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: **March 8, 2023**
TIME: **1:00 – 3:00 PM**
LOCATION: **Zoom Video Conference Meeting**

Join Zoom Meeting:
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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 ADD YOUR NAME TO THE CHAT if you would like to address the Commission.

AGENDA

1. **CALL TO ORDER – Commissioner Lydia Lam, Chair**
   Instructions for Zoom:
   - 1.1 Please use your computer to join the Zoom meeting.
   - 1.2 Join Zoom meeting by computer (preferable) or phone.
   - 1.3 Input your name when you first join so we know who you are.
   - 1.4 You can join Zoom by one tap mobile dialing.
   - 1.5 You can join Zoom by landline using any "dial by location" number and manually entering the Meeting ID and following # prompts.
   - 1.6 Mute and unmute yourself by clicking on the microphone icon at the bottom of computer screen, or *6 by phone.
   - 1.7 Adjust volume by using the arrow next to the microphone icon.

2. **INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS**
   Carol Kim, Appointed to EMSC 1/24/2023, representing First District Supervisor Hilda Solis

3. **CONSENT AGENDA:** *Commissioners/Public may request that an item be held for discussion. All matters are approved by one motion unless held.*

   - 3.1 **Minutes**
     January 18, 2023
   - 3.2 **Committee Reports**
     - 3.2.1 Base Hospital Advisory Committee
     - 3.2.2 Provider Agency Advisory Committee
   - 3.3 **Policies**
     - 3.3.1 Reference No. 326: Psychiatric Urgent Care Center Standards
     - 3.3.2 Reference No. 328: Sobering Center Standards

3.3.3 Reference No. 506: Trauma Triage
3.3.4 Reference No. 506.1: Trauma Triage Decision Scheme
3.3.5 Reference No. 526: Behavioral/Psychiatric Crisis Patient Destination
3.3.6 Reference No. 528: Intoxicated (Alcohol) Patient Destination
3.3.7 Reference No. 604: Prehospital Care Forms

END OF CONSENT AGENDA

4. BUSINESS

Business (Old)

4.1 Prehospital Care of Mental Health and Substance Abuse Emergencies (Attachment)
4.2 Ambulance Patient Offload Time (APOT) (Attachment)
4.3 Ad Hoc Workgroup: Alameda EMS Corps for LA County
4.4 Measure B Advisory Board (MBAB) – EMSC Representation (Vote Required)

Business (New)

4.5 EMSC Goals/Workplan (Attachments)
4.6 Return to In-Person Meetings – FAQs (Attachment)

5. LEGISLATION

6. DIRECTORS' REPORTS

6.1 Richard Tadeo, EMSC Executive Director, EMS Director

Correspondence

6.1.1 (1/12/23) EMT Local Optional Scope Program Approval – La Habra Heights FD
6.1.2 (1/17/23) Lucas Approval – Long Beach FD
6.1.3 (1/17/23) Lucas Approval – San Gabriel FD
6.1.4 (1/31/23) Termination of Ambulnz Health, LLC Ambulance Operations
6.1.5 (2/07/23) Joint Statement on Lights & Siren Vehicle Operations on EMS Responses
6.1.6 (2/14/23) Inappropriate Utilization of 9-1-1 for Interfacility Patient Transfers

6.2 Marianne Gausche-Hill, EMS Medical Director

7. COMMISSIONERS' COMMENTS / REQUESTS

8. ADJOURNMENT

To the meeting of May 17, 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
January 18, 2023
Zoom Meeting

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

GUESTS

David Molyneux/W-Cst Amb	Andy Reno/Long Beach FD	John Wasmund	Jenn Nulty/Torr-FD
Shelly Trites/TMMC	Britney Alton/BFD	Clayton Kazan, MD	Roger Braum
Matthew Pall	Adrienne Roel/CAL-NEP	Lorrie Donegan	Adena Tessler/HASC
Rafael De La Rosa			

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

1. 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 Commission Liaison Denise Watson. A quorum was present with 13 Commissioners for roll call, with a total of 16 Commissioners present.

2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

Executive Director, Richard Tadeo, reported the next EMSC meeting is March 8, 2023, one week early, and will be virtual based on the Board of Supervisors' (Board) findings to continue teleconferenced meetings under Assembly Bill (AB) 361. Provider Agency Advisory and Base Hospital Advisory committee meetings scheduled for February will be virtual.

3. NOMINATING COMMITTEE

3.1 Commissioner Paul Rodriguez provided a list of names recommended by the Nominating Committee for the 2023 EMSC Chair (Commissioners Lydia Lam and Carol Meyer), and Vice-Chair (Commissioner Diego Caivano). Hearing no additional nominees nor objections, Commissioner Diego Caivano was declared and acclaimed by current Chair Lam to serve a second term as Vice Chair for 2023. A vote was taken for the Chair selection.

Motion/Second by Commissioners Rodriguez/Bixler to approve Commissioner Lydia Lam to serve a second term as EMSC Chair for 2023 was approved and carried by majority vote:

Aye (13): *Alam, Bixler, Cheung, Espinosa, Hisserich, Meyer, Olney, Ower, Powel, Rodriguez, Saeki, Snyder, Uner*
No (0):
Abstain (1): *Lam*
Absent (4): *Caivano, Lott, Tarpley, Washburn*

3.2 Chair and Vice Chair for 2023 Assume Duties

3.3 Standing Committee Nominees
Standing Committees were approved and appointed by Chair Lam.

4. 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.

4.1 Minutes

4.2.1 November 16, 2022 Minutes were approved

4.2 Committee Reports

4.2.1 Base Hospital Advisory Committee (BHAC)
4.2.2 Provider Agency Advisory Committee (PAAC)

4.3 Policies

4.3.1 Reference No. 519: Management of Multiple Casualty Incidents
This policy is before the Commission to establish the change in the number of patients LA County Trauma Centers can receive during multiple casualty incidents from 10 to 20 with no differentiation between adults or children.

Discussion revealed that no distinction is made between Level 1 and Level 2 in terms of destination, the Trauma Hospital Advisory Committee (THAC) reviewed this policy with good acceptance and understanding that patient distribution would be reasonable and that his policy will go back to a workgroup to hash out the details and update the policy.

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

END OF CONSENT AGENDA

5. BUSINESS

Business (Old)

5.1 Prehospital Care of Mental Health and Substance Abuse Emergencies

Director Tadeo reviewed EMSC goals related to the September 2015 Report by the ad hoc committee on Prehospital Care of Mental Health and Substance Abuse Emergencies, and goals established in old business to determine next steps.

Suicide Screening Tool pilot was implemented with Santa Monica Fire Department. The EMS Agency is waiting for their six-month report and will update the EMSC when available.

Commissioner Cheung requested updates and follow-ups on:

1. Uptake and utilization of the Alternate Destination Policy on the psychiatric urgent cares (PUCC) and sobering centers (SC) –
   Director Tadeo reported the EMS Agency is reviewing existing policies on PUCC and SC standards along with behavioral health destination policies to ensure compliance with regulations. A draft will go to the BHAC and PAAC committee meetings in February and will be presented to the EMSC in March. The EMS Agency will reach out to EMS providers and additional PUCCs to establish more interest. The PUCC and SC at Martin Luther King, Jr. Community Hospital is up and operational, and we will reach out to them when policy is approved to add to resources.

2. Long Beach Fire and Police Dispatch Co-Response Pilot –
   The EMS Agency will follow up on this pilot and report back to the EMSC.

3. Rollout of Olanzapine –
   Denise Whitfield, MD, EMS Agency Education Director, reported that all providers completed the EMS Update training by December 31, 2022, and the rollout of olanzapine was included in Part II of the update which surrounded behavioral health and the new protocols in regards to management of the agitated patient. The EMS Agency is waiting for numbers in terms of how often olanzapine is used which initially required a Base contact but thought it might be a barrier, so it is now a standing order. Over the next year, this will be reviewed to see how it is utilized within the County.

   Marianne Gausche-Hill, MD, EMS Agency Medical Director, reported the EMS Agency will look at the use of olanzapine as part of quality improvement and will add language to the policy to include look-alike because it looks like ondansetron and both are orally disintegrating tablets (ODTs). There are similarities in wording and packaging, and it was recommended that the EMS Agency provide input on the packaging of these two medications to create a markedly obvious difference to help with properly administering these drugs if it is within their purview to do so.

5.2 Ambulance Patient Offload Time (APOT)

Director Tadeo reported implementation and rollout of FirstWatch has been completed, Verdugo Dispatch software upgrades are in process before integration with FirstWatch, and separate policies have been completed addressing ambulance patient offload delays (APOD) and APOT (Reference No. 503 and Reference No. 505). The EMS Agency is monitoring hospitals and exclusive operating area providers that have long egregious APOT to ensure compliance with time requirement standards and will request corrective actions where necessary.

5.3 Ad Hoc Workgroup: Alameda EMS Corps for LA County

Jacqui Rifenburg, EMS Agency Assistant Director, reported this is on hold pending availability of Alameda EMS Corps representatives to meet with the workgroup in person.

Director Tadeo continued with review of the EMSC goals:

Lights and Sirens Workgroup –
After discussion, the consensus was to remove lights and sirens as an EMSC goal as it is operational. The EMS Agency will distribute national position papers on lights and sirens to the provider agencies and recommend they take these into consideration when developing operational policies while considering local traffic patterns and public safety.

Motion/Second by Commissioners Meyer/Hisserich that the EMS Agency provide the national position papers on lights and sirens to all provider agencies and recommend they take these into consideration when developing operational policies while considering local traffic patterns and public safety was carried by majority vote:

Aye (10): Alam, Cheung, Espinosa, Hisserich, Lam, Meyer, Olney, Ower, Saeki, Washburn
No (3): Powell, Rodriguez, Snyder, Uner
Abstain (0):
Absent (4): Bixler, Caivano, Lott, Tarpley

Develop mechanisms to ensure that during disasters local EMS resources are not deployed outside of the County if needed but used locally –
Director Tadeo reported the local EMS agency is most appropriate to determine availability of resources in the County and region and this will be removed as a goal.

Business (New)

5.4 Measure B Advisory Board (MBAB) – EMSC Representation (Vote Required)

Director Tadeo requested this be tabled and reported that Measure B funds are the result of annual trauma assessments on property taxes and when there are unallocated funds the MBAB convenes to approve projects proposed by constituents for trauma, emergency medical services, bioterrorism, and bio-surveillance. As the unallocated funds have not yet been finalized and the process is still in negotiations with trauma hospitals in terms of allocation for trauma funding, we will defer until next year depending upon the amount of funds available and will provide an update at the March meeting.

Questions were raised surrounding Sexual Assault Response Team (SART) funding availability and it was reported that Measure B funds were not the appropriate resource for this funding since MBAB is specific to trauma.

5.5 EMSC Bylaws – PAAC Updates (Attachment)

Director Tadeo confirmed Commission acceptance of language added to the EMSC Bylaws for the addition of one educational representative to PAAC, and reported the representative selected as the PAAC educational provider is Adrienne Roel and the alternate is Carolyn Jack.

Motion/Second by Commissioners Uner/Ower to approve the language as written into EMSC Bylaws was approved and carried unanimously.

5.6 EMSC Ordinance Status

Commission Liaison Watson reported the EMSC Ordinance Membership Composition change request is with County Counsel pending final approval before submission to the Board of Supervisors. We will report back to the EMSC upon approval.

6. LEGISLATION

Director Tadeo reported on the following legislation:

AB 40: References APOT as 20 minutes 90% of the time and requires an audit tool be developed by EMS Authority to include that EMS providers have a signature portion on their ePCR to document patient transfer of care. EMSAAC is watching this Bill closely.

AB 55: Increases the reimbursement for medical emergency transports from $100 to $350 per transport and requires local EMS Agencies to set prevailing wages for EMTs. Local EMS agencies are concerned that as regulatory agencies, establishing prevailing wages for EMTs would be a conflict. Requests are being made to work with the author of this Bill to make amendments.

SB 67 – Mandatory reporting of controlled substance overdoses by first responders to the State legislators. A process is already in place to capture these through data submitted to the EMS Authority. The definition of EMS providers includes the local EMS Agency which is problematic.

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

7.1 Richard Tadeo, EMSC Executive Director, EMS Director

7.1.1 EMS Organizational Chart & Roster and announced Mark Ferguson was promoted to Chief, Office of Prehospital Certification and Training Program Approvals; Miguel Ortiz-Reyes is the new Director of the Paramedic Training Institute; James Eads, Chief Disaster Response and Emergency Coordination retired December 2022; and Jeffrey Morgan, Chief Information Officer, is retiring at the end of January 2023. The EMS Agency will seek replacements for these positions.

7.1.2 Annual Data Report

Director Tadeo provided a report on the 2022 EMS Agency system demographic data, provider impression, behavioral psychiatric complaints, noting that 9-1-1 volume for providers is stabilizing to pre-pandemic numbers, response times are stable for STEMI, sepsis, stroke, and trauma for both adult and pediatric. The EMSC should contact Director Tadeo with requests for data or benchmarking to be presented in future reports.

7.1.3 Board Report on Addressing the Inappropriate Transport of Psychiatric Patients in South Los Angeles

Supervisor Holly J. Mitchell's Board Motion to address the inappropriate transports of psychiatric patients in South Los Angeles to Martin Luther King, Jr. Community Hospital (MLK) was discussed. Overall, the data does not support inappropriate transports to MLK.

Correspondence

7.1.4 (12/22/22) Pedi-DOSE Study Cards for Ambulances

7.1.5 (12/15/22) Waiver Extension, LA County Ref. No. 455, Private Ambulance Vehicle Age Limit

7.1.6 (12/21/22) Expansion of the Los Angeles (LA) County ECMO Pilot to Long Beach Medical Center

The EMSAAC conference is May 31, and June 1, 2023, at the Omni San Diego Hotel in San Diego, California. The theme is Engineering Excellence.

7.2 Marianne Gausche-Hill, M.D., EMS Medical Director
LA County Respiratory Illness Update (COVID, RSV, Influenza)
Dr. Gausche-Hill reported RSV surge tracking through December 2022 shows those numbers are coming down significantly with kids boarding through the emergency department. COVID numbers are going down simultaneously, but there are still workforce issues, call offs, staff retiring, and difficulty hiring which is also true for ambulance services but slightly better than in the recent past.

The EMS Agency is involved in several trials and studies:

1. Just-in-Time training – Western Regional Alliance for Pediatric Medicine – to create a document for emergency department staff caring for children for extended periods of time which they cannot transfer.

2. PediDOSE Study – National Institute of Health (NIH) funded trial looking at standardized dosing for children for seizures.

3. Stay on Scene – to provide post return of spontaneous circulation (ROSC) care or post cardiac arrest care to prevent rearrest. We will submit an NIH grant for that to National Heart, Lung and Blood. This will become the usual protocol where we will do our usual care and then transition to a bundle of care to improve outcomes for patients post cardiac arrest.

4. Submitted a UG3UH3 Grant to study an adaptive trial supraglottic vs. bag mask and ventilation trial that has also been submitted to National Heart and Blood Institute called Pedi-PART which is a pediatric prehospital airway resuscitation trial.

There was additional reporting on developing performance measures for stroke and STEMI, continuing to work with quality improvement committees, the Pediatric Readiness project, correspondence item 7.1.4 addressing study cards for ambulances, and 7.1.6 the ECMO pilot.

Nichole Bosson, M.D., EMS Agency Assistant Medical Director provided additional details about the ECMO pilot including patient enrollment, participating providers, and desired outcomes.

As these get implemented, we will plan to incorporate training in the EMS Update. Presentation of results will be provided to the EMSC when available. All of these trials are under the waiver of informed consent.

8. COMMISSIONERS' COMMENTS / REQUESTS

Commissioner Atilla Uner recommended including interfacility transfers (IFTs) as an EMSC goal as there are a lot of delays for various reasons and requested a report on where suspected hang ups are and where potential improvements can be made to advocate for a better system.

Commissioner Robert Ower recommended a workgroup between hospital emergency rooms or hospital management in general and ambulance providers to find a solution for IFT and bariatric transport issues.

Director Tadeo will reach out to the Hospital Association of Southern California (HASC) regarding coming up with a workgroup to address IFT delays which also ties in with the issue of critical care transports.

Adena Tessler, HASC, addressed the EMSC stating that workforce is an issue and many providers have moved their remaining staff to emergency transports which yields a greater compensation and there may need to be a review of transport reimbursement rates.

9. **ADJOURNMENT:**
The next EMSC meeting will be March 8, 2023 due to calendar conflicts. Adjournment by Chair Lam at 3:04 p.m.

Motion/Second by Commissioners Uner/Ower to adjourn was approved and carried unanimously.

Next Meeting: Wednesday, March 8, 2023, 1:00-3:00pm
Join by Zoom Video Conference Call
https://us06web.zoom.us/j/85816449796?pwd=OVNCZEdPUkM0blhhckJzTkMxUnFwUT09
Meeting ID: 858 1644 9796
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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

February 8, 2023

MEMBERSHIP / ATTENDANCE (VIA Zoom)

	REPRESENTATIVES		EMS AGENCY STAFF
☑	Erick Cheung, MD, Chair	EMS Commission	Marianne Gausche-Hill, MD
☑	Garry Olney, DNP Vice Chair	EMS Commission	Kelsey Wilhelm, MD
☐	Atilla Under, MD, MPH	EMS Commission	Richard Tadeo
☑	Lydia Lam, MD	EMS Commission	Christine Clare
☑	Diego Caivano, MD	EMS Commission	Fritz Bottger
☐	Carol Meyer, RN	EMS Commission	Susan Mori
☑	Carole Snyder, RN.	EMS Commission	Jacqui Rifenburg
☑	Brian Saeki	EMS Commission	Ami Boonjaluksa
☐	James Lott, PsyD, MBA	EMS Commission	David Wells
☐	Nabila Alam	EMS Commission	Sara Rasnake
☑	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	Laura Leyman
☑	Samantha Verga-Gates	Southern Region	Jennifer Calderon
☑	Laurie Donegan	Southern Region	Karen Rodgers
☑	Shelly Trites	Southern Region	Denise Watson
☑	Christine Farnham	Southern Region, Alternate	Gary Watson
☑	Ryan Burgess	Western Region	Aldrin Fontela
☑	Susana Sanchez	Western Region, Alternate	Sandy Montero
☑	Erin Munde	Western Region, Alternate	Priscilla Romero
☑	Laurie Sepke	Eastern Region	
☑	Alina Candal	Eastern Region	
☑	Jenny Van Slyke	Eastern Region, Alternate	GUESTS
☑	Lila Mier	County Region	Jamie Khan, MD
☑	Emerson Martell	County Region	Amar Shah, MD
☑	Yvonne Elizarraraz	County Region	Won Ki Chae, MD
☐	Antoinette Salas	County Region	Gabriel Campion, MD
☑	Shira Schlesinger, MD	Base Hospital Medical Director	Tina Crews
☐	Robert Yang, MD	Base Hospital Medical Director, Alternate	Michael Harter
☐	Adam Brown	Provider Agency Advisory Committee	Danielle Ogaz
☑	Jennifer Nulty	Prov. Agency Advisor Committee, Alternate	
☑	Erica Candelaria	Pediatric Advisory Committee Representative	
☑	Heidi Ruff	Ped AC Representative, Alternate	
☑	John Foster	MICN Representative	
☐	Vacant	MICN Representative, Alternate	

	PREHOSPITAL CARE COORDINATORS				
☑	Melissa Turpin (SMM)	☑	Travis Fisher (CSM)	☑	Lorna Mendoza (SFM)
☑	Jessica Strange (SJS)	☑	Lauren Spina (CSM)	☑	Brandon Koulabouth (AMH)
☑	Karyn Robinson (GWT)	☑	Coleen Harkins (AVH)	☐	Allison Bozigian (HMN)

1. **CALL TO ORDER:** The meeting was called to order at 1:01 by Dr. Erick Cheung, Chair.

2. **APPROVAL OF MINUTES**: The meeting minutes for December 7, 2022, were approved as presented.

   M/S/C (Burgess/Sepke)

3. **INTRODUCTIONS/ANNOUNCEMENTS:**
   - Dr. Erick Cheung, BHAC Chair for 2023, Psychiatrist at UCLA Hospital, and the Chief Medical Officer for UCLA Neuro-Psychiatric Hospital. His appointment to the EMS Commission comes from the Southern California Psychiatric Society, and he has served on the EMS Commission for 12 years.
   - Jenny Van Slyke introduced John Foster, who will assist her with education for Huntington Hospital Prehospital Care Program and the Pasadena Fire Department.
   - EMS Physicians.
   - Dr. Bosson, Dr. Whitfield, and Dr. Patel are deployed in part of the international response to the earthquake in Turkey.

   3.1 EMS Agency Staff Changes – Richard Tadeo presented the current EMS Agency Organizational Chart.

   3.2 EMS Annual Data Report – The Annual Data Report released December 2022 was reviewed and hard copies were mailed to all hospitals.

   3.3 Diversion and APOT Memo – Richard Tadeo shared a memo that was sent to all hospitals and provider agencies on January 5, 2023.

   3.4 EMSAAC Conference – Will be held May 31 & June 1, 2023, in San Diego.

4. **REPORTS & UPDATES:**

   4.1 EMS Update 2023

   EMS Update 2023 will begin in September. Proposed topics include Professionalism, Death Notification, Tranexamic acid (TXA), Blood Transfusion in the instance of 9-1-1 Re-triage, and Handoff Reporting.

   4.2 EmergiPress

   Online CE education can be accessed through the APS Portal or the EMS website. The latest edition, “Consent for Minors.”

   4.3 ECMO Pilot

   We will continue to enroll patients in the ECMO Pilot Program through the end of the year. MemorialCare Long Beach Medical Center and Long Beach Fire Department are now participating in the ECMO Program. Stakeholders in the ECMO Pilot have created a manuscript on the challenges of creating a regional system for advanced cardiac arrest care. The manuscript has been accepted and will be published by Resuscitation. All EMS Agency publications are available on the EMS website under the resources section.

4.4 Data Collaboratives

The collaborative groups meet quarterly to discuss and explore research opportunities, data collection, and opportunities for system improvement. The goal is for meaningful data that will drive change in how we provide or improve EMS care and a greater understanding on a regional level.

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 of midazolam for children six months – thirteen years of age with seizures. Currently in phase one, the Usual Care Phase, and will not transition to the Intervention Phase until 2024. It is essential to capture all patients with a provider impression of SEAC or SEPI and enter the information into the base screener or submit a paramedic self-report.

5. OLD BUSINESS:

None

6. NEW BUSINESS:

6.1 Ref. No. 326, Psychiatric Urgent Care Center

Section III. Policies and Procedures, E: Extensive discussion on shortening the 6 hours to 2 hours to submit data of EMS patients transported to an emergency department after arrival at the PUCC. The 6-hour window may be due to an evolving disease process instead of an EMS missed triage. If the time remains the same, then every record would have to be adjudicated to determine if the transport was because of an EMS missed triage; shortening the time would be able to capture patients who were miss triaged by EMS.

Approved with the recommended changes to sections, III. Policies and Procedures, E. 3. and 4., from the total number of EMS-transported patients transferred to an acute care emergency department within 2 hours or after 2 hours of arrival to the Psychiatric Urgent Care Center (PUCC).

M/S/C (Schlesinger/Caivano)

6.2 Ref. No. 328, Sobering Center Standards

Approved with the recommended changes to sections, III. Policies and Procedures, E. 3. and 4., from the total number of EMS-transported patients transferred to an acute care emergency department within 2 hours or after 2 hours of arrival to the Sobering Center (SC).

M/S/C (Schlesinger/Caivano)

6.3 Ref. No. 526, Behavioral/Psychiatric Crisis Patient Destination

Approved as presented

M/S/C (Strange/Caffey)

6.4 Ref. No. 528, Intoxicate (Alcohol) Patient Destination

Approved as presented

M/S/C (Strange/Caffey)

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

Approved as presented

M/S/C (Sepke/Turpin)

6.6 Ref. No 505, Ambulance Patient Offload Time (APOT)

Approved with the recommended changes to section, II. Responsibilities of EMS Personnel to Mitigate Extended AOPT, C. 3., to add normal vital signs upon arrival, and if any patient has received medications in the field and may require ongoing assessments (i.e., Narcan, narcotics, or epinephrine, etc.), a report must be done before patient offloading to discuss if the waiting room is appropriate.

M/S/C (Van Slyke/Verga-Gates)

6.7 Ref. No. 506, Trauma Triage

Approved with the clarifying language in Principle 2., distinguishing when base contact to a trauma center or when trauma center notification is appropriate.

M/S/C (Van Slyke/Burgess)

(National Trauma Guidelines)
https://journals.lww.com/jtrauma/pages/articleviewer.aspx?year+2022&issue=08000&article=00019&type=Fulltext

6.8 Ref. No. 506.1, Trauma Triage Decision Scheme

Discussion regarding the removal of adults greater than 55 years as a Special Consideration for trauma center consideration (National Trauma Guidelines). Concern that patients in this age group are at higher risk even with a minor trauma injury and other considerations, SBP less than 110mmHG alone may not determine how sick a patient may be.

Approved as presented

M/S/C (Van Slyke/Burgess)

6.9 Ref. No. 604, Prehospital Care Forms

Approved as presented

M/S/C (Burgess/Hisserich)

6.10 Ref. No. 1302, Airway Management

Approved with the recommended changes: Principle 15., adding a target of 30-35 cm when mild hyperventilation is warranted or until a patient's clinical status changes improve.

M/S/C (Van Slyke/Candal)

6.11 'Base Contact for trauma patients.'

(Discussed in agenda item, 6.7, Ref. No. 506, Trauma Triage)

6.12 Emergency Severity Index (ESI)

Annual hospital impact surveys will be sent to all hospitals in March to obtain data on patient volumes. All hospitals use the ESI as their triage standard in the emergency department.

6.13 Tranexamic Acid (TXA)

The group was not concerned about the implementation of Tranexamic Acid (TXA). A presentation of TXA will be given to the group when TXA is added to the trauma protocol and the medical control guidelines 1317 series.

7. OPEN DISCUSSION

Starting in April, the summary of changes for policies will be sent out at the quarterly updates. Lily Choi will oversee this process.

AB 361 allowed all Brown Act Meetings (BHAC, PAAC, and EMS Commission) to meet virtually. The introduction of AB 2449 is a hybrid of AB 361. The plan is for all Brown Act Meetings to meet in person beginning in April.

Item for the April BHAC Agenda

- Base Contact for AMA patients when the patient is no longer on the scene

8. NEXT MEETING: BHAC's next meeting is on April 12, 2023.

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

ACCOUNTABILITY: Laura Leyman

9. ADJOURNMENT: The meeting was adjourned at 15:10

EMERGENCY MEDICAL SERVICES COMMISSION
PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, February 15, 2023

In compliance with Assembly Bill 361 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 IN ATTENDANCE	ORGANIZATION
X Kenneth Powell, Chair	EMSC, Commissioner
X Paul Rodriquez, Vice-Chair	EMSC, Commissioner
X Paul Espinosa	EMSC, Commissioner
James Lott, PsyD, MBA	EMSC, Commissioner
X Robert Ower	EMSC, Commissioner
X Gary Washburn	EMSC, Commissioner
Brian Bixler	EMSC, Commissioner
X John Hisserich	EMSC, Commissioner
Jason Tarpley, MD	EMSC, Commissioner
X Sean Stokes	Area A *(Rep to Medical Council)*
X Justin Crosson	Area A, Alternate
X Keith Harter	Area B
Clayton Kazan, MD	Area B, Alternate
X Todd Tucker	Area C
X Jeffrey Tsay	Area C, Alternate
Kurt Buckwalter	Area E
Ryan Jorgenson	Area E, Alternate
Wade Haller	Area F
X Andrew Reno	Area F, Alternate
X Adam Brown	Area G *(Rep to BHAC)*
Jennifer Nulty	Area G, Alternate
X Doug Zabilski	Area H
X Tyler Dixon	Area H, Alternate
X David Hahn	Area H, Alternate
Julian Hernandez	Employed Paramedic Coordinator
X Tisha Hamilton	Employed Paramedic Coordinator, Alt
X Rachel Caffey	Prehospital Care Coordinator
X Jenny Van Slyke	Prehospital Care Coordinator, Alternate
Andrew Respicio	Public Sector Paramedic Coordinator
X Paul Voorhees	Public Sector Paramedic Coordinator, Alt
Maurice Guillen	Private Sector Paramedic
Scott Buck	Private Sector Paramedic, Alternate
X Tabitha Cheng, MD	Provider Agency Medical Director
X Tiffany Abramson, MD	Provider Agency Medical Director, Alt
X Andrew Lara	Private Sector Nurse Staffed Amb Program
Gary Cevello	Private Sector Nurse Staffed Amb Program,
Michael Kaduce	EMT Training Program
X Scott Jaeggi	EMT Training Program, Alternate
X Scott Atkinson	Paramedic Training Program
David Fillip	Paramedic Training Program, Alternate
X Adrienne Roel	EMS Educator
Caroline Jack	EMS Educator, Alternate

EMS AGENCY STAFF	EMS AGENCY STAFF
Richard Tadeo	Marianne Gausche-Hill, MD
Christine Clare	Jacqueline Rifenburg
Ami Boonjaluksa	Frederick Bottger
Jennifer Calderon	Lily Choi
Mark Ferguson	Aldrin Fontela
Natalie Greco	Laurie Lee-Brown
Laura Leyman	Nnabuike Nwanonenyi
Miguel Ortiz-Reyes	Lorrie Perez
Sara Rasnake	Karen Rodgers
Priscilla Romero	Andrea Solorio
Denise Watson	Gary Watson
David Wells	Christine Zaiser

GUESTS	ORGANIZATION
Stephanie Hall, MD	Keck Medicine of USC
Christina Eclarino	LA County Public Health
Jennifer Breeher	Alhambra FD
Damien Cyphers	Liberty Ambulance
Jessie Castillo	PRN Ambulance
Marianne Newby	UCLA Center for Prehosp Care
Katie Ward	La Habra Heights FD
Britney Alton	Burbank FD
Shelley Peterson	Lifeline Ambulance
Sheryl Gradney	LACoFD
Ryan Weddle	Monterey Park FD
Puneet Gupta, MD	LACoFD
Carissa Kinkor	Liberty Ambulance
Erich Ekstedt	Downey FD
Josh Parker	PRN Ambulance
Danielle Thomas	Lifeline Ambulance
Christopher Jeffreys	Compton FD
Travis Moore	La Verne FD
Catherine Borman	Santa Monica FD
Roger Yang, MD	Huntington Hosp / PasadenaFD
Dave Molyneux	West Coast Ambulance
Ilse Wogau	LACoFD
Sal Rios, MD	LAC+USC Medical Ctr
Louis Mendoza	Liberty Ambulance
Heather Calka	UCLA Center for Prehosp Care
Edmond St. Cyr	Burbank FD
Kelsey Wilhelm, MD	Compton FD
Jason Hansen	Pasadena FD
Lyn Riley	LACo Sheriff
Marc Cohen, MD	Represents 5 Area FDs
Mick Hannan	Long Beach FD
Roger Braum	Culver City FD
Joseph Nakagawa, MD	McCormick Amb / Hawthorne
Gloria Guerra	LACoFD
Natalie Hernandez	
Danielle Ogaz	LACoFD
Dee Josing	LACoFD
Ling Vuong-Shaffer	LACoFD
Paula LaFarge	LACoFD
Heidi Ruff	LAFD
Kristina Crews	LACoFD
Victor Lemus	Compton FD

1. CALL TO ORDER - Chairman Powell called meeting to order at 1:00 p.m.

- Chairman Powell thanked Robert Ower for his commitment as Chairman of this Committee during 2022.

2. INTRODUCTIONS AND ANNOUNCEMENTS

2.1 Committee Membership Changes *(Chairman Powell)*
- Area G Representative: Chief Adam Brown (Torrance FD) replacing Chief Alec Miller.
- New Position on Committee: Prehospital EMS Educator
  - Adrienne Roel, RN – Primary Representative
  - Carolyn Jack, RN – Alternate Representative

2.2 Keck Hospital Acute Care Hospital at Home Program *(Richard Tadeo)*
Mr. Tadeo introduced Dr. Stephanie Hall, Chief Medical Officer, Keck University Hospital, to discuss a new program that may involve prehospital responses.
- Dr. Hall provided information on a Hospital at Home program which Keck University is seeking approval from the Centers for Medicare & Medicaid Services (CMS). If approved, this program would allow Keck University Hospital to care for in-patients within patient home's and may affect paramedics' transportation decisions.
- As of now, there are no changes to the care and/or transport of patients enrolled in this program. Further information will be provided to providers if prehospital is impacted.

2.3 Document Reviews/Testing by EMS Personnel *(Richard Tadeo)*
Mr. Tadeo reviewed the following letters/documents:
- EMS Authority's executive order allowing EMS professionals to administer the COVID-19 vaccination, conduct testing, and work in alternate sites will be rescinded effective March 1, 2023.
- EMS Agency's letter of support, describing a study conducted on vehicular accidents related to the use of lights and sirens during EMS responses. This information was sent to all public and private providers.
- EMS Agency's letter regarding the inappropriate utilization of 9-1-1 for interfacility patient transfers. This letter was also sent to all public and private providers; and hospitals.

2.4 Virtual and Hybrid Commission Meetings *(Richard Tadeo)*
Mr. Tadeo reviewed a letter from the County Board of Supervisors, dated January 12, 2023, describing the return of in-person meetings for all public meetings which follow the Brown Act. The upcoming change may affect this Committee on April 19, 2023. Formal announcement will be provided at a later date.

2.5 Persons Experiencing Homelessness: Research Project *(Dr. Tiffany Abramson, Provider Agency MD)*
Dr. Abramson introduced a research project which looks at how persons experiencing homelessness (PEH) are affecting our EMS providers and the EMS system. Dr. Abramson will send all providers a request to participate in an interview process. Any questions can be directed to Dr. Abramson at tiffany.abramson@med.usc.edu

3. APPROVAL OF MINUTES - (Zabilski / Kazan) December 21, 2022 minutes were approved as written.

4. REPORTS & UPDATES

4.1 2022 Annual EMS Data Report *(Richard Tadeo)*
This report was reviewed and is available on the EMS Agency webpage.

4.2 EMS and Law Enforcement Co-Response (ELCoR) Taskforce *(Marianne Gausche-Hill, MD)*

- Dr. Gausche-Hill thanked the following for their service during the deployment to Turkey for assisting in the recovery of survivors from the 7.8 earthquake:
  - Los Angeles County Fire Department, California Taskforce 2, USAR Team
  - EMS Agency Staff: Dipesh Patel, MD; Denise Whitfield, MD; and Nichole Bosson, MD
- ELCoR taskforce conducted their first meeting. Next meeting is pending announcement.
- A subgroup has been formed to develop scenarios that would integrate law enforcement and EMS policies.

4.3 PediDOSE Trial *(Marianne Gausche-Hill, MD)*

As of January 1, 2023, the Los Angeles County EMS system entered into an NIH-funded trial, which is evaluating standardized dosing of *midazolam*, based on age of the pediatric patient for the treatment of seizures. This "usual care" phase does not affect our current treatment protocols; paramedics and base hospitals are asked to complete a self-report document for all EMS witnessed pediatric seizure patients.

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

- Data collaboratives continue to meet and review data results.
- The following link was made available for those wanting to review data results from a cardiac arrest project on post-ROSC bundle of care: https://www.tandfonline.com/doi/abs/10.1080/10903127.2023.2172633?journalCode=ipec20

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

- Long Beach FD and MemorialCare Long Beach Medical Center are now participating in this pilot program.
- ECMO Pilot participants have created a manuscript on how to develop an ECMO program within a large-scale EMS system. This manuscript has recently been published in the Resuscitation Journal and can be reviewed at the following weblink: https://authors.elsevier.com/a/1gYWC14RWGNfYo
- An educational webinar is being planned for all provider agencies and paramedics involved in this pilot program. The plan is to have this webinar during the month of April 2023; input was given on which day of the week would be best attended.

4.6 EMS Update 2023 *(Marianne Gausche-Hill, MD)*

- Possible topics include: Discussion on professionalism; providing death notifications; use of Tranexamic Acid (TXA) for specific trauma patients; monitoring blood transfusions during trauma re-triage; and information on providing patient reports during transfer of care.
- Committee also recommended other topics including: provider burn-out and Just Culture.

4.7 ITAC Update *(Marianne Gausche-Hill, MD)*

Meeting was cancelled this month; next meeting is scheduled for May 1, 2023.

4.8 EmergiPress *(Marianne Gausche-Hill, MD)*

- January 2023 EmergiPress is available on the EMS Agency's webpage and includes the following topics: consent of minors; pediatric assessments; and the importance of ECGs. All are available on SCORM files which allow provider agencies to provide continuing education via an LMS.
- This Committee recommended an educational topic to review the new trauma guidelines.

4.9 Expansion of Scope: Tranexamic Acid (TXA) for Severe Trauma *(Marianne Gausche-Hill, MD)*

- TXA medication is currently listed in the basic scope of practice for paramedics within the State of California.
- TXA assists with clot formation in patients with multi-trauma injuries, which has shown in trial studies to reduce mortality by 32%.

- Currently, Los Angeles County is reviewing this medication for possible implementation into the EMS system with a formal report to be presented in the future and possibly included in EMS Update 2023.

4.10 Expansion of Scope: Blood Monitoring for 911 Trauma Re-Triage *(Marianne Gausche-Hill, MD)*

- EMS Agency is reviewing the possibility of approving paramedics in Los Angeles County (during 911 re-triage) to monitor blood transfusions during inter-facility transports.
- Any questions or concerns can be directed to Dr. Gausche-Hill at MGausche-hill@dhs.lacounty.gov

5. UNFINISHED BUSINESS

5.1 Reference No. 207, EMS Commission Advisory Committees *(Chris Clare)*

Policy presented as information only.

Policy I.C.12: After a brief discussion of the selection process for this new membership position ("EMS Educator"), the descriptive wording will remain as written.

6. NEW BUSINESS

6.1 Reference No. 326, Psychiatric Urgent Care Center (PUCC) Standards *(Ami Boonjaluksa)*

Policy reviewed and approved as written.

6.2 Reference No. 526, Behavioral / Psychiatric Crisis Patient Destination *(Ami Boonjaluksa)*

Upon discussion and review, this policy was approved with the following recommendation:

- Principle 5: change the word "may" to "could" to read "could be transported by EMS (basic life support) or law enforcement…"

6.3 Reference No. 328, Sobering Center (SC) Standards *(Ami Boonjaluksa)*

Policy reviewed and approved as written.

6.4 Reference No. 528, Intoxicated (Alcohol) Patient Destination *(Ami Boonjaluksa)*

Upon discussion and review, this policy was approved with the following recommendation:

- Policy III.B: add "Suicidal Ideation" to the Exclusion Criteria.

M/S/C (Kazan/Roel) Approve, with above recommendations:
Reference No. 326, Psychiatric Urgent Care Center (PUCC) Standards
Reference No. 526, Behavioral / Psychiatric Crisis Patient Destination
Reference No. 328, Sobering Center (SC) Standards
Reference No. 528, Intoxicated (Alcohol) Patient Destination

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

6.6 Reference No. 505, Ambulance Patient Offload Time (APOT) *(Chris Clare)*

After lengthy discussion, the following roll call results revealed a consensus to Table policies:

11 (eleven) members requested policies to be tabled;
5 (five) members requested policies to be approved and move forward; and
2 (two) members abstained.

M/S/C (Voorhees/Brown) Table the following policies:
Reference No. 503.1, Diversion Request Requirements for Emergency Department Saturation and Reference No. 505, Ambulance Patient Offload Time (APOT)

6.7 Reference No. 506, Trauma Triage *(Chris Claie and Lorrie Perez)*
6.8 Reference No. 506.1, Trauma Triage Decision Scheme *(Lorrie Perez)*

Policies reviewed and approved as written.

M/S/C (Zabilski/Voorhees) Approve:
Reference No. 506, Trauma Triage and Reference No. 506.1, Trauma Triage Decision Scheme

6.9 Reference No. 1302, MCG: Airway Management *(Marianne Gausche-Hill, MD)*

Policy presented as information only.

7. OPEN DISCUSSION

7.1 Base Contact When Patient Has Eloped *(Doug Zabilski, Area H Representative)*
Chief Zabilski advised the EMS Agency that providers are receiving pushback from base hospitals when paramedics call the base hospital for AMA patients who meet trauma center criteria, but who have eloped prior to base contact. (Reference No. 834, Patient Refusal of Treatment/Transport And Treat and Release at Scene)

Upon further discussion, Committee member requested that the EMS Agency add wording to policy stating that base hospital contact is not required for AMA patients when patient is no longer on scene.

8. NEXT MEETING - April 19, 2023

9. ADJOURNMENT - Meeting adjourned at 3:34 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PSYCHIATRIC URGENT CARE CENTER (PUCC) STANDARDS** REFERENCE NO. 326

PURPOSE: To establish minimum standards for the designation of Psychiatric Urgent Care Centers (PUCC).

AUTHORITY: Health & Safety Code, Division 5, Sections 1797.220, 1798
California Code of Regulations, Title 22, Division 9, Chapter 5

DEFINITIONS:

Behavioral/Psychiatric Crisis: A provider impression for patients who are having a mental health crisis or a mental health emergency. This is not for anxiety or agitation secondary to medical etiology.

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 medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification (Ref. No. 1200.2) are also considered to have an emergency medical condition.

Psychiatric Urgent Care Center (PUCC): A mental health facility authorized by the Department of Mental Health and approved by the EMS Agency by meeting the requirements in this Standards.

PUCC EMS Liaison Officer: A qualified administrative personnel appointed by the PUCC to coordinate all activities related to receiving patients triaged by paramedics whose primary provider impression is Behavioral/Psychiatric Crisis.

POLICY:

I. General Requirements

A. Licensed or certified by the California Department of Public Health as a mental health treatment facility

B. Authorized by the Department of Mental Health to provide mental health services

C. Have a fully executed Psychiatric Urgent Care Designation Agreement with the EMS Agency

D. Operate 24 hours a day, 7 days a week, 365 days a year

E. Provide up to 23 hours of immediate care focusing on intensive crisis services

F. Provide and maintain adequate parking for ambulance vehicles to ensure access of PUCC

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

G. Appoint a PUCC EMS Liaison Officer to act as a liaison between the EMS Agency and the authorized EMS provider agency

H. Accept all patients who have been triaged by paramedics regardless of the patient's ability to pay (see Inclusion Criteria in Ref. No. 526, Behavioral/Psychiatric Crisis Patient Destination)

I. Notify the EMS Agency within 24 hours when there is a change in status with respect to protocols and/or the ability to care for patients

J. Maintain General Liability Insurance as follows:

1.	General aggregate	$2 million
2.	Products/completed operations aggregate	$1 million
3.	Personal and advertising injury	$1 million
4.	Each occurrence	$1 million
5.	Sexual Misconduct	$2 million per claim and $2 million aggregate
6.	Worker's Compensation and Employers Liability	$1 million per accident

II. PUCC Leadership and Staffing Requirements

A. PUCC EMS Liaison Officer

1. Responsibilities:

a. Implement and ensure compliance with the PUCC Standards

b. Maintain direct involvement in the development, implementation and review of PUCC policies and procedures related to receiving patients triaged by paramedics to the PUCC

c. Serve as the key personnel responsible for addressing variances in the care and sentinel events as it relates to patients triaged by paramedics to the PUCC

d. Liaison with EMS Provider Agencies and law enforcement agencies

e. Serve as the contact person for the EMS Agency and be available upon request to respond to County business

B. A physician licensed in the State of California shall be on-call at all times.

C. A registered nurse licensed in the State of California shall be on-site at all times.

D. Staffing may be augmented by licensed psychiatric nurse practitioners, licensed vocational nurses, social workers, and other mental health professionals.

E. All medical and nursing staff shall have current certification on Cardiopulmonary Resuscitation (CPR) through the American Heart Association or Red Cross.

III. Policies and Procedures

Develop, maintain and implement policies and procedures that address the following:

A. Receipt, immediate evaluation, short term management and monitoring of patients who meet PUCC triage inclusion criteria

B. Timely transfer of patients who require a higher level of care to an acute care hospital utilizing non-911 ambulance provider(s)

C. Immediate transfer of patients with emergency medical condition to the most accessible 9-1-1 receiving facility/emergency department

D. Record keeping of EMS Report Forms

E. Submit monthly data to the EMS Agency for the following:

1. Total number of EMS transported patients who were evaluated
2. Total number of EMS transported patients who were treated and released
3. Total number of EMS transported patients who were transferred to an acute care emergency department within two (2) hours or less of arrival to the PUCC
4. Total number of EMS transported patients transferred to an acute care emergency department after two (2) hours of arrival to the PUCC
5. Total number of EMS transported patients admitted to another care facility
6. Total number of EMS transported patients who experienced an adverse event resulting from the services provided

F. Procedure for notifying the EMS Agency of patient transfers from PUCC requiring 9-1-1 transport for an emergency medical condition within six hours of admission to the PUCC; notification shall be provided as soon as possible, but not to exceed 72 hours after such transport(s)

IV. Equipment and Supplies

A. Dedicated telephone line to facilitate direct communication with EMS personnel

B. ReddiNet® capability to communicate PUCC’s real-time capacity status

C. Public Access Device/Layperson Automated External Defibrillator on site with staff trained on its proper use

D. An up-to-date community referral list of services and facilities available to patients

V. Procedure for Approval to be a designated PUCC

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

1. The rationale for the request to be a designated PUCC

2. A document verifying that the facility has been approved by the Department of Mental Health to provide mental health services (i.e., written service agreement)

3. The proposed date the PUCC will open to accept patients triaged by paramedics to the PUCC

4. Copies of the policies and procedures required in Section III

5. Proposed Staffing

6. Hours of operation

B. Site Visit

1. Once all General Requirements are met, the EMS Agency will coordinate a site visit to verify compliance with all the requirements.

2. Administrative and field personnel from local EMS provider agencies will be invited to exchange contact information, and become familiar with the physical layout of the facility.

C. PUCC Designation/Re-Designation

1. PUCC initial designation and re-designation is granted for a period of one year after a satisfactory review by the EMS Agency.

VI. Other Requirements

A. The EMS Agency reserves the right to perform scheduled site visits or request additional data from the PUCC at any time.

B. The PUCC shall immediately (within 72 hours) provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the PUCC Standards including structural changes or relocation of the PUCC.

C. The PUCC shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw as a designated PUCC.

D. The PUCC shall notify the EMS Agency within 15 days, in writing of any change in status of the PUCC EMS Liaison by submitting Ref. no. 621.2, Notification of Personnel Change Form.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 326.1, Designated Psychiatric Urgent Care Center (PUCC) Roster
Ref. No. 526, Behavioral/Psychiatric Crisis Patient Destination
Ref. No. 621.2, Notification of Personnel Change Form

Reference No. 326

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/15/2023	2/15/2023	N
	Base Hospital Advisory Committee	2/8/2023	2/8/2023	Y
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

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

REFERENCE NO. 326, Psychiatric Urgent Care Center (PUCC) Standards

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
III. Policies and Procedures, E.3 and E.4	BHAC 2-8-23	Change time frame from 6 hours to 2 hours to capture EMS mis-triage	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **SOBERING CENTER (SC) STANDARDS** REFERENCE NO. 328

PURPOSE: To establish minimum standards for the designation of Sobering Centers (SC).

AUTHORITY: Health & Safety Code, Division 5, Sections 1797.220, 1798
California Code of Regulations, Title 22, Division 9, Chapter 5

DEFINITIONS:

Alcohol Intoxication: A patient who appears to be impaired from alcohol, demonstrated by diminished physical and mental control **with** evidence of recent alcohol consumption (e.g., alcohol on breath, presence of alcoholic beverage container(s)) and **without** other acute medical or traumatic cause. Alcohol intoxication is typically associated with one of more of the following:

- Speech disturbance – incoherent, rambling, slurring
- Decline in cognitive function – confusion, inappropriate behavior, impaired decision-making capacity
- Imbalance – unsteady on feet, staggering, swaying
- Poor coordination – impaired motor function, inability to walk a straight line, fumbling for objects

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 and oxygen saturation – except isolated asymptomatic hypertension) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification (Ref. No. 1200.2) are also considered to have an emergency medical condition.

Sobering Center (SC): A non-correctional facility designated by a city or county to provide a safe, supportive environment for intoxicated individuals to become sober. A SC shall be approved by the EMS Agency by meeting the requirements in this Standards.

SC EMS Liaison Officer: A qualified administrative personnel appointed by the SC to coordinate all activities related to receiving patients triaged by paramedics whose primary provider impression is Alcohol Intoxication.

POLICY:

I. General Requirements

A designated SC shall be:

A. A federally qualified Health Center and Clinic or

B. Certified by the California State Department of Health Care Services, Substance Use Disorder Compliance Division or

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

C. Accredited as a Sobering Center under the standards developed by the National Sobering Collaborative and

D. Designated by a city or county to provide a safe, supportive environment for intoxicated individuals to become sober

E. Have a fully executed Sobering Center Designation Agreement with the EMS Agency

F. Operate 24 hours a day, 7 days a week, 365 days a year

G. Provide and maintain adequate parking for ambulance vehicles to ensure access of SC

H. Appoint a SC EMS Liaison Officer to act as a liaison between the EMS Agency and the authorized EMS provider agency

I. Accept all patients who have been triaged by paramedics regardless of the patient's ability to pay (see Inclusion Criteria in Ref. No. 528, Intoxicated (Alcohol) Patient Destination)

J. Notify the EMS Agency within 24 hours when there is a change in status with respect to protocols and/or the ability to care for patients

K. Maintain General Liability Insurance as follows:

1.	General aggregate	$2 million
2.	Products/completed operations aggregate	$1 million
3.	Personal and advertising injury	$1 million
4.	Each occurrence	$1 million
5.	Sexual Misconduct	$2 million per claim and $2 million aggregate
6.	Worker's Compensation and Employers Liability	$1 million per accident

II. SC Leadership and Staffing Requirements

A. SC EMS Liaison Officer

1. Responsibilities:

a. Implement and ensure compliance with the SC Standards

b. Maintain direct involvement in the development, implementation and review of SC policies and procedures related to receiving patients triaged by paramedics to the SC

c. Serve as the key personnel responsible for addressing variances in the care and sentinel events as it relates to patients triaged by paramedics to the SC

d. Liaison with EMS Provider Agencies and law enforcement agencies

e. Serve as the contact person for the EMS Agency and be available upon request to respond to County business

B. A physician licensed in the State of California shall be on call at all times.

C. A registered nurse licensed in the State of California shall be on-site at all times.

D. Staffing may be augmented by licensed nurse practitioners, licensed vocational nurses, social workers, and other mental health professionals.

E. All medical and nursing staff shall have current certification on Cardiopulmonary Resuscitation (CPR) through the American Heart Association or Red Cross.

III. Policies and Procedures

Develop, maintain and implement policies and procedures that address the following:

A. Receipt, immediate evaluation, short term management and monitoring of patients who meet SC triage inclusion criteria

B. Timely transfer of patients who require a higher level of care to an acute care hospital utilizing non-911 ambulance provider(s)

C. Immediate transfer of patients with emergency medical condition to the most accessible 9-1-1 receiving facility/emergency department

D. Record keeping of EMS Report Forms

E. Submit monthly data to the EMS Agency for the following:

1. Total number of EMS transported patients who were evaluated

2. Total number of EMS transported patients who were treated and released

3. Total number of EMS transported patients who were transferred to an acute care emergency department within two (2) hours or less of arrival to the SC

4. Total number of EMS transported patients who were transferred to an acute care emergency department after two (2) hours of arrival to the SC

5. Total number of EMS transported patients admitted to another care facility

6. Total number of EMS transported patients who experienced an adverse event resulting from services provided

F. Procedure for notifying the EMS Agency of patient transfers from SC requiring 9-1-1 transport for an emergency medical condition within six hours of admission to the SC; notification shall be provided as soon as possible, but not to exceed 72 hours after such transport(s)

IV. Equipment and Supplies

A. Dedicated telephone line to facilitate direct communication with EMS personnel

B. ReddiNet® capability to communicate SC's real-time capacity status

C. Public Access Device/Layperson Automated External Defibrillator on site with staff trained on its proper use.

D. An up-to-date community referral list of services and facilities available to patients

V. Procedure for Approval to be a designated SC

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

1. The rationale for the request to be a designated SC

2. A document verifying that the facility has been designated by a city or county to provide a safe, supportive environment for intoxicated individuals to become sober

3. The proposed date the SC will open to accept patients triaged by paramedics to the SC

4. Copies of the policies and procedures required in Section III

5. Proposed Staffing

6. Hours of operation

B. Site Visit

1. Once all General Requirements are met, the EMS Agency will coordinate a site visit to verify compliance with all the requirements.

2. Administrative and field personnel from local EMS provider agencies will be invited to exchange contact information, and become familiar with the physical layout of the facility.

C. SC Designation/Re-Designation

SC initial designation and re-designation is granted for a period of one year after a satisfactory review by the EMS Agency.

VI. Other Requirements

A. The EMS Agency reserves the right to perform scheduled site visits or request additional data from the SC at any time.

B. The SC shall immediately (within 72 hours) provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the SC Standards including structural changes or relocation of the SC.

C. The SC shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw as a designated SC.

D. The SC shall notify the EMS Agency within 15 days, in writing of any change in status of the SC EMS Liaison by submitting Ref. No. 621.2, Notification of Personnel Change Form.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 501, **9-1-1 Receiving Hospital Directory**
Ref. No. 528, **Intoxicated (Alcohol) Patient Destination**
Ref. No. 621.2, **Notification of Personnel Change Form**

Reference No. 328

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/15/2023	2/15/2023	N
	Base Hospital Advisory Committee	2/8/2023	2/8/2023	Y
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

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

REFERENCE NO. 328, Sobering Center (SC) Standards

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
III. Policies and Procedures, E.3 and E.4	BHAC 2-8-23	Change time frame from 6 hours to 2 hours to capture EMS mis-triage	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **TRAUMA TRIAGE** REFERENCE NO. 506

PURPOSE: To establish criteria and standards which ensure that patients requiring the care of a trauma center are appropriately triaged and transported.

AUTHORITY: California Code of Regulations, Title 13, Section 1105(c) California Code of Regulations, Title 22, Section 100236 et seq. Health and Safety Code, Div. 2.5, Section 1797 et seq., and 1317.

PRINCIPLES:

1. Trauma patients should be secured and transported from the scene as quickly as possible, consistent with optimal trauma care.

2. Paramedics shall make base hospital contact to the receiving trauma center on all injured patients who meet trauma triage criteria and/or guidelines. Notification to the receiving trauma center shall be made whenever paramedic judgment determines transport to the trauma center is in the patient's best interest. Contact shall be accomplished in such a way as not to delay transport.

3. Do not delay transport of hypotensive patients with penetrating torso trauma in order to apply spinal motion restriction.

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

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

POLICY:

I. Trauma Criteria – Requires immediate transportation to a designated trauma center

Patients who fall into one or more of the following categories are to be transported directly to the designated trauma center, if transport time does not exceed 30 minutes.

A. Systolic blood pressure less than 90 mmHg, or less than 70 mmHg in infants age less than one year

B. Respiratory rate greater than 29 breaths/minute (sustained), less than 10 breaths/minute, less than 20 breaths/minute in infants age less than one year, or requiring ventilatory support

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

C. Cardiopulmonary arrest with penetrating torso trauma unless based upon the paramedic's thorough assessment is found apneic, pulseless, asystolic, and without pupillary reflexes upon arrival of EMS personnel at the scene

D. All penetrating injuries to head, neck, torso, and extremities proximal to the elbow or knee

E. Blunt head injury associated with a suspected skull fracture, altered level of consciousness (Glasgow Coma Score less than or equal to 14), seizures, unequal pupils, or focal neurological deficit

F. Injury to the spinal column associated with acute sensory or motor deficit

G. Blunt injury to chest with unstable chest wall (flail chest)

H. Diffuse abdominal tenderness

I. Suspected pelvic fracture (excluding isolated hip fracture from a ground level fall)

J. Extremity with:

1. Neurological/vascular compromise and/or crushed, degloved, or mangled extremity

2. Amputation proximal to the wrist or ankle

3. Fractures of two or more proximal (humerus/femur) long-bones

4. Bleeding not controlled by direct pressure requiring the usage of a hemorrhage control tourniquet or hemostatic agent (approved provider agencies only)

K. Fall from height > 10 feet (all patients)

L. Passenger space intrusion of greater than 12 inches into an occupied passenger space

M. Ejected from vehicles (partial or complete)

N. Auto versus pedestrian/bicyclist/motorcyclist thrown, run over, or with significant (greater than 20 mph) impact

O. Unenclosed transport crash with significant (greater than 20 mph) impact

P. Major / Critical Burn (excluding those in which the MAR is a recognized Burn Center, e.g., LAC+USC Medical Center, Torrance Memorial Medical Center, West Hills Hospital):

1. Patients 15 years of age or older with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 20% Total Body Surface Area (TBSA)

2. Patients ≤ 14 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 10% TBSA

II. Trauma Guidelines – Mechanism of injury and patient history are the most effective methods of selecting critically injured patients before unstable vital signs develop. Paramedics and base hospital personnel should consider mechanism of injury and patient history when determining patient destination. At the discretion of the base hospital, transportation to a trauma center is advisable for:

A. Passenger space intrusion of greater than 18 inches into any unoccupied passenger space

B. Automobile versus pedestrian/bicyclist/motorcyclist (impact equal to or less than 20 mph)

C. Injured victims of vehicular crashes in which a fatality occurred in the same vehicle

D. Patients requiring extrication

E. Vehicle telemetry data consistent with high risk of injury

F. Injured patients (excluding isolated minor extremity injuries):

1. on anticoagulation or antiplatelet therapy, other than aspirin-only

2. with bleeding disorders

III. Special Considerations – Consider transporting injured patients with the following to a trauma center:

A. Patients in blunt traumatic full arrest who, based on a paramedic's thorough patient assessment, was not found apneic, pulseless, and without organized ECG activity (narrow complex supraventricular rhythm) upon the arrival of EMS personnel at the scene

B. Systolic blood pressure less than 110 mmHg may represent shock after age 65 years

C. Heart rate greater than systolic blood pressure for ≥ 14 years of age

D. Child (0-9 years of age) unrestrained or in an unsecured child safety seat

E. Pregnancy greater than 20 weeks gestation

F. Prehospital judgment

IV. Extremis Patients - Requires immediate transportation to the MAR:

A. Patients with an obstructed airway or those with concern for imminent airway obstruction due to inhalation injury

B. Patients, as determined by the base hospital personnel, whose lives would be jeopardized by transportation to any destination but the MAR

V. When, for whatever reason, base hospital contact cannot be made, the destination decision for injured patients will be made by paramedics using the principles set forth above.

VI. 9-1-1 Trauma Re-Triage – This section applies to injured patients in emergency departments of non-trauma centers whose injuries were initially estimated by EMS to be less serious (under triaged) or patients who self-transported (walk-in) to a non-trauma center, and subsequently assessed by the non-trauma center physician to require immediate trauma center care. The referring facility shall utilize the procedure outlined below to expedite transfer arrangements and rapid transport to the trauma center. This process should be reserved for patients with life-threatening traumatic injuries requiring emergent surgical intervention.

A. Determine if the injured patient meets any of the following 9-1-1 Trauma Re-Triage criteria:

1. Persistent signs of poor perfusion

2. Need for immediate blood replacement therapy

3. Intubation required

4. Glasgow Coma Score less than 9

5. Glasgow Coma Score deteriorating by 2 or more points during observation

6. Penetrating injuries to head, neck and torso

7. Extremity injury with neurovascular compromise or loss of pulses

8. Patients, who in the judgement of the evaluating emergency physician, have high likelihood of requiring emergent life- or limb-saving intervention within two (2) hours.

B. Contact the designated receiving trauma center or pediatric trauma center if the patient is less than or equal to 14 years of age and transport does not exceed 30 min. Do not delay transfer by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

C. Contact 9-1-1 for transportation. The paramedic scope of practice (Ref. No. 803) does not include paralyzing agents and blood products.

D. Prepare patient and available medical records for immediate transport. Do not delay transport for medical records which could be sent at a later time.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506.1 **Trauma Triage Decision Scheme**
Ref. No. 506.2 **9-1-1 Trauma Re-Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 803, **Paramedic Scope of Practice**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**

Reference No. 506, Trauma Triage

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/15/23	02/15/2023	No
	Base Hospital Advisory Committee	2/8/23	02/08/23	No
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee	1/25/23	01/25/2023	No
	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 ANGLES

REFERENCE No. 506.1 Trauma Triage Decision Scheme

Physiological Assessment

- **Systolic blood pressure (SBP):** < 90 mmHg, or < 70 mm Hg in infant < 1 yr.
- **Respiratory rate:** > 29 breaths/minute (sustained), < 10 breaths/minute, < 20 breaths/minute in infant < 1 yr., or requiring ventilatory support
- Cardiopulmonary arrest with penetrating torso trauma

Anatomical Injury Assessment

- ALL penetrating injuries to head, neck, torso, and extremities above the elbow or knee
- Blunt head injury associated with: suspected skull fracture, GCS ≤ 14, seizures, unequal pupils, or focal neurological deficit Spinal injury associated with acute sensory or motor deficit
- Blunt chest injury with unstable chest wall (flail chest)
- Diffuse abdominal tenderness
- Suspected pelvic fracture (excluding isolated hip fracture from a ground level fall)
- Extremity with: neuro/vascular compromise and/or crushed, degloved or mangled; amputation proximal to the wrist or ankle; or fractures of ≥ 2 proximal (humerus/femur) long-bones bleeding requiring tourniquet or hemostatic agent
- Major/Critical Burns: ≥15 years with 2nd or 3rd degree burns ≥ 20% TBSA; ≤ 14 years with 2nd or 3rd degree burns ≥ 10% TBSA

YES

YES

Mechanism of Injury Assessment

- Falls: All patients > 10 feet
- Passenger Space Intrusion: > 12 inches into an occupied passenger space
- Ejected from vehicle (partial or complete)
- Auto v. pedestrian/bicyclist/motorcyclist thrown, run over, or impact > 20 mph
- Unenclosed transport crash with significant impact (> 20 mph)

YES → **Contact Base/Trauma Center, Immediate transport to designated Trauma Center**

Trauma Guidelines Assessment

- Passenger Space Intrusion > 18 inches into an unoccupied passenger space
- Auto versus pedestrian/bicyclist/motorcyclist (impact ≤ 20 mph)
- Injured victims of vehicle crashes with a fatality in the same vehicle
- Patients requiring extrication
- Vehicle telemetry data consistent with high risk of injury
- Injured patients (excluding isolated minor extremity injuries): on anticoagulation therapy other than aspirin-only; or with bleeding disorders

YES → **Consult with Trauma Center/Base Hospital, transport to designated Trauma Center is advisable**

Special Considerations Assessment

- Blunt traumatic full arrest
- SBP < 110 mmHg may represent shock after age 65 years
- HR > SBP for age ≥ 14 years
- Child (0-9 Yrs.) unrestrained or in an unsecured child safety seat
- Pregnancy > 20 weeks
- Prehospital judgement

YES → **Consider transport to designated Trauma Center**

EFFECTIVE: 05-01-12
REVISED: 01-12-23
SUPERSEDES: 04-01-22

Reference No. 506.1, Trauma Triage Decision Scheme

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/15/23	02/15/2023	No
	Base Hospital Advisory Committee	2/8/23	02/08/23	No
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee	1/25/23	01/25/2023	No
	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

(PARAMEDIC)

SUBJECT: **BEHAVIORAL / PSYCHIATRIC CRISIS PATIENT DESTINATION** REFERENCE NO. 526

PURPOSE: To provide guidelines for the transport of patients with a primary provider impression of Behavioral/Psychiatric Crisis to the most appropriate facility that is staffed, equipped and prepared to administer medical care appropriate to the needs of the patient.

AUTHORITY: Health & Safety Code, Division 5, Sections 1797.220, 1798
California Code of Regulations, Title 22, Division 9, Chapter 5

DEFINITIONS:

Behavioral/Psychiatric Crisis: A provider impression for patients who are having a mental health crisis or a mental health emergency. This is not for anxiety or agitation secondary to medical etiology.

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, and oxygen saturation – except isolated asymptomatic hypertension) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification (Ref. No. 1200.2) are also considered to have an emergency medical condition.

Mental Health Crisis: Is a non-life-threatening situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress, considering harm to self or others, disoriented or out of touch with reality, has a compromised ability to function, or is otherwise agitated and unable to be calmed. Examples of mental health crisis includes:

- Talking about suicide threats
- Talking about threatening behavior
- Self-injury, but not needing immediate medical attention
- Alcohol or substance abuse
- Highly erratic or unusual behavior
- Eating disorders
- Not taking their prescribed psychiatric medications
- Emotionally distraught, very depressed, angry or anxious

Mental Health Emergency: Is a life-threatening situation in which an individual is imminently threatening harm to self or others, severely disoriented or out of touch with reality, has a severe inability to function, or is otherwise distraught and out of control. Examples of a mental health emergency includes:

- Acting on a suicide threat
- Homicidal or threatening behavior

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

- Self-injury needing immediate medical attention
- Severely impaired by drugs or alcohol
- Highly erratic or unusual behavior that indicates very unpredictable behavior and/or inability to care for themselves

Most Accessible Receiving Facility (MAR): Is the geographically closest (by distance) 9-1-1 Receiving Hospital approved by the EMS Agency to receive patients with emergency medical conditions from the 9-1-1 system.

Psychiatric Urgent Care Center (PUCC): A mental health facility authorized by the Department of Mental Health and approved by the EMS Agency by meeting the requirements in Ref. No. 326, Psychiatric Urgent Care Center Standards.

PRINCIPLES:

1. EMS provider agencies must be approved by the Emergency Medical Services (EMS) Agency to triage patients with behavioral/psychiatric crisis to a designated PUCC.

2. Patients with a provider impression of Agitated Delirium must be transported to an emergency department for evaluation.

3. Paramedics who have completed an 8-hour educational session regarding the triage of patients to a PUCC are the only EMS personnel authorized to utilize this policy.

4. Patients exhibiting mental health crisis who meet PUCC inclusion criteria may also be released at the scene to the local law enforcement agency. Law enforcement officers are highly encouraged to transport these patients to a designated PUCC. Paramedics shall document on the EMS Report Form to whom the patient was released.

5. Patients receiving olanzapine who are cooperative and meet the criteria for screening as per *Ref. 526.1 Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center (PUCC)*, may be transported by EMS (basic life support) or released to law enforcement to the PUCC.

6. In instances where there is a potential for the patient to harm self or others, EMS personnel shall consider seeking assistance from law enforcement.

7. Any patient who meets the triage criteria for transport to a PUCC, but who requests to be transported to an emergency department of a general acute care hospital, shall be transported to the emergency department of a general acute care hospital.

8. In all cases, the health and well-being of the patient is the overriding consideration in determining patient destination. Factors to be considered include severity and stability of the patient's illness or injury; status of the receiving facility; anticipated transport time; requests by the patient, family, guardian or physician; and EMS personnel and base hospital judgment.

POLICY:

I. Responsibilities of the Paramedic

A. Complete an 8-hour educational session regarding the triage of patients to a designated PUCC

B. Comply with all patient destination policies established by the EMS Agency

II. EMS Provider Agency Requirements and Responsibilities

A. Submit a written request to the Director of the EMS Agency for approval to triage patients who meet PUCC Inclusion Criteria. The written request shall include the following:

1. Date of proposed implementation date

2. Scope of deployment (identify response units)

3. Course/Training Curriculum addressing all items in Section IV

4. Identify a representative to act as the liaison between the EMS Agency, designated PUCC(s), and the EMS Provider Agency

5. Policies and procedures listed in Section B

B. Develop, maintain and implement policies and procedures that address the following:

1. Completion of one Medical Clearance Criteria Screening Tool for each patient (see sample Ref. No. 526.1)

2. Pre-arrival notification of the PUCC

3. Patient report to a licensed health care provider or physician at the PUCC

4. Confirmation that PUCC has the capacity to accept the patient prior to transport

C. Develop a Quality Improvement Plan or Process to review variances and adverse events

D. Comply with data reporting requirements established by the EMS Agency

III. Psychiatric Urgent Care Clinic (PUCC) Patient Triage Criteria

A. Inclusion Criteria – patients who meet the following criteria may be triaged for transport to a designated PUCC provided the PUCC can be accessed within a fifteen (15) minute transport time:

1. Provider impression of behavior/psychiatric crisis; and

a. Voluntarily consented or 5150 hold; and

b. Ambulatory, does not require the use of a wheelchair; and

c. NO emergent medical condition or trauma (with exception of ground level fall with injuries limited to minor abrasions below the clavicle); and

d. No focal neurological deficit

2. Age: ≥ 18 years and ≤65 years old

3. Vital Signs

a. Heart rate ≥60 bpm and ≤120 bpm

b. Respiratory rate ≥12 rpm and ≤24 rpm

c. Pulse oximetry ≥94% on room air

d. SBP ≥100 and <180 mmHg

Note: Isolated mild to moderate hypertension (i.e., SBP ≤180mmHg with no associated symptoms such as headache, neurological changes, chest pain or shortness of breath) in a patient with a history of hypertension is not a reason to exclude referral to a PUCC

4. Glasgow Coma Scale (GCS) Score of ≥14

5. If history of Diabetes Mellitus, no evidence of ketoacidosis and a blood glucose ≥60 mg/dL and <250 mg/dL

B. Exclusion Criteria – patients who meet the following conditions shall not be triaged to a PUCC, patient destination shall be in accordance with Ref. No. 502, Patient Destination or appropriate Specialty Care Center Patient Destination policy (i.e., Trauma Center, STEMI, Stroke):

1. Any emergent medical condition

2. Focal neurological deficit

3. Any injury that meet trauma center criteria or guideline

4. Complaint of chest pain, shortness of breath, abdominal/pelvic pain, or syncope

5. Open wounds or bleeding

6. Intoxication of drugs and/or alcohol

7. Suspected pregnancy

8. Requires special medical equipment

9. Intellectual or developmental disability

10. Exhibits dangerous behavior

11. Signs and symptoms of agitated delirium (Reference No. 1208, Agitated Delirium)

12. EMS personnel feels the patient is not stable enough for PUCC

IV. Paramedic Training Curriculum – the 8-hour paramedic educational session regarding the triage of patients to a PUCC shall include, at minimum, the following:

A. An overview of the curriculum, educational objectives, resources and operational structure

B. Impact of mental health crisis/emergency on local public health and emergency medical system resources

C. Overview of PUCC capabilities and resources

D. Review of mental health disorders

E. In-depth review of the Inclusion and Exclusion Criteria, and the Medical Clearance Criteria Screening Tool for PUCC

F. Legal and Ethics, include considerations for release at scene, refusal of treatment or transport (Against Medical Advice)

G. Interactions with other agencies (i.e., law enforcement, mental health professional)

H. Patient care documentation

I. Quality improvement process and sentinel event reporting

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 326, **Psychiatric Urgent Care Center (PUCC) Standards**
Ref. No. 326.1, **Designated Psychiatric Urgent Care Center Roster**
Ref. No. 502, **Patient Destination**
Ref. No. 526.1, **Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center**
Ref. No. 1200.3 **Provider Impressions**
Ref No. 1208 **Agitated Delirium**
Ref No. 1209 **Behavioral/Psychiatric Crisis**

Reference No. 526

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/15/2023	2/15/2023	Y
	Base Hospital Advisory Committee	2/8/2023	2/8/2023	N
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

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

REFERENCE NO. 526, Behavioral/Psychiatric Crisis Patient Destination

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Principles, 5	PAAC 2-15-23	Change language to make it more permissible for EMS to release patient to law enforcement to transport to PUCC	Change made
III. Psychiatric Urgent Care Clinic (PUCC) Patient Triage Criteria	PAAC 2-15-23	Include in the exclusion criteria the intoxicated patient	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC)

SUBJECT: **INTOXICATED (ALCOHOL) PATIENT DESTINATION** REFERENCE NO. 528

PURPOSE: To provide guidelines for the transport of patients with a primary provider impression of Alcohol Intoxication to the most appropriate facility that is staffed, equipped and prepare to administer medical care appropriate to the needs of the patient.

AUTHORITY: Health & Safety Code, Division 5, Sections 1797.220, 1798
California Code of Regulations, Title 22, Division 9, Chapter 5

DEFINITIONS:

Alcohol Intoxication: A patient who appears to be impaired from alcohol, demonstrated by diminished physical and mental control **with** evidence of recent alcohol consumption (e.g., alcohol on breath, presence of alcoholic beverage container(s)) and **without** other acute medical or traumatic cause. Alcohol intoxication is typically associated with one of more of the following:

- Speech disturbance – incoherent, rambling, slurring
- Decline in cognitive function – confusion, inappropriate behavior, impaired decision-making capacity
- Imbalance – unsteady on feet, staggering, swaying
- Poor coordination – impaired motor function, inability to walk a straight line, fumbling for objects

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, and oxygen saturation – except isolated asymptomatic hypertension) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification (Ref. No. 1200.2) are also considered to have an emergency medical condition.

Sobering Center (SC): A non-correctional facility designated by a city or county to provide a safe, supportive environment for intoxicated individuals to become sober. A SC shall be approved by the EMS Agency by meeting the requirements in this Standards.

PRINCIPLES:

1. EMS provider agencies must be approved by the Emergency Medical Services (EMS) Agency to triage patients with alcohol intoxication to a designated SC.

2. Paramedics who have completed an 8-hour education session regarding the triage of patients to a SC are the only EMS personnel authorize to utilize this policy.

3. Patients exhibit alcohol intoxication who meet SC inclusion criteria may also be released at scene to local law enforcement agency. Law enforcement officers are highly

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

encouraged to transport these patients to a designated SC. Paramedics shall document on the EMS Report Form to whom the patient was released.

4. In instances where there is potential for the patient to harm self or others, EMS personnel shall consider seeking assistance from law enforcement.

5. Any patient who meets the triage criteria for transport to a SC, but who requests to be transported to an emergency department of a general acute care hospital, shall be transported to the emergency department of a general acute care hospital.

6. In all cases, the health and well-being of the patient is the overriding consideration in determining patient destination. Factors to be considered include severity and stability of the patient's illness or injury; status of the receiving facility; anticipated transport time; requests by the patient, family, guardian or physician; and EMS personnel and base hospital judgment.

POLICY:

I. Responsibilities of the Paramedic

A. Complete an 8-hour educational session regarding the triage of patients to a designated SC.

B. Comply with all patient destination policies established by the EMS Agency.

II. EMS Provider Agency Requirements and Responsibilities

A. Submit a written request to the Director of the EMS Agency for approval to triage patients who meet SC Inclusion Criteria. The written request shall include the following:

1. Date of proposed implementation date

2. Scope of deployment (identify response units)

3. Course/Training Curriculum addressing all items in Section IV

4. Identify a representative to act as the liaison between the EMS Agency, designated SC(s), and the EMS Provider Agency

5. Policies and procedures listed in Section B

B. Develop, maintain and implement policies and procedures that address the following:

1. Completion of one Medical Clearance Criteria Screening Tool for each patient (see sample Ref. No. 528.1)

2. Pre-arrival notification of the SC

3. Patient report to a licensed health care provider or physician at the SC

4. Confirmation that SC has the capacity to accept the patient prior to transport

C. Develop a Quality Improvement Plan or Process to review variances and adverse events.

D. Comply with data reporting requirements established by the EMS Agency.

III. Sobering Center (SC) Patient Triage Criteria

A. Inclusion Criteria – patients who meet the following criteria may be triaged for transport to a designated SC provided the SC can be accessed within a fifteen (15) minute transport time:

1. Provider impression of alcohol intoxication (found on the street, a shelter or in police custody); and

a. Voluntarily consented or have implied consent to go to the SC; and

b. Cooperative and do not require restraints; and

c. Ambulatory, does not require the use of a wheelchair; and

d. NO emergent medical condition or trauma (with exception of ground level fall with injuries limited to minor abrasions below the clavicle); and

e. No focal neurological deficit

2. Age: ≥ 18 years old and ≤65 years old

3. Vital Signs

a. Heart rate ≥60 bpm and ≤120 bpm

b. Respiratory rate ≥12 rpm and ≤24 rpm

c. Pulse oximetry ≥94% on room air

d. SBP ≥100 and <180 mmHg

Note: Isolated mild to moderate hypertension (i.e., SBP ≤180mmHg with no associated symptoms such as headache, neurological changes, chest pain or shortness of breath) in a patient with a history of hypertension is not a reason to exclude referral to a SC

4. Best Glasgow Coma Scale (GCS) Score of ≥14.

Best GCS – upon initial assessment, an inebriated person may not have spontaneous eye opening without stimulation and may not be fully

oriented which = GCS of 13. Upon secondary assessment, if eyes remain open with minimal confusion, GCS is 14 and meets criteria.

5. If history of Diabetes Mellitus, no evidence of ketoacidosis and a blood glucose ≥60 mg/dL and <250 mg/dL

B. Exclusion Criteria – patients who meet the following conditions shall not be triaged to a SC, patient destination shall be in accordance with Ref. No. 502, Patient Destination or appropriate Specialty Care Center Patient Destination policy (i.e., Trauma Center, STEMI, Stroke):

1. Any emergent medical condition

2. Focal neurological deficit or change from baseline

3. Any injury that meet trauma center criteria or guideline

4. Complaint of chest pain, shortness of breath, abdominal/pelvic pain, or syncope

5. Bleeding including any hemoptysis or GI bleed

6. Suicidal ideations

7. On anticoagulants

8. Suspected pregnancy

9. Bruising or hematoma above the clavicles

10. Intellectual or developmental disability

11. EMS personnel feels the patient is not stable enough for SC

IV. Paramedic Training Curriculum – the 8-hour paramedic educational session regarding the triage of patients to a SC shall include, at minimum, the following:

A. An overview of the curriculum, educational objectives, resources and operational structure

B. Impact of alcohol intoxication on local public health and emergency medical system resources

C. Overview of SC capabilities and resources

D. Review of mental health disorders

E. In-depth review of the Inclusion and Exclusion Criteria, and the Medical Clearance Criteria Screening Tool for SC

F. Legal and Ethics, include considerations for release at scene, refusal of treatment or transport (Against Medical Advice)

G. Interactions with other agencies (i.e., law enforcement, mental health professional)

H. Patient care documentation

I. Quality improvement process and sentinel event reporting

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 328, **Sobering Center (SC) Standards**
Ref. No. 328.1, **Designated Sobering Center Roster**
Ref. No. 502, **Patient Destination**
Ref. No. 528.1, **Medical Clearance Criteria Screening Tool for Sobering Center**
Ref. No. 1200.3 **Provider Impressions**
Ref. No. 1241 **Overdose/Poisoning/Ingestion**

Reference No. 528

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/15/2023	2/15/2023	Y
	Base Hospital Advisory Committee	2/8/2023	2/8/2023	N
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

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

REFERENCE NO. 528, Intoxicated (Alcohol) Patient Destination

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
III. Sobering Center Patient (SC) Patient Triage Criteria	PAAC 2-15-23	Recommendation to include in the exclusion criteria that intoxicated patients with behavioral health, i.e., suicide, etc., be transported to a psychiatric facility not a sobering center.	Change not made Intoxicated patients with suicidal ideations (SI) are best treated in the emergency department not the psychiatric urgent care. However, suicidal ideations were added to the Sobering Center Exclusion Criteria to ensure intoxicated patients with SI are not transported to a sobering center. This will align with Ref No. 526. in which the intoxicated patient was added to the PUCC exclusion criteria

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

DRAFT

SUBJECT: **PREHOSPITAL CARE FORMS** (EMT, PARAMEDIC, MICN)
REFERENCE NO. 604

PURPOSE: To outline the appropriate process for procurement of prehospital care forms which includes: EMS Report Form, Advanced Life Support (ALS) Continuation Form, Base Hospital Form, Base Hospital Form Page 2, and Base Hospital Multiple Casualty Incident (MCI) Form.

PRINCIPLES:

1. Prehospital care forms are revised on a regular basis to reflect medical advances, integrate evidence-based medical practices and perform relevant EMS system analysis.

2. Sequence number duplication is costly and time consuming to correct. Every effort shall be made to ensure that duplication does not occur.

POLICY:

I. EMS Report Forms and Base Hospital Forms provided by the EMS Agency

A. Routine Distribution of Base Hospital Forms

1. The form vendor contracted by the EMS Agency distributes Base Hospital Forms every three months, based on projected base contact call volume.

2. The EMS Agency will:

a. Coordinate the form distribution with the form vendor to ensure base hospitals have a sufficient supply of forms available.

b. Maintain an inventory of forms distributed and reconcile monthly with the form vendor's records.

B. EMS Report Forms

1. The private EMS provider shall:

a. Utilize EMS Agency supplied EMS Report forms only for patient transports where base contact is made

b. Contact the EMS Agency's Data Systems Management Chief (or designee) to coordinate a date and time to pick-up EMS Report Forms at the EMS Agency at least one week prior to desired form pick-up date.

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

2. The public EMS provider shall maintain EMS Agency-supplied EMS Report forms on each apparatus, to be utilized only during electronic patient care record (ePCR) system failure.

3. The EMS Agency shall maintain an inventory of forms distributed and reconcile monthly with the form vendor's records.

C. Requests for ALS Continuation Forms, Base Hospital Page 2, and Base Hospital MCI Forms

1. The requesting party shall e-mail their request to the EMS Agency's Data System Management Chief for ALS Continuation forms, Base Hospital Page 2, or Base Hospital MCI forms as soon as the need becomes evident.

2. The EMS Agency will acknowledge the request and confirm pick up arrangements with the requesting party.

II. Base Hospital Forms **NOT** provided by the EMS Agency

A. Form Approval Procedure

1. The requesting base hospital shall submit a written request to the Director of the EMS Agency advising the EMS Agency of their desire to utilize their own form.

2. Submit a DRAFT form to the EMS Agency for approval prior to printing the forms. Each time a revision is made, the form shall be approved prior to printing.

3. Forms must have all of the appropriate copies for distribution and contain all current data elements.

B. Form Printing Procedure

1. Print no more than a 6-month supply of forms as data elements may change.

III. Fees

A. There is no charge to utilize EMS Agency-supplied EMS Report Forms or Base Hospital Forms.

B. Base hospitals utilizing their own forms are responsible for all costs incurred by such processes.

CROSS REFERENCES:

Prehospital Care Manual
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 608, **Retention and Disposition of Prehospital Patient Care Records**

Reference No. 604, Ordering of Forms

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/19/22	10/19/22	No
	Base Hospital Advisory Committee	12/7/22- Tabled 2/8/23	2/8/23	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)

4.1 BUSINESS (OLD)

Suspected Excited-Agitated Delirium

Integrated Medical Intervention Plan

Four Phases of ExD

- High body temperature
- Delirium with agitation
- Respiratory arrest
- Cardiac arrest

PHYSICAL CHARACTERISTICS

- Dilated pupils
- Profuse sweating/high body temperature
- Skin discoloration (e.g., flushing)
- Uncontrollable shaking, shivering (e.g., substance withdrawal)
- Respiratory distress (difficulty in breathing)

BEHAVIORAL CUES

Physical Behaviors

- Demonstrates violent or bizarre behavior
- Demonstrates aggression toward inanimate objects (e.g., glass, shiny objects, etc.)
- Running into traffic
- Naked or stripping off clothing (to cool down)
- Says "I can't breathe" (indicative of respiratory distress, escalating into respiratory arrest spiral/exhaustive mania)
- Apparent superhuman strength
- Seemingly unlimited endurance
- Resists violently
- Muscle rigidity
- Diminished sense of pain
- Self-induced injuries

Psychological Behaviors

- Demonstrates intense paranoia
- Demonstrates extreme agitation
- Rapid emotional changes (e.g., laughing, crying, sadness, anger, panic, etc.)
- Disoriented about place, time, purpose
- Disoriented about self (visions of grandeur)
- Hallucinations
- Scattered ideas about things
- Easily distracted
- Psychotic in appearance
- Described as "just snapped" or "flipped out"

Communication Behaviors

- Screaming for no apparent reason
- Pressured, loud, incoherent speech
- Grunting; guttural sounds
- Talks to invisible people
- Irrational speech

These behavioral cues only help identify the person as an elevated-risk candidate for a sudden death, but are not a clinical diagnosis.

Suspected Excited-Agitated Delirium

Integrated Medical Intervention Plan

WHO IS AT RISK?

- 91% - 99% male
- 31-45 years of age (generally)
- Person usually involved in a struggle
- Death usually follows bizarre behavior episode, and/or use of illegal drugs or prescription medications.

GOAL

The primary goal of a coordinated police and fire response is to protect agitated, combative, or violent individuals from injuring themselves, protecting the community, and City of Long Beach first responders from injury.

ACTION STEPS

Dispatcher

- Identify possible behavioral cues and related information from caller.
- Dispatch officers, EMS, supervisor.
- Assist first responders with establishing a rally point.
- Log call activity to begin documentation.

First Responders

- While unit is enroute, confirm the designated rally point.
- Identify immediate safety concerns.
- Develop a coordinated plan for the safe restraint and medical treatment of the individual.
- Respond together to the incident location from the rally point.

- **Police** - Restrain the person as quickly as possible, make an effort to minimize stress and injury to the individual (e.g., team takedown, taser). Do not permit the person to remain in the prone position (roll onto the side, or sit upright, if safe and reasonable).

- **Fire** - Quickly approach the restrained person and provide medical aid. Consider chemical sedation to reduce the person's stress and exertions, if consistent with treatment protocol. Transport the person to the hospital and ask PD to assist, if needed.

Remember to be proactive.
It's better to request the resource and not need it, than need it and not have it.

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL

Time Period October 1, 2022 through December 31, 2022

APOT Standard: within 30 minutes, 90% of the time

HOSPITAL	Total # of records	No. of valid records	% of valid records	Q4 2022								% of Time on Diversion*
				</=30 mins		30-60 mins		61-120 mins		>120 mins		
ANTELOPE VALLEY - NEWHALL REGION												
Antelope Valley Hospital	4,107	1,980	48%	1,072	54%	590	30%	214	11%	104	5%	25%
Palmdale Regional Medical Center	2,775	1,309	47%	757	58%	330	25%	160	12%	62	5%	7%
Henry Mayo Newhall Hospital	3,651	1,739	48%	1,180	68%	436	25%	112	6%	11	0.6%	18%
ANTELOPE VALLEY TOTAL	*10,533*	*5,028*	*48%*	*3,009*	*60%*	*1,356*	*27%*	*486*	*10%*	*177*	*4%*	17% AVG
SAN FERNANDO VALLEY REGION												
Dignity Health-Northridge Hospital Medical Center	2,883	2,877	100%	2,322	81%	424	15%	122	4%	9	0.3%	39%
West Hills Hospital and Medical Center	1,644	1,504	91%	901	60%	402	27%	172	11%	29	2%	32%
Kaiser Foundation - Woodland Hills	555	514	93%	395	77%	66	13%	42	8%	11	2%	61%
Encino Hospital Medical Center	546	545	100%	492	90%	36	7%	15	3%	2	0.4%	12%
Providence Cedars-Sinai Tarzana Medical Center	1,416	1,393	98%	1,097	79%	230	17%	61	4%	5	0.4%	27%
LAC Olive Medical Center	651	643	99%	532	83%	78	12%	27	4%	6	0.9%	74%
Pacifica Hospital of the Valley	680	680	100%	609	90%	42	6%	22	3%	7	1%	33%
Kaiser Foundation - Panorama City	708	706	100%	584	83%	105	15%	16	2%	1	0.1%	44%
Providence Holy Cross Medical Center	1,771	1,750	99%	1,621	93%	94	5%	30	2%	5	0.3%	52%
Mission Community Hospital	950	950	100%	828	87%	106	11%	14	1%	2	0.2%	27%
Valley Presbyterian Hospital	1,484	1,484	100%	1,311	88%	125	8%	40	3%	8	0.5%	46%
Sherman Oaks Hospital	1,460	1,460	100%	1,237	85%	156	11%	62	4%	5	0.3%	21%
Providence Saint Joseph Medical Center	3,344	3,284	98%	2,475	75%	656	20%	148	5%	5	0.2%	16%
Adventist Health Glendale	1,883	1,840	98%	1,227	67%	410	22%	175	10%	28	2%	44%
Dignity Health-Glendale Memorial Hosp. and Health Ct	1,616	1,614	100%	1,318	82%	205	13%	83	5%	8	0.5%	29%
USC Verdugo Hills Medical Center	736	571	78%	375	66%	130	23%	52	9%	14	2%	66%
SAN FERNANDO VALLEY TOTAL	*22,327*	*21,815*	98%	*17,324*	*79%*	*3,265*	*15%*	*1,081*	*5%*	*145*	*0.7%*	39% AVG
SAN GABRIEL VALLEY REGION												
Huntington Hospital	3,053	2,569	84%	2,001	78%	348	14%	171	7%	49	2%	64%
Alhambra Hospital	976	974	100%	880	90%	75	8%	18	2%	1	0.1%	33%
San Gabriel Valley Medical Center	1,067	747	70%	503	67%	124	17%	74	10%	46	6%	45%
USC Arcadia Hospital	2,525	1,552	61%	819	53%	402	26%	231	15%	100	6%	78%
Greater El Monte Community Hospital	1,750	773	44%	396	51%	217	28%	119	15%	41	5%	51%

% total may not equal 100% due to rounding.

* Includes ED ALS and Provider ALS

Data source: LA TEMIS EMS Fire-Rescue 01-23-2023

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL

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Garfield Medical Center	866	697	80%	611	88%	46	7%	24	3%	16	2%	45%
Monterey Park Hospital	458	383	84%	344	90%	25	7%	12	3%	2	0.5%	19%
Kaiser Foundation Hospital - Baldwin Park	1,569	691	44%	241	35%	225	33%	159	23%	66	10%	74%
Emanate Health Inter-Community Hospital	1,526	782	51%	368	47%	214	27%	145	19%	55	7%	24%
Emanate Health Queen of the Valley Hospital	2,519	1,392	55%	820	59%	299	21%	194	14%	79	6%	21%
Emanate Health Foothill Presbyterian Hospital	1,933	884	46%	287	32%	327	37%	189	21%	81	9%	21%
San Dimas Community Hospital	778	392	50%	221	56%	86	22%	47	12%	68	17%	13%
Pomona Valley Hospital Medical Center	5,342	2,713	51%	1,318	49%	843	31%	442	16%	110	4%	19%
SAN GABRIEL VALLEY TOTAL	*24,362*	*14,549*	60%	*8,809*	*61%*	*3,231*	*22%*	*1,825*	*13%*	*714*	*5%*	31% AVG
EAST REGION												
Beverly Hospital	1,350	644	48%	390	61%	158	25%	76	12%	20	3%	34%
Whittier Hospital Medical Center	1,123	538	48%	325	60%	132	25%	57	11%	24	4%	11.0%
PIH Health Whittier Hospital	4,010	1,727	43%	663	38%	775	45%	258	15%	31	2%	33%
PIH Health Downey Hospital	2,009	1,406	70%	886	63%	309	22%	156	11%	55	4%	44%
Kaiser Foundation Hospital - Downey	2,077	1,199	58%	467	39%	305	25%	265	22%	162	14%	77%
Los Angeles Community Hospital at Norwalk	425	201	47%	97	48%	56	28%	31	15%	17	8%	9%
Coast Plaza Hospital	913	444	49%	159	36%	109	25%	103	23%	73	16%	19%
Lakewood Regional Medical Center	1,947	1,168	60%	401	34%	268	23%	269	23%	230	20%	53%
EAST REGION TOTAL	*13,854*	*7,327*	53%	*3,388*	*46%*	*2,112*	*29%*	*1,215*	*17%*	*612*	*8%*	35% AVG
METRO REGION												
Dignity Health-California Hospital Medical Center	1,331	1,330	100%	910	68%	232	17%	140	11%	48	4%	68%
PIH Health Good Samaritan Hospital	2,145	2,142	100%	1,673	78%	367	17%	90	4%	12	0.6%	58%
Adventist Health White Memorial	1,026	810	79%	620	77%	122	15%	55	7%	13	2%	1%
Community Hospital of Huntington Park	2,056	1,100	54%	384	35%	340	31%	262	24%	114	10%	5%
East Los Angeles Doctors Hospital	1,524	824	54%	507	62%	185	22%	104	13%	28	3%	1%
LAC+USC Medical Center	4,573	4,389	96%	3,531	80%	608	14%	220	5%	30	0.7%	57%
Children's Hospital Los Angeles	260	257	99%	254	99%	1	0.4%	2	0.8%			37%
Hollywood Presbyterian Medical Center	1,921	1,904	99%	1,483	78%	317	17%	99	5%	5	0.3%	15%
Kaiser Foundation Hospital - Los Angeles	812	785	97%	590	75%	145	18%	47	6%	3	0.4%	57%

% total may not equal 100% due to rounding.

* Includes ED ALS and Provider ALS

Data source: LA TEMIS EMS Fire-Rescue 01-23-2023

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL

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				</=30 mins		30-60 mins		61-120 mins		>120 mins		
Cedars Sinai Medical Center	3,316	2,926	88%	1,361	47%	803	27%	378	13%	193	7%	45%
METRO REGION TOTAL	*18,964*	*16,467*	87%	*11,313*	*69%*	*3,120*	*19%*	*1,397*	*8%*	*446*	*3%*	34% AVG
WEST REGION												
Southern California Hospital at Culver City	944	940	100%	595	63%	234	25%	90	10%	21	2%	28%
Kaiser Foundation Hospital - West Los Angeles	1,463	1,360	93%	803	59%	353	26%	162	12%	42	3%	55%
Cedars Sinai Marina Del Rey Hospital	1,592	1,346	85%	954	71%	299	22%	88	7%	5	0.4%	37%
Providence Saint John's Health Center	1,910	1,617	85%	1,213	75%	262	16%	111	7%	31	2%	23%
Santa Monica - UCLA Medical Center	642	494	77%	382	77%	68	14%	31	6%	13	3%	47%
Ronald Reagan UCLA Medical Center	1,571	1,494	95%	1,277	85%	158	11%	45	3%	14	0.9%	65%
WEST REGION TOTAL	*8,122*	*7,251*	89%	*5,224*	*72%*	*1,374*	*19%*	*527*	*7%*	*126*	*2%*	43% AVG
SOUTH REGION												
Centinela Hospital Medical Center	3,971	2,866	72%	1,384	48%	826	29%	411	14%	245	9%	11%
Memorial Hospital of Gardena	2,505	2,004	80%	1,418	71%	381	19%	151	8%	54	3%	19%
Martin Luther King, Jr. Community Hospital	2,392	1,727	72%	1,161	67%	409	24%	132	8%	25	1%	27%
St. Francis Medical Center!	3,097	1,953	63%	851	44%	395	20%	380	19%	327	17%	30%
LAC Harbor-UCLA Medical Center	2,768	2,007	73%	1,503	75%	276	14%	158	8%	70	3%	50%
Kaiser Foundation Hospital - South Bay	1,258	909	72%	569	63%	221	24%	98	11%	21	2%	46%
Torrance Memorial Medical Center	2,904	1,898	65%	992	52%	609	32%	265	14%	32	2%	23%
Providence Little Company of Mary Med. Ctr.-Torrance	1,994	1,474	74%	1,092	74%	259	18%	98	7%	25	2%	19%
Providence Little Company of Mary Med. Ctr.-San Pedr	1,813	1,301	72%	891	68%	299	23%	91	7%	20	2%	25%
College Medical Center	1,039	1,008	97%	767	76%	145	14%	61	6%	35	3%	53%
Dignity Health-St. Mary Medical Center	2,218	2,207	100%	1,455	66%	455	21%	233	11%	64	3%	57%
MemorialCare Long Beach Medical Center	2,473	2,188	88%	1,584	72%	291	13%	158	7%	155	7%	79%
Catalina Island Medical Center	67	66	99%	66	100%							N/A
SOUTH REGION TOTAL	*28,499*	*21,608*	76%	*13,733*	*64%*	*4,566*	*21%*	*2,236*	*10%*	*1,073*	*5%*	36% AVG
ALL HOSPITALS	**126,661**	**86,794**	**69%**	**62,800**	**72%**	**19,024**	**22%**	**8,767**	**10%**	**3,293**	**4%**	33% AVG

% total may not equal 100% due to rounding.

* Includes ED ALS and Provider ALS

Data source: LA TEMIS EMS Fire-Rescue 01-23-2023

Los Angeles County Emergency Medical Services Agency

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					</=30 mins		30-60 mins		61-120 mins		>120 mins	
Alhambra Fire Department	AH	944	944	100%	884	94%	42	4%	17	2%	1	0.1%
Arcadia Fire Department	AF	628	627	100%	495	79%	105	17%	22	4%	5	0.8%
Beverly Hills Fire Department	BH	527	527	100%	355	67%	137	26%	32	6%	3	0.6%
Burbank Fire Department	BF	1,202	1,202	100%	958	80%	199	17%	42	3%	3	0.2%
Compton Fire Department*	CM	404	394	98%	387	98%	6	2%	1	0.3%		
Culver City Fire Department	CC	617	617	100%	418	68%	143	23%	49	8%	7	1%
Downey Fire Department	DF	1,362	1,362	100%	998	73%	228	17%	98	7%	38	2.8%
El Segundo Fire Department	ES	222	222	100%	182	82%	28	13%	12	5%		
Glendale Fire Department	GL	2,620	2,620	100%	1,949	74%	466	18%	178	7%	27	1%
Los Angeles Fire Department	CI	43,106	43,097	100%	33,506	78%	6,834	16%	2,320	5%	437	1%
Los Angeles County Fire Department*	CF	54,129	26,009	48%	11,792	45%	6,834	26%	2,320	9%	437	2%
Los Angeles County Sherriff's Department	CS	32	31	97%	31	100%						
La Habra Heights Fire Department	LH	36	36	100%	36	100%						
La Verne Fire Department	LV	549	548	100%	474	86%	53	10%	18	3%	3	0.5%
Long Beach Fire Department	LB	6,257	6,252	100%	4,397	70%	1,054	17%	519	8%	282	5%
Manhattan Beach Fire Department	MB	364	364	100%	352	97%	10	3%	2	0.5%		
Monrovia Fire Department*	MF	86	78	91%	68	87%	7	9%	2	3%	1	1%
Montebello Fire Department	MO	122	114	93%	110	96%	2	2%	2	2%		
Monterey Park Fire Department	MP	699	699	100%	676	97%	15	2%	5	0.7%	3	0.4%
Pasadena Fire Department	PF	2,017	2,017	100%	1,652	82%	249	12%	103	5%	13	0.6%
Redondo Beach Fire Department*	RB	428	193	45%	81	42%	79	41%	26	13%	7	4%
San Gabriel Fire Department	SG	390	390	100%	357	92%	22	6%	8	2%	3	0.8%
San Marino Fire Department	SA	127	127	100%	100	79%	16	13%	10	8%	1	0.8%
Santa Monica Fire Department*	SM	1,059	700	66%	678	97%	16	2%	6	0.9%		
Sierra Madre Fire Department	SI	146	146	100%	114	78%	26	18%	6	4%		
South Pasadena Fire Department	SP	217	216	100%	184	85%	23	11%	8	4%	1	0.5%
Torrance Fire Department	TF	1,878	1,572	84%	1,032	66%	358	23%	151	10%	31	2%
West Covina Fire Department	WC	799	799	100%	683	85%	84	11%	29	4%	3	0.4%
*Data is not utilized to calculate unless no associated *transport* unit. APOT times are calculated utilizing *transporting* ambulance times.												
American Medical Response	AR	11,597	4,967	43%	2,464	50%	1,635	33%	617	12%	251	5%

% total may not equal 100% due to rounding.

Data source: LA TEMIS EMS Fire-Rescue 01-30-2023

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY PROVIDER

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					</=30 mins		30-60 mins		61-120 mins		>120 mins	
CARE Ambulance Service (Faulk)	CA	35,987	15,535	43%	5,368	35%	5,404	35%	3,327	21%	1,436	9%
McCormick Ambulance Service	WM	13,992	6,196	44%	1,733	28%	2,571	41%	1,339	22%	553	9%
TOTAL ALL PROVIDERS		*68,637*	*32,858*	48%	*14,446*	*44%*	*10,483*	*32%*	*5,630*	*17%*	*2,299*	*7%*

% total may not equal 100% due to rounding.

Data source: LA TEMIS EMS Fire-Rescue 01-30-2023

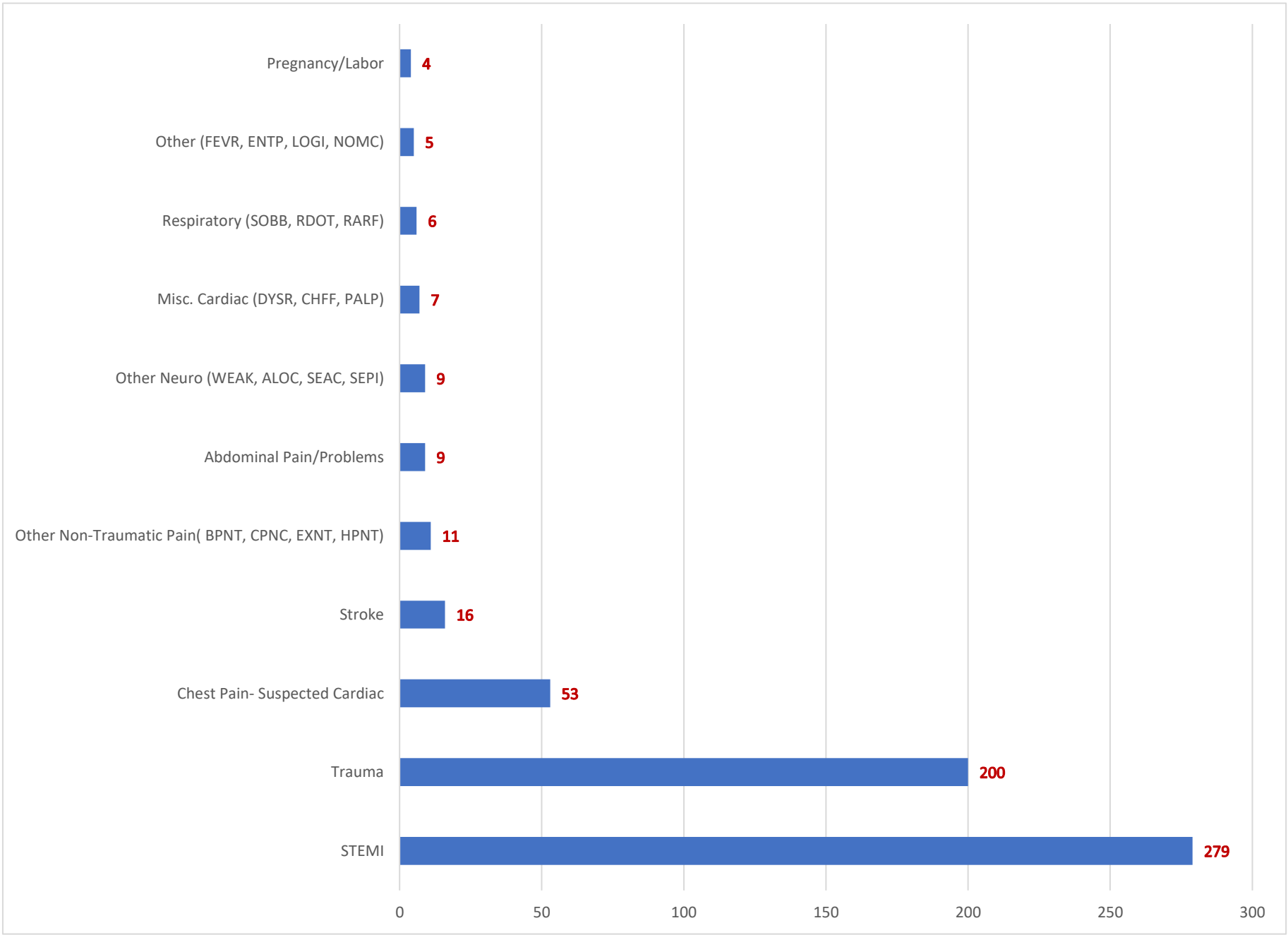
EMERGENCY MEDICAL SERVICES COMMISSION (EMSC)

SUGGESTED GOALS/OBJECTIVES FOR 2023

GOAL/OBJECTIVE	PRIORITY (YES/NO)	IF PRIORITY WHO ASSIGNED	POTENTIAL ACTIONS
Work on processes/policies to address and reduce Ambulance Patient Offload Delays (APOD)	Yes	EMSC Ambulance Patient Offload Times (APOT) Workgroup	1. Implementation and rollout of FirstWatch real-time data on ambulances waiting to offload *(Completed)* 2. Develop separate policy addressing APOT and APOD *(Completed)* 3. Socialize the CHA APOT Toolkit *(Completed)* 4. Identify best practices of hospitals 5. Monitor implementation of Ref. No. 505.
Continue working on the recommendations from the *Ad Hoc Committee on the Prehospital Care of Mental Health and Substance Abuse Emergencies* specifically address Suicide Risk Protocols	Yes	EMS Agency Santa Monica Fire Dept.	1. Suicide Screening Tool pilot with Santa Monica Fire Department *(Pilot Implemented, awaiting 6-month report)* 2. Alternate Destination 3. Long Beach Update 4. EMS Update – Behavioral training, implement Olanzapine
Evaluate the Alameda EMS Corps program that focuses on increasing the number of underrepresented emergency medical health care professions through youth development, mentorship, job			1. Determine funding (Measure A) https://ems.acgov.org/ems-assets/docs/Cmmty-Svcs/EMS-Corps/fenton-alameda_county_health_dept-

GOAL/OBJECTIVE	PRIORITY (YES/NO)	IF PRIORITY WHO ASSIGNED	POTENTIAL ACTIONS
training and sponsorship and determine its applicability to Los Angeles County			ems_corps_brochure-parallel-fold_v06.pdf 2. Consider State Presentation for LA EMSC WERC *(Completed)* 3. Convened Workgroup 1/18/2023 – Awaiting response from Alameda program director
Interfacility Transport Delays (requested for inclusion at Jan 2023 meeting). Need further discussion by EMSC			

9-1-1 INTERFACILITY TRANSPORTS FROM HOSPITALS
January 1 through December 31, 2022



Data obtained from LA-EMS on 2-23-2023

Frequently Asked Questions

Returning to In-Person Meetings

1. WHEN DO BOARD-CREATED BODIES RETURN TO IN-PERSON MEETINGS?

- The Governor announced the COVID-19 State of Emergency, will end on February 28, 2023, thereby withdrawing the exceptions to the teleconference requirements under AB 361.
- In-person meetings will begin on March 1, 2023.

2. WHAT ARE COMMISSIONERS' OPTIONS FOR ATTENDING MEETINGS VIA TELECONFERENCE/ VIRTUALLY?

- AB 2449 – Became effective on January 1, 2023. Provisions of this bill permit members of a legislative body of a local agency to participate remotely and to not identify their location under certain narrow conditions including:
  - At least a quorum of members is present **in person** from a singular public location and the member who seeks to participate remotely must announce if any person over 18 years old is present.
  - The legislative body provides two-way audio-visual platform or two-way telephonic services with live webcasting of meeting; and
  - The agenda notifies the public of the ways to access the meeting and offer public comment via a call-in or internet-based service option, and **in person.**
  - Commissioners who seek to meet without identifying each teleconference location in the notice and agenda of the meeting, and without making each teleconference location accessible to the public must have **"just cause" or "emergency circumstances"** justifying the remote appearance (refer to bill for details).
  - A member may not participate remotely for "just cause" for more than two meetings per year and may not participate remotely for any reason for more than three consecutive months or 20% of meetings per year. Each Commission will need to track and monitor commissioners' use of this provision to ensure compliance with the law.
  - Commission staff or commission liaisons should also work closely with their County Counsel to discuss the circumstances specific to their commission to assist with applying the provisions of AB 2449.

- **TRADITIONAL BROWN ACT**
  - At least a quorum of the membership of the legislative body must participate from locations within the legislative body's jurisdiction.
  - An agenda must be posted at each teleconference location.
  - The address of each teleconference location must be listed in the notice and agenda, including a room number, if applicable.
  - Each teleconference location must be fully accessible to the public.
  - Each teleconference location must be ADA-compliant.
  - All votes taken must be conducted by roll call.

- **ALTERNATE MEETING LOCATIONS**
  - In partnership with the Los Angeles County Library, the Executive Office of the Board of Supervisors has identified library locations throughout the County (subject to availability) that may be used as alternate meeting locations, with access to hybrid meeting equipment.
  - Commission staff can reserve a conference room for a commissioner to participate remotely in a Commission meeting; however, at least a quorum of members must be present in person at the primary meeting location.
  - These library locations are offered as an alternative option and convenience for Commissioners that aligns with the traditional teleconferencing options under the Brown Act.
  - Meeting locations would be posted on the agenda and members of the public would also be permitted to attend the meeting from that location.
  - Commission staff can access the QR Code for locations and protocols.

3. WILL COMMISSIONERS WHO HAVE NOT SHOWN PROOF OF VACCINATION BE REQUIRED TO PROVIDE A NEGATIVE ANTIGEN OR PCR TEST PRIOR TO RETURNING TO AN IN-PERSON MEETING?

- Based on current guidance, screening and testing is no longer required in most community settings; therefore, at this time commissioners who have not provided proof of vaccination will not be required to provide a negative Antigen or PCR test prior to retuning to in-person meetings.

4. WHAT ARE THE STANDARD PROTOCOLS FOR SAFELY MEETING IN PERSON?

- As COVID-19 numbers periodically change, it is always a good practice to follow the guidelines provided by the Department of Public Health to ensure standard protocols are followed for meeting safely.

- In the link provided below, there is information on masks, hand hygiene, cleansing, and social distance that you may consider as you build your safety protocols for in-person meetings.

For additional information visit LAC | DPH |Best Practice Guidance for Businesses to Prevent COVID-19 (lacounty.gov)

5. ARE COMMISSIONS REQUIRED TO OPEN THEIR MEETINGS WITH THE LAND ACKNOWLEDGEMENT?

- On November 1, 2022, the Board of Supervisors adopted a Countywide Land Acknowledgment and has opened its meetings verbally announcing and displaying visually the Land Acknowledgment.

- The Board motion does not require Commissions to begin each meeting with the Land Acknowledgment.

- Should your Commission choose to begin each meeting with the Land Acknowledgement, an initial item should be placed on the agenda for approval by the commission. Below is a sample agenda item:

Recommendation: Adopt the Board of Supervisors Countywide Land Acknowledgment approved on November 1, 2022; and instruct staff to open all meetings with the following Land Acknowledgement, to be verbally announced and displayed visually:

> "*The County of Los Angeles recognizes that we occupy land originally and still inhabited and cared for by the Tongva, Tataviam, Serrano, Kizh, and Chumash Peoples. We honor and pay respect to their elders and descendants -- past, present, and emerging -- as they continue their stewardship of these lands and waters. We acknowledge that settler colonization resulted in land seizure, disease, subjugation, slavery, relocation, broken promises, genocide, and multigenerational trauma. This acknowledgment demonstrates our responsibility and commitment to truth, healing, and reconciliation and to elevating the stories, culture, and community of the original inhabitants of Los Angeles County. We are grateful to have the opportunity to live and work on these ancestral lands. We are dedicated to growing and sustaining relationships with Native peoples and local tribal governments, including (in no particular order) the: Fernandeño Tataviam Band of Mission Indians, Gabrielino Tongva Indians of California Tribal Council, Gabrieleno/Tongva San Gabriel Band of Mission Indians, Gabrieleño Band of Mission Indians - Kizh Nation, San Manuel Band of Mission Indians, San Fernando Band of Mission Indians. To learn more about the First Peoples of Los Angeles County, please visit the Los Angeles City/County Native American Indian Commission website at* Los Angeles City/County Native American Indian Commission – government organization (lacounty.gov).

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

Hilda L. Solis
First District

Holly J. Mitchell
Second District

Lindsey P. Horvath
Third District

Janice K. Hahn
Fourth District

Kathryn Barger
Fifth District

Richard Tadeo
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

January 12, 2023

Fabiola Huerta, City Manager
La Habra Heights Fire Department
1245 North Hacienda Boulevard
La Habra Heights, CA 90631

Dear Ms. Huerta

EMT LOCAL OPTIONAL SCOPE PROGRAM APPROVAL

This letter is to confirm La Habra Heights Fire Department (LH) was approved for training in May 2022 and implementation by the Los Angeles County Emergency Medical Services (EMS) Agency for the following EMT local optional scope of practice skills:

- Naloxone intranasal for suspected opiate overdose
- Epinephrine auto-injector for suspected anaphylaxis
- Perform finger stick glucose testing for suspected hypoglycemia

The quality improvement process required for implementation of the EMT skills will be reviewed as deemed necessary by the EMS Agency. Submission of the training rosters to the EMS Agency is required for purposes of record keeping for the optional scope program.

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

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:gk
01-09

c: Director, EMS Agency
Gary Watson, Prehospital Operations, EMS Agency
Kathryn Ward, Nurse Educator La Habra Heights Fire Department
Dr. Richard Guess, Medical Director, La Habra Heights Fire Department

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

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

January 17, 2023

Xavier Espino, Fire Chief
Long Beach Fire Department
3205 North Lakewood Boulevard
Long Beach, California 90808

Dear Chief Espino:

LUCAS® APPROVAL

This is to confirm that Long Beach Fire Department (LB) has been approved by the Los Angeles County Emergency Medical Services (EMS) Agency for the utilization of the cardiopulmonary assist device, LUCAS® as local optional scope of practice for patients in non-traumatic cardiopulmonary arrest.

The quality improvement process and data collection required for LUCAS® approval will be reviewed during your annual program review or as deemed necessary by the EMS Agency. LB may be required to submit data to the EMS Agency on LUCAS® placement and utilization for purposes of systemwide aggregate reporting.

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

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:gk
01-14

c: Director, EMS Agency
EMS Agency Prehospital Program Coordinator, Gary Watson
Medical Director, Long Beach Fire Department
EMS Director, Long Beach Fire Department
Andy Reno, Nurse Educator, Long Beach Fire Department
Don Gerety, Educator Long Beach Fire Department

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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Santa Fe Springs, CA 90670

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

January 17, 2023

Steven Wallace, Fire Chief
San Gabriel Fire Department
1303 South Del Mar Avenue
San Gabriel, California 91776

Dear Chief Wallace:

LUCAS® APPROVAL

This is to confirm that San Gabriel Fire Department (SG) has been approved by the Los Angeles County Emergency Medical Services (EMS) Agency for the utilization of the cardiopulmonary assist device, LUCAS® as local optional scope of practice for patients in non-traumatic cardiopulmonary arrest.

The quality improvement process and data collection required for LUCAS® approval will be reviewed during your annual program review or as deemed necessary by the EMS Agency. SG may be required to submit data to the EMS Agency on LUCAS® placement and utilization for purposes of systemwide aggregate reporting.

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

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:gk
01-13

c: Director, EMS Agency
EMS Agency Prehospital Program Coordinator, Gary Watson
Medical Director, San Gabriel Fire Department
EMS Director, San Gabriel Fire Department
Johnna Corbett, Nurse Educator, San Gabriel Fire Department

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

January 31, 2023

VIA EMAIL

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."

TO: Distribution

FROM: Richard Tadeo
Director

TERMINATION OF AMBULNZ HEALTH, LLC AMBULANCE OPERATIONS

This is to inform you that on January 30, 2023, the Los Angeles County Emergency Medical Services (EMS) Agency received notification that Ambulnz Health, LLC (AZ) is terminating all ambulance transportation operations in Los Angeles County, effective today, **Tuesday, January 31, 2023 at 11:59 p.m.**

Ambulance transportation services, which include, Basic Life Support (EMT), Advanced Life Support (Paramedic), and Specialty Care Transport (Critical Care Transport – Registered Nurse and/or Respiratory Therapist) will no longer be provided by AZ after the above referenced date/time.

If you need ambulance services, please refer to Prehospital Care Policy Reference No. 401.1, Licensed Ambulance and Aircraft Operators for a list of current Los Angeles County licensed ambulance providers (attached).

If you have any questions, please contact David Wells, Chief of Prehospital Operations, at dwells@dhs.lacounty.gov.

RT:ps

Distribution: CEO, 9-1-1 Receiving Hospitals
ED Director, 9-1-1 Receiving Hospitals
ED Medical Director, 9-1-1 Receiving Hospitals
Fire Chief, Each Public Provider Agency
Medical Director, Each Public Provider Agency
CEO, Each Private Ambulance Company
Operations Manager, Each Private Ambulance Company
CEO, Each Skilled Nursing Facility
CEO, Each Dialysis Center
CEO, Each Convalescent Care Facility

c. EMS Commission
Hospital Association of Southern California

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

February 7, 2023

TO: Fire Chiefs, Each Public Provider Agency
CEO, Each Private Provider Agency

FROM: Richard Tadeo
EMS Agency Director

SUBJECT: JOINT STATEMENT ON LIGHTS & SIREN VEHICLE OPERATIONS ON EMERGENCY MEDICAL SERVICES (EMS) RESPONSES

The Emergency Medical Services (EMS) Commission recommended at its January 18, 2023 meeting, that the EMS Agency provide to all Los Angeles County EMS provider agencies the national position paper on the utilization of lights and sirens during emergency response and transport.

The EMS Agency is requesting EMS provider agencies to take these into consideration when developing operational policies while considering local traffic patterns.

If you have any questions, please do not hesitate to contact me.

RT:rt

Attachment

c. EMS Commission

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

February 14, 2022

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

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

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

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

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

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

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

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

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

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

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

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

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

Sponsoring Organizations and Representatives:

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

References:

1. Use of warning lights and siren in emergency medical vehicle response and patient transport. *Prehosp and Disaster Med*. 1994;9(2):133-136.
2. Grant CC, Merrifield B. Analysis of ambulance crash data. The Fire Protection Research Foundation. 2011. Quincy, MA.
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4. Ray AF, Kupas DF. Comparison of crashes involving ambulances with those of similar-sized vehicles. *Prehosp Emerg Care*. 2005;9(4):412-415.
5. U.S. Fire Administration. Firefighter fatalities in the United States in 2013. 2014. Emmitsburg, MD.
6. Maguire BJ. Transportation-related injuries and fatalities among emergency medical technicians and paramedics. *Prehosp Disaster Med*. 2011;26(5): 346-352.
7. Maguire BJ, Hunting KL, Smith GS, Levick NR. Occupational fatalities in emergency medical services: A hidden crisis. *Ann Emerg Med*, 2002;40: 625-632.
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10. Kupas DF. Lights and siren use by emergency medical services: Above all, do no harm. National Highway Traffic Safety Administration. 2017. Available online at https://www.ems.gov/pdf/Lights_and_Sirens_Use_by_EMS_May_2017.pdf
11. Watanabe BL, Patterson GS, Kempema JM, Magailanes O, Brown LH. Is use of warning lights and sirens associated with increased risk of ambulance crashes? A contemporary analysis using national EMS information system (NEMSIS) data. *Ann Emerg Med*. 2019;74(1):101-109.
12. Jarvis JL, Hamilton V, Taigman M, Brown LH. Using red lights and sirens for emergency ambulance response: How often are potentially life-saving interventions performed? *Prehosp Emerg Care*. 2021; 25(4): 549-555.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Richard Tadeo
Director

Marianne Gausche-Hill, MD
Medical Director

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

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

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

February 14, 2023

TO: Distribution

FROM: Richard Tadeo
Director, EMS Agency

SUBJECT: **INAPPROPRIATE UTILIZATION OF 9-1-1 FOR INTERFACILITY PATIENT TRANSFERS**

It has come to the attention of the EMS Agency that 9-1-1 is being utilized inappropriately by hospitals for interfacility patient transfers (IFT). Utilization of 9-1-1 for IFTs is only appropriate for patients in the emergency department who meet criteria for Trauma Re-Triage, Ref. No. 506.2, and ST-Elevation Myocardial Infarction (STEMI), Ref. No. 513.1.

Patients in need of higher level of care transfer outside of Ref. No. 506.2 or Ref. No. 513.1 shall be transported through established agreements with ambulance providers. Every effort shall be made to ensure that appropriate transfer arrangements between the sending and receiving facilities comply with EMTALA and Title 22 patient transfer requirements, which include an accepting physician and utilization of appropriate type and level of transport.

The use of 9-1-1 resources and personnel for interfacility transfer of patients who do not meet Trauma Re-Triage or STEMI criteria take emergency responders out of service for extended periods of time and away from their primary responsibility of serving their community for potentially life-threatening emergencies. Private Advanced Life Support (ALS) ambulance providers or private Critical Care Transport (CCT) providers should always be contacted for patient transfers that do not need emergent trauma or STEMI care.

Repeated violations for inappropriate use of 9-1-1 will result in a programmatic review of your policies and procedures as a 9-1-1 receiving hospital and/or suspension of Specialty Care Center designations, if applicable.

Please contact me at (562) 378-1610 or Ami Boonjaluksa at (562) 387-1596 for any questions.

RT:ab
02:05

Attachments: Ref. No. 506.2, 9-1-1 Trauma Re-Triage
Ref. No. 513.1, Emergency Department Interfacility Transport of Patients with ST-Elevation Myocardial Infarction

Distribution:
Chief Executive Officer, Each 9-1-1 Receiving Facility
Emergency Department Medical Director, Each 9-1-1 Receiving Facility
Emergency Department Director, Each 9-1-1 Receiving Facility

c: Fire Chief, Each Fire Department
Paramedic Coordinator, Each Fire Department
Medical Director, Each Fire Department
Prehospital Care Coordinators, All Paramedic Base Hospitals
Hospital Association of Southern California
EMS Commission

(HOSPITAL, PARAMEDIC, MICN)

SUBJECT: **9-1-1 TRAUMA RE-TRIAGE**

REFERENCE NO. 506.2

STEP 1

Determine if patient meets 9-1-1 Trauma Re-triage Criteria:

Perfusion:
- Persistent signs of poor perfusion
- Need for immediate blood replacement therapy

Respiratory Criteria:
- Intubation required

GCS / Neurologic Criteria:
- GCS <9
- GCS deteriorating by 2 or more during observation

Anatomic Criteria:
- Penetrating injuries to head, neck, chest, or abdomen
- Extremity injury with neurovascular compromise or loss of pulses

Provider Judgment:
- Patients, who in the judgment of the evaluating emergency physician, have a high likelihood of requiring emergent life- or limb-saving intervention within 2 hours

STEP 2

Contact the designated Trauma Center for a *"9-1-1 Trauma Re-triage"*

Do NOT delay transport by initiating any diagnostic procedure that do not have direct impact on immediate resuscitative measures

Designated Trauma Center:
XXXXXXXXXXXXXXXX
Contact Number:
999.999.9999
Notify:
Transfer Center / Trauma Surgeon / Emergency Physician

STEP 3

Contact 9-1-1 for transportation

Standard Paramedic Scope does **NOT** include paralyzing agents, blood products.

STEP 4

Prepare patient, diagnostic imaging, and paperwork (to include initial EMS Report Form if applicable) for immediate transport

9-1-1 Trauma Re-triage: The movement of patients meeting specific high-acuity criteria from a non-trauma center to a trauma center for trauma care.

Trauma Transfer: The movement of other trauma patients to a trauma center that do not meet 9-1-1 Emergency Trauma Re-triage criteria.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMERGENCY DEPARTMENT INTERFACILITY TRANSPORT OF PATIENTS WITH ST – ELEVATION MYOCARDIAL INFARCTION** (ALS PROVIDERS, HOSPITALS) REFERENCE NO. 513.1

PURPOSE: To define the transportation options available for the **Emergency Department** (ED) interfacility transfer of patients diagnosed with ST-elevation myocardial infarction (STEMI) and who may require emergent percutaneous coronary intervention (PCI).

AUTHORITY: Health and Safety Code 1797.220 and 1798
California Code of Regulations, Title 22, Sections 100147 and 100169 and Division 9, Chapter 7.1
Social Security Act Section 1867(a) (EMTALA) of the United States Code, Section 42

POLICY:

I. The ED interfacility transfer of STEMI patients shall comply with current EMTALA and Title 22 transfer laws and regulations for both sending and receiving hospitals.

II. Transfer agreements between approved STEMI Receiving Centers (SRC) and STEMI Referral Facilities (non-approved SRCs and non-PCI capable facilities) are the optimal practice to facilitate the transfer process.

III. Transportation arrangements are the responsibility of the STEMI Referral Facility (SRF). The appropriate transport modality (as defined in Ref. No. 517, Private Provider Agency Transport/Response Guidelines) should be made in consultation with the receiving SRC.

TRANSPORTATION OPTIONS:

1. Private Advanced Life Support (ALS) and/or Critical Care Transport (CCT) provider agencies are to be utilized when agreements are in place and the ALS/CCT transport unit is available within 10 minutes of the initial transport request.

2. The jurisdictional 9-1-1 provider agency may be contacted when a private ALS transport unit is not available within 10 minutes. Patient destination shall comply with Ref. No. 513, ST-Elevation Myocardial Infarction Patient Destination.

   A. 9-1-1 should be accessed only when the patient is ready for immediate transport.

   B. Patients are to be transported to the SRC as directed by the SRF physician (base hospital contact/notification guidelines apply).

   C. Transport units may bypass the most accessible SRC to a prearranged receiving SRC within 30 minutes if, the provider-based resources at the time of transport allow.

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CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 513, **ST-Elevation Myocardial Infarction (STEMI) Patient Destination**
Ref. No. 517, **Private Provider Agency Transport/Response Guidelines**

Emergency Medical Treatment and Active Labor Act (EMTALA)