COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES

PROVIDER AGENCY ADVISORY COMMITTEE

MEETING NOTICE

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

DATE: April 15, 2026

TIME: 1:00 pm

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

AGENDA
(Revised 4/2/26)

1. CALL TO ORDER

2. INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS

2.1 Committee Membership Changes – EMS Educator
2.2 EMSAAC Conference 2026 (May 27- 28)
2.3 Joint Educational Session (June 2nd) – Care for Transgender Patients
2.4 EMSC Educational Forum (November 5th)
2.5 Retirement Announcement: Laura Leyman and Laurie Sepke
2.6 National Pediatric Readiness Project (NPRP) (April/May meetings)
2.7 Sidewalk CPR
2.8 General Public Ambulance Rates

3. APPROVAL OF MINUTES: February 11, 2026

4. UNFINISHED BUSINESS

No unfinished business

5. NEW BUSINESS

Policies for Discussion; Action Required:

5.1 Reference No. 426, Private Provider Water Ambulance Interfacility Transport
5.2 Reference No. 426.1, Private Provider Water Ambulance Insurance Requirements
5.3 Reference No. 505, Ambulance Patient Offload Time (APOT)
5.4 Reference No. 606, Documentation of Prehospital Care

Policies for Discussion; No Action Required:

5.5 Reference No. 607, Electronic Data Submission

6. REPORTS AND UPDATES

6.1 Health Data Exchange
6.2 EMS Update 2026
6.3 EmergiPress
6.4 ITAC
6.5 EMS and Law Enforcement Co-Response (ELCoR) Committee
6.6 Research Initiatives & Pilot Studies
    6.6.1 Prehospital Blood Transfusion - LA DROP
    6.6.2 PediDOSE Trial
    6.6.3 Pedi-PART
6.7 California Office of Traffic Safety (OTS) Grants Projects
6.8 Cardiac Arrest Taskforce
6.9 Upcoming Mass Gathering Events

7. OPEN DISCUSSION

8. NEXT MEETING: June 17, 2026

9. ADJOURNMENT

2026 Annual EMSAAC CONFERENCE

BACK TO THE FUTURE

2026 ANNUAL CONFERENCE

EMS REIMAGINED

Hilton®
LA / Universal City
May 27 & 28, 2026

EMERGENCY MEDICAL SERVICES ADMINISTRATORS' ASSOCIATION OF CALIFORNIA — EMSAAC

Pre-Conferences held concurrently on Tuesday, May 26

- **CQI: THE NEXT ERA OF EMS QUALITY**
- **GREAT SCOTT! THERE'S THAT WORD AGAIN: 'DISASTER'**

Presented by: EMS Administrators' Association of California
Monitor the EMSAAC website for current information: www.EMSAAC.org

BACK TO THE FUTURE: EMS REIMAGINED

The EMS Administrators' Association of California (EMSAAC) cordially invites California's EMS leaders and professionals to join us for the EMSAAC Annual Conference 2026 at a new location, the Hilton LA in Universal City. EMSAAC continues to lead the way in creating conferences that are meaningful and exciting to attend. This year's theme, Back to the Future, is a time-travel story where the meaning centers on taking control of your destiny, showing how past choices shape the future, and proving you can change your life for the better. We will use time travel as a narrative device to explore themes of mental wellness, CQI, research topics, risk management and many others. The theme lays down the foundation for a broad variety of subject matter to interest all levels of prehospital care personnel and managers including ambulance providers, fire department personnel, military and law enforcement partners, LEMSA personnel, ED nurses, physicians, emergency preparedness coordinators and anyone who provides EMS to their community. The conference includes lectures, panel discussions, and opportunities to network with current leaders and innovators in EMS as well as preview new and upcoming equipment, products and services.

About EMSAAC

EMSAAC is composed of administrators from 34 Local EMS Agencies (LEMSAs). These county-designated agencies are responsible for planning, coordinating, implementing, monitoring, and evaluating a local, integrated system of emergency medical services. The LEMSAs work with the California EMS Authority to ensure compliance with applicable laws, regulations and guidelines statewide.

Continuing Education Credits

This conference has been designed to provide instructor-based continuing education for nurses and prehospital care professionals through the Los Angeles County Emergency Medical Services Agency. This course is approved by the California Board of registered Nursing, BRN Provider #17168, for up to 10.5 contact hours. California EMS CE is provided by the Los Angeles County EMS Agency, CEP #19-0001. Up to 10.5 hours of instructor-based CE will be issued to EMTs, paramedics and MICNS upon completion.

The Orange County EMS Agency, a division of the Orange County Health Care Agency, is applying for physician CME approval.

EMSAAC
EMERGENCY MEDICAL SERVICES ADMINISTRATORS' ASSOCIATION OF CALIFORNIA

IN COLLABORATION WITH THE
EMERGENCY MEDICAL DIRECTORS
ASSOCIATION OF CALIFORNIA

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Santa Barbara
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Santa Cruz
Sierra-Sac Valley
Solano
Stanislaus
Tuolumne
Ventura
Yolo

EMSAAC

May 27 & May 28, 2026

Pre-Conference May 26

See page 7 for all registration information

Hilton

Make your hotel reservations today!

Rates & Reservation Info

Please make your reservations and be sure to request the group code **EMS** reduced conference rate of $259 per night plus taxes. This low rate includes:

- Complimentary Basic Wi-Fi access
- Complimentary use of fitness center and pool
- Group rate 3 day pre-/post-conference
- No resort fee
- Reduce parking:
  Day Self - $16, Valet $24
  Overnight Self - $35, Valet $45
- Free shuttle to Universal Studios

Hilton LA/Universal City
555 Universal Hollywood Drive, Universal City, California 91608
Group Link: https://www.hilton.com/en/attend-my-event/buruchf-ems-07a56847-d177-4cdd-b0f3-d5de1eebc1f1/
In-House Reservations: 818-623-1434
from 7am-7pm, Monday-Saturday.
Refer to group code EMS when booking.

The Resort – Moments from the Magic of Universal Studios

In the heart of Los Angeles' entertainment district and moments from the MAGIC of Universal Studios, the hotel is adjacent to Universal Studios Hollywood, with a free shuttle to get you there. Looking on to the Hollywood Hills, the hotel is a half mile from Universal CityWalk shopping and just as close to the local Metro station. Perks include access to our fitness center and outdoor pool. Located in Universal City, Hilton Los Angeles/Universal City is in the entertainment district, within a 15-minute walk of Universal Studios Hollywood and Universal CityWalk. This hotel is 2.8 mi (4.5 km) from Warner Brothers Studio and 2.8 mi (4.5 km) from Hollywood Bowl and just 6 miles from Burbank Airport (29 from LAX) with access to CityWalk and the Metro.

A block of rooms will be held until April 25, 2026. After this date, reservations will be accepted on a space and rate available basis only. Check-in time is 4:00 p.m. and check-out time is 11:00 a.m.

Your Stay

All of the 495 rooms have amazing views of the surroundings of the hotel, some including views inside Universal Studios. The amenities featured include air conditioning, outdoor pool, multiple on-site restaurants and bars, business and concierge services, room service and gift shop. In-room amenities include, but not limited to, mini-refrigerator, coffee maker, work desk, hair dryer and in-room safe.

Conference Program

Tuesday, May 26, 2026

Pre-conferences – CQI and Disaster
Main conference registration
for early arrivals

DAY 1 - Wednesday, May 27, 2026

7:00 am
"Great Scott" Meet the Exhibitors & Ongoing Registration
Continental Breakfast in Exhibit Hall

8:00 am - 8:10 am
"Far Out" Introduction
Shaun Vincent, EMSAAC President

8:10 am - 8:40 am
"Welcome Home Marty!" – Introduction to Los Angeles
LA County Sheriff's Emergency Services Detail

8:40 am - 9:40 am
KEYNOTE SPEAKER
"Don't Be Such a Square" – Don't Lose Yourself
Cody Spaulding, The Salty Paramedic

This presentation focuses on the mental health of first responders by providing different tools to use in your personal lives and careers to maintain good mental health despite dealing with trauma on the job, family issues, personal issues, etc. It aims to offer new outlooks on many different aspects of the job that can be used in your own personal experiences and possibly take back to colleagues so that the workplace also can start new positive trends to maintain good mental health for all of the employees. The 8 key takeaways are "Identify, Find Your Why, Reset, Show Compassion, Invest in Yourself, Create an Outlet, Prioritize Your Life & Laugh." The Salty Paramedic utilizes his own experiences as a firefighter/paramedic so others can relate. The goal is to help drive home the importance of good mental health.

9:40 am - 10:15 am
Time Travel with Exhibitors

10:15 am - 10:45 am
EMS Data Time Machine: Rewinding Decisions, Fast-Forwarding Care
Remle Crowe, Director of Research, ESO

Marty and Doc weren't the only ones trying to change the future. EMS clinicians do it every shift. But here's the twist: while EMS makes split-second decisions in the field, they often do not see the impact once the patient vanishes behind the ED doors. This session fires up the flux capacitor of integrated data - from dispatch to discharge - to travel beyond the present and see the ripple effects of prehospital care. We'll explore how outcome-linked EMS data can be the DeLorean that takes us back to understand what happened and forward to re-imagine training, protocols, and even policy. By the end, you'll see how data isn't just numbers, but a time machine for better patient care and a better future for our workforce.

10:45 am - 11:45 am
Starting From Scratch – What Would EMS Look Like If You Built It Today?
Doug Wolfberg, EMS Attorney

EMS has evolved into something of a Frankenstein, with much of our practice and deployment based more on our history than evidence or proven best practices. This session will be a great thought exercise on how we'd build an EMS system (operationally, financially and clinically) if we wiped out the current system on an etch-a-sketch and started over with a clean slate. From how we access emergency health care to how we respond, and how/where we deliver services, EMS would look a lot different if we weren't constrained by past practices and "tradition."

11:45 am - 1:00 pm
75 Jigowatts – Lunch with Exhibitors and Colleagues

1:00 pm - 2:30 pm
Research Panel – "Where We're Going, We Don't Need Roads" OR DO WE?
Moderators:
Karl Sporer, MD, Napa County EMS Agency
Nichole Bosson, MD, LA County EMS Agency

Organized by EMDAC each year, rave reviews are received for a panel of different researchers in the field of EMS. They present data, trials or published papers keeping the audience abreast of the newest innovations and thinking backed by evidence-based foundations.

1) Intramuscular Epinephrine

Scott Youngquist, MD
University of Utah School of Medicine

2) Prehospital Ultrasound

Brian Strain, DO
Medical Director, GMR Central CA

Jonathon Warren, MD
UCLA Health/Harbor UCLA

3) Trauma Triage

Craig Newgard, MD, MPH
UC San Francisco

2:30 pm – 2:45 pm
The Future of California's EMS

Elizabeth Basnett, Director
California EMS Authority

2:45 pm – 3:15 pm
"Give Me A Tab": Break with Exhibitors

3:15 pm – 4:15 pm
Traumatic Brain Injury: "Gray Matters"
Jake Toy, MD
Gerard Waworundeng, MSN, RN, MICN
LA County EMS Agency

Prompt recognition and treatment of patients with traumatic brain injury (TBI) by EMS clinicians is critical toward improving trauma patient outcomes. After identifying gaps in

prehospital TBI care in our region, we launched a large-scale quality improvement initiative in partnership with prehospital and hospital-based stakeholders to enhance the delivery of evidence-based care. Using the Model for Improvement and multiple Plan-Do-Study-Act (PDSA) cycles, we drove systemwide change.

5:30 pm - 6:30 pm
Return for the "Daddy-O" President's Reception – Dress for Back to the Future
Exhibit Hall (light hors d'oeuvres)

DAY 2 - Thursday May 28, 2026

7:30 am
Reality with the Dreamboat Exhibitors
Continental Breakfast in Exhibit Hall

8:30 am - 8:45 am
Destiny – Passing of the Gavel from President Shaun Vincent to President-Elect Richard Tadeo

8:45 am - 9:00 am
EMSAAC Leadership Award & Jim Pointer California Innovation Award
Richard Tadeo, EMSAAC President-Elect
EMDAC Representative

9:00 am - 10:30 am
KEYNOTE SPEAKER
Risk Management – Don't Be a Slacker!
Gordon Graham, Lexipol

Gordon Graham is a risk management expert and a practicing attorney who has presented a common sense risk management approach to hundreds of thousands of public safety professionals around the world. The 5-step risk management process is a continuous cycle: Identify risks, Analyze risks, Evaluate/Prioritize risks, Treat risks, and Monitor & Review them, ensuring threats are proactively managed from discovery to ongoing control for business resilience.

10:30 am – 11:15 am
Alternate Timeline with Exhibitors

11:15 pm – 12:15 pm
Flux: Fad, Trend or Standard of Care?
Doug Wolfberg, EMS Attorney

When do new clinical procedures, interventions and practices become a legal standard of care? When does a new procedure go from a "really cool idea" to a legal liability if you're not doing it? (Whole blood is a great recent example.) And, conversely, when is it time to ditch long-standing clinical practices that are no longer supported by evidence and data.

12:15 pm – 1:15 pm *60 Jigowatts – Lunch & Final Visit with Exhibitors*

1:15 pm – 2:00 pm

"Far Out" Hospital-Generated Solutions to APOT
Jenny Van Slyke, MICN
Sara Hildago-Lopez, MICN
Huntington Hospital

Ambulance wait times have long been a problem in California – no matter if you are in the north or south. Despite best practices, toolkits and legislation, the overcrowding problems and delays continue. This is how a southern California hospital redesigned APOT processes and will share their best approaches.

2:00 pm – 2:45 pm
"Get in Sync" EMS Enhancing Law Enforcement and EMS Collaboration

Law enforcement and EMS collaboration often work together in EMS patient encounters. Establishing a forum for the local exchange of ideas to support a collaborative approach between EMS and Law Enforcement is presented as a best practice. Los Angeles County created the EMS Law Enforcement Co-Response Committee (ELCoR) to improve the development of EMS policy, practice, and training through establishing a pathway for law enforcement input. In this presentation, Los Angeles County EMS Agency describes establishing ELCoR and the successful outcomes of specific projects. Napa County EMS Agency will describe a similar process under development.

- *Hawthorne Police Department*
  -- Joe Nakagawa, MD
- *Los Angeles County EMS Agency*
  -- Nichole Bosson, MD
  -- Denise Whitfield, MD
  -- Shira Schlesinger, MD
  -- Michael Kim, MD
- *Napa County EMS*
  -- Shaun Vincent

2:45 pm – 3:00 pm
Rollin' Through – Stretch Break & Snack

3:00 pm – 4:00 pm
"Capacitor of the Future": Dispatch Redirection of EMS Calls

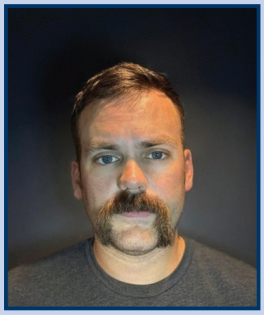
Redirection involves triaging and rerouting 911 callers with low-acuity complaints to urgent care facilities, community clinics, telehealth, and mental health crisis teams, amongst other services. The aim is to get patients to the definitive care they need when they need it, while also reducing unnecessary emergency responses and lowering the cost of care. This discussion will be facilitated by the Inland Counties Emergency Medical Agency, exploring the real solutions that have been implemented by CONFIRE in San Bernardino County and by Global Medical Response in 22 of the states they serve.

- *Amber Anya, ICEMA, Moderator*
- *Brian Henrickson, GMR*
- *Leslie Parham, ECNS*
- *Nathan Cooke, CONFIRE*

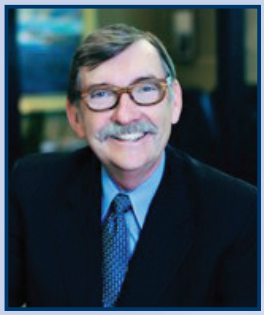
4:00 pm

Conclusion: "Make Like a Tree and Get Out of Here!"
Final Raffles & Wrap Up

Keynote Speakers



Cody Spaulding, "The Salty Paramedic – The Salty Paramedic is a seasoned EMS/Fire professional and mental-health advocate dedicated to supporting first responders through honest conversations, relatable storytelling, and educational content. Blending experience from the field with a genuine passion for helping others, Cody creates a welcoming space where first responders can learn, laugh, and feel understood. Through social media, podcasting, public speaking, and his book Don't Lose Yourself, The Salty Paramedic empowers all first responders to prioritize their well-being, strengthen their resilience, and stay connected to the heart of why they serve.



Gordon Graham, Risk Management Expert – Gordon Graham is a 33-year veteran (now retired) of California law enforcement. In this capacity, he served as a street cop, supervisor, manager, and executive. Mr. Graham was awarded a B.A. in Business from San Francisco State College, a teaching credential from California State University, Long Beach, a master's degree in Safety and Systems Management from the University of Southern California, and a juris doctorate from Western State University. He has taken his background as a cop, risk manager and attorney and is the co-founder of Lexipol, a company designed to standardize public safety practices across America. He has presented to public safety personnel from around the world and is an educator at the University of Virginia.

Faculty

Amber Anaya
Assistant EMS Administrator
ICEMA
San Bernardino, California

Elizabeth Basnett
Director
EMS Authority
Assistant Secretary, CA HHS
Sacramento, California

Nichole Bosson, MD, MPH, FAEMS
Medical Director
Los Angeles County EMS Agency
Director, EMS Fellowship
Harbor-UCLA Medical Center
Santa Fe Springs, California

Nathan Cooke
Interim Executive Director
CONFIRE
San Bernardino, California

Remle Crowe
Senior Director of Research & Data Enablement
ESO
Adjunct Assistant Professor, UT Health
San Antonio, Texas

Brian Henricksen
Director – EMS Transformation
Global Medical Response
Philadelphia, Pennsylvania

Sara Hidalgo-Lopez, RN, MSN, MICN
Emergency Department Charge Nurse
Huntington Hospital
Pasadena, California

Michael Kim, MD
Associate Medical Director
Paramedic Training Institute
Los Angeles County EMS Agency
Santa Fe Springs, California

Craig Newgard, MD, MPH
Professor Emergency Medicine
Zuckerberg San Francisco General Hospital
San Francisco, California

Leslie Parham
Consultant
ECNS
San Bernardino, California

Shira Schlesinger, MD, MPH, FAEMS
Director of Education and Innovation
Los Angeles County EMS Agency
Santa Fe Springs, California

Jennifer Shepard, Paramedic
Deputy
Emergency Services Detail
LA County Sheriff's Department
Los Angeles, California

Karl Sporer, MD
Medical Director
Napa County EMS Agency
Napa, California

Brian Strain, DO
Medical Director, GMR Central CA
EMS Medical Director, Adventist
Health Central Valley
Hanford, California

Richard Tadeo
EMS Director
Los Angeles County EMS Agency
Santa Fe Springs, California

Jake Toy, DO, MS
EMS Physician
Los Angeles County EMS Agency
Santa Fe Springs, California

Shaun Vincent
EMS Administrator
Napa County EMS Agency
Napa, California

Jenny Van Slyke, MBA, BSN, MICN
Prehospital Program Manager
Huntington Hospital
Pasadena, California

Jonathan Warren, MD
US/EMS Fellow
UCLA Health/LA County EMS Agency
Harbor-UCLA Medical Center
Torrance, California

Gerard Waworundeng, MSN, RN, MICN
EMS Systems Quality Manager
Los Angeles County EMS Agency
Santa Fe Springs, California

Denise Whitfield, MD, MBA, FAEMS
Assistant Medical Director
Los Angeles County EMS Agency
Santa Fe Springs, California

Doug Wolfberg
Founding Partner
Page, Wolfberg & Wirth
Mechanicsburg, Pennsylvania

Scott Youngquist, MD
Associate Professor of Emergency Medicine
University of Utah School of Medicine
CMO, Salt Lake City Fire Department
Salt Lake City, Utah

CONFERENCE REGISTRATION

May 27 & 28, 2026
Universal City, Los Angeles

All registrations are taken ONLINE only at emsaac.org

Payments can be made by credit card, PayPal or through a PO or check. Confirmation and W-9 available on the website. Registration fees include all conference materials and food & beverage for breakfasts, breaks, lunches and President's reception.

CQI Pre-Conference (separate registration) – The Next Era of EMS Quality **May 26, 11am – 4:00pm** Limited seating	$160
Disaster Pre-Conference (separate registration) – Great Scott!! There's That Word Again: Disaster **May 26, 11am – 4:00pm** Limited seating	$160
EARLY Conference Registration – if payment **received May 6 before 5:00 p.m.** NOTE: The first 50 paid registrations will be entered into a raffle for a special door prize.	$475
Late or onsite Registration – received May 6 after 5:00 p.m.	$550
Virtual Option Unavailable	NA

Simultaneous pre-conferences ** select only one** requires separate registration (see above)
Pre-conferences are deep dives led by experts in the specific fields.

Pre-Conference

CQI: The Next Era of EMS Quality

May 26, 2026
11:00 am – 4:30 pm (lunch included)

Tired of chasing "gotcha" charts, drowning in reviews, or feeling like your quality program isn't moving the needle? This hands-on workshop will help your organization shift from compliance-focused chart review to a culture of learning and system improvement.
It's time to move beyond the outdated QA model of hunting "bad apples" and punishing documentation errors. In the next era of EMS quality, we build systems that empower clinicians, not intimidate them. We design and use measures that actually reflect clinical care, not just checkbox completion. We create psychological safety so EMS clinicians feel motivated to report concerns, ask questions, and problem-solve. Join us and step into a future where quality management feels like collaboration—not correction—and where your data becomes a roadmap to better care, stronger teams, and sustainable improvement.
This will be a hands-on workshop whether you are new to CQI or a long-time coordinator, these are the up-and-coming approaches.

Faculty:
Remle Crowe
Senior Director of Research & Data Enablement,
ESO and Adjunct Assistant Professor,
UT Health, San Antonio

EMSAAC CQI Committee

Pre-Conference

Great Scott! There's That Word Again: Disaster

May 26, 2026
11:00 am – 4:30 pm (lunch included)

Led by disaster response and crisis management expert Michael Marsh, this course leverages more than 28 years of experience supporting state, county, and federal agencies in strengthening operational efficiency and preparedness for emergency incidents, natural disasters, and high-visibility events. Participants will engage in hands-on, practical learning focused on developing, implementing, and evaluating processes to effectively respond to, mitigate, and recover from rapidly evolving incidents.

Course objectives include:

- Medical Surge & Continuum of Care
- Coordination, Leadership and Communications
- Crisis Standards of Care & Ethical Decision-Making
- Medical Logistics & Resource Management

Faculty:
Michael Marsh
Principal Consultant
Marsh EMS Consulting
Midlothian, Texas

EMSAAC Disaster Committee

Sponsors & Exhibitors

Many generous sponsors and exhibitors make the EMSAAC Conference possible. The conference is an outstanding opportunity to see the latest and greatest new EMS tools and applications as well as to meet the representatives and directly discuss material needs. The following is a list of sponsors and exhibitors to date; others will be joining this distinguished group:

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Medic Ambulance

SCAA
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Helping Heroes Save Lives

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EMS BILLING
SINCE 2016

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SkyLife
Air Ambulance

FirstNet Authority

acbb Association for the Advancement of Blood & Biotherapies

Caring for Transgender and Gender Diverse Patients

A review of the NAEMSP Position Statement

Dr. Veronica Case
Oschner Medical Center
New Orleans, LA

Tuesday
June 2, 2026
11:45am - 12:45pm

Presented Virtually
https://ucla.zoom.us/j/94784637563?pwd=jg9ACPNIgPta3M6Am2f2gMfP8sp8ph.1
Meeting ID: 947 8463 7563 Passcode: 497001

Los Angeles County EMS Agency
Joint Educational Session

1 hour CE Credit - Instructor Based
CEP# 19-0001; BRN CEP# 15456 Objectives available upon request

Pediatric Readiness Saves Lives

National PRP Pediatric Readiness Project
Ensuring Emergency Care for All Children

National PRP Prehospital Pediatric Readiness Project
Ensuring Emergency Care for All Children

EDs: Join the nationwide assessment March–May at PedsReady.org

ASSESSMENT OPENS MARCH 3

High levels of Pediatric Readiness in emergency departments (EDs)—or scoring a minimum of 88 points (ideally 100) on the National Pediatric Readiness Project Assessment—improve outcomes for children. While research in prehospital settings is ongoing, a similar impact is anticipated.

High levels of Pediatric Readiness in EDs are associated with the potential for:

60% lower mortality risk in injured children[1,2]

76% lower mortality risk in ill children[1,3]

2,143 children's lives saved across the U.S. each year[3]

and only cost between $4–48 per patient.[4]

The Power of PECCs:
Designating individuals as pediatric emergency care coordinators (PECCs), or pediatric champions, in EMS agencies and EDs is the best way to increase readiness.

Prehospital research is currently underway with the evaluation of the 2024 Prehospital Pediatric Readiness Project Assessment results.

You can help save children's lives.
PedsReady.org

For references, visit https://bit.ly/pedsreadyimpact.

The EMSC Innovation and Improvement Center website is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award (U07MC37471) totaling $2.5M with 0 percent financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS or the U.S. government. For more information, visit HRSA.gov.
251031 | Updated 12/22/2025.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

Tel: (562) 378-1500
Fax: (562) 378-1107

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

March 24, 2026

TO: Fire Chief, All 9-1-1 Paramedic Provider Agencies
CEO, Private Provider Agencies
City Manager, Each Los Angeles County City

FROM: Richard Tadeo
Director

SUBJECT: **GENERAL PUBLIC AMBULANCE RATES JULY 1, 2026 THROUGH JUNE 30, 2027**

Attached are the maximum allowable rates to the general public for ambulance transportation as of July 1, 2026, as per section 7.16.340, Modification of Rates, of the County Ordinance (Attachment I).

Transportation services provided on or after July 1, 2026 may not be billed above the allowable maximum rates per the attached rate schedule.

If you have any questions, please contact David Wells, Chief of Prehospital Operations at (562) 378-1677 or dwells@dhs.lacounty.gov.

RT:dw

Attachment

c: Georgina Glaviano, County Counsel, Health Services
Julio Alvarado, Director, Contracts and Grants
Ruth Guerrero, Contract Manager, Contracts and Grants
Cristina Talamantes, Ordinance Liaison, Board of Supervisors
Executive Office

ATTACHMENT I

COUNTY OF LOS ANGELES
GENERAL PUBLIC AMBULANCE RATES
EFFECTIVE JULY 1, 2026

7.16.280 Rate schedule for Ambulances.

A. A ground ambulance operator shall charge no more than the following rates for one patient:

Rates Effective July 1, 2026

1.	Response to a non-emergency call with equipment and personnel at an advanced life support (ALS) level	$3,336.00
2.	Response to an emergency call with equipment and personnel at an advanced life support (ALS) level	$3,572.00
3.	Response to a non-emergency call with equipment and personnel at a basic life support (BLS) level	$2,222.00
4.	Response to an emergency call with equipment and personnel at a basic life support (BLS) level	$2,385.00
5.	Mileage Rate. Each mile or fraction thereof	$31.00
6.	Waiting Time. For each 30-minute period or fraction thereof after the first 30 minutes of waiting time at the request of the person hiring the ambulance	$189.00
7.	Standby Time. The base rate for the prescribed level of service and, in addition, for each 30-minute period or fraction thereof after the first 30 minutes of standby time	$180.00

B. This section does not apply to a contract between the ambulance operator and the county where different rates or payment mechanisms are specified.

***Editor's note:** Fee changes in this section include changes made by the Director of Emergency Medical Services Agency in accordance with County Code Section 7.16.340 – Modification of Rates are effective July 1, 2023, and every July 1 thereafter.

7.16.310 Special charges.

A. A ground ambulance operator shall charge no more than the following rates for special ancillary services:

Rates Effective July 1, 2026

1.	Request for service after 7:00 p.m. and before 7:00 a.m. of the next day will be subject to an additional maximum charge of	$33.00
2.	Persons requiring oxygen shall be subject to an additional maximum charge per tank or fraction thereof, and oxygen delivery equipment to include nasal cannula and/or oxygen mask, of	$127.00
3.	Neonatal transport	$316.00
4.	Registered Nurse or Respiratory Therapist Specialty Care Transport with equipment and personnel for up to 3 hours of transportation time	$4,018.00
5.	Registered Nurse and Respiratory Therapist Specialty Care Transport with equipment and personnel for up to 3 hours of transportation time	$4,540.00
6.	Registered Nurse and/or Respiratory Therapist per hours after the first 3 hours	$226.00
7.	Volume ventilator	$246.00
8.	Disposable medical supplies	$37.00

B. Where other special services are requested or needed by any patient or authorized representative thereof, a reasonable charge commensurate with the cost of furnishing such special service may be made, provided that the ambulance operator shall file with the Director of the Department of Health Services a schedule of each special service proposed and the charge therefore, which charge shall be effective unless modified, restricted, or denied by the Director of the Department of Health Services. Special services are defined as services provided to a patient that are unique and individual to a specific patient's needs, and are performed on a limited basis.

C. Charges for special services provided to patients that are new services, but will become an industry standard, must be reviewed and a rate commensurate with the service developed prior to ambulance operators charging such rate to the general public. Such rates shall not be charged to patients until approved by the Board of Supervisors.

D. This section does not apply to a contract between an ambulance operator and the county where different rates or payment mechanisms are specified.

(Ord. 2011-0031 § 28, 2011: Ord. 2003-0058 § 4, 2003: Ord. 96-0067 § 18, 1996: Ord. 94-0038 § 2, 1994: Ord. 91-0071 § 3, 1991: Ord. 90-0088 § 2, 1990: Ord. 89-0092 § 3, 1989: Ord. 88-0181 § 33, 1988; Ord. 88-0170 § 3, 1988: Ord. 87-0131U § 2, 1987: Ord. 86-0111 § 2, 1986: Ord. 85-0120U § 2, 1985: Ord. 83-0201 § 4, 1983: Ord. 83-0017 § 3 (part), 1983: Ord. 82-0105 § 3, 1982: Ord. 12077 § 1 (part), 1980: Ord. 11806 § 1 (part), 1978: Ord. 5860 Ch. 4 § 1010, 1951.)

***Editor's note:** Fee changes in this section include changes made by the Director of Emergency Medical Services Agency in accordance with County Code Section 7.16.310 – Modification of Rates and are effective July 1, 2023 and every July 1 thereafter.

7.16.340 Modification of rates.

The maximum rates chargeable to the general public as set forth in Sections 7.16.280 and 7.16.310 of this chapter shall be adjusted effective July 1, 1992, and on July 1st of each year thereafter, to reflect changes in the value of the dollar. For each of the one-year periods respectively beginning July 1, 1992 and July 1, 1993, such adjustments shall be made by multiplying the base amounts by the percentage change in the transportation portion of the Consumer Price Index for All Urban Consumers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February. Beginning July 1, 1994, and on each July 1 thereafter, such adjustments shall be determined by multiplying the base amounts by the average of the percentage changes of the transportation portion and of the medical portion of the Consumer Price Index for All Urban Consumers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February. Beginning July 1, 2017, and on every July 1 thereafter, such adjustments shall be determined by multiplying seventy-five (75) percent of the base amounts by the percentage change of the minimum wage change in Los Angeles County as defined in County Code Section 8.100.040 – Minimum Wage and by multiplying twenty-five (25) percent of the base amounts by the percentage change of the Medical Care line item of the Consumer Price Index for all Urban Customers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February, except for the following changes: Registered Nurse/Respiratory Therapist per hour after the first three (3) hours adjustment shall be determined by multiplying the current charge by the percentage change of the minimum wage change in Los Angeles County as defined in County Code Section 8.100.040 – Minimum Wage: mileage adjustment shall be determined by multiplying the current charge for the percentage change of the transportation line item of the Consumer Price Index for All Urban Customers, Western Region, as compiled as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February: and Oxygen, Disposable Medical Supplies, and a Ventilator adjustment shall be determined by multiplying the current charges by the percentage change of the Medical Care line item of the Consumer Price Index for all of the Customers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February. Beginning July 1, 2024, and on every July 1 thereafter, such adjustments shall be determined by multiplying seventy-five (75) percent of the base amounts by the percentage change of the minimum wage change in Los Angeles County as defined in County Code Section 8.100.040 – Minimum Wage, or by two percent, whichever is higher, and by multiplying twenty-five (25) percent of the base amounts by the percentage change of the Medical Care line item of the Consumer Price Index for all Urban Consumers, Western Region, as compiled and reported by the Bureau of Labor Statistics for the 12-month period ending with the last day of the prior month of February. The result so determined shall be rounded to the nearest whole number and added or subtracted, as appropriate, to the rate. The Director of the department of health services shall initiate implementation of these rate changes by notifying in writing each licensed private ambulance operator in Los Angeles County thereof, and any other individual or agency requesting such notification from the Director. Such notice shall be sent by first class mail no later than June 15 of the prior period.

(Ord. 94-0038 § 3, 1994: Ord. 91-0071 § 4, 1991: Ord. 88-0170 § 4, 1988: Ord. 83-0017 § (part), 1983: Ord. 11806 § 1 (part), 1978: Ord. 5860 Ch. 4 § 1017, 1951.)

EMERGENCY MEDICAL SERVICES COMMISSION
PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday – February 11, 2026

MEMBERSHIP / ATTENDANCE

	MEMBERS IN ATTENDANCE	ORGANIZATION
X	Carol Meyer, Chair	EMSC, Commissioner
X	Kenneth Powell, Vice Chair	EMSC, Commissioner
	Jason Cervantes	EMSC, Commissioner
	James Lott, PsyD, MBA	EMSC, Commissioner
	Gary Washburn	EMSC, Commissioner
	Kristin Kolenda	EMSC, Commissioner
	Ken Lieberman	EMSC, Commissioner
	Paul Camacho	EMSC, Commissioner
X	Sean Stokes	Area A *(Rep to Medical Council)*
	Patrick Nulty	Area A, Alternate
X	Keith Harter	Area B
X	Clayton Kazan, MD	Area B, Alternate
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 *(Rep to BHAC)*
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	Melissia Turpin	Prehospital Care Coordinator, Alternate
X	Bryan Sua	Public Sector Paramedic Coordinator
	Drew Pryor	Public Sector Paramedic Coordinator, Alt
	Danielle Thomas	Private Sector Paramedic
	Scott Buck	Private Sector Paramedic, Alternate
X	Tabitha Cheng, MD	Provider Agency Medical Director
X	Tiffany Abramson, MD	Provider Agency Medical Director, Alt
X	Robert Ower	Private Sector Nurse Staffed Amb Program
X	Jonathan Lopez	Private Sector Nurse Staffed Amb Program,
	Scott Jaeggi	EMT Training Program
	Albert Laicans	EMT Training Program, Alternate
X	Ray Mosack	Paramedic Training Program
	Vacant	Paramedic Training Program, Alternate
X	Jennifer Nulty	EMS Educator
	Heather Calka	EMS Educator, Alternate

EMS AGENCY STAFF	EMS AGENCY STAFF
Richard Tadeo	Nichole Bosson, MD
Jacqueline Rifenburg	Shira Schlesinger, MD
David Wells	Dipesh Patel, MD
Ami Boonjaluksa	Michael Kim, MD
HanNa Kang	Jake Toy, MD
Jennifer Calderon	Jonathan Warren, MD
Natalie Greco	Paul Aragon, MD

GUESTS	ORGANIZATION
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
Kathyrn 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
Taggert 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

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 1-7th. 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 or Priscilla Ross at 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 (≤ 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.

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 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

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

Annual System Report presented by Richard Tadeo. The 14th 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.

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

REFERENCE NOs. 426, Private Provider Water Ambulance Interfacility Transport & 426.1, Water Ambulance Insurance Requirements

REF	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
426	To establish standards, procedures, and operational requirements for the safe and effective interfacility transport of patients by watercraft within Los Angeles County to ensure continuity of care, patient safety, and regulatory compliance when marine transport is necessary due to geography, access limitations, or operational need. Private Provider seeking ability to transport patients to and from Catalina Island for appointments, discharge, or hospitalization which monitoring of patient is necessary which would preclude transport via ferry nor appropriate for air. Policy developed by working with subject matter experts from Public Provider Agencies and the United States Coast Guard.	PAAC – 4/15/26		
426.1	Insurance Requirements set forth by the County of Los Angeles.			

SUBJECT: **PRIVATE PROVIDER WATER AMBULANCE INTERFACILITY TRANSPORT** (EMT, PARAMEDIC, MICN) REFERENCE NO. 426

PURPOSE: To establish standards, procedures, and operational requirements for the safe and effective interfacility transport of patients by watercraft within Los Angeles County to ensure continuity of care, patient safety, and regulatory compliance when marine transport is necessary due to geography, access limitations, or operational need.

AUTHORITY: Health & Safety Code, Div. 2.5, Sections 1797.204, 1797.220, 1798.2, 1798.101(b)(1)
California Code of Regulations, Title 13, Division 2 - Chapter 5: Article 1
California Code of Regulations, Title. 22, § 70649 & § 100094.02
Code of Federal Regulations (CFR) Title 33, 46, 47, & 49
Los Angeles County Code, Title 7 Div 2, Chapter 7.16, Ambulances

DEFINITIONS:

Certificate of Documentation with Coastwise Endorsement: Registration for vessels over 5 net tons used in commercial operations, authorizing transport of passengers or merchandise between US points in coastwise trade.

Commercial Service: Transportation of passengers or goods between points in the United States for economic gain.

Emergency Medical Condition: A condition or situation in which an individual has an immediate need for medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure – except isolated asymptomatic hypertension, oxygen saturation) are also indications of an emergency medical condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification are also considered to have an emergency medical condition.

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 Transfer (IFT): The transport of a patient from one health facility to another health facility as defined above. For the purposes of this policy, transport options for IFTs involve the use of authorized ground, air and water ambulance transport vehicles.

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

Passenger: an individual other than the owner, master, captain, or crew, who is carried on a non-recreational vessel.

Patient: A person who seeks or appears to require medical assessment and/or medical treatment.

Vessel Safety Check: A comprehensive inspection performed by the United States Coast Guard Auxiliary to assess the safety and compliance of vessels with the applicable laws, regulations, and recommended practices.

Water Ambulance: A specially equipped and appropriately staffed watercraft authorized and designated by the EMS Agency to transport sick or injured people and provide medical care while traveling on the water that is designed and outfitted with medical equipment and safety gear so patients can be monitored and receive necessary medical treatment while being transported to a designated appropriate medical facility.

Water Ambulance Transport: The transport of a patient on a designated water ambulance operated in accordance with applicable maritime and EMS policies and procedures.

PRINCIPLES:

1. The Los Angeles County EMS Agency is the regulatory authority responsible for the development of policies and procedures for local EMS transport. Water ambulances operating in Los Angeles County must be classified and authorized by the EMS Agency to provide interfacility patient transport.

2. Water ambulance providers (excluding public agencies) that provide or make available watercraft transport shall adhere to all applicable federal, state, and local statutes, ordinances, policies, and procedures related to water ambulance operations, including qualifications of crew members and vessel maintenance.

3. Planned and structured initial and recurrent training programs specific to the water ambulance service mission and scope of care of the medical crew must be ensured and documented for all regularly scheduled water ambulance crew members.

4. Any privately owned/operated water ambulance service providing services in Los Angeles County shall be licensed in accordance with Los Angeles County Code, Chapter 7.16, Ambulances.

5. Water ambulance transport may be used when a patient requires ambulance-level medical care or monitoring and a reasonable transport time to a receiving facility can be achieved by water OR if air transport is unavailable, contraindicated by weather, landing zone, or other safety concerns or would result in a significant delay compared with boat transfer.

6. A water ambulance shall only be used for patient transport at the level of care which the boat has been authorized to provide.

7. A water ambulance shall only be authorized for interfacility transportation.

8. Authorization of a water ambulance shall be limited to less than six passengers.

9. All water ambulance transports shall include an interface with Catalina Island Medical Center, Avalon Fire, and Los Angeles County Fire for patient transportation on Catalina.

POLICY:

I. General Provisions

A. No person or organization shall provide or hold themselves out as providing water ambulance services unless that person or entity has been authorized and designated by the EMS agency as a water ambulance provider.

B. The EMS Agency shall maintain an inventory of designated water ambulance providers. This inventory shall include, but not be limited to, the number and type of authorized water ambulances, the patient capacity of each water ambulance, and the level of patient care authorized to be provided by water ambulance personnel for each authorized water ambulance provider.

C. Each designated water ambulance provider shall submit monthly data on all interfacility transports utilizing an EMS Agency approved data reporting template developed by the provider. Data is due no later than 25 calendar days after the end of each month.

D. Water ambulance providers shall be responsible for arranging ground ambulance transportation by a Los Angeles County licensed ambulance operator from the water ambulance docking area to the designated receiving medical facility.

II. Water Ambulance

A. Motorized boats used as a water ambulance shall be less than 100 gross tons and carry no more than 6 passengers.

B. Vessels shall meet all applicable federal, state and local requirements for licensing, operation, safety, and equipment as outlined in:

1. Title 46 CFR- Subchapter C - Uninspected Passenger Vessels.

2. Title 33 CFR- Navigation and navigable waters.

3. State of California Division of Boating and Waterways - Special Requirements for Passenger Vessels.

4. City of Avalon, Two Harbors, and Port of Los Angeles Harbor and Navigation codes.

5. International Maritime Association Convention on the International Regulation for Preventing Collison at Sea (COLREGS).

6. California Code of Regulations, Title 13 Division 2 - Chapter 5 Article 1- Special Vehicles: Ambulances.

7. Los Angeles County Code, Title 7 Div 2, Chapter 7.16, Ambulances.

C. All water ambulances shall maintain a current valid Certificate of Documentation with a coastwise endorsement from the United States Coast Guard.

D. All water ambulances shall undergo a vessel safety check (VSC) by a United States Coast Guard Auxiliary Vessel Examiner. Proof of VSCs shall be submitted to the EMS Agency for approval to begin operation, and proof of a current valid VSC decal shall be maintained on file with the EMS Agency and renewed annually.

E. Insurance

1. Providers who transport patients on a water ambulance must maintain all appropriate insurance coverage which must at minimum include:

    a. Commercial General Liability.

    b. Automobile Liability.

    c. Professional Liability.

    d. Worker's Compensation.

    e. Employer's Liability.

    f. Hull & Machinery insurance on each vessel for physical damage up to its declared valuation.

    g. Protection & Indemnity for all liabilities arising from the vessel operation (including liability to Jones Act crew, third parties on board and wreck removal).

2. If a water ambulance provider utilizes leased employees, or, is an employee leasing or temporary staffing firm or a professional employer organization (PEO), coverage also shall include an Alternate Employer Endorsement naming the County as the Alternate Employer, and the endorsement form shall be modified to provide that County will receive not less than thirty (30) days advance written notice of cancellation of this coverage provision.

3. Complete insurance requirements for operating a water ambulance in Los Angeles County are identified in a separate attachment.

F. Licensure – Operator/Vessel

Every water ambulance operator shall procure and maintain an ambulance operator's license and pay an annual operator and ambulance license fee in the amount set forth in Section 7.14.010 of County Code under the appropriate heading in order to operate in any incorporated city or unincorporated area of the county.

G. All water ambulances shall carry a minimum of a satellite phone and 2 (two) very high frequency (VHF) radios. One radio must be a fixed-mount VHF with digital selective calling (DSC), AIS equipped and MMSI registered and programmed. The second radio must be a 5 watt or higher waterproof, floating handheld VHF radio, preferably with DSC. All radio equipment is subject to FCC regulations regarding vessel size and passenger load.

H. Equipment

All water ambulances shall be equipped with the minimum required medical equipment and supplies which the provider and the water ambulance is authorized for (BLS, ALS, SCT) the level of care required.

I. Patient Compartment

1. All water ambulances shall have a patient compartment covered on all sides with sufficient space to access patients head, torso and lower extremities while on the litter/cot.

2. The entry and opening of the patient compartment shall be large enough to safely load and unload the patient without excessive lifting angles or obstruction.

3. The patient compartment must have a mounting system to secure at least one patient litter or cot, raised at least 12 inches off the floor to allow working space and reduce exposure to water on deck.

4. The litter/cot must be fitted or accompanied by restraint straps at the chest, waist, and legs to keep the patient secure during vessel motion and sudden maneuvers.

5. Handrails or grab points shall be available around the patient compartment to stabilize both crew and patient in rough conditions.

6. The patient compartment must allow at least one EMS provider to be positioned at the patient's head and another along the side, without blocking exits.

7. Water ambulance patient compartment shall maintain functioning climate control (heating/cooling) for patient comfort and safety.

J. Operations

1. The crew shall conduct and document predeparture safety operation and emergency checklist following the standards outlined in 46 CFR Subchapter C §26.03 and Tach 1 & 2, including but not limited to:

   a. communication systems,
   b. weather hazards
   c. life jackets
   d. medical equipment
   e. patient securing systems.

2. All water ambulance transports shall include an interface with Catalina Island Medical Center, Avalon Fire, and Los Angeles County Fire for patient transportation on Catalina.

3. The patient shall be secured to a stretcher or appropriate device, which is itself secured to the vessel to prevent movement.

4. All EMS personnel and the patient must wear appropriately fitted personal flotation devices unless this clearly interferes with critical life-saving procedures.

5. Prior to departure, EMS crew will notify dispatch and the receiving facility of patient condition and estimated time of arrival.

6. Continuous or specific interval communication with dispatch shall be maintained during transport as applicable.

7. Quarterly drills shall be performed covering the following operational areas by the Captain with the deckhand(s), additional crew and medical crew:

   a. Fire Drill: Simulate a fire (e.g., engine compartment), practice donning gear, deploying extinguishers, and shutdown procedures.
   b. Abandon Ship Drill: Don life jackets, deploy life raft or dinghy, muster at designated points, and practice boarding. Test alarms and radio distress calls.
   c. Man Overboard (MOB) Drill: Mark position, return to "victim," practice recovery using throw lines or boarding ladder.

K. Incidents

1. All incidents shall follow the notification and documentation requirements and procedures outlined in 46 CFR Part 4.

2. In addition to the Coast Guard reporting, the EMS Agency shall be notified immediately.

III. Crew

A. Captain/Operator - required to possess a current valid Operator of Uninspected Passenger Vessel (OUPV) license from the US Coast Guard for vessels under 100 gross tons carrying less than 6 passengers.

B. Deckhand(s) - One qualified crew member, at a minimum, in addition to the operator and medical crew shall be onboard to assist in operation of the vessel and equipment and help handle onboard emergencies including protection and evacuation of passengers.

C. Medical Crew

1. A minimum 2 licensed/certified/accredited EMS clinicians (EMT, Paramedic, or qualified MD or RN) on board during patient transport, in compliance with Ref No. 517 for interfacility transport.

2. Medical crew shall complete an initial and annual course which addresses the elements identified in Section III.E.1-3. of this policy or complete and maintain certification from a course approved by the National Maritime Center in accordance with Standards of Training Certification and Watchkeeping, Basic Training (STCW BT).

D. Marine safety drug testing requirement - the captain/operator and any crew member (deckhand(s) and medical crew) with duties that affect safe operation including engine navigation, line handling, passenger safety, or assisting passengers with emergencies shall comply with all drug testing requirements from 46 CFR Parts 4 and 16, 49 CFR Part 40 and 33 CFR Part 95.

E. The vessel captain and deckhand crew shall be trained and maintain current certification in a course approved by the National Maritime Center in accordance with Standards of Training for Certification and Watchkeeping, Basic Training (STCW BT) to include the following:

1. Personal Survival techniques
2. Personal Safety and Social responsibility
3. Basic Firefighting
4. Basic First aid and CPR

IV. Patient Eligibility

A. Must be medically stable for marine environment.

B. Online medical control must be available in the event of an unexpected deterioration in patients' condition.

C. Must be accompanied by appropriate medical personnel based on medical condition

V. Quality Improvement (QI)

A. At minimum, the QI program shall include: (Refer to Ref. No. 620)

1. A statement of QI program goals and objectives.

2. A description of how the QI program is integrated into the organization.

3. A description of those processes used in conducting QI activities, action plans and results.

4. Methods to document those processes used in QI activities.

5. Methods used to retrieve data regarding patient care and outcomes.

6. Description of how the QI program is integrated into the Los Angeles County EMS system.

B. Provider Agency Responsibilities:

1. Implement and maintain a Quality Improvement (QI) Program in conjunction with the assigned base hospitals and receiving hospitals.

2. Evaluate prehospital care/interfacility transport performance standards.

3. Designate a representative to participate in the LA County EMS QI program.

4. Records of QI activities shall be maintained by the provider and available for review by the EMS Agency.

5. Ensure a patient care record is completed for every IFT response regardless of patient disposition and available for review by the EMS Agency.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 426.1 **Private Provider Water Ambulance Insurance Requirements**
Ref. No. 502, **Patient Destination**
Ref. No. 517 **Private Provider Agency Transport/Response Guidelines**
Ref. No. 517.1 **Guidelines for Determining Interfacility Level of Transport**
Ref. No. 520 **Transport/Transfer of Patients from Catalina Island**
Ref. No. 520.1, **Catalina Island Medical Center (AHM) Transfer/Transport Process**
Ref. No. 606 **Documentation of Prehospital Care**
Ref. No. 703.1 **Private Provider Interfacility Transport ALS Unit Inventory**
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**

Code of Federal Regulations (CFR):
Title 33 CFR Subchapter C and part 95
Title 46 CFR Subchapter C
Title 46 CFR Subchapter C §26.03 and Tach 1 & 2
Title 46 CFR §11.302 and parts 4 and 16
Title 47 CFR Telecommunication
Title 49 CFR Part 40

Emergency Medical Treatment and Labor Act (EMTALA)

CERTIFICATE OF INSURANCE REQUIREMENTS

Insurance must be provided by an insurance company acceptable to County's Risk Manager, with an A.M. Best rating of not less than A:VII.

The following elements must be present on the Certificate of Insurance (COI):

1. The COI must include the name of each insurer providing coverage, and its' NAIC (National Association of Insurance Commissioners) identification number(s).

2. The "Certificate Holder" section of the COI must list the certificate holder as:

   County of Los Angeles
   EMS Agency
   10100 Pioneer Blvd., Suite 200
   Santa Fe Springs, CA 90670

3. The COI must indicate that the County be given written notice of cancellation by mail at least ten (10) days in advance of said cancellation for nonpayment, and thirty (30) calendar days in advance of modification or termination.

4. Identify any insured retentions or deductibles exceeding $100,000.

5. Include copies of the Additional Insured Endorsements to the commercial general liability policy, naming the County of Los Angeles, its Special Districts, its officials, officers and employees as an additional insured for all activities.

6. **General liability** Insurance (written on Insurance Services Office [ISO] policy form CG 00 01 or its equivalent) must have limits of not less than the following:

General Aggregate:	$5 Million
Products/Completed Operations Aggregate:	$1 Million
Personal and Advertising Injury:	$1 Million
Each Occurrence:	$1 Million

7. **Professional Liability** Insurance covering liability arising from any error, omission, negligent or wrongful act of Contractor, its officers or employees with limits of not less than **$2 Million** per occurrence and **$3 Million** aggregate.

8. **Sexual Misconduct Liability** Insurance covering liability arising from any claims arising from negligent employment, investigation, supervision, training or retention of, or failure to report proper authorities, a person(s) who committed any act of abuse, molestation, harassment, mistreatment or maltreatment of sexual nature with limits of not less than **$2 Million** per occurrence and **$2 Million** aggregate.

9. **Hull and Machinery Liability** Insurance must be included on the vessel for physical damage up to its declared valuation, including Protection & Indemnity for all liabilities arising from the vessel operation (including liability to Jones Act crew, third parties on board, wreck removal) up to **$25 Million** in limit to the extent possible, Vessel Pollution Liability up to **$25 Million**, if not included within the Protection & Indemnity.

10. **Workers Compensation and Employers' Liability** Insurance providing workers compensations benefits, as required by the Labor Code of the State of California or by any other state, and for which Contractor is responsible. This insurance must include Employers' Liability coverage with limits of not less than the following:

Each Accident:	$1 Million
Disease – Policy Limit:	$1 Million
Disease – Each Employee:	$1 Million

11. Contractors using employees that are leased, temporary, or from a Professional Employer Organization (PEO) must submit documentation of Workers Compensation insurance for such employees that includes identification of the contractor.

12. Contractor must provide current Alternate Employer Endorsement for any leased, temporary or PEO which names the County as an "Alternate Employer." The endorsement must also provide that the County will not receive less than 30 days advance written notice of cancellation of this coverage.

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

REFERENCE NO. 505, [Ambulance Patient Offload Time (APOT)]

SECTION	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
Policy II. E	Language added to be consistent with state regulations. Identifying specific “hospital licensed personnel”.			

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

SUBJECT: **AMBULANCE PATIENT OFFLOAD TIME (APOT)** REFERENCE NO. 505

PURPOSE: To establish a policy for the safe and rapid transfer of patient care responsibilities from emergency medical services (EMS) personnel to emergency department (ED) medical personnel.

AUTHORITY: California Health and Safety Code, Division 2.5 Sections 1797.120, 1797.225

DEFINITIONS:

Ambulance patient offload time (APOT): Time interval between the arrival of an ambulance at the location outside the hospital ED where the patient will be unloaded from the ambulance and the time the patient is transferred to the ED gurney, bed, chair or other acceptable location (facility equipment time) and the ED assumes responsibility for the care of the patient. The APOT Standard in Los Angeles County is within 30 minutes, 90% of the time. Currently, the data source for APOT is the EMS Providers' electronic patient care report completed by the transporting unit.

Facility Equipment Time: The time the patient is transferred to the ED gurney, bed, chair or other acceptable location.

PRINCIPLES:

1. As per the Emergency Medical Treatment & Labor Act (EMTALA), the responsibility for patient care lies with the receiving facility once the patient arrives at the hospital property.

2. Hospitals have the responsibility to ensure policies and processes are in place that facilitate the rapid and appropriate transfer of patient care from EMS personnel. Hospital staff shall make every effort to offload patients from ambulance gurneys as soon as possible.

3. Extended APOT is a healthcare system and hospital throughput issue. Extended APOT negatively impacts EMS providers' ability to respond to subsequent 9-1-1 calls resulting in delayed response times and may affect public safety and patient outcomes.

4. Each hospital shall have a policy and a multidisciplinary team-based approach to ensure the ability of the facility to remain open to accept patients arriving by ambulance in the ED.

5. Hospitals that have extended APOT should assign appropriate personnel to remain with patients while waiting for an ED treatment bay in order to release EMS personnel back to the community.

6. The State of California Emergency Medical Services Authority has adopted Standardized Methods for Data Collection and Reporting of APOT which has been adopted by Los Angeles County.

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

7. The accurate documentation by EMS professionals of the time metrics for APOT is imperative to appropriately evaluate and monitor APOT.

POLICY:

I. Responsibilities of Hospital ED Personnel to Mitigate Extended APOT

A. Immediately acknowledge EMS patient arrival and provide visual assessment; receive verbal patient report as soon as possible upon arrival in the ED to determine whether the patient needs an ED treatment bay or can be sent to other areas of the ED to await urgent or emergency care.

B. Transfer patient to the hospital gurney, bed, chair, wheelchair or waiting room as appropriate for patient condition within 30 minutes of arrival at the ED.

C. Confirm with EMS personnel the “facility equipment time” to be documented on the ePCR of the EMS personnel.

D. If unable to immediately offload patient, provide a safe area in the ED within direct sight of ED medical personnel where the EMS personnel can temporarily wait while hospital’s patient remains on the ambulance gurney.

E. Inform the ambulance transport crew of the anticipated time for the offload of the patient.

F. For extended APOT, provide information to the onsite supervisor of EMS personnel regarding the steps that are being taken by the hospital to resolve extended APOT.

G. Notify the Nursing Supervisor/Administrator on Duty that the ED is experiencing extended APOT and request assistance with patient throughput challenges.

II. Responsibilities of EMS Personnel to Mitigate Extended APOT

A. Upon arrival at ED, EMS personnel will present to the customary ambulance receiving area for a triage assessment by assigned ED staff (e.g., charge nurse).

B. Provide a verbal patient report to assigned ED staff, transfer patient to hospital equipment as directed by ED staff.

C. If the APOT estimate is ≥ 30 minutes, and the patient meets **ALL** criteria listed below, EMS personnel will inform the appropriate ED staff (e.g., charge nurse) that the patient will be offloaded in the waiting room. EMS personnel shall provide a transfer of care report to the appropriate ED staff (e.g., triage nurse).

1. Age 18 years or older; or pediatric patients if accompanied by an adult

2. Normal mental status (GCS 15)

3. Normal vital signs upon arrival to the ED per Ref. No. 1380 for adults
   - SBP ≥ 90mmHg
   - HR 60-100
   - RR 12-20

- O2 Saturation ≥94% on room air
- Or per Ref. No. 1309 for pediatrics

4. Ambulatory with steady gait without assistance (as appropriate for age)

5. Without suicidal ideation or suspected substance abuse and not on psychiatric hold (i.e., 5585 (pediatric), 5150 (adult))

6. No chest pain, syncope, or acute neurologic symptoms (e.g., focal weakness, dizziness/vertigo)

7. No ongoing ALS intervention required

8. Patients who received medications that may require ongoing reassessment (e.g., naloxone, narcotics, epinephrine) shall be discussed with the appropriate ED staff (e.g., triage nurse) prior to being offloaded in the waiting room.

D. If APOT estimate is > 30 minutes and the patient does not meet the criteria listed in II. C., each individual EMS personnel (EMT or Paramedic), in order to facilitate EMS field operations, may observe up to 4 patients within their scope of practice at the discretion of the EMS provider's supervisor, while awaiting patient offload to facility equipment.

1. Coordination will be done by the EMS Provider agency's on-site supervisor to identify the EMS personnel who will monitor patients awaiting transfer of care to ED staff and those that may be released to accept other emergency calls.

2. Hospitals should provide gurneys or cots for these patients, to allow EMS personnel to maintain their field operations.

3. EMS Provider agency's on-site supervisor may authorize the placement of temporary cots to house EMS patients being observed by EMS personnel awaiting transfer of care to ED staff.

E. Document the "facility equipment time" on the electronic patient care record (ePCR) to capture the time patient care is transferred to ED personnel. This shall be done in consultation with hospital licensed personnel (physician, mid-level practitioner, or registered nurse) accepting responsibility for the care of the patient.

F. Notify EMS Supervisor if Provider ALS Diversion Threshold is met as defined in Ref. No. 503.1.

III. Responsibilities of the EMS Agency

A. The EMS Agency will routinely analyze and report APOT data. Hospitals that do not meet the APOT Standard will be notified and may be requested to develop a corrective action plan.

B. At any given time, the EMS Agency via the Medical Alert Center (MAC) will establish phone notification with hospital administration in instances wherein 3 or

more ambulance transport crew are waiting to offload for time periods of 30 minutes or more.

C. After an evaluation of a hospital's status and regional/system resources, the EMS Agency via the MAC may place a hospital on Specialty Care Center Diversion (e.g., Trauma, STEMI, Stroke) in addition to ED ALS and/or ED BLS Diversion in instances wherein the APOT is estimated to exceed 2 hours.

D. In instances whereby extended APOT threatens public health and safety by preventing EMS response to emergency medical incidents, the EMS Agency, with appropriate notification to hospital, may authorize EMS personnel provided the patient meets **ALL** the criteria listed in II.C to:

1. Inform ED medical personnel that they are transitioning patient care **and**

2. Immediately offload patient to a hospital bed or other suitable hospital sitting or reclining device as appropriate for patient condition**.**

In these instances, EMS personnel shall make every attempt to notify ED Charge Nurse that they must immediately return to service. EMS personnel shall provide a verbal transfer of care report to ED medical personnel.

E. Procedure for requesting corrective action plan from hospitals that have persistent delays in APOT

Month	Action 1	Audit Result	Action 2
1st	EMS Agency audits Hospital's compliance with APOT Standard.	Hospital consistently demonstrate prolonged APOT, and EMS Providers have consistently requested to place Hospital on ALS and/or BLS Diversion	EMS Agency notifies hospital's ED Director and ED Nurse Manager, via email or telephone, of audit results, requests corrective action plan and assists in determining solutions.
2nd	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital fails to demonstrate incremental improvement in APOT.	EMS Agency sends a written notice to Hospital's ED Director and Nurse Manager notifying them of the audit results and their non-compliance.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
3rd	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT.	EMS Agency notifies Hospital's CEO in writing of audit results and request a corrective action plan be submitted within 15 calendar days.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.

Month	Action 1	Audit Result	Action 2
4th	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT.	Within 15 days of the EMS Agency's receipt of Hospital's corrective action plan, a written approval or request additional modifications to the plan.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
5th	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT.	EMS will request modification to Hospital's corrective action plan.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
6th	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT	See Policy III.F.
		Hospital's compliance threshold improves.	Monitor to ensure Hospital maintains improvement in APOT.

F. Failure of a hospital to implement corrective action plan to improve APOT six months after initial request from EMS to implement corrective action plan may result in additional action from the EMS Agency, which may include but not limited to:

1. Reduction in 9-1-1 transports to hospital
2. Temporary suspension of Specialty Care Center Designation
3. Others as identified

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 503.1, **Diversion Request Requirements for Emergency Department Saturation**

California EMSA: Ambulance Patient Offload Time (APOT) Standardized Methods for Data Collection and Reporting

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

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

REFERENCE NO. 202.2
(ATTACHMENT B)

REFERENCE NO. 606, [Documentation of Prehospital Care]

SECTION	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
Principle 4	Revised to reflect that an EMS record must be completed for every EMS response that results in patient contact.			
Policy I, B. 1.	Revised to reflect that an EMS record must be completed for every EMS response that results in patient contact			
Policy I, B. 2.	Added the documentation requirement for transfer of care.			
Policy I, C. 2.	Removed EMS Report Form as it should only be used for ePCR system failure.			
Policy I, D. 1.	Removed EMS Report Form as it should only be used for ePCR system failure.			
Policy I, E. 1.	Removed alternate means of MCI documentation as one standard EMS record is required. The EMS Agency can no longer manually enter records into the EMS Repository, so no alternative options are available.			
Policy I, E. 4.	Removed that the provider agency should submit copies and logs to the EMS Agency. No alternative options are available for MCI documentation.			
Policy I, F. 2.	Removed EMS Report Form as it should only be used for ePCR system failure.			
Policy I, G. 2.,3.	Removed EMS Report Form as it			

	should only be used for ePCR system failure.			
Policy I, H.	Removed Completion of the Advanced Life Support Continuation Form as this information is documented on the ePCR.			
Policy III, A. 2.	Removed EMS Report Form as it should only be used for ePCR system failure.			
Policy III, B. 1.	Revised to reflect that any changes to the EMS record are done on the ePCR.			
Policy III, B. 2., 3.	Removed EMS Report Form as it should only be used for ePCR system failure.			
Policy II, C.3.,d.	Added Provider Code/Unit to specify which provider is delivering Med Com.			
Policy II, C.3.,k.	Removed method of transport to align with MCI form.			
Policy II, C.3.,l.	Revised to aligned with specialty care options on the base form.			
Policy II, C.3.,4.	Removed language related to submitting records pertaining to MCI within 10 business days as the process is no longer in place; updated to show how to obtain MCI forms and who to contact.			
Policy II, C.3.,6.,	Removed language pertaining to BLS ONLY including the documentation in the comment section of an MCI form.			
Policy II, C.3.7a	Revised to ensure only one base form or MCI record is created per patient			

	and that no other patients are documented on the same form			
Policy II, C.3.,7b.	Removed for the same reason as above pertaining to BLS patients and documenting in the comment section of another patient's base form			
Policy II, C.3.,7.	Defined how and where to document BLS runs, and BLS are not entered into TEMIS.			

(EMT, PARAMEDIC, MICN)

SUBJECT: **DOCUMENTATION OF PREHOSPITAL CARE** REFERENCE NO. 606

PURPOSE: To identify the base hospital and Emergency Medical Services (EMS) provider procedures for documentation of prehospital care.

AUTHORITY: California Code of Regulations, Title 22, Sections 100128, 100129, 100170, 100171

DEFINITIONS

EMS Response: The physical response of an EMS provider due to activation of the EMS system with a request for medical evaluation.

Multiple Casualty Incident (MCI): The combination of numbers of ill/injured patients and the type of injuries going beyond the capability of an entity's normal first response.

Patient: A person who seeks or appears to require medical assessment and/or medical treatment.

Patient Contact: An EMS response that results in an actual patient or patients.

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

PRINCIPLES:

1. The EMS Record and the Base Hospital Form are:

    a. Patient care records
    b. Legal documents
    c. Quality improvement instruments
    d. Billing resources (EMS Record only)
    e. Records of canceled calls, no patient found, public assist involving a person, and person contact/no patient (EMS Record only)

2. Any assessment or treatment provided to, and medical history obtained from, the patient shall be accurately and thoroughly documented on the EMS Record.

3. Any person who alters or modifies the medical record of any person, with fraudulent intent, or who, with fraudulent intent, creates any false medical record, is guilty of a misdemeanor (section 471.5 of the California Penal Code).

4. An EMS Record must be completed for every EMS response ~~regardless of patient disposition~~that results in patient contact.

POLICY:

I. EMS Record Completion – Paramedic/EMT Personnel

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

A. EMS providers shall document prehospital care according to procedures identified in the LA-EMS National Emergency Medical Services Information System (NEMSIS) Data Dictionary.

B. Electronic EMS Patient Care Record (ePCR) Completion

1. Paramedic/EMT personnel shall complete one EMS Agency approved ePCR (one for each patient) for every EMS response ~~which includes the following:~~

~~a. Patient contact made~~
~~b. Cancelled on scene~~
~~c. Cancelled prior to arrival at scene~~
~~d. No patient contact~~

~~No patient found~~that results in patient contact.

2. Document the "facility equipment time" on the ePCR to capture the time patient care is transferred to ED personnel. This shall be done in consultation with hospital licensed personnel (physician, mid-level practitioner, or registered nurse) accepting responsibility for the care of the patient.

C. Paper-Based EMS Report Form Completion

1. Paramedic/EMT personnel may document on a paper-based EMS Report Form if ePCR system failure occurs.

~~2. Private EMS providers shall utilize a paper-based EMS Report Form only for patients where base contact is made unless approved to electronically submit ePCR data.~~

D. Multiple Providers

1. In the event of an automatic or mutual aid incident when two first responding providers have each completed an EMS Record, or patient care is transferred from one ALS provider agency to another, each provider agency shall document the Original Sequence Number from the other provider's patient care record in the space designated for Original Sequence Number. ~~If utilizing a paper EMS Report Form, document in the space designated for Second Sequence number. DO NOT cross out or line through the imprinted Sequence Number if utilizing a paper EMS Report Form.~~

2. The provider agency transferring patient care must have a mechanism in place to provide immediate transfer of patient information to the transporting agency.

E. Multiple Casualty Incidents (MCI)

1. One standard EMS Record must be initiated for each patient transported in an MCI. ~~Provider agencies may use alternate means of documenting MCIs if the EMS Agency is notified prior to implementation and agrees with the proposed process.~~

2. Documentation should include the following, at minimum:

a. Name
b. Provider Impression
c. Chief Complaint
d. Mechanism of Injury, if applicable
e. Age and units of age
f. Gender
g. Brief patient assessment
h. Brief description of treatment provided
i. Transporting provider (provider code and unit number) and level of service (ALS, BLS or Helicopter)
j. Destination
k. Receiving facility

3. Non-transported patients should be documented on a standard EMS Record or a patient log.

~~4. Each provider agency should submit copies of all records and logs pertaining to an MCI to the EMS Agency within 10 business days of the incident. MCI documents should be hand carried or delivered to the EMS Agency in an envelope clearly marked with the incident date and location.~~

F. Completion of the EMS Record Prior to Distribution

1. EMTs and paramedics responsible for documenting prehospital care shall ensure that EMS Records are completed in their entirety prior to dissemination to the receiving facility. In most instances, this means that the record is completed at the scene or upon arrival at the receiving facility.

~~2. An exception to this is when a first responding agency utilizing paper-based EMS Report Forms is giving the receiving hospital (red) copy to a transporting agency. In the interest of expediting the transfer of care, it is recognized that information such as the unit times may not be documented on the receiving hospital (red) copy of the EMS Report Form.~~

G. Field Transfer of Care

1. When patient care has been transferred from the first responding ALS or BLS provider agency to a BLS provider agency for transport to a receiving facility, the provider agency receiving the patient should **NOT** generate an ePCR with a new Sequence Number (this will result in the same patient being entered into the ESO Repository with two different sequence numbers).

~~2.~~ The provider agency that receives the BLS patient for transport to a receiving facility shall complete their agency's ePCR and document the Sequence Number generated by the first responding ALS or BLS provider agency's ePCR on their ePCR ~~or paper-based EMS Report Form~~.

~~3.~~2.

~~4. If utilizing a paper-based EMS Report Form, the receiving hospital (red) copy of the EMS Report Form, as well as the PCR from the BLS transport provider (red copy), must accompany the patient to the receiving facility where it becomes part of the patient's medical record.~~

~~5.~~3. It is the responsibility of the EMS Provider to ensure that a completed copy of the EMS Record is provided to the receiving facility upon transfer of care.

~~H. Completion of Advanced Life Support Continuation Form~~

~~1. If utilizing a paper-based EMS Report Form, required for each patient on whom advanced airway management is necessary.~~

~~2. Paramedics completing this form must ensure that the demographic information (patient name, date, provider code/unit, incident #) and Sequence Number are legibly and accurately transcribed from the EMS Report Form.~~

II. Base Hospital Form - MICN and/or Physicians

A. Base hospital personnel (MICNs and physicians) shall document prehospital care according to procedures identified in the Base Hospital Documentation Manual.

B. Base Hospital Form Completion

1. MICNs and/or physicians shall complete one EMS Agency approved Base Hospital Form (one for each patient in which medical direction is given) for every base hospital paramedic radio/telephone contact.

2. MICNs and/or physicians may document base hospital data electronically in lieu of the standard Base Hospital Form if the base hospital has received prior authorization from the EMS Agency.

C. Base Hospital Directed Multiple Casualty Incidents (MCI)

1. EMS Agency-approved MCI Base Hospital Forms may be utilized for incidents involving three or more patients.

2. Physicians and MICNs should limit requested information to **only** that which is essential to determine destination or medical management. Additional information and Sequence Numbers should be obtained after the MCI has cleared.

3. The following should be documented for MCIs involving three or more patients, when base contact is made for online medical control:

a. Date
b. Time
c. Sequence number/Triage tag number
d. Provider Code/Unit ~~and unit~~ managing the MCI
e. Chief complaint
f. Mechanism of injury, if applicable
g. Age and units of age
h. Gender
i. Brief patient assessment, when possible

j. Brief description of treatment provided, when possible
k. Transporting Pprovider Code /Unit~~, method of transport (ALS, BLS or Helicopter)~~
l. ~~Destination~~ Specialty Care Destination
m. Receiving Facility

~~4. Upon request of the EMS Agency the base hospital should submit all records pertaining to an MCI to the EMS Agency within 10 business days.~~MCI forms are maintained at the EMS Agency. For additional forms, contact the Base Coordinator via email.~~:~~

~~5.~~4. ~~~~

~~6.~~5. Provider agencies may use alternate means of reporting MCIs. Base Hospitals will be notified by the EMS Agency when alternate reporting methods will be implemented by various provider agencies.

~~7.~~1. ~~MCIs involving **ONLY** BLS patients: BLS patients who are transported to a receiving facility should be documented on one Base Hospital Form in the Comments Section (provided no medical direction is given).~~

~~8. MCIs involving ALS **and** BLS Patients:~~
~~9.~~
~~9.~~6. One standard Base Hospital Form or one EMS Agency-approved MCI Base Hospital Form must be completed for each ALS patient.~~who required no medical direction in the Comments Section on the base form for hospital notification purposes.~~

~~BLS patients on whom no medical direction has been given do not require a Base Hospital Form. The number and disposition of the BLS patients may be documented on the Base Hospital Form of an ALS patient in the Comments Section.~~

7. ~~MCIs involving **ONLY** BLS patients: BLS~~ patients who are reported to the base and transported to the base hospital or another receiving facility ~~to a receiving facility~~ should be documented on an MCI Base Hospital Form for tracking purposes~~one Base Hospital Form in the Comments Section (provided no medical direction is given).~~ These patients do not need to be entered into the TEMIS database.

~~10.~~8. Alternate methods of documenting MCIs may be initiated by base hospitals with the approval of the EMS Agency.

III. Modification of Patient Care Records

A. Modifying the Patient Care Record (additions, deletions or changes) after the Patient Care Record has been completed or disseminated:

1. An audit trail of changes made to an electronic record will be included on the ePCR.

~~2. For paper-based EMS Report Forms, make corrections by drawing a single line through the incorrect item or narrative (the writing underneath the single line must remain readable).~~

~~Make the changes on the original, noting the date and time the changes were made, with the signature of the individual making the changes adjacent to the correction. Ideally, changes should be made by the individual who initially completed the form. Under no circumstances should changes to either patient assessment or patient treatment documentation be made by an individual who did not participate in the response.~~

B. Making substantive changes (documentation of additional medications, defibrillation attempts, pertinent comments, complaints, etc.) to the EMS Record:

1. ~~For electronic documentation systems, P~~patient care related corrections are to be made as per provider agency policy. The provider agency shall notify its receiving hospital(s) of the mechanism by which ePCRs are updated and when an ePCR is updated. If the receiving hospital receives a printed copy of the record, a printed copy of the revised record will be provided directly to them.

~~2. Photocopy the paper-based EMS Report Form with the changes and send the copy, along with a cover letter, to all entities that received the original form (EMS Agency, receiving facility). The cover letter should explain the modifications and request that the modified copy be attached to the original copy.~~

~~3. Do not re-write the incident on a new paper-based EMS Report Form because this would result in a mismatch in Sequence Number. If the form requiring corrections has been mutilated or soiled and cannot be photocopied, then a new form may be used to re-write the incident provided the Sequence Number of the new form has been replaced with the Sequence Number from the original form.~~

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 608, **Retention and Disposition of Prehospital Patient Care Records**
Ref. No. 640, **LA-EMS NEMSIS Data Dictionary**
Ref. No. 644, **Base Hospital Documentation Manual**

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

REFERENCE NO. 607, [Electronic Submission of Prehospital Data]

SECTION	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
Principle 5	Revised to meet upcoming ALS ePCR data submission requirements for private providers.			

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **ELECTRONIC SUBMISSION OF PREHOSPITAL DATA**

REFERENCE NO. 607

PURPOSE: To establish procedures for the submission of electronic data by prehospital care providers.

AUTHORITY: California Assembly Bill No. 1129
California Code of Regulations, Title 22, Chapter 4, Sections 100169, 100170
Health Insurance Portability and Accountability Act (HIPAA), 2009
Health and Safety Code, Section 130202
Health Information Technology for Economic and Clinical Health Act (HITECH)

DEFINITION:

Electronic Data: Patient Care Records submitted in electronic format (as per LA-EMS NEMSIS Data Dictionary) or field electronic Patient Care Records (ePCRs).

PRINCIPLES:

1. All submission of electronic personal health information (PHI) shall be in compliance with HIPPA regulations.

2. PCRs require redundant back-up and emergency down time procedures.

3. The provider agency will ensure that the electronic data is compliant with the EMS Agency's data system requirement.

4. All vendors must be compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards. Provider agencies cannot utilize an ePCR until their selected vendor has been approved to submit data electronically to the EMS Agency.

5. All public and exclusive operating area (EOA) provider agencies, ~~and~~ as well as private advanced life support (ALS) providers~~, specialty care transport (SCT) who make base contact~~, shall submit data electronically to the EMS Agency, which meets the LA-EMS NEMSIS Data Dictionary requirements~~, to the EMS Agency~~.

POLICY:

I. Provider Agency Responsibilities

   A. Prior to implementation of an Electronic Data System

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

1. Electronic Data Submission Plan

   Submit a plan, approved by the department's Fire Chief or private provider agency's Chief Executive Officer, to the EMS Agency for approval which includes:

   a. Ability to transmit data to the EMS Agency which meets the LA-EMS NEMSIS Data Dictionary requirements.

   b. A successful mechanism to provide immediate transfer of patient information to additional providers, including transporting agency (if necessary).

   c. System to ensure a Patient Care Record is created by each EMS provider for every EMS response regardless of patient disposition.

      i. If two (2) or more units from the same EMS provider are dispatched, at least one (1) EMS field personnel is required to initiate and complete an ePCR.

      ii. If two (2) or more units from different EMS providers are dispatched and patient care information can be shared electronically, at least one (1) EMS field personnel is required to initiate and complete an ePCR.

      iii. If two (2) or more units from different EMS providers are dispatched and patient care information cannot be shared electronically, at least one (1) EMS field personnel from each EMS provider is required to initiate and complete an ePCR.

   d. Process for confirming that an ePCR has been successfully generated for each patient.

   e. A successful mechanism for receiving facilities to have the electronic record available upon the patient's transfer of care and any patient care related revisions made after leaving the receiving facility.

   f. Back-up system available in case of system failure.

   g. Staff members assigned to act as a liaison between the vendor and the EMS Agency to identify and correct data issues.

2. Notify the EMS Agency's Data Systems Management Chief once a vendor has been selected and provide an estimated field implementation date.

3. Notify all hospitals that provider transports to of the intent to convert to an ePCR system and the tentative start date.

B. Implementation

1. Ensure the selected vendor contacts the EMS Agency's Data Systems Management Chief to discuss the data format, transmission procedures and obtain sequence number format.

2. Maintain a staff member to act as liaison between the vendor and the EMS Agency to identify and correct data issues.

3. Submit validated test files, meeting the LA-EMS NEMSIS Data Dictionary and LA-EMS Schematron, and the corresponding copies of the ePCRs in PDF format, that accurately reflect the documentation in the electronic record upon import.

C. Ongoing

1. Transmit validated data to the EMS Agency for import into the ESO Repository within 48 hours of the incident date. Files with validation errors will be rejected and must be corrected and re-transmitted prior to import.

2. Address and correct data related issues as they arise.

3. Implement annual data field and export program changes within three months of publication.

II. EMS Agency Responsibilities

A. Review and approve the electronic data submission plan.

B. Liaison with the provider agency and receiving hospital(s) to establish a mutually agreed upon method by which the receiving hospital(s) will obtain the ePCR.

C. Meet with the provider agency and vendor to review electronic data submission plan and provide the Sequence Number formatting, LA-EMS NEMSIS Data Dictionary and LA-EMS Schematron

D. Review validated test files, and the corresponding copies of the ePCR in PDF format, for completeness and accuracy and provide a report to the provider agency and vendor with noted deficiencies.

E. Ongoing

1. Monitor incoming data and notify the provider as issues arise and follow up with provider as needed to ensure data issues are addressed and resolved.

2. Present data field changes annually to the Provider Agency Advisory Committee.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 608, **Retention and Disposition of Prehospital Patient Care Records**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**

LA-EMS NEMSIS Data Dictionary
LA-EMS Schematron