COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 378-1610 FAX (562) 941-5835
http://ems.dhs.lacounty.gov

DATE: **May 18, 2022**
TIME: **1:00 – 3:00 PM**
LOCATION: **Zoom Video Conference Meeting**

Join Zoom Meeting:
https://us06web.zoom.us/j/85816449796?pwd=OVNCZEdPUkM0blhhckJzTkMxUnFwUT09
Meeting ID: 858 1644 9796
Passcode: 162162

Dial by your location (Use any number)
+1 720 707 2699 US (Denver)
+1 253 215 8782 US (Tacoma)

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 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
EMS Agency Personnel Changes – Richard Tadeo, EMS Director and EMSC Executive Director

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**
   March 16, 2022

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

3. **POLICIES**
   - 3.1 Reference No. 202: Prehospital Care Policy Development and Revision
   - 3.2 Reference No. 521: Stroke Patient Destination

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
- 4.4 EMSC Workplan (Goals/Objectives) for Fiscal Year 2021-22 Annual Report (Attachment)
- 4.5 Bylaws (Attachment)

BUSINESS (NEW)

- 4.6 EMS Lights and Sirens Use (Attachment)
  - NHTSA Lights and Siren Use by Emergency Medical Services (EMS): Above All Do No Harm https://www.ems.gov/pdf/Lights_and_Sirens_Use_by_EMS_May_2017.pdf
- 4.7 Safe Transports (Attachments)
  - NHTSA Working Group Best-Practice Recommendations for the Safe Transportation of Children in Emergency Ground Ambulances https://www.nhtsa.gov/staticfiles/nti/pdf/811677.pdf
- 4.8 EMS Commission Membership: Addition of Substance Use Disorder Representative

V. LEGISLATION

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

2021 EMS Annual Data Report (Attached)

CORRESPONDENCE

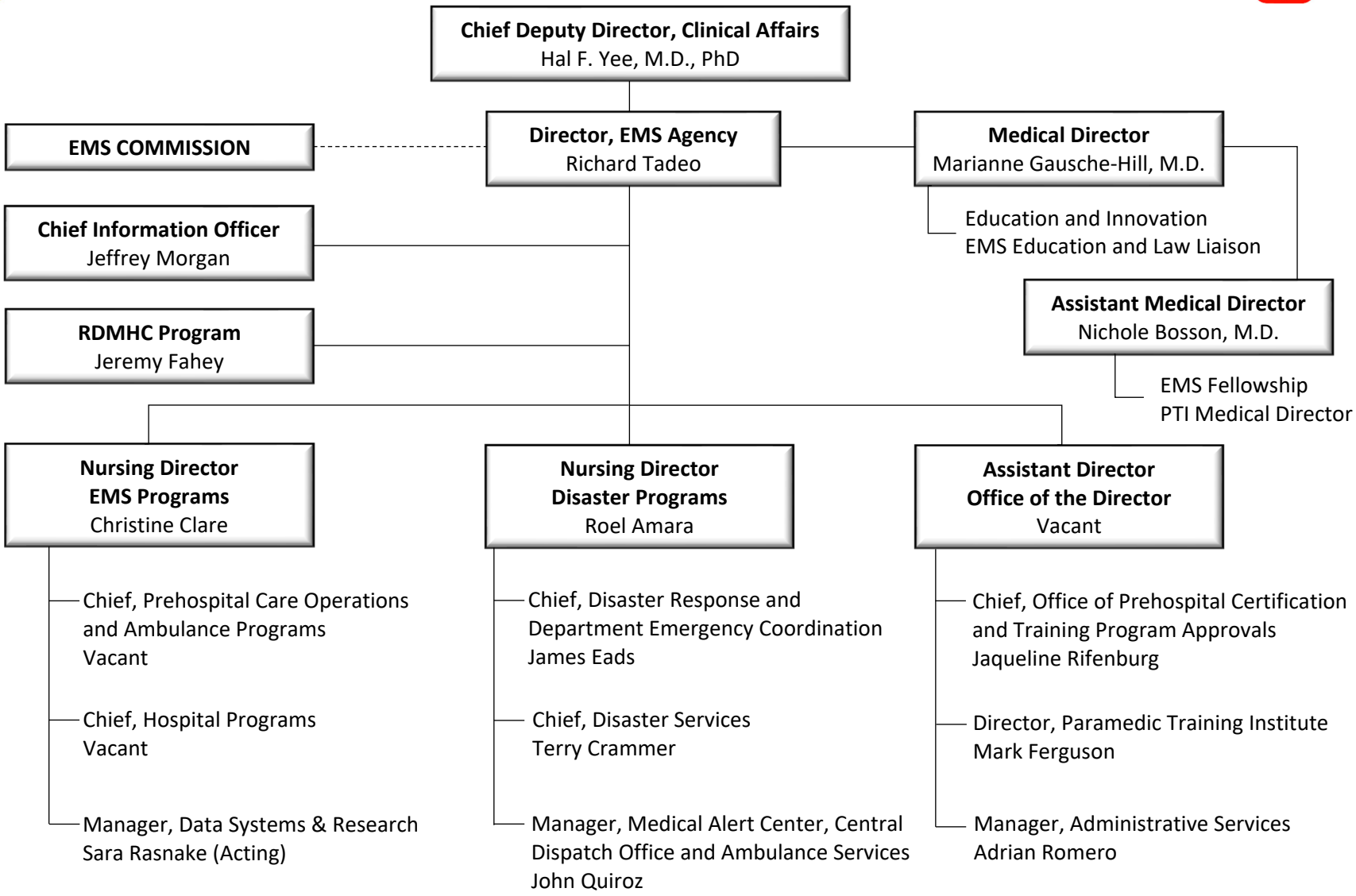
- 6.1 (03-10-2022) Distribution: General Public Ambulance Rates July 1, 2022 Through June 30, 2023
- 6.2 (03-14-2022) Chief Anthony Marrone, LACoFD: Adolescent Patient Destination to Psychiatric Urgent Care Centers (PUCC)
- 6.3 (03-17-2022) Distribution: Designation of Primary Stroke Center – Cedars-Sinai Marina Del Rey Hospital
- 6.4 (03-18-2022) Executive Leadership Team: Appointment of Emergency Medical Services Agency Director
- 6.5 (03-29-2022) Distribution: Reminder – Standard Guidance for First Responders Entering Hospital / Healthcare Facilities
- 6.6 (04-06-2022) Genia Gorin, Eastwestproto, Inc., dba LifeLine Ambulance: Paramedic Provider Program Approval
- 6.7 (04-07-2022) Donald Anderson, Long Beach Fire Department: Paramedic Carts 2 through 5: Approval
- 6.8 (04-12-2022) EMS Agency Staff: Nursing Directors – Roel Amara and Chris Clare
- 6.9 (04-26-2022) Accurate Documentation of Ambulance Patient Offload Time (APOT)
- 6.10 (04-28-2022) Fernando Pelaez, Montebello Fire: Hemostatic Dressing Program Approved

VII. COMMISSIONERS' COMMENTS / REQUESTS

VIII. ADJOURNMENT

To the meeting of July 20, 2022

LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES AGENCY
ORGANIZATIONAL CHART
APRIL 2022



Approved by: Richard Tadeo _____ Approved by: Hal F. Yee, M.D., Ph.D. _____

April 2022 Director, EMS Agency Chief Deputy Director, Clinical Affairs

County of Los Angeles • Department of Health Services

LOS ANGELES COUNTY EMS AGENCY

10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670
(562) 378-1500 ● FAX (562) 941-5835
E-mail: (first initial) (last name)@dhs.lacounty.gov
Website - http://ems.dhs.lacounty.gov

DIRECTOR'S OFFICE

Director	Richard Tadeo	(562) 378-1610
Administrative Support	Vanessa Gonzalez	(562) 378-1607
Medical Director	Marianne Gausche-Hill, M.D.	(562) 378-1600
Assistant Medical Director	Nichole Bosson, M.D.	(562) 378-1602
Director of Education and Innovation	Denise Whitfield, M.D.	(562) 378-1663
EMS Educator and CE Specialist	Millicent Wilson, M.D.	(562) 378-1648
Administrative Assistant	Sidney Harris	(562) 378-1609
Chief, Information Technology	Jeffrey Morgan	(562) 378-1622
Certification & Training Program Approvals		
Chief, Certification & Training Program Approvals	Jacqueline Rifenburg	(562) 378-1640
Civilian Investigator	Robert Orozco	(562) 378-1633
EMS Training Program Approval Manager	David Wells	(562) 378-1638
EMS Training Program Approval Coordinators:	Vacant	(562) 378-1689
	Andrea Solorio	(562) 378-1690
EMS Personnel Certification Manager	Nicholas Todd	(562) 378-1632
EMS Personnel Certification Specialists:		
Paramedic/MICN Accreditation	Lynne An	(562) 378-1637
EMT Certification	Susan Miller	(562) 378-1635
	Amber Yi	(562) 378-1634
Paramedic Training Institute		
Program Director	Mark Ferguson	(562) 378-1571
Medical Director	Dipesh Patel, M.D.	(562) 378-1576
Training Coordinators	Charmaine Kane	(562) 378-1570
	Hannah Deloria	(562) 378-1574
Paramedic Instructors:	Kelsea Mauerhan	(562) 378-1579
	Mariana Munatones	(562) 378-1578
	Steven Robinson	(562) 378-1577
	Sam Calderon	(562) 378-1573
	Vacant	(562) 378-1572

EMS PROGRAMS

Nursing Director	Christine Clare	(562) 378-1661
EMS Commission Liaison/Administrative Support	Denise Watson	(562) 378-1606
Prehospital Care Operations		
Chief, Prehospital Care Operations	Christine Clare (Acting)	(562) 378-1661
Prehospital Program Manager	Natalie Greco	(562) 378-1680
Prehospital Program Coordinators		

ALS Public Providers	Gary Watson	(562) 347-1679
ALS Private Providers	Nwanonenyi Nnabuike	(562) 378-1684
Specialty Care Transport Providers	Christine Zaiser	(562) 378-1678
Ambulance Licensing Manager	Phillip Santos	(562) 378-1674
Civilian Investigators:	Kurt Kunkel	(562) 378-1687
	Vacant	(562) 378-1675
Ambulance Licensing Hearing Board Manager	Susan Mori	(562) 378-1609
Ambulance Program Monitoring Manager	Christopher Rossetti	(562) 378-1688
Contract Program Auditors:	Helain Hence	(562) 378-1693
	Lily Martini	(562) 378-1686
	Gabriela Ramirez	(562) 378-1692
	Ofelia Rodriguez	(562) 378-1691
EMS System Quality Improvement / Pilot Studies	Susan Mori	(562) 378-1609
EMS Dispatch / AED Programs	Gregory Klein	(562) 378-1685

Hospital Programs

Chief, Hospital Programs	Christine Clare (Acting)	(562) 378-1661
Trauma Center / Paramedic Base Hospital / Stroke Center		
Hospital Program Manager	Lorrie Perez	(562) 378-1655
Hospital Program Coordinator (Stroke)	Frederick Bottger	(562) 378-1653
Hospital Program Coordinator (Base)	Laura Leyman	(562) 378-1654
STEMI Receiving Center / Emergency Department Approved for Pediatrics (EDAP) / Pediatric Medical Center (PMC) / Sexual Assault Response Team (SART)		
Hospital Program Manager	Lily Choi	(562) 378-1652
Hospital Program Coordinator	Karen Rodgers	(562) 378-1659

EMS System Data Management

EMS Data Systems Manager	Sara Rasnake (Acting)	(562) 378-1658
EMS Data Coordinators	Sara Rasnake	(562) 378-1658
	Vacant	
Epidemiologist	Shaohua (Sean) Chen	(562) 378-1657
EMS Data Collection Supervisor	Patricia Hollis	(562) 378-1677
ESO Solutions - Technical Support Staff	Eddie Light, Garrett Sarmiento, Thinh (Matthew) Le	
	Trauma One Support (866) 766-9471 Option 3, 3, 4	
	LA TEMIS Support (866) 766-9471 Option 3, 3, 5	

DISASTER PROGRAMS

Nursing Director	Roel Amara	(562) 378-1598
Administrative Support	Olivia Castro	(562) 378-1608

Disaster Services

Chief, Disaster Services	Terry Crammer	(562) 378-1646
Hospital Preparedness Program		
DRC, Hospital and Surge Programs	Christopher Sandoval	(562) 378-1645
Ambulatory Surgical Centers, Home Health and Dialysis	Laurie Lee-Brown	(562) 378-1651
Clinics, Long Term Care and EMS Disaster Workgroup	Jennifer Calderon	(562) 378-1647
Grant Compliance/Audits	Isabel Sanchez	(562) 378-1642
Business Continuity/Training and Exercises	Darren Verrette	(562) 378-1641

Emergent Infectious Disease	Ami Boonjaluksa	(562) 378-1643
Homeland Security Grant Program	Justin Manntai	(562) 378-1650

Disaster Response / Department Emergency Coordination (DEC) Program / MHOAC Program

Chief, Disaster Response	Jim Eads	(562) 378-2445
Mobile Medical System Program Manager	Jerry Crow	(562) 378-2443
Chempack Program Manager	Jerry Crow	(562) 378-2443
DEC Nurse Consultant and Educator	Elaine Forsyth	(562) 378-1505
EMS Fleet	David Lee	(562) 378-2446
Warehouse Supervisor	Robert Smock	(562) 378-2440
DEC/MHOAC Program Manager	Michael Noone	(562) 378-1510
DEC Program Coordinator	John Opalski	(562) 378-1504
Regional Disaster Medical & Health Specialist	Jeremy Fahey	(562) 378-1508
Joint Regional Intelligence Center Liaison	Ralph Torres	(562) 378-1151

Medical Alert Center (MAC) / Ambulance Services / Central Dispatch Office

Program Manager	John Quiroz	(562) 378-1512
MAC Operations Manager	Richard Jurado	(562) 378-1502
Nurse Consultant	Olester Santos	(562) 378-1506
Ambulance Services Operations Manager	Robert Moore	(747) 210-3401
Central Dispatch Office Manager	Mike Jones	(562) 378-1518
QI Coordinator and Educator	James Crabtree	(562) 378-2442

ADMINISTRATIVE SERVICES

Assistant Director	Roel Amara (Acting)	(562) 378-1598

EMS Reimbursement Programs/Contracts & Grants/Personnel/Finance

Administrative Services Manager	Adrian Romero	(562) 378-1595
Fiscal Services Manager	Maria Morales	(532) 378-1591
Building/Property Management Liaison	Tamara Butler	(532) 378-1589
Contracts Manager	Angelica Maldonado	(532) 378-1593
Reimbursement Program Coordinator	Jimmy Duarte	(532) 378-1590
Reimbursement Program Auditor	Lynn Trevino	(562) 378-1509
Ambulance Overflow Invoice Processing	Sheila Prince	(562) 378-1501

INTERIM EXECUTIVE DIRECTOR
Kay Fruhwirth
(562) 378-1604
KFruhwirthr@dhs.lacounty.gov

COMMISSION LIAISON
Denise Watson
(562) 378-1606
DWatson@dhs.lacounty.gov

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

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

MINUTES
March 16, 2022
Zoom Meeting

☐ *Brian S. Bixler	Peace Officers' Assn. of LAC	Kay Fruhwirth	Interim Executive Director
☒ Diego Caivano, M.D.	L.A. County Medical Assn.	Denise Watson	Commission Liaison
☒ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Marianne Gausche-Hill, MD	EMS Medical Director
☒ John Hisserich, Dr.PH	Public Member, 3rd District	Nichole Bosson, MD	EMS Asst. Med Dir
☒ Lydia Lam, M.D.	So. CA Chapter American College of Surgeons	Richard Tadeo	EMS Asst. Director
☒ James Lott, PsyD, MBA	Public Member, 2nd District	Vanessa Gonzalez	EMS Staff
☒ Carol Meyer, RN	Public Member, 4th District	Jacqui Rifenburg	EMS Staff
☐ *Gloria Molleda	League of CA Cities/LA County	Christine Clare	EMS Staff
☒ Robert Ower, RN	LAC Ambulance Association	Karen Rodgers	EMS Staff
☒ Garry Olney, DNP	Hospital Assn. of So. CA	Laura Leyman	EMS Staff
☒ Carl Povilaitis	LA County Police Chiefs' Assn.	Denise Whitfield	EMS Staff
☒ Kenneth Powell	LA Area Fire Chiefs' Assn.	Natalie Greco	EMS Staff
☒ Paul S. Rodriguez	CA State Firefighters' Assn.	Susan Mori	EMS Staff
☒ Jeffrey Rollman	So. CA Public Health Assn.	David Wells	EMS Staff
☐ *Joseph Salas	Public Member, 1st District	Andrea Solorio	EMS Staff
☒ Jason Tarpley, M.D.	American Heart Association	Christine Zaiser	EMS Staff
☒ Carole A, Snyder, RN	Emergency Nurses Assn.	Adrian Romero	EMS Staff
☒ Atilla Uner, M.D., MPH	American College of Emergency Physicians CAL-ACEP	Kelsey Wilhelm	EMS Staff
		Sara Rasnake	EMS Staff
☒ Gary Washburn	Public Member, 5th District	Jennifer Calderon	EMS Staff

GUESTS

Shelly Trites/Torr Memorial	Matthew Pall/Canejo Health	Adena Tessler/HASC	Jenn Nulty/Torr-FD
Andy Reno/Long Beach Fire	Daniel	David Molyneux/West Coast Ambulance	Ethan Forsgren
Joe Nakagawa/Torr Memorial	Laurie Donegan		

(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 1:00 p.m. by Chairman Lydia Lam. A quorum was present with 16 Commissioners on the call.

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

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

Kay Fruhwirth, Interim EMS Agency Director and Interim EMSC Executive Director, did roll call of the Commissioners.

III. CONSENT AGENDA

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

Policies held for discussion:

3.5 Reference No. 706: ALS EMS Aircraft inventory:
Clarification was provided to establish that the policy applies to paramedic staffed air ambulances. If the air ambulance is staffed with critical care trained personnel, the inventory needs to comply with Ref. 713.

3.6 Reference No. 713: Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory:
Clarification was provided to establish policy would allow for Disposable Supraglottic Airway Devices which would include King-LT, i-gel® and laryngeal mask airway.

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

1. MINUTES

January 19, 2022 Minutes were approved.

2. COMMITTEE REPORTS

2.1 Base Hospital Advisory Committee – Dark
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
Dr. Marianne Gausche-Hill, EMS Agency Medical Director, reported behavioral health emergencies will be part of a suite of treatment protocols and medical control guidelines to be the subject of EMS Update 2022 Part II. In addition, there will be scenario-based breakout sessions.

Commissioner Atilla Uner reported the State EMS Commission is looking at behavioral health response protocols and stated that the State Scope of Practice Committee will review all behavioral policies currently in existence to determine best practices.

4.2 Ambulance Patient Offload Time (APOT)

Richard Tadeo, EMS Agency Assistant Director, reported the EMS Agency is still in process of implementing the First Watch product. Los Angeles City Fire (LAFD) and Long Beach Fire (LBFD) are both deployed, and the EMS Agency is working with Verdugo Dispatch. The delay at Verdugo is related to the upgrade of their CAD system. Once the CAD system is upgraded, First Watch will have access and the remaining 13 fire departments from the Foothill areas will also display the ambulances waiting to offload. We are working with South Bay Regional Communications Center but facing some challenges due to their current dispatch series. Once First Watch is fully deployed, the data will also be available for the hospitals to view their dashboard. The App is currently deployed with Care Ambulance, McCormick, AMR, LBFD and LAFD.

A Hospital Status Dashboard from First Watch was displayed, and an explanation of the data was given as it relates to ALS and BLS ambulances from the 9-1-1 system waiting to offload at each hospital. The EMS Agency is scheduling training with First Watch to review the analytics to increase capabilities to include more data in the future.

It was requested that additional columns be added to the display to include the number of patients seen daily or monthly at each hospital, the number of runs each hospital receives within a 24-hour period, and the number of available ER beds to compare the data for like facilities and create more context. While these are good suggestions, more funding is likely needed for additional columns to be added.

The APOT workgroup will meet March 17, 2020, and discussion will include moving towards a standalone APOT/Ambulance Patient Offload Delay (APOD) policy separate from the diversion policies, implementation of hospital-based ambulance offload teams, and how to move forward with best practices. A report will be given at the May Commission meeting.

4.3 LA County COVID Update – EMS Agency

Dr. Gausche-Hill reported on two provider impressions used by EMS to track the COVID-19 outbreak and compared data for Respiratory Distress-Other and medical Cardiac Arrests for the years 2019 through 2022. She also reported on the 9-1-1 hospital admissions from the CHA/CDPH COVID-19 poll. We are seeing downward trending of all COVID-19 infections both in the prehospital phase of care and in decreasing hospital admissions. Workforce issues are less than previous but still are impacting hospitals and include staff getting ill with COVID-19 infection, specifically with the Omicron variant, and having to call off from work.

Blood shortages appear to have stabilized and are not at crisis level at this time. All hospitals have developed strategies to conserve blood and should remain going forward. Chairman Lam reported trauma center strategies included hospital collaborations with other hospitals to ensure they were all okay with blood supplies and educated facilities to only use blood when needed.

BUSINESS (NEW)

4.4 EMSC Workplan (Goals/Objectives) for Fiscal Year 2021-22 Annual Report

The Commission discussed potential goals and objectives including:

- Decrease APOT, monitor APOT and require corrective action plans
- Use of ambulance offload teams within service areas
- Disaster planning (all systems-type disaster training should include how to care for self in future with the goal to look at a broader disaster plan)
- Focus on use of staffing resources specifically sending ambulance personnel out of County to staff strike teams when we have needs in the County. There should be organization from EMS Agency to take care of itself first and Commission can assist. Participate in staff and EMS provider workgroups when asked to send resources
- Increased efficiency in lab and imaging turnaround times in ED is one task for APOT to discuss with hospitals for corrective action plans
- Recommend training program to teach underserved how to become EMTs (Attachment – Alameda EMS Corps)
- Field assessments for mental health issues
- Implementation of the Suicide Risk Screening protocols (pilot study to be implemented)
- Integrate private ambulance providers into the Hospital Preparedness Program (HPP)
- Transportation Safety to include use of lights and sirens as operational and medical treatment indications/contra-indications and adverse effects

Commissioner Jeff Rollman will share information with the Commissioners on a white paper released February 2022 that focused on lights and sirens utilization, as well as two policies instituted in Pennsylvania on transportation safety on lights and sirens and pediatric transportation.

Motion/Second by Commissioners Ower/Meyer to review suggestions presented and have Commissioners evaluate and make committees to move forward was approved and carried unanimously.

4.5 Bylaws Amendments (Attachment)

Ms. Fruhwirth reported on changes required to the Bylaws due to the dissolution of the Data Advisory Commission, as well as clean-up of old outdated information that no longer applies. Amended Bylaws will be shared at the May 18, 2022 meeting.

Motion/Second by Commissioners Ower/Povilaitis to approve the Bylaws Amendments was approved and carried unanimously.

4.6 EMS Commission Representative for Measure B Advisory Board (Vote Required)

EMS Commission representation on the Measure B Advisory Board (MBAB) is the chairman or their designee. Since Chairman Lam currently serves on the MBAB representing Trauma Surgeons, the Commission should nominate a representative to fill the EMS Commission seat on the MBAB.

Motion/Second by Commissioners Rodriguez/Hisserich for Commissioner Carol Meyer to remain the EMS Commission Representative for the MBAB was approved and carried unanimously.

V. LEGISLATION

Ms. Fruhwirth reported on the following legislation:

5.1 AB 2117 – Gipson Bill in relation to the Mobile Stroke Unit – Sponsored by LA County and Board of Supervisors.

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

CORRESPONDENCE

Ms. Fruhwirth reported on correspondence.

6.1 (01-04-2022) David Eisner, MD, Culver City Fire Department: Alternate Destination Pilot Program Approval
Commissioner Kenneth Powell reported Culver City Fire has had five transports to date, but one patient's conditions changed in route and ended up transporting to ER. Pilot started in January 2022. Law enforcement also transports to the same facilities. Bed availability is also a consideration for the facilities, and location of facilities is also an issue.

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

The Los Angeles Marathon will be held March 20, 2022, and the EMS Agency will provide the Mobile Medical System as a first aid station at the finish line, along with providing staff to command post to assist if needed.

Ms. Fruhwirth announced her retirement effective March 30, 2022. The new EMS Agency Director will be announced prior to March 30, 2022, and that person will also be the EMS Commission Executive Director. We will notify the Commission when the new EMS Agency Director is announced.

EMSAAC Conference is June 1-2, 2022 in San Diego. *EMS Rocks and Recovers* is the theme.

Dr. Gausche-Hill reported on EMS Update 2022, implementation of i-gel®, which is a supraglottic device. Dr. Bosson led the pilot efforts and will now be rolled out in LA County for adults and children with the plan that bag-mask ventilation is the first line skill for management respiratory failure; however, i-gel® can be used as an advanced airway by paramedics with specific indications. The plan is to train and implement the skill in LA County and track patients over time through EMS reporting of use and adverse events and all that are now part of the database.

We are participating in a Pedi-Dose trial which is funded by the National Institute of Health, National Institute of Neurologic Disease and Strokes, to evaluate a standardized dose for children based on age for seizures using intranasal or intramuscular dosing of midazolam. There is a steering committee and Pedi-Dose operational team which Dr. Gausche-Hill and Dr. Denise Whitfield are both on. LA County EMS Agency will be required to provide information for the study, and all paramedics have to self-report patients with a provider impression of seizure. This was funded by the National Institutes of Health and approved through IRBs. Exception for informed consent activities is being implemented throughout the County.

Dr. Nichole Bosson, EMS Agency Assistant Medical Director, reported on an EMS Treat & Refer Quality Improvement (QI) Project for patient transports and non-transports that was initiated due to a concern about an increased proportion of non-transported patients during the COVID-19 pandemic.

VII. COMMISSIONERS' COMMENTS / REQUESTS

None.

Public Comment:
Matthew Pall, Managing Director, Conejo Health, requested another seat be added to the EMS Commission Composition to include a nomination from an organization specializing in substance use and addiction.

Ms. Fruhwirth explained that nothing precludes the addition of another seat on the Commission, that nominations come from professional organizations or associations, and that it is at the will of the Commission. This will be added to the May agenda for discussion.

Mr. Pall will email Denise Watson, Commission Liaison, information on organizations and/or associations representing substance use and addiction professionals.

VIII. ADJOURNMENT:

Adjournment by Chairman Lam at 3:15 p.m. to the meeting of May 18, 2022. Zoom meetings will continue following mandates by the State and County until further notice.

Motion/Second by Commissioners Meyer/Ower to adjourn to the meeting of Wednesday, May 18, 2022, was approved and carried unanimously.

Next Meeting: Wednesday, May 18, 2022, 1:00-3:00pm
Join by Zoom Video Conference Call
https://us06web.zoom.us/j/85816449796?pwd=OVNCZEdPUkM0blhhckJzTkMxUnFwUT09

Meeting ID: 858 1644 9796
Passcode: 162162

One tap mobile
+17207072699,85816449796# US (Denver)
+12532158782,85816449796# US (Tacoma)

Dial by your location (Use any number)
+1 720 707 2699 US (Denver)
+1 253 215 8782 US (Tacoma)

Recorded by:
Denise Watson
Secretary, Health Services Commission

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

April 13th, 2022

MEMBERSHIP / ATTENDANCE (VIA Zoom)

	REPRESENTATIVES		EMS AGENCY STAFF
☐	Carol Meyer., Chair	EMS Commission	Dr. Marianne Gausche-Hill
☑	Carole Snyder, RN., Vice Chair	EMS Commission	Dr. Nichole Bosson
☐	Atilla Under, MD, MPH	EMS Commission	Richard Tadeo
☑	Lydia Lam, MD	EMS Commission	Christine Clare
☐	Diego Caivano, MD	EMS Commission	Jacqueline Rifenburg
☐	Erick Cheung, MD	EMS Commission	Natalie Greco
☐	Garry Olney	EMS Commission	Sara Rasnake
☐	Paul Rodriquez	EMS Commission	Susan Mori
☐	Jim Lott	EMS Commission	Lorrie Perez
☑	John Hisserich	EMS Commission	Dr. Denise Whitfield
☑	Brian Bixler	EMS Commission	Christine Zaiser
☑	Robert Ower	EMS Commission	Karen Rodgers
☑	Rachel Caffey	Northern Region	David Wells
☑	Melissa Carter	Northern Region	Andrea Solorio
☑	Charlene Tamparong	Northern Region, Alternate	Laura Leyman
☑	Samantha Verga-Gates	Southern Region	Fritz Bottger
☑	Laurie Donegan	Southern Region	Lily Choi
☐	Shelly Trites	Southern Region	Denise Watson
☑	Christine Farnham	Southern Region, Alternate	**GUESTS**
☑	Ryan Burgess	Western Region	Zach Halpern
☑	Susana Sanchez	Western Region, Alternate	Dr. Clayton Kazan
☐	Erin Munde	Western Region, Alternate	Jaime Akiva
☑	Laurie Sepke	Eastern Region	J. Curry
☑	Alina Candal	Eastern Region	
☑	Jenny Van Slyke	Eastern Region, Alternate	
☑	Lila Mier	County Region	
☑	Emerson Martell	County Region	
☑	Yvonne Elizarraraz	County Region	
☑	Antoinette Salas	County Region	
☑	Shira Schlesinger, MD	Base Hospital Medical Director	
☐	Robert Yang, MD	Base Hospital Medical Director, Alternate	
☑	Alec Miller	Provider Agency Advisory Committee	
☑	Jennifer Nulty	Prov. Agency Advisor Committee, Alternate	
☑	Erica Candelaria, PCC QVH	Pediatric Advisory Committee Representative	
☐	Heidi Ruff, PCC HMN	PED AC Representative, Alternate	
☐	Naomi Leland	MICN Representative	
☐	Jennifer Breeher	MICN Representative, Alternate	

	PREHOSPITAL CARE COORDINATORS		
☑	Melissa Turpin (SMM)	☑ Travis Fisher (CSM)	☑ Katie Bard (CAL)
☑	Jessica Strange (SJS)	☑ Lauren Spina (CSM)	☑ Lorna Mendoza (SFM)
☑	Karyn Robinson (GWT)	☑ Coleen Harkins (AVH)	

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

2. **APPROVAL OF MINUTES**: The meeting minutes for December 8th, 2021, were approved as presented.

3. **INTRODUCTIONS/ANNOUNCEMENTS:**
   - New EMS Agency Director Richard Tadeo was announced.
   - Chris Clare will replace Ricky Tadeo as the Nursing Director, EMS Programs.
   - Roel Amara has been promoted to the Nursing Director, Disaster Programs.
   - Denise Watson, secretary for EMS Commission will be attending BHAC and PAAC.
   - 2022 EMSAAC Conference will be held in San Diego on June 1 & 2, 2022.
   - EMSA will host the STEMI Summit on June 27, 2022 and Stroke Summit on June 28, 2022. The virtual conference is free, offering CME and CE to participants.
   - 'Alert' Status on ReddiNet® has been removed. Hospitals were using the Alert Status to divert ALS providers when hospitals were busy but not on ED diversion. Pomona Valley Hospital will keep the 'Alert' Status as it borders with San Bernardino County which use this status. There will be further discussions and if determined the 'Alert' status is valuable, it will be added to policy and reactivated.
   - Revised EMS Personnel Certification Fees was presented by Jacqui Rifenburg.

4. **REPORTS & UPDATES:**

4.1 <u>EMS Update 2022</u>

Part 1: Airway Management and Introduction to i-gel.
- The final train-the-trainer session will be on April 21, 2022
- Implementation on July 1, 2022.

Part 2: Behavioral Health Policies.
- Training sessions will take place on June 21, 29, 30, and July 7, 2022.
- Implementation on September 1, 2022.

4.2 <u>EmergiPress</u>

Online CE education can be accessed two ways: the APS portal the same portal as EMS Update, or on the EMS website. The most recent EmergiPress edition provides education on Left Mechanical Circulatory Device (LVAD).

4.3 <u>ECMO Pilot</u>

Hospital Status Update- UCLA and Cedars Sinai are open to receive ECMO patients but USC remains closed.
Change to the ECMO Protocol: Prepare the patient for transport after the 2nd defibrillation is performed and mobilize the patient to the ECMO facility after the 3rd defibrillation, if the patient remains in refractory V-fib. Long scene times will preclude the patient from receiving ECMO therapy and positive patient outcomes.

4.4 <u>Data Collaboratives</u>

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

SRC Collaborative:

COVID Impact Projects

- A recent analysis has been provided to the Journal of Prehospital Emergency Care to look at the correlation between EMS response for time-sensitive emergencies and the COVID burden. The manuscript is currently out for peer review. The next step will be to analyze the outcomes within this group.
- A preliminary analysis on the impact of STEMI looking at the time to intervention for STEMI pre and post COVID. Dr. Shavelle is the lead for this study.
- Analysis for out of hospital cardiac arrests (OHCA) before and during COVID. Reports from other systems demonstrated an increase in cardiac arrest, non-shockable rhythms, and poor outcomes. From these results, we are strategizing ways to make a change that will benefit our system.

Other Aspects

- Post Resuscitation Care analysis led by Dr. Toy and Dr. Schlesinger looking at our post-resuscitation care protocols. The analysis demonstrates the association of push dose epinephrine use after ROSC reduces rates of rearrest, but it did not demonstrate the impact of our policy on rearrest rates. Will continue to educate the need to stay and resuscitate the patient on the scene immediately after ROSC to prevent rearrest which occurs 40% of the time.
- Collaboration has begun with a researcher out of the University of Pittsburg for a potential trial in California looking at a bundle of care to prevent rearrest.

Stroke Data Collaborative:

- Looking at the impact of COVID in terms of stroke outcomes and the impact of stroke volume by the facility as we built up the stroke system
- A recent submission to the Journal of Stroke looking at the benefit of routing stroke patients up to 24 hours from LKWT. Directing patients to a Thrombectomy Stroke Center (TSC), or Comprehensive Stroke Center (CSC) with a LAMS Score of 4 or 5 in the late periods is showing improved patient outcomes.

Pediatrics:

- PediDOSE workgroup is moving forward, and we anticipate being one of the earlier participants in the study which may begin in 2023.
- BRUE Studies (Brief, Resolved, Unexplained Events) are ongoing at the participating PMC facilities.
- The EMS Agency, in collaboration with CHLA, plan to examine pediatric outcomes for OHCA.
- National Pediatric Airway Management Trial is an upcoming trial and if funded, the EMS Agency is hoping to participate.

Trauma Consortium:

- Southern California Regional Trauma Consortium is currently focusing on imaging in pregnant patients.
- Dr. Inaba is examining complications from needle thoracostomy and the need for additional education to prevent identified complications.

4.5 Base Data Audits

A base data workgroup was started after the implementation of provider impression, to determine the data fields important for base medical control. Previous base audits were based on the old standards. Moving forward, we are developing specific reports to evaluate data compliance. The new reports will roll out in June at the upcoming base surveys.

4.6 First Watch

The EMS Agency has received funding from the COVID Provider Relief Fund to implement FirstWatch countywide. FirstWatch is an online service that provides real-time data for transporting providers, and providers waiting to offload. The time parameters are hospital arrival time, and end scene time (transfer of patient care). The data reports will be collected from the provider's ePCR at facility equipment time (more accurate) and from the dispatch centers. Providers currently registered with FirstWatch are Care Ambulance, McCormick Ambulance, AMR, Los Angeles Fire Department, Verdugo dispatch, and Long Beach Fire Department.

4.7 Health Data Exchange

The EMS Agency was granted preliminary approval for a multi-year implementation of the Health Data Exchange (HDE). The HDE will give hospitals the ability to recognize the prehospital care record through a bar code and automatically download and append the record to the hospital EMR. In exchange, the patient outcome data would be available to the 9-1-1 EMS providers.

5. OLD BUSINESS:

5.1 None

6. NEW BUSINESS:

Action Needed:

6.1 Ref. No. 202, Prehospital Care Policy Development and Revision-

Approved with recommended changes: Pg. 2, I. D. - add that notification would be provided of policies updated on the EMS website.

M/S/C (Burgess/Bixler)

6.2 Ref. No. 521, Stroke Patient Destination

Approved as presented.

M/S/C (Verga-Gates/Donegan)

Informational Only

6.3 Ref. No. 1210, Cardiac Arrest
6.4 Ref. No. 1210-P, Cardiac Arrest
6.5 Ref. No. 1216-P, Newborn/Neonatal Resuscitation
6.6 Ref. No. 1234, Airway Obstruction
6.7 Ref. No. 1234-P, Airway Obstruction
6.8 Ref. No. 1237, Respiratory Distress
6.9 Ref. No. 1237-P, Respiratory Distress
6.10 Ref. No. 1243, Traumatic Arrest
6.11 Ref. No. 1243-P, Traumatic Arrest
6.12 Ref. No. 1244, Traumatic Injury
6.13 Ref. No. 1244-P, Traumatic Injury
6.14 Ref. No. 1245, Potential COVID-19 Patients
6.15 Ref. No. 1302, MCG: Airway Management and Monitoring

6.16 Ref. No. 1309, MCG: Color Code Drug Doses
6.17 Ref. No. 1317.25, MCG: Midazolam
6.18 Ref. No. 1317.35, MCG: Drug Reference-Oxygen
6.19 Ref. No. 1325, MCG: Mechanical Circulatory Support Devices
6.20 Ref. No. 1350, MCG: Pediatric Patients
6.21 Ref. No. 1373, MCG: Treatment Protocol Quality Improvement Fallout Data Dictionary

7. OPEN DISCUSSION

Jenny Van Slyke: Asked about data collection requirements for offline medical control. This would occur in situations where provider impression does not require base contact, and base contact is made for provider clarification.
Ricky Tadeo: Table for now, pending the rollout of the new base audit reports.

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

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

ACCOUNTABILITY: Laura Leyman

9. ADJOURNMENT: The meeting was adjourned at 3:05 P.M.

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

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, April 20, 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.
☑ Keith Harter	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
☑ Tyler Dixon	Area H, Alt.
☑ Matthew Potter	Area H, Alt. *(Rep to DAC)*
☑ Julian Hernandez	Employed Paramedic Coordinator
☑ Tisha Hamilton	Employed Paramedic Coordinator, Alt.
☐ Rachel Caffey	Prehospital Care Coordinator
☐ Jenny Van Slyke	Prehospital Care Coordinator, Alt.
☑ Andrew Respicio	Public Sector Paramedic 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)	
Richard Tadeo	Marianne Gausche-Hill, MD
Nicole Bosson, MD	Denise Whitfield, MD
Christine Clare	Fritz Bottger
Lily Choi	Natalie Greco
John Quiroz	Laurie Lee-Brown
Laura Leyman	Susan Mori
Lorrie Perez	Sara Rasnake
Jacqueline Rifenburg	Karen Rogers
Phillip Santos	Andrea Solorio
Gary Watson	Denise Watson
David Wells	Christine Zaiser

PUBLIC ATTENDEES (Virtual)	
Roger Yang, MD	Huntington Hospital & Pasadena FD
Edmond St. Cyr	Burbank FD
Jack Ewell	LA County Sheriff's Dept
Jennifer Breeher	Alhambra FD
Andrew Reno	Long Beach FD
Aspen Di-Ilolo	Monterey Park FD
Catherine Borman	Santa Monica FD
Paula LaFarge	LA County FD
Ivan Orloff	Downey FD
Jason Hansen	Pasadena FD
Yun Son Kim	LA County FD
Kristina Crews	LA County FD
Shane Cook	LA County FD
Aaron Hartney	REACH Air
Karen Bustillos	Sierra Madre FD
Richard Oishi	Arcadia FD
Luis Manjarrez	Glendale FD
Kyle Carson	FirstMed Ambulance
Mario Ienni	Monterey Park FD
Ryan Weddle	Monterey Park FD
Tom McClung	REACH Air
Nicholas Amsler	McCormick Ambulance
Michelle Evans	
Jessie Castillo	PRN Ambulance
Paul Perkins	Intersurgical, INC / i-gel Rep

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

2. **INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS**

2.1 EMS Agency Staff Changes *(Richard Tadeo)*

- Chairman Ower introduced Richard Tadeo as the new EMS Agency Director, replacing Cathy Chidester.

- The EMS Agency's revised organizational chart was presented with the following changes:

  - Christine Clare has been promoted to Nursing Director and will oversee the EMS Programs, including Prehospital Care Operations and Ambulance Licensing; Hospital Programs, including the specialty care programs; and Data Systems & Research.
  - Roel Amara has been promoted to Nursing Director and will oversee all Disaster Programs, including Disaster Response and Department Emergency Coordination; Disaster Services; the Medical Alert Center; Grant Services; and the Los Angeles County ambulance services.
  - Jacqueline Rifenburg will continue overseeing Prehospital certifications.
  - Richard Tadeo will continue to oversee the Paramedic Training program while the EMS Agency seeks to fill an Assistance Director position.
  - Denise Watson will continue to be assigned to the EMS Commission as liaison and secretary. Denise will also participate in future Commission subcommittees.

  The revised organizational chart and contact information sheet will be distributed to Committee after this meeting.

2.2 Committee Membership Changes *(Robert Ower)*

The following changes were introduced by Chairman Ower:

- Area B Representative: Keith Harter, Battalion Chief, Los Angeles County Fire Department, replacing Dustin Robertson.
- Area H, Alternate Representative: Tyler Dixon, Assistant Chief, Los Angeles Fire Department, replacing Chief Anthony Hardaway.

2.3 i-gel Purchases & Transition (*Nichole Bosson, MD)*

Providers with questions or seeking instructions regarding the purchasing of the igel product or the exchange of the KING airway, may contact the following person:

Paul Perkins, EMS Account Executive
Intersurgical, Inc
PPerkins@intersurgicalinc.com
(480) 531-3372.

2.4 Alert Status on ReddiNet® *(Chris Clare)*

The "Alert Status" that was added to the ReddiNet system in Los Angeles County, has been removed. Since San Bernardino County continues to use this function, it will continue to be displayed on the ReddiNet system at Pomona Valley Hospital. The EMS Agency will continue to evaluate the need for this function through APOT studies and if found to be necessary, the "Alert Status" function will be added back to ReddiNet and placed into policy.

2.5 Training on Professionalism in EMS *(Marianne Gausche-Hill, MD)*

- The EMS Agency is exploring the possibility of developing training modules that would strengthen the current culture of our EMTs and paramedics as professionals.
- This training would support the EMTs and paramedics in creating a long-lasting and successful career in paramedicine. Without any punitive implications, this would assist in providing an understanding that the actions they take may impact their career and their license. Dr. Gausche-Hill requested feedback on what the various agencies are currently doing [if any] to assist in the promotion of professionalism within their agency. Any provider interested in working with the EMS Agency on the development of this type of education may contact Dr. Gausche-Hill via email at mgausche-hill@dhs.lacounty.gov.

2.6 Mandatory Annual Paramedic Skills *(Marianne Gausche-Hill, MD)*

- The EMS Agency is exploring the possibility of developing training modules to assist with on-going skills maintenance of certain patient care modalities that are infrequently utilized but may have a high impact on patient outcome (ex, needle thoracostomy, intraosseous needle placement, difficult childbirths, pediatric airway skills, transcutaneous pacing and cardioversions).
- The EMS Agency requested feedback from this Committee and participation in a task force that would develop the program. Those interested in this project may contact Dr. Gausche-Hill at the email listed above.

2.7 FirstWatch® – Real Time Data Analysis *(Richard Tadeo)*

- FirstWatch® continues to be implemented. Currently, Long Beach FD and Los Angeles FD are participating in this system, along with the EOA providers. The EMS Agency is continuing to work with Verdugo Dispatch Center to include the 13 jurisdictional fire departments.
- The EMS Agency is seeking continued funding for the costs of the annual subscription for subsequent years.

2.8 Heath Data Exchange *(Richard Tadeo)*

- As described during the August 2021 Committee meeting, Health Data Exchange is an automated process for EMS providers to upload their electronic patient care records directly into the hospitals' electronic medical record. Because of the bidirectional platform, providers agencies would be allowed to access the patient care data for quality improvement purposes. During the August 2021 Committee meeting, it was reported that this project was placed on hold due to the reallocation of funds.
- Most recently, the County of Los Angeles has received additional funding through the American Recovery Act; the EMS Agency has received preliminary approval for partial funding to be directed to this project.
- This will be a multi-year grant project and as funds are allocated to this project, the EMS Agency will resurrect the project and begin conducting meetings with EMS providers and hospitals with the intention to move forward with the project.

3. APPROVAL OF MINUTES (Kazan/Respicio) February 16, 2022 minutes were approved as written.

4. REPORTS & UPDATES

4.1 EMS Data Changes 2022 *(Sara Rasnake)*

The document "Summary of EMS Report Form/Documentation Manual Changes - July 2022" was provided in meeting packet and reviewed. Implementation of these changes will occur on July 1, 2022.

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

Weekly reports for EMS Provider Impressions Related to COVID-19 was reviewed, revealing a continual decline in the number of COVID cases (positive cases, hospitalizations and deaths) in Los Angeles County since January 2022.

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

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

- Part 1 of EMS Update 2022 (igel implementation) is near completion. Final session is scheduled for April 21, 2022.
- The final version of this training session will be emailed out to trainers, which can be uploaded to your learning management systems.

4.3.2 Behavioral Health Emergencies

- Tentative dates for Train-the-Trainer are June 21, 29, 30 and July 7. These will be in-person, afternoon sessions.
- This training module will also include the introduction of Olanzapine for the use in patients who are agitated but cooperative.
- More information will be announced as time gets closer.

4.4 ITAC Update *(Denise Whitfield, MD)*

Previous ITAC meeting was held on February 7, 2022. The following topics were reviewed:

- BVM Select™ – DEFERRED for further discussion once FDA approved.
- XDCuff® (soft restraint device) – Recommended as OPTIONAL USE.
- Prehospital Ultrasound – Would require State approval as paramedic optional scope of practice if a provider is interested. ITAC also recommended PILOT study if provider approval is given.

4.5 EmergiPress *(Denise Whitfield, MD)*

- April 2022 EmergiPress is now available on the EMS Agency's webpage and covers the topic of mechanical circulatory devices / LVADs.
- Providers wanting access to the EmergiPress share folders can contact Dr. Whitfield at the following email dwhitfield@dhs.lacounty.gov

4.6 Data Collaboratives (*Nichole Bosson, MD)*

- STEMI/OHCA Data Collaborative
    - The EMS Agency will be revising and resubmitting a recently submitted transcript which looked at the responses to time-sensitive emergencies, as it relates to the COVID burden

within the Los Angeles County system. Publication is planned to be available within a couple of months.
  - Collaborative group is continuing to review the impact of COVID on out of hospital cardiac arrests (OHCA). Looking at the impact of the rising challenges of certain neighborhoods and groups within our system.
  - Collaborative group also working on a study that look at the impact of our post-ROSC treatment protocols in the prevention of re-arrests (ex, rapid administration of fluids, use of push-dose epinephrine, and staying on scene to stabilize the patient prior to transport). This study will be presented to the Society of Academic Emergency Medicine, as an oral abstract, in May 2022.

- Stroke Data Collaborative

  - Document submitted that looked at the routing of patients, demonstrating a significant number of thrombectomies, even in the late presenting patients (up to 16-24 hours), which supports our current system. Once document is published, it will be sent to the stakeholders.
  - This collaborative also reviewing the impact of our stroke system with the addition of additional stroke centers.

- Pediatric Collaborative Group

  - Collaborative group currently collecting data on OHCA in pediatric patients.
  - There are multiple Pediatric Medical Centers (PMC) working in collaboration with the EMS Agency to review Brief Resolved Unexplained Event (BRUE).
  - A study on PediDOSE, which is based on a fixed age-based dosing for seizures, has begun. Los Angeles County may transition to this system in 2023.

- Trauma Collaborative Group

  There continues to be several ongoing hospital-based studies. However, there are currently no studies related to prehospital.

Dr. Gausche-Hill reminded all providers that our studies rely heavily on the provider's documentation and expressed the importance of accurate and thorough patient care documentation.

4.7 ECMO Pilot *(Nichole Bosson, MD)*

- Currently, there are three receiving hospitals and five provider agencies participating in this study.
- Policies have been revised to emphasize the need for mobilizing rapidly from the scene.
- This pilot is anticipated to continue for one additional year.
- ECMO Study flow chart was provided in Committee packet.

5. UNFINISHED BUSINESS

There was no unfinished business.

6. NEW BUSINESS

The following policies required Action:

6.1 Reference No. 202, Prehospital Care Policy Development and Revision *(Chris Clare)*

Policy reviewed and approved as written.

M/S/C (Zabilski/Tucker) Approve: Reference No. 202, Prehospital Care Policy Development and Revision

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

After lengthy discussion and review, this policy was approved with the following recommendations:

- Page 3, Policy III.:
  - Provide more clarity as to the functions of the EMS personnel vs. the Mobile Stroke Unit (MSU) personnel.
  - Provide more clarity in describing the necessity of a Provider Impression of STRK, regardless of the mLAPSS.

Once the above changes are made, this policy will return to Committee as Information Only.

M/S/C (Kazan/Jorgenson) Approve Reference No. 521, Stroke Patient Destination, with the above recommendations.

The following policies were presented to make aware of the addition of the igel (supraglottic airway) and presented as Information Only and :

6.3 Reference No. 1210, Treatment Protocol: Cardiac Arrest
6.4 Reference No. 1210-P, TP: Cardiac Arrest, Pediatric
6.5 Reference No. 1216-P, TP: Newborn/Neonatal Resuscitation
6.6 Reference No. 1234, TP: Airway Obstruction
6.7 Reference No. 1234-P, TP: Airway Obstruction, Pediatric
6.8 Reference No. 1237, TP: Respiratory Distress
6.9 Reference No. 1237-P, TP: Respiratory Distress, Pediatric
6.10 Reference No. 1243, TP: Traumatic Arrest
6.11 Reference No. 1243-P, TP: Traumatic Arrest, Pediatric
6.12 Reference No. 1244, TP: Traumatic Injury
6.13 Reference No. 1244-P, TP: Traumatic Injury, Pediatric
6.14 Reference No. 1245, TP: Potential COVID-19 Patients
6.15 Reference No. 1302, MCG: Airway Management and Monitoring
6.16 Reference No. 1317.35, MCG: Drug Reference – Oxygen
6.17 Reference No. 1350, MCG: Pediatric Patients
6.18 Reference No. 1373, MCG: Treatment Protocol Quality Improvement Fallout Dictionary
6.19 Reference No. 1309, MCG: Color Code Drug Doses
6.20 Reference No. 1317.25, MCG: Midazolam
6.21 Reference No. 1325, MCG: Mechanical Circulatory Support Devices

7. OPEN DISCUSSION

7.1 Backboards, Inventory PAR Level *(Nichole Bosson, MD)*

With agreement from providers agencies, the EMS Agency will review all inventory lists to determine the possibility of adjusting the PAR levels of units carrying backboards. Feedback can be directed to Dr. Nichole Bosson at nbosson@dhs.lacounty.gov.

7.2 Bag Mask Ventilation Bags *(Nichole Bosson, MD)*

- The EMS Agency has been receiving many questions regarding the BMV mask sizing that was recently modified within the unit inventory lists.
- To assist with these inquiries, the EMS Agency is developing a table that lists manufacturers and their bag sizes which will assist in determining which bags are required to be carried on the provider's units. This table will be distributed once complete.

8. NEXT MEETING: June 22, 2022

9. ADJOURNMENT: Meeting adjourned at 3:08 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PREHOSPITAL CARE POLICY DEVELOPMENT AND REVISION** (EMT, PARAMEDIC, MICN) REFERENCE NO. 202

PURPOSE: To establish procedures by which prehospital care policies are developed, revised and withdrawn.

AUTHORITIES: Health & Safety Code 1797.220
California Code of Regulations, Sections 100148, 100168, 100169, 100170

POLICY:

I. Development of Prehospital Care Policies

A. New Policies

1. The process will be initiated by the EMS Agency following the steps outlined in this policy.

2. Suggestions for new policies or revisions will be considered from any interested agency or individual.

3. EMS Agency staff will develop a first draft with input from internal staff and appropriate external agencies and organizations.

B. Policies with Minor Revisions

1. Prehospital care policies will be reviewed routinely and revised every three years or as needed.

2. If there are no substantive changes, the policy will be re-dated and re-signed.

C. Policies with Major Revisions

1. The EMS Agency Director, or their designee, shall assign draft policy revisions or new policies to appropriate EMSC subcommittees and ad hoc workgroups for review and recommendations. Assignments will be based on application to the committee's mission statement.

2. Simultaneously, the policy will be submitted to other appropriate EMS advisory committees (e.g., Specialty Care Center Advisory Committees) and stakeholder groups for review and comment.

3. In cases where recommendations are contradictory and/or issues are complex, policies may be returned to committee a second time for further review and comment.

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

4. EMS Agency staff will prepare a summary of comments received from the EMSC subcommittees or other advisory groups utilizing Ref. No. 202.2, Summary of Comments. This summary, along with a final draft, and Ref. No. 202.1, Committee Assignment, will be forwarded to the EMSC for final review and recommendations.

5. Following endorsement by the EMSC, the newly developed or revised policy will be submitted to the EMS Agency Director and Medical Director for approval and signature.

D. Distribution of New Policies or Revised Policies with Substantive Changes

1. Once signed, a new or newly revised policy will be posted on the EMS Agency website prior to its effective date.

2. In general, new and revised policies are released on January 1st, April 1st, July 1st, and September 1st. Policies that are time critical may be released earlier than the scheduled release dates.

3. Summary of substantial changes, if applicable, and listing of all policies that are deleted or have changes, will be emailed to stakeholders upon release.

II. Procedure to Withdraw an Outdated Policy

A. The EMS Agency will identify outdated policies during routine review every three years or as needed.

B. A policy may be withdrawn if the situation for which it was written has changed substantially or no longer exists.

C. If there is doubt about whether a policy is still applicable, it will be submitted to the advisory committee appropriate to the subject matter.

D. Review of the EMS Agency's web site is continuous and policies will be removed or replaced as needed to maintain an updated policy manual.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 202.1, **Policy Review - Committee Assignment**
Ref. No. 202.2, **Policy Review - Summary of Comments**

Reference No. 202, Prehospital Care Policy Development and Revision

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	04/20/22	04/20/22	No
	Base Hospital Advisory Committee	4/13/22	4/13/22	Yes
	Data Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

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

REFERENCE NO. 202, Prehospital Care Policy Development and Revision

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy, I.D.	BHAC 4/13/2022	Add 3. “Summary of substantial changes, if applicable, and listing of all policies that are deleted or have changes, will be e-mailed to stakeholders upon release.”	Adopted

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

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

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

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

DEFINITIONS:

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

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

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

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

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

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

Mobile Stroke Unit (MSU): Mobile specialized stroke unit as approved by the LA County EMS Agency and defined in Ref. No. 817, Regional Mobile Response Teams.

PRINCIPLES:

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

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

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

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

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

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

POLICY:

I. Responsibility of the Provider Agency

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

1. No history of seizures or epilepsy

2. Age 40 years or older

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

4. Blood glucose between 60 and 400 mg/dL

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

B. Perform LAMS on ALL patients with suspected stroke

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

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

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

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

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

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

II. Responsibility of the Base Hospital

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

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

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

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

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

III. Destination of Stroke Patients assessed and treated by EMS providers:

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

1. Patients with a LAMS of 3 or less shall be transported to the <u>closest</u> stroke center (PSC, or CSC).

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

IV. Destination of Stroke Patients assessed and treated by a Mobile Stroke Unit (MSU):

A. Ischemic stroke patients with CT imaging demonstrating a large vessel occlusion shall be transported to the closest Level I or II CSC.

B. The following patients shall be transported to the closest Level I CSC:

1. <u>Hemorrhagic Stroke</u>
2. Intraparenchymal or subarachnoid hemorrhage demonstrated on non-contrast CT
3. Subdural or epidural hemorrhage
4. Pathology needing emergency neurosurgical intervention

2. If transport time to the CSC is greater than 30 minutes, the patient shall be transported to the most accessible PSC.

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

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

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

1. Geographic isolation of incident location (e.g., Antelope Valley, Malibu, Gorman, Catalina Island)
2. Immediate availability of air ambulance
3. Accessibility of a fully licensed and permitted helipad at the stroke center
4. Transport capability from helipad to the emergency department of the stroke center

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 322, **Stroke Receiving Center Standards**
Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No, 517, **Regional Mobile Response Teams**
Ref. No. 1200, **Treatment Protocols**
Ref. No. 1251, **Stroke/Acute Neurological Deficits**

Reference No. 521, Stroke Patient Destination

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSC Advisory Committees	Provider Agency Advisory Committee	04/20/22	04/20/22	Y
	Base Hospital Advisory Committee	04/13/22	04/13/22	
	Data Advisory Committee			
Other Committees / Resources	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Pediatric Advisory Committee			
	County Counsel			
	Other:			

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

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

REFERENCE NO. STROKE PATIENT DESTINATION

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy III	PAAC 4/20/22	Break Policy III into two sections to provide clarity: 1. Those assessed and treated by EMS providers 2. Those assessed and treated by a Mobile Stroke Unit	Adopted

EMERGENCY MEDICAL SERVICES COMMISSION (EMSC)

SUGGESTED GOALS/OBJECTIVES FOR 2022

GOAL/OBJECTIVE	PRIORITY (YES/NO)	IF PRIORITY WHO ASSIGNED	POTENTIAL ACTIONS
Work on processes/policies to address and reduce Ambulance Patient Offload Delays (APOD)	Yes	EMSC Ambulance Patient Offload Times (APOT) WorkGroup	1. Implementation and rollout of FirstWatch realtime data on ambulances waiting to offload 2. Develop separate policy addressing APOT and APOD 3. Socialize the CHA APOT Toolkit 4. Identify best practices of hospitals
Continue working on the recommendations from the *Ad Hoc Committee on the Prehospital Care of Mental Health and Substance Abuse Emergencies* specifically address Suicide Risk Protocols			
Evaluate the Alameda EMS Corps program that focuses on increasing the number of underrepresented emergency medical health care professions through youth development, mentorship, job training and sponsorship and determine its applicability to Los Angeles County			

GOAL/OBJECTIVE	PRIORITY (YES/NO)	IF PRIORITY WHO ASSIGNED	POTENTIAL ACTIONS
Evaluate the *Joint Statement on Lights and Siren Vehicle Operations on Emergency Medical Services (EMS) Responses* and determine what actions if any Los Angeles County should adopt			
Develop mechanisms to ensure that during disasters local EMS resources are not deployed outside of the County, if needed, but used locally.		EMS Agency Disaster Services section EMS Provider workgroup	

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY GAVIN NEWSOM, *Governor*

EMERGENCY MEDICAL SERVICES AUTHORITY
10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: March 16, 2022 **ITEM NUMBER: 8A**

SUBJECT: Alameda EMS Corps Presentation

PRESENTER: Michael Gibson
Executive Director, Alameda EMS Corps

CONSENT: ___ ACTION: ___ INFORMATION: _X_

FISCAL IMPACT

The Employment Development Department is requesting $20 million General Fund annually from 2022-23 through 2024-25, totaling $60 million, to launch a program that provides targeted Emergency Medical Technician training.

SUMMARY

The Targeted EMT Training Program targets at-risk youth and those who may have barriers to employment for roles as Emergency Medical Technicians. Trainings will be developed, in partnership with local public health systems and their contracted emergency medical providers, building on the Emergency Medical Services Corps Alameda County model, with replication in 5-10 counties throughout the State.

The program, developed and tested in Alameda County, includes 380 hours of classroom instruction following a pre-course in medical terminology. Students will also participate in 20 hours of direct medical treatment and job shadowing, and receive intensive wrap-around support, including case management, mentoring, life coaching and job readiness. A training stipend of $1,000 a month will allow participants to focus on their training program without part-time or full-time employment.

Funding for this program will additionally support a comprehensive evaluation of the pilot programs to demonstrate results, as well as, coordinated program development, technical assistance, and community of practice.

Local EMS Agencies are central to this program. Labor and Workforce Development Agency is proposing that LEMSAs, or their overarching Public Health Departments, will be the recipients of this operational funding, as they certify all training programs hosted within their jurisdictions.

BACKGROUND

The Alameda EMS Corps Program was originally established in 2017. The purpose of this program is to increase the number of underrepresented Emergency Medical Technicians through youth development and job training. The Alameda County Health Care Services Agency's EMS Corps is a 5-month paid (stipend) program for young people between the ages of 18 to 26. Participants receive Emergency Medical Technician (EMT) training and life coaching, and additionally participate in community service events.

Over the past decade, the Alameda EMS Corps Program has graduated 19 cohorts and boasts 250 total graduates with over 200 currently working in the field as EMS Personnel. Since piloting in 2017, the program has achieved a 100% passing sate on the National Registry Exam – well above the national average.

The Alameda EMS Corps Vision Statement is as follows:
To be a national model that provides an opportunity for young adults to become competent and successful health care providers.

The Alameda EMS Corps Mission Statement is as follows:
To increase the number of underrepresented emergency medical health care professionals through youth development, mentorship, job training, and sponsorship.

More information on the Alameda EMS Corps can be found on their website at:
https://ems.acgov.org/index.page

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 Chair. 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

Article IV. Duties of Officers

A. The Chair shall:

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

B. The Vice Chair shall:

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

Article V. Committees

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

A. Standing Committees

1. Provider Agency Advisory Committee

   This committee is responsible for all matters regarding prehospital licensure, certification and accreditation, policy development

pertinent to the practice, operation and administration of prehospital care and the educational components associated with the delivery of prehospital care.

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

2. Base Hospital Advisory Committee

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

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

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.

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; 3/16/22

Joint Statement on Lights & Siren Vehicle Operations on Emergency Medical Services (EMS) Responses

February 14, 2022

Douglas F. Kupas, Matt Zavadsky, Brooke Burton, Shawn Baird, Jeff J. Clawson, Chip Decker, Peter Dworsky, Bruce Evans, Dave Finger, Jeffrey M. Goodloe, Brian LaCroix, Gary G. Ludwig, Michael McEvoy, David K. Tan, Kyle L. Thornton, Kevin Smith, Bryan R. Wilson

The National Association of EMS Physicians and the then National Association of State EMS Directors created a position statement on emergency medical vehicle use of lights and siren in 1994 (1). This document updates and replaces this previous statement and is now a joint position statement with the Academy of International Mobile Healthcare Integration, American Ambulance Association, American College of Emergency Physicians, Center for Patient Safety, International Academies of Emergency Dispatch, International Association of EMS Chiefs, International Association of Fire Chiefs, National Association of EMS Physicians, National Association of Emergency Medical Technicians, National Association of State EMS Officials, National EMS Management Association, National EMS Quality Alliance, National Volunteer Fire Council and Paramedic Chiefs of Canada.

In 2009, there were 1,579 ambulance crash injuries (2), and most EMS vehicle crashes occur when driving with lights and siren (L&S) (3). When compared with other similar-sized vehicles, ambulance crashes are more often at intersections, more often at traffic signals, and more often with multiple injuries, including 84% involving three or more people (4).

From 1996 to 2012, there were 137 civilian fatalities and 228 civilian injuries resulting from fire service vehicle incidents and 64 civilian fatalities and 217 civilian injuries resulting from ambulance incidents. According to the U.S. Fire Administration (USFA), 179 firefighters died as the result of vehicle crashes from 2004 to 2013 (5). The National EMS Memorial Service reports that approximately 97 EMS practitioners were killed in ambulance collisions from 1993 to 2010 in the United States (6).

Traffic-related fatality rates for law enforcement officers, firefighters, and EMS practitioners are estimated to be 2.5 to 4.8 times higher than the national average among all occupations (7). In a recent survey of 675 EMS practitioners, 7.7% reported being involved in an EMS vehicle crash, with 100% of those occurring in clear weather and while using L&S. 80% reported a broadside strike as the type of MVC (8). Additionally, one survey found estimates of approximately four "wake effect" collisions (defined as collisions *caused* by, but not *involving* the L&S operating emergency vehicle) for every crash involving an emergency vehicle (9).

For EMS, the purpose of using L&S is to improve patient outcomes by decreasing the time to care at the scene or to arrival at a hospital for additional care, but only a small percentage of medical emergencies have better outcomes from L&S use. Over a dozen studies show that the average time saved with L&S response or transport ranges from 42 seconds to 3.8 minutes. Alternatively, L&S response increases the chance of an EMS vehicle crash by 50% and almost triples the chance of crash during patient transport (11). Emergency vehicle crashes cause delays to care and injuries to patients, EMS practitioners, and the public. These crashes also increase emergency vehicle resource use through the need for additional vehicle responses, have long-lasting effects on the reputation of an emergency organization, and increases stress and anxiety among emergency services personnel.

Despite these alarming statistics, L&S continue to be used in 74% of EMS responses, and 21.6% of EMS transports, with a wide variation in L&S use among agencies and among census districts in the United States (10).

Although L&S response is currently common to medical calls, few (6.9%) of these result in a potentially lifesaving intervention by emergency practitioners (12). Some agencies have used an evidence-based or quality improvement approach to reduce their use of L&S during responses to medical calls to 20-33%, without any discernable harmful effect on patient outcome. Additionally, many EMS agencies transport very few patients to the hospital with L&S.

Emergency medical dispatch (EMD) protocols have been proven to safely and effectively categorize requests for medical response by types of call and level of medical acuity and urgency. Emergency response agencies have successfully used these EMD categorizations to prioritize the calls that justify a L&S response. Physician medical oversight, formal quality improvement programs, and collaboration with responding emergency services agencies to understand outcomes is essential to effective, safe, consistent, and high-quality EMD.

The sponsoring organizations of this statement believe that the following principles should guide L&S use during emergency vehicle response to medical calls and initiatives to safely decrease the use of L&S when appropriate:

- The primary mission of the EMS system is to provide out-of-hospital health care, saving lives and improving patient outcomes, when possible, while promoting safety and health in communities. In selected time-sensitive medical conditions, the difference in response time with L&S may improve the patient's outcome.
- EMS vehicle operations using L&S pose a significant risk to both EMS practitioners and the public. Therefore, during response to emergencies or transport of patients by EMS, L&S should only be used for situations where the time saved by L&S operations is anticipated to be clinically important to a patient's outcome. They should not be used when returning to station or posting on stand-by assignments.
- Communication centers should use EMD programs developed, maintained, and approved by national standard-setting organizations with structured call triage and call categorization to identify subsets of calls based upon response resources needed and medical urgency of the call. Active physician medical oversight is critical in developing response configurations and modes for these EMD protocols. These programs should be closely monitored by a formal quality assurance (QA) program for accurate use and response outcomes, with such QA programs being in collaboration with the EMS agency physician medical director.
- Responding emergency agencies should use response based EMD categories and other local policies to further identify and operationalize the situations where L&S response or transport are clinically justified. Response agencies should use these dispatch categories to prioritize expected L&S response modes. The EMS agency physician medical director and QA programs must be engaged in developing these agency operational policies/guidelines.
- Emergency response agency leaderships, including physician medical oversight and QA personnel should monitor the rates of use, appropriateness, EMD protocol compliance, and medical outcomes related to L&S use during response and patient transport.

- Emergency response assignments based upon approved protocols should be developed at the local/department/agency level. A thorough community risk assessment, including risk reduction analysis, should be conducted, and used in conjunction with local physician medical oversight to develop and establish safe response policies.
- All emergency vehicle operators should successfully complete a robust initial emergency vehicle driver training program, and all operators should have required regular continuing education on emergency vehicle driving and appropriate L&S use.
- Municipal government leaders should be aware of the increased risk of crashes associated with L&S response to the public, emergency responders, and patients. Service agreements with emergency medical response agencies can mitigate this risk by using tiered response time expectations based upon EMD categorization of calls. Quality care metrics, rather than time metrics, should drive these contract agreements.
- Emergency vehicle crashes and near misses should trigger clinical and operational QA reviews. States and provinces should monitor and report on emergency medical vehicle crashes for better understanding of the use and risks of these warning devices.
- EMS and fire agency leaders should work to understand public perceptions and expectations regarding L&S use. These leaders should work toward improving public education about the risks of L&S use to create safer expectations of the public and government officials.

In most settings, L&S response or transport saves less than a few minutes during an emergency medical response, and there are few time-sensitive medical emergencies where an immediate intervention or treatment in those minutes is lifesaving. These time-sensitive emergencies can usually be identified through utilization of high-quality dispatcher call prioritization using approved EMD protocols. For many medical calls, a prompt response by EMS practitioners without L&S provides high-quality patient care without the risk of L&S-related crashes. EMS care is part of the much broader spectrum of acute health care, and efficiencies in the emergency department, operative, and hospital phases of care can compensate for any minutes lost with non-L&S response or transport.

Sponsoring Organizations and Representatives:

Academy of International Mobile Healthcare Integration
American Ambulance Association
American College of Emergency Physicians
Center for Patient Safety
International Academies of Emergency Dispatch
International Association of EMS Chiefs
International Association of Fire Chiefs
National Association of EMS Physicians
National Association of Emergency Medical Technicians
National Association of State EMS Officials
National EMS Management Association
National EMS Quality Alliance
National Volunteer Fire Council
Paramedic Chiefs of Canada

References:

1. Use of warning lights and siren in emergency medical vehicle response and patient transport. *Prehosp and Disaster Med*. 1994;9(2):133-136.
2. Grant CC, Merrifield B. Analysis of ambulance crash data. The Fire Protection Research Foundation. 2011. Quincy, MA.
3. Kahn CA, Pirallo RG, Kuhn EM. Characteristics of fatal ambulance crashes in the United States: an 11-year retrospective analysis. *Prehosp Emerg Care*. 2001;5(3):261-269.
4. Ray AF, Kupas DF. Comparison of crashes involving ambulances with those of similar-sized vehicles. *Prehosp Emerg Care*. 2005;9(4):412-415.
5. U.S. Fire Administration. Firefighter fatalities in the United States in 2013. 2014. Emmitsburg, MD.
6. Maguire BJ. Transportation-related injuries and fatalities among emergency medical technicians and paramedics. *Prehosp Disaster Med*. 2011;26(5): 346-352.
7. Maguire BJ, Hunting KL, Smith GS, Levick NR. Occupational fatalities in emergency medical services: A hidden crisis. *Ann Emerg Med*, 2002;40: 625-632.
8. Drucker C, Gerberich SG, Manser MP, Alexander BH, Church TR, Ryan AD, Becic E. Factors associated with civilian drivers involved in crashes with emergency vehicles. *Accident Analysis & Prevention*. 2013; 55:116-23.
9. Clawson JJ, Martin RL, Cady GA, Maio RF. The wake effect: emergency vehicle-related collisions. *Prehosp Disaster Med*. 1997; 12 (4):274-277.
10. Kupas DF. Lights and siren use by emergency medical services: Above all, do no harm. National Highway Traffic Safety Administration. 2017. Available online at https://www.ems.gov/pdf/Lights_and_Sirens_Use_by_EMS_May_2017.pdf
11. Watanabe BL, Patterson GS, Kempema JM, Magailanes O, Brown LH. Is use of warning lights and sirens associated with increased risk of ambulance crashes? A contemporary analysis using national EMS information system (NEMSIS) data. *Ann Emerg Med*. 2019;74(1):101-109.
12. Jarvis JL, Hamilton V, Taigman M, Brown LH. Using red lights and sirens for emergency ambulance response: How often are potentially life-saving interventions performed? *Prehosp Emerg Care*. 2021; 25(4): 549-555.

EMS VEHICLE OPERATIONS/SAFETY
STATEWIDE BLS PROTOCOL

Criteria:

A. All EMS operations, including incident responses and patient transports. [1]

System Requirements:

A. EMS agencies may use this protocol to fulfill the agency's requirement for a policy regarding the management of personnel safety and the safe operation of EMS vehicles as required by EMSS Act regulation 28 Pa. Code § 1027.3 (p).

Policy:

A. Use of lights and other warning devices:

1. **[EMS System Act regulation 28 Pa. Code § 1027.3(i)]** EMS vehicle may not use emergency lights or audible warning devices, unless they do so in accordance with standards imposed by 75 Pa.C.S. (relating to Vehicle Code) and are transporting or responding to a call involving a patient who presents or is in good faith perceived to present a combination of circumstances resulting in a need for immediate medical intervention. When transporting the patient, the need for immediate medical intervention must be beyond the capabilities of the ambulance crew using available supplies and equipment.
2. The use of L&S during response or transport should not be confused with whether a patient had an emergency condition requiring urgent assessment, treatment, or transport by EMS providers. Many patients that require emergency assessment, treatment, and transport may be appropriately and safety cared for by EMS personnel without the use of a L&S response or transport.

B. Response to incident:

1. The EMSVO is responsible for the mode of response to the scene based upon information available at dispatch. If the PSAP or dispatch center provides a response category based upon EMD criteria, EMS vehicles shall respond with L&S only when the dispatch category is consistent with a L&S response. [2] Response mode may be altered based upon additional information that is received by the dispatch center while the EMS vehicle is enroute to scene.
2. L & S use is generally NOT appropriate in the following circumstances:
   a. "Stand-bys" at the scene of any fire department-related incident that does not involve active interior structural attack, hazardous materials (see below), known injuries to firefighters or other public safety personnel or the need for immediate deployment of a rehabilitation sector.
   b. Carbon monoxide detector alarm activations without the report of any ill persons at the scene.
   c. Assist to another public safety agency when there is no immediate danger to life or health.
   d. Response to a hospital for immediate interfacility transport.
   e. Response to a medical alarm system activation.
   f. Response to patients who have apparently expired.
   g. EMS agencies should consider whether L&S should be used when responding to emergency requests for EMS at facilities where health care personnel are already available to patients who are not suspected to be in cardiac arrest – for example skilled nursing facilities and medical offices.
   h. EMS agencies should consider whether L&S should be used when responding to MVCs with unknown injuries.
3. Special circumstances may justify L&S use to an emergency incident scene when the emergency vehicle is not transporting a crew for the purposes of caring for a patient:
   a. Transportation of personnel or materials resources considered critical or essential to the management of an emergency incident scene. Transportation of human or materials resources considered critical or essential to the prevention or treatment of acute illness/injury at a medical facility or other location at which such a circumstance may occur (i.e. transportation of an amputated limb, organ retrieval, etc).

C. Patient transport:

1. The EMS provider primarily responsible for patient care during transportation will advise the driver of the appropriate mode of transportation based upon the medical condition of the patient.
2. In most situations, the use of L&S during patient transport is not indicated: [4]
   a. Emergent transport should be used in any situation in which the most highly trained EMS practitioner believes that the patient's condition will be worsened by a delay equivalent to the time that can be gained by emergent transport. Medical command may be used to assist with this decision. The justification for using this criterion should be documented on the patient care report.
   b. Examples of Medical Conditions that May Benefit by L&S Transport
      1) Inability to obtain or maintain a patent airway
      2) Critically unstable patient with impending cardiac arrest.
   c. The vast majority of patient's will not have better medical outcomes by decreasing transport time by the time saved by L&S transport.
   d. The patient's physiologic responses to L&S use (increased tachycardia and blood pressure) may be detrimental to some patient's medical conditions.
   e. When EMS providers are not restrained, the increased risk of EMS vehicle crash while using L&S may increase the risk of injury to EMS providers. The extremely poor prognosis for patients transported with CPR in progress does not justify the use of L&S transport for most patients in cardiac arrest.
   f. **When in doubt,** contact with a medical command may provide additional direction related to whether there is an urgent need to transport with L&S.
3. No emergency warning lights or siren will be used when ALS care is not indicated (for example, ALS cancelled by BLS or ALS released by medical command). [5]
4. Mode of transport for interfacility transfers will be based upon the medical protocol and the directions of the referring physician or medical command physician who provides the orders for patient care during the transport. Generally, interfacility transport patients have been stabilized to a point where the minimal time saved by L&S transport is not of importance to patient outcome.
5. Exceptions to these policies can be made under extraordinary circumstances (e.g., disaster conditions or a back log of high priority calls where the demand for EMS vehicles exceeds available resources). These exceptions should be documented.
6. Systems with field supervisors may consider a policy requiring notification of the supervisor before any L&S transport.

D. Other operational safety considerations:

1. The following procedures should be followed for safe EMS vehicle operations:
   a. Operational Issues:
      1) Daytime running lights or low-beam headlights will always be on (functioning as daytime running lights) while operating EMS vehicles during L&S and non-L&S driving.
      2) L&S should **both** be used when exercising any moving privilege (examples include, proceeding through a red light or stop sign after coming to a complete stop or opposing traffic in an opposing land or one-way street) granted to EMS vehicles that are responding or transporting in an emergency mode.
      3) When traveling in an opposing traffic lane, the maximum speed generally should not exceed 20 m.p.h.
   b. PSAP and Dispatch Centers: EMS systems are encouraged to cooperate with the dispatch centers in developing procedures to "downgrade" the response of incoming units to Non-L&S when initial on-scene units determine that there is no immediate threat to life.
   c. Documentation: The dispatch category (e.g., "code 3", "ALS emergency", etc.) that justifies L&S response should be documented on the patient care report. The justification for using L&S during transport should also be documented on the patient care report (e.g., "gunshot wound to the abdomen", "systolic BP<90", etc.).
   d. Seat Belt and Restraint Use: Seat belts or restraints will be securely fastened to the following individuals when the vehicle is in motion:
      1) All EMS vehicle operators
      2) All patients on stretcher, following manufacturer's recommendation for straps.

3) All non-EMS passengers (cab and patient compartment)
4) All EMS practitioners (when patient care allows)
5) All infants and children - See Safe Transportation of Children in Ground Ambulances Guideline #124.

e. Avoid Distracted EMSVOs
1) Distracted driving is responsible for many MVCs, and EMS agencies should assure that policies reduce the risk of a distracted driving accident.
a) EMSVOs should not view pagers, cell phone screens, text messages, or mobile data terminals or enter data into GPS devices while an EMS vehicle is in motion.
(1) These functions should be the responsibility of another EMS provider when another provider is in the vehicle.
(2) When another EMS vehicle provider is not available, the EMSVO should stop the vehicle before using a cell phone or viewing a pager.
(3) EMS agencies should work with PSAPs and dispatch centers to create policies that reduce distracted driving. For example, radio communication should be used instead of a pager message when communicating a message to an EMS vehicle that is known to be travelling.

f. Sterile Cockpit Operations
1) When responding or transporting with L&S, there should be no communication with the EMSVO that is not specific to the mission or function of driving the vehicle.

Notes:

1. These guidelines are secondary to and do not supersede the Pennsylvania Motor Vehicle Code.
2. Dispatch centers/PSAPs and EMS regions are encouraged to have medically approved EMD protocols that differentiate which emergency situations or conditions are appropriate for L&S responses (for example, "Echo", "code 3", "red", etc…) from a lesser level of response (for example, "Alpha", "Bravo", "Code 2", "Yellow", etc…) based upon medical questions asked by the dispatcher. The dispatch category classification, or determinant that justifies L&S use should be documented on the PCR.
3. Firefighters cross trained as EMS providers who respond in an EMS vehicle to a fire station or fire incident in order to complete a fire apparatus crew are considered an exception to this policy.
4. In most cases (more than 95% - 99% of EMS incidents), EMS providers can perform the initial care required to stabilize the patient's condition to a point where the small amount of time gained by L&S transport will not affect the patient's medical condition or outcome. In previous studies and in most situations, L&S transport generally only decreases transport time by a couple of minutes or less.
5. L &S may be indicated in some situations where ALS is indicated, but not available or cancelled, because the ALS crew cannot rendezvous with the BLS crew prior to transport to the closest appropriate medical facility.

Performance Parameters:

A. Review for correlation between dispatch classification/category and documented mode of response to scene.

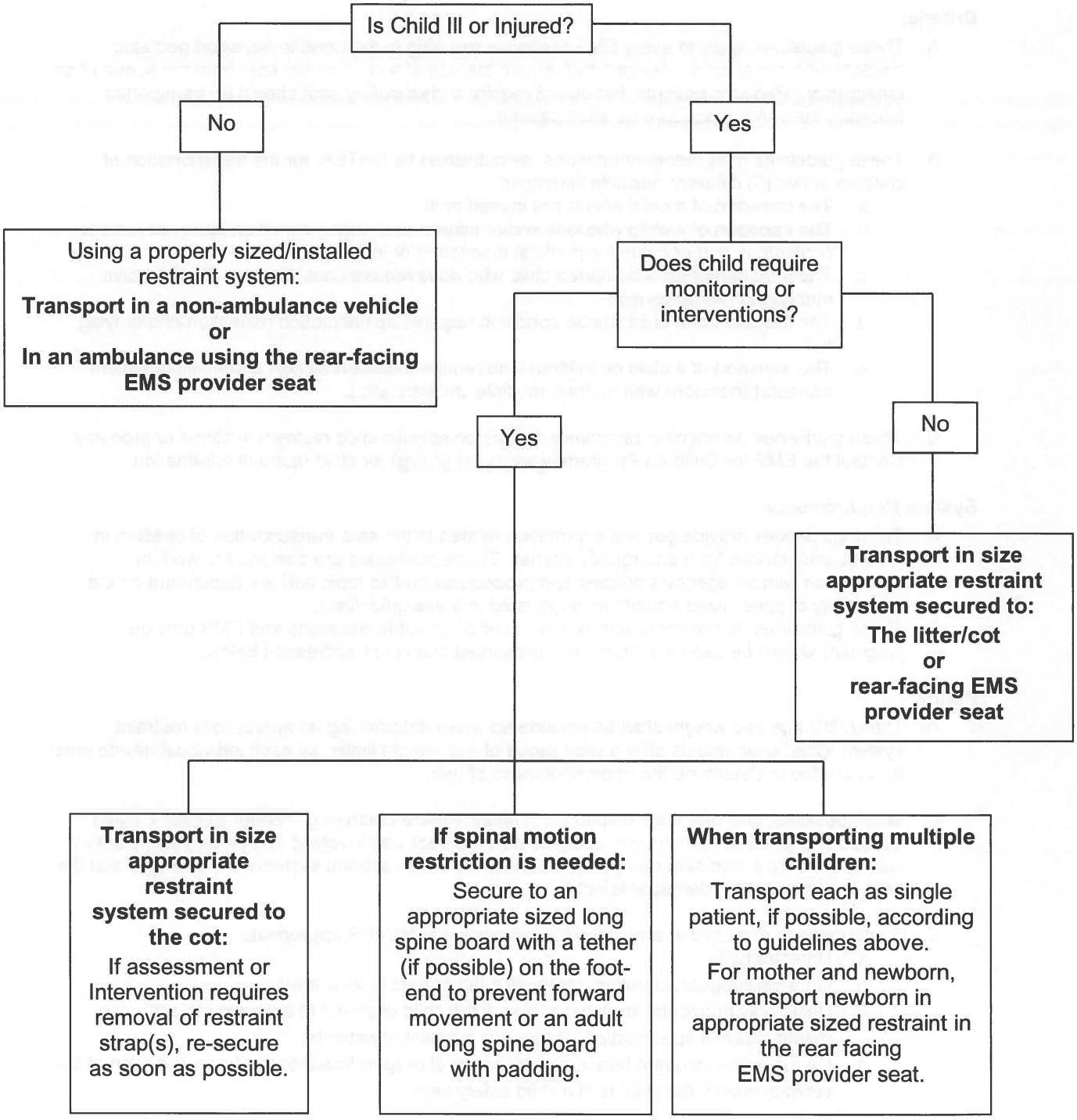
B. Monitor percentage of "911" calls using L&S during response to EMS calls. Routine or scheduled transports should be excluded. [Potential benchmark <50% of responses with L&S].

C. Review for documentation of reason for L&S transport when patient does not meet criteria listed in section C.2.b.(1 & 2).

D. Monitor percentage of urgent/emergent ("911") calls using L&S during transport. [Potential benchmark <1%% of patients transported with L&S]

E. Treat every L&S patient transport as a sentinel event for QI and medical director review.

SAFE TRANSPORTATION OF CHILDREN IN GROUND AMBULANCES
STATEWIDE BLS GUIDELINE



Use of Car Seats:

When possible, and with the exception of a minor vehicle crash (i.e. fender-bender), avoid transporting children in their own safety seats if the seat was involved in a motor vehicle crash. Use of the child's own seat can be considered if no other restraint systems are available and the seat shows no visible damage.

Transport of a child in any of the following ways is NEVER appropriate if:

- Unrestrained
- On parent/guardian's lap or held in their arms
- Using only the horizontal cot straps, if the child doesn't fit according to the manufacturer's specifications
- On the bench seat or a seat perpendicular to the vehicle's motion, i.e. seated sideways, even in a child safety seat

SAFE TRANSPORTATION OF CHILDREN IN GROUND AMBULANCES
STATEWIDE BLS GUIDELINE

Criteria:

A. These guidelines apply to every EMS response resulting in the need to transport pediatric patients who are of an age/weight that require the use of a child safety seat from the scene of an emergency. Pediatric patients that do not require a child safety seat should be transported following the same procedure as adult patients.

B. These guidelines offer recommendations, as published by NHTSA, for the transportation of children in five (5) different possible situations:
   a. The transport of a child who is not injured or ill.
   b. The transport of a child who is ill and/or injured and whose condition *does not* require continuous and/or intensive medical monitoring or intervention.
   c. The transport of an ill or injured child who *does* require continuous and/or intensive monitoring or intervention.
   d. The transport of a child whose condition requires spinal motion restriction and/or lying flat.
   e. The transport of a child or children who require transport as part of a multiple patient transport (newborn with mother, multiple children, etc.).

C. These guidelines do not offer recommendations on specific child restraint systems or products. Contact the EMS for Children Program (www.paemsc.org) for child restraint information.

System Requirements:

A. These guidelines provide general information related to the safe transportation of children in ground ambulances from emergency scenes. These guidelines are designed to work in conjunction with an agency's policies and procedures on this topic and are dependent on the availability of specialized equipment suggested in these guidelines.
B. These guidelines do not comprehensively cover all possible situations and EMS provider judgment should be used if a situation is presented that is not addressed below.

Policy:

A. The child's age and weight shall be considered when determining an appropriate restraint system. Child seat models offer a wide range of age/weight limits, so each individual device must be evaluated to determine the appropriateness of use.

B. When possible, and with the exception of a minor vehicle crash (e.g. "fender-bender"), avoid transporting children in their own safety seats if the seat was involved in a motor vehicle crash. Use of the child's own seat can be considered if no other restraint systems are available and the seat shows no visible damage/defect.

C. Transportation of a child in any of the following ways is NEVER appropriate:
   a. Unrestrained;
   b. On a parent/guardian/other caregiver's lap or held in their arms;
   c. Using only horizontal stretcher straps, if the child does not fit according to cot manufacturer's specifications for proper restraint of patients;
   d. On the multi-occupant bench seat or any seat perpendicular to the forward motion of the vehicle, even if the child is in a child safety seat.

D. Situation Guidelines:

*(*Ideal transport method is in **bold**, with acceptable alternatives listed if ideal is not achievable)*

1. Transport of an uninjured/not ill child
   a. **Transport child in a vehicle other than a ground ambulance using a properly-installed, size-appropriate child restraint system.**
   b. Transport in a size-appropriate child seat properly installed on the rear-facing EMS provider's seat.

c. Consider delaying the transport of the child (ensuring appropriate adult supervision) until additional vehicles are available without compromising other patients on the scene. Consult medical command if necessary.

2. Transport of an ill/injured child *not* requiring continuous intensive medical monitoring or interventions
   a. **Transport child in a size-appropriate child restraint system secured appropriately on the cot.**
   b. Transport child in the EMS provider's seat in a size-appropriate restraint system.
   c. Transport child on the cot using three horizontal straps (chest, waist, knees) and one vertical restraint across each shoulder.

3. Transport of an ill/injured child whose condition requires continuous intensive monitoring or intervention.
   a. **Transport child in a size-appropriate child restraint system secured appropriately to the cot.**
   b. With the child's head at the top of the cot, secure the child to the cot with three horizontal straps and one vertical strap across each shoulder. If assessment/intervention requires the removing of restraint strap(s), restraints should be re-secured as quickly as possible.

4. Transport of an ill/injured child who requires spinal motion restriction or lying flat.
   a. **Secure the child to a size-appropriate spine board (when appropriate) and secure the spine board to the cot, head first, with a tether at the foot (if possible) to prevent forward movement, and with three horizontal restraints (chest, waist, and knees) and a vertical restraint across each shoulder.**
   b. Secure the child to a standard spine board with padding added as needed and secure using the strap configuration listed above.

5. Transport of a child or children requiring transport as part of a multiple patient transport (newborn with mother, multiple children, etc.).
   a. **If possible, for multiple patients, transport each as a single patient according to the guidance provided for situations 1 through 4. For mother and newborn, transport the newborn in an approved size-appropriate restraint system in the rear-facing EMS provider seat with a belt-path that prevents both lateral and forward movement, leaving the cot for the mother.**
   b. Consider the use of additional units to accomplish safe transport, remembering that non-patient children should be transported in non-EMS vehicles, if possible.
   c. When available resources prevent meeting the criteria for situations 1 through 4 for all child patients, transport using space available in a non-emergency mode, exercising extreme caution and driving at a reduced speed.
   d. **Note**: Even with childbirth in the field, it is NEVER appropriate to transport a child held in the parent/guardian/caregiver's arms or on a parent/guardian/caregiver's lap.

E. Reference: Working Group Best-Practice Recommendations for the Safe Transportation of Children in Emergency Ground Ambulances. National Highway Traffic Safety Administration (NHTSA), September 2012, available at www.ems.gov

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

DATA FACTS

LOS ANGELES COUNTY EMS SYSTEM REPORT

MARCH 1, 2022

ISSUE 10

Message from the Director and Medical Director

INSIDE THIS ISSUE:

SPECIAL POINTS OF INTEREST:

- **ED Disposition and Patient Type (page 11)**
- **Injury Severity Scores (pages 14-15)**
- **Paramedic Base Hospital Contact Volume (page 20)**

We are dedicating this 10th year issue of the EMS System Report to Cathy Chidester, EMS Agency Director. Cathy's vision to publish annual system reports came to fruition in July 2012 with the following goals:

Goal 1 – Provide EMS data to our system participants, and in doing so encourage them to recognize the importance of their data in managing our system.

Cathy Chidester
Director

Goal 2 – Highlight data gaps and its impact on our ability when making data driven decisions and the limitations of evaluating the quality of care rendered to our patients.

Goal 3 – Demonstrate how the EMS system design parallels the healthcare needs of the community and addresses the leading causes of death and disability (e.g., heart attack, stroke, and trauma).

These goals have guided the continued improvement and accuracy of our EMS and hospital data in the past 10 years and have supported policy and protocol changes, comprehensive quality improvement projects, publications, and system improvements.

Cathy has provided the vision, collaboration and leadership for the County that saved many lives during the COVID-19 pandemic, and has been recognized over the past 31 years for her superior leadership, and advocacy for the care of the prehospital patients in Los Angeles County, and the State of California.

We extend our best wishes for a healthy and prosperous retirement.

There have been many projects and programs implemented that I am very proud of during my time as the Director of the EMS Agency. Our efforts in the development of new data systems, transitioning to electronic patient care records, ensuring data accuracy, and utilizing our data for quality improvement, system monitoring, responsiveness and research is one of the most important and my favorite endeavor.

Dr. Marianne Gausche-Hill
Medical Director

The annual data reports have accomplished our goals and has allowed our constituents and leaders to understand our prehospital medical care and the importance of operating as a system. I am so proud of my part in the development of the EMS system and know that our EMS Agency leadership will continue the necessary work to ensure continued excellence.

- Cathy Chidester -

2021 System Demographics

69 9-1-1 Receiving Hospitals

- 38 EDAP (Emergency Department Approved for Pediatrics)
- 9 Pediatric Medical Centers
- 7 Pediatric Trauma Centers
- 15 Trauma Centers
- 21 Paramedic Base Hospitals
- 36 STEMI Receiving Centers
- 23 Comprehensive Stroke Centers
- 30 Primary Stroke Centers
- 49 Perinatal Centers
- 44 Hospitals with Neonatal Intensive Care Unit
- 13 SART (Sexual Assault Response Team)
- 13 Disaster Resource Centers
- 1 Sobering Center
- 7 Psychiatric Urgent Care Center

EMS Provider Agencies

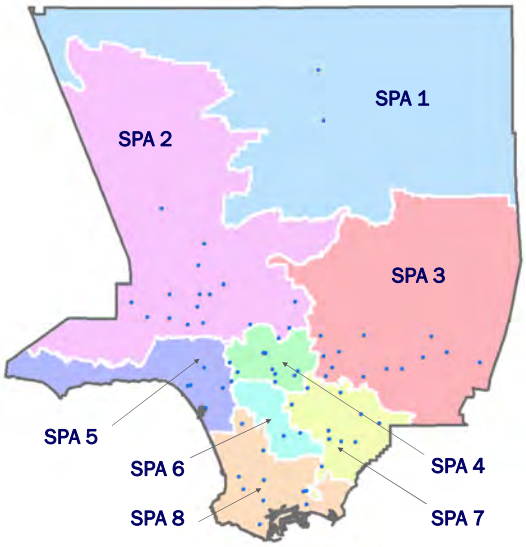
- 31 Public Safety EMS Provider Agencies
- 34 Licensed Basic Life Support Ambulance Operators
- 17 Licensed Advanced Life Support Ambulance Operators
- 20 Licensed Critical Care Transport Ambulance Operators
- 6 Licensed Ambulette Operators

EMS Practitioners

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

ADULT EMS PROVIDER IMPRESSION by Service Planning Area (SPA)

COUNTYWIDE TOP 10 ADULT EMS PROVIDER IMPRESSIONS	2018 No.	2018 %	2019 No.	2019 %	2020 No.	2020 %
Traumatic Injury	118,549	15%	120,909	15%	102,560	13%
Behavioral/Psychiatric	56,752	7%	59,420	7%	58,136	8%
Weakness - General	54,964	7%	54,199	7%	53,409	7%
No Medical Complaint	49,953	6%	48,555	6%	41,110	5%
Body Pain-Non Traumatic	40,645	5%	43,771	5%	36,832	5%
Abdominal Pain	38,206	5%	39,256	5%	35,688	5%
Altered Level of Consciousness	35,373	4%	29,465	4%	24,820	3%
Respiratory Distress	32,120	4%	32,702	4%	34,205	5%
Cold / Flu	16,305	2%	15,766	2%	20,899	3%
Chest Pain - Suspected Cardiac	21,125	3%	21,812	3%	19,320	3%
Total Adult EMS Responses	791,900		801,661		759,972	



	Top 10 Adult EMS Provider Impressions	2018 No.	2018 %	2019 No.	2019 %	2020 No.	2020 %
SPA 1	Traumatic Injury	7,151	14%	9,788	17%	5,932	11%
	Body Pain-Non Traumatic	4,085	8%	4,464	8%	3,492	6%
	Behavioral/Psychiatric	4,062	8%	4,007	7%	3,443	6%
	No Medical Complaint	2,788	5%	2,730	5%	1,940	4%
	Abdominal Pain	3,235	6%	3,201	6%	2,952	5%
	Weakness - General	2,784	5%	2,575	5%	2,688	5%
	Respiratory Distress	1,860	4%	2,179	4%	2,019	4%
	Chest Pain - Suspected Cardiac	1,554	3%	1,767	3%	1,428	3%
	Altered Level of Consciousness	1,857	4%	1,669	3%	1,395	3%
	Seizure	1,485	3%	1,586	3%	1,287	2%
Total SPA 1 Adult EMS Responses		51,368		56,824		54,767	
SPA 2	Traumatic Injury	18,981	14%	18,247	13%	18,243	14%
	Weakness - General	11,077	8%	11,030	8%	11,012	8%
	Behavioral/Psychiatric	9,163	7%	9,707	7%	10,249	8%
	No Medical Complaint	9,131	7%	9,087	7%	8,109	6%
	Altered Level of Consciousness	6,493	5%	6,683	5%	4,921	4%
	Respiratory Distress	6,389	5%	6,620	5%	7,040	5%
	Abdominal Pain	5,584	4%	5,685	4%	6,350	5%
	Body Pain - Non-Traumatic	5,429	4%	5,395	4%	5,154	4%
	Syncope/Near Syncope	4,786	4%	5,054	4%	3,867	3%
	Chest Pain - Suspected Cardiac	3,939	3%	4,043	3%	3,911	3%
Total SPA 2 Adult EMS Responses		135,030		136,833		132,977	
SPA 3	Traumatic Injury	22,151	17%	24,900	19%	18,207	15%
	Behavioral/Psychiatric	9,108	7%	8,975	7%	8,412	7%
	Body Pain - Non-Traumatic	7,932	6%	8,008	6%	6,139	5%
	Weakness - General	8,328	6%	7,594	6%	7,531	6%
	No Medical Complaint	7,398	6%	6,999	5%	5,601	5%
	Abdominal Pain	6,411	5%	6,124	5%	5,382	4%
	Respiratory Distress	5,110	4%	5,461	4%	5,508	4%
	Altered Level of Consciousness	5,515	4%	4,571	3%	3,960	3%
	Syncope/Near Syncope	4,348	3%	4,465	3%	3,322	3%
	Chest Pain - Suspected Cardiac	3,102	2%	3,614	3%	3,198	3%
Total SPA 3 Adult EMS Responses		129,597		131,879		123,464	

	Top 10 Adult EMS Provider Impressions	2018 No.	%	2019 No.	%	2020 No.	%
SPA 4	Traumatic Injury	11,649	12%	10,331	11%	10,951	12%
	Behavioral/Psychiatric	7,098	7%	7,767	8%	7,800	9%
	Weakness - General	7,059	7%	7,373	8%	7,239	8%
	No Medical Complaint	6,343	7%	6,604	7%	6,169	7%
	Abdominal Pain	3,895	4%	4,515	5%	3,915	4%
	Body Pain - Non-Traumatic	3,444	4%	4,073	4%	3,954	4%
	Altered Level of Consciousness	4,653	5%	3,688	4%	3,275	4%
	Respiratory Distress	3,401	4%	3,423	4%	4,399	5%
	Seizure	2,835	3%	2,989	3%	2,478	3%
	Overdose/Poisoning	2,308	2%	2,920	3%	3,315	4%
Total SPA 4 Adult EMS Responses		95,524		95,477		91,353	

SPA 5	Traumatic Injury	10,797	18%	9,190	16%	8,179	17%
	No Medical Complaint	4,977	8%	4,074	7%	3,413	7%
	Weakness - General	4,185	7%	3,995	7%	3,352	7%
	Behavioral/Psychiatric	3,933	7%	3,981	7%	4,014	8%
	Syncope/Near Syncope	2,582	4%	2,498	4%	1,537	3%
	Abdominal Pain	2,011	3%	2,252	4%	1,858	4%
	Body Pain - Non-Traumatic	1,698	3%	2,119	4%	1,772	4%
	Altered Level of Consciousness	2,493	4%	1,949	3%	1,769	4%
	Respiratory Distress	1,945	3%	1,944	3%	1,858	4%
	Nausea/Vomiting	1,666	3%	1,684	3%	1,230	3%
Total SPA 5 Adult EMS Responses		59,682		56,379		48,224	

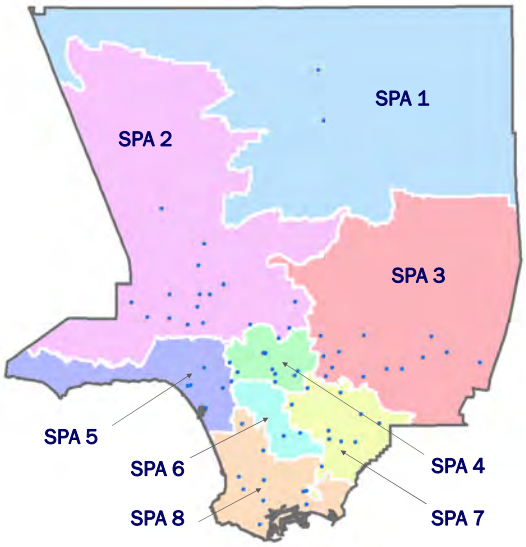
SPA 6	Traumatic Injury	14,742	13%	13,758	12%	13,788	12%
	Behavioral/Psychiatric	8,089	7%	8,892	8%	9,225	8%
	Weakness - General	7,638	7%	8,160	7%	9,046	8%
	Abdominal Pain	6,591	6%	7,143	6%	6,378	6%
	Body Pain - Non-Traumatic	6,585	6%	6,967	6%	6,462	6%
	No Medical Complaint	6,929	6%	6,954	6%	6,803	6%
	Respiratory Distress	5,016	4%	5,158	5%	5,550	5%
	Cold/Flu	3,609	3%	3,707	3%	4,339	4%
	Seizure	3,695	3%	3,950	4%	3,529	3%
	Altered Level of Consciousness	4,395	4%	3,346	3%	2,955	3%
Total SPA 6 Adult EMS Responses		111,500		111,695		112,044	

SPA 7	Traumatic Injury	13,581	15%	14,608	16%	10,740	13%
	Behavioral/Psychiatric	6,458	7%	7,193	8%	6,397	8%
	Body Pain - Non-Traumatic	5,773	7%	6,136	7%	4,519	6%
	Weakness - General	5,853	7%	5,386	6%	5,030	6%
	No Medical Complaint	5,231	6%	5,110	6%	3,340	4%
	Abdominal Pain	4,387	5%	4,194	5%	3,566	4%
	Respiratory Distress	3,276	4%	3,067	3%	3,071	4%
	Altered Level of Consciousness	3,654	4%	2,712	3%	2,343	3%
	Syncope/Near Syncope	2,664	3%	2,554	3%	2,060	3%
	Chest Pain - Suspected Cardiac	2,463	3%	2,526	3%	2,083	3%
Total SPA 7 Adult EMS Responses		88,437		89,297		80,058	

SPA 8	Traumatic Injury	19,497	16%	20,087	16%	16,919	14%
	Behavioral/Psychiatric	8,841	7%	8,898	7%	8,839	7%
	Weakness - General	8,040	7%	8,086	7%	7,696	6%
	No Medical Complaint	7,156	6%	6,997	6%	5,871	5%
	Body Pain - Non-Traumatic	5,699	5%	6,609	5%	5,532	5%
	Abdominal Pain	6,092	5%	6,142	5%	5,433	5%
	Altered Level of Consciousness	6,313	5%	4,847	4%	4,275	4%
	Respiratory Distress	5,123	4%	4,850	4%	4,903	4%
	Syncope/Near Syncope	4,070	3%	3,821	3%	3,010	3%
	Chest Pain - Suspected Cardiac	3,385	3%	3,289	3%	2,930	2%
Total SPA 8 Adult EMS Responses		120,762		123,277		120,090	

PEDIATRIC EMS PROVIDER IMPRESSION by Service Planning Area (SPA)

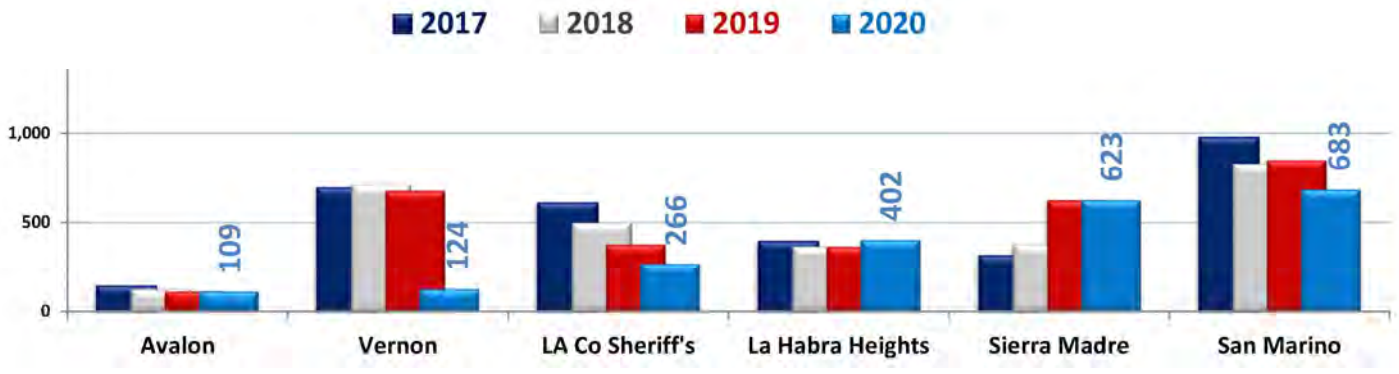
COUNTYWIDE TOP 10 PEDIATRIC EMS PROVIDER IMPRESSIONS	2018 No.	2018 %	2019 No.	2019 %	2020 No.	2020 %
Traumatic Injury	8,440	23%	8,641	23%	5,736	22%
No Medical Complaint	5,150	14%	4,746	13%	3,155	12%
Seizure	4,904	14%	5,609	15%	3,502	14%
Respiratory Distress	1,987	6%	2,140	6%	1,015	4%
Behavioral/Psychiatric	1,894	5%	1,709	5%	1,351	5%
Cold/Flu	1,625	4%	1,789	5%	1,000	4%
Fever	1,399	4%	1,456	4%	1,083	4%
Choking	636	2%	798	2%	824	3%
Allergic Reaction	775	2%	845	2%	661	3%
Weakness - General	679	2%	886	2%	614	2%
Total Pediatric Responses	36,117		36,945		25,675	

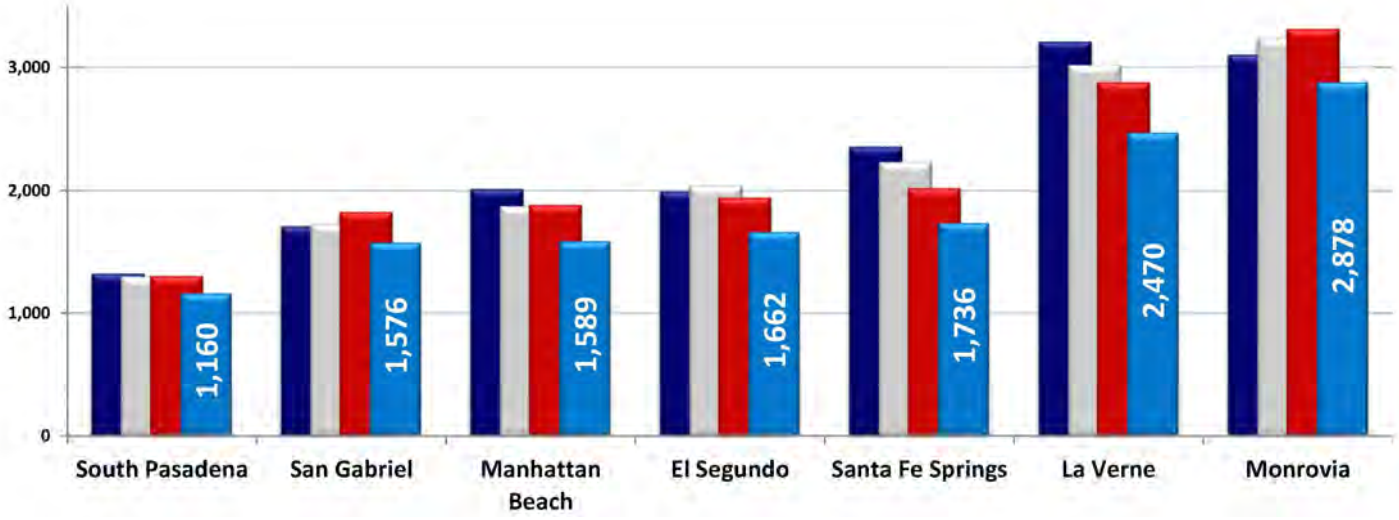


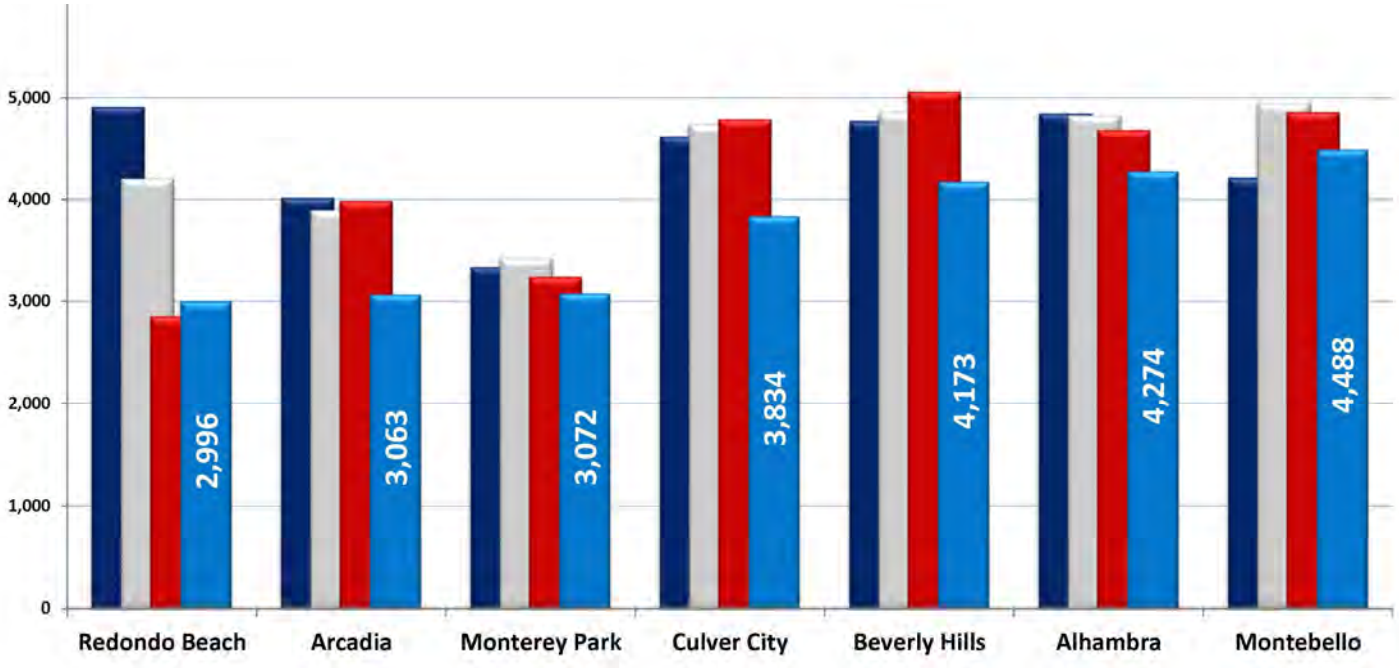
	Top 10 Pediatric EMS Provider Impressions	2018 No.	2018 %	2019 No.	2019 %	2020 No.	2020 %
SPA 1	Traumatic Injury	699	21%	830	24%	534	22%
	No Medical Complaint	531	16%	504	15%	284	12%
	Seizure	420	13%	475	14%	270	11%
	Behavioral/Psychiatric	286	9%	245	7%	155	6%
	Cold/Flu	169	5%	141	4%	119	5%
	Fever	109	3%	119	3%	84	3%
	Respiratory Distress	197	6%	229	7%	106	4%
	Body Pain - Non-Traumatic	132	4%	69	2%	48	2%
	Syncope/Near Syncope	64	2%	83	2%	46	2%
	Choking	42	1%	78	2%	97	4%
Total SPA 1 Pediatric EMS Responses		3,298		3,457		2,425	
SPA 2	Traumatic Injury	926	23%	1,019	19%	844	21%
	Seizure	566	14%	898	17%	620	15%
	No Medical Complaint	469	12%	688	13%	496	12%
	Respiratory Distress	210	5%	348	6%	201	5%
	Cold/Flu	158	4%	307	6%	170	4%
	Fever	167	4%	282	5%	245	6%
	Behavioral/Psychiatric	252	6%	241	4%	210	5%
	Weakness - General	110	3%	181	3%	106	3%
	Allergic Reaction	110	3%	183	3%	139	3%
	Nausea/Vomiting	84	2%	170	3%	101	2%
Total SPA 2 Pediatric EMS Responses		3,967		5,385		4,069	
SPA 3	Traumatic Injury	1,611	25%	1,792	28%	961	24%
	Seizure	865	13%	911	14%	593	15%
	No Medical Complaint	936	14%	737	12%	428	10%
	Respiratory Distress	322	5%	343	5%	122	3%
	Behavioral/Psychiatric	341	5%	179	3%	206	5%
	Fever	209	3%	225	4%	180	4%
	Syncope/Near Syncope	201	3%	203	3%	108	3%
	Cold/Flu	184	3%	179	3%	112	3%
	Choking	130	2%	171	3%	159	4%
	Body Pain - Non-Traumatic	194	3%	131	2%	65	2%
Total SPA 3 Pediatric EMS Responses		6,516		6,333		4,077	

	Top 10 Pediatric EMS Provider Impressions	2018 No.	%	2019 No.	%	2020 No.	%
SPA 4	Traumatic Injury	503	19%	476	18%	361	19%
	Seizure	392	15%	471	17%	284	15%
	No Medical Complaint	399	15%	360	13%	238	13%
	Cold/Flu	162	6%	148	5%	81	4%
	Behavioral/Psychiatric	111	4%	141	5%	100	5%
	Fever	152	6%	102	4%	87	5%
	Respiratory Distress	147	5%	142	5%	57	3%
	Syncope/Near Syncope	71	3%	84	3%	36	2%
	Allergic Reaction	60	2%	78	3%	66	4%
	Weakness - General	71	3%	77	3%	79	4%
Total SPA 4 Pediatric EMS Responses		2,701		2,705		1,860	
SPA 5	Traumatic Injury	643	30%	473	24%	356	27%
	No Medical Complaint	258	12%	209	11%	137	10%
	Seizure	213	10%	192	10%	134	10%
	Sting/Venomus Bites	55	3%	173	9%	168	13%
	Nausea/Vomiting	75	3%	84	4%	32	2%
	Respiratory Distress	139	6%	93	5%	45	3%
	Cold/Flu	84	4%	79	4%	31	2%
	Allergic Reaction	102	5%	76	4%	68	5%
	Syncope/Near Syncope	66	3%	74	4%	27	2%
	Behavioral/Psychiatric	72	3%	61	3%	67	5%
Total SPA 5 Pediatric EMS Responses		2,175		1,941		1,338	
SPA 6	Traumatic Injury	1,350	20%	1,308	20%	1,014	21%
	Seizure	884	13%	1,032	16%	622	13%
	No Medical Complaint	1,001	15%	970	15%	734	15%
	Cold/Flu	497	7%	510	8%	260	5%
	Fever	330	5%	328	5%	210	4%
	Respiratory Distress	422	6%	400	6%	225	5%
	Behavior/Psychiatric	296	4%	310	5%	248	5%
	Weakness -General	151	2%	192	3%	172	4%
	Nausea/Vomiting	198	3%	172	3%	122	3%
	Body Pain - Non-Traumatic	174	3%	148	2%	114	2%
Total SPA 6 Pediatric EMS Responses		6,647		6,649		4,865	
SPA 7	Traumatic Injury	1,153	22%	1,256	24%	722	22%
	Seizure	767	15%	801	16%	512	15%
	No Medical Complaint	817	16%	670	13%	369	11%
	Respiratory Distress	226	4%	291	6%	105	3%
	Behavioral/Psychiatric	256	5%	284	6%	186	6%
	Cold/Flu	174	3%	195	4%	105	3%
	Fever	171	3%	185	4%	112	3%
	Syncope/Near Syncope	178	3%	160	3%	88	3%
	Body Pain - Non-Traumatic	169	3%	154	3%	62	2%
	Choking	91	2%	143	3%	136	4%
Total SPA 7 Pediatric EMS Responses		5,150		5,152		3,339	
SPA 8	Traumatic Injury	1,555	27%	1,487	28%	976	25%
	Seizure	797	14%	829	16%	501	13%
	No Medical Complaint	739	13%	608	11%	488	13%
	Respiratory Distress	324	6%	294	6%	166	4%
	Behavioral/Psychiatric	280	5%	248	5%	190	5%
	Cold/Flu	197	3%	230	4%	131	3%
	Fever	183	3%	168	3%	128	3%
	Syncope/Near Syncope	152	3%	138	3%	96	2%
	Allergic Reaction	122	2%	134	3%	86	2%
	Choking	134	2%	124	2%	161	4%
Total SPA 8 Pediatric EMS Responses		5,663		5,323		3,883	

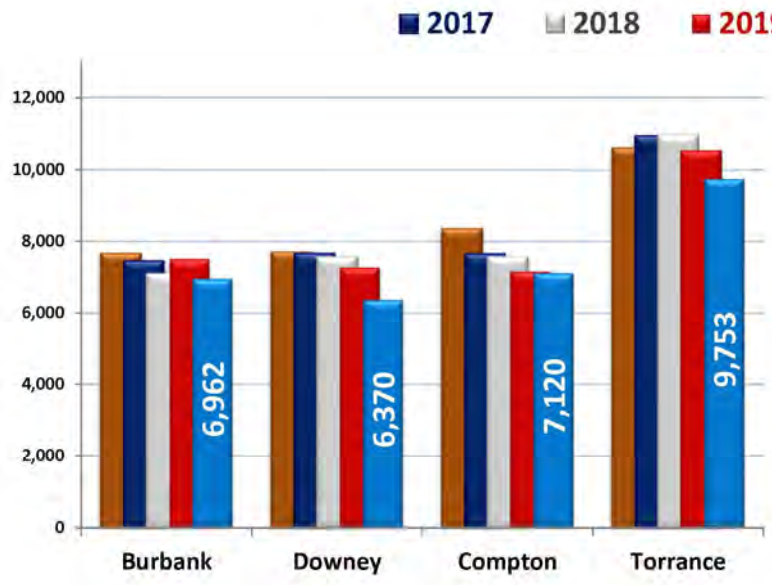
EMS Responses by 9-1-1 Jurisdictional Provider Agency

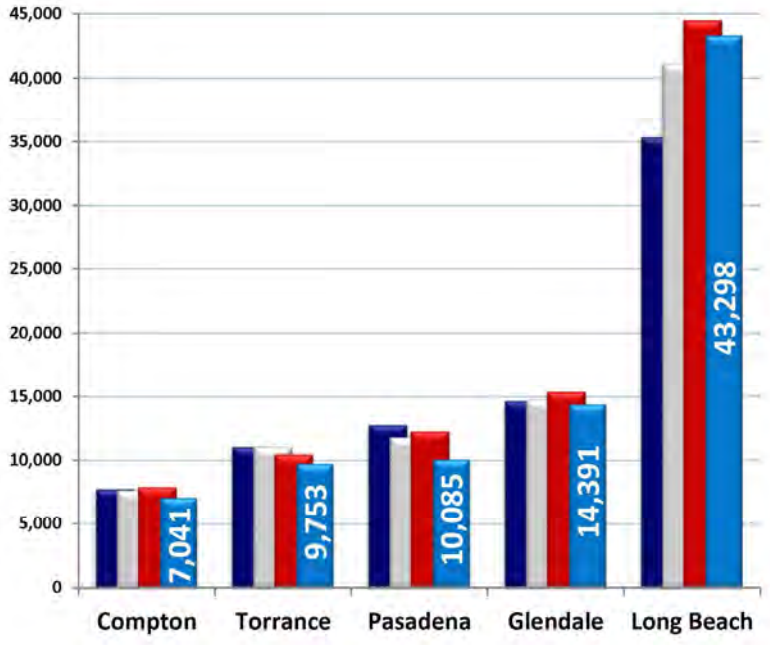


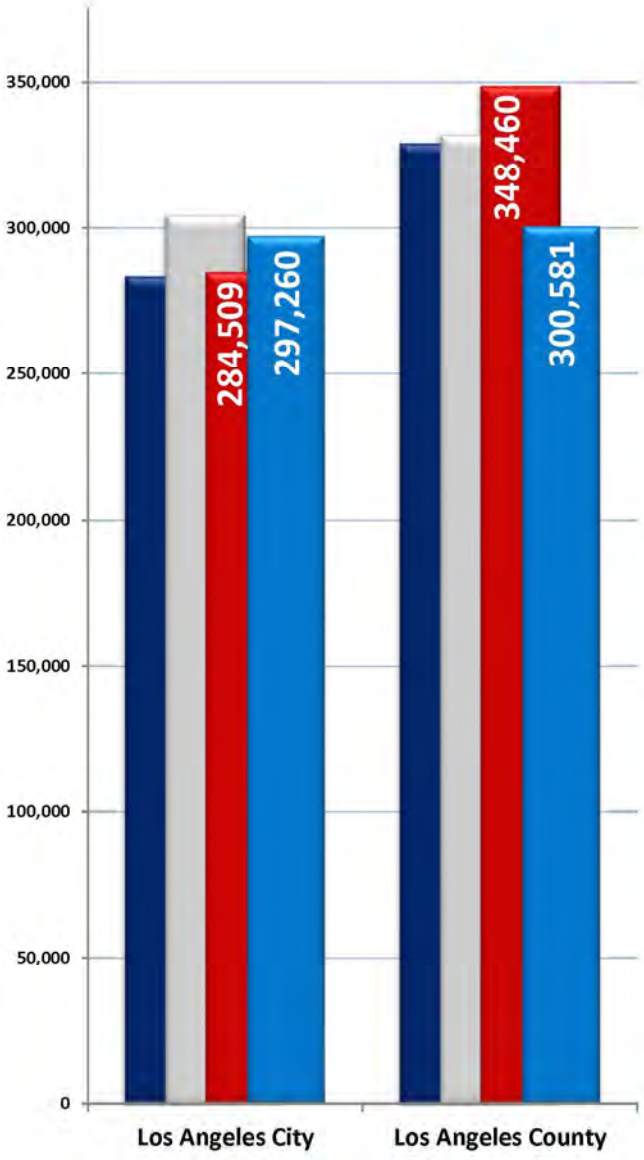


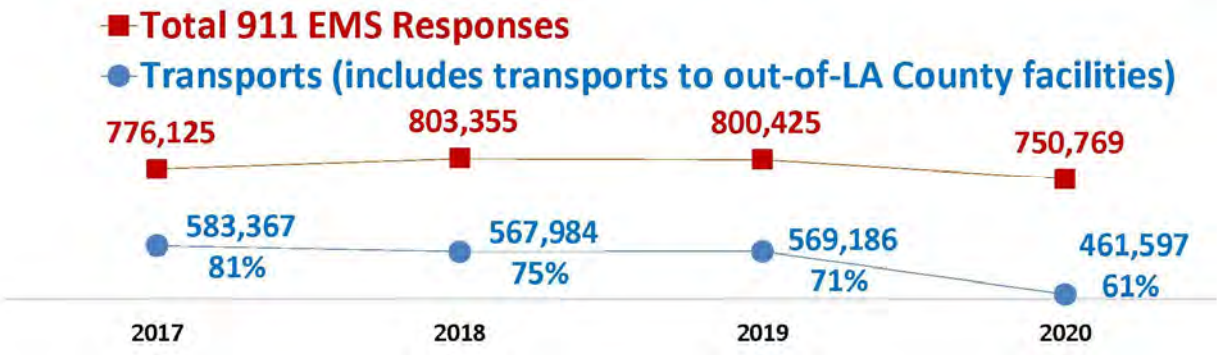


EMS Responses by 9-1-1 Jurisdictional Provider Agency



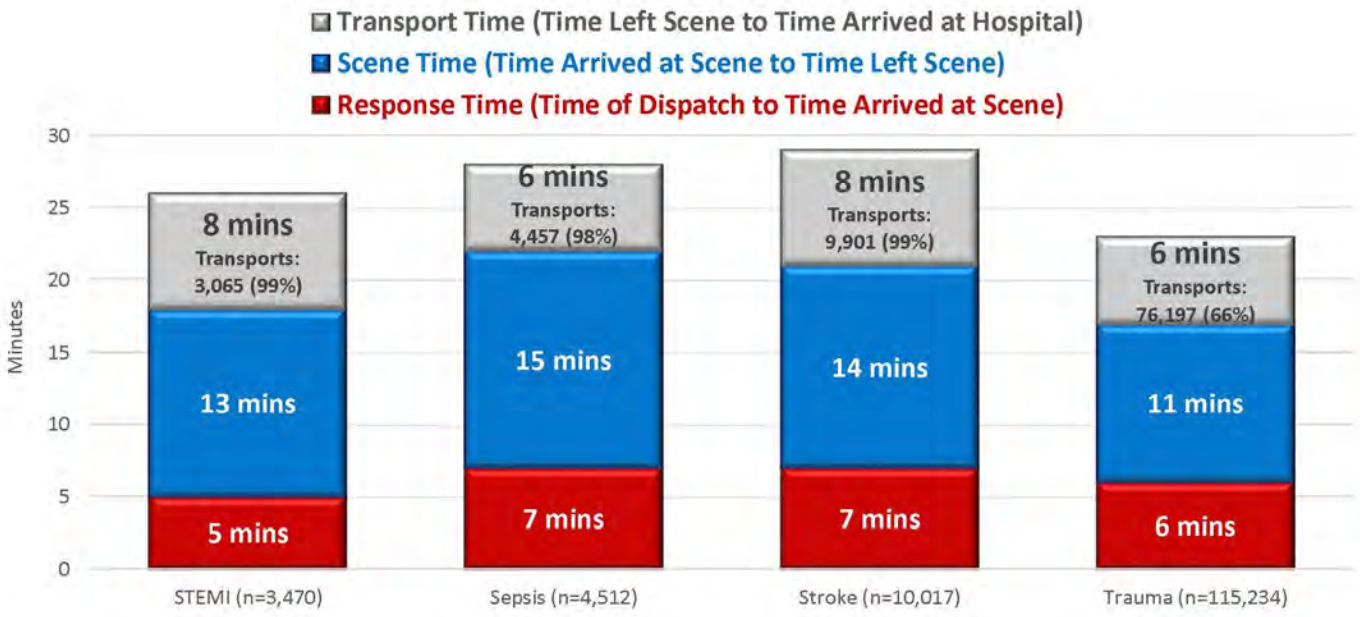






2020 EMS Times: Adult (Median)

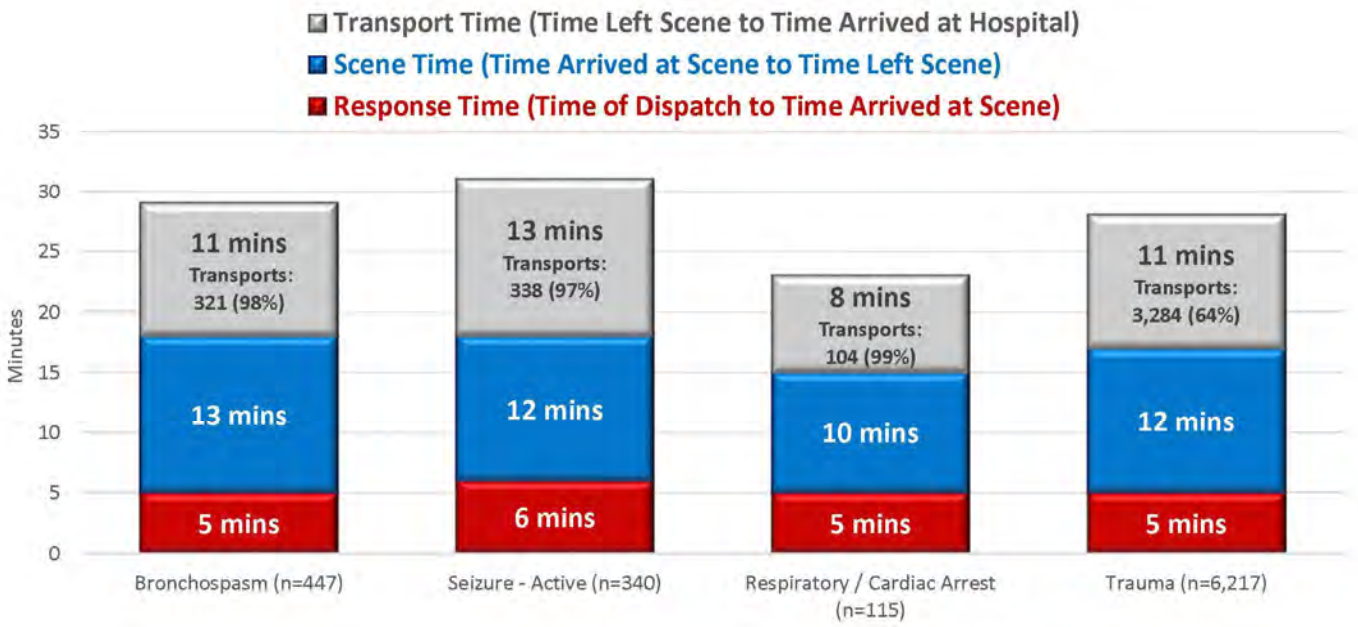
LA County EMS Transport Time of ADULT Patients with Provider Impressions STEMI, Stroke, Sepsis and Traumatic Injuries



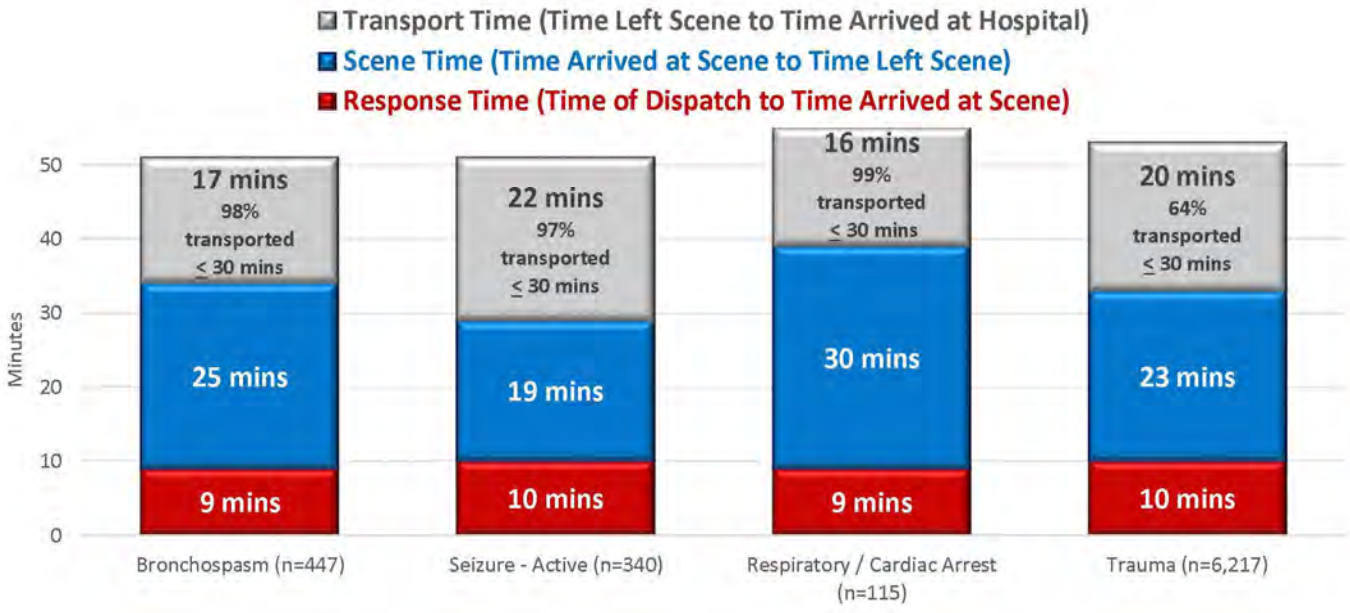
2020 EMS Times (90th Percentile)

2020 EMS Times: Pediatric (Median)

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

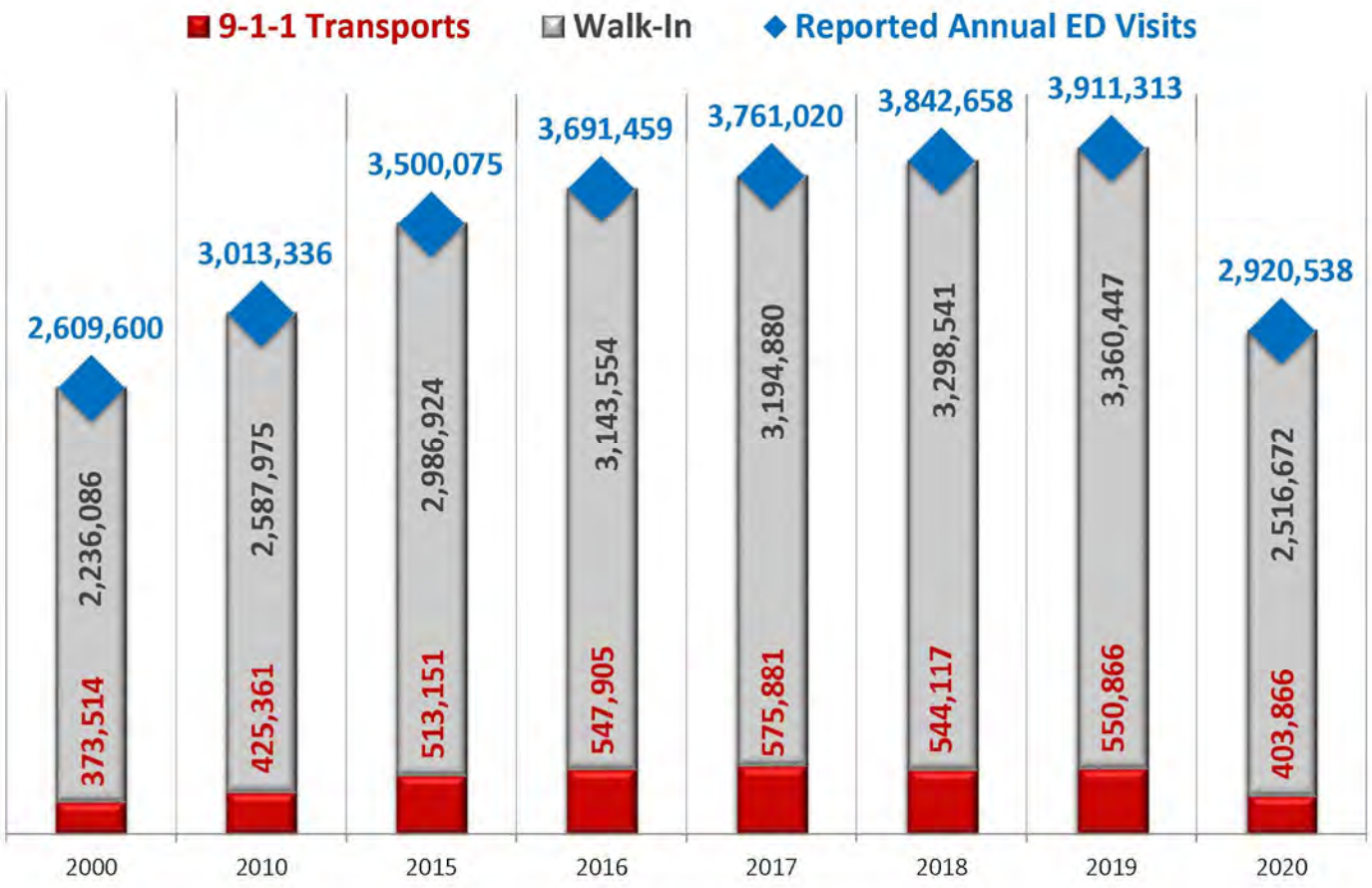


2020 EMS Times: Pediatric (90th Percentile)

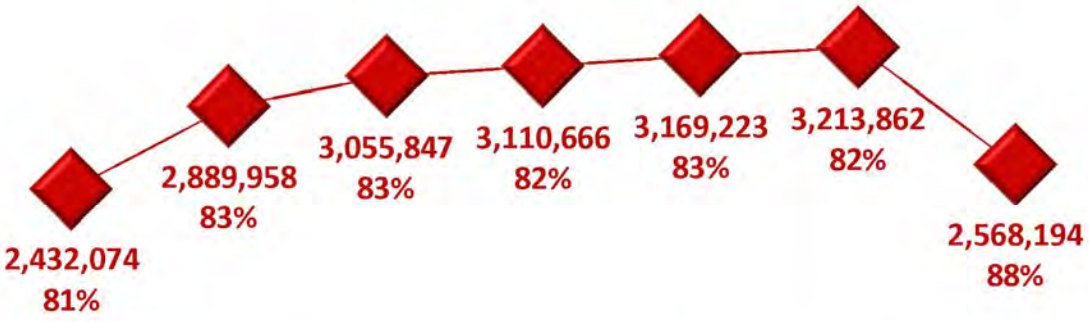


Emergency Department Volume

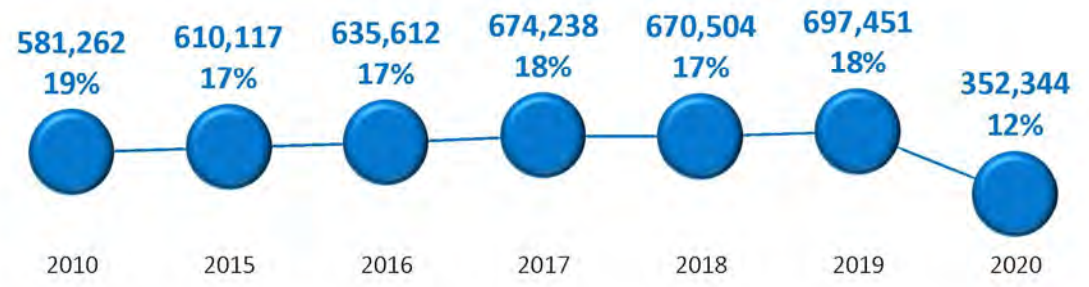
(9-1-1 Receiving Hospitals within Los Angeles County)



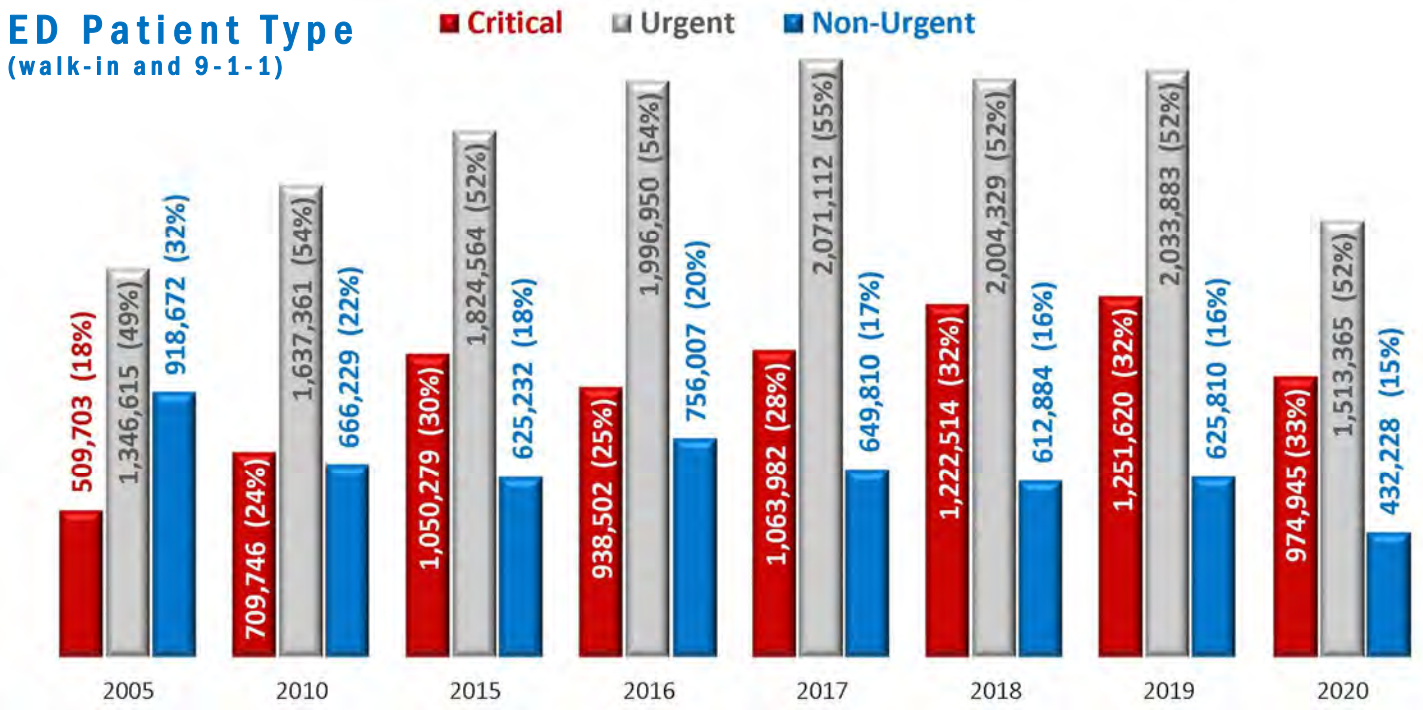
Adult:
15 years and older



Pediatric:
14 years and younger

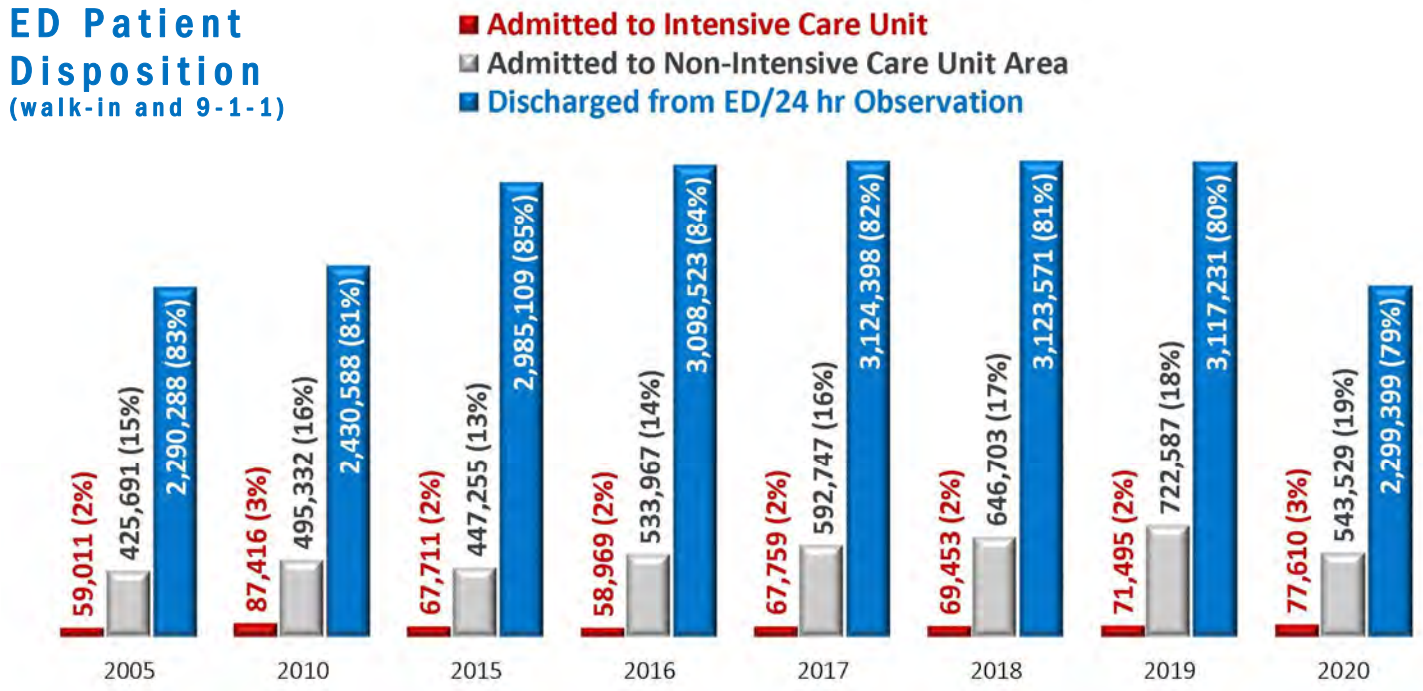


ED Patient Type
(walk-in and 9-1-1)

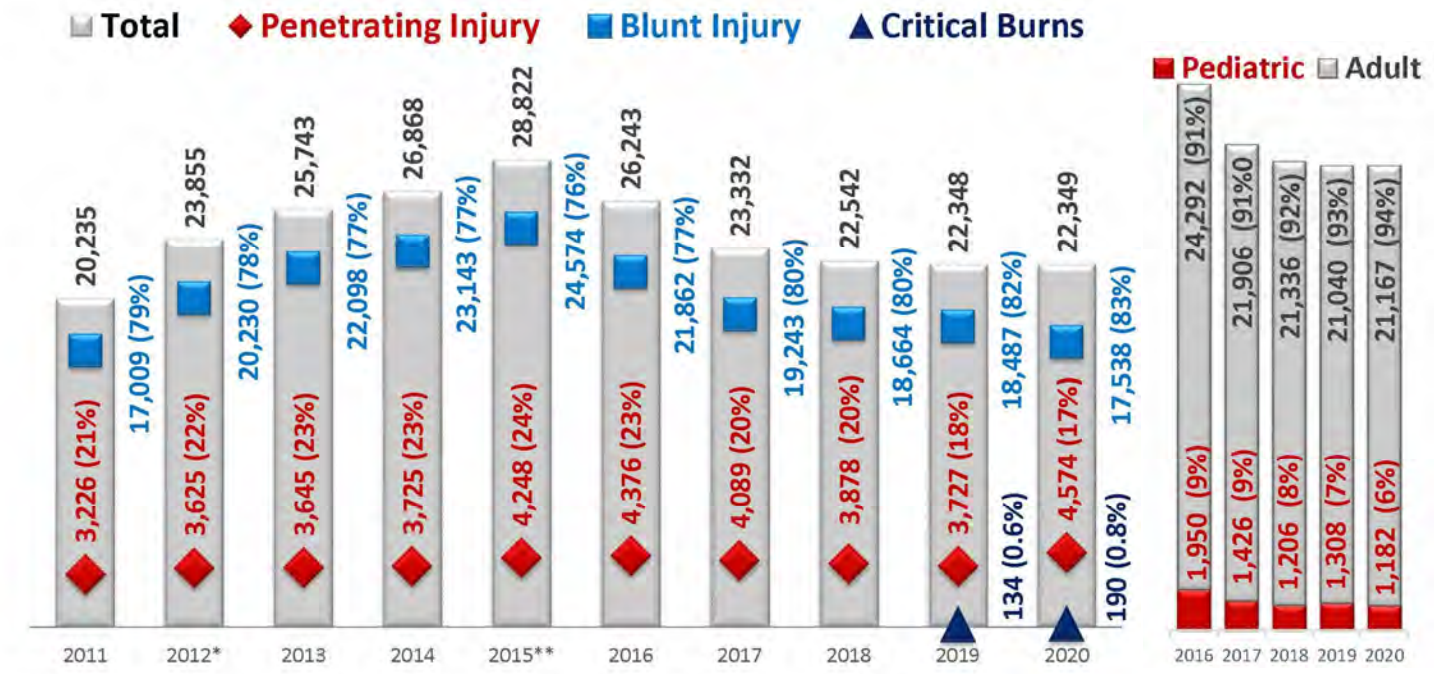


Critical—a patient presents an acute injury or illness that could result in permanent damage, injury or death (head injury, vehicular accident, shooting). Applicable Current Procedural Terminology (CPT) codes for this level of service would be 99284 (detailed history, detailed physical, and medical decision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

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

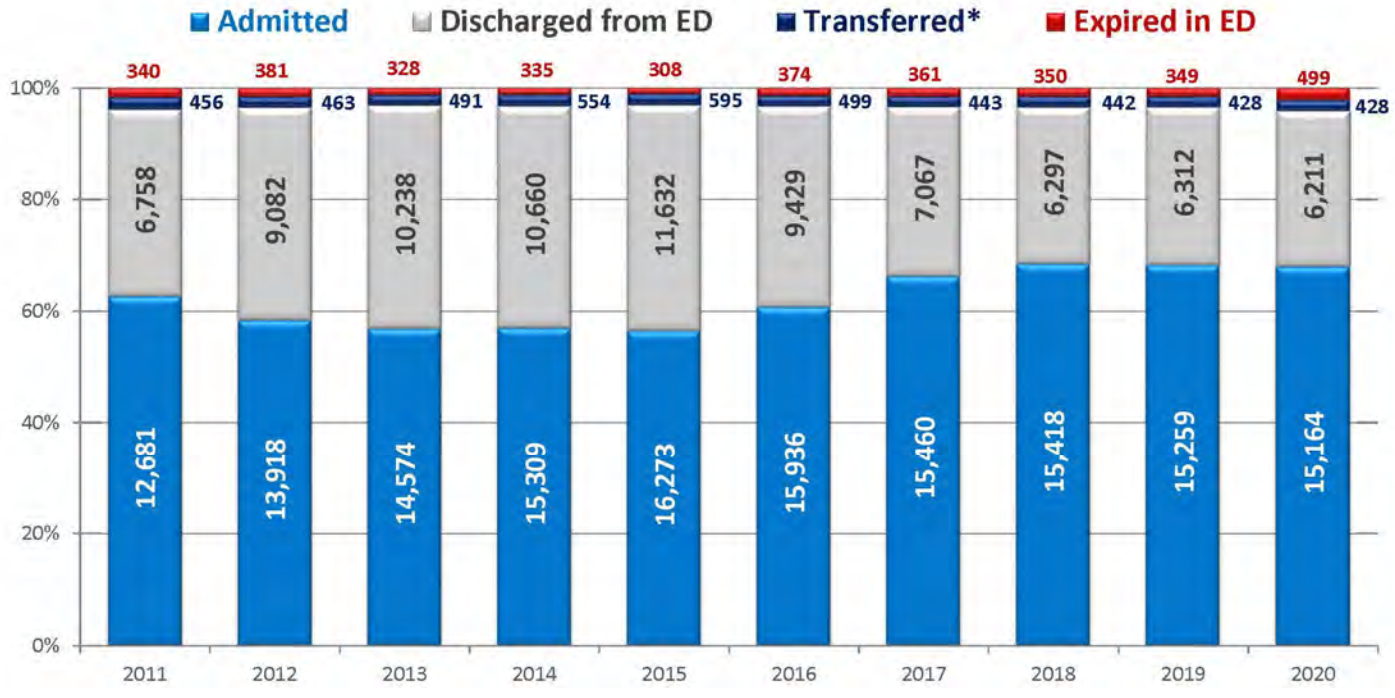


Trauma Center Volume



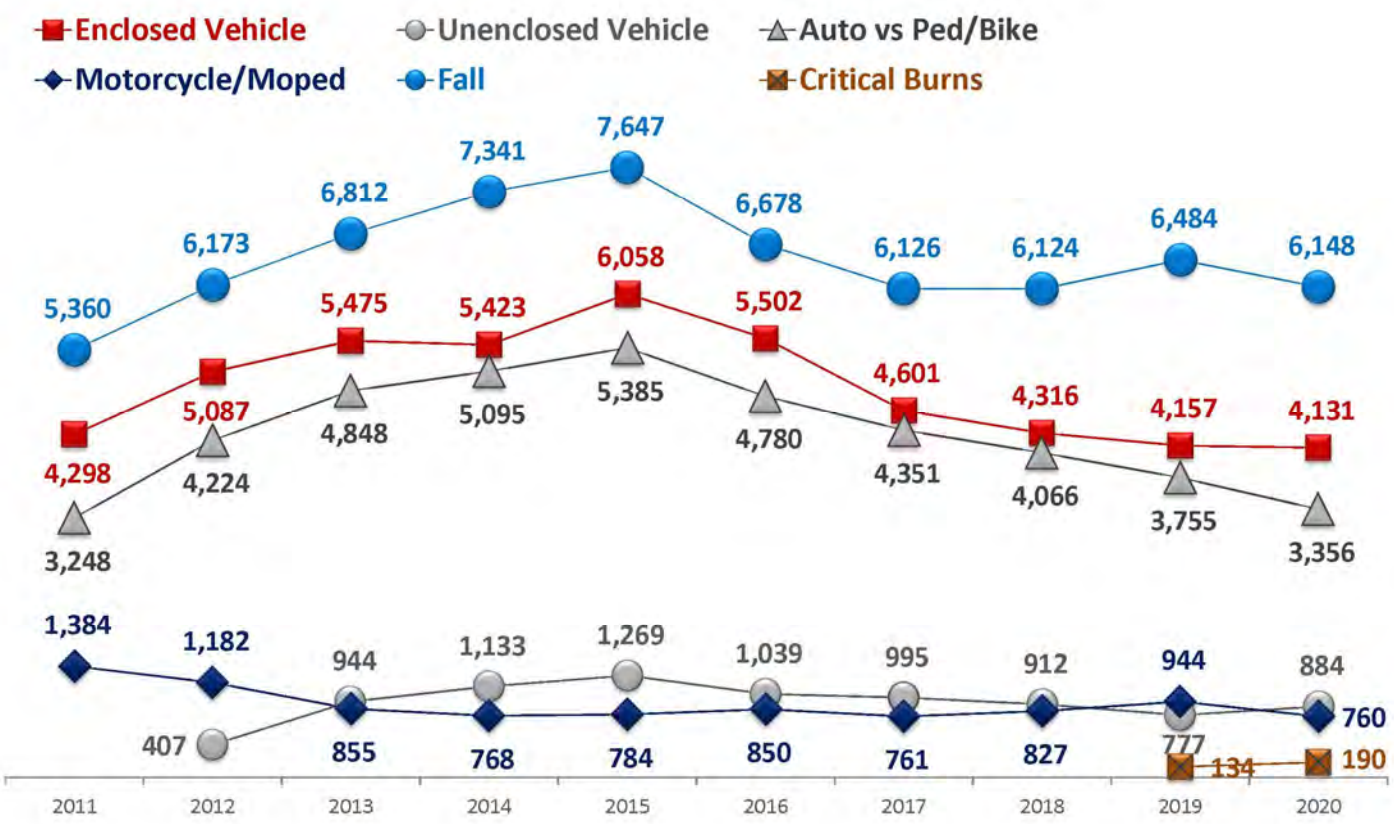
*2012: LA County adopted the Centers for Disease Control and Prevention Guidelines for Field Triage of Injured Patients
**2015 : Trauma Center Registry inclusion criteria was reduced.
***2019: Critical Burns added as a Trauma Center Criteria

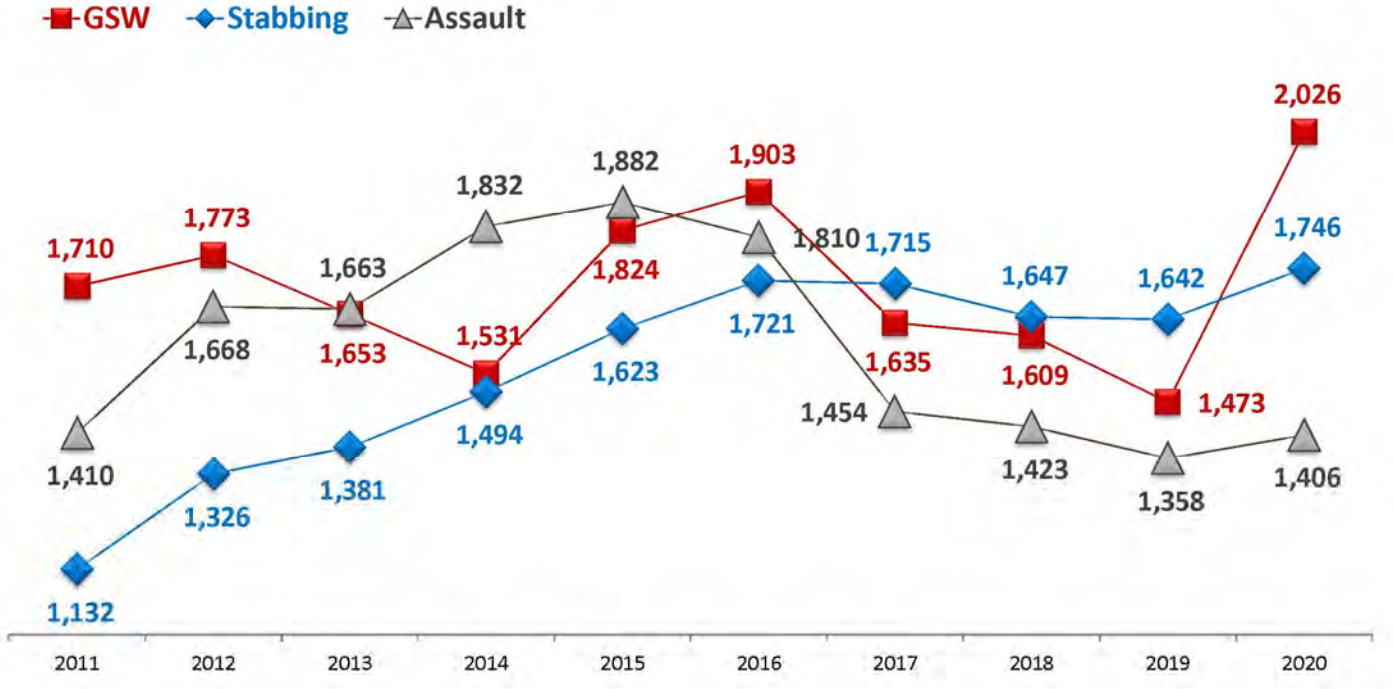
Patient Disposition of Trauma Center Patients



* Transferred to another health facility

Mechanism of Injury: Patients Transported to Trauma Centers

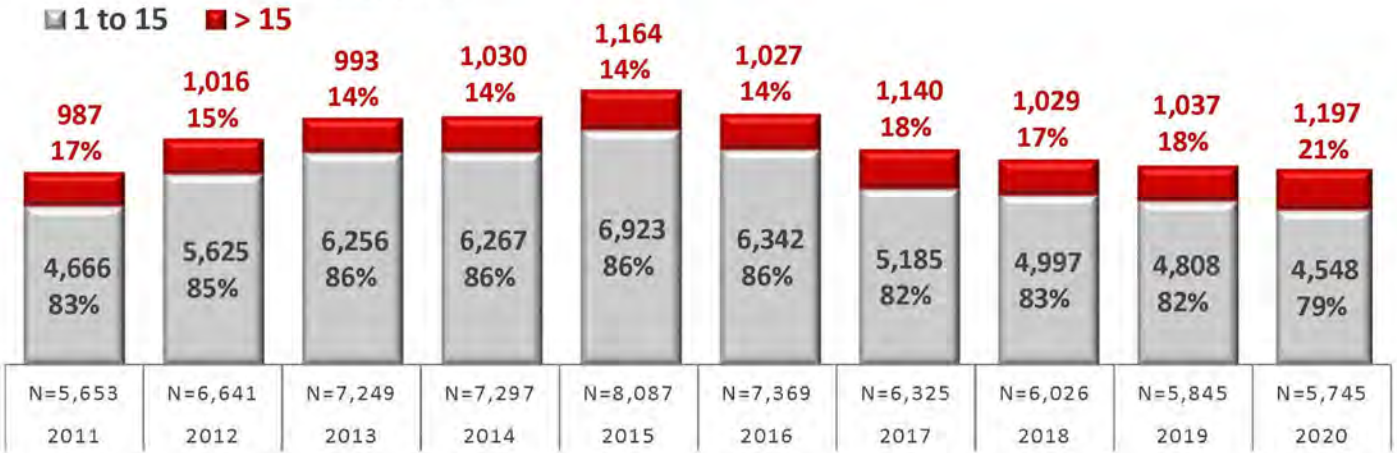




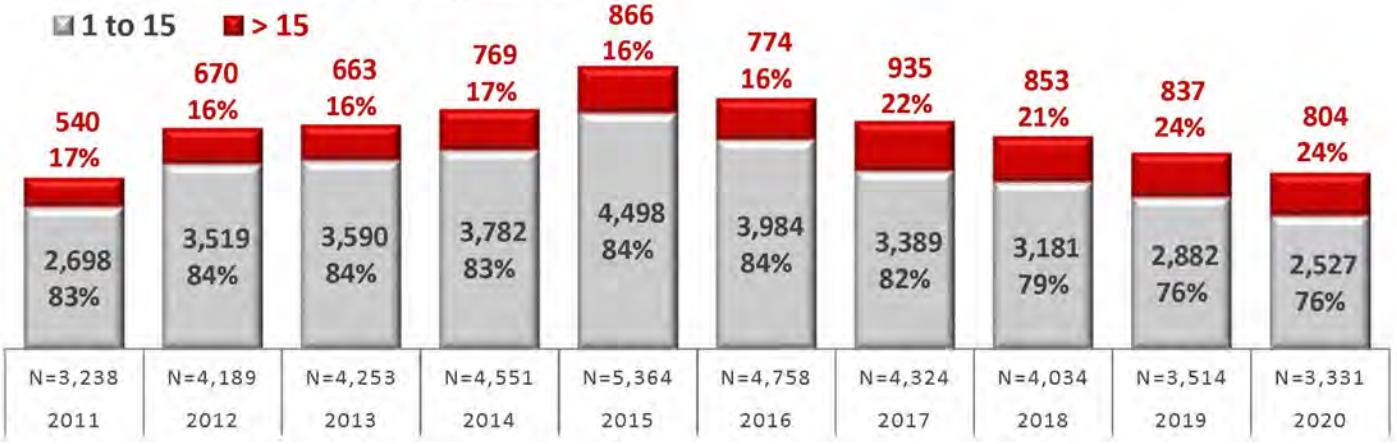
Injury Severity Score by Mechanism of Injury

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

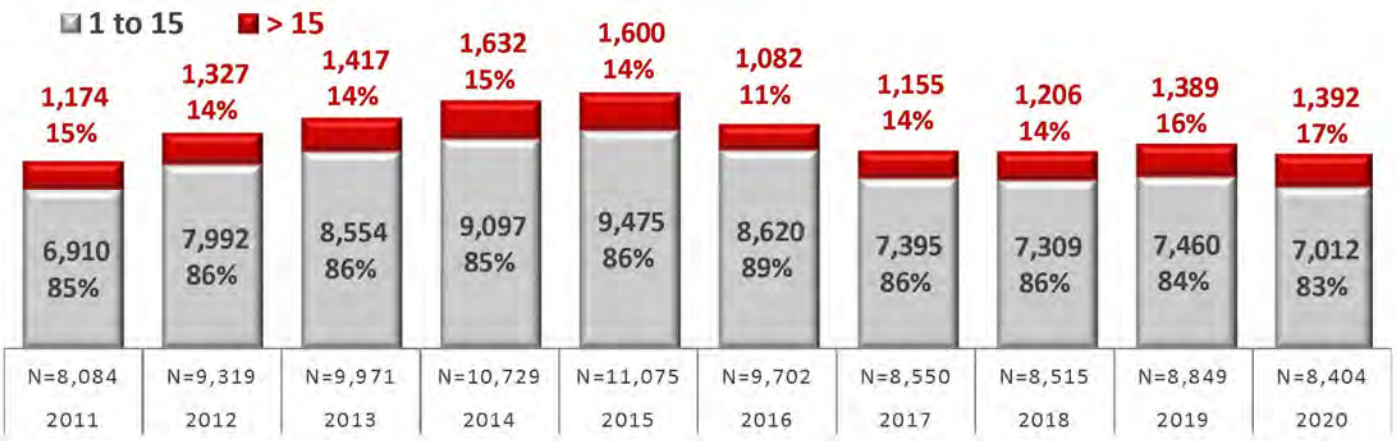
Motor Vehicular Accident



Automobile vs Pedestrian/Bicycle

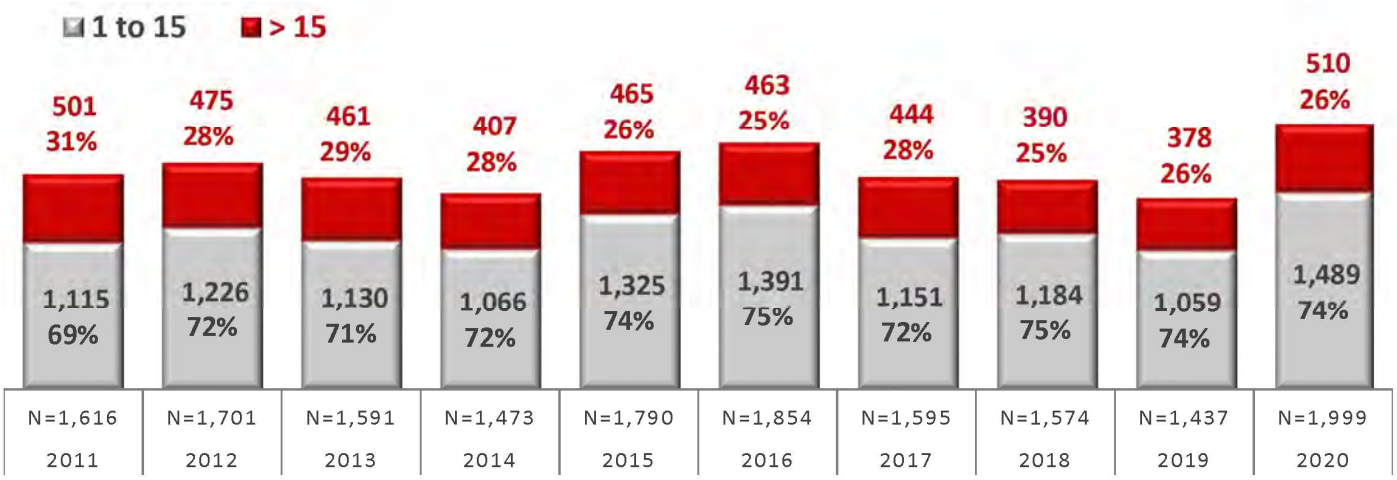


Other Blunt Injuries

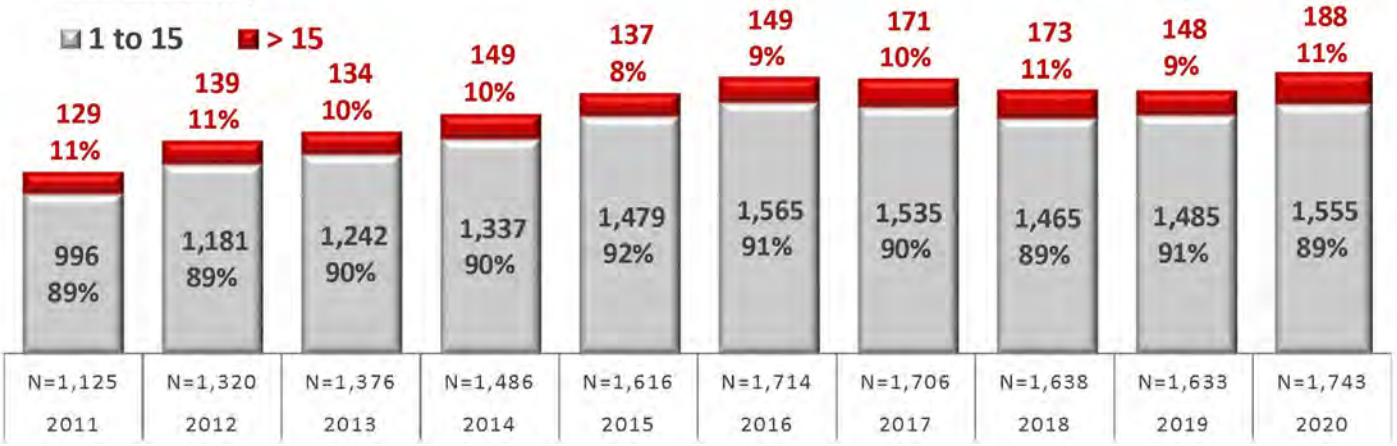


Injury Severity Score by Mechanism of Injury

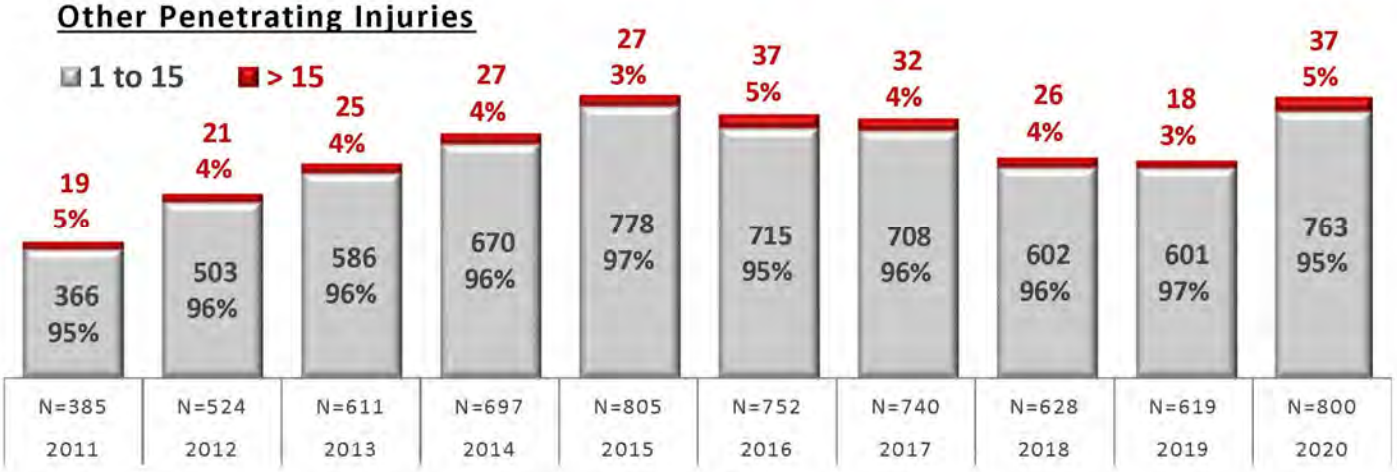
Gunshot Wound



Stab Wound



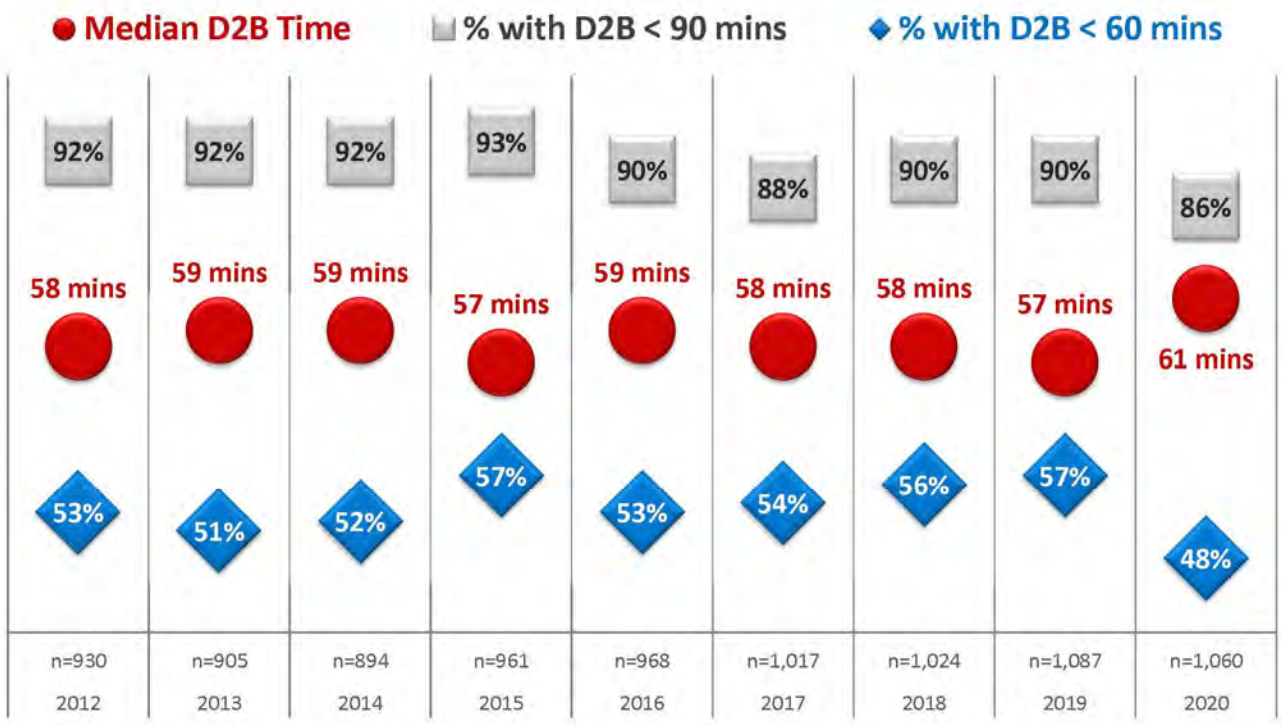
Other Penetrating Injuries



ST-Elevation Myocardial Infarction (STEMI)

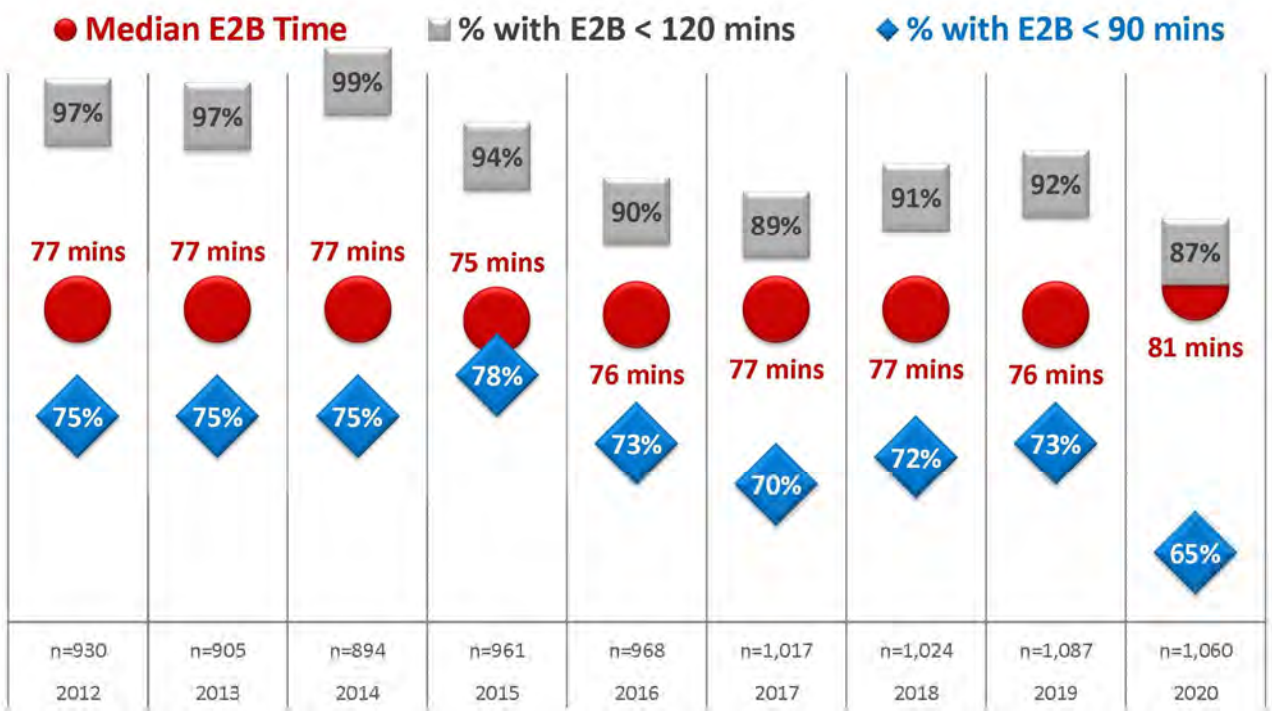
STEMI Receiving Center: Door-to-Device (D2B) Time

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



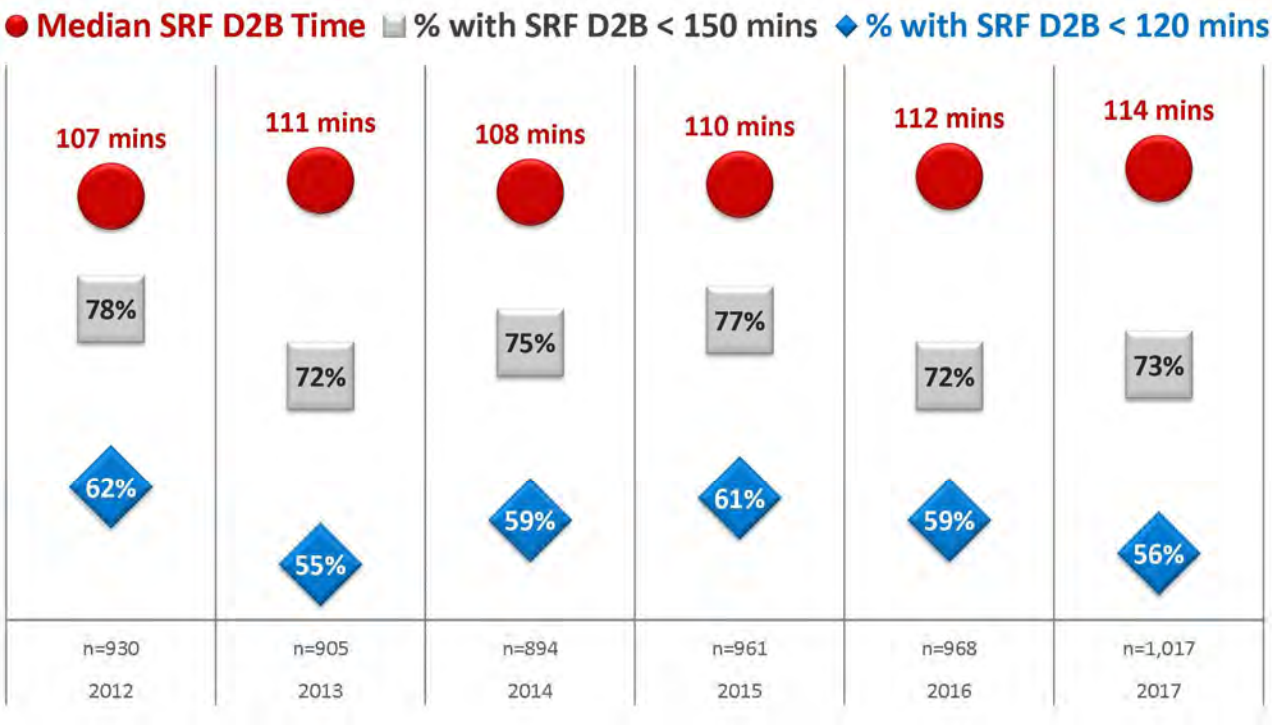
STEMI Receiving Center: EMS Medical Contact-to-Device (E2B) Time

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



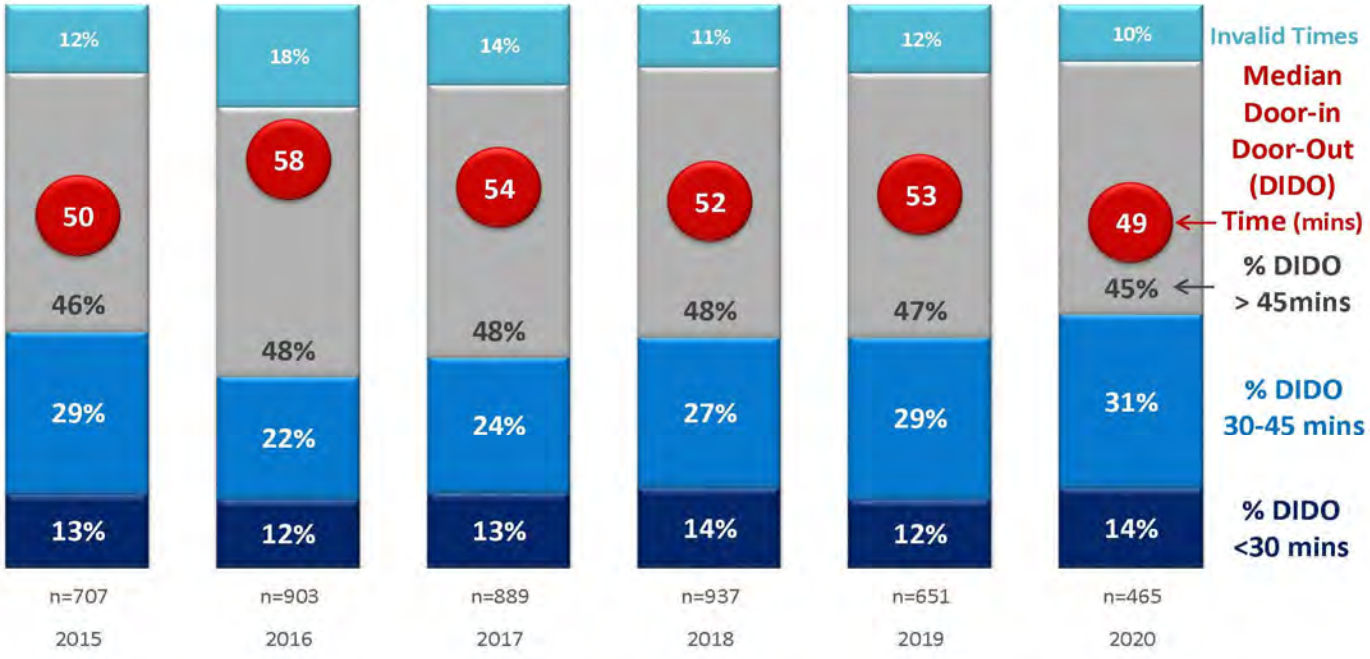
STEMI Referral Facility (SRF): Door-to-Device (D2B) Time

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

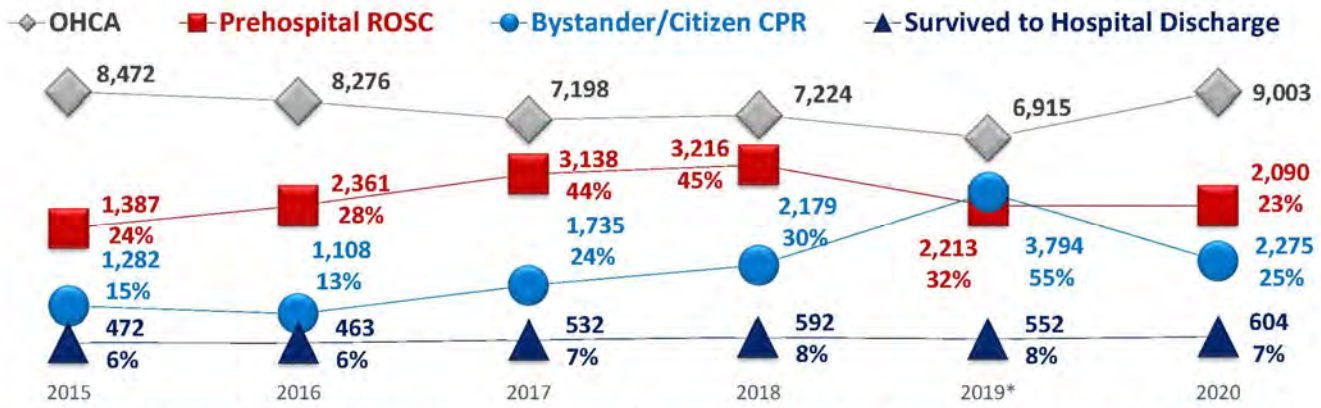


STEMI Referral Facility (SRF): Door-in Door-out (DIDO) Time

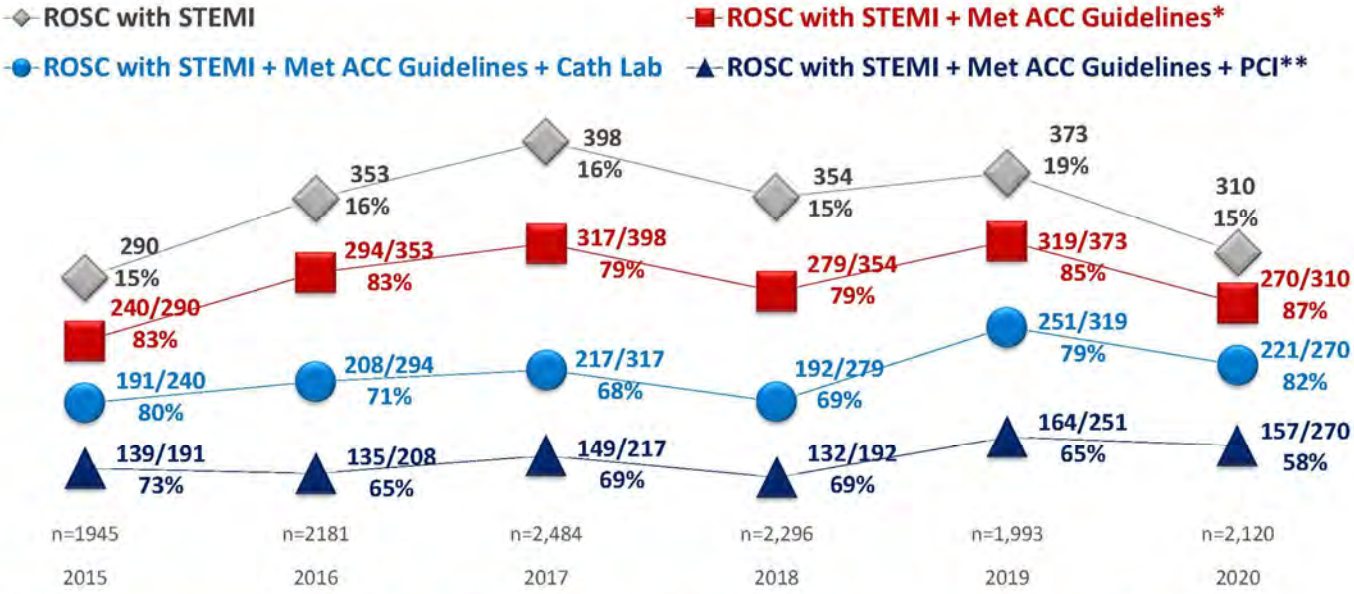
LA County Target: < 30 minutes



Out of Hospital Cardiac Arrest (OHCA)

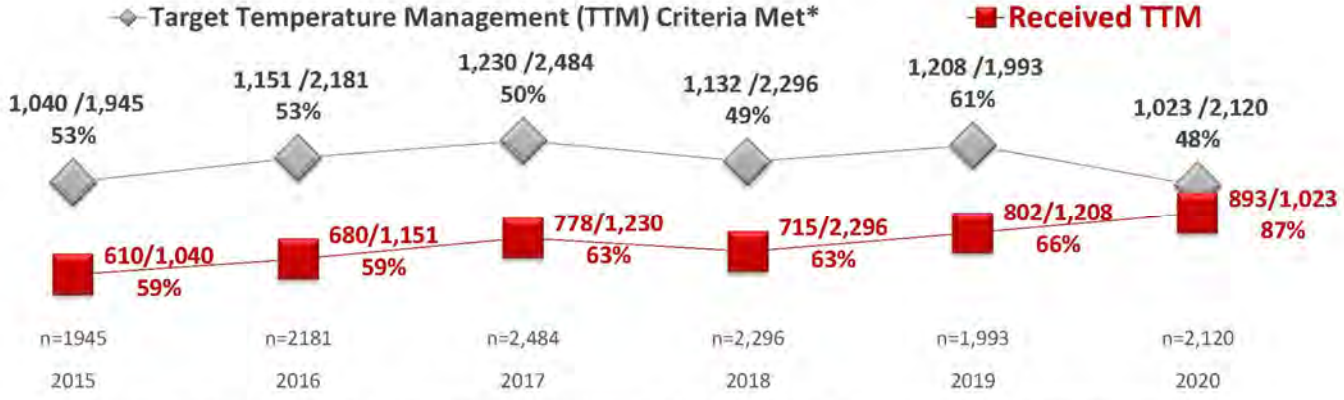


*2019 OHCA population is based on Provider Impression Cardiac Arrest Non-Traumatic, which was fully implemented April 1, 2019. DOAs were excluded. 2015-2018 OHCA population was based on Chief Complaint of Cardiac Arrest.



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

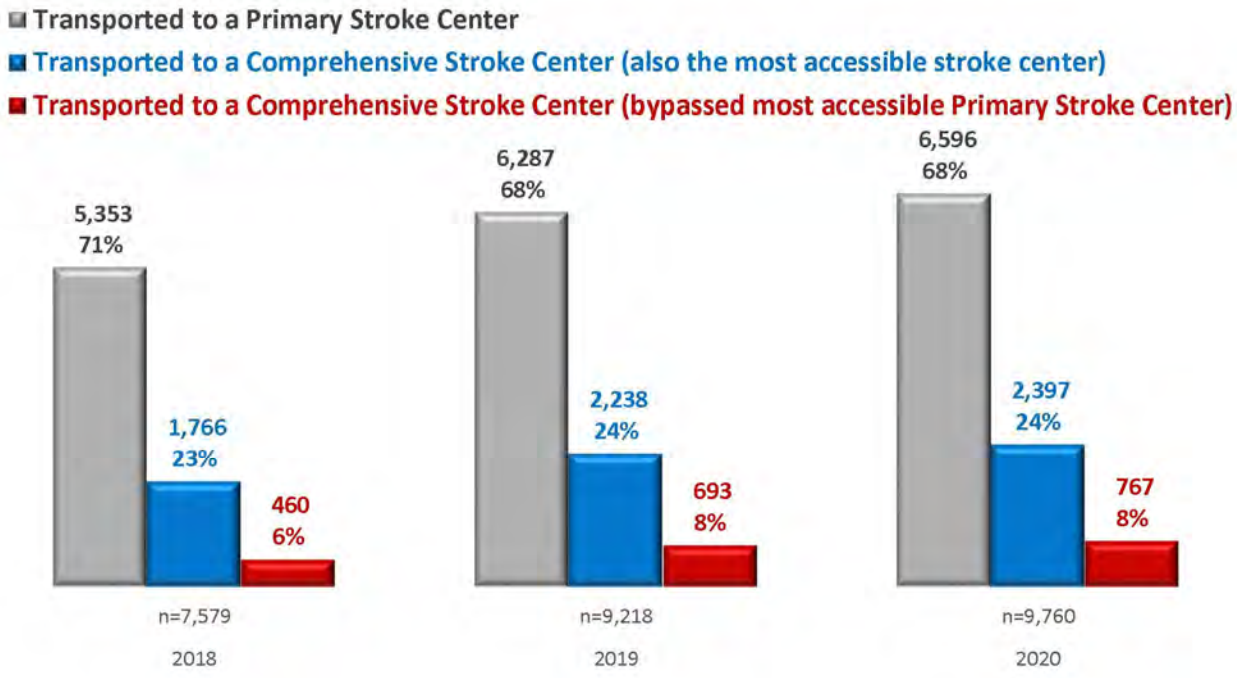
**PCI - Percutaneous Coronary Intervention is a procedure used to open or widen a narrowed or blocked coronary artery to restore blood flow supplying the heart.



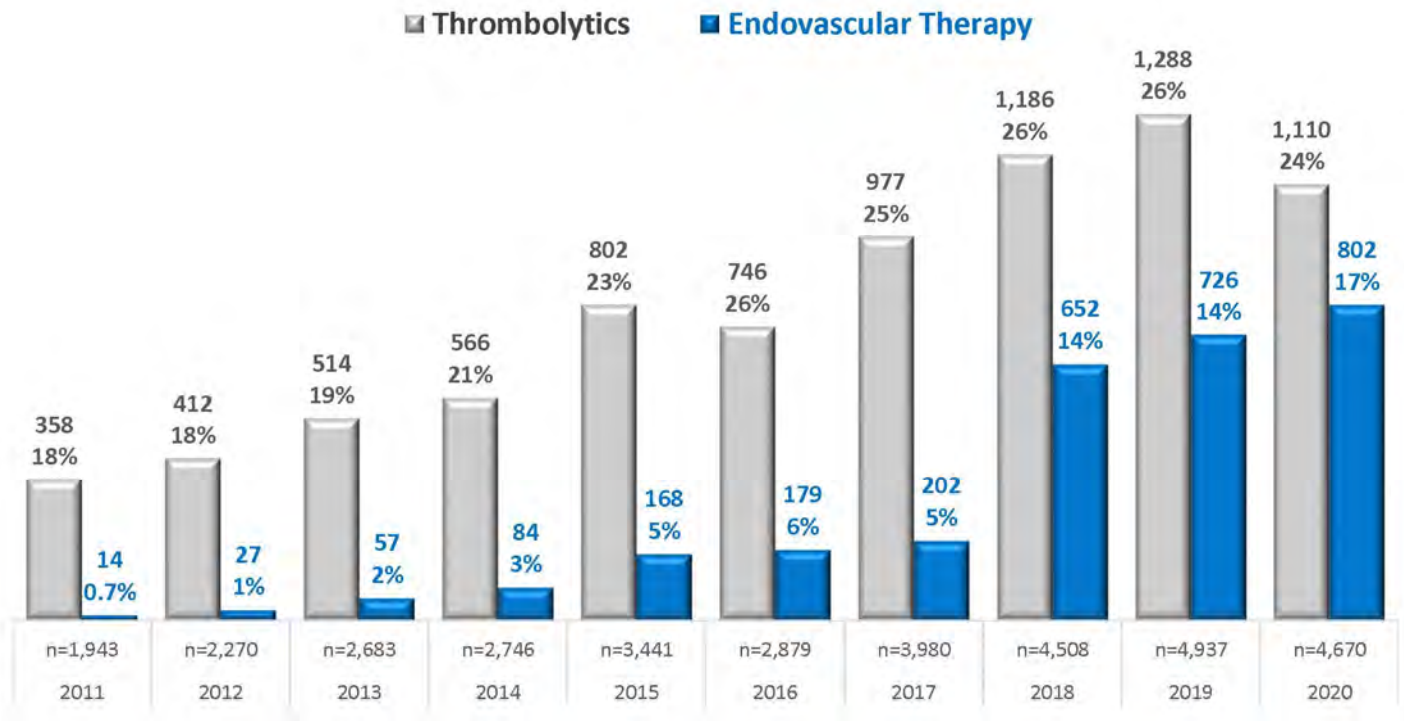
*TTM criteria excludes: died in ED, age <18, awake/responsive, end stage terminal illness, core temp <35 and pre-exiting DNR

Suspected Stroke Patient Destination

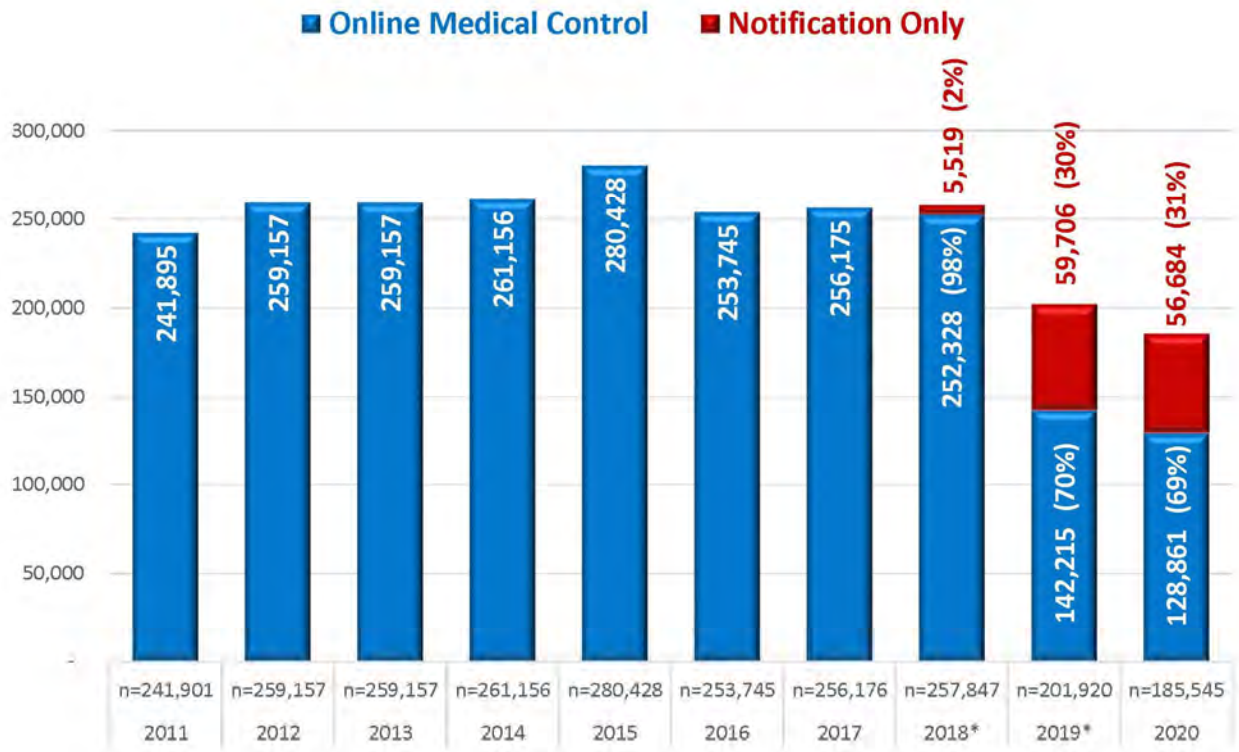
The routing of suspected stroke patients with large vessel occlusions based on a Los Angeles Motor Scale (LAMS) score of 4 or 5 to designated Comprehensive Stroke Centers began on January 8, 2018.



Treatment—All Ischemic Stroke



Paramedic Base Hospital Contact Volume



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

EMS AGENCY

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

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

For data request please complete and submit Reference No. 622.1 at https://file.lacounty.gov/SDSInter/dhs/1036072_622.1.pdf

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

Kay Fruhwirth
Interim Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

March 10, 2022

TO: Fire Chief, All 9-1-1 Paramedic Provider Agencies
CEO, Private Provider Agencies
City Manager, Each Los Angeles County City

FROM: Kay Fruhwirth KF
Interim Director

SUBJECT: GENERAL PUBLIC AMBULANCE RATES JULY 1, 2022 THROUGH JUNE 30, 2023

Attached are the maximum allowable rates to the general public for ambulance transportation as of July 1, 2022, as per section 7.16.340, Modification of Rates, of the County Ordinance (attachment I).

Transportation services provided on or after July 1, 2022 may not be billed above the allowable maximum rates per the attached rate schedule.

If you have any questions, please contact Jacqui Rifenburg, Interim Chief Prehospital Operations at (562) 378-1640.

KF:jr

Attachment

c: Brian Chu, Deputy County Counsel, Health Services
Julio Alvarado, Director, Contracts and Grants
Enrique Sandoval, Contract Manager, Contracts and Grants
Cristina Talamantes, Ordinance liaison, Board of Supervisors
Executive Office

COUNTY OF LOS ANGELES
GENERAL PUBLIC AMBULANCE RATES
EFFECTIVE JULY 1, 2022

Section 7.16.280 Rate Schedule For Ambulances

A. A ground ambulance operator shall charge no more than the following rates for one patient:

Rates Effective July 2022

1.	Response to a non-emergency call with equipment and personnel at an advanced life support (ALS) level	**$2,532.00**
2.	Response to an emergency 9-1-1 call with equipment and personnel at an advanced life support (ALS) level	**$2,710.00**
3.	Response to a nonemergency call with equipment and personnel at a basic life support (BLS) level	**$1,687.00**
4.	Response to an emergency 9-1-1 call with equipment and personnel at a basic life support {BLS) level	**$1,809.00**
5.	Mileage rate. Each mile or fraction thereof	**$23.00**
6.	Waiting time. For each 30-minute period or fraction thereof after the first 30 minutes of waiting time at the request of the person hiring the ambulance	**$143.00**
7.	Standby time. The base rate for the prescribed level of service and, in addition, for each 30-minute period or fraction thereof after the first 30 minutes of standby time	**$137.00**

B. This section does not apply to a contract between the ambulance operator and the County where different rates or payment mechanisms are specified.

Section 7.16.310 Special Charges

A. A ground ambulance operator shall charge no more than the following rates for special ancillary services:

1.	Request for services after 7 PM and before 7 AM of the next day will be subject to an additional maximum charge of	**$29.00**
2.	Persons requiring oxygen, shall be subject to an additional maximum charge per tank or fraction thereof, and oxygen delivery equipment to include nasal cannula and/or oxygen mask, of	**$108.00**
3.	Neonatal transport	**$271.00**
4.	Registered nurse or respiratory therapist specialty care transport with equipment and personnel for up to 3 hours of transportation time	**$3049.00**
5.	Registered nurse **and** respiratory therapist specialty care transport with equipment and personnel for up to 3 hours of transportation time	**$3445.00**
6.	Registered Nurse and/or Respiratory Therapist per hour after the first 3 hours	**$172.00**
7.	Volume ventilator	**$209.00**
8.	Disposable medical supplies	**$31.00**

B. Where other special services are requested or needed by any patient or authorized representative thereof,a reasonable charge commensurate with the cost of furnishing such special service may be made, provided that the ambulance operator shall file with the Director of the Department of Health Services a schedule of each special service proposed and the charge therefore, which charge shall be effective unless modified, restricted, or denied by the Director of the Department of Health Services. Special services are defined as services provided to a patient that are unique and individual to a specific patient's needs and are performed on a limited basis.

C. Charges for special services provided to patients that are new services, but will become an industry standard, must be reviewed and a rate commensurate with the service developed prior to ambulance operators charging such rate to the general public. Such rates shall not be charged to patients until approved by the Board of Supervisors.

D. This section does not apply to a contract between an ambulance operator and the County where different rates or payment mechanisms are specified.

Section 7.16.340 Modification of Rates.

The maximum rates chargeable to the general public as set forth in Sections 7.16.280 and 7.16.310 of this chapter shall be adjusted effective July 1, 1992, and on July 1st of each year thereafter, to reflect changes in the value of the dollar. For each of the one year periods respectively beginning July 1, 1992 and July 1, 1993 such adjustments shall be made by multiplying the base amounts by the percentage change in the transportation portion of the Consumer Price Index for All Urban Consumers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February. Beginning July 1, 1994, and on each July 1 thereafter, such adjustments shall be determined by multiplying the base amounts by the average of the percentage changes of the transportation portion and of the medical portion of the Consumer Price Index for All Urban Consumers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February. Beginning July 1, 2017, and on every July 1 thereafter, such adjustments shall be determined by multiplying seventy-five (75) percent of the base amounts by the percentage change of the minimum wage change in Los Angeles County as defined in County Code Section 8.100 .040 - Minimum Wage and by multiplying twenty-five (25) percent of the base amounts by the percentage change of the Medical Care line item of the Consumer Price Index for all Urban Customers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February, except for the following changes: Registered Nurse/Respiratory Therapist per hour after the first three (3) hours adjustment shall be determined by multiplying the current charge by the percentage change of the minimum wage change in Los Angeles County as defined in County Code Section 8.100 .040 - Minimum Wage: mileage adjustment shall be determined by multiplying the current charge for the percentage change of the transportation line item of the Consumer Price Index for All Urban Customers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February: and Oxygen, Disposable Medical Supplies, and a Ventilator adjustment shall be determined by multiplying the current charges by the percentage change of the Medical Care line item of the Consumer Price Index for all Urban Customers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12 month period ending with the last day of the prior month of February. The result so determined shall be rounded to the nearest whole number and added or subtracted, as appropriate, to the rate. The result so determined shall be rounded to the nearest whole number and added or subtracted, as appropriate, to the rate. The Director of the Department of Health Services, or authorized designee, shall initiate implementation of these rate changes by notifying in writing each licensed private ambulance operator in Los Angeles County thereof, and any other individual or agency requesting such notification from the Director. Such notice shall be sent by first class mail no later than June 15 of the prior period.

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

Kay Fruhwirth
Interim Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

March 14, 2022

Chief Anthony Marrone
Interim Fire Chief
Los Angeles County Fire Department
1320 North Eastern Avenue
Los Angeles, California 90063

Dear Chief Marrone,

ADOLESCENT PATIENT DESTINATION TO PSYCHIATRIC URGENT CARE CENTERS (PUCC)

This is to approve Los Angeles County Fire Department's (CF) request to expand the age criteria for transport to EMS Agency designated Psychiatric Urgent Care Centers (PUCC). Effective immediately, CF may begin transporting adolescents (13 to 17 years old) who meet inclusion criteria to PUCCs.

CF may use Prehospital Policy Reference No. 526.1, Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center, to screen adolescent patients. In addition, the transport of adolescent patients may include those placed on an involuntary hold per California Health & Safety Code Section 5585, or those being accompanied by a parent or legal guardian.

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

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:RT:gk
03-10

c: Interim Director, EMS Agency ✓
Saman Kashani, Assistant Medical Director, CF

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

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

March 17, 2022

VIA E-MAIL

TO: Distribution

FROM: Kay Fruhwirth KF
Interim Director

SUBJECT: **DESIGNATION OF PRIMARY STROKE CENTER**

The Emergency Medical Services Agency is pleased to announce that effective Monday, March 21, 2021, at 0700 **Cedars-Sinai Marina Del Rey Hospital** is designated as Primary Stroke Center (PSC). This brings the total number of 9-1-1 Designated Stroke Centers in Los Angeles County to 54.

Please visit the EMS Agency website at http://ems.dhs.lacounty.gov for the most current information about the new PSC and a map showing the approved hospitals. If you have any questions, please feel free to contact Fritz Bottger, Stroke Program Coordinator, at (562) 378-1653.

KF:fb
03-12

Distribution: Medical Director, EMS Agency
Fire Chief, Each Fire Department
Paramedic Coordinator, Each Provider Agency
Nurse Educator, Each Fire Department
Prehospital Care Coordinator, Each Base Hospital
Stroke Coordinator, Each Approved Stroke Center
Stroke Medical Director, Each Approved Stroke Center
Medical Alert Center
ReddiNet®

Health Services
LOS ANGELES COUNTY

March 18, 2022

313 N. Figueroa Street, Suite 909
Los Angeles, CA 90012

Tel: (213) 288-7989
Fax: (213) 481-0503

www.dhs.lacounty.gov

"To advance the health of our patients and our communities by providing extraordinary care"

www.dhs.lacounty.gov

TO: Executive Leadership Team

FROM: Hal F. Yee, Jr., M.D., Ph.D.
Chief Deputy Director, Clinical Affairs

SUBJECT: **APPOINTMENT OF EMERGENCY MEDICAL SERVICES AGENCY DIRECTOR**

I am pleased to announce the appointment of Richard Tadeo, as the Department of Health Services' (DHS') Emergency Medical Services (EMS) Agency Director, effective March 31, 2022.

Mr. Tadeo began working for DHS in 1989 as a Staff Nurse at Harbor-UCLA Medical Center. In 1996, Mr. Tadeo was promoted to Nursing Instructor at the EMS Agency and worked as the Base Program Coordinator. Over the years at the EMS Agency, he moved into supervisory and program management positions. Since 2010, Mr. Tadeo has been one of the EMS Agency's Assistant Directors whose responsibilities includes overseeing the EMS Programs. Most recently, his responsibilities during the COVID-19 response included overseeing the data collection from all hospitals, both private and public, in Los Angeles County, which was integral to the COVID-19 modeling used to monitor and predict COVID-19 impact on the hospital system.

Mr. Tadeo's experience and knowledge of the EMS system, regulations and policies as well as his established relationships with EMS Agency constituents will serve him well as he moves into this new role.

An enormous thanks to Kay Fruhwirth for stepping in as Interim Director prior to her retirement at the end of this month. Kay's valued contributions to the EMS Agency since Sept 2001 have included Chief of Disaster Programs and EMS Assistant Director.

Please join me in congratulating Richard on his promotion and extend him your full support.

HFY:kf

c: EMS Agency Staff
EMS Agency Constituents

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

Richard Tadeo
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

March 29, 2022

VIA E-MAIL

TO: Distribution

FROM: Richard Tadeo
Director

Marianne Gausche-Hill, MD
Medical Director

SUBJECT: REMINDER - STANDARD GUIDANCE FOR FIRST REPONDERS ENTERING HOSPITAL / HEALTHCARE FACILITIES

The Emergency Medical Services (EMS) Agency has recently received several notices from healthcare facilities advising that EMS personnel are not following the guidelines on the proper use of personal protective equipment (PPE) upon entering healthcare facilities. This memorandum serves as a reminder of these guidelines.

On August 25, 2021, the EMS Agency distributed a memorandum to all hospitals and EMS providers of the following standardized expectations of the proper use of PPE:

> ***All first responders (law enforcement, fire and EMS personnel) must wear, at minimum, a surgical mask upon entering a hospital or medical facility. The surgical masks, covering nose and mouth, must be worn at all times, while in the facility. N95 respirators and additional PPE must be worn as appropriate based on the medical condition of the patient and treatments administered.***

During a collaborative meeting on August 23, 2021, between the EMS Agency, Hospital Association of Southern California (HASC); and leaders from first responders and hospitals, the above guideline was agreed upon and included that any instances in which first responders do not comply with wearing a surgical mask [at all times] while inside healthcare facilities, that these instances should be referred to their employer as soon as possible and that additional education and/or disciplinary action be initiated.

The EMS Agency is asking for your assistance to ensure that your agency continues to strive for compliance with the above guideline in order to protect the health and safety of your EMS personnel and the patients they serve. Thank you for your immediate attention. If you have any questions regarding this subject, please contact either of us at mgausche-hill@dhs.lacounty.gov or rtadeo@dhs.lacounty.gov.

Distribution:
- Hospital CEOs
- LA Area Fire Chiefs Association
- Each Fire Chief
- LA County Police Chiefs Association
- Each Police Chief
- LA Ambulance Association
- Ambulance CEOs
- Public and Private Provider Agencies

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

Tel: (562) 378-1500
Fax: (562) 946-6594

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

April 6, 2022

Genia Gorin, President
Eastwestproto, Inc. dba LifeLine Ambulance
6605 E. Washington Blvd.
Commerce, CA 90040

CERTIFIED

Dear Ms. Gorin:

PARAMEDIC PROVIDER PROGRAM APPROVAL

This is to advise you that the Emergency Medical Services (EMS) Agency's review of LifeLine Ambulance's (LE) Advanced Life Support (ALS) Paramedic Provider Program is complete. LE's request to become an ALS Provider in Los Angeles County was approved as of March 30, 2022. The Paramedic Provider Agreement No. is **H-709487**.

On January 4, 2022, the EMS Agency performed an inventory inspection of LE's new ALS units, rescue ambulance (RA) #629 and RA #630. Both RAs' #629 and #630 currently meet the requirements of Reference No. 703.1, Private Provider Non-9-1-1 ALS Unit Inventory. New ALS units must be approved prior to deployment.

The units should be designated on the EMS report form as **RA 629** and **RA 630** with a provider code of **LE**. Methodist Hospital of Southern California (AMH) is the assigned base hospital for these units.

LE will be utilizing the electronic patient care record (ePCR) system *"ImageTrend"* for its patient care data submission.

LE's request for waiver to operate its paramedic program on a continuous 24-hour per day basis was granted by the former EMS Agency Director, Cathy Chidester.

The EMS Agency welcomes LE as a new paramedic provider and wishes you much success. If you or your staff have any questions, please contact Nnabuike Nwanonenyi, Prehospital Programs Coordinator at (562) 378-1684.

Sincerely,

Richard Tadeo
Director

RT:JR:nn
04-01

C. Teena Turocy, Paramedic Coordinator, LifeLine Ambulance
Dr. Drew Hood, M.D., Medical Director, LifeLine Ambulance
Certifications Section, EMS Agency
TEMIS Section, EMS Agency
Prehospital Care Coordinator, Methodist Hospital of Southern California

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

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

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

April 7, 2022

Donald Anderson
Assistance Fire Chief / Operations
Long Beach Fire Department
3205 Lakewood Boulevard
Long Beach, California 90712

CERTIFIED MAIL

Dear Chief Anderson:

PARAMEDIC CARTS 2 through 5: APPROVAL

This is to advise you that the Long Beach Fire Department (LB) has been approved to operate golf carts (CT) 2 through 5, as paramedic units while staffed with two Los Angeles County accredited paramedics. The purpose of these golf cart units is to allow a rapid response and administer medical aid prior to the arrival of an ALS transport unit in areas and/or events with large numbers of people.

The Emergency Medical Services (EMS) Agency has on file inspection documents stating that CT-2 through CT-5 have been verified and meets the requirements of equipment listed in Reference No. 703, ALS Unit Inventory. Controlled drugs were verified as being secured in a double-locking mechanism.

These units shall be identified on the EMS Report Form as provider "LB", with unit code of "CT-2" through "CT-5". The assigned base hospital is Dignity Health – St. Mary Medical Center (SMM).

Special Events: During special events (e.g., Long Beach Grand Prix), LB is approved to downgrade these ALS carts to Assessment Unit (AU) Carts [staffed with one paramedic and one EMT], carrying only Reference No. 704, Assessment Unit Inventory. In addition, during special events only, these carts are approved to carry controlled drugs that are secured under double-lock and access is only by a LA County accredited paramedic.

If there are any questions, please contact Gary Watson, Prehospital Programs Coordinator at (562) 378-1679.

Sincerely,

Richard Tadeo

Richard Tadeo
Director

RT:gw
4-08

c. Fire Chief, Long Beach Fire Department
Medical Director, Long Beach Fire Department
Paramedic Coordinator, Long Beach Fire Department
PCC, Dignity Health – St. Mary Medical Center

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

Richard Tadeo
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

April 12, 2022

TO: EMS Agency Staff

FROM: Richard Tadeo
Director

SUBJECT: NURSING DIRECTORS – ROEL AMARA AND CHRIS CLARE

It is my pleasure to announce that Roel Amara and Chris Clare have accepted the Nursing Director positions in the EMS Agency. Roel will oversee Disaster Programs and Chris will oversee EMS Programs.

Both Roel and Chris have extensive knowledge of their respective programs and have consistently demonstrated excellent management and oversight skills.

Please join me in congratulating Roel and Chris on their promotions.

Additional changes during this transition include:

- Management of Prehospital Operations and Ambulance Licensing Section will transition from Jacqueline Rifenburg to Chris Clare in the following weeks.
- Paramedic Training Institute will start reporting to Jacqueline Rifenburg.
- Administrative Services will continue to report to Roel until further notice.
- Information Technology will continue to report to me.

Thank you for your patience during this transition period. Please contact me if you have any questions.

RT:rt

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

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

April 26, 2022

TO: Distribution **VIA E-MAIL**

FROM: Richard Tadeo
Director, EMS Agency

SUBJECT: **ACCURATE DOCUMENTATION OF AMBULANCE PATIENT OFFLOAD TIME (APOT)**

As you may be aware, the installation of FirstWatch to capture Ambulance Patient Offload Times (APOT) at all 9-1-1 receiving hospitals is in its final phase of implementation. The EMS Agency has received feedback from several hospitals that the data displayed may not be 100% accurate. The EMS Agency's review of multiple records show that EMS professionals are not consistently capturing the required data. Please ensure that your EMS professionals are made aware of the following critical date/time elements to be captured on the electronic patient care record (ePCR):

1. Arrival at Facility Date and Time
2. On Facility Equipment Date and Time

Hospital personnel are requested to collaborate with EMS professionals to ensure capturing the accurate "On Facility Equipment Date and Time" is incorporated into the workflow during patient transfer of care.

Thank you for your attention to this important issue to reduce delays in APOT. If you have any questions or concerns, feel free to contact me at (562) 378-1610 or Chris Clare, Nursing Director- EMS Programs at (562) 378-1661.

RT:ps
04-21a

Distribution: Fire Chief, Each Public EMS Provider Agency
CEO, Each Ambulance Company
Medical Director, Each EMS Provider Agency
Paramedic Coordinator, Each EMS Provider Agency
CEO, Each 9-1-1 Receiving Hospital
ED Medical Director, Each 9-1-1 Receiving Hospital
ED Director, Each 9-1-1 Receiving Hospital
Prehospital Care Coordinator, Each Paramedic Base Hospital
Base Hospital Medical Director, Each Paramedic Base Hospital

c. Hospital Association of Southern California
EMS Commission
Medical Director, EMS Agency

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Richard Tadeo
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

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

April 28, 2022

Fernando Pelaez, Fire Chief
Montebello Fire Department
600 N. Montebello Boulevard
Montebello, CA 90640

Dear Chief Pelaez,

HEMOSTATIC DRESSING PROGRAM APPROVED

This is to inform you that Montebello Fire Department (MO) has been approved by the Los Angeles County Emergency Medical Services (EMS) Agency for the utilization of QuikClot® Combat Gauze™ in patients with traumatic external hemorrhage not amenable to other methods of control.

The approved quality improvement process required for evaluating the implementation of hemostatic dressings will be reviewed during your annual program review or as deemed necessary by the EMS Agency. Additionally, MO may be required to submit data to the EMS Agency for purposes of system evaluation and aggregate reporting on the use of hemostatic dressings.

Please contact me at (562) 378-1600 or Susan Mori at (562) 378-1681 for any questions or concerns.

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:SM
04-18

c: Director, EMS Agency
Medical Director, Montebello Fire Department
EMS Director, Montebello Fire Department
Paramedic Coordinator, Montebello Fire Department
Nurse Educator, Montebello Fire Department