COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

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

DATE: January 21, 2026
TIME: 1:00 – 3:00 PM
LOCATION: 10100 Pioneer Boulevard, First Floor
Cathy Chidester Conference Room 128
Santa Fe Springs, CA 90670

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

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

AGENDA

1. CALL TO ORDER – Commissioner Diego Caivano, Chair

2. NOMINATIONS/SELECTIONS FOR 2026:
- 2.1 Chair
- 2.2 Vice Chair
- 2.3 Measure B (MBAB) Representative
- 2.4 Standing Committee Assignments

3. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS
- 3.1 EMSAAC Conference, May 27-28, 2026, Hilton LA/Universal City

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

- 4.1 **Minutes**
  - 4.1.1 November 19, 2025
- 4.2 **Committee Reports**
  - 4.2.1 Base Hospital Advisory Committee – December 10, 2025
  - 4.2.2 Provider Agency Advisory Committee – December 17, 2025
- 4.3 **Policies**
  - 4.3.1 Reference No. 510: Pediatric Patient Destination
  - 4.3.2 Reference No. 511: Perinatal Patient Destination
  - 4.3.3 Reference No. 604: Prehospital Care Forms
  - 4.3.4 Reference No. 608: Retention and Disposition of Prehospital Patient Care Records

4.3.5 Reference No. 803: Los Angeles County Paramedic Scope of Practice
4.3.6 Reference No. 803.1: Los Angeles County Paramedic Scope of Practice (Table Format)
4.3.7 Reference No. 840: Medical Support During Tactical Operations
4.3.8 Reference No. 842: Mass Gathering and Special Events Interface with Emergency Medical Services
4.3.9 Reference No. 842.1: EMS Resource Guidelines for Mass Gathering and Special Events

END OF CONSENT AGENDA

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5. BUSINESS

Business (Old)
5.1 Field Evaluation of Suicidal Ideation and Behavior
5.2 Ambulance Patient Offload Time (APOT)
5.3 Interfacility Transfer Taskforce
5.4 Cardiac Arrest Taskforce

Business (New)
5.5 EMS Goals Planning Document 2026

6. LEGISLATION

7. DIRECTORS' REPORTS

7.1 Richard Tadeo, Director-EMS Agency, Executive Director-EMS Commission

Correspondence
7.1.1 (11/17/25) Addition of Automated External Defibrillators to Basic Life Support Ambulance Equipment and AED Service Provider Program Requirements
7.1.2 (12/01/25) Name Change for Cedars-Sinai Marina Del Rey Hospital
7.1.3 (12/09/25) Optimizing Pediatric Readiness of 9-1-1 Receiving Hospitals in Los Angeles County Through Integration into Emergency Management Program
7.1.4 (12/09/25) Optimizing Pediatric Readiness of 9-1-1 Receiving Hospitals in Los Angeles County Through Integration into Emergency (12.Management Program (LA Peds Ready 2.0)
7.1.5 (12/18/25) Updated Requirements for Capnography Sampling Devices, Magnesium Sulfate, and Portable Section Devices (ALS Unit Inventories)
7.1.6 (12/24/25) Tournament of Roses Parade
7.1.7 (12/08/25) Cardiac Arrest Task Force Letter – 9-1-1 Providers
7.1.8 (12/2025) Cardiac Arrest Task Force Letter – Hospitals
7.1.9 EMS System Report

7.2 Nichole Bosson, MD, Medical Director, EMS Agency

8. COMMISSIONERS' COMMENTS / REQUESTS

9. ADJOURNMENT

Adjournment to the meeting of March 18, 2026

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
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MINUTES
NOVEMBER 19, 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	Jacqueline Rifenburg	EMS Staff
☒ Tarina Kang, M.D.	Hospital Assn. of So. CA	Michael Kim, MD	EMS Staff
☐ Carol Kim	Public Member, 1st District	Lily Choi	EMS Staff
☐ Kristin Kolenda, Captain	Peace Officers Association	Paul Aragon, MD	EMS Staff
☒ Lydia Lam, M.D.	American College of Surgeons	Mark Ferguson	EMS Staff
☒ Kenneth Liebman	LACo Ambulance Association	Sara Rasnake	EMS Staff
☒ James Lott, PsyD, MBA	Public Member, 2nd District	Jon Warren, MD	EMS Staff
☐ Carol Meyer, RN	Public Member, 4th District	David Wells	EMS Staff
☒ Kenneth Powell	LA Area Fire Chiefs' Assn.	Aldrin Fontela	EMS Staff
☐ Connie Richey, RN	Public Member 3rd District	Jake Toy, MD	EMS Staff
☒ Stephen G. Sanko, MD	American Heart Association	Miguel Ortiz-Reyes	EMS Staff
☒ Carole A, Snyder, RN	Emergency Nurses Assn.		EMS Staff
☒ Saran Tucker	So. CA Public Health Assn.		EMS Staff
☒ Atilla Uner, M.D., MPH	CAL-ACEP		
☐ VACANT	Public Member, 5th District		

GUESTS

Jennifer Shepard, LASD	Dave Molyneux, Amwest	Marve Elvi Henry AVMC
Jack Yandell, IAEP	Laurie Donegan APCC	

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 1:08 p.m. Commission introductions were made and there was a quorum of 11 members present.

2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

EMSC Executive Director Richard Tadeo introduced Jennifer Shepard, Deputy Paramedic/Paramedic Coordinator, LA County Sheriff's Department, and announced that Governor Gavin Newsom appointed her to the State EMSC.

The Annual EMSAAC Conference will be held May 27-28, 2026, at the Hilton Los Angeles/Universal City. This year's theme is "Back to the Future _ EMS Reimagined."

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

Chair Caivano opened the floor for discussion and called for a vote on the Consent Agenda.

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
Commissioner Uner expressed concern on the requirement that 60% of the receiving hospital's emergency department physician staff must have Emergency Medicine Board Certification (EMBC).

Director Tadeo clarified that this requirement will only apply to 15 of the 69 designated 9-1-1 receiving hospitals in LA County. These are the community hospitals that do not have specialty care center designations such as Emergency Department (ED) Approved for Pediatrics (EDAP), paramedic base hospital, trauma, STEMI, or stroke. Designated specialty care centers are required to have 100% of ED attending physicians have the minimum required board certification. EDAP is an exception which requires 60%. This revision is being made in light of EMBC being in existence for over 30 years and would continue to provide grandfather status of non-boarded physicians who have long standing employment and practice in the ED. The policy was reviewed and endorsed by the Hospital Association of Southern California.

3.3.3 Reference No. 513.2: 9-1-1 Interfacility Transfer Checklist for STEMI Re-Triage
Commissioner Uner questioned if policy requirement is working.

Director Tadeo responded that the IFT workgroup is currently looking at ED to ED transfers and will be looking at the inpatient IFT issues when this current assessment is completed.

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

Motion/Second by Commissioners Powell/Snyder to approve the Consent Agenda was carried.

Ayes: (11) Diego Caivano, Ken Domer, Tarina Kang, Lydia Lam, Ken Liebman, James Lott, Ken Powell, Stephen Sanko, Carole Snyder, Saran Tucker, Atilla Uner.
Nays: (0)
Abstains: (0)

Absent: (7) Jason Cervantes, Paul Camacho, Erick Cheung, Carol Kim, Kristin Kolenda, Carol Meyer, Connie Richey.

END OF CONSENT AGENDA

4. BUSINESS

Business (Old)

4.1 Field Evaluation of Suicidal Ideation and Behavior

Director Tadeo reported there are no updates. The workgroup will continue working on developing a mechanism to evaluate the effectiveness of the suicide screening tool.

4.2 Ambulance Patient Offload Time (APOT)

Jacqueline Rifenburg, Assistant Director, EMS Agency, reported on third quarter 2025 APOT, and noted some challenges with meeting the 30-minute threshold created by the State, but also noted there is some improvement. She reported on comparisons between EMS Agency data taken from CEMSIS and State data and concluded the data is close with relatively small outliers.

Director Tadeo reported that Assembly Bill (AB) 40 called for the State to implement an APOT audit tool. Modifications have been made to the tool and hospitalS can now download files and filter them. The State engaged hospitals with one-on-one meetings, and EMSAA has identified the 15 top hospitals with the most offload delays. Twelve (12) of the 15 hospitals are in LA County. The EMS Agency has been participating in these meetings and the meetings have been collaborative. EMSAA is also collecting best practices of various hospitals and will be sharing these practices in the future.

4.3 Interfacility Transfer Taskforce

Ms. Rifenburg reported the IFT workgroup continues to meet and will be working with a few hospitals. Data shows that inappropriate 9-1-1 IFT transfers is trimming down.

4.4 Cardiac Arrest Taskforce

Vice Chair Sanko discussed three letters (attached) and the goals of the cardiac arrest taskforce which continues to work with hospitals, fire departments, and community stakeholders to achieve the American Heart Association's (AHA) 2030 goals of processing positive patient-centered cardiac outcomes. The taskforce is comparing the gap between outcomes from 2024 and where the AHA hopes to be by 2030 to build a team and develop a one-page action plan crafted by them (with taskforce member support) on how to meet the needs to reach these objectives. This action plan will be submitted to the EMS Agency by end of second quarter 2026.

Commissioner Ken Domer recommended copying City Managers on the action plan request letters as they have a vital role with fire departments in their cities.

The EMS Agency will finalize the letters and send them out by December 31, 2025.

Business (New)

4.5 Nominating Committee

Commissioners James Lott, Stephen Sanko, and Kenneth Powell were selected as the Nominating Committee to identify candidates for the 2026 EMSC Chair and Vice Chair. Commission Liaison Denise Watson will schedule a meeting with the Committee to discuss recommendations to bring back to the January 21, 2026, EMSC meeting.

5. LEGISLATION

Director Tadeo reported that legislation is currently on recess, but referenced the following:

5.1 AB 40 – Refers to Ambulance Patient Offload Time (APOT) discussion.

5.2 SB 660 – California Health and Human Services Data Exchange Framework requires the exchange of health information among health care entities and government agencies in the state. This bill expands the entities specifically required to execute a data sharing agreement no later than July 1, 2026.

5.3 SB 1456 – This bill updates the State Athletic Commission Act and directs ambulance drivers to go to trauma centers if services are deployed during boxing matches. The EMS Agency met with the Athletic Commission and is developing an information page on the various Trauma Centers in Los Angeles County. This information page will be part of the information disseminated by the Athletic Commission to event organizers.

6. DIRECTORS' REPORTS

6.1 Richard Tadeo, EMS Agency Director, EMSC Executive Director

Director Tadeo discussed the correspondence below, and reported on specific events and levels of security that will be LA County EMS Agency's responsibility in and around the city related to the Los Angeles Olympics (LA 2028), as well as the FIFA World Cup 2026.

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

Denise Whitfield, MD, Assistant Medical Director, LA County EMS Agency, reported that she is co-chairing with Dr. Saman Kashani, Assistant Medical Director at LA County Fire Department (LACoFD) for the medical host committee for the FIFA World Cup 2026, and that preparations are ongoing. Primary medical planning will fall within the jurisdiction of LACoFD. They are having monthly meetings in preparation for the eight FIFA World Cup matches which will all be held at SoFi Stadium from June 12 – July 10, 2026. There will be a FIFA Fan Festival 2026 for Angelinos and for fans from around the world from June 11-15, 2026, to be held at the Los Angeles Coliseum which is Los Angeles Fire Department's (LAFD) jurisdiction. LAFD has been invited to engage with planning. There will be four-to-five fan zones, and requests for proposals (RFPs) for watch parties should include medical plans so medical resources will be available.

Director Tadeo added that EMS Agency Reference No. 517, Private Provider Response Policy, and Reference No. 842, Mass Gathering Policy, are being reviewed so that jurisdictional 9-1-1 providers, when approving permits, include an enforceable medical plan in order to reduce the impact of incidents from these venues to the 9-1-1 system.

6.2 Nichole Bosson, MD, Medical Director, EMS Agency

6.2.1 Medical Control Guideline (MCG) Reference No. 1359: Care of Sexual Assault/Human Trafficking/Intimate Partner Violence Patient. This MCG outlines best practices to communicate and provide guidance for first responders on

treating these patients to not trigger or re-traumatize them upon encounters.

ECPR:
The official system of care for Extracorporeal Cardiopulmonary Resuscitation (ECPR) was launched July 1, 2025. There are currently five centers and we are hoping to expand to other areas of the County. Thus far, there are good neurologic outcomes for the survivors, and first quarter data appears to be holding to similar metrics as the pilot. We are monitoring the data closely and assessing how we can optimize ECPR and who should receive this therapy.

LA-DROP
LA-DROP is our prehospital blood transfusion pilot program with Compton and LA County Fire Departments which began April 1, 2025. As of today, there are 33 transfusions in LA County. We have been able to do these transfusions safely with minimal blood wasted. We will continue to monitor this program. We are in communication with LAFD about a program in the future and looking at expanding strategically.

Pedi-PART and PediDOSE
The Pedi-PART and PediDOSE studies are prehospital airway resuscitation trials for pediatrics as well as seizure, age-based dosing and are ongoing. PediDOSE enrollment will continue until the end of next summer, and Pedi-PART will continue enrolling over the next two years.

EMS UPDATE
EMS Update is coming, and Dr. Shira Schlesinger is handling this with a focus on pediatric resuscitation to improve patient outcome, updating care of pregnant patients, and enhancing the use of capnography.

TRAUMA DASHBOARDS
Trauma dashboards are now live and posted on the EMS Agency website. Congratulations to Drs. Shira Schlesinger and Jake Toy of the LA County EMS Agency for doing a stellar job on this. Preventative and post-crash care is also live on the EMS Agency website. A link will be sent to the Commissioners.

Dr. Whitfield gave the following report:

THORASITE
Thorasite was a project that came out of our Innovation, Technology and Advancement Committee, and it is currently in use by a few fire departments and available for optional use throughout LA County. Thorasite is for needle thoracostomy placement. There was a commercial device, basically a card, that you put along the axilla and a few fire departments volunteered with us to do a study on the feasibility and accuracy of the device. We wrote up a paper recently that was accepted for publication and prehospital emergency care that will be published in the future.

PROTOCOL APP
The Protocol App was launched last year with EMS Update and a study was conducted. Paramedics from the system were recruited to participate in two simulated trauma scenarios using the app or not using the app. We partnered with Compton and Long

Beach Fire Departments and the following trends were identified. Those who used the app trended to do better. We are looking to recruit 10 more pairs to finish out the study. We have additional funding for 2026 to look at our app a little closer, and Dr. Jake Toy is assisting with that. We will assess frequency of use and overall use, comparing usage in areas where training was associated with the study for differences before and after, and decision-making tools to further evaluate the application. The study was looking at displacement accuracy and quality improvements.

7. COMMISSIONERS' COMMENTS / REQUESTS

Commissioner Uner questioned Consent Agenda Item 3.3.6, Reference No. 1109.2, and asked what grant funding allocations does this policy apply to?

Director Tadeo explained that Reference No. 1109.2 policy is intended for grant funding allocations administered through the EMS Agency such as Urban Area Security Initiative, Hospital Preparedness Programs, and State Homeland Security Grants allocated to hospitals and EMS providers. The Purpose verbiage will be revised to clarify.

8. ADJOURNMENT

Adjournment by Chair Caivano at 2:20 PM.

Next Meeting: Wednesday, January 21, 2026, 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

EMERGENCY MEDICAL SERVICES COMMISSION
STANDING COMMITTEE ASSIGNMENTS
2026

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

COMMITTEE	2024	2025	2026
Provider Agency Advisory Committee **PAAC**	Chair: **Kenneth Powell** Vice Chair: **Paul Espinosa** Commissioners: James Lott, PsyD, MBA Ken Liebman Jason Cervantes Carol Kim Carol Meyer Stephen Sanko, MD Gary Washburn Staff: **Gary Watson**	Chair: **Carol Meyer, RN** Vice Chair: **Ken Powell** Commissioners: Jason Cervantes Kenneth Powell James Lott, PsyD, MBA Gary Washburn Kristin Kolenda Ken Liebman Staff: **Gary Watson**	Chair: **Carol Meyer, RN** Vice Chair: **Ken Powell** Commissioners: Jason Cervantes James Lott, PsyD, MBA Ken Domer Kristin Kolenda Ken Liebman Staff: **Gary Watson**
Base Hospital Advisory Committee **BHAC**	Chair: **Erick Cheung, MD** Vice Chair: **Diego Caivano, MD** Commissioners: Atilla Uner, MD, MPH Lydia Lam, MD Carole Snyder, RN Brian Saeki Saran Tucker, Ph.D., MPH Tarina Kang, MD Staff: **Laura Leyman**	Chair: **Tarina Kang, MD** Vice Chair: **Lydia Lam, MD** Commissioners: Erick Cheung, MD Carole Snyder, RN Atila Uner, MD, MPH Brian Saeki Saran Tucker, PhD, MPH Connie Richey, RN Carol Kim Staff: **Laura Leyman**	Chair: **Tarina Kang, MD** Vice Chair: **Lydia Lam, MD** Commissioners: Erick Cheung, MD Carole Snyder, RN Atila Uner, MD, MPH Saran Tucker, PhD, MPH Connie Richey, RN Carol Kim Staff: **Laura Leyman**


SAVE THE DATE
MAY 27 & 28, 2026
EMSAAC 2026 CONFERENCE
BACK TO THE FUTURE
2026 ANNUAL CONFERENCE
EMS REIMAGINED
EMERGENCY
2DAFUTR
Presented by:
EMS Administrators' Association of California
Monitor the EMSAAC website for current information: www.emsaac.org
HILTON LA/UNIVERSAL CITY
MAY 26, 2026 PRE-CONFERENCES
CQI: THE NEXT ERA OF EMS QUALITY
GREAT SCOTT! THERE'S THAT WORD AGAIN: 'DISASTER'

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

December 10, 2025

	Representatives			Representatives	
	Tarina Kang, MD, Chair	EMS Commission	X	Rachel Caffey	Northern Region
	Lydia Lam, MD, Vice Chair	EMS Commission		Jessica Strange	Northern Region
	Atilla Under, MD, MPH	EMS Commission		Michael Wombold	Northern Region, Alternate
	Connie Richey, RN	EMS Commission	X	Samantha Verga-Gates	Southern Region
	Saran Tucker, PhD, MPH	EMS Commission	X	Laurie Donegan	Southern Region
	Carol Synder, RN	EMS Commission	X	Shelly Trites	Southern Region
	Erick Cheung, MD	EMS Commission	X	Christine Farnham	Southern Region, Alternate
	Brian Saeki	EMS Commission	X	Ryan Burgess	Western Region, Alternate
	Carol Kim	EMS Commission	X	Travis Fisher	Western Region
X	Gabriel Campion	Base Hospital Medical Director	X	Lauren Spina	Western Region
	Salvador Rios	Base Hospital Medical Director, Alternate		Susana Sanchez	Western Region
X	Adam Brown	Provider Agency Representative	X	Kate Bard	Western Region
X	David Hickman	Provider Agency Representative, Alt.	X	Laurie Sepke	Eastern Region
X	Elizabeth Charter	PedAC Representative	X	Alina Candal	Eastern Region
	Desiree Noel	PedAC Representative, Alternate	X	Jenny Van Slyke	Eastern Region, Alternate
X	Colleen Greer	MICN Representative	X	Lila Mier	County Region
	Vacant	MICN Representative, Alternate		Emerson Martell	County Region
			X	Antoinette Salas	County Region
			X	Yvonne Elizarraraz	County Region

EMS Agency			Prehospital Care Coordinators	Guests
Denise Whitfield, MD	Lorrie Perez	X	Brandon Koulabouth (AMH)	Ryan Heckman (TFD)
Shira Schlesinger, MD	Priscilla Ross	X	Jeannette Souza (TMH)	Sheryl Gradney(LACoFD)
Jake Toy, MD	Mark Ferguson	X	Kelly Bui (SFM)	Jennifer Nulty (BHFD)
Michael Kim, MD	Fritz Bottger	X	Melissia Turpin (SMM)	
Dipesh Patel, MD	Sara Rasnake	X	Melissa Carter (HCH)	
Jacqueline Rifenburg	Lily Choi	X	Allison Bozigian (HMN)	
Richard Tadeo		X	Mary Jane Evangelista (QVH)	
Jon Warren, MD				
Paul Aragon, MD				
David Wells				

1. **CALL TO ORDER:** The meeting was called to order at 1:05 p.m. by Chair Pro Tem , Gabriel Campion, MD.

2. **INTRODUCTIONS/ANNOUNCEMENTS:**

2.1 **EMSAAC Conference 2026**: Scheduled for May 26-28, 2026, at the Universal Hilton, Universal City. Pre-conference sessions (CQI and Disaster) will be held on May 26; the main conference will be May 27-28.

2.2 **EMS Trauma Compendium:** Most of the NEMSP Prehospital Trauma Compendium has been published and are available on the EMS website. A policy crosswalk will be conducted to assess alignment with current EMS policies and identify any recommendations.

2.3 **Joint Education Session – March**: Dr. Amelia Breyer, MD, LEMSA Medical Director for San Francisco, will present on prehospital in End-Of-Life-Care. CE will be offered; CME will not be available.

2.4 **EMS Awards Nominations**: Nominations for the 2025-2026 EMS Awards are now open via the EMS Authority's website.

2.5 **Personnel Announcement**: Shelly Trites, Prehospital Care Coordinator (Torrance Hospital) is retiring after 41 years career in nursing. Jeanette Sousa will be assuming her role.

3. **APPROVAL OF MINUTES**

3.1 The meeting minutes for October 8, 2025 and August 13, 2025.

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

4. **OLD BUSINESS**

4.1 MICN Certification Fee**:** Distribution of the MICN Certification and Renewal payment letter is postponed pending accurate invoice verification. Once validated, a letter outlining the process will be issued, with a minimum of two months' lead time before it takes effect.

5. **NEW BUSINESS**

5.1 2025 AHA Updates: Dr. Whitfield reviewed key 2025 AHA guideline updates and identified potential impact on EMS policies. Select pediatric and adult protocols are under review, with any necessary revisions anticipated in the April policy update cycle. Several items were noted as educational only, with no immediate policy changes required. A final summary will be shared with the EMS update materials.

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

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

Added respiratory status to the first section to align with 506.2 for consistency.

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

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

Presented again without changes due to lack of quorum at the prior meeting.

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

6.3 Ref. No. 604, Prehospital Care Forms

Revisions made to clarify that EMS forms are used only during ePCR system failures and to reorganize sections in the policy for clarity.

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

6.4 Ref. 608., Retention and Disposition of Prehospital Patient Care Records

Minor updates to align with electronic data submission by private ALS providers.

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

6.5 Ref. No. 815, Honoring Prehospital Do Not Resuscitate Orders, Physician Order for Life Sustaining Treatment and End of Life Option

A clarification was made to indicate that patients whose care goals can be met on scene should not be transported unless necessary or requested.

Discussion included referencing the full POST form and addressing conflicts with power or attorney; these will be handled through education and future policy review.

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

6.6 Ref. No. 840. Medical Support During Tactical Operations

The policy underwent a three-year review. Updates included terminology changes, minor edits, and a revision to Principle 4 to better reflect tactical emergency casualty care guidelines.

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

Policies for Discussion: No Action Required

Magnesium Sulfate is referenced across multiple policies below related to preeclampsia and eclampsia. These references provide guidance on indications, dosing and coordination of patient care.

6.7 Ref. No. 1217, Pregnancy Complications

Policy was presented, no comments.

6.8 Ref. No. 1217-P, Pregnancy Complications

Policy was presented, no comments.

6.9 Ref. No. 1317. XX, MCG: Drug Reference-Magnesium Sulfate

A question was raised regarding interpretation of medications not authorized versus those allowed under a prehospital physician order. It was clarified that unauthorized treatments should not be administered. Any deviations must be reviewed by the base medical director. While the drug may have other clinical uses, dosing on the drug card applies to its intended use, and any alternate dosing requires a base physician order.

6.10 Ref. No. 1231, Seizure

Clarification was provided regarding the preferred treatment approach for pregnant patients with seizures, with guidance to follow current protocol.

6.11 Ref. No. 1200.2, Base Contact Requirements

Policy was presented, no comments.

6.12 Ref. No. 1200.3, Provider Impressions

Policy was presented, no comments.

6.13 Ref. No. 1202, General Medical

Policy was presented, no comments.

Adenosine Dosing Update: Dosing changes noted in policy 1213 and 1317.

6.14 Ref. No 1213, Cardiac Dysrhythmia – Tachycardia.

Policy was presented, no comments.

6.15 Ref. No. 1317.1, MCG: Drug Reference – Adenosine

A question was raised about mixing Adenosine with 20 mL NS for rapid push. It was clarified that while this is not indicated on the drug card, doing so would not be considered incorrect or out scope.

6.16 Ref. No. 1220, Burns

Clarification that treatment of running water on the affected area is for pain relief and the policy does not differentiate by burn degree, including first-degree burns.

A question was raised regarding whether on-scene treatment for burns > 20% TBSA could delay transport to the trauma center. It was clarified that if the patient is stable, appropriate treatment should be prioritized, and trauma does not automatically override on-scene care, and providers should use their judgement.

6.17 Ref. No. 1220-P, Burns

A concern was raised about hypothermia risk using running water for pediatric burns. It was noted that warming methods may be used to maintain warmth while providing appropriate treatment.

6.18 Ref. No.1222-P, Hyperthermia (Environmental)

Policy was presented, no comments.

6.19 Ref. No. 1309, MCG: Color Code Drug Doses

Policy was presented, no comments.

6.20 Ref. No. 1317.33, MCG: Drug Reference – Ondansetron

Policy was presented, no comments.

6.21 Ref. No. 1317. 1-45, Mechanism of Action

Drug card mechanism-of-action language was reviewed for clarity and general understanding. All drug cards were evaluated and revised as needed.

7. REPORTS & UPDATES:

7.1 EMS Update

Train the Trainer dates will be released soon. The session will be longer this year to include all trainers in the skills portion, even sections not directly applicable to base hospitals, to improve understanding of paramedic training. Multiple sessions will be held in March.

EMS update topic suggestions are collected year-round. Please submit any audio calls that highlight relevant topics or protocol changes for this year's update.

7.2 EmergiPress

EmergiPress is available on the APS portal. The next issue will cover Senate Bill 43, which allows 5150 placements for patients unable to meet their basic living needs due to pervasive drug use. Education is being developed to assist prehospital and the base hospitals regarding this law.

All pre-2024 EmergiPress issues will be removed from the website. Contact Dr. Schlesinger for access to earlier editions.

7.3 ITAC Update (Tabled)

7.4 ELCOR

The last joint educational session addressed EMS decision-making with law enforcement disengagement, highlighting case law and the reduced liability risk associated with protocol adherence, patient communication and thorough documentation. The session will be made available for future reference.

Dr. Kim is revising the protocol training EMS Update videos for law enforcement and developing education to reinforce their role in the EMS system, including staying on scene in certain situations and early intervention guidance.

These topics will be highlighted at the EMSAAC Conference in 2026.

7.5 Research Initiative & Pilot Studies

7.5.1 Prehospital Blood Transfusion Pilot – LA DROP

The pilot with Compton and LA County Fire Department is ongoing with 37 blood transfusions so far and successful patient outcomes. Expansion is being considered with LAFD and Los Angeles General Hospital.

The EMS Agency will be addressing guidance on balancing blood transfusions in patients with traumatic full arrest, administering to those with potential benefit while considering risk in futile cases to support base hospitals in decision making.

7.5.2 PediDOSE Trial

Patient enrollment is ongoing, with the study scheduled to conclude next year. Inclusion of pediatrics at 6 months of age will begin starting July1, 2026.

7.5.3 Pedi-PART

Approximately 350 patients have been enrolled. Continued emphasis on study adherence is critical; encourage paramedics to use the assigned airway to support study integrity. The study will continue for several more years.

7.5.4 California Office of Traffic Safety (OTS) Grants Projects

The EMS County dashboard is live. Dr Schlesinger provided a tutorial on how to navigate the dashboard and interpret the different types of data available. The dashboard can be accessed here:

https://dhs.lacounty.gov/emergency-medical-services-agency/home/dashboard/

7.6 Cardiac Arrest Taskforce

Meets monthly with the primary mission to identify ways to meet the 2026 AHA guidelines for in-hospital and out-of-hospital cardiac arrest. All provider agencies have received their CARES report, with hospitals receiving them as well. Letters will be sent to provider agencies and hospitals outlining the rationale for this initiative, its goals, and requesting that each site develop a strategic plan to meet the AHA 2026 objectives. Several listening and learning sessions will be offered to support the development and implementation of these plans.

7.7 Health Data Exchange

No new updates. Challenges continue with hospital security teams using ESO security system and with larger health systems who operate outside of LA County and California. Sustainment continues into FY 2027.

8. OPEN DISCUSSION:

Starting in 2026, all base hospitals will be asked to present their base QI during the surveys to highlight work and accomplishments not fully captured in the written QI reports. This will be included in the base survey notification letter and discussed at the pre-survey meeting

9. NEXT MEETING: February 4, 2026

10. ADJOURNMENT: The meeting was adjourned at 2:24 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 – December 17, 2025

MEMBERSHIP / ATTENDANCE

MEMBERS IN ATTENDANCE	ORGANIZATION
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
Sean Stokes	Area A *(Rep to Medical Council)*
Patrick Nulty	Area A, Alternate
X Keith Harter	Area B
Clayton Kazan, MD	Area B, Alternate
Jeffrey Tsay	Area C
X Luis Manjarrez	Area C, Alternate
Geoffrey Dayne	Area E
Victor Lemus	Area E, Alternate
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
Jenny Van Slyke	Prehospital Care Coordinator
X Melissia Turpin	Prehospital Care Coordinator, Alternate
X Bryan Sua	Public Sector Paramedic Coordinator
Drew Pryor	Public Sector Paramedic Coordinator, Alt
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
Albert Laicans	EMT Training Program, Alternate
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	Denise Whitfield, MD
David Wells	Shira Schlesinger, MD
Ami Boonjaluksa	Dipesh Patel, MD
Natalie Greco	Jake Toy, MD
Sara Rasnake	Jonathan Warren, MD
Mark Ferguson	

GUESTS	ORGANIZATION
Karen Bustillos	UCLA Ctr for Prehospital Care
Danielle Ogaz	LACoFD
Catherine Borman	Santa Monica FD
Jennifer Shepard	LASD
Eric Eckels	All Town Ambulance
Ryan Herman	Torrance FD
Kristina Crews	LACoFD
Puneet Gupta, MD	LACoFD
Angelica Loza-Gomez, MD	GL, SI, MO, Verdugo Dispatch
Saman Kashani, MD	LACoFD
Nicole Mitchell	Redondo Beach FD
Johnna Cobert	UCLA Ctr for Prehospital Care
Adrienne Roel	UCLA Ctr for Prehospital Care
Brian Fong, MD	Cal-Med Ambulance
Travont White	Burbank FD
Joe Nakagawa, MD	Hawthorne PD, LHFD
Theodor Eckland	Pasadena FD
Nanci Medina	LAFD
Caroline Jack	Beverly Hills FD
Salvador Rios, MD	AMR, McCormick, Monrovia FD
Kathyrn Ward	UCLA Ctr for Prehospital Care
Jesse Castillo	PRN Ambulance
Jim Goldsworthy	LAFD Air Ops, Redondo Bch FD
Dave Molyneux	AM West Ambulance

Quorum was established.

1. **CALL TO ORDER –** The meeting was called to order by Vice-Chair Kenneth Powell at 1:02 p.m.

2. **INTRODUCTIONS AND ANNOUNCEMENTS**

2.1 EMS Award Nominations *(Jacqui Rifenburg)*

Submissions for the 2025 California EMS Award nominations are currently open on the EMSA awards page.

2.2 EMS Physicians Trauma Compendium *(Nichole Bosson, MD)*

A summary list of trauma related clinical guidelines released by the National Association of EMS Physicians (NAEMSP) was shared to the committee. This compendium outlines evidence-based recommendations for EMS agencies and clinicians on management of different trauma situations in the field. More to come on the alignment of current EMS policies with the 2025 national best practices.

2.3 EMSAAC Conference 2026 *(Jacqui Rifenburg)*

Scheduled for May 27 and 28, 2026 at the Hilton Los Angeles / Universal City. Two preconference sessions (Disaster and EMS Quality) will be conducted on May 26th.

2.4 Joint Educational Session – End of Life Care (March 3, 2026) *(Shira Schlesinger, MD)*

- The December 2, 2025 Joint Educational session titled "Legal Pitfalls in Responding to Behavioral Crisis" presented by Eric Jaeger, JD, NRP will be available for download to learning management systems (LMS).
- All are invited to attend the PedAC/MAC Joint Educational Session on March 3, 2025, from 11:45 am – 1:00 pm. Topic is titled "End of Life Care" presented virtually by Amelia Breyer, MD, LEMSA Medical Director for San Fransico. 1 hour CE will be provided. CME will not be offered for this session only.

3. APPROVAL OF MINUTES (K. Harter / A. Brown) October 15, 2025, minutes were approved as written.

4. UNFINISHED BUSINESS

Policies for Discussion; Action Required:

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

For consistency respiratory status added to the first section to align with 506.2.

Policy reviewed and approved as written.

M/S/C (A. Brown/ M. Conroy) Approve: Reference No. 506.3, 9-1-1 Interfacility Transfer Checklist for Trauma Re-Triage.

5. NEW BUSINESS

5.1 2025 AHA Updates *(Denise Whitfield, MD)*

Dr. Whitfield reviewed key 2025 American Heart Association (AHA) guideline updates. Select pediatric and adult protocols are under review with anticipated revisions during the April policy update cycle. A final summary of EMS Policy changes to be provided with EMS Update 2026.

Policies for Discussion; Action Required:

5.2 Reference No. 604, Prehospital Care Forms *(Sara Rasnake)*

Policy reviewed and approved as written.

M/S/C (L. Manjarrez / M. Conroy): Reference No. 604, Prehospital Care Forms.

5.3 Reference No. 608, Retention and Disposition of Prehospital Patient Care Records *(Sara Rasnake)*

Policy reviewed and approved as written.

M/S/C (J. Hernandez / A. Brown) Approve: Reference No. 608, Retention and Disposition of Prehospital Patient Care Records.

5.4 Reference No. 840, Medical Support During Tactical Operations *(Nichole Bosson, MD)*

Policy reviewed and approved as written.

M/S/C (K. Harter / A. Brown) Approve: Reference No. 840, Medical Support During Tactical Operations.

5.5 Reference No. 517, Private Provider Agency Transport/Response Guidelines *(Denise Whitfield, MD)*

Policy tabled by the EMS Agency pending review of feedback from the Ambulance Association.

Tabled: Reference No. 517, Private Provider Agency Transport/Response Guidelines.

5.6 Reference No. 815, Honoring Prehospital Do Not Resuscitate Orders, Physician Orders for Life Sustaining Treatment and End of Life Option (Aid-In-Dying Drug) *(Denise Whitfield, MD)*

Policy tabled by the EMS Agency pending discussion on documentation requirement.

Tabled: Reference No. 815, Honoring Prehospital Do Not Resuscitate Orders, Physician Orders for Life Sustaining Treatment and End of Life Option (Aid-In-Dying Drug).

5.7 Reference No. 842, Mass Gathering and Special Events Interface with Emergency Medical Services *(Denise Whitfield, MD)*

Policy reviewed and approved as written.

M/S/C (A. Brown / L. Manjarrez) Approve: Reference No. 842, Mass Gathering and Special Events Interface with Emergency Medical Services.

5.8 Reference No. 842.1, EMS Response Guidelines for Mass Gatherings and Special Events (*Denise Whitfield, MD)*

Policy reviewed and approved as written.

M/S/C (A. Brown / L. Manjarrez) Approve: Reference No. 842.1, EMS Response Guidelines for Mass Gatherings and Special Events.

Policies for Discussion; No Action Required:

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

5.9 Magnesium Sulfate for Pre-Eclampsia/Eclampsia *(Denise Whitfield, MD)*

5.9.1 Reference No. 1217, TP: Pregnancy Complications
Policy to be updated to list Midazolam administration before Magnesium Sulfate for Seizure / Eclampsia (≥ 20 weeks pregnant to 6 weeks postpartum).

5.9.2 Reference No. 1217-P, TP: Pregnancy Complications (Pediatric)
Policy to be updated to list Midazolam administration before Magnesium Sulfate for Seizure / Eclampsia (≥ 20 weeks pregnant to 6 weeks postpartum).

5.9.3 Reference No. 1317.XX, MCG: Drug Reference – Magnesium Sulfate
IM route remains under review pending State clarification and is anticipated to be removed from policy.

5.9.4 Reference No. 1231, TP: Seizure

5.9.5 Reference No. 1200.2, TP: Base Contact Requirements

5.9.6 Reference No. 1200.3, TP Provider Impressions

5.9.7 Reference No. 1202, TP: General Medical

5.9.8 Reference No. 803, Los Angeles County Paramedic Scope of Practice

5.9.9 Reference No. 803.1, Los Angeles County Paramedic Scope of Practice

5.10 Reference No. 1213, TP: Cardiac Dysrhythmias - Tachycardia *(Nichole Bosson, MD)*

5.10.1 Reference No. 1317.1. MCG: Drug Reference – Adenosine
Adenosine 6mg dose removed. Data shows conversion rates are higher with initial dosing of 12mg. Effective July 1, 2026.

5.11 Reference No. 1220, TP: Burns *(Nichole Bosson, MD)*

5.12 Reference No. 1220-P, TP: Burns *(Nichole Bosson, MD)*

5.13 Reference No. 1222-P, TP: Hyperthermia (Environmental) (Pediatric) *(Nichole Bosson, MD)*

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

5.14.1 Ref. No. 1317.3, MCG: Drug Reference – Ondansetron

5.15 Reference No. 1317.1 thru 1317.41, MCG; Drug Reference (Mechanism of Action) *(Shira Schlesinger, MD)*
Drug reference cards were modified with simplified language to improve clarity and understanding.

6. REPORTS AND UPDATES

6.1 Health Data Exchange *(Richard Tadeo)*

- This program continues to progress with additional meetings and hospital participation.
- DHS-IT discovered security issues with non-DHS health systems.
- The first draft of Business Associate Agreements (BAA) between providers and hospitals is anticipated to be completed in the first quarter of 2026 and distributed to providers.

6.2 EMS Update *(Shira Schlesinger, MD)*

- A summary of topics covered in EMS Update 2026 discussed. Train the trainer dates release soon.
- The EMS Agency to distribute a memo regarding 2026 updates in ALS equipment requirements.
- Recommendations of vendors or models for teaching distal femur IO landmarks, please forward to Dr. Schlesinger at sschlesinger2@dhs.lacounty.gov.

6.3 EmergiPress *(Shira Schlesinger, MD)*

The next edition to include Senate Bill (SB) 43, changes to "Gravely Disabled" now defined as a person as a results of mental health disorder, or a co-occurring mental health disorder and severe substance use disorder. Notification of release to be provided.

6.4 ITAC Update *(Tabled)*

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

- ELCoR continues to meet quarterly.
- Dr. Michael Kim is revising the education module for co-response to the agitated person, with focus on law enforcement (LE) officers as the learner.
- AED and optional skills survey was sent to all LE agencies to better understand the status of the system, identify how we can support our LE agencies, and improve LE and EMS engagement.
- For committee topic recommendations, please contact Dr. Bosson at nbosson@dhs.lacounty.gov.

6.6 Research Initiatives and Pilot Studies

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

- 38 patients have been transfused, including the first postpartum hemorrhage.
- The pilot will continue as structured for one year. Strategic planning for expansion remains in progress.

6.6.2 PediDOSE Trial *(Nichole Bosson, MD)*

- Patient enrollment remains ongoing, the study is expected to conclude at the end of August 2026.
- Case reviews have identified instances of weight-based dosing, suggesting outdated reference may still be in use in the field. Paramedics are encouraged to utilize the RAPID LA County Medic mobile application.
- Dr. Bosson thanked all providers for their participation in this pilot project for maintained consistency in PCR completion.

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

- Patient enrollment remains ongoing.
- Dr. Bosson reported improvement with study arm adherence of "even/odd day assignment" for the last 2 months.
- The National study team has provided challenge coins. For thoughts on how EMS could distribute these coins, particularly recognizing people within your organization who have made efforts to make the study successful, please contact Dr. Bosson at nbosson@dhs.lacounty.gov.

6.6.4 California Office of Traffic Safety (OTS) Grants Projects (*Shira Schlesinger, MD*)

The Road Crashes LA County Dashboard is live on the EMS Agency webpage. Dr. Schlesinger provided a brief overview to navigating the dashboard and interpreting the data available.

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

This one-year task force is chaired by Steve Sanko, MD. The mission is to identify strategies to improve outcomes to meet the 2030 American Heart Association goals. All provider agencies received their baseline cardiac arrest data for 2024. Additionally, a letter from the EMS Commission was sent to all provider agencies and hospitals to identify their strategies for targeting improvements in cardiac arrest outcomes.

6.8 Upcoming Mass Gathering Events *(Denise Whitfield, MD)*

- FIFA World Cup 26
  A brief overview of the planning status provided to the group. Dr. Kashani (CF) and Dr. Whitfield will co-lead from a medical perspective. All matches will be at SoFi. Fan fest will take place at the LA Coliseum. Additional fan zones and viewing locations are still being determined. Once all venues determined, plan to move include jurisdictional provider agencies to develop medical action plans. More to come.
- LA 28
  Current focus is on the World Cup; however, planning meetings have commenced. More to come.
- Dr. Kashani announced a tentative date of April 1, 2026, for training on targeted violence to mass gatherings. FEMA will be assisting with this training.

7. OPEN DISCUSSION

7.1 Perspective of Prehospital Providers Survey *(Nichole Bosson, MD)*
Discussed after 6.6.3. UCSF and Alameda EMS have requested assistance to distribute this voluntary opportunity to paramedics in LA County to participate in a study via a virtual interview to better understand how EMS clinicians care for children with acute agitation and behavioral dysregulation. Participants will receive a $100 amazon gift card.

7.2 Chapter 6. Critical and Specialty Care Program Regulations (*Richard Tadeo)*
The draft regulations were approved by the State EMS Commission with an anticipated date for release late Spring 2026.

7.3 Assembly Bill 40 – APOT (*Richard Tadeo)*
EMS Authority has recently revised the APOT audit tool. Provider agencies are encouraged to engage with receiving hospital personnel to better sync facility equipment time (transfer of care) at the time of transfer. Providers facility equipment time is the measure which EMSA will use for their data reports and there is no requirement for the provider to modify the time.

8. NEXT MEETING – February 11, 2026

9. ADJOURNMENT - Meeting adjourned at 2:50 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT-I, PARAMEDIC, MICN)

SUBJECT: **PEDIATRIC PATIENT DESTINATION** REFERENCE NO. 510

PURPOSE: To ensure that 9-1-1 pediatric patients are transported to the most appropriate facility that is staffed, equipped, and prepared to administer emergency and/or definitive care appropriate to the needs of the pediatric patient.

AUTHORITY: Health and Safety Code, Division 2.5, Section 1797.220
California Code of Regulations, Title 13, Section 1105 C

DEFINITIONS:

Brief Resolved Unexplained Event (BRUE): A brief episode characterized by any one of the following (for children 12 months of age or younger): absent, decreased, or irregular breathing; color change (usually cyanosis or pallor); marked change in muscle tone (usually limpness or hypotonia, may also include hypertonia); and/or altered level of responsiveness.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic or comprehensive emergency department that is designated by the Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system.

Newly Born: Infants transitioning from the fluid filled environment of the womb to the air-filled environment. For the purposes of field care and destination, this is also referred to as 'newborn' and includes the period from birth up to 24 hours.

Pediatric Medical Center (PMC): A licensed acute care hospital that is designated by the EMS Agency to receive critically **ill** pediatric patients via the 9-1-1 system based on guidelines outlined in this policy. These centers also provide referral services for critically ill pediatric patients.

Pediatric Patient: Children 14 years of age or younger.

Pediatric Trauma Center (PTC): A licensed acute care hospital that is designated by the EMS Agency to receive critically **injured** pediatric patients via the 9-1-1 system based on guidelines outlined in this policy. These centers provide tertiary-level pediatric care and serve as referral centers for critically injured pediatric patients.

PRINCIPLE:

In all cases, the health and well-being of the patient is the overriding consideration in determining patient destination. Factors to be considered include severity and stability of the patient's illness or injury; current status of the pediatric receiving facility; anticipated transport time; request by the patient, family, guardian or physician; and EMS personnel and base hospital judgment.

POLICY:

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

I. Guidelines for transporting pediatric patients to a specialty care center (i.e., EDAP, PMC, PTC, Perinatal, Sexual Assault Response Team Center, or Trauma Center):

A. Patients who require transport, and do not meet guidelines for transport to a PMC or PTC should be transported to the most accessible EDAP.

1. Newly born patient requiring assisted ventilation and/or chest compression should be transported to the most accessible EDAP that is also a Perinatal Center with a NICU.

2. Newly born patient without distress should be transported to the nearest EDAP that is also a Perinatal Center.

B. BLS units shall call for an ALS unit on pediatric patients who meet criteria for Base Hospital Contact and ALS Transport as listed in Ref. No. 1200.1, Treatment Protocols General Instructions.

C. BLS units shall transport pediatric patients not requiring ALS unit response to the most accessible EDAP unless criteria are met for Treat and Refer as outlined in Ref. No. 834, Patient Refusal of Treatment/Transportation and Treat and Release at Scene.

D. Patients meeting conditions listed in Section II:

1. Should be transported to the most accessible PMC if ground transport is ≤30 minutes.

2. If ground transport time to a PMC is >30 minutes, the patient may be transported to the most accessible EDAP.

E. Patients meeting trauma criteria/guidelines as per Ref. No. 506, Trauma Triage:

1. Should be transported to the most accessible PTC if the transport time is ≤30 minutes.

2. If a PTC cannot be accessed but a trauma center can be accessed under the parameter in (E.1), the patient may be transported to the trauma center.

3. If a PTC or trauma center cannot be accessed as specified above, the patient may be transported to the most accessible PMC, or if >30 minutes to the closet EDAP.

F. Pediatric patients who have an uncontrollable, life-threatening situation (e.g., unmanageable airway or uncontrollable hemorrhage) should be transported to the most accessible EDAP.

G. Pediatric patients may be transported to a non-EDAP provided all of the following are met:

1. The patient, family, or private physician requests transport to a non-EDAP facility.

2. The patient, family, or private physician is made aware that the receiving facility is not an EDAP and may not meet current EDAP standards.

3. The base hospital concurs and contacts the requested facility and ensures that the facility has agreed to accept the patient.

4. All of the above shall be documented on the Patient Care Record.

II. Critically **ill** pediatric patients exhibiting conditions listed below should be transported to a PMC:

A. Cardiac dysrhythmia

B. Severe respiratory distress

C. Cyanosis

D. Altered mental status without signs of improvement

E. Status epilepticus

F. Brief Resolved Unexplained Event (BRUE) ≤12 months of age

G. Focal neurologic signs not associated with trauma (e.g.; pediatric stroke, atypical migraine, petit mal seizures)

H. Post cardiopulmonary arrest in whom return of spontaneous circulation (ROSC) is achieved

IV: For multi-casualty incidents see Ref. No. 519, Management of Multiple Casualty Incidents, for destination.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 316, **EDAP Standards**
Ref. No. 318, **Pediatric Medical Care (PMC) Standards**
Ref. No. 324, **Sexual Assault Response Team (SART) Standards**
Ref. No. 501, **9-1-1 Receiving Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 508.1, **SART Center Roster**
Ref. No. 511, **Perinatal Patient Destination**
Ref. No. 512, **Burn Patient Destination**
Ref. No. 516, **Cardiac Arrest Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 816, **Physician at Scene**
Ref. No. 832, **Treatment/Transport of Minors**
Ref. No. 834, **Patient Refusal of Treatment/Transport and Treat and Release at Scene**

Ref. No. 1200.1, **Treatment Protocols General Instructions**

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

REFERENCE NO. 510, *Pediatric Patient Destination*

	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	12/02/25	12/02/25	
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	12/02/25	12/02/25	
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT-I, PARAMEDIC, MICN)

SUBJECT: **PERINATAL PATIENT DESTINATION** REFERENCE NO. 511

PURPOSE: To provide guidelines for transporting perinatal patients to the most accessible facility appropriate to their needs.

DEFINITIONS:

Emergency Department Approved for Pediatrics (EDAP): A licensed basic or comprehensive emergency department that is designated by the Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system.

Newly born: Infants transitioning from the fluid filled environment of the womb to the air-filled environment. For the purposes of field care and destination, this is also referred to as 'newborn' and includes the period from birth up to 24 hours.

Perinatal: Patients who are at least 20 weeks pregnant.

Perinatal Center: A general acute care hospital with a basic emergency department permit and obstetrical service. This terminology is not intended to indicate the absence or presence of a neonatal intensive care unit (NICU).

PRINCIPLES:

1. Perinatal patients should be transported to the most accessible facility appropriate to their needs. This determination will be made by the base hospital physician or mobile intensive care nurse (MICN) after consideration of the guidelines established in this policy. Final authority for patient destination rests with the base hospital handling the call.

2. If delivery occurs prior to arrival at a hospital, the mother and the newborn should be transported to the same facility.

3. BLS units shall call for an ALS unit on perinatal patients who meet criteria outlined in Ref. No. 1200.4, BLS Upgrade to ALS Assessment; or transport perinatal patients to the most accessible perinatal center.

4. In all cases, the health and well-being of the patient is the overriding consideration in determining patient destination. Factors to be considered include: severity and stability of the patient's illness or injury; current status of the pediatric receiving facility; anticipated transport time; and request by the patient, family, guardian or physician.

5. For destination, specific for the newly born, refer to Ref. No. 510, Pediatric Patient Destination.

POLICY:

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

I. The following perinatal patients should be transported to the most accessible perinatal center:

   A. Patients who appear to be in active labor, whether or not delivery appears imminent

   B. Patients whose chief complaint appears to be related to the pregnancy

   C. Patients who appear to be having perinatal complications

   D. Injured patients who do not meet trauma criteria or guidelines

   E. Patients with hypertension (SBP ≥140mmHg or DBP ≥ 90mmHg)

   F. New-onset seizure

II. Post-partum patients (up to 6 weeks) with hypertension (SBP ≥140mmHg or DBP ≥ 90mmHg) or with new-onset seizure shall be transported to a perinatal center.

III. Perinatal patients who have delivered prior to arriving at a health facility should be transported to the most accessible perinatal center with an EDAP. Also consider a perinatal center with a NICU, per Ref. No. 510.

IV. Perinatal patients meeting trauma criteria and/or guidelines, per Ref. No. 506, Trauma Triage, should be transported to a trauma center.

V. Perinatal patients in cardiac arrest should be transported to a ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) with a Perinatal Center when feasible.

VI. Perinatal patients for whom transportation to a perinatal center would exceed 30 minutes should be transported to a receiving facility which is also an EDAP.

VII. The following perinatal patients should be transported to the most accessible receiving (MAR) facility:

   A. In acute respiratory distress

   B. Chief complaint is clearly not related to the pregnancy

VIII. Consideration may be given by the base hospital to:

   A. Patients who are equal to or less than 34 weeks pregnant, whose chief complaint appears to be related to the pregnancy should be directed to a perinatal receiving facility with a NICU.

   B. Honor patient destination requests for those patients who have made previous arrangements for obstetrical care at a given hospital. This consideration should be based on the following:

      1. If the condition of the patient permits such transport

2. Transportation to the requested obstetrical facility would not exceed 30 minutes and would not unreasonably remove the ALS unit from its area of primary response

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 502, **Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 516, **Cardiac Arrest (Non-Traumatic) Patient Destination**
Ref. No. 834, **Patient Refusal of Treatment/Transport and Treat and Release at Scene**
Ref. No. 1200.4, **BLS Upgrade to ALS Assessment**

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

REFERENCE NO. 511, *Perinatal Patient Destination*

	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	12/02/25	12/02/25	
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	12/02/25	12/02/25	
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PREHOSPITAL CARE FORMS** (EMT, PARAMEDIC, MICN)
REFERENCE NO. 604

PURPOSE: To outline the appropriate process for procurement of prehospital care forms which includes: EMS Report Form, Advanced Life Support (ALS) Continuation Form, Base Hospital Form, Base Hospital Form Page 2, and Base Hospital Multiple Casualty Incident (MCI) Form.

PRINCIPLES:

1. Base Hospital Forms are revised on a regular basis to reflect medical advances, integrate evidence-based medical practices and perform relevant EMS system analysis.

2. EMS Report Forms shall be used as a backup in the event of an electronic patient care report (ePCR) system failure and are not revised or printed on a routine basis.

3. Sequence number duplication is costly and time consuming to correct. Every effort shall be made to ensure that duplication does not occur.

POLICY:

I. EMS Report Forms and Base Hospital Forms provided by the EMS Agency

A. Distribution of Base Hospital Forms

1. The vendor contracted by the EMS Agency distributes Base Hospital Forms quarterly based on projected base contact call volume.

2. The EMS Agency will:

a. Coordinate the form distribution with the form vendor to ensure base hospitals have a sufficient supply of forms available.

B. Requests for Base Hospital Page 2 and Base Hospital MCI Forms

1. The requesting party shall e-mail their request to the EMS Agency's Base Hospital Coordinator for Base Hospital Page 2 or Base Hospital MCI forms as soon as the need becomes evident.

2. The EMS Agency will acknowledge the request and confirm pick up arrangements with the requesting party.

C. EMS Report Forms and ALS Continuation Forms

1. The public and private EMS provider shall:

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

a. Contact the EMS Agency's Data Systems Management Chief (or designee) to coordinate a date and time to pick-up EMS Report Forms or ALS Continuation Forms at the EMS Agency at least one week prior to desired form pick-up date.

b. Shall maintain EMS Agency-supplied EMS Report forms on each apparatus, to be utilized only during electronic patient care record (ePCR) system failure.

2. The EMS Agency shall maintain an inventory of forms distributed and reconcile monthly with the form vendor's records.

II. Base Hospital Forms **NOT** provided by the EMS Agency

A. Form Approval Procedure

1. The requesting base hospital shall submit a written request to the Director of the EMS Agency advising the EMS Agency of their desire to utilize their own form.

2. Submit a DRAFT form to the EMS Agency for approval prior to printing the forms. Each time a revision is made, the form shall be approved prior to printing.

3. Forms must include all appropriate copies for distribution and contain all current data elements.

B. Form Printing Procedure

1. Print no more than a one-year supply of forms as data elements may change.

III. Fees

A. There is no charge to utilize EMS Agency-supplied EMS Report Forms or Base Hospital Forms.

B. Base hospitals utilizing their own forms are responsible for all costs incurred by such processes.

CROSS REFERENCES:

Prehospital Care Manual
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 608, **Retention and Disposition of Prehospital Patient Care Records**

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

REFERENCE NO. 604, *Prehospital Care Forms*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee	12/10/25	12/10/25	
	Provider Agency Advisory Committee	12/17/25	12/17/25	
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:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **RETENTION AND DISPOSITION OF PREHOSPITAL PATIENT CARE RECORDS** (EMT, PARAMEDIC, MICN) REFERENCE NO. 608

PURPOSE: To outline the appropriate procedure for retention and disposition of Prehospital Patient Care Records which includes but is not limited to the following formats: electronic patient care record (ePCR), EMS Report Form, Base Hospital Form, Multiple Casualty Incident (MCI) Base Hospital Form, Base Hospital Form Page 2, Advanced Life Support (ALS) Continuation Form, Triage Tags, base hospital radio contact logs, base hospital medical control audio recordings, and private provider agency patient care records.

AUTHORITY: California Code of Regulations, Title 22, Sections 100128, 100170
California Welfare and Institutions Code Section 14124.1
California Health and Safety Code section 1797.98(e)
Health Insurance Portability and Accountability Act of 1996

PRINCIPLES:

1. Prehospital patient care records contain patient information which is protected under the Health Insurance Portability and Accountability Act (HIPAA) and shall be maintained in accordance with HIPAA regulations.

2. Prehospital care providers and base hospitals have an obligation to ensure the security of confidential patient information.

3. Personnel responsible for all aspects of prehospital patient care record maintenance (including data entry personnel) shall receive appropriate training related to patient care record confidentiality.

4. Prehospital patient care records shall be maintained in a secure location with access limited to authorized personnel.

5. Provider agencies and base hospitals are responsible for maintaining the original copy of prehospital patient care records.

6. Original patient care records of all patients shall be retained for a minimum of seven years. Original patient care records of minors shall be kept for at least one year after such minors have reached the age of 18, but in no event less than seven years following the provision of service.

7. Records shall be accessible for audit review by EMS Agency personnel.

8. All records related to either suspected or pending litigation shall be retained indefinitely.

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

POLICY:

I. Provider Agency Prehospital Patient Care Records:

A. EMS Report Forms and ALS Continuation Forms are utilized only during electronic patient care record (ePCR) system failure and are distributed as follows:

1. White (Original) - Retained by the EMS Provider Agency that initiates the form.

2. Red (Receiving Hospital) - Left with the receiving facility for transported patients. This copy becomes part of the patient's medical record at the receiving facility. If the patient is not transported, disposition is at the discretion of the EMS Provider Agency that initiates the form.

3. Yellow (EMS Agency) - Sent to the EMS Agency within 30 days of the last day of the preceding month. The EMS Agency shall retain until the data has been entered into the Trauma Emergency Medical Information System (TEMIS) database.

B. Private provider agency-specific, non-9-1-1 prehospital patient care records are completed for all patients and are distributed as follows:

1. Original copy - Retained by the private provider agency that initiates the form.

2. Duplicate copy – Left with the receiving facility for patients transported to a healthcare facility. This copy becomes part of the patient's medical record at the receiving facility. If patient is not transported to a healthcare facility, disposition is at the discretion of the private provider agency that initiates the form.

C. Triage Tags - In the event of a multiple casualty incident where triage tags are utilized, the original triage tag will remain with the patient, if transported, the triage tag should become part of the patient's medical record at the receiving facility. If the patient is not transported, the triage tag is to be retained as the original patient care record.

II. Base Hospital Records: Base Hospital Form, MCI Base Hospital Form, and Base Hospital Form Page 2 are utilized, as applicable, for all patients requiring base hospital contact and are distributed as follows:

A. White (Original) - Retained by the Base Hospital that initiates the form.

B. Complimentary - Used at the discretion of the Base Hospital.

C. Complimentary - Used at the discretion of the Base Hospital.

III. Maintenance of Prehospital Care Patient Records

A. Prehospital patient care records shall be delivered to the EMS Agency in a manner that ensures form security and patient confidentiality.

B. Prehospital patient care records in paper format, may be stored electronically upon written approval by the EMS Agency.

IV. Destruction of Prehospital Care Patient Records

A. Prehospital patient care records that are eligible for destruction shall be disposed of in accordance with all applicable laws.

B. Complimentary and supplemental copies of prehospital patient care records shall be disposed of in accordance with all applicable laws.

CROSS REFERENCES:

Prehospital Care Policy Manual:
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**

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

REFERENCE NO. 608, *Retention and Disposition of Prehospital Care Patient Records*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee	12/10/25	12/10/25	
EMS ADVISORY	Provider Agency Advisory Committee	12/17/25	12/17/25	
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:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC)

SUBJECT: **LOS ANGELES COUNTY PARAMEDIC SCOPE OF PRACTICE** REFERENCE NO. 803

PURPOSE: To define the scope of practice of a paramedic accredited in Los Angeles County.

AUTHORITY: California Health and Safety Code, Division 2.5, Section 1797.172
California Code of Regulations, Title 22, Chapter 4, Section 100145.

DEFINITION:

Los Angeles County Paramedic Scope of Practice: Skills, procedures, and medication administration approved by the Los Angeles County EMS Agency Medical Director.

PRINCIPLES:

1. Paramedics working in Los Angeles County shall be trained and tested in the Los Angeles County paramedic scope of practice approved by the EMS Agency Medical Director.

2. Procedures or medications may be added as part of the Los Angeles County scope of practice or through a trial study.

3. A paramedic may perform any activity identified in Ref. No. 802, Los Angeles County EMT Scope of Practice.

4. Paramedics shall be licensed in the State, accredited by the County, employed, and sponsored by an approved paramedic service provider. The paramedic shall be on duty in order to perform the Los Angeles County paramedic scope of practice.

5. Advanced life support activities carried out by paramedics at the scene of a medical or trauma emergency or during transport shall be under the following conditions:

    a. Offline medical control following Ref. No. 1200, Treatment Protocols, et al.

    b. Online medical direction by a base hospital physician or Mobile Intensive Care Nurse (MICN)

    c. Direct medical supervision as outlined in Ref. No. 816, Physician at the Scene.

POLICY:

I. A Los Angeles County accredited paramedic or a supervised paramedic intern is authorized to perform and utilize all aspects of the Los Angeles County Paramedic Scope of Practice during training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfers.

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

The paramedic scope of practice includes Ref. No. 802, Los Angeles County EMT Scope of Practice, in addition to the following:

A. Patient assessment:

1. Use capnometry and measuring devices to measure capnography waveforms

2. Utilize electrocardiographic devices and monitor electrocardiogram, including 12-lead electrocardiograms (ECG) per Ref. No. 1308, Medical Control Guideline: Cardiac Monitoring / 12-Lead ECG

3. Obtain venous or capillary blood samples

4. Use electronic devices to measure glucose

B. Airway management and monitoring:

1. Use basic and advanced airway maneuvers as per Ref. No. 1302, Medical Control Guideline: Airway Management and Monitoring

2. Utilize mechanical ventilation devices for continuous positive airway pressure per Ref. No. 1315, Medical Control Guideline: Continuous Positive Airway Pressure (CPAP)

C. Rescue and emergency care:

1. Perform needle thoracostomy per Ref. No. 1335, Medical Control Guideline: Needle Thoracostomy

2. Perform defibrillation

3. Perform synchronized cardioversion

4. Perform transcutaneous pacing per Ref. No. 1365, Medical Control Guideline: Transcutaneous Pacing (TCP)

5. Utilize Valsalva maneuver

6. Monitor thoracostomy tubes

7. Monitor blood product transfusions

D. Intravenous, intraosseous and pre-existing vascular access devices (PVAD) per Ref. No. 1375, Medical Control Guideline: Vascular Access

E. Medication Administration:

1. Administer approved medications by the following routes:

a. Oral

b. Intranasal

c. Sublingual

d. Transcutaneous

e. Topical

f. Inhalation

g. Rectal

h. Intravenous

i. Intraosseous

j. Intramuscular

k. Subcutaneous

2. Administer and/or monitor the following medications (using pre-packaged unit dose products when available):

a. 10%, 25%, and 50% dextrose

b. adenosine

c. aerosolized/nebulized albuterol by hand held nebulizer or hand held mask

d. amiodarone

e. aspirin

f. atropine sulfate

g. blood products (monitoring transfusion)

h. buprenorphine (if approved agency)

i. calcium chloride

j. diazepam *(disaster caches only)*

k. diphenhydramine hydrochloride

l. epinephrine

m. fentanyl

n. glucagon

o. hydroxocobalamin

p. ketorolac

q. lidocaine

r. magnesium sulfate

s. midazolam

t. morphine sulfate

u. naloxone hydrochloride

v. normal saline solution

w. nitroglycerin tablet or spray

x. olanzapine

y. ondansetron

z. potassium, equal to or less than 40meq/L *(transport infusion only)*

aa. pralidoxime chloride (2-PAMCl)

bb. sodium bicarbonate

cc. total parenteral nutrition *(transport infusion only)*

dd. tranexamic acid

II. Pilot Programs

Procedures or medications may be implemented on a trial basis when approved by the Medical Director of the EMS Agency.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 802, **EMT Scope of Practice**
Ref. No. 802.1, **Los Angeles County EMT Scope of Practice**
Ref. No. 803.1, **Los Angeles County Paramedic Scope of Practice**
Ref. No. 816, **Physician at the Scene**
Ref. No. 830, **Paramedic Trial and Scientific Studies**
Ref. No. 1006, **Paramedic Accreditation, Continuous Accreditation, and Reaccreditation**
MCG. No. 1333, **Monitoring Transfusion of Blood Products**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **LOS ANGELES COUNTY PARAMEDIC SCOPE OF PRACTICE**

REFERENCE 803.1

IN ADDITION TO THE FOLLOWING, THE PARAMEDIC SCOPE OF PRACTICE INCLUDES REFERENCE NO. 802, LOS ANGELES COUNTY EMT SCOPE OF PRACTICE

PATIENT ASSESSMENT

1. Use capnometry and measuring devices to measure capnography waveforms
2. Utilize electrocardiographic devices and monitor electrocardiograms (ECG), including 12-lead ECGs
3. Obtain venous or capillary blood samples
4. Use electronic devices to measure glucose

AIRWAY MANAGEMENT & OXYGEN ADMINISTRATION

1. Use a laryngoscope to visualize the airway and remove a foreign body with Magill forceps
2. Insert and perform pulmonary ventilation by use of:
   a. supraglottic airway (i-gel) in adult and pediatric patients
   b. oral endotracheal intubation in adults and pediatric patients over the age of twelve (12) or height greater than the length of the pediatric resuscitation tape
   c. stomal intubation
3. Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP).

RESCUE & EMERGENCY CARE

1. Perform needle thoracostomy
2. Perform defibrillation
3. Perform synchronized cardioversion
4. Perform transcutaneous pacing for symptomatic bradycardia
6. Utilize Valsalva maneuver
7. Monitor thoracostomy tubes
8. Monitor blood product transfusions

INTRAVENOUS & INTRAOSSEOUS ACCESS

1. Insert intravenous (IV) catheters, saline locks, or needles in peripheral veins
2. Monitor and administer medications and IV fluids through external venous pre-existing vascular access devices (PVADs) in the following:
   a. cardiac arrest
   b. extremis due to circulatory shock
   c. base station order
3. Monitor and administer normal saline solution
4. Monitor and adjust IV solutions of potassium, maximum 40mEq/L
5. Monitor total parenteral nutrition (TPN)
6. Perform adult and pediatric intraosseous insertion per Ref. No. 1375

MEDICATION ADMINISTRATION

1. Administer approved medications by the following routes:
   a. oral
   b. intranasal
   c. sublingual
   d. transcutaneous
   e. topical
   f. inhalation
   g. rectal
   h. intravenous
   i. intraosseous
   j. intramuscular
   k. subcutaneous
2. Administer the following medications (using pre-packaged unit dose products when available):
   a. 10%, 25%, and 50% dextrose
   b. adenosine
   c. aerosolized/nebulized albuterol by handheld nebulizer or handheld mask
   d. amiodarone
   e. aspirin
   f. atropine sulfate
   g. buprenorphine (if approved agency)
   h. calcium chloride
   i. diazepam *(disaster caches only)*
   j. diphenhydramine hydrochloride
   k. epinephrine
   l. fentanyl
   m. glucagon
   n. hydroxocobalamin
   o. ketorolac
   p. lidocaine
   q. magnesium sulfate
   r. midazolam
   s. morphine sulfate
   t. naloxone hydrochloride
   u. nitroglycerin tablet or spray
   v. olanzapine
   w. ondansetron
   x. pralidoxime chloride (2-PAMCl)
   y. sodium bicarbonate
   z. tranexamic acid (TXA)

PILOT PROGRAM

Procedures or medications may be implemented on a trial basis when approved by the Medical Director of the EMS Agency.

CROSS REFERENCES:

SUBJECT: **LOS ANGELES COUNTY PARAMEDIC SCOPE OF PRACTICE**

REFERENCE 803.1

	Prehospital Care Manual: Ref. No. 802 Ref. No. 802.1 Ref. No. 803 Ref. Series 1200s Ref. Series 1300s

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

REFERENCE NO. 803 & 803.1, *Paramedic Scope of Practice (policy) and Field Reference*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee	12/10/25	12/10/25	
	Provider Agency Advisory Committee	12/17/25	12/17/25	
OTHER COMMITTEES / RESOURCES	Medical Council	12/02/25	12/02/25	
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **MEDICAL SUPPORT DURING TACTICAL OPERATIONS**

EMT, PARAMEDIC, MICN, PHYSICIAN
REFERENCE NO. 840

PURPOSE: To provide direction for tactical emergency medical services (TEMS) personnel assigned to a tactical team by an agency that is conducting a preplanned law enforcement incident.

To provide guidance for emergency transportation operational canines injured in the line of duty.

AUTHORITY: Health and Safety Code 1797.10, 1797.220, 1797.221, 1798
California Code of Regulations, Title 22, Division 9, Chapter 3

DEFINITIONS:

Peace Officer Standards and Training (POST): The California Commission on Peace Officer Standards and Training develops training standards and evaluates/approves curriculum for basic police officer training programs in California.

Tactical Medicine Training Program: A POST-certified and EMSA-approved, specific operational training program for tactical medicine providers and operators that trains EMS personnel to safely deliver medical care during a law enforcement response.

Tactical Emergency Medical Services (TEMS) Personnel: Physicians, Emergency Medical Technicians (EMTs), paramedics or Mobile Intensive Care Nurses (MICNs) that have successfully completed a tactical medicine training program, that provide medical care during a tactical response utilizing their authorized scope of practice.

Weapons of Mass Destruction (WMD): Weapons or devices intended to cause death or serious bodily injury to a significant number of people through the release of toxic chemicals. A disease organism, or radiation.

Hot Zone: The area in which there is a direct and immediate threat.

Warm Zone: The area deemed by law enforcement to no longer have direct or immediate threats, which can be utilized to perform tactical field care and triage of victims.

Cold Zone: The area where no significant danger or threat is reasonably anticipated for the provider or patient.

Operational Canine (K-9): A dog that is part of a team of law enforcement officers or EMS providers, with specific training in and duties that may include, but not limited to, search and rescue, passive alert dog, and service dog.

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

PRINCIPLES:

1. Training is a critical role in the ability of TEMS personnel to effectively support law enforcement and contribute to the safe and successful resolution of critical incident responses.

2. These guidelines are not intended to replace existing EMS policies or circumvent the established response of EMS in the local county.

3. While medical support is important at any tactical operation, agencies should carefully consider the risk versus benefit of adding armed personnel with limited firearms and tactical experience.

4. Approach to care should follow the principles of Tactical Emergency Casualty Care (TECC) where the priority in the hot zone is patient evacuation and hemorrhage control, limited care is provided in the warm zone to address immediate life threats and additional patient care should ideally be provided in the cold zone.

5. The TEMS provider agency should participate in the pre-planning of incident management.

6. EMS personnel who operate in the cold zone should receive an orientation to TEMS operations.

7. K-9 units are an integral part of the team, working collaboratively with EMS responders and police officers as first responders to incidents and crime scenes. Operational K-9s injured in the line of duty may require immediate transport to a facility capable of caring for their injuries.

POLICY:

I. Certification

   A. Paramedics and MICNs that are a member of a TEMS team shall be employed on duty and sponsored by an approved Advanced Life Support (ALS) provider.

      1. Paramedics shall be licensed by the State and accredited in Los Angeles County.

      2. MICNs shall have a current California license as a Registered Nurse and a current Los Angeles County MICN certification.

   B. EMTs shall be certified by the State and have successfully completed the Los Angeles County local scope of practice.

II. Training

   A. TEMS personnel who operate within a hot zone shall be trained, at minimum, through a POST-certified and EMSA-approved or equivalent tactical medicine training program. The training hour requirements as outlined in POST/EMSA Recommendations are:

1. Non-law enforcement TEMS personnel

    a. An 80-hour minimum course which includes didactic and skills training, tactical weapons operations, medical scenarios and includes final written, skills and tactical medical scenario examinations.

2. Law Enforcement TEMS personnel

    a. Must be pre-qualified by successful completion of a POST-approved Basic Special Weapons and Tactics (SWAT) course and an approved WMD training including medical care for WMD.

    b. A 40-hour minimum course which includes didactic and skills training, medical scenarios and includes final written, skills and tactical medical scenario examinations.

III. Deployment

A. TEMS personnel should be familiar with the location of the nearest medical centers, paramedic base hospitals and specialty centers such as trauma, pediatric trauma centers, etc.

B. When responding to jurisdictions outside of Los Angeles County, TEMS personnel shall operate within their accredited scope of practice.

IV. Emergency Treatment and Transportation of an Injured Operational K-9

A. A licensed Los Angeles County Ambulance Operator is authorized to transport an operational K-9 injured in the line of duty, to a veterinary medical facility capable of treating the K-9 if the unit is unencumbered and no person is requiring medical services of the ambulance at the time the decision is made to transport the K-9.

B. It is the responsibility of the handler to maintain control of the K-9 while providing medical treatment en-route. If comfortable, EMS personnel may assist in the moving and transportation of the K-9 while allowing the necessary space in the back of the ambulance for the handler to render care.

C. An injured K-9 may be aggressive towards its handler, therefore, the EMS personnel should only assist with the K-9’s care when it is determined to be safe and at the direction of the handler.

D. The handler is responsible to have all necessary equipment and supplies to care for the injured K-9. EMS personnel may provide additional supplies (dressings, etc.) as needed.

E. It is the handler’s responsibility to be familiar with, and provide directions to, the most appropriate receiving veterinary facility. EMS personnel, or their dispatch, at the request of the handler, may contact the veterinary facility (contact information will be provide by the handler) while en-route, in order to provide an estimated time of arrival to the facility.

CROSS REFERENCES:

Prehospital Care Policy Manual:
Ref. No. 422, **Authorization for Paramedic Provider Status of a Los Angeles County Based Law Enforcement Agency**
Ref. No. 502, **Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 802, **Emergency Medical Technician (EMT) Scope of Practice**
Ref. No. 802.1, **EMT Scope of Practice, Table Forma)**
Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**
Ref. No. 803.1, **Los Angeles County Paramedic Scope of Practice, Table Format**
Ref. No. 1006, **Paramedic Accreditation**
Ref. No. 1010, **Mobile Intensive Care Nurse (MICN) Certification/Recertification**

California Peace Officer Standards and Training (POST) in collaboration with the Emergency Medical Services Authority, *Tactical Medicine, Operational Programs and Standardized Training Recommendations*, July 2009.

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

REFERENCE NO. 840, *Medical Support During Tactical Operations*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee	12/10/25	12/10/25	
	Provider Agency Advisory Committee	12/17/25	12/17/25	
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:			

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, HOSPITALS)

SUBJECT: **MASS GATHERING AND SPECIAL EVENTS INTERFACE WITH EMERGENCY MEDICAL SERVICES**

REFERENCE NO. 842

PURPOSE: To establish guidelines for the delivery of Emergency Medical Services (EMS) to protect the health and safety of the participants during mass gatherings and special events of various size and intensity so that participants have access to the appropriate level of care and to minimize the impact of these events on the local EMS system.

AUTHORITY: Health & Safety Code, Sections 1797.202, 1797.204, 1797.220, 1798, 1798.6(a)
Health Insurance portability and Accountability Act 164.501
California Code of Regulations, Title 22, Sections 100063, 100144, 100167(a), 100169
Los Angeles County Code Title 7, Business Licenses, Chapter 7.16, Ambulances

DEFINITIONS:

After Action Review/Report (AAR): A structured review or de-briefing process for analyzing what happened, why it happened, and how it can be done better by those responsible for an event.

Build in/build out plan (also known as "set-up" and "strike out"): Refers to terminology related to special events for the "set up" of a permitted and approved floor plan on/in a stadium, field, building or other structure. "Strike out" is the process in set construction of dismantling, storing or discarding the materials used.

Event Action Plan: A plan that contains objectives that reflect the event strategy and specific control actions for the event. The Medical Action Plan is the part of the Event Action Plan that is specific to medical resources and assignments.

Event Footprint: The area(s) that is within the control of the event promoter, which may include the venue, the parking lot, and any extended area in which an event is being held.

Event Medical Facility: The main medical facility in which medical care is being provided and/or being directed during a mass gathering or special event. This may include a first aid station, medical station, or any combination thereof.

Harm Reduction: Policies, programs and practices that aim primarily to reduce the adverse health, social and economic consequences, such as alcohol and drug education pamphlets etc.

Intensity of Event: The level of intensity (low, medium, or high) as designated by jurisdictional provider agency, is based on the number of attendees, weather considerations, geography, the propensity for alcohol and/or drug use, physical exertion, duration, and history of like events

Jurisdictional Provider Agency: The local fire department.

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

Mass Gathering: An organized assembly of 5,000 or more people.

Medical Action Plan (MAP): A plan that explains the medical resources, services, and coordination that will be provided during an event that is provided by the promoter/venue.

Medical Alert Center (MAC): Assists provider agencies and base hospitals with patient destination decisions and multiple casualty incidents. It serves as the control point for VMED28 and ReddiNet systems.

Participant: Any person attending or working at the event.

Recurring Events: A mass gathering that occurs on a daily, weekly, monthly, seasonally, or annual basis at a fixed venue and with an existing developed (proven/successful) plan to manage the health and safety of participants and type of event. Examples include professional sport event, the annual county fair, etc.

Special Event: A gathering that does not meet the definition of a mass gathering, but has the potential to impact the local EMS response, as determined by the jurisdictional provider's discretion. Examples could include a parade, one time concert, etc.

PRINCIPLE:

A Medical Action Plan (MAP) shall be created for every mass gathering or special event at the request/discretion of the jurisdictional provider agency.

POLICY:

I. The Medical Action Plan (MAP) shall include, but not be limited to, the following considerations:

   A. Event description, including event name, and expected number of participants.

   B. Participant safety (may include an extended footprint) including harm reduction.

   C. Communications Plan that secures a mechanism for direct, two-way communication between the jurisdictional provider agency and medical staff. Consider the following:

      - Two-way radios
      - Cellular service may be overwhelmed
      - Coordination with the MAC

   D. Medical resources that are appropriate to the number of participants – to include quantities, locations, hours of operation, and staffing levels (Advanced Life Support (ALS), Basic Life Support (BLS), Medical Doctor (MD), Registered Nurse (RN), and volunteers for the following:

      - Transport ambulances
      - Fixed resources –first aid stations, event medical facility
      - Mobile resources- mobile teams/carts, foot/cycle teams
      - Contingency plan if resources become overwhelmed

E. Weather related plans

F. Evacuation plan

G. Build in/build out plan

II. Responsibility of the Promoter/Event Venue

A. Notify the jurisdictional provider agency of the event, participate in the permitting process, develop and review the event MAP with the event medical staff and the jurisdictional provider agency.

B. Submit the MAP for approval to the jurisdictional provider agency at a minimum of twenty-one (21) calendar days prior to the event.

C. Submit any final changes to the MAP to the jurisdictional provider agency at a minimum of seventy-two (72) hours prior to the event. The jurisdictional provider agency will respond within twenty-four (24) hours.

D. Utilize ambulance operators licensed by Los Angeles County (Ref. No. 401.1, Licensed Ambulance and EMS Aircraft Operators) with a minimum of Basic Life Support (BLS) level of service.

E. Incorporate and utilize harm reduction programs for events when applicable.

F. Participate in an AAR upon the request of the jurisdictional provider agency or the Los Angeles County EMS Agency. AARs shall be held within fourteen (14) days post-event unless otherwise approved by the jurisdictional provider agency.

III. Responsibility of the Jurisdictional Provider Agency

A. Review and respond to EAP and the MAP within fourteen (14) calendar days prior to the event. Respond to any final changes to the MAP within twenty-four (24) hours.

B. Verify EMS personnel utilized in the event are appropriately licensed, accredited, and/or certified in Los Angeles County.

To verify an EMT/Paramedic:
https://emsverification.emsa.ca.gov/Verification/

To verify a registered nurse/licensed vocational nurse/physician:
https://www.breeze.ca.gov/

To verify a physician is Board Certified or Board Eligible in Emergency Medicine:
https://www.certificationmatters.org/find-my-doctor/.org

C. When necessary to protect health and safety, may require additional or more stringent requirements than listed in this policy (i.e., medical staffing requirements).

D. Educate the event promoter/venue regarding licensed ambulance company capabilities and hospital resources.

E. Notify the Los Angeles County EMS Agency MAC at 866-940-4401 or via email at lemsadutyofficer@dhs.lacounty.gov of the event as soon as possible, if there is an anticipated regional or multi-jurisdictional impact to the EMS system.

F. Assist with the coordination of the AAR for any event that meets the definition of Multiple Casualty Incident (MCI) as outlined in Ref. No. 519, Management of Multiple Casualty Incidents.

IV. Responsibility of the Emergency Medical Services (EMS) Agency

A. The EMS Agency Medical Director, upon request will:

1. Coordinate a review of the MAP and provide recommendations to the event medical provider and the jurisdictional provider agency

2. Respond within three (3) business days

A sample MAP is included in Ref. No. 842.2, Mass Gathering and Special Events Medical Action Plan

B. Medical Alert Center (MAC), upon request will:

1. Notify the hospitals surrounding the event at least seven (7) calendar days prior to the event

2. Assign personnel to staff the event command center upon request of the jurisdictional provider agency

3. Poll area hospitals for emergency department capacity as needed

4. Monitor the number of patient transports during the event.

5. Open an MCI on the ReddiNet when the number of patients and types of illnesses/injuries are expected to exceed the capabilities of the nearest hospitals.

a. Provide patient destination

b. Notify the Medical Officer on Duty (MOD) and the Administrator on Duty (AOD)

c. Provide a summary of incident with final disposition of all patients to the jurisdictional provider agency and EMS Agency Administration within 72 hours post event.

6. In accordance with Ref. No. 519, Management of Multiple Casualty Incidents, assist with an AAR as needed or requested.

V. Responsibility of the Event Medical Provider

A. Provide adequate equipment and supplies to manage care based on the level of service (BLS, ALS) and number of participants.

B. Identify the event medical facility and ambulance staging locations.

C. Submit a list of event medical personnel to the jurisdictional provider agency at least ten (10) calendar days prior to the event to include:

- Name of person
- Type of license or certification (EMT, Paramedic, Nurse, or Physician), number and expiration date
- Include all volunteers or non-licensed personnel or students that will be attending the event, if applicable.

A sample roster is included in Ref. No. 842.3, Mass Gathering and Special Events Event Roster.

D. Submit any changes to previously approved event personnel to the jurisdictional provider agency at least seventy-two (72) hours prior to the event. The jurisdictional provider agency will respond within twenty-four (24) hours.

E. Maintain a patient care log, to be submitted to the EMS Agency and the jurisdictional provider agency within seventy-two (72) hours after the conclusion of the event, which shall include at a minimum:

- Patient information or patient identifier
- Age
- Chief complaint
- Treatment
- Disposition
- Diagnosis, if a physician is on site
- Destination, if transported

A sample patient care log is included in Ref. No. 842.4, Mass Gathering and Special Event Patient Care Log

F. A patient care record (PCR) shall be generated for each patient that receives an assessment and/or treatment at a mass gathering or special event. All patient care should be documented in accordance to Ref. No. 606, Documentation of Prehospital Care.

G. Provide patient care records (PCRs) for review by the EMS Agency or jurisdictional provider agency when requested.

H. Participate in the After Action Review/Report (AAR) as requested.

VI. Responsibility of the Prehospital Providers

A. Nurses shall be licensed by the State of California and preferably have experience in emergency medical care and triage of seriously ill or injured patients.

B. Paramedics shall be licensed by the State of California, accredited in Los Angeles County and on duty for an approved LA County ALS provider.

C. EMTs shall be certified by the State of California and adhere to the Los Angeles County Scope of Practice.

D. Assess participants and escort them to the event medical facility, as appropriate, and per the event's MAP. Following assessment, the participant shall be referred to the event physician on scene, if applicable. If medical staffing levels do not include a physician, EMS providers will follow Ref. No. 1200, Treatment Protocol, et al.

E. Participants must be medically appropriate to be transported to the event medical facility that is staffed with a licensed health care professional. Medically appropriate patients may include altered level of consciousness (ALOC) without evidence of head trauma or history of recent seizure or active seizure. Any patient meeting Ref. No. 506, Trauma Triage criteria shall be transported directly to a trauma center coordinated through MAC or the jurisdictional provider without delay, or if neither are available, contact the designated base hospital.

F. Once the event has been declared an MCI, the paramedics shall take direction from the MAC or jurisdictional provider for patient destination and treatment per Ref No. 1200, Treatment Protocol, et al.

VII. Responsibility of the Primary Contracted Physician at the Event, if applicable

A. Be Board Certified in Emergency Medicine and familiar with the Los Angeles County Paramedic and EMT scopes of practice. Additional physicians must be Board Certified or Board Eligible in Emergency Medicine.

B. Be familiar with the Los Angeles County prehospital care policies.

C. Maintain communication with the jurisdictional incident commander, event coordinator and other medical staff.

D. Take responsibility for medical oversight of all licensed or certified health care professionals providing patient care at the event.

E. Take responsibility for the care and disposition for all patients at the designated event medical facility.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 412, **EMT Automated External Defibrillator (AED) Service Provider Program Requirements**
Ref. No. 506, **Trauma Triage**
Ref. No. 517, **Private Provider Agency Transport / Response Guidelines**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 802, **EMT Scope of Practice**
Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**
Ref. No. 816, **Physician at the Scene**
Ref. No. 842.1, **Resource Guidelines for Mass Gatherings and Special Events**
Ref. No. 842.2, **Mass Gathering and Special Events Medical Action Plan (MAP)**
Ref. No. 842.3, **Mass Gathering and Special Events Event Roster**
Ref. No. 842.4, **Mass Gathering and Special Events Patient Care Log**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, HOSPITALS)

SUBJECT: **EMS RESOURCE GUIDELINES FOR MASS GATHERINGS AND SPECIAL EVENTS**

REFERENCE NO. 842.1

PURPOSE: To establish resource guidelines for Emergency Medical Services (EMS) during mass gatherings and special events of various sizes and intensity.

AUTHORITY: Health & Safety Code, Section 1797.220
Los Angeles County Code Title 7, Business Licenses, Chapter 7.16, Ambulances

DEFINITIONS:

Cooling Station: An air-conditioned public facility or shelter where people may go for relief during periods of extreme heat.

Event Medical Facility/Medical Station: A temporary location with the ability to provide basic and advanced medical care.

An Event Medical Facility/Medical Station/First Aid Station may be staffed with a:

Emergency Medical Responder (EMR): A person who is trained to provide first aid.

EMT: A person who is trained to provide first aid level care within the scope of practice of an Emergency Medical Technician (EMT) that is currently licensed by the State of California and LA County accredited.

Paramedic: A person who is trained to provide advanced first aid level care within the scope of practice of a paramedic that is currently licensed by the State of California, LA County accredited, and on-duty for an approved ALS provider in Los Angeles County.

Nurse: The nurse must hold a current California license. It is preferred that the nurse have experience in emergency medical care and triage of seriously ill or injured patients.

Physician: The physician must hold a current California license and be Board Certified or Eligible in Emergency Medicine.

First Aid Station: A temporary location with the ability to provide first aid and/or basic medical care.

Medical Cart: A motorized, drivable mode of transportation (e.g. golf cart or all-terrain vehicle (ATV)), approved by the EMS Agency if ALS response, with the capacity to transport a patient in the supine position to the first aid station, and is staffed with a mobile team.

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

Mobile Cart: A motorized, drivable mode of transportation (e.g. golf cart or ATV), approved by the EMS Agency if ALS response, with the capacity to transport a patient in a sitting position and is staffed with a mobile team.

Mobile Teams: A team of two or more EMT or higher medical personnel that has appropriate treatment supplies commensurate to the provider's skill level, and has communications capability with, at a minimum, the First Aid Station. Mobile teams are separate from ambulance personnel.

Warming Station: A shelter where people can go to stay warm and dry.

PRINCIPLES:

1. Mass gathering events should have event-specific medical action plans (MAP) that meet guidelines outlined in this policy. Some events, such as high intensity events, may require additional resources in order to protect health and safety beyond these recommendations. Final approval of a MAP is at the discretion of the jurisdictional provider agency.

2. Staffing modifications may be required by the jurisdictional provider agency based on the type of event.

POLICY:

I. The jurisdictional provider agency may require the event venue/promoter to make free drinking water readily available.

II. Event venue/promoter must provide adequate signage to direct participants to medical/first aid stations, water, and cooling/warming stations.

III. Depending on history and size of an event, the jurisdictional provider agency and/or EMS Agency may require additional medical resources including but not limited to medical personnel, an onsite medical aid facility, and additional private provider ambulance resources in order to safely provide services at an event and decrease the impact on the local 9-1-1 response. Additionally, the event medical aid facility may be required to provide services for up to four hours or more post event to ensure continuation of medical care and to provide ongoing medical coverage for event participants.

IV. All on site medical personnel shall be accredited/certified/licensed and follow Los Angeles County Prehospital Care Policies and Protocols.

V. All medical equipment and supplies must be equivalent to the level of service (BLS, ALS) being provided.

VI. Event medical providers must have radio communication with the jurisdictional provider agency at all times during the event.

VII. Event provider, in conjunction with the Department of Public Health, should provide harm reduction and education about specific hazards, which may include, but not limited to, alcohol and drugs that may be present at an event.

VIII. Mass gatherings and special events have been placed into categories as identified below. Each of these categories are then broken down by “levels” with the medical staffing recommendations specified for each level as follows:

Los Angeles County, Emergency Medical Services Agency
Prehospital Care Policy, Ref. 842.1
Mass Gatherings & Special Event Staffing Level Recommendations
(Based on Peak Attendance Estimates)

Medical Faculty (Fac.) to have AED certified member with device.
Mobile and Medical Facility Personnel must have radio communications with Command Staff.
Mobile and Medical Carts may be staffed by Medical Facility or Mobile Personnel as needed.

SPECIAL EVENT Low Intensity (no alcohol)		SPECIAL EVENT Low Intensity (alcohol permitted)		SPECIAL EVENT Moderate Intensity (alcohol permitted)		SPECIAL EVENT High Intensity (alcohol permitted)	
5k to 10k	Level 1	5k to 10k	Level 5	5k to 10k	Level 5	<=3k	Level 6
10k to 20k	Level 2	10k to 25k	Level 6	10k to 20k	Level 6	3k to 15k	Level 8
20k to 30k	Level 3	25k to 40k	Level 7	20k to 30k	Level 7	15k to 30k	Level 9
30k to 40k	Level 4	40k to 50k	Level 8	30k to 40	Level 8	30k to 40k	Level 10
40k to 50k	Level 5	>50k	Level 9	40k to 50	Level 9	40k to 50k	Level 11
>50k	Level 6			>50k	Level 10	>50k	Level 12

Event Level	1st Aid Tent (F.R.)	Med Fac. EMT	Med Fac. PM	Med Fac. RN	Med Fac. MD	Mobile EMT (F.R.)	Mobile PM/EMT (1 each)	Mobile Cart	Medical Cart w/gurney	BLS Amb.	ALS Ambulance
Level 1	1										
Level 2	1	1				1					
Level 3	1	1				1					
Level 4	1	1				1	1			1	
Level 5		2				1	1	1		1	
Level 6		2	1	1			2	1			1
Level 7		2	1	1		1	2	1		1	1
Level 8		1	2	1	1	1	1		1	1	2
Level 9		1	2	2	1	1	2	1	1	1	3
Level 10		1	2	2	1	2	2	1	1	1	3
Level 11		1	2	3	2	2	3	1	1	1	3
Level 12		2	2	4	2	2	4	2	1	1	3

IX. Event venue/promoter must provide the following outdoor weather contingency requirements:

A. Hot Weather

1. <u>80 to 89 Degrees</u>

- Free drinking water readily available with signage.
- Cooling station(s) suitable to the number of participants.

2. <u>90 to 94 Degrees</u>

- Free drinking water readily available with signage.
- Cooling station(s) suitable to the number of participants.
- Minimum of one shade area to include misters/cooling station(s).

- Mobile cart added to Levels 5 & 6.
- One additional ALS Ambulance or MD for Level 10 events.

3. 95 Degrees and Above

- Free drinking water readily available with signage.
- Cooling station(s) suitable to the number of participants.
- Half of canopy shade areas to include misters (one minimum)/cooling station(s).
- Mobile cart added to Levels 5 & 6.
- Second mobile cart added for Level 7 or greater.
- One additional ALS Ambulance or MD for Level 9 or greater events.
- MD treatment tent(s) to include portable air conditioning.

B. Cold Weather

1. Rain

- Disposable (aluminum/mylar) blankets suitable to the number of participants.

2. Below 60 Degrees

- Portable heaters and disposable (aluminum/mylar) blankets suitable for number of participants.
- Consider warming stations, if needed.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 842, **Mass Gathering and Special Events Interface with Emergency Medical Services**

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

REFERENCE NO. 842 & 842.1, *Mass Gathering & Special Events Policy & Resource Guidelines*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee			
	Provider Agency Advisory Committee	12/17/25	12/17/25	
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:			

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

EMERGENCY MEDICAL SERVICES COMMISSION (EMSC)

SUGGESTED GOALS/OBJECTIVES FOR 2026

GOAL/OBJECTIVE	PRIORITY (YES/NO)	IF PRIORITY WHO ASSIGNED	POTENTIAL ACTIONS
1. Work on processes/policies to address and reduce Ambulance Patient Offload Delays (APOD)	Yes		1. Implementation and rollout of FirstWatch real-time data on ambulances waiting to offload. *(Completed)* 2. Develop separate policy addressing APOT and APOD. *(Completed)* 3. Redistribute the CHA APOT Toolkit. *(Completed)* 4. Identify best practices of hospitals, in collaboration with EMSA's implementation of AB40. 5. Monitor implementation of Ref. No. 505. 6. AB 40 signed by the Governor, needs emergency regulations from State EMS Authority and revisit Ref. No. 505. 7. Continue to provide regular reports to the Commission. 8. Participate with EMSA's implementation of the emergency regulations on AB40.
2. Continue working on the recommendations from the *Ad Hoc Committee on the Prehospital Care of Mental Health and Substance Abuse Emergencies* specifically address Suicide Risk Protocols	Yes	Behavioral Health Workgroup	1. Reconvened Workgroup to be chaired by Commissioner Cheung. (Completed) 2. Workgroup will focus on field evaluation of suicidal ideation. 3. Develop guidelines and education to address assessment and management of patients experiencing suicidal ideation. (Completed)

GOAL/OBJECTIVE	PRIORITY (YES/NO)	IF PRIORITY WHO ASSIGNED	POTENTIAL ACTIONS
			4. Provide training to the new Medical Control Guidelines and Suicide Screening tool. (Completed) 5. Investigate opportunities to support reimbursement for transport to alternate destinations.
3. Interfacility Transport Delays (requested for inclusion at Jan 2023 meeting). Need further discussion by EMSC	Yes	IFT Workgroup	1. Workgroup convened with representation from the EMSC, hospitals, EMS providers and the EMS Agency. (Completed) 2. IFT transfer worksheet developed for Trauma Re-Triage and STEMI Transfer. 3. Assessment Questionnaire for hospital and EMS provider agencies to determine scope of problem and explore potential solutions. 4. Develop a database to capture inappropriate use of 911 for IFTs. (Completed) 5. Engage hospital leadership of hospitals with inappropriate utilization of 911.
4. Improve patient-centered outcomes from cardiac arrest across Los Angeles County, to meet or exceed the 2030 targets set by the American Heart Association (AHA).	Yes	Cardiac Arrest Workgroup	1. Develop a workgroup to assess current outcomes of cardiac arrest care and gather potential interventions to improve outcomes. 2. Understand barriers to health equities. 3. Engage key stakeholders. (Completed) 4. Identify potential partners. (Completed) 5. Provide workshops for EMS Providers and Hospitals.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

November 17, 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: CEO/President, Each Private Ambulance Operator

FROM: Richard Tadeo
Director, EMS Agency

SUBJECT: **ADDITION OF AUTOMATED EXTERNAL DEFIBRIALLTORS TO BASIC LIFE SUPPORT AMBULANCE EQUIPMENT AND AED SERVICE PROVIDER PROGRAM REQUIREMENTS**

Effective October 1, 2025, Automated External Defibrillators (AED) and supporting equipment were added as required inventory in Reference No. 710, Basic Life Support Ambulance Equipment (attached). The following equipment is now required on all Basic Life Support (BLS) Ambulances:

- Automated External Defibrillator (AED)
- Adult AED defibrillation pads - (2)
- Razor/trimmer - (1)

In addition to the above equipment, each ambulance operator must meet the requirements and be approved as an AED Service Provider as outlined in Reference No. 412, AED Service Provider Program Requirements (attached).

Please review the referenced policies above and submit a complete application (attached) to request approval as an AED Service Provider to the EMS Agency, Attn: Greg Klein at gklein@dhs.lacounty.gov. Application questions should be directed to him as well.

Ambulance Operators must receive approval and verify the above required equipment has been added to all BLS Units using the attached attestation form, no later than Tuesday, March 31, 2026.

Failure to comply and successfully be approved and stock AEDs on all BLS Units by the above deadline will jeopardize the continued operation of your Ambulance Operator Business License. In addition, all new unit requests shall have the required inventory at time of inspection for approval.

Thank you for your cooperation in this matter. If you have any questions regarding the required inventory or compliance, please contact David Wells, Prehospital Operations Chief at 562-378-1677 or dwells@dhs.lacounty.gov.

Attachments

RT:dw
11-18a

c. Operations Manager, Each Private Ambulance Operator
Medical Director, Each Private Ambulance Operator

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

MEMORANDUM

December 1, 2025

TO: Distribution **VIA-EMAIL**

FROM: Richard Tadeo
Director

SUBJECT: **NAME CHANGE FOR CEDARS-SINAI MARINA DEL REY HOSPITAL**

Effective Monday, December 15th, 2025 at 0700, Cedars-Sinai Marina Del Rey Hospital's name will be changed to Cedars-Sinai Marina Hospital in Reddinet® and all EMS Agency databases. The 3-letter hospital identification code will remain as DFM.

Please update all systems and ensure personnel are notified of the name change.

If you have any questions, please contact Ami Boonjaluksa, Chief Hospital Programs at (562) 378-1596 or ABoonjaluksa2@dhs.lacounty.gov.

RT:jr:ab
12-04

Distribution:
Medical Director, EMS Agency
Fire Chief, All Public Provider EMS Agencies
Paramedic Coordinators, All Public Provider EMS Agencies
Nurse Educators, All Public Provider EMS Agencies
CEO, All Licensed Private Ambulance Providers
Paramedic Coordinator, All Licensed Private Ambulance Providers
CEO, All 9-1-1 Receiving Hospitals
ED Medical Director, All 9-1-1 Receiving Hospitals
ED Clinical Director, All 9-1-1 Receiving Hospitals
Medical Director, All Paramedic Base Hospitals
Prehospital Care Coordinators, All Paramedic Base Hospitals
Medical Alert Center
ReddiNet®
Hospital Association of Southern California
EMS Commission

License: 930000096
Effective: 11/19/2024
Expires: 11/18/2025
Licensed Capacity: 103

State of California
Department of Public Health

In accordance with applicable provisions of the Health and Safety Code of California and its rules and regulations, the Department of Public Health hereby issues

this **License** *to*

Cedars-Sinai Marina Hospital

to operate and maintain the following **General Acute Care Hospital**

Cedars-Sinai Marina Hospital
4650 Lincoln Blvd
Marina Del Rey, CA 90292-6306

Bed Classifications/Services/Stations
103 General Acute Care
12 Intensive Care
91 Unspecified General Acute Care

Other Approved Services
Basic Emergency Medical
Mobile Unit - Computed Tomography (CT) Scan
Mobile Unit - Magnetic Resonance Imaging (MRI)
Nuclear Medicine
Occupational Therapy
Outpatient Services - General
Outpatient Services - Laboratory/Radiology
Outpatient Services - Spine Center at 4640 Admiralty Way, Suite 600, Marina Del Rey
Physical Therapy
Respiratory Care Services
Social Services
Speech Pathology

This **LICENSE** is not transferable and is granted solely upon the following conditions, limitations and comments:
None

TOMÁS J. ARAGÓN, MD, DrPH
Director and State Public Health Officer

Joshua Williams
Joshua Williams, Staff Services Manager I

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, L.A. Acute/Ancillary Unit, 3400 Aerojet Ave., Suite 323, El Monte, CA 91731, (626) 312-1135

POST IN A PROMINENT PLACE

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

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First District

Holly J. Mitchell
Second District

Lindsey P. Horvath
Third District

Janice K. Hahn
Fourth District

Kathryn Barger
Fifth District

Richard Tadeo, RN
Director

Nichole Bosson, MD, MPH
Medical Director

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

December 9, 2025

TO: Distribution **VIA EMAIL**

FROM: Richard Tadeo
Director, EMS Agency

Dr. Mohsen Saidinejad
Director of Pediatric Research and Scholarship, Department of Emergency Medicine Harbor-UCLA Medical Center

SUBJECT: OPTIMIZING PEDIATRIC READINESS OF 9-1-1 RECEIVING HOSPITALS IN LOS ANGELES COUNTY THROUGH INTEGRATION INTO EMERGENCY MANAGEMENT PROGRAM

The Los Angeles (LA) County Emergency Medical Services (EMS) Agency in collaboration with Harbor-UCLA Medical Center will be leading an effort aiming to improve pediatric readiness of 9-1-1 receiving hospital emergency departments in LA County. Both Emergency Department Approved for Pediatrics (EDAP) and non-EDAP hospitals are being invited to participate in this project.

As background, the first national assessment of pediatric readiness of the nation's emergency departments was conducted in 2013 with a subsequent assessment in 2021. In the 2021 National Pediatric Readiness Project (NPRP) assessment, the national median score for EDs was **69.5** out of 100. In LA County 100% of hospitals participated. Scores varied greatly, with EDAP hospitals in the county having an average score of 92 and non-EDAPs averaging 70. This indicates that the designation of a hospital ED as EDAP through EMS agency verification had a significant impact on readiness score. Furthermore, having an ED readiness score of 88/100 or higher is associated with lower mortality for ill and injured children, with a reduction in poor outcomes by up to 76%.

The goal of this project, (LA Peds Ready 2.0) which builds on the first LA Pediatric Readiness Project aimed at improving readiness of non-EDAP Hospitals (2016-2017), is to engage the Pediatric Liaison Nurses (PdLNs) of the EDAP hospitals to work with pediatric champions (PC) at non-EDAP hospitals in a "train the trainer" format. The goal is to have each PdLN work with 2-3 non-EDAP hospital PCs to teach them about conducting virtual or in-person simulations and perform gap analysis, as well as to help them interact with our web-based products such as podcasts, webinars, interactive learning modules, and other activities.

The EMS agency is requesting your participation in helping improve day-to-day pediatric readiness and disaster preparedness of your hospitals.

We will be developing an intervention bundle to help you with specific pediatric readiness activities that are aimed to improve ED readiness score. The following represents the activities and/or opportunities related to pediatric readiness that will be included for the PdLN group:

- Completion of the national Pediatric Readiness assessment in Spring 2026
- Attendance of the train the trainer orientation session (PdLNs)
- Participation in online simulation training session.
- Participation in the orientation session for LA Peds Ready website resources
- Opportunity to engage in the upcoming National Pediatric Readiness Quality collaborative expected to launch in early 2026.
- Coordination of a site visit with the non-EDAP hospital (can do a single session)

We are therefore, requesting your participation in this exciting opportunity through LA Peds Ready 2.0 and help improve day-to-day readiness well as disaster preparedness and response for of LA County Hospitals.

We hope you will consider participating in the LA Peds Ready 2.0 Project. Please submit your interest by clicking on the participant interest form **here**

We will plan a virtual welcome and train the trainer orientation in January 2026 to describe specifics of the project including the virtual and in person simulation and web-based resources.

Please be aware that by agreeing to participate in this project, you will agree to complete all the activities listed in the scope of work. A $2000 incentive payment will be provided to each participating PdLNs through a collaboration between the Hospital Preparedness Program (HPP) and the Pediatric Liaison Association of Los Angeles County.

If you have any questions, please email Robin Goodman, MSN, RN, CPEN, Nancy McGrath, MS, RN, CPNP-AC/PC, or Laura Garcia, RN.

We look forward to your response by December 5, 2025, and to your participation in this incredible program.

RT:ab:ms
12-11

Distribution: Medical Director, EMS Agency
CEO, EDAP Hospitals
ED Administrative Director, EDAP Hospitals
Pediatric Liaison Nurse, EDAP Hospitals

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

Hilda L. Solis
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Second District

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Third District

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Kathryn Barger
Fifth District

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Director

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

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

December 9, 2025

TO: Distribution **VIA EMAIL**

FROM: Richard Tadeo
Director, EMS Agency

Dr. Mohsen Saidinejad
Director of Pediatric Research and Scholarship, Department of Emergency Medicine Harbor-UCLA Medical Center

SUBJECT: OPTIMIZING PEDIATRIC READINESS OF 9-1-1 RECEIVING HOSPITALS IN LOS ANGELES COUNTY THROUGH INTEGRATION INTO EMERGENCY MANAGEMENT PROGRAM (LA PEDS READY 2.0)

The Los Angeles (LA) County Emergency Medical Services (EMS) Agency, in collaboration with Harbor-UCLA Medical Center, is leading an effort to improve the Pediatric Readiness of 9-1-1-receiving hospital emergency departments (EDs) in LA County. Both Emergency Department Approved for Pediatrics (EDAP) and non-EDAP hospitals are being invited to participate in this project.

As background, the first national assessment of Pediatric Readiness in the nation's EDs was conducted in 2013, followed by a subsequent evaluation in 2021. In the 2021 National Pediatric Readiness Project (NPRP) assessment, the national median score for EDs was **69.5** out of 100. In LA County, 100% of hospitals participated. Scores varied widely, with EDAP hospitals in the county averaging 92 and non-EDAP hospitals averaging 70. An ED readiness score of 88 or higher is associated with lower mortality among ill and injured children, with a reduction of up to 76%.

The goal of LA Peds Ready 2.0 is to enhance Pediatric Readiness at non-EDAP hospitals. Pediatric Liaison Nurses (PdLN) from EDAP hospitals will collaborate with Pediatric Champions at non-EDAP hospitals to demonstrate clinical case simulations, guide the use of EMS for Children (EMSC) Innovation & Improvement Center (EIIC) web resources and toolkits, and support preparation for the Spring 2026 pediatric readiness assessment.

The LA County EMS Agency is requesting your participation in improving day-to-day Pediatric Readiness and disaster preparedness within your hospital system.

We will create an intervention bundle to support targeted Pediatric Readiness activities, improve your readiness score, and serve as training resources.

The list below outlines the Pediatric Readiness activities your facility will be expected to participate in during the project. Please make sure that you complete all the listed activities:

- *Completion of the national Pediatric Readiness Assessment in March 2026*
- *Attendance at a virtual orientation session*
- *Participation in online simulations and in web-based interactive learning (at least 2)*
- *Participate in one in-person visit tailored to your site's needs.*
- *Completion of the national Pediatric Readiness reassessment at the conclusion of LA Peds Ready 2.0. (June 2027)*

In addition to this, each site will get the following resources:

- *Access to all the interactive learning modules on the EIIC website*
- *Access to web-based resources (clinical pathways, best practice protocols, infographics, webinars, quizzes, and other readiness-related content on the LA Peds Ready website).*

We hope you will consider participating in the LA Peds Ready 2.0 Project. Please submit your interest by clicking on the participant interest form **here.** A virtual welcome and informational session will be held on February 19, 2026. We recognize that not all interested hospitals can attend the kick-off session, so a recording will be available and can be shared with you upon request.

Please be aware that by agreeing to participate in this project, you will agree to complete all the activities listed in the scope of work. A $2000 incentive payment will be provided to each participating hospital through the Hospital Preparedness Program (HPP), through a participant agreement and master contract.

If you have any questions, please email Robin Goodman, MSN, RN, CPEN, Nancy McGrath, MS, RN, CPNP-AC/PC, or Laura Garcia, RN.

We look forward to your response by January 16, 2026, and to your participation in LA Peds Ready 2.0 to help LA County be pediatric-ready.

RT:ab:ms
12-10

Distribution: Medical Director, EMS Agency
CEO, 9-1-1 Receiving Hospitals, Non-EDAP
ED Administrative Director, 9-1-1 Receiving Hospitals, Non-EDAP
ED Medical Directors, 9-1-1 Receiving Hospitals, Non-EDAP
ED Nurse Manager, 9-1-1 Receiving Hospitals, Non-EDAP
ED Pediatric Champion, 9-1-1 Receiving Hospitals, Non-EDAP

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."

December 18, 2025

TO: Distribution

FROM: Nichole Bosson, MD, MPH
Medical Director

SUBJECT: UPDATED REQUIREMENTS FOR CAPNOGRAPHY SAMPLING DEVICES, MAGNESIUM SULFATE, AND PORTABLE SUCTION DEVICES

This is to inform Los Angeles County approved Advanced Life Support (ALS) Provider Agencies of updates to the ALS unit inventories.

Effective July 1, 2026, all ALS units and ALS Assessment units will require a minimum of 1 adult $EtCO_2/O_2$ oral-nasal cannula with universal connector (for spontaneously breathing patients) and 2 $EtCO_2$ sampling lines with airway adaptor (for positive-pressure ventilation). Pediatric-size $EtCO_2/O_2$ oral-nasal cannulas are not required but are encouraged and may be carried as optional equipment.

Also, effective July 1, 2026, Magnesium Sulfate will be added to inventory for all ALS units. The formulary and minimum inventory will be identified in early 2026.

Lastly, effective January 1, 2027, all ALS units will require a battery-powered portable suction device that is capable of being removed from the ambulance as needed, in addition to a manual backup suction device. A cannister size of ≥500mL is preferred.

These changes were made in consultation with the Provider Agency Advisory Committee and the Medical Advisory Council with the goal of improving patient safety.

If you have any questions, please feel free to contact me at 562-378-1600 or David Wells, Chief of Prehospital Operations at 562-378-1677.

Distribution: Fire Chief, Each Fire Department
Medical Director, Each ALS Provider Agency
Paramedic Coordinator, Each ALS Provider Agency
CEO/President, Each ALS Ambulance Company
Nurse Educator, Each ALS Provider Agency

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

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

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First District

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Second District

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Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Richard Tadeo
Director

Nichole Bosson, MD
Medical Director

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

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

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

December 24, 2025

TO: FAX/E-Mail Distribution (see attachment)

FROM: Richard Tadeo
Director

SUBJECT: **Tournament of Roses Parade 2026**

This year's *Tournament of Roses Parade* is scheduled to take place on Thursday, January 1, 2026 in the City of Pasadena. The event is expected to draw hundreds of thousands of spectators and participants. The reported event hours are:

- 8:00 a.m. to 5:30 p.m.

The Emergency Medical Services (EMS) Agency encourages emergency departments in the area to prepare and staff adequately. The Medical Alert Center (MAC) will conduct a ReddiNet® Multi-Casualty Incident (MCI) poll to manage patient destinations. Hospitals must complete the MCI poll "Victim List" for patient tracking purposes of all event-related patients, including those who may self-transport.

Please ensure that all affected personnel are properly informed. If you have any questions or need further information, please contact the MAC Supervisor at (562) 378-1703.

RT:nh

Attachment

Distribution:

Paramedic Coordinator, Pasadena Fire Department
Prehospital Care Coordinator, Each Hospital
Emergency Department Director, Adventist Health Glendale
Emergency Department Director, Adventist Health White Memorial
Emergency Department Director, Alhambra Hospital Medical Center
Emergency Department Director, Adventist Health White Memorial Montebello
Emergency Department Director, Children's Hospital of Los Angeles
Emergency Department Director, Dignity Health-California Hospital Medical Center
Emergency Department Director, Dignity Health-Glendale Memorial Hospital and HC
Emergency Department Director, East Los Angeles Doctors Hospital
Emergency Department Director, Garfield Medical Center
Emergency Department Director, PIH Health - Good Samaritan Hospital
Emergency Department Director, Greater El Monte Community Hospital
Emergency Department Director, Hollywood Presbyterian Medical Center
Emergency Department Director, Huntington Memorial Hospital
Emergency Department Director, Kaiser Foundation Hospital - Sunset
Emergency Department Director, Los Angeles General Medical Center
Emergency Department Director, USC Arcadia Hospital
Emergency Department Director, Monterey Park Hospital
Emergency Department Director, Providence Saint Josephs Medical Center
Emergency Department Director, San Gabriel Valley Medical Center
Emergency Department Director, USC Verdugo Hills Hospital

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION
10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
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http://ems.dhs.lacounty.gov

Cardiac Arrest Task Force
Los Angeles County EMS Commission

December 8, 2025

To: (Name) - Fire Chief
Cc: (Name) - Medical Director
Fire Department
(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 American Heart Association Emergency Cardiovascular Care 2030 Impact Goals and Call to Action to Improve Cardiac Arrest Outcomes: A Scientific Statement From the American Heart Association

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,

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

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

Attachments: (Provider Agency) performance report
AHA 2030 Cardiac Arrest Goals

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION
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(562) 378-1610 FAX (562) 941-5835
http://ems.dhs.lacounty.gov

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
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EMERGENCY MEDICAL SERVICES AGENCY

DATA FACTS

LOS ANGELES COUNTY EMS SYSTEM REPORT

DECEMBER 1, 2025

ISSUE 14

Message from the Director and Medical Director

We are dedicating this 14th edition of the Los Angeles County Emergency Medical Services (EMS) System Data Report to Chris Clare who retired in September 2025. The EMS Agency first met Chris in 2007 when she came to the EMS Agency with an impressive nursing resume from various facilities both in and outside the County. Her variety of experiences as an emergency department nurse, nursing director, educator and mobile intensive care nurse was a good fit for the Prehospital Care Operations division. One of Chris' first assignment was to manage the EMS Data Repository of the Trauma and Emergency Medicine Information System (TEMIS). In this capacity, she laid the groundwork for transitioning our EMS providers from paper-based EMS reports to electronic data capture. She developed system reports and data dictionaries for each system component, established data clean-up processes and collaborated with our EMS provider agencies and 9-1-1 receiving hospitals to develop performance metrics utilizing TEMIS.

Richard Tadeo
Director

In 2013, Chris was the EMS Agency's Outstanding Nurse of the Year.

In her tenure, Chris also managed the Hospital Programs and Data Systems Management and Research divisions. In these roles, she was instrumental in establishing and revising standards for 9-1-1 receiving hospitals and specialty care centers such as Trauma, STEMI, Stroke, Pediatric Medical Care, Emergency Department Approved for Pediatrics, Sexual Assault Response Team and Extracorporeal Cardiopulmonary Resuscitation. Her experience with establishing systems of care was essential in providing analysis to proposed specialty care center regulatory changes in California.

In 2022, Chris promoted to Nursing Director, which expanded her management role to include overseeing prehospital care, ambulance licensing, enforcement & investigation, policy and protocol revisions, and contract development.

Chris' extensive knowledge and expertise with the various EMS programs has enabled the EMS Agency to develop our comprehensive data systems to support the various EMS programs and regionalize systems of care. Chris' work has profoundly impacted the medical care of Los Angeles County residents who call 9-1-1 and has provided a solid foundation for our EMS system to continue evolving and innovating to meet the constantly changing needs of our patients.

Dr. Nichole Bosson
Medical Director

We extend our best wishes for a happy retirement to Chris.

INSIDE THIS ISSUE:

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PARAMEDIC BASE SYSTEM	20

SPECIAL POINTS OF INTEREST:

- Emergency Severity Index (page 7)
- Trauma Mechanism of Injury (page 10)
- STEMI Performance Metrics (pages 12-13)
- OHCA Overall Survival (pages 14-17)
- Stroke Performance Metrics (page 19)

2025 System Demographics

69 9-1-1 Receiving Hospitals

- 37 EDAP (Emergency Department Approved for Pediatrics)
- 8 Pediatric Medical Centers
- 7 Pediatric Trauma Centers
- 15 Trauma Centers
- 21 Paramedic Base Hospitals
- 35 STEMI Receiving Centers
- 27 Comprehensive Stroke Centers
- 25 Primary Stroke Centers
- 44 Perinatal Centers
- 42 Hospitals with Neonatal ICU
- 13 SART (Sexual Assault Response Team)
- 13 Disaster Resource Centers
- 7 Psychiatric Urgent Care Centers

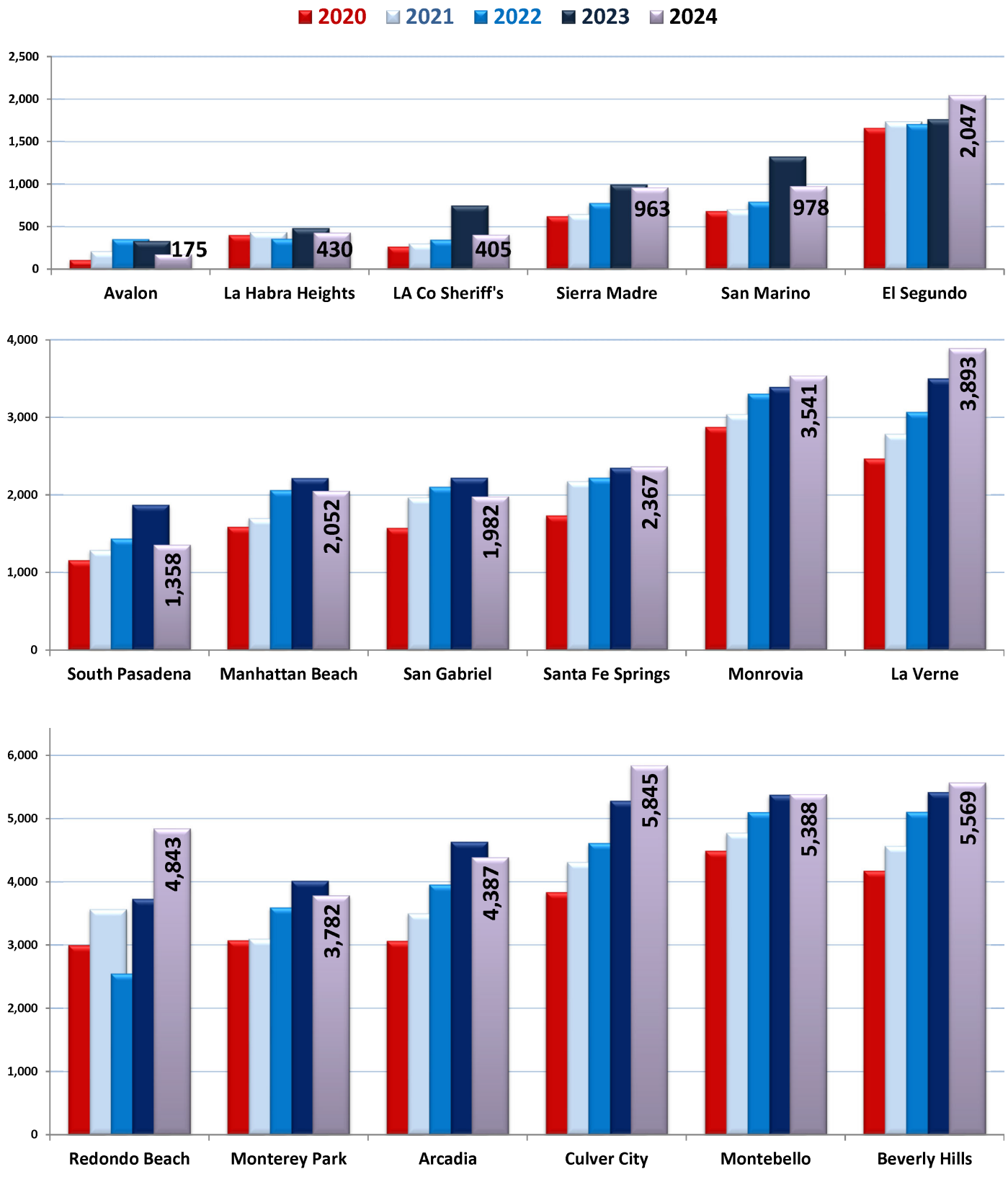
EMS Provider Agencies

- 33 Public Safety EMS Provider Agencies
- 38 Licensed Basic Life Support Ambulance Operators
- 16 Licensed Advanced Life Support Ambulance Operators
- 16 Licensed Specialty Care Transport Ambulance Operators
- 2 Licensed Ambulette Operators

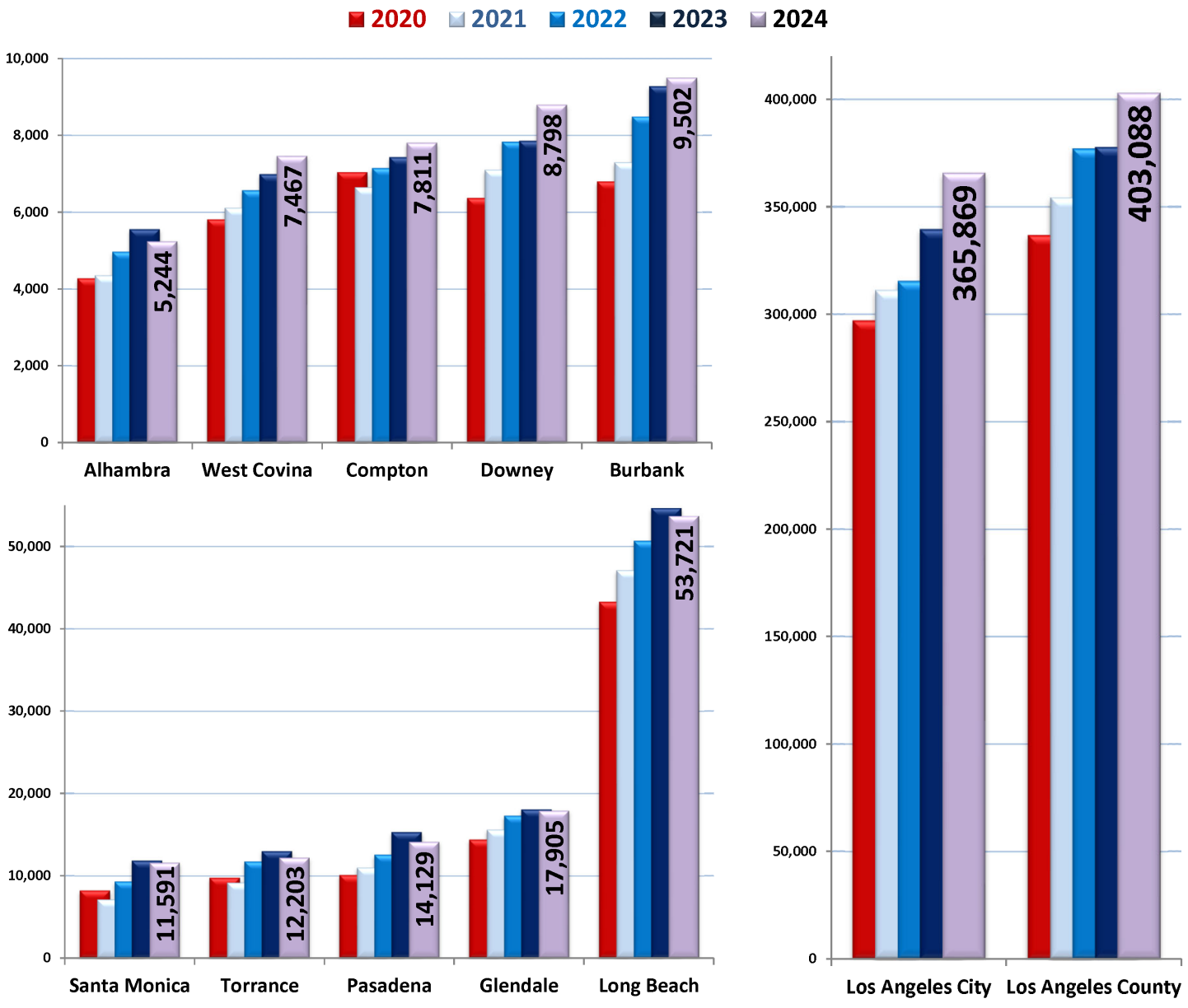
EMS Practitioners

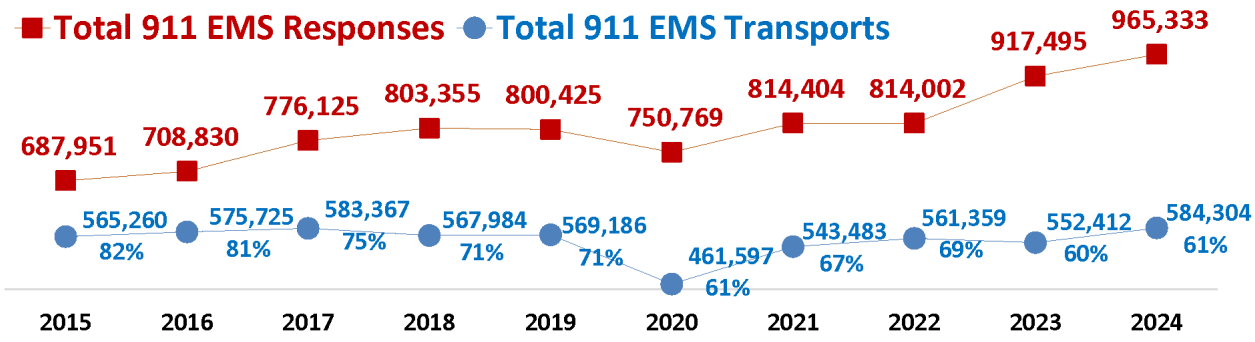
- 4,606 Accredited Paramedics
- 8,349 Certified EMTs by LA Co EMS Agency
- 877 Certified Mobile Intensive Care Nurses

EMS Responses by 9-1-1 Jurisdictional Provider Agency



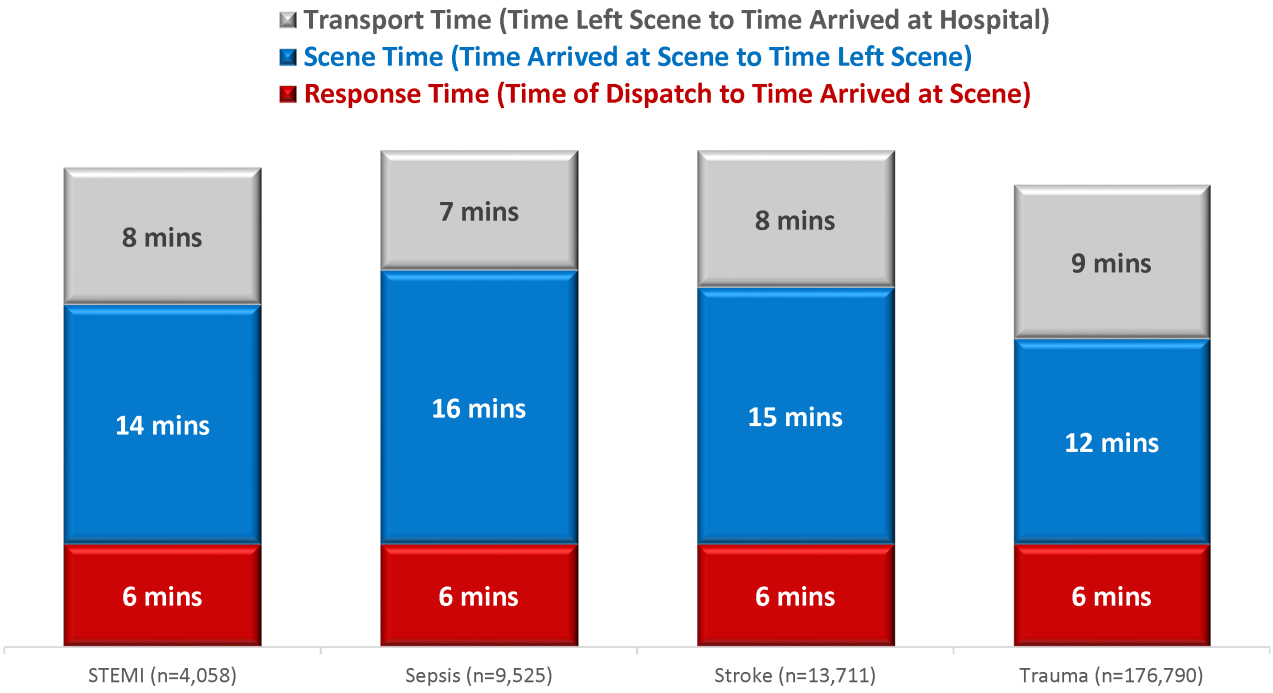
EMS Responses by 9-1-1 Jurisdictional Provider Agency



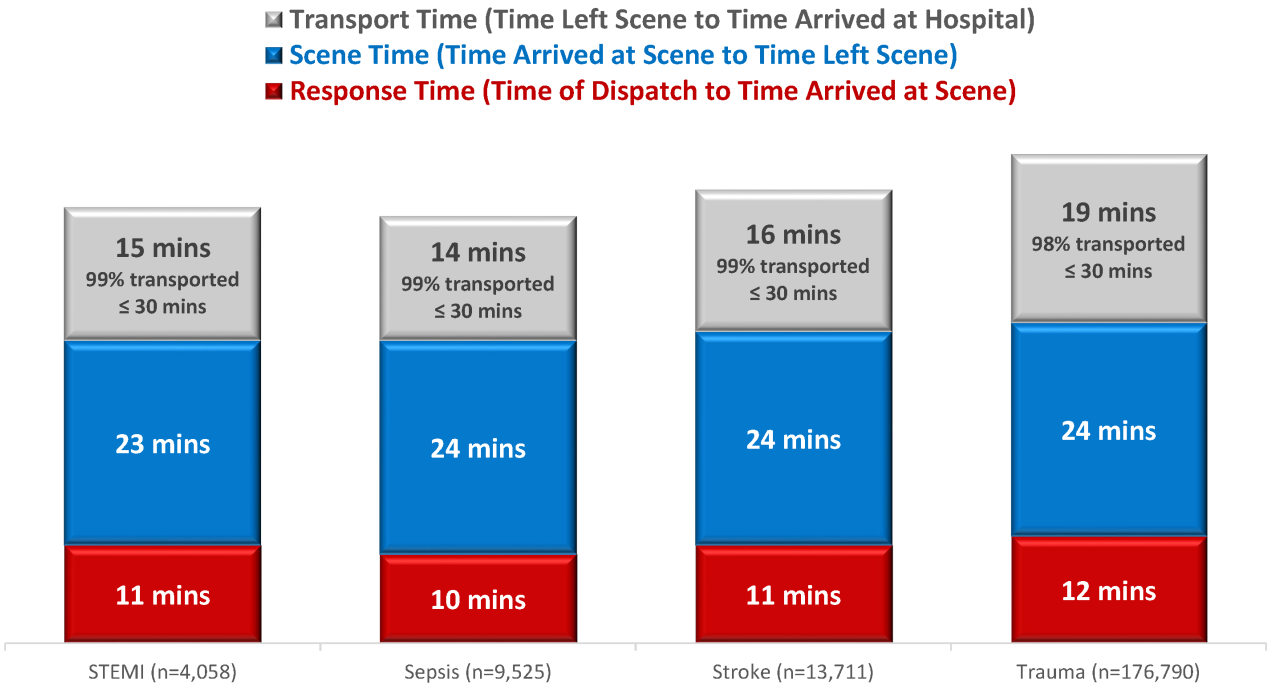


2024 EMS Times: Adult (Median)

Provider Impressions: STEMI, Stroke, Sepsis and Traumatic Injuries

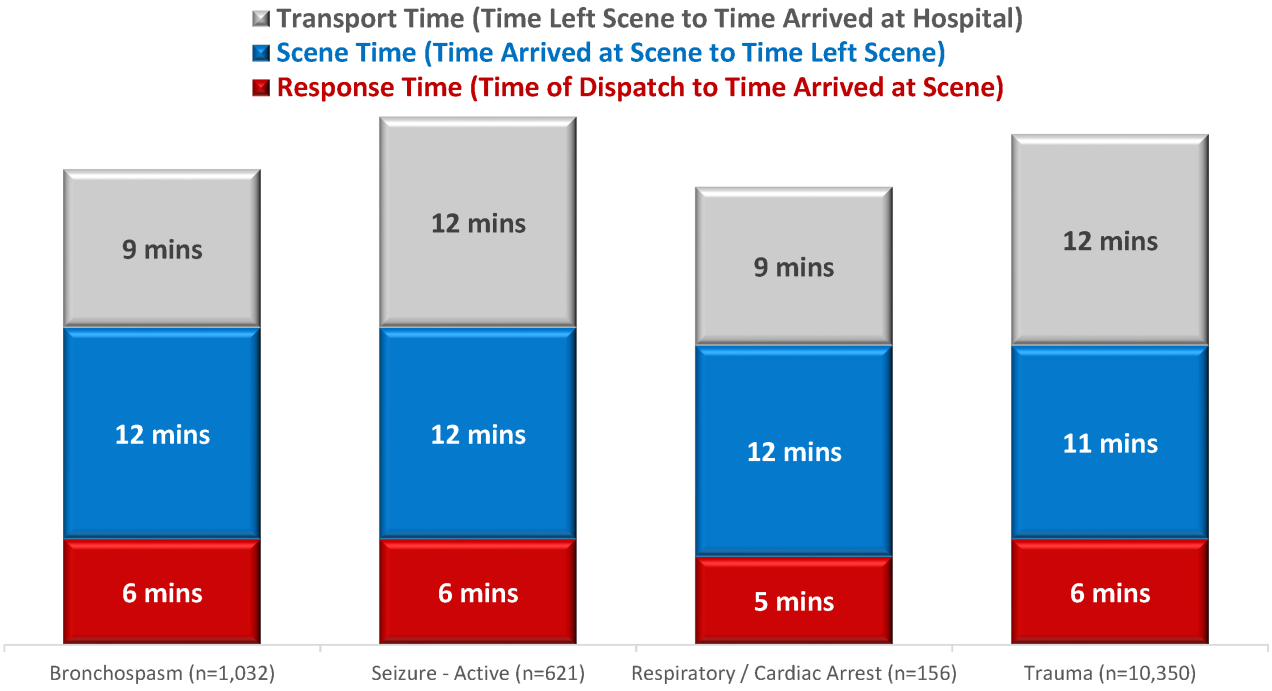


2024 EMS Times Adult: (90th Percentile)

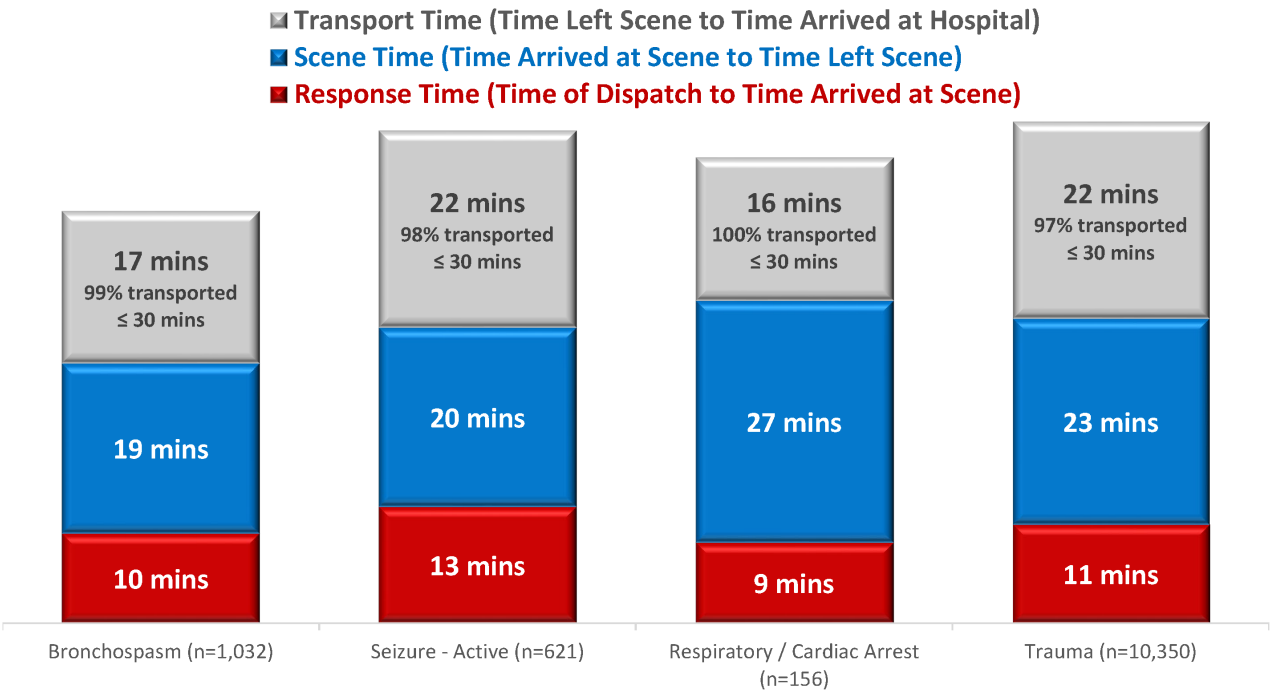


2024 EMS Times: Pediatric (Median)

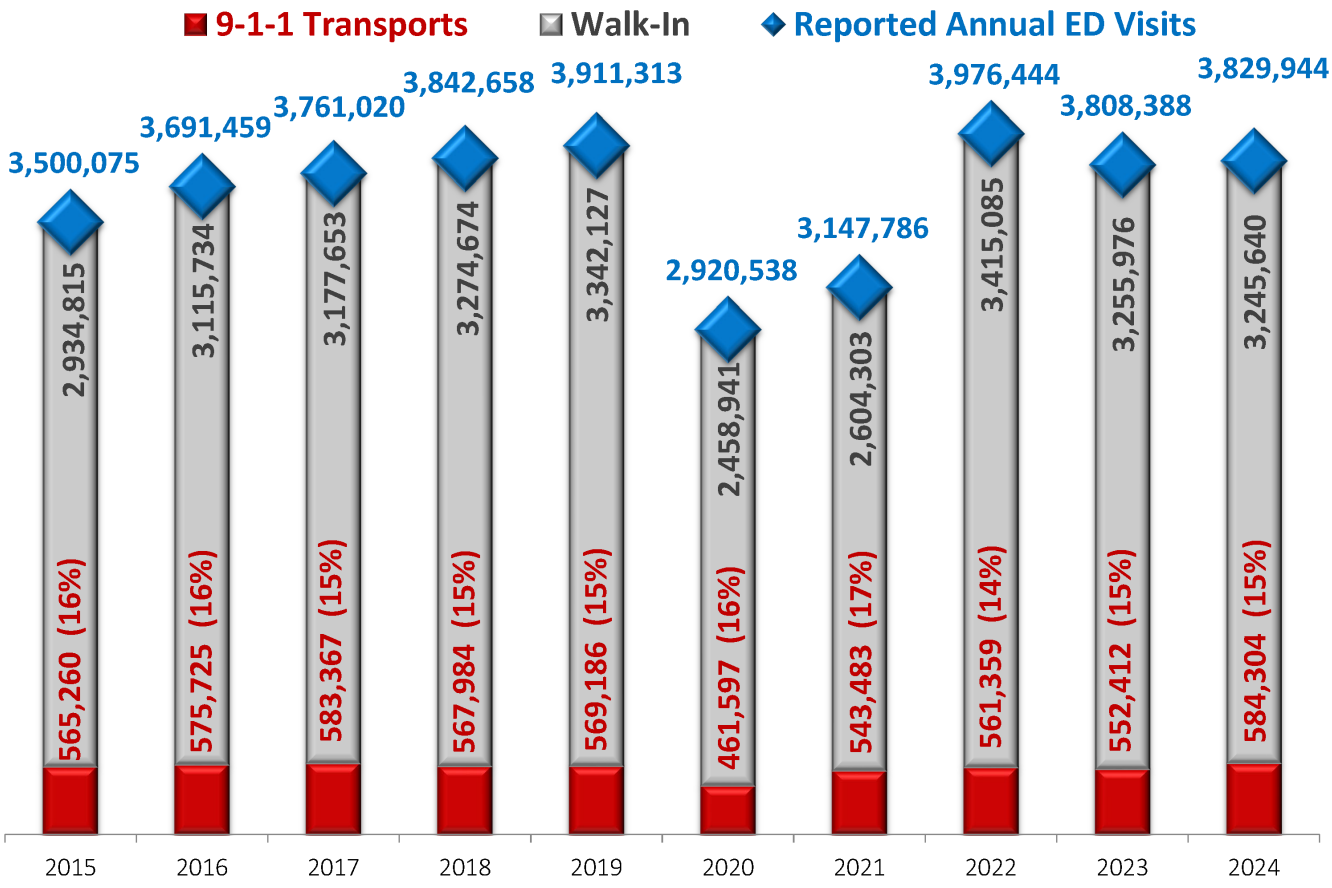
Provider Impressions: Bronchospasm, Seizure, Respiratory/Cardiac Arrest and Traumatic Injuries

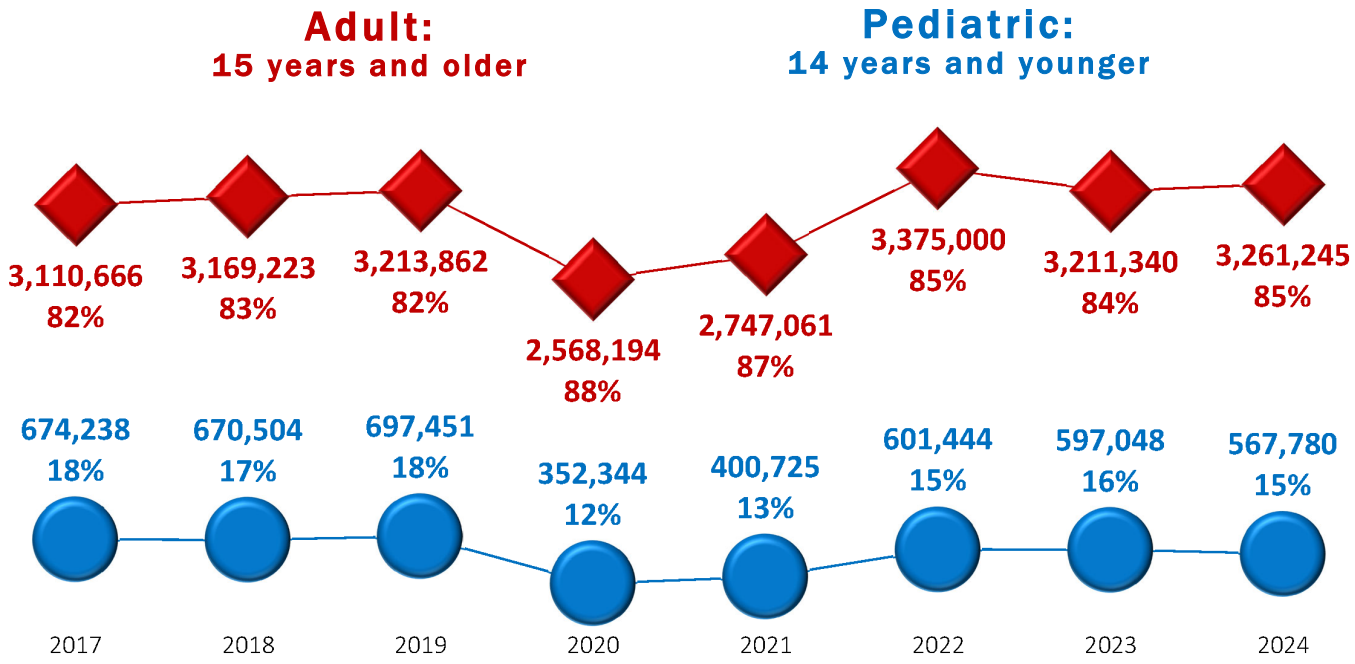


2024 EMS Times: Pediatric (90th Percentile)

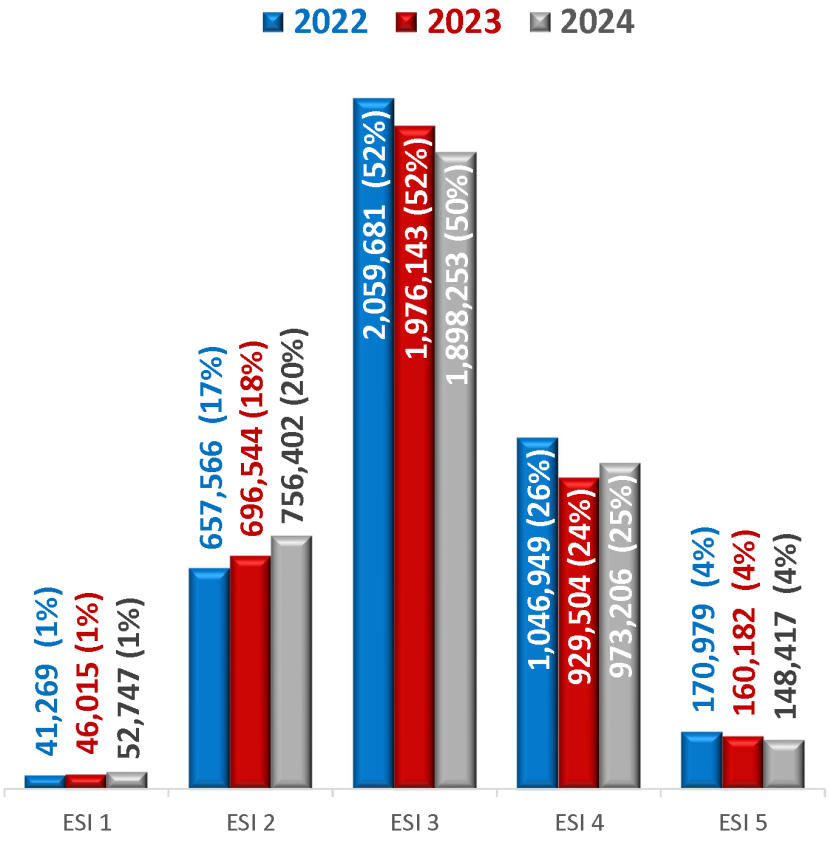


Emergency Department Volume





Emergency Severity Index (ESI)



ESI 1—Patient requiring immediate life-saving interventions: airway, emergency medications, or other hemodynamic; and/or any of the following conditions: intubated, apneic, pulseless, severe respiratory distress, SPO2 <90, acute mental status changes, or unresponsive (defined as nonverbal and not following commands (acutely); or requires noxious stimulus

ESI 2—Patient with a high risk of deterioration or signs of a time critical problem; confused/lethargic/disoriented; or severe pain/distress. Pediatric fever is age 1 to 28 days; temperature >38.0 C.

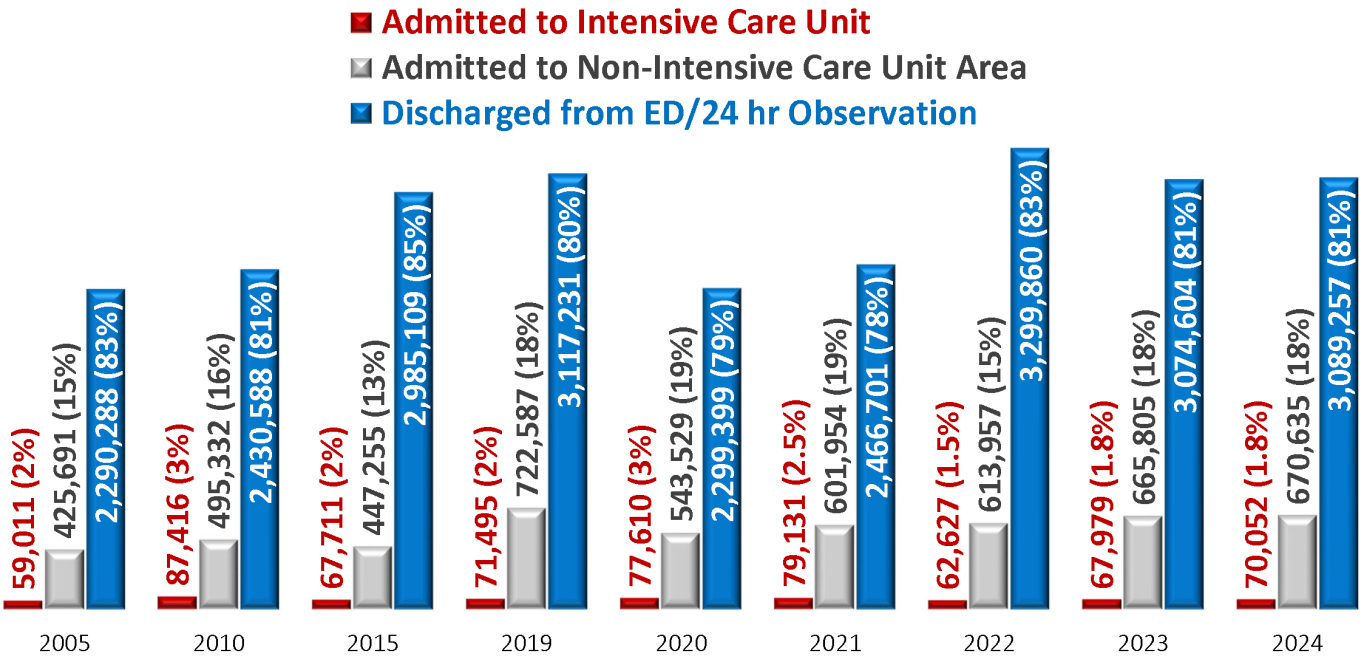
ESI 3—Patient is currently stable but requires multiple different types of resources* to diagnose or treat condition (e.g., diagnostic tests and procedures).

ESI 4—A patient requiring a single resource* such as only an x-ray or sutures.

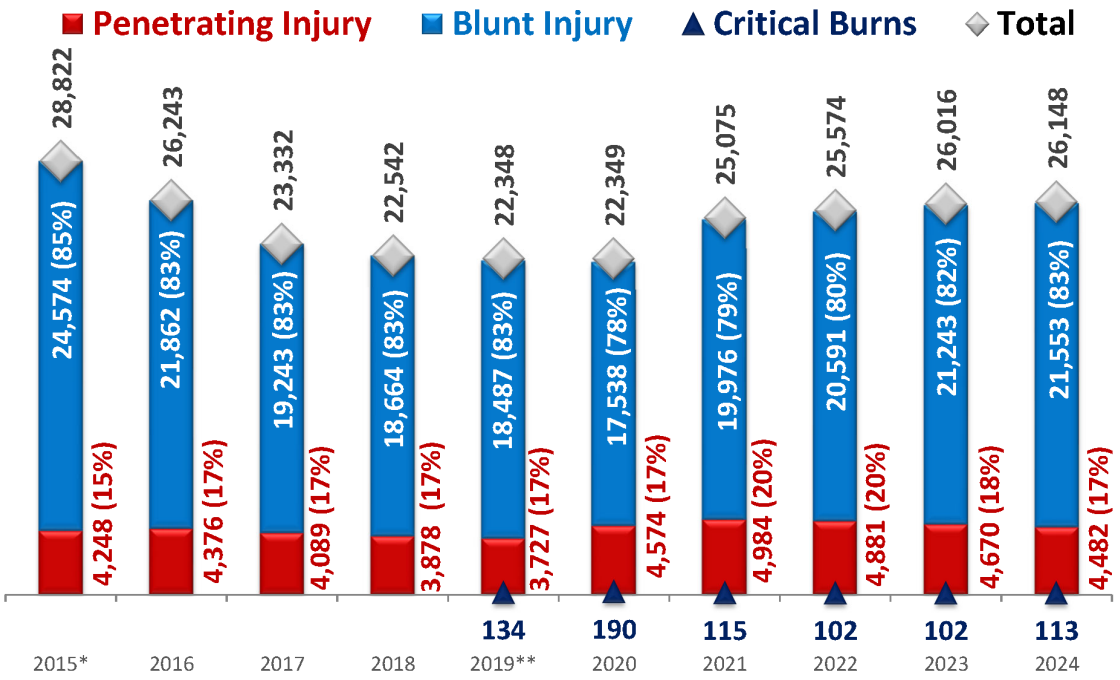
ESI 5—A patient not needing any resources*.

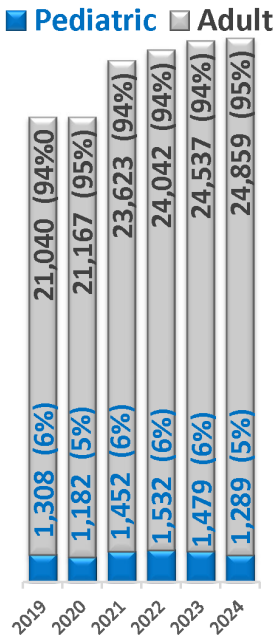
*The following are not considered resources: simple wound care-dressing/recheck; sling, PO medications, saline lock, history and physical-including a pelvic exam; point of care testing; tetanus immunization; prescription refills, crutches; splint

ED Patient Disposition (walk-in and 9-1-1)



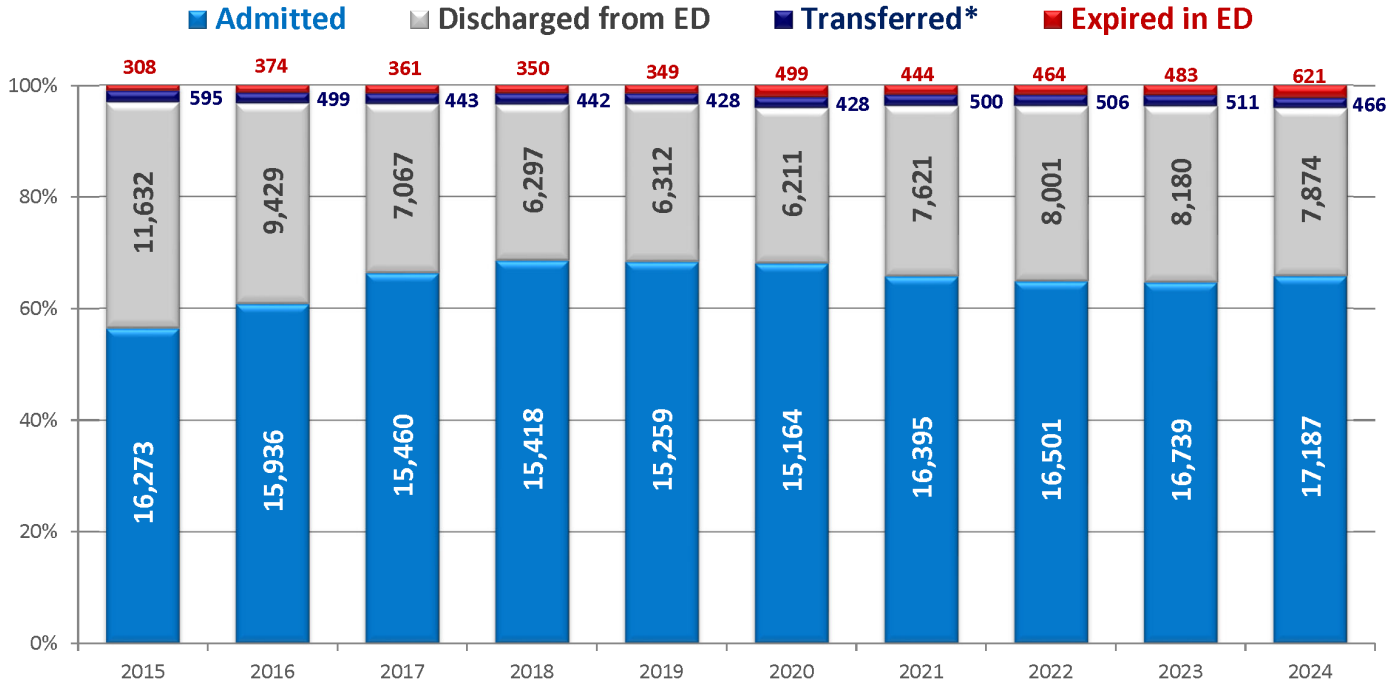
Trauma Center Volume (includes EMS transports and Walk-In patients who met trauma center criteria/guidelines)





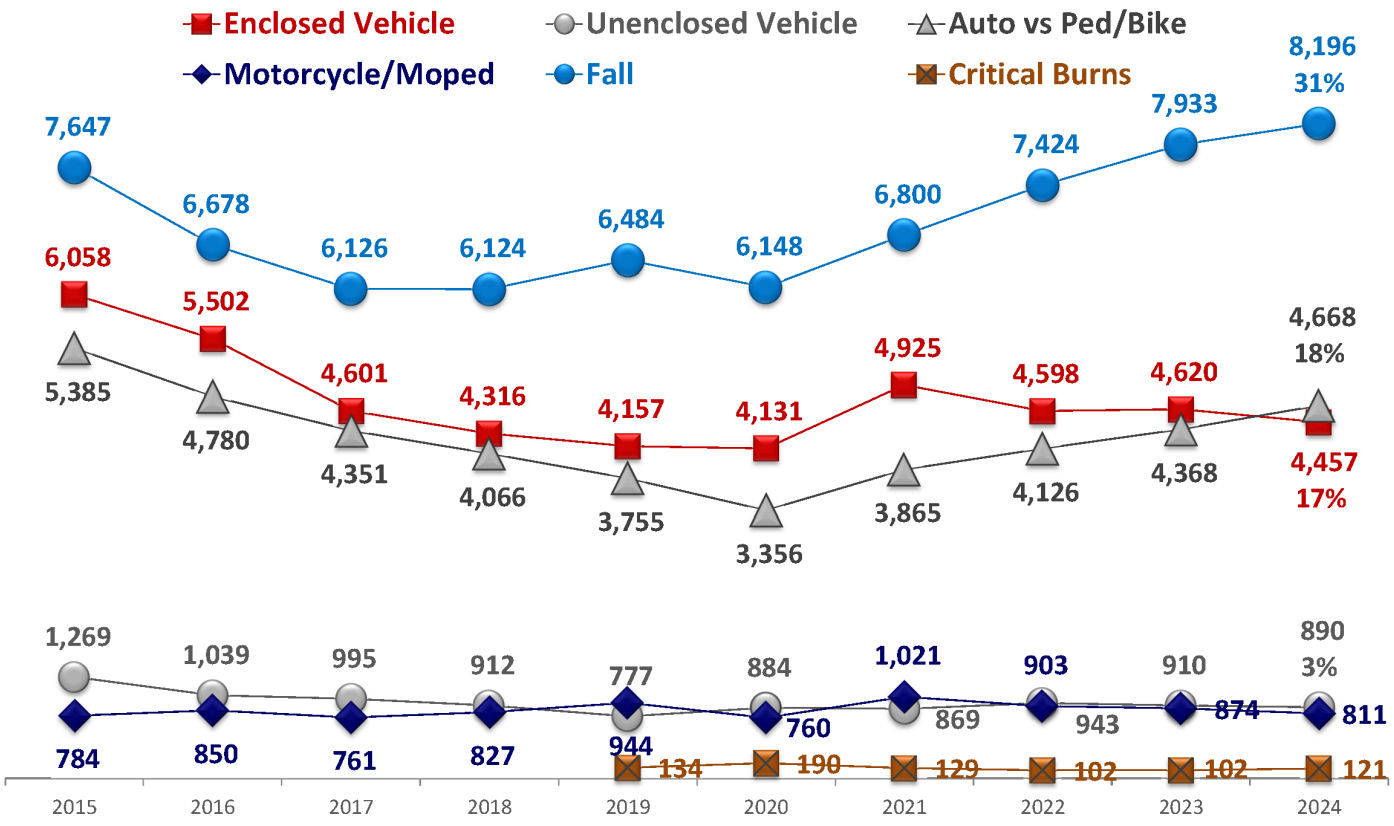
*2015 : Trauma Center Registry inclusion criteria was revised.
**2019: Critical Burns added as a Trauma Center Criteria

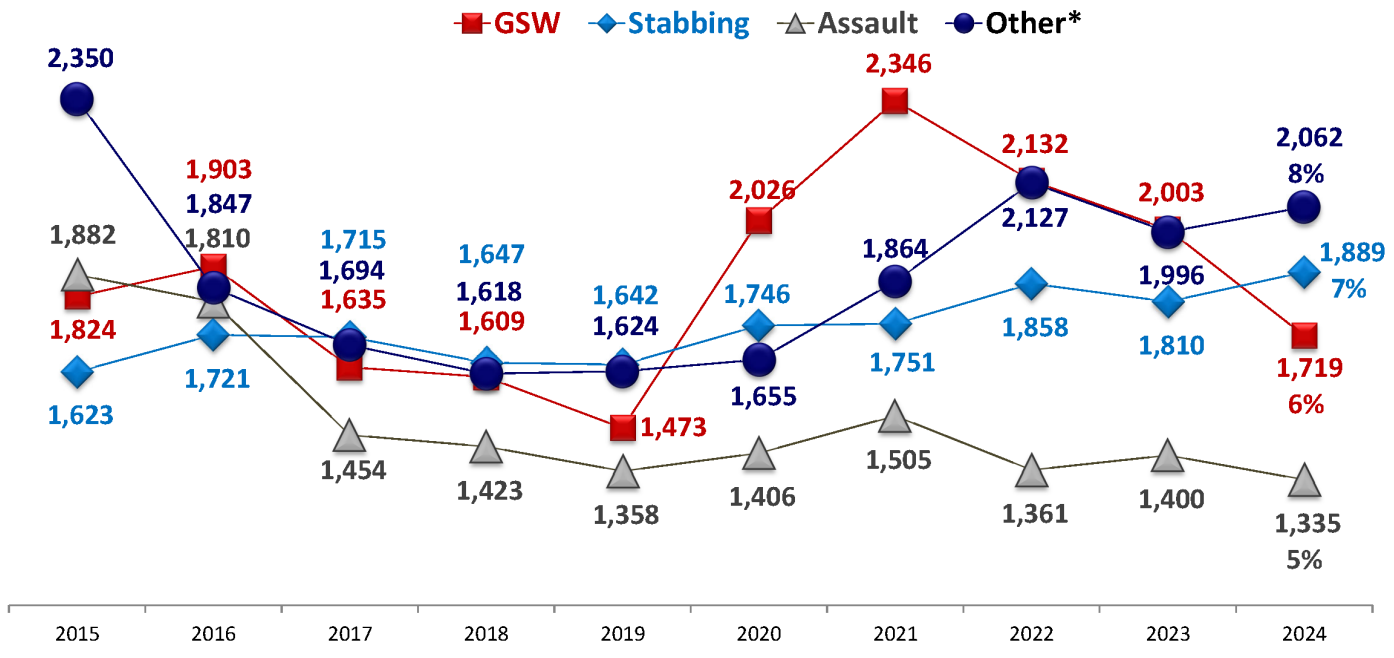
Patient Disposition of Trauma Center Patients



* Transferred to another health facility

Mechanism of Injury: Patients Transported to Trauma Centers



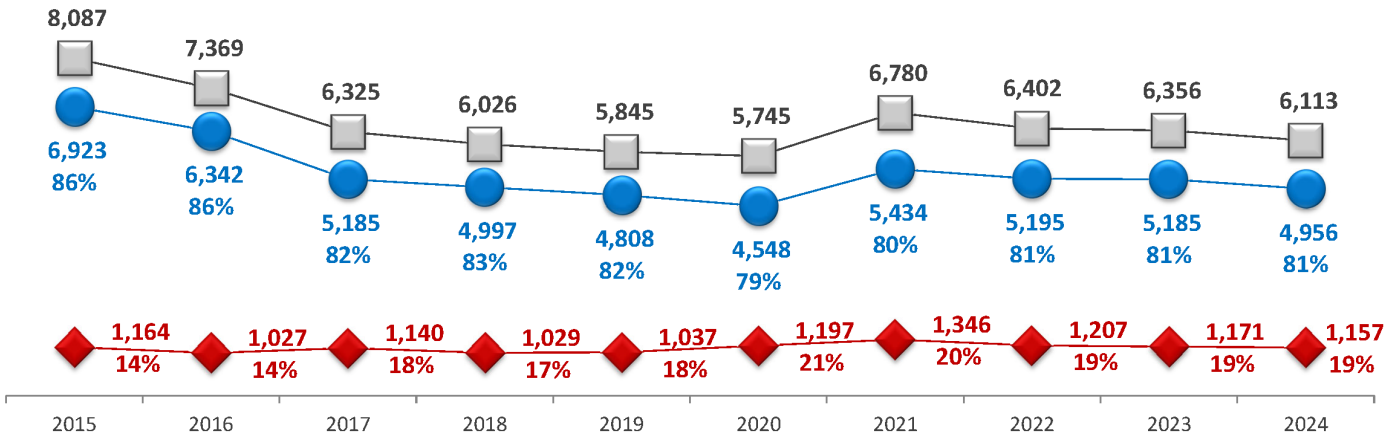


* Other: includes Sports, Work Related, Self-Inflicted, Unknown

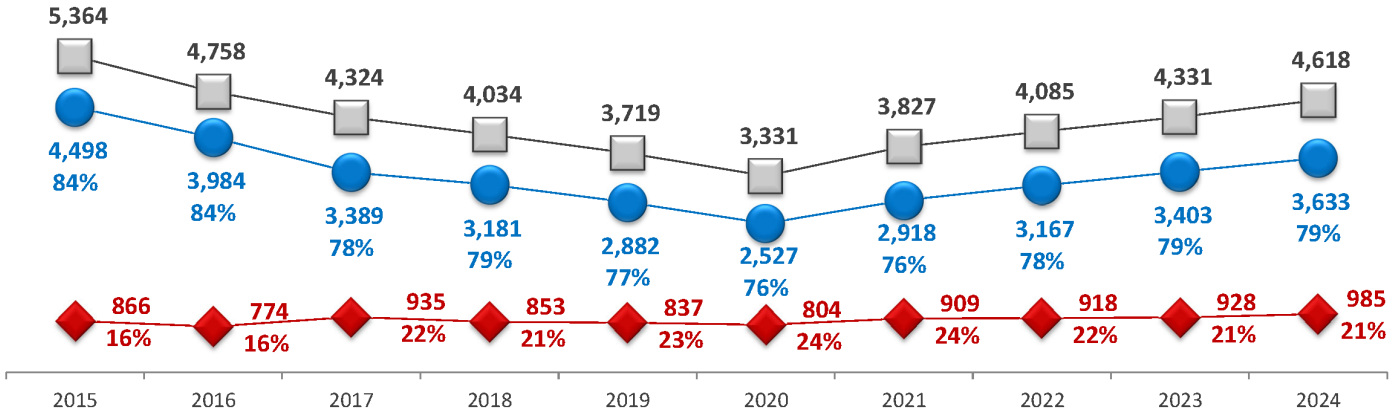
Injury Severity Score by Mechanism of Injury

Injury Severity Score (ISS): Is an established medical score to assess trauma severity. It correlates with mortality, morbidity and hospitalization time after trauma. It is used to define the term major trauma. A major trauma (or polytrauma) is defined as the ISS being greater than 15.

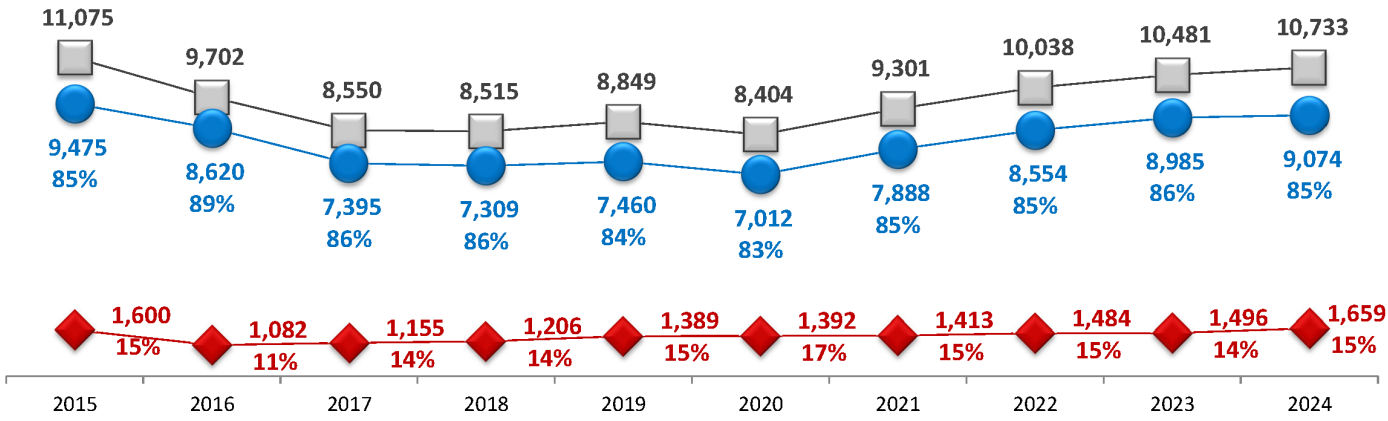
Motor Vehicle Accident



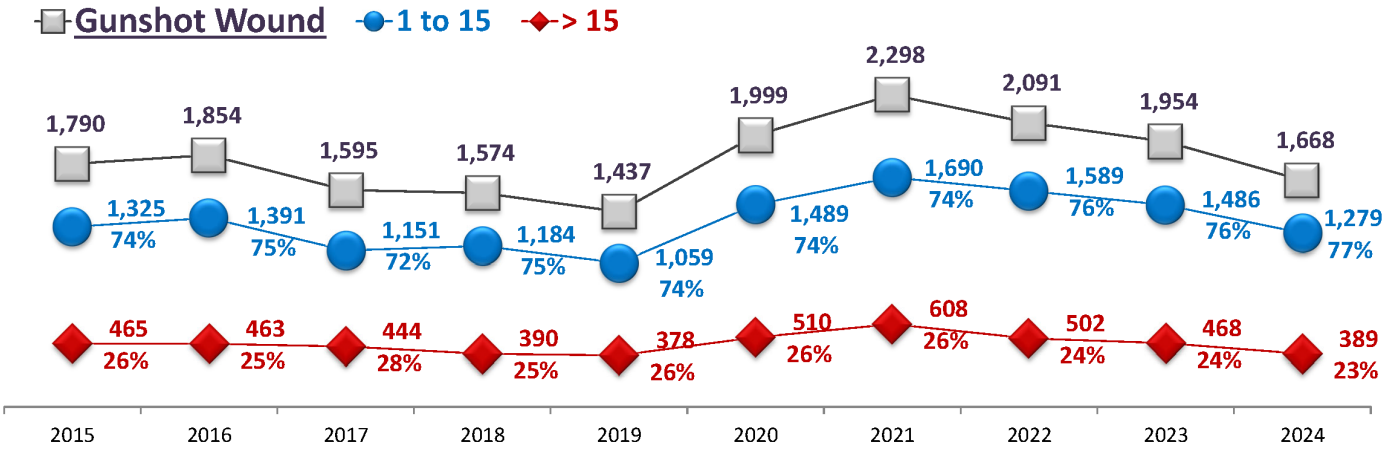
Automobile vs Pedestrian/Bicycle

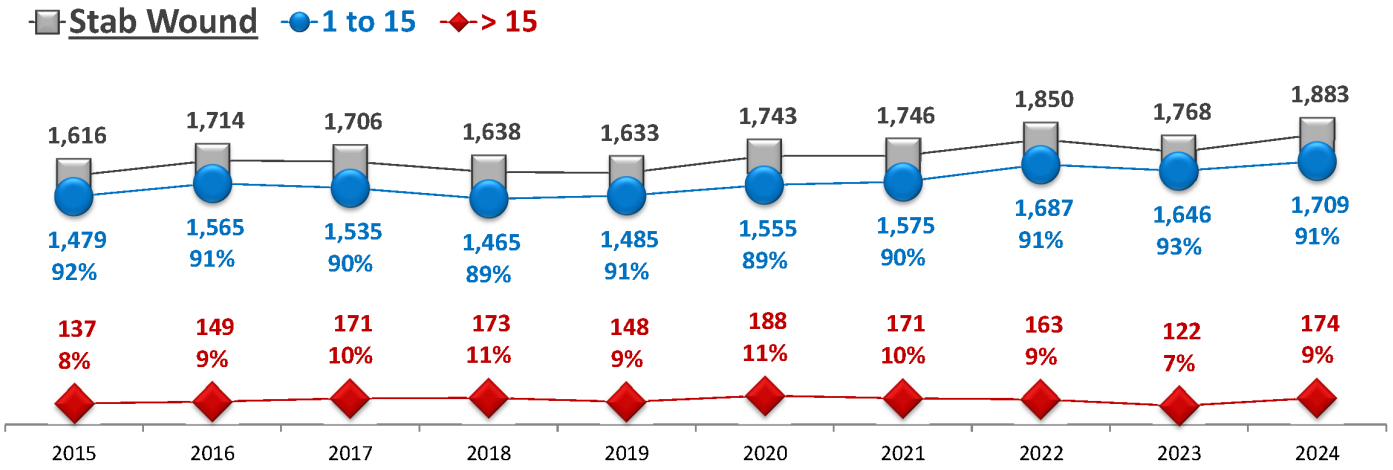


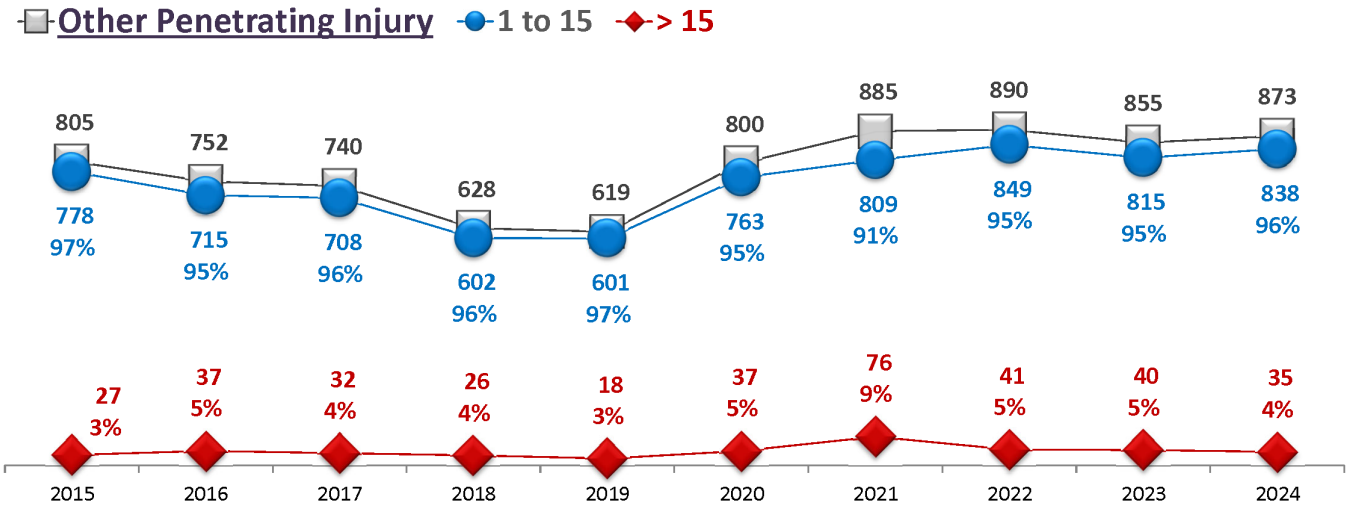
Other Blunt Injuries



Injury Severity Score by Mechanism of Injury



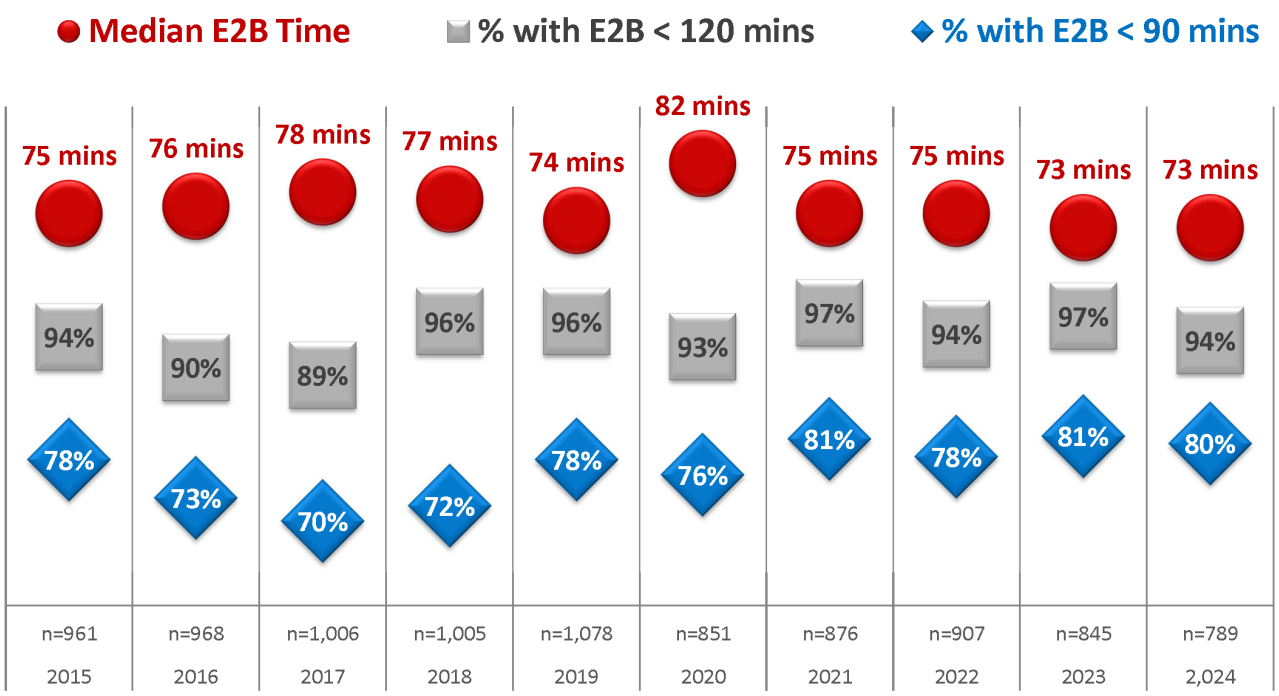




ST-Elevation Myocardial Infarction (STEMI)

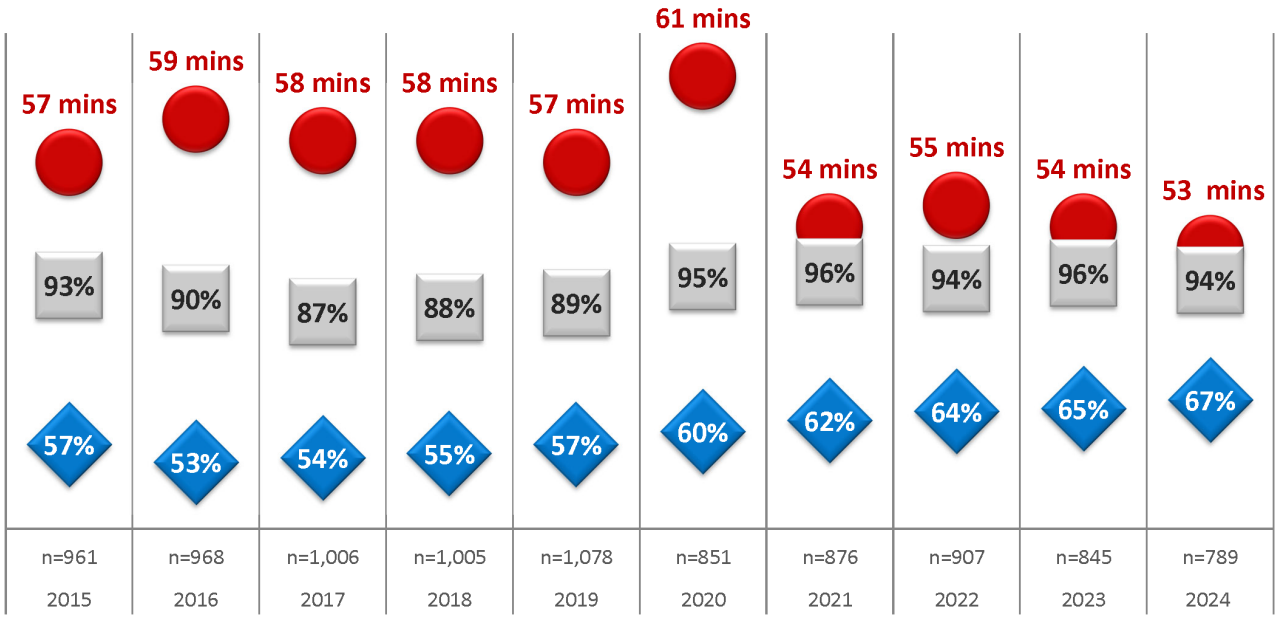
STEMI Receiving Center: EMS Medical Contact-to-Device (E2B) Time

LA County Target: within 120 minutes 90% of the time



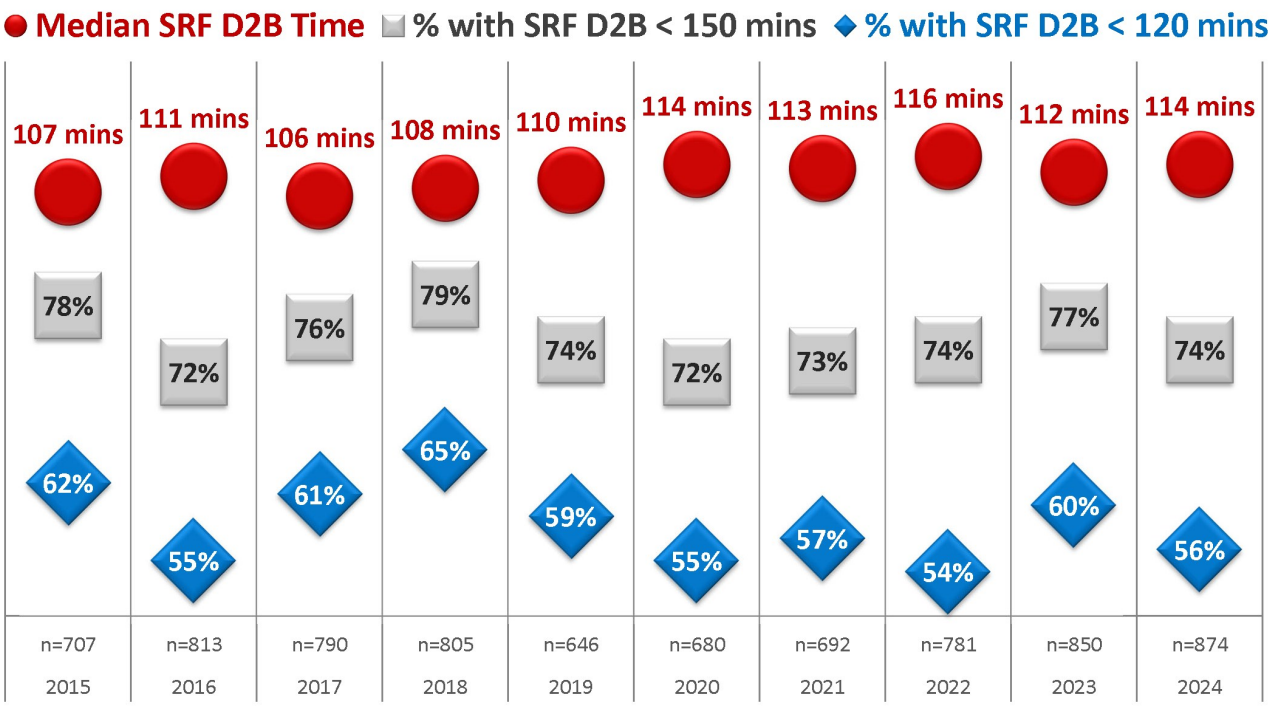
STEMI Receiving Center: Door-to-Device (D2B) Time

LA County Target: within 90 minutes 90% of the time



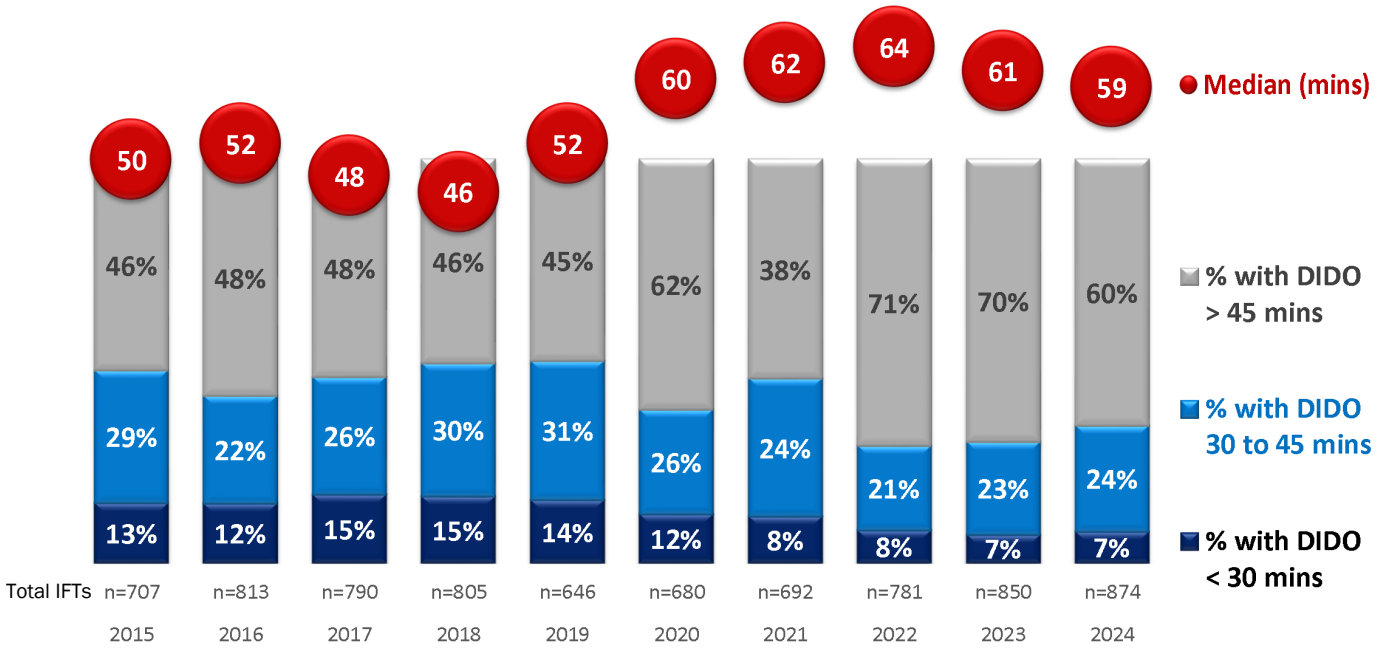
STEMI Referral Facility: Door-to-Device (D2B) Time

LA County Target: within 150 minutes 90% of the time



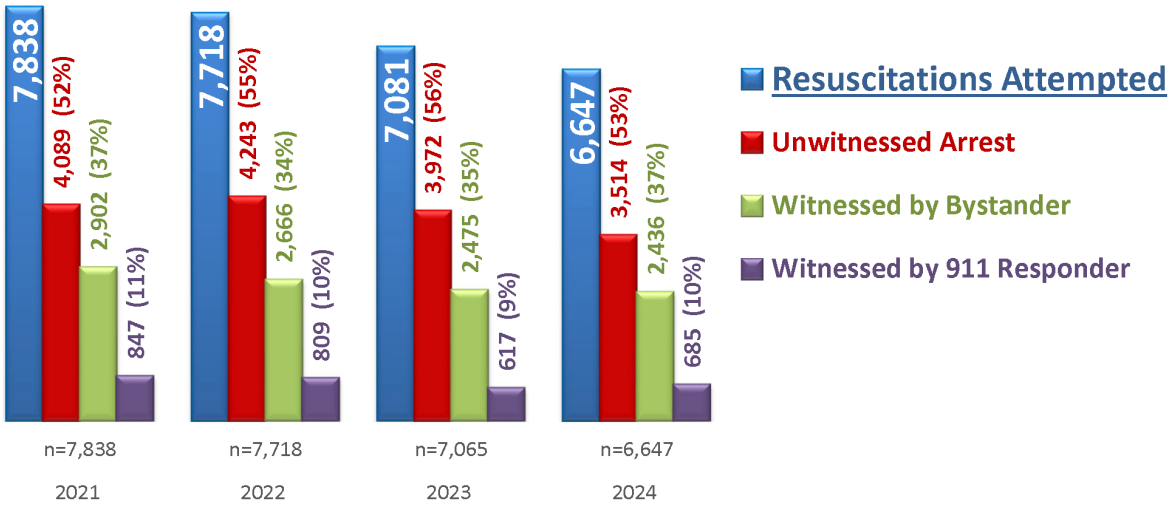
STEMI Referral Facility: Door-in Door-out (DIDO) Time

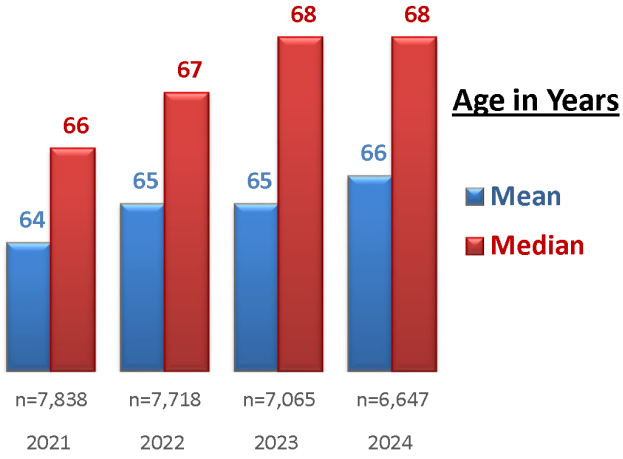
LA County Target: < 30 minutes

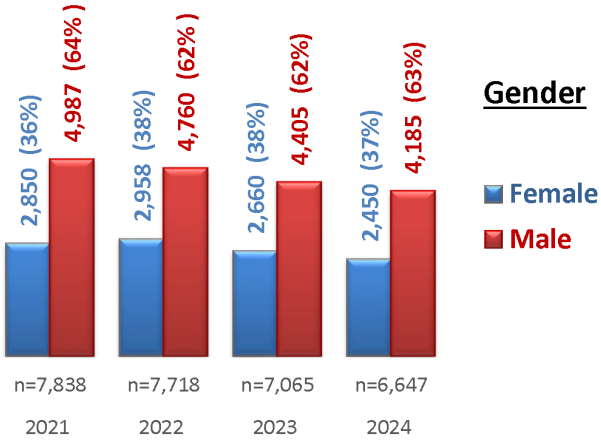


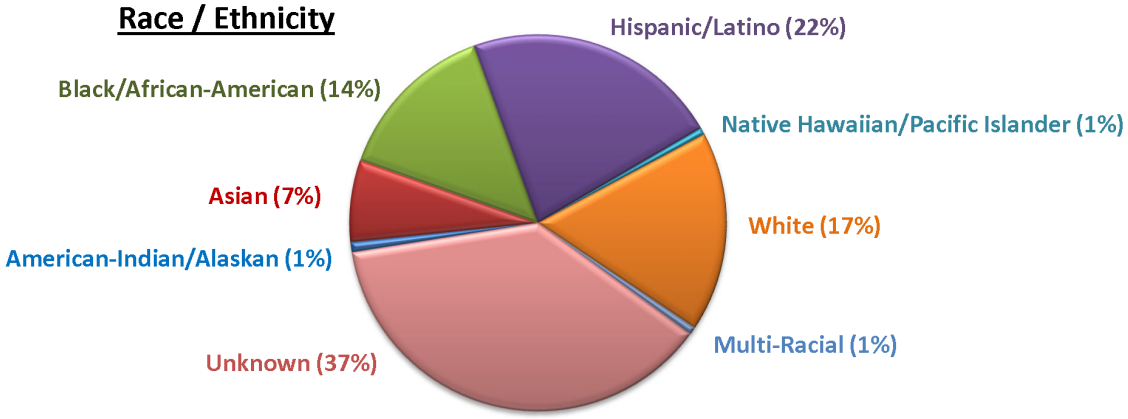
Out of Hospital Cardiac Arrest (OHCA)

Non-Traumatic Etiology



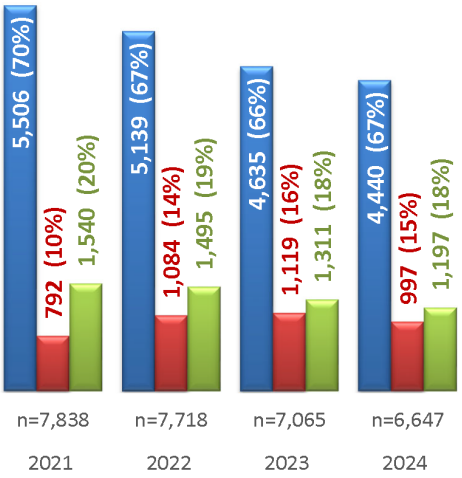




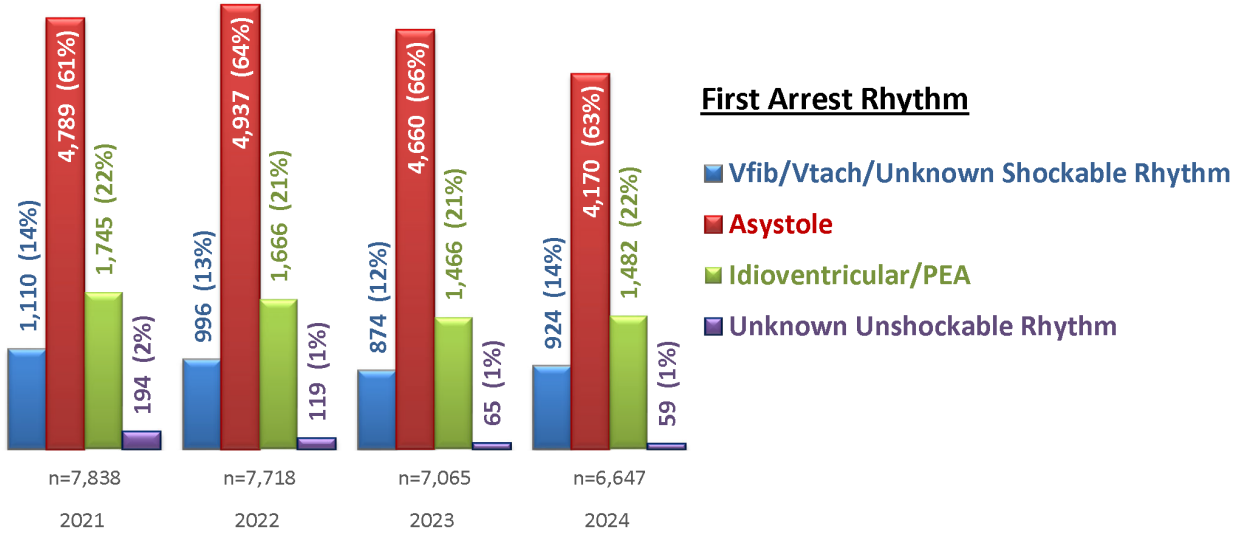


Data Source: Cardiac Arrest Registry to Enhance Survival

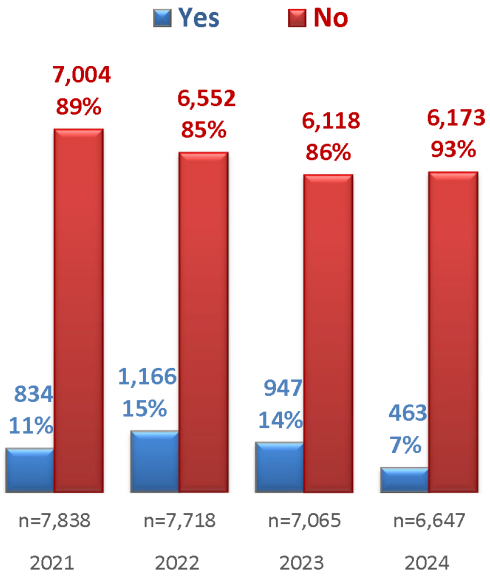
Arrest Location



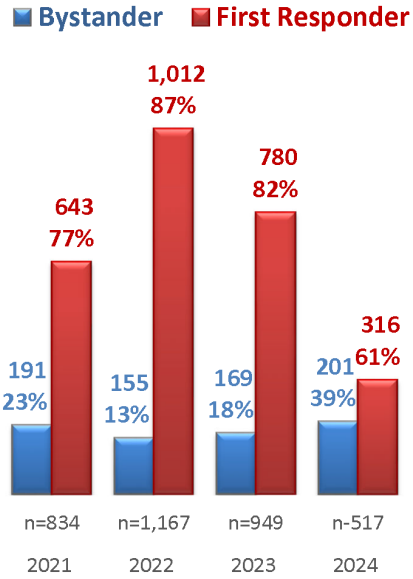
First Arrest Rhythm



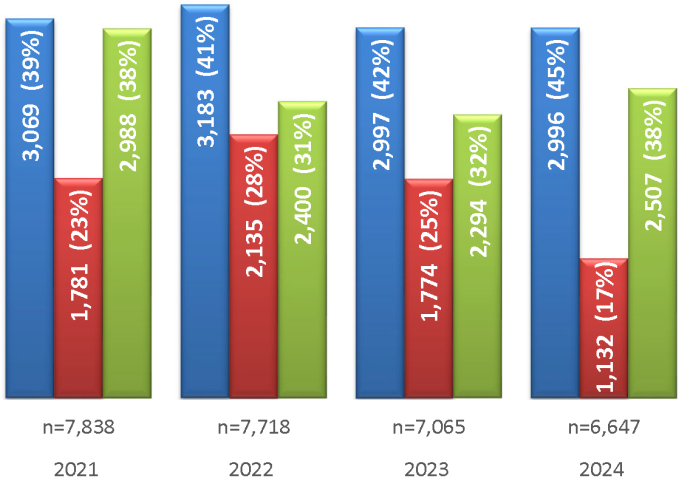
Was an AED Applied prior to EMS Arrival?



Who First Applied AED?

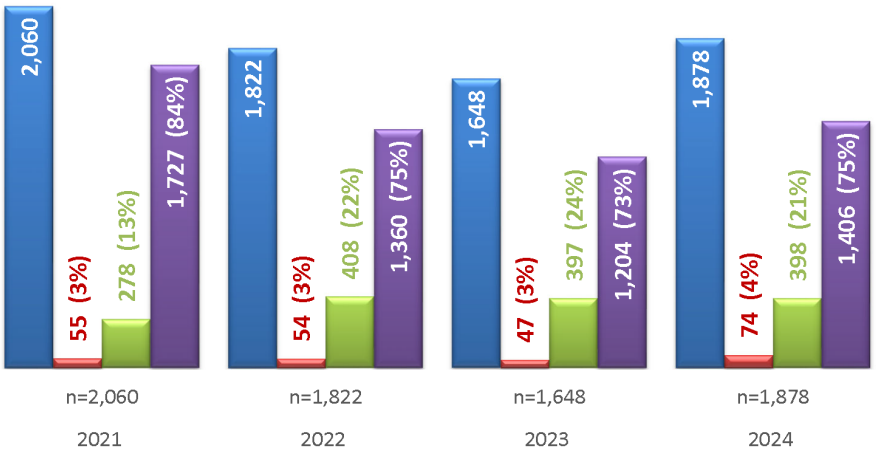


Out of Hospital Cardiac Arrest (OHCA)
Return of Spontaneous Circulation (ROSC)



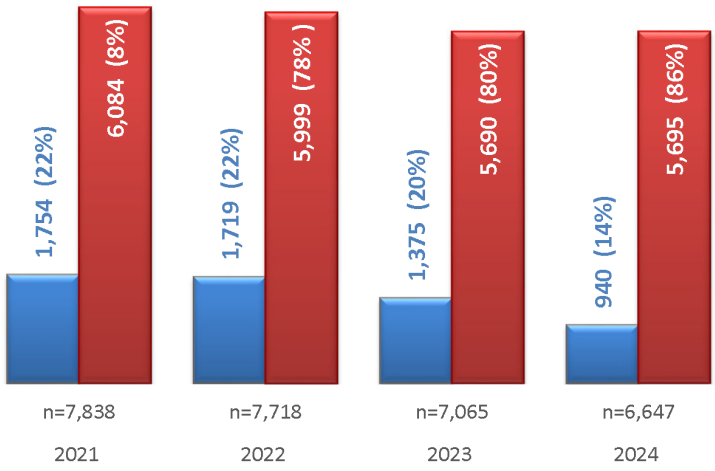
Who Initiated CPR?

- Bystander
- First Responder
- EMS



Who First Defibrillated the Patient?

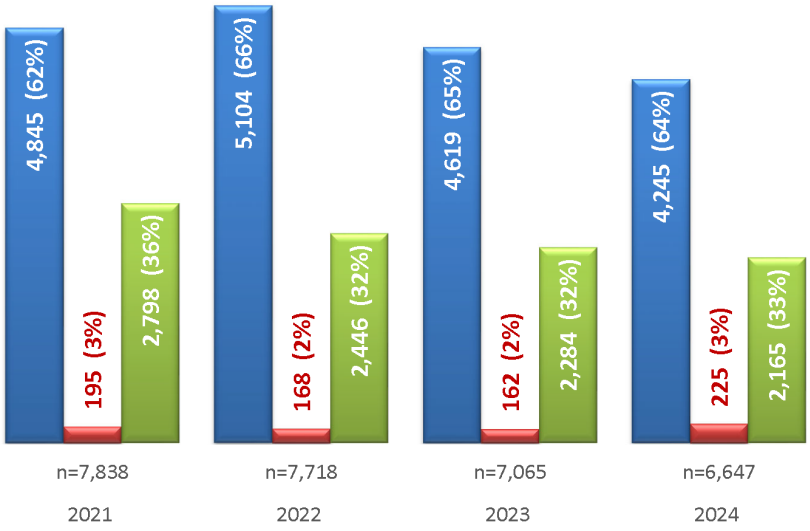
- Patients Defibrillated
- Bystander
- First Responder
- Responding EMS Personnel



Sustained ROSC

- Yes
- No

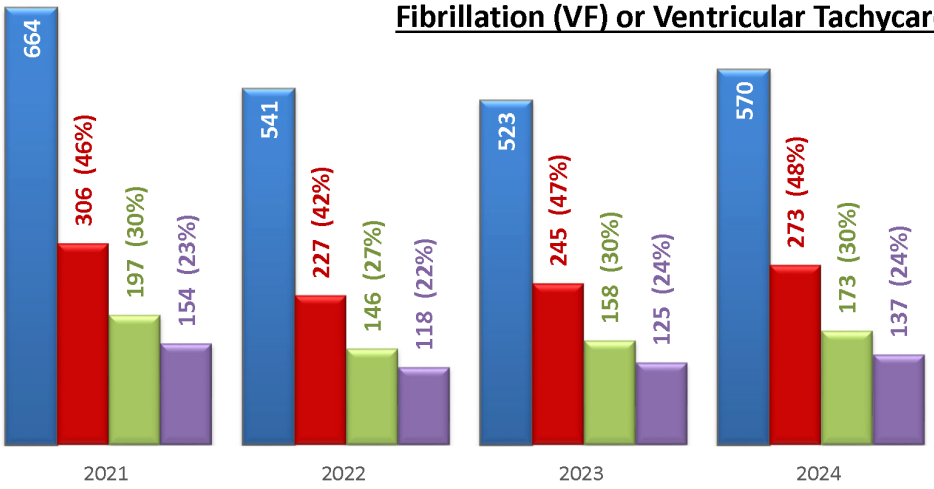
Data Source: Cardiac Arrest Registry to Enhance Survival



Prehospital Outcome

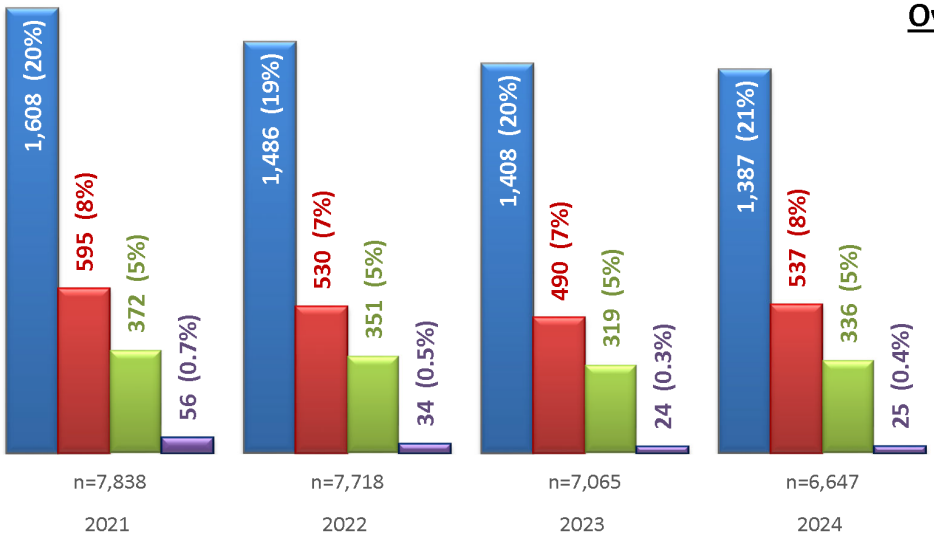
- Pronounced in the Field
- Pronounced in ED
- Ongoing Resuscitation in ED

Outcome of Witnessed Arrest with Initial Cardiac Rhythm of Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT)



- Initial Rhythm VF/VT
- Admitted to Hospital
- Discharged Alive
- With Good or Moderate Cerebral Performance (CPC 1 or 2)

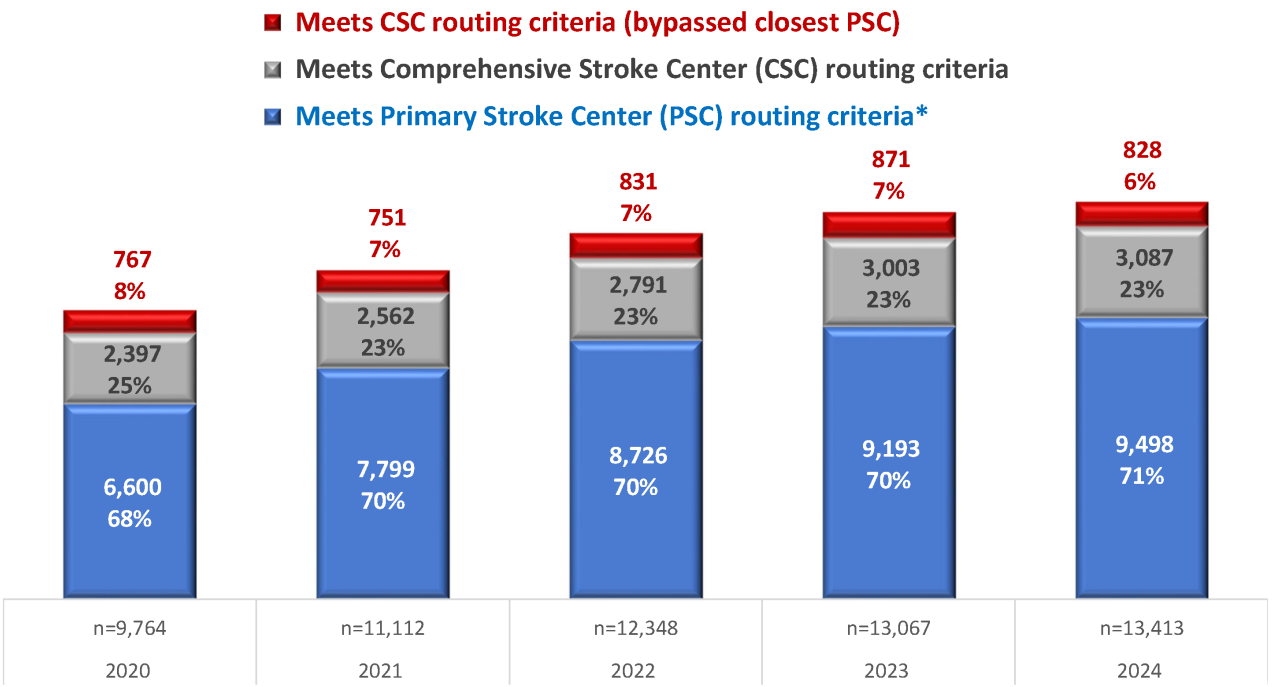
Overall Cardiac Arrest Outcome



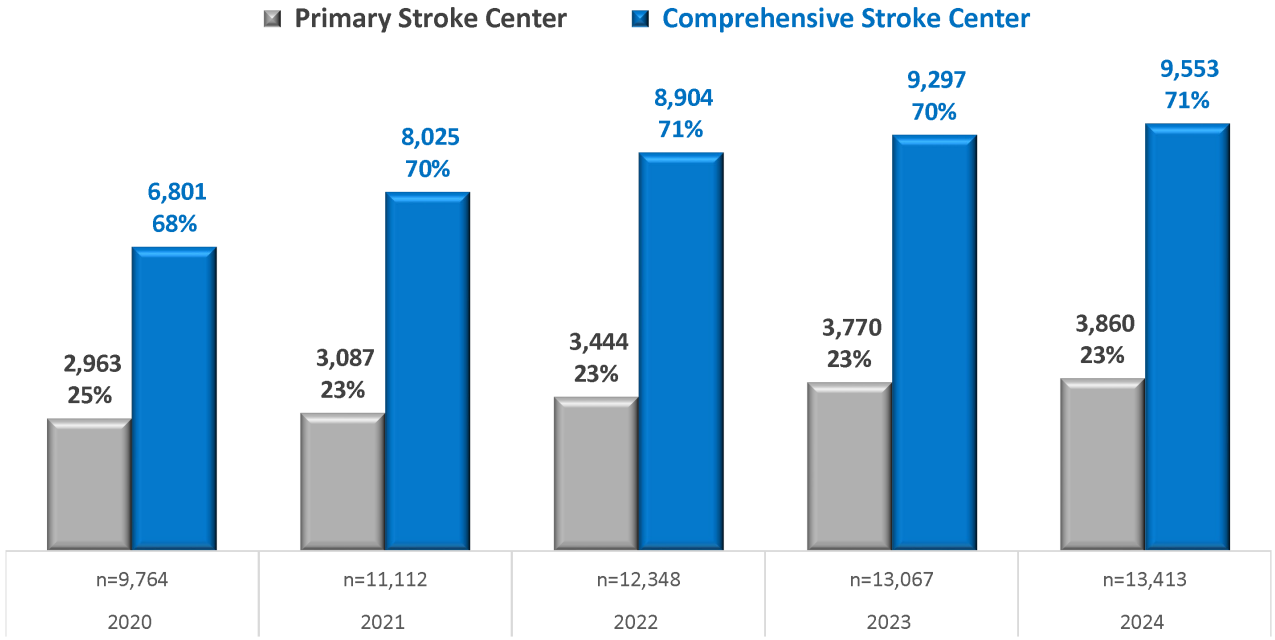
- Overall Survival to Hospital Admission
- Overall Survival to Hospital Discharge
- With Good or Moderate Cerebral Performance (CPC 1 or 2)
- Missing Hospital Outcome

Suspected Stroke Patient Destination

Suspected stroke patients with large vessel occlusions based on a Los Angeles Motor Scale (LAMS) score of 4 or 5 are routed to designated Comprehensive Stroke Centers.



This chart is based on routing criteria. *Includes transports to CSC when CSC is the closest stroke center.

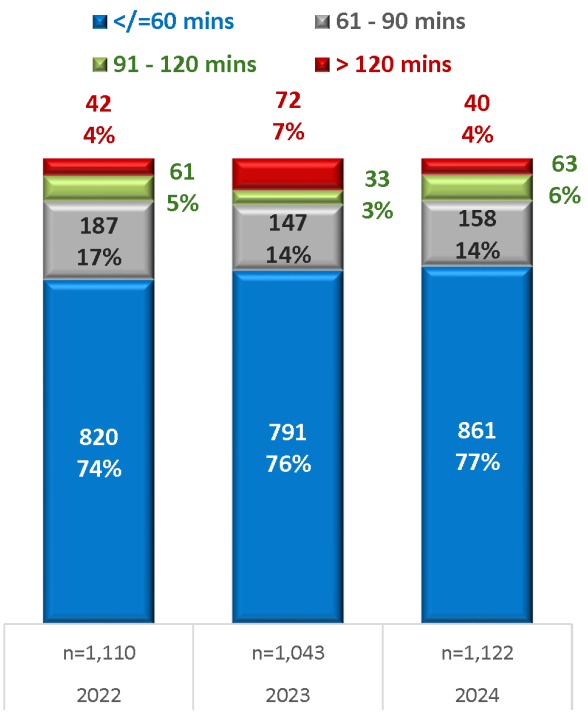


This chart is based on the Stroke Center Designation of the receiving facility, regardless of routing criteria.

Final Diagnosis = Ischemic Stroke

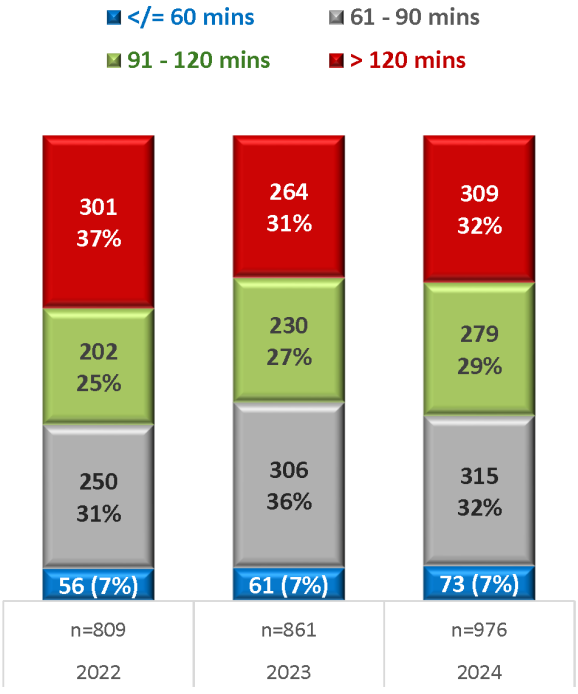
Door-to-Needle (D2N) Times

LA County Target: within 60 mins 75% of the time

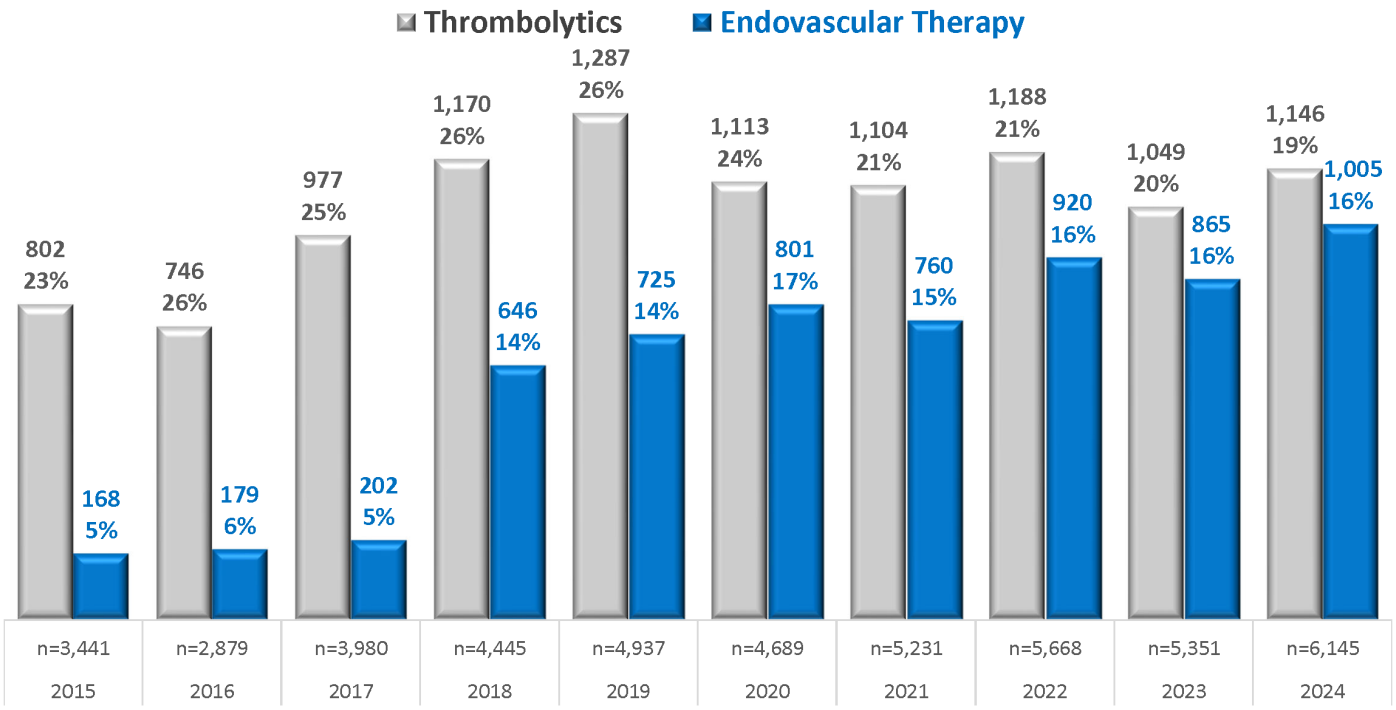


Door-to-Device (D2D) Times

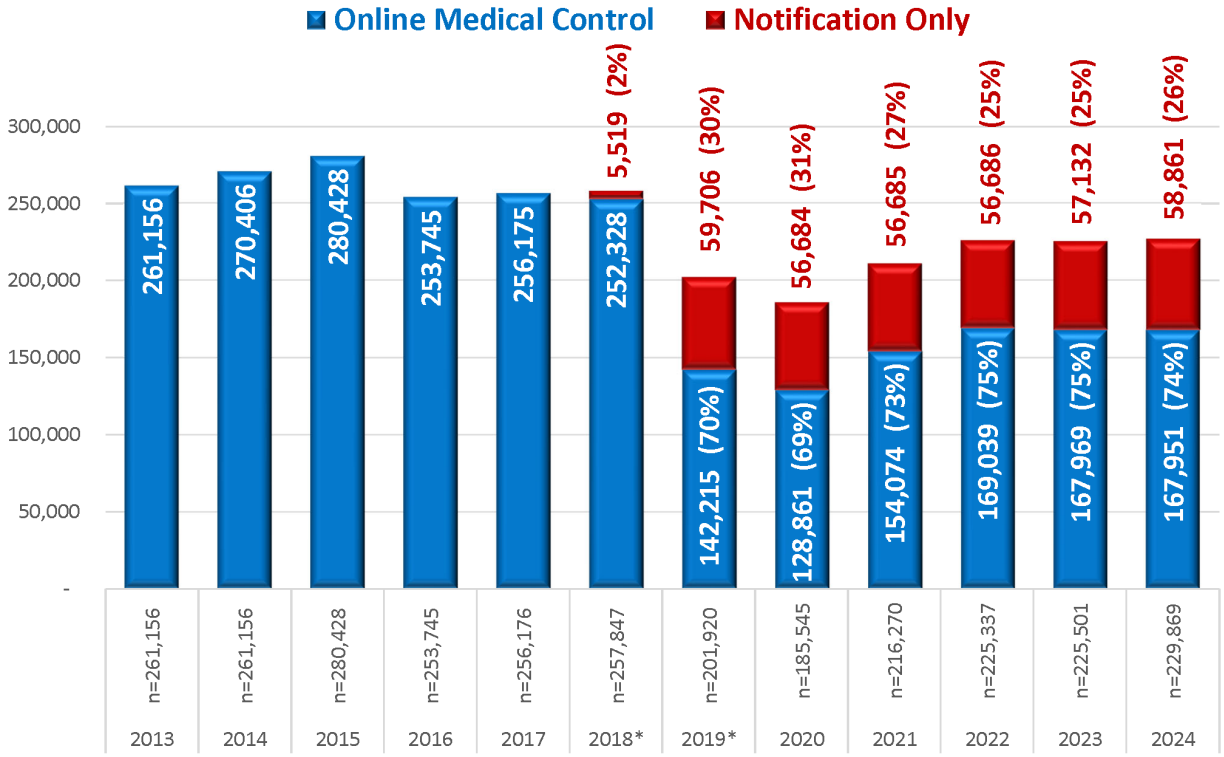
LA County Target: withnin 120 mins 50% of the time



Treatment—All Ischemic Stroke



Paramedic Base Hospital Contact



* Phased-in implementation of New Treatment Protocols started in July 1, 2018 and was fully implemented in April 1, 2019. The New Treatment Protocols reduced the number of EMS responses requiring online medical control.

EMS AGENCY

To ensure timely, compassionate, and quality emergency and disaster medical services.

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Web: http//ems.dhs.lacounty.gov

For data request please complete and submit Reference No. 622.1 at https://file.lacounty.gov/SDSInter/dhs/1179056_622.pdf