Health & Safety Code § 1797.220 and the Emergency Medical Services Authority, Dispatch Program Guidelines, the EMS Agency collaborated with 9-1-1 dispatch centers to develop Reference No. 227, Dispatching of Emergency Medical Services and Reference No. 227.1, Dispatch Pre-Arrival Instructions.

Attached are program monitoring tools that were developed based on Reference Nos. 227, 227.1, and 620, EMS Quality Improvement Program. The EMS Agency staff will work with your dispatch coordinator to establish a mutually agreed upon date and time for Los Angeles County Fire's site visit.

Program reviews are designed to verify compliance with Reference. Nos. 227, 227.1, and 620 and will include at minimum, the following:

- Review of policies/procedures, which must be available during the program review and upon request from the EMS Agency
- Dispatcher/Call-Taker employee file review to confirm compliance with applicable required certifications and/or continuing education requirements
- Review of the Quality Improvement Program

Please contact me at (562) 378-1600 or Greg Klein at (562) 378-1685 for any question or concerns.

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:JT:SM:gk
07-17

c. √Director, EMS Agency
Dr Clayton Kazan, Dispatch Center Medical Director
Assistant Chief Tony Ramirez
Fire Chief Daryl Osby

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.

August 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 (LANCASTER)

This is to report that Star Behavior Health Urgent Care Center (SBH-LA), Lancaster, has successfully completed its site visit conducted by the Emergency Medical Services (EMS) Agency on July 28, 2021 for designation as a Psychiatric Urgent Care Center (PUCC). The EMS Agency has determined SBH-LA meets the requirements of Reference No. 326, Psychiatric Urgent Care Center (PUCC).

Effective August 17, 2021, SBH-LA is a designated PUCC. This approval is valid indefinitely, unless terminated by the EMS Agency or voluntarily withdrawn by SBH-LA.

SBH-LA 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-LA 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 October 31, 2021.

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

LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES AGENCY

Transports to Sobering Center (SC) and Psychiatric Urgent Care Centers (PUCC)

SC*	9/1	10/1	11/1	12/1	1/1	2/1	3/1	4/1	5/1	6/1	7/1	9/1	9/20	10/1	11/1	12/1	1/1	2/1	3/1	4/1	6/21	7/21
Sobering Unit	126	128	100	99	95	94	104	43	-	-	-	-	-	-	-	-	-	-	-	-	96	7
CP	1	6	1	5	-	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AP	2	2	3	4	4	3	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	129	136	104	108	99	101	104	44	-	-	-	-	-	-	-	-	-	-	-	-	96	7

PUCC**	9/1	10/1	11/1	12/1	1/1	2/1	3/1	4/1	5/1	6/1	7/1	8/1	9/1	10/1	11/1	12/1	1/1	2/1	3/1	4/1	6/21	7/21
CP	9	9	3	3	10	7	12	7	-	9	3	4	4	2	2	-	3	-	2	2	4	-
AP	2	11	4	4	8	6	5	6	-	9	11	6	5	11	3	16	3	8	6	2	-	3
TAD									2			12	7	4	7	14	15	10	7	8	3	3
Total	11	20	7	7	18	13	17	13	2	18	14	22	16	17	12	30	21	18	15	12	7	6

*Sobering Center closed April 2020 - April 2021 for COVID overflow

**Star Facilities are not included in this report. Will be included when data is available.

CP = LAFD Community Paramedicine Unit

AP = Advanced Practice Unit both LAFD & LACoFD

TAD = LACoFD hybrid program with telemedicine

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Holly J. Mitchell
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

August 24, 2021

MEMORANDUM

TO: **EMS Provider Agencies - Fire Chiefs, Medical Directors, Paramedic Coordinators, EMS Educators, Licensed Ambulance Operators**

FROM: **Marianne Gausche-Hill, MD**

SUBJECT: **Notification of Fatal or Non-Fatal Submersion Incidents by EMS to Public Health**

As a part of Los Angeles County's efforts to prevent drownings at public pools, the Board of Supervisors passed a motion on June 8, 2021, that directs Fire and Emergency Medical Services (EMS) to immediately notify the Los Angeles Department of Public Health (LA-DPH) of any submersion incidents involving pools and spas.

The Los Angeles County EMS Agency will be initiating training for all 9-1-1 EMS Provider Agencies to notify LA-DPH of all submersion incidents fatal or not, that occur in any swimming pool or spa. Training will occur in September 2021.

Effective October 1st all submersion incidents in pools or spas shall be reported to LA-DPH Duty Officer at 213-989-7140 immediately after transfer of care to emergency department staff or termination of resuscitation in the field.

LA-DPH will request the following information:

- Location Address / Location Name (if applicable)
- Type of public pool (municipal, public, school, apartment, etc.)
- Summary of incident (age and victim status)
- Was there a contamination (e.g., visible blood, vomit, or other bodily fluids in the pool water)?
- Was the pool still in use following the incident?

Thanks so much for your cooperation in ensuring the ongoing safety of the public.

Attachments:
Notification from LA-DPH
Treatment Protocols - Ref. No.1225 and 1225-P Submersion, Ref. No. 1210 and 1210-P Cardiac Arrest

c: Base Hospital Medical Directors, Prehospital Care Coordinators, ED Medical Directors, ED Administrative Directors

IMMEDIATE NOTIFICATION OF FATAL OR NONFATAL DROWNINGS

Purpose: To assist the Department of Public Health (DPH) in promptly investigating fatal or nonfatal drownings at public pools in order to ensure safety and water treatment can verified before reopening the public pool.

Background: DPH is responsible for ensuring that public swimming pools are operated and maintained in a safe and sanitary manner. When drownings occur at public pools, DPH will investigate to see if all required safety equipment and enclosures were present. DPH will also ensure that the pool is closed until required cleaning and disinfecting is performed as indicated by an onsite evaluation.

As part of the County's efforts to prevent drownings at pools, the Board of Supervisors passed a motion on June 8, 2021 that directs Fire and Emergency Medical Services (EMS) to immediately notify DPH of any drowning incidents.

WHAT: DPH is requesting notification for all submersion incidents (fatal or not). Notify pool operator that pool is to remain closed until DPH performs an onsite visit.

WHERE: At any public swimming pool or spa located Countywide (including unincorporated and incorporated areas). Public swimming pools/spas include: Municipal (city parks), Public (YMCA, gym, hotel, spa, water park), and Apartments (including condominiums).

WHEN: Once EMS has transported the victim to the hospital or related facility, or resuscitation is discontinued.

HOW: Call the **DPH Duty Officer** at **213-989-7140**
(This number is only to be used by First Responders/Health Care Providers/Government Agencies and not to be shared with the public)

The Duty Officer will ask for the following information:

- Location Address
- Location Name (if applicable)
- Type of Public Pool (municipal, public, school, apartment, etc.)
- Summary of incident – What happened? How did it occur?
- Age of victim
- Victim status – Alive, responsive, …
- Was there visible blood, vomit, or other bodily fluid in the pool water?
- Was the pool still in use following the incident?

Treatment Protocol: CARDIAC ARREST **Ref. No. 1210**

Base Hospital Contact: Required prior to transport for all cardiac arrest patients who do not meet criteria for determination of death per *Ref. 814*.

1. For patients meeting *Ref. 814* Section I criteria for determination of death in the field – document Provider Impression as *DOA – Obvious Death*

2. Resuscitate cardiac arrest patients on scene ❶

3. Initiate chest compressions at a rate of 100-120 per min, depth 2 inches or 5 cm ❷
   Minimize interruptions in chest compressions

4. Assess airway and initiate basic and/or advanced airway maneuvers prn ❸❹ *(MCG 1302)*
   King LT is the preferred advanced airway ❺
   Monitor waveform capnography throughout resuscitation ❻

5. Administer high-flow **Oxygen** (15L/min) *(MCG 1302)*

6. Initiate cardiac monitoring *(MCG 1308)*
   Briefly assess rhythm every 2 minutes, minimizing pauses, or continuously via rhythm display technology ❼

V-FIB/PULSELESS V-TACH: ❽

7. **Defibrillate biphasic at 200J** immediately or per manufacturer's instructions
   Repeat at each 2-minute cycle as indicated

8. Establish vascular access *(MCG 1375)*
   Establish IO if any delay in obtaining IV access

9. Begin **Epinephrine** after defibrillation x2:
   Epinephrine (0.1mg/mL) administer 1mg (10mL) IV/IO
   Repeat every 5 min x2 additional doses; maximum total dose 3mg ❾

   CONTACT BASE to discuss additional epinephrine doses in cases where it may be indicated due to recurrent arrest or conversion to PEA

10. After defibrillation x3 (for refractory or recurrent V-Fib/V-Tach without pulses):
    Amiodarone 300mg (6mL) IV/IO
    Repeat **Amiodarone 150mg (3mL) IV/IO** x1 prn after additional defibrillation x2, maximum total dose 450mg

ASYSTOLE/PEA:

11. **Epinephrine (0.1mg/mL) administer 1mg (10mL) IV/IO**
    Repeat every 5 min x2; administer first dose as early as possible; maximum total dose 3mg ❾

    CONTACT BASE to discuss additional epinephrine doses in cases where it may be indicated due to refractory PEA or recurrent arrest

12. Consider and treat potential causes ❿

13. **Normal Saline 1L IV/IO rapid infusion**
    Repeat x1 for persistent cardiac arrest
    For suspected hypovolemia, administer both liters simultaneously

14. For patients with renal failure or other suspected hyperkalemia: ⓫
    Calcium Chloride 1gm (10mL) IV/IO
    Sodium Bicarbonate 50mEq (50mL) IV/IO

TERMINATION OF RESUSCITATION:

15. If resuscitative efforts are unsuccessful and the patient does not meet ALL criteria for Termination of Resuscitation in *Ref. 814, Section II.A.*, **CONTACT BASE** to consult with Base Physician ❽

RETURN OF SPONTANEOUS CIRCULATION (ROSC): ⓬⓭

16. Initiate post-resuscitation care immediately to stabilize the patient prior to transport ⓮
17. Establish advanced airway prn ❺
18. Raise head of stretcher to 30 degrees if blood pressure allows, otherwise maintain supine
19. Continue low volume ventilations at 10 per minute ⓯
20. Immediately resume CPR if patient re-arrests
21. For SBP < 90 mmHg:
    Normal Saline 1L IV/IO rapid infusion

    If no response after **Normal Saline 250mL,** or worsening hypotension and/or bradycardia:

    Push-dose Epinephrine – mix 9mL Normal Saline with 1mL Epinephrine 0.1mg/mL (IV formulation) in a 10mL syringe. Administer **Push-dose Epinephrine (0.01mg/mL) 1mL IV/IO** every 1-5 minutes as needed to maintain SBP > 90mmHg ⓱
    CONTACT BASE concurrent with initial dose of **Push-dose Epinephrine**
22. Perform 12-lead ECG and transmit to the SRC ⓰

23. Check blood glucose
    For blood glucose < 60mg/dL
    Dextrose 10% 125mL IV and reassess
    If glucose remains < 60mg/dL, repeat 125 mL for a total of 250 mL

24. For suspected narcotic overdose: ⓲
    Naloxone 2-4mg (2-4mL) IV/IO/IM/IN (For IN, 1mg per nostril or 4mg/0.1mL IN if formulation available)
    Maximum dose all routes 8 mg

25. Contact **Public Health 213-989-7140** for all submersion incidents involving pools or spas after transfer of patient care in the emergency department or upon termination of field resuscitation in the field (this requirement is effective 10/1/21). ⓳

SPECIAL CONSIDERATIONS

❶ Maintaining perfusion with high-quality CPR throughout resuscitation is essential to ensuring good patient outcome. Transporting the patient in cardiac arrest causes interruptions in CPR and reduces CPR quality. Patients who are resuscitated until ROSC on scene have higher neurologically intact survival.

❷ Chest compressions are the most important aspect of cardiac arrest resuscitation. Maintaining continuous chest compressions should take priority over any medication administration or transport.

❸ Hyperventilation reduces venous return and worsens patient outcomes. Both continuous and interrupted (30:2) compressions/ventilations are acceptable. Regardless of ventilation method used, ventilations should be no more frequent than 10 per minute with a volume approximately 1/3 of the bag, just enough to see chest rise.

❹ Bag-mask ventilation (BMV) with a viral filter is the preferred method of airway management. BMV in cardiac arrest has been associated with improved patient outcomes and advanced airway placement should be deferred until after return of spontaneous circulation (ROSC) unless BMV is inadequate. If a decision is made to transport the patient in refractory cardiac arrest and inability to maintain effective ventilations with BMV is anticipated, consider advanced airway prior to transport.

❺ King LT is the preferred advanced airway unless specifically contraindicated. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality.

❻ $ETCO_2$ should be > 10 with a “box-shaped” waveform during effective CPR. A flat or wavy waveform or $ETCO_2$ < 10 may indicate ineffective compressions or airway obstruction. A sudden increase in $ETCO_2$ is suggestive of ROSC. The waveform can also be used to confirm ventilation rate if an advanced airway or asynchronous ventilation with continuous compressions is used.

❼ If you are able to observe the underlying rhythm during compressions via rhythm display technology, do not pause for the rhythm check. In order to minimize pauses in chest compressions, pulse checks should only be performed during rhythm checks when there is an organized rhythm with signs of ROSC, such as normal capnography or sudden rise in capnography.

❽ Patients in persistent cardiac arrest with refractory V-Fib (persistent V-Fib after 3 unsuccessful shocks) or EMS-witnessed arrest of presumed cardiac etiology may have a good outcome despite prolonged resuscitation. For these patients, resuscitation may be continued on scene for up to 40 minutes, as long as resources allow, in order to maximize the chances for field ROSC, which is strongly associated with improved survival with good neurologic outcome. Earlier transport may be initiated for providers using a mechanical compression device who are transporting a patient to a STEMI Receiving Center (SRC) for extracorporeal membrane oxygenation (ECMO) initiation.

❾ Epinephrine may improve outcomes if given early in non-shockable rhythms, but can worsen outcomes early in shockable rhythms, where defibrillation is the preferred initial treatment. Epinephrine is most likely to be effective if it is given early and after chest compressions have begun. The likelihood of meaningful survival declines after three (3) doses of epinephrine. Resuscitation should continue focused on quality CPR, defibrillation, and identifying reversible causes. Additional doses of epinephrine should only be administered with Base order.

⑩ Potential causes that can be treated in the field include hypoxia, hypovolemia, hyperkalemia, hypothermia, toxins, and tension pneumothorax. Hypoglycemia is a very rare cause of cardiac arrest and should not be assessed until after ROSC. If environmental hypothermia is suspected, resuscitation efforts should not be abandoned until the patient is re-warmed, or after consultation with the Base Physician.

⑪ Treat suspected hyperkalemia with calcium and sodium bicarbonate as soon as possible. The sooner it is administered, the more likely it is to be effective. Flush the line between medication administration.

⑫ Post cardiac arrest patients are at high risk for re-arrest during transport. Fluid resuscitation, vasopressor support, and avoidance of hyperventilation are recommended to decrease the risk of re-arrest.

⑬ All cardiac arrest patients, with or without ROSC, shall be transported to the most accessible open SRC if ground transport is 30 minutes or less, as initiation of targeted temperature management and early coronary angiography in a specialty center have been shown to improve outcomes.

⑭ Approximately 60% of patients will re-arrest shortly after ROSC. Anticipate this decline as the epinephrine administered during the resuscitation begins to lose effect. Initiating post-resuscitation care, including fluids and preparing push-dose epinephrine for use as needed, can prevent re-arrest. These steps should be initiated immediately after ROSC to stabilize the patient for approximately 5 minutes prior to transport to reduce chances of re-arrest en route.

⑮ $ETCO_2$ can help guide your ventilation rate; target $ETCO_2$ 35-45 mmHg. Just after ROSC, the $ETCO_2$ may be transiently elevated. This will decrease appropriately with ventilation and does not require hyperventilation to normalize. Persistently elevated $ETCO_2$ and/or “sharkfin” waveform may indicate respiratory failure as cause of the cardiac arrest. Falsely low $ETCO_2$ measurements can occur if there is a leak with BMV or shock.

⑯ An ECG with STEMI after ROSC requires notification of ECG findings to the SRC.

⑰ **Push-dose Epinephrine** is appropriate for non-traumatic shock including cardiogenic shock. Additional doses beyond 10mL may need to be prepared for prolonged transports.

⑱ Narcotic overdose should be suspected in cases where there is drug paraphernalia on scene or there is a witness report. Pinpoint pupils may be present, but hypoxia during cardiac arrest can cause mydriasis (dilated pupils) instead.

⑲ EMS is assisting the Department of Public Health (DPH) in promptly investigating fatal or nonfatal drownings at public pools or spas in order to ensure safety can be verified before reopening. Contacting the on-call DPH officer will allow timely investigation of these incidents and prevent future incidents.

Treatment Protocol: CARDIAC ARREST **Ref. No. 1210-P**

Base Hospital Contact Required.

1. For patients meeting *Ref. 814* Section I criteria for determination of death in the field – document *DOA – Obvious Death* ❶
2. Resuscitate cardiac arrest patients on scene ❷
3. Assess airway and initiate basic airway maneuvers *(MCG 1302)*
4. Assist respirations with bag-mask-ventilations (BMV) with viral filter, using **high-flow Oxygen 15L/min**; squeeze bag just until chest rise and then release - state "squeeze, release, release" to avoid hyperventilation ❸
5. For suspected foreign body (no chest rise with BMV): ❹
   Perform direct laryngoscopy and use pediatric Magill forceps to remove visible obstruction(s)
6. Initiate chest compressions at a rate of 100-120 compressions per minute with a compression to ventilation rate of 15:2 ❺❻
7. Initiate cardiac monitoring *(MCG 1308)*
   Briefly assess rhythm every 2 minutes, minimizing pauses, or continuously via rhythm display technology ❼❽
8. Establish vascular access *(MCG 1375)* ❾
9. **CONTACT BASE** concurrent with ongoing management

ASYSTOLE/PEA

10. **Epinephrine (0.1mg/mL) 0.01mg/kg IV/IO**, dose per *MCG 1309*
    May repeat every 5 min x2, maximum single dose 1mg ❿

    CONTACT BASE for additional epinephrine doses
11. Consider and treat potential causes ⓫
12. **Normal Saline 20mL/kg IV/IO** per *MCG 1309*
    May repeat x2

V-FIB/PULSELESS V-TACH

13. **Defibrillate at 2J/kg**, dose per *MCG 1309*
    Repeat at **4J/kg** at each 2-minute cycle as indicated
14. **Epinephrine (0.1mg/mL) 0.01mg/kg IV/IO**, dose per *MCG 1309*
    Begin after second defibrillation
    May repeat every 5 min x2, maximum single dose 1mg ❿

CONTACT BASE for additional epinephrine doses

15. For persistent or recurrent V-Fib/V-Tach without pulses:
Amiodarone (50mg/mL) 5 mg/kg IV/IO, dose per *MCG 1309*

RETURN OF SPONTANEOUS CIRCULATION ⓬⓭

16. Initiate post-resuscitation care on scene to stabilize the patient prior to transport ⓮
17. Establish advanced airway prn ⓯
18. Raise head of stretcher to 30 degrees if blood pressure allows, otherwise maintain supine
19. Continue ventilation at 20 breaths per minute or every 2-3 seconds
20. For SBP < 70mmHg:
Normal Saline 20mL/kg IV/IO rapid infusion per *MCG 1309*
Repeat x1 for persistent poor perfusion

    If no response after **Normal Saline 20mL/kg,** or worsening hypotension and/or bradycardia:
Push-dose Epinephrine – mix 9mL Normal Saline with 1mL Epinephrine (0.1mg/mL) IV formulation in a 10mL syringe; administer **Push-dose Epinephrine (0.01mg/mL)** per *MCG 1309* every 1-5 minutes as needed to maintain SBP > 70mmHg ⓰
21. Check blood glucose ⓱
For blood glucose < 60mg/dL
Dextrose 10% 5mL/kg IV/IO per *MCG 1309*
22. For suspected narcotic overdose: ⓲
Naloxone (1mg/mL) 0.1mg/kg IM/IN/IO/IV, dose per *MCG 1309*
23. Contact **Public Health 213-989-7140** for all submersion incidents involving pools or spas after transfer of patient care in the emergency department or upon termination of resuscitation in the field (this requirement is effective 10/1/21). ⓳

SPECIAL CONSIDERATIONS

❶ EMS Personnel are mandated reporters of child abuse and neglect, and a report should be made when suspected as per *Ref. 822*. Communicate suspicion for child abuse and/or neglect to accepting ED staff when home suggests children could be at risk for harm (e.g., unkept home, evidence of drug or alcohol abuse, unsafe living conditions, known or suspected domestic violence), when the history does not match with the severity of physical findings (e.g., child posturing after a roll off the couch), when patterned injury or burns or noted (e.g., circular burns as from a cigarette, whip marks on the skin, burns of both hands or feet), or when child reports physical or sexual abuse. Children < 3 years of age and those with developmental delay are at increased risk of abuse. This must also be accompanied by notification to the Department of Children and Family Services (DCFS).

❷ Maintaining perfusion with high-quality CPR throughout resuscitation is essential to ensuring good patient outcome. Transporting the patient in cardiac arrest causes interruptions in CPR and reduces CPR quality. Similar to adults in OHCA, pediatric patients who are resuscitated on scene have higher neurologically intact survival. Transport may be initiated sooner if scene safety concerns.

❸ EMS personnel should remain on scene up to 20 minutes to establish chest compressions, vascular access and epinephrine administration for nonshockable rhythms or until return of spontaneous circulation (ROSC) is achieved; for shockable rhythms, remain on scene until 3 defibrillations or until ROSC is achieved. The best results occur when resuscitation is initiated and maintained on scene, and post ROSC care is initiated.

❹ Bag-mask ventilation (BMV) with a viral filter is the preferred method of airway management. BMV in cardiac arrest has been associated with improved patient outcomes and advanced airway placement should be deferred until after ROSC unless BMV is inadequate. Children < 3 years of age are at high risk for foreign body aspiration. Foreign body aspiration should be suspected if there is a history of possible aspiration or when there is no chest rise with BMV after repositioning of the airway.

❺ Chest compressions are the most important aspect of cardiac arrest resuscitation. Maintaining chest compressions should take priority over any medication administration or transport.

❻ Hyperventilation reduces venous return and worsens patient outcomes. Both continuous and interrupted (15:2) compressions/ventilations are acceptable. Regardless of ventilation method used, ventilations should be no more frequent than 10 per minute with a volume just enough to see chest rise and then release the bag to allow for exhalation (“squeeze, release, release”). Once ROSC is achieved ventilation rates can increase to 20 per minute.

❼ If you are able to observe the underlying rhythm during compressions via rhythm display technology, do not pause for the rhythm check.

❽ $ETCO_2$ should be > 10 with a “box-shaped” waveform during effective CPR. A flat or wavy waveform or $ETCO_2$ < 10 may indicate ineffective compressions or airway obstruction. A sudden increase in $ETCO_2$ is suggestive of ROSC. The waveform can also be used to confirm ventilation rate if an advanced airway or asynchronous ventilation with continuous compressions is used.

❾ Peripheral venous access may be difficult to obtain in infants and small children. Consider IO placement as primary vascular access in patients for whom venous access is unlikely to be achieved

rapidly. For older children, make two attempts at venous access and, if unsuccessful, place and IO for vascular access.

⑩ Epinephrine may improve outcomes if given *early* in nonshockable rhythms and should be given within 5 minutes of the resuscitation. For shockable rhythms, where defibrillation is the preferred initial treatment, epinephrine should be given after the second defibrillation. Epinephrine is most likely to be effective if it is given early and after chest compressions have begun. The likelihood of meaningful survival declines after three (3) doses of epinephrine. Resuscitation should continue focused on quality CPR, defibrillation, and identifying reversible causes. Additional doses of epinephrine should only be administered with Base order if indicated, based on the individual patient.

⑪ Potential causes that can be treated in the field include hypoxia, hypovolemia, hyperkalemia, hypothermia, toxins, and tension pneumothorax. Hypoxia and Hypovolemia are common causes of PEA arrest in children. Hypoglycemia is a very rare cause of cardiac arrest and should not be assessed until after ROSC.

⑫ Post cardiac arrest patients are at high risk for re-arrest during transport. Fluid resuscitation, vasopressor support, and avoidance of hyperventilation are recommended to decrease the risk of re-arrest.

⑬ $ETCO_2$ can help guide your ventilation rate; target $ETCO_2$ 35-45 mmHg. Just after ROSC, the $ETCO_2$ may be transiently elevated. This will decrease appropriately with ventilation and does not require hyperventilation to normalize. Persistently elevated $ETCO_2$ and/or “sharkfin” waveform may indicate respiratory failure as cause of the cardiac arrest. Falsely low $ETCO_2$ measurements can occur if there is a leak with BMV or shock.

⑭ Re-arrest shortly after ROSC is common. Anticipate this decline as the epinephrine administered during the resuscitation begins to lose effect. Consider initiating post-resuscitation care prior to transport, if the scene allows, in order to reduce chances of re-arrest en route. Considerations include suspected cause of arrest and anticipated transport time to a Pediatric Medical Center. Pediatric patients with ROSC should be transported to a Pediatric Medical Center if within 30 minutes.

⑮ In the ROSC patient, BMV is preferred method for ventilation; in a patient longer than the length-based resuscitation tape (e.g., Broselow tape) or > 40 kg body weight King LT is the preferred advanced airway unless specifically contraindicated. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality.

⑯ **Push-dose Epinephrine** is appropriate for non-traumatic shock including cardiogenic shock. Additional doses beyond 10mL may need to be prepared for prolonged transports. For patients < 10kg, transfer the diluted **Push-dose Epinephrine** to a smaller (1mL or 3mL) syringe in order to administer the dose accurately.

⑰ In pediatric patients, post-arrest hypoglycemia should be treated with Dextrose 10% half-the dose delivered (2.5 mL/kg) and then blood glucose rechecked, and if measured glucose > 60 mg/dL no additional dextrose should be delivered.

If the rechecked blood glucose is < 60 mg/dL then administer an additional Dextrose 10% 2.5 mL/kg IV/IO; Hyperglycemia > 180 mg/dL should be avoided to optimize outcome.

⓲ Narcotic overdose should be suspected in cases where there is drug paraphernalia on scene or there is a witness report. Pinpoint pupils may be present, but hypoxia during cardiac arrest more often causes mydriasis (dilated pupils) instead.

⓳ EMS is assisting the Department of Public Health (DPH) in promptly investigating fatal or nonfatal drownings at public pools or spas in order to ensure safety can be verified before reopening. Contacting the on-call DPH officer will allow timely investigation of these incidents and prevent future incidents.

Treatment Protocol: SUBMERSION **Ref. No. 1225**

Base Hospital Contact: Required for ALOC and decompression emergencies (*Ref. 518*).

1. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*

2. For cardiac arrest, treat per *TP 1210, Cardiac Arrest* ❶

3. Administer **Oxygen** prn *(MCG 1302)*
   For suspected decompression illness ❷, provide **high flow Oxygen 15 L/min** and **CONTACT BASE**

4. Maintain supine if suspected decompression illness

5. Advanced airway prn *(MCG 1302)*

6. Initiate cardiac monitoring *(MCG 1308)*

7. Provide warming measures ❸

8. Establish vascular access prn *(MCG 1375)*

9. For altered level of consciousness, treat in conjunction with *TP 1229, Altered Level of Consciousness (ALOC)*

10. For respiratory distress, treat in conjunction with *TP 1237, Respiratory Distress* ❹

11. For poor perfusion or for suspected decompression illness:
    Normal Saline 1L IV rapid infusion; use warm saline if available
    Reassess after each 250 mL increment for evidence of worsening respiratory distress and if noted **CONTACT BASE** to discuss need to continue or hold Normal Saline based on patient condition ❹

    For persistent poor perfusion, treat in conjunction with *TP 1207, Shock/Hypotension*

12. Contact **Public Health 213-989-7140** for all submersion incidents involving pools or spas after transfer of patient care in the emergency department or upon termination of resuscitation in the field. ❺

SPECIAL CONSIDERATIONS

❶ Cardiac arrest from drowning should be treated per *TP 1210, Cardiac Arrest*. Ventilation is particularly important as the cardiac arrest is almost always due to respiratory failure. In cases of cold water drowning follow usual protocols for resuscitation while simultaneously rewarming the patient. Patients with hypothermia due to cold water drowning, may have good neurologic outcome despite prolonged resuscitation; resuscitative efforts should continue until the patient is rewarmed. Consultation with the Base Physician is required before consideration of termination of resuscitation in patients with suspected hypothermia.

❷ Decompression illness includes arterial gas embolism from barotrauma and decompression sickness (aka “the bends”) due to dissolved nitrogen in the blood coming out of solution. Decompression illness most frequently occurs in scuba divers after breathing compressed air at depth. While arterial gas embolism presents almost immediately after ascent, decompression sickness is often delayed and should be considered in any patient with symptoms (e.g. respiratory distress, ALOC, chest or body pain) within 24 hours of completing a dive. All patients with possible decompression illness need immediate evaluation for possible hyperbaric treatment. Per *Ref. 518*, contact Base immediately to discuss.

❸ Warming measures should include moving the patient to a warm environment as quickly as possible, removing wet clothing/items, covering with an emergency/rescue blanket or other blankets/sheets, and using warm Normal Saline if available.

❹ Rales may be present in patients after submersion/drowning due to direct lung injury and/or aspiration of water. This is not an indication of cardiogenic pulmonary edema (such as from congestive heart failure) and does not prohibit administration of IV fluids. IV fluids should be initiated and continued unless respiratory status worsens during administration.

❺ EMS is assisting the Department of Public Health (DPH) in promptly investigating fatal or nonfatal drownings at public pools or spas in order to ensure safety can be verified before reopening. Contacting the on-call DPH officer will allow timely investigation of these incidents and prevent future incidents.

Treatment Protocol: SUBMERSION **Ref. No. 1225-P**

Base Hospital Contact: Required for ALOC and decompression emergencies (*Ref. 518*).

1. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*
2. For cardiac arrest, treat per *TP 1210-P, Cardiac Arrest* ❶
3. Administer **Oxygen** prn *(MCG 1302)*
   For suspected decompression illness ❷, provide **high-flow Oxygen 15L/min** and **CONTACT BASE**
4. Maintain supine if suspected decompression illness
5. Advanced airway prn *(MCG 1302)*
6. Initiate cardiac monitoring *(MCG 1308)*
7. Provide warming measures ❸ ❹
8. Establish vascular access prn *(MCG 1375)*
9. For altered level of consciousness, treat in conjunction with *TP 1229-P, Altered Level of Consciousness (ALOC)*
10. For respiratory distress, treat in conjunction with *TP 1237-P, Respiratory Distress* ❺
11. For poor perfusion or for suspected decompression illness:
    Normal Saline 20mL/kg IV rapid infusion per *MCG 1309*; use warm saline if available ❺
    For persistent poor perfusion, treat in conjunction with *TP 1207-P, Shock/Hypotension*
12. Contact **Public Health 213-989-7140** for all submersion incidents involving pools or spas after transfer of patient care in the emergency department or upon termination of field resuscitation in the field. ❻

SPECIAL CONSIDERATIONS

❶ Cardiac arrest from drowning should be treated per *TP 1210-P, Cardiac Arrest*. Ventilation is particularly important as the cardiac arrest is almost always due to respiratory failure. In cases of cold water drowning follow usual protocols for resuscitation while simultaneously rewarming the patient. Patients with hypothermia due to cold water drowning, may have good neurologic outcome despite prolonged resuscitation; resuscitative efforts should continue until the patient is rewarmed. Consultation with the Base Physician is required before consideration of termination of resuscitation in patients with suspected hypothermia.

❷ Decompression illness includes arterial gas embolism from barotrauma and decompression sickness (aka “the bends”) due to dissolved nitrogen in the blood coming out of solution. Decompression illness most frequently occurs in scuba divers after breathing compressed air at depth. While arterial gas embolism presents almost immediately after ascent, decompression sickness is often delayed and should be considered in any patient with symptoms (e.g. respiratory distress, ALOC, chest or body pain) within 24 hours of completing a dive. All patients with possible decompression illness need immediate evaluation for possible hyperbaric treatment. Per *Ref. 518*, contact Base immediately to discuss.

❸ Warming measures should include moving the patient to a warm environment as quickly as possible, removing wet clothing/items, covering with an emergency/rescue blanket or other blankets/sheets, and using warm Normal Saline if available.

❹ Infants and small children are at high risk for hypothermia due to their large surface area to body mass ratio, reduced ability to shiver, and limited body fat.

❺ Rales may be present in patients after submersion/drowning due to direct lung injury and/or aspiration of water. This is not an indication of cardiogenic pulmonary edema (such as from congestive heart failure), which is extremely rare in children, and does not prohibit administration of IV fluids. IV fluids should be initiated and continued unless respiratory status worsens during administration.

❻ EMS is assisting the Department of Public Health (DPH) in promptly investigating fatal or nonfatal drownings at public pools or spas in order to ensure safety can be verified before reopening. Contacting the on-call DPH officer will allow timely investigation of these incidents and prevent future incidents.

EMERGENCY MEDICAL SERVICES AGENCY
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Board of Supervisors

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Director

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Medical Director

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

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

August 25, 2021

TO: Distribution

FROM: Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

SUBJECT: STANDARD GUIDANCE FOR FIRST RESPONDERS ENTERING HOSPITAL/HEALTH FACILITIES

In light of the Public Health Order regarding Health Care Worker Vaccination Requirement, the Hospital Association of Southern California (HASC) and the Emergency Medical Services (EMS) Agency held a meeting with representatives from first responders' and hospitals' leadership on August 23, 2021. The goal of the meeting was to standardize expectations when first responders enter hospital facilities to avoid confusion with the Health Order which may impede and negatively impact the provision of medical care to patients.

The following principles were established at the meeting:

- Law enforcement, fire, and EMS personnel are not classified as "visitors" when accessing hospital/medical facilities for patient care and transport (see CDPH All Facilities Letter (AFL) 21-31 and Frequently Asked Questions issued August 20, 2021).
- Law enforcement, fire, and EMS personnel, when on duty, are considered first responders and/or pre-hospital care workers.
- Facility staff should not be requesting verification of vaccination status and/or COVID-19 tests results of first responders who are entering the facilities.
- Employers of first responders are responsible for supplying its employees with surgical or N95 respirators. Hospitals/medical facilities are requested to make surgical masks readily available for first responders at the point of entry of the facility.
- Law enforcement agencies will instruct and educate their officers that a surgical mask is required and a best practice for health hygiene to prevent exposure to any infectious diseases while in the hospital.
- Law enforcement officers will request a detainee to wear a mask recognizing that they cannot force the detainee to do wear the mask. Hospital staff will need to address, following their normal procedures, mask wearing by the patient.

- The employers of first responder are responsible for addressing compliance with the Public Health Officer's vaccination mandate as applicable.

Effective immediately, all first responders must wear, at minimum, a surgical mask upon entering a hospital or medical facility. The surgical masks, covering nose and mouth, must be worn at all times while in the facility. N95 respirators and additional personal protective equipment shall be worn as appropriate.

Any instances in which first responders do not comply with wearing a surgical mask at all times while in healthcare facilities, should be referred to their employer as soon as possible. Hospitals/medical facilities are requested to make surgical masks readily available for first responders at the point of entry of the facility.

Any facility that wishes to establish a policy that varies from this guidance should reach out to their local first responder agency administration with their specific policy. The EMS Agency has established great relationships and communications throughout our system and appreciate your cooperation. Please contact Dr. Gausche-Hill at mgausche-hill@dhs.lacounty.gov or Cathy Chidester at cchidester@dhs.lacounty.gov if you have any questions.

c: Hospital CEO
CDPH
Department of Public Health

Distribution:
Hospital Association of Southern California
LA County Police Chiefs Association
LA Area Fire Chiefs Association
LA Ambulance Association
Each Fire Chief
Each Chief of Police
Ambulance CEO

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September 30, 2021

TO: County Commissions

FROM: Celia Zavala
Executive Officer

SUBJECT: **CONTINUED TELECONFERENCED COMMISSION MEETINGS AND COUNTY VACCINATION MANDATE**

As you may know, on June 11, 2021, Governor Gavin Newsom issued Executive Order N-08-21, which extends through September 30, 2021, the suspension of the Brown Act provisions related to meetings via teleconferencing. On September 10, 2021, the Legislature passed Assembly Bill 361 ("AB 361") to enhance public access to local legislative body meetings during the COVID-19 pandemic and future applicable emergencies. In essence, AB 361 allows meetings via teleconferencing after September 30, 2021,[1] under certain conditions and pursuant to certain requirements.

AB 361 allows local legislative bodies to hold teleconferenced meetings without complying with the usual Brown Act teleconferencing requirements if:

(A) the legislative body holds a meeting during a declared state of emergency; and
(B) either one of the following occurs:
(i) State or local health officials have imposed or recommended measures to promote social distancing; or
(ii) the legislative body determines, by majority vote, that as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

AB 361 also set forth requirements for instructions on the agenda for a teleconferenced meeting, disruption during broadcasting of a teleconferenced meeting, opportunity for public comment in "real time," timed public comment, and continued use of teleconferenced meetings.

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[1] AB 361 took effect immediately after the Governor signed it into law on September 16, 2021. However, to provide clarity around the applicable procedures governing local legislative body meetings and to ensure that critical governmental functions are not affected, on September 20, 2021, the Governor issued Executive Order N-15-21, which suspends the relevant amended provisions of the Brown Act under AB 361 until Executive Order N-08-21 expires on September 30, 2021.

The State of Emergency is still in effect. In addition, the County's Best Practices to Prevent COVID-19, Guidance for Businesses and Employers, recommends "*[w]henever possible, [to] take steps to reduce crowding indoors and enable employees and customers to physically distance from each other. Generally, at least 6 feet of distance (2 arm lengths) is recommended, although this is not a guarantee of safety, especially in enclosed or poorly ventilated spaces.*" In alignment with these recommendations and to ensure the safety of members of the public and employees while guaranteeing the public's right to attend and participate in meetings of local legislative bodies, effective October 1, 2021, the Board of Supervisors ("Board") and commissions, task forces, committees, etc., which were either created by the Board or at the Board's direction and are subject to the Brown Act, will continue to meet via teleconferencing, in compliance with AB 361. As required by AB 361, the Board will reconsider the circumstances of the State of Emergency to determine whether teleconferencing should continue. Commissions that are statutorily and independently created are urged to do the same.

In addition, please note, on August 10, 2021, the Board of Supervisors mandated that all County employees must provide **proof of full vaccination by October 1, 2021.** This mandate applies to all County workers, Commissioners, Board members, interns, and volunteers.

The County has partnered with **Fulgent**, a leader in laboratory testing services, to maintain employee COVID-19 vaccination records. Commissioners without an Employee (E) or Contractor (C) number are not currently included in the Fulgent database and cannot yet submit their vaccination status information. The HR team is partnering with the Department of Human Resources (DHR) and Fulgent to ensure that all Commissioners, Board members, volunteers, and other County workers without an E or C number are added to the vaccination verification system. We anticipate that this information will be uploaded soon, and additional notification will be provided once the remaining Commissioners are added to the system. **At this time, all Commissioners with an E number can submit their vaccination records by uploading their vaccination documentation to the Fulgent database. The instructions on how to submit your records are attached.**

Should you have questions regarding this letter, you may contact Twila P. Kerr of my staff at tkerr@bos.lacounty.gov or (213) 974-1431.

CZ:TPK:mr

Attachment

County of Los Angeles Workforce COVID-19 Testing Protocol

Register for testing

Prior to testing please register online at lac.fulgentgenetics.com. Though this can be done on-site at the time of testing, **registering online ahead of time will help to speed up the testing process.** This only has to be done one time and once complete, you will receive a Fulgent QR code which can be used to verify your information for all future tests.

Select an LA County testing site

Please contact your Departmental Human Resources office for your required testing frequency. You can review a list of active test sites here.

WHAT TO EXPECT ON THE FIRST DAY OF TESTING

1. **On test day, bring the following to your test site**

   A) **A form of identification** (your LA County employee badge or other government issued ID)

   B) Your **Fulgent QR code** and/or your **E/C County ID number**

   C) Your **insurance card** (you will only need this on the first day of testing; the information will be saved for all future tests through LA County)

2. **Collect your sample**

   Fulgent uses a self-collect shallow nasal swab collection process as demonstrated in the following video:
   https://www.youtube.com/watch?v=L_1UgXM9tqw

3. **View your results**

   Within 1-2 days of submitting your sample, you should receive either an email or text message with a screening ID (in the format **FSS-SCR123456**) along with the link to view your test result.

   Link: results.fulgentgenetics.com

   Negative test result: Your supervisor will see you as cleared for work.

   Positive test result: Your supervisor will see you as not cleared. Do not report for work and contact your Departmental Human Resources office immediately.

Please contact us if you have any questions!

Fulgent's Client Services Team
Phone: 1 (626) 350-0537 | **Email:** lacsupport@fulgentgenetics.com

Frequently Asked Questions

How do I know if I need to test?

If you have been fully vaccinated (2 shots of Moderna or Pfizer or 1 shot of Johnson & Johnson) and your vaccine record has been verified through Fulgent then you do not need to test on a weekly basis.

If you are unvaccinated or semi-vaccinated you may need to test either once or twice per week depending on your department's requirements. Please speak with your supervisor or Human Resources department for more information on your testing policy.

I recently received my vaccination, how can I change my vaccination status?

Please visit lac.fulgentgenetics.com to edit/upload your vaccination status. You will be asked to either upload your CDPH smart QR code or a physical picture of your card so that we can verify your status. Once complete and your vaccination status has been verified, you will no longer be required to test on a weekly basis.

Who is my result shared with?

Your result is secure in our system and is only shared with your employer and any relevant State or local reporting agencies. Within LA County, your supervisor and department administrators will have access to your testing data to ensure you are in compliance with LA County's testing/ vaccination policies.

Why do I need my insurance card?

Tests administered at LA County facilities are free to you. The County of Los Angeles is working to cover the cost of testing, either through your insurance carriers or other County funding. Your insurance information may be used to verify your coverage if carriers are billed. Regardless, testing will remain at no cost to you.

What happens if I miss my testing day?

To help ensure LA County is compliant with California's mandate for testing and vaccination of County employees, a notification will be sent to both the employee and the employee's supervisor when an employee is out of testing compliance. Please visit your nearest testing site to collect a new sample as soon as possible and contact your Department HR office.

Workforce COVID-19 Vaccination Verification

For proof of vaccination, you will need:

- A CDPH digital vaccine card QR code
  Please go to page 5 for instructions on how to get your CDPH digital vaccine QR code

OR

- A digital photo of your hard copy vaccine card

Please have the following ready before starting registration

- Employee or contractor ID number
- LA County department name
- Preferred email address
- Proof of vaccination

Notice for Department of Health Services (DHS) employees

As a reminder, the process for the DHS workforce is as follows:

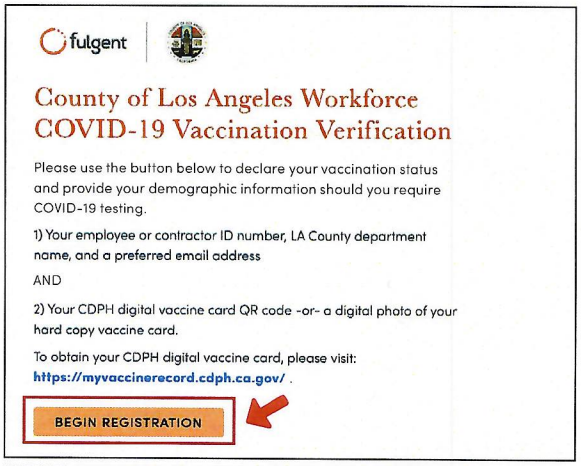
If you were vaccinated by DHS, your vaccination verification is complete. If you received your vaccination outside of DHS, you must submit a copy of your vaccination record to your local Employee Health Services.

DHS employees do not need to submit their vaccination records into the Fulgent database.

How to Register Online

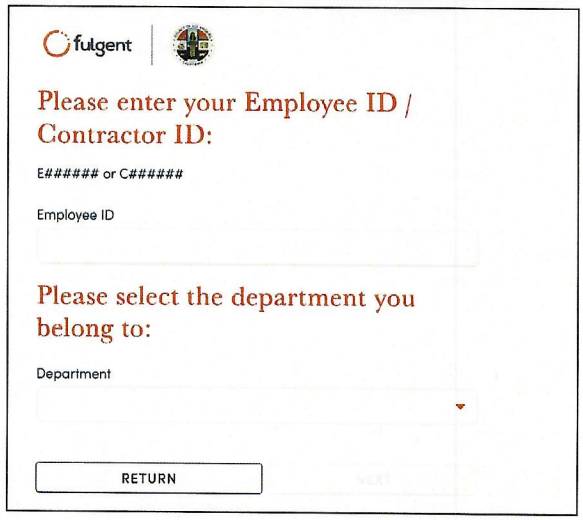
Verifying LAC employee status

1 **Visit lac.fulgentgenetics.com and** click the button "Begin Registration".

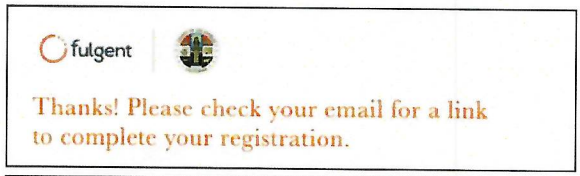


2 **Verify your information by entering the following:**

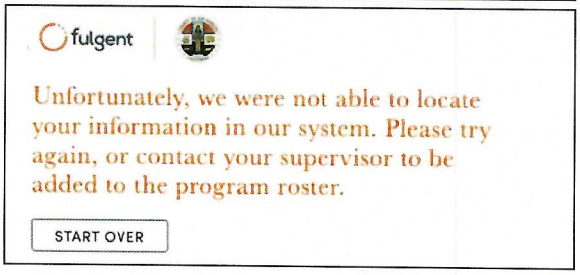
- Employee ID / Contractor ID
  E/C #: [format - E/C######]
- Department you belong to
  i.e., DHS, Fire Dept, DHR, etc.
- First Name
- Last Name
- Date of Birth
- Preferred Email Address



3 **If your information matches in our system**
You will be sent a unique URL link to your preferred email address to complete the rest of your registration.



If your information does not match in our system
Please double-check your information and try again, or contact your supervisor to be added to the program roster.



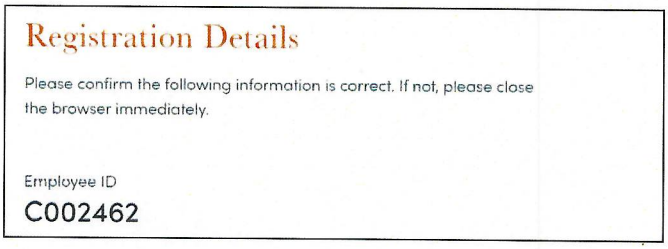
4978 Santa Anita Ave, Suite 205, Temple City, CA 91780 | www.FulgentGenetics.com | info@fulgentgenetics.com | P +1 626.350.0537 | F +1 626.454.1667
 D# GUIDE-LAC Workforce Covid-19 Vaccination Verification-2021-V1.1

Completing the rest of your registration

4 **Login to your email account** and find an email from Fulgent Genetics with the subject line "Complete Your Registration".

In the email, click on "Complete Registration"

Confirm your identity and that all information is correct.



If you don't get an email or see a discrepancy with your information, please contact Fulgent's Client Services team at:

Phone: 1 (626) 350-0537

Email: lacsupport@fulgentgenetics.com

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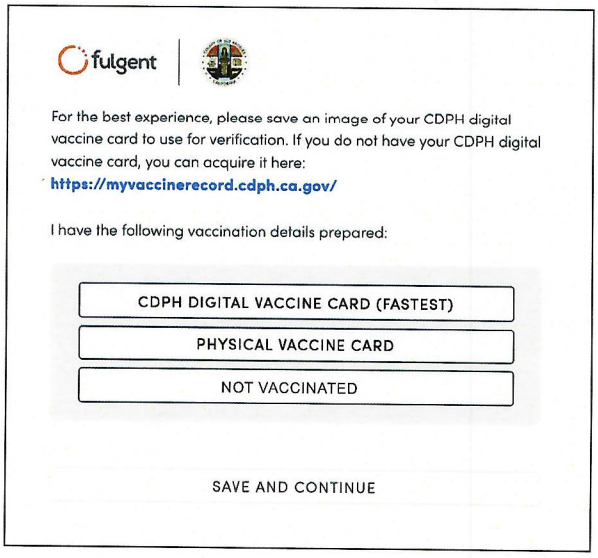
5 **Select one of the following, regarding your vaccination details:**

- **CDPH Digital Vaccine Card (Fastest method)**
  Please go to page 5 for instructions on how to get your CDPH digital vaccine QR code
- **Physical Vaccine Card (Manual entry)**
  Upload image or take a photo of your vaccine card
  Enter dose manufacturer, dose date, dose lot number
- **Not Vaccinated**



Please Note: By providing your vaccination records, you are affirming that the information you have provided herein is true and complete, and that you understand that the County of Los Angeles will use this information to document your vaccination status and will verify this information against vaccination records maintained by Healthvana for the California Department of Public Health.

Completing the rest of your registration continued

6 **If you've submitted your vaccine card showing full vaccination,** we have sent an email notification as a record of your submission-in-review. When the review is completed, you will receive an additional notification email to confirm that your submission has been verified.

You do not need to perform regular COVID-19 testing per LA County policy.

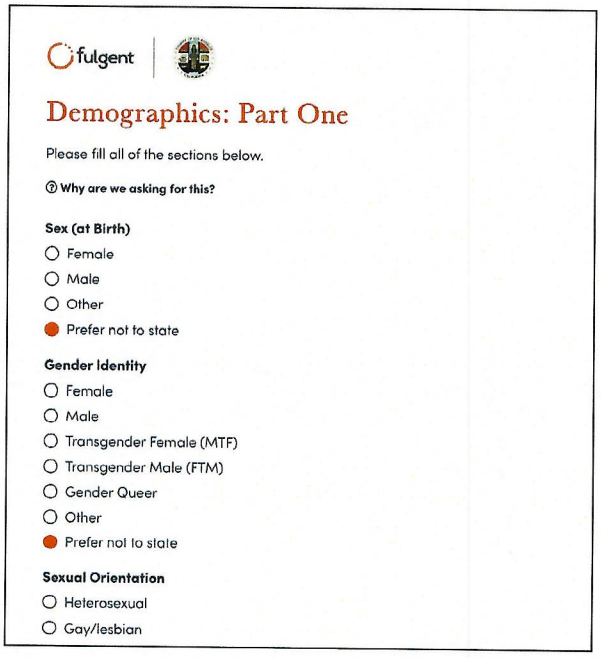
Until you are fully vaccinated, you may need to participate in regular COVID-19 testing

Please contact your Departmental Human Resources office for your required testing frequency and to review the list of test sites available to you. Upon completion of your tests, you will receive an email confirming your compliance state.

7 **Fill out your demographics, you will be asked the following:**

- Address
- SMS Capable Phone Number (Optional)
- Sex (at birth)*
- Gender*
- Sexual Orientation*
- Race*
- Ethnicity*

* This information is required for result reporting to the State of California and the County Department of Public Health to help track and trend the impact of COVID-19 on different communities.



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8 **Once registration is complete, please check your email to receive your unique QR code for COVID-19 testing. Please contact us if you have any questions!**

For the most streamlined testing experience, **please save, print, or keep a screenshot of this QR code on your mobile device and present it to testing staff for scanning at each visit.**

Please contact your Departmental Human Resources office for your required testing frequency and to review the list of test sites available to you. Upon completion of your tests, you will receive an email confirming your compliance state.

Fulgent's Client Services Team
Phone: 1 (626) 350-0537
Email: lacsupport@fulgentgenetics.com

How to Access Your CDPH Digital COVID-19 Vaccination Record

Registration

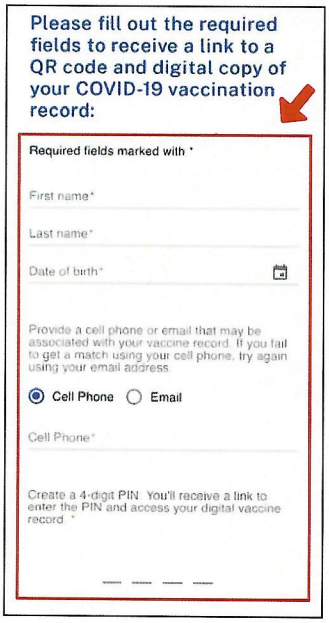
1 Visit the following website:
myvaccinerecord.cdph.ca.gov

2 Once loaded, proceed to enter the following information:

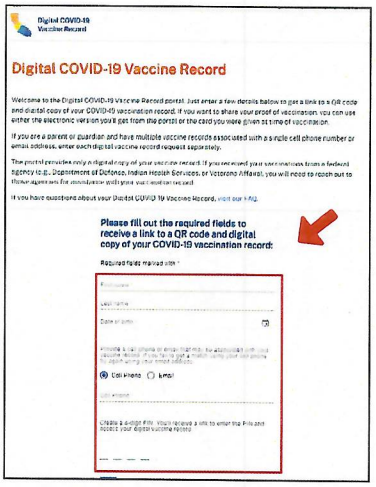
- Legal First Name
- Legal Last Name
- Date of Birth
- Receiving Preferences
- Personal 4-digit Pin Number

Please remember your 4-digit pin number

On Mobile



On Desktop



Next Steps

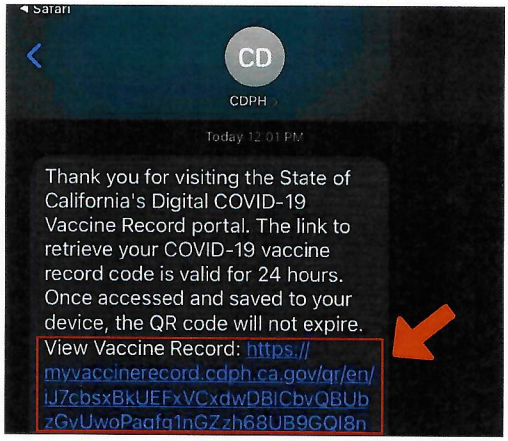
After submission, you'll receive either an email or a text message based your on preferences.

Text Message - Go to page 6

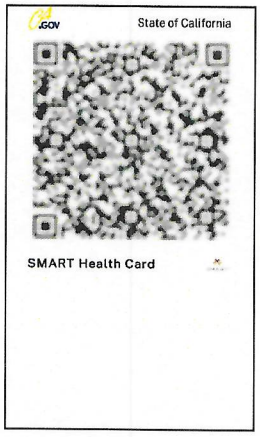
Email - Go to page 7

Retrieving your QR code by Text Message

1 Upon receiving a text message, **open the URL** link on your mobile phone.



2 **Enter your personal 4-digit pin number** to be presented with your QR code.



3 Tap and hold the QR code to download image onto your mobile device.

On iOS

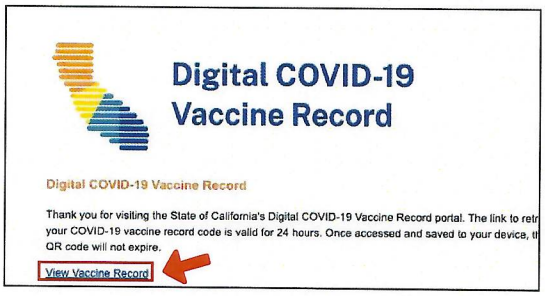
On Android

fulgent

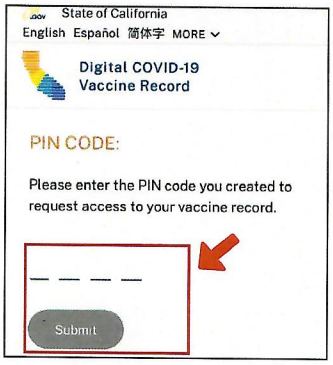
Retrieving your QR Code by Email

1 **Sign into your email account** using the same email address used during registration.

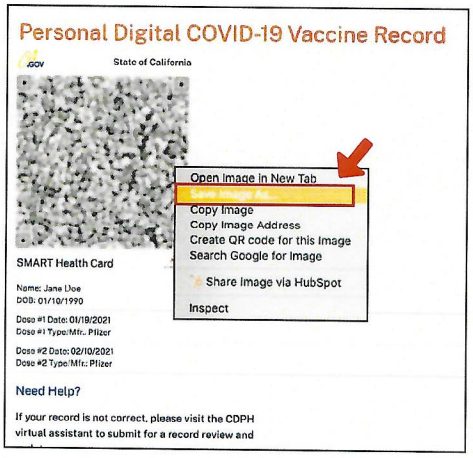
2 Find an email from the CA Department of Public Health with the subject line **"Digital COVID-19 Vaccine Record"**. Click on **"View Vaccine Record"**.



3 **Enter your personal 4-digit pin number** to be presented with your QR code.



4 When presented with your QR Code, right-click on the QR code to download image onto your computer.



FAQ

Visit: myvaccinerecord.cdph.ca.gov/faq

Need more help?

For questions and other assistance obtaining your digital COVID-19 Vaccine Record, please contact the California Department of Public Health.

P +1 833.422.4255
Monday - Friday 8:00AM - 8:00PM
Saturday - Sunday 8:00AM - 5:00PM