



# 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>

## LOS ANGELES COUNTY BOARD OF SUPERVISORS

**Hilda L. Solis**

First District

**Holly J. Mitchell**

Second District

**Lindsey P. Horvath**

Third District

**Janice K. Hahn**

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## COMMISSIONERS

**Diego Caivano, MD, Chair**

LA County Medical Association

**Chief Paul Camacho**

Los Angeles County Police Chiefs' Assn.

**Mr. Jason Cervantes**

California Professional Firefighters

**Erick H. Cheung, MD**

Southern CA Psychiatric Society

**Mr. Ken Domer**

League of Calif. Cities/LA County Chapter

**Tarina Kang, MD**

Hospital Association of Southern CA

**Ms. Carol Kim**

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

**Captain Kristin Kolenda**

Peace Officers Association of LA County

**Lydia Lam, MD**

American College of Surgeons

**Mr. Kenneth Liebman**

LA County Ambulance Association

**James Lott, PsyD, MBA**

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

**Carol Meyer, RN**

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

**Chief Kenneth Powell**

Los Angeles Area Fire Chiefs Association

**Connie Richey, RN**

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

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

American Heart Association

Western States Affiliate

**Carole A. Snyder, RN**

Emergency Nurses Association

**Saran Tucker, PhD, MPH**

Southern California Public Health Assn.

**Atilla Uner, MD, MPH**

California Chapter-American College of

Emergency Physicians (CAL-ACEP)

**VACANT**

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

## EXECUTIVE DIRECTOR

**Richard Tadeo, RN**

(562) 378-1610

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

## COMMISSION LIAISON

**Denise Watson, BSB**

(562) 378-1606

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

DATE: March 18, 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.*

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

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## AGENDA

1. **CALL TO ORDER** – Diego Caivano, MD, Chair
2. **INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS**
  - 2.1 Denise Watson, EMSC Liaison, Retiring Effective March 27, 2026
  - Vanessa Gonzalez, Interim EMSC Liaison, Effective March 27, 2026
  - 2.2 EMSAAC Conference, May 27-28, 2026, Hilton LA/Universal City
3. **CONSENT AGENDA:** *Commissioners/Public may request that an item be held for discussion. All matters are approved by one motion unless held.*
  - 3.1 **Minutes**
    - 3.1.1 January 21, 2026
  - 3.2 **Committee Reports**
    - 3.2.1 Base Hospital Advisory Committee – February 4, 2026
    - 3.2.2 Provider Agency Advisory Committee – February 11, 2026
  - 3.3 **Policies**
    - 3.3.1 Reference No. 414: Specialty Care Transport Provider
    - 3.3.2 Reference No. 511: Perinatal Patient Destination
    - 3.3.3 Reference No. 517: Private Provider Agency  
Transport/Response Guidelines
    - 3.3.4 Reference No. 703: ALS Unit Inventory
    - 3.3.5 Reference No. 703.I: Private Provider Interfacility Transfer  
ALS Unit Inventory
    - 3.3.6 Reference No. 704: Assessment Unit Inventory
    - 3.3.7 Reference No. 706: ALS EMS Aircraft Inventory
    - 3.3.8 Summary of Changes: Reference Nos. 703, 703.1, 704, 706

**END OF CONSENT AGENDA**

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4. **BUSINESS**

**Business (Old)**

- 4.1 Field Evaluation of Suicidal Ideation and Behavior
- 4.2 Ambulance Patient Offload Time (APOT)
- 4.3 Interfacility Transfer Taskforce
- 4.4 Cardiac Arrest Taskforce

**Business (New)**

- 4.5 September 16, 2026, EMSC Meeting Date Change to September 9, 2026

5. **LEGISLATION**

6. **DIRECTORS' REPORTS**

- 6.1 Richard Tadeo, Director – EMS Agency, Executive Director – EMS Commission

**Correspondence**

- 6.1.1 (02/24/2026) From EMS Authority: Exceedance of Ambulance Patient Offload Standards – January 2026 Electronic Notification
- 6.1.2 (03/03/2026) Retirement Letter – EMSC Liaison Denise Watson, March 27, 2026
- 6.2 Nichole Bosson, MD, Medical Director – EMS Agency

7. **COMMISSIONERS' COMMENTS / REQUESTS**

8. **ADJOURNMENT**

- Adjournment to the meeting of May 20, 2026

# BACK TO THE FUTURE EMS REIMAGINED

2026  
ANNUAL  
CONFERENCE

## SAVE THE DATE

MAY 27 & 28, 2026

EMSAAC 2026 CONFERENCE



Presented by:  
EMS Administrators'  
Association of California

Monitor the EMSAAC website for  
current information: [www.emsaac.org](http://www.emsaac.org)

HILTON LA/UNIVERSAL CITY

MAY 26, 2026 PRE-CONFERENCES

EQI: THE NEXT ERA OF EMS QUALITY

GREAT SCOTT! THERE'S THAT WORD AGAIN: 'DISASTER'



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**MINUTES  
JANUARY 21, 2026**

<input checked="" type="checkbox"/> Diego Caivano, M.D.	LACo Medical Association	Richard Tadeo	Executive Director
<input type="checkbox"/> Jason Cervantes	CA Professional Firefighters	Denise Watson	EMSC Liaison
<input checked="" type="checkbox"/> Erick H. Cheung, M.D.	So. CA Psychiatric Society	Nichole Bosson, MD	EMS Staff
<input type="checkbox"/> Paul Camacho, Chief	LACo Police Chiefs' Assn.	Denise Whitfield, MD	EMS Staff
<input checked="" type="checkbox"/> Kenneth Domer	League of CA Cities/LA Co	Jacqueline Rifenburg	EMS Staff
<input checked="" type="checkbox"/> Tarina Kang, M.D.	Hospital Assn. of So. CA	Jon Warren, MD	EMS Staff
<input checked="" type="checkbox"/> Carol Kim	Public Member, 1 <sup>st</sup> District	Michael Kim, MD	EMS Staff
<input type="checkbox"/> Kristin Kolenda, Captain	Peace Officers Association	Jake Toy, MD	EMS Staff
<input checked="" type="checkbox"/> Lydia Lam, M.D.	American College of Surgeons	Mark Ferguson	EMS Staff
<input checked="" type="checkbox"/> Kenneth Liebman	LACo Ambulance Association	Sara Rasnake	EMS Staff
<input type="checkbox"/> James Lott, PsyD, MBA	Public Member, 2 <sup>nd</sup> District	Christine Zaiser	EMS Staff
<input type="checkbox"/> Carol Meyer, RN	Public Member, 4 <sup>th</sup> District	HanNa Kang	EMS Staff
<input checked="" type="checkbox"/> Kenneth Powell	LA Area Fire Chiefs' Assn.	Aldrin Fontela	EMS Staff
<input type="checkbox"/> Connie Richey, RN	Public Member 3 <sup>rd</sup> District	David Wells	EMS Staff
<input checked="" type="checkbox"/> Stephen G. Sanko, MD	American Heart Association	Vanessa Gonzalez	EMS Staff
<input checked="" type="checkbox"/> Carole A. Snyder, RN	Emergency Nurses Assn.	Aldrin Fontela	EMS Staff
<input type="checkbox"/> Saran Tucker	So. CA Public Health Assn.	Ami Boonjaluksa	EMS Staff
<input checked="" type="checkbox"/> Atila Uner, M.D., MPH	CAL-ACEP		
<input type="checkbox"/> VACANT	Public Member, 5 <sup>th</sup> District		
<b>GUESTS</b>			
Jennifer Shepard, LASD	Laurie Donegan APCC	Jack Yandell, IAEP	
Omar Khattab, USC/LAGMC	Michael Stone, USC/LAGMC		

**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 1:01 p.m. EMSC Liaison, Denise Watson, called the roll and a quorum of 11 members were present. Chair Caivano opened the floor for a report from the Nominating Committee.

**2. NOMINATIONS/SELECTIONS FOR 2026:**

- 2.1 Chair
- 2.2 Vice Chair
- 2.3 Measure B (MBAB) Representative
- 2.4 Standing Committee Assignments

Commission Liaison Denise Watson reported on behalf of the Nominating Committee: Stephen Sanko, Ken Powell, and James Lott, and provided their recommendations for 2026 EMSC Chair and Vice Chair. Recommendations were announced, declines and further nominations were made, and the following selections were made.

***Motion/Second by Commissioners Cheung/Caivano for current Chair Diego Caivano to continue a second term as Chair for 2026 was carried by majority vote.***

***Motion/Second by Commissioners Cheung/Sanko for current Vice Chair Stephen Sanko to continue a second term as Vice Chair for 2026 was carried by majority vote.***

EMSC Executive Director Richard Tadeo reported on Standing Committee Assignments and noted that current MBAB representative Commissioner Carol Meyer was interested in continuing as 2026 MBAB representative. There was no opposition.

***Motion/Second by Commissioners Kim/Lam for Measure B (MBAB) Representative Commissioner Carol Meyer to continue as 2026 MBAB Representative and Standing Committee Assignments to remain the same was carried by majority vote.***

**3. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS**

3.1 Director Tadeo reported on the Annual EMSAAC Conference to be held May 27-28, 2026, at the Hilton/Los Angeles/Universal City. Flyers were available at the meeting.

**4. 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.

**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 – **Held for Discussion**

4.3.9 Reference No. 842.1: EMS Resource Guidelines for Mass Gathering and Special Events

***Motion/Second by Commissioners Cheung/Uner to approve the Consent Agenda was carried unanimously excluding Policies 4.3.8: “Reference No. 842: Mass Gathering...” which was held for discussion by Vice Chair Sanko.***

Ayes: (11) *Diego Caivano, Erick Cheung, Ken Domer, Tarina Kang, Carol Kim, Lydia Lam, Ken Liebman, Ken Powell, Stephen Sanko, Carole Snyder, Atilla Uner.*

Nays: (0)

Abstains: (0)

Absent: (7) Jason Cervantes, Paul Camacho, Kristin Kolenda, James Lott, Carol Meyer, Connie Richey, Saran Tucker.

**Discussion: Policies 4.3.8: Reference No. 842: Mass Gathering and Special Events Interface with Emergency Medical Services, Reference No. 842, Page 4:**

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

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”

Vice Chair Sanko questioned if the policy language above, “...upon request”, means that the MAC notifies the hospital emergency department (ED) seven (7) days prior every time or only upon the hospital’s request, and noted the importance of ED Medical Director notification.

Director Tadeo explained that when the EMS Agency is notified of an event, an action plan is created with all the forms necessary to identify who the MAC is, who the administrators and medical officers on duty are, and the communication that will be in place. The action plan gets disseminated 7 days in advance to the appropriate receiving hospitals and providers through mass email unless there is not sufficient lead time given to the Agency about the event.

It was discussed and confirmed that EMTs hired for special events do operate in their full scope of practice, they are required to be certified, and direct/indirect physician oversight depends upon the scope of the incident (see Reference No. 842.1).

***Motion/Second by Commissioners Sanko/Snyder to approve Policies 4.3.8 “Reference No. 842: Mass Gathering and Special Events Interface with Emergency Medical Services” as presented in the Consent Agenda was carried and approved unanimously.***

**END OF CONSENT AGENDA**

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**5. BUSINESS**

**Business (Old)**

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

Director Tadeo reported there are no updates, and noted the workgroup is looking at exploring opportunities to support reimbursement for transport to alternate destinations as one of their goals for 2026. The Commission agreed this is a good goal for 2026.

**5.2 Ambulance Patient Offload Time (APOT)**

EMS Agency Assistant Director Jacqueline Rifenburg provided a comparison report on fourth quarter APOT with side-by-side reference to 2025 and 2024 fourth quarter results and noted that 80% of the hospitals showed improvement in 2025 over 2024, and six (6) out of the 69 hospitals had less favorable results in 2025 than in 2024.

Commissioner Carole Snyder acknowledged that APOT results look better by 6 or 10 minutes and asked if a column could be added showing the number of licensed ED beds for each facility as well as a bed breakdown and the size of the hospitals to make comparisons by region.

Director Tadeo reported on Assembly Bill (AB) 40 and noted that the State EMS Authority identified 15 hospitals with the worst APOT, and of those 15 there were nine (9) in Los Angeles County. The State has engaged those individual hospitals to determine if they have submitted and/or implemented their mitigation strategies. Each of the 9 LA County hospitals have submitted them. There are ongoing challenges with hospital throughput constraints, construction and capacity limitations, and the need for more accurate data on licensed beds versus staffed beds. There was further discussion on maximizing utilization of the audit tool to facilitate data accuracy and on identifying trends to improve APOT.

There was a request for assistance from the Hospital Association of Southern California (HASC) with the multiple ways to count beds in hospitals, identifying the different types of beds not just licensed beds but including those made into offices, staff beds, etc., and determining when a hospital is at capacity. It was noted the ReddiNet system is aligned with those definitions and already in place.

**5.3 Interfacility Transfer Taskforce**

Assistant Director Rifenburg reported the IFT workgroup will not meet in February so that they can gather more data. Statistics were provided on the last six months of appropriate 9-1-1 IFT transports compared to IFTs that were inappropriate for 9-1-1 retriage via the 9-1-1 system. The EMS Agency is working with those facilities with high inappropriate IFTs via the 9-1-1 system on a one-on-one basis and reported overall improvement with utilization through the 9-1-1 system.

It was emphasized that 9-1-1 is not a resource for IFTs but is a community resource that is being used occasionally for patients that critically need that time-sensitive transfer, but other resources that can get them there in a reasonable amount of time are not available. There was further discussion regarding identifying funding streams to create resources for those types of situations such as utilizing Measure B funds. However, at the July 15, 2025, Board of Supervisors' (BOS) meeting there were about \$20 million in unallocated funds that would typically go through the Measure B Advisory Board (MBAB), but the BOS opted to allocate those funds to Martin Luther King, Jr. Community Hospital (MLK) and Catalina Island Medical Center, and then there was a remainder of \$20 million which was allocated equally to each BOS' District to determine how those funds would be allocated.

An IFT checklist was developed for referral facilities to use for trauma and STEMI retriage. The STEMI checklist has been finalized and distributed as an attachment to the STEMI patient destination policy. The trauma checklist is in the process of being refined to be consistent with the Trauma Re-triage policy. Once endorsed by the other subcommittees and the Commission, it will be released as an attachment to the Trauma Re-triage policy.

There was discussion on what happens with cases not being transferred and if there is a mechanism to review these cases. The expectation is that the Cognito form is completed for every 9-1-1 IFT transport request even if no transport occurs, and the Cognito form has a section to document the reason for not transporting the patient.

**5.4 Cardiac Arrest Taskforce**

Vice Chair Sanko reported on community-based engagement to promote cardiac arrest preparedness with our community health and our community clinic syndicate with their recommendations on improving dissemination of bystander CPR, AED uptake, as well

as getting information from hospitals post arrest for patients that survive. The taskforce will soon be hearing about survivor services, responsible models for medical oversight, training, minimums and engagement with faith-based communities and civic groups to promote preparedness. To date, there have been 42 recommendations. Starting Monday, January 26, 2026, monthly clinics with both fire departments and hospitals on preparing their cardiac arrest surveillance and improvement plans that are due at the end of the second quarter will begin.

**Business (New)**

**5.5 EMS Goals Planning Document 2026**

Director Tadeo reviewed the four items listed on the EMSC Goals Planning Document for 2026.

Commissioner Erick Cheung indicated that Goal two (2) (Mental Health and Substance Abuse) Potential Action #2 regarding the “field evaluation of suicidal ideation” should be marked complete.

An additional Potential Action for Goal four (4) (Cardiac Arrest Workgroup) is “to finalize and work towards implementation of the task force recommendations when completed.”

**6. LEGISLATION**

Director Tadeo reported that the session has started and proposed legislation is coming in, but there is no anticipation for a lot of EMS systems legislation. He reported California Department of Public Health (CDPH) came out with a new regulation in terms of nurse-to-patient ratio for inpatient psychiatric hospitals of one nurse to six patients. The implementation is the end of January 2026. The Hospital Association of Southern California and the California Police Chiefs’ Association have expressed concerns on the impact, specifically the closure of beds to comply with the new regulation. These organizations are requesting CDPH to delay implementation to allow hospitals to hire and adequately onboard qualified clinicians.

Commissioner Cheung added that neither HASC nor the hospitals themselves are opposed to the six-to-one ratio, but the implementation timeline is way too fast. These regulations were released in draft form in late December 2025, for implementation on January 31, 2026, and hospitals simply do not have enough nurses and time to comply with the regulations. The hospitals do not have a choice but to close beds or face a \$30,000 per day fine for being out of compliance. The estimated ED impact is that anywhere from 10% to 30% of beds would have to be closed in those facilities, meaning several hundred beds across the state would have to be closed at least temporarily until they could hire to fall within ratio.

Director Tadeo reported on a ballot measure being proposed and organized by a private coalition to impose a half cent general tax in Los Angeles County. This tax is intended to provide funding to the healthcare safety net in the County which is heavily impacted by the federal funding cuts imposed by HR1. It is estimated that 700,000 undocumented immigrants in the County will lose their medical insurance coverage and will seek healthcare through the safety net network. If passed, this sales tax is expected to generate \$1 billion dollars. The tax is for five (5) years and can be repealed should the financial outlook from the federal government become more favorable in future years. The sales tax exempts groceries, prescription medications and durable medical equipment. This proposed ballot measure is expected to be on the Board of Supervisors’ meeting agenda in February 2026.

## 5. **DIRECTORS' REPORTS**

### 5.1 Richard Tadeo, EMS Agency Director, EMSC Executive Director

Director Tadeo discussed the EMS Annual Systems Report and dedicated it to Chris Clare who retired in September 2025, and acknowledged her work with the data system. He reviewed the various data components in the report, graphs, and charts, and provided overall statistics contained within the report.

Director Tadeo reported that the Health Data Exchange (HDE) Business Associate Agreement (BAA) with EMS provider agencies has been approved in form by County Counsel and the department's Contracts and Grants Division. We have contacted and sent the BAA for execution to the seven (7) EMS provider agencies (Burbank, Glendale, LA City, LA County, Pasadena, San Marino, and South Pasadena fire departments) that transport to Adventist Health Glendale (the only hospital fully on boarded in HDE). All 7 agencies have expressed interest in signing the BAA. This BAA is necessary to provide these EMS provider agencies access to the patient outcomes of patients these agencies transport to Adventist Health Glendale.

As hospitals go-live on HDE, the EMS providers transporting patients to the hospital will be contacted for execution of the BAA with the County.

Saint Francis Medical Center is expected to be the next hospital to go-live which would be a great addition to the southeast area of the county. Many hospitals continue the discovery phase. Some of the technical issues that have been identified in this discovery phase is the different versions of Health Level 7 (HL7) and whether it is compatible with HDE. (HL7 is the gold standard for securing electronic transmission of medical information, and security requirement of the various hospital EHRs.)

### **Correspondence**

5.1.1 (09/03/25) EMS Agency Changes

5.1.2 (09/04/25) New 9-1-1 Alternate Destination Respite & Sobering Center – MLK Campus

5.1.3 (09/29/25) Allocation of Pediatric Trauma Center Funding – Cedars-Sinai Medical Center

5.1.4 (09/29/25) Allocation of Pediatric Trauma Funding – Dignity Health Northridge Hospital Medical Center

5.1.5 (10/01/25) EMS Plan 2023-24 EMS Agency Approval Letter

### 5.2 Nichole Bosson, MD, Medical Director, EMS Agency

Dr. Bosson provided updates on clinical projects and initiatives including:

#### **LA-DROP**

LA-DROP – Prehospital Blood Transfusion Pilot Program with Compton and LA County Fire Departments which began April 1, 2025. There are ongoing efforts to secure funding for this including a blood transfusion pilot.

#### **Pedi-PART and PediDOSE**

The Pedi-PART and PediDOSE studies – Prehospital airway resuscitation trials for pediatrics and seizure, age-based dosing. PediDOSE enrollment target is up to 2029 patients and will continue until the end of summer 2026. LA County has contributed over 300 patients.

### **EMS UPDATE**

EMS Update – Dr. Shira Schlesinger is overseeing the EMS Update training which focuses on pediatric resuscitation, care of pregnant patients, and enhanced use of capnography.

### **CARDIAC ARREST AND COMMUNITY ENGAGEMENT**

Dr. Bosson emphasized the EMS Agency's role in community discussions on cardiac arrest and the need for better hospital in-patient cardiac arrest data.

### **TRAUMA DASHBOARDS**

Trauma dashboards are live and posted on the EMS Agency website. Preventative and post-crash care is also live on the EMS Agency website. The web link was emailed to the Commissioners upon conclusion of the November 18, 2025, EMSC meeting.

### **ELCoR**

EMS and Law Enforcement Co-response Task Force is being led by Dr. Michael Kim with a focus on training law enforcement officers on managing agitated persons and improving collaboration and communication between EMS and law enforcement.

Assistant Medical Director, Denise Whitfield, MD, reported on the following:

### **RAPID MEDIC Mobile APP Project**

The Protocol App project is nearing completion, and the results will be shared soon. The protocol app committee will analyze usage data and reconvene to identify improvements.

### **2026 FIFA World Cup**

The 2026 FIFA World Cup will be in Los Angeles and will host eight (8) matches at SoFi Stadium. There will be a Fan Fest at the Coliseum, there are plans for fan zones, team hotels, and related operations. There will be a FEMA hospital readiness workshop scheduled for April 1, 2026.

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

Commission comments included concerns about vaccination access, survivorship groups, and medical oversight for film/television productions.

## **7. ADJOURNMENT**

Adjournment by Chair Caivano at 2:52 PM.

**Next Meeting:** Wednesday, March 18, 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

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



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



**BASE HOSPITAL ADVISORY  
COMMITTEE MINUTES**

**February 4, 2026**

Representatives			Representatives		
X	Tarina Kang, MD, Chair	EMS Commission	X	Rachel Caffey	Northern Region
	Lydia Lam, MD, Vice Chair	EMS Commission	X	Jessica Strange	Northern Region
	Atilla Under, MD, MPH	EMS Commission	X	Michael Wombold	Northern Region, Alternate
	Connie Richey, RN	EMS Commission	X	Samantha Verga-Gates	Southern Region
	Saran Tucker, PhD, MPH	EMS Commission	X	Laurie Donegan	Southern Region
	Carol Synder, RN	EMS Commission	X	Jeanette Souza	Southern Region
	Erick Cheung, MD	EMS Commission	X	Christine Farnham	Southern Region, Alternate
	Brian Saeki	EMS Commission	X	Ryan Burgess	Western Region, Alternate
	Carol Kim	EMS Commission	X	Travis Fisher	Western Region
X	Gabriel Champion	Base Hospital Medical Director	X	Lauren Spina	Western Region
	Salvador Rios	Base Hospital Medical Director, Alternate	X	Susana Sanchez	Western Region
	Adam Brown	Provider Agency Representative	X	Kate Bard	Western Region
X	David Hickman	Provider Agency Representative, Alt.		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
	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)	Taylor Hill (SJS)
	Shira Schlesinger, MD	Paula Cho	X	Taylor Ornelas (AVH)	Sheryl Gradney( LACoFD)
	Jake Toy, MD	Christine Zaiser	X	Melissa Carter (HCH)	Jennifer Nulty (BHFD)
	Michael Kim, MD	Hanna Kang	X	Melissia Turpin (SMM)	
	Nicole Bosson, MD	Sara Rasnake	X	Allison Bozigian (HMN)	
	Jacqueline Rifenburg		X		
	Richard Tadeo				
	Jon Warren, MD				
	Ami Boonjaluksa				
	David Wells				

1. **CALL TO ORDER:** The meeting was called to order at 1:00 p.m. by Chair, Tarina Kang, 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 **Joint Education Session – March 3, 2026:** 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.

2.3 **EMSC Educational Forum – November 5<sup>th</sup>** in Fairfield, CA. There will be a hands-on skills component covering femur and humeral IO insertion.

3. **APPROVAL OF MINUTES**

3.1 The meeting minutes for December 10<sup>th</sup>, 2025

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

4. **NEW BUSINESS**

None

5. **OLD BUSINESS**

5.1 Ref. No. 511, Perinatal Patient Destination

The policy was updated to include “recently postpartum” emphasizing transport to the most appropriate and accessible facility. The term “recently postpartum” was intentionally left flexible to allow for clinical judgment. Special circumstances could apply to pregnant injured patients who do not meet trauma criteria or guidelines.

Approved as presented, M/S/C (Wombold/Verga-Gates)

6. **Policies for Information Only: No Action Required**

*AHA Updates*

6.1 Ref. No. 1210/1210-P, Cardiac Arrest

Added: Pregnant patients > 20 weeks treat in conjunction with TP 1217, Pregnancy Complication. No comment.

6.2 Ref. No. 1213, Cardiac Dysrhythmia – Tachycardia

Added: AHA guidelines under special consideration specifying polymorphic ventricular tachycardia (VT) should be treated with defibrillation. No comment.

6.3 Ref. No. 1216-P Newborn/Neonatal Resuscitation

Changed: The time to clamping and cutting the umbilical cord from 30 seconds to 60 seconds. No comment.

6.4 Ref. No. 1234/1234-P, Airway Obstruction

Changed: Initiate back blows first before abdominal thrusts. No comment.

6.5 Ref. No.1325, Mechanical Circulatory Support (MCS) Devices

Added: If the LVAD is not functioning and the patient is unconscious, start chest compressions while troubleshooting the device and recognizing poor perfusion. No comment.

*Capnography*

6.6 Ref. No.1204/1204-P, Fever/Sepsis

6.7 Ref. No.1209/1209-P, Behavioral /Psychiatric Crisis Retention

6.8 Ref. No.1229/1229-P, Altered Level of Consciousness (ALOC)

6.9 Ref. No.1237-P, Respiratory Distress

6.10 Ref. No.1241/1241-P, Overdose/Poisoning/Ingestion

6.11 Ref. No.1302, Airway Management and Monitoring

6.12 Ref. No.1305, Capnography

Removed: "If available" language in adult protocols. Pediatric capnography remains optional if available. No comment

6.13 Ref. No. 1214, Pulmonary Edema/CHF

Clarified: When nitroglycerin should be held to prevent excessive hypotension. No comment.

6.14 Ref. No. 1217/1217-P, Pregnancy Complications

Removed: Preeclampsia is no longer a base contact requirement. Clarified that base contact is not required to administer magnesium when diagnosis is clear. Intramuscular injection is preferred, but magnesium can be given via any route.

6.15 Ref. No. 1200.2, Base Contact Requirements

Changed: Preeclampsia to eclampsia for base hospital contact. No comment.

6.16 Ref. No 1375, Vascular Access

Added: Femoral and humeral IO options across all age groups, and pediatric guidance for distal and humeral IO. No comment

**7. REPORTS & UPDATES:**

7.1 EMS Update

- Beginning in 2026, completion of the EMS Update or Train-the-Trainer course will be required for Base Hospital Medical Directors, in accordance with the Base Hospital Standards, to ensure ongoing engagement in the base program.
- APS platform changed in January, users must check their email for a temporary password and re-establish the access to the system.

7.2 EmergiPress

- The latest EmergiPress has been released, next update (March/April) will focus on SMR and pediatrics.
- A suggestion was made to include policy updates in EmergiPress when policies are not covered in the EMS Update.

### 7.3 ITAC Update

- Reviewed a new manual resuscitator device not fully aligned with current policy, a subgroup will evaluate it and provide recommendations.
- Discussed improving information sharing and documentation between prehospital and hospital systems using technology to reduce documentation burden and support patient care.

### 7.4 ELCOR

- Law enforcement medical training modules are completed, pediatric critical intervention modules are in production, and distribution is planned through the Police Chiefs Association and other channels.
- Established new email addresses for law enforcement to contact the EMS Agency directly.
- Surveyed law enforcement agencies about AED programs scope options; cost was the main barrier, though many respondents are currently participating or interested.
- Discussed ongoing issues, including misconception about “county-only” medical clearance for jails, weapon safety, and EMS and law enforcement coordination.

### Research Initiative & Pilot Studies

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

- Over 40 transfusions to date (including post-partum hemorrhage and trauma) with good temperature control, minimal waste, and no safety issues.
- One-year pilot milestone approaching (April 1); expansion is being considered, with ongoing efforts to secure funding and increase blood donation.

#### 7.5.2 PediDOSE

- Age-based dosing down to six months of age begins July 1, 2026, training will occur before implementation.
- Study enrollment is ongoing, with results comparing weight vs. age-based dosing expected later this year.

#### 7.5.3 Pedi-PART

- Approximately 400 patients enrolled in LA County and 900 nationally, with no set end date: continued emphasis on protocol adherence and use of monitoring (pads and capnography).
- A recognition program is in place for paramedics who demonstrate excellent adherence and patient care (challenge coins and gift cards).

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

- Year three of trauma data analysis is underway, focusing on improving the dashboard and using data to evaluate clinical care and policy decisions.
- Collaboration continues with Public Works, Public Health, and trauma centers to use data for policy and infrastructure improvements.

### 7.7 Cardiac Arrest Taskforce

- Countywide initiative has been established by the Commission to improve cardiac arrest outcomes.
- Strategy sessions are held monthly with focus on Bystander CPR, AED access and mapping, system-wide best practices.

### 7.8 Upcoming Mass Gathering Events

- World Cup planning is underway, matches and fan events throughout LA County.
- Medical coordination will be led by the EMS Agency and LA County Fire.
- Targeted Violence/Mass Casualty Hospital Response Workshop is scheduled for April 1, 2026 (hospital and agency leadership invited).
- LA Marathon planning is in progress.

### 7.9 Health Data Exchange

- Updates on hospital onboarding include Cedars-Sinai Medical Center, Huntington Hospital, Ronald Reagan UCLA Medical Center, and Harbor-UCLA Medical Center
- St. Francis is in progress.
- Some facilities are delayed due to contract and technical version issues.
- For provider agencies, there has been signed agreements
- Major private ambulance contractors are currently onboarded, with smaller providers to be added as they initiate ePCR data submission.

### 7.10 2025 EMS Annual Data Report

- EMS Annual Report was presented by Richard Tadeo and dedicated to Chris Clare in recognition of her contributions to EMS data systems.

## 8. **OPEN DISCUSSION:**

### Base Authority Fact-Finding Process:

- As a reminder, the base hospital has the authority to address concerns directly with a provider or receiving hospital. Please attempt to resolve the issue whenever appropriate, issues that cannot be resolved at the base level should be referred to the EMS Agency. This year, the EMS Agency will be visiting referral 9-1-1 hospitals to establish points of contact.

### Base Survey- Quality Improvement Presentation.

- Starting in 2026, base hospitals will provide a brief quality improvement presentation during the survey to highlight their current QI program, key initiatives, performance indicators, and outcomes. This will supplement the required QI document submission and allow for a more comprehensive representation of your program's work. Richard Tadeo reiterated that this also offers an opportunity to showcase your efforts to hospital leadership.

## 9. **NEXT MEETING: April 8, 2026**

## 10. **ADJOURNMENT:** The meeting was adjourned at 2:40 p.m.

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



# EMERGENCY MEDICAL SERVICES COMMISSION PROVIDER AGENCY ADVISORY COMMITTEE



## MINUTES

Wednesday – February 11, 2026

### MEMBERSHIP / ATTENDANCE

<b>MEMBERS IN ATTENDANCE</b>	<b>ORGANIZATION</b>	<b>EMS AGENCY STAFF</b>	<b>EMS AGENCY STAFF</b>
X Carol Meyer, Chair	EMSC, Commissioner	Richard Tadeo	Nichole Bosson, MD
X Kenneth Powell, Vice Chair	EMSC, Commissioner	Jacqueline Rifenburg	Shira Schlesinger, MD
Jason Cervantes	EMSC, Commissioner	David Wells	Dipesh Patel, MD
James Lott, PsyD, MBA	EMSC, Commissioner	Ami Boonjaluksa	Michael Kim, MD
Gary Washburn	EMSC, Commissioner	HanNa Kang	Jake Toy, MD
Kristin Kolenda	EMSC, Commissioner	Jennifer Calderon	Jonathan Warren, MD
Ken Lieberman	EMSC, Commissioner	Natalie Greco	Paul Aragon, MD
Paul Camacho	EMSC, Commissioner		
X Sean Stokes	Area A ( <i>Rep to Medical Council</i> )		
Patrick Nulty	Area A, Alternate		
X Keith Harter	Area B		
X Clayton Kazan, MD	Area B, Alternate		
X Jeffrey Tsay	Area C		
X Luis Manjarrez	Area C, Alternate		
X Geoffrey Dayne	Area E		
X Victor Lemus	Area E, Alternate		
X Joel Davis	Area F		
Andrew Reno	Area F, Alternate		
X Adam Brown	Area G ( <i>Rep to BHAC</i> )		
X Stefan Viera	Area G, Alternate		
Matthew Conroy	Area H		
X Marc Cohen, MD	Area H, Alternate		
X Michael Campana	Area H, Alternate		
X Julian Hernandez	Employed Paramedic Coordinator		
X Tisha Hamilton	Employed Paramedic Coordinator, Alt		
X Jenny Van Slyke	Prehospital Care Coordinator		
X Melissa Turpin	Prehospital Care Coordinator, Alternate		
X Bryan Sua	Public Sector Paramedic Coordinator		
Drew Pryor	Public Sector Paramedic Coordinator, Alt		
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		
X Ray Mosack	Paramedic Training Program		
<i>Vacant</i>	Paramedic Training Program, Alternate		
X Jennifer Nulty	EMS Educator		
Heather Calka	EMS Educator, Alternate		
		<b>GUESTS</b>	<b>ORGANIZATION</b>
		Bijan Arab, MD	FALCK Ambulance
		Michael Stone, MD	LA General MC
		Danni Yang, MD	Harbor-UCLA MC
		Jorge Fazzini	West Coast Ambulance
		Tyri Williams	Pasadena FD
		Ryan Herman	Torrance FD
		Kristina Crews	LACoFD
		Connor Cudeback	Stryker
		Justin Crosson	Santa Monica FD
		Saman Kashani, MD	LACoFD
		Shelby Ermis	Premier Ambulance
		Abraham Baca	Glendale College
		Ryan Jorgensen	La Habra Heights FD
		Danielle Ogaz	LACoFD
		David Milligan	Montebello FD
		Joe Nakagawa, MD	Hawthorne PD, LHFD
		Lyn Riley	LASD, LH, SA
		Nanci Medina	LAFD
		Caroline Jack	Beverly Hills FD
		Ken Kaufmann	MedTrans Ambulance
		Kathryn Ward	UCLA Ctr for Prehospital Care
		Michael Habbeshaw	All Town Ambulance
		Jim Goldsworthy	LAFD Air Ops, Redondo Bch FD
		Dave Molyneux	AM West Ambulance
		Kimberly Tan	UCLA Ctr for Prehospital Care
		Louis Mendoza	Lifeline Ambulance
		Taggart Diehl	UCLA Ctr for Prehospital Care

**Quorum was established.**

**1. CALL TO ORDER** – Chair Carol Meyer, called meeting to order at 1:02 p.m.

## **2. INTRODUCTIONS AND ANNOUNCEMENTS**

### **2.1 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. EMSAAC link: [www.EMSAAC.org](http://www.EMSAAC.org)

### **2.2 Joint Educational Session – End of Life Care (*Shira Schlesinger, MD*)**

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 “Hospice, Palliative Care, and EMS Understanding End of Life Care” presented virtually by Amelia Breyer, MD, LEMSA Medical Director for San Fransico.

**2.3 EMSC Educational Forum (November 5, 2026) (Shira Schlesinger, MD)**

Scheduled for November 5, 2026 in Fairfield, CA. The EMSC forum will feature a dedicated pediatric skills area for the conference, to include femoral intraosseous (IO) access and airway management.

**2.4 UCSF Behavioral Health Study (Nichole Bosson, MD)**

Ongoing UCSF study interviewing paramedics on pediatric behavioral emergencies. Seeking 10 additional LA County paramedics for one-hour virtual interviews. Participation is voluntary; \$100 compensation is provided to participants.

**2.5 SideWalk CPR 2026 (Natalie Greco)**

National AED and CPR is the week of June 1-7<sup>th</sup>. All agencies are encouraged to participate and host their own event. The goal is to increase public hands-only CPR training and provider participation. Last year, nineteen public providers and three private providers registered. Registration requested by March 30, 2026.

For questions, please contact Natalie Greco at [ngreco@dhs.lacounty.gov](mailto:ngreco@dhs.lacounty.gov) or Priscilla Ross at [pross2@dhs.lacounty.gov](mailto:pross2@dhs.lacounty.gov).

**3. APPROVAL OF MINUTES (K. Harter / M. Cohen) December 17, 2025, minutes were approved as written.**

David Wells provided clarification per Ref. No. 815 on documentation fields for DNR/POLST (already exists in eDisposition.31).

**4. UNFINISHED BUSINESS**

**Policies for Discussion; Action Required:**

**4.1 Reference No. 517, Private Provider Agency Transport/Response Guidelines (Nichole Bosson, MD)**

Policy reviewed and approved with the following recommendation:

Policy: I.B.6: add word "private" to read "private provider medical director".

**M/S/C (R. Ower / C. Kazan) Approve: Reference No. 517, Private Provider Agency Transport/Response Guidelines.**

**5. NEW BUSINESS**

**Policies for Discussion; Action Required:**

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

Policy reviewed and approved with the following recommendation:

Medical Advisory Council to review and finalize the definition of "perinatal" specific to clarification of "recently post-partum".

**M/S/C (J. Davis / A. Brown): Reference No. 511, Perinatal Patient Destination.**

**5.2 Reference No. 703, ALS Unit Inventory (David Wells)**

Policy reviewed and approved as written.

**M/S/C (A. Brown / M. Campana) Approve: Reference No. 703, ALS Unit Inventory.**

Magnesium sulfate updated to align with state guidance. Consensus to require vial formulation with premix optional.

**5.3** Reference No. 703.1, Private Provider Interfacility Transfer ALS Unit Inventory (David Wells)

Policy reviewed and approved as written.

**M/S/C (R. Ower / A. Brown) Approve: Reference No. 703.1, Private Provider Interfacility Transfer ALS Unit Inventory.**

**5.4** Reference No. 704, Assessment Unit Inventory (David Wells)

Policy reviewed and approved as written.

**M/S/C (A. Brown / R. Ower) Approve: Reference No. 704, Assessment Unit Inventory.**

**5.5** Reference No. 706, ALS EMS Aircraft Inventory (David Wells)

Policy reviewed and approved as written.

**M/S/C (K. Harter / A. Brown) Approve: Reference No. 706, ALS EMS Aircraft Inventory.**

Magnesium sulfate updated to align with state guidance. Consensus to require vial formulation with premix optional.

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

The following policies were reviewed as information only:

**5.6** AHA Updates (Nichole Bosson, MD)

Policies updated to align with 2025 AHA Guidelines.

5.6.1 Reference No. 1210, TP: Cardiac Arrest

5.6.2 Reference No. 1210-P, TP: Cardiac Arrest (Pediatric)

5.6.3 Reference No. 1213, TP: Cardiac Dysrhythmia – Tachycardia

5.6.4 Reference No. 1216-P, TP: Newborn / Neonatal Resuscitation (Pediatric)

5.6.5 Reference No. 1234, TP: Airway Obstruction

5.6.6 Reference No. 1234-P, TP: Airway Obstruction

5.6.7 Reference No. 1325, MCG: Mechanical Circulatory Support Devices

**5.7** Capnography (Nichole Bosson, MD)

Policies updated to reflect adult nasal/oral capnography will be required effective July 1, 10126. Pediatric capnography remains optional.

5.7.1 Reference No. 1204, TP: Fever / Sepsis

5.7.2 Reference No. 1204-P, TP: Fever / Sepsis (Pediatric)

5.7.3 Reference No. 1209, TP: Behavioral / Psychiatric Crisis

5.7.4 Reference No. 1209-P, TP: Behavioral / Psychiatric Crisis (Pediatric)

5.7.5 Reference No. 1229, TP: Altered Level of Consciousness (ALOC)

5.7.6 Reference No. 1229-P, TP: Altered Level of Consciousness (ALOC) (Pediatric)

5.7.7 Reference No. 1237-P, TP: Respiratory Distress (Pediatric)

5.7.8 Reference No. 1241, TP: Overdose / Poisoning / Ingestion

5.7.9 Reference No. 1241-P, TP: Overdose / Poisoning / Ingestion (Pediatric)

5.7.10 Reference No. 1302, MCG: Airway Management and Monitoring

5.7.11 Reference No. 1375, MCG: Capnography

**5.8** Reference No. 1214, TP: Pulmonary Edema / CHF (Nichole Bosson, MD)

Nitroglycerin hold parameters updated.

**5.9 Reference No. 1217, TP: Pregnancy Complication (Nichole Bosson, MD)**

Discussed in conjunction with agenda item 5.2. Preeclampsia to be treated with magnesium sulfate IV infusion. Eclampsia to be treated with magnesium sulfate IV infusion or IM/IO route if vascular access cannot be established (IM administration is preferred over IO).

**5.10 Reference No. 1217-P, TP: Pregnancy Complication (Nichole Bosson, MD)**

**5.14 Reference No. 1200.2, TP: Base Contact Requirements (Nichole Bosson, MD)**

Base contact required for eclampsia (not preeclampsia).

**5.15 Reference No. 1375, MCG: Vascular Access (Dipesh Patel, MD)**

Updated to align with EMS Update 2026 training. Added distal femur access for pediatrics ( $\leq 14$  years) and proximal humerus for adults ( $> 14$  years).

**6. REPORTS AND UPDATES**

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

- This program continues to progress with additional meetings and hospital participation.
- Several Business Associate Agreements (BAA) between providers and hospitals completed.
- Training and access coordination pending.

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

- Train-the-Trainer sessions scheduled for March 2026.
- Due to the required skills sign-off component, all providers agencies must designate a representative to attend a Train-the-Trainer session.
- Skills sign-offs to be required within the 2026 calendar year (not 3-month deadline).
- An optional virtual pediatric simulation platform was demonstrated. Interest from educators. More to come.

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

The January/February edition includes Senate Bill (SB) 43 implementation and provides guidance for paramedics managing potentially gravely disabled patients who may refuse care or transport.

**6.4 ITAC Update (Shira Schlesinger, MD)**

Butterly BVM (bag-valve-mask) to be evaluated by the ITAC committee.

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

- ELCoR continues to meet quarterly. Objective to expand collaboration and improve coordination between EMS and law enforcement.
- Dr. Bosson and Richard Tadeo scheduled to meet with the President of the LA County Police Chiefs' Association.
- Dr. Kim finalizing the education module for co-response to the agitated person, with focus on law enforcement (LE) officers as the learner.
- For committee topic recommendations, please contact Dr. Bosson at [nbosson@dhs.lacounty.gov](mailto:nbosson@dhs.lacounty.gov).

**6.6 Research Initiatives and Pilot Studies**

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

- 48 patients have been transfused, including postpartum hemorrhage and trauma.
- Ongoing expansion and national interest.
- Dr. Kim presented data from CAL-DROP at the National Association of EMS Physicians (NAEMSP).

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

- Patient enrollment remains ongoing, the study is expected to conclude later this year.
- Age-based dosing for patients six months of age and older will begin July 1, 2026; training incorporated into EMS Update 2026.

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

- Patient enrollment remains ongoing.
- The EMS Agency distributed defibrillation pads (required in addition to capnography for positive pressure ventilation) to those providers who have utilized this equipment as part of this ongoing Pedi-PART trial.
- Reminder to reinforce education and emphasis on study arm adherence of “even/odd day assignment.”
- Recognition through the issuance of challenge coins to be awarded for behind-the-scenes participating personnel who have supported this study.

### 6.7 California Office of Traffic Safety (OTS) Grants Projects (Nichole Bosson, MD)

The LA County Dashboard for crash-related data and post-crash care is live on the EMS Agency webpage.

### 6.8 Cardiac Arrest Task Force (Nichole Bosson, MD)

Monthly collaborative strategy sessions have been scheduled for February through June 2026. Focus to improve out of hospital cardiac arrest survival rates. All public provider agencies are encouraged to participate.

### 6.9 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. Fan zone locations have been determined. Plan to 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.
- FEMA Training  
Targeted Violence/Mass Casualty Hospital Response Workshop is scheduled for April 1, 2026. Training is hospital focused; however, provider agencies have been invited to participate. For interest, please contact Terry Crammer at [tcrammer@dhs.lacounty.gov](mailto:tcrammer@dhs.lacounty.gov)

### 6.10 Annual EMS System Report 2025 (Richard Tadeo)

Annual System Report presented by Richard Tadeo. The 14<sup>th</sup> edition dedicated to Chris Clare in recognition of her contributions to the EMS system. Report link: [EMS Report 2025](#)

## 7. OPEN DISCUSSION

### 7.1 Ketorolac Concentration (Nichole Bosson, MD)

Discussion regarding Ketorolac 15 mg/mL vs. 30 mg/mL formulation. No strong consensus for change. Decision to maintain current formulation.

## 8. NEXT MEETING – April 15, 2026

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

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

SUBJECT: **SPECIALTY CARE TRANSPORT PROVIDER**

REFERENCE NO. 414

PURPOSE: To define the criteria to be approved as a Registered Nurse/Respiratory Specialty Care Transport (SCT) Provider in Los Angeles County.

AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.52, 1797.178, 1798.170  
Emergency Medical Treatment and Labor Act of 2006  
Los Angeles County Code, Title 7. Chapter 7.16. Ambulances

DEFINITIONS:

**Advanced Life Support (ALS) Transport:** A ground or air ambulance transport of a patient who may require skills or treatment modalities that do not exceed the Los Angeles County paramedic scope of practice.

**Basic Life Support (BLS) Transport:** A ground or air ambulance transport of a patient who may require skills or treatment modalities that do not exceed the Los Angeles County EMT scope of practice.

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

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

**Registered Nurse-Staffed SCT (RN-SCT):** A ground or air ambulance interfacility transport of a patient who may require skills or treatment modalities that exceed the Los Angeles County paramedic scope of practice, but do not exceed the California RN scope of practice.

**Respiratory Care Practitioner Staffed SCT (RCP-SCT):** A ground or air ambulance interfacility transport of a patient who requires the skills or treatment modalities that exceed the Los Angeles County EMT or Paramedic scope of practice but does not exceed the California RCP scope of practice.

**Specialty Care Transport (SCT):** An interfacility transport of a critically injured or ill patient by a ground or air ambulance, including the provision of the medically necessary supplies and services, at a level of service beyond the scope of practice of the paramedic.

PRINCIPLES:

EFFECTIVE: 02-01-88

PAGE 1 OF 10

REVISED: ~~04-01-2022 XX-XX-XX~~

SUPERSEDES: ~~04-01-2022 07-01-18~~

APPROVED:

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

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

1. A BLS private ambulance provider must be approved by the EMS Agency prior to performing SCTs.
2. Staffing an approved SCT vehicle/unit consists of a minimum of one RN and/or RCP and two EMTs. Physicians, RNs, RCPs, perfusionists, or other personnel may be added to the SCT team as needed.
3. RCPs may be utilized to perform duties commensurate with their scope of practice; however, additional transport personnel (EMTs, RNs, physicians, or paramedics) must accompany the RCP based on the level of acuity and anticipated patient care requirements.
4. This policy does not apply when RNs and/or RCPs employed by a healthcare facility are utilized by a Los Angeles County licensed provider agency to provide interfacility patient transport (i.e., emergent situations, specialized transport teams, etc.).
5. Any violation of this policy or ordinance could result in a program request denial or the cancellation of a provider's SCT program.
6. The EMS Agency shall be notified, with 72 hours, in writing of any changes in Transport Medical Director or RN and/or RCP Transport Coordinator, utilizing Ref. No. 621.1, Notification of Personnel Changes.
7. SCT Provider shall immediately notify the EMS Agency in the event the Transport Medical Director abruptly resigns or is otherwise unable to fulfill his/her duties and no immediate replacement is available.

**POLICY:**

**I. Application Requirements**

- A. A private ambulance provider must be licensed by the County of Los Angeles as a basic life support (BLS) provider and:
  1. Have maintained continuous operations within Los Angeles County for a minimum of six (6) months; AND
  2. If newly licensed ambulance provider successfully complete an unannounced site visit to review compliance with County Ordinance and EMS Agency policies with no action items, OR
  3. If licensed ambulance provider operating in Los Angeles County for one (1) year or greater, had no action items on most recent annual site visit or successfully complete an unannounced site visit six (6) months after the annual site visit with no action items; AND
  4. Must not be in violation of any applicable standards, provisions, or requirements of state statute, regulation, County Code, or local policies and procedures.
- B. Appoint a Transport Medical Director
- C. Appoint a Transport Coordinator

- D. Request for approval of an SCT program must be made in writing to the Director of the Los Angeles County EMS Agency and shall include the following:
1. Specify the type of SCT services the provider will supply (RN-SCT, RCP-SCT or both)
  2. Proposed identification and location of the SCT units
  3. Procedures and protocols as outlined in Section V of this policy
  4. The SCT orientation program, initial and annual skill competencies used for RNs, EMTs, RCPs and, if applicable, other medical personnel
  5. Current standardized procedures and patient care protocols for emergency or deteriorating conditions, which have been approved and signed by the Transport Medical Director
  6. Documentation of qualifications of the proposed Transport Medical Director (resumé/curriculum vitae, copy of medical license and applicable board certification), and a background check utilizing the forms provided by the EMS Agency to include a DOJ/FBI live scan, as identified in Ref. No. 420, Private Ambulance Operator Medical Director
  7. Documentation of qualifications of the proposed SCT Coordinator(s) (resumé(s) or curriculum vitae, copy of current license(s), and certifications) and a background check utilizing the forms provided by the EMS Agency to include a DOJ/FBI live scan
  8. Copy of the current QI Plan (including specific indicators which will be utilized to monitor the SCT program and a tracking with a formal review mechanism for monitoring sentinel/adverse events, near misses, or issues regarding non-compliance with current policies and procedures outside of QI activities) as outlined in Section VI of this policy.
  9. The documents needed for approval of an SCT program are due to the EMS Agency as a complete packet within 90 (ninety) days of receipt of letter from the EMS Agency acknowledging the request for approval. If a complete packet (application) is not received within a 90 (ninety) day period, or after the completion of three (3) EMS Agency reviews of the SCT program application submission, the request will be denied. A subsequent request for approval will not be accepted for six (6) months. This will result in the providers' inability to provide SCT services until approved by the EMS Agency.

II. Personnel Requirements

A. Transport Medical Director

1. Shall meet the qualifications and requirements of Ref. No. 420, Private Ambulance Operator Medical Director.

2. Shall be approved by the Medical Director or designee of the EMS Agency.
3. Responsibilities:
  - a. Sign and approve, in advance, all medical protocols, standardized procedures in accordance with Section 2725 of the Business and Professions Code, and SCT policies and procedures.
  - b. Approve and oversee the orientation, ongoing training, and annual competencies of all SCT medical personnel.
  - c. Be familiar with the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act (HIPAA) requirements.
  - d. Attend the EMS Agency Orientation Program within six (6) months of assuming the position of Transport Medical Director.
  - e. Participate in and approve the development, implementation, and ongoing evaluation of the provider SCT quality improvement (QI) program.
  - f. Sign and submit (if not already in file) the following forms:
    - 1) Ref. No. 701.1, Physician Confirmation of Agreement to Purchase Drugs and Medical Supplies
    - 2) Ref. No. 702.1, Provider Agency Medical Director Notification of Controlled Drug Program Implementation

**B. Transport Coordinator**

1. RN Coordinator: Providers utilizing RNs for SCTs shall have an RN Coordinator who:
  - a. Holds a current unrestricted RN license in the State of California;
  - b. Has a minimum of one year experience performing specialty care ambulance transports; and
  - c. Meets all requirements of a transport RN if performing specialty care transports.
2. RCP Coordinator: Providers utilizing RCPs for SCTs shall have a RCP Coordinator who:
  - a. Holds a current unrestricted RCP license in the State of California;
  - b. Has a minimum of one year experience in performing specialty

care ambulance transports; and

- c. Meets all requirements of a transport RCP if performing specialty care transports.

The RN Coordinator may function as the RCP Coordinator; however, the RCP Coordinator may NOT function as the RN Coordinator.

3. The Transport Coordinator shall:
  - a. Sign and approve, in advance, all standardized procedures in accordance with Section 2725 of Business and Professions Code and ensure compliance with all SCT policies and procedures.
  - b. Ensure all transport staff meet the requirements as stated in Section II. C below.
  - c. Maintain records and documentation for all SCT personnel demonstrating orientation to the RN/RCP-staffed SCT program, ongoing education and annual competencies.
  - d. Maintain documentation of all applicable licensure, certification and/or accreditation requirements for all SCT personnel.
  - e. Be familiar with EMTALA and HIPAA.
  - f. Participate in and approve the development, implementation and ongoing evaluation of the SCT QI program in collaboration with the Transport Medical Director.
  - g. Attend the EMS Agency Orientation Program within six (6) months of assuming the role of Transport Coordinator.
  - h. Perform annual skills competency evaluation of all SCT personnel.
  - i. Submit a written and signed affirmation of adherence to all federal, state, and local rules, regulations and laws, including Los Angeles County prehospital care policies and procedures as outlined in Title 7, Chapter 7.16, Ambulances.

C. Transport Personnel

1. Two (2) EMTs comprise the BLS interfacility transport team; additional personnel (physicians, RNs, and/or RCPs) shall be added to the BLS team based on the acuity and anticipated needs of the patient during transport.

Staffing exceptions must be approved by the EMS Agency prior to utilization by the ambulance provider.

2. RNs, RCPs and EMTs shall:

- a. Possess a current unrestricted license or certification to practice in California.
  - b. Maintain certification by the American Heart Association (AHA) or American Red Cross (ARC) in healthcare provider level cardiopulmonary resuscitation (CPR).
  - c. Successfully complete the SCT provider's RN/RCP Staffed Interfacility SCT Program Orientation approved by the SCT Medical Director and reviewed by the EMS Agency.
  - d. Successfully complete an initial and annual skills competency evaluation conducted by the provider agency, approved by SCT Medical Director and reviewed by the EMS Agency.
  - e. Be familiar with EMTALA and HIPAA.
  - f. Submit a written and signed affirmation of adherence to all federal, state, and local rules, regulations and laws, including Los Angeles County prehospital care policies and procedures as outlined in Title 7, Chapter 7.16, Ambulances.
3. In addition to the requirements listed in Section II. C. 2. all transport RNs shall meet the following initial and ongoing requirements:
- a. Initial
    - 1) Have a minimum employment equivalent of one year full-time (36-40 hours/week) nursing experience within the last three (3) years as an RN performing direct patient care within a critical care area or as a SCT provider relevant to the type of SCT transports the RN will provide (pediatric vs. adults), prior to employment as an SCT nurse within Los Angeles County; OR
    - 2) Have a valid Certified Emergency Nurse (CEN), Critical Care RN (CCRN), Certified Transport RN (CTRN) or Certified Flight RN (CFRN) certification: and
    - 3) Be currently certified in AHA or ARC Advanced Cardiac Life Support (ACLS) and, if participating in pediatric transports, currently certified in AHA or ARC Pediatric Advanced Life Support (PALS).
  - b. Ongoing
    - 1) Maintain certification in AHA or ARC ACLS and, if participating in pediatric transports, maintain certification in AHA or ARC PALS; and
    - 2) Complete 96 hours of documented direct patient care

critical care experience (licensed acute care hospital or SCT provider per year ), and complete a total of 20 continuing education (CE) contact hours approved by the California Board of Registered Nursing (BRN) annually, that are relevant to direct patient critical care and type of transports performed OR obtain/maintain CEN, CCRN, CTRN or CFRN certification.

4. In addition to the requirements listed in Section II. C. 2., all transport RCPs shall meet the following initial and ongoing requirements:
  - a. Initial
    - 1) Have a minimum employment equivalent of one year full-time (36-40 hours per week) respiratory care experience within the last three (3) years performing direct patient care within an acute care or respiratory care hospital, relevant to the type of SCT transports the RCP will provide (pediatric vs. adults), prior to employment as a transport RCP within Los Angeles County; OR
    - 2) Have successfully passed the Adult Critical Care Specialty (ACCS) Examination and are credentialed and in good standing with the National Board for Respiratory Care (NBRC); and
    - 3) Be currently certified in AHA or ARC ACLS and, if participating in pediatric transports, currently certified in AHA or ARC PALS.
  - b. Ongoing
    - 1) Maintain certification in AHA or ARC ACLS and, if participating in pediatric transports, maintain certification in AHA or ARC PALS: and
    - 2) Complete 96 hours of documented direct patient care critical care experience (licensed acute care hospital or SCT provider) per year and complete a total of 20 CE contact hours approved by the Respiratory Care Board annually, that are relevant to direct patient critical care and type of transports performed; OR
    - 3) Obtain/maintain credential as ACCS from the NBRC.

### III. Subcontracting SCT Services

- A. If the licensed BLS provider intends to subcontract SCT services, the EMS Agency must be notified in advance for approval.

- B. The subcontracting company must submit program information through the licensed BLS provider to the EMS Agency for approval prior to providing SCT services.
- C. Subcontractors must meet the same standards/requirements as the ambulance provider, including insurance.

IV. Insurance Requirements

- A. It is the ambulance provider agency's responsibility to ensure insurance requirements are maintained as required by the Los Angeles County Code of Ordinance.
- B. Minimum insurance levels must be maintained as outlined in Title 7, Chapter 7.16, Ambulances, with the exception of Professional Liability. Professional Liability limits must be maintained at \$2,000,000 per claim and \$3,000,000 per aggregate.

V. Policies and Procedures

Provider shall have a policy and procedure manual that includes, at a minimum, the following:

- A. Requirements of the SCT orientation program, ongoing training and process utilized to verify initial and annual personnel requirements, skills competency for registered nurses, EMTs, RCPs and, if applicable, other medical personnel.
- B. Standardized procedure(s) development, training and evaluation
- C. Procedures and criteria for contacting the Transport Medical Director and SCT Coordinator if needed during a patient transport.
- D. Requirements for copies of the interfacility transfer paperwork that complies with Title 22, Section 70749.
- E. Record retention procedures which meet the requirements listed in Ref. No. 608, Retention and Disposition of Prehospital Patient Care Records.
- F. The sending physician's Statement of Responsibility for the patient during transfer in accordance with EMTALA.
- G. Current patient care protocols for emergency or deteriorating conditions which include procedures that should be followed for changes in destination due to unforeseen changes in the patient's condition or other unexpected circumstances.
- H. A controlled drug policy which meets the requirements of Ref. No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles and if applicable, Ref. No. 702, Controlled Drugs Carried on ALS, SCT and APRU Units.

- I. Procedures for terminal cleaning/sterilization of reusable medical equipment (e.g., ventilators, high velocity oxygen delivery devices, IV pumps, etc.), to include documentation and retention of records demonstrating compliance.

#### VI. Quality Improvement (QI) Program

- A. The Provider Agency shall have a QI Program that meets the standards outlined in Ref. No. 618, EMS Quality Improvement Program (EQIP) Committees, and Ref. No. 620, EMS Quality Improvement Program.
- B. Records of QI activities shall be maintained by the provider and available for review by the EMS Agency.

#### VII. Required Equipment

- A. Each transport vehicle shall include minimum standard inventory required by Ref. No. 710, Basic Life Support Ambulance Equipment.
- B. RN staffed SCT vehicles shall also be equipped with the additional inventory specified in Ref. No. 712, Nurse Staffed Specialty Care Transport Unit Inventory.
- C. RCP staffed SCT vehicles shall also be equipped with the additional inventory specified in Ref. No. 713, Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory.
- D. In addition, each transport vehicle shall have equipment and supplies commensurate with the scope of practice of any additional transport medical personnel (e.g. balloon pump technicians, neonatal intensive care unit transport teams, etc.) staffing the SCT unit. This requirement may be fulfilled through the utilization of appropriate kits (cases/packs), which must be removed if the vehicle is being utilized for BLS or ALS transport purposes.
- E. Biomedical equipment used for patient care must show evidence of ongoing maintenance, , and safety certification (e.g., service agreements, calibration logs, etc.).
- F. If a dedicated ambulance (unit) is not being utilized strictly for SCT transports, and the provider is utilizing “jump bags” or its equivalent to store medical equipment and medication for the unit, the “jump bag” or its equivalent must be numbered/assigned a unique identifier. Additionally, that numbering must be marked on the individual bag(s).
- G. Provider agencies may request to place additional SCT units (or jump bags) into service and shall notify the EMS Agency for inventory inspection and approval. Requests and inventory inspections shall be done prior to deployment.

#### VIII. Program Review

- A. The EMS Agency shall perform periodic on-site audits of transport records, QI processes, equipment/vehicle inspections, and personnel qualifications to ensure

compliance with this policy.

- B. Non-compliance with this policy may lead to the EMS Agency suspending or revoking approval of the SCT program.
- C. SCT programs that do not operate for a period of 6 consecutive months or greater, may result in program suspension or termination.

CROSS REFERENCE:

Prehospital Care Manual:

- Ref. No. 420 **Private Ambulance Operator Medical Director**
- Ref. No. 517, **Provider Agency Transport/Response Guidelines**
- Ref. No. 608, **Retention and Disposition of Prehospital Patient Care Records**
- Ref. No. 618, **EMS Quality Improvement Program (EQIP) Committees**
- Ref. No. 620, **EMS Quality Improvement Program**
- Ref. No. 621, **Notification of Personnel Change**
- Ref. No. 621.1, **Notification of Personnel Change Form Provider Agency & Training Programs**
- Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
- Ref. No. 701.1, **Physician Confirmation of Agreement to Purchase Drugs and Medical Supplies**
- Ref. No. 702, **Controlled Drugs Carried on ALS, SCT and APRU Units**
- Ref. No. 702.1, **Provider Agency Medical Director Notification of Controlled Drug Program Implementation**
- Ref. No. 710, **Basic Life Support Ambulance Equipment**
- Ref. No. 712, **Nurse Staffed Specialty Care Transport Unit Inventory**
- Ref. No. 713, **Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory**
- Ref. No. 802, **Emergency Medical Technician (EMT) Scope of Practice**
- Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**

Business and Professions Code:

- California Nursing Practice Act, Section 2725**
- California Respiratory Care Practice Act, Sections 3700 et al**
- Centers for Medicare & Medicaid Services, Department of Health and Human Services**
- Title 22, California Code of Regulations Division 5, Section 70749**

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

(EMT-I, PARAMEDIC, MICN)  
REFERENCE NO. 511

SUBJECT: **PERINATAL PATIENT DESTINATION**

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 or, based on clinical judgment, recently post-partum.

**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. 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. Final authority for patient destination rests with the base hospital handling the call when base contact is made.
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. For destination, specific for the newly born, refer to Ref. No. 510, Pediatric Patient Destination.

POLICY:

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

EFFECTIVE DATE: 06-15-87  
REVISED: 10-01-23  
SUPERSEDES: 10-01-20

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

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

- 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. Traumatically injured pregnant patients  $\geq 20$  weeks who do not meet trauma criteria or guidelines and are not transported to a trauma center
  - E. Patients with hypertension (SBP  $\geq 140$ mmHg or DBP  $\geq 90$ mmHg)
  - F. New-onset seizure
- II. Post-partum patients (up to 6 weeks) with hypertension (SBP  $\geq 140$ mmHg or DBP  $\geq 90$ mmHg) or with new-onset seizure shall be transported to a perinatal center.
- III. Perinatal patients who have just 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. Consider transporting traumatically injured pregnant patients  $\geq 20$  weeks that do not meet trauma criteria and/or guidelines to a trauma center per special considerations, Ref. No. 506.
- 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. Pregnant or perinatal patients who have just delivered for whom transportation to a perinatal center would exceed 30 minutes should be transported to a receiving facility which is also an EDAP.
- VII. Perinatal patients whose chief complaint is clearly not related to the pregnancy and have no specialty center needs should be transported to the most accessible receiving (MAR) facility.
- VIII. Consideration may be given to:
- A. Perinatal 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**

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)  
REFERENCE NO. 517

SUBJECT: **PRIVATE PROVIDER AGENCY  
TRANSPORT/RESPONSE GUIDELINES**

PURPOSE: To provide guidelines for private ambulance providers handling requests for emergency and non-emergency transports.

AUTHORITY: Los Angeles County Code, Title 7, Business License, Division 2, Chapter 7.16  
Health & Safety Code, Division 2, Section 1250,  
Health & Safety Code, Division 2.5, Sections 1797.52 - 1797.84, California Code  
of Regulations Section 100174  
California Code of Regulations, Title 13, Division 2, Chapter 5. Special Vehicles,  
Article 1. Ambulances  
Emergency Medical Treatment and Labor Act of 2006 (EMTALA)

DEFINITIONS:

**Extremis:** A life-threatening, time critical situation (e.g., unmanageable airway, uncontrollable hemorrhage) that, without immediate stabilization, could result in serious and immediate jeopardy to the health of an individual (in the case of a pregnant woman, the health of the woman or her unborn child), such that the patient’s life would be jeopardized by transportation to any destination but the most accessible receiving (MAR) facility.

**Health Facility:** A health facility may include, but not limited to, any of the following:

- General Acute Care Hospital
- Skilled Nursing Facility
- Clinic/Urgent Care Center
- Physician Office
- Dialysis Center
- Intermediate Care Facility
- Acute Psychiatric Facility

**Interfacility Transport (IFT):** The transport of a patient from one health facility to another health facility as defined above.

**Response Time:** The time from initial dispatch to arrival at the physical location/address of incident

**9-1-1 Response:** An emergency response by the primary emergency transportation provider or its designee for that geographic area in which the response is requested. Requests for a 9-1-1 response are generally made by the public but may include requests from health facilities.

PRINCIPLES:

1. A private provider agency must be licensed by the County of Los Angeles as a Basic Life Support provider. Each of the company’s ambulance vehicles that operate within the County of Los Angeles shall also be licensed by the County.

EFFECTIVE: 01-05-88  
REVISED: 07-01-24  
SUPERSEDES: 01-01-22

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

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

2. Private provider agencies are prohibited from dispatching an ambulance to any call that would normally be considered an emergency 9-1-1 call for the authorized emergency transportation provider for that geographical area. A private provider agency may only dispatch an ambulance to such a call if the request is from either the 9-1-1 jurisdictional provider or the primary emergency transportation provider requesting backup services.
3. Private provider agencies may be contracted to provide response services within a mass gathering or special event to reduce the impact on the local 9-1-1 response system in accordance with a jurisdictional provider approved medical action plan as described in Ref. No. 842.
  - a. Private provider agencies shall not operate within a mass gathering or special event as defined in Ref. No. 842 without an approved medical action plan from the jurisdictional provider agency.
4. Any ambulance personnel observing the scene of a traffic collision or other emergency should:
  - a. Contact their respective dispatch center and request that the jurisdictional 9-1-1 provider agency be notified
  - b. Follow the internal policy developed by their employer in regard to stopping at the scene of an observed emergency
5. It is the responsibility of the requested transport provider, in consultation with the facility requesting the transport, to provide the appropriate level of transport (Basic Life Support, Advanced Life Support or Specialty Care Transport) based on the transferring physician's determination of the medical needs of the patient (Refer to Ref. No. 517.1, Guidelines for Determining Level of Interfacility Transport). At minimum, one (1) transport personnel must accompany the patient and occupy the patient compartment at all times.
6. Health facilities shall provide the transport personnel with appropriate transfer documents in compliance with Title 22 and EMTALA transfer requirements.
7. A health facility may not have the staffing and equipment available to assess, treat and/or monitor a patient for extended time frames. Therefore, 9-1-1 emergency responses may be necessary for those patients whose condition may deteriorate while waiting for a private provider response.
8. If it is known that transfer arrangements were not made, the transporting unit shall make every possible effort to contact the receiving facility and advise them of the patient's imminent arrival. This may be done through the provider's dispatch center.
9. Patients with a valid Do-Not-Resuscitate (DNR) form or order; or Physician Orders for Life Sustaining Treatment (POLST) shall be transported as outlined in Reference No. 815, et. al.
10. The transferring physician, in consultation with the receiving physician, assumes responsibility for determining the appropriateness of the transfer. It is not the responsibility of the base hospital or the transport personnel to determine whether the transfer is appropriate.

11. Private provider agencies shall ensure that a patient care record (PCR) is completed for each patient transport performed including, but not limited to, critical care transports. The PCR shall include documentation regarding patient monitoring and care during transport, from the time of the patient contact at the sending facility until transfer of care at the receiving health facility or other patient destination. For patients transported to a health facility, each private provider agency shall ensure there is a mechanism in place to provide the receiving facility with a copy of the transport PCR at the time of transfer of care.

POLICY:

I. Transport Modalities

A. Basic Life Support (BLS) Transport

1. Unit is staffed with two EMTs
2. Requests may be for emergency or non-emergency response
3. Patient requires care which does not exceed the Los Angeles County EMT scope of practice
4. Patient does not meet the requirement for upgrade to the jurisdictional provider agency ALS assessment per Reference 1200.4
5. Patients who develops an extremis condition enroute shall be diverted to the most accessible facility appropriate to the needs of the patient.

B. Advanced Life Support (ALS) Transport

1. Unit is staffed with two paramedics unless the ambulance provider has been given approval by the EMS Agency to staff ALS IFT units with one paramedic and one EMT.
2. Requests may be for emergency or non-emergency response.
3. Patient requires skills or treatment modalities which do not exceed the Los Angeles County paramedic scope of practice.
4. Base hospital contact is not required to monitor therapies established by the sending facility prior to transport if such therapies fall within the Los Angeles County paramedic scope of practice.
5. If the patient's condition deteriorates or warrants additional therapies enroute, paramedics shall treat the patient in accordance with Ref. No. 1200, Treatment Protocols, et al. and make Base contact. The base hospital will determine if the patient may be transported to the original destination requested by the sending facility, which should occur whenever possible, or if the patient requires diversion to the most accessible receiving facility appropriate to the needs of the patient.
6. Paramedics may not accept standing orders or medical orders from the transferring physician, receiving physician nor private provider agency medical director.

- C. Nurse and/or Respiratory Care Practitioner (RCP) Specialty Care Transport (SCT)
1. Unit is staffed by a qualified registered nurse and/or RCP and two EMTs or paramedics. Other medical personnel (e.g., physician, perfusionist, etc.) may be added to meet the needs of the patient.
  2. Requests may be for emergency or non-emergency response.
  3. Patient requires, or may require, skills or treatment modalities that are within the nurse's and/or RCP's scope of practice.
  4. Registered nurses and RCPs are not required to make base hospital contact. Nurses and RCPs may follow medical orders of the transferring physician and/or orders approved by their SCT Medical Director within their applicable scope of practice for patient care enroute. However, if paramedic(s) are part of the SCT transport team, they can only perform medical orders received from a base hospital.
  5. Patient destination requested by the sending facility will be honored; however, if the patient's condition deteriorates enroute, the registered nurse or RCP may determine it is in the patient's best interest to divert the patient to the most accessible facility appropriate to the needs of the patient.

II. Transport Requests and Response Levels

- A. If a transport request is received under the following circumstances and it is determined that the patient has an emergency medical condition, the dispatcher shall immediately refer the request to the jurisdictional 9-1-1 provider.
1. A private citizen requesting ambulance transportation
  2. If the patient is at a health facility but has not been evaluated and stabilized to the extent possible by a physician prior to the facility requesting transport
- B. If upon arrival at a health facility or private residence and EMTs or paramedics find that the patient has an emergency medical condition, the EMS personnel shall determine whether it is in the best interest of the patient to request the jurisdictional 9-1-1 provider to respond or to provide treatment and rapid transport to the most accessible receiving facility. If on-scene personnel determine that immediate transport is indicated, the jurisdictional 9-1-1 provider shall be notified and justification shall be documented on the patient care record.
- C. Emergency Response Requests
1. Request by a 9-1-1 Provider Agency  
  
Ambulance providers shall dispatch an ambulance within the maximum response times for emergency calls specified in the County Code in response to an emergency call from a public safety agency or authorized emergency transportation provider for that geographical area, unless the

caller is immediately advised of a delay in responding to the call.  
Response times for emergency and non-emergent request are as follows:

- a. For an emergent response (code 3) maximum response times are:  
Urban area – 8 min and 59 seconds (five hundred thirty-nine (539) seconds)  
Rural area – 20 min and 59 seconds (twelve hundred fifty-nine (1259) seconds)  
Wilderness area – as soon as possible
  - b. For a non-emergent (code 2) the maximum response times are:  
Urban area – 15 minutes and 59 seconds (nine hundred fifty-nine (959) seconds)  
Rural area – 25 minutes (one thousand five hundred (1,500) seconds)  
Wilderness area – as soon as possible
2. Request by a Health Facility
- a. If a physician in the emergency department at the health facility has evaluated and stabilized the patient to the extent possible and arranged an interfacility transfer, the patient may be transported via a private ground (or air) ambulance and the jurisdictional 9-1-1 provider is not ordinarily contacted.
- D. Non-Emergency Response Requests - Request by a Health Facility or Private Citizen
1. A request for transport of a patient who has, or is perceived to have a stabilized medical condition that requires transport, and the patient does not have an emergency medical condition
  2. Transports are handled by a private ambulance provider with BLS, ALS, or SCT staffed units, depending upon the medical requirements of the patient and the EMS personnel's scope of practice
- E. Mass Gathering and Special Event Transports
1. When approved by a jurisdictional provider agency as part of a mass gathering or special event medical action plan, the contracted private provider may transport a patient from the event to a designated receiving hospital per the patient criteria specified in the medical action plan.
  2. When the medical action plan's specified criteria for private provider agency transport are not met, a 9-1-1 response from the jurisdictional provider agency should be initiated for transport.
  3. If extenuating circumstances exist (e.g. mass casualty incident, etc.) whereby the jurisdictional provider agency is unable to respond in a timely fashion appropriate for the patient condition, the private provider should exercise their clinical judgment as to whether it is in the patient's best

interest to transport the patient prior to the arrival of the jurisdictional provider agency. The rationale for the decision to transport shall be documented on an EMS patient care record.

4. Private provider agencies shall maintain a copy of the approved medical action plan to demonstrate policy and ordinance adherence upon inspection for a minimum of four (4) years.

III. Role of the Base Hospital in ALS Interfacility Transports

- A. Provide immediate medical direction to paramedics if the patient's condition deteriorates or warrants additional therapies during transport.
- B. Determine if the patient may be transported to the original destination requested by the sending facility, which should occur whenever possible, or if the patient requires diversion to the most accessible receiving facility appropriate to the needs of the patient if the patient's condition changes while enroute to the pre-designated facility. If diverted, the base hospital shall:
  1. Contact the new receiving hospital and communicate all appropriate patient information.
  2. Advise the original receiving hospital that a diversion has occurred.
- C. Clarify the scope of practice of EMS personnel when requested to do so by a sending facility.

CROSS REFERENCES:

Prehospital Care Manual:

- Ref. No. 304, **Role of the Base Hospital**
- Ref. No. 414, **Specialty Care Transport (SCT) Provider**
- Ref. No. 502, **Patient Destination**
- Ref. No. 506, **Trauma Triage**
- Ref. No. 510, **Pediatric Patient Destination**
- Ref. No. 511, **Perinatal Patient Destination**
- Ref. No. 513, **ST Elevation Myocardial Infarction Patient Destination**
- Ref. No. 513.1, **Interfacility Transport of Patients with St-Elevation Myocardial Infarction**
- Ref. No. 514, **Prehospital EMS Aircraft Operations**
- Ref. No. 516, **Return of Spontaneous Circulation (ROSC) Patient Destination**
- Ref. No. 517.1, **Guidelines for Determining Level of Interfacility Transport**
- Ref. No. 802, **EMT Scope of Practice**
- Ref. No. 802.1, **EMT Scope of Practice, Field Reference**
- Ref. No. 803, **Paramedic Scope of Practice**
- Ref. No. 803.1, **Paramedic Scope of Practice, Field Reference**
- Ref. No. 815, **Honoring Prehospital Do-Not-Resuscitate (DNR) Orders, Physician Orders for Life Sustaining Treatment and End of Life Option (Aid-in-Dying Drug)**
- Ref. No. 815.1, **Emergency Medical Services Prehospital Do Not Resuscitate (DNR) Form**
- Ref. No. 815.2, **Physician Orders for Life Sustaining Treatment (POLST) Form**
- Ref. No. 842, **Mass Gathering and Special Events Interface with Emergency Medical Services**

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELESSUBJECT: **ALS UNIT INVENTORY**

REFERENCE NO. 703

PURPOSE: To provide a standardized minimum inventory on all Advanced Life Support (ALS) Units.

PRINCIPLE: Any equipment or supplies carried for use in providing emergency medical care must be maintained in good working order.

## POLICY:

- I. Providers may only carry one narcotic analgesic on the ALS units. Provider Agency Medical Directors may request approval from the Emergency Medical Services (EMS) Agency's Medical Director to carry Fentanyl.
- II. ALS Units shall carry the following equipment. Transport vehicles shall also be equipped and supplied according to the Department of the California Highway Patrol, California Administrative Code, Title 13.
- III. All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.
- IV. Radio transmitter-receiver (Hand-Held) shall meet Los Angeles County Department of Communications, Spec. No. 2029/2031/2033.

<b>MEDICATIONS</b>			
Adenosine	<b>24mg</b>	Ketorolac 15mg/mL OR	<b>4</b> OR
Albuterol (pre-mixed w/ NS)	<b>20mg</b>	Ketorolac 30mg/2mL	<b>2</b>
Amiodarone	<b>900mg</b>	Lidocaine 2% (for infusions via IO access)	<b>200mg</b>
Aspirin (chewable 81mg)	<b>648mg</b>	Magnesium Sulfate 50% (500mg/mL) (7/01/26)	<b>10gm</b>
Atropine sulfate (1mg/10mL)	<b>3mg</b>	Midazolam	<b>20mg</b>
Calcium chloride	<b>1gm</b>	Morphine sulfate	<b>20mg</b>
Dextrose 10%/Water 250mL	<b>3 bags</b>	Naloxone	<b>4mg</b>
Dextrose - glucose paste/gel	<b>30gm</b>	Normal saline (for injection)	<b>2 vials</b>
Diphenhydramine	<b>100mg</b>	Normal saline 100mL (intravenous fluids)	<b>1 bag</b>
DuoDote kits or equivalent	9	Normal saline 1000mL (intravenous fluids)	<b>6 bags</b>
AtroPen (when available) *		Nitroglycerin (SL) spray, tablets, or single-dose powder packets	1 pump/bottle or 36 packets
Auto-Injector 1.0mg	6*	Olanzapine 10mg ODT	<b>40mg</b>
Auto-Injector 0.5mg – Pediatric Use	6*	Ondansetron 4mg ODT	<b>16mg</b>
Epinephrine (1mg/mL)	<b>5mg</b>	Ondansetron 4mg IV	<b>16mg</b>
Epinephrine (0.1mg/mL)	<b>7mg</b>	Sodium bicarbonate	<b>50mL</b>
Fentanyl (requires EMS Agency approval)	<b>500mcg</b>	Tranexamic Acid (TXA) premix 1gm in 100mL bag OR	<b>2 bags or</b>
Glucagon	<b>1mg</b>	1 gm vial/Normal saline 100mL bag	<b>2 sets</b>

EFFECTIVE: 01-01-78

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REVISED: 04-01-26

SUPERSEDES: 1-01-25

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

Director, EMS Agency

Medical Director, EMS Agency

<b>SUPPLIES</b>			
Adhesive dressing (Band-Aids®)	<b>1 box</b>	Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5" 14G	<b>2</b>
Airways – Nasopharyngeal:		Contaminated needle container	<b>1</b>
Large (34-36)	<b>1</b>	Continuous Positive Airway Pressure (CPAP) device: (requires EMS Agency approval)	
Medium (26-28)	<b>1</b>	CPAP Masks:	
Small (20-22)	<b>1</b>	Small	<b>1</b>
Airways – Oropharyngeal:		Medium	<b>1</b>
Large	<b>1</b>	Large	<b>1</b>
Medium	<b>1</b>	Endotracheal tubes w/stylets Sizes 6.0-8.0	<b>2 each</b>
Small Adult/Child	<b>1</b>	Endotracheal Tube introducer	<b>2</b>
Infant	<b>1</b>	End Tidal CO2 Colorimetric Detector (Adult)	<b>1</b>
Neonate	<b>1</b>	Extrication device or short board	<b>1</b>
Alcohol prep pads	<b>1 box</b>	Filter, viral HEPA	<b>2</b>
Backboards	<b>2</b>	Flashlight or penlight	<b>1</b>
Bag-Mask-Ventilation (BMV) device w/ O2 inlet & reservoir:		Gauze bandages	<b>6</b>
Bag Volume >900 mL	<b>1</b>	Gauze sponges 4x4 (sterile)	<b>12</b>
Bag Volume 400-700 mL	<b>1</b>	Gloves, sterile	<b>2 pair</b>
Bag Volume 200-450 mL	<b>1</b>	Gloves, unsterile	<b>1 box</b>
Bag-Mask-Ventilation (BMV) Masks:		Glucometer	<b>1</b>
Large	<b>1</b>	Test strips (note date opened) and Lancets (auto retractable)	<b>5 each</b>
Medium	<b>1</b>	Hand-held nebulizer pack w/spacer	<b>2</b>
Small Adult/Child	<b>1</b>	Hemostats, padded	<b>1</b>
Toddler	<b>1</b>	Intraosseous device (requires EMS Agency approval)	<b>1</b>
Infant	<b>1</b>	Intraosseous needles:	
Neonate	<b>1</b>	45mm	<b>2</b>
Burn pack or burn sheet	<b>1</b>	25mm	<b>2</b>
Cervical collars (rigid):		15mm	<b>2</b>
Adult (adjustable)	<b>4</b>	Intravenous catheters: Sizes 16G - 22G	<b>5 each</b>
Pediatric	<b>2</b>	Intravenous tubing - Macro drip	<b>12</b>
Cardiac Monitor-Defibrillator w/oscilloscope	<b>1</b>	i-gel (Disposable Supraglottic Airway):	
Defibrillator/Pacing pads: adult and pediatric	<b>2 each</b>	Neonate (size 1)	<b>1</b>
ECG electrodes: Adult and Pediatric	<b>6 each</b>	Infant (size 1.5)	<b>1</b>
ECG, 12-lead & transmission capable	<b>1</b>	Small pediatric (size 2)	<b>1</b>
Noninvasive blood pressure monitor with adult and pediatric cuff	<b>1 each</b>	Large pediatric (size 2.5)	<b>1</b>
		Small adult (size 3)	<b>1</b>
Pulse oximeter: adult and pediatric	<b>1 each</b>	Medium adult (size 4)	<b>1</b>
Transcutaneous pacing (requires EMS Agency approval)	<b>1</b>	Large adult+ (size 5)	<b>1</b>
Waveform capnography monitoring		Laryngoscope blades:	
EtCO <sub>2</sub> /O <sub>2</sub> oral-nasal cannula w/universal connect (adult) (7/1/26)	<b>1</b>	Adult: curved & straight	<b>1 each</b>
EtCO <sub>2</sub> sampling lines with airway adaptor	<b>2</b>	Pediatric: Miller #1 & #2	<b>1 each</b>
Color Code Drug Doses, Ref. No. 1309 (current)	<b>1</b>		

<b>SUPPLIES (continued)</b>			
Laryngoscope handle:		Scissors	<b>1</b>
Adult (compatible w/pediatric blades)	<b>1</b>	Sphygmomanometer:	
Magill forceps:		Thigh	<b>1</b>
Adult	<b>1</b>	Adult	<b>1</b>
Pediatric	<b>1</b>	Pediatric	<b>1</b>
Manometer OR Airflow Meter Device with rate and volume capability	<b>2</b> <b>OR</b> <b>1</b>	Infant	<b>1</b>
Mucosal Atomization Device (MAD)	<b>3</b>	Splints:	
Needle, filtered-5micron (if utilizing glass ampule)	<b>2</b>	Long	<b>2</b>
Normal saline for irrigation	<b>1000mL</b>	Short	<b>2</b>
OB pack w/bulb syringe/clamps/scissors (no scalpel)	<b>1</b>	Splints – traction:	
Oxygen cannulas:		Adult	<b>1</b>
Adult	<b>3</b>	Pediatric	<b>1</b>
Pediatric	<b>3</b>	Stethoscope	<b>1</b>
Oxygen masks – (non-rebreather):		Suction unit: portable w/battery, adapter & >500mL cannister (1/01/27)	<b>1</b>
Adult	<b>4</b>	Suction unit (portable) backup w/adapter	<b>1</b>
Pediatric	<b>2</b>	Suction catheters:	
Infant	<b>2</b>	Size 8Fr.	<b>1</b>
Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	<b>1</b>	Size 10Fr.	<b>2</b>
Personal Protective Equipment:		Size 12Fr.	<b>4</b>
Mask per provider	<b>1</b>	Tonsillar tip	<b>1</b>
Gown per provider	<b>1</b>	Syringes sizes: 1mL – 60mL w/luer adapter	<b>Assorted</b>
Eye protection per provider	<b>1</b>	Tape (various types, must include cloth)	<b>1</b>
Radio transmitter-receiver (Hand-Held)	<b>1</b>	Thermometer (Oral or axillary)	<b>1</b>
Saline locks	<b>4</b>	Tourniquets (IV)	<b>2</b>
		Tourniquets (C-TECC/CoTCCC approved)	<b>2</b>
		Vaseline gauze or Commercial chest seal	<b>2</b>

<b>APPROVED OPTIONAL EQUIPMENT</b>	
Albuterol (all required if using MDI): Metered Dose Inhaler (MDI) Metered-Dose-Inhaler (MDI) Spacer Metered-Dose-Inhaler (MDI) Mask	Laryngoscope handle: Pediatric - FDA Approved
	Magnesium Sulfate 50% premix 4gm in 100mL bag (7/01/26)
	Mechanical CPR device (requires EMS Agency approval)
Buprenorphine (requires EMS Agency approval)	Normal saline 250 or 500 mL
EtCO <sub>2</sub> /O <sub>2</sub> oral-nasal cannula w/universal connect - Pediatric	Oxygen masks - simple
Hemostatic dressings – EMS Authority approved dressings only	Positive end expiratory pressure (PEEP) valve
Hydroxocobalamin (requires EMS Agency approval)	Resuscitator w/ positive pressure demand valve (flow rate not to exceed 40L/min)
Impedance Threshold Device	Video laryngoscope (requires EMS Agency notification)
Intravenous tubing, blood	

This policy is intended as an ALS Unit inventory only. Supply and resupply shall be in accordance with Ref. No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles.

CROSS REFERENCES:

Prehospital Care Manual:

- Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
- Ref. No. 702, **Controlled Drugs Carried on ALS, SCT and APRU Units**
- Ref. No. 710, **Basic Life Support Ambulance Equipment**
- Ref. No. 712, **Nurse Staffed Specialty Care Transport Unit Inventory**
- Ref. No. 1104, **Disaster Pharmaceutical Caches Carried by First Responders**

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELESSUBJECT: **PRIVATE PROVIDER INTERFACILITY  
TRANSFER ALS UNIT INVENTORY**(PARAMEDIC, MICN)  
REFERENCE NO. 703.1

PURPOSE: To provide a standardized minimum inventory for private provider agencies approved for Advanced Life Support (ALS) interfacility transfer units.

PRINCIPLE: Any equipment or supplies carried for use in providing emergency medical care must be maintained in good working order.

## POLICY:

- I. Providers may only carry one narcotic analgesic on the ALS units. Provider Agency Medical Directors may request approval from the EMS Agency's Medical Director to carry Fentanyl.
- II. ALS Units shall carry the following equipment. Transport vehicles shall also be equipped and supplied according to the Department of the California Highway Patrol, California Administrative Code, Title 13.
- III. All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.
- IV. Radio transmitter-receiver (Hand-Held) shall meet Los Angeles County Department of Communications, Spec. No. 2029/2031/2033.

<b>MEDICATIONS</b>			
Adenosine	<b>24mg</b>	Ketorolac 15mg/mL OR Ketorolac 30mg/2mL	<b>4</b> or <b>2</b>
Albuterol (pre-mixed w/ NS)	<b>10mg</b>		
Amiodarone	<b>450mg</b>	Midazolam	<b>20mg</b>
Aspirin (chewable 81mg)	<b>648mg</b>	Morphine sulfate	<b>20mg</b>
Atropine sulfate (1mg/10mL)	<b>3mg</b>	Naloxone	<b>4mg</b>
Calcium chloride	<b>1gm</b>	Normal saline (for injection)	<b>2 vials</b>
Dextrose 10%/Water 250mL	<b>2 bags</b>	Normal saline 1000mL (intravenous fluids)	<b>4 bags</b>
Dextrose - glucose paste/gel	<b>30gm</b>	Nitroglycerin (SL) spray, tablets, or single dose powder packets	<b>1 pump/bottle or 10 packets</b>
Diphenhydramine	<b>50mg</b>	Olanzapine 10mg ODT	<b>20mg</b>
Epinephrine (1mg/mL)	<b>5mg</b>	Ondansetron 4mg ODT	<b>16mg</b>
Epinephrine (0.1mg/mL)	<b>5mg</b>	Ondansetron 4mg IV	<b>16mg</b>
Fentanyl (requires EMS Agency approval)	<b>500mcg</b>		

EFFECTIVE: 06-19-18  
REVISED: 04-01-26  
SUPERSEDES: 7-01-23

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

<b>SUPPLIES</b>			
Adhesive dressing (Band-Aids®)	<b>1 box</b>	Color Code Drug Doses, Ref. No. 1309 (current)	<b>1</b>
Airways – Nasopharyngeal:		Contaminated needle container	<b>1</b>
Large (34-36)	<b>1</b>	Endotracheal tubes w/stylets - sizes 6.0-8.0	<b>1 each</b>
Medium (26-28)	<b>1</b>	Endotracheal Tube introducer	<b>2</b>
Small (20-22)	<b>1</b>	End Tidal CO2 Colorimetric Detector (Adult)	<b>1</b>
Airways – Oropharyngeal:		Extrication device or short board	<b>1</b>
Large	<b>1</b>	Filter, viral HEPA	<b>2</b>
Medium	<b>1</b>	Flashlight or penlight	<b>1</b>
Small Adult/Child	<b>1</b>	Gauze bandages	<b>6</b>
Infant	<b>1</b>	Gauze sponges 4x4 (sterile)	<b>12</b>
Neonate	<b>1</b>	Gloves, sterile	<b>2 pair</b>
Alcohol prep pads	<b>1 box</b>	Gloves, unsterile	<b>1 box</b>
Backboards	<b>2</b>	Glucometer	<b>1</b>
Bag-Mask-Ventilation (BMV) device w/O2 inlet & reservoir:		Test strips (note date opened) and Lancets (auto retractable)	<b>5 each</b>
Bag Volume 200-450 mL	<b>1</b>	Hand-held nebulizer pack w/spacer	<b>2</b>
Bag Volume 400-700 mL	<b>1</b>	Hemostats, padded	<b>1</b>
Bag Volume >900 mL	<b>1</b>	Intravenous catheters: Sizes 16G - 22G	<b>5 each</b>
Bag-Mask-Ventilation (BMV) Masks:		Intravenous tubing - Macro drip	<b>6</b>
Large	<b>1</b>	i-gel (Disposable Supraglottic Airway)	
Medium	<b>1</b>	Neonate (size 1)	<b>1</b>
Small Adult/Child	<b>1</b>	Infant (size 1.5)	<b>1</b>
Toddler	<b>1</b>	Small pediatric (size 2)	<b>1</b>
Infant	<b>1</b>	Large pediatric (size 2.5)	<b>1</b>
Neonate	<b>1</b>	Small adult (size 3)	<b>1</b>
Burn pack or burn sheet	<b>1</b>	Medium adult (size 4)	<b>1</b>
Cervical collars (rigid):		Large adult+ (size 5)	<b>1</b>
Adult (adjustable)	<b>4</b>	Laryngoscope blades:	
Pediatric	<b>2</b>	Adult: curved & straight	<b>1 each</b>
Cardiac Monitor-Defibrillator w/oscilloscope	<b>1</b>	Pediatric: Miller #1 & #2	<b>1 each</b>
Defibrillator/Pacing pads: adult and pediatric	<b>2 each</b>	Laryngoscope handle:	
ECG electrodes: Adult and Pediatric	<b>6 each</b>	Adult (compatible w/ pediatric blades)	<b>1</b>
ECG, 12-lead & transmission capable	<b>1</b>	Magill forceps:	
Noninvasive blood pressure monitor with adult and pediatric cuff	<b>1 each</b>	Adult	<b>1</b>
Pulse oximeter: adult and pediatric	<b>1 each</b>	Pediatric	<b>1</b>
Transcutaneous pacing (requires EMS Agency approval)	<b>1</b>	Manometer OR Airflow Meter Device with rate and volume capability	<b>2 OR 1</b>
Waveform capnography monitoring (7/1/26)	<b>1</b>	Mucosal Atomization Device (MAD)	<b>2</b>
EtCO <sub>2</sub> /O <sub>2</sub> oral-nasal cannula w/universal connect (adult)	<b>1</b>	Needle: Commercial Catheter-Over-Needle Chest Decompression 3.0-3.5" 14G	<b>2</b>
EtCO <sub>2</sub> sampling lines with airway adaptor	<b>1</b>		

<b>SUPPLIES (continued)</b>			
Needle, filtered-5micron (if utilizing glass ampule)	<b>2</b>	Splints:	
Normal saline for irrigation	<b>1000mL</b>	Long	<b>2</b>
OB pack w/ bulb syringe/clamps/scissors (no scalpel)	<b>1</b>	Short	<b>2</b>
Oxygen cannulas:		Splints – traction:	
Adult	<b>3</b>	Adult	<b>1</b>
Pediatric	<b>3</b>	Pediatric	<b>1</b>
Oxygen masks – (non-rebreather):		Stethoscope	<b>1</b>
Adult	<b>4</b>	Suction unit: portable w/battery, adapter & >500mL cannister (1/01/27)	<b>1</b>
Pediatric	<b>2</b>	Suction unit (portable) backup w/adapter	<b>1</b>
Infant	<b>2</b>	Suction catheters:	
Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)		Size 8Fr.	<b>1</b>
		Size 10Fr.	<b>2</b>
		Size 12Fr.	<b>4</b>
Personal Protective Equipment:		Tonsillar tip	<b>1</b>
Mask	1 per provider	Syringes sizes: 1mL – 60mL w/luer adapter	<b>assorted</b>
Gown	1 per provider	Tape (various types, must include cloth)	<b>1</b>
Eye Protection	1 per provider	Thermometer (Oral or axillary)	<b>1</b>
Radio transmitter receiver (Hand-Held)	<b>1</b>	Tourniquets (IV)	<b>2</b>
Saline locks	<b>4</b>	Tourniquets (C-TECC/CoTCCC approved)	<b>2</b>
Scissors	<b>1</b>	Vaseline gauze or Commercial Chest Seal	<b>2</b>
Sphygmomanometer:			
Thigh	<b>1</b>		
Adult	<b>1</b>		
Pediatric	<b>1</b>		
Infant	<b>1</b>		

<b>APPROVED OPTIONAL EQUIPMENT</b>	
Albuterol (all required if using MDI): Metered Dose Inhaler (MDI) Metered-Dose-Inhaler (MDI) Spacer Metered-Dose-Inhaler (MDI) Mask	Lidocaine 2% (for infusions via IO access)
	Mechanical CPR Device (requires EMS Agency approval)
	Normal saline 250 or 500 mL
Continuous Positive Airway Pressure (CPAP) Device w/masks: small/medium/large (requires EMS Agency approval)	Oxygen Masks – simple
EtCO <sub>2</sub> /O <sub>2</sub> oral-nasal cannula w/universal connect - Pediatric	Positive end expiratory pressure (PEEP) valve
Glucagon	Pediatric Laryngoscope Handle – FDA Approved
Hemostatic Dressings – EMS Authority approved dressings only	Resuscitator with positive pressure demand valve (flow rate not to exceed 40L/min)
Impedance Threshold Device (requires EMS Agency approval)	Sodium Bicarbonate
Intraosseous Device w/needles: 15mm/25mm/45mm (requires EMS Agency approval)	Video laryngoscope (requires EMS Agency notification)

This policy is intended as a Private Provider Interfacility Transfer ALS Unit inventory only. Supply and resupply shall be in accordance with Ref. No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles.

CROSS REFERENCES:

Prehospital Care Manual:

- Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
- Ref. No. 702, **Controlled Drugs Carried on ALS, SCT and APRU Units**
- Ref. No. 710, **Basic Life Support Ambulance Equipment**
- Ref. No. 712, **Nurse Staffed Specialty Care Transport Unit Inventory**
- Ref. No. 713, **Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory**

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

(PARAMEDIC, MICN)  
REFERENCE NO. 704

SUBJECT: **ASSESSMENT UNIT INVENTORY**

PURPOSE: To provide a standardized minimum inventory on all Assessment Units.

PRINCIPLE:

1. Any equipment or supplies carried for use in providing emergency medical care must be maintained in good working order.
2. The minimum required amounts may be augmented according to anticipated needs in consultation with the Provider Agency Medical Director and the Medical Director of the Emergency Medical Services Agency
3. This policy is intended as an Assessment Unit inventory only. Supply and resupply shall be in accordance with Ref. No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles.

POLICY:

- I. Assessment Units shall carry the following equipment.
- II. All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.
- III. Radio transmitter receiver (Hand-Held) shall meet Los Angeles County Department of Communications, Spec. No. 2029/2031/2033.

<b>MEDICATIONS*</b>			
Adenosine	<b>12mg</b>	Ketorolac 15mg/mL OR Ketorolac 30mg/2mL	<b>4</b> or <b>2</b>
Albuterol (pre-mixed w/NS)	<b>5mg</b>		
Aspirin (chewable 81mg)	<b>648mg</b>	Naloxone	<b>2mg</b>
Atropine sulfate (1mg/10ml)	<b>1mg</b>	Normal saline (for injection)	<b>2 vials</b>
Dextrose 10%/Water 250mL	<b>1 bag</b>	Normal saline 250 or 500 mL (intravenous fluids)	<b>2 bags</b>
Dextrose - glucose paste/gel	<b>30gm</b>	Nitroglycerin (SL) spray, tablets, or single dose powder packets	<b>1 pump/bottle or 36 packets</b>
Epinephrine (1mg/mL)	<b>1mg</b>	Olanzapine 10mg ODT	<b>20mg</b>
Epinephrine (0.1mg/mL)	<b>2mg</b>	Ondansetron 4mg ODT	<b>16mg</b>
Glucagon	<b>1mg</b>	Ondansetron 4mg IV	<b>16mg</b>
		Sodium bicarbonate	<b>50ml</b>

EFFECTIVE: 01-01-78  
REVISED: 04-01-26  
SUPERSEDES: 12-01-23

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

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

<b>SUPPLIES</b>			
Airways – Oropharyngeal:		Intravenous catheters: Sizes 16G - 22G	<b>2 each</b>
Large	<b>1</b>	Intravenous Tubing - macrodrip	<b>2</b>
Medium	<b>1</b>	Laryngoscope Blades:	
Small Adult/Child	<b>1</b>	Adult, curved and straight	<b>1 each</b>
Infant	<b>1</b>	Pediatric, Miller #1 & #2	<b>1 each</b>
Neonate	<b>1</b>	Laryngoscope Handle:	
Adhesive dressing (Band-Aids®)	<b>5</b>	Adult (compatible w/ pediatric blades)	<b>1</b>
Alcohol prep pads	<b>5</b>	Magill Forceps:	
Bag-Mask-Ventilation (BMV) device w/O <sub>2</sub> inlet & reservoir:		Adult	<b>1</b>
Bag Volume >900 mL	<b>1</b>	Pediatric	<b>1</b>
Bag Volume 400-700 mL	<b>1</b>	Manometer	<b>2</b>
Bag Volume 200-450mL	<b>1</b>	OR Airflow Meter Device with rate and volume capability	<b>OR 1</b>
Bag-Mask Ventilation (BMV) – Masks:		Mucosal Atomization Device (MAD)	<b>2</b>
Large	<b>1</b>	Needle, filtered-5micron (if utilizing glass ampule)	<b>1</b>
Medium	<b>1</b>	Normal saline for irrigation	<b>1000mL</b>
Small Adult/Child	<b>1</b>	OB pack w/bulb syringe/clamps/scissors (no scalpel)	<b>1</b>
Toddler	<b>1</b>	Oxygen cannulas:	
Infant	<b>1</b>	Adult	<b>1</b>
Neonate	<b>1</b>	Pediatric	<b>1</b>
Burn pack or burn sheet	<b>1</b>	Oxygen Masks (non-rebreather):	
Cardiac Monitor-Defibrillator w/oscilloscope	<b>1</b>	Adult	<b>1</b>
Defibrillator/Pacing pads (adult and pediatric)	<b>2 each</b>	Pediatric	<b>1</b>
ECG Electrodes: Adult and Pediatric	<b>6 each</b>	Infant	<b>1</b>
ECG, 12-lead & transmission capable	<b>1</b>	Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	<b>1</b>
Noninvasive blood pressure monitor with adult and pediatric cuff	<b>1 each</b>		
Pulse Oximeter: adult and pediatric	<b>1 each</b>	Personal Protective Equipment	
Transcutaneous pacing	<b>1</b>	Mask per provider	<b>1</b>
Waveform capnography monitoring		Gown per provider	<b>1</b>
EtCO <sub>2</sub> /O <sub>2</sub> oral-nasal cannula w/universal connect (adult) (7/1/26)	<b>1</b>	Eye protection per provider	<b>1</b>
EtCO <sub>2</sub> sampling lines with airway adaptor	<b>1</b>	Radio transmitter receiver (Hand-Held)	<b>1</b>
Cervical collars (rigid):		Saline locks	<b>2</b>
Adult (adjustable)	<b>1</b>	Scissors	<b>1</b>
Pediatric	<b>1</b>	Sphygmomanometer:	
Color Code Drug Doses, Ref. No. 1309 (current)	<b>1</b>	Thigh	<b>1</b>
Contaminated needle container	<b>1</b>	Adult	<b>1</b>
Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5" 14G	<b>2</b>	Pediatric	<b>1</b>
		Infant	<b>1</b>



DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELESSUBJECT: **ALS EMS AIRCRAFT INVENTORY**

REFERENCE NO. 706

**PURPOSE:** To provide a standardized minimum inventory on all Advanced Life Support (ALS) Emergency Medical Services (EMS) aircraft.

**PRINCIPLE:** Any equipment or supplies carried for use in providing emergency medical care must be maintained in good working order.

**POLICY:**

- I. Each ALS EMS aircraft shall have on board equipment and supplies commensurate with the scope of practice of the medical flight crew. This requirement may be fulfilled through the utilization of appropriate kits (cases/packs) which can be carried aboard a given flight.
- II. ALS EMS aircraft shall have sufficient space to carry the following minimum medical equipment and supplies.
- III. Controlled drugs shall be secured on the EMS aircraft in accordance with Ref. No. 702, Controlled Drugs Carried on ALS Units.
- IV. All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.
- V. Radio transmitter-receiver (Hand-Held) shall meet Los Angeles County Department of Communications, Spec. No. 2029/2031/2033.

<b>MEDICATIONS</b>			
Adenosine	<b>24mg</b>	Ketorolac 15mg/mL <b>OR</b> Ketorolac 30mg/2mLs	<b>4 or 2</b>
Albuterol (pre-mixed w/NS)	<b>20mg</b>		
Amiodarone	<b>600mg</b>	Lidocaine 2% (for infusions via IO access)	<b>200mg</b>
Aspirin (chewable 81mg)	<b>648mg</b>	Magnesium Sulfate 50% (500mg/mL) (7/01/26)	<b>10gm</b>
Atropine sulfate (1mg/10mL)	<b>3mg</b>	Midazolam	<b>15mg</b>
Calcium chloride	<b>2gm</b>	Morphine sulfate	<b>20mg</b>
Dextrose 10%/Water 250mL	<b>2 bags</b>	Naloxone	<b>2mg</b>
Dextrose - glucose paste/gel	<b>30gm</b>	Normal saline (for injection)	<b>3 vials</b>
Diphenhydramine	<b>100mg</b>	Normal saline 100mL (intravenous fluids)	
DuoDote kits or equivalent	<b>9</b>	Normal saline 1000mL (intravenous fluids)	<b>4 bags</b>
AtroPen (when available) *		Nitroglycerin (SL) spray, tablets, or single dose powder packets	<b>1 pump/bottle or 36 packets</b>
Auto-Injector 1.0mg	<b>6*</b>	Olanzapine 10mg ODT	<b>20mg</b>
Auto-Injector 0.5mg – Pediatric Use	<b>6*</b>	Ondansetron 4mg ODT	<b>16mg</b>
Epinephrine (1mg/mL)	<b>7mg</b>	Ondansetron 4mg IV	<b>16mg</b>
Epinephrine (0.1mg/mL)	<b>6mg</b>	Sodium bicarbonate	<b>100mL</b>
Fentanyl (requires EMS Agency approval)	<b>500mcg</b>	Tranexamic Acid (TXA) premix 1gm in 100mL bag <b>OR</b> 1 gm vial/Normal saline 100mL bag	<b>2 bags or 2 sets</b>
Glucagon	<b>1mg</b>		

EFFECTIVE: 01-01-78  
REVISED: 04-01-26  
SUPERSEDES: 12-01-23

PAGE 1 OF 4

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

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

<b>SUPPLIES</b>			
Adhesive dressing (Band-Aids®)	<b>1 box</b>	Color Code Drug Doses, Ref. No. 1309 (current)	<b>1</b>
Airways – Nasopharyngeal:		Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5" 14G	<b>2</b>
Large (34-36)	<b>1</b>	Contaminated needle container	<b>1</b>
Medium (26-28)	<b>1</b>	Continuous Positive Airway Pressure (CPAP) device (requires EMS Agency approval)	
Small (20-22)	<b>1</b>	CPAP Masks:	
Airways – Oropharyngeal:		Small	<b>1</b>
Large	<b>1</b>	Medium	<b>1</b>
Medium	<b>1</b>	Large	<b>1</b>
Small Adult/Child	<b>1</b>	Endotracheal tubes w/ stylets Sizes 6.0-8.0	<b>2 each</b>
Infant	<b>1</b>	Endotracheal tube introducer	<b>2</b>
Neonate	<b>1</b>	End Tidal CO2 Colorimetric Detector (Adult)	<b>1</b>
Alcohol prep pads	<b>20</b>	Extraction device or short board	<b>1</b>
Backboard	<b>1</b>	Filter, viral HEPA	<b>2</b>
Bag-Mask-Ventilation (BMV) device w/ O2 inlet & reservoir:		Flashlight or Penlight	<b>1</b>
Bag Volume >900 mL mL	<b>1</b>	Gauze bandages	<b>6</b>
Bag Volume 400-700 mL	<b>1</b>	Gauze sponges 4x4 (sterile)	<b>12</b>
Bag Volume 200-450	<b>1</b>	Gloves, sterile	<b>2 pair</b>
Bag-Mask-Ventilation (BMV) Masks:		Gloves, unsterile	<b>1 box</b>
Large	<b>1</b>	Glucometer	<b>1</b>
Medium	<b>1</b>	Test strips (note date opened) and Lancets (auto retractable)	<b>5 each</b>
Small Adult/Child	<b>1</b>	Hand-held nebulizer pack w/spacer	<b>2</b>
Toddler	<b>1</b>	Intraosseous device (requires EMS Agency approval)	
Infant	<b>1</b>	Intraosseous needle: 45mm	<b>2</b>
Neonate	<b>1</b>	Intraosseous needle: 25mm	<b>2</b>
Burn pack or burn sheet	<b>1</b>	Intraosseous needle: 15mm	<b>2</b>
Cardiac Monitor-Defibrillator w/oscilloscope		Intravenous catheters: Sizes 16G - 22G	<b>4 each</b>
Defibrillator/Pacing pads: (adult and pediatric)	<b>2 each</b>	Intravenous tubing - Macro drip	<b>5</b>
ECG electrodes: adult and pediatric	<b>6 each</b>	i-gel (Disposable Supraglottic Airway):	
ECG, 12-lead & transmission capable	<b>1</b>	Neonate (size 1)	<b>1</b>
Noninvasive blood pressure monitor with adult and pediatric cuff	<b>1 each</b>	Infant (size 1.5)	<b>1</b>
Pulse oximeter: adult and pediatric	<b>1 each</b>	Small pediatric (size 2)	<b>1</b>
Transcutaneous pacing (requires EMS Agency approval)	<b>1</b>	Large pediatric (size 2.5)	<b>1</b>
Waveform capnography monitoring	<b>1</b>	Small adult (size 3)	<b>1</b>
EtCO <sub>2</sub> /O <sub>2</sub> oral-nasal cannula w/universal connect (adult)	<b>1 (7/1/26)</b>	Medium adult (size 4)	<b>1</b>
EtCO <sub>2</sub> sampling lines with airway adaptor	<b>2</b>	Large adult+ (size 5)	<b>1</b>
Cervical collars (rigid):		Laryngoscope blades:	
Adult (adjustable)	<b>1</b>	Adult: curved & straight	<b>1 each</b>
Pediatric	<b>1</b>	Pediatric: Miller #1 & #2	<b>1 each</b>

<b>SUPPLIES (continued)</b>			
Laryngoscope handle:		Scissors	<b>1</b>
Adult (compatible w/pediatric blades)	<b>1</b>	Syringes 1mL – 60mL w/luer adapter	<b>Assorted</b>
Magill forceps:		Hemostats, padded	<b>1</b>
Adult	<b>1</b>	Sphygmomanometer:	
Pediatric	<b>1</b>	Thigh	<b>1</b>
Manometer OR Airflow Meter Device with rate and volume capability	<b>2</b>	Adult	<b>1</b>
	<b>OR 1</b>	Pediatric	<b>1</b>
Mucosal Atomization Device (MAD)	<b>2</b>	Infant	<b>1</b>
Needle, filtered-5micron (if utilizing glass ampule)	<b>2</b>	Splints:	
Normal saline for irrigation	<b>1 bottle</b>	Long	<b>2</b>
OB pack w/bulb syringe/clamps/scissors (no scalpel)	<b>1</b>	Short	<b>2</b>
Oxygen cannulas:		Splints – traction:	
Adult	<b>2</b>	Adult	<b>1</b>
Pediatric	<b>2</b>	Pediatric	<b>1</b>
Oxygen masks – (non-rebreather):		Stethoscope	<b>1</b>
Adult	<b>2</b>	Suction unit: portable w/battery, adapter & >500mL cannister (1/01/27)	<b>1</b>
Pediatric	<b>2</b>	Suction unit (portable) backup w/adaptor	<b>1</b>
Infant	<b>2</b>	Suction catheters:	
Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	<b>1</b>	Size 8Fr.	<b>1</b>
		Size 10Fr.	<b>2</b>
Personal Protective Equipment:		Size 12Fr.	<b>4</b>
Mask	<b>1 per provider</b>	Tonsillar tip	<b>1</b>
Gown	<b>1 per provider</b>	Tape (various types, must include cloth)	<b>1</b>
Eye protection	<b>1 per provider</b>	Thermometer (Oral or axillary)	<b>1</b>
Radio transmitter receiver (Hand-Held)	<b>1</b>	Tourniquets (IV)	<b>2</b>
Saline locks	<b>4</b>	Tourniquets (C-TECC/CoTCCC approved)	<b>2</b>
		Vaseline gauze or Commercial chest seal	<b>2</b>

<b>APPROVED OPTIONAL EQUIPMENT</b>	
Albuterol (all required if using MDI): Metered Dose Inhaler (MDI) Metered-Dose-Inhaler (MDI) Spacer Metered-Dose-Inhaler (MDI) Mask	Laryngoscope handle: Pediatric - FDA Approved
	Magnesium Sulfate 50% premix 4gm in 100mL bag (7/01/26)
	Mechanical CPR device (requires EMS Agency approval)
Buprenorphine (requires EMS Agency approval)	Normal saline 250 or 500 mL
Dextrose 25%	Oxygen masks – simple
EtCO <sub>2</sub> /O <sub>2</sub> oral-nasal cannula w/universal connect - Pediatric	Positive end expiratory pressure (PEEP) valve
Hemostatic dressings – EMS Authority approved dressings only	Resuscitator w/ positive pressure demand valve (flow rate not to exceed 40L/min)
Hydroxocobalamin (requires EMS Agency approval)	
Impedance Threshold Device	Video laryngoscope (requires EMS Agency notification)
Intravenous tubing, blood	

This policy is intended as an ALS Unit inventory only. Supply and resupply shall be in accordance with Ref. No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles.

CROSS REFERENCES:

Prehospital Care Manual:

- Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
- Ref. No. 702, **Controlled Drugs Carried on ALS, SCT and APRU Units**
- Ref. No. 710, **Basic Life Support Ambulance Equipment**
- Ref. No. 712, **Nurse Staffed Specialty Care Transport Unit Inventory**
- Ref. No. 712, **Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory**
- Ref. No. 1104 **Disaster Pharmaceutical Caches Carried by First Responders**

DEPARTMENT OF HEALTH SERVICES  
COUNTY OF LOS ANGELES

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

REFERENCE NO. 202.2  
(ATTACHMENT B)

**REFERENCE NOS. 703, 703.1, 704, 706**

REF	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
703, 704, 703.1, 706	Reformatted and clarified for consistency with all ALS unit inventory policies	PAAC – 2/11/26		
703, 704, 703.1, 706	Reduced minimum par of Dextrose – glucose paste/gel to 30gm	PAAC – 2/11/26		
703, 704, 703.1, 706	Added: EtCO <sub>2</sub> /O <sub>2</sub> oral-nasal cannula w/universal connect to align with EMS Update 2026 (July 1, 2026)	PAAC – 2/11/26		
703, 704, 703.1, 706	Increased: EtCO <sub>2</sub> /O <sub>2</sub> sampling lines with airway adaptor to align with EMS Update 2026 (July 1, 2026)	PAAC – 2/11/26		
703, 706	Added: Magnesium Sulfate 50% to align with EMS Update 2026 (July 1, 2026)	PAAC – 2/11/26	Magnesium discussion for required inventory.	Magnesium Sulfate 50% (500mg/mL) 10gm and Normal Saline 100mL (intravenous fluids) required inventory. Magnesium Sulfate 50% premix 4gm in 100mL bag added to approved optional equipment.
703, 704, 703.1, 706	Added: Intraosseous needles to align with EMS Update 2026 (July 1, 2026)	PAAC – 2/11/26		
703, 704, 703.1, 706	Added: Suction unit: portable w/battery, adapter & >500mL cannister (January 1, 2027)	PAAC – 2/11/26		
703, 704, 703.1, 706	Added: EtCO <sub>2</sub> /O <sub>2</sub> oral-nasal cannula w/universal connect (pediatric) as optional equipment to align with EMS Update 2026 (July 1, 2026)	PAAC – 2/11/26		

EFFECTIVE: 03-31-97

REVISED: 10-01-25

SUPERSEDES: 04-01-25

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

REFERENCE NO. 202.2  
 (ATTACHMENT B)

703, 704, 703.1, 706	Added: Video laryngoscope (requires EMS Agency notification) to optional equipment	PAAC – 2/11/26		
703, 704, 703.1, 706	Added: EtCO <sub>2</sub> /O <sub>2</sub> oral-nasal cannula w/universal connect (pediatric) as optional equipment to align with EMS Update 2026 (July 1, 2026)	PAAC – 2/11/26		
703, 704, 706	Added: Buprenorphine (requires EMS Agency approval) as optional equipment	PAAC – 2/11/26		
703, 704, 706	Added: Hydroxocobalamin (requires EMS Agency approval) as optional equipment	PAAC – 2/11/26		
703, 704, 703.1, 706	Clarification for approved tourniquets for hemorrhage control to align CA EMSA guidance	PAAC – 2/11/26		
703, 704, 703.1, 706	Added to Vaseline gauze “or Commercial Chest Seal”	PAAC – 2/11/26		
703, 704, 703.1, 706	Added Positive end expiratory pressure (PEEP) valve	PAAC – 2/11/26		

**EMERGENCY MEDICAL SERVICES AUTHORITY**

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



**DATE:** February 24, 2026  
**TO:** Commission on EMS  
**FROM:** Elizabeth Basnett, Director  
Dr. Hernando Garzon, Chief Medical Officer

**SUBJECT:** Exceedance of Ambulance Patient Offload (APOT) Standards – January 2026 Electronic Notification pursuant to Title 22, Division, 9, Chapter 1.2, § 100007.02.

**Background**

The Commission on Emergency Medical Services (EMS) is receiving the following report to summarize all activities associated with the implementation of Assembly Bill 40 (Rodriguez, 2023-2024) related to Ambulance Patient Offload Times (APOT). The Emergency Medical Services Authority (EMSA) has included the following background information to summarize the events and activities which demonstrate implementation of AB 40 requirements:

**APOT Audit Tool Portal – Enhancements**

- *No updates have been applied to the system since the previous report.*

**APOT Audit Tool Portal – Utilization Summary**

- To date, 215 hospitals have registered for the audit tool, an increase of 14 from last month. EMSA is working with the California Hospital Association to increase registration.

**Hospital APOT Reduction Plan Compliance**

- EMSA staff continue to track and document all Hospital APOT Reduction Protocols.
- As of February 18, 2026, 177 hospitals have submitted their 2025 annual update, an increase of 15 from last month.
- EMSA is engaging LEMSAs and the California Hospital Association to increase compliance.

**Summary APOT Data for January 2026**

- For January 2026 data, there were 222,469 records that met APOT criteria, an increase of roughly 2,000 records from last month. EMSA continually conducts

targeted outreach to LEMSAs whose EMS providers were not compliant or documenting the new AB 40 elements correctly.

- EMSA calculated 90<sup>th</sup> percentile offload time for all general acute care hospitals (GACHs) with emergency departments using the specifications outlined in the emergency regulations on February 18, 2025, for January data. EMSA identified GACHs that exceeded their LEMSA APOT standard. These GACHs will be instructed to implement their hospital APOT reduction protocols. Summary information based on January 2026 APOT data and audits can be found below.
  - 317 of 327 hospitals (96%) had at least one EMS patient transport which met APOT documentation criteria.
  - Of the 317 hospitals, 297 (93%) had more than sixty (60) EMS patient transports to their facility for the month of January.
  - Of the 297 hospitals, 166 (55%) hospitals exceeded their local APOT standard. an increase of 3 from last month.
  - 116 hospitals submitted APOT audit reports, an increase of 5 from last month.
  - Of those 116 hospitals, 54 (46%) already met their LEMSA APOT standard.
- EMSA is working with our partners to provide additional education surrounding best practices for auditors, specifically focused on targeted auditing by hospitals to gain compliance with local APOT standards.

**Approach to Bi-Weekly Meetings**

- EMSA is focusing the bi-weekly meetings on the 15 hospitals experiencing the longest offload delays that exceed their local APOT standard. This targeted approach aims to address the needs of the communities served by these hospitals and to directly influence the reduction of offload delays.
- In February, EMSA hosted 10 meetings (initial or follow up) with hospitals. This is a decrease of 5 from January. There are 4 additional meetings scheduled to take place before the end of February. Meeting participants include hospital representatives, EMS providers, and LEMSAs. This does not include daily conversations with hospitals, LEMSAs, and EMS providers associated with AB 40 compliance, utilization of the APOT audit tool, and sharing best practices. EMSA continues to request the 15 hospitals who most significantly exceed their local APOT standard to meet for discussion, time permitting.

Meetings in November 2025: 21
Meetings in December 2025: 12

Meetings in January 2026: 15
Meetings in February 2026 (to date): 10

### **Exceedance of Ambulance Patient Offload (APOT) Standards – Detail**

- The following GACHs were identified as exceeding the local APOT standard established by their LEMSA (*page 4, below*). In accordance with Title 22, Division, 9, Chapter 1.2, § 100007.02 "Exceedance of APOT Standards - Required Actions," EMSA instructed the general acute care hospitals in the table below to implement their APOT reduction protocol no later than five (5) business days after the date of notification (February 24, 2026). All hospitals received the following detailed statistics and data points used to make this determination:
  - Monthly offload count
  - 90th percentile APOT
  - Local APOT standard
  - Exceedance of standard
  - Count of records exceeding standard
  - Percent of records above standard
  - Audit Completed (Yes or No)

**Report Note:** Hospitals with less than 60 offloads are excluded from our assessment and the table included in this report for the following reasons:

- Not all EMS provider agencies are reporting to the new data standard, resulting in some hospitals with significant numbers of missing records for transport they received. This deficiency of data may bias the APOT calculation.
- This approach aligns with the California Department of Health Care Services' Data De-Identification Guidelines

## Local EMS Agency APOT Standards (For January 2026)

<b>Local EMS Agency</b>	<b>APOT Standard (Hours:Minutes:Seconds)</b>
Alameda County EMS Agency	0:30:00
Central California EMS Agency	0:30:00
Coastal Valleys EMS Agency	0:20:00
Contra Costa County EMS Agency	0:20:00
El Dorado County EMS Agency	0:30:00
Inland Counties EMS Agency	0:25:00
Imperial County EMS Agency	0:20:00
Kern County EMS Agency	0:30:00
Los Angeles County EMS Agency	0:30:00
Marin County EMS Agency	0:20:00
Merced County EMS Agency	0:30:00
Monterey County EMS Agency	0:30:00
Mountain Counties EMS Agency	0:30:00
Napa County EMS Agency	0:20:00
North Coast EMS Agency	0:30:00
Northern California EMS Agency	0:20:00
Orange County EMS Agency	0:30:00
Riverside County EMS Agency	0:30:00
Sacramento County EMS Agency	0:25:00
San Benito County EMS Agency	0:30:00
San Diego County EMS Agency	0:30:00
San Francisco County EMS Agency	0:30:00
San Joaquin County EMS Agency	0:20:00
San Luis Obispo County EMS Agency	0:20:00
San Mateo County EMS Agency	0:20:00
Santa Barbara County EMS Agency	0:30:00
Santa Clara County EMS Agency	0:20:00
Santa Cruz County EMS Agency	0:30:00
Sierra-Sacramento Valley EMS Agency	0:30:00
Solano County EMS Agency	0:30:00
Stanislaus County EMS Agency	0:30:00
Tuolumne County EMS Agency	0:20:00
Ventura County EMS Agency	0:30:00
Yolo County EMS Agency	0:20:00

## Hospitals Exceeding Their Local APOT Standard (1 of 3)

LEMSA	CEMSIS Facility ID	Hospital Name	Offload Count	90th Percentile APOT	Local APOT Standard	Amount Exceeding (HH:MM:SS)	Percent of Compliant Records (Goal of 90%)
Los Angeles County EMS Agency	20244	Lakewood Regional Medical Center	502	1:47:46	0:30:00	1:17:46	57.8%
Los Angeles County EMS Agency	20446	Saint Francis Medical Center	1057	1:38:13	0:30:00	1:08:13	49.8%
Los Angeles County EMS Agency	20038	Beverly Hospital	258	1:25:14	0:30:00	0:55:14	58.9%
Riverside County EMS Agency	20162	Hemet Valley Medical Center	1256	1:22:45	0:30:00	0:52:45	43.1%
Los Angeles County EMS Agency	20531	Adventist Health White Memorial	259	1:21:52	0:30:00	0:51:52	63.7%
Los Angeles County EMS Agency	20401	Santa Monica - UCLA Medical Center and Orthopaedic Hospital	297	1:21:37	0:30:00	0:51:37	65.0%
San Diego County EMS Agency	20510	University of California, San Diego Medical Center	1331	1:21:06	0:30:00	0:51:06	56.0%
Contra Costa County EMS Agency	20194	Kaiser Permanente, Richmond	1054	1:07:18	0:20:00	0:47:18	46.4%
Inland Counties EMS Agency	20461	St. Mary Medical Center	1579	1:09:01	0:25:00	0:44:01	31.4%
San Diego County EMS Agency	20337	Paradise Valley Hospital	410	1:12:53	0:30:00	0:42:53	62.7%
Kern County EMS Agency	20028	Bakersfield Memorial Hospital	1314	1:12:25	0:30:00	0:42:25	48.3%
Los Angeles County EMS Agency	20240	Harbor UCLA Medical Center	1030	1:09:47	0:30:00	0:39:47	74.2%
Inland Counties EMS Agency	20520	Victor Valley Global Medical Center	607	1:02:23	0:25:00	0:37:23	35.3%
Los Angeles County EMS Agency	20451	Providence Saint John's Health Center	680	1:06:43	0:30:00	0:36:43	61.9%
Alameda County EMS Agency	20004	Alameda County Medical Center, Highland	1151	1:06:20	0:30:00	0:36:20	60.5%
Los Angeles County EMS Agency	20081	Community Hospital of Huntington Park	444	1:05:32	0:30:00	0:35:32	71.4%
Los Angeles County EMS Agency	20068	Citrus Valley Medical Center, Queen of the Valley Campus	775	1:04:50	0:30:00	0:34:50	59.5%
Los Angeles County EMS Agency	20270	Marina Del Rey Hospital	277	1:03:00	0:30:00	0:33:00	61.7%
Los Angeles County EMS Agency	20276	Memorial Hospital Of Gardena	960	1:02:41	0:30:00	0:32:41	71.7%
Riverside County EMS Agency	20278	Menifee Valley Medical Center	382	1:02:07	0:30:00	0:32:07	56.3%
Los Angeles County EMS Agency	20129	Foothill Presbyterian Hospital	463	1:02:05	0:30:00	0:32:05	66.7%
Kern County EMS Agency	20224	Kern Medical	1040	1:01:53	0:30:00	0:31:53	53.5%
Los Angeles County EMS Agency	20350	PIH Health Hospital, Whittier	823	0:58:35	0:30:00	0:28:35	59.3%
Los Angeles County EMS Agency	20067	Emanate Health- InterCommunity Hospital	420	0:57:31	0:30:00	0:27:31	66.0%
Los Angeles County EMS Agency	20054	Cedars-Sinai Medical Center	1165	0:57:11	0:30:00	0:27:11	69.4%
Los Angeles County EMS Agency	20316	Norwalk Community Hospital	118	0:57:07	0:30:00	0:27:07	76.3%
Inland Counties EMS Agency	20098	Desert Valley Hospital	1006	0:51:50	0:25:00	0:26:49	54.9%
Riverside County EMS Agency	20374	Riverside Community Hospital	2182	0:56:13	0:30:00	0:26:13	65.2%
San Diego County EMS Agency	20416	Sharp Chula Vista Medical Center	1417	0:55:39	0:30:00	0:25:39	62.2%
Los Angeles County EMS Agency	20357	Providence Little Company of Mary Medical Center, Torrance	1035	0:55:10	0:30:00	0:25:10	71.9%
Riverside County EMS Agency	20535	Loma Linda University Medical Center, Murrieta	855	0:54:26	0:30:00	0:24:26	72.3%
Alameda County EMS Agency	20190	Kaiser Permanente, Oakland Medical Center	815	0:53:47	0:30:00	0:23:47	60.5%
Los Angeles County EMS Agency	20289	Methodist Hospital of Southern California	878	0:53:31	0:30:00	0:23:31	71.1%
Sacramento County EMS Agency	20475	Sutter Medical Center - Sacramento	1681	0:48:30	0:25:00	0:23:30	49.5%
Kern County EMS Agency	20281	Mercy Hospital	769	0:53:09	0:30:00	0:23:09	60.3%
Los Angeles County EMS Agency	20385	San Dimas Community Hospital	223	0:52:49	0:30:00	0:22:49	82.1%
San Diego County EMS Agency	62998	UC San Diego Health East Campus Medical Center	593	0:52:47	0:30:00	0:22:47	74.5%
San Diego County EMS Agency	20419	Sharp Memorial Hospital	1818	0:52:26	0:30:00	0:22:26	74.6%
Alameda County EMS Agency	20525	Washington Hospital, Fremont	1126	0:52:21	0:30:00	0:22:20	66.6%
Los Angeles County EMS Agency	20171	Hollywood Presbyterian Medical Center	616	0:52:08	0:30:00	0:22:08	74.7%
Alameda County EMS Agency	20515	Stanford Health Care - ValleyCare	680	0:51:52	0:30:00	0:21:52	76.2%
Los Angeles County EMS Agency	20045	California Hospital Medical Center	617	0:51:36	0:30:00	0:21:36	79.9%
Riverside County EMS Agency	20442	Inland Valley Medical Center	1142	0:51:15	0:30:00	0:21:15	79.8%
Alameda County EMS Agency	20011	Alta Bates Summit Medical Center, Summit Campus	1303	0:51:06	0:30:00	0:21:06	69.4%
Santa Clara County EMS Agency	20400	Santa Clara Valley Medical Center	1045	0:40:49	0:20:00	0:20:49	72.1%
Los Angeles County EMS Agency	20518	USC Verdugo Hills Hospital	253	0:49:48	0:30:00	0:19:48	81.8%
Alameda County EMS Agency	20393	San Leandro Hospital	559	0:49:31	0:30:00	0:19:31	61.9%
Central California EMS Agency	20219	Kaweah Delta Medical Center	2229	0:49:23	0:30:00	0:19:23	57.2%
Los Angeles County EMS Agency	20106	PIH Health Hospital, Downey	627	0:49:22	0:30:00	0:19:22	76.9%
Kern County EMS Agency	20389	Adventist Health Bakersfield	1521	0:49:04	0:30:00	0:19:04	58.4%
Los Angeles County EMS Agency	20207	Kaiser Permanente, Los Angeles	523	0:49:01	0:30:00	0:19:01	77.8%
Los Angeles County EMS Agency	20255	MemorialCare Long Beach Medical Center	994	0:49:00	0:30:00	0:19:00	83.3%
Kern County EMS Agency	20287	Mercy Hospital SW - Bakersfield	697	0:48:59	0:30:00	0:18:59	61.8%
Los Angeles County EMS Agency	20152	Greater El Monte Community Hospital	279	0:48:39	0:30:00	0:18:39	75.6%
Inland Counties EMS Agency	20083	Community Hospital of San Bernardino	653	0:43:35	0:25:00	0:18:35	66.6%
San Francisco County EMS Agency	62636	CPMC-Van Ness	971	0:47:43	0:30:00	0:17:43	71.1%
Riverside County EMS Agency	20195	Kaiser Permanente, Riverside	651	0:47:03	0:30:00	0:17:03	76.2%
Alameda County EMS Agency	20185	Kaiser Permanente, Fremont	494	0:46:43	0:30:00	0:16:43	73.5%
Central California EMS Agency	20186	Kaiser Permanente, Fresno	1004	0:46:30	0:30:00	0:16:30	76.3%
Los Angeles County EMS Agency	20215	Kaiser Permanente, Downey	599	0:46:25	0:30:00	0:16:25	73.1%
San Diego County EMS Agency	20406	Scripps Memorial Hospital, Encinitas	899	0:46:16	0:30:00	0:16:16	78.0%
Alameda County EMS Agency	20112	Eden Medical Center	1086	0:45:46	0:30:00	0:15:46	72.6%
Riverside County EMS Agency	20388	San Geronio Memorial Hospital	898	0:45:39	0:30:00	0:15:39	71.3%
San Francisco County EMS Agency	20050	CPMC Mission Bernal Campus	819	0:45:27	0:30:00	0:15:27	75.0%
Orange County EMS Agency	20139	Garden Grove Hospital and Medical Center	403	0:44:49	0:30:00	0:14:49	79.7%

**Report Note:** Hospitals with less than 60 qualifying records were excluded from this assessment to adhere to California Department of Health Care Services' Data De-Identification Guidelines.

## Hospitals Exceeding Their Local APOT Standard (2 of 3)

LEMSA	CEMSIS Facility ID	Hospital Name	Offload Count	90th Percentile APOT	Local APOT Standard	Amount Exceeding (HH:MM:SS)	Percent of Compliant Records (Goal of 90%)
Orange County EMS Agency	20256	UCI Health - Los Alamitos	479	0:44:44	0:30:00	0:14:44	78.5%
Contra Costa County EMS Agency	20208	Kaiser Permanente, Walnut Creek	954	0:34:28	0:20:00	0:14:28	63.5%
Los Angeles County EMS Agency	20204	Kaiser Permanente, South Bay	528	0:44:23	0:30:00	0:14:23	80.7%
Inland Counties EMS Agency	20066	Chino Valley Medical Center	372	0:39:20	0:25:00	0:14:20	74.5%
Riverside County EMS Agency	20211	Kaiser Permanente, Moreno Valley	426	0:44:12	0:30:00	0:14:13	80.3%
Los Angeles County EMS Agency	20144	Adventist Health Glendale	710	0:44:12	0:30:00	0:14:12	78.0%
San Francisco County EMS Agency	20447	Saint Francis Memorial Hospital	765	0:44:11	0:30:00	0:14:11	73.6%
Los Angeles County EMS Agency	20042	Southern California Hospital at Culver City	270	0:44:03	0:30:00	0:14:03	76.3%
Los Angeles County EMS Agency	20149	Good Samaritan Hospital, Los Angeles	900	0:44:00	0:30:00	0:14:00	75.9%
Contra Costa County EMS Agency	20087	Contra Costa Regional Medical Center	502	0:33:58	0:20:00	0:13:58	67.5%
Riverside County EMS Agency	20090	Corona Regional Medical Center	967	0:43:47	0:30:00	0:13:47	81.1%
San Francisco County EMS Agency	20199	Kaiser Permanente, San Francisco	460	0:43:44	0:30:00	0:13:44	77.0%
San Diego County EMS Agency	20408	Scripps Mercy Hospital	2201	0:43:30	0:30:00	0:13:30	79.4%
Los Angeles County EMS Agency	20514	Valley Presbyterian Hospital	485	0:43:25	0:30:00	0:13:25	83.7%
San Diego County EMS Agency	20497	Tri-City Medical Center	1010	0:43:00	0:30:00	0:13:00	78.2%
San Diego County EMS Agency	20409	Scripps Mercy Hospital, Chula Vista	1040	0:43:00	0:30:00	0:13:00	78.9%
San Francisco County EMS Agency	20504	UCSF Medical Center at Parnassus	755	0:42:59	0:30:00	0:12:59	75.2%
Orange County EMS Agency	20345	UCI Health - Placentia Linda	583	0:42:42	0:30:00	0:12:42	80.4%
Los Angeles County EMS Agency	20496	Torrance Memorial Medical Center	817	0:42:38	0:30:00	0:12:38	78.3%
Santa Clara County EMS Agency	20321	O'Connor Hospital, San Jose	1001	0:32:13	0:20:00	0:12:13	72.7%
Kern County EMS Agency	20027	Bakersfield Heart Hospital	445	0:41:53	0:30:00	0:11:53	73.5%
Contra Costa County EMS Agency	20474	Sutter Delta Medical Center	1069	0:31:38	0:20:00	0:11:38	72.8%
Santa Clara County EMS Agency	20150	Good Samaritan Hospital, San Jose	1031	0:31:13	0:20:00	0:11:13	71.3%
Los Angeles County EMS Agency	20348	Pomona Valley Hospital Medical Center	1239	0:41:04	0:30:00	0:11:04	77.3%
Orange County EMS Agency	20130	UCI Health - Fountain Valley	791	0:41:04	0:30:00	0:11:04	82.2%
Alameda County EMS Agency	62356	Kaiser Permanente, San Leandro Medical Center	809	0:40:48	0:30:00	0:10:48	72.1%
Los Angeles County EMS Agency	20055	Centinela Hospital Medical Center	2416	0:40:44	0:30:00	0:10:44	79.8%
Los Angeles County EMS Agency	20108	East Los Angeles Doctors Hospital	350	0:40:40	0:30:00	0:10:40	83.1%
San Joaquin County EMS Agency	20247	Adventist Health Lodi Memorial	805	0:30:39	0:20:00	0:10:39	74.8%
Contra Costa County EMS Agency	20214	Kaiser Permanente, Antioch	1037	0:30:34	0:20:00	0:10:34	70.9%
Los Angeles County EMS Agency	20183	Kaiser Permanente, Baldwin Park	363	0:40:32	0:30:00	0:10:32	77.7%
San Joaquin County EMS Agency	20457	St. Joseph's Medical Center of Stockton	2323	0:30:27	0:20:00	0:10:27	74.9%
Orange County EMS Agency	20509	University of California, Irvine Medical Center	817	0:40:26	0:30:00	0:10:26	81.4%
Kern County EMS Agency	20372	Ridgecrest Regional Hospital	256	0:39:58	0:30:00	0:09:58	84.8%
Inland Counties EMS Agency	20366	Redlands Community Hospital	1034	0:34:35	0:25:00	0:09:35	77.5%
Alameda County EMS Agency	20008	Alta Bates Summit Medical Center, Alta Bates Campus	445	0:39:22	0:30:00	0:09:22	76.9%
San Diego County EMS Agency	20407	Scripps Memorial Hospital, La Jolla	1540	0:39:13	0:30:00	0:09:13	82.9%
Los Angeles County EMS Agency	20328	College Medical Center	231	0:39:00	0:30:00	0:09:00	86.1%
San Luis Obispo County EMS Agency	20431	Sierra Vista Regional Medical Center	427	0:29:00	0:20:00	0:09:00	85.0%
San Francisco County EMS Agency	20048	California Pacific Medical Center, Davies Campus Hospital	381	0:38:46	0:30:00	0:08:46	83.7%
San Diego County EMS Agency	20347	Pomerado Hospital	531	0:38:35	0:30:00	0:08:35	80.4%
Riverside County EMS Agency	20441	Rancho Springs Medical Center	714	0:38:01	0:30:00	0:08:01	80.4%
Imperial County EMS Agency	20117	El Centro Regional Medical Center	676	0:28:00	0:20:00	0:08:00	76.9%
Kern County EMS Agency	20096	Delano Regional Medical Center	223	0:37:59	0:30:00	0:07:59	81.2%
San Francisco County EMS Agency	20462	St. Mary's Medical Center, San Francisco	625	0:37:26	0:30:00	0:07:26	85.3%
Orange County EMS Agency	20172	Huntington Beach Hospital	434	0:37:17	0:30:00	0:07:17	85.7%
Merced County EMS Agency	20283	Mercy Medical Center, Merced	1505	0:37:05	0:30:00	0:07:05	83.7%
Los Angeles County EMS Agency	20460	St. Mary Medical Center, Long Beach	988	0:37:00	0:30:00	0:07:00	85.6%
Los Angeles County EMS Agency	20387	San Gabriel Valley Medical Center	216	0:36:48	0:30:00	0:06:48	86.1%
Orange County EMS Agency	20239	La Palma Intercommunity Hospital	182	0:36:32	0:30:00	0:06:32	86.8%
Sacramento County EMS Agency	20282	Mercy Hospital of Folsom	358	0:31:18	0:25:00	0:06:18	84.1%
Alameda County EMS Agency	20463	Saint Rose Hospital	476	0:36:15	0:30:00	0:06:15	83.4%
Santa Clara County EMS Agency	20368	Regional Medical Center of San Jose	1363	0:26:00	0:20:00	0:06:00	80.7%
Central California EMS Agency	20085	Community Regional Medical Center, Fresno	4638	0:35:12	0:30:00	0:05:12	82.3%
Los Angeles County EMS Agency	20145	Glendale Memorial Hospital and Health Center	591	0:35:03	0:30:00	0:05:03	84.9%
Inland Counties EMS Agency	20444	St. Bernardine Medical Center	1662	0:30:01	0:25:00	0:05:01	83.5%
Merced County EMS Agency	20274	Memorial Hospital Los Banos	276	0:34:57	0:30:00	0:04:57	86.6%
Central California EMS Agency	20001	Adventist Health Hanford	1119	0:34:54	0:30:00	0:04:54	83.3%
Sacramento County EMS Agency	20508	UC Davis Medical Center	1597	0:29:45	0:25:00	0:04:45	83.8%

**Report Note:** Hospitals with less than 60 qualifying records were excluded from this assessment to adhere to California Department of Health Care Services' Data De-Identification Guidelines.

## Hospitals Exceeding Their Local APOT Standard (3 of 3)

LEMSA	CEMSIS Facility ID	Hospital Name	Offload Count	90th Percentile APOT	Local APOT Standard	Amount Exceeding (HH:MM:SS)	Percent of Compliant Records (Goal of 90%)
San Joaquin County EMS Agency	20484	Sutter Tracy Community Hospital	368	0:24:45	0:20:00	0:04:44	84.2%
Contra Costa County EMS Agency	20179	John Muir Medical Center, Concord	1173	0:24:35	0:20:00	0:04:35	84.7%
San Diego County EMS Agency	20153	Sharp Grossmont Hospital	2431	0:34:17	0:30:00	0:04:17	86.4%
Coastal Valleys EMS Agency	20203	Kaiser Permanente, Santa Rosa	712	0:24:14	0:20:00	0:04:14	87.6%
Los Angeles County EMS Agency	20528	West Hills Hospital and Medical Center	550	0:34:12	0:30:00	0:04:12	83.8%
San Joaquin County EMS Agency	20094	Dameron Hospital	675	0:24:10	0:20:00	0:04:10	82.2%
Orange County EMS Agency	20308	Foothill Regional Medical Center	138	0:34:09	0:30:00	0:04:09	86.2%
Los Angeles County EMS Agency	20356	Providence Little Company of Mary Medical Center, San Pedro	379	0:34:04	0:30:00	0:04:04	85.8%
Inland Counties EMS Agency	64989	Loma Linda University Children's Hospital	373	0:28:58	0:25:00	0:03:58	84.7%
San Francisco County EMS Agency	20386	Zuckerberg San Francisco General Hospital and Trauma Center	1055	0:33:56	0:30:00	0:03:56	87.5%
Los Angeles County EMS Agency	20333	Palmdale Regional Medical Center	1137	0:33:55	0:30:00	0:03:55	87.2%
Coastal Valleys EMS Agency	20478	Sutter Santa Rosa Regional Hospital	722	0:23:49	0:20:00	0:03:49	84.2%
Central California EMS Agency	20443	Saint Agnes Medical Center	2580	0:33:38	0:30:00	0:03:38	85.7%
Sacramento County EMS Agency	20205	Kaiser Permanente, South Sacramento Medical Center	1592	0:28:27	0:25:00	0:03:27	85.1%
Santa Clara County EMS Agency	20202	Kaiser Permanente, Santa Clara Medical Center and Medical Office	828	0:23:25	0:20:00	0:03:25	82.5%
Riverside County EMS Agency	20375	Riverside University Health System Medical Center	1872	0:33:11	0:30:00	0:03:11	85.0%
Los Angeles County EMS Agency	20361	Providence Tarzana Medical Center	406	0:33:04	0:30:00	0:03:04	87.4%
Riverside County EMS Agency	20559	Temecula Valley Hospital	650	0:32:50	0:30:00	0:02:50	87.1%
Sacramento County EMS Agency	20280	Mercy General Hospital	846	0:27:46	0:25:00	0:02:46	85.8%
Los Angeles County EMS Agency	20209	Kaiser Permanente, West Los Angeles	538	0:32:44	0:30:00	0:02:44	87.9%
Central California EMS Agency	20429	Sierra View Medical Center	629	0:32:37	0:30:00	0:02:37	86.6%
Los Angeles County EMS Agency	20315	Northridge Hospital Medical Center	1442	0:32:25	0:30:00	0:02:25	88.2%
Central California EMS Agency	20265	Madera Community Hospital	576	0:32:09	0:30:00	0:02:09	87.5%
Santa Clara County EMS Agency	20200	Kaiser Permanente, San Jose	829	0:22:07	0:20:00	0:02:07	86.6%
Inland Counties EMS Agency	20300	Montclair Hospital Medical Center	202	0:27:07	0:25:00	0:02:06	86.1%
Inland Counties EMS Agency	20252	Loma Linda University Medical Center	1384	0:26:50	0:25:00	0:01:50	86.4%
San Joaquin County EMS Agency	20099	Doctors Hospital of Manteca	397	0:21:50	0:20:00	0:01:50	88.2%
Alameda County EMS Agency	20005	Alameda Hospital	262	0:31:40	0:30:00	0:01:40	87.4%
Inland Counties EMS Agency	20382	San Antonio Regional Hospital	1799	0:26:38	0:25:00	0:01:38	88.3%
Orange County EMS Agency	20530	Anaheim Global Medical Center	200	0:31:37	0:30:00	0:01:37	87.0%
Sacramento County EMS Agency	20288	Methodist Hospital of Sacramento	784	0:26:23	0:25:00	0:01:23	86.6%
Los Angeles County EMS Agency	20294	Mission Community Hospital	348	0:31:09	0:30:00	0:01:09	88.8%
Santa Clara County EMS Agency	20115	El Camino Hospital	902	0:21:00	0:20:00	0:01:00	87.6%
San Diego County EMS Agency	20198	Kaiser Permanente, San Diego	961	0:31:00	0:30:00	0:01:00	89.4%
Los Angeles County EMS Agency	20073	Coast Plaza Hospital	246	0:30:57	0:30:00	0:00:57	89.4%
Imperial County EMS Agency	20344	Pioneers Memorial Hospital	348	0:20:32	0:20:00	0:00:32	88.5%
Inland Counties EMS Agency	20555	Kaiser Permanente, Ontario	945	0:25:30	0:25:00	0:00:30	89.2%
Los Angeles County EMS Agency	20242	LAC USC Medical Center	1894	0:30:27	0:30:00	0:00:27	89.4%
Orange County EMS Agency	20002	AHMC Anaheim Regional Medical Center	532	0:30:17	0:30:00	0:00:17	89.5%
Alameda County EMS Agency	20059	Children's Hospital & Research Center Oakland	156	0:30:14	0:30:00	0:00:14	88.5%
San Diego County EMS Agency	20561	Palomar Medical Center	1760	0:30:07	0:30:00	0:00:07	89.8%
Los Angeles County EMS Agency	20163	Henry Mayo Newhall Memorial Hospital	1287	0:30:07	0:30:00	0:00:07	89.9%

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**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>

March 3, 2026

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**VACANT**

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

**EXECUTIVE DIRECTOR**

**Richard Tadeo, RN**

(562) 378-1610

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

**COMMISSION LIAISON**

**Denise Watson, BSB**

(562) 378-1606

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

Emergency Medical Services Commissioners  
 County of Los Angeles  
 Emergency Medical Services Commission  
 10100 Pioneer Boulevard, Suite 200  
 Santa Fe Springs, California 90670

**RETIREMENT FROM COUNTY SERVICE EFFECTIVE MARCH 27, 2026**

Dear Commissioners,

I am writing to inform you that after nearly 19 years of service I am retiring from the County of Los Angeles effective March 27, 2026, and my last meeting in the capacity of Emergency Medical Services (EMS) Commission Liaison will be on March 18, 2026.

It has been a great honor, privilege, and pleasure to serve the EMS Commission and residents of LA County in this assignment for the past eight (8) years since March of 2018. I appreciate each one of you and thank you for making my work here on the EMS Commission flow with relative ease. This has been an enjoyable and enlightening journey through the EMS disaster and prehospital healthcare system, and I have gained tremendous insight and knowledge through being surrounded by your unwavering professionalism and expertise.

Thank you for your commitment to the work that you do on the EMS Commission to ensure the best possible healthcare outcomes for the residents of LA County. Thank you for the personal sacrifices that each one of you makes. And thank you for being generous with your time. Your efforts do not go unnoticed.

Should you have any questions, please contact Executive Director Richard Tadeo at (562) 378-1610.

Thank you, again, and please know that you will always be in my heart.

Sincerely,

Denise Watson, BSB, EMS Commission Liaison  
 Secretary, Health Services Commission  
 County of Los Angeles, Department of Health Services  
 Emergency Medical Services Agency / Commission  
 10100 Pioneer Boulevard, Suite 200  
 Santa Fe Springs, CA 90670

c: Executive Offices of the Board of Supervisors  
 Christina Ghaly, MD, Director of Health Services  
 Richard Tadeo, Director, EMS Agency; Executive Director, EMS Commission  
 Jacqueline Rifenburg, Assistant Director, EMS Agency