COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

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

DATE: November 19, 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 – (Revised 11/17/2025)

1. CALL TO ORDER – Commissioner Diego Caivano, Chair

2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS
Jennifer Shepard, Deputy Paramedic/Paramedic Coordinator, LA County Sheriff's Department ~ Appointed by Governor Gavin Newsom to represent the Peace Officers' Association on the State EMS Commission

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

3.1 **Minutes**
- 3.1.1 September 10, 2025

3.2 **Committee Reports**
- 3.2.1 Base Hospital Advisory Committee – October 8, 2025
- 3.2.2 Provider Agency Advisory Committee – October 15, 2025

3.3 **Policies**
- 3.3.1 Reference No. 227: Dispatching of 9-1-1 Emergency Medical Services
- 3.3.2 Reference No. 302: 9-1-1 Receiving Hospital Standards
- 3.3.3 Reference No. 513.2: 9-1-1 Interfacility Transfer Checklist for STEMI Re-Triage
- 3.3.4 Reference No. 1109: Guidelines for Grant Funded Items and Inventory of Grant Funded Equipment
- 3.3.5 Reference No. 1109.1: Maintenance Log
- 3.3.6 Reference No. 1109.2: Grant Funded Item Disposition Form
- 3.3.7 Reference No. 1112: Hospital Evacuation

END OF CONSENT AGENDA

4. BUSINESS
Business (Old)
- 4.1 Field Evaluation of Suicidal Ideation and Behavior
- 4.2 Ambulance Patient Offload Time (APOT)
- 4.3 Interfacility Transfer Taskforce

Business (Old) Continued

4.4 Cardiac Arrest Taskforce
- 4.4.1 Draft Letter to Providers
- 4.4.2 Draft Letter to Hospitals
- 4.4.3 Summary of Comments

Business (New)

4.5 Nominating Committee – 2026 Chair and Vice Chair

5. LEGISLATION

6. DIRECTORS' REPORTS

6.1 Richard Tadeo, Director, EMS Agency / Executive Director, EMS Commission

Correspondence

- 6.1.1 (09/03/25) EMS Agency Changes
- 6.1.2 (09/04/25) New 9-1-1 Alternate Destination Respite & Sobering Center – MLK Campus
- 6.1.3 (09/29/25) Allocation of Pediatric Trauma Center Funding – Cedars-Sinai Medical Center
- 6.1.4 (09/29/25) Allocation of Pediatric Trauma Funding – Dignity Health Northridge Hospital Medical Center
- 6.1.5 (10/01/25) EMS Plan 2023-24 EMS Agency Approval Letter

6.2 Nichole Bosson, MD, Medical Director, EMS Agency
- 6.2.1 Medical Control Guideline Reference No. 1359: Care of Sexual Assault/Human Trafficking/Intimate Partner Violence Patient

7. COMMISSIONERS' COMMENTS / REQUESTS

8. ADJOURNMENT

Adjournment to the meeting of January 21, 2026

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MINUTES
SEPTEMBER 10, 2025

☒ Diego Caivano, M.D.	LACo Medical Association	Richard Tadeo	Executive Director
☐ Jason Cervantes	CA Professional Firefighters	Denise Watson	Commission Liaison
☒ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Nichole Bosson, MD	EMS Staff
☒ Paul Camacho, Chief	LACo Police Chiefs' Assn.	Denise Whitfield, MD	EMS Staff
☒ Kenneth Domer	League of CA Cities/LA Co	Christine Clare	EMS Staff
☒ Tarina Kang, M.D.	Hospital Assn. of So. CA	Jacqueline Rifenburg	EMS Staff
☒ Carol Kim	Public Member, 1st District	Lily Choi	EMS Staff
☐ Kristin Kolenda, Captain	Peace Officers Association	Dipesh Patel, MD	EMS Staff
☐ Lydia Lam, M.D.	American College of Surgeons	David Wells	EMS Staff
☒ Kenneth Liebman	LACo Ambulance Association	William Aragon, MD	EMS Staff
☐ James Lott, PsyD, MBA	Public Member, 2nd District	Sara Rasnake	EMS Staff
☐ Carol Meyer, RN	Public Member, 4th District	Tamara Butler	EMS Staff
☐ Kenneth Powell	LA Area Fire Chiefs' Assn.	Michael Kim	EMS Staff
☐ Connie Richey, RN	Public Member 3rd District	Fritz Bottger	EMS Staff
☒ Stephen G. Sanko, MD	American Heart Association	Christine Zaiser	EMS Staff
☒ Carole A, Snyder, RN	Emergency Nurses Assn.	Michael Kim, MD	EMS Staff
☐ Saran Tucker	So. CA Public Health Assn.	Ami Boonjaluksa	EMS Staff
☒ Atilla Uner, M.D., MPH	CAL-ACEP		
☐ Gary Washburn	Public Member, 5th District		

GUESTS

Nicole Reid, LACOFD	Duane Anderson, ZOLL	David Page, EMS Corps	Lila Mier, LA General

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. EMSC Chair Diego Caivano called the meeting to order at 1:07 p.m. Introductions were made and there was a quorum with 10 commissioners present.

2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

2.1 Executive Director Richard Tadeo introduced Mr. Kenneth Domer, City Manager for the City of La Verne, as the new EMS Commissioner representing the League of California Cities. He is replacing Mr. Brian Saeki, City Administrator for the City of Vernon.

2.2 EMSC Vice-Chair Stephen Sanko announced that the Cardiac Survivor Conference at LA General Medical Center has been delayed.

2.3 Mr. David Page, Director of EMS Education for EMS Corps at Public Works Alliance (PWA), gave a presentation on the EMS Corps' mission to train youth in underserved communities to become EMTs, and noted that they are modeled out of Alameda County's EMS Corps program which is now in their 25th cohort with over 400 graduates. He provided context and history on the Freedom House where in 1967 a group of African American men were trained as the first EMTs in Pittsburgh, Pennsylvania by Drs. Peter Safar and Nancy Caroline who created the first national standard paramedic curriculum for the U.S. Department of Transportation (DOT) which is a tradition the EMS Corps continues to honor. The PWA EMS Corps program is a 380-hour, five-month program that offers East Los Angeles College credit, wraparound support, life coaching, mentors, counseling, healing circles, monthly stipends, and is described as a whole-person, trauma-informed curriculum.

Mr. Page played a video of a graduate from the Ventura County cohort who described her life before the EMS Corps, successful program completion, and her renewed hope after securing employment with a local ambulance company as an EMT. He spoke about the cohort in Whittier that graduated on September 9, 2025, and a current cohort in Compton, and announced that additional cohorts are in progress and/or slated to begin in the LA County area including an all-women's cohort at the former Camp David Gonzalez Detention Center in Calabasas. Ongoing program expansion is in the works in Fresno, San Bernardino, San Francisco, New Mexico, Newark, New Jersey, and there are currently three active cohorts in LA County.

Mr. Page noted outcomes in terms of 600 graduates, 30% of graduates have navigated the foster system, 85% are eligible for the Workforce Innovation and Opportunity Act (WIOA), an 80% or more program completion rate, and 85% to 95% of students pass on their first attempt on the national registry. There is funding for two more sites in Southeast Los Angeles, and that grant sunsets in 2027. The intent is to have the program be self-sustainable, but the hope is to connect and collaborate with other agencies and more employers.

Commissioner Carol Kim suggested appealing to each Supervisorial District as they typically have some amount of discretionary funds and look at community-based organizations and programs to provide some funding to.

Mr. Page requested support with this suggestion in appealing to the Board of Supervisors.

3. CONSENT AGENDA: *All matters are approved by one motion unless held.*
Executive Director Richard Tadeo explained that the current Consent Agenda includes Minutes from the March 12th and May 21st meetings, and due to the lack of quorums and July 16, 2025, meeting cancellation, those Minutes are included here for technical purposes for approval.

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

3.1 **Minutes**
- 3.1.1 March 12, 2025: Scheduled for approval on May 21st agenda.
- 3.1.2 May 21, 2025: Board appointment pending–no quorum. Added to July 16th agenda. July 16, 2025: Cancelled. March/May Minutes included in September 10th agenda.

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

Discussion: Reference No. 412

Vice Chair Sanko questioned if changes to policy will affect public access or availability of automated external defibrillators (AEDs).

Chris Clare, EMS Agency Nursing Director, clarified that the policy changes do not affect public access nor availability of AEDs, and expressed that the EMS Agency can now receive data on AED usage electronically for public providers, and they no longer need to report on it. AED data from private usage will need to report on that.

3.3.5 Reference No. 412.1: AED Service Provider Program Applications **(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)
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

Discussion: Reference No. 503, Page 1, 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.

Commissioner Atilla Uner questioned if a discrepancy exists between hospitals requesting diversion due to staffing, whereas fire departments and paramedics cannot; and, if it is feasible to eliminate diversion altogether as EMS providers may get fined for ambulance patient offload delays (APOD), whereas hospitals do not.

Director Tadeo expressed that there is no discrepancy because diversion is a request and not an absolute closure to 911 traffic. Paramedics and EMTs should continue transporting to hospitals on diversion if there is no alternate hospital except for internal disasters which are generally due to a physical plant breakdown that will compromise patient safety.

Commissioner Uner requested Policy Reference No. 503 be pulled from the Consent Agenda and held for discussion.

3.3.10 Reference No. 503.2: Diversion Request Quick Reference Guide
3.3.11 Reference No. 513: ST-Elevation Myocardial Infarction (STEMI) 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

Discussion: Reference No. 526, Page 3, Exclusion Criteria B-1:

1. Any emergent medical condition.

Commissioner Uner opened with the discussion to consider deleting Exclusion Criteria B-1 (ECB-1) from both Reference Nos. 526 and 528 because the criteria is too broad and makes the paramedic responsible for ruling out conditions they may not recognize.

Commissioner Erick Cheung expressed that the term "known" might be missing from ECB-1 and opined that there is an assumption that a person cannot be held to a standard of knowing all things about a patient in that situation where a rapid dialysis could not be known in the time that they are transporting to an alternate destination.

Nichole Bosson, M.D., EMS Agency Medical Director, expressed that there are multiple policies where this terminology is used, and the spirit of the exclusion criteria is that a person cannot know all medical conditions during transport.

Director Tadeo expressed that the current changes to Reference Nos. 526 and 528 are that the educational requirements were deleted because the curriculum has been standardized, and recommended approving both policies as to form and taking the Commission's concerns back to the subcommittees for further review.

3.3.16 Reference No. 528: Intoxicated (Alcohol) Patient Destination

Discussion: Reference No. 528, Page 3, Exclusion Criteria B-1:

1. Any emergent medical condition.

See discussion notes above under Reference No. 526.

3.3.17 Reference No. 701: Supply and Resupply of Designated Provider
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

Discussion: Reference No. 838: Application of Patient Restraints

Commissioner Uner questioned if this policy should include text that says any person that gets restrained should have a patient care record (PCR).

Director Tadeo expressed that the Documentation Policy requires that a PCR be completed for every patient encounter that meets the State's definition of patient.

3.3.23 Reference No. 1318: Medical Control Guideline: ECPR Patient Algorithm

Motion/Second by Commissioners Snyder/Cheung to approve the Consent Agenda was carried without Policies 3.3.9, Reference No. 503 that was held by Commissioner Uner.

Ayes: (10) *Diego Caivano, Erick Cheung, Paul Camacho, Ken Domer, Tarina Kang, Carol Kim, Ken Liebman, Stephen Sanko, Carole Snyder, Atilla Uner*
Nays: (0)
Abstains: (0)
Absent: (9) *Jason Cervantes, Kristin Kolenda, Lydia Lam, James Lott, Carol Meyer,*

Ken Powell, Connie Richey, Saran Tucker, Gary Washburn

Discussion: Reference No. 503: Guidelines for Hospitals Requesting Diversion of ALS/BLS Patients, Page 1, 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.

Commissioner Uner expressed concern about Principle 1 and hospitals requesting diversion specifically related to staffing, whereas fire departments and paramedics cannot; and EMS providers may get fined for APOD whereas hospitals do not and questioned the feasibility of eliminating diversion altogether.

Commissioner Carole Snyder recommended keeping Principle 1 in the diversion policy and gave an example of requesting diversion when nurse-to-patient ratios are one-to-four with 73 patients in the waiting room and the emergency department is under-staffed with physicians and nurses and unable to care for additional patients due to inadequate staffing.

Commissioner Carol Kim recommended discussing offline as the actual definitions of what is being talked about seem like different scenarios, but both seem to be problematic. She also expressed concern regarding fines.

Ms. Clare stated the policy revisions made were due to the addition of the eCPR diversion because of the new program for eCPR, and this addition to the policy really needs to be publicized. She suggested approval of the policy as is, and continuing discussion regarding Page 1, Principle 1 at a later date.

Commissioner Uner agreed that this works for now to not make problems with eCPR, but when this is discussed at Commission and gets passed again with the EMSC votes, the Commission has a responsibility to read every line and reconsider things. If we just have a discussion on whether or not this would meet how we treat the participants in the EMS system, that would be prudent enough.

Vice Chair Sanko added to the discussion examples of appropriate requests for diversion as related to patients waiting in the ED for 12 hours and other hospitals also feeling stressed, and perhaps a broader discussion about equity is warranted.

Chair Caivano called for a motion to approve 3.3 Policies, 3.3.9 Reference No. 503.

Motion/Second by Commissioners Snyder/Camacho to approve item 3.3 Policies, 3.3.9 Reference No. 503 from the Consent Agenda was carried.

Ayes: (10) *Diego Caivano, Erick Cheung, Paul Camacho, Ken Domer, Tarina Kang, Carol Kim, Ken Liebman, Stephen Sanko, Carole Snyder, Atilla Uner*

Nays: (0)

Abstains: (0)

Absent: (9) *Jason Cervantes, Kristin Kolenda, Lydia Lam, James Lott, Carol Meyer, Ken Powell, Connie Richey, Saran Tucker, Gary Washburn*

END OF CONSENT AGENDA

4. BUSINESS

Business (Old)

4.1 Field Evaluation of Suicidal Ideation and Behavior

Director Tadeo reported there are no updates, but this item will remain on the agenda as there may be an evaluation of the implementation of the screening tool.

4.2 The Public Works Alliance EMS Corps

The Public Works Alliance EMS Corps presentation provided program updates.

4.3 Ambulance Patient Offload Time (APOT)

Ms. Clare provided copies of second quarter 2025 APOT report, and noted the State created an APOT audit tool where hospitals can now look at records at the State level and match them to the patients received in their ED. There are a few challenges with the audit process that the State is addressing to streamline the audit tool and process. Commissioner Snyder will inquire about the PIH Whittier Hospital's auditing process and bring information back to the next EMSC.

Commissioner Snyder referred to Sutter Medical Center, Sacramento, having given a presentation at the State EMSC June meeting where part of their APOT committee brought in case management to skilled nursing facilities (SNF) and all those roadblocks to their coalition so everybody was at the table to try to figure out solutions and their APOT went down. That might be strategy to consider for our APOT committee going forward.

Director Tadeo reported that Assembly Bill (AB) 40 required emergency regulations to be put forth and one of those was the audit tool. Since the State only had a short amount of time and the tool has a lot of technical defects, they were given a 60-day moratorium to fix those issues. The EMS Agency is not able to implement those regulations based on the workload and challenges with the audit tool. We are concerned about the one-and-one-half (1½) to two (2) hour APOT for EMS offloaded patients, and we will continue to focus on reducing APOT with our hospital groups that have those problems. We are working closely with EMSAAC as my peer group of EMS administrators to address this issue because it does not only impact LA County.

Commissioner Snyder asked if a column could be added at the end of the APOT report that says, "this was 2024" and "this was "2025" to compare the data from the previous year for the differences in the times from one year ago until current to see who has been successful at decreasing their APOT and contacting them to see how they achieved their success, while taking into consideration the differences between the hospitals and if it is a like-to-like hospital. She recommended bringing additional agencies into the APOT committee such as SNFs which is a big barrier to getting people out.

Director Tadeo reported he is reaching out to Hospital Association of Southern California (HASC) to have a more cohesive voice from Los Angeles County and will reach out to Huntington Hospital who gave a presentation a year ago to see if their program has any changes or if they have continued to maintain their low APOT time.

Commissioner Uner stated Antelope Valley Hospital has decreased their APOT tremendously. Twenty percent of our patients come from Kern County, so we're going to look at what we are doing differently to change and share that.

Chair Caivano asked if any providers in their hospitals use National Emergency Department Overcrowding Scale (NEDOCS) times, or if their hospitals provide a NEDOCS to know what their hospital is doing from the point of view of your ED compared to the rest of the hospitals. He described this as a tool that when it comes to APOT helps them to understand when to repatriate and when they are not repatriating, and it should be something that gets appropriated into this.

Commissioner Tarina Kang asked if the data being presented was manually input into the data report or where does it come from.

Ms. Clare responded that staff download the data from our EMS data base and create the graphs manually to regionalize it.

Commissioner Kang expressed an interest to how people are non-manually putting this data in to create dashboards because this is a highly manual process on their end.

Vice Chair Sanko commented that at Los Angeles General Medical Center, the effect of their prehospital care coordinators working closely with ED operations leaders has had an important effect and has decreased their diversion time by half which is an important example of a collaboration between ED nurses and ED physician leadership.

4.4 Interfacility Transfer Taskforce

Ms. Clare reported on the creation of an IFT Cognito form to be completed by the provider agency any time 9-1-1 is contacted for an IFT. The purpose is to gather data on the types of IFT 9-1-1 calls originating from emergency departments. This went into effect the beginning of July 2025. They are looking at what the true utilization is and what the true numbers are. Only the data from July was presented and they will be adding the data for August soon.

4.5 Cardiac Arrest Taskforce

Vice Chair Sanko reported cardiac arrest taskforce was initiated in June 2025, with the goal of bringing our hospitals and fire departments into alignment with the American Heart Association's 2030 goals of cardiac arrest processing patient centered outcomes. We have prompted area 9-1-1 fire departments to create a plan on how they intend to meet these goals. We have worked collaboratively with HASC to start the process of crafting a letter to area hospitals to promote creation of their own plans to reach the proposed metrics for in-hospital cardiac arrest, neuro, and tech survival. They have proposed online every other month clinics to assist both fire departments and hospitals in crafting that plan. There was a four-month effort from students, school administrators and PTAs on promoting student competition to generate and recognize fresh ideas on bystander response. We heard from the Board of Supervisors' (Board) office regarding guidance on how to craft effective recommendations to the Board and other policy decision makers, and in near future will be hearing from regional philanthropy survivors and co-response-survivors in our community health clinics. We have a particular focus on hearing from non-clinicians in this effort to make this truly a more collaborative and community-based effort to improve outcomes.

4.6 Annual Report Fiscal Year 2024-2025

Director Tadeo stated that the Annual Report to the Board of Supervisors for Fiscal Year 2024-25 is being submitted for approval.

Motion/Second by Commissioners Uner/Cheung to approve Fiscal Year 2024-2025 Annual Report to the Board of Supervisors was carried.

Ayes: (10) *Diego Caivano, Erick Cheung, Paul Camacho, Ken Domer, Tarina Kang, Carol Kim, Ken Liebman, Stephen Sanko, Carole Snyder, Atilla Uner*
Nays: (0)
Abstain: (0)
Absent: (9) *Jason Cervantes, Kristin Kolenda, Lydia Lam, James Lott, Carol Meyer, Ken Powell, Connie Richey, Saran Tucker, Gary Washburn*

5. LEGISLATION

Director Tadeo reported on the following legislation:

5.1 AB 40 – Refer to item 4.3 discussion.

5.2 AB 645 – EMS Dispatcher Training requires the EMS Authority to develop, and adopt upon commission approval, minimum standards for a public safety dispatcher or telecommunicator to complete the EMS Dispatcher Training by January 1, 2027. This is at the Appropriations Committee at the State level. We are watching this bill.

5.3 AB 1328 – Increase in reimbursement for Medicare. This was put on hold as of last Friday.

5.4 Code of Regulations Chapter 1 – This is still being worked through by the State. The biggest contention here is grandfather rights on who has the authority to administer their EMS, particularly for fire departments who have been providing or administering their EMS services before 1980. Hopefully these issues will resolve through regulations and should be up for public comment by the end of December 2025.

5.5 Code of Regulations Chapter 6 – Specialty care center consolidation of the Trauma, STEMI, Stroke and EMS for Children regulations into this one Chapter. This was sent out for public comment and the deadline was August 17, 2025. One issue is a statement that pediatric trauma centers need to also have an American College of Surgeon verification. We have seven pediatric trauma centers who are primarily adult, but they also provide care to pediatric patients. The regulations as currently drafted will need to have dual verification. There will be negative consequences to the system if those pediatric trauma centers that we locally designate are not recognized by the State. The EMS Authority is willing to address this issue, and we are comfortable that it will not disrupt our pediatric trauma system.

5.6 Senate Bill (SB) 43 – The definition of gravely disabled includes Substance Abuse Disorder. The Department of Mental Health and Department of Public Health presented at HASC on the specific criteria that would qualify a substance abuse disorder as gravely disable. The patient must meet six (6) of the 11 criteria to be deemed gravely disabled.

Commissioner Cheung reported on the AB 43 inclusion of Severe Substance Abuse Disorder for co-occurring mental health and substance use disorders, but the most pivotal change that EMS needs to be aware of is the portion that use to read, “inability to provide one’s own food, clothing, and shelter,” also now includes personal safety and medical needs which is very relevant to the expansion of a scope of patients who EMS likely will encounter. Being able to count 6 out of 11 criteria that meet substance use will be best estimate, but the part about providing one’s own medical needs is a substantial change. The question is whether there is thought about providing some educational awareness to the EMS community in tandem with law enforcement getting the education. The required 30-minute training video for the Lanterman-Petris-Short (LPS) Act designated personnel was released this week.

Director Tadeo noted that the EMS Agency will look at this from the Agency standpoint on education once the guidelines are received from the Department of Mental Health.

6. DIRECTORS' REPORT

6.1 Richard Tadeo, EMS Agency Director, EMSC Executive Director

6.1.1 Measure B Advisory Board (MBAB)

The 2025 MBAB process was suspended due to the Board of Supervisors Motions that dispersed the available $28M one-time unallocated portion of the Measure B funds. At the July 15, 2025, Board of Supervisors meeting the following actions related to Measure B was taken.

1. Motion by Supervisorial District 2 – Direct the Director of the Department of Health Services or her designee, in consultation with County Counsel, to allocate a total of $9M in one-time funding from the Measure B Fund balance in Fiscal Year 2025-26 for Martin Luther King, Jr. Community Hospital to support and maintain vital emergency department care services for qualified Measure B purposes. Motion Not Carried.

2. Motion by Supervisorial District 4 – Approve and authorize the Director of Health Services to allocate the $20M of the un-proposed, unallocated, one-time, available Measure B funding evenly between the five Supervisorial Districts to maintain emergency room operations and availability, trauma, emergencies, bioterrorism response needs, and for specific qualified Measure B purposes as allowable; and, in consultation with County Counsel, work in conjunction with each Supervisorial District and the Chief Executive Office to identify projects within each District that meet the requirements of Measure B. Motion Carried.

3. Department of Health Services Board Letter – Request approval to increase the Measure B Trauma, Emergency, and Bioterrorism Response property assessment rate as authorized under the provisions of Measure B, approved by Los Angeles County voters on November 3, 2002. Allocate $6M of the unallocated one-time funds to Catalina Island Medical Center and $2M to the construction of a new disaster warehouse for LA General Medical Center. Motion Carried.

4. Motion by Supervisorial District 5 – Direct the Chief Executive Officer, in coordination with Directors of the Department of Health Services (DHS), Department of Public Health (DPH) and the Measure B Advisory Board (MBAB), to report back in writing within 90 days with an analysis of the formula utilized to allocate future ongoing funding and one-time Measure B funding to non-County hospitals and recommend any needs-based changes. Motion Carried.

The EMS Agency and the CEO's office have met with each of the Board Offices to present the project proposals received for consideration by the MBAB for funding. The EMS Agency anticipates that it will receive the funding proposals from each Supervisorial District in October. The proposals will be evaluated by the EMS Agency in consultation with County Counsel to validate that it meets the Measure B funding criteria. We anticipate the funded proposals will be released in late October.

Vice Chair Sanko commented that innovation has been promoted in our system funding mechanisms such as the Measure B competitive application program. Many of our municipal 9-1-1 provider agencies, our fire departments, have set budgets every year. If they want to implement new innovation or have to pay a little more for medications that are harder to get, or do anything in the field, they need these types of sources of funding. I would strongly promote the EMS Agency support a return to that committee being able to identify competitive projects such as the expansion of prehospital blood transfusion programs as well as any project supporting expansion of ECPR both of which are life-saving be provided with those funding sources.

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.

Director Tadeo reported the public hearing is to seek public comments on the development of an RFP for a successor EOA contract for emergency ambulance transportation services. This stems from a lawsuit from the 1980's filed by the City of Lomita against the County claiming that the County is responsible for providing emergency ambulance transportation services. The city prevailed in that lawsuit. Of the four options provided by the Court, the County adopted two:

1. A non-competitive process by contracting with cities that have "grandfather" rights to administer their EMS programs and/or emergency ambulance transportation services. The cities that qualify for this option are those cities that provided EMS services and/or emergency ambulance transportation services before 1980.
2. A competitive process through a Request for Proposal for the unincorporated areas of the County and cities that DO NOT have "grandfather" rights.

The public hearing is part of the competitive process. The EMS Agency will make a good-faith effort to incorporate feedback from the public hearing into the development of the RFP. The EMS Agency will be meeting with the various cities impacted by the RFP to provide information on the process.

Director Tadeo reported that the Hospital Preparedness Program Award and the $9.1 Million Dollars normally received annually from the federal government to give to our hospitals for preparedness activities has been cut to $5.1M, that is a decrease in funding of $4M. We were advised that we will get a second allocation that will bring us up to almost $8.7M, so there is a reduction of about $300,000, which means the hospitals will see a reduction in the grant allocations.

The Health Data Exchange (HDE) is in full implementation. This is the automatic transfer of the providers' electronic Patient Care Records (ePCR) into the electronic health record management systems of the hospitals. Adventist Health Glendale is fully implemented are getting the ePCRs and the EMS Agency is receiving patient outcome data. Director Tadeo is working with Contracts and Grants to have a Data Use Agreement or Business Associate Agreement (BAA) for the EMS providers to access their outcome data of the patients they transported. This will probably take a couple of months complete. Of the Phase I hospitals which include the trauma and base hospitals: we have our DHS facilities, our two trauma centers - Harbor-UCLA Medical Center and Los Angeles General Medical Center, and Olive View Medical Center. We are having weekly discovery meetings with the vendor.

The Providence health system has six hospitals, and one has signed on. They are waiting for corporate to decide, but we anticipate they will move forward in having their six hospitals participate with HDE.

We have received BAAs from Long Beach Memorial, St. Francis, Pomona Valley, Cedars, Huntington Hospital, Henry Mayo and Ronald Reagan UCLA. We are working with corporate office of Dignity Health to see how to develop and enterprise BAAs for the four hospitals.

We have started reaching out to our Phase II hospitals which include the non-trauma, non-base, but are STEMI and Stroke centers. Our Phase III would be our community hospitals that do not have specialty care designations.

6.2 Nichole Bosson, MD, Medical Director, EMS Agency
Dr. Bosson reported on EMS Agency pilot programs and new initiatives:

LA-DROP and CAL-DROP
LA-DROP and wider, CAL-DROP, is our prehospital blood transfusion program which began April 1, 2025. As of today, 19 patients have been transfused in LA County. Total across all pilot sites have nearly 40 patients. Ventura County has 18, Riverside County has two. We submitted our first quarterly report to EMSA and completed April through June's data, at which time we had 15 patients that met inclusion criteria of which 12 patients were transfused. We are tracking safety outcomes (i.e., scene times) to ensure that this is not causing an increase in scene time, but transfusions are happening enroute. We have not yet seen any indication that scene time has increased. We are tracking adverse events for any allergic reactions to transfusions. We are tracking blood waste and thus far, nearly 150 units of blood have been handled by the LA-DROP program and only two units had to be wasted that were not recycled. Those generated discussion and corrective actions and things were implemented to prevent that from happening in the future. We are having a very good safety profile thus far. I want to commend Drs. Clayton Kazan and Kelsey Wilhelm who have put in a huge amount of effort. It is really on their initiative that this is successful thus far. It is too early for efficacy

outcomes, but positive to see majority of patients are surviving from admission and at least to 24 hours. This is an indication that we are not transfusing patients who are futile and there are anecdotal reports that the patients are demonstrating physical improvements in vital signs or mental status with the transfusions.

There are three active programs thus far, and we expect San Bernardino will initiate their first programs this Fall as well as Sacramento County. That will make five additional counties that have started to join our CAL-DROP discussions and are considering the pre-implementation. This is an expanding effort. You may be aware of the AHRQ report that just came out that reviews all the data thus far on prehospital blood transfusion. And indicates that we still need more data to really understand the real impact of this on patient-centered outcomes. Many national organizations have come out and said we should be doing this based on what is happening thus far, but we are hoping to contribute to those data, and we are going to be collaborating with the other local EMS agencies to put forth an IRB application to be able to look at and publish our data uniformly as a collaborative.

ECPR:
The official system of care for ECPR was launched July 1, 2025, after the success of the pilot. We have five centers, and hoping to expand to other areas of the County where there is no access to ECPR centers, and we are looking to eventually have access across the county. Antelope Valley and Pomona Valley are some of those areas, and we have had meetings with our DHS hospitals that are currently able to offer the therapy internally and we are hoping to transition to their designation in the future as well. This is ongoing. We had our first quality improvement (QI) quarterly meeting this September. The data suggests similar outcomes and canulations during the pilot was about 30% which continue after the pilot. This is a good sign that as we expand, the survivors are almost all surviving with good neurologic outcome.

RAPID
RAPID is our protocol mobile application which we launched this year. It is now fully deployed. We deployed updates to the web-based version to support our base hospitals based on some feedback to improve the MICN workflow. We are continuing explore avenues to further optimize both the RAPID protocol app and our LA County Drug Doses app to support our field clinicians and MICNs. This is an incredibly important initiative that we continue to move forward to give them real time tools especially as our field protocols and interventions continue to expand and get more complex. Our paramedics need these tools.

TRAUMA DASHBOARDS
The trauma dashboards, which Dr. Shira Schlesinger has really taken the lead on, should be live by the end of September 2025. We are collaborating with ESO to develop the dashboards. These will be demonstrating our trauma patient demographics distribution of injury, as well as patient outcomes from everything from the crash data to hospital care and discharge. These will be live and updated on at least a monthly basis with filtering capability by community and by different metrics so both the public and stakeholders can view in real time what is happening with our trauma care and we can use it as a way to support initiatives to improve crash care and outcomes.

Pedi-PART and PediDOSE
Pedi-PART and PediDOSE are prehospital airway resuscitation trials for pediatrics as well as our seizure age-based dosing study. They are ongoing. PediDOSE has over

5,000 patients enrolled nationwide at 20 sites including LA County and it will be completed in August 2026. We continue with the age-based dosing for patients 12 months and older and just received authorization by the Data Safety Monitoring Board to decrease that to six months. We are looking at our system to see the best timing for that transition. We will continue to enroll in the study until next August 2026 at which time we should shortly thereafter understand which is the best approach to dosing.

Pedi-PART study which started later, is now at 900 patients enrolled across the 10 sites nationally. We are contributing a large number of those patients from LA County. We expect another interim analysis to occur very soon which we have every 300 patients to determine whether stopping goals are met. So, we will see if that occurs, and if not we will continue to enroll BVM strategy versus BVM+iGel strategy. The study is going quite well.

ELCoR

The ELCoR taskforce is a standing committee with EMS and law enforcement colleagues. We distributed a survey that went out today to all law enforcement in LA County. We would like to get a better understanding of the AED programs to understand the scope of these programs at the different law enforcement agencies, as well as the local optional scope to practice items, things like epi autoinjectors and naloxone, to really understand what our law enforcement agencies are doing, what are the barriers to implementing these programs more widely, and how we can support them.

Dr. Bosson reported she will follow up with Commissioner Paul Camacho and Chief Sid just to provide any support that their agencies may need to complete the super short survey. And this will help our taskforce to identify next steps to help these programs and we want to continue to collaborate with law enforcement.

The EMS Agency updates are on our website and all of the publications and initiatives we are doing with our data, and what are we looking at to advance the system, is posted. Dr. Jake Toy, EMS Agency, updated the website and it has 10 years of studies that we have done, not just the EMS Agency medical professionals, but collaborations with different system stakeholders and people using our data.

Dr. Denise Whitfield, EMS Agency Assistant Medical Director, reported on buprenorphine, an EMS initiation treatment as part of a medical assisted therapy for opioid use disorder. We applied for a $400,000 grant from the State but unfortunately LA County did not receive the grant. Two other counties were the recipients for this year. However, we are still moving forward with getting approval from the State for paramedics to be able to distribute buprenorphine for appropriate patients, and then once we get that approval in 2026, we will offer that as an optional scope for our provider agencies that would like to participate, and we have had interest from our larger agencies as well as a few smaller agencies. So, if it is practical for them and they're able to get on board then we will be looking to do that.

7. COMMISSIONERS' COMMENTS / REQUESTS

Vice Chair Sanko complimented the EMS Agency on the fantastic list of projects that the EMS Agency is helping to develop and promote. He pointed out that for many of our 9-1-1 provider agencies leadership, for the chiefs, this is not on their radar, and in order to meet the need of translating these fantastic important life saving ideas into practice, the Commission should keep that in mind over the course of the next year or two if there are any opportunities to promote increased requirements for having medical directors per number of members

overseen. He gave an example of one medical director overseeing an organization with 3500 field members and half a million incidents a year. He suggested more nurse educators and more EMS physicians need to be involved in order to translate these great ideas and projects into effective change.

Commissioner Uner congratulated the EMS Agency doctors for their many accomplishments and thanked them for putting all the research on the EMS Agency website.

Director Tadeo announced that this was Chris Clare's last meeting as she would be retiring. He acknowledged her contribution to the EMS system.

8. ADJOURNMENT

Adjournment by Chair Caivano at 3:07 PM.

Next Meeting: Wednesday, November 19, 2025, 1:00-3:00 PM
Emergency Medical Services Agency
10100 Pioneer Boulevard, First Floor
Cathy Chidester Hearing Room 128
Santa Fe Springs, CA 90670

Recorded by:
Denise Watson
Secretary, Health Services Commission

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

October 8, 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			Travis Fisher	Western Region
X	Gabriel Campion	Base Hospital Medical Director		X	Lauren Spina	Western Region
	Salvador Rios	Base Hospital Medical Director, Alternate		X	Susana Sanchez	Western Region
	Adam Brown	Provider Agency Representative		X	Kate Bard	Western Region
X	Jennifer Nulty	Provider Agency Representative, Alternate			Laurie Sepke	Eastern Region
	Elizabeth Charter	PedAC Representative		X	Alina Candal	Eastern Region
	Desiree Noel	PedAC Representative, Alternate			Jenny Van Slyke	Eastern Region, Alternate
X	Colleen Greer	MICN Representative			Lila Mier	County Region
	Vacant	MICN Representative, Alternate			Emerson Martell	County Region
					Antoinette Salas	County Region
					Yvonne Elizarraraz	County Region

EMS Agency			Prehospital Care Coordinators		Guests
Denise Whitfield, MD	Lorrie Perez		X	Brandon Koulabouth (AMH)	Jeannette Souza (TMH)
Shira Schlesinger, MD	Priscilla Ross		X	Tahnee Harvey (AVH)	Vandy Uphoff (HMH)
Jake Toy, MD	Mark Ferguson		X	Kelly Bui (SFM)	Ashley Sanello,MD (TOR)
Michael Kim, MD	Fritz Bottger		X	Melissia Turpin (SMM)	Kelsey Wilhem, MD (HGH)
Dipesh Patel, MD			X	Melissa Carter (HCH)	Ryan Heckman (TFD)
Jacqueline Rifenburg			X	Allison Bozigian (HMN)	
Richard Tadeo			X	Mary Jane Evangelista (QVH)	
Jon Warren, MD					
Paul Aragon, MD					
David Wells					
Ami Boonjaluska					

1. **CALL TO ORDER:** The meeting was called to order at 1:03 p.m. by EMS Commissioner Chair, Tariana Kang, MD.

2. **INTRODUCTIONS/ANNOUNCEMENTS:**

2.1 Dr Shira Schlesinger announced that registration for the EMS for Children Forum, to be held in person on November 13, 2025, in Fairfield, California, is now open.

2.2 The Joint Educational Session will be on December 2, 2025, and will cover the topic *Legal Pitfalls in Responding to Behavioral Crises.*

2.3 Mark Ferguson discussed the change to the MICN certification fee process. Going forward, payment for the MICN certification will be requested prior to recertification. Invoices will now be issued two months in advance of the recertification date. Instead of payment being due after recertification, it will now be required before the end of the MICN certification cycle.

3. **APPROVAL OF MINUTES**

3.1 The meeting minutes for August 13, 2025, were deferred due to absence of a quorum.

4. **NEW BUSINESS**

4.1 Ref. No. 1303, Medical Control Guideline: Algorithm for Prehospital Cath Lab Activation

The medical control guideline has been in place since 2015, and the EMS Agency is seeking feedback regarding its use by the base hospitals for early STEMI activation. The consensus is that the medical control guideline is not used due to the reliability of ECG transmissions and the ability for early ECG readings by a physician.

5. **OLD BUSINESS: NONE**

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

6.1 Ref. No. 506.3, 9-1-1 Interfacility Transfer Checklist for Trauma Re-Triage (New)

Richard Tadeo decided to move the policy forward without formal approval or a quorum. The checklist was formatted into policy form to make it easier for hospitals to locate. The checklist is intended to guide hospitals in determining appropriate 9-1-1 IFT transfers. It has already been distributed to hospitals and ED leadership, and it is currently in use.

A concern was raised regarding the proceeding with policy 506.3 because the language in the policy 506.3 is not consistent with policies 506.1 and 506.2.

Richard stated that the trauma criteria is the same, even if the language differs from the other polices.

6.2 Ref. No. 513.2, 9-1-1 Interfacility Transfer Checklist for STEMI Re-Triage (New)

Richard Tadeo decided to move the policy forward without formal approval or a quorum. The checklist was formatted into policy form to make it easier for hospitals to locate. The checklist is intended to guide hospitals in determining appropriate 9-1-1 IFT transfers. It has already been distributed to hospitals and ED leadership and is currently in use. This step simply finalizes it as policy.

Policies for Discussion: No Action Required

6.3 Ref. No. 510, Pediatric Patient Destination

Notable change is the definition of a newly born is now considered to be from birth up to the 24 hours of life. In cases of resuscitation, policy 1216-P would be referenced instead of policy 1210-P.

6.4 Ref. No. 511, Perinatal Patient Destination

Notable change is the definition of a newly born is now considered to be from birth up to the 24 hours of life.

Policies for Discussion: No Action Required

6.5 Ref. No. 1203-P Treatment Protocol: Diabetic Emergencies

Special Consideration added: Blood glucose levels less than 50mg/dl maybe normal in the newly born but consider treatment if blood glucose is less than 40mg/dl and patient is symptomatic.

6.6 Ref. No. 1216-P, Treatment Protocol: Newborn/Neonatal Resuscitation

Special Consideration added: Routine blood glucose checks in vigorous newborns are not necessary.

6.7 Ref. No. 1213-P, Treatment Protocol: Cardiac Dysrhythmia - Tachycardia

Added Language and Guidance: For persistent poor perfusion, treat in conjunction with treatment protocol 1207-P, Shock /Hypotension.

6.8 Ref. No. 1309, Medical Control Guideline: Color Code Drug Doses

PediDOSE age base dosing (6-16 months): The group favored implementing the new PediDOSE dosing at the same time as EMS Update.

There was confusion about the color cards red and purple where it lists the age range of 0-5 months in the card causing confusion as to why the age would be listed in that color card for that age.

It was noted that paramedics find it easier to understand the Color Code Drug Doses in the Rapid App.

6.8.1 Ref. No.1231-P Treatment Protocol Seizure

Added the PediDOSE dosing 6-16 months to align with Medical Control Guideline 1309, Color Code Drug Doses.

6.8.2 Ref. No. 1317.25, Medical Control Guideline: Drug Reference – Midazolam

Added the PediDOSE dosing 6-16 months to align with Medical Control Guideline 1309, Color Code Drug Doses.

6.9 Ref. No.1317.XX, Medical Control Guideline: Drug Reference – Normal Saline (New)

New Policy, no comments noted.

6.10 Ref. No.1317.17, Medical Control Guideline: Drug Reference -Epinephrine

Added the language to clarify the continue dosing of epinephrine as needed to maintain normal blood pressure

6.11 Ref. No.1320, Medical Control Guideline: Level of Consciousness

No comments noted

6.12 Ref. No.1359, Medical Control Guideline: Care of the Sexual Assault/Human Trafficking/Intimate Partner Violence Patient (New)

Suggestion to bring the policy to the ELCOR Committee

7. REPORTS & UPDATES:

7.1 Trauma Dashboard

Dr. Schlesinger presented the draft of the Post Crash Care Trauma Dashboard, which will be available to the base hospitals and all stakeholders. This project was funded by a grant from the Office of Transportation.

7.2 EMS Update

The EMS Agency has started meeting with the EMS Update committee to discuss topics and develop content. Our primary focus will be the new changes to policy and procedures. Topics include out of hospital pediatric cardiac arrest, humeral and distal femur IO/ IVs, side stream capnography, Pedi-Part and PediDOSE updates, policy changes to GCS, heat and burn emergencies, care of assault patients, and the introduction of magnesium for preeclampsia and hypertension in pregnancy.

A question was raised about whether field care audit continuing education hours will be provided in EMS Update. The base emphasized that this type of learning is not only valuable but also highly engaging, and well received, playing a key role in the continued education development for prehospital providers. Dr. Schlesinger will meet with the certification department to clarify the rules and ensure compliance with state regulations.

Richard Tadeo noted that the Education Advisory committee, developed by Los Angeles County EMS for educational development, was disbanded by the EMS Commission due to the National curriculum. The EMS Agency will revisit the idea of forming a committee to address continuing education for EMTs, paramedics and MICNs.

7.3 EmergiPress

The September & October editions focus on Home Dialysis, offering guidance to prehospital providers as there is an increase in cases, particularly with home hemodialysis. Dr. Schlesinger is currently soliciting topic suggestions.

7.4 ITAC Update (Tabled)

7.5 ELCOR

Dr. Kim is developing video modules for law enforcement to provide a basic overview of the EMS system. It was noted that there were several key aspects of our system, such as specialty centers, that law enforcement may not fully understand. The police chiefs stated they can be shared during agency morning briefings. Additionally, the EMS Agency working on educational content for managing critically ill patients

7.6 Research Initiative & Pilot Studies

7.6.1 Prehospital Blood Transfusion Pilot – LA DROP

There have been 24 blood transfusions to date, with overall successful outcomes. The base hospitals are urged to make prompt decisions regarding blood transfusions, and in traumatic arrest cases, to assess whether the patient will benefit from it. Despite some challenges there have been great outcomes. Efforts are ongoing to ensure more blood is administered in the field.

7.6.2 PediDOSE Trial

No updates

7.6.3 Pedi-PART

The education section of the EMS Update will focus on case studies, complications, and adherence to odd and even day for airway management.

7.6.4 California Office of Traffic Safety (OTS) Grants Projects

7.6.5 RAPID LA County Medic Mobile Application

No updates

7.7 Cardiac Arrest Task Force

Richard Tadeo provided a summary of the CARES report and provided report cards to providers, offering baseline data aligned with AHA 2030 goals for out-of-hospital cardiac arrest. The target goals include a 40% rate for bystander CPR, 20% for AED application in public spaces, and outcome data for adult patients with CPC scores of 1-2. The plan is to also align all hospitals with the 2030 AHA goals and working with HASC to send out letters requesting their plans on how they will meet these goals.

7.8 Health Data Exchange

The weekly DHS hospital discovery meetings have been challenging, particularly in getting IT and clinical operations to collaborate. This issue spans across DHS hospitals, including Harbor-UCLA Medical Center (HGH), Los Angeles General Medical Center (LMC), and Olive View. Ongoing discussions with UCLA and ESO continue and working with Saint Francis Medical Center (SFM), Pomona Valley Hospital Medical Center (PVC) and the Providence System to finalize agreements. Phase 2 includes the STEMI and Stroke centers. The EMS Agency is also in the in the process of finalizing agreements with providers. The grant covering the subscription cost is valid through December 2027, and the EMS Agency continues to explore ways to sustain beyond that period.

8. **OPEN DISCUSSION: None**

9. **NEXT MEETING: December 10, 2025**

10. **ADJOURNMENT:** The meeting was adjourned at 2:23 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 – October 15, 2025

MEMBERSHIP / ATTENDANCE

MEMBERS IN ATTENDANCE	ORGANIZATION
X Carol Meyer, Chair	EMSC, Commissioner
X Kenneth Powell, Vice-Chair	EMSC, Commissioner
Jason Cervantes	EMSC, Commissioner
James Lott, PsyD, MBA	EMSC, Commissioner
Gary Washburn	EMSC, Commissioner
Kristin Kolenda	EMSC, Commissioner
Ken Lieberman	EMSC, Commissioner
Paul Camacho	EMSC, Commissioner
X Sean Stokes	Area A *(Rep to Medical Council)*
X Patrick Nulty	Area A, Alternate
X Keith Harter	Area B
X Clayton Kazan, MD	Area B, Alternate
X Jeffrey Tsay	Area C
X Luis Manjarrez	Area C, Alternate
X Geoffrey Dayne	Area E
Victor Lemus	Area E, Alternate
X Joel Davis	Area F
Andrew Reno	Area F, Alternate
X Adam Brown	Area G *(Rep to BHAC)*
X Stefan Viera	Area G, Alternate
X Matthew Conroy	Area H
X Marc Cohen, MD	Area H, Alternate
Michael Campana	Area H, Alternate
X Julian Hernandez	Employed Paramedic Coordinator
Tisha Hamilton	Employed Paramedic Coordinator, Alt
X Jenny Van Slyke	Prehospital Care Coordinator
Melissia Turpin	Prehospital Care Coordinator, Alternate
X Bryan Sua	Public Sector Paramedic Coordinator
Drew Pryor	Public Sector Paramedic Coordinator, Alt
Danielle Thomas	Private Sector Paramedic
Scott Buck	Private Sector Paramedic, Alternate
X Tabitha Cheng, MD	Provider Agency Medical Director
X Tiffany Abramson, MD	Provider Agency Medical Director, Alt
X Robert Ower	Private Sector Nurse Staffed Amb Program
X Jonathan Lopez	Private Sector Nurse Staffed Amb Program,
Scott Jaeggi	EMT Training Program
X Albert Laicans	EMT Training Program, Alternate
X Ray Mosack	Paramedic Training Program
Vacant	Paramedic Training Program, Alternate
X Jennifer Nulty	EMS Educator
X Heather Calka	EMS Educator, Alternate

EMS AGENCY STAFF	EMS AGENCY STAFF
Richard Tadeo	Nichole Bosson, MD
Jacqueline Rifenburg	Shira Schlesinger, MD
Jake Toy, MD	William Aragon, MD
Ami Boonjaluksa	Mark Ferguson
Natalie Greco	Carola Jimenez
Sara Rasnake	Gary Watson
David Wells	Christine Zaiser

GUESTS	ORGANIZATION
Ivy Valenzuela	LA County Public Health
Danielle Ogaz	LACoFD
Paula LaFarge	LACoFD
Jameel Sylvia	UCLA Ctr for Prehospital Care
Andrew Lara	First Rescue Ambulance
Taggart Diehl	UCLA Ctr for Prehospital Care
Kristina Crews	LACoFD
Kelsey Wilhelm, MD	Compton FD
Angelica Loza-Gomez, MD	GL, SI, MO, Verdugo Dispatch
Mike Noone	Orange County EMS Agency
Gagandeep Grewal, MD	Orange County EMS Agency
Kimberly Tan	Alhambra FD
Adrienne Roel	UCLA Ctr for Prehospital Care
Brian Fong, MD	Cal-Med Ambulance
Mike Ferniz	Lifeline Ambulance
Joe Nakagawa, MD	Hawthorne PD
Theodor Eckland	Pasadena FD
Arthur Aguilar	West Coast Ambulance
Caroline Jack	Beverly Hills FD
Scott Simsian	Lifeline Ambulance
Katie Ward	UCLA Ctr for Prehospital Care
Karyn Robinson	Monterey Park FD
Jorge Fazzini	West Coast Ambulance
Dave Molyneux	AM West Ambulance
Jesse Castillo	PRN Ambulance
Jim Goldsworthy	LAFD Air Ops, Redondo Bch FD
Ryan Heckman	Torrance FD
Salvador Rios, MD	AMR, McCormick, Monrovia FD

1. **CALL TO ORDER –** Chair Carol Meyer, called meeting to order at 1:00 p.m.

2. **INTRODUCTIONS AND ANNOUNCEMENTS**

2.1 Membership Changes *(Chair)*

Vice-Chair announced the following new members:

- Danielle Thomas, representing Private Sector Paramedic

2.2 Dedicated Infection Control Office (DICO) / Infection Control Assessment & Response (ICAR) *(Ivy Valenzuela, Los Angeles County Public Health)*

- LA County Public Health reviewed results of the questionnaires from 2024 and ride-a-long observations from 7 fire departments and 4 private ambulance companies.
- After reviewing the results, LA County Public Health identified that there's a need for improvement in hand hygiene and cleaning of the glucose meter after each patient use.

- By the end of 2024, 100% of providers had a DICO representative identified within their department. However, only 68% had their DICO contact information posted on their website. (Posting is a requirement according to SB 432.)
- Prior to today's meeting, participating providers received a personalized report with results, recommendations, and educational materials addressing identified gaps.
- Public Health will be providing two (2) DICO training sessions. One on December 8, 2025, and another on December 9, 2025. (Only need to attend one session to complete the requirement) Registration information will be sent out by Public Health as the dates gets closer.

2.3 Appointment to the State EMS Commission *(Nichole Bosson, MD)*

- Dr. Bosson announced the appointment of LA County Sheriff Deputy, Jennifer Shepard, to the State Emergency Medical Services Commission. This announcement was initially released by Governor Newson on September 11, 2025.

2.4 EMS for Children Educational Forum – Registration Flyer *(Shira Schlesinger, MD)*

- The 28th Annual EMS For Children Educational Forum is scheduled for November 13, 2025, at the North Bay Healthcare Green Valley Administration Center, located in Fairfield, California.
- For more information and registration, visit the following webpage: https://emsa.ca.gov/ems-for-children/

2.5 December Joint Educational Flyer *(Shira Schlesinger, MD)*

- All are invited to attend the PedAC/MAC Joint Educational Session on December 2, 2025, from 11:45am-1:00pm. Held virtually at the following link: https://ucla.zoom.us/j/96671330620?pwd=eEQIl0AkfnIa1RklyMYzKC8NZrLiUf.1
- Topic is titled "Legal Pitfalls in Responding to Behavioral Crisis" presented virtually by Eric Jaeger, JD, NRP. 1 hour CE will be provided.

2.6 EMS Agency Administrative Responsibility Changes

Following Chris Clare's retirement, the EMS Agency has made the following changes to administrative personnel responsibilities:

- Jacqui Rifenburg, Assistant Director, will oversee: Certification & Training Program Approvals; Data Systems & Research; Hospital Programs; Paramedic Training Institute; and Prehospital Operations.
- Roel Amara, Nursing Director, will oversee: Administrative Services & Finance; Disaster Services, Disaster Response & Emergency Coordination Program; Medical Alert Center, Ambulance Services and Central Dispatch Office.

3. APPROVAL OF MINUTES (Harter / J. Nulty) August 20, 2025, minutes were approved as written.

4. UNFINISHED BUSINESS

Policies for Discussion; Action Required:

EMS Agency Director *(Richard Tadeo)* announced that, after receiving a recommendation from this Committee, starting today the EMS Agency has implemented an update to the Ref. No. 202.2 form, listing the summary of changes for each policy being reviewed and requiring an action from this Committee. This will provide Committee members with the rationale for changes made to policies.

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

Policy reviewed and approved as written.

M/S/C (Ower/Conroy) Approve: Reference No. 227, Dispatching of 9-1-1 Emergency Medical Services.

There was discussion on the upcoming Assembly Bill 645, that may affect this policy. Once this Bill is approved, Policy will be reviewed and adjusted accordingly.

4.2 Reference No. 414, Specialty Care Transport Provider *(David Wells)*

During policy review, several Committee and public comments were received. Due to a lack of consensus, policy not approved. The following results were from the roll call to determine policy acceptance:
Nay – 1 Yea – 1 Abstained – 13

Reference No. 414, Specialty Care Transport Provider; approval recommendation not carried. Additional review recommended.

5. NEW BUSINESS

5.1 PAAC Representatives for Critical and Specialty Care Program Committees *(Richard Tadeo)*

Due to recent changes of the California Code of Regulations (Title 22, Div. 9, Chapter 6), Critical and Specialty Care Programs; Specialty Care Committees listed below, now require representation from EMS.

After hearing nominations, the following individuals will represent this Committee at the following meetings:

- Stroke Advisory – Caroline Jack, Beverly Hills Fire Department
- SRC Advisory – Salvador Rios, MD, AMR/WM Ambulance & Monrovia FD Medical Director
- Pediatric Advisory – Adrienne Roel, UCLA Center for Prehospital Care
- Trauma Advisory – Clayton Kazan, MD, Los Angeles County Fire Department and Marc Cohen, MD, Los Angeles City Fire Department

Representatives are asked to provide feedback to this Committee on pertinent discussion topics from the represented Advisory Committees listed above. Thank you all for your dedication.

5.2 Reference No. 1303, MCG: Algorithm for Prehospital Cath Lab Activation *(Nichole Bosson, MD)*

- This policy was presented as information only. No opposition received.

Policies for Discussion; Action Required:

5.3 Reference No. 506.3, 9-1-1 Interfacility Transfer Checklist for Trauma Re-Triage *(Jacqui Rifenburg)*

Policy Tabled by the EMS Agency and will be presented after further clarity and revision.

Tabled: Reference No. 506.3, 9-1-1 Transfer Checklist for Trauma Re-Triage, retracted by EMS Agency.

5.4 Reference No. 513.2, 9-1-1 Interfacility Transfer Checklist for STEMI Re-Triage *(Jacqui Rifenburg)*

Policy reviewed and approved as written.

M/S/C (Conroy/Hernandez) Approve: Reference No. 513.2, Interfacility Transfer Checklist for STEMI Re-Triage.

Policies for Discussion; No Action Required:

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

5.5 Reference No. 510, Pediatric Patient Destination *(Nichole Bosson, MD)*

5.6 Reference No. 511, Perinatal Patient Destination *(Nichole, Bosson, MD)*

5.7 Reference No. 1203-P, Treatment Protocol: Diabetic Emergencies (Pediatric) *(Nichole Bosson, MD)*

5.8 Reference No. 1216-P, TP: Newborn/Neonatal Resuscitation *(Nichole Bosson, MD)*

5.9 Reference No. 1213-P, TP: Cardiac Dysrhythmia-Tachycardia (Pediatric) *(Nichole Bosson, MD)*

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

5.10.1 Ref. No. 1231-P, Treatment Protocol: Seizures (Pediatric)

5.10.2 Ref. No. 1317.25, MCG: Drug Reference - Midazolam

5.11 Reference No. 1317.XX, MCG: Drug Reference – Normal Saline *(Nichole Bosson, MD)*

5.12 Reference No. 1317.17, MCG: Drug Reference - Epinephrine *(Nichole Bosson, MD)*

5.13 Reference No. 1320, MCG: Level of Consciousness *(Shira Schlesinger, MD)*

After reviewing this policy, Committee recommended that additional education be provided through EMS Update, EmergiPress or other educational means.

5.14 Reference No. 1359, MCG: Care of the Sexual Assault / Human Trafficking / Intimate Partner Violence Patient *(Nichole Bosson, MD)*

Committee Chair, Carol Meyer, dismissed herself due to a personal matter.
Committee Vice-Chair, Kenneth Powell, resumed the meeting as Chair.

6. REPORTS AND UPDATES

6.1 Health Data Exchange *(Richard Tadeo)*

- This program continues to progress with additional meetings and hospital participation.
- LA County Contracts and Grants is reviewing of Business Associate Agreements between providers and hospitals.

6.2 Trauma Dashboard *(Shira Schlesinger, MD)*

- Dr. Schlesinger provided a demonstration of the LA Trauma Care /Post-Crash Care Dashboard, that will be available on the EMS Agency's webpage in the near future.
- This aggregate data comes from law enforcement databases to include roadway crashes within Los Angeles County, when injuries are either suspected or verified.
- Dashboard will provide information on the type of crash; location of crash; type of injuries; prehospital and hospital treatments; ALS units on scene; and other categories of potential interest.
- The goal of this dashboard is to visualize trends and identify potential changes within our EMS system related to post-crash care.

6.3 EMS Update 2026 *(Shira Schlesinger, MD)*

- Primary focus will be pediatric cardiac arrest response, which will include an in-person training component. Date of completion for the in-person component is still under review.
- Other topics include:
  - Advanced capnography
  - Use of magnesium for hypertension in pregnancy
  - Humeral head and distal femoral Intraosseous sites
- Goal is to complete the asynchronous education within 2 hours or less; with a deadline of July 1, 2026.

6.4 EmergiPress *(Shira Schlesinger, MD)*

- Next edition will be available next week; the topic will include the response to dialysis emergencies within the home for peritoneal and hemodialysis.
- November/December 2025 edition will be related to Senate Bill 43 going into effect on January 1, 2026, regarding the placement of 5150 (psychiatric holds) on patients with grave disabilities related to substance abuse or intoxication.

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

No update provided.

6.6 Research Initiatives and Pilot Studies

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

- LA County has entered into the 6th month of this program.
- As of October 14, 2025, there have been a total of 25 transfusions in LA County.
- Analysis from the 2nd Quarter data will be available in late October 2025.
- Harbor UCLA Medical Center will be hosting a blood donation event on October 31, 2025, for those interested in supporting this project.

- LA County Sheriff's Department and the Los Angeles City Fire Department is looking into participating in this prehospital blood transfusion program later next year.

6.6.2 PediDOSE Trial *(Nichole Bosson, MD)*

- In September 2025, the Data and Safety Monitoring Board (DSMB) from the PediDose Trial, announced that the age for this study can be reduced to 6 months and older; instead of the current age of 12 months and older.
- Dr. Bosson asked the Committee if the change should take place now or during EMS Update 2026.
- Committee recommended implementing this new change during EMS Update 2026; rather than implementing earlier.

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

- The EMS Agency distributed defibrillation pads to those providers who have utilized this equipment as part of the ongoing participation with the Pedi-PART Trial.
- Providers are reminded to place defibrillator pads on every pediatric patient that receives positive pressure ventilation.

6.6.4 California Office of Traffic Safety (OTS) Grants Projects

6.6.4.1 RAPID LA County Medic Mobile Application *(Nichole Bosson, MD)*

- Because of the collaboration with Harbor UCLA Medical Center, Department of Emergency Medicine, this project continues to receive grant funding.
- This funding will continue to allow the EMS Agency to discover ways of improving EMS care in Los Angeles County through the Trauma Dashboard, outlined by Dr. Schlesinger in 6.2 above.
- EMS Agency continues to receive suggestions on updating the current drug dosing mobile application and continues to seek funding for both applications.
- If providers and/or hospitals are interested in an on-site training session for this mobile application, please contact Denise Whitfield, MD at DWhitfield@dhs.lacounty.gov

6.7 Cardiac Arrest Task Force *(Nichole Bosson, MD)*

- This one-year task force is Chaired by Steve Sanko, MD.
- All provider agencies should have received a report card, providing them with a baseline regarding their cardiac arrest resuscitation outcomes.
- This task force will be developing a letter that describes methods in which to improve outcomes to meet American Heart Association goals.

7. OPEN DISCUSSION

7.1 Moment of Silence for REACH Air Transport Nurse *(Nichole Bosson, MD)*

- Dr. Bosson called for a moment of silence to acknowledge the tragic event of the REACH Air helicopter crash that took the life of flight nurse, Susan (Suzie) Smith, on October 6, 2025, in Sacramento. The Committee observed a one-minute pause in respect.

8. NEXT MEETING – December 17, 2025

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DISPATCHING OF 9-1-1 EMERGENCY MEDICAL SERVICES** REFERENCE NO. 227

PURPOSE: To establish minimum requirements for the dispatching of 9-1-1 emergency medical services.

AUTHORITY: California Health and Safety Code, Division 2.5, Section 1797.220, 1797.223, 1799.107

DEFINITIONS:

Continuing Dispatch Education: Development and implementation of educational experiences designed to enhance knowledge and skill in the application of dispatch.

Dispatch Center Medical Director: A physician designated by an approved Public Safety Answering Point (PSAP) Emergency Medical Dispatch Provider Agency who meets the requirements outlined in Ref. No. 411, Provider Agency Medical Director and is approved by the Los Angeles County EMS Agency Medical Director. This physician shall possess knowledge of emergency medical services (EMS) systems in California, the local jurisdiction and be familiar with dispatching systems and methodologies.

Dispatch Quality Improvement: A program designed to evaluate, monitor, and improve performance and compliance with policies and procedures to ensure safe, efficient, and effective delivery of emergency medical dispatching.

Emergency Medical Dispatch (EMD): A system of telecommunications established to enable the general public to request emergency assistance, which provides medically approved pre-arrival instructions, and dispatches a level of response according to pre-established provider guidelines to assess medical emergencies by a specially trained dispatcher.

Emergency Medical Dispatcher/ Call taker: An employee of an agency providing emergency medical dispatch services who has completed a nationally recognized dispatch program or Provider Agency specific program approved by the EMS Agency, and who is currently certified as an Emergency Medical Dispatcher (EMD), or Emergency Medical Technician (EMT) with current local scope of practice training. An Emergency Medical Dispatcher/Call taker is specially trained to provide post-dispatch/pre-arrival instructions.

Post-dispatch/Pre-arrival instructions: Telephone rendered protocols reflecting current evidence based medical practice and standards, including instructions intended to encourage callers to provide simple lifesaving maneuvers to be used after EMS units have been dispatched and prior to their arrival.

PRINCIPLES:

1. All callers requesting emergency medical care should have direct access to qualified dispatch personnel for the provision of EMS.

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

2. Public Safety Answering Point (PSAP) Provider Agencies that implement Emergency Medical Dispatch (EMD) shall comply with the State of California EMS statutes and regulations and Los Angeles County EMS Agency Prehospital Care policies.

3. The emergency medical dispatching protocols developed by the dispatch center shall be approved by the Dispatch Center Medical Director and available for review by the EMS Agency.

POLICY

I. Dispatch Center Designation

A. Dispatch center designation approval is granted 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 periodic site visits to evaluate compliance with program requirements or request data at any time.

II. Program Requirements

A. Each dispatch center shall have a qualified Dispatch Center Medical Director to oversee protocol development, quality improvement and shall have a Dispatch Coordinator to oversee daily operations.

B. Ensures the Emergency Dispatch Coordinator, Medical Director or dispatch agency representative attends the Dispatch Center Advisory meetings scheduled by the Los Angeles County EMS Agency.

C. The following shall be submitted to the EMS Agency upon request:

1. An EMD program compliant with State and EMS Agency standards and approved by the Dispatch Center Medical Director:

a. Name of the nationally recognized commercial program to be utilized.

OR

b. An Internally developed program.

2. Pre-determined interview questions.

3. Guidelines and procedures used in the dispatch of EMS Resources.

4. Post-dispatch/Pre-arrival instructions that are clearly defined in compliance with EMS Agency guidelines.

5. Quality Improvement Program

6. Education standards and qualifications for call-takers and dispatchers.

7. Name, contact information, and credentials of the Dispatch Center Medical Director as identified in Ref. No. 411.

III. Dispatch Center Medical Director

A. Requirements

The dispatch center Medical Director shall meet requirements as outlined in Ref. No. 411 and be approved by the EMS Agency Medical Director.

B. Responsibilities

1. Provides medical direction and oversight of the emergency medical dispatch program by review and approval of:

   a. Policies and procedures related to Emergency Medical Dispatch and patient care.

   b. Standards for qualifying education and continuing education.

   c. Dispatch guidelines including pre-arrival instructions.

2. Oversees quality improvement (QI) and compliance standards.

3. Performs ongoing periodic review of dispatch records for identification of potential patient care issues.

4. Provides oversight and participates in dispatch quality improvement, risk management and compliance activities.

IV. Emergency Dispatch Coordinator

A. Requirements

Meets the requirements of an emergency medical dispatcher and possesses comprehensive skills and abilities in management of a 9-1-1 dispatch center.

B. Responsibilities

1. Oversees daily operations of the center and ensures staffing on a continuous 24-hour basis of qualified Emergency Medical Dispatchers/Call-Takers that meets the EMS provider agency’s needs.

2. Ensures a dispatch supervisor or designee is readily accessible 24 hours daily.

3. Ensures for availability of a 24-hour contact phone number and e-mail to be utilized to coordinate or disseminate information in case of critical incident or disease outbreak.

4. Ensures all staff meet the requirements of an Emergency Medical Dispatcher by maintaining records and documentation demonstrating compliance.

5. Coordinates QI activities with the Medical Director.

   a. Provides ongoing monthly collection of data and review of dispatch records for identification of potential patient care issues.

   b. Participates in dispatch quality improvement, risk management and compliance meetings and activities.

V. Emergency Medical Dispatcher / Call-Taker Qualifications

A. Initial Qualifications

1. A current and valid BLS certification equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level. Must include hands-on skills validation (e.g., American Heart Association (AHA) or American Red Cross (ARC).

2. EMD Certification, or the completion of the Dispatch Center's self-developed course in EMD training with a minimum initial training of twenty-four (24) hours approved by the Dispatch Center Medical Director and the EMS Agency.

B. Ongoing requirements

1. Maintain certification as an EMD from a nationally recognized program or the dispatch center's approved internally developed program.

   OR

2. Complete a minimum of (twenty-four) 24 hours of continuing dispatch education (CDE) every two years. Education may be attained through in-person or virtual training with appropriate subject matter relating to emergency medical dispatch.

3. Maintain BLS certification at the healthcare provider level that includes hands-on skills validation (e.g., AHA, ARC).

V. Quality Improvement:

A. The Emergency Medical Dispatch Center shall have a Quality Improvement Program that will evaluate indicators specific to the dispatch of emergency medical services to foster continuous improvement in performance and quality patient care.

B. Each QI Program shall have a written plan that is reviewed annually and updated as needed. The plan should include, at minimum, the following components:

1. Mission statement, objectives, and goals for process improvement

2. Organizational chart or narrative description of how the QI program is integrated within the dispatch center, process(s) for data collection and reporting. Include templates utilized in standardize reports

3. Key performance measures or indicators related to delivery of emergency medical dispatching. Methods or activities designed to address deficiencies and measure compliance to protocol standards as established by the EMD Medical Director through ongoing random case review for each emergency medical dispatcher

4. A description of methods used to provide ongoing feedback and disseminate findings to dispatch personnel.

5. Activities designed to acknowledge excellence in the delivery of emergency medical dispatch performance.

C. The QI process shall:

1. Monitor the quality of medical instruction given to callers, including ongoing random case review for each emergency medical dispatcher and observing telephone care rendered by emergency medical dispatchers for compliance with defined standards.

2. Conduct random or incident specific case reviews to identify calls/practices that demonstrate excellence in dispatch performance and/or identify practices that do not conform to defined policy or procedures so that appropriate training can be initiated.

3. Review EMD reports, and/or other records of patient care to compare performance against medical standards of practice.

4. Recommend training, policies and procedures for quality improvement.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 227.1, **Dispatch Prearrival Instructions**
Ref. No. 411, **9-1-1 Provider Agency Medical Director**
Ref. No: 620, **EMS Quality Improvement Program**

POLICY REVIEW – COMMITTEE ASSIGNMENT REFERENCE NO. 202.1
(ATTACHMENT A)

REFERENCE NO. 227, *Dispatching of 9-1-1 Emergency Medical Services*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee			
EMS ADVISORY	Provider Agency Advisory Committee	8/20/25 10/15/25	10/15/25	
OTHER COMMITTEES / RESOURCES	Medical Council			
OTHER COMMITTEES / RESOURCES	Trauma Hospital Advisory Committee			
OTHER COMMITTEES / RESOURCES	Pediatric Advisory Committee			
OTHER COMMITTEES / RESOURCES	Ambulance Advisory Board			
OTHER COMMITTEES / RESOURCES	EMS QI Committee			
OTHER COMMITTEES / RESOURCES	Hospital Association of Southern California			
OTHER COMMITTEES / RESOURCES	County Counsel			
OTHER COMMITTEES / RESOURCES	Disaster Healthcare Coalition Advisory Committee			
OTHER COMMITTEES / RESOURCES	Other: EMS Dispatch Committee	7/28/25	7/28/25	

*****See Ref. No. 202.2, **Policy Review - SUMMARY OF CHANGES/COMMENTS (Rationale for Revision)**

POLICY REVIEW - SUMMARY OF CHANGES/COMMENTS (Rationale for Revision)

REFERENCE NO. 227, Dispatching of 9-1-1 Emergency Medical Services

SECTION	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
Authority	Deleted EMSA Dispatch Program Guidelines- no longer relevant			
Definitions	Revised to make consistent with other policies			
Principle 3	No longer relevant			
Principle 4	Added language to ensure EMD protocol changes are available for LEMSA review			
Policy I.	Clarified designation requirements			
Policy II.	Reorganized for better flow			
Policy III.	Revised Medical Director requirements as Dispatch needs to be overseen by a qualified, local MD familiar with LA Co EMS practices			
Policy IV	Reformatted and clarified to make consistent with other policies			
Policy V	Reformatted and clarified to make consistent with other policies			
Policy VI	Revised to make consistent with Ref. No. 620			

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITAL)

SUBJECT: **9-1-1 RECEIVING HOSPITAL STANDARDS**

REFERENCE NO. 302

PURPOSE: To outline the guidelines to be approved as a 9-1-1 receiving hospital.

AUTHORITY: Health & Safety Code 1797.88, 1798.175(a)(1)(2)

DEFINITIONS:

9-1-1 Receiving Hospital: A licensed, general acute care hospital with a permit for basic or comprehensive emergency medical service and approved by the Los Angeles County Emergency Medical Services (EMS) Agency to receive patients with emergency medical conditions from the 9-1-1 system.

Advanced Cardiovascular Life Support (ACLS): Resuscitation course that is recognized by the EMS Agency (e.g., American Heart Association, American Red Cross).

Ambulance Arrival at the Emergency Department: The time the ambulance stops (actual wheel stop) at the location outside the hospital emergency department where the patient is unloaded from the ambulance.

Ambulance Patient Offload Time (APOT): The time the patient is physically transferred from the ambulance equipment on to the hospital equipment and hospital staff assume care of the patient. The Standard for Los Angeles County is 90% of all ambulance transports have an APOT of 30 minutes or less.

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (ABMS) including an examination designed to assess 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 anticipated progression to board certification based on the timeframe specified by the ABMS.

Emergency Department (ED) Nurse Leader: A Registered Nurse currently licensed to practice in the State of California.

Emergency Department (ED) Medical Director: A physician licensed in the State of California, Board Certified in Emergency Medicine (EM) or Pediatric Emergency Medicine (PEM) and privileged by the hospital in EM.

Pediatric Advanced Life Support (PALS): Pediatric Resuscitation course that is recognized by the EMS Agency (e.g., American Heart Association, American Red Cross).

VMED28: Formerly known as HEAR (Hospital Emergency Administrative Radio). This is an interoperable radio voice communication system (155.340.156.7) utilized by hospital administrative staff during emergencies. This provides communication redundancy in the event

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

of multiple casualty incidents and disaster situations when normal channels of communication are not available.

PRINCIPLES:

1. Patients who call 9-1-1 receive optimal care when transported to a facility that is staffed, equipped and prepared to administer emergency medical care appropriate to their needs.

2. Emergency departments (ED) equipped with the communications required of 9-1-1 receiving facilities drill regularly with other system participants and can communicate effectively during multi-casualty incidents (MCI) and disasters.

3. Data collection and evaluation is critical to assess system performance and evaluate for educational and improvement needs.

POLICY:

I. General Requirements

9-1-1 Receiving Hospital shall:

A. Be accredited by a Centers for Medicare and Medicaid Services (CMS) recognized Hospital Accreditation Organization within six (6) months of designation

B. Have an Emergency Department open and caring for walk-in patients for a minimum of one (1) month prior to requested date for receiving 9-1-1 patients.

C. Appoint a physician on staff to function as the ED Medical Director.

D. Appoint an administrative manager to function as the ED Nurse Leader.

E. Ensure that at least 60% of the ED attending physicians are BC or BE in Emergency Medicine (EM) or Pediatric Emergency Medicine (PEM). For ED physicians who are not EM or PEM BC or BE, they shall have current ACLS and PALS provider or instructor certification and an affidavit signed by the ED Medical Director and Chief Medical Officer verifying competency in caring for adult and pediatric patients needing all levels of emergency care.

F. Have an operational ReddiNet® terminal with redundant connectivity via satellite and internet.

G. Collaborate with EMS provider agencies to provide and maintain a means of obtaining prehospital electronic patient care records through designated web portal(s) with ability to print records. Paramedic providers are required to document patient care on electronic medical record system. Although, BLS providers are not required by regulations to utilize electronic records, most BLS providers have transitioned from paper-based EMS records to electronic medical record systems.

H. Have VMED28 radio for communication with paramedic providers and the Medical Alert Center during multiple casualty incidents.

I. Maintain a dedicated telephone line to facilitate direct communication with the paramedic base hospitals, 9-1-1 personnel, and the Medical Alert Center.

J. Have an interfacility transfer policy, approved by the EMS Agency, that addresses the following:

1. For hospitals that are not designated Trauma, STEMI, Stroke, EDAP, Perinatal, PMC or SART centers, transfer policies shall address higher level of care transfers to Specialty Care Centers.

2. For designated Specialty Care Centers, transfer policies shall be established with surrounding referral facilities.

3. Compliance with Title XXII transfer requirements and Emergency Medical Treatment and Active Labor Act (EMTALA) to include: accepting physician and confirmation that the receiving facility has capacity, capability and qualified personnel to treat the condition.

4. Mechanisms to obtain appropriate transportation for the effective interfacility transfer of patients which should include written agreements with private ambulance companies.

5. Utilization of 9-1-1 for interfacility transfer is only for patients who meet specific Trauma Re-Triage criteria (Ref. No. 506 and 506.2) or confirmed STEMI patients (Ref. No. 513.1)

a. A mechanism shall be implemented to ensure that each transfer for which 9-1-1 was used is tracked reviewed for appropriateness, with corrective measures taken when indicated to ensure proper use of resources.

b. All transfers utilizing the 9-1-1 system should be logged, with documentation of the results of the review

K. Execute and maintain a Specialty Care Center Designation Master Agreement – Exhibit A-5, 9-1-1 Receiving Facility, with the EMS Agency.

L. Provide updated contact information to the base hospital(s) and the EMS Agency whenever there is a change in key personnel as per Ref. No. 621.

M. Maintain an accurate list of hospital services and contact information in the ReddiNet® for disaster and MCI purposes.

N. When implemented, collect and submit data to the EMS Agency on all patients transported via the 9-1-1 system.

O. Have a process to ensure that all patients transported via ambulance are offloaded in a timely manner and transfer of care to hospital staff meets the current Ambulance Patient Offload Time (APOT).

P. Have a mechanism in place to ensure physician consultation is available for medical services provided.

Q. Respond timely and participate in all EMS requested drills/surveys including, but not limited to: MCI drills, annual Hospital Impact Survey, National Pediatric Readiness Project.

II. ED Leadership Requirements

A. ED Medical Director responsibilities:
1. Acts as a liaison to the EMS Agency as it relates to EMS practices and policies
2. Collaborates with the ED Nurse Leader to ensure on-going compliance with these Standards
3. Stays current on LA County EMS policies
4. Ensures on-going education of ED physician staff in the care of adult and pediatric patients as well as current EMS policy

B. ED Nurse Leader responsibilities:
1. Collaborates with the ED Medical Director to ensure on-going compliance with these Standards.
2. Act as a liaison to the EMS Agency.
3. Stays current on LA County EMS policies
4. Ensures on-going education of ED staff in current EMS policy

III. Procedure for Approval to be a 9-1-1 Receiving Hospital

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

1. The rationale for the request to be a 9-1-1 receiving hospital.

2. A document verifying the hospital has a permit for basic or comprehensive emergency medical service.

3. Proof of accreditation by a CMS-approved accrediting organization within six (6) months of designation.

4. Most recent two (2) months, (current and previous months) of ED physician schedules, along with proof of BC or BE in EM or PEM. For those ED physicians who are not BC or BE, provide copies of current ACLS certification and signed affidavit.

5. Number of patients treated during the previous month in the following categories:
   a. Total ED visits
   b. Total admitted to the ICU (not just from the ED)
   c. Cardiac arrests (hospital-wide)

d. Total surgical cases requiring general anesthesia
e. Total interfacility transfers for higher level of care

6. Interfacility transfer policy and all transfer and transport agreements.

7. The proposed date the emergency department (ED) would open to 9-1-1 traffic.

B. Site Visit

1. Once all required communication systems are installed and hospital staff training on the equipment is complete, the EMS Agency will coordinate a site visit.

2. Administrative and field personnel from local EMS provider agencies will be invited to exchange contact information, participate in the VMED28 and the ReddiNet® system tests, and become familiar with the physical layout of the facility.

3. Representatives from the nearest paramedic base hospital (Administrative, Medical Director and/or Prehospital Care Coordinator) will provide contact information, explain the role and function of the paramedic base, and discuss how patient information is communicated to the surrounding 9-1-1 receiving hospitals.

4. EMS Agency role at the site visit:

a. Conduct ReddiNet® drill and VMED28 test

b. Explain the role of the Medical Alert Center and provide contact information

c. Discuss disaster preparedness activities

d. Review the Prehospital Care Policy Manual, Treatment Protocols and other relevant materials:
i. Ref. No. 502, Patient Destination
ii. Ref. No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients
iii. Ref. No. 503.1, Hospital Diversion Request Requirements for Emergency Department Saturation
iv. Ref. No. 506.2, 9-1-1 Trauma Re-Triage
v. Ref. No. 513.1, Interfacility Transport of Patients with ST-Elevation Myocardial Infarction
vi. Ref. No. 620.2, Notification of Personnel Change
vii. EMS Agency staff contacts
viii. Paramedic Base hospital/receiving hospital contacts
ix. EMS Agency meeting calendar
x. Situation Report/Problem resolution
xi. EmergiPress

e. Conduct an exit interview to include outstanding items needed and timeline as to when hospital can expect to be designated as 9-1-1 receiving.

IV. Receipt of Ambulance Transports

A. All 9-1-1 Receiving Hospitals shall have a process to ensure that all patients transported via ambulance are offloaded in a timely manner and transfer of care to hospital staff meets the current Ambulance Patient Offload Time (APOT).

1. An ambulance crew that has been waiting in excess of 60 mins shall notify their immediate supervisor and the department charge nurse.

2. The ambulance provider shall notify their dispatch center of the extended wall time and to begin tracking.

CROSS REFERENCES:

Prehospital Care Manual:
Reference No. 304, **Role of the Base Hospital**
Reference No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**
Reference No. 503.1, **Hospital Diversion Request Requirements for Emergency Department Saturation**
Reference No. 506, **Trauma Triage**
Reference No. 506.2, **9-1-1 Trauma Re-Triage**
Reference No. 621, **Notification of Personnel Change**
Reference No. 621.1, **Notification of Personnel Change Form**
Reference No. 513.1, **Emergency Department Interfacility Transport of Patients with ST-Elevation Myocardial Infarction**

Reference No. 302, 9-1-1 Receiving Hospital Standards

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee			
	Base Hospital Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California	9/4/25	09/04/2025	No
	County Counsel			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITAL, ALS PROVIDERS)

SUBJECT: **9-1-1 INTERFACILITY TRANSFER CHECKLIST FOR STEMI RE-TRIAGE** REFERENCE NO. 513.2

9-1-1 STEMI IFT Checklist

Yes	No	
❒	❒	ECG read by Physician is interpreted as *acute* ST-Elevation Myocardial Infarction (STEMI).
❒	❒	The patient is in the emergency department and not admitted to the hospital.

If no to either, do not utilize 9-1-1, contact a private ambulance to transport patient. If meets **both** criteria, follow procedure below:

- ❒ Transmit positive STEMI ECG to STEMI Receiving Center (SRC) for review by the SRC Physician.
- ❒ ED Physician: Calls SRC Physician to discuss patient.
- ❒ Verify transfer is accepted by SRC.
  - ❒ Physician accepted patient.
  - ❒ Facility has bed and cath lab available.
- ❒ Determine, in consultation with SRC Physician, need for EMERGENT PCI.

  For NON-emergent PCI (e.g. urgent or NSTEMI), arrange for appropriate level of care transport (BLS, ALS or RN) via private ambulance. ***Do not call 9-1-1*** and follow hospital policy for transfer.
- ❒ For **EMERGENT PCI ONLY**, if ETA is greater than 10 minutes for private ambulance transport, verify patient is not receiving medication outside of paramedic scope of practice (IV drips except NS) then call 9-1-1 for transport (after patient and paperwork is prepared). If patient needs level of care beyond paramedic scope of practice, contact private ambulance service for appropriate level of transport – RN Specialty Care or ALS or BLS with hospital RN to accompany.
- ❒ Immediately prepare patient for transport: Copy ED records including all ECGs, initial EMS Report Form including field ECG when applicable, labs, relevant diagnostic imaging, etc.
- ❒ Ensure hospital-specific transfer paperwork completed.
- ❒ ED RN: Calls SRC and gives patient report to accepting RN or house supervisor.

Patient Name	Medical Record #
Sending Hospital	Receiving Hospital
Accepting MD	Report given to

PROVIDE COPY TO TRANSPORTING AGENCY

POLICY REVIEW – COMMITTEE ASSIGNMENT REFERENCE NO. 202.1
(ATTACHMENT A)

REFERENCE NO. 513.2, *9-1-1 Interfacility Transfer Checklist for STEMI Re-Triage*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee	10/08/25	10/08/25	
	Provider Agency Advisory Committee	10/15/25	10/15/25	
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:			

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **GUIDELINES FOR GRANT FUNDED ITEMS AND INVENTORY OF GRANT FUNDED EQUIPMENT** REFERENCE NO. 1109

PURPOSE: To provide guidelines to purchase, store, maintain, decommission and dispose of equipment, supplies, and pharmaceuticals that have been purchased with grant funds.

AUTHORITY: Code of Federal Regulations (CFR), Title 2, Subtitle A, Chapter II, Part 200, subpart D, 200.311 federal guidelines for HPP, UASI, and SHSGP

DEFINITIONS:

Awardee - The authorized administrator for the grant. Also referenced as grantee or recipient.

Acquisition date- The date when the asset is received or recipient gains control of asset.

Cache – All items intended for use during a surge.

Consumable equipment/supplies – Any single-use item **OR** a single item (not pharmaceutical) that costs under $500.00. These items are replenished immediately after use at the sub-awardee's expense. Equipment and/or supplies (not pharmaceuticals) with a purchase price of less than $500 per individual item.

Disposition - Refers to the status of an asset's location through transfer of ownership (returned, exchanged), change in location, no longer useful or feasible to maintain (decommissioned or disposed) or unable to be found (lost or stolen).

Durable equipment and supplies – Any single item with a purchase price between $500 and $4,999 per individual item. These items are normally reusable and last more than one year. These items are expected to be maintained or replaced during their useful life.

Inventory – A complete list of items such as property or goods in stock or an itemized list of current assets such as a list of goods on hand.

Grant-funded items – Any item purchased with grant funds; i.e. real property, durable equipment, consumable equipment/supplies, and pharmaceuticals.

PAR Level – Periodic Automatic Replenishment. The expected minimum level of inventory is required to be held to be sure supply needs are met.

Pharmaceuticals – A compound manufactured for use as a medicinal drug and is a single-use item. These items are replenished immediately after use at the sub-awardee's expense.

Real property – Any single item that costs $5,000 or more. These items are meant to be maintained or replaced during their useful life. Can be referred to as "Tangible Property".

Sub-awardee – Receiver of grant funds, equipment, supplies, and/or pharmaceuticals. Also referenced as sub-grantee or sub-recipient.

Surge – The sudden rise to an abnormal or temporarily excessive level.

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

Tangible Property - See Real Property

Useful life - Useful life refers to the estimated duration of utility placed on assets, including equipment and vehicles. Useful life estimations terminate at the point when assets are expected to become obsolete, require major repairs, or cease to deliver economical results.

PRINCIPLES:

1. All grant-funded items must be inventoried and verified annually.

2. Sub-awardees of grant-funded items are responsible for their storage, security, and maintenance (real property, durable equipment, consumable equipment/supplies, and pharmaceuticals). Therefore, the sub-awardees shall have processes in place to ensure adequate safeguards exist to maintain equipment/supplies and to prevent damage, loss, or theft of equipment/supplies.

3. Grant-funded consumable equipment/supplies and pharmaceuticals are intended for medical surge. PAR levels should be maintained unless level changes are approved in writing by the EMS Agency for emergencies. Rotation of consumables is highly recommended and encouraged to minimize replacement costs and wastage. The exception to this principle is pre-positioned antibiotics which are NOT to be rotated or opened unless directed by the County Health Officer. Chempack also should not be rotated (See Ref. No. 1108- Chempack Deployment for Nerve Agent Release)

4. In the event the real property or durable equipment is rotated into use, the maintenance log will reflect the change in disposition.

5. No action will be taken by any sub-awardee to remove or dispose of any grant-funded real property, durable equipment, or pharmaceutical unless directed by the EMS Agency. Any action taken by the sub-awardee to remove or dispose of any grant-funded real property, durable equipment, or pharmaceutical without prior written approval from the EMS Agency may result in the sub-awardee replacing the item(s) at their expense, as determined by the EMS Agency.

6. Sub-awardees of grant funded items are financially responsible for any item lost, stolen or willfully neglected by poor inventory, use or maintenance practices as determined by the EMS Agency and/or grant awardee.

POLICY:

I. Purchasing/Acquisition

A. The sub-awardee shall maintain acquisition records for all grant-funded items. Records to be maintained shall include:

1. Purchasing:

i. Purchase Order

ii. Packing Slip
iii. Invoice
iv. Serial number(s), if applicable
v. Model number(s), if applicable
vi. Proof of Payment (e.g. canceled check)
vii. Vendor
viii. Price
ix. Manufacturer

Note: The EMS Agency will schedule a time to place grant asset tags on real property and durable equipment.

2. Acquisition

i. Retain copy of the distribution form provided by the EMS Agency
ii. Ensure item is correctly entered in the County's approved Inventory Management System (IMS), if applicable.

B. Record Retention

1. Real property-10 years from acquisition
2. Durable equipment- 5 years from acquisition
3. Pharmaceuticals- 3 years from time of dispensing or disposal.
4. Consumable equipment/supplies- 2 years from time of use or disposal

II. Inventory Tracking

A. The sub-awardee shall maintain an inventory log of all grant-funded items. This inventory log shall be made available to the EMS Agency upon request. Note: This can be printed with the County's IMS approved software, if applicable.

B. The sub-awardee shall use County approved IMS, if available. Required fields include:

1. Acquisition date
2. Description of item
3. Storage location of item
4. Quantity
5. Model number(s), if applicable
6. Serial number(s), if applicable
7. Tag number(s), if applicable
8. Condition of Property
   i. Excellent-New or unused (1)
   ii. Usable-Can be used with repair or modification (4)
   iii. Repairable- Can be economically repaired and used (7)
   iv. Salvage- Some value but repair is impractical (X)
   v. Scrap-No value

C. A physical inventory must be taken annually with the results submitted to the appropriate Disaster Services Program Manager at the EMS Agency. This can

be done via the County's approved IMS, if applicable.

III. Maintenance

A. The sub-awardee shall retain a maintenance log of all real property, and durable equipment. This maintenance log shall be updated monthly. (Reference 1109.1). This can also be done electronically using the County's approved IMS, if applicable.

B. Required fields in the IMS include:

1. Acquisition date
2. Description of item
3. Model No.
4. Serial No.
5. Tag No.
6. Condition of Property
7. Date inspected and/or serviced
8. Notes
9. Initials
10. Name of person verifying inspection

C. Sub-awardee shall store and maintain all real property, durable equipment, consumable equipment/supplies, and pharmaceuticals per the manufacturer's stated recommendations and/or Los Angeles County guidance, plans or policies.

IV. Disposition of Real Property, Durable Equipment, or Pharmaceuticals

A. Returned

1. The sub-awardee is responsible for the following:

a. Notify the Disaster Services Program Manager at the EMS Agency on the sub-awardee's letterhead with the following information:

i. Purchase date of the property, equipment, or pharmaceuticals they would like to return
ii. Description of property, equipment, or pharmaceuticals intended to be returned
iii. Quantity
iv. Model number(s), if applicable
v. Serial number(s), if applicable
vi. Tag number(s), if applicable
vii. Condition of Property
viii. Reason for return

b. Retain property, equipment, or pharmaceuticals until notified by Disaster Services Program Manager at the EMS Agency

i. If approved to proceed, complete and submit Grant Funded Item Disposition Form (Ref. No. 1109.2)
ii. If denied, follow instructions provided by the EMS Agency representative.

c. Provide additional information as requested by the EMS Agency.

d. If approved, schedule the return of the real property, durable equipment, or pharmaceuticals with the Disaster Services Program Manager at the EMS Agency and/or necessary warehouse staff.

e. Retain a copy of the signed Grant Funded Item Disposition Form, once it is received, for a minimum of five years. Receipt should happen within 10 business days once everything is inventoried and determined to be in a deployable condition.

2. The EMS Agency is responsible for the following:

a. Approve or deny the request for a return. This is done in conjunction with the Disaster Response and Coordination Chief or Homeland Security Grant Manager (HSGM).

b. Notify sub-awardee of the decision with instructions for returning real property, durable equipment, or supplies.

c. If approved for return, notify necessary warehouse staff to assist with coordination.

d. Warehouse receiving staff will sign the Grant Funded Item Disposition Form (Ref. No. 1109.2) and provide a copy to appropriate EMS staff.

e. Items are transferred into the warehouse inventory using the County's approved IMS.

f. HSGM updates necessary paperwork for location change and submits updated Equipment Inventory List to appropriate grant awardee (UASI or SHSP).

g. Inventorying and inspecting returned items. Notifying sub-awardee if there are discrepancies.

h. Provide a copy of the signed and completed Grant Funded Item Disposition Form (Ref. No. 1109.2) within 10 business days of sub-awardee returning real property, durable equipment, or pharmaceuticals.

B. Exchanged

1. The sub-awardee is responsible for the following:

   a. Notify the Disaster Services Program Manager at the EMS Agency on the sub-awardee's letterhead with the following information:

      i. Description of property, equipment, or pharmaceuticals intended to be exchanged
      ii. Quantity
      iii. Model number(s), if applicable
      iv. Serial number(s), if applicable
      v. Tag number(s), if applicable
      vi. Condition of Property
      vii. Reason for exchange

   b. Retain property, equipment, or pharmaceuticals until notified by Disaster Services Program Manager at the EMS Agency

      i. If approved to proceed, complete and submit Grant Funded Item Disposition Form (Ref. No. 1109.2)
      iii. If denied, follow instructions provided by the EMS Agency representative.

   c. Provide additional information as requested by the EMS Agency.

   d. If approved, schedule exchanging the real property, durable equipment, or pharmaceuticals with the Disaster Services Program Manager at the EMS Agency and/or necessary warehouse staff.

   e. Sign the Distribution Form provided for the new item and accept the new item using the County's approved IMS, if applicable.

   f. Maintain a copy of the signed Grant Funded Item Disposition Form, once it is received, for a minimum of five years. Receipt should happen within 10 business days once everything is inventoried and determined to be in a deployable condition.

2. The EMS Agency is responsible for the following:

   a. Approve or deny the request for an exchange. This is done in conjunction with the Disaster Response and Coordination Chief or Homeland Security Grant Manager (HSGM).

   b. Notify sub-awardee of the decision with instructions for exchanging real property, durable equipment, or supplies.

c. If approved for exchange, notify necessary warehouse staff to assist with coordination.

d. Warehouse receiving staff will sign the Grant Funded Item Disposition Form (Ref. No. 1109.2) and provide a copy to appropriate EMS staff.

e. Have sub-awardee sign new distribution form and provide them a copy.

f. Items are transferred into the warehouse inventory using the County's approved IMS.

g. HSGM updates necessary paperwork for location change and submits updated Equipment Inventory List to appropriate grant awardee (UASI or SHSP).

h. Inventorying and inspecting returned items. Notifying sub-awardee if there are discrepancies.

i. Provide a copy of the signed and completed Grant Funded Item Disposition Form (Ref. No. 1109.2) within 10 business days of sub-awardee returning real property, durable equipment, or pharmaceuticals.

C. Decommissioned (Past useful life, too costly to repair or expired)

1. The sub-awardee is responsible for the following:

a. Notify the Disaster Services Program Manager at the EMS Agency on the sub-awardee's letterhead with the following information:

i. Description of property, equipment, or pharmaceuticals intended to be decommissioned
ii. Quantity
iii. Model number(s), if applicable
iv. Serial number(s), if applicable
v. Tag number(s), if applicable
vi. Condition of Property
vii. Reason for decommissioning
viii. Quotes or other support documentation to support decommissioning

b. Retain property, equipment, or pharmaceuticals until notified by Disaster Services Program Manager at the EMS Agency

i. If approved to proceed, complete and submit Grant Funded Item Disposition Form (Ref. No. 1109.2)
iv. If denied, follow instructions provided by the EMS Agency representative.

c. Provide additional information as requested by the EMS Agency.

d. If approved, schedule decommissioning the real property, durable equipment, or pharmaceuticals with the Disaster Services, Program Manager, at the EMS Agency and/or necessary warehouse staff. Note: In some instances, the sub-awardee may be given permission to decommission the item and not return it to the EMS Agency.

e. Retain a copy of the signed Grant Funded Item Disposition Form, once it is received, for a minimum of five years. Receipt should happen within 10 business days of receipt of all necessary paperwork.

2. The EMS Agency is responsible for the following:

a. Approve or deny the request for decommissioning. This is done in conjunction with the Disaster Response and Coordination Chief or Homeland Security Grant Manager (HSGM).

b. Notify sub-awardee of the decision with instructions for decommissioning real property, durable equipment, or supplies.

c. If approved for decommissioning and needs to be returned, notify necessary warehouse staff to assist with coordination.

d. Warehouse receiving staff will sign the Grant Funded Item Disposition Form (Ref. No. 1109.2) and provide copy to appropriate EMS staff.

e. Items are transferred into the warehouse using the County's approved IMS.

f. HSGM updates necessary paperwork for disposition status and submits updated Equipment Inventory List to appropriate grant awardee (UASI or SHSP).

g. Inventorying and inspecting decommissioned items. Notifying sub-awardee if there are discrepancies.

h. Provide a copy of the signed and completed Grant Funded Item Disposition Form (Ref. No. 1109.2) within 10 business days of sub-awardee returning real property, durable equipment, or pharmaceuticals.

D. Lost, Missing, or Stolen Real Property, Durable Equipment, or Pharmaceuticals

1. The sub-awardee is responsible for the following:

a. Notify the Disaster Services Program Manager at the EMS Agency within 10 days upon knowledge of lost, missing, or stolen real property, durable equipment, or pharmaceuticals. Provide on the sub-

awardee's letterhead the following information:

i. Description of property, equipment, or pharmaceuticals that were lost, missing or stolen
ii. Quantity
iii. Model number(s), if applicable
iv. Serial number(s), if applicable
v. Tag number(s), if applicable
vi. Date last seen
vii. Actions taken to find or recover the items

b. If the item(s) are presumed stolen and the purchase/replacement price is greater than $500, a police report must accompany this request. If no police report is provided the sub-awardee will be 100% responsible as it will be considered lost/misplaced and not stolen.

c. If the real property, durable equipment, or pharmaceuticals are within their useful life or not expired, the sub-awardee is responsible for replacing the lost or stolen equipment with the same make and model of the lost, missing, or stolen equipment. If the equipment is no longer manufactured, the equipment will be replaced with like-kind property, per the EMS Agency's approval.

d. Upon the sub-awardee's receipt of the replacement property, the following information will be provided to the Disaster Services, Program Manager, at the EMS Agency. (See section 1.A.1. Acquisition)

i. Purchase Order
ii. Packing Slip
iii. Invoice
iv. Vendor
v. Manufacturer
vi. Serial number(s), if applicable
vii. Model number(s), if applicable
viii. Proof of payment (e.g. canceled check)
ix. Incident Action Plan, addressing how this could be avoided in the future i.e. security, inventory, tracking changes made, etc.

e. Maintain all paperwork per section I. Purchasing/Acquisition for the replacement, if required.

f. Retain a copy of the signed Grant Funded Item Disposition Form, once it is received, for a minimum of five years. Receipt should happen within 10 business days of receipt of all necessary paperwork.

2. The EMS Agency is responsible for the following:

a. Notify sub-awardee of the receipt of required documents and provide guidance on next steps.

b. Once all documentation has been received, notify sub-awardee if the item needs to be replaced and provide a timeline for them to acquire the items, if necessary.

c. Schedule a time to place grant asset tag on new equipment, if applicable.

d. HSGM updates necessary paperwork for disposition status and submits updated Equipment Inventory List to appropriate grant awardee (UASI or SHSP).

e. Provide a copy of the signed and completed Grant Funded Item Disposition Form (Ref. No. 1109.2) within 10 business days of sub-awardee providing all necessary documents.

E. Location Change

1. The sub-awardee (lending facility) is responsible for the following:

a. Obtain permission to move item location from the Disaster Services Program Manager at the EMS Agency. ***Note: only applies to items NOT being requested to be moved by the EMS Agency i.e. Resource Request.***

b. Provide the following information:

i. Description of property, equipment, or pharmaceuticals intended to be moved
ii. Quantity
iii. Model number(s), if applicable
iv. Serial number(s), if applicable
v. Tag number(s), if applicable
vi. Reason for relocation

c. Retain property, equipment, or pharmaceuticals until notified by Disaster Services Program Manager at the EMS Agency

d. Provide additional information as requested by the EMS Agency.

e. If approved, schedule relocating the real property, durable equipment, or pharmaceuticals with the requesting/borrowing sub-awardee.

f. Use either the policies available in the Prehospital Care Policy Manual listed below or use internal distribution form for tracking where assets are going.

i. Reference 1102.3: DRC Equipment Release Agreement
ii. Reference 1106.1: Adult LPC Inventory and Checklist for Items Deployed
iii. Reference 1106.2: Pediatric LPC Inventory and Checklist for Items Deployed
iv. Reference 1107.1: M/SS Cache Inventory and Checklist for Items Deployed

g. Maintain a copy of the signed tracking form that was used, this should be maintained until the item is returned by the recipient.

h. Inventory and check loaned equipment within 10 days of being returned and notify recipient and the EMS Agency if there is any significant damage or missing items.

2. The requesting/borrowing sub-awardee is responsible for the following:

a. Signing the tracking form that is provided by the lending facility.

b. Maintaining a copy of the tracking form.

c. Maintaining, securing property and equipment while assigned to sub-awardee.

d. Follow manufacturers instructions for use. If uncertain on how to use contact lending facility or EMS Agency to get instructions and guidance.

e. Identify any functional/operational issues immediately and notify lending facility.

f. Replenish the supplies/pharmaceuticals once they are available.

g. Ensure real property is cleaned, inventoried for completeness and operational before returning to lending facility.

h. Receive and maintain a signed copy of items returned. **Note: Lending facility will verify equipment is clean, complete and operational within 10 business days of return.**

3. The EMS Agency is responsible for the following:

a. Approve or deny the request for relocation.

b. Notify lending facility of the decision with any instructions for relocating real property, durable equipment, or supplies (pharmaceuticals).

c. Connect the lending facility with the borrowing/requesting sub-awardee, if initiated by a resource request.

d. Update ReddiNet, if initiated by a resource request.

e. Make sure the relocation is reflected in the approved County IMS software.

f. Provide guidance to borrowing/requesting sub-awardee, as needed.

g. Assist with mitigating issues between lending facility and receiving sub-awardee.

F. Disposing of Real Property, Durable Equipment, or Pharmaceuticals that are broken, beyond repair, beyond their useful life, or expired

1. The sub-awardee will notify the Disaster Services Program Manager at the EMS Agency on the sub-awardee's letterhead within 30 days if any real property, durable equipment, or pharmaceuticals needs to be disposed.

2. The sub-awardee is responsible for providing the following information:

a. Purchase date of item(s)
b. Description of items they would like to dispose
c. Quantity
d. Model number(s), if applicable
e. Serial number(s), if applicable
f. Tag number(s), if applicable
g. Reason for requesting disposal

i. If disposing of real property or durable equipment that is broken or beyond repair but has not reached the end of its useful life, provide a detailed explanation for the reason to dispose of this item(s).

h. Retain real property, durable equipment, or pharmaceuticals until notified by the EMS Agency.

i. If approved, complete and submit Grant Funded Item Disposition Form (Ref No. 1109.2) to the EMS Agency or through the approved County inventory management system
ii. If denied, follow the instructions provided.

i. Any action taken by the sub-awardee to remove or dispose of any grant-funded item(s) without prior written approval from the EMS Agency may result in the sub-awardee replacing the item(s) at their expense, as determined by the EMS Agency.

3. The EMS Agency is responsible for the following:

    a. Approve or deny the request
    b. Notify sub-awardee of the decision
    c. Make necessary changes in the County IMS, if applicable.
    d. Verify the sub-awardee does not have items listed in the updated inventory
    e. Complete any other documentation necessary to meet Awardee grant requirements
    f. Maintain records according to Federal, State, and Local record retention policies

        i. Real Property – 10 years
        ii. Durable Property – 5 years
        iii. Pharmaceuticals – 3 years from time of disposal or dispensing
        iv. Consumable – 2 years from time of distribution

CROSS REFERENCE:
Federal guidelines for HPP, UASI, and SHSGP
California State Grant Guidelines
County of Los Angeles Inventory Management Policies and Procedures
Pre-positioning of Antibiotics Storage and Distribution Plan

Prehospital Care Manual:

Ref. No. 1102.2, **DRC Equipment Checklist for Items Deployed to Other Facilities**
Ref. No. 1106, **Mobilization of Local Pharmaceutical Caches (LPCs)**
Ref. No. 1107, **Mobilization of Medical/Surgical Supply (M/SS) Caches**
Ref. No. 1108, **Chempack Deployment for Nerve Agent Release**
Ref. No. 1109.1, **Maintenance Log**
Ref. No. 1109.2, **Grant Funded Item Disposition Form**

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

REFERENCE NO. 1109, Guidelines for Grant Funded Items and Inventory of Grant Funded Equipment

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definitions	*(example: BHAC 2-14-23)*	*(example: Change the wording to "Law enforcement operation e.g. active shooter, bomb threat, hostage situation")*	*(example: Change made)*
Title Change	*DRC Coordinators (6/16/2025)*	*Guidelines for Grant Funded Items and , Inventory of Grant Funded Equipment*	*Change made*
	Disaster Coalition Advisory Committee (10/2/2025)	*No Changes*	

MAINTENANCE LOG

Name of Facility: _____ **Month:** _____

Item #	Acqusition date	Description of Item	Model#	Serial #	Grant Tag #	Condition	Date Inspected	Notes*	Initials
EX	1-Mar-15	DLX Tent	ASAP-18	1234567890	00025	4	20250515	Passed visual inspection	JH
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

Condition of Property Legend:

- **1** Excellent-new or unused
- **4** Usable-can be used without significant repair
- **7** Repairable-can be economically repaired
- **X** Salavage- some value but repair is impractical
- **S** Scrap-no value

Notes:

Passed visual inspection
Passed visual and mechanical inspection
Failed visual and mechanical inspection
Failed visual inspection only
Failed mechanical inspection only
Other issue: *(Briefly Describe)*

I certify the above equipment was inspected following manufacturers guidelines and is in the condition stated above.

_____ _____

Name of Emergency Management Officer **Date reviewed**

GRANT FUNDED ITEM DISPOSITION FORM

REFERENCE NO. 1109.2

Name of Facility: _____ **Facility Code:** _____

Item #	Purchase date (if known)	Description of Item	Model#	Serial #	Grant Tag #	Condition Code*	Disposition	Misc Comments
EX	1-Mar-15	DLX Tent	ASAP-18	12345678	00025	X	Decommissioned	20250515
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

Condition Code Legend:

- **1** Excellent-new or unused
- **4** Usable-can be used without significant repair
- **7** Repairable-can be economically repaired
- **X** Salavage- some value but repair is impractical
- **S** Scrap-no value
- **NA** Not Applicable (Lost or stolen)

Disposition Legend:

- **Returned** No longer needed or wanted (Condition 1, 4 or 7)
- **Exchanged** Newer model or improved model available (Condition **NOT** X or S)
- **Decommissioned** Useful life expired, too costly to repair based on remaining life (Condition X)
- **Disposed** (Condition X or S)
- **Lost** (Condition NA)
- **Stolen** (Condition NA)
- **Location Change** Moved to another facility (Condition 1, 4 or 7)

Name of Authorized Releaser _____ **Signature of Releaser** _____ **Date Form Submitted** _____

Authorized County Approver _____ **Signature of Authorized County Approver** _____ **Date Form Approved** _____

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITAL)

SUBJECT: **HOSPITAL RELOCATION/EVACUATION** REFERENCE NO. 1112

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

AUTHORITY: Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Emergency Preparedness Requirements, Condition of Participation, Title 42 CFR 482.15
National Fire Protection Association: Health Care Facilities Code 99, 2012 Edition

DEFINITIONS:

Delayed Evacuation: Movement of patients to another healthcare facility (External) when there is no imminent threat to life/safety. Movement of patients is similar to inter-facility transfers. Use hospital's contracted resources.

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

Full Evacuation: All patients are transferred from the facility to another healthcare facility. (External)

Partial Evacuation: Some patients are evacuated to another healthcare facility. (External)

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

Rescue/Immediate Evacuation: Dangerous life/safety conditions at the facility that need immediate movement out of the hospital. Treated as a Multi-Casualty Incident (External) (Ref. No. 519)

Internal Relocation: Patients are transferred within the hospital (Internal). This can be done as a **horizontal relocation**, movement on the same floor or as a **vertical relocation**, movement to a safe area on another floor.

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

PRINCIPLES:

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

    a. Procedures for
        i. Internal relocation
        ii. Delayed evacuation
        iii. Partial or Full evacuation
        iv. Rescue/Immediate Evacuation
    b. Identifies evacuation triggers and who has authorization to activate
    c. Follows established accreditation, regulatory and corporate standards
    d. Identifies training standards, role, responsibilities and expectations of staff.

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

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

4. Unified Command will be established for all evacuations which should include a hospital administrator, the local fire department liaison and the Fire Operational Area Coordinator (FOAC) representative, if utilized.

POLICY:

I. Responsibilities of a Hospital Requiring Evacuation

    a. Internal Relocation (within same facility)

        i. Notify Medical Alert Center (MAC) via ReddiNet or call (562) 378-1789 to request diversion due to Internal Disaster.

        ii. If relocating patients to non-patient care areas, i.e., surge tents, lobby, conference rooms, etc., notify the appropriate regulatory agency per hospital plans

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

    b. Full Evacuation or Partial Evacuation (to another facility)

        i. Notify Medical Alert Center (MAC) (562) 378-1789 or via ReddiNet to request diversion due to Internal Disaster.
        ii. Notify California Department of Public Health (CDPH) licensing and certification (L&C) at (800) 228-1019, M-F 8 am-5 pm, select # 2 for Hospital. After hours, weekends and holidays contact (626) 927-9293 as

soon as reasonably possible.

iii. Coordinate evacuation by contacting other hospitals that facility has transfer agreements or within corporate system utilizing transfer centers, if applicable

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

v. If additional resources are needed for the evacuation, request assistance from the Los Angeles County Department of Health Services Emergency Medical Services (EMS) Agency by notifying the MAC via ReddiNet or call (562) 378-1789. Immediately discontinue 3 and 4 above to avoid duplication of efforts and resources.

vi. Request a coordination call to take place once the FOAC arrives at the hospital**.**

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

viii. Respond to service level poll (ReddiNet) within ten (10) minutes and should be reported as “Black”.

ix. Respond to HAvBED poll (ReddiNet) within ten (10) minutes and report all beds as “zeros.”

x. Utilize ReddiNet HAvBED Assessment Poll bed availability to determine receiving facility assignments and acceptance. Every effort should be made to distribute patient destinations to hospitals throughout the county to avoid any single hospital from being overburdened.

xi. Maintain a log of transferred patients that includes:

1. Name of patient
2. Type of hospital service needed (i.e. medical/surgical, ICU, etc.)
3. Mode of transportation (Ambulance, Bus, Helicopter, etc)
4. Level of service- BLS, ALS, CCT
5. Name of company
6. Vehicle identifier
7. Receiving facility

xii. Maintain an equipment log of items sent with patient

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

II. Responsibilities of the EMS Agency

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

b. Place evacuating healthcare facility on diversion for Internal Disaster.

c. Conduct service level polls (ReddiNet) for all hospitals to determine their ability to take transfers or their need to evacuate their facility.

d. Conduct HAvBED poll (ReddiNet) for all hospitals.

e. Notify Public Health of pending hospital evacuation(s).

f. Notify jurisdictional fire department and law enforcement agency about hospital evacuation within their jurisdiction.

g. Coordinate transportation resources.

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

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

   iii. If the above is inadequate, request transportation resources from California Region I Disaster Medical and Health Specialist (Region/State)

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

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

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

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

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

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

c. Reported HAvBED availability shall serve as transfer acceptance to the evacuating facility. Every effort will be made to distribute patient destinations to hospitals throughout the county to avoid any single receiving hospital from being overburdened.

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

e. Maintain a log of patients who are received from evacuating hospital that includes information as identified on Reference No. 1112.3 – Received Patient Evacuation Tracking.

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

IV. Responsibilities of Public Health

a. Ensure that the evacuating facility notifies California Department of Healthcare Access and Information (HCAI) is notified.
b. Notify the State Long Term Care Ombudsman program is notified if the hospital is licensed for a Distinct Part Skilled Nursing Unit.
c. Monitor the evacuation of patients to other health care facilities to ensure their medical record information/medications/necessary life sustaining equipment are with them upon transfer.
d. Ensure that there are no patients remaining in the evacuated hospital.
e. Notify/update the California Department of Public Health (CDPH) headquarters of the event, the number of patients affected and the extent of the damage to the hospital building.
f. Ensure the hospital has obtained the requisite signoffs for re-occupancy from the California Department of Healthcare Access and Information (HCAI)/local fire clearance and that the hospital can reopen and accept patients.

V. Responsibilities of FOAC

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

Cross Reference:
Prehospital Care Manual:
Reference No. 519- **Management of Multiple Casualty Incidents**

POLICY REVIEW - SUMMARY OF COMMENTS

REFERENCE NO. 202.2
(ATTACHMENT B)

REFERENCE NO. 1112, Hospital Evacuation

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Title	*Provider Agency Advisory Committee (6/18/2025)*	*Change title to "Hospital Relocation /Evacuation"*	*Change Made*
Purpose	*Hospital Workgroup*	*Delete EMS Agency and replace with MHOAC*	*Change Made*
Purpose	*Hospital Workgroup*	*Delete "requesting and mobilizing" and replace with "coordination of"*	*Change Made*
Authority	*Hospital Workgroup*	*Delete JCAHO reference*	*Change Made*
Authority	*Hospital Workgroup*	*Add DHHS, CMS, EP Title 42 CFR 482.15…*	*Change Made*
Definitions	*Hospital Workgroup*	*Add "Delayed Evacuation" and definition*	*Change Made*
Definitions	*Hospital Workgroup*	*Add "Evacuation" and definition*	*Change Made*
Definitions	*Hospital Workgroup*	*Modify definition of "Full Evacuation"*	*Change Made*
Definitions	*Hospital Workgroup*	*Change definition of "Partial Evacuation"*	*Change Made*
Definitions	*Hospital Workgroup*	*Add "Planned Evacuation" and definition*	*Change Made*
Definitions	*Hospital Workgroup*	*Add "Rescue/Immediate Evacuation" and definition*	*Change Made*

POLICY REVIEW - SUMMARY OF COMMENTS

REFERENCE NO. 202.2
(ATTACHMENT B)

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definitions	*Hospital Workgroup*	*Add "Internal Relocation" and definition"*	*Change Made*
Definitions	*DRC Coordinators (6/18/2025)*	*Add "External Relocation" and definition to identify normal day to day process.*	***Added the word External after definitions that required evacuation. Delayed Evacuation would be normal procedure***
Definitions	*Provider Agency Advisory Committee (6/18/2025)*	*Add Fire Operational Area Coordination to definitions*	***Not added. FOAC was added to principles***
Principles 1	*Hospital Workgroup*	*Add and Number as #1 "Hospital has an Approved EOP… with a,b,c and d bullet points"*	*Change Made*
Principles 1	*DRC Coordinators (6/18/2025)*	*Add "Internal relocation" to bullet points*	*Change Made*
Principle 2	*DRC Coordinators (6/18/2025)*	*Renumbered from 1 to 2. Add "or relocation" after the word evacuation*	*Change Made*
Principle 2	*DRC Coordinators (6/18/2025)*	*Delete "from a natural" and "such as an earthquake"*	*Change Made*
Principle 3	*Hospital Workgroup*	*Renumbered from #2*	*Change Made*
Principles 4	*DRC Coordinators (6/18/2025)*	*Add statement that Unified Command should be established and have representatives from Hospital Administration, Local fire Department and FOAC if utilized.*	*Change Made*
Policy I	*Hospital Workgroup*	*Delete Section I details but maintain title and reformat to address multiple situations i.e. relocation or evacuations*	*Changes Made*

POLICY REVIEW - SUMMARY OF COMMENTS

REFERENCE NO. 202.2
(ATTACHMENT B)

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy I.a.	*DRC Coordinators (6/18/2025)*	*Change "Partial evacuation" to "internal relocation (within same facility)"*	*Change Made*
Policy I.a.ii.	*DRC Coordinators (6/18/2025)*	*Revise wording: If relocating patients to a non-patient care space (such as surge tents, lobby, conference rooms, etc.), notify the appropriate regulatory agency per hospital plans (e.g., California Department of Public Health [CDPH]). If contacting CDPH, call their licensing and certification (L&C) unit at 1 (800) 228-1019 and select #2 for hospital (Mon-Fri 8 am – 5pm). For non-business hours, contact 626-927-9293.*	*Change Made*
Policy I.b.	*DRC Coordinators (6/18/2025)*	*Add parenthesis around "to another facility"*	*Change Made*
Policy I.b.vi	*Requested by evacuation drill participants (EMS Admin/UCLA)*	Request a coordination call to take place once the FOAC arrives at the hospital**.**	*Change added*
Policy I.b.vii and viii	*DRC Coordinators (6/18/2025)*	*Add "ReddiNet" after all appropriate polls i.e. HAvBED or service level poll*	*Changes Made*
Policy I.b.x.	*Requested by evacuation drill participants (EMS Admin/UCLA)*	Utilize ReddiNet HAvBED Assessment Poll bed availability to determine receiving facility assignments and acceptance. Every effort should be made to distribute patient destinations to hospitals throughout the county to avoid any single hospital from being overburdened.	*Change added*
Policy	*Hospital workgroup*	*Get input from FOAC and CDPH/LACDPH*	*Had FOAC and CDPH review and add comments as necessary*
Policy II	*Hospital Workgroup*	*Reformat EMS numbering. Delete "Specific"*	*Changes Made*
Policy II.a	*Hospital Workgroup*	**Delete:**" Coordinate the overall Medical and Health resources in the County. **Add:** "Function as the lead	*Changes Made*

POLICY REVIEW - SUMMARY OF COMMENTS

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
		coordinator if MHOAC support is requested	
Policy II.b	*Hospital Workgroup*	**Add:** "Place evacuating healthcare facility on diversion for Internal Disaster."	*Changes Made*
Policy II.c.	*Hospital Workgroup*	**Add:** "Conduct service level…for"	*Changes Made*
Policy II.d.	*Hospital Workgroup*	**Add:** Conduct HAvBED poll (ReddiNet) for all hospitals	*Changes Made*
Policy II.e.	*Hospital Workgroup*	**Delete:** phone number	*Changes Made*
Policy II.f.	*Hospital Workgroup*	**Add:** "… about hospital evacuation within their jurisdiction." **Delete:** "to coordinate and ensure evacuation routes to minimize any risks associated with the evacuation".	*Changes Made*
Policy II.g.	*Hospital Workgroup*	**Add:** "Coordinate" **Delete:** "provide"	*Changes Made*
Policy II.g.i	*Hospital Workgroup*	**Delete:** Deploy local ambulance resources, if additional resources needed activate local Ambulance Strike Teams (AST) or **Add:** Request activation of Fire Operational Area Coordinator (FOAC).	*Changes Made*
Policy II.g.iii	*Hospital Workgroup*	**Add: "**California … Disaster Medical and Health Specialist (Region/State)"	*Changes Made*
Policy II.h.	*Hospital Workgroup*	**Delete: "…**individual … being evacuated … the following information … **Delete:** "Patient destination information including number of patients by type to each facility"	*Changes Made*

POLICY REVIEW - SUMMARY OF COMMENTS

REFERENCE NO. 202.2
(ATTACHMENT B)

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy II.i.	*Hospital Workgroup*	**Add: "**Provide FOAC with names of receiving hospitals and bed availability"	*Changes Made*
Policy II.j.	*Hospital Workgroup*	**Add: "**Provide the receiving hospital the potential number of patients assigned to their facility."	*Changes Made*
Policy III	*Internal*	*Added Receiving Facility responsibilities*	
Policy III.c.	*Requested by evacuation drill participants (EMS Admin/UCLA)*	Reported HAvBED availability shall serve as transfer acceptance to the evacuating facility. Every effort will be made to distribute patient destinations to hospitals throughout the county to avoid any single receiving hospital from being overburdened	*Change Added*
Policy IV	*CDPH*	*Provided language for inclusion of policy*	*Change Made*
Policy V	*FOAC*	*Provided language for inclusion of policy*	*Change Made*
	DCAC (10/2/2025)	*Approved as presented*	

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

Time Period July 1, 2025 through September 30, 2025

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

HOSPITAL	Q3 2025										Q3 2024
	Total # of records*	≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	90th percentile (hh:mm:ss)
ANTELOPE VALLEY - NEWHALL REGION											
Antelope Valley Medical Center	5,827	4,634	80%	1,042	18%	142	2%	9	0.2%	00:39:37	00:45:36
Henry Mayo Newhall Memorial Hospital	3,898	3,582	92%	250	6%	58	1%	8	0.2%	00:27:04	00:31:37
Palmdale Regional Medical Center	3,165	2,662	84%	440	14%	59	2%	4	0.1%	00:36:26	00:39:00
ANTELOPE VALLEY TOTAL	*12,890*	*10,878*	84%	*1,732*	13%	*259*	2%	*21*	0.2%	*00:36:06*	*00:38:58*
SAN FERNANDO VALLEY REGION											
Adventist Health Glendale	1,976	1,856	94%	115	6%	5	0.3%			00:26:00	00:42:02
Dignity Health - Glendale Memorial Hospital & Health Center	1,457	1,336	92%	105	7%	16	1%			00:28:00	00:32:41
Dignity Health - Northridge Hospital Medical Center	4,081	3,747	92%	302	7%	26	0.6%	6	0.1%	00:27:50	00:31:24
Encino Hospital Medical Center	296	290	98%	4	1%	2	0.7%			00:14:39	00:18:49
Kaiser Foundation Hospital - Panorama City	942	851	90%	82	9%	9	1%			00:29:54	00:32:12
Kaiser Foundation Hospital - Woodland Hills	709	624	88%	63	9%	20	3%	2	0.3%	00:32:48	00:34:22
Mission Community Hospital	926	879	95%	46	5%	1	0.1%			00:25:07	00:26:40
Olive View-UCLA Medical Center	1,035	976	94%	49	5%	8	0.8%	2	0.2%	00:24:59	00:33:31
Pacifica Hospital of the Valley	772	755	98%	14	2%	3	0.4%			00:16:06	00:18:44
Providence Cedars-Sinai Tarzana Medical Center	1,152	1,063	92%	79	7%	8	0.7%	2	0.2%	00:28:34	00:32:13
Providence Holy Cross Medical Center	1,886	1,797	95%	71	4%	17	1%	1	0.1%	00:20:02	00:22:59
Providence Saint Joseph Medical Center	4,111	3,580	87%	497	12%	32	0.8%	2	0.0%	00:32:39	00:41:00
Sherman Oaks Hospital	1,240	1,178	95%	50	4%	12	1%			00:22:22	00:28:51
UCLA West Valley Medical Center	1,814	1,568	86%	223	12%	17	1%	6	0.3%	00:32:46	00:39:27
USC Verdugo Hills Hospital	615	537	87%	56	9%	20	3%	2	0.3%	00:35:57	00:57:53
Valley Presbyterian Hospital	1,559	1,447	93%	93	6%	17	1%	2	0.1%	00:26:25	00:25:13
SAN FERNANDO VALLEY TOTAL	*24,571*	*22,484*	92%	*1,849*	8%	*213*	0.9%	*25*	0.1%	*00:28:28*	*00:34:15*
SAN GABRIEL VALLEY REGION											
Alhambra Hospital Medical Center	654	635	97%	17	3%	2	0.3%			00:17:00	00:22:00
Emanate Health Foothill Presbyterian Hospital	1,594	1,020	64%	457	29%	115	7%	2	0.1%	00:54:31	00:54:02
Emanate Health Inter-Community Hospital	1,478	1,030	70%	352	24%	91	6%	5	0.3%	00:51:14	00:41:33
Emanate Health Queen of the Valley Hospital	2,745	1,939	71%	638	23%	140	5%	28	1%	00:49:44	00:44:50
Garfield Medical Center	1,053	1,016	96%	27	3%	9	0.9%	1	0.1%	00:17:00	00:16:25
Greater El Monte Community Hospital	1,196	849	71%	269	22%	70	6%	8	0.7%	00:49:29	00:48:22
Huntington Hospital	3,824	3,555	93%	232	6%	35	1%	2	0.1%	00:26:00	00:33:50
Kaiser Foundation Hospital - Baldwin Park	1,331	869	65%	335	25%	108	8%	19	1%	00:58:49	01:19:58
Monterey Park Hospital	366	354	97%	8	2%	4	1%			00:18:24	00:21:40
Pomona Valley Hospital Medical Center	4,677	3,447	74%	929	20%	254	5%	47	1%	00:50:11	00:48:40
San Dimas Community Hospital	742	624	84%	87	12%	26	4%	5	0.7%	00:39:19	00:43:55
San Gabriel Valley Medical Center	605	544	90%	47	8%	12	2%	2	0.3%	00:30:03	00:34:38
USC Arcadia Hospital	3,337	2,545	76%	604	18%	170	5%	18	0.5%	00:47:13	00:44:02
SAN GABRIEL VALLEY TOTAL	*23,602*	*18,427*	78%	*4,002*	17%	*1,036*	4%	*137*	0.6%	*00:45:06*	*00:45:00*

* *Meets California APOT reporting criteria*

% total may not equal 100% due to rounding.

Data source: ESO Suite (10/06/2025)

Los Angeles County Emergency Medical Services Agency

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

Time Period July 1, 2025 through September 30, 2025

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

HOSPITAL	Q3 2025										Q3 2024
	Total # of records*	≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	90th percentile (hh:mm:ss)
EAST REGION											
Adventist Health White Memorial Montebello	1,452	923	64%	325	22%	158	11%	46	3%	01:13:11	01:17:14
Coast Plaza Hospital	746	634	85%	86	12%	23	3%	3	0.4%	00:36:51	01:07:01
Kaiser Foundation Hospital - Downey	1,914	1,116	58%	523	27%	242	13%	33	2%	01:10:18	01:29:00
Norwalk Community Hospital	407	333	82%	57	14%	14	3%	3	0.7%	00:43:00	00:46:05
PIH Health Downey Hospital	1,851	1,317	71%	346	19%	147	8%	41	2%	01:02:00	00:59:01
PIH Health Whittier Hospital	3,182	2,065	65%	891	28%	198	6%	28	0.9%	00:52:10	00:56:02
UCI Health - Lakewood	1,685	1,148	68%	334	20%	156	9%	47	3%	01:06:55	01:52:14
Whittier Hospital Medical Center	973	885	91%	68	7%	19	2%	1	0.1%	00:28:18	00:26:17
EAST REGION TOTAL	*12,210*	*8,421*	69%	*2,630*	22%	*957*	8%	*202*	2%	*00:58:16*	*01:06:05*
METRO REGION											
Adventist Health White Memorial	724	473	65%	150	21%	78	11%	23	3%	01:14:23	01:17:13
Cedars-Sinai Medical Center	3,810	2,650	70%	930	24%	212	6%	18	0.5%	00:50:12	00:53:09
Children's Hospital Los Angeles	257	250	97%	5	2%	2	0.8%			00:19:26	00:14:55
Community Hospital of Huntington Park	1,708	1,130	66%	389	23%	155	9%	34	2%	01:03:38	01:09:56
Dignity Health - California Hospital Medical Center	2,099	1,606	77%	380	18%	100	5%	13	0.6%	00:46:43	00:54:43
East Los Angeles Doctors Hospital	1,224	1,030	84%	141	12%	46	4%	7	0.6%	00:37:09	00:39:06
Hollywood Presbyterian Medical Center	1,896	1,490	79%	333	18%	68	4%	5	0.3%	00:43:31	00:45:05
Kaiser Foundation Hospital - Los Angeles	1,681	1,379	82%	241	14%	58	3%	3	0.2%	00:40:23	00:33:52
Los Angeles General Medical Center	6,345	5,725	90%	529	8%	78	1%	13	0.2%	00:29:55	00:31:51
PIH Health Good Samaritan Hospital	2,600	2,056	79%	437	17%	101	4%	6	0.2%	00:41:58	00:38:50
METRO REGION TOTAL	*22,344*	*17,789*	80%	*3,535*	16%	*898*	4%	*122*	0.5%	*00:43:09*	*00:45:01*
WEST REGION											
Cedars-Sinai Marina Del Rey Hospital	1,734	1,235	71%	381	22%	108	6%	10	0.6%	00:51:00	00:44:25
Kaiser Foundation Hospital - West LA	1,720	1,271	74%	347	20%	93	5%	9	0.5%	00:50:14	00:55:16
Providence Saint John's Health Center	2,346	1,490	64%	594	25%	224	10%	38	2%	01:04:00	00:49:36
Ronald Reagan UCLA Medical Center	1,696	1,487	88%	174	10%	30	2%	5	0.3%	00:33:00	00:35:34
Santa Monica-UCLA Medical Center & Orthopaedic Hospital	1,419	846	60%	455	32%	102	7%	16	1%	00:55:40	00:42:17
Southern California Hospital at Culver City	569	424	75%	109	19%	32	6%	4	0.7%	00:49:15	00:56:35
WEST REGION TOTAL	*9,484*	*6,753*	71%	*2,060*	22%	*589*	6%	*82*	0.9%	*00:51:52*	*00:48:00*
SOUTH REGION											
Catalina Island Medical Center	51	51	100%							00:05:06	00:11:26
Centinela Hospital Medical Center	6,923	5,094	74%	1,689	24%	137	2%	3	0.0%	00:41:08	00:40:56
College Medical Center	546	459	84%	32	6%	36	7%	19	3%	01:02:00	00:42:00
Dignity Health - St. Mary Medical Center	3,157	2,778	88%	347	11%	29	1%	3	0.1%	00:32:00	00:49:00
Harbor-UCLA Medical Center	2,923	2,041	70%	584	20%	215	7%	83	3%	01:00:39	00:52:44
Kaiser Foundation Hospital - South Bay	1,386	1,034	75%	269	19%	78	6%	5	0.4%	00:45:37	00:38:40
Martin Luther King, Jr. Community Hospital	3,582	3,132	87%	387	11%	52	1%	11	0.3%	00:32:53	00:22:45

% total may not equal 100% due to rounding.

* *Meets California APOT reporting criteria*

Data source: ESO Suite (10/06/2025)

Los Angeles County Emergency Medical Services Agency

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

Time Period July 1, 2025 through September 30, 2025

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

HOSPITAL	Q3 2025										Q3 2024
	Total # of records*	≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	90th percentile (hh:mm:ss)
Memorial Hospital Of Gardena	3,227	2,636	82%	514	16%	67	2%	10	0.3%	00:37:06	00:26:14
MemorialCare Long Beach Medical Center	3,120	2,600	83%	300	10%	130	4%	90	3%	00:46:14	00:49:00
Providence Little Company of Mary Medical Center San Pedro	852	733	86%	104	12%	12	1%	3	0.4%	00:34:00	00:37:39
Providence Little Company of Mary Medical Center Torrance	2,302	1,623	71%	552	24%	120	5%	7	0.3%	00:47:51	00:56:41
St. Francis Medical Center	4,133	1,928	47%	1,379	33%	718	17%	108	3%	01:18:07	01:05:49
Torrance Memorial Medical Center	1,793	1,136	63%	563	31%	82	5%	12	0.7%	00:50:29	00:49:59
SOUTH REGION TOTAL	*33,995*	*25,245*	74%	*6,720*	20%	*1,676*	5%	*354*	1%	*00:47:42*	*00:45:25*
ALL HOSPITALS	**139,096**	**109,997**	**79%**	**22,528**	**16%**	**5,628**	**4%**	**943**	**1%**	**00:43:25**	**00:44:47**

Los Angeles County Emergency Medical Services Agency

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

Time Period September 1, 2025 through September 30, 2025

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

HOSPITAL	Sep-25										CEMSIS
	Total # of records*	≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	90th percentile (hh:mm:ss)
ANTELOPE VALLEY - NEWHALL REGION											
Antelope Valley Medical Center	1,843	1,456	79%	333	18%	51	3%	3	0.2%	00:39:37	0:39:55
Henry Mayo Newhall Memorial Hospital	1,235	1,144	93%	76	6%	13	1%	2	0.2%	00:26:04	
Palmdale Regional Medical Center	1,017	851	84%	145	14%	18	2%	3	0.3%	00:36:56	0:37:35
ANTELOPE VALLEY TOTAL	*4,095*	*3,451*	84%	*554*	14%	*82*	2%	*8*	0.2%	*00:36:32*	
SAN FERNANDO VALLEY REGION											
Adventist Health Glendale	645	605	94%	38	6%	2	0.3%			00:26:00	
Dignity Health - Glendale Memorial Hospital & Health Center	496	454	92%	39	8%	3	0.6%			00:29:00	
Dignity Health - Northridge Hospital Medical Center	1,317	1,201	91%	102	8%	10	0.8%	4	0.3%	00:28:16	
Encino Hospital Medical Center	102	100	98%	2	2%					00:14:35	
Kaiser Foundation Hospital - Panorama City	301	275	91%	24	8%	2	0.7%			00:29:28	
Kaiser Foundation Hospital - Woodland Hills	208	185	89%	16	8%	7	3%			00:32:36	0:32:41
Mission Community Hospital	299	276	92%	22	7%	1	0.3%			00:26:56	
Olive View-UCLA Medical Center	339	306	90%	27	8%	6	2%			00:29:55	
Pacifica Hospital of the Valley	250	242	97%	6	2%	2	0.8%			00:17:49	
Providence Cedars-Sinai Tarzana Medical Center	401	367	92%	32	8%	2	0.5%			00:29:17	
Providence Holy Cross Medical Center	579	558	96%	16	3%	5	0.9%			00:20:02	
Providence Saint Joseph Medical Center	1,353	1,168	86%	171	13%	13	1%	1	0.1%	00:33:22	0:33:48
Sherman Oaks Hospital	411	383	93%	23	6%	5	1%			00:24:25	
UCLA West Valley Medical Center	582	505	87%	73	13%	3	0.5%	1	0.2%	00:32:05	0:31:18
USC Verdugo Hills Hospital	192	174	91%	14	7%	4	2%			00:29:54	
Valley Presbyterian Hospital	515	468	91%	38	7%	9	2%			00:28:01	
SAN FERNANDO VALLEY TOTAL	*7,990*	*7,267*	91%	*643*	8%	*74*	1%	*6*	0.1%	*00:29:04*	
SAN GABRIEL VALLEY REGION											
Alhambra Hospital Medical Center	196	191	97%	5	3%					00:17:00	
Emanate Health Foothill Presbyterian Hospital	315	222	70%	74	23%	19	6%			00:52:31	0:52:31
Emanate Health Inter-Community Hospital	355	259	73%	73	21%	21	6%	2	0.6%	00:50:27	0:51:01
Emanate Health Queen of the Valley Hospital	675	479	71%	156	23%	35	5%	5	0.7%	00:49:18	0:50:00
Garfield Medical Center	302	292	97%	8	3%	2	0.7%			00:16:04	
Greater El Monte Community Hospital	239	169	71%	51	21%	17	7%	2	0.8%	00:53:00	0:51:55
Huntington Hospital	1,202	1,122	93%	70	6%	10	0.8%			00:25:00	
Kaiser Foundation Hospital - Baldwin Park	285	217	76%	51	18%	16	6%	1	0.4%	00:49:12	0:46:39
Monterey Park Hospital	100	99	99%	1	1%					00:15:00	
Pomona Valley Hospital Medical Center	1,043	843	81%	161	15%	32	3%	7	0.7%	00:39:03	0:39:11
San Dimas Community Hospital	155	134	86%	13	8%	6	4%	2	1%	00:36:44	0:37:21
San Gabriel Valley Medical Center	186	169	91%	13	7%	3	2%	1	0.5%	00:29:00	
USC Arcadia Hospital	904	672	74%	177	20%	48	5%	7	0.8%	00:50:00	0:49:59

* *Meets California APOT reporting criteria*

% total may not equal 100% due to rounding.

Data source: ESO Suite (10/21/2025)

Los Angeles County Emergency Medical Services Agency

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

Time Period September 1, 2025 through September 30, 2025

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

HOSPITAL	Sep-25										CEMSIS
	Total # of records*	≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	90th percentile (hh:mm:ss)
SAN GABRIEL VALLEY TOTAL	*5,957*	*4,868*	82%	*853*	14%	*209*	4%	*27*	0.5%	*00:42:00*	
EAST REGION											
Adventist Health White Memorial Montebello	347	226	65%	78	22%	35	10%	8	2%	01:08:03	**1:09:10**
Coast Plaza Hospital	185	166	90%	14	8%	4	2%	1	0.5%	00:32:49	
Kaiser Foundation Hospital - Downey	517	300	58%	137	26%	65	13%	15	3%	01:14:00	**1:11:53**
Norwalk Community Hospital	83	72	87%	9	11%	2	2%			00:35:18	**0:35:37**
PIH Health Downey Hospital	523	362	69%	105	20%	43	8%	13	2%	01:03:16	**1:00:48**
PIH Health Whittier Hospital	670	464	69%	148	22%	49	7%	9	1%	00:55:31	**0:55:31**
UCI Health - Lakewood	458	316	69%	90	20%	37	8%	15	3%	01:06:52	**1:05:54**
Whittier Hospital Medical Center	227	217	96%	9	4%	1	0.4%			00:25:48	
EAST REGION TOTAL	*3,010*	*2,123*	71%	*590*	20%	*236*	8%	*61*	2%	*00:59:54*	
METRO REGION											
Adventist Health White Memorial	213	140	66%	39	18%	28	13%	6	3%	01:22:00	**1:20:12**
Cedars-Sinai Medical Center	1,129	776	69%	277	25%	70	6%	6	0.5%	00:49:39	**0:49:29**
Children's Hospital Los Angeles	88	85	97%	2	2%	1	1%			00:24:02	
Community Hospital of Huntington Park	373	235	63%	67	18%	53	14%	18	5%	01:26:20	**1:25:53**
Dignity Health - California Hospital Medical Center	666	499	75%	123	18%	41	6%	3	0.5%	00:51:05	**0:49:47**
East Los Angeles Doctors Hospital	251	214	85%	22	9%	11	4%	4	2%	00:39:25	**0:42:10**
Hollywood Presbyterian Medical Center	573	451	79%	102	18%	20	3%			00:43:23	**0:43:31**
Kaiser Foundation Hospital - Los Angeles	562	456	81%	83	15%	21	4%	2	0.4%	00:41:43	**0:41:19**
Los Angeles General Medical Center	1,969	1,772	90%	170	9%	22	1%	5	0.3%	00:30:08	
PIH Health Good Samaritan Hospital	854	672	79%	155	18%	26	3%	1	0.1%	00:40:22	**0:40:45**
METRO REGION TOTAL	*6,678*	*5,300*	79%	*1,040*	16%	*293*	4%	*45*	0.7%	*00:44:24*	
WEST REGION											
Cedars-Sinai Marina Del Rey Hospital	546	360	66%	138	25%	42	8%	6	1%	00:57:00	**0:56:47**
Kaiser Foundation Hospital - West LA	534	380	71%	119	22%	31	6%	4	0.7%	00:52:59	**0:51:08**
Providence Saint John's Health Center	751	460	61%	190	25%	82	11%	19	3%	01:13:44	**1:13:12**
Ronald Reagan UCLA Medical Center	515	446	87%	54	10%	12	2%	3	0.6%	00:34:06	**0:33:57**
Santa Monica-UCLA Medical Center & Orthopaedic Hospital	451	265	59%	135	30%	44	10%	7	2%	01:03:51	**1:06:00**
Southern California Hospital at Culver City	180	127	71%	41	23%	12	7%			00:50:14	**0:49:58**
WEST REGION TOTAL	*2,977*	*2,038*	68%	*677*	23%	*223*	7%	*39*	1%	*00:57:07*	
SOUTH REGION											
Catalina Island Medical Center	13	13	100%							00:05:06	
Centinela Hospital Medical Center	2,203	1,639	74%	525	24%	37	2%	2	0.1%	00:40:28	**0:40:43**
College Medical Center	196	152	78%	17	9%	18	9%	9	5%	01:20:00	**1:22:24**

** Meets California APOT reporting criteria*

% total may not equal 100% due to rounding.

Data source: ESO Suite (10/21/2025)

Los Angeles County Emergency Medical Services Agency

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

Time Period September 1, 2025 through September 30, 2025

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

HOSPITAL	Sep-25										CEMSIS
	Total # of records*	≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	90th percentile (hh:mm:ss)
Dignity Health - St. Mary Medical Center	1,019	846	83%	157	15%	14	1%	2	0.2%	00:36:00	**0:35:00**
Harbor-UCLA Medical Center	973	681	70%	190	20%	77	8%	25	3%	01:01:40	**1:01:40**
Kaiser Foundation Hospital - South Bay	487	331	68%	114	23%	40	8%	2	0.4%	00:52:07	**0:52:09**
Martin Luther King, Jr. Community Hospital	1,074	960	89%	103	10%	10	1%	1	0.1%	00:30:57	**0:30:07**
Memorial Hospital Of Gardena	1,011	810	80%	164	16%	31	3%	6	0.6%	00:38:07	**0:38:58**
MemorialCare Long Beach Medical Center	967	790	82%	100	10%	47	5%	30	3%	00:48:40	**0:49:00**
Providence Little Company of Mary Medical Center San Pedro	270	217	80%	48	18%	5	2%			00:42:02	**0:41:46**
Providence Little Company of Mary Medical Center Torrance	942	667	71%	220	23%	54	6%	1	0.1%	00:48:07	**0:48:35**
St. Francis Medical Center	1,197	550	46%	393	33%	201	17%	53	4%	01:21:24	**1:21:24**
Torrance Memorial Medical Center	797	518	65%	224	28%	50	6%	5	0.6%	00:53:01	**0:49:45**
SOUTH REGION TOTAL	*11,149*	*8,174*	73%	*2,255*	20%	*584*	5%	*136*	1%	*00:48:28*	
ALL HOSPITALS	**41,856**	**33,221**	**79%**	**6,612**	**16%**	**1,701**	**4%**	**322**	**1%**	**00:43:24**	

** Meets California APOT reporting criteria*

% total may not equal 100% due to rounding.

Data source: ESO Suite (10/21/2025)

Los Angeles County Emergency Medical Services Agency

AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY PROVIDER

Time Period July 1, 2025 through September 30, 2025

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

EMS Provider Agency	Code	Q3 2025									Q3 2024
		Total # of records*	≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	90th percentile (hh:mm:ss)
Alhambra Fire Department	AH	952	926	97%	25	3%	1	0.1%			00:17:00	00:18:00
Arcadia Fire Department	AF	793	693	87%	90	11%	10	1%			00:33:00	00:31:00
Avalon Fire Department	AV	51	51	100%							00:05:06	00:02:00
Beverly Hills City Fire Department	BH	730	580	79%	131	18%	19	3%			00:42:00	00:51:00
Burbank Fire Department	BF	1,605	1,473	92%	130	8%	2	0.1%			00:29:00	00:35:00
Compton Fire Department	CM	378	376	99%	2	0.5%					00:15:00	00:10:00
Culver City Fire Department	CC	1,010	793	79%	179	18%	34	3%	4	0.4%	00:42:00	00:58:00
Downey Fire Department	DF	1,498	1,185	79%	209	14%	88	6%	16	1%	00:51:00	00:59:00
El Segundo Fire Department	ES	317	287	91%	26	8%	4	1%			00:30:00	00:29:00
Glendale Fire Department	GL	2,811	2,585	92%	197	7%	29	1%			00:28:00	00:40:00
La Habra Heights Fire Department	LH	7	4	57%	3	43%					01:00:00	00:25:00
La Verne Fire Department	LV	598	524	88%	60	10%	10	2%	4	0.7%	00:35:00	00:36:00
LACoFD	CF	59	58	98%			1	2%			00:10:45	00:17:07
LAFD	CI	50,225	43,783	87%	5,333	11%	1,006	2%	103	0.2%	00:33:37	00:37:41
Long Beach Fire Department	LB	6,870	5,889	86%	672	10%	205	3%	104	2%	00:37:00	00:51:00
Los Angeles County Sheriff's Department	CS	45	40	89%	2	4%	3	7%			00:31:00	00:06:00
Manhattan Beach Fire Department	MB	376	347	92%	26	7%	3	0.8%			00:28:00	00:19:00
Monrovia Fire Department	MF	316	307	97%	8	3%	1	0.3%			00:20:00	00:17:00
Montebello Fire Department	MO	546	541	99%	4	0.7%			1	0.2%	00:15:00	00:16:00
Monterey Park Fire Department	MP	760	752	99%	8	1%					00:12:00	00:11:00
Pasadena Fire Department	PF	2,442	2,298	94%	130	5%	13	0.5%	1	0.0%	00:25:00	00:33:00
Redondo Beach Fire Department	RB	2	2	100%							00:00:00	00:00:00
San Gabriel Fire Department	SG	334	329	98%	4	1%	1	0.3%			00:15:00	00:15:00
San Marino Fire Department	SA	172	156	91%	13	7%	2	1%	1	0.6%	00:27:00	00:34:00
Santa Fe Springs Fire Rescue	SS	129	128	99%	1	0.8%					00:08:00	00:13:00
Santa Monica Fire Department	SM	349	338	97%	6	2%	5	1%			00:19:00	00:19:00
Sierra Madre City Fire Department	SI	150	129	86%	18	12%	3	2%			00:35:00	00:29:00
South Pasadena Fire Department	SP	260	244	94%	14	5%	2	0.8%			00:23:00	00:32:00
Torrance Fire Department	TF	713	550	77%	127	18%	33	5%	3	0.4%	00:46:10	00:47:32
West Covina Fire Department	WC	1,138	992	87%	129	11%	16	1%	1	0.1%	00:33:00	00:30:00
American Medical Response	AR	15,258	11,982	79%	2,624	17%	575	4%	77	0.5%	00:42:46	00:47:44
Falck Mobile Health Corp. (Care Ambulance)	CA	29,561	20,504	69%	6,562	22%	2,127	7%	368	1%	00:55:23	01:09:17
Westmed Ambulance Inc. (McCormick Ambulance)	WM	18,641	11,151	60%	5,795	31%	1,435	8%	260	1%	00:57:41	00:51:36
TOTAL ALL PROVIDERS		***139,096***	***109,997***	***79%***	***22,528***	***16%***	***5,628***	***4%***	***943***	***0.7%***	***00:43:25***	***00:48:55***

** Meets California APOT reporting criteria*

% total may not equal 100% due to rounding.

Data source: ESO Suite (10/06/2025)

[ON OFFICIAL EMS Commission 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 Chief Physician [Last Name]:

On behalf of the Los Angeles County EMS Commission and the Commission's Cardiac Arrest Task Force, we thank you for your continued service to our communities as frontline providers of life-saving emergency medical care.

We write to you 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 Cardiac Arrest Registry for Enhance Survival (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. The goals that we are striving to reach for all communities in LA County by the end of calendar year 2030 are:

1. Increasing bystander CPR rates to >50%;

2. Increasing pre-EMS AED application by bystanders in public settings to >20%;

3. Improving neurologically intact survival among adults after OHCA in the home to >8% and to >19% for those occurring in public settings, with additional specific outcome targets for pediatric patients; and,

4. Ensuring outcome equity by achieving these metrics in all communities, including historically underrepresented populations and in communities with low socioeconomic status.

We respectfully request that all fire departments in Los Angeles County providing 9-1-1 emergency medical services 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 so that you can meet these goals in the community you serve by the end of CY2030.

We suggest that this plan should:

- Reflect the input of a multi-disciplinary working group within your fire department as well as other entities in your community (e.g., police departments, school district, parent teacher association, parks and recreation, public safety commission, civic groups and others);

- Reflect your commitment to clinical excellence through engaging in quality improvement efforts, ensuring timely debriefing with frontline members, and deepening community partnerships with local hospitals and other community stakeholders;

- Include engagement with community members, particularly those in underserved areas disproportionately affected by cardiac arrest;

- Strongly consider utilizing one or more nationally recognized tools, such as the Citizen CPR Foundation's HeartSafe Communities Program (https://citizencpr.org/heartsafe-community/), the American Heart Association's Cardiac Emergency Response Plan (https://cpr.heart.org/en/training-programs/cardiac-emergency-response-plan-cerp), or similar frameworks, to work with other community stakeholders to foster local ownership and readiness; and,

- 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.

A series of online, interactive "clinics" will be hosted from November 2025 through June 2026 to support your team as they prepare this important document, and we strongly encourage one or more members of your team to take advantage of these sessions in order to optimize your plan. These sessions will include useful examples of high-quality plans for your team to model.

Your agency's plan should be **reviewed and approved by your executive leadership team (Fire Chief and Chief Physician)** and also signed off on by the Mayor or City Council of the communities you serve, and submitted to Denise Watson, EMS Commission Liaison, at dwatson@dhs.lacounty.gov, no later than **June 30, 2026 (end of Q2 2026)**. These plans, in turn, will inform the Task Force's system-level recommendations and help drive local, regional, and philanthropic investments to support your efforts.

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.

Thank you again for your dedication and partnership in this life-saving work. Together, we aim to increase the number of our neuro-intact survivors in Los Angeles County from 300 to 500 each year – and this could be any one of us.

For any questions regarding this ask or the work of the Cardiac Arrest Task Force, please contact Stephen Sanko, MD, Chair of the LA County Cardiac Arrest Task Force at SSanko@dhs.lacounty.gov or Nichole Bosson, Medical Director, LA County EMS Agency at nbosson@dhs.lacounty.gov.

With respect and gratitude,

Stephen Sanko, MD, FACEP, FAEMS
Vice Chair, Los Angeles County EMS Commission
Chair, LA County Cardiac Arrest Task Force
Director, Southern California Chapter, Sudden Cardiac Arrest Foundation
EMS Fellowship Director and Adjunct Associate Professor of Clinical Emergency Medicine, USC
SSanko@dhs.lacounty.gov

Diego M. Caivano, MD, Emergency Medicine
Chair, Los Angeles County EMS Commission
Board Certified, American Board of Emergency Medicine
Kaiser Permanente Baldwin Park Medical Center
diego.m.caivano@kp.org

Attachments: [Provider agency performance report]
AHA 2030 Cardiac Arrest Goals

[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 the Commission's 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:

1. Improving neurologically-intact survival after **in-hospital cardiac arrest** to >24% among adults and >45% among children;
2. Increasing community bystander CPR rates in adults to >50%;
3. Increasing community bystander AED application in adults to >20%; and,
4. Ensuring outcome equity by achieving these metrics in all communities, including historically underrepresented populations and in communities with low socioeconomic status.

To meet these ambitious and life-saving goals by the end of CY2030, we respectfully request that your hospital develop a **one-page written plan** describing your institution's strategy to:

1. **Capture and review all patients with:**
   - Out-of-hospital cardiac arrest (OHCA), transported to your facility with or without pulses;
   - ED-witnessed in-hospital cardiac arrest (ED-IHCA); and,
   - In-hospital cardiac arrest (IHCA) patients, with loss of pulses in your med/surgery ward, telemetry, stepdown or ICU areas

2. **Improve survival and neurologic outcomes** among these groups in alignment with the AHA's 2030 targets, particularly in underserved and historically underrepresented communities;

3. **Implement the AHA's 2030 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
   - Neurology
   - ED and Inpatient Nursing
   - Pediatrics, for those hospitals who admit children to the inpatient setting
   - Social Work
   - Physical/Occupational/Rehabilitation Therapy

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) and/or other related peer support resources;

8. **Support regional collaboration** by:
   - Meeting with your local 9-1-1 Fire Department Chief and Chief Physician(s), who are intimately involved with the care of your shared cardiac arrest patients;
   - Designating a representative from your CPR committee to participate in the **LA County In-Hospital Resuscitation Listserv/Forum**, a quarterly online forum for sharing data-informed best practices;
   - Having at least one member of your **c-suite leadership attend the annual Los Angeles 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.

Area fire departments who provide 9-1-1 emergency medical services, are also focusing on these and additional goals for patients with out-of-hospital cardiac arrest, and are also encouraged to compose their own plans to meet their respective 2030 goals.

A series of online, interactive "clinics" will be hosted from November 2025 through June 2026 to support your team as they prepare this important document, and we strongly encourage one or

more members of your team to take advantage of these sessions in order to optimize your plan. These sessions will include useful examples of high-quality plans for your team to model.

Your hospital plan should be **reviewed and approved by your executive leadership team (CEO, CMO, and CNO)** and submitted to Denise Watson, EMS Commission Liaison, at dwatson@dhs.lacounty.gov, no later than **June 30, 2026 (end of Q2 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.

For any questions regarding this ask or the work of the Cardiac Arrest Task Force, please contact Stephen Sanko, MD, Chair of the LA County Cardiac Arrest Task Force at SSanko@dhs.lacounty.gov or Nichole Bosson, Medical Director, LA County EMS Agency at nbosson@dhs.lacounty.gov.

With sincere appreciation for your life-saving work,

Stephen Sanko, MD, FACEP, FAEMS
Vice Chair, Los Angeles County EMS Commission
Chair, LA County Cardiac Arrest Task Force
Director, Southern California Chapter, Sudden Cardiac Arrest Foundation
EMS Fellowship Director and Adjunct Associate Professor of Clinical Emergency Medicine, USC
SSanko@dhs.lacounty.gov

Diego M. Caivano, MD, Emergency Medicine
Chair, Los Angeles County EMS Commission
Board Certified, American Board of Emergency Medicine
Kaiser Permanente Baldwin Park Medical Center
diego.m.caivano@kp.org

[HASC Representative Name][Title][Email address]

Summary of Comments

- The goal of improving neurologically intact survival after **in-hospital cardiac arrest** to >24 % - Does this exclude patient's that have already arrested in the ED or prehospital environment? Historically those patients do not do well with multiple arrests.
- It may be helpful to provide the link to the actual AHA 2030 goals document/website.
- When are the interactive clinics? Is this scheduled going to be mailed or posted and will they be in person, virtual or both?
- Can this information and example/model plans be also sent via email to all the recipients of this letters as a follow up?
- Can all of the resources be posted on the LAC-EMSA for self-services/access?
- What, if any, resources will be available for FD and Hospitals to use over the next 5 years from LAC-EMSA or others to help achieve goals that they may write into their 1-page plan?
- Some cities have a "Community Risk Reduction Officer" or others in a municipal agency who are more apt at putting together the one-page plan. So rather than it saying, "Led or co-led by your EMS Medical Director", maybe add "or approved by". In those cases where the EMS Director provides oversight and review of others by may not be in a position to lead or co-lead such.
- In the statement: "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." The City Manager should also be involved in the process since the Chiefs report to them.
- For it to be approved by the City Council or even the mayor in some cases, it may have to be on agenda for approval. This may be a process for some cities, though if it can be on a consent calendar, it does help spread the news about it and wouldn't want it to stop a city from moving forward.
- One thought is that there could be coordinated Cardiac Arrest Awareness Week where proclamations are requested from cities and through that, information about the efforts and support shown by Councils.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

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

Health Services
http://ems.dhs.lacounty.gov

September 3, 2025

TO: EMS Agency Staff

FROM: Richard Tadeo, EMS Agency Director

SUBJECT: OFFICE OF THE DIRECTOR CHANGES

The following organizational changes to the Office of the EMS Director will become **effective on September 29, 2025**. These changes are being made in light of Chris Clare's well-deserved retirement from her position of Nursing Director-EMS Programs.

Jacqui Rifenburg will provide overall oversight to the Data Systems & Research, Hospital Programs and Prehospital Care Operations sections.

Roel Amara will provide overall oversight to the Administrative Services & Finance section.

The new assignments will be as follows:

Roel Amara: Administrative Services & Finance
Disaster Services
Disaster Response & Emergency Coordination Program
Medical Alert Center, Ambulance Services & Central Dispatch Office

Jacqui Rifenburg: Certification & Training Program Approvals
Data Systems & Research
Hospital Programs
Paramedic Training Institute
Prehospital Care Operations

These changes will remain in effect until further notice. Please contact me if you have any questions,

RT:jr

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

September 4, 2025

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

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

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

TO: Distribution **VIA E-MAIL**

FROM: Richard Tadeo
Director

SUBJECT: NEW 9-1-1 ALTERNATE DESTINATON RESPITE & SOBERING CENTER – MLK CAMPUS

The Los Angeles County Emergency Medical Services (EMS) Agency is pleased to announce that Respite & Sobering Center – MLK Campus (XML) has been designated as a 9-1-1 Alternate Destination Site, located at **12021 Wilmington Ave., Building 18, Suite 102, Los Angeles, 90059**.

Effective **Monday, September 15, 2025, at 0700**, XML will operate as a Sobering Center for patients with alcohol intoxication and will be open to receive EMS-transported patients who meet the criteria outlined in Reference No. 528.1, Medical Clearance Criteria Screening Tool for Sobering Center and ground transport is 30 minutes or less. Ambulance access is available through the designated sally port.

As a reminder, only paramedics with a current Triage to Alternate Destination (TAD) accreditation, working for an EMS Agency-approved TAD Provider Agency can screen and transport patients to a sobering center.

The Alternate Destinations Tab on ReddiNet® will be updated with the new facility. Contact details, including the direct EMS notification phone line will be available on the ReddiNet® general information page.

For questions, please contact Ami Boonjaluksa, Chief of Hospital Programs at (562) 378-1596.

RT:ab:ll
09-06

Distribution: Medical Director, EMS Agency
Fire Chief, Each Fire Department
Paramedic Coordinator, Each Provider Agency
Prehospital Care Coordinator, Each Base Hospital
Nurse Educator, Each Fire Department
Medical Alert Center
EMS Commission
ReddiNet®
Chief, Data Systems and Research, EMS Agency

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

September 29, 2025

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

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

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

Dr. Peter Slavin
Chief Executive Officer
Cedars-Sinai Medical Center
8700 Beverly Boulevard
Los Angeles, CA 90048-1865

Dear Dr. Slavin,

ALLOCATION OF PEDIATRIC TRAUMA CENTER FUNDING (RICHIE'S FUND) FOR FISCAL YEAR 2024-2025

The Board of Supervisors approved the Memorandum of Agreement for Trauma Center Provisions for Reimbursement authorizing the distribution of California Health and Safety Code, Division 2.5, Chapter 2.5, Section 1797.98a(e), (Richie's fund) from collections through June 30, 2024. A warrant in the amount of **$40,180.00** (No. TS0035621112) was issued and mailed directly to your facility by the Auditor Controller's Office on June 25, 2025.

Within six (6) months of receipt of these funds, the Emergency Medical Services (EMS) Agency is requesting documentation be provided to substantiate appropriate use of expenditures to augment pediatric services.

If you have any questions or need additional information, please contact Lorrie Perez, Trauma System Program Manager, at (562) 378-1655, or Jacqueline Rifenburg, Assistant Director, at (562) 378-1640.

Sincerely,

Richard Tadeo
Director

RT:lp
09-29

c: Expenditure Management, Department of Health Services
Trauma Director, Cedars-Sinai Medical Center
Trauma Program Manager, Cedars-Sinai Medical Center
(All above via e-mail)

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

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

September 29, 2025

Dr. Jeremy Zoch
Chief Executive Officer
Dignity Health-Northridge Hospital Medical Center
18300 Roscoe Boulevard
Northridge, CA 91328-4105

Dear Dr. Zoch,

ALLOCATION OF PEDIATRIC TRAUMA CENTER FUNDING (RICHIE'S FUND) FOR FISCAL YEAR 2024-2025

The Board of Supervisors approved the Memorandum of Agreement for Trauma Center Provisions for Reimbursement authorizing the distribution of California Health and Safety Code, Division 2.5, Chapter 2.5, Section 1797.98a(e), (Richie's fund) from collections through June 30, 2024. A warrant in the amount of **$600,000.00** was issued as an electronic fund transfer (Confirmation, EFT# 202506256632680) directly to your facility by the Auditor Controller's Office on June 30, 2025.

Within six (6) months of receipt of these funds, the Emergency Medical Services (EMS) Agency is requesting documentation be provided to substantiate appropriate use of expenditures to augment pediatric services.

If you have any questions or need additional information, please contact Lorrie Perez, Trauma System Program Manager, at (562) 378-1655, or Jacqueline Rifenburg, Assistant Director, at (562) 378-1640.

Sincerely,

Richard Tadeo
Director

RT:lp
09-33

c: Expenditure Management, Department of Health Services
Trauma Director, Dignity Health-Northridge Hospital Medical Center
Trauma Program Manager, Dignity Health-Northridge Hospital Medical Center
(All above via e-mail)

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

EMERGENCY MEDICAL SERVICES AUTHORITY
11120 INTERNATIONAL DR., SUITE 200
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

October 1, 2025

Richard Tadeo, EMS Director
Los Angeles County Emergency Medical Services Agency
10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

Dear Richard Tadeo,

This letter is in response to Los Angeles County Emergency Medical Service (EMS) Agency's 2024 EMS, Triage to Alternate Destination (TAD), Trauma, St-Elevation Myocardial Infarction (STEMI), Stroke, EMS for Children (EMSC), and Quality Improvement (QI) plan submissions to Emergency Medical Service Authority (EMSA) on June 17, 2025.

EMSA has reviewed the EMS plan based on compliance with statutes, regulations, and case law. It has been determined that the plan meets all EMS system components identified in Health and Safety Code (HSC) § 1797.103 and is approved for implementation pursuant to HSC § 1797.105(b). Based on the transportation documentation provided, please find the enclosed EMS area/subarea status, compiled by EMSA.

EMSA has also reviewed the TAD, Trauma, STEMI, Stroke, EMSC, and QI plans based on compliance with Chapters 5, 6.1, 6.2, 6.3, 6.4, and 10 of the California Code of Regulations, Title 22, Division 9, and Title 22, §100117.01, and §100124.01 has been approved for implementation.

Per HSC § 1797.254, local EMS agencies must annually submit EMS plans to EMSA. Los Angeles County EMS Agency will only be considered current if an EMS plan is submitted each year.

Your 2025 EMS plan will be due on or before October 1, 2026. Concurrently with the EMS plan, please submit an annual TAD, Trauma, STEMI, Stroke, EMSC, and QI plan.

If you have any questions regarding the EMS plan review, please contact Roxanna Delao, EMS Plans Coordinator, at (916) 903-3260 or roxanna.delao@emsa.ca.gov.

Sincerely,

Angela Wise, Branch Chief
EMS Quality and Planning
On behalf of Elizabeth Basnett, Director
Enclosure: AW: jg

EMERGENCY MEDICAL SERVICES AUTHORITY
11120 INTERNATIONAL DR., SUITE 200
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

Los Angeles County EMS Agency 2024 EMS Areas and Subareas	Non-Exclusive	Exclusive	Method to Achieve Exclusivity	Emergency Ambulance	ALS	LALS	All Emergency Ambulance Services	9-1-1 Emergency Response	7-digit Emergency Response	ALS Ambulance	All CCT/ALS Ambulance Services	Critical Care Transport	Standby Service with Transport Authorization
Area/Subarea Name	**EXCLUSIVITY**			**TYPE**			**LEVEL**						
Los Angeles County													
EOA 1		X	Competitive	X				X					
EOA 2		X	Competitive	X				X					
EOA 3		X	Competitive	X				X					
EOA 4		X	Competitive	X				X					
EOA 5		X	Competitive	X				X					
EOA 6		X	Competitive	X				X					
EOA 7		X	Competitive	X				X					
EOA 8		X	Competitive	X				X					
EOA 9		X	Competitive	X				X					
City of Alhambra		X	Non-Competitive	X				X					
City of Arcadia		X	Non-Competitive	X				X					
City of Avalon		X	Non-Competitive	X				X					
City of Beverly Hills		X	Non-Competitive	X				X					
City of Burbank		X	Non-Competitive	X				X					
City of Culver City		X	Non-Competitive	X				X					

City of Downey		X	Non-Competitive	X				X					
City of El Segundo		X	Non-Competitive	X				X					
City of Glendale		X	Non-Competitive	X				X					
City of Hermosa Beach		X	Non-Competitive	X				X					
City of La Verne		X	Non-Competitive	X				X					
City of Long Beach		X	Non-Competitive	X				X					
City of Los Angeles		X	Non-Competitive	X				X					
City of Manhattan Beach		X	Non-Competitive	X				X					
City of Monterey Park		X	Non-Competitive	X				X					
City of Pasadena		X	Non-Competitive	X				X					
City of San Fernando		X	Non-Competitive	X				X					
City of San Gabriel		X	Non-Competitive	X				X					
City of San Marino		X	Non-Competitive	X				X					
City of Santa Monica		X	Non-Competitive	X				X					
City of Sierra Madre		X	Non-Competitive	X				X					
City of South Pasadena		X	Non-Competitive	X				X					
City of Torrance		X	Non-Competitive	X				X					
City of West Covina		X	Non-Competitive	X				X					
City of Vernon	X												

Medical Control Guideline: Care of the Sexual Assault/Human Trafficking/ Intimate Partner Violence Patient

DEFINITIONS:

Intimate Partner Violence (IPV): The willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another.

Sexual Assault: Any form of non-consensual sexual conduct/contact with another person, including when the victim is unable to give consent due to age, cognitive disability or voluntary/involuntary incapacitation by drugs or alcohol.

Human Trafficking: Involves labor or services, by means of force, fraud or coercion for the purposes of subjection into commercial sex acts or other involuntary servitude. If the person is under 18 years of age, no force, fraud or coercion is required.

PRINCIPLES:

1. Victims of IPV, sexual assault, and human trafficking transcend gender, sexual orientation, race, culture, age, ability, education, occupation, class and nationality. There is no “right” or “wrong” type of victim, and there is no “correct” response for a victim.

2. It is not the role of EMS to determine whether a sexual assault incident has occurred.

3. Drugs and alcohol are a contributing factor in many sexual assault cases. One should keep an elevated index of suspicion when responding to patients under the influence.

4. Human trafficking can be difficult to detect; victims may be fearful or resistant to disclosure. EMS personnel should be alert to warning signs of human trafficking, which can include:

    A. Individuals isolated/segregated from contact with responders, physically or emotionally bullied by others, or who lack control of their own ID/documents

    B. Signs of physical neglect (e.g. malnourished, unreasonable injuries)

    C. Unsuitable living conditions or unreasonable/unsafe working environments

    D. Responders approached and asked for protection from other individuals at a scene

5. If the patient has an on-scene support person, transport this person with the patient if possible. Use judgment as abusers may attempt to remain close to interfere and intimidate the victim.

6. Patient Care Records (PCRs) may be subpoenaed for court. It is important that field documentation be specific, objective, complete, and timely. Using quotes to document the patient’s words verbatim is preferred.

7. Law enforcement notification should be made as soon as possible, if not already present, for all suspected cases of sexual assault, human trafficking or IPV. Ref. No. 822

and 823 describe reporting guidelines for child, elder or dependent adult abuse; which may include sexual assault, human trafficking or IPV.

8. When determining the most appropriate destination, the emergency medical needs of the patient take priority. Every effort should be made to transport sexual assault patients to a specialty care center that has an affiliated designated SART Center. If EMS personnel determine that such a transport would unreasonably remove the transport unit from its primary response area, the patient should be transported to the most accessible receiving (MAR) facility.

9. Transfer of care to the receiving facility should include the report of sexual assault, IPV and/or human trafficking so that the facility can implement their specific care plans for such patients.

GUIDELINES:

1. Ensure your safety. Do not confront a suspected abuser and maintain an exit strategy at all times.

2. Follow appropriate treatment protocol(s) based on provider impression.

3. Use judgment when assigning the EMS patient care provider, if possible, noting the gender of the clinician can be triggering to the victim.

4. Attempt a private audience with the patient in cases of IPV where the abuser may be present, maintaining regard for safety. If at all possible, avoid treating the patient in kitchen or bedrooms as kitchens have a variety of potential weapons (knives, glass, pans) and bedrooms may contain concealed weapons and fewer escape routes.

5. Support the victim. Use the phrases: “I believe you.”; “I am sorry this happened to you”; “It’s not your fault”; “I’m here to help you.”

6. Ask about abuse but do not force disclosure.

7. Explain, in advance, each treatment/procedure and offer the patient simple choices (e.g. to sit up or recline on the gurney).

8. Mirror the patient’s language (e.g., do not say ‘rape’ or ‘sexual assault’ if the patient has not used those words).

9. Keep the assessment brief and injury focused:

    A. Do not interview the patient about the details of the assault.

    B. Assess the patient for injuries.

    C. Specifically evaluate for strangulation injuries, as this is common with IPV/sexual assault and signs may be subtle.

        i. Signs/symptoms may include: soft tissue neck injury, swelling, or tenderness, ligature marks or neck contusion, dyspnea, voice hoarseness or inability to speak, painful or difficulty swallowing, neurological signs (e.g., altered level of consciousness (ALOC), seizures, stroke-like

symptoms, visual changes), facial, intraoral, or conjunctival petechial hemorrhage, subcutaneous emphysema, bladder and/or bowel incontinence.

ii. Encourage transport to the hospital for suspected or reported strangulation regardless of physical findings for evaluation of potential serious underlying injuries given the high morbidity and mortality.

D. In the absence of hemorrhage, there is rarely a need to visualize genitalia.

10. Preserve physical evidence:

A. Transport the patient 'as found'. Discourage showering, removing/changing clothes, brushing teeth, using mouthwash, smoking, eating or drinking. Do not allow the patient to wash or clean their hands as this may disturb evidence collection during a sexual assault forensic examination.

B. If necessary to cut off the patient's clothes, cut around soiled, torn or damaged area(s) by six (6) inches.

C. Place any removed clothes or items in a paper bag. Plastic bags degrade important organic material/evidence.

D. Bag items separately to avoid cross-contamination.

E. Do not clean, irrigate or apply ointment to wounds. When wound dressing is indicated, apply dry sterile gauze to wounds.

F. If the patient needs to urinate or vomit, preserve in a clean container when possible, e.g., urinal or emesis basin.

G. Retain all equipment and supplies used in treatment such as bandages, sheets, and any bodily fluids.

H. Maintain chain of custody for each item at all times, to ensure the forensic process. This is best accomplished by having the patient keep all evidence collected at scene in their possession or having law enforcement maintain possession, if present.

11. Transport the patient to the most appropriate destination as per Ref. No. 508. And inform the receiving hospital clinicians of the suspected abuse.

12. If the patient is not transported and human trafficking is suspected, offer the patient the 24/7 National Human Trafficking Hotline number 888-373-7888; one can also text the hotline by sending "BEFREE" or "HELP" to 233733.

13. Contact law enforcement if not already present at the scene and ensure reporting is completed.

14. Documentation:

A. Be specific, objective, complete and timely.

B. Use the victim's own language. Document exact statements from the victim and others present in quotes whenever possible.

C. Do not use terms like "alleged", or "supposed". You may state 'reported' or simply describe what is told to you and by whom.

D. Include injury descriptions and physical examination findings; it is important to include observed as well as findings on palpation e.g., tenderness.

Resources:
https://humantraffickinghotline.org/en
https://www.thehotline.org/?utm_source=youtube&utm_medium=organic&utm_campaign=domestic_violence
https://rainn.org/
https://startbybelieving.org/