



COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES



PROVIDER AGENCY ADVISORY COMMITTEE

MEETING NOTICE

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

DATE: June 17, 2026
TIME: 1:00 pm
LOCATION: Cathy Chidester Conference Room [1st Floor Hearing Room]
Los Angeles County EMS Agency
10100 Pioneer Boulevard
Santa Fe Springs, California 90670

AGENDA

1. CALL TO ORDER

2. INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS

- 2.1 Joint Educational Session (Sept 1st) – Heat Stroke - Phoenix Fire Dept
- 2.2 EMSC Educational Forum (November 5th)
- 2.3 Sidewalk CPR
- 2.4 Survey: Paramedic's Perception on Care of People Experiencing Homelessness

3. APPROVAL OF MINUTES: April 15, 2026

4. UNFINISHED BUSINESS

No unfinished business

5. NEW BUSINESS

- 5.1 Pediatric Perinatal Protocols

Policies for Discussion; Action Required:

- 5.2 Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene
- 5.3 Reference No. 834.1, Patient Refusal of Treatment/Transport and Treat and Release at Scene, Quick Reference Guide

Policies for Discussion; No Action Required:

- 5.4 Reference No. 227, Dispatch of 9-1-1 Emergency Medical Services
- 5.5 Reference No. 1200.2, Treatment Protocol: Base Contact Requirements
- 5.6 Reference No. 1224, 1224-P, Treatment Protocol: Stings / Venomous Bites
- 5.7 Reference No. 1325, Medical Control Guideline: Mechanical Circulatory Support Devices
- 5.8 Reference No. 1337, Medical Control Guideline: Naloxone Distribution By EMS Providers (Leave Behind Naloxone)

6. REPORTS AND UPDATES

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

7. OPEN DISCUSSION

8. NEXT MEETING: August 19, 2026

9. ADJOURNMENT



EMERGENCY MEDICAL SERVICES COMMISSION PROVIDER AGENCY ADVISORY COMMITTEE



MINUTES

Wednesday – April 15, 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	Denise Whitfield, MD
Jason Cervantes	EMSC, Commissioner	David Wells	Shira Schlesinger, MD
James Lott, PsyD, MBA	EMSC, Commissioner	Ami Boonjaluksa	Michael Kim, MD
X Ken Domer	EMSC, Commissioner	Jennifer Calderon	Jonathan Warren, MD
Kristin Kolenda	EMSC, Commissioner	Mark Ferguson	Natalie Greco
Ken Liebman	EMSC, Commissioner	Sara Rasnake	Christine Zaiser
X Sean Stokes	Area A (<i>Rep to Medical Council</i>)	Gary Watson	
X Patrick Nulty	Area A, Alternate		
X Keith Harter	Area B		
X Clayton Kazan, MD	Area B, Alternate		
Jeffrey Tsay	Area C		
X Luis Manjarrez	Area C, Alternate		
Victor Lemus	Area E		
X Geoffrey Dayne	Area E, Alternate		
Joel Davis	Area F		
Andrew Reno	Area F, Alternate		
X Adam Brown	Area G (<i>Rep to BHAC</i>)		
X Stefan Viera	Area G, Alternate		
X Matthew Conroy	Area H		
X Marc Cohen, MD	Area H, Alternate		
X Michael Campana	Area H, Alternate		
X Julian Hernandez	Employed Paramedic Coordinator		
Tisha Hamilton	Employed Paramedic Coordinator, Alt		
Jenny Van Slyke	Prehospital Care Coordinator		
X Melissa Turpin	Prehospital Care Coordinator, Alternate		
Bryan Sua	Public Sector Paramedic Coordinator		
X Drew Pryor	Public Sector Paramedic Coordinator, Alt		
<i>Vacant</i>	Private Sector Paramedic		
Scott Buck	Private Sector Paramedic, Alternate		
X Tabitha Cheng, MD	Provider Agency Medical Director		
X Tiffany Abramson, MD	Provider Agency Medical Director, Alt		
Jonathan Lopez	Private Sector Nurse Staffed Amb Program		
<i>Vacant</i>	Private Sector Nurse Staffed Amb Program, Alt		
Scott Jaeggi	EMT Training Program		
Albert Laicans	EMT Training Program, Alternate		
Ray Mosack	Paramedic Training Program		
<i>Vacant</i>	Paramedic Training Program, Alternate		
X Heather Calka	EMS Educator		
X Catherine Borman	EMS Educator, Alternate		
		GUESTS	ORGANIZATION
		Bijan Arab, MD	FALCK Ambulance
		Salvador Rios, MD	Monrovia FD / AMR Ambulance
		Kelsey Wilhelm, MD	Compton FD
		Jorge Fazzini	West Coast Ambulance
		Tyri Williams	Pasadena FD
		Angela Loza-Gomez, MD	Area C Medical Director
		Kristina Crews	LACoFD
		Jennifer Nulty	Beverly Hills FD
		Michael Rivera	Santa Monica FD
		Jennifer Shepard	LA County Sheriff's Department
		Tassia Trink	Torrance FD
		Emilio Gaona	Royalty Ambulance
		Karyn Robinson	Montebello FD
		Danielle Ogaz	LACoFD
		Jessie Castillo	PRN Ambulance
		Duane Anderson	Zoll Medical
		Lyn Riley	LASD, LH, SA
		Ruben Balayan	West Coast Ambulance
		Caroline Jack	Beverly Hills FD
		Ken Kaufmann	MedTrans Ambulance
		Kathryn Ward	UCLA Ctr for Prehospital Care
		Adrienne Roel	Culver City FD
		Jim Goldsworthy	LAFD Air Ops, Redondo Bch FD
		Dave Molyneux	AM West Ambulance
		Kimberly Tan	UCLA Ctr for Prehospital Care
		Louis Mendoza	Lifeline Ambulance
		Theodor Ecklund	Pasadena FD
		Nicole Mitchell	Rescue Advancement
		Sergio Zavala	Downey FD
		Patricia Guerara	Burbank and San Gabriel FD
		Ed Marquez	Glendale FD
		Johnna Corbet	UCLA Ctr for Prehospital Care

Quorum was established

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

- Richard Tadeo, EMS Agency Director, welcomed Commissioner Ken Domer to the meeting.

2. INTRODUCTIONS AND ANNOUNCEMENTS

2.1 Committee Membership Changes (*Chair, Carol Meyer*)

Chair announced the following membership changes:

- Area E:
 - Victor Lemus (Compton FD), moved from Alternate to Primary Representative.
 - Geoffrey Dayne (Santa Fe Springs Fire Rescue), moved from Primary to Alternate Representative.
- Nurse Staffed Ambulance Program:
 - Jonathon Lopez (Premier Ambulance), moved from Alternate to Primary Representative.
 - Alternate Representative remains vacant.

- 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.

SUBJECT: **PATIENT REFUSAL OF TREATMENT/TRANSPORT AND TREAT AND RELEASE AT SCENE** REFERENCE NO. 834

PURPOSE: To provide guidelines for EMS personnel to determine which patients who do not wish to be transported to the hospital have decision-making capacity to refuse EMS treatment and/or transport, and to identify those who may be safely released at scene.

AUTHORITY: California Health and Safety Code, Division 2.5, Sections 1797.220, 1798, (a). California Welfare and Institution Code, Sections 305, 625, 5150, and 5170. Title 22, California Code of Regulations, Section 100169.

DEFINITIONS:

Adult: A person at least eighteen years of age.

Against Medical Advice (AMA): A patient or a legal representative of a patient who has decision-making capacity and who refuses treatment and/or transport for **an emergency medical condition** as advised by EMS providers, physician on scene, and/or Base personnel.

Assess, Treat, and Release: A patient who does not desire transport to the emergency department for evaluation and after an assessment and/or treatment by EMS personnel, **does not** have an ongoing emergent medical condition, a high-risk presentation, or social risk factors and is released at scene to follow-up with the patient's regular healthcare provider or a doctor's office or clinic. This also includes patients for whom transport does not align with established comfort-focused goals of care (i.e., Physician Orders for Life Sustaining Treatment, Do-Not-Resuscitate, or Advanced Healthcare Directive) and needs are met on scene per Reference 815.

Authorized Advanced Health Care Provider: An EMS physician authorized to direct EMS care on the scene or via telemedicine as per Ref. 816 – Physician at the Scene, or an advanced practiced provider who is identified by the EMS Provider Agency Medical Director to provide medical direction via telemedicine as approved by the EMS Agency Medical Director.

Decision-Making Capacity: The ability to understand the nature and consequences of proposed health care. This includes understanding the significant risks and benefits and having the ability to make and communicate a decision regarding the proposed health care in the patient's primary language, if feasible. A person has decision-making capacity if they are able to:

- Communicate the need for treatment, the implications of receiving and of not receiving treatment, and alternative forms of treatment that are available, and
- Relate the above information to their personal values, and then make and convey a decision.

The lack of decision-making capacity may be:

EFFECTIVE: 11-08-93
REVISED: 07-01-25
SUPERSEDES: 10-01-23

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APPROVED: _____

Director, EMS Agency

Medical Director, EMS Agency

-
- Temporarily lost (e.g., due to unconsciousness, influence of mind-altering substances, mental illness, or cognitive impairment)
 - Permanently lost (e.g., due to irreversible coma, persistent vegetative state, untreatable brain injury, or dementia)
 - Never existed (e.g., due to profound neurodevelopmental disorder, those who are deemed by the Court as incompetent or a person under conservatorship)

Emancipated Minor: A person under the age of 18 years is an emancipated minor if any of the following conditions are met:

- Married or previously married
- Currently or previously in a valid domestic partnership
- On active military duty
- The person has received a declaration of emancipation pursuant to Section 7122 of the California Family Code, which includes all of the following: at least fourteen (14) years of age, living separate and apart from their parents and managing their own financial affairs (may be verified by DMV Identification Card)

Emergency Medical Condition: A condition or situation in which a medical illness is suspected in a patient and there is an immediate need for medical attention. Patients with any abnormal vital signs: heart rate and rhythm, respiratory rate, blood pressure (except for isolated asymptomatic hypertension), oxygen saturation, and temperature (Ref. 1380 – Medical Control Guideline Vital Signs); and/or those who meet any criteria for Base Contact (Ref. 1200.2 – Base Contact Requirements) are considered to have an emergency medical condition.

High Risk Presentation: Features by history or presentation that are likely to be high risk for complications, progression of disease, underlying serious illness or injury, or require Base Contact. High risk chief complaints include chest pain, abdominal pain, pregnancy, gastrointestinal bleeding, syncope, neurologic symptoms (e.g., dizziness/vertigo, weakness, visual changes), and altered mental status. High risk features include:

- Patients less than 12 months of age
- Patients older than 70 years of age
- Patients with complicating comorbidities (i.e., active underlying cardiac, respiratory, kidney, liver, oncologic (cancer) or neurologic disease, or who are immunocompromised (e.g., history of HIV, chemotherapy, transplantation))

Implied Consent: This is a type of consent involving the presumption that an unconscious or a person lacking decision-making capacity would consent to lifesaving care. This shall include minors with an emergency medical condition when a parent or legal representative is not available.

Lift Assist: EMS is dispatched to a scene to assist with transfer of a patient to a bed or wheelchair.

LPS-Evaluator: An individual that is authorized under CA WIC § 5150 et seq. to evaluate and place a patient on a 5150/5585 written hold application, such as all law enforcement (LE) personnel and clinicians who are LPS-authorized by the County Department of Mental Health. Examples include, Psychiatric Emergency Team (PET), Psychiatric Mobile Response Team (PMRT), Mental Evaluation Team (MET), Systemwide Mental Assessment Response Teams (SMART), or others. LPS refers to “Lanterman-Petris-Short”, the names of the original state legislators who authored CA WIC § 5150 et seq.

Medical Home: A team-based health care delivery model, which is led by a health care provider (i.e., primary care physician) to provide continuous, coordinated, and comprehensive medical care.

Minor: A person less than eighteen years of age.

Minor Not Requiring Parental Consent is a person who:

- Is 12 years or older and in need of care for a reportable medical condition or substance abuse
- Is pregnant and requires care related to the pregnancy
- Is in immediate danger of suspected physical or sexual abuse
- Is an emancipated minor

No Contact / No Patient: EMS is dispatched to a scene and is either cancelled prior to arriving at scene or no patient is found.

Patient: A person who seeks or appears to require medical assessment and/or medical treatment (Ref. 606, Documentation of Prehospital Care)

Person Contact / No Patient: EMS is dispatched to a scene and a person is identified as a potential patient, is alert and appropriate for situation and declines assessment by EMS.

Psychiatric Hold (5150 / 5585): Refers to California Welfare and Institutions Code (WIC) § 5150 et seq. which defines the legal standard for involuntary detainment and evaluation of a person who, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled. “5150” refers to the code for adult patients, “5585” refers to the code for minors (under age 18). This is a written application by an authorized LPS-evaluator certified by the County to place an individual on a psychiatric hold. An authorized LPS-evaluator must provide the written application (“psychiatric hold” document) which must accompany the patient to the facility where they are transported.

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

Released Following Protocol Guidelines: Disposition for patients who lack established decision-making capacity or in whom capacity cannot be determined due to inability to access or assess the patient, and for whom EMS personnel have exhausted all options (including law enforcement when appropriate) such that EMS cannot safely access and/or transport the patient to the hospital.

Social Risk Factors: Persons experiencing homelessness, patients in congregate living, and those who are a resident of skilled nursing facilities.

Treatment in Place: A patient who, after an assessment and treatment by EMS personnel and medical clearance by an authorized advanced healthcare provider (e.g., physician, nurse practitioner, physician assistant) on scene (Ref. 816 Physician at the Scene) or via Telemedicine, does not require ambulance transport to an emergency department. Appropriate follow-up should be arranged by the authorized advanced healthcare provider on scene or via Telemedicine.

PRINCIPLES:

1. An adult or emancipated minor who has decision-making capacity has the right to determine the course of their medical care including the refusal of care. These patients must be advised of the risks and consequences resulting from refusal of medical care. A patient less than eighteen (18) years of age, with the exception of minors not requiring parental consent, must have a parent or legal representative to refuse evaluation, treatment, and/or transport for an emergency medical condition.
2. A patient determined by EMS personnel or the base hospital to lack decision-making capacity may not refuse care AMA. Mental illness, drugs, alcohol, or physical/mental impairment may impair a patient's decision-making capacity but are not sufficient to eliminate decision-making capacity.
3. Patients who have attempted suicide, or who have expressed a method, a plan, or intent to commit suicide ([MCG 1306](#)), should receive an evaluation by an LPS-evaluator for a psychiatric hold. LPS evaluator determination is the legal authority for placement or non-placement of a psychiatric hold (5150 / 5585).
4. A patient on a psychiatric hold may not be released at scene and cannot sign-out AMA. The patient can refuse any medical treatment as long as it is not an imminent threat to life or limb.
5. At no time are EMS personnel expected to put themselves in danger by attempting to treat and/or transport a patient who refuses care.
6. For patients determined to lack decision-making capacity or in whom capacity cannot be determined due to inability to access or assess the agitated patient, EMS personnel should refer to MCG 1307.4, EMS and Law Enforcement Co-Response to follow the escalation and communication pathway to engage law enforcement's assistance.
7. Patients for whom 9-1-1 is called but are not transported represent a potentially high-risk group and provider agencies should/shall have quality review programs specific to this patient population.

POLICY:

- I. **Adult With Decision-Making Capacity or Minor (Not Requiring Parental Consent) Refusing Transport Against Medical Advice**
 - A. EMS personnel shall advise the patient of the risks and consequences which may result from refusal of treatment and/or transport. The patient should be advised to seek immediate medical care.
 - B. Base contact should be made prior to the patient leaving the scene for patients who would otherwise meet Base Contact criteria (Ref. 1200.2 – Base Contact Requirements) in order for Base personnel to have the opportunity to interview the patient and to evaluate the appropriateness of the AMA. If the patient elopes from the scene, EMS personnel are not required to make Base Contact.
 - C. EMS personnel shall relay all the circumstances to the Base including assessment and care rendered, reasons for refusal, and the patient's plan for transportation and follow-up care.

- D. EMS personnel shall make Base Contact prior to releasing a child at the scene with a parent or caregiver for all pediatric patients less than or equal to 12 months of age.
 - E. EMS personnel shall have the patient or their legal representative, as appropriate, sign the release (AMA) section of the Patient Care Record (EMS Report Form/Electronic Patient Care Record/ePCR). The signature shall be witnessed, preferably by a family member.
 - F. A patient's refusal to sign the AMA section should be documented on the Patient Care Record.
- II. Individual Lacking Decision-Making Capacity or a Minor (Requiring Parental Consent)
- A. The patient should be transported to an appropriate receiving facility under implied consent. A psychiatric hold is not required.
 - B. If EMS personnel or the base hospital determines it is necessary to transport the patient against their will and the patient resists, or the EMS personnel believe the patient will resist, assistance from law enforcement should be requested in transporting the patient. Law enforcement may consider the placement of a psychiatric hold on the patient but this is not required for transport. In cases where law enforcement's decision is to not engage, EMS personnel should follow guidelines outlined in MCG 1307.4, EMS and Law Enforcement Co-Response.
 - C. Law enforcement should be involved whenever EMS personnel believe a parent or other legal representative of the patient is acting unreasonably in refusing immediate care and/or transport.
- III. Patients Assessed, Treated, and Released
- A. EMS personnel shall assess the patient for an ongoing emergency medical condition, high risk presentations, social risk factors, and assess that the patient or their legal representative has the capacity to decline transport.
 - B. Patients with an ongoing emergency medical condition, high risk presentation or social risk factors who do not desire transport to the emergency department shall be handled as refusing transport against medical advice (refer to Policy Section I). Patients with established comfort-focused goals of care as defined above for whom comfort needs are met on scene do not require refusal against medical advice.
 - C. Patients or the legal representatives of patients who contact EMS for minor complaints in order to have an assessment performed and determination made of the seriousness of the complaint and need for treatment, but later *decline transport* qualify to be assessed, treated, and released.
 - 1. In such cases, the EMS personnel should perform an assessment including vital signs, and after the patient or patient's legal representative's states they do not wish transport, the patient may be assessed, treated, and released at the scene.

2. Patients should be instructed by EMS to follow-up with the patient's medical home or primary care physician. The advice given should be documented on the Patient Care Record. The following statement is recommended: "After our assessment, you feel that you do not wish to be transported and you do not require immediate care in the emergency department. You should seek care with your regular healthcare provider or a doctor's office or clinic within 24 hours. If you have worsening or persistent symptoms or change your mind and desire transport, recontact 9-1-1."

D. EMS personnel should not require patients who are Assessed, Treated and Released at scene to sign the release (AMA) section of the Patient Care Record, as this implies that the patient is at significant risk by not utilizing the EMS system for treatment and/or transportation.

E. If subsequent to further assessment and discussion, the patient or the patient's legal representative desires transport, EMS personnel should transport the patient to the hospital per destination policies.

IV. Documentation

A. Public Assist and Person Contact/No Patient does not require completion of a Patient Care Record. Documentation should follow the EMS provider agency's operational policy.

B. A Patient Care Record must be completed for each patient or contact encounter (i.e., Lift Assist, AMA, Assess, Treat and Release, and Treatment in Place), including those refusing emergency medical evaluation, care and/or transportation against medical advice and those released at scene. EMS personnel shall ensure that documentation is in compliance with Ref. 606 – Documentation of Prehospital Care. Patient Care Record documentation should include:

1. AMA:

- a. Patient history and assessment, including findings of an emergency medical condition or requirement to make Base Contact
- b. Assessment by EMS that the patient or legal representative is alert and has the decision-making capacity to refuse EMS assessment
- c. What the patient is refusing (i.e., medical care, transport) and reason for refusal
- d. Risk and consequences of refusing care and/or transport, benefits of transport, and alternatives as explained to the patient or legal representative
- e. Statement that the patient understands and verbalizes the risks

- and consequences of refusing care and/or transport
 - f. Signature of patient or legal representative
 - g. Patient's plan for follow-up care
 - h. Contact with Base Hospital, as applicable
 - i. For Minors, the relationship of the person(s) to whom the patient is being released
2. Assess, Treat and Release:
- a. Patient history and assessment, including absence of findings of an emergency medical condition
 - b. Assessment by EMS that the patient or legal representative is alert and has the capacity to make collaborative decision making with EMS to accept on-scene treatment, understand the need to have capacity for appropriate follow-up, but decline transport
 - c. Discussion with patient including risks of non-transport, benefits of transport, and alternatives
 - d. Plan for follow-up care including when to recall 9-1-1, seek emergency department care or follow-up with their medical home
 - e. If Base contact was made (when applicable)
 - f. For Minors, the relationship of the person(s) to whom the patient is being released
3. Released Following Protocol Guidelines
- a. Patient history and assessment, including incomplete assessments and description of barriers to completing assessment
 - b. All responding agencies on scene
 - c. Base hospital medical direction, if applicable
 - d. Name and assignment of the highest-ranking law enforcement officer involved in the decision-making, and LPS evaluator information, if applicable
 - e. Reasons stated by law enforcement for disengagement when applicable
 - f. Any follow up plans and resources requested and/or provided to the patient
4. Treatment in Place:

- a. Document as per Assess, Treat, and Release and also include the name of the authorized advanced health care provider

V. Quality Improvement

- A. Each Provider Agency shall have a quality improvement program for patients who are not transported to the ED. The quality improvement program should include but may not be limited to the following:
 1. Monitor data on the frequency, percent, and type of nontransports.
 2. Establish a process for review of patient care records on a percentage of nontransports to include assessment of impact on the patient's outcome, and education/training provided as indicated by this review.
 3. Develop a process for evaluating rate of repeat call to 9-1-1 or "rekindles".
- B. Base Hospital shall incorporate patients released at the scene into their Quality Improvement Program (Ref. 304 – Paramedic Base Hospital Standards). The quality improvement program may include but not limited to the following:
 1. Review of select number of Base Hospital contacts for non-transports and provide education to base personnel as appropriate from that review.
 2. Inclusion of cases of patients released at the scene in Base Hospital Audio Recording Reviews.
 3. Notification of EMS provider agency quality improvement staff when the base has knowledge of patients who are released at the scene and return for evaluation in the emergency department.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 304, **Paramedic Base Hospital Standards**

Ref. No. 606, **Documentation of Prehospital Care**

Ref. No. 832, **Treatment/Transport of Minors**

Ref. No. 816, **Physician At The Scene**

Ref. No. 1200, **Treatment Protocols**, et al.

Ref. No. 1200.2, **Base Contact Requirements**

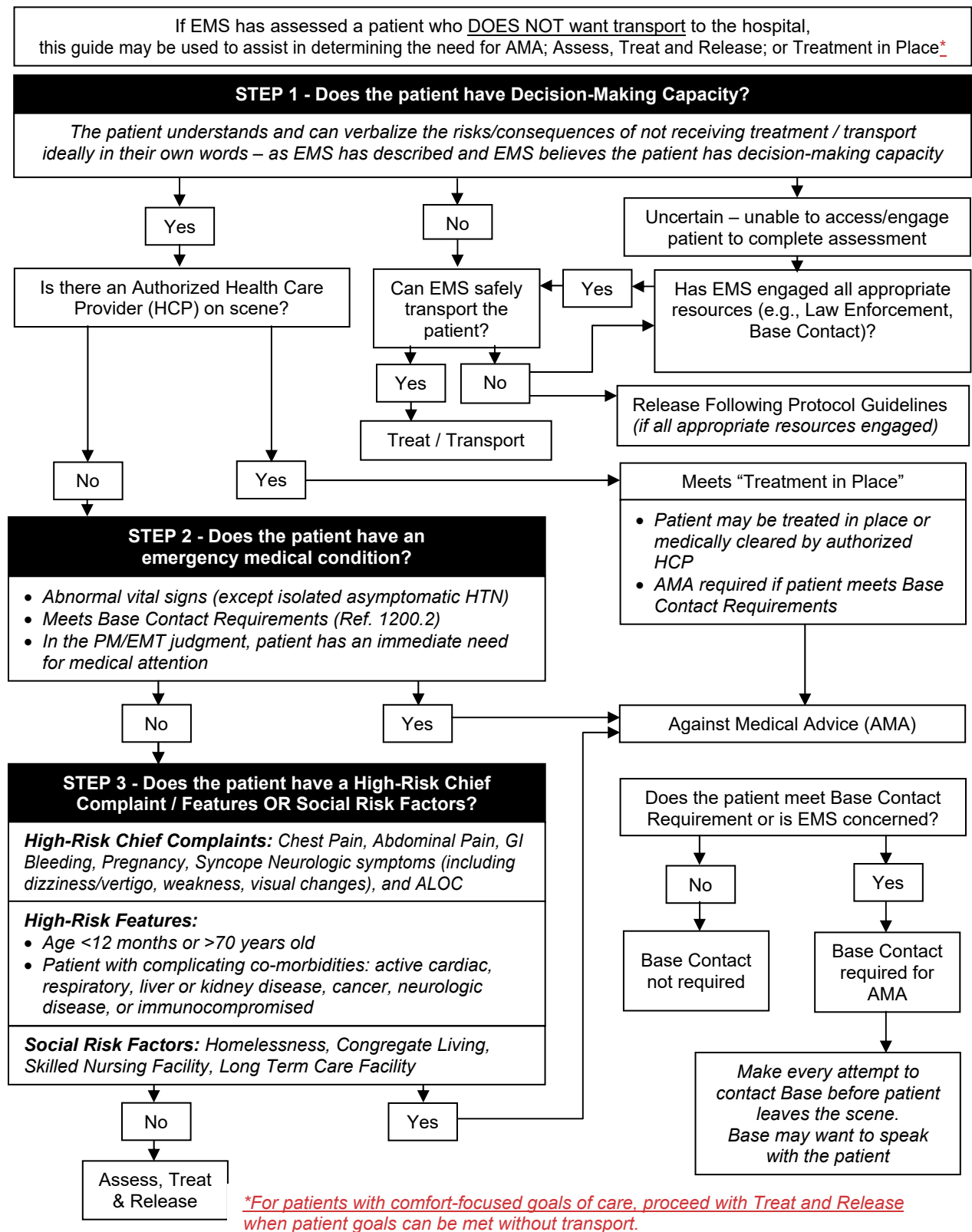
Ref. No. 1306, **Medical Control Guideline: Evaluation and Care of Patients at Risk of Suicide**

Ref. No. 1307.4 **Medical Control Guideline: EMS and Law Enforcement Co-Response**

Ref. No. 1309, **Color Code Drug Doses**

Ref. No. 1380, **Medical Control Guidelines: Vital Signs**

SUBJECT: PATIENT REFUSAL OF TREATMENT/TRANSPORT AND TREAT AND RELEASE AT SCENE REFERENCE NO. 834.1
QUICK REFERENCE GUIDE



SUBJECT: **DISPATCHING OF 9-1-1 EMERGENCY
MEDICAL SERVICES**

REFERENCE NO. 227

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

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

DEFINITIONS:

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

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

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

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

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

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

PRINCIPLES:

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

EFFECTIVE: 02-15-10
REVISED: 01-01-26
SUPERSEDES: 01-01-22

PAGE 1 OF 5

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

2. Public Safety Answering Point (PSAP) Provider Agencies that implement Emergency Medical Dispatch (EMD) shall comply with the State of California EMS statutes and regulations and Los Angeles County EMS Agency Prehospital Care policies.
3. The emergency medical dispatching protocols developed by the dispatch center shall be approved by the Dispatch Center Medical Director and available for review by the EMS Agency.

POLICY

- I. Dispatch Center Designation
 - A. Dispatch center designation approval is granted based on maintenance of these standards and after a satisfactory review and approval by the EMS Agency.
 - B. The EMS Agency reserves the right to perform periodic site visits to evaluate compliance with program requirements or request data at any time.
- II. Program Requirements
 - A. Each dispatch center shall have a qualified Dispatch Center Medical Director to oversee protocol development, quality improvement and shall have a Dispatch Coordinator to oversee daily operations.
 - B. Ensures the Emergency Dispatch Coordinator, Medical Director or dispatch agency representative attends the Dispatch Center Advisory meetings scheduled by the Los Angeles County EMS Agency.
 - C. The following shall be submitted to the EMS Agency upon request:
 1. An EMD program compliant with State and EMS Agency standards and approved by the Dispatch Center Medical Director:
 - a. Name of the nationally recognized commercial program to be utilized.
 - OR
 - b. An Internally developed program.
 2. Pre-determined interview questions.
 3. Guidelines and procedures used in the dispatch of EMS Resources.
 4. Post-dispatch/Pre-arrival instructions that are clearly defined in compliance with EMS Agency guidelines.
 5. Quality Improvement Program
 6. Education standards and qualifications for call-takers and dispatchers.

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

III. Dispatch Center Medical Director

A. Requirements

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

B. Responsibilities

1. Provides medical direction and oversight of the emergency medical dispatch program by review and approval of:
 - a. Policies and procedures related to Emergency Medical Dispatch and patient care.
 - b. Standards for qualifying education and continuing education.
 - c. Dispatch guidelines including pre-arrival instructions.
2. Oversees quality improvement (QI) and compliance standards.
3. Performs ongoing periodic review of dispatch records for identification of potential patient care issues.
4. Provides oversight and participates in dispatch quality improvement, risk management and compliance activities.

IV. Emergency Dispatch Coordinator

A. Requirements

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

B. Responsibilities

1. Oversees daily operations of the center and ensures staffing on a continuous 24-hour basis of qualified Emergency Medical Dispatchers/Call-Takers that meets the EMS provider agency's needs.
2. Ensures a dispatch supervisor or designee is readily accessible 24 hours daily.
3. Ensures for availability of a 24-hour contact phone number and e-mail to be utilized to coordinate or disseminate information in case of critical incident or disease outbreak.

4. Ensures all staff meet the requirements of an Emergency Medical Dispatcher by maintaining records and documentation demonstrating compliance.
5. Coordinates QI activities with the Medical Director.
 - a. Provides ongoing monthly collection of data and review of dispatch records for identification of potential patient care issues.
 - b. Participates in dispatch quality improvement, risk management and compliance meetings and activities.

V. Emergency Medical Dispatcher / Call-Taker Qualifications

A. Initial Qualifications

1. A current and valid BLS certification equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level. Must include hands-on skills validation (e.g., American Heart Association (AHA) or American Red Cross (ARC)).
2. EMD Certification, or EMT certification and the completion of the Dispatch Center's self-developed course in EMD training with a minimum initial training of twenty-four (24) hours approved by the Dispatch Center Medical Director and the EMS Agency.

B. Ongoing requirements

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

OR

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

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

3.4. Demonstrates compliance with protocols and established standards with the department's quality assurance.

V. Quality Improvement / Quality Assurance (QI/QA):

- A. The Emergency Medical Dispatch Center shall have a QI/QA Program that will evaluate indicators specific to the dispatch of emergency medical services to foster continuous improvement in performance and quality patient care.
- B. Each QI/QA Program shall have a written plan that is reviewed annually and updated as needed. The plan should include, at minimum, the following

components:

1. Mission statement, objectives, and goals for process improvement
 2. Organizational chart or narrative description of how the QI/QA program is integrated within the dispatch center, process(s) for data collection and reporting. Include templates utilized used in standardized reports
 - ~~3.~~ Key performance measures or indicators related to delivery of emergency medical dispatching
 - ~~3.4.~~ Methods or activities designed to address deficiencies and measure compliance to protocol standards as established by the EMD Medical Director through ongoing random case review for each emergency medical dispatcher
 - ~~4.5.~~ A description of methods used to provide ongoing feedback and disseminate findings to dispatch personnel
 - ~~5.6.~~ Activities designed to acknowledge excellence in the delivery of emergency medical dispatch performance
- C. The QI/QA process shall:
1. Monitor the quality of medical instruction given to callers, including ongoing random case review for each emergency medical dispatcher and observing telephone care rendered by emergency medical dispatchers for compliance with policies and/or defined standards.
 2. Conduct random or incident specific case reviews to identify calls/practices that demonstrate excellence in dispatch performance and/or identify practices that do not conform to policy or standards so that appropriate training can be initiated.
 3. Review EMD reports, and/or other records of patient care to compare performance against medical standards of practice.
 4. Recommend training, policies and procedures for quality improvement.

CROSS REFERENCES:

Prehospital Care Manual:

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

PRINCIPLES:

1. Base Contact is made by paramedics to establish online medical direction for additional guidance on field care beyond what is contained in the offline treatment protocols.
2. Once the patient is no longer present and under the care of the paramedic medical direction is not needed. Therefore, this policy does not apply and Base Contact is not required.
3. Base Contact for all patients shall be made according to the requirements below and at the judgment of the treating paramedic. Access to online medical direction is not limited to those conditions listed below.
4. For children 13 to 36 months of age, Base Contact and/or transport is required, except those with no medical complaint or with isolated minor extremity injury.
5. Children less than or equal to 12 months of age must be transported in accordance with [Ref. No. 510](#), regardless of provider impression or field treatment rendered, and if a parent or caregiver refuses transport, Base Contact shall be made prior to signing the patient out Against Medical Advice (AMA).
6. Base Contact criteria below still apply if the patient is on scene and refusing transport (AMA). This includes parents or legal guardians who refuse transport of a pediatric patient.
7. This document provides a quick reference list for Base Contact requirements; it does not replace the treatment protocols or the guidance there within, which shall be followed at all times unless otherwise directed by online medical direction.

GUIDELINES:

1. Base Contact is required when consultation with the base would be helpful such as:
 - a. Patient presentation renders the provider impression and appropriate treatment protocol unclear
 - b. Additional or unlisted treatments are required
2. Base Contact is required for children who meet transport guidelines to a Pediatric Medical Center ([Ref. 510](#))
3. Base Contact is required for patients in traumatic full arrest who do not meet criteria for determination of death per [Ref. 814](#). In these instances, Base Contact shall be made with the Trauma Center.
4. Base Contact is required for the following provider impressions in all patients:

- a. Anaphylaxis
 - b. Cardiac Arrest – Non-traumatic (unless patient meets determination of death by Ref. 814)
 - c. Childbirth
 - d. Dystonic Reaction
 - e. Hypotension
 - f. Respiratory Failure
 - g. Shock
 - h. Stroke / CVA / TIA
5. Additionally, Base Contact is required for the following provider impressions in pediatric patients:
- a. BRUE
 - b. Chest Pain – Suspected Cardiac / Chest Pain - STEMI
 - c. Pregnancy/Labor
 - d. Newborn
6. Base Contact is required for the following provider impressions under the specified conditions:
- a. Airway Obstruction
 - Severe respiratory distress or respiratory arrest
 - b. Altered Level of Consciousness (ALOC)
 - Persistent ALOC of unclear etiology
 - c. Behavioral Crisis / Psychiatric Crisis
 - Treatment with midazolam
 - EMS concern for suicidal intent in person not on 5150/5585 hold and refusing voluntary treatment or transport
 - d. Burns
 - ≥ 15 years with 2nd or 3rd degree burns ≥20% TBSA
 - ≤ 14 years with 2nd or 3rd degree burns ≥10% TBSA
 - d.e. Cardiac Dysrhythmia
 - Rapid atrial fibrillation with poor perfusion
 - Symptomatic bradycardia
 - Wide complex tachycardia
 - e.f. Medical Device Malfunction

Treatment Protocol: BASE CONTACT REQUIREMENTS

Ref. No. 1200.2

- Ventricular Assist Device (VAD) malfunction

f.g. Overdose / Poisoning / Ingestion

- If signing out AMA

g.h. Pregnancy Complication

- >20 weeks with vaginal bleeding

h.i. Respiratory Distress (of any etiology e.g. Bronchospasm, Pulmonary Edema, Other)

- Severe respiratory distress unresponsive or not amenable to CPAP
- Unmanageable airway

i.j. Seizure

- Pregnant patient
- Status epilepticus

j.k. Submersion / Drowning

- ALOC
- Decompression illness

k.l. Traumatic Injury

- Crush syndrome
- Prolonged entrapment >30 minutes
- Trauma criteria or guidelines met
- Traumatic arrest not meeting criteria for determination of death per Ref. 814

7. Base Contact is required concurrently when the following treatments are initiated:

- a. Adenosine in pediatric patients
- b. Cardioversion
- c. Midazolam for treatment of agitation in an adult patient with behavioral/psychiatric crisis without immediate safety risk
- d. Push-dose epinephrine
- e. Transcutaneous pacing

8. Base Contact is required prior to initiating the following treatments:

- a. Additional dosing of normal saline or medications (e.g., midazolam, opiate analgesia) after the maximum dose is administered per protocol
- b. Calcium chloride for patients with calcium channel blocker overdose
- c. Cardioversion of a patient with adequate perfusion, or awake with a narrow complex tachycardia, or any atrial fibrillation
- d. Midazolam for treatment of agitation in a pediatric patient with behavioral/psychiatric crisis

without immediate safety risk

- e. IO placement beyond the indications listed in [MCG 1375](#)
- f. Sodium bicarbonate for symptomatic bradycardia with suspected hyperkalemia or for dysrhythmia due to possible tricyclic antidepressant or other toxic overdose
- g. Transcutaneous pacing if HR >40

1. Assess airway and initiate basic and/or advanced airway maneuvers prn (*MCG 1302*)
2. Prioritize treatment of systemic symptoms
For signs or symptoms of allergic reaction, treat in conjunction with *TP 1219, Allergy*
For poor perfusion (*MCG 1355*), treat in conjunction with *TP 1207, Shock/Hypotension*
3. Keep patient calm and limit activity
~~Position affected extremity at or below level of the heart~~
4. For SNAKE bites:
Splint the affected area
Elevate the extremity at or above the level of the heart
CONTACT BASE for destination guidance; strongly consider transport to a hospital with antivenom when feasible ①
5. For INSECT (bee, wasp, ant), spider and scorpion stings:
Remove stinger if visualized ②
Apply cold pack
6. For MARINE envenomation (e.g., jelly fish, stingrays and scorpion fish):
Remove barb when applicable
Soak area in hot water if available ③
7. Establish vascular access, preferably in the non-envenomated extremity, prn (*MCG 1375*)
8. For continued pain after specific measures above: refer to *MCG 1345, Pain Management*
9. For nausea or vomiting:
Ondansetron 4mg ODT/IV/IM, may repeat x1 in 15 min prn

SPECIAL CONSIDERATIONS

- ① For symptomatic patients, particularly those with severe symptoms (e.g., rapid swelling, respiratory distress, bradycardia, tachycardia, poor perfusion), direct transport to a hospital with antivenom will allow for rapid treatment which can improve patient outcomes. Symptoms may not be immediately apparent in the field.
- ①.② Remove stinger by scraping patient's skin with the edge of a flat surface (credit card or similar). Do not attempt to pull the stinger out with fingernails or tweezers, as this may cause release of additional venom.
- ②.③ Do not use vinegar given the type of jellyfish endemic to California.



Treatment Protocol: STINGS / VENOMOUS BITES

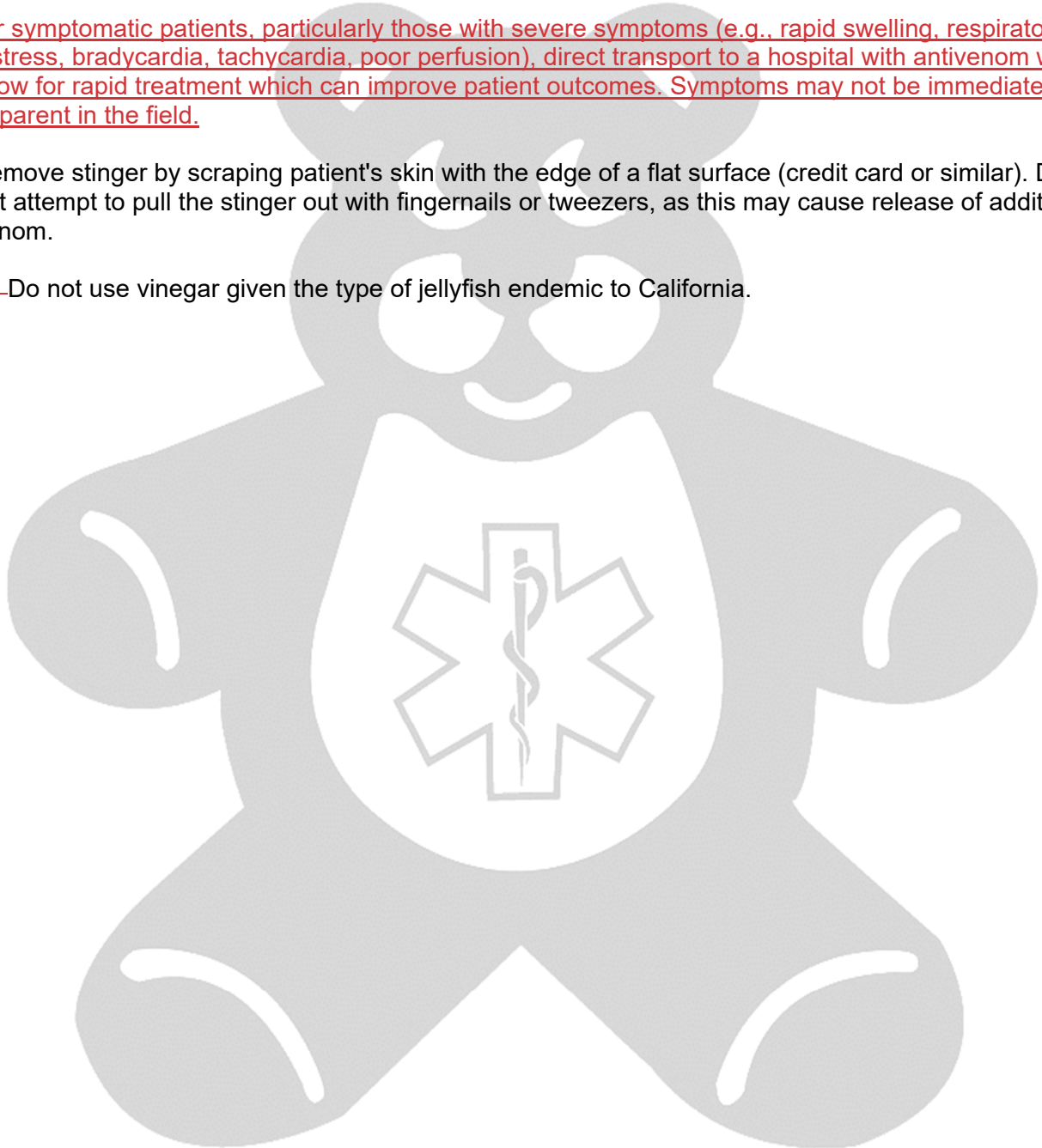
Ref. No. 1224-P

1. Assess airway and initiate basic and/or advanced airway maneuvers prn (*MCG 1302*)
2. Prioritize treatment of systemic symptoms
For signs or symptoms of allergic reaction, treat in conjunction with *TP 1219-P, Allergy*
For poor perfusion (*MCG 1355*), treat in conjunction with *TP 1207-P, Shock/Hypotension*
3. Keep patient calm and limit activity
~~Position affected extremity at or below level of the heart~~
4. For SNAKE BITES:
Splint the affected area
Elevate the extremity ~~to~~ at or above the level of the heart
CONTACT BASE for destination guidance; strongly consider transport to a hospital with antivenom when feasible 1
5. For INSECT (bee, wasp, ant), SPIDER and SCORPION STINGS:
Remove stinger if visualized ~~2 1~~
Apply cold pack
6. For MARINE ENVENOMATIONS (e.g., jelly fish, stingrays and scorpion fish):
Remove barb when applicable
Soak area in hot water ~~3 2~~
7. Establish vascular access, preferably in the non-venomated extremity, prn (*MCG 1375*)
8. For continued pain after specific measures above: refer to *MCG 1345, Pain Management*
Dose per *MCG 1309*
9. For nausea or vomiting in patients ≥ 4 years old:
Ondansetron 4mg ODT



SPECIAL CONSIDERATIONS

- ① For symptomatic patients, particularly those with severe symptoms (e.g., rapid swelling, respiratory distress, bradycardia, tachycardia, poor perfusion), direct transport to a hospital with antivenom will allow for rapid treatment which can improve patient outcomes. Symptoms may not be immediately apparent in the field.
- ② Remove stinger by scraping patient's skin with the edge of a flat surface (credit card or similar). Do not attempt to pull the stinger out with fingernails or tweezers, as this may cause release of additional venom.
- ③ ~~②~~ Do not use vinegar given the type of jellyfish endemic to California.



Medical Control Guideline: MECHANICAL CIRCULATORY SUPPORT DEVICES

PRINCIPLES:

1. A Mechanical Circulatory Support (MCS) device is an implanted device that is used to partially or completely replace the function of a failing heart in adults and children. MCS devices may be used as a bridge to transplant or as destination therapy for those who are not transplant candidates.
2. There are several types of MCS devices. A ventricular assist device (VAD) can support the function of the left ventricle with a left ventricular assist device (LVAD), the right ventricle (RVAD), or both ventricles (biventricular device). A total artificial heart (TAH) replaces the heart itself. The most common device is currently a LVAD.
3. MCS patients have a coordinator available 24 hours a day who will provide direction on managing the device. Contact information for the device coordinator may be located on the device, refrigerator, medical-alert bracelet or on a card in the patient's wallet.
4. The patient and family members receive extensive training on their specific MCS device and should be utilized in the care of the patient.
5. Many MCS device patients are on anticoagulants and prone to bleeding.
6. MCS device patients are preload dependent and may be harmed by vasodilators (e.g., nitrates).
7. Most MCS device patient emergencies will NOT be related to malfunction of the device.

Ventricular Assist Devices (VAD)

8. Due to the continuous (non-pulsatile) flow of VAD devices, vital signs such as blood pressure, heart rate, and pulse oximetry are unobtainable or unreliable and perfusion status should be based on the clinical exam. Capnography will read accurately and can provide valuable information on the patient's perfusion status.
9. All VAD patients can be defibrillated and cardioverted, if indicated.
10. Chest compressions may dislodge the internal VAD tubes from the heart, causing the patient to bleed into the thoracic and/or abdominal cavities; however, chest compression should be performed on VAD patients in cardiac arrest when in accordance with the patient's wishes.

Total Artificial Heart (TAH)

11. The TAH produces pulsatile flow with a palpable pulse and measurable blood pressure.

12. TAH patients cannot be defibrillated or cardioverted and do not produce an ECG tracing.
13. Systolic hypertension increases afterload and may lead to pulmonary edema. In this situation, careful administration of vasodilators may be considered.
14. Chest compressions should not be performed on TAH patients because non-compressible mechanical chambers have replaced the ventricles.

GUIDELINES:

1. If there is concern for device malfunction, call the MCS device coordinator directly to assist with troubleshooting.
2. Mechanical Circulatory Device resources are available 24/7 at the following institutions:
 - Cedars-Sinai Medical Center – (310) 887-0599
 - Ronald Reagan - UCLA Medical Center (310) 825-6301, pager #93544
 - Keck Hospital of USC – (323) 442-6077
3. When a MCS patient is experiencing signs and symptoms related to the device, every effort should be made to transport the patient to their MCS hospital. Allow the family member or caregiver to ride with the patient if treatment and space permit. If transport to the MCS hospital is not feasible, strongly consider transport to the closest SRC with cardiothoracic surgery capabilities.
4. If the MCS coordinator is not reachable and/or additional orders are required, contact the Base hospital.
5. Treat MCS patients by the appropriate treatment protocol, based on your provider impression.
6. Attempt to locate an Advanced Healthcare Directive and/or a Standardized Patient-Designated Directives [e.g., Physician Orders for Life-sustaining Therapy (POLST), State DNR Form]. Most MCS device patients have made end-of-life care decisions.
7. Given that MCS devices are preload dependent, administer fluids early when directed by the Treatment Protocol.
8. All of the patient's MCS device equipment must accompany them to the hospital. Make sure all equipment is safely secured prior to transport to ensure that the driveline is not pulled or cut during transport. Spinal motion restriction and/or splinting may be modified to protect the integrity of the MCS device equipment.

Ventricular Assist Devices (VAD)

9. Do not administer nitroglycerin; give only aspirin and morphine or fentanyl when treating patients with provider impressions Chest Pain - Suspected Cardiac or Chest Pain - STEMI.

10. Utilize clinical parameters for patient assessment (e.g., skin color, capillary refill, level of consciousness and general appearance), because these patients will not have a blood pressure and/or palpable pulse.
11. The patient's underlying rhythm only requires treatment if the patient has signs of poor perfusion. If external defibrillation or cardioversion is necessary, apply the pads as to avoid an internal Pacemaker/Implanted Cardioverter Defibrillator (ICD) and use the standard amount of energy. DO NOT disconnect the system controller from the percutaneous lead (driveline) or stop the pump prior to delivering the shock.
12. The absence of a palpable pulse can make confirming cardiac arrest in VAD patients difficult. Assess poor perfusion by surrogate markers such as cool skin temperature, central cyanosis, poor capillary refill, and a low mean arterial pressure. Perfusion is considered adequate if any of the following is present: (1) normal skin color and temperature; (2) normal capillary refill; (3) mean arterial pressure greater than 50 mmHg; (4) partial pressure of end-tidal carbon dioxide greater than 20 mmHg.
13. Unresponsive VAD patients with poor perfusion are likely in cardiac arrest. Perform external chest compressions while a second clinician assesses for VAD malfunction in consultation with the device coordinator. Chest compressions should only be initiated if resuscitation is in agreement with the patient's Advanced Health Care Directive or Standardized Patient-Designated Directives (e.g., POLST, State DNR Form).
14. In an unconscious, pulseless patient with a VAD, a capnography reading of < 20 is an objective indicator of poor systemic perfusion and should prompt initiation of chest compressions.

Total Artificial Heart (TAH)

15. Do not administer epinephrine. The resulting increase in afterload may cause pulmonary edema and circulatory collapse.
16. For patients in respiratory distress with a systolic blood pressure >150mmHg, administration of nitroglycerin should be considered. Alternatively, the patient may be assisted in self-administration of their home dose of oral hydralazine.
17. For patients in cardiac arrest, assess for TAH malfunction in consultation with the device coordinator. Do not perform chest compressions or attempt defibrillation. The only therapeutic option is to restore the function of the device.

**Medical Control Guideline: NALOXONE DISTRIBUTION BY EMS PROVIDERS
(LEAVE BEHIND NALOXONE)**

PURPOSE: To authorize and describe procedures for EMS personnel to distribute naloxone kits to individuals at risk for experiencing or witnessing an opioid overdose.

PRINCIPLES:

1. Opioid overdose is one of the leading causes of death in the United States.
2. Naloxone is a life-saving medication that reverses an opioid overdose by blocking the opioid receptor, reversing the toxic effects of the overdose, with minimal to no effect on an individual if opioids are not present in their system.
3. Providing overdose prevention, recognition, and response education to drug users and their neighbors, friends, and families is a harm reduction intervention that saves lives.
4. The Naloxone Distribution Project (NDP) is a federally funded "Leave Behind Naloxone" initiative administered by the Department of Health Care Services (DHCS) in California to combat opioid overdose-related deaths through the free distribution of naloxone to qualifying entities for the purpose of distribution to persons at risk for opioid overdose and those in a position to assist those persons at risk. EMS agencies in California are qualified entities to participate in this program.
5. EMS personnel are encouraged to distribute naloxone to individuals at risk for opioid overdose, or any person in a position to assist individuals at risk, and train these individuals on appropriate naloxone use.

GUIDELINES:

1. EMS provider agencies may obtain naloxone kits, intended for layperson use, for distribution by EMS personnel to opioid overdose at risk individuals through the following mechanisms:
 - a. NDP by completing and submitting an application to the DHCS to participate in the NDP program (free of charge).
https://www.dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx
https://www.dhcs.ca.gov/individuals/Documents/NDP_Application.pdf
 - b. EMS provider's normal supply chain
2. Naloxone shall not be distributed to patients or bystanders from the responding EMS unit's (i.e., ALS/Assessment Unit) inventory supply.
3. EMS personnel may distribute naloxone, after performing a patient assessment, to individuals who are at risk for opioid overdose or to persons in a position to assist the individual at risk if the at-risk individual meets any ONE of the following criteria:
 - a. ~~The individual was treated by EMS for an opioid overdose with naloxone or supportive care~~Opioid overdose (requiring naloxone administration, supportive care, or monitoring)

- b. ~~The individual's history or physical exam demonstrates evidence of illicit opioid use (history of intravenous drug use, track marks, needles present, etc.)~~ History or physical exam with evidence of illicit drug use or paraphernalia (e.g., history of intravenous drug use, track marks, needles present in belongings, etc.)
 - c. ~~The individual's history~~ History or physical exam ~~demonstrates~~ with indicating prescription or recreational opioid use (~~prescribed or recreational~~)
 - d. ~~The P~~ physical environment has opioids or drug paraphernalia present
4. Distribution of naloxone to opioid at risk individuals must occur in accordance with the following procedures:
- a. Distribution Process
 - i. Assess and confirm the individual receiving the naloxone has decision making capacity
 - ii. Offer leave behind naloxone to the patient, and/or appropriate bystander(s); EMS may distribute to the patient and/or others present for whom EMS assesses risk~~family~~
 - ii. —
 - iii. If the individual(s) agrees to receive naloxone, perform teaching and/or direct the recipient to training aids just-in-time training on correct use ~~to the patient and family/supporting persons, if present~~
 - iv. Document leave behind naloxone distribution in the ePCR
 - iv. — ~~(distributed "leave behind naloxone should be described in narrative and accounted for as a medication administered in the ePCR, distinct from therapeutically administered naloxone).~~
 - b. Training
 - i. ~~Perform training for~~ Train the individual receiving naloxone including:
 - ~~Recognizing signs and symptoms of overdose~~
 - ~~Calling 911~~
 - ~~Naloxone administration~~
 - ~~Rescue breathing~~
 - Post-overdose care Assessing scene safety
 - Providing V verbal/tactile stimulation
 - Administering naloxone
 - Calling 9-1-1
 - Performing Recovery position/CPR when indicated
 - Positioning the patient in recovery
 - Staying with the patient until first responders arrive
 - ii. ~~Recommend that the trained individual can complete further training online at~~ Additional bystander training can be found at:
<https://www.getnaloxonenow.org/#home>
 - c. Disposition
 - i. ~~PAI~~ patients treated for opioid overdose should be managed in accordance with TP 1241 or 1241-P, Overdose / Poisoning / Ingestion

- ii. Patients who decline transport against medical advice should still be offered "Leave Behind Naloxone"
- d. End of Shift
- i. Re-stock naloxone kits
 - ii. Submit naloxone distribution log per provider agency procedures and in accordance with NDP requirements if participating in the NDP program.
<https://www.dhcs.ca.gov/individuals/Pages/Naloxone-Distribution-Project.aspx>
 - ~~iii. Submit naloxone distribution logs to the EMS Agency quarterly~~