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: January 15, 2025
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 EMSAAC Annual Conference, May 28 & 29, 2025 with disaster pre-conference on May 27, 2025.

3. ELECTION OF OFFICERS

3.1 Nominating Committee Nominations for 2025 EMSC Chair/Vice-Chair
3.2 Standing Committee Nominations
3.3 Measure B Advisory Board Representative

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

4.1 **Minutes**
- 4.1.1 September 11, 2024
- 4.1.2 November 20, 2024

4.2 **Committee Reports**
- 4.2.1 Base Hospital Advisory Committee – October 9, 2024
- 4.2.2 Provider Agency Advisory Committee – October 16, 2024
- 4.2.3 Base Hospital Advisory Committee – December 11, 2024
- 4.2.4 Provider Agency Advisory Committee – December 18, 2024

4.3 **Policies**
- 4.3.1 Reference No. 222, Downgrade or Closure of 9-1-1 Receiving Hospital, Perinatal, Inpatient Psychiatric or Emergency Medical Services
- 4.3.2 Reference No. 411, 9-1-1 Provider Agency Medical Director
- 4.3.3 Reference No. 420, Private Ambulance Operator Medical Director
- 4.3.4 Reference No. 505, Ambulance Patient Offload Time (APOT)
- 4.3.5 Ref. No. 519, Management of Multiple Casualty Incidents
- 4.3.6 Reference No. 702, Controlled Drugs Carried on ALS, SCT and APRU Units

4.3.7 Reference No. 817, Regional Mobile Response Teams
4.3.8 Reference No. 823, Elder Abuse and Dependent Adult Abuse Reporting Guidelines

END OF CONSENT AGENDA

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5. BUSINESS

Business (Old)

5.1 Field Evaluation of Suicidal Ideation and Behavior
5.1.1 Medical Control Guideline: Evaluation and Care of Patients At Risk of Suicide
5.2 Ambulance Patient Offload Time (APOT)
5.2.1 Feldmeier, M., et al. (2024). Patterns in California Ambulance Patient Offload Times by Local Emergency Medical Services Agency *JAMA Open Network*, 7(12) 12), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2828075
5.3 The Public Works Alliance EMS Corps.
5.4 Cardiac Arrest Taskforce

Business (New)

5.5 EMSC Workplan (Goals/Objectives for 2025)

6. LEGISLATION

6.1 Chapter 1, EMS System Regulations (Previously Chapter 13)
6.2 Chapter 7, Trauma Care Systems

7. DIRECTORS' REPORTS

7.1 Richard Tadeo, EMS Agency Director/EMSC Executive Director

Correspondence

7.1.1 (11/27/24) Waiver Extension: Private Ambulance Vehicle Age Limit
7.1.2 (12/16/24) Hydroxocobalamin Approval for Local Optional Scope

7.2 Nichole Bosson, MD, EMS Medical Director
7.2.1 Medical Director's Report

8. COMMISSIONERS' COMMENTS / REQUESTS

9. ADJOURNMENT

To the meeting of March 12, 2025


EMSAAC
EMERGENCY MEDICAL SERVICES ADMINISTRATORS' ASSOCIATION OF CALIFORNIA
2025 Annual Conference
SAVE THE DATE
MAY 28 & 29, 2025
Loews Coronado Hotel, San Diego
California Dreamin'
United in Our Mission
Pre-Conference, May 27: California Screamin' - Your Disaster Medical Response
Presented by: EMS Administrators' Association of California
Monitor the EMSAAC website for current information: www.EMSAAC.org

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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.

EXECUTIVE DIRECTOR
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COMMISSION LIAISON
Denise Watson
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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.

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MINUTES
November 20, 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.	Nichole Bosson, MD	EMS Staff
☐ Tarina Kang, M.D.	Hospital Assn. of So. CA	Christine Clare	EMS Staff
☐ Carol Kim	Public Member, 1st District	Jacqueline Rifenburg	EMS Staff
☐ Kristin Kolenda, Chief	Peace Officers Association	Natalie Greco	EMS Staff
☒ Lydia Lam, M.D.	American College of Surgeons	Tracy Harada	EMS Staff
☒ Kenneth Liebman	LACo Ambulance Association	Paula Cho	EMS Staff
☐ James Lott, PsyD, MBA	Public Member, 2nd District	Sara Rasnake	EMS Staff
☒ Carol Meyer, RN	Public Member, 4th District	HanNa Kang	EMS Staff
☒ Kenneth Powell	LA Area Fire Chiefs' Assn.	Mariana Munatones	EMS Staff
☒ Connie Richey, RN	Public Member 3rd District	Ami Boonjaluksa	EMS Staff
☐ Brian Saeki	League of CA Cities/LA Co	Christine Zaiser	EMS Staff
☒ Stephen G. Sanko, MD	American Heart Association	Lily Choi	EMS Staff
☒ Carole A, Snyder, RN	Emergency Nurses Assn.	Mark Ferguson	EMS Staff
☐ Saran Tucker	So. CA Public Health Assn.	Michael Kim, MD	EMS Staff
☒ Atilla Uner, M.D., MPH	CAL-ACEP		EMS Staff
☐ *Gary Washburn	Public Member, 5th District		EMS Staff

GUESTS

Shelly Trites – APCC Alt Rep. Torrance Memorial	Dave Molyneux – AmWest Ambulance	Andy Reno - LBFD
Catherine Borman - SMFD	Jennifer Nulty - TFD	Joel Davis - LBFD
Michael Stone – USC	Clayton Kazan, MD - LACoFD	

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 1:05 p.m. A quorum was not met as only 9 commissioners were present.

2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

Richard Tadeo, EMS Agency Director/EMSC Executive Director read Dr. Ron Stewart's commencement address to the 200th Paramedic Training Institute class in his memoriam.

EXECUTIVE DIRECTOR
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COMMISSION LIAISON
Denise Watson
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3. CONSENT AGENDA – *All matters approved by one motion unless held.*
Chair Snyder deferred Consent Agenda since a quorum was not met and opened the floor for discussion.

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
Commissioner Erick Cheung reported on the latest updates from the committee. A draft policy was presented to Base Hospital and Provider Agency Advisory Committees for feedback and discussion. Request to provide definitions about suicidal patient encounters. A decision point being considered is if the Colombia-Suicide Severity Rating Scale, an evidence-based screening tool with 6 questions, will be mandatory, recommended or not included at all. This is being evaluated by having discussions with County Counsel and Risk Management. Once they have this information they will know with more certainty in which direction to head with the policy.

4.2 Ambulance Patient Offload Time (APOT)
Christine Clare, EMS Agency Nursing Director, reported on the third quarter 2024 APOT report. There are still two providers who are underreported and the deadline for resolution is today. The EMS Agency has not heard back from the State regarding issuing the state reports with the 30-minute time window, but that request has been made. Once receiving complete data consistently, the goal is to provide reports for every meeting.

The orange highlighted sections in the report are highlighting the 90th percentile APOT over 30 minutes.

4.3 The Public Works Alliance – EMS Corps.
Jacqueline Rifenburg, EMS Agency Assistant Director, reported that the Whittier site will be starting their first cohort January 2025. They will be using East Los Angeles Community College as their college credit provider. This is not a new EMT program as they are utilizing East LA Community College and it will be part of their EMT program. Their goal is to reach out to the youth who have been in the judicial system and get them on career path. The Compton site is still in the works.

Mrs. Rifenburg attended their first Board of Directors meeting in Alameda County earlier this month, where she met with other prospective site coordinators from other areas.

4.4 Cardiac Arrest Taskforce

The Commission endorsed the formulation of the Cardiac Arrest Taskforce with a primary goal to evaluate the system in terms of cardiac arrest treatment and outcome at the September meeting. The target is to align our system and meet the American Heart Association's (AHA) 2030 goals. Director Tadeo and Christine Clare met with Dr. Stephen Sanko, Dr. Shira Schlesinger, and Dr. Nichole Bosson to brainstorm on what they envision the group to be. A draft agenda was provided along with a list of the taskforce membership. If anyone from the public is interested in reviewing the AHA 2030 goals, they can contact Director Tadeo and he can provide a pdf of the AHA 2030 goals and objectives.

Dr. Sanko is confident that this group will end up with several recommendations that can help to improve outcomes and can be forwarded to the Board of Supervisors.

Business (New)

4.5 Nominating Committee

Commissioners Kenneth Powell, Dr. Sanko, and Dr. Cheung volunteered for the Nominating Committee to identify candidates for the EMSC Chair and Vice Chair for 2025. Their recommendations will be presented at the January 15, 2025, meeting. If any commissioners are interested in being chair or vice chair, they can contact Director Tadeo who will share with the nominating committee.

5. LEGISLATION

Director Tadeo reported on the following legislation:

5.1 EMS Regulations – Chapter 1 – These are the EMS regulations that the State is looking at and they are focused on the administration of EMS. They deal with grandfather rights 201 and 224. Last year the State had a listening session with their workgroup and 13 major stakeholders. They drafted specific goals and now they are finalizing and continuing to meet with a core group of stakeholders. They anticipate in December they will issue a draft of the regulations and go for public comment next year. They are hopeful the longstanding issues that resulted in litigation between counties, cities and other jurisdictions will be resolved by revising Chapter 1.

5.2 AB 1168 (Bennett) – This was to overturn of the court case between the City of Oxnard and County of Ventura. It has been approved by both houses of the state legislature, but it was vetoed by the Governor. It would have retroactively given the city of Oxnard grandfather rights to do emergency ambulance transportation.

5.3 AB 1843 – Passed and signed by the Governor and will go into effect January 1, 2025. It requires peer support services for private ambulance employees. This aligns with a state law that passed in 2019 that required public providers to provide peer support. One thing that is specific to this, is that it must be a labor management agreement not part of union contracting.

5.4 Prop 35 – This prop was on the November election ballet and passed with 67% Yes. This is for the permanent tax on medical managed care. Managed care plans pay taxes to the state to support a variety of health programs which include emergency room and prehospital care. This is not collecting any additional taxes; it is using taxes that are already being collected.

5.4 Ms. Clare mentioned AB 1300 that was passed and signed by the Governor and goes into effect January 1, 2025. It requires that if a hospital is closing perinatal services or inpatient psychiatric beds, a public hearing is required. The EMS Commission is designated by the Board of Supervisors to conduct these public hearings.

6. DIRECTOR'S REPORT

6.1 Richard Tadeo, EMS Agency Director, EMSC Executive Director
Director Tadeo reported on the following:

The 2025 Annual EMSAAC Conference will be taking place in San Diego, CA on May 28 and 29, with a pre-conference on May 27th.

The EMS Plans for Los Angeles County have been approved by the EMS Authority. Plans have been submitted since 2017 through 2024 and it has been a great effort to meet all the requirements.

Correspondence

6.1.1 (08/26/24) Annual Influenza and COVID-19 Immunization or Masking Requirements

6.1.2 (09/30/24) Medical Alert Cert 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
On December 1st, 2024, the pilot program will go into effect and the hospital or provider will be able to review the status of other hospitals on the Reddinet system and use that data to determine where to transport that patient. The data will be monitored monthly for 6 months. In 3 months, they will have a comprehensive evaluation and meet with the hospitals and impacted providers.

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
Dr. Bosson reported on the following:

6.2.1 Extracorporeal Cardiopulmonary Resuscitation (ECPR) Receiving Center Standards
The 4-year ECMO pilot has concluded. This pilot was the use of ECMO for patients with refractory out of hospital cardiac arrest, which has been shown in select patients to vastly improve their outcomes. The pilot demonstrated successful implementation of this therapy in our system. There was a total of 232 patients enrolled over the course of 5 years. 59 were ultimately cannulated for ECMO and that's usually anticipated because patients may be deemed as not eligible or achieve spontaneous circulation and not require it. Of the patients who received cannulation, 27% survived to hospital discharge, which was a substantial increase. The taskforce has decided to move this pilot into a system of care and they have released standards for ECPR hospitals to become designated as ECPR receiving centers. These hospitals will already be acting as STEMI receiving centers in LA County. They must also be base hospitals so they can coordinate the notification process. This project aligns well as one of many components to identify all the ways to improve cardiac arrest outcomes for patients in our system. The process will begin in July 2025, after receiving the initial applications from the current pilot participants. Training will also be included for all provider agencies during EMS

Update 2025 so they have the information on which patients qualify.

6.2.2 Marburg Virus Disease Protocols

The Marburg virus does not currently exist in the United States. There is an outbreak isolated in Rwanda at this time according to the CDC website. This is a viral hemorrhagic fever similar to Ebola. The United States has arranged that travelers from Rwanda stop at three airports, not including LAX, where they are initially screened. We don't anticipate receiving these patients however because this is an active outbreak of a potentially fatal disease, Public Health has issued guidance and we have, in collaboration with them, put out guidance to the provider agencies including what to do if they encounter a potential patient.

The public health order was released for influenza and COVID-19 vaccines. It states that for this viral season, both vaccines are required. This includes EMS clinicians. Clinicians have the option to receive the vaccines or decline and mask for the duration of the season, through April 1, 2025.

Dr. Bosson demonstrated the mobile protocol app which contains EMS policies and protocols and can be used by clinicians in the field.

There have been 90 enrollments in Pedi-PART since June 2024 and 270 overall. They are close to the 300 needed for the first interim analysis. There continues to be continued enrollment in PediDOSE and we are getting more paramedic self-reports.

LA DROP (Development and Rapid Operationalization of Prehospital Blood Transfusion) is the LA County initiative to implement prehospital blood transfusions. There is also CAL Drop which is the collaboration across the five different LEMSA's which meets monthly to share resources and procedures. Corona Fire has implemented as of today. The initiative is moving forward in California and the workgroup is working to finalize the operational plans and funding. We are expecting a launch in LA County in 2025.

We are applying for hydroxocobalamin as a local optional scope of practice item in LA County. Los Angeles Fire Department has requested to implement this primarily for the exposure of their own personnel in fire situations, but it will also benefit patients with the right clinical scenario. We have applied to the State and will be presenting in December. Several other LEMSA's already use this, and we have aligned with their protocols. We expect very few uses and will be notifying the Trauma hospitals who act as our burn surge hospitals because they're most likely to receive a patient that gets this treatment.

Dr. Denise Whitfield reported an update on plans to initiate an ALS skills verification program. Over a year ago a committee identified 12 skills of which ALS skills sheets were created for ongoing skills maintenance training to ensure there is a standardized teaching tool that can be used throughout LA County. During the annual EMS Update, there will be 12 skills total which will be divided by odd and even year, and we will be verifying that within a 3-year period all paramedics in our system have had verification that they are competent in these skills. The first 2 years, 2025 and 2026 will start with a trial of providers reporting to us and in 2027, as part of EMS Update, every paramedic would have the skill verified and report that they have completed it within the 3 years.

Dr. Shira Schlesinger reported that EMS Update 2025 will be 11 modules that can be completed separately with a single test at the end. The modules will include a range of topics that include changes in protocols and policies; to changes in the behavioral health MCG that was a result of the ELCOR committee. Introduction will begin in late March and with training to start in April.

Dr. Schlesinger reported that there will be a joint educational session after the Pediatric Advisory Committee on Tuesday, December 3rd covering the prehospital utilization of blood in New Orleans. It will be virtual with 1 hour of CE or CME.

7. COMMISSIONERS' COMMENTS / REQUESTS

8. ADJOURNMENT:
Adjournment by Chair Snyder at 2:17 p.m. to the meeting of Wednesday, January 15, 2025.

Next Meeting: Wednesday, January 15, 2025, 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.

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 Ad Hoc Committee on the Evaluation of 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

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.

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

December 11, 2024

	REPRESENTATIVES		EMS AGENCY STAFF
☑	Erick Cheung, MD, Chair	EMS Commission	Nichole Bosson, MD
☐	Diego Caivano, MD, Vice Chair	EMS Commission	Denise Whitfield, MD
☐	Atilla Under, MD, MPH	EMS Commission	Shira Schlesinger, MD
☐	Lydia Lam, MD	EMS Commission	Jake Toy, MD
☐	Saran Tucker	EMS Commission	Michael Kim, MD
☐	Carol Synder, RN	EMS Commission	Richard Tadeo
☐	Tarina Kang, MD	EMS Commission	Chris Clare
☐	Brian Saeki	EMS Commission	Jacqueline Rifenburg
☐	Vacant	EMS Commission	Mark Ferguson
☑	Rachel Caffey	Northern Region	Sara Rasnake
☑	Jessica Strange	Northern Region	Sam Calderon
☐	Michael Wombold	Northern Region, Alternate	Aldrin Fontela
☑	Samantha Verga-Gates	Southern Region	Hannah Kang
☑	Laurie Donegan	Southern Region	Lily Choi
☑	Shelly Trites	Southern Region	Mariana Munatones
☑	Christine Farnham	Southern Region, Alternate	Priscilla Romero
☑	Ryan Burgess	Western Region, Alternate	Laura Leyman
☑	Travis Fisher	Western Region	
☑	Lauren Spina	Western Region	
☐	Susana Sanchez	Western Region	
☐	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	Kelsey Wilhem, MD
☑	Gabriel Campion, MD	Base Hospital Medical Director	Shane Cook, LACoFD
☐	Salvador Rios, MD	Base Hospital Medical Director, Alternate	Victor Lemus, Compton FD
☑	Adam Brown	Provider Agency Advisory Committee	
☑	Jennifer Nulty	Prov. Agency Advisor Committee, Alternate	
☑	Elizabeth Charter	Pediatric Advisory Committee Representative	
☐	Desiree Noel	Ped AC Representative, Alternate	
☑	John Foster	MICN Representative	
☐	Vacant	MICN Representative, Alternate	

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

1. **CALL TO ORDER:** The meeting was called to order at 1:02 p.m. by EMS Commissioner Chair, Erick Cheung, MD.

2. **INTRODUCTIONS/ANNOUNCEMENTS:**

2.1 EMSAAC 2025 Conference Save the Date Flyer was included in the packet.

3. **APPROVAL OF MINUTES**

3.1 The Meeting Minutes for October 9, 2024, were approved as presented.

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

4. **Old Business: None**

5. **NEW BUSINESS**

5.1 Cognito Form

The EMS Agency now has its own Cognito Forms account, separate from the one managed by LA County Fire and will be taking over the *STEMI Feedback Forms* and adding additional forms, such as a *Pediatric Feedback Form*. The *Incident Form* has been revised to streamline the submission process. This change aims to improve efficiency and accessibility for everyone using the system.

5.2 Pediatric Surge

The Pediatric Surge Plan and policy updates were presented by Essence Wilson, Disaster Program Manager.

5.3 High-flow Oxygen for Traumatic Brain Injury

Dr. Bosson discussed the inconsistencies in the use of high-flow oxygen in traumatic brain injury (TBI) cases in the field. To strengthen messaging, literature and evidence supporting TBI protocol will be distributed to the group.

5.4 Pilot Program-Elimination of Service Area Boundaries

The pilot program started on December 1, 2024, aimed at evaluating the feasibility of eliminating service area boundaries while maintaining effective patient distribution. The EMS Agency will utilize First Watch and the APOT times for data collection. The duration of the pilot is expected to last three months.

Policies for Discussion: No Action Required

5.5 Ref. No. 1317XX, MCG: Hydroxocobalamin

The policy has been added for optional use for the treatment of suspected cyanide exposure. It has been incorporated in the subsequent policies below and will be added to MCG 1309 and the Mobile Protocol Application. This policy will go into effect on April 1, 2024.

5.5.1 Ref. No. 803/803.1, Los Angeles County Paramedic Scope of Practice

5.5.2 Ref. No. 1236/1236-P, Inhalation Injury

5.5.3 Ref. No. 1238/1238-P, Carbon Monoxide Exposure

5.5.4 Ref. No. 1240/1240-P, Hazmat

5.5.5 Ref. No. 1300-Table of Contents

5.6 Ref. No. 222, Downgrade or Closure of 9-1-1 Receiving Hospital

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

Richard Tadeo encouraged hospitals to establish a process involving EMTs, nurses and paramedics to effectively assess facility equipment time (when the patient is physically offloaded off the provider equipment) to validate real-time data in accordance with State regulations. It is important to note that the signature on the ePCR time stamp indicates the nurse's acknowledgement of patient receipt, which does not pertain to facility equipment time.

Approved as presented, M/S/C (Strange/Fisher)

- Two members expressed dissent to the changes in Ref. No 505.

5.8 MCG XXX/MCG XXX.1 Evaluation and Care of Patients at Risk of Suicide

The MCG will help to address an approach by EMS personnel and MICNs regarding suicide risk evaluation in the field. County Counsel and Risk Management indicated the Columbia Suicide Severity Risk Scale (C-SSRS) should remain a recommended tool for evaluating a patient's suicide risk assessment. This MCG will be incorporated in EMS Update.

Informational Policies: No Action Required

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

The policy was referred following concerns from the Provider Agency Advisory Committee (PAAC) about the term 'Base Contact' and its implications for the providers. Additional details regarding hospital notification have been included in the policy. It has been acknowledged that there is a necessity for education among all parties involved in MCIs.

6. REPORTS & UPDATES:

6.1 EMS Update 2025

The special consideration for mild hyperventilation targeting an end tidal ETCO2 of 30-35 mmHg in traumatic brain injury (TBI) cases has been removed from treatment protocol 1244. This information will be incorporated into EMS Update and evidence supporting this decision will be disseminated to the group.

6.2 EmergiPress

The November/December issue has been released.

6.3 ITAC Update (Tabled)

6.4 Research Initiatives & Pilot Studies

6.4.1 ECMO Pilot – The pilot program concluded in September 2024 with a total enrollment of 232 patients with a cannulation rate of 25% and a survival rate of 25%. The ECPR centers are scheduled to be designated on July 1, 2025, coinciding with the training on the criteria for these centers and revised policies for EMS Update.

6.4.2 Prehospital Blood Transfusion Pilot: No updates

6.4.3 Thorasite Pilot: The pilot program will conclude in December 2024 and the data will be presented in 2025.

6.5 PediDOSE Trial

A revised edition of the PediDOSE poster has been distributed to the hospitals with an updated phone number and additional reporting details were added.

6.6 Pedi-PART

Please encourage paramedics to the strict adherence to the assigned study arms: utilize i-gel on odd days and bag-valve mask (BVM) on even days.

6.7 California Office of Traffic Safety (OTS) Grants Projects

6.7.1 Mobile Protocol Application

The release of the Mobile Protocol Application is scheduled for January 2025

6.7.2 Trauma Dashboards/Curriculum

No updates reported.

7. OPEN DISCUSSION

All three PIH Enterprise hospitals have been comprised and remain on downtime protocols with limitied access to phones, computers, or emails. Despite the circumstances, the hospitals are fully operational.

8. NEXT MEETING: February 5, 2025

9. ADJOURNMENT: The meeting was adjourned at 15:02

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

ACCOUNTABILITY: Laura Leyman

EMERGENCY MEDICAL SERVICES COMMISSION
PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, December 18, 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
	Sean Stokes	Area A *(Rep to Medical Council)*
X	Patrick Nulty	Area A, Alternate
	Keith Harter	Area B
X	Clayton Kazan, MD	Area B, Alternate
	Todd Tucker	Area C
X	Jeffrey Tsay	Area C, Alternate
	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
X	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,
X	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	Richard Tadeo
Chris Clare	Michael Kim, MD
David Wells	Jacqueline Rifenburg
Bijan Arab, MD	Jonathon Warren, MD
Ami Boonjaluksa	Jennifer Calderon
Paula Cho	Aldrin Fontela
Mark Ferguson	HanNa Kang
Natalie Greco	Tracy Harada
Sandra Montero	Sara Rasnake
Priscilla Ross	Essence Wilson
Christine Zaiser	

GUEST	ORGANIZATION
Erick Cheung, MD	UCLA Health
Angelica Loza-Gomez, MD	GL, SI, MO, Verdugo
Heidi Ruff	LAFD – Air Operations
Jim Goldsworthy	LAFD – Air Operations
Kristina Crews	LACoFD
Joe Nakagawa, MD	Hawthorne PD, WM
Alfredo Estrada	Montebello FD
Marc Cohen, MD	LAFD, BH, TF
Salvador Rios, MD	Monrovia FD, AR
Jessi Castillo	PRN Ambulance
Patricia Guevara	Burbank FD, SG
Nanci Medina	LAFD
Valentina Triamarit	LACoFD
Catherine Borman	Santa Monica FD
Michael Stone, MD	LA General – EMS Fellow
Issac Yang	Redondo Beach FD
Michelle Evans	West Coast Ambulance
Adrienne Roel	Culver City FD
David Milligan	Montebello FD
Peter Garcia	Burbank FD
Danielle Ogaz	LACoFD
Paula LaFarge	LACoFD
Ryan Shook	Santa Monica FD
Heather Calka	Glendale FD
Todd McClung	Reach Air
Andrew Lara	First Rescue Ambulance
Theodor Ecklund	Pasadena FD
Louis Mendoza	Glendale FD

1. CALL TO ORDER – Chair Kenneth Powell, called meeting to order at 1:00 p.m.

2. INTRODUCTIONS AND ANNOUNCEMENTS

2.1 Provider Agency Hospital Emergency Response Team (HERT) Drills *(Shira Schlesinger, MD)*

- Offer to all providers to participate in HERT Drills. If interested, email Dr. Schlesinger at sschlesinger2@dhs.lacounty.gov. Will assist in coordination and development of scenario.

2.2 EMSAAC 2025 Annual Conference *(Richard Tadeo)*

- Save the Date: May 28 & 29, 2025, @Loews Coronado Bay Resort with a Disaster Medical Response pre-conference on May 27th.

3. APPROVAL OF MINUTES (Brown/Conroy) October 16, 2024, minutes were approved as written.

5. NEW BUSINESS

5.5 Reference No. 13XX, Medical Control Guideline: Evaluation and Care of Patients at Risk of Suicide *(Erick Cheung, MD & Denise Whitfield, MD)*

- Due to time constraints, Agenda Item 5.5 was moved to be addressed at this time.
- Dr. Whitfield and Dr. Cheung presented updates and clarification to the medical control guideline (MCG) in addition to addressing two points from prior meeting, screening and disposition; and legal issues.
- Richard Tadeo emphasized that this is a guideline which provides tools, standardization in approach, and legal protections for extremely fluid situations for what is already being performed in the field without any guidance and protection.
- Member discussion points included that an MCG is a standard, document doesn't change disposition, law enforcement acts independently, and MCG increases education necessity.

4. UNFINISHED BUSINESS

Policies for Discussion; Action Required:

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

Policy reviewed and approved with the following recommendation to Policy Section I.C.2.:

- For the continuity of patient care during transport, the transporting Paramedic should attempt to contact the Base Hospital or make a notification to the Receiving Facility, if time permits. With the dynamic situation of an MCI, this may not be feasible.

M/S/C (Jack/Cheng) Approved

Policies for Discussion; No Action Required:

4.2 Reference No. 1200.2, Treatment Protocol: Base Contact Requirements *(Denise Whitfield, MD)*

Policy reviewed

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

Policy reviewed. Education to be provided with EMS Update 2025. Recommendation to evaluate the structure of the treatment protocol and revise in a manner similar to the cardiac arrest protocol.

5. NEW BUSINESS

5.1 Pediatric Surge Plan *(Essence Wilson)*

- Revised Pediatric Acute Surge Plan presented.
- A pediatric medical surge plan to be developed.

5.2 Cognito Form *(Jacqui Rifenburg)*

- Now housed by EMS.
- STEMI form updated, additional forms to follow including the EMS Situation Report.

Policies for Discussion; No Action Required:

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

- AB40 – APOT Hospital Requirements
- Validation tool and compliance by the California EMS Authority (EMSA), not the EMS Agency.
- APOT Standard is 30 minutes, 90% compliance.

- Start time is arrival at facility; End time is when transferred to facility equipment.
- Encouraged personnel to communicate with emergency department staff to validate facility equipment time.
- Richard Tadeo requested a vote for this policy.

M/S/C (Kazan/Conroy) Approved

5.4 Reference No. 1317.XX Hydroxocobalamin *(Nichole Bosson, MD)*
5.4.1 Reference No. 803 / 803.1, Los Angeles County Paramedic Scope of Practice
5.4.2 Reference No. 1236 / 1236-P, Treatment Protocol: Inhalation Injury
5.4.3 Reference No. 1238 / 1238-P, Treatment Protocol: Carbon Monoxide Exposure
5.4.4 Reference No. 1240 / 1240-P, Treatment Protocol: HAZMAT
5.4.5 Reference No. 1300, Medical Control Guidelines (Table of Contents)

- Received approval from EMSA for Paramedic Local Optional Scope of Practice.
- Optional for all providers.
- Will be added to Ref. No. 1309 for Color Code Drug Dosage, dose cannot be rounded in application but is appropriate to the nearest whole number.

6. REPORTS AND UPDATES

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

- Due to time constraints, Agenda Item 6.6 was moved to be addressed at this time.
- RALPH devices are being **recalled** due to a hardware issue with a chip which causes the day to be incorrect. **ALL** RALPH devices must be returned to the EMS Agency to return to the vendor. Once repairs are completed, the devices will be reissued. Please contact Carola Jimenez at RJimenez2@dhs.lacounty.gov to coordinate returning of all issued devices.
- Study compliance remains a significant challenge 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. Reminders to personnel is essential.
- Completion of paramedic self-reports (PSR) continue to do well with nearly 100% compliance.
- Providers were also reminded to ensure placement of the defibrillation pads on all patients in this study. Replacement pediatric defibrillation pads for Zoll will be distributed by the EMS Agency and reimbursed by the study for Lifepack.
- Providers who currently do not currently have a contract or are not engaged in contract negotiations are eligible to receive access to the premium Zoll cardiac monitor case review program. This access will continue only through the duration of the study. Please provide the name, phone, and email of the individual to be provided access to Dr. Bosson at Nbosson@dhs.lacounty.gov.
- A voluntary, auxiliary study is commencing for paramedics participating in Pedi-PART. The focus is interviewing paramedics on their recent experiences in pediatric resuscitation and perceived challenges in terminating resuscitation. Participants will receive $50 for completion. Please contact Dr. Bosson via email above for paramedics interested in participating.

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

- Currently in development with workgroup meeting regularly.

6.2 EmergiPress *(Shira Schlesinger, MD)*

- Nov/Dec released, SCORM file updated due to learning management system (LMS) issues.
- Topic recommendations, please forward to Dr. Schlesinger at sschlesinger2@dhs.lacounty.gov

6.3 ITAC Update *(tabled)*

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

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

- Los Angeles County FD (LACoFD) was awarded grant funding.
- Targeted start date in the spring of 2025 by LACoFD in the South Bay area. Compton FD is continuing to seek funding.

6.4.2 ECMO Pilot *(Nichole Bosson, MD)*

- There were 232 patients enrolled in this pilot, with approximately 50 patients treated with eCPR and a 25% survival rate of those cannulated.
- 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, all provider agencies will be trained on ECMO protocol with systemwide implementation on July 1, 2025. Strict adherence to the protocol is necessary for the system.

6.4.3 ThoraSite *(Denise Whitfield, MD)*

- Results will be shared next year

6.5 PediDOSE Trial *(Nichole Bosson, MD)*

- Improvement noted systemwide on compliance rates for the PSRs. The goal remains for paramedics to complete a PSR on all pediatric seizure responses.
- An error with a phone number was noted on the PediDOSE poster. This has been corrected and updated posters have been distributed.
- The age will be reduced to 12 months after completion of EMS Update 2025.

6.7 California Office of Traffic Safety (OTS) Grants Projects

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

- Projected systemwide release date is the end of January 2025.
- Recruiting for 48 paramedic pairs to participate in a study utilizing the application at Harbor-UCLA Simulation lab. Participants will receive $50 and 2 hours of EMS CE, more to follow.

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

- Vendor chosen, contract in process.

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

- Task force transitioning to a committee in January 2025.
- Document on body worn cameras by law enforcement, EMS providers, and possible healthcare implications (HIPPA, etc.) is posted on the EMS Agency's webpage under Medical Director updates.

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

- ALS Skills will commence with EMS Update 2025.

7. OPEN DISCUSSION

None

8. NEXT MEETING - February 12, 2025

9. ADJOURNMENT - Meeting adjourned at 3:02 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DOWNGRADE OR CLOSURE OF 9-1-1 RECEIVING HOSPITAL, PERINATAL, INPATIENT PSYCHIATRIC OR EMERGENCY MEDICAL SERVICES** REFERENCE NO. 222

PURPOSE: To establish a procedure to be followed if a general acute care facility plans to downgrade or eliminate emergency medical services; eliminate perinatal or inpatient psychiatric services or close the hospital completely.

AUTHORITY: California Code of Regulations 70105(a), 70351(a), 70351(b)(1), 70351(b)(5), 70367(a)
Health and Safety Code, Sections 1255.1, 1255.2, 1255.25, 1300

PRINCIPLES:

1. Hospitals with a basic or comprehensive emergency department permit provide a unique service and an important link to the community in which they are located. In certain instances, the reduction or withdrawal of these services may have a profound impact on the emergency medical services (EMS) available in their area and to the community at large.

2. Every effort should be made to ensure that essential emergency medical services are continued until emergency care can be provided by other facilities, or until EMS providers can adjust resources to accommodate anticipated needs.

3. Before any changes are finalized, the EMS Agency should have sufficient time and opportunity to develop an EMS Impact Evaluation Report (IER) that examines the closure's effect on the community.

4. Before approving a downgrade or closure of emergency medical, perinatal or inpatient psychiatric services, the California State Department of Public Health (CDPH) shall receive a copy of the IER to determine the expected impact of the changes, including access to emergency care and the effect of the closure on emergency services provided by other entities.

PROCEDURE:

I. Responsibilities of the Health Facility Proposing the Downgrade or Closure

   A. As soon as possible but not later than 180 days prior to a planned reduction of EMS services or closing of a health facility, or 120 days prior to eliminating perinatal or inpatient psychiatric services, the facility shall provide a written notice of the proposed downgrade or elimination of said services to the following entities:

      1. The EMS Agency.

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

2. The local government entity in charge of the provision of health services and the Board of Supervisors of the county in which the health facility is located.

3. The city council of the city in which the health facility is located.

4. The CDPH, Licensing and Certification Division.

5. All health care service plans.

6. Other entities under contract with the hospital that provide services to enrollees.

B. Not less than 180 days prior to closing a health facility or reducing EMS services, or 120 days prior to eliminating perinatal or inpatient psychiatric services, the facility shall provide public notice, including a notice posted at the entrance to all affected facilities:

The required notice shall include:

1. A description of the proposed reduction or elimination.

2. The description shall be limited to publicly available data, including the number of beds eliminated, if any, the probable decrease in the number of personnel, and a summary of any service that is being eliminated, if applicable.

3. A description of the three nearest available comparable services in the community. If the health facility closing these services serves Medi-Cal or Medicare patients, the health facility shall specify if the providers of the nearest available comparable services serve these patients.

4. A telephone number and address for each of the following where interested parties may offer comments:

   a. The health facility.

   b. The parent entity, if any, or contracted company, if any, that acts as the corporate administrator of the health facility.

   c. The chief executive officer.

5. The notice shall be provided in a manner that is likely to reach a significant number of community residents serviced by the facility to include:

   a. A continuous notice posted in a conspicuous location on the home page of the health facility’s internet website.

   b. A notice published in a conspicuous location within a newspaper of general circulation serving the geographical area in which the facility

is located. The notice shall continue for a minimum of 15 publications dates.

c. A continuous notice posted in a conspicuous location within the internet website of a newspaper of general circulation serving the local geographical area in which the facility is located.

d. A notice posted at the entrance of every community clinic within Los Angeles County that grants voluntary permission for posting.

6. The facility should make reasonable efforts at public notice including, but not limited to:

a. Advertising the change in terms easily understood by a layperson.

b. Soliciting media coverage regarding the change.

c. Informing patients of the facility of the impending change.

d. Notifying contracting health care service plans.

7. <u>For elimination of perinatal and inpatient psychiatric services ONLY</u>, the public notice shall also include:

a. Statistically, deidentified and aggregated data about the health facility's patients who received either inpatient psychiatric services or perinatal services as applicable, within the past five (5) years, including, but not limited to all of the following:

i. The conditions treated.

ii. The ethnicities of patient served if patient voluntarily shared their ethnicity with the health facility. Data on ethnicities shall only be shared on the public notice to the extent to which is does not disclose any personal information in a manner that would link the information disclosed to the individual to whom it pertains.

iii. The ages of patients served.

iv. Whether the patients served had private insurance, Medi-Cal, Medicare, or no insurance.

v. A justification for the health facilities to eliminate services.

8. This does not apply to county facilities subject to Health & Safety Code Section 1442.5.

C. Notify planning or zoning authorities of the proposed downgrade or closure of 9-1-1 receiving hospital or emergency medical services so that street signage can be removed.

D. A hospital is not subject to the above if CDPH:

1. Determines that the use of resources to keep the emergency department (ED) open substantially threatens the stability of the hospital as a whole.

2. Cites the ED for unsafe staffing practices.

II. Responsibilities of the Local EMS Agency

A. Develop an IER in consultation with impacted hospitals and 9-1-1 providers. Include, at minimum, the following evaluation criteria if downgrading or closing 9-1-1 receiving hospital or emergency medical services:

1. The hospital's geographic proximity to other facilities within a five and ten mile radius.

2. The annual number of 9-1-1 basic life support (BLS) and advanced life support (ALS) transports.

3. The number of ED treatment stations and total emergency department volume.

4. The number of paramedic contacts per month if the hospital is a paramedic base hospital.

5. The number of trauma patients received per month if the hospital is a designated trauma center.

6. The number of ST-Elevation Myocardial Infarction (STEMI) patients received per month if the hospital is a designated STEMI receiving center.

7. The number of stroke patients received per month if the hospital is a designated stroke center.

8. The number of perinatal patients received per month if hospital is closing perinatal services.

9. The number of psychiatric patients received per month if hospital is closing inpatient psychiatric unit.

10. A list of the services provided by the hospital and the surrounding facilities (Emergency Department Approved for Pediatrics (EDAP), STEMI Receiving Center, Pediatric Medical Center (PMC), Disaster Resource Center (DRC), Approved Stroke Center, Sexual Assault Response Team (SART) Center, burn, perinatal, inpatient psychiatric, Trauma Center).

11. The average emergency department diversion of surrounding facilities.

B. If the facility is closing only perinatal and/or inpatient psychiatric unit, develop an IER in consultation with impacted hospitals and 9-1-1 providers. Include, at minimum, the following evaluation criteria:

1. The hospital's geographic proximity to other facilities within a five and ten mile radius.

2. The number of perinatal patients received per month if hospital is closing perinatal services.

3. The number of psychiatric patients received per month if hospital is closing inpatient psychiatric unit.

4. A list of the services provided by the hospital and the surrounding facilities (Emergency Department Approved for Pediatrics (EDAP), perinatal, inpatient psychiatric, as applicable.

C. Conduct at least one public hearing if the service being downgraded or closed is the facility's perinatal, inpatient psychiatric unit(s) or emergency department. The public hearing shall be conducted by the Emergency Medical Services Commission (EMSC).

1. The EMSC may hold the public hearing at their normally scheduled meeting or convene a special meeting at the request of the Director of the EMS Agency.

2. The hearing shall be held within 30 days following notification of the intent to downgrade or close emergency medical services or 60 days following notification of intent to close perinatal or inpatient psychiatric services.

D. Reconfigure the EMS system as needed. If the EMS Agency determines that the downgrade or closure of a hospital ED, perinatal service or psychiatric inpatient unit will significantly impact the EMS system, the Agency shall:

1. Determine the reason(s) a hospital has applied to do so; and

2. Determine whether any system changes may be implemented to maintain the hospital services within the system; or

3. Develop strategies to accommodate the loss of the ED or other identified specialized service to the system.

E. Forward the IER to the Board of Supervisors for adoption.

F. Forward the IER to CDPH within three days of its adoption by the Board of Supervisors and within 60 calendar days after the initial notification from hospital of the proposed downgrade or closure.

III. Following receipt of the IER, CDPH shall notify the hospital, in writing, of its decision regarding the application to downgrade or close emergency services or the facility.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 206, **Emergency Medical Services Commission Ordinance No. 12332 - Chapter 3.20 of the Los Angeles County Code**

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)

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

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

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

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

DEFINITIONS:

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

Facility Equipment Time: The time the patient is transferred to the ED gurney, bed, chair or other acceptable location.

PRINCIPLES:

1. As per the Emergency Medical Treatment & Labor Act (EMTALA), the responsibility for patient care lies with the receiving facility once the patient arrives at the hospital property.

2. Hospitals have the responsibility to ensure policies and processes are in place that facilitate the rapid and appropriate transfer of patient care from EMS personnel. Hospital staff shall make every effort to offload patients from ambulance gurneys as soon as possible.

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

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

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

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

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

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

POLICY:

I. Responsibilities of Hospital ED Personnel to Mitigate Extended APOT

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

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

C. Confirm with EMS personnel the “facility equipment time” to be documented on the ePCR of the EMS personnel.

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

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

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

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

II. Responsibilities of EMS Personnel to Mitigate Extended APOT

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

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

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

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

2. Normal mental status (GCS 15)

3. Normal vital signs upon arrival to the ED per Ref. No. 1380 for adults
   - SBP ≥ 90mmHg
   - HR 60-100
   - RR 12-20

- O2 Saturation ≥94% on room air
- Or per Ref. No. 1309 for pediatrics

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

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

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

7. No ongoing ALS intervention required

8. Patients who received medications that may require ongoing reassessment (e.g., naloxone, narcotics, epinephrine) shall be discussed with the appropriate ED staff (e.g., triage nurse) prior to being offloaded in the waiting room.

D. If APOT estimate is > 30 minutes and the patient does not meet the criteria listed in II. C., each individual EMS personnel (EMT or Paramedic), in order to facilitate EMS field operations, may observe up to 4 patients within their scope of practice at the discretion of the EMS provider's supervisor, while awaiting patient offload to facility equipment.

1. Coordination will be done by the EMS Provider agency's on-site supervisor to identify the EMS personnel who will monitor patients awaiting transfer of care to ED staff and those that may be released to accept other emergency calls.

2. Hospitals should provide gurneys or cots for these patients, to allow EMS personnel to maintain their field operations.

3. EMS Provider agency's on-site supervisor may authorize the placement of temporary cots to house EMS patients being observed by EMS personnel awaiting transfer of care to ED staff.

E. Document the "facility equipment time" on the electronic patient care record (ePCR) to capture the time patient care is transferred to ED personnel. This shall be done in consultation with hospital licensed personnel accepting responsibility for the care of the patient.

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

III. Responsibilities of the EMS Agency

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

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

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

D. In instances whereby extended APOT threatens public health and safety by preventing EMS response to emergency medical incidents, the EMS Agency, with appropriate notification to hospital, may authorize EMS personnel provided the patient meets **ALL** the criteria listed in II.C to:

1. Inform ED medical personnel that they are transitioning patient care **and**

2. Immediately offload patient to a hospital bed or other suitable hospital sitting or reclining device as appropriate for patient condition**.**

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

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

Month	Action 1	Audit Result	Action 2
1st	EMS Agency audits Hospital's compliance with APOT Standard.	Hospital consistently demonstrate prolonged APOT, and EMS Providers have consistently requested to place Hospital on ALS and/or BLS Diversion	EMS Agency notifies hospital's ED Director and ED Nurse Manager, via email or telephone, of audit results, requests corrective action plan and assists in determining solutions.
2nd	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital fails to demonstrate incremental improvement in APOT.	EMS Agency sends a written notice to Hospital's ED Director and Nurse Manager notifying them of the audit results and their non-compliance.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
3rd	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT.	EMS Agency notifies Hospital's CEO in writing of audit results and request a corrective action plan be submitted within 15 calendar days.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.

Month	Action 1	Audit Result	Action 2
4th	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT.	Within 15 days of the EMS Agency's receipt of Hospital's corrective action plan, a written approval or request additional modifications to the plan.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
5th	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT.	EMS will request modification to Hospital's corrective action plan.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
6th	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT	See Policy III.F.
		Hospital's compliance threshold improves.	Monitor to ensure Hospital maintains improvement in APOT.

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

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

CROSS REFERENCE:

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

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

Reference No. 505, Ambulance Patient Offload Time (APOT)

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	12/18/24	12/18/24	No
	Base Hospital Advisory Committee	12/11/24	12/11/24	Yes
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			
	Emergency Health Services Committee, HASC	12/3/24	12/3/24	No

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

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

REFERENCE NO. 505, Ambulance Patient Offload Time (APOT)

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definition (Facility Equipment Time)	BHAC 12/3/2024	Delete the phase "…and the ED assumes responsibility for the care of the patient."	Changes Made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **MANAGEMENT OF MULTIPLE CASUALTY INCIDENTS**

REFERENCE NO. 519

PURPOSE: To provide guidelines for the efficient management of multiple casualty incidents (MCI) through coordination between prehospital care personnel, receiving facilities, and the Medical Alert Center (MAC) to allow for maximum resource allocation, patient distribution, and to prevent unnecessary delays in patient care and transport.

To provide guidelines for transition from a MCI response to a Mass Casualty Incident Management Response.

This policy defines the roles of the provider agency, MAC, base hospital, and receiving facilities during an MCI.

DEFINITIONS : Refer to Ref. No. 519.1, Multiple Casualty Incidents (MCI) – Definitions.

PRINCIPLES:

1. The Incident Command System (ICS) should be utilized at all MCI's.

2. Terminology is standardized.

3. Expedient and accurate documentation is essential.

4. The MAC is equipped to communicate with multiple receiving facilities simultaneously and can rapidly assess system wide emergency department bed status, hospital, and ambulance resources.

5. Request for hospital diversion status should be considered when determining patient destination; however, if appropriate, patients may be directed to hospitals requesting diversion (Exception: Internal Disaster).

6. Patients requiring Advanced Life Support (ALS) treatment or procedures should be transported by paramedics whenever possible; however, these patients may be transported by Basic Life Support (BLS) units based on available resources during the MCI. BLS units may transport to other than the Most Accessible Receiving (MAR) facility if the patient meets specialty care center criteria and based on available system resources.

7. The EMS Agency will facilitate a post-incident debriefing of large scale incidents to include all affected agencies.

8. To maintain system readiness, provider agencies, hospitals, MAC, and other disaster response teams should carry out regularly scheduled MCI, disaster drills, and monthly VMED28 radio checks.

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

9. On any MCI in which the need for air transport is identified, early notification to air operations providers is essential in order to ensure rapid access to medical care and preserve life. Air transport should be reserved for immediate patients whose transport destination is greater than can be achieved quickly by available ground ambulances.

POLICY:

I. Role of the Provider Agency

A. Institute ICS as necessary.

B. Implement MCI Triage Guidelines (modified START & Jump START) as necessary (see Ref. No. 519.2, MCI Triage Guidelines).

C. Establish early communication with the:

1. MAC, to support incident management;

2. Base hospital, if indicated and feasible, for the purpose of medical direction and/or patient destination.

3. The transporting paramedic should make every attempt to notify the receiving facility if time permits. With the dynamic situation of an MCI, this may not be feasible.

D. If the need for additional ALS and/or BLS transport units exceeds the jurisdictional provider agency's capability, additional transport resources may be requested by the jurisdictional dispatch center or the Fire Operational Area Coordinator (FOAC) as per Ref. No. 519.3, Multiple Casualty Incident Transportation Management.

E. Request hospital based medical resources (i.e., HERT) from the MAC as outlined in Ref. No. 817, Regional Mobile Response Team if necessary.

F. Provide the following scene information to the MAC:

1. Nature of incident

2. Location of incident

3. Medical Communications Coordinator (Med Com) provider unit and agency

4. Agency in charge of incident

5. Total number of estimated immediate, delayed, minor and deceased patients. If indicated, include total number and category of pediatric patients

6. Nearest receiving facilities including trauma centers, PMCs, PTCs, and

EDAPs

7. Transporting provider, unit number, and destination

8. Type of hazardous material, contamination, level of decontamination completed, if indicated

9. Name of law enforcement agency on scene if involved in patient care and/or transportation

G. Document the following patient information on the appropriate Patient Care Record:

1. Patient name

2. Chief complaint

3. Triage category

4. Mechanism of injury

5. Age

6. Sex

7. Brief patient assessment

8. Brief description of treatment provided

9. Sequence number

10. Transporting provider, unit number, and destination

H. Reassess situational status to identify available resources and resource needs. If the anticipated resource needs exceed available local and mutual aid resources, contact the FOAC. Additional resources beyond the operational area shall be requested through the Regional Disaster Medical and Health Coordinator (RDMHC) via the MAC.

C. Whenever departmental resources allow, the EMS provider agency should consider assigning a provider agency representative to report to the MAC to assist with communications and coordination of patient destination.

II. Role of the MAC

A. Provide prehospital care personnel with emergency department bed availability and diversion status as indicated by the ReddiNet poll.

B. Arrange for additional ambulance transport units as requested by the FOAC or RDMHC.

C. Coordinate activation of Regional Mobile Response Teams as requested.

D. Coordinate Air ambulance resources.

E. Notify receiving facilities of incoming patients immediately via the ReddiNet®.

F. Document, under the authority of the EMS Administrator on Duty (AOD) lifting of trauma catchment and service areas.

G. Maintain an “open MCI victim list” via the ReddiNet® for 72 hours.

H. Complete a written report to include a summary of the incident and final disposition of all patients involved as indicated.

I. Notify the EMS AOD and Medical Officer on Duty (MOD) per MAC policies and procedures.

J. The EMS Agency, as the Medical and Health Operational Area Coordinator (MHOAC) for the County of Los Angeles, will assess the situational status and evaluate available resources and resource needs. If the anticipated resource needs exceed the available resources the EMS Agency, via its role as the RDMHC, will request resources from surrounding counties.

K. Maintain an EMS provider agency Medical/Health Resource Directory and assist EMS providers with MCI resource management when requested.

III. Role of the Base Hospital

A. Provide EMS personnel with emergency department bed availability and diversion status.

B. Assist EMS personnel as needed with patient destination.

C. Provide medical direction as needed.

D. Notify receiving facilities of incoming patients.

IV. Role of the Receiving Facility

A. Provide the MAC or base hospital with emergency department bed availability upon request.

B. Trauma Centers are automatically designated to accept 20 Immediate patients (adult and pediatric) from MCIs, if needed MAC will distribute patients systemwide based on the incident.

C. When activated by the EMS Agency, Burn Resource Centers (BRC) can accept up to 20 critically burned patients (includes both adult and pediatric).

D. Accept MCI patients as directed by the MAC or base hospital.

E. Monitor VMED 28 and ReddiNet®, recognizing that these are the default methods for MCI communications since Base Contact and/or notification may not be feasible when field resources are limited.

F. Provide the MAC or base hospital with patient disposition information, sequence numbers, and/or triage tags when requested and enter information into the ReddiNet®.

G. Maintain the "Receiving Facility" copy of the Patient Care Record and/or triage tag as part of the patient's medical record.

H. Ensure that requested patient information is entered as soon as possible into the ReddiNet® "MCI victim list" for all patients received from the MCI. The "MCI victim list" will remain open for 72 hours after the incident.

I. Notify the MAC if resource needs exceed available resources.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 201, **Medical Direction of Prehospital Care**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 506, **Trauma Triage**
Ref. No. 510 **Pediatric Patient Destination**
Ref. No. 511, **Perinatal Patient Destination**
Ref. No. 519.1, **MCI Definitions**
Ref. No. 519.2, **MCI Triage Guidelines**
Ref. No. 519.3, **Multiple Casualty Incident Transportation Management**
Ref. No. 519.4, **MCI Transport Priority Guidelines**
Ref. No. 519.5, **MCI Field Decontamination Guidelines**
Ref. No. 519.6, **Regional MCI Maps and Bed Availability Worksheets**
Ref. No. 803, **Paramedic Scope of Practice**
Ref. No. 807, **Medical Control during Hazardous Material Exposure**
Ref. No. 814, **Determination/Pronouncement of Death**
Ref. No. 817, **Regional Mobile Response Team**
Ref. No. 842, **Mass Gathering Interface with Emergency Medical Services**

FIRESCOPE's Field Operations Guide ICS 420-1. December 2012

Reference No. 519, Management of Multiple Casualty Incidents

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/16/24 12/19/24	12/19/24	Yes
	Base Hospital Advisory Committee	10/9/2024	10/9/2024	No
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric 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. 519, Management of Multiple Casualty Incidents

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy I.C.2	PAAC 12/18/2024	Add “and feasible” after “if indicated”	Adopted

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

.

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **REGIONAL MOBILE RESPONSE TEAMS** REFERENCE NO. 817

PURPOSE: To establish a formal mechanism for providing rapid advanced emergency medical care at the scene in which a higher level of on-scene emergency medical expertise, physician field response, is requested by the on-scene prehospital care provider.

AUTHORITY: Health and Safety Code, Division 2.5, Section 1798. (a)

DEFINITIONS:

9-1-1 Jurisdictional Provider: The local governmental agency that has jurisdiction over a defined geographic area for the provision of prehospital emergency medical care. In general, these are cities and fire districts that have been defined in accordance with the Health and Safety Code, Division 2.5, Section 1797.201.

Exclusive Operating Area (EOA) Provider: Prehospital emergency medical transportation agencies/companies that have the exclusive rights to provide emergency 9-1-1 medical transportation in predefined geographic areas. These include cities and ambulance companies that have exclusive emergency transportation rights as defined by the Health and Safety Code, Division 2.5, Section 1797.201 and Section 1797.224, and referenced in the Los Angeles County EMS Plan.

Fire Operational Area Coordinator (FOAC): Los Angeles County Fire Department is the FOAC for the County, which is contacted through its Dispatch Center.

Hospital Emergency Response Team (HERT): Organized group of health care providers from a designated Level I Trauma Center, with Emergency Medical Services (EMS) Agency approval as a HERT provider, who are available 24 hours/day to respond and provide a higher level of on-scene surgical and medical expertise.

Incident Commander: The highest-ranking official of the jurisdictional agency at the scene of the incident and responsible for the overall management of the incident.

Medical Alert Center (MAC): Serves as the control point for the VMED28 and ReddiNet® systems and the point of contact when a HERT is requested. The MAC shall contact an approved HERT provider based on the incident location.

Mobile Stroke Unit (MSU): Organized group of health care providers with highly specialized equipment associated with a designated Comprehensive Stroke Center, who are available to respond and provide a higher level on-scene stroke care. A MSU is approved by the EMS Agency to be deployed in the prehospital setting to provide rapid assessment of a suspected stroke patient utilizing a mobile computed tomography (CT) scanner. If indicated, the MSU may also provide rapid treatment with intravenous thrombolytic therapy.

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

Physician Field Response: Is a situation in which a higher level of on-scene emergency medical or surgical expertise is warranted due to the nature of the emergency and requested by the on-scene prehospital care provider.

Qualified Specialist: A physician licensed in the State of California who is Board Certified or Board Eligible in the corresponding specialty by American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).

Standard Precautions: Is a combination of the major features of Universal Precautions (UP) and Body Substance Isolation (BSI). Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include: hand hygiene, use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices.

VMED28: The VMED28 frequency is the primary method of communications with paramedic providers to coordinate patient destination activities with the Medical Alert Center (MAC). The VMED28 also serves as a back-up communication system for intra-hospital communication and between hospitals and the MAC.

POLICY:

I. Hospital Emergency Response Team (HERT):

A. Composition of a HERT

1. Each HERT deployment shall identify a Team Leader who is a qualified specialist with the training in accordance with the approved HERT provider's internal policy on file with the EMS Agency.

2. The Team Leader is responsible for organizing, supervising, and accompanying members of the team to a scene where a physician field response has been requested.

3. The Team Leader shall be familiar with base hospital operations, scene hazard training, and the EMS Agency's policies, procedures, and protocols.

4. The Team Leader is responsible for retrieving the life-saving equipment and PPE and determining if augmentation is required based upon the magnitude and nature of the incident.

   PPE shall include the following:
   a. Safety Goggles
   b. Leather Gloves
   c. Helmet with HERT labeled on both sides (e.g., Bullard ® Advent ®);
   d. Jumpsuit (e.g., Nomex®); and
   e. National Fire Protection Association (NFPA) approved safety boot with minimum six-inch rise, steel toe, and steel shank.

The standard life-saving equipment and PPE referenced above shall be predetermined, preassembled, readily available, clearly labeled, and stored in a predetermined location. Based upon the magnitude and nature of the incident, the standard life-saving equipment and PPE may require augmentation.

5. The Team Leader will determine the ultimate size and composition of the team based upon the magnitude and nature of the incident.

6. At least one physician on the HERT shall be a qualified Los Angeles County Base Hospital Physician.

7. The Team Leader will report to, and be under the authority of the Incident Commander or their designee. Other members of the team will be directed by the Team Leader.

B. Purpose of the HERT:

1. A HERT is utilized in a situation where additional medical or surgical expertise is needed on scene.

2. This includes, but is not limited to, the following situations:

   a. A life-saving procedure, such as an amputation, is required due to the inability to extricate a patient by any other means.
   b. Prolonged entrapment of a patient requiring extended scene care.
   c. Need for assistance with analgesia, sedation, and/or difficult airway management.
   d. A mass casualty incident with need for field triage of a large number of patients.

C. Activation of the HERT:

1. The Incident Commander or designee shall contact the MAC via the VMED28. The determination of the appropriate mode of transportation of the team (ground versus air) will be mutually agreed upon. The anticipated duration of the incident should be considered in determining the need for a HERT; it will typically be a minimum of 30 minutes before a team arrives on scene.

2. MAC shall contact an approved HERT provider regarding the request. The Team Leader will organize the team and equipment in accordance with the HERT provider's internal policy, and the magnitude and nature of the incident.

3. The Team Leader, or designee, shall inform the MAC of the number of team members that will require transport, and the total estimated weight of equipment to be transported with the HERT.

4. HERT members should be assembled and ready to depart within

20 minutes of a request with standard life-saving equipment and in appropriate level of personal protective equipment (PPE) in accordance with the HERT provider's internal policy on file with the EMS Agency.

5. MAC will notify the Incident Commander of the ETA of the HERT if they are arriving by ground transportation. When air transport is utilized, MAC will indicate the time that the HERT is assembled with the standard life-saving equipment and prepared to leave the helipad.

6. MAC will maintain records of all HERT activations to include clinical and operational considerations that prompted need for the HERT, information on responding EMS and HERT units or teams, and incident after action reviews when necessary.

D. Transportation of the HERT:

1. MAC will arrange transportation of the HERT through coordination with the Central Dispatch Office or the FOAC.

2. Upon the conclusion of the incident, HERT will contact the MAC and transportation of the team back to the originating facility will be arranged.

E. Responsibilities of a HERT:

1. Upon arrival of the HERT, the Team Leader will report directly to the on-scene Incident Commander or designee (i.e., Medical Group Supervisor). HERT members will, at a minimum, have visible identification that clearly identifies the individual as a health care provider (physician, nurse, etc.) and a member of the HERT.

2. Medical Control for the incident shall be in accordance with Ref. No. 816, Physician at the Scene.

F. Approval Process of a HERT:

1. Level I Trauma Centers interested in providing a HERT must develop internal policies to comply with all requirements and submit evidence of the ability to meet all requirements of this policy, as well as an initial and continuing education plan for HERT members, to the EMS Agency for review and approval as a HERT provider.
2. The internal policy will include a HERT Medical Director and a HERT Program Manager who are responsible for oversight of the HERT and serve as the points of contact for communications from the EMS Agency.

II. Mobile Stroke Unit (MSU) Program

A. General Requirements:

1. Be approved by the EMS Agency

2. Have, at minimum, one MSU that has been licensed by the California Department of Motor Vehicles as an emergency response vehicle.

3. Designate a MSU Medical Director who shall be responsible for the functions of the MSU. The MSU Medical Director shall be a qualified specialist, licensed in the State of California and Board Certified in Neurology, Neurosurgery or Neuroradiology.

4. Staff the MSU with a critical care transport nurse, paramedic and a CT technician. A stroke neurologist may also be included as part of the response team on the vehicle or by telemedicine.

5. Implement a quality improvement program for program monitoring and evaluation.

6. Designate a MSU Program Manager who shall be responsible for ensuring timely and accurate data collection and who works with the MSU Medical Director to develop a data collection process and a quality improvement program.

B. The MSU Program shall develop an activation and dispatch procedure in collaboration with the 9-1-1 jurisdictional provider.

C. A written Agreement between an Exclusive Operating Area (EOA) Provider and the MSU Program shall be in place if the MSU will be used to transport stroke patients. The written Agreement shall address, at minimum, the following:

1. Dispatch

2. Interaction between staff of the MSU and the 9-1-1 Jurisdictional Provider/EOA Provider

3. Transportation arrangements

4. Billing

5. Data Collection

6. Liability

D. The MSU Program shall develop policies and procedures that address patient care and include the following: patient assessment and identification of patients requiring MSU services; indications for CT and procedures for transmission and reporting, indications and contraindications for thrombolytic therapy, and reporting of adverse events.

E. Approval Process of a MSU

1. MSU Programs shall submit a letter of intent to the EMS Agency

outlining the following:

a. Qualifications of the composition of MSU program
b. Proposed response area
c. Deployment and dispatch plan for integration with the 9-1-1 jurisdictional provider
d. Data collection and quality improvement process

2. If the MSU will be used to transport stroke patients, submit a copy of the written Agreement with the 9-1-1 Jurisdictional Provider/EOA Provider.

3. The EMS Agency will review and verify the submitted information. If the submitted information is satisfactory, the EMS Agency will approve the MSU program.

CROSS REFERENCES:
Prehospital Care Manual:
Ref. No. 201, **Medical Management of Prehospital Care**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 521, **Stroke Patient Destination**
Ref. No. 816, **Physician at the Scene**

Reference No. 817, Regional Mobile Response Teams

	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	10/9/24	10/09/2024	Yes
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee	12/4/24	12/4/2024	No
	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. 817, Regional Mobile Response Teams

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy I, C.3	BHAC 10/09/2024	Change 'Team Leader' to 'HERT Facility (e.g., Base Station)'	Modified wording and change 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**

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)

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

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

DEFINITIONS:

Suicide Risk Screening: A standardized method to identify individuals who may be at risk for suicide, and to estimate a patient's current level of risk for suicide by asking specific questions about a patient's thoughts 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.)

Suicide Risk Assessment: A thorough and systematic evaluation that is typically performed after suicide risk screening. A trained mental health clinician (e.g. a psychiatrist, social worker, or psychologist in an ED or PUCC setting) performs a detailed clinical assessment to confirm suspected suicide risk, to estimate the immediate danger, and to delineate treatment. Assessment takes into account chronic and acute risk factors, protective factors, and medical and mental health history.

Suicidal Ideation (SI): Thoughts of death or ending one's life. Different types of SI include the following (in increasing level of severity):

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 act on 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 to a plan, such as deciding on the timing, location, and/or preparations to end their life (e.g., gathering pills, acquiring a weapon, writing a suicide note, researching the location for a traumatic/deadly injury)	**(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".)

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 way of attempting to cope with emotional distress or psychological pain.

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

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

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).

Danger to Self: The 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).

LPS-Evaluator: An individual that is authorized under CA WIC 5150 et seq. to evaluate and place a patient on a 5150/5585 hold application, such as all law enforcement (LE) personnel and clinicians who are LPS-authorized by the County Department of Mental Health. Examples include: 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 the CA Health and Safety Code (subdivision (a) or (b) of Section 1250 or 1250.2).

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.

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)

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.
2. Several suicide risk screening tools are evidence-based and validated. They consist of simple, plain-language questions that anyone can ask, and are free and available online (such as the C-SSRS and ASQ). Suicide risk screening has been promoted by numerous public health agencies (CDC, AHRQ, WHO, FDA, SAMHSA, and CDPH), and is similar to public health campaigns related to knowing the signs of stroke or bystander CPR.
3. Suicide risk screening can be performed by EMS personnel to assist with the evaluation of patients who express suicidal ideation or behaviors.
4. CA WIC 5150 et seq. defines the situations when a patient may be involuntarily detained and transported on a psychiatric hold, and who is authorized to issue a psychiatric hold.

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. Evaluate primary psychiatric crises by obtaining relevant clinical history and managing per treatment protocol (*TP 1209 or 1209-P, Behavioral/Psychiatric Crisis*).

3. It is critical to establish rapport with the patient to facilitate trust and open communication and to optimize the evaluation and screening of suicide risk.

4. The evaluation of suicide risk should generally include an inquiry of the patient's suicidal ideation and behaviors, including whether the patient has passive SI, active SI, contemplation of suicide method, intent to die by suicide, a plan to commit suicide, and/or suicide attempts.

    A. To assist with evaluating the level of suicide risk, it is recommended to utilize the Columbia Suicide Severity Risk Scale (C-SSRS) to administer standardized 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.

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

5. Evaluate the reliability of information, especially in situations where a patient may be suspected of minimizing or evading questions about SI or suicidal behaviors.

    A. Obtain information from key third parties when feasible.

    B. Document if the patient lacks capacity or is unwilling to participate in the evaluation.

6. When a patient has been evaluated by an authorized LPS-Evaluator (including LE) regarding placement of a 5150/5585 hold, that evaluation shall generally take precedence in determining whether a patient can be transported involuntarily.

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 5150/5585 hold, base contact is required for AMA.

7. 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, LE or LPS evaluator determination takes precedence as they are the legal authority for placement or non-placement of a 5150/5585 hold; document the course of escalation and LPS/LE evaluator information.

8. 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.

        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. • Report your C-SSRS screening results when communicating with the Base to aid with AMA decision-making.
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. • Report your C-SSRS screening results when communicating with the Base to aid with AMA decision-making.
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, information from key third parties, as well as any mental health evaluation performed by an LPS-Evaluator, if applicable.

In general, patients will be transported to the MAR or PUCC when EMS is called to respond either on a voluntary basis or on a 5150 / 5585 hold. For patients with decision-making capacity refusing transport against medical advice, standardized suicide risk screening is a useful tool to facilitate communication between EMS, LE and the Base Hospital.

1. Patients who are low-risk should receive a voluntary evaluation at the MAR or PUCC (Reference No. 526, Behavioral / Psychiatric Crisis Patient Destination).

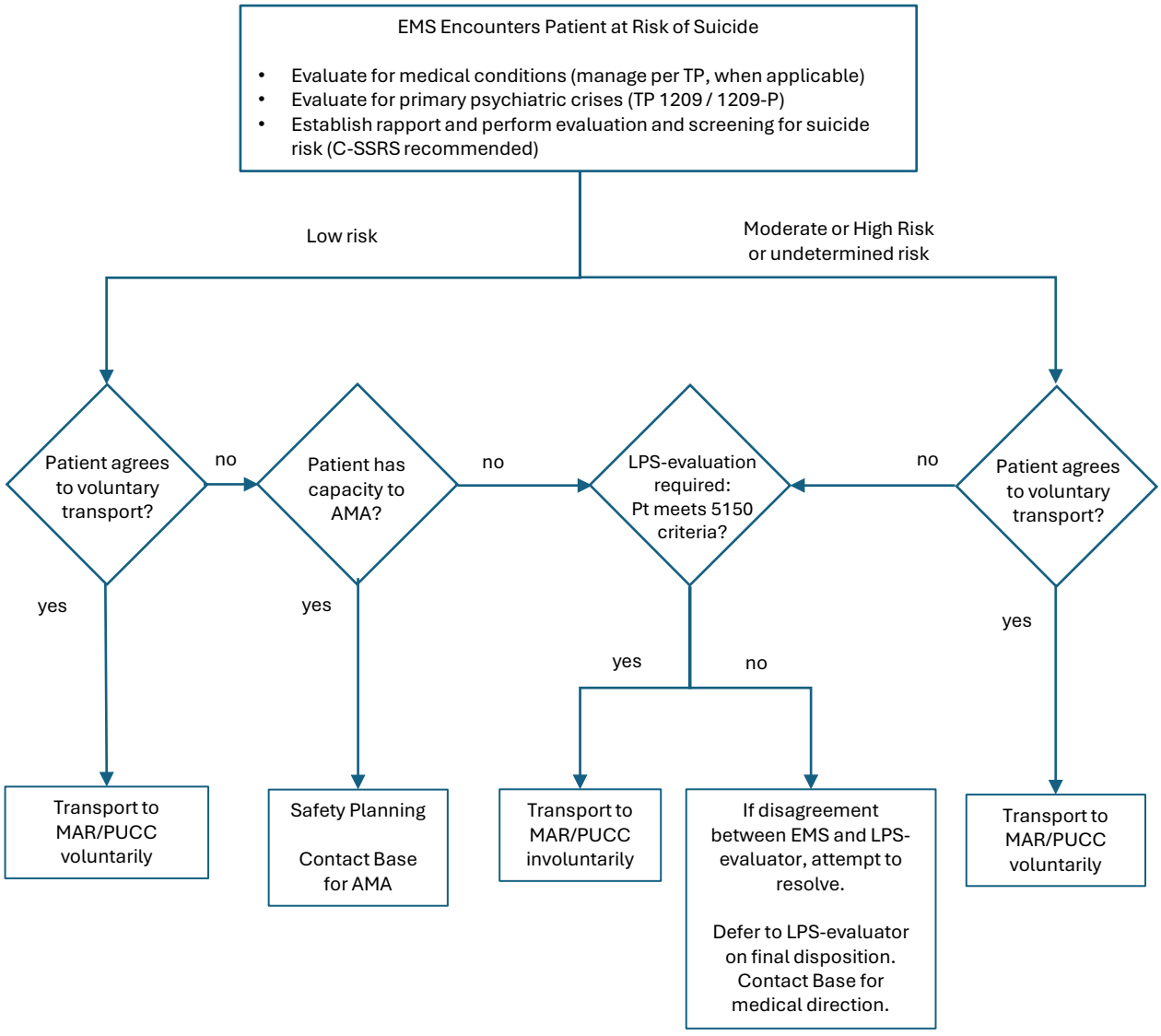
    A. For patients with decision-making capacity (or guardians in the case of minors) who refuse transport, and who have not been placed on a 5150/5585 hold, contact Base to discuss AMA. Report your C-SSRS screening results when communicating with the Base to aid with AMA decision-making.

    B. Patients who lack decision-making capacity, 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. Report your C-SSRS screening results when communicating with the Base to aid with AMA decision-making.

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. Report your C-SSRS screening results when communicating with the Base to aid with AMA decision-making.


EMS Encounters Patient at Risk of Suicide
• Evaluate for medical conditions (manage per TP, when applicable)
• Evaluate for primary psychiatric crises (TP 1209 / 1209-P)
• Establish rapport and perform evaluation and screening for suicide risk (C-SSRS recommended)
Low risk
Moderate or High Risk or undetermined risk
Patient agrees to voluntary transport?
no
Patient has capacity to AMA?
no
LPS-evaluation required: Pt meets 5150 criteria?
no
Patient agrees to voluntary transport?
yes
yes
yes
no
yes
Transport to MAR/PUCC voluntarily
Safety Planning
Contact Base for AMA
Transport to MAR/PUCC involuntarily
If disagreement between EMS and LPS-evaluator, attempt to resolve.
Defer to LPS-evaluator on final disposition. Contact Base for medical direction.
Transport to MAR/PUCC voluntarily

JAMA Network Open

Original Investigation | Emergency Medicine

Patterns in California Ambulance Patient Offload Times by Local Emergency Medical Services Agency

Madeline Feldmeier, BS; Karen Patricia Reyes, BA; Crystal Chen, BS; Karl A. Sporer, MD; Zita Konik, MD; Hernando Garzón, MD; Renee Y. Hsia, MD, MSc

Abstract

IMPORTANCE Ambulance offload delays are a timely and crucial issue with implications for patients, emergency medical services (EMS) agencies, hospitals, and communities. Published data on recent patterns in ambulance patient offload times (APOTs) are sparse.

OBJECTIVE To examine patterns in APOT by California local EMS agency and variation between and within local agencies.

DESIGN, SETTING, AND PARTICIPANTS This cohort study used APOT reports from the California EMS Authority and local EMS agencies between January 1, 2021, and June 30, 2023, to examine patterns in ambulance offload times. County-level population data were collected from the US Census Bureau to calculate mean annual offloads per 1000 population.

EXPOSURE Ambulance transport to emergency departments.

MAIN OUTCOMES AND MEASURES Ambulance offload volumes, mean annual offloads per 1000 population, APOT-1 (a reporting metric that includes the 90th percentile ambulance offload time and number of offloads to a specific hospital) weighted means (SDs), and APOT-1 medians (IQRs).

RESULTS A total of 5 913 399 offloads across 34 California local EMS agencies were analyzed. The APOT-1 weighted mean (SD) across the state was 42.8 (27.3) minutes, and the median (IQR) monthly hospital-level APOT-1 was 28.9 (14.9-46.3) minutes. Nearly one-half of local EMS agencies (16 of 34 [47.1%], accounting for 79.2% of all offloads) experienced an APOT-1 weighted mean greater than the 30-minute standard set by the state. Moreover, 20 of 33 local EMS agencies (60.6%) reported an annual APOT-1 weighted mean that was worse in 2023 than 2021.

CONCLUSIONS AND RELEVANCE In this cohort study, approximately half of all agencies consistently reported ambulance offload times greater than the 30-minute state standard, and there was significant variation between and within agencies. These findings may spur collaborative efforts between stakeholders to determine the most effective strategies for addressing systemic issues resulting in long APOT across California.

JAMA Network Open. 2024;7(12):e2451022. doi:10.1001/jamanetworkopen.2024.51022

Key Points

Question What are the most recent patterns in patient offload times for ambulances transporting patients to emergency departments in California?

Findings In this cohort study of 5 913 399 offloads across 34 local emergency medical services (EMS) agencies, the mean ambulance offload time across the state was 42.8 minutes, and the median monthly offload time by hospital was 28.9 minutes. Nearly half of all local EMS agencies (16 of 34) had a mean offload time greater than the 30-minute standard set by the state.

Meaning These findings are particularly concerning given that patients rely on and expect a rapid response from ambulance services, and offload delays decrease ambulance availability for other patients in the vicinity.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Introduction

There has been increasing attention paid to rising response times for emergencies requiring ambulance transport. Central to this issue are long ambulance patient offload times (APOTs), a crucial interval marking the duration from an ambulance's arrival at the emergency department (ED) to the point where the patient is formally transferred to the ED's care.[1] More commonly known as wall time,

APOT has garnered widespread attention globally[2,3] and locally in the US,[4,5] particularly as EDs continue to face long wait times and chronic crowding and boarding.[6-10]

Empirical evidence has shown that the implications of long ambulance offload times extend beyond the inconvenience of delays in patient care. Offload delays are associated with an increased length of stay in the ED[11,12] and increased patient mortality.[2,12] An ambulance stuck at the wall means decreased availability of critical care services in the community and increased ambulance response times for other patients in the vicinity who may require ambulance transport.[13-18] It also means a loss of ambulance unit hours (each hour of ambulance service) for emergency medical services (EMS) systems (eg, in California, Riverside and San Bernardino Counties logged 20 535 total delay hours in 2012, resulting in $3 million in lost unit hours[14]). In light of these sobering implications, offload delays remain a persistent problem and are ultimately a symptom of larger system-level issues, such as ED and hospital crowding.[14]

California operates under a 2-tiered EMS system that includes the state EMS Authority and 34 local EMS agencies (27 single-county and 7 multicounty), offering a unique model for studying APOT. While the role of the EMS Authority is to ensure equitable coordination, administration, and integration of the 34 local EMS agencies, each agency is responsible for delivering EMS within its own geographic region. In 2015, increasing strain on EMS systems across the state prompted the development of a standard methodology for APOT reporting, and reporting was mandated for all agencies beginning in 2019.[19,20]

Despite mandated reporting over the past 5 years, there are no published studies to date that examine the most recent patterns in APOT across California. A previous study from 2018 introduced the reporting metric APOT-1, which includes the 90th percentile ambulance offload time and number of offloads to a specific hospital.[21] The study also examined offload times across 9 California local EMS agencies. However, it was published before APOT reporting was mandated by the state, and most EMS agencies were excluded. Another study from Los Angeles examined patterns in the total time ambulances were out of service from 2001 to 2002, but it was published more than 2 decades ago and evaluated 1 city only.[16] The present study addresses these crucial gaps in the literature and offers a current statewide analysis of APOTs across all 34 local EMS agencies in California from January 1, 2021, through June 30, 2023. We hypothesized that there would be substantial variation in offload times between and within local EMS agencies, with the most severe offload delays showing little improvement over the study period.

Methods

Data Sources

This cohort study was approved by the University of California, San Francisco Institutional Review Board with a waiver of informed consent because the study did not constitute human participants research. The study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

We used APOT reports from the California EMS Authority and local EMS agencies to examine patterns in APOT-1 and county-level population data from the US Census Bureau to determine mean ambulance offload volumes per 1000 population for each local EMS agency. Our primary source of APOT data was the EMS Authority website,[22] which provides publicly available monthly, hospital-level APOT reports for each local EMS agency. EMS Authority data for April through June 2023 were aggregated at the local EMS agency level (rather than hospital level), and no reports were available for January through March 2023. To address these gaps in the data, we supplemented the EMS Authority reports with APOT reports directly from local EMS agencies. We contacted EMS medical directors and administrators in all 34 local EMS agencies to request hospital-level data for January through March 2023 (further details provided in the eMethods in Supplement 1). We included all entries that reported a 90th percentile offload time of 0, as a 0 time can be reported when the transfer of care from EMS to the ED occurs immediately upon arrival at the hospital. After merging

data from the EMS Authority and local EMS agencies, missing data comprised 5% of monthly APOT reports. The final dataset included monthly offload volumes and APOT-1 90th percentile offload times by hospital (or by EMS agency for April through June 2023).

Study Outcomes

Our primary outcomes, calculated for each local EMS agency, were (1) offload volumes, (2) mean annual offloads per 1000 population, (3) APOT-1 weighted mean accompanied by the standard deviation, and (4) APOT-1 median accompanied by the interquartile range. Offload volumes, weighted means (SDs), and medians (IQRs) were reported for the entire study period, annually, and biannually.

Statistical Analysis

Given that our datasets were aggregated as monthly offload volumes and APOT-1 90th percentile offload times by hospital, all measures were calculated from these 90th percentile times. Using population data from the US Census Bureau, we calculated the mean annual offloads per 1000 population. We divided the total number of offloads for each local EMS agency over the entire study period by the product of the county (or counties for multicounty agencies) population size and the duration of observation and then multiplied the result by 1000. Mean annual offloads per 1000 population were normalized to account for missing months of data. This observation provides a standardized measure of how often offloads occur within a given population over a specific period and serves as an additional descriptor for each EMS agency.

Next, we examined APOT-1 weighted means. The APOT-1 weighted mean is the standard measure reported by the EMS Authority and accounts for variation in the number of offloads to each hospital. Weighted means for each hospital were calculated by multiplying the APOT-1 90th percentile time by the number of offloads to that hospital and then dividing the product by the total number of offloads for that local EMS agency. We then aggregated the weighted times by local EMS agency to derive the overall weighted mean for that agency. By multiplying the reported APOT-1 90th percentile time for a hospital by the percentage of offloads the hospital accounted for within its respective agency, we ensured that all offloads were weighted equally, revealing the severity of APOT in each local EMS agency as experienced by each offload or patient. In addition, and for completeness, we calculated the weighted standard deviation. To calculate the standard deviation, we first determined the weighted variance by finding the squared differences between each data point and the weighted mean, multiplying by their respective weights, and averaging these values. The standard deviation is the square root of the weighted variance. Of note, this method does not adjust for sample size, which may lead to a slight underestimation of the population variability.

Separately, we reported the median, or the central monthly APOT-1 time, across hospitals within a given local EMS agency, irrespective of the number of offloads. The median offers a measure of central tendency that is less influenced by outliers, providing insight into the typical offload time experienced by hospitals within each agency. When paired with the IQR, this measure provides insight into the range of APOT-1 times that most hospitals are experiencing within a given agency.

By incorporating these 2 distinct measures (weighted mean [SD] and median [IQR]), our analysis provides a comprehensive overview of offload times. The weighted mean offers an aggregate perspective by considering offload volumes, allowing us to discern overarching trends and compare APOT-1 times across local EMS agencies, while the median offers additional insight into the central tendency of offload times, mitigating the influence of outliers and providing a representative measure of typical offload times hospitals are experiencing within each agency. Together, these measures offer complementary perspectives, enabling a thorough understanding of offload times across California, from overall trends to typical experiences within the population served. All analyses were performed using Python, version 3.8.5 (Python Software Foundation). Modules used included Pandas, version 2.0.3; Seaborn, version 0.11.0; Matplotlib, version 3.3.2; and Geopandas, version 0.13.2.

Results

To examine APOT-1 patterns across California from January 2021 through June 2023, we analyzed 5 913 399 offloads across 34 local EMS agencies. The APOT-1 weighted mean (SD) across the state was 42.8 (27.3) minutes, and the median monthly hospital-level APOT-1 was 28.9 minutes (IQR, 14.9-46.3 minutes).

Table 1 provides summary statistics by local EMS agency, including local EMS agency population, offload volumes, annual offloads per 1000 population, APOT-1 weighted means, and APOT-1 medians for all 34 local EMS agencies over the study period. Local EMS agency populations ranged from 54 641 residents in Tuolomne to 9 730 857 in Los Angeles. The highest and lowest offload volumes were reported in Los Angeles (1 172 724 offloads) and San Benito (5745 offloads),

Table 1. Summary Statistics of Ambulance Offload Volumes and Times for the 34 California Local EMS Agencies, January 2021 to June 2023

Local EMS agency	Local EMS agency population, No.	Offload volume, No.	Mean annual offloads per 1000 population[a]	APOT-1, min	
				Weighted mean (SD)	Median (IQR)
Alameda	1 631 498	259 025	64	50.4 (7.7)	45.0 (34.0-56.8)
Central California	1 806 916	367 568	81	55.8 (5.4)	39.3 (27.6-51.1)
Coastal Valleys	573 145	104 772	73	21.4 (7.9)	10.0 (7.0-20.5)
Contra Costa	1 158 662	197 765	76	49.2 (0.4)	41.3 (31.6-55.0)
El Dorado[b]	192 902	25 105	65	16.4 (12.4)	12.6 (8.1-26.9)
Imperial[b]	179 045	15 441	45	26.4 (3.8)	22.2 (16.8-29.0)
Inland	2 227 204	395 543	71	51.4 (9.3)	23.1 (11.4-45.7)
Kern	914 427	161 936	71	54.4 (11.5)	48.0 (37.0-60.0)
Los Angeles	9 730 857	1 172 724	48	50.1 (31.1)	41.0 (27.7-56.0)
Marin	256 613	35 617	56	13.5 (1.2)	13.1 (10.1-14.3)
Merced	288 913	51 022	71	47.1 (10.8)	38.4 (24.5-52.5)
Monterey	433 588	57 229	59	17.5 (3.0)	15.6 (11.2-20.3)
Mountain Valley	106 187	87 878	92	34.0 (5.8)	27.6 (16.5-37.8)
Napa	134 617	22 732	75	15.2 (1.9)	14.4 (9.4-18.7)
North Coast	229 935	46 695	81	6.2 (2.3)	5.0 (3.0-7.9)
Northern California	77 435	12 384	71	7.5 (0.3)	6.0 (4.0-9.6)
Orange	3 148 913	450 010	57	32.3 (12.9)	30.7 (22.3-40.6)
Riverside	2 473 361	409 346	66	51.4 (17.6)	45.3 (27.9-69.4)
Sacramento	1 585 826	310 263	78	66.8 (16.8)	55.6 (33.8-74.2)
San Benito	67 509	5745	34	10.3 (1.4)	10.3 (7.0-12.7)
San Diego	3 273 860	393 684	48	46.3 (13.3)	43.4 (33.4-54.2)
San Francisco	809 566	185 057	91	36.2 (9.4)	30.0 (22.6-39.0)
San Joaquin	794 537	162 211	82	39.8 (6.4)	35.4 (30.8-40.0)
San Luis Obispo	281 050	35 697	56	13.3 (0.2)	12.9 (12.2-14.1)
San Mateo	731 477	94 520	52	14.6 (5.0)	12.4 (9.8-17.5)
Santa Barbara	440 898	68 249	62	13.5 (2.2)	11.8 (10.6-14.6)
Santa Clara[b]	1 880 367	186 248	50	27.6 (0.3)	20.2 (12.9-27.7)
Santa Cruz	262 087	34 596	59	20.6 (0.8)	15.9 (10.2-20.0)
Sierra-Sacramento Valley	1 251 155	274 463	88	23.9 (15.5)	11.0 (6.0-21.0)
Solano	449 585	82 698	74	23.3 (4.4)	23.2 (19.8-29.3)
Stanislaus[c]	551 793	41 157	75	41.6 (7.0)	38.3 (32.6-45.2)
Tuolumne	54 641	12 907	94	10.4 (1.4)	10.0 (8.1-10.0)
Ventura	833 977	115 966	56	22.8 (4.6)	20.6 (17.5-23.9)
Yolo	218 568	37 146	68	49.0 (21.6)	48.8 (30.1-70.4)
California total	39 051 114	5 913 399	60	42.8 (27.3)	28.9 (14.9-46.3)

Abbreviations: APOT-1, 90th percentile ambulance patient offload time; EMS, emergency medical services.

[a] Mean annual offloads per 1000 population were determined using county population data from the US Census Bureau.

[b] Local EMS agencies with offload results missing for more than 10% of the study period.

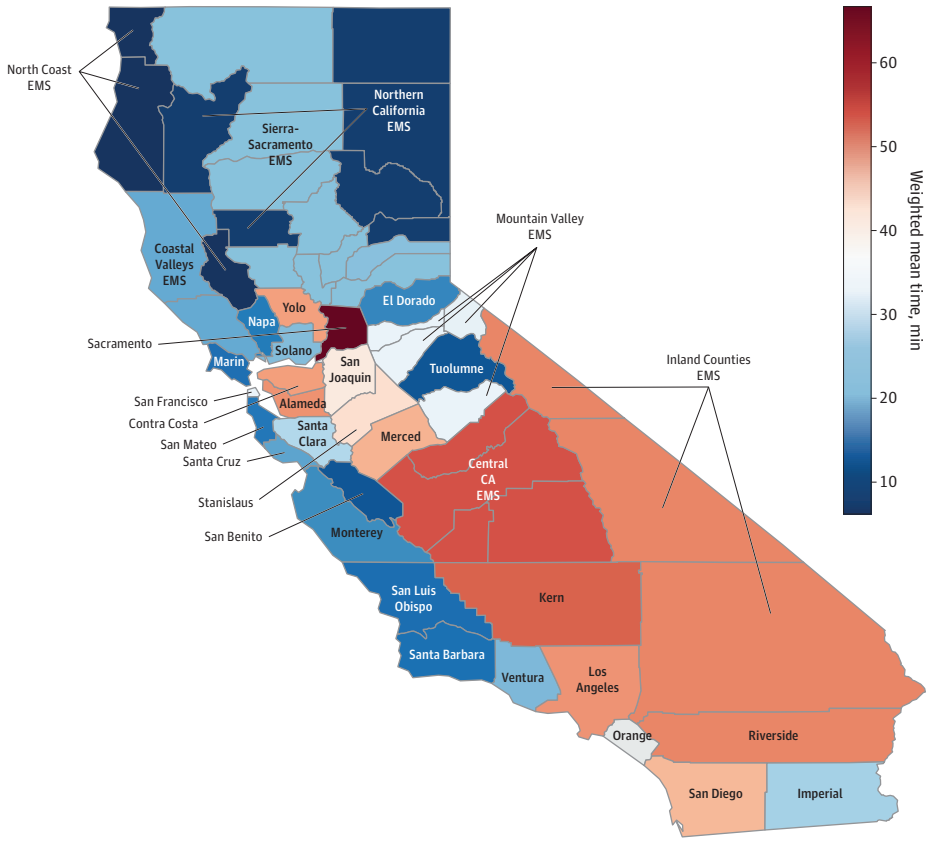
[c] Stanislaus was part of the Mountain Valley local EMS agency until July 1, 2022. Results for the Stanislaus local EMS agency are reported from July 2022 through June 2023.

respectively. The highest annual ambulance offload rates were 94 offloads per 1000 population for the Tuolumne EMS agency, followed by Mountain Valley (92 offloads per 1000 population) and San Francisco (91 offloads per 1000 population). In contrast, the lowest annual offload rates were observed for San Diego (48 offloads per 1000 population), Imperial (45 offloads per 1000 population), and San Benito (34 offloads per 1000 population).

The APOT-1 weighted means also varied by local EMS agency. **Figure 1** (with full results shown in Table 1) reveals the gradient of geographic variation in APOT-1 weighted means by agency. The highest APOT-1 weighted mean (SD) over the study period was 66.8 (16.8) minutes in Sacramento, while the lowest was 6.2 (2.3) minutes in the North Coast region. Of the total 34 local EMS agencies, 16 (47.1%, comprising 79.2% of all offloads) had an APOT-1 weighted mean greater than the 30-minute standard set by the state. Thirteen local EMS agencies (38.2%, comprising 69.0% of all offloads) experienced an APOT-1 weighted mean of more than 30 minutes for all 3 years of the study period, and 7 (20.6%) were among the top 10 APOT-1 weighted means for all 3 years. Of 33 local EMS agencies (we excluded Stanislaus as it was not an independent agency in 2021), 20 (60.6%) had an annual APOT-1 weighted mean that was worse in 2023 than in 2021.

Figure 2 (results provided in Table 1) depicts monthly hospital-level APOT-1 medians within local EMS agencies. Consistent with patterns in APOT-1 weighted means, the highest median APOT-1 time was 55.6 minutes (IQR, 33.8-74.2 minutes) in Sacramento, and the lowest was 5.0 minutes (IQR, 3.0-7.9 minutes) in the North Coast region. Variation, reported as IQR (Q1-Q3) within local EMS agencies, ranged from 41.5 minutes (27.9-69.4 minutes) for the Riverside local EMS agency to 1.9 minutes for both the San Luis Obispo (12.2-14.1 minutes) and Tuolumne (8.1-10.0 minutes) agencies.

Figure 1. Heat Map of Ambulance Patient Offload Time Weighted Means for California's 34 Local Emergency Medical Services (EMS) Agencies, January 2021 to June 2023



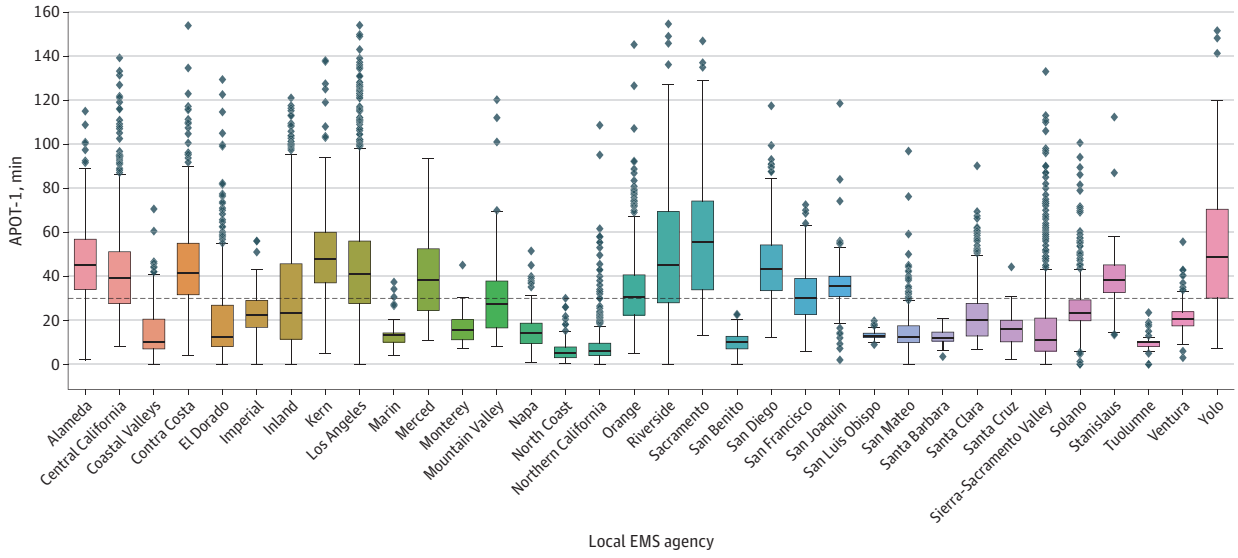
Overall, 13 of the 34 local EMS agencies (38.2%) had a median APOT-1 greater than the 30-minute standard.

Offload delays were also variable within local EMS agencies, with APOT-1 weighted means higher than corresponding medians for all 34 agencies (Table 1). For example, the weighted mean (SD) for Inland was 51.4 (9.3) minutes, while the median was 23.1 minutes (IQR, 11.4-45.7 minutes).

We further analyzed outcomes by year (**Table 2**, with biannual results shown in eTable 1 in Supplement 1). In 2021, the APOT-1 weighted mean (SD) in California was 41.8 (33.3) minutes; in 2022, 43.5 (23.3) minutes; and from January through June 2023, 43.1 (22.1) minutes. Annual results by local EMS agency were similar to overall patterns with a few notable exceptions. First, in 2021, the highest APOT-1 weighted mean (SD) was 73.4 (38.1) minutes for the Central California EMS agency (includes Fresno, Kings, Madera, and Tulare Counties), but this mean dropped to 45.0 (16.6) and 44.9 (5.4) minutes in 2022 and 2023, respectively. The APOT-1 weighted mean (SD) in Merced also dropped substantially over the study period from 55.1 (10.9) minutes in 2021 to 45.3 (9.6) minutes in 2022 and 33.0 (10.8) minutes in 2023. However, several other local EMS agencies experienced an increase in APOT-1 over the study period. In San Francisco, the APOT-1 weighted mean (SD) increased from 30.3 (7.2) minutes in 2021 to 44.8 (9.4) minutes in 2023 and in San Diego, from 38.7 (10.6) minutes in 2021 to 54.5 (13.3) minutes in 2023.

Figure 3 displays temporal patterns in monthly APOT-1 weighted means for the 5 local EMS agencies with the highest and lowest weighted means over the study period. Only agencies that reported for all 30 months of the study period were included, with complete monthly results by agency shown in eTable 2 in Supplement 1. For the 5 local EMS agencies with the highest APOT-1 weighted means, fluctuations in monthly means were relatively uniform. Notable spikes in APOT-1 were observed in August 2021, January 2022, and December 2022. The APOT-1 weighted means were more volatile among the 5 local EMS agencies with the highest means compared with the lowest. For example, monthly means (SDs) in Central California (1 of the 5 highest) ranged from 36.8 (7.2) minutes in October 2022 to 103.2 (62.7) minutes in August 2021. In contrast, monthly means (SDs) in Marin (1 of the 5 lowest) ranged from 14.6 (0.9) minutes in August 2022 to 10.9 (0.0) minutes in June 2023.

Figure 2. Variation in 90th Percentile Ambulance Patient Offload Time (APOT-1) by California Local Emergency Medical Services (EMS) Agency, January 2021 to June 2023



The horizontal bar inside the boxes indicates the median, and the lower and upper ends of the boxes are the first and third quartiles. The whiskers indicate values within 1.5 times the interquartile range from the upper or lower quartile, and data more extreme than the whiskers are plotted individually as outliers (diamonds).

Discussion

In this cohort study, we provide the first, to our knowledge, comprehensive and up-to-date illustration of the widespread variation in ambulance offload delays across California. Nearly one-half of all local EMS agencies (16 of 34, representing 79% of all offloads) had an APOT-1 weighted mean greater than the 30-minute standard set by the state. Similarly, 13 of 34 EMS agencies had a median APOT-1 that did not meet the state standard; in other words, at least 50% of monthly hospital offload reports for those agencies were longer than 30 minutes.

We found that long offload times were more common among certain regions and hospitals. Notably, 13 of the 34 local EMS agencies (comprising 69% of all offloads) experienced an APOT-1

Table 2. Summary Statistics of Ambulance Offload Volumes and Times for the 34 California Local EMS Agencies by Year

	2021			2022			2023 (January-June)		
	Offload volume, No.	APOT-1, min		Offload volume, No.	APOT-1, min		Offload volume, No.	APOT-1, min	
Local EMS agency		Weighted mean (SD)	Median (IQR)		Weighted mean (SD)	Median (IQR)		Weighted mean (SD)	Median (IQR)
Alameda	100 345	53.2 (14.0)	47.2 (39.4-59.2)	107 024	50.3 (14.5)	43.8 (31.5-56.0)	51 656	45.5 (7.7)	43.0 (32.0-49.0)
Central California	139 645	73.4 (38.1)	43.8 (30.3-70.5)	151 035	45.0 (16.6)	37.3 (26.3-44.4)	76 888	44.9 (5.4)	40.5 (26.7-47.2)
Coastal Valleys	39 823	20.1 (9.0)	10.0 (7.0-22.0)	43 549	23.2 (12.9)	10.3 (7.0-20.5)	21 400	20.0 (7.9)	9.9 (7.0-18.3)
Contra Costa	78 749	44.7 (14.7)	39.6 (30.8-51.0)	99 501	52.8 (23.0)	41.8 (33.7-58.9)	19 515[a]	49.1 (0.4)	49.4 (49.0-49.4)
El Dorado	6073[a]	16.8 (18.0)	12.6 (7.8-27.2)	12 552	14.5 (13.8)	12.2 (8.0-24.6)	6480	19.6 (12.4)	17.3 (8.9-30.0)
Imperial	3287[a]	23.3 (8.2)	22.1 (20.6-25.8)	11 756	27.3 (7.6)	23.5 (17.2-29.8)	398[a]	25.4 (3.8)	12.9 (11.8-19.6)
Inland	153 026	55.6 (24.5)	19.7 (10.0-41.4)	160 138	49.6 (17.0)	31.0 (14.4-50.1)	82 379	47.2 (9.3)	22.2 (11.0-46.6)
Kern	63 296	53.4 (15.5)	49.0 (39.0-60.0)	63 961	54.6 (14.1)	46.0 (36.2-60.8)	34 679	55.7 (11.5)	52.4 (37.4-58.0)
Los Angeles	414 021	45.7 (55.3)	34.0 (22.0-47.9)	494 224	54.1 (22.5)	47.1 (34.0-63.0)	264 479	49.4 (31.1)	43.0 (30.0-55.0)
Marin	13 893	13.4 (1.2)	13.1 (11.7-14.0)	15 696	13.7 (1.5)	13.7 (10.0-14.9)	6028	13.1 (1.2)	12.6 (9.1-14.4)
Merced	20 124	55.1 (10.9)	48.8 (35.3-59.0)	22 137	45.3 (9.6)	35.6 (24.5-45.2)	8761	33.0 (10.8)	18.8 (15.8-25.9)
Monterey	24 610	16.7 (5.1)	14.2 (11.4-18.9)	19 929[a]	16.4 (3.6)	15.2 (10.1-19.0)	12 690	20.8 (3.0)	20.1 (11.7-21.7)
Mountain Valley	51 742	35.2 (8.4)	33.6 (28.0-40.7)	28 799	35.8 (12.7)	24.0 (12.9-38.4)	7337	18.7 (5.8)	19.0 (12.0-26.0)
Napa	9578	14.9 (4.8)	14.4 (9.6-18.4)	7798[a]	14.8 (3.7)	12.7 (9.2-18.6)	5356	16.3 (1.9)	15.8 (12.0-19.0)
North Coast	17 693	5.6 (2.9)	5.0 (2.8-6.9)	19 334	6.4 (2.8)	5.0 (4.0-7.6)	9668	7.0 (2.3)	6.0 (3.0-11.4)
Northern California	5897	7.3 (7.8)	6.0 (4.0-8.8)	5491	7.6 (8.9)	6.0 (4.0-10.6)	996[a]	7.5 (0.3)	7.3 (7.2-7.6)
Orange	163 308	29.8 (11.6)	28.0 (19.8-37.4)	186 657	34.5 (14.8)	33.3 (24.4-44.3)	100 045	32.3 (12.9)	32.1 (26.0-46.5)
Riverside	158 323	52.1 (26.9)	45.1 (32.8-72.0)	166 719	52.6 (31.1)	44.7 (22.2-67.8)	84 304	47.8 (17.6)	49.7 (30.1-65.9)
Sacramento	124 590	62.0 (22.8)	49.0 (32.8-69.1)	125 941	69.2 (26.0)	56.6 (33.6-78.9)	59 732	71.6 (16.8)	69.6 (55.0-80.0)
San Benito	2220	9.3 (3.2)	10.6 (6.6-12.6)	2439	10.7 (1.8)	11.0 (8.4-16.8)	1086	11.3 (1.4)	8.6 (5.8-11.8)
San Diego	141 296	38.7 (10.6)	37.8 (29.7-46.5)	160 577	48.2 (14.6)	45.7 (35.2-57.9)	91 811	54.5 (13.3)	52.8 (43.2-63.7)
San Francisco	73 056	30.3 (7.2)	26.0 (21.0-33.0)	72 967	37.7 (10.4)	32.0 (24.0-40.0)	39 034	44.8 (9.4)	44.3 (32.2-53.0)
San Joaquin	64 355	38.1 (6.4)	35.0 (30.7-38.9)	67 767	39.9 (7.3)	35.6 (29.5-40.2)	30 089	43.2 (6.4)	38.0 (33.8-44.6)
San Luis Obispo	14 978	13.4 (1.4)	13.2 (12.4-13.8)	16 293	13.5 (1.9)	12.9 (12.0-14.4)	4426[a]	12.3 (0.2)	12.4 (12.2-12.4)
San Mateo	34 498	11.8 (3.0)	10.0 (9.0-14.4)	38 682	15.1 (4.1)	13.6 (10.5-18.5)	21 340	18.4 (5.0)	14.9 (11.2-23.4)
Santa Barbara	26 308	14.1 (2.7)	12.8 (10.9-14.7)	29 007	13.3 (2.9)	11.4 (10.2-15.1)	12 934	12.9 (2.2)	10.8 (9.6-13.0)
Santa Clara	64 325[a]	24.2 (12.6)	17.7 (12.6-23.2)	98 567	29.9 (16.3)	21.0 (13.5-30.2)	23 356[a]	27.3 (0.3)	27.3 (27.1-27.5)
Santa Cruz	15 933	21.2 (3.1)	15.4 (10.3-20.9)	14 942	20.4 (2.9)	15.7 (10.1-19.0)	3721[a]	19.0 (0.8)	19.5 (18.7-19.6)
Sierra-Sacramento	109 411	21.7 (17.5)	10.0 (6.0-17.2)	113 873	24.4 (19.1)	11.0 (7.0-23.0)	51 179	27.7 (15.5)	11.0 (6.0-28.1)
Solano	34 425	22.4 (4.4)	22.4 (18.3-26.1)	34 744	22.7 (4.8)	23.3 (20.0-30.1)	13 529	27.1 (4.4)	29.4 (26.7-34.0)
Stanislaus[b]	NA	NA	NA	26 902	41.9 (7.0)	38.3 (27.1-44.9)	14 255[a]	41.1 (7.0)	40.6 (34.2-45.7)
Tuolumne	5299	11.7 (5.9)	8.5 (7.0-11.9)	5108	8.9 (2.7)	10.0 (9.0-10.0)	2500	10.7 (1.4)	10.0 (10.0-11.5)
Ventura	44 650	21.6 (4.6)	20.1 (17.5-23.0)	48 400	23.8 (4.9)	21.7 (18.1-24.8)	22 916	22.9 (4.6)	19.9 (15.7-24.8)
Yolo	14 411	46.9 (24.9)	48.3 (28.8-69.0)	15 001	52.4 (28.7)	49.0 (32.6-69.6)	7734	46.3 (21.6)	41.5 (30.7-78.8)
California total	2 233 188	41.8 (33.3)	26.0 (13.9-43.0)	2 487 510	43.5 (23.3)	30.5 (15.6-49.0)	1 192 701	43.1 (22.1)	32.0 (16.1-49.4)

Abbreviations: APOT-1, 90th percentile ambulance patient offload time; EMS, emergency medical services; NA, not available.

[a] Local EMS agencies with offload results missing for 1 or more months.

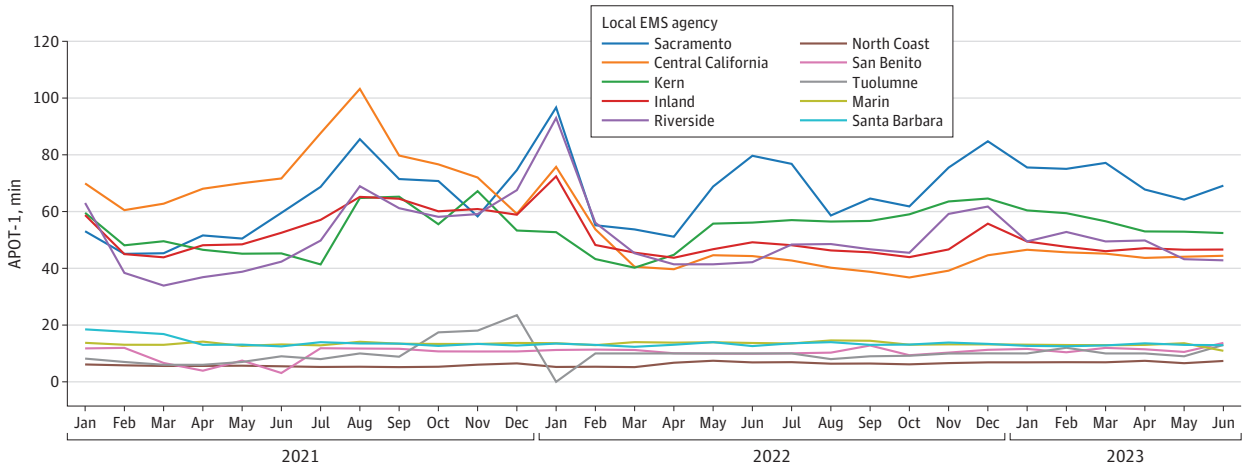
[b] Stanislaus was part of the Mountain Valley local EMS agency until July 1, 2022. Results for the Stanislaus local EMS agency are reported from July 2022 through June 2023.

weighted mean of more than 30 minutes for all 3 years of the study period and 7 were among the top 10 APOT-1 weighted means across all 3 years, suggesting that the most severe regional offload delays are not random but are consistently more severe in certain geographic regions. Moreover, long offload times have persisted, and potentially worsened, even as the COVID-19 pandemic subsided in 2022 and 2023. We found that 20 local EMS agencies had an annual APOT-1 weighted mean that was worse in 2023 than in 2021. These findings are particularly sobering as they reveal that pandemic-related surges in ED crowding and boarding[6,23] have not fully recovered to prepandemic levels and may persist without rigorous system-level intervention.

Offload delays were also highly variable within local EMS agencies, and APOT-1 weighted means were higher than corresponding medians for all 34 agencies. Notably, the weighted mean for the Inland agency was 51.4 minutes, while the median was just 23.1 minutes (less than one-half of the weighted mean). Given that the weighted mean accounts for each offload equally while the median represents the middle monthly APOT-1 time by hospital, the considerable 28.3-minute difference between the 2 may have been driven by a small proportion of monthly reports with high offload volumes and long offload times. Patient characteristics and disposition may also have a significant impact on APOT. For instance, EMS cases deemed "alerts" from the field, such as patients with ST-segment elevation myocardial infarction, stroke, and trauma, will likely not experience APOT delays. Further examination of hospital, seasonal, and patient characteristics within agencies may offer valuable guidance to EMS and hospitals as they develop targeted strategies to reduce APOT within their jurisdictions. For instance, agencies experiencing high APOT-1 weighted means and medians may require broad, regional, or local interventions, while those with high weighted means but much lower medians (eg, Inland) may direct efforts toward specific hospitals or improve planning for seasonal or other unexpected surges.

Finally, our temporal analysis showed that monthly fluctuations in offload times were relatively consistent across local EMS agencies. However, it is important to note that our study was conducted during the COVID-19 pandemic, and some of these monthly patterns may have been influenced by surges in COVID-19 infections (ie, the spike in APOT-1 in August 2021 may be due to increased infections during the Delta wave and in January 2022 due to the Omicron wave). Despite difficulty disentangling pandemic-related increases in APOT delays from other underlying factors, national data suggest that EMS activations were increasing prior to the COVID-19 pandemic.[24] Additionally, 90% of EDs regularly reported overcrowding even before the COVID-19 pandemic, with minimal capacity to absorb spikes in demand,[7,25] suggesting that an overall increase in offload delays may have persisted regardless of the pandemic.

Figure 3. Patterns in Monthly 90th Percentile Ambulance Patient Offload Time (APOT-1) Weighted Means for the 5 California Local Emergency Medical Services (EMS) Agencies With the Longest and Shortest Times, January 2021 to June 2023



While this is the first study to examine longitudinal patterns in APOT across California, it is not the first to suggest that hospital and ED crowding have become increasingly concerning in recent years.[26,27] Our findings confirm that offload delays in California have, in fact, shown little to no improvement, even as the COVID-19 pandemic receded in 2022 and 2023. In fact, from April through September 2023, the California EMS Authority reported more than 65 000 hours in delays greater than 30 minutes.[28] Despite differences in EMS systems across the country, we would expect the overall implications of our findings to extend nationally. Issues with APOT, ED crowding, and boarding are not confined to California.[29-32] By investigating the severity and variation in APOT across California, we have gained a better understanding of potential drivers and, eventually, solutions to improve timely access to emergency care and encourage conversation and collaboration among stakeholders nationally.

Successful and sustainable interventions aimed at improving ambulance offload delays and ED crowding are 2-fold. Short-term and stopgap solutions to mitigate offload delays may include appointing EMS personnel as patient flow coordinators or liaisons in the ED[33-36] or hiring an offload nurse to ensure the efficient transfer of care from EMS to the ED team.[37] Such interventions have already been implemented in individual hospitals. For example, in April 2022, Community Regional Medical Center in Fresno implemented an offload zone, or ED hallway with additional beds staffed by licensed vocational nurses, to promote the efficient transfer of care from EMS to the ED team. Similarly, Santa Clara County's Valley Medical Center launched the Ambulance Patient Offload Delay Patient Triage Pilot Program through which an ambulance nurse assigns incoming 911 ambulance patients a severity score to determine which patients should be assigned directly to ED beds vs sent to the waiting room.

While these targeted interventions may help alleviate the immediate burden of offload delays in the short term, sustainable long-term relief will require comprehensive, system-level initiatives that tackle the root causes of ED crowding (eg, inpatient crowding, discharge delays, staffing shortages, hospital throughput).[38] At its core, long APOTs reflect downstream issues associated with hospital crowding and are a symptom, rather than the root, of the problem.

Limitations

Our study has several limitations. First, the majority of offload data used in this study was obtained from publicly available APOT reports from the California EMS Authority; however, there were sporadic gaps in the data, and no EMS Authority reports were available for January through March 2023 (the period during which the EMS Authority took over APOT reporting in the California EMS Information System). We addressed these gaps by obtaining monthly hospital-level APOT reports directly from local EMS agencies, and there may be variation between the 2 sources for which we were unable to account. Second, EMS Authority data between April and June 2023 are at the local EMS agency rather than the hospital level. These agency-level reports do not account for hospital-level variation, and APOT-1 monthly means for individual hospitals during this 3-month period are not included in overall medians and interquartile ranges. However, the goal of this study was to provide an overview of APOT across the state, and we do not expect that these missing data played a substantial role in the overall metrics. Third, EMS Authority data from April through June 2023 only include records submitted using the National EMS Information System, version 3.4 standard. Some EMS agencies transitioned to National EMS Information System, version 3.5 in early 2023 and have decreased representation during these months. Fourth, 100% of the Los Angeles EMS agency's offload data and approximately 60% of San Diego's data were missing from the 2023 EMS Authority and California EMS Information System reports and instead were obtained directly from the respective local EMS agencies. Fifth, data for the latter months of 2023 were not yet available from the EMS Authority, limiting our 2023 findings to January through June. Given that this study was intended to be a general overview of APOT in California and our biannual results (eTable 1 in Supplement 1) do not show any remarkable differences between first and second half data in 2021 and 2022, we do not expect the results for July to December 2023 to substantially change our overall

findings. Finally, we examined annual offloads per 1000 population by local EMS agency using county populations, and agencies may transport patients outside of their county or region. With this said, only a small percentage of all transports in California are to hospitals outside of an agency's jurisdiction, so we do not expect this to substantially affect our results.

Conclusions

In this cohort study, we found significant variation in the severity of ambulance offload delays between and within California local EMS agencies, with approximately one-half of agencies consistently reporting offload times greater than the 30-minute state standard. The most severe delays are persistent in certain geographic regions, reflecting greater ED and hospital crowding that has not improved in recent years. Our findings should spur collaborative efforts among stakeholders to address the deeper issues causing ambulance offload delays across the state.

ARTICLE INFORMATION

Accepted for Publication: October 23, 2024.

Published: December 16, 2024. doi:10.1001/jamanetworkopen.2024.51022

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Author Contributions: Mss Feldmeier and Reyes had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Feldmeier, Chen, Hsia.

Acquisition, analysis, or interpretation of data: All authors.

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Supervision: Hsia.

Conflict of Interest Disclosures: None reported.

Data Sharing Statement: See Supplement 2.

Additional Contributions: The authors thank the California Emergency Medical Services Authority and emergency medical services administrators, medical directors, and staff who provided the data for this project.

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SUPPLEMENT 1.

eMethods. Additional Details on Methods for Data Collection
eTable 1. Biannual Summary Statistics of Ambulance Offload Volumes and Times
eTable 2. Monthly APOT-1 Weighted Means for the 5 Local EMS Agencies With the Highest and Lowest APOT-1 Weighted Means Over the Study Period

SUPPLEMENT 2.

Data Sharing Statement

EMERGENCY MEDICAL SERVICES COMMISSION (EMSC)

SUGGESTED GOALS/OBJECTIVES FOR 2025

GOAL/OBJECTIVE	PRIORITY (YES/NO)	IF PRIORITY WHO ASSIGNED	POTENTIAL ACTIONS
1. Work on processes/policies to address and reduce Ambulance Patient Offload Delays (APOD)	Yes		1. Implementation and rollout of FirstWatch real-time data on ambulances waiting to offload. *(Completed)* 2. Develop separate policy addressing APOT and APOD. *(Completed)* 3. Redistribute the CHA APOT Toolkit. *(Completed)* 4. Identify best practices of hospitals. 5. Monitor implementation of Ref. No. 505. 6. AB 40 signed by the Governor, needs emergency regulations from State EMS Authority and revisit Ref. No. 505.
2. Continue working on the recommendations from the *Ad Hoc Committee on the Prehospital Care of Mental Health and Substance Abuse Emergencies* specifically address Suicide Risk Protocols	Yes	Behavioral Health Workgroup	1. Reconvened Workgroup to be chaired by Commissioner Cheung. 2. Workgroup will focus on field evaluation of suicidal ideation. 3. Develop guidelines and education to address assessment and management of patients experiencing suicidal ideation.

GOAL/OBJECTIVE	PRIORITY (YES/NO)	IF PRIORITY WHO ASSIGNED	POTENTIAL ACTIONS
4. Interfacility Transport Delays (requested for inclusion at Jan 2023 meeting). Need further discussion by EMSC	Yes	IFT Workgroup	1. Workgroup convened with representation from the EMSC, hospitals, EMS providers and the EMS Agency. 2. IFT transfer worksheet developed for Trauma Re-Triage and STEMI Transfer. 3. Assessment Questionnaire for hospital and EMS provider agencies to determine scope of problem and explore potential solutions.
5. Improve patient-centered outcomes from cardiac arrest across Los Angeles County, to meet or exceed the 2030 targets set by the American Heart Association (AHA).	Yes	Cardiac Arrest Workgroup	1. Develop a workgroup to assess current outcomes of cardiac arrest care and gather potential interventions to improve outcomes. 2. Understand barriers to health equities. 3. Engage key stakeholders. 4. Identify potential partners.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

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First District

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Second District

Lindsey P. Horvath
Third District

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Fourth District

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Fifth District

Richard Tadeo, RN
Director

Nichole Bosson, MD, MPH
Medical Director

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

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

November 27, 2024

To: Licensed Los Angeles County Private Ambulance Providers
City Manager, Each Los Angeles County City

From: Richard Tadeo
Director

Subject: **WAIVER EXTENSION: PRIVATE AMBULANCE VEHICLE AGE LIMIT**

In a letter dated September 22, 2021, the Director of the Los Angeles County Emergency Medical Services (EMS) Agency waived specific requirements of the Prehospital Care Reference No. 455, Private Ambulance Vehicle Age Limit as follows:

Maximum "age out" of an ambulance vehicle is changed from eight (8) years (10 years with an approved exemption) to twelve (12) years, if the following requirements are met.

1. **Only ambulance vehicles that have been previously and continuously licensed by the County, prior to the vehicles eight (8) year age, are eligible to renew annually up to the twelve (12) year age out limit.**

2. An ambulance over the age of eight (8) years, from date of manufacture, may not obtain a **new** ambulance vehicle license in Los Angeles County.

3. Exemption requests are no longer required when an ambulance vehicle reaches eight (8) years of age. The vehicle's license can be renewed through the normal process, up to the 12-year age out limit.

As Director of the EMS Agency, I hereby extend this waiver to December 31, 2025, and reserve the right to change, modify, or cancel this waiver at any time without cause.

If you have any questions please contact Christopher Rossetti, Ambulance Program Manager, at (562) 378-1688.

RT:cr
11-10a

c: Georgina Glaviano, Deputy County Counsel, Health Services
Julio Alvarado, Director, Contracts and Grants
Christina Talamantes, Ordinance Liaison, Board of Supervisors Executive Office

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

EMERGENCY MEDICAL SERVICES AUTHORITY
11120 International Drive, Suite 200
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

December 16, 2024

Nicole Bosson, MD
EMS Medical Director
Los Angeles County EMS Agency
10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

Dear Dr. Bosson:

This letter is to inform you that the Los Angeles County EMS request for Paramedic use of Hydroxocobalamin for adult patients has been approved through December 31, 2027.

Documentation guidelines for this approved LOSOP include:

1. Use the following medication code for all uses of Hydroxocobalamin: Hydroxocobalamin Injectable Solution **(372434)**

The Emergency Medical Services Medical Directors Association of California (EMDAC) Scope of Practice (SOP) committee reviewed your requests on December 10, 2024, in conjunction with the EMS Authority, and your request was approved.

If you have any questions, please contact Michelle Brown by phone at (916) 537-6845 or by email at scopeofpractice@emsa.ca.gov.

Sincerely,

H Garzon, M.D.

Hernando Garzon, MD
Interim Chief Medical Director
Emergency Medical Service Authority

cc: Richard Tadeo, Administrator, Los Angeles County EMS Agency