COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

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

DATE: July 15, 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

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 May 20, 2026

3.2 **Committee Reports**
- 3.2.1 Base Hospital Advisory Committee – June 10, 2026
- 3.2.2 Provider Agency Advisory Committee – June 17, 2026

3.3 **Policies**
- 3.3.1 Reference No. 204: Medical Council
- 3.3.2 Reference No. 324: Sexual Assault Response Team (SART) Center Standards
- 3.3.3 Reference No. 834: Patient Refusal of Treatment/Transport and Treat and Release at Scene
- 3.3.4 Reference No. 834.1: Patient Refusal of Treatment/Transport and Treat and Release at Scene Quick Reference Guide

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)

4.6 Commission Annual Report

5. LEGISLATION

6. DIRECTORS' REPORTS

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

Correspondence

6.1.1 (05/27/2026) From EMS Authority: Exceedance of Ambulance Patient Offload (APOT) Standards – April 2026 Electronic Notification pursuant to Title 22, Division, 9, Chapter 1.2, § 100007.02

6.2 Nichole Bosson, MD, Medical Director – EMS Agency

7. COMMISSIONERS' COMMENTS / REQUESTS

8. ADJOURNMENT

Adjournment to the meeting of September 9, 2026

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/

MINUTES
May 20, 2026

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

GUESTS

Samuel Calderon, LACoFD	Laurie Donegan, APCC	Jack Yandell, IAEP
Dave Molyneux, AmWest Ambulance	Michael Stone	

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 1:03 p.m. There was a quorum of 13 commissioners present.

2. **INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS**
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.

3. **CONSENT AGENDA:** *Commissioners/Public may request that an item be held for discussion. All matters are approved by one motion unless held.* EMS Agency Director Richard Tadeo explained that the current Consent Agenda includes Minutes from the March 18th meeting, due to the lack of quorum, those Minutes are included here for technical purposes for approval.

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**
- 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
  Commissioner Uner questioned whether a perinatal patient over 20 weeks should be transported through the Most Assessable Receiving (MAR) for a non-pregnancy-related condition, such as an ankle fracture, should be transported to a perinatal center. Director Tadeo responded that transport to a perinatal center would only occur if the patient's condition or injury was related to the pregnancy or perinatal condition.
- 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
  Commissioner Uner recommended increasing the required Sodium Bicarbonate supply to 100 mL per vehicle to align with EMS protocols. Medical Director Dr. Nichole Bosson agreed with the recommendation.
  Commissioner Uner also recommended replacing the specified tonsillar tip suction catheters with a large-bore suction catheter since it would limit it to the yankauer which he doesn't believe would be sufficient. He also suggested adding a no-touch thermometer option, but the no-touch thermometer recommendation was disallowed due to accuracy concerns identified in 2022–2023.
  Director Tadeo agreed to adopt the recommendations regarding the Sodium Bicarbonate supply and large-bore suction catheters, and they will be forwarded to the Provider Agency Advisory Committee for further review.

  Motion/Second by Commissioners Uner/Cheung to approve the recommended changes to Policies 3.3.8 "Reference No. 703: ALS Unit Inventory", 3.3.11: "Reference No. 706: ALS EMS Aircraft Inventory" and was carried unanimously.

- 3.3.9 Reference No. 703.1: 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

Motion/Second by Commissioners Kang/Uner to approve the Consent Agenda was carried unanimously excluding Policies 3.3.5: "Reference No. 511: Perinantal Patient Destination", 3.3.8: "Reference No. 703: ALS Unit Inventory", 3.3.11: "Reference No. 706: ALS EMS Aircraft Inventory"

END OF CONSENT AGENDA

4. BUSINESS

Business (Old)

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

Director Richard Tadeo, EMS Assistant Director Jacqui Rifenburg, and Commissioner Dr. Erick Cheung discussed next steps for the workgroup. One area of focus is expanding the use of psychiatric urgent care centers. A review of potential facilities identified only one additional psychiatric urgent care center that currently appears to meet the necessary criteria. The workgroup plans to distribute a survey to other psychiatric urgent care centers to determine which of the required criteria they currently meet. Director Tadeo also reported that he has been participating in discussions with the LA Safety Net Consortium regarding anticipated healthcare budget cuts and their financial impact. He noted that behavioral health remains a primary concern, as limited behavioral health resources contribute to emergency departments' inability to reduce patient volumes. A workgroup is evaluating additional psychiatric urgent care centers that could serve as referral destinations for emergency department patients. It was noted that the number of patients transported from the 911 system is relatively small compared with those brought in by law enforcement or those who present as walk-in patients. Assistant Director Jacqui Rifenburg reported that, of the nine psychiatric urgent care centers in Los Angeles County, only two have not been approved by the EMS Agency. The survey will be distributed to those facilities to identify any gaps and determine how outstanding issues can be resolved.

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

Assistant Director Jacqui Rifenburg presented the first-quarter Ambulance Patient Offload Time (APOT) data report.

Commissioner Carole Snyder reported that the state's audit database has been unavailable since April 19. Director Tadeo added that the state is in the process of transitioning its data systems to a cloud-based platform, a process that has experienced implementation challenges. The current priority is migrating the central registry for EMT and paramedic licensure, followed by the transition of all EMS databases to the new cloud-based system, EMS Flow. Director Tadeo noted that APOT data reporting may be delayed during the transition. The EMS Agency will use its own APOT data to verify the accuracy of the data submitted once the state system is fully operational. Correspondence Item 6.1.1 from the Director of EMSAA highlighted ongoing efforts to address Ambulance Patient Offload Time (APOT). The list presented ranked hospitals based on APOT performance, with the 15 hospitals experiencing the highest APOT receiving targeted bi-weekly follow-up calls to monitor the implementation of their APOT mitigation plans. At the time of the report, nine hospitals were being actively monitored; that number has since decreased to seven, indicating progress in reducing APOT among the targeted facilities.

4.3 **Interfacility Transfer Taskforce**

Assistant Director Rifenburg reported on the nine months of data collected regarding 911 interfacility transports (IFTs). The data showed monthly variability. For the period from July through October 2025, some transports were classified as "unknown." The IFT Workgroup determined that these cases required adjudication, and beginning in November 2025, the group began reviewing charts and databases to determine whether the transports were appropriate or not. At the previous meeting, it was agreed to continue data collection through July 2026. Assistant Director Rifenburg also reported that many of the high-utilizing facilities identified since the taskforce's inception have significantly reduced their use of 911 for interfacility transports. The current area of concern is the increased use of 911 by long-term acute care facilities for patient transfers. The group plans to discuss this issue with the California Department of Public Health (CDPH) and engage with long-term acute care facility leadership to review transport appropriateness and the policies that should be in place. Director Tadeo mentioned another option they are considering is reaching out to County Counsel in developing a policy on interfacility transports utilizing the 911 system.

Cardiac Arrest Taskforce

Vice Chair Sanko reported that the Cardiac Arrest Task Force is approaching its one-year anniversary and has completed its fifth month of educational clinics for provider agencies and hospitals. The Task Force has asked fire departments and hospitals to develop a one-page plan outlining how they intend to achieve the American Heart Association (AHA) 2030 goals for improving patient-centered outcomes for both out-of-hospital and in-hospital cardiac arrests. Participation has included a minimum of 30 representatives from provider agencies and up to 100 participants from hospitals. Vice Chair Sanko reported that the Task Force has also met with several hospitals and hospital systems to help harmonize their implementation plans. The emphasis is on system-wide participation, ensuring that all facilities within a health system, rather than individual facilities alone, are engaged in achieving the AHA 2030 goals.

4.4 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

AB1607 – The Richie Fund is currently set to expire on January 1, 2027. EMSAAC is co-sponsoring the bill to extend the fund's authorization. The bill has advanced through several committees, and an amendment was adopted to extend the expiration date to January 1, 2037.

SB985 - This bill addresses the testing and implementation of the Next Generation 911 emergency communications system. It requires the consortium, which is being established under California Office of Emergency Services (OES), to provide quarterly progress reports. The bill also specifies that OES may not issue a Request for Proposals (RFP) until the criteria established by the board have been met.

AB 2405 – Sponsored by Assembly member Gibson in South Los Angeles, this bill would require law enforcement officers to transport patients to the nearest emergency department whenever they are transporting an individual for medical care. Director Tadeo has been working with the Supervisor's Office, which supports the bill but is also considering its broader operational implications. The proposed requirement could affect existing transportation arrangements already established by the Sheriff's Department. For example, individuals in

custody who receive care through Correctional Health Services are often transported to designated hospitals rather than the closest emergency department. The bill would also impact law enforcement agencies that have contracts with specific hospitals to perform medical clearance. The bill includes language authorizing the Attorney General to impose fines on law enforcement agencies that fail to comply with its requirements. The legislation has passed both the Health Committee and the Public Safety Committee and will next be considered by the Appropriations Committee. Commissioner Camacho will share this information at the upcoming Los Angeles County Police Chiefs' Association meeting.

6. DIRECTORS' REPORTS

5.1 Richard Tadeo, EMS Agency Director, EMSC Executive Director

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

The report was released in late March and presented three recommendations regarding the allocation of Measure B funds. The report addresses the 18% of total Measure B funding allocated to the 13 non-County trauma hospitals.

Each year, a meeting is coordinated with the Hospital Association and participating hospitals to develop the funding allocation formula. The formula considers the fixed costs associated with operating as a trauma center, the costs of serving as a base hospital, and a flat fee for maintaining specialty call panels. In addition, Intergovernmental Transfer (IGT) matching funds are allocated based on the number of Medi-Cal-eligible patients served, with hospitals treating higher-acuity patients receiving greater reimbursement.

The report outlined three options: (1) maintain the current allocation method; (2) have the Measure B Advisory Board conduct an annual needs-based assessment to determine allocations, which would require issuing a Request for Proposals (RFP) and retaining a consultant; or (3) dissolve the Measure B Advisory Board and transfer its responsibilities to the EMS Commission.

The hospital funding allocations have been completed and a Board letter was scheduled for consideration on June 9 for approval.

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

Each member of the Board of Supervisors was allocated $4 million for projects within their district. Most of the money has been allocated except for $300,000.

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. The team was looking forward to transitioning to Phase 2, comparing Supraglottic Airway (SGA) to Endotracheal Intubation (ETI) in other EMS systems around the country, however it was determined that there were insufficient number of patients and not enough funds to complete that phase of the trial. They are looking at an observational data collection period that will allow them to gather further data on the ventilation component, which is another component of the trial. They are gathering cardiac monitor files to understand ventilation strategies in addition to airway device strategies in pediatric patients. This will not impact the provider agencies, but the team will continue to collaborate with hospitals for the data. It is still a funded National Institute of Health (NIH) trial, and we are participating in the efforts to analyze the data and to put forth manuscripts that really help to inform pediatric airway management in EMS systems.

PediDose
Enrollment for PediDose will continue until the end of July 2026. Our protocols will remain unchanged but that will be the end of the data collection. We hope to be able to provide future protocols for our system to optimize our strategy for pediatric seizure management by the fall.

LA-DROP
We now have over 100 transfusions across all five (5) sites in California and more than 50% have occurred in Los Angeles County. We continue to meet and collaborate with the 5 counties that have implemented and there are several more counties in California that have been approved. We expect to expand within the year to include LA County Sheriff's Department carrying blood on Air 5 as well as Pasadena Fire Department who will mirror Compton Fire Department's program. LA County Fire received additional funding to expand to additional units in other areas including Pomona Valley. This continues to be an effort to bring prehospital blood transfusion access to more areas over the county.

Prehospital Lung Ultrasound Pilot
The pilot launched on April 1st. The prehospital lung ultrasound is a very accurate way to identify pulmonary edema in patients out on the field. We currently have six (6) enrollments and paramedics at Burbank and Sierra Madre Fire Departments have been trained. Sierra Madre Fire has put the ultrasounds on their ambulances and Burbank Fire is finishing up with the contracting. This will be a before and after evaluation and we're looking through two patient outcomes and ED diagnosis. Once complete, this will be the first study to look at patient centered outcome in the application of prehospital lung ultrasound.

Stroke Routing Analysis
For the past two years, we have been working with collaborators at UCLA, as well as the EMS Agency, to evaluate our current two-tiered stroke routing system. Under this system, patients are routed based on their LAMS score, either to their designated Primary Stroke Center or to the nearest Comprehensive Stroke Center (CSC).
We recognize that there are limitations to that stroke scale in the field and to all stroke scales and so we engaged with collaborators to look at the impact of direct to CSC routing for all our EMS stroke patients. The analysis examined four key areas:

Access: Whether all EMS stroke patients would have access to a Comprehensive Stroke Center
Hospital volumes: The impact on patient volumes at both Comprehensive Stroke Centers and Primary Stroke Centers.
Transport and treatment times: The effect on EMS transport times and time to intervention so we can understand the impact on thrombolysis and thrombectomy.
Accuracy: How much would we reduce the under triage of patients who currently are being routed to primary stroke centers who could benefit from going to a comprehensive stroke center.
The group is gathering data and reactions from all our systems to better understand how this impacts individual hospitals and engage with our primary stroke centers and comprehensive stroke centers to understand the impact of this potential change and how we might optimize our system if we decide to move forward. This is a data gathering exercise without a specific plan on whether to make a change, but we recognize that 15-16% of patients being routed to a primary stroke center would benefit from routing to a comprehensive stroke center.

Trauma Data Collaborative
We currently have multiple data collaborative groups including, STEMI cardiac arrests, Stroke data, Pediatric and the Southern California trauma consortium that we engage with but much of their focus has been on prospective trials in hospital-based data collection. With the Trauma Data collaborative, we want to ensure that we leverage our trauma data to understand how we can improve our EMS system. With the trauma dashboard that is being led by Dr. Jake Toy, there are many opportunities to derive questions that we start to answer with our data.

EMS UPDATE
EMS update is ongoing with Dr. Shira Schlesinger as the lead. We are updating the perinatal policies to include magnesium sulfate for the treatment of preeclampsia and eclampsia. We are also including capnography to spontaneously ventilating patients with a focus on pediatric arrest resuscitation. We recognized through a QI project that our outcomes of pediatric out of hospital cardiac arrests can be improved and this intersects with Dr. Sanko's efforts with the cardiac arrest taskforce. All trainings and updated policies will go live on July 1st.

PROTOCOL MOBILE APPLICATION Project (Rapid LA County Medic)
A publication which describes how we created the protocol mobile application (RAPID) was accepted and it is in preproduction online. We also received funding through the Board of Supervisors to update our LA County Drug Doses mobile application, 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 Office of Traffic Safety (OTS) Grant, we are looking at utilization of RAPID throughout the County. Dr. Toy has done some data analysis. We will be reconvening our taskforce to look at ways we can improve.

Vimeo Channel
A new public-facing Vimeo channel has been launched to expand educational opportunities and improve communication with EMS providers. As an example, Dr. Bosson and Dr. Whitfield worked with UCLA toxicology experts to create a resource listing hospitals that stock antivenom, which was shared through RAPID. Dr. Whitfield also created an EmergiPress video on snakebite management that was posted on the Vimeo channel. This was a great demonstration on how using multiple resources can help with delivering information rapidly.

Sidewalk CPR
Sidewalk CPR awareness week is June 1st though June 7th. We will be kicking off at Los Angeles General Medical Center with a press event. We are encouraging everyone to get trained and train people so that we can continue the efforts and increase our bystander CPR rates in the county.

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

2026 FIFA World Cup
The Medical Hosts Committee continues to meet monthly, and planning efforts are progressing. A larger stakeholder meeting will be held at SoFi Stadium, where all matches will take place, to review operational plans. Planning has been coordinated with the Los Angeles County Fire Department, the independently contracted medical team supporting SoFi Stadium, and the private company providing on-field medical care for players. Additional events, including Fan Fests at the Coliseum, are being coordinated by the Los Angeles Fire Department. Jurisdictional fire departments have been connected with Fan Fest organizers and the Medical Alert Center to support emergency action planning, including preparedness for potential mass casualty incidents. A mass casualty preparedness workshop was held for hospitals in collaboration with FEMA. The workshop focused on mass casualty response planning and provided hospitals with an opportunity to review their hospital readiness plans. The opening match will be for the USA team on June 12th.

LA 28
Meetings have been led by the U.S. Secret Service due to the event's designation as a National Special Security Event (NSSE). Subcommittees have been established and are reporting through the Secret Service structure. We will have more movement after the World Cup.

7. COMMISSIONERS' COMMENTS / REQUESTS

Commissioner Eric reported that, effective June 1, CDPH will require specific nurse-to-patient ratios in acute psychiatric hospital facilities. The new requirements are expected to reduce psychiatric bed availability. HASC and CHA have been highly involved, and a pause in implementation is not anticipated. The mandate includes a 6:1 ratio for adult patients and a 5:1 ratio for pediatric patients, and statewide hiring needs are estimated at approximately 910 full-time psychiatric nurses.
Hospitals operating these facilities are considering temporary or prolonged bed closures to avoid daily fines of $15,000–$30,000. Current ratios are already 6:1; however, they may be met using a range of qualified staff. Dr. Chueng will provide contact information of the behavioral health leads to the Commissioners.

8. ADJOURNMENT

Next Meeting: Wednesday, July 15, 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:
Vanessa Gonzalez
Management Secretary III

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

June 10, 2026

MEMBERSHIP / ATTENDANCE

	Representatives			Representatives	
	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		Jeanette Souza	Southern Region
	Carol Synder, RN	EMS Commission	X	Christine Farnham	Southern Region, Alternate
	Erick Cheung, MD	EMS Commission	X	Ryan Burgess	Western Region, Alternate
	Brian Saeki	EMS Commission	X	Travis Fisher	Western Region
	Carol Kim	EMS Commission	X	Lauren Spina	Western Region
X	Gabriel Campion	Base Hospital Medical Director	X	Susana Sanchez	Western Region
X	Salvador Rios	Base Hospital Medical Director, Alternate	X	Kate Bard	Western Region
X	Adam Brown	Provider Agency Representative	X	Aspen Di Ioli	Eastern Region
	David Hickman	Provider Agency Representative, Alt.	X	Alina Candal	Eastern Region
X	Elizabeth Charter	PedAC Representative	X	Jenny Van Slyke	Eastern Region, Alternate
	Desiree Noel	PedAC Representative, Alternate	x	Lila Mier	County Region
X	Colleen Greer	MICN Representative	X	Emerson Martell	County Region
	Vacant	MICN Representative, Alternate		Antoinette Salas	County Region
			X	Yvonne Elizarraraz	County Region

EMS Agency			Prehospital Care Coordinators	Guests
Ami Boonjaluksa	Priscilla Ross	X	Brandon Koulabouth (AMH)	Shane Cook (LACoFD)
Shira Schlesinger, MD	Hanna Kang	X	Mary Jane Evangelista (QVH)	Laurie Sepke (PVC)
Lorrie Perez	Paula Cho	X	Lauren Hawk (HCH)	Tassia Trink (TOR FD)
Michael Kim, MD	Mark Ferguson	X		Ashley Sanello, MD (TOR)
Nicole Bosson, MD		X		Thomas Vu, MD (SFMC)
Jacqueline Rifenburg				Kelsey Wilhelm, MD (HGH)
Paul Aragon, MD				
Lily Choi				

1. **CALL TO ORDER:** The meeting was called to order at 1:01 P.M. by Dr. Gabriel Campion, Chair Pro Tempore

2. **INTRODUCTIONS/ANNOUNCEMENTS:**
   2.1 **Joint Educational Session** – *Heat Stroke by Phoenix Fire Department* on September 1, 2026, will feature the Phoenix Fire Medical Director and Fire Chief to discuss heat stroke management strategies, including on-scene cold-water immersion

   2.2 **EMSC Educational Forum** will be held in Fairfield, CA on November 5, 2026, and will focus on pediatric care across prehospital and emergency department settings.

   2.3 **National Pediatric Readiness Project (NPRP)** survey closed May 31. The national completion rate was reported at 82% with California achieving a 98% completion rate.
   - Only seven hospitals statewide did not complete the survey; three were located in Los Angeles County

   2.4 **CPR and AED Awareness Week** occurred Jun 1-7. The EMS Agency coordinated a community event to kick off the week with LA General Medical Center, LA County Fire and LA City Fire and the American Red Cross and trained more than 300 individuals on hands only CPR.
   - Forty-six (46) provider agencies and organizations registered to participate

   2.5 Christine Farnham, PCC from Providence Little Company of Mary Torrance announced she will be retiring.

3. **APPROVAL OF MINUTES**: The meeting minutes for April 8, 2026, were approved as submitted.

   M/S/C (Brown/Wombold)

4. **NEW BUSINESS**
   4.1 Pediatric Perinatal Protocols
   - Dr. Bosson proposed to consolidate adult and pediatric perinatal protocols to reduce complexity, minimize potential confusion, and standardize treatment of pregnant patients regardless of age.
   - Review of two years of data identified only one pediatric patient requiring differentiated protocol application
   - Committee members expressed no significant concerns regarding the proposed direction

5. **OLD BUSINESS**
   .

6. **POLICIES (ACTION REQUIRED)**
   6.1 Reference No. 834, Patient Refusal of Treatment or Transport
   - Policy updated to allow treatment and release documentation for patients with established comfort-focused care goals.
   - Clarifies that these patients do not require Against Medical Advice (AMA) documentation.
   - Recommendation made to specify that base contact is not required in these situations.
   - Additional suggestion made to improve future documentation processes.

   Motion carried
   Policy approved

   6.2 Reference No. 834.1, AMA Quick Reference Guide

- Revisions align flowchart with comfort-focused goals-of-care provisions.
- Discussion included placement of explanatory footnotes and visual formatting improvements

Motion carried
Policy approved

POLICIES FOR INFORMATION ONLY (NO ACTION REQUIRED0

6.3 Reference No. 1200.2, Base Contact Requirements
- Policy updated to align with burn treatment protocols.
- Burn criteria requiring base contact were added for consistency.

6.4 Reference No. 1224/1224-P, Stings / Venomous Bites
- Protocol revised to support destination decisions for snake envenomation patients.
- Hospitals reporting availability of at least one adult dose of antivenom are listed in the Rapid App Quick Reference Guideline.
- Emphasis placed on transporting rattlesnake bite patients to facilities with antivenom availability whenever feasible.
- Educational materials regarding snakebite management have been released.

6.5 Reference No. 1325, Mechanical Circulatory Support Devices
- Updated transport guidance for patients with LVADs and other mechanical circulatory support devices.
- When transport to a patient's MCS hospital is not feasible, transport to the nearest STEMI Receiving Center (SRC) is strongly encouraged.

6.6 Reference No. 1337, Naloxone Distribution
- Updated application link to participate in the naloxone distribution project.
- Eligibility language simplified and aligned with statewide guidance
- Documentation requirements updated to reflect new NEMSIS reporting fields.
- Additional discussion ongoing regarding naloxone distribution for walk-up individuals who are not EMS patients.

7. REPORTS & UPDATES

7.1 EMS Update
- Clarification provided regarding intraosseous (IO) implementation timeline – between now and December 31, IOs will start being performed in new sites, distal femur in pediatrics and humeral heads for adults.
- Ondansetron updates clarified – IV/IM administration approved for patients six months or older; ODT dosing remains unchanged.
- Clarification regarding drowning resuscitation – it is reasonable to perform ventilations first prior to compressions; however, if it is not feasible due to lack of equipment, etc., do not delay initiation of compressions.
- Clarification on magnesium sulfate – can be mixed in 100mls of water or normal saline.

7.2 EmergiPress
- May/June edition focuses on snake envenomation.
- Included educational content developed with UCLA toxicology experts.
- July/August edition will focus on pediatric cervical spine assessment.

7.3 ITAC Update
- Committee continues to meet quarterly

- Topics discussed include Butterly BVM, AI to support data transfer between the field and hospital, language translation tools, alternative hemostatic agents
- Next meeting scheduled for August 3rd

7.4 ELCoR Committee
- Educational modules being developed for law enforcement personnel
- Once available, everyone is encouraged, especially provider agencies to engage with their local law enforcement to help disseminate
- Ongoing projects:
  - Medical clearance and custody-related educational resources
  - Pediatric critical patient response education to help law enforcement and dispatch communicate with hospitals

7.5 Research Initiatives & Pilot Studies

7.5.1 LA DROP
- Prehospital blood transfusion pilot exceeded one year of operation
- 69 transfusions completed within Los Angeles County, 150 transfusions for all of CAL DROP
- Program continues to demonstrate safety and feasibility with maintaining cold chain storage and limiting waste
- Expansion planned for additional provider agencies – LA Sheriffs, Pasadena Fire, LA County Fire Pomona region
- Working on additional education for base hospitals as program expands
- LA County Fire has begun using the Life Flow Rapid Infuser

7.5.2 PediDOSE
- The age-based guidance will include 6 months and above on July 1st.
- Data collections for patient enrollment will conclude after July 31st – base screeners, study documents, QR codes, PediDOSE brand will shut down
- No changes to protocols at this time until data is released

7.5.3 Pedi-PART
- Phase I enrollment completed
- Phase II will not proceed due to statistical limitations
- Proposed Phase III observational study under review
- Future work will focus on outcome data collection and ventilation analysis

7.5.4 Prehospital Lung Ultrasound (PLUS)
- Pilot launched with Sierra Madre Fire and Burbank Fire
- The study is evaluating the use of ultrasound to improve identification and treatment of pulmonary edema
- Currently, not inviting additional participants for the pilot

7.6 California Office of Traffic Safety (OTS) Grants Projects
- Survey of Rapid LA County Medic App users to be distributed
- Stakeholder meetings planned with the Department of Public Works, Department of Public Health, trauma centers, and injury prevention coordinators to discuss crash prevention and post-crash care initiatives

7.7 Cardiac Arrest Taskforce
- The final hospital educational clinic is scheduled for June 22nd.
- Initiative remains focused on achieving AHA 2030 cardiac arrest survival goals.
- Hospitals are encouraged to continue developing cardiac arrest improvement plans.
- Reached out to city councils and city managers to engage in their support.

7.8 Upcoming Mass Gathering Events

- World Cup activities and fan events underway throughout Los Angeles County.
- The EMS Agency released a Mass Casualty Incident video and preparedness activities though Vimeo
- Planning efforts will transition toward LA28 Olympic and Paralympic Games following the World Cup.

7.9 Health Data Exchange

- Participating hospitals remain in varying stages of implementation.
- Data matching with EMS records and hospital EMR records continues to be challenging.
- Additional education will be provided to providers regarding the importance of accurate patient documentation
- Standardization opportunities continue to be discussed to match records

8. OPEN DISCUSSION:

- Discussion on resource deployment model
- There is interest in reviving the Resource Deployment Workgroup to provide greater clarity regarding permissible resource deployment practices and to identify potential opportunities for implementation within Los Angeles County.
- Currently, more than 50% of systems across the country use different models.

9. NEXT MEETING: BHAC's next meeting is scheduled for **August 12, 2026**, location is the EMS Agency, Cathy Chidester Conference Room 1:00 P.M.

ACTION: Meeting notification, agenda, and minutes to be distributed electronically prior to the meeting.

ACCOUNTABILITY: Ami Boonjaluksa

10. ADJOURNMENT: The meeting was adjourned at 14:37 P.M.

EMERGENCY MEDICAL SERVICES COMMISSION
PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday – June 17, 2026

MEMBERSHIP / ATTENDANCE

	MEMBERS IN ATTENDANCE	ORGANIZATION
	Carol Meyer, Chair	EMSC, Commissioner
X	Kenneth Powell, Vice Chair	EMSC, Commissioner
	Jason Cervantes	EMSC, Commissioner
	James Lott, PsyD, MBA	EMSC, Commissioner
	Ken Domer	EMSC, Commissioner
	Kristin Kolenda	EMSC, Commissioner
	Ken Liebman	EMSC, Commissioner
X	Sean Stokes	Area A *(Rep to Medical Council)*
X	Patrick Nulty	Area A, Alternate
X	Keith Harter	Area B
	Clayton Kazan, MD	Area B, Alternate
	Jeffrey Tsay	Area C
X	Luis Manjarrez	Area C, Alternate
X	Victor Lemus	Area E
X	Geoffrey Dayne	Area E, Alternate
	Joel Davis	Area F
	Andrew Reno	Area F, Alternate
X	Adam Brown	Area G *(Rep to BHAC)*
X	Stefan Viera	Area G, Alternate
X	Matthew Conroy	Area H
X	Marc Cohen, MD	Area H, Alternate
X	Michael Campana	Area H, Alternate
X	Julian Hernandez	Employed Paramedic Coordinator
	Tisha Hamilton	Employed Paramedic Coordinator, Alt
	Jenny Van Slyke	Prehospital Care Coordinator
	Melissia Turpin	Prehospital Care Coordinator, Alternate
	Bryan Sua	Public Sector Paramedic Coordinator
	Drew Pryor	Public Sector Paramedic Coordinator, Alt
	Vacant	Private Sector Paramedic
	Scott Buck	Private Sector Paramedic, Alternate
	Tabitha Cheng, MD	Provider Agency Medical Director
X	Tiffany Abramson, MD	Provider Agency Medical Director, Alt
	Jonathan Lopez	Private Sector Nurse Staffed Amb Program
	Vacant	Private Sector Nurse Staffed Amb Program,
	Scott Jaeggi	EMT Training Program
	Albert Laicans	EMT Training Program, Alternate
	Ray Mosack	Paramedic Training Program
	Vacant	Paramedic Training Program, Alternate
	Heather Calka	EMS Educator
	Catherine Borman	EMS Educator, Alternate

EMS AGENCY STAFF	EMS AGENCY STAFF
Richard Tadeo	Nichole Bosson, MD
Jacqueline Rifenburg	Denise Whitfield, MD
David Wells	Shira Schlesinger, MD
Natalie Greco	Michael Kim, MD
Jennifer Calderon	Jonathan Warren, MD
Han Na Kang	Nnabuike Nwanonenyi
Gerard Waworundeng	Gary Watson

GUESTS	ORGANIZATION
Teri Salmon	LACoFD
David Milligan	Montebello FD
Kelsey Wilhelm, MD	Compton FD
Danielle Ogaz	LACoFD
Tyri Williams	Pasadena FD
Angela Loza-Gomez, MD	Area C Medical Director
Kristina Crews	LACoFD
Jennifer Nulty	Beverly Hills FD
James Duarte	Torrance FD
Konnor Pacheco	Lifeline Ambulance
Tassia Trink	Torrance FD
Puneet Gupta, MD	LACoFD
Michael Stone	USC Medical Center
Kristine Kuru	West Coast Ambulance
Jessie Castillo	PRN Ambulance
Rudolph Heib	Premier Ambulance
Lyn Riley	LASD, LH, SA
Caroline Jack	Beverly Hills FD
Kathyrn Ward	UCLA Ctr for Prehospital Care
Adrienne Roel	Culver City FD
Jim Goldsworthy	LAFD Air Ops, Redondo Bch FD
Kimberly Tan	UCLA Ctr for Prehospital Care

Quorum was established

1. **CALL TO ORDER –** Vice-Chair Kenneth Powell, called meeting to order at 1:00 p.m.

2. **INTRODUCTIONS AND ANNOUNCEMENTS**

2.1 Joint Educational Session – Heat Stroke *(Denise Whitfield, MD)*

- Phoenix Fire Department will be presenting Heat Stroke Management at the next joint educational session, scheduled for September 1, 2026. More information to follow.

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

- The in-person only, annual Forum is scheduled for November 5, 2026, in Fairfield California.
- EMS and CME will be provided.

2.3 Sidewalk CPR *(David Wells)*

- The EMS Agency thanked the 46 providers and organizations who participated in this year's Sidewalk CPR event, held June 1, 2026. There were over 300 individuals trained in Hands Only CPR.

- Providers are encouraged to continue providing the EMS Agency with the number of citizens trained at the individual locations. These numbers can be sent to either Natalie Greco (NGreco@dhs.lacounty.gov) or Priscilla Ross (PRoss2@dhs.lacounty.gov)

2.4 Survey: Paramedic's Perception on Care of People Experiencing Homelessness *(Tiffany Abramson, MD)*

- Dr. Abramson is working with UCLA and Stanford University, to research how EMS cares for individuals experiencing homelessness. Participation from EMS personnel to complete a short survey is requested.
- Those interested in participating in this anonymous 5–10-minute interview, may contact Dr. Abramson at Tiffany.Abramson@med.usc.edu .

3. APPROVAL OF MINUTES (Brown / Conroy) April 15, 2026, minutes were approved as written.

4. UNFINISHED BUSINESS

No unfinished business

5. NEW BUSINESS

5.1 Pediatric Perinatal Protocols *(Nichole Bosson, MD)*

- The EMS Agency asked this Committee for feedback on combining three Treatment Protocols related to pregnancy into one single Treatment Protocol. This would allow ease of reference for paramedics during the treatment of pregnant patients.
- The three Treatment Protocols that would be combined include:
  TP 1215-P, Childbirth Mother
  TP 1217-P, Pregnancy Complications and
  TP 1218-P, Pregnancy / Labor
- Minimal comments received; however, those who would like to provide comments via email, may contact Dr. Bosson at NBosson@dhs.lacounty.gov

Policies for Discussion; Action Required:

5.2 Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene *(Nichole Bosson, MD)*

Policy reviewed and approved as written.

M/S/C (Cohen / Lemus) Approve: 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 *(Nichole Bosson, MD)*

Policy reviewed and approved as written.

M/S/C (Cohen / Lemus) Approve: Reference No. 834.1, Patient Refusal of Treatment/Transport and Treat and Release at Scene, Quick Reference Guide.

Policies for Discussion; No Action Required:

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

5.4 Reference No. 227, Dispatch of 9-1-1 Emergency Medical Services *(David Wells)*
Policy will be returned after Dispatch Committee review.

5.5 Reference No. 1200.2, Treatment Protocol: Base Contact Requirements *(Nichole Bosson, MD)*

5.6 Reference Nos. 1224 / 1224-P, Treatment Protocol: Stings / Venomous Bites *(Nichole Bosson, MD)*

- Introduction of the Quick Reference Guide on the RAPID phone application.

5.7 Reference No. 1325, Medical Control Guideline: Mechanical Circulatory Support Devices *(Nichole Bosson, MD)*

5.8 Reference No. 1337, Medical Control Guideline: Naloxone Distribution by EMS Providers (Leave Behind Naloxone) *(Denise Whitfield, MD)*

- Recommended language revisions provided by Committee Member (Keith Harter, Area B); these will be reviewed by the EMS Agency.

6. REPORTS AND UPDATES

6.1 Health Data Exchange *(Richard Tadeo)*

- There has been a brief pause in the HDE project while the EMS Authority transitions their EMS repository into a cloud-based system. Provider's account activation will resume in approximately 4 weeks.
- Pomona Valley Hospital Medical Center will begin HDE in early July 2026.
- Memorial Hospital of Long Beach is currently conducting tests.
- Dignity Health Hospitals / Common Spirit has five hospitals that will be starting their Business Associate Agreements (BAA).
- Ronald Reagan UCLA Medical Center pushed their discovery phase to September 2026.
- Kaiser Foundation has shown interest, and the EMS Agency is beginning to meet.

6.2 EMS Update *(Shira Schlesinger, MD)*

- Providers were reminded that the classroom portion of EMS Update 2026 must be completed by the end of June 2026; the skills portion must be completed by the end of December 2026.

6.3 EmergiPress *(Shira Schlesinger, MD)*

- The May-June edition on snake bite management will be posted on the EMS Agency's webpage.
- The July edition will review pediatric cervical spine evaluation.

6.4 ITAC Update *(Shira Schlesinger, MD)*

- ITAC met in May 2026; next meeting is scheduled for August 3, 2026.
- Discussion on the Butterfly BVM device; and data sharing between field personnel and hospitals.
- A product called Vital Voice, offering a real-time offline language translation platform, is currently under review. Dr. Whitfield shared a video, demonstrating the potential use of this product.
- Those interested in piloting the Vital Voice product can reach out to Dr. Whitfield at (DWhitfield@dhs.lacounty.gov)

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

- Committee continues to meet quarterly.
- Representatives from the ELCOR Committee presented at the 2026 EMSAAC conference.
- New workgroup has been formed to discuss and prepare guidelines related to medical clearances prior to booking.
- A work group continues to address topics related to law enforcement and the treatment of pediatric critical events. Educational videos are in the process of being developed to share with law enforcement partners; with a go-live date in early October 2026. These videos will encourage on-scene treatment prior to EMS arrival, instead of a rapid "load and go" approach.
- This week, various groups from across the United States met in Sacramento to observe training sessions held by the Sacramento fire and police departments. This session demonstrated a response to active shooter scenarios, which followed a model developed by the International Mass Casualty Incident (IMCI) organization. ELCOR will be reviewing this model to determine if it's applicable to the Los Angeles County system.

6.6 Research Initiatives and Pilot Studies

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

- As of this meeting, there have been a total of 71 prehospital blood transfusions.
- During a recent EMS Medical Directors' Association of California (EMDAC) meeting held in Sacramento, there was an open forum discussion on how the Cal-DROP program can be sustainable, maintain its quality, and how more can be integrated into the EMS system.
- LA Sheriff's Department is planning to implement within the next couple of months; Pasadena FD is in the planning process of implementation; LACoFD will be expanding into the Eastern region of the County (late 2026); and LA City FD has shown interest in participating.
- Additional agencies interested in participating may contact Dr. Bosson.
- Dr. Wilhelm (Compton FD) has identified several sources of funding that may support expansion of the blood transfusion program.
- A tool kit is being developed to address all aspects when developing and implementing this program. More information to come.

6.6.2 PediDOSE Trial *(Nichole Bosson, MD)*

- Continuing to transition to the age-based dosing from ages 6 months and older. This will be posted on July 1st and goes into effect systemwide on this date.
- Completion of study enrollment will be completed on July 31, 2026.
- Effective August 1st, all documents related to the PediDOSE trial are to be removed from paramedic resources and units, including paramedic self-reporting (PSR).
- Results of this study should become available October-November 2026, and a decision will be made on how this may change the pediatric seizure medication dosing within our EMS system.
- Drug dosing application is currently being updated to show clearer instructions and reduce any redundancies.

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

- As announced in a previous meeting, Phase I of this study was completed in March 2026.
- Original plan was to move to Phase II, comparing the use of a Supraglottic Airway with Endotracheal Intubation in the pediatric population. However, due to potentially having an insufficient number of participants, Phase II will not be completed. Therefore, the Trial will move forward to Phase III, outcome data collection, which would not involve provider agencies.
- Pending NIH approval, the EMS Agency will continue with outcome data collection, which will end in March 2027.
- RALPH devices that were collected are now being returned to the manufacturer.
- Pedi-PART challenge coins were distributed to providers.
- Pediatric Readiness Scores – the EMS Agency is attempting to retrieve more information regarding the use and distribution of these scores, as well as how provider agencies may request their own scores. More information will follow.

6.6.4 Prehospital Lung Ultrasound *(Jonathon Warren, MD)*

- Goal of the 1-year Pilot is to look at how lung ultrasound, in addition to paramedic evaluations, can improve their diagnostic accuracy for pulmonary edema. Therefore, expedite appropriate treatment and care of those patients.
- Sierra Madre FD has 8 enrollments, and Burbank FD is pending implementation. More information will follow.

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

- RAPID Mobile Application: This year's grant funding will be used to look at the current mobile application and conduct updates/revisions for improvement.
- Post-Crash Care: Stakeholder meetings have started. Currently reviewing crash prevention and innovative maps that utilize our trauma center data to identify high priority / high-risk corridors throughout the County.

- Provider and/or hospital representatives who are interested in participating in these Post-Crash Care meetings can contact Dr. Schlesinger at SSchlesinger2@dhs.lacounty.gov . Next meeting will be held in mid-July 2026.

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

- A memorandum from the EMS Commission Task Force was distributed to providers, announcing a deadline extension to the end of 2026, to provide a plan on how their agency will address their department's needs and concerns related to improving cardiac arrest outcomes.
- The goal of this plan is to engage in the thought process and activities of how we can measure and improve cardiac arrest outcomes, with the target of meeting the AHA 2030 goals.
- June 22, 2026, (2pm) is the last task force meeting that will be held in efforts to share ideas and support for plan development. Providers interested in attending this meeting may reach out to Dr. Bosson for more information.
- Task Force Chair (Stephen Sanko, MD) has offered to meet with any individual provider or hospital, if they have questions regarding the development of their plans. Those interested in meeting with Dr. Sanko individually or sharing their proposed plans, may contact him at SSanko@dhs.lacounty.gov

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

- All FIFA World Cup soccer matches are held at SoFi Stadium (LA Stadium). As of today, there have been two of eight matches completed. There are six more matches scheduled through July 2026.
- LA Coliseum held the Fan Fest event. LAFD and LACoFD have been performing exceptionally in preparing for these events. Fan Fest completed this weekend without issue.
- Several official Fan Zones will be held across the County; mostly in LAFD and LACoFD jurisdictions but also include Burbank and Downey.
- LA28 Olympic planning is continuing. Medical subcommittees are starting to meet and will increase once the World Cup event closes.

7. OPEN DISCUSSION

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

- As mentioned in previous meeting, during Fall 2026, CHLA will be conducting a simulation study for pediatric resuscitation (Tele-EMS) and will be offering an opportunity for provider agencies to participate. This study will not be evaluating paramedic knowledge but instead, trying to optimize pediatric medical care. Details will be distributed later this week.

7.2 Stroke Routing Analysis *(Nichole Bosson, MD)*

- Over the past 2 years, the EMS Agency and UCLA have been evaluating the LA County stroke system, to explore ways of optimizing the routing of stroke patients.
- Analysis of the data collected was presented to this Committee through a Power Point presentation.
- This Committee will be updated as more information on this review is completed.

7.3 Retirement Announcement *(Richard Tadeo)*

- EMS Agency Director presented a scroll from the Los Angeles County Board of Supervisors, announcing the retirement of Gary Watson, as of July 30, 2026.
- Future correspondences may be directed to Natalie Greco at NGreco@dhs.lacounty.gov or Greg Klein at GKlein@dhs.lacounty.gov.

8. NEXT MEETING – August 19, 2026

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **MEDICAL COUNCIL** REFERENCE NO. 204

PURPOSE: To describe the composition and function of a Medical Council that will advise the Emergency Medical Services (EMS) Agency's Medical Director.

POLICY:

I. There shall be a Medical Council that provides specialized advice to the Medical Director of the EMS Agency (Chair).

II. Medical Council membership shall include physician representative of the following:

   A. Paramedic Base Hospitals

   B. 9-1-1 provider agencies

   C. Private ambulance operators

III. Ex Officio Medical Council membership shall include:

   A. A Prehospital Care Coordinator representing the EMS Commission's Base Hospital Advisory Committee

   B. A Paramedic Coordinator representing the EMS Commission's Provider Agency Advisory Committee

   C. A member of the Trauma Hospital Advisory Committee

   D. Other physician specialists as required for specific subject matters

IV. The Medical Council shall meet quarterly as scheduled by the chairperson.

V. Functions of the Medical Council shall include, but not limited, to:

   A. Providing specialized advice to the EMS Agency Medical Director to meet statutory responsibilities to develop written medical policies and procedures, standards of patient care, and to maintain medical oversight of the local EMS system.

   B. Assisting in the evaluation of prehospital emergency medical care treatment procedures or drugs for use on a trial basis by prehospital clinicians.

   C. Providing liaison between the EMS Agency Medical Director and Medical Directors from Base Hospitals, 9-1-1 Provider Agencies and Private Ambulance Operators.

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

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 304, **Paramedic Base Hospital Standards**
Ref. No. 411, **9-1-1 Provider Agency Medical Director**
Ref. No. 420, **Private Ambulance Operator Medical Director**

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

REFERENCE NO. 204, *Medical Council*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee			
	Provider Agency Advisory Committee			
OTHER COMMITTEES / RESOURCES	Medical Council	6/2/2026	6/2/2026	
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

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

REFERENCE No. 204, Medical Council

REF	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
204	Clarifying language to align with correct membership of Medical Council. Removal of language not appropriate and updating on cross references.	MAC – 6/2/26		

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **SEXUAL ASSAULT RESPONSE TEAM (SART) CENTER STANDARDS** REFERENCE NO. 324

PURPOSE: To establish minimum standards for the designation of Sexual Assault Response Team (SART) Centers. The SART Centers provide care to victims of sexual assault, sexual exploitation, and/or human trafficking by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

The goal of the Los Angeles County Emergency Medical Services (EMS) Agency is to transport these patients to a SART Center, where healthcare practitioners have special training in treating victims of sexual assault/abuse and in the collection of forensic evidence.

AUTHORITY: California Code of Regulations, Penal Code, Part 4, Title 6
California Code of Regulations, Title 16, Division 14, Article 8
California Code of Regulations, Title 16, Division 13.8, Article 4

DEFINITIONS:

Advanced Practice Provider (APP): A licensed healthcare provider who is not a physician that possesses advanced graduate level education and specialized training to diagnose, treat, and manage common medical conditions. Examples are nurse practitioners and physician assistants.

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

Board Eligible (BE): Successful completion of a residency program with progression to board certification based on the time frame specified by the ABMS or AOA.

California Governor's Office of Emergency Service (Cal OES): Cal OES Public Safety Division provides funding to programs that train law enforcement, court education, victim notification, victim/witness assistance, reducing crime lab backlogs, and post-conviction DNA testing. Cal OES has developed the standardized forensic-medical forms which must be used to document the sexual assault examination.

Commercial Sexual Exploitation of Children (CSEC): Any range of crimes and activities involving the sexual abuse or exploitation of a child for the financial benefit of any person or in exchange for anything of value (including monetary and non-monetary benefits) given or received by any person. https://dcfs.lacounty.gov/youth/sexual-exploitation/

Department of Children and Family Services (DCFS): A mandated component of Emergency Response Services, administered by the Los Angeles County Department of Children and Family

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

Services. The Child Protection Hotline (CPH), (800) 540-4000, intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect, sexual assault, or exploitation, which includes commercial sexual exploitation and human trafficking, to determine whether an in-person investigation and consultation is required.

Patient: A person who has been sexually assaulted, commercially sexually exploited, or human trafficked. The patient can also be identified as the victim and/or survivor. In the criminal justice system, the patient is identified as a crime victim. For rape crisis centers providing counseling and advocacy, the patient is identified as a survivor.

Qualified Medical Specialist: A physician licensed in the State of California who is BC or BE in the corresponding specialty by the ABMS or AOA.

Qualified Health Care Professional: Any physician or surgeon, or a registered nurse or an Advanced Practice Provider working in consultation with a physician and surgeon pursuant to the California Penal Code 13823.5 (e).

Rape Crisis Advocate: An individual who is affiliated with a Rape Crisis Center and functions as a support person for the patient throughout the entire medical/legal process and who meets the requirements of Penal Code 679.04.

Sexual Assault Forensic Examiner (SAFE) / Sexual Assault Nurse Examiner (SANE): A specially trained healthcare provider (i.e., physician, nurse practitioner, physician assistant, registered nurse) who independently and competently performs sexual assault forensic medical exams. Examiners are trained healthcare professionals who perform adult and adolescent sexual assault forensic medical examinations, and/or child sexual abuse forensic medical examinations.

Sexual Assault Response Team (SART): A coordinated interdisciplinary intervention model between law enforcement, crime laboratory, District Attorney's (DA) Office, medical and advocacy experts to meet the forensic needs of the criminal justice system and the medical and emotional needs of the sexual assault/abuse victim.

Sexual Assault Response Team (SART) Centers: A hospital sponsored program that is designated by the EMS Agency to receive patients who are victims of sexual assault/abuse. A SART Center specializes in forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 120 hours), which has the capabilities of providing comprehensive medical forensic examinations and psychological support. The center consists of knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards.

Nurse Practitioner (NP): An advanced practice registered nurse who meets Board education and certification requirements and possesses additional advanced practice educational preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary and/or acute care. Maintains an active NP certification from a nationally recognized certifying organization.

Physician Assistant (PA): A licensed and highly skilled professional who provides medical services including diagnosis, treatment, and prescribing medication under the supervision of a licensed physician or surgeon.

Quality Improvement (QI): The analysis of performance and systematic effort to improve it.

POLICY:

I. SART Center Designation / Re-Designation Agreement:

A. SART Center initial designation and SART Center re-designation is granted for a period of three years after satisfactory review by the EMS Agency.

B. The EMS Agency reserves the right to perform scheduled site visits or request additional data of the SART Center at any time.

C. The SART Center shall immediately provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the SART Center Standards.

D. The SART Center shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the SART program.

E. The SART Center shall notify the EMS Agency within 15 days, in writing of any change in status of the SART Medical Advisor or SART Program Director/Coordinator by submitting the Notification of Personnel Change Form (Reference No. 621.2).

F. Execute and maintain a Specialty Care Center SART Center Designation Agreement with the EMS Agency.

II. General SART Center Requirements

A. All designated SART Centers shall be sponsored by a hospital and the hospital shall be:

1. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and

a. Be approved for Basic or Comprehensive Emergency Medical Services

b. Be accredited by a Centers for Medicare & Medicaid Services (CMS) recognized Hospital Accreditation Organization

c. Have a SART team available 24 hours a day, 7 days a week.

d. Have a dedicated private space away from the emergency department that provides a secure area for the examination and interview process

B. SART Center Leadership Requirements:

1. SART Center Medical Advisor

a. Qualifications:

i. A physician BC in Emergency Medicine,

Obstetrics/Gynecology, Family Practice or Pediatrics with education and interest in the care of patients/victims of sexual assault, commercial sexual exploitation, and human trafficking.

OR

An Advanced Practice Professional (NP or PA) with education and interest in the care of patients/victims of sexual assault, commercial sexual exploitation, and human trafficking.

ii. Completion of the initial SAFE Course for adult/adolescent and pediatrics, minimum of 40-hour curriculum, in compliance with the medical forensic examination standards set forth in the Penal Code 13823.11

iii. Complete eight hours of approved continuing medical education (CME) related to sexual assault forensic examination every three years

b. Responsibilities:

i. Be available for consultation with forensic examiners as needed

ii. Ensure up-to-date knowledge and skills regarding sexual assault forensic medical examination performance and interpretation of findings

iii. Coordinate medical care across departmental and multidisciplinary services as needed

iv. Provide medical oversight in the development, implementation, and maintenance of a comprehensive QI program as it pertains to the care of the sexual assault, commercial sexual exploitation, or human trafficking victim

v. Collaborate with the SART Center Program Director on educational programs: review and ensure content is medically sound and appropriate

vi. Be available for consultation with other SART Centers, EMS providers, EMS Agency, community hospitals (non-SART), local health clinics, law enforcement, local crime laboratory, rape crisis advocacy response groups, DA's Office and forensic examiners.

c. A written job description defining the authority and responsibilities of the SART Center Medical Advisor shall exist

2. SART Program Director

   a. Qualifications

      i. A Registered Nurse currently licensed to practice in the State of California, or Advanced Practice Provider

      ii. Completion of the initial SAFE Course for adult/adolescent and pediatrics, minimum of 40 hours curriculum, in compliance with the medical forensic examination standards set forth in the Penal Code 13823.11

      iii. Completion of eight hours of Board of Registered Nursing (BRN) approved continuing education (CE) related to sexual assault forensic examinations every three years

   b. Responsibilities

      i. Implement and ensure compliance with the SART Center Standards

      ii. Ensure that a chairperson is designated for the Multidisciplinary SART Center Committee

      iii. Ensure that a QI process is in place to identify, review, and correct deficiencies in the delivery of care to the sexual assault, commercial sexual exploitation, or human trafficking victim

      iv. Ensure that appropriate sexual assault, commercial sexual exploitation, and human trafficking education programs are provided to the SART Center personnel in collaboration with the SART Center Medical Advisor

      v. Maintain records of completed continuing education by SART Center personnel

      vi. Liaison with other SART Centers, EMS providers, EMS Agency, community hospitals, local health clinics, law enforcement, local crime laboratory, rape crisis advocacy response groups, DA's Office and forensic examiners as needed

      vii. Serve as a contact person for the EMS Agency and be available upon request to respond to County business regarding SART Center issues

      viii. Ensures the EMS Agency is notified, in writing, when there is a personnel change of the SART Center Medical Advisor or SART Center Program Director

      ix. Ensure compliance with SART Center Standards and EMS

Agency policies and procedures related to the care of sexual assault/abuse, commercial sexual exploitation, or human trafficking victims

ix. Ensure that the QI reports are presented at applicable SART or hospital committees (e.g.: ED, hospital-wide QI, and/or pediatric committees)

x. Ensures that all SART Center policies and procedures are reviewed at least annually with multidisciplinary committee approval at least triennial

c. A written document defining the authority and responsibilities of the SART Center Program Director shall exist

C. Personnel

1. Sexual Assault Forensic Examiner (SAFE) / Sexual Assault Nurse Examiner (SANE)

a. Qualifications:

i. Licensed as a Physician, Registered Nurse, or Advanced Practice Provider in the State of California

ii. Completion of the initial SAFE Course for adult/adolescent and pediatrics, minimum of 40-hour curriculum, in compliance with the medical forensic examination standards set forth in the Penal Code 13823.11

iii. Completion of eight hours of BRN or CME approved CE related to sexual assault forensic examinations every three years

b. A written job description defining the authority and responsibilities of the SAFE/SANE Examiner shall exist

2. Rape Crisis Center Personnel

a. Rape Crisis Center Director provides leadership advocating for the needs and rights of the survivors, provides Cal OES training for rape crisis advocates, and maintains on-call schedules indicating 24-hour, 7 days a week availability

b. Rape Crisis Center Advocate shall have successful completion of a 40-hour training consistent with Cal OES training and in-service requirements set forth in the Penal Code 679.04

c. A written document defining the authority and responsibilities of the Rape Crisis Center Director and Advocate shall exist

III. Competency

Competency of all SART Center examiners shall be evaluated during orientation and at least annually to ensure up-to-date knowledge and skills regarding sexual assault forensic medical exam performance and interpretation of findings to include the following:

A. Consents

1. Explains exam
2. Obtains consents per the Cal OES forms and protocols
3. Assesses patient's understanding of explanation

B. Interview – Uses therapeutic approach to information gathering (Assault History)

C. Obtains complete history per Cal OES forms and protocols and clarifies events as needed

D. Examination

1. Physical exam per Cal OES protocol
2. Exam relevant to history or per Cal OES protocol
3. Identifies physical findings

E. Evidence Collection

1. Identifies appropriate areas for collection
2. Collects evidence accurately per Cal OES protocols
3. Handles, labels, and packages evidence properly
4. Demonstrates and maintains chain of custody

F. Equipment – Demonstrates proficiency in use of site specific equipment (alternate light source, camera, digital imaging system, colposcope, etc.)

G. Documentation – Accurately and properly completes the most current Cal OES 2-923 Form to include accurate documentation of injuries

H. Medical Care

1. Assesses and explains risks of sexually transmitted infections and HIV post exposure prophylaxis (PEP), and/or pregnancy
2. Offers appropriate screening and/or diagnostic tests as applicable
3. Appropriately offers and administers medications and/or treatments as indicated

4. Provides and reviews with patient, recommended aftercare instructions

5. Provides appropriate referrals

IV. Multidisciplinary SART Center Committee

A. The multidisciplinary SART Center Committee should meet, at a minimum, on a quarterly basis and more frequently as needed, to review system-related performance issues. The committee members or a designee shall attend at least 50% of the meetings.

B. The multidisciplinary SART Center committee shall include representatives from the following:

1. EMS Provider(s), as applicable

2. Emergency Department

3. Law Enforcement

4. SAFE/SANE

5. Rape crisis advocacy groups

6. Local crime laboratory

7. District Attorney's (DA) Office

C. Responsibilities:

1. Review and ensure compliance with the SART Center Standards

2. Review and ensure the coordination of SART services across departmental and multidisciplinary lines

3. Review and ensure a comprehensive and multidisciplinary quality improvement (QI) program as per Section V

4. Review and discuss the development and implementation of policies and procedures listed in Section VI

5. Maintain attendance rosters and meeting minutes. The minutes shall reflect the review including, when appropriate, the analysis and proposed corrective actions.

V. Quality Improvement (QI) Program Requirements

QI program shall be developed as per Reference No. 620, EMS Quality Improvement Program, and monitored by the SART Center Director and SART Center Medical Advisor.

A. Program shall be an organized multidisciplinary program for the purpose of improving care of the sexual assault, commercial sexual exploitation, and human trafficking victim and ensuring the integrity of evidence collection.

B. A written SART QI Program plan shall be developed, monitored, and reviewed by the SART Center Program Director and Medical Advisor at a minimum of every two years.

C. SART personnel shall interface with EMS, emergency department, law enforcement, SAFE/SANE, local crime laboratory, rape crisis advocate, DA's Office and other relevant services regarding identified QI issues as needed.

D. A written QI plan, tracking and trending reports, agenda, minutes and attendance rosters shall be maintained.

E. Timely QI review should occur following each exam. This review should include:

1. Review of Cal OES examination form documentation

2. Review of forensic digital images which must also be retrievable for summons at the DA's request

3. Evidence collection procedures and management

4. Incorporation of feedback information from the crime laboratory when available

F. Submit data as requested by the EMS Agency for quality improvement purposes to include number of medical examinations, based on the following categories: Adult, Pediatric, Suspects, and DCFS referrals to the Medical Hub as applicable.

VI. Policies

A. There shall be a current SART Center policy manual reviewed and signed by the Program Director and Medical Advisor and readily accessible in the SART Center.

B. SART Centers shall follow the Cal OES protocols and utilize the current Cal OES forms and shall establish specific written policies that address, but are not limited to, the following:

1. Hours of operation, patients served (adults and/or pediatric), provisions for after-hours and mobile examinations

2. Role and responsibilities of the SART members

2. Patient care management to include:

a. Providing examination within 120 hours from time of sexual assault

b. Physician availability and/or consultation of the sexually abused,

commercially sexually exploited, or human trafficked patient

c. Patient request for a physician examination

4. Consent for forensic evaluation

5. Unconscious sexual assault patient

6. Strangulation sexual assault patient

7. Alcohol and Drug Facilitated Sexual Assault (DFSA) patient (or Loss of Awareness protocol)

8. Management of Injuries

9. Family presence during examination

10. SART Activation or “CALL-OUT” procedures

11. Emergency Department Medical Screening Examination

12. Referral of pediatric patients who are victims of sexual assault to hospitals with a pediatric SART, if applicable.

13. Patient referral from non-SART hospitals

14. Treatment recommendations and aftercare instructions for the following:

a. Sexually transmitted infection prophylaxis

b. Pregnancy prophylaxis

c. Healthcare referral and follow up

d. HIV information and referral for immediate HIV PEP

e. First Aid Instructions

f. Referrals for counseling and mental health follow up

15. Medical record storage and release, including digital images

16. Evidence collection and storage, including locked refrigerator storage

17. Routine maintenance and monitoring of equipment

18. Specific populations and their needs, which include but are not limited to the following:

a. Persons with disabilities

b. Hearing impaired

c. Elderly

d. Pregnant

e. Provision foreign language translation

f. Suspect exams:

i. Process ensuring that the victims do not come in contact with the suspect

ii. Back-up-procedure to ensure the same examiner does not perform both the victim and suspect exam whenever possible, and a policy in preventing cross contamination if the same examiner does both exams

g. Lesbian, gay, bisexual, transgender/transsexual, queer/questioning, intersex, and asexual (LGBTQIA)

19. Interface with the other agencies/departments, including:

a. Law enforcement

b. Local crime laboratory

c. County/City DA's Office

d. Local rape crisis center

e. Other SART centers

f. Adult Protective Services

g. DCFS

h. Shelters for battered women

i. Child abuse and neglect treatment centers

j. County/City Public Health Departments

k. County/City Victim Witness Assistance Programs

l. Local Health Clinics

m. County Mental Health Services

VIII. Space, Equipment, Supplies, and Medications

A. Safety for patients and the SART members, privacy and confidentiality for

patients, and comfortable peaceful surroundings are important considerations.

B. SART equipment, supplies, and medications shall be easily accessible, labeled, and logically organized.

C. The following are minimum requirements for space, equipment, supplies, and medications:

1. The SART Center shall be a designated space located away from the emergency department and include:

   a. Designated examination room

   b. Designated patient bathroom

   c. Waiting room for the patients, family members, and friends which ensures privacy

   d. Separate waiting area for law enforcement which supports their report writing

   e. Evidentiary examination supplies and sexual assault evidence collection kit storage

   f. Storage for administrative and forensic medical records

2. The following is the minimum required equipment, supplies, and medications:

   a. Locked specimen refrigerator for storage of evidence with chain of custody

   b. Sexual assault evidence collection kits from the local crime laboratory

   c. Small copier near the exam room

   d. Accessible fax machine

   e. Videocamera, Camera, or Colposcope with photographic capabilities

   f. Alternate light source

   g. Swab dryer

   h. Digital imaging system

   i. Examination table with stirrups

   j. Secure area to preserve the chain of custody

   k. Locked file cabinets to store forensic records

l. Medications for:

i. Pregnancy prophylaxis

ii. Treatment of sexually transmitted diseases after sexual assault as recommended by current Center for Disease Control and Prevention (CDC) guidelines

CROSS REFERENCE:

Prehospital Care Policy Manual
Reference No. 508, **Sexual Assault Patient Destination**
Reference No. 508.1, **SART Center Roster**
Reference No. 620, **EMS Quality Improvement Program**
Reference No. 621, **Notification of Personnel Change**
Reference No. 621.2, **Notification of Personnel Change Form**
Reference No. 822, **Suspected Child Abuse/Neglect Reporting Guidelines**

REFERENCES:

California Clinical Forensic Medical Training Center California Sexual Assault Response Team (SART) Manual, https://www.ccfmtc.org/
Cal OES 2-923 Adult/Adolescent Sexual Assault Forensic Medical Report
Cal OES 2-924 Abbreviated Adult/Adolescent Sexual Assault Examination Forensic Medical Report, https://www.ccfmtc.org/forensic-medical-examination-forms/
"Sexual Assault and Abuse and STDs -2021 STD Treatment Guidelines." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 23 July 2021, Federal Violence Against Women Act (VAWA).

ACKNOWLEDGEMENTS

The Los Angeles County Sexual Assault Coordinating Council (LACSACC), and the California Coalition Against Sexual Assaults (CALCASA) made significant contributions in the development of these SART Center Standards.

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

REFERENCE NO. 324, *Sexual Assault Response Team (SART) Center Standards*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee			
	Provider Agency Advisory Committee			
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee	6/2/26	6/2/26	
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

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

REFERENCE No. 324, Sexual Assault Response Team (SART) Center Standards

REF	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
324	Updating of language to reflect current National Standards.	PedAC – 6/2/26		

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/PARAMEDIC/MICN)

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:

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, mush 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 or Base contact.

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 Rick 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**

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

REFERENCE NO. 834 & 834.1, *Patient Refusal of Treatment/Transport and Treat and Release at Scene and AMA Quick Reference Guide*

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee	6/10/26	6/10/26	Policy III, B – add "base contact not required"
	Provider Agency Advisory Committee	6/17/26	6/17/26	
OTHER COMMITTEES / RESOURCES	Medical Council	6/2/26	6/2/26	
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

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

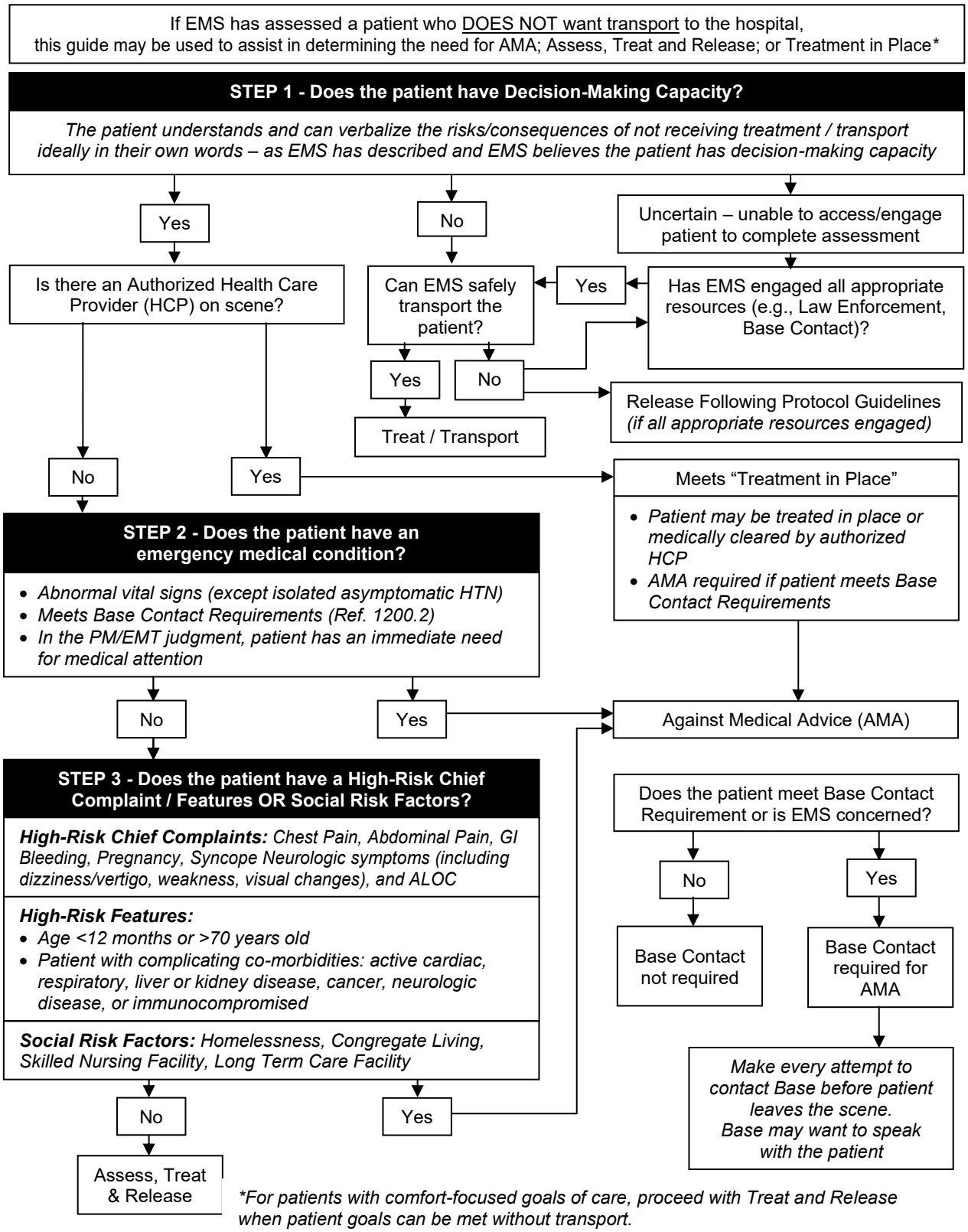
POLICY REVIEW - SUMMARY OF CHANGES/COMMENTS (Rationale for Revision)

REFERENCE No. 834 & 834.1, Patient Refusal of Treatment/Transport and Treat and Release at Scene & AMA Quick Reference Guide

REF	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
834	Addition of language to Assess, Treat and Release to include patients that transport does not align with comfort-focused goals of care.	MAC – 6/2/26	N/A	
		BHAC – 6/10	Requested the additional language that base contact is not required	Change made
		PAAC – 6/17	N/A	

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

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



*For patients with comfort-focused goals of care, proceed with Treat and Release when patient goals can be met without transport.

County of Los Angeles, California
Emergency Medical Services Commission
Annual Report to the Board of Supervisors
Fiscal Year 2025–2026

County of Los Angeles
Department of Health Services
Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, California 90670
Phone: (562) 378-1500 / Fax: (562) 378-1107
http://ems.dhs.lacounty.gov

COUNTY OF LOS ANGELES BOARD OF SUPERVISORS

Hilda L. Solis	Holly J. Mitchell	Lindsey P. Horvath	Janice Hahn	Kathryn Barger
First District	Second District	Third District	Fourth District	Fifth District

FROM THE DIRECTOR'S DESK

The County of Los Angeles Emergency Medical Services (EMS) Agency is committed to creating, updating, and implementing new and existing policies and medical control guidelines that produce high levels of quality patient care in the prehospital emergency medical care setting. We provide State EMT certifications, ambulance licensing, emergency medical and disaster dispatch services, and are home to the Paramedic Training Institute where paramedics and mobile intensive care nurses receive EMS updates and training.

Our team of medical doctors and nurses, EMS healthcare professionals and providers, as well as our EMS support staff are dedicated to working collectively in the advancement of medical technology through innovation, pilot programs, medical trials and studies, EMS updates and training, and collaborations with our EMS partners and stakeholders. Through these strategic alliances, we can identify and develop standards of care that become best practices in healthcare with measurable, deliverable, and effective patient outcomes.

The EMS Commission (EMSC) provides valuable insight, guidance and support to the EMS Agency on policies and guidelines that ensure safety nets are in place and producing extraordinary and appropriate protections for our residents. The Annual Report is provided to the Board of Supervisors to report on Commission activities and legislation with potential impact to the EMS system.

As Director of the EMS Agency and Executive Director of the EMS Commission, I am honored to work together with the high caliber of Supervisors, Commissioners, EMS partners, stakeholders, and exceptional groups of knowledgeable and engaged professionals who represent the success of the emergency medical and disaster-related system of care in LA County. Many thanks to each of you for your dedication, hard work, and significant contributions.

Sincerely,

Richard Tadeo, RN, BSN
EMS Director
EMSC Executive Director

MISSION STATEMENT

To support and guide the Emergency Medical Services (EMS) Agency activities to ensure timely, compassionate, and quality emergency and disaster medical services.

HISTORICAL BACKGROUND

The Emergency Medical Services Commission (EMSC) was established by the Board of Supervisors (Board) in October 1979. On April 7, 1981, the Board approved and adopted Ordinance No. 12332 of Title 3: Advisory Commissions and Committees, Los Angeles County Code Chapter 3.20, Emergency Medical Services Commission, to establish the Commission in accordance with California Health and Safety Code Division 2.5 Sections:

1797.270 – Emergency Medical Care Committee Formation
1797.272 – Emergency Medical Care Committee Membership
1797.274 – Emergency Medical Care Committee Duties
1797.276 – Emergency Medical Care Committee Annual Report

On January 29, 2008, the Board approved amending the subject Ordinance to revise the selection of the licensed paramedic representative previously nominated by the California Rescue and Paramedic Association (CRPA) to be made by the California Professional Firefighters' Association Emergency Medical Services Committee because CRPA ceased operations.

On November 1, 2011, in consultation with the Department of Health Services (DHS), the EMSC amended the Ordinance to add two commission seats. One member to be nominated by the Los Angeles County Police Chiefs' Association (LACPCA), and the second to be nominated by the Southern California Public Health Association (SCPHA). These seats are beneficial to the EMSC and the County by allowing for expert input by law enforcement and public health. With this amendment, the addition of two commission seats increased the number of commissioners from 17 to 19. The EMSC makes recommendations on Ordinance updates as the nominating associations' names change with time. The integrity of the EMSC stays intact and remains at 19. On October 8, 2024, the California Fire Fighters Association seat was changed to California Professional Fire Fighters.

COMMISSION MEMBERSHIP

The EMSC consists of 19 members seated on behalf of medical and health associations, city and county professionals, law enforcement and fire department agencies, and one public member from each County of Los Angeles Board of Supervisors' District. The Executive Director and EMS Commission Liaison are County employees and represent the EMSC as staff.

ABOUT THE COMMISSION

The EMSC acts in an advisory capacity to the Board and the Department of Health Services (DHS) on matters impacting emergency medical and disaster care services. The EMSC performs functions of the Emergency Medical Care Committee as defined in Sections 1750 et seq. of the Health and Safety Code and reviews policies and procedures impacting prehospital care for LA County residents. Duties include:

- Acting in an advisory capacity to the Board and DHS regarding County policies, programs, and standards for emergency medical and disaster care services throughout the County, including paramedic services.
- Monitors studies of elements of the emergency medical care system and its initiatives as requested by the Board and/or the Director of DHS and delineates problems and deficiencies and recommends appropriate solutions.
- Acquires and analyzes information necessary for measuring the impact and quality of emergency medical care services.
- Reports findings, conclusions, and recommendations to the Board.
- Reviews and comments on submitted plans and proposals for emergency medical care services.

- Recommends, when the need arises, that LA County engage independent contractors for the performance of specialized temporary or occasional services to the EMSC which members of the classified service cannot perform and for which LA County otherwise has the authority to contract.
- Advises the Director on policies, procedures and standards that affect the certification/accreditation of mobile intensive care nurses and paramedics.
- Advises the Director on proposals of any public or private organization to initiate or modify a program of paramedic services or training.
- Arbitrates differences in the field of paramedic services and training between all sectors of the community including, but not limited to, county agencies, municipalities, public safety agencies, community colleges, hospitals, private companies, and physicians.
- Conducts regular meetings and public hearings.
- Participates on EMSC Standing Committees: Provider Agency Advisory and Base Hospital Advisory.

MEETINGS

The EMSC meetings are held in accordance with The Ralph M. Brown Act, which is a California state law that mandates meetings are open to the public, allow free public access, and allow for public comments concerning public business.

Meetings are in-person and are held at the EMS Agency on the third Wednesday of every odd-numbered month with January as month one (1) from 1:00 pm to 3:00 pm. The agenda is posted in advance on the EMS Agency Website under the EMS Commission Agenda tab, and on the front door of the EMS Agency located at:

Emergency Medical Services Agency:
10100 Pioneer Boulevard, First Floor
Cathy Chidester Conference Room 128
Santa Fe Springs, California 90670
(562) 378-1500
http://ems.dhs.lacounty.gov/

Regular Meeting Dates in FY 2025-26
July 16, 2025 – September 10, 2025 – November 19, 2025
January 21, 2026 – March 18, 2026 – May 21, 2026

ANNUAL WORKPLAN
GOALS AND OBJECTIVES FOR FY 2026-27

The EMS Commission's goals and objectives align with the County's and DHS's mission, vision, and values through strategic alliances and establishing workgroups to develop studies and surveys and analyze policies and practices to identify solutions that ensure measurable, quality outcomes for patients and communities in Los Angeles County.

Goals and Objectives:

- Continue monitoring processes/policies to address/reduce Ambulance Patient Offload Delays (APOD).
- Support collaborative efforts of EMS constituents to identify throughput issues that contribute to APOD.
- Support the implementation of ambulance offload teams to assist hospitals with extreme APOD.
- Continue working on recommendations from the ad hoc committee on the Prehospital Care of Mental Health and Substance Abuse Emergencies, specifically suicide risk protocols.
- Establish behavioral health workgroup to address suicide risk protocols, focus on field evaluation of suicidal ideation, develop guidelines and education to address assessment and management of patients experiencing suicidal ideation.
- Establish workgroup to address cardiac arrest outcomes to improve the quality of care.
- Monitor progress of ad hoc workgroup on Interfacility Transport (IFT) delays on critical care transports.
- Monitor the success of EMS Update 2025-26 on behavioral health emergencies and treatment protocols.
- Review and recommend policies, directives, and pilots for adoption by the EMS Agency.

- Monitor changes to treatment protocols.
- Support disaster planning with emphasis on broader regional disaster plans.
- Support EMT/paramedic training programs that serve the underserved communities.
- Monitor progress of ad hoc workgroup for LA County EMS Corps Programs.
- Invite subject matter experts to provide information and training in the field of emergency medical care.
- Monitor State and federal legislation affecting the EMS system.
- Advise on and recommend topics for EMS education.
- Support the EMS Agency's efforts to ensure timely and accurate data submission from all EMS providers and specialty care centers.
- Participate on the Measure B Advisory Board and ensure constituent groups are aware of the Measure B allocation process of the un-allocated Measure B funds.
- Support the monitoring of the Emergency Ambulance Transportation Agreements which expire in 2027.

ONGOING LONG-TERM PROJECTS

- Monitor processes/policies to address and reduce Ambulance Patient Offload Delays (APOD).
- Continue working on recommendations from the ad hoc committee on the Prehospital Care of Mental Health and Substance Abuse Emergencies, specifically suicide risk protocols.
- Monitor the progress of the Field Evaluation of Suicidal Ideation and Behavior Workgroup.
- Support annual EMS Update training for EMS professionals and providers.
- Support education efforts for Bystander, Hands-Only CPR training (Sidewalk CPR).
- Monitor legislation with potential impact to the EMS system.
- Monitor and support the Public Works Alliance – EMS Corps programs established in LA County.
- Monitor and support EMS pilots and trial studies to improve the delivery of emergency medical care.
- Monitor Alternative Destination Volume Reports for psychiatric urgent care and sobering center facilities that EMS transports directly to.
- Monitor, support, and make recommendations to the Cardiac Arrest Care ad hoc workgroup for improvements in patient outcomes.
- Continue to support the collaboration of EMS-Law Enforcement Co-Response (ELCoR) workgroup.
- Continue monitoring resource allocations in emergency situations.
- Continue to monitor the progress of the State EMS Authority on changes to Chapter 1.
- Continue implementation of Health Data Exchange to all hospitals.
- Improve patient-centered outcomes from cardiac arrest across Los Angeles County, to meet or exceed the 2030 targets set by the American Heart Association (AHA).
- Monitor the progress of the Interfacility Transport Delay workgroup.

ACCOMPLISHMENTS AND SIGNIFICANT OUTCOMES FISCAL YEAR 2024-25

- Approved the FY 2023-24 EMSC Annual Report at the September 11, 2024, meeting.
- Approved EMSC Ordinance changes.
- Approved re-vote on Consent Calendar if lack of quorum.
- Monitored implementation and rollout of Health Data Exchange.
- Monitored separate policy addressing APOT and APOD.
- Supported redistribution of the CHA APOT Toolkit.
- Established new EMSC goals and objectives for FY 2025-26.
- Recommended re-establishment of ad hoc workgroup to advance the September 2016 *Prehospital Care of Mental Health and Substance Abuse Emergencies* Report recommendations.
- Completed Ordinance Changes to Los Angeles County Ordinance, Chapter 3.20: Emergency Medical Services Commission Section 3.20.040: Composition due to association name changes, and established membership have nexus to work in or practice in LA County.
- Approved Ordinance change for paramedic to be nominated by California Professional Firefighters.
- Endorsed language changes in the EMSC Ordinance membership to include a requirement for commissioners to work in or practice in Los Angeles County.
- Monitored psychiatric urgent care and alternate transport volumes and outcomes of transports.

- Endorsed and monitored EMS pilot projects and system enhancement tools (PediPart, PediDose).
- Monitored legislation impacting the EMS system and Board priorities.
- Approved new Chair and Vice Chair selections for 2025 and 2026.
- Approved Commissioner selection for EMSC Measure B Advisory Board Representation and approved nominating committee and standing committee selections.

- Prehospital Care Policies and Medical Control Guidelines Reviewed: `
  - 201: Medical Management of Prehospital Care
  - 227: Dispatching of 9-1-1 Emergency Medical Services
  - 302: 9-1-1 Receiving Hospital Standards
  - 321: Extracorporeal Cardiopulmonary Resuscitation (ECPR) Receiving Center Standards
  - 411: 9-1-1 Provider Agency Medical Director
  - 412: AED Service Provider Program Requirements
  - 412.1: AED Service Provider Program Application
  - 412.2: AED Service Provider Annual Report
  - 414: Specialty Care Transport Provider
  - 424: Triage to Alternate Destination (TAD) Paramedic Provider Program
  - 426: Private Provider Water Ambulance Catalina Island Interfacility Transport
  - 426.1 Private Provider Water Ambulance Insurance Requirements
  - 455: Private Ambulance Vehicle Age Limit and Licensure Requirements
  - 503: Guidelines for Hospitals Requesting Diversion of ALS/BLS Patients
  - 503.2: Diversion Request Quick Reference Guide
  - 505: Ambulance Patient Offload Time (APOT)
  - 510: Pediatric Patient Destination
  - 511: Perinatal Patient Destination
  - 513: ST.Elevation Myocardial Infarction (STEI) Patient Destination
  - 513.2 9-1-1 Interfacility Transfer Checklist for STEMI Re-Triage
  - 516: Cardiac Arrest (Non-Traumatic) Patient Destination
  - 517: Private Provider Agency Transport/Response Guidelines
  - 520: Transport/Transfer of Patients from Catalina Island
  - 520.1: Catalina Island Medical Center (AHM) Transfer/Transport Process
  - 526: Behavioral/Psychiatric Crisis Patient Destination
  - 528: Intoxicated (Alcohol) Patient Destination
  - 604: Prehospital Care Forms
  - 606: Documentation of Prehospital Care
  - 608: Retention and Disposition of Prehospital Patient Care Records
  - 701: Supply and Resupply of Designated Provider Units/Vehicles
  - 703: ALS Unit Inventory
  - 703.1 Private Provider Interfacility Transfer ALS Unit Inventory
  - 704: Assessment Unit Inventory
  - 706: ALS EMS Aircraft Inventory
  - 710: Basic Life Support Ambulance Equipment
  - 803: Los Angeles County Paramedic Scope of Practice
  - 803.1 Los Angeles County Paramedic Scope of Practice (Table Format)
  - 814: Determination/Pronouncement of Death in the Field
  - 830: EMS Pilot and Scientific Studies
  - 834: Patient Refusal of Treatment/Transport and Treat and Release at Scene

- 838: Application of Patient Restraints
- 840: Medical Support During Tactical Operations
- 842: Mass Gathering and Special Events Interface with Emergency Medical Services
- 842.1 EMS Resource Guidelines for Mass Gathering and Special Events
- 1109 Guidelines for Grant Funded Items and Inventory of Grant Funded Equipment
- 1109.1 Maintenance Log
- 1109.2 Grant Funded Item Disposition Form
- 1112 Hospital Evacuation
- 1318: Medical Control Guideline: ECPR Patient Algorithm

➢ Legislation Reviewed:

- AB 40: Requires local emergency medical services agencies (LEMSAs) to develop a standard ambulance patient offload time (APOT) that does not exceed 30 minutes in at least 90 percent of the time. The bill passed.
- AB 582: Addresses the response to wildfires and the evacuation of long-term care and skilled nursing facilities. This bill requires these facilities to submit their disaster planes to the Medical Health Operational Are Coordinator (MHOAC).
- AB 645: Establishes minimum training standards for EMS dispatchers. The bill requires the EMS Authority to develop, and adopt upon Commission approval, minimum training standards for public safety dispatchers and telecommunicators to complete EMS Dispatcher Training by January 1, 2027.
- AB 1328: Medi-Cal reimbursement for non-emergency transportation.
- AB 1607: The Richie Fund is currently set to expire on January 1, 2027. EMSAAC is co-sponsoring the bill to extend the fund's authorization. The bill has advanced through several committees, and an amendment was adopted to extend the expiration date to January 1, 2037.
- AB 2405: Sponsored by Assembly member Gibson in South Los Angeles, this bill would require law enforcement officers to transport patients to the nearest emergency department whenever they are transporting an individual for medical care.
- AB 2075: Restricts visitation at long-term care facilities during a public health emergency by prohibiting visitors and preventing patients from leaving the facility. This is currently a wait-and-see bill.
- SB 43: Expands the definition of "gravely disabled" to include individuals with a substance use disorder. The Department of Mental Health and the Department of Public Health presented to HASC on the specific criteria required for a substance use disorder to qualify as grave disability. A patient must meet six of the eleven (11) established criteria to be considered gravely disabled.
- SB 660: Expands the California Health and Human Services Data Exchange Framework by requiring additional health care entities and government agencies to execute a data sharing agreement for the exchange of health information no later than July 1, 2026.
- SB 1456: Updates the State Athletic Commission Act and directs ambulance drivers to go to trauma centers if services are deployed during boxing matches. The EMS Agency met with the Athletic Commission and is developing an information page on the various Trauma Centers in Los Angeles County.
- SB 985: This bill addresses the testing and implementation of the Next Generation 911 emergency communications system. It requires the consortium, which is being established under California Office of Emergency Services (OES), to provide quarterly progress reports. The bill also specifies that OES may not issue a Request for Proposals (RFP) until the criteria established by the board have been met.

- EMS Regulations – Chapter 1 (Previously Chapter 13): The State is continuing to address issues related to grandfather rights, particularly regarding the authority of fire departments that provided or administered EMS services before 1980. The remaining issues are expected to be addressed through regulations, with public comment anticipated by December 2025.
- EMS Regulations – Chapter 6: The proposed regulations consolidate Trauma, STEMI, Stroke, and EMS for Children specialty care center requirements into a single chapter. During the public comment period, concerns were raised that locally designated pediatric trauma centers are not recognized by the State, which could negatively affect the pediatric trauma system by requiring dual verification. The EMS Authority has indicated it is willing to address this issue, and staff are confident it will not disrupt the existing pediatric trauma system.

EMERGENCY MEDICAL SERVICES COMMISSION

Photo Not Available
Kristin Kolenda
Peace Officers Association

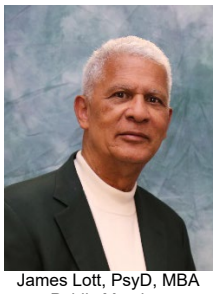

Diego Caivano, MD,
Chair – 2025
LA County Medical Association


Erick H. Cheung, MD, PhD
Southern California Psychiatric Society

Photo Not Available
Paul Camacho, Chief
Los Angeles County Police Chiefs' Association

Photo Not Available
Connie Richey, RN
Public Member
Third Supervisorial District


Lydia Lam, MD
American College of Surgeons


James Lott, PsyD, MBA
Public Member
Second Supervisorial District


Carol Meyer, RN
Vice Chair – 2024
Public Member, Fourth District

Photo Not Available
Ken Domer
League of California Cities
Los Angeles County Division


Tarina Kang, M.D.
Hospital Association of Southern California


Kenneth Liebman
Los Angeles County Ambulance Association


Kenneth Powell, Chief
Los Angeles Area Fire Chiefs' Association


Jason Cervantes, Firefighter/
Paramedic, California
Professional Firefighters


Saran Tucker, Ph.D., MPH
Southern California Public Health Association


Ms. Carol Kim
Public Member
First Supervisorial District


Stephen Sanko, MD
Vice Chair – 2025
American Heart Association
Western States Affiliate


Carole A. Snyder, RN
Chair – 2024
Emergency Nurses Association


Atilla Uner, MD, MPH
California Chapter – American College of Emergency Physicians (CAL-ACEP)

VACANT
Public Member
Fifth Supervisorial District


Richard Tadeo, RN, BSN
EMS Agency Director
EMSC Executive Directo

Photo Not Available
Vanessa Gonzalez
Management Secretary III
Interim EMS Commission Liaison

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY GAVIN NEWSOM, *Governor*

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

DATE: May 27, 2026

TO: Commission on EMS

FROM: Elizabeth Basnett, Director
Dr. Hernando Garzon, Chief Medical Officer

SUBJECT: Exceedance of Ambulance Patient Offload (APOT) Standards – April 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 (AB) 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, 223 hospitals have registered for the audit tool. 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.
- To date, 180 hospitals have submitted their annual update for 2025.
- EMSA is engaging local emergency medical services agencies (LEMSAs) and the California Hospital Association to increase compliance.

Summary APOT Data for April 2026

- NOTE: A disruption in data flow from the CEMSIS data repository vendor resulted in no records populating the audit tool after April 20th. As a result, only data from April 1-20 was used in this report and APOT analysis.

- For April 2026 data, there were 135,449 records that met APOT criteria, a decrease of 62,310 records from last month. EMSA continually conducts targeted outreach to LEMSAs with EMS providers who are not compliant or are documenting the new AB 40 elements incorrectly.
- For April 2026, using specifications outlined in the emergency regulations, EMSA calculated 90th percentile offload time for all general acute care hospitals (GACHs) with emergency departments on May 18, 2026. GACHs identified by EMSA as in exceedance of their local APOT standard will be instructed to implement their hospital APOT reduction protocols.
- Summary information based on April 2026 APOT data and audits can be found below:
    - 315 of 327 hospitals (96%) had at least one EMS patient transport that met APOT documentation criteria.
    - Of the 315 hospitals, 272 (86%) had more than 60 EMS patient transports to their facility for the current month.
    - Of the 272 hospitals, 112* (41%) exceeded their local APOT standard. **Representation is limited due to the April data flow disruption. This number also excludes all hospitals in Alameda County. Please reference the report notes on page 3.*
    - 81 hospitals submitted APOT audit reports, a decrease of 37 from last month.
    - Of those 81 hospitals, 45 (56%) 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 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 May, EMSA reached out to 15 hospitals for bi-weekly calls. Of those contacted, eleven responded and participated in these meetings, an increase of two from prior month. 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 December 2025: 12
Meetings in January 2026: 17
Meetings in February 2026: 10
Meetings in March 2026: 12
Meetings in April 2026: 6
Meetings in May 2026 (to date): 11 **Meeting invites sent to 15 hospitals*

Exceedance of Ambulance Patient Offload (APOT) Standards – Detail

- The following GACHs were identified as exceeding the local APOT standard established by their LEMSA *(page 5, below)*. In accordance with Title 22, Division, 9, Chapter 1.2, § 100007.02 "Exceedance of APOT Standards - Required Actions," EMSA instructed the GACHs in the table below to implement their APOT reduction protocol no later than five business days after the date of notification (May 26, 2026). All hospitals received the following detailed statistics and data points used to make this determination:
    - Total monthly offloads
    - Percent of offloads meeting standard (Goal: 90%)
    - 90th percentile APOT
    - Local APOT standard
    - Amount exceeding standard
    - Count of offloads exceeding standard
    - Percent of records exceeding standard
    - Audit completed (Yes or No)

Report Note:
During this reporting period, a data flow disruption was discovered for one of the larger Alameda County EMS Providers, resulting in roughly 50% of their data not being populated into CEMSIS. Due to the scope of this missing data set, EMSA has excluded all Alameda hospitals from this month's assessment. Any hospitals significantly impacted by this disruption were also excluded from the Exceedance report. These issues are being investigated by the LEMSAs. EMSA has advised affected LEMSAs and hospitals to use their best judgement on whether they should implement their APOT reduction plans.

During April 2026, there was a data flow disruption between CEMSIS and the APOT Audit Tool. This limited April APOT data to only include records between April 1st through April 20th. EMSA used this same timeframe to conduct analysis and APOT compliance for April 2026 data.

Hospitals with fewer than 60 offloads are excluded from our assessment and the table is 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. EMSA estimates that 95% of all expected APOT records are represented in this report.
- This approach aligns with the California Department of Health Care Services' (DHCS) Data De-Identification Guidelines.

Local EMS Agency APOT Standards (For April 2026 Data)

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	0:25:00
San Luis Obispo County EMS Agency	0:30:00
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 2)

LEMSA	Hospital Name	Total Offloads	Percent of Offloads Meeting Standard (Goal: 90%)	90th Percentile APOT (HH:MM:SS)	Local APOT Standard (HH:MM:SS)	Amount Exceeding Standard (HH:MM:SS)
Riverside County EMS Agency	Hemet Valley Medical Center	779	39.4%	1:31:37	0:30:00	1:01:37
Riverside County EMS Agency	Menifee Valley Medical Center	258	38.8%	1:31:09	0:30:00	1:01:09
Riverside County EMS Agency	Inland Valley Medical Center	764	70.9%	1:18:35	0:30:00	0:48:35
Los Angeles County EMS Agency	Citrus Valley Medical Center, Queen of the Valley Campus	463	62.4%	1:14:42	0:30:00	0:44:42
Kern County EMS Agency	Bakersfield Memorial Hospital	868	56.8%	1:11:14	0:30:00	0:41:14
Los Angeles County EMS Agency	Beverly Hospital	182	61.5%	1:10:06	0:30:00	0:40:06
Contra Costa County EMS Agency	Kaiser Permanente, Richmond	716	57.1%	0:59:38	0:20:00	0:39:38
San Diego County EMS Agency	University of California, San Diego Medical Center	877	59.5%	1:08:00	0:30:00	0:38:00
Riverside County EMS Agency	Loma Linda University Medical Center, Murrieta	565	62.1%	1:04:39	0:30:00	0:34:39
Inland Counties EMS Agency	St. Mary Medical Center	962	39.3%	0:59:22	0:25:00	0:34:22
Kern County EMS Agency	Kern Medical	683	58.1%	1:03:37	0:30:00	0:33:37
Los Angeles County EMS Agency	Saint Francis Medical Center	727	60.7%	1:02:27	0:30:00	0:32:27
Inland Counties EMS Agency	Victor Valley Global Medical Center	326	39.0%	0:55:04	0:25:00	0:30:03
Riverside County EMS Agency	Kaiser Permanente, Riverside	356	76.4%	0:59:25	0:30:00	0:29:24
Santa Clara County EMS Agency	Santa Clara Valley Medical Center	688	67.9%	0:48:29	0:20:00	0:28:29
San Diego County EMS Agency	Sharp Chula Vista Medical Center	951	62.6%	0:57:47	0:30:00	0:27:47
San Diego County EMS Agency	Paradise Valley Hospital	277	67.1%	0:56:20	0:30:00	0:26:20
Los Angeles County EMS Agency	Providence Saint John's Health Center	280	68.9%	0:56:18	0:30:00	0:26:18
Los Angeles County EMS Agency	Lakewood Regional Medical Center	256	75.8%	0:55:23	0:30:00	0:25:23
Los Angeles County EMS Agency	Harbor UCLA Medical Center	682	81.8%	0:55:04	0:30:00	0:25:04
Los Angeles County EMS Agency	Pomona Valley Hospital Medical Center	836	69.6%	0:54:25	0:30:00	0:24:25
Los Angeles County EMS Agency	Methodist Hospital of Southern California	504	72.2%	0:54:10	0:30:00	0:24:10
Los Angeles County EMS Agency	Emanate Health- InterCommunity Hospital	254	67.3%	0:52:42	0:30:00	0:22:42
Inland Counties EMS Agency	Desert Valley Hospital	583	57.6%	0:46:57	0:25:00	0:21:57
Los Angeles County EMS Agency	Greater El Monte Community Hospital	166	76.5%	0:51:47	0:30:00	0:21:47
Contra Costa County EMS Agency	Contra Costa Regional Medical Center	349	70.8%	0:41:36	0:20:00	0:21:36
Los Angeles County EMS Agency	Marina Del Rey Hospital	184	76.6%	0:51:07	0:30:00	0:21:07
Los Angeles County EMS Agency	PIH Health Hospital, Downey	319	79.3%	0:51:02	0:30:00	0:21:02
Inland Counties EMS Agency	Community Hospital of San Bernardino	312	66.0%	0:44:05	0:25:00	0:19:05
Los Angeles County EMS Agency	Cedars-Sinai Medical Center	736	71.7%	0:48:57	0:30:00	0:18:57
Central California EMS Agency	Kaiser Permanente, Fresno	673	75.6%	0:47:53	0:30:00	0:17:53
Los Angeles County EMS Agency	California Hospital Medical Center	425	79.3%	0:46:22	0:30:00	0:16:22
Kern County EMS Agency	Adventist Health Bakersfield	969	65.7%	0:46:19	0:30:00	0:16:19
Los Angeles County EMS Agency	PIH Health Hospital, Whittier	531	69.1%	0:45:18	0:30:00	0:15:18
Los Angeles County EMS Agency	Foothill Presbyterian Hospital	290	67.2%	0:45:12	0:30:00	0:15:12
Los Angeles County EMS Agency	Kaiser Permanente, Los Angeles	322	79.5%	0:45:06	0:30:00	0:15:06
Los Angeles County EMS Agency	Community Hospital of Huntington Park	289	77.2%	0:45:01	0:30:00	0:15:01
Los Angeles County EMS Agency	San Dimas Community Hospital	161	79.5%	0:45:00	0:30:00	0:15:00
Los Angeles County EMS Agency	East Los Angeles Doctors Hospital	190	80.5%	0:44:20	0:30:00	0:14:20
Los Angeles County EMS Agency	MemorialCare Long Beach Medical Center	615	85.7%	0:44:12	0:30:00	0:14:12
Los Angeles County EMS Agency	Adventist Health White Memorial	147	83.7%	0:43:49	0:30:00	0:13:49
Riverside County EMS Agency	Riverside Community Hospital	1551	76.5%	0:43:49	0:30:00	0:13:49
Sacramento County EMS Agency	Sutter Medical Center - Sacramento	1094	65.3%	0:38:30	0:25:00	0:13:30
San Diego County EMS Agency	Sharp Memorial Hospital	1170	78.6%	0:43:28	0:30:00	0:13:28
Los Angeles County EMS Agency	Kaiser Permanente, South Bay	345	80.0%	0:43:19	0:30:00	0:13:19
Riverside County EMS Agency	Kaiser Permanente, Moreno Valley	255	75.3%	0:43:19	0:30:00	0:13:19
San Diego County EMS Agency	Scripps Mercy Hospital	1580	75.3%	0:43:15	0:30:00	0:13:15
San Diego County EMS Agency	Scripps Mercy Hospital, Chula Vista	682	80.6%	0:43:15	0:30:00	0:13:15
Los Angeles County EMS Agency	Kaiser Permanente, Baldwin Park	269	76.2%	0:42:30	0:30:00	0:12:30
Los Angeles County EMS Agency	Kaiser Permanente, Downey	359	80.5%	0:42:25	0:30:00	0:12:25
Los Angeles County EMS Agency	Torrance Memorial Medical Center	567	78.5%	0:41:44	0:30:00	0:11:44
Santa Clara County EMS Agency	O'Connor Hospital, San Jose	677	70.5%	0:31:17	0:20:00	0:11:17
Contra Costa County EMS Agency	Sutter Delta Medical Center	775	71.7%	0:31:15	0:20:00	0:11:15
Kern County EMS Agency	Mercy Hospital	486	75.7%	0:41:09	0:30:00	0:11:09
Riverside County EMS Agency	San Gorgonio Memorial Hospital	544	77.6%	0:41:08	0:30:00	0:11:08
Central California EMS Agency	Kaweah Delta Medical Center	1415	70.2%	0:40:48	0:30:00	0:10:48
Contra Costa County EMS Agency	Kaiser Permanente, Antioch	646	72.4%	0:30:44	0:20:00	0:10:45
Kern County EMS Agency	Bakersfield Heart Hospital	301	79.1%	0:40:31	0:30:00	0:10:31
San Diego County EMS Agency	UC San Diego Health East Campus Medical Center	403	77.4%	0:40:06	0:30:00	0:10:06

Report Note: Hospitals with fewer than 60 qualifying records were excluded from this assessment to adhere to California DHCS Data De-Identification Guidelines.

Hospitals Exceeding Their Local APOT Standard (2 of 2)

LEMSA	Hospital Name	Total Offloads	Percent of Offloads Meeting Standard (Goal: 90%)	90th Percentile APOT (HH:MM:SS)	Local APOT Standard (HH:MM:SS)	Amount Exceeding Standard (HH:MM:SS)
Los Angeles County EMS Agency	Southern California Hospital at Culver City	129	79.1%	0:40:00	0:30:00	0:10:00
Contra Costa County EMS Agency	Kaiser Permanente, Walnut Creek	608	73.8%	0:30:00	0:20:00	0:10:00
Riverside County EMS Agency	Rancho Springs Medical Center	484	82.2%	0:39:34	0:30:00	0:09:34
San Francisco County EMS Agency	UCSF Medical Center at Parnassus	458	77.5%	0:39:20	0:30:00	0:09:20
Inland Counties EMS Agency	Montclair Hospital Medical Center	126	83.3%	0:33:57	0:25:00	0:08:57
Central California EMS Agency	Madera Community Hospital	368	78.8%	0:38:54	0:30:00	0:08:54
San Francisco County EMS Agency	CPMC-Van Ness	745	80.0%	0:38:41	0:30:00	0:08:41
Los Angeles County EMS Agency	Providence Little Company of Mary Medical Center, Torrance	576	83.5%	0:37:41	0:30:00	0:07:41
Merced County EMS Agency	Mercy Medical Center, Merced	954	83.6%	0:37:33	0:30:00	0:07:33
Coastal Valleys EMS Agency	Kaiser Permanente, Santa Rosa	559	85.9%	0:27:14	0:20:00	0:07:14
Inland Counties EMS Agency	Chino Valley Medical Center	230	83.9%	0:31:30	0:25:00	0:06:30
Los Angeles County EMS Agency	USC Verdugo Hills Hospital	105	85.7%	0:36:24	0:30:00	0:06:24
Kern County EMS Agency	Mercy Hospital SW - Bakersfield	484	80.4%	0:36:02	0:30:00	0:06:02
Riverside County EMS Agency	Temecula Valley Hospital	456	83.6%	0:35:16	0:30:00	0:05:17
Central California EMS Agency	Saint Agnes Medical Center	1797	83.0%	0:35:16	0:30:00	0:05:16
Santa Clara County EMS Agency	Good Samaritan Hospital, San Jose	703	82.5%	0:25:16	0:20:00	0:05:16
Inland Counties EMS Agency	Redlands Community Hospital	550	85.3%	0:29:42	0:25:00	0:04:42
Santa Clara County EMS Agency	Kaiser Permanente, Santa Clara Medical Center and Medical Offices	618	79.1%	0:24:41	0:20:00	0:04:41
San Francisco County EMS Agency	CPMC Mission Bernal Campus	511	85.3%	0:34:34	0:30:00	0:04:34
Los Angeles County EMS Agency	Good Samaritan Hospital, Los Angeles	555	86.7%	0:34:28	0:30:00	0:04:28
Riverside County EMS Agency	Corona Regional Medical Center	670	84.3%	0:34:24	0:30:00	0:04:24
Los Angeles County EMS Agency	West Hills Hospital and Medical Center	406	86.5%	0:34:19	0:30:00	0:04:19
Inland Counties EMS Agency	Kaiser Permanente, Ontario	543	85.8%	0:29:13	0:25:00	0:04:13
Orange County EMS Agency	UCI Health - Los Alamitos	312	84.9%	0:34:10	0:30:00	0:04:10
Santa Clara County EMS Agency	Regional Medical Center of San Jose	967	82.5%	0:24:10	0:20:00	0:04:10
San Francisco County EMS Agency	Kaiser Permanente, San Francisco	336	84.8%	0:34:04	0:30:00	0:04:05
San Francisco County EMS Agency	UCSF Health Hyde Hospital	417	84.2%	0:34:00	0:30:00	0:04:00
Los Angeles County EMS Agency	Hollywood Presbyterian Medical Center	360	86.4%	0:33:57	0:30:00	0:03:57
Los Angeles County EMS Agency	Adventist Health Glendale	117	87.2%	0:33:47	0:30:00	0:03:47
Inland Counties EMS Agency	St. Bernardine Medical Center	904	85.7%	0:28:16	0:25:00	0:03:16
Los Angeles County EMS Agency	San Gabriel Valley Medical Center	170	88.2%	0:33:14	0:30:00	0:03:14
Orange County EMS Agency	Anaheim Global Medical Center	115	87.8%	0:33:13	0:30:00	0:03:13
San Diego County EMS Agency	Sharp Grossmont Hospital	1611	87.4%	0:32:46	0:30:00	0:02:46
Los Angeles County EMS Agency	Coast Plaza Hospital	146	87.0%	0:32:37	0:30:00	0:02:37
Sacramento County EMS Agency	Mercy Hospital of Folsom	212	87.3%	0:27:36	0:25:00	0:02:36
Santa Clara County EMS Agency	Kaiser Permanente, San Jose	555	86.5%	0:22:31	0:20:00	0:02:31
Los Angeles County EMS Agency	Valley Presbyterian Hospital	330	88.5%	0:32:29	0:30:00	0:02:29
Los Angeles County EMS Agency	Kaiser Permanente, West Los Angeles	403	88.3%	0:32:28	0:30:00	0:02:28
Los Angeles County EMS Agency	Palmdale Regional Medical Center	706	87.3%	0:32:25	0:30:00	0:02:25
Sacramento County EMS Agency	UC Davis Medical Center	1115	86.9%	0:27:14	0:25:00	0:02:14
San Diego County EMS Agency	Tri-City Medical Center	790	87.6%	0:32:08	0:30:00	0:02:08
Riverside County EMS Agency	Riverside University Health System Medical Center	1218	87.2%	0:32:01	0:30:00	0:02:01
Orange County EMS Agency	AHMC Anaheim Regional Medical Center	263	86.7%	0:31:54	0:30:00	0:01:54
Central California EMS Agency	Community Regional Medical Center, Fresno	2918	87.4%	0:31:50	0:30:00	0:01:50
Sacramento County EMS Agency	Kaiser Permanente, South Sacramento Medical Center	994	86.8%	0:26:42	0:25:00	0:01:42
Kern County EMS Agency	Delano Regional Medical Center	177	85.9%	0:31:41	0:30:00	0:01:41
Los Angeles County EMS Agency	Antelope Valley Hospital	1261	88.5%	0:31:34	0:30:00	0:01:34
Sacramento County EMS Agency	Methodist Hospital of Sacramento	528	85.6%	0:26:30	0:25:00	0:01:30
Inland Counties EMS Agency	Loma Linda University Children's Hospital	202	87.6%	0:25:45	0:25:00	0:00:45
Inland Counties EMS Agency	Loma Linda University Medical Center	762	89.4%	0:25:37	0:25:00	0:00:37
Los Angeles County EMS Agency	Olive View UCLA Medical Center	178	89.3%	0:30:24	0:30:00	0:00:24
San Francisco County EMS Agency	UCSF Health Stanyan Hospital	339	89.7%	0:30:07	0:30:00	0:00:07
Imperial County EMS Agency	El Centro Regional Medical Center	414	89.9%	0:20:02	0:20:00	0:00:02

Report Note: Hospitals with fewer than 60 qualifying records were excluded from this assessment to adhere to California DHCS Data De-Identification Guidelines.