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: **January 19, 2022**
TIME: **1:00 – 3:00 PM**
LOCATION: **Zoom Video Conference Meeting**
Join Zoom Meeting:
https://zoom.us/j/97565380793?pwd=L1dhaUVybnMyK2tiZE95Q29jK3RDdz09
Meeting ID: 975 6538 0793
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The Commission meetings are open to the public. You may address the Commission on any agenda item before or during consideration of that item, and on other items of interest which are not on the agenda, but which are within the subject matter jurisdiction of the Commission. Public comment is limited to three (3) minutes and may be extended by Commission Chair as time permits.

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

AGENDA

I. CALL TO ORDER – Chairman Paul Rodriguez

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

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

III. NOMINATION COMMITTEE
3.1 Nomination of Chair and Vice Chair (Vote Required)
3.2 Standing committee assignments

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

4.1 **MINUTES**
November 17, 2021

4.2 **COMMITTEE REPORTS**
4.2.1 Base Hospital Advisory Committee
4.2.2 Data Advisory Committee
4.2.3 Provider Agency Advisory Committee

5 **POLICIES**

4.3.1 Reference No. 201: Medical Management of Prehospital Care
4.3.2 Reference No. 414: Specialty Care Transport Provider
4.3.3 Reference No. 419: Prehospital EMS Aircraft Operations
4.3.4 Reference No. 503.1: Diversion Request Requirements for Emergency Department Saturation
4.3.5 Reference No. 802: Emergency Medical Technician Scope of Practice
4.3.6 Reference No. 807: Medical Control During Hazardous Material Exposure
4.3.7 Reference No. 814: Determination/Pronouncement of Death in the Field

END OF CONSENT AGENDA

V. BUSINESS

BUSINESS (OLD)

5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies
5.2 Ambulance Patient Offload Time (APOT)
5.3 LA County COVID-19 Update – EMS Agency
5.4 Data Advisory Committee (DAC) Meeting Frequency

BUSINESS (NEW)

5.5 EMSC Workplan (Goals/Objectives) for Fiscal Year 2021-22 Annual Report
5.6 AB 389 (Grayson D) Ambulance Services (Attachment)

VI. LEGISLATION

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

CORRESPONDENCE – Highlighted items left over from November 17, 2021

7.1 (08-24-2021) Distribution: Notification of Fatal or Non-Fatal Submersion Incidents by EMS to Public Health

7.2 (09-30-2021) From Board of Supervisors Executive Office: Commission Meetings and County Vaccination Mandate

7.3 (11-15-2021) Distribution: Emergency Department Status of Community Hospital Long Beach

7.4 (01-03-2022) Distribution: Revised EMS Personnel Certification Fees

7.5 Los Angeles Times Article - https://www.latimes.com/california/story/2022-01-03/l-a-county-see-delays-in-911-ambulance-calls-as-omicron-taxes-hospitals

7.6 Los Angeles Time Article - https://www.latimes.com/california/story/2022-01-04/covid-hospitalizations-top-summer-surge-in-l-a

7.7 (01-06-2022) Distribution: Reissuance of August 2021 Guidance for Emergency Medical Services Personnel Entering Healthcare Facilities

VIII. COMMISSIONERS' COMMENTS / REQUESTS

IX. ADJOURNMENT

To the meeting of March 16, 2022

EMERGENCY MEDICAL SERVICES COMMISSION
STANDING COMMITTEE ASSIGNMENTS
2022

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

COMMITTEE	2021	2022
Provider Agency Advisory Committee **PAAC**	Chair: **Robert Ower** Vice Chair: **Kenneth Powell** Commissioners: Gene Harris Paul Rodriguez Brian Bixler John Hisserich Staff: **Gary Watson**	Chair: **Robert Ower** Vice Chair: **Kenneth Powell** Commissioners: Carl Povilaitis Paul Rodriguez Brian Bixler John Hisserich Staff: **Gary Watson**
Base Hospital Advisory Committee **BHAC**	Chair: **Carol Meyer, MPA, RN** Vice Chair: **Carole Snyder, RN** Commissioners: Atilla Uner, MD, MPH Lydia Lam, MD Diego Caivano, MD Erick Chung, MD Garry Olney, DNP Staff: **Laura Leyman**	Chair: **Carol Meyer, MPA, RN** Vice Chair: **Garry Olney, DNP** Commissioners: Atilla Uner, MD, MPH Lydia Lam, MD Diego Caivano, MD Erick Chung, MD Carole Snyder, RN Staff: **Laura Leyman**
Data Advisory Committee **DAC**	Chair: **Jeffrey Rollman** Vice Chair: **Joe Salas** Commissioners: Nerses Sanossian, MD James Lott, PsyD Gloria Molleda Gary Washburn Staff: **Sara Rasnake**	Chair: **Jeffrey Rollman** Vice Chair: **Joe Salas** Commissioners: Jason Tarpley, MD James Lott, PsyD Gloria Molleda Gary Washburn Staff: **Sara Rasnake**

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MINUTES
November 17, 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.	Denise Watson	Commission Liaison
☒ 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	Richard Tadeo	EMS Staff
☒ James Lott, PsyD, MBA	Public Member, 2nd District	Millicent Wilson	EMS Staff
☒ 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.	Jacqui Rifenburg	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
☐ *Gary Washburn	Public Member, 5th District	Gary Watson	EMS Staff
		Laura Leyman	EMS Staff

GUESTS

Samantha Gates/LBM	Marc Eckstein, MD	Mark Gamble/HASC	Jenn Nulty/Torr-FD
Rex Pritchard/LB-FD/CPF	Saman Kashani/LACoFD	Brit Alton/Burb-FD	Catherine Borman
Adam VanGerpen/LAFD	Clayton Kazan/LACoFD	Andy Reno/LB-FD	
Marty Creel/CSFA	Shelly Trites/Torr Mem	Jodi Mannino	
Puneet Gupta/LACoFD	Catherine Borman/SMFD	Caroline Jack	

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

I. CALL TO ORDER

The Emergency Medical Services (EMS) 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 1:03 p.m. by Chairman Paul Rodriguez. A quorum was present with 17 Commissioners on the call.

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

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

Cathy Chidester, EMS Agency Director and EMSC Executive Director, did roll call of the Commissioners.

Marianne Gausche-Hill, MD, EMS Agency Medical Director, presented Dr. Marc Eckstein with a scroll from the LA County Board of Supervisors to honor and celebrate his work in emergency medical services, as well as his service on the EMSC.

III. CONSENT AGENDA

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

Commissioner Atilla Uner questioned Policies, Reference No. 838, asking 1) if this applies to field responses only or interfacility (IFT) transports as well; and 2) if it would be a conflict for EMS providers to create an internal policy to have all IFT transports place patients in restraints given the high rate of mortality on IFT patient elopement.

Dr. Gausche-Hill confirmed Reference No. 838 applies to both, and if significant concern for patient elopement exists, the language allows room for restraints if necessary.

A typographical error on Reference No. 227.1 (Policies, Reference No. 227), Page 4 of 15, line 3, says “intra-mammary,” and will be corrected to “infra-mammary.”

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

1. MINUTES

September 15, 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. 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: Flow Chart 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
Kay Fruhwirth, EMS Agency Nursing Director, reported on the status of the nine (9) recommendations made in the Prehospital Care report from September 2016. Most recommendations have been completed with a few items remaining in progress.

Director Chidester questioned if item 4.1 should be kept as Old Business or removed.

The EMSC agreed 4.1 should remain a standing item on the agenda with regular updates. This work was for educational updates to make improvements in areas of prehospital care of mental health and substance abuse emergencies and will also intersect with the 9-8-8 nationwide mental health crisis and suicide prevention line recently designated by the Federal Communications Commission (FCC).

4.1.1 Ad Hoc Workgroup on the Pre-Hospital Care of Mental Health and Substance Abuse Emergencies – Recommendation Eight
Dr. Gausche-Hill reported on treatment protocols and Medical Control Guidelines (MCG) that are up for approval and will be integrated with current policies and included in EMS Update 2022 which includes patients with agitation and expanded scope to include Olanzapine. The approved policies will be submitted to the State for expanded scope for the Olanzapine and will roll out in 2022. The MCG for Suicidal Risk Assessment may be a pilot program at some point.

Commissioner Erick Cheung commented that the MCG for Suicidal Risk is innovative, fundamentally essential for prehospital care and provides access for pre-hospitals to accurately assess the risk of an individual they are encountering.

4.2 Ambulance Patient Offload Time (APOT)
Richard Tadeo, EMS Agency Assistant Director, reported that the EMS Agency is in the process of purchasing the FirstWatch product. Los Angeles County ISD and County Counsel are reviewing the contract. The EMS Agency is also engaged with the dispatch centers to determine technical requirements for implementation.

No APOT report was provided, but data is being collected and ambulance staffing is stabilizing.

4.3 LA County COVID Update – EMS Agency
Dr. Gausche-Hill provided an update on the COVID Daily Tracking Report for LA County covering prehospital data for provider impressions through May 2021 and reported an uptick in respiratory distress. Hospitalizations in the medical/surgical wards

and ICUs peaked in August with the Delta surge, but overall have stabilized although not at zero.

At least 80% of all LA County eligible individuals are vaccinated. This will increase with Pfizer's approval for children ages 5-11 to be immunized.

There are no pediatric COVID case surges around the country at this time; however, Children's Hospital Association (CHA) and the American Academy of Pediatrics (AAP) have declared a national mental health emergency in children which is the indirect effect of COVID such as loss of parents and loved ones, and direct effects of long-COVID, Multi-inflammatory Syndrome in Children and myocarditis. Overall, numbers for children infected with Covid-19 are relatively low.

Pfizer and Merck applied to the Food and Drug Administration (FDA) for an oral anti-viral that is effective against COVID if given early into disease.

4.4 EMS Commission Membership – Vote Required

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

Items 4.4 and 4.4.1 were held from September 15, 2021 EMSC meeting for comments from both CPF and CSFA.

Public Comment:
Rex Pritchard, President of Long Beach Firefighters Local 372 and Second District Vice President for CPF, originally requested the Ordinance change through Supervisor Janice Hahn's office for CPF to become the nominating organization for paramedic representation on the EMSC removing CSFA who currently makes the nomination for this seat on the Commission.

Mr. Pritchard reiterated that CPF feels they are the appropriate body to have appointing authority as they represent 99% of paramedics in LA County, have a lot of interaction with the EMS Agency regarding APOT, and want what is best for patients and the EMS system. He reiterated CPF's plan to keep the current firefighter representative, Chairman Paul Rodriguez, in the seat and will always ensure an active paramedic is on the Commission.

There was discussion that CPF is a labor organization involved in bargaining, and CSFA is not a labor organization with membership including firefighters, public and private.

Commissioner Kenneth Powell stated the Los Angeles Area Fire Chiefs' Association is in support of this change.

Public Comment:
Marty Creel, Interim Executive Director for California State Firefighters Association (CSFA) since October 2021, expressed that CSFA would like to keep the seat on the Commission to know what the trends are and what is going on in Los Angeles County EMS system.

Motion/Second by Commissioners Bixler/Hisserich to approve the Ordinance change for nominations for Paramedic Representation from California State Firefighter's Association (CSFA) to California

Professional Firefighters (CPF) was approved and carried by majority vote:

Aye (11): Bixler, Hisserich, Lam, Lott, Molleda, Olney, Povilaitis, Powell, Rollman, Salas, Tarpley

No (3): Ower, Snyder, Uner

Abstain (2): Meyer, Rodriguez

Absent During Vote (1): Cheung

Director Chidester explained that CSFA remains the nominating organization until the ordinance change process is complete, which could take up to six (6) months. We will work with County Counsel, the Chief Executive Office and the Board of Supervisors to complete the ordinance change.

4.5 EMS Commission Ordinance and Composition Review
Kay Fruhwirth, EMS Agency Nursing Director, provided an overview of the EMS Commission Ordinance Composition with clean-up language to ensure all seats on the Commission have a nexus to Los Angeles County, either working in and/or practicing in. These modifications will be incorporated as part of the EMS Commission Ordinance Composition change process as noted above.

BUSINESS (NEW)

4.6 Data Advisory Committee Meeting Frequency
Commissioner Jeff Rollman reported that DAC came to a consensus to potentially change this committee to an ad hoc meeting if DAC decisions come up since they do not require six (6) meetings per year. This will be discussed in December, as well as membership composition, and DAC will bring recommendations to the Commission in January 2022.

4.7 Data Report
Dr. Gausche-Hill provided highlights of the data report covering specialty care, ED visits, trauma, STEMI, stroke, and cardiac arrests. She thanked Richard Tadeo for preparing the data report, and reviewed EMS system demographics.

4.8 EMSC Workplan (Goals/Objectives) for Fiscal Year 2021-22 Annual Report
Tabled to the meeting of January 19, 2022.

4.9 Nominating Committee for 2022 Chair and Vice Chair
Commissioner Robert Ower volunteered to chair the committee, and Commissioners John Hisserich and Carole Snyder will assist. Recommendations will be brought back to the EMSC in January 2022.

4.10 EMS Agency Meeting Schedule 2022
No discussion on this handout.

V. LEGISLATION

5.1 AB389 (Grayson D) Ambulance Services
Tabled to the meeting of January 2022.

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

Director Chidester reported the closure of Long Beach Community due to staffing issues, and that the EMS Agency will prepare an Impact Evaluation Report. No public hearing is required as this is an urgent closure due to patient safety issues. They have been closed to 9-1-1 traffic.

Dr. David Duncan, EMS Authority Director, retired November 11, 2021, and the new Acting Director will be Elizabeth Basnett and Dr. Hernando Garzon will serve as Medical Director.

Director Chidester announced her retirement effective January 28, 2022. Kay Fruhwirth will be the Interim Director until Los Angeles County Department of Health Services finds a replacement. She thanked the Commission for being very active, engaged and for their great work.

The correspondence below was also reviewed. Correspondence items 6.4 and 6.6 will be discussed further at the January 2022 meeting.

CORRESPONDENCE:

Director Chidester reported on correspondence.

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

VII. COMMISSIONERS' COMMENTS / REQUESTS

None.

VIII. ADJOURNMENT:

Adjournment by Chairman Rodriguez at 3:11 p.m. to the meeting of January 19, 2022. Zoom meetings will continue following mandates by the State and County until further notice.

Motion/Second by Commissioners Bixler/Hisserich to adjourn to the meeting of Wednesday, January 19, 2022, was approved and carried unanimously.

Next Meeting: Wednesday, January 19, 2022, 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
Passcode: 991629

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Recorded by:
Denise Watson
Secretary, Health Services Commission

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

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

December 8th, 2021

MEMBERSHIP / ATTENDANCE (VIA Zoom)

	REPRESENTATIVES		EMS AGENCY STAFF
☑	Carol Meyer., Chair	EMS Commission	Dr. Marianne Gausche-Hill
☑	Carole Snyder, RN., Vice Chair	EMS Commission	Dr. Nichole Bosson
☐	Atilla Under, MD, MPH	EMS Commission	Richard Tadeo
☑	Lydia Lam, MD	EMS Commission	Christine Clare
☑	Diego Caivano, MD	EMS Commission	Jacqueline Rifenburg
☑	Erick Cheung, MD	EMS Commission	John Telmos
☑	Garry Olney	EMS Commission	Cathy Jennings
☑	Paul Rodriquez	EMS Commission	Susan Mori
☑	Gloria Molleda	EMS Commission	Lorrie Perez
☑	Jim Hisserich	EMS Commission	Dr. Denise Whitfield
☑	Jim Lott	EMS Commission	Christine Zaiser
☑	Robert Ower	EMS Commission	Karen Rodgers
☑	Rachel Caffey	Northern Region	Gary Watson
☑	Melissa Carter	Northern Region	David Wells
☑	Charlene Tamparong	Northern Region, Alternate	Dr. Kelsey Wilhelm
☑	Samantha Verga-Gates	Southern Region	Andrea Solorio
☑	Laurie Donegan	Southern Region	Laura Leyman
☑	Shelly Trites	Southern Region	Cathy Chidester
☑	Christine Farnham	Southern Region, Alternate	Kay Fruhwirth
☑	Paula Rosenfield	Western Region	Jerry Crow
☑	Ryan Burgess	Western Region	**GUESTS**
☑	Susana Sanchez	Western Region, Alternate	Dr. Amar Shah, CSM
☐	Erin Munde	Western Region, Alternate	
☑	Laurie Sepke	Eastern Region	
☑	Alina Candal	Eastern Region	
☑	Jenny Van Slyke	Eastern Region, Alternate	
☑	Lila Mier	County Region	
☑	Emerson Martell	County Region	
☑	Yvonne Elizarraraz	County Region	
☑	Antoinette Salas	County Region	
☑	Shira Schlesinger, MD	Base Hospital Medical Director	
☐	Robert Yang, MD	Base Hospital Medical Director, Alternate	
☑	Alec Miller	Provider Agency Advisory Committee	
☐	Jennifer Nulty	Provider Agency Advisor Committee, Alternate	
☑	Heidi Ruff, PCC HMN	Pediatric Advisory Committee Representative	
☑	Michael Natividad, PCC AMH	PED AC Representative, Alternate	
☐	Laarni Abenojo	MICN Representative	
☐	Naomi Leland	MICN Representative, Alternate	

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

1. **CALL TO ORDER:** The meeting was called to order at 1:02 pm by Carol Meyer, Chair

2. **APPROVAL OF MINUTES**: The meeting minutes for October 13, 2021, were approved as submitted.

   M/S/C (Farnham/Olney)

3. **INTRODUCTIONS/ANNOUNCEMENTS:**
   - Cathy Chidester announced her retirement effective January 28, 2021. Kay Fruhwirth will be the Interim Director beginning January 1, 2021.
   - Chris Clare announced the EMS Staff changes for the Hospital Programs:
     - Laura Leyman replaces Lorrie Perez as the Base Program Coordinator (Lorrie was promoted to the Trauma System Program Manager).
     - Lily Choi is the new STEMI Receiving Centers Manager.
   - Richard Tadeo announced the upcoming retirement of Cathy Jennings December 15th and John Telmos in January 2022.
   - Chris Farnham announced the new APCC Officers for 2022:
     - Shelly Trites (TOR) President
     - Melissa Carter (HCH) Vice President
     - Yvonne Elizarraraz (HGH) Treasurer
     - Melissia Turpin (SMM) Secretary
   - Community Hospital of Long Beach permanently closed their Emergency Department on November 24, 2021. The facility will be converted to a behavioral health campus, and currently the hospital has 28 inpatient psychiatric beds.
   - California EMS Awards 2021 sponsored by the EMS Authority will be held on March 14, 2022, at the LA County Fire Museum. There are many different categories of awards including: heroism, distinguished service, community service and EMS educator. The Committee member were highly encouraged to nominate LA County EMS practitioners.
   - Emergency Medical Services Authority (EMSA) - Personnel Guidance Policy that was implemented during COVID for emergency medical service (EMS) personnel, and EMS training programs has been extended through March 31, 2022.

4. **REPORTS & UPDATES:**

   4.1 <u>EMS Update 2021</u>

   The planning and preparation for EMS Update 2022 is underway, it will be delivered in two parts:

   1. Introduction to i-gel for the EMS system and expansion for the pediatric patients. In addition, the module will include i-gel training with focus on airway management and optimizing effective oxygenation and ventilation for adults and pediatrics. The online module will go live in April 2022 and the practical component will include in-person training for the provider agencies. The first component of EMS Update will be completed by July 2022.
      - There will be one date for Train the Trainer, and Intersurgical, manufacturer of the i-gel, will be available to demo the i-gel and to answer any questions.
      - The MICN's are only required to attend the online portions of EMS Update 2022.

   2. Behavioral Health Policies: The second online module will be available September 1, 2022.

4.2 EmergiPress

The next edition of EmergiPress will be available at the end of December or early January 2022 and will include the topics of Precipitous Childbirth, Difficult Deliveries, and Newborn Resuscitation in the field. An online format will be available for educators who wish to upload the modules to a Learning Management System.

4.3 ECMO Pilot

The ECMO Pilot is ongoing, with a significant increase in enrollment over the last couple of months. We are hopeful to have data for an interim analysis by April or May 2022. The pilot provider agencies can enroll patients and will continue to enroll patients next year. Per protocol, the pilot provider agencies are directed to contact the ECMO Base Hospital for patients that meet inclusion criteria. If ECMO service needs to be temporarily suspended, send a message via the Reddinet and notify the EMS Agency. The ECMO diversion will not impact receiving STEMI or cardiac arrest patients.

4.4 I-gel Pilot

The i-gel pilot program was concluded at the end of September 2021, there were 102 patients enrolled. The participating providers included Torrance Fire, Culver City Fire, County Fire, and Pasadena Fire. Dr. Bosson presented the results of the data in detail. Overall, the i-gel pilot program was successful and the feedback from the paramedics were very positive. Beginning January 2022, County Fire will move forward with the i-gel training for adult patients.

4.5 Data Collaboratives

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

SRC Collaborative:

- Examining the effect of COVID on STEMI and cardiac arrest outcomes and the impact on our system.
- *Ongoing projects*: review of post ROSC protocols, re-arrest, and patient outcomes, and bystander CPR and disparities in our system.

Stroke Data Collaborative:

- Currently working on publication for 24-hour routing to TSC and CSC Centers for acute ischemic strokes. The study showed that of those patients that were rerouted, 28% received thrombectomy and 9% had LKWT of 16-24 hours. There is potential for patients to benefit from re-routing due to the extended time windows.

Upcoming plans when data system issues are resolved:

- Expansion of the Mobile Stroke Unit and how it will impact our system.
- How routing may impact the stroke patients with LAMS Score of 0-3, and what is the frequency of an LVO diagnosis, and what is the false negative rate.
- Identifying ICH patients, which currently are not identifiable in the prehospital setting, and routing for ICH patients.

Pediatrics:

- PediDose has been funded and the EMS Agency is a participating site. Children's Hospital Los Angeles (CHH) and LAC Harbor-UCLA Medical Center (HGH) are the only participating receiving centers however, the EMS Agency is submitting system data on all pediatric seizure patients. The trial is looking at standardizing dosing by age for pediatric seizure patients.
- Identifying low risk BRUE patients for routing to EDAPS versus PMC's.
- National Pediatric Airway Management Trial is an upcoming trial and if funded, the EMS Agency is hoping to participate.

Trauma Consortium:

- Southern California Regional Trauma Consortium is a Regional Group, not just LA County, conducting multi-site studies on:
    - Imagining in pregnancy patients
    - Isolated sternal fractures.

5. OLD BUSINESS:

5.1 First Watch

Is a data mining software that collects dispatch data in real time. The information will be used to identify delays in Ambulance Patient Offload Time (APOT) in a timely mannter. The EMS Agency has applied for a grant and currently are in contract negotiations. Provider agencies that are currently using First Watch are Los Angeles Fire Department and Care, WestMed/McCormick, and AMR North Division ambulance companies. The data will be used to determine the need to place a hospital on ED Saturation to divert ambulance traffic. Long Beach and Verdugo Dispatch Centers have agreed to participate, and there are plans to reach out to the South Bay Regional Dispatch Centers. After approval, implementation could begin in 2-4 weeks. Digital EMS has agreed to develop an interface with First Watch, free of charge, to allow the automatic download of the "Facility Equipment" Time from the ePCR to the FirstWatch system.

6. NEW BUSINESS:

6.1 Ref. No. 201, Medical Management of Prehospital Care

Approved as presented.

M/S/C (Farnham/Burgess)

6.2 Ref. No. 414, Specialty Care Transport Provider

Approved as presented.

M/S/C (Farnham/Sepke)

6.3 Ref. No. 419, Prehospital EMS Aircraft Operations

Approved with changes made by Med Council: Pg.3, letter E and recommended changes: Pg. 5, letter G- to add language that would emphasize timely transmission of the EMS record.

M/S/C (Van Slyke/Caivano)

6.4 Ref. No. 503.1, Diversion Request Requirements for Emergency Department Saturation

Approved with recommended changes: revise letter D and include “triage assessment and transfer of care report will be given to the triage RN.”

M/S/C (Caivano/Lott)

6.5 Ref. No.802, EMT Scope of Practice

Approved as presented.

M/S/C (Van Slyke, Farnham)

6.6 Ref. No. 807, Medical Control During Hazardous Material Exposure

Approved as presented.

M/S/C (Van Slyke, Farnham)

6.7 Ref. No. 814, Determination / Pronouncement of Death in the Field

Approved with recommendations: Pg. 3 number 8, add “sinus.”

Recommendations to clarify Ref. No.1243 to align with Ref. No. 814.

Commissioner Lott opposes approval of 814 as discussed.

M/S/C (Van Slyke/Lam)

The Following Policies were presented as Informational Only

6.8 Ref. No. 1203, Diabetic Emergencies
6.9 Ref. No. 1204, Fever/Sepsis
6.10 Ref. No. 1210-P, Cardiac Arrest
6.11 Ref. No. 1212-P, Cardiac Dysrhythmia
6.12 Ref. No. 1213, Cardiac Dysrhythmia-Tachycardia
6.13 Ref. No. 1219, Allergy
6.14 Ref. No. 1232, Stroke/CVA/TIA
6.15 Ref. No. 1232-P, Stroke/CVA/TIA
6.16 Ref. No. 1237, Respiratory Distress
6.17 Ref. No. 1237-P, Respiratory Distress
6.18 Ref. No. 1243, Traumatic Arrest
6.19 Ref. No. 1244, Traumatic Injury
6.20 Ref. No. 1309, Color Code Drug Doses
6.21 Ref. No. 1317.1, Drug Reference-Adenosine
6.22 Ref. No. 1317.3, Drug Reference- Albuterol
6.23 Ref. No. 1317.1, Drug Reference- Epinephrine
6.24 Ref. No. 1317.19, Drug Reference- Fentanyl
6.25 Ref. No. 1345, Pain Management
6.26 Ref. No. 1373, Treatment Protocol Quality Improvement Fallout Data Dictionary

7. OPEN DISCUSSION:

None

8. NEXT MEETING: BHAC's next meeting is scheduled for February 9th, 2022

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

ACCOUNTABILITY: Laura Leyman

9. ADJOURNMENT: The meeting was adjourned at 3:10 P.M.

EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE
WEDNESDAY, December 8, 2021

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

MEMBERSHIP / ATTENDANCE		
MEMBERS	ORGANIZATION	EMS AGENCY
☒ Jeffrey Rollman, Chair	EMS Commissioner (Southern California Public Health Assn.)	Christine Clare
□ Joe Salas, Vice Chair	EMS Commissioner (Public Member 1st District)	Nichole Bosson
□ Jim Lott	EMS Commissioner (Public Member, 2nd District)	Richard Tadeo
☒ Gloria Molleda	EMS Commissioner (League of Calif. Cities/LA County Division)	
□ Gary Washburn	EMS Commissioner (Public Member, 5th District)	
□ Matt Armstrong	Ambulance Advisory Board (LACAA)	
☒ Kris L. Thomas	Ambulance Advisory Board (alternate)	
☒ Christine Farnham	Base Hospital Advisory Committee (BHAC) (RN)	OTHERS
☒ Shelly Trites	BHAC (alternate)	
□ Ryan Burgess	Hospital Association of Southern California (HASC)	
□ Nathan McNeil	HASC (alternate)	
□Don Gerety	Long Beach Fire Department (LBFD)	
□ Brenda Bridwell	LBFD (alternate)	
□ Sean Stokes	Los Angeles Area Fire Chiefs Association	
□ VACANT	LA Area Fire Chiefs Association (alternate)	
☒ Yun Son Kim	Los Angeles County Fire Department (LACoFD)	
□ VACANT	LACoFD (alternate)	
□ Matthew Potter	Los Angeles Fire Department (LAFD)	
□ John Smith	LAFD (alternate)	
☒ Marc Cohen	Medical Council (MD)	
□ VACANT	Medical Council (alternate)	
□ Daniel Dobbs	Provider Agency Advisory Committee (PAAC)	
□ Ivan Orloff	PAAC (alternate)	
□ Tchaka Shepherd	Trauma Hospital Advisory Committee (THAC) (MD)	
□ David Hanpeter	THAC (MD) (alternate)	
☒ Marilyn Cohen	THAC (RN)	
☒ Gilda Cruz-Manglapus	THAC (RN) (alternate)	
☒ Present *Excused □ Absent		

1. **CALL TO ORDER:** The meeting was called to order at 10:03 am by Commissioner Rollman.

2. **APPROVAL OF MINUTES:** The minutes of the August 11, 2021 were approved as written.

3. **INTRODUCTIONS/ANNOUCEMENTS** *(Chris Clare)*

   - Laura Leyman has moved into the role of Base Hospital Program Coordinator.
   - Lily Choi has returned to the EMS Agency and is the SRC Program Manager.

4. **REPORTS & UPDATES**

   4.1 Service Changes *(Chris Clare)*

   9-1-1 Receiving Facility Closure

   Community Hospital Long Beach closed to 9-1-1 traffic on November 17, 2021 and completely closed the Emergency Department on November 24, 2021. All acute care patient units have closed and they are turning the facility into a behavioral health campus.

   Specialty Services

   PIH Health Hospital – Downey was designated a STEMI Receiving Center effective November 1, 2021.

San Dimas Community Hospital was designated a Primary Stroke Center effective November 15, 2021.

4.2 Prehospital Research Studies *(Nichole Bosson)*

Ongoing Prehospital Research Study:

- Extracorporeal Membrane Oxygenation (ECMO) pilot is on-going and there has been an increase in enrollments now that COVID burden has lessened.

Data Collaborative Projects:

- STEMI Receiving Center (SRC):
  - Out of Hospital Cardiac Arrest and the impact of COVID
  - Bystander CPR training access
  - Post Return of Spontaneous Circulation and re-arrest
- Stroke
  - Change to 24-hour routing for stroke
  - Lower LA Motor Score (LAMS) and incidents of large vessel occlusion
  - Routing for patients experiencing and intracerebral hemorrhage.
- Pediatric
  - PediDOSE- pediatric seizure with standardized midazolam dosing. This is a multi-site randomized trial.
  - Have applied for approval for a pediatric airway trial
  - Brief Resolved Unexpected Event (BRUE) study involving five Pediatric Medical Centers (PMC) and evaluating the possibility to route to Emergency Department Approved for Pediatrics instead of PMCs.
- Trauma
  - Southern California Trauma Research Collaborative is a Regional Group, not just LA County, conducting multi-site studies:
    - Imaging in Pregnancy
    - Isolated sternal fractures

5. UNFINISHED BUSINESS

5.1 CF/CI Data Submission *(Chris Clare)*

Los Angeles County Fire Department (CF): Has submitted data through September 30, 2021.

Los Angeles Fire Department (CI): Has submitted all records through June 30, 2021. They have begun submitted records from July 1, 2021 however some issues have been identified and they are working with their vendor, Stryker, to resolve the issues.

5.2 First Watch *(Richard Tadeo)*

First Watch is a software program that data mines electronic Patient Care Records (ePCR) and dispatch centers. Hospitals can also utilize and enter information if they separately contract with them. The EMS Agency applied for a grant to cover initial deployment, building of necessary interfaces and first year of service. This will cover Verdugo, Long Beach and South Bay dispatch centers. CI and CF's EOA transportation providers already utilize First Watch. The EMS Agency will be able to have timely access to evaluate impacted hospitals and providers with the goal of reducing Ambulance Patient Offload Time (APOT). The EMS Agency will have access to the following aggregate numbers:

- Ambulance(s) enroute to hospital
- Ambulance(s) arrival at hospital
- Average time waiting to offload patient(s)
- Longest time waiting to offload patient

The goal is to have full implementation by early 2021

5.3 Meeting Frequency

The Data Advisory Committee (DAC) Activity Summary from 2017 through August 2021 (Attachment I) was shared with the Committee. The Committee members recommended that a roll call vote be taken to dissolve the DAC as it currently exists and make DAC ad hoc. All members in attendance voted in the affirmative to change DAC to an ad hoc committee except Commissioner Rollman who abstained.

5.4 Committee Membership Structure *(Richard Tadeo)*

Withdrawn due to affirmative vote on item 5.3

6. NEW BUSINESS

None

7. NEXT MEETING: To be determined

8. ADJOURNMENT: The meeting was adjourned at 10:37 am by Commissioner Rollman.

Data Advisory Committee Activity Summary 2017 through Present

Meeting Date	Met or Cancelled	Actions Taken or Agenda Items Requiring Vote
February 8, 2017	Met	None
April 12, 2017	Cancelled due to lack of agenda items	
June 14, 2017	Met	None
August 9, 2017	Cancelled due to lack of agenda items	
October 11, 2017	Cancelled due to lack of agenda items	
December 13, 2017	Met	Recommendation: Have Stryker present at EMS Commission to address plans to resolve re: data transmission issues for LAFD and LACoFD (Done at 1-17-2018 EMSC meeting)
February 14, 2018	Met	No Quorum. No outstanding items.
April 11, 2018	Cancelled due to lack of agenda items	
June 13, 2018	Cancelled due to lack of agenda items	
August 8, 2018	Cancelled due to lack of agenda items	
October 10, 2018	Cancelled due to lack of agenda items	
December 12, 2018	Cancelled due to lack of agenda items	
February 13, 2019	Cancelled due to lack of agenda items	
April 10, 2019	Cancelled due to lack of agenda items	
June 12, 2019	Met	None
August 14, 2019	Cancelled due to lack of agenda items	
October 9, 2019	Cancelled due to lack of agenda items	
December 11, 2019	Cancelled due to lack of agenda items	
February 12, 2020	Cancelled due to lack of agenda items	
April 8, 2020	Cancelled due to lack of agenda items	
June 10, 2020	Cancelled due to lack of agenda items	
August 12, 2020	Met	None
October 14, 2020	Cancelled due to lack of agenda items	
December 9, 2020	Cancelled due to lack of agenda items	
February 10, 2021	Cancelled due to lack of agenda items	
April 14, 2021	Met	None
June 9, 2021	Cancelled due to lack of agenda items	
August 11, 2021	Met	Recommendation: Determine process to change DAC to ad hoc

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

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, December 15, 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.
☑ Kurt Buckwalter	Area E
☐ *Vacant*	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.
☐ *Vacant*	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
Denise Whitfield, MD	Jennifer Calderon
Christine Clare	Elaine Forsyth
Laura Leyman	Susan Mori
Lorrie Perez	Jacqueline Rifenburg
Karen Rogers	Andrea Solorio
John Telmos	Gary Watson
David Wells	Christine Zaiser

PUBLIC ATTENDEES (Virtual)	
Zachary Rubin, MD	LA County Public Health
Christina Eclarino	LA County Public Health
Kelsey OYong	LA County Public Health
Angelica Loza-Gomez, MD	Glendale/Montebello FD
Marc Cohen, MD	Three Area Fire Departments
Andrew Pachon, MD	
Drew Bernard, MD	Emergency Ambulance
Adrienne Roel	Culver City/El Segundo FD
Aspen Di-Ilolo	Monterey Park FD
Britney Alton	Burbank FD
Catherine Borman	Santa Monica FD
Mike Bruschel	
Daniel Nausha	Pasadena FD
Erich Ekstedt	Downey FD
Johnna Corbett	Four Area Fire Departments
Katie Ward	La Habra Heights FD
Kristina Crews	LACoFD/Compton FD
Lyn Riley	LACo Sheriff Air Ops
Marianne Newby	Three Area Fire Departments
Paula LaFarge	LACoFD
Richard Oishi	Arcadia FD
Rinka Shiraishi	Glendale FD
Roger Braum	Culver City FD
Ryan Jorgensen	La Habra Heights FD
Sheryl Gradney	LACoFD
Wolfgang Knabe	
Craig Hammond	Glendale FD
Luis Manjarrez	Glendale FD
Caroline Jack	Beverly Hills FD

1. **CALL TO ORDER:** 1:02 p.m.: Chair, Robert Ower, called meeting to order.

2. **INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS**

2.1 EMS Agency Staff Changes *(Cathy Chidester)*

- Cathy Chidester announced her retirement as Director of the EMS Agency effective January 28, 2022. Until the County identifies and hires a new Director, Kay Fruhwirth will be the Interim Director starting January 1, 2022.
- John Telmos announced his retirement as Chief of the Prehospital Care Section effective January 28, 2022.
- Cathlyn Jennings, Manager of the Prehospital Care Section has retired effective December 14, 2021.

2.2 Community Hospital of Long Beach Closure *(Cathy Chidester)*

Effective November 17, 2021, Community Hospital Long Beach has closed its Emergency Department to all 9-1-1 transports. Since this closure was due to a public safety issue (personnel/staffing), a public hearing was waived. An impact analysis concluded that there would be minimal impact to the community.

2.3 California EMS Awards 2021 *(Cathy Chidester)*

- On March 14, 2022, California EMS Authority is presenting the 2021 California EMS Awards program and will take place at the LA County Fire Museum, in Bellflower.
- Nominations for an EMS award can be submitted through the following weblink and is due by December 31, 2021: https://emsa.ca.gov/awards/

2.4 EMSA – Personnel Guidance Policy *(Richard Tadeo)*

- Memo from the EMS Authority dated November 12, 2021 was reviewed. This memo describes the waiver extensions for EMT and paramedic licenses and certifications; and ends March 31, 2022.
- Additional questions can be directed to Nicole Mixon, Personnel Standards Managers, EMS Authority, at (916) 431-3690 or Nicole.mixon@emsa.ca.gov

3. **APPROVAL OF MINUTES (Kaduce/Mah)** October 20, 2021 minutes were approved as written.

4. **REPORTS & UPDATES**

4.1 Disaster Services Update - EMS COVID-19 Vaccination Survey
(Kelsey Oyong, Los Angeles County Department of Public Health)

- Public Health presented the results of a survey conducted in November 2021 of EMS providers, regarding their staff's COVID vaccination rates.
- Results revealed that of the 61 [public and private] providers, 49 providers responded to the survey, 86% of the personnel were fully vaccinated:
- Public Health expressed that they were encouraged by the vaccination coverage amongst the EMS personnel and feel that the County is prepared for the anticipated surges. Providers were encouraged to receive the upcoming COVID boosters.
- Questions regarding this survey may be directed to Kelsey OYong at koyong@ph.lacounty.gov

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

- There has been an increased number of COVID-19 cases over the past two weeks in Los Angeles County.
- The EMS Agency continues to monitor two Provider Impressions [Respiratory Distress and Cardiac Arrest] as it relates to COVID-19. Currently, there has been no spike in the use of these Provider Impressions, unlike what was seen one year ago.
- There was discussion on the new long-acting monoclonal antibody for high-risk patients. This is a prophylactic therapy for COVID-19 and is in limited supply. The EMS Agency will be working with Public Health on the distribution process of this medication, which requires federal registration.
- The next EMS Agency COVID-19 Update (ZOOM Conference Call) will be on January 3, 2022. Information on this update will be distributed as in the past, prior to the meeting.

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

EMS Update 2022 will include the following training modules:

- Module 1: iGel (supraglottic airway for adults and pediatric patients). The current KING-LTD airway will be phased out as they expire. There will be an on-line and in-person portion to the iGel training. In-person module will be required for providers only. Roll out will be during the months of May and June 2022, with an implementation date of July 1, 2022.
- Module 2: Behavioral health policies. Training will be online only. Roll out will be during the months of July and August 2022, with an implementation date of September 1, 2022.
- Train-the-Trainer classes will be scheduled during the months of March and April 2022.

4.4 ITAC Update *(Denise Whitfield, MD)*

This Committee met in November 2021 and reviewed three products:

1. Life Flow® PLUS – an intravenous infusion pump. Approved as optional use.
2. ResQR Device – assists with correct chest location and timing of compression during CPR. Approved as optional use for law enforcement and EMTs.
3. Video Laryngoscope – Approved as optional use if device is FDA approved and provider utilizing the device has an appropriate training program before implementation and ongoing skills training and is incorporated into provider's quality improvement program.

4.5 EmergiPress *(Denise Whitfield, MD)*

Next edition will be posted during the first week of January 2022 and will be focusing on emergency child birth.

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

- There are no new publications to report since previous meeting.
- Topics within the following data collaborative groups were discussed:

  - Cardiac Collaborative Group:
    a. STEMI and Out-of-Hospital Cardiac Arrests – Group is researching outcomes that are focused on the impacts of COVID-19 as it relates to STEMI and out-of-hospital cardiac arrests.
    b. Looking at CPR training opportunities throughout Los Angeles County including the language and racial disparities in training, which may have an impact on the bystander CPR rates. The results will be presented at the National Association

of EMS Physicians Conference in January 2022; and to an upcoming PAAC meeting.
    c. Reviewing the Post-ROSC protocols and how it may relate to re-arrest frequencies.
- Stroke Collaborate Group:
    a. Big interest in looking at large vessel occlusions amongst the low LAM Scores and patients transported to Primary Stroke Centers.
- Pediatric Collaborate Group:
    a. BRUE study is being developed and will include five Pediatric Medical Centers (PMCs) in Los Angeles County. Potentially identifying low-risk BRUE patients that may not require PMC transport.
    b. Pedi-Dose Study - Los Angeles County will be participating in a national trial that involves standardized dosing for pediatric seizure management based on patient's age. In the future, this could influence a change to the treatment protocols.
- Trauma Collaborative Group:
    a. Los Angeles County will be participating in Southern California Consortium that is mostly in-hospital and includes areas such as imaging in pregnancy and management of isolated sternal fractures.

- Although there are no new publications to report since the previous meeting, the following two publication topics are available for review and will be distributed to the Committee:

    - Equitable Allocation of Remdesivir for the COVID-19 Pandemic in Los Angeles County.
    - Utilizing the iGel during pediatric airway management.

4.7 ECMO Pilot *(Nichole Bosson, MD)*

Data continues to be collected for this anticipated 2-year pilot. This Committee will continue to receive updates.

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

This pilot ended in late September 2021 and the following highlights were presented:

- 102 patients were enrolled (primarily cardiac arrests).
- 88% had successful placement (83% on the first attempt)
- Most common complication: Emesis / regurgitation (However, this did not interrupt ventilation)
- Hypoxia was very rare during iGel placement
- Overall conclusion: Pilot was found to be successful and Los Angeles County will move towards adding the iGel within the paramedic system.

Providers who participated in the iGel pilot may continue using the iGel. However, providers who did not participate, will be required to wait until EMS Update 2022 before implementing.

Dr. Bosson thanked all the fire departments who participated in this pilot and the following nurse educators for their extensive participation in reviewing patient care records: Jenny Van Slyke (Pasadena FD), Adrienne Roel (Culver City FD), Nancy Alvarez (Los Angeles FD) and Jenn Nulty (Torrance FD).

5. UNFINISHED BUSINESS

There was no unfinished business.

6. NEW BUSINESS

The following policies required Action to be taken:

6.1 Reference No. 807, Medical Control During Hazardous Material Exposure *(Richard Tadeo)*

Policy reviewed and approved as presented.

M/S/C (Dobbs/Kazan) Approve Reference No. 807, Medical Control During Hazardous Material Exposure

6.2 Reference No. 201, Medical Management of Prehospital Care *(John Telmos)*

Policy reviewed and approved as presented.

M/S/C (Dobbs/Kazan) Approve Reference No. 201, Medical Management of Prehospital Care

6.3 Reference No. 414, Specialty Care Transport Provider *(John Telmos)*

Policy reviewed and approved as presented.

M/S/C (Miller/Kaduce) Approve Reference No 414, Specialty Care Transport Provider

6.4 Reference No. 419, Prehospital EMS Aircraft Operations *(John Telmos)*

Policy reviewed and approved as presented.

M/S/C (Kazan/Dobbs) Approve Reference No. 419, Prehospital EMS Aircraft Operations

6.5 Reference No. 503.1, Diversion Request Requirements for Emergency Department Saturation *(Richard Tadeo)*

Following lengthy discussion, there was a lack of consensus to proceed and the following roll call vote was conducted:

Committee Representation	Roll Call Vote
Area A – Sean Stokes	Yea
Area B – Clayton Kazan, MD	Nay
Area C – Ken Leasure	Nay
Area E – Kurt Buckwalter	Nay
Area F – Wade Haller	Nay
Area G – Alec Miller	Yea
Area H – Doug Zabilski	Nay
Employed Paramedic Coordinator	Not in Attendance
Prehospital Care Coordinator – Rachel Caffey	Yea
Public Sector Paramedic – Daniel Dobbs	Yea
Private Sector Paramedic	Not in Attendance
Provider Agency Medical Director – Ashley Sanello, MD	Yea
Nurse Staffed Ambulance	Not in Attendance
EMT Training Programs – Michael Kaduce	Abstained
Paramedic Training Programs – David Mah	Abstained

MOTION: Tied with FIVE votes in favor and FIVE votes against and TWO abstentions. Policy will move forward and be presented to the EMS Commission on January 19, 2022, for further recommendation.

6.6 Reference No. 802, EMT Scope of Practice *(Richard Tadeo)*

Policy reviewed and approved as presented.

M/S/C (Kaduce/Leasure) Approve Reference No. 802, EMT Scope of Practice

6.7 Reference No. 814, Determination / Pronouncement of Death in the Field *(Nichole Bosson, MD)*

Policy reviewed and approved as presented.

M/S/C (Dobbs/Leasure) Approve Reference No. 814, Determination / Pronouncement of Death in the Field

The following policies were presented as Information Only:

6.8 Reference No. 1243, Traumatic Arrest *(Nichole Bosson, MD)*
6.9 Reference No. 1203, Diabetic Emergencies *(Richard Tadeo)*
6.10 Reference No. 1203-P, Diabetic Emergencies *(Richard Tadeo)*
6.11 Reference No. 1204, Fever/Sepsis *(Richard Tadeo)*
6.12 Reference No. 1210-P, Cardiac Arrest (Pediatric) *(Richard Tadeo)*
6.13 Reference No. 1212-P, Cardiac Dysrhythmia (Pediatric) *(Marianne Gausche-Hill, MD)*
- Committee recommended the removal of the last sentence in Special Considerations No. 2

6.14 Reference No. 1213, Cardiac Dysrhythmia – Tachycardia *(Richard Tadeo)*
6.15 Reference No. 1219, Allergy *(Nichole Bosson, MD)*
6.16 Reference No. 1219-P, Allergy (Pediatric) *(Nichole Bosson, MD)*
6.17 Reference No, 1232, Stroke/CVA/TIA *(Marianne Gausche-Hill, MD)*
6.18 Reference No. 1232-P, Stroke/CVA/TIA (Pediatric) *(Marianne Gausche-Hill, MD)*
6.19 Reference No. 1237, Respiratory Distress *(Nichole Bosson, MD)*
6.20 Reference No. 1237-P, Respiratory Distress (Pediatric) *(Nichole Bosson, MD)*
6.21 Reference No. 1244, Traumatic Injury *(Nichole Bosson, MD)*
6.22 Reference No. 1309, Color Code Drug Doses *(Richard Tadeo)*
6.23 Reference No. 1317.1, Drug Reference-Adenosine *(Denise Whitfield, MD)*
6.24 Reference No. 1317.3, Drug Reference-Albuterol *(Richard Tadeo)*
6.25 Reference No. 1317.17, Drug Reference-Epinephrine *(Richard Tadeo)*
6.26 Reference No. 1317.19, Drug Reference-Fentanyl *(Richard Tadeo)*
6.27 Reference No. 1345, Pain Management *(Richard Tadeo)*
6.28 Reference No. 1373, Treatment Protocol Quality Improvement Fallout Data Dictionary *(Richard Tadeo)*

7. OPEN DISCUSSION

7.1 Release of Policies After Formal Changes *(Richard Tadeo)*
After Committee recommendation, the EMS Agency will restart the release of updated policies three times per year.

7.2 Community Paramedicine and Triage to Alternate Destination Regulations - Open for Public Comment *(John Telmos)*
- The EMS Authority is currently taking public comments for the proposed Community Paramedicine and Triage to Alternate Destination Regulations.
- The following weblink provides you with information on how to provide public comments: https://emsa.ca.gov/public_comment/
- Deadline for submitting comments is January 17, 2022.

8. **NEXT MEETING: December 15, 2021**

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **MEDICAL MANAGEMENT OF PREHOSPITAL CARE** REFERENCE NO. 201

PURPOSE: To provide guidelines for prospective, concurrent and retrospective medical management of the emergency medical services (EMS) system in Los Angeles County by the EMS Agency, hospitals, and provider agencies.

AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.176 and 1798(a)
California Code of Regulations, Title 22, Section 100169
Health Insurance Portability and Accountability Act of 1996
Hospital Preparedness Program (HPP) Agreement

DEFINITIONS:

Medical management consists of three components:

Prospective: Prior to delivery of patient care – off-line medical direction that utilizes scientific principles and practice standards to establish training objectives, and curriculum development for the standardization of patient care.

Concurrent: During delivery of patient care – on-line or on-scene medical direction of prehospital personnel caring for patients in the field. This allows for individualization of patient care and the ability to quickly intervene to ensure optimal use of system resources through direct communication or observation.

Retrospective: Following delivery of patient care – off-line medical direction composed of field care audits and case reviews for the purpose of ensuring quality improvement.

PRINCIPLES:

1. Medical management provides the framework and authorization for EMS personnel to provide emergency treatment outside the hospital. It implies that there is accountability throughout the planning, implementation, monitoring, and evaluation of the EMS system and requires a collaborative effort among all system participants. Medical management is based upon national, state, and community standards of care.

2. The EMS Agency, base hospitals, and provider agencies are responsible for ensuring that EMS personnel have experience in and knowledge of local EMS agency policies, procedures, and guidelines.

POLICY:

I. Prospective Medical Management

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

A. The Medical Director of the EMS Agency shall ensure the development, implementation, and revision of written treatment protocols, medical policies and procedures including but not limited to:

1. Medical Control Guidelines
2. Treatment Protocols
3. Base Hospital Contact and Transport Criteria
4. Local EMT Scope of Practice
5. Local paramedic scope of practice and accreditation requirements
6. Policies for the initiation, completion, review, evaluation, and retention of patient care records.

B. Base hospitals shall maintain written agreements with the EMS Agency indicating concurrence with the requirements of the EMS Agency's policies and procedures.

C. Provider agencies shall comply with applicable agreements, State and local policies and procedures specified in the Prehospital Care Manual.

II. Concurrent Medical Management

A. The EMS Agency shall ensure that a communication system is in place to allow for direct voice communication between paramedics, their assigned base hospital, and the Los Angeles County Medical Alert Center.

B. Base hospitals shall:

1. Maintain telecommunication equipment capable of communicating with ALS Units assigned to the hospital.
2. Ensure that a base hospital physician is immediately available for consultation when an ALS Unit contacts the base, and that either a base hospital physician or MICN provides direct voice communication for medical treatment orders and/or patient destination or other disposition.
3. Ensure that base hospital physicians and MICNs giving medical direction to paramedics are trained in, and have experience in and knowledge of, base hospital communications and the local EMS agency policies, procedures, and protocols.
4. Utilize the Los Angeles County Treatment Protocols. Any consistent deviation from these protocols must be requested in writing and approved by the Medical Director of the EMS Agency.
5. Complete Base Hospital Report Forms approved by the EMS Agency as defined in Ref. No. 606, Documentation of Prehospital Care.
6. Provide a mechanism to record, retain, and retrieve audio recordings of all voice field communications between the base and receiving hospitals and the paramedics.

C. Provider agencies shall:

1. Ensure that paramedics utilize and maintain telecommunications with assigned base hospitals.

2. Comply with requirements specifically addressed in medical treatment policies including, but not limited to, Ref. No. 1200, Treatment Protocols, et al., and Ref. No. 1300, Medical Control Guidelines, et al.

3. Ensure that EMS personnel have education and knowledge of local EMS agency policies, procedures, and protocols.

4. Complete an EMS patient care record approved by the EMS Agency as defined in Ref. No. 606, Documentation of Prehospital Care.

III. Retrospective Medical Management

A. The Medical Director of the EMS Agency shall:

1. Maintain a systemwide quality improvement program that addresses system issues and develops standards for prehospital care.

2. Ensure that written records of prehospital care are reviewed on an ongoing basis.

3. Ensure that mechanisms are in place to provide organized evaluation of and continuing education for EMS personnel, including evaluation of skills programs.

4. Maintain a system-wide prehospital care database and make relevant data available to system participants.

B. Base hospitals shall:

1. Maintain a quality improvement program approved by the EMS Agency.

2. Participate in the EMS Agency's quality improvement program to include making available relevant records for program monitoring and evaluation. A mechanism shall be in place for provider agencies to obtain their respective audio communications for review and educational purposes as approved by each individual base hospital's Protected Health Information and Risk Management policies. It is recommended that an agreement for release and limited use of paramedic base hospital audio recordings be utilized for the release of such audio communications (see sample form Ref. No. 201.1). Patient confidentiality shall be maintained at all times.

3. Include in the hospital's quality improvement (QI) plan indicators that, at a minimum, include review of the following:

a. Base Hospital Report Forms

b. Paramedic base hospital audio communications between paramedics and base hospital physicians and MICNs

4. Collect Treatment Protocol data on runs when the base hospital is the receiving hospital, including ED diagnosis.

5. Provide a continuing education program for prehospital care personnel approved by the EMS Agency as defined in Ref. No. 1013, EMS Continuing Education (CE) Provider Approval and Program Requirements, which:

   a. Complements the continuing education program provided by the assigned provider agencies.

   b. Demonstrates a relationship between the base hospital's quality improvement program and the continuing education program offered.

6. Develop an internal system of documentation for audio communications and records reviewed, actions recommended and/or taken, and problem resolution.

7. Participate in the EMS Agency's countywide data collection program.

C. Provider Agencies shall:

1. Maintain a quality improvement program approved by the EMS Agency.

2. Participate in the EMS Agency's quality improvement program to include making available relevant records for program monitoring and evaluation. As part of the QI program, provider agencies may obtain copies of their respective audio paramedic communications from base hospitals for review and educational purposes provided that they have developed a written plan for security and confidentiality.

3. Include in the provider agency's QI plan, indicators that, at a minimum, include review of EMS patient care records that are:

   a. Completed by EMTs and/or paramedics on patients for whom either a paramedic unit was not dispatched, was canceled, or transport by ambulance did not occur.

   b. Completed by EMTs and/or paramedics on patients for whom no base contact was made, when indicated by provider impression, treatment protocol or medical control guideline, but the patient was transported by ambulance.

   c. Completed by EMTs and/or paramedics on patients for whom neither base hospital contact nor transport occurred when indicated by provider impression, treatment protocol or medical control guideline

4. Develop an internal system of documentation for EMS patient care records and records reviewed, actions recommended and/or taken and resolution of problems.

5. Participate in the EMS Agency's countywide data collection program as described in Ref. No. 606, Documentation of Prehospital Care, Ref. No. 607, Electronic Submission of Prehospital Data, and Ref. No. 608, Disposition of the Prehospital Care Patient Care Records.

6. Provider agencies that have a continuing education program approved by the EMS Agency shall:

   a. Ensure that it complement~~s~~ the CE program provided by the assigned base hospital(s).

   b. Demonstrate~~s~~ a relationship between the provider agency's quality improvement program and the continuing education offered.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 201.1, **Sample Agreement for Release and Limited Use of Paramedic Base Hospital Audio Recordings**
Ref. No. 214 **Base Hospital and Provider Agency Reporting Responsibilities**

Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 608, Retention and **Disposition of the Prehospital Care Patient Care Records**
Ref. No. 620, **EMS Quality Improvement Program (EQIP)**
Ref. No. 1013, **Prehospital Continuing Education (CE) Provider Approval and Program Requirements**
Ref. No. 1200, **Los Angeles County Treatment Protocols**, et al.
Ref. No. 1300, **Medical Control Guidelines**, et al.

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

REFERENCE NO 201, Medical Management of Prehospital Care

	Committee/Grou	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	12/08/21	12/08/21	No Comments
	Provider Agency Advisory Committee	12/15/21	12/15/21	No Comments
	Data Advisory Committee			
OTHER COMMITTEES / RESOURCES	Medical Council	12/7/2021	12/07/21	No Comments
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **SPECIALTY CARE TRANSPORT PROVIDER** REFERENCE NO. 414

PURPOSE: To define the criteria to be approved as a Registered Nurse/Respiratory Specialty Care Transport (SCT) Provider in Los Angeles County.

AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.52, 1797.178, 1798.170
Business and Professions Code, Section 3700-~~3706~~
Emergency Medical Treatment and Labor Act of 2006
Los Angeles County Code, Title 7. Chapter 7.16. Ambulances
Los Angeles County Code, Title 7 Chapter 7.08. Denial or Revocation Conditions

DEFINITIONS:

Advanced Life Support (ALS) Transport: A ground or air ambulance transport of a patient who requires or may require skills or treatment modalities that do not exceed the paramedic scope of practice. An ALS transport may be required for either a non-emergency or emergency transport.

Basic Life Support (BLS) Transport: A ground or air ambulance transport of a patient who requires skills or treatment modalities that do not exceed the Los Angeles County EMT scope of practice. A BLS transport may be sufficient to meet the needs of the patient requiring either non-emergency or emergency transport.

Registered Nurse-Staffed SCT (RN-SCT): A ground or air ambulance interfacility transport of a patient who may require skills or treatment modalities that exceed the paramedic scope of practice, but do not exceed the RN scope of practice. A nurse-staffed SCT may be required for either a non-emergency or emergency interfacility transport.

Respiratory Care Practitioner Staffed SCT (RCP-SCT): A ground or air ambulance interfacility transport of a patient who requires the skills or treatment modalities that exceed the Los Angeles County EMT scope of practice but does not exceed the RCP scope of practice. A RCP-staffed SCT may be required for either a non-emergency or emergency interfacility transport.

Specialty Care Transport (SCT): An interfacility transport of a critically injured or ill patient by a ground vehicle, including the provision of the medically necessary supplies and services, at a level of service beyond the scope of practice of the paramedic.

PRINCIPLES:

1. A private ambulance provider must be licensed by the County of Los Angeles as a basic life support (BLS) provider in order to be eligible for approval as a SCT provider.

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

2. A BLS private ambulance provider must be approved by the EMS Agency to employ registered nurses (RNs) and/or respiratory care practitioners (RCPs) to staff and provide interfacility SCTs.

3. Staffing a SCT vehicle/unit consists of a minimum of one RN and/or RCP and two EMTs. Physicians, RNs, RCPs, perfusionists, or other personnel may be added to the SCT team as needed.

4. RCPs may be utilized to perform duties commensurate with their scope of practice; however, additional transport personnel (EMTs, RNs, physicians, or paramedics) must accompany the RCP based on the level of acuity and anticipated patient care requirements.

5. This policy does not apply when RNs and/or RCPs employed by a healthcare facility are utilized by an ALS or BLS provider agency to provide interfacility patient transport (i.e., emergent situations, specialized transport teams, etc.).

6. Any violation of this policy or ordinance could result in a program request denial or the cancellation of a provider's SCT program.

POLICY:

I. Eligibility Requirements

A BLS ambulance provider licensed by Los Angeles County may be approved to utilize RNs and/or RCPs to provide interfacility transports if the eligibility requirements outlined in this policy are met.

A. Transport Medical Director

1. Provider shall have a medical director who is currently licensed as a physician in the State of California, qualified by training and/or experience, current practice in acute critical care medicine and board certified or eligible by the American Board of Emergency Medicine or in their corresponding specialty.

2. The Medical Director or designee of the EMS Agency must approve all Transport Medical Director Candidates.

3. The Transport Medical Director shall:

a. Sign and approve, in advance, all medical protocols and SCT policies and procedures.

b. Oversee the ongoing training of all SCT medical personnel.

c. Be familiar with the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements.

d. Attend the EMS Orientation Program within six months of employment as a Transport Medical Director.

e. Participate in the development, implementation, and ongoing evaluation of a quality improvement (QI) program.

f. Sign and submit Ref. No. 701.1, Provider Agency Drug Authorizing Physician Confirmation of Agreement to Purchase Drugs and Medical Supplies for the SCT provider.

g. Sign and submit Ref. No. 702.4, Provider Agency Medical Director Notification of Controlled Substance Program Implementation for the SCT provider (if applicable).

B. Transport Coordinator

1. RN Coordinator: Providers utilizing RNs to staff SCTs shall have a Coordinator who is currently licensed in the State of California as a RN, meets all minimum requirements of a transport RN, has a minimum of one year experience in ambulance transports, and current practice in emergency medicine, critical care nursing or specialty care transports (minimum of 96 working hours annually).

2. RCP Coordinator: Providers utilizing RCPs to staff SCTs shall have a RCP Coordinator who is currently licensed in the State of California as a RCP, meets all minimum requirements of a transport RCP, has a minimum of one year experience in ambulance transports, and current practice in acute respiratory care or specialty care transports (minimum of 96 working hours annually).

   The RN Coordinator may function as the RCP Coordinator; however, the RCP Coordinator may NOT function as the RN Coordinator.

3. The Transport Coordinator shall:

   a. Sign and approve, in advance, all policies and procedures to be followed for SCTs.

   b. Maintain documentation indicating that all SCT personnel have been oriented to the RN/RCP-staffed SCT program.

   c. Maintain documentation of all applicable licensure, certification and/or accreditation requirements for all SCT personnel.

   d. Be familiar with EMTALA and HIPAA.

   e. Ensure the development, implementation and ongoing evaluation of a QI program in collaboration with the Transport Medical Director.

   f. Attend the EMS Agency Orientation Program within six months of employment as Transport Coordinator.

   g. Perform annual skills competency evaluation of all medical personnel.

h. Submit a written and signed affirmation of adherence to all federal, state, and local rules, regulations and laws, including Los Angeles County prehospital care policies and procedures as outlined in Title 7, Chapter 7.16, Ambulances.

C. Transport Personnel

1. Two EMTs comprise the BLS interfacility transport team; additional personnel (physicians, RNs, and/or RCPs) shall be added to the BLS team based on the acuity and anticipated needs of the patient during transport.

   Staffing exceptions must be approved by the EMS Agency prior to utilization by the ambulance provider.

2. RNs, RCPs and EMTs shall:

   a. Be currently licensed or certified for unrestricted practice in California.

   b. Be currently certified by AHA or equivalent in healthcare provider level cardiopulmonary resuscitation (CPR).

   c. Successfully complete a RN/RCP Staffed Interfacility SCT Program Orientation sponsored by the provider agency and approved by the EMS Agency.

   d. Successfully complete an annual skills competency evaluation conducted by the provider agency and approved by the EMS Agency.

   e. Be familiar with EMTALA and HIPAA.

   f. Submit a written and signed affirmation of adherence to all federal, state, and local rules, regulations and laws, including Los Angeles County prehospital care policies and procedures as outlined in Title 7, Chapter 7.16, Ambulances.

3. In addition to the requirements listed in Section I. C. 2. all transport RNs shall:

   a. Have a minimum of two years nursing experience in a critical care area relevant to the type of SCT transports the RN will provide (pediatric vs. adults), within the previous ~~18~~ 24 months prior to employment as a transport nurse.

   b. Be currently certified in Advanced Cardiac Life Support (ACLS) and, if participating in pediatric transports, currently certified in Pediatric Advanced Life Support (PALS).

   c. For full-time transport nurses, complete a total of 30 continuing education (CE) contact hours approved by the California Board of Registered Nursing (BRN) annually, that are relevant to their

clinical setting and types of transports performed.

d. For part-time (working less than 32 hours per week as a transport RN), complete 96 hours of documented critical care experience per year or complete a total of 30 CE contact hours approved by the California BRN annually, that are relevant to their clinical setting and type of transports performed.

e. Recommendation: Certified Emergency Nurse (CEN), Critical Care Registered Nurse (CCRN), ~~and/or~~ Mobile Intensive Care Nurse (MICN), or Certified Flight Nurse (CFRN).

4. In addition to the requirements listed in Section I. C. 2., all transport RCPs shall:

a. Have a minimum of two years respiratory care experience in an acute care or respiratory care hospital, relevant to the type of SCT transports the RCP will provide (pediatric vs. adults), within 18 months prior to employment as a transport RCP or have successfully passed the Adult Critical Care Specialty (ACCS) Examination, and are in good standing with the National Board for Respiratory Care (NBRC).

b. Be current in ACLS and, if participating in pediatric transports, be current in PALS.

c. For full-time transport RCPs, complete 30 CE contact hours approved by the Respiratory Care Board of California annually, that are relevant to their clinical setting and type of transports performed.

d. For part time transport RCPs (working less than 32 hours per week as a transport RCP), complete 96 hours of documented critical care experience per year or complete a total of 30 CE contact hours approved by the Respiratory Care Board of California annually, that are relevant to their clinical setting and type of transports performed.

D. Subcontracting SCT Services

1. If the licensed BLS provider intends to subcontract SCT services, the EMS Agency must be notified in advance for approval.

2. The subcontracting company must submit program information through the licensed BLS provider to the EMS Agency for approval prior to providing SCT services.

3. Subcontractors must meet the same standards/requirements as the ambulance provider, including insurance.

E. Insurance Requirements

1. It is the ambulance provider agency’s responsibility to ensure insurance

requirements are maintained as required by the Los Angeles County Code of Ordinance.

2. Minimum insurance levels must be maintained as outlined in Title 7, Chapter 7.16, Ambulances, with the exception of Professional Liability. Professional Liability limits must be maintained at $2,000,000 per claim and $3,000,000 per aggregate.

F. Policies and Procedures

Provider shall have a policy and procedure manual that includes, at a minimum, the following:

1. A description of the interfacility transport orientation program and process utilized to verify skill competency for registered nurses, EMTs, RCPs and, if applicable, other medical personnel.

2. Identify the Transport Medical Director, and RN and/or RCP Transport Coordinator. The EMS Agency shall be notified in writing of any changes in these key personnel utilizing Ref. No. 621.1, Notification of Personnel Changes.

3. Procedures for contacting the Transport Medical Director and SCT Coordinator if needed during a patient transport.

4. Interfacility transfer paperwork that complies with Title 22, Section 70749.

5. Record retention procedures which meets the requirements listed in Ref. No. 608, Retention and Disposition of Prehospital Patient Care Records.

6. The sending physician’s Statement of Responsibility for the patient during transfer in accordance with EMTALA.

7. Procedures to be followed for changes in destination due to unforeseen changes in the patient’s condition or other unexpected circumstances.

8. Current patient care protocols which have been approved by the Transport Medical Director.

9. A controlled drug policy which meets the requirements of Ref. No. 701, Supply and Resupply of Designated EMS Units/Vehicles and if applicable, Ref. No. 702, Controlled Drugs Carried on ALS Units.

G. Quality Improvement (QI) Program

1. The Provider Agency shall have a QI Program that meets the standards outlined in Ref. No. 618, EMS Quality Improvement Program Committees, and Ref. No. 620, EMS Quality Improvement Program.

2. Records of QI activities shall be maintained by the provider and available for review by the EMS Agency.

H. Required Equipment

1. Each transport vehicle shall include as minimum standard inventory all items required by Ref. No. 710, Basic Life Support Ambulance Equipment.

2. RN staffed SCT vehicles shall also be equipped with the standardized inventory specified in Ref. No. 712, Nurse Staffed Critical Care Inventory.

3. RCP staffed SCT vehicles shall also be equipped with the standardized inventory specified in Ref. No. 713, Respiratory Care Practitioner Staffed Critical Care Inventory.

4. In addition, each transport vehicle shall have equipment and supplies commensurate with the scope of practice of any additional transport medical personnel (e.g. balloon pump technicians, neonatal intensive care unit transport teams, etc.) staffing the SCT unit. This requirement may be fulfilled through the utilization of appropriate kits (cases/packs), which must be removed if the vehicle is being utilized for BLS transport purposes.

5. Biomedical equipment used for patient care must show evidence of ongoing maintenance and safety certification (e.g., service agreements, calibration logs, etc.).

6. If a dedicated ambulance (unit) is not being utilized strictly for SCT transports, and the provider is utilizing “jump bags” or its equivalent to store medical equipment and medication for the unit, the “jump bag” or its equivalent must be numbered/assigned a unique identifier. Additionally, that numbering must be marked on the individual bag(s).

7. Provider agencies may request to place additional SCT units (or jump bags) into service and shall notify the EMS Agency for inventory inspection and approval. Requests and inventory inspections shall be done prior to deployment.

II. Application Process and Program Review

Request for approval of a SCT program must be made in writing to the Director of the Los Angeles County EMS Agency and shall include the following:

A. Specify the type of SCT services the provider will supply (RN-SCT, RCP-SCT or both).

B. Proposed identification and location of the SCT units.

C. Procedures and protocols as outlined in Section I. F.

D. Documentation of qualifications of the proposed Transport Medical Director (resumé/curriculum vitae, copy of medical license and applicable board certification).

E. Documentation of qualifications of the proposed SCT Coordinator(s) (resumé(s)

or curriculum vitae, copy of current license(s) and certifications).

F. Copy of the current QI Plan (include specific indicators which will be utilized to monitor the SCT program) as outlined in Section I. G.

G. Statement acknowledging agreement to comply with all policies and procedures of the EMS Agency, including immediate notification in writing of a change in Transport Medical Director, or SCT Coordinator (Ref. No. 621.1).

H. The documents needed for approval of a SCT program are due to the EMS Agency as a **complete** packet within 30 (thirty) days of receipt of letter from the EMS Agency acknowledging the request for approval. If a complete packet (application) is not received within a 30 (thirty) day period, the request will be denied. A subsequent request for approval will not be accepted for 90 (ninety) days. This will result in the providers' inability to provide SCT services until approved by the EMS Agency.

III. Program Review

A. The EMS Agency shall perform periodic on-site audits of transport records, QI processes, equipment/vehicle inspections, and personnel qualifications to ensure compliance with this policy.

B. Non-compliance with this policy may lead to the EMS Agency suspending or revoking approval of the SCT program.

C. SCT programs that do not operate for a period of 6 consecutive months or greater, may result in program suspension or termination.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 414.~~4~~1 **Verification of Employment Letter**
Ref. No. 421 **Private Ambulance Operator Medical Director**
Ref. No. 517, **Provider Agency Transport/Response Guidelines**
Ref. No. 608, **Retention and Disposition of Prehospital Patient Care Records**
Ref. No. 618, **EMS Quality Improvement Program Committees**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 701, **Supply and Resupply of Designated EMS 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 Unit Inventory**
Ref. No. 713, **Respiratory Care Practitioner (RCP) Critical Care Unit Inventory**
Ref. No. 802, **Emergency Medical Technician (EMT) Scope of Practice**
Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**

Business and Professions Code:
California Nursing Practice Act, Section 2725
California Respiratory Care Practice Act, Sections 3700 ~~et al~~-3700
Centers for Medicare & Medicaid Services, Department of Health and Human Services
Title 22, California Code of Regulations Division 5, Section 70749

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

REFERENCE NO 414, Specialty Care Transport Provider

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	12/08/21	12/08/21	No Comments
	Provider Agency Advisory Committee	12/15/21	12/15/21	No Comments
	Data Advisory Committee			
OTHER COMMITTEES / RESOURCES	Medical Council	12/7/2021	12/07/21	No Comments
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **PREHOSPITAL EMS AIRCRAFT OPERATIONS** REFERENCE NO. 419

PURPOSE: To establish minimum standards for EMS aircraft operations in the County of Los Angeles.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 8, Section 100276-100306. Los Angeles County, Code of Ordinances, Title 7, Business Licenses, Division 2, Chapter 7.16 Ambulances.

DEFINITIONS:

Advanced Life Support (ALS): Definitive prehospital emergency medical care approved by the local EMS Agency, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital or Ref. No. 1200, Treatment Protocols, et al., during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the staff of that hospital.

Basic Life Support (BLS): Those procedures and skills contained in the EMT-I scope of practice, including emergency first aid and cardiopulmonary resuscitation.

Classifying and Authorizing EMS Agency: The Los Angeles County EMS Agency, which classifies EMS Aircraft into categories and approves utilization of such aircraft within its jurisdiction.

Continuation of 9-1-1 Call: In urban or other areas where helicopter landings may be unsafe, a hospital's State approved and licensed heliport or designated landing site is utilized for transfer of the patient from the ground crew to the medical flight crew for continuation of the 9-1-1 call.

Designated Dispatch Center: An agency which has been designated by the local EMS Agency for the purpose of coordinating air ambulance or rescue aircraft response to the scene of a medical or traumatic emergency within the jurisdiction of the local EMS Agency.

Emergency Medical Services (EMS) Aircraft: Any aircraft utilized for the purpose of prehospital emergency patient response and transport. EMS aircraft includes air ambulances and all categories of rescue aircraft.

Medical Flight Crew: The individual(s), excluding the pilot, specifically assigned to care for the patient during aircraft transport

Primary Provider Agency: The provider agency authorized to provide 9-1-1 emergency medical services within a city or unincorporated area of Los Angeles County by the governmental authority responsible for that geographic area.

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

PRINCIPLES:

1. The Los Angeles County EMS Agency is responsible for the integration of EMS aircraft into the Los Angeles County EMS patient transport system and for the development of policies and procedures related to the integration of this specialized resource. EMS aircraft operating in Los Angeles County must be classified and authorized by the EMS Agency in order to provide prehospital patient transport.

2. EMS aircraft providers (excluding agencies of the federal government) who provide or make available prehospital air transport or medical personnel, either directly or indirectly, or any hospital where an EMS aircraft is based, housed, or stationed permanently or temporarily, shall adhere to all federal, state, and local statutes, ordinances, policies, and procedures related to EMS aircraft operations, including qualifications of flight crews and aircraft maintenance.

3. Availability and appropriateness of EMS aircraft transport shall be determined by the primary EMS provider agency on scene. This will be based on the patient's status, ground ambulance response time, and proximity to a receiving facility staffed and equipped to meet the needs of the patient(s), i.e., trauma centers, pediatric trauma center, etc. versus the most accessible receiving facility (MAR).

4. If base hospital contact is established and directing the patient's care, the base hospital shall be the medical authority in determining patient destination and treatment in accordance with all applicable prehospital care policies.

5. No EMS aircraft shall respond to an incident without formal dispatch from a designated dispatch center or request from the primary provider agency responsible for the area in which the incident has occurred.

6. The primary provider agency requesting EMS aircraft response shall assume medical management responsibility at the scene and shall be responsible for proper protection of the emergency landing site during its use in the event that a licensed heliport is not available. This shall include, but not be limited to, fire protection, rescue services, exclusion of extraneous individuals, control of duties performed in the immediate vicinity of the aircraft (special attention will be paid to the main rotor, the tail rotor, and the effects of rotor downwash), and patient protection during landing.

7. The authority for safety of the EMS aircraft and persons associated with the EMS aircraft shall rest with the Pilot In Command (PIC). This shall include the supervision of those persons directly involved in loading/unloading patients and/or supplies.

POLICY:

I. Dispatch Criteria

Availability and appropriateness of EMS aircraft transport shall be determined by the primary provider agency on scene with regard to, but not limited to, the following:

A. The determination of ground versus air transport should be based on the time of day, incident location, weather conditions, traffic obstructions, etc.

B. An EMS aircraft should be considered for dispatch to an incident any time ground response will result in an extended estimated time of arrival, and/or incident

location is inaccessible by ground ambulance.

C. If aeromedical transport is indicated and the requested/most accessible EMS aircraft is unavailable or has declined the request due to conditions not conducive to air transport, the next most accessible EMS aircraft provider should be requested, until all resources have been exhausted. If a request for services is refused by a particular provider (e.g. weather), the reason for the flight refusal will be conveyed to any subsequent recipient of the request for service.

D. Patients meeting trauma center criteria should be transported by EMS aircraft when a trauma center cannot be accessed by ground within 30 minutes (Ref. No. 506, Trauma Triage).

E. For patients requiring ALS level care whose condition is deteriorating and transport to a 9-1-1 receiving facility is extended, transport by EMS aircraft may be considered.

F. The designated dispatch center or primary provider agency requesting/dispatching EMS aircraft responses shall notify the following facilities/agencies as early as possible, and prior to patient/EMS aircraft arrival. Examples of these facilities/agencies include, but are not limited to the following:

1. Local fire department

2. Local law enforcement for scene jurisdiction

3. Base hospital, if applicable, in accordance with established policies and procedures.

4. Receiving hospital (when possible, the receiving hospital should be notified by both the EMS Aircraft and the base hospital handling the call).

5. Medical Alert Center

G. Dispatch of EMS aircraft may not be appropriate under certain circumstances and patients may require transport to the most accessible 9-1-1 receiving facility (MAR) staffed and equipped to handle the patient in compliance with State and local EMS policies and procedures.

1. The patient has an uncontrollable life-threatening situation (e.g., obstructed airway).

2. There are conditions not conducive to air transport such as inadequate landing site, poor weather, etc.

3. Air transport is not immediately available when the patient is ready for transport and the risks of delaying transport outweigh the risks of transporting by ground.

II. Cancelation

A. When an EMS aircraft response has been requested, the decision to cancel the EMS aircraft may be made by one or more of the following, as appropriate for the

incident:

1. Primary provider EMS personnel
2. Incident commander
3. PIC of the EMS aircraft
4. Requesting personnel and/or organization
5. Base Hospital Physician

B. The designated dispatch center or primary provider agency managing the requests for an EMS aircraft shall notify all affected parties of the cancelation of an EMS aircraft.

III. Patient Destination/Landing Sites

A. The base hospital directing the patient's care shall determine patient destination in accordance with the applicable patient destination policies, provided the receiving facility has a State approved and licensed heliport or designated landing site. Hospital diversion status is also a consideration in determining patient destination. The base hospital shall contact the receiving facility and relay all pertinent information concerning the patient's condition.

B. If base hospital contact cannot be established or maintained, the decision for patient destination shall be made by the highest medical authority on scene. Hospital diversion status may be obtained from the Medical Alert Center (MAC) or via the ReddiNet system. Pertinent patient information and ETA should be relayed directly to the receiving hospital, through the MAC or the designated dispatch center.

C. All applicable destination policies will be followed for patients treated under Ref. No. 1200, Treatment Protocols, et al. Hospital diversion status and availability of a State approved, and licensed heliport or designated landing site are factors that need to be considered. Paramedics shall contact the receiving facility directly and relay all required information concerning the patient's condition. If the aircraft is unable to communicate with the receiving facility (terrain related), all efforts should be made to communicate with the receiving facility via the base hospital, dispatch center, or the MAC.

D. All patient destinations, with respect to safety factors, shall be approved by the PIC.

E. In all situations where temporary emergency landing sites are used, the PIC of each EMS aircraft will exercise primary authority and responsibility for the safe operation of the aircraft. If a hospital with a State approved and licensed heliport or designated landing site is in proximity to an incident requiring EMS aircraft transport, such heliport or landing site may be utilized for continuation of the 9-1-1 call and is not in violation of the Emergency Medical Treatment and Active Labor Act (EMTALA).

F. When pediatric and adult trauma patients are transported together in one aircraft, the receiving trauma center shall also be a pediatric trauma center.

IV. Communication/Record Keeping

A. EMS aircraft shall have the capability of communicating with each of the following:

1. Designated dispatch center
2. EMS ground units at scene of an emergency
3. Designated base hospitals
4. Receiving hospitals
5. Other appropriate facilities or agencies
6. Required FAA facilities

B. Whenever possible, direct communication should be established.

C. All EMS aircraft shall utilize appropriate radio frequencies for dispatch, routing and coordination of flights. This excludes use of Med 1-8 and Hospital Emergency Administrative Radio (V MED 28) for these purposes.

D. Each EMS aircraft shall establish base hospital contact with their assigned base hospital or the appropriate area base hospital pursuant to Ref. No. 1200, Treatment Protocols, et al., unless the call is a prearranged, specialty center, interfacility transfer.

E. When receiving a patient(s) from ground units, the medical flight crew shall ensure that, if applicable, base hospital contact has been made and/or continued. Such contact shall not unnecessarily delay patient transport.

F. In the event voice communication cannot be established or maintained with the base hospital, paramedics shall utilize Ref. No. 1200, Treatment Protocols, et al.

G. All applicable prehospital care policies and procedures related to record keeping shall apply to EMS aircraft operations. The EMS Record should be available to the receiving facility at transfer of care, or as soon as feasible.

V. Medical Control

A. All EMS policies and procedures for medical control and patient destination shall apply to the medical flight crew.

B. In situations where the medical flight crew is less medically qualified than the ground personnel from whom they receive patients, the medical flight crew may assume patient care responsibility only in accordance with policies and procedures established by the EMS Agency.

C. Medical flight crewmembers who have an expanded scope of practice (Physicians/RNs) beyond Ref. No. 803, Paramedic Scope of Practice, may only utilize specific treatments/procedures for which they are licensed, trained and qualified. In such cases, notification to the receiving facility shall be made and base hospital medical direction is not required.

D. If a physician is aboard an EMS aircraft, under no circumstances will the presence of said physician endorse the violation of recognized limits of scope of practice of any EMT-I, paramedic, or RN aboard the aircraft.

VI. Quality Improvement

A. The EMS Agency, base hospitals, trauma centers, and provider agencies shall conduct regular review of all trauma related EMS aircraft responses.

B. Documentation on the Patient Care Report and Base Hospital Form should include an explanation for the use of an air ambulance (i.e., mountain rescue).

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 511, **Perinatal Patient Destination**
Ref. No. 512, **Burn Patient Destination**
Ref. No. 516 Cardiac Arrest Patient Destination
Ref. No. 518, **Decompression Emergencies/Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 520, **Transport of Patients from Catalina Island**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 802, **Emergency Medical Technician Scope of Practice**
Ref. No. 803, **Paramedic Scope of Practice**
Ref. No. 1200, **Treatment Protocols**, et al.

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

REFERENCE NO 419, Prehospital EMS Aircraft Operations

	Committee/Grou	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	12/08/21	12/08/21	No Comments
	Provider Agency Advisory Committee	12/15/21	12/15/21	No Comments
	Data Advisory Committee			
OTHER COMMITTEES / RESOURCES	Medical Council	12/7/2021	12/07/21	No Comments
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

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

Reference No. 419 Prehospital EMS Aircraft Operations

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy 1. E	MAC/ December 7, 2021	Change language to read the following “For patients requiring ALS level care whose condition is deteriorating and transport to a 9-1-1 receiving facilities extended, transport by EMS aircraft may be considered”	adopted
Policy IV-G	BHAC/December 8, 2021	Add the following language “the EMS record should be available to the receiving facility at transfer of care, or as soonest feasible”	adopted

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

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

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

DEFINITIONS:

Advanced Life Support Patient (ALS): A patient who requires paramedic assessment and/or intervention listed in Ref. No. 803, Los Angeles County Paramedic Scope of Practice, this includes but not limited to patients meeting Base contact criteria outline in Ref. No. 1200, Treatment Protocols, et al.

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

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

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

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

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

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

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

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

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

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

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

PRINCIPLES:

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

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

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

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

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

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

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

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

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

POLICY:

I. Responsibilities Prior to reaching Hospital Diversion Threshold

A. ED Charge Nurse

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

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

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

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

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

B. Hospital Administration (CEO or administrative designee)

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

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

3. Assesses the ED for special considerations.

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

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

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

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

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

9. Monitors hospital diversion hours.

10. Includes diversion in the ED performance improvement process.

II. ED ALS Diversion

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

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

request policy that is consistent with the following guidelines:

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

    a. Units waiting to offload

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

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

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

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

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

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

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

3. The Medical Alert Center shall:

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

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

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

4. Hospital Administration (CEO or administrative designee)

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

    b. Monitors diversion hours

    c. Includes diversion in the ED performance improvement process.

C. ED BLS Diversion

1. A hospital or an EMS provider agency may request to place a hospital on ED BLS diversion by contacting the Medical Alert Center. ED BLS

diversion requests will be considered for approval when the BLS Diversion Threshold is met and status of system resources.

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

III. Diversion Audits

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

IV. APOT

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

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

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

D. Upon arrival, EMS personnel will initially present to the customary ambulance receiving area for a triage assessment by assigned ED staff (e.g., charge nurse). If the APOT estimate is ≥ 30 minutes, and the patient meets **ALL** criteria listed below, EMS personnel will inform the appropriate ED staff (e.g., charge nurse) that the patient will be offloaded in the waiting room. EMS personnel shall provide a transfer of care report to the appropriate ED staff (e.g., triage nurse).

1. Age 18 years or older; or pediatric patients if accompanied by an adult

2. Normal mental status (GCS 15)

3. Normal vital signs per Ref. No. 1380 for adults
   - SBP ≥ 90mmHg
   - HR 60-100
   - RR 12-20
   - O2 Saturation ≥94% on room air
   - Or per Ref. No. 1309 for pediatrics

4. Ambulatory with steady gait without assistance (as appropriate for age)

5. Not suicidal or not on psychiatric hold (5150)

6. No chest pain, syncope, or acute neurologic symptoms (e.g., focal weakness, dizziness/vertigo)

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**
Ref. No. 503.2, **Diversion Request Quick Reference Guide**
Ref. No. 802, **Emergency Medical Technician (EMT) Scope of Practice**
Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**
Ref. No. 1309, **Color Code Drug Doses**
Ref. No. 1380, **Vital Signs**

California EMSA: Ambulance Patient Offload Time (APOT) Standardized Methods for Data Collection and Reporting

Reference No. 503.1, Diversion Request Requirements for Emergency Department Saturation

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSC Advisory Committees	Provider Agency Advisory Committee	12/15/21	12/15/21	Y
	Base Hospital Advisory Committee	12/08/21	12/08/21	Y
	Data Advisory Committee			
Other Committees / Resources	Medical Council	11/30/21	11/30/21	
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Pediatric Advisory Committee	11/31/21	11/30/21	
	County Counsel			
	Other:			

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

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

REFERENCE NO. 503.1, Diversion Request Requirements for ED Saturation

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy IV.D.	BHAC 12/8/21	Replace draft language "If the APOT estimate is ≥ 30 minutes, and the patient meets **ALL** criteria listed below, EMS personnel will transport the patient to the waiting room to offload. EMS personnel will initially present to ambulance triage to determine APOT. EMS personnel shall notify the triage nurse of the patient's arrival and provide a transfer of care report." with "Upon arrival, EMS personnel will initially present to the customary ambulance receiving area for a triage assessment by assigned ED staff (e.g., charge nurse). If the APOT estimate is ≥ 30 minutes, and the patient meets **ALL** criteria listed below, EMS personnel will inform the appropriate ED staff (e.g., charge nurse) that the patient will be offloaded in the waiting room. EMS personnel shall provide a transfer of care report to the appropriate ED staff (e.g., triage nurse)."	Adopted
Policy IV.D.6.	PAAC 12/15/21	Delete "No chest pain, syncope, or acute neurologic symptoms (e.g., focal weakness, dizziness/vertigo)" Committee Vote: Nays = 5 Yeas = 5 Abstain = 2	Not adopted

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/PARAMEDIC)

SUBJECT: **EMERGENCY MEDICAL TECHNICIAN (EMT) SCOPE OF PRACTICE**

REFERENCE NO. 802

PURPOSE: To define the scope of practice for an Emergency Medical Technician (EMT) in Los Angeles County.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 2, Section 100063

DEFINITIONS:

Approved EMS Provider: A jurisdictional 9-1-1 fire department or an ambulance operator currently licensed in Los Angeles County.

PRINCIPLES:

1. In order to function as an EMT in Los Angeles County, an individual must be certified/licensed in the State of California as an EMT, Advanced EMT (AEMT), or Paramedic.

2. EMS personnel are responsible to adhere to the scope of practice while functioning as an EMT in Los Angeles County.

3. When EMT personnel arrive prior to an advanced life support (ALS) unit, they shall assess the patient and make appropriate care and transport decisions as per Ref. No.1200.1, Treatment Protocols General Instructions and Ref. No. 502, Patient Destination.

4. When EMTs assist patients with a physician prescribed medication or administer approved medications, as listed in Section III of this policy, an ALS unit must be en route or the patient must be transported to the most accessible receiving facility that meets the needs of the patient, if the ALS unit estimated time of arrival (ETA) exceeds the ETA to the MAR. The rationale for the decision to transport shall be documented on the EMS patient care record.

5. EMT personnel may immediately transport hypotensive patients with life-threatening, penetrating injuries to the torso to the closest trauma center, not the most accessible receiving (MAR), when the transport time is less than the estimated time of ALS arrival. The transporting unit should make every effort to contact the receiving trauma center.

6. If EMT personnel encounter a life-threatening situation (unmanageable airway or uncontrollable hemorrhage), they should exercise their clinical judgment as to whether it is in the patient's best interest to transport the patient prior to the arrival of an ALS unit if their estimated time of arrival (ETA) exceeds the ETA to the MAR. The rationale for the decision to transport shall be documented on an EMS patient care record.

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

7. EMT personnel may honor a patient request for transport to a facility other than the MAR if the patient is deemed stable and only requires basic life support (BLS).

8. EMTs may transfer care of a patient to another EMT team if necessary.

POLICY:

I. Basic Scope of Practice

During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer, a certified EMT or a supervised EMT student is authorized to do any of the following:

A. Patient Assessment

1. Evaluate the ill or injured patient

2. Obtain diagnostic signs to include, but not limited to:

a. respiratory rate
b. pulse rate
c. skin signs
d. blood pressure
e. level of consciousness
f. pupil status
g. pain
h. pulse oximetry (if available)

B. Rescue and Emergency Medical Care

1. Provide basic emergency care

2. Perform cardiopulmonary resuscitation (CPR)

3. Utilize mechanical adjuncts for basic cardiopulmonary resuscitation ***(Requires EMS Agency approval – Approved EMS Providers)***

4. Use a public access Automated External Defibrillator (AED) ***(Carrying an AED requires EMS Agency approval as an AED Service Provider)***

5. Administer oral glucose or sugar for suspected hypoglycemia

6. Apply mechanical restraints per Ref. No. 838, Application of Patient Restraints

7. Use various types of stretchers

8. Perform field triage

9. Extricate entrapped persons

10. Set up for ALS procedures under paramedic direction

C. Airway Management and Oxygen Administration

1. Use the following airway adjuncts:

   a. oropharyngeal airway
   b. nasopharyngeal airway
   c. suction devices

2. Administer oxygen using delivery devices per Ref. No. 1304, MCG Airway Management and Monitoring, including, but not limited to:

   a. nasal cannula
   b. mask – nonrebreather, partial rebreather, simple
   c. blow-by
   d. humidifier

3. Use manual and mechanical ventilating devices:

   a. bag-mask ventilation (BMV) device
   b. continuous positive airway pressure (CPAP)
      (Requires EMS Agency approval – Approved EMS Providers)

4. Ventilate advanced airway adjuncts via bag-device:

   a. endotracheal tube
   b. perilaryngeal airway device (King LTS-D)
   c. tracheostomy tube or stoma

5. Suction airway including:

   a. oropharynx
   b. nasopharynx
   c. tracheostomy tube or stoma

D. Trauma Care

1. Provide initial prehospital emergency trauma care including, but not limited to:

   a. tourniquets for bleeding control
   b. hemostatic dressings ***(State EMSA approved dressings only)***
   c. extremity splints
   d. traction splints

2. Use spinal motion restriction devices

E. Assist Patients with Prescribed Emergency Medications

Assist patients with the administration of their physician-prescribed emergency devices and medications, provided the indications are met and there are no contraindications, to include but not limited to:

1. Sublingual nitroglycerin
2. Aspirin
3. Bronchodilator inhaler or nebulizer
4. Epinephrine device (autoinjector)
5. Patient-operated medication pump

II. Patient Transport and Monitoring by an Approved EMS Provider

A. Transport and monitor patients in the prehospital setting and/or during an interfacility transfer by an approved EMS Provider

B. Transport patients with one or more of the following medical devices:

1. nasogastric (NG) tube
2. orogastric (OG) tube
3. gastrostomy tube (GT)
4. saline/heparin lock
5. foley catheter
6. tracheostomy tube
7. ventricular assist device (VAD)
8. surgical drain(s)
9. medication patches
10. indwelling vascular lines

a. pre-existing vascular access device (PVAD)
b. peripherally inserted central catheter (PICC)
c. patient-operated medication pump

C. Monitor, maintain at a preset rate, or turn off if necessary, the following intravenous (IV) fluids:

1. glucose solutions
2. isotonic balanced salt solutions (normal saline)
3. ringer’s lactate

III. Local Additional Scope of Practice Requiring Approval by the Los Angeles County EMS Agency:

Approved EMS Providers may apply for approval authorization to train EMT personnel to administer and add to vehicle inventory the following therapies:

A. Naloxone (including distribution of Leave Behind Naloxone per MCG 1337)

B. Epinephrine autoinjector

C. Aspirin

D. Finger stick blood glucose testing

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 412, **EMT AED Service Provider Program Requirements**
Ref. No. 502, **Patient Destination**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 517, **Private Provider Agency Transport/Response Guidelines**
Ref. No. 517.1, **Guidelines for Determining Interfacility Level of Transport**
Ref. No. 802.1, **Los Angeles County EMT Scope of Practice – Field Reference**
Ref. No. 838, **Application of Patient Restraints**
Ref. No. 1302, **Medical Control Guideline: Airway Management and Monitoring**
Ref. No. 1337, **Naloxone Distribution by EMS Providers (Leave Behind Naloxone)**

Los Angeles County Code, Title 7, Business Licenses, Chapter 7.16, Ambulances

Reference No. 802, EMT Scope of Practice

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSC Advisory Committees	Provider Agency Advisory Committee	12/15/21	12/15/21	
	Base Hospital Advisory Committee	12/08/21	12/08/21	
	Data Advisory Committee			
Other Committees / Resources	Medical Council	11/30/21	11/30/21	
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Pediatric Advisory Committee	11/31/21	11/30/21	
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICE
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN, HOSPITAL)

SUBJECT: **MEDICAL CONTROL DURING HAZARDOUS MATERIAL EXPOSURE**

REFERENCE NO. 807

PURPOSE: To safely manage medical emergencies at a hazardous materials incident while preventing exposure to responders, minimizing exposure to victims through effective decontamination, and preventing or minimizing secondary contamination of transporting vehicles and receiving facilities.

AUTHORITY: Health and Safety Code 1798 (a)

DEFINITIONS:

Decontamination: The process of removing, neutralizing or reducing contamination from personnel or equipment, preventing or minimizing the spread of contamination by persons and equipment.

Hazardous Materials (HazMat) Response Team: An organized team of trained personnel who respond to a hazardous materials incident for the purpose of control and stabilization of the incident. This function is performed by the public fire service within Los Angeles County.

Health Hazmat Response Unit: A response unit within the County of Los Angeles Fire Department responsible for public health issues related to hazardous materials releases. The cities of Pasadena, Vernon, and Long Beach respond their own Health Hazmat Response Unit within their respective jurisdictions.

Medical Alert Center (MAC): Assists the provider agencies and base hospitals with patient destination decisions with multiple casualty incidents. It serves as the control point for VMED28 and ReddiNet® systems.

Medical Communications Coordinator (Med Com): Establishes communications with the MAC or designated base hospital to obtain status of available hospital beds. The Med Com assigns appropriate patient destinations based on available resources. This position receives basic patient information and condition from Treatment Dispatch Manager and provides the MAC or base hospital with information on the assigned patient destinations and transporting ambulance unit.

Poison Control Center: A facility designated by the Emergency Medical Services Authority that provides information and advice to the public and health professionals regarding the management of patients who have or may have ingested, inhaled or otherwise been exposed to poisonous or possibly toxic substances.

Radiation Management Program: This is a County-wide program (Department of Public Health – Environment Health) responsible for protecting the public from unnecessary

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

radiation exposure. With the County, Radiation Management works under contract with the California Department of Public Health to provide the delivery of these services.

VMED28 Radio: The VMED28 frequency is the primary method of communications with paramedic providers to coordinate patient destination activities with the Medical Alert Center (MAC). The VMED28 also serves as a back-up communication system for intra-hospital communication and between hospitals and the MAC.

PRINCIPLES:

1. Donning appropriate personal protective equipment (PPE) protects prehospital responders from significant toxic exposure.

2. Accurate information obtained by prehospital personnel about the health effects of the hazardous material ensures appropriate prehospital evaluation and treatment for victims.

3. Decontamination prior to transport minimizes continued exposure of the victim and secondary contamination of health care personnel.

4. Prehospital care provided should be consistent with certification or licensure.

5. To the extent possible, unnecessary contamination of patient transport vehicles, equipment or receiving hospital facilities should be prevented.

6. Early notification of surrounding facilities will assist with efficient deployment of hospital decontamination team members.

7. Receiving hospitals should follow their established guidelines for handling victims of hazardous materials incidents.

POLICY:

I. Medical Control

   A. Medical control during a hazardous materials exposure incident shall be provided by a physician and/or mobile intensive care nurse (MICN) from a base hospital.

   B. Involved base hospital personnel may contact the MAC regarding bed availability, Regional Mobile Response Team activation, poison control information, or other needed medical control services.

II. Role of EMS personnel:

   A. Check in with the Incident Commander on scene and coordinate EMS activities with the personnel responsible for decontamination.

   B. Ensure that proper personal protective equipment is worn.

   C. Ensure that victims who may have a life threatening condition are treated as soon as possible.

1. If chemical, treat in conjunction with decontamination, if possible.

2. If radiation, do not delay treatment and transport to decontaminate.

D. Ensure that victims who do not have a life threatening condition but are contaminated by a hazardous substance are decontaminated before treatment.

E. Ensure that all victims with chemical contamination undergo decontamination procedures prior to transportation from the scene.

F. Ensure that patients who are not contaminated are treated consistent with current prehospital care policies and procedures.

III. Role of the Med Com:

Contact the MAC via VMED28 or landline at (562) 378-1789 or the assigned base hospital and provide the following information:

1. Incident location

2. Hazardous material involved (if known)

3. Number and severity of victims

4. Chief complaint of patients

5. Measures already implemented to limit exposure and decontaminate victims

6. Other information as noted in Ref. No. 519, Management of Multiple Casualty Incidents and Ref. No. 519.5, MCI Field Decontamination Guidelines, as appropriate (depending on the number of victims)

7. Patient destination when hospital/bed availability is known

IV. Role of the MAC/Base Hospital:

A. Contact the Poison Control Center at (800) 222-1222 (Chemical) or the Department of Public Health, Radiation Management Division (213) 974-1234 (Radiation) and provide them with a brief description of the incident and the hazardous materials involved and request treatment and decontamination information. In particular, determine if any special precautions must be taken to avoid contamination of health care workers, transport unit, hospital, other bystanders, etc.

B. Notify the Med Com of any precautions that should be taken at scene.

C. Identify and poll the appropriate Hospital Response Group(s) to determine bed availability (MAC function).

D. Provide hospital/bed availability of hospitals with decontamination teams to

the Med Com.

E. Notify receiving hospitals of incoming patients and inform them of any relevant treatment or precaution information that has been obtained from the Poison Control Center or other reliable source.

CROSS REFERENCES

Prehospital Care Manual:

Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 519.1, **MCI-Definitions**
Ref. No. 519.4, **MCI Field Decontamination Guidelines**
Ref. No. 805, **California Poison Control System**
Ref. No. 807.1, **Prehospital HazMat Incident Flowchart**
Ref. No. 817, **Regional Mobile Response Team**

Reference No. 807, Medical Control During Hazardous Material Exposure

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	12/15/21	12/15/21	N
	Base Hospital Advisory Committee	12/08/21	12/08/2021	N
	Data 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

(EMT/ PARAMEDIC/MICN)

SUBJECT: **DETERMINATION / PRONOUNCEMENT OF DEATH IN THE FIELD**

REFERENCE NO. 814

PURPOSE: This policy is intended to provide EMS personnel with parameters to determine whether or not to withhold resuscitative efforts in accordance with the patient's wishes, and to provide guidelines for base hospital physicians to discontinue resuscitative efforts and pronounce death.

AUTHORITY: California Health and Safety Code, Division 2.5
California Probate Code, Division 4.7
California Family Code, Section 297-297.5
California Health and Safety Code, Division 1, Part 1.8, Section 443 et seq.

DEFINITIONS:

Advance Health Care Directive (AHCD): A written document that allows patients who are unable to speak for themselves to provide health care instructions and/or appoint a Power-of-Attorney for Health Care. There is no one standard format for an AHCD. Examples of AHCDs include:

- Durable power of attorney for Healthcare (DPAHC)
- Healthcare proxies
- Living wills (valid in California if dated prior to 7-1-2000; advisory but not legally binding after that date)

Agent: An individual, eighteen years of age or older, designated in a durable power of attorney for health care to make health care decisions for the patient, also known as "attorney-in-fact".

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

Conservator: Court-appointed authority to make health care decisions for a patient.

Determination of Death: To conclude that a patient has died by conducting an assessment to confirm the absence of respiratory, cardiac, and neurologic function.

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

Immediate Family: The spouse, domestic partner, parent, adult children, adult sibling(s), or family member intimately involved in the care of the patient.

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

Organized ECG Activity: A sinus, atrial or junctional (supraventricular) rhythm.

Pronouncement of Death: A formal declaration by a base hospital physician that life has ceased.

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

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

PRINCIPLES:

1. Resuscitative efforts are of no benefit to patients whose physical condition precludes any possibility of successful resuscitation.

2. EMTs and paramedics may **determine** death based on specific criteria set forth in this policy.

3. Base hospital physicians may **pronounce** death based on information provided by the paramedics in the field and guidelines set forth in this policy.

4. If there is any objection or disagreement by family members or EMS personnel regarding terminating or withholding resuscitation, basic life support (BLS) resuscitation, including defibrillation, may continue or begin immediately and paramedics should contact the base hospital for further directions.

5. Aggressive resuscitation in the field to obtain the return of spontaneous circulation (ROSC) is encouraged. Transporting patients without ROSC is discouraged.

6. EMS personnel should honor valid do-not-resuscitate (DNR) orders and other patient designated end-of-life directives in the field and act in accordance with the patient's wishes when death appears imminent.

POLICY:

I. EMS personnel may determine death in the following circumstances:

   A. In addition to the absence of respiration, cardiac activity, and neurologic reflexes, one or more of the following physical or circumstantial conditions exist:

      1. Decapitation

      2. Massive crush injury

      3. Penetrating or blunt injury with evisceration of the heart, lung or brain

4. Decomposition

5. Incineration

6. Pulseless, non-breathing victims with extrication time greater than fifteen minutes, where no resuscitative measures can be performed prior to extrication.

7. Penetrating trauma patients who, based on the paramedic's thorough assessment, are found apneic, pulseless, asystolic, and without pupillary reflexes upon the arrival of EMS personnel at the scene.

8. Blunt trauma patients who, based on a paramedic's thorough patient assessment, are found apneic, pulseless, and without organized ECG activity (sinus, atrial or junctional rhythm) due to traumatic mechanism upon the arrival of EMS personnel at the scene.

    a. For patients with shockable ventricular rhythm, defibrillate as per TP 1243/1243-P in attempt to restore organized ECG activity prior to determination of death.

9. Pulseless, non-breathing victims of a multiple victim incident where insufficient medical resources preclude initiating resuscitative measures.

10. Drowning victims, when it is reasonably determined that submersion has been greater than one hour.

11. Rigor mortis (requires assessment as described in Section I, B.)

12. Post-mortem lividity (requires assessment as described in Section I, B.)

B. If the initial assessment reveals rigor mortis and/or post-mortem lividity only, EMTs and/or paramedics shall perform the following assessments (may be performed concurrently) to confirm the absence of respiratory, cardiac, and neurologic function for determination of death in the field:

1. Assessment of respiratory status:

    a. Assure that the patient has an open airway.

    b. Look, listen and feel for respirations. Auscultate the lungs for a minimum of 30 seconds to confirm apnea.

2. Assessment of cardiac status:

    a. Auscultate the apical pulse for a minimum of 60 seconds to confirm the absence of heart sounds.

    b. Adults and children: Palpate the carotid pulse for a minimum of 60 seconds to confirm the absence of a pulse.

c. Infants: Palpate the brachial pulse for a minimum of 60 seconds to confirm the absence of a pulse.

3. Assessment of neurological reflexes:

a. Check for pupillary response with a penlight or flashlight to determine if pupils are fixed and dilated.

b. Check and confirm unresponsive to pain stimuli.

C. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I. A. require immediate BLS measures to be initiated. If one or more of the following conditions is met, resuscitation may be discontinued and the patient is determined to be dead:

1. A valid standardized patient-designated directive indicating DNR.

2. A valid AHCD with written DNR instructions or the agent identified in the AHCD requesting no resuscitation.

3. Immediate family member present at scene:

a. With a patient-designated directive on scene requesting no resuscitation

b. Without said documents at scene, with full agreement of immediate family requesting no resuscitation, and EMS providers concur

4. Parent or legal guardian is required and must be present at scene to withhold or terminate resuscitation for patients less than 18 years of age.

II. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I require immediate cardiopulmonary resuscitation in accordance with Ref. No. 1210, Treatment Protocol: Cardiac Arrest. Base contact for medical direction shall be established when indicated by Ref. No. 1210.

A. EMS Personnel may determine death if a patient is in **asystole** after 20 minutes of quality cardiopulmonary resuscitation on scene and meets ALL of the following criteria:

1. Patient 18 years or greater

2. Arrest not witnessed by EMS personnel

3. No shockable rhythm identified at any time during the resuscitation

4. No ROSC at any time during the resuscitation

5. No hypothermia

B. Base Physician consultation for pronouncement is not required if Section A is

met.

C. Base Physician contact shall be established to guide resuscitation and to make decisions regarding timing of transport, if transport is indicated, for all patients in cardiopulmonary arrest who do not meet the conditions described in Section I or IIA of this policy.

D. In the event that immediate family members on scene request termination of resuscitation after resuscitation is in progress, and the patient does not meet criteria in section IIA, base physician consultation shall be made for termination and pronouncement. This does not apply to brief initiation of CPR while establishing patient/family wishes as per I.C.3.

III. Physician guidelines for transport versus termination

A. Resuscitation should be continued on-scene until one of the following:

1. ROSC is confirmed with a palpable pulse and corresponding rise in $EtCO_2$ Paramedics should stabilize the patient on scene after ROSC (for approximately 5 minutes) per TP 1210 and initiate transport once ROSC is maintained.

2. Base physician determines further resuscitative efforts are futile

B. Patients who have NOT maintained ROSC after on-scene resuscitation and stabilization should NOT be transported unless the Base physician determines transport is indicated.

1. Early transport for patients with ongoing resuscitation is NOT advised.

2. The decision to transport a patient with refractory OHCA should be based on the availability of therapies at the receiving center that are not available on scene.

IV. Crime Scene Responsibility, Including Presumed Accidental Deaths and Suspected Suicides

A. Responsibility for medical management rests with the most medically qualified person on scene.

B. Authority for crime scene management shall be vested in law enforcement. To access the patient, it may be necessary to ask law enforcement officers for assistance to create a “safe path” that minimizes scene contamination.

C. If law enforcement is not on scene, EMS personnel should attempt to create a "safe path" and secure the scene until law enforcement arrives.

V. Procedures Following Pronouncement of Death

A. The deceased should not be moved without the coroner’s authorization. Any invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient

should be left in place.

NOTE: If it is necessary to move the deceased because the scene is unsafe, the body is creating a hazard, or the body is at risk of loss through fire or flood, the EMS personnel may relocate the deceased to a safer location, or transport to the most accessible receiving facility.

B. If law enforcement or the coroner confirms that the deceased will not be a coroner's case and the personal physician is going to sign the death certificate, any invasive equipment used during the resuscitation may be removed.

C. EMS personnel should remain on scene until law enforcement arrives. During this time, when appropriate, the provider should provide grief support to family members.

VI. Required Documentation for Patients Determined Dead/Pronounced in the Field

A. The time and criteria utilized to determine death; the condition, location and position of the body, and any care provided.

B. The location and the rationale if the deceased was moved. If the coroner authorized movement of the deceased, document the coroner's case number (if available) and the coroner's representative who authorized the movement.

C. Time of pronouncement and name of the pronouncing physician if base hospital contact was initiated

D. The name of the agent identified in the AHCD or patient-designated directive or the name of the immediate family member who made the decision to withhold or withdraw resuscitative measures. Obtain their signature on the EMS Report Form.

E. If the deceased is **not** a coroner's case and their personal physician is going to sign the death certificate:

1. Document the name of the coroner's representative who authorized release of the patient, and

2. The name of the patient's personal physician signing the death certificate, and

3. Any invasive equipment removed

VII. End of Life Option Act

A. Resuscitation shall be withheld on patients in cardiopulmonary arrest who have self-administered an aid-in-dying drug (see Ref. No. 815.4, End of Life Option Field Quick Reference Guide).

B. Document the presence of a Final Attestation and attach a copy if available.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 516, **Cardiac Arrest (Non-Traumatic) Patient Destination**
Ref. No. 518, **Decompression Emergencies/Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 815, **Honoring Prehospital Do Not Resuscitate Orders**
Ref. No. 815.1, **EMSA/CMA Prehospital Do Not Resuscitate (DNR) Form**
Ref. No. 815.2, **Physician Orders for Life-Sustaining Treatment (POLST) Form**
Ref. No. 815.3, **Sample - Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner**
Ref. No. 815.4, **End of Life Option Field Quick Reference Guide**
Ref. No. 819, **Organ Donor Identification**

Reference No. 814, Determination and Pronouncement of Death in the Field

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSC Advisory Committees	Provider Agency Advisory Committee	12/15/2021	12/15/2021	
	Base Hospital Advisory Committee	12/8/2021	12/8/2021	Y
	Data Advisory Committee			
Other Committees / Resources	Medical Council	11/30/2021	11/30/2021	
	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. 814, Determination/Pronouncement of Death in the Field

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definitions	BHAC 12/8/21	Add “sinus” before “atrial”	Adopted
Policy I.A.8.	BHAC 12/8/21	Add “sinus” before “atrial”	Adopted

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."

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.

EXECUTIVE OFFICE
BOARD OF SUPERVISORS
CELIA ZAVALA
EXECUTIVE OFFICER

COUNTY OF LOS ANGELES
EXECUTIVE OFFICE
BOARD OF SUPERVISORS

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

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:

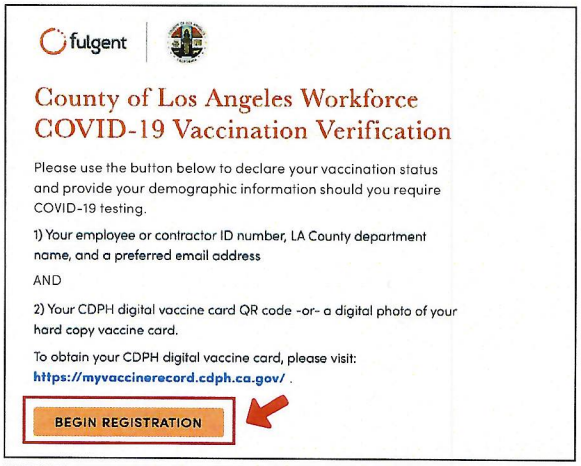
If you were vaccinated by DHS, your vaccination verification is complete. If you received your vaccination outside of DHS, you must submit a copy of your vaccination record to your local Employee Health Services.

DHS employees do not need to submit their vaccination records into the Fulgent database.

How to Register Online

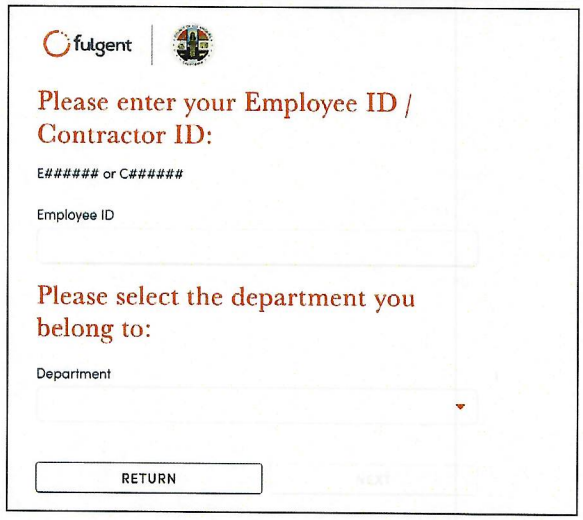
Verifying LAC employee status

1 **Visit lac.fulgentgenetics.com and** click the button "Begin Registration".

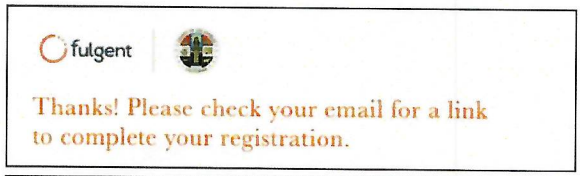


2 **Verify your information by entering the following:**

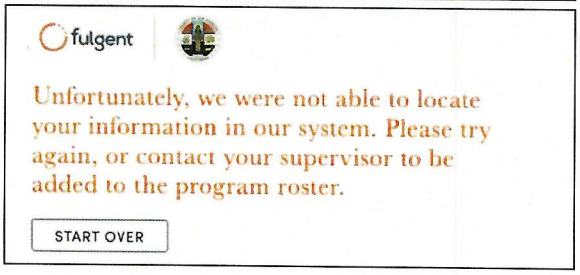
- Employee ID / Contractor ID
  E/C #: [format - E/C######]
- Department you belong to
  i.e., DHS, Fire Dept, DHR, etc.
- First Name
- Last Name
- Date of Birth
- Preferred Email Address



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.



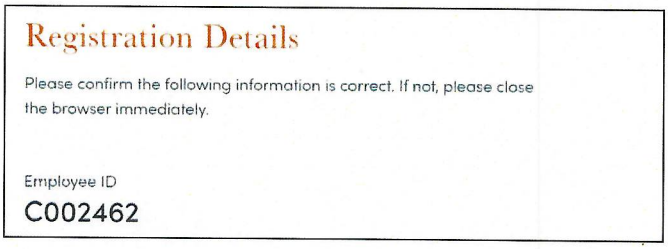
4978 Santa Anita Ave, Suite 205, Temple City, CA 91780 | www.FulgentGenetics.com | info@fulgentgenetics.com | P +1 626.350.0537 | F +1 626.454.1667
 D# GUIDE-LAC Workforce Covid-19 Vaccination Verification-2021-V1.1

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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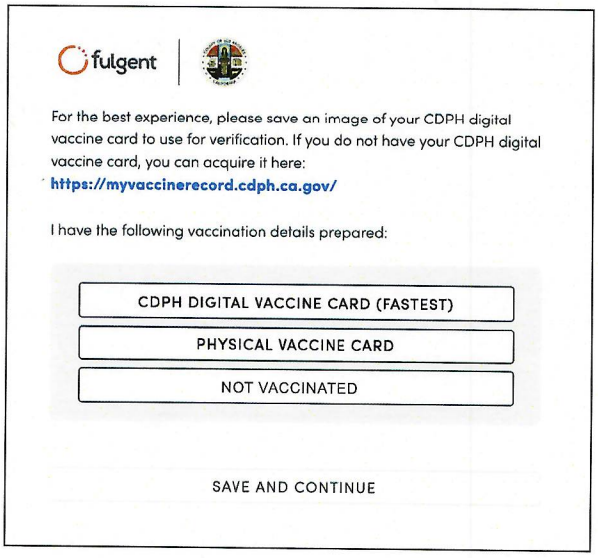
5 **Select one of the following, regarding your vaccination details:**

- **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.

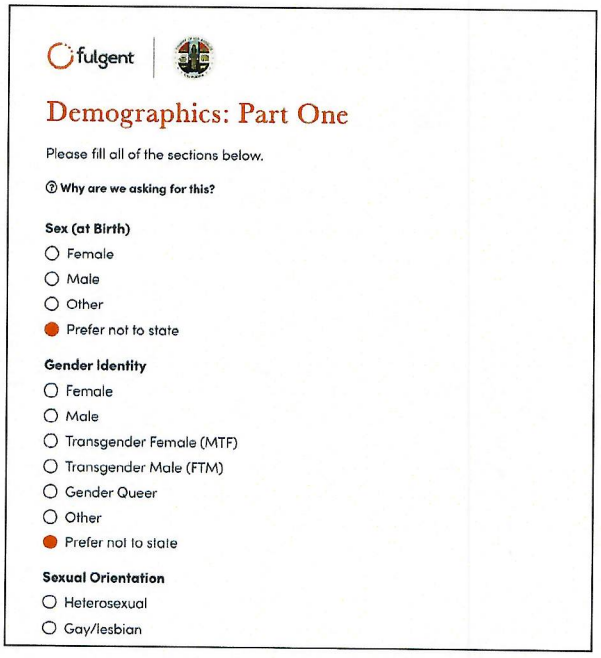
Until you are fully vaccinated, you may need to participate in regular COVID-19 testing

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

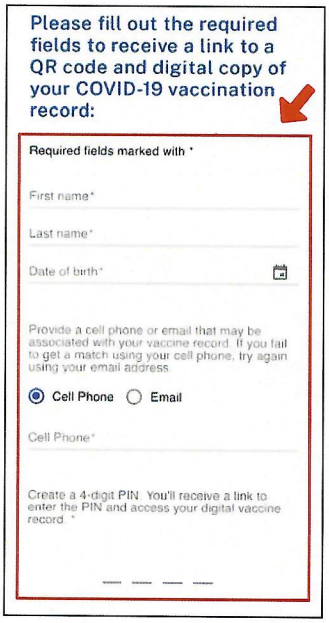
1 Visit the following website:
myvaccinerecord.cdph.ca.gov

2 Once loaded, proceed to enter the following information:

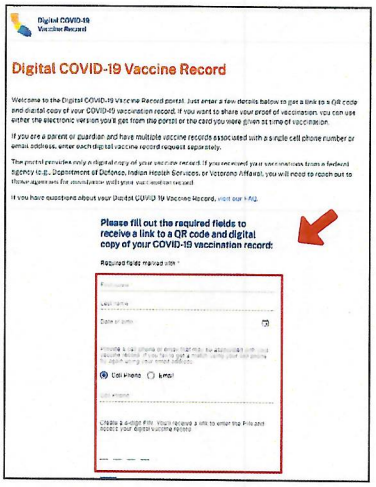
- Legal First Name
- Legal Last Name
- Date of Birth
- Receiving Preferences
- Personal 4-digit Pin Number

Please remember your 4-digit pin number

On Mobile



On Desktop



Next Steps

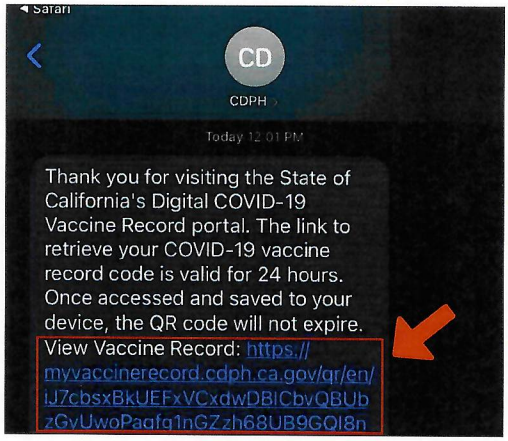
After submission, you'll receive either an email or a text message based your on preferences.

Text Message - Go to page 6

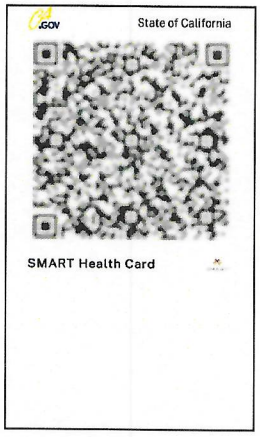
Email - Go to page 7

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

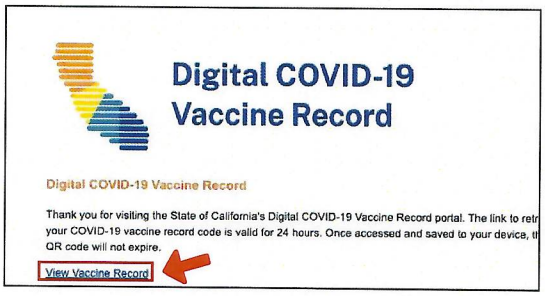
On Android

fulgent

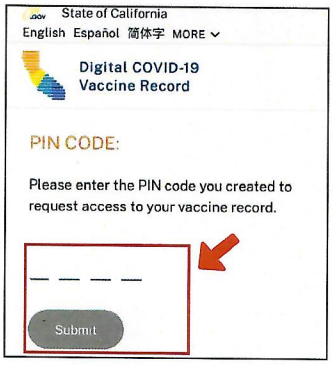
Retrieving your QR Code by Email

1 **Sign into your email account** using the same email address used during registration.

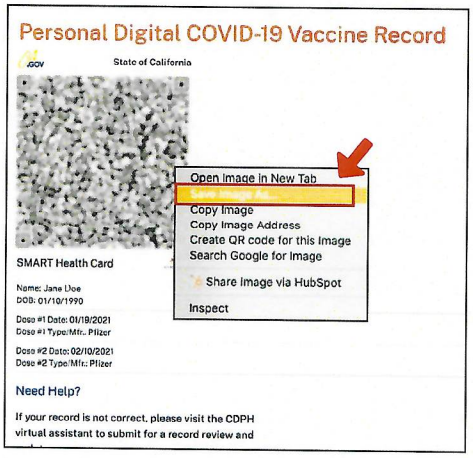
2 Find an email from the CA Department of Public Health with the subject line **"Digital COVID-19 Vaccine Record"**. Click on **"View Vaccine Record"**.



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

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

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First District

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Second District

Sheila Kuehl
Third District

Janice Hahn
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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."

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

November 15, 2021

VIA E-MAIL

TO: Distribution

FROM: Cathy Chidester
Director

SUBJECT: **EMERGENCY DEPARTMENT STATUS OF COMMUNITY HOSPITAL LONG BEACH**

Community Hospital Long Beach (LBC) located at 1720 Termino Avenue, Long Beach, will be closing its Emergency Department. **Effective Wednesday, November 17, 2021, at 8:00 a.m., ALL 9-1-1 transports to LBC's Emergency Department shall be discontinued.** The ReddiNet will display LBC as being on Internal Disaster.

Patients who would have been transported to LBC must be transported to surrounding approved 9-1-1 receiving hospitals as outlined in Reference No. 502, Patient Destination.

Thank you for your attention to this matter. If you have any questions, please call me or Christine Clare, Chief Hospital and Data Systems Programs (562) 378-1661 or cclare@dhs.lacounty.gov.

CC:cac
11-05

Distribution:
Medical Director, EMS Agency
Emergency Medical Services Commission
Hospital Licensing Unit, Health Facilities Division
Medical Alert Center
Hospital Association of Southern California
Fire Chief, Los Angeles County Fire Department
Paramedic Coordinator, Los Angeles County Fire Department
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Operations Manager, Care Ambulance Company
CEO and ED Director, Dignity Health – St. Mary Medical Center
CEO and ED Director, MemorialCare Long Beach Medical Center
CEO and ED Director, College Medical Center
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CEO and ED Director, Kaiser Foundation Hospital – South Bay
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Prehospital Care Coordinator, Dignity Health – St. Mary Medical Center
Prehospital Care Coordinator, MemorialCare Long Beach Medical Center

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."

January 3, 2022

TO: All EMS Personnel
All Provider Agencies
All Base Hospitals

FROM: Cathy Chidester
Director

SUBJECT: REVISED EMS PERSONNEL CERTIFICATION FEES

In compliance with County policy, a fee study was recently conducted which resulted in changes to certification fees charged by the EMS Agency. Effective March 1, 2022, fees for EMT and MICN certification/recertification and Paramedic accreditation will be revised as follows:

	Current Fees	Fees Effective March 1, 2022
EMT		
Certification	$160	$190
Recertification - *certification issued by LA County EMS current or lapse less than 12 mos*	$120	$149
Recertification - *certification issued by another CA entity current or lapse less than 12 mos*	$160	$190
Recertification - *lapse 12 mos to less than 24 mos*	$160	$190
MICN		
Certification	$175	$142
Recertification - *current or lapse less than 6 mos*	$ 50	$ 96
Recertification - *lapse 6 mos to less than 12 mos*	$200	$159
Recertification - *lapse 12 mos to less than 24 mos*	$300	$210
Challenge	$300	$210
Paramedic		
Accreditation	$150	$155
Reaccreditation - *lapse less than 6 mos*	$ 50	$100
Reaccreditation - *lapse 6 mos or more*	$150	$155
Duplicate Card	$ 12	$ 16

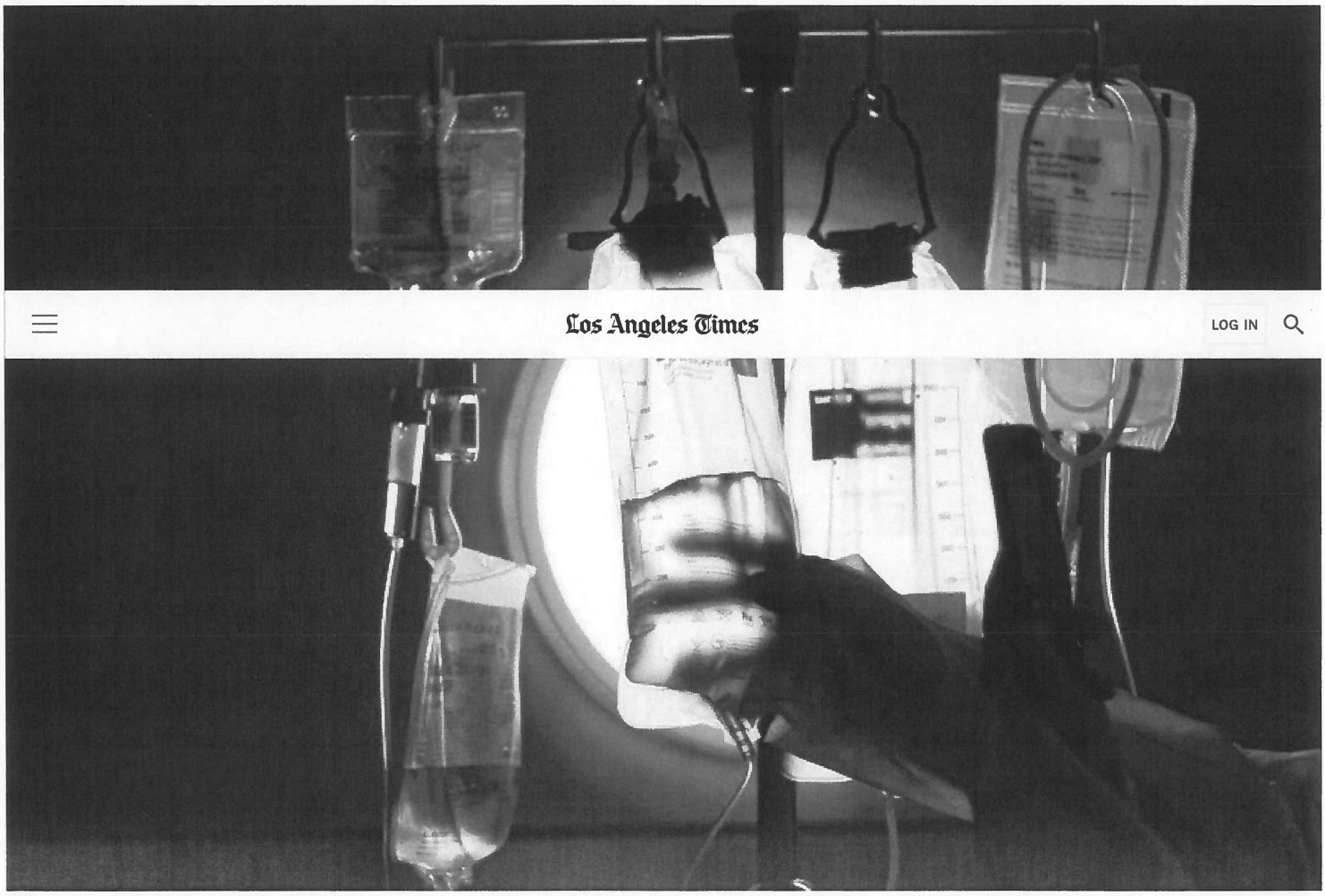
For any questions, please contact Nicholas Todd, EMS Personnel Manager, at (562) 378-1632 or at Ntodd@dhs.lacounty.gov .

CC:jr

c: Los Angeles County Emergency Medical Services Commission

CALIFORNIA

L.A. County sees delays in ambulance response to 911 calls as COVID-19 taxes hospitals



Angelenos are being asked to avoid the ER unless they have a true medical emergency. Meanwhile, hospitalizations of children with COVID-19 are rising. (Jae C. Hong / Associated Press)

BY RONG-GONG LIN II, LUKE MONEY, HOWARD BLUME, EMILY ALPERT REYES

JAN. 3, 2022 5:39 PM PT

Los Angeles County is beginning to see delays in ambulance response to 911 calls, as more employees are unable to work due to COVID-related illnesses and ambulances are forced to wait to offload patients at hospitals, health officials said Monday.

"People should reach out to their physicians for suggestions to treat mild COVID symptoms," the county Department of Health Services said in a statement to The Times. "Do not seek COVID testing at emergency departments but at established sites."

Meanwhile, hospitalizations of children with coronavirus infections in L.A. County have tripled in the last month.

There were 3.25 times as many children up to age 4 hospitalized on Christmas than on Dec. 4. Over the same period, hospitalizations of 12- to 17-year-olds were 3 times higher, while those of 5- to 11-year-olds were 1.5 times higher.

Studies have shown that the Omicron variant is less likely than Delta to infect the lungs, which in adults could reduce the possibility of pneumonia and breathing problems.

But Omicron owes its ultra-contagiousness to its prowess at infecting the upper respiratory system, and that could pose a problem for children, Dr. Scott Gottlieb, a former commissioner of the U.S. Food and Drug Administration, told CBS' "Face the Nation" on Sunday. Toddlers, he said, "have trouble with upper-airway infections. And you're in fact seeing more croup-like infections and bronchiolitis in New York City among children. So, that could be a challenge for young kids, and we are seeing rising hospitalizations among that pediatric segment.

"This has not been a benign disease in young children. There's a perception that young children haven't been hit hard to date from coronavirus. That's just not true. We've recorded more than 600 pediatric deaths from COVID over the last two years," Gottlieb said. To put that in perspective, he added, there have been only three pediatric flu deaths over the course of the pandemic.

"So this is affecting children, and particularly young children," he said. "And this new strain could have a predilection for the upper airway, which could be a bigger challenge in young kids because of the way that it binds to the airway cells."

To reduce coronavirus spread, health officials are urging L.A. County residents to use masks that are medical grade, such as surgical, or blue, masks or N95, KN95 or KF94s. Wearing an old, loose, cloth mask alone is less effective. Placing a cloth mask on top of a surgical one can be more effective than a surgical mask alone as it tightens the fit.

Officials on Monday urged people to avoid going to the emergency room unless they have a true medical emergency.

"While we continue to experience the surge in cases, [the Department of] Public Health is reminding residents to avoid visiting the emergency room unless they need emergency medical care. Residents should not be visiting the emergency department solely to get a COVID test or for minor complaints that could be resolved through their primary care physician," the county said in a statement.

"Emergency room visits should be reserved for those patients who are feeling severely ill — for example, those who are short of breath — or who have serious concerns about their health and who require immediate emergency care."

L.A. County reported 16,269 new coronavirus cases Monday, an artificially low tally due to delays in reporting over the New Year's weekend.

The county recorded 23,553 new cases Saturday and 21,200 more Sunday, far above last winter's peak average of 16,000 a day. Those weekend numbers are also likely to be undercounts due to the holiday.

About 22.5% — more than 1 in 5 — L.A. County residents getting tested over the past week were positive for the coronavirus. The transmission rate in Los Angeles County is now estimated to be greater than at any point since the early months of the pandemic, as cases explode across California. Every infected person in L.A. County is transmitting the virus to an average of two others, according to state estimates published Monday afternoon. During last winter's surge, the estimated transmission rate never exceeded 1.4, according to the county Department of Health Services.

L.A. school officials have ordered students and staff to undergo mandatory coronavirus testing before returning to campus Jan. 10 after winter break. Health officials urged that all staff and students be tested before or during the first few days of school.

Employees at all public and private schools in L.A. County will have to wear medical-grade masks at work, and students and staff must wear masks outdoors in crowded spaces, under tightened rules issued recently.

L.A. County Public Health Director Barbara Ferrer said in a statement that staff, teachers and students should get booster shots as soon as they are eligible. Boosters are available for those age 16 and older.

"An important protection from transmission of this airborne virus are well-fitting, higher-grade masks, and these should be worn by everyone at schools when indoors and in outdoor crowded spaces. And where possible, children and staff should have a negative COVID-19 test the first week they return to the classroom," Ferrer said.

The federal government has begun the process to make younger teenagers eligible for booster shots. The U.S. Food and Drug Administration on Monday authorized boosters for 12- to 15-year-olds, but the U.S. Centers for Disease Control and Prevention must make a recommendation before the shots are made available for that age group.

"The data shows there are no new safety concerns following a booster in this population," the FDA said in a statement. The agency said there were no new cases of myocarditis, an inflammation in the heart, reported.

The FDA also cut from six months to five months the authorized amount of time between the second dose of the Pfizer-BioNTech primary vaccination series and a booster shot, for anyone age 12 and older.

In addition, the agency authorized certain children age 5 to 11 with weakened immune systems to receive a third dose of a COVID-19 vaccine.

CALIFORNIA COVID-19 PANDEMIC

Rong-Gong Lin II

Twitter Instagram Email Facebook

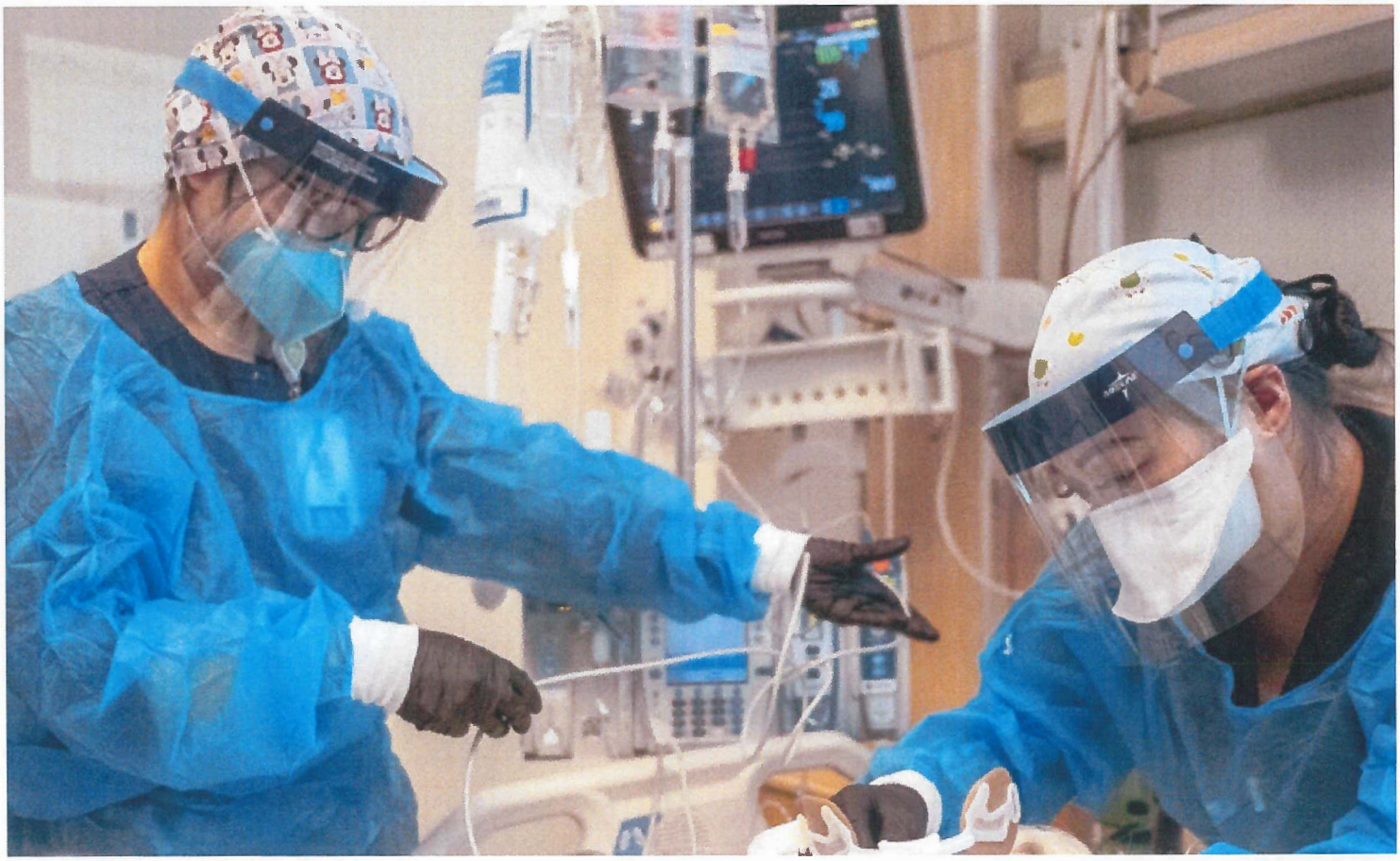
Rong-Gong Lin II is a metro reporter based in San Francisco who specializes in covering statewide earthquake safety issues and the COVID-19 pandemic. The Bay Area native is a graduate of UC Berkeley and started at the Los Angeles Times in 2004.

Luke Money

7.6 EMS DIRECTOR'S REPORTS

CALIFORNIA

Hospitals see big jumps in COVID-19 patients, but this surge is different from last winter



Registered nurse Akiko Gordon, left, and respiratory therapist Janssen Redondo tend to a COVID-19 patient inside the ICU at Martin Luther King Jr. Community Hospital in Los Angeles on Friday. (Francine Orr / Los Angeles Times)

BY LUKE MONEY, RONG-GONG LIN II, EMILY ALPERT REYES

JAN. 4, 2022 5 AM PT

The number of coronavirus-positive patients has spiked dramatically across Southern California since Christmas — but some health officials are noting important differences in how the latest surge is playing out in hospitals compared with last winter's devastating wave.

In Los Angeles, Orange and Ventura counties, the coronavirus-positive patient count has more than doubled in the last nine days. And in L.A. and San Bernardino counties, the daily hospital census has surpassed the peak seen during last summer's spike.

Some officials remain concerned that hospitals could still face challenges as the highly contagious Omicron variant infects people at what experts are calling an unprecedented rate. But there are signs that the crunch at a number of Southern California's hospitals may not be as severe as last year, before vaccines were widely available.

Roughly two-thirds of patients who have tested positive at hospitals run by the L.A. County Department of Health Services were admitted for something other than the coronavirus, according to Health Services Director Dr. Christina Ghaly.

That is starkly different from what the county's public hospitals saw in earlier surges, when most coronavirus-positive patients were hospitalized because they had been sickened by the virus, Ghaly said.

This time around, many "may have not known they were COVID-positive ... but they're in the hospital for something else," Ghaly said.

CALIFORNIA

L.A. Unified orders COVID testing before school resumes amid high Omicron anxiety

Jan. 3, 2022

"The difference we are seeing this year is largely due to the fact that we have a higher number of individuals who have been vaccinated and boosted," department officials wrote in a statement to The Times. "With the Omicron variant being highly transmissible, we can't emphasize enough the importance of having everyone get vaccinated and boosted as soon as they are eligible."

It's unclear whether this same trend is playing out statewide. The California Department of Public Health did not immediately respond Monday when asked how many coronavirus-positive patients have been hospitalized directly because of COVID-19 compared with those found to have an ancillary infection upon admission.

But if the current trend holds, Southern California may avoid some of the worse-case hospitalization scenarios envisioned weeks ago.

Dr. Robert Wachter, chair of the UC San Francisco Department of Medicine, held out cautious hope that a surge in coronavirus patients at his institution's hospitals were stabilizing.

"Still too soon to be sure and, to me, an argument to be more careful, but it's hopeful," Wachter wrote on Twitter.

"Omicron," he added, "may be hitting a big immunity wall" in San Francisco.

That's not to say there aren't risks to health and public safety due to soaring coronavirus infections, however.

In L.A. County, officials said they've "begun to see delays in ambulance response to 911 calls due to several factors, including a decrease in staff that are unable to report to work due to COVID-related illness and ambulances experiencing extended waiting times to offload patients at hospitals."

According to the L.A. County Department of Health Services: "People should reach out to their physicians for suggestions to treat mild COVID symptoms. Do not seek COVID testing at emergency departments but at established sites. We urge all L.A. County residents to do their part in helping stop the spread of COVID-19 during this latest surge."

CALIFORNIA

L.A. County coronavirus transmission rate at highest point since early months of pandemic

Jan. 3, 2022

On Sunday, 1,994 coronavirus-positive patients were hospitalized in L.A. County — up 121% from the tally seen on Christmas Day.

L.A. County surpassed its summertim

However, the number of seriously ill patients remains well shy of last summer. On Sunday, 278 COVID-19 patients were in intensive care units countywide — about 40% below the August peak.

The latest totals also are a far cry from last winter, when more than 8,000 COVID-19 patients were hospitalized countywide on the worst days, and ICUs were at times inundated with more than 1,700.

Southern California has the worst per capita COVID-19 hospitalization rate in the state. Regionwide, for every 100,000 residents, 21 people are hospitalized with a coronavirus infection. Experts have said it's a concern when that rate is 5 or worse.

The comparable rates are 17 in the Greater Sacramento area, 15 in the San Joaquin Valley, and 10 in the San Francisco Bay Area and rural Northern California.

Within Southern California, the Inland Empire has the worst rates, with San Bernardino County's at 31 and Riverside County's at 25. L.A. and San Diego counties have a rate of 20; Ventura County, 18; and Orange County, 17.

Like L.A., San Bernardino County has already surpassed its summertime hospitalization peak. As of Sunday, there were 655 people with coronavirus infections in its hospitals, 113% of the summer peak of 580 hospitalizations.

San Diego and Ventura counties have reached 98% of the number of coronavirus-positive patients seen at the peak of their summer surges. Orange County, at 92%, and Riverside County, at 88%, are approaching theirs as well.

Roughly 87% of current hospitalized patients are unvaccinated in Orange County, figures show.

CALIFORNIA

What should I do if I test positive for the coronavirus?

Jan. 2, 2022

Given the high level of local transmission, Ventura County officials announced the region would close its buildings to the public as a precaution for three weeks starting Wednesday. Services will still be offered online and by appointment.

"More people are infectious and spreading the virus indoors," Ventura Public Health Officer Dr. Robert Levin said in a statement. "Taking these steps — limiting close contacts, wearing a mask indoors to prevent getting infected and infecting others, isolating when symptomatic, testing and getting vaccinated — can reduce the likelihood of severe COVID affecting you, your family and community."

Starting Monday, Newport Beach alsc

CALIFORNIA

How safe are indoor gyms during Omicron surge? What experts say

Jan. 3, 2022

Though the statewide patient count remains below the height of last summer's surge, it too is swelling rapidly. There were 6,789 coronavirus-positive patients hospitalized throughout California on Sunday, an 81% increase since Christmas.

Health officials have long cautioned that even if Omicron infections are milder than Delta ones, significant spikes will invariably fuel a rise in COVID-19 hospitalizations.

How severe that proves to be, however, remains to be seen. So far, COVID-19 hospitalizations have not risen as fast as coronavirus cases — perhaps a result of Omicron's lower severity, on average, to many people.

It's also possible that vaccinations can partly explain why there's a lower rate of hospitalization. L.A. County Public Health Director Barbara Ferrer last month estimated that while 15% to 20% of coronavirus cases required hospitalization during the surges of 2020 and last winter, only 5% to 6% of cases required hospitalization during the summer Delta surge, which "really reflects the power of those vaccines."

It's too soon to say what that percentage will be for the current surge.

"Because some people may not be hospitalized right away after testing positive for COVID-19, increases in hospitalizations generally lag behind increases in cases. As a result, it is too soon to say whether there will be a change in the percentage of cases hospitalized associated with the recent increase in cases," the state Department of Public Health said in a statement.

CALIFORNIA

Younger adults driving coronavirus surge in Southern California

Jan. 1, 2022

Still, the number of coronavirus cases has raised alarms.

L.A. County recorded 23,553 new cases Saturday and 21,200 more Sunday, far above last winter's peak average of 16,000 cases a day. And officials said those numbers are likely undercounts because of lags in weekend reporting.

According to estimates from California's COVID-19 computer models published Monday morning, every infected person in L.A. County is on average tr the

"We hope that by working together to implement essential public health safety measures, we can stay safe, protect those we love and keep our schools and businesses open," Ferrer said in a statement Sunday. "During this surge, given the spread of a more infectious strain of the virus, lapses can lead to explosive transmission."

CALIFORNIA

L.A. COVID-19 cases skyrocket to 27,000 as health officials plead: 'Act responsibly'

Dec. 31, 2021

Officials said the latest spike in cases can be attributed both to the Omicron variant, which is estimated to be two to four times as transmissible as Delta, and increased travel and large gatherings over the recent holiday season.

The ultra-contagious nature of Omicron, officials say, heightens the urgency for residents to take steps to protect themselves. Those include wearing masks while in indoor public settings, avoiding crowded situations and — most importantly — getting vaccinated and boosted when eligible.

To date, about 75% of all Californians have received at least one COVID-19 vaccine dose, and 67.5% are considered fully vaccinated. However, that still leaves millions who have yet to roll up their sleeves, including all children under the age of 5, who are not yet eligible.

"We all need to do our part to really protect 2022; it's already not looking so great for the first couple of months," said Dr. Regina Chinsio-Kwong, an Orange County deputy health officer. "But the reassuring part of all this is we have known, basic preventive measures that we can take for ourselves and our families."

CALIFORNIA | COVID-19 PANDEMIC | COVID-19 VACCINES

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."

January 6, 2022

TO: See Distribution

FROM: Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

SUBJECT: REISSUANCE OF AUGUST 2021 GUIDANCE FOR EMERGENCY MEDICAL SERVICES PERSONNEL ENTERING HEALTHCARE FACILITIES

In light of the more transmissible Omicron variant and issues that have arisen with application of this guidance, the Emergency Medical Services (EMS) Agency is reissuing the August 2021 guidance that was developed in collaboration with the Hospital Association of Southern California (HASC), the EMS Agency, first responders and hospital representatives. The guidance standardized acceptable practices when first responders enter healthcare facilities in order to avoid confusion and unnecessary requirements, which may impede and negatively impact the provision of emergency medical care to patients.

The following principles were established and are still applicable:

- Law enforcement, fire, and EMS personnel, when on duty, are considered first responders and or pre-hospital care workers.
- First responders are not classified as "visitors" when accessing hospitals/healthcare facilities for patient care and transport (see CDPH All Facilities Letter (AFL) 21-31 and Frequently Asked Questions issued August 20, 2021).
- Hospital/Skilled Nursing Facility/Clinic staff are not responsible for verifying vaccination status and/or COVID-19 test results of first responders/EMS personnel who enter the facility. Therefore, first responders should not be detained to inquire about vaccination status nor required to be tested when arriving at a healthcare facility to provide emergency medical services including transportation.
- Employers of first responders are responsible for supplying its employees with surgical or N-95 masks.

- Law enforcement agencies are responsible to instruct and educate their officers that a surgical mask is necessary and a best practice for health hygiene to prevent exposure to any infectious diseases when they are in a hospital/healthcare facility and require them to comply with wearing a mask when inside a healthcare facility.

- Law enforcement officers cannot force a detainee to wear a 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 mandates, as applicable.

Effective immediately, all first responders must wear, at minimum, a surgical mask upon entering a hospital or healthcare facility. The surgical masks must be worn at all times while in the facility. N-95 masks 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, should be referred directly to their employer, as soon as possible, by the healthcare 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 me at kfruhwirth@dhs.lacounty.gov if you have any questions.

Distribution:
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Administrator, Each Skilled Nursing Facility
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