



**LOS ANGELES COUNTY  
BOARD OF SUPERVISORS**

**Hilda L. Solis**

First District

**Holly J. Mitchell**

Second District

**Lindsey P. Horvath**

Third District

**Janice K. Hahn**

Fourth District

**Kathryn Barger**

Fifth District

**COMMISSIONERS**

**Diego Caivano, MD, Chair**

LA County Medical Association

**Paul Camacho, Chief**

LA County Police Chiefs' Association

**Mr. Jason Cervantes**

California Professional Firefighters

**Erick H. Cheung, MD**

Southern California Psychiatric Society  
Association

**Mr. Kenneth Domer**

League of California Cities LA County

**Tarina Kang, MD**

Hospital Association of Southern CA

**Ms. Carol Kim**

Public Member (1<sup>st</sup> District)

**Captain Kristin Kolenda**

LA County Peace Officers' Association

**Lydia Lam, MD**

American College of Surgeons

**Mr. Kenneth Liebman**

LA County Ambulance Association

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Public Member (2<sup>nd</sup> District)

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American Heart Association Western  
States Region

**Carole A. Snyder, RN**

Greater LA County Chapter Emergency  
Nurses Association California State  
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**Atilla Uner, MD, MPH**

California Chapter-American College of  
Emergency Physicians (CAL-ACEP)

**Mr. Gary Washburn**

Public Member (5<sup>th</sup> District)

**EXECUTIVE DIRECTOR**

**Richard Tadeo**

(562) 378-1610

[RTadeo@dhs.lacounty.gov](mailto:RTadeo@dhs.lacounty.gov)

**COMMISSION LIAISON**

**Denise Watson**

(562) 378-1606

[DWatson@dhs.lacounty.gov](mailto:DWatson@dhs.lacounty.gov)

**COUNTY OF LOS ANGELES EMERGENCY MEDICAL  
SERVICES COMMISSION**

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

(562) 378-1610 FAX (562) 941-5835

<http://ems.dhs.lacounty.gov>

DATE: September 10, 2025  
TIME: 1:00 – 3:00 PM  
LOCATION: 10100 Pioneer Boulevard, First Floor  
Cathy Chidester Conference Room 128  
Santa Fe Springs, CA 90670

*The Commission meetings are open to the public. You may address the Commission on any agenda item before or during consideration of that item, and on other items of interest which are not on the agenda, but which are within the subject matter jurisdiction of the Commission. Public comment is limited to three (3) minutes and may be extended by the Commission Chair as time permits.*

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

**AGENDA**

1. **CALL TO ORDER** – Commissioner Diego Caivano, Chair
2. **INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS**
  - 2.1 Commissioner Kenneth Domer, League of California Cities, LA County
  - 2.2 Cardiac Survivor Recognition Day at Los Angeles General Medical Center
  - 2.3 Mr. Dave Page, EMS Corps/Public Works Alliance Presentation
3. **CONSENT AGENDA:** Commissioners/Public may request that an item be held for discussion. All matters are approved by one motion unless held.
  - 3.1 **Minutes**
    - 3.1.1 March 12, 2025
    - 3.1.2 May 21, 2025–Board appointment was pending–no quorum.
  - 3.2 **Committee Reports**
    - 3.2.1 Base Hospital Advisory Committee – April 9, 2025
    - 3.2.2 Base Hospital Advisory Committee – June 11, 2025
    - 3.2.3 Base Hospital Advisory Committee – August 13, 2025
    - 3.2.4 Provider Agency Advisory Committee – April 16, 2025
    - 3.2.5 Provider Agency Advisory Committee – June 18, 2025
    - 3.2.6 Provider Agency Advisory Committee – August 20, 2025
  - 3.3 **Policies**
    - 3.3.1 Reference No. 201: Medical Management of Prehospital Care
    - 3.3.2 Reference No. 321: Extracorporeal Cardiopulmonary Resuscitation (ECPR) Receiving Center Standards
    - 3.3.3 Reference No. 411: 9-1-1 Provider Agency Medical Director
    - 3.3.4 Reference No. 412: AED Service Provider Program Requirements
    - 3.3.5 Reference No. 412.1: AED Service Provider Program Application (**For Deletion**)
    - 3.3.6 Reference No. 412.2: AED Service Provider Annual Report (**For Deletion**)
    - 3.3.7 Reference No. 424: Triage to Alternate Destination (TAD) Paramedic Provider Program

- 3.3.8 Reference No. 455: Private Ambulance Vehicle Age Limit and Licensure Requirements
- 3.3.9 Reference No. 503: Guidelines for Hospitals Requesting Diversion of ALS/BLS Patients
- 3.3.10 Reference No. 503.2: Diversion Request Quick Reference Guide
- 3.3.11 Reference No. 513: ST-Elevation Myocardial Infarction (ST-EI) Patient Destination
- 3.3.12 Reference No. 516: Cardiac Arrest (Non-Traumatic) Patient Destination
- 3.3.13 Reference No. 520: Transport/Transfer of Patients from Catalina Island
- 3.3.14 Reference No. 520.1: Catalina Island Medical Center (AHM) Transfer/Transport Process
- 3.3.15 Reference No. 526: Behavioral/Psychiatric Crisis Patient Destination
- 3.3.16 Reference No. 528: Intoxicated (Alcohol) Patient Destination
- 3.3.17 Reference No. 701: Supply and Resupply of Designated Provider Units/Vehicles
- 3.3.18 Reference No. 710: Basic Life Support Ambulance Equipment
- 3.3.19 Reference No. 814: Determination/Pronouncement of Death in the Field
- 3.3.20 Reference No. 830: EMS Pilot and Scientific Studies
- 3.3.21 Reference No. 834: Patient Refusal of Treatment/Transport and Treat and Release at Scene
- 3.3.22 Reference No. 838: Application of Patient Restraints
- 3.3.23 Reference No. 1318: Medical Control Guideline: ECPR Patient Algorithm

## **END OF CONSENT AGENDA**

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### **4. BUSINESS**

#### **Business (Old)**

- 4.1 Field Evaluation of Suicidal Ideation and Behavior
- 4.2 The Public Works Alliance EMS Corps
- 4.3 Ambulance Patient Offload Time (APOT)
- 4.4 Interfacility Transfer Taskforce
- 4.5 Cardiac Arrest Taskforce

#### **Business (New)**

- 4.6 Annual Report Fiscal Year 2024-2025

### **5. LEGISLATION**

- 5.1 AB 40 (APOT Emergency Regulations)
- 5.2 AB 645 (EMS Dispatcher Training)
- 5.3 AB 1328 (Dispatch)
- 5.4 CA Code of Regulations Chapter 1 (EMS Administration)
- 5.5 CA Code of Regulations Chapter 6 (Specialty Care Center)

**6. DIRECTORS' REPORTS**

- 6.1 Richard Tadeo, Director, EMS Agency / Executive Director, EMS Commission  
6.1.1 Measure B Advisory Board (MBAB)

**Correspondence**

- 6.1.2 (03/06/25) Los Angeles Development & Rapid Operationalization of Prehospital Blood (LA-DROP) Pilot Program Approval  
6.1.3 (03/17/25) Los Angeles Development & Rapid Operationalization of Prehospital Blood (LA-DROP) Pilot  
6.1.4 (04/01/25) Permanent Removal of Service Area Boundaries  
6.1.5 (05/18/25) EMS Week 2025 – May 18-24  
6.1.6 (06/05/25) Ambulette Operator Business License Approval  
6.1.7 (06/11/25) Extracorporeal Cardiopulmonary Resuscitation Receiving Center Program Designation Status  
6.1.8 (06/17/25) RAPID LA County Medic / Drug Doses Mobile Application  
6.1.9 (06/17/25) Los Angeles County EMS Plan 2023-2024 Submission  
6.1.10 (06/23/25) Temporary Helipad Closure – Cedars-Sinai Medical Center  
6.1.11 (06/23/25) Combined Ref. Nos. 1200-1300 PDF Document  
6.1.12 (06/25/25) Designation of Extracorporeal Cardiopulmonary Resuscitation Receiving Center  
6.1.13 (07/02/25) 9-1-1 Interfacility Transports  
6.1.14 (08/19/25) Notice of Public Hearing: Request for Proposal (RFP) of replacement agreements for current Exclusive Operating Area (EOA) Agreements set to expire 6/30/2027 for Emergency Ambulance Transportation Services in LA County.

- 6.2 Nichole Bosson, MD, Medical Director, EMS Agency

**7. COMMISSIONERS' COMMENTS / REQUESTS**

**8. ADJOURNMENT**

Adjournment to the meeting of November 19, 2025



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**COUNTY OF LOS ANGELES**

**EMERGENCY MEDICAL SERVICES COMMISSION**

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

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<http://ems.dhs.lacounty.gov>

**DATE: July 16, 2025 – MEETING CANCELLED**

**TIME: 1:00 – 3:00 PM**

**LOCATION: 10100 Pioneer Boulevard, First Floor  
Cathy Chidester Conference Room 128  
Santa Fe Springs, CA 90670**

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**AGENDA - CANCELLED**

1. **CALL TO ORDER** – Commissioner Diego Caivano, Chair
2. **INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS**  
EMS Corps Presentation
3. **CONSENT AGENDA:** Commissioners/Public may request that an item be held for discussion. All matters are approved by one motion unless held.
  - 3.1 **Minutes**
    - 3.1.1 May 21, 2025
  - 3.2 **Committee Reports**
    - 3.2.1 Base Hospital Advisory Committee – June 11, 2025
    - 3.2.2 Provider Agency Advisory Committee – June 18, 2025
  - 3.3 **Policies**
    - 3.3.1 Reference No. 412: AED Service Provider Program Requirements
    - 3.3.2 Reference No. 412.1: AED Service Provider Program Application (**For Deletion**)
    - 3.3.3 Reference No. 412.2: AED Service Provider Annual Report (**For Deletion**)
    - 3.3.4 Reference No. 455: Private Ambulance Vehicle Age Limit and Licensure Requirements
    - 3.3.5 Reference No. 520: Transport/Transfer of Patients from Catalina Island
    - 3.3.6 Reference No. 520.1 Catalina Island Medical Center (AHM) Transfer/Transport Process
    - 3.3.7 Reference No. 701: Supply and Resupply of Designated Provider Units/Vehicles
    - 3.3.8 Reference No. 710: Basic Life Support Ambulance Equipment
    - 3.3.9 Reference No. 834: Patient Refusal of Treatment/Transport and Treat and Release at Scene

**END OF CONSENT AGENDA**

**4. BUSINESS**

**Business (Old)**

- 4.1 Field Evaluation of Suicidal Ideation and Behavior
- 4.2 The Public Works Alliance EMS Corps
- 4.3 Ambulance Patient Offload Time (APOT)
- 4.4 Interfacility Transfer Taskforce
- 4.5 Project 2030 (Cardiac Arrest Taskforce)

**Business (New)**

None

**5. LEGISLATION**

- 5.1 AB 40 (APOT Emergency Regulations)
- 5.2 AB 645 (EMS: Dispatcher Training)
- 5.3 CA Code of Regulations Chapter 1 (EMS Administration)
- 5.4 CA Code of Regulations Chapter 6 (Specialty Care Center)

**6. DIRECTORS' REPORTS**

- 6.1 Richard Tadeo, EMS Agency Director/EMSC Executive Director

**Correspondence**

- 6.1.1 (05/18/25) EMS Week 2025 – May 18-24
- 6.1.2 (06/05/25) Ambulette Operator Business License Approval
- 6.1.3 (06/11/25) Extracorporeal Cardiopulmonary Resuscitation Receiving Center Program Designation Status
- 6.1.4 (06/17/25) RAPID LA County Medic / Drug Doses Mobile Application
- 6.1.5 (06/17/25) Los Angeles County EMS Plan 2023-2024 Submission
- 6.1.6 (06/23/25) Temporary Helipad Closure – Cedars-Sinai Medical Center
- 6.1.7 (06/23/25) Combined Ref. Nos. 1200-1300 PDF Document
- 6.1.8 (06/25/25) Designation of Extracorporeal Cardiopulmonary Resuscitation Receiving Center
- 6.1.9 (07/02/25) 9-1-1 Interfacility Transports

- 6.2 Nichole Bosson, MD, EMS Agency Medical Director

**7. COMMISSIONERS' COMMENTS / REQUESTS**

**8. ADJOURNMENT**

Adjournment to the meeting of September 10, 2025



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EMERGENCY MEDICAL SERVICES COMMISSION  
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**INTERIM COMMISSION**

**LIAISON**

**Vanessa Gonzalez**

(562) 378-1607

[VGonzalez3@dhs.lacounty.gov](mailto:VGonzalez3@dhs.lacounty.gov)

DATE: May 21, 2025  
TIME: 1:00 – 3:00 PM  
LOCATION: 10100 Pioneer Boulevard, First Floor  
Cathy Chidester Conference Room 128  
Santa Fe Springs, CA 90670

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

**AGENDA**

1. **CALL TO ORDER** – Commissioner Diego Caivano, Chair
2. **INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS**
  - 2.1 Cardiac survivor recognition day at LA General Medical Center
3. **CONSENT AGENDA:** *Commissioners/Public may request that an item be held for discussion. All matters are approved by one motion unless held.*
  - 3.1 **Minutes**
    - 3.1.1 March 12, 2025
  - 3.2 **Committee Reports**
    - 3.2.1 Base Hospital Advisory Committee – April 9, 2025
    - 3.2.2 Provider Agency Advisory Committee – April 16, 2025
  - 3.3 **Policies**
    - 3.3.1 Reference No. 201, Medical Management of Prehospital Care
    - 3.3.2 Reference No. 321, Extracorporeal Cardiopulmonary Resuscitation (ECPR) Receiving Center Standards
    - 3.3.3 Reference No. 411, 9-1-1 Provider Agency Medical Director
    - 3.3.4 Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS/BLS Patients
    - 3.3.5 Reference No. 503.2, Diversion Request Quick Reference Guide
    - 3.3.6 Reference No. 513, ST-Elevation Myocardial Infarction (STEMI) Patient Destination
    - 3.3.7 Reference No. 516, Cardiac Arrest (Non-Traumatic) Patient Destination
    - 3.3.8 Reference No. 814, Determination/Pronouncement of Death in the Field
    - 3.3.9 Reference No. 830, EMS Pilot and Scientific Studies
    - 3.3.10 Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release At Scene

- 3.3.11 Reference No. 838, Application of Patient Restraints
- 3.3.12 Reference No. 1318, Medical Control Guideline: ECPR Patient Algorithm

## **END OF CONSENT AGENDA**

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### **4. BUSINESS**

#### **Business (Old)**

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

### **5. Business (New)**

- 5.1 AB 1328- Dispatch

### **6. LEGISLATION**

### **7. DIRECTORS' REPORTS**

- 7.1 Richard Tadeo, EMS Agency Director/EMSC Executive Director

#### **Correspondence**

- 7.1.1 (03/06/25) Los Angeles Development & Rapid Operationalization of Prehospital Blood (LA-DROP) Pilot Program Approval
- 7.1.2 (03/17/25) Los Angeles Development & Rapid Operationalization of Prehospital Blood (LA-DROP) Pilot
- 7.1.3 (04/01/25) Permanent Removal of Service Area Boundaries

- 7.2 Nichole Bosson, MD, EMS Medical Director

### **8. COMMISSIONERS' COMMENTS / REQUESTS**

### **9. ADJOURNMENT**

To the meeting of July 16, 2025



# COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

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## EXECUTIVE DIRECTOR

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## INTERIM COMMISSION

**LIAISON**

**Vanessa Gonzalez**

(562) 378-1607

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## MINUTES March 12, 2025

<input checked="" type="checkbox"/> Diego Caivano, M.D.	LACo Medical Association	Richard Tadeo	Executive Director
<input type="checkbox"/> *Jason Cervantes	CA Professional Firefighters	Vanessa Gonzalez	Commission Liaison
<input checked="" type="checkbox"/> Erick H. Cheung, M.D.	So. CA Psychiatric Society	Christine Clare	EMS Staff
<input checked="" type="checkbox"/> Paul Camacho, Chief	LACo Police Chiefs' Assn.	Nichole Bosson, MD	EMS Staff
<input checked="" type="checkbox"/> Tarina Kang, M.D.	Hospital Assn. of So. CA	Christine Clare	EMS Staff
<input type="checkbox"/> *Carol Kim	Public Member, 1 <sup>st</sup> District	Jacqueline Rifenburg	EMS Staff
<input checked="" type="checkbox"/> Kristin Kolenda, Captain	Peace Officers Association	Denise Whitfield, MD	EMS Staff
<input type="checkbox"/> *Lydia Lam, M.D.	American College of Surgeons	HanNa Kang	EMS Staff
<input checked="" type="checkbox"/> Kenneth Liebman	LACo Ambulance Association	Samuel Calderon	EMS Staff
<input type="checkbox"/> *James Lott, PsyD, MBA	Public Member, 2 <sup>nd</sup> District	Michael Kim, MD	EMS Staff
<input checked="" type="checkbox"/> Carol Meyer, RN	Public Member, 4 <sup>th</sup> District	Jon Warren, MD	EMS Staff
<input checked="" type="checkbox"/> Kenneth Powell	LA Area Fire Chiefs' Assn.	Jake Toy, MD	EMS Staff
<input checked="" type="checkbox"/> Connie Richey, RN	Public Member 3 <sup>rd</sup> District	Sara Rasnake	EMS Staff
<input type="checkbox"/> *Brian Saeki	League of CA Cities/LA Co	Priscilla Ross	EMS Staff
<input checked="" type="checkbox"/> Stephen G. Sanko, MD	American Heart Association	Lily Choi	EMS Staff
<input checked="" type="checkbox"/> Carole A. Snyder, RN	Emergency Nurses Assn.	Mariana Munatones	EMS Staff
<input type="checkbox"/> *Saran Tucker	So. CA Public Health Assn.	David Wells	EMS Staff
<input type="checkbox"/> *Atilla Uner, M.D., MPH	CAL-ACEP		
<input type="checkbox"/> *Gary Washburn	Public Member, 5 <sup>th</sup> District		

## GUESTS

Nicole Reid, LACOFD

Samantha Verga-Gates, LBM

Michael Stone, USC EMS

Fellow

(\*) = Absent

### 1. CALL TO ORDER

The Emergency Medical Services (EMS) Commission (EMSC) meeting was held at the EMS Agency at 10100 Pioneer Boulevard, First Floor, Cathy Chidester Conference Room 128, Santa Fe Springs, CA 90670. Vice Chair Dr. Stephen Sanko provided general instructions and called the meeting to order at 1:03 p.m. There was a quorum of 11 commissioners present.

### 2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

2.1 Richard Tadeo, EMS Agency Director/EMSC Executive Director announced that the 2025 Emergency Medical Services Administrators' Association of California (EMSAAC) annual conference will be May 28 – 29, 2025 in San Diego, CA with a pre-conference on disaster response on May 27<sup>th</sup>.

2.2 The LA County EMS System Report  
Director Tadeo presented the EMS System Report to the Commissioners.

3. **Consent Agenda** – *All matters approved by one motion unless held.*

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

3.1 **Minutes**

3.1.1 January 15, 2025

3.2 **Committee Reports**

3.2.1 Base Hospital Advisory Committee – February 5, 2025

3.2.2 Provider Agency Advisory Committee – February 2, 2025

3.3 **Policies**

3.3.1 **Reference No. 215, EMS and Law Enforcement Co-Response Committee**

Dr. Nichole Bosson, EMS Medical Director, gave a background on the EMS and Law Enforcement Co-Response Committee (ELCoR). The committee was set-up two years ago in response to challenges that were happening on-scene between EMS and law enforcements co-response to agitated persons. The Committee implemented a medical control guideline, and an EMS Update training video that included Commissioners Paul Camacho and Kenneth Powell to assist with guidance. The collaboration was a great opportunity to have an open discussion between EMS and law enforcement, and they felt that they should continue to meet as a standing committee. Reference No. 215 codifies the ELCoR committee into a policy. The goal of this committee is to foster ideas, discussion and collaborations to improve field care. This policy outlines the committee's activities to support this endeavor, the frequency of the meetings, and committee membership which includes leadership and practicing clinicians for both EMS and law enforcement and representatives of many of our key agencies. Currently, Dr. Shira Schlesinger is leading a workgroup on pediatric critical emergencies which will include training and guidance for law enforcement to assist in the resuscitation of critical pediatrics.

3.3.2 Reference No. 1116, Hospital – Adopt-A-Shelter Program (For Deletion)

3.3.3 Reference No. 1124, Disaster Preparedness Exercise/Drills

3.3.4 Reference No. 1130, Trauma Center Emergency Preparedness

***Motion/Second by Commissioners Snyder/Meyer to approve Consent Agenda was carried unanimously.***

**END OF CONSENT AGENDA**

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4. **BUSINESS**

**Business (Old)**

4.1 **Field Evaluation of Suicidal Ideation and Behavior**

The Medical Control Guidelines for suicide screening were approved at the previous commission meeting. The committee has created education related to screening of suicidal risks and interaction with law enforcement that will be included in EMS Update 2025. It includes two case scenarios based on real cases and there is also an example they can use of the Columbia Suicide Severity Rating (C-SSRS) screening to estimate risks with guidance on documentation. EMS Update will be available in April for completion in June.

4.2 The Public Works Alliance EMS Corps

Jacqueline Rifenburg, EMS Agency Assistant Director, gave an update on the EMS Corps Whittier site. They have a full cohort, and they will be starting in the next few months. The Compton site is currently working on getting an MOU signed.

4.3 Cardiac Arrest Taskforce

There has been discussion of initiating this task force to help LA County provide leadership amongst other counties on how to pursue achieving process and patient centered outcomes that have been recommended by the American Heart Association's 2030 project. These include improving bystander CPR, AED accessibility, and improvement of neuro intact survival for out of hospital and in-hospital cardiac arrest. One of the strategies of this task force is to ask the provider agencies and hospital systems to develop their own proposals for how they plan to improve survival and improve outcomes. Dr. Stephen Sanko, EMS Commission Co-Chair, along with Adena Tessler from the Hospital Association of Southern California (HASC), created a slideshow for the executive committee to discuss what some of the asks will be of their hospitals. Dr. Sanko presented the slideshow to the commissioners.

The taskforce will meet monthly with representatives from the EMS Commission as well as additional stake holders and representatives from EMS Agency committees. Groups of interest to present to the workgroup during the meetings are: policy decision makers in high-risk areas, community health clinics, cardiology survivors, media representatives, public health, law enforcement, dispatch centers, and various other groups. If anyone is interested in being a part of the taskforce, please contact Dr. Sanko.

4.4 Interfacility Transfer Taskforce

Christine Clare, EMS Agency Nursing Director, discussed the Interfacility Transfer Taskforce. They met in February and one of the key discussion points was a request that was brought up by the physicians regarding the possibility of creating a centralized database for all 9-1-1 IFT's. They discussed some data elements and logistics that would need to be completed and are working on a sample form that would be requested by individual providers to complete and be submitted to the EMS Agency who would be able to evaluate the impact it might have on 9-1-1 services and identify if its certain facilities, times of day, or types of patients. The next meeting is scheduled for March 24, 2025.

Another discussion item is funding, which is the root cause of critical care transport. The taskforce is tasked with addressing 9-1-1 activation for ER transfers that do not belong within the STEMI or trauma re-triage categories. The EMS agency is going to continue meeting with hospital leadership and hospital systems where we find those ER transfers utilizing the 9-1-1 system inappropriately for transport.

Dr. Sanko pointed out two items that he hopes are explored through this taskforce; first, the dissemination of policy amongst ER's and ER staff to improve understanding of what the policy is and what the guidelines are. The second item is, has the possibility of EMS physician oversight in real time been brought up in the group? When LA County Fire physicians are involved, often they can be helpful in determining appropriateness and destinations for interfacility transfers. Ms. Clare responded that real time physician involvement from the fire department to the hospitals has been discussed, unfortunately it's not always available, so it becomes a challenge. Regarding dissemination of the polices and trainings, there was a creation of two different checklist, one for STEMI and one for Trauma that was sent to all the hospitals through HASC, unfortunately sometimes it doesn't always get to the appropriate person and that's continual issue being worked on. We also now have contracts with every 9-1-1 receiving hospital including non-

specialty care centers, and part of the contract is to have transfer agreements for higher level of care and transportation arrangements and protocols. This gives the agency ability to go into the community hospitals to request a corrective action plan or improvement plan for things that may not be up to par.

Commissioner Carol Meyer asked if the policy regarding requirements for Nurse Staffed ambulance has been looked over by the EMS Agency and whether there can be some flexibility to ensure nurse staffed could be a little more reasonable. Director Tadeo responded that we are in the process of reviewing the policy, and those standards were set by a committee of subject matter experts that were in the nurse staff ambulance business and once we have reviewed and made recommendations to the policy, the EMS Agency will reconvene the workgroup and discuss the revisions.

In terms of reimbursement, last year when we did a 20% across the board increase in the maximum rates for ambulance reimbursement, we did remove the 9-1-1 language so that the ER-to-ER transfers could be billed at that emergency rate.

4.5 Alternate Destination

Ms. Clare gave an overview of the Alternate Destination Volume. The data starts in 2020 which is when we started designating alternate destinations and goes through 2024. One of the biggest differences is a change in volume. In 2024 we started comparing what EMS documented as where the patient was transported to with what we were given by the alternate destinations and verifying that the numbers matched. Our plan for transport to alternate destination was approved by EMSA for implementation system-wide last year. Since then, we have had three fire departments, Santa Monica, Culver City and Los Angeles County Fire, that have been approved to train their paramedics to do the assessment and take their patients directly to an alternate destination.

In 2023, the David L. Murphy Sobering Center suspended their services because they wanted to focus on becoming a fentanyl sobering center, instead of an alcohol sobering center and EMS cannot transport fentanyl overdoses to an alternate destination. They have reached out to us, and they are looking at reconverting some of those beds to alcohol sobering. MLK Behavioral Health has also reached out to establish a sobering center on their site; they are in the process of applying. We have also reached out to Long Beach Fire Department because the psychiatric urgent care center in Long Beach's volume is very low. They have never had an alternate destination program, and they are interested in participating and are currently working through the process.

5. Business (New)

5.1 2025 EMS Commission Goals and Objectives

One of the four goals for the Commission is psych and behavioral health and the last recommendation has been completed by the taskforce. Dr. Cheung thinks that if we were to push this further, the pursuit of facilitating the process of alternate destination through advocacy is very important. He motioned we keep it as an objective and maintain it with the goal to investigate what the avenue will be to appropriately advocate for reimbursement for alternate destinations.

***Motion/Second by Commissioners Cheung/Snyder to keep the AD Hoc Committee on the Prehospital Care of Mental Health and Substance Abuse Emergencies as a 2025 goal was carried unanimously.***

Director Tadeo reported that the commission has met the objectives regarding the Ambulance Patient Offload Delays (APOD). We have an APOD policy, and we recently amended that policy to include workflow in documenting facility equipment time. We will continue to keep it as a goal

and will keep reporting the data to the commission for another year. We will also keep the Interfacility Transport Delays (IFT) and Cardiac Arrest Workgroup as 2025 goals since they are ongoing.

**6. LEGISLATION**

Director Tadeo reported on the following legislation:

Over 30% of the legislators of the state of California are new. The deadline for submission of bills was February 21<sup>st</sup> and there is currently nothing new that is impacting EMS.

Chapter 6 Regulations - The specialty care programs: STEMI, Stroke, EMS for Children and Trauma were all separate chapters, and they have been combined as Chapter 6. The regulations were sent out a few weeks ago for public comment and the deadline for submission to EMSA is April 3, 2025.

Regarding the new federal administration and funding, it has not officially been announced but we are expecting about a billion-dollar cut in Medi-Cal and it would primarily impact our programs for our undocumented population.

HPP funding has been approved through congress for the next few years.

**DIRECTORS' REPORT**

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

Health Data Exchange – There was a kick-off meeting with the trauma centers and base hospitals last week. The implementation phase is three years, and we are working to be able to sustain funding for the entire county on yearly subscription. If we have all 69 hospitals participate it would be about \$1.8 million on an annual basis.

Measure B Advisory Board (MBAB) – MBAB will be meeting this year to rank project proposals for the unallocated portion of the Measure B funds. Every year there is a surplus and the Board of Supervisors formed the MBAB to review and accept one-time funding proposals. Jacqui Rifenburg will start accepting projects April 7, 2025 – June 26, 2025. The MBAB group will convene in September to rank and determine which projects will be funded. We are currently waiting for finance to let us know how much funding we will have available.

Sidewalk CPR – We are seeking proclamation from the Board to make the first week of June CPR acknowledgement week.

RAPID LA County Medic Mobile App is published online and available for download.

**Correspondence**

- 7.1.1 (01/16/25) Dextrose 10% (250 ml) Solution – Shortage Mitigation
- 7.1.2 (02/03/25) Countywide Sidewalk Cardiac Resuscitation Week
- 7.1.3 (02/04/25) RAPID LA County Medic Mobile Application
- 7.1.4 (02/20/25) Ref No. 505, Ambulance Patient Offload Time (APOT)
- 7.1.5 (02/20/25) Rescission of all Ambulance Licensing Waivers and Exemptions Effective Immediately

7.2 Nichole Bosson, MD, EMS Medical Director  
 Dr. Bosson reported on the following:

Pedi-Part and Pedi-Dose are ongoing with no major updates. We will be transitioning to

the new dosage schedule for Pedidose on July 1<sup>st</sup>. We will also be doing reinforcement training on Pedi-Part at EMS Update.

LA Drop is our blood transfusion pilot. It is a partnership between Los Angeles County Fire Department, Compton Fire Department, Harbor-UCLA Medical Center, the EMS Agency and the San Diego Blood Bank to implement prehospital blood transfusion on ALS units in LA County. This will go live on April 1, 2025. A memo will go out to all receiving hospitals next week with more information including the protocol our paramedics will be operating under and a FAQ document.

We are moving to an ECPR\* regional system after the success of the pilot, and we are now currently underway with designating the ECPR centers. Essentially all hospitals that are designated ECPR centers will go live July 1<sup>st</sup> to coincide with the training of our system, which will be included in EMS Update.

Dr. Shira Schlesinger reported that EMS Update will go out April 1<sup>st</sup> with Train-the-Trainer sessions on March 24 and 26. A lot of work has been done with our largest departments that are using Target Solutions or Vector Solutions rather than APS, to determine how this can be released in a way that is most accessible on their platform. We have been partnering with the UCLA Center for Prehospital Care and Ronald Reagan UCLA to develop two educational modules around ECMO, how is it used in general, how it is used for ECPR, and how it impacts the field which will augment our EMS Update. These educational modules provide a more foundational understanding of the role of ECMO and how it is evolving in use in hospital care as well as out of hospital care.

\* ECPR – ECMO Cardiopulmonary Resuscitation; ECMO – extracorporeal membrane oxygenation

## **7. COMMISSIONERS' COMMENTS / REQUESTS**

### **8. ADJOURNMENT:**

Adjournment by Chair Caivano at 2:53 p.m. to the meeting of Wednesday, May 21, 2025.

**Next Meeting:** Wednesday, May 21, 2025, 1:00-3:00 p.m.  
Emergency Medical Services Agency  
10100 Pioneer Boulevard, First Floor  
Cathy Chidester Hearing Room 128  
Santa Fe Springs, CA 90670

Recorded by:  
Vanessa Gonzalez  
Management Secretary III

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



# COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

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

(562) 378-1610 FAX (562) 941-5835

<http://ems.dhs.lacounty.gov/>

## MINUTES May 21, 2025

### LOS ANGELES COUNTY BOARD OF SUPERVISORS

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First District

**Holly J. Mitchell**

Second District

**Lindsey P. Horvath**

Third District

**Janice K. Hahn**

Fourth District

**Kathryn Barger**

Fifth District

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**Chief Paul Camacho**

*Los Angeles County Police Chiefs' Assn.*

**Tarina Kang, MD**

*Hospital Association of Southern CA (HASC)*

**Ms. Carol Kim**

*Public Member (1<sup>st</sup> District)*

**Captain Kristen Kolenda**

*Peace Officers Association of LA County*

**Lydia Lam, MD**

*American College of Surgeons*

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*LA County Ambulance Association*

**James Lott, PsyD., MBA**

*Public Member (2<sup>nd</sup> District)*

**Carol Meyer, RN**

*Public Member (4<sup>th</sup> District)*

**Chief Kenneth Powell**

*Los Angeles Area Fire Chiefs Association*

**Connie Richey, RN**

*Public Member (3<sup>rd</sup> District)*

**Mr. Brian Saeki**

*League of Calif. Cities/LA County Division*

**Stephen G. Sanko, MD, Vice Chair**

*American Heart Association*

*Western States Affiliate*

**Carole A. Snyder, RN**

*Emergency Nurses Association*

**Saran Tucker, PhD, MPH**

*Southern California Public Health Assn.*

**Atilla Uner, MD, MPH**

*California Chapter-American College of*

*Emergency Physicians (CAL-ACEP)*

**Mr. Gary Washburn**

*Public Member (5<sup>th</sup> District)*

### EXECUTIVE DIRECTOR

**Richard Tadeo**

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[RTadeo@dhs.lacounty.gov](mailto:RTadeo@dhs.lacounty.gov)

### COMMISSION LIAISON

**Denise Watson**

(562) 378-1606

[DWatson@dhs.lacounty.gov](mailto:DWatson@dhs.lacounty.gov)

<input checked="" type="checkbox"/> Diego Caivano, M.D.	LACo Medical Association	Richard Tadeo	Executive Director
<input type="checkbox"/> *Jason Cervantes	CA Professional Firefighters	Vanessa Gonzalez	Commission Liaison
<input type="checkbox"/> Erick H. Cheung, M.D.	So. CA Psychiatric Society	Christine Clare	EMS Staff
<input checked="" type="checkbox"/> Paul Camacho, Chief	LACo Police Chiefs' Assn.	Nichole Bosson, MD	EMS Staff
<input type="checkbox"/> Tarina Kang, M.D.	Hospital Assn. of So. CA	Christine Clare	EMS Staff
<input type="checkbox"/> *Carol Kim	Public Member, 1 <sup>st</sup> District	Jacqueline Rifenburg	EMS Staff
<input type="checkbox"/> Kristin Kolenda, Captain	Peace Officers Association	Denise Whitfield, MD	EMS Staff
<input type="checkbox"/> *Lydia Lam, M.D.	American College of Surgeons	Mark Ferguson	EMS Staff
<input checked="" type="checkbox"/> Kenneth Liebman	LACo Ambulance Association	HanNa Kang	EMS Staff
<input checked="" type="checkbox"/> *James Lott, PsyD, MBA	Public Member, 2 <sup>nd</sup> District	Sam Calderon	EMS Staff
<input checked="" type="checkbox"/> Carol Meyer, RN	Public Member, 4 <sup>th</sup> District	David Wells	EMS Staff
<input checked="" type="checkbox"/> Kenneth Powell	LA Area Fire Chiefs' Assn.	Sara Rasnake	EMS Staff
<input checked="" type="checkbox"/> Connie Richey, RN	Public Member 3 <sup>rd</sup> District	Paula Cho	EMS Staff
<input type="checkbox"/> *Brian Saeki	League of CA Cities/LA Co	Fritz Bottger	EMS Staff
<input checked="" type="checkbox"/> Stephen G. Sanko, MD	American Heart Association	Christine Zaiser	EMS Staff
<input checked="" type="checkbox"/> Carole A. Snyder, RN	Emergency Nurses Assn.	Michael Kim, MD	EMS Staff
<input type="checkbox"/> *Saran Tucker	So. CA Public Health Assn.	Ami Boonjaluksa	EMS Staff
<input checked="" type="checkbox"/> *Atilla Uner, M.D., MPH	CAL-ACEP		
<input type="checkbox"/> *Gary Washburn	Public Member, 5 <sup>th</sup> District		

### GUESTS

Nicole Reid, LACOFD

Shelly Trites, APCC

Michael Stone, USC EMS  
Fellow

(\*) = Absent

### 1. CALL TO ORDER

The Emergency Medical Services (EMS) Commission (EMSC) meeting was held at the EMS Agency at 10100 Pioneer Boulevard, First Floor, Cathy Chidester Conference Room 128, Santa Fe Springs, CA 90670. Chair Dr. Diego Caivano provided general instructions and called the meeting to order at 1:04 p.m. There was a quorum of 10 commissioners present.

### 2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

2.1 Dr. Stephen Sanko, EMSC Commission Vice-Chair, reported on the Cardiac Survivor conference at LA General Medical Center that will occur in September 2025. The final date is still pending. The vision is that the provider agencies and hospitals will be invited to bring an administrator and survivor so that they can collectively support a call to action for improved outcomes and awareness of this issue, in particular, the disparities in availability and use of public access defibrillators.

3. **Consent Agenda** – All matters approved by one motion unless held.

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

3.1 **Minutes**

3.1.1 March 12, 2025

3.2 **Committee Reports**

3.2.1 Base Hospital Advisory Committee – April 9, 2025

3.2.2 Provider Agency Advisory Committee – April 16, 2025

3.3 **Policies**

3.3.1 Reference No. 201, Medical Management of Prehospital Care

3.3.2 Reference No.321, Extracorporeal Cardiopulmonary Resuscitation (ECPR) Receiving Center Standards

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

3.3.4 Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS/BLS Patients

3.3.5 Reference No. 503.2, Diversion Request Quick Reference Guide

3.3.6 Reference No. 513, ST-Elevation Myocardial Infarction (STEMI) Patient Destination

3.3.7 Reference No. 516, Cardiac Arrest (Non-Traumatic) Patient Destination

3.3.8 Reference No. 814, Determination/Pronouncement of Death in the Field

3.3.9 Reference No. 830, EMS Pilot and Scientific Studies

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

3.3.11 Reference No. 838, Application of Patient Restraints

3.3.12 Reference No. 1318, Medical Control Guideline: ECPR Patient Algorithm

***Motion/Second by Commissioners Meyer/Snyder to approve Consent Agenda was carried unanimously.***

**END OF CONSENT AGENDA**

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4. **BUSINESS**

**Business (Old)**

4.1 **Field Evaluation of Suicidal Ideation and Behavior**

Dr. Denise Whitfield, Assistant Medical Director, EMS Agency, reported on the latest update on Field Evaluation of Suicidal Ideation and Behavior. The policies have been approved and they incorporated, as an optional tool, the Columbia Suicide Severity Rating (C-SSRS) screener. It is part of the training for EMS Update 2025 which is currently in the process of being completed. She, along with Dr. Erick Cheung, wrote a publication describing the process for putting together a policy related to suicide screening, which has been submitted to the Prehospital Emergency Care Journal (PEC).

4.2 **The Public Works Alliance EMS Corps**

Jacqueline Rifenburg, EMS Agency Assistant Director, reported that the Compton site will be open in the next 3 – 4 months. The MOU has been signed by the EMS

Agency, Public Works Alliance and East Los Angeles Community College. The first cohort out of the Oxnard EMS Corp will be graduating their first class. Mrs. Rifenburg will ask Public Works Alliance to attend a Commission meeting to present information on the work they are doing.

4.3 Ambulance Patient Offload Time (APOT)

Christine Clare, EMS Agency Nursing Director, discussed the Ambulance Patient Offload Time (APOT) report. The hospitals highlighted in orange are noted for APOT being above the 90<sup>th</sup> percentile. The goal is 90% of the time patients will be offloaded within 30 minutes. There was a request for the total number of failed records, meaning the runs would not be included, and this report showed it was less than 4% county wide, and there are no agencies with a significantly higher number than any other. It's a very low number now that we're getting electronic data from all the providers and most of the failed records are because of documentation error. The providers are notified of the errors, and they should go back to clean them up and resubmit. When compared to the 4<sup>th</sup> quarter 2024 report, almost every region went up slightly by a minute or two for the 90<sup>th</sup> percentile but this was peak respiratory illness season.

Director Tadeo reported that the AB40 regulations came out in February and the State has pulled back on releasing it again because they found out there were many problems with the draft regulations. The biggest concern for Los Angeles County is the requirement for a validation tool. We anticipate that the new regulations will come out for public comment in June. We will notify the system so everyone can provide their comments and recommendations.

Director Tadeo also stated that we are moving towards all the private ambulance providers moving to electronic submission to our database. The current regulations only require advanced life support runs to be submitted to the EMS Agency. It will be easier for the private ambulance companies to provide all their data which includes BLS, IFTs and nursing home patients and it would benefit the system so we can have a better idea of the times and types of transports. The private ambulance companies have been advised that they are expected to have electronic data submission to the EMS Agency by January 1, 2026.

EMSA conducted a bed availability pilot project that included hospitals in California, Washington and Oregon. The project includes using their EMR or whichever system the hospital is using to manage their bed count and pushing to a central repository to determine the actual staffing and patient census in different units. If the pilot project is successful, the idea was to move it statewide. We are working with ReddiNet to start looking at how we can implement that in LA County. It launched a couple of weeks ago so we will be monitoring it and will continue working with the Hospital Association and ReddiNet to refine that system.

4.4 Cardiac Arrest Taskforce

The taskforce has made introductory presentations to HASC, Med Council, the SRC committee and CPR committees of 22 various hospitals. The standing meetings will be held on the 4<sup>th</sup> Monday of the month, the first being on June 23<sup>rd</sup> at 8:30 a.m. If anyone is interested in participating or have any questions, please contact Dr. Stephen Sanko. Dr. Nichole Bosson, EMS Medical Director, mentioned that the taskforce is planning to create a simplified version of the CARES reports for both SRC hospitals and provider agencies, with the idea of highlighting the 2030 AHA goals and their status in terms of bystander CPR AED access outcomes. This will allow them to better distribute information to leadership and the community to engage in conversation.

4.5 Interfacility Transfer Taskforce

Ms. Clare reported that the interfacility transfer taskforce is continuing to meet monthly. During the March meeting a draft form was created for the EMS providers to complete a specific Cognito form when 9-1-1 was utilized for transfer. It is being reviewed by the different committees to get additional feedback. It has also been presented to the LA Area Fire Chiefs, Provider Agency Advisory Committee and it will be taken to Med Council next month. The goal is that anytime 9-1-1 is used for an IFT transfer this form would be completed and come to the EMS Agency. The EMS Agency will log and track it and work to identify the types of issues, whether it is certain providers, hospitals or type of patients. They are hoping for the form to be completed and presented for final approval by the June IFT meeting.

5. BUSINESS (New) - NONE

6. LEGISLATION

Director Tadeo reported on the following legislation:

Chapter 1 is the renumbering of EMS administration and EMSA is actively pursuing this. The sticking point is 201 rights and 224. 201 determines who has the grandfather rights to continue administering prehospital care. There is a set date for the Health and Safety code 1797.201, that providers that were providing a level of service before 1980 can continue providing that until an agreement with the local EMS Agency is established.

1797.224 is regarding contracting for creating exclusive operating areas. In Los Angeles we created exclusive operating areas to have a well-coordinated system for emergency ambulance transports. Some of the cities including Torrance, Long Beach, Glendale, and LA City (to name a few) have grandfather rights to provide emergency ambulance transports by contract. It has not come up for public comment, but it is with the Office of Administrative Law.

Chapter 6 which is the consolidation of our specialty care systems including Trauma, STEMI, Stroke and EMS for Children opened for public comment in February and the deadline for comments was in March. EMSA is reviewing all the comments. One of the new requirements for STEMI and Stroke is the data submission. The State is developing a data dictionary for STEMI so the State can receive those reports.

AB 1328 is a bill for Medi-Cal reimbursement for non-emergency transportation. It needs to go through the appropriations committee which was supposed to meet on May 23<sup>rd</sup> but it has been postponed.

AB 645 establishes minimum standards for medical dispatchers. This will be an improvement to the system and shouldn't be an issue in Los Angeles County because we already have our dispatch standards. This will impact the more rural areas with less funding because they would need to have a higher standard for their community.

AB 582 is in response to the fires and evacuation of long-term care and skilled nursing facilities. The change here is for the facilities to submit their disaster plans to the Medical Health Operation Care Coordinator (MHOAC).

The Hospital Preparedness Program (HPP) and the Public Health Emergency Preparedness funding is not a line item in the proposed budget by the federal administration and anticipated the funding for these programs will be eliminated. We are working closely with Dr. Ghaly, Allan

Wecker, our department CEO and Public Health to lobby our representatives to maintain this program because it is a successful program. The HPP funding at stake is \$9.1 million for Los Angeles County.

**DIRECTORS' REPORT**

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

The permanent removal of service area boundaries was a successful initiative. This has been in existence since 1989 and was carving out specific jurisdictions, primarily in the Downtown and South Los Angeles area so that hospitals stay open to ambulance traffic. Through mergers and acquisitions the 11 hospitals originally participating have dwindled down to 4 or 5. We started a pilot project in December and had Adventist White Memorial, PIH Good Samaritan and Dignity Health California Hospital Medical Center eliminate their service areas using the same guidelines for destination and diversion as we use for the rest of the County. One of the tools we added to determine patient destination was the ambulance status screen displayed shown in Reddinet. The pilot project utilized it as part of determining the better facility to go to depending on how many ambulances are waiting to offload and how many are in route. The feedback was that it was a useful tool. It has not been rolled out to be used for destination decisions countywide at this time as not all providers are on the FirstWatch system yet. Verdugo dispatch is now online and that covers all the 12 cities in the foothill areas. This would not be used for patient offload time because the end time would be when they are clear for the next call rather than the facility equipment time but a good indicator of how many ambulances are at the hospital.

Health Data Exchange (HDE) – We have spoken to all the trauma and base hospitals and there is a lot of expressed interest from these hospitals and we're at the point we will start engaging with our STEMI and Stroke centers which are neither base nor trauma. We're entertaining health system participation, for instance some Providence Hospitals that are not base or trauma, but they are comprehensive stroke and STEMI centers. We have conducted a demo for our EMS providers since they will have access to the data and will have another demo session on May 22<sup>nd</sup>. One of the requirements for the providers to participate is for them to have a business associate agreement with us, as well as with our vendor, ESO, because they will be accessing patient outcome data through the HDE.

**Correspondence**

- 7.1.1 (03/06/25) Los Angeles Development & Rapid Operationalization of Prehospital Blood (LA-DROP) Pilot Program Approval
- 7.1.2 (03/17/25) Los Angeles Development & Rapid Operationalization of Prehospital Blood (LA-DROP) Pilot
- 7.1.3 (04/01/25) Permanent Removal of Service Area Boundaries

7.2 Nichole Bosson, MD, EMS Medical Director  
 Dr. Bosson reported on the following:

Pedi-Part, the Pediatric airway resuscitation trial, is ongoing and there are over 600 patients enrolled. For every 300 patients, they do an interim analysis to see if we have met our needs for the study or continue enrollment. We've been enrolling for a year now and have been very successful in LA County contributing over 200 of those patients.

Pedi-Dose is one year from completion, and we will be enrolling through next August. As of July 1<sup>st</sup>, will be including age 12 months and older in the dosing.

LA Drop, the prehospital blood transfusion pilot, launched April 1<sup>st</sup>. There has been 9 prehospital blood transfusions in LA County, and 16 total across all of Cal Drop which includes Ventura County, Corona, Compton and LA County Fire Departments. The 9 transfusions in LA County all met criteria and have been transfused rapidly with positive effects on initial arrival to the ED. There has been no trouble getting blood because a partnership was developed between Compton Fire, LA County Fire and the San Diego blood bank. Corona Fire is using life stream and Ventura County Fire partnered with their local trauma center. There is limitation of expanding LA Drop to the entirety of LA County, it is unlikely that San Diego blood bank would be able to support this expansion. We would need to seek alternatives. The other goal with this program that is underway, is to increase the blood donation supply. As we expand on these programs, we want to engage the community to recognize that they can contribute to the sustainability of the program.

ECPR center designation is underway. We've had 3 site visits thus far and received another application in queue, so we are on track for the system roll out for July 1<sup>st</sup>.

Rapid LA County Medic is live. There were some loading issues with the data but those have been resolved with the latest push out. We have already began meeting with Perceptronics and Reddinet, thinking about the next phase of some of the features we'd like to input, including some real time destination guidance and decision-making support.

We now have the contacts in place to begin building the live trauma dashboards. Our target for having a live dashboard with trauma metrics is October of this year. We are working with ESO to develop those using our trauma and EMS Data.

Dr. Denise Whitfield, EMS Agency Assistant Director, reported on the plan to apply for a grant for prehospital buprenorphine, a medication given to patients with opioid use disorder. It is part of a medically assisted treatment to help with opioid addiction. They initially looked into this just before COVID and there were not many emergency departments that had emergency department physicians that could prescribe buprenorphine. At the time there was a special waiver that was required with the DEA license. The waiver is no longer needed, and a lot of emergency departments have increased their availability and improved liaison to initial care, wrap around services, and getting patient follow-up care if they are enrolled in these programs. We decided to reassess and looked to our provider agencies to see if any were interested and we got commitments from some of our larger agencies, including LA City Fire, LA County Fire and Long Beach Fire. We are planning to apply for a grant for up to \$400,000 to start a program through the State.

**7. COMMISSIONERS' COMMENTS / REQUESTS – NONE**

8. **ADJOURNMENT:**

Adjournment by Chair Caivano at 2:24 p.m. to the meeting of Wednesday, July 16, 2025.

**Next Meeting:** Wednesday, July 16, 2025, 1:00-3:00 p.m.  
Emergency Medical Services Agency  
10100 Pioneer Boulevard, First Floor  
Cathy Chidester Hearing Room 128  
Santa Fe Springs, CA 90670

Recorded by:  
Vanessa Gonzalez  
Management Secretary III

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



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



**BASE HOSPITAL ADVISORY  
 COMMITTEE MINUTES**

**April 9, 2025**

REPRESENTATIVES		EMS AGENCY STAFF
<input checked="" type="checkbox"/>	Tariana Kang, MD, Chair	EMS Commission
<input type="checkbox"/>	Lydia Lam, MD, Vice Chair	EMS Commission
<input type="checkbox"/>	Atilla Under, MD, MPH	EMS Commission
<input type="checkbox"/>	Connie Richey, RN	EMS Commission
<input type="checkbox"/>	Saran Tucker, PhD, MPH	EMS Commission
<input type="checkbox"/>	Carol Synder, RN	EMS Commission
<input type="checkbox"/>	Erick Cheung, MD	EMS Commission
<input type="checkbox"/>	Brian Saeki	EMS Commission
<input type="checkbox"/>	Carol Kim	EMS Commission
<input checked="" type="checkbox"/>	Rachel Caffey	Northern Region
<input type="checkbox"/>	Jessica Strange	Northern Region
<input checked="" type="checkbox"/>	Michael Wombold	Northern Region, Alternate
<input checked="" type="checkbox"/>	Samantha Verga-Gates	Southern Region
<input type="checkbox"/>	Laurie Donegan	Southern Region
<input checked="" type="checkbox"/>	Shelly Trites	Southern Region
<input checked="" type="checkbox"/>	Christine Farnham	Southern Region, Alternate
<input checked="" type="checkbox"/>	Ryan Burgess	Western Region, Alternate
<input checked="" type="checkbox"/>	Travis Fisher	Western Region
<input checked="" type="checkbox"/>	Lauren Spina	Western Region
<input checked="" type="checkbox"/>	Susana Sanchez	Western Region
<input checked="" type="checkbox"/>	Kate Bard	Western Region
<input checked="" type="checkbox"/>	Laurie Sepke	Eastern Region
<input checked="" type="checkbox"/>	Alina Candal	Eastern Region
<input checked="" type="checkbox"/>	Jenny Van Slyke	Eastern Region, Alternate
<input checked="" type="checkbox"/>	Lila Mier	County Region
<input checked="" type="checkbox"/>	Emerson Martell	County Region
<input checked="" type="checkbox"/>	Antoinette Salas	County Region
<input checked="" type="checkbox"/>	Yvonne Elizarraraz	County Region
<input checked="" type="checkbox"/>	Gabriel Campion, MD	Base Hospital Medical Director
<input checked="" type="checkbox"/>	Salvador Rios, MD	Base Hospital Medical Director, Alternate
<input checked="" type="checkbox"/>	Adam Brown	Provider Agency Advisory Committee
<input checked="" type="checkbox"/>	Jennifer Nulty	Prov. Agency Advisor Committee, Alternate
<input type="checkbox"/>	Elizabeth Charter	PedAC Representative
<input type="checkbox"/>	Desiree Noel	PedAC Representative, Alternate
<input type="checkbox"/>	John Foster	MICN Representative
<input type="checkbox"/>	Vacant	MICN Representative, Alternate
<b>PREHOSPITAL CARE COORDINATORS</b>		
<input checked="" type="checkbox"/>	Melissia Turpin (SMM)	<input type="checkbox"/> Allison Bozigian (HMN)
<input checked="" type="checkbox"/>	Mary Jane Evangelista (QVH)	<input checked="" type="checkbox"/> Brandon Koulabouth (AMH)
<input checked="" type="checkbox"/>	Kelly Bui (SFM)	<input type="checkbox"/> Annette Mason (AVH)
		<b>GUESTS</b>
		Kelsey Wilhem, MD
		Shane Cook, LACoFD
		Clayton Kazan, MD
		Sherly Gradney, LACoFD
		Taylor Hill (SJS)

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

2. **INTRODUCTIONS/ANNOUNCEMENTS:**

2.1 Brief round-the-room introductions were held, followed by announcement of new Prehospital Care Coordinators, Mary Jane Evangelista (QVH), and Kelly Bui (SFM).

2.2 EMSAAC 2025 Conference Save the Date Flyer for May 28<sup>th</sup>– 29<sup>th</sup>, was provided in the packet. There is a pre-conference on “Disaster Management” scheduled for May 27<sup>th</sup>, 2025.

2.3 The Joint Educational Session will focus on Pediatric Cardiac Arrest and is scheduled for June 3<sup>rd</sup>, 2025, from 11:45 a.m.-1:00 p.m. (Flyer and meeting details provided).

3. **APPROVAL OF MINUTES**

3.1 The meeting minutes for February 7, 2025, were approved as presented.

M/S/C (Wombold/Sepke)

4. **OLD BUSINESS: None**

5. **NEW BUSINESS**

**Policies for Discussion: Action Required**

5.1 Ref. No. 814, Determination/Pronouncement of Death in the Field

Approved as presented, M/S/C (Campion/Brown)

6. **Policies for Discussion: No Action**

6.1 Ref. No. 1309, Color Code Drug Doses

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

6.3 Ref. No. 526.1, Medical Clearance Criteria Screening Tool for Psychiatric  
Urgent Care Centers (PUCC)

6.4 Ref. No. 838, Application of Patient Restraints

6.5 Ref. No. 1200.2, Base Contact Requirements

6.6 Ref. No. 1200.3, Provider Impressions

6.7 Ref. No. 1200.4, BLS Upgrade to ALS Assessment

6.8 Ref. No. 1209, Behavioral/Psychiatric Crisis

Recommendation: ‘Special Consideration’ to incorporate capnography monitoring for patients who are given sedation

6.9 Ref. No. 1307, Care of the Patient with Agitated Delirium

6.10 Ref. No. 1307.3, Common Etiologies of Agitation

6.11 Ref. No. 1317.25, Midazolam

6.12 Ref. No. 1373, Treatment Protocol Quality Improvement Fallout Data Dictionary

6.13 Ref. No. 644, Base Hospital Documentation Manual & Data Dictionary

Review: the ‘Drug/Defib’ and ‘PTBC’ fields and provide clear instructions for documentation of ‘Field Whole Blood’ and ‘Interfacility Whole Blood’

6.13.1 MCI Documentation Manual

6.14 Ref. No. Summary of Changes 2025

**Information Policies: No Action Required**

6.15 Ref. No. 1240-P, Hazmat

**7. REPORTS & UPDATES:**

7.1 Sidewalk CPR

Sidewalk CPR is scheduled for Monday, June 2, 2025, at Grand Park in downtown LA from 10:00 a.m. to 12:00 p.m. The event will be introduced by Dr. Bosson and will kick off with a press conference featuring speakers from LA County Fire, LA City Fire, American Heart Association (AHA), a representative from the LA County Board of Supervisors, and a cardiac arrest survivor sharing their story. Participants will receive hands-only CPR and AED training.

7.2 EMS Update 2025

EMS Update has been released and must be completed by June 30, 2025. There will be 3.5 hours of CE given after completion. There are supplementary material folders and training videos that are available to help support your in-person training of EMS Update topics. Feedback regarding EMS Update 2025 is welcomed as well as suggestions for next year EMS Update 2026 training.

7.3 EmergiPress

The next edition will be 'HERT' (Hospital Emergency Response Team). The film provides answers to when to activate the HERT and an understanding of their resources. Everyone is encouraged to watch the video by January 2026, and CE hours are available.

7.4 ITAC Update (Tabled)

7.5 ELCoR Task Force

The committee has completed its first project: Law Enforcement Co-Response to Agitated Persons, presented in EMS Update 2025. The committee meets on a quarterly basis to address issues that intersect with law enforcement operations. The current focus areas are developing education and resources for law enforcement on pediatric critical emergencies and other opportunities, such as the use of AED for adult cardiac arrest cases

7.6 Research Initiatives & Pilot Studies

7.6.1 Prehospital Blood Transfusion Pilot – LA DROP

The pilot program launched on April 1, 2025, in collaboration with three other counties across California. Information and supporting materials for the LA Drop pilot are available on the EMS website under *EmergiPress* and "Updates from the Medical Director" tab. Provider agencies that are currently live are Compton Fire and County Fire Department squads 21,161,158. County Fire is scheduled to expand in two weeks to include stations 171, 172, 173, 14, 36,116,110, and 41.

### 7.6.2 Thorasite Pilot

Dr Whitfield presented findings from the Thorasite pilot study, which evaluated the use of the Thorasite device for lateral needle thoracostomy. The results were favorable with no reported adverse events or anatomical misplacements, indicating that the device can be used safely and effectively in the field. It will be added as optional inventory for ALS providers.

### 7.7 PediDOSE Trial

Beginning July 1, 2025, PediDOSE will transition to include age-based dosing of midazolam for patients aged 12 to 16 months. Continue to operate under the current protocol until July 1, 2025. The EMS Agency appreciates your participation and collaboration and look forward to the successful completion of the study and the insights it will provide.

### 7.8 Pedi-PART

The base screen submission has been helpful to identify potential patients ensuring that everyone is enrolled. To date, 190 patients have been enrolled in the study. The primary challenge has been adherence to the study arm, specifically following assigned airway management based on odd and even days.

### 7.9 California Office of Traffic Safety (OTS) Grants Projects

#### 7.9.1 RAPID LA County Medic Mobile Application

The Mobile Protocol Application has been released and is now available for use. Training on its utilization is provided in EMS Update. A video resource on how to use the application is now posted on the EMS website, along with the links to download the application.

#### 7.9.2 Trauma Dashboards/Curriculum

The EMS Agency has a contract with ESO to operationalize live dashboards, with the goal of completing this initiative by October 1<sup>st</sup>. The objective is to have the real-time dashboards that reflect the injuries encountered in the field, the care provided and patient outcomes from the trauma centers.

### 7.10 Health Data Exchange

A kickoff meeting was held last month with ESO and the participating trauma and base hospitals to provide an overview of the Health Data Exchange (HDE) initiative. Meetings with the individual facilities will be scheduled over the next few months, and the EMS Agency will continue to provide regular updates. Glendale Adventist is expected to be the first hospital to go live with the system.

## 8. OPEN DISCUSSION

- An issue has come up regarding how to document when a patient cannot be fully assessed or may or may not have capacity and is left on scene. A possible solution is the 'Released Following Protocol Guidelines' which is currently in NEMESIS and can be easily implemented. The plan is to bring it back at the next meeting with more clear delineations of when this option would be recommended.

- The EMS Agency has been invited to participate in a program aimed at treating patients with Buprenorphine for the treatment of opioid use disorder. The challenge is ensuring a continuum of care at the hospital; however, it was discovered that most hospitals have a CA Bridge program in place, which offers ongoing services. This presents an opportunity to implement the EMS Bridge program in LA County and the EMS Agency will continue to provide updates as more details become available.

**9. ADJOURNMENT:** The meeting was adjourned at 3:00 p.m.

**NEXT MEETING:** June 11, 2025

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

**ACCOUNTABILITY:** Laura Leyman

### 3.2.2 COMMITTEE REPORTS



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



## BASE HOSPITAL ADVISORY COMMITTEE MINUTES

**June 11, 2025**

Representatives			Representatives		
	Tariana Kang, MD, Chair	EMS Commission	X	Rachel Caffey	Northern Region
	Lydia Lam, MD, Vice Chair	EMS Commission	X	Jessica Strange	Northern Region
	Atilla Under, MD, MPH	EMS Commission	X	Michael Wombold	Northern Region, Alternate
	Connie Richey, RN	EMS Commission	X	Samantha Verga-Gates	Southern Region
	Saran Tucker, PhD, MPH	EMS Commission	X	Laurie Donegan	Southern Region
	Carol Synder, RN	EMS Commission	X	Shelly Trites	Southern Region
	Erick Cheung, MD	EMS Commission	X	Christine Farnham	Southern Region, Alternate
	Brian Saeki	EMS Commission		Ryan Burgess	Western Region, Alternate
	Carol Kim	EMS Commission	X	Travis Fisher	Western Region
X	Gabriel Champion	Base Hospital Medical Director	X	Lauren Spina	Western Region
	Salvador Rios	Base Hospital Medical Director, Alternate	X	Susana Sanchez	Western Region
X	Adam Brown	Provider Agency Representative		Kate Bard	Western Region
X	Jennufer Nulty	Provider Agency Representative, Alternate		Laurie Sepke	Eastern Region
X	Elizabeth Charter	PedAC Representative	X	Alina Candal	Eastern Region
	Desiree Noel	PedAC Representative, Alternate		Jenny Van Slyke	Eastern Region, Alternate
	John Foster	MICN Representative		Lila Mier	County Region
	Vacant	MICN Representative, Alternate	X	Emerson Martell	County Region
			X	Antoinette Salas	County Region
				Yvonne Elizarraraz	County Region
EMS Agency			Prehospital Care Coordinators		Guests
	Nichole Bosson, MD	Ami Boonjaluska	X	Brandon Koulabouth (AMH)	Shane Cook, LACo. Fire
	Denise Whitfield, MD	Lily Choi	X	Annette Mason (AVH)	Taylor Hill, (SJS)
	Shira Schlesinger, MD	Lorrie Perez	X	Kelly Bui (SFM)	Colleen Green (SMM)
	Jake Toy, MD	Prsicilla Romero	X	Melissia Turpin (SMM)	
	Michael Kim, MD	Mark Ferguson		Melissa Carter (HCH)	
	Dipesh Patel, MD	Andreas Solorio		Allison Bozigian (HMN)	
	Bijan Arab, MD	Gerward Waworundeng		Mary Jane Evangelista (QVH)	
	Jon Warren, MD	Fredrick Bottger			
	Richard Tadeo	Paula Cho			
	Chris Clare	David Wells			
		Mariana Munatones			

**1. CALL TO ORDER:** The meeting was called to order by Chair Pro Tempore, Base Hospital Medical Director, Gabriel Campion, MD, at 1:03 p.m.

**2. INTRODUCTIONS/ANNOUNCEMENTS:**

2.1 Dr. Nichole Bosson announced the launch of EMS Corps, an EMT training program designed to support and represent underprivileged communities. Dr. Michael Kim serves as the Medical Director. EMS professionals interested in getting involved are encouraged to reach out. Flyers for the program were provided at the meeting.

2.2 Ami Boonjaluksa announced that starting July 1, 2025, the combined 1200 & 1300 protocols on the EMS website will no longer include hyperlinks. Only a PDF version will be available. Some base hospitals expressed concern about the short notice and the impact on their workflow. Richard Tadeo recommended using the Rapid LA County app as an alternative. The change is due to ongoing issues with hyperlink functionality in the combined version.

**3. APPROVAL OF MINUTES**

3.1 The meeting minutes for February 5, 2025, were approved as presented.

M/S/C (Brown/Wombold)

**4. Old Business**

4.1 Revised Base Hospital Documentation Manual Summary of Changes 2025: Additional updates since the April meeting include four additions:

- 1) Data entry instructions for Mechanical Compression Device (MCD)
- 2) Data entry instructions for Rearrest
- 3) Revised definition for Drug/Defib for recording blood product for IFT
- 4) New code, 'Released Following Field Guidelines' for Reason for No Transport

**5. NEW BUSINESS**

5.1 Paramedic Communication System Modernization: Ami Boonjaluksa presented an overview of the Paramedic Communication System Modernization, outlining the current systems limitations and proposed plans to improve functionality, reliability and long-term and feasibility. The PowerPoint presentation will be shared with the base group following the meeting.

**6. Policies for Discussion: Action Required**

6.1 Ref. No. 520, Transport/Transfer of Patients from Catalina Island

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

6.2 Ref. No. 520.1, Catalina Island Medical Center (AHM) Transfer/Transport Process

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

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

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

## **Policies for Discussion: No Action Required**

6.4 Ref. No 1307.4, EMS and Law Enforcement Co-Response – minor changes to align with the Ref. No. 834 changes.

6.5 Ref. No. 1222, Hyperthermia (Environmental) – presented by Dr. Arab for discussion only, there were no suggested changes.

## **7. REPORTS & UPDATES:**

### 7.1 EMS Update 2025

EMS Update is available and must be completed by July 1, 2025, to maintain active status. Planning for the 2026 EMS Update will begin soon. Those interested in participating should contact Dr. Schlesinger.

### 7.2 EmergiPress

The latest edition focuses on Mechanical Compression Device (MCD) use and placement. Training videos are available to show how to transfer a patient with a MCD without interrupting CPR.

### 7.3 ITAC Update

The next meeting is scheduled for August and will only be held if there is a proposal to review a new device or technology.

### 7.4 ELCoR Task Force

The ELCoR Task Force will continue to collaborate with law enforcement on key projects, including pediatric emergency response, the use of AEDs, and training on the co-response of law enforcement and EMS for agitated persons. Once content for the co-response is finalized and approved by the committee, the curriculum will be submitted to POST for statewide law enforcement use.

### 7.5 Research Initiatives & Pilot Studies

#### 7.5.1 Prehospital Blood Transfusion Pilot – LA DROP

To date, ten blood transfusions have been administered in Los Angeles County under the pilot program all within protocol, with no waste reported. Cases included trauma, AV fistula bleeds, and one pediatric patient. Interest from trauma centers continues to grow, and the aim is to expand the pilot. To do so, a sustainable model is needed. A toolkit will be developed to support agencies interested in implementing the program. The first blood donation event to help support the program is scheduled for June 13<sup>th</sup>, 2025. The plan is to continue the pilot for one year to build the necessary infrastructure for future expansion.

#### 7.5.2 PediDOSE Trial

The pilot program will continue for one more year. Protocols will be updated on July 1, 2025, to include patients 12 months of age and older. The focus remains on evaluating age-based dosing for seizure treatment.

#### 7.5.3 Pedi-PART

Over 600 patients have been enrolled so far, one-third coming from the LA system. The

EMS agency appreciates the continued efforts of base screener in enrolling patients. Study arm adherence remains a challenge, and the agency is working on ways to support providers. Providers can now place stickers on the BVM to serve as a visual cue to remind providers of their assignment and help support adherence to the protocol.

#### 7.5.4 California Office of Traffic Safety (OTS) Grants Projects

##### 7.5.5 RAPID LA County Medic Mobile Application

The EMS Agency continues to encourage the use of the application. The next phase includes developing a destination decision tool and to improve the use of the drug dose feature. The EMS Agency is also looking at ways to study how the paramedics use the app through scenario-based reviews.

##### 7.5.6 Trauma Dashboards/Curriculum

The dashboards are still in development. The input regarding the curriculum from those who participated in discussion are being developed into modules.

#### 7.6 Health Data Exchange

Glendale Adventist is now online, and the EMS Agency is working on agreements to provide outcome data to providers. The EMS Agency met with several health systems, including Providence, Dignity Health, Cedars-Sinai and UCLA Ronald Reagan. Phase 2 will include hospitals without specialties but within participating systems. The first-year subscription begins at the go-live date and will be covered by the County.

### 8. OPEN DISCUSSION

- There was a robust discussion about the upcoming removal of the hyperlinks from the combined 1200 & 1300 protocols and the short notice given. Base hospitals expressed concern that the limited time would not allow for proper MICN training, especially with the EMS Update completion deadline. Many of the base hospitals rely on the combined protocols during calls due to the ease of navigation with hyperlinks to other protocols. The EMS Agency was not aware that the combine protocols were the primary source used and acknowledged the concern about the hyperlink's accuracy. Richard Tadeo stated he will bring the feedback for internal discussion but could not commit to postponing the sunseting date of the combined version protocols.

9. **NEXT MEETING:** August 13, 2025

10. **ADJOURNMENT:** The meeting was adjourned at 2:33 p.m.

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

**ACCOUNTABILITY:** Laura Leyman

### 3.2.3 COMMITTEE REPORTS



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



## BASE HOSPITAL ADVISORY COMMITTEE MINUTES

**August 13, 2025**

Representatives			Representatives			
X	Tariana Kang, MD, Chair	EMS Commission	X	Rachel Caffey	Northern Region	
	Lydia Lam, MD, Vice Chair	EMS Commission	X	Jessica Strange	Northern Region	
	Atilla Under, MD, MPH	EMS Commission	X	Michael Wombold	Northern Region, Alternate	
	Connie Richey, RN	EMS Commission	X	Samantha Verga-Gates	Southern Region	
	Saran Tucker, PhD, MPH	EMS Commission	X	Laurie Donegan	Southern Region	
	Carol Synder, RN	EMS Commission	X	Shelly Trites	Southern Region	
	Erick Cheung, MD	EMS Commission	X	Christine Farnham	Southern Region, Alternate	
	Brian Saeki	EMS Commission	X	Ryan Burgess	Western Region, Alternate	
	Carol Kim	EMS Commission	X	Travis Fisher	Western Region	
X	Gabriel Champion	Base Hospital Medical Director	X	Lauren Spina	Western Region	
	Salvador Rios	Base Hospital Medical Director, Alternate		Susana Sanchez	Western Region	
X	Adam Brown	Provider Agency Representative	X	Kate Bard	Western Region	
X	Jennifer Nulty	Provider Agency Representative, Alternate	X	Laurie Sepke	Eastern Region	
X	Elizabeth Charter	PedAC Representative	X	Alina Candal	Eastern Region	
	Desiree Noel	PedAC Representative, Alternate	X	Jenny Van Slyke	Eastern Region, Alternate	
	John Foster	MICN Representative	X	Lila Mier	County Region	
	Vacant	MICN Representative, Alternate	X	Emerson Martell	County Region	
			X	Antoinette Salas	County Region	
			X	Yvonne Elizarraraz	County Region	
EMS Agency			Prehospital Care Coordinators		Guests	
	Nichole Bosson, MD	Ami Boonjaluska	Natalie Greco	X	Brandon Koulabouth (AMH)	Shane Cook, LACo.Fire
	Denise Whitfield, MD	Lily Choi	Sara Rasnake	X	Annette Mason (AVH)	Annette Cornell (HCH)
	Shira Schlesinger, MD	Lorrie Perez		X	Kelly Bui (SFM)	
	Jake Toy, MD	Priscilla Ross		X	Melissia Turpin (SMM)	
	Michael Kim, MD	Mark Ferguson			Melissa Carter (HCH)	
	Dipesh Patel, MD	Andrea Solorio		X	Allison Bozigian (HMN)	
	Jacquelyn Rifenburg	Gerward Waworundeng		X	Mary Jane Evangelista (QVH)	
	Richard Tadeo	Jennifer Calderon				
	Chris Clare	Paula Cho				
	David Wells	Aldrin Fontela				
	Jon Warren, MD	Sandy Montero				

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

**2. INTRODUCTIONS/ANNOUNCEMENTS:**

2.1 Dr. Shira Schlesinger announced the EMS for Children Forum will be held on November 13, 2025, in Fairfield, California (in person). Topics include the Pediatric Assessment Triangle, Respiratory Illness, Seizure, E-Bike Trauma and TBI – Pediatric EPIC.

2.2 Dr. Schlesinger reintroduced Dr. John Warren, returning for his second year of EMS fellowship, and Dr. Paul Argon, joining as a new EMS fellow. Please add them to your email list for continuing education.

2.3 The Joint Educational Session on September 2, 2025, will cover pediatric burns, presented by Dr. Kevin Mackey from Sacramento Fire.

**3. APPROVAL OF MINUTES**

3.1 The meeting minutes for June 11, 2025, were approved as presented.

M/S/C (Campion/Wombold)

**4. Old Business**

4.1 1200/1300 Combined PDF

We are extending the sunset of the combined PDF 1200/1300 protocols while working with the vendor of the RAPID Web App. The RAPID Protocol App currently allows you to open multiple protocols at once. While this is different from using links to navigate, it ensures the most up-to-date version is available.

**5. NEW BUSINESS**

5.1 Board of Supervisors and Measure B

At the July 15, 2025, Board Meeting, DHS requested an increase in overall Measure B collection. Of the \$20 million available at FY 24-25 year-end, The Board of Supervisors elected to equally distributed to the Board of Supervisors for district projects. This will eliminate the availability of MBAB funds for this year. Richard Tadeo is meeting with each Supervisor to propose allocating a portion of these funds to hospitals for upgrading their radio systems. Final recommendations are expected by the end of September. A board memo will be sent out identifying all funding proposals from the board offices.

5.2 Airway Evidence-Based Guidelines

Dr. Bosson presented slides on prehospital airway management, highlighting the summary recommendations. Minor edits will be made to our treatment protocols, particularly the teaching points, to align with these findings. The study also identified a gap in pediatric airway literature, emphasizing the importance of following the Pedi-Part study assignments on even and odd days. The publication was included in the packet.

**6. Policies for Discussion: Action Required**

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

The notable change was extending the ground transport from 15 minutes to 30 minutes.

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

6.2 Ref. No. 528, Intoxicated (Alcohol) Patient Destination

The notable change was extending the ground transport from 15 minutes to 30 minutes.

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

**Policies for Discussion: No Action Required**

6.3 Ref. No 511, Perinatal Patient Destination

6.3.1 Ref. No. 1217/1217-P, Treatment Protocol: Pregnancy Complication

The notable change is the blood pressure parameters, now separating systolic blood pressure (140 mmHg) and diastolic (90 mmHg) readings, as these values indicate the need for transport to a perinatal center.

6.4 Ref. No 836, Communicable Disease Exposure and Testing

6.4.1 Ref. No. 836.1, Communicable Disease Exposure and Testing Flowchart

6.4.2 Ref. No. 836.2, Communicable Disease Exposure and Notification Report Form

6.4.3 Ref. No. 836.3, Communicable Disease Exposure Court Petition to Test Accused Blood

There were no changes to the process or procedure. Minor updates include redefining standard precautions, and updating the terminology for designated officer to DICO (Designated Infection Control Officer)

6.5 Ref. No. 1200.1, Treatment Protocol: General Instructions

Added language to support the use of multiple protocols and treatment simultaneously and allowing the treatment within scope of practice.

6.6 Ref. No. 1209-P, Treatment Protocol: Behavioral/Psychiatric Crisis

Added the dosing for midazolam IV for agitated patients that aligns with the Medical Control Guidelines 1317.25.

6.7 Ref. No 1302, Medical Control Guideline: Airway Management and Monitoring

Additional considerations include stoma intubation and the option to perform sedation for patients who become agitated after an advanced airway placement.

6.7.1 Ref. No. 1210/1210-P, Treatment Protocol: Cardiac Arrest

Key changes in special considerations include allowing SGA placement prior to transport and identifying SGA as the preferred pediatric advanced airway, consistent with protocol 1210 and MCG 1302.

6.7.2 Ref. No. 1237/1237-P, Treatment Protocol: Respiratory Distress

Same language as in MCG 1302, supporting the need for sedation after advanced airway placement.

6.7.3 Ref. No. 1243/1243-P, Treatment Protocol: Traumatic Arrest

Key changes in special considerations identifying SGA as the preferred advanced airway. It may be placed after initial resuscitation priorities are complete or during transport if BMV is ineffective. Clarifying language was also added regarding commotio cordis.

Trauma patients will be enrolled in the Pedi-Part Study.

6.7.4 Ref. No. 1317.25, Medical Control Guideline: Midazolam

Same language as in MCG 1302, supporting the need for sedation after advanced airway placement.

6.8 Ref. No 1234/1234-P, Treatment Protocol: Airway Obstruction

The notable change in special considerations is the removal of SGA as a contraindication for airway obstruction, aligning with MCG 1302 allowing paramedics to use their judgement and available tools to relieve the obstruction.

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

Added language to clarify the idea that if the ECG is poor quality and cannot be reliably read by the machine or paramedic, it should not be used to guide care. Use a good-quality ECG instead.

A schematic of ECG limb placement was added to the existing precordial lead placement diagram.

The group requested that ECG limb placement on the schematic be adjusted to show placement on the upper arms instead of near the chest.

6.10 Ref. No. 1375, Medical Control Guideline: Vascular Access

Additional language was added to emphasize the teaching point to avoid IO placement at a site where fracture is suspected.

6.11 Ref. No. 1213, Treatment Protocol: Cardiac Dysrhythmia – Tachycardia

Added the cardioversion joule dose for narrow complex tachycardia to match the format used for other tachyarrhythmias.

6.12 Ref. No. 1222, Treatment Protocol: Hyperthermia (Environmental)

Added that water immersion is permissible but not required, as its use depends on provider agency's capabilities, though it remains the gold standard for heat stroke.

6.13 Ref. No. 1010, Mobile Intensive Care Nurse (MICN) Certification

Added a limit on how many EMS CE hours can be obtained daily towards CE requirements.

## 7. REPORTS & UPDATES:

### 7.1 Sidewalk CPR

The event was held at Grand Park in Long Beach, with a total of 4500 people trained countywide, up from 880 last year. Sincere thanks to all the volunteers, hospitals and providers agencies who participated.

### 7.2 EmergiPress

The August edition is on *Heat Related Emergencies* and reinforces the updated hyperthermia protocol and is now available on the APS portal. Send any topic suggestions for future EmergiPress to Dr. Schlesinger.

### 7.3 ITAC Update

At the last meeting we reviewed prehospital suction devices, comparing manual and battery-powered options. Battery-powered devices suctioned faster but had smaller canisters which can be an issue if there is excessive amount of emesis.

### 7.4 Cardiac Arrest Task Force 'Project 2030'

This taskforce, initiated by the EMS Commission and chaired by Dr. Sanko, focuses on AHA goals to improve bystander CPR, AED use and cardiac arrest outcomes. CARES summary report cards were shared with providers to make the data more actionable and shareable. We would like to do the same for hospitals, but current CARES reports do not provide hospital specific metrics, so we have reached out to CARES for options.

### 7.5 ELCOR

Continue to meet with law enforcement to build a better understanding of the EMS system. We hope to meet with the police chiefs to strengthen collaboration and mutual understanding. These meetings have provided valuable education on our part, and we would like this exchange to go both ways.

### 7.6 Research Initiative & Pilot Studies

#### 7.6.1 Prehospital Blood Transfusion Pilot – LA DROP

The pilot program is with Compton and County Fire with approximately eleven units in the South Bay, primarily transporting to Harbor-UCLA Medical Center. The first quarterly blood transfusion report shows strong safety metrics, minimal wastage and overall feasibility. Results indicate both safety and physiological benefit. The expansion plan will focus on mapping potential patients and prioritizing additional units and agencies as resources allow.

### 7.6.2 PediDOSE Trial

Have transitioned to the new dosing schedule, which includes age-based dosing for patients twelve months and older. Some concerns were raised about safety when age and color coding don't align but experts have confirmed this is safe. The pilot will continue for another year as we study whether age or weight-based dosing is better. The only protocol change is a teaching point that if a child is extremely undersized child due to a genetic disorder or malnutrition, weight-based dosing can be used.

### 7.6.3 Pedi-PART

Dr. Bosson presented data showing low study adherence, 60% compliance on even days (BVM) and 40% on odd days (SGA). Want to focus on pediatric cardiac arrest patients and ask the base hospitals to help support providers with airway assignments and decision making to improve adherence. The goal is to increase compliance to 85% system wide.

### 7.6.4 California Office of Traffic Safety (OTS) Grants Projects

#### 7.6.5 RAPID LA County Medic Mobile Application

The RAPID App includes new icons: a blue pill bottle with the EMS Agency logo for the Pediatric Color Code and a red siren for the RAPID logo. The RAPID App study is complete, with appreciation to all the volunteers. The study included randomization of critical scenarios and user feedback. The training identified areas where users required further clarification, and the training proved beneficial. We are offering additional in person training to any agency to ensure optimal utilization of the app.

#### 7.6.6 Trauma Dashboards/Curriculum

We have reviewed the initial draft, and it looks great. We continue to develop, and it will be available next month.

### 7.7 Health Data Exchange

Nearly all trauma hospitals have agreed to participate in HDE, with only a few deferring due to EMR upgrades. Of the 21 base hospitals, only four have declined. We are finalizing agreements with Henry May Newhall Hospital, Pomona Valley Hospital Medical Center, Ronald Reagan UCLA Medical Center, and St. Francis Medical Center. Adventist Health White Memorial has advanced to phase two of expansion, and work continues to complete agreements with additional hospitals. On the provider side, Glendale Fire is now online and has requested direct access to their own data.

## 8. OPEN DISCUSSION

- A question was raised about giving Narcan IO since it is not listed in the protocol. Dr. Bosson clarified that any medication authorized to be given IV can also be given IO.
- Richard Tadeo discussed preparations for the FIFA Work Cup and the Olympics, with law enforcement and fire chiefs collaborating on best practices and response planning. There is a countywide task force working with FIFA coordinators to develop a medical plan. Dr. Whitfield provided updates on upcoming events at SoFi Stadium, including the eight 2026 FIFA matches and the 2027 Super Bowl., with LA County Fire as the lead agency. Dr. Kashani and Dr. Whitfield are leading coordination with the Los Angeles Sports and Entertainment Commission, the official host of these events.

- A question was raised about Ref. No. 502 and ED diversion regarding the 15-minute transport guideline. Richard Tadeo explained that the 15 minutes time serves as a guide to ensure units are not unreasonably removed from their coverage area.
- The meeting concluded with a celebration of Chris Clare's upcoming retirement and her final BHAC meeting.

**9. NEXT MEETING:** October 8, 2025

**10. ADJOURNMENT:** The meeting was adjourned at 2:45 p.m.

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

**ACCOUNTABILITY:** Laura Leyman



## EMERGENCY MEDICAL SERVICES COMMISSION PROVIDER AGENCY ADVISORY COMMITTEE



### MINUTES

Wednesday - April 16, 2025

### MEMBERSHIP / ATTENDANCE

MEMBERS IN ATTENDANCE	ORGANIZATION	EMS AGENCY STAFF	EMS AGENCY STAFF
X Carol Meyer, Chair	EMSC, Commissioner	Richard Tadeo	Nichole Bosson, MD
X Kenneth Powell, Vice-Chair	EMSC, Commissioner	Denise Whitfield, MD	Shira Schlesinger, MD
Jason Cervantes	EMSC, Commissioner	Jake Toy, MD	Chris Clare
James Lott, PsyD, MBA	EMSC, Commissioner	Jacqueline Rifenburg	Ami Boonjaluksa
Gary Washburn	EMSC, Commissioner	Frederick Bottger	Sam Calderon
Kristin Kolenda	EMSC, Commissioner	Paula Cho	Mark Ferguson
Ken Lieberman	EMSC, Commissioner	Aldrin Fontela	Natalie Greco
Paul Camacho	EMSC, Commissioner	Carola Jimenez	Han Na Kang
		Nnabuike Nwanonyeni	Sara Rasnake
X Sean Stokes	Area A ( <i>Rep to Medical Council</i> )	Gary Watson	Gerard Waworundeng
Patrick Nulty	Area A, Alternate	David Wells	
X Keith Harter	Area B		
X Clayton Kazan, MD	Area B, Alternate		
<i>Vacant</i>	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 ( <i>Rep to BHAC</i> )		
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 Melissa 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, Alt		
Scott Jaeggi	EMT Training Program		
Albert Laicans	EMT Training Program, Alternate		
X Ray Mosack	Paramedic Training Program		
<i>Vacant</i>	Paramedic Training Program, Alternate		
Jennifer Nulty	EMS Educator		
Heather Calka	EMS Educator, Alternate		
		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: Melissa 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](mailto: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](mailto: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](mailto: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](mailto: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 Nwanonyi)

- 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 Nwanonyi (BK) at [Nwanon@dhs.lacounty.gov](mailto: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.



### 2.3 Disaster Cache Support (Terry Crammer)

- The EMS Agency thanked the Santa Fe Springs Fire Rescue and Los Angeles County Sheriff's Department for assisting with the transport of a Chempack from the Disaster Staging Area to Catalina Island this morning.
- Chempacks are planned to be distributed to other hospitals in the County.

### 2.4 Microsoft Teams (David Wells)

- All QI meetings and other meetings (i.e., ELCOR) that are conducted virtually, will no longer have the capability of being recorded.
- Prior to entering these virtual meetings, individuals outside the Los Angeles County system, will be required to sign-in using CAPTCHA. (CAPTCHA is a security measure to differentiate between human users and bots online.)

3. **APPROVAL OF MINUTES** (Harter/P. Nulty) April 16, 2025, minutes were approved as written.

### 4. UNFINISHED BUSINESS

There was no unfinished business.

### 5. NEW BUSINESS

#### 5.1 Side-Stream Capnography (Nichole Bosson, MD)

- Due to the importance of capnography, the EMS Agency is moving forwards to have the side-stream (nasal) capnography a required piece of equipment on all ALS units; this is in addition to the capnography already carried on ALS units.
- The EMS Agency has received supportive feedback from provider agencies to carry this additional equipment on paramedic units. Inventory policies and treatment protocols will be revised to include this additional piece of equipment.
- Once related policies/protocols are revised, they will be brought to this Committee for review and any further input.

#### 5.2 Portable Suction Devices (Denise Whitfield, MD)

- The EMS Agency received provider feedback that there are various portable suction devices being utilized but are not adequate for field use. In efforts to determine best equipment options, related to portable suctioning, input was received from Committee members; and will be further researched during future ITAC meetings.

### **Policies for Discussion; Action Required:**

#### 5.3 Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene (Nichole Bosson, MD)

Policy reviewed and approved as written.

**M/S/C (Brown/P. Nulty) Approve: 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 (Nichole Bosson, MD)

This policy was reviewed and voted upon as part of Reference No. 834.

#### 5.5 Reference No. 412, AED Service Provider Program Requirements (David Wells)

Policy reviewed and approved as written.

##### 5.5.1 Reference No. 412.1

Policy deleted.

### **5.5.2** Reference No. 412.2

Policy deleted.

**M/S/C (Ower/Harter) Approve: Reference No. 412, AED Service Provider Program Requirements; and Approve to Delete: Reference No. 412.1 and Reference 412.2.**

### **5.6** Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles *(David Wells)*

Committee had the following recommendation:

- Pg. 1, Policy: I. A.: replace the word “track” to read: “track utilization to maintain adequate inventory”

**M/S/C (Ower/Brown) Approve: Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles, with recommendation.**

### **5.7** Reference No. 710, Basic Life Support Ambulance Equipment *(David Wells)*

Policy reviewed and approved as written.

**M/S/C (Ower/Brown) Approve: Reference No. 710, Basic Life Support Ambulance Equipment.**

### **5.8** Reference No. 520, Transport of Patients from Catalina Island *(Chris Clare & John Quiroz)*

#### **5.8.1** Reference No. 520.1, Catalina Island Medical Center (AMH) Transfer Process

Policies reviewed and approved as written.

**M/S/C (Ower/Brown) Approve: Reference No. 520, Transport of Patients from Catalina Island.  
Approve: Reference No. 520.1, Catalina Island Medical Center (AMH) Transfer Process.**

### **5.9** Reference No. 455, Private Ambulance Vehicle Age Limit Requirements and Exemptions *(David Wells)*

Policy reviewed and approved as written.

**M/S/C (Ower/Mosack) Approve: Reference No. 455, Private Ambulance Vehicle Age Limit Requirements and Exemptions.**

### **5.10** Reference No. 1112, Hospital Evacuation *(Terry Crammer)*

Policy reviewed as information only and feedback was requested from Committee.

Committee had the following recommendation:

- Pg. 1, DEFINITIONS: add the definition of “FOAC”

## **Policies for Discussion; No Action Required:**

The following policy was reviewed as **information only**:

### **5.11** Reference No. 1222, Treatment Protocol: Hypothermia (Environmental)

*(Nichole Bosson, MD & Bijan Aram, MD)*

- Dr. Aram provided a power point presentation on the recommended field treatment of heat-related emergencies and included the proposed changes to this policy. This was presented as information only; no voting required.

## **6. REPORTS AND UPDATES**

### **6.1** Health Data Exchange *(Richard Tadeo)*

- Implementation of Phase I continues, which includes trauma and base hospitals.
- Adventist Health – Glendale went live in March 2025. Data is more robust than expected.
- Some trauma and base hospitals have paused the implementation of HDE due to other priorities (transitioning to new electronic medical records systems, which is an approximately 3-year project).

- This project is now moving towards Phase II, which include the implementation of the non-trauma and non-base hospitals.
- Currently, there are DHS and multiple other hospitals within LA County that are in various stages of implementing the HDE system.
- The EMS Agency has completed two online informational sessions for the EMS providers and how HDE can be utilized.
- All provider agencies participating in the HDE project will be required to sign a Business Associate Agreement (BAA).
- Although there is an annual subscription cost to participate in this system, provider agencies will not be charged for using the HDE system. Using grant funding, the first-year's subscription will be paid by the County of Los Angeles. The EMS Agency is seeking further funding to sustain the hospitals' cost of this program. However, if funding is not available, participating hospitals have agreed to accept any subsequent costs.

## **6.2 Sidewalk CPR (David Wells)**

- This year's Sidewalk CPR was very successful. The EMS Agency thanks all those who participated.
- Please continue submitting your number of participants to the EMS Agency.
- The Sidewalk CPR button continues to be live on the EMS Agency's website, where you can access the informational videos and survivor stories.

## **6.3 EMS Update 2025 (Denise Whitfield, MD & Mark Ferguson)**

- Providers are reminded that EMS Update is to be completed and sent to the Certification Section of the EMS Agency by June 30, 2025. If not completed, suspension notices will be sent out on July 15<sup>th</sup>.

## **6.4 EmergiPress (Denise Whitfield, MD)**

- A new EmergiPress will be coming out this month titled, "Mechanical Compression Devices", focusing on the transition of the pre-hospital mechanical devices to the hospital.

## **6.5 ITAC (Denise Whitfield, MD)**

- No updates currently.

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

- Continuing to meet monthly with the law enforcement partners.
- Dr. Joe Nakagawa (Hawthorne PD) led a great discussion during a State meeting on June 17, 2025. Specifically, the interactions between law enforcement and EMS personnel related to mental health emergencies.
- This Task Force is currently working on improving the interactions between law enforcement and EMS personnel as it relates to mental health emergencies and the law enforcement response to critical pediatric patients. Looking to develop training videos and other training materials to present to surrounding law enforcement agencies.

## **6.7 Research Initiatives and Pilot Studies**

### **6.7.1 Prehospital Blood Transfusion – LA DROP (Nichole Bosson, MD & Kelsey Wilhelm, MD)**

- This 1–2-year Pilot started on April 1, 2025, and currently there have been 11 transfusions in LA County.
- Continuous field education and quality improvement is being conducted on all cases and potential cases. Reports are routinely provided to the State, with no major issues or blood transfusion reactions reported.
- A tool kit is being developed to outline the steps needed to participate, when it is appropriate, for providers who are interested in joining this pilot. Implementation questions can be directed to either Compton FD's Medical Director, Kelsey Wilhelm, MD or LA County FD's Medical Director, Clayton Kazan, MD.

### 6.7.2 eCPR Centers (Nichole Bosson, MD)

- A list of participating hospitals will be available by June 24, 2025. System will go live on July 1, 2025.
- Site visits and designations have already been given to Cedars Sinai Medical Center, MemorialCare Long Beach Medical Center and Torrance Memorial Medical Center. Two other applications from Dignity Health-Northridge Hospital Medical Center and Ronald Reagan UCLA Medical Center have been received and are in the process of completing their designation.
- On July 1, 2025, Reference No. 501, 9-1-1 Receiving Hospital Directory, will be updated and the Reddi-Net system will include eCPR Centers. This list will be updated on a quarterly basis, as necessary.

### 6.7.3 PediDOSE Trial (Nichole Bosson, MD)

- On July 1, 2025, the Pediatric Seizure protocol (Ref. 1231-P) and the Rapid LA County Medic mobile/web application will be updated to reflect the new changes in age-based dosing of midazolam. (The age-based dosing will move from age 17 months and up; to the new age of 12 months and up.)
- Enrollment into this Trial will continue for one more year.
- A new report card for the paramedic self-reporting (PSR) is now being utilized.
- Arcadia FD was recognized as being the top performer over the entire course of the study, with an 81% completion rate of PSRs.
- Provider agencies with a 100% PSR completion rate during the month of May include Culver City FD, La Verne FD, Monrovia FD, Monterey Park FD, Sierra Madre FD, Redondo Beach FD and Los Angeles County FD. (Some providers had no enrollments)

### 6.7.4 Pedi-PART (Nichole Bosson, MD)

- Adherence to the study parameters is currently the biggest struggle. (Utilizing the correct airway adjunct on the correct day)
  - In attempts to improve the compliance, the EMS Agency will be implementing the use of reminder stickers that can be placed on the airway devices (primarily on pediatric BMVs). These stickers will remind paramedic of the need for placement of defibrillation pads and which airway to be used on a specific day. Once available, the EMS Agency will distribute these to each provider agency.
  - Providers are encouraged to share any ideas they might be utilizing as a tool for their department(s).
- If providers are having trouble with the QR code links, please inform the EMS Agency so it can be resolved as quickly as possible.
- Zoll Premium Case Review – providers who do not have the Zoll Premium Case Review already, have the opportunity for free access, during the Pedi-PART trial. Those needing access, should contact their Zoll representative or the EMS Agency.
  - Having the Zoll-Premium Case Review option on your cardiac monitor allows Trial organizers to access the cardiac monitor files to understand ventilation during Pedi-PART. The ventilation component is of great importance to understand the outcomes of the two different airway strategies.
  - Questions on this or alternate methods to send your data can be directed to Dr. Bosson at [NBosson@dhs.lacounty.gov](mailto:NBosson@dhs.lacounty.gov)
- Those interested in obtaining RALPH devices, may contact Carola Jimenez at [RJJimenez2@dhs.lacounty.gov](mailto:RJJimenez2@dhs.lacounty.gov)

## 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 is now available. The goal is for providers and base hospitals to utilize the application on a regular/frequent basis.
- This resource is in real-time and allows access to all current LA County treatment protocols and policies.
- Funding is being sought to provide updates to the current application, including the addition of patient destination decisions.

- The April 2025, application testing did not receive enough participation; therefore, Long Beach FD will be partnering with the EMS Agency to conduct further scenario-based trauma simulations to evaluate how the application can be improved and best utilized in the field. The Long Beach FD simulations will begin in July 2025. Results from the April and now the July simulations, will be shared with providers once completed.

#### **6.8.2 Trauma Dashboards/Curriculum (Denise Whitfield, MD)**

- Trauma dashboards continue with their development. More information will come later.

### **7. OPEN DISCUSSION**

#### **7.1 Engagement with Immigration and Customs Enforcement (I.C.E.) Agents After Enforcement Actions** (Richard Tadeo)

- Due to recent I.C.E. enforcements being conducted within Los Angeles County, the EMS Agency Director inquired if there is a need for any prehospital guidelines.
- Those wanting to speak privately on this subject, may contact Richard Tadeo at (562) 378-1500.

### **8. NEXT MEETING – August 20, 2025**

### **9. ADJOURNMENT - Meeting adjourned at 2:46 p.m.**



3.2.6 COMMITTEE REPORTS

**EMERGENCY MEDICAL SERVICES COMMISSION  
PROVIDER AGENCY ADVISORY COMMITTEE**



**MINUTES**

Wednesday – August 20, 2025

**MEMBERSHIP / ATTENDANCE**

**MEMBERS IN ATTENDANCE**

**ORGANIZATION**

**EMS AGENCY STAFF**

**EMS AGENCY STAFF**

Carol Meyer, Chair	EMSC, Commissioner	Richard Tadeo	Nichole Bosson, MD
X Kenneth Powell, Vice-Chair	EMSC, Commissioner	Denise Whitfield, MD	Shira Schlesinger, MD
Jason Cervantes	EMSC, Commissioner	Chris Clare	Jacqueline Rifenburg
James Lott, PsyD, MBA	EMSC, Commissioner	Jake Toy, MD	Michael Kim, MD
Gary Washburn	EMSC, Commissioner	William Aragon, MD	Jonathan Warren, MD
Kristin Kolenda	EMSC, Commissioner	Paula Cho	Lily Choi
Ken Lieberman	EMSC, Commissioner	Mark Ferguson	Nattie Greco
Paul Camacho	EMSC, Commissioner	Laura Leyman	Lorna Mendoza
		Mariana Munatones	Nnabuike Nwanonyi
X Sean Stokes	Area A ( <i>Rep to Medical Council</i> )	Priscilla Ross	Christopher Sandoval
X Patrick Nulty	Area A, Alternate	Gary Watson	David Wells
X Keith Harter	Area B	Christine Zaiser	
X Clayton Kazan, MD	Area B, Alternate	<b>GUESTS</b>	<b>ORGANIZATION</b>
X Jeffrey Tsay	Area C	Lyn Riley	LA County Sheriff – Air Ops
X Luis Manjarrez	Area C, Alternate	Danielle Ogaz	LACoFD
X Geoffrey Dayne	Area E	Jim Goldsworthy	LAFD – Air Ops
Victor Lemus	Area E, Alternate	Ryan Shook	Santa Monica FD
X Joel Davis	Area F	Jorge Fazzini	West Coast Ambulance
Andrew Reno	Area F, Alternate	Johnna Corbet	UCLA Ctr for Prehospital Care
X Adam Brown	Area G ( <i>Rep to BHAC</i> )	Edward Valde	Mt. San Antonio College
Stefan Viera	Area G, Alternate	Kelsey Wilhelm, MD	Compton FD
X Matthew Conroy	Area H	Peter Garcia	Burbank FD
X Marc Cohen, MD	Area H, Alternate	Kristina Crews	LACoFD
X Michael Campana	Area H, Alternate	Kathryn Ward	UCLA Ctr for Prehospital Care
Julian Hernandez	Employed Paramedic Coordinator	Adrienne Roel	UCLA Ctr for Prehospital Care
X Tisha Hamilton	Employed Paramedic Coordinator, Alt	Armando Jurado	Lifeline Ambulance
Jenny Van Slyke	Prehospital Care Coordinator	Samuel Calderon	LACoFD
Melissia Turpin	Prehospital Care Coordinator, Alternate	Andrew Lara	First Rescue Ambulance
X Bryan Sua	Public Sector Paramedic Coordinator	Caroline Jack	Beverly Hills FD
Drew Pryor	Public Sector Paramedic Coordinator, Alt	Jennifer Shepard	LA County Sheriff – SEB
Vacant	Private Sector Paramedic	Catherine Borman	Santa Monica FD
Scott Buck	Private Sector Paramedic, Alternate	Paula La Farge	LACoFD
X Tabitha Cheng, MD	Provider Agency Medical Director	Jessie Castillo	PRN Ambulance
X Tiffany Abramson, MD	Provider Agency Medical Director, Alt	Joe Nakagawa, MD	Hawthorne Police Department
X Robert Ower	Private Sector Nurse Staffed Amb Program	Ben Esparza	LAFD
X Jonathan Lopez	Private Sector Nurse Staffed Amb Program, EMT Training Program	Theodor Ecklund	Pasadena FD
Scott Jaeggi	EMT Training Program, Alternate	Jodi Slicker	Pasadena FD
Albert Laicans	Paramedic Training Program	Patricia Guevara	UCLA Ctr for Prehospital Care
X Ray Mosack	Paramedic Training Program, Alternate	Salvador Rios, MD	AMR, McCormick Ambulance
Vacant	EMS Educator	Mike Port, MD	LACoFD
X Jennifer Nulty	EMS Educator, Alternate		
Heather Calka			

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

**2. INTRODUCTIONS AND ANNOUNCEMENTS**

**2.1 Membership Changes** (*Vice-Chair*)

Vice-Chair announced the following new members:

- Area C, Alternate: Luis Manjarrez, Glendale FD
- Area E, Alternate: Victor Lemus, Compton FD
- Area H, Alternate: Marc Cohen, MD, Los Angeles (City) Fire Department

**2.2 EMS Provider Disaster Preparedness Workshop** (Nnabuike Nwanonyi)

- Workshop will take place on October 20, 2025, from 8:00 am through 3:00 pm.
- Didactic portion will take place at the EMS Agency, followed by an MCI-based functional exercise which will take place at the EMS Agency’s Disaster Staging Facility.
- This event can accept up to 40 participants; currently there are 21 registrants signed up.

- Flyer for this event was placed in this meeting's packet and is also available at the EMS Agency's front desk. You may also contact Nnabuike Nwanonyi at [nwanon@dhs.lacounty.gov](mailto:nwanon@dhs.lacounty.gov)

### 2.3 EMS For Children Educational Forum – Save the Date (*Chris Clare*)

- This Educational Forum will be presented in-person only on November 13, 2025, in Fairfield, CA.
- Forum will provide an excellent source of continuing education which will focus on pediatric patients and EMS providers. More information will follow.

### 2.4 Joint Educational Session: Burns Be Gone (*Shira Schlesinger, MD*)

- Kevin Mackey, MD, Medical Director, Sacramento Fire Department, will be conducting this educational session on the prehospital treatment of pediatric burns.
- This 1-hour session will be held virtually only on September 2, 2025, from 11:45 am through 1:00 pm. (Immediately following the Pediatric Advisory Committee meeting)
- You may join this session by following this link:  
<https://ucla.zoom.us/j/94255342749?pwd=C9bjAlhNOhqa5bY8mDIEbNzyWI01a.1>

### 2.5 New EMS Fellows (*Shira Schlesinger, MD*)

- The following two physicians are part of the EMS Fellowship program:
  - Jonathon Warren, MD: this is Dr. Warren's second year of a 2-year Fellowship.
  - Paul Aragon, MD: (previously a firefighter/paramedic) will be involved in a 1-year Fellowship.

## 3. **APPROVAL OF MINUTES** (*Harter / P. Nulty*) June 18, 2025, minutes were approved as written.

## 4. **UNFINISHED BUSINESS**

There was no unfinished business.

## 5. **NEW BUSINESS**

### 5.1 IV Zofran in Pediatric Patients (*Nichole Bosson, MD*)

- Pediatric Advisory Committee recommended that the EMS Agency add the intravenous (IV) formulation of Ondansetron to the pediatric Treatment Protocols. Currently, Ondansetron is only allowed to be administered to the pediatric patient through the ODT (oral disintegrated tablets) route.
- Committee was approached to determine if there was any opposition to adding this change to the medication formulary. Hearing no opposition, the EMS Agency will move forward in making changes to the affected policies, including Ref. No. 1309, Color Code Drug Doses.

### 5.2 Board of Supervisors and Measure B Funding (*Richard Tadeo*)

- During the July 15, 2025, Board of Supervisor's meeting, the Department of Health Services requested approval for an increase in Measure B rate. The Board Letter also contained one-time allocation from the unallocated portion of the Measure B funds to Catalina Island (\$6 million (M)) and LA General Hospital (\$2 M). The approval of these requests reduced the \$28 M unallocated funds to \$20 M. Two competing motions were introduced for the use of the remaining one-time funds. The motions introduced by Supervisors Hahn and Solis was adopted. This motion directed DHS to allocate the remaining \$20 M of unallocated one-time funds equally to each of the five Supervisorial Districts for projects that meet Measure B funding criteria. As a result, there is no remaining unallocated funding available for the MBAB project proposals in 2025, leading to the suspension of the current process.
- The EMS Agency has met with each of the Board offices to provide information on the various projects received through the MBAB project proposal process and highlighted the projects that originated from organizations within their District. The EMS Agency anticipates receiving the disbursement plan from each District sometime in September.

### 5.3 Evidence-Based Guidelines for Prehospital Airway Management (Nichole Bosson, MD)

- This 2023 publication studied the best airway approach for adult and pediatric patients during out of hospital cardiac arrests, trauma, and medical emergencies. Airways in this study included bag-mask-ventilation, supraglottic airway and endotracheal intubation.
- Dr. Bosson reviewed the results of this publication with the Committee and added that the LA County EMS policies will be realigned based on the recommendations of this study.

### 5.4 Project 2030, Cardiac Arrest Task Force (Nichole Bosson, MD)

- Dr. Bosson provided an overview of this new Taskforce that began June 2025.
- Taskforce formed at the request of the EMS Commission and is Chaired by Steve Sanko, MD. The goal is to move Los Angeles County towards meeting the American Heart Association's 2030 Guidelines. These guidelines include both EMS and hospital recommendations.
- This multidisciplinary taskforce has a 1-year timeline to provide the EMS Agency with potential interventions to improve our system's current practices.

### 5.5 EMS Update 2026 (Shira Schlesinger, MD)

- Now recruiting for participants on the EMS Update 2026 Committee.
- Those interested may contact Dr. Schlesinger at [SSchlesinger2@dhs.lacounty.gov](mailto:SSchlesinger2@dhs.lacounty.gov)

### 5.6 Drug Cards (Shira Schlesinger, MD)

- The EMS Agency received a request from a paramedic student to make the language on the drug references (listed under Ref. No. 1317) more understandable.
- During this modification, if providers have any further suggestions, please contact Dr. Schlesinger at her email above.

## **Policies for Discussion; Action Required:**

### 5.7 Reference No. 227, Dispatching of 9-1-1 Emergency Medical Services (David Wells)

Upon review and discussion, policy tabled to review changes to Principle 3 and Policy I. A.

**Tabled: Reference No. 277, Dispatching of 9-1-1 Emergency Medical Services.**

### 5.8 Reference No. 414, Specialty Care Transport Provider (David Wells)

Committee received public comments from Andrew Lara, RN, First Rescue Ambulance Service. Following additional discussion, this Policy was tabled until next meeting.

**Tabled: Reference No. 414, Specialty Care Transport Provider.**

#### 5.8.1 Reference No. 414.1, Sample Verification of Employment Letter (David Wells)

This policy was reviewed and tabled as part of Reference No. 414, above.

**Tabled: Reference No. 414.1, Sample Verification of Employment Letter.**

### 5.9 Reference No. 424, Triage to Alternate Destination (TAD) Paramedic Provider Program (Mark Ferguson)

Policy reviewed and approved as written.

**M/S/C (Cohen/Harter) Approve: Reference No. 424, Triage to Alternate Destination (TAD) Paramedic Provider Program.**

### 5.10 Reference No. 526, Behavioral/Psychiatric Crisis Patient Destination (Chris Clare)

Policy reviewed and approved with the following recommendation:

- PRINCIPLES: 2. Include wording "Advanced Practice Providers" after the first word "Paramedic".

**M/S/C (Kazan/Brown) Approve: Reference No. 526, Behavioral/Psychiatric Crisis Patient Destination, with recommendation.**

**5.11 Reference No. 528, Intoxicated (Alcohol) Patient Destination (Chris Clare)**

Policy reviewed and approved with the following recommendation:

- PRINCIPLES: 2. Include wording “Advanced Practice Providers” after the first word “Paramedic”.

**M/S/C (Kazan/Brown) Approve: Reference No. 528, Intoxicated (Alcohol) Patient Destination, with recommendation.**

**Policies for Discussion; No Action Required:**

The following policies were reviewed as information only:

**5.12 Reference No. 511, Perinatal Patient Destination (Shira Schlesinger, MD)**

**5.12.1** Reference No. 1217/1217-P, Pregnancy Complication

**5.13 Reference No. 836, Communicable Disease Exposure and Testing (Chris Clare)**

**5.13.1** Reference No. 836.1, Communicable Disease Exposure and Testing Flowchart

**5.13.2** Reference No. 836.2, Communicable Disease Exposure and Notification Report Form

**5.13.3** Reference No. 836.3, Court Petition for Order to Test Accused Blood

**5.14 Reference No. 1200.1, Treatment Protocol: General Instructions (Nichole Bosson, MD)**

**5.15 Reference No. 1209-P, TP: Behavioral/Psychiatric Crisis (Nichole Bosson, MD)**

**5.16 Reference No. 1302, MCG: Airway Management and Monitoring (Nichole Bosson, MD)**

**5.16.1** Reference No. 1210/1210-P, TP: Cardiac Arrest

**5.16.2** Reference No. 1237/1237-P, TP: Respiratory Distress

**5.16.3** Reference No. 1243/1243-P, TP: Traumatic Arrest

**5.16.4** Reference No. 1317.25, MCG: Drug Reference - Midazolam

Recommendation: Committee recommended adding language to policies above (sections 5.16 through 5.16.4), listing the contraindications of i-gel utilization.

**5.17 Reference No. 1234/1234-P, TP: Airway Obstruction (Nichole Bosson, MD)**

**5.18 Reference No. 1308, MCG: Cardiac Monitoring / 12-Lead ECG (Nichole Bosson, MD)**

**5.19 Reference No. 1375, MCG: Vascular Access (Nichole Bosson, MD)**

**5.20 Reference No. 1213, TP: Cardiac Dysrhythmia – Tachycardia (Nichole Bosson, MD)**

**5.21 Reference No. 1222, TP: Hyperthermia (Environment) (Nichole Bosson, MD)**

**5.22 Reference No. 901, Paramedic Training Program Approval (Mark Ferguson)**

**5.23 Reference No. 906, Emergency Medical Technician Training Program Approvals (Mark Ferguson)**

**5.24 Reference No. 1106, Mobilization of Local Pharmaceutical Caches (LPCs) (Chris Sandavol)**

**5.24.1** Reference No. 1106.4, EMS LPC Inventory and Checklist for Items Deployed

**6. REPORTS AND UPDATES**

**6.1 Health Data Exchange (Richard Tadeo)**

- The HDE project has moved from Phase I, which included trauma and base hospitals to Phase II and STEMI and Stroke Centers are now being encouraged to participate.
- Individual hospital system’s progress for joining the project was reviewed.
- DHS hospitals (LA General Medical Center, Harbor UCLA Medical Center and Olive View-UCLA Medical Center), continue to make progress. All have agreed on the data elements that will be collected and submitted to HDE, including data from emergency departments and physician notes.

- Provider agencies wanting to participate, must have a signed Business Associate Agreement with the County of Los Angeles. Fulfilling this requirement allows the provider access to hospitals' PHI data. HIPPA compliance is also required of the providers.
- More information will be provided at the next meeting.

## **6.2 Sidewalk CPR (Natalie Greco)**

- The EMS Agency thanked all those who participated in this year's Sidewalk CPR campaign.
- Systemwide, the total number of individuals trained are 4,149; 1,300 more than the previous year.
- A reminder was given that the Sidewalk CPR button on the EMS Agency webpage, remains live for access to informational videos and a survivor video.

## **6.3 EmergiPress (Shira Schlesinger, MD)**

- July/August version of EmergiPress (Heat-related emergencies) is now accessible on the EMS Agency's webpage and has been sent out to all provider agency EMS educators.
- If your agency has not received this information automatically and would like to be included in the distribution list for EmergiPress, contact Dr. Schlesinger at [SSchlesinger2@dhs.lacounty.gov](mailto:SSchlesinger2@dhs.lacounty.gov).

## **6.4 ITAC (Denise Whitfield, MD)**

- Earlier this month, ITAC completed a suction device evaluation to determine the quality of suction devices needed during use in the prehospital setting.
- At the conclusion of this evaluation, ITAC made the following recommendations for all 9-1-1 responding units:
  - Utilize a portable battery-powered suction unit with large capacity canister
  - Explore ways to optimize the battery life of the suction unit
  - As a back-up, have a manual suction device immediately available.

## **6.5 EMS and Law Enforcement Co-Response (ELCOR) Committee (Nichole Bosson, MD)**

- Committee continues to meet quarterly.
- Currently this committee is modifying specific EMS modules that will be shared with LE colleagues.
- Shira Schlesinger, MD, is working to provide guidance to LE when responding to pediatric emergencies.
- The EMS Agency will be meeting with area Police Chiefs in efforts to build a stronger collaboration.
- Exploring LE's AED programs and Public Safety First Aid Optional Scope of Practice, to determine current readiness and/or needs for guidance during critical / medical responses.

## **6.6 Research Initiatives and Pilot Studies**

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

- The 1<sup>st</sup> Quarterly report of LA DROP pilot was recently released; with a total of 15 transfusions and minimal wastage.
- First meeting was held to develop a strategic expansion plan; to support providers and hospitals who wish to participate in the LA DROP pilot (including LAFD, LA County Sheriff, other trauma hospitals and blood banks).
- Currently, the pilot will continue as structured for at least one year to ensure stability and safety. This will also allow for expansion to other providers and hospitals.
- Dr. Kazan, LACoFD, provided the Committee with an update on total transfusions in LA County: LACoFD reports 15 transfusions, and Compton FD reports 3 transfusions (18 total to date).
- Dr. Kazan also provided insight to the importance of this pilot in saving lives needing blood transfusions in the field.

### **6.6.2 PediDOSE Trial (Nichole Bosson, MD)**

- A Special Considerations note was added to the appropriate pediatric policies regarding treatment of those with severe growth restrictions.

- Torrance FD provided laminated PediDOSE charts that can be posted inside your ALS units. (Charts were available to pick-up after meeting)

### **6.6.3 Pedi-PART (Nichole Bosson, MD)**

- Medical Director thanked all provider agencies for their diligent participation in this pilot project. The efforts of all providers within the Los Angeles County EMS system continue to provide a large contribution to this national study; providing more than 1/3 of the pilot data. (over 300 patients have been enrolled from LA County, thus far)
- One challenge every department is having is adherence with the “even/odd day” assignment. The EMS Agency distributed small stickers to providers, that can be placed on airway equipment, in efforts to remind paramedics of the correct airway for the specific day. Other ideas are welcomed.
- Zoll’s cardiac monitor case review is available to all provider agencies.

### **6.6.4 California Office of Traffic Safety (OTS) Grants Projects**

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

- Mobile application received recent upgrade, including a new siren ICON.
- EMS Agency thanks those providers who participated in the new protocol application study (Long Beach FD, Compton FD and Torrance FD).
- If there are providers or base hospitals wanting training on the new mobile protocol application, please contact Denise Whitfield, MD, at [DWhitfield@dhs.lacounty.gov](mailto:DWhitfield@dhs.lacounty.gov)

#### **6.6.4.2 Trauma Dashboards (Shira Schlesinger, MD)**

- Trauma dashboards continue development. Expected to “go live” at the end of September 2025.

### **6.7 Buprenorphine Program (Denise Whitfield, MD)**

- Los Angeles County was not awarded grant funding for this program.
- The EMS Agency plans to apply for Local Optional Scope through the EMS Authority. While this is pending, policies will be developed for a planned implementation in 2026.
- Provider agencies interested in providing departmental training on this program, please contact the EMS Agency as there may be limited funding available from the State. However, the training must be completed by the end of September 2025.

### **6.8 Language Interpretation Services for EMS (Denise Whitfield, MD)**

- Starting in November 2025, Dr. Whitfield will be working with a medical student on a project to explore the availability of language interpretation within Los Angeles County. Currently, there are over 200 languages spoken within the County.
- Dr. Whitfield is asking providers to answer a short survey on the type of interpretive services your agency uses. Survey will be emailed on a future date.

## **7. OPEN DISCUSSION**

### **7.1 PAAC Representation for PedAC, Stroke and SEMI (Richard Tadeo)**

- The California Code of Regulations (Title 22, Div. 9, Chapter 6), Critical and Specialty Care Programs, is now requiring representation from this Committee to attend specialty center Committee meetings.
- At the next PAAC meeting, the EMS Agency will be requesting nominees from PAAC to attend the following meetings: Stroke Advisory Committee, SRC Advisory Committee and Pediatric Advisory Committee.
- Thank you to those who plan to participate.

**7.2 Context for Policy Changes** (*Adam Brown*)

- Committee member requested that during policy revisions, that the rationale for the changes be provided to the Committee ahead of time so they know why the change is being made.

**7.3 Retirement for Chris Clare** (*Chris Clare*)

- Chris Clare announced her retirement; stating this will be her last PAAC meeting. Chris expressed her thankfulness and gratitude for everyone's support during the many projects over the past several years.

**8. NEXT MEETING** – October 15, 2025

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

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)  
REFERENCE NO. 201

SUBJECT: **MEDICAL MANAGEMENT OF PREHOSPITAL CARE**

**PURPOSE:** To provide guidelines for prospective, concurrent and retrospective medical management of the emergency medical services (EMS) system in Los Angeles County by the EMS Agency, hospitals, and provider agencies.

**AUTHORITY:** Health and Safety Code, Division 2.5, Sections 1797.176, 1797.220 and 1798(a)  
California Code of Regulations, Title 22, Section 100091.04, 100096.01 - .03  
Health Insurance Portability and Accountability Act of 1996  
Hospital Preparedness Program (HPP) Agreement

**DEFINITIONS:**

Medical management consists of three components:

- Prospective:** Prior to delivery of patient care – off-line medical direction that uses scientific principles and practice standards to establish training objectives, and curriculum development for the standardization of patient care.
- Concurrent:** During delivery of patient care – on-line or on-scene medical direction of prehospital personnel caring for patients in the field. This allows for individualization of patient care and the ability to ensure optimal use of system resources through direct communication or observation.
- Retrospective:** Following delivery of patient care – off-line medical direction composed of field care audits and case reviews for the purpose of ensuring quality improvement.

**PRINCIPLES:**

1. Medical management provides the framework and authorization for EMS personnel to provide emergency treatment outside the hospital. It implies that there is accountability throughout the planning, implementation, monitoring, and evaluation of the EMS system and requires a collaborative effort among all system participants. Medical management is based upon national, state, and community standards of care.
2. The EMS Agency, base hospitals, and provider agencies are responsible for ensuring that EMS personnel have experience in and knowledge of local EMS agency policies, procedures, and guidelines.

**POLICY:**

- I. Prospective Medical Management

EFFECTIVE DATE: 04-30-98

PAGE 1 OF 5

REVISED: XX-XX-XX

SUPERSEDES: 04-01-22

APPROVED: \_\_\_\_\_

Director, EMS Agency

Medical Director, EMS Agency

- 
- A. The Medical Director of the EMS Agency shall ensure the development, implementation, and revision of written treatment protocols, medical policies and procedures including but not limited to:
    - 1. Medical Control Guidelines
    - 2. Treatment Protocols
    - 3. Base hospital contact and destination guidelines
    - 4. Local EMT scope of practice
    - 5. Local paramedic scope of practice and accreditation requirements
    - 6. Policies for the initiation, completion, review, evaluation, and retention of patient care records.
  - B. Base hospitals shall maintain written agreements with the EMS Agency indicating concurrence with the requirements of the EMS Agency's policies and procedures.
  - C. Provider agencies shall comply with applicable agreements, State and local policies and procedures specified in the Prehospital Care Manual.
- II. Concurrent Medical Management
- A. The EMS Agency shall ensure that a communication system is in place to allow for direct voice communication between paramedics, their assigned base hospital, and the Los Angeles County Medical Alert Center.
  - B. Base hospitals shall:
    - 1. Maintain telecommunication equipment capable of communicating with ALS Units assigned to the hospital.
    - 2. Ensure that a base hospital physician is immediately available for consultation when an ALS Unit contacts the base, and that either a base hospital physician or MICN provides direct voice communication for medical treatment orders and/or patient destination or other disposition.
    - 3. Ensure that base hospital physicians and MICNs giving medical direction to paramedics are trained in, and have experience in and knowledge of, base hospital communications and the local EMS agency policies, procedures, and protocols.
    - 4. Use the Los Angeles County Treatment Protocols. Any consistent deviation from these protocols must be requested in writing and approved by the Medical Director of the EMS Agency.
    - 5. Complete Base Hospital Report Forms approved by the EMS Agency as defined in Ref. No. 606, Documentation of Prehospital Care.

6. Provide a mechanism to record, retain, and retrieve audio recordings of all voice field communications between the base and receiving hospitals and the paramedics.

C. Provider agencies shall:

1. Ensure that paramedics use and maintain telecommunications with assigned base hospitals.
2. Comply with requirements specifically addressed in medical treatment policies including, but not limited to, Ref. No. 1200, Treatment Protocols, et al., and Ref. No. 1300, Medical Control Guidelines, et al.
3. Ensure that EMS personnel have education and knowledge of local EMS agency policies, procedures, and protocols.
4. Complete an EMS patient care record approved by the EMS Agency as defined in Ref. No. 606, Documentation of Prehospital Care.

III. Retrospective Medical Management

A. The Medical Director of the EMS Agency shall:

1. Maintain a systemwide quality improvement program that addresses system issues and develops standards for prehospital care.
2. Ensure that written records of prehospital care are reviewed on an ongoing basis.
3. Ensure that mechanisms are in place to provide organized evaluation of and continuing education for EMS personnel, including evaluation of skills programs.
4. Maintain a system-wide prehospital care database and make relevant data available to system participants.

B. Base hospitals shall:

1. Maintain a quality improvement program approved by the EMS Agency.
2. Participate in the EMS Agency's quality improvement program to include making available relevant records for program monitoring and evaluation. A mechanism shall be in place for provider agencies to obtain their respective audio communications for review and educational purposes as approved by each individual base hospital's Protected Health Information and Risk Management policies. It is recommended that an agreement for release and limited use of paramedic base hospital audio recordings be utilized for the release of such audio communications (see sample form Ref. No. 201.1). Patient confidentiality shall be maintained at all times.
3. Include in the hospital's quality improvement (QI) plan indicators that, at a minimum, include review of the following:

- a. Base Hospital Report Forms
  - b. Paramedic base hospital audio communications between paramedics and base hospital physicians and MICNs
4. Collect data on runs when the base hospital is the receiving hospital, including ED diagnosis.
  5. Provide a continuing education program for prehospital care personnel approved by the EMS Agency as defined in Ref. No. 1013, EMS Continuing Education (CE) Provider Approval and Program Requirements, which:
    - a. Complements the continuing education program provided by the assigned provider agencies.
    - b. Demonstrates a relationship between the base hospital's quality improvement program and the continuing education program offered.
  6. Develop an internal system of documentation for audio communications and records reviewed, actions recommended and/or taken, and problem resolution.
  7. Participate in the EMS Agency's countywide data collection program.
- C. Provider Agencies shall:
1. Maintain a quality improvement program approved by the EMS Agency.
  2. Participate in the EMS Agency's quality improvement program to include making available relevant records for program monitoring and evaluation. As part of the QI program, provider agencies may obtain copies of their respective audio paramedic communications from base hospitals for review and educational purposes provided that they have developed a written plan for security and confidentiality.
  3. Include in the provider agency's QI plan, indicators that, at a minimum, include review of EMS patient care records that are:
    - a. Completed by EMTs and/or paramedics on patients for whom either a paramedic unit was not dispatched, was canceled, or transport by ambulance did not occur.
    - b. Completed by EMTs and/or paramedics on patients for whom no base contact was made, when indicated by provider impression, treatment protocol or medical control guideline, but the patient was transported by ambulance.
    - c. Completed by EMTs and/or paramedics on patients for whom neither base hospital contact nor transport occurred when indicated by provider impression, treatment protocol or medical control guideline

4. Develop an internal system of documentation for EMS patient care records and records reviewed, actions recommended and/or taken and resolution of problems.
5. Participate in the EMS Agency's countywide data collection program as described in Ref. No. 606, Documentation of Prehospital Care, Ref. No. 607, Electronic Submission of Prehospital Data, and Ref. No. 608, Retention and Disposition of the Prehospital Care Patient Care Records.
6. Provider agencies that have a continuing education program approved by the EMS Agency shall:
  - a. Demonstrates a relationship between the provider agency's quality improvement program and the continuing education offered.
  - b. Ensures ongoing clinical competency and skill maintenance of EMS clinicians.

## CROSS REFERENCE:

Prehospital Care Manual:

- Ref. No. 201.1, **Sample Agreement for Release and Limited Use of Paramedic Base Hospital Audio Recordings**
- Ref. No. 214 **Base Hospital and Provider Agency Reporting Responsibilities**
- Ref. No. 606, **Documentation of Prehospital Care**
- Ref. No. 607, **Electronic Submission of Prehospital Data**
- Ref. No. 608, **Retention and Disposition of the Prehospital Care Patient Care Records**
- Ref. No. 620, **EMS Quality Improvement Program (EQIP)**
- Ref. No. 1013, **Prehospital Continuing Education (CE) Provider Approval and Program Requirements**
- Ref. Nos. 1200, **Los Angeles County Treatment Protocols**
- Ref. Nos. 1300, **Medical Control Guideline**

**POLICY REVIEW – COMMITTEE ASSIGNMENT**

REFERENCE NO. 202.1  
 (ATTACHMENT A)

**REFERENCE NO. 201, Medical Management of Prehospital Care**

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSA ADVISORY	Base Hospital Advisory Committee			
	Provider Agency Advisory Committee			
OTHER COMMITTEES / RESOURCES	Medical Council	3/4/2025	3/4/2025	No
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other: DRC Coordinators			

\*See Ref. No. 202.2, **Policy Review - Summary of Comments**

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES



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

REFERENCE NO. 321

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

**AUTHORITY:** California Code of Regulations (CCR), Title 22, Division 9, Chapter 6.2

**DEFINITIONS:**

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

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

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

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

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

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

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

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

EFFECTIVE:  
REVISED:  
SUPERSEDES:

PAGE 1 OF 10

APPROVED: \_\_\_\_\_  
Director, EMS Agency

\_\_\_\_\_  
Medical Director, EMS Agency

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

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

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

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

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

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

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

POLICY:

- I. ECPR Designation / Re-Designation
  - A. ECPR initial designation and re-designation is granted for up to three years based on maintenance of these standards and after a satisfactory review and approval by the EMS Agency.
  - B. The EMS Agency reserves the right to perform a scheduled on-site survey or request additional data at any time.
  - C. Prior to designation, the hospital shall be currently designated as a STEMI Receiving Center (SRC) for a minimum of five years and meet the SRC performance metrics, listed in Ref. No. 320.3, including first-medical contact to balloon time and door to balloon time, for a minimum of 12 months.
  - D. The ECPR Receiving Center must have an existing veno-arterial (V-A) ECMO program for a minimum of 12 months with quality improvement processes and managed a minimum of 6 patients on V-A circuit.
  - E. The ECPR Receiving Center must currently operate as an LA County designated Paramedic Base Hospital.

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- F. To be considered for ECPR designation, the hospital must provide workflow on receiving potential ECPR candidates to include but not limited to: procedures for receiving prenotification from EMS; team activation; ED workflow; location and procedures for cannulation; assessment for initiation and withdrawal of ECPR; multi-disciplinary team care while on ECPR and post-cannulation; and quality improvement program.
  - G. The ECPR Receiving Center shall immediately provide written notice to the Medical Director of the EMS Agency if unable to adhere to any of the provisions set forth in these ECPR Standards.
  - H. The ECPR Receiving Center shall provide a 90-day, written notice to the EMS Agency Medical Director of intent to withdraw from the ECPR program.
  - I. The ECPR Receiving Center shall notify the EMS Agency, in writing, of any change in status of the ECPR Medical Director, ECPR Program Manager, or data entry personnel by submitting Reference No. 621.2, Notification of Personnel Change Form.
- II. General Hospital Requirements
- A. Appoint an ECPR Medical Director and ECPR Program Manager who shall be responsible for meeting the ECPR Program requirements and allocate non-clinical time such that they can meet the requirements of the ECPR standards.
  - B. Have a fully executed Specialty Care Center ECPR Designation Agreement with the EMS Agency.
- III. ECPR Leadership Requirements
- A. ECPR Medical Director
    - 1. Qualifications:
      - a. A qualified specialist in emergency medicine, cardiology, pulmonology, critical care, or surgery (thoracic, cardiovascular, or trauma), or other qualified specialist with specific training and experience in ECMO support and credentialed to perform ECMO cannulation.
      - b. This person typically serves as the ECMO Director, providing oversight for the ECMO program including the ECPR program.
    - 2. Responsibilities:
      - a. Provide medical oversight for the ongoing performance of the ECPR program
      - b. Ensure the credentialing of clinicians who care for ECMO patients and/or who will manage the ECMO circuit
      - c. Collaborate with the ECPR Program Manager to ensure adherence to these standards

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- d. Participate in the relevant hospital committees associated with ECMO, cardiac arrest, and post-resuscitation care.
  - e. Liaison with hospital administration, ECPR Program Manager, medical and clinical staff across the patient's continuums of care
  - f. Ensure continuing education and competency evaluation in ECMO
  - g. Attend 100% of the EMS Agency's SRC and ECPR QI Meetings onsite or via video conference. Fifty percent (50%) of meetings may be attended by an alternate ECPR qualified specialist from the same ECPR Receiving Center.
  - h. Confirm proper and valid data submission to the EMS Agency
- B. ECPR Program Manager
- 1. Qualifications:
    - a. A physician, advanced practitioner (physician assistant, nurse practitioner), registered nurse, or respiratory therapist licensed in the State of California, or a certified clinical perfusionist, with a minimum of 1-year ICU experience.
    - b. Knowledgeable in the care of the ECMO and post-cardiac arrest patient.
    - c. Experience with program management and quality improvement.
    - d. This person typically serves as the hospital's ECMO Coordinator.
  - 2. Responsibilities:
    - a. Collaborate with the ECPR Medical Director to ensure adherence to these Standards
    - b. Confirm hospital policies are consistent with these Standards
    - c. Implement, maintain, and monitor ECPR QI programs
    - d. Ensure continuing education and competency evaluation in ECMO
    - e. Ensure that program availability is consistent with EMS policies and processes are in place to maximize the 24/7 team availability
    - f. Collaborate with the ED Medical and Clinical Directors on the management of patients with OHCA who meet criteria for ECMO
    - g. Liaison with hospital administration, ECPR Medical Director, medical and clinical staff across the ECMO patient continuums of care

- h. Participate in the relevant hospital committees associated with ECMO, cardiac arrest, and post-resuscitation care
- i. Serve as a contact person for the EMS Agency and be available upon request to respond to County business
- j. Attend 100% of the EMS Agency's SRC and ECPR QI Meetings onsite or via video conference. For both, fifty percent (50%) of meetings may be attended by an alternate clinician from the ECPR team.
- k. Ensure processes are in place to identify and track patients transported to the ECPR center by EMS
- l. Provide oversight of complete, accurate and timely data collection and submission

IV. ECPR Program Personnel Requirements

- A. Sufficient qualified ECMO cannulators to maintain program availability 24 hours per day/7 days per week/365 days per year
- B. ECMO specialists (clinicians trained to operate the ECMO circuit)
- C. An ECPR team available 24/7/365 to evaluate and care for the ECMO candidate upon the patient's arrival to the ED or within 5 minutes thereof, which includes at a minimum:
  - a. One ECMO-trained physician dedicated to the ECPR team and on call at only one facility at a time
  - b. One ECMO specialist dedicated to the ECPR team
- D. Other qualified specialist available to manage the other aspects of the patient's care including the resuscitation
- E. Cardiothoracic and/or vascular surgery available on call 24/7/365
- F. All physicians performing emergent ECMO cannulation must maintain current board certification, or be board eligible, in their specialty of practice

V. Training and Continuing Education

- A. ECPR Program Manager and Medical Director shall ensure staff are sufficiently trained and maintain competency in ECMO. Regular team-based simulation are highly encouraged.
- B. Training opportunities shall include, but not limited to:
  - 1. Didactic lectures
  - 2. Hands-on training with ECMO equipment
  - 3. Bedside training

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4. Simulations

- C. For facilities performing V-A ECMO <24 cases per year (average < 2/month) and/or if ECMO personnel are not involved in ECPR patient management for more than two (2) months consecutively, team-based ECPR patient simulations shall occur to ensure at least one ECPR patient experience quarterly. Simulations should include all aspects of the process from patient arrival with EMS, to cannulation with ongoing resuscitation and through ICU management, and should involve the relevant clinicians.
- D. ECPR Receiving Centers should provide periodic ECPR Base Hospital education with collaboration between the ECPR Program Manager/Medical Director, Prehospital Care Coordinator/Base Hospital Medical Director and EMS provider agencies.

VII. ECPR Program Plan

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

- A. Job descriptions and organization structure clarifying the relationship between the ECPR Medical Director, ECPR Program Manager and the ECPR team
- B. ECPR team activation guidelines with the ability to track activations and cancelations
- C. A process for immediate notification of the emergency physician and ECPR team upon EMS notification of an ECMO candidate transport
- D. A single call activation system to directly activate the ECPR team
- E. Policy and procedures outlining the following:
  - 1. ECPR team activation
  - 2. ED workflow for the potential ECPR patient
  - 3. Indications and contraindications for ECPR
  - 4. Clinical management of the ECPR patient including but not limited to:
    - a. Process for transfer from prehospital to hospital equipment while minimizing interrupting chest compressions
    - b. Coordination between ECPR team and the clinical care team (e.g., emergency department clinicians and/or cath lab staff)
    - c. Transition of the patient through phases of care (ED, cath lab, ICU)
  - 5. ECMO circuit management
  - 6. Maintenance of equipment

7. Policy for termination of ECPR therapy in patients who fail to recover and cannot be weaned, including involvement of a multi-disciplinary team, and availability of long-term cardiac support either on site or through transfer agreements
  8. Follow-up of the ECPR patient short and long-term outcomes
  9. Process for the triage and treatment of simultaneously arriving ECPR patients
- F. Plan to ensure 100% of ECPR patients receive immediate evaluation for reversible causes of OHCA.
1. Immediate coronary angiography for patients without an obvious alternate noncardiac cause
  2. Imaging and/or thrombolysis/thrombectomy for suspected massive pulmonary embolus
- G. Post resuscitation care policies, including initiation of TTM
- H. Involvement of a multidisciplinary team to include but not limited to emergency medicine, cardiology, neurology and/or intensive care medicine with experience in prognostication, respiratory therapy and palliative care.
- I. A process for feedback to the transporting paramedics on the patient's presumed diagnosis and ED disposition
- J. A process to collaborate with EMS provider agencies to integrate electronic prehospital patient care (ePCR) records into the hospital electronic medical record
- VIII. Equipment and Supplies
- A. ECMO supplies shall be easily accessible, readily available, and in close proximity to the ED and/or cath lab depending on the designated location(s) for cannulation.
- B. Required ECMO equipment and supplies include:
1. ECMO system that consists of a suitable blood pump, a system for servo-regulation, blood heat exchanger and warming unit
  2. Appropriate disposable materials including membrane oxygenator tubing packs and connectors
  3. Primed circuit or appropriate solution (crystalloid or blood) available to prime the circuit
  4. Device for monitoring the level of anticoagulation including its appropriate supplies
  5. Backup components for the ECMO system and supplies for all circuit components

6. Adequate lighting to support surgical interventions
  7. Supplies for revision of cannulation and for exploration of bleeding complications
  8. Access to blood bank, pharmaceuticals and radiology as needed
- C. A mechanical compression device must be available in emergency department for transition on patient arrival and use during cannulation
- IX. Data Collection and Submission Requirements
- A. Participate in the data collection process established by the EMS Agency.
  - B. Ensure adequate data entry personnel to meet data entry requirements. Back-up data entry personnel should be identified and trained in the event primary data personnel is unable to meet the data entry requirements.
  - C. Collaborate with ED and Base Hospital personnel to ensure capture and entry of patients meeting inclusion criteria into the Los Angeles County EMS Agency STEMI Receiving Center (SRC) database ECPR tab on an ongoing basis.
  - D. Maintain an Emergency Department (ED) Log to capture patients who are transported to the ED due to ECPR designation.
  - E. Submit data to the EMS Agency, within 45 days of patient's discharge, which shall include all patients who meet data inclusion criteria and all applicable data elements listed in Ref. No. 648, STEMI Receiving Center Data Dictionary
  - F. Maintain a minimum 90% compliance for:
    1. Capture of patients meeting the data inclusion criteria
    2. Data field completion
    3. Data field accuracy
    4. Timely data entry
  - G. Maintain active membership in the Extracorporeal Life Support Organization (ELSO). Submission of relevant data to ELSO for all ECMO and ECPR patients is highly encouraged but not required.
- X. Quality Improvement
- A. ECPR Program must include a comprehensive-multidisciplinary QI Meeting. This committee can be in conjunction with the SRC committee currently established.
    1. Meeting participation should include the ECPR Medical Director, ECPR Program Manager, EMS clinicians and educators, emergency physicians, interventional cardiologists, ED and cath lab personnel, critical care

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- personnel, neurology, as well as other healthcare specialties involved in the care of ECPR patients such as vascular surgery, and thoracic surgery.
2. Meeting to be held quarterly, at a minimum.
  3. Meeting minutes and roster must be maintained for each meeting and available for review.
- B. Pertinent aspects of care such as treatment and management of the ECPR patients, should be tracked and trended with the identification of areas requiring improvement and the action(s) necessary to improve care.
- C. The ECPR QI program shall:
1. Review the care and outcome on all (100%) ECPR patients and track and trend the following, at a minimum:
    - a. All ECPR related deaths
    - b. Major complications such as: limb ischemia, thromboembolism, hemorrhage requiring blood transfusion, ischemic stroke, infection, and organ injury
    - c. Any delays in care
  2. Address other issues, processes, or personnel trends identified from hospital specific data (i.e., increase in fallouts over time).
  3. ECPR center shall have a mechanism to provide feedback to EMS Providers (i.e., encrypted/secure e-mail). The feedback shall be provided within one (1) week of patient arrival at the ECPR center. Feedback shall include, but be not limited to, the following:
    - a. Date of service, sequence number, provider unit, patient age and gender, whether the patient received ECMO, survived to admission (and discharge if known) and positive feedback when a job was well done
    - b. Any quality-of-care concerns

## CROSS REFERENCE

### Prehospital Care Manual

- Ref. No. 320, **ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) Standards**
- Ref. No. 320.1, **Target Temperature Management Guidelines**
- Ref. No. 320.3, **SRC Performance Measures**
- Ref. No. 502, **Patient Destination**
- Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**
- Ref. No. 513, **S-T Elevation Myocardial Infarction (STEMI) Patient Destination**
- Ref. No. 516, **Cardiac Arrest Patient Destination**
- Ref. No. 621.2, **Notification of Personnel Change Form**
- Ref. No. 648, **STEMI Receiving Center Data Dictionary**

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

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

**ACKNOWLEDGEMENTS:**

The input of the ECPR Program Workgroup comprised of subject matter experts from Cedars-Sinai Medical Center, Los Angeles General Medical Center, MemorialCare Long Beach Medical Center, and Ronald Reagan UCLA Medical Center was essential in the initial development of these standards. Additional contributions were made by the Medical Council of the LA County EMS Agency, the LA County EMS Commission, the American Heart Association, and the Los Angeles County Medical Association. Information was also referenced from the Extracorporeal Life Support Organization (ELSO).

Reference No. 321, Extracorporeal Cardiopulmonary Resuscitation (ECPR) Receiving Center Standards

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/12/2025	2/12/2025	No
	Base Hospital Advisory Committee	2/5/2025	2/5/2025	No
OTHER COMMITTEES/RESOURCES	Medical Council	3/3/2025	3/3/2025	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other: LA County ECMO Pilot Study Workgroup	8/8/2024	8/8/2024	No
	SRC Advisory Committee	10/1/2024	10/1/2024	No

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

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

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

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

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

DEFINITIONS:

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

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

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

PRINCIPLE:

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

POLICY

- I. 9-1-1 Provider Agency Medical Director
  - A. Qualifications
    1. BC or BE in Emergency Medical Services (EMS) or Emergency Medicine (EM), with proof of significant experience and practice in EMS.
    2. Current, unrestricted license to practice as a physician in the State of California
    3. Engaged in the practice, supervision, or teaching of EM and/or EMS.
    4. Knowledgeable on the current policies, procedures, and protocols of the Los Angeles County EMS Agency.

EFFECTIVE: 02-01-1994  
REVISED: XX-XX-XX  
SUPERSEDES: 04-01-24

APPROVED: \_\_\_\_\_  
Director, EMS Agency

\_\_\_\_\_  
Medical Director, EMS Agency

**B. Responsibilities**

1. Represents the medical needs of his/her 9-1-1 patients by describing EMS activity and advocating for optimal medical care and public health measures with policy decision makers within the jurisdiction of their provider agencies, in coordination with their chain of command.
2. Attend an EMS system orientation provided by the EMS Agency within six (6) months of hire.
3. Participate in a field care observation (ride-along) with the sponsoring agency within six (6) months of hire.
4. Attend the annual program review or participate in the exit summary.
5. Attends at least 50% of the Medical Advisory Council meetings. For meetings in which the medical director is unable to be present, designates a representative to attend for the purpose of receiving information.
6. Medical Direction and Supervision of Patient Care
  - a. Advises the provider agency in planning and evaluating the delivery of prehospital medical care by EMTs and paramedics.
  - b. Reviews and approves the medical content of all EMS training performed by the provider agency and ensures compliance with continuing education requirements of the State and local EMS Agency.
  - c. Reviews and approves the medical components of the provider agency's dispatch system.
  - d. Assists in the development of policies and procedures to optimize patient care.
  - e. Reviews and recommends to the Innovation, Technology and Advancement Committee (ITAC) any new medical monitoring devices under consideration and ensures compliance with State and local regulation.
  - f. Evaluates compliance with the legal documentation requirements of patient care.
  - g. Participates in direct observation of field responses as needed. Medical direction during a direct field observation may be provided by the Provider Agency Medical Director in lieu of the base hospital under the following conditions:
    - i. The EMTs, paramedics, advanced practice providers, if applicable, and Provider Agency Medical Director on scene must be currently employed by, or contracted with, the same provider agency.

- ii. If base contact has already been established, the Provider Agency Medical Director may assume medical direction of patient care. The base hospital shall be informed that the Provider Agency Medical Director is on scene. They are not required to accompany the patient to the hospital.
  - iii. EMS personnel shall document the involvement of the Provider Agency Medical Director on the EMS Report Form when orders are given.
  - iv. The receiving hospital shall be notified of all patients whose field care is directed by a Provider Agency Medical Director.
  - h. Participates as needed with appropriate EMS committees and the local medical community.
  - i. Ensures provider agency compliance with Los Angeles County EMS Agency controlled substance policies and procedures.
6. Audit and Evaluation of Patient Care
- a. Assist the provider agency in the development and implementation of a continuous quality improvement program to ensure the provision of quality medical care. Provides recommendations for training and operational changes based on quality improvement results.
  - b. Evaluates the adherence of provider agency medical personnel to medical policies, procedures and protocols of the Los Angeles County EMS Agency.
  - c. Coordinates delivery and evaluation of patient care with base and receiving hospitals.
7. Investigation of Medical Care Issues
- a. Reviews incidents with unusual or adverse patient outcomes, inadequate performance of EMS personnel, and complaints related to the delivery of medical care.
  - b. Evaluates medical performance, gathers appropriate facts and, as needed, forwards those facts in writing to the Los Angeles County EMS Agency Medical Director.
  - c. Ensures that appropriate actions (e.g., training, counseling, etc.) are taken on cases with patient care issues with adverse outcomes, near misses, etc.
- II. Role and Responsibilities of the EMS Provider Agency
- A. Designates and maintains a Medical Director at all times.
  - B. Ensures Medical Director is involved in the development and approval of all medically related policies, procedures, quality improvement and medical dispatch programs, as applicable.

- C. Ensure Medical Director has direct access to the department manager (e.g., Fire Chief) to discuss EMS performance, projects and concerns.
- D. Provides the EMS Agency with notification of any changes in the designated Medical Director as specified in Reference No. 621, Notification of Personnel Change.
- E. Immediately notify the EMS Agency in the event the Medical Director abruptly resigns or is otherwise unable to fulfill his/her duties and no immediate replacement is available.

CROSS REFERENCE:

Prehospital Care Manual:

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

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

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	10/16/24	10/16/2024	No
	Base Hospital Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council	9/3/2024 3/4/2025	9/3/2024 3/4/2025	No Yes
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	EMS Commission	1/15/25		Yes
	LA Area Fire Chiefs Association	4/10/25	4/10/25	Yes

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

**POLICY REVIEW - SUMMARY OF COMMENTS**

REFERENCE NO. 202.2  
 (ATTACHMENT B)

**REFERENCE NO. 411, 9-1-1 Provider Agency Medical Director**

<b>SECTION</b>	<b>COMMITTEE/DATE</b>	<b>COMMENT</b>	<b>RESPONSE</b>
Policy I, B	EMS Commission 1/15/2025	Add new #1 "Represents the medical needs of his/her 9-1-1 patients by describing EMS activity and advocating for optimal medical care and public health measures with policy decision makers within the jurisdiction of their provider agencies, including meeting directly with policy decision-makers to whom the 9-1-1 provider agency reports (e.g., mayor, public safety committee, etc.) on a semi-annual basis to discuss community health needs."	Added
Policy II, C.	EMS Commission 1/15/2025	Add new C. "Ensure Medical Director has direct access to the department manager (e.g. Fire Chief) to discuss EMS performance, projects and concerns."	Added
Policy I, B	Medical Advisory Council 3/4/2025	Change wording from "...within the jurisdiction of their provider agencies, including meeting directly with policy decision-makers..." To "...jurisdiction of their provider agencies. Recommend meeting directly with policy decision-makers to..."	Change Made
Policy I, B	LA Area Fire Chiefs Association	Delete sentence "Recommend meeting directly with policy decision-makers to..."	Change made

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

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

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

**AUTHORITY:** Health and Safety Code, Division 2.5, Sections 1797.106, 1797.170, 1797.190 & 1797.215.  
California Code of Regulations, Title 22, Division 9, Chapter 2.3, 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.

**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 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 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 municipal agency or organization which 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.
3. An approved AED service provider and their authorized personnel shall be recognized statewide.

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EFFECTIVE DATE: 08-01-88

PAGE 1 OF 2

REVISED: xx-01-25

SUPERSEDES: 10-01-19

APPROVED: \_\_\_\_\_  
Director, EMS Agency

\_\_\_\_\_  
Medical Director, EMS Agency

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 31<sup>st</sup> for the previous 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.

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. May conduct a site survey prior to approval.
- C. Shall provide written approval authorizing AED services within thirty (30) calendar days, when all requirements have been met.
- D. May suspend or revoke 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.

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 changing, adding, or upgrading AEDs.
- C. Complete and submit the AED Service Provider Annual Report by March 31<sup>st</sup> 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.

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. 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:
  - 1. EMS Agency policies for EMTs.
  - 2. Agency/Organizational Policies for Public Safety

CROSS REFERENCE:

Prehospital Care Manual:

- 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. 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**

Reference No. 412, AED Service Provider Program Requirements

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	6/18/25	6/18/2025	No
	Base Hospital Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council	6/3/25	6/3/2025	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

SUBJECT: **AED SERVICE PROVIDER  
PROGRAM APPLICATION**

(EMT/PUBLIC SAFETY)  
REFERENCE NO. 412.1

---

## **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

<b>Name of Provider</b>			
<b>Address</b>		<b>City</b>	<b>Zip Code</b>
<b>Program Coordinator</b>		<b>Title</b>	
<b>Phone</b>		<b>Email</b>	
<b>AED Manufacturer</b>		<b>Model</b>	
<input type="checkbox"/> Cardiac Science <input type="checkbox"/> Defibtech or Cintas <input type="checkbox"/> Heartsine <input type="checkbox"/> Medtronic <input type="checkbox"/> Philips <input type="checkbox"/> Welch Allyn <input type="checkbox"/> Zoll <input type="checkbox"/> Other _____		<input type="checkbox"/> Powerheart <input type="checkbox"/> G3 pro <input type="checkbox"/> G3 Plus <input type="checkbox"/> G3 Automatic <input type="checkbox"/> Lifeline <input type="checkbox"/> Reviver (DDU-100) <input type="checkbox"/> Samaritan <input type="checkbox"/> Samaritan PAD <input type="checkbox"/> Lifepak 1000 <input type="checkbox"/> Lifepak CR Plus <input type="checkbox"/> FRx <input type="checkbox"/> FR2+ <input type="checkbox"/> On-Site <input type="checkbox"/> AED 10 <input type="checkbox"/> AED 20 <input type="checkbox"/> AED plus <input type="checkbox"/> AED pro <input type="checkbox"/> M Series <input type="checkbox"/> E Series <input type="checkbox"/> Other _____	
<b>Total Number of AEDs</b>		<b>Location of AEDs (patrol vehicles, ambulances, etc.)</b>	
<b>Provider Response Area (if not an existing 9-1-1 provider)</b>		<b>Pediatric Equipment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Frequency of AED Checks (* Per Manufacturer's Recommendation)</b> <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		<b>AED Response Form</b> <input type="checkbox"/> Approved PCR <input type="checkbox"/> County EMS <input type="checkbox"/> Self Designed	
<b>Curriculum</b>			
<input type="checkbox"/> American Heart Association <input type="checkbox"/> American Safety Health Institute <input type="checkbox"/> Other _____		<input type="checkbox"/> American Red Cross <input type="checkbox"/> Peace Officer's Standards and Training <input type="checkbox"/> Other _____ (must submit training material for approval)	
<b>Frequency of checking individual AED skill proficiency</b>			
<input type="checkbox"/> Every 2 years <input type="checkbox"/> Annually <input type="checkbox"/> Every 6 months <input type="checkbox"/> Other _____			

Completed by: \_\_\_\_\_ / \_\_\_\_\_  
(Signature) (Print name)

Title: \_\_\_\_\_



SUBJECT: **AED SERVICE PROVIDER ANNUAL REPORT**

REFERENCE NO. 412.2

## 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 31<sup>st</sup> 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](mailto:aedprograms@dhs.lacounty.gov)**  
**Fax: (562) 941-5835**

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

SUBJECT: **TRIAGE TO ALTERNATE DESTINATION (TAD)  
PARAMEDIC PROVIDER PROGRAM**

REFERENCE NO. 424

**PURPOSE:** To outline criteria for the approval of a triage to alternate destination (TAD) paramedic provider program in Los Angeles County.

**AUTHORITY:** Health & Safety Code, Division 2.5, Section §1797-1863  
California Code of Regulations, Title 22, Division 9, Chapter 5

**DEFINITIONS:**

**Advanced Life Support (ALS):** Patient care requiring paramedic level assessment and/or intervention(s) listed in Ref. No. 803, Los Angeles County Paramedic Scope of Practice.

**Designated TAD Facility:** A mental health (Psychiatric Urgent Care Center) or non-correctional (Sobering Center) facility approved by the Los Angeles County Emergency Medical Services (EMS) Agency to receive patients assessed and triaged by paramedics for psychiatric care or sobering services.

**Paramedic Provider Agency:** A fire or law enforcement agency or licensed ambulance operator that meets the requirements outlined in Ref. No. 406, Authorization for Paramedic Provider Status, which includes, but not limited to: employing and sponsoring paramedics to provide ALS services; participating in EMS system programs (e.g., quality improvement); and complying with all applicable federal and state statutes and regulations, and local policies, procedures, guidelines and protocols.

**TAD Paramedic:** A California licensed and Los Angeles County accredited paramedic who has completed the training requirements of an EMS Agency approved TAD Paramedic Training Program and received TAD specific accreditation.

**TAD Paramedic Provider Agency:** A paramedic provider agency authorized by the EMS Agency to participate in the TAD Program.

**TAD Paramedic Training Program:** A training program approved by the EMS Agency to provide education on triage to alternate destinations for patients requiring psychiatric care or sobering services through didactic and clinical education and competency testing.

**TAD Program:** A system-wide ALS program developed by the EMS Agency and approved by the Emergency Medical Services Authority to assess and triage patients requiring psychiatric care to designated Psychiatric Urgent Care Centers, or sobering services to designated Sobering Centers in accordance with the California Code of Regulations, Chapter 5, Division 9.

**PRINCIPLES:**

1. The EMS Agency is the approving authority for TAD Programs in Los Angeles County.

EFFECTIVE DATE: 04-01-24

PAGE 1 OF 6

REVISED: XX-XX-XX

SUPERSEDES: 4-01-24

APPROVED: \_\_\_\_\_  
Director, EMS Agency

\_\_\_\_\_  
Medical Director, EMS Agency

2. The EMS Agency has oversight authority to conduct onsite visits, inspect, investigate, and discipline a Designated TAD Facility, TAD paramedic, TAD paramedic provider agency, TAD paramedic training program, and TAD programs for any violations to the standards set forth herein through denial, probation, suspension, or revocation of the approval and/or accreditation.
3. No person or organizations shall offer a TAD paramedic training program or TAD programs without the authorization from the EMS Agency.
4. The EMS Agency may exclude existing paramedic provider agencies from participating in the TAD program. Reasons may include: no designated TAD facilities can be accessed within patient destination transport guidelines, EMS resources are unreasonably removed from the paramedic provider agency's primary area of response, and participation will negatively impact patient care. The EMS Agency will provide the paramedic provider agency a written response outlining the reasons for exclusion.
5. A TAD paramedic's decision to transport to a designated TAD facility shall not be based on, or affected by, a patient's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any other characteristics listed in Section 51 of the Civil Code except in circumstances in which age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient. A violation of Section 51 of the Civil Code will result in immediate termination from the program.
6. Maintaining skills competency and effective quality improvement program are important components for implementing and sustaining a successful TAD program. TAD provider agencies must ensure active clinical practice and participation in the quality improvement program for their TAD paramedics.

**POLICY:**

- I. TAD Paramedic Provider Agency Program Requirements
  - A. Be approved by the EMS Agency as a TAD paramedic provider agency.
    1. Must meet the requirements outlined in Ref. No. 406, Authorization for Paramedic Provider Status.
    2. Have a Medical Director who meets the requirements in Ref. No. 411, Provider Agency Medical Director.
    3. Incorporate the TAD paramedic provider agency program into existing continuing education and quality improvement programs.
  - B. Have a TAD Paramedic Training Program approved by the EMS Agency.
    1. Administration, faculty requirements, and TAD course standards and curriculum must meet California Code of Regulations, Title 22, Division 5, Chapter 5, §100189, Community Paramedic and Transportation to Alternate Destination Training Programs Administration and Faculty Requirements.

2. Interested training programs must complete and submit an EMS Agency TAD Training Program Application packet to the EMS Agency for approval. The application packet must contain the following:
  - a. Faculty forms containing the names and qualifications of the training program director, program medical director, and instructors.
  - b. A statement verifying that the course meets the requirements contained in the current version of the United States Department of Transportation (U.S. DOT) National Education Standards.
  - c. An outline of course objectives.
  - d. Performance objectives for each skill.
  - e. A minimum of one (1) final comprehensive competency-based examination must be administered to test the paramedic's skills and knowledge of the TAD Program.

C. Documentation and Data

1. Electronic Patient Care Report (ePCR) documentation must be in accordance with Ref. No. 606, Documentation of Prehospital Care.
2. Submission of ePCR data to the EMS Agency must be in accordance with current NEMESIS Standards and comply with the requirements in Ref. No. 607, Electronic Submission of Prehospital Data.
3. Retention and disposition of patient care records must comply with Ref. No. 608, Retention and Disposition of Prehospital Patient Care Records.

II. TAD Paramedic Training Program Approval Process

- A. Training Program Director of proposed TAD training program shall submit a written request to the EMS Agency Office of Certification and Training Program Approvals.
- B. Notification of program approval or deficiencies with application requirements shall be made in writing by the EMS Agency to the requesting paramedic training program within ninety (90) days of receiving the request for approval.
- C. The EMS Agency shall approve and establish the effective date of the TAD paramedic training program approval in writing upon the program satisfactory meeting and documenting compliance with all program requirements.
- D. TAD paramedic training program approval is valid for four (4) years ending on the last day of the month in which the request is approved. This approval is not transferable from person to person or between training programs.
- E. The EMS Agency shall notify the California EMS Authority in writing of the training program approval.

III. TAD Paramedic Provider Agency Program Disciplinary Actions

- A. The EMS Agency shall conduct an annual review of the TAD paramedic provider agency program to ensure compliance with all requirements.
- B. Failure to comply with the requirements set forth herein may result in denial, probation, suspension, or revocation of approval.
- C. Procedure for notification of noncompliance:
  1. The EMS Agency shall provide a written notification of noncompliance to the TAD paramedic provider agency within ten (10) days of finding noncompliance.
  2. Within fifteen (15) days from receipt of the notification, the TAD paramedic provider agency, shall submit in writing evidence of compliance or a plan to comply within sixty (60) days from the day of receipt of the notification.
  3. Within fifteen (15) days from receipt of the TAD paramedic provider agency response or within thirty days (30) from the mailing date of the notification of noncompliance if no response is received, the EMS Agency shall issue a decision letter by certified mail to the California EMS Authority and the TAD paramedic provider agency identifying one or more of the following actions:
    - a. Accept the evidence of compliance provided.
    - b. Accept the plan for meeting compliance provided.
    - c. Place the TAD paramedic provider agency on probation.
    - d. Immediately suspend or revoke the approval for the paramedic provider agency to implement TAD.
  4. The decision letter shall also include, but not be limited to the following:
    - a. The date of the EMS Agency's decision.
    - b. Specific requirements the TAD paramedic provider agency failed to meet.
    - c. The probation and suspension effective and ending date, if applicable.
    - d. The terms and conditions of the probation or suspension, if applicable.
    - e. The revocation date, if applicable.

IV. TAD Paramedic Accreditation

- A. The TAD paramedic applicant shall submit an EMS Personnel Information/Sponsorship Update Form and meet the following eligibility criteria:
1. Proof of an active, unrestricted California issued paramedic license,
  2. Hold a current Los Angeles County Paramedic Accreditation,
  3. Last four (4) numbers of social security number or individual tax identification number, and
  4. A course completion certificate issued by an approved TAD Paramedic Training Program.
  5. Application must be signed by an approved TAD Provider Agency sponsoring entity.
- B. The EMS Agency shall review the EMS Personnel Information/Sponsorship Update Form and notify the applicant in writing within thirty (30) business days from the date of submission that the application is:
1. Incomplete or illegible and required corrective action, or
  2. The TAD accreditation has been approved and the TAD accreditation information has been entered into the Central Registry database, or
  3. The TAD accreditation has been denied, including the reason for the denial and notification of the applicant's right to appeal.
- C. The EMS Agency shall register the TAD paramedic accreditation into the Central Registry database within five (5) business days of the TAD paramedic accreditation being approved.
- D. The initial TAD paramedic accreditation shall expire on the last day of the month, two (2) years from the effective date of the TAD paramedic initial accreditation.
- E. TAD paramedic accreditation shall be renewed every two (2) years. The following eligibility criteria for renewal must be submitted to the EMS Agency:
1. Proof of current, unrestricted California issued paramedic license, and
  2. Proof of completion of four (4) hours of approved TAD continuing education (CE).
- F. To be eligible for reinstatement of a TAD paramedic accreditation that has expired twelve (12) months or less, the following eligibility criteria must be submitted to the EMS Agency:
1. Proof of current, unrestricted California issued paramedic license, and
  2. Proof of completion of four (4) hours of approved TAD paramedic CE.

- G. To be eligible for reinstatement of a TAD paramedic accreditation that has been expired for more than twelve (12) months, the following eligibility criteria must be submitted to the EMS Agency:
1. Proof of current, unrestricted California issued paramedic license, and
  2. Proof of successful completion of an approved TAD paramedic training program within the last year from the submission date of the reinstatement application.

**CROSS REFERENCES:**

Prehospital Care Policy Manual:

Ref. No. 406, **Authorization for Paramedic Provider Status**

Ref. No. 411, **Provider Agency Medical Director**

Ref. No. 526, **Behavioral/Psychiatric Crisis**

Ref. No. 526.1, **Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center (PUCC)**

Ref. No. 528, **Intoxicated (Alcohol) Patient Destination**

Ref. No. 528.1, **Medical Clearance Criteria Screening Tool for Sobering Center**

Ref. No. 602, **Confidentiality of Patient Information**

Ref. No. 606, **Documentation of Prehospital Care**

Ref. No. 607, **Electronic Submission of Prehospital Patient Data**

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

Ref. No. 620, **EMS Quality Improvement Program**

Ref. No. 621, **Notification of Personnel Change**

Ref. No. 621.1, **Notification of Personnel Change Form Provider Agency/Training Programs**

Ref. No. 622, **Release of EMS Data**

Ref. No. 640, **EMS Documentation Manual**

Ref. No. 913, **Triage to Alternate Destination (TAD) Paramedic Provider Program Requirements**

**POLICY REVIEW – COMMITTEE ASSIGNMENT**

REFERENCE NO. 202.1  
 (ATTACHMENT A)

**REFERENCE NO. 424, Triage to Alternate Destination (TAD) Paramedic Provider Program**

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSA ADVISORY	Base Hospital Advisory Committee			
	Provider Agency Advisory Committee	8/20/2025	08/20/2025	No
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other: DRC Coordinators			

\*See Ref. No. 202.2, **Policy Review - Summary of Comments**

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

SUBJECT: **PRIVATE AMBULANCE VEHICLE AGE LIMIT  
AND LICENSURE REQUIREMENTS**

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.

**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 of manufacture (“Model Year”) from the date listed on the vehicle registration.
2. The EMS Agency Director 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 of the operator and shall not be transferable to another ambulance vehicle.
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.
4. An ambulance vehicle license will be closed upon removal from service or sale.
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 ambulance vehicle business license may be renewed up to twelve (12) years from date of manufacture provided licensure and all requirements are continuously maintained from license issuance.
- C. Any ambulance vehicle for which licensure fees are not paid 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. Vehicle Sale or Removal From Service

EFFECTIVE: 09-01-10  
REVISED: XX-XX-XX  
SUPERSEDES: 07-01-19

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APPROVED: \_\_\_\_\_  
Director, EMS Agency

\_\_\_\_\_  
Medical Director, EMS Agency

- A. Following the sale, removing from service or vehicle has “aged out” by reaching its twelve (12) year anniversary from date of manufacture, 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.
    - b. Affix the seal removed from the vehicle.
  4. Submit the completed form with the seal to the EMS Agency within ten (10) calendar days.

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**

Reference No. 455, Private Ambulance Vehicle Age Limit and Licensure

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	6/18/25	6/18/2025	No
	Base Hospital Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

SUBJECT: **GUIDELINES FOR HOSPITALS REQUESTING  
DIVERSION OF ALS/BLS PATIENTS**

(HOSPITAL)  
REFERENCE NO. 503

**PURPOSE:** To outline the procedure for receiving hospitals and EMS providers to request diversion of advanced life support (ALS) and basic life support (BLS) patients.

**AUTHORITY:** Health & Safety Code, Division 2.5, Sections, 1797.220  
California Code of Regulations, Title 13, Section 1105 (c)

**DEFINITIONS:**

**Advanced Life Support Patient (ALS):** A patient who requires paramedic assessment and/or intervention listed in Ref. No. 803, Los Angeles County Paramedic Scope of Practice, this includes but not limited to patients meeting Base contact requirements outlined in Ref. No. 1200, Treatment Protocols, et al.

**Basic Life Support Patient (BLS):** A patient who only requires Emergency Medical Technician (EMT) assessment and/or intervention as listed in Ref. No. 802, Emergency Medical Technician (EMT) Scope of Practice.

**PRINCIPLE:**

1. A receiving hospital may request diversion of 9-1-1 ALS and/or BLS patients away from its emergency department (ED) when unable to care for additional patients due to inadequate staffing, equipment, and/or critical systems or infrastructure.
2. An EMS provider agency may request diversion of 9-1-1 ALS and/or BLS patient away from an ED that is unable to assume care of the patient due to prolonged ambulance patient offload time as outlined in Ref. No. 503.1
3. Base hospitals will honor diversion requests based on patient condition and available system resources.
4. Hospital diversion data are used in EMS system analysis, and to formulate critical early indicators of syndrome-specific illness outbreaks within the County.

**POLICY:**

- I. In general, diversion requests shall be communicated through the ReddiNet system.
- II. Each hospital shall maintain a current diversion policy which requires the decision to request diversion be made jointly by representatives of the hospital's administration, emergency department, specialty services, and nursing. The name and title of the authorizing hospital administrator or designee are required to complete the diversion request process.

EFFECTIVE: 2-01-88  
REVISED: XX-XX-XX  
SUPERCEDES: 01-01-22

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APPROVED: \_\_\_\_\_  
Director, EMS Agency

\_\_\_\_\_  
Medical Director, EMS Agency

- III. EMS Agency staff may perform unannounced site visits to hospitals requesting diversion to ensure compliance with these guidelines.

PROCEDURE:

- A. Receiving hospitals are responsible for maintaining and updating ReddiNet diversion status to ensure that accurate information is available for patient destination decisions. Telephone communication is necessary when the ReddiNet system is not operational or when a hospital is requesting diversion due to ED BLS or internal disaster. The Medical Alert Center (MAC) shall be notified via telephone at (866) 940-4401.
- B. Diversion Request Categories
1. ED Saturation (ED ALS, ED BLS, Provider ED) – ED resources (beds, equipment and/or staff are fully committed or are not sufficient to care for additional incoming ALS and/or BLS patients. The procedure for requesting diversion due to ED saturation shall be in accordance with Ref. No. 503.1, Diversion Request Requirements for Emergency Department Saturation. ED BLS Diversion requires approval by the EMS Agency Administrator On-Duty (AOD) via the Medical Alert Center.
  2. Computerized Tomography (CT) Scanner – Hospital is unable to provide essential diagnostic procedures due to lack of a functioning CT scanner.
  3. Trauma (trauma centers and pediatric trauma centers only) – Hospital is unable to care for additional trauma patients because the trauma team is fully committed caring for trauma patients. The rationale for a temporary diversion request shall be communicated via the ReddiNet system using the applicable reason code. Reason codes include the following:
    - a. Critical Equipment Unavailable: Diversion may be requested when critical equipment essential to definitive diagnosis or treatment of trauma patients is unavailable.
    - b. Operating Room (OR) Unavailable: Diversion may be requested when both the primary and the back-up ORs and staff are fully encumbered caring for trauma patients to the extent that the care of additional trauma patients may be jeopardized.
    - c. Trauma Team Encumbered: Diversion may be requested when trauma resources, including the trauma surgeon, are fully encumbered to the extent that the care of additional trauma patients may be jeopardized.
    - d. Other: For any other circumstances in which the trauma center may become temporarily unable to meet contractual requirements, to the extent that the care of certain trauma patients may be jeopardized, the trauma center shall contact the EMS Agency to request a waiver in advance of the diversion. If a waiver is granted, the hospital and the MAC will jointly ensure that affected base hospitals and EMS provider agencies are properly advised of the nature and extent of the waiver.

4. Pediatric Medical Center (PMC) – Diversion may be requested only when critical equipment essential to definitive diagnosis or treatment of critical medical pediatric patients is unavailable. Lack of available Pediatric Intensive Care Unit beds alone is not sufficient cause to request PMC diversion.
  
5. ST Elevation Myocardial Infarction (STEMI) (STEMI receiving centers only) – Diversion may be requested only when all cardiac catheterization laboratories (cath labs) are fully encumbered caring for STEMI patients, to the extent that the care of additional STEMI patients may be jeopardized. ED saturation is not sufficient cause to request SRC Diversion. The SRC may request STEMI diversion under any of the following conditions:
  - a. The SRC is unable to perform emergent percutaneous coronary intervention because the cardiac cath staff is already fully committed to caring for STEMI patients in the cath lab. STEMI patients should be transported to the most accessible open SRC regardless of ED diversion status.
  
  - b. The SRC experiences critical mechanical failure of essential cath lab equipment. SRCs must notify the EMS Agency SRC System Program Manager directly at (562) 378-1652 as to the nature of the mechanical failure or equipment issue if the anticipated diversion is expected to exceed 24 hours.
  
6. Stroke
  - a. Primary Stroke Center (PSC): Diversion may be requested only when there is no means to perform diagnostic brain imaging – CT scan or MRI. The reason for diversion must be documented in ReddiNet. ED saturation is not sufficient cause to request PSC diversion.
  
  - b. Comprehensive Stroke Center (CSC): Hospital is unable to care for additional stroke patients because the stroke team is fully committed caring for stroke patients. The rationale for a temporary diversion request shall be communicated via the ReddiNet system using the applicable reason code. Reason codes include the following:
    - i. Critical Equipment Unavailable: Diversion may be requested when critical equipment essential to definitive diagnosis or treatment of stroke patients is unavailable.
  
    - ii. Interventional Radiology (IR) Room Unavailable: Diversion may be requested when both the primary and back-up IRs and staff are fully encumbered caring for stroke patients to the extent that the care of additional stroke patients may be jeopardized.
  
    - iii. Stroke Team Encumbered: Diversion may be requested when stroke resources, are fully encumbered to the extent that the care of additional stroke patients may be jeopardized.

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7. Extracorporeal Cardiopulmonary Resuscitation (ECPR) – Diversion may be requested when the hospital has no means to perform ECPR due to lack of available qualified personnel, lack of critical resources or no pumps. ED saturation is not sufficient cause to request ECPR diversion. ECPR diversion does not divert patients in cardiac arrest with the exception of patients meeting ECPR criteria for whom another ECPR receiving facility is available within the 30-minute transport time.
  8. Internal Disaster – Diversion of both ALS and BLS patients may be requested when a facility disruption threatens the ED or significant patient care services, to the extent that care of additional patients may be jeopardized.
    - a. A hospital requesting diversion due to internal disaster must notify the MAC by telephone and provide the name of the administrator authorizing the diversion and the rationale for internal disaster. Appropriate rationale include:
      - i. Power outage impacting patient care, which cannot be sufficiently mitigated by emergency generators
      - ii. Critical infrastructure or systems failure impacting patient care, which cannot be sufficiently mitigated by emergency back-up procedures
      - iii. Fire
      - iv. Bomb threat/explosion
      - v. Flooding
      - vi. Water disruption/contamination
      - vii. Hazardous materials contamination of patient care areas
      - viii. Other – Must be approved by the EMS Agency through the MAC or Health Facilities Inspection Division of the Department of Public Health. **Internal Disaster does not apply to work actions.**
    - b. For situations in which a hospital knows in advance that it will need to divert to internal disaster, hospital shall notify the EMS Agency in writing, well in advance of the scheduled diversion. It is the responsibility of the hospital to notify area base hospital(s) and all affected EMS provider agencies.
    - c. Upon request by the EMS Agency, a hospital shall submit an after-action report within 60 days of the incident when a hospital's diversion due to internal disaster is greater than four (4) hours.

CROSS REFERENCE:

Prehospital Care Manual:

- Ref. No. 502, **Patient Destination**
- Ref. No. 503.1, **Diversion Request Requirements for Emergency Department Saturation**
- Ref. No. 503.2, **Diversion Request Quick Reference Guide**
- Ref. No. 506, **Trauma Triage**
- Ref. No. 508, **Sexual Assault Patient Destination**
- Ref. No. 510, **Pediatric Patient Destination**
- Ref. No. 511, **Perinatal Patient Destination**
- Ref. No. 512, **Burn Patient Destination**
- Ref. No. 513, **ST Elevation MI Patient Destination**
- Ref. No. 516, **Cardiac Arrest Patient Destination**
- Ref. No. 802, **Emergency Medical Technician (EMT) Scope of Practice**
- Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**

Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS/BLS Patients

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/12/2025	2/12/2025	No
	Base Hospital Advisory Committee	2/5/2025	2/5/2025	Yes
OTHER COMMITTEES/RESOURCES	Medical Council	3/3/2025	3/3/2025	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

**POLICY REVIEW - SUMMARY OF COMMENTS**

REFERENCE NO. 202.2  
(ATTACHMENT B)

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**REFERENCE NO. 503, Guidelines for Hospitals Requesting Diversion of ALS/BLS Patients**

<b>SECTION</b>	<b>COMMITTEE/DATE</b>	<b>COMMENT</b>	<b>RESPONSE</b>
Procedure,B,7	BHAC 02/05/2025	Add "lack of critical equipment" after 'lack of qualified personnel'	Adopted

### 3.3.10 POLICIES

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)  
REFERENCE NO. 503.2

SUBJECT: **DIVERSION REQUEST  
QUICK REFERENCE GUIDE**

TYPE OF DIVERSION	REQUEST VIA / DURATION	RATIONALE
ED Saturation – ED ALS	Request via ReddiNet. Diversion will be for 2 hours. ReddiNet will automatically re-open hospital at the end of 2 hours	All ED treatment bays are full and 30% or greater of ED has patients are either in Resuscitative or Immediate/Emergent conditions.
ED Saturation – ED BLS	Request via telephone to the Medical Alert Center. Diversion will be up to 4 hours. ReddiNet will automatically re-open hospital at the end of 4 hours.	Implemented on a case-by-case basis during periods of extreme surge of patients (i.e., disease outbreak/epidemic/pandemic). Hospital must have at least 3 ambulance patients (ALS/BLS) waiting for over <u>60 minutes</u> to transfer patient to hospital equipment.
ED Saturation – Provider ED ALS	EMS Provider must contact the Medical Alert Center. Diversion will be for 2 hours. ReddiNet will automatically re-open hospital at the end of 2 hours.	Hospital must have at least 3 ambulance patients (ALS/BLS) waiting for over <u>30 minutes</u> to transfer patient to hospital equipment.
Computerized Tomography (CT) Scanner	Request via ReddiNet, duration will be based on the resolution of inability to perform CT scans.	Unable to provide essential diagnostic procedures due to lack of a functioning CT scanner.
Trauma	Request via ReddiNet, duration will be based on the resolution of the rational for diversion.	Unavailable Critical Equipment or Operating Room, or Trauma Team Encumbered
Pediatric Medical Center (PMC)	Request via ReddiNet, duration will be based on the resolution of the rational for diversion.	Unavailable critical equipment that is essential to definitive diagnosis or treatment of medical pediatric patients. <i>Lack of available PICU beds alone is not sufficient cause to request PMC Diversion.</i>
ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC)	Request via ReddiNet, Diversion will be for 3 hours. ReddiNet will automatically re-open hospital at the end of 3 hours	Cardiac Catheterization laboratories (cath labs) are fully encumbered caring for STEMI patient or mechanical failure of critical cath lab equipment.
	Hospital must notify the EMS Agency SRC System Program Manager for mechanical failure/equipment issue that is expected to exceed 24 hours.	

TYPE OF DIVERSION	REQUEST VIA / DURATION	RATIONALE
Primary Stroke Center (PSC)	Requested via ReddiNet, Diversion will be for 2 hours. Reddinet will automatically re-open hospital at the end of 2 hours.	Unable to perform diagnostic brain imaging (CT scan or MRI).
Comprehensive Stroke Center (CSC)	Requested via ReddiNet, Diversion will be for 2 hours. Reddinet will automatically re-open at the end of 2 hours.	Unavailable Critical Equipment or Interventional Radiological (IR) Room, or Stroke Team Encumbered
Extracorporeal Cardiopulmonary Resuscitation (ECPR)_	Request via ReddiNet, duration will be based on the resolution of the rational for diversion.	Unavailable critical equipment or qualified personnel to perform ECPR. <i>ECPR diversion does not divert patients in cardiac arrest.</i>
Internal Disaster	Hospital must notify the Medical Alert Center via telephone, duration will be based on resolution of the rational for internal disaster.	Power Outage Critical infrastructure or system failure impacting patient care Fire Bomb threat/explosion Flooding Water disruption/contamination HAZMAT in patient care areas <i>Internal Disaster does not apply to work actions.</i>

Reference No. 503.2, Diversion Request Quick Reference Guide

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/12/2025	2/12/2025	No
	Base Hospital Advisory Committee	2/5/2025	2/5/2025	Yes
OTHER COMMITTEES/RESOURCES	Medical Council	3/3/2025	3/3/2025	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

**POLICY REVIEW - SUMMARY OF COMMENTS**

REFERENCE NO. 202.2  
(ATTACHMENT B)

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**REFERENCE NO.** 503.2, Diversion Request Quick Reference Guide

<b>SECTION</b>	<b>COMMITTEE/DATE</b>	<b>COMMENT</b>	<b>RESPONSE</b>
ED Saturation – ED BLS, Request Via / Duration	BHAC 02/05/2025	Change ‘Diversion will be for 4 hours.’ To ‘Diversion will be up to 4 hours.’	Adopted
ED Saturation – ED BLS, Rationale	BHAC 02/05/2025	Change word ‘crews’ to ‘patients’	Adopted
ED Saturation – Provider ED, Rationale	BHAC 02/05/2025	Change word ‘crews’ to ‘patients’	Adopted

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

SUBJECT: **ST-ELEVATION MYOCARDIAL INFARCTION (STEMI)  
PATIENT DESTINATION**

(PARAMEDIC, MICN)  
REFERENCE NO. 513

**PURPOSE:** To ensure that 9-1-1 patients with ST-elevation myocardial infarction (STEMI) are transported to the most appropriate facility that is staffed, equipped, and prepared to administer emergency and/or definitive care appropriate to the needs of a STEMI patient.

**AUTHORITY:** Health & Safety Code, Division 2.5, Sections, 1798

**DEFINITIONS:**

**ST-Elevation Myocardial Infarction (STEMI):** An acute myocardial infarction that generates ST-segment elevation on the prehospital 12-lead electrocardiogram (ECG).

**STEMI Receiving Center (SRC):** A facility licensed for a cardiac catheterization laboratory and cardiovascular surgery by the Department of Public Health, Health Facilities Inspection Division, and approved by the Los Angeles County EMS Agency as a SRC.

**PRINCIPLES:**

1. STEMI is a clinical diagnosis that is made based on the patient's presentation and the presence of ST-elevation on the electrocardiogram (ECG). The 12-lead ECG in the prehospital care setting plays a key role in determining the most appropriate treatment and destination for patients with suspected cardiac symptoms.
2. In all cases, the health and wellbeing of the patient is the overriding consideration in determining patient destination. Factors to be considered include: clinical presentation, severity, and stability of the patient's condition; current status of the SRC; anticipation of transport time; and request by the patient, family, guardian, or physician.
3. Prehospital identification and communication of STEMI can reduce critical "door-to-intervention" times for STEMI patients.

**POLICY:**

- I. A prehospital 12-lead ECG should be performed in accordance with the Ref. No. 1308, Cardiac Monitoring/12-lead ECG Medical Control Guideline.
- II. If the 12-lead ECG demonstrates STEMI (or manufacturer's equivalent) and this is consistent with the paramedic interpretation and/or the clinical presentation of the patient, transmit the 12-lead ECG directly to the receiving SRC. The provider impression is Chest Pain – STEMI (CPMI).
- III. For any patient with a software interpretation of STEMI on the 12-lead ECG where the paramedic provider impression differs or is uncertain, base contact should be

EFFECTIVE: 05-15-06  
REVISED: XX-XX-XX  
SUPERCEDES: 01-01-23

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APPROVED: \_\_\_\_\_  
Director, EMS Agency

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Medical Director, EMS Agency

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- established to clarify the provider impression and to determine the destination, including whether transport to the SRC is required.
- IV. In general, patients with a provider impression of Chest Pain – STEMI (CPMI), (including hypotensive patients with signs and symptoms consistent with cardiogenic shock) shall be transported to the most accessible open SRC if ground transport is 30 minutes or less regardless of service area boundaries.
  - V. Paramedics shall notify the receiving SRC and discuss catheterization (cath) lab activation criteria for all patients with a provider impression of Chest Pain – STEMI (CPMI), including 9-1-1 interfacility transports of patients with a STEMI 12-lead ECG from a non-SRC ED to an SRC.
  - VI. Provide properly labeled, at a minimum patient name and sequence number, 12-lead ECGs to the receiving facility (in either paper or electronic format) as part of the patient's prehospital medical record.
  - VII. Document the findings of the 12-lead ECG on the Patient Care Record.
  - VIII. STEMI patients should be transported to the most accessible SRC regardless of **ED Diversion** status.
  - IX. If ground transport time to **any** SRC is greater than 30 minutes, the patient shall be transported to the most accessible receiving facility.
  - X. If the closest SRC has requested **STEMI Diversion** (as per Ref. No. 503), STEMI patients, including STEMI patients complicated by out-of-hospital cardiac arrest (OHCA) should be transported to the **next** most accessible **open** SRC if ground transport time is less than 30 minutes.
  - XI. Interfacility Transfer of STEMI patients from a STEMI Referral Facility (SRF) Emergency Department to a SRC via the 9-1-1 system: SRFs are strongly encouraged to enter into interfacility transfer agreements with the most accessible SRC (See Ref. No. 320.2).
    - A. Patients are to be transported to the SRC as directed by the SRF physician (base hospital contact/notification guidelines apply).
    - B. Transport units may bypass the most accessible SRC to the prearranged receiving SRC within 30 minutes, if the EMS provider resources at the time of transport allow.

CROSS REFERENCE:

Prehospital Care Manual:

- Ref. No. 501, **Hospital Directory**
- Ref. No. 502, **Patient Destination**
- Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
- Ref. No. 506, **Trauma Triage**
- Ref. No. 513.1, **Interfacility Transport of the ST-Elevation Myocardial Infarction Patient**
- Ref. No. 516, **Cardiac Arrest Patient Destination**
- Ref. No. 517, **Private Provider Agency Transport/Response Guidelines**

- Ref. No. 1210, **Cardiac Arrest**
- Ref. No. 1211, **Cardiac Chest Pain**
- Ref. No. 1212, **Cardiac Dysrhythmia – Bradycardia**
- Ref. No. 1213, **Cardiac Dysrhythmia – Tachycardia**
- Ref. No. 1303, **Cath Lab Activation Algorithm**
- Ref. No. 1308, **Cardiac Monitoring/12-Lead ECG**

**POLICY REVIEW – COMMITTEE ASSIGNMENT**

REFERENCE NO. 202.1  
 (ATTACHMENT A)

**REFERENCE NO. 513, ST-Elevation Myocardial Infarction (STEMI) Patient Destination**

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSA ADVISORY	Base Hospital Advisory Committee	2/05/2025	2/05/2025	No
	Provider Agency Advisory Committee	2/12/2025	2/12/2025	No
OTHER COMMITTEES / RESOURCES	Medical Council	3/04/2025	3/04/2025	No
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

\*See Ref. No. 202.2, **Policy Review - Summary of Comments**

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

SUBJECT: **CARDIAC ARREST (NON-TRAUMATIC)  
PATIENT DESTINATION**

(PARAMEDIC, MICN)  
REFERENCE NO. 516

**PURPOSE:** To ensure that 9-1-1 patients in cardiopulmonary arrest (non-traumatic) are transported to the most appropriate facility that is staffed, equipped, and prepared to perform resuscitative measures.

This policy does not apply to traumatic arrest or to decompression emergencies. For traumatic arrest, refer to Ref. No. 506, Trauma Triage. For decompression emergencies, refer to Ref. No. 518, Decompression Emergencies/Patient Destination.

**AUTHORITY:** Health & Safety Code, Division 2.5, Sections, 1798

**DEFINITIONS:**

**Cardiac Etiology:** Sudden cardiac death from ischemic heart disease, congenital heart disease, channelopathy, or dysrhythmia. One presumes cardiac etiology when it is a sudden event without evidence of alternate causes (e.g. trauma, terminal illness, overdose, sepsis, drowning, or respiratory arrest).

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

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

**ST-Elevation Myocardial Infarction (STEMI):** An acute myocardial infarction that generates ST-segment elevation on the prehospital 12-lead electrocardiogram (ECG).

**STEMI Receiving Center (SRC):** An acute care facility licensed for a cardiac catheterization laboratory and cardiovascular surgery by the California Department of Public Health and designated by the Los Angeles County EMS Agency as a SRC.

**PRINCIPLES:**

1. In all cases, the health and well-being of the patient is the overriding consideration in determining patient destination. Factors to be considered include: clinical presentation, severity and stability of the patient's condition; current status of the SRC; anticipation of transport time; and request by the patient, family, guardian or physician.
2. Optimal post cardiac arrest treatment may include an interventional cardiac procedure in a significant percentage of patients.

EFFECTIVE: 02-01-12  
REVISED: XX-XX-XX  
SUPERCEDES: 10-01-24

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APPROVED: \_\_\_\_\_  
Director, EMS Agency

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Medical Director, EMS Agency

3. Resuscitation efforts for patients greater than 14 years of age who are in non-traumatic cardiopulmonary arrest should take place in the field until ROSC is achieved or the patient is pronounced. Transport of patients without ROSC is discouraged with the exception of patients who meet ECPR criteria, and are transported on a mechanical compression device.
4. For cardiac arrest in patients age 14 and younger, refer to Ref. No. 510, Pediatric Patient Destination.
5. Patients with refractory ventricular fibrillation (3 or more shocks) or EMS witnessed arrests of presumed cardiac etiology may benefit from transport to the SRC for consideration of percutaneous coronary intervention despite prolonged resuscitation.
6. Patients in cardiac arrest with hanging or submersion mechanisms are asphyxial in the large majority of cases and should be considered a medical cardiac arrest for field management and transport destination unless there is strong evidence of cervical spine injury.

POLICY:

- I. Establish base hospital contact for medical direction for all cardiac arrest patients who do not meet criteria for determination of death per Ref. No. 814, Determination/Pronouncement of Death in the Field.
- II. For patients with STEMI complicated by out-of-hospital cardiac arrest, direct contact with the receiving SRC shall be established for patient notification and/or to discuss cath lab activation criteria.
- III. Patients with non-traumatic cardiac arrest who meet ALL of the following criteria should be transported to the closest ECPR Receiving Center if ground transport is 30 minutes or less regardless of service area boundaries:
  - A. Age  $\geq 15$  to  $\leq 75$  years old
  - B. Mechanical compression device (MCD) is available and the patient's body habitus can accommodate the use of the device
  - C. Initial shockable rhythm with refractory or recurrent ventricular fibrillation/ventricular tachycardia OR presumed massive pulmonary embolus given clinical circumstances of the arrest
  - D. Scene time can be limited to no more than 15 minutes (no system or patient factors that will significantly delay transport)
  - E. The patient does NOT: have a do-not-resuscitate order, known terminal illness, or baseline severe neurologic dysfunction.
- IV. For transports to the ECPR receiving center, contact should be made directly with the receiving ECPR center as soon as possible **while en route.**

- 
- V. Patients with non-traumatic cardiac arrest who do not meet ECPR criteria shall be transported to the most accessible SRC if ground transport is 30 minutes or less regardless of service area boundaries including:
- A. Patients with sustained ROSC
  - B. Patients with ROSC who re-arrest en route
  - C. Patients with persistent cardiac arrest for whom the Base Physician determines transport is required, because futility is not met despite lack of ROSC with on scene resuscitation
  - D. Patients transported on Base judgment for ECPR when the closest SRC is an ECPR receiving center
  - E. Patients who have progressed into cardiopulmonary arrest while en route and had a pre-arrest STEMI 12-lead ECG.
- VI. For patients who deteriorate into out-of-hospital cardiac arrest while en route to the most assessible receiving facility (MAR), rerouting to the closest SRC should be considered when feasible based on available resources and estimated transport times.
- VII. Cardiac arrest patients should be transported to the most accessible SRC (and ECPR receiving center when applicable) regardless of **ED Diversion** status.
- VIII. If ground transport time to a SRC is greater than 30 minutes, the patient shall be transported to the MAR.
- VI. For ECPR patients: If the closest ECPR receiving center is on ECPR diversion AND there is another ECPR center available within a 30 minute transport, consideration should be made to route to the next open ECPR center if total time from cardiac arrest to that ECPR center is less than 60 minutes. If no open ECPR center is reachable within these time intervals, the patient shall be transported to the closest SRC regardless of ECPR status.
- VII. If the closest SRC has requested **STEMI Diversion** (as per Ref. No. 503), cardiac arrest patients with STEMI should be transported to the **next** most accessible **open** SRC if ground transport time is less than 30 minutes, otherwise transport will continue to the closest SRC. Cardiac arrest patients without STEMI should be routed to the closest SRC regardless of ED or STEMI Diversion status.

CROSS REFERENCE:

Prehospital Care Manual:

- Ref. No. 501, **Hospital Directory**
- Ref. No. 502, **Patient Destination**
- Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
- Ref. No. 506, **Trauma Triage**
- Ref. No. 510, **Pediatric Patient Destination**
- Ref. No. 517, **Private Provider Agency Transport/Response Guidelines**
- Ref. No. 518, **Decompression Emergencies/Patient Destination**

SUBJECT: **CARDIAC ARREST (NON-TRAUMATIC)**  
**PATIENT DESTINATION**

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REFERENCE NO. 516

Ref. No. 814, **Determination/Pronouncement of Death in the Field**  
Ref. No. 1210, **Cardiac Arrest**  
Ref. No. 1303, **Algorithm for Cath Lab Activation**  
Ref. No. 1308, **Cardiac Monitoring/12-Lead ECG**

Reference No. 516, Cardiac Arrest (Non-Traumatic) Patient Destination

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/12/2025	2/12/2025	No
	Base Hospital Advisory Committee	2/5/2025	2/5/2025	No
OTHER COMMITTEES/RESOURCES	Medical Council	3/3/2025	3/3/2025	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

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

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**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 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.

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EFFECTIVE: 05-01-92  
REVISED: XX-XX-XX  
SUPERSEDES: 01-01-22

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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. 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.  
  
If 9-1-1 air transport is being utilized, 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.

- 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.**

- 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.

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

1. Once appropriate transfer arrangements have been made, AHM shall contact a private air ambulance provider directly and request air transport for an IFT. AHM 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
- f. Patient destination
- g. Payer source (if any)

2. If the transport is declined AHM shall contact Baywatch Avalon to assist in arranging transportation.

3. AHM shall notify Baywatch Avalon for transportation coordination once arrangements have been made .

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

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**

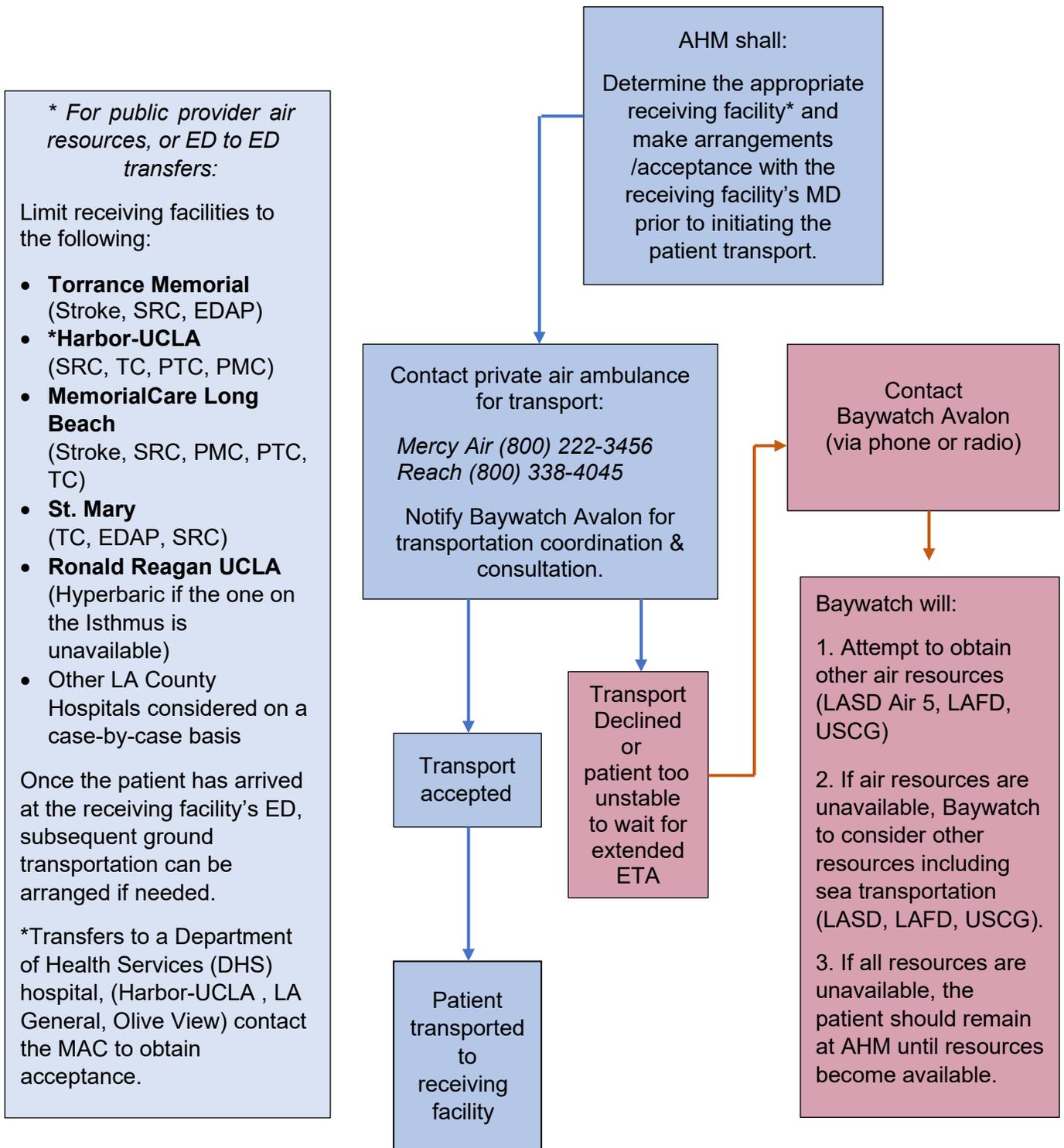
Reference No. 520, Transport/Transfer of Patients form Catalina Island

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	6/18/25	6/18/2025	No
	Base Hospital Advisory Committee	6/11/25	6/11/2025	No
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES  
 COUNTY OF LOS ANGELES

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



SUBJECT: **BEHAVIORAL / PSYCHIATRIC CRISIS  
PATIENT DESTINATION**

(PARAMEDIC)  
REFERENCE NO. 526

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

**AUTHORITY:** Health & Safety Code, Division 2.5, Chapter 13  
Health & Safety Code, Division 5, Sections 1797.220, 1798  
California Code of Regulations, Title 22, Division 9, Chapter 3.3

**DEFINITIONS:**

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

**Emergency Medical Condition:** A condition or situation in which an individual has an immediate need for medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure, and oxygen saturation – except isolated asymptomatic hypertension) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification (Ref. No. 1200.2) are also considered to have an emergency medical condition.

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

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

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

- Acting on a suicide threat

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EFFECTIVE: 10-01-20  
REVISED: XX-XX-XX  
SUPERSEDES: 04-01-23

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APPROVED: \_\_\_\_\_

Director, EMS Agency

Medical Director, EMS Agency

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

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

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

PRINCIPLES:

1. EMS provider agencies must be approved by the Emergency Medical Services (EMS) Agency to triage patients with behavioral/psychiatric crisis to a designated PUCC.
2. Paramedics and Advanced Practice Providers who have completed the EMS Agency approved provider training regarding the triage of patients to a PUCC are the only EMS personnel authorized to utilize this policy.
3. Patients experiencing a behavioral/psychiatric crisis who have altered level of consciousness (ALOC) must be transported to an emergency department for evaluation.
4. Patients exhibiting mental health crisis who meet PUCC inclusion criteria may also be released at the scene to the local law enforcement agency. Law enforcement officers are highly encouraged to transport these patients to a designated PUCC. Paramedics shall document on the EMS Report Form to whom the patient was released.
5. Patients receiving olanzapine who are cooperative and meet the criteria for screening as per *Ref. 526.1 Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center (PUCC)*, may be transported by EMS (basic life support) or released to law enforcement to the PUCC.
6. In instances where there is a potential for the patient to harm self or others, EMS personnel shall consider seeking assistance from law enforcement.
7. Any patient who meets the triage criteria for transport to a PUCC, but who requests to be transported to an emergency department of a general acute care hospital, shall be transported to the emergency department of a general acute care hospital.
8. In all cases, the health and well-being of the patient is the overriding consideration in determining patient destination. Factors to be considered include severity and stability of the patient's illness or injury; status of the receiving facility; anticipated transport time; requests by the patient, family, guardian or physician; and EMS personnel and base hospital judgment.

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POLICY:

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

A. Inclusion Criteria – patients who meet the following criteria may be triaged for transport to a designated PUCC if ground transport is 30 minutes or less:

1. Provider impression of behavior/psychiatric crisis; and
  - a. Voluntarily consented or 5150 hold; and
  - b. Ambulatory, does not require the use of a wheelchair; and
  - c. No emergent medical condition or trauma (with exception of ground level fall with injuries limited to minor abrasions below the clavicle); and
  - d. No focal neurological deficit
2. Age:  $\geq 18$  years and  $\leq 65$  years old
3. Vital Signs
  - a. Heart rate  $\geq 60$  bpm and  $\leq 120$  bpm
  - b. Respiratory rate  $\geq 12$  rpm and  $\leq 24$  rpm
  - c. Pulse oximetry  $\geq 94\%$  on room air
  - d. SBP  $\geq 100$  and  $< 180$  mmHg

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

4. Glasgow Coma Scale (GCS) Score of  $\geq 14$
5. If history of Diabetes Mellitus, no evidence of ketoacidosis and a blood glucose  $\geq 60$  mg/dL and  $< 250$  mg/dL

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

1. Any emergent medical condition
2. Focal neurological deficit
3. Any injury that meet trauma center criteria or guideline

4. Complaint of chest pain, shortness of breath, abdominal/pelvic pain, or syncope
5. Open wounds or bleeding
6. Intoxication of drugs and/or alcohol
7. Suspected pregnancy
8. Requires special medical equipment
9. Intellectual or developmental disability
10. Exhibits dangerous behavior
11. Patients treated with midazolam for agitation (Reference No. 1209, Behavioral/Psychiatric Crisis)
12. EMS personnel feels the patient is not stable enough for PUCC

CROSS REFERENCES:

Prehospital Care Manual:

- Ref. No. 326, **Psychiatric Urgent Care Center (PUCC) Standards**  
Ref. No. 502, **Patient Destination**  
Ref. No. 526.1, **Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center**  
Ref. No. 913, **Triage to Alternate Destination (TAD) Paramedic Training Provider Program Requirements**  
Ref. No. 1200.3 **Provider Impressions**  
Ref No. 1209 **Behavioral/Psychiatric Crisis**

**POLICY REVIEW – COMMITTEE ASSIGNMENT**

REFERENCE NO. 202.1  
 (ATTACHMENT A)

**REFERENCE NO. 526, Behavioral/Psychiatric Crisis Patient Destination**

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSA ADVISORY	Base Hospital Advisory Committee	8/13/2025	08/13/2025	No
	Provider Agency Advisory Committee	8/20/2025	08/20/2025	Yes
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other: DRC Coordinators			

\*See Ref. No. 202.2, **Policy Review - Summary of Comments**

**POLICY REVIEW - SUMMARY OF COMMENTS**

REFERENCE NO. 202.2  
(ATTACHMENT B)

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**REFERENCE NO.** 526, Behavioral/Psychiatric Crisis Patient Destination

<b>SECTION</b>	<b>COMMITTEE/DATE</b>	<b>COMMENT</b>	<b>RESPONSE</b>
Principles, 2	PAAC 08/21/2025	Add: 'and Advanced Practice Providers" after 'Paramedics'	Change Made

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

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

**AUTHORITY:** Health & Safety Code, Division 2.5, Chapter 13  
Health & Safety Code, Division 5, Sections 1797.220, 1798  
California Code of Regulations, Title 22, Division 9, Chapter 3.3

**DEFINITIONS:**

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

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

**Emergency Medical Condition:** A condition or situation in which an individual has an immediate need for medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure, and oxygen saturation – except isolated asymptomatic hypertension) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification (Ref. No. 1200.2) are also considered to have an emergency medical condition.

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

**PRINCIPLES:**

1. EMS provider agencies must be approved by the Emergency Medical Services (EMS) Agency to triage patients with alcohol intoxication to a designated SC.
2. Paramedics and Advanced Practice Providers who have completed the EMS Agency approved provider training regarding the triage of patients to a SC are the only EMS personnel authorize to utilize this policy.

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EFFECTIVE: 10-01-20  
REVISED: XX-XX-XX  
SUPERSEDES: 04-01-23

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APPROVED:

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Director, EMS Agency

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Medical Director, EMS Agency

3. Patients exhibit alcohol intoxication who meet SC inclusion criteria may also be released at scene to local law enforcement agency. Law enforcement officers are highly encouraged to transport these patients to a designated SC. Paramedics shall document on the EMS Report Form to whom the patient was released.
4. In instances where there is potential for the patient to harm self or others, EMS personnel shall consider seeking assistance from law enforcement.
5. Any patient who meets the triage criteria for transport to a SC, but who requests to be transported to an emergency department of a general acute care hospital, shall be transported to the emergency department of a general acute care hospital.
6. In all cases, the health and well-being of the patient is the overriding consideration in determining patient destination. Factors to be considered include severity and stability of the patient's illness or injury; status of the receiving facility; anticipated transport time; requests by the patient, family, guardian or physician; and EMS personnel and base hospital judgment.

POLICY:

I. Sobering Center (SC) Patient Triage Criteria

- A. Inclusion Criteria – patients who meet the following criteria may be triaged for transport to a designated SC provided the SC if ground transport is 30 minutes or less:
  1. Provider impression of alcohol intoxication (found on the street, a shelter or in police custody); and
    - a. Voluntarily consented or have implied consent to go to the SC; and
    - b. Cooperative and do not require restraints; and
    - c. Ambulatory, does not require the use of a wheelchair; and
    - d. NO emergent medical condition or trauma (with exception of ground level fall with injuries limited to minor abrasions below the clavicle); and
    - e. No focal neurological deficit
  2. Age:  $\geq 18$  years old and  $\leq 65$  years old
  3. Vital Signs
    - a. Heart rate  $\geq 60$  bpm and  $\leq 120$  bpm
    - b. Respiratory rate  $\geq 12$  rpm and  $\leq 24$  rpm
    - c. Pulse oximetry  $\geq 94\%$  on room air

- d. SBP  $\geq$ 100 and  $<$ 180 mmHg

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

4. Best Glasgow Coma Scale (GCS) Score of  $\geq$ 14.

Best GCS – upon initial assessment, an inebriated person may not have spontaneous eye opening without stimulation and may not be fully oriented which = GCS of 13. Upon secondary assessment, if eyes remain open with minimal confusion, GCS is 14 and meets criteria.

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

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

1. Any emergent medical condition
2. Focal neurological deficit or change from baseline
3. Any injury that meet trauma center criteria or guideline
4. Complaint of chest pain, shortness of breath, abdominal/pelvic pain, or syncope
5. Bleeding including any hemoptysis or GI bleed
6. Suicidal ideations
7. On anticoagulants
8. Suspected pregnancy
9. Bruising or hematoma above the clavicles
10. Intellectual or developmental disability
11. EMS personnel feels the patient is not stable enough for SC

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 328, **Sobering Center (SC) Standards**

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- Ref. No. 328.1, **Designated Sobering Center Roster**
- Ref. No. 502, **Patient Destination**
- Ref. No. 528.1, **Medical Clearance Criteria Screening Tool for Sobering Center**
- Ref. No. 913, **Triage to Alternate Destination (TAD) Paramedic Training Provider Program Requirements**
- Ref. No. 1200.3 **Provider Impressions**
- Ref. No. 1241 **Overdose/Poisoning/Ingestion**

**POLICY REVIEW – COMMITTEE ASSIGNMENT**

REFERENCE NO. 202.1  
 (ATTACHMENT A)

**REFERENCE NO. 528, Intoxicated (Alcohol) Patient Destination**

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMSA ADVISORY	Base Hospital Advisory Committee	8/13/2025	08/13/2025	No
	Provider Agency Advisory Committee	8/20/2025	08/20/2025	Yes
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other: DRC Coordinators			

\*See Ref. No. 202.2, **Policy Review - Summary of Comments**

**POLICY REVIEW - SUMMARY OF COMMENTS**

REFERENCE NO. 202.2  
(ATTACHMENT B)

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**REFERENCE NO.** 528, Intoxicated (Alcohol) Patient Destination

<b>SECTION</b>	<b>COMMITTEE/DATE</b>	<b>COMMENT</b>	<b>RESPONSE</b>
Principles, 2	PAAC 08/21/2025	Add: 'and Advanced Practice Providers" after 'Paramedics'	Change Made

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

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

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

**AUTHORITY:** California Health and Safety Code, Division 10, Uniform Controlled Substances Act  
California Health and Safety Code, Division 2.5, Chapter 5, Section 1798.  
California Code of Regulations, Title 22, Chapter 3.3, Article 6, Section 100096.01.  
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 statement, “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 utilization 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.
  - D. Each provider agency shall have policies and procedures, reviewed, approved,

EFFECTIVE DATE: 06-08-76

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REVISED: XX-XX-XX

SUPERSEDES: 10-01-19

APPROVED: \_\_\_\_\_  
Director, EMS Agency

\_\_\_\_\_  
Medical Director, EMS Agency

and signed by the provider agency Medical Director, in place for the procurement, transport, storage, distribution, and disposal of restricted drugs and devices. These policies 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 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 expired medications;
  - c. Proper 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 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 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. 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 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 provider 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 units, from low volume to high volume utilizers.
    - ii. The Medical Director of the provider agency may temporarily reduce the minimum inventory par levels.
    - iii. Provider agencies 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 provider agency may contact the LAC EMS Agency to obtain approval to receive pharmaceuticals from the disaster preparedness pharmaceutical cache.
  - 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. Dilution of a medication to achieve the desired formulation (e.g., epinephrine 1mg/mL to achieve epinephrine 0.1mg/mL).
  - c. Change in formulation of a medication that is not on the LAC EMS Agency approved list of formulations (Ref. MCG 1309).
  - 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 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 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**

Reference No. 701, Supply and Resupply of Designated Provider Units/Vehicles

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	6/18/25	6/18/2025	Yes
	Base Hospital Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council	6/6/25	6/3/2025	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

**POLICY REVIEW - SUMMARY OF COMMENTS**

REFERENCE NO. 202.2  
(ATTACHMENT B)

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**Reference No. 701, Supply and Resupply of Designated Provider Units/Vehicles**

<b>SECTION</b>	<b>COMMITTEE/DATE</b>	<b>COMMENT</b>	<b>RESPONSE</b>
Policy I, A.	PAAC 6/18/2025	Add 'utilization' after 'track'	Revised

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC)  
REFERENCE NO. 710

SUBJECT: **BASIC LIFE SUPPORT AMBULANCE EQUIPMENT**

**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

**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.

EFFECTIVE: 06-30-78  
REVISED: XX-XX-XX  
SUPERSEDES: 07-01-23

PAGE 1 OF 6

APPROVED:

\_\_\_\_\_  
Director, EMS Agency

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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. <ul style="list-style-type: none"> <li>If soft ties are used, they should be at least three inches wide (before tying) to maintain a two-inch width while in use.</li> </ul>	1 set
Automated External Defibrillator (AED) <ul style="list-style-type: none"> <li>Razor/Trimmer</li> </ul>	1 each
Adult AED Defibrillation Pads	2
Bandages, 4 in. sterile compresses or equivalent	12
Bag-valve device with O <sub>2</sub> inlet and reservoir <ul style="list-style-type: none"> <li>Bag Volume 400-700 mL <sup>1</sup></li> <li>Bag Volume 900-1500 mL <sup>1</sup></li> </ul>	1 each
Bag-valve mask <ul style="list-style-type: none"> <li>Large</li> <li>Medium</li> <li>Small adult/child</li> <li>Toddler</li> <li>Infant</li> <li>Neonate</li> </ul>	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: <ul style="list-style-type: none"> <li>Thigh</li> <li>Adult</li> <li>Child</li> <li>Infant</li> </ul>	1 each
*Cervical Collars, rigid: <ul style="list-style-type: none"> <li>Adult</li> <li>Child</li> <li>Infant *2 pediatric adjustable meets infant requirement</li> </ul>	2 each
Dextrose – glucose paste/gel	15gms
Emesis basin, disposable bags or covered containers	1
Hemostatic dressings—EMS Authority approved dressings only - <b>optional</b>	2

MINIMUM INVENTORY	QUANTITIES
Immobilizer, Head: <ul style="list-style-type: none"> <li>• Disposable or Reusable</li> </ul>	2
Linen: <ul style="list-style-type: none"> <li>• Sheets</li> <li>• Pillows</li> </ul>	4 2
<b>Manometer (Optional)</b>	2
Obstetrical supplies, sterile, including (no scalpel): <ul style="list-style-type: none"> <li>• Gloves</li> <li>• Umbilical cord clamps</li> <li>• Dressings, towels</li> <li>• Scissors</li> <li>• Bulb syringe</li> <li>• Clear plastic bag</li> </ul>	1 kit or supplies as indicated
Oropharyngeal airways: <ul style="list-style-type: none"> <li>• Two (2) adult</li> <li>• Two (2) children</li> <li>• One (1) infant</li> <li>• One (1) newborn</li> </ul>	6
Oxygen cannulas <ul style="list-style-type: none"> <li>• Adult</li> <li>• Child</li> </ul>	1 each
Oxygen masks, non-rebreather <ul style="list-style-type: none"> <li>• Adult</li> <li>• Child</li> <li>• Infant</li> </ul>	1 each
Oxygen masks, simple <b>(Optional)</b> <ul style="list-style-type: none"> <li>• Adult</li> <li>• Child</li> <li>• Infant</li> </ul>	1 each
Oxygen, portable <ul style="list-style-type: none"> <li>• "D" or "E" FULL cylinder with one (1) oxygen flow control regulator for use between both cylinders</li> </ul>	1
Oxygen, vehicle (house) <ul style="list-style-type: none"> <li>• "M" or "H" cylinder with a minimum of 1000 psi and one (1) oxygen flow control regulator</li> </ul>	1
Personal Protective Equipment (PPE) (Personal Body Substance Isolation Equipment) <ul style="list-style-type: none"> <li>• mask</li> <li>• gown</li> <li>• eye protection</li> </ul>	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 <ul style="list-style-type: none"> <li>• Cardboard splints (recommended for general use)</li> <li>• Inflatable air splints (recommended to immobilize lower arms and lower legs) <b>(Optional)</b></li> </ul>	4 each
Splint, traction	1
Stretchers: <ul style="list-style-type: none"> <li>• Stretchers with wheels and the following: <ul style="list-style-type: none"> <li>○ mattresses should be covered with impervious plastic material or the equivalent</li> <li>○ have the capability to elevate both the head and foot</li> <li>○ straps to secure the patient to the stretcher, including shoulders, waist, and legs</li> <li>○ a means of securing the stretcher in the vehicle</li> <li>○ adjustable to four different levels</li> </ul> </li> </ul>	1
<ul style="list-style-type: none"> <li>• Collapsible stretcher and the following: <ul style="list-style-type: none"> <li>○ straps to secure the patient to the stretcher and a means of securing the stretcher in the vehicle</li> </ul> </li> </ul>	1
<ul style="list-style-type: none"> <li>• Device to secure a child or infant to the stretcher</li> </ul>	1
Suction equipment, portable, capable of at least: <ul style="list-style-type: none"> <li>• a negative pressure equivalent to 300mm of mercury</li> <li>• 30 liter per minute air flow rate for 30 minutes of operation.</li> </ul>	1
Suction equipment, vehicle (house), capable of at least: <ul style="list-style-type: none"> <li>• a negative pressure equivalent to 300mm of mercury</li> <li>• 30 liter per minute air flow rate for 30 minutes of operation</li> </ul>	1
Suction Tubing: <ul style="list-style-type: none"> <li>• Non-collapsible, plastic, semi-rigid, whistle-tipped, finger controlled type is preferred. *</li> <li>• Flexible catheters for tracheostomy suctioning (8Fr.-12Fr.)</li> </ul>	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 <b>(Optional)</b>	1

PERSONAL PROTECTION EQUIPMENT (PPE)*	QUANTITIES
Escape hood ( <b>Optional</b> )	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	2

AMBULANCE STRIKE TEAM ADDITIONAL SUPPLIES*	QUANTITIES
Ballistic vest, protective ( <b>Optional – risk dependent**</b> )	2
Field Operations Guide (FOG)	1
Footwear covers, single use	2 pairs
Duodote (atropine 2.1mg and pralidoxime chloride 600mg) or equivalent ( <b>Optional</b> )	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.

<sup>1</sup> **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**

Reference No. 710, Basic Life Support Ambulance Equipment

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	6/18/25	6/18/2025	No
	Base Hospital Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council	6/3/25	6/3/2025	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

(EMT/ PARAMEDIC/MICN)  
REFERENCE NO. 814

SUBJECT: **DETERMINATION / PRONOUNCEMENT  
OF DEATH IN THE FIELD**

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**PURPOSE:** This policy is intended to provide EMS personnel with parameters to determine whether or not to withhold resuscitative efforts in accordance with the patient's wishes, and to provide guidelines for base hospital physicians to discontinue resuscitative efforts and pronounce death.

**AUTHORITY:** California Health and Safety Code, Division 2.5  
California Probate Code, Division 4.7  
California Family Code, Section 297-297.5  
California Health and Safety Code, Division 1, Part 1.8, Section 443 et seq.

**DEFINITIONS:**

**Advance Health Care Directive (AHCD):** A written document that allows patients who are unable to speak for themselves to provide health care instructions and/or appoint a Power-of-Attorney for Health Care. There is no one standard format for an AHCD. Examples of AHCDs include:

- Durable Power of Attorney for Healthcare (DPAHC)
- Healthcare proxies
- Living wills (valid in California if dated prior to 7-1-2000; advisory but not legally binding after that date)

**Agent:** An individual, eighteen years of age or older, designated in a durable power of attorney for health care to make health care decisions for the patient, also known as "attorney-in-fact".

**Aid-in-Dying Drug:** A drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to terminal illness. The prescribed drug may take effect within minutes to several days after self-administration.

**Conservator:** Court-appointed authority to make health care decisions for a patient.

**Determination of Death:** To conclude that a patient has died by conducting an assessment to confirm the absence of respiratory, cardiac, and neurologic function.

**End of Life Option Act:** This California state law authorizes an adult, eighteen years or older, who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease to make a request for an "aid-in-dying drug" prescribed for the purpose of ending his or her life in a humane and dignified manner.

**Immediate Family:** The spouse, domestic partner, parent, adult children, adult sibling(s), or family member intimately involved in the care of the patient.

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EFFECTIVE: 10-10-80  
REVISED: XX-XX-XX  
SUPERSEDES: 04-01-22

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APPROVED: \_\_\_\_\_  
Director, EMS Agency

\_\_\_\_\_  
Medical Director, EMS Agency

**Organized ECG Activity:** A sinus, atrial or junctional (supraventricular) rhythm.

**Pronouncement of Death:** A formal declaration by a base hospital physician that life has ceased.

**Standardized Patient-Designated Directives:** Forms or medallions that recognize and accommodate a patient's wish to limit prehospital treatment at home, in long term care facilities, or during transport between facilities. Examples include:

- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form (Ref. No. 815.1)
- Physician Orders for Life-Sustaining Treatment (POLST, Ref. No. 815.2)
- State EMS Authority-approved DNR Medallion

**PRINCIPLES:**

1. Resuscitative efforts are of no benefit to patients whose physical condition precludes any possibility of successful resuscitation.
2. EMTs and paramedics may **determine** death based on specific criteria set forth in this policy.
3. Base hospital physicians may **pronounce** death based on information provided by the paramedics in the field and guidelines set forth in this policy.
4. If there is any objection or disagreement by family members or EMS personnel regarding terminating or withholding resuscitation, basic life support (BLS) resuscitation, including defibrillation, may continue or begin immediately and paramedics should contact the base hospital for further directions.
5. Aggressive resuscitation in the field to obtain the return of spontaneous circulation (ROSC) is encouraged. Transporting patients without ROSC is discouraged with the exception of patients who meet ECPR criteria and are transported on a mechanical compression device.
6. EMS personnel should honor valid do-not-resuscitate (DNR) orders and other patient designated end-of-life directives in the field and act in accordance with the patient's wishes when death appears imminent.

**POLICY:**

- I. EMS personnel may determine death in the following circumstances:
  - A. In addition to the absence of respiration, cardiac activity, and neurologic reflexes, one or more of the following physical or circumstantial conditions exist:
    1. Decapitation
    2. Massive crush injury
    3. Penetrating or blunt injury with evisceration of the heart, lung or brain

4. Decomposition
  5. Incineration
  6. Pulseless, non-breathing victims with extrication time greater than fifteen minutes, where no resuscitative measures can be performed prior to extrication.
  7. Penetrating trauma patients who, based on the paramedic's thorough assessment, are found apneic, pulseless, asystolic, and without pupillary reflexes upon the arrival of EMS personnel at the scene.
  8. Blunt trauma patients who, based on a paramedic's thorough patient assessment, are found apneic, pulseless, and without organized ECG activity (sinus, atrial or junctional rhythm) due to traumatic mechanism upon the arrival of EMS personnel at the scene.
    - a. For patients with shockable ventricular rhythm, defibrillate as per TP 1243/1243-P in attempt to restore organized ECG activity prior to determination of death.
  9. Pulseless, non-breathing victims of a multiple victim incident where insufficient medical resources preclude initiating resuscitative measures.
  10. Drowning victims, when it is reasonably determined that submersion has been greater than one hour.
  11. Rigor mortis (requires assessment as described in Section I, B.)
  12. Post-mortem lividity (requires assessment as described in Section I, B.)
- B. If the initial assessment reveals rigor mortis and/or post-mortem lividity only, EMTs and/or paramedics shall perform the following assessments (may be performed concurrently) to confirm the absence of respiratory, cardiac, and neurologic function for determination of death in the field:
1. Assessment of respiratory status:
    - a. Assure that the patient has an open airway.
    - b. Look, listen and feel for respirations. Auscultate the lungs for a minimum of 30 seconds to confirm apnea.
  2. Assessment of cardiac status:
    - a. Auscultate the apical pulse for a minimum of 60 seconds to confirm the absence of heart sounds.
    - b. Adults and children: Palpate the carotid pulse for a minimum of 60 seconds to confirm the absence of a pulse.
-

- c. Infants: Palpate the brachial pulse for a minimum of 60 seconds to confirm the absence of a pulse.
    3. Assessment of neurological reflexes:
      - a. Check for pupillary response with a penlight or flashlight to determine if pupils are fixed and dilated.
      - b. Check and confirm unresponsive to pain stimuli.
  - C. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I. A. require immediate BLS measures to be initiated. If one or more of the following conditions is met, resuscitation may be discontinued and the patient is determined to be dead:
    1. A valid standardized patient-designated directive indicating DNR.
    2. A valid AHCD with written DNR instructions or the agent identified in the AHCD requesting no resuscitation.
    3. Immediate family member present at scene:
      - a. With a patient-designated directive on scene requesting no resuscitation
      - b. Without said documents at scene, with full agreement of immediate family requesting no resuscitation, and EMS providers concur
    4. Parent or legal guardian is required and must be present at scene to withhold or terminate resuscitation for patients less than 18 years of age.
- II. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I require immediate cardiopulmonary resuscitation in accordance with Ref. No. 1210, Treatment Protocol: Cardiac Arrest. Base contact for medical direction shall be established when indicated by Ref. No. 1210.
- A. EMS Personnel may determine death if a patient is in **asystole** after 20 minutes of quality cardiopulmonary resuscitation on scene and meets ALL of the following criteria:
    1. Patient 18 years or greater
    2. Arrest not witnessed by EMS personnel
    3. No shockable rhythm identified at any time during the resuscitation
    4. No ROSC at any time during the resuscitation
    5. No hypothermia
-

- 
- B. Base Physician consultation for pronouncement is not required if Section A is met.
  - C. Base Physician contact shall be established to guide resuscitation and to make decisions regarding timing of transport, if transport is indicated, for patients in cardiopulmonary arrest who do not meet the conditions described in Section I or IIA of this policy. ECPR candidates are transported prior to Base Contact.
  - D. In the event that immediate family members on scene request termination of resuscitation after resuscitation is in progress, and the patient does not meet criteria in section IIA, base physician consultation shall be made for termination and pronouncement. This does not apply to brief initiation of CPR while establishing patient/family wishes as per I.C.3.
- III. Physician guidelines for transport versus termination
- A. Resuscitation should be continued on-scene until one of the following:
    - 1. ROSC is confirmed with a palpable pulse and corresponding rise in EtCO<sub>2</sub> Paramedics should stabilize the patient on scene after ROSC (for approximately 5 minutes) per TP 1210 and initiate transport once ROSC is maintained.
    - 2. The patient is determined to be an ECPR candidate and has not achieved ROSC despite initial on scene resuscitation (scene time limited to ≤15 minutes prior to transport).
    - 3. Base physician determines further resuscitative efforts are futile
  - B. Patients who have NOT maintained ROSC after on-scene resuscitation and stabilization should NOT be transported unless the Base physician determines transport is indicated and/or the patient meets ECPR criteria.
    - 1. Early transport for patients with ongoing resuscitation is NOT advised.
    - 2. The decision to transport a patient with refractory OHCA should be based on the availability of therapies at the receiving center that are not available on scene.
- IV. Crime Scene Responsibility, Including Presumed Accidental Deaths and Suspected Suicides
- A. Responsibility for medical management rests with the most medically qualified person on scene.
  - B. Authority for crime scene management shall be vested in law enforcement. To access the patient, it may be necessary to ask law enforcement officers for assistance to create a "safe path" that minimizes scene contamination.
  - C. If law enforcement is not on scene, EMS personnel should attempt to create a "safe path" and secure the scene until law enforcement arrives.
-

V. Procedures Following Pronouncement of Death

- A. The deceased should not be moved without the coroner's authorization. Any invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient should be left in place.

**NOTE: If it is necessary to move the deceased because the scene is unsafe, the body is creating a hazard, or the body is at risk of loss through fire or flood, the EMS personnel may relocate the deceased to a safer location, or transport to the most accessible receiving facility.**

- B. If law enforcement or the coroner confirms that the deceased will not be a coroner's case and the personal physician is going to sign the death certificate, any invasive equipment used during the resuscitation may be removed.
- C. EMS personnel should remain on scene until law enforcement arrives. During this time, when appropriate, the provider should provide grief support to family members.

VI. Required Documentation for Patients Determined Dead/Pronounced in the Field

- A. The time and criteria utilized to determine death; the condition, location and position of the body, and any care provided.
- B. The location and the rationale if the deceased was moved. If the coroner authorized movement of the deceased, document the coroner's case number (if available) and the coroner's representative who authorized the movement.
- C. Time of pronouncement and name of the pronouncing physician if base hospital contact was initiated
- D. The name of the agent identified in the AHCD or patient-designated directive or the name of the immediate family member who made the decision to withhold or withdraw resuscitative measures. Obtain their signature on the EMS Report Form.
- E. If the deceased is **not** a coroner's case and their personal physician is going to sign the death certificate:
1. Document the name of the coroner's representative who authorized release of the patient, and
  2. The name of the patient's personal physician signing the death certificate, and
  3. Any invasive equipment removed

VII. End of Life Option Act

- A. Resuscitation shall be withheld on patients in cardiopulmonary arrest who have
-

self-administered an aid-in-dying drug (see Ref. No. 815.4, End of Life Option Field Quick Reference Guide).

- B. Document the presence of a Final Attestation and attach a copy if available.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 516, **Cardiac Arrest (Non-Traumatic) Patient Destination**

Ref. No. 518, **Decompression Emergencies/Patient Destination**

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

Ref. No. 606, **Documentation of Prehospital Care**

Ref. No. 815, **Honoring Prehospital Do Not Resuscitate Orders**

Ref. No. 815.1, **EMSA/CMA Prehospital Do Not Resuscitate (DNR) Form**

Ref. No. 815.2, **Physician Orders for Life-Sustaining Treatment (POLST) Form**

Ref. No. 815.3, **Sample - Final Attestation For An Aid-In-Dying Drug to End My Life in a  
Humane and Dignified Manner**

Ref. No. 815.4, **End of Life Option Field Quick Reference Guide**

Ref. No. 819, **Organ Donor Identification**

Reference No. 814, Determination/Pronouncement of Death in Field

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	4/16/25	4/16/2025	No
	Base Hospital Advisory Committee	4/9/2025	4/9/2025	No
OTHER COMMITTEES/RESOURCES	Medical Council	3/4/2025	3/4/2025	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

SUBJECT: **EMS PILOT AND SCIENTIFIC STUDIES**

REFERENCE NO. 830

**PURPOSE:** To provide a uniform procedure for acquiring authorization to conduct a pilot or a scientific study to perform additional prehospital treatment procedures or administer additional drugs not currently scope of practice.

**AUTHORITY:** Health & Safety Code, Division 2.5, Sections 1797.221, 24170-24179.5  
California Code of Regulations, Title 22, Division 9, Chapter 43.3, Article 2, Section 100091.02  
Federal Policy for the Protection of Human Subjects, DHHS Regulations 45 CRF 46, FDA Regulations-CRF Title 21

**DEFINITION:**

**Pilot or Scientific Study:** For the purposes of this policy, a pilot or scientific study is an evaluation of an intervention (i.e., medication, device, protocol, or other treatment) that is prospectively tested in a study population. Testing may include the introduction or withholding of the proposed intervention.

**Investigator(s):** The individual or team of individuals that is leading the pilot or scientific study.

**Institutional Review Board:** The Institutional Review Board (IRB) is a committee responsible for reviewing and approving all human subjects research to ensure the welfare of the participants is protected.

**PRINCIPLES:**

1. All pilot or scientific studies must be submitted for review and approval by the EMS Agency Medical Director or designee prior to implementation.
2. The EMS Agency Medical Director may approve or conduct a pilot or scientific study evaluating the safety, feasibility, and/or efficacy of the prehospital medication, device, protocol, or other treatment within the local EMS system involving EMTs and/or paramedics. The study shall be consistent with any requirements established by the California EMS Authority for pilot or scientific studies conducted within the prehospital emergency medical care system, and, where applicable, with the California Health and Safety Code, Division 104, Part 5, Chapter 6, Article 5, Section 111550-111610.
3. No medication, device, protocol, or other treatment that is specifically excluded by the California EMS Authority from use in the EMS system shall be included in a pilot or scientific study without the approval of the EMS Agency Medical Director and the California EMS Authority.
4. Any pilot or scientific study using data or information under the authority of, or maintained and managed by, the EMS Agency must be approved by the EMS Agency Director and Medical Director prior to implementation.

EFFECTIVE DATE: 06-01-79

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REVISED: XX-XX-XX

SUPERSEDES: 09-01-21

APPROVED: \_\_\_\_\_  
Director, EMS Agency

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Medical Director, EMS Agency

5. When applicable, IRB approval will be required prior to implementation of a pilot or scientific study at the discretion of the EMS Agency Medical Director.
6. Requests for implementation of procedures and/or medications currently approved for local additional scope or optional use within Los Angeles County are not subject to this policy. Such requests will be processed as identified per Los Angeles County Scope of Practice policies (Ref. No. 802 and 803) and applicable approved unit inventory policies.

**POLICY:**

- I. An investigator shall include the following information in a pilot or scientific study proposal submitted to the EMS Agency Medical Director:
  - A. Background material on the proposed intervention (i.e., relevant studies or other medical literature).
  - B. Statement of the pilot or study objective(s).
  - C. Proposed timeline and duration for the pilot or scientific study.
  - D. Description of the proposed intervention including medical conditions for which it will be used and the patient population that may benefit.
  - E. Description of the proposed pilot or scientific study design and the method for evaluating the effectiveness and the safety of the intervention.
  - F. Description of the data collection process.
  - G. Description of specific and measurable outcome(s) to evaluate safety, feasibility, and/or efficacy of the intervention.
  - H. Plan for quarterly reports that detail the descriptive characteristics and outcomes (safety and effectiveness) that will be collected and reported.
  - I. Recommended policies and procedures to be instituted by the EMS Agency regarding the use and medical control of the intervention used, if necessary.
  - J. A description of the training and competency testing required to implement the study. The pilot or scientific study should have a primary instructor who is knowledgeable, skilled and current in the subject matter relevant to the educational material for the proposed pilot or scientific study.
  - K. Statement of ~~costs~~ anticipated risks and potential benefits to patient and/or EMS personnel.
  - L. Statement of legal authority for the use of the proposed intervention.
  - M. Letters from provider agencies participating in the pilot or scientific study indicating their willingness to participate.
  - N. Letters from partner entities indicating willingness to participate, when applicable. Review by participating entities local IRB may also be required in some cases.
  - O. IRB approval when applicable. If there is intent to publish the pilot or scientific

study results, an approved IRB is required. In addition, an IRB may be required based on the proposed study design and estimated risk to the patient or EMS personnel.

- II. An investigator shall also submit a data use request if there is intent to use data that are maintained or managed by the EMS Agency as part of the pilot or scientific study (Refer to Ref. Nos. 622, 622.1 through 622.5).
- III. An investigator shall adhere to the following stipulations after submission:
  - A. Allow up to 14 business days after proposal submission to receive notification from the EMS Agency of receipt of the proposal.
  - B. Provide any missing required information and resubmit study proposal revisions as requested by the EMS Agency Medical Director.
  - C. Allow up to 45 business days after EMS Agency receipt of a complete proposal to receive notification of approval or denial. Expect up to a total of 60 business days between complete study proposal submission and the EMS Agency approval/denial notification.
  - D. Refrain from commencing any pilot or scientific study activities (including training) until approval has been granted by the EMS Agency.
- IV. An investigator shall adhere to the following requirements if pilot or scientific study approval is granted:
  - A. In collaboration with the EMS Agency, notify all hospitals, EMS provider agencies, and appropriate private entities or political jurisdictions involved or affected by the study.
  - B. Conduct training sessions for those involved in the study including all hospitals, EMS provider agencies, and personnel as applicable.
  - C. Submit quarterly reports, within 30 days of the end of the quarter, to the EMS Agency Medical Director on the progress of the study, number of patients enrolled/treated, descriptive characteristics, and safety and effectiveness outcomes with appropriate interim analysis when applicable.
  - D. Share pilot or scientific study reports with the Medical Advisory Council when requested.
  - E. Immediately inform the EMS Agency Medical Director of any unanticipated adverse events or departure from the protocol, including discontinuation of the study, prior to its completion.
  - F. Provide the final report to the EMS Agency at the conclusion of the study (and interim as determined by the EMS Agency Medical Director during the approval process) based on the agreed upon data analysis plan and target outcomes.
- V. The EMS Agency responsibilities are the following:

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- A. Notify the study proposer within 14 business days of receiving the request for pilot or scientific study that it was received and if necessary, request any missing information.
- B. Involve the Medical Advisory Council; Innovation, Technology, and Advancement Committee (ITAC); or any other relevant Specialty Care Center Advisory Committee to assist with the evaluation and approval of the proposed study, if warranted.
- C. Notify the investigator within forty-five (45) days from receipt of the complete proposal of approval or denial of the proposed pilot or scientific study, or for the need for approval by the California EMS Authority.
- D. In cases where California EMS Authority approval is required, including for pilots or scientific studies where Local Optional Scope of Practice approval is required, the EMS Agency will work with the investigator to submit the pilot or scientific study proposal to the California EMS Authority for approval. Study investigators are responsible for preparing the necessary materials for submission to the California EMS Authority. The EMS Agency will further:
- a. Assist with submission of a request for Local Optional Scope of Practice, when applicable.
  - b. Notify the investigator of approval or disapproval of the pilot or scientific study by the California EMS Authority.
  - c. Submit the investigator's written study conclusions or progress report to the California EMS Commission (EMSC) within 18 months of the initiation of the pilot or scientific study intervention. The conclusion or progress report should include, at a minimum, the study objective(s), number of patients studied, beneficial effects, adverse reactions or complications, appropriate statistical evaluation, and general conclusions. If the trial or scientific study is extended beyond the initially-approved time frame, submit a final report to the California EMSC.
- E. Discontinue a pilot or scientific study for safety or other concerns at any time at the EMS Agency Medical Director's discretion.
- F. Provide a written conclusion based on the results of the pilot or scientific study, which will include one of the following:
1. Implementation: Suitable for systemwide implementation as directed by the EMS Agency Medical Director
  2. Optional Use: EMS provider agencies maintain responsibility for education, training, and oversight of product/procedure/innovation use
  3. Pilot: Require that an EMS provider agency continue a specified pilot period and continue to submit pilot data to the EMS Agency on a quarterly basis
  4. Insufficient Data: There is insufficient data to support continuation of the study. Discontinuation of the study indefinitely. This conclusion may change with introduction of new/additional evidence.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 204, **Medical Advisory Council**

Ref. No. 205, **Innovation, Technology, and Advancement Committee (ITAC)**

Ref. No. 622, **Release of EMS Data**

Ref. No. 622.1, **Data Request and Levels of Support**

Ref. No. 622.2, **Limited Data Set Information**

Ref. No. 622.3, **Intended Use of Limited Data Set Information**

Ref. No. 622.4, **Data Use Agreement**

Ref. No. 622.5, **Confidentiality Agreement**

Ref. No. 802, **Emergency Medical Technician (EMT) Scope of Practice**

Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**

Reference No. 830, EMS Pilot and Scientific Studies

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/12/2025	2/12/2025	Yes
	Base Hospital Advisory Committee	2/5/2025	2/5/2025	No
OTHER COMMITTEES/RESOURCES	Medical Council	3/3/2025	3/3/2025	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

**POLICY REVIEW - SUMMARY OF COMMENTS**

REFERENCE NO. 202.2  
(ATTACHMENT B)

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**REFERENCE NO. 830, EMS Pilot and Scientific Studies**

<b>SECTION</b>	<b>COMMITTEE/DATE</b>	<b>COMMENT</b>	<b>RESPONSE</b>
Principles, 2	PAAC 02/12/2025	Concerns regarding the term EMS Clinicians.	Changed wording to EMT's and/or paramedics

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

(EMT/PARAMEDIC/MICN)

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

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

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

**DEFINITIONS:**

**Adult:** A person at least eighteen years of age.

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

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

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

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

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

The lack of decision-making capacity may be:

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

EFFECTIVE: 11-8-93  
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SUPERSEDES: 01-01-23

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APPROVED:

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Director, EMS Agency

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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 “Lanternman-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

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patient less than eighteen (18) years of age, with the exception of minors not requiring parental consent, must 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. 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.
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.
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

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 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**

Reference No. 834, Patient Treatment/Transport and Treat and Release At Scene

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/12/2025	2/12/2025	No
	Base Hospital Advisory Committee	2/5/2025	2/5/2025	No
OTHER COMMITTEES/RESOURCES	Medical Council	3/3/2025	3/3/2025	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other: LA County ECMO Pilot Study Workgroup			
	SRC Advisory Committee			

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

Reference No. 834, Patient Treatment/Transport and Treat and Release At Scene

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	6/18/25	6/18/2025	No
	Base Hospital Advisory Committee	6/11/25	6/11/2025	No
OTHER COMMITTEES/RESOURCES	Medical Council	6/3/25	6/3/2025	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other: LA County ECMO Pilot Study Workgroup			
	SRC Advisory Committee			

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

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

(EMT/ PARAMEDIC/MICN)  
REFERENCE NO. 838

**SUBJECT: APPLICATION OF PATIENT RESTRAINTS**

**PURPOSE:** To provide guidelines for emergency procedures and use of restraints in the field or during transport of patients who are violent or potentially violent, or who may harm self or others.

**AUTHORITY:** California Code of Regulations, Title 22, Sections 100063, 100145, 100169(a)(1,2) and (c)(1)  
Welfare and Institutions Code, 5150  
California Code of Regulations, Title 13, Section 1103.2  
Health and Safety Code, Section 1798(a)

**PRINCIPLES:**

1. The safety of the patient, community, and responding personnel is of paramount concern when considering the use of restraints.
2. Staff should be properly trained in the appropriate use and application of restraints and in the monitoring of patients in restraints.
3. The application of restraints is a high-risk procedure due to the possibility of injury to both the patient and the provider; therefore, the least restrictive method that protects the patient and emergency medical services (EMS) personnel from harm should be utilized.
4. Restraints should be used in situations where the patient is potentially violent or is exhibiting behavior that is dangerous to self or others, only as necessary, when all lesser restrictive measures (e.g., verbal de-escalation) have failed.
5. EMS personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol, substance abuse, metabolic disorders, emotional stress and, behavioral and psychiatric disorders. Base contact criteria shall be strictly adhered to for those conditions that require it.
6. Authority for scene management (e.g., controlling the activities that occur in the environment or space around the patient; ensuring bystanders are kept away; and EMS personnel are provided with a safe environment to treat the patient) shall be coordinated by law enforcement (LE), where applicable.
7. The responsibility for patient health care management rests with the highest medical authority on scene. Therefore, medical intervention and patient destination shall be determined by EMS personnel according to applicable policies.
  - a. The preferred restraint modality should be coordinated with LE, when applicable.
  - b. The method of restraint used should allow for adequate monitoring of vital signs and should not restrict the patient's ability to breathe freely. Restraints should not prevent ability to protect the airway nor compromise neurological or vascular status.

EFFECTIVE: 02-15-95  
REVISED: 07-01-25  
SUPERSEDES: 09-01-22

PAGE 1 OF 4

APPROVED: \_\_\_\_\_

Director, EMS Agency

Medical Director, EMS Agency

8. This policy is not intended to negate the need for LE personnel to use appropriate restraint equipment approved by their respective agency to establish scene management control.

## POLICY

### I. Forms of Restraining Devices

- A. Restraint devices applied by EMS personnel (including for the purpose of interfacility transport of psychiatric patients) must be either padded hard restraints or soft restraints (i.e., vest with ties, Velcro or seatbelt type). Both methods must be keyless and allow for quick release. Restraints shall be applied as four point padded wrist and ankle restraints, or a two-point padded wrist and belt restraint.
- B. The following methods of restraint shall NOT be utilized by EMS personnel:
1. Applying hard plastic ties or any restraint device requiring a key to remove.
  2. Restraining a patient's hands and feet behind their back.
  3. Restraining patients in prone position.
  4. Placing a patient on a gurney and then placing a device (e.g., backboard, scoop stretcher or flats) on top of the patient, referred to as "Sandwich" method.
  5. Applying materials in a manner that could cause vascular, neurological or respiratory compromise (e.g., restriction of limbs, the neck or chest using gauze bandage or tape).
- C. In some situations, it may be necessary for LE to apply restraints (e.g., handcuffs, flex-cuffs, herein referred to as LE-restraint), which are not approved by EMS protocols. When appropriate, patients requiring ongoing patient care or EMS transported patients should have LE-restraints discontinued in favor of an EMS approved restraint intervention.

### II. Application and Monitoring of Restraints

- A. A restrained patient shall never be left unattended.
- B. Any restraint device used must allow for rapid removal if the patient's airway, breathing, or circulation becomes compromised.
- C. Restrained extremities should be evaluated for pulse quality, capillary refill, color, temperature, nerve and motor function immediately following application and at a minimum of every 15 minutes thereafter (or more often if clinically indicated). Any abnormal findings require adjustment, removal and reapplication of restraints if necessary.
- D. Restraint methods must allow the patient to straighten the abdomen and chest such that they can take full breaths.

- E. Under no circumstances are patients to be transported in the prone position regardless of who applies the restraint.
- F. EMS personnel must ensure that the patient's position allows for adequate monitoring of vital signs, does not compromise respiratory, circulatory, or neurological status, and does not preclude any necessary medical intervention to protect or manage the airway should vomiting occur.
- G. EMS restraints shall not be attached to movable side rails of a gurney.
- H. Restraint devices applied by LE require the officer's continued presence to ensure patient and scene management safety.
  - 1. The LE officer should accompany the patient in the ambulance.
  - 2. In the unusual event that this is not possible, the LE officer should follow by driving in tandem with the ambulance on a pre-determined route.
  - 3. A method to alert the LE officer of any problems that may develop during transport should be discussed prior to leaving the scene.
  - 4. If the patient is handcuffed by LE officers, consideration should be made to transition to the least restrictive restraints that are safe for the patient and responders, including consideration of transfer to EMS restraints.

### III. Pharmacologic Management of the Patient in Restraints

- A. A patient who has undergone physical restraint should not be allowed to continue to struggle against the restraints as this may lead to injury (i.e., rhabdomyolysis, strains, sprains, severe acidosis, cardiac ischemia).
- B. Patients who are agitated while in physical restraint may receive midazolam by EMS personnel to reduce agitation with continued monitoring for respiratory depression, in accordance with (*TP 1209, Psychiatric/Behavioral Emergencies*).
  - 1. If the patient remains agitated in BLS care and there is an ongoing concern for patient safety, ALS upgrade shall be initiated.
  - 2. Resuscitation and monitoring equipment, including oxygen and bag valve mask, should be near the patient and accessible prior to proceeding with sedation.
  - 3. Initiate monitoring of pulse oximetry, cardiac rhythm, and capnography (when available) as soon as possible peri-/post-sedation and prior to transport. Contact Base for guidance if persistent agitation prevents monitoring prior to transport.

### IV. Required Documentation on the Patient Care/EMS Report Form

- A. Reason restraints were applied
- B. Type of restraints applied
- C. Identity of agency/medical facility applying restraints

- C. Assessment of the overall cardiac and respiratory status of the patient; and the circulatory, motor and neurological status of the restrained extremities at a minimum of every 15 minutes
- E. Reason for removing or reapplying the restraints or any abnormal findings
- V. Quality Assurance:
  - A. Develop a process for review of selected cases where physical restraint and/or medication are used by EMS personnel to manage agitation, with attention to the type of restraint(s) used, the quality and frequency of physiologic monitoring, protocol compliance, and documentation compliance.
  - B. Agencies shall track the use of medications for the purpose of management of agitated patients.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 502, **Patient Destination**

Ref. No. 703, **ALS Unit Inventory**

Ref. No. 1200.2, **Base Contact Requirements**

Reference No. 838, Application of Patient Restraints

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	4/16/25	4/16/2025	Yes
	Base Hospital Advisory Committee	4/9/25	4/9/2025	No
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

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

**POLICY REVIEW - SUMMARY OF COMMENTS**

REFERENCE NO. 202.2  
(ATTACHMENT B)

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**REFERENCE NO. 838, Application of Patient Restraints**

<b>SECTION</b>	<b>COMMITTEE/DATE</b>	<b>COMMENT</b>	<b>RESPONSE</b>
Policy III. B. 3	PAAC 4/16/2025	Revise wording to address if patient continues to have persistent agitation.	Revised
Policy IV. B.	AAC 4/16/2025	Remove "...the appropriateness of restraint for the patient..."	Adopted

## PRINCIPLES:

1. Some patients with out-of-hospital cardiac arrest who are refractory to conventional cardiopulmonary resuscitation have improved outcomes if extracorporeal membrane oxygenation (ECMO) is used to provide ongoing resuscitation support. ECMO treatment for patient in cardiac arrest is called extracorporeal cardiopulmonary resuscitation (ECPR) or extracorporeal life support (ECLS).
2. Currently it is not known exactly which patients are able to benefit from ECPR but certain patients including patients with refractory ventricular fibrillation/ventricular tachycardia (rVF/VT) cardiac arrest have been shown to have up to 30% improved survival.
3. For all patients with OHCA, management should be conducted to minimize interruptions in chest compressions and prioritize standard therapies, including chest compressions and defibrillation for shockable rhythms, and early epinephrine for non-shockable rhythms.
4. While usual protocols emphasize prolonged on scene resuscitation for rVF/VT, patients for whom ECPR is indicated and a mechanical compression device (MCD) is available to maintain quality chest compression during transport should be transported as soon as possible once ECPR criteria are met in order to minimize the low-flow time prior to cannulation for ECPR. Goal scene time is no more than 15 minutes.
5. Patients for whom there is a significant delay in transport due to extrication challenges or lack of MCD availability should be resuscitated on scene to achieve return of spontaneous circulation (ROSC) since ECPR is unlikely to be initiated in patients more than 60 minutes after cardiac arrest onset.
6. Patients transported with ongoing resuscitation should have an advanced airway in place to ensure adequate ventilations during movement and transport, and an Impedance Threshold Device (ITD) attached when available.
7. Epinephrine beyond 3 doses is associated with worse outcomes in patients with rVF/VT. Additional epinephrine for patients who re-arrest into a non-shockable rhythm should be considered on a case-by-case basis.
8. Contact directly with the ECPR Receiving Center Base facilitates clear communication and reduces delays. MICNs and Base physicians should be familiar with the differences in the field management priorities for these patients.
9. In general, patients for whom contact is made with a non-ECPR SRC Base for medical direction should not be redirected to an ECPR Receiving Center, since the delay will result in poor ECPR candidacy; in such cases, medical direction should focus on optimizing the resuscitation to achieve ROSC.
10. When the ECPR Receiving Center is the closest accessible SRC, additional patients who do not meet the ECPR criteria for immediate transport may be considered for ECPR on a case-by-case basis if the ECMO team feels the patient could benefit. Early contact with the ECPR SRC Base should be made in these cases to determine if early transport prior to ROSC is advisable.

GUIDELINES:

1. Paramedics shall identify patients who meet ECPR criteria and manage the patient per TP 1210, Cardiac Arrest while prioritizing transport.
2. Scene time for ECPR eligible patients should be limited to  $\leq 15$  minutes.
3. A maximum of 3 doses of epinephrine (total of 3mg) is indicated during the resuscitation. Push-dose epinephrine is appropriate and should be administered after ROSC to prevent re-arrest when indicated.
4. An advanced airway should be inserted as soon as feasible to facilitate ventilations during transport.
5. Communication with the ECPR Receiving Center Base should occur immediately after transport is initiated. Base will ensure the hospital is prepared to receive the patient and can activate the ECMO team.
6. The ECPR Receiving Center Base will confirm priorities including chest compressions via MCD, defibrillations, and advanced airway with capnography monitoring, and will activate the ECMO team when indicated prior to patient arrival.

**INITIATE TREATMENT OF NON-TRAUMATIC CARDIAC ARREST PER TP 1210**

- Potential eCPR Candidate (ALL of the following):**
1. Age  $\geq 15$  and  $\leq 75$
  2. Initial rhythm VF/VT refractory after  $\geq 2$  defibrillations or ROSC with recurrent arrest  
OR  
Suspected massive PE\* (any rhythm)
  3. Mechanical Compression Device in use
  4.  $\leq 30$  minutes ground transport to the eCPR Center
  5. **NO** do-not-resuscitate order, **terminal illness\*\***, or severe baseline neurologic dysfunction

**Yes to  
ALL**

\*Sudden cardiac death from massive PE may be suspected in a patient with recent immobilization from prolonged travel or hospitalization/surgery or known prior PE; symptoms are typically sudden in onset with preceding dyspnea and/or chest pain.

\*\*Terminal illness refers to patients who are chronically ill with severe end-organ dysfunction and/or metastatic cancer. In general, patients with significant chronic comorbidities are poor candidates for eCPR. If in doubt and patient otherwise meets criteria, contact and route to the eCPR center.

- Maintain continuous chest compressions with a mechanical compression device
- Insert an advanced airway, i-gel preferred if no contraindications
- Prioritize transport to the eCPR Receiving Center (limit scene time to  $\leq 15$  minutes)
- Continue management per TP 1210 en route
- Contact the eCPR Receiving Center Base immediately once en route, if not done prior, to notify of the patient for ECMO team activation

Reference No. 1318, ECPR Patient Algorithm

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	2/12/2025	2/12/2025	No
	Base Hospital Advisory Committee	2/5/2025	2/5/2025	No
OTHER COMMITTEES/RESOURCES	Medical Council	3/3/2025	3/3/2025	No
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other: LA County ECMO Pilot Study Workgroup	8/8/2024	8/8/2024	No
	SRC Advisory Committee	10/1/2024	10/1/2024	No

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

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

**Time Period April 1, 2025 through June 30, 2025**

APOT Standard: within 30 minutes, 90% of the time											
HOSPITAL	Total # of records*	Q2 2025									
		≤30:00min	30:01 - 60:00min	60:01 - 120:00min	>120:00min	90th percentile (hh:mm:ss)	% of Time on Diversion				
<b>ANTELOPE VALLEY - NEWHALL REGION</b>											
Antelope Valley Medical Center	5,600	4,334	77%	1,103	20%	142	3%	21	0.4%	0:41:46	0.3%
Henry Mayo Newhall Memorial Hospital	3,664	3,407	93%	221	6%	31	0.8%	5	0.1%	0:26:14	0.3%
Palmdale Regional Medical Center	3,118	2,516	81%	510	16%	83	3%	9	0.3%	0:39:11	0.3%
<b>ANTELOPE VALLEY TOTAL</b>	<b>12,382</b>	<b>10,257</b>	<b>83%</b>	<b>1,834</b>	<b>15%</b>	<b>256</b>	<b>2%</b>	<b>35</b>	<b>0.3%</b>	<b>0:37:33</b>	<b>0.3%</b>
<b>SAN FERNANDO VALLEY REGION</b>											
Adventist Health Glendale	2,034	1,725	85%	269	13%	39	2%	1		0:35:11	
Dignity Health - Glendale Memorial Hospital & Health Center	1,403	1,257	90%	124	9%	22	2%			0:30:51	1%
Dignity Health - Northridge Hospital Medical Center	3,749	3,416	91%	297	8%	33	0.9%	3	0.1%	0:28:52	11%
Encino Hospital Medical Center	328	325	99%	1	0.3%	2	0.6%			0:14:34	
Kaiser Foundation Hospital - Panorama City	981	908	93%	70	7%	2	0.2%	1	0.1%	0:27:34	23%
Kaiser Foundation Hospital - Woodland Hills	735	636	87%	72	10%	26	4%	1	0.1%	0:36:24	31%
Mission Community Hospital	899	843	94%	53	6%	3	0.3%			0:26:07	2%
Olive View-UCLA Medical Center	922	866	94%	50	5%	5	0.5%	1	0.1%	0:25:12	33%
Pacifica Hospital of the Valley	660	640	97%	18	3%	2	0.3%			0:16:52	21%
Providence Cedars-Sinai Tarzana Medical Center	1,013	918	91%	84	8%	11	1%			0:29:36	24%
Providence Holy Cross Medical Center	1,974	1,877	95%	81	4%	15	0.8%	1	0.1%	0:20:25	27%
Providence Saint Joseph Medical Center	3,972	3,359	85%	565	14%	46	1%	2	0.1%	0:35:15	11%
Sherman Oaks Hospital	1,209	1,134	94%	64	5%	11	1%			0:25:27	4%
UCLA West Valley Medical Center	1,601	1,193	75%	316	20%	88	5%	4	0.2%	0:46:21	17%
USC Verdugo Hills Hospital	595	488	82%	78	13%	23	4%	6	1%	0:44:53	11%
Valley Presbyterian Hospital	1,413	1,320	93%	71	5%	20	1%	2	0.1%	0:24:14	17%
<b>SAN FERNANDO VALLEY TOTAL</b>	<b>23,488</b>	<b>20,905</b>	<b>89%</b>	<b>2,213</b>	<b>9%</b>	<b>348</b>	<b>1%</b>	<b>22</b>	<b>0.1%</b>	<b>0:31:17</b>	<b>15%</b>
<b>SAN GABRIEL VALLEY REGION</b>											
Alhambra Hospital Medical Center	664	652	98%	10	2%	2	0.3%			0:16:00	6%
Emanate Health Foothill Presbyterian Hospital	1,561	916	59%	481	31%	141	9%	23	1%	1:01:30	1%
Emanate Health Inter-Community Hospital	1,396	1,008	72%	309	22%	74	5%	5	0.4%	0:49:25	
Emanate Health Queen of the Valley Hospital	2,805	1,976	70%	630	22%	171	6%	28	1%	0:53:00	1%
Garfield Medical Center	994	958	96%	24	2%	11	1%	1	0.1%	0:17:00	5%
Greater El Monte Community Hospital	1,215	805	66%	274	23%	120	10%	16	1%	1:02:30	4%
Huntington Hospital	3,920	3,588	92%	289	7%	40	1%	3	0.1%	0:29:00	3%
Kaiser Foundation Hospital - Baldwin Park	1,242	725	58%	278	22%	176	14%	63	5%	1:25:52	13%
Monterey Park Hospital	356	342	96%	11	3%	3	0.8%			0:19:52	1%
Pomona Valley Hospital Medical Center	4,706	3,688	78%	779	17%	214	5%	25	0.5%	0:43:31	5%
San Dimas Community Hospital	734	633	86%	80	11%	19	3%	2	0.3%	0:35:03	
San Gabriel Valley Medical Center	558	505	91%	30	5%	20	4%	3	0.5%	0:28:40	1%
USC Arcadia Hospital	3,190	2,512	79%	567	18%	105	3%	6	0.2%	0:41:52	1%
<b>SAN GABRIEL VALLEY TOTAL</b>	<b>23,341</b>	<b>18,308</b>	<b>78%</b>	<b>3,762</b>	<b>16%</b>	<b>1,096</b>	<b>5%</b>	<b>175</b>	<b>0.7%</b>	<b>0:45:36</b>	<b>3%</b>

\* Meets California APOT reporting criteria

**Los Angeles County Emergency Medical Services Agency**  
**AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL**  
**Time Period April 1, 2025 through June 30, 2025**

APOT Standard: within 30 minutes, 90% of the time											
HOSPITAL	Total # of records*	Q2 2025									
		≤30:00min	30:01 - 60:00min	60:01 - 120:00min	>120:00min	90th percentile (hh:mm:ss)	% of Time on Diversion				
<b>EAST REGION</b>											
Adventist Health White Memorial Montebello	1,576	1,090	69%	319	20%	151	10%	16	1%	1:01:29	0.3%
Coast Plaza Hospital	899	698	78%	153	17%	35	4%	13	1%	0:44:41	1%
Kaiser Foundation Hospital - Downey	1,737	914	53%	457	26%	293	17%	73	4%	1:29:33	12%
Norwalk Community Hospital	333	257	77%	58	17%	18	5%			0:43:53	9%
PIH Health Downey Hospital	1,822	1,328	73%	332	18%	138	8%	24	1%	0:57:09	8%
PIH Health Whittier Hospital	2,959	1,914	65%	837	28%	194	7%	14	0.5%	0:53:00	12%
UCI Health - Lakewood	1,516	961	63%	343	23%	178	12%	34	2%	1:09:12	7%
Whittier Hospital Medical Center	960	855	89%	90	9%	12	1%	3	0.3%	0:30:59	2%
<b>EAST REGION TOTAL</b>	<b>11,802</b>	<b>8,017</b>	<b>68%</b>	<b>2,589</b>	<b>22%</b>	<b>1,019</b>	<b>9%</b>	<b>177</b>	<b>1%</b>	<b>1:00:40</b>	<b>6%</b>
<b>METRO REGION</b>											
Adventist Health White Memorial	729	511	70%	136	19%	66	9%	16	2%	1:03:08	1%
Cedars-Sinai Medical Center	3,630	2,339	64%	979	27%	275	8%	37	1%	0:57:02	40%
Children's Hospital Los Angeles	270	264	98%	5	2%	1	0.4%			0:17:50	0.3%
Community Hospital of Huntington Park	1,689	946	56%	528	31%	189	11%	26	2%	1:06:07	2%
Dignity Health - California Hospital Medical Center	1,889	1,432	76%	373	20%	80	4%	4	0.2%	0:45:07	29%
East Los Angeles Doctors Hospital	1,227	1,017	83%	168	14%	34	3%	8	0.7%	0:38:54	0.3%
Hollywood Presbyterian Medical Center	1,662	1,406	85%	214	13%	41	2%	1	0.1%	0:35:05	0.3%
Kaiser Foundation Hospital - Los Angeles	1,538	1,298	84%	201	13%	38	2%	1	0.1%	0:36:59	16%
Los Angeles General Medical Center	5,301	4,868	92%	374	7%	55	1%	4	0.1%	0:27:59	13%
PIH Health Good Samaritan Hospital	2,519	1,915	76%	483	19%	111	4%	10	0.4%	0:44:54	9%
<b>METRO REGION TOTAL</b>	<b>20,454</b>	<b>15,996</b>	<b>78%</b>	<b>3,461</b>	<b>17%</b>	<b>890</b>	<b>4%</b>	<b>107</b>	<b>0.5%</b>	<b>0:44:45</b>	<b>11%</b>
<b>WEST REGION</b>											
Cedars-Sinai Marina Del Rey Hospital	1,554	1,135	73%	298	19%	111	7%	10	0.6%	0:54:00	37%
Kaiser Foundation Hospital - West LA	1,689	1,193	71%	350	21%	134	8%	12	0.7%	0:55:41	28%
Providence Saint John's Health Center	2,348	1,519	65%	614	26%	194	8%	21	0.9%	0:57:14	2%
Ronald Reagan UCLA Medical Center	1,713	1,506	88%	173	10%	28	2%	6	0.4%	0:32:17	59%
Santa Monica-UCLA Medical Center & Orthopaedic Hospital	1,379	796	58%	417	30%	128	9%	38	3%	1:07:10	27%
Southern California Hospital at Culver City	655	486	74%	110	17%	55	8%	4	0.6%	0:51:00	23%
<b>WEST REGION TOTAL</b>	<b>9,338</b>	<b>6,635</b>	<b>71%</b>	<b>1,962</b>	<b>21%</b>	<b>650</b>	<b>7%</b>	<b>91</b>	<b>1%</b>	<b>0:53:18</b>	<b>29%</b>
<b>SOUTH REGION</b>											
Catalina Island Medical Center	57	57	100%							0:05:11	
Centinela Hospital Medical Center	6,538	4,809	74%	1,605	25%	119	2%	5	0.1%	0:40:23	
College Medical Center	619	519	84%	52	8%	34	5%	14	2%	0:50:00	50%
Dignity Health - St. Mary Medical Center	2,944	2,407	82%	441	15%	92	3%	4	0.1%	0:40:00	11%
Harbor-UCLA Medical Center	2,810	2,036	72%	543	19%	178	6%	53	2%	0:54:36	22%
Kaiser Foundation Hospital - South Bay	1,451	1,173	81%	220	15%	51	4%	7	0.5%	0:39:00	9%
Martin Luther King, Jr. Community Hospital	3,672	3,154	86%	448	12%	62	2%	8	0.2%	0:34:26	23%

**Los Angeles County Emergency Medical Services Agency**  
**AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL**  
**Time Period April 1, 2025 through June 30, 2025**

APOT Standard: within 30 minutes, 90% of the time											
HOSPITAL	Total # of records*	Q2 2025									
		≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	% of Time on Diversion
Memorial Hospital Of Gardena	2,830	2,402	85%	387	14%	35	1%	6	0.2%	0:33:55	2%
MemorialCare Long Beach Medical Center	3,175	2,616	82%	293	9%	135	4%	131	4%	0:51:00	32%
Providence Little Company of Mary Medical Center San Pedro	788	665	84%	108	14%	15	2%			0:37:01	14%
Providence Little Company of Mary Medical Center Torrance	2,172	1,425	66%	576	27%	154	7%	17	0.8%	0:55:41	6%
St. Francis Medical Center	3,887	1,728	44%	1,329	34%	694	18%	136	3%	1:23:18	8%
Torrance Memorial Medical Center	1,876	1,073	57%	672	36%	117	6%	14	0.7%	0:51:41	22%
<b>SOUTH REGION TOTAL</b>	<b>32,819</b>	<b>24,064</b>	<b>73%</b>	<b>6,674</b>	<b>20%</b>	<b>1,686</b>	<b>5%</b>	<b>395</b>	<b>1%</b>	<b>0:49:07</b>	<b>15%</b>
<b>ALL HOSPITALS</b>	<b>133,624</b>	<b>104,182</b>	<b>78%</b>	<b>22,495</b>	<b>17%</b>	<b>5,945</b>	<b>4%</b>	<b>1,002</b>	<b>1%</b>	<b>0:44:59</b>	<b>11%</b>

**Los Angeles County Emergency Medical Services Agency**  
**AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY PROVIDER**  
**Time Period April 1, 2025 through June 30, 2025**

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

EMS Provider Agency	Code	Total # of records*	Q2 2025								
			≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)
Alhambra Fire Department	AH	967	950	98%	12	1%	4	0.4%	1	0.1%	00:15:00
Arcadia Fire Department	AF	828	760	92%	66	8%	2	0.2%			00:29:00
Avalon Fire Department	AV	54	54	100%							00:05:11
Beverly Hills City Fire Department	BH	771	564	73%	164	21%	41	5%	2	0.3%	00:51:00
Burbank Fire Department	BF	1,648	1,449	88%	187	11%	12	0.7%			00:33:00
Compton Fire Department	CM	318	316	99%	2	0.6%					00:12:00
Culver City Fire Department	CC	943	753	80%	125	13%	61	6%	4	0.4%	00:47:00
Downey Fire Department	DF	1,394	1,107	79%	192	14%	83	6%	12	0.9%	00:52:00
El Segundo Fire Department	ES	299	275	92%	21	7%	3	1%			00:28:00
Glendale Fire Department	GL	2,880	2,487	86%	346	12%	45	2%	2	0.1%	00:35:00
La Habra Heights Fire Department	LH	16	14	88%	2	13%					00:38:00
La Verne Fire Department	LV	568	515	91%	38	7%	12	2%	3	0.5%	00:30:00
LACoFD	CF	82	81	99%	1	1%					00:14:32
LAFD	CI	47,146	40,832	87%	5,203	11%	1,031	2%	80	0.2%	00:34:13
Long Beach Fire Department	LB	6,654	5,501	83%	785	12%	244	4%	124	2%	00:42:00
Los Angeles County Sheriff's Department	CS	19	18	95%	1	5%					00:29:00
Manhattan Beach Fire Department	MB	331	283	85%	41	12%	7	2%			00:37:00
Monrovia Fire Department	MF	320	315	98%	4	1%	1	0.3%			00:19:00
Montebello Fire Department	MO	538	531	99%	6	1%	1	0.2%			00:16:00
Monterey Park Fire Department	MP	696	693	100%	3	0.4%					00:10:00
Pasadena Fire Department	PF	2,558	2,380	93%	156	6%	21	0.8%	1	0.0%	00:27:00
Redondo Beach Fire Department	RB	2	2	100%							00:00:00
San Gabriel Fire Department	SG	319	313	98%	6	2%					00:14:00
San Marino Fire Department	SA	199	182	91%	15	8%	2	1%			00:29:00
Santa Fe Springs Fire Rescue	SS	130	129	99%	1	0.8%					00:06:00
Santa Monica Fire Department	SM	356	350	98%	4	1%	2	0.6%			00:18:00
Sierra Madre City Fire Department	SI	174	155	89%	18	10%	1	0.6%			00:31:00
South Pasadena Fire Department	SP	241	225	93%	14	6%	2	0.8%			00:26:00
Torrance Fire Department	TF	728	578	79%	120	16%	26	4%	4	0.5%	00:40:10
West Covina Fire Department	WC	1,141	1,011	89%	107	9%	23	2%			00:32:00
American Medical Response	AR	14,511	11,214	77%	2,629	18%	574	4%	94	0.6%	00:44:31
Falck Mobile Health Corp. (Care Ambulance)	CA	28,843	19,684	68%	6,495	23%	2,273	8%	391	1%	00:57:48
Westmed Ambulance Inc. (McCormick Ambulance)	WM	17,950	10,461	58%	5,731	32%	1,474	8%	284	2%	00:59:09
<b>TOTAL ALL PROVIDERS</b>		<b>133,624</b>	<b>104,182</b>	<b>78%</b>	<b>22,495</b>	<b>17%</b>	<b>5,945</b>	<b>4%</b>	<b>1,002</b>	<b>0.7%</b>	<b>00:44:59</b>

\* Meets California APOT reporting criteria

**[ON OFFICIAL LETTERHEAD]**

*Cardiac Arrest Task Force*  
Los Angeles County EMS Commission  
[Date]

**To: [Hospital CEO, CMO, and CNO]**  
[Hospital Name]  
[Address]

**Subject: Request for Hospital Strategic Plan to Improve Cardiac Arrest Outcomes by 2030**

Dear [CEO Last Name], [CMO Last Name], and [CNO Last Name]:

On behalf of the Los Angeles County EMS Commission and its Cardiac Arrest Task Force, we thank you for your institution's essential role in saving the lives of patients who suffer cardiac arrest—whether in the community or while under hospital care. We are writing today to ask for your institution's partnership in helping Los Angeles County achieve the **American Heart Association's 2030 cardiac arrest survival goals**.

These goals include measurable improvements in survival to hospital discharge with good neurologic outcomes (CPC 1–2) for both out-of-hospital and in-hospital cardiac arrest, while explicitly closing the survival gap in underrepresented populations and underserved communities.

To meet these ambitious and life-saving goals, we respectfully request that your hospital develop a **one-page written plan** describing your institution's strategy to:

1. **Measure and improve outcomes for both:**
  - Out-of-hospital cardiac arrest (OHCA) patients who arrive at your facility, and
  - In-hospital cardiac arrest (IHCA) patients who experience pulseless events under your care;
2. **Improve survival and neurologic outcomes** in alignment with the AHA's 2030 targets, particularly in underserved and historically underrepresented communities;
3. **Implement the AHA's 2020 Cardiac Arrest Survivorship Statement**, including integration of patient-centered discharge planning, psychosocial support, and cognitive and physical rehabilitation for survivors;
4. **Incorporate patient and co-survivor voices** into your hospital's improvement strategy, especially voices from communities most impacted by health inequities in cardiac arrest outcomes;
5. **Build and support a multi-disciplinary improvement team**, including leadership and participation from your CPR committee physician chair and members of the following departments:
  - Emergency Medicine
  - Cardiology
  - Critical Care
  - Social Work

- Physical/Occupational/Rehabilitation Therapy
- Nursing
- 6. **Benchmark your progress** using a recognized national tool, such as the **AHA’s Get With the Guidelines – Resuscitation (GWTG-R) registry** or equivalent data-driven quality improvement platform;
- 7. **Foster survivorship connections**, including referring survivors and co-survivors to the **Cardiac Arrest Survivors Alliance** ([www.casahearts.org](http://www.casahearts.org)) and related peer support resources;
- 8. **Support regional collaboration** by:
  - Designating a representative from your CPR committee to participate in the **LA County In-Hospital Resuscitation Listserv**, a quarterly online forum for sharing data-informed best practices;
  - Having at least one member of your **c-suite leadership attend the annual LA County cardiac arrest survivors gathering** alongside one cardiac arrest survivor from your facility;
  - For hospitals within larger systems: **sharing your plan across sister hospitals** to encourage alignment and system-wide improvement.

Your plan should be **reviewed and approved by your executive leadership team (CEO, CMO, and CNO)** and submitted to the Los Angeles County EMS Agency no later than **March 31, 2026 (end of Q1 2026)**. Plans will inform the Task Force’s system-level recommendations and help drive local, regional, and philanthropic investments to support your efforts.

We are confident that with your leadership, Los Angeles County can become a national model for equitable, data-driven, and survivor-centered cardiac arrest care. Please send your completed plan and any questions to [email address] and [name], Program Manager for the Cardiac Arrest Task Force.

With sincere appreciation for your life-saving work,

**Stephen Sanko, MD**

Vice Chair, Los Angeles County EMS Commission

Chair, LA County Cardiac Arrest Task Force

Director, Southern California Chapter, Sudden Cardiac Arrest Foundation

[Email Address] | [Phone Number]

**[ON OFFICIAL LETTERHEAD]**

*Cardiac Arrest Task Force*

Los Angeles County EMS Commission

[Date]

**To: The Honorable Mayor and Members of the City Council**

[City Name]

[City Hall Address]

**Subject: Upcoming Review of Local 9-1-1 EMS Cardiac Arrest Improvement Plan**

Dear Mayor and City Councilmembers,

We are writing to inform you of an important county-wide initiative currently underway to improve cardiac arrest survival across Los Angeles County, in alignment with the **American Heart Association's 2030 Goals** for equitable, neurologically intact survival.

As part of this effort, every **local fire department that provides 9-1-1 emergency medical services** is being asked to review its current performance in responding to out-of-hospital cardiac arrests and to **develop a brief plan to improve both process- and patient-centered outcomes** by the year 2030.

You should expect to receive your fire department's proposed plan in the coming months for your **review and sign-off**, signifying local leadership's support and commitment to saving more lives in your community. This plan will be based on department-specific data, involve input from a multidisciplinary team, and include engagement with community voices—especially in neighborhoods with historically lower bystander CPR and AED use rates.

We sincerely appreciate your **partnership in this life-saving work**, and we thank you for your ongoing leadership in public safety and community health.

With respect and gratitude,

**Stephen Sanko, MD**

Vice Chair, Los Angeles County EMS Commission

Chair, LA County Cardiac Arrest Task Force

Director, Southern California Chapter, Sudden Cardiac Arrest Foundation

[Email Address] | [Phone Number]

**[ON OFFICIAL LETTERHEAD]**

*Cardiac Arrest Task Force*

Los Angeles County EMS Commission

[Date]

**To: Fire Chief [Name]**

**Cc: EMS Medical Director [Name]**

[Fire Department Name]

[Address]

Subject: Request for Strategic Plan to Improve Cardiac Arrest Outcomes by 2030

Dear Chief [Last Name] and EMS Medical Director [Last Name]:

On behalf of the Los Angeles County EMS Commission and the Cardiac Arrest Task Force, thank you for your continued service to our communities as frontline providers of life-saving emergency medical care. As Vice Chair of the LA County EMS Commission and Chair of the Cardiac Arrest Task Force, I write today to enlist your leadership in helping Los Angeles County meet — and exceed — the 2030 cardiac arrest outcome goals set forth by the American Heart Association (AHA).

The Los Angeles County EMS Agency previously shared with you the attached **out-of-hospital cardiac arrest (OHCA) performance report** specific for your agency, derived from the CARES registry and county-wide analyses. The report highlights current performance across key benchmarks and identifies specific opportunities for improvement in alignment with AHA's 2030 goals, including:

1. Increasing bystander CPR rates to >50%;
2. Increasing pre-EMS AED application in public settings to >20%;
3. Improving neurologically intact survival after OHCA to >8% at home and >19% in public settings for adults and additional outcome targets for pediatrics;
4. Ensuring outcome equity by matching these metrics in historically underrepresented populations and in communities with low socioeconomic status.

**We respectfully request that your agency develop a one-page written plan**, led or co-led by your EMS Medical Director, to describe your department's approach to closing the performance gap identified in your report. This plan should:

- Be composed by a multi-disciplinary working group within your department;
- Reflect your commitment to both clinical excellence and community partnership;
- Include engagement with community members, particularly those in underserved neighborhoods disproportionately affected by cardiac arrest;
- Consider use of nationally recognized tools, such as the Citizen CPR Foundation's HeartSafe Communities Program or similar frameworks, to foster local ownership and readiness;

- Be reviewed and approved by your department's leadership and signed by your city's Mayor and/or City Council to ensure institutional alignment and support.

Plans will be due no later than **March 31, 2026**. Your plan, alongside those of your peers, will inform the next phase of system-wide strategy and resource advocacy across LA County.

The Cardiac Arrest Task Force will continue to convene subject matter experts across clinical, operational, and community domains throughout 2025 and 2026. Your department's insights and innovations will be instrumental to our collective success. Together, we can ensure that every resident of Los Angeles County — regardless of where they live, their income, or their identity — has a meaningful chance at surviving cardiac arrest with a good neurologic outcome.

Please send your completed plan and any questions to [email address] and [name], Program Manager for the Cardiac Arrest Task Force.

Thank you again for your dedication and partnership in this life-saving work.

With respect and gratitude,

**Stephen Sanko, MD**

Vice Chair, Los Angeles County EMS Commission

Chair, LA County Cardiac Arrest Task Force

Director, Southern California Chapter, Sudden Cardiac Arrest Foundation

[Email Address] | [Phone Number]



**LOS ANGELES COUNTY  
BOARD OF SUPERVISORS**

**Hilda L. Solis**

First District

**Holly J. Mitchell**

Second District

**Lindsey P. Horvath**

Third District

**Janice K. Hahn**

Fourth District

**Kathryn Barger**

Fifth District

**COMMISSIONERS**

**Diego Caivano, MD, Chair**

LA County Medical Association

**Paul Camacho, Chief**

LA County Police Chiefs' Association

**Mr. Jason Cervantes**

California Professional Firefighters

**Erick H. Cheung, MD**

Southern California Psychiatric Society  
Association

**Mr. Kenneth Domer**

League of California Cities LA County

**Tarina Kang, MD**

Hospital Association of Southern CA

**Ms. Carol Kim**

Public Member (1<sup>st</sup> District)

**Captain Kristin Kolenda**

LA County Peace Officers' Association

**Lydia Lam, MD**

American College of Surgeons

**Mr. Kenneth Liebman**

LA County Ambulance Association

**James Lott, PsyD, MBA**

Public Member (2<sup>nd</sup> District)

**Carol Meyer, RN**

Public Member (4<sup>th</sup> District)

**Chief Kenneth Powell**

LA Area Fire Chiefs' Association

**Connie Richey, RN**

Public Member (3<sup>rd</sup> District)

**Stephen Sanko, MD, Vice Chair**

American Heart Association Western  
States Region

**Carole A. Snyder, RN**

Greater LA County Chapter Emergency

Nurses Association California State  
Council

**Saran Tucker, PhD, MPH**

Southern California Public Health  
Association

**Atilla Uner, MD, MPH**

California Chapter-American College of  
Emergency Physicians (CAL-ACEP)

**Mr. Gary Washburn**

Public Member (5<sup>th</sup> District)

**EXECUTIVE DIRECTOR**

**Richard Tadeo**

(562) 378-1610

[RTadeo@dhs.lacounty.gov](mailto:RTadeo@dhs.lacounty.gov)

**COMMISSION LIAISON**

**Denise Watson**

(562) 378-1606

[DWatson@dhs.lacounty.gov](mailto:DWatson@dhs.lacounty.gov)

4.6 BUSINESS (NEW)

**COUNTY OF LOS ANGELES EMERGENCY MEDICAL  
SERVICES COMMISSION**

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

(562) 378-1610 FAX (562) 941-5835

<http://ems.dhs.lacounty.gov>

September 10, 2025

TO: Supervisor Kathryn Barger, Chair  
Supervisor Hilda L. Solis  
Supervisor Holly J. Mitchell  
Supervisor Lindsey P. Horvath  
Supervisor Janice K. Hahn

FROM: Richard Tadeo, EMS Director, EMS Agency  
Executive Director, EMS Commission

SUBJECT: **ANNUAL REPORT OF THE EMERGENCY MEDICAL SERVICES  
COMMISSION – FISCAL YEAR 2024-25**

Respectfully submitted, is the Fiscal Year 2024-25 Annual Report of the Emergency Medical Services Commission (EMSC) activities and is being submitted in compliance with LA County Code Title 3, Chapter 3.20, Section 3.20.070.5.

The Annual Report will provide a snapshot into EMS Agency policies and medical control guidelines reviewed and/or approved during the fiscal year, as well as a look at legislation reviewed that may have potential impact to the emergency medical care system.

The EMSC meetings continue to be held in person at the EMS Agency located at 10100 Pioneer Boulevard, First Floor, Cathy Chidester Conference Room 128, Santa Fe Springs, California, 90670, on the third Wednesday of every odd-numbered month beginning with January as month one (1), from 1:00 pm to 3:00 pm.

Please feel free to contact me by phone or email with any questions or concerns you may have at (562) 378-1610 or [RTadeo@dhs.lacounty.gov](mailto:RTadeo@dhs.lacounty.gov). You may also contact EMSC Liaison, Denise Watson, at (562) 378-1606 or [DWatson@dhs.lacounty.gov](mailto:DWatson@dhs.lacounty.gov).

RT:DW

Attachment

c: Christina R. Ghaly, M.D., Director of Health Services  
Aries Limbaga, M.D., Chief Deputy Director, Health Services Operations  
Edward Morrissey, Assistant County Counsel  
Georgina Glaviano, Deputy County Counsel  
Edward Yen, Executive Officer, Board of Supervisors  
Health Deputies, Board of Supervisors  
EMS Commission



**County of Los Angeles, California  
Emergency Medical Services Commission  
Annual Report to the Board of Supervisors  
Fiscal Year 2024–2025**



**County of Los Angeles  
Department of Health Services  
Emergency Medical Services Agency  
10100 Pioneer Boulevard, Suite 200  
Santa Fe Springs, California 90670  
Phone: (562) 378-1500 / Fax: (562) 941-5835  
<http://ems.dhs.lacounty.gov>**



## COUNTY OF LOS ANGELES BOARD OF SUPERVISORS

Hilda L. Solis  
First District

Holly J. Mitchell  
Second District

Lindsey P. Horvath  
Third District

Janice Hahn  
Fourth District

Kathryn Barger  
Fifth District

### ***FROM THE DIRECTOR'S DESK***

The County of Los Angeles Emergency Medical Services (EMS) Agency is committed to creating, updating, and implementing new and existing policies and medical control guidelines that produce high levels of quality patient care in the prehospital emergency medical care setting. We provide State EMT certifications, ambulance licensing, emergency medical and disaster dispatch services, and are home to the Paramedic Training Institute where paramedics and mobile intensive care nurses receive EMS updates and training.



Our team of medical doctors and nurses, EMS healthcare professionals and providers, as well our EMS support staff are dedicated to working collectively in the advancement of medical technology through innovation, pilot programs, medical trials and studies, EMS updates and training, and collaborations with our EMS partners and stakeholders. Through these strategic alliances, we can identify and develop standards of care that become best practices in healthcare with measurable, deliverable, and effective patient outcomes.

The EMS Commission (EMSC) provides valuable insight, guidance and support to the EMS Agency on policies and guidelines that ensure safety nets are in place and producing extraordinary and appropriate protections for our residents. The Annual Report is provided to the Board of Supervisors to report on Commission activities and legislation with potential impact to the EMS system.

As Director of the EMS Agency and Executive Director of the EMS Commission, I am honored to work together with the high caliber of Supervisors, Commissioners, EMS partners, stakeholders, and exceptional groups of knowledgeable and engaged professionals who represent the success of the emergency medical and disaster-related system of care in LA County. Many thanks to each of you for your dedication, hard work, and significant contributions.

Sincerely,

Richard Tadeo, RN, BSN  
EMS Director  
EMSC Executive Director

## **MISSION STATEMENT**

To support and guide the Emergency Medical Services (EMS) Agency activities to ensure timely, compassionate, and quality emergency and disaster medical services.

## **HISTORICAL BACKGROUND**

The Emergency Medical Services Commission (EMSC) was established by the Board of Supervisors (Board) in October 1979. On April 7, 1981, the Board approved and adopted Ordinance No. 12332 of Title 3: Advisory Commissions and Committees, Los Angeles County Code Chapter 3.20, Emergency Medical Services Commission, to establish the Commission in accordance with California Health and Safety Code Division 2.5 Sections:

- 1797.270 – Emergency Medical Care Committee Formation
- 1797.272 – Emergency Medical Care Committee Membership
- 1797.274 – Emergency Medical Care Committee Duties
- 1797.276 – Emergency Medical Care Committee Annual Report

On January 29, 2008, the Board approved amending the subject Ordinance to revise the selection of the licensed paramedic representative previously nominated by the California Rescue and Paramedic Association (CRPA) to be made by the California State Firefighters' Association Emergency Medical Services Committee because CRPA ceased operations.

On November 1, 2011, in consultation with the Department of Health Services (DHS), the EMSC amended the Ordinance to add two commission seats. One member to be nominated by the Los Angeles County Police Chiefs' Association (LACPCA), and the second to be nominated by the Southern California Public Health Association (SCPHA). These seats are beneficial to the EMSC and the County by allowing for expert input by law enforcement and public health. With this amendment, the addition of two commission seats increased the number of commissioners from 17 to 19. The EMSC makes recommendations on Ordinance updates as the nominating associations' names change with time. The integrity of the EMSC stays intact and remains at 19.

## **COMMISSION MEMBERSHIP**

The EMSC consists of 19 members seated on behalf of medical and health associations, city and county professionals, law enforcement and fire department agencies, and one public member from each County of Los Angeles Board of Supervisors' District. The Executive Director and EMS Commission Liaison are County employees and represent the EMSC as staff.

## **ABOUT THE COMMISSION**

The EMSC acts in an advisory capacity to the Board and the Department of Health Services (DHS) on matters impacting emergency medical and disaster care services. The EMSC performs functions of the Emergency Medical Care Committee as defined in Sections 1750 et seq. of the Health and Safety Code and reviews policies and procedures impacting prehospital care for LA County residents. Duties include:

- Acting in an advisory capacity to the Board and DHS regarding County policies, programs, and standards for emergency medical and disaster care services throughout the County, including paramedic services
- Monitors studies of elements of the emergency medical care system and its initiatives as requested by the Board and/or the Director of DHS and delineates problems and deficiencies and recommends appropriate solutions.
- Acquires and analyzes information necessary for measuring the impact and quality of emergency medical care services.
- Reports findings, conclusions, and recommendations to the Board.
- Reviews and comments on submitted plans and proposals for emergency medical care services.
- Recommends, when the need arises, that LA County engage independent contractors for the performance of specialized temporary or occasional services to the EMSC which members of the classified service cannot perform and for which LA County otherwise has the authority to contract.

- Advises the Director on policies, procedures and standards that affect the certification/accreditation of mobile intensive care nurses and paramedics.
- Advises the Director on proposals of any public or private organization to initiate or modify a program of paramedic services or training.
- Arbitrates differences in the field of paramedic services and training between all sectors of the community including, but not limited to, county agencies, municipalities, public safety agencies, community colleges, hospitals, private companies, and physicians.
- Conducts regular meetings and public hearings.
- Participates on EMSC Standing Committees: Provider Agency Advisory and Base Hospital Advisory.

## MEETINGS

The EMSC meetings are held in accordance with The Ralph M. Brown Act which is a California state law that mandates meetings are open to the public, allow free public access, and allow for public comments concerning public business.

Meetings are in-person and held at the EMS Agency on the third Wednesday of every odd-numbered month with January as month one (1) from 1:00 pm to 3:00 pm. The agenda is posted in advance on the EMS Agency Website under the EMS Commission Agenda tab, and on the front door of the EMS Agency located at:

Emergency Medical Services Agency:  
10100 Pioneer Boulevard, First Floor  
Cathy Chidester Conference Room 128  
Santa Fe Springs, California 90670  
(562) 378-1500  
<http://ems.dhs.lacounty.gov/>

### Regular Meeting Dates in FY 2024-25

July 17, 2024 – September 18, 2024 – November 20, 2024  
January 15, 2025 – March 12, 2025 – May 21, 2025

## ANNUAL WORKPLAN GOALS AND OBJECTIVES FOR FY 2025-26

The EMS Commission's goals and objectives align with the County's and DHS's mission, vision, and values through strategic alliances and establishing workgroups to develop studies and surveys and analyze policies and practices to identify solutions that ensure measurable, quality outcomes for patients and communities in Los Angeles County.

### Goals and Objectives:

- Continue monitoring processes/policies to address/reduce Ambulance Patient Offload Delays (APOD).
- Support collaborative efforts of EMS constituents to identify throughput issues that contribute to APOD.
- Support the implementation of ambulance offload teams to assist hospitals with extreme APOD.
- Continue working on recommendations from the ad hoc committee on the Prehospital Care of Mental Health and Substance Abuse Emergencies, specifically suicide risk protocols.
- Establish behavioral health workgroup to address suicide risk protocols, focus on field evaluation of suicidal ideation, develop guidelines and education to address assessment and management of patients experiencing suicidal ideation.
- Establish workgroup to address cardiac arrest outcomes to improve the quality of care.
- Monitor progress of ad hoc workgroup on Interfacility Transport (IFT) delays on critical care transports.
- Monitor the success of EMS Update 2025-26 on behavioral health emergencies and treatment protocols.
- Review and recommend policies, directives, and pilots for adoption by the EMS Agency.
- Monitor changes to treatment protocols.
- Support disaster planning with emphasis on broader regional disaster plans.
- Support EMT/paramedic training programs that serve the underserved communities.

- Monitor progress of ad hoc workgroup for LA County EMS Corps Programs.
- Invite subject matter experts to provide information and training in the field of emergency medical care.
- Monitor State and federal legislation affecting the EMS system.
- Advise on and recommend topics for EMS education.
- Support the EMS Agency's efforts to ensure timely and accurate data submission from all EMS providers and specialty care centers.
- Participate on the Measure B Advisory Board and ensure constituent groups are aware of the Measure B allocation process of the un-allocated Measure B funds.
- Support the monitoring of the Emergency Ambulance Transportation Agreements which expire in 2027.

### **ONGOING LONG-TERM PROJECTS**

- Monitor processes/policies to address and reduce Ambulance Patient Offload Delays (APOD).
- Continue working on recommendations from the ad hoc committee on the Prehospital Care of Mental Health and Substance Abuse Emergencies, specifically suicide risk protocols.
- Monitor the progress of the Field Evaluation of Suicidal Ideation and Behavior Workgroup.
- Support annual EMS Update training for EMS professionals and providers.
- Support education efforts for Bystander, Hands-Only CPR training (Sidewalk CPR).
- Monitor legislation with potential impact to the EMS system.
- Monitor and support the Public Works Alliance – EMS Corps programs established in LA County.
- Monitor and support EMS pilots and trial studies to improve the delivery of emergency medical care.
- Monitor Alternative Destination Volume Reports for psychiatric urgent care and sobering center facilities that EMS transports directly to.
- Monitor, support, and make recommendations to the Cardiac Arrest Care ad hoc workgroup for improvements in patient outcomes.
- Continue to support the collaboration of EMS-Law Enforcement Co-Response (ELCoR) workgroup.
- Monitor and support pilot project with service area hospitals' pilot to eliminate service area boundaries.
- Monitor effectiveness of FirstWatch system implementation on real-time dispatch data information.
- Continue monitoring resource allocations in emergency situations.
- Continue to monitor the progress of the State EMS Authority on changes to Chapter 5.
- Continue to monitor progress of General Public Ambulance Rate Increases and recommendations.

### **ACCOMPLISHMENTS AND SIGNIFICANT OUTCOMES FISCAL YEAR 2024-25**

- Approved the FY 2023-24 EMSC Annual Report at the September 11, 2024, meeting.
- Approved EMSC Ordinance changes.
- Approved re-vote on Consent Calendar if lack of quorum.
- Monitored Implementation and rollout of FirstWatch real-time data on ambulances waiting to offload.
- Monitored separate policy addressing APOT and APOD.
- Supported redistribution of the CHA APOT Toolkit.
- Monitored pilot project on the Medical Control Guideline for Suicide Risk Assessment.
- Established new EMSC goals and objectives for FY 2025-26.
- Recommended re-establishment of ad hoc workgroup to advance the September 2016 *Prehospital Care of Mental Health and Substance Abuse Emergencies* Report recommendations.
- Recommended Ordinance Changes to Los Angeles County Ordinance, Chapter 3.20: Emergency Medical Services Commission Section 3.20.040: Composition due to association name changes, and established membership have nexus to work in or practice in LA County.
- Approved Ordinance change for paramedic to be nominated by California Professional Firefighters.
- Endorsed language changes in the EMSC Ordinance membership to include a requirement for commissioners to work in or practice in Los Angeles County.
- Monitored psychiatric urgent care and alternate transport volumes and outcomes of transports.
- Endorsed and monitored EMS pilot projects and system enhancement tools (ECMO, First Watch, igel).
- Monitored legislation impacting the EMS system and Board priorities.
- Approved new Chair and Vice Chair selections for 2024 and 2025.

- 
- Approved Commissioner selection for EMSC Measure B Advisory Board Representation and approved nominating committee and standing committee selections.
  - Prehospital Care Policies and Medical Control Guidelines Reviewed:
    - 205: Innovation, Technology, and Advancement Committee (ITAC)
    - 215: EMS and Law Enforcement Co-Response Committee
    - 222: Downgrade or Closure of 9-1-1 receiving hospital, Perinatal, Inpatient Psychiatric or emergency Medical Services
    - 411: 9-1-1 Provider Agency Medical Director (Held)
    - 420: Private Ambulance Operator Medical Director
    - 505: Ambulance Patient Offload Time (APOT)
    - 515: Air Ambulance Transport
    - 519: Management of Multiple Casualty Incidents
    - 702: Controlled Drugs Carried on ALS, SCT and APRU Units
    - 817: Regional Mobile Response Teams
    - 823: Elder Abuse and Dependent Adult Abuse Reporting Guidelines
    - 1116: Hospital – Adopt-A-Shelter Program (For Deletion)
    - 1124: Disaster Preparedness Exercise/Drills
    - 1130: Trauma Center Emergency Preparedness
    - 1306: Evaluation and Care of Patients at Risk of Suicide
  - Legislation Reviewed:
    - AB 40: Requires local emergency medical services agencies (LEMSAs) to develop a standard ambulance patient offload time (APOT) not to exceed 30 minutes 90 percent of the time. This bill passed.
    - AB 1168: Retroactively awards 201 rights of EMS providers, cities, and fire districts to continue providing prehospital emergency medical services at the same level and with the same administration as they did before June 1, 1980, under specific conditions. This bill results from a lawsuit where the City of Oxnard vs. the County of Ventura had a joint power agreement and Oxnard wanted to separate from the exclusive operating area which would leave less affluent areas without the same level of service and fragment the EMS system. This bill was approved by the Senate and Assembly. L.A. County opposes this bill and is actively campaigning for Governor Gavin Newsom to veto this bill.
    - SB 1180: Requires insurers to cover community paramedicine, triage to alternate destinations, and mobile integrated health. This will go through Appropriations Committee. This is a wait-and-see bill.
    - AB 2075: Restriction of visitation at long-term care facilities – patients cannot leave, and no visitors are allowed during a public health emergency. This is a wait-and-see bill.
    - EMS Regulations – Chapter 1 (Previously Chapter 13): Emergency Medical Services Authority and Commission on Emergency Medical Services. The adopting agency requested its conflict-of-interest code be incorporated by reference into the California Code of Regulations (CCR). The State is moving forward with legislation. Complex issue dealing primarily with emergency transportation. Issues regarding grandfather rights and the administration of EMS need to be resolved.
    - EMS Regulations – Chapter 6: Specialty Care Programs – STEMI, Stroke, EMS for Children, and Trauma were all separate Chapters that have all been combined as Chapter 6. The deadline for public comment submissions was April 3, 2025.
    - EMS Regulations – Chapter 7: Trauma Care Systems. This is with the Office of Administrative Law. It will be renumbered and incorporated into the Specialty Care Center Designation Regulations along with STEMI, Stroke, and EMS for Children.

- The Big Bill: Under the new federal administration and funding, there is an anticipated billion dollar cut in Medi-Cal, and it will have significant impacts on programs for the undocumented population.
- Hospital Preparedness Program (HPP) funding has been approved through Congress for the next few years.

**EMERGENCY MEDICAL SERVICES COMMISSION**



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LA County Medical Association



Erick H. Cheung, MD, PhD  
Southern California Psychiatric  
Society

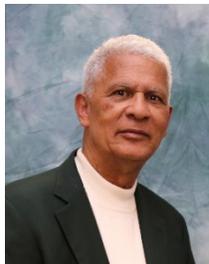


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Los Angeles County Police  
Chiefs' Association

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communities by ensuring  
quality emergency and  
disaster medical services."*



**Health Services**  
<http://ems.dhs.lacounty.gov>

March 6, 2025

Kelsey Wilhelm, MD, Medical Director  
Compton Fire Department  
201 S. Acacia Avenue  
Compton, California 90220

**CERTIFIED**

Dear Dr. Wilhelm:

**LOS ANGELES DEVELOPMENT & RAPID OPERATIONALIZATION  
OF PREHOSPITAL BLOOD (LA-DROP) PILOT PROGRAM  
APPROVAL**

This letter is to confirm that Compton Fire Department (CM) and Los Angeles County Fire Department (CF) have been approved by the Emergency Medical Services (EMS) Agency for the Los Angeles Development & Rapid Operationalization of Prehospital Blood (LA-DROP) pilot for a twenty-four (24) month period at which time the pilot will be re-evaluated for efficacy and feasibility.

All CM Rescue Squads and the following CF units have been designated for participation in the pilot:

- Battalion 7—10, 36, 41, 116
- Battalion 18—21, 158, 161
- Battalion 20—14, 171, 172, 173

The quality improvement plan for the pilot requires both CM and CF to submit quarterly reports to the EMS Agency. These reports will include, at minimum, the following items:

- Descriptive characteristics for patients meeting criteria for prehospital blood transfusion (PHBT)
- Descriptive characteristics for patients who received PHBT
- Time metrics
- Safety outcomes
- Efficacy outcomes
- Appropriate statistical evaluation

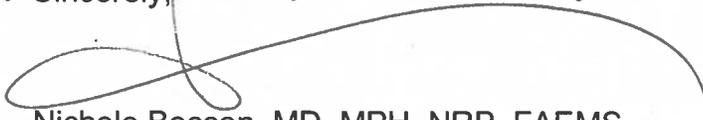
Additional data may be requested from CM and CF if deemed necessary by the EMS Agency to assess pilot program objectives.

**In addition to the above requirements, please report all sentinel events within 24 hours of occurrence.**

Dr. Kelsey Wilhelm  
March 6, 2025  
Page 2

The quarterly reports are due thirty (30) days after the end of each quarter and should be addressed to me at [NBosson@dhs.lacounty.gov](mailto:NBosson@dhs.lacounty.gov) and copy Gerard Waworundeng at [GWaworundeng@dhs.lacounty.gov](mailto:GWaworundeng@dhs.lacounty.gov)).

Sincerely,



Nichole Bosson, MD, MPH, NRP, FAEMS  
Medical Director

NB:gw  
03-01

- c. Director, EMS Agency  
Fire Chief, Compton Fire Department  
Fire Chief, Los Angeles County Fire Department  
Medical Director, Los Angeles County Fire Department  
Quality Improvement Director, Los Angeles County Fire Department  
Nursing Director, EMS Programs, EMS Agency  
Chief, Prehospital Operations, EMS Agency  
Chief, Data Systems and Research, EMS Agency



**EMERGENCY MEDICAL SERVICES AGENCY**  
LOS ANGELES COUNTY

March 17, 2025

**MEMORANDUM**

**Los Angeles County Board of Supervisors**

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**Richard Tadeo, RN**  
Director

**Nichole Bosson, MD, MPH**  
Medical Director

**TO:** Distribution

**FROM:** Nichole Bosson, MD, MPH  
Medical Director, LA County EMS Agency

**SUBJECT: LOS ANGELES DEVELOPMENT & RAPID OPERATIONALIZATION OF PREHOSPITAL BLOOD (LA-DROP) PILOT**

This is to notify you that the Los Angeles Development & Rapid Operationalization of Prehospital Blood (LA-DROP) Pilot will begin April 1, 2025.

The prehospital blood transfusion pilot provider agencies include the Los Angeles County Fire Department (units specified below) and Compton Fire Department. LA-DROP is a partnership with these provider agencies, Harbor-UCLA Medical Center, the San Diego Blood Bank, and the Los Angeles County EMS Agency. The California EMS Authority has approved prehospital blood transfusion in local optional scope of practice for LA County.

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

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

Participating Pilot Units	
Region	Units
LA County Fire Battalion 7	s10, s36, s41, s116
LA County Fire Battalion 18	s21, s100, s161
LA County Fire Battalion 20	S14, s171, s172, s173
Compton Fire	All Units

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

Participating ALS units will be equipped with blood products, either low-titer O positive whole blood (LTO+WB) or packed red blood cells (PRBC), which may be administered to **adult patients (≥15 years old) in hemorrhagic shock from trauma or post-partum hemorrhage per the attached protocol**. Blood storage and administration will be rigorously monitored per The Association for the Advancement of Blood & Biotherapies (AABB) Standards.

Paramedics will follow usual base contact and destination policies. **All 9-1-1 receiving centers should be aware of this pilot and the attached hospital resource document**, in particular Trauma Centers and Base Hospitals. Base Hospitals will receive a separate communication with additional training resources.

Data are collected for system quality improvement and patient safety monitoring. Outcome reporting, including identification of any transfusion reactions, is required by the California EMS Authority. Therefore, a participating provider agency medical director will be contacting hospitals for limited data on transfused patients and provide a HIPAA-compliant form for submission.



**Health Services**  
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For more background on the program, you may view this video, which introduces the training program and rationale for the prehospital blood transfusion pilot in LA County: <https://vimeo.com/1062996337>. Further details are also available in the attached Facts and Questions.

To support the program, there will be increased opportunities to donate blood and we will notify you when these opportunities are available.

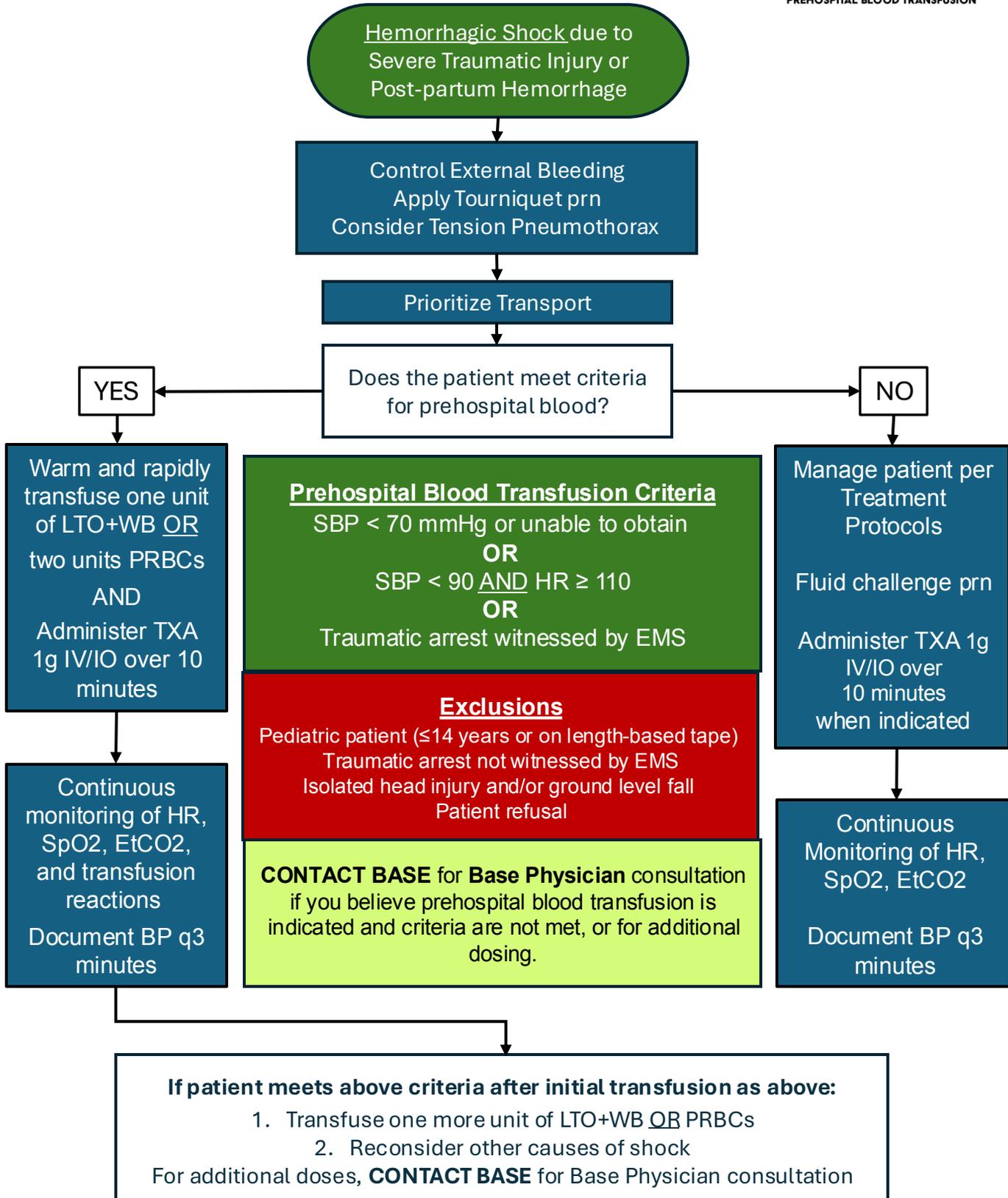
If you have any questions please contact me at [nbosson@dhs.lacounty.gov](mailto:nbosson@dhs.lacounty.gov) or (562) 378-1600.

Attachments:

Prehospital Blood Transfusion Protocol, Checklist and Consent Tool  
Receiving Hospital Resource Document  
Facts and Questions

c: Director, EMS Agency  
Fire Chiefs, Public Provider Agencies  
Medical Directors, Public Provider Agencies  
Paramedic Coordinators, Public Provider Agencies  
EMS Educators, Public Provider Agencies  
Medical Directors, Ambulance Companies  
Paramedic Coordinators, Ambulance Companies  
Direct of Operations, EOA Provider Agencies  
Medical Director, Paramedic Base Hospitals  
Prehospital Care Coordinator, Paramedic Base Hospitals  
Chief Executive Officers, 9-1-1 Receiving Hospitals  
ED Managers, 9-1-1 Receiving Centers  
Hospital Association of Southern California  
California EMS Authority

# Prehospital Blood Transfusion Pilot Protocol



# LA-DROP

## Blood Administration Field Checklist

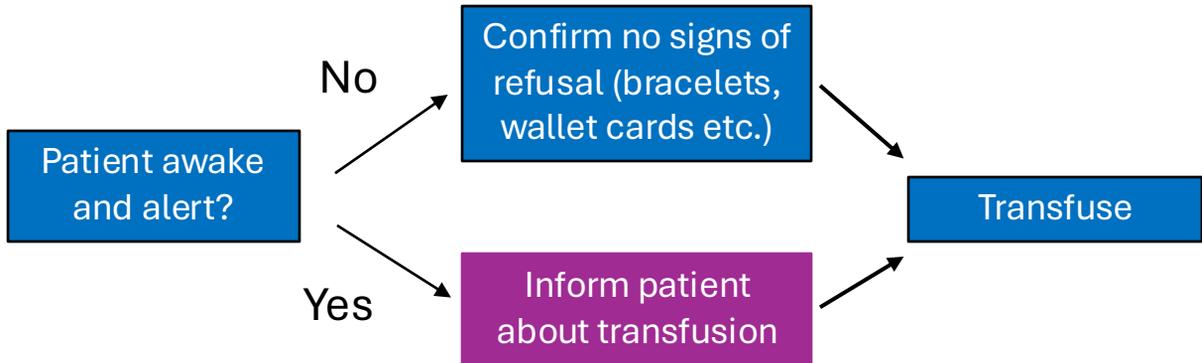


- Ensure external bleeding controlled, think "MARCH"
- Place patient on cardiac monitor
  - Obtain HR, BP, SPO2 and ETCO<sub>2</sub>
- Establish 2 large bore IVs (preferred) or IOs if unable
- Confirm indications and rule out contraindications
- Inform patient of transfusion or use implied consent and look for refusal markers
- Remove blood product and relock the cooler
- Inspect the blood bag for integrity and blood clots
- Perform cross check with a second paramedic:
  - Product Type (Whole Blood or pRBCs)
  - Rh Factor (O positive or O negative)
  - Expiration Date
- Prime blood tubing and warmer with saline
- Spike 1 unit of blood to the Y connector with primed tubing
- Verify that blood is flowing and no extravasation at access site
- Rapidly transfuse the entire bag of blood by rapid infuser or pressure bag
- Reassess to determine if patient meets indications for additional 1 unit of blood:
  - If yes, transfuse 1 additional unit (LTO+WB or pRBCs)
  - If no, flush remaining blood in tubing with NS on Y connector until clear
- Administer TXA 1 g IV/IO as soon as feasible
- Immediately recheck vital signs, continuous monitoring, reassess BP q3 mins
- Maintain IV/IO line patency
- Continuously monitor for transfusion reaction
- Apply patient wristband for hospital awareness

Hemorrhagic shock is due to traumatic injury or post-partum hemorrhage.
<b>Prehospital Blood Transfusion Criteria</b> SBP < 70 mmHg or unable to obtain OR SBP < 90 AND HR ≥ 110 OR Traumatic arrest witnessed by EMS
<b>Exclusions</b> Pediatric patient (≤14 years or on length-based tape) Traumatic arrest not witnessed by EMS Isolated head injury and/or ground level falls Patient refusal
<b>CONTACT BASE for Base Physician</b> consultation if you believe prehospital blood transfusion is indicated and criteria are not met, or for additional dosing.

<b>Actions to take for suspected transfusion reaction:</b> <ul style="list-style-type: none"> <li>✓ <b>STOP TRANSFUSION</b></li> <li>✓ Disconnect tubing from IV; flush IV port</li> <li>✓ Follow Treatment Protocols (e.g., 1214, 1219)</li> <li>✓ Document reaction in ePCR and report reaction during verbal hand-off</li> <li>✓ Provide blood bag and all tubing to hospital for testing</li> </ul>
---

# Blood Transfusion Consent



## Scripting Suggestions:

- "We need to give you a life saving blood transfusion due to your severe bleeding. The risks are very low and include allergy, fever, or breathing reactions and we will monitor you closely. There is a very rare chance of disease transmission, about 1 in 1 million."

## Special Circumstances:

- **If patient sex is female and of childbearing age (<50 years):** "Depending on your blood type, your body may produce a reaction from a blood transfusion that has a potential risk of affecting future pregnancies."
- **If patient refuses blood or carries documentation/identifying marker of blood refusal:** "Because I want to make sure I respect your decisions, I want to confirm that you do not want to be treated with blood products even if that means you might die. Is that correct?"

### For minors (< 18 years):

If parent/guardian on scene, inform them of need for transfusion.  
If no parent/guardians on scene, utilize implied consent.

**CONTACT BASE for Base Physician consultation on all refusals of blood transfusions**

Risk	Risk per unit of blood	Severity
Allergic reactions: - Mild - Moderate - Severe	1 in 100  1 in 50,000	Ranges from - Hives and itching to - Low BP, nausea, difficulty breathing to - Shock
Fever	1 in 200	Temporary; not harmful
Injury to the lungs	1 in 1,200 to 190,000	1:10 risk of death if complication occurs
Contamination of product causing bacterial infection in patient's bloodstream.	1 in 10,000 to 100,000	Severe to life-threatening
Too much fluid in your bloodstream	Less than 1 in 100	Ranges from mild to severe
Too much iron in your bloodstream and tissues	Can occur after 10-20 red blood cell transfusions if patient is not bleeding	Ranges from mild to severe
Breaking apart of red blood cells	1 in 25,000	Ranges from mild to severe
Viral infection	Every unit of blood is tested for all major viruses; the risk of getting HIV, Hepatitis C, or Hepatitis B from a blood transfusion is close to 1 in 1,000,000 to 1,500,000.	



## Receiving Hospital Resource Document

### What can you expect when EMS transports a pilot patient to your facility?

Patients who meet criteria for transfusion will have had low-titer Group O+ whole blood (LTO+WB) rapidly warmed and transfused via large bore IV or IO.

Patients will arrive with a neon green wristband labeled “EMS Blood Tx”, which will have a scannable QR code that links to more program specific information. All used blood bags (including segments) and tubing will be left with the accepting nurse for further blood bank testing as needed.

EMS will report transfusion related information during verbal patient handover including:

- Indication for transfusion
- Type of blood product administered
- Total volume of blood product administered
- If transfusion was stopped prior to completion and, if so, why
- Any adverse reactions including suspected transfusion reactions
- Any additional medications given (e.g., TXA)

Further patient care details can be found in the prehospital electronic patient care record.

### Alloimmunization Guidance

Patients are transfused with low-titer Group O+ whole blood (LTO+WB) as part of the LA-DROP prehospital blood transfusion program to save their life. This LTO+WB is Rh-positive, meaning it has the potential to alloimmunize an Rh-negative patient by triggering the development of anti-D antibodies. Anti-D antibodies will not harm the patient but could possibly impact future pregnancies.

If the patient is Rh-negative and potentially desires pregnancy in the future:

Consult your hospital's transfusion medicine service and pharmacist about recommended management strategies and treatment plans including **administration of Rh immunoglobulin (Rhlg) within 72 hours**. If needed, you may contact the Director of the Harbor-UCLA Transfusion Medicine Service at 424-306-6227 for technical program questions. Additional resources are available at [www.allohopefoundation.org](http://www.allohopefoundation.org).

Recommendations for management of potential Rh-alloimmunization:

- Discuss the potential for Rh antibody (anti-D) formation. If there is no possibility that the patient will be pregnant in the future, Rhlg carries little benefit. If future pregnancies are possible, consider whether to administer Rhlg to prevent anti-D development.
- Standard Dose: A **300 microgram** dose of Rhlg can suppress the immune response to up to **30 mL** LTO+WB. Each unit of LTO+WB is approximately 500 mL.
- Rhlg administration is contraindicated if the Rh-positive RBC volume transfused is >20% of the patient's total blood volume due to the potential for marked red cell splenic sequestration and hemolysis.

For Rh-negative patients, we recommend repeating Type and Screen testing **6-12 weeks** following the exposure to the LTO+WB to determine the development of anti-D antibodies. If antibody testing remains negative, then it is unlikely that patients will develop anti-D later. If the patient may become pregnant and has developed anti-D, the patient should be informed of the potential impact on future pregnancies and understand the importance of sharing this information with their healthcare providers. If they become pregnant, the patient should be referred to an obstetrician who specializes in maternal-fetal medicine.

### Patient outcomes and adverse event reporting

The participating EMS Provider Agency Medical Directors will reach out to the Trauma Program Managers or other established hospital points of contact for limited critical outcome data, including transfusion reactions. Data will be obtained via a secure HIPAA-compliant form. Timely and complete outcome data will ensure patient safety and is required by the California EMS Authority. The receiving hospital blood bank will be contacted by the Director of Transfusion Medicine at Harbor-UCLA should any look backs or other notifications be required.



# LA-DROP PROGRAM FAQs

## How does the LA-DROP program help the community?

The LA-DROP program helps save lives by giving blood transfusions to people who are bleeding a lot, such as after an injury or childbirth. Paramedics can give blood right away at the scene, which helps prevent organ damage and increases the chances of survival.

## Is the blood safe?

Yes. The blood used in this program is the same as what hospitals use. It is tested for diseases like HIV and hepatitis and stored under strict rules to keep it safe.

## Who can get a blood transfusion before going to the hospital?

People who are bleeding badly from injuries or childbirth and need emergency care from 9-1-1 paramedics.

## How does this program support national healthcare goals?

This program helps reduce preventable deaths by giving life-saving blood transfusions before a patient reaches the hospital. It is part of a national effort to improve emergency care. LA-DROP is a collaborator in the Prehospital Blood Transfusion Initiative Coalition (<https://prehospitaltransfusion.org/>).

## How will the program's success be measured?

The program will track things like survival rates, how quickly blood is given, any problems that happen, and how much blood is used or wasted.

## What kind of blood is used?

The program mainly uses O+ whole blood, which contains red blood cells, plasma, and platelets. This type of blood is best for stopping bleeding and saving lives. It is donated by volunteers and kept cold to keep it fresh.

If whole blood is not available, red blood cells (RBCs) may be used instead.

## Why is whole blood important?

- **Red blood cells (RBCs)** carry oxygen to the body.
- **Plasma and platelets** help stop bleeding by making clots.
- **Blood volume** helps keep blood pressure stable.



# LA-DROP PROGRAM FAQs

## How is blood stored and transported?

Blood is kept in special refrigerators inside paramedic vehicles at a safe temperature just as it is in the hospitals.

## How are paramedics trained for this?

Paramedics learn how to store and give blood, follow safety rules, recognize bad reactions, and keep proper records.

## What happens to unused blood?

Unused blood is sent to hospitals where it can be used before it expires, so it doesn't go to waste.

## Are there any risks?

Blood transfusions are very safe, but there are small risks, such as:

- **Mild reactions** (like allergies or fevers) happen in 1-3% of cases and can be treated with medicine.
- **Serious reactions** (like lung injury) are very rare (1 in 100,000 transfusions).
- **Infections** from blood are extremely rare (1 in 1.5-2 million transfusions).
- **Antibody formation** might happen, which could make future transfusions or pregnancies more complicated, but the risk is low.
- **Cold blood** can lower body temperature, so special devices warm it up before it is given.

## Can persons of childbearing age get this blood?

Yes. There is a small chance that receiving this blood could affect future pregnancies, but the benefit of saving a life is more important. Using our local numbers, we estimate this would happen in only 1 out of 10,000 transfusions. Hospitals have guidelines to manage this risk.

For more information, visit: <https://allohopefoundation.org/>

## Can children receive this blood?

Children under 15 are not included in this program, but in special cases, a hospital doctor might allow it.

## What if someone has a religious objection to blood transfusions?

All blood comes from human donors. If someone does not want a blood transfusion for religious reasons, they should tell the first responders or carry a card or bracelet. In emergencies, options may be limited.

## Will getting blood before the hospital limit other treatments?

No. Receiving blood early does not stop doctors from giving more blood or medicine later if needed. In fact, early transfusions help the body and may reduce the need for more blood later.



# LA-DROP PROGRAM FAQs

## Is this blood type universal?

O+ blood can be given to most people. However, O- blood would be even safer for all patients, but there isn't enough O- blood available.

## More information about whole blood:

- **How much blood is in one unit?** About 500 mL (half a liter).
- **How is whole blood different from red blood cells?** Whole blood has plasma and platelets, which help stop bleeding. Red blood cells alone only help carry oxygen.
- **Why use whole blood instead of separate components?** Whole blood is more natural and reduces the number of donors a patient is exposed to.

## Is the blood irradiated?

No, because irradiation slightly damages red blood cells. In emergencies, there isn't enough time to irradiate the blood, and it isn't needed for most patients.

## Are the platelets in whole blood effective?

Yes, platelets in cold-stored whole blood work well for up to 14 days and help stop bleeding.

## Will this blood change my blood type?

No, but if you get a lot of it, it might temporarily affect lab test results.

## Can I still receive other blood products later?

Yes, you can receive more blood products if needed after getting whole blood.

## How can I help by donating blood?

Blood donations are needed to save lives. You can donate at local blood banks. **Who can donate blood?**

- You must be at least **16 years old** (with parental consent) or **17 without consent**.
- You must weigh at least **110 lbs (50 kg)**.
- You must be in **good health**.

For more details, visit:

- [San Diego Blood Bank](#)
- [Red Cross](#)



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**Richard Tadeo, RN**  
Director

**Nichole Bosson, MD, MPH**  
Medical Director

April 1, 2025

TO: Distribution

VIA E-MAIL

FROM: Richard Tadeo, RN  
Director, EMS Agency

SUBJECT: **PERMANENT REMOVAL OF SERVICE AREA BOUNDARIES**

On December 1, 2024, the Los Angeles County Emergency Medical Services (EMS) Agency, in cooperation with the affected hospitals, suspended all Service Area boundaries. This patient destination change affected the following defined service areas:

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

This suspension is now permanent. Patient destination within these service area boundaries will be based upon Ref. No. 502, Patient Destination. Diversion of patients shall follow Ref. No. 503, Guidelines for Hospital Requesting Diversion of ALS/BLS patients.

On April 15, 2025, the following Prehospital Care References will be deleted:

- Ref. No. 509, Service Area Hospital
- Ref. No. 509.2, Shared Service Area for Dignity Health – California Hospital Medical Center and PIH Health Good Samaritan Hospital
- Ref. No. 509.2a, Shared Service Area for Dignity Health – California Hospital Medical Center and PIH Health Good Samaritan Hospital – Map
- Ref. Nos. 509.4, Shared Service Area for Adventist Health – White Memorial, East Los Angeles Doctors Hospital and Community Hospital of Huntington Park
- Ref. Nos. 509.4a, Shared Service Area for Adventist Health – White Memorial, East Los Angeles Doctors Hospital and Community Hospital of Huntington Park – Map

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

RT:cc

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

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**Nichole Bosson, MD, MPH**  
Medical Director

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

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

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communities by ensuring  
quality emergency and  
disaster medical services.*



**Health Services**  
**<http://ems.dhs.lacounty.gov>**

May 18, 2025

**VIA EMAIL**

TO: Distribution

FROM: Richard Tadeo  
EMS Agency Director

Nichole Bosson, MD, MPH  
EMS Agency Medical Director

**SUBJECT: EMS WEEK 2025 – MAY 18-24**

This year's theme is **"We Care for Everyone."**

Let's celebrate this year's EMS week by showing our gratitude toward our EMS professionals (EMTs, paramedics, firefighters, nurses, physicians). EMS week is also the time to educate the public about the essential services provided by EMS to our communities.

This past year has been filled with EMS innovations and together we have accomplished so much as a system. We launched our RAPID LA County Medic Mobile Application, which provides access to all LA County EMS policies, protocols, and guidelines for the purposes of field care, education, and training. We are moving forward with the Health Data Exchange, which will automatically transfer EMS patient care records into the hospitals' patient record management systems improving data and communications to support patient care. We are expanding access to extracorporeal cardiopulmonary resuscitation (ECPR) with the regional system of care to improve outcomes in patients with out-of-hospital cardiac arrest. We started the prehospital blood transfusion pilot program to save the lives of patients experiencing life-threatening blood loss in the field. Our research initiatives for pediatric airway and seizure management are ongoing and will advance the EMS care of critically ill and injured children.

Let us not lose sight of our collective mission to ensure quality emergency and disaster medical services and take this opportunity to provide our support and respect to all our EMS professionals.

**HAPPY EMS WEEK!**

Distribution:

- Fire Chiefs
- CEO, Ambulance Operator
- EMS Provider Agency Medical Directors
- Paramedic Coordinators
- EMS Educators, EMS Providers
- CEO, Each 9-1-1 Receiving Hospital
- Prehospital Care Coordinators
- Base Hospital Medical Directors
- Trauma Program Managers, Medical Directors
- STEMI Program Managers, Medical Directors
- Stroke Program Managers, Medical Directors
- EDAP, Pediatric Liaison Nurses, Medical Directors
- Pediatric Medical Centers, Program Managers, Medical Directors
- Hospital Association of Southern California
- EMS Commission



**EMERGENCY MEDICAL  
SERVICES AGENCY**  
LOS ANGELES COUNTY

**Los Angeles County  
Board of Supervisors**

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First District

**Holly J. Mitchell**  
Second District

**Lindsey P. Horvath**  
Third District

**Janice K. Hahn**  
Fourth District

**Kathryn Barger**  
Fifth District

**Richard Tadeo, RN**  
Director

**Nichole Bosson, MD, MPH**  
Medical Director

June 5, 2025

Jacob J. Silva, CEO  
Cuore Inc. dba Heart Transportation  
11629 Clark Street, Suite 201  
Arcadia, CA 91006

**E-MAILED/CERTIFIED**

### **AMBULETTE OPERATOR BUSINESS LICENSE APPROVAL**

This letter is in response to the Ambulance Licensing Hearing Board (Hearing Board) correspondence dated May 19, 2025, regarding the Cuore Inc. dba Heart Transportation (Heart Transportation) application for a Los Angeles County Ambulette Operator's Business License (Business License). Pursuant to the Hearing Board's decision, following your public hearing held on April 22, 2025, Heart Transportation has been granted a Business License.

Heart Transportation will receive their Business License from the Los Angeles County Emergency Medical Services Agency (EMS Agency) once it is issued by the Treasurer – Tax Collector's Office, in the next few weeks. In the interim, maintain a copy of this letter as proof of your business license status.

### **Ambulette Vehicle Licensing**

In addition to the Ambulette Operator's Business License, each ambulette vehicle must be inspected and licensed by the EMS Agency prior to placing units into service in the unincorporated areas of the county or in those cities that have adopted the Los Angeles County Code.

The initial licensing fee is **\$365.72**, which includes \$1.00 for the California Disability Access Fee.

The inventory inspection of each vehicle to be licensed will be based on the requirements specified in the Ambulette Vehicle Equipment Inspection Form (copy enclosed).

To arrange an inspection, please contact Christopher Rossetti, Ambulance Programs, at [rossetti@dhs.lacounty.gov](mailto:rossetti@dhs.lacounty.gov). Copies of the following current and up-to-date documents will also be required for each vehicle to be licensed:

- Verification of Odometer Testing and Certification (Weights and Measures)
- California Department of Motor Vehicle Registration
- Insurance Card

### **Insurance**

Every ambulette operator shall obtain and maintain in full force and effect the minimum insurance coverage types and limits as specified in Sections 7.17.040 (D), .17.110, 7.17.120 and 7.17.130 of the County Code. Such insurance shall be primary to and not contributing with any other commercial insurance policies are self-insurance programs maintained by the county. Such insurance shall be provided by insurer(s) satisfactory to the County with an AM Best rating not less than "A- VII". The general liability (GL) and automobile liability (AL) insurance policies shall name the County of Los Angeles as an additional insured.

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

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Fax: (562) 941-5835

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**Health Services**  
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All insurance policies shall provide that the EMS Agency be given written notice at least thirty (30) days in advance of the cancellation of any policies. It is Heart Transportation's responsibility to submit updated documents of continued insurance coverage that meets or exceeds the minimums specified in the County Code on an ongoing basis.

Please submit the following current and up-to-date insurance documents:

- A Certificate of Insurance that names the County of Los Angeles, EMS Agency as an additional insured and certificate holder
- The additional Insured Endorsement for the GL insurance policy listing the County as an additional insured
- If the AL covers only "Scheduled Autos", Heart Transportation must submit a vehicle schedule from the insurer.

### **Ongoing Requirement**

Pursuant to Count Code, Section 7.08.030, 7.08.050 and Prehospital Care Policy Reference No. 621 Notification of Personnel Change, Heart Transportation shall notify the EMS Agency, in writing, of any changes in management staff of Heart Transportation, and in the event of any such changes, shall provide the EMS Agency with an updated organizational chart reflecting the change.

Please be advised, the EMS Agency will be conducting a site visit to verify compliance with the Los Angeles County Code, Title 7, Chapter 7.17, Ambulettes within six (6) months of commencement of operations as a condition of licensure approval.

If you have any questions, please contact Christopher Rossetti, Ambulance Programs, at [crossetti@dhs.lacounty.gov](mailto:crossetti@dhs.lacounty.gov).

Sincerely,



Richard Tadeo  
Director

RT:hk  
06-18a

### Attachments

- c. County Counsel  
Treasurer-Tax Collector  
CEO's Office



**EMERGENCY MEDICAL  
SERVICES AGENCY**  
LOS ANGELES COUNTY

June 11, 2025

**Los Angeles County  
Board of Supervisors**

**Hilda L. Solis**  
First District

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Third District

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Fourth District

**Kathryn Barger**  
Fifth District

**Richard Tadeo**  
Director

**Nichole Bosson, MD, MPH**  
Medical Director

Mr. Keith Hobbs

**CERTIFIED**

President & Chief Executive Officer  
Torrance Memorial Medical Center  
3330 W. Lomita Boulevard  
Torrance, CA 90505

Dear Mr. Hobbs:

**EXTRACORPOREAL CARDIOPULMONARY RESUCITATION RECEIVING CENTER  
PROGRAM DESIGNATION STATUS**

On April 29, 2025 the Emergency Medical Services (EMS) Agency completed a site visit to review Torrance Memorial Medical Center's (TOR) Extracorporeal Cardiopulmonary Resuscitation (ECPR) Receiving Center's Program for initial ECPR Program Designation. After reviewing all submitted documents and conducting a site visit, the EMS Agency grants approval of TOR's ECPR Program. It is the expectation that administration allots the necessary time for staff to ensure the program requirements are met on a continual basis.

Your designation status will begin on **July 1, 2025** for a period of three years from the date of your site visit. Additionally, TOR agrees to permit the EMS Agency to conduct scheduled site visits during the confirmation period, if necessary, to ensure compliance with the ECPR Standards.

Congratulations and thank you again for your commitment to this program. If you have any questions, please feel free to contact me at (562) 378-1600, or Priscilla Ross, SRC and ECPR Programs Coordinator, at (562) 378-1660 or [Pross2@dhs.lacounty.gov](mailto:Pross2@dhs.lacounty.gov).

Sincerely,

Nichole Bosson, MD, MPH  
Medical Director

NB:pr  
06-09

c: Director, EMS Agency  
ECPR Program Medical Director, Torrance Memorial Medical Center  
ECPR Program Clinical Directors, Torrance Memorial Medical Center  
(via e-mail)

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

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Fax: (562) 941-5835

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**EMERGENCY MEDICAL  
SERVICES AGENCY**  
LOS ANGELES COUNTY

June 17, 2025

**VIA-EMAIL**

**Los Angeles County  
Board of Supervisors**

**Hilda L. Solis**  
First District

**Holly J. Mitchell**  
Second District

**Lindsey P. Horvath**  
Third District

**Janice K. Hahn**  
Fourth District

**Kathryn Barger**  
Fifth District

**Richard Tadeo, RN**  
Director

**Nichole Bosson, MD, MPH**  
Medical Director

**TO:** Los Angeles County Mobile Intensive Care Nurses (MICNs)  
Los Angeles County Paramedics

**FROM:** Richard Tadeo  
Director

**SUBJECT: RAPID LA COUNTY MEDIC / DRUG DOSES MOBILE  
APPLICATION**

The Los Angeles County Emergency Medical Services (EMS) Agency has fully deployed the **RAPID LA County Medic / Drug Doses (RAPID)**. This is a mobile application for the Los Angeles County Prehospital Treatment Protocols (Ref. Nos. 1200s), EMS Medical Control Guidelines (Ref. Nos. 1300s), Prehospital Care Policies, Drug Doses and Just-In-Time Training videos of high risk-low frequency field treatment procedures.

The RAPID application offers quick access to the most current protocols and guidelines, supporting field care, education, and training. It is intended for use by licensed/accredited/certified EMS clinicians (paramedics, MICNs, physicians) within Los Angeles County.

The RAPID mobile application can be downloaded to a smartphone or accessed via a desktop browser.

**To download RAPID, access the following links:**

**Android:** [Google Play Store](#)

**iPhone:** [Apple Store](#)

**Desktop/Web Version:** [RAPID Website](#)

Upon opening the application, you will be required to read and accept a "Disclaimer" to access RAPID. The mobile application has a "Feedback" feature to provide recommendations to the EMS Agency to further improve RAPID.

RT:ab  
06-11

- c. Medical Director, EMS Agency  
Prehospital Care Coordinators, Each Base Hospital  
Paramedic Coordinators, Each EMS Provider Agency  
Base Hospital Physicians, Each Base Hospital  
Medical Directors, Each EMS Provider Agency  
Program Directors, Paramedic Training Schools  
EMS Commission

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Santa Fe Springs, CA 90670

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

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**Health Services  
<http://ems.dhs.lacounty.gov>**



**EMERGENCY MEDICAL SERVICES AGENCY**  
LOS ANGELES COUNTY

**Los Angeles County Board of Supervisors**

**Hilda L. Solis**  
First District

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Second District

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Third District

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**Kathryn Barger**  
Fifth District

**Richard Tadeo, RN**  
Director

**Nichole Bosson, MD, MPH**  
Medical Director

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June 17, 2025

Elizabeth Basnett  
Director  
Emergency Medical Services Authority  
11120 International Drive, Suite 200  
Rancho Cordova, California 95670

**LOS ANGELES COUNTY EMS PLAN 2023-2024 SUBMISSION**

Dear Ms. Basnett:

In accordance with Section 1797.254 of the Health and Safety Code, I am pleased to forward the Los Angeles County Fiscal Year 2023-2024 Annual EMS Plan to the Emergency Medical Services Authority.

If you have any questions regarding the plan, please contact me, at (562) 378-1610 or Natalie Greco, Prehospital Programs at (562) 378-1680.

Sincerely,

  
Richard Tadeo  
Director

RT:ng



**Health Services**  
<http://ems.dhs.lacounty.gov>



June 23, 2025

Los Angeles County Board of Supervisors

Hilda L. Solis  
First District

Holly J. Mitchell  
Second District

Lindsey P. Horvath  
Third District

Janice K. Hahn  
Fourth District

Kathryn Barger  
Fifth District

Richard Tadeo, RN  
Director

Nichole Bosson, MD, MPH  
Medical Director

TO: Distribution

FROM: Richard Tadeo  
Director

SUBJECT: TEMPORARY HELIPAD CLOSURE – CEDARS-SINAI MEDICAL CENTER

This is to advise you of the temporary closure of Cedars-Sinai Medical Center's (CSM) helipad beginning **Monday, June 30, 2025, at 4:00 a.m. through Tuesday, July 1, 2025, at 12:00 p.m.** for annual fire suppression testing and surface repairs. The ReddiNet® Emergency Medical Communications System will reflect this closure and will be updated upon re-opening of the helipad.

During this period of closure, we are requesting provider agencies and base hospitals direct air ambulance transport to other surrounding trauma centers. However, CSM's trauma service will otherwise remain open to ground transport.

If you have any questions or concerns, please contact Lorrie Perez, Trauma System Program Manager, at (562) 378-1655.

RT:lp  
06-03

- c: Medical Director, EMS Agency
- Medical Alert Center
- Emergency Medical Services Commission
- Hospital Association of Southern California
- Paramedic Coordinator, Los Angeles County Fire Department
- Paramedic Coordinator, Los Angeles County Sheriff's Department
- Paramedic Coordinator, Los Angeles City Fire Department
- Prehospital Care Coordinator, Ronald Regan UCLA Medical Center
- Prehospital Care Coordinator, Providence Saint Joseph Medical Center
- Prehospital Care Coordinator, Northridge Hospital Medical Center
- Prehospital Care Coordinator, LAC+USC Medical Center
- Prehospital Care Coordinator, Dignity Health-California Hospital Medical Center
- Trauma Program Manager, Ronald Regan UCLA Medical Center
- Trauma Program Manager, Providence Saint Joseph Medical Center
- Trauma Program Manager, Dignity Health-Northridge Hospital Medical Center
- Trauma Program Manager, LAC+USC Medical Center
- Trauma Program Manager, Dignity Health-California Hospital Medical Center
- Trauma Program Manager, Huntington Hospital
- Trauma Medical Director, Ronald Regan UCLA Medical Center
- Trauma Medical Director, Providence Saint Joseph Medical Center
- Trauma Medical Director, Dignity Health-Northridge Hospital Medical Center
- Trauma Medical Director, LAC+USC Medical Center
- Trauma Medical Director, Dignity Health-California Hospital Medical Center
- Trauma Medical Director, Huntington Hospital

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Health Services  
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**EMERGENCY MEDICAL SERVICES AGENCY**  
LOS ANGELES COUNTY

June 23, 2025

**Los Angeles County Board of Supervisors**

**Hilda L. Solis**  
First District

**Holly J. Mitchell**  
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**Lindsey P. Horvath**  
Third District

**Janice K. Hahn**  
Fourth District

**Kathryn Barger**  
Fifth District

**Richard Tadeo, RN**  
Director

**Nichole Bosson, MD, MPH**  
Medical Director

TO: Prehospital Care Coordinators (PCCs)

**VIA-EMAIL**

FROM: Richard Tadeo  
Director

**SUBJECT: COMBINED REF. NOS. 1200-1300 PDF DOCUMENT**

This is in response to the concern raised at the Base Hospital Advisory Committee regarding the planned July 1<sup>st</sup> sunset of the transitional combined Ref. Nos. 1200-1300 pdf document. The EMS Agency has evaluated its current resources and workload and given the extensive policy revisions scheduled for the July 1st release, the updated combined 1200–1300 document will be made available on or before **Monday, July 21, 2025**. This will serve as the final release, as the document is rescheduled to sunset on September 30, 2025.

The EMS Agency strongly encourages the transition to the use of other resources including the RAPID LA County Medic/Drug Doses mobile application and EMS Agency website for treatment protocol access and as an educational resource. Additionally, the EMS Agency recommends that downtime procedures be implemented, for example having a printed copy of the treatment protocols (TP) and medical control guidelines (MCG) readily accessible in the paramedic radio room. The downtime TP and MCG document will need to be updated when new and revised protocols and guidelines are released.

For questions, please contact Ami Boonjaluksa, Chief Hospital Programs at [ABoonjaluksa2@dhs.lacounty.gov](mailto:ABoonjaluksa2@dhs.lacounty.gov).

RT:ab  
06-16

c: Medical Director, EMS Agency

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

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Fax: (562) 941-5835

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**Health Services**  
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June 25, 2025

Los Angeles County Board of Supervisors

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First District

Holly J. Mitchell  
Second District

Lindsey P. Horvath  
Third District

Janice K. Hahn  
Fourth District

Kathryn Barger  
Fifth District

Richard Tadeo, RN  
Director

Nichole Bosson, MD, MPH  
Medical Director

TO: Distribution

VIA E-MAIL

FROM: Nichole Bosson, MD, MPH  
Medical Director

SUBJECT: DESIGNATION OF EXTRACORPOREAL CARDIOPULMONARY RESUSCITATION RECEIVING CENTER

The Emergency Medical Services (EMS) Agency is pleased to announce that the following facilities have been designated as an Extracorporeal Cardiopulmonary Resuscitation (ECPR) Receiving Center: Cedars – Sinai Medical Center (CSM), MemorialCare Long Beach Medical Center (LBM), Dignity Health – Northridge Hospital Medical Center (NRH), Torrance Memorial Medical Center (TOR), and Ronald Reagan UCLA Medical Center (UCL).

**Effective Tuesday, July 1, 2025 at 0700 CSM, LBM, NRH, TOR, and UCL will operate as an ECPR receiving center for Los Angeles County** and can receive 9-1-1 patients with out-of-hospital cardiac arrest (OHCA) refractory to conventional therapies and who meet ECPR criteria as outlined in Reference No. 516, Cardiac Arrest (Non-traumatic) Patient Destination.

The Hospital Status Screen for CSM, LBM, NRH TOR, and UCL on ReddiNet® will be updated to reflect the change with an ECPR pill embedded.

Please visit EMS Agency website at <http://ems.dhs.lacounty.gov> for the most current information about the new ECPR centers. An ECPR map will be released in the coming weeks. If you have any questions, please feel free to contact me at (562) 378-1600, or Ami Boonjaluksa, Chief of Hospital Programs at (562) 378-1596.

NB:pr  
06-14

Distribution: Director, EMS Agency  
Fire Chief, Each Fire Department  
Paramedic Coordinator, Each Provider Agency  
Nurse Educator, Each Fire Department  
Prehospital Care Coordinator, Each Base Hospital  
ECPR Program Manager, Each approved ECPR Center  
ECPR Medical Director, Each approved ECPR Center  
SRC Program Manager, Each approved STEMI Center  
SRC Medical Director, Each approved STEMI Center  
Medical Alert Center  
ReddiNet®

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Santa Fe Springs, CA 90670

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Health Services  
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EMERGENCY MEDICAL SERVICES AGENCY  
LOS ANGELES COUNTY

July 2, 2025

Los Angeles County  
Board of Supervisors

MEMORANDUM

Hilda L. Solis  
First District

TO: All Public Provider Agencies

Holly J. Mitchell  
Second District

FROM: Richard Tadeo   
Director

Lindsey P. Horvath  
Third District

Janice K. Hahn  
Fourth District

Kathryn Barger  
Fifth District

SUBJECT: 9-1-1 Interfacility Transfers

Richard Tadeo, RN  
Director

Nichole Bosson, MD, MPH  
Medical Director

In September 2023, the EMS Commission formed a workgroup to evaluate and address challenges with interfacility transfers (IFTs). One of the focuses of this workgroup is decreasing the utilization of 9-1-1 for these transfers.

To better track the utilization of 9-1-1 for IFTs and identify trends so they can be addressed, the EMS Agency is asking that a 9-1-1 IFT form (attached) be completed for every incident where 9-1-1 is contacted to perform an IFT, even if the transport is not completed. A link to the form located on the EMS Agency website:

<https://dhs.lacounty.gov/emergency-medical-services-agency/home/online-services/>.

This form is HIPPA compliant, and we ask that the Medical Director or other designee with the appropriate knowledge to determine medical appropriateness, complete the review.

Please begin utilization of the 9-1-1 IFT Form **effective immediately**.

Contact Chris Clare, Nursing Director, with any questions at [cclare@dhs.lacounty.gov](mailto:cclare@dhs.lacounty.gov) or (562) 378-1661.

Thank you for your assistance in addressing this concern.

RT:cc

Attachment

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

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

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**EMERGENCY MEDICAL  
SERVICES AGENCY**  
LOS ANGELES COUNTY

July 2, 2025

**Los Angeles County  
Board of Supervisors**

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First District

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Second District

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Third District

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Fourth District

**Kathryn Barger**  
Fifth District

**Richard Tadeo, RN**  
Director

**Nichole Bosson, MD, MPH**  
Medical Director

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**MEMORANDUM**

**TO:** All Public Provider Agencies

**FROM:** Richard Tadeo   
Director

**SUBJECT: 9-1-1 Interfacility Transfers**

In September 2023, the EMS Commission formed a workgroup to evaluate and address challenges with interfacility transfers (IFTs). One of the focuses of this workgroup is decreasing the utilization of 9-1-1 for these transfers.

To better track the utilization of 9-1-1 for IFTs and identify trends so they can be addressed, the EMS Agency is asking that a 9-1-1 IFT form (attached) be completed for every incident where 9-1-1 is contacted to perform an IFT, even if the transport is not completed. A link to the form located on the EMS Agency website:

<https://dhs.lacounty.gov/emergency-medical-services-agency/home/online-services/>.

This form is HIPPA compliant, and we ask that the Medical Director or other designee with the appropriate knowledge to determine medical appropriateness, complete the review.

Please begin utilization of the 9-1-1 IFT Form **effective immediately**.

Contact Chris Clare, Nursing Director, with any questions at [cclare@dhs.lacounty.gov](mailto:cclare@dhs.lacounty.gov) or (562) 378-1661.

Thank you for your assistance in addressing this concern.

RT:cc

Attachment



**Health Services**  
<http://ems.dhs.lacounty.gov>

# 9-1-1 IFT Form

Interfacility transports using 9-1-1 system

9-1-1 Provider \*

Date \*

Time (military) \*

Sequence Number \*

Scene Incident Facility \*

How did Patient Arrive at Incident Facility \*

Comment To Other - Scene

Receiving Hospital \*

Reason for Transfer \*

Was Transfer Completed?

Yes  No

If Transfer not completed, Why?

Appropriate based on chart review? \*

If Inappropriate, why? \*

Name/Title of person who completed the chart review (in the event further information is needed) \*

Other comments

Please attach PCR(s), IFT Checklist and other relevant documents such as ECG(s)

Upload

or drag files here.



August 19, 2025

**Los Angeles County  
Board of Supervisors**

**NOTICE FOR A PUBLIC HEARING**

**Hilda L. Solis**  
First District

**Holly J. Mitchell**  
Second District

**Lindsey P. Horvath**  
Third District

**Janice K. Hahn**  
Fourth District

**Kathryn Barger**  
Fifth District

The Department of Health Services, Emergency Medical Services (EMS) Agency, will hold a public hearing to seek public comment on the development of a Request for Proposal (RFP) for the Exclusive Operating Areas (EOA) Agreements for Emergency Ambulance Transportation Services in Los Angeles County. The RFP is to determine replacement agreements to the current EOA Agreements set to expire on June 30, 2027.

The EMS Agency will make a good-faith effort to incorporate feedback from the public hearing into the development of the RFP.

In accordance with the Bagley-Keene Open Meeting Act. A public hearing is set as follows:

**Richard Tadeo, RN**  
Director

**Nichole Bosson, MD, MPH**  
Medical Director

Date: Tuesday, September 23, 2025  
Time: 1:00 - 4:00 p.m.  
Location: Los Angeles County EMS Agency  
10100 Pioneer Boulevard  
Santa Fe Springs, CA 90670  
First Floor Cathy Chidester Conference Room

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

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

If you desire to speak at the hearing, you will be required to complete a speaker card prior to being recognized by the EMS Agency. Each speaker will have a 3-minute time limit for comments/questions.

If you have any questions, please contact Jacqueline Rifenburg at [jrifenburg@dhs.lacounty.gov](mailto:jrifenburg@dhs.lacounty.gov) or (562) 378-1640

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- c: County Counsel
- CEO's Office
- Health Deputy, Each Board of Supervisor Office
- Southern California Ambulance Association
- Private Basic Life Support Providers
- Los Angeles Area Fire Chiefs Association
- Hospital Association of Southern California
- Los Angeles County Emergency Medical Services Commission
- Coalition of Government
- Los Angeles County Division League of California Cities
- City Managers of contract cities of Los Angeles County Fire Department
- City Managers and Fire Chiefs of:
  - Compton
  - Monrovia
  - Montebello
  - Santa Fe Springs
  - Redondo Beach



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