



COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

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

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

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

LOS ANGELES COUNTY BOARD OF SUPERVISORS

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Western States Affiliate

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Emergency Nurses Association

Saran Tucker, PhD, MPH

Southern California Public Health Assn.

Atila Uner, MD, MPH

California Chapter-American College of

Emergency Physicians (CAL-ACEP)

VACANT

Public Member (5th District)

EXECUTIVE DIRECTOR

Richard Tadeo, RN

(562) 378-1610

RTadeo@dhs.lacounty.gov

INTERIM COMMISSION LIAISON

Vanessa Gonzalez

(562) 378-1607

vgonzalez3@dhs.lacounty.gov

DATE: May 20, 2026
TIME: 1:00 – 3:00 PM
LOCATION: 10100 Pioneer Boulevard, First Floor
Cathy Chidester Conference Room 128
Santa Fe Springs, CA 90670

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

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

AGENDA

1. **CALL TO ORDER** – Diego Caivano, MD, Chair
2. **INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS**
 - 2.1 EMSAAC Conference, May 27-28, 2026, Hilton LA/Universal City
3. **CONSENT AGENDA:** Commissioners/Public may request that an item be held for discussion. All matters are approved by one motion unless held.
 - 3.1 **Minutes**
 - 3.1.1 January 21, 2026
 - 3.1.2 March 18, 2026 – Meeting held with no quorum/no votes
 - 3.2 **Committee Reports**
 - 3.2.1 Base Hospital Advisory Committee – February 4, 2026
 - 3.2.2 Provider Agency Advisory Committee – February 11, 2026
 - 3.2.3 Base Hospital Advisory Committee – April 8, 2026
 - 3.2.4 Provider Agency Advisory Committee – April 15, 2026
 - 3.3 **Policies March 18 & May 20, 2026:**
 - 3.3.1 Reference No. 414: Specialty Care Transport Provider
 - 3.3.2 Reference No. 426: Private Provider Water Ambulance Catalina Island Interfacility Transport
 - 3.3.3 Reference No. 426.1: Private Provider Water Ambulance Insurance Requirements
 - 3.3.4 Reference No. 505: Ambulance Patient Offload Time (APOT)
 - 3.3.5 Reference No. 511: Perinatal Patient Destination
 - 3.3.6 Reference No. 517: Private Provider Agency Transport/Response Guidelines
 - 3.3.7 Reference No. 606: Documentation of Prehospital Care
 - 3.3.8 Reference No. 703: ALS Unit Inventory

- 3.3.9 Reference No. 703.I: Private Provider Interfacility Transfer
ALS Unit Inventory
- 3.3.10 Reference No. 704: Assessment Unit Inventory
- 3.3.11 Reference No. 706: ALS EMS Aircraft Inventory
- 3.3.12 Summary of Changes: Reference Nos.703, 703.1, 704, 706

END OF CONSENT AGENDA

4. BUSINESS

Business (Old)

- 4.1 Field Evaluation of Suicidal Ideation and Behavior
- 4.2 Ambulance Patient Offload Time (APOT)
- 4.3 Interfacility Transfer Taskforce
- 4.4 Cardiac Arrest Taskforce
- 4.5 September 16, 2026, EMSC Meeting Date Change to September 9, 2026

Business (New)

5. LEGISLATION

6. DIRECTORS' REPORTS

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

Correspondence

- 6.1.1 (02/24/2026) From EMS Authority: Exceedance of Ambulance Patient Offload Standards – January 2026 Electronic Notification
- 6.1.2 (03/03/2026) Retirement Letter – EMSC Liaison Denise Watson, March 27, 2026
- 6.1.3 (03/11/2026) Pediatric Prehospital Airway Resuscitation Trial (Pedi-PART) Study Closure
- 6.1.4 (03/24/2026) General Public Ambulance Rates July 1, 2026, through June 30, 2027
- 6.1.5 (03/31/2026) EMS Administration of Magnesium Sulfate for Preeclampsia and Eclampsia
- 6.1.6 (04/06/2026) From Chief Executive Office: Report Back of the Allocation Formula for Ongoing and One-Time Measure B Funding for Non-County Trauma Hospitals
- 6.1.7 (04/15/2026) Region I Long-Term Care Mutual Aid Program (LTC-MAP) (Proposed Project Period: August 1, 2026 – July 31, 2027)
- 6.1.8 (04/22/2026) Updated Timeline for Cardiac Arrest Task Force
- 6.1.9 (04/27/2026) From Dr. Christina R. Ghaly, DHS Director: Disbursement Plan for the 2025 Unallocated Measure B Funds

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

7. COMMISSIONERS' COMMENTS / REQUESTS

8. ADJOURNMENT

Adjournment to the meeting of July 15, 2026



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**MINUTES
JANUARY 21, 2026**

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

GUESTS

Jennifer Shepard, LASD	Laurie Donegan APCC	Jack Yandell, IAEP
Omar Khattab, USC/LAGMC	Michael Stone, USC/LAGMC	

1. CALL TO ORDER

The Emergency Medical Services (EMS) Commission (EMSC) meeting was held at the EMS Agency at 10100 Pioneer Boulevard, First Floor, Cathy Chidester Conference Room 128, Santa Fe Springs, CA 90670. EMSC Chair Diego Caivano called the meeting to order at 1:01 p.m. EMSC Liaison, Denise Watson, called the roll and a quorum of 11 members were present. Chair Caivano opened the floor for a report from the Nominating Committee.

2. NOMINATIONS/SELECTIONS FOR 2026:

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

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

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

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

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

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

3. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

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

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

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

4.1 Minutes

4.1.1 November 19, 2025

4.2 Committee Reports

4.2.1 Base Hospital Advisory Committee – December 10, 2025

4.2.2 Provider Agency Advisory Committee – December 17, 2025

4.3 Policies

4.3.1 Reference No. 510: Pediatric Patient Destination

4.3.2 Reference No. 511: Perinatal Patient Destination

4.3.3 Reference No. 604: Prehospital Care Forms

4.3.4 Reference No. 608: Retention and Disposition of Prehospital Patient Care Records

4.3.5 Reference No. 803: Los Angeles County Paramedic Scope of Practice

4.3.6 Reference No. 803.1: Los Angeles County Paramedic Scope of Practice (Table Format)

4.3.7 Reference No. 840: Medical Support During Tactical Operations

4.3.8 Reference No. 842: Mass Gathering and Special Events Interface with Emergency Medical Services – **Held for Discussion**

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

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

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

Nays: (0)

Abstains: (0)

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

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

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

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

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

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

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

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

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

END OF CONSENT AGENDA

5. BUSINESS

Business (Old)

5.1 Field Evaluation of Suicidal Ideation and Behavior

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

5.2 Ambulance Patient Offload Time (APOT)

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

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

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

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

5.3 Interfacility Transfer Taskforce

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

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

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

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

5.4 Cardiac Arrest Taskforce

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

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

Business (New)

5.5 EMS Goals Planning Document 2026

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

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

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

6. LEGISLATION

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

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

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

5. **DIRECTORS' REPORTS**

5.1 Richard Tadeo, EMS Agency Director, EMSC Executive Director

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

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

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

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

Correspondence

5.1.1 (09/03/25) EMS Agency Changes

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

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

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

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

5.2 Nichole Bosson, MD, Medical Director, EMS Agency

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

LA-DROP

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

Pedi-PART and PediDOSE

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

EMS UPDATE

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

CARDIAC ARREST AND COMMUNITY ENGAGEMENT

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

TRAUMA DASHBOARDS

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

ELCoR

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

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

RAPID MEDIC Mobile APP Project

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

2026 FIFA World Cup

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

6. COMMISSIONERS' COMMENTS / REQUESTS

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

7. ADJOURNMENT

Adjournment by Chair Caivano at 2:52 PM.

Next Meeting: Wednesday, March 18, 2026, 1:00-3:00 PM
Emergency Medical Services Agency
10100 Pioneer Boulevard, First Floor
Cathy Chidester Hearing Room 128
Santa Fe Springs, CA 90670

Recorded by:
Denise Watson
Secretary, Health Services Commission

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



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**MINUTES
March 18, 2026**

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<input type="checkbox"/> James Lott, PsyD, MBA	Public Member, 2 nd District		
<input checked="" type="checkbox"/> Carol Meyer, RN	Public Member, 4 th District		
<input checked="" type="checkbox"/> Kenneth Powell	LA Area Fire Chiefs' Assn.		
<input type="checkbox"/> Connie Richey, RN	Public Member 3 rd District		
<input checked="" type="checkbox"/> Stephen G. Sanko, MD	American Heart Association		
<input type="checkbox"/> Carole A. Snyder, RN	Emergency Nurses Assn.		
<input checked="" type="checkbox"/> Saran Tucker	So. CA Public Health Assn.		
<input checked="" type="checkbox"/> Atila Uner, M.D., MPH	CAL-ACEP		
<input type="checkbox"/> VACANT	Public Member, 5 th District		
GUESTS			
Antoinette Salas, APCC	Robert Ower, Premier Ambulance	Jack Yandell, IAEP	
Samuel Calderon, LACoFD	Andy Gonzalez, NAGE/IAEP		

1. CALL TO ORDER

The Emergency Medical Services (EMS) Commission (EMSC) meeting was held at the EMS Agency at 10100 Pioneer Boulevard, First Floor, Cathy Chidester Conference Room 128, Santa Fe Springs, CA 90670. EMSC Roll was taken by Commission Liaison Denise Watson. Nine (9) commissioners were present. The meeting was held with no quorum. No motions or votes were taken.

2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

2.1 Director Tadeo announced that Denise Watson, Commission Liaison will be retiring this month. Vanessa Gonzalez will serve as the Interim Commission Liaison.

2.2 Director Tadeo reported on the Annual EMSAAC Conference to be held on May 27-28, 2026, at the Hilton Los Angeles/Universal City. There will be two pre-conferences, CQI and Disaster on May 26th. Keynote speakers include Gordon Graham, a risk management expert and Cody Spaulding, "The Salty Paramedic" who will be speaking on first responder mental health.

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

3.1 **Minutes**

3.1.1 January 21, 2026

3.2 **Committee Reports**

3.2.1 Base Hospital Advisory Committee – February 4, 2026

3.2.2 Provider Agency Advisory Committee – February 11, 2026

3.3 **Policies**

3.3.1 Reference No. 414: Specialty Care Transport Provider

3.3.2 Reference No. 511: Perinatal Patient Destination

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

3.3.4 Reference No. 703: ALS Unit Inventory

3.3.5 Reference No. 703.1: Private Provider Interfacility Transfer ALS Unit Inventory

3.3.6 Reference No. 704: Assessment Unit Inventory

3.3.7 Reference No. 706: ALS EMS Aircraft Inventory

3.3.8 Summary of Changes: Reference Nos. 703, 703.1, 704, 706

END OF CONSENT AGENDA

4. **BUSINESS**

Business (Old)

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

EMS Agency Assistant Director Jacqueline Rifenburg reported that she, Dr. Denise Whitfield, Adam Kipust and Dr. Gausche-Hill presented the work that was done with this committee at the National Association of EMS Physicians (NAEMSP) conference in January. They will be discussing a descriptive study on the volume of behavioral health calls that have received Olanzapine since the implementation of treatment protocols.

Director Tadeo reported that the state will form a Behavioral Health Response Coalition to address the evolving response primarily from law enforcement agencies to behavioral health. The coalition is to establish a best practice and will be coordinated by the State EMSA, California Health Executives, the California behavioral organization, 9-1-1 alliance, California Ambulance Association, California Hospital Association and other groups.

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

Assistant Director Rifenburg will provide Q1 APOT data at the May EMS commission meeting. Director Tadeo reported on Assembly Bill (AB) 40 and notes that it is closed after going out for public comment. It is now with the Office of Administrative Law to review the permanent proposed regulations. There is not much change from the emergency regulations that were put forth last year. The correspondence from the State EMSA includes their implementation of APOT with details including how many hospitals are participating in using the APOT tool and how big a change using the tool has changed their compliance. A few hospitals in the county have engaged with EMS

providers to adjudicate the APOT time. The correspondence includes a listing of the hospitals that they have been tracking, and they are targeting the top 15 hospitals that have the worst APOT to engage them with implementing their mitigation strategies. As of the last quarter we had nine (9) hospitals on the list, but now we are at seven (7). They are continuing their bi-weekly meetings with these hospitals, and their plan is to consolidate best practices for APOT. One of the best practices that hospitals have come up with is creating an APOT alley, which is an ambulance offload area with a dedicated clinician to accept the patient.

4.3 Interfacility Transfer Taskforce

Assistant Director Rifenburg reported the taskforce will meet in April to discuss how they will be moving forward after having six (6) months' worth of data, July through December 2025. On average there are about 70 9-1-1 IFT's monthly, 63% are deemed appropriate and 37% deemed inappropriate use of 9-1-1.

4.4 Cardiac Arrest Taskforce

Vice Chair Sanko reported that the taskforce will have their 3rd meeting with the hospitals and providers agencies this month to help them develop institutional plans to meet the American Heart Association's (AHA) 2030 goals. Attendance has been growing; in February there were 45 representatives at the provider agency clinic and 115 at the hospital clinic. Some of the forthcoming task force meetings will be on survivorship, promoting care prior to hospital discharge and a session planned for novel AED deployment strategies.

Business (New)

4.5 The September 16th EMSC meeting will be moved to September 9th due to the State EMS Commission meeting being held on the same day.

5. LEGISLATION

A total of 1,897 bills were introduced - 608 senate bills, and 1,289 assembly bills. 40% of the bills introduced are health related.

AB1607 – Sponsored by Mark Gonzalez, representative of the 58th district. Part of this bill is being cosponsored by CalACEP and the EMS Administrators Association of California and it is regarding the Maddy and Richie funds. In the last fiscal year, LA County received close to \$5 million dollars for the Maddy fund, primarily to fund physicians. For LA County, 58% of funding goes to physician funding for indigent care, 25% for hospitals that provide indigent care, 10% administrative and 70% for discretionary EMS funding. In LA County it was earmarked to have a pediatric trauma center in the San Fernando Valley and that gave us the ability to designate Northridge Hospital as a pediatric trauma hospital. The Richie fund put in additional \$2 for every \$10 moving violation and that is to generate funds for pediatric trauma, and of that fund we receive about \$700,000 a year, and \$600,000 goes to maintain Northridge and each of the five (5) other pediatric trauma centers received about \$40,000 annually. The Richie fund has a sunset date of January 1, 2027, and the change would be removing the date and aligning it with the Maddy fund.

SB 796 – Authorizes lifeguards, firefighters and peace officers to be trained to administer first aid. Their skills testing would be tested and authorized by the LEMSA medical director. This wouldn't impact Los Angeles County first responders as the Board of Supervisors already adopted for LA County fire to have first aid training.

SB 945 – A senate bill that would make it a requirement for high school graduates to complete

CPR and AED training.

AB 1923 – This bill would set aside \$300 million to assist distressed hospitals. Any hospital is eligible to apply for these funds. A requirement would be for them to show documentation that they are being impacted by the federal cuts, including H.R. 1.

6. DIRECTORS' REPORTS

5.1 Richard Tadeo, EMS Agency Director, EMSC Executive Director

Proposed General Sales Tax

Director Tadeo provided an update of the proposed general sales tax for the County, the Board of Supervisors voted 4 to 1 to add this measure to the June 2nd ballot. This tax is a half cent general sales tax in LA County for the next five (5) years. This would exclude groceries, pharmaceuticals, and durable medical equipment and it expected to generate close to \$1 billion annually. The funds are being used to address the anticipated short fall from H.R. 1. It is estimated that about 700,000 residents in the County will lose Medicare benefits and this fund is going to be used to assist in continuing health care for these individuals. There is a formula that is being proposed on how the funding would be dispersed and the intent is to have an oversight committee that will make sure the goals and objectives of the measure are being met.

Measure B

We have reached out to DHS finance and Measure B should have enough funding to move forward with its proposal process this year. Once we have a final amount, correspondence will be sent to request proposals. In 2025 \$20 million was allocated evenly between the five (5) Board of Supervisors and we are currently working on their MOU's.

Health Data Exchange

Director Tadeo reported that we are continuing to implement the Health Data Exchange (HDE) and Saint Francis Medical Center is slated to go-live on March 31st. We have received the signed Business Associate Agreement (BAA) from LA County, Pasadena, and San Marino Fire Departments. We are still waiting for Burbank, Glendale and Los Angeles city fire departments to sign their agreements. We will have an orientation with all fire departments to show how to get access and participate in the HDE.

Designated Psychiatric Urgent Care Centers

We have conducted the first annual review of the designated psychiatric urgent care centers, and they are doing great. We will include the data they have submitted into our report for the EMS Plan.

9-1-1 Receiving Hospital Designation

We have been able to establish 9-1-1 receiving hospital designation agreements. 15 of our 69 9-1-1- receiving hospitals are not specialty care designated. We have sent them letters and will start a technical assistant survey to start engaging these hospitals and their emergency departments in meeting the standards to become a 9-1-1 receiving hospital. We will be looking at their transfer agreements and arrangements as part of how we're going to address the IFT issue using 9-1-1- as the mode of transport. We are also going to look at the structure of EMS in terms of umbrella hospitals that we have established.

Boat Transport for Interfacility Transfers (IFT)

We are currently developing a boat IFT policy. The current EMS boat transport providers for Catalina Island are jurisdictional 911 providers and the Coast Guard and only provide emergency transportation for 911/emergency calls. The Catalina Island Medical Center (CIMC) Board of Directors opted to embark on partnering with a private IFT transportation provider utilizing a privately owned and operated boat. We do not have any policies regarding IFT boat transportation. In light of CIMC receiving Measure B funding, the EMS Agency formulated an Ad Hoc meeting comprised of subject matter experts such as the Coast Guard and 911 jurisdictional boat provider to establish minimum standards. The policy will come to the Commission for endorsement, and it will be the first local policy in the state to address this type of transport.

Correspondence

- 6.1.1 (02/24/2026) From EMS Authority: Exceedance of Ambulance Patient Offload Standards – January 2026 Electronic Notification
- 6.1.2 (03/03/2026) Retirement Letter – EMSC Liaison Denise Watson, March 27, 2026
- 6.1.3 (09/29/25) Allocation of Pediatric Trauma Center Funding – Cedars-Sinai

- 6.2 Nichole Bosson, MD, Medical Director, EMS Agency
Dr. Bosson provided updates on clinical projects and initiatives including:

Pedi-PART

Phase 1 of the Pedi-PART trial has closed as of March 17th. The study closure came quickly as it was determined that enrolling further patients was not going to change the analysis. Of the over 1,200 patients received, LA County enrolled over 400 patients in the trial. The goal is to switch to phase 2 and use the remainder of the trial time and funding to evaluate the second question which is comparing SGA to ETI as a strategy for pediatric patients in the hospital setting. During this phase we will not be enrolling in LA County since we do not currently perform intubation for pediatrics. This will be concentrated at the sites that currently perform pediatric intubation as well as supraglottic airway placement. Our data will continue to contribute to the trial because we have submitted data on the use of supraglottic airways as well as BVM.

Prehospital Lung Ultrasound Pilot

The prehospital lung ultrasound pilot does not have a confirmed launch date, but it could be as soon as April 1st. Dr. Jonathan Warren is leading the effort and will be working with Sierra Madre Fire Department, Burbank Fire Department, USC Arcadia, and Saint Joseph Medical Center. We were approved by EMSA to have a local optional scope of practice for performance of lung ultrasound in patients 18 years and older presenting with respiratory distress. The goal of this pilot is to understand how prehospital lung ultrasound can improve diagnostic accuracy in the field for pulmonary edema and to differentiate this condition and initiate earlier treatment from bronchospasms, pneumonia, etc. There is a low rate of identifying pulmonary edema correctly in the field because of the challenges of the field environment. The plan of the pilot is to collect 1 year of prospective data using the ultrasound and compare it to 1 year of retrospective data without the availability of the ultrasound. The team will review 100% of the images and provide feedback to the paramedics.

PediDose

We are still enrolling patients and on July 1st we will begin including patients 6 months and older in the age base dosing. This will be short lived as the trial will only be enrolling patients until the end of July and we will hopefully receive the results in the fall. Our dosing of midazolam will continue on an age-based administration.

LA-DROP

LA-DROP – Prehospital blood transfusion Pilot Program with Compton and LA County Fire Departments. We are coming up on 1 year of this pilot program and we have demonstrated safety of this protocol with only 1 potentially mild transfusion reaction that was recognized and treated by the hospital. There have been 52 transfusions as of the last report. We've had low wastage of field blood, less than 1% and are working with the hospitals to optimize recycling of the blood. The scope of the program is 14 units between Compton Fire and LA County Fire. LA County Fire has received preliminary funding, and we expect them to expand on their program to potentially double their number of units. LA Sheriffs also received funding and will be implementing a single unit on their AIR 5 unit. Pasadena Fire Department and Los Angeles Fire Department are exploring options to implement programs in collaboration with Los Angeles General Hospital. We continue to meet monthly with the Cal Drop collaborative and other LEMSA's who have implemented or would like to implement the program.

EMS UPDATE

Dr. Shira Schlesinger is overseeing the EMS Update training which focuses on pediatric resuscitation, care of pregnant patients, and enhanced use of capnography. We have begun the Train-the-Trainer sessions and will be launching multiple initiatives that will go live July 1st.

RAPID APP Project

A publication which describes how we created the protocol application was accepted and it is in preproduction online. We also received funding through the Board of Supervisors to update our drug doses app, which will allow us to optimize the current application, that was developed 7 years ago, to better integrate with RAPID and be more nimble in terms of the way in which we dose medications as we introduce additional medications and dosing schedules. Dr. Denise Whitfield, Assistant Medical Director, reported we have completed enrollment for a study that we were working with paramedics on use with simulated trauma scenarios. We are completing the data analysis but plan to publish the results when they become available. Also, as part of our OTS Grant, we are looking at use of the app throughout the County and Dr. Toy has done some data analysis. We will be reconvening our taskforce to look at ways we can improve.

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

2026 FIFA World Cup

Dr. Whitfield is working with Dr. Saman Kashani, Assistant Medical Director for LA County Fire as the hosting city medical co-chairs. They are working on medical plans with provider agencies and the Los Angeles sports entertainment commission. There will be eight (8) matches from mid-June to mid-July at SOFI stadium. They are working on medical preparation for heat emergencies and working with Public Health for protocols. FIFA is also giving recommendations for all sites across the country. There will be a fanfest held at the Los Angeles Coliseum along with 10 fan zones that will be held throughout the month.

7. **COMMISSIONERS' COMMENTS / REQUESTS**

8. **ADJOURNMENT**

Next Meeting: Wednesday, May 20, 2026, 1:00-3:00 PM
Emergency Medical Services Agency
10100 Pioneer Boulevard, First Floor
Cathy Chidester Hearing Room 128
Santa Fe Springs, CA 90670

Recorded by:
Denise Watson
Secretary, Health Services Commission

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



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



**BASE HOSPITAL ADVISORY
COMMITTEE MINUTES**

February 4, 2026

Representatives			Representatives		
X	Tarina Kang, MD, Chair	EMS Commission	X	Rachel Caffey	Northern Region
	Lydia Lam, MD, Vice Chair	EMS Commission	X	Jessica Strange	Northern Region
	Atilla Under, MD, MPH	EMS Commission	X	Michael Wombold	Northern Region, Alternate
	Connie Richey, RN	EMS Commission	X	Samantha Verga-Gates	Southern Region
	Saran Tucker, PhD, MPH	EMS Commission	X	Laurie Donegan	Southern Region
	Carol Synder, RN	EMS Commission	X	Jeanette Souza	Southern Region
	Erick Cheung, MD	EMS Commission	X	Christine Farnham	Southern Region, Alternate
	Brian Saeki	EMS Commission	X	Ryan Burgess	Western Region, Alternate
	Carol Kim	EMS Commission	X	Travis Fisher	Western Region
X	Gabriel Champion	Base Hospital Medical Director	X	Lauren Spina	Western Region
	Salvador Rios	Base Hospital Medical Director, Alternate	X	Susana Sanchez	Western Region
	Adam Brown	Provider Agency Representative	X	Kate Bard	Western Region
X	David Hickman	Provider Agency Representative, Alt.		Laurie Sepke	Eastern Region
X	Elizabeth Charter	PedAC Representative	X	Alina Candal	Eastern Region
	Desiree Noel	PedAC Representative, Alternate	X	Jenny Van Slyke	Eastern Region, Alternate
	Colleen Greer	MICN Representative	X	Lila Mier	County Region
	Vacant	MICN Representative, Alternate		Emerson Martell	County Region
			X	Antoinette Salas	County Region
			X	Yvonne Elizarraraz	County Region
EMS Agency			Prehospital Care Coordinators		Guests
	Denise Whitfield, MD	Lorrie Perez	X	Brandon Koulabouth (AMH)	Taylor Hill (SJS)
	Shira Schlesinger, MD	Paula Cho	X	Taylor Ornelas (AVH)	Sheryl Gradney(LACoFD)
	Jake Toy, MD	Christine Zaiser	X	Melissa Carter (HCH)	Jennifer Nulty (BHFD)
	Michael Kim, MD	Hanna Kang	X	Melissia Turpin (SMM)	
	Nicole Bosson, MD	Sara Rasnake	X	Allison Bozigian (HMN)	
	Jacqueline Rifenburg		X		
	Richard Tadeo				
	Jon Warren, MD				
	Ami Boonjaluksa				
	David Wells				

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

2. **INTRODUCTIONS/ANNOUNCEMENTS:**

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

2.2 **Joint Education Session – March 3, 2026:** Dr. Amelia Breyer, MD, LEMSA Medical Director for San Francisco, will present on prehospital in End-Of-Life-Care. CE will be offered; CME will not be available.

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

3. **APPROVAL OF MINUTES**

3.1 The meeting minutes for December 10th, 2025

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

4. **NEW BUSINESS**

None

5. **OLD BUSINESS**

5.1 Ref. No. 511, Perinatal Patient Destination

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

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

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

AHA Updates

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

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

6.2 Ref. No. 1213, Cardiac Dysrhythmia – Tachycardia

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

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

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

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

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

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

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

Capnography

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

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

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

6.9 Ref. No.1237-P, Respiratory Distress

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

6.11 Ref. No.1302, Airway Management and Monitoring

6.12 Ref. No.1305, Capnography

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

6.13 Ref. No. 1214, Pulmonary Edema/CHF

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

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

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

6.15 Ref. No. 1200.2, Base Contact Requirements

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

6.16 Ref. No 1375, Vascular Access

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

7. REPORTS & UPDATES:

7.1 EMS Update

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

7.2 EmergiPress

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

7.3 ITAC Update

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

7.4 ELCOR

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

Research Initiative & Pilot Studies

7.5.1 Prehospital Blood Transfusion Pilot – LA DROP

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

7.5.2 PediDOSE

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

7.5.3 Pedi-PART

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

7.6 California Office of Traffic Safety (OTS) Grants Projects

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

7.7 Cardiac Arrest Taskforce

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

7.8 Upcoming Mass Gathering Events

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

7.9 Health Data Exchange

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

7.10 2025 EMS Annual Data Report

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

8. **OPEN DISCUSSION:**

Base Authority Fact-Finding Process:

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

Base Survey- Quality Improvement Presentation.

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

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

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

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



EMERGENCY MEDICAL SERVICES COMMISSION PROVIDER AGENCY ADVISORY COMMITTEE



MINUTES

Wednesday – February 11, 2026

MEMBERSHIP / ATTENDANCE

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

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 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.



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



**BASE HOSPITAL ADVISORY
COMMITTEE MINUTES**

April 8, 2026

Representatives			Representatives		
X	Tarina Kang, MD, Chair	EMS Commission	X	Rachel Caffey	Northern Region
	Lydia Lam, MD, Vice Chair	EMS Commission	X	Jessica Strange	Northern Region
	Atilla Under, MD, MPH	EMS Commission	X	Michael Wombold	Northern Region, Alternate
	Connie Richey, RN	EMS Commission		Samantha Verga-Gates	Southern Region
	Saran Tucker, PhD, MPH	EMS Commission	X	Laurie Donegan	Southern Region
	Carol Synder, RN	EMS Commission	X	Jeanette Souza	Southern Region
	Erick Cheung, MD	EMS Commission	X	Christine Farnham	Southern Region, Alternate
	Brian Saeki	EMS Commission	X	Ryan Burgess	Western Region, Alternate
	Carol Kim	EMS Commission	X	Travis Fisher	Western Region
X	Gabriel Campion	Base Hospital Medical Director	X	Lauren Spina	Western Region
	Salvador Rios	Base Hospital Medical Director, Alternate		Susana Sanchez	Western Region
X	Adam Brown	Provider Agency Representative	X	Kate Bard	Western Region
	David Hickman	Provider Agency Representative, Alt.		Laurie Sepke	Eastern Region
X	Elizabeth Charter	PedAC Representative	X	Alina Candal	Eastern Region
	Desiree Noel	PedAC Representative, Alternate		Jenny Van Slyke	Eastern Region, Alternate
	Colleen Greer	MICN Representative	X	Lila Mier	County Region
	Vacant	MICN Representative, Alternate	X	Emerson Martell	County Region
			X	Antoinette Salas	County Region
			X	Yvonne Elizarraraz	County Region
EMS Agency			Prehospital Care Coordinators		Guests
	Dipesh, Patel, MD	Priscilla Ross	X	Brandon Koulabouth (AMH)	Shane Cook (LACoFD)
	Shira Schlesinger, MD	Hannah Kang	X	Taylor Ornelas (AVH)	Catherine Borman (SMFD)
	Lorrie Perez	Christine Zaiser	X	Melissa Carter (HCH)	Jennifer Nulty (BHFD)
	Michael Kim, MD	Mark Ferguson	X	Melissia Turpin (SMM)	Ashley Sanello, MD (TMH)
	Nicole Bosson, MD	Sara Rasnake	X	Allison Bozigian (HMN)	Thomas Vu, MD (SFMC)
	Jacqueline Rifenburg	Gary Watson			Kelsey Wilhelm, MD (HGH)
	Richard Tadeo				
	David Wells				
	Ami Boonjaluksa				
	Tracy Harada				

1. **CALL TO ORDER:** The meeting was called to order at 1:02 p.m. by Chair, Tarina Kang, MD.
2. **INTRODUCTIONS/ANNOUNCEMENTS:**
 - 2.1 **EMSAAC Conference 2026:** Scheduled for May 26-28, 2026, at the Universal Hilton, Universal City with pre-conference sessions on May 26 (CQI and Disaster). Keynote speakers include EMS professionals and experts in mental health and risk management.
 - 2.2 **Joint Education Session –** Upcoming session topic: *Care for Transgender and Gender-Diverse Patients*. The session will be led by a national expert in the field. Sessions will be recorded and will be made available for future access.
 - 2.3 **EMSC Educational Forum –** Annual Education Forum scheduled for November 5 In Fairfield, CA. Additional pediatric-focused track to be presented at the California Fire, EMS & Disaster Conference (Indian Wells)
 - 2.4 **National Pediatric Readiness Project (NPRP) –** California currently at 39% completion. Hospitals are encouraged to verify completion status
 - 2.5 **Sidewalk CPR:** National CPR & AED Awareness Week: June 1-7. Registration ongoing; deadline extended. Contact Priscilla Ross or Natalie Greco for registration assistance.
 - 2.6 **Retirement announcements -** Laura Leyman (EMS Agency Base Hospital Coordinator), Laurie Speke (PVC) and Laurie Donegan (LBM) and recognition of long-standing contributions to EMS.

3. APPROVAL OF MINUTES

- 3.1 The meeting minutes for February 4th, 2025
Approved as presented, M/S/C (Burgess/Farnham)

4. NEW BUSINESS

- 4.1 Radio Communication System Testing:
Planned radio testing across three shifts in May with the goal to improve base contact reliability and identify communication gaps. Providers and base hospitals will coordinate directly. A memo will be distributed with schedule and expectations.
- 4.2 Ref. No 644, Base Hospital Documentation Manual & Data Dictionary 2026
Discussion encompassed agenda items 4.2-4.4, including updates to the Base Hospital Documentation Manual & Data Dictionary 2026, Summary of Changes 2026, and Base Hospital Form 2026. Key updates include addition of magnesium sulfate and mechanism of injury category electric bicycle. Alignment with electronic data systems and updates to align with medical control guidelines and documentation.
- 4.3 Summary of Changes 2026
- 4.4 Base Hospital Form 2026

5. OLD BUSINESS: Policies for Discussion (Action Required)

- 5.1 Ref. No. 505, Ambulance Patient Offload Time (APOT)
Clarification provided on the definition of licensed hospital personnel.
No discussion.

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

5.2 Ref. No.606, Documentation of Prehospital Care

Updated EMS record requirements (ePCR) and removed outdated paper documentation references and practices.

No discussion.

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

6. Policies for Information Only: (No Action Required)

6.1 Ref. No. 607, Electronic Submission of Prehospital Data

Expanded to include ALS private providers and removed specialty care transport requirements.

No discussion.

7. REPORTS & UPDATES:

7.1 EMS Update

- EMS Update was released on April 1, and completion is required by June 30.
- Clarification provided on pediatric medication dosing and magnesium administration.

7.2 EmergiPress

- The latest issue focused on SB 43 and patient evaluation.
- Upcoming topic: Cervical spine evaluation and spinal motion restriction in children.

7.3 ITAC Update

- Reviewed and discussed streamlining data- sharing platforms
- Exploring a new device, the Butterfly BVM. There will be an opportunity to evaluate the device using mannequins. If there is sufficient interest, we may consider a potential trial for the device.

7.4 ELCOR Committee

- Dr. Kim is developing a module covering the EMS system, orienting them to the EMS structure and their role as first responders and understanding specialty destinations.
- Dr. Schlesinger is developing modules on critical pediatric response and looking at ways to enhance communication and understanding between law enforcement and EMS.

7.5 Research Initiative & Pilot Studies

7.5.1 Prehospital Blood Transfusion Pilot – LA DROP

- Over 50 transfusions to date with < 1% waste rate.
- Work is being done to establish more funding and to expand the program in Los Angeles County.

7.5.2 PediDOSE

- PediDOSE enrollment will end at the end of July; no system changes are expected at this time.
- Inclusion of patients six months and older begins July 1.
- Results of the study are expected later this year.

7.5.3 Pedi-PART

- Phase 1 enrollment is complete with 1200 patients enrolled, including 400 from Los Angeles County.

- Phase 2 has begun comparing SGA to ETI in pediatric patients. California sites will not participate in enrollment as participation requires current performance of pediatric ETI.
- Dr. Bosson presented challenge coins to base hospitals in recognition of their participation in the study.

7.6 California Office of Traffic Safety (OTS) Grants Projects

- Crash data dashboard is now available on the EMS Agency website.
- Dr. Toy will be analyzing high priority crash areas and regional data trends and will engage stakeholders in meetings to review findings and discuss next steps.

7.7 Cardiac Arrest Taskforce

- Led by Dr. Sanko, evaluating cardiac arrest outcomes across adult, pediatric, and bystander metrics.
- Baseline report cards distributed to hospitals and provider agencies.
- Improvement plan deadline extended through year-end.
- Monthly sessions to address strategies, barriers and best practice for bystander CPR, and AED access.
- Working with Public Health and AHA on CPR/AED initiatives aligned with 2030 outcome goals.

7.8 Upcoming Mass Gathering Events

- Regional Planning for FIFA World Cup events (June 12-July 17) is in progress.
- Eight matches will occur at the SoFi Stadium: fan zones at LA Coliseum and other locations.
- Hospitals are advised to review surge capacity, staffing and disaster protocols.
- EMS Agency is planning coordination for 2028 Summer Olympics.

7.9 Health Data Exchange

- St. Francis Medical Center now live, onboarding underway with MemorialCare Long Beach, Ronald Reagan UCLA Medical Center, and Pomona Valley Hospital, with target onboarding in the fall.
- Agreements with Cedars-Sinai Medical Center and Huntington Hospital are near completion and working with Providence and Commonspirit systems.
- Engagement with Kaiser Permanente and other systems is ongoing.
- Increasing provider agency involvement, with several agencies completing agreements and training for administrative and critical access.

8. **OPEN DISCUSSION:**

Measure B Funding Update:

- Funding for FY 2026-2027 is anticipated to begin July 1, 2026, pending confirmation of available funds (estimated \geq \$50M). Reimbursement requires proper documentation and invoicing. Policy discussion at the Board level includes potential changes to allocation methodology, including need-based models; however, no final decision has been made. Notification to stakeholders will follow funding confirmation

System Downtime & Infrastructure Risk.

- Recent hospital copper thefts incidents disrupted communication systems, highlighting vulnerabilities. Hospitals should review and test downtime procedures.

EMS Education & Training Resources

- The EMS Agency has launched Vimeo-based platform to centralize training materials, including CPR education, LUCAS device training, and rapid response modules. Agencies may download and incorporate these resources into local training and continuing

education programs.

Prehospital Lung Ultrasound Pilot

- One year pilot program has launched evaluating prehospital lung ultrasound use in adult patients with respiratory distress. Participating agencies include Sierra Madre and Burbank Fire Department. The study aims to improve diagnostic accuracy for conditions such as CHF and pulmonary edema, with anticipated enrollment of 350 patients.

9. NEXT MEETING: June 10, 2026

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

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

ACCOUNTABILITY: Laura Leyman

- EMS Educator:
Heather Calka (UCLA Center for Prehospital Care), moved from Alternate to Primary Representative.
Catherine Borman (Santa Monica FD), filling the Alternate position.

2.2 EMSAAC Conference 2026 (*Richard Tadeo*)

- Annual Conference is being held at the Hilton -LA/Universal City, from May 27 & 28, 2026.
- The theme is “Back to the Future, EMS Reimagined”, with keynote speakers Cody Spaulding, Gordon Graham, and several speakers from Los Angeles County.
- May 26th Pre-Conference sessions on CQI and Disaster.
- Registration is now open at emsaac.org

2.3 Joint Educational Session – Care for Transgender Patients (*Denise Whitfield, MD*)

- Dr. Veronica Case, from Oschner Medical Center in New Orleans, will be presenting this virtual-only educational session on June 2, 2026, from 11:45 am – 12:45pm. 1 hour CE Credit will be provided.
- Invitations to this session will be distributed within the Pediatric Advisory Committee and Medical Advisory Committee agendas.

2.4 EMSC Educational Forum (*Shira Schlesinger, MD*)

- This annual forum will be held via in-person only on November 5, 2026, in Fairfield, California.
- This is a full day educational event covering multiple pediatric topics.
- More information including keynote speakers and registration will be available on the EMS Authority’s webpage shortly.

2.5 Retirement Announcement (*Chair, Carol Meyer*)

Chair announced the following retirements:

Laura Leyman, EMS Agency, Base Hospital Programs
Laurie Sepkie, PCC, Pomona Valley Hospital Medical Center

2.6 National Pediatric Readiness Project (NPRP) (*Shira Schlesinger, MD*)

- Area hospitals are being asked to complete the NPRP survey by May 31, 2026. The goal is to have 100% participation. Providers are asked to remind their local hospitals of this survey’s participation.
- For questions, contact Shira Schlesinger, MD, at SSchlesinger2@dhs.lacounty.gov

2.7 Prehospital Pediatric Readiness Program

- Analysis reports from the survey conducted in 2024, involving prehospital providers, is now complete.
- The survey’s GAP analysis report has been distributed to the individual providers. Those who have not received or are now requesting an additional copy of the report may contact Dr. Schlesinger.

2.8 Sidewalk CPR (*Natalie Greco*)

- The National CPR and AED Awareness Week is June 1 – 7, 2026. All providers are encouraged to host this “hands-only” public event.
- Currently, there are 16 public providers and 3 private providers who have pre-registered.
- Registration remains open until the end of April 2026. Once registered, all county-wide event locations will be posted on the EMS Agency’s webpage.
- Those wanting to register or wanting more information, may contact Natalie Greco at NGreco@dhs.lacounty.gov

2.9 General Public Ambulance Rates (*David Wells*)

- Ambulance rates for fiscal year 2026-2027 have been distributed to all Los Angeles County provider agencies and cities. These new rates go into effect July 1, 2026.
- To request a copy of this document, please contact David Wells at Dwells@dhs.lacounty.gov or you can access through the EMS Agency webpage.

3. **APPROVAL OF MINUTES** (**Cohen / Brown**) February 11, 2026, minutes were approved as written.

4. UNFINISHED BUSINESS

Policies for Discussion; Action Required:

No unfinished business

5. NEW BUSINESS

Policies for Discussion; Action Required:

5.1 Reference No. 426, Private Provider Water Ambulance Interfacility Transport (David Wells)

Policy reviewed and approved as written.

M/S/C (Brown / Manjarrez) Approve: Reference No. 526, Private Provider Water Ambulance Interfacility Transport.

5.2 Reference No. 426.1, Private Provider Water Ambulance Insurance Requirements (David Wells)

Policy reviewed and approved as written.

M/S/C (Brown / Manjarrez) Approve: Reference No. 526.1, Private Provider Water Ambulance Insurance Requirements.

5.3 Reference No. 505, Ambulance Patient Offload Time (APOT) (Jacqui Rifenburg)

Policy reviewed and approved as written.

M/S/C (Hernandez / Harter) Approve: Reference No. 505, Ambulance Patient Offload Time.

5.4 Reference No. 606, Documentation of Prehospital Care (Sara Rasnake / Ami Boonjaluksa)

Policy reviewed and approved as written.

M/S/C (Brown / Nulty) Approve: Reference No. 606, Documentation of Prehospital Care.

Policies for Discussion; No Action Required:

The following policies were reviewed as information only:

5.6 Reference No. 607, Electronic Data Submission (Sara Rasnake)

Upon review, Committee recommended the following language change to align with Ref. 606:

- Page 2, I. A. 1. c.: “System to ensure a Patient Care Record is created by each EMS provider for every response that result in patient contact.”

M/S/C (Brown / Calka) Approve: Reference No. 607, Electronic Data Submission, with recommendation.

6. REPORTS AND UPDATES

6.1 Health Data Exchange (Richard Tadeo)

- Provider agencies continue to submit their Business Associate Agreements (BAA) for the HDE system. Providers are asked to include the name of the primary person who will be the Administrator for the HDE.
- Due to the sensitivity of having access to Patient Health Information (PHI), providers are encouraged to limit the number of individuals given access to the HDE system.
- Several hospitals are currently in the technical discovery phase and have signed BAAs. The technical discovery phase takes approximately 3-4 months before proceeding.

6.2 EMS Update 2026 (Shira Schlesinger, MD)

- EMS Update 2026 training started April 1, 2026.
- LMS training material was sent to all super-users. If you did not receive this material, please contact Shira Schlesinger, MD, at SSchlesinger2@dhs.lacounty.gov
- Dr. Schlesinger will be requesting participation from EMS Educators in an upcoming educational workgroup to review various educational topics and delivery methods.
- Revision to Ref. No. 1217, TP: Pregnancy Complication, post-EMS Update training. Dr. Bosson informed Committee of the addition of Special Considerations No. 11, providing specific guidance for when to administer midazolam during eclamptic seizures.
- Dr. Whitfield provided information on the future tracking of ALS Skills during EMS Update 2027. A worksheet was developed by the EMS Agency to assist providers in the tracking of the ALS skills.

6.3 EmergiPress (Shira Schlesinger, MD)

- The April 2026 EmergiPress will be available soon. Topic is on cervical spine evaluation and spinal motion restriction in younger children.
- The next EmergiPress will be on snakebites.
- Suggestions for future educational topics can be provided to Dr. Schlesinger.

6.4 ITAC Update (Shira Schlesinger, MD)

- ITAC is reviewing two products for use in Los Angeles County: Butterfly BVM and Cold Vest.
- Once these reviews are complete, a recommendation will be presented to this Committee.

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

- A training module was presented to the LA Area Police Chiefs on co-response to behavioral health emergencies. The plan is to have this module disseminated to area law enforcement agencies.
- The following additional training modules are being developed and will be provided to law enforcement personnel: pediatric emergencies, the basics of the EMS system in Los Angeles County, and specialty care center destinations.
- Topics currently under review include the processes when placing a person on a 72-hour hold; prebooking clearance during the jail process; and law enforcement “scoop-and-run” scenario.

6.6 Research Initiatives and Pilot Studies

6.6.1 Prehospital Blood Transfusion – LA DROP (Nichole Bosson, MD; Clayton Kazan, MD; Kelsey Wilhelm, MD)

- This pilot has been ongoing for one year; with 60 transfusions recorded.
- LACoFD will be testing the “Life Flow” device, to increase the blood infusion rate; and is currently planning to expand this pilot to the Eastern Region of LA County in the Fall.
- Compton FD is developing a tool kit to assist providers with setting up a blood transfusion program within their own agency.
- LA County Sheriff and Pasadena FD will be joining this pilot in the near future.
- Providers who are interested in participating in this pilot may contact the EMS Agency.

6.6.2 PediDOSE Trial (Nichole Bosson, MD)

- Effective July 1, 2026, the LA County system will be lowering the age-based dosing of midazolam to 6-months of age. (*Currently, the starting age is 12-months and older*)
- All providers must transition on this day.
- Starting August 1, 2026, providers will no longer need to complete a paramedic self-report (PSR) for this trial. However, the age-based dosing protocol will continue.
- Results of the study will be collected and results presented at the end of this year.

6.6.3 Pedi-PART (Nichole Bosson, MD)

- Phase I of this study (field data collection) is now complete.
- To comply with the NIH regulations, all materials related to this study must be removed from ALS units and electronic devices (phones/tablets). Return the RALPH devices to the EMS Agency.

- Outcome data from this study will be shared when available.
- Dr. Bosson acknowledged the enormous support and effort of all those involved in this study, and distributed a Pedi-PART challenge coin to all PAAC members, provider representatives and EMS Educators.

6.6.4 Prehospital Lung Ultrasound Pilot (Nichole Bosson, MD)

- This 1-year pilot recently started with Sierra Madre FD and Burbank FD.
- As of today, one patient has been enrolled by Sierra Madre FD.
- The goal is to understand the role of lung ultrasound to improve the paramedic's ability to identify pulmonary edema and distinguish from other respiratory distress pathology.
- Due to limited resources, the EMS Agency is not accepting applications from other providers wanting to participate.

6.7 California Office of Traffic Safety (OTS) Grants Projects (Denise Whitfield, MD; Shira Schlesinger, MD)

- Rapid Protocol Application: To receive feedback from end-users, the protocol application task force will reconvene in late April 2026.

Dr. Whitfield shared to the Committee, that during a 2025 scenario-based study, using the app was very beneficial during pediatric treatments, due to the high stress level pediatric population can produce.

- Dashboard on Crash-Related Data and Post-Crash Care: Maps were created to show the high-risk areas throughout LA County for injury-producing crashes. To improve patient outcome, the post-crash care metrics are being analyzed.

The EMS Agency will be hosting the following two sets of meetings:

1. Meetings with non-medical stakeholders (public health and public works) to review crash prevention. These meetings are planned for June and July 2026. Calendar invites will follow.
2. Meetings with EMS stakeholders to identify ways of improving post-crash care. Meetings are scheduled for June 16 and July 23, 2026.

6.8 Cardiac Arrest Task Force (Nichole Bosson, MD)

- This EMS Commission task force has been meeting with the goal of improving the current LA County cardiac arrest outcome and efforts to achieve the 2030 AHA goals.
- Task force has asked providers for a simplified plan on how their agency will address their department's needs and concerns related to improving community patient outcomes in cardiac arrest. Examples: AEDs in public domains, participating in bystander CPR training, etc.
- The EMS Agency has received provider's concerns surrounding the short timeline to complete this project. Timeline has now been extended by the Commission until the end of 2026.
- The EMS Agency will reach out to area hospitals, the Department of Public Health and other stakeholders, to facilitate their participation.

6.9 Upcoming Mass Gathering Events (Denise Whitfield, MD)

- The FIFA 26 World Cup will take place in LA County during the months of June/July 2026. Dr. Whitfield reviewed an EMS Agency document identifying the matches held at SoFi Stadium, the fan fest at LA Memorial Coliseum; and multiple fan zones throughout the County. This document also included planning assumptions for medical surge, foreign visitors, mass gatherings and event specific events.
- LA 2028 Olympics planning phase has begun. This event is a National Special Security Event (NSSE), which is considered a high-profile event. U.S. Secret Service will lead all security aspects.
- Superbowl 2027 planning phase has begun.

6.10 Training/Educational Videos (Schira Schlesinger, MD)

- Dr. Schlesinger introduced the new EMS Agency's video webpage which contain several educational videos previously used in EmergiPress, EMS Updates, Just-in-Time Training, Sidewalk CPR, Joint Educational Sessions and other public educational topics.
- If you have educational videos you would like to post, please contact Dr. Schlesinger at SSchlesinger2@dhs.lacounty.gov

7. OPEN DISCUSSION

7.1 CHLA Pediatric Resuscitation SIMS Study (Nichole Bosson, MD)

- This Fall, investigators from Children's Hospital Los Angeles (CHLA) will be partnering with the Boston Medical Center, to conduct several pediatric resuscitation simulations.
- This study is seeking volunteer paramedics to participate in this 4-hour SIMS exercise. CE will be provided and there will be two \$100 stipends per paramedic for their participation.
- More information and contact information will be distributed at a later date.

7.2 Snake Bites (Nichole Bosson, MD)

- The EMS Agency is developing a quick reference guide for field treatment of patients with venomous snake bites. This will include several resources such as toxicology, names of hospitals stocking the antivenom, and assistance in making transportation decisions.
- This will be added to the Rapid mobile application; applicable Treatment Protocols; and presented in an EmergiPress education.
- More information will follow.

7.3 Radio Days (David Wells)

- During recent EMS Agency ALS unit inspections, it was identified that there were provider agencies (public and private) having difficulty making base contact with the hand-held radios.
- To assist in raising awareness and resolving this issue, the EMS Agency will be asking providers to participate in a "radio day test" activity. This is in the planning phase and once finalized, an announcement along with instructions will be distributed to all providers.

7.4 Measure B Funds – Update (Richard Tadeo)

- Unallocated funds from the 2025 Measure B have been allocated to specific providers. Those who will be receiving funds for their approved projects have been notified.
- The EMS Agency is waiting to hear from the Board of Supervisors regarding the 2026 Measure B funds. Information will follow.

8. NEXT MEETING – June 17, 2026

9. ADJOURNMENT - Meeting adjourned at 2:44 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **SPECIALTY CARE TRANSPORT PROVIDER**

REFERENCE NO. 414

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

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

DEFINITIONS:

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

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

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

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

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

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

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

PRINCIPLES:

EFFECTIVE: 02-01-88

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

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

APPROVED:

Director, EMS Agency

Medical Director, EMS Agency

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

POLICY:

I. Application Requirements

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

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

II. Personnel Requirements

A. Transport Medical Director

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

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

B. Transport Coordinator

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

care ambulance transports; and

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

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

3. The Transport Coordinator shall:

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

C. Transport Personnel

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

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

- 2. RNs, RCPs and EMTs shall:

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

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

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

III. Subcontracting SCT Services

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

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

IV. Insurance Requirements

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

V. Policies and Procedures

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

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

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

VI. Quality Improvement (QI) Program

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

VII. Required Equipment

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

VIII. Program Review

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

compliance with this policy.

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

CROSS REFERENCE:

Prehospital Care Manual:

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

Business and Professions Code:

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

DRAFT

SUBJECT: **PRIVATE PROVIDER WATER AMBULANCE** (EMT, PARAMEDIC, MICN)
CATALINA ISLAND INTERFACILITY TRANSPORT 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.

EFFECTIVE: xx-01-26
REVISED: NEW
SUPERSEDES: NEW

PAGE 1 OF 8

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 as determined by the on-site referring/sending physician.
 - 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)

POLICY REVIEW – COMMITTEE ASSIGNMENT

REFERENCE NO. 202.1
 (ATTACHMENT A)

REFERENCE NO. 426 & 426.1, *Private Provider Water Ambulance Catalina Island Interfacility Transport & Private Provider Water Ambulance Catalina Island Interfacility Transport Insurance Requirements*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee			
	Provider Agency Advisory Committee	4/15/26	4/15/26	
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other: Southern California Ambulance Association (SCAA)			

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

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

REFERENCE NO. 202.2
 (ATTACHMENT B)

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

REF	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
426	<p>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.</p> <p>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.</p> <p>Policy developed by working with subject matter experts from Public Provider Agencies and the United States Coast Guard.</p>	PAAC – 4/15/26		
426.1	Insurance Requirements set forth by the County of Los Angeles.			

DEPARTMENT OF HEALTH SERVICES
 COUNTY OF LOS ANGELES

DRAFT

SUBJECT: **PRIVATE PROVIDER WATER AMBULANCE INSURANCE REQUIREMENTS** (EMT, PARAMEDIC, MICN)
 REFERENCE NO. 426.1

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.

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.

EFFECTIVE DATE: 11-01-22

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REVISED: 04-01-25

SUPERSEDES: 07-01-23

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 ≥ 90 mmHg
 - HR 60-100
 - RR 12-20

- O2 Saturation $\geq 94\%$ 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
1 st	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.
2 nd	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.
3 rd	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
4 th	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.
5 th	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.
6 th	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

POLICY REVIEW – COMMITTEE ASSIGNMENT

REFERENCE NO. 202.1
 (ATTACHMENT A)

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

		Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
ADVISORY	EMS	Base Hospital Advisory Committee	4/8/26	4/8/26	
		Provider Agency Advisory Committee	4/15/26	4/15/26	
OTHER COMMITTEES / RESOURCES		Medical Council			
		Trauma Hospital Advisory Committee			
		Pediatric Advisory Committee			
		Ambulance Advisory Board			
		EMS QI Committee			
		Hospital Association of Southern California			
		County Counsel			
		Disaster Healthcare Coalition Advisory Committee			
		Other: Southern California Ambulance Association (SCAA)			

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

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

REFERENCE NO. 202.2
(ATTACHMENT B)

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".			

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

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

SUBJECT: **PERINATAL PATIENT DESTINATION**

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

DEFINITIONS:

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

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

Perinatal: Patients who are at least 20 weeks pregnant or, based on clinical judgment, recently post-partum.

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

PRINCIPLES:

1. Perinatal patients should be transported to the most accessible facility appropriate to their needs. Factors to be considered include: severity and stability of the patient's illness or injury; current status of the pediatric receiving facility; anticipated transport time; and request by the patient, family, guardian or physician. Final authority for patient destination rests with the base hospital handling the call when base contact is made.
2. If delivery occurs prior to arrival at a hospital, the mother and the newborn should be transported to the same facility.
3. BLS units shall call for an ALS unit on perinatal patients who meet criteria outlined in Ref. No. 1200.4, BLS Upgrade to ALS Assessment; or transport perinatal patients to the most accessible perinatal center.
4. For destination, specific for the newly born, refer to Ref. No. 510, Pediatric Patient Destination.

POLICY:

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

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

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APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

- A. Patients who appear to be in active labor, whether or not delivery appears imminent
 - B. Patients whose chief complaint appears to be related to the pregnancy
 - C. Patients who appear to be having perinatal complications
 - D. Traumatically injured pregnant patients ≥ 20 weeks who do not meet trauma criteria or guidelines and are not transported to a trauma center
 - E. Patients with hypertension (SBP ≥ 140 mmHg or DBP ≥ 90 mmHg)
 - F. New-onset seizure
- II. Post-partum patients (up to 6 weeks) with hypertension (SBP ≥ 140 mmHg or DBP ≥ 90 mmHg) or with new-onset seizure shall be transported to a perinatal center.
- III. Perinatal patients who have just delivered prior to arriving at a health facility should be transported to the most accessible perinatal center with an EDAP. Also consider a perinatal center with a NICU, per Ref. No. 510.
- IV. Perinatal patients meeting trauma criteria and/or guidelines, per Ref. No. 506, Trauma Triage, should be transported to a trauma center. Consider transporting traumatically injured pregnant patients ≥ 20 weeks that do not meet trauma criteria and/or guidelines to a trauma center per special considerations, Ref. No. 506.
- V. Perinatal patients in cardiac arrest should be transported to a ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) with a Perinatal Center when feasible.
- VI. Pregnant or perinatal patients who have just delivered for whom transportation to a perinatal center would exceed 30 minutes should be transported to a receiving facility which is also an EDAP.
- VII. Perinatal patients whose chief complaint is clearly not related to the pregnancy and have no specialty center needs should be transported to the most accessible receiving (MAR) facility.
- VIII. Consideration may be given to:
- A. Perinatal patients who are equal to or less than 34 weeks pregnant, whose chief complaint appears to be related to the pregnancy should be directed to a perinatal receiving facility with a NICU.
 - B. Honor patient destination requests for those patients who have made previous arrangements for obstetrical care at a given hospital. This consideration should be based on the following:
 - 1. If the condition of the patient permits such transport
 - 2. Transportation to the requested obstetrical facility would not exceed 30 minutes and would not unreasonably remove the ALS unit from its area of primary response

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 502, **Patient Destination**

Ref. No. 506, **Trauma Triage**

Ref. No. 510, **Pediatric Patient Destination**

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

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

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)
REFERENCE NO. 517

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

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

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

DEFINITIONS:

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

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

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

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

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

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

PRINCIPLES:

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

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

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

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

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

POLICY:

I. Transport Modalities

A. Basic Life Support (BLS) Transport

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

B. Advanced Life Support (ALS) Transport

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

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

II. Transport Requests and Response Levels

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

Ambulance providers shall dispatch an ambulance within the maximum response times for emergency calls specified in the County Code in response to an emergency call from a public safety agency or authorized emergency transportation provider for that geographical area, unless the

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

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

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

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

III. Role of the Base Hospital in ALS Interfacility Transports

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

CROSS REFERENCES:

Prehospital Care Manual:

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DOCUMENTATION OF PREHOSPITAL CARE**

(EMT, PARAMEDIC, MICN)
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 that results in patient contact.

POLICY:

- I. EMS Record Completion – Paramedic/EMT Personnel

EFFECTIVE DATE: 06-25-74

PAGE 1 OF 5

REVISED: 04-01-24

SUPERSEDES: 04-01-21

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 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.
- 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.
 - 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.
 - 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.

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.

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.
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.

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 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 Provider Code /Unit
 - l. Specialty Care Destination
 - m. Receiving Facility
4. MCI forms are maintained at the EMS Agency. For additional forms, contact the Base Coordinator via email.
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.
6. One standard Base Hospital Form or one EMS Agency-approved MCI Base Hospital Form must be completed for each ALS patient.
7. BLS patients who are reported to the base and transported to the base hospital or another receiving facility should be documented on an MCI Base Hospital Form for tracking purposes. These patients do not need to be entered into the TEMIS database.
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.
- B. Making substantive changes (documentation of additional medications, defibrillation attempts, pertinent comments, complaints, etc.) to the EMS Record:

1. 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.

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 – COMMITTEE ASSIGNMENT

REFERENCE NO. 202.1
 (ATTACHMENT A)

REFERENCE NO. 606, *Documentation of Prehospital Care*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee	4/8/26	4/8/26	
	Provider Agency Advisory Committee	4/15/26	4/15/26	
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other: Southern California Ambulance Association (SCAA)			

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

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

REFERENCE NO. 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			

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

REFERENCE NO. 202.2
 (ATTACHMENT B)

	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			

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

REFERENCE NO. 202.2
(ATTACHMENT B)

	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.			

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)
REFERENCE NO. 607

SUBJECT: **ELECTRONIC SUBMISSION OF
PREHOSPITAL DATA**

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 HIPAA 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, as well as private advanced life support (ALS) providers, shall submit data electronically to the EMS Agency, which meets the LA-EMS NEMSIS Data Dictionary requirements.

POLICY:

- I. Provider Agency Responsibilities
 - A. Prior to implementation of an Electronic Data System
 1. Electronic Data Submission Plan

EFFECTIVE DATE: 12-01-09
REVISED: 01-01-24
SUPERSEDES: 04-01-21

PAGE 1 OF 4

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

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 that results in patient contact.
 - 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

POLICY REVIEW – COMMITTEE ASSIGNMENT

REFERENCE NO. 202.1
 (ATTACHMENT A)

REFERENCE NO. 607, *Electronic Submission of Prehospital Data*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Base Hospital Advisory Committee	4/8/26	4/8/26	
	Provider Agency Advisory Committee	4/15/26	4/15/26	Revised to align with the changes made in Reference 606 Documentation of Prehospital Care.
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
Other: Southern California Ambulance Association (SCAA)				

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

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

REFERENCE NO. 202.2
(ATTACHMENT B)

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

SECTION	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
Principle 1	Corrected the acronym for Health Insurance Portability and Accountability Act (HIPAA)	R. Ower 5/6/2026		
Principle 5	Revised to meet upcoming ALS ePCR data submission requirements for private providers.			
Policy I, A. 1. c	Revised to reflect that an EMS record must be completed for every EMS response that results in patient contact.	PAAC 4/15/2026	Revised to align with the changes made in Reference 606 Documentation of Prehospital Care.	

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

REFERENCE NO. 703

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

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

POLICY:

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

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

EFFECTIVE: 01-01-78

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REVISED: 04-01-26

SUPERSEDES: 1-01-25

APPROVED: _____

Director, EMS Agency

Medical Director, EMS Agency

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

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

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

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

CROSS REFERENCES:

Prehospital Care Manual:

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

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

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

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

POLICY:

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

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

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

PAGE 1 OF 4

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

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

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

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

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

CROSS REFERENCES:

Prehospital Care Manual:

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC, MICN)
REFERENCE NO. 704

SUBJECT: **ASSESSMENT UNIT INVENTORY**

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

PRINCIPLE:

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

POLICY:

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

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

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

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APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

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

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

REFERENCE NO. 706

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

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

POLICY:

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

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

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

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APPROVED: _____
Director, EMS Agency

APPROVED: _____
Medical Director, EMS Agency

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

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

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

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

CROSS REFERENCES:

Prehospital Care Manual:

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

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

REFERENCE NO. 202.2
(ATTACHMENT B)

REFERENCE NOS. 703, 703.1, 704, 706

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

EFFECTIVE: 03-31-97

REVISED: 10-01-25

SUPERSEDES: 04-01-25

PAGE 1 OF 2

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

REFERENCE NO. 202.2
 (ATTACHMENT B)

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

Los Angeles County Emergency Medical Services Agency
AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY PROVIDER
Time Period January 1, 2026 through March 31, 2026

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

EMS Provider Agency	Code	Total # of records*	2026 Q1								2025 Q1	
			≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	90th percentile (hh:mm:ss)
Alhambra Fire Department	AH	1,015	974	96%	33	3%	8	0.8%			00:19:00	00:16:00
Arcadia Fire Department	AF	808	661	82%	113	14%	31	4%	3	0.4%	00:39:00	00:33:00
Avalon Fire Department	AV	55	54	98%			1	2%			00:06:00	00:06:10
Beverly Hills City Fire Department	BH	728	515	71%	169	23%	40	5%	4	0.5%	00:49:00	00:55:00
Burbank Fire Department	BF	1,661	1,499	90%	150	9%	10	0.6%	2	0.1%	00:30:00	00:37:00
Compton Fire Department^	CM											00:12:00
Culver City Fire Department	CC	954	746	78%	172	18%	36	4%			00:43:00	00:45:00
Downey Fire Department	DF	1,572	1,318	84%	189	12%	57	4%	8	0.5%	00:39:00	01:31:00
El Segundo Fire Department	ES	365	302	83%	53	15%	9	2%	1	0.3%	00:41:00	00:32:00
Glendale Fire Department	GL	2,838	2,375	84%	356	13%	95	3%	12	0.4%	00:38:00	00:41:00
La Habra Heights Fire Department^	LH											00:24:00
La Verne Fire Department	LV	643	544	85%	67	10%	27	4%	5	0.8%	00:43:00	00:40:00
LACoFD^	CF	51	50	98%			1	2%			00:16:00	00:16:51
LAFD	CI	47,801	41,192	86%	5,068	11%	1,363	3%	178	0.4%	00:35:17	00:39:30
Long Beach Fire Department	LB	6,886	5,905	86%	613	9%	251	4%	117	2%	00:40:00	00:50:00
Los Angeles County Sheriff's Department	CS	27	27	100%							00:15:00	00:15:00
Manhattan Beach Fire Department	MB	329	296	90%	27	8%	6	2%			00:31:00	00:35:00
Monrovia Fire Department^	MF											00:16:00
Montebello Fire Department^	MO											00:15:00
Monterey Park Fire Department	MP	802	792	99%	9	1%	1	0.1%			00:12:00	00:11:00
Pasadena Fire Department	PF	2,606	2,331	89%	236	9%	36	1%	3	0.1%	00:31:00	00:29:00
Redondo Beach Fire Department^	RB											06:27:48
San Gabriel Fire Department	SG	332	322	97%	8	2%	2	0.6%			00:15:00	00:16:00
San Marino Fire Department	SA	176	157	89%	14	8%	5	3%			00:31:00	00:30:00
Santa Fe Springs Fire Rescue^	SS											00:05:00
Santa Monica Fire Department^	SM											00:20:00
Sierra Madre City Fire Department	SI	175	139	79%	27	15%	9	5%			00:46:00	00:41:00
South Pasadena Fire Department	SP	268	243	91%	20	7%	4	1%	1	0.4%	00:30:00	00:27:00
Torrance Fire Department	TF	2,195	1,668	76%	396	18%	110	5%	21	1%	00:47:13	00:53:07
West Covina Fire Department	WC	1,190	892	75%	244	21%	50	4%	4	0.3%	00:46:00	00:35:00
American Medical Response	AR	15,100	12,980	86%	1,583	10%	448	3%	89	0.6%	00:35:46	00:59:31
Falck Mobile Health Corp. (Care Ambulance)	CA	24,875	16,937	68%	5,445	22%	2,031	8%	462	2%	01:00:02	01:19:45
Westmed Ambulance Inc. (McCormick Ambulance)	WM	17,118	12,216	71%	3,377	20%	1,181	7%	344	2%	00:56:06	01:10:50
TOTAL ALL PROVIDERS		130,570	105,135	81%	18,369	14%	5,812	4%	1,254	1%	00:43:48	00:55:35

* Meets California APOT reporting criteria

^ Utilizes contracted ambulances for transport

Los Angeles County Emergency Medical Services Agency
AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL
Time Period January 1, 2026 through March 31, 2026

APOT Standard: within 30 minutes, 90% of the time											
HOSPITAL	Total # of records*	2026 Q1								2025 Q1	
		≤30:00min	30:01 - 60:00min	60:01 - 120:00min	>120:00min	90th percentile (hh:mm:ss)	90th percentile (hh:mm:ss)				
ANTELOPE VALLEY - NEWHALL REGION											
Antelope Valley Medical Center	5,748	5,100	89%	506	9%	128	2%	14	0.2%	0:31:31	0:58:20
Henry Mayo Newhall Memorial Hospital	3,847	3,553	92%	238	6%	51	1%	5	0.1%	0:26:44	0:37:04
Palmdale Regional Medical Center	3,246	2,875	89%	303	9%	62	2%	6	0.2%	0:32:00	0:53:58
ANTELOPE VALLEY TOTAL	12,841	11,528	90%	1,047	8%	241	2%	25	0.2%	0:30:18	0:51:09
SAN FERNANDO VALLEY REGION											
Adventist Health Glendale	2,049	1,632	80%	315	15%	84	4%	18	0.9%	0:42:37	0:43:00
Dignity Health - Glendale Memorial Hospital & Health Center	1,629	1,424	87%	167	10%	38	2%			0:33:00	0:35:55
Dignity Health - Northridge Hospital Medical Center	4,177	3,595	86%	429	10%	134	3%	19	0.5%	0:35:03	0:31:52
Encino Hospital Medical Center	485	447	92%	24	5%	12	2%	2	0.4%	0:24:37	0:38:12
Kaiser Foundation Hospital - Panorama City	822	746	91%	71	9%	5	0.6%			0:29:28	0:33:53
Kaiser Foundation Hospital - Woodland Hills	741	663	89%	66	9%	12	2%			0:30:27	0:50:14
Mission Community Hospital	1,016	911	90%	89	9%	15	1%	1	0.1%	0:30:17	0:29:01
Olive View-UCLA Medical Center	944	840	89%	73	8%	26	3%	5	0.5%	0:31:14	0:28:25
Pacifica Hospital of the Valley	717	684	95%	26	4%	6	0.8%	1	0.1%	0:22:56	0:16:32
Providence Cedars-Sinai Tarzana Medical Center	1,213	1,084	89%	108	9%	19	2%	2	0.2%	0:30:15	0:38:46
Providence Holy Cross Medical Center	1,688	1,547	92%	101	6%	31	2%	9	0.5%	0:27:07	0:23:59
Providence Saint Joseph Medical Center	3,690	3,305	90%	356	10%	28	0.8%	1	0.0%	0:30:21	0:41:00
Sherman Oaks Hospital	1,393	1,260	90%	103	7%	25	2%	5	0.4%	0:29:42	0:30:45
UCLA West Valley Medical Center	1,629	1,374	84%	222	14%	30	2%	3	0.2%	0:34:19	0:57:54
USC Verdugo Hills Hospital	734	582	79%	101	14%	44	6%	7	1%	0:50:05	0:42:00
Valley Presbyterian Hospital	1,504	1,242	83%	168	11%	75	5%	19	1%	0:46:09	0:29:31
SAN FERNANDO VALLEY TOTAL	24,431	21,336	87%	2,419	10%	584	2%	92	0.4%	0:33:18	0:37:28
SAN GABRIEL VALLEY REGION											
Alhambra Hospital Medical Center	694	663	96%	24	3%	7	1%			0:21:16	0:19:00
Emanate Health Foothill Presbyterian Hospital	1,348	835	62%	374	28%	114	8%	25	2%	1:00:55	1:42:39
Emanate Health Inter-Community Hospital	1,248	765	61%	353	28%	111	9%	19	2%	1:01:00	1:10:35
Emanate Health Queen of the Valley Hospital	2,354	1,351	57%	685	29%	255	11%	63	3%	1:09:00	0:59:36
Garfield Medical Center	946	891	94%	36	4%	19	2%			0:19:33	0:19:33
Greater El Monte Community Hospital	864	597	69%	176	20%	75	9%	16	2%	1:00:40	1:18:28
Huntington Hospital	4,076	3,635	89%	376	9%	61	1%	4	0.1%	0:31:37	0:30:48
Kaiser Foundation Hospital - Baldwin Park	1,237	963	78%	231	19%	37	3%	6	0.5%	0:40:50	1:43:34
Monterey Park Hospital	407	388	95%	11	3%	7	2%	1	0.2%	0:19:00	0:21:00
Pomona Valley Hospital Medical Center	3,798	2,741	72%	783	21%	226	6%	48	1%	0:51:00	0:57:15
San Dimas Community Hospital	791	614	78%	113	14%	47	6%	17	2%	0:54:52	1:06:00
San Gabriel Valley Medical Center	710	596	84%	71	10%	39	5%	4	0.6%	0:39:43	0:43:11
USC Arcadia Hospital	2,768	1,895	68%	609	22%	222	8%	42	2%	0:58:24	0:57:47
SAN GABRIEL VALLEY TOTAL	21,241	15,934	75%	3,842	18%	1,220	6%	245	1%	0:50:18	0:59:14

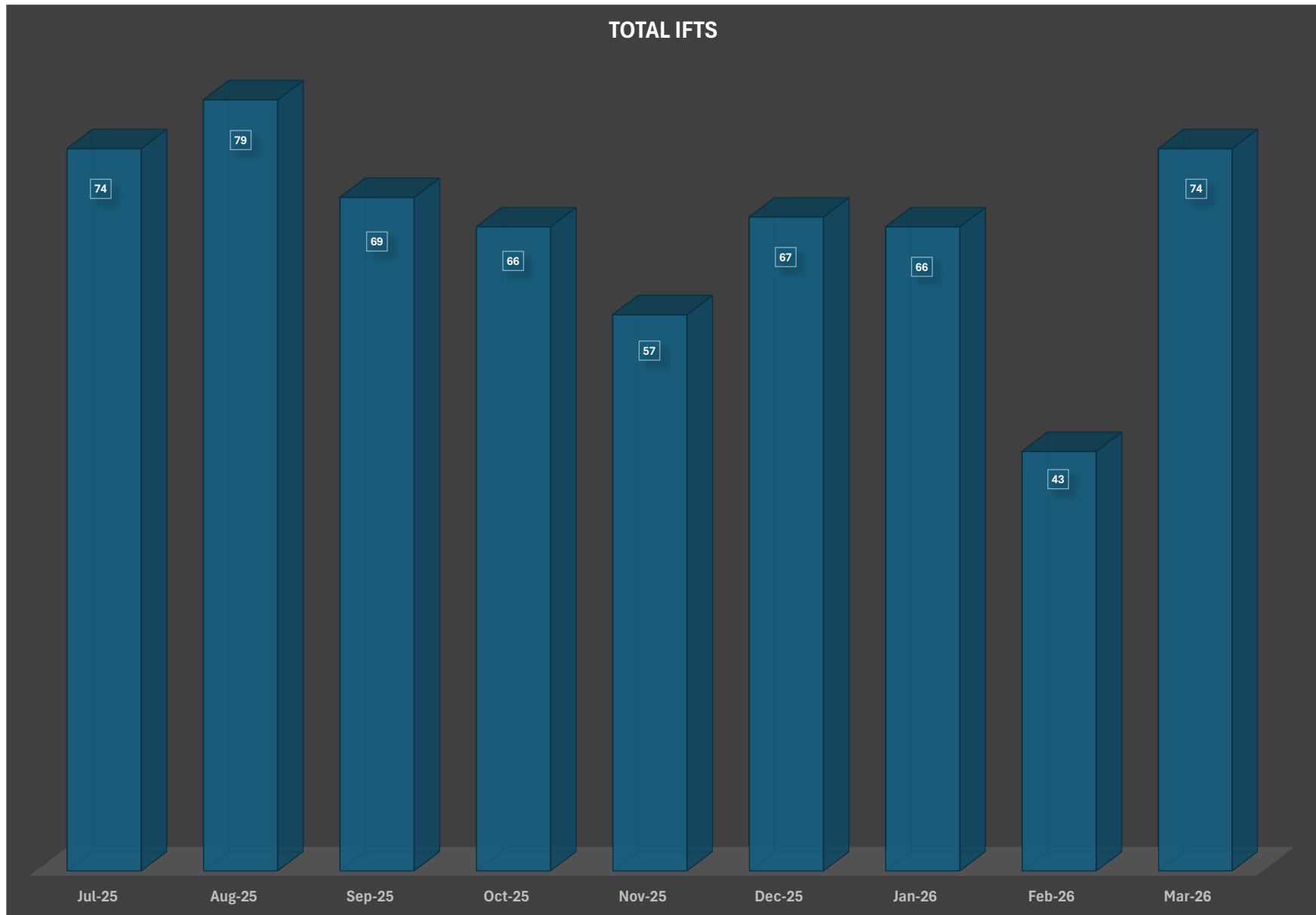
Los Angeles County Emergency Medical Services Agency
AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL
Time Period January 1, 2026 through March 31, 2026

APOT Standard: within 30 minutes, 90% of the time											
HOSPITAL	Total # of records*	2026 Q1								2025 Q1	
		≤30:00min	30:01 - 60:00min	60:01 - 120:00min	>120:00min	90th percentile (hh:mm:ss)	90th percentile (hh:mm:ss)				
EAST REGION											
Adventist Health White Memorial Montebello	955	580	61%	259	27%	95	10%	21	2%	1:06:47	1:14:53
Coast Plaza Hospital	780	669	86%	89	11%	21	3%	1	0.1%	0:34:32	1:27:28
Kaiser Foundation Hospital - Downey	1,756	1,307	74%	363	21%	83	5%	3	0.2%	0:46:40	2:10:45
Norwalk Community Hospital	343	255	74%	53	15%	30	9%	5	1%	1:00:31	0:58:04
PIH Health Downey Hospital	2,006	1,499	75%	351	17%	135	7%	21	1%	0:53:00	1:33:57
PIH Health Whittier Hospital	2,504	1,518	61%	713	28%	248	10%	25	1%	1:02:12	1:01:24
UCI Health - Lakewood	1,488	851	57%	310	21%	218	15%	109	7%	1:43:55	2:18:36
Whittier Hospital Medical Center	946	872	92%	67	7%	7	0.7%			0:26:32	0:58:49
EAST REGION TOTAL	10,778	7,551	70%	2,205	20%	837	8%	185	2%	0:58:04	1:32:36
METRO REGION											
Adventist Health White Memorial	727	489	67%	119	16%	92	13%	27	4%	1:16:29	1:05:23
Cedars-Sinai Medical Center	3,440	2,373	69%	798	23%	237	7%	32	1%	0:53:32	1:00:00
Children's Hospital Los Angeles	294	292	99%	2	0.7%					0:17:06	0:16:40
Community Hospital of Huntington Park	1,361	940	69%	259	19%	127	9%	35	3%	1:08:45	1:40:54
Dignity Health - California Hospital Medical Center	1,833	1,441	79%	267	15%	112	6%	13	0.7%	0:49:22	0:53:12
East Los Angeles Doctors Hospital	990	826	83%	122	12%	35	4%	7	0.7%	0:38:07	0:45:19
Hollywood Presbyterian Medical Center	1,728	1,354	78%	263	15%	98	6%	13	0.8%	0:48:26	0:54:23
Kaiser Foundation Hospital - Los Angeles	1,385	1,077	78%	232	17%	71	5%	5	0.4%	0:47:54	0:43:03
Los Angeles General Medical Center	5,858	5,344	91%	433	7%	73	1%	8	0.1%	0:29:02	0:30:44
PIH Health Good Samaritan Hospital	2,605	1,988	76%	482	19%	123	5%	12	0.5%	0:45:15	0:50:38
METRO REGION TOTAL	20,221	16,124	80%	2,977	15%	968	5%	152	0.8%	0:44:58	0:51:07
WEST REGION											
Cedars-Sinai Marina Del Rey Hospital	860	571	66%	211	25%	73	8%	5	0.6%	0:56:00	0:49:13
Kaiser Foundation Hospital - West LA	1,614	1,401	87%	178	11%	33	2%	2	0.1%	0:34:10	0:56:59
Providence Saint John's Health Center	1,568	1,080	69%	324	21%	146	9%	18	1%	1:02:08	1:05:43
Ronald Reagan UCLA Medical Center	1,453	1,307	90%	116	8%	24	2%	6	0.4%	0:30:07	0:38:02
Santa Monica-UCLA Medical Center & Orthopaedic Hospital	437	301	69%	76	17%	46	11%	14	3%	1:09:00	1:22:40
Southern California Hospital at Culver City	739	570	77%	134	18%	31	4%	4	0.5%	0:43:40	0:48:49
WEST REGION TOTAL	6,671	5,230	78%	1,039	16%	353	5%	49	0.7%	0:46:05	0:57:00
SOUTH REGION											
Catalina Island Medical Center	55	54	98%			1	2%			0:06:00	0:06:10
Centinela Hospital Medical Center	7,169	5,952	83%	1,083	15%	124	2%	10	0.1%	0:36:19	0:44:41
College Medical Center	675	604	89%	41	6%	24	4%	6	0.9%	0:31:00	0:48:00
Dignity Health - St. Mary Medical Center	2,972	2,587	87%	285	10%	85	3%	15	0.5%	0:36:00	0:50:00
Harbor-UCLA Medical Center	3,011	2,295	76%	395	13%	227	8%	94	3%	1:02:37	1:06:57
Kaiser Foundation Hospital - South Bay	1,552	1,302	84%	192	12%	53	3%	5	0.3%	0:36:45	0:53:42
Martin Luther King, Jr. Community Hospital	3,194	3,012	94%	154	5%	26	0.8%	2	0.1%	0:24:06	0:41:15

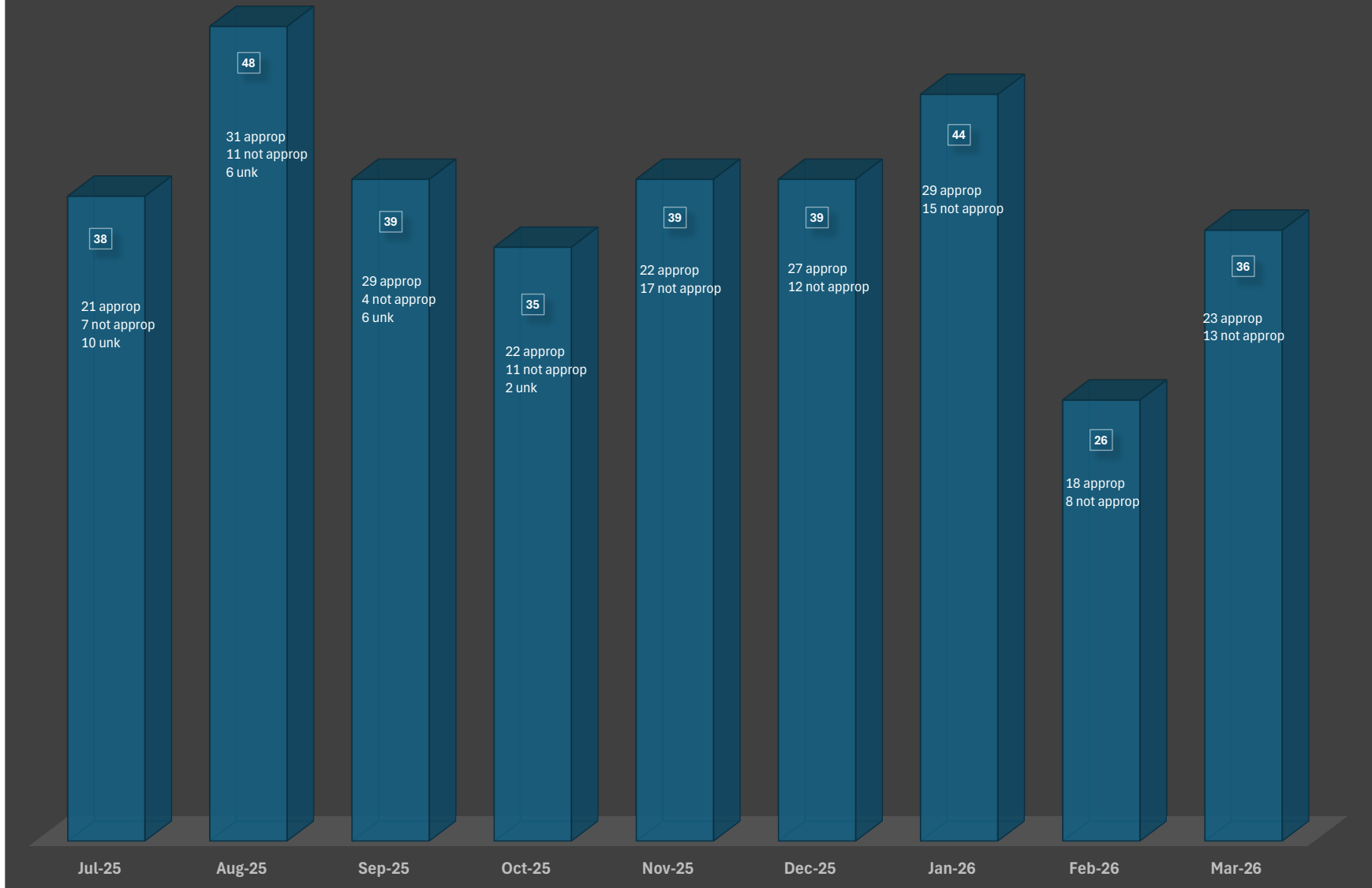
Los Angeles County Emergency Medical Services Agency
AMBULANCE PATIENT OFFLOAD TIME (APOT) REPORT BY 9-1-1 RECEIVING HOSPITAL
Time Period January 1, 2026 through March 31, 2026

APOT Standard: within 30 minutes, 90% of the time											
HOSPITAL	Total # of records*	2026 Q1								2025 Q1	
		≤30:00min		30:01 - 60:00min		60:01 - 120:00min		>120:00min		90th percentile (hh:mm:ss)	90th percentile (hh:mm:ss)
Memorial Hospital Of Gardena	2,942	2,301	78%	427	15%	164	6%	50	2%	0:48:46	0:48:16
MemorialCare Long Beach Medical Center	3,066	2,607	85%	245	8%	114	4%	100	3%	0:45:00	0:52:00
Providence Little Company of Mary Medical Center San Pedro	993	863	87%	106	11%	22	2%	2	0.2%	0:33:37	0:44:59
Providence Little Company of Mary Medical Center Torrance	2,901	2,151	74%	557	19%	165	6%	28	1%	0:49:51	1:00:25
St. Francis Medical Center	3,233	1,635	51%	914	28%	503	16%	181	6%	1:31:18	1:44:15
Torrance Memorial Medical Center	2,624	2,069	79%	441	17%	101	4%	13	0.5%	0:42:16	0:59:07
SOUTH REGION TOTAL	34,387	27,432	80%	4,840	14%	1,609	5%	506	1%	0:45:54	0:58:00
ALL HOSPITALS	130,570	105,135	81%	18,369	14%	5,812	4%	1,254	1%	0:43:48	0:55:35

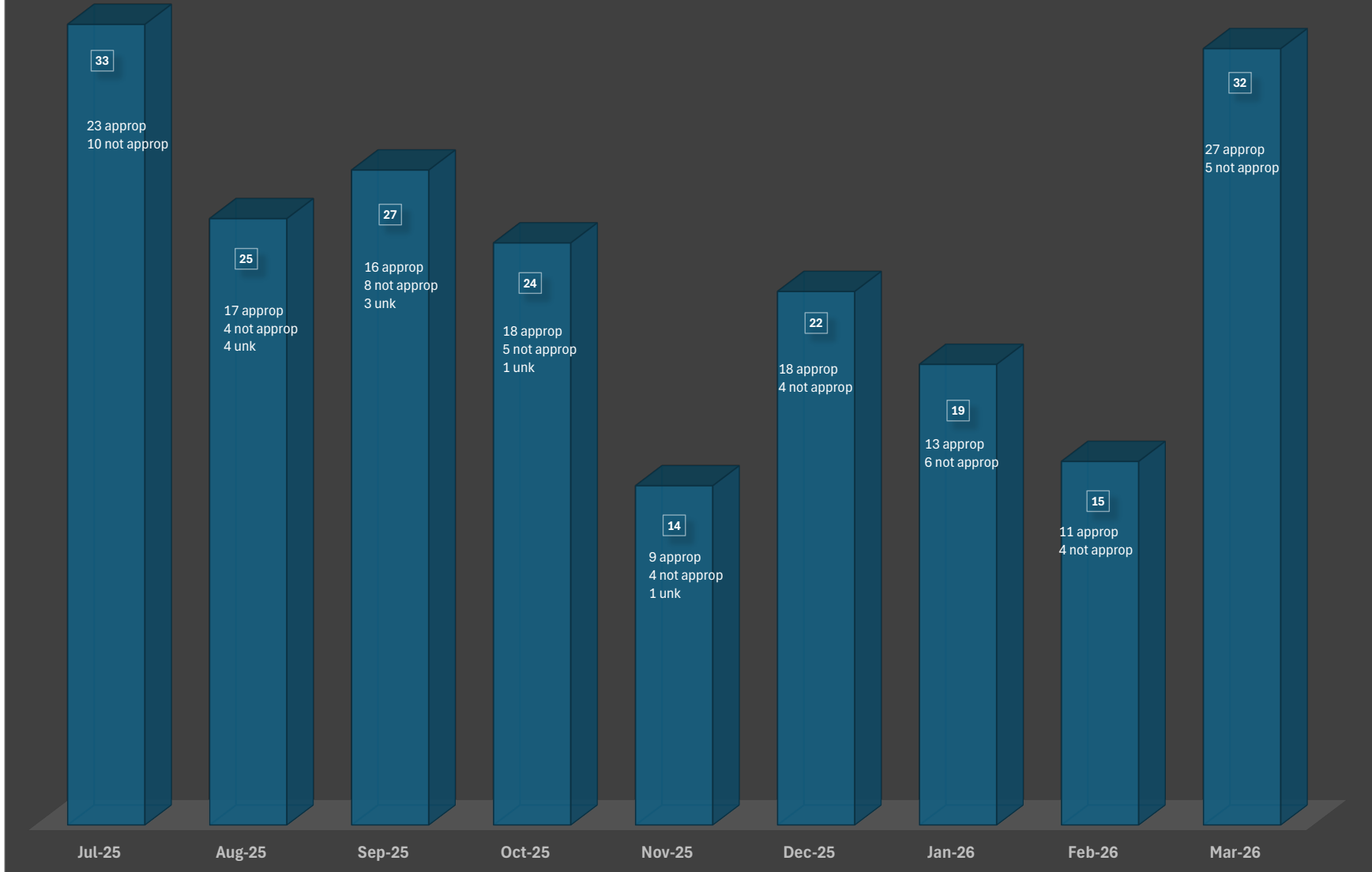
* Meets California APOT reporting criteria



STEMI IFTS

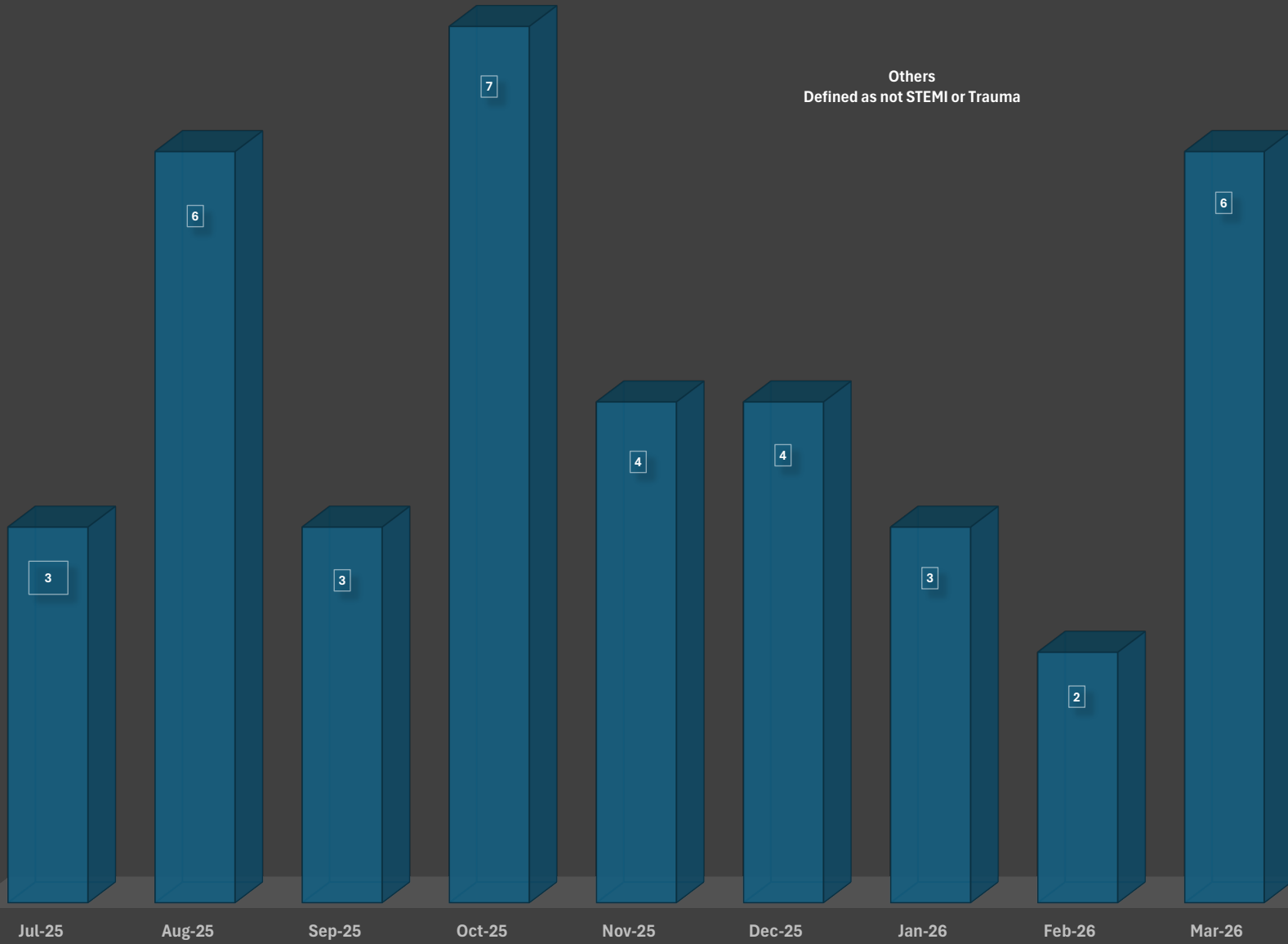


TRAUMA IFTS



OTHERS

Others
Defined as not STEMI or Trauma



EMERGENCY MEDICAL SERVICES AUTHORITY

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



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

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

Background

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

APOT Audit Tool Portal – Enhancements

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

APOT Audit Tool Portal – Utilization Summary

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

Hospital APOT Reduction Plan Compliance

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

Summary APOT Data for January 2026

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

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

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

Approach to Bi-Weekly Meetings

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

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

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

Exceedance of Ambulance Patient Offload (APOT) Standards – Detail

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

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

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

Local EMS Agency APOT Standards (For January 2026)

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

Hospitals Exceeding Their Local APOT Standard (1 of 3)

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

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

Hospitals Exceeding Their Local APOT Standard (2 of 3)

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

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

Hospitals Exceeding Their Local APOT Standard (3 of 3)

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

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



COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION
 10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
 (562) 378-1610 FAX (562) 941-5835
<http://ems.dhs.lacounty.gov>

March 3, 2026

**LOS ANGELES COUNTY
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the Emergency Physicians (CAL-ACEP)

VACANT

Public Member (5th District)

EXECUTIVE DIRECTOR

Richard Tadeo, RN

(562) 378-1610

RTadeo@dhs.lacounty.gov

COMMISSION LIAISON

Denise Watson, BSB

(562) 378-1606

DWatson@dhs.lacounty.gov

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

RETIREMENT FROM COUNTY SERVICE EFFECTIVE MARCH 27, 2026

Dear Commissioners,

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

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

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

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

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

Sincerely,

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

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



**EMERGENCY MEDICAL
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LOS ANGELES COUNTY

**Los Angeles County
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Richard Tadeo, RN
Director

Nichole Bosson, MD, MPH
Medical Director

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

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

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

March 11, 2026

MEMORANDUM

TO: Distribution

FROM: Nichole Bosson, MD, MPH
Medical Director, LA County EMS Agency

SUBJECT: Pediatric Prehospital Airway Resuscitation Trial (Pedi-PART) Study Closure

This is to notify you that the Pediatric Prehospital Airway Resuscitation Trial (Pedi-PART) will end enrollment in Los Angeles County on Tuesday, March 17, 2026 at 23:59.

LA County EMS Provider Agencies began enrollment in Pedi-PART Stage I in June of 2024. Stage I of the trial compared an airway management strategy of primary bag-mask ventilation (BVM) to BVM with early supraglottic airway (SGA) placement in an even-odd day assignment. Based on current and projected nationwide enrollments, the decision has been made to transition to preparing for Stage II of the trial. Stage II will compare strategies of primary SGA vs primary endo-tracheal intubation (ETI) following BVM. LA County EMS Provider Agencies will not participate in Stage II of the trial.

Importantly, LA County has enrolled more than 400 patients in this important trial and contributed approximately one third of the total study enrollments nationwide. These data will be incredibly important to understand prehospital pediatric airway management and improve future patient outcomes.

Analysis of clinical outcomes from Stage I is ongoing. No conclusions can be drawn regarding study outcomes until these analyses are complete.

Importantly, the decision to conclude Stage I is not related to participant outcomes and no safety concerns have been identified.

Paramedics will continue to treat patients per current treatment protocols. At the conclusion of the trial, paramedics should provide airway management via BVM, SGA, and ETI when indicated and according to LA County scope of practice, for all patient ages. We will collect follow up outcomes on enrolled patients, but no new patients should be enrolled or randomized.

Please remove all study materials, QBERRT, and RALPH devices from the ALS units and work stations. Also remove any reference materials specific to Pedi-PART from tablets and other electronic devices. RALPH devices should be returned to the EMS Agency at your earliest convenience.

We appreciate all of you for your valuable contributions to this enormous countywide effort, which will contribute to improved pediatric patient outcomes. A huge thank you goes to all the paramedics who participated and provided the excellent patient care to these patients.



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

If you have any questions please contact me at nbosson@dhs.lacounty.gov or 562-378-1615.

c: Director, EMS Agency
Fire Chiefs, Public Provider Agencies
Medical Directors, Public Provider Agencies
Paramedic Coordinators, Public Provider Agencies
EMS Educators, Public Provider Agencies
Medical Directors, Ambulance Companies
Paramedic Coordinators, Ambulance Companies
Director of Operations, EOA Provider Agencies
Medical Director, Paramedic Base Hospitals
Prehospital Care Coordinator, Paramedic Base Hospitals
Chief Executive Officers, 9-1-1 Receiving Hospitals
ED Managers, 9-1-1 Receiving Centers
Pediatric Liaison Nurses, Emergency Departments Approved for Pediatrics
Pediatric Medical Directors, Emergency Departments Approved for Pediatrics
Hospital Association of Southern California
California EMS Authority



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

March 24, 2026

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Fifth District

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**

Richard Tadeo, RN
Director

Nichole Bosson, MD, MPH
Medical Director

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

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**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 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.)



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Nichole Bosson, MD, MPH
Medical Director

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Santa Fe Springs, CA 90670

Tel: (562) 378-1500
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*"To advance the health of our
communities by ensuring
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disaster medical services."*

March 31, 2026

MEMORANDUM

TO: Distribution

FROM: Nichole Bosson, MD, MPH
Medical Director, LA County EMS Agency

SUBJECT: **EMS Administration of Magnesium Sulfate for Preeclampsia and Eclampsia**

Beginning July 1, 2026, Los Angeles County EMS Treatment Protocols will include magnesium sulfate for the management of preeclampsia and eclampsia. This is in alignment with recent [EMS Model Guidelines](#) developed by the National Association of EMS Physicians in collaboration with the American College of Obstetrics and Gynecology. Paramedic training is currently ongoing.

Paramedics will administer magnesium sulfate via the intravenous or intramuscular route to patients who are pregnant at ≥ 20 -weeks gestation and patients up 6 weeks postpartum with preeclampsia or eclampsia. This addition to the treatment protocols allows for the timely care of obstetric emergencies in the prehospital setting.

Kindly share this information with your emergency department and, if applicable, perinatal services clinicians. If you have any questions, please contact me at nbosson@dhs.lacounty.gov or 562-378-1615.

Attachments:
Treatment Protocols 1217 and 1217-P

c:

- Director, EMS Agency
- Chief Executive Officers, 9-1-1 Receiving Hospitals
- Chief Medical Officers, 9-1-1 Receiving Hospitals
- ED Managers, 9-1-1 Receiving Centers
- Hospital Association of Southern California



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

Base Hospital Contact: Required for vaginal bleeding at > 20 weeks pregnancy, newborn delivery, or eclampsia. ①②③

1. Do not delay transport for treatment if suspected eclampsia; Manage delivery en route
2. Assess airway and initiate basic and/or advanced airway maneuvers prn (*MCG 1302*)
3. Administer **Oxygen** prn (*MCG 1302*)
4. Establish vascular access (*MCG 1375*)
Vascular access should not take precedence over controlled delivery or emergency transport
5. For poor perfusion (*MCG 1355*):
Normal Saline 1L IV rapid infusion
Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops
6. If crown is showing with amniotic sac intact, pinch sac and twist the membrane to rupture

BREECH DELIVERY

7. Support presenting part and allow newborn to deliver
8. If head does not deliver, place gloved hand inside mother and form “V” formed with fingers by baby’s face to provide an opening for the airway

PROLAPSED CORD

9. Manually elevate presenting fetal part off the umbilical cord; maintain elevation of the presenting part until transfer of care ④
10. Wrap cord with moist gauze

NUCHAL CORD

11. If nuchal cord is loose attempt slipping the cord over the head prior to delivery
12. If the cord is too tight to easily slip over the head, clamp the cord in two places 1 inch apart and cut the cord with scissors

SHOULDER DYSTOCIA

13. Perform McRoberts maneuver with suprapubic pressure in order to deliver the anterior shoulder ⑤

ELEVATED BLOOD PRESSURE / PREECLAMPSIA (≥20 weeks pregnant to 6 weeks postpartum) 6 7

14. For all patients with SBP ≥140mmHg or DBP ≥90mmHg:

Check blood pressure at least every 5 minutes

15. For preeclampsia:
SBP ≥140 or DBP ≥90mmHg and any of following: Severe headache, blurred vision, or upper abdominal pain, **OR**
SBP ≥160 or DBP ≥110mmHg, regardless of symptoms

Magnesium Sulfate 4g in 100mL Normal Saline or Sterile Water IV, infuse over 20 minutes
Consider **Magnesium Sulfate 5g (10mL) IM** mixed with **lidocaine 2% 1mL** in each buttock for a total of 10g (20mL), if vascular access cannot be established 7

SEIZURE / ECLAMPSIA (≥20 weeks pregnant to 6 weeks postpartum) 8 9

16. Place patient in recovery position or displace the uterus leftward 10

17. For active seizure:

Midazolam 10mg (2mL) IM/IN, or

Midazolam 5mg (1mL) IV/IO, if existing vascular access, repeat x1 in 2 min prn

Maximum total dose prior to Base contact 10mg all routes

18. For all eclampsia also administer:

Magnesium Sulfate 4g in 100mL Normal Saline or Sterile Water IV, infuse over 20 minutes
or,

Magnesium Sulfate 5g (10mL) IM mixed with **lidocaine 2% 1mL** in each buttock for a total of 10g (20mL), if vascular access cannot be established 7 9

POST-PARTUM HEMORRHAGE 11

19. Massage the mother's lower abdomen (fundal massage)

20. Establish 2 IVs, large bore catheter (16g or 18g) preferred

21. Administer **Normal Saline 1L IV rapid infusion**

Repeat x1 for ongoing hemorrhage and/or poor perfusion

Reassess after each 250mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

22. For patients within 3 hours post-delivery with ongoing bleeding and one or more of the following:

Systolic blood pressure (SBP) <90 mmHg, OR

Heart rate > SBP, OR

Estimated blood loss >500mL

Tranexamic Acid (TXA) 1 gram in 50 or 100mL Normal Saline IV/IO, infuse over 10 minutes

CARDIAC ARREST (\geq 20 weeks pregnant) 8

23. Initiate resuscitation and treat in conjunction with *TP 1210, Cardiac Arrest* 12
CONTACT BASE to discuss early transport 13
24. Displace the uterus leftward in conjunction with chest compressions 14

SPECIAL CONSIDERATIONS

- ① This protocol was intended for complications of pregnancy at the time of delivery; if patient is known to be pregnant and has complaints not associated with labor or delivery treat per *TP 1202, General Medical or most applicable protocol*.
- ② If the patient has vaginal bleeding associated with known pregnancy > 20 weeks, Contact Base and communicate signs and symptoms so that the receiving hospital can pre-notify OB consultants as needed.
- ③ Any delivery after the first trimester (12 weeks) should be considered childbirth for the purposes of this treatment protocol and paramedics should contact Base to discuss the management and transport. In general, delivery prior to 20 weeks gestation is nonviable and does not require resuscitation. However, dates can be incorrectly estimated, therefore, Base Contact is strongly encouraged. Any *potentially viable birth* should be resuscitated in the field and transported to a perinatal center that is also an EDAP (with a NICU if ≤34 weeks gestation). Births prior to 20 weeks do not necessarily require specialty center care and can be transported to the MAR.
- ④ In addition to manually elevating the presenting part from the umbilical cord, placing the patient in Trendelenburg position during transport can help to elevate the presenting part off the cord to maintain blood flow to the fetus. Do not attempt to push a prolapsed cord back in.
- ⑤ Shoulder dystocia is inability to deliver the anterior shoulder, which usually occurs in large newborns. If delivery fails to progress after head delivers, hyperflex mother's hips tightly in knee to chest position (McRoberts maneuver) and apply firm suprapubic pressure in attempt to dislodge anterior shoulder.
- ⑥ Elevated blood pressure in a pregnant or recently post-partum patient (up to 6 weeks) is a sign of potential preeclampsia. Treat patients that meet criteria for preeclampsia with Magnesium Sulfate immediately. All patients who are ≥ 20 weeks pregnant or ≤ 6 weeks post-partum with hypertension (SBP ≥140mmHg or DBP ≥90mmHg) should be transported to a Perinatal Center for evaluation.
- ⑦ There are no data on intraosseous administration of Magnesium Sulfate in the setting of preeclampsia or eclampsia. If IV access cannot be obtained, IM administration is preferred over IO.
- ⑧ If gestational age is unknown, it can be estimated by fundal height. Fundal height at the umbilicus or above is consistent with pregnancy ≥20 weeks.
- ⑨ Eclampsia is characterized by new-onset tonic-clonic, focal, or multifocal seizures in the absence of other causative conditions such as hypoglycemia or drug/alcohol withdrawal in patients ≥ 20 weeks pregnant up to 6 weeks postpartum. Patients with eclampsia may or may not be hypertensive and eclamptic seizures may be brief. Treat all eclampsia patients with magnesium sulfate, even if their seizure has stopped.
- ⑩ The recovery position lessens the likelihood of aspiration or other airway complications and allows improved blood return to the heart by shifting the uterus off the inferior vena cava. If the patient must be placed supine (e.g. for airway management or vascular access), ensure displacement of the uterus leftward, either manually or by placing a blanket or sheets below the right hip to rotate the pelvis 20 degrees leftward.

- ⑪ Some bleeding is normal during delivery, typically up to 500mL. Bleeding is reduced with fundal massage after placental delivery, which promotes contraction of the uterus. Post-partum hemorrhage is typically defined as blood loss with signs of poor perfusion and/or cumulative blood loss $\geq 1000\text{mLs}$, however, if despite fundal massage the estimated blood loss is $> 500\text{ mLs}$ and there is ongoing hemorrhage, initiate TXA and fluids concurrently.
- ⑫ Airway management should be prioritized during the resuscitation of a pregnant patient in cardiac arrest. Pregnant patients are more vulnerable to hypoxemia, hypercarbia, and subsequent acidosis due to physiologic changes that occur with pregnancy. Providing adequate oxygenation and ventilation optimizes cardiac arrest resuscitation in particular for pregnant patients.
- ⑬ Pregnant patients are a special population that may benefit from rapid field transport for definitive care. A resuscitative delivery (emergency cesarean) plays a central role in the resuscitation of pregnant patients when accessible shortly after cardiac arrest. The recommended time interval for completion of a resuscitative delivery when cardiac arrest is witnessed in hospital is 5 minutes though studies have reported increased survival when completed within ten minutes of cardiac arrest. Recent data also supports use of extracorporeal cardiopulmonary resuscitation (ECPR) in pregnant or peripartum patients in cardiac arrest not responsive to standard resuscitation.
- ⑭ Manual left lateral uterine displacement alleviates aortocaval compression which improves blood return to the heart, cardiac stroke volume, and cardiac perfusion pressure while chest compressions are being performed. If limited personnel, a blanket or sheets may be placed below the right hip to rotate the pelvis 20 degrees leftward.



Base Hospital Contact: Required for vaginal bleeding at > 20 weeks pregnancy, newborn delivery, or eclampsia. ① ② ③ ④

1. Do not delay transport for treatment if suspected eclampsia; Manage delivery en route
2. Assess airway and initiate basic and/or advanced airway maneuvers prn (MCG 1302)
3. Administer **Oxygen** prn (MCG 1302)
4. Establish vascular access (MCG 1375)
Vascular access should not take precedence over controlled delivery or emergency transport
5. For poor perfusion (MCG 1355):
Normal Saline 20mL/kg IV/IO rapid infusion per MCG 1309
CONTACT BASE for persistent poor perfusion to obtain order for additional **Normal Saline 20mL/kg IV/IO** per MCG 1309
6. If crown is showing with amniotic sac intact, pinch sac and twist the membrane to rupture

BREECH DELIVERY

7. Support presenting part and allow newborn to deliver
8. If head does not deliver, place gloved hand inside mother and form “V” formed with fingers by baby’s face to provide an opening for the airway

PROLAPSED CORD

9. Manually elevate presenting fetal part off the umbilical cord; maintain elevation of the presenting part until transfer of care ⑤
10. Wrap cord with moist gauze

NUCHAL CORD

11. If nuchal cord is loose attempt slipping the cord over the head prior to delivery
12. If the cord is too tight to easily slip over the head, clamp the cord in two places 1 inch apart and cut the cord with scissors

SHOULDER DYSTOCIA

13. Perform McRobert’s maneuver with suprapubic pressure in order to deliver the anterior shoulder ⑥



Treatment Protocol: PREGNANCY COMPLICATION

Ref. No. 1217-P

ELEVATED BLOOD PRESSURE / PREECLAMPSIA (≥20 weeks pregnant to 6 weeks postpartum) 7 8

14. For all patients with SBP ≥140mmHg or DBP ≥90mmHg:

Check blood pressure at least every 5 minutes

15. For preeclampsia:

SBP ≥140 or DBP ≥90mmHg and any of following: Severe headache, blurred vision, or upper abdominal pain, **OR**

SBP ≥160 or DBP ≥110mmHg, regardless of symptoms

Magnesium Sulfate 4g in 100mL Normal Saline or Sterile Water IV, infuse over 20 minutes

Consider **Magnesium Sulfate 5g (10mL) IM** mixed with **lidocaine 2% 1mL** in each buttock for a total of 10g (20mL), if vascular access cannot be established 8

SEIZURE / ECLAMPSIA (≥20 weeks pregnant to 6 weeks postpartum) 9 10

16. Place patient in recovery position or displace the uterus leftward 11

17. For active seizure:

Midazolam 10mg (2mL) IM/IN, or

Midazolam 5mg (1mL) IV/IO, if existing vascular access, repeat x1 in 2 min prn

Maximum total dose prior to Base contact 10mg all routes

18. For all eclampsia also administer:

Magnesium Sulfate 4g in 100mL Normal Saline or Sterile Water IV, infuse over 20 minutes

or,

Magnesium Sulfate 5g (10mL) IM mixed with **lidocaine 2% 1mL** in each buttock for a total of 10g (20mL), if vascular access cannot be established 8 10

POST-PARTUM HEMORRHAGE 12

19. Massage the mother's lower abdomen (fundal massage)

20. Establish 2 IVs, large bore catheter (16g or 18g) preferred

21. **Normal Saline 20mL/kg IV/IO rapid infusion** per [MCG 1309](#)

CONTACT BASE for persistent poor perfusion to obtain order for additional **Normal Saline 20mL/kg IV/IO** per [MCG 1309](#)

CARDIAC ARREST (≥ 20 weeks pregnant) 9

22. Initiate resuscitation and treat in conjunction with [TP 1210, Cardiac Arrest](#) 13

CONTACT BASE to discuss early transport 14

23. Displace the uterus leftward in conjunction with chest compressions 15



SPECIAL CONSIDERATIONS

- ① Pediatric patients who are pregnant must be evaluated for child maltreatment and are at high risk for complications during delivery for the mother and the newborn.
- ② This protocol was intended for complications of pregnancy at the time of delivery; if patient is known to be pregnant and has complaints not associated with labor or delivery treat per [TP 1202-P, General Medical](#) or most applicable protocol.
- ③ If the patient has vaginal bleeding associated with known pregnancy >20 weeks, Contact Base and communicate signs and symptoms so that the receiving hospital can pre-notify OB consultants as needed.
- ④ Any delivery after the first trimester (12 weeks) should be considered childbirth for the purposes of this treatment protocol and paramedics should contact Base to discuss the management and transport. In general, delivery prior to 20 weeks gestation is nonviable and does not require resuscitation. However, dates can be incorrectly estimated, therefore, Base Contact is strongly encouraged. Any *potentially viable birth* should be resuscitated in the field and transported to a perinatal center that is also an EDAP (with a NICU if ≤ 34 weeks gestation). Births prior to 20 weeks do not necessarily require specialty center care and can be transported to the MAR.
- ⑤ In addition to manually elevating the presenting part from the umbilical cord, placing the patient in Trendelenburg position during transport can help to elevate the presenting part off the cord to maintain blood flow to the fetus. Do not attempt to push a prolapsed cord back in.
- ⑥ Shoulder dystocia is inability to deliver the anterior shoulder, which usually occurs in large newborns. If delivery fails to progress after head delivers, hyperflex mother's hips tightly in knee to chest position and apply firm suprapubic pressure in attempt to dislodge anterior shoulder (McRobert's maneuver).
- ⑦ Elevated blood pressure in a pregnant or recently post-partum patient (up to 6 weeks) is a sign of potential preeclampsia. Treat patients that meet criteria for preeclampsia with Magnesium Sulfate immediately. All patients who are ≥ 20 weeks pregnant or ≤ 6 weeks post-partum with hypertension (SBP ≥ 140 mmHg or DBP ≥ 90 mmHg) should be transported to a Perinatal Center for evaluation.
- ⑧ There are no data on intraosseous administration of Magnesium Sulfate in the setting of preeclampsia or eclampsia. If IV access cannot be obtained, IM administration is preferred over IO.
- ⑨ If gestational age is unknown, it can be estimated by fundal height. Fundal height at the umbilicus or above is consistent with pregnancy ≥ 20 weeks.
- ⑩ Eclampsia is characterized by new-onset tonic-clonic, focal, or multifocal seizures in the absence of other causative conditions such as hypoglycemia or drug/alcohol withdrawal in patients ≥ 20 weeks pregnant up to 6 weeks postpartum. Patients with eclampsia may or may not be hypertensive and eclamptic seizures may be brief. Treat all eclampsia patients with magnesium sulfate, even if their seizure has stopped.



Treatment Protocol: PREGNANCY COMPLICATION

Ref. No. 1217-P

- ⑪ The recovery position lessens the likelihood of aspiration or other airway complications and allows improved blood return to the heart by shifting the uterus off the inferior vena cava. If the patient must be placed supine (e.g. for airway management, vascular access, chest compressions, etc.), ensure displacement of the uterus leftward, either manually or by placing a blanket or sheets below the right hip to rotate the pelvis 20 degrees leftward.
- ⑫ Some bleeding is normal during delivery, typically up to 500mL. Bleeding is reduced with fundal massage after placental delivery, which promotes contraction of the uterus. Post-partum hemorrhage is defined as blood loss with signs of poor perfusion and/or cumulative blood loss $\geq 1000\text{mLs}$.
- ⑬ Airway management should be prioritized during the resuscitation of a pregnant patient in cardiac arrest. Pregnant patients are more vulnerable to hypoxemia, hypercarbia, and subsequent acidosis due to physiologic changes that occur with pregnancy. Providing adequate oxygenation and ventilation optimizes cardiac arrest resuscitation in particular for pregnant patients.
- ⑭ Pregnant patients are a special population that may benefit from rapid field transport for definitive care. A resuscitative delivery (emergency cesarean) plays a central role in the resuscitation of pregnant patients when accessible shortly after cardiac arrest. The recommended time interval for completion of a resuscitative delivery when cardiac arrest is witnessed in hospital is 5 minutes though studies have reported increased survival when completed within ten minutes of cardiac arrest. Recent data also supports use of extracorporeal cardiopulmonary resuscitation (ECPR) in pregnant or peripartum patients in cardiac arrest not responsive to standard resuscitation.
- ⑮ Manual left lateral uterine displacement alleviates aortocaval compression which improves blood return to the heart, cardiac stroke volume, and cardiac perfusion pressure while chest compressions are being performed. If limited personnel, a blanket or sheets may be placed below the right hip to rotate the pelvis 20 degrees leftward.

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**Chief
Executive
Office.**

COUNTY OF LOS ANGELES

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, CA 90012
(213) 974-1101 ceo.lacounty.gov

ACTING CHIEF EXECUTIVE OFFICER

Joseph M. Nicchitta

April 6, 2026

To: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell, Chair Pro Tem
Supervisor Lindsey P. Horvath
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Joseph M. Nicchitta 
[Joseph M. Nicchitta \(Apr 3, 2026 19:46:53 PDT\)](#)
Acting Chief Executive Officer

REPORT BACK ON THE ALLOCATION FORMULA FOR ONGOING AND ONE-TIME MEASURE B FUNDING FOR NON-COUNTY TRAUMA HOSPITALS (ITEM NO. 20, AGENDA OF JULY 15, 2025)

On July 15, 2025, the Board of Supervisors (Board) directed the Chief Executive Officer (CEO), in coordination with the Directors of the Department of Health Services (DHS) and the Department of Public Health (DPH) and the Measure B Advisory Board (MBAB), to report back in 90 days with an analysis of the formula utilized to allocate future ongoing and one-time Measure B funding to non-County hospitals and recommend any needs-based changes. A summary of our report and options is below, with additional details in the attachment.

Measure B Background

Measure B was adopted in November 2002 by County voters to levy a small parcel tax on properties in Los Angeles County (County) to support the Countywide system of trauma hospitals (both County and non-County), Emergency Medical Services (EMS), and bioterrorism response activities. Your Board adjusted the Measure B assessment rate in 2008, 2010, 2012, 2022, and 2025.



"To Enrich Lives Through Effective And Caring Service"

Measure B Allocation Methodology

As of July 1, 2025, non-County trauma hospitals were allocated 18.54 percent of the County's total of \$426.8 million in ongoing Measure B funding. The current methodology allocates funding based on several factors including the proportion of patients who are enrolled in Medi-Cal or are underinsured and lack the financial resources to afford necessary medical care. By using this methodology, DHS directly addresses disparities in access to healthcare and targets resources toward populations with the greatest need. DHS and the 13 non-County trauma hospitals have annually reviewed the methodology, which is presented to your Board for approval, then memorialized in the Trauma Center Provisions for Reimbursement Memorandum of Agreement.

Consultation with Measure B Advisory Board

To gain a broader perspective on the impact of potential changes to the allocation methodology for future ongoing and one-time Measure B funding to non-County hospitals, we consulted with all current MBAB members¹. Members expressed substantial concern that re-allocation of the funding to the non-County trauma hospitals to a broader set of non-County hospitals would potentially put at risk the ability of the non-County trauma hospitals to maintain the current level of trauma services within the County. This is due to financial strain from medical costs, heavy reliance on public payer reimbursements that often pay less than the cost to deliver services, and the uncertainty with future federal funding. The consensus is that the current allocation methodology for ongoing funding should remain unchanged.

Options Moving Forward

Option A: Maintain Current Board-Approved Methodology

Given the current state of maintaining hospital operations and the uncertainty over future federal funding, your Board could consider maintaining the current allocation methodology for all existing ongoing funding, all new one-time funding, and all new ongoing funding for non-County trauma hospitals. Such a course of action would present the least risk of disrupting the trauma system, which has been performing well, with 97 to 99 percent of all patient transports being completed in under 30 minutes. The data also show that the median patient transport time is roughly similar across supervisorial districts, differing by no more than three minutes.

¹ MBAB membership details are included in the attachment.

Option B: Allocate Increases in Ongoing Funding based on Needs-Based Criteria

Your Board could elect to maintain the current ongoing funding levels for non-County hospitals, but designate that any future increases in ongoing funding be allocated using a new needs-based methodology. This option may present an increased long-term risk of disrupting the current trauma system since the growth in ongoing Measure B revenue has historically been allocated to current recipients to support ongoing cost escalation.

Option C: Allocate One-Time Funding based on Needs-Based Criteria

Your Board could also consider applying a needs-based methodology to only the one-time Measure B funding. This would mitigate the risk of disruption to the trauma system, while allowing one-time funding to be allocated as available based on a needs assessment, leading to more targeted and impactful investments. Given the anticipated loss of federal funding in the coming years, however, one-time Measure B funding may be critical in preserving and stabilizing existing trauma services across the County.

Among the options listed above, the current MBAB members support Option C. Under this option, your Board may wish to consider making two additional changes.

- Transfer the responsibility for making recommendations on one-time Measure B funding from the MBAB to the EMS Commission, which would allow the MBAB to be disbanded. The MBAB process, which was suspended in 2020, 2022, 2024, and 2025, suggests that MBAB has been underutilized. The EMS Commission is a 19-member body that advises your Board on policies and standards for emergency medical care services in the County.
- Transition from the current MBAB model, where individual agencies request funding for specific projects, and instruct the EMS Commission to instead conduct an annual assessment of operational needs for the trauma and EMS system. As with the MBAB process, the EMS Commission would then submit their findings to the CEO, which would review the available one-time funding and submit final recommendations to your Board.

Further Analysis of Allocation to Non-County Trauma Hospitals

Should your Board wish to further assess the allocations to non-County trauma hospitals, to assess each hospital's ongoing level of need, patient and community benefits, and impacts of any changes in funding, further expertise and analysis is required. In a future scenario where allocations shift, the County does not currently and may not know the actual impacts or the risk of disruption to the trauma system. The CEO recommends that such an analysis be conducted by a qualified healthcare consultant after conducting outreach to the 13 non-County

Each Supervisor
April 6, 2026
Page 4

trauma hospitals receiving Measure B funding. The consultant should assess how these hospitals use Measure B funding and whether the current funding allocation for non-County trauma hospitals represents the highest and best use of Measure B funds. Following this assessment, the CEO will work with the consultant, DHS, and other stakeholders to present recommendations to your Board.

Next Steps

The CEO is prepared to move forward with the options above and the potential for further analysis upon additional direction from your Board.

Should you have any questions concerning this matter, please contact me or Erika Bonilla at (213) 974-9689 or ebonilla@ceo.lacounty.gov.

JMN:JG:MRM
EB:KK:RAL:GM:yjf

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Health Services
Public Health
Measure B Advisory Board

ADDENDUM TO REPORT BACK ON THE ALLOCATION FORMULA FOR ONGOING AND ONE-TIME MEASURE B FUNDING FOR NON-COUNTY TRAUMA HOSPITALS (ITEM NO. 20, AGENDA OF JULY 15, 2025)

Measure B Background

Prior to the passage of Measure B, the County's public hospitals and trauma system faced tremendous financial strain due to the increasing costs of maintaining trauma-level services, and many trauma centers, including those operated by the County, were at risk of closure. Because trauma centers require trained staff to be available at all times, specialized equipment, and ongoing training and education to maintain certification, they are expensive to maintain. The trauma system consistently faces financial pressure, and like all hospital systems, is facing ongoing uncertainties with respect to federal healthcare programs and funding. In allocating Measure B funding, the County's priority has been to support the 15 Countywide trauma centers, to prevent any destabilization of the trauma system and "downstream" impacts to other hospitals and emergency providers.

The County's approximately 9.8 million residents are served by 15 trauma centers, including two managed by DHS (Los Angeles General and Harbor-UCLA Medical Centers) and the 13 non-County trauma hospitals. The largest share of Measure B funding has been allocated to support the County's two trauma centers and to support emergency care at the Olive View-UCLA Medical Center. The second largest share has been dedicated to maintaining operational readiness and continued operations at the remaining 13 non-County trauma centers, which sustains a Countywide trauma network that ensures timely access to fully staffed emergency care regardless of location. Measure B initially funded 10 non-County trauma hospitals (100 percent of trauma centers, at the time) but three trauma centers have since been added to better serve areas that were identified as underserved. Local trauma systems are under the governance of the State's EMS Authority (EMS Authority). As required by State law, local EMS agencies, including the County EMS Agency, operated by DHS, develop plans for the trauma system and submit them to the EMS Authority for approval. After approval, any significant changes to the trauma system must also be submitted to the EMS Authority for approval prior to the implementation of the changes.

Measure B Allocation Methodology to Non-County Trauma Centers

Historically, the methodology used to distribute Measure B funds to non-County trauma hospitals was largely based on the volume of trauma-related care provided to uninsured patients. With the passage of the Affordable Care Act, which expanded eligibility for Medicaid and authorized the creation of and provided subsidies for health insurance exchanges, the number of uninsured individuals decreased significantly and, consequently, the volume of uninsured trauma claims declined as well. Due to these changes, DHS, including the EMS Agency, worked with the non-County trauma hospitals and the Hospital Association of Southern

California to develop a new funding methodology, as of Fiscal Year 2015-16, that incorporated new metrics for reimbursement.

The new methodology allocates funding based on several factors including the proportion of patients who are enrolled in Medi-Cal or are underinsured and lack the financial resources to afford necessary medical care. By using this methodology, DHS directly addresses disparities in access to healthcare and targets resources toward populations with the greatest need. DHS and the 13 non-County trauma hospitals have reviewed the methodology annually, which is presented to your Board for approval, then memorialized in the Trauma Center Provisions for Reimbursement Memorandum of Agreement.

Under the most recent Measure B rate increase, which was approved by your Board on July 15, 2025, with an effective date of July 1, 2025, the total additional ongoing Measure B funding was estimated to be \$86.599 million annually. Of this amount, your Board approved new allocations totaling \$6.286 million for Public Health Emergency Preparedness programs and \$80.312 million to supplement existing programs funded by Measure B (subtotals do not tie to the overall total, due to rounding). Existing programs were allocated a prorated share of the new ongoing Measure B funding based on the previous year’s allocation. Based on this formula, non-County trauma hospitals were allocated 18.54 percent of the new ongoing funding, consistent with their share of existing funding:

Existing Ongoing Measure B Program	% Allocation
County DHS Hospitals	70.29%
<i>Non-County Trauma Hospitals</i>	<i>18.54%</i>
DPH	5.97%
Physician Services for Indigents Program	1.79%
Trauma Access Expansion (Fire, Sheriff, LA City)	1.48%
EMS Agency	1.14%
Human Relations Commission/Anti-Hate Initiative	0.35%
City of Long Beach	0.34%
City of Pasadena	0.10%
Total Allocation for Existing Ongoing Programs	100.00%

Measure B Oversight Committee

On [November 12, 2002](#), your Board instructed the Auditor-Controller (A-C) to establish a Measure B Oversight Committee to monitor the collection and expenditure of the property tax revenues. On February 20, 2003, a committee was formed with representatives from the Chief Executive Office (formerly Chief Administrative Office), DHS, County Counsel, Assessor, Treasurer and Tax Collector and the A-C. DHS was given the operational responsibility for authorizing the

disbursement of Measure B funds based on allocations and directives from your Board, with recommended expenditures to be considered by your Board as part of the budget process. In subsequent years, funding allocations were revised based on revenue estimates and recommendations by various stakeholders on identified needs, in alignment with allowable Measure B uses and subject to your Board's approval.

Currently, ongoing Measure B funding is allocated to the following:

- County DHS Hospitals (Trauma and Non-Trauma) – (LA General, Harbor-UCLA, and Olive View-UCLA Medical Centers)
- Non-County Trauma Hospitals
- DPH
- Physician Services for Indigents Program
- Trauma Access Expansion (County Fire, Sheriff, LA City Fire)
- EMS Agency
- Human Relations Commission/Anti-Hate Initiative
- City of Long Beach
- City of Pasadena

Measure B Advisory Board (MBAB)

To establish a process for allocating the accumulated one-time funding, on [July 11, 2017](#), your Board established the MBAB to advise on options and/or recommendations for spending unallocated Measure B funds, in a manner that would ensure the maximum benefit to County residents. The MBAB consists of representatives from various stakeholder groups, including a representative for the non-County trauma hospitals, as appointed by the Hospital Association of Southern California.

The current voting MBAB members¹ are:

1. Rachelle Anema, County A-C
2. Dr. Christina Ghaly, County DHS
3. Azar Kattan, County DPH
4. Dr. Lydia Lam, Southern California Chapter of the American College of Surgeons
5. Carol Meyer, County EMS Commission
6. Jon O'Brien, County Fire Department
7. Adena Tessler, Non-County Trauma Hospitals, Hospital Association of Southern California
8. Richard Tadeo, County EMS Agency

¹ One seat, for a Registered Emergency Room Nurse to be appointed by the California Nurses' Association, is currently vacant.

Proposals for the use of these one-time Measure B funds are solicited from various stakeholder groups, including non-County trauma hospitals, and submitted to the MBAB. After an evaluation and ranking process, the MBAB submits their findings to the Chief Executive Office, which reviews the available one-time funding and submits final recommendations to your Board. The one-time funds are allocated solely at the discretion of your Board, and the allocation is contingent upon Board-approval in the County's annual budget process or in a budget adjustment.

Since its inception, the MBAB has submitted recommendations for the use of one-time Measure B funds four times in 2018, 2019, 2021, and 2023. In 2020, the MBAB process was suspended due to early estimates about funding uncertainties related to the COVID-19 pandemic. The MBAB process was also suspended in 2022 and 2024, due to a minimal amount of available, unallocated one-time funding, then again in 2025 (July 15, 2025), when your Board elected to actively direct the recommendations. As of now, all available one-time Measure B funding has been allocated.



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

April 15, 2026

**Los Angeles County
Board of Supervisors**

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Nichole Bosson, MD, MPH
Medical Director

Mandi Posner, Deputy Director
Center for Health Care Quality
California Department of Public Health

**REGION I LONG-TERM CARE MUTUAL AID PROGRAM (LTC-MAP)
(Proposed Project Period: August 1, 2026 – July 31, 2027)**

Dear Ms. Posner,

The Los Angeles County Emergency Medical Services (EMS) Agency, serving as the county's Medical and Health Operational Area Coordinator and a committed member of Mutual Aid Region 1, strongly supports the collaborative initiative by LeadingAge California and the California Association of Health Facilities (CAHF) to develop and implement a Long-Term Care Mutual Aid Program (LTC-MAP) in our region. This project is critical enhancement to our collective disaster preparedness, response, and recovery capabilities for nursing homes.

This project will directly benefit approximately 491 skilled nursing facilities in Region 1 including Los Angeles, Orange, Ventura, Santa Barbara, and San Luis Obispo counties, by establishing coordinated protocols, comprehensive training, and robust regional exercises to protect long-term residents and staff during any emergency.

Recent disasters, such as the January 2025 Los Angeles County wildfires, have proven that greater coordination and structure are essential for effective evacuation planning, surge capacity, real-time communication, and continuity of care for long-term care residents. The LTC-MAP will deliver these improvements and save lives by strengthening coordination among skilled nursing facilities, public health, emergency management, emergency medical services, and all relevant partners and stakeholders.

Participation in the LTC-MAP ensures that facilities and regional partners achieve improved communication, highly effective evacuation coordination, and reliable continuity of care for residents during emergencies.

The Los Angeles County EMS Agency supports the LTC-MAP and its role in strengthening regional preparedness and safeguarding older adults.

Sincerely,

Richard Tadeo
Director

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."*



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California State Council

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Atilla Uner, MD, MPH

California Chapter of American College of the

Emergency Physicians (CAL-ACEP)

Mr. Gary Washburn

Public Member (5th District)

EXECUTIVE DIRECTOR

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Vanessa Gonzalez

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

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

(562) 378-1610 FAX (562) 378-1107

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

4-22-2026

TO: Distribution

FROM: Stephen Sanko, MD, FACEP, FAEMS
Vice Chair, Los Angeles County EMS Commission
Chair, LA County Cardiac Arrest Task Force
Director, Southern California Chapter,
Sudden Cardiac Arrest Foundation

Diego Caivano, MD
Chair, Los Angeles County EMS Commission

SUBJECT: Updated Timeline for Cardiac Arrest Task Force

On behalf of the Los Angeles County EMS Commission and its Cardiac Arrest Task Force, we thank you and your teams for your leadership and early engagement in developing your organizations plan to improve cardiac arrest outcomes in alignment with the American Heart Association's 2030 Goals. We are encouraged by the formation of multidisciplinary teams across many organizations and by the thoughtful early efforts to engage external and community partners.

It has become clear that additional time is needed for these relationships to mature, for ideas to develop organically, and for plans to undergo appropriate review and endorsement by your governance and oversight bodies. Accordingly, **we are adjusting the timeline and extending the period for plan development through January 1, 2027.**

This extension is intended to support—not delay—meaningful progress. We encourage you to continue to participate in the plan development clinics, taking place virtually on the 4th Monday of each month (3rd Monday in May) at 2pm for 9-1-1 provider agencies and 4pm for hospitals. We will be enhancing the discussion and collaborative idea-sharing focus of these clinics. We welcome you to share your draft plans with us in the weeks and months ahead, so that we can provide feedback based on what we have learned from this process so far.

For EMS Provider Agencies, we further recognize that approval by the City Mayor or City Council has posed challenges within this timeline. Approval by the City Manager is an alternative for individual municipalities, or, in the case that your city does not have a City Manager, the Public Safety Commission.

We remain confident that, through this collective effort, Los Angeles County can significantly increase survival from cardiac arrest and reduce longstanding inequities in outcomes. We sincerely appreciate your leadership and partnership in this life-saving work. Please reach out with any questions, SSanko@dhs.lacounty.gov.

Distribution:

Chief Executive Officers, 9-1-1 Receiving Hospitals
Chief Medical Officers, 9-1-1 Receiving Hospitals
Chief Nursing Officers, 9-1-1 Receiving Hospitals
Base Hospital Medical Directors, Base Hospitals
Prehospital Care Coordinators, Base Hospitals
Medical Directors, STEMI Receiving Center Programs
Program Managers, STEMI Receiving Center Programs
Fire Chiefs, 9-1-1 Provider Agencies
Medical Directors, 9-1-1 Provider Agencies

c. EMS Commission



April 27, 2026

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Fifth District

TO: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell
Supervisor Lindsey P. Horvath
Supervisor Janice K. Hahn
Supervisor Kathryn Barger

FROM: Christina R. Ghaly, M.D. *Chaly*
Director

SUBJECT: **DISBURSEMENT PLAN FOR THE 2025
UNALLOCATED MEASURE B FUNDS**

Christina R. Ghaly, M.D.
Director

Nina J. Park, M.D.
Chief Deputy Director, Clinical Affairs & Population Health

Aries Limbaga, DNP, MBA
Chief Deputy Director, Operations

Elizabeth M. Jacobi, J.D.
Administrative Deputy

On July 15, 2025, the Board of Supervisors (Board) approved a Motion by Supervisors Hahn and Solis, as amended to, among other things, approve and authorize the Director of the Department of Health Services (DHS) to allocate the \$20 million of unproposed, unallocated, one-time available Measure B funding evenly between the five (5) Supervisorial Districts for projects that meet the requirements of Measure B. The Motion also directed the Director of DHS to execute the necessary agreements.

The Alhambra
1000 S. Fremont Ave.
Alhambra, CA 91803

Attachment I lists the funding disbursement allocated by each Supervisorial District. Upon full execution of all necessary agreements, any remaining unallocated funding will be returned to the Measure B fund balance.

Tel: (213) 288-8050
Fax: (213) 481-0503

If you have any questions, please contact Richard Tadeo, EMS Agency Director, at (562) 378-1610 or via email at rtadeo@dhs.lacounty.gov.

www.dhs.lacounty.gov

CRG:rt

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

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and our communities by providing
extraordinary care"*

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**2025 ONE-TIME MEASURE B FUNDING
DISBURSEMENT BY SUPERVISORIAL DISTRICT**

Supervisorial District 1	Description	Allocated Funding
1. Adventist Health - Montebello	Funding to support and maintain vital emergency department care services and bioterrorism response for qualified Measure B purposes.	\$1,000,000.00
2. Greater El Monte Community Hospital	Funding to support and maintain vital emergency department care services and bioterrorism response for qualified Measure B purposes.	\$1,000,000.00
3. Montebello Fire Department	Purchase EMS equipment – ten (10) automated external defibrillators (AED) and two (2) AED training units Construction of new Fire Station, funds will be specifically allocated to the “paramedic” component of the Fire Station.	\$50,000.00 \$750,000.00
4. Emanate Health – Queen of the Valley	Funding to support and maintain vital emergency department care services and bioterrorism response for qualified Measure B purposes.	\$500,000.00
5. Children’s Hospital of Los Angeles	Funding to support and maintain vital emergency department care services.	\$350,000.00
6. Los Angeles County Fire Department	Expansion of the Prehospital Blood Transfusion Pilot Program to SD1’s district.	\$350,000.00
	Unallocated	\$0.00

Supervisorial District 2	Description	Allocated Funding
1. Martin Luther King Jr. Community Hospital	Funding to support and maintain vital emergency department care services for qualified Measure B purposes.	\$4,000,000.00
	Unallocated	\$0.00

Supervisorial District 3	Description	Allocated Funding
1. Martin Luther King Jr. Community Hospital	Funding to support and maintain vital emergency department care services for qualified Measure B purposes.	\$4,000,000.00
	Unallocated	\$0.00

ATTACHMENT I

Supervisory District 4	Description	Allocated Funding
1. City of Long Beach, Public Health Emergency Management	The funding will sustain critical operational capacity for the Long Beach Local Distribution Site. The requested funds will offset essential operational costs including the Fire Department's portion of the lease and utilities, equipment maintenance, and chemical, biological, radiological, and nuclear (CBRN) supplies. Funding will support six (6) full-time logistics staff who keep the LDS fully functional, maintain medical inventory, and provide ground support and delivery services to local hospitals and healthcare facilities. These trained staff enable the City to activate the LDS immediately in an emergency, rather than waiting for contracted services, which could cost critical hours during a public health incident.	\$1,500,000.00
2. Catalina Island Medical Center (CIMC)	CT scanners are a mandatory requirement of emergency departments (ED). As a Critical Access Hospital, CIMC is required to have a fully functional ED, 24 hrs./day, 7 day/week. The CT Scanner is 7 years old, passed its useful life, out of warranty and has failing electrical wiring. This past February 2025, the CT broke and estimates for replacement parts will take 4-6 months. Without a CT scanner Catalina Island residents and visitors would be without a critical diagnostic tool for trauma diagnostics. The replacement CT scanner would significantly increase the ability to diagnose trauma level patients, provide clearer images for more accurate diagnostics, allow for tests currently unable to perform, and a response time that is 200% faster than the current model.	\$1,400,000.00
3. Dignity Health St. Mary Medical Center	Replace the CarePoint legacy software and hardware of the Paramedic Base Hospital radio and telephone communication consoles. <i>This replacement is necessary to ensure real-time online medical control communication between the hospital Mobile Intensive Care Nurses / Base Hospital Physicians and the on-scene paramedics and emergency medical technicians. The current CarePoint software platform is outdated, in its end-of-life, and can no longer be supported by the manufacturer.</i>	\$220,033.75
4. MemorialCare Long Beach Medical Center	Replace the CarePoint legacy software and hardware of the Paramedic Base Hospital radio and telephone communication consoles.	\$112,278.30
5. PIH Health Whittier Hospital	Replace the CarePoint legacy software and hardware of the Paramedic Base Hospital radio and telephone communication consoles.	\$129,804.85

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Supervisorial District 4	Description	Allocated Funding
6. St. Francis Medical Center	Replace the CarePoint legacy software and hardware of the Paramedic Base Hospital radio and telephone communication consoles.	\$137,172.65
7. Torrance Memorial Medical Center	Replace the CarePoint legacy software and hardware of the Paramedic Base Hospital radio and telephone communication consoles.	\$124,289.50
8. Providence Little Company of Mary Hospital Torrance	Replace the CarePoint legacy software and hardware of the Paramedic Base Hospital radio and telephone communication consoles.	\$151,578.80
9. City of Downey Fire Department	Integrate EMS resources of the Cities of Compton, Downey and Santa Fe Springs with the Countywide hospital digital communications system (ReddiNet) and FirstWatch Solutions to enhance situational awareness and ED bed resources. The Downey Fire Communications Center provides fire and EMS dispatch services to the Cities of Compton, Downey and Santa Fe Springs.	\$34,806.58
10. Avalon Fire Department	Purchase EMS equipment - powered ambulance gurney, powered stair chair and LUCAS 3 mechanical chest compression devices.	\$102,730.06
11. LA County Emergency Medical Services Agency	Upgrade the Color Code Drug Doses Mobile Application.	\$75,950.00
	Unallocated	\$11,355.50

Supervisorial District 5	Description	Allocated Funding
1. Martin Luther King Jr. Community Hospital	Funding to support and maintain vital emergency department care services for qualified Measure B purposes.	\$1,000,000.00
2. Los Angeles County Sheriff's Department	Enhance capability of the Los Angeles County Sheriff's Department EMS Air response by equipping its flight-based advanced life support unit with the ability to perform prehospital whole blood transfusions.	\$200,000.00
3. Antelope Valley Medical Center	Replace the CarePoint legacy software and hardware of the Paramedic Base Hospital radio and telephone communication consoles.	\$143,350.39
4. Adventist Health Glendale	Replace the CarePoint legacy software and hardware of the Paramedic Base Hospital radio and telephone communication consoles.	\$142,730.35
5. Henry Mayo Newhall Hospital	Replace the CarePoint legacy software and hardware of the Paramedic Base Hospital radio and telephone communication consoles.	\$124,214.10
6. Huntington Hospital	Replace the CarePoint legacy software and hardware of the Paramedic Base Hospital radio and telephone communication consoles.	\$149,602.84

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Supervisorial District 5	Description	Allocated Funding
7. Providence St. Joseph Medical Center	Replace the CarePoint legacy software and hardware of the Paramedic Base Hospital radio and telephone communication consoles.	\$122,083.30
8. USC Arcadia Hospital	Replace the CarePoint legacy software and hardware of the Paramedic Base Hospital radio and telephone communication consoles.	\$180,625.00
9. San Marino Fire Department	Purchase EMS equipment: one (1) power ambulance gurney two (2) cardiac monitors one (1) autopulse mechanical CPR device sixty (60) individual first aid kits twenty (20) trauma kits eighteen (18) Push-to-Talk Radio Earpiece Accessories	\$45,843.95 \$127,105.13 \$29,551.00 \$6,471.27 \$4,617.48 \$11,161.58 Total: \$224,750.41
10. South Pasadena Fire Department	Purchase EMS equipment - one (1) cardiac monitor and two (2) power cots and loading systems	\$65,117.93 \$132,278.40 Total: \$197,396.33
11. La Verne Fire Department	Purchase EMS equipment – two (2) cardiac monitors	\$86,448.98
12. Glendale Fire Department	Purchase EMS equipment – six (6) Autopulse NXT and three (3) cardiac monitors/defibrillators	\$169,085.82 \$165,501.61 Total: \$334,587.43
13. Burbank Fire Department	Purchase EMS equipment – fifteen (15) Automated External Defibrillators (AED)	\$25,981.81
14. Monrovia Fire & Rescue	Purchase EMS equipment – two (2) cardiac monitors	\$95,988.59
15. Pasadena Public Health	Purchase City Mobile Command Unit	\$150,000.00
16. Antelope Valley Medical Center	Funding to support and maintain vital emergency department care services and bioterrorism response for qualified Measure B purposes.	\$500,000.00
	Unallocated	\$322,240.47