COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

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

DATE: November 20, 2024
TIME: 1:00 – 3:00 PM
LOCATION: 10100 Pioneer Boulevard, First Floor
Cathy Chidester Conference Room 128
Santa Fe Springs, CA 90670

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 the Commission Chair as time permits.

NOTE: Please *sign in* if you would like to address the Commission.

AGENDA

1. CALL TO ORDER – Commissioner Carole Snyder, Chair

2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

2.1 In Memoriam, Dr. Ron Stewart – Paramedic Training Institute's First Medical Director

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**
3.1.1 September 11, 2024

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. 411, 9-1-1 Provider Agency Medical Director
3.3.2 Reference No. 420, Private Ambulance Operator Medical Director
3.3.3 Reference No. 702, Controlled Drugs Carried on ALS, SCT and APRU Units
3.3.4 Reference No. 823, Elder Abuse and Dependent Adult Abuse Reporting Guidelines

END OF CONSENT AGENDA

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4. BUSINESS

Business (Old)
4.1 Field Evaluation of Suicidal Ideation and Behavior
4.2 Ambulance Patient Offload Time (APOT)
4.3 The Public Works Alliance EMS Corps.
4.4 Cardiac Arrest Taskforce

Business (New)
4.5 Nominating Committee

5. LEGISLATION
5.1 EMS Regulations – Chapter 1
5.2 AB 1168 (Bennett)

6. DIRECTORS' REPORTS
6.1 Richard Tadeo, EMS Agency Director/EMSC Executive Director

Correspondence
6.1.1 (08/26/24) Annual Influenza and COVID-19 Immunization or Masking Requirement for Healthcare Personnel During Respiratory Virus Season
6.1.2 (09/30/24) Medical Alert Center Phone Number Changes
6.1.3 (10/10/24) Shortage of Intravenous Fluids
6.1.4 (10/15/24) Pilot Program – Elimination of Service Area Boundaries. Suspension of Ref. Nos. 509, 509.2 & .2a, 509.4 & .4a
6.1.5 (10/23/24) Marburg Virus Disease Protocols
6.1.6 (10/31/24) Star View Behavioral Health Site Approval

6.2 Nichole Bosson, MD, EMS Medical Director
6.2.1 Extracorporeal Cardiopulmonary Resuscitation (ECPR) Receiving Center Standards
6.2.2 Marburg Virus Disease Protocols

7. COMMISSIONERS' COMMENTS / REQUESTS

8. ADJOURNMENT
To the meeting of January 15, 2025

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/

MINUTES
September 11, 2024

☒ Diego Caivano, M.D.	LACo Medical Association	Richard Tadeo	Executive Director
☒ Jason Cervantes	CA Professional Firefighters	Vanessa Gonzalez	Commission Liaison
☒ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Christine Clare	EMS Staff
☒ Paul Espinosa, Chief	LACo Police Chiefs' Assn.	Roel Amara	EMS Staff
☒ Tarina Kang, M.D.	Hospital Assn. of So. CA	Jake Toy, MD	EMS Staff
☒ Carol Kim	Public Member, 1st District	Paula Cho	EMS Staff
☐ *Kristin Kolenda, Chief	Peace Officers Association	Priscilla Ross	EMS Staff
☐ *Lydia Lam, M.D.	American College of Surgeons	Sara Rasnake	EMS Staff
☐ *Kenneth Liebman	LACo Ambulance Association	Ami Boonjaluksa	EMS Staff
☒ James Lott, PsyD, MBA	Public Member, 2nd District	Andrea Solorio	EMS Staff
☒ Carol Meyer, RN	Public Member, 4th District	Sandy Montero	EMS Staff
☒ Kenneth Powell	LA Area Fire Chiefs' Assn.	Jennifer Calderon	EMS Staff
☒ Connie Richey, RN	Public Member 3rd District	Laura Leyman	EMS Staff
☐ *Brian Saeki	League of CA Cities/LA Co	Tracy Harada	EMS Staff
☒ Stephen G. Sanko, MD	American Heart Association	Christine Zaiser	EMS Staff
☒ Carole A, Snyder, RN	Emergency Nurses Assn.	David Wells	EMS Staff
☐ *Saran Tucker	So. CA Public Health Assn.	Gerard Waworundeng	EMS Staff
☐ *Atilla Uner, M.D., MPH	CAL-ACEP	Ha Na Kang	EMS Staff
☐ *Gary Washburn	Public Member, 5th District	Mark Ferguson	EMS Staff

GUESTS

Georgina Glaviano – County Counsel	Jennifer Nulty/ TFD
Laurie Donegan/APCC/LBM	Michael Stone / USC

(*) = Absent

1. CALL TO ORDER

The Emergency Medical Services (EMS) Commission (EMSC) meeting was held at the EMS Agency at 10100 Pioneer Boulevard, First Floor, Cathy Chidester Conference Room 128, Santa Fe Springs, CA 90670. Chair Carole Snyder provided general instructions and called the meeting to order at 1:02 p.m. There was a quorum of 12 commissioners present.

2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

Richard Tadeo, EMS Agency Director/EMSC Executive Director announced the Board of Supervisors' appointment of Captain Kristin Kolenda who will represent the Peace Officers Association of Los Angeles County and Connie Richey as a Public Member for the 3rd District on the EMSC.

3. CONSENT AGENDA – *All matters approved by one motion unless held.*
Chair Snyder called for approval of the Consent Agenda and opened the floor for discussion.

3.1 **Minutes**
3.1.1 July 17, 2024

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. 205: Innovation, Technology, and Advancement Committee (ITAC)
3.3.2 Reference No. 515: Air Ambulance Transport
Commissioner Lott questioned the wording "shall be" versus "should be". Director Tadeo responded that "should" is more permissible and "shall" is a must.

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

END OF CONSENT AGENDA

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4. BUSINESS

Business (Old)

4.1 Field Evaluation of Suicidal Ideation and Behavior
Commissioner Erick Cheung reported on the progress of the workgroup's assessment of treating suicidal ideation patients in the field. Dr. Cheung anticipates that the final report will be available at the next EMS Commission meeting. This Ad Hoc committee has met four times and the purpose was to evaluate the current state of EMS field evaluation and disposition of individuals who are experiencing suicidal ideation and behaviors. Commissioner Cheung also reported on the Survey of EMS Providers Opinions on the Evaluation of Patients at Risk for Suicide. The LAC-EMS Agency deployed the survey to all LA County EMS providers from July 22 to August 9, 2024. The purpose was to gain a better understanding of EMS clinicians experience and perspectives on evaluating and managing patients with suicidal ideation or behaviors.

Director Tadeo asked the Commission to endorse moving forward with the medical control guidelines and treatment protocol associated with suicidal ideation.

Motion/Second by Commissioners Caivano/Meyer to endorse to move forward was carried unanimously.

4.2 Ambulance Patient Offload Time (APOT)
Christine Clare, EMS Agency Nursing Director, reported on the second quarter APOT report. While there still is not 100% of data received from the EOA providers, there are greater numbers than EMS has ever had. The EMS Agency is continuing to work with AMR and McCormick to obtain 100% of records. Full compliance is anticipated by the end of this month.

The first two columns in the report show there is a disposition that the patient was transported to a hospital emergency department, and they were transported by that unit. There may be occasions where perhaps the provider puts the receiving hospital in there,

and they don't document that they transported the patient. The columns highlighted in orange are the ones that exceed our designated 30-minute APOT 90% of the time. Previously there have been some reports shared that are highlighted in 20-minute timeframes as EMSA reports for a 20-minute offload time. Ms. Clare has requested the state to run their APOT reports at 30 minutes so we can validate the data they have to ensure accuracy in what's being reported.

4.3 The Public Works Alliance – EMS Corps.

Director Tadeo reported no new updates. We continue to support them, and we'll continue to reach out to them for any new updates.

Dr. Jake Toy, EMS Agency Medical Director of Data and QI, reported that Dr. Denise Whitfield, EMS Agency Assistant Medical Director, is working with the alliance group and they are partnering with the cities of Whittier and Compton to provide a venue. EMS is working as a liaison between them and the community in those areas.

Business (New)

4.4 Annual Report

Director Tadeo reported that the annual report is ready for approval. It is required by the Board to be submitted annually by the Commission.

Motion/Second by Commissioners Lott/Caivano to approve the Annual Report was carried unanimously.

4.5 Alternative Destination Volume Reports

Ms. Clare reported on the alternative destination volume report for the psych urgent cares that EMS transports to directly. There are significant volume changes between 2022, 2023, and 2024. Initially the volumes reported were from the alternate care destination site, not the EMS providers. Several of the sites weren't good at capturing when EMS brought in the patients and were including law enforcement in their reported numbers. The EMS Agency started validating the EMS volumes from the EMS providers and linking the patient.

The David L. Murphy Sobering Center closed to EMS transports and suspended their services in November 2023. They changed the services provided, more specifically for the skid row patients with fentanyl overdoses. They wanted to work with street medicine teams to monitor those patients and at this time that type of sobering center is not recognized by the State, so they are no longer part of our system for alternate destination program. At this time, we do not have any EMS designated sobering centers within Los Angeles County. A company has reached out that does have sobering centers in other areas of the state and is looking to develop one in Pomona. Once complete, the EMS Agency will survey them to make sure they meet the requirements and bring them up in our system.

Star Behavioral Health Psychiatric Urgent Care Center in Long Beach has very low patient volumes due to the fact that Long Beach Fire Department was not part of the pilot project and cannot transport there. Now that we have our Triage to Alternate Destination program approved by the State, we reached out to Long Beach Fire, and they are going through the process of becoming an alternate destination provider. We look forward to having them join the system as we know that will help the Long Beach area significantly.

Commissioner Sanko encouraged the Commission to support further efforts for sobering centers in downtown and other high-risk areas. Director Tadeo reported that we are 9

months into the approval of our programs and staff is going back to the Psychiatric Urgent Care centers to begin site visits.

5. LEGISLATION

Director Tadeo reported on the following legislation:

AB 40 – The budget for State EMSA was approved and EMSA is beginning to hire more staff. The deadlines for submission of hospital policies to address surge and APOT was September 1st. According to the latest report, Hospital Association is almost at 100% submission, they have two or three hospitals from LA County that have not submitted their policies to EMSA. HASC has provided template policies and checklists that the hospitals can use to address APOT surges. The EMSA workgroup to develop the regulations is anticipated to start meeting before the end of the year with expected draft regulations for public comment to be released sometime in the second quarter 2025.

AB 1168 (Bennett) – Would retroactively grant 201 rights to the City of Oxnard. It has been approved by the Senate and Assembly and LA County is actively campaigning for the Governor to veto the bill. Concerns that if it goes into effect it could dismantle the EMS Act. State has a workgroup to address all the 201 and 224 issues that have arisen over the years with all the contingencies.

EMSA is currently reorganizing and renumbering the EMS regulations to make them more consistent. There will be no content changes made.

6. DIRECTOR'S REPORT

6.1 Richard Tadeo, EMS Agency Director, EMSC Executive Director

Director Tadeo reported on the following:

Correspondence

6.1.1 (07/08/24) Provider Impression Agitated Delirium
6.1.2 (08/01/24) EMT AED Service Provider Program Approval
6.1.3 (08/06/24) Designation of Comprehensive Stroke Center
6.1.4 (08/06/24) Transcutaneous Pacing Program Approval
6.1.5 (08/12/24) Intraosseous Program Approval

Director Tadeo reported that the EMS Law Enforcement Co-Response (ELCoR) workgroup will become permanent. There has been a lot of positive engagement between law enforcement and EMS providers as it relates to mental health and there are additional opportunities to collaborate. Upcoming agenda items will include integration with 9-8-8.

Director Tadeo reported that the Mobile Medical System which included a tractor trailer and ICU/ED trailer have been redeployed with LASD and LAFD respectively. It was discovered during COVID that deployment of tents is faster and requires less training and staff to deploy and can be moved by helicopter if needed. The ICU/ED trailer was never utilized as designed and requires several days and multiple staff to set up.

Director Tadeo reported that the service area hospitals: PIH Health Good Samaritan, Dignity Health – California Hospital Medical Center and Adventist Health White Memorial; have agreed to pilot eliminating the service areas. Compliance with the service area boundaries is cumbersome for the providers to remember and it is felt that it has outlived its usefulness. The providers will incorporate the ambulance data from

ReddiNet with the normal destination and diversion policies to determine the appropriate destination regardless of service area boundaries. The pilot will be for 6-months, and the EMS Agency will be providing monthly data to the affected hospitals.

Director Tadeo reported that the EMS Agency has developed ALS skills sheets and will be requiring paramedics to complete for each accreditation cycle to maintain their local accreditation. Currently evaluating how to implement.

Roel Amara, EMS Agency Nursing Director – Disaster Programs
Mr. Amara gave the following update related to upcoming large scale event preparation:

In 2026, LA will be one of the sites for the World Cup organized by the US Soccer Federation is responsible for the medical plan. There will be 8 matches held at SoFi Stadium. Commissioner Caivano expressed his concerns regarding security and safety when dealing with international crowds. He described his experience at the Copa America soccer final match in Miami wherein security and safety were major issues.

As the host city, all medical planning and processes are to be coordinated by the City of LA. The City of LA has designated LA County FD as the primary medical responder. The EMS Agency is working with LA City Emergency Management Department and LA County FD to convene the mass gathering workgroup which will begin meeting regularly in October. LA City has also formed a health and medical committee whose membership includes the EMS Agency and Public Health. Director Tadeo also stated that there have already been meetings with the City and County Offices of Emergency Management to begin planning. Updates will be presented at future Commission meetings.

In 2028, the City of LA will be hosting the summer Olympics. There will be events taking place in the cities of LA, Long Beach, Inglewood, and Carson and the Sepulveda Basin area.

Request was made by Chair Snyder to ensure the hospitals receive decontamination training and the Disaster Resource Centers be evaluated to ensure they are ready in case of a large-scale event during these events.

7. COMMISSIONERS' COMMENTS / REQUESTS

7.1 Commissioner Sanko's Data Request

Commissioner Sanko reviewed the request that he brought forth at the July Commission meeting. Goal of the request is to meet the AHA goal of improving outcomes of the cardiac arrest patient. Requesting an ad hoc workgroup for cardiac arrest to look at current status of cardiac arrest care, outcomes and equality and suggest strategies to improve outcome.

EMS Commission endorsed the development of a cardiac arrest workgroup. This will be added to the EMS Commission goals for 2024-2024.

8. ADJOURNMENT:

Adjournment by Chair Snyder at 2:17 p.m. to the meeting of Wednesday, November 20, 2024.

Next Meeting: Wednesday, November 20, 2024, 1:00-3:00 p.m.
Emergency Medical Services Agency
10100 Pioneer Boulevard, First Floor

Cathy Chidester Hearing Room 128
Santa Fe Springs, CA 90670

Recorded by:
Vanessa Gonzalez
Management Secretary III

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

IN MEMORIAM

RONALD D. STEWART, OC, ONS, BA, BSc, ME, FRCPC, DSc
Professor of Emergency Medicine
Director of Humanities
Faculty of Medicine, Dalhousie University, Halifax, Nova Scotia, Canada and
1st Medical Director, Paramedic Training Institute, Los Angeles County (1974-1978)

A message to the newest residents of wonderland

(Commencement Address to PTI's 200th Class Graduation)

'Would you tell me please, which way I ought to go from here?
'That depends a good deal on where you want to get to,' said the Cat.
"I don't much care where,' said Alice.
'Then it doesn't matter which way you go,' said the Cat.
Charles L Dodson (Lewis Carroll) (1832-1898)
Alice's Adventures in Wonderland

It seems so long ago, the seventies in fact, that a recently-arrived and wet-behind-the-ears Canadian physician in the new program in emergency medicine at LA County-USC Medical Center, I accidentally met not one, but two Cheshire cats in that "Wonderland" we know as EMS in its formative days. Just after arriving "down the rabbit hole" and while attending a "red-blanket" patient with respiratory failure on the medicine admitting ward at "Big County," I encountered two young firemen dressed in crisp white smocks, well pressed navy blue trousers and very shiny black boots. Not patent-leather dress shoes, mind you, but boots. They looked awkward and uncertain, and I was exactly that. We immediately struck up a friendship, as I did with many others who followed, and those friendships have lasted these 35 years. Little did I know it at the time, these two, and many more like them, were to profoundly influence my life and career in ways that I could not have then imagined.

The two paramedics I had met were, to me, Cheshire Cats at the beginning of my journey into the wonderland that was L.A., and emergency medicine. As was the Cheshire Cat with Alice, they were inquisitive, practical, and insisted on the "whys" of things, questioning even the most sacred of medical cows and demanding of me to do the same. They didn't know that's what they were doing, but they were. Fundamental to their creed, something they always seemed to return to, was how best to do the job entrusted to them; caring for those who needed them and concern for their wider community. This mixture of commitment and an ever-present desire to learn more and do better was the first of many lessons they taught me.

Those were the early days of EMS, perhaps, in some ways, the "golden afternoon" of our ongoing wonderland. We didn't, at the time, know quite where we wanted to get to. But, unlike the Cheshire Cat's advice, it DID matter how we got there. In providing care to others, we never really get to where we might like to be. We face enormous challenges in modern EMS, and we continue to struggle with system design, evidenced-based care, and the "politics" of it all. In the "golden afternoon" we weren't quire as restrained as now, and we didn't always get things right. Just as Alice did, we had to return to "reality" from the land of our idealism and un-reality, to the soiled landscape of our imperfect world and our failure to reach our finest aspirations.

But the basic values of commitment I saw in those early fellow-travelers still have to be the basis for whatever we are doing in EMS. People in the system will change. The issues we face may as well. But what must never change is our commitment to the fundamental “anchors” in the professional lives of many members of the 199 classes that came before you, a desire to do the ‘right thing,’ to deliver the best care possible and a commitment to the broader community and to each other. Never lose this. Please don’t let the grinding demands of your professional everyday lives diminish your sense of ethics and the mystery and privilege of what you are doing. You will not perhaps know the good you do in your work, just as we never imagined at the beginning of the road that what we were doing would last, let alone be celebrated. Without a sense of greater purpose, without a sense of service (for that’s what it is about), you will not only be less than satisfied in your work, but you risk becoming cynical and unhappy, and a greater concern in what we do, careless.

Be assured the choice of career you have made is one with the almost-unlimited opportunities to do good, to enrich yourself as a person and to do better for your community. If I have one wish for each of you, it is to realize this and to recognize the privilege of taking care of others, whatever their creed, color or blood alcohol level.

It is with a sense of profound gratitude and also pride in what this paramedic program has accomplished that I celebrate with you your achievement and choice of service. I am grateful, above all, for each one of those 200 classes helping to make me a better physician… and a better person.

Thank you.

Fondly,
Ron Stewart

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

October 9, 2024

	REPRESENTATIVES		EMS AGENCY STAFF
☑	Erick Cheung, MD, Chair	EMS Commission	Denise Whitfield, MD
☐	Diego Caivano, MD, Vice Chair	EMS Commission	Chris Clare
☐	Atilla Under, MD, MPH	EMS Commission	Jacqueline Rifenburg
☐	Lydia Lam, MD	EMS Commission	Laura Leyman
☐	Saran Tucker	EMS Commission	Priscilla Ross
☐	Carol Synder, RN	EMS Commission	Roel Amara
☐	Tarina Kang, MD	EMS Commission	Lorrie Perez
☐	Brian Saeki	EMS Commission	Ami Boonjaluksa
☐	Vacant	EMS Commission	Natalie Greco
☑	Rachel Caffey	Northern Region	Sara Rasnake
☑	Jessica Strange	Northern Region	Sam Calderon
☑	Michael Wombold	Northern Region, Alternate	Mariana Munatones
☑	Samantha Verga-Gates	Southern Region	Hannah Kang
☐	Laurie Donegan	Southern Region	Mark Ferguson
☑	Shelly Trites	Southern Region	Gerard Waworundeng
☑	Christine Farnham	Southern Region, Alternate	Michael Kim, MD
☑	Ryan Burgess	Western Region, Alternate	Christine Zaiser
☐	Travis Fisher	Western Region	David Wells
☑	Lauren Spina	Western Region	Aldrin Fontela
☐	Susana Sanchez	Western Region	Paula Cho
☐	Cherry Jaudalso	Western Region	
☐	Laurie Sepke	Eastern Region	
☐	Alina Candal	Eastern Region	
☑	Jenny Van Slyke	Eastern Region, Alternate	
☑	Lila Mier	County Region	
☑	Emerson Martell	County Region	
☑	Antoinette Salas	County Region	GUESTS
☑	Yvonne Elizarraraz	County Region	
☑	Gabriel Campion, MD	Base Hospital Medical Director	Clayton Kazan, MD LACoFD
☑	Salvador Rios, MD	Base Hospital Medical Director, Alternate	Vandy Uphoff (HMH)
☑	Adam Brown	Provider Agency Advisory Committee	Ashley Sanello, MD (TOR)
☑	Jennifer Nulty	Prov. Agency Advisor Committee, Alternate	Shane Cook, LACoFD
☐	Heidi Ruff	Pediatric Advisory Committee Representative	Elizabet Charter (AMH)
☐	Desiree Noel	Ped AC Representative, Alternate	
☑	John Foster	MICN Representative	
☐	Vacant	MICN Representative, Alternate	

	PREHOSPITAL CARE COORDINATORS				
☑	Melissia Turpin (SMM)	☑	Allison Bozigian (HMN)	☑	Melissa Carter
☑	Jesika Mejia (QVH)	☑	Brandon Koulabouth (AMH)		
☐	Thomas Ryan (SFM)	☑	Annette Mason (AVH)		

1. CALL TO ORDER: The meeting was called to order at 1:00 p.m. by EMS Commissioner Chair, Erick Cheung, MD.

2. INTRODUCTIONS/ANNOUNCEMENTS:

2.1 Mariana Munatones has been appointed as the new program manager for EDAP, PMC and the SART Centers, where she will focus on developing a quality improvement program for pediatrics and establishing a pediatric database.

2.2 Dr. Salvador Rios of Providence St. Joseph Hospital has been appointed as the Base Hospital Advisory Alternative for Medical Council.

3. APPROVAL OF MINUTES

3.1 The Meeting Minutes for August 14, 2024, were approved as presented.

Approved as presented, M/S/C (Wombold/Verga-Gates)

4. REPORTS & UPDATES:

4.1 EMS Update 2025

A recent email was sent to the EMS Update Committee to confirm their participation in this year's EMS Update. Those interested in participating should contact Dr. Schlesinger.

4.2 EmergiPress

The September edition of EmergiPress can be found on the EMS website or on the APS Training Portal. The December issue will focus on polices concerning EMS and Law Enforcement Co-Response.

4.3 ITAC- (No Updates)

4.4 Research Initiative & Pilot Studies

4.4.1 ECMO Pilot: The ECMO Pilot has concluded, with more than 200 patients enrolled and 50 patients who received ECPR, resulting in a 30% survival to hospital discharge. Operational procedures remain unchanged, however data from the pilot will now be collected in the SRC database.

4.4.2 Prehospital Blood Transfusion Pilot: The State has approved the prehospital blood transfusion pilot, and the EMS Agency is currently developing operational plans with County Fire, Compton Fire and Harbor-UCLA Medical Center and aiming for implementation in 2025.

4.4.3 Thorasite Pilot: There have been 150 needle thoracostomy placements to date. Outcomes with the trauma centers are being tracked to ensure no adverse results. The pilot program will conclude this year, and aggregate data during the pilot will be presented in 2025.

4.5 PediDOSE Trial

The treatment protocol for pediatric seizure is via intranasal or intramuscular administration only. It is essential for paramedics to gather parent contact information and ensure that it is documented in the ePCR.

4.6 Pedi-PART

All potential patients should be submitted via the Red Cap link. It is important to remind the paramedics to collect and document parent contact information in the ePCR. Please encourage paramedics to randomize treatment based on odd and even dates.

4.7 ELCoR Task Force

There is a EmergiPress video module and a case study sheet available on the EMS Agency website that summarizes Medical Control Guideline 1307.4, which pertains to EMS and Law Enforcement Co-Response. This will be presented in greater detail in EMS Update 2025. This task force has been valuable to the understanding of each other's perspectives and will be a permanent agenda item for this committee.

A reference document concerning the legal and privacy issues related to body-worn cameras will be accessible on the EMS website. Notification will be provided once it is posted.

Dr. Schlesinger is working on law enforcement educational products for common encounters such as respiratory failure, choking, and pediatric cardiac arrest; and sharing best practices with law enforcement on initial stabilizing steps and waiting for EMS arrival on scene.

4.8 ECPR Regional System

The hospitals involved in the ECMO pilot program will be designated ECPR centers beginning in January and operations will remain the same. Starting on July 1, 2025, any centers interested in becoming ECPR Centers may apply. EMS Update will incorporate the policies for these changes. The only changes to the pilot program hospitals will be reporting the data in the SRC database.

4.9 California Office of Traffic Safety (OTS) Grants Projects

4.9.1 Mobile Protocol Application

The Mobile Protocol Application is set to launch at the end of this month. Among the features are Rapid Access Treatment Protocols, Just- In-Time Videos, Provider Impressions, and a Quick Reference Guidelines Tab. Training sessions have been recorded and will be available for future educational purposes.

4.9.2 Trauma Dashboards

Dr. Schlesinger presented a preliminary proof of concept for the post-crash care dashboard, which incorporated data from the Statewide Integrated Traffic Records System (SWITRS), as well as data from prehospital emergency medical services and the trauma hospitals.

4.10 Health Data Exchange (HDE)

The EMS Agency will organize informational sessions with hospitals that have expressed interest in the recent inquiry regarding participation in the health data exchange program. These sessions will provide details on funding and the preparations required by hospitals before implementation.

5. Old Business

Policies for Discussion; Action Required

5.1 Ref. No. 823, Elder Abuse and Dependent Adult Abuse Reporting Guidelines

Approved as presented, M/S/C (Spina/Farnham)

6. New Business

6.1 Ad Hoc Committee on the Evaluation of Suicidal Ideation and Behaviors

Dr. Cheung provided an overview of the committee's assessment looking at the current practice in Los Angeles County in the management of individuals with suicidal ideation and behaviors. Survey results showed strong support for developing educational protocols, and a draft protocol was introduced. The findings revealed that suicidal ideation and behavior are common, yet no established guidance exists for EMS clinicians, raising concerns about decision-making and liability. The survey showed strong support for protocols and education to improve the overall management for patients with suicidal ideation or behaviors. There was substantial dialogue regarding the feasibility of implementing the Columbia Suicide Severity Risk Scale and if the suggested draft proposed will influence existing practice. Request was made to review this topic at a future meeting.

Policies for Discussion: Action Required

6.2 Ref. No. 519, Management of Multiple Casualty Incidents

Approved as presented, M/S/C (Van Slyke/Wombold)

6.3 Ref. No 817, Regional Mobile Response Teams

Approved with the recommend changes: C.,3 to replace 'Team Leader' with a more general term.
(Dr. Rios/Verga-Gates)

Informational Policies: No Action Required

6.4 Ref. No. 1010, Mobile Intensive Care Nurse (MICN) Certification
6.5 Ref. No. 1200.2, Base Contact Requirements
6.6 Ref. No. 1209, Behavioral/Psychiatric Crisis
6.7 Ref. No. 1209-P, Behavioral/Psychiatric Crisis

7. OPEN DISCUSSION (None)

8. NEXT MEETING: December 11, 2024

9. ADJOURNMENT: The meeting was adjourned at 14:57

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

ACCOUNTABILITY: Laura Leyman

EMERGENCY MEDICAL SERVICES COMMISSION
PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, October 16, 2024

MEMBERSHIP / ATTENDANCE

MEMBERS IN ATTENDANCE	ORGANIZATION
X Kenneth Powell, Chair	EMSC, Commissioner
Paul Espinosa, Vice-Chair	EMSC, Commissioner
James Lott, PsyD, MBA	EMSC, Commissioner
Ken Lieberman	EMSC, Commissioner
Jason Cervantes	EMSC, Commissioner
Carol Kim	EMSC, Commissioner
Carol Meyer	EMSC, Commissioner
Gary Washburn	EMSC, Commissioner
X Sean Stokes	Area A *(Rep to Medical Council)*
X Patrick Nulty	Area A, Alternate
X Keith Harter	Area B
X Clayton Kazan, MD	Area B, Alternate
X Todd Tucker	Area C
Jeffrey Tsay	Area C, Alternate
X Ryan Jorgensen	Area E
X Geoffrey Dayne	Area E, Alternate
X Joel Davis	Area F
Andrew Reno	Area F, Alternate
X Adam Brown	Area G *(Rep to BHAC)*
X Stefan Viera	Area G, Alternate
X Matthew Conroy	Area H
Tim Wuerfel	Area H, Alternate
David Hahn	Area H, Alternate
Julian Hernandez	Employed Paramedic Coordinator
Tisha Hamilton	Employed Paramedic Coordinator, Alt
Rachel Caffey	Prehospital Care Coordinator
X Jenny Van Slyke	Prehospital Care Coordinator, Alternate
X Bryan Sua	Public Sector Paramedic Coordinator
Vacant	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 Robert Ower	Private Sector Nurse Staffed Amb Program
Jonathan Lopez	Private Sector Nurse Staffed Amb Program,
Scott Jaeggi	EMT Training Program
X Albert Laicans	EMT Training Program, Alternate
Ray Mosack	Paramedic Training Program
Vacant	Paramedic Training Program, Alternate
X Caroline Jack	EMS Educator
X Jennifer Nulty	EMS Educator, Alternate

EMS AGENCY STAFF	EMS AGENCY STAFF
Nichole Bosson, MD	Denise Whitfield, MD
Shira Schlesinger, MD	Jake Toy, MD
Chris Clare	Michael Kim, MD
Roel Amara	Jacqueline Rifenburg
Bijan Arab, MD	Jonathon Warren, MD
Ami Boonjaluksa	Jennifer Calderon
Paula Cho	Lily Choi
Terry Crammer	Mark Ferguson
Natalie Greco	Tracy Harada
HanNa Kang	Laura Leyman
Lorna Mendoza	Sandra Montero
Mariana Munatones	Nnabuike Nwanonenyi
Lorrie Perez	Sara Rasnake
Gary Watson	Gerard Waworundeng
David Wells	Christine Zaiser

GUEST	ORGANIZATION
Dawn Terashita, MD	LA County Public Health
Erick Cheung, MD	UCLA Health
Ilse Wogan	LACoFD
Ryan Ockey	LAFD
Ben Esparza	LAFD
Heidi Ruff	LAFD – Air Operations
Jim Goldsworthy	LAFD – Air Operations
Nanci Medina	LAFD
Valentina Triamarit	LACoFD
Catherine Borman	Santa Monica FD
Kristina Crews	LACoFD
Issac Yang	Redondo Beach FD
Michelle Evans	West Coast Ambulance
Ryan Shook	Santa Monica FD
Travis Moore	La Verne FD
Patricia Guevara	Burbank FD
Alfredo Estrada	Montebello FD
Freddy Jimenez	Montebello FD
Ivy Valenzuela	LA County Public Health
Peter Garcia	Burbank FD
Adrienne Roel	UCLA Ctr for Prehosp Care
Michael Stone, MD	LA General – EMS Fellow
Marc Cohen, MD	Medical Director, Multiple FDs
Rom Rubimian, MD	LAFD
Joe Nakagawa, MD	Medical Director, Hawthorne PD
Salvador Rios, MD	Medical Director, Monrovia FD
Toni Arellano	LACoFD
Kristina Hong	Downey FD
Sergio Zavala	Downey FD
Kelsey Wilhelm, MD	Medical Director, Compton FD
Puneet Gupta, MD	Assist Med Director, LACoFD
Armando Jurado	Lifeline Ambulance
Jessi Castillo	PRN Ambulance

1. CALL TO ORDER – Chair Kenneth Powell, called meeting to order at 1:01 p.m.

2. INTRODUCTIONS AND ANNOUNCEMENTS

2.1 Los Angeles County's Health Officer Order No. 2024.01.01 *(Dawn Terashita, MD; LA County Public Health)*

- The current Health Officer Order was reviewed including the requirements for receiving and tracking the influenza and COVID-19 vaccines within each provider agency.
- Dr. Terashita presented a review of the Marburg Virus that is currently in the Republic of Rwanda. Currently, there are no reported cases in the United States.

- Providers are encouraged to continue following blood and body fluid precautions, utilizing personal protective equipment.
- Terry Cramer, EMS Agency Disaster Services, announced that the EMS Agency is updating three policies to include information on the Marburg Virus; these policies will be sent to all providers once completed.
- Los Angeles County has three specialty pathogen treatment centers: Kaiser Foundation Hospital - Los Angeles (KFL), Ronald Reagan UCLA Medical Center (UCL) and Cedars Sinai Medical Center (CSM).

2.2 PAAC Membership Changes *(Chair, Kenneth Powell)*

- Area A, Alternate: Patrick Nulty, BC, Santa Monica FD
- Area E, Representative: Ryan Jorgensen, La Habra Heights FD
- Area E, Alternate: Geoffrey Dayne, Santa Fe Spring Fire Rescue.
- Area F, Representative: Joel Davis, Long Beach FD
- Area H, Alternate: Tim Wuerfel, BC, Los Angeles Fire Department.
- Nurse Staffed Ambulance, Representative: Robert Ower, Premier Ambulance.
- Paramedic Training Programs, Representative: Raymond Mosack, Mount San Antonio College

3. APPROVAL OF MINUTES (Harter/Tucker) August 21, 2024, minutes were approved as written.

4. REPORTS & UPDATES

4.1 EMS Update 2025 *(Shira Schlesinger, MD)*

- Preparation for EMS Update 2025 as begun. The first planning committee meeting will occur in November 2024; invitations will be sent soon.
- If interested in being part of this planning committee and have not heard from Dr. Schlesinger yet, please email her at sschlesinger2@dhs.lacounty.gov
- The current plan is to complete Train-the-Trainer classes by the end of March 2025, start provider agency training in April 2025 and end in June 2025.

4.2 Emergi-Press *(Shira Schlesinger, MD)*

- The September 2024 Emergi-Press is now available on the EMS Agency's webpage, APS platform and Target Solutions.
- After inquiry, it was identified that the public providers are utilizing an APS platform to complete the online training and private providers are printing hard copies of the educational material directly from the EMS Agency's webpage to complete the education. Note: EMS Update and EmergiPress is available to all private provider accredited paramedics via the EMS Agency APS site.

4.3 ITAC Update

- Tabled until next meeting.

4.4 Research Initiatives and Pilot Studies *(Nichole Bosson, MD)*

4.4.1 ECMO Pilot

- Data collection for the pilot has completed. Data collection is now being completed through the EMS Agency SRC database.
- There have been >200 patients enrolled in this pilot, with approximately 50 patients treated with eCPR and nearly a 30% survival rate (previously, survival rate of refractory V-fib [<5%]).
- Once the data analysis is complete, results will be shared to this Committee.
- At this time, the existing ECMO Centers will continue to receive patients meeting the ECMO criteria and only the existing ECMO pilot providers will continue operating under the pilot protocol.
- During EMS Update 2025, it is planned to have all provider agencies trained on ECMO protocol.

4.4.2 Prehospital Blood Transfusion *(Nichole Bosson, MD)*

- Los Angeles County has received authorization from the California EMS Authority to implement the prehospital administration of blood transfusions (either whole blood or packed red blood cells).
- Providers participating in this Pilot include Los Angeles County FD and Compton FD.
- LA County EMS will be working with four other California EMS Agencies in collecting data over the next two years of this pilot; with an anticipated start date in the spring of 2025.

4.4.3 ThoraSite *(Denise Whitfield, MD)*

- The EMS Agency is continuing to monitor the use of this landmarking device for needle thoracostomies from four participating provider agencies.
- Currently, there has been 175 needle thoracostomy placements.
- The plan is to complete this Pilot at the end of this calendar year (2024), at which time the EMS Agency will review the aggregate data. Once data has been analyzed, information will be presented back to this Committee.

4.5 PediDOSE Trial *(Nichole Bosson, MD)*

- Dr. Bosson reviewed a chart summarizing the compliance rates for the paramedic self-reports (PSR). The goal is to have paramedics complete a PSR on all pediatric seizure responses.
- Provider agencies were reminded to ensure that all parents/caregivers are notified of their child's enrollment into the study. Also, to collect parent/caregiver's name and phone numbers. This is a federal requirement for this study.
- Committee member requested a list of patient care records that indicate no PSR completion. This would allow provider agencies to educate their personnel to improve compliance rates. The EMS Agency will collaborate with CHLA to provide the provider agencies with the requested information.

4.6 Pedi-PART *(Nichole Bosson, MD)*

- Completion of PSRs continue to do well with nearly 100% compliance.
- The RALPH devices have been distributed to all public providers. The RALPH device provides the field paramedic with information on which airway device to be utilized for the specific day (i-gel vs bag-mask-ventilation [BMV]). For those who have not received this device, contact Terry Crammer at tcrammer@dhs.lacounty.gov
- The current challenge with the study is with randomization. (i-gels are being placed on BMV days; and only BMVs are being used on the i-gel days.) Paramedics were reminded to continue following the correct randomization schedule, which is provided by utilizing the RALPH device.
- Providers were also reminded to ensure placement of the defibrillation pads on all patients in this study. Replacement defibrillation pads can be supplied by the EMS Agency upon request.
- Providers who do not have the Zoll cardiac monitor case review program, can now access this through your Zoll representative at no charge.

4.7 California Office of Traffic Safety (OTS) Grants Projects

4.7.1 Mobile Protocol Application *(Nichole Bosson, MD and Denise Whitfield, MD)*

- Train-the-Trainer for this protocol application was completed earlier this month and recordings of this training will be available on the EMS Agency webpage for future use.
- The application is now available for Beta testing by the providers.
- At the end of October 2024 and after additional modifications, the final version of this application will be released for systemwide use.
- Once released, the application will be routinely updated by the EMS Agency, allowing for access to up-to-date information by providers.

4.7.2 Trauma Dashboards/Curriculum *(Shira Schlesinger, MD)*

- Patient assessment elements have been filmed for the first module of the training for the trauma dashboard. This module is planned to be released within the next couple of months. Thank you to Torrance Fire Department for providing a location for this filming.

- Static version of the dashboard is complete. Currently working with vendors to create a live version of similar data.
- Dr. Schlesinger presented through PowerPoint slides various types of reports that can be retrieved from the dashboard which combines data from the LA County's TEMIS system and the Statewide Integrated Traffic Records System (SWITRS). These reports include demographics, crash characteristics, injury area/types, and post-crash care (both prehospital and hospital).

4.8 Health Data Exchange *(Chris Clare)*

- This is a bi-directional data exchange system between the hospitals and provider agencies. The goal is for the prehospital patient care records to automatically populate into the hospital's patient care record and provider agencies to obtain patient outcome and distinct billing fields (if applicable). This may help with quality improvement and evaluation of care in the field by the providers.
- The EMS Agency is currently working with base hospitals and trauma centers to go live with this project, with an expected implementation date in 2025.

4.9 EMS and Law Enforcement Co-Response (ELCOR) Task Force *(Nichole Bosson, MD)*

- This taskforce's initial focus was the mental health emergencies and the concern with law enforcement disengagement. As a result of this taskforce, the EMS Agency developed a new Medical Control Guideline and a training PowerPoint, developed by Michael Kim, MD.
- The current plan is to include in EMS Update 2025 a module that describes the best practice for communication between EMS and law enforcement personnel.
- Because of the value of the ELCOR taskforce, this joint taskforce will transition to a formal Committee to establish representation and address various issues between EMS and law enforcement.
- There have been two workgroups formed that are reviewing body cameras worn by law enforcement (led by Denise Whitfield, MD) and response to pediatric critical events (led by Shira Schlesinger, MD).
- Dr. Whitfield described the workgroup's review of the body worn cameras by law enforcement and possible healthcare implications (HIPPA, etc.). As a result, this workgroup developed a reference document that will be posted on the EMS Agency's webpage for EMS provider use.
- Dr. Schlesinger described the workgroup's review of the law enforcement response to pediatric critical events. This workgroup has developed a draft recommendation list of supplies and equipment for law enforcement to carry in their patrol cars and is currently working on developing a script for future training videos.

4.10 ALS Skill Sheets *(Denise Whitfield, MD)*

- PowerPoint slides were reviewed, showing the EMS Agency's proposed plan for implementing the ALS Skill sheets. There are 12 ALS skills total.
- Skills training would begin during EMS Update 2025, and paramedics would need to complete verification of 6 skills per year, rotating skills every other year.
- The first deadline for completing all 12 ALS skills will be during EMS Update 2027.
- The EMS Agency is currently in discussion with the LA Area Fire Chiefs for final review and approval of this program.
- The point of contact for the training requirements is Jennifer Calderon, Training Program Approvals Section, jrcalderon@dhs.lacounty.gov.

4.11 ECPR Regional System *(Nichole Bosson, MD, and Chris Clare)*

- The EMS system is continuing ECPR with hospitals who are already ECPR designated and for the providers who are already participating in this program.
- EMS Update 2025 will have a component regarding ECPR and at that time the plan is to change the cardiac arrest destination policy to add ECPR designation.

5. UNFINISHED BUSINESS

None

6. NEW BUSINESS

6.1 EMS Documentation Manual *(Sara Rasnake)*

- Due to transitioning to the National EMS Information System (NEMSIS), the EMS Documentation Manual has been retired and was replaced with the new LA County EMS NEMSIS Data Dictionary.
- Because there are various electronic patient care record (ePCR) platforms in Los Angeles County, it is important that documentation aligns with each specific provider agency's process. The EMS Agency recommends that each provider agency develop their own documentation manual to be tailored to their own unique ePCR set-up.

6.2 EMS Documentation Manual Evaluation *(Sara Rasnake)*

6.2 Ad Hoc Committee on Suicidal Ideation and Behaviors

- *(Erick Cheung, MD, Psychiatry, UCLA Health / LA County EMS Commissioner)*

On behalf of the EMS Commission, Dr. Cheung presented the following information:

- The purpose of this Ad Hoc Committee's was to evaluate the current state of EMS field evaluation and disposition of individuals with suicidal ideation and behaviors, and then to propose recommendations for improving policies, practices, and training.
- Dr. Cheung reviewed the progress of this Ad Hoc Committee including results of a survey that was distributed to LA County EMTs, paramedics and MICNs. From this survey, it was concluded that encounters for suicide risk are common, current protocols/resources are limited and there's a need for more guidance in our system.
- A draft Medical Control Guideline (Evaluation and Care of Patients at Risk of Suicide) was reviewed and included recommendations from the Ad Hoc Committee.
- PAAC members voiced opposition to the draft Medical Control Guideline, including the use of the Columbia Suicide Severity Rating Scale (C-SSRS), and the disposition of high risk and low risk patients.
- Further revisions are pending and will be brought back to this Committee in the future.

Policies for Discussion; Action Required:

6.3 Reference No. 411, Provider Agency Medical Director *(David Wells)*

Policy reviewed and approved as written.

M/S/C (Kazan/Davis) Approved: Reference No. 411, Provider Agency Medical Director

6.4 Reference No. 420, Private Ambulance Operator Medical Director *(David Wells)*

Policy reviewed and approved as written.

M/S/C (Kazan/Van Slyke) Approved: Reference No. 420, Private Ambulance Operator Medical Director

6.5 Reference No. 702, Controlled Drugs Carried on ALS Units *(David Wells)*

Policy reviewed and approved with the following recommendation:

- Replace the lists of individual personnel with the words "ALS personnel" in the following sections: Section III. B; Section III. E. 1.; and Section III. E. 3.

M/S/C (Tucker/Kazan) Approved: Reference No. 702, Controlled Drugs Carried on ALS Units, with recommendation.

6.6 Reference No. 817, Regional Mobile Response Teams *(Nichole Bosson, MD)*

Policy reviewed and approved as written.

M/S/C (Van Slyke/Kazan) Approve: Reference No. 817, Regional Mobile Response Teams

6.7 Reference No. 519, Management of Multiple Casualty Incidents *(Denise Whitfield, MD)*

After lengthy review and discussion, this policy was tabled until additional revisions are completed by the EMS Agency.

TABLED: Reference No. 519, Management of Multiple Casualty Incidents

Due to time restraints the following policies will resume discission at the next Committee meeting on December 18, 2024:

Policies for discussion; No Action required:

6.8 Reference No. 1202.2, Treatment Protocol: Base Contact Requirements *(Denise Whitfield, MD)*

6.9 Reference No. 1209/1209-P, Behavioral / Psychiatric Crisis *(Nichole Bosson, MD and Denise Whitfield, MD)*

7. OPEN DISCUSSION

Deferred until next Committee meeting.

8. NEXT MEETING - December 18, 2024

9. ADJOURNMENT - Meeting adjourned at 3:10 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: 9-1-1 **PROVIDER AGENCY MEDICAL DIRECTOR** REFERENCE NO. 411

PURPOSE: To describe the role and responsibilities of Medical Directors of approved 9-1-1 Los Angeles County Emergency Medical Services (EMS) Provider Agencies.

AUTHORITY: California Health and Safety Code, Division 2.5, 1791.90

DEFINITIONS:

Board Certified (BC): Successful completion of the evaluation process through the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in a particular specialty.

Board Eligible (BE): Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA.

Provider Agency Medical Director: A physician designated by an approved 9-1-1 EMS Provider Agency and approved by the Los Angeles County EMS Agency Medical Director, to provide advice and coordinate the medical aspects of field care, to provide oversight of all medications utilized by EMTs, paramedics, and advanced practice providers, if applicable, including controlled medications, and to oversee the provider's quality improvement process, as defined by the Los Angeles County EMS Agency

PRINCIPLE:

Medical Directors enhance the quality of prehospital care by providing medical expertise in EMS and serve as a liaison between the EMS Agency Medical Director, hospitals, and other Private Ambulance Operator and Public Provider Medical Directors to ensure the delivery of safe and effective medical care.

POLICY

I. 9-1-1 Provider Agency Medical Director

A. Qualifications

1. BC or BE in Emergency Medical Services (EMS) or Emergency Medicine (EM), with proof of significant experience and practice in EMS.

2. Current, unrestricted license to practice as a physician in the State of California

3. Engaged in the practice, supervision, or teaching of EM and/or EMS.

4. Knowledgeable on the current policies, procedures, and protocols of the Los Angeles County EMS Agency.

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

B. Responsibilities

1. Attend an EMS system orientation provided by the EMS Agency within six (6) months of hire.

2. Participate in a field care observation (ride-along) with the sponsoring agency within six (6) months of hire.

3. Attend the annual program review or participate in the exit summary.

4. Attends at least 50% of the Medical Advisory Council meetings. For meetings in which the medical director is unable to be present, designates a representative to attend for the purpose of receiving information.

5. Medical Direction and Supervision of Patient Care

   a. Advises the provider agency in planning and evaluating the delivery of prehospital medical care by EMTs and paramedics.

   b. Reviews and approves the medical content of all EMS training performed by the provider agency and ensures compliance with continuing education requirements of the State and local EMS Agency.

   c. Reviews and approves the medical components of the provider agency's dispatch system.

   d. Assists in the development of policies and procedures to optimize patient care.

   e. Reviews and recommends to the Innovation. Technology and Advancement Committee (ITAC) any new medical monitoring devices under consideration and ensures compliance with State and local regulation.

   f. Evaluates compliance with the legal documentation requirements of patient care.

   g. Participates in direct observation of field responses as needed. Medical direction during a direct field observation may be provided by the Provider Agency Medical Director in lieu of the base hospital under the following conditions:

      i. The EMTs, paramedics, advanced practice providers, if applicable, and Provider Agency Medical Director on scene must be currently employed by, or contracted with, the same provider agency.

      ii. If base contact has already been established, the Provider Agency Medical Director may assume medical direction of patient care. The base hospital shall be informed that the Provider Agency Medical Director is on scene. They are not required to accompany the patient to the hospital.

iii. EMS personnel shall document the involvement of the Provider Agency Medical Director on the EMS Report Form when orders are given.

iv. The receiving hospital shall be notified of all patients whose field care is directed by a Provider Agency Medical Director.

h. Participates as needed with appropriate EMS committees and the local medical community.

i. Ensures provider agency compliance with Los Angeles County EMS Agency controlled substance policies and procedures.

6. Audit and Evaluation of Patient Care

a. Assist the provider agency in the development and implementation of a continuous quality improvement program to ensure the provision of quality medical care. Provides recommendations for training and operational changes based on quality improvement results.

b. Evaluates the adherence of provider agency medical personnel to medical policies, procedures and protocols of the Los Angeles County EMS Agency.

c. Coordinates delivery and evaluation of patient care with base and receiving hospitals.

7. Investigation of Medical Care Issues

a. Reviews incidents with unusual or adverse patient outcomes, inadequate performance of EMS personnel, and complaints related to the delivery of medical care.

b. Evaluates medical performance, gathers appropriate facts and, as needed, forwards those facts in writing to the Los Angeles County EMS Agency Medical Director.

c. Ensures that appropriate actions (e.g., training, counseling, etc.) are taken on cases with patient care issues with adverse outcomes, near misses, etc.

II. Role and Responsibilities of the EMS Provider Agency

A. Designates and maintains a Medical Director at all times.

B. Ensures Medical Director is involved in the development and approval of all medically related policies, procedures, quality improvement and medical dispatch programs, as applicable.

C. Provides the EMS Agency with notification of any changes in the designated Medical Director as specified in Reference No. 621, Notification of Personnel Change.

D. Immediately notify the EMS Agency in the event the Medical Director abruptly resigns or is otherwise unable to fulfill his/her duties and no immediate replacement is available.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 205, **Innovation, Technology and Advancement Committee (ITAC)**
Ref. No. 214, **Base Hospital and Provider Agency Reporting Responsibilities**
Ref. No. 414, **Specialty Care Transport Provider**
Ref. No. 422**, Authorization for Paramedic Provider Status of a Los Angeles County Based Law Enforcement Agency**
Ref. No. 621, **Notification of Personnel Change**
Ref. No. 621.1, **Notification of Personnel Change Form Provider & Training Programs**
Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Ref. No. 702, **Controlled Drugs Carried on ALS and SCT Units**
Ref. No. 816, **Physician at the Scene**

Reference No. 411, 9-1-1 Provider Agency Medical Director

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/16/24	10/16/2024	No
	Base Hospital Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council	9/3/24	09/03/2024	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PRIVATE AMBULANCE OPERATOR MEDICAL DIRECTOR** REFERENCE NO. 420

PURPOSE: To describe the role and responsibilities of Medical Directors of licensed Los Angeles County Private Ambulance Operators.

AUTHORITY: California Health and Safety Code, Division 2.5, 1791.90

DEFINITIONS:

Board Certified (BC): Successful completion of the evaluation process through the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in a particular specialty.

Board Eligible (BE): Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA.

Private Ambulance Operator Medical Director: A physician designated by a licensed EMS Private Ambulance Operator and approved by the Los Angeles County EMS Agency Medical Director, to provide advice and coordinate medical aspects of field care, to include oversight of all medications utilized by EMTs, paramedics, and SCT providers (if applicable) including controlled medications, and oversees the private provider agency's quality improvement process, as defined by the Los Angeles County EMS Agency.

PRINCIPLE:

Medical Directors enhance the quality of prehospital care by providing medical expertise in EMS and serve as a liaison between the EMS Agency Medical Director, hospitals, and other Private Ambulance Operator and Public Provider Medical Directors to ensure the delivery of safe and effective medical care.

POLICY

I. Private Ambulance Operator Medical Director

A. Qualifications:

1. BC or BE in Emergency Medical Services (EMS) or Emergency Medicine (EM), with proof of significant experience and practice in EMS.

2. Current, unrestricted license to practice as a physician in the State of California

3. Engaged in the practice, supervision, or teaching of EM and/or EMS.

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

4. Knowledgeable on the current policies, procedures, and protocols of the Los Angeles County EMS Agency.

B. Responsibilities:

1. Attend an EMS system orientation provided by the EMS Agency within six (6) months of hire.

2. Attend the annual program review(s) – BLS, ALS, SCT or participate in the exit summary.

3. Attends at least 50% of the Medical Advisory Council meetings. For meetings in which the medical director is unable to be present, designates a representative to attend for the purpose of receiving information.

4. Medical Direction and Supervision of Patient Care

   a. Advises the private ambulance operator in planning and evaluating the delivery of prehospital medical care by EMTs and, if applicable, paramedics, nurses, and respiratory therapists.

   b. Reviews and approves the medical content of all EMS training performed by the private ambulance operator. If approved as a continuing education provider in Los Angeles County, ensures compliance with State and local EMS Agency continuing education requirements.

   c. Assists in the development and approval of policies and procedures to optimize patient care.

   d. Evaluates compliance with the legal documentation requirements of patient care.

   e. Provides oversight and participates in the private ambulance operator's Quality Improvement program.

   f. Ensures private ambulance operator compliance with Los Angeles County EMS Agency controlled substance policies and procedures, if applicable.

   g. Participates as needed with appropriate EMS committees and the local medical community.

5. Audit and Evaluation of Patient Care

   a. Assists the private ambulance operator in the development and implementation of a continuous quality improvement program to ensure the provision of quality medical care. Provides

recommendations for training and operational changes based on quality improvement results.

b. Evaluates private ambulance operator medical personnel for adherence to medical policies, procedures and protocols of the Los Angeles County EMS Agency.

c. Provides ongoing periodic review of dispatch and patient care records for identification of potential patient care issues.

d. Reviews the delivery and evaluation of patient care with base and receiving hospitals, as applicable.

6. Investigation of Medical Care Issues

a. Reviews incidents with unusual or adverse patient outcomes, inadequate performance of EMS personnel, and complaints related to the delivery of medical care.

b. Evaluates medical performance and appropriate facts and as needed, forwards those facts in writing to the Los Angeles County EMS Agency Medical Director.

c. Ensures that appropriate actions (e.g., training, counseling, etc.) are taken related to patient care issues with adverse outcomes, near misses, etc.

II. Role and Responsibilities Of The Private Ambulance Operator

A. Designates and maintains a Medical Director at all times.

B. Ensures Medical Director is involved in the development and approval of all medically related policies, procedures, quality improvement and medical dispatch programs, as applicable.

C. Provides the EMS Agency with notification of any changes in the designated Medical Director as specified in Reference No. 621, Notification of Personnel Change.

D. Immediately notify the EMS Agency in the event the Medical Director abruptly resigns or is otherwise unable to fulfill his/her duties and no immediate replacement is available.

CROSS REFERENCE:

Prehospital Care Manual:
Reference No. 226, **Private Provider Agency Non 9-1-1 Medical Dispatch**
Reference No. 414, **Specialty Care Transport Provider**
Reference No. 517, **Private Provider Agency Transport/Response Guidelines**

Reference No. 620, **EMS Quality Improvement Program**
Reference No. 621, **Notification of Personnel Change**
Reference No. 621.1, **Notification of Personnel Change Form Provider Agency & Training Programs**
Reference No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Reference No. 702, **Controlled Drugs Carried on ALS and SCT Units**
Reference No. 816, **Physician at the Scene**

Reference No. 420, Private Ambulance Operator Medical Director

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/16/24	10/16/2024	No
	Base Hospital Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council	9/3/24	09/03/2024	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC, SCT, APRU)

SUBJECT: **CONTROLLED DRUGS CARRIED ON ALS SCT AND APRU UNITS** REFERENCE NO. 702

PURPOSE: To ensure accountability for all controlled drugs issued to Advanced Life Support (ALS), Specialty Care Transport (SCT), and Advanced Practitioner Response (APRU) units.

AUTHORITY: Health and Safety Code, Chapter 5, 1797.220 and 1798
California Business and Professions Code, Section 4005 and 4119 .01, 4034.5
Department of Justice, DEA Regulations, Title 21, Code of Federal Regulations, Section 1300-END
Controlled Substances Act, 21 USC 801-890

DEFINITIONS:

Provider Agency Medical Director: A physician who has been appointed by an approved EMS Provider Agency, meets the criteria outlined in Ref. No. 411, 9-1-1 Provider Agency Medical Director or Ref. No. 420, Private Ambulance Operator Medical Director, is approved by the EMS Agency Medical Director, and agrees to procure controlled drugs under their DEA Registrant, and provide oversight of all medications utilized by EMTs, paramedics, SCT personnel and advanced practice providers, including controlled medications.

Automated Drug Delivery System (ADDS): A mechanical pharmaceutical storage and dispensing system that utilizes computer-controlled tracking of medications.

PRINCIPLES:

1. Effective controls and procedures are essential to guard against theft and diversion of controlled drugs due to the risks associated with mishandling of these drugs.

2. Controlled drugs will be restocked and stored only in full amounts. Unused, partial doses shall be discarded appropriately.

3. Providers shall carry only one narcotic analgesic on the ALS units. Provider Agency Medical Directors who intend to carry Fentanyl, in lieu of morphine sulfate, shall contact the EMS Agency's Medical Director for approval.

4. Implementation of a paperless (electronic tracking) Daily Controlled Inventory Form requires the prior approval of the EMS Agency.

5. Provider agencies may utilize an ADDS for storage and dispensing of controlled drugs.

6. It is the responsibility of the Provider Agency Medical Director to be knowledgeable of the Federal, State, and local regulations that govern controlled drugs.

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

7. Provider Agency Medical Director shall be involved in the development and approval of all medically related policies and/or procedures, including controlled drugs, quality improvement and medical dispatch programs.

8. Formulation of controlled drugs shall adhere to Ref. No. 1309, Color Code Drug Dosages and stocked in single patient use unit dosages.

9. Minimum quantities of the following approved controlled drugs carried on approved ALS, SCT and APRU Units shall be sufficient to treat a minimum of two (2) patients as identified in EMS Agency approved unit inventory policies with maximum inventory quantities identified within each approved EMS Providers controlled drug policy.
   a. Fentanyl
   b. Morphine sulfate
   c. Midazolam

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POLICY:

I. Provider Agencies shall obtain Controlled Drugs through its appointed Medical Director.

II. Controlled Drug Program:

   A. Provider agencies shall maintain a controlled drug program in accordance with the policies and procedures set forth by the EMS Agency.

   B. Provider agencies shall have a policy(s) in place, approved by the EMS Agency, which address, at minimum, the following:

      1. Description of the methodology (safe, etc.) utilized to store controlled drugs in locations other than the ALS unit(s).

      2. Description of the procedure used to track inventory control (restocking and dispensing) of controlled drugs.

      3. Description of procedure for restocking controlled drugs on an ALS unit(s).

      4. Identify the level of personnel who have access to the controlled drug storage area.

III. Controlled Drug Security:

   A. Controlled drug security requirements apply to all provider agencies.

   B. Paramedics assigned to an ALS unit, Registered Nurses (RN) assigned to a SCT unit, and Advanced Practitioners assigned to an APRU shall be responsible for maintaining the correct controlled drug inventory and security of the drug keys (or confidentiality of the keypad/padlock combination) for their assigned unit at all times.

   C. Controlled drugs shall not be stored in any location other than the EMS Agency approved primary storage safe, on ALS, SCT or APRU unit(s) or ADDS. Alternate storage areas shall be reviewed and authorized by the EMS Agency prior to implementation. The authorization process requires EMS Agency

inspection of the storage facility and approval of the provider agency internal policy specifying the location, security, access, and procedure for obtaining drugs from the alternate controlled drug locations. If utilizing an electronic system to track controlled substances, there must be an electronic entry by two authorized personnel anytime the secured storage container is accessed, in addition to a physical count of the inventory conducted.

D. Controlled drugs shall be secured on the ALS, SCT or APRU unit(s) under double lock. Provider agencies that have more than one approved ALS/SCT/APRU unit must have unique double locking mechanisms for each ALS/SCT/APRU unit.

E. Daily Inventory Procedures of controlled drugs on an ALS, SCT or APRU unit:

1. Controlled drugs shall be inventoried by physical count by two paramedics for ALS; two RNs or one paramedic and one RN for SCT; or one advanced practitioner and one RN or paramedic for APRU, at least daily, and anytime there is a change in personnel.

2. The key to access-controlled drugs shall be in the custody of the individual who performed the inventory.

3. The Daily Controlled Drug Inventory Form, Ref. No. 702.2 or its equivalent, shall be co-signed with the names of the relinquishing and the receiving paramedic or RN or advanced practitioner, as applicable. Entries shall be in blue or black ink only, or electronic equivalent.

4. Errors shall be corrected by drawing a single line through the incorrect wording; the writing underneath the single line must remain readable. The individual making the change should initial adjacent to their correction. Correction fluid or other erasure material is not permitted.

5. The Daily Controlled Drug Inventory Form, Ref. No. 702.2 or its equivalent, must be maintained by the provider agency for a minimum of three years. An entry shall be made on this form for each of the following situations:

    a. Change of shift.

    b. Any change to the controlled drug inventory.

    c. Any time there is a change of responsible personnel.

    d. Providers authorized to participate in the 1:1 Staffing Program for Interfacility Transports are required to inventory controlled drugs at the end of the specified shift, when two paramedics are available to count and co-sign for the drugs.

F. Electronic (paperless) Daily Inventory Procedures of Controlled drugs on an ALS, SCT or APRU unit

1. To implement an electronic tracking system for daily inventory, the provider agency shall choose a system that meets the following requirements

    a. The system must fulfill all requirements listed in section III-C and E-5 above and possess the ability to produce a printed or electronic daily drug inventory report by, at minimum, calendar month.

    b. Electronic documentation must verify the identity of the receiving and relinquishing party at change of shift or change of responsible personnel, when medications are used, and at the time of restocking.

    c. Access to the system shall require at minimum, an employee identification number and a personal identification number. Biometric (fingerprint, retinal scan, etc.) may be used in addition to or in lieu of the above requirements and is strongly encouraged.

    d. The system must comply with all federal, state, and local regulations/policies.

    e. The provider agency must have the ability to revert to a paper system in the event of temporary or long-term downtime of the electronic system.

G. Lost or Missing Controlled Drug

a. Any lost, missing, or discrepancy of controlled drugs shall be reported by the following business day (telephone notification is acceptable) to the paramedic coordinator, the EMS Agency, and the authorizing Provider Agency Medical Director. Verbal notification must be followed by a written report within three business days including completion of Ref. No. 702.3, Lost/Missing Controlled Drug Reporting Form.

b. A police report must be completed for any missing, lost, or suspected diversion of a controlled drug.

c. Any significant loss, breakage, or discrepancy in the count requires notification to the DEA, utilizing DEA Form 106 or electronically via the DEA web site, within one business day of discovery.

d. Any loss shall initiate supervisory review at the involved provider agency. If a provider agency's internal investigation into a controlled drug loss exceeds 30 days, the provider shall submit a status update to the Provider Agency Medical Director and the EMS Agency at the 30th day.

H. Disposal of controlled drugs

The provider agency shall dispose of expired controlled drugs through a DEA licensed pharmaceutical reverse distributor and/or by implementing the

guidelines outlined in the Code of Federal Regulations, 1317, Disposal of Controlled Substance by Registrants.

IV. Record Keeping:

A. All controlled drugs issued to a provider agency must be accounted for. The provider agency shall retain a copy (printed or electronic) of the Patient Care Record (PCR) for each patient to whom a controlled drug was administered and maintain it with any completed controlled drug inventory and report forms, drug orders, invoices, or other associated documentation in a separate file for a minimum of three years.

B. If the total amount of the drug is not administered, the remaining amount shall be wasted at the receiving facility, or in a container approved for destruction of controlled drugs.

1. Document the amount of wasted drugs (partial or whole) in the “Drug Waste/Witness” section of the PCR.

2. Obtain the signature of the witness who observed the disposal of the remaining solution and print the witness’ name on the PCR. A witness shall include a registered nurse, physician, pharmacist, or if none of these options are available, a second paramedic with a current California paramedic license.

C. Controlled drug inventories and logs are subject to inspection by the EMS Agency, the issuing pharmacy, the California Board of Pharmacy, and agents of the Bureau of Narcotic Enforcement Administration of the Department of Justice, and the Federal Drug Enforcement Administration.

V. ADDS

Provider agencies that use ADDS for storage and dispensing of controlled drugs are responsible for ensuring compliance with State and Federal regulations as it relates to implementing and maintaining the system.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 214, **Base Hospital and Provider Agency Reporting Responsibilities**
Ref. No. 411, **9-1-1 Provider Agency Medical Director**
Ref. No. 420, **Private Ambulance Operator Medical Director**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Ref. No. 702.1, **Provider Agency Medical Director Notification of Controlled Drug Program Implementation**
Ref. No. 702.2, **Daily Controlled Drug Inventory Form**
Ref. No. 702.3, **Lost / Missing Controlled Drug Reporting Form**
Ref. No. 702.4, **Monthly Drug Storage Inspection Form**
Ref. No. 703, **ALS Unit Inventory**

Ref. No. 703.1, **Private Provider Interfacility Transfer ALS Unit Inventory**
Ref. No. 706, **ALS EMS Aircraft Inventory**
Ref. No. 712, **Nurse Staffed Specialty Care Transport Unit Inventory**
Ref. No. 719, **Fireline Emergency Medical Technician-Paramedic (FEMP) Inventory**

Reference No. 702, Controlled Drugs Carried on ALS, SCT and APRU Units

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/16/24	10/16/2024	Yes
	Base Hospital Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council	9/3/24	09/03/2024	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

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

REFERENCE NO. 702, Controlled Drugs Carried on ALS, SCT and APRU Units

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
ALL	PAAC 10/16/2024	Add “APRU” throughout policy whenever “SCT” is referenced	Changes Made

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

(EMT, PARAMEDIC, MICN)

SUBJECT: **ELDER ABUSE AND DEPENDENT ADULT ABUSE REPORTING GUIDELINES**

REFERENCE NO. 823

PURPOSE: To define the required reporting procedures for prehospital care personnel regarding known or suspected elder or dependent adult abuse.

AUTHORITY: Welfare and Institutions Code, Division 9, Sections 15600, et seq.

DEFINITIONS:

Abandonment: The desertion or willful forsaking of an elder or dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care or custody.

Abuse of an elder or a dependent adult: Physical abuse (including sexual abuse), neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or mental suffering, or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

Dependent Adult: Any person between the ages of 18 and 64 years, who has physical or mental limitations that restrict their ability to carry out normal activities or to protect their rights. This includes, but is not limited to, persons who have physical or developmental disabilities. It also includes individuals whose physical or mental abilities have diminished because of age, as well as any 18 to 64 year-old who is admitted as an inpatient to a 24-hour health facility.

Elder: Any person who is 65 years of age or older.

Mandated Reporter: Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency, or a local law enforcement agency is a mandated reporter.

Neglect: The negligent failure of any person having care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a like position would exercise.

Physical abuse: Assault, battery, unreasonable physical constraint, prolonged or continual deprivation of food or water, sexual assault or battery or rape (including spousal rape, incest, sodomy, oral copulation, or penetration by a foreign object).

Reasonable suspicion: An objectively reasonable suspicion of abuse that a person should entertain, based upon the facts, and drawing upon the person's training and experience.

Self-neglect: Failure of the elder or dependent adult to exercise a reasonable degree of care in providing for their own needs in such areas as personal hygiene, food, clothing, and shelter.

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

PRINCIPLES:

1. Elder and dependent adults may be subjected to abuse, neglect, or abandonment.

2. Health care providers are mandated to report known or suspected abuse, neglect or self-neglect of elder or dependent adults to protect and ensure the safety of these individuals.

3. When two or more mandated reporters are present at the scene and jointly have knowledge of a known or reasonably suspected instance of elder or dependent adult abuse, the telephone report can be made by a selected member of the reporting team. Any member who has knowledge that the designated reporter failed to uphold their agreement shall thereafter make the report. Transfer of care to the hospital does not meet the reporting obligation.

4. Reports made under this law are confidential. The identity of persons making reports of elder or dependent adult abuse is also confidential. This information is shared between the investigating and licensing agencies. This information will be shared with the district attorney in a criminal prosecution resulting from the report, by court order, or when the reporter waives confidentiality.

5. Reporting is the individual responsibility of the mandated reporter. No supervisor or administrator may prohibit the filing of the required report.

POLICY:

I. EMTs, Paramedics, and Mobile Intensive Care Nurses (MICNs) are mandated reporters and shall file a telephone and written report whenever, in their professional capacity or within the scope of their employment, the following occurs:

   A. The reporter has observed or has knowledge of an incident or injury that reasonably appears to be the result of abuse, neglect, or self-neglect; or

   B. The reporter is told by an elder or a dependent adult that he or she has experienced behavior constituting abuse, neglect, or self-neglect; or

   C. The reporter reasonably suspects abuse, neglect, or self-neglect.

II. Mandated reporters have immunity from civil and criminal liability for making a good faith report of a known or suspected elder or dependent adult abuse. This immunity includes taking photographs of the victim to submit with the report.]

III. Failure to report abuse, neglect, or self-neglect of an elder or dependent adult is a misdemeanor, punishable by not more than six months in the county jail or by a fine of $1,000 or both. A mandated reporter who willfully fails to report abuse, neglect, or self-abuse of an elder or dependent adult, where that abuse results in death or great bodily injury, is punishable by not more than one year in the county jail or by a fine of not more than $5,000 or both.

IV. Reporting Procedures:

A. For an abuse allegedly caused by another resident of a long-term care facility diagnosed with dementia by a licensed physician with no evidence of serious bodily harm, the Report of Suspected Dependent Adult/Elder Abuse Form SOC 341 (Reference No. 823.1) shall be submitted within 24 hours to the following:

1. Local law enforcement agency and

2. Long Term Care Ombudsman
1527 Fourth Street, 2nd Floor
Santa Monica CA 90401
Central intake: (800) 334-9473
After Hours Crisis Line: (800) 231-4024
Email: ombudsman2@wiseandhealthyaging.org

B. For all other instances of abuse, a verbal report and a written report shall be submitted.

1. Verbal Reports

a. Reports of abuse, neglect, self-neglect **shall be made immediately, no later than two (2) hours**, **by telephone** to the local law enforcement agency by calling 9-1-1 or non-emergency number.

Reports are to include the following information, if available:

i. The name, address, telephone number, and occupation of the person making the report;

ii. The name, address, and age of the elder or dependent adult;

iii. Date, time, and place of the incident;

iv. Other details, including the reporter's observations and beliefs concerning the incident;

v. Any statement relating to the incident made by the victim;

vi. The name(s) of any individual(s) believed to have knowledge of the incident; and

vii. The name(s) of the individual believed to be responsible for the incident and their relationship to the victim.

2. Written Reports

a. The Report of the Suspected Dependent Adult/Elder Abuse form SOC 341 (Ref. No. 823.1) must be completed and submitted **within 24 hours of the initial verbal report**. Form SOC 341 (Ref.

No. 823.1) is available on the EMS Agency website at: http://file.lacounty.gov/SDSInter/dhs/206345_823-1.pdf

Reports shall be submitted according to the following:

i. Suspected/known abuse that occurred in a **long-term care facility, skilled nursing facility, licensed nursing home, rehabilitation center, intermediate care facility or adult day health care program:**

   a. Local law enforcement agency

   b. Long Term Care Ombudsman
   1527 Fourth Street, 2nd Floor
   Santa Monica CA 90401
   Central Intake: (800) 334-9473
   After Hours Crisis Line: (800) 231-4024
   Email:ombudsman2@wiseandhealthyaging.org

   c. California Department of Public Health
   Licensing and Certification
   Los Angeles Central Intake: (562) 345-6884;
   Fax (562) 409-5096
   To make a complaint online:
   https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/Complaint.aspx

ii. Suspected/know abuse that occurred in a **residential care facility, assisted living facility, board and care home or adult day program**:

   a. Local Law enforcement agency

   b. Long Term Care Ombudsman
   1527 Fourth Street, 2nd Floor
   Santa Monica CA 90401
   Central Intake: (800) 334-9473
   After Hours Crisis Line: (800) 231-4024
   Email:
   ombudsman2@wiseandhealthyaging.org

   c. California Department of Social Services
   Community Care Licensing Division
   Email: letusno@dss.ca.gov
   To make a complaint online: File a complaint (ca.gov)
   (844) 538-8766

iii. Suspected/known abuse that occurred in the community, such as **private dwellings, independent senior living apartments, or state developmental centers**:

a. Local law enforcement agency

b. California Department of Social Services Adult Protective Services (APS)
Los Angeles County Aging and Disabilities Department
510 S. Vermont Ave. 11th Floor Los Angeles, CA 90020
24-hour Abuse Hotline:(877) 477-3646
Email: LetUsNo@dss.ca.gov
To make a complaint online:
https://hsslacountyprod.wellsky.com/assessments/?WebIntake=A6DCB64F-7D31-4B6D-88D6-0A8FA7EA505F

iv. Suspected/known abuse that occurred in a **State Mental Hospital**:

a. Local law enforcement agency and

b. California Department of State Hospitals Ombudsman Email:
DSHOmbudsman@dsh.ca.gov
(844) 210-6207

3. For non-emergency or non-life threatening reports that do not require an immediate response from APS, online reporting is available via the following link:
https://hsslacountyprod.wellsky.com/assessments/?WebIntake=A6DCB64F-7D31-4B6D-88D6-0A8FA7EA505F

V. EMS Report Form Documentation:

Document the name of the responding agency (i.e., EMS Provider, Law Enforcement) designated to meet the reporting obligation in the narrative section of the EMS Report Form.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 823.1, **Report of Suspected Dependent Adult/Elder Abuse Form (SOC 341)**
Ref. No. 823.1a, **Report of Suspected Dependent Adult/Elder Abuse Form Instructions**

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

REFERENCE NO. 823, Elder Abuse and Dependent Adult Abuse Reporting Guidelines

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy IV	BHAC 08/14/2024	Verify abuse in residential care facility is reported the same as that occurring in long-term care, assisted living, and adult day care centers.	Changes Made

Reference No. 823, Elder Abuse and Dependent Adult Abuse Reporting Guidelines

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	8/14/24	8/14/2024	No
	Base Hospital Advisory Committee	8/14/24 10/09/24	10/09/2024	Yes
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)

[DRAFT] Medical Control Guideline: Evaluation and Care of Patients At Risk of Suicide

DEFINITIONS:

5150 / 5585 (AKA "Hold", "Psychiatric Hold", "Mental Health Hold", or "LPS Hold"): Refers to California Welfare and Institutions Code (WIC) section 5150 et seq. which describes the legal standard for involuntary detainment and evaluation of a person who, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled. "5150" refers to the code for adult patients, "5585" refers to the code for minors (under age 18).

LPS-Evaluator: An individual that is authorized under CA WIC 5150 to evaluate and place a patient on a 5150/5585 hold application, such as all law enforcement (LE) personnel and clinicians that are LPS-authorized by the County Department of Mental Health, for example mental health assessment clinicians (Psychiatric Emergency Team (PET), Psychiatric Mobile Response Team (PMRT), Mental Evaluation Team (MET), Systemwide Mental Assessment Response Teams (SMART), or others). LPS refers to "Lanterman-Petris-Short", the names of the original state legislators who authored the CA WIC 5150 et seq. code.

LPS facility: Treatment facilities that are specifically designated by the county for mental health evaluation and treatment, approved by the State Department of Health Care Services, and licensed as a health facility as defined in subdivision (a) or (b) of Section 1250 or 1250.2 of the Health and Safety Code.

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

Danger to Self: A term used in CA WIC 5150 et seq, to define probable cause for detaining a patient involuntarily for the purpose of evaluation, who as a result of a mental illness poses a risk to themselves (e.g., has suicidal ideation or behavior).

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

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

A person may lack decision-making capacity as follows:

- Temporarily lost (e.g., due to unconsciousness, influence of mind-altering substances, mental illness, or cognitive impairment)
- Permanently lost (e.g., due to irreversible coma, persistent vegetative state, untreatable brain injury, or dementia)
- Never existed (i.e., due to profound neurodevelopmental or medical disorder),
- Legally determined to lack capacity (i.e. persons who are deemed incompetent by a Court, or a person under conservatorship)

Suicide Risk Assessment: A thorough and systematic evaluation that is typically performed by a trained mental health clinician, to confirm suspected suicide risk, to estimate the immediate danger, and to delineate treatment. A suicide risk assessment may utilize structured clinical questionnaires and/or open-ended detailed clinical assessments that consider the patient's

thoughts and behaviors, chronic and acute risk factors, protective factors, and medical and mental health history.

Suicide Risk Screening: A standardized method to identify individuals who may be at risk for suicide, and in most cases to estimate a patient's current level of risk for suicide by asking specific questions about a patient's thoughts, feelings, and behaviors. The Columbia Suicide Severity Rating Scale (C-SSRS, https://cssrs.columbia.edu/) is a commonly used, evidence-based method of suicide risk screening that can be administered by a variety of personnel, such as all healthcare personnel, law enforcement personnel, educators, clergy, and the lay public. See MCG XXX.1 for C-SSRS.

(Note: The C-SSRS is validated in patients from ages 6 and above, though many younger children can also understand the questions.)

Self-injurious behaviors: Behaviors in which a person intentionally harms themselves, with or without intent to die (a patient's intent to die must be specifically asked, or implied). For example, patients may "self-harm" (e.g., cutting, burning, or punching oneself), without intent to die, as a means of attempting to cope with emotional distress or psychological pain.

Suicidal behaviors: Self-injurious behavior with the intent to die.

Suicidal Ideation (SI): Thoughts of death or ending one's life, including the following:

- **Passive SI:** A wish to be dead or to go to sleep and not wake-up **(C-SSRS Q1)**
- **Active SI:** Actual thoughts of wanting to kill oneself **(C-SSRS Q2)**
- **Suicide Method**: Contemplation of one or more ways or means of ending their life, *without* formulating a specific plan **(C-SSRS Q3)**
- **Suicidal Intent**: Intention to carry out suicidal thoughts or behaviors, with the specific goal to kill oneself or to die **(C-SSRS Q4)**
- **Suicide Plan**: Specific thoughts of converting a method (ways or means) to a plan, such as: the timing, and/or preparations (e.g., gathering pills, acquiring a weapon, writing a suicide note, researching the location for a traumatic/deadly injury) needed to end their life **(C-SSRS Q5)**

Suicide Attempt: A self-injurious behavior where a person specifically intends to die **(C-SSRS Q6)**

Suicide: Death caused by self-injurious behavior with any intent to die as a result of that behavior. (Note: The following terms are discouraged from use: "completed suicide", "successful suicide", and "failed suicide". Preferred terms are "suicide" and "suicide attempt".)

Safety Planning: Interventions made by healthcare personnel, first responders, or others, to reduce the patient's risk of suicide or self-harm.

9-8-8: The three digit emergency number for the 24/7 National Suicide and Crisis Lifeline that provides free and confidential emotional support to people in suicidal crisis or emotional distress.

PRINCIPLES:

1. Psychiatric emergencies (including those related to mental health and substance abuse) are emergent clinical conditions, and as such are best treated by EMS personnel who are trained, equipped, and experienced to evaluate and manage such patients.

GUIDELINES:

1. Evaluate the patient for medical conditions immediately if the patient has made a suicide attempt or is suspected of making a suicide attempt. Manage medical conditions with the appropriate treatment protocol based on provider impression.

2. Establish rapport with the patient to facilitate trust and open communication and to optimize the screening and evaluation of suicide risk.

    A. Evaluate the reliability of information, especially in situations where a patient may be suspected of minimizing or evading questions about SI or self-injurious behaviors.
    B. Obtain information from key third parties to assist with the screening and evaluation of suicide risk, when feasible.

3. To assist with evaluating the level of risk for patients with reported or suspected suicidal ideation or behavior, it is recommended to utilize the Columbia Suicide Severity Risk Scale (C-SSRS) to administer standardized suicide risk screening questions. (MCG XXX.1). C-SSRS questions should be asked verbatim, all instructions should be followed, and attention paid to the specified time frames.

    For additional recommendations regarding disposition, refer to MCG XXX.1

4. When a patient has been evaluated by LE or an LPS-Evaluator regarding placement of a 5150/5585 hold, that evaluation shall generally take precedence in determining patient disposition.
    A. Exceptions include when the EMS provider determines that the patient has a medical need that requires transport to a medical facility. (e.g., need for evaluation for trauma or other emergency physical conditions)
    B. For patients that do not meet criteria for a hold, Base contact is required for AMA.

5. In situations where there may be disagreement with LE or an LPS-evaluator regarding the placement or non-placement of a 5150/5585 hold, and/or transport that cannot be resolved, the following steps should be taken.
    A. EMS provider shall contact higher authority (e.g. EMS Captain or Battalion Chief) to seek resolution, which may be facilitated by a call with the LE or LPS higher authorities.
    B. LE provider should contact higher authority (e.g. Field supervisor or Watch commander).
    C. LPS evaluators (such as PET, SMART, MET) should contact higher authority
    D. In cases of continued disagreement, EMS personnel may contact LAC EMSA Medical Alert Center ((562) 378-1789) to discuss with the EMS Medical Officer On-Duty (MOD).

6. Safety planning: EMS providers can perform safety planning to help reduce the patient's risk of suicide or self-harm with the following interventions:
    A. **Establish mental health services:** Provide the national suicide lifeline phone number (9-8-8), and recommend the patient call their mental health provider, or take steps to establish mental health care (e.g., LA County Department of Mental Health 800-854-7771, or contact their insurance provider)
    B. **Help the patient identify support contacts:** Identify a family member, friend or other trusted individual who they can reach out to for help and recommend that they be accompanied or supported in the short term.

C. **Reduce access to suicide means:** Provide direction to the patient or key third parties (e.g., family, friends) to remove or secure any identified or potential means of suicide, especially firearms, knives, pills, or other toxins.
    I. Firearms can be secured through use of gun locks, storage lockers, or transferred to family or friend for safekeeping. LE personnel can also be contacted to advise about securing firearms.
D. **Reduce the risk of alcohol or drugs**: Recommend that the patient avoid use of alcohol or any other drugs, and/or take steps to limit their availability.

DRAFT - MCG XXX.1 Recommended Standardized Screening for Suicide Risk: Columbia Suicide Severity Risk Scale (C-SSRS)

Instructions: Ask questions in quotations, mark "yes" or "no".
Follow the instructions in the grey prompts.

	YES	NO	EMS Decision Support
1. "In the past month, have you wished you were dead or wished you could go to sleep and not wake up?" *(Passive SI)*	low risk		Low Risk: Recommend voluntary evaluation at MAR/PUCC. • If patient refuses, and has decision making capacity, contact Base to discuss AMA and engage in safety planning. • If patient refuses, and lacks decision making capacity, contact LE or LPS evaluator for eval of a 5150/5585 hold. If pt does not meet hold criteria, contact Base to discuss AMA.
2. "In the past month, have you actually had any thoughts about killing yourself?" *(Active SI)*	low risk		
If YES to 2, ask questions 3, 4, 5 and 6 **If NO to 2, ask question 6**			
3. "Have you thought about how you might do this?" *(Suicide method)*	moderate risk		Moderate or High Risk: Immediate mental health evaluation is indicated, transport to MAR/PUCC. • Maintain close observation of the patient and awareness of the potential for elopement or self-injurious behavior • For patients who refuse transport, contact law enforcement (or LPS evaluator) for eval of a 5150 / 5585 hold. If pt does not meet hold criteria, contact Base to discuss AMA.
4. "Have you had any intention of acting on these thoughts of killing yourself" (as opposed to you have the thoughts but you definitely would not act on them)? *(Suicide intent)*	high risk		
5. "Have you started to work out, or worked out, the details of how to kill yourself? Do you intend to carry out this plan?" *(Suicide plan)*	high risk		
Always Ask Question 6			
6a. "Have you *ever* done anything, started to do anything, or prepared to do anything to end your life?" Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, went to the roof but didn't jump, tried to hang yourself, etc. *(Suicide attempt)*	moderate risk		
6b. "Was this in the past 3 months?" *(Suicide attempt, recent)*	high risk		

MAR = Most Accessible Receiving facility, PUCC = Psychiatric Urgent Care Center (Ref No. 526)

Recommended guidance for disposition:

Determination of patient disposition shall consider all information obtained during the field evaluation and should not rely solely on the results of the C-SSRS screening, including: the patient's medical and behavioral or psychiatric condition, as well as any mental health evaluation performed by an LPS-Evaluator, if applicable.

6. Patients who are low-risk should receive a voluntary evaluation at the MAR or PUCC (Reference No. 526, Behavioral / Psychiatric Crisis Patient Destination).
    A. For patients with decision-making capacity (or guardians in the case of minors) who refuse transport, and who have not been placed on a 5150/5585 hold, contact Base to discuss AMA.
    B. Patients who lack capacity, (or who are uncooperative, unreliable, or unable to engage in their treatment and safety planning), should be transported to MAR/PUCC for further evaluation. For patients who refuse transport, contact LE or an LPS-Evaluator for evaluation of a 5150/5585 hold. If patient does not meet criteria for hold, contact Base to discuss AMA.

2. Patients who are moderate-risk or high-risk require immediate mental health evaluation at the MAR or PUCC (Ref No. 526).
    A. Maintain close observation of the patient and awareness of the potential for elopement or self-injurious behavior
    B. For patients who refuse transport, contact LE or an LPS-Evaluator for evaluation of 5150/5585 hold. Results from the field evaluation and C-SSRS should be shared with LE or LPS-Evaluator. If patient does not meet criteria for hold, contact Base to discuss AMA.

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY PROVIDER

Time Period July 1, 2024 through September 30, 2024

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

EMS Provider Agency	Code	Total # of records	# of valid records	% of valid records	Q3 2024								90th percentile (hh:mm:ss)
					≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		
Alhambra Fire Department	AH	981	981	100%	950	97%	25	3%	6	0.6%			00:18:00
Arcadia Fire Department	AF	844	844	100%	753	89%	82	10%	9	1%			00:31:00
Avalon Fire Department	AV	10	10	100%	10	100%							00:02:00
Beverly Hills City Fire Department	BH	813	813	100%	602	74%	158	19%	53	7%			00:51:00
Burbank Fire Department	BF	1,503	1,502	100%	1,259	84%	219	15%	24	2%			00:35:00
Compton Fire Department	CM	1,385	1,385	100%	1,378	99%	7	0.5%					00:10:00
Culver City Fire Department	CC	936	936	100%	669	71%	177	19%	78	8%	12	1%	00:58:00
Downey Fire Department	DF	1,498	1,498	100%	1,135	76%	222	15%	106	7%	35	2%	00:59:00
El Segundo Fire Department	ES	329	329	100%	308	94%	19	6%	2	0.6%			00:29:00
Glendale Fire Department	GL	2,860	2,860	100%	2,347	82%	417	15%	87	3%	9	0.3%	00:40:00
La Habra Heights Fire Department	LH	24	24	100%	23	96%	1	4%					00:25:00
La Verne Fire Department	LV	739	739	100%	639	86%	57	8%	37	5%	6	0.8%	00:36:00
LACoFD	CF	101	101	100%	100	99%	1	1%					00:17:07
LAFD	CI	49,253	49,252	100%	41,422	84%	6,234	13%	1,454	3%	142	0.3%	00:37:41
Long Beach Fire Department	LB	7,155	7,155	100%	5,735	80%	886	12%	362	5%	172	2%	00:51:00
Los Angeles County Sheriff's Department	CS	10	10	100%	10	100%							00:06:00
Manhattan Beach Fire Department	MB	407	407	100%	395	97%	11	3%	1	0.2%			00:19:00
Monrovia Fire Department	MF	686	686	100%	675	98%	11	2%					00:17:00
Montebello Fire Department	MO	981	981	100%	967	99%	14	1%					00:16:00
Monterey Park Fire Department	MP	713	713	100%	702	98%	10	1%	1	0.1%			00:11:00
Pasadena Fire Department	PF	2,437	2,437	100%	2,156	88%	234	10%	45	2%	2	0.1%	00:33:00
Redondo Beach Fire Department	RB	77											00:00:00
San Gabriel Fire Department	SG	340	340	100%	337	99%	3	0.9%					00:15:00
San Marino Fire Department	SA	185	184	99%	160	87%	19	10%	4	2%	1	0.5%	00:34:00
Santa Fe Springs Fire Rescue	SS	244	244	100%	238	98%	6	2%					00:13:00
Santa Monica Fire Department	SM	1,214	752	62%	732	97%	15	2%	5	0.7%			00:19:00
Sierra Madre City Fire Department	SI	190	190	100%	173	91%	15	8%	2	1%			00:29:00
South Pasadena Fire Department	SP	227	227	100%	201	89%	22	10%	4	2%			00:32:00
Torrance Fire Department	TF	868	804	93%	602	75%	158	20%	41	5%	3	0.4%	00:47:32
West Covina Fire Department	WC	1,133	1,133	100%	1,021	90%	98	9%	12	1%	2	0.2%	00:30:00
*American Medical Response**	AR	2,499	2,499	100%	1,901	76%	452	18%	116	5%	30	1%	00:47:44
Falck Mobile Health Corp. (Care Ambulance)	CA	30,342	30,144	99%	18,878	63%	7,301	24%	3,114	10%	851	3%	01:09:17
*Westmed Ambulance Inc. (McCormick Ambulance)**	WM	8,977	8,977	100%	5,310	60%	2,713	30%	777	8%	177	2%	00:51:36
TOTAL ALL PROVIDERS		***119,961***	***119,157***	**99%**	***91,788***	***77%***	***19,587***	***16%***	***6,340***	***5%***	***1,442***	***1%***	***00:48:55***

Data with eDisposition.21 and eDisposition.30 "ON".
* Incomplete data submitted

% total may not equal 100% due to rounding.
Data source: ESO Suite (10/22/2024)

Los Angeles County Emergency Medical Services Agency

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

Time Period July 1, 2024 through September 30, 2024

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

HOSPITAL	Filters on*		Total # of records	# of valid records	% of valid records	Q3 2024									
	Total # of records	# of valid records				≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	% of Time on Diversion
ANTELOPE VALLEY - NEWHALL REGION															
Antelope Valley Medical Center	2,533	2,533	8,199	4,295	52%	3,405	79%	645	15%	190	4%	55	1%	0:45:36	19%
Henry Mayo Newhall Memorial Hospital	2,102	2,102	5,900	3,712	63%	3,305	89%	335	9%	57	2%	15	0.4%	0:31:37	3%
Palmdale Regional Medical Center	1,548	1,548	4,939	2,594	53%	2,129	82%	382	15%	65	3%	18	0.7%	0:39:00	6%
ANTELOPE VALLEY TOTAL	*6,183*	*6,183*	*19,038*	*10,601*	*56%*	*8,839*	*83%*	*1,362*	*13%*	*312*	*3%*	*88*	*0.8%*	*0:38:58*	*9%*
SAN FERNANDO VALLEY REGION															
Adventist Health Glendale	2,321	2,321	2,480	2,453	99%	1,960	80%	396	16%	95	4%	2	0.1%	0:42:02	1%
Dignity Health - Glendale Memorial Hospital & Health Center	1,399	1,399	1,469	1,467	100%	1,298	88%	143	10%	23	2%	3	0.2%	0:32:41	6%
Dignity Health - Northridge Hospital Medical Center	3,768	3,768	4,360	4,350	100%	3,864	89%	404	9%	77	2%	5	0.1%	0:31:24	12%
Encino Hospital Medical Center	394	394	444	444	100%	421	95%	16	4%	6	1%	1	0.2%	0:18:49	
Kaiser Foundation Hospital - Panorama City	831	831	909	907	100%	799	88%	96	11%	11	1%	1	0.1%	0:32:12	40%
Kaiser Foundation Hospital - Woodland Hills	585	585	735	664	90%	580	87%	65	10%	17	3%	2	0.3%	0:34:22	43%
Mission Community Hospital	1,022	1,022	1,161	1,160	100%	1,082	93%	71	6%	7	0.6%			0:26:40	8%
Olive View-UCLA Medical Center	872	872	997	971	97%	853	88%	85	9%	33	3%			0:33:31	42%
Pacifica Hospital of the Valley	663	663	737	737	100%	722	98%	14	2%	1	0.1%			0:18:44	37%
Providence Cedars-Sinai Tarzana Medical Center	1,081	1,081	1,302	1,253	96%	1,101	88%	140	11%	12	1%			0:32:13	22%
Providence Holy Cross Medical Center	1,953	1,953	2,312	2,285	99%	2,157	94%	103	5%	21	1%	4	0.2%	0:22:59	33%
Providence Saint Joseph Medical	3,769	3,768	4,258	4,130	97%	3,234	78%	789	19%	103	2%	4	0.1%	0:41:00	14%
Sherman Oaks Hospital	1,464	1,464	1,651	1,651	100%	1,500	91%	133	8%	18	1%			0:28:51	4%
UCLA West Valley Medical Center	1,724	1,724	2,219	1,982	89%	1,610	81%	312	16%	60	3%			0:39:27	19%
USC Verdugo Hills Hospital	488	488	764	593	78%	433	73%	109	18%	36	6%	15	3%	0:57:53	35%
Valley Presbyterian Hospital	1,586	1,586	1,790	1,789	100%	1,658	93%	104	6%	26	1%	1	0.1%	0:25:13	18%
SAN FERNANDO VALLEY TOTAL	*23,920*	*23,919*	*27,588*	*26,836*	*97%*	*23,272*	*87%*	*2,980*	*11%*	*546*	*2%*	*38*	*0.1%*	*0:34:15*	*21%*
SAN GABRIEL VALLEY REGION															
Alhambra Hospital Medical Center	708	708	759	759	100%	721	95%	34	4%	4	0.5%			0:22:00	7%
Emanate Health Foothill Presbyterian Hospital	1,516	1,496	3,066	2,029	66%	1,437	71%	433	21%	143	7%	16	0.8%	0:54:02	1%
Emanate Health Inter-Community Hospital	1,498	1,488	2,800	2,009	72%	1,625	81%	315	16%	67	3%	2	0.1%	0:41:33	
Emanate Health Queen of the Valley Hospital	2,955	2,923	5,248	3,750	71%	2,965	79%	597	16%	159	4%	29	0.8%	0:44:50	1%
Garfield Medical Center	1,035	1,035	1,301	1,156	89%	1,110	96%	31	3%	11	1%	4	0.3%	0:16:25	6%
Greater El Monte Community Hospital	1,102	1,097	2,337	1,420	61%	1,085	76%	245	17%	79	6%	11	0.8%	0:48:22	16%
Huntington Hospital	3,972	3,969	4,910	4,390	89%	3,855	88%	436	10%	93	2%	6	0.1%	0:33:50	7%

* data with eDisposition.21 and eDisposition.30 filters "on"

% total may not equal 100% due to rounding.

Data source: ESO Suite (10/22/2024)

Los Angeles County Emergency Medical Services Agency

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

Time Period July 1, 2024 through September 30, 2024

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

HOSPITAL	Filters on*		Total # of records	# of valid records	% of valid records	Q3 2024									
	Total # of records	# of valid records				≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	% of Time on Diversion
Kaiser Foundation Hospital - Baldwin Park	1,358	1,349	2,627	1,673	64%	1,018	61%	389	23%	211	13%	55	3%	1:19:58	26%
Monterey Park Hospital	430	430	504	450	89%	427	95%	17	4%	5	1%	1	0.2%	0:21:40	2%
Pomona Valley Hospital Medical Center	5,037	4,976	9,763	6,862	70%	5,332	78%	1,062	15%	394	6%	74	1%	0:48:40	12%
San Dimas Community Hospital	721	716	1,435	1,009	70%	851	84%	92	9%	49	5%	17	2%	0:43:55	3%
San Gabriel Valley Medical Center	630	630	838	654	78%	576	88%	46	7%	28	4%	4	0.6%	0:34:38	3%
USC Arcadia Hospital	3,780	3,766	5,510	4,465	81%	3,582	80%	652	15%	191	4%	40	0.9%	0:44:02	3%
SAN GABRIEL VALLEY TOTAL	*24,742*	*24,583*	*41,098*	*30,626*	*75%*	*24,584*	*80%*	*4,349*	*14%*	*1,434*	*5%*	*259*	*0.8%*	*0:45:00*	*7%*
EAST REGION															
Adventist Health White Memorial Montebello	1,838	1,835	2,452	2,096	85%	1,498	71%	306	15%	193	9%	99	5%	1:17:14	8%
Coast Plaza Hospital	756	749	1,585	1,090	69%	799	73%	162	15%	95	9%	34	3%	1:07:01	1%
Kaiser Foundation Hospital - Downey	1,585	1,581	2,886	1,827	63%	1,122	61%	336	18%	274	15%	95	5%	1:29:00	36%
Norwalk Community Hospital	435	435	844	590	70%	487	83%	73	12%	23	4%	7	1%	0:46:05	7%
PIH Health Downey Hospital	1,823	1,821	2,913	2,152	74%	1,628	76%	319	15%	164	8%	41	2%	0:59:01	11%
PIH Health Whittier Hospital	3,655	3,650	6,908	4,578	66%	3,045	67%	1,152	25%	350	8%	31	0.7%	0:56:02	8%
UCI Health - Lakewood	1,600	1,595	1,630	1,618	99%	895	55%	336	21%	240	15%	147	9%	1:52:14	17%
Whittier Hospital Medical Center	1,041	1,039	2,114	1,468	69%	1,356	92%	92	6%	15	1%	5	0.3%	0:26:17	1%
EAST REGION TOTAL	*12,733*	*12,705*	*21,332*	*15,419*	*72%*	*10,830*	*70%*	*2,776*	*18%*	*1,354*	*9%*	*459*	*3%*	*1:06:05*	*11%*
METRO REGION															
Adventist Health White Memorial	758	757	1,140	911	80%	620	68%	158	17%	103	11%	30	3%	1:17:13	3%
Cedars-Sinai Medical Center	3,450	3,449	4,669	4,122	88%	2,939	71%	889	22%	264	6%	30	0.7%	0:53:09	34%
Children's Hospital Los Angeles	258	258	318	312	98%	306	98%	6	2%					0:14:55	
Community Hospital of Huntington Park	1,734	1,729	3,541	2,159	61%	1,244	58%	612	28%	259	12%	44	2%	1:09:56	3%
Dignity Health - California Hospital Medical Center	1,587	1,587	1,875	1,873	100%	1,382	74%	331	18%	142	8%	18	1%	0:54:43	28%
East Los Angeles Doctors Hospital	1,303	1,302	2,424	1,563	64%	1,301	83%	195	12%	43	3%	24	2%	0:39:06	1%
Hollywood Presbyterian Medical Center	1,776	1,776	2,095	2,082	99%	1,607	77%	376	18%	87	4%	12	0.6%	0:45:05	1%
Kaiser Foundation Hospital - Los	1,154	1,154	1,401	1,361	97%	1,183	87%	156	11%	22	2%			0:33:52	38%
Los Angeles General Medical Center	5,610	5,609	6,927	6,747	97%	5,964	88%	654	10%	122	2%	7	0.1%	0:31:51	33%
PIH Health Good Samaritan Hospital	3,057	3,057	3,486	3,482	100%	2,858	82%	520	15%	99	3%	5	0.1%	0:38:50	7%
METRO REGION TOTAL	*20,687*	*20,678*	*27,876*	*24,612*	*88%*	*19,404*	*79%*	*3,897*	*16%*	*1,141*	*5%*	*170*	*0.7%*	*0:45:01*	*15%*
WEST REGION															
Cedars-Sinai Marina Del Rey Hospital	1,272	1,272	1,704	1,449	85%	1,153	80%	237	16%	57	4%	2	0.1%	0:44:25	40%
Kaiser Foundation Hospital - West LA	1,514	1,510	1,837	1,727	94%	1,235	72%	351	20%	133	8%	8	0.5%	0:55:16	38%
Providence Saint John's Health Center	1,779	1,571	2,550	1,873	73%	1,432	76%	316	17%	109	6%	16	0.9%	0:49:36	17%
Ronald Reagan UCLA Medical Center	1,538	1,491	1,955	1,868	96%	1,597	85%	196	10%	62	3%	13	0.7%	0:35:34	60%
Santa Monica-UCLA Medical Center & Orthopaedic Hospital	789	587	1,406	649	46%	541	83%	68	10%	34	5%	6	1%	0:42:17	33%

* data with eDisposition.21 and eDisposition.30 filters "on"

% total may not equal 100% due to rounding.

Data source: ESO Suite (10/22/2024)

Los Angeles County Emergency Medical Services Agency

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

Time Period July 1, 2024 through September 30, 2024

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

HOSPITAL	Filters on*		Total # of records	# of valid records	% of valid records	Q3 2024									
	Total # of records	# of valid records				≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	% of Time on Diversion
Southern California Hospital at Culver City	1,005	1,005	1,132	1,126	99%	780	69%	243	22%	83	7%	20	2%	0:56:35	15%
WEST REGION TOTAL	*7,897*	*7,436*	*10,584*	*8,692*	*82%*	*6,738*	*78%*	*1,411*	*16%*	*478*	*5%*	*65*	*0.7%*	*0:48:00*	*34%*
SOUTH REGION															
Catalina Island Medical Center	11	11	161	157	98%	155	99%	2	1%					0:11:26	
Centinela Hospital Medical Center	3,558	3,558	7,912	5,367	68%	4,183	78%	1,026	19%	146	3%	12	0.2%	0:40:56	
College Medical Center	682	682	709	687	97%	576	84%	67	10%	29	4%	15	2%	0:42:00	50%
Dignity Health - St. Mary Medical Center	3,168	3,168	3,188	3,179	100%	2,500	79%	496	16%	166	5%	17	0.5%	0:49:00	19%
Harbor-UCLA Medical Center	2,618	2,600	5,038	3,799	75%	2,985	79%	505	13%	229	6%	80	2%	0:52:44	32%
Kaiser Foundation Hospital - South Bay	930	927	1,722	1,257	73%	1,034	82%	171	14%	47	4%	5	0.4%	0:38:40	14%
Martin Luther King, Jr. Community Hospital	2,079	2,079	3,655	2,528	69%	2,413	95%	81	3%	25	1%	9	0.4%	0:22:45	45%
Memorial Hospital Of Gardena	1,395	1,395	3,303	2,076	63%	1,929	93%	113	5%	29	1%	5	0.2%	0:26:14	4%
MemorialCare Long Beach Medical Center	3,344	3,342	3,951	3,686	93%	3,069	83%	324	9%	140	4%	153	4%	0:49:00	33%
Providence Little Company of Mary Medical Center San Pedro	721	720	1,000	911	91%	767	84%	116	13%	23	3%	5	0.5%	0:37:39	17%
Providence Little Company of Mary Medical Center Torrance	1,741	1,670	3,622	2,474	68%	1,742	70%	514	21%	189	8%	29	1%	0:56:41	7%
St. Francis Medical Center	1,805	1,802	5,202	3,063	59%	2,419	79%	296	10%	253	8%	95	3%	1:05:49	20%
Torrance Memorial Medical Center	1,747	1,699	3,928	2,771	71%	1,940	70%	668	24%	153	6%	10	0.4%	0:49:59	22%
SOUTH REGION TOTAL	*23,799*	*23,653*	*43,391*	*31,955*	*74%*	*25,712*	*80%*	*4,379*	*14%*	*1,429*	*4%*	*435*	*1%*	*0:45:25*	*20%*
ALL HOSPITALS	**119,961**	**119,157**	**190,907**	**148,741**	**78%**	**119,379**	**80%**	**21,154**	**14%**	**6,694**	**5%**	**1,514**	**1%**	**0:44:47**	**17%**

* data with eDisposition.21 and eDisposition.30 filters "on"

% total may not equal 100% due to rounding.

Data source: ESO Suite (10/22/2024)

ORDER NO. 2024-01-01 OF THE LOS ANGELES COUNTY HEALTH OFFICER

ORDER OF THE LOS ANGELES COUNTY HEALTH OFFICER

ANNUAL INFLUENZA AND COVID-19 IMMUNIZATION OR MASKING REQUIREMENT FOR HEALTHCARE PERSONNEL DURING RESPIRATORY VIRUS SEASON

Original Issue Date: Monday, August 26, 2024

Please read this Order carefully.

SUMMARY OF THE ORDER:
This Order requires that each year, Healthcare Personnel (HCP) in all Licensed Healthcare Facilities a) be immunized with both an annual influenza vaccine and the most recently updated COVID-19 vaccines authorized for use in the United States for the current respiratory virus season or b) wear a Respiratory Mask while in contact with patients or working in Patient-Care Areas for the duration of the respiratory virus season, all as further defined below.

BACKGROUND:
Many respiratory viruses, including COVID-19, circulate year-round in the United States and California. From late fall to spring, COVID-19 and influenza pose significant risks to medically vulnerable individuals and those exposed through necessity due to their circumstances. Patients, clients, and residents in healthcare settings may continue being concerned about their potential exposure to COVID-19 and influenza when they seek care, and some—most especially young children, pregnant women, elderly individuals, and persons with chronic health conditions who are immunocompromised—are at greater risk for serious complications, including hospitalization, admission to the intensive care unit (ICU), intubation or mechanical ventilation, or death, due to these infections.

Vaccine formulations that target SARS-CoV-2 and influenza continue providing good protection against severe disease, although vaccination does not prevent all infection or transmission. Unvaccinated individuals, however, have higher risk of infection, as well as serious complications if infected.

As such, unvaccinated HCP are not only at higher risk for infection with influenza and COVID-19 but can also spread these viruses to their coworkers and patients. When HCP are vaccinated, there is a reduced risk to those who interact with them, especially when they are also wearing a Well-Fitted Mask.

It is recommended that each year, at the start of the respiratory virus season, HCP be immunized with both the annual influenza vaccine and the most recently updated COVID-19 vaccines authorized for use in the United States for the current respiratory virus season. In California, acute care hospitals must offer free on-site annual influenza vaccinations to their employees and require all employees to be vaccinated. If an employee chooses not to be vaccinated, they must

provide a written declaration that he or she has declined the vaccination to the hospital [See, Cal. Health & Safety Code §1288.7(a)].

In addition, occupational safety regulations require healthcare facilities, including hospitals, skilled nursing facilities, intermediate care facilities, and Emergency Medical Services (EMS) provider agencies, make the annual influenza vaccine available to all employees with occupational exposure and ensure that each employee who declines the vaccine signs a statement declining vaccination [See, 8 Cal. Code Regs. §5199 (c)(6)(D) & (h)(10)].

In Los Angeles County, a Health Officer Order (Order) requiring that HCP be either vaccinated against influenza or masked while in contact with patients or working in Patient-Care Areas, has been issued annually since 2013. Since that time, the average rate of hospital-based HCP influenza immunization rates in Los Angeles County has increased.

There is a need to continue efforts to increase immunization rates to protect both HCP and the patients they serve. We strongly encourage other licensed and unlicensed healthcare and direct care entities to voluntarily adopt the same measures for their employees to protect their personnel and patients during the respiratory virus season.

This Order is effective within the County of Los Angeles Public Health Jurisdiction, defined as all cities and unincorporated areas within the County of Los Angeles, except for the cities of Long Beach and Pasadena that must follow their respective City Health Officer orders and guidance. This Order will continue until it is revised, rescinded, superseded, or amended in writing by the County Health Officer.

UNDER THE AUTHORITY OF CALIFORNIA HEALTH AND SAFETY CODE (HSC) SECTION 120175, THE COUNTY OF LOS ANGELES HEALTH OFFICER ORDERS:

1) **Purpose.** Influenza and COVID-19 pose a risk to persons within Los Angeles County. Vaccination against influenza and COVID-19 is still the most important strategy to prevent serious illness and death from these respiratory illnesses. When healthcare providers and workers in health care settings are vaccinated, there is a reduced risk to those who interact with them.

   This Order continues the requirement that every Licensed Healthcare Facility, as defined in Paragraph 3a, including but not limited to, licensed acute care hospital, skilled nursing facility, intermediate care facility, and emergency medical services provider agency within the County of Los Angeles public health jurisdiction implement a program under which healthcare personnel a) receive both an annual influenza vaccine and the most recently updated COVID-19 vaccines authorized for use in the United States for the current respiratory virus season or b) wear a Respiratory Mask while in contact with patients or working in Patient-Care Areas for the duration of the respiratory virus season.

2) **Intent.** The primary intent of this Order is to lower the risk of influenza and COVID-19 transmission to patients and staff by requiring all Licensed Healthcare Facilities in Los Angeles County to, as a protective measure, require HCP (as defined in Paragraph 4b) who decline an annual influenza vaccine or most recently updated COVID-19 vaccine for the

current respiratory virus season to wear a Respiratory Mask (as defined in 4c) while in contact with patients or working in Patient-Care Areas for the duration of the respiratory virus season.

3) **Licensed Healthcare Facilities Subject to this Order.** This Order applies to the following licensed health care facilities:
    a. Licensed Healthcare Facilities:
        i. General Acute Care Hospitals*
        ii. Skilled Nursing Facilities (including Subacute Facilities)*
        iii. Intermediate Care Facilities*
        iv. Emergency Medical Services (EMS) Provider Agencies
        v. Congregate Living Health Facilities*
        vi. Chemical Dependency Recovery Hospitals*
        vii. Acute Psychiatric Hospitals*
        viii. Dialysis Centers
        ix. Home Health Agencies
        x. Primary Care Clinics
        xi. Ambulatory Surgery Centers
        xii. Hospice Facilities*
4) **Definitions.** For purposes of this Order, the following terms have the meanings given below:
    a. **Respiratory Virus Season.** The term "Respiratory Virus Season" refers to November 1 of one year through April 30 of the following year. If surveillance data in a particular year demonstrate that the respiratory virus season is different than November 1 to April 30, this period may be amended in an updated order.
    b. **Healthcare Personnel.** The term "Healthcare Personnel (HCP)" refers to all paid and unpaid employees, contractors, students, volunteers, and Emergency Medical Services (EMS) healthcare personnel, who have direct patient contact or work in Patient-Care Areas in Licensed Healthcare Facilities subject to this Order and the prehospital care setting (e.g., any setting in which medical care is provided prior to the patient's arrival at a hospital). This includes, but is not limited to, physicians, nurses, aides, physical therapists, emergency medical technicians (EMTs), paramedics, contract workers, students, volunteers, registration/reception staff, housekeeping, and maintenance personnel.
    c. **Respiratory Mask.** The term "Respiratory Mask" refers to what can be a surgical, procedure, or N-95 mask also designated by some manufacturers as isolation, dental, or medical procedure facemasks.
    d. **Patient-Care Areas**. The term "Patient-Care Areas" refers to areas in facilities that include, but are not limited to, patient or resident rooms and areas where patients

receive diagnostic or treatment services, can be taken for procedures or tests, and are allowed to be present (e.g., elevators, hallways, and nurses' stations). These areas also include any prehospital setting in which EMS personnel are in contact with patients and other areas facility administrators deem could result in exposure to patients and possible disease transmission.

e. **Licensed Healthcare Facilities that provide Inpatient Care.** This term refers to Licensed Healthcare Facilities to which persons are admitted for a 24-hour stay or longer, and includes only General Acute Care Hospitals, Skilled Nursing Facilities (including Subacute Facilities), Intermediate Care Facilities, Congregate Living Health Facilities, Chemical Dependency Recovery Hospitals, Acute Psychiatric Hospitals, and Hospice Facilities (See Licensed Healthcare Facilities noted with an asterisk, listed in Paragraph 3a) subsections (i), (ii), (iii), (v), (vi), (vii), and (xii).

5) **Influenza and COVID-19 Vaccination Requirement.** All employees of a Licensed Healthcare Facility (as defined in Paragraph 3a) who meet the definition of Healthcare Personnel (as defined in Paragraph 4b) must receive both an annual influenza vaccine and the most recently updated COVID-19 vaccines authorized for use in the United States for the current respiratory virus season prior to or during the respiratory virus season, annually defined as November 1–April 30, or wear a Respiratory Mask while in contact with patients or working in Patient-Care Areas.
By November 1 of each respiratory virus season, HCP who decline either or both an influenza or COVID-19 immunization, as described above, must provide their employer, on a form provided by their employer, a written declaration for each vaccine that they have declined. HCP who decline or have not yet obtained both an annual influenza vaccine and the most recently updated COVID-19 vaccines authorized for use in the United States for the current respiratory virus season must wear a Respiratory Mask while in contact with patients or working in Patient-Care Areas for the duration of the respiratory virus season.

6) **Maintenance of Records.** Consistent with applicable privacy laws and regulations, the operator of the Licensed Healthcare Facility must maintain records of all HCP vaccination or declination status.

   a. The facility must provide such records to the Los Angeles County Department of Public Health or their designee promptly upon request, and in any event, no later than three business days after receiving the request.

   b. Operators of the facilities subject to the requirement must maintain records with the following information: (1) full name and date of birth of HCP; (2) vaccine manufacturer; and (3) date of vaccine administration.

   c. For unvaccinated workers: a declination form signed by the unvaccinated HCP.

7) **Reporting.** Upon request by the Los Angeles County Department of Public Health or the EMS Agency, facilities and EMS provider agencies must report their HCP influenza and COVID-19 immunization rates within the requested timeframe either through the CDC's National Healthcare Safety Network or a tool provided by the EMS Agency.

8) **Masking and Other Infection Control Policies and Practices.** Nothing in this Order limits otherwise applicable requirements related to Personal Protective Equipment, personnel training, and infection control policies and practices.

9) **Access to Vaccinations.** All Licensed Healthcare Facilities covered by this Order are encouraged to provide onsite vaccinations for HCP and all employees, easy access to nearby vaccinations, and education and outreach on vaccinations. Of note, facilities must also comply with vaccination related and other requirements set forth by California law and/or occupational safety regulations that apply to their site.

10) **Copies.** The County shall promptly provide copies of this Order by: (a) posting it on the Los Angeles Department of Public Health's website: publichealth.lacounty.gov, (b) providing it to any member of the public requesting a copy, and (c) issuing a press release to publicize the Order throughout the County.

11) **Severability.** If any subsection, sentence, clause, phrase, or word of this Order or any application of it to any person, structure, gathering, or circumstance is held to be invalid or unconstitutional by a decision of a court of competent jurisdiction, then such decision will not affect the validity of the remaining portions or applications of this Order.

12) **Amendments to Order.** This Order may be revised or amended in the future to reflect evolving local or overarching public health conditions.

13) **Statutory Authority.** This Order is issued pursuant to California Health and Safety Code (HSC) section 120175.

14) **Issue Date.** This Order is issued on Monday, August 26, 2024, and will continue until it is revised, rescinded, superseded, or amended in writing by the County Health Officer.

IT IS SO ORDERED:

MD, MPH

8/26/2024

Muntu Davis, M.D., M.P.H.
County Health Officer, County of Los Angeles

Issue Date

Health Officer Order Resources

For additional information regarding this Health Officer Order, the following documents will be available at the Los Angeles County Department of Public Health website at:
http://ph.lacounty.gov/acd/respvirusseasonhoo.htm

- Frequently Asked Questions about the Order

COVID-specific resources for Healthcare Providers are accessible here:
http://publichealth.lacounty.gov/acd/ncorona2019/

Further questions may be directed to the Los Angeles County Department of Public Health, Acute Communicable Disease Control Program at (213) 240-7941, Monday through Friday, 8:00am-5:00pm.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

10100 Pioneer Boulevard, Suite 200
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Tel: (562) 378-1500
Fax: (562) 941-5835

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

DATE: September 30, 2024

TO: All DHS Hospital Chief Nursing Officers and Chief Medical Officers

FROM: John Quiroz, JQ
Nurse Manager

SUBJECT: MEDICAL ALERT CENTER PHONE NUMBER CHANGES

This is to inform all licensed DHS hospitals in Los Angeles County of scheduled changes to the Medical Alert Center (MAC) Telephone system taking effect on October 22, 2024, at 0700. The changes result from upgrading our phone system to voice-over-internet provider technology. Although most MAC numbers remain unchanged, we must alert you to a new phone system option that will affect hospital personnel.

- To contact the MAC for **DHS Patient Transfers,** call **(866) 940-4401** and **select option 3.**

- The **MAC Supervisor Line at (562) 941-1037** for direct access to a supervisor on duty remains unaffected by the system upgrade and should be used for non-emergency communications.

- All previous direct phone extensions to individual MAC coordinators will be eliminated and replaced. Your calls to MAC should be directed to the **DHS Patient Transfer Line** above or the callback number that we provide in our message to you.

Please ensure that all concerned hospital personnel are made aware of the change to the Provider Line and that telephone directories are updated in advance of the change. Should you or your staff have any questions, please contact the MAC at (562) 941-1037.

Thank you.

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Health Services
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October 10, 2024

TO: Distribution

FROM: Nichole Bosson, MD, MPH
Medical Director

SUBJECT: **Shortage of Intravenous Fluids**

Given the current shortage in sterile fluid for intravenous injection, the Los Angeles County EMS Agency would like to emphasize the need to implement mitigation strategies including those outlined in LA County EMS Ref 701. Additional strategies specific to intravenous fluid conservation may be found in this document: IV Fluid Shortage Strategies (hhs.gov)

During this period of shortage, we recommend the following approach to prehospital intravenous fluid resuscitation:

1) Defer intravenous fluid administration during the prehospital phase of care unless the patient has signs of poor perfusion requiring immediate intravenous therapy.
2) Do not administer intravenous fluids to asymptomatic patients for the purposes of treating hyperglycemia or isolated tachycardia without poor perfusion.
3) For patients with signs or symptoms of dehydration who are awake and alert, consider an oral rehydration strategy.
4) Provide antiemetic therapy and temperature management when indicated, to reduce fluid losses.

Please contact me at nbosson@dhs.lacounty.gov if you have any questions regarding these recommendations.

Distribution:
EMS Provider Agencies

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

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Second District

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Third District

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Kathryn Barger
Fifth District

Richard Tadeo, RN
Director

Nichole Bosson, MD, MPH
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."

October 15, 2024

TO: Distribution **VIA E-MAIL**

FROM: Richard Tadeo, RN
Director, EMS Agency

SUBJECT: **PILOT PROGRAM - ELIMINATION OF SERVICE AREA BOUNDARIES SUSPENSION of Ref. Nos. 509, 509.2 & .2a, 509.4 & .4a**

Effective December 1, 2024, at 7:00 a.m., the Los Angeles County Emergency Medical Services (EMS) Agency, in cooperation with the affected hospitals, is suspending all Service Area boundaries.

This patient destination change will affect the following defined service areas:

- Shared Service Area for Dignity Health California Hospital Center and PIH Health Good Samaritan Hospital
- Adventist Health White Memorial Medical Center

Patient destination within these service area boundaries will be based upon Ref. No. 502, Patient Destination. Diversion of patients shall continue to comply with Ref. No. 503, Guidelines for Hospital Requesting Diversion of ALS/BLS patients. Hospitals within these service area boundaries may request diversion of advanced life support (ALS) patients utilizing the ReddiNet® system. Requests for diversion of basic life support (BLS) patients will require approval by the EMS Agency Administrator On-Duty (AOD) via the Medical Alert Center, as per Ref. No. 503.

If all hospitals within the current service area are on ALS diversion, and the patient does not meet specialty care center destination criteria (e.g., trauma, STEMI, etc.) the EMS provider and/or Mobile Intensive Care Nurse (MICN) will review the Ambulance Status information in the ReddiNet® system. Based upon the number of ambulances 'Enroute' and 'At Fac' along with the 'Elapsed Time' waiting to offload, a determination will be made as to patient destination.

Thank you for your attention to this matter and your support of the EMS system. If you have any questions, feel free to contact me at (562) 378-1610 or Chris Clare, Nursing Director – EMS Programs at (562) 378-1661.

RT:cc

Attachment: Ref. No. 509.1, Elimination of Service Areas Pilot Program

Distribution: Medical Director, EMS Agency
Medical Alert Center
Fire Chief, Each Public Provider Agency
CEO, Each Private Ambulance Company
Medical Director, Each EMS Provider Agency
Paramedic Coordinator, Each EMS Provider Agency
Hospital Association Southern California
Prehospital Care Coordinators, Each Paramedic Base Hospital
CEO & ED Director, Adventist Health White Memorial Medical Center
CEO & ED Director, Community Hospital of Huntington Park
CEO & ED Director, Dignity Health California Hospital Medical Center
CEO & ED Director, East Los Angeles Doctor's Hospital
CEO & ED Director, PIH Health Good Samaritan Hospital
CEO & ED Director, Los Angeles General Medical Center
ReddiNet®

SUBJECT: **ELIMINATION OF SERVICE AREAS PILOT PROGRAM** REFERENCE NO. 509.1

I. Purpose: To provide guidelines for the implementation of a pilot program to study the impact of eliminating the service area boundaries in the Los Angeles downtown region.

II. Principles:

A. Current patient destination policies are based on established service area boundaries and requests to divert ALS patients. For the purposes of this pilot program:

1. The following Service Area boundaries and patient destination policies will be suspended during the duration of the pilot program:

   a. Ref. No. 509.2, Shared Service Area for Dignity Health-California Hospital Medical Center and PIH Health Good Samaritan Hospital

   b. Ref. No. 509.4, Service Area for Adventist Health-White Memorial Medical Center

2. Diversion requests shall be in accordance with Ref. No. 503.1, Diversion Request Requirements for Emergency Department Saturation. Other diversion request categories (Trauma, STEMI, Stroke and Pediatric Medical Center) shall be in accordance with Ref. No. 503, Guidelines for Hospitals Requesting Diversion of ALS/BLS Patients.

B. Patient destination decisions will be made based on real-time Ambulance Status displayed on the ReddiNet Hospital Status screen when **all** 9-1-1 Receiving Facilities have requested Diversion to ALS patients. The number of ambulances "Enroute," number of ambulances "At Fac," and the "Elapsed Time" waiting to offload patients will be the determining factors used for patient destination decisions.

C. Hospital destination for patients who meet Specialty Care Center Criteria and/or Guidelines (e.g., Trauma, STEMI, Stroke, Pediatric) shall be in accordance with the corresponding specialty care center patient destination policy.

III. Participating Hospitals:

A. Dignity Health – California Hospital Medical Center – *Paramedic Base Hospital*

B. PIH Health Good Samaritan Hospital

C. Adventist Health White Memorial Medical Center (WMH)

D. The following hospitals are currently located within WMH's service area and will be secondarily affected:

APPROVED: Richard Tadeo
Director, EMS Agency

1. Community Hospital of Huntington Park
2. East Los Angeles Doctors Hospital

E. Los Angeles General Medical Center – *Paramedic Base Hospital*

F. Other Hospitals that may be impacted by this pilot project include: MLK Community Hospital, Centinela Hospital Medical Center, Hollywood Presbyterian Medical Center, Kaiser Foundation Los Angeles, Children's Hospital Los Angeles

IV. Policy

A. Transport of Patients by EMT Personnel

EMT personnel transporting basic life support (BLS) level patients shall transport patients to the most accessible receiving facility (MAR) regardless of diversion status or number of patients waiting to offload. Diversion of BLS patients may only occur if the EMS Agency has authorized BLS Diversion of a particular hospital.

B. Transport of Patients by Paramedic Personnel

Paramedic personnel shall determine hospital destination based on ALS Diversion status of emergency departments (ED) within the 15-minute transport time. ALS patients shall generally be transported to the MAR. However, paramedic personnel should utilize Reddinet data to determine destinations based on a combination of transport time, diversion status, and the number of patients waiting to offload. ALS patients may be transported to a hospital with a modestly longer transport time if the MAR has a greater number of patients waiting to offload. Hospitals on ALS diversion status shall be bypassed if another facility not on ALS diversion is accessible within a 15-minute transport time.

Example:
Hospital A is the MAR with a 5-minute ETA. Hospital A has 2 ambulances "Enroute," 3 ambulances "At Fac," and "Elapsed Time" for all 3 "At Fac" have been waiting over 30 minutes to offload.
Hospital B is 2 minutes farther with a 7-minute ETA. Hospital B has 1 ambulance "Enroute," 1 ambulance "At Fac," and "Elapse time" is 10 minutes to offload.
The patient should be transported to Hospital B.

C. Transports Requiring Online Medical Control via Paramedic Base Hospital Contact

Paramedic base hospital personnel shall determine hospital destination based on the same criteria in Section B for patients who do not meet Specialty Care Center Criteria and/or Guidelines.

D. Transports of Patient Meeting Specialty Care Center Criteria and/or Guidelines

Patients who meet Specialty Care Center Criteria and/or Guidelines (Trauma, STEMI, Stroke, Pediatric Medical Center) shall be transported in accordance with the applicable patient destination policy.

V. Monitoring

The EMS agency shall provide the following reports:

A. Number of EMS patients transported in CY 2023 to all participating hospitals and other hospitals that may be impacted by the pilot project.

B. Ambulance patient offload times (APOT) of all participating hospitals and other hospitals that may be impacted by the pilot for CY 2023.

C. Top three (3) provider impressions of patient transported to participating hospitals and other hospitals that may be impacted by the pilot for CY 2023.

D. Upon implementation of the pilot project, monthly number of EMS patients transported to all participating hospitals and other hospitals that may be impacted by the pilot project. This report shall continue throughout the duration of the pilot project.

E. Upon implementation of the pilot project, monthly APOT of all participating hospitals and other hospitals that may be impacted by the pilot project. This report shall continue throughout the duration of the pilot project.

F. Upon implementation of the pilot project, monthly top three (3) provider impressions of patients transported to participating hospitals and other hospitals that may be impacted by the pilot project. This report shall continue throughout the duration of the pilot project.

VI. Term of Pilot Project

The pilot project will be implemented for two quarters (6 months). Evaluation of the data by the participating hospitals and the EMS Agency will be conducted, at minimum, on a quarterly basis. Continuation of the pilot project will be based on the findings at the end of quarter Extension of the pilot project may be considered but not to exceed 1 year total.

EMERGENCY MEDICAL SERVICES AGENCY
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Health Services
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October 23, 2024

TO: Distribution

FROM: Nichole Bosson, MD, MPH
Medical Director

SUBJECT: **Marburg Virus Disease Protocols**

In early October, the Centers for Disease Control and Prevention (CDC) issued a Health Advisory about the Republic of Rwanda's outbreak of Marburg virus disease (MVD). MVD is a rare but highly fatal viral hemorrhagic fever caused by infection by one of two viruses, Marburg virus or Ravn virus. These are within the virus family *Filoviridae*, which also includes Ebola viruses.

In light of the current outbreak we have updated guidance for EMS personnel in the event they encounter patients that meet suspected MVD criteria. The following documents are attached and can also be found on the EMS Agency Website:

1) 911 EMS Provider Marburg Virus Disease (MVD) Patient Assessment and Transportation Guidelines
2) LAX Suspect Marburg Virus Disease (MVD) Patient Assessment andTransportation Guidelines
3) Regional emerging infectious disease transportation concept of operations

At this time, the likelihood for exposure to MVD in Los Angeles County is low. The CDC has implemented public health entry screening for travelers entering the U.S from Rwanda at John K. Kennedy International Airport (JFK), New York, Chicago O'Hare International Airport (ORD), Illinois, and Washington-Dulles International Airport (IAD), Virginia. Potential travelers identified through this screening process who require MVD symptom monitoring and whose itinerary includes Los Angeles County will be monitored by the Los Angeles County Department of Public Health.

Please contact me at nbosson@dhs.lacounty.gov if you have any questions.

Distribution:
EMS Provider Agencies

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Health Services
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October 31, 2024

CERTIFIED

Mr. Stephen Albrecht
Senior Regulatory Administrator
1501 Hughes Way Suite 410
Long Beach, CA 90801

9-1-1 ALTERNATE DESTINATION SITE APPROVAL: STAR VIEW BEHAVIORAL HEALTH URGENT CARE CENTER

Dear Mr. Albrecht:

The letter is to advise you that the Los Angeles County Emergency Medical Services (EMS) Agency has completed the scheduled site visits and program evaluation of Star View Behavioral Health Urgent Care Center for City of Industry, Long Beach, and Lancaster.

The purpose of the visits were to assess operational standards, review the EMS triage and offload procedures, and analyze EMS data at each facility. Additionally, the reviews verified adherence to the administrative requirements outlined in Reference No.326, Psychiatric Urgency Care Center Standards.

The EMS Agency is pleased to inform you that all Star View Behavioral Health Urgent Care Centers have met all required standards.

We appreciate your collaboration in the renewal process for the Star View Behavioral Health Urgent Care Centers. Your partnership with the EMS Agency in the Alternate Destination Program is valued, and we commend your dedication to delivering quality care to patients who benefit from your services. If you or your staff have any questions, please contact Laura Leyman, Psychiatric Urgent Care Coordinator, at (562) 378-1654.

Sincerely,

Richard Tadeo
Director, EMS Agency

RT: ll
10-21

c. Director, EMS Agency
Senior Administration, Star View Behavioral Health Urgent Care Center
Administration Star View Behavioral Health Urgent Care Center
Asst. Administration, Star View Behavioral Health Urgent Care Center
Program Director, Star View Behavioral Health Urgent Care Center

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EXTRACORPOREAL CARDIOPULMONARY RESUSCITATION (ECPR) RECEIVING CENTER STANDARDS**

REFERENCE NO. 321

PURPOSE: To establish minimum standards for the designation of an Extracorporeal Cardiopulmonary Resuscitation (ECPR) Receiving Center to ensure that select patients transported by the 9-1-1 system in Los Angeles County with out-of-hospital cardiac arrest (OHCA) refractory to conventional therapies and who meet ECPR criteria, are transported to a hospital appropriate to their needs.

AUTHORITY: California Code of Regulations (CCR), Title 22, Division 9, Chapter 7.1

DEFINITIONS:
Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialists (ABMS) or American Osteopathic Association (AOA) including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in a particular specialty.

Board Eligible (BE): Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA for a specific specialty.

Extracorporeal Membrane Oxygenation (ECMO): Provision of oxygen and carbon dioxide exchange through the use of extracorporeal circuit consisting minimally of a blood pump, artificial lung, and vascular access cannula, using blood flows sufficient to support oxygenation and concomitantly enhance carbon dioxide removal. Also known as extracorporeal life support (ECLS).

ECMO Candidate: A patient with out-of-hospital cardiac arrest that meets LA County EMS criteria for consideration of extracorporeal membrane oxygenation; this includes patients with initial shockable rhythm refractory to conventional cardiopulmonary resuscitation or with recurrent arrest, and select other patients with potential reversible etiologies.

ECMO Coordinator: A registered nurse (RN), respiratory therapist (RT), or perfusionist who specializes in the management and operation of the ECMO machine.

ECMO Specialist: A technical specialist trained to manage the ECMO machine and the needs of the patient on ECMO.

ECPR Medical Director: A qualified physician specialist privileged by the hospital to perform cannulation and active in performing ECMO who is responsible for the ECMO program.

ECPR Program Manager: A physician, advanced practitioner, registered nurse (RN), respiratory therapist (RT), or perfusionist appointed by the hospital to monitor, coordinate, and evaluate the ECPR Program and responsible for the supervision and training of the staff, maintenance of equipment, and collection of patient data.

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

Extracorporeal Cardiopulmonary Resuscitation (ECPR) Receiving Center: A licensed general acute care facility that is designated by the Los Angeles County EMS Agency as a STEMI Receiving Center, meets all the requirements listed in this policy and has been designated by the LA County EMS Agency as an ECPR receiving center.

Out-of-Hospital Non-traumatic Cardiac Arrest (OHCA): Sudden, sometimes temporary cessation of function of the heart not due to a traumatic cause.

Perfusionist: An individual who has specialized training and certification in managing the heart-lung machine in the operating room and/or ECMO at the bedside.

Promptly Available: Able to be physically present in the emergency department (ED) within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, should not have a measurable harmful effect on the course of the patient management or outcome.

Qualified Specialist: A physician licensed in the State of California who has become BC or BE in the corresponding specialty by American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).

Return of Spontaneous Circulation (ROSC): Following cardiopulmonary arrest, ROSC is the restoration of a spontaneous perfusing rhythm. Signs include: palpable pulse, breathing (more than an occasional gasp), a measurable blood pressure and/or a sudden rise in capnography to a normal/high reading.

STEMI Receiving Center (SRC): A licensed general acute care facility that meets the minimum hospital STEMI care requirements pursuant to CCR Section 100270.124 and is able to perform percutaneous coronary intervention (PCI), manage cardiac arrest and post-resuscitation care, and is designated as a SRC by the Los Angeles County EMS Agency.

POLICY:

I. ECPR Designation / Re-Designation

A. ECPR initial designation and re-designation is granted for up to three years based on maintenance of these standards and after a satisfactory review and approval by the EMS Agency.

B. The EMS Agency reserves the right to perform a scheduled on-site survey or request additional data at any time.

C. Prior to designation, the hospital shall be currently designated as a STEMI Receiving Center (SRC) for a minimum of five years and meet the SRC performance metrics, listed in Ref. No. 320.3, including first-medical contact to balloon time and door to balloon time, for a minimum of 12 months.

D. The ECPR Receiving Center must have an existing veno-arterial (V-A) ECMO program for a minimum of 12 months with quality improvement processes and managed a minimum of 6 patients on V-A circuit.

E. The ECPR Receiving Center must currently operate as an LA County designated Paramedic Base Hospital.

F. To be considered for ECPR designation, the hospital must provide workflow on receiving potential ECPR candidates to include but not limited to: procedures for receiving prenotification from EMS; team activation; ED workflow; location and procedures for cannulation; assessment for initiation and withdrawal of ECPR; multi-disciplinary team care while on ECPR and post-cannulation; and quality improvement program.

G. The ECPR Receiving Center shall immediately provide written notice to the Medical Director of the EMS Agency if unable to adhere to any of the provisions set forth in these ECPR Standards.

H. The ECPR Receiving Center shall provide a 90-day, written notice to the EMS Agency Medical Director of intent to withdraw from the ECPR program.

I. The ECPR Receiving Center shall notify the EMS Agency, in writing, of any change in status of the ECPR Medical Director, ECPR Program Manager, or data entry personnel by submitting Reference No. 621.2, Notification of Personnel Change Form.

II. General Hospital Requirements

A. Appoint an ECPR Medical Director and ECPR Program Manager who shall be responsible for meeting the ECPR Program requirements and allocate non-clinical time such that they can meet the requirements of the ECPR standards.

B. Have a fully executed Specialty Care Center ECPR Designation Agreement with the EMS Agency.

III. ECPR Leadership Requirements

A. ECPR Medical Director

1. Qualifications:

a. A qualified specialist in emergency medicine, cardiology, pulmonology, critical care, or surgery (thoracic, cardiovascular, or trauma), or other qualified specialist with specific training and experience in ECMO support and credentialed to perform ECMO cannulation.

b. This person typically serves as the ECMO Director, providing oversight for the ECMO program including the ECPR program.

2. Responsibilities:

a. Provide medical oversight for the ongoing performance of the ECPR program

b. Ensure the credentialing of clinicians who care for ECMO patients and/or who will manage the ECMO circuit

c. Collaborate with the ECPR Program Manager to ensure adherence to these standards

d. Participate in the relevant hospital committees associated with ECMO, cardiac arrest, and post-resuscitation care.

e. Liaison with hospital administration, ECPR Program Manager, medical and clinical staff across the patient's continuums of care

f. Ensure continuing education and competency evaluation in ECMO

g. Attend 100% of the EMS Agency's SRC and ECPR QI Meetings onsite or via video conference. Fifty percent (50%) of meetings may be attended by an alternate ECPR qualified specialist from the same ECPR Receiving Center.

h. Confirm proper and valid data submission to the EMS Agency

B. ECPR Program Manager

1. Qualifications:

a. A physician, advanced practitioner (physician assistant, nurse practitioner), registered nurse, or respiratory therapist licensed in the State of California, or a certified clinical perfusionist, with a minimum of 1-year ICU experience.

b. Knowledgeable in the care of the ECMO and post-cardiac arrest patient.

c. Experience with program management and quality improvement.

d. This person typically serves as the hospital's ECMO Coordinator.

2. Responsibilities:

a. Collaborate with the ECPR Medical Director to ensure adherence to these Standards

b. Confirm hospital policies are consistent with these Standards

c. Implement, maintain, and monitor ECPR QI programs

d. Ensure continuing education and competency evaluation in ECMO

e. Ensure that program availability is consistent with EMS policies and processes are in place to maximize the 24/7 team availability

f. Collaborate with the ED Medical and Clinical Directors on the management of patients with OHCA who meet criteria for ECMO

g. Liaison with hospital administration, ECPR Medical Director, medical and clinical staff across the ECMO patient continuums of care

h. Participate in the relevant hospital committees associated with ECMO, cardiac arrest, and post-resuscitation care

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

j. Attend 100% of the EMS Agency's SRC and ECPR QI Meetings onsite or via video conference. For both, fifty percent (50%) of meetings may be attended by an alternate clinician from the ECPR team.

k. Ensure processes are in place to identify and track patients transported to the ECPR center by EMS

l. Provide oversight of complete, accurate and timely data collection and submission

IV. ECPR Program Personnel Requirements

A. Sufficient qualified ECMO cannulators to maintain program availability 24 hours per day/7 days per week/365 days per year

B. ECMO specialists (clinicians trained to operate the ECMO circuit)

C. An ECPR team available 24/7/365 to evaluate and care for the ECMO candidate upon the patient's arrival to the ED or within 5 minutes thereof, which includes at a minimum:
   a. One ECMO-trained physician dedicated to the ECPR team and on call at only one facility at a time
   b. One ECMO specialist dedicated to the ECPR team

D. Other qualified specialist available to manage the other aspects of the patient's care including the resuscitation

E. Cardiothoracic and/or vascular surgery available on call 24/7/365

F. All physicians performing emergent ECMO cannulation must maintain current board certification, or be board eligible, in their specialty of practice

V. Training and Continuing Education

A. ECPR Program Manager and Medical Director shall ensure staff are sufficiently trained and maintain competency in ECMO. Regular team-based simulation are highly encouraged.

B. Training opportunities shall include, but not limited to:

1. Didactic lectures

2. Hands-on training with ECMO equipment

3. Bedside training

4. Simulations

C. For facilities performing V-A ECMO <24 cases per year (average < 2/month) and/or if ECMO personnel are not involved in ECPR patient management for more than two (2) months consecutively, team-based ECPR patient simulations shall occur to ensure at least one ECPR patient experience quarterly. Simulations should include all aspects of the process from patient arrival with EMS, to cannulation with ongoing resuscitation and through ICU management, and should involve the relevant clinicians.

D. ECPR Receiving Centers should provide periodic ECPR Base Hospital education with collaboration between the ECPR Program Manager/Medical Director, Prehospital Care Coordinator/Base Hospital Medical Director and EMS provider agencies.

VII. ECPR Program Plan

The hospital shall develop and maintain an ECPR Program Plan pertaining to the care of the ECPR patient. The plan shall be reviewed by the ECPR Program Manager annually and approved by the appropriate committee(s) minimally every three years. The ECPR Program Plan should include, at minimum, the following:

A. Job descriptions and organization structure clarifying the relationship between the ECPR Medical Director, ECPR Program Manager and the ECPR team

B. ECPR team activation guidelines with the ability to track activations and cancelations

C. A process for immediate notification of the emergency physician and ECPR team upon EMS notification of an ECMO candidate transport

D. A single call activation system to directly activate the ECPR team

E. Policy and procedures outlining the following:

1. ECPR team activation

2. ED workflow for the potential ECPR patient

3. Indications and contraindications for ECPR

4. Clinical management of the ECPR patient including but not limited to:

    a. Process for transfer from prehospital to hospital equipment while minimizing interrupting chest compressions
    b. Coordination between ECPR team and the clinical care team (e.g., emergency department clinicians and/or cath lab staff)
    c. Transition of the patient through phases of care (ED, cath lab, ICU)

5. ECMO circuit management

6. Maintenance of equipment

7. Policy for termination of ECPR therapy in patients who fail to recover and cannot be weaned, including involvement of a multi-disciplinary team, and availability of long-term cardiac support either on site or through transfer agreements

8. Follow-up of the ECPR patient short and long-term outcomes

9. Process for the triage and treatment of simultaneously arriving ECPR patients

F. Plan to ensure 100% of ECPR patients receive immediate evaluation for reversible causes of OHCA.

1. Immediate coronary angiography for patients without an obvious alternate noncardiac cause
2. Imaging and/or thrombolysis/thrombectomy for suspected massive pulmonary embolus

G. Post resuscitation care policies, including initiation of TTM

H. Involvement of a multidisciplinary team to include but not limited to emergency medicine, cardiology, neurology and/or intensive care medicine with experience in prognostication, respiratory therapy and palliative care.

I. A process for feedback to the transporting paramedics on the patient's presumed diagnosis and ED disposition

J. A process to collaborate with EMS provider agencies to integrate electronic prehospital patient care (ePCR) records into the hospital electronic medical record

VIII. Equipment and Supplies

A. ECMO supplies shall be easily accessible, readily available, and in close proximity to the ED and/or cath lab depending on the designated location(s) for cannulation.

B. Required ECMO equipment and supplies include:

1. ECMO system that consists of a suitable blood pump, a system for servo-regulation, blood heat exchanger and warming unit

2. Appropriate disposable materials including membrane oxygenator tubing packs and connectors

3. Primed circuit or appropriate solution (crystalloid or blood) available to prime the circuit

4. Device for monitoring the level of anticoagulation including its appropriate supplies

5. Backup components for the ECMO system and supplies for all circuit components

6. Adequate lighting to support surgical interventions

7. Supplies for revision of cannulation and for exploration of bleeding complications

8. Access to blood bank, pharmaceuticals and radiology as needed

C. A mechanical compression device must be available in emergency department for transition on patient arrival and use during cannulation

IX. Data Collection and Submission Requirements

A. Participate in the data collection process established by the EMS Agency.

B. Ensure adequate data entry personnel to meet data entry requirements. Back-up data entry personnel should be identified and trained in the event primary data personnel is unable to meet the data entry requirements.

C. Collaborate with ED and Base Hospital personnel to ensure capture and entry of patients meeting inclusion criteria into the Los Angeles County EMS Agency STEMI Receiving Center (SRC) database ECPR tab on an ongoing basis.

D. Maintain an Emergency Department (ED) Log to capture patients who are transported to the ED due to ECPR designation.

E. Submit data to the EMS Agency, within 45 days of patient's discharge, which shall include all patients who meet data inclusion criteria and all applicable data elements listed in Ref. No. 648, STEMI Receiving Center Data Dictionary

F. Maintain a minimum 90% compliance for:

1. Capture of patients meeting the data inclusion criteria

2. Data field completion

3. Data field accuracy

4. Timely data entry

G. Maintain active membership in the Extracorporeal Life Support Organization (ELSO). Submission of relevant data to ELSO for all ECMO and ECPR patients is highly encouraged but not required.

X. Quality Improvement

A. ECPR Program must include a comprehensive-multidisciplinary QI Meeting. This committee can be in conjunction with the SRC committee currently established.

1. Meeting participation should include the ECPR Medical Director, ECPR Program Manager, EMS clinicians and educators, emergency physicians, interventional cardiologists, ED and cath lab personnel, critical care

personnel, neurology, as well as other healthcare specialties involved in the care of ECPR patients such as vascular surgery, and thoracic surgery.

2. Meeting to be held quarterly, at a minimum.

3. Meeting minutes and roster must be maintained for each meeting and available for review.

B. Pertinent aspects of care such as treatment and management of the ECPR patients, should be tracked and trended with the identification of areas requiring improvement and the action(s) necessary to improve care.

C. The ECPR QI program shall:

1. Review the care and outcome on all (100%) ECPR patients and track and trend the following, at a minimum:

a. All ECPR related deaths

b. Major complications such as: limb ischemia, thromboembolism, hemorrhage requiring blood transfusion, ischemic stroke, infection, and organ injury

c. Any delays in care

2. Address other issues, processes, or personnel trends identified from hospital specific data (i.e., increase in fallouts over time).

3. ECPR center shall have a mechanism to provide feedback to EMS Providers (i.e., encrypted/secure e-mail). The feedback shall be provided within one (1) week of patient arrival at the ECPR center. Feedback shall include, but be not limited to, the following:

a. Date of service, sequence number, provider unit, patient age and gender, whether the patient received ECMO, survived to admission (and discharge if known) and positive feedback when a job was well done

b. Any quality-of-care concerns

CROSS REFERENCE

Prehospital Care Manual

Ref. No. 320, **ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) Standards**
Ref. No. 320.1, **Target Temperature Management Guidelines**
Ref. No. 320,3, **SRC Performance Measures**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**
Ref. No. 513, **S-T Elevation Myocardial Infarction (STEMI) Patient Destination**
Ref. No. 516, **Cardiac Arrest Patient Destination**
Ref. No. 621.2, **Notification of Personnel Change Form**
Ref. No. 648, **STEMI Receiving Center Data Dictionary**

Ref. No. 1308, **Medical Control Guideline: Cardiac Monitoring / 12-Lead ECG**

Current American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

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