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: **November 16, 2022**
TIME: **1:00 – 3:00 PM**
LOCATION: **Zoom Video Conference Meeting**

Join Zoom Meeting:
https://us06web.zoom.us/j/85816449796?pwd=OVNCZEdPUkM0blhhckJzTkMxUnFwUT09
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The Commission meetings are open to the public. You may address the Commission on any agenda item before or during consideration of that item, and on other items of interest which are not on the agenda, but which are within the subject matter jurisdiction of the Commission. Public comment is limited to three (3) minutes and may be extended by Commission Chair as time permits.

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

AGENDA

I. CALL TO ORDER – Lydia Lam, Chair

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.
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6) Mute and unmute yourself by clicking on the microphone icon at the bottom of computer screen, or *6 by phone.
7) Volume is adjusted by using the little arrow next to the microphone icon.

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

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

1. MINUTES
September 21, 2022

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

3. POLICIES

3.1 Reference No. 408: Advanced Life Support Unit Staffing
3.2 Reference No. 832: Treatment/Transport of Minors
3.3 Reference No. 834: Patient Refusal of Treatment/Transport and Treat and Release at Scene

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 Ad Hoc Workgroup: Alameda EMS Corps for LA County

BUSINESS (NEW)

4.5 Provider Agency Advisory Committee – Seat Request from California Nurse and EMS Professionals (CAL-NEP) – Adrienne Roel
4.6 Nominating Committee for 2023 Chair and Vice Chair

V. LEGISLATION

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

CORRESPONDENCE

6.1 (09-28-2022) Distribution: Emergency Medical Technician (EMT) And Paramedic Vaccination Requirement Update
6.2 (10-12-2022) Distribution: Prehospital Care Policy Ref. No. 505, Ambulance Patient Offload Time
6.3 (10-27-2022) Distribution: Executive Order on Waivers Related to COVID

VII. COMMISSIONERS' COMMENTS / REQUESTS

VIII. ADJOURNMENT

To the meeting of January 18, 2023

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

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

MINUTES
September 21, 2022
Zoom Meeting

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

GUESTS

David Molyneux/W-Cst Amb	Andy Reno/Long Beach FD	Mark Gamble/HASC	Jenn Nulty/Torr-FD
Shira Schlesinger/H-UCLA	Puneet Gupta/LACoFD	Samantha Gates	Adena Tessler/HASC

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

I. CALL TO ORDER

The Emergency Medical Services (EMS) Commission (EMSC) meeting was held via Zoom Video Conferencing 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 Chair Lydia Lam. Roll call was taken by Executive Director Richard Tadeo. A quorum was present with 14 Commissioners on the call.

II. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

Chair Lam welcomed meeting participants, provided instructions for public comments using Zoom, and reported EMSC meetings will continue by teleconference until further notice.

III. CONSENT AGENDA – *All matters are approved by one motion unless held.*

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

1. MINUTES

July 20, 2022 Minutes were approved

2. COMMITTEE REPORTS

2.1 Base Hospital Advisory Committee (BHAC)
2.2 Provider Agency Advisory Committee (PAAC)

3. POLICIES

3.1 Reference No.518: Decompression Patient Destination
3.2 Reference No. 1010: MICN Certification
3.3 Reference No. 1011: MICN Field Observation

Motion/Second by Commissioners Meyer/Ower to approve the Consent Agenda was approved by majority vote:

Aye (11): Bixler, Hisserich, Lam, Lott, Meyer, Olney, Ower, Povilaitis, Powell, Snyder, Uner

No (0):

Abstain (1): Saeki

Absent During Vote (2): Cheung, Washburn

Absent (3): Caivano, Rodriguez, Tarpley

END OF CONSENT AGENDA

IV. BUSINESS

BUSINESS (OLD)

4.1 Prehospital Care of Mental Health and Substance Abuse Emergencies

4.1.1 Suicide Risk Screening Tool Pilot Program Approval

Director Tadeo reviewed a May 16, 2022 letter from Marianne Gausche-Hill, MD, EMS Agency Medical Director, to Santa Monica Fire Department (SMFD) confirming approval for SMFD to implement the Suicide Risk Screening Tool Pilot Program. The letter outlines the required data for tracking, as well as quarterly reporting expectations.

Dr. Gausche-Hill commented that this project provides insight to paramedics into suicide risk assessment and whether or not they feel they can do the risk assessment and do it safely. She will provide regular updates to the Commission throughout the trial.

Director Tadeo reported on second quarter transport status of patients taken directly from the field to various psychiatric urgent care centers (PUCC) and

sobering centers (SC). Staff will reach out to the centers for understanding of the low number of transports and report back to the Commission.

Discussion followed about adding additional mental health facilities for direct transports from the field and bed capacities of the current facilities. This is currently a pilot project, and the State is working on technical language through administrative law to revise the community paramedicine and alternate destination regulation which will list the components to move forward with designating PUCC and SC outside of a pilot program. This regulation is anticipated for final release in January 2023. Commissioner Olney will email a copy of a letter from Dr. Ruiz that was submitted to the LA County Board of Supervisors which lists bed capacities for the PUCCs and SCs.

4.2 Ambulance Patient Offload Time (APOT)

4.2.1 Q2 2022 APOT Report

Director Tadeo reported there are no significant changes compared to the first quarter APOT report. The percent of diversion was added to the report in order to compare diversion versus APOT.

We are continuing to work with providers on data validity with both the arrival time at the hospital and facility equipment time.

There was discussion on State requirements for APOT information to transition from self-reported data to utilizing the California Emergency Medical Services Information System (CEMSIS) as the data source. Los Angeles County's plan for compliance will involve the upgrade of the current Trauma Emergency Medical Information Services (TEMIS) legacy system in order to submit National Emergency Medical Services Information System (NEMSIS) 3.5 data standards.

Director Tadeo reported that the County is moving towards upgrading our legacy system to NEMSIS standard 3.5 to become compliant with CEMSIS by the end of the first quarter of 2023. This will require moving the current contract to a new program since our legacy system is old and was previously maintained by the vendor, Lancet Technology, who was purchased by ESO Solutions in December 2019. Since we are not yet 3.5 compliant, we are unable to send data to the State. The State anticipates they will be able to accept NEMSIS 3.5 in January of 2023

The difference between Los Angeles City Fire Department (LAFD) and LA County Fire Department (LACoFD) is that LAFD transports and can extract the transport data from their patient care record (PCR). LACoFD transports are done by contracted 9-1-1 exclusive operating area (EOA) ambulances (Faulk, McCormick, and AMR), and the EOA providers have different systems so the records used for calculating APOT is with the transport agencies. We will work with the State to see what kind of data they will be using.

4.2.2 Reference No 505: Ambulance Patient Offload Time (APOT)

Director Tadeo reported on changes made to Reference Number 505 and noted that it has gone through BHAC, PAAC, and Hospital Association of Southern California (HASC) Emergency Health Services (EHS) Committee for review. The definition for APOT is 30 minutes 90% of the time starting when

the ambulance arrives at their customary place, parks, and puts on the brake, and the end time is when the patient is transferred to a hospital bed, gurney or chair and care for the patient is assumed by hospital personnel. The State standard is 20 minutes 90% of the time. Given the time that paramedics offload from the ambulance and transport or wheel the patient into the emergency department (ED), the workgroup recommended to add on 10 minutes and that is what was adopted, 30 minutes 90% of the time.

The EMS Agency will identify and prioritize hospitals with the most egregious problems with APOT to engage with, based on staffing and workload rather than using the 90% compliance threshold. We have engaged with leadership of at least three (3) hospital systems which has been very productive. We will give the ED an opportunity to fix their problems if that is where the problem lies. We will escalate on the third month which is when the Chief Executive Officer is advised in writing about the lack of incremental improvement in APOT, or if there is no corrective action plan that has been implemented. If at the end of six months there is no demonstrable improvement in APOT, the agency will consider a reduction in 9-1-1 transports to hospitals.

Commissioner Olney requested California Department of Public Health review this policy to be consistent with any kind of regulations that ties in with licensing, and the EMS Agency will do that.

Further discussion ensued on whether BHAC and PAAC have seen all of the changes in the current version of Reference Number 505 and if there is a need to send the policy through the committees again. Director Tadeo recommended moving the policy forward and if any changes need to be made prior to the three-year policy review cycle, then the policy will be revised accordingly and brought back to the committees and the EMS Commission.

Mr. Mark Gamble with HASC confirmed that HASC appreciates the work that Director Tadeo and the EMS Agency did on this policy, and HASC is in support of implementing the policy as written. Members on the EHS Committee also on the BHAC are in support this new version.

Motion/Second by Commissioners Meyer/Lott to approve policy Reference No. 505 was approved by majority vote:

Aye (13): Bixler, Cheung, Hisserich, Lam, Lott, Meyer, Ower, Povilaitis, Powell, Saeki, Snyder, Uner, Washburn

No: (0)

Abstain (0):

Absent During Vote (1): Olney

Absent (3): Caivano, Rodriguez, Tarpley

4.3 LA County COVID-19 Update – EMS Agency

Dr. Gausche-Hill reported on the reduction in COVID-19 cases with a general positive average of less than 6%. There is a decline in patient hospitalizations and deaths due

to COVID-19. Weekly CHA poll is on a downward trend from the second Omicron surge (BA.5, etc.). Monoclonal antibodies are not active against current variants. Overall, in the prehospital settings, provider impression for respiratory distress and cardiac arrests are within the pre-pandemic levels.

A recent LA County Public Health order was issued to align with the State order rescinding the testing requirement for workers exempt due to medical reasons or religious beliefs and for visitors to hospitals. Everyone still needs to be masked in those settings.

Governor Gavin Newsom declared a state of emergency for monkeypox in California with over 2,000 cases in LA County with the large majority being males in varying age groups. There are a few cases in the pediatric population. An antiviral, Tecovirimat (TPOXX), is available for treatment of severe cases.

The EMS Agency was contacted by Public Health and has distributed Tecovirimat to all of our DRCs who then make it available for the umbrella hospitals, which includes PO dosing as well as IV dosing. All of the pharmacists have been notified about the availability of this medication. In addition, Public Health has a 24-hour hotline that anybody can call and talk to an on-call physician through Public Health if they have questions regarding monkeypox. It is a viral disease and usually endemic in Africa, but it has spread to Europe and then to the United States. We are not seeing large increases now, although there has been spread in the United States.

Because of the declared emergency, the EMS Agency was able to get approval of Local Optional Scope of Practice for paramedics and EMTs to be involved in monkeypox vaccination programs. The vaccine is given either intradermally or subcutaneously. We were approved to give subcutaneously, and Dr. Gausche-Hill created teaching slides and an information packet. We do have some EMS provider agencies that are assisting their local public health in providing monkeypox vaccination.

The recommendation for monkeypox is to mask and wear gloves and eye protection as well, but absolutely gloves and masks. Generally, it is more contact transmitted although it can be aerosol generating. So, it is important for those procedures to fully use PPE just as you would do with COVID-19.

Several memos have gone out, one related to vaccination, one related to PPE when monkeypox first started appearing in our jurisdiction. Overall, there have been some contacts with EMS and monkeypox patients but no transmission or any high-risk exposures. There is either no risk or low risk which does not require treatment, but just close monitoring is recommended. Bare skin touching a monkeypox lesion is a potential for transmission.

4.4 EMS Commission Ordinance

Denise Watson, EMS Commission Liaison, reported the EMSC Ordinance membership language is being revised to reflect current membership. The Department of Health Services Contracts & Grants section is reviewing the language and the Ordinance is tentatively set for submission to the LA County Board of Supervisor for approval by the end of November 2022.

4.5 Ad Hoc Workgroup: Alameda EMS Corps for LA County

Jacqueline Rifenburg, EMS Assistant Director, reported a workgroup is being formed

consisting of Commissioners Caivano, Lott, Meyer, Olney, some Providence Hospital staff, Dr. Wilhelm with the EMS Agency, and Mr. Michael Gibson who is the Director of the Alameda EMS Corp. The workgroup will be meeting this month, and they will provide an update at the next EMSC meeting. Anyone interested in joining this workgroup should contact Ms. Rifenburg.

BUSINESS (NEW)

4.6 Public Education on Specialty Care Centers

Director Tadeo reported the EMS Agency is planning a 40-year celebration in commemoration of the Trauma system's 40th year anniversary in December 2023 to possibly be held at the California Endowment Center.

There was discussion about creating a brochure or public service announcement educating the public on the proper use of ERs, the differences between trauma centers, stroke centers, STEMI centers, and urgent cares. Anyone interested in participating on the planning committee, please contact Director Tadeo.

Dr. Gausche-Hill reported that the trauma kits Bill is on Governor Newsom's desk for signature. She reported that the EMS Agency was asked by some of the provider agencies to apply to the State for blood transfusion as part of a 9-1-1 re-triage scenario, meaning that paramedics could monitor blood transfusions so those could be ongoing during transport. The plan is to request before December and will report back to the Commission about that Expansion and Local Optional Scope for 9-1-1 Re-Triage.

Chair Lam suggested an educational use of the ER system, urgent care system, and acknowledging that there are different specialty centers, is important for the public to understand, and Trauma Hospital Advisory Committee (THAC) will probably do something promoting trauma.

4.7 Annual Report Fiscal Year 2021-22

Director Tadeo reviewed the Annual Report noting a correction to Fiscal Year references on page 6. Please forward any information or changes to Ms. Watson.

4.8 Meeting Date Changes from 3rd to 4th Wednesday, March 22, and September 27, 2023

Director Tadeo reported meeting date conflicts for March and September of 2023. The proposed dates also conflict, so these meetings will be March 8, and September 13.

V. LEGISLATION

Director Tadeo reported on the following legislation:

AB 2260 – Trauma Kits available to the public – on Governor Newsom's desk.

AB 2130 – The addition of 20 minutes for EMT training on Human Trafficking. Slated to become effective July 1, 2024.

AB2117 – Mobile Stroke Unit (MSU) – on Governor Newsom's desk. Designates the MSU as a site of service so the MSU can bill for the services they provide.

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

Director Tadeo reported on correspondence

CORRESPONDENCE

6.1 (07-26-2022) Distribution: EMS Training Program Approval Manager

6.2 (07-27-2022) Marcel Loh: Re-Instatement of STEMI and Cardiac Arrest Receiving Status of Hollywood Presbyterian Medical Center

6.3 (08-04-2022) Anish Mahajan, Harbor-UCLA: Allocation of Pediatric Trauma Center Funding (Richie's Fund) for FY 2021-2022

6.4 (08-04-2022) Thomas M. Priselac, Cedars-Sinai: Allocation of Pediatric Trauma Center Funding (Richie's Fund) for FY 2021-2022

6.5 (08-04-2022) Paul Viviano, Children's Hospital: Allocation of Pediatric Trauma Center Funding (Richie's Fund) for FY 2021-2022

6.6 (08-04-2022) Paul Watkins, Dignity Health Northridge: Allocation of Pediatric Trauma Center Funding (Richie's Fund) for FY 2021-2022

6.7 (08-04-2022) Jorge Orozco, LAC+USC: Allocation of Pediatric Trauma Center Funding (Richie's Fund) for FY 2021-2022

6.8 (08-04-2022) John Bishop, Memorial Care Long Beach: Allocation of Pediatric Trauma Center Funding (Richie's Fund) for FY 2021-2022

6.9 (08-04-2022) Johnese Spisso, Ronald Reagan UCLA: Allocation of Pediatric Trauma Center Funding (Richie's Fund) for FY 2021-2022

6.10 (08-15-2022) Distribution: Suspension of Service Area Boundaries for Centinela Hospital Medical Center
This allows Centinela Hospital to put themselves on diversion. This will allow providers to be proactive when they know APOT is going to be prolonged. This was implemented in mid-August and we have not had any negative feedback from lifting their service area.

We will have three vacancies: Commissioner Jeffrey Rollman moved to Texas, Public Health; Chief Carl Povilaitis is retiring at the end of this month, LA County Police Chiefs' Association; and Joseph Salas resigned as he has taken on a different role, Public Member representing Supervisor Hilda L. Solis's 1st District. We will notify those associations that we need new representation.

A couple of meetings ago it was requested to email the EMSC packets and limit mailing of hard copies. Almost all commissioners want to receive by email only. For those who still want paper packets we will continue mailing to Commissioners who requested hard copies.

American Medical Response is suspending their interfacility transport program which involves basic life support, advanced life support and critical care transport due to financial reasons. The employees will be incorporated into their 9-1-1 operations to support their 9-1-1 EOA contract. It is 180-day contract termination plan that is dependent on the termination clause they have with their individual contracts. This will impact Huntington and Providence Hospitals who they have contracts with.

Dr. Gausche-Hill reported on the Pedi-DOSE Trial which is a National Institute of Health funded study called Pediatric Dose Optimization for Seizures in EMS. Currently we have trained everyone to the initial phase of the study which involves data collection on "usual care." We operate under our current protocols, and paramedics call to give a self-report on patients six months to 13 years. Overall, it is a great process where they have a link on their electronic Patient Care Record (ePCR), and they put in the data. It is a good way to collect data prospectively over time. We will be notified by the investigators when it is our turn to go to the intervention phase. A memo regarding this was distributed to all 9-1-1 providers as well as Base Hospital personnel. In the intervention phase, we will modify our protocols and

our mobile application to include dosing by age and there will be an educational program prior to implementation. Our plan is to try to align this with EMS Update 2023 or 2024 depending upon when we initiate that phase.

VII. COMMISSIONERS' COMMENTS / REQUESTS

Commissioner Carol Meyer reported she spent two hours with Commissioner Carole Snyder at PIH Health-Whittier in the ED watching APOT time. She witnessed two offloads that went pretty smooth. It was insightful and she appreciated invitation.

Commissioner Atilla Uner announced the use of Buprenorphine (to treat opiate withdrawal in the field – opiate replacement therapy or medically assisted therapy by EMS in the field) has been moved out of trial study phase to the Local Option Scope of Practice, and any LEMSA can apply for that through the Scope of Practice Committee. This was voted on by the State EMS Commission today.

VIII. ADJOURNMENT:

Adjournment by Chair Lam at 2:27 p.m.

Next Meeting: Wednesday, November 16, 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

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Recorded by:
Denise Watson
Secretary, Health Services Commission

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

October 12, 2022

MEMBERSHIP / ATTENDANCE (VIA Zoom)

	REPRESENTATIVES		EMS AGENCY STAFF
☑	Carol Meyer, RN Chair	EMS Commission	Marianne Gausche-Hill. MD
☑	Carole Snyder, RN., Vice Chair	EMS Commission	Nichole Bosson, MD
☐	Atilla Under, MD, MPH	EMS Commission	Denise Whitfield, MD
☑	Lydia Lam, MD	EMS Commission	Kelsey Wilhem, MD
☑	Diego Caivano, MD	EMS Commission	Richard Tadeo
☐	Erick Cheung, PhD	EMS Commission	Christine Clare
☐	Garry Olney, DNP	EMS Commission	Jacqui Rifenburg
☑	Paul Rodriquez, FF/Paramedic	EMS Commission	Ami Boonjaluksa
☐	Jim Lott, PsyD, MBA	EMS Commission	David Wells
☐	John Hisserich	EMS Commission	Lorrie Perez
☐	Brian Bixler, Captain	EMS Commission	Lily Choi
☑	Robert Ower, RN	EMS Commission	Susan Mori
☑	Rachel Caffey	Northern Region	Natalie Greco
☑	Melissa Carter	Northern Region	Christine Zaiser
☑	Charlene Tamparong	Northern Region, Alternate	Karen Rodgers
☐	Samantha Verga-Gates	Southern Region	Aldrin Fontela
☑	Laurie Donegan	Southern Region	Priscilla Romero
☑	Shelly Trites	Southern Region	Fritz Bottger
☑	Christine Farnham	Southern Region, Alternate	Denise Watson
☑	Ryan Burgess	Western Region	Gary Watson
☑	Susana Sanchez	Western Region, Alternate	
☑	Erin Munde	Western Region, Alternate	
☑	Laurie Sepke	Eastern Region	
☑	Alina Candal	Eastern Region	
☐	Jenny Van Slyke	Eastern Region, Alternate	GUESTS
☐	Lila Mier	County Region	Zach Halpern, MD
☑	Emerson Martell	County Region	Amar Shah, MD
☑	Yvonne Elizarraraz	County Region	Won Ki Chae, MD
☑	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	Pediatric Advisory Committee Representative	
☑	Heidi Ruff	PED AC Representative, Alternate	
☐	Naomi Leland	MICN Representative	
☐	John Foster	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)	☑	Brandon Koulabouth (AMH)

1. **CALL TO ORDER:** The meeting was called to order at 1:00 by Carol Meyer, Chair.

2. **APPROVAL OF MINUTES**: The meeting minutes for August 10, 2022, were approved as presented.

3. **INTRODUCTIONS/ANNOUNCEMENTS:**
   3.1 No changes from the June 2022 LA County EMS Organizational Chart version.

4. **REPORTS & UPDATES:**

4.1 EMS Update 2022

EMS Update Part 2 is completed as of October 1, 2022, including the Behavioral Health Policies and Olanzapine. In addition, base reporting and paramedic self-reporting for PediDOSE has begun. LACoFD and LAFD have been given extensions for completing until the end of the year.

4.2 EmergiPress

Online CE education can be accessed through the APS or EMS websites. The next edition will be released in October, focusing on Toxicology Emergencies.

4.3 ECMO Pilot

The ECMO Pilot Program will continue to enroll patients through July 2023 with a target goal of 80 patients. ECMO patients who meet the criteria and are 30 minutes from an ECMO Center will be routed to UCLA or Cedar Sinai Hospital. USC accepts ECMO patients only if they are the closest SRC facility.

Long Beach Memorial Hospital is completing the ECMO Pilot Program requirements, and Long Beach Fire will begin training this month with the hope that both will be on board by the end of the year.

Per the request from other EMS systems, the process for ECMO in refractory V-fib arrest is in progress.

4.4 Data Collaboratives

Dr. Bosson provided an overview of each of the collaboratives. The collaborative groups meet quarterly to discuss and explore research opportunities, data collection, and opportunities for system improvement.

SRC Collaborative:

COVID Impact Projects

- Dr. Shavelle is looking at the impact of COVID on STEMI Care. During the COVID pandemic, the STEMI system managed to maintain D2B (door to balloon) and FMC (first medical contact) times, which is a testament to LA County's well-established system.

Other Aspects

- Dr. Toy has taken the lead on the Post Resuscitation Care project, looking at post-resuscitation care protocols. The manuscript is currently under revision and will be shared with the group once published.
- The manuscript on access to CPR training is in progress.

Stroke Data Collaborative:

- The manuscript on the Frequency of Thrombectomy in Early and Late Post-Onset Time Windows Among EMS Transported Patients with Acute Ischemic Stroke has been accepted by the Journal of Stroke Interventional and Vascular Neurology. It will be shared with the group once published.

- A recent revision has been submitted to the Journal of Stroke, looking at the benefit of routing stroke patients up to 24 hours from LKWT. Evaluation of the data supports that when patients with a later stroke time window are routed to a CSC, thrombectomy is performed 25% of the time.

Pediatrics

- The abstract data for the Brief, Resolved, Unexplained Events (BRUE) Study has been written and submitted.
- Dr. Kelsey Wilhem and researchers at CHLA are looking at a descriptive analysis of the current state of pediatric OHCA (out-of-hospital cardiac arrest) in Los Angeles County. They are specifically looking at how long providers are staying in the field.
- The grant for National Pediatric Airway Management Trial is being re-submitted, and if funded, it would compare i-gel and BVM in pediatric respiratory emergencies.

Trauma Consortium:

- Southern California Regional Trauma Consortium is currently focusing on imaging pregnant patients and isolated sternal fractures in hospital studies.
- Denise Whitfield and Dr. Kelsey Wilhem are taking the lead on a pilot study looking at needle thoracostomy safety. The study will look at using a device to locate an insertion site for needle thoracostomy. They will examine how the ThoraSite device compares to the current landmark approach. In the next phase, they will collaborate with Dr. Inaba at USC collecting outcome data from patients across the system who received needle thoracostomy.

Independent

- Cardiac Arrest Study, with collaboration from researchers, medical directors, and administrators across California, is looking at implementing a prospective trial bundle of post-resuscitative care to prevent rearrest, which occurs 40% of the time and is associated with poor outcomes.
- Dr. Toy presented our EMS data on non-transport patients at the American College of Emergency Physicians (ACEP) conference. The write-up for the data which supports the safety of low-risk non-transported patients is in progress.

4.5 PediDOSE Study (**Pedi**atric **D**ose **O**ptimization for **S**eizure in **E**MS)

PediDOSE Study is a National Institute of Health-funded study evaluating age-based dosing for children with seizures. The study is currently in phase one, the Usual Care Phase, which means protocols remain the same and parental consent is unnecessary. After the transfer of care, the provider and the base hospital (if base contact is made) will self-report and enter the patient's data at Children's Hospital Los Angeles (CHH). Patient enrollment is six months to 13 years of age with Provider impression of SEPI (Seizure Postictal) or SEAC (Seizure Active). In phase two, the Intervention Phase, Medical Control guideline 1309 will change to age-based dosing for midazolam.

5. OLD BUSINESS:

None

6. NEW BUSINESS:

Informational Only

6.1 Ref. No. 408. ALS Unit Staffing
6.2 Ref. No. 510. Pediatric Patient Destination
6.3 Ref. No. 832. Treatment/Transport of Minor
6.4 Ref. No. 834. Patient Refusal of Treatment/Transport and Treat and Release at Scene
6.5 TP 1200.2- Base Contact Requirements
6.6 TP 1203- Diabetic Emergencies
Suggestion: add special consideration # 3 of Ref. No. 1203-P to the Ref. No. 1203, to provide clarity as to when it is appropriate to use an IO
6.7 TP 1203-P- Diabetic Emergencies
6.8 TP 1212 - Cardiac Dysrhythmia- Bradycardia
6.9 TP 1219 - Allergy
6.10 TP 1219 - P Allergy
6.11 TP 1225 - Submersion
6.12 TP 1241 - Overdose/Poisoning/Ingestion
6.13 TP 1241-P - Overdose/Poisoning/Ingestion
6.14 MCG 1309 - Color Code Drug Doses
6.15 MCG 1317.9 - Drug Reference - Atropine
6.16 MCG 1317.13 - Drug Reference – Dextrose
6.17 MCG 1317.25 – Drug Reference – Midazolam
6.18 MCG 1355 – Perfusion Status

7. OPEN DISCUSSION

There was discussion regarding the language in policy Ref No. 502, Patient Destination, which states that restrained patients shall be transported to the most accessible receiving (MAR) facility.
Interpretation of the policy has raised concerns about when a restrained patient is transported to the closest facility, and the facility is on diversion. As per Ref. No. 502, Policy II, A., 4, the patient can be diverted.

8. NEXT MEETING: BHAC's next meeting is scheduled for December 7, 2022.

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

ACCOUNTABILITY: Laura Leyman

9. ADJOURNMENT: The meeting was adjourned at 13:25.

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

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, October 19, 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
☑ Paul Rodriguez	EMSC, Commissioner
☐ James Lott, PsyD, MBA	EMSC, Commissioner
☐ Brian Bixler	EMSC, Commissioner
☑ John Hisserich, DrPH	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
☑ Jeff Tsay	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.
☐ David Hahn	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
☑ Tabitha Cheng, MD	Provider Agency Medical Director
☐ Tiffany Abramson, MD	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.
☑ Scott Atkinson	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	Jacqueline Rifenburg
Ami Boonjaluksa	Susan Mori
Laura Leyman	Aldrin Fontela
Christine Zaiser	Denise Watson
Terry Cramer	Jake Toy, MD
Karen Rodgers	Gary Watson
Kelsey Wilhelm, MD	

PUBLIC ATTENDEES (Virtual)	
Damien Cyphers	Liberty Ambulance
Jennifer Breeher	Alhambra FD
Sean Wise	West Covina FD
Heidi Ruff	LAFD Air Operations
Travis Moore	La Verne FD
Britney Alton	Burbank FD
Carissa Kinkor	Liberty Ambulance
Joseph Nakagawa, MD	McCormick Amb / Hawthorne PD
Louis Mendoza	Liberty Ambulance
Daniel Graham	Liberty Ambulance
Jessie Castillo	PRN Ambulance
Nicholas Amsler	McCormick Ambulance
Katie Ward	La Habra Heights FD
Sameer Mistry, MD	Liberty, AMWest, Ambuserve Amb
Marianne Newby	UCLA Ctr for Prehospital Care
Catherine Borman	Santa Monica FD
Paula LaFarge	Los Angeles County FD
Mick Hannan	Long Beach FD
Kelsey Wilhelm, MD	Compton FD
Richard Oishi	Arcadia FD
Adrienne Roel	Culver City FD
Marc Cohen, MD	Four Area Fire Departments
Erich Ekstedt	Downey FD
Heather Caulk	UCLA Ctr for Prehospital Care

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

2. INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS

2.1 PAAC Membership Changes *(Robert Ower)*

Chairman introduced the following new member:

- Area H, Alternate: David Hahn, Los Angeles Fire Department, replacing Matthew Potter.

2.2 Medical Director, Los Angeles Fire Department *(Marianne Gausche-Hill, MD)*

Dr. Gausche-Hill welcomed and congratulated Marc Cohen, MD as the newly appointed Acting Medical Director for the Los Angeles [City] Fire Department.

3. APPROVAL OF MINUTES (Hisserich / Rodriquez) August 17, 2022 minutes were approved as written.

4. REPORTS & UPDATES

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

- Los Angeles County continues to see multiple COVID variants; but does not seem to be affecting the prehospital environment. Hospitals are still seeing many cases of COVID-19; however, death rates have declined.
- California Governor has declared that the State of Emergency is over and will take effect in February 2023. All Executive Orders that affected paramedic and EMTs (i.e., vaccination/immunization programs) will cease. EMS Agency will clarify with the State if paramedics may continue participating with the immunization programs (influenza vaccines, etc.).
- Los Angeles County Public Health released an updated Health Officer Order (September 17, 2022), to align with the recent change to the State Health Officer's Health Care Worker Vaccine Requirement Order. This new Order speaks of updated testing requirements for workers; COVID-19 immunization requirements; as wells as a reminder to all EMS providers and emergency departments, to continue wearing masks while at work and while caring for patients.

4.2 PediDose Study *(Marianne Gausche-Hill, MD)*

- Los Angeles County is participating in a National Institute of Health – funded, 4-year study, titled Pediatric Dose Optimization for Seizures in EMS (PediDose).
  - Phase One of the two phases started after completion of EMS Updated 2022 (Part 1) and includes the tracking of patients using current LA County Provider Impressions: Seizure, Active (SEAC) or Seizure, Postictal (SEPI). This phase includes a self-reporting section for prehospital and base hospital personnel after using one of the above provider impressions.
  - Phase Two is the Intervention phase in which additional training will be required. When this phase begins, there will be changes to Reference No. 1309, Color Code Drug Doses.

4.3 SRC Inclusion Criteria *(Marianne Gausche-Hill, MD)*

- In attempts to reduce the number of false-positives, the EMS Agency has changed the SRC Inclusion Criteria from a 12-lead ECG computer reading to a Provider Impression of CPMI (Chest Pain - STEMI).
- Due to this change, it is important to remember that if a paramedic believes the patient is having an MI (myocardial infarction) to ensure "CPMI" is documented on the patient care record.
- Reference No. 648, STEMI Receiving Center Data Dictionary inclusion criteris, was reviewed to point out changes.

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

The following projects continue within each Collaborative Group:

- STEMI/OHCA Data Collaborative
  - Ongoing projects
- Stroke Data Collaborative
  - Currently reviewing data results of stroke center accessibility, outcomes of stroke patients, timing of strokes, and how COVID-19 affects stroke patients
- Pediatric Data Collaborative
  - BRUE (Brief Resolved Unexplained Events)
  - Pediatric cardiac arrest data (conducted by Dr. Kelsey Wilhelm)
- Trauma Data Collaborate
  - Ongoing projects

Dr. Gausche-Hill expressed the importance for field paramedics to receive a summary of the Data Collaborative research results. A plan to disseminate will include the providing information through newsletters and/or EmergiPress publications.

4.5 ECMO Pilot *(Marianne Gausche-Hill, MD)*

- Cedar-Sinai Medical Center and Ronald Reagan UCLA Medical Center continue to participate in the ECMO Pilot program; as well as several public providers. This Pilot will most likely continue for at least one more year.
- Dr. Gausche-Hill congratulated Los Angeles County Fire Department for receiving the Productivity & Quality Award for the Arrive-Alive Program.

4.6 EMS Update 2022 *(Denise Whitfield, MD / Jacqui Rifenburg)*

Jacqui Rifenburg acknowledged that there has been very good compliance with the completion of EMS Update 2022 (Parts 1 and 2). Exception to this is a few MICNs and two fire departments who have been given extensions. (LAFD and LACoFD will complete the training by January 1, 2023)

- Dr. Whitfield thanked all participants in the Los Angeles County EMS system for completing the robust, two-part training requirements, that were due October 1, 2022.
- Olanzapine was added to paramedic inventories and treatment protocols, effective October 1, 2022.

4.7 ITAC Update *(Denise Whitfield, MD)*

This Committee met on August 1, 2022 and the following products were under review:

- SAM ThoraSite Device: a plastic device that fits over the axilla, to assist with appropriate placement of the needle thoracostomy. The plan is to have a pilot study of this device, starting in 2023. Three provider agencies have expressed interest in participating.
- SAM Pelvic Sling: medical device for suspected pelvic trauma. After receiving concerns from various trauma surgeons, this Committee found that there was insufficient favorable data to implement this device in the prehospital setting.
- ECG 12-Lead Acquisition Device: obtains ECGs without artifact. Once FDA approved, this device will be resubmitted to ITAC for review.

4.8 EmergiPress *(Denise Whitfield, MD)*

Next edition will be out in October 2022, with a toxicology theme.

4.9 Ebola Update *(Terry Cramer)*

- September 20, 2022, Ebola outbreak first reported from Uganda. Previous outbreak was in 2012. Currently, there have been a total of 63 Ebola cases and 29 deaths.
- Due to multiple travel checks between Uganda and the United States, there is low probability of patients entering the U.S. with the Ebola virus.
- In California, there are six (6) designated facilities that can accept suspected Ebola patients. Four (4) of these facilities are within Los Angeles County: Kaiser Permanente - Los Angeles, Ronald Reagan UCLA Medical Center, Children's Hospital of Los Angeles and Cedar-Sinai Medical Center.
- Providers are reminded, that for a suspected Ebola patient, to call the Medical Alert Center (MAC) for patient destination, rather than the base hospital.
- An EMS Agency document titled "911 EMS Provider Ebola Virus Disease (EVD), Patient Assessment and Transportation Guidelines" (Rev. 10/17/22) was reviewed and distributed to the Committee. This document is posted on the EMS Agency's webpage.

5. UNFINISHED BUSINESS

5.1 Reference No. 505, Ambulance Patient Offload Time (APOT) *(Richard Tadeo)*

Policy reviewed. However, no action is needed by Committee due to policy being approved by EMS Commission on September 21, 2022. The approved and signed policy is currently posted on the EMS Agency's webpage.

6. NEW BUSINESS

6.1 Additional PAAC Membership Position: CAL-NEP *(Adrienne Roel, Culver City FD)*

Presentation given to Committee requesting to add a new seat on Committee to be filled by a representative from the California Nurse and EMS Professionals (CAL-NEP) association.

M/S/C (Hisserich / Stokes) Approve to add new Committee membership.

After Motion, the following roll call vote was conducted:

Committee Representation:	Roll Call Vote:
Area A – Sean Stokes	Yea
Area B – Clayton Kazan, MD	Yea
Area C – Todd Tucker	Yea
Area E – Kurt Buckwalter	Yea
Area F –	Not in attendance
Area G –	Not in attendance
Area H – Doug Zabilski	Yea
Employed Paramedic Coordinator – Julian Hernandez	Yea
Prehospital Care Coordinator – Rachel Caffey	Yea
Public Sector Paramedic Coordinator – Paul Voorhees	Yea
Private Sector Paramedic Coordinator –	Not in attendance
Provider Agency Medical Director – Tabitha Cheng, MD	Yea
Nurse Staffed Ambulance – Andrew Lara	Abstained due to unfamiliarity
EMT Training Programs – Michael Kaduce	Yea
Paramedic Training Programs – Scott Atkinson	Yea

ROLL CALL CONSENSUS: Committee was in favor of adding a new seat to this Committee for CAL-NEP representative. Topic will move forward in seeking approval at the next EMS Commission meeting, scheduled for November 16, 2022.

6.2 Reference No. 408, ALS Unit Staffing *(Marianne Gausche-Hill, MD)*

Policy reviewed and approved as written.

M/S/C (Zabilski / Kaduce) Approve: Reference No. 408, ALS Unit Staffing

6.3 Reference No. 510, Pediatric Patient Destination *(Marianne Gausche-Hill, MD)*

Policy reviewed and approved with the following recommendation:

- Page 3, Policy II, D.: Remove the word "Persistent".

M/S/C (Kazan / Kaduce) Approve: Reference No. 510, Pediatric Patient Destination, with above recommendation.

6.4 Reference No. 832, Treatment / Transport of Minors *(Marianne Gausche-Hill, MD)*

Policy reviewed and approved as written.

M/S/C (Kazan / Hernandez) Approve: Reference No. 832, Treatment / Transport of Minors

6.5 Reference No. 834, Patient Refusal of Treatment / Transport and Treat and Release at Scene *(Marianne Gausche-Hill, MD)*

Policy reviewed and approved as written.

M/S/C (Hisserich / Jorgenson) Approve: Reference No. 834, Patient Refusal of Treatment / Transport and Treat and Release at Scene

6.6 Reference No. 604, Ordering Prehospital Care Forms *(Sara Rasnake)*

Policy reviewed and approved as written.

M/S/C (Kazan / Tucker) Approve: Reference No. 604, Ordering Prehospital Care Forms

The following policies were presented as <u>Information Only</u>:

6.7 Reference No. 703, ALS Unit Inventory *(Gary Watson)*
6.8 Reference No. 703.1, Private Provider Non-911 ALS Unit Inventory *(Gary Watson)*
6.9 Reference No. 704, Assessment Unit Inventory *(Gary Watson)*
6.10 Reference No. 706, ALS EMS Aircraft Inventory *(Gary Watson)*
6.11 Reference No. 712, Nurse Staffed Specialty Care Transport Unit Inventory *(Gary Watson)*
6.12 Reference No. 713, Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory *(GW)*
6.13 Reference No. 719, Fireline Emergency Technician-Paramedic (FEMP) Inventory *(Gary Watson)*
6.14 Treatment Protocol 1200.2 – Base Contact Requirements *(Marianne Gausche-Hill, MD)*
6.15 Treatment Protocol 1203 – Diabetic Emergencies *(Nichole Bosson, MD)*
6.16 Treatment Protocol 1203-P – Diabetic Emergencies [Pediatrics] *(Nichole Bosson, MD)*
6.17 Treatment Protocol 1212 – Cardiac Dysrhythmia – Bradycardia *(Nichole Bosson, MD)*
6.18 Treatment Protocol 1219 – Allergy *(Nichole Bosson, MD)*
6.19 Treatment Protocol 1219-P – Allergy [Pediatric] *(Nichole Bosson, MD)*
6.20 Treatment Protocol 1225 – Submersion *(Chris Clare/Richard Tadeo)*
6.21 Treatment Protocol 1241 – Overdose/Poisoning/Ingestion *(Nichole Bosson, MD)*

6.22 Treatment Protocol 1241-P – Overdose/Poisoning/Ingestion [Pediatric] *(Nichole Bosson, MD)*
6.23 Medical Control Guideline 1309 – Color Code Drug Doses *(Richard Tadeo)*
6.24 Medical Control Guideline 1317.9 – Drug Reference – Atropine *(Denise Whitfield, MD)*
6.25 Medical Control Guideline 1317.13 – Drug Reference – Dextrose *(Richard Tadeo)*
6.26 Medical Control Guideline 1317.25 – Drug Reference – Midazolam *(Nichole Bosson, MD)*
6.27 Medical Control Guideline 1355 – Perfusion Status *(Nichole Bosson, MD)*

7. OPEN DISCUSSION

7.1 Law Enforcement Tactical Disengagement *(Nichole Bosson, MD)*

The EMS Agency is seeking input and participation in developing a task force, in collaboration with law enforcement, to address engagement / disengagement rather than taking down a person who may have a mental health crisis and not in danger of harming self. Those interested in participating on this task force may contact Jacqui Rifenburg at JRifenburg@dhs.lacounty.gov.

7.2 High Volume Utilizers *(Kelsey Wilhelm, MD)*

The EMS Agency is seeking input on possible mitigation strategies for addressing patients who are high-volume utilizers. Providers who wish to participate in a task force or provide any feedback may contact Kelsey Wilhelm, MD at KWilhelm@dhs.lacounty.gov

7.2 Hospital Destination for the Restrained Patient *(Denise Whitfield, MD & Marianne Gausche-Hill, MD)*

After discussion regarding "Destination of Restrained Patients" (Reference No. 502, Patient Destination), it was concluded that this topic requires further discussion by the EMS Agency and then present back to this Committee.

8. NEXT MEETING: December 21, 2022

9. ADJOURNMENT: Meeting adjourned at 3:15 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES **DRAFT 8-16-2022**

SUBJECT: **ADVANCED LIFE SUPPORT UNIT STAFFING** REFERENCE NO. 408

PURPOSE: To identify the policy adopted by the Los Angeles County Board of Supervisors for staffing Advanced Life Support (ALS) units.

POLICY: "All ALS units, both public and private, shall be staffed with at least two State licensed paramedics accredited in Los Angeles County, two mobile intensive care nurses (MICN), a combination of paramedic and MICN, or the combination of a paramedic and an Advanced Practice Provider (Physician Assistant or Nurse Practitioner) who has completed an orientation program approved by the Los Angeles County EMS Agency. Exceptions may be made on a temporary basis in those instances where one member of the ALS unit is injured, becomes ill, or is otherwise incapacitated while on duty or is unavailable for duty because of unusual and unforeseen circumstances, and therefore is unable to perform as a member of the unit, for a period not to exceed the end of the scheduled shift. In each instance where an ALS unit operates with less than the minimum staff stated herein, it shall be reported at the end of the calendar month to the Director of Emergency Medical Services Agency."

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

Reference No. 408, Advanced Life Support Unit Staffing

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/19/22	10/19/2022	No
	Base Hospital Advisory Committee	10/12/22	10/12/2022	No
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT-I/EMT-P/MICN)

SUBJECT: **TREATMENT/TRANSPORT OF MINORS** REFERENCE NO. 832

PURPOSE: To describe the guidelines for treatment and/or transport of a patient under the age of eighteen.

AUTHORITY: Health and Safety Code Section 124260
California Family Code 6922, 6925, 6926, 6927, 6929, 7002, 7050, 7122, 7140
Business and Professions Code 2397

DEFINITIONS:

Emergency Medical Condition: A condition or situation in which an individual has an immediate need for medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure – except isolated asymptomatic hypertension, oxygen saturation) are also indications of an emergency condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification are also considered to have an emergency medical condition.

Implied Consent: In the absence of a parent or legal representative, emergency treatment and/or transport of a minor may be initiated without consent.

Legal Representative: A person who is granted custody or conservatorship of another person by a court of law.

Minor: A person less than eighteen years of age.

Minor not requiring parental consent is a person who is:

1. Married or was previously married.
2. Currently or prvieously in a valid domestic partnership.
3. Not married and has an emergency medical condition and parent is not available.
4. On active duty with the Armed Forces.
5. Self-sufficient 14 years of age or older, living separate and apart from his/her parents, and managing his/her own financial affairs.
6. An emancipated minor with a declaration by the court or an identification card from the Department of Motor Vehicles.
7. Seeking care related to the treatment or prevention of pregnancy.
8. In need of care for sexual assault or rape.

APPROVED:

Director, EMS Agency

Medical Director, EMS Agency

9. Seeking care related to an abortion.

10. 12 years of age or older and in need of care for communicable reportable disease, prevention of a sexually transmitted infection (STI), alcohol or substance abuse, or outpatient mental health.

Voluntary Consent: Treatment or transport of a minor child shall be with the verbal or written consent of the parents or legal representative.

PROCEDURES:

I. Treatment/Transport of Minors

A. In the absence of a parent or legal representative, minors with an emergency medical condition shall be treated and transported to the appropriate receiving facility or a specialty care center (e.g. EDAP, PMC, PTC, SART Center, Trauma Center, etc.).

Minors should be transported using a restraint device appropriate for their size, weight, transport position, and medical condition. Restraint devices used should comply with the Federal Motor Vehicle Safety Standard (FMVSS) 213.

C. Hospital or provider agency personnel shall make every effort to inform a parent or legal representative where their child has been transported.

D. If prehospital care personnel believe a parent or other legal representative of a minor is making a decision which appears to be endangering the health and welfare of the minor by refusing indicated immediate care or transport, law enforcement authorities should be involved.

E. Infants ≤ 12 months of age shall be transported, regardless of chief complaint and /or mechanism of injury, in accordance with Ref. No. 1200.2, Treatment Protocol: Base Contact Criteria.

II. Minors **Not** Requiring Transport

A. A minor child (excluding children ≤ twelve (12) months of age) who is evaluated by EMS personnel and determined not to be injured, to have sustained only minor injuries, or to have illnesses or injuries not requiring immediate treatment or transportation, may be released to:

1. Self (consideration should be given to age, maturity, environment and other factors that may be pertinent to the situation)

2. Parent or legal representative

3. A responsible adult at the scene

4. Designated care giver

5. Law enforcement

B. Children 13 - 36 months of age require base hospital contact and/or transport, except those with no medical complaint or with isolated minor extremity injury.

C Prehospital care personnel shall document on the EMS Report Form to whom the patient was released.

CROSS REFERENCE:

Prehospital Care Manual
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 508.1, **SART Center Roster**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 822, **Suspected Child Abuse Reporting Guidelines**
Ref. No. 834, **Patient Refusal of Treatment / Transport & Treat & Release at Scene**
Ref. No. 1200.2 **Treatment Protocol: Base Contact Requirements**

Reference No. 832, Treatment/Transport of Minor

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/19/22	10/19/2022	No
	Base Hospital Advisory Committee	10/12/22	10/19/22	No
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/PARAMEDIC/MICN)

SUBJECT: **PATIENT REFUSAL OF TREATMENT/TRANSPORT AND TREAT AND RELEASE AT SCENE** REFERENCE NO. 834

PURPOSE: To provide guidelines for EMS personnel to determine which patients who do not wish to be transported to the hospital have decision-making capacity to refuse EMS treatment and/or transport, and to identify those who may be safely released at scene.

AUTHORITY: California Health and Safety Code, Division 2.5, Sections 1797.220, 1798, (a). California Welfare and Institution Code, Sections 305, 625, 5150, and 5170. Title 22, California Code of Regulations, Section 100169.

DEFINITIONS:

Adult: A person at least eighteen years of age.

Against Medical Advice (AMA): A patient or a legal representative of a patient who has decision-making capacity and who refuses treatment and/or transport for **an emergency medical condition** as advised by EMS providers, physician on scene, and/or Base personnel.

Assess, Treat, and Release: A patient who does not desire transport to the emergency department for evaluation and after an assessment and/or treatment by EMS personnel, **does not** have an ongoing emergent medical condition, a high-risk presentation, or social risk factors and is released at scene to follow-up with the patient's regular healthcare provider or a doctor's office or clinic.

Authorized Advanced Health Care Provider: An EMS physician authorized to direct EMS care on the scene or via telemedicine as per Ref. 816 – Physician at the Scene, or an advanced practiced provider who is identified by the EMS Provider Agency Medical Director to provide medical direction via telemedicine as approved by the EMS Agency Medical Director.

Decision-Making Capacity: The ability to understand the nature and consequences of proposed health care. This includes understanding the significant risks and benefits and having the ability to make and communicate a decision regarding the proposed health care in the patient's primary language, if feasible. A person has decision-making capacity if they are able to:

- Communicate the need for treatment, the implications of receiving and of not receiving treatment, and alternative forms of treatment that are available, and
- Relate the above information to their personal values, and then make and convey a decision.

The lack of decision-making capacity may be:

- Temporarily lost (e.g., due to unconsciousness, influence of mind-altering substances, mental illness, or cognitive impairment)
- Permanently lost (e.g., due to irreversible coma, persistent vegetative state,

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

untreatable brain injury, or dementia)
- Never existed (i.e., due to profound neurodevelopmental disorder, those who are deemed by the Court as incompetent or a person under conservatorship)

Emancipated Minor: A person under the age of 18 years is an emancipated minor if any of the following conditions are met:
- Married or previously married
- Currently or previously in a valid domestic partnership
- On active military duty
- The person has received a declaration of emancipation pursuant to Section 7122 of the California Family Code, which includes all of the following: at least fourteen (14) years of age, living separate and apart from their parents and managing their own financial affairs (may be verified by DMV Identification Card)

Emergency Medical Condition: A condition or situation in which a medical illness is suspected in a patient and there is an immediate need for medical attention. Patients with any abnormal vital signs: heart rate and rhythm, respiratory rate, blood pressure (except for isolated asymptomatic hypertension), oxygen saturation, and temperature (Ref. 1380 – Medical Control Guideline Vital Signs); and/or those who meet any criteria for Base Contact (Ref. 1200.2 – Base Contact Requirements) are considered to have an emergency medical condition.

High Risk Presentation: Features by history or presentation that are likely to be high risk for complications, progression of disease, underlying serious illness or injury, or require Base Contact. High risk chief complaints include chest pain, abdominal pain, pregnancy, gastrointestinal bleeding, syncope, neurologic symptoms (e.g., dizziness/vertigo, weakness, visual changes), and altered mental status. High risk features include:

- Patients less than 12 months of age
- Patients older than 70 years of age
- Patients with complicating comorbidities (i.e., active underlying cardiac, respiratory, kidney, liver, oncologic (cancer) or neurologic disease, or who are immunocompromised (e.g., history of HIV, chemotherapy, transplantation))

Implied Consent: This is a type of consent involving the presumption that an unconscious or a person lacking decision-making capacity would consent to lifesaving care. This shall include minors with an emergency medical condition when a parent or legal representative is not available.

Lift Assist: EMS is dispatched to a scene to assist with transfer of a patient to a bed or wheelchair.

Medical Home: A team-based health care delivery model, which is led by a health care provider (i.e., primary care physician) to provide continuous, coordinated, and comprehensive medical care.

Minor: A person less than eighteen years of age.

Minor Not Requiring Parental Consent is a person who:
- Is 12 years or older and in need of care for a reportable medical condition or substance abuse
- Is pregnant and requires care related to the pregnancy

- Is in immediate danger of suspected physical or sexual abuse
- Is an emancipated minor

No Contact / No Patient: EMS is dispatched to a scene and is either cancelled prior to arriving at scene or no patient is found.

Patient: A person who seeks or appears to require medical assessment and/or medical treatment (Ref. 606, Documentation of Prehospital Care)

Person Contact / No Patient: EMS is dispatched to a scene and a person is identified as a potential patient, is alert and appropriate for situation and declines assessment by EMS.

Psychiatric Hold: A patient who is held against their will for evaluation under the authority of Welfare and Institutions Code (e.g., Section 5150, 5585 [minors]) because the patient is a danger to themselves, a danger to others, and/or gravely disabled (i.e., unable to care for self). This is a written order by law enforcement officer, County mental health worker, or a health worker certified by the County to place an individual on a psychiatric hold.

Public Assist: EMS is dispatched to a scene for assistance for nonmedical issues involving a person.

Social Risk Factors: Persons experiencing homelessness, patients in congregate living, and those who are a resident of skilled nursing facilities.

Treatment in Place: A patient who, after an assessment and treatment by EMS personnel and medical clearance by an authorized advanced healthcare provider (e.g., physician, nurse practitioner, physician assistant) on scene (Ref. 816 Physician at the Scene) or via Telemedicine, does not require ambulance transport to an emergency department. Appropriate follow-up should be arranged by the authorized advanced healthcare provider on scene or via Telemedicine.

PRINCIPLES:

1. An adult or emancipated minor who has decision-making capacity has the right to determine the course of their medical care including the refusal of care. These patients must be advised of the risks and consequences resulting from refusal of medical care. A patient less than eighteen (18) years of age, with the exception of minors not requiring parental consent, mush have a parent or legal representative to refuse evaluation, treatment, and/or transport for an emergency medical condition.

2. A patient determined by EMS personnel or the base hospital to lack decision-making capacity may not refuse care AMA or be released at scene. Mental illness, drugs, alcohol, or physical/mental impairment may impair a patient’s decision-making capacity but are not sufficient to eliminate decision-making capacity.

3. In situations where patients who have attempted suicide or expressed suicidal intent, or where other factors lead EMS personnel to suspect suicidal intent, such patients should be regarded as lacking decision-making capacity. These patients may decline treatment but cannot decline transport.

4. A patient on a psychiatric hold may not be released at scene and cannot sign-out AMA. The patient can refuse any medical treatment as long as it is not an imminent threat to

life or limb.

5. At no time are EMS personnel to put themselves in danger by attempting to treat and/or transport a patient who refuses care.

6. Patients for whom 9-1-1 is called but are not transported represent a potentially high-risk group and provider agencies should/shall have quality review programs specific to this patient population.

POLICY:

I. Adult With Decision-Making Capacity or Minor (Not Requiring Parental Consent) Refusing Transport Against Medical Advice

A. EMS personnel shall advise the patient of the risks and consequences which may result from refusal of treatment and/or transport. The patient should be advised to seek immediate medical care.

B. Base contact should be made prior to the patient leaving the scene for patients who would otherwise meet Base Contact criteria (Ref. 1200.2 – Base Contact Requirements) in order for Base personnel to have the opportunity to interview the patient and to evaluate the appropriateness of the AMA. Base personnel should be allowed to speak to the patient and/or family prior to the patient leaving the scene.

C. EMS personnel shall relay all the circumstances to the Base including assessment and care rendered, reasons for refusal, and the patient's plan for transportation and follow-up care.

D. EMS personnel shall make Base Contact prior to releasing a child at the scene with a parent or caregiver for all pediatric patients less than or equal to 12 months of age .

E. EMS personnel shall have the patient or their legal representative, as appropriate, sign the release (AMA) section of the Patient Care Record (EMS Report Form/Electronic Patient Care Record/ePCR). The signature shall be witnessed, preferably by a family member.

F. A patient's refusal to sign the AMA section should be documented on the Patient Care Record.

II. Individual Lacking Decision-Making Capacity or a Minor (Requiring Parental Consent)

A. The patient should be transported to an appropriate receiving facility under implied consent. A psychiatric hold is not required.

B. If EMS personnel or the base hospital determines it is necessary to transport the patient against their will and the patient resists, or the EMS personnel believe the patient will resist, assistance from law enforcement should be requested in transporting the patient. Law enforcement may consider the placement of a psychiatric hold on the patient but this is not required for transport.

C. Law enforcement should be involved whenever EMS personnel believe a parent or other legal representative of the patient is acting unreasonably in refusing immediate care and/or transport.

III. Patients Assessed, Treated, and Released

A. EMS personnel shall assess the patient for an ongoing emergency medical condition, high risk presentations, social risk factors, and assess that the patient or their legal representative has the capacity to decline transport.

B. Patients with an ongoing emergency medical condition, high risk presentation or social risk factors who do not desire transport to the emergency department shall be handled as refusing transport against medical advice (refer to Policy Section I).

C. Patients or the legal representatives of patients who contact EMS for minor complaints in order to have an assessment performed and determination made of the seriousness of the complaint and need for treatment, but later *decline transport* qualify to be assessed, treated, and released.

1. In such cases, the EMS personnel should perform an assessment including vital signs, and after the patient or patient's legal representative's states they do not wish transport, the patient may be assessed, treated, and released at the scene.

2. Patients should be instructed by EMS to follow-up with the patient's medical home or primary care physician. The advice given should be documented on the Patient Care Record. The following statement is recommended: "After our assessment, you feel that you do not wish to be transported and you do not require immediate care in the emergency department. You should seek care with your regular healthcare provider or a doctor's office or clinic within 24 hours. If you have worsening or persistent symptoms or change your mind and desire transport, recontact 9-1-1."

D. EMS personnel should not require patients who are Assessed, Treated and Released at scene to sign the release (AMA) section of the Patient Care Record, as this implies that the patient is at significant risk by not utilizing the EMS system for treatment and/or transportation.

E. If subsequent to further assessment and discussion, the patient or the patient's legal representative desires transport, EMS personnel should transport the patient to the hospital per destination policies.

IV. Documentation

A. Public Assist and Person Contact/No Patient does not require completion of a Patient Care Record. Documentation should follow the EMS provider agency's operational policy.

B. A Patient Care Record must be completed for each patient or contact encounter (i.e., Lift Assist, AMA, Assess, Treat and Release, and Treatment in Place),

including those refusing emergency medical evaluation, care and/or transportation against medical advice and those released at scene. EMS personnel shall ensure that documentation is in compliance with Ref. 606 – Documentation of Prehospital Care. Patient Care Record documentation should include:

1. AMA:

    a. Patient history and assessment, including findings of an emergency medical condition or requirement to make Base Contact

    b. Assessment by EMS that the patient or legal representative is alert and has the decision-making capacity to refuse EMS assessment

    c. What the patient is refusing (i.e., medical care, transport) and reason for refusal

    d. Risk and consequences of refusing care and/or transport, benefits of transport, and alternatives as explained to the patient or legal representative

    e. Statement that the patient understands and verbalizes the risks and consequences of refusing care and/or transport

    f. Signature of patient or legal representative

    g. Patient’s plan for follow-up care

    h. Contact with Base Hospital, as applicable

    i. For Minors, the relationship of the person(s) to whom the patient is being released

2. Assess, Treat and Release:

    a. Patient history and assessment, including absence of findings of an emergency medical condition

    b. Assessment by EMS that the patient or legal representative is alert and has the capacity to make collaborative decision making with EMS to accept on-scene treatment, understand the need to have capacity for appropriate follow-up, but decline transport

    c. Discussion with patient including risks of non-transport, benefits of transport, and alternatives

    d. Plan for follow-up care including when to recall 9-1-1, seek emergency department care or follow-up with their medical home

    e. If Base contact was made (when applicable)

f. For Minors, the relationship of the person(s) to whom the patient is being released

3. Treatment in Place:

a. Document as per Assess, Treat, and Release and also include the name of the authorized advanced health care provider

V. Quality Improvement

A. Each Provider Agency shall have a quality improvement program for patients who are not transported to the ED. The quality improvement program should include but may not be limited to the following:

1. Monitor data on the frequency, percent, and type of nontransports.

2. Establish a process for review of patient care records on a percentage of nontransports to include assessment of impact on the patient's outcome, and education/training provided as indicated by this review.

3. Develop a process for evaluating rate of repeat call to 9-1-1 or "rekindles".

B. Base Hospital shall incorporate patients released at the scene into their Quality Improvement Program (Ref. 304 – Paramedic Base Hospital Standards). The quality improvement program may include but not limited to the following:

1. Review of select number of Base Hospital contacts for AMA and provide education to base personnel as appropriate from that review.

2. Inclusion of cases of patients released at the scene in Base Hospital Audio Recording Reviews.

3. Notification of EMS provider agency quality improvement staff when the base has knowledge of patients who are released at the scene and return for evaluation in the emergency department.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 304, **Paramedic Base Hospital Standards**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 832, **Treatment/Transport of Minors**
Ref. No. 816, **Physician At The Scene**
Ref. No. 1200, **Treatment Protocols**, et al.
Ref. No. 1200.2, **Base Contact Requirements**
Ref. No. 1309, **Color Code Drug Doses**
Ref. No. 1380, **Medical Control Guidelines: Vital Signs**

Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/19/22	10/19/2022	No
	Base Hospital Advisory Committee	10/12/22	10/19/22	No
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)

CALNEP

California Nurse and EMS Professionals

CalNEP is a subcommittee of the Cal Chiefs Association, we are a group of EMS Professionals of all ranks who network, collaborate, and work together to bring the best education, patient care, and management to the Fire EMS Community in California. If you have not yet connected with the CalNEP group and are an EMS Educator, Coordinator, or Manager, contact us and get involved! We have regularly scheduled non-mandatory meetings every other month.

*Your department must be a current member with Cal Chiefs to join CalNEP

Southern CalNEP Leadership

Caroline Jack, President (cjack@nbfd.net)
Rhonda Rosati, Vice President (rhondar@cityofbrea.net)
Jennie Simon, Secretary (jennie.simon@sbcfire.com)

Northern CalNEP Leadership

Ryan Nishimoto, President (ryan.nishimoto@acgov.org)

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

DATE: September 28, 2022

MEMORANDUM

TO: EMS Provider Agencies - Fire Chiefs, Medical Directors, Paramedic Coordinators, EMT Program Directors

FROM: Marianne Gausche-Hill, MD
Medical Director

SUBJECT: **EMERGENCY MEDICAL TECHNICIAN (EMT) AND PARAMEDIC VACCINATION REQUIREMENT UPDATE**

The Los Angeles County Department of Public Health released Health Care Worker Vaccination Requirement updates effective September 17, 2022. See the link below for the complete Vaccination Requirement Order from the Los Angeles Department Public Health Officer.

http://publichealth.lacounty.gov/media/Coronavirus/docs/HOO/HOO_HealthCareWorkerVaccination.pdf.

Essentially, the Order of the Health Officer rescinds the testing requirement for workers exempt to the vaccine due to medical reasons or religious beliefs. The Order also states that facilities should maintain testing capacity at their worksite and have the ability to ramp up testing at their worksite in the event of outbreaks or if it is required again at a future date. It also provides an update on the timing of required booster doses consistent with the current Centers for Disease Control and Prevention (CDC) recommendations.

The Health Care Worker Vaccine Requirement has not changed, but the testing has changed. The attached Health Order includes a table of COVID-19 immunization requirements for covered workers, which includes Emergency Medical Services (EMS). It outlines the types of vaccines that are accepted, the primary vaccination series, when to get the vaccine booster, and which vaccine booster dose to receive. They also outline that those with COVID-19 infection, after completion of their primary series, may defer booster administration up to 90 days from the date of the first positive test or clinical diagnosis.

In addition, the key change here is related to ongoing testing requirements for workers exempt due to medical reasons or religious beliefs. See attached Order of the Health Officer where the information is highlighted in yellow and provides the link for additional resources.

Please contact me at mgausche-hill@dhs.lacounty.gov .

MGH:dw

Attachment

c: EMS Agency Director

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LOS ANGELES COUNTY

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Marianne Gausche-Hill, MD
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To advance the health of our communities by ensuring quality emergency and disaster medical services.

October 12, 2022 **VIA E-MAIL**

TO: Hospital CEOs, Each 9-1-1 Receiving Facility

FROM: Richard Tadeo, EMS Agency Director

SUBJECT: PREHOSPITAL CARE POLICY REF. NO 505, AMBULANCE PATIENT OFFLOAD TIME

This is to provide you a copy of the recently approved Prehospital Care Policy Ref. No. 505, Ambulance Patient Offload Time. **This policy becomes effective November 1, 2022.**

This policy provides guidelines for EMS Provider Agencies, designated 9-1-1 Receiving Facilities and the EMS Agency to address delays in ambulance patient offload times (APOT). The policy also outlines specific mitigating strategies to address hospitals that have consistently demonstrated extensive delays in APOT.

The policy was presented to the Hospital Association of Southern California through its Emergency Health Services Committee on its September 6, 2022, meeting. Most of the recommendations were adopted and incorporated into the policy. The Los Angeles County EMS Medical Council also reviewed the policy.

The policy was also reviewed by the Emergency Medical Services (EMS) Commission's subcommittees (Base Hospital Advisory Committee and Provider Agency Advisory Committee) prior to the final endorsement of the policy by the EMS Commission on September 21, 2022.

The EMS Agency recognizes the challenges faced by hospitals regarding staffing and patient placement; however, the widespread problem with APOT delays have negatively impacted the EMS system. APOT delays have increased response time by emergency transport ambulances to the next 9-1-1 emergency medical call and has the potential to compromise the timely transport of patients with emergency medical conditions. The implementation of this policy is crucial to ensure the EMS system safety net. The process outlined in the policy provides a framework for the EMS Agency to work with hospitals in reducing APOT delays.

Please do not hesitate to contact me at (562) 378-1610 or rtadeo@dhs.lacounty.gov if you have any questions.

RT:rt

c. ED Administrative Director, Each 9-1-1 Receiving Facility
Fire Chief, Each EMS Provider Agency
CEO, EOA Ambulance Provider
Hospital Association of Southern California
EMS Commission

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

SUBJECT: **AMBULANCE PATIENT OFFLOAD TIME (APOT)** REFERENCE NO. 505

PURPOSE: To establish a policy for the safe and rapid transfer of patient care responsibilities from emergency medical services (EMS) personnel to emergency department (ED) medical personnel.

AUTHORITY: California Health and Safety Code, Division 2.5 Sections 1797.120, 1797.225

DEFINITIONS:

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

PRINCIPLES:

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

2. Extended APOT is a healthcare system and hospital throughput issue. Extended APOT negatively impacts EMS providers' ability to respond to subsequent 9-1-1 calls resulting in delayed response times and may affect public safety and patient outcomes.

3. Each hospital shall have a policy and a multidisciplinary team-based approach to ensure the ability of the facility to remain open to accept patients arriving by ambulance in the ED.

4. Hospitals that have extended APOT should assign appropriate personnel to remain with patients while waiting for an ED treatment bay in order to release EMS personnel back to the community.

5. As per the Emergency Medical Treatment & Labor Act (EMTALA), the responsibility for patient care lies with the receiving facility once the patient arrives at the hospital property. Hospital staff shall make every effort to offload patients from ambulance gurneys as soon as possible.

6. The State of California Emergency Medical Services Authority has adopted Standardized Methods for Data Collection and Reporting of APOT which has been adopted by Los Angeles County.

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

APPROVED: Richard Tadlock
Director, EMS Agency

Marianne Gausche-Hill
Medical Director, EMS Agency

POLICY:

I. Responsibilities of Hospital ED Personnel to Mitigate Extended APOT

A. Immediately acknowledge EMS patient arrival and provide visual assessment; receive verbal patient report as soon as possible upon arrival in the ED to determine whether the patient needs an ED treatment bay or can be sent to other areas of the ED to await urgent or emergency care.

B. Transfer patient to the hospital gurney, bed, chair, wheelchair or waiting room as appropriate for patient condition within 30 minutes of arrival at the ED.

C. If unable to immediately offload patient, provide a safe area in the ED within direct sight of ED medical personnel where the EMS personnel can temporarily wait while hospital's patient remains on the ambulance gurney.

D. Inform the ambulance transport crew of the anticipated time for the offload of the patient.

E. For extended APOT, provide information to the onsite supervisor of EMS personnel regarding the steps that are being taken by the hospital to resolve extended APOT.

F. Notify the Nursing Supervisor/Administrator on Duty that the ED is experiencing extended APOT and request assistance with patient throughput challenges.

II. Responsibilities of EMS Personnel to Mitigate Extended APOT

A. Upon arrival at ED, EMS personnel will present to the customary ambulance receiving area for a triage assessment by assigned ED staff (e.g., charge nurse).

B. Provide a verbal patient report to assigned ED staff, transfer patient to hospital equipment as directed by ED staff.

C. If the APOT estimate is ≥ 30 minutes, and the patient meets **ALL** criteria listed below, EMS personnel will inform the appropriate ED staff (e.g., charge nurse) that the patient will be offloaded in the waiting room. EMS personnel shall provide a transfer of care report to the appropriate ED staff (e.g., triage nurse).

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

2. Normal mental status (GCS 15)

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

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

5. Without suicidal ideation or suspected substance abuse and not on psychiatric hold (i.e., 5585 (pediatric), 5150 (adult))

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

D. Document the “facility equipment time” on the electronic patient care record (ePCR) to capture the time patient care is transferred to ED personnel.

E. Notify EMS Supervisor if Provider ALS Diversion Threshold is met as defined in Ref. No. 503.1.

III. Responsibilities of the EMS Agency

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

B. At any given time, the EMS Agency via the Medical Alert Center (MAC) will establish phone notification with hospital administration in instances wherein 3 or more ambulance transport crew are waiting to offload for time periods of 30 minutes or more.

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

D. In instances whereby extended APOT threatens public health and safety by preventing EMS response to emergency medical incidents, the EMS Agency, with appropriate notification to hospital, may authorize EMS personnel to inform ED medical personnel that they are transitioning patient care and immediately offloading a patient to a hospital bed or other suitable hospital sitting or reclining device as appropriate for patient condition provided the patient meets **ALL the criteria listed in II.E. and**:

1. Normal vital signs

2. Alert and oriented

3. No ALS intervention in place

In these instances, EMS personnel shall make every attempt to notify ED Charge Nurse that they must immediately return to service. EMS personnel shall provide a verbal transfer of care report to ED medical personnel.

E. Procedure for requesting corrective action plan from hospitals that have persistent delays in APOT

Month	Action 1	Audit Result	Action 2
1st	EMS Agency audits Hospital’s compliance with APOT	Hospital consistently demonstrate prolonged APOT and EMS Providers have consistently	EMS Agency notifies hospital’s ED Director, via email or telephone, of audit results, requests corrective action plan and assists in determining

Month	Action 1	Audit Result	Action 2
	Standard.	requested to place Hospital on ALS and/or BLS Diversion	solutions.
2nd	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital fails to demonstrate incremental improvement in APOT.	EMS Agency sends a written notice to Hospital's ED Director notifying them of the audit results and their non-compliance.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
3rd	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT.	EMS Agency notifies Hospital's CEO in writing of audit results and request a corrective action plan be submitted within 15 calendar days.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
4th	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT.	Within 15 days of the EMS Agency's receipt of Hospital's corrective action plan, a written approval or request additional modifications to the plan.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
5th	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT.	EMS will request modification to Hospital's corrective action plan.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
6th	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT	See Policy III.F.
		Hospital's compliance threshold improves.	Monitor to ensure Hospital maintains improvement in APOT.

F. Failure of a hospital to implement corrective action plan to improve APOT six months after initial request from EMS to implement corrective action plan may result in additional action from the EMS Agency, which may include but not limited to:

1. Reduction in 9-1-1 transports to hospital
2. Temporary suspension of Specialty Care Center Designation
3. Others as identified

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 503.1, **Diversion Request Requirements for Emergency Department Saturation**

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

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

DATE: October 27, 2022

MEMORANDUM

TO: Distribution List

FROM: Marianne Gausche-Hill, MD
Medical Director

SUBJECT: **TERMINATION OF GOVERNOR GAVIN NEWSOM'S EXECUTIVE ORDERS, RESCINDING UTILIZATION OF OUT-OF-STATE MEDICAL PERSONNEL AND EMERGENCY MEDICAL SERVICE PERSONNEL LICENSING, CERTIFICATION, TRAINING AND SCOPE OF PRACTICE WAIVERS**

Please see attached announcement. The County of Los Angeles Emergency Medical Services (EMS) agency wanted to make hospitals as well as Fire Departments and other EMS stake holders aware of the Governor's announcement to terminate the state of emergency for COVID-19.

Authorizations and waivers shall terminate effective February 28th, 2023. These include utilization of out-of-state personnel and paramedics being allowed to work in static health care sites such as hospitals, alternate care centers, shelter care centers, in-home settings and nursing homes. In addition, the expanded scope including conducting COVID-19 and Influenza testing as well as the provision of COVID-19, influenza, and monkeypox vaccinations will be rescinded for EMT and paramedics.

Please contact Dr. Marianne Gausche-Hill at mgausche-hill@dhs.lacounty.gov if there are any questions regarding this memo.

MGH:cdt

Attachment

Distribution List:
Fire Chief, Each Fire Department
CEO/President, Each Ambulance Company
Medical Director, Each EMS Provider Agency
Prehospital Care Coordinator, Each Base Hospital
Base Hospital Medical Director, Each Base Hospital
Emergency Management Officers
CEO and Emergency Department Medical Director and Nurse Manager, Each 911 Receiving Facilty

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

DATE: **October 17, 2022**

TO: **Local Emergency Medical Service Agency Administrators and Medical Directors**

FROM: **Elizabeth Basnett, EMEDM**
Acting Director, EMS Authority

Hernando Garzon, MD
Acting Medical Director, EMS Authority

SUBJECT: **POLICY UPDATE: TERMINATION OF GOVERNOR GAVIN NEWSOM'S EXECUTIVE ORDERS, N-11-22 AND N-4-22 -RESCINDING UTILIZATION OF OUT-OF-STATE MEDICAL PERSONNEL AND EMERGENCY MEDICAL SERVICE PERSONNEL LICENSING, CERTIFICATION, TRAINING AND SCOPE OF PRACTICE WAIVERS**

Pursuant to Governor Gavin Newsom's announcement this afternoon regarding the termination of the State of Emergency, the Director of the California Emergency Medical Services Authority (EMSA) rescinds the authorization of out-of-state medical personnel to render medical services and terminates waivers associated with the utilization of EMSA California Medical Assistance (CAL-MAT) teams and professional licensing, certification, and scope of practice of Chapter 2, 3 and 4 of Division 2.5 of the California Health and Safety Code (HSC), including accompanying regulations.

The following authorizations and waivers shall terminate, effective February 28th, 2023.

Out-of-State Personnel

- Utilization of out-of-state personnel, including, but not limited to, medical personnel, entering California to assist in preparing for, responding to, mitigating the effects of, and recovering from COVID-19 as prescribed in Government Code Section 179.5 with respect to licensing and certification.

Paramedic Licensees

- Perform their current scope of practice in hospitals, medical facilities, alternate care sites, shelter care sites, in-home settings, or any additional setting (static sites).

- Conduct oropharyngeal and/or nasopharyngeal COVID-19 and Influenza testing.
- Provide COVID-19, Influenza and Monkeypox vaccinations.
- Conduct Monoclonal Antibody administrations and/or monitoring.

Advanced Emergency Medical Technician (AEMT) and Emergency Medical Technician (EMT) Certified Personnel

- Perform their current scope of practice in hospitals, medical facilities, alternate care sites, shelter care sites, in-home settings, or any additional setting (static sites).
- Provide COVID-19, Influenza and Monkeypox vaccinations to all persons 6 months of age and older based on U.S. Center for Disease Control and Prevention (CDC) and U.S. Food and Drug Administration (FDA) guidelines.

CAL-MAT Personnel

- Utilization of CAL-MAT personnel beyond 60-days of service.

For additional information or questions regarding EMS personnel licensing, certification, or exams, please email the EMSA at paramedic@emsa.ca.gov.

For additional information or questions regarding scope of practice authorizations, please email the EMSA at scopeofpractice@emsa.ca.gov.

Elizabeth Basnett, EMEDM
Acting Director, Emergency Medical Services Authority

H Garzon, M.D.

Hernando Garzon, MD
Acting Medical Director, Emergency Medical Services Authority