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

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Mr. Gary Washburn
Public Member (5th District)

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COMMISSION LIAISON
Denise Watson
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DATE: **March 16, 2022**
TIME: **1:00 – 3:00 PM**
LOCATION: **Zoom Video Conference Meeting**
Join Zoom Meeting:
https://us06web.zoom.us/j/85816449796?pwd=OVNCZEdPUkM0blhhckJzTkMxUnFwUT09
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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 Dr. Lydia Lam

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

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

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

1. **MINUTES**
   January 19, 2022

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

3. **POLICIES**
   - 3.1 Reference No. 205: Innovation, Technology, and Advancement Committee (ITAC)
   - 3.2 Reference No. 703: ALS Unit Inventory
   - 3.3 Reference No. 703.1: Private Provider Non 9-1-1 ALS Unit Inventory
   - 3.4 Reference No. 704: Assessment Unit Inventory
   - 3.5 Reference No. 706: ALS EMS Aircraft Inventory
   - 3.6 Reference No. 713: Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory
   - 3.7 Reference No. 719: Fireline Emergency Technician-Paramedic (FEMP) Inventory
   - 3.8 Reference No. 836: Communicable Disease Exposure and Testing

END OF CONSENT AGENDA

IV. BUSINESS

BUSINESS (OLD)

- 4.1 Prehospital Care of Mental Health and Substance Abuse Emergencies
- 4.2 Ambulance Patient Offload Time (APOT)
- 4.3 LA County COVID-19 Update – EMS Agency

BUSINESS (NEW)

- 4.4 EMSC Workplan (Goals/Objectives) for Fiscal Year 2021-22 Annual Report
- 4.5 Bylaws Amendments
- 4.6 EMS Commission Representative for Measure B – (Vote Required)

V. LEGISLATION

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

CORRESPONDENCE

- 6.1 (01-04-2022) David Eisner, MD, Culver City Fire Department: Alternate Destination Pilot Program Approval
- 6.2 (01-26-2022) Distribution: Super Bowl LVI Experience and Game February 5 through February 13, 2022
- 6.3 (02-07-2022) Chief Executive Office: Measure B Advisory Board Recommendations for Spending Available Unallocated 2021 Measure B Funds

VII. COMMISSIONERS' COMMENTS / REQUESTS

VIII. ADJOURNMENT

To the meeting of May 18, 2022

LOS ANGELES COUNTY BOARD OF SUPERVISORS
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Atilla Uner, MD, MPH
California Chapter-American College of Emergency Physicians (CAL-ACEP)
Mr. Gary Washburn
Public Member (5th District)

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MINUTES
January 19, 2022
Zoom Meeting

☒ Captain Brian S. Bixler	Peace Officers' Assn. of LAC	Cathy Chidester	Executive Director
☒ Diego Caivano, M.D.	L.A. County Medical Assn.	Vanessa Gonzalez	EMS Staff
☒ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Marianne Gausche-Hill	EMS Medical Director
☒ Carl Povilaitis	LAC Police Chiefs' Assn.	Richard Tadeo	EMS Asst. Director
☒ John Hisserich, Dr.PH	Public Member, 3rd District	Nichole Bosson	EMS Asst. Medical Director
☒ Lydia Lam, M.D.	So. CA Chapter American College of Surgeons	Sara Rasnake	EMS Staff
☒ James Lott, PsyD, MBA	Public Member, 2nd District	Laura Leyman	EMS Staff
☒ Carol Meyer, RN	Public Member, 4th District	Christine Clare	EMS Staff
☐ Gloria Molleda Ab	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.	Gary Watson	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. Ab	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	Kelsey Wilhelm	EMS Staff
	CAL-ACEP	John Telmos	EMS Staff
☒ Gary Washburn	Public Member, 5th District	Gary Watson	EMS Staff

GUESTS

Samantha Gates - Long Beach Memorial	Jenn Nulty – Torrance Fire Department	Shelly Trites - Torrance Memorial	Clayton Kazan – Los Angeles County Fire Department
Mark Gamble - Hospital Association of Southern California	Brit Alton – Burbank Fire Department	David Molyneux - Westcoast Ambulance	Andrew Reno – Long Beach Fire Department

(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 1:02 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 Cathy Chidester, in relation to her upcoming retirement, with a scroll from the LA County Board of Supervisors to honor and celebrate her work in emergency medical services, as well as her service on the EMSC.

III. NOMINATION COMMITTEE

3.1 Nomination of Chair and Vice Chair (Vote Required)

The Nomination Committee members were Commissioners Robert Ower, John Hisserich, Carol Snyder and Commission Liaison Denise Watson. Commissioner Ower reported that the nominees for the 2022 EMS Commission Chairman were Dr. Lydia Lam, Joseph Salas and Dr. Diego Caivano. Nominees for Vice-Chair were Chief Kenneth Powell and Dr. Diego Caivano. The floor was opened for additional nominations and discussion.

Commissioner Joseph Salas withdrew his name from the Commission Chairman nomination.

Motion/Second by Commissioners Meyer/Salas to elect Dr. Lydia Lam as Chairman.

Motion/Second by Commissioners Snyder/Salas to elect Dr. Diego Caivano as Chairman.

Dr. Lydia Lam (12): Bixler, Cheung, Hisserich, Lam, Lott, Meyer, Ower, Povilaitis, Powell, Rodriguez, Rollman, Uner

Dr. Diego Caivano (2): Caivano, Snyder

Abstain (1): Salas

Absent During Vote (2): Olney, Washburn

Dr. Lydia Lam was appointed the 2022 EMS Commission Chairman.

Motion/Second by Commissioners Lott/Hisserich to elect Commissioner Kenneth Powell as Vice-Chair

Motion/Second by Commissioners Meyer/Snyder to elect Commissioner Dr. Diego Caivano as Vice-Chair.

Chief Kenneth Powell (3): Bixler, Povilaitis, Powell

Dr. Diego Caivano (11): Caivano, Cheung, Hisserich, Lam, Lott, Meyer, Ower, Rodriguez, Rollman, Snyder, Uner

Abstain (1): Salas

Dr. Diego Caivano was appointed as the 2022 Vice-Chair.

Commissioner Rodriguez passed the Chairmanship to newly elected Chairman Dr. Lydia Lam who proceeded with the meeting.

3.2 Standing Committee Assignments
Ms. Chidester went over the 2022 Standing Committee assignments. There is a rule within the ordinance that a person can serve as a chair on each committee for 2 years. All commissioners are welcome to attend any committee meeting. If a commissioner would like to be on the committee as a chair or vice-chair next year or if anyone has questions, they can contact Richard Tadeo, EMS Assistant Director. Commissioner Lott asked to be added to the distribution lists for future committee agendas and meeting minutes.

IV. CONSENT AGENDA

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

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

4.1 MINUTES

November 17, 2021, Minutes were approved.

4.2 COMMITTEE REPORTS

4.2.1 Base Hospital Advisory Committee
4.2.2 Data Advisory Committee
4.2.3 Provider Agency Advisory Committee

4.3 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
Dr. Gausche-Hill reported that we will be rolling out all our treatment protocols for behavioral psychiatric crisis and agitated delirium as well as the new Medical Control Guidelines for verbal de-escalation in September 2022 as EMS Update 2022, Part II. Dr. Cheung will be assisting with some of the educational components, and his assistance and expertise is appreciated as we move this program forward.

The State of California EMS authority approved Los Angeles County's request for the use of Olanzapine, and that will be added to our scope of practice. Olanzapine is an oral disintegrating tab that is used to help patients with agitation if they have not fully responded to verbal de-escalation and they are cooperative enough to take medication.

This will all be part of the training for EMS Update. EMS Update will start with igel which is a superglottic airway device. Train-the-trainer will begin in the summer with a rollout in September. Dr. Denise Whitfield reported Train-the-Trainer for the igel component will be held in April and we're looking to go live on July 1st. Train-the-Trainer for behavioral health will be late June and going live September 1st.

Commissioner Erick Cheung commented that this was a huge step forward but there is still additional work to be done. There is some outstanding follow-up related to dispatch criteria that will come along over time. The commission should not lose sight of the work that was done preliminarily on assessment in the field of suicide risk. We brought that into our scope of work the past year, but decided it was a bit too much to roll out at once. Commissioner Cheung thinks that this is a critical next element to work on related to training and education and to help our field providers feel more confident in being able to assess and determine who is really at risk for suicide. Dr. Gausche-Hill mentioned that a fire department had volunteered to possibly conduct a pilot study.

Director Chidester mentioned that the Department of Mental Health continues to work with their advisory committee on the 9-8-8 system. There has been very positive data and remarks from the Los Angeles City Police Department's dispatch in transferring calls to the suicide hotline. Commissioner Bixler, who worked with that program, said that last year there was 1,400 calls diverted. These calls were handled by Didi Hirsch and the national suicide hotline. Hoping to exceed those numbers as they get more chances to train.

5.2 Ambulance Patient Offload Time (APOT)

Richard Tadeo reported that EMS instituted a lot of Reference 855. Hospitals and EMS providers implement 855 by rapid triage. We also included BLS Diversion which has provided respite for our provider agencies. To ensure our 9-1-1 system is intact we held daily calls with our exclusive operating area ambulance companies and LA County Fire. There were discussions on their personnel, number of ambulances that should be within the region, and we assisted them with helping other providers to be their backup systems. We also elicited the assistance of our Health Facilities Inspection Division with CDPH to visit the hospitals that have problems with offload time delays. They identified staffing was limited because staff is getting sick and unable to return to work. Good news to report is that the state and federal government have been able to provide our hospitals with ambulance offload teams and augmented the staffing of transport providers as well. The department also utilized DHS EMT's from our ambulance section to help assist hospitals watch or monitor patients while they wait for beds in the hospital.

FirstWatch purchase order was issued on December 28, 2021, and we are moving forward with the installation which will take about eight weeks. We will have real time data related to ambulances that are waiting to be offloaded. Hopefully this will eliminate the multiple telephone calls to determine the status of hospitals in terms of APOT. This was funded through the COVID Relief Funds.

Director Chidester mentioned agenda item 7.5 which is the LA Times article regarding ambulance offload times. The last three weeks with the COVID surge we have had a

very challenging time in our system. Hospitals, fire departments and ambulance companies have had excessive sick calls with staff becoming COVID positive. It's been very challenging to maintain the 9-1-1 system. There have been daily calls with our ambulance companies and fire departments to try to find actions that mitigate the impact of these sick calls to help ensure the ambulances are able to respond into the 911 system. We have had some nonresponses; we've had bad outcomes and we've had some delays. We have had ambulance companies take cots into the hospitals so that they can leave the patient in the hospital and be able to go back into service. The good news is that speaking to ambulance companies daily has helped, and the number of sick calls within the ambulance companies is starting to decrease.

Commissioner Carole Snyder commented that the nurses the State has sent are at hospitals for a certain time and it would be interesting to see data on how it affects the offload time by having six nurses and six paramedics assigned to that hospital. Also, the MOUs for these additional staffing requires mandatory 20 hours of overtime per week. This is not sustainable for hospitals to maintain.

The State EMS Commission has a committee that they put together to discuss APOT delays and solutions. This committee has been put together to look at the long-time problem of APOT but doing it during the pandemic has exacerbated the problem.

Commissioner Atila Uner, who is on the committee, said they have met three times and it is still very preliminary. There are a lot of stake holders that have different ideas on what is the most important next step, but everyone does agree it is a problem. He will update the commission with any recommendations they come up with.

State Assemble Member Freddie Rodriguez held a hearing regarding APOT times, with representatives from the fire departments, ambulance companies, hospitals, and EMS agencies in attendance. There was discussion about legislation and short-term quick fixes, along with longer term legislative fixes. Mark Gamble, from the Hospital Association of Southern California, stated that it is headed towards legislation.

5.3 LA County COVID Update – EMS Agency

Dr. Gausche-Hill provided an update on COVID-19. We are showing signs that we are getting close to the peak for this surge. Over the last week we have averaged over 40,000 positive cases a day. The number of deaths has not peaked at this point, but it is nowhere near the range that we had in the previous surge, a year ago. Hospitalizations are continuing to go up and we are still on the rise as we go forward in the pandemic. At our peak in 2021, there were over 8,000 hospital inpatients with active COVID-19 infections. What we're seeing now is only about a third of people testing positive for COVID are being admitted for COVID-19. There is a bump in the ICU's COVID patients, but not an alarming amount. The daily tracking continues to go up, but not at the same slope. San Diego County is starting to see a decrease in the wastewater evidence of virus, which is also being reported in the Sacramento area.

Another marker for us is cardiac arrest. Each time we had a surge we had a similar increase in the number of cardiac arrests in LA County. In 2022, we are still seeing elevated cardiac arrests compared to what we saw in 2019. At the end of 2020, we saw a huge increase in the number of cardiac arrests. Overall, our feeling is that we are still able to handle this increase. It has been a real challenge with workforce outages, which has been the biggest issue with EMTs, paramedics, physicians, and

nursing staff. We will continue to monitor the impacts of COVID by continuing to have weekly or monthly calls with all our stakeholders, hospitals and fire departments.

Dr. Gausche-Hill also mentioned that there is a huge shortage of blood. Harbor-UCLA had to close for two hours because of lack of blood to resuscitate trauma patients. There have been weekly calls with trauma center leadership discussing how to address this problem. Many of the hospitals have hosted/scheduled blood drives, as well as, working with their blood banks. Dr. Muntu Davis, Medical Director, LAC Department of Public Health (DPH), and Dr. Gasuche-Hill sent hospitals a letter asking them to develop strategies for conservation of blood and to have stand up blood drives. Additionally, they were encouraged to work together in multidisciplinary teams to ensure appropriate use of blood products during this time of shortage. One of the major reasons for the shortage is people are not donating blood. We're seeing a shortage in O negative and O positive, as well as A and B types which is highly unusual. Dr. Gausche-Hill has been in discussion with various blood banks, and they are going to prioritize blood allocations to trauma centers throughout the State.

Commissioner Ower asked what is the protocol towards donating if you are ill, have COVID-19 or have been exposed? Dr. Gausche-Hill stated that the CDC recommends waiting to donate until 14 days past your last symptoms. To get the word out, Dr. Gausche-Hill has been on multiple radio stations discussing the shortage, and the American Red Cross declared a national crisis for blood shortages. Dr. Christina Ghaly, Director-DHS, and Dr. Barbara Ferrer, Director-DPH, have also made these announcements and are messaging this to the public. Hospitals are also starting to put out information on donating.

5.4 Data Advisory Committee (DAC)

Commissioner Jeff Rollman provided an update on the Data Advisory Committee (DAC) status. Historically, DAC was more active but over the past five years many of these committee meetings were cancelled and the meetings that were held had few action items. During the December 8, 2021, meeting the committee held a vote on whether the members would like to disband in favor of moving towards an ad hoc committee as needed. The majority voted to disband and to move this forward to the commission to discuss the next steps. Commissioner Lott agreed that this committee is better suited as an ad hoc advisory committee, not a standing committee. Richard Tadeo commented that our specialty care, trauma, and STEMI centers all have data standards that are promulgated on a State or federal level. We do have standing data workgroups that look at those data elements. We have standards for EMS providers to comply with and he is confident that data issues will be addressed adequately. If the commission adopts this motion, we will have to go back and look at the commission bylaws to reflect this change. We can incorporate this with the previous changes that have not been finalized.

The ad hoc data committee would be needed if any of the commissioners notice a data gap. Our data systems are currently in silos so if there needs to be an integration or a gap is identified that we are not meeting we can raise it through the other subcommittees. Most of the issues brought up are by our subject matter experts.

Motion/Second by Commissioners Lott/Uner to disband the standing Data Advisory Committee and make it an ad hoc committee as needed and was approved and carried by majority vote:

Aye (13): Bixler, Caivano, Lam, Lott, Meyer, Ower, Povilaitis, Powell, Rodriguez, Salas, Snyder, Owner, Hisserich

Abstain (1): Rollman

Absent During Vote (3): Cheung, Olney, Washburn

BUSINESS (NEW)

5.5 EMSC Workplan (Goals/Objectives) for Fiscal Year 2021-22 Annual Report
The EMSC work plan annual report contains a portion that asks for the commission's goals and objectives for the year. The goals and objectives are usually based on what has been on our agenda, particularly old business because that tends to be what the commission is working on consistently. Director Chidester suggested the commission create a small group to discuss the workplan or goals and objectives for next year. The workplan always includes the prehospital care of mental health and substance abuse emergencies, patient offload times, monitoring COVID and the effect on the hospital and EMS system and looking at the data reports. There was recently a request from a law enforcement agency to become an ALS provider and this could be something that the commission might be interested in adding to the workplan. This would be an opportunity for the commission to steer work they want done in the future.

5.6 AB 389 (Grayson D) Ambulance Services
The EMS Agency, under the Department of Health Services, prepares the ambulance contracting for the 9-1-1 emergency ambulance transport for Los Angeles County Fire Department and other jurisdictional fire departments that do not do their own transports. It is a very complex Request for Proposals (RFP) process that establishes exclusive operation areas, and the RFP is done every 10 years.

The Grayson Bill, which was passed allows fire departments to do the contracting for ambulance transport services. Historically, the EMS Agency does the contracting for the ambulance services in our large zones. In LA County, any fire department that has done ambulance transport prior to 1980 can continue to do ambulance transports and they have the rights to that area. There are current cities within our zones that do not do their own transport and are covered by our agreement. This bill would allow these cities to go ahead and contract for their own ambulance services outside of Department of Health Services and the EMS Agency. The current 9-1-1 Emergency Ambulance Transportation Agreements expire in 2027. Because our system is so large staff, will start working on the next RFP beginning in 2023 so that the contracts are in place when the current contracts expire.

VI. LEGISLATION

Legislation is currently not in session, no legislation report.

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

Director Chidester reported that the EMS Agency has been working to assist hospitals with their needs and getting them staff and equipment. We are also working with ambulance companies to ensure that they are staffed well enough and have ambulances to respond to the 9-1-1 calls.

Director Chidester also wanted to recognize and reflect on the recent deaths of an LAPD officer and a nurse who worked in the emergency department at LAC+USC. She wanted to recognize the families, departments, and hospitals that worked with them and were affected

by these deaths.

Dr. Gausche-Hill discussed the updated memo regarding Notification of Fatal or Non-Fatal Submersion Incidents by EMS to Public Health. There is reporting of all drownings in public pools to Public Health, there is a singular number to call. They are tracking these calls to ensure that public pools are safe. LA County Fire Department has a separate electronic mechanism for keeping track that they have worked out with Public Health. Hotel and apartment building pools are considered public sites. What we are recommending for EMS is that any submersion injury should be reported to Public Health, and they will vet whether that location is something they will investigate.

Dr. Denise Whitfield, Education Director, EMS Agency, reported that we have been receiving allocations of the monoclonal antibody sotrovimab from the State. It is the only one that is effective against the Omicron variant. Previously allocated therapeutics are not as effective. We have a very limited supply coming from the State and for that reason we have focused our allocation on acute care hospitals geographically distributed across the county. Through a resource request and their capacity to provide infusions they can request it from us. We have been allocating on a weekly basis. There are also two State sites that are providing monoclonal antibodies. They are in Hawaiian Gardens and Lakewood. Dr. Whitfield will post a list of all the acute care hospitals that have received sotrovimab allocations. This will not guarantee that they will have it available since it's such a small supply. We are asking them to tier the most vulnerable patients (immunocompromised or unvaccinated and high-risk). There is also a link to a federal site in which you can enter your zip code, and you can find out where some of these therapeutics have gone.

The antivirals, paxlovid and molnupiravir have been allocated by Public Health, in terms of identifying pharmacies throughout LA County and that list has been given to the State. The medications go directly to these pharmacies and physicians can write a prescription for the two antivirals. There is very strict guidance associated with these therapeutics and there are a few medications that may cause an interaction with at least the molnupiravir. We have tried to be as thoughtful as possible of these allocations and the key thing is to make sure we have a good geographic distribution, especially in the areas where there is a high instance of COVID.

CORRESPONDENCE:

Director Chidester reported on correspondence.

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 of Long Beach
7.4 (01-03-2022) Distribution: Revised EMS Personnel Certification Fees
7.5 Los Angeles Times Article
7.6 Los Angeles Times Article
7.7 (01-06-22) Distribution: Reissuance of August 2021 Guidance for Emergency Medical Services Personnel Entering Healthcare Facilities

VIII. COMMISSIONERS' COMMENTS / REQUESTS

Commissioner Joseph Salas thanked Commissioner Rodriguez for his past service as the EMS Commission Chairman.

IX. ADJOURNMENT:

Adjournment by Chairman Lam at 2:34 p.m. to the meeting of March 16, 2022. Zoom meetings will continue following mandates by the State and County until further notice.

Next Meeting: Wednesday, March 16, 2022, 1:00-3:00pm
Join by Zoom Video Conference Call

Join Zoom Meeting
https://us06web.zoom.us/j/85816449796?pwd=OVNCZEdPUkM0blhhckJzTkMxUnFwUT09
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Recorded by:
Vanessa Gonzalez
Management Secretary III, DHS - Emergency Medical Services Agency

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

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES
BASE HOSPITAL ADVISORY COMMITTEE

MEETING NOTICE

Date: February 9, 2022
Time: 1:00 P.M.
Location: Zoom Meeting

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

BASE HOSPITAL ADVISORY COMMITTEE
DARK FOR February 9, 2022

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

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, February 16, 2022

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
☑ Ryan Jorgenson	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 Coordinator
☑ Paul Voorhees	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)	
Kay Fruhwirth	Marianne Gausche-Hill, MD
Richard Tadeo	Nicole Bosson, MD
Denise Whitfield, MD	Kelsey Wilhelm, MD
Jennifer Calderon	Christine Clare
Natalie Greco	Laura Leyman
Susan Mori	John Quiroz
Lorrie Perez	Jacqueline Rifenburg
Sara Rasnake	Phillip Santos
Karen Rogers	Gary Watson
Andrea Solorio	Christine Zaiser
David Wells	

PUBLIC ATTENDEES (Virtual)	
Angelica Loza-Gomez, MD	Verdugo Fire Communications, Glendale/Montebello FD
Drew Bernard, MD	Emergency Ambulance
Puneet Gupta, MD	LA County FD
Jennifer Breeher	Alhambra FD
Adrienne Roel	Culver City/El Segundo FD
Aspen Di-Ilolo	Monterey Park FD
Britney Alton	Burbank FD
Lyn Riley	LA Co Sheriff Air Ops
Caroline Jack	Beverly Hills FD
Erich Ekstedt	Downey FD
Katie Ward	La Habra Heights FD
Kristina Crews	LACoFD/Compton FD
Rinka Shiraishi	Glendale FD
Roger Braum	Culver City FD
Luis Manjarrez	Glendale FD
Daniel Dobbs	Culver City FD
Jason Hansen	Pasadena FD
Yun Son Kim	LA County FD
Adam Barnes	Harbor-UCLA Med Ctr
Sarah Zyzanski	Harbor-UCLA Med Ctr
Carrissa Kinkor	Liberty Ambulance
Todd Tucker	Glendale FD
Shane Cook	LA County FD
Damien Cyphus	Liberty Ambulance
Daniel Orca	All Town Ambulance
Ilse Wogau	LA County FD
Jeff Tsay	San Marino FD
Carlos Garcia	Montebello FD
Linh Vuong-Shaffer	LA County FD
Aaron Hartney	REACH
Cody Martin	Lifeline Ambulance
Michelle Evans	

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

2. **INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS**

2.1 Changes to EMS Certification Fees *(Jacqui Rifenburg)*

Effective March 1, 2022, certification fees will have a slight increase for EMT and paramedic certifications and recertifications.

2.2 2022 EMSAAC Annual Conference – June 1 & 2, 2022 *(Kay Fruhwirth)*

Brochure was provided announcing this year's annual Emergency Medical Services Administrators' Association of California (EMSAAC) Conference, which will be held in-person at the Omni San Diego Hotel on June 1 and June 2, 2022. Registration can be completed at the following webpage: emsaac.org/conference

2.3 Survey – Post-Cardiac Arrest Management *(Nichole Bosson, MD)*

Public providers were reminded to participate in a brief survey related to post-cardiac arrest management that is being conducted by the University of Pittsburg. The purpose of this study is to discover various ways to prevent re-arrest of patients in ROSC. This study is being considered for a trial in Los Angeles County as well as several other counties in California. Survey can be completed by following the weblink: https://pitt.co1.qualtrics.com/jfe/form/SV_9NWKvGiVrUigAHb

Please complete this survey within the next two weeks. Questions can be directed to Nichole Bosson, MD at nbosson@dhs.lacounty.gov

2.4 Survey – EMS for Children *(Marianne Gausche-Hill, MD)*

State EMS Authority is requesting participation from all providers in completing a survey that looks at performance measures related to EMS for children. A request to participate was sent out to all providers in January 2022; and provider are encouraged to participate by going to the following weblink: emscsurveys.org

2.5 Changes to PAAC Membership *(Robert Ower)*

The following positions were selected by the Los Angeles Area Fire Chiefs Association:

- Area E, Alternate: Ryan Jorgenson, La Habra Heights Fire Department, filling the vacancy.
- Public Sector Paramedic Coordinator, Alternate: Paul Voorhees, Culver City Fire Department, replacing Daniel Dobbs.

3. **APPROVAL OF MINUTES (Kaduce/Zabilski)** December 15, 2021 minutes were approved as written.

4. **REPORTS & UPDATES**

4.1 Disaster Services Update *(Jennifer Calderon)*

The November 2022 statewide medical and health disaster exercise has been CANCELLED due to the ongoing COVID-19 response.

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

- Graphs were presented indicating that the number of COVID-19 cases within Los Angeles County hospitals have declined since the mid-January peak. Tracking of the Omicron variant through waste water testing assisted in predicting this peak.
- During the peak of mid-January, approximately 26% of the patient who were admitted to hospitals had COVID-19; 60% of these patients did not present with COVID symptoms but instead had other medical conditions (ex, appendicitis, etc.).
- Reports have shown that with the Omicron variant patients who are unvaccinated are far more likely to have a severe illness than those who are vaccinated. Although LA County is seeing a downward trend in the number of COVID cases, it is still recommended for all to receive their vaccination due to the continued risks involved.

Monoclonal Antibodies *(Denise Whitfield, MD)*
Moving forward, there's an additional step for hospitals to follow when requesting monoclonal antibodies. All hospitals will continue placing their requests through the ReddiNet system; however, these requests must also be entered in a portal so that the order may be verified. The new portal, Health Partner Ordering Platform (HPOP), is operated by CDPH for allocating and/or requesting therapeutic products. Questions on this new portal may be directed to Denise Whitfield, MD, at dwhitfield@dhs.lacounty.gov

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

EMS Update 2022 will take place in two parts:

4.3.1 i-gel Implementation (for adult and pediatric patients)

- Will replace the KING airway as they expire.
- There will be an online and in-person training portion for the i-gel training.
- Train-the-Trainer is planned for April 2022; sign-ups will occur at the end of March. Go live deadline will be July 1, 2022.
- The EMS Agency is looking into possible discount purchases and possible buy back options from Intersurgical Incorporated. Information will be provided in the future.

4.3.2 Behavioral Health Emergencies

- Online module only.
- Sign-ups for Train-the-Trainer is planned for early June 2022. Go live deadline will be October 1, 2022.

4.4 ITAC Update *(Denise Whitfield, MD)*

- Previous meeting was held on February 7, 2022.
- Items currently under review are:
  - XDcuff® Reusable Limb Restraint
  - The BVM Select™
  - Prehospital ultrasound and potential uses
- Results of ITAC reviews of the above items will be presented to PAAC when complete.
- The next ITAC meeting is scheduled for May 2, 2022.

4.5 EmergiPress *(Denise Whitfield, MD)*

The most recent EmergiPress (January 2022) features the topic of child birth and includes three videos on emergency childbirth and complications. These videos were produced from grant funding received by the EMS Agency.

4.6 Data Collaboratives (*Nichole Bosson, MD)*

The following Data Collaborative groups were summarized:

SRC/Out of Hospital Cardiac Arrest Collaborative:

- A manuscript will be submitted next week that looked at the association of sensitive emergency responses and COVID.
- An abstract will be released on post-ROSC guidelines. So far, there have been no significant impact on the post-ROSC care that is currently being used. However, preliminary results reveal that if the patient receives push-dose epinephrine after ROSC care, they are less likely to re-arrest.
- Upon completion of this study, this group expects to develop a bundle of care to prevent re-arrests after ROSC.

Pediatric Collaborative:

- Studies are ongoing with BRUE and Pedi-Dose.
- Work group has been developed to implement the Pedi-Dose system.

Trauma Collaborative:
Nothing new to report.

4.7 ECMO Pilot *(Nichole Bosson, MD)*

- LAC+USC Medical Center has returned and participating in the pilot study.
- Cedars Sinai Medical Center continues to be in the pilot study.
- Ronald Reagan UCLA Medical Center is temporarily off pilot.
- Study group for this pilot is in the process of revising field policies in attempts to reduce scene times.

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

Nothing new to report. This pilot study has concluded and will be part of the systemwide EMS Update 2022 to implement i-gels into the prehospital system beginning July 1, 2022.

4.9 Dispatch Guidance for Tourniquet Use *(Marianne Gausche-Hill, MD)*

Angelica Loza-Gomez, MD, Medical Director for Verdugo Fire Communications (9-1-1 dispatch center), presented a newly developed dispatch protocol /prearrival instructions, for “Bleeding Wounds” and the use of a tourniquet.

4.10 Epinephrine Shortage *(Nichole Bosson, MD)*

- Currently, there is a nationwide drug short of prefilled cardiac epinephrine (0.1mg/mL) which is affecting many of our LA County providers.
- Studies have shown that greater than 3mg is not beneficial to patient outcome during cardiac arrest. Recently, the EMS Agency sent out a memo dated January 27, 2020, to all ALS providers, reminding of the maximum dose. This dosage is outlined in all LA County’s cardiac arrest treatment protocols and should be followed along with good quality CPR.

- Providers experiencing medication shortages are also encouraged to review the mitigation strategies listed within Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles.

4.11 Pedi-Dose Study *(Marianne Gausche-Hill, MD)*

- This Pediatric Dose Optimization Trial is funded by the National Institute of Health (NIH), to evaluate the use of age-specific dosing for children 6 months through 13 years of age who are actively seizing. The emphasis is to rapidly treat the seizing patient which is known to help with preventing status epilepticus.
- Currently, there are 20 EMS Agencies around the United Stated involved; Los Angeles being the largest with 29 provider agencies.
- Children's Hospital of Los Angeles, Harbor UCLA Medical Center and the EMS Agency is working together on this project, which will impact the prehospital care systemwide, once implemented.
- A steering committee has been formed to explore ways for a smooth transition.
- Implementation date is not yet determined. However, there will be a 4-month lead time to allow for education and training.
- Providers will be given a 1-hour training session and paramedics will be required to complete a self-report for each study participant.

5. UNFINISHED BUSINESS

There was no unfinished business.

6. NEW BUSINESS

6.1 Reference No. 703, ALS Unit Inventory *(Richard Tadeo)*
6.2 Reference No. 703.1, Private Provider Non 9-1-1 ALS Unit Inventory
6.3 Reference No. 704, Assessment Unit Inventory
6.4 Reference No. 706, ALS EMS Aircraft Inventory
6.5 Reference No. 713, Respiratory Care Practitioner Staffed Critical Care Transport Unit Inventory
6.6 Reference No. 719, Fireline Emergency Medical Technician-Paramedic (FEMP) Inventory
6.7 Reference No. 836, Communicable Disease Exposure and Testing *(Christine Clare)*

All policies listed in 6.1 through 6.7 were reviewed and approved as presented.

M/S/C (Miller/Hisserich) Approve:

Reference No. 703, ALS Unit Inventory *(Richard Tadeo)*
Reference No. 703.1, Private Provider Non 9-1-1 ALS Unit Inventory
Reference No. 704, Assessment Unit Inventory
Reference No. 706, ALS EMS Aircraft Inventory
Reference No. 713, Respiratory Care Practitioner Staffed Critical Care Transport Unit Inventory
Reference No. 719, Fireline Emergency Medical Technician-Paramedic (FEMP) Inventory
Reference No. 836, Communicable Disease Exposure and Testing

7. OPEN DISCUSSION

7.1 LAAFCA Chair Announcement *(Alec Miller, Torrance Fire Department)*

Chief Miller announced his new role as Chair of LAAFCA; also thanked Fire Chief Kenneth Powell, and Captain Daniel Dobbs of Culver City Fire Department, for their active roles and participation with LAAFCA and all the Committees of the EMS Agency.

Chairman Ower also thanked LAAFCA members and Captain Dobbs for their involvement with this Committee.

7.2 Firefighter Requirements *(Jacqui Rifenburg)*

Reminder to all providers that it is a minimum requirement for all firefighters in California to maintain either a public safety first-aid course or EMT certification; and a current CPR certification. If a firefighter does not have either a public safety first-aid course or EMT; and a current CPR certification; he/she may not work as a firefighter until this certification is obtained.

7.3 Air Ops Inventory *(Ilse Wogau, Nurse Educator, LACo Fire Department)*

Request was made to revisit the aircraft inventory list (Reference No. 706, ALS EMS Aircraft Inventory) as some amounts of supplies can be reduced. (ex, normal saline bags, etc).

EMS Agency asks that this request be emailed to Jacqui Rifenburg (jrifenburg@dhs.lacounty.gov) for evaluation and review.

8. NEXT MEETING: April 20, 2022

9. ADJOURNMENT: Meeting adjourned at 2:20 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **INNOVATION, TECHNOLOGY AND ADVANCEMENT COMMITTEE (ITAC)** REFERENCE NO. 205

PURPOSE: To describe the composition and function of an Innovation, Technology and Advancement Committee (ITAC) that will advise the Emergency Medical Services Agency (EMS) Director and Medical Director on instituting new products, introducing innovative technologies, implementing new evidence for procedures or protocols, and providing oversight for the implementation of novel equipment.

POLICY:

I. Committee Activities

Functions of the ITAC shall include, but not limited to, the following:

A. Provide operational insights for the use of new products.

B. Perform evidence based literature review regarding technologies for which the Los Angeles County EMS Agency is considering for possible implementation.

C. Develop standardized policy and recommendations for the implementation of new innovations, technologies and products used in Los Angeles County.

D. Provide recommendations to the EMS Agency Director and Medical Director regarding new technologies.

II. Meeting Frequency

The Committee will meet quarterly on “as needed” basis (additional meetings may be held as determined by the chair).

III. Committee Membership Structure

A. Membership is aimed to provide broad areas of expertise to address operational functionality, appropriate scientific review, and practical policy development for the use of new technologies

1. Chaired by the EMS Agency

2. Three physician representatives from the Medical Council (Ref. No. 204)

3. Representative from Provider Agency Advisory Committee (Ref. No. 207)

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

4. Representative from Base Hospital Advisory Committee (Ref. No. 207)

5. Representative from Pediatric Advisory Committee (Ref. No. 216)

6. Representative from a Primary EMT Training Program

7. Representative from a Primary Paramedic Training Program

B. The Committee may elect to invite Subject Matter Experts to provide operational, technical and financial information on an "as needed" basis.

CROSS REFERENCES

Prehospital Care Manual:
Ref. No. 204, **Medical Council**
Ref. No. 207, **EMS Commission Advisory Committees**
Ref. No. 216, **Pediatric Advisory Committee**

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

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

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

POLICY:

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

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

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

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

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

SUPPLIES			
Adhesive dressing (Band-Aids®)	**1 box**	Color Code Drug Doses, Ref. No. 1309	**1**
Airways – Nasopharyngeal:		Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5" 14G	**2**
Large (34-36)	**1**	Contaminated needle container	**1**
Medium (26-28)	**1**	Continuous Positive Airway Pressure (CPAP) device: [3, 7,] **9-1-1 paramedic provider agencies only**	
Small (20-22)	**1**		
Airways – Oropharyngeal:		Small	**1**
Large	**1**	Medium	**1**
Medium	**1**	Large	**1**
Small Adult/Child	**1**	Endotracheal tubes w/ stylets Sizes 6.0-8.0	**2 each**
Infant	**1**	Tube introducer	**2**
Neonate	**1**	End Tidal CO2 Detector or Aspirator (Adult)	**1**
Alcohol prep pads	**1 box**	Extrication device or short board	**1**
Backboards	**2**	Filter, viral HEPA [11]	**2**
Bag-Mask-Ventilation (BMV) device w/ O_2 inlet & reservoir:		Flashlight or penlight	**1**
Bag Volume 650-1000 mL	**1**	Gauze bandages	**6**
Bag Volume 400-700 mL	**1**	Gauze sponges 4x4 (sterile)	**12**
Bag Volume 200-450 mL	**1**	Gloves, sterile	**2 pair**
Bag-Mask-Ventilation (BMV) Masks:		Gloves, unsterile	**1 box**
Large	**1**	Glucometer w/ strips	**1**
Medium	**1**	Lancets (automatic retractable)	**5**
Small Adult/Child	**1**	Hand-held nebulizer pack	**2**
Toddler	**1**	Hemostats, padded	**1**
Infant	**1**	Intraosseous device: [3, 7] **9-1-1 paramedic provider agencies only**	
Neonate	**1**		
Burn pack or burn sheet	**1**	Adult	**1**
Cervical collars (rigid):		Pediatric	**1**
Adult (adjustable)	**4**	Intravenous catheters: Sizes 16G - 22G	**5 each**
Pediatric	**2**	Intravenous tubing - Macrodrip	**12**
Cardiac Monitor-Defibrillator w/ oscilloscope	**1**	i-gel (Disposable Supraglottic Airway):	
Defibrillator pads or paste (including pediatric)	**2 each**	Neonate (size 1)	**1**
ECG electrodes:		Infant (size 1.5)	**1**
Adult	**6**	Small pediatric (size 2)	**1**
Pediatric	**6**	Large pediatric (size 2.5)	**1**
Pulse oximeter	**1**	Small adult (size 3)	**1**
Transcutaneous pacing	**1**	Medium Adult (size 4)	**1**
Waveform capnography	**1**	Large adult+ (size 5)	**1**
ECG, 12-lead & transmission capable **9-1-1 paramedic provider agencies only**	**1**	Laryngoscope blades:	
		Adult: curved & straight	**1 each**
		Pediatric: Miller #1 & #2	**1 each**

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

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

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

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

CROSS REFERENCES:

Prehospital Care Manual:

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

SUBJECT: **PRIVATE PROVIDER NON 9-1-1 ALS UNIT INVENTORY**

REFERENCE NO. 703.1

PURPOSE: To provide a standardized minimum inventory for private provider agencies approved for Advanced Life Support (ALS) interfacility transfers.

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

POLICY:

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

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

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

MEDICATIONS			
Adenosine	**24mgs**	Epinephrine (0.1mg/mL)	**5mgs**
Albuterol (pre-mixed w/ NS)	**10mgs**	Fentanyl [1, 2]	**500mcgs**
Albuterol / Metered Dose Inhaler (MDI) [10]	**2**	Ketorolac 15mg/mL **OR** Ketorolac 30mg/2mLs	**4** / **2**
Amiodarone	**450mgs**		
Aspirin (chewable 81mg)	**648mgs**	Midazolam [3]	**20mgs**
Atropine sulfate (1mg/10mL)	**3mgs**	Morphine sulfate [4]	**20mgs**
Calcium chloride	**1gm**	Naloxone	**4mgs**
Dextrose 10% / Water 250mL	**2 bags**	Normal saline (for injection)	**2 vials**
Dextrose solution (glucose paste may be substituted)	**45gms**	Nitroglycerin (SL) spray, tablets, or single dose powder packets	**1 pump/ bottle/ or 10 packets**
Diphenhydramine	**50mgs**	Ondansetron 4mg ODT	**16mgs**
Epinephrine (1mg/mL)	**5mgs**	Ondansetron 4mg IV	**16mgs**
INTRAVENOUS FLUIDS			
Normal saline 1000 mL	**4 bags**	Normal saline 250 or 500 mL	**2 bags**

APPROVED: _____ _____

Director, EMS Agency Medical Director, EMS Agency

SUPPLIES			
Adhesive dressing (Band-Aids®)	**1 box**	Contaminated needle container	**1**
Airways – Nasopharyngeal:		Endotracheal tubes w/ stylets Sizes 6.0-8.0	**1 each**
Large (34-36)	**1**	Tube introducer	**2**
Medium (26-28)	**1**	End Tidal CO2 Detector or Aspirator (Adult)	**1**
Small (20-22)	**1**	Extrication device or short board	**1**
Airways – Oropharyngeal:		Filter, viral HEPA [10]	**2**
Large	**1**	Flashlight or penlight	**1**
Medium	**1**	Gauze bandages	**6**
Small Adult/Child	**1**	Gauze sponges 4x4 (sterile)	**12**
Infant	**1**	Gloves, sterile	**2 pair**
Neonate	**1**	Gloves, unsterile	**1 box**
Alcohol prep pads	**1 box**	Glucometer w/ strips	**1**
Backboards	**2**	Lancets (automatic retractable)	**5**
Bag-Mask-Ventilation (BMV) device w/ O_2 inlet & reservoir:		Hand-held nebulizer pack	**2**
Bag Volume 200-450 mL	**1**	Hemostats, padded	**1**
Bag Volume 400-700 mL	**1**	Intravenous catheters: Sizes 16G - 22G	**5 each**
Bag Volume 650-1000 mL	**1**	Intravenous tubing - Macrodrip	**6**
Bag-Mask-Ventilation (BMV) Masks:		i-gel (Disposable Supraglottic Airway)	
Large	**1**	Neonate (size 1)	**1**
Medium	**1**	Infant (size 1.5)	**1**
Small Adult/Child	**1**	Small pediatric (size 2)	**1**
Toddler	**1**	Large pediatric (size 2.5)	**1**
Infant	**1**	Small adult (size 3)	**1**
Neonate	**1**	Medium adult (size 4)	**1**
Burn pack or burn sheet	**1**	Large adult+ (size 5)	**1**
Cervical collars (rigid):		Laryngoscope blades:	
Adult (adjustable)	**4**	Adult: curved & straight	**1 each**
Pediatric	**2**	Pediatric: Miller #1 & #2	**1 each**
Cardiac Monitor-Defibrillator w/ oscilloscope	**1**	Laryngoscope handle:	
Defibrillator pads or paste (including pediatric)	**2 each**	Adult (compatible w/ pediatric blades)	**1**
ECG electrodes:		Magill forceps:	
Adult	**6**	Adult	**1**
Pediatric	**6**	Pediatric	**1**
Pulse oximeter	**1**	Metered-Dose-Inhaler (MDI) Mask [10]	**2**
Color Code Drug Doses, Ref. No. 1309	**1**	Metered-Dose-Inhaler (MDI) Spacer [10]	**2**
Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5” 14G	**2**	Mucosal Atomization Device (MAD)	**2**
		Needle, filtered-5micron [6]	**2**

SUPPLIES (continued)			
OB pack & bulb syringe [7]	**1**	Normal saline for irrigation	**1 bottle**
Oxygen cannulas:		Splints:	
Adult	**3**	Long	**2**
Pediatric	**3**	Short	**2**
Oxygen masks – (non-rebreather):		Splints – traction:	
Adult	**3**	Adult	**1**
Pediatric	**3**	Pediatric	**1**
Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	**1**	Stethoscope	**1**
Personal Protective Equipment:		Suction unit (portable) w/adapter	**1**
Mask	1 per provider	Suction catheters:	
Gown	1 per provider	Size 8Fr.	**1**
Eye Protection	1 per provider	Size 10Fr.	**2**
Radio transmitter receiver (Hand-Held) [8]	**1**	Size 12Fr.	**4**
Saline locks	**4**	Tonsillar tip	**1**
Scissors	**1**	Syringes sizes: 1mL – 60mL w/ luer adapter	**assorted**
Sphygmomanometer:		Tape (various types, must include cloth)	**1**
Thigh	**1**	Thermometer (Oral or axillary)	**1**
Adult	**1**	Tourniquets (IV)	**2**
Pediatric	**1**	Tourniquets (commercial for bleeding control)	**2**
Infant	**1**	Vaseline gauze	**2**

APPROVED OPTIONAL EQUIPMENT	
Continuous Positive Airway Pressure (CPAP) Device [2]	Mechanical CPR Device [2]
Glucagon	Pediatric Laryngoscope Handle FDA-Approved
Hemostatic Dressings [2]	Resuscitator with positive pressure demand valve (flow rate not to exceed 40L/min)
Impedance Threshold Device [2]	Sodium Bicarbonate
Lidocaine 2% [2, 9]	Transcutaneous Pacing [2]
Intraosseous Device [2]	Waveform Capnography

[1] Fentanyl carried on ALS Unit is not to exceed 1500mcgs.
[2] Requires EMS Agency approval, which includes an approved training program and QI method prior to implementation.
[3] Midazolam carried on ALS Unit is not to exceed 40mgs.
[4] Morphine sulfate carried on ALS Unit is not to exceed 60mgs.
[6] Optional, if not utilizing glass ampules.
[7] OB Kits with clamps / scissors (no scalpels.)
[8] Los Angeles County Department of Communications, Spec. No. 2029/2031/2033.
[9] Utilized with infusions through IO access.
[10] As supply allows.

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

CROSS REFERENCES:

Prehospital Care Manual:

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

SUBJECT: **ASSESSMENT UNIT INVENTORY** REFERENCE NO. 704

PURPOSE: To provide a standardized minimum inventory on all Assessment Units.

PRINCIPLE:

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

2. The minimum required amounts may be augmented according to anticipated needs in consultation with the Provider Agency Medical Director or the Medical Director of the Emergency Medical Services Agency

POLICY:

I. Assessment Units shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency.

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

MEDICATIONS*			
Adenosine	**6mgs**	Glucagon	**1mg**
Albuterol (pre-mixed with NS)	**5mgs**	Ketorolac 15mgs/mL **OR** Ketorolac 30mgs/2mLs	**4**
Albuterol MDI (Metered Dose Inhaler) [5]	**2**		**2**
Aspirin (chewable 81 mg)	**648mgs**	Naloxone	**2mgs**
Atropine sulfate (1 mg/10 ml)	**1mg**	Normal saline (for injection)	**2 vials**
Dextrose 10% / Water 250 mL	**1**	Nitroglycerin (SL) spray, tablets, or single dose powder packets	**1 pump/ bottle/ or 36 packets**
Dextrose solution (glucose paste may be substituted)	**100gms**	Ondansetron 4mg ODT	**16mgs**
Epinephrine (1mg/mL)	**1mg**	Ondansetron 4mg IV	**16mgs**
Epinephrine (0.1mg/mL)	**2mgs**	Sodium bicarbonate	**50mls**
INTRAVENOUS FLUIDS			
Normal saline 250 or 500 mL	**2 bags**		
SUPPLIES*			
Airways – Oropharyngeal:		Bag-Mask Ventilation (BMV) – Masks:	
Large	**1**	Large	**1**
Medium	**1**	Medium	**1**
Small Adult/Child	**1**	Small Adult/Child	**1**
Infant	**1**	Infant	**1**
Neonate	**1**	Neonate	**1**

APPROVED: _____ _____

Director, EMS Agency Medical Director, EMS Agency

SUPPLIES*(continued)			
Adhesive dressing (Band-Aids®)	**5**	Tube Introducer	**2**
Alcohol prep pads	**5**	Magill Forceps:	
Bag-Mask-Ventilation (BMV) device w/O_2 inlet & reservoir:		Adult	**1**
Bag Volume 200-450 mL	**1**	Pediatric	**1**
Bag Volume 400-700 mL	**1**	MDI Spacer [5]	**2**
Bag Volume 650-1000 mL	**1**	MDI Mask [5]	**2**
Burn pack or burn sheets	**1**	Mucosal Atomization Device (MAD)	**2**
Cardiac Monitor-Defibrillator w/ oscilloscope	**1**	Needle, filtered-5micron [1]	**1**
Defibrillator pads or paste (including pediatric)	**2**	Normal saline for irrigation	**1 bottle**
ECG Electrodes:		OB pack and bulb syringe	**1**
Adult	**6**	Oxygen cannula:	
Pediatric	**6**	Adult	**1**
Cervical collars (rigid):		Pediatric	**1**
Adult (adjustable)	**1**	Oxygen Masks (non-rebreather):	
Pediatric	**1**	Adult	**1**
Color Code Drug Doses, Ref. No. 1309	**1**	Pediatric	**1**
Contaminated needle container	**1**	Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	**1**
Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5” 14G	**2**	Personal Protective Equipment:	
Endotracheal tubes with stylets Sizes: 6.5-7.5	**1 each**	Mask	**1 per provider**
		Gown	**1 per provider**
		Eye protection	**1 per provider**
End Tidal CO_2 Detector or Aspirator (Adult)	**1**	Radio transmitter receiver (Hand-Held) [4]	**1**
Filter, viral HEPA [5]	**2**	Saline locks	**2**
Flashlight or Penlight	**1**	Scissors	**1**
Gauze sponges 4x4 (sterile)	**4**	Sphygmomanometer:	
Gauze bandages	**2**	Thigh	**1**
Gloves, unsterile	**6 pairs**	Adult	**1**
Glucometer with strips	**1**	Pediatric	**1**
Lancets (automatic retractable)	**2**	Infant	**1**
Hand-held nebulizer pack	**1**	Stethoscope	**1**
Intravenous catheters: Sizes 16G - 22G	**2 each**	Tape (various types, must include cloth)	**1**
Intravenous Tubing	**2**	Laryngoscope Blades:	
Laryngoscope Handle: Adult (compatible w/ pediatric blades)	**1**	Adult, curved and straight	**1 each**
		Pediatric, Miller #1 & #2	**1 each**

SUPPLIES*(continued)			
i-gel (Disposable Supraglottic Airway):		Suction catheters:	
Neonate (size 1)	**1**	Size 8Fr.	**1**
Infant (size 1.5)	**1**	Size 10Fr.	**2**
Small pediatric (size 2)	**1**	Size 12Fr.	**4**
Large pediatric (size 2.5)	**1**	Tonsillar Tip	**1**
Small adult (size 3)	**1**	Syringes sizes: 1ml – 60ml w/luer adapter	**assorted**
Medium adult (size 4)	**1**	Thermometer (Oral or axillary)	**1**
Large adult+ (size 5)	**1**	Tourniquets (IV)	**2**
Suction Unit (portable) w/adapter	**1**	Tourniquets (commercial for bleeding control)	**2**
		Vaseline gauze	**2**

APPROVED OPTIONAL EQUIPMENT	
Continuous Positive Airway Pressure (CPAP) Device [2]	Lidocaine 2% [3]
Hemostatic Dressings [2]	Splints: Long & Short
Intraosseous Device: [2] Adult & Pediatric	Splints – traction: Adult & Pediatric

[1] Optional, if not utilizing glass ampules.
[2] Requires EMS Agency approval, which includes an approved training program and QI method prior to implementation.
[3] Utilized with infusions through IO access.
[4] Los Angeles County Department of Communications, Spec. No. 2029/2031/2033.
[5] As supply allows.

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

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 416, **Assessment Units**
Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**

SUBJECT: **ALS EMS AIRCRAFT INVENTORY** REFERENCE NO. 706

PURPOSE: To provide a standardized minimum inventory on all Advanced Life Support (ALS) Emergency Medical Services (EMS) aircraft.

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

POLICY:

I. Each ALS EMS aircraft shall have on board equipment and supplies commensurate with the scope of practice of the medical flight crew. This requirement may be fulfilled through the utilization of appropriate kits (cases/packs) which can be carried aboard a given flight.

II. ALS EMS aircraft shall have sufficient space to carry the following minimum medical equipment and supplies. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency.

III. Controlled drugs shall be secured on the EMS aircraft in accordance with Ref. No. 702, Controlled Drugs Carried on ALS Units.

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

MEDICATIONS			
Adenosine	**18mgs**	Glucagon	**1mg**
Albuterol (pre-mixed w/ NS)	**20mgs**	Ketorolac 15mg/mL	**4**
Albuterol / Metered Dose Inhaler (MDI) [11]	**2**	**OR** Ketorolac 30mg/2mLs	**2**
Amiodarone	**600mgs**	Lidocaine 2% [4]	**200mg**
Aspirin (chewable 81mg)	**648mgs**	Midazolam [5]	**15mgs**
Atropine sulfate (1mg/10mL)	**3mgs**	Morphine sulfate [6]	**20mgs**
Calcium chloride	**2gms**	Naloxone	**2mgs**
Dextrose 10% / Water 250mL	**2 bags**	Normal saline (for injection)	**3 vials**
Dextrose solution (glucose paste may be substituted)	**45gms**	Nitroglycerin (SL) spray, tablets, or single dose powder packets	**1 pump/ bottle/ or 36 packets**
Diphenhydramine	**100mgs**	Ondansetron 4mg ODT	**16mgs**
Epinephrine (1mg/mL)	**7mgs**	Ondansetron 4mg IV	**16mgs**
Epinephrine (0.1mg/mL)	**6mgs**	Sodium bicarbonate	**100mLs**
Fentanyl [2, 3]	**500mcgs**		
INTRAVENOUS FLUIDS			
Normal saline 1000 mL	**6 bags**	Normal saline 250 or 500 mL	**2 bags**

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

SUPPLIES			
Adhesive dressing (Band-Aids®)	**1 box**	Color Code Drug Doses, Ref. No. 1309	**1**
Airways – Nasopharyngeal:		Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5" 14G	**2**
Large (34-36)	**1**	Contaminated needle container	**1**
Medium (26-28)	**1**	Continuous Positive Airway Pressure (CPAP) device: [3, 7]	
Small (20-22)	**1**	Small	**1**
Airways – Oropharyngeal:		Medium	**1**
Large	**1**	Large	**1**
Medium	**1**	Endotracheal tubes w/ stylets Sizes 6.0-8.0	**2 each**
Small Adult/Child	**1**	Tube introducer	**2**
Infant	**1**	End Tidal CO2 Detector or Aspirator (Adult)	**1**
Neonate	**1**	Extrication device or short board	**1**
Alcohol prep pads	**20**	Filter, viral HEPA [11]	**2**
Backboard	**1**	Flashlight or Penlight	**1**
Bag-Mask-Ventilation (BMV) device w/ O_2 inlet & reservoir:		Gauze bandages	**6**
Bag Volume 200-450 mL	**1**	Gauze sponges 4x4 (sterile)	**12**
Bag Volume 400-700 mL	**1**	Gloves, sterile	**2 pair**
Bag Volume 650-1000 mL	**1**	Gloves, unsterile	**1 box**
Bag-Mask-Ventilation (BMV) Masks:		Glucometer w/ strips	**1**
Large	**1**	Lancets (automatic retractable)	**5**
Medium	**1**	Hand-held nebulizer pack	**2**
Small Adult/Child	**1**	Intraosseous device: [3, 7]	
Toddler	**1**	Adult	**1**
Infant	**1**	Pediatric	**1**
Neonate	**1**	Intravenous catheters: Sizes 16G - 22G	**4 each**
Burn pack or burn sheet	**1**	Intravenous tubing - Macrodrip	**5**
Cervical collars (rigid):		i-gel (Disposable Supraglottic Airway):	
Adult (adjustable)	**1**	Neonate (size 1)	**1**
Pediatric	**1**	Infant (size 1.5)	**1**
Cardiac Monitor-Defibrillator w/ oscilloscope	**1**	Small pediatric (size 2)	**1**
Defibrillator pads or paste (including pediatric)	**2 each**	Large pediatric (size 2.5)	**1**
ECG electrodes:		Small adult (size 3)	**1**
Adult (multi-use)	**8-10**	Medium Adult (size 4)	**1**
Pediatric (multi-use)	**8-10**	Large adult+ (size 5)	**1**
ECG, 12-lead & transmission capable	**1**	Laryngoscope blades:	
Noninvasive blood pressure monitor	**1**	Adult: curved & straight	**1 each**
Pulse oximeter	**1**	Pediatric: Miller #1 & #2	**1 each**
Transcutaneous pacing	**1**	Laryngoscope handle:	
Waveform capnography	**1**	Adult (compatible w/ pediatric blades)	**1**

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

APPROVED OPTIONAL EQUIPMENT	
Dextrose 25%	Resuscitator w/ positive pressure demand valve (flow rate not to exceed 40L/min)
Hemostatic dressings [3]	

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

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

CROSS REFERENCES:

Prehospital Care Manual:

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

SUBJECT: **RESPIRATORY CARE PRACTITIONER STAFFED SPECIALTY CARE TRANSPORT UNIT INVENTORY** REFERENCE NO. 713

PURPOSE: To provide a standardized minimum inventory on all Respiratory Care Practitioner (RCP) Specialty Care Transport (SCT) Units.

PRINCIPLE:

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

POLICY:

I. RCP staffed SCT vehicles shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied according to Ref. No. 710, Basic Life Support Ambulance Equipment.

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

MEDICATIONS			
Albuterol (pre-mixed w/ NS)	**30mgs**	Atrovent	**2mgs**
Albuterol Meter Dose Inhaler (MDI) [1]	**2**		

SUPPLIES			
Airways – Nasopharyngeal:		Bag-Mask-Ventilation (BMV) device w/ O_2 inlet &reservoir:	
Large (34-36)	**1**	Bag Volume 200-450 mL	**1**
Medium (26-28)	**1**	Bag Volume 400-700 mL	**1**
Small (20-22)	**1**	Bag Volume 650-1000 mL	**1**
Airways – Oropharyngeal:		Bag-Mask-Ventilation (BMV) Masks:	
Large	**1**	Large	**1**
Medium	**1**	Medium	**1**
Small Adult/Child	**1**	Small Adult/Child	**1**
Infant	**1**	Toddler	**1**
Neonate	**1**	Infant	**1**
Airway guard (bite blocker)	**2**	Neonate	**1**

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

SUPPLIES (continued)			
Cell phone (personal or company)	**1**	Oxygen Cannulas:	
Color Code Drug Doses, Ref. No. 1309	**1**	Adult	**3**
Coupler/Quick Connect (oxygen connection)	**2**	Pediatric	**3**
End tidal CO_2 detector:		Oxygen masks:	
Adult	**2**	Adult	**3**
Pediatric	**2**	Pediatric	**3**
$ETCO_2$ filter line	**6**	Oxygen:	
Filter, viral HEPA [1]	**2**	Hose	**1**
Gloves, sterile	**2**	Key	**2**
Gloves, non-sterile	**1 box**	Regulator	**2**
Nebulizer kit (including hand held and mask)	**2 each**	Tree	**2**
Heat / Moisture Exchange (HME) Ventilator Filters:		Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	**1**
Adult	**4**		
Pediatric	**2**		
* **King LTS-D** (Disposable Supraglottic Airway Device) w/60mL syringe:	**(AND/OR)**	* **i-gel** (Disposable Supraglottic Airway):	
Neonate (size 0)	**1**	Neonate (size 1)	**1**
Pediatric (size 1)	**1**	Infant (size 1.5)	**1**
Pediatric (size 2)	**1**	Small pediatric (size 2)	**1**
Pediatric (Size 2.5)	**1**	Large pediatric (size 2.5)	**1**
Small Adult (Size 3)	**1**	Small adult (size 3)	**1**
Adult (Size 4)	**1**	Medium Adult (size 4)	**1**
Large Adult (Size 5)	**1**	Large adult+ (size 5)	**1**
Laryngoscope handle:		PEEP valve:	
Adult (compatible w/ pediatric blades)	**1**	Adult	**1**
Laryngoscope blades:		Pediatric	**1**
Adult, Curved & Straight	**1 each**	Personal Protective Equipment:	
Pediatric, Miller 0, 1, & Miller 2	**1 each**	Mask	**1 per provider**
Magill forceps:		Gown	**1 per provider**
Adult	**1**	Eye protection	**1 per provider**
Pediatric	**1**	Portable suction (battery operated)	**1**
Metered-Dose-Inhaler (MDI) Mask [1]	**2**	Pulse oximeter	**1**
Metered-Dose-Inhaler (MDI) Spacer [1]	**2**	Pulse oximeter probes:	
Normal saline pillows (ampoules/inhalant)	**10**	Adult	**2**
Penlight	**1**	Pediatric	**2**

SUPPLIES (continued)			
Sphygmomanometer:		Scissors	**1**
Thigh	**1**	Ventilator circuits (disposable):	
Adult	**1**	Adult	**4**
Pediatric	**1**	Pediatric	**2**
Infant	**1**	Ventilator filters	**4**
Suction catheters:		Ventilator (non-pneumatic or pneumatic)	**1**
Size 8Fr.	**1**	If utilizing ventilator to fulfill non-invasive CPAP requirement, must have 1 set of the following necessary equipment:	
Size 10Fr.	**2**		
Size 12Fr.	**4**	Circuit	**1**
Size 14Fr.	**1**	Masks:	
Stethoscope	**1**	Small	**1**
Syringes 10mL	**2**	Medium	**1**
Tape (various types, must include cloth)	**1**	Large	**1**
Thermometer (Oral or axillary)	**1**	Waveform capnography	**1**
APPROVED OPTIONAL EQUIPMENT			
Endotracheal tubes w/ stylets Sizes 2.0-8.0	**2 each**	Levalbuterol	**7.5mgs**
High velocity oxygen delivery system	**1**	Tracheostomy mask:	
High velocity oxygen delivery nasal cannulas:		Adult	**2**
Adult	**2**	Pediatric	**2**
Pediatric	**2**	Venturi mask	**1**

This policy is intended as a RCP Inventory only.
[1] As supply allow
* Requires EMS Agency approved training and quality improvement program.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 414, **Specialty Care Transport (SCT) Provider**
Ref. No. 710, **Basic Life Support Ambulance Equipment**
Ref. No. 712, **Nurse Staffed Specialty Care Transport Unit Inventory**

SUBJECT: **FIRELINE EMERGENCY TECHNICIAN-PARAMEDIC (FEMP) INVENTORY**

(PARAMEDIC)
REFERENCE NO. 719

PURPOSE: To provide a standardized minimum inventory on all Fireline Emergency Technician Paramedic (FEMP) Units.

PRINCIPLE:

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

POLICY:

I. FEMP units shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied according to Ref. No. 710, Basic Life Support Ambulance Equipment.

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

FEMP ALS PACK INVENTORY			
ALS Airway Equipment			
ET Tubes (Cuffed), Sizes 6.0 – 8.0	**1 each**	Laryngoscope Handle:	**1**
Stylette: Adult	**1**	Miller/McIntosh blades- Adult	**1 each**
ETT holder	**1**	Magill Forceps:	
Tube Introducer	**1**	Adult	**1**
End Tidal CO2 detector or Aspirator	**1**	Needle thoracostomy kit: 3-3.5” / 14G	**1**
Hand Held Nebulizer	**2**	Suction Device, Manual or portable	**1**
i-gel (Disposable Supraglottic Airway):		Suction Catheters:	
Small adult (size 3)	**1**	Size 10Fr.	**2**
Medium adult (size 4)	**1**	Size 12Fr.	**4**
Large adult+ (size 5)	**1**	Water soluble lubricant	**5**

APPROVED: _____ Director, EMS Agency

_____ Medical Director, EMS Agency

FEMP ALS PACK INVENTORY (continued)

IV and Medication Administration Supplies

Adhesive tape	**1**	Needles:	
Alcohol Preps	**6**	18G	**6**
IV Administration Set: Macro Drip	**2**	23G	**5**
IV Catheters:		Syringes:	
14G	**2**	Tuberculin	**2**
16G	**2**	5mL	**2**
20G	**2**	10mL	**2**
Saline 0.9% IV	**200ml**	Tourniquets	**2**

Miscellaneous

Antiseptic Hand Wipes	**10**	Infection Control Packs	**1**
BLS Pack	**1**	Locked Container System	**1**
Cellular Phone / Means of Communication	**1**	Numbered Controlled Substance Seals	**4**
Contaminated Needle Container	**1**	Patient Care Record	**12**
Controlled Substance Log Sheet	**1**	Red Bio-Hazard Bags	**2**
FEMP Pack Inventory Sheet	**1**	Tourniquets (Commercial, for bleeding control)	**2**

Biomedical Equipment

Glucometer	**1**	Monitor / Defibrillator	**1**
		OR	
Lancets (retractable)	**5**	Compact Semi-Automatic AED w/screen	**1**
EKG electrodes (disposable), Adult	**2 sets**	Monitor/AED electrode wires	**1 set**
Pulse oximeter (Optional)	**1**	Monitor/AED defibrillator patches, Adult	**2**

Medications

Adenosine	**18mg**	Ketorolac 15 mgs/mL	**4**
		OR	
Aspirin, chewable, 80mg	**1 bottle**	Ketorolac 30 mgs/2mLs	**2**
Albuterol Sulfate	**15mg**	Midazolam	**20mg**
Atropine Sulfate	**2mg**	Morphine Sulfate	**40mg**
Diphenhydramine	**200mg**	Naloxone	**4mg**
Epinephrine (1mg/mL)	**4mg**	Nitroglycerin spray or tablets	**1**
Epinephrine (0.1mg/mL)	**4mg**	Ondansetron IV	**16mg**
Fentanyl*	**600mcg**	Ondansetron 4mg ODT	**16mg**
Glucagon	**1mg**		

FEMP BLS PACK INVENTORY			
Supplies			
Airway, Nasopharyngeal:			
Medium Adult	**1**	Nasal Cannula:	
Large Adult	**1**	Adult	**1**
Airways, Oropharyngeal:		Oxygen "C" Cylinder or larger	**2**
Medium Adult	**1**	w/regulator	**1**
Large Adult	**1**	Oxygen Mask, Non-rebreather	**1**
Bag-Mask-Ventilation (BMV) device w/O_2 inlet and reservoir:		Patient Care Record	**12**
Bag Volume 650-1000 mL	**1**	Pen (black or blue ink)	**1**
Bag-Mask Ventilation (BMV) Masks:		Pencil (wet environments)	**1**
Medium Adult	**2**	Penlight or Flashlight	**1**
Large Adult	**2**	Petroleum Dressing	**2**
Bandages:		Scissors	**1**
Kerlix/Kling 4.5, Sterile	**4**	Space blanket	**1**
4x4 Compress, Sterile	**6**	Sphygmomanometer:	
Triangular	**2**	Adult	**1**
Burn Sheet	**1**	Splint, Moldable	**1**
Dextrose, Oral	**1**	Stethoscope	**1**
Duct Tape	**1**	Tape, 1 Inch	**1**
Eye Wash	**1 bottle**	Thermometer (Oral or axillary)	**1**
Face-Mask (disposable), w/eye shield	**1**	Trauma Dressing 10x30	**4**
Gloves, sterile	**2 pair**	Writing Pad	**1**
Approved Optional Equipment			
Insect Sting Swabs		Moleskin	
Mask, Pocket w/O2		Pulse oximeter	
		Slinter kit	

*Requires EMS Agency approval. Provider agency may only stock fentanyl or morphine sulfate, not both controlled substances.

Additional items for re-stock should be maintained and secured in the vehicle or in the Medical Unit Trailer.

NOTE: Providers should stock maximum allowed quantities of medical supplies and medications, especially controlled substances, to avoid mid-incident restock. Incident medical units may not be capable of re-supplying controlled substances.

Controlled substances should be secured as per LA County Prehospital Care Policy Ref. No. 702 and the FEMP provider's standard operating procedures.

The FEMP should report to the incident with the full complement of EMS supplies ready to work. The incident will re-supply the FEMP to the best of its ability.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 702, **Controlled Drugs Carried on ALS Units**
Ref. No. 804, **Fireline Emergency Medical Technician- Paramedic (FEMP)**

Reference Nos. 703, ALS Unit Inventory
703.1, Private ALS Unit Inventory
704, Assessment Unit Inventory
706, ALS EMS Aircraft Inventory
713, RCP Staffed / SCT Staffed Inventory
719, Fireline Medic Inventory

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSC Advisory Committees	Provider Agency Advisory Committee	02/16/22	02/16/22	
	Base Hospital Advisory Committee			
	Data Advisory Committee			
Other Committees / Resources	Medical Council	03/01/22	03/01/22	
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Pediatric Advisory Committee			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, HOSPITALS)

SUBJECT: **COMMUNICABLE DISEASE EXPOSURE AND TESTING** REFERENCE NO. 836

PURPOSE: To provide guidelines for EMS personnel exposed to blood, airborne biological agents, or other potentially infectious material.

AUTHORITY: California Health and Safety Code, Division 105, Chapter 3.5, Sections 120260-120263
California Health and Safety Code, Sections 1797.188 -189, 120980, 121050-121070
U.S. Department of Labor-Occupational Safety and Health Administration Bloodborne Pathogens Standard 1910.1030 6-8-2011
California Occupational Safety and Health Standards Exposure Control Plan for Bloodborne Pathogens (2001)
Ryan White HIV/AIDS Treatment Modernization Act of 2006
Code of Federal Regulations, Title 45, Section 164.512.b.4 (October 2007)
California Code of Regulations, Title 8, Section 5193 and 5199

DEFINITIONS:

Aerosol transmissible disease (ATD) or aerosol transmissible pathogen (ATP): A disease or pathogen for which droplet or airborne precautions are required such as tuberculosis (TB), Severe Acute Respiratory Syndrome coronavirus 2 (SARS Co-V-2) (COVID-19), and pertussis.

Airborne infectious disease (AirID): 1) An ATD transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles; 2) a novel (unknown ATP) disease process suspected of being transmitted as above.

Attending physician of the source patient: Any physician or surgeon who provides health care services to the source patient.

Available blood or patient sample: Blood, other tissue, or material legally obtained in the course of providing health care services and in the possession of the physician or other health care provider of the source patient **prior to the release of the source patient from the physician's or health care provider's facility**.

Body Substance Isolation (BSI): A method of infection control designed to approach all body fluids as being potentially infectious. It is the preferred infection control concept for EMS personnel.

Certifying physician: Any physician consulted by the exposed individual for the exposure incident.

Communicable disease: Any disease that is transferable through an exposure incident, as determined by the certifying physician.

APPROVED:

Director, EMS Agency Medical Director, EMS Agency

Designated officer: An official or officer designated by the prehospital emergency medical services provider or private ambulance company. This person is responsible for coordinating communicable disease exposure and testing procedures for EMS personnel.

Exposed individual: Any individual health care provider, first responder, or any other person, including, but not limited to, any employee, volunteer, or contracted agent of any health care provider, who is exposed, within the scope of their employment, to the blood or other potentially infectious materials of a source patient.

Exposure certification: A determination by the certifying physician on the exposure's significance.

Health facility infection control officer: The official or officer who has been designated by the health facility to communicate with a designated officer, or his or her designee.

Legal representative: For purposes of giving consent to communicable disease testing, whenever the word "source patient" is used herein, it shall also be deemed to mean the source patient's legal representative.

Personal Protective Equipment (PPE): Specialized clothing or equipment worn by personnel for protection from exposure to blood or other potentially infectious material. See "universal infection control precautions".

Significant exposure: Direct contact with blood or other potentially infectious materials of a patient in a manner that is capable of transmitting a communicable disease.

Source patient: Any person receiving health care services whose blood or other potentially infectious material is the source of a significant exposure to prehospital care personnel.

Standard Precautions: A combination of the major features of Universal Precautions and Body Substance Isolation based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents.

Universal Infection Control Precautions: A method of infection control in which human blood and certain human body fluids are treated as if known to be infectious for blood borne pathogens.

Urgency reporting requirement: A disease required to be reported immediately by telephone or reported by telephone within one working day pursuant to subdivisions (h) and (i) of Section 2500 of Title 17 of the California Code of Regulations.

PRINCIPLES:

1. EMS personnel must observe "body substance isolation" in situations where there is a potential for contact with blood, body fluids, or other potentially infectious material.

2. EMS personnel are frequently exposed to blood and other potentially infectious materials of patients whose communicable disease infection status is unknown. EMS personnel who experience a significant exposure to these substances are permitted, under certain conditions, to learn the communicable disease infection status of the source patient.

3. Early knowledge of infection with a communicable disease is important to allow exposed persons to make informed health care decisions and take measures to reduce the transmission of the infection to others.

4. A health care provider shall not draw blood, or a patient sample for the sole purpose of communicable disease testing, if the source patient refuses communicable disease testing. If the source patient's communicable disease status is unknown and the patient refuses communicable disease testing, only available blood or patient sample may be tested for any communicable disease.

5. California law prohibits an exposed individual from attempting to directly obtain informed consent to communicable disease testing from a source patient.

6. EMS personnel exposed/infected with SARS-CoV-2 (COVID-19) shall follow their departmental policies and procedures.

POLICY:

I. Designated Officer

A. EMS provider agencies must appoint a designated officer. The designated officer, or his or her designee, shall be available either onsite or on call 24 hours per day as determined by the EMS Provider.

B. An employer of a prehospital emergency medical care personnel that maintains an internet web site shall post the title and telephone number of the designated officer or the facility's infection control officer in a conspicuous location on its internet web site accessible from the home page.

II. Infection Control Officer

A. The health facility infection control officer, or his or her designee, shall be available either onsite or on call 24 hours per day as determined by the health facility.

B. A health facility that maintains an internet web site shall post the title and telephone number of the health facility infection control officer in a conspicuous location on its internet web site accessible from the home page.

III. Evaluation and Certification of an Exposure

A. In the event of an exposure to blood or other potentially infectious material of a patient, exposed EMS personnel are to follow their provider agency's post-exposure protocol, including the completion of the Ref. No. 836.2, Communicable Disease Exposure and Notification Form, or the equivalent.

1. The exposed individual shall make a written request for exposure certification within 72 hours of the exposure and a physician should promptly evaluate the exposure.

2. No physician or other exposed individual shall certify their own exposure; however, an employing physician may certify the exposure of one of their

employees.

3. **EMS personnel with a significant exposure should seek medical evaluation and treatment immediately.**

B. The certifying physician shall provide written certification of the exposure's significance within 72 hours of the request. The certification shall include the nature and extent of the exposure.

C. The health facility infection control officer shall notify:

1. The exposed individual's designated officer; and,

2. The Los Angeles County Health Officer or designee at (213) 240-7941 from 8 a.m. to 5 p.m. Monday through Friday, or (213) 974-1234 during non-business hours and ask for the on-call physician.

D. The designated officer shall immediately notify their employee health officer if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition.

E. The exposed individual shall be counseled regarding the likelihood of transmission, limitations of the tests performed, need for follow up testing, and the procedures that the exposed individual must follow regardless of the source patient's test results.

F. Within 72 hours of certifying the exposure as significant, the certifying physician shall provide written certification to the source patient's attending physician. The certification shall: a) indicate that a significant exposure has occurred, b) request information regarding the communicable disease status of the source patient and the availability of blood or other patient samples. The source patient's attending physician shall respond to the request for information within three working days.

G. **Many source patients are discharged from the emergency department; therefore, the exposure certification should be made immediately available to the emergency department where the source patient is being treated. This may allow the source patient to consent to communicable disease testing while still in the emergency department**.

IV. Communicable Disease Status of Source Patient

A. Known Communicable Disease Status

1. If the source patient's communicable disease status is known, the source patient's attending physician shall obtain consent to disclose the communicable disease status to the exposed individual.

2. If the source patient cannot be contacted, or refuses to consent to the

disclosure, then the exposed individual may be informed of the communicable disease status by the attending physician as soon as possible after the exposure has been certified as significant.

B. Unknown Communicable Disease Status

1. If the communicable disease status of the source patient is unknown, and blood or other patient samples are available, and the exposed individual has tested negative on a baseline test for communicable diseases, the source patient shall be given an opportunity to give a voluntary, written, informed consent to test for communicable diseases.

2. The source patient shall be provided with medically appropriate pretest counseling and referred to appropriate posttest counseling and follow-up if necessary. The source patient shall be offered medically appropriate counseling whether or not he or she consents to testing.

3. Within 72 hours after receiving a written certification of significant exposure, the source patient's attending physician shall make a good faith effort to notify the source patient about the significant exposure. A good faith effort to notify includes, but is not limited to, a documented attempt to locate the source patient by telephone or by first-class mail with certificate of mailing. An attempt to locate the source patient and the results of that attempt shall be documented in the source patient's medical record.

4. An inability to contact the source patient after a good faith effort, or the inability of the source patient to provide informed consent **shall constitute a refusal of consent** provided all the following conditions are met:

   a. The source patient has no authorized legal representative,

   b. The source patient is incapable of giving consent, and

   c. In the opinion of the attending physician, the source patient will be unable to grant informed consent within the 72-hour period required to respond.

5. **If the source patient refuses consent to test for communicable diseases, any available blood or patient sample of the source patient may be tested. The source patient shall be informed that the available blood or patient sample will be tested despite their refusal, and the exposed individual shall be informed of the results regarding communicable diseases.**

6. If the source patient is deceased, consent to perform a test for any communicable disease on any blood or patient sample of the source patient legally obtained in the course of providing health care services at the time of the exposure shall be deemed granted.

7. The source patient shall have the option not to be informed of the test

result. If a source patient refuses to provide informed consent to communicable disease testing and refuses to learn the results of testing, documentation of the refusal shall be signed. The source patient's refusal to sign shall be construed as a refusal to be informed of the test results. Test results shall only be placed in the source patient's medical record when the patient has agreed in writing to be informed of the results. If the source patient refuses to be informed of the test results, the test results shall only be provided to the exposed individual in accordance with applicable Federal and State occupational health and safety standards.

V. Confidentiality and Liability

A. The exposed individual shall be informed that any identifying information about the communicable disease test results and medical information regarding the communicable disease status of the source patient shall be kept confidential and may not be further disclosed, except as authorized by law. The exposed individual shall be informed of the civil and criminal penalties for which they would be **personally** liable for violating Health and Safety Code Section 120980.

B. The costs for communicable disease testing and counseling of the exposed individual, and/or the source patient, shall be borne by the employer of the exposed individual.

C. The source patient's identity shall be encoded on the communicable disease test result record.

D. If the health care provider has acted in good faith in complying with Health and Safety Code Chapter 3.5, the health care provider shall not be subject to civil or criminal liability or professional disciplinary action for:

1. Performing communicable disease tests on the available blood or patient sample of the source patient.

2. Disclosing the communicable disease status of a source patient to the source patient, the source patient's attending physician, the certifying physician, the exposed individual, or any attending physician of the exposed individual.

E. Any health care provider or first responder or any exposed individual who willfully performs or permits the performance of a test for communicable disease on a source patient that results in economic, bodily, or psychological harm to the source patient, without adhering to the procedure set forth in Health and Safety Code Chapter 3.5 is guilty of a misdemeanor, punishable by imprisonment in the county jail for a period not to exceed one year, or a fine not to exceed ten thousand dollars ($10,000), or both.

VI. Coroner's Cases

If the source patient is pronounced dead in the field, the County Medical Examiner/Coroner may test for any communicable disease when an autopsy is performed. The certifying physician or the exposed EMS personnel's employer shall notify the County Medical Examiner/Coroner of the exposure. If the County Medical

Examiner/Coroner confirms a diagnosis of any communicable disease in the source patient, they shall notify the County Health Officer, who in turn shall apprise the exposed individual of the source patient's communicable disease status. The County Medical Examiner/Coroner shall adhere to the procedure defined in Health and Safety Code 1797.189 in carrying out this process.

VII. Source Patient in Custody or Charged with a Crime

If the source patient is in custody or charged with a crime and refuses to voluntarily consent to communicable disease testing, Health and Safety Code 121060, 121060.1, and 121065 allows for the exposed health care provider to petition the court. The court may require the source patient to provide three specimens of blood to be tested for HIV, hepatitis B, and hepatitis C by court order (Ref. No. 836.3).

VIII. Aerosol Transmissible Disease

Provider agencies shall have written procedures to be followed in the event of an exposure incident in accordance with the California Code of Regulations, Title 8, Section 5199.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 836.1, **Communicable Disease Exposure and Testing Flow Chart**
Ref. No. 836.2, **Communicable Disease Exposure and Notification Report Form**
Ref. No. 836.3, **Court Petition for Order to Test Accused Blood**

Reportable Diseases and Conditions:
http://www.publichealth.lacounty.gov/acd/docs/ReportableDiseaseListMarch2020.pdf

Reference No. 836, Communicable Disease Exposure and Testing

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/16/2022	2/16/2022	No
	Base Hospital Advisory Committee			
	Data Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council	3/1/2022	3/1/2022	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

Hilda L. Solis
First District

Holly J. Mitchell
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer Blvd, 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

January 4, 2022

David Eisner, MD, Medical Director
Culver City Fire Department
9770 Culver Boulevard
Culver City, California 90232

CERTIFIED

Dear Dr. Eisner:

ALTERNATE DESTINATION PILOT PROGRAM APPROVAL

This letter is to confirm that Fire Department (CC) has been approved by the Emergency Medical Services (EMS) Agency for the Alternate Destination to the Psychiatric Urgent Care Center pilot for 12 months at which time the pilot will be re-evaluated for efficacy and feasibility.

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

- Number of patient contacts considered for alternate transport to Exodus Recovery Services (EXM) (includes screening partial and completed) and Provider Impression
- Number of contacts transferred to EXM
- Number of contacts declined transport to EXM
- Number of contacts refusing care against medical advice (AMA)
- Number of contacts treated and refer in place, no AMA
- Number of meeting inclusion criteria and transported to EXM
- Number of meeting exclusion criteria transported to EXM
- Number of contacts transported to EXM and redirected after arrival
- Adverse reactions or complications
- Outcome data for patients transported to EXM to include the following:
    - Secondary transport to an emergency department or mental health facility
    - Treated at EXM and discharged or left against medical advice
- Appropriate statistical evaluation
- **Number of rekindles requiring ALS intervention and/or hospitalization, in addition to the above requirements, please report all sentinel events within 24 hours of occurrence.**

The quarterly reports are due thirty (30) days after the end of each quarter and should be addressed to me at MGausche-Hill@dhs.lacounty.gov (cc Susan Mori at sumori@dhs.lacounty.gov).

Sincerely,

Marianne Gausche-Hill

Marianne Gausche-Hill, M.D.
Medical Director

MGH:JT:sm
01-02

c. Director, EMS Agency
Gary Watson, Prehospital Operations, EMS Agency
Fire Chief, Culver City Fire Department

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
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Fifth District

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Director

Marianne Gausche-Hill, MD
Medical Director

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

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Fax: (562) 941-5835

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

January 26, 2022

TO: FAX/E-Mail Distribution (see attachment)

FROM: Cathy Chidester
Director

SUBJECT: **SUPER BOWL LVI EXPERIENCE AND GAME FEBRUARY 5 THROUGH FEBRUARY 13, 2022**

This is to advise you of the Super Bowl Experience activities, which are scheduled to take place February 5 through 12, 2022 in the cities of Los Angeles (LA) and Inglewood; and Super Bowl LVI which will be held at the SoFi Stadium in the City of Inglewood on February 13, 2022. These events are expected to draw hundreds of thousands of spectators and participants.

A summary of events and estimated number of participants are listed below:

Event and Location	Dates of Operation	Estimated Participants
Super Bowl Experience at LA Convention Center	February 5-12, 2022, closed Feb 7 and 9	10,000 per day
NFL House at Hudson Loft in LA City	February 10-12 from 12:00 pm to 12:00 am	Invitation only, 1,000 per day
NFL Honors at Hollywood Park	February 10 at 3 pm	Invitation only, 1,500
Friday Night Party – Academy Museum of Motion Pictures in LA City	February 11 at 7:30 pm	Invitation only, 1,350
Super Bowl LVI Music Fest at Crypto.com Arena	February 10-12, 2022	20,000 per day
Super Bowl LVI Sunday at SoFi Stadium	February 13, 2022	70,000 -100,000

The NFL is working with the various venues and local EMS provider agencies to ensure onsite medical aid stations are operational and transportation resources are readily available. Hospitals in the

surrounding areas should anticipate the potential for an increase in emergency department visits and staff accordingly. Additionally, please ensure that hospital staff utilize the private ambulance companies for interfacility transfers and avoid calling 9-1-1. This will allow emergency ambulances to remain available to respond to 9-1-1 calls.

Should an unanticipated incident occur at any of the venues that results in a large number of patient transports, the Medical Alert Center (MAC) will conduct a ReddiNet® Multi-Casualty Incident (MCI) poll to manage patient destinations to surrounding hospitals. If an MCI is initiated, it is imperative that hospitals complete the MCI poll "Victim List" for patient tracking purposes of all event-related patients, including those who may self-transport.

Please ensure that all affected personnel are informed. If you have any questions or need further information, please contact John Quiroz, Manager Medical Alert Center at (562) 378-1512 or the MAC Supervisor at (562) 941-1037.

CC:kf

Attachment

c: Medical Alert Center Staff
Hospital Association of Southern California

Distribution:

Emergency Department Director, Adventist Health Glendale
Emergency Department Director, Adventist Health White Memorial
Emergency Department Director, Cedars Sinai Medical Center
Emergency Department Director, Cedars Sinai Marina Del Rey Hospital
Emergency Department Director, Children's Hospital of Los Angeles
Emergency Department Director, Community Hospital of Huntington Park
Emergency Department Director, Dignity Health-California Hospital Medical Center
Emergency Department Director, Dignity Health-Glendale Memorial Hospital
Emergency Department Director, East Los Angeles Doctors Hospital
Emergency Department Director, PIH Health-Good Samaritan Hospital
Emergency Department Director, Harbor-UCLA Medical Center
Emergency Department Director, Hollywood Presbyterian Medical Center
Emergency Department Director, Kaiser Foundation Hospital – Los Angeles
Emergency Department Director, Kaiser Foundation Hospital – West Los Angeles
Emergency Department Director, LAC+USC Medical Center
Emergency Department Director, Los Angeles Community Hospital
Emergency Department Director, Martin Luther King Jr. Community Hospital
Emergency Department Director, Memorial Hospital of Gardena
Emergency Department Director, Providence Little Company of Mary MC, Torrance
Emergency Department Director, Ronald Reagan UCLA Medical Center
Emergency Department Director, St. Francis Medical Center
Emergency Department Director, Southern California Hospital at Culver City
Emergency Department Director, Torrance Memorial Medical Center

Paramedic Coordinator, Los Angeles City Fire Department
Paramedic Coordinator, Los Angeles County Fire Department

Prehospital Care Coordinator, Each Base Hospital

Chief Executive Officer/President, Each Private Ambulance Company

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
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FESIA A. DAVENPORT
Chief Executive Officer

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JANICE HAHN
Fourth District

KATHRYN BARGER
Fifth District

February 7, 2022

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

From: Fesia A. Davenport
Chief Executive Officer

MEASURE B ADVISORY BOARD RECOMMENDATIONS FOR SPENDING AVAILABLE UNALLOCATED 2021 MEASURE B FUNDS

On July 11, 2017, the Board of Supervisors (Board) approved a motion by Supervisors Barger and Hahn that directed the Chief Executive Office (CEO) to implement the Measure B Advisory Board (MBAB) to guide the Board on options and/or recommendations for spending unallocated Measure B funds. This is the third annual report to the Board regarding the work completed by the MBAB and recommendations for spending unallocated Measure B funds. In 2020, the MBAB process was suspended due to COVID-19.

BACKGROUND

In November 2002, voters in the County of Los Angeles (County) approved Measure B, which authorized the County to levy a special tax on building improvements to provide funding for the countywide system of trauma centers, emergency medical services, and for bioterrorism response throughout the County.

As directed in the July 11, 2017 Board motion, the MBAB will provide advice to the Board on options and/or recommendations for spending future unallocated Measure B funds. Actual allocation of funding will be solely at the discretion of the Board and contingent upon Board approval.

The MBAB is co-chaired by budget managers from the CEO Health and Mental Health Services Division and the County's Emergency Medical Services Agency (EMS) and includes one member from each of the following entities: Auditor-Controller, Department of Health Services (DHS), Department of Public Health, County of Los Angeles Fire Department, a representative of non-County trauma hospitals, as appointed by the Hospital Association of Southern California, the chair (or delegate) of the Los Angeles County Emergency Medical Services Commission, a surgeon practicing at a trauma hospital in the County as appointed by the Southern California chapter of the American College of Surgeons, and a registered nurse practicing in an emergency department of a designated trauma hospital in the County, as appointed by the California Nurses Association.

Proposals for the Measure B funding are submitted to the MBAB each year from April 1 through July 15 and are reviewed and ranked by the MBAB using a three-level ranking system. Additional information on the Measure B funding process can be found in Attachment I.

MEASURE B PROPOSALS FOR 2021

The MBAB received 39 funding proposals for consideration; however, one proposal was removed prior to the MBAB's review of the proposal submission, based on County Counsel's review and determination that the proposal was for expenditures not authorized for Measure B funding, and five proposals were withdrawn by the proposers, leaving 33 proposals for consideration. Of the 33 proposals submitted, many contained requests for multiple components resulting in the MBAB ranking 52 distinct projects.

The amount of Measure B unallocated funding available to fund these projects totaled approximately $13.0 million. The 52 proposed projects totaling $25,741,641 were considered by the MBAB members and then ranked based on their level of priority. The description of each proposal and their numeric ranking is included in Attachment II.

RECOMMENDATIONS

Based on the evaluation conducted by the MBAB and the $13.0 million of funding available to cover the cost of these requests, the CEO is recommending that the Board approve one-time funding for all proposals receiving a ranking of 1.75 or higher, totaling approximately $12.52 million, as shown on Attachment II. This would fund 28 of the 52 proposed projects. If the Board approves these recommendations, the CEO will work with EMS and the impacted County and non-County entities to implement these initiatives. Unless otherwise instructed by the Board by February 21, 2022, the CEO will work with the EMS and DHS to allocate funding as outlined herein, to the requesting

organizations. Final funding allocations will be approved as part of the Board's regular budget process.

If you have any questions concerning this matter, please contact me or Mason Matthews, Budget and Finance Division, at (213) 974-2395 or mmatthews@ceo.lacounty.gov.

FAD:JMN:MM
MM:EB:cc

Attachments

c: Executive Office, Board of Supervisors
County Counsel
Auditor-Controller
Emergency Medical Services Agency
Fire
Health Services
Public Health
California Nurses Association
Hospital Association of Southern California
Southern California Chapter, American College of Surgeons

ATTACHMENT I

MEASURE B ADVISORY BOARD
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Measure B Funding
Process for Submitting Funding Proposals
2021

Background

Measure B is a special property assessment that was passed by the voters of Los Angeles County on November 5, 2002. This assessment is imposed upon all improvements (buildings) located in Los Angeles County and is added to Los Angeles County property taxes to provide funding for the Countywide System of Trauma Centers, Emergency Medical Services, and Bioterrorism Response.

The use of Measure B funds is restricted to four areas and authorized expenditures must fall within one of these areas:

Trauma Centers	• Maintain all aspects of countywide system of trauma centers. • Expand system of trauma centers to cover all areas of the county. • Provide financial incentives to keep existing trauma centers within the system. • Pay for the costs of trauma centers, including physician and other personnel costs.
Emergency Medical Services	• Coordinate and maintain a countywide system of emergency medical services. • Pay for the costs of emergency medical services, including physician and other personnel costs.
Bioterrorism Response	• Enable stockpiling of safe and appropriate medicines to treat persons affected by a bioterrorism or chemical attack. • Train health care workers and other emergency personnel to deal with the medical needs of those exposed to a bioterrorism or chemical attack. • Provide medical screenings and treatment for exposure to biological or chemical agents in the event of a bioterrorism or chemical attack. • Ensure the availability of mental health services in the event of a terrorist attack.
Administration	• Defray administrative expenses, including payment of salaries and benefits for personnel in the Los Angeles County Department of Health Services and other incidental expenses. • Recover the costs of the special election in 2002. • Recover the reasonable costs incurred by the county in spreading, billing and collecting the special tax.

Submitting a Proposal

Proposals for Measure B funding can be submitted each year from April 15 through July 15 of that year. The proposals will be reviewed prior to the Measure B Advisory Board (MBAB) proposal review meeting,

to insure the proposed expenditures are authorized for Measure B funding. Any proposals for expenditures not authorized for under Measure B will be removed and the submitting entity will be notified of this action.

The MBAB will review and rank all submitted requests for Measure B funding with proposed expenditures that are authorized for Measure B at the MBAB proposal review meeting, typically scheduled in September of each year. If additional time is needed to review and evaluate the requests, another meeting will be scheduled typically later in September or in October of that year.

Below are the steps for submitting a proposal:

1. Complete the Measure B Proposal form and submit it, along with any supporting documents, via mail or email to the Los Angeles County EMS Agency no later than 5:00 pm on July 15 of the year to allow adequate time for the proposals to be reviewed and distributed prior to the first MBAB proposal review meeting. Supporting documents include price quotations for equipment purchases, budget, and pertinent financial statements. Financial statements will be required for funding request to offset the operational loss for providing a specific service (e.g. Trauma Services). The financial statements must clearly show direct expenses incurred and revenue received and expected to be received from all sources (including subsidy and donations) for providing the service. For proposed new services or activities, a detailed budget must accompany the funding request, that includes a list of personnel, equipment, supplies and services costs, and an explanation of how these costs are determined. Additionally, when a request requires the hiring of personnel or incurring other long-term financial obligations (e.g. lease) for future years, the requesting entity must provide supporting documentation demonstrating how they will cover the personnel cost and these obligations if Measure B funding is not available in future years. Every requesting entities must provide a letter from the organization's Department Head/Executive Office approving the proposal submission.

2. Proposers are encouraged to attend the MBAB proposal review meeting(s) to provide a brief overview of their project, limited to two minutes and be available to answer any questions that the members of the MBAB may have related to their proposal. If a second meeting is also scheduled for review of proposals, the proposers are encouraged to also attend this meeting. The first meeting is typically scheduled in September of the year and if another meeting is needed, it will be scheduled typically later in September or in October of that year.

3. After reviewing all eligible proposals, the MBAB members will rank score the projects while the proposers are in attendance. However, the ranking score given by the MBAB does not guarantee approval by the Board of Supervisors.

Evaluating and Rank Ordering of the Proposals

After reviewing all eligible proposals submitted for a given year, the MBAB will rank the proposals using a three-level ranking system. Each qualified proposal will be given a high priority (Score of 3), medium priority (Score of 2), or low priority (Score of 1) score. All MBAB members may vote on any proposals being considered, even if they are affiliated with the requesting entity, or has an interest in or will benefit from a proposal(s), unless it is deemed inappropriate by the MBAB Co-Chairs. The ranking will be done by each MBAB voting member providing a number ranking and an average score will be determined using all voting member rankings for each proposal.

When evaluating/ranking each proposal, the committee may take into consideration the following:

- Consistency with the original intent of Measure B
- Regional or system-wide application and impact
- Improves overall services of trauma, EMS or bioterrorism
- Addresses any major gap in the system to ensure access and health equity
- Feasibility of proposed project, given the available time and resources
- Completeness of proposal

Board Consideration

A memo to the Board of Supervisors providing information on all the eligible proposals that were submitted and reviewed will be written by the Co-Chairs. The Board memo will highlight the amount of unallocated Measure B funding that is available and the rank order score of each proposal. It shall be the Board's sole discretion and decision on what proposals are to be funded, as well as the amount awarded.

Once a proposal is approved by the Board, additional processes may need to be implemented prior to disbursement of the funds. This includes entering into a written agreement with the County outlining the use of the funding and the timeframe for incurring expenses. Typically, any Measure B funds that are awarded should be expended within 12 months of award. All Measure B funding is awarded on a reimbursement basis, with the receiving entity incurring the expense and then submitting the claim or invoice to Los Angeles County - Department of Health Services / Health Services Administration Finance for reimbursement.

If you have any questions regarding submitting a proposal, please contact Kay Fruhwirth, EMS Agency Nursing Director at kfruhwirth@dhs.lacounty.gov or 562-378-1596.

MEASURE B ADVISORY BOARD
PROPOSAL NAME/DESCRIPTION
2021

#	Proposal Name/Description	Funding Request	Ranking
	Requests Recommended for Funding		
1.	Hospital Association of Southern California (HASC) on behalf of the Non-County Trauma Hospitals requests funding to cover trauma program costs associated with operating a trauma center, specifically the cost of physician call coverage. The request is for $6.9 million and is made up of approximately $3,938,834 in Measure B funds for an inter-governmental transfer (IGT) and another $2,961,166 in federal matching funds.	$3,938,834	2.88
2.	Emergency Medical Services Agency requests funding for the Hospital Emergency Response Team (HERT) to cover supplies and training. The HERT is a valuable resource, which provides higher level care to critical trauma and medical patients in the field for situations in which delays getting to the Trauma Center would result in harm to the patient.	$87,185	2.75
3.	Emergency Medical Services Agency requests funding for a Learning Management System and Instructional Design to improve EMS content delivery, distribute standardized learning content and efficiently track learner completion for the over 12,000 EMS personnel throughout Los Angeles County	$228,100	2.63
4.	HASC on behalf of the Non-County Trauma Hospitals requests funding to cover trauma program costs associated with operating a trauma center, specifically the cost to support timely data collection, analysis, and performance improvement-patient safety (PIPS). The request is for $3.9 million and is made up of approximately $2,226,297 in Measure B funds for an IGT and another $1,673,703 in federal matching funds.	$2,226,297	2.38
5.	Los Angeles Fire Department Air Operations requests funding for Phase I implementation of Flight Data Monitoring (FDM). FDM technology integrates flight following tracking with aircraft's onboard systems, which provide real-time location and immediate notification to remote users in the event of aircraft systems warning or failure.	$105,640	2.25
6.	Hawthorne Police Department requests funding to conduct Stop the Bleed training for 250 community members.	$21,000	2.25
7.	PIH Health Whittier Hospital requests funding to replace the base station radio system.	$164,704	2.25
8.	Compton Fire Department requests funding to purchase eight (8) Automated Emergency Defibrillators (AEDs) that are compatible with their monitor/defibrillators would improve the transition of care from basic life support to advanced life support.	$25,110	2.13
9.	Los Angeles County Fire Department requests funding to expand their Assessment Engines, upgrading 44 engines to assessment engines.	$1,734,960	2.13

#	Proposal Name/Description	Funding Request	Ranking
10.	HASC on behalf of the Non-County Trauma Hospitals requests funding to cover trauma program costs associated with operating a trauma center, specifically the cost for up-to-date education for credentialing of trauma center staff that support clinical patient care, data and performance improvement.	$260,000	2.13
11.	Monterey Park Fire Department requests funding to purchase two (2) monitor/defibrillators in order to replace their aging units.	$95,017	2.0
12.	Alhambra Fire Department requests funding to purchase eight (8) monitor/defibrillators in order to be placed on the frontline apparatus and Rescue Ambulances in their city.	$340,000	2.0
13.	Downey Fire Department requests funding to purchase two (2) monitor/defibrillators and accessories in order to be placed on the frontline apparatus and Rescue Ambulances in their city.	$91,563	2.0
14.	South Pasadena Fire Department requests funding to purchase three (3) monitor/defibrillators in order to replace their aging units.	$85,060	2.0
15.	San Gabriel Fire Department requests funding to purchase three (3) monitor/defibrillators in order to be placed on the frontline apparatus and Rescue Ambulances in their city.	$150,360	2.0
16.	Monrovia Fire Department requests funding to purchase two (2) monitor/defibrillators in order to place an additional paramedic assessment unit in service and update an existing unit.	$89,000	2.0
17.	HASC on behalf of the Non-County Trauma Hospitals requests funding to cover the cost of doing Stop the Bleed community outreach.	$520,000	2.0
18.	San Gabriel Fire Department requests funding to upgrade the three (3) monitor/defibrillators with Real BVM, RescueNet Live and Traumatic Brain Injury dashboard.	$13,500	1.88
19.	Long Beach Health and Human Services request funding to lease a warehouse space and do the build out for use a local distribution site to support mass prophylaxis in a bioterrorism event to cover seven (7) months of lease payments.	$764,416	1.88
20.	HASC on behalf of the Non-County Trauma Hospitals requests funding to cover the cost to deliver injury prevention programs within each trauma centers' community.	$260,000	1.88
21.	Torrance Fire Department requests funding to purchase four (4) automated chest compression devices to be placed on the Paramedic Rescue Ambulances and ALS Paramedic Engines in their city.	$79,424	1.75
22.	Torrance Fire Department requests funding to purchase two (2) power load stretcher for the BLS ambulances in their city.	$110,515	1.75
23.	Redondo Beach Fire Department requests funding to purchase three (3) automated chest compression devices to be placed on the fire units in their city.	$69,159	1.75
24.	Culver City Fire Department requests funding to purchase twenty-six (26) automated chest compression devices to be placed on fire units in the cities of Burbank, Monrovia, Montebello, Long Beach, Pasadena, Santa Monica and Culver City.	$683,803	1.75

#	Proposal Name/Description	Funding Request	Ranking
25.	Monterey Park Fire Department requests funding to purchase one (1) automated chest compression devices to be placed on one fire unit in their city.	$15,584	1.75
26.	El Segundo Fire Department requests funding to purchase three (3) automated chest compression devices to be placed on the fire units in their city.	$60,510	1.75
27.	San Marino Fire Department requests funding to purchase one (1) power load stretcher for the Rescue ambulance in their city.	$48,065	1.75
28.	The Regents of the University of California through the David Geffen School of Medicine Department of Emergency Medicine UCLA Center for Prehospital Care requests funding for an instructional designer to collaborate with EMS educators to curate lessons and create innovative, just-in-time online module content.	$253,903	1.75
	Requests Not Recommended for Funding		
29.	Hawthorne Police Department requests funding to create a pilot simulation-based training program focused on improving the delivery of EMS care through the collaboration between law enforcement first responders and EMS transport agencies.	249,550	1.63
30.	Antelope Valley Hospital Trauma Program requests funding to purchase two (2) rapid infusers.	$71,390	1.63
31.	St. Mary Medical Center Trauma Program requests funding to purchase one (1) ultrasound system.	$49,789	1.63
32.	El Segundo Fire Department requests funding to purchase three (3) power load stretcher for the three paramedic transporting rescue ambulances in their city.	$87,475	1.5
33.	San Gabriel Fire Department requests funding to purchase two (2) automated chest compression devices to be placed on the fire units in their city.	$40,199	1.5
34.	Los Angeles Fire Department requests funding to purchase replacement decontamination equipment on their fire apparatus.	$70,351	1.5
35.	HASC on behalf of the Non-County Trauma Hospitals requests funding to cover the cost of cover the cost of educating the public pertaining to trauma centers and trauma systems.	$433,333	1.5
36.	Ronald Reagan UCLA Medical Center Trauma Program requests funding to purchase one (1) ultrasound system.	$93,000	1.5
37.	Torrance Memorial Medical Center requests funding for the construction and development of a Simulation Lab.	$227,755	1.5
38.	Antelope Valley Hospital Medical Center Forensic Services Unit requests funding to offset the cost of services that are not reimbursable such as forensic examinations for physical assault associated with child abuse and domestic violence.	$282,250	1.5
39.	San Gabriel Medical Center Forensic Services Unit requests funding to offset the cost of services that are not reimbursable such as forensic examinations for physical assault associated with child abuse and domestic violence.	$433,200	1.5

#	Proposal Name/Description	Funding Request	Ranking
40.	San Marino Fire Department requests funding to purchase one Combi Tool used to extricate trapped patients during traffic collisions and building collapse.	$13,429	1.38
41.	Redondo Beach Fire Department requests funding to purchase one Utility Terrain Vehicle to deploy to mass gathering/special events.	$46,567	1.38
42.	St. Mary Medical Center Trauma Program requests funding to purchase three (3) rapid infusers.	$50,241	1.38
43.	Los Angeles Fire Department requests funding to purchase four (4) hazmat trailers and nine (9) radiation detectors to replace outdated equipment.	$63,480	1.25
44.	Hawthorne Police Department requests funding to pay a program manager to run the simulation lab and organize simulation training with law enforcement and EMS.	$60,000	1.25
45.	Ronald Reagan UCLA Medical Center Trauma Program requests funding to purchase one (1) rapid infuser to replace outdated equipment.	$45,000	1.25
46.	Department of Health Services Housing for Health requests funding to cover the operational costs of the Sobering Center for one year.	$5,070,000	1.25
47.	Los Angeles Fire Department requests funding to purchase four (4) box trucks to replace the existing decontamination trailers.	$1,000,000	1.0
48.	St. Mary Medical Center Trauma Program requests funding to purchase one (1) set of skin graft handles.	$961	1.0
49.	Torrance Memorial Medical Center requests funding to cover the salary cost for one year of a technician to manage the simulation laboratory.	$105,000	1.0
50.	Torrance Memorial Medical Center requests funding to purchase disposable supplies that would be used in the simulation laboratory.	$10,535	1.0
51.	Antelope Valley Hospital Medical Center Forensic Services Unit requests funding to assist in the development of a database software program and first responder and community training materials.	$6,321	1.0
52.	San Gabriel Medical Center Forensic Services Unit requests funding to develop a database software program and fund a data programmer.	$75,237	1.0

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

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

BYLAWS

Article I. General Commission Description

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

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

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

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

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

Article II. Officers

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

Article III. Election and Replacement of Officers

A. Election of Officers:

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

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

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

B. Replacement of Officers

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

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

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

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

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

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

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

Article IV. <u>Duties of Officers</u>

A. The Chair shall:

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

B. The Vice Chair shall:

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

Article V. Committees

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

A. Standing Committees

1. Provider Agency Advisory Committee

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

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

2. Base Hospital Advisory Committee

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

a. Chaired by an EMS Commissioner.

b. Two or more EMS Commissioners.

c. Two currently employed base hospital prehospital care coordinators from each of the major geographic regions.

   i. Northern Region
   ii. Southern Region
   iii. Western Region
   iv. Eastern Region
   v. County Region

d. One provider agency representative selected by the Provider Agency Advisory Committee.

e. One base hospital medical director selected by the Medical Council.

f. One currently employed MICN selected by the Association of Prehospital Care Coordinators (APCC).

3. Data Advisory Committee

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

a. Chaired by an EMS Commissioner

b. Two or more EMS Commissioners.

c. One base hospital administrator or assistant administrator, or a non-administrator duly authorized to represent a base hospital administrator/assistant administrator selected by the Hospital Association of Southern California (HASC).

d. One public sector paramedic provider representative selected by the Provider Agency Advisory Committee.

e. One public sector paramedic provider representative selected by the Los Angeles County Fire Department.

f. One public sector paramedic provider representative from the Los Angeles Fire Department.

g. One public sector paramedic provider representative from the Long Beach Fire Department.

h. One private sector paramedic provider representative selected by the LACAA.

i. One prehospital care coordinator selected by the Base Hospital Advisory Committee.

j. A trauma program manager and one physician selected by the Trauma Hospital Advisory Committee.

k. One base hospital medical director selected by the Medical Council.

l. One fire chief selected by the LAAFCA.

B. Scope and Responsibilities of Standing Committees

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

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

C. Officers and Composition of Standing Committees

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

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

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

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

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

D. Activity Requirements

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

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

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

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

E. Special Committees

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

   a. The task will be short term.

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

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

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

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

Article VI. Meetings

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

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

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

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

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

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

Article VII. Amendments

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

Adopted by the Commission 7/15/81

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