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: September 9, 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
- 3.1.2 July 15, 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
- 3.2.3 Provider Agency Advisory Committee – August 19, 2026

3.3 **Policies**
- 3.3.1 Reference No. 204: Medical Council
- 3.3.2 Reference No. 227: Dispatching of 9-1-1 Emergency Medical Services
- 3.3.3 Reference No. 324: Sexual Assault Response Team (SART) Center Standards
- 3.3.4 Reference No. 706: ALS EMS Aircraft Inventory
- 3.3.5 Reference No. 834: Patient Refusal of Treatment/Transport and Treat and Release at Scene
- 3.3.6 Reference No. 834.1: Patient Refusal of Treatment/Transport and Treat and Release at Scene Quick Reference Guide

END OF CONSENT AGENDA

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4. BUSINESS

Business (Old)

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

Business (New)

4.5 Commission Annual Report
4.6 Emergency Medicine Board Certification/Board Eligibility Requirements for Specialty Care Centers

5. LEGISLATION

6. DIRECTORS' REPORTS

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

Correspondence

6.1.1 (07/29/2026) Exceedance of Ambulance Patient Offload Standards
6.1.2 (08/10/2026) Expansion of LA-Drop Pilot to Pasadena
6.1.3 (08/04/2026) Los Angeles Development and Rapid Operationalization of Prehospital Blood (LA-Drop) Program Report
6.1.4 (08/28/2026) Updated APOT Regulatory Guidance and Audit Tool Relaunch
6.1.5 (09/02/2026) 2026 One-Time Measure B Funding Proposals

6.2 Nichole Bosson, MD, Medical Director – EMS Agency

6.2.1 2026 FIFA World Cup Attendance Emergency Department Patient Screening

7. COMMISSIONERS' COMMENTS / REQUESTS

8. ADJOURNMENT

Adjournment to the meeting of November 18, 2026

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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.

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MINUTES
July 15, 2026

☐ Diego Caivano, M.D.	LACo Medical Association	Richard Tadeo	Executive Director
☐ VACANT	CA Professional Firefighters	Vanessa Gonzalez	Interim EMSC Liaison
☐ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Nichole Bosson, MD	EMS Staff
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☐ 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		
☐ Lydia Lam, M.D.	American College of Surgeons		
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☒ Atilla Uner, M.D., MPH	CAL-ACEP		
☐ VACANT	Public Member, 5th District		

GUESTS

Samantha Verga-Gates, LBM – LA County APCC	Hasan Mahm, LA General Medical Center	Jennifer Shepard, LASD

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. Seven (7) commissioners were present. The meeting was held with no quorum. No motions or votes were taken.

2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

2.2 EMS Agency Director Richard Tadeo reported Randy Mantooth from the TV show *Emergency!* passed away on July 9, 2026. *Emergency!* was very instrumental in making the public aware of the new profession of paramedics in the 1970's.

Director Tadeo also welcomed back physicians Dr. Bosson and Dr. Whitfield who were deployed to Venezuela for earthquake assistance mission.

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**
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3.3 **Policies**
3.3.1 Reference No. 204: Medical Council
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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**
Director Tadeo reported that there is no new update. An investigation was conducted to identify additional potential Psychiatric Urgent Care Centers within the County. It was determined that there is one additional potential center in the San Fernando area that should be contacted, as there is currently no designated center in that area.

4.2 **Ambulance Patient Offload Time (APOT)**
Assistant Director Jacqui Rifenburg presented the second-quarter Ambulance Patient Offload Time (APOT) data report. The report demonstrated a significant improvement compared to the second quarter of 2025. Improvement was also noted between the first and second quarters of 2026.
An email was received from the State regarding the APOT audit tool. Due to database issues, the State has temporarily paused operation of the APOT audit tool through August 2026. During this operational pause, monthly data and reports will not be available. The State anticipates resuming the tool in September 2026. The State is transitioning its data systems to a new vendor, Cloudwick. The APOT audit tool was previously supported by Imagetrend; however, that service agreement has expired. The transition of the Los Angeles County EMS data repository to Cloudwick was successful, with more than 99% compliance in data submissions from the local EMS repository to the State. The new data system will provide participating LEMSAs with enhanced reporting capabilities. Los Angeles and Sierra-Sacramento EMS will participate in a pilot project to evaluate and maximize the use of the State's reporting capabilities.
The State previously identified the 15 hospitals with the most significant APOT concerns and based on workload and performance, is working directly with these facilities to implement APOT improvement plans and identify best practices. Last year, 11 Los Angeles County hospitals were included on the list; this year, that number has decreased to five. It was noted that some of the hospitals experienced construction that required the temporary closure of emergency department treatment bays, reducing

their overall capacity. Once construction is completed, reopening the treatment areas can take additional time due to the more stringent approval and regulatory requirements for healthcare facilities.

4.3 **Interfacility Transfer Taskforce**

Assistant Director Rifenburg reported that an Interfacility Transfer taskforce meeting is scheduled for August. She will continue collecting data to establish a full year of information for analysis. Assistant Director Rifenburg will also meet with Kaiser to discuss significant changes they are implementing to improve their IFT process.

4.4 **Cardiac Arrest Taskforce**

Vice Chair Sanko reported that the most recent meeting focused on 12 strategies to increase defibrillator access to and use, especially in our more vulnerable communities. The Task Force will be on hiatus in July and will resume in August, with a focus on developing a final report with recommendations for policy decision-makers.

The Task Force has continued its monthly clinics with hospitals and prehospital providers. Hospital clinics have included discussions on Get with the Guidelines resuscitation module, and data dictionary, which have been well received. The hospital clinics will resume in August, when Chief Medical Information Officers (CMIOs) will discuss surge strategies.

The Taskforce also reviewed case examples with the fire departments, who have provided their draft plans. Discussions included strategies to improve dispatch operations, CPR metrics, and cardiac arrest handoff training between provider agencies and their local hospitals. The fire department clinics have concluded with a review session planned for the fall to assist with finalizing their plans. The EMS Agency sent a letter to city managers outlining this effort and so the fire departments can coordinate with their local public safety committees and city councils.

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

Business (New)

4.6 **Commission Annual Report**

The Commission Annual Report requires action by the Commission. Commissioners were asked to review the report and provide any comments, suggested changes, or additional recommendations.

5. LEGISLATION

AB1607 – The Richie Fund was established to support pediatric trauma services and provides nearly $600,000 to Dignity Health – Northridge Hospital Medical Center for its pediatric trauma center. The Richie Fund is set to expire on December 31, 2026, and the bill would extend the fund through 2037. The bill has passed through all committees and is pending a final vote on the Senate floor. The State Legislature is currently on recess and is expected to reconvene on August 2. If the bill does not pass, Dignity Health – Northridge Hospital Medical Center may have to withdraw from the pediatric trauma system, as there are insufficient pediatric trauma cases to sustain the program.

SB985 – The bill was pulled by the author; however, its intent was to establish an advisory board to support the statewide 911 system revamp. The bill was initially opposed because it did not include representation from EMS administrators.

AB 2405 – Sponsored by Assembly member Gibson in South Los Angeles, this bill would direct law enforcement officers to transport behavioral health patients to the nearest emergency department. The bill has undergone multiple amendments, and another amendment is anticipated when the legislative session resumes. The initial version of the bill included language about STEMI and Stroke centers, which raised a lot of concern from EMS because law enforcement does not have clinical skills to assess those types of patients. The last iteration of the amendment which would come out August 2nd, it would be limited to a 5150 but there is also language noting that law enforcement may continue to transport to LPS designated facilities that are freestanding psychiatric facilities, urgent care centers, or contacting the Department of Mental Health.

SB660 – This reporting mechanism requires all healthcare providers, particularly those receiving Medicaid and Medicare funding, as well as EMS providers and EMS agencies, to participate in the Health Data Exchange Framework. CDPH is seeking to obtain data on all patients. This aligns with the local Health HDE project. EMSA is working with the Department of Health Care Access and Information (HCAI) to establish an intermediary agreement that would allow EMS providers to avoid developing individual data pipelines to CDPH. Instead, data submitted by EMS providers to the local EMS Agency and subsequently to the State EMS Authority (EMSA) could be utilized and submitted to HCAI. The current minimum requirement is that all identified participating entities execute a data-sharing agreement.

Chapter 1.2 – APOT Emergency Regulations: The regulation passed and have been returned to the Office of Administrative Law for final approval.

Chapter 6 – Specialty Care Systems: The Commission approved the regulations, which were also submitted to the Office of Administrative Law for final approval. This chapter addresses Trauma, STEMI, Stroke, and EMS for Children regulations.

6. DIRECTORS' REPORTS

6.1 Richard Tadeo, EMS Agency Director, EMSC Executive Director

Trauma Funding

The 2026-2027 Trauma funding was approved. 18% of the funding will go to the 13 non-county trauma centers in Los Angeles County.

Los Angeles Health Services

The Los Angeles County Department of Health Services is undergoing a rebranding and will now be known as Los Angeles (LA) Health Services. This change reflects the department's transition to a one-system healthcare system that includes not only County-operated hospitals but also more than 20 comprehensive health centers and clinics operated by the department.

FIFA

The last game was held in Los Angeles County, with two additional watch parties remaining in Los Angeles. Incidents at SoFi Stadium were minimal, and most transports occurred at the Los Angeles Memorial Coliseum during the Fan Fest.

There are several motions that will be presented to the Board of Supervisors on July 21 and July 28, 2026. One motion from Supervisor Mitchell's office proposes a review of Measure B funding for the 13 non-county trauma centers, as well as the unallocated funding. One recommendation is for the County Chief Administrative Office to review the current funding formula to determine whether Measure B funds are being maximized to

its fullest potential.
Another motion concerns the Measure B Advisory Board (MBAB) process. In previous years, the MBAB process began in March, with project funding requests based on an estimated dollar amount. However, the final funding amount is not known until July, when the fiscal year closes. The CEO's Office has requested that the timeline be moved from February or March to mid-August, when the final funding amount will be available, allowing projects to be considered without relying on estimates. Although this would result in a shorter timeline for the Measure B process, it would align the process with the County's fiscal year.
The report resulting from last year's Board motion was to evaluate the 18% funding allocated to trauma centers. The CEO's Office developed three recommendations: (1) leave the current funding structure unchanged; (2) conduct a needs analysis for both the unallocated funds distributed by the Measure B Advisory Board (MBAB) and the 18% trauma center funding; or (3) disband the MBAB and transfer its responsibilities to the EMS Commission. The new motion being introduced by Supervisor Mitchell's Office calls for another review by a consultant of the current trauma funding allocations. The motion is geared towards determining whether the allocations continue to meet the intent of Measure B and whether changes are needed.

Measure ER, a half-cent sales tax in Los Angeles County, passed in the July 2 election. The tax, known as the Essential Services Restoration General Sales Tax, will be collected for five years and is expected to generate about $1 billion in revenue.
The spending plan allocates 45% to the Uninsured Program, 22% to LA Health Services hospitals and clinics, 10% to the Department of Public Health, 5% each to reproductive health providers and nonprofit safety-net hospitals, 4% to school-based health programs, 3% to the Department of Public Social Services, 2.5% each to Correctional Health Services and In-Home Supportive Services (IHSS), and 1% to the Pasadena and Long Beach public health departments.
The proposed $450 million allocation would be used to develop a program similar to Healthy LA. The program would provide coverage to patients who are expected to lose Medicaid or experience a reduction in their Medi-Cal coverage. The number of patients who may lose coverage is not yet known, particularly given new requirements, such as enrolling twice a year, which may create an administrative burden for healthcare providers. The current proposed eligibility criteria include individuals who are at or below 138% of the federal poverty level, reside in Los Angeles County, are age 19 or older, and are ineligible for full-scope Medi-Cal due to immigration status under federal rules. The County is identifying the department that will be responsible for administering the program and is developing safeguards and audit processes to ensure the funds are used for their intended purpose.

Correspondence

5.1.1 (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
Dr. Bosson provided updates on clinical projects and initiatives including:

Pedi-PART

Dr. Nichole Bosson reported that Pedi-Part is still awaiting final approval and that she is hopeful a decision will be made soon regarding support for additional data collection to further inform the ventilation component of the study. The additional data collection

would be conducted by the existing research associates, for which staffing is already available, and would not impact provider agencies' procedures or workload.

PediDose

Enrollment for the pediatric seizure study is expected to be completed at the end of the month. The new protocols were released on July 1, and the team anticipates having study results by the fall. The findings will be presented at the January Commission meeting and will help determine the optimal dosing for pediatric seizure management and inform future treatment protocols. The goal is to identify the most rapid and effective treatment to terminate seizures quickly and improve patient outcomes.

LA-DROP

Funding has been received from several sources in partnership with the Lundquist Institute, Harbor-UCLA Medical Center, Los Angeles County Fire Department, and Compton Fire Department. Additional funding from various sources is expected to substantially expand the program over the next several months. Information regarding the planned expansion will be shared with the system toward the end of the year once the timelines are finalized.

The Los Angeles County Fire Department is expected to expand the program into the Pomona area and stock additional blood units in that region. The Los Angeles County Sheriff's Department is also expected to implement its program in the fall. Establishing partnerships with trauma centers and blood banks remains critical to the program's sustainability. Currently, there is no blood wastage due to these partnerships, and efforts are ongoing to expand the infrastructure needed to bring the program to additional areas throughout Los Angeles County.

The program has been in place for more than one year as a pilot and continues to operate in pilot status. National recommendations from the National Association of EMS Physicians and other organizations support prehospital blood as first-line therapy for hemorrhagic shock. Efforts are continuing to determine how the program can be expanded and supported countywide.

Prehospital Lung Ultrasound Pilot

The pilot is now fully implemented with Sierra Madre Fire and Burbank Fire. The last update was that there were nine enrollments, and it is expected the number will increase significantly. This pilot focuses on improving paramedic accuracy for identifying pulmonary edema in order to optimize field treatment for that condition. It is anticipated this is a one-year pilot, with retrospective data collection to compare the effectiveness of adding ultrasounds. Ultimately to evaluate the role of ultrasounds in our system and how this technology can be leveraged in our system.

Stroke Routing Analysis

We released the analysis of the direct to CSC routing for our Stroke centers. We continue to gather feedback from our system on that analysis, and we are planning to do a parallel analysis with current data to understand patient outcomes and incorporate that into the discussions and decision making around stroke routing.

Trauma Data Collaborative

The upcoming Trauma Hospital Advisory Council will discuss the recently published Trauma Compendium, which compiles 16 position statements, recommendations, and related guidance from the National Association of EMS Physicians. The Council will critically evaluate the County's trauma protocols in relation to these recommendations and make any necessary updates to ensure alignment with current recommendations

for trauma care.

EMS UPDATE

EMS update is complete in terms of the didactic component. We will still see our provider agencies completing the hands-on component over the next few months. This expands our IO insertion to include the distal femur location for pediatrics and the humeral IO for adult patients. It also increases the use of capnography in our system to expand to spontaneously ventilating patients. It introduced magnesium sulfate as a treatment for preeclampsia and eclampsia for our perinatal patients and provided key updates in terms of our protocol changes such as cool running water for burns and our treatment of pediatric cardiac arrest. We're also developing a method to implement evaluations that relate to our EMS Update training.

Dr. Shira Schlesinger started the Education Advisory Committee, a voluntary group of educators throughout the system that can provide input, support for both development of education and dissemination of education and more collaboration across the system in terms of using our resources for our EMS clinicians across the system. This will be planned as a quarterly meeting moving forward and we're inviting interested parties to join.

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

LA 28

Subcommittee meetings for LA28 have begun, with all meetings organized by the Secret Service. The subcommittees include medical, medical venues, and EMS. The most recent meeting focused on the staffing requirements for each venue. One of the tasks was to develop an estimate of the number of ambulances and personnel needed at each venue and determine how those resources could be staffed within the existing system.

7 COMMISSIONERS' COMMENTS / REQUESTS

8 ADJOURNMENT

Next Meeting: Wednesday, September 9, 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.

EMERGENCY MEDICAL SERVICES COMMISSION
PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday – August 19, 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
	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
	Victor Lemus	Area E
X	Geoffrey Dayne	Area E, Alternate
X	Joel Davis	Area F
	Andrew Reno	Area F, Alternate
X	Adam Brown	Area G *(Rep to BHAC)*
	Stefan Viera	Area G, Alternate
	Matthew Conroy	Area H
X	Marc Cohen, MD	Area H, Alternate
X	Michael Campana	Area H, Alternate
X	Julian Hernandez	Employed Paramedic Coordinator
	Tisha Hamilton	Employed Paramedic Coordinator, Alt
	Jenny Van Slyke	Prehospital Care Coordinator
X	Melissia Turpin	Prehospital Care Coordinator, Alternate
X	Bryan Sua	Public Sector Paramedic Coordinator
X	Drew Pryor	Public Sector Paramedic Coordinator, Alt
	Vacant	Private Sector Paramedic
	Scott Buck	Private Sector Paramedic, Alternate
X	Tabitha Cheng, MD	Provider Agency Medical Director
X	Tiffany Abramson, MD	Provider Agency Medical Director, Alt
X	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
X	Ray Mosack	Paramedic Training Program
	Vacant	Paramedic Training Program, Alternate
X	Heather Calka	EMS Educator
X	Catherine Borman	EMS Educator, Alternate

Quorum was established

EMS AGENCY STAFF	EMS AGENCY STAFF
Richard Tadeo	Nichole Bosson, MD
Jacqueline Rifenburg	Denise Whitfield, MD
David Wells	Shira Schlesinger, MD
Greg Klein	Michael Kim, MD
HanNa Kang	Ellen Cappello, MD
Nnabuike Nwanonenyi	

GUESTS	ORGANIZATION
Jennifer Hunt	Long Beach FD
Joe Nakagawa, MD	La Habra Heights FD, Hawthorne
Paula Lafarge	LACoFD
Danielle Ogaz	LACoFD
Patricia Guevara	Burbank FD, San Gabriel FD
Kathyrn Ward	UCLA Ctr for Prehospital Care
Kristina Crews	LACoFD
Jennifer Nulty	Beverly Hills FD
Jessie Castillo	PRN Ambulance
Johnna Corbert	UCLA Ctr for Prehospital Care
Tassia Trink	Torrance FD
Michael Stone	USC Medical Center
Caroline Jack	Beverly Hills FD
Adrienne Roel	Culver City FD
Luis Mendoza	Lifeline Ambulance
James Durate	Torrance FD
J. Warren	SMFD

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 – September 1, 2026 – Phoenix Fire Department: 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 (November 5, 2026) *(Shira Schlesinger, MD)*

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

2.3 Introduction of new EMS Fellow – Ella Cappello, MD *(Shira Schlesinger, MD)*

- Dr. Cappello was introduced to Committee as the EMS Fellow through June 2027.

2.4 EMS Update Committee - Recruitment *(Shira Schlesinger, MD)*

- First meeting will be scheduled for September.
- Contact Dr. Schlesinger if interested in participating at sschlesinger2@dhs.lacounty.gov.

2.5 PPRP and NPRP Open Assessments (Shira Schlesinger, MD)

- Pediatric Readiness Surveys are conducted every five (5) years
- National Pediatric Readiness Project (NPRP) Survey is a hospital-based survey, which concluded June 30, 2026.
- Prehospital Pediatric Readiness Project (PPRP) Survey will be open in 2029.
- Both surveys are open for self-assessment if changes to organization have been made since last survey and can assist in evaluating areas of improvement.

2.6 Moment of Silence – In Remembrance of Randolph Mantooth (Richard Tadeo)

- Moment of silence to honor Randolph Mantooth and his contributions to EMS as one of the lead actors from the show Emergency.
- A memorial will be conducted at the Fire Museum. More information to follow.

2.7 Disaster Preparedness Workshop (Nnabuike Nwanonenyi)

- The course scheduled for October 27th has reached capacity. If interested in attending, please email nwanon@dhs.lacounty.gov to be placed on a waitlist.

2.8 Defibrillation Pads (Nichole Bosson, MD)

- Zoll Defibrillation pads are being distributed to 9-1-1 ALS Fire Departments through the Pedi-PART study. Contact Andres Robles at arobles5@dhs.lacounty.gov to coordinate pickup for departments that could not pick up at today's meeting.

2.9 Pediatric Database (Ami Boonjaluksa)

- A database has recently been developed and went live July 1, 2026, for Emergency Departments Approved for Pediatrics (EDAP) to assist with systemwide Quality Improvement.
- Pediatric Liaison Nurses (PDLN) at each hospital will be reviewing prehospital records for patients who arrive at their facility. Records can only be reviewed by the PDLN which their facility was the documented destination.
- A request was made to emphasize to prehospital personnel of the importance of accurately documenting the destination for pediatric patients to assist the PDLNs in the data gathering.

3. APPROVAL OF MINUTES (Manjarrez / Cohen) June17, 2026, minutes were approved as written.

4. UNFINISHED BUSINESS

No unfinished business

5. NEW BUSINESS

5.1 RAPID LA County Medic Mobile Application: Comparing Other Mobile Applications *(Nichole Bosson, MD)*

- Dr. Bosson discussed several potential critical patient safety issues and the importance of using the RAPID LA County Medic Mobile Application. No other application has been developed nor supported by the EMS Agency.
- The RAPID application has been live for one year. The EMS Agency is committed to the application for workflow improvement and additional features.
- Dr. Bosson requesting assistance from all providers to discuss using the RAPID application and for issues or areas which could be improved to contact the EMS Agency.

5.2 NAEMSP Prehospital Trauma Compendium *(Nichole Bosson, MD)*

- Systematic Reviews of trauma care has resulted in the development of 17 documents. Sixteen (16) of the documents are position statements which provide evidence-based recommendations for field care of trauma, two (2) of the position statement recommendations remain pending.

- The seventeenth (17th) document is a comprehensive literature review.
- A summary of the Trauma Compendium was presented at the meeting with brief examples of where some protocols or guidelines may be revised.
- Current compendium documents will be distributed to all providers.

5.3 EMS Update 2027 Topics *(Shira Schlesinger, MD)*

5.3.1 Expanded Scope of Practice: IV Tylenol, ketamine, buprenorphine

5.3.2 Management of IV Fistula Bleeds

- Facilitated discussion by Dr. Schlesinger with committee members and attendees regarding potential paramedic scope of practice changes and educational options for Los Angeles County EMS system in 2027 and beyond. Topics included administration of antihypertensive agents to pregnant patients, buprenorphine, IV Tylenol, ketamine, training delivery options, and EMT specific training.
- Group acknowledged the value of the discussion and appreciated the opportunity to provide input.

Policies for Discussion; Action Required:

5.4 Reference No. 227, Dispatching of 9-1-1 Emergency Medical Services *(David Wells)*

Policy reviewed and approved as written.

M/S/C (Cohen / Hernandez) Approve: Reference No. 227, Dispatching of 9-1-1 Emergency Medical Services

Policies for Discussion; No Action Required:

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

5.5 Reposting of Policies Related to the PediDOSE Trial Completion *(Nichole Bosson, MD)*

5.5.1 Reference No. 1231-P, Treatment Protocol: Seizure (Pediatric)
5.5.2 Reference No. 1309, MCG: Color Code Drug Doses
5.5.3 Reference No. 1317.25, MCG: Drug Reference – Midazolam

- PediDOSE study has been completed. Policies revised to remove reference to the study.
- QRG within the Rapid App will retain "PediDOSE" for provider familiarity.

5.6 Reference No. 706, ALS EMS Aircraft Inventory *(Nichole Bosson, MD / Denise Whitfield, MD)*

- Inventory for magnesium modified to allow for option due to flight mission and space.

6. REPORTS AND UPDATES

6.1 Health Data Exchange *(Richard Tadeo)*

- Several hospitals have commenced participation in Health Data Exchange.
- Business Associate Agreements (BAA) have been completed or in process with public provider agencies which transport patients to a participating HDE hospital.

6.2 EMS Update *(Shira Schlesinger, MD)*

- EMS Update 2026 review course is now available.
- Reminder that the skills portion must be completed by December 2026.

6.3 EmergiPress *(Shira Schlesinger, MD)*

- The July-August edition on pediatric cervical spine evaluation will be available soon.
- Email Dr. Schlesinger at sschlesinger2@dhs.lacounty.gov for recommendations for future releases.

6.4 Innovation, Technology, and Advancement Committee (ITAC) *(Shira Schlesinger, MD)*

- ITAC met August 3, 2026.
- Committee found insufficient evidence for use of the cooling vest.

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

- Committee continues to meet quarterly.
- Continue to develop guidelines related to medical clearances prior to booking.
- New goal established to support expansion of Law Enforcement AED programs.
- Working to establish a pathway with the Police Chiefs Association to disseminate law enforcement EMS education.

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 80+ prehospital blood transfusions.
- Pasadena Fire will be holding a press conference tomorrow, with the goal to implement the program once the blood bank agreement is complete; LA Sheriff's Department is planning to implement within the next couple of months; 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.
- Protocol for administration of blood to pediatrics is being developed by CAL-DROP.

6.6.2 PediDOSE Trial *(Nichole Bosson, MD)*

- Completion of study enrollment 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 by the end of 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)*

- Pending NIH approval, the EMS Agency will continue with outcome data collection, which will end in March 2027.
- Dr. Bosson requested providers continue to upload data to the Zoll cloud.

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

- Sierra Madre FD and Burbank FD are enrolling patients. More information will follow.

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

- Dr. Whitfield thanked those who participated in feedback studies for the RAPID Mobile Application.

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

- The deadline to provide a plan on how their agency will address their department's needs and concerns related to improving cardiac arrest outcomes is at the end of 2026.

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

- Superbowl 2027.
- LA28 Olympic planning is continuing.

7. OPEN DISCUSSION

7.1 Measure B Funding *(Richard Tadeo)*

- Measure B (MBAB) funding MOUs for prior proposals approved for 2025/2026 are currently being processed.
- MBAB process timeline extension approved by the Board of Supervisors to evaluate available funding and develop the notification to allow acceptance of proposals for potential projects in approximately 4 weeks.

7.2 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.

8. NEXT MEETING – October 21, 2026

9. ADJOURNMENT - Meeting adjourned at 3:05 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: **DISPATCHING OF 9-1-1 EMERGENCY MEDICAL SERVICES** REFERENCE NO. 227

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

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

DEFINITIONS:

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

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

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

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

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

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

PRINCIPLES:

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

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

2. Public Safety Answering Point (PSAP) Provider Agencies that implement Emergency Medical Dispatch (EMD) shall comply with the State of California EMS statutes and regulations and Los Angeles County EMS Agency Prehospital Care policies.

3. The emergency medical dispatching protocols developed by the dispatch center shall be approved by the Dispatch Center Medical Director and available for review by the EMS Agency.

POLICY

I. Dispatch Center Designation

A. Dispatch center designation approval is granted based on maintenance of these standards and after a satisfactory review and approval by the EMS Agency.

B. The EMS Agency reserves the right to perform periodic site visits to evaluate compliance with program requirements or request data at any time.

II. Program Requirements

A. Each dispatch center shall have a qualified Dispatch Center Medical Director to oversee protocol development, quality improvement and shall have a Dispatch Coordinator to oversee daily operations.

B. Ensures the Emergency Dispatch Coordinator, Medical Director or dispatch agency representative attends the Dispatch Center Advisory meetings scheduled by the Los Angeles County EMS Agency.

C. The following shall be submitted to the EMS Agency upon request:

1. An EMD program compliant with State and EMS Agency standards and approved by the Dispatch Center Medical Director:

a. Name of the nationally recognized commercial program to be utilized.

OR

b. An Internally developed program.

2. Pre-determined interview questions.

3. Guidelines and procedures used in the dispatch of EMS Resources.

4. Post-dispatch/Pre-arrival instructions that are clearly defined in compliance with EMS Agency guidelines.

5. Quality Improvement Program

6. Education standards and qualifications for call-takers and dispatchers.

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

III. Dispatch Center Medical Director

A. Requirements

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

B. Responsibilities

1. Provides medical direction and oversight of the emergency medical dispatch program by review and approval of:

   a. Policies and procedures related to Emergency Medical Dispatch and patient care.

   b. Standards for qualifying education and continuing education.

   c. Dispatch guidelines including pre-arrival instructions.

2. Oversees quality improvement (QI) and compliance standards.

3. Performs ongoing periodic review of dispatch records for identification of potential patient care issues.

4. Provides oversight and participates in dispatch quality improvement, risk management and compliance activities.

IV. Emergency Dispatch Coordinator

A. Requirements

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

B. Responsibilities

1. Oversees daily operations of the center and ensures staffing on a continuous 24-hour basis of qualified Emergency Medical Dispatchers/Call-Takers that meets the EMS provider agency’s needs.

2. Ensures a dispatch supervisor or designee is readily accessible 24 hours daily.

3. Ensures for availability of a 24-hour contact phone number and e-mail to be utilized to coordinate or disseminate information in case of critical incident or disease outbreak.

4. Ensures all staff meet the requirements of an Emergency Medical Dispatcher by maintaining records and documentation demonstrating compliance.

5. Coordinates QI activities with the Medical Director.

   a. Provides ongoing monthly collection of data and review of dispatch records for identification of potential patient care issues.

   b. Participates in dispatch quality improvement, risk management and compliance meetings and activities.

V. Emergency Medical Dispatcher / Call-Taker Qualifications

A. Initial Qualifications

1. A current and valid BLS certification equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level. Must include hands-on skills validation (e.g., American Heart Association (AHA) or American Red Cross (ARC).

2. EMD Certification, or EMT certification and the completion of the Dispatch Center's self-developed course in EMD training with a minimum initial training of twenty-four (24) hours approved by the Dispatch Center Medical Director and the EMS Agency.

B. Ongoing requirements

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

   OR

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

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

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

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

A. The Emergency Medical Dispatch Center shall have a QI/QA Program that will evaluate indicators specific to the dispatch of emergency medical services to foster continuous improvement in performance and quality patient care.

B. Each QI/QA Program shall have a written plan that is reviewed annually and updated as needed. The plan should include, at minimum, the following components:

1. Mission statement, objectives, and goals for process improvement

2. Organizational chart or narrative description of how the QI/QA program is integrated within the dispatch center, process(s) for data collection and reporting. Include templates used in standardized reports

3. Key performance measures or indicators related to delivery of emergency medical dispatching

4. Methods or activities designed to address deficiencies and measure compliance to protocol standards as established by the EMD Medical Director through ongoing random case review for each emergency medical dispatcher

5. A description of methods used to provide ongoing feedback and disseminate findings to dispatch personnel

6. Activities designed to acknowledge excellence in the delivery of emergency medical dispatch performance

C. The QI/QA process shall:

1. Monitor the quality of medical instruction given to callers, including ongoing random case review for each emergency medical dispatcher and observing telephone care rendered by emergency medical dispatchers for compliance with policies and/or defined standards.

2. Conduct random or incident specific case reviews to identify calls/practices that demonstrate excellence in dispatch performance and/or identify practices that do not conform to policy or standards so that appropriate training can be initiated.

3. Review EMD reports, and/or other records of patient care to compare performance against medical standards of practice.

4. Recommend training, policies and procedures for quality improvement.

CROSS REFERENCES:

Prehospital Care Manual:

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

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

REFERENCE NO. 227, Dispatching of 9-1-1 Emergency Medical Services

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee			
	Provider Agency Advisory Committee	6/17/26 8/19/26	Info Only 8/19/26	
OTHER COMMITTEES / RESOURCES	Medical Council	6/02/26	6/02/26	
	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: 9-1-1 Dispatch Center	6/27/26	6/27/26	

***See Ref. No. 202.2, Policy Review - SUMMARY OF CHANGES/COMMENTS**

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

REFERENCE No. 227, *Dispatching of 9-1-1 Emergency Medical Services*

REF	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
227	Clarifying language to align with dispatch agencies requirements	MAC – 6/2/26 PAAC – 6/17/26 (info only) Dispatch Workgroup – 6/27/26 PAAC – 8/19/26	No comments	Approved by all

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

SUBJECT: **ALS EMS AIRCRAFT INVENTORY** REFERENCE NO. 706

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

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

POLICY:

I. Each ALS EMS aircraft shall have on board equipment and supplies commensurate with the scope of practice of the medical flight crew. This requirement may be fulfilled through the utilization of appropriate kits (cases/packs) which can be carried aboard a given flight.

II. ALS EMS aircraft shall have sufficient space to carry the following minimum medical equipment and supplies.

III. Controlled drugs shall be secured on the EMS aircraft in accordance with Ref. No. 702, Controlled Drugs Carried on ALS Units.

IV. All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.

V. Radio transmitter-receiver (Hand-Held) shall meet Los Angeles County Department of Communications, Spec. No. 2029/2031/2033.

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

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

SUPPLIES			
Adhesive dressing (Band-Aids®)	**1 box**	Color Code Drug Doses, Ref. No. 1309 (current)	**1**
Airways – Nasopharyngeal:		Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5" 14G	**2**
Large (34-36)	**1**	Contaminated needle container	**1**
Medium (26-28)	**1**	Continuous Positive Airway Pressure (CPAP) device **(requires EMS Agency approval)**	
Small (20-22)	**1**	CPAP Masks:	
Airways – Oropharyngeal:		Small	**1**
Large	**1**	Medium	**1**
Medium	**1**	Large	**1**
Small Adult/Child	**1**	Endotracheal tubes w/ stylets Sizes 6.0-8.0	**2 each**
Infant	**1**	Endotracheal tube introducer	**2**
Neonate	**1**	End Tidal CO2 Colorimetric Detector (Adult)	**1**
Alcohol prep pads	**20**	Extrication device or short board	**1**
Backboard	**1**	Filter, viral HEPA	**2**
Bag-Mask-Ventilation (BMV) device w/ O_2 inlet & reservoir:		Flashlight or Penlight	**1**
Bag Volume >900 mL mL	**1**	Gauze bandages	**6**
Bag Volume 400-700 mL	**1**	Gauze sponges 4x4 (sterile)	**12**
Bag Volume 200-450	**1**	Gloves, sterile	**2 pair**
Bag-Mask-Ventilation (BMV) Masks:		Gloves, unsterile	**1 box**
Large	**1**	Glucometer	**1**
Medium	**1**	Test strips (note date opened) and Lancets (auto retractable)	**5 each**
Small Adult/Child	**1**	Hand-held nebulizer pack w/spacer	**2**
Toddler	**1**	Intraosseous device **(requires EMS Agency approval)**	
Infant	**1**	Intraosseous needle: 45mm	**2**
Neonate	**1**	Intraosseous needle: 25mm	**2**
Burn pack or burn sheet	**1**	Intraosseous needle: 15mm	**2**
Cardiac Monitor-Defibrillator w/oscilloscope		Intravenous catheters: Sizes 16G - 22G	**4 each**
Defibrillator/Pacing pads: (adult and pediatric)	**2 each**	Intravenous tubing - Macrodrip	**5**
ECG electrodes: adult and pediatric	**6 each**	i-gel (Disposable Supraglottic Airway):	
ECG, 12-lead & transmission capable	**1**	Neonate (size 1)	**1**
Noninvasive blood pressure monitor with adult and pediatric cuff	**1 each**	Infant (size 1.5)	**1**
Pulse oximeter: adult and pediatric	**1 each**	Small pediatric (size 2)	**1**
Transcutaneous pacing **(requires EMS Agency approval)**	**1**	Large pediatric (size 2.5)	**1**
Waveform capnography monitoring	**1**	Small adult (size 3)	**1**
$EtCO_2/O_2$ oral-nasal cannula w/universal connect (adult)	**1**	Medium adult (size 4)	**1**
$EtCO_2$ sampling lines with airway adaptor	**2**	Large adult+ (size 5)	**1**
Cervical collars (rigid):		Laryngoscope blades:	
Adult (adjustable)	**1**	Adult: curved & straight	**1 each**
Pediatric	**1**	Pediatric: Miller #1 & #2	**1 each**

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

APPROVED OPTIONAL EQUIPMENT	
Albuterol **(all required if using MDI):** Metered Dose Inhaler (MDI) Metered-Dose-Inhaler (MDI) Spacer Metered-Dose-Inhaler (MDI) Mask	Intravenous tubing, blood
	Laryngoscope handle: Pediatric - FDA Approved
	Mechanical CPR device **(requires EMS Agency approval)**
Buprenorphine **(requires EMS Agency approval)**	Normal saline 250 or 500 mL
Dextrose 25%	Oxygen masks – simple
$EtCO_2/O_2$ oral-nasal cannula w/universal connect - Pediatric	Positive end expiratory pressure (PEEP) valve
Hemostatic dressings – EMS Authority approved dressings only	Resuscitator w/ positive pressure demand valve (flow rate not to exceed 40L/min)
Hydroxocobalamin **(requires EMS Agency approval)**	
Impedance Threshold Device	Video laryngoscope **(requires EMS Agency notification)**

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

CROSS REFERENCES:

Prehospital Care Manual:

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

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

REFERENCE No. 706, *ALS EMS Aircraft Inventory*

REF	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
706	Change of language to allow provider to carry either Magnesium vials or premix.	PAAC – 8/19/26	No comments	Info only

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

REFERENCE NO. 706, ALS EMS Aircraft Inventory

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee			
	Provider Agency Advisory Committee	8/19/26	n/a	
OTHER COMMITTEES / RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Pediatric Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of Southern California			
	County Counsel			
	Disaster Healthcare Coalition Advisory Committee			
	Other:			

***See Ref. No. 202.2, Policy Review - SUMMARY OF CHANGES/COMMENTS**

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)**

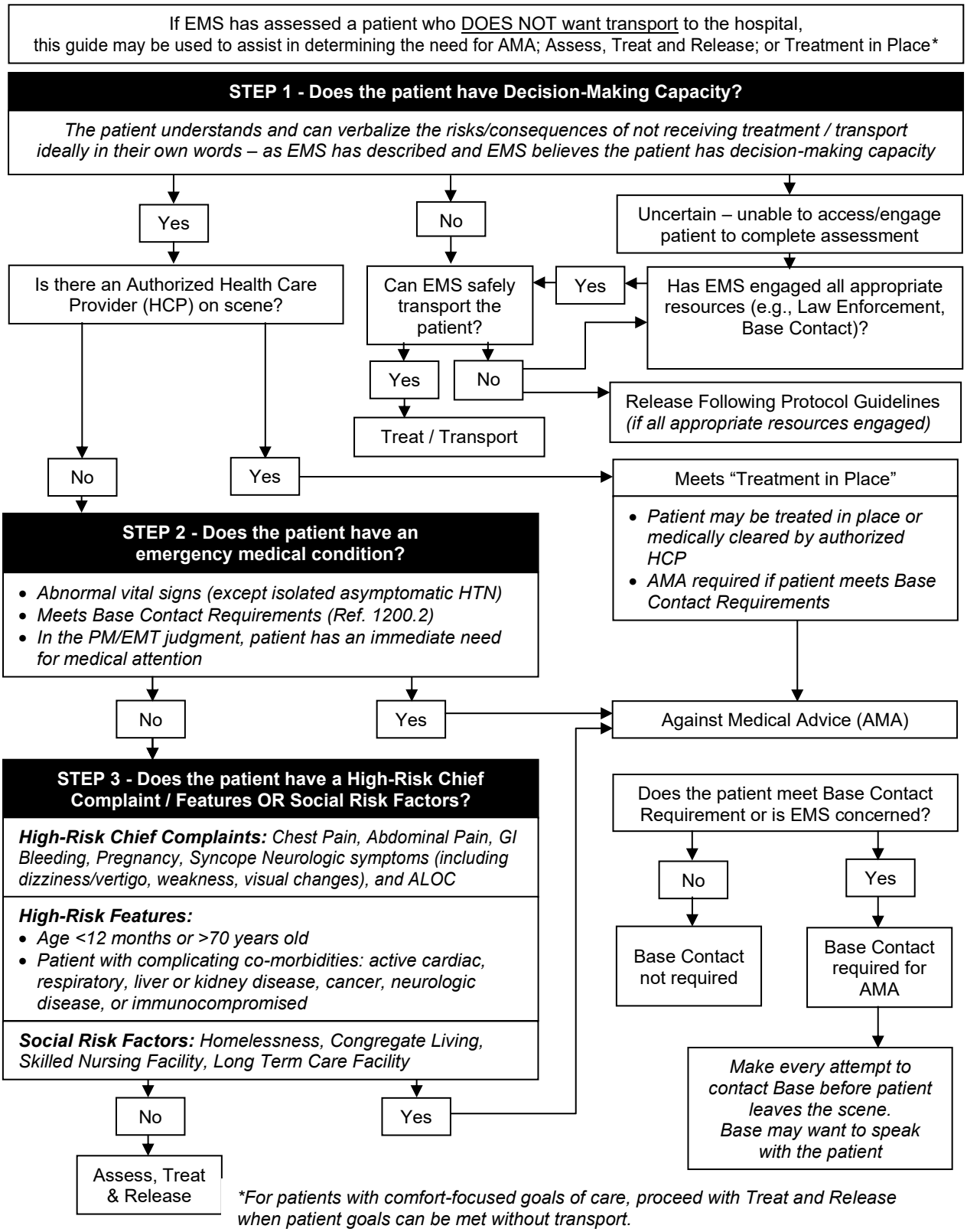
POLICY REVIEW - SUMMARY OF CHANGES/COMMENTS (Rationale for Revision)

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



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

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Kristin Kolenda
Peace Officers Association

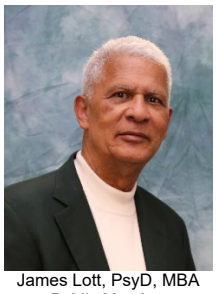

Diego Caivano, MD,
Chair – 2025
LA County Medical Association


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

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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
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California Chapter – American College of Emergency Physicians (CAL-ACEP)

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

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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: July 29, 2026

TO: Commission on EMS

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

SUBJECT: Exceedance of Ambulance Patient Offload Standards – June 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, 228 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, 78 plans have been submitted for 2026.
- EMSA is engaging local emergency medical services agencies (LEMSAs) and the California Hospital Association to increase compliance.

June 2026 APOT Reporting and Operational Adjustments

- Due to ongoing technical problems populating the audit tool with CEMSIS data, hospitals and LEMSAs could not conduct the APOT data audit process for June 2026 data. This issue has been escalated to the highest levels, including a review of contract compliance, and efforts to resolve the technical difficulties

are ongoing. At the same time, EMSA has been preparing to transition to an improved data platform, called EMS Flow, which will resolve the technical challenges impacting the APOT audit tool.

- In response to the technical issues described above, EMSA is temporarily pausing APOT audits, compliance evaluations, and all ongoing biweekly calls with facilities exceeding their local APOT standard through August 2026. No monthly APOT data reports will be issued during this period. EMSA anticipates that the current pause will remain in effect through September 1, 2026. During this period, EMSA will continue monitoring unaudited APOT data internally; however, no compliance determinations or official reports will be issued. This pause allows EMSA to refocus efforts on APOT-related priorities, including dashboard development, transitioning to EMS Flow, and creating training and resource materials to support these initiatives.

Summary of Biweekly APOT Meetings

- EMSA has been conducting biweekly meetings focused on the 15 hospitals with the longest offload delays that exceed their local APOT standard. This target discussion aims to address the needs of the communities served by these hospitals and to directly influence the reduction of offload delays.

- Initial meetings typically include hospital leadership along with LEMSA and EMS representatives, while follow-up sessions generally with the hospital unless EMS/LEMSA involvement is needed. Common participants include hospital executives, emergency department (ED) managers, quality improvement staff, prehospital coordinators, and EMS/LEMSA representatives.

- Each meeting documents attendees, challenges identified, actions taken or planned, outstanding questions, and follow-up items. Hospitals frequently report challenges such as staffing shortages, high patient volumes, transfer delays, construction impacts, data discrepancies, APOT documentation confusion, missing ambulance notifications, inconsistent record corrections, and tension between EMS and ED staff.

- Hospitals have implemented a variety of solutions, including APOT reduction plans, increased use of audit tools, best-practice adoption, collaboration with EMS/LEMSAs, quality improvement initiatives, hiring consultants, heightened leadership engagement, equipment or space enhancements, staff hiring and reassignment, education efforts, and temporary diversion when necessary.

- EMSA also promotes several best practices: maintaining consistent communication with EMS providers, conducting real-time audits with timestamped signatures, expanding APOT education, using whole-hospital approaches, performing proactive audit-tool reviews, targeting specific records for audits, and exporting audit reports before submission.

- To date, EMSA has met with 30 unique hospitals all of which have been one of the top-15 exceeders of all local APOT standard.

Local EMS Agency APOT Standards (June 2026)

Local EMS Agency	APOT Standard (H:MM:SS)
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	**0:25:00***
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

* Sierra-Sacramento Valley's APOT standard was updated to 25 minutes, effective July 1, 2026 (formerly 30 minutes).

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

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

August 10, 2026

MEMORANDUM

TO: Distribution

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

SUBJECT: EXPANSION OF LA-DROP PILOT TO PASADENA

This is to notify you that Pasadena Fire, in collaboration with Huntington Health, will be participating in the Los Angeles Development & Rapid Operationalization of Prehospital Blood (LA-DROP) Pilot. The start date is anticipated to be August 20, 2026, but may be later depending on supply from the blood vendor.

Pasadena Fire joins the previously participating pilot provider agencies, which include the Los Angeles County Fire Department (units specified below) and Compton Fire Department. We anticipate further expansion of the pilot in the coming months to include LA Sheriffs Department Air5 and additional LA County Fire units.

Participating Pilot Units	
Region	*Units*
LA County Fire Battalion 7	s10, s36, s41, s116
LA County Fire Battalion 18	s21, s158, s161
LA County Fire Battalion 20	s14, s171, s172, s173
Compton Fire	All Units

Participating ALS units, or responding supervisor units in some areas, are equipped with blood products, either low-titer O positive whole blood (LTO+WB) or packed red blood cells (PRBC), which may be administered to **patients in hemorrhagic shock from trauma or post-partum hemorrhage per the attached protocol**. Blood storage and administration is rigorously monitored per The Association for the Advancement of Blood & Biotherapies (AABB) Standards. Thus far there have been 79 persons transfused in the field and over 500 units of blood handled by EMS with <1% discard rate.

Paramedics will continue to follow usual base contact and destination policies. **All 9-1-1 receiving centers should be aware of this pilot and the attached hospital resource document**, in particular Trauma Centers and Base Hospitals. Base Hospitals have also received additional training resources.

Data are collected for system quality improvement and patient safety monitoring. Outcome reporting, including identification of any transfusion reactions, is required by the California EMS Authority. Therefore, a participating provider agency medical director will be contacting hospitals for limited data on transfused patients and provide a HIPAA-compliant form for submission.

For more background on the program, you may view this video, which introduces the training program and rationale for the prehospital blood transfusion pilot in LA County: https://vimeo.com/1062996337. Further details are also available in the attached Facts and Questions.

To support the sustainability of the program, there are many opportunities to donate blood and we encourage you to participate by supporting blood drives; there have been more than 500 donations to the program thus far,

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

Attachments:

Prehospital Blood Transfusion Protocol, Checklist and Consent Tool
Receiving Hospital Resource Document
Facts and Questions

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

Prehospital Blood Transfusion Pilot Protocol

LA-DROP
PREHOSPITAL BLOOD TRANSFUSION

Hemorrhagic Shock due to Severe Traumatic Injury or Post-partum Hemorrhage

Control External Bleeding
Apply Tourniquet prn
Consider Tension Pneumothorax

Prioritize Transport

Does the patient meet criteria for prehospital blood?

YES

Warm and rapidly transfuse one unit of LTO+WB OR two units PRBCs

AND

Administer TXA 1g IV/IO over 10 minutes

Continuous monitoring of HR, SpO2, EtCO2, and transfusion reactions

Document BP q3 minutes

Prehospital Blood Transfusion Criteria

SBP < 70 mmHg or unable to obtain

OR

SBP < 90 AND HR ≥ 110

OR

Traumatic arrest witnessed by EMS

Exclusions

Pediatric patient (≤14 years or on length-based tape)
Traumatic arrest not witnessed by EMS
Isolated head injury and/or ground level fall
Patient refusal

CONTACT BASE for **Base Physician** consultation if you believe prehospital blood transfusion is indicated and criteria are not met, or for additional dosing.

NO

Manage patient per Treatment Protocols

Fluid challenge prn

Administer TXA 1g IV/IO over 10 minutes when indicated

Continuous Monitoring of HR, SpO2, EtCO2

Document BP q3 minutes

If patient meets above criteria after initial transfusion as above:

1. Transfuse one more unit of LTO+WB OR PRBCs
2. Reconsider other causes of shock

For additional doses, **CONTACT BASE** for Base Physician consultation

LA-DROP
Blood Administration Field Checklist

- ❑ Ensure external bleeding controlled, think "MARCH"
- ❑ Place patient on cardiac monitor
  - ❑ Obtain HR, BP, SPO2 and $ETCO_2$
- ❑ Establish 2 large bore IVs (preferred) or IOs if unable
- ❑ Confirm indications and rule out contraindications
- ❑ Inform patient of transfusion or use implied consent and look for refusal markers
- ❑ Remove blood product and relock the cooler
- ❑ Inspect the blood bag for integrity and blood clots
- ❑ Perform cross check with a second paramedic:
  - ❑ Product Type (Whole Blood or pRBCs)
  - ❑ Rh Factor (O positive or O negative)
  - ❑ Expiration Date
- ❑ Prime blood tubing and warmer with saline
- ❑ Spike 1 unit of blood to the Y connector with primed tubing
- ❑ Verify that blood is flowing and no extravasation at access site
- ❑ Rapidly transfuse the entire bag of blood by rapid infuser or pressure bag
- ❑ Reassess to determine if patient meets indications for additional 1 unit of blood:
  - If yes, transfuse 1 additional unit (LTO+WB or pRBCs)
  - If no, flush remaining blood in tubing with NS on Y connector until clear
- ❑ Administer TXA 1 g IV/IO as soon as feasible
- ❑ Immediately recheck vital signs, continuous monitoring, reassess BP q3 mins
- ❑ Maintain IV/IO line patency
- ❑ Continuously monitor for transfusion reaction
- ❑ Apply patient wristband for hospital awareness

Hemorrhagic shock is due to traumatic injury or post-partum hemorrhage.

Prehospital Blood Transfusion Criteria

SBP < 70 mmHg or unable to obtain
OR
SBP < 90 AND HR ≥ 110
OR
Traumatic arrest witnessed by EMS

Exclusions

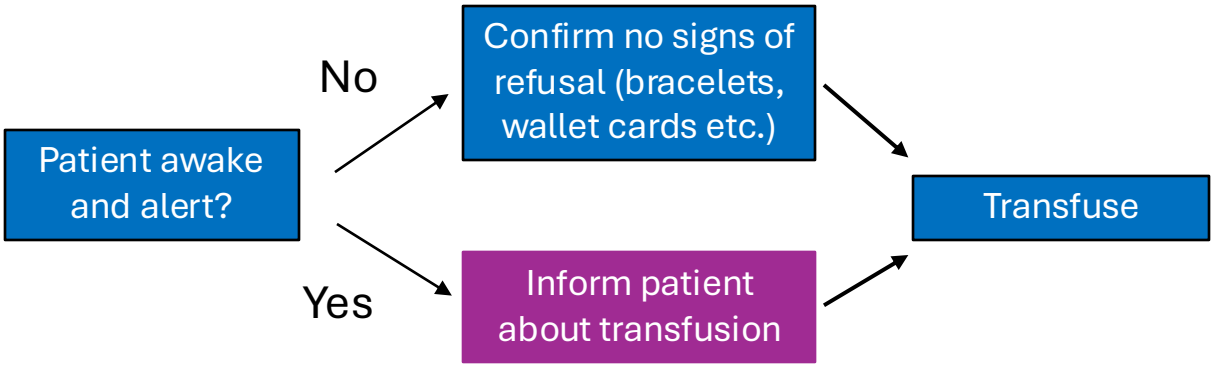
Pediatric patient (≤14 years or on length-based tape)
Traumatic arrest not witnessed by EMS
Isolated head injury and/or ground level falls
Patient refusal

CONTACT BASE for **Base Physician** consultation if you believe prehospital blood transfusion is indicated and criteria are not met, or for additional dosing.

Actions to take for suspected transfusion reaction:

- ✓ STOP TRANSFUSION
- ✓ Disconnect tubing from IV; flush IV port
- ✓ Follow Treatment Protocols (e.g., 1214, 1219)
- ✓ Document reaction in ePCR and report reaction during verbal hand-off
- ✓ Provide blood bag and all tubing to hospital for testing

Blood Transfusion Consent



Scripting Suggestions:

- *"We need to give you a life saving blood transfusion due to your severe bleeding. The risks are very low and include allergy, fever, or breathing reactions and we will monitor you closely. There is a very rare chance of disease transmission, about 1 in 1 million."*

Special Circumstances:

- **If patient sex is female and of childbearing age (<50 years):** *"Depending on your blood type, your body may produce a reaction from a blood transfusion that has a potential risk of affecting future pregnancies."*
- **If patient refuses blood or carries documentation/identifying marker of blood refusal:** "*Because I want to make sure I respect your decisions, I want to confirm that you do not want to be treated with blood products even if that means you might die. Is that correct?"*

For minors (< 18 years):
If parent/guardian on scene, inform them of need for transfusion.
If no parent/guardians on scene, utilize implied consent.

CONTACT BASE for Base Physician consultation on all refusals of blood transfusions

Risk	Risk per unit of blood	Severity
Allergic reactions: - Mild - Moderate - Severe	 1 in 100 1 in 50,000	Ranges from - Hives and itching to - Low BP, nausea, difficulty breathing to - Shock
Fever	1 in 200	Temporary; not harmful
Injury to the lungs	1 in 1,200 to 190,000	1:10 risk of death if complication occurs
Contamination of product causing bacterial infection in patient's bloodstream.	1 in 10,000 to 100,000	Severe to life-threatening
Too much fluid in your bloodstream	Less than 1 in 100	Ranges from mild to severe
Too much iron in your bloodstream and tissues	Can occur after 10-20 red blood cell transfusions if patient is not bleeding	Ranges from mild to severe
Breaking apart of red blood cells	1 in 25,000	Ranges from mild to severe
Viral infection	Every unit of blood is tested for all major viruses; the risk of getting HIV, Hepatitis C, or Hepatitis B from a blood transfusion is close to 1 in 1,000,000 to 1,500,000.	

Receiving Hospital Resource Document

What can you expect when EMS transports a pilot patient to your facility?
Patients who meet criteria for transfusion will have had low-titer Group O+ whole blood (LTO+WB) or packed red blood cells (PRBCs) rapidly warmed and transfused via large bore IV or IO. All used blood bags (including segments) and tubing will be left with the accepting nurse for further blood bank testing as needed.

EMS will report transfusion related information during verbal patient handover including:

- Indication for transfusion
- Type of blood product administered
- Total volume of blood product administered
- If transfusion was stopped prior to completion and, if so, why
- Any adverse reactions including suspected transfusion reactions
- Any additional medications given (e.g., TXA)

Further patient care details can be found in the prehospital electronic patient care record.

Alloimmunization Guidance
Patients are transfused with low-titer Group O+ whole blood (LTO+WB) or packed red blood cells (PRBCs) as part of the LA-DROP prehospital blood transfusion program to save their life. These blood products are Rh-positive, meaning it has the potential to alloimmunize an Rh-negative patient by triggering the development of anti-D antibodies. Anti-D antibodies will not harm the patient but could possibly impact future pregnancies.

If the patient is Rh-negative and has the potential for pregnancy in the future:
Consult your hospital's transfusion medicine service and pharmacist about recommended management strategies and treatment plans including **administration of Rh immunoglobulin (RhIg) within 72 hours**. If needed, you may contact the Director of the Harbor-UCLA Transfusion Medicine Service at 424-306-6227 for technical program questions. Additional resources are available at www.allohopefoundation.org.

- Clinical practice guidelines: https://allohopefoundation.org/clinical-practice-guidelines/
- Patient information template : https://allohopefoundation.org/wp-content/uploads/2026/02/Patient-Guidance-Letters.pdf

Recommendations for management of potential Rh-alloimmunization:

- Discuss the potential for Rh antibody (anti-D) formation. If there is no possibility that the patient will be pregnant in the future, RhIg carries little benefit. If future pregnancies are possible, consider whether to administer RhIg to prevent anti-D development.
- Standard Dose: A **300 microgram** dose of RhIg can suppress the immune response to up to **30 mL** LTO+WB. Each unit of LTO+WB is approximately 500 mL.
- RhIg administration is contraindicated if the Rh-positive RBC volume transfused is >20% of the patient's total blood volume due to the potential for marked red cell splenic sequestration and hemolysis.

For Rh-negative patients, we recommend repeating Type and Screen testing **6-12 weeks** following the exposure to the LTO+WB to determine the development of anti-D antibodies. If antibody testing remains negative, then it is unlikely that patients will develop anti-D later. If the patient may become pregnant and has developed anti-D, the patient should be informed of the potential impact on future pregnancies and understand the importance of sharing this information with their healthcare providers. If they become pregnant, the patient should be referred to an obstetrician who specializes in maternal-fetal medicine.

Patient outcomes and adverse event reporting
The participating EMS Provider Agency Medical Directors, Nurse Educators, and/or Quality Improvement Directors will reach out to the Trauma Program Managers and Prehospital Care Coordinators or other established hospital points of contact for limited critical outcome data, including transfusion reactions. Data will be obtained via a secure HIPAA-compliant form. Timely and complete outcome data will ensure patient

LA-DROP PROGRAM FAQs

How does the LA-DROP program help the community?

The LA-DROP program helps save lives by giving blood transfusions to people who are bleeding a lot, such as after an injury or childbirth. Paramedics can give blood right away at the scene, which helps prevent organ damage and increases the chances of survival.

Is the blood safe?

Yes. The blood used in this program is the same as what hospitals use. It is tested for diseases like HIV and hepatitis and stored under strict rules to keep it safe.

Who can get a blood transfusion before going to the hospital?

People who are bleeding badly from injuries or childbirth and need emergency care from 9-1-1 paramedics.

How does this program support national healthcare goals?

This program helps reduce preventable deaths by giving life-saving blood transfusions before a patient reaches the hospital. It is part of a national effort to improve emergency care. LA-DROP is a collaborator in the Prehospital Blood Transfusion Initiative Coalition (https://prehospitaltransfusion.org/).

How will the program's success be measured?

The program will track things like survival rates, how quickly blood is given, any problems that happen, and how much blood is used or wasted.

What kind of blood is used?

The program mainly uses O+ whole blood, which contains red blood cells, plasma, and platelets. This type of blood is best for stopping bleeding and saving lives. It is donated by volunteers and kept cold to keep it fresh.

If whole blood is not available, red blood cells (RBCs) may be used instead.

Why is whole blood important?

- **Red blood cells (RBCs)** carry oxygen to the body.
- **Plasma and platelets** help stop bleeding by making clots.
- **Blood volume** helps keep blood pressure stable.

safety and is required by the California EMS Authority. The receiving hospital blood bank will be contacted by the Director of Transfusion Medicine at Harbor-UCLA should any look backs or other notifications be required.

LA-DROP PROGRAM FAQs

How is blood stored and transported?

Blood is kept in special refrigerators inside paramedic vehicles at a safe temperature just as it is in the hospitals.

How are paramedics trained for this?

Paramedics learn how to store and give blood, follow safety rules, recognize bad reactions, and keep proper records.

What happens to unused blood?

Unused blood is sent to hospitals where it can be used before it expires, so it doesn't go to waste.

Are there any risks?

Blood transfusions are very safe, but there are small risks, such as:

- **Mild reactions** (like allergies or fevers) happen in 1-3% of cases and can be treated with medicine.
- **Serious reactions** (like lung injury) are very rare (1 in 100,000 transfusions).
- **Infections** from blood are extremely rare (1 in 1.5-2 million transfusions).
- **Antibody formation** might happen, which could make future transfusions or pregnancies more complicated, but the risk is low.
- **Cold blood** can lower body temperature, so special devices warm it up before it is given.

Can persons of childbearing age get this blood?

Yes. There is a small chance that receiving this blood could affect future pregnancies, but the benefit of saving a life is more important. Using our local numbers, we estimate this would happen in only 1 out of 10,000 transfusions. Hospitals have guidelines to manage this risk.

For more information, visit: https://allohopefoundation.org/

Can children receive this blood?

Children under 15 are not included in this program, but in special cases, a hospital doctor might allow it.

What if someone has a religious objection to blood transfusions?

All blood comes from human donors. If someone does not want a blood transfusion for religious reasons, they should tell the first responders or carry a card or bracelet. In emergencies, options may be limited.

Will getting blood before the hospital limit other treatments?

No. Receiving blood early does not stop doctors from giving more blood or medicine later if needed. In fact, early transfusions help the body and may reduce the need for more blood later.

LA-DROP PROGRAM FAQs

Is this blood type universal?

O+ blood can be given to most people. However, O- blood would be even safer for all patients, but there isn't enough O- blood available.

More information about whole blood:

- **How much blood is in one unit?** About 500 mL (half a liter).
- **How is whole blood different from red blood cells?** Whole blood has plasma and platelets, which help stop bleeding. Red blood cells alone only help carry oxygen.
- **Why use whole blood instead of separate components?** Whole blood is more natural and reduces the number of donors a patient is exposed to.

Is the blood irradiated?

No, because irradiation slightly damages red blood cells. In emergencies, there isn't enough time to irradiate the blood, and it isn't needed for most patients.

Are the platelets in whole blood effective?

Yes, platelets in cold-stored whole blood work well for up to 14 days and help stop bleeding.

Will this blood change my blood type?

No, but if you get a lot of it, it might temporarily affect lab test results.

Can I still receive other blood products later?

Yes, you can receive more blood products if needed after getting whole blood.

How can I help by donating blood?

Blood donations are needed to save lives. You can donate at local blood banks. **Who can donate blood?**

- You must be at least **16 years old** (with parental consent) or **17 without consent**.
- You must weigh at least **110 lbs (50 kg)**.
- You must be in **good health**.

For more details, visit:

- San Diego Blood Bank
- Red Cross

COUNTY OF LOS ANGELES FIRE DEPARTMENT

1320 NORTH EASTERN AVENUE
LOS ANGELES, CALIFORNIA 90063-3294
(323) 881-2401
www.fire.lacounty.gov

ANTHONY C. MARRONE
FIRE CHIEF
FORESTER & FIRE WARDEN

"Proud Protectors of Life, the Environment, and Property"

August 4, 2026

TO: THE HONORABLE BOARD OF SUPERVISORS

FROM: ANTHONY C. MARRONE, FIRE CHIEF

LOS ANGELES DEVELOPMENT AND RAPID OPERATIONALIZATION OF PREHOSPITAL BLOOD (LA-DROP) PROGRAM REPORT

I am pleased to provide your Honorable Board with the enclosed report on the County of Los Angeles Fire Department's Los Angeles Development and Rapid Operationalization of Prehospital Blood (LA-DROP) program, which delivers life-saving whole blood transfusions to patients before they reach the hospital, reducing the time to treatment for severe hemorrhage by approximately 20 to 25 minutes.

Launched on April 1, 2025, through a partnership among public safety, healthcare, and blood bank organizations, LA-DROP was established to improve survival for patients experiencing traumatic injuries, postpartum hemorrhage, and other life-threatening bleeding emergencies, especially those in low-income communities and communities of color. To date, the program has transfused 81 patients, achieved a 69 percent survival-to-hospital-discharge rate, maintained a blood discard rate of less than 1 percent, and now serves approximately 500,000 residents.

Building on its early success, LA-DROP will expand to 11 additional fire stations in November 2026 while continuing to strengthen partnerships, encourage community blood donation, and support the advancement of prehospital blood transfusion through the statewide CAL-DROP collaborative.

If you have any questions, please contact me at (323) 881-6180.

ACM:al

c: Joseph Nicchita, Edward Yen, Dr. Christina Ghaly, Richard Tadeo, Each Board Deputy

COUNTY OF LOS ANGELES FIRE DEPARTMENT

LA-DROP

PREHOSPITAL BLOOD TRANSFUSION PROGRAM

PROGRAM REPORT · APRIL 2025 – JULY 2026

TABLE OF CONTENTS

SECTION I: PROGRAM BACKGROUND

In September 2023, Fire Chief Anthony C. Marrone tasked the Department's Training and Emergency Medical Services (EMS) Bureau with developing a prehospital blood transfusion program for Los Angeles County. After participating in a County Racial Justice Learning Exchange that highlighted disparities in severe trauma and postpartum hemorrhage outcomes in low-income communities and communities of color, Chief Marrone directed the implementation of the Department's prehospital blood transfusion program to improve survival outcomes for these vulnerable patients. With this goal in mind, the County of Los Angeles Fire Department (County Fire), Compton Fire Department (CFD), Harbor-UCLA Medical Center, the Los Angeles County EMS Agency, the Lundquist Institute, and San Diego Blood Bank came together to form the Los Angeles Development and Rapid Operationalization of Prehospital Blood (LA-DROP) collaborative.

LA-DROP played a leading role in expanding the California paramedic scope of practice to include initiation of blood transfusions and established a research collaborative to evaluate program outcomes. On April 1, 2025, the program went live at County Fire and CFD. It was California's second prehospital blood transfusion program, following shortly after the Corona Fire Department in Riverside County.

PROGRAM TIMELINE

SEPTEMBER 2023
Program Inception
Chief Marrone directive
LA-DROP collaborative formed

2024 – 25
Pilot Preparation
Scope of practice expanded
Paramedics trained

APRIL 2025
Program Launch
California's second prehospital blood transfusion program

2025 – 26
Pilot Phase
Battalions 7, 18, and 20 in SD 2
Compton Fire Dept.

NOVEMBER 2026
San Gabriel Valley
11 additional stations in SD 1
funded through Measure B

FROM THE BATTLEFIELD TO THE NEIGHBORHOOD

WWI & WWII
1914 – 1945
First large-scale transfusions; Dr. Charles Drew's blood banking enables civilian blood drives

IRAQ & AFGHANISTAN
2001
Ruggedized storage brings blood to the point of injury, transforming combat survival

SAN ANTONIO
2017
The first large-scale civilian prehospital blood transfusion program in ground EMS

LOS ANGELES
APRIL 2025
LA-DROP brings prehospital blood to the Los Angeles County and Compton Fire Departments

PREHOSPITAL BLOOD TRANSFUSION COALITION

TODAY
Over 400 EMS agencies carry blood nationwide, yet only ~3% of the population is covered

SECTION II: WHY PREHOSPITAL BLOOD?

In a county rich in trauma centers, why transfuse in the field? Because any length of time with uncontrolled bleeding dramatically worsens a patient's chance of survival. Hemorrhage is the leading cause of preventable death in trauma, and trauma is the leading cause of death for patients aged 1 to 45. For decades, paramedics could offer only saline, a fluid that carries no oxygen and does not clot. Whole blood restores oxygen-carrying capacity while providing clotting factors and platelets. LA-DROP also targets mothers with postpartum hemorrhage (PPH). The United States ranks 55th globally in maternal mortality, and, in California, hemorrhage is the second leading cause of postpartum death.

43%
OF U.S. TRAFFIC FATALITIES WERE ALIVE WHEN EMS ARRIVED

#1
CAUSE OF DEATH, AGES 1–45: TRAUMA · HEMORRHAGE MOST PREVENTABLE

55th
U.S. GLOBAL RANK IN MATERNAL MORTALITY · PPH MOST COMMON CAUSE

20–25
MINUTES EARLIER TO FIRST TRANSFUSION VS. HOSPITAL ARRIVAL

Traffic collisions account for 20 of 70 trauma transfusions to date.

Whole blood transfusion initiated in the field prior to hospital arrival.

THE EVIDENCE: PENETRATING TRAUMA, NEW ORLEANS (DUCHESNE ET AL., 2024)

8 vs 27
MINUTES TO FIRST TRANSFUSION, PREHOSPITAL VS. HOSPITAL

7% vs 29%
IN-HOSPITAL MORTALITY, TRANSFUSED EARLY VS. LATE

143
PATIENTS STUDIED, MEDIAN AGE 34

SECTION III: HOW THE PROGRAM WORKS

THE BLOOD

LA-DROP primarily uses **Low-Titer O-Positive Whole Blood (LTOWB)**, which contains red cells, plasma and platelets. Only 7% of the population is O-negative, compared with 38% is O-positive, making LTOWB the most practical universal product for emergency transfusion.

A unit of Low-Titer O-Positive Whole Blood: red blood cells, plasma, and platelets in a single unit.

THE COLD CHAIN

Every unit rides in an **Autonomous Portable Refrigeration Unit (APRU)** holding a constant 2–6°C and reporting its temperature to the cloud for remote monitoring, 24/7. Units arrive approximately seven days after donation and have a 35-day shelf life. When the units reach 14 days until expiration, the Fire Department exchanges the blood through the San Diego Blood Bank, where it is inspected and redistributed to Harbor-UCLA. When County Fire or CFD transfuse a patient, the blood is restocked within 24 hours.

Autonomous Portable Refrigeration Unit providing continuous cold-chain monitoring.

PEDIATRIC CAPABILITY

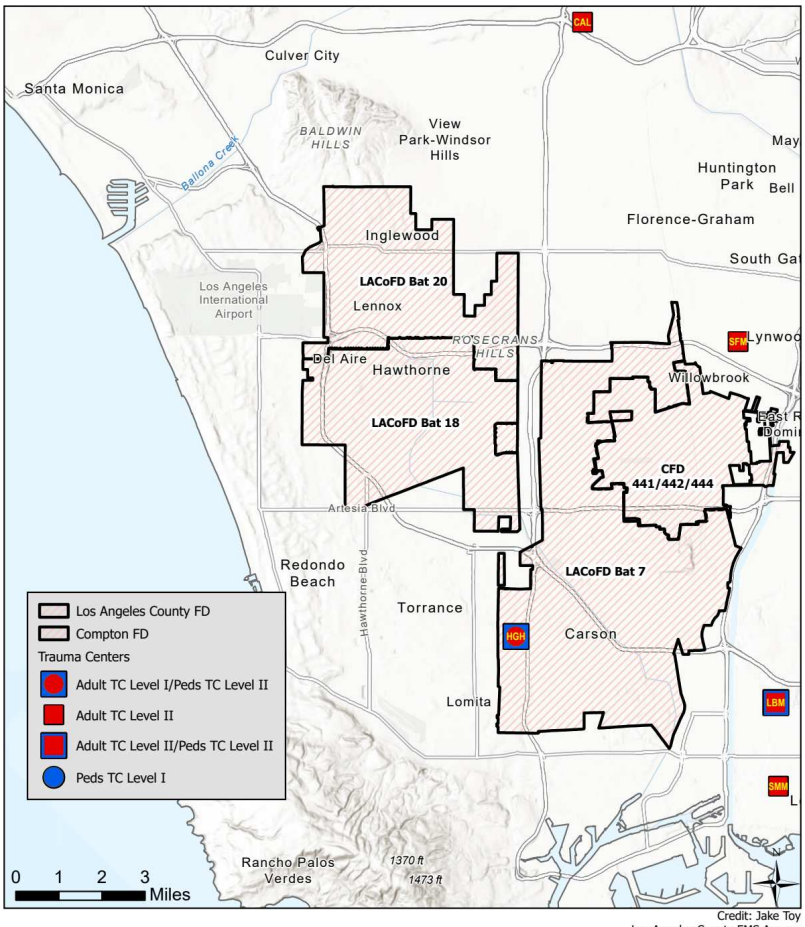
Weight-based dosing protocols extend the program to children through partial-unit dosing. All pediatric transfusions are performed under the guidance of Base Hospital physicians.

THE FIELD SEQUENCE

1	2	3	4	5	6
ASSESS	**ACCESS**	**WARM**	**TRANSFUSE**	**MONITOR**	**HAND OFF**
Control external bleeding; monitor, obtain vitals	Two IVs, or intraosseous if unable	Blood tubing runs through a portable warmer	LTOWB begun on scene or en route	Vital signs and transfusion reactions watched continuously	Empty units stay with the patient for blood bank testing

SECTION IV: DATA-DRIVEN DEPLOYMENT

LA-DROP Pilot Coverage Areas

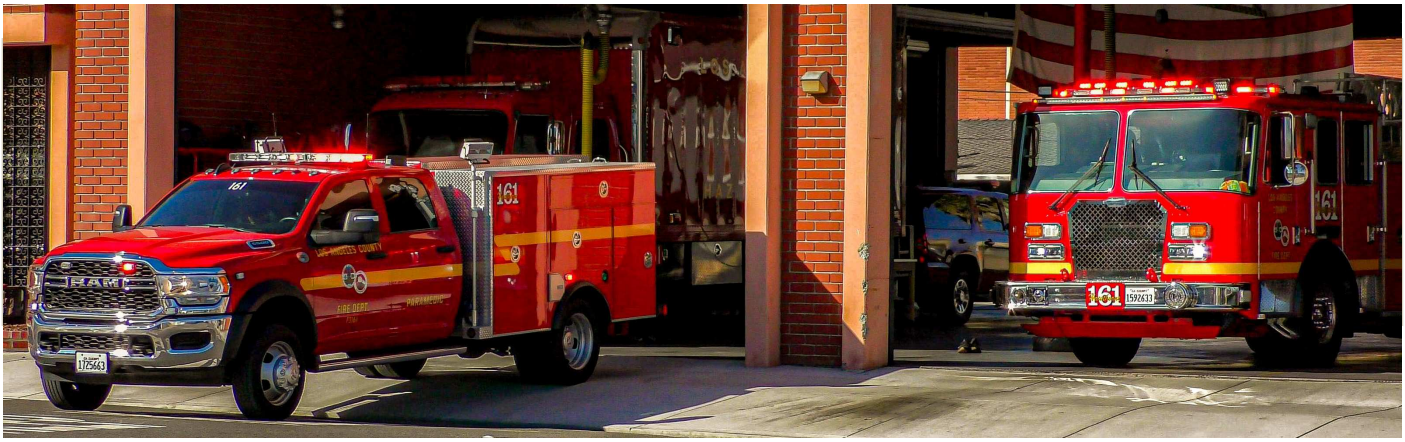


Credit: Jake Toy
Los Angeles County EMS Agency

Deployment areas were not chosen at random. Two years of patient data identified where critical trauma patients are encountered most frequently across the County.

The pilot footprint concentrates blood-carrying squads where the need is highest and where trauma patients are transported predominantly to Harbor-UCLA Medical Center, enabling the unit-exchange partnership that keeps blood waste under 1%.

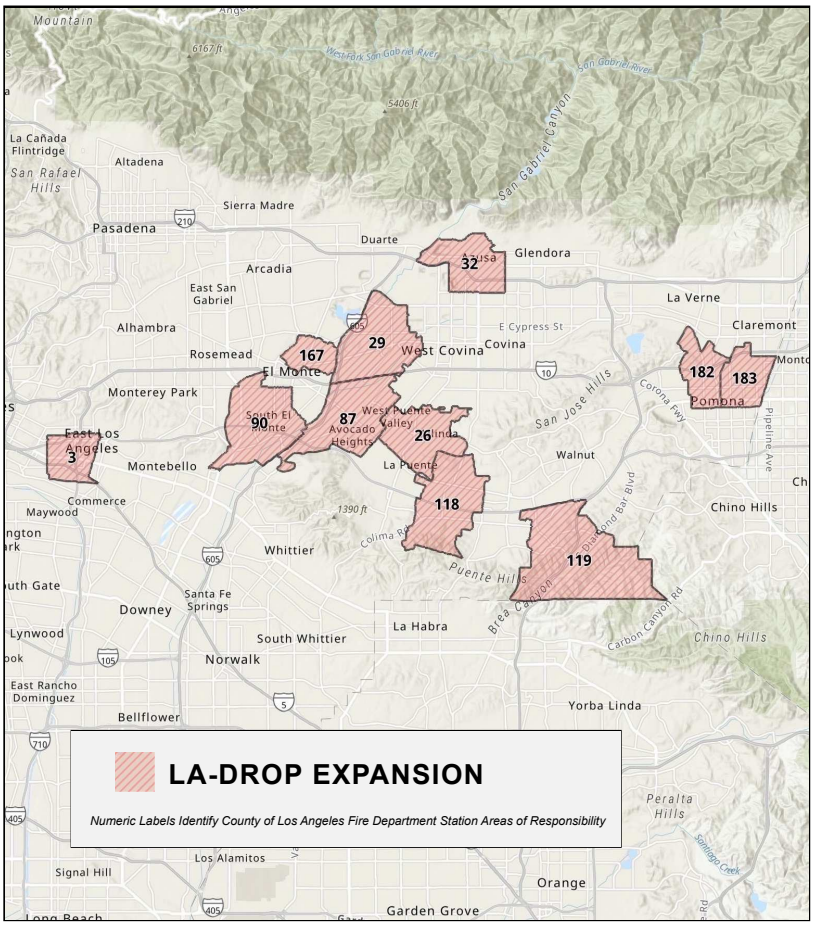
The map on the left shows the LA-DROP pilot coverage area, encompassing 12 fire stations in the cities of Inglewood, Hawthorne, Lawndale, Gardena, Carson, and Compton, and in the unincorporated communities of South Los Angeles and Willowbrook. Notably, Willowbrook is also home to Charles R. Drew University of Medicine and Science. The university was named for Dr. Charles Drew, who pioneered blood banking and without whom prehospital blood transfusion would not be possible.



Blood-equipped paramedic squads strategically deployed throughout the pilot service area.

SECTION IV: DATA-DRIVEN DEPLOYMENT

LA-DROP Expansion Coverage Areas



Building on the pilot program's early success, LA-DROP is preparing to expand into the San Gabriel Valley and surrounding communities. The next phase will add 11 stations serving El Monte, South El Monte, La Puente, Industry, Walnut, Azusa, Pomona, East Los Angeles, Basset, and nearby unincorporated areas.

The same data-driven approach used to establish the original pilot footprint will guide this next deployment. Participating stations are positioned to strengthen geographic coverage, reduce the time to first transfusion, and place whole blood closer to patients experiencing life-threatening hemorrhage.

Fire Station 167, one of the stations supporting LA-DROP's planned expansion into eastern Los Angeles County.

SECTION V: COLLABORATION AND INNOVATION

LA-DROP's success is built on strong partnerships, a commitment to data collection and research, and continuous innovation to improve outcomes for critically ill and injured patients. LA-DROP inspired the larger CAL-DROP collaborative, which brings together the five California counties currently operating prehospital blood transfusion programs. LA-DROP and CAL-DROP freely share developed resources and lessons learned to help agencies seeking to launch their own programs. The Los Angeles County EMS Agency governs protocols, paramedic scope of practice, and quality assurance; the Lundquist Institute supports the research collaborative; and San Diego Blood Bank sustains the supply of low-titer O-positive whole blood. Every unit carried in the field is managed within a shared stewardship system that returns unused blood to hospital circulation, protecting the regional blood supply while extending lifesaving treatment into the community.

FIRST IN. FIRST TO SAVE.

San Diego Blood Bank's Guardian's Circle Rapid Response Team is a dedicated corps of O-type donors who give whole blood and red cells to support emergency transfusion in the field and in trauma centers. Every unit carried by paramedics begins with a community member who chose to donate.

We thank our community blood donors who provide the foundation for every prehospital transfusion.

SECTION VI: THE COMMUNITY BLOOD SUPPLY

Every unit LA-DROP carries begins with a volunteer donor. The program's long-term sustainability depends on growing the region's donor base alongside its clinical footprint.

3%	45%
OF ELIGIBLE U.S. POPULATION DONATE BLOOD EACH YEAR	OF THE U.S. POPULATION IS TYPE-O

More than 60% of the population is eligible to donate, yet only 6.8 million of 340 million people give each year. LA-DROP aims to be a galvanizing force for community blood donation across Los Angeles County.

Community-donated whole blood is prepared for emergency use, forming the foundation of LA-DROP's prehospital transfusion supply.

SECTION VII: PILOT COVERAGE & EXPANSION

EXISTING DEPLOYMENT

Lawndale, Gardena, Hawthorne, Inglewood, Carson, Compton, and the unincorporated communities of South Los Angeles, Willowbrook and El Camino Village.

Together, they represent approximately 500,000 residents, or 5% of the County's population.

PLANNED EXPANSION

El Monte, South El Monte, La Puente, Industry, Walnut, Azusa, Pomona, and the unincorporated communities of East Los Angeles and Basset.

With $350,000 in Measure B funding secured by Supervisor Hilda Solis, LA-DROP is scaling to 11 additional stations.

Blood pre-deployed at SoFi Stadium for the FIFA World Cup.

MOBILE BLOOD BANK

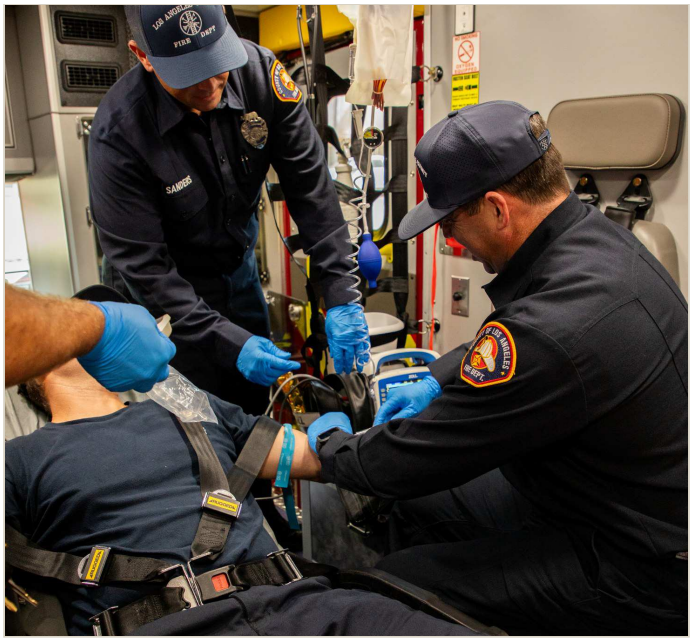
Twelve field-deployed units make LA-DROP a rapid-response mobile blood bank for disasters, a capability that did not exist in Los Angeles County EMS before the pilot program launched.

"I am proud to support this pilot program in our district that faces high rates of emergency incidents where access to blood before reaching the hospital is a matter of life or death. I look forward to more lives being saved."

THE HONORABLE HOLLY J. MITCHELL, LOS ANGELES COUNTY SUPERVISOR, SECOND DISTRICT

SECTION VIII: RESULTS TO DATE

79 PATIENTS TRANSFUSED COUNTY FIRE 75 · COMPTON FD 4	**69%** SURVIVED TO HOSPITAL DISCHARGE	**500K** RESIDENTS SERVED · 5% OF LA COUNTY
<1% BLOOD DISCARD RATE · EXCEPTIONAL STEWARDSHIP	**37** MEDIAN PATIENT AGE · 75% MALE · 25% FEMALE	**25–50%** EXPECTED MORTALITY OF QUALIFYING PATIENTS



County Fire paramedics establish IV access during a transfusion training.

Whole blood rides aboard LA-DROP paramedic squads, ready for immediate transfusion.

"Time is the difference between life and death. This program allows paramedics to begin life-saving transfusions in the field, giving patients a real chance to survive when minutes matter most."

DR. KELSEY WILHELM
DIRECTOR, EMS AND DISASTER PREPAREDNESS PROGRAMS, HARBOR-UCLA,
MEDICAL DIRECTOR, COMPTON FIRE DEPARTMENT

SECTION IX: PATIENT OUTCOMES

A 69% survival-to-discharge rate, in a population selected for 25–50% expected mortality, is an encouraging early signal. Every chart is reviewed as part of the LA-DROP and CAL-DROP research collaborative, building the evidence base for prehospital blood transfusion nationwide.

PATIENT OUTCOMES

SURVIVED TO DISCHARGE	69%
EXPIRED	21%
STILL HOSPITALIZED	10%

TOTAL OF 75 COUNTY FIRE PATIENTS

Every LA-DROP transfusion is documented and reviewed. The distribution of causes and outcomes below reflects all 75 County Fire patients transfused between April 1, 2025 and July 28, 2026.

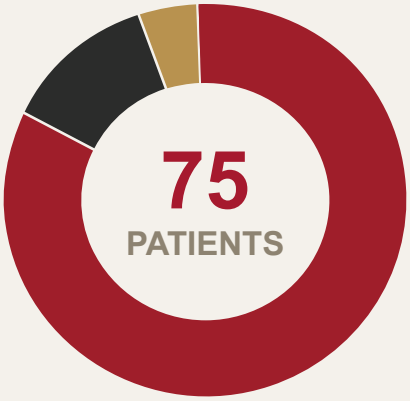
"Having reviewed every single chart, there are some patients where it appears that the blood made all the difference."

DR. CLAYTON KAZAN

MEDICAL DIRECTOR,
COUNTY OF LOS ANGELES
FIRE DEPARTMENT

TRANSFUSIONS BY CAUSE

- **TRAUMA** — 63 · 84%
- **MEDICAL HEMORRHAGE** — 10 · 13%
- **POSTPARTUM** — 2 · 3%



SECTION X: PROGRAM INVESTMENT

$380,000

QUALITY & PRODUCTIVITY COMMISSION · DEC 2024

Productivity Investment Fund award: equipment acquisition and the program's first 100 units of whole blood.

$350,000

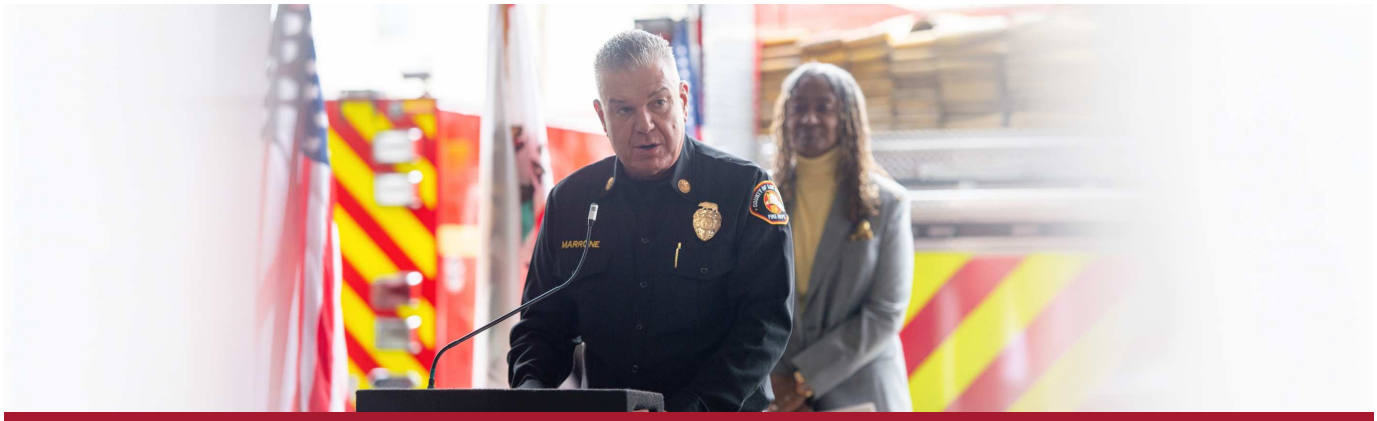
MEASURE B · SUPERVISOR HILDA SOLIS · 2026

Funds the San Gabriel Valley expansion: 11 additional stations, launching November 2026.

$50,000

VITALANT FOUNDATION GRANT JUNE 2026

New rapid infusion devices allowing blood to be transfused faster in the field.



"The LA-DROP prehospital blood transfusion pilot program underscores the LACoFD's ongoing commitment to enhancing trauma response and delivering critical care to patients in need, before they reach the hospital. By integrating this advanced capability, the LACoFD is one of few agencies Statewide to utilize this innovative life-saving protocol, with the goal to significantly improve patient outcomes."

ANTHONY C. MARRONE, FIRE CHIEF, LA COUNTY FIRE DEPARTMENT

SECTION XI: UNIT ECONOMICS & REIMBURSEMENT

Most of the cost of a prehospital blood program is up-front equipment. Once that infrastructure is in place, transfusing a critically ill patient costs about $1,200.

UNIT ECONOMICS

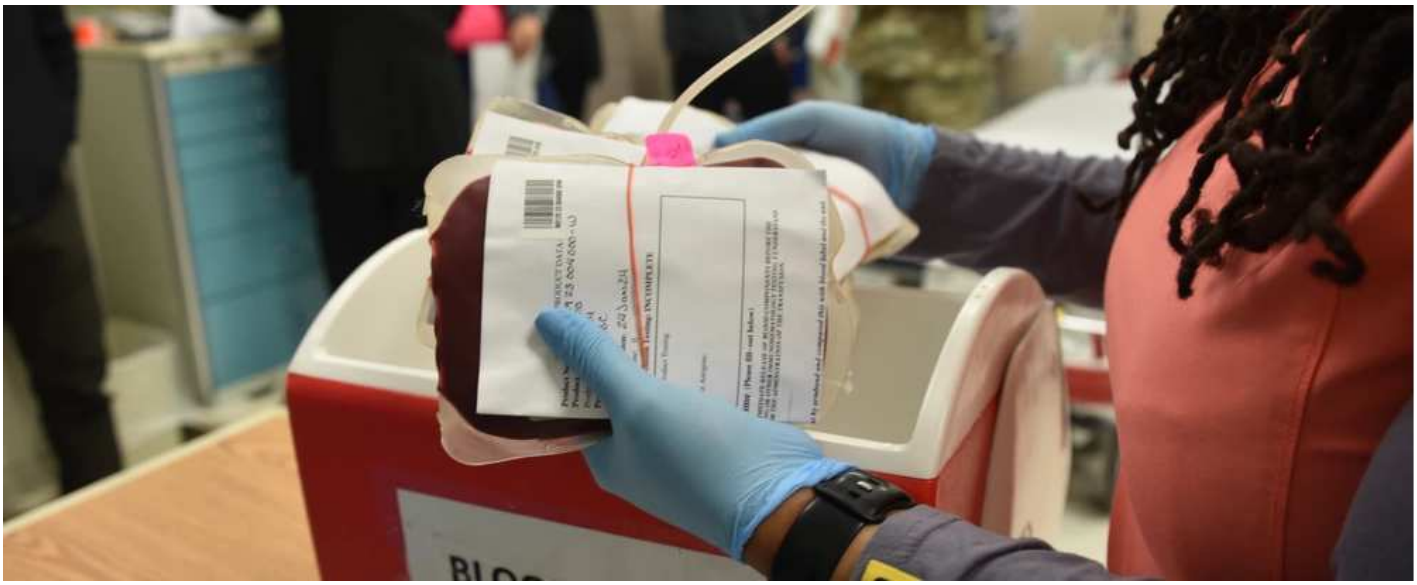
Whole blood, per unit	**$725**
Packed red blood cells, per unit	**$448**
Equipping one vehicle (cooler, warmer, monitoring)	**~$25,000**
Cost per patient transfused (once equipped)	**~$1,200**

20–25 MIN
TIME SAVED BY STARTING TRANSFUSION IN THE PREHOSPITAL SETTING

$0
CURRENT EMS REIMBURSEMENT FOR WHOLE BLOOD DELIVERED IN THE FIELD

THE REIMBURSEMENT GAP

Because current EMS reimbursement policies do not cover prehospital blood transfusions, each transfusion represents an unreimbursed cost to the provider agency, creating one of the greatest challenges to sustaining these programs nationwide. To address this reimbursement gap, the Department intends to seek available Measure B and Measure ER funding to support the long-term sustainability of the program.



Unused blood units are exchanged through San Diego Blood Bank, inspected, and redistributed to the Harbor-UCLA Trauma Center.

SECTION XII: THE FUTURE OF LA-DROP

Built on LA-DROP's success, CAL-DROP is a statewide coalition of EMS agencies, fire departments, hospitals and blood banks serving over 2 million Californians across five counties (Los Angeles, Riverside, Sacramento, San Bernardino and Ventura), with 100+ prehospital transfusions, 1,000+ community blood donations, and under 2% EMS blood waste. Nationally, the Prehospital Blood Transfusion Initiative Coalition advances policy, reimbursement reform and scope-of-practice standards for timely access to blood.

2M+	100+	1,000+	<2%
CALIFORNIANS COVERED ACROSS FIVE COUNTIES	PREHOSPITAL TRANSFUSIONS STATEWIDE	COMMUNITY BLOOD DONATIONS	EMS BLOOD WASTE ACROSS CAL-DROP

FIRE DEPARTMENTS

Compton
Corona
LA County
Ontario
Sacramento
San Bernardino County
Ventura County

BLOOD BANKS

LifeStream
San Diego Blood Bank
Vitalant

HOSPITALS

Harbor-UCLA
UC Davis Medical Ctr.
Ventura Co. Medical
Riverside Community

EMS AGENCIES

Inland Counties
LA County
Riverside County
Sacramento
Ventura County

CAL-DROP PREHOSPITAL BLOOD TRANSFUSION

PREHOSPITAL BLOOD TRANSFUSION INITIATIVE COALITION

LOOKING AHEAD

- **San Gabriel Valley Expansion:** Launch 11 additional stations in November 2026.
- **Countywide Expansion:** Continue expanding access to prehospital blood transfusions across Los Angeles County.
- **Sustainable Funding:** Pursue EMS reimbursement reform and Measure B/ Measure ER funding.
- **Blood Supply:** Expand the Rapid Response Team of O-type donors.
- **Program Evaluation:** Continue research and share outcomes through the CAL-DROP collaborative.

Our mission is to save lives in Los Angeles by providing emergent blood transfusions to people with severe bleeding from injuries, childbirth, and other causes—before they reach the hospital. Through strategic partnerships and a robust community-driven blood donor network, LA-DROP aims to reduce preventable deaths and strengthening Los Angeles' emergency medical response system with innovative prehospital care.

LA-DROP MISSION STATEMENT

LA-DROP
PREHOSPITAL BLOOD TRANSFUSION

LA-DROP unites the Los Angeles County Fire Department, Compton Fire Department, the Los Angeles County Department of Health Services, Harbor-UCLA Medical Center, the Los Angeles County EMS Agency, the Lundquist Institute, and San Diego Blood Bank in a shared mission: to bring lifesaving blood to the patient, wherever the emergency occurs.

COUNTY OF LOS ANGELES FIRE DEPARTMENT CALIFORNIA

SCAN THE QR CODE
FOR UPDATES

QUALITY & PRODUCTIVITY COMMISSION

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: August 28, 2026

TO: LEMSA Administrators
LEMSA Medical Directors
EMS Providers

FROM: Elizabeth Basnett, Director
Hernando Garzon, MD, Chief Medical Officer

SUBJECT: Updated APOT Regulatory Guidance and Audit Tool Relaunch

Amendments to Chapter 1.2 Delivering Equitable and Person-Centered Care - Ambulance Patient Offload Time were approved by the Office of Administrative Law and are effective as of July 23, 2026. EMSA is providing the following guidance to implement new and updated requirements related to these regulations.

Updates to the Audit Tool:
Beginning September 1, 2026, the audit tool will only populate records which exceed your local APOT standard, referred to as Ambulance Patient Offload Delay (APOD). General Acute Care Hospitals (GACHS) with Emergency Departments will only be able to view and audit APOD records, as all other records will no longer be available for viewing.

Hospitals are advised to input notes into the audit tool when discrepancies are identified to serve as preliminary evidence. Hospitals should be prepared to present supporting documentation or evidence to LEMSAs or EMS Providers during the reconciliation process.

Hospitals choosing to utilize the APOD Audit Tool are required to submit their completed audits between the 4th and the 10th of the month for the proceeding month's data. All APOD and entered discrepant records will be locked and automatically submitted at 11:59pm on the 10th of the month.

APOD Discrepancy Review Process/Requirements:
Pursuant to CCR, Title 22, § 100003.01. Verification of CEMSIS Data Used for APOD:

> *(3) Upon receipt of the notification from the GACH, the LEMSA shall coordinate a review with the GACH and relevant EMS transport provider agency or agencies, wherein:*
> *(A) LEMSA facilitates the review process and does not act as an advocate for any party.*
> *(B) LEMSA reviews available documentation and provides input regarding the accuracy of the information.*

(C) LEMSA documents:
(i) Evidence reviewed;
(ii) Positions of all parties;
(iii) Basis for resolution or reasons for unresolved status;
(iv) Any concerns about process or pressure.
(D) The timeline in Section 100003.01(b)(4) may be extended by LEMSA upon showing of good cause.

To streamline this process, EMSA will provide each LEMSA with a consolidated spreadsheet listing all APOD discrepancies identified by GACHs in their jurisdiction. Utilization of this template is not required and is for LEMSA internal uses only. LEMSAs are not required to report any information or finding back to EMSA.

If the EMS Provider agency agrees with a discrepancy, they shall correct the ePCR and resubmit the revised record by the 15th calendar day of the month following the reporting month. While records corrected after the 15th may be excluded from EMSA's APOT compliance assessment, these revisions should be made to ensure accurate retrospective analysis by GACHs, LEMSAs and EMSA.

Implementation of "Real-Time" Audit Process:
Pursuant to CCR, Title 22, § 100006.01. (b) (2026) EMS transport providers shall:

> *Ensure the date and time entered for the "destination transfer of care" time (NEMSIS element eTimes.12) is viewable to the emergency department medical personnel at time of transfer of care.*

Hospitals and EMS Providers should ensure their teams are trained to do the following:

1. **EMS Provider manually documents the TOC date and time** and makes it viewable to ED staff at the time of transfer of care.
2. Prior to signature, **ED staff review the TOC** to verify accuracy. If they disagree, ED staff should provide supporting evidence and request that the EMS provider make the correction at that time.
3. **Upon agreement on the transfer of care time**, ED staff should also sign to confirm the transfer of care.

This workflow results in GACH staff serving as "real time auditors" and agreeing with the times recorded by EMS. Real-time verification diminishes the need for GACHs to conduct monthly audits and for LEMSAs to coordinate a discrepancy review process. All APOT records should follow logical timestamp order: eTimes.11, eTimes.12, eOther.19 (TOC signature date/time). Monitoring logical timestamps has been incorporated into APOT dashboards, expected October 2026 (SSO required).

Connect directly with our APOT Team at APOT@emsa.ca.gov.

September 2, 2026

TO: Distribution

FROM: Richard Tadeo
Emergency Medical Services Agency Director
Co-chair Measure B Advisory Board

SUBJECT: 2026 ONE-TIME MEASURE B FUNDING PROPOSALS

This memo is to inform you and your constiuents that the Measure B Advisory Board (MBAB) will be accepting proposals for funding consideration beginning October 13 through December 17, 2026.

The MBAB Funding Proposal Process (Attachment I) provides the detailed information on what expenditures are allowable under Measure B and the process for submitting a proposal as well as the process the MBAB uses to evaluate and rank the proposals to make funding recommendations to the Board of Supervisors.

A virtual submitters conference will be held via Teams on Wednesday, September 30, 2026, from 10:00 am until 10:30 am. This meeting will address the MBAB Funding Proposal Process. The link to join the submitters conference is:

Join Meeting Here
Meeting ID: 248 194 895 136 338
Passcode: Jw7aj7Ln

To submit a project for MBAB considered, please complete the Measure B Funding Proposal Form (Attachment II) and submit it to the Emergency Medical Services Agency no later than 5:00 pm on December 17, 2026. Any proposals submitted after December 17, 2026, will not be considered and will be returned to the submitter.

If you have any questions please contact Jacqui Rifenburg, Assistant Director, EMS Agency at jrifenburg@dhs.lacounty.gov or (562) 378-1640.

RT:jr

Attachments

Distribution:
American College of Surgeons, Southern California Chapter
American Heart Association, Western States Affiliate
California Chapter of American College of Emergency Physicians
California Professional Firefighters
California Nurses Association Emergency Department Nurses
Health Deputy, Each Board of Supervisor Office
Hospital Association of Southern California
League of California Cities Los Angeles County Chapter
Greater Los Angeles County Chapter of the Emergency Nurses Association
Los Angeles County Medical Association
Los Angeles County Police Chiefs Association
Los Angeles Area Fire Chiefs Association
Los Angeles City Fire Department Air Operations
Los Angeles County 9-1-1 Receiving Hospitals
Los Angeles County Approved Emergency Medical Technician Training Programs
Los Angeles County Approved Paramedic Training Programs
Los Angeles County Department of Health Services
Los Angeles County Department of Public Health
Los Angeles County Emergency Medical Services Commission
Los Angeles County Fire Department
Los Angeles County Hospital and Healthcare Commission
Los Angeles County Medical Association
Los Angeles County Police Chiefs' Association
Los Angeles County Public Health Commission
Los Angeles County Sheriff Department – Air Operations
Measure B Advisory Board Members
Professional Peace Officers' of Los Angeles County
Southern California Ambulance Association
Southern California Public Health Association
Southern California Psychiatric Society

MEASURE B ADVISORY BOARD
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

2026 One-Time Measure B Funding
Process for Submitting Funding Proposals

Background

Measure B is a special property assessment that was passed by the voters of Los Angeles County on November 5, 2002. This assessment is imposed upon all improvements (buildings) located in Los Angeles County and is added to Los Angeles County property taxes to provide funding for the Countywide System of Trauma Centers, Emergency Medical Services (EMS), and Bioterrorism Response.

The use of Measure B funds is restricted to four areas and authorized expenditures must fall within one of these areas:

Trauma Centers	• Maintain all aspects of countywide system of trauma centers. • Expand system of trauma centers to cover all areas of the county. • Provide financial incentives to keep existing trauma centers within the system • Pay for the costs of trauma centers, including physician and other personnel costs
Emergency Medical Services	• Coordinate and maintain a countywide system of emergency medical services • Pay for the costs of emergency medical services, including physician and other personnel costs
Bioterrorism Response	• Enable stockpiling of safe and appropriate medicines to treat persons affected by a bioterrorism or chemical attack • Train health care workers and other emergency personnel to deal with the medical needs of those exposed to a bioterrorism or chemical attack • Provide medical screenings and treatment for exposure to biological or chemical agents in the event of a bioterrorism or chemical attack • Ensure the availability of mental health services in the event of a terrorist attack
Administration	• Defray administrative expenses, including payment of salaries and benefits for personnel in the Los Angeles County Department of Health Services and other incidental expenses • Recover the costs of the special election in 2002 • Recover the reasonable costs incurred by the county in spreading, billing and collecting the special tax

Submitting a Proposal

Proposals for One-Time Measure B funding must be submitted to The EMS Agency between **October 13 through December 17, 2026**. All proposals will be reviewed by the Chief Executive Office, County

Counsel and the EMS Agency to ensure the proposed expenditures qualify for Measure B funding. Any proposal that does not qualify for Measure B funding will be removed from MBAB consideration and the proposer will be notified of this action.

All qualified proposals for One-Time Measure B funding will be forwarded to the MBAB members for review and ranking at the MBAB proposal review meeting(s), typically scheduled in January and February of the following year.

Below are the steps to submit a proposal:

1. Complete the Measure B Proposal form and submit it, along with any supporting documents, via mail or email to the Los Angeles County EMS Agency **no later than 5:00 pm on December 17, 2026.** Supporting documents **must** include price quotations for equipment purchases, budget, and pertinent financial statements. Financial statements are required for proposals to offset the operational loss for providing a specific service (e.g. Trauma Services). The financial statements must clearly show direct expenses incurred and revenue received and expected to be received from all sources (including subsidy and donations) for providing the service. For proposed new services or activities, a detailed budget must accompany the proposal, that includes a list of personnel, equipment, supplies and services costs, and an explanation of how these costs are determined. Additionally, when a proposal requires the hiring of personnel or incurring other long-term financial obligations (e.g. lease) for future years, the proposer must provide supporting documentation demonstrating how they will cover the personnel cost and these obligations if Measure B funding is not available in future years. If the proposer is a County Department, the proposer must provide a letter from the Department Head/Director or Chief Executive Officer approving the proposal submission.

2. Proposers are encouraged to attend the MBAB proposal review meeting(s) to provide a brief overview of their proposal, limited to two minutes, and be available to answer any questions that the members of the MBAB may have related to their proposal.

3. After reviewing all qualified proposals, the MBAB members will score the proposals during the proposal review meeting(s). The ranking score given by the MBAB members does not guarantee funding recommendations by MBAB nor approval by the Board of Supervisors to fund the proposal.

Evaluating and Rank Ordering of the Proposals

The MBAB members will review and score each qualified proposal using a five-level scoring system: high priority (Score of 5), medium high priority (Score of 4), medium priority (Score of 3), medium low priority (Score of 2), or low priority (Score of 1). MBAB members will score proposals being considered, even if they are affiliated with the proposing entity, or have an interest in or will benefit from a proposal(s), unless it is deemed inappropriate by the MBAB Co-Chairs.

The proposals will be ranked based on the total score provided by each voting MBAB member. MBAB members will be determining its funding recommendations to the Board of Supervisors based on the ranking of each proposal and the funding amount available for one-time funding.

MBAB members will take into consideration the following when evaluating and scoring each proposal:

- Consistency with the original intent of Measure B
- Regional or system-wide application and impact
- Improves overall services of trauma, EMS or bioterrorism
- Addresses any major gap in the system to ensure access and health equity
- Feasibility of proposed project, given the available time and resources
- Completeness of proposal

Board Consideration

A memo to the Board of Supervisors providing information on all the qualified proposals that were submitted and reviewed will be written by the Co-Chairs. The Board memo will highlight the available One-Time Measure B funding, the rank order score of each proposal and the proposals recommended for funding. It shall be the Board's sole discretion and decision on what proposals are to be funded, as well as the amount awarded.

Once a proposal is approved by the Board, additional processes may need to be implemented prior to disbursement of the funds. This includes entering into a written agreement with the County outlining the use of the funding and the timeframe for incurring expenses. Typically, One-Time Measure B funds that are awarded should be expended within 12 months of award on a reimbursement basis. Funding awardees (proposers) incur the expense and then submit a claim or invoice to Los Angeles County Health Services Finance Division for reimbursement.

If you have any questions regarding submitting a proposal, please contact Jacqui Rifenburg, EMS Agency Assistant Director at jrifenburg@dhs.lacounty.gov or 562-378-1640.

Los Angeles County Measure B Funding Proposal 2026

Measure B funding will be allocated on a one-time basis with all expenditures to be completed within 12 months of award. If the proposal requires year to year funding the proposer must provide supporting documents on how they will cover the on-going costs in future years.

Requesting Entity Name:	
Point of Contact Name:	
Point of Contact Phone:	
Point of Contact email address:	
Amount of Funding Requested:	
Brief Project Description:	
Describe the gap in Emergency Medical Services, Trauma Services or Bioterrorism Preparedness that the requested funds addresses: ***Discuss the current situation, strategy to solve the identified gap and how the allocation of Measure B funds benefits the citizens of Los Angeles County)***	

Justification: ***Place a checkmark next to each of the applicable statements and incorporate comments into your brief 2-3 paragraph narrative justification.***	☐ Achieves compliance with legal requirements, mandate, citation or audit. ☐ Increases capacity to meet patient care demand. ☐ Provides for improvements in emergency preparedness activities. ☐ Improves timely access to healthcare. ☐ Provides a new service for patients. ☐ Improves efficiency. ☐ Increases patient safety/reduces risk. ☐ Other Narrative Justification:
Timeline **When *funds will be needed, how long will it take to implement. Explain/list the major milestones to achieve implementation and the approximate timeline for each.***	

Provide as separate attachments the following supporting documents:

- List of equipment and price quotations for equipment purchases.
- Financial statements will be required for funding request to offset the operational loss for providing a specific service (e.g. Trauma Services). The financial statements must clearly show direct expenses incurred and revenue received and expected to be received from all sources (including subsidy and donations) for providing the service, with the request for Measure B funding no more than the gap between the revenue and expenses.

- For proposed new services or activities, a detailed budget must accompany the funding request, that includes a list of personnel, equipment, supplies and services costs, and an explanation of how these costs are determined.

- When a request requires the hiring of personnel or incurring other long-term financial obligations (e.g. lease) for future years, the requesting entity must provide supporting documentation demonstrating how they will cover the personnel cost and these obligations if Measure B funding is not available in future years.

- If the proposer is a Los Angeles County department, provide a letter from the Department's Department Head or Chief Executive Officer approving the addition of the requested item to the department's budget.

- Project Timeline: Include project start date once funded, total time needed to complete project and major milestones along the timeline.

Submit all documents via mail or email no later than December 17, 2026 to:

Los Angeles County

Emergency Medical Services Agency

Measure B Advisory Board

10100 Pioneer Boulevard, Suite 200

Santa Fe Springs, CA 90670

Attention: Jacqui Rifenburg

jrifenburg@dhs.lacounty.gov

2026 FIFA World Cup Attendance Emergency Department Patient Screening

County of Los Angeles Public Health

Background

The **Los Angeles County Department of Public Health (Public Health) Syndromic Surveillance Project**[1] monitors and analyzes patient data from 96% of emergency departments (EDs) in Los Angeles (LA) County. Syndromic surveillance data feeds come from each hospital's electronic medical record (EMR) system and are transmitted to local and state public health departments in near real-time for detecting and monitoring disease outbreaks and increases in health conditions of public health importance. While extremely timely, syndromic data contains very limited clinical information – self-reported chief complaints, coded diagnoses, and triage notes (from some but not all EDs); they do not contain full clinician notes or patient interviews for additional context like illness or injury exposures or presence at mass gathering events.

Methods

To enhance traditional syndromic surveillance during the 2026 FIFA World Cup, Public Health asked all syndromic-participating hospitals to screen ED patients for attendance at FIFA-related events from June 11th to July 17th, 2026, and to document patient attendance using the specific keyword "**FIFA2026**" along with the FIFA event location in the patient's EMR chief complaint and/or triage notes.

Information collected through this effort was reviewed daily, and ED encounters which contained keywords relevant to FIFA events and locations were manually (1) reviewed for unusual and concerning health conditions or suspicious circumstances; (2) categorized by acute health condition based on chief complaints and diagnoses, and (3) assessed for increased volumes.

Results

Hospital Participation

Fifty hospitals participated in the effort to document ED visits with FIFA World Cup attendance. Twenty-four (48%) of these hospitals recorded at least one ED visit with the specified "**FIFA2026**" keyword, while ten (20%) hospitals documented at least one ED visit using other keywords that were not "**FIFA2026**" but were relevant to FIFA events and locations such as: "FIFA", "World Cup," "FanFest", "SoFi", and "Coliseum" (Figure 1). Sixteen (32%) hospitals had zero FIFA attendee ED patient encounters but reported screening participation to Public Health during pre-FIFA recruitment or mid-FIFA check-ins (Figure 1). We consider these hospitals as having participated, since EDs with lower patient volumes or those located farther away from FIFA events may, by chance, not have encountered any FIFA attendee ED patients.

HOSPITAL PARTICIPATION

50 hospitals

Number of hospitals that documented ED visits with FIFA attendance and/or reported participation in patient screening during Public Health outreach

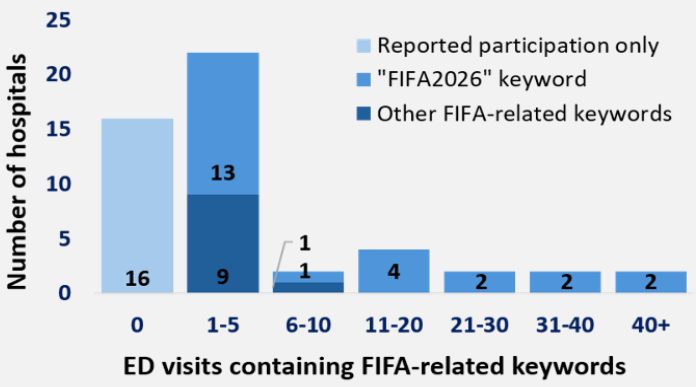


Figure 1. Distribution of the number of ED visits containing FIFA-related keywords per hospital, among all hospitals from June 11 to July 17, 2026.

[1] For information about the Los Angeles County Department of Public Health Syndromic Surveillance Project, visit the website at http://www.publichealth.lacounty.gov/acd/syndromic/

LOCATION OF FIFA EVENT ATTENDANCE AMONG ED PATIENTS

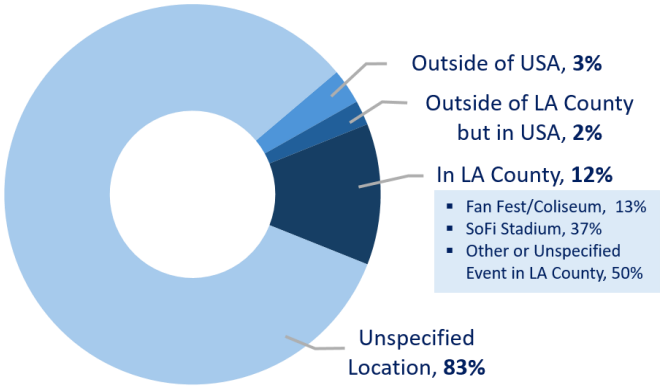


Figure 2. FIFA event location reported among ED visits noting FIFA attendance (N=333) from June 11 to July 17, 2026.

Table 1. Acute health categorizations among FIFA event attendees for ED visits (N = 333) from June 11 to July 17, 2026. [2]

Category [3]	% of FIFA event-related ED visits
Injury	25%
Gastrointestinal	17%
Cardiovascular	9%
Respiratory	9%
Alcohol-related	6%
Rash/Skin	5%
Dizziness/weakness/syncope	4%
Genitourinary	4%
Musculoskeletal pain/conditions with no documentation of acute injury event	4%
Other	17%

Characteristics and Health Categorizations of FIFA Attendee ED Visits

Public Health review observed that 20% of ED visits from June 11 to July 17, 2026 having a FIFA-related keyword were false positives, with the keyword appearing in phrases that explicitly denied FIFA attendance (e.g. "not a FIFA attendee") and therefore not actually associated with FIFA event attendance.

Of the ED visits with FIFA-related attendance, approximately 5% indicated FIFA event attendance outside of LA County (Figure 2). Among the ED visits noting FIFA event attendance within LA County, 37% attended a match at SoFi Stadium and 13% attended a Fan Fest event at LA Memorial Coliseum (Figure 2).

Over three hundred FIFA event- associated ED visits were manually reviewed during the surveillance period. Injury-related (25%) were the most common acute health category, followed by gastrointestinal (17%) (Table 1). There were no concerning or large increases in trends during the surveillance period, and routine follow-up of individual ED visits flagged for review did not identify any unusual activity.

Conclusions

The supplemental screening effort undertaken by hospitals enabled Public Health to assess health conditions among FIFA attendees, providing valuable insights which complemented Public Health's broader surveillance activities during the FIFA World Cup. Data completeness and timeliness can vary among facilities; robust reporting of chief complaint and diagnoses by hospital staff into patient EMR provides more reliable syndromic surveillance data. Boosting syndromic surveillance data with event attendance information serves as an important strategy for improving timely situational awareness during mass-gathering events.

THANK YOU **We thank our hospital partners for their participation in this effort.**

[2] The depicted syndrome classifications reflect daily Public Health determinations using what EMR data were available *when FIFA attendance was first noted for each visit* during the screening period. The categorizations are preliminary as diagnoses could have been subsequently added to the patient EHR.

[3] Acute health categories include but are not limited to the following chief complaints and diagnoses: Injury (fall, sprain, dislocation); Gastrointestinal (vomiting, abdominal pain); Cardiovascular (chest pain, palpitations); Respiratory (cough, shortness of breath), Alcohol-related (intoxication, alcohol poisoning); Rash/skin (insect bite, cellulitis); Genitourinary (urinary tract infection, kidney stones); Musculoskeletal pain/conditions with no documentation of acute injury event (myalgia, back pain); Other (sepsis, pregnancy complications)