COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES

PROVIDER AGENCY ADVISORY COMMITTEE

MEETING NOTICE

The Provider Agency Advisory Committee meetings are open to the public. You may address this Committee on any agenda item before or during consideration of that item, and on other items of interest that are not on the agenda, but which are within the subject matter jurisdiction of this Committee.

DATE: June 18, 2025

TIME: 1:00 pm

LOCATION: IN-PERSON MEETING
Cathy Chidester Conference Room [1st Floor Hearing Room]
Los Angeles County EMS Agency
10100 Pioneer Boulevard
Santa Fe Springs, California 90670

AGENDA

1. CALL TO ORDER

2. INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS

2.1 EMS Corps

3. APPROVAL OF MINUTES: April 16, 2025

4. UNFINISHED BUSINESS

There was no unfinished business.

5. NEW BUSINESS

5.1 Side-Stream Capnography
5.2 Portable Suction Devices

Policies for Discussion; Action Required:

5.3 Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene
5.4 Reference No. 1307.4, MCG: EMS And Law Enforcement Co-Response
5.5 Reference No. 412, AED Service Provider Program Requirements
  5.5.1 Reference No. 412.1, AED Service Provider Program Application *(For deletion)*
  5.5.2 Reference No. 412.2, AED Service Provider Annual Report *(For deletion)*
5.6 Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles
5.7 Reference No. 710, Basic Life Support Ambulance Equipment
5.8 Reference No. 520, Transport of Patients from Catalina Island
  5.8.1 Reference No. 520.1, Catalina Island Medical Center (AMH) Transfer Process
5.9 Reference No. 455, Private Ambulance Vehicle Age Limit Requirements and Exemptions
5.10 Reference No. 1112, Hospital Evacuation

Policies for Discussion; No Action Required:

5.11 Reference No. 1222, Treatment Protocol: Hyperthermia (Environmental)

6. REPORTS AND UPDATES

6.1 Health Data Exchange
6.2 Sidewalk CPR
6.3 EMS Update 2025
6.4 EmergiPress
6.5 ITAC
6.6 ELCoR Committee
6.7 Research Initiatives and Pilot Studies
  6.7.1 LA DROP
  6.7.2 PediDOSE Trial
  6.7.3 Pedi-PART
6.8 California Office of Traffic Safety (OTS) Grants Projects
  6.8.1 RAPID LA County Medic Mobile Application
  6.8.2 Trauma Dashboards

7. OPEN DISCUSSION

8. NEXT MEETING: August 20, 2025

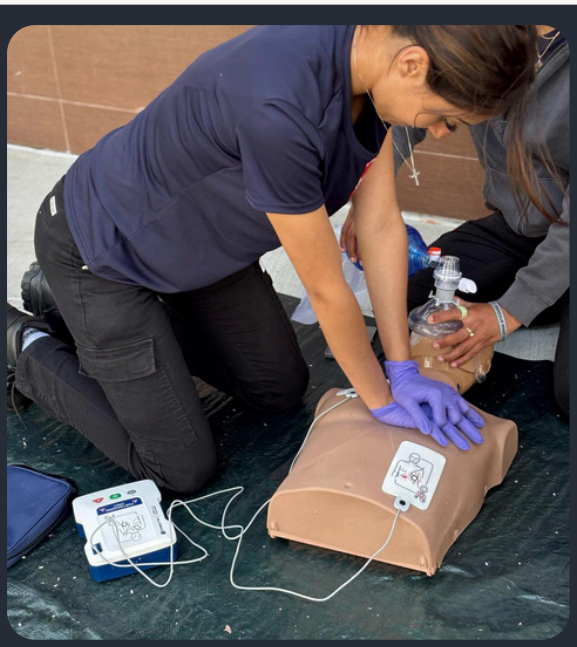
9. ADJOURNMENT

YOU ARE CORDIALLY INVITED

Thank you for indicating your interest and willingness to be a volunteer!

As a select & valued member of the EMS Corps community, your expertise and dedication are instrumental in shaping the next generation of emergency medical professionals.

We are pleased to invite you to participate in our upcoming EMT training sessions, featuring hands-on skill demonstrations and scenario-based simulations. To complete the process, scan the QR code for available dates and times.



OUR MISSION

EMS Corps is on a mission to increase the number of underrepresented EMTs through training, mentorship, and youth development. Your time, knowledge, and presence directly impact our mission to uplift and empower young adults from underserved communities

SIGN UP NOW!

Scan the QR Code below to volunteer.

THANK YOU for being part of our mission.

EMERGENCY MEDICAL SERVICES COMMISSION
PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES
Wednesday - April 16, 2025

MEMBERSHIP / ATTENDANCE

	MEMBERS IN ATTENDANCE	ORGANIZATION
X	Carol Meyer, Chair	EMSC, Commissioner
X	Kenneth Powell, Vice-Chair	EMSC, Commissioner
	Jason Cervantes	EMSC, Commissioner
	James Lott, PsyD, MBA	EMSC, Commissioner
	Gary Washburn	EMSC, Commissioner
	Kristin Kolenda	EMSC, Commissioner
	Ken Lieberman	EMSC, Commissioner
	Paul Camacho	EMSC, Commissioner
X	Sean Stokes	Area A *(Rep to Medical Council)*
	Patrick Nulty	Area A, Alternate
X	Keith Harter	Area B
X	Clayton Kazan, MD	Area B, Alternate
	Vacant	Area C
	Jeffrey Tsay	Area C, Alternate
	Ryan Jorgensen	Area E
	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
	Matthew Conroy	Area H
	Tim Wuerfel	Area H, Alternate
X	David Hahn	Area H, Alternate
X	Julian Hernandez	Employed Paramedic Coordinator
	Tisha Hamilton	Employed Paramedic Coordinator, Alt
	Jenny Van Slyke	Prehospital Care Coordinator
X	Melissia Turpin	Prehospital Care Coordinator, Alternate
X	Bryan Sua	Public Sector Paramedic Coordinator
	Drew Pryor	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
	Robert Ower	Private Sector Nurse Staffed Amb Program
	Jonathan Lopez	Private Sector Nurse Staffed Amb Program,
	Scott Jaeggi	EMT Training Program
	Albert Laicans	EMT Training Program, Alternate
X	Ray Mosack	Paramedic Training Program
	Vacant	Paramedic Training Program, Alternate
	Jennifer Nulty	EMS Educator
	Heather Calka	EMS Educator, Alternate

EMS AGENCY STAFF	EMS AGENCY STAFF
Richard Tadeo	Nichole Bosson, MD
Denise Whitfield, MD	Shira Schlesinger, MD
Jake Toy, MD	Chris Clare
Jacqueline Rifenburg	Ami Boonjaluksa
Frederick Bottger	Sam Calderon
Paula Cho	Mark Ferguson
Aldrin Fontela	Natalie Greco
Carola Jimenez	Han Na Kang
Nnabuike Nwanonenyi	Sara Rasnake
Gary Watson	Gerard Waworundeng
David Wells	

GUESTS	ORGANIZATION
Lyn Riley	LA County Sheriff's Dept
Ilse Wogau	LACoFD
Jim Goldsworthy	LAFD Air Operations
Jessie Castillo	PRN Ambulance
Luis Manjarrez	Glendale FD
Michael Stone, MD	USC EMS Fellow
Jennifer Shepard	LA County Sheriff's Dept
Caroline Jack	Beverly Hills FD
Issac Yang	Redondo Beach FD
Kelsey Wilhelm, MD	Compton FD
Kimberly Tan	UCLA Ctr for Prehospital Care
Joe Nakagawa, MD	Hawthorne PD
Marc Cohen, MD	LAFD; Multiple FDs Med Director
L. Mendoza	Lifeline Ambulance
Danielle Thomas	Lifeline Ambulance
David Milligan	Montebello FD
Danielle Ogaz	LACoFD
Dave Molyneux	AM West Ambulance
Travis Moore	La Verne FD
Theodor Ecklund	Pasadena FD
Edward Valdez	Mt Sac College
Puneet Gupta, MD	LACoFD
Jorge Fazzini	West Coast Ambulance
Israel Razo	Monrovia FD
Paula La Farge	LACoFD
Peter Garcia	Burbank FD
Catherine Borman	Santa Monica FD
Johnna Corbett	UCLA Ctr for Prehospital Care
Marianne Newby	UCLA Ctr for Prehospital Care
Jennifer Hunt	Long Beach FD
Ed Marquez	Glendale FD
Nicole Reid	LACoFD
Karyn Robinson	Montebello FD

1. CALL TO ORDER – Chair Carol Meyer, called meeting to order at 1:05 p.m.

2. INTRODUCTIONS AND ANNOUNCEMENTS

2.1 Committee Membership Changes *(Commissioner Meyer)*

The following Committee membership changes were announced:

- Committee Vice-Chair: Commissioner, Fire Chief Kenneth Powell, replacing Paul Espinosa.
- Prehospital Care Coordinator, Alternate: Melissia Turpin from Dignity Health – St. Mary Medical Center. *(Jenny Van Slyke will move to the Primary Representative position)*
- EMS Educator, Alternate: Heather Calka, UCLA Center for Prehospital Care. *(Jennifer Nulty will remain as the Primary Representative)*

2.2 EMSAAC 2025 Annual Conference *(Richard Tadeo)*

- EMS Agency Director reminded attendees of the upcoming EMSAAC Conference, scheduled for May 28 and 29, 2025, with a pre-conference on disaster medical response on May 27, 2025. Sign up information was provided inside the distributed brochure and also located at the following weblink: https://emsaac.org/conference/

2.3 Joint Educational Session *(Shira Schlesinger, MD)*

- The next PedAC/MAC Joint Educational Session, titled "Don't Drop the Beat: Pediatric Cardiac Arrest", will take place on June 3, 2025, 11:45am-1:00pm via ZOOM. Information to join this educational session was distributed. Calendar invite will be sent to all providers.

3. APPROVAL OF MINUTES (Harter/Mosack) February 12, 2025, minutes were approved as written.

4. UNFINISHED BUSINESS

There was no unfinished business.

5. NEW BUSINESS

5.1 9-1-1 IFT Cognito Form *(Chris Clare)*

- A workgroup was formed to review the appropriateness of 9-1-1 IFTs; and to determine what interventions are needed to address concerns.
- To assist in determining the appropriateness of 9-1-1 IFTs, a Cognito form was developed. This form is to be completed by the provider (and hospital) after each 9-1-1 IFT call-out.
- Once form is completed, this information will be provided to the EMS Agency for review and to evaluate for trends.

Policies for Discussion; Action Required:

5.2 Reference No. 814, Determination/Pronouncement of Death in the Field *(Nichole Bosson, MD)*

Policy reviewed and approved as written.

M/S/C (Brown/Harter) Approve: Reference No. 814, Determination/Pronouncement of Death in the Field.

Policies for Discussion; No Action Required:

The following policies were reviewed as **information only**:

5.3 Reference No. 1309, MCG: Color Code Drug Doses *(Nichole Bosson, MD)*

Agitated Delirium Changes *(Shira Schlesinger, MD)*

5.4 Reference No. 526, Behavioral/Psychiatric Crisis Patient Destination
5.5 Reference No. 526.1, Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Centers (PUCC)
5.6 Reference No. 838, Application of Patient Restraints

Committee had the following recommendation:

- Pg 3, III.B.3. (Last sentence): Add wording to include contacting the base hospital, when possible.

5.7 Reference No. 1200.2, Treatment Protocol: Base Contact Requirements
5.8 Reference No. 1200.3, Treatment Protocol: Provider Impressions
5.9 Reference No. 1200.4, Treatment Protocol: BLS Upgrade to ALS Assessment
5.10 Reference No. 1209, Treatment Protocol: Behavioral / Psychiatric Crisis
5.11 Reference No. 1307, MCG: Care of the Patient with Agitation

5.12 Reference No. 1307.3, MCG: Common Etiologies of Agitation, Field Presentation, Likelihood Verbal De-Escalation
5.13 Reference No. 1317.25, MCG: Drug Reference – Midazolam
5.14 Reference No. 1373, MCG: Treat Protocol Quality Improvement Fallout Data Dictionary

6. REPORTS AND UPDATES

6.1 Sidewalk CPR *(David Wells)*

- Los Angeles County's Sidewalk CPR event will be held on Monday, June 2, 2025, at Grand Park in downtown Los Angeles, from 10:00 a.m. to 12:00 p.m.
- Dr. Bosson will start off the event which will include press coverage and speakers from LA County Fire Department, Los Angeles (City) Fire Department, American Heart Association and a cardiac arrest survivor.
- Currently, 38 hospitals, private providers, and public providers have signed up to provide training at various sites in the County during the week. Please contact the EMS Agency if you are planning to host an event, so this information can be posted on the EMS Agency webpage.
- More information can be found on the EMS Agency's webpage; including various training locations, training videos and interviews with cardiac arrest survivors.

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

- Paramedic and MICN training for this year's EMS Update has started and must be completed by June 30, 2025. (3.5 hours of continuing education is available).
- Feedback for EMS Update 2025 and suggestions for Update 2026 are welcomed.
- If your department was not able to send a representative to a Train-the-Trainer class and you're in need to train your staff, please contact Dr. Schlesinger at SSchlesinger2@dhs.lacounty.gov.

6.3 EmergiPress *(Shira Schlesinger, MD)*

- The March/April 2025 EmergiPress has been posted on the EMS Agency's webpage. Topic: HERT (Hospital Emergency Response Team). One (1) hour of continuing education (CE) credit is available.
- Providers are encouraged to share this information with your staff and complete the training prior to the end of 2025.

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

- This standing committee is meeting quarterly with local law enforcement colleagues.
- Task Force is developing a law enforcement training module on the co-response of the agitated person. (Similar to the training in EMS Update 2025)
- Other topics being reviewed include law enforcement responses to pediatric patients and critically ill patients.
- Task Force is looking for law enforcement agencies willing to participate in the filming of future educational topics. If interested, contact Dr. Bosson at NBosson@dhs.lacounty.gov

6.5 Research Initiatives and Pilot Studies

6.5.1 Prehospital Blood Transfusion – LA DROP *(Nichole Bosson, MD)*

- Pilot started on April 1, 2025, with LA County Fire Department and Compton Fire Department.
- Compton Fire Department reported the first case in Los Angeles County to administer pre-hospital blood product on April 15, 2025.
- Los Angeles County Fire Department currently has three squads capable of providing blood products and plan to expand to 11 total squads.
- Currently, Ventura and Riverside Counties have also implemented this pilot. Sacramento and San Bernardino Counties soon to be approved.

6.5.2 ThoraSite Pilot *(Denise Whitfield, MD)*

- Pilot involved the use of a landmarking device for needle thoracostomy insertion and concluded in December 2024. Aggregated quality improvement data was presented through a PowerPoint presentation.
- Due to the positive data outcome, this device has been approved for optional use in LA County.
- Thank you to LA County, Torrance, Culver City and Compton Fire Departments for their participation.

6.6 PediDOSE Trial *(Nichole Bosson, MD)*

- Enrollment continues. No changes to report.
- Starting July 1, 2025, this trial will transition to include patients 12-16 months of age in the age-based dosing of midazolam.

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

- Nationally, there are currently 591 patients enrolled in this study (nearly 200 from LA County). The EMS Agency should soon be receiving the second study analysis.
- Zoll Medical: Providers who currently do not have the Zoll premium case review account, will be eligible for a free membership to include this case review feature throughout the study. The Zoll research team (led by Chris Graft) has reached out to the providers who qualify for the free product, to arrange for installation. Additional questions/support can be directed to Dr. Bosson.
- **Reminder:** As part of this study, all pediatric patients requiring respiratory support (including seizure patients) are to have pediatric pacing pads applied and utilized, for accurate monitoring. Used pacing pads will be replaced through the EMS Agency.
- RALPH Devices: Provides the paramedic with the correct airway technique for the day (i-gel or BMV) during airway management. The repaired devices will be redistributed to public providers, if willing to utilize. The use of the RALPH device is optional.

6.8 California Office of Traffic Safety (OTS) Grants Projects

6.8.1 RAPID LA County Medic Mobile Application *(Nichole Bosson, MD and Denise Whitfield, MD)*

- Application has been working well. However, an intermittent connectivity issue has been reported and the vendor is working hard to resolve.
- Drug Doses Application: A new version of this application is being distributed, which should resolve the above issue. If providers continue experiencing issues, please contact Dr. Whitfield at DWhitfield@dhs.lacounty.gov.
- Protocol Application Study: On April 17 and 18, 2025, the EMS Agency and several paramedics will be testing this application with two types of scenarios.
- Providers interested in joining the EMS Agency in continuing this study at their own department, may contact Dr. Whitfield. This study requires the completion of two scenarios by 72 paramedics. As an incentive to participate, there will be a cash distribution of $120.00 and continuing education offered to all participants.

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

- Signed contracts to operationalize live dashboards have been completed between the EMS Agency and ESO. ESO will be creating a data repository and the initial visualization for the trauma dashboard.

6.9 Health Data Exchange *(Richard Tadeo)*

- Phase I of this project has started with meetings between ESO and the participating Trauma and Base hospitals. These meetings have provided an overview of the HDE initiative.
- Meetings with individual hospitals will be scheduled over the next few months.
- Adventist Health – Glendale, is expected to be the first hospital to go live with the HDE system.
- Once the "Business Associate Agreement" is complete, providers can begin participating in these meetings. The EMS Agency Director will reach out to the providers.

7. OPEN DISCUSSION

7.1 Mechanical Compression Devices – Pediatric Patients *(Nichole Bosson, MD)*

- Prior to this meeting, provider agencies and hospitals have asked the EMS Agency whether mechanical compression devices may be utilized on pediatric patients (14 years and under).
- After reviewing the manufacturer's guidelines from Auto Pulse and Lucas devices, it was found that the use of these devices on pediatric patients are no longer contraindicated. However, the device must "fit" the patient. To determine if the device fits the patient, videos are available for review. Those interested in these videos, contact Dr. Kelsey Wilhelm at KWilhelm@dhs.lacounty.gov
- The EMS Agency has designed a future EmergiPress educational video on the proper use of the Auto Pulse and Lucas devices; focusing on the patient transfer from field devices to hospital devices. These videos are also available by contacting Dr. Shira Schlesinger.

7.2 Trauma Throw Bags – Distribution *(Nnabuike Nwanonenyi)*

- Trauma throw bags will be distributed today at the EMS Disaster Warehouse, following this meeting. Paperwork and process for obtaining these bags was explained.
- The intent of these trauma bags is for them to be carried on supervisor vehicles and distributed at scenes of major trauma incidents.
- Any questions or to request an alternate pick-up time, contact Nnabuike Nwanonenyi (BK) at Nwanon@dhs.lacounty.gov

7.3 Capnography for Spontaneous Breathing Patients *(Nichole Bosson, MD)*

- Currently, inventory lists for paramedic units only state that the waveform capnography is mandatory. After discussing the importance of using side-stream capnography on specific conscious patients, this Committee and Medical Directors from two of the larger provider agencies in LA County, supported the transition of making this item "mandatory" for all ALS units.

7.4 Naloxone Level Behind Program *(David Wells)*

- The EMS Agency was approached by the Department of Public Health, to determine the status of public provider's participation in the Leave Behind Narcan program. The EMS Agency encourages all provider agencies currently or planning to participate in the program to attend the CDPH webinar. *(See Ref. 1337, MCG: Naloxone Distribution by EMS Providers)*

7.5 Buprenorphine Program *(Nichole Bosson, MD and Denise Whitfield, MD)*

- Due to the large volume of residents in Los Angeles County experiencing an opiate abuse disorder, the EMS Agency felt it would be beneficial to explore the possibility of implementing an EMS Buprenorphine Program in the LA County EMS system.
- This opiate abuse disorder treatment program is being funded by the State of California. Currently this paramedic-initiated Program is being utilized in Alameda County (Northern California).
- As part of the California Bridge Program, emergency departments have paired with social services to find ways to treat patients with an opioid addiction disorder. Since this infrastructure is now functioning, the Program is looking into the benefits of adding paramedic-initiated treatment to this project (including the administration of buprenorphine).
- Providers interested in joining the EMS Agency on this project, can contact either Dr. Bosson or Dr. Whitfield.

8. NEXT MEETING – June 18, 2025

9. ADJOURNMENT - Meeting adjourned at 3:05 p.m.

(EMT/PARAMEDIC/MICN)

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

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

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

DEFINITIONS:

Adult: A person at least eighteen years of age.

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

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

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

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

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

The lack of decision-making capacity may be:

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

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

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

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

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

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

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

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

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

LPS-Evaluator: An individual that is authorized under CA WIC *§* 5150 et seq. to evaluate and place a patient on a 5150/5585 written 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 CA WIC *§* 5150 et seq.

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

Minor: A person less than eighteen years of age.

Minor Not Requiring Parental Consent is a person who:

- Is 12 years or older and in need of care for a reportable medical condition or substance abuse
- Is pregnant and requires care related to the pregnancy
- Is in immediate danger of suspected physical or sexual abuse
- Is an emancipated minor

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

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

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

Psychiatric Hold (5150 / 5585): Refers to California Welfare and Institutions Code (WIC) *§* 5150 et seq. which defines 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). This is a written application by an authorized LPS-evaluator certified by the County to place an individual on a psychiatric hold. An authorized LPS-evaluator must provide the written application (“psychiatric hold” document) which must accompany the patient to the facility where they are transported.

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

Released Following Protocol Guidelines: Disposition for patients who lack established decision-making capacity or in whom capacity cannot be determined due to inability to access or assess the patient, and for whom EMS personnel have exhausted all options (including law enforcement when appropriate) such that EMS cannot safely access and/or transport the patient to the hospital.

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

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

PRINCIPLES:

1. An adult or emancipated minor who has decision-making capacity has the right to determine the course of their medical care including the refusal of care. These patients must be advised of the risks and consequences resulting from refusal of medical care. A

patient less than eighteen (18) years of age, with the exception of minors not requiring parental consent, mush have a parent or legal representative to refuse evaluation, treatment, and/or transport for an emergency medical condition.

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

3. Patients who have attempted suicide, or who have expressed a method, a plan, or intent to commit suicide (*MCG 1306*), should receive an evaluation by an LPS-evaluator for a psychiatric hold. LPS evaluator determination is the legal authority for placement or non-placement of a psychiatric hold (5150 / 5585).

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

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

~~5.~~6. For patients determined to lack decision-making capacity or in whom capacity cannot be determined due to inability to access or assess the agitated patient, EMS personnel should refer to MCG 1307.4, EMS and Law Enforcement Co-Response to follow the escalation and communication pathway to engage law enforcement's assistance.

~~6.~~7. Patients for whom 9-1-1 is called but are not transported represent a potentially high-risk group and provider agencies should/shall have quality review programs specific to this patient population.

POLICY:

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

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

B. Base contact should be made prior to the patient leaving the scene for patients who would otherwise meet Base Contact criteria (Ref. 1200.2 – Base Contact Requirements) in order for Base personnel to have the opportunity to interview the patient and to evaluate the appropriateness of the AMA. If the patient elopes from the scene, EMS personnel are not required to make Base Contact.

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

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

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

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

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

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

B. If EMS personnel or the base hospital determines it is necessary to transport the patient against their will and the patient resists, or the EMS personnel believe the patient will resist, assistance from law enforcement should be requested in transporting the patient. Law enforcement may consider the placement of a psychiatric hold on the patient but this is not required for transport. In cases where law enforcement's decision is to not engage, EMS personnel should follow guidelines outlined in MCG 1307.4, EMS and Law Enforcement Co-Response.

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

III. Patients Assessed, Treated, and Released

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

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

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

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

2. Patients should be instructed by EMS to follow-up with the patient's medical home or primary care physician. The advice given should be documented on the Patient Care Record. The following statement is recommended: "After our assessment, you feel that you do not wish to be transported and you do not require immediate care in the emergency

department. You should seek care with your regular healthcare provider or a doctor's office or clinic within 24 hours. If you have worsening or persistent symptoms or change your mind and desire transport, recontact 9-1-1."

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

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

IV. Documentation

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

B. A Patient Care Record must be completed for each patient or contact encounter (i.e., Lift Assist, AMA, Assess, Treat and Release, and Treatment in Place), including those refusing emergency medical evaluation, care and/or transportation against medical advice and those released at scene. EMS personnel shall ensure that documentation is in compliance with Ref. 606 – Documentation of Prehospital Care. Patient Care Record documentation should include:

1. AMA:

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

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

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

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

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

f. Signature of patient or legal representative

g. Patient's plan for follow-up care

h. Contact with Base Hospital, as applicable

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

2. Assess, Treat and Release:

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

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

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

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

e. If Base contact was made (when applicable)

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

3. Released Following Protocol Guidelines

a. Patient history and assessment, including incomplete assessments and description of barriers to completing assessment

b. All responding agencies on scene

c. Base hospital medical direction, if applicable

d. Name and assignment of the highest-ranking law enforcement officer involved in the decision-making, and LPS evaluator information, if applicable

e. Reasons stated by law enforcement for disengagement when applicable

f. Any follow up plans and resources requested and/or provided to the patient

~~3.~~4. Treatment in Place:

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

V. Quality Improvement

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

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

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

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

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

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

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

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

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 304, **Paramedic Base Hospital Standards**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 832, **Treatment/Transport of Minors**
Ref. No. 816, **Physician At The Scene**
Ref. No. 1200, **Treatment Protocols**, et al.
Ref. No. 1200.2, **Base Contact Requirements**
Ref. No. 1306, **Medical Control Guideline: Evaluation and Care of Patients at Risk of Suicide**
Ref. No. 1307.4 **Medical Control Guideline: EMS and Law Enforcement Co-Response**
Ref. No. 1309, **Color Code Drug Doses**
Ref. No. 1380, **Medical Control Guidelines: Vital Signs**

Medical Control Guideline: EMS AND LAW ENFORCEMENT CO-RESPONSE Ref. No. 1307.4

DEFINITION

Agitation: A hyper-aroused state (ranging in severity from anxious and cooperative to violent and combative) in which the individual exhibits excessive, repeated, and purposeless motor or verbal behaviors (e.g., pacing, fidgeting, clenching fists or teeth, prolonged staring, picking at clothing or skin, responding to internal stimuli such as hallucinations, threatening or carrying out violent acts).

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

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

The lack of decision-making capacity may be:

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

Minor: A person less than eighteen years of age.

PRINCIPLES:

1. EMS and Law Enforcement often co-respond to the scene when there is an agitated patient perceived to pose risk to themself and/or others.

2. EMS focus is on the duty to the patient, whereas Law Enforcement has a duty to the public. This may result in differences in the approach to scene management.

3. Each situation is unique and dynamic such that no guideline can be comprehensive or specific. The flow diagram below represents a general approach, but must be adapted to the individual circumstances of the response.

4. Early, clear and open communication will facilitate arriving at the best possible outcome for the person. The conflict resolution pathway (Guideline #4) should be employed whenever there is not full agreement between EMS and Law Enforcement on whether to remain engaged.

5. The decision for Law Enforcement to engage, and/or to apply a 5150 or 5585, will be according to their policies, procedures, and the law. While Law Enforcement will

ultimately determine if there is an immediate threat, engagement should be a consensus-driven decision based on the assessment of EMS and Law Enforcement on scene. For cases where there is ongoing disagreement and a successful resolution cannot be reached on scene, an after action review shall be undertaken at a later agreed upon date, in collaboration with both agencies.

GUIDELINES:

1. Refer to the flow diagram below for guidance.

2. When the agitated person is a minor, apply the guidelines with the following caveats:

    a. If the minor is alone, the general approach will be to engage.
    b. If the minor is in the care of a parent or legal guardian, the principles of capacity assessment are applied to that parent or legal guardian, with consideration for how they can assist in de-escalating the situation and provide an alternative to engagement.
    c. Involve the Department of Child and Family Services as appropriate, https://dcfs.lacounty.gov/, 800-540-4000.
    d. Refer also to Ref. No. 832, Treatment/Transport of Minors.

3. Consider the following Mental Health Resources:

    a. Request response of local jurisdictional resources as available.
    b. Request a Crisis Response Team from the Department of Mental Health Access Center 24/7 Contact Line: 800-854-7771.
    c. For any patient left on scene, inform the patient of the '988' hotline, which provides telemedicine mental health resources.

4. For situations where Law Enforcement decision is to disengage or defer and EMS remains concerned about immediate risk to the patient and/or others, the following communication strategy should be employed in a stepwise fashion until a final solution is agreed upon:

    a. The highest ranking EMS and Law Enforcement personnel on scene discuss their rationale for the decision to engage versus disengage.
    b. Mental health resources are identified and requested to the scene to provide alternative methods for de-escalation and management. Consider contacting the Base Hospital for further guidance on resources and strategies.
    c. If not already on scene, the EMS and Law Enforcement supervisors are requested to the scene and discuss face-to-face.
    d. The EMS supervisor speaks with the Law Enforcement Watch Commander.
    e. If no resolution is achieved, EMS shall defer to Law Enforcement and not engage on their own if there is a perceived risk to EMS personnel and/or the patient.

5. Document decision-making and involved personnel on the ePCR including:
    a. All responding agencies on scene
    b. EMS assessment
    c. Name and assignment of the highest ranking Law Enforcement Officer involved in the decision-making

d. Reasons for Law Enforcement decision for disengagement when applicable
e. Any follow up plans and resources requested and/or provided to the patient for non-transport decisions
f. For non-transports, document the appropriate disposition per Ref 834, Patient Refusal of Treatment/Transport and Release at Scene

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **AED SERVICE PROVIDER PROGRAM REQUIREMENTS** (EMT/PUBLIC SAFETY) REFERENCE NO. 412

PURPOSE: To establish policies and procedures for ~~AED service providers,~~ EMT and Public Safety AED service providers~~,~~ in Los Angeles County.

AUTHORITY: Health and Safety Code, Division 2.5, Sections~~;~~ 1797.106~~170~~, 1797.170~~190~~, 1797.19~~06~~ & 1797.215.
California Code of Regulations, Title 22, Division 9, Chapter 2.3~~1.5~~, Sections 100025.01, 100025.07, 100026.01, 100027.05, & 100027.06.
California Code of Regulations, Title 22, Division 9, Chapter 3.1, Sections 100065.06 &100066.03. ~~First Aid and CPR Standards and Training for Public Safety Personnel 100017 100021 100022, Chapter 2 Sections 100056,100056.1, 100063, 100063.1.~~

DEFINITIONS:

Automated External Defibrillator (AED): An external defibrillator capable of cardiac rhythm analysis that will charge and deliver a shock, either automatically or by user interaction, after electronically detecting and assessing ventricular fibrillation or ventricular tachycardia.

Authorized Individual: EMT or public safety ~~-~~personnel employed by an ~~EMT~~ AED service provider who has met the training requirements and is authorized to use an AED.

EMT (Emergency Medical Technician): An individual who is currently certified in California as an EMT.

EMT AED Service Provider: An agency or organization ~~approved by the EMS agency and is~~ which is responsible for and authorizes its EMTs to operate an AED, approved by the EMS Agency for the purpose of providing AED services to the general public.

Public Safety AED Service Provider: A~~n~~ municipal agency or organization ~~approved by the EMS agency~~ which ~~and~~ is responsible for and authorizes its public safety personnel to operate an AED, approved by the EMS Agency, for the purpose of providing ~~-~~AED services to the general public.

Public Safety Personnel: Firefighter, lifeguard, or peace officer (as defined by Section 830 of the Penal Code) not employed as an EMT.

PRINCIPLES:

1. All AED service provider agencies shall meet State regulations and established EMS Agency policies.

2. Only agencies or organizations that employ EMTs and/or public safety personnel are eligible for approval as an AED service provider.

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

3. An approved AED service provider and their authorized personnel shall be recognized statewide.

POLICY

I. Approving Authority

The EMS Agency shall be the approving authority for all AED service provider programs whose headquarters/local operations are located within Los Angeles County.

II. Application Requirements

An organization or agency employing certified EMTs and/or employing public safety personnel of a municipality may seek approval by submitting the following:

1. A complete and signed Los Angeles County EMS Agency AED Service Provider Program Application.

2. Required documents as identified in the application instructions.

III. Program Requirements

A. Program Coordinator

1. Each program shall designate a program coordinator who is an individual designated by the fire chief, supervisor, or general manager of the AED service provider organization or agency.

2. The duties shall include but are not limited to:

a. Program management.

b. Ensure maintenance of AED equipment.

c. Submission of required data annually via the AED Annual Report by March 31st for the perrevious calendar year.

d. Ensure that a California licensed physician, physician assistant, registered nurse, or paramedic, who has the ability to interpret electrocardiogram (ECG) rhythms, will timely and competently:

i. Download post-use data and review all cases where an AED was applied or indicated.

ii. Maintain required data set for annual report.

iii. Review and summarize system performance.

iv. Provide and document recommendations, as indicated, for modification of system design, performance protocols, or training standards designated to improve patient outcome.

e. Comply with department and EMS Agency policies and procedures.

B. AED Service Provider Program Personnel

1. AED service provider program authorized personnel must:

a. Complete an Emergency Medical Services Authority or Los Angeles County EMS Agency approved Public Safety First Aid training program every two (2) years.

OR

b. Maintain certification as an EMT in California or licensure as a Paramedic in California.

c. Complete approved CPR training equivalent to BLS for the Healthcare Provider (AHA) or professional Rescuer (ARC) every two (2) years.

2. AED service provider program authorized personnel must receive:

a. An orientation to the proper use, maintenance, and periodic inspection of the AED service provider's specific AED device(s).

b. Instruction in documentation, internal response and operational plan to include notification of the jurisdictional 9-1-1 Advanced Life Support (ALS) provider (if applicable), reporting requirements, and EMS Agency policies and procedures related to AED use.

c. Continued competency training and documented demonstration of skills proficiency which shall occur, at a minimum, every two (2) years.

~~II.~~IV. Program Approval

The EMS Agency:

A. Shall notify the applicant within fourteen (14) business days that the application was received and specify what information, if any, is missing or deficient.

~~B. Shall review and approve all first aid and/or Cardiopulmonary Resuscitation (CPR)/AED training programs which are not approved by American Heart Association (AHA), American Red Cross (ARC), American Safety Health Institute (ASHI), Peace Officer's Standards and Training (POST), or the EMS Authority.~~

~~C.~~B. May conduct a site survey prior to approval.

~~D.~~C. Shall provide written approval authorizing AED services within thirty (30) calendar days, when all requirements have been met.

~~E.~~D. May suspend or revoke ~~or suspend~~ an AED program, prohibiting the use of AEDs, if the AED service provider:

1. Is found to be out of compliance with applicable state regulations and/or EMS Agency policies, procedures, or reporting requirements.

2. Fails to correct identified deficiencies within the specified length of time after receiving written notice from the EMS Agency.

~~III. Program Staff Requirements~~

~~Each program shall designate a program coordinator.~~

~~A. Requirements~~

~~An individual designated by the fire chief, supervisor, or general manager of the AED service provider organization or agency.~~

~~B. The duties shall include but are not limited to:~~

~~1. Program management.~~

~~2. Submission of required data annually via AED Annual Report.~~

~~3. Ensure that a California licensed physician, physician assistant, registered nurse, or paramedic, who has the ability to interpret electrocardiogram (ECG) rhythms, will timely and competently:~~

~~a. Review all cases where an AED was applied.~~

~~b. Maintain required data set for annual report.~~

~~c. Review and summarize system performance.~~

~~d. Make recommendations, as indicated, for modification of system design, performance protocols, or training standards designated to improve patient outcome.~~

~~4. Comply with department and EMS Agency policies and procedures.~~

~~IV. Program Requirements~~

~~A. Initial Application~~

~~An organization or agency employing certified EMTs and/or employing public safety personnel may seek approval by submitting the following:~~

~~1. A complete application, Los Angeles County EMS Agency Ref. No. 412.1, AED Service Provider Program Application.~~

2. A written request or letter of intent which includes the following:

   a. A statement that the organization or agency is willing to abide by Los Angeles County EMS Agency Ref. No. 412, AED Service Provider Program Requirements.

   b. An assurance that all AED devices in use meet current AHA Emergency Cardiovascular Care (ECC) guidelines.

   c. Report changes in key personnel or equipment to the Los Angeles County EMS Agency within thirty (30) days.

   d. Notification of discontinuance of an approved EMS AED program will be sent to the Los Angeles County EMS Agency within thirty (30) days of closure.

B. Public Safety Programs Initial Training Requirements:

1. CPR and First aid training not less than 21 hours. POST-approved basic academy training covers this training requirement.

2. AED training and orientation of authorized personnel shall include the following topics and skills:

   a. Proper use, maintenance, and periodic inspection of the AED.

   b. The necessity of CPR, defibrillation, advanced life support (ALS), and adequate airway care.

   c. Overview of the EMS system, 9-1-1 access, interaction with EMS personnel, and organization's internal response and operational plan.

   d. Assessment of an unconscious patient, to include evaluation of airway, breathing, and circulation to determine cardiac arrest.

   e. Appropriate care if rhythm analysis reports "no shock advised".

   f. AED safety precautions to enable the individual to administer a shock without jeopardizing the safety of the patient, rescuers, or bystanders.

   g. Recognition that an electrical shock has been delivered to the patient and that the defibrillator is no longer charged.

   h. Rapid, accurate assessment of the patient post defibrillation.

   i. Appropriate care following defibrillation.

   j. Documentation and reporting requirements

~~C. Public Safety Programs Skills Competency:~~

~~1. Complete a retraining course in first aid, CPR, and AED use once every two (2) years at a minimum which consists of not less than eight (8) hours.~~

~~**OR**~~

~~2. Pass a competency based written and skills pretest on first aid, CPR, and AED use every two (2) years at a minimum with the following restrictions:~~

~~a. Appropriate retraining is provided on those topics indicated necessary by the pretest in addition to any new developments in first aid, CPR, and AED use.~~

~~b. Successful completion of a written test covering the topics on which retraining occurred.~~

~~c. The hours for the retraining may be reduced to those hours needed to cover the topics indicated necessary by the pretest.~~

~~D. EMT Programs Training and Competency Requirements:~~

~~1. CPR with AED training to the level of health care provider or professional rescuer in accordance with current AHA ECC guidelines.~~

~~2. Orientation to the use and maintenance of the EMT service provider's specific AED device(s).~~

~~3. Instruction in documentation, internal response and operational plan, reporting requirements, and EMS Agency policies and procedures related to AED use.~~

~~4. Continued competency training and documented demonstration of skills proficiency which shall occur, at a minimum, every two (2) years.~~

~~E. Provide the following to the EMS Agency or EMS Authority upon request for each AED authorized user:~~

~~1. If an EMT AED provider, EMT certification number with expiration date and issuing agency.~~

~~2. Date of most recent CPR/AED training.~~

~~3. Most recent AED skills competency date.~~

~~F. Maintenance of Equipment/Supplies~~

~~1. Have a written policy with the procedure to be used to ensure AED equipment is properly maintained.~~

~~2. All AEDs and supplies shall be maintained and inspected after each use and, at a minimum, every thirty (30) days.~~

~~G. Response and Operational Plan shall include the following:~~

~~1. How emergency response will be activated, e.g. 9-1-1 call, internal number, radio, etc.~~

~~2. Geographical response area, location of each AED and number of AEDs in service.~~

~~3. Response personnel.~~

~~4. Scene safety.~~

~~5. Documentation post AED application.~~

V. AED Service Program Review and Reporting

A. Approved programs shall be subject to periodic on-site surveys by the EMS Agency.

B. The EMS Agency shall be notified in writing within thirty (30) days of any change to program coordinator, and for~~/or~~ changing, adding, or upgrading AEDs.

C. Complete and submit the ~~Ref. No. 412.2,~~ AED Service Provider Annual Report ~~and submit~~ by March 31st for the previous calendar year. 9-1-1 Fire Departments with an ALS program are exempt from this requirement.

D. Provide the following to the EMS Agency or EMS Authority upon request for each authorized user:

1. If an EMT AED provider, EMT certification number with expiration date and issuing agency.

2. Training Rosters or Certification Documents demonstrating:

a. Date of most recent CPR/AED training.

b. Most recent AED skills competency date.

~~C.~~

VI. Record Keeping

A. Each program shall maintain the following records for four (4) years which shall be available for review:

1. All documentation required for program approval to include list of authorized personnel and certification/training credentials.~~.~~

2. Training and competency materials with rosters.

~~3. Instructional and testing material.~~

~~4.~~3. Maintenance/inspection log sheets.

4. Curriculum vitae and qualifications for the program coordinator and medical reviewer.

5. Documentation of AED application reviews, recommendation and quality assurance.

B. Patient care records shall be maintained in accordance with: ~~EMS Agency policies.~~

1. EMS Agency policies for EMTs.

~~B.~~2. Agency/Organizational Policies for Public Safety

CROSS REFERENCE:

Prehospital Care Manual:
~~Ref. No. 412.1, **EMT AED Service Provider Program Application**~~
~~Ref. No. 412.2 **AED Service Provider Annual Report**~~
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 608, **Retention and Disposition of Prehospital Care Records**
Ref. No. 621, **Notification of Personnel Change**
~~Ref. No. 610, **Retention of Prehospital Care Records**~~
~~Ref. No. 814, **Determination/Pronouncement of Death in the Field**~~
Ref. No. 802, **Emergency Medical Technician (EMT) Scope of Practice**
Ref. No. 911, **Public Safety First Aid (PSFA) and Basic Tactical Casualty Care (BTCC)Training Program Requirements**

Los Angeles County EMS Agency AED Service Provider Program Application
Los Angeles County EMS Agency AED Service Provider Annual Report Form

AED Service Provider Program Application

To apply for approval as an AED service provider, the following documents/information needs to be submitted to the LA County EMS Agency:

- ☐ Curriculum Vitae (resume) of Program Coordinator
- ☐ Training materials including:
  - Curriculum to be used (if other than American Heart Association (AHA), American Red Cross (ARC), American Safety Health Institute (ASHI), or Peace Officer's Standards and Training (POST)
  - Documentation to be used for orientation and training for specific AED device(s)
  - Skill/training/testing sheet if other than AHA, ARC, ASHI, or POST
- ☐ Documentation of current EMT Certifications for all EMTs including issuing agency and expiration date.
- ☐ Departmental policy and procedures pertaining to AED Program shall include:
  - Internal response and operational plan
  - AED event procedures
  - CPR/AED initial training and retraining requirements
  - Frequency of checking authorized user's competency skills
  - Maintenance of equipment/devices
  - Data collection for quality assurance and annual report
- ☐ AED skill competency check list.
- ☐ AED response form (if other than an approved PCR or LA County EMS Agency form).
- ☐ AED maintenance check list.
- ☐ Letter of intent to include items listed in LA County Ref. No. 412, Automated External Defibrillator (AED) Service Provider Program Requirements.

Return completed application and required documentation to:

Los Angeles County EMS Agency
Attn: AED Program Coordinator
10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670
Phone: (562) 378-1633

AED Service Provider Program Application

Name of Provider		
Address	**City**	**Zip Code**
Program Coordinator	**Title**	
Phone	**Email**	

AED Manufacturer

□ Cardiac Science
□ Defibtech or Cintas
□ Heartsine
□ Medtronic
□ Philips
□ Welch Allyn
□ Zoll
□ Other _____

Model

□ Powerheart
□ G3 pro
□ G3 Plus
□ G3 Automatic
□ Lifeline
□ Reviver (DDU-100)
□ Samaritan
□ Samaritan PAD
□ Lifepak 1000
□ Lifepak CR Plus
□ FRx
□ FR2+
□ On-Site
□ AED 10
□ AED 20
□ AED plus
□ AED pro
□ M Series
□ E Series
□ Other _____

Total Number of AEDs	**Location of AEDs (patrol vehicles, ambulances, etc.)**
Provider Response Area (if not an existing 9-1-1 provider)	**Pediatric Equipment?** □ Yes □ No
Frequency of AED Checks (* Per Manufacturer's Recommendation) □ Daily □ Weekly □ Monthly	**AED Response Form** □ Approved PCR □ County EMS □ Self Designed

Curriculum

□ American Heart Association
□ American Safety Health Institute
□ Other _____
□ American Red Cross
□ Peace Officer's Standards and Training (must submit training material for approval)

Frequency of checking individual AED skill proficiency

□ Every 2 years □ Annually □ Every 6 months
□ Other _____

Completed by: _____/_____
(Signature) (Print name)

Title: _____

AED SERVICE PROVIDER ANNUAL REPORT

As required by State law and local polices, the following statistical information is required on an annual basis, due by March 31st for the previous calendar year.

AED Service Provider Name: _____

Reporting period: _____

1. Population served (estimate): _____

2. Number of responses to patients where an AED was used initially: _____

(To include **initial AED use only**, including use before ALS arrival. **DO NOT** include responses where only paramedic/ALS manual defibrillation was used. This information will be captured in the patient care records for ALS responses.)

3. Number of resuscitations attempted: _____

4. Number of resuscitations not attempted: _____

Ref. No. 814, Determination/Pronouncement of Death in the Field, valid Do-Not-Resuscitate (DNR), Advanced Health Care Directive (AHCD), Physicians Orders for Life Sustaining Treatment (POLST), personal physician, or family at scene requesting to withholding resuscitation efforts.

5. Number of patients on whom an AED was applied: _____

6. Total number **WITNESSED** arrest (seen or heard by AED provider personnel): _____

a) Number who received bystander CPR prior to arrival of emergency medical care _____

b) Number with initial rhythm of V-Fib or V-Tach (AED indicated shock advised with initial application) _____

c) Number who received a shock from an AED operated by the AED service provider _____

7. Total number **UNWITNESSED** arrest (prior to arrival of AED provider personnel): _____

a) Number who received bystander CPR prior to arrival of emergency medical care _____

b) Number with initial rhythm of V-Fib or V-Tach (AED indicated shock advised with initial application) _____

c) Number who received a shock from an AED operated by the AED service provider _____

8. Problems associated with AED operation or application: □ **Yes** □ **No**

If you answered yes, check appropriate box below and provide additional information.

a) **Equipment failure**

Machine shocks rhythm other than V-Fib or V-Tach	□
No discharge	□
Tape/Battery Malfunction	□
Other	□

_____

_____

_____

b) Lack of skill proficiency □ **Yes** □ **No**

_____

_____

_____

9. Name of MD, RN, PA, or Paramedic primary reviewer of AED application (s):

_____

Contact number: _____ Email address: _____

10. Manufacturer/Model of the AEDs: _____

Number of AEDs in Service: _____ Pediatric Pads □ **Yes** □ **No**

11. Number of personnel by level authorized to use AEDs within your agency:

a) EMT: _____

b) Public Safety personnel (**Non-EMT)**: _____
(Peace Officers, Lifeguards and Firefighters)

c) Non-licensed/non-certified personnel: _____
(Lay public/employees)

12. Frequency of individual AED/CPR skills competency verification:

☐ Every 2 years (EMT only) ☐ Annually ☐ Every 6 months Other: _____

AED Program Coordinator: _____ Title: _____

Email: _____ Contact Number: _____

AED Program Coordinator's Signature: _____ Date: _____

Submit report via mail, e-mail or fax to:

Los Angeles County EMS Agency
Attn: AED Coordinator
10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670
e-mail: aedprograms@dhs.lacounty.gov

Fax: (562) 941-5835

DEPARTMENT OF HEALTH SERVICES **DRAFT 4-23-2025**
COUNTY OF LOS ANGELES

SUBJECT: **SUPPLY AND RESUPPLY OF DESIGNATED** (~~PARAMEDIC~~ALL PROVIDER AGENCIES)
~~**EMS**~~ **PROVIDER UNITS/VEHICLES** REFERENCE NO. 701

PURPOSE: To provide a policy for ~~9-1-1~~ provider agencies (public and private) to procure, store, and distribute medical supplies and pharmaceuticals identified in the ~~ALS~~ Unit Inventory that require specific physician authorization.

AUTHORITY: California Health and Safety Code, Division 10, Uniform Controlled Substances Act~~; and~~
California Health and Safety Code, Division 2.5, Chapter 5, Section 1798.
California Code of Regulations, Title 22, Chapter 3.34, Article 6, Section 100096~~168~~.01.
Code of Federal Regulations, Title 21, Section 801.109.

DEFINITION:

Restricted Drugs and Devices: Drugs and devices bearing the symbol statement "Rx Only"; or the ~~legend~~ statement~~s~~, "Caution, federal law prohibits dispensing without prescription~~,~~";; or "Federal law restricts this device to sale by or on the order of a physician," or words of similar import.

POLICY:

I. Responsibilities of the Provider Agency

A. Each provider agency shall have a mechanism to procure, store, track and distribute its own restricted drugs and devices under the license and supervision of a physician who meets the requirements specified in Ref. No. 411, Provider Agency Medical Director or Ref. No. 420, Private Ambulance Operator Medical Director.

B. Provider agency shall furnish the EMS Agency with a completed Ref. No. 701.1, Physician Confirmation of Agreement to Purchase Drugs and Medical Supplies indicating that the respective physician will assume responsibility for providing medical authorization for procuring restricted drugs and devices.

C. Mechanisms of procurement may include the following:

1. Procurement of restricted drugs and devices from a hospital that determines it has the legal authority to resell pharmaceuticals and supplies to a provider agency.

2. Procurement of restricted drugs and devices through another legally authorized source, including but not limited to, a pharmaceutical distributor or wholesaler.

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

D. Each provider agency shall have policies and procedures, reviewed, approved, and signed by the provider agency mMedical dDirector, in place for the procurement, transport, storage, distribution, and disposal of restricted drugs and devices. These policies shall be reviewed by the local Emergency Medical Services (EMS) Agency and shall include, but are not limited to, the following:

1. Identification (by title) of individuals responsible for procurement and distribution.

2. A determination of reasonable quantities of supplies and pharmaceuticals that must be maintained to resupply ALS units between deliveries by distributor to prevent or reduce the possibility of short supply from routine use, expiration, or during a regional/nation-wide shortage. Routine order amounts should be based on historical use data and other internal considerations.

3. Maintenance of copies of all drug orders, invoices, and logs associated with restricted drugs and devices for a minimum of three years.

4. Procedures for completing a monthly inventory, which includes:

   a. Ensuring medications are stored in original packaging;

   b. Checking medications for expiration dates, rotating stock for use prior to expiration, and exchanging for currentexpired medications;

   c. Properly disposing of expired medications that cannot be exchanged;

   d. Accounting for restricted drugs and devices in stock and/or distributed to ALS units and other transport units; and

   e. Returning medications to the pharmaceutical distributor if notified of a recall.

5. Storage of drugs (other than those carried on the ALS unit itself) that complies with the following:

   a. Drugs must be stored in a locked cabinet or storage area.

   b. Drugs may not be stored on the floor (Storage of drugs on pallets is acceptable).

   c. Antiseptics and disinfectants must be stored separately from internal and injectable medications.

   d. Flammable substances, e.g., alcohol, must be stored in accordance with local fire codes.

   e. Storage area is maintained within a temperature range that will

maintain the integrity, stability, and effectiveness of drugs.

6. A mechanism for procuring, storing, distributing, and accounting for controlled drugs that is consistent with the requirements outlined in Ref. No. 702, Controlled Drugs Carried on ALS and SCT Units.

II. Pharmaceutical Shortages

A. Notification

1. Pharmaceutical recalls, shortages and other pharmaceutical-related concerns are identified through notifications from:

a. The Food and Drug Administration (FDA)

b. ~~Public and private p~~Provider agencies

2. Once notification is received, FDA is contacted to verify report and retrieve an expected recovery date.

3. If notification content from the FDA is expected to impact the Los Angeles County (LAC) EMS System, all ALS providers will be formally notified by the EMS Agency's Medical Director.

B. Mitigation Strategies

Mitigation strategies are identified in two categories as follows: 1. Those that can be implemented by the ~~EMS~~ provider agency simultaneous with written notification to the LAC EMS Agency Medical Director, and 2. those that require prior approval of the LAC EMS Agency Medical Director prior to implementation.

1. Mitigation strategies which can be implemented by the ~~EMS~~ provider ~~Agency~~ agency with notification of the LAC EMS Agency Medical Director.

a. Inventory Reduction:

i. Provider agency may redistribute its current pharmaceutical inventory amongst its own ~~ALS~~ units, from low volume to high volume utilizers.

ii. The Medical Director of the ~~EMS Provider~~ provider ~~Agency~~ agency may temporarily reduce the minimum inventory par levels.

iii. Provider agencies ~~(public and private)~~ that are low volume utilizers may redistribute a portion of its current inventory to other provider agencies that are high volume utilizers, with the exception of controlled substances.

b. Provider agencies should attempt procurement from other pharmaceutical vendor resources.

c. The ~~EMS Provider~~ provider ~~Agency~~ agency may contact the LAC EMS Agency to obtain approval to receive pharmaceuticals from the disaster preparedness pharmaceutical cache ~~to provider agencies in most need~~.

d. Use of expired medications as per published FDA extensions.

2. Mitigation strategies that require LA EMS Agency Medical Director approval prior to implementation:

a. Change in opioid medication from what has previously been approved (i.e., change from morphine to fentanyl).

~~b. Use of blanket extension expiration dates on for medications in shortage.~~

~~c.~~b. Dilution of ~~any~~ a medication to achieve the desired formulation (e.g., epinephrine 1mg/mL to achieve epinephrine 0.1mg/mL).

~~d.~~c. Change in formulation of a medication that is not on the LAC EMS Agency approved list of formulations (Ref. MCG 1309).

~~e.~~d. Approval for extension of use past expiration dates for medications not on the FDA extension list.

C. Recovery Phase

Once it has been identified that the current pharmaceutical shortage has resolved and provider agencies have received back-ordered medications, the following shall take place:

1. All ~~ALS~~ units shall return to the minimum inventory amounts, as outlined in appropriate unit inventory lists.

2. Pharmaceuticals acquired from the EMS Agency or other provider agencies ~~(private and public)~~ are to be equally replenished by the acquiring agency.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 411, **Provider Agency Medical Advisor**
Ref. No. 420, Private Ambulance Operator Medical Director
Ref. No. 702, **Controlled Drugs Carried on ALS Units**
Ref. No. 703, **ALS Unit Inventory**
Ref. No. 703.1 Private Provider Interfacility Transfer ALS Unit Inventory
Ref. No. 704, **Assessment Unit Inventory**

Ref. No. 706, ALS EMS Aircraft Inventory
Ref. No. 710, Basic Life Support Ambulance Equipment
Ref. No. 712, Nurse Staffed Specialty Care Transport Unity Inventory
Ref. No. 713, Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory
Ref. No. 719, Fireline Emergency Medical Technician Paramedic (FEMP) Inventory

PURPOSE: To provide minimum equipment standards for private basic life support (BLS) ambulance providers and to ensure a system wide standardized inventory of supplies and equipment to promote safety, readiness, and the ability to meet the requirements of an "all hazards" disaster response in the event of a declared emergency.

AUTHORITY: California Administrative Code, Title 13, Section 1103
California Highway Patrol (CHP) Handbook 82.4, Chapter 4.5: Recommended Ambulance Equipment
California Vehicle Code Section 2418.5
Health and Safety Code 1797.220 and 1798
~~Senate Bill 409~~

DEFINITIONS:

Personal Protective Equipment: For the purpose of this policy, personal protective equipment (PPE) is garments/equipment designed to protect/minimize hazardous exposure to prehospital care responders.

PRINCIPLES:

1. Ambulances shall be maintained in good mechanical repair and sanitary condition.

2. Any equipment carried for use in providing emergency medical care must be maintained in clean condition and good working order. Medical supplies and solutions shall be replaced prior to the expiration date.

3. All reusable medical supplies and equipment should be maintained in clean, ready-to-use condition and be disinfected or sterilized per manufacturer's recommendations.

4. Whenever a patient with a known or suspected communicable disease has been transported, the patient compartment and all interior surfaces, including fixed equipment, should be thoroughly cleansed with soap, water, and disinfectant. Supplies such as pillows, blankets, and linens should be disposable or autoclaved. * (* indicates language specific to the CHP Handbook)

5. All ambulance providers must be integrated into the disaster medical response system in order to participate in state and local disaster response or a declared emergency.

6. Ambulance personnel should not function within an operational area requiring PPE beyond their level of provision and training.

7. In any workplace where N95, or equivalent masks are necessary to protect the health of employees or whenever such masks are required by the employer, the employer shall have a written policy and provide training in the proper use and operation of the device.

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

NOTE: Ambulances dedicated for infant transportation or when staffed and equipped for use in conjunction with newborn intensive care nursery services as specified in Title 22, CAC, Sections 70481 – 70487, need not concurrently carry items of emergency care equipment or supplies as specified herein that would interfere with the specialized care and transportation of an infant in an incubator or isolette.

POLICY:

I. Required Vehicle Safety Equipment:

A. A siren and steady burning red warning lamp that meet requirements established by the CHP Handbook, Section 818.

B. Seat belts or equivalent restraints for every sitting position. A child or infant not secured to a gurney should be secured in an appropriate child/infant restraint device.

C. A fire extinguisher of the dry chemical or the carbon dioxide type, with a minimum 4-B:C rating, maintained as prescribed by the State Fire Marshal in Title 19, CAC, Section 597. The use of vaporizing liquid extinguishers is prohibited.

D. A portable, battery-operated light.

E. A spare wheel with inflated tire of the appropriate load rating.

F. A jack and tools for wheel changes.

G. Maps or electronic mapping device covering the areas in which the ambulance provides service.

H. Patient compartment door latches operable from inside and outside the vehicle on all emergency ambulances manufactured and first registered after January 1, 1980.

II. Personnel PPE Training

Prior to use, all personnel who may be required to utilize PPE shall receive training in accordance with OSHA requirements (Ref. 26 CFR 1910.132 [f]. At minimum, training shall consist of:

A. Identification of when and what type of PPE is necessary; how to properly don, doff, adjust, and wear PPE; the limitations of the PPE; and the proper care, maintenance, useful life, and disposal of the PPE (Ref. 29 CFR 1910.132 [f] [1] [1-5]).

B. Demonstration of the ability to use PPE properly before being allowed to perform work requiring the use of PPE (Ref. 29 CFR 1910.132 [f] [2].

C. Verification that each employee has received and understands the required training through a written certification that contains the course title, date of the training, and the name of the employee trained.

D. Proper fit testing for any respiratory protection in accordance with OSHA requirements (Ref. 29 CFR 1910.134).

III. Minimum Levels of Recommended Emergency Care Equipment and Supplies

MINIMUM INVENTORY	QUANTITIES
Adhesive tape, rolls of 1 in., 2 in. and, 3 in.	2 each
Ankle and wrist restraints. • If soft ties are used, they should be at least three inches wide (before tying) to maintain a ~~two inch~~two-inch width while in use.	1 set
Automated External Defibrillator (AED) • Razor/Trimmer	1 each
Adult AED Defibrillation Pads	2
Bandages, 4 in. sterile compresses or equivalent	12
Bag-valve device with 0_2 inlet and reservoir • Bag Volume 400-700 mL [1] • Bag Volume 900-1500 mL [1]	1 each
Bag-valve mask • Large • Medium • Small adult/child • Toddler • Infant • Neonate	1 each
Bandages, 2 in. or 3 in. soft, rolled stretch (Kerlix or Kling type)	6
Bandages, 3 in. x 3 in. or 4 in. x 4 in. sterile gauze pads	4
Bandages, universal dressings (trauma dressings), 10 in. x 30 in or larger	2
Bandage scissors	1
Bedpan/fracture pan	1
Blood pressure manometer, cuff and stethoscope: • Thigh • Adult • Child • Infant	1 each
*Cervical Collars, rigid: • Adult • Child • Infant *2 pediatric adjustable meets infant requirement	2 each
Dextrose – glucose paste/gel	15gms
Emesis basin, disposable bags or covered containers	1

MINIMUM INVENTORY	QUANTITIES
Hemostatic dressings–EMS Authority approved dressings only - **optional**	2
Immobilizer, Head: • Disposable or Reusable	2
Linen: • Sheets • Pillows	4 2
Manometer **(Optional)**	2
Obstetrical supplies, sterile, including (no scalpel): • Gloves • Umbilical cord clamps • Dressings, towels • Scissors • Bulb syringe • Clear plastic bag	1 kit or supplies as indicated
Oropharyngeal airways: • Two (2) adult • Two (2) children • One (1) infant • One (1) newborn	6
Oxygen cannulas • Adult • Child	1each
Oxygen masks, non-rebreather • Adult • Child • Infant	1 each
Oxygen masks, simple **(Optional)** • Adult • Child • Infant	1 each
Oxygen, portable • "D" or "E" FULL cylinder with one (1) oxygen flow control regulator for use between both cylinders	1
Oxygen, vehicle (house) • "M" or "H" cylinder with a minimum of 1000 psi and one (1) oxygen flow control regulator	1
Personal Protective Equipment (PPE) (Personal Body Substance Isolation Equipment) • mask • gown • eye protection	2 each
Saline, sterile isotonic, in clearly labeled plastic liter (quart) containers	2

MINIMUM INVENTORY	QUANTITIES
Spine boards, rigid, approximately 14 inches in width with one at least 30 inches in length, and the other approximately 72 inches in length with straps for immobilization of suspected spinal or back injuries	2
Splints, short, medium, and long • Cardboard splints (recommended for general use) • Inflatable air splints (recommended to immobilize lower arms and lower legs) **(Optional)**	4 each
Splints, traction	1
Stretchers: • Stretchers with wheels and the following: ○ mattresses should be covered with impervious plastic material or the equivalent ○ have the capability to elevate both the head and foot ○ straps to secure the patient to the stretcher, including shoulders, waist, and legs ○ a means of securing the stretcher in the vehicle ○ adjustable to four different levels	1
• Collapsible stretcher and the following: ○ straps to secure the patient to the stretcher and a means of securing the stretcher in the vehicle	1
• Device to secure a child or infant to the stretcher	1
Suction equipment, portable, capable of at least: • a negative pressure equivalent to 300mm of mercury • 30 liter per minute air flow rate for 30 minutes of operation.	1
Suction equipment, vehicle (house), capable of at least: • a negative pressure equivalent to 300mm of mercury • 30 liter per minute air flow rate for 30 minutes of operation	1
Suction Tubing: • Non-collapsible, plastic, semi-rigid, whistle-tipped, finger controlled type is preferred. * • Flexible catheters for tracheostomy suctioning (8Fr.-12Fr.)	1 each
Thermometer (Oral or axillary)	1
Tongue depressors	6
Tourniquets (commercial, for control of bleeding)	2
Water, sterile, (quarts)	2
Urinal	1
Chemotherapy spill kit **(Optional)**	1

PERSONAL PROTECTION EQUIPMENT (PPE)*	QUANTITIES
Escape hood **(Optional)**	2
Gloves, work (multiple use, leather)	2 pairs
Hearing protection	2 sets
Jacket, EMS, with reflective stripes	2
Rescue helmet	2
Respiratory protection mask (N95) and general purpose mask	2 each
Safety vest meeting ANSI/ISEA 107-2020 standards Type P: Class 3 ~~or equivalent~~	2

~~* OSHA Safety & Health Information Bulletin: "CBRN Escape Respirator", provides guidance on use, selection, and training. The minimum PPE is Level D, if applicable.~~

AMBULANCE STRIKE TEAM ADDITIONAL SUPPLIES*	QUANTITIES
Ballistic vest, protective **(Optional – risk dependent**)**	2
Field Operations Guide (FOG)	1
Footwear covers, single use	2 pairs
Duodote (atropine 2.1mg and pralidoxime chloride 600mg) or equivalent (**Optional)**	1/person
MRE (meal ready to eat) (3 meals/day/member for 3 days)	18

*Maintained at deployment location, not required in vehicle unless deployed.
**Mandatory for deployment to areas of civil unrest.
[1] **Device volume, not delivered volume.**

CROSS REFERENCES:

OSHA Regulations:
Ref. No. 29 CFR 1910.132
Ref. No. 29 CFR 1910.134
OSHA Safety & Health Information Bulletin: "CBRN Escape Respirator" provides guidance on use, selection, and training. The minimum PPE is Level D, if applicable.

Emergency Medical Services Authority (EMSA):
EMSA Guidelines #216

California Highway Patrol:
Ref. 299, Ambulance Inventory

Prehospital Care Manual:
Ref. No. 703, **ALS Unit Inventory**
Ref. No. 703.1 Private Provider Interfacility Transfer ALS Unit Inventory
Ref. No. 704, **Assessment Unit Inventory**

SUBJECT: **TRANSPORT/TRANSFER OF PATIENTS FROM CATALINA ISLAND** (EMT, PARAMEDIC, MICN) REFERENCE NO. 520

PURPOSE: To ensure that 9-1-1 patients located on Catalina Island are transported to the most appropriate facility staffed, equipped, and prepared for their medical emergency.

AUTHORITY: Health & Safety Code, Div. 2.5, Sections 1797.204, 1797.220, 1798.2, 1798.101(b)(1)
California Code of Regulations, Title 22. Section ~~100276~~100166.01, et seq.
California Code of Regulations, Title 22, Section 70649
Emergency Medical Treatment and Labor Act (EMTALA)

DEFINITIONS:

Emergency Medical Condition: Condition in which the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to a patient's health, bodily function impairment, or serious dysfunction of any body organ or part. For the purposes of this policy, this includes women in labor.

Interfacility Transfer (IFT): The transfer of a patient from a licensed health facility to another licensed health facility. For the purposes of this policy, transport options for IFTs involve the use of EMS transport vehicles.

Standby Emergency Medical Service, Physician on Call: Medical care provided in a specifically designated area of the hospital which is equipped and maintained at all times to receive patients with urgent medical problems and capable of providing physician service within a reasonable time.

9-1-1 Response: The physical response of an EMS provider due to activation of the EMS system with a request for medical evaluation. For purposes of this policy, this includes emergency responses to the field, licensed healthcare facility, a physician's office, or clinic.

PRINCIPLES:

1. Emergency medical services (EMS) procedures on Catalina Island have been modified to accommodate the island's limited medical and transport options, its unique geography, and distance from the mainland; nevertheless, the interfacility transfer of patients from Catalina Island Medical Center (AHM) shall comply with current EMTALA and Title 22 transfer laws and regulations for both sending and receiving hospitals.

2. AHM, the only available medical facility on the island, is licensed as a standby emergency medicine service. Emergency, inpatient, and diagnostic services are limited and there are no obstetrical or surgical services.

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

3. AHM is not easily accessible from other areas of the island, for example, travel time from the Isthmus to Avalon is approximately 45-60 minutes by boat or ground transport.

4. Air transport is the preferred means for transporting critical patients off the island and may be limited by weather and availability.

5. Boat transport is an option if an air ambulance is unavailable, but like aircraft, weather may be a limiting factor. Paramedics, in consultation with the base hospital, shall determine if a boat will be used instead of an air ambulance.

6. Transportation arrangements for interfacility transfers (IFTs) from AHM are the responsibility of AHM. The appropriate transport modality should be made in consultation with the receiving hospital, which may include the utilization of 9-1-1 transport providers. AHM will make arrangements with the receiving hospital's physician to accept the patient prior to the transfer. These arrangements may be accomplished through one of the paramedic base hospitals.

POLICY:

I. 9-1-1 Responses

A. Paramedic personnel, in consultation with the base hospital, shall determine whether an emergency medical condition exists which requires immediate transport to a 9-1-1 receiving facility. If such a condition exists, air transportation shall be requested.

B. If it is determined that the ETA for air transportation is prolonged, or the patient's condition precludes management in the field, prehospital personnel may opt to transport the patient to AHM to stabilize the patient while awaiting air transportation. Under these circumstances AHM is obligated to comply with Title 22 and EMTALA transfer laws. The transport and destination arrangements already made by the paramedics in consultation with the base hospital should be utilized to expedite the transfer of the patient. The paramedics should remain with the patient and assist AHM personnel until care can be transferred to the medical personnel accompanying the patient to the mainland.

C. There is no back-up paramedic capability on Catalina Island. If paramedics get another 9-1-1 call while assisting AHM personnel as described in Policy 1.B., all patient care shall be assumed by AHM personnel. AHM should provide updated verbal report(s) to the receiving hospital.

~~D. If paramedics or the base hospital determine a patient does not have an emergency medical condition or need air transport, but the AHM physician concludes otherwise, the 9-1-1 system should be activated, and 9-1-1 air transport should be initiated.~~

~~Prior to transport, the sending physician will make arrangements/acceptance for the transfer of the patient with the receiving physician.~~

D. In the event a patient arrives at AHM by private transportation, the examining physician has evaluated and stabilized the patient to the best extent possible and

determines the patient's condition warrants immediate transport, the 9-1-1 system should be activated, 9-1-1 air transport should be initiated, and arrangements for the transfer have been made with an accepting physician. In the event that the patient needs additional medical care during transport (e,g,. sedated and intubated, medications outside of paramedic scope of practice, etc.) private air ambulance will need to be arranged.

~~E.~~ If 9-1-1 air transport is being utilized, ~~In such instances,~~ paramedics must establish base hospital contact with their assigned base hospital when medical direction for advanced life support (ALS) procedures is required. If the base hospital physician or mobile intensive care nurse (MICN) has questions about the patient care provided prior to transport, they should speak directly with the AHM physician.

~~F.~~E. EMS personnel shall request an air ambulance in accordance with their agency's policies and procedures. It may be necessary for the base hospital to facilitate communication between paramedics and air ambulance dispatch. Paramedics on scene, in collaboration with the base hospital, may ask Command and Control to dispatch a specific resource based on patient need or scene circumstances.

A 9-1-1 air transport request shall be initiated as follows:

Los Angeles County Fire Department Command and Control will determine if a helicopter can be dispatched from one of the following (not necessarily in this order):

1. Los Angeles County Fire Department (2 paramedics)
2. Los Angeles County Sheriff's Department (2 paramedics)
3. Los Angeles City Fire Department (2 paramedics)
4. Mercy Air (1 nurse, 1 paramedic, other medical personnel as appropriate)
5. Reach Air (1 nurse, 1 paramedic, other medical personnel as appropriate)
6. U.S. Coast Guard Search and Rescue (rescue swimmer*)

***If unable to accommodate a Los Angeles County paramedic to accompany the patient to the receiving facility, the paramedic handling the call may transfer care to the U.S. Coast Guard.**

Additionally, Baywatch Avalon should be consulted if Mercy/Reach is not available or declines the call.

It is extremely important that the Catalina Island paramedics be apprised of transportation arrangements as soon as possible to facilitate patient care.

~~G.~~F. EMS personnel may request boat transport if an air ambulance is not available and weather permits. Base hospital contact may be needed to facilitate communication between paramedics and boat dispatch. Paramedics on scene, in collaboration with the base hospital, may ask Command and Control to dispatch a specific resource based on patient need or scene circumstances.

A 9-1-1 boat transport request shall be initiated as follows:

1. Los Angeles County Fire Department Command and Control will

determine if a boat can be dispatched from one of the following (not necessarily in this order):

a. Los Angeles County Fire Department (2 paramedics)
b. Los Angeles County Sheriff's Department (2 paramedics)
c. Long Beach Fire Department (3 paramedics)

2. Paramedics who transport patients from Catalina Island into another provider agency's jurisdiction on the mainland must contact that provider agency's dispatch center for notification and dispatch the appropriate advanced or basic life support transport.

II. IFT Transportation Options

A. AHM shall make every effort to facilitate an IFT through a private air ambulance provider. Use of public providers for IFT transports should be considered as a last resort.

~~A. 9-1-1 Response:~~

~~The jurisdictional 9-1-1 provider agency may be contacted when the AHM physician has evaluated and stabilized the patient to the extent possible and determines the patient's emergency medical condition warrants immediate transport.~~

B. Private Air Ambulance Provider ~~or Medical Alert Center:~~ (See Reference No. 520.1, Catalina Island Medical Center (AHM) Transfer/Transport Process)

1. ~~If~~ Once appropriate transfer arrangements have been made, AHM ~~may~~ shall contact ~~either~~ a private air ambulance provider directly ~~or the Medical Alert Center (MAC)~~ and request air transport for an IFT. AHM ~~and/or the MAC~~ shall make every effort to notify the air ambulance provider of the acuity of the call when requesting air transport. At minimum, the following information will be provided:

a. Patient's name
b. Diagnosis
c. Vital signs
d. Pertinent medical history
e. Any therapy required or in progress ~~(MAC must consider scope of practice issues)~~
f. Patient destination
g. Payer source (if any)

~~2.~~ If the transport is declined AHM may ~~C~~contact the Medical Alert Center (MAC) to assist in arranging transportation. ~~determine if an air ambulance can be dispatched from one of the following (in this order):~~

2.

~~a. Private air ambulance provider**~~
~~b. Los Angeles County Fire Department Command and Control~~
~~c. Los Angeles Fire Department Operations Control Dispatch~~

~~**If a private air ambulance provider is requested to do an IFT, payer source may be a factor in determining whether they will respond.~~

~~The MAC will provide Los Angeles County Command and Control with a report detailing the process/rationale used to determine which air ambulance was utilized.~~

~~3. AHM shall make every effort to facilitate an IFT through a private air ambulance provider. Use of public providers for IFT transports should be considered as a last resort.~~

3. ~~If requested by the provider agency,~~ AHM shall notify Baywatch Avalon for transportation coordination once arrangements have been made~~make every effort to meet the air ambulance at the helipad with the patient to expedite transportation~~.

4. If all air resources are unavailable or decline the transport, then sea resources can be contacted through the MAC. In the event that all transportation resources are unavailable, the patient shall remain at AHM until transportation resources become available.

~~4.~~

C. 9-1-1 Response:

The jurisdictional 9-1-1 provider agency may be contacted when the AHM physician has evaluated and stabilized the patient to the extent possible and determines the patient's emergency medical condition warrants immediate transport.

III. Non-emergency Patient Transportation

Ambulatory patients who do not have an emergency medical condition and require no medical assistance or monitoring enroute but are instructed to seek further medical care on the mainland, may be transported by private transport, commercial boat, or helicopter service. Such patients would be equivalent to patients on the mainland who are released at scene or instructed to seek medical care via private transportation.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 418, **Authorization and Classification of EMS Aircraft**
Ref. No. 502, **Patient Destination**
Ref. No. 514, **Prehospital EMS Aircraft Operations**
Ref. No. 816, **Physician at the Scene**
Ref. No. 520.1, **Catalina Island Transfer Process/Algorithm**

SUBJECT: **CATALINA ISLAND MEDICAL CENTER (AHM) TRANSFER/TRANSPORT PROCESS** (EMT, PARAMEDIC, MICN) REFERENCE NO. 520.1

AHM Shall:

Determine the appropriate Receiving Facility* and make arrangements /acceptance with the Receiving Facility's MD** prior to initiating the patient transportfer.

Contact private air ambulance for transport:

Mercy Air (800) 222-3456
Reach (800) 338-4045

Notify Baywatch Avalon for transportation coordination & consultation.

Contact MAC to arrange transport (800) 940-4401 AND Baywatch Avalon (via phone or radio)

** The Baywatch MAC will: first 1. aAttempt to obtain other air resources (LACoFD, LASD Air 5, LAFD, USCG)
2. iIf air resources are unavailable, Baywatch to consider contact other resourcesresources including then sea resources transportation will be contacted (LACoFD, LASD, LAFD, USCG).

3. If all resources are unavailable, the patient should remain at AHM until resources become available.

AHM should notify Baywatch Avalon should be notified of all IFTs and consulted

Transport Accepted

Transport Declined OR Patient too unstable to wait for extended ETA

Patient transported to Receiving Facility

** For Public Provider Non-Private Air Resources, or ED to ED Transfers:*

Limit Receiving Facilities to the following:

- **Torrance Memorial** (Stroke, SRC, EDAP)
- ***Harbor-UCLA** (SRC, TC, PTC, PMC)
- **MemorialCare Long Beach** (Stroke, SRC, PMC, PTC, TC)
- **St. Mary** (TC, EDAP, SRC)
- **Ronald Reagan UCLA** (Hyperbaric if the one on the Isthmus is unavailable)
- Other LA County Hospitals considered on a case-by-case basis

Once the patient has arrived at the Receiving Facility's ED, subsequent ground transportation can be arranged if needed.

**Transfers to a Department of Health Services (DHS) hospital, (Harbor-UCLA , LA General, Olive View) contact the MAC to obtain acceptance.

DEPARTMENT OF HEALTH SERVICES DRAFT 4-8-2025
COUNTY OF LOS ANGELES

SUBJECT: **PRIVATE AMBULANCE VEHICLE AGE LIMIT AND LICENSURE REQUIREMENTS ~~AND EXEMPTIONS~~** REFERENCE NO. 455

PURPOSE: To establish a procedure that defines the maximum age limit requirements for an ambulance vehicle to be licensed for operation in Los Angeles County ~~and be granted an exemption beyond the defined age limit~~.

AUTHORITY: Los Angeles County Code, Title 7, Business Licenses Chapter 7.16 Ambulance, Section 7.16.210, Ambulance – Mechanical requirements.

PRINCIPLES:

1. The EMS Agency may grant or issue an initial vehicle license in Los Angeles County for an ambulance that is no more than eight (8) ~~-~~years-old as determined by the date ~~the vehicle was first placed in service ("First Sold") date, provided this date is not greater than one (1) year~~of ~~from the~~ manufacture ("Model Year") from the date listed on the vehicle registration.

2. The EMS Agency Director ~~may make individual exceptions to extend the age limit up to two (2) years beyond the eight-year age limitation (known as a vehicle exemption)~~has authorized age limit to a maximum of twelve (12) years to meet the needs of public convenience and necessity. This authorization reserves the ambulance vehicle license to the specific vehicle and shall not be transferable to another ambulance vehicle or ambulance provider.

3. Vehicles must continuously meet all inspection requirements for business licensure in Los Angeles County to qualify for sale and new licensure for another ambulance provider~~an exemption~~.

4. An a~~A~~mbulance vehicle license will be closed upon removal from service or sale.

~~3.~~5. Ambulance vehicles for which licensure or inspection requirements expire shall be immediately removed from service until compliance has been met.

POLICY:

I. Basic Requirements

A. The EMS Agency, Ambulance Programs Section, will not issue an initial/new ambulance business license to any vehicle over eight (8) ~~-~~years of age.

B. An ~~A~~ambulance ~~Operator~~ vehicle business license may be renewed up to twelve (12) years from date of manufacture provided licensure and all requirements are

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continuously maintained from license issuance~~obtain a two (2) year extension for currently licensed ambulance vehicles over eight years of age~~.

~~B.~~C. Any ambulance vehicle for which licensure fees are not paid ~~prior to~~within sixty (60) days of expiration shall not be eligible for licensure renewal. If the vehicle is less than eight (8) years of age, vehicle shall be eligible for a new ambulance vehicle license application.

II. ~~Procedure for Obtaining Vehicle Exemptions~~Vehicle Sale or Removal From Service

~~A.~~ Following the sale, removing from service or vehicle has ~~The Ambulance Operator must submit a written request for an exemption to the EMS Agency Director thirty (30) calendar days prior to the date in which the vehicle is scheduled to reach the eight year age limit, as defined by the greater "Model Year," or "First Sold" date listed on the vehicle registration. Requests for multiple vehicles exemptions may be included in one letter.~~

~~B. The letter requesting an exemption must include the following information for each vehicle:~~

~~1. Identification (Unit number)~~
~~2. "Model Year" and "Year First Sold," whichever is greater~~
~~3. Make, Model, and type (i.e., Ford, Leader E350)~~
~~4. License plate number~~
~~5. Vehicle Identification Number (VIN)~~
~~6. Current mileage~~

~~C. Copies of the following vehicle documents must be submitted with the letter requesting an exemption and all vehicle documents must be current at the time of submission to qualify for a vehicle exemption:~~

~~a. Registration~~
~~b. Weights and Measures – Certificate of Inspection~~
~~c. California Highway Patrol (CHP) Inspection Report~~
~~d. CHP Identification (ID) Card~~
~~e. Insurance Identification Card, or comparable (as proof of vehicle insurance coverage)~~

~~D. Upon receipt, the EMS Agency will review the exemption request and all supporting documents for compliance.~~

~~E. Vehicles that meet the conditions referenced above will receive a two (2) year exemption to the eight (8) year age limit. The exemption expires 10 years from the date that the vehicle was first placed in service ("First Sold") date, provided the date is not greater than one (1) year from the manufacture ("Model Year") date listed on the vehicle registration.~~

~~F. Upon exemption approval, the Ambulance Operator will receive a letter from the EMS Agency authorizing the vehicle(s) to operate an additional two (2) years beyond the 8-year age limit.~~

~~G. The Ambulance Operator shall maintain a copy of the exemption letter in their administrative files, and in each applicable vehicle granted an exemption.~~

~~H.~~A. ~~A vehicle has~~ "aged out" by~~when~~ reaching~~it reaches~~ its twelve (12) ~~0~~ year anniversary from date of manufacture, ~~and is no longer eligible to operate in Los Angeles County. Following this date,~~ the Ambulance Operator must:

1. Remove the vehicle from service in Los Angeles County if not already performed.~~.~~

2. Notify the EMS Agency of the removal from service and request the EMS Agency Seal Form.

3. Once the form is received:

   a. Complete the required documentation.
   ~~1.~~
   b. Affix the seal removed from the vehicle~~Remove the Los Angeles County issued seal from the vehicle and return it to the EMS Agency~~.

4. Submit the completed form with the seal to the EMS Agency within ten (10) calendar days.

~~2.~~ ~~.~~

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 450, **Los Angeles County Code, Title 7, Business Licenses, Division 2, Chapter 7.16 Ambulances**
Ref. No. 454, **Ambulance Vehicle Color Scheme and Insignia Guidelines**
Ref. No. 710, **Basic Life Support Ambulance Equipment**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITAL)

SUBJECT: **HOSPITAL EVACUATION – Final Draft v8** REFERENCE NO. 1112

PURPOSE: To define the responsibilities of each hospital and the Los Angeles County ~~Emergency Medical Services Agency and~~ Medical and Health Operational Area Coordinator (MHOAC) in hospital evacuation(s) and to provide guidelines for coordination of resources during disasters that result in partial or full hospital evacuation(s).

AUTHORITY: ~~Joint Commission on Accreditation of Healthcare Organizations, Environment of Care, Emergency Management Standards~~
Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Emergency Preparedness Requirements, Condition of Participation, Title 42 CFR 482.15
National Fire Protection Association: Health Care Facilities Code 99, 2012 Edition

DEFINITIONS:

Delayed Evacuation: When there is no imminent threat to life/safety. Movement of patients is similar to inter-facility transfers. Use hospital's contracted resources.

Evacuation: The movement of patients from a potentially dangerous location to a safer location.

Full Evacuation: All patients are transferred from the facility to an outside area, another hospital or other alternative facility.

Partial Evacuation: When some of the patients are evacuated to another healthcare facility (External).

Planned Evacuation: An evacuation that is conducted in a planned or phased manner in response to an impending emergency.

Rescue/Immediate Evacuation: Dangerous life/safety conditions at the facility that need immediate movement out of the hospital. Treated like an Multicasualty Incident

Internal Relocation: ~~1)~~ Patients are transferred within the hospital (Internal). This can be done as a **horizontal ~~evacuation~~** relocation, ~~which involves moving patients horizontally to one side of a set of fire barrier doors~~ movement on the same floor or as a **vertical ~~evacuation~~** relocation, ~~which involves moving patients~~ movement to a safe area on another floor.

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PRINCIPLES:

1. Hospital has an approved Emergency Operations Plan (EOP) specific to the facility which includes:

    a. Partial and Full evacuation procedures
    b. Identifies evacuation triggers and who has authorization to activate
    c. Follows established accreditation, regulatory and corporate standards
    d. Identifies training standards, role, responsibilities and expectations of staff.

2. Evacuation of a hospital may be necessary following an emergency such as a facility fire or structural damage from a natural disaster.

3. The decision to evacuate a hospital will be based on the ability of the hospital to meet the medical needs of the patients. Immediate threats to life, such as internal fires or unstable structures will require Rescue/Immediate evacuation. Prolonged utilities disruptions may also result in the need to evacuate a hospital.

POLICY:

I. Responsibilities of a Hospital Requiring Evacuation

a. Determine need for partial or full evacuation and the time frame needed

~~i. Partial Evacuation~~ Internal Relocation

~~1. Ensure patients are relocated to area out of "immediate danger" while implementing evacuation plan.~~

~~2. Implement EOP for evacuation.~~

1. Notify Medical Alert Center (MAC) via ReddiNet or call (562) 347-1789 to request diversion due to Internal Disaster.

2. "If relocating patients to non-patient care areas, i.e., surge tents, lobby, conference rooms, etc., notify California Department of Public Health (CDPH) licensing and certification (L&C) at (800) 228-1019, M-F 8 am-5 pm, select # 2 for Hospital. After hours, weekends and holidays contact (626) 927-9293."
3. , .

~~ii.~~ Full Evacuation or Partial Evacuation to another facility

~~1. Ensure patients are relocated to area out of "immediate danger" while implementing evacuation plan.~~

~~2. Implement EOP for evacuation.~~

1. Notify Medical Alert Center (MAC) via ReddiNet or call (562) 347-1789 to request diversion due to Internal Disaster.

2. Notify California Department of Public Health (CDPH) licensing and certification (L&C) at (800) 228-1019, M-F 8 am-5 pm, select # 2 for Hospital. After hours, weekends and holidays contact (626) 927-9293 as soon as reasonably possible.

3. Coordinate evacuation by contacting other hospitals in corporate system utilizing transfer centers, if applicable (~~Kaiser, Catholic Healthcare West, etc.).~~

4. Contact contracted ambulance providers, if applicable, to assist in the transportation of evacuating patients.

5. If additional resources are needed for the evacuation, request assistance from the Los Angeles County Department of Health Services Emergency Medical Services (EMS) Agency by notifying the MAC via ReddiNet or call (562) 347-1789 . Immediately discontinue 3. and 4 above. to avoid duplication of efforts and resources. ~~The MAC will take control of coordinating transportation assignments and receiving facility assignments.~~

6. Hospital will gather information necessary to assist the MAC assigning transportation resources and identifying appropriate receiving hospitals. (Reference No. 1112.1 – Hospital Evacuation Tool)

   ~~i. Point of Contact (POC) name and phone number~~

   ~~ii. Total number of patients needing evacuation~~

   ~~iii. Isolation requirements, if applicable~~

   ~~iv. Total number of types and level of transportation needed~~

   ~~1. Med Surge-BLS~~
   ~~2. Telemetry-ALS~~
   ~~3. Critical Care (ICU, CCU, etc) Critical Care Transport (CCT)~~
   ~~4. Pediatric Critical Care (NICU, PICU, etc) Special CCT~~
   ~~5. Pediatric-BLS~~
   ~~6. OB/GYN-BLS~~
   ~~7. Trauma-ALS~~
   ~~8. Burn-ALS~~
   ~~9. OR- (???)~~
   ~~10. Specialty Care Transport (Isolation, Psych, bariatric, BICU, neonatal, etc)~~

7. Respond to service level poll within ten (10) minutes and should be reported as "Black".

8. Respond to HAvBED poll within ten (10) minutes ~~would be all~~ and report all beds as "zeros."

9. Maintain a log of transferred patients that includes ~~the following~~ information as identified on Reference No. 1112.2 – Patient Evacuation Tracking.

   ~~b. Name of patient~~

   ~~c. Receiving facility~~

   d. ~~Type of hospital service needed (i.e. medical/surgical, ICU, etc.)~~

10. Maintain an equipment log of items sent with patient that includes information as identified in Reference No. 1112.4 - Evacuation Equipment Accounting Record.

    ~~e. Mode of transportation- including~~
    ~~i. Name of transport company~~
    ~~ii. Vehicle identifier~~
    ~~iii. Type-BLS, ALS, CCT~~

11. Provide medical records and medications of transferred patients to the transport provider when possible.

II. Responsibilities of the EMS Agency

a. ,Function as the lead coordinator if MHOAC support is requested.

b. Place evacuating health care facility on diversion for Internal ~~Diversion~~ Disaster ~~status~~.

c. Conduct service level poll for all hospitals to determine their ability to take transfers or their need to evacuate their facility.

d. Conduct ~~bed availability assessment~~ HAvBED poll for all hospitals.

e. Notify Public Health of pending hospital evacuation(s) ~~at (213) 989-7140~~.

~~**Note: PH Healthcare Facility Inspection Division (HFID) is responsible for polling bed availability from LTC facilities.**~~

~~f.~~ Notify jurisdictional fire department and law enforcement agency about hospital evacuation within their jurisdiction. ~~to coordinate and ensure evacuation routes to minimize any risks associated with the evacuation.~~

g. Coordinate transportation resources

   i. Request activation of Fire Operational Area Coordinator (FOAC)

ii. Consider alternate transportation (i.e. buses).

h. Provide the evacuating hospital ~~being~~ with the transportation resources being dispatched and the estimated time of arrival

i. Provide FOAC with names of receiving hospitals and bed availability.

j. Provide the receiving hospital the potential number of patients assigned to their facility.

k. If the above is inadequate, request transportation resources from Region I and/or the State.

III. Responsibilities of the Receiving Facility (Non-Evacuating Hospitals)

a. Respond to service level poll within ten (10) minutes.

b. Respond to HAvBED poll ~~bed availability poll assessment~~ within sixty (60) minutes. The number reported will be used by the EMS Agency to determine bed assignments.

c. Implement surge strategy policy/plan to accommodate patients that may be received from evacuating hospital.

d. ~~Enter information~~ Maintain a log of ~~on~~ patients who are received from evacuating hospital that includes information as identified on ~~into the ReddiNet MCI module.~~ Reference No. 1112.3 – Received Patient Evacuation Tracking.

e. Coordinate the return of accompanying equipment with sending facility.

IV. Responsibilities of Public Health (From CDPH)

~~a. PH Healthcare Facility Inspection Division (HFID) is responsible for polling bed availability from LTC facilities, if needed.~~

b. Ensure that the evacuating facility notifies California Department of Healthcare Access and Information (HCAI) is notified.

c. Notify the State Long Term Care Ombudsman program is notified if the hospital is licensed for a Distinct Part Skilled Nursing Unit.

d. Monitor the evacuation of patients to other health care facilities to ensure their medical record information/medications/necessary life sustaining equipment are with them upon transfer.

e. Ensure that there are no patients remaining in the evacuated hospital.

f. Notify/update the California Department of Public Health (CDPH) headquarters of the event, the number of patients affected and the extent of the damage to the hospital building.

g. Ensure the hospital has obtained the requisite sign-offs for re-occupancy from the California Department of Healthcare Access and Information (HCAI)/local fire clearance and that the hospital can reopen and accept patients.

V. Responsibilities of FOAC (From FOAC representatives)

a. Upon receiving notification from the EMS Agency's Central Dispatch (CDO) center, the Los Angeles County Fire Department dispatch will activate the FOAC.
b. Information necessary for ambulance resource requests must include the following:
    i. Requesting facility, contact name, position, phone number and email
    ii. Name or identifier of the Hospital Command Agency representative
    iii. Type of incident
    iv. Specific evacuation needs
        1. Number of potential evacuees
        2. Number and type of transport units
            a. BLS
            b. ALS
            c. CCT
    v. Reporting location and contact person for arriving units
    vi. Approximate expected duration
    vii. Potential hazards during evacuation
    viii. Radio channel, frequency
c. Coordinate the deployment of ten or more ambulances
    i. Response Time Frames
        1. Level I-Immediate response, with first transport unit arriving on scene within 8 minutes and 59 seconds
        2. Level II-Tiered response, with the first transport unit arriving on scene within 30-60 minutes.
d. Coordinate a conference call with the following
    i. EOA contracted transport provider
    ii. CDO
    iii. EMS Agency AOD
    iv. MHOAC
    v. RDMHC, if resources are needed outside of Los Angles County
    vi. Additional agencies as necessary
e. *Coordinate the return of any accompanying staff to sending facility.*

Treatment Protocol: HYPERTHERMIA (ENVIRONMENTAL) **Ref. No. 1222**

1. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*

2. Administer **Oxygen** prn *(MCG 1302)*

3. Initiate cardiac monitoring *(MCG 1308)*
   For patients with dysrhythmias, treat in conjunction with *TP 1212, Bradycardia* or *TP 1213, Tachycardia*

4. Initiate temperature monitoring if available

5. Establish vascular access prn *(MCG 1375)*

6. Initiate cooling measures ❶
   For altered patients perform on-scene cooling with ice bath immersion if possible, monitor for mental status improvement, immersion not to exceed 15 minutes ❷

7. For patients with fever due to presumed infection/sepsis, treat per *TP 1204, Fever/Sepsis* ❸

8. For patients with seizure, treat in conjunction with *TP 1231, Seizure*

~~7.~~9. For altered level of consciousness, consider other causes per *TP 1229, ALOC*

~~8.~~10. For adequate perfusion and normal mental status, encourage oral hydration

~~9.~~11. For poor perfusion *(MCG 1355)* or if unable to take fluids orally:
   Normal Saline 1L IV rapid infusion
   Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

   For persistent poor perfusion, treat in conjunction with *TP 1207, Shock/Hypotension*

Treatment Protocol: HYPERTHERMIA (ENVIRONMENTAL) **Ref. No. 1222**

SPECIAL CONSIDERATIONS

1. Cooling measures for patients with normal level of consciousness should include moving patient to a cooler environment (e.g. ambulance with air conditioner), removing clothing, applying wet towels, applying ice packs to cheeks/palms/soles, and fanning/blowing cool air from air conditioning vents.

2. Altered level of consciousness, including confusion, lethargy, unresponsiveness and seizures, in patients with suspected heat emergency should be treated as heatstroke, a time-critical emergency, with a goal of decreasing body temperature by at least 3°C within the first 30 minutes of care to decrease the risk of cardiovascular collapse. The most efficient method for performing this is to initiate cold-water immersion by submerging the patient in cold or ice water for up to 15 minutes. This should be initiated on-scene or during transport if equipment is available.

3. This protocol is intended for hyperthermia due to environmental exposures and toxic ingestions.