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: November 18, 2026
TIME: 1:00 – 3:00 PM
LOCATION: 10100 Pioneer Boulevard, First Floor
Cathy Chidester Conference Room 128
Santa Fe Springs, CA 90670

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

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

AGENDA

1. CALL TO ORDER – Diego Caivano, MD, Chair

2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS
- 2.1 2027 EMSAAC Conference Save-the-Date
- 2.2 EMS Annual Data Report
- 2.3 California EMS Awards Nomination

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 September 9, 2026

3.2 **Committee Reports**
- 3.2.1 Base Hospital Advisory Committee – October 14, 2026
- 3.2.2 Provider Agency Advisory Committee – October 21, 2026

3.3 **Policies**
- 3.3.1 Reference No. 530: Use of 9-1-1 Services for Interfacility Transfer of Patients
- 3.3.2 Reference No. 842: Mass Gathering and Special Event Interface with EMS.
- 3.3.3 Reference No. 842.4: Mass Gathering and Special Events Patient Care Log

END OF CONSENT AGENDA

LOS ANGELES COUNTY BOARD OF SUPERVISORS
Hilda L. Solis
First District
Holly J. Mitchell
Second District
Lindsey P. Horvath
Third District
Janice K. Hahn
Fourth District
Kathryn Barger
Fifth District

COMMISSIONERS
Diego Caivano, MD, Chair
LA County Medical Association
Chief Paul Camacho
Los Angeles County Police Chiefs' Assn.
Chris Reade
California Professional Firefighters
Erick H. Cheung, MD
Southern CA Psychiatric Society
Matthew Hawkesworth
League of Calif. Cities/LA County Chapter
Tarina Kang, MD
Hospital Association of Southern CA
Ms. Carol Kim
Public Member (1st District)
Captain Kristin Kolenda
Peace Officers Association of LA County
Lydia Lam, MD
American College of Surgeons
Mr. Kenneth Liebman
LA County Ambulance Association
James Lott, PsyD, MBA
Public Member (2nd District)
Carol Meyer, RN
Public Member (4th District)
Chief Kenneth Powell
Los Angeles Area Fire Chiefs Association
Connie Richey, RN
Public Member (3rd District)
Stephen G. Sanko, MD, Vice Chair
American Heart Association Western States Affiliate
Carole A. Snyder, RN
Emergency Nurses Association
Saran Tucker, PhD, MPH
Southern California Public Health Assn.
Atilla Uner, MD, MPH
California Chapter-American College of Emergency Physicians (CAL-ACEP)
VACANT
Public Member (5th District)

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INTERIM COMMISSION LIAISON
Vanessa Gonzalez
(562) 378-1607
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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 Nominating Committee – 2027 Chair and Vice Chair

5. LEGISLATION

6. DIRECTORS' REPORTS

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

Correspondence

6.1.1 (09/17/2026) STEMI and Pediatric Referral Hospital Requirements Effective October 1, 2026
6.1.2 (09/21/2026) Ronald Reagan UCLA Designated Hyperbaric Chamber
6.1.3 (09/28/2026) Los Angeles County Long Term Care Mutual Aid Program (LTC-MAP) for Evacuation and Resources/Assets
6.1.4 (10/08/2026) Name Update for Catalina Island Medical Center
6.1.5 (11/04/2026) Expansion of LA-DROP Pilot to El Monte

6.2 Nichole Bosson, MD, Medical Director – EMS Agency

7. COMMISSIONERS' COMMENTS / REQUESTS

8. ADJOURNMENT

Adjournment to the meeting of January 20, 2026

LOS ANGELES COUNTY BOARD OF SUPERVISORS
Hilda L. Solis
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Southern California Chapter
American College of Surgeons
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Public Member (3rd District)
Stephen Sanko, MD, Vice Chair
American Heart Association
Western States Region
Carole A. Snyder, RN
Greater Los Angeles County Chapter of the
Emergency Nurses Association
California State Council
Saran Tucker, PhD, MPH
Southern California Public Health Association
Atilla Uner, MD, MPH
California Chapter of American College of
the Emergency Physicians (CAL-ACEP)
VACANT
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MINUTES
September 9, 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
☒ Paul Camacho, Chief	LACo Police Chiefs' Assn.	Jacqueline Rifenburg	EMS Staff
☒ Matthew Hawkesworth	League of CA Cities/LA Co	David Wells	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	Ella Cappello	EMS Staff
☒ Lydia Lam, M.D.	American College of Surgeons	Ami Boonjaluksa	EMS Staff
☒ Kenneth Liebman	LACo Ambulance Association		
☐ James Lott, PsyD, MBA	Public Member, 2nd District		
☐ Carol Meyer, RN	Public Member, 4th District		
☒ Kenneth Powell	LA Area Fire Chiefs' Assn.		
☐ Connie Richey, RN	Public Member 3rd District		
☒ 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

Chris Reade, California Professional Firefighters	Hasan Makda, LA General Medical Center

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 1:09pm. There was a quorum of 11 commissioners present.

2. INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

EMS Agency Director Richard Tadeo introduced two new commissioners: Matthew Hawkesworth representing the League of California Cities, Los Angeles County Chapter, and Chris Reade, representing the California Professional Firefighters.

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

Motion/Second by Commissioners Snyder/Kim to approve the Consent Agenda was carried unanimously.

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.

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

Assistant Director Jacqui Rifenburg reported that the hospitals received the updated APOT tool and the Cloudwick system resumed use on September 1, 2026. The update APOT tool will only populate records which exceed the APOT standard. Director Tadeo referenced correspondence 6.1.4 regarding the APOT Regulatory Guidance and Audit tool relaunch. Hospitals are advised to incorporate APOT time verification into their workflow at the time of transfer of care, with nurses encouraged to discuss the offload time documented in the EPCR with the provider.

Director Tadeo had previously reported that, of the 15 hospitals with the most egregious APOT, 13 were in LA County. As of April 2026, that number has decreased to five, reflecting significant progress. With the relaunch of the APOT audit tool, the goal is to remove all LA County hospitals from the list.

4.3 **Interfacility Transfer Taskforce**

The taskforce serves as a Commission working group to address interfacility transfers (IFTs), primarily the inappropriate use of 9-1-1. After one year of data collection, IFT volume has stabilized at 60-70 transfers per month, with 30 STEMI transfers. The

taskforce will continue engaging hospital leadership regarding identified inappropriate 9-1-1 use rather than continuing to track all cases.
Providers also reported 9-1-1 activations for inpatient transfers from long-term acute care hospitals. The taskforce will begin collecting data and engaging the California Department of Public Health's (CDPH) Health Facilities Inspection Division, its enforcement branch, to clarify requirements for appropriate transfers from inpatient and ICU settings.

4.4 **Cardiac Arrest Taskforce**

Hospitals and provider agencies are developing plans to achieve the American Heart Association (AHA) 2030 goals for improving patient-centered outcomes for both out of hospital and in hospital cardiac arrests. The submission deadline has been extended to January 1, 2027. The taskforce completed six months of educational clinics to assist agencies and hospitals in developing their plans. Dr. Sanko invited hospitals and provider agencies to share their draft plans for feedback prior to final submission.

Business (New)

4.5 **Commission Annual Report**

Motion/Second carried by Commissioners Cheung/Snyder to approve the Commission Annual Report was carried unanimously.

4.6 **Emergency Medicine Board Certification/Board Eligibility Requirements for Specialty Care Centers**

Dr. Nichole Bosson reviewed current emergency physician qualification standards for specialty centers and 911-receiving hospitals. Existing standards require physicians attending emergency departments at STEMI, stroke, pediatric, and trauma centers to be board-certified or board-eligible in emergency medicine. She noted that a long-standing attestation process has allowed some physicians who do not meet these qualifications to continue working in emergency departments.
Dr. Bosson outlined a proposal to end the attestation process at specialty centers by January 1, 2029. During the transition period, hospitals employing physicians who are not board-certified or board-eligible would attest that those physicians had completed relevant continuing education within the previous five years. Examples include stroke-related training, such as NIHSS and large-vessel-occlusion identification, and STEMI-related competencies, such as ECG interpretation and CPR. Physicians who do not meet the applicable requirements could work in fast-track or urgent-care areas but not in the acute emergency department.
For 911-receiving hospitals, the current standard requires emergency physicians to staff at least 60% of positions. Dr. Bosson proposed moving toward a standard requiring all such positions to be staffed by physicians who are board-certified or board-eligible in emergency medicine, with January 1, 2029 as the target date. She stated that supervised employment pathways for senior residents would remain available.
Dr. Bosson cited the specialty's ongoing advances and the importance of continuing education and current qualifications as the rationale for the proposed changes.
Commissioner Snyder asked whether monitoring is currently in place. Director Tadeo reported that on-site surveys have begun at the 15 community hospitals to assess compliance with the criteria. He added that 2029 was selected because it marks the tenth year and coincides with renewal of the Master Designation Agreement, which covers all designations. By then, the 911-receiving hospital agreement would have been in place for approximately three to four years.
Commissioner Cheung asked about the extent of the gap and the percentage of physicians affected. Director Tadeo described the gap as small and reported that, of

the 15 community hospitals, eight had been surveyed; approximately three of those eight appeared not to meet the current 60% requirement. A physician-level percentage was not provided.
Director Tadeo added that the department had requested plans from the three hospitals to address the requirement but had not yet received responses. As a next step toward preparing for the 2029 contract, the department plans to engage the hospital association and seek its endorsement of the proposed direction. The matter would also proceed through the committee process. Director Tadeo noted that the 911-receiving hospital policy sets out the requirements, which are also incorporated into the contract for hospitals to review and execute.

5. LEGISLATION

AB1607 – The Richie Fund supports pediatric trauma services and provides nearly $600,000 to Dignity Health – Northridge Hospital Medical Center for its pediatric trauma center. Originally set to expire on December 31, 2026, the fund has been amended for an additional 10 years. The extension was approved by the Legislature and is awaiting the Governor's signature.

AB 2405 – AB2405 would have required law enforcement to transport behavioral health patients to the nearest emergency department, raising concerns among behavioral health and law enforcement agencies. The bill was amended to require 5150 patients be transported to the most appropriate receiving facility. It has passed the Assembly and Senate and is awaiting the Governor's signature.

6. DIRECTORS' REPORTS

6.1 Richard Tadeo, EMS Agency Director, EMSC Executive Director

In July, Supervisor Holly Mitchell introduced a motion to review Measure B funding allocations to non-county hospitals. The motion directs the CEO's office to coordinate with LA Health Services and Public Health to engage a consultant to assess whether funding allocations remain consistent with the Measure B mandate approved by voters in 2002. The review extends beyond trauma hospitals. The CEO's office is convening a county team to develop the scope of work and identify a consultant, with an 180-day turnaround anticipated. The review is prompted by the expected decrease in funding from HR1.
The Measure B Advisory Board (MBAB) is convening with $22 million available for funding. The proposal process has been delayed by six months, moving from March to August, to ensure the exact funding amount is available. Proposals will be accepted from October 17 through December 17, 2026. The MBAB will convene in January or February to review and rate proposals, with funding recommendations presented to the Board in April.

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

Heart Heros Initiative
The Heart Hero Initiative, led by the Department of Public Health in 2023, aimed to train at least 500,000 people in bystander CPR across Los Angeles County. Our agency, hospitals, and provider agencies participated. A difference-in-differences analysis comparing bystander CPR rates in Los Angeles County with Sacramento and San Francisco Counties found that the initiative increased bystander CPR rates for public cardiac arrests.

LA-DROP
The LA-DROP program has been ongoing for over a year, with outcomes analysis still pending. The team has begun evaluating the program's criteria and sharing preliminary findings. A recently published online analysis assessed how effectively the criteria identify patients requiring blood transfusions, with heart rate and blood pressure combinations being the most significant indicators. Work continues with partners to refine the criteria and improve identification of patients who may benefit from prehospital blood transfusions.
The program continues to expand. In August 2026, Pasadena Fire Department launched its program and has completed one prehospital blood transfusion. Los Angeles County is expected to expand the program to the East Region in November. The Los Angeles County Sheriff's Department's program has been approved and is awaiting equipment for deployment on Air 5, which will serve as a countywide resource to provide blood to areas without access. Los Angeles Fire Department is also preparing to launch a program and is currently procuring equipment.

ELCoR
ELCor, the EMS and law enforcement co-response committee, continues to be engaged and productive. A collaborative group is working with Correctional Health Services to develop a resource for hospitals regarding documentation of medical stability exams. This effort addresses the increased use of EMS and hospital resources due to patient transfers between jails and hospitals and repeated medical clearance exams. The initiative has provided an opportunity for Correctional Health Services, LA Health Services, and Emergency Medical Services to collaborate on a resource that will be disseminated soon.
The second law enforcement education module, focused on EMS systems, is in development. Feedback on the draft has been received and revisions are underway.

Pedi-PART
Resumption of data collection for the observational phase has been approved, with collection expected to begin within the next few weeks. The six-month data collection period will include retrospective data through March 2027 and will support additional study components focused on pediatric ventilation.

PediDose
PediDose is closed officially as of July 31, 2026. We continue our age-based dosing of pediatric seizure, and we are anticipating the release of the data on January 15th at the EMSP meeting.

EMS UPDATE

EMS Update received positive feedback this year, particularly the EMT-focused module, which was tailored to their specific needs. The goal is to engage public and private provider agencies in delivering the module to their EMTs to enhance system performance. An ongoing quality improvement dashboard is also being developed to evaluate the impact of EMS Update training over time. Initial measures will focus on capnography use and patient assessments before and after sedation, particularly for agitated patients, as well as magnesium use following its implementation for eclampsia and pre-eclampsia.

Planning for EMS Update 2027 has begun, with potential topics including hemorrhage control, which aligns with the LA-DROP program, and the implementation of non-opioid analgesics, such as Tylenol. A case-based approach is being considered to enhance paramedic engagement.

2026 FIFA WORLD CUP ATTENDANCE EMERGENCY DEPARTMENT PATIENT SCREENING

The Department of Public Health developed a summary of its collaboration with hospitals to screen patients presenting from FIFA events, providing an overview of potential scenarios during mass gatherings in Los Angeles County. Commissioner Snyder asked whether hospitals could receive regular updates during the Olympics. The discussion noted that hospitals would need more than a month's notice to establish a process for modifying their electronic health records so the required data could be retrieved without running a separate report.

Director Tadeo reported that several medical and health subcommittees are involved in planning for LA28. The LA28 health component has begun visiting sites in Los Angeles and Orange County. During these visits, representatives will work with local providers to assess resource needs and clarify that venues and event promoters are responsible for providing on-site medical support, rather than relying on the 911 system to actively support events.

7 COMMISSIONERS' COMMENTS / REQUESTS

8 ADJOURNMENT

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

Recorded by:
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.

SAVE THE DATE

JUNE 2 – 3, 2027

PRE-CONFERENCES: JUNE 1, 2027

HILTON LOS ANGELES / UNIVERSAL CITY

EMS Walk of Fame

2027 EMSAAC CONFERENCE

CELEBRATING 35 YEARS OF EMS EXCELLENCE

PRE-CONFERENCES JUNE 1, 2027

CQI IN THE SPOTLIGHT:
DRIVING A HIGHER STANDARD THROUGH QUALITY

LEADERSHIP ON CENTER STAGE:
PEOPLE. PERFORMANCE. A STRONGER TOMORROW.

EMSAAC
EMERGENCY MEDICAL SERVICES ADMINISTRATORS' ASSOCIATION OF CALIFORNIA

Monitor the EMSAAC website for current information: www.emsaac.org

LOS ANGELES COUNTY EMS AGENCY

DATA FACTS

LOS ANGELES COUNTY EMS SYSTEM REPORT

NOVEMBER 15, 2026

ISSUE 15

Message from the Director and Medical Director

This 15th edition of the Los Angeles County Emergency Medical Services (EMS) System Data Report is a product of the evolution of EMS data collection in Los Angeles County. Our first data report, published in 2012, began with basic volume reports for overall EMS responses and trauma, ST-elevation myocardial infarction (STEMI), and base hospital contact incidents. Our EMS data were primarily obtained through manual data abstraction from paper EMS Report Forms. In the second edition, we introduced reporting on additional early clinical and process outcomes including return of spontaneous circulation (ROSC) following out-of-hospital cardiac arrest (OHCA), use of therapeutic hypothermia, and pediatric destination. In subsequent editions, we began evaluating specialty care access across our system; we included geographic information system (GIS) mapping of EMS incidents and specialty care center transports, including driving times to these centers. We published our first trauma risk-adjusted mortality and included data on stroke care in 2015.



Richard Tadeo
Director

From 2016 through 2019, EMS agencies transitioned from paper-based EMS Report Forms to electronic patient care reports (ePCR). This improved data accuracy and allowed us to report on response, scene and transport times for critical provider impressions requiring time-sensitive interventions. Our specialty care center data also evolved into collecting specific performance metrics allowing us to benchmark our system and system participants.

Our trauma center reports expanded to include mechanisms of injuries and injury severity scores. More recently, we have adapted our data reports to evaluate resource needs and drive system improvements. In 2021, we included data to demonstrate the COVID-19 burden experienced in 2020.

In 2023, we started reporting Cardiac Arrest Registry for Enhanced Survival (CARES) data. This opened opportunities for us to engage our EMS agencies and clinicians on performance metrics for OHCA and benchmark our system against California and the nation. In 2024, we published emergency department (ED) patient acuity using the Emergency Severity Index (ESI) and behavioral health visits to EDs. This most recent edition continues to advance the use of our data. We include an updated risk-adjusted trauma analysis across the county showing that our trauma system continues to provide timely access to critical trauma care for all residents and visitors in the county with good patient outcome.



Dr. Nichole Bosson
Medical Director

We are introducing 12-lead electrocardiogram (ECG) performance metrics and the first report on the new Extracorporeal Cardiopulmonary Resuscitation (ECPR) Program. This data report is a reflection of the evolution of our data system and its role in advancing quality and performance improvement activities that enhance patient care and outcomes.

Our data inform the development, growth and refinement of our prehospital and regional systems of care, Beyond these direct contributions to our EMS system, our data also support EMS research and pilot programs that advance evidence-based prehospital care.

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STEMI SYSTEM	10
ECPR PROGRAM	12
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STROKE SYSTEM	18
PARAMEDIC BASE SYSTEM	20

SPECIAL POINTS OF INTEREST:

- Emergency Severity Index (page 5)
- Trauma Mechanism of Injury (page 7)
- STEMI Performance Metrics (pages 10-11)
- Behavioral Health (page 13)
- OHCA Overall Survival (pages 14-17)
- Stroke Performance Metrics (page 19)

2026 System Demographics

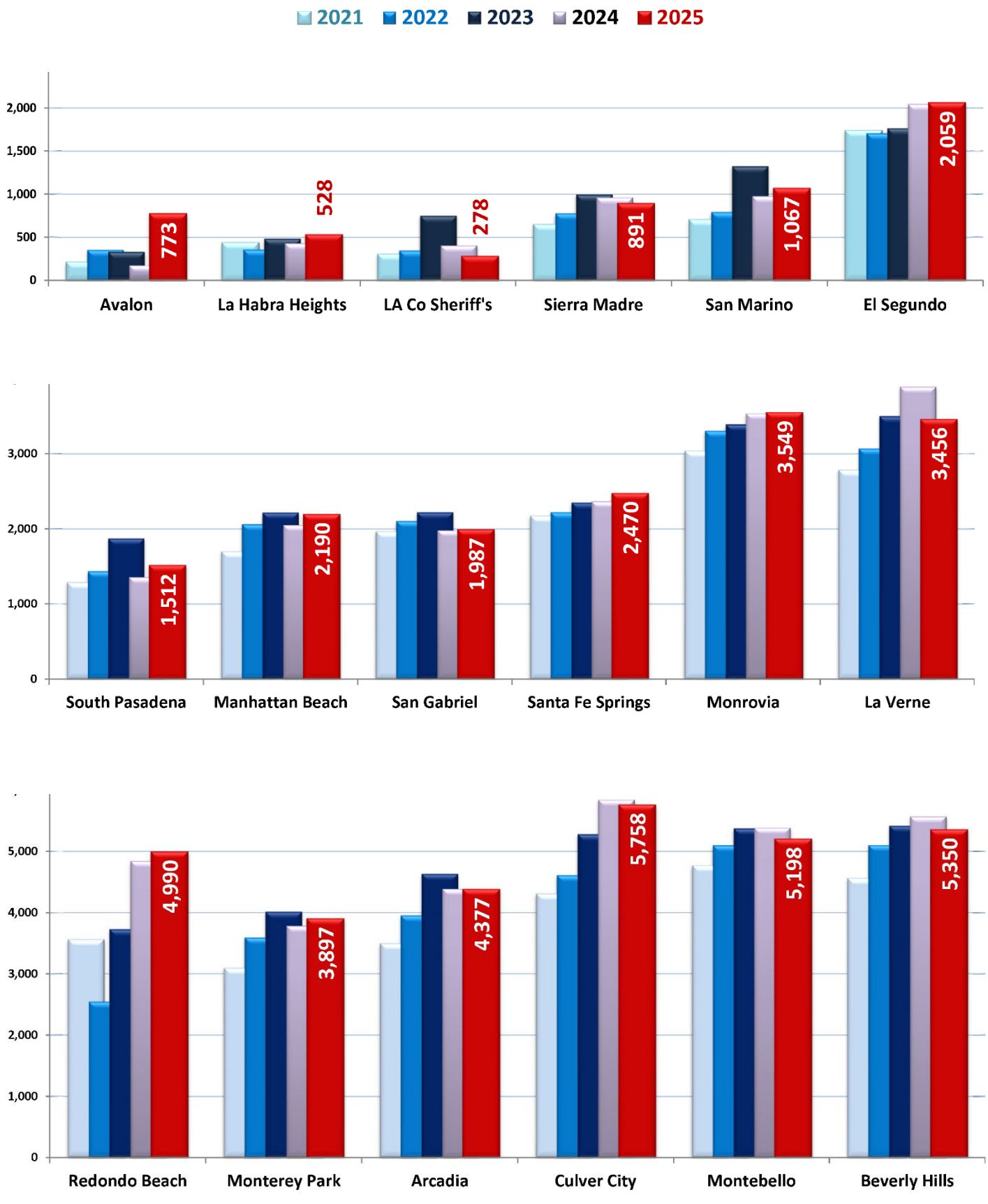
69 9-1-1 Receiving Hospitals
- 37 EDAP (Emergency Department Approved for Pediatrics)
- 8 Pediatric Medical Centers
- 7 Pediatric Trauma Centers
- 15 Trauma Centers
- 21 Paramedic Base Hospitals
- 35 STEMI Receiving Centers
- 24 Comprehensive Stroke Centers
- 24 Primary Stroke Centers
- 5 ECPR Centers
- 40 Perinatal Centers
- 42 Hospitals with Neonatal ICU
- 11 SART (Sexual Assault Response Team)
- 13 Disaster Resource Centers

Alternate Destinations
- 7 Psychiatric Urgent Care & 1 Sobering Centers

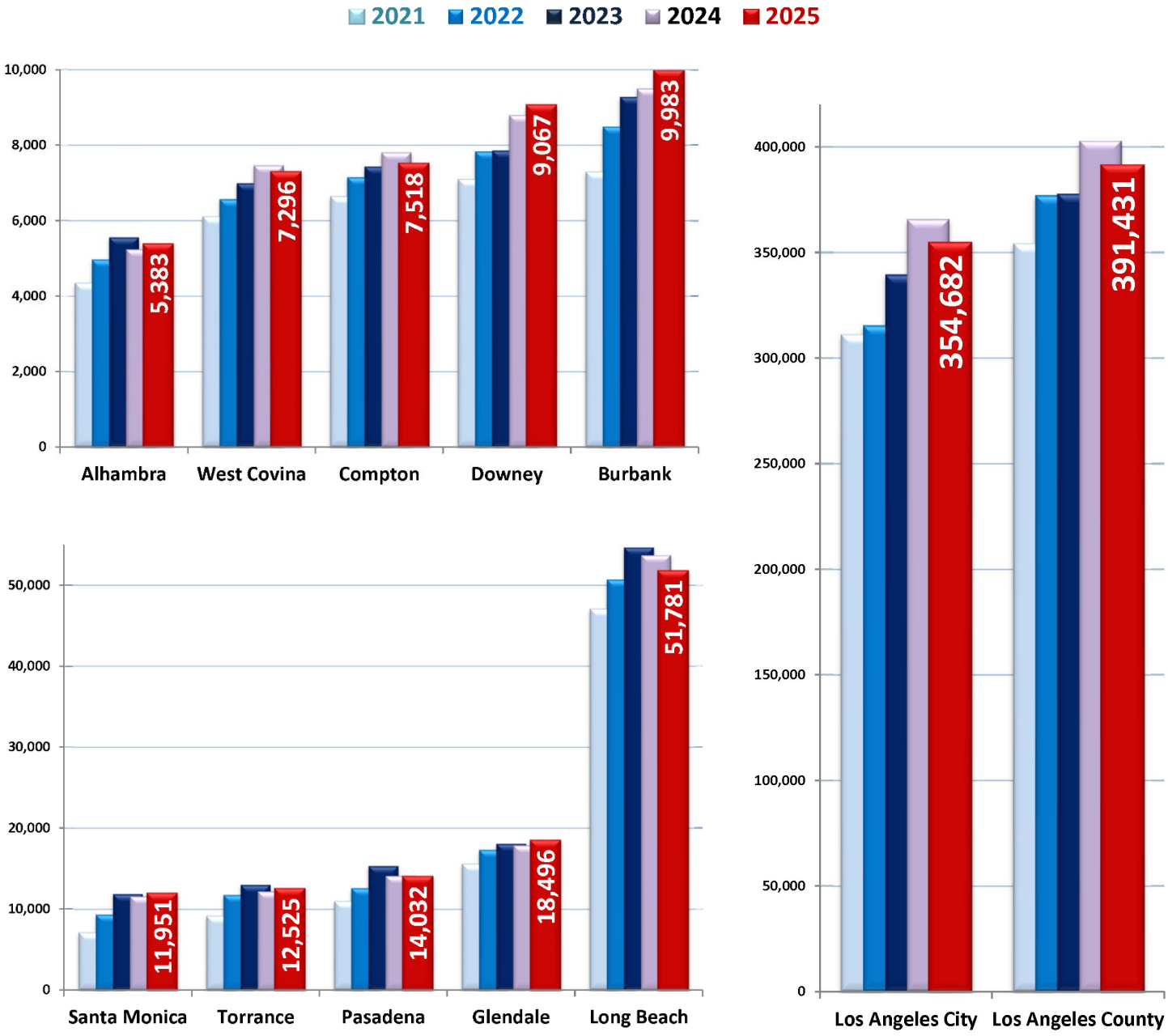
EMS Provider Agencies
- 31 Public Safety EMS Provider Agencies
- 38 Licensed BLS Ambulance Operators
- 16 Licensed ALS Ambulance Operators
- 16 Licensed Specialty Care Transport Ambulance Operators
- 3 Licensed Ambulette Operators

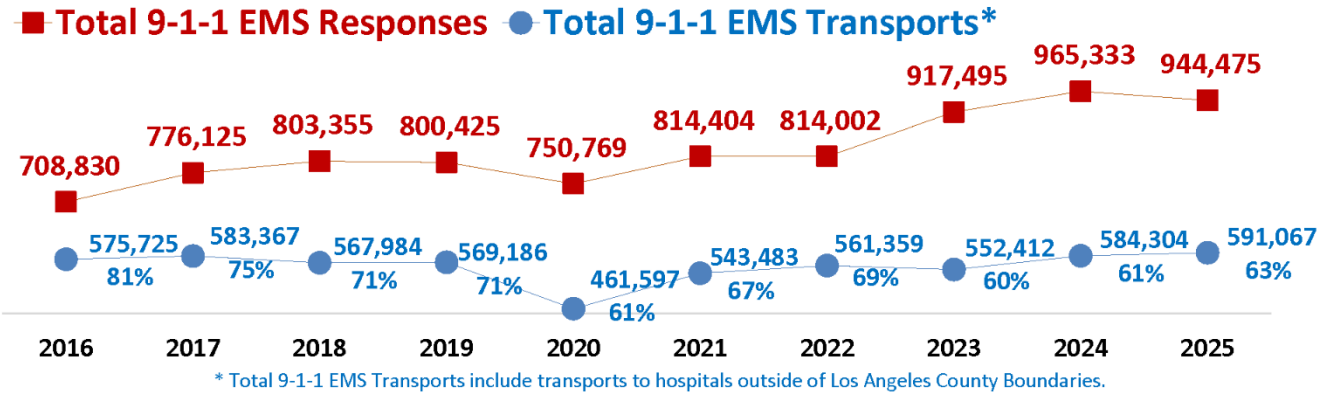
EMS Practitioners
- 4,820 Accredited Paramedics
- 9,303 Certified EMTs by LA Co EMS Agency
- 902 Certified Mobile Intensive Care Nurses

EMS Responses by 9-1-1 Jurisdictional Provider Agency



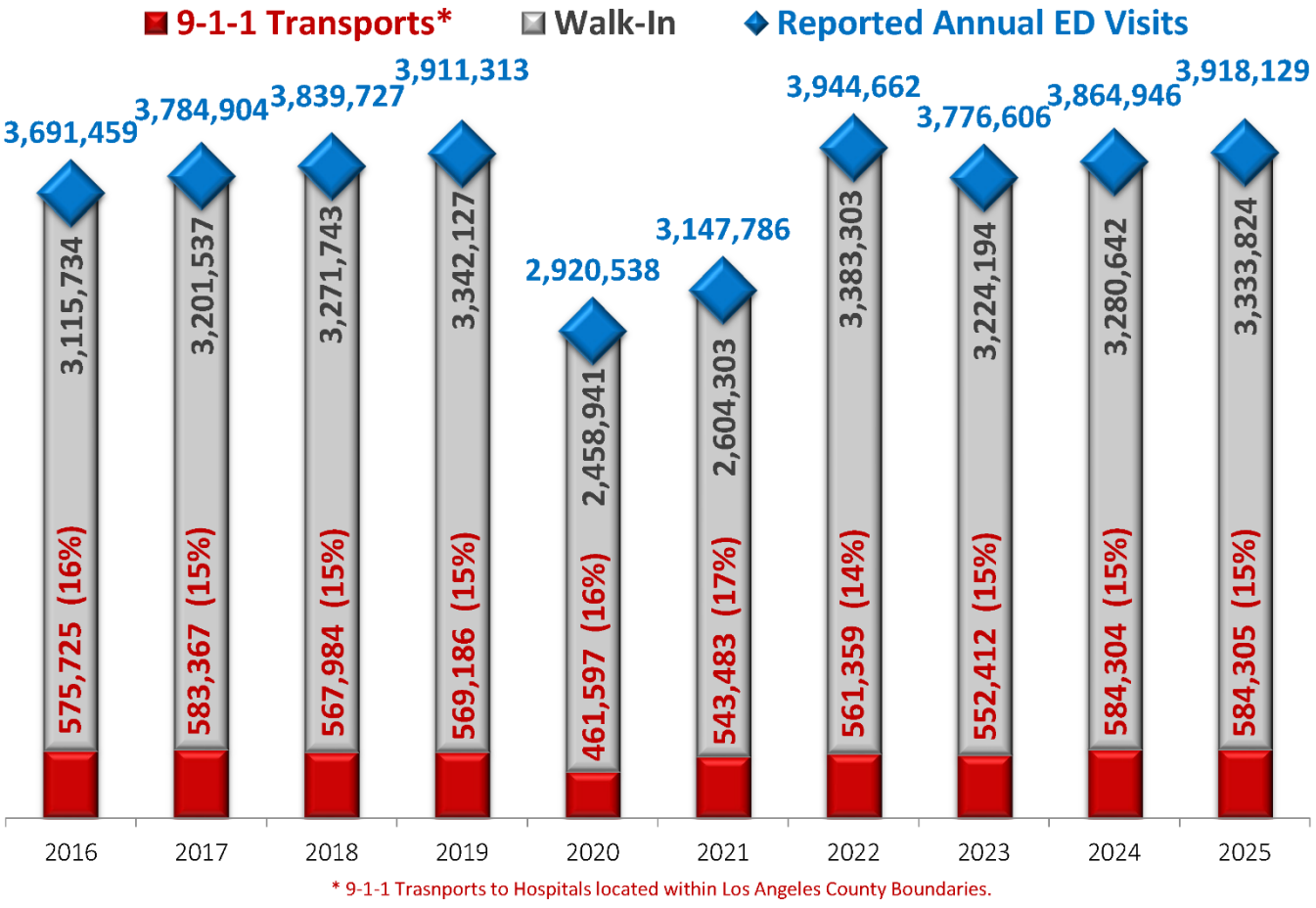
EMS Responses by 9-1-1 Jurisdictional Provider Agency





* Total 9-1-1 EMS Transports include transports to hospitals outside of Los Angeles County Boundaries.

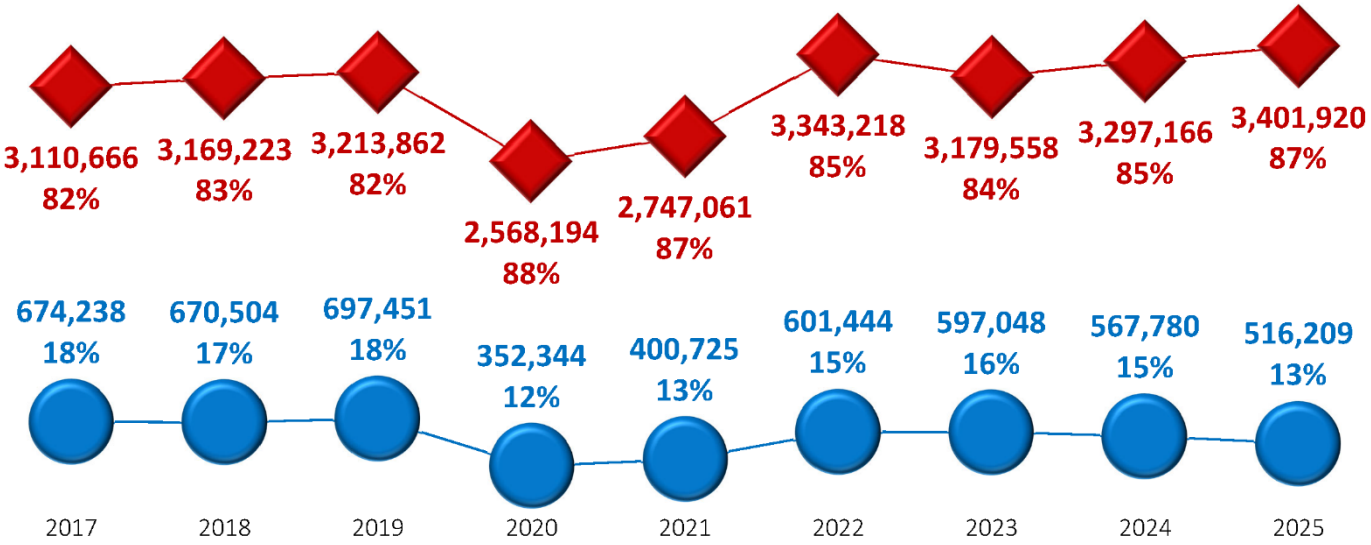
Emergency Department Volume



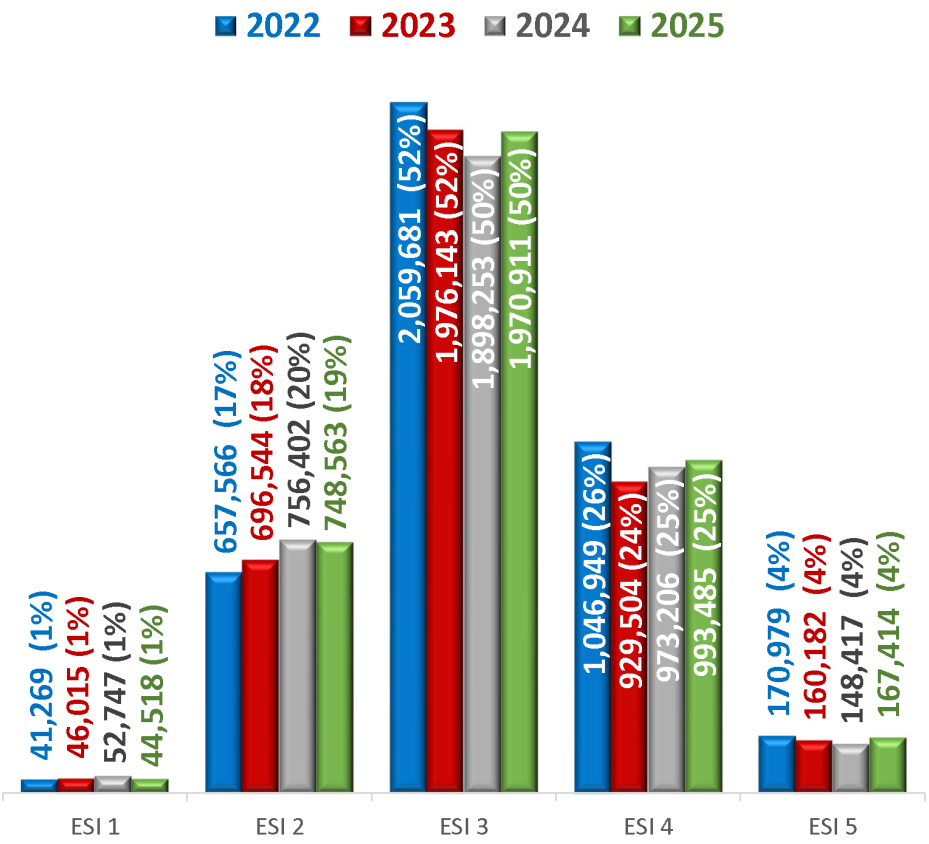
* 9-1-1 Trasnports to Hospitals located within Los Angeles County Boundaries.

ADULT:
15 years and older

PEDIATRIC:
14 years and younger



Emergency Severity Index (ESI)



ESI 1—Patient requiring immediate life-saving interventions: airway, emergency medications, or other hemodynamic; and/or any of the following conditions: intubated, apneic, pulseless, severe respiratory distress, SPO2 <90, acute mental status changes, or unresponsive (defined as nonverbal and not following commands (acutely); or requires noxious stimulus

ESI 2—Patient with a high risk of deterioration or signs of a time critical problem; confused/lethargic/disoriented; or severe pain/distress. Pediatric fever is age 1 to 28 days; temperature >38.0 C.

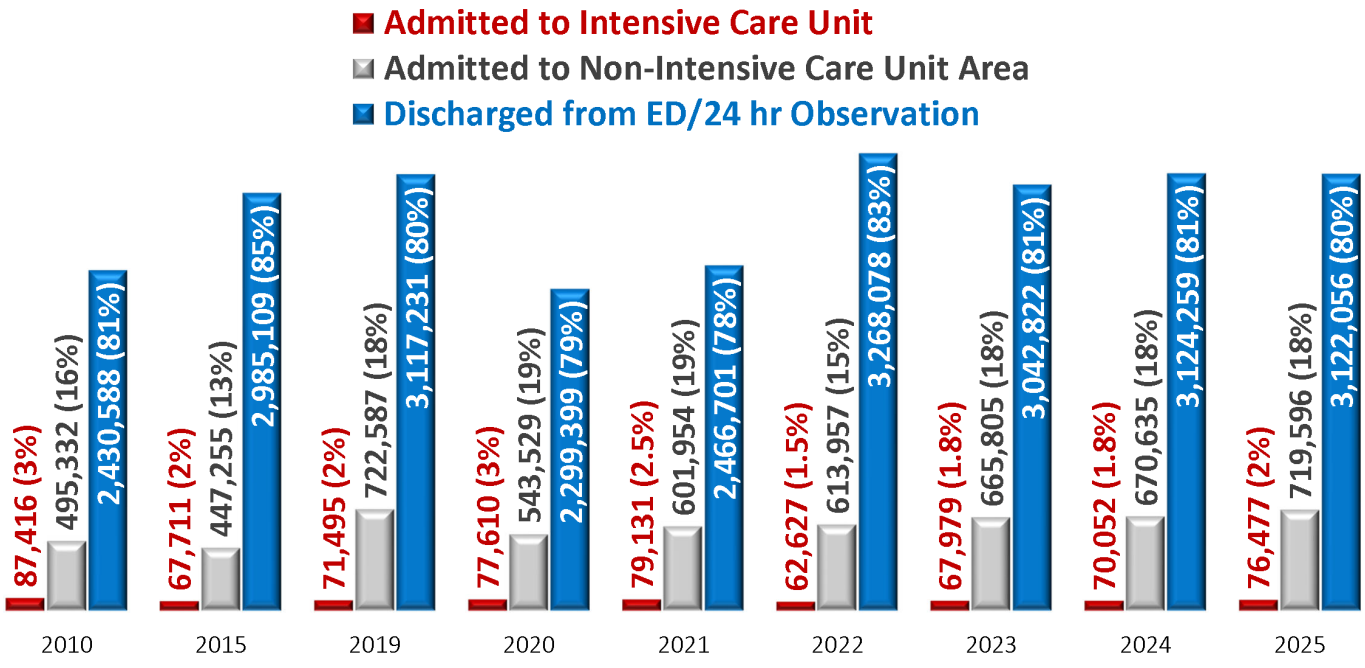
ESI 3—Patient is currently stable but requires multiple different types of resources* to diagnose or treat condition (e.g., diagnostic tests and procedures).

ESI 4—A patient requiring a single resource* such as only an x-ray or sutures.

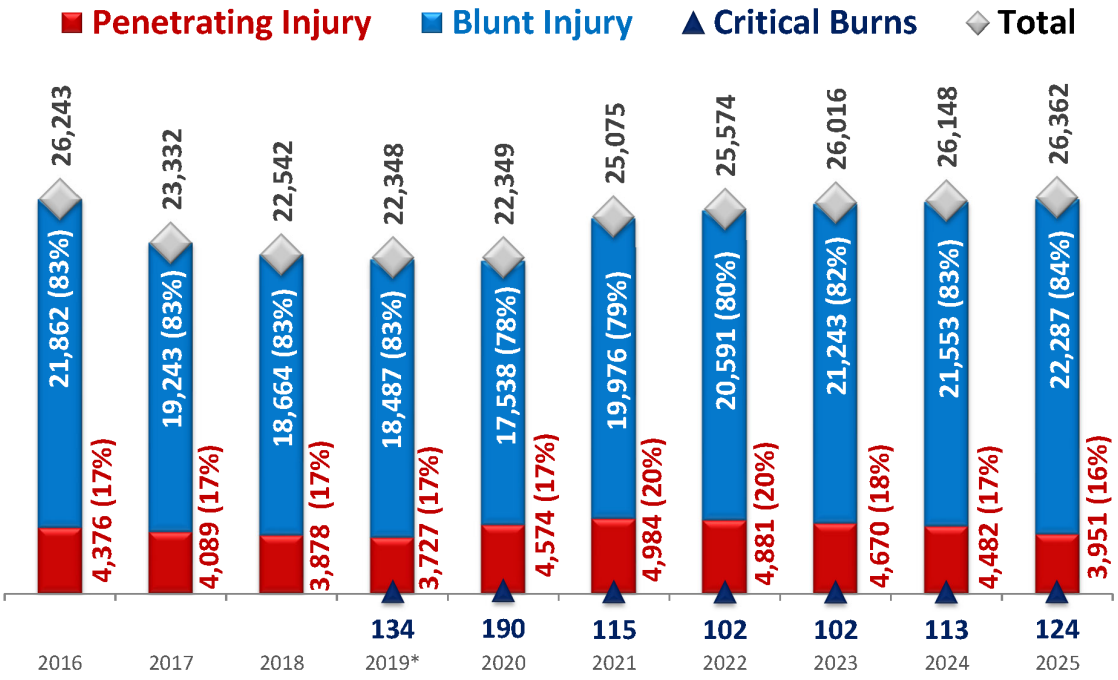
ESI 5—A patient not needing any resources*.

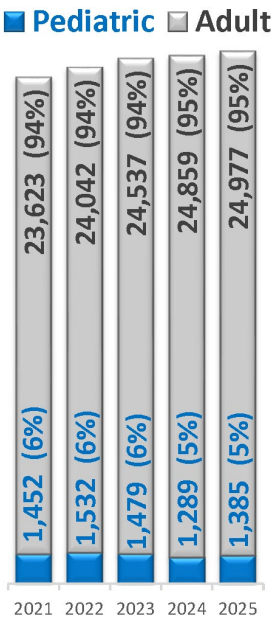
*The following are not considered resources: simple wound care-dressing/recheck; sling, PO medications, saline lock, history and physical-including a pelvic exam; point of care testing; tetanus immunization; prescription refills, crutches; splint

ED Patient Destination (walk-in and 9-1-1)



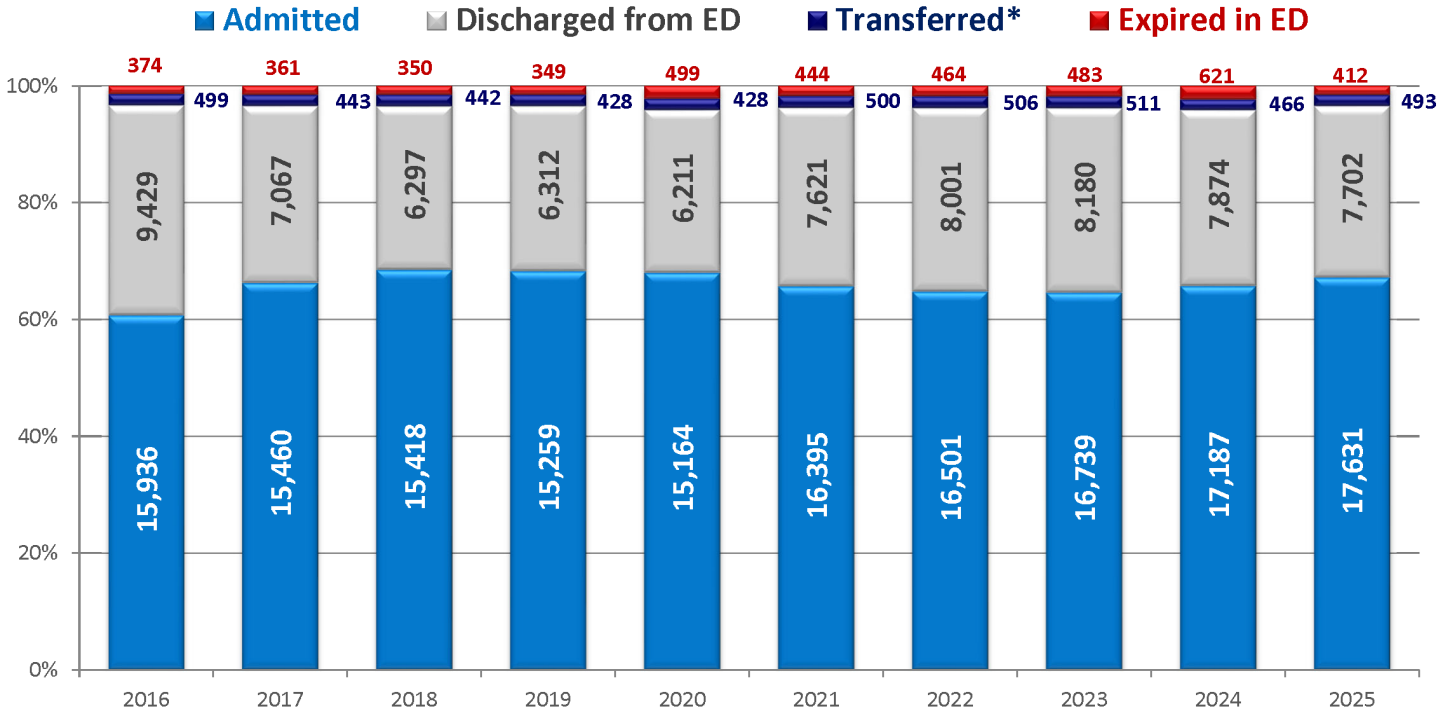
Trauma Center Volume (includes EMS Transports and Walk-In patients who met trauma center criteria or guidelines)



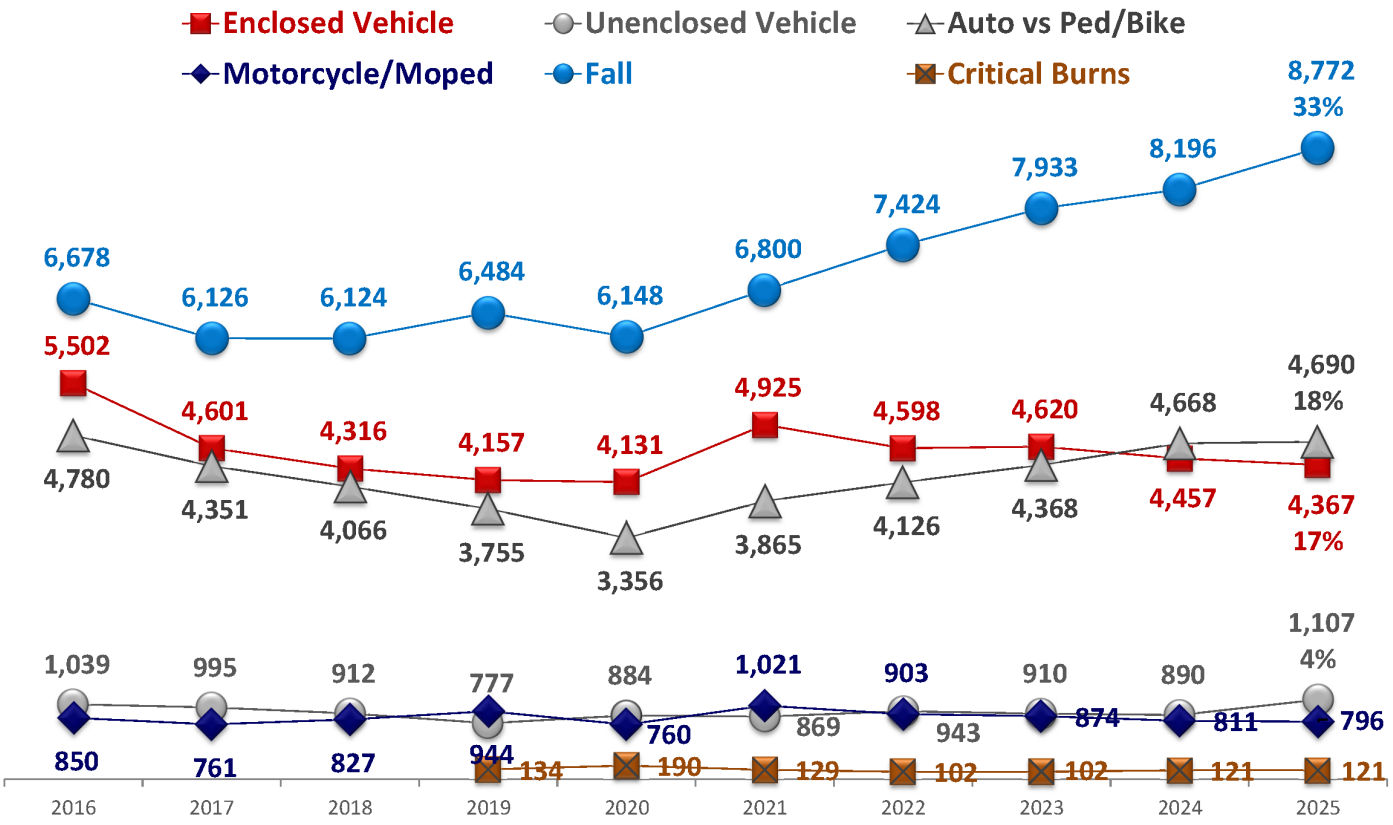


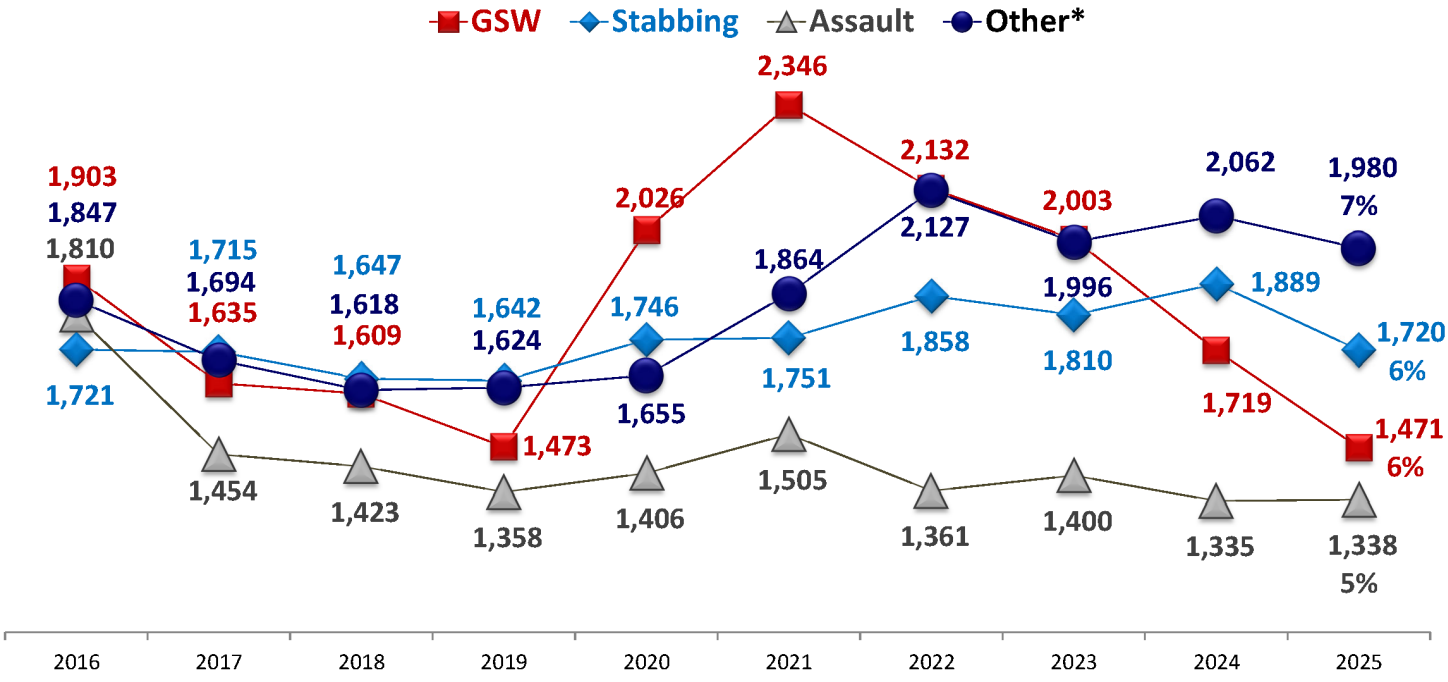
*2019: Critical Burns added as a Trauma Center Criteria

Patient Disposition of Trauma Center Patients



Mechanism of Injury: Patients Transported to Trauma Centers

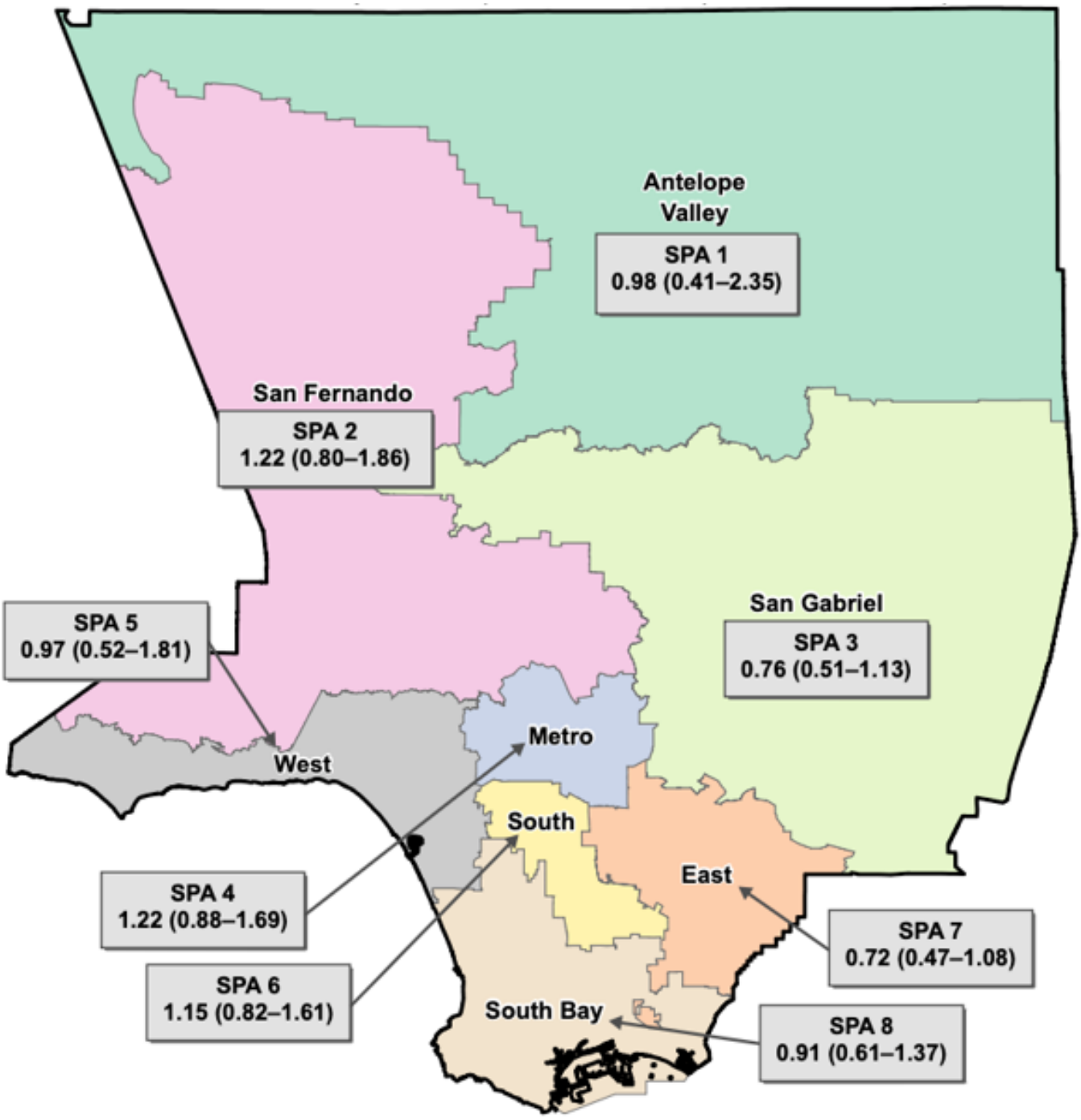




* Other: includes Sports. Work Related. Self-Inflicted. Un-

Trauma Risk-Adjusted Mortality by Service Planning Area (SPA)

Haider* Risk-adjusted Mortality Estimates:
Odds Ratio (99.3% Confidence Interval)



Survival Outcomes After Traumatic Injury across the Los Angeles County Regionalized Trauma System

Traumatic injuries from car accidents, falls, or violence are one of the leading causes of death and disability, and a well-organized trauma care system is critical to ensuring people survive after serious injuries.

To ensure that the residents of Los Angeles County receive high-quality and equitable trauma care, the Los Angeles County EMS Agency looked at survival rates for all patients who suffered a traumatic injury and were taken to one of 15 trauma centers in the county between October 1, 2023 and September 30, 2025. We compared outcomes across the county's different Service Planning Areas (SPAs), which are geographic regions used to organize health services.

Given that residents living in different regions of the county can differ in age, health status, and the types of injuries they sustain, we accounted for these differences using a risk-adjusted analysis when predicting the odds of death after a traumatic injury in each region.

Each service planning area was analyzed separately and compared to all other service planning areas. The findings are presented using odds ratios (OR), and 99.3% confidence intervals (CI) with an odds ratio greater than 1 representing odds of death. When the confidence interval includes 1, there is no significant difference in risk-adjusted mortality.

Los Angeles County EMS Agency Finding:

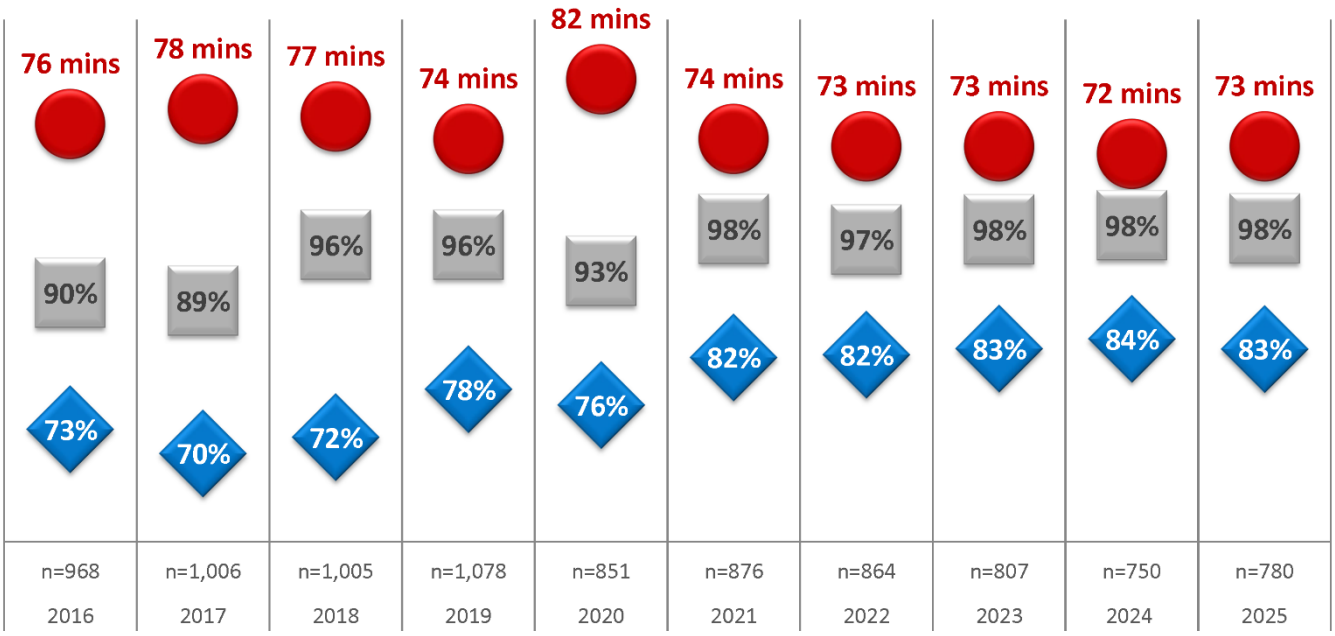
Mortality rates after traumatic injury were similar across all Service Planning Areas in Los Angeles County, with no significant differences detected. This reflects the strength and consistency of the county's regionalized trauma system.

* Haider AH, Hashmi ZG, Zafar SN, et al. Developing best practices to study trauma outcomes in large databases: An evidence-based approach to determine the best mortality risk adjustment model. Journal of Trauma and Acute Care Surgery. 2014;76(4):1061-1066. doi: 10.1097/TA.0000000000000182

ST-Elevation Myocardial Infarction (STEMI)

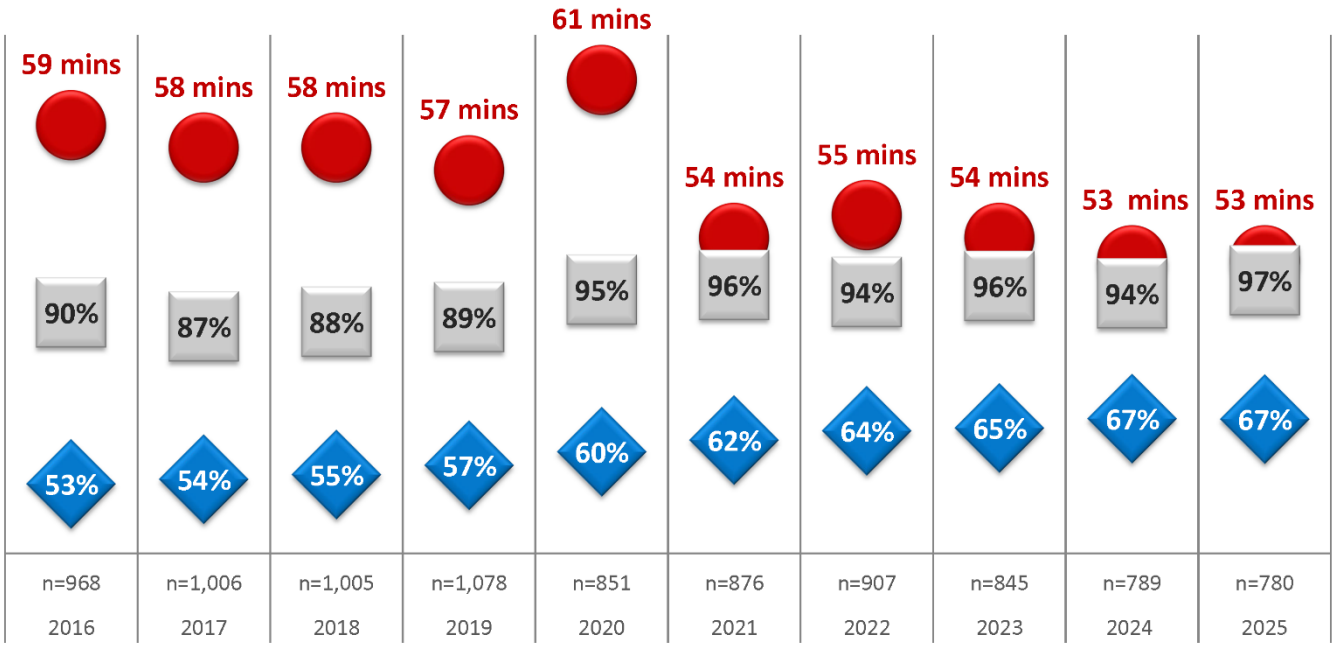
STEMI Receiving Center: EMS Medical Contact-to-Device (E2B) Time

LA County Target: within 120 minutes 90% of the Time



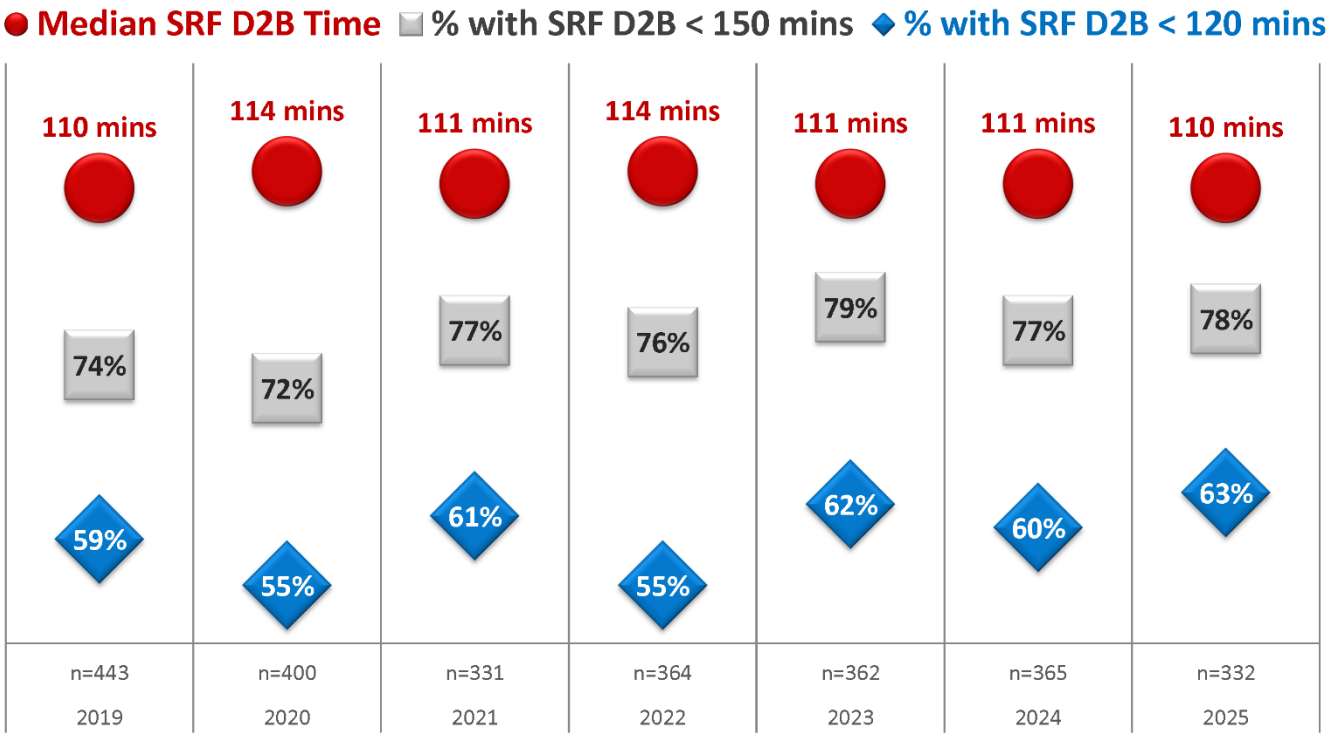
STEMI Receiving Center: Door-to-Device (D2B) Time

LA County Target: within 90 minutes 90% of the Time



STEMI Referral Facility: Door-to-Device (D2B) Time

LA County Target: within 150 minutes 90% of the Time



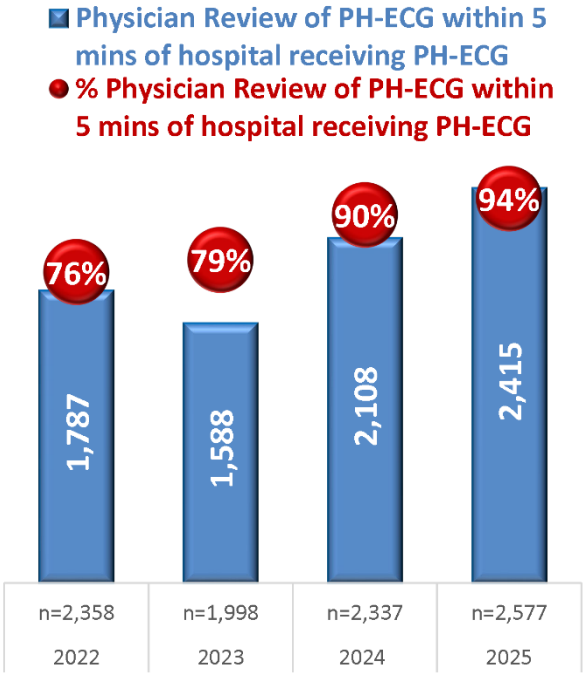
"n" values represent number of interfacility transports with valid time values

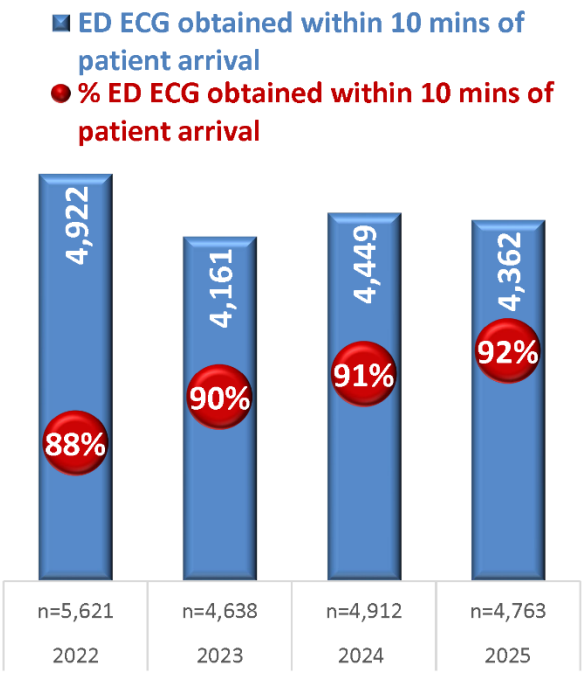
12-Lead Electrocardiogram (ECG) Performance Metrics

LA County Target:

Physician review of prehospital (PH) ECG: within 5 mins of hospital receiving PH-ECG 90% of the time

ED ECG obtained within 10 mins of patient arrival 90% of the time

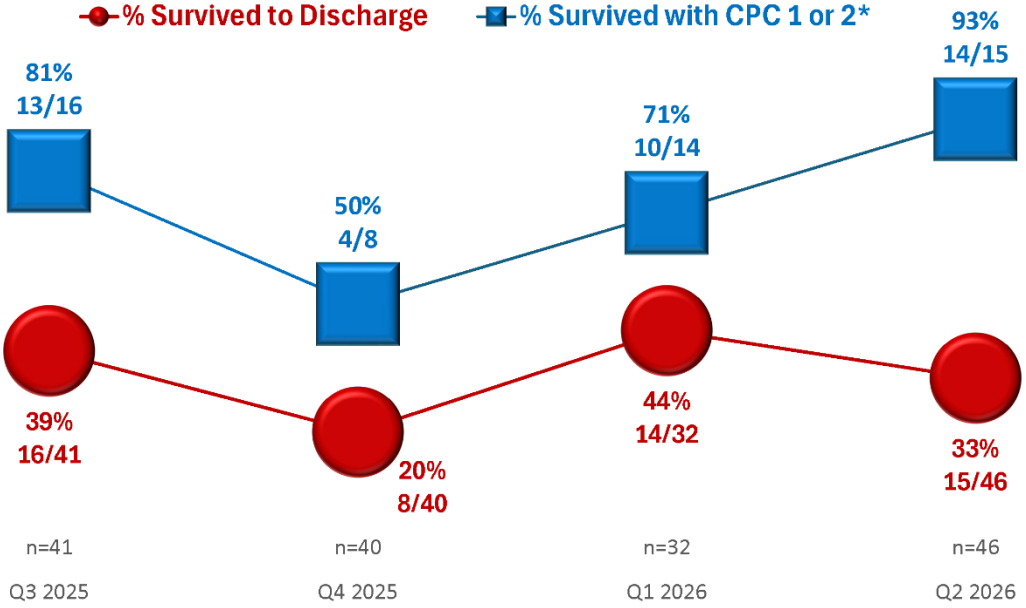




Extracorporeal Cardiopulmonary Resuscitation (ECPR)

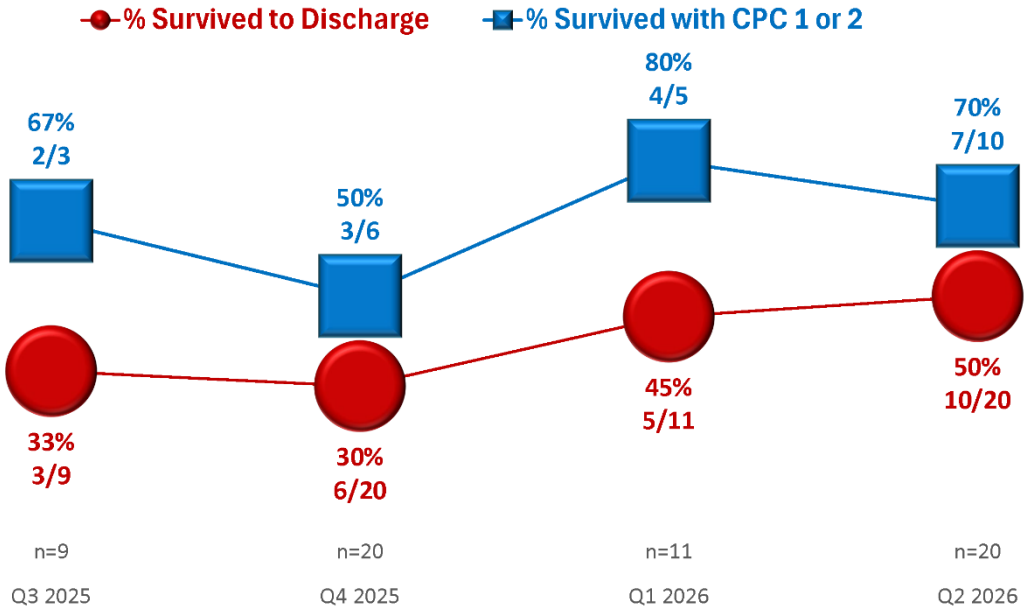
ECPR Program was established in Los Angeles County in June 2025 with the designation of the first five (5) ECPR Receiving Centers.

Routed to ECPR Receiving Center



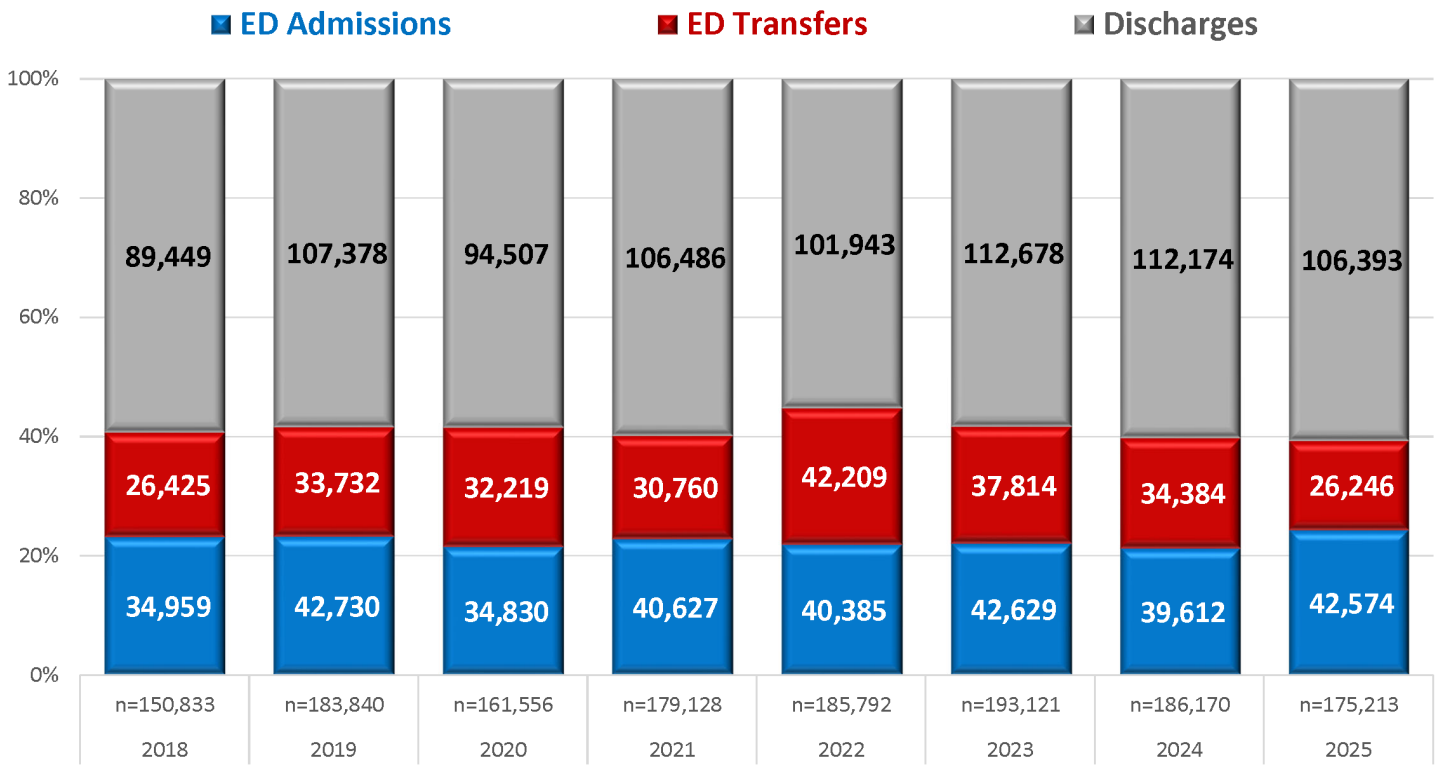
*** CPC (Cerebral Performance Category):**
1-Good Cerebral Performance: conscious, alert, able to work, and lead a normal life. May have mild neurological or psychological deficits.
2-Moderate Cerebral Disability: conscious with sufficient function for independent activities of daliy living and part-time work in a sheltered environment

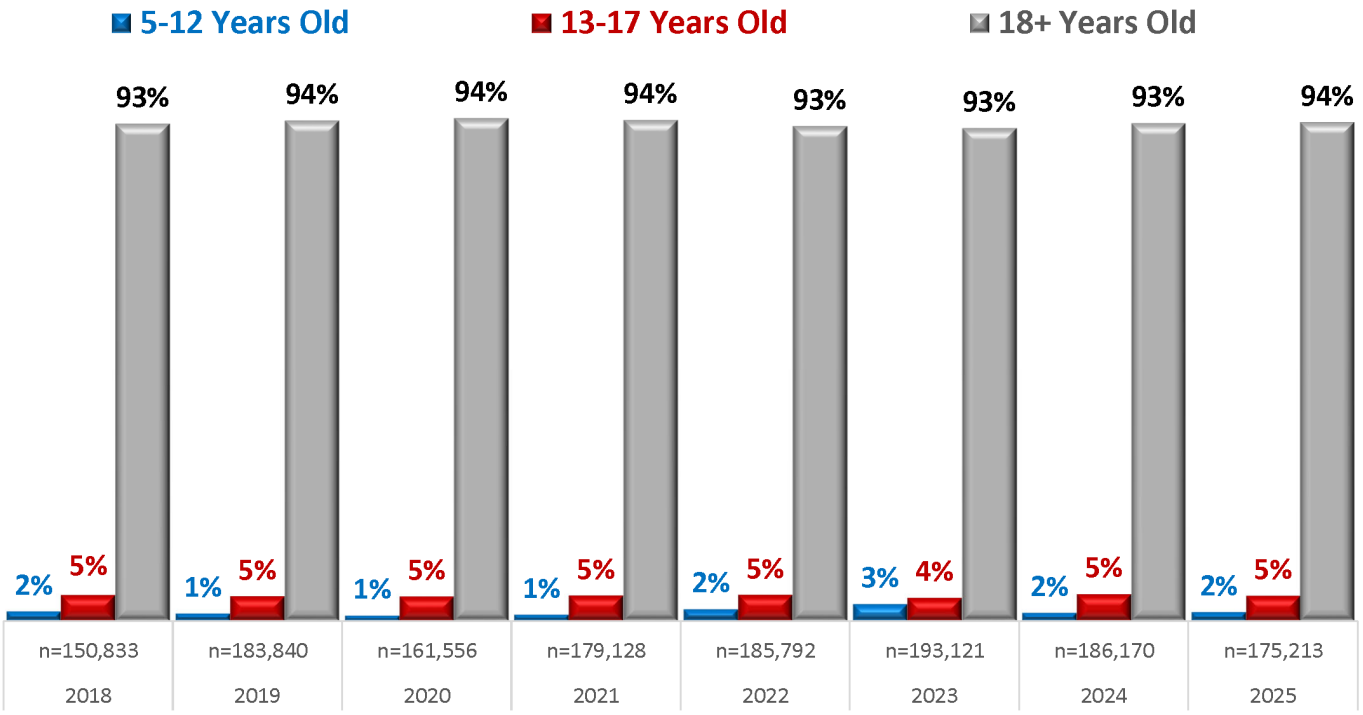
Received ECPR Treatment at a Designated ECPR Receiving Center



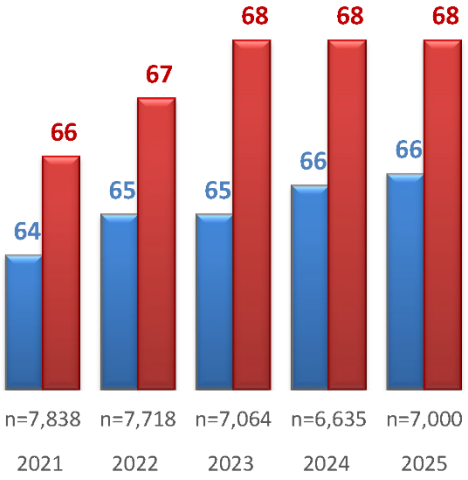
Behavioral Health Visits at Emergency Departments

Includes walk-in and 911 transports (self-reported by the 69 9-1-1 LA receiving hospitals)



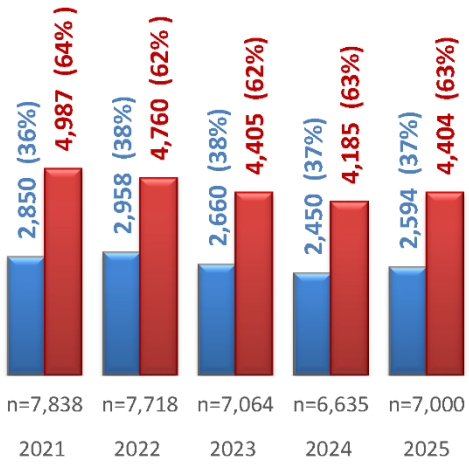


Out-of-Hospital Cardiac Arrest (OHCA)



Age in Years

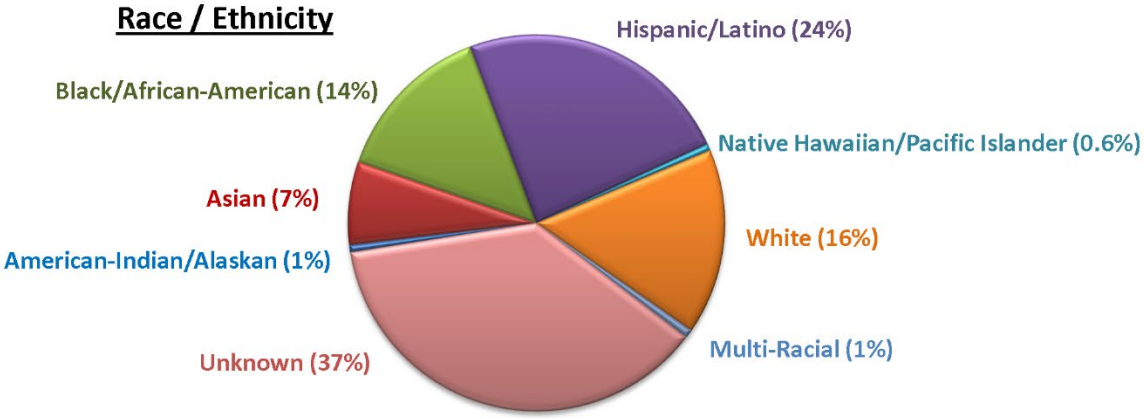
- Mean
- Median



Sex

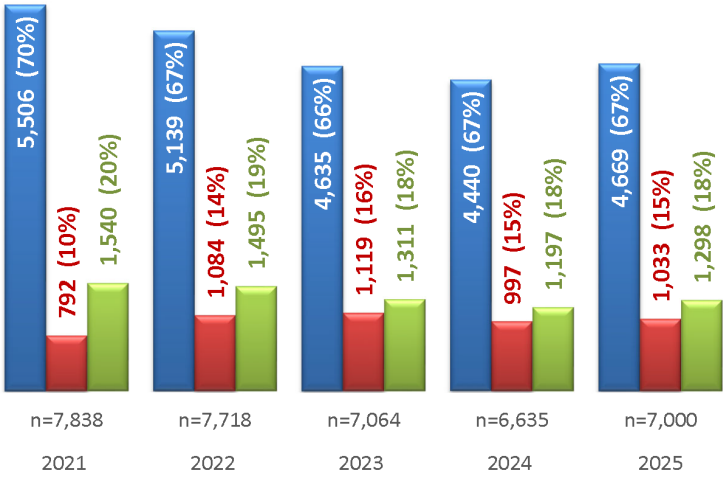
- Female
- Male

Race / Ethnicity

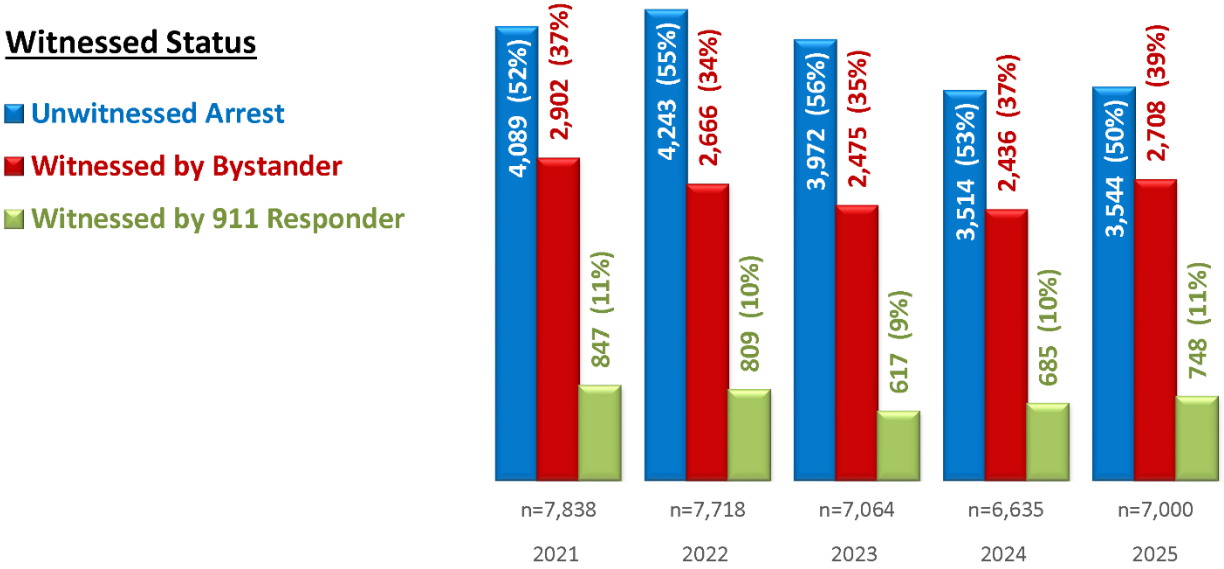


Arrest Location

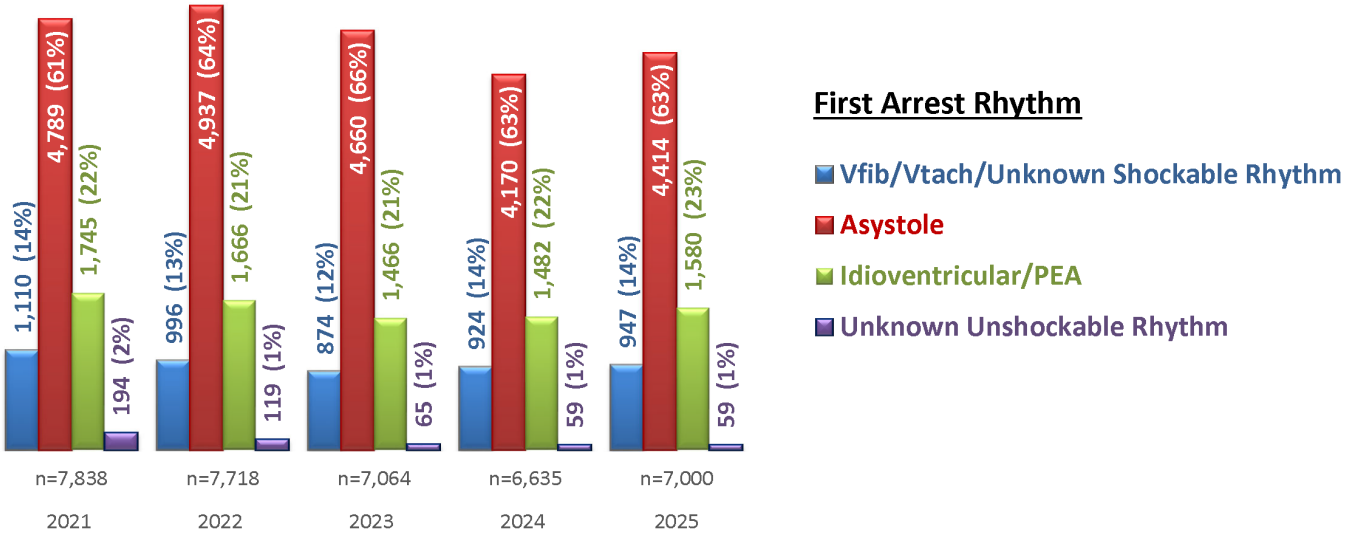
- Home/Residence
- Nursing Home
- Public Setting



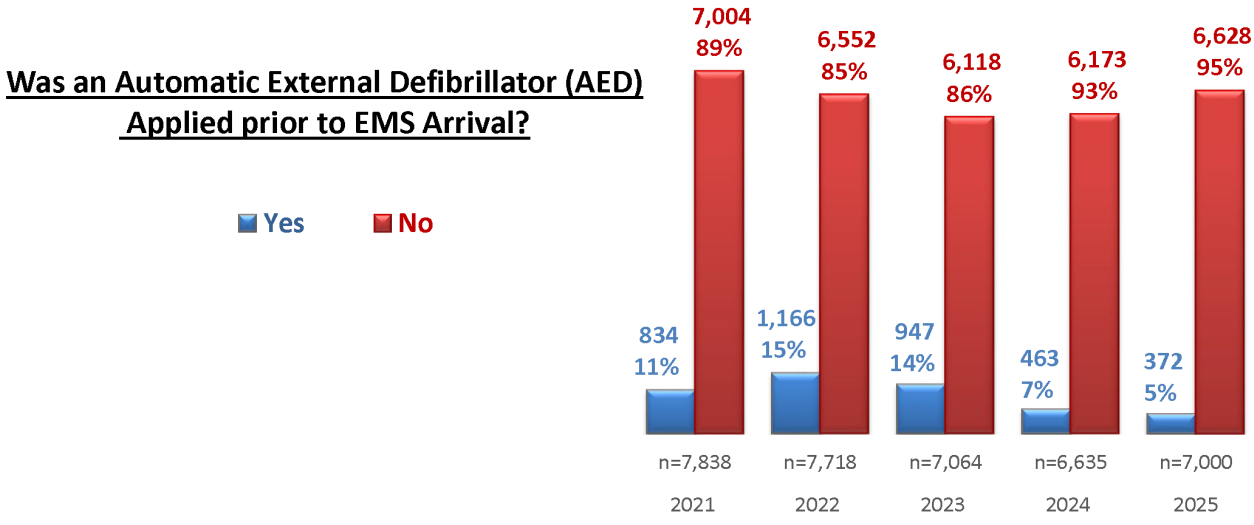
Witnessed Status



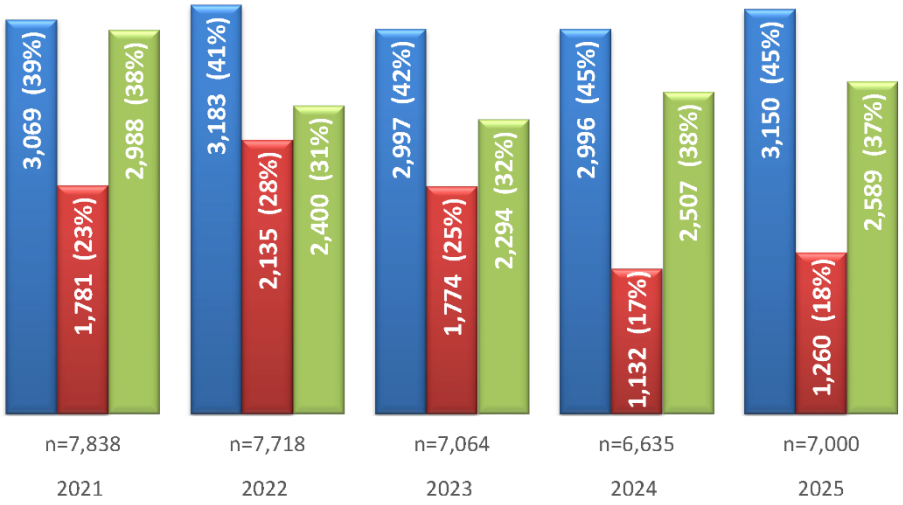
First Arrest Rhythm



Was an Automatic External Defibrillator (AED) Applied prior to EMS Arrival?

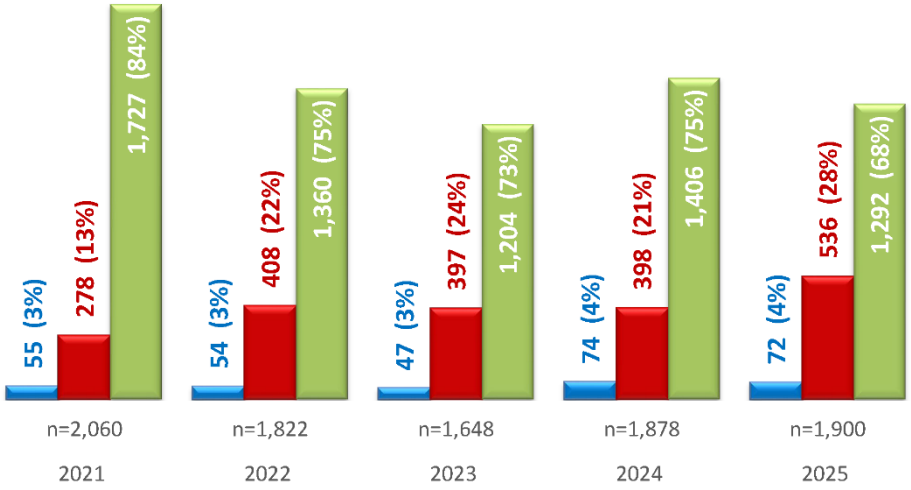


Out of Hospital Cardiac Arrest (OHCA)
Return of Spontaneous Circulation (ROSC)



Who Initiated CPR?

- Bystander
- First Responder
- EMS

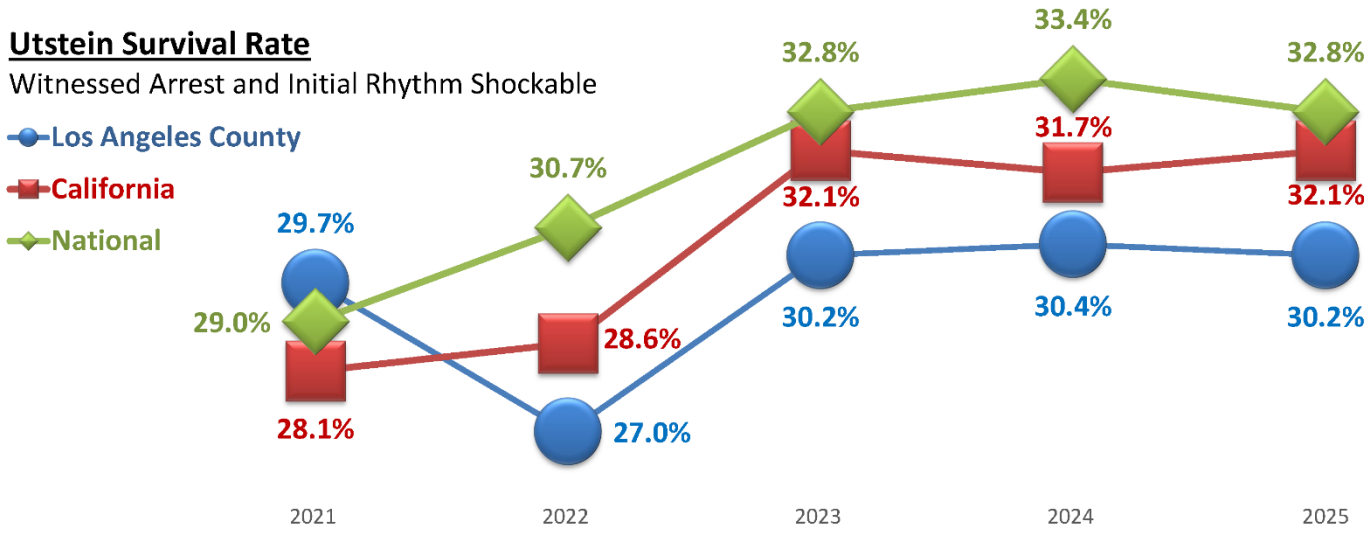


Who First Defibrillated the Patient?

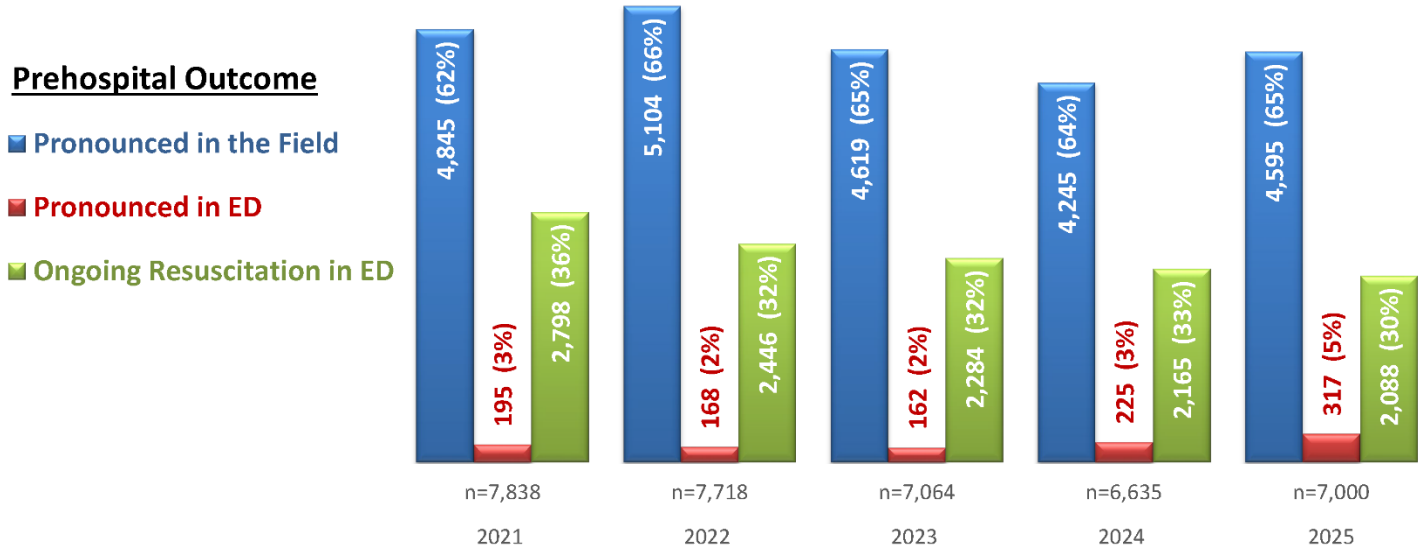
- Bystander
- First Responder
- Responding EMS Personnel

Utstein Survival Rate

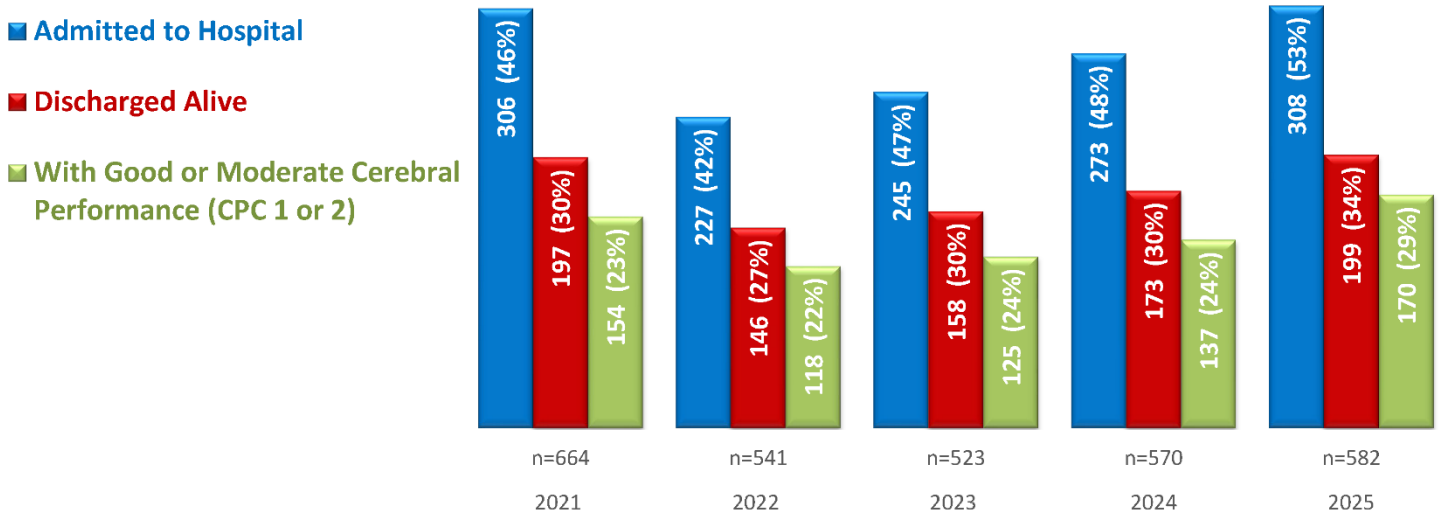
Witnessed Arrest and Initial Rhythm Shockable



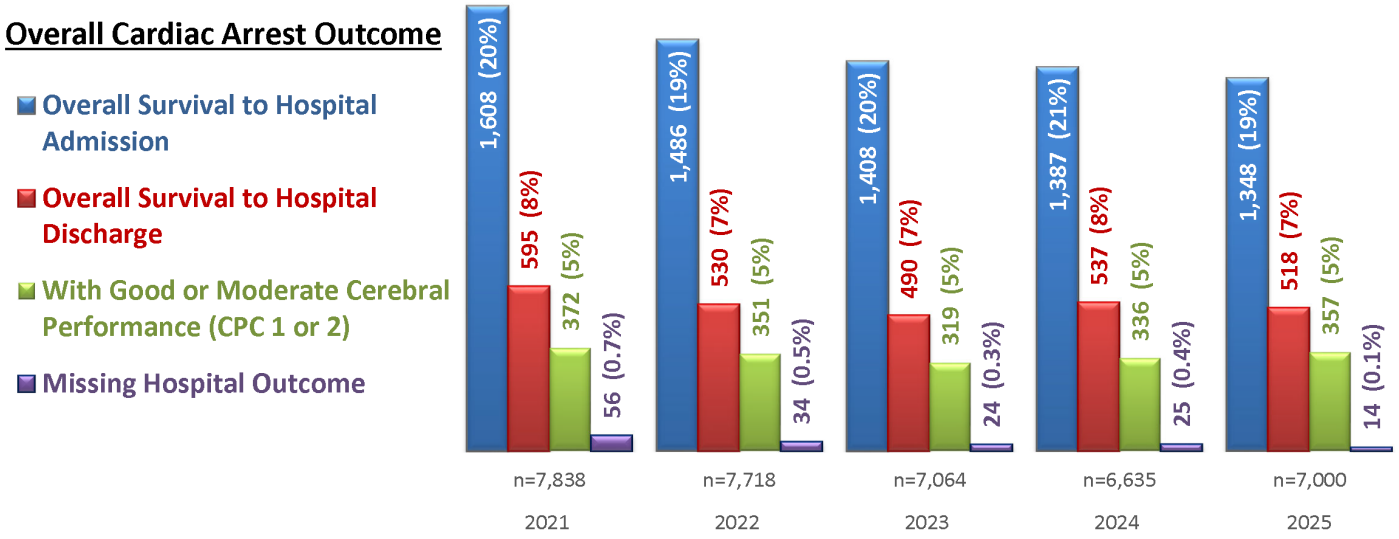
Prehospital Outcome



Outcome of Witnessed Arrest with Initial Cardiac Rhythm of Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT)

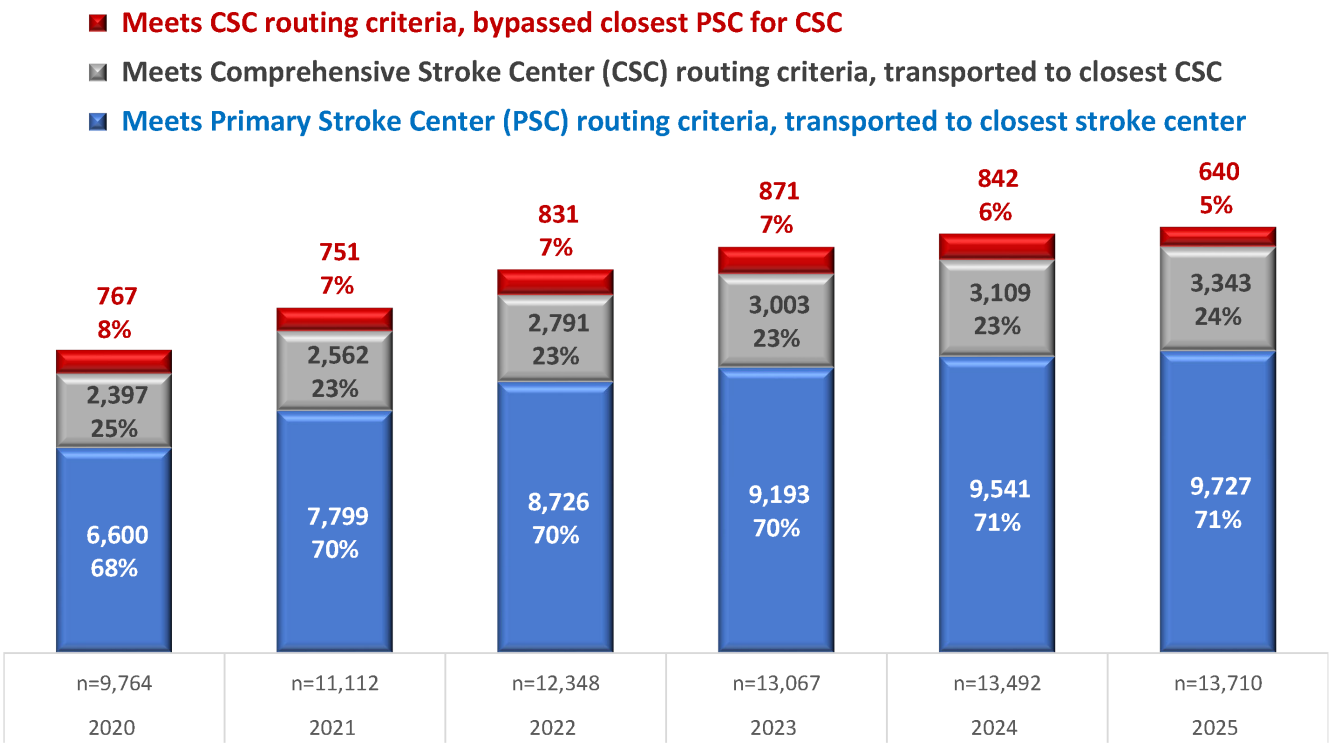


Overall Cardiac Arrest Outcome

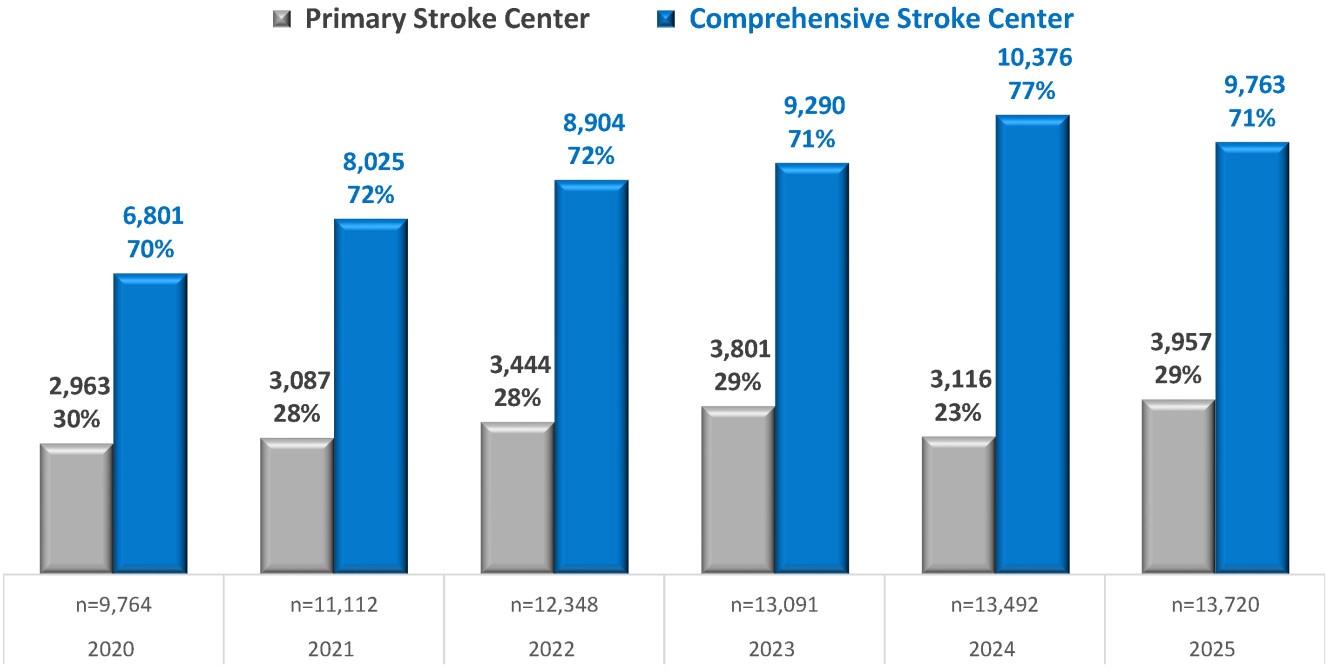


Suspected Stroke Patient Destination

Suspected stroke patient with large vessel occlusions based on a Los Angeles Motor Scale (LAMS) score of 4 or 5 are routed to designated Comprehensive Stroke Centers



This chart is based on routing criteria. Includes transports to CSC when CSC is the closest stroke center.

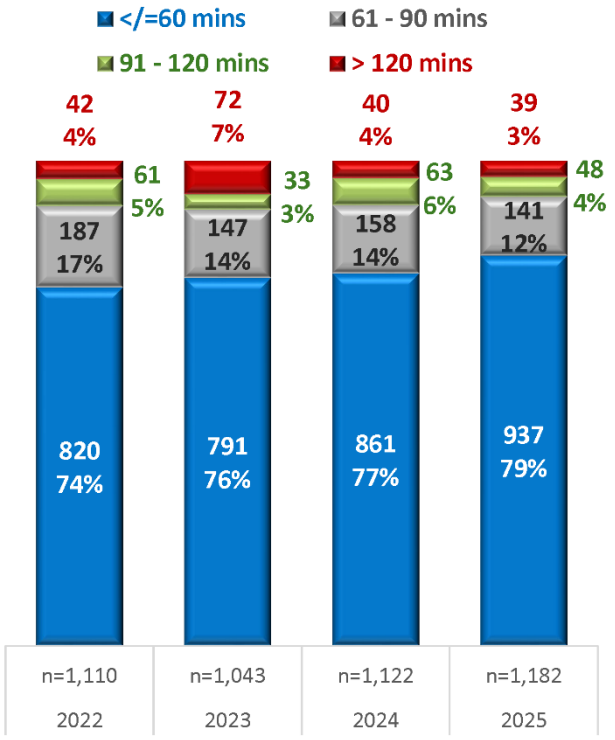


This chart is based on the Stroke Center Designation of the receiving facility, regardless of routing criteria.

Final Diagnosis = Ischemic Stroke

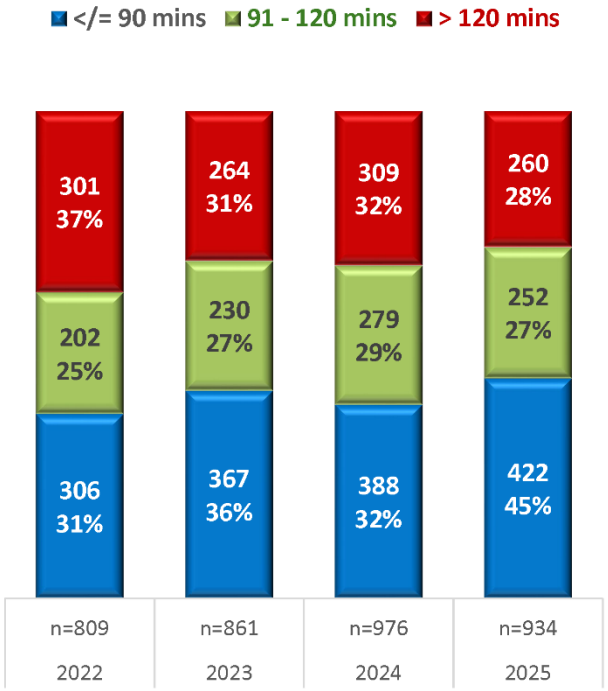
Door-to-Needle (D2N) Times

LA County Target: within 60 mins 75% of the time

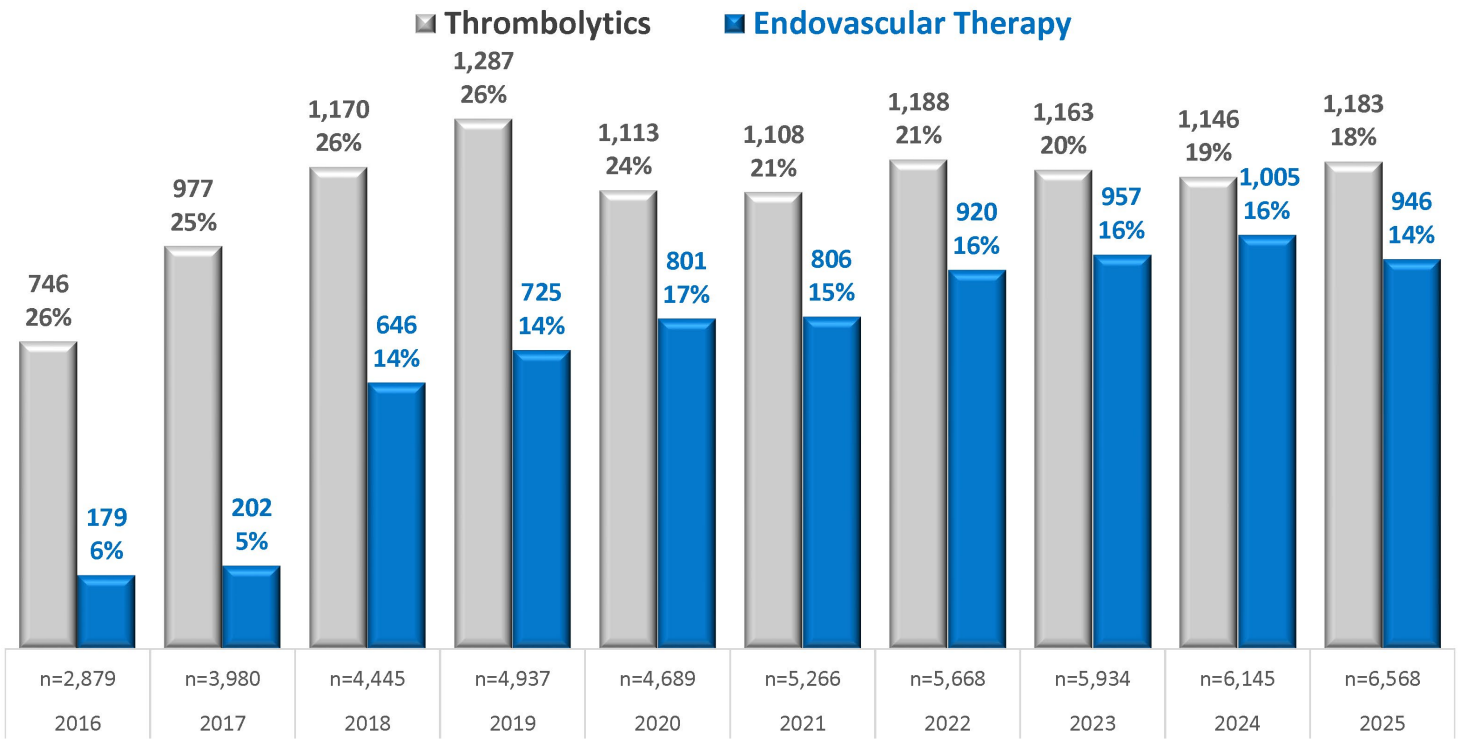


Door-to-Device (D2D) Times

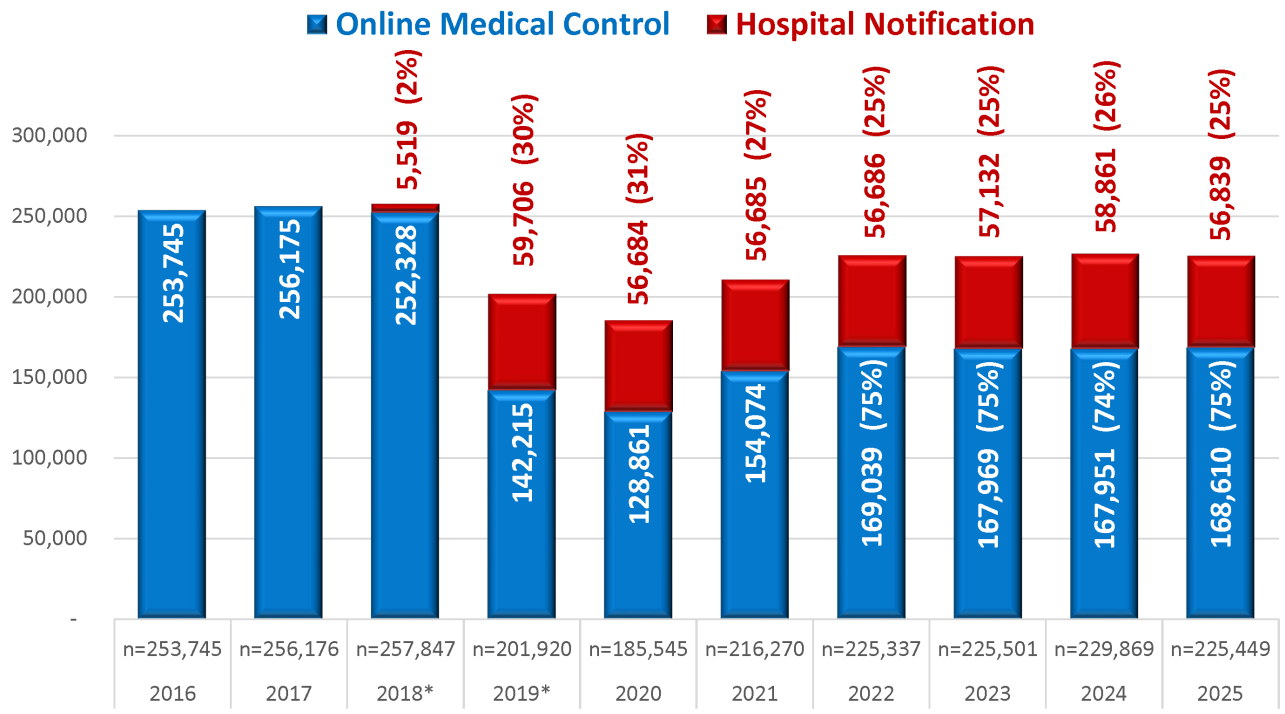
LA County Target: withnin 120 mins 50% of the time



Treatment – All Ischemic Stroke



Paramedic Base Hospital Contact



* Phased-in implementation of New Treatment Protocols started in July 1, 2018 and was fully implemented in April 1, 2019.
The New Treatment Protocols reduced the number of EMS responses requiring online medical control.



EMS AGENCY

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

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

BASE HOSPITAL ADVISORY COMMITTEE MINUTES

October 14, 2026

MEMBERSHIP / ATTENDANCE

	Representatives			Representatives	
X	Tarina Kang, MD, Chair	EMS Commission		Rachel Caffey	Northern Region
	Lydia Lam, MD, Vice Chair	EMS Commission	X	Jessica Strange	Northern Region
	Atilla Under, MD, MPH	EMS Commission	X	Michael Wombold	Northern Region, Alternate
	Connie Richey, RN	EMS Commission	X	Samantha Verga-Gates	Southern Region
	Saran Tucker, PhD, MPH	EMS Commission	X	Jeanette Souza	Southern Region
	Carol Synder, RN	EMS Commission		Nicole Mitchell	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
	Adam Brown	Provider Agency Representative	X	Aspen Di Ioli	Eastern Region
	David Hickman	Provider Agency Representative, Alt.	X	Alina Candal	Eastern Region
X	Kristina DeLaurantey	PedAC Representative	X	Jenny Van Slyke	Eastern Region, Alternate
	Desiree Noel	PedAC Representative, Alternate		Lila Mier	County Region
X	Colleen Greer	MICN Representative		Emerson Martell	County Region
	Vacant	MICN Representative, Alternate	X	Antoinette Salas	County Region
			X	Yvonne Elizarraraz	County Region

EMS Agency		Prehospital Care Coordinators	Guests
Ami Boonjaluksa	X	Lauren Hawk (HCH)	Clayton Kazan, MD (LACoFD)
Nichole Bosson, MD	X	Melissia Turpin (SMM)	Sheryl Gradney (LACoFD)
Lorrie Perez	X	Allison Bozigian (HMN)	Tassia Trink (TOR FD)
Denise Whitfield, MD	X	Rogelio Flores (SFM)	Ashley Sanello, MD (TOR)
Richard Tadeo	X		Thomas Vu, MD (SFMC)
Michael Kim, MD			Kelsey Wilhelm, MD (HGH)
Aldrin Fontela			Timothy Behen (TOR FD)
Mark Ferguson			

1. **CALL TO ORDER:** The meeting was called to order at 1:04 P.M. by Dr. Tarina Kang, Chair. Dr. Kang also recognized Emergency Nurses Week and the contributions of emergency nurses.

2. **INTRODUCTIONS/ANNOUNCEMENTS:**

2.1 **Joint Educational Session**
The Joint Educational Session will be on *Sepsis* on December 1, 2026, presented by Dr. Russell Kerbel, Medical Director for Sepsis Prevention, UCLA Health.

2.2 **EMSC Educational Forum**
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 **2027 EMSAAC Conference**
The conference is scheduled for June 2-3 at the Universal Hilton, a preconference on CQI and Leadership will be held on June 1. The theme is EMS Walk of Fame, connecting historical perspectives with new technology. Artificial intelligence and many other interesting topics are being considered.

2.4 **Measure B 2026 – Measure B Advisory Board Process**
Approximately $22 million was reported to be available, with applications due December 17. Proposal presentations and MBAB review are anticipated in late January or early February. Funding recommendations are targeted for Board of Supervisor approval April or early May, with funds available July 1 and execution of the MOUs and MOAs beginning at that time.

Hospitals that were not previously funded by a Board Office in 2025 were encouraged to consider submitting another proposal for base hospital upgrades, potentially through a coordinated hospital association submission. Those that were funded should have received MOAs. Contracts were prioritized based on the date of Board Supervisor approval. Continue with your project that was approved, any other upgrades not listed on the MOU will not be reimbursed retroactively.

A consultant review of the Measure B allocation for noncounty trauma hospitals, including consideration of financially distressed hospitals, was discussed. No allocation change was announced.

2.5 **New EMS Fellows**
Dr. Whitfield introduced Ella Cappello from Harbor-UCLA and Hasan Makda from LA General.

2.6 **The California Hospital Outcome Portal (CHOP)**
CHOP replaces Hospital Hub and is intended to provide access to ePCRs from multiple provider systems. New users should submit the request CHOP form to A.Boonjaluksa. for forwarding to the state. Additionally, existing Hospital Hub users should have received instructions to establish multifactor authentication to CHOP. Users who have not received access information should contact A.Boonjaluksa.

2.7 **The 2027 EMS Agency Meeting Calendar**
The 2027 EMS Agency Meeting Calendar is available in the packet and on the website. Ami Boonjaluksa will send calendar invitations for next year's BHAC meetings.

R. Tadeo also announced that the Department of Health Services rebranded to Los Angeles Health Services (LAHS) with the potential change to email domains.

3. **APPROVAL OF MINUTES**: The meeting minutes for June 10, 2026, were approved as submitted.

M/S/C (Dr. Rios/Wombold)

4. NEW BUSINESS

4.1 Rapid LA County Medic Application: Department Support of Use of the Application vs. Other 3rd Party Applications

Members were asked to reinforce use of the official LA County RAPID application or EMS Agency website for current treatment protocols and medication dosing. Outdated protocols in third-party applications have contributed to patient care concerns.

Application improvements, including medication dosing resources, are underway. Users should update the app and leave it connected to the internet for several hours to cache protocols for offline use. Just-in-time videos remain online only.

4.2 EMS Agency Roster

The updated EMS Agency Roster was provided. Vacancies and continued hiring restrictions were noted.

4.3 BLS Ondansetron

Ondansetron has been added to the state EMT basic scope. Local implementation will be addressed through future revisions to Refs. 802 and 802.1 and the 2027 EMS Update. No agency implementation requests had been received at the time of the meeting.

4.4 Length Base Resuscitation Tape

Changes to newer Broselow tapes no longer align directly with the county's prehospital weight dosing approach. Interim options discussed included PediaTape Quick Tape or appropriately marking individual weight divisions on newer Broselow tapes. Provider agencies should notify the EMS Agency before using an alternative tape so it can assess consistency with current field dosing references. Hospital use remains governed by each hospital's own policies.

4.5 Pediatric Database

Required fields will be reduced, focusing on EMS sequence numbers and hospital outcomes for pediatric patients transported by BLS and ALS. System changes are anticipated in December, with compliance monitoring beginning in January after the fields are updated. Hospitals were encouraged to support Pediatric Liaison Nurses (PDLNs) in obtaining ePCRs and sequence numbers and developing workflows to capture BLS arrivals, which may be more difficult to track than ALS arrivals.

4.6 New Chapter 6 Requirements of the California State Regulations

Per State Regulations, a pediatric-specific data collection process is required to support a pediatric system of care and guide quality improvement efforts across the system.

The focus is on non-designated referral hospitals which include identifying a Pediatric Emergency Care Coordinator (PECC) and the need to establish a transfer process, develop facility-specific transfer policies, IFT agreements with receiving facilities, and appropriate transport modalities: BLS, ALS, or critical care transport.

Additionally, State Regulations included that STEMI Referral Facilities must develop policies and procedures to administer thrombolytics for qualifying patients; however, in LA County, rapid transfer should be prioritized and thrombolytic therapy considered when rapid transfer cannot be achieved.

4.7 MICN Exam Update

A revised MICN examination is planned for the following year, after changing the scantron platform and paramedic accreditation examination. M. Ferguson and the physician group will review a reported outdated exam questions.

M. Ferguson also reported that hospitals should contact the EMS Agency regarding renewal billing concerns, including individuals who may not be able to renew. Billing holds or corrections may be arranged as appropriate.

5. OLD BUSINESS

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6. POLICIES (ACTION REQUIRED)

6.1 Reference No. 530, Use of 9-1-1 Services for Interfacility Transfer of Patients

The new policy was presented to clarify permissible use of the 9-1-1 system for interfacility transfers and provide a local reference for referral hospitals and EMS personnel. Discussion clarified that all listed criteria must be met. A physician's determination that a transfer is urgent does not independently authorize 9-1-1 use outside the policy's authorized transfer categories, discussed as trauma re-triage and STEMI transfers.

Members recommended revising the policy to clarify that all criteria must be met to use the 9-1-1 system for ED-to-ED transfers and to consolidate the EMTALA requirements.

M/S/C (Jessica Strange/Dr. Rios)

6.2 Reference No. 1013, CE Approval Requirements

The proposed revision would prohibit a private residence or post office box as a continuing education provider's headquarters or business address. Members raised concerns about home-based administrative offices, online education, unintended effects on legitimate businesses, and the distinction between an office address and the location where instruction occurs. Members requested provider input and review of safety, zoning, and County compliance considerations. The chair announced that the motion did not pass as many members abstained from voting.

The item was deferred for further research and stakeholder feedback. M. Ferguson will clarify the proposal and return to the committee for consideration.

POLICIES FOR INFORMATION ONLY (NO ACTION REQUIRED

6.3 Reference No. 501, 9-1-1 Receiving Hospital Directory

Ronald Reagan UCLA Medical Center's approved hyperbaric chamber capability for onshore incidents was added to the receiving hospital directory. Staff discussed destination coordination through the Medical Alert Center and on-call dive physician.

6.4 Reference No. 1309, MCG Color Code Drug Doses

6.4.1 Reference No. 1231-P, Treatment Protocol: Seizure (Pediatric)

6.4.2 Reference No. 1317.25, MCG: Drug Reference – Midazolam

PediDOSE related policies. Enrollment ended in July. Current age-based pediatric seizure dosing continues for patients six months and older while results are pending. Study-specific materials related to consent, notification, PSR QR codes, and data collection should be removed. Guidance for severely underweight pediatric patients was simplified to use the appropriate color-code dosing reference.

7. REPORTS & UPDATES

7.1 EMS Update

The EMS Update planning committee held its first meeting; additional members are welcome. Interested participants should contact the education coordinator.

7.2 EmergiPress

The next EmergiPress issue is expected before the end of the month and will address wide-complex tachycardias.

7.3 **ITAC Update**
No updates reported.

7.4 **ELCoR Committee**
Dr. Bosson reported a new introductory EMS video for law enforcement, pediatric emergency videos in development, and ongoing education on coordinated responses to agitated persons. Potential projects include dispatch-supported law enforcement AED deployment and alignment of EMS policies with coordinated responses to intentional mass casualty incidents.

Collaboration with Correctional Health Services and county hospitals is underway to standardize medical stability evaluations for jail intake and review cases involving repeated transfers. Guidance will be shared after review and approval.

The EMS Agency will also explore notifications for newly posted educational videos.

7.5 **Research Initiatives & Pilot Studies**

7.5.1 **LA DROP**
The program reported 88 transfusions to date. Pasadena Fire is participating, and expansion involving additional LA County Fire units and the Sheriff's Department is anticipated, subject to equipment procurement and implementation needs.

Discussion addressed countywide expansion, additional hospital and agency partners, data oversight, implementation resources, and pediatric guidance.

Dr. Wilhelm reported that a pediatric base physician dosing guidance will be developed in collaboration with the EMS Agency, and that the team received a Bronze Eagle Award.

7.5.2 **PediDOSE**
PediDOSE results are expected to be presented in January. Current post-study clinical protocols remain in place pending review of the findings.

7.5.3 **Pedi-PART**
Pedi-PART randomized enrollment ended in March. An additional year of observational data collection, March to March, is underway, including hospital outcomes and cardiac monitor files for related ventilation analyses.

Hospitals may receive retrospective and prospective outcome requests. Agencies without consistently available monitor files are being excluded from this phase to avoid requesting outcomes that cannot support the analysis.

7.5.4 **Prehospital Lung Ultrasound (PLUS)**
The pilot is underway with Sierra Madre and Burbank Fire, in collaboration with USC Arcadia and Providence St. Joseph's. It focuses on adults with moderate to severe respiratory distress and identifying pulmonary edema to improve treatment decisions.

The pilot is anticipated to last one year, with enrollment and timing to be reassessed. Ultrasound findings do not independently authorize needle decompression; existing tension pneumothorax treatment criteria continue to apply.

Tele-EMS CHLA Study
The simulation study is recruiting emergency physicians to provide remote medical direction during pediatric resuscitation scenarios. Adult emergency physicians were still being sought for October 20–21, with additional dates in November.

Participation involves a 3-4 hour availability window and reported compensation of $200. Interested physicians may contact Dr. Bosson or Dr. Todd Chang from CHLA.

7.6 **Cardiac Arrest Taskforce**
Hospital and provider agency plans supporting the AHA 2030 goals are due January 1. Plans should identify proposed activities, implementation barriers, and data needs and be advanced for leadership support. Dr. Sanko is available to review draft plans.

Andres Robles is the new point of contact that has assumed coordination following Denise Watson's retirement.

Dr. Toy's work publishing the impact of the Heart Heroes initiative demonstrated encouraging evidence of increase bystander CPR following coordinated community education on hands only CPR.

7.7 **Upcoming Mass Gathering Events**
Planning continues for the next Super Bowl, with additional information expected following NFL's visit to LA County in the winter.

LA28 planning includes venue medical action plans, defined approval processes for outside medical personnel, and healthcare system preparedness. Further updates will be shared as planning progresses.

7.8 **Health Data Exchange**
HDE implementation and initial subscription support have been extended through additional funding. Hospital onboarding and provider business associate agreements (BAAs) continue.

Additional updates included participation by the Adventist Health hospital group, anticipated Ronald Reagan UCLA onboarding beginning next year, pending final BAAs for Cedars and Huntington, and corporate coordination with CommonSpirit (possible separate data system for CommonSpirit and Dignity Health) and Providence (corporate BAA). However, Los Angeles Health Services participation is paused during discussions concerning transition to EPIC.

The trauma registry is moving to a cloud-based platform, with January 1 identified as the target implementation date.

8. OPEN DISCUSSION:

8.1 **Base Order for Magnesium Sulfate**
Dr. Whitfield reviewed cases involving magnesium sulfate ordered for indications other than those addressed in prehospital treatment protocols without clear indication-specific dosing and administration instructions. Base physicians must provide explicit orders appropriate to the indication, medication dosing, and appropriate administration, and be mindful of paramedic scope of practice and the concentration of the medication carried by them.

Sedation for Agitated Patient with Head Injury
Dr. Bosson emphasized case-specific review, clinical judgment risks, and readiness to manage complications should a paramedic administer midazolam outside of protocol. The best decisions prioritize patient safety and minimize risks throughout care.

Witnessing Controlled Substance Waste
Reference No. 702 prioritizes a registered nurse, physician, or pharmacist to witness controlled substance waste, with a second paramedic used when those options are unavailable.

Concerns included nurses being asked to sign without directly witnessing the relevant activity, diversion investigations, liability, and differing hospital practices. Members proposed removing nurses from the requirement or revising the witness hierarchy.

The policy requires review and will be discussed at the next internal EMS Agency policy review committee.

9. **NEXT MEETING:** BHAC's next meeting is scheduled for **December 9, 2026**, in 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 14:55 P.M.

EMERGENCY MEDICAL SERVICES COMMISSION
PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday – October 21, 2026

MEMBERSHIP / ATTENDANCE

MEMBERS IN ATTENDANCE	ORGANIZATION
X Carol Meyer, Chair	EMSC, Commissioner
X Kenneth Powell, Vice Chair	EMSC, Commissioner
Jason Cervantes	EMSC, Commissioner
James Lott, PsyD, MBA	EMSC, Commissioner
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
X Clayton Kazan, MD	Area B, Alternate
Jeffrey Tsay	Area C
X Luis Manjarrez	Area C, Alternate
Victor Lemus	Area E
X Geoffrey Dayne	Area E, Alternate
X Joel Davis	Area F
Andrew Reno	Area F, Alternate
X Adam Brown	Area G *(Rep to BHAC)*
X James Duarte	Area G, Alternate
Matthew Conroy	Area H
X Marc Cohen, MD	Area H, Alternate
X Michael Campana	Area H, Alternate
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
Drew Pryor	Public Sector Paramedic Coordinator, Alt
Scott Buck	Private Sector Paramedic
Vacant	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
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	Mark Ferguson
Ami Boonjaluksa	Natalie Greco
Sara Rasnake	

GUESTS	GUESTS
Jim Goldsworthy	
Danielle Ogaz	
Kristina Crews	
Jonathan Warren, MD	
Timothy Behen	
Karen Bustillos	
Grant Gardymet	
Karyn Robinson	
Salvador Rios	
Caroline Jack	
Joe Nakagawa, MD	
Matt Armstrong	
Jennifer Nulty	
Theodor Ecklund	
Kimberly Tan	
Michael Stone	
Adrienne Roel	
Kathryn Ward	
Patricia Guevara	
Johnna Corbett	
Josh Dean	
Tassia Trink	
Nicole Mitchell	
Connor Cudeback	
Jessie Castillo	
Sergio Zavala	
Crytal James	

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

2. **INTRODUCTIONS AND ANNOUNCEMENTS**

2.1 EMSAAC Conference 2027 *(Richard Tadeo)*

- Save the Date: June 2 & 3, 2027 with a preconference session on June 1. Conference will be held at the Hilton Los Angeles/Universal City. More information to follow.

2.1 Joint Educational Session – December 1, 2026 – Sepsis *(Denise Whitfield, MD)*

- Sepsis for prehospital providers will be presented at the next joint educational session, scheduled for December 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.

2.3 Measure B 2026 – MBAB Process *(Richard Tadeo)*

- Formal notice has been distributed for this year's Measure B Funding Proposal Process.
- Deadline for proposal submissions to the EMS Agency is December 17, 2026 at 5:00 p.m.
- Proposals submitted after the deadline will not be considered and returned to the submitter.

2.4 Area G Membership *(David Wells)*

- Area G Representative: Timothy Behen will replace Adam Brown beginning in December.
- Area G Alternate Representative: James Duarte replaces Stefan Viera.

2.5 EMS Agency Roster (David Wells)

- An updated roster with contact information has been distributed.

2.7 Designated Infection Control Officer (DICO) Workshop (Nnabuike Nwanonenyi)

- A survey will be sent to all providers to determine need and interest for the workshop.
- At least 20 personnel are required to hold the training.
- A DICO and training is required for all providers.

3. APPROVAL OF MINUTES (Powell / Calka) August 19, 2026, minutes were approved as written.

4. UNFINISHED BUSINESS

No unfinished business

5. NEW BUSINESS

5.1 BLS Ondansetron *(Nichole Bosson, MD)*

- Ondansetron has been added to the EMT scope of practice.
- Training will be included via EMS Update 2027.

5.2 Length Based Resuscitation Tape *(Nichole Bosson, MD)*

- Current version of Broselow does not break down the individual weight in kg per the Color Code.
- Encourage either marking the current version of Broselow or Pediatape by using a Broselow from 2011-2017 as the template.
- Exploring future options and open to suggestions; contact nbosson@dhs.lacounty.gov.

5.3 New Chapter 6 Requirements *(Richard Tadeo)* Final Approved Regulation Text (www.emsa.ca.gov)

5.3.1 Subchapter 4: EMS for Children (Page 57)

5.3.2 EMS Provider Requirements (Page 63)

- A designated Pediatric Emergency Care Coordinator is now required for all EMS providers.
- More information and discussion to follow as the requirements are implemented.

Policies for Discussion; Action Required:

5.4 Reference No. 530, Use of 9-1-1 Services for Interfacility Transfer of Patients *(Jacqueline Rifenburg)*

- Policy was developed at the request of the EMS Commission IFT workgroup.
- Request to add a definition for Licensed Acute Care Facilities

Policy reviewed and approved with the added definition.

M/S/C (Davis / Lopez) Approve: Reference No. 530, Use of 9-1-1 Services for Interfacility Transfer of Patients

5.5 Reference No. 1013, EMS Continuing Education (CE) Provider Approval and Program Requirements *(Mark Ferguson)*

Tabled: Reference No. 1013, EMS Continuing Education (CE) Provider Approval and Program Requirements

Policies for Discussion; No Action Required:

5.6 Reference No. 501, 9-1-1 Receiving Hospital Directory *(Ami Boonjaluksa)*

- Added approval of Ronald Reagan UCLA Medical Center's hyperbaric chamber for onshore incidents.

5.7 Reference No. 842, Mass Gathering and Special Events Interface with Emergency Medical Services *(Denise Whitfield, MD)*

- Revised to require the patient care log be submitted to the jurisdictional 9-1-1 provider and submit to the EMS Agency for significant issue or upon request.

5.8 Reference No. 842.4, Mass Gathering and Special Events Patient Care Log *(Denise Whitfield, MD)*

- Revised as identified in Ref. No. 842. Dr, Whitfield noted this includes all patient care encounters.

6. REPORTS AND UPDATES

6.1 Health Data Exchange *(Richard Tadeo)*

- Memorial Care Long Beach Medical Center is now online.
- Documentation of patient name, date of birth and receiving facility must be accurate.

6.2 EMS Update *(Shira Schlesinger, MD)*

- First workgroup meeting was held.
- Dr. Schlesinger requested providers who used a paper form for the pediatric simulation to provide the document for evaluation and improvement of EMS Update simulations.

6.3 EmergiPress *(Shira Schlesinger, MD)*

- The next edition will review wide-complex tachydysrhythmias.
- Email Dr. Schlesinger at sschlesinger2@dhs.lacounty.gov for recommendations for future releases.

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

- Next meeting will be cancelled due to lack of agenda items.

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

- Orientation to the EMS system video education developed for law enforcement. Additional videos are under development.
- All videos will be posted on the EMS Agency Vimeo page.
- Working to establish a pathway with the Police Chiefs Association to disseminate law enforcement EMS education and encourage providers to engage with their law enforcement agencies.
- Continue to develop guidelines and collaborate with Correctional Health related to improving processes for medical clearances prior to booking and the use of 9-1-1.
- New goal was established to support expansion of Law Enforcement AED programs.

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 88+ prehospital blood transfusions.
- Pasadena Fire commenced in August; LA Sheriff's Department is planning to implement soon; LACoFD will be expanding into the Eastern region of the County (late 2026); and LA City FD is continuing in the planning phase.
- Plasma use in prehospital care is increasing, which may facilitate system-wide expansion.
- Additional agencies interested in participating may contact Dr. Bosson.
- Protocol for administration of blood to pediatrics has been developed by CAL-DROP.
- LA Drop earned the Bronze Eagle Award from Los Angeles County.
- Two articles have been published in the Prehospital Emergency Care Journal related to LA DROP
    - Evaluation of blood criteria
    - Blood administration and interface with the LA County Hospital Emergency Response Team.

6.6.2 PediDOSE Trial *(Nichole Bosson, MD)*

- All documents related to the PediDOSE trial must be removed from paramedic resources and units, including paramedic self-reporting (PSR).
- Results of this study will be available in January 2027, and a decision will be made on how this may change the pediatric seizure medication dosing within our EMS system.

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

- The EMS Agency continues with outcome data collection, which will end in March 2027.

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

- Sierra Madre FD (April 2026) and Burbank FD (July 2026) are enrolling patients.
- More than 30 ultrasounds have been performed.
- Quality of scans have been of good quality.
- Working towards obtaining patient outcome data from hospitals.

6.7 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.
- Summary report will be presented to EMS Commission early next year.
- Andres Robles is the point of contact for submissions at arobles5@dhs.lacounty.gov.

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

- Superbowl: February 2027
  - Planning is underway
- LA28 Olympics
  - Hospital Preparedness meeting this week
  - Working with EMS, venues and event providers
  - Developing processes for credentialing of out of state personnel and ambulance operators

6.9 Chapter 1 Public Comment *(Richard Tadeo)*

- Chapter 1 Regulations have been released for public comment and encouraged providers to review.
- The deadline to submit comments to the EMS Authority (EMSA) is December 11, 2026.

7. OPEN DISCUSSION

7.1 EMSA Director *(Richard Tadeo)*

- Director Elizabeth Basnett has been promoted to California Governor's Office of Emergency Services (Cal OES).
- EMSA Chief Medical Officer, Dr. Hernando Garzon will be the Acting Director effective 11/02/2027.

7.2 DHS Rebranding *(Richard Tadeo)*

- Los Angeles County Department of Health Services is now Los Angeles Health Services (LAHS).

7.3 RAPID LA County Medic Mobile Application *(Nichole Bosson, MD)*

- Working on drug doses update to improve user experience.
- Current update to application (app) will now cache all pdf documents if app is left open. Documents will cache if opened individually.

7.4 ALS Skills *(Denise Whitfield, MD/Mark Ferguson)*

- Inquiry from membership regarding ALS skills requirements for new graduates, lateral transfers, and paramedics from other jurisdictions.
- New graduates skills cycle starts from date of graduation. EMS Agency will evaluate and develop guidance for lateral transfers and new paramedics from other counties and states.

- ALS skills spreadsheet is locked to ensure a clean data transfer for paramedics to ensure credit for completion for the correct personnel. Additional personnel can be added to the bottom of the worksheet. Any questions, contact Mark Ferguson at maferguson@dhs.lacounty.gov.

7.5 Area D Reinstatement *(David Wells)*

- Inquiry from membership regarding status of Area D reinstatement to PAAC representation. The reinstatement request will be added to a future EMS Commission agenda for consideration.

7.6 Dispatch Committee Agenda *(David Wells)*

- Inquiry from membership regarding dispatch agenda being received. Process for a timelier distribution of the agenda packet has been revised to incorporate the quarterly meeting.

7.7 Chief Brown *(Carol Meyer/Adam Brown)*

- Chief Brown's contributions to the EMS system were acknowledged by this committee.

7.8 Mass Gatherings and Special Events *(Denise Whitfield, MD)*

- Inquiry from membership regarding response and transport for mass gatherings and special events and the jurisdictional provider authority. Ref. No. 842 and Ref. No. 517 incorporate language which requires private providers, venues, and promoters to work with and receive approval for the medical action plan from the jurisdictional 9-1-1 provider.

8. NEXT MEETING – December 16, 2026

9. ADJOURNMENT - Meeting adjourned at 2:31 p.m.

LOS ANGELES HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

SUBJECT: **USE OF 9-1-1 SERVICES FOR INTERFACILITY TRANSFER OF PATIENTS** (HOSPITALS) REFERENCE NO. 530

PURPOSE: To establish requirements governing acute care hospitals use of the 9-1-1 emergency medical services system for interfacility transfer; protect 9-1-1 resources for community emergencies; promote timely access to definitive care; and ensure transfers comply with applicable federal and state law and Los Angeles County Emergency Medical Services Agency ("EMS Agency") policies.

AUTHORITY: Health and Safety Code Sections 1797.204, 1797.220, 1798, and other applicable provisions of Division 2.5.
California Code of Regulations, Title 22, Division 9, Sections 100091.02 and 100096.03
California Code of Regulations, Title 22, Division 9, Section 100139
California Code of Regulations, title 22, Division 5, Chapter 1, Article 6, governing patient transfers, as applicable.
Emergency Medical Treatment and Labor Act (“EMTALA”), Social Security Act section 1867, codified at 42 U.S.C. § 1395dd.
42 C.F.R. § 489.24.
Applicable EMS Agency policies, procedures, protocols, and destination requirements.

DEFINITIONS:

Emergency Department Patient: A patient receiving evaluation or treatment in a hospital emergency department (ED) who has not been admitted by the hospital as an inpatient.

EMS Clinician: a trained healthcare professional with appropriate licensure, certification or accreditation to provide pre-hospital and out-of-hospital emergency medical care, stabilization, and transport.

Interfacility Transfer: The movement of a patient from one healthcare facility to another for continued treatment or acts to an appropriate level.

Inpatient: A patient who has been formally admitted to the hospital regardless of the patient's physical location at the time transportation is requested.

Licensed Acute Care Hospital: A health facility that provides 24-hour inpatient care that is licensed by California Department of Public Health. Examples: General Acute Care Hospital (GACH) and Long Term Acute Care Hospital (LTAC).

Private Ambulance Provider: An ambulance provider licensed in LA County authorized to perform interfacility transportation outside the 9-1-1 response system.

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

9-1-1 Interfacility Transfer: An interfacility transfer initiated through the 9-1-1 system rather than through a hospital's contracted or otherwise authorized interfacility transportation provider.

POLICY:

I. The Role of 9-1-1 Response

A. The 9-1-1 system is a critical community resource, intended to transport patients from the out-of-hospital scene of an emergency to the closest appropriate 9-1-1 receiving facility.

B. Per LA County EMS policies, the use of 9-1-1 for an ED to ED transfer is only authorized for patients who meet Trauma Re-triage criteria (Ref. No. 506 and 506.2) or patients with STEMI who are being transferred for emergent coronary angiography (Ref. No. 513.1 and 513.2).

C. A physician's determination that a patient requires urgent transfer does not independently authorize use of the 9-1-1 system when the patient does not meet an authorized category.

II. Hospital Interfacility Transfer Preparedness

A. Each hospital shall maintain written policies operational plans and adequate contractual arrangements with authorized ambulance providers to ensure timely access to basic life support, advanced life support, critical care or other appropriate interfacility transportation.

B. A hospital shall not rely on the 9-1-1 system as a substitute for:

1. Adequate interfacility transfer contracts or transportation capacity;
2. Routine or scheduled transportation;
3. Delays in obtaining authorization or payment;
4. Inadequate hospital staffing or administrative planning;
5. A preferred ambulance provider's unavailability; or
6. A transportation level that should reasonably have been anticipated based on the patient's condition.

C. Hospitals shall maintain contingency arrangements with more than one qualified transportation provider when reasonably necessary to address foreseeable capacity limitations or service interruptions.

D. The transferring and receiving hospitals remain responsible for complying with EMTALA and all applicable federal and state transfer requirements. Use of the 9-1-1 system does not alter or transfer those responsibilities to the EMS Agency, the responding EMS provider agency, or the EMS clinician.

E. Activation of 9-1-1 does not establish that an otherwise deficient transfer complies with EMTALA or state law.

III. Inpatient Interfacility Transfers

A. The 9-1-1 system shall not be used to transport patients admitted to the inpatient setting from one hospital to another. A patient's location in the emergency department does not make the patient eligible for a 9-1-1 interfacility transfer if the patient has already been admitted as an inpatient.

B. Hospitals shall arrange inpatient transfers through an authorized interfacility ambulance provider at the level of care appropriate to the patient's condition.

IV. Emergency Department (ED) Patient Interfacility Transfers

A. The 9-1-1 system may be used for an ED to ED transfer only when all the following apply:

1. Patient has not been admitted as an inpatient;
2. Patient meets an express transfer category authorized by this policy and the applicable referenced EMS Agency policy;
3. Patient requires time sensitive specialty care that is not available at the sending hospital;
4. Receiving hospital has accepted the patient, unless an applicable EMS Agency policy expressly provides otherwise;
5. Sending on-scene physician determines that transfer is medically appropriate;
6. Requirements of EMTALA and applicable state transfer laws have been satisfied;
7. The patient's transportation needs are within the authorized scope, staffing, equipment, and capabilities of the responding 9-1-1 transport unit; and
8. The hospital follows all applicable EMS Agency notifications, consultation, checklist, documentation, and destination requirements.

B. The availability of a 9-1-1 response and/or transport unit does not by itself establish eligibility for a 9-1-1 interfacility transfer.

C. The sending hospital remains responsible for the patient's examination, monitoring, stabilization, treatment, and appropriate transport unit until responsibility is appropriately transferred to the receiving facility.

D. The sending hospital shall not direct EMS clinicians to provide care outside their scope of practice or transport a patient whose anticipated needs exceed the transport unit’s capabilities.

E. Responding EMS clinicians retain responsibility for complying with applicable scope of practice, medical control, patient care, patient destination, and operational policies. A response to the hospital does not guarantee that the patient will be transported via the 9-1-1 system.

F. If the patient's condition or transportation needs are judged to exceed the responding unit’s capabilities, responding EMS clinicians shall inform hospital personnel so hospital may identify an appropriate transportation resource. In cases of disagreement, EMS clinicians should follow applicable medical control and escalation procedures.

G. The hospital shall provide responding clinicians with all information necessary for safe transport, including the patient's condition, treatment provided, medication infusions, allergies, infection control precautions, anticipated deterioration risks, and receiving facility information. Required transfer records shall accompany the patient or be transmitted to the receiving hospital in accordance with applicable law.

V. EMS Agency Oversight

A. The EMS Agency may review any 9-1-1 activation involving an actual or attempted interfacility transfer to evaluate:

1. Compliance with this policy;
2. Patient safety;
3. Appropriate use of EMS resources;
4. Accuracy of information provided to dispatch and responding personnel;
5. Compliance with applicable clinical criteria and checklists; and
6. Opportunities for system or hospital level improvement.

B. The hospital shall cooperate with an EMS Agency review and provide requested records consistent with applicable law.

C. When the EMS Agency identifies apparent noncompliance, it may require one or more of the following:

1. A written explanation;
2. A case review or root cause analysis;
3. A corrective action plan;
4. Revision of hospital policies or transfer procedures;
5. Staff education or competency validation;
6. Improvement of ambulance contracting or contingency arrangements;
7. Prospective monitoring or periodic reporting; or
8. Other corrective measures reasonably related to the identified risk.

D. Suspected violations of EMTALA or other applicable law may be referred to the appropriate regulatory or enforcement agency. The EMS Agency's finding that an activation was inconsistent with this policy does not by itself constitute a determination that the hospital violated EMTALA.

E. Repeated knowing materially misleading or patient endangering misuse of the 9-1-1 system may result in enhanced corrective action or referral to an appropriate oversight agency.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 320.2, **Sample Memorandum of Understanding Agreement for Interfacility Transfer of Acute STEMI Patients**
Ref. No. 506, **Trauma Triage**
Ref. No. 506.2, **Trauma Re-Triage**

Ref. No. 506.3, **9-1-1 Interfacility Transfer Checklist for Trauma Re-Triage**
Ref. No. 513, **ST-Elevation Myocardial Infarction (STEMI) Patient Destination**
Ref. No. 513.1, **Interfacility Transport of Patients with ST-Elevation Myocardial Infarction**
Ref. No. 513.2**, Interfacility Transfer Checklist for STEMI Re-Triage**

Federal Authority

United States Code, Title 42, Section 1395dd Examination and treatment for emergency medical conditions and women in labor

Code of Federal Regulations, Title 42, Section 489.24 Special responsibilities of Medicare hospitals in emergency cases

Emergency Medical Treatment and Active Labor Act (EMTALA)

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

REFERENCE NO. 530, Use of 9-1-1 Services for Interfacility Transfer of Patients

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee	10/14/26	10/14/26	Y
EMS ADVISORY	Provider Agency Advisory Committee	10/21/26	10/21/26	Y
OTHER COMMITTEES / RESOURCES	Medical Council			
OTHER COMMITTEES / RESOURCES	Trauma Hospital Advisory Committee			
OTHER COMMITTEES / RESOURCES	Pediatric Advisory Committee			
OTHER COMMITTEES / RESOURCES	Ambulance Advisory Board			
OTHER COMMITTEES / RESOURCES	EMS QI Committee			
OTHER COMMITTEES / RESOURCES	Hospital Association of Southern California			
OTHER COMMITTEES / RESOURCES	County Counsel			
OTHER COMMITTEES / RESOURCES	Disaster Healthcare Coalition Advisory Committee			
OTHER COMMITTEES / RESOURCES	Other: 9-1-1 Dispatch Center			

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

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

REFERENCE No. 530, *Use of 9-1-1 Services for Interfacility Transfer of Patients*

REF	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
530	New policy addressing hospital utilization of 911 for interfacility transfers of in-patients	BHAC 10/14	Add “only when all the following apply to Policy:IV:A	Approved with addition of language
		PAAC 10/21	Add definition of “Licensed Acute Care Hospital”	Approved with addition of definition

LOS ANGELES HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

(EMT, PARAMEDIC, HOSPITALS)

SUBJECT: **MASS GATHERING AND SPECIAL EVENTS INTERFACE WITH EMERGENCY MEDICAL SERVICES**

REFERENCE NO. 842

PURPOSE: To establish guidelines for the delivery of Emergency Medical Services (EMS) to protect the health and safety of the participants during mass gatherings and special events of various size and intensity so that participants have access to the appropriate level of care and to minimize the impact of these events on the local EMS system.

AUTHORITY: Health & Safety Code, Sections 1797.202, 1797.204, 1797.220, 1798, 1798.6(a)
Health Insurance portability and Accountability Act 164.501
California Code of Regulations, Title 22, Sections 100063, 100144, 100167(a), 100169
Los Angeles County Code Title 7, Business Licenses, Chapter 7.16, Ambulances

DEFINITIONS:

After Action Review/Report (AAR): A structured review or de-briefing process for analyzing what happened, why it happened, and how it can be done better by those responsible for an event.

Build in/build out plan (also known as "set-up" and "strike out"): Refers to terminology related to special events for the "set up" of a permitted and approved floor plan on/in a stadium, field, building or other structure. "Strike out" is the process in set construction of dismantling, storing or discarding the materials used.

Event Action Plan: A plan that contains objectives that reflect the event strategy and specific control actions for the event. The Medical Action Plan is the part of the Event Action Plan that is specific to medical resources and assignments.

Event Footprint: The area(s) that is within the control of the event promoter, which may include the venue, the parking lot, and any extended area in which an event is being held.

Event Medical Facility: The main medical facility in which medical care is being provided and/or being directed during a mass gathering or special event. This may include a first aid station, medical station, or any combination thereof.

Harm Reduction: Policies, programs and practices that aim primarily to reduce the adverse health, social and economic consequences, such as alcohol and drug education pamphlets etc.

Intensity of Event: The level of intensity (low, medium, or high) as designated by jurisdictional provider agency, is based on the number of attendees, weather considerations, geography, the propensity for alcohol and/or drug use, physical exertion, duration, and history of like events

Jurisdictional Provider Agency: The local fire department.

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

Mass Gathering: An organized assembly of 5,000 or more people.

Medical Action Plan (MAP): A plan that explains the medical resources, services, and coordination that will be provided during an event that is provided by the promoter/venue.

Medical Alert Center (MAC): Assists provider agencies and base hospitals with patient destination decisions and multiple casualty incidents. It serves as the control point for VMED28 and ReddiNet systems.

Participant: Any person attending or working at the event.

Recurring Events: A mass gathering that occurs on a daily, weekly, monthly, seasonally, or annual basis at a fixed venue and with an existing developed (proven/successful) plan to manage the health and safety of participants and type of event. Examples include professional sport event, the annual county fair, etc.

Special Event: A gathering that does not meet the definition of a mass gathering but has the potential to impact the local EMS response, as determined by the jurisdictional provider's discretion. Examples could include a parade, one time concert, etc.

PRINCIPLE:

A Medical Action Plan (MAP) shall be created for every mass gathering or special event at the request/discretion of the jurisdictional provider agency.

POLICY:

I. The Medical Action Plan (MAP) shall include, but not be limited to, the following considerations:

   A. Event description, including event name, and expected number of participants.

   B. Participant safety (may include an extended footprint) including harm reduction.

   C. Communications Plan that secures a mechanism for direct, two-way communication between the jurisdictional provider agency and medical staff. Consider the following:

      - Two-way radios
      - Cellular service may be overwhelmed
      - Coordination with the MAC

   D. Medical resources that are appropriate to the number of participants – to include quantities, locations, hours of operation, and staffing levels (Advanced Life Support (ALS), Basic Life Support (BLS), Medical Doctor (MD), Registered Nurse (RN), and volunteers for the following:

      - Transport ambulances
      - Fixed resources –first aid stations, event medical facility
      - Mobile resources- mobile teams/carts, foot/cycle teams
      - Contingency plan if resources become overwhelmed

E. Weather related plans

F. Evacuation plan

G. Build in/build out plan

II. Responsibility of the Promoter/Event Venue

A. Notify the jurisdictional provider agency of the event, participate in the permitting process, develop and review the event MAP with the event medical staff and the jurisdictional provider agency.

B. Submit the MAP for approval to the jurisdictional provider agency at a minimum of twenty-one (21) calendar days prior to the event.

C. Submit any final changes to the MAP to the jurisdictional provider agency at a minimum of seventy-two (72) hours prior to the event. The jurisdictional provider agency will respond within twenty-four (24) hours.

D. Utilize ambulance operators licensed by Los Angeles County (Ref. No. 401.1, Licensed Ambulance and EMS Aircraft Operators) with a minimum of Basic Life Support (BLS) level of service.

E. Incorporate and utilize harm reduction programs for events when applicable.

F. Participate in an AAR upon the request of the jurisdictional provider agency or the Los Angeles County EMS Agency. AARs shall be held within fourteen (14) days post-event unless otherwise approved by the jurisdictional provider agency.

III. Responsibility of the Jurisdictional Provider Agency

A. Review and respond to EAP and the MAP within fourteen (14) calendar days prior to the event. Respond to any final changes to the MAP within twenty-four (24) hours.

B. Verify EMS personnel utilized in the event are appropriately licensed, accredited, and/or certified in Los Angeles County.

To verify an EMT/Paramedic:
https://emsverification.emsa.ca.gov/Verification/

To verify a registered nurse/licensed vocational nurse/physician:
https://www.breeze.ca.gov/

To verify a physician is Board Certified or Board Eligible in Emergency Medicine:
https://www.certificationmatters.org/find-my-doctor/.org

C. When necessary to protect health and safety, may require additional or more stringent requirements than listed in this policy (i.e., medical staffing requirements).

D. Educate the event promoter/venue regarding licensed ambulance company capabilities and hospital resources.

E. Notify the Los Angeles County EMS Agency MAC at 866-940-4401 or via email at lemsadutyofficer@dhs.lacounty.gov of the event as soon as possible, if there is an anticipated regional or multi-jurisdictional impact to the EMS system.

F. Assist with the coordination of the AAR for any event that meets the definition of Multiple Casualty Incident (MCI) as outlined in Ref. No. 519, Management of Multiple Casualty Incidents.

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

A. The EMS Agency Medical Director, upon request will:

1. Coordinate a review of the MAP and provide recommendations to the event medical provider and the jurisdictional provider agency

2. Respond within three (3) business days

A sample MAP is included in Ref. No. 842.2, Mass Gathering and Special Events Medical Action Plan

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

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

2. Assign personnel to staff the event command center upon request of the jurisdictional provider agency

3. Poll area hospitals for emergency department capacity as needed

4. Monitor the number of patient transports during the event.

5. Open an MCI on the ReddiNet when the number of patients and types of illnesses/injuries are expected to exceed the capabilities of the nearest hospitals.

a. Provide patient destination

b. Notify the Medical Officer on Duty (MOD) and the Administrator on Duty (AOD)

c. Provide a summary of incident with final disposition of all patients to the jurisdictional provider agency and EMS Agency Administration within 72 hours post event.

6. In accordance with Ref. No. 519, Management of Multiple Casualty Incidents, assist with an AAR as needed or requested.

V. Responsibility of the Event Medical Provider

A. Provide adequate equipment and supplies to manage care based on the level of service (BLS, ALS) and number of participants.

B. Identify the event medical facility and ambulance staging locations.

C. Submit a list of event medical personnel to the jurisdictional provider agency at least ten (10) calendar days prior to the event to include:

- Name of person
- Type of license or certification (EMT, Paramedic, Nurse, or Physician), number and expiration date
- Include all volunteers or non-licensed personnel or students that will be attending the event, if applicable.

A sample roster is included in Ref. No. 842.3, Mass Gathering and Special Events Event Roster.

D. Submit any changes to previously approved event personnel to the jurisdictional provider agency at least seventy-two (72) hours prior to the event. The jurisdictional provider agency will respond within twenty-four (24) hours.

E. Maintain a patient care log and submit to the jurisdictional provider agency within seventy-two (72) hours after the conclusion of the event, and to the EMS Agency in the case of a significant incident or upon request, which shall include at a minimum:

- Patient information or patient identifier
- Age
- Chief complaint
- Treatment
- Disposition
- Diagnosis, if a physician is on site
- Destination, if transported

A sample patient care log is included in Ref. No. 842.4, Mass Gathering and Special Event Patient Care Log

F. A patient care record (PCR) shall be generated for each patient that receives an assessment and/or treatment at a mass gathering or special event. All patient care should be documented in accordance to Ref. No. 606, Documentation of Prehospital Care.

G. Provide patient care records (PCRs) for review by the EMS Agency or jurisdictional provider agency when requested.

H. Participate in the After Action Review/Report (AAR) as requested.

VI. Responsibility of the Prehospital Providers

A. Nurses shall be licensed by the State of California and preferably have experience in emergency medical care and triage of seriously ill or injured patients.

B. Paramedics shall be licensed by the State of California, accredited in Los Angeles County and on duty for an approved LA County ALS provider.

C. EMTs shall be certified by the State of California and adhere to the Los Angeles County Scope of Practice.

D. Assess participants and escort them to the event medical facility, as appropriate, and per the event's MAP. Following assessment, the participant shall be referred to the event physician on scene, if applicable. If medical staffing levels do not include a physician, EMS providers will follow Ref. No. 1200, Treatment Protocol, et al.

E. Participants must be medically appropriate to be transported to the event medical facility that is staffed with a licensed health care professional. Medically appropriate patients may include altered level of consciousness (ALOC) without evidence of head trauma or history of recent seizure or active seizure. Any patient meeting Ref. No. 506, Trauma Triage criteria shall be transported directly to a trauma center coordinated through MAC or the jurisdictional provider without delay, or if neither are available, contact the designated base hospital.

F. Once the event has been declared an MCI, the paramedics shall take direction from the MAC or jurisdictional provider for patient destination and treatment per Ref No. 1200, Treatment Protocol, et al.

VII. Responsibility of the Primary Contracted Physician at the Event, if applicable

A. Be Board Certified in Emergency Medicine and familiar with the Los Angeles County Paramedic and EMT scopes of practice. Additional physicians must be Board Certified or Board Eligible in Emergency Medicine.

B. Be familiar with the Los Angeles County prehospital care policies.

C. Maintain communication with the jurisdictional incident commander, event coordinator and other medical staff.

D. Take responsibility for medical oversight of all licensed or certified health care professionals providing patient care at the event.

E. Take responsibility for the care and disposition for all patients at the designated event medical facility.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 412, **EMT Automated External Defibrillator (AED) Service Provider Program Requirements**
Ref. No. 506, **Trauma Triage**
Ref. No. 517, **Private Provider Agency Transport / Response Guidelines**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 802, **EMT Scope of Practice**
Ref. No. 803, **Los Angeles County Paramedic Scope of Practice**
Ref. No. 816, **Physician at the Scene**
Ref. No. 842.1, **Resource Guidelines for Mass Gatherings and Special Events**
Ref. No. 842.2, **Mass Gathering and Special Events Medical Action Plan (MAP)**
Ref. No. 842.3, **Mass Gathering and Special Events Event Roster**
Ref. No. 842.4, **Mass Gathering and Special Events Patient Care Log**

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

REFERENCE NO. 842, Mass Gathering and Special Event Interface with EMS. 842.4, Mass Gathering and Special Events Patient Care Log

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY	Base Hospital Advisory Committee			
	Provider Agency Advisory Committee	10/21/26	10/21/26	N
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: 9-1-1 Dispatch Center			

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

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

REFERENCE No. 842, *Mass Gathering and Special Events Interface with Emergency Medical Services.* **843.4,** *Mass Gatherings and Special Events Patient Care Log*

REF	Rationale for Revision	COMMITTEE/DATE	COMMENT	RESPONSE
842	Clarification of language regarding the responsibility of the Event Medical Provider	PAAC 10/21	None	Approved

LOS ANGELES HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

SUBJECT: **MASS GATHERINGS AND SPECIAL EVENTS**
PATIENT CARE LOG

(EMT, PARAMEDIC, HOSPITAL)
REFERENCE NO. 842.4

Name of Event/Incident: _____				**Event/Incident Date: _____**			
Time	**Patient Name/Patient Identifier**	**Age**	**M/F**	**Chief Complaint**	**Treatment**	**Disposition**	**Diagnosis**

Must be submitted within 72 hours to the jurisdictional provider agency after the event and to the EMS Agency upon request.

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Practice and Policy Insights

The Evaluation and Management of Patients With Suicidal Ideation or Behavior by Emergency Medical Services

Development of a Comprehensive Policy in Los Angeles County, CA, USA

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Abstract: Emergency medical services (EMS) clinicians, such as paramedics and emergency medical technicians, frequently respond to 911 calls involving patients with suicidal ideation or behavior (SIB); however, guidance for these complex prehospital encounters remains limited. This article describes the Los Angeles County EMS Agency's (LAC-EMSA) initiative to develop a comprehensive policy for evaluating and managing patients with SIB. A quality improvement (QI) committee approach was used to assess current practices, identify targets for improvement, design countermeasures, and implement policy changes. Key activities included reviewing national model guidelines and California's EMS agencies' policies; conducting interdisciplinary case reviews of EMS encounters with patients with SIB; surveying emergency departments on suicide screening practices; collecting EMS clinicians' perspectives on challenges and potential interventions; and evaluating commonly used suicide risk screening instruments. Findings were synthesized through committee discussions, identifying five critical domains for improvement: (1) standardized terminology; (2) evidence-based guidance for evaluating suicide risk; (3) enhanced decision support for patient disposition; (4) protocols for safety planning; and (5) strategies for collaboration with law enforcement and conflict resolution. The committee recommended a new comprehensive policy addressing these domains which was subsequently developed and implemented. Limitations include the initiative's focus on a single county EMS system, the absence of validated prehospital suicide risk screening tools, and the need for evaluation of the policy's effectiveness. This initiative demonstrates that EMS agencies can leverage QI methodologies to create evidence-informed policies that advance prehospital care for SIB and reduce variability in practice.

Keywords: suicide, mental health, emergency medical services, law enforcement

Emergency medical services (EMS) clinicians, which include paramedics and emergency medical technicians in the United States (US), commonly respond to 911 calls for patients with suicidal ideation or behavior (SIB). However, standardized protocols remain scarce for these complex prehospital encounters. In 2022 in the US, 13.2 million people seriously considered suicide, 3.8 million planned an attempt, 1.6 million attempted, and 49,000 died (CDC, 2024). While national EMS encounter data are limited, the National EMS Information System (NEMSIS) reported over two million behavioral or psychiatric complaints from 2024 to 2025 (National Emergency Medical Services Information System, 2025), many related to suicide risk (Cheung et al., 2024).

Existing literature reveals minimal EMS guidance for the evaluation and management of SIB. DeCou et al. (2021) noted Washington State protocols focused only on scene safety and hospital transport, calling for improved clinical guidance on suicide screening and management. Wilfond et al. (2019) suggested EMS training to direct patients to crisis services, but no implementation reports exist. Model guidelines from the National Association of State EMS Officials (NASEMSO), the lead EMS organization in the US whose consensus-based guidelines

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are frequently used to shape local EMS protocols (NASEMSO, 2022), advise that patients with *suicidal intent* lack decision-making capacity and cannot refuse transport to an emergency receiving facility. A survey of 229 EMS clinicians highlighted challenges in adding lethal means counseling to training (Stanley et al., 2024). A 2024 consensus statement emphasized the need for EMS to collaborate with law enforcement and resources such as 988 (the national suicide prevention center hotline) but offered no guidance on clinical approach (Levy et al., 2024). The 988 system, which launched in 2022, largely operates independently from the 911 system. However, if a 988 caller requires an emergency field response, the call is transferred to 911, typically resulting in the deployment of a law enforcement officer (Cheung et al., 2024).

Los Angeles County (LAC), among the largest EMS systems in the US with over 16,000 EMS clinicians, handles 5–8 million annual 911 calls. Seven percent (7%) involve behavioral health emergencies (BHEs), with 40–50% related to suicidal ideation (SI), suicidal behavior (SB), or suicide attempt (SA) – the equivalent of approximately 700 calls daily (Cheung et al., 2024). BHE–related emergency department (ED) visits in LAC rose 38% from 2018–2023 (Los Angeles County Emergency Medical Services Agency, 2024). The LAC EMS Agency (LAC-EMSA) governs all emergency medical services in the County, including establishing policies and clinical protocols, and certifying prehospital clinicians. In 2016, LAC-EMSA launched a performance improvement project to enhance 911 responses to BHEs. Key changes included revising clinical protocols for mental health emergencies, providing detailed competencies and training in de-escalation, reducing law enforcement involvement, and creating alternate destination protocols. However, policies for patients with SIB remained limited to medical care post suicide-attempt and transport refusal guidelines mirroring NASEMSO guidelines (NASEMSO, 2022).

In January 2024, LAC-EMSA established an ad hoc committee to evaluate the current state of EMS field evaluation and disposition of patients with SIB, and to propose recommendations for improvement and innovation in policy, practices, and training.

Methods

Quality Improvement Approach and Analysis

The LAC-EMSA Ad Hoc Committee on Suicidal Ideation or Behavior was composed of 23 members, including representatives from EMS (paramedics, emergency medical technicians (EMTs), medical directors), law enforcement officers, emergency physicians, psychiatrists, and psychiatric mobile crisis teams. The Committee met quarterly for one year, with monthly working-group meetings guided by a Lean A3 quality improvement (QI) framework to: (1) perform a current state analysis, (2) identify targets for improvement, and (3) develop countermeasures (Lean Enterprise Institute, n.d; Harolds, 2023; Ojo et al., 2022) (see Figure 1).

Current State Analysis

Current state analysis began with a review of NASEMSO guidelines and all California EMS agencies' local policies (n = 34) for suicide-related content (California Emergency Medical Services Authority, n.d.). Findings were cataloged and discussed. The Committee reviewed and discussed two prototype case scenarios involving SIB, using audio recordings within the past two years from EMS clinicians to hospitals that provide real-time medical direction. Observations from each discipline were discussed at Committee meetings. Additionally, the Committee surveyed all LAC EDs (n = 69) by email and telephone to assess suicide screening practices and alignment opportunities with EMS.

Identification of Targets for Improvement

A 13-question survey covering field experience, training, and interventions was sent to 13,983 LAC-EMSA–certified clinicians (8,488 EMTs, 4,618 paramedics, and 877 mobile intensive care nurses) to evaluate frontline EMS perspectives and identify areas for protocol improvement. Responses used a 5-point Likert scale and descriptive analysis was performed in Excel. Findings were reviewed at the committee level to guide potential countermeasures.

To evaluate potential applicability of an evidence-based screening instrument for EMS risk stratification, a subgroup reviewed the characteristics of four that are commonly used in ED settings: Columbia Suicide Severity Rating Scale (C-SSRS), Ask about Suicide Questionnaire (ASQ), Suicidal Behaviors Questionnaire (SBQ), and Patient Health Questionnaire-9 (PHQ-9) (Powsner et al., 2023). Each tool was reviewed for clarity, format, accessibility, risk stratification, age/language options, validated settings, and sensitivity/specificity. Findings were presented to the Committee to develop a consensus recommendation.

Development of Countermeasures

Finally, the Committee reviewed the current state analysis, identified targets for improvement, achieved consensus on

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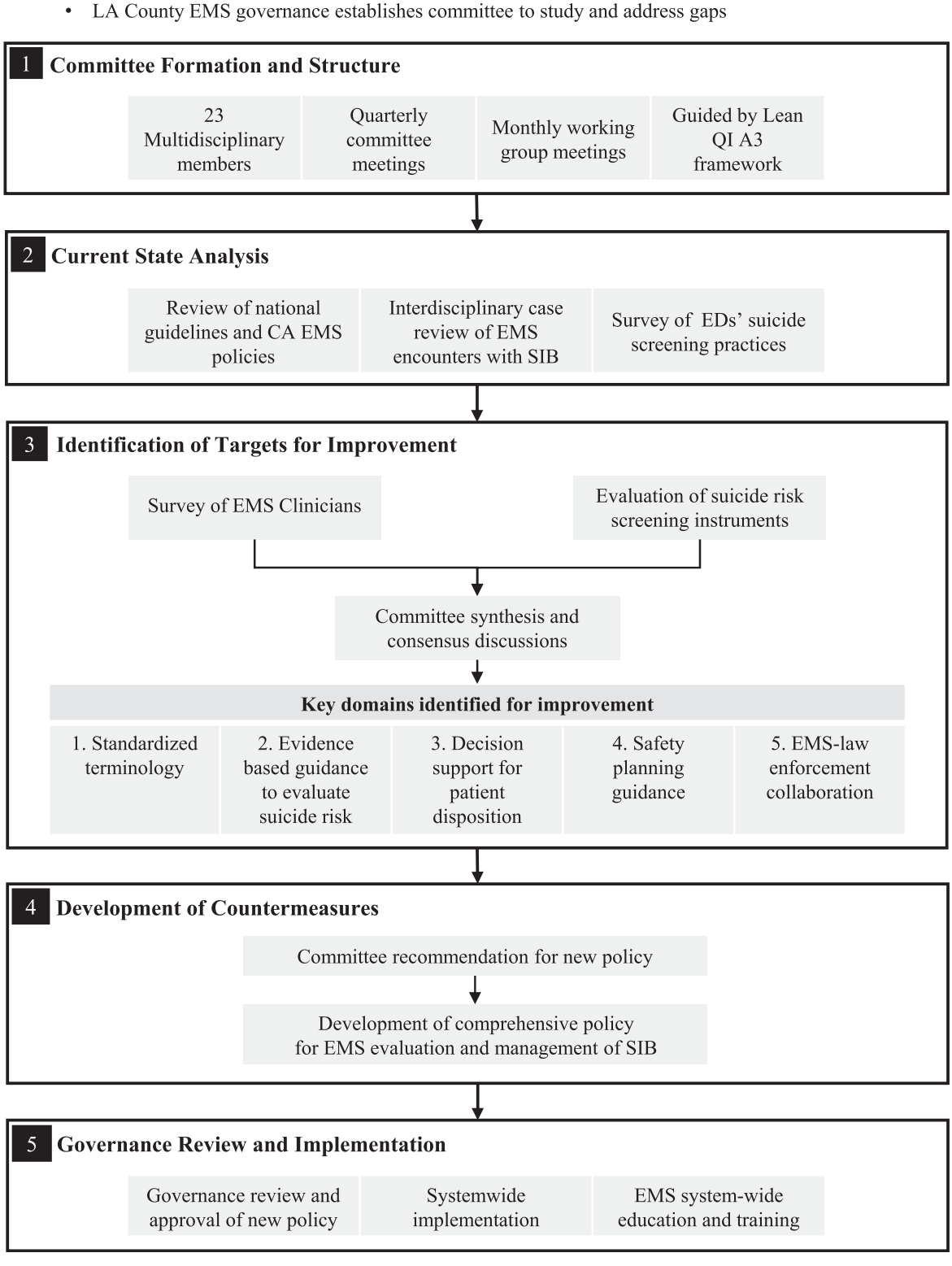

Figure 1. Process map for EMS committee on suicidal ideation or behavior. QI = quality improvement; EMS = emergency medical services; SIB = suicidal ideation or behavior; LA = Los Angeles; CA = California.

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recommendations for countermeasures, and integrated these into a novel policy to improve the EMS care of SIB. Results were presented to LAC-EMS stakeholders and approved by LAC-EMSA governance.

Results

Current State Analysis

National Guidelines and California EMS Agencies' Policy Review

The most recent *National Model EMS Clinical Guidelines* states: "Individuals who have attempted suicide, verbalized suicidal intent, or had other factors that lead EMS clinicians to suspect suicidal intent, should not be regarded as having decision-making capacity and may not decline transport to a medical facility" (The National Association of State Emergency Medical Services Officials, Medical Directors Council, 2022, pp. 23–24). No other clinical guidance is provided. LAC-EMSA's pre-existing policy was modeled verbatim from the national guidelines.

California, which has a population of over 39 million residents, has 34 local EMS agencies that are collectively responsible for one or more of CA's 58 counties; each agency had publicly available policies available for review (California Emergency Medical Services Authority, n.d.). Sixteen (47%) contained content specific to suicide or suicide-related keywords. Twelve of the 16 policies (75%) provided the NASEMSO guidelines verbatim, while the remaining four policies referenced patients who are a "danger to self" in the context of managing patients with agitation and the use of restraints, for example: "Behavioral restraints are to be used only when necessary, in situations where the patient is potentially violent and is exhibiting behavior that is dangerous to self or others. Only reasonable force sufficient to restrain the patient shall be used" (San Joaquin County Emergency Medical Services Agency, 2023, p. 1).

Committee discussions on the NASEMSO guidelines highlighted ambiguity and lack of practical guidance. First, the policy conflates *suicidal intent* and *suicide attempt* with *decisional capacity*. These are not clinically equivalent; the evaluation of decisional capacity is a distinct process across medical and mental health conditions. Additionally, using capacity as the basis for involuntary transport conflicts with state law on psychiatric holds for patients with SIB (Note: There is no *federal* law in the US on involuntary psychiatric holds). California's state law stipulates that a patient can be involuntarily detained if they are a danger to themselves or others due to a mental illness, or they are gravely disabled due to a mental illness or severe substance use disorder (California Welfare and Institutions Code, n.d.). Second, the phrase "other factors that lead EMS clinicians to suspect suicidal intent" was deemed vague. Without clear criteria and training to differentiate levels of suicide risk (e.g., passive vs. active SI, method, plan, means, intent), EMS clinicians are not equipped to reliably assess intent. This results in an overly broad approach where any suicidal presentation is treated as lacking capacity and requiring transport. In summary, the current EMS protocols lack sufficient clinical guidance and conflict with state laws regarding the involuntary detention and transport of patients with SIB.

Case Studies of Sample EMS-to-Base Hospital Call Encounters

When EMS clinicians encounter challenging situations, they may call their base hospital to receive directions and clinical guidance in real-time. These calls are routinely recorded. The committee reviewed two encounters with SIB that were deemed exemplary by EMS agency staff and the committee chair (Box 1). The following observations emerged:

1. Current policy directs EMS to provide immediate medical care for any suicide attempt. EMS' default practice is to transport *all* patients with a suicide attempt or *any* SIB to the ED, but some patients refuse. LE is then asked to assess for an involuntary psychiatric hold (IPH) under California law. If criteria are not met, disposition decisions often stall, with EMS either urging LE to detain or reluctantly leaving the patient in the field.
2. Avoidable ED visits likely occur for patients with SI who are low-risk who could benefit from direct behavioral health linkage, avoiding negative experiences of involuntary transport (potentially in restraints or handcuffs). However, the frequency is difficult to estimate given the lack of any "low risk" screening metrics or documentation.
3. Lack of defined terminology hinders communication; hospital clinicians, who are called by EMS to provide real-time medical guidance, hesitate to rely on EMS and LE assessments of SIB due to unclear communication, training, and evaluation methods.
4. Medical-legal concerns were expressed by all clinical disciplines, particularly the contrasting risks of allowing patients with SIB to refuse transport versus transporting a patient against their will without an IPH.
5. Mobile mental health crisis teams offer trained evaluators with IPH authority and are a preferred responder; however, they lack efficient response times and 24/7 availability.
6. *Alternate destination* protocols to transport a patient with SIB to a psychiatric urgent care center or crisis stabilization unit (i.e., facilities that are not

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Box 1. Sample EMS-to-hospital radio call of a patient with suicidal ideation

EMS contacted a Base Hospital mobile intensive care nurse (MICN) for real-time guidance on a refusal of transport and potential release against medical advice (AMA) of a 54-year-old male with a provider impression of "behavioral with a secondary of overdose of alcohol."

The MICN obtained information from different parties on scene. EMS reported that the patient had stated "suicidal ideation" to family members who had called 9-1-1. When EMS arrived and evaluated the patient "he denied all of it." The MICN requested to speak to the law enforcement officer, who had been the first responder on the scene, who reported that the family had been urging the patient to go to an alcohol rehabilitation program, to which the patient stated he would "rather put a bullet in his head than go to rehab." The MICN then requested to speak to the patient's son who said that the patient was "drinking a lot, breaking down, and saying that he was going to kill himself."

Ultimately, the law enforcement officers determined that the patient did not meet criteria for an involuntary psychiatric hold. EMS urged transport to an ED for further evaluation, but the patient vehemently refused, creating uncertainty about releasing the patient AMA. After much deliberation the MICN agreed to provide medical direction for an AMA release. Before leaving the scene, EMS instructed the patient's son to "call us again if anything gets worse."

emergency departments) are available but are underused due to strict exclusion criteria.

7. No protocols exist for safety planning when patients are not transported.

Survey of LA County Emergency Department Suicide Risk Screening Practices

Fifty-five facilities (55 of 69 total EDs in LAC, 80%) responded to the Committee's inquiry of which suicide risk screening instrument each facility uses. Fifty-two EDs (52 of 55, 95%) utilize the C-SSRS, and 3 (5%) utilize the ASQ or the Patient Safety Screener-3.

Identification of Targets for Improvement

Survey of EMS Clinicians

Six hundred sixty four (664) surveys were initiated by respondents, 10 had missing data resulting in 654 completed surveys for analysis (4.7% response rate, 654 respondents/13,983 survey recipients). By discipline, 344 surveys were completed by EMTs (53%), 219 by paramedics (33%), and 91 by MICNs (14%) (Table 1; Electronic Supplementary Material 1 [ESM 1]). Average completion time was 10 min using a 5-point Likert scale (*strongly disagree* = 1, *disagree* = 2, *neutral* = 3, *agree* = 4, *strongly agree* = 5).

Fifty-nine percent reported formal training on SIB (EMTs 52%, paramedics 61%, MICNs 84%); however, only 38% of EMTs and 36% of paramedics agree or strongly agree that it was adequate (EMT $\mu = 3.07$, *SD* 1.22, $n = 344$; Paramedic $\mu = 3.03$, *SD* 1.23, $n = 219$). Additionally, only 37% of respondents (34% of EMTs, 30% of paramedics, 68% of MICNs) agreed or strongly agreed they had received "adequate written guidance" on the evaluation and management of SIB from their agency or employer ($\mu = 3.02$, *SD* 1.29, $n = 654$).

A large majority of respondents (82%) agreed or strongly agreed that "evaluating and managing patients at risk for suicide is a scenario that warranted improved guidelines and training" ($\mu = 4.29$, *SD* 0.94, $n = 654$). Additionally, 76% agreed or strongly agreed that "patient care would be improved if EMS clinicians were provided with clearly written protocols and education" ($\mu = 4.1$, *SD* 1.03, $n = 654$).

Five proposed interventions were rated highly ($\mu > 4.1$) by all EMS clinicians, specifically: protocols on interacting with LE, safety planning guidance, evidence-based screening questions to help determine risk level, protocols on determining disposition, and defining terminology (Table 1). One proposed intervention, "the ability (for EMS) to place a patient on an involuntary psychiatric hold"

Table 1. Key findings from a survey of LAC-EMS clinicians' perspectives on the evaluation and management of patients with suicidal ideation or behavior

Proposed interventions: "Patient care would be improved if EMS clinicians were provided with…"	*M*[1,2]	*SD*[1,2]	% Agree or strongly agree[1,2]
… clear written protocols on interacting with LE regarding patient at risk for suicide (such as involuntary holds, transportation, and managing interagency disagreements)	4.36	0.87	87%
… clear written protocols on best practices for helping patients and family members to develop a safety plan when the patient is not transported	4.26	0.98	82%
… clear written, evidence-based screening questions that help to determine a patient's level of risk for suicide (ex., low risk, moderate risk, high risk)	4.18	1.02	81%
… clear written protocols on determining the disposition for patients who are at risk for suicide	4.14	1.01	79%
… clear written definitions and education on the terms used to describe the variations in suicidal ideation or behaviors	4.11	1.03	78%
… the ability to place a patient on an involuntary psychiatric hold	3.57	1.41	57%

Note. EMS = emergency medical services; LE = Law enforcement; (1) 5-point Likert scale: 1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, 5 = *strongly agree*; (2) Data reported for all respondents ($n = 654$): EMT = paramedic, and mobile intensive care nurse.

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was notably less favorable, with a mean score of 3.57 (*SD* 1.41, *n* = 654).

Evaluation of Potential Suicide Risk Screening Resources

To evaluate the feasibility of suicide risk screening tools for EMS, the committee reviewed four instruments commonly used in healthcare settings: C-SSRS, ASQ, SBQ-R, and PHQ-9 (Powsner et al., 2023) (ESM 1). C-SSRS uses up to six scripted yes/no questions, offers simple scoring with three risk levels, triage guidance, and is freely available on paper or mobile app. ASQ also uses scripted questions but requires narrative documentation; its complexity and paper-only format reduce usability. ASQ scoring provides three levels of risk (*negative*, *non-acute positive*, and *acute positive*); a nonacute positive screen requires a "brief suicide safety assessment to determine if a full mental health evaluation is needed." SBQ-R includes four questions with multiple-choice answers and a numeric scoring system, making it less

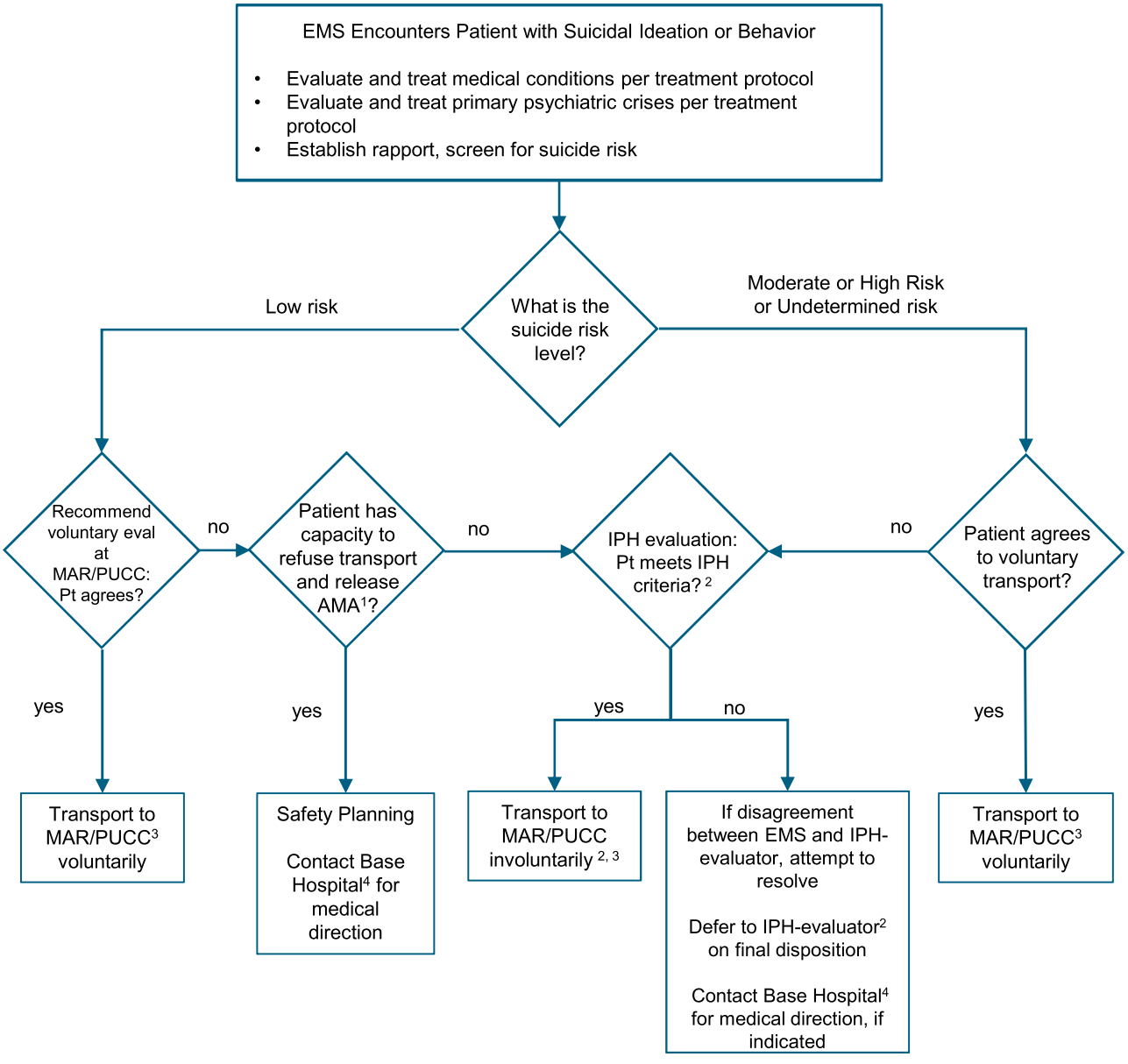

Figure 2. Decision support flowchart for patients with suicidal ideation or behavior. (1) AMA = against medical advice; (2) IPH = involuntary psychiatric hold; involuntary transport may occur via law enforcement or EMS if the patient has been placed on an IPH; (3) MAR = most accessible receiving facility; PUCC = psychiatric urgent care center; (4) Base hospital = an approved acute care facility that is designated to receive calls from EMS provider agencies and provide online medical direction.

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practical for EMS. PHQ-9 was not recommended as it focuses on depression, with only one item on suicidal ideation.

The committee reached consensus that the C-SSRS was the most practical option for EMS, but debated mandating its use due to lack of EMS-specific validation, favoring it as an optional training and guidance tool.

Development of Countermeasures

Committee Recommendations

Based on the current state analysis, the committee recommended that LAC-EMSA develop a new policy for patients with SIB that includes: principles of care; clear definitions of terms describing suicidal ideation or suicidal behaviors; evidence-based guidance for differentiating suicide risk levels; decision-support protocols for patient disposition; safety planning guidance; and best practices for interacting with law enforcement and resolving conflicts.

Policy Development

The Committee developed a novel comprehensive policy, *Evaluation and Care of Patients at Risk for Suicide*, to implement its recommendations (Department of Health Services, LAC EMS Agency, 2025). Key provisions include:

1. **Core principles of care** for patients with SIB, emphasizing that psychiatric emergencies are emergent clinical conditions best managed by trained EMS personnel; and that managing suicidal crises is within the scope of EMS practice.
2. **Definitions of key terms**, such as suicide risk screening, assessment, suicidal ideation (passive/active), method, intent, plan, attempt, suicidal behaviors, safety planning, decision-making capacity, and terminology related to IPHs (Crosby et al., 2011).
3. **Guidelines for patient evaluation**, including:
   - Building rapport and eliciting key clinical information on SIB (e.g., passive or active SI, method, intent, plan, attempts). The C-SSRS is recommended as a reference but not required.
   - Assessing reliability of information, obtaining collateral information from key third parties, and evaluating decision-making capacity per appropriate policy.
4. **Disposition guidance** based on suicide risk level (Figure 2), including alternate destination protocols where appropriate.
5. **Safety planning guidance**, including connecting patients to mental health services, engaging supportive third parties, reducing access to lethal means (especially firearms), and avoiding substance use.
6. **Guidance for EMS interactions with law enforcement and IPH evaluators**, deferring to state laws on involuntary detention and transport.
7. **Escalation pathways** for resolving conflicts between EMS and IPH evaluators.

A decision-support flowchart (Figure 2) was created to assist with disposition. Patients at moderate or high risk – or when risk is unclear – who refuse voluntary transport should be evaluated by an IPH-authorized clinician. If disagreement persists, final disposition defaults to the IPH evaluator per state law. The use of restraints is addressed in existing protocols and should only be used when clinically necessary, after less restrictive measures fail.

Low-risk patients with decision-making capacity who do not meet IPH criteria may decline transport; EMS should provide safety planning with Base Hospital support as needed.

The policy was reviewed by LAC-EMSA committees, endorsed by the governing body in January 2025, and implemented systemwide on July 1, 2025.

Discussion

As part of a comprehensive effort to improve the 911 EMS response to BHEs that began in 2016, the LAC-EMSA identified significant gaps in protocols for evaluating and managing SIB (Cheung et al., 2024). A multidisciplinary committee was convened to review current practices using a QI framework. Analysis of NASEMSO model guidelines, commonly adopted by California's EMS agencies, revealed that existing protocols lacked clarity and sufficient scope. The Committee's review of case scenarios highlighted challenges with the current state of defaulting to transport all patients with SIB to EDs, complications when patients refuse transport, and communication gaps among providers.

A countywide EMS clinician survey confirmed the need for clearer protocols, education, and training, and informed the development of a comprehensive policy addressing major areas of need. Chief among these was establishing improved decision-support criteria for involuntary detention and transport. The new policy aligns EMS practices with California law, which grants authority for involuntary psychiatric holds (IPH) to law enforcement (LE) and designated mental health professionals (California Welfare and Institutions Code, n.d.). In LAC, EMS personnel are not authorized IPH-evaluators, although this may vary in other jurisdictions or countries. Ultimately, when a patient has been evaluated by an authorized IPH-evaluator, that evaluation takes precedence in determining whether a patient can be detained and transported involuntarily. This clarification in policy marks a significant shift from prior practice

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and acknowledges that some patients with SIB will *not* meet detention or transport criteria. Importantly, the new policy provides guidance on safety planning with the patient and key third parties to reduce suicide risk, drawing from current best practices.

Concerns were raised about the expanded knowledge required for EMS clinicians and limited training time. However, these were outweighed by recognition of the high frequency of SIB encounters and strong clinician support for improved protocols. Some committee members argued suicidal crises fall outside EMS scope and should remain under LE purview, but others countered that this perpetuates stigma and reinforces the criminalization of mental illness – an approach associated with negative patient experiences (Britton et al., 2025; Kaltiala-Heino et al., 1997). LE officers have noted that their on-scene priority is determining whether criminal activity has occurred (Cheung et al., 2024), and emerging trends to disengage from non-criminal mental health calls risk leaving individuals without support (La, 2025; Scott v. Smith, 2024; Romney, 2025). The committee emphasized the principle that psychiatric emergencies, including SIB, are clinical conditions best managed by trained EMS personnel.

For many patients with SIB, EDs may offer limited therapeutic benefit, including inconsistent access to mental health specialists. Alternate destinations – such as psychiatric urgent care centers, crisis stabilization units, or behavioral emergency units – were strongly favored but remain limited by geographic availability and strict inclusion criteria. California's 2020 regulatory changes enabling alternate destination transport present opportunities to revisit these criteria as systems gain experience (State of California Emergency Medical Services, Health and Human Services Agency, 2020). Addressing EMS reimbursement models for alternate destinations at state and federal levels is also critical to improving access.

Limitations

There are important limitations to this policy initiative. Several strategies to analyze the current state were deployed within the QI framework, including case studies and surveys, and each approach may benefit from further study or replication with a research approach. The scope was limited to Los Angeles County, a large metropolitan EMS system with resources that may differ from other jurisdictions, impacting generalizability. Policy review was restricted to California EMS agencies and national EMS guidelines; other US or international agencies or governments may provide comprehensive guidance on SIB, though none was identified in published literature. While this initiative succeeded under the localized governance of the US EMS system, it may not be generalizable to other countries. The QI approach used within this initiative may be nonetheless applicable, and an evaluation of the current state should include careful consideration of any existing national healthcare policies and statutory frameworks that govern EMS protocols for SIB. A comparison of policies on SIB that may exist within other countries is a valuable area of future inquiry.

A key caveat is the absence of validated suicide risk screening tools for the EMS environment. While the new LAC-EMSA policy does not mandate the use of a specific evidence-based instrument, it endorses the C-SSRS as a practical guide consistent with regional ED practices. Feasibility and operationalization of C-SSRS – or any tool – by EMS require further study. Similarly, while the policy aims to improve training, inter-agency communication, and patient care (including reducing unnecessary ED visits), its effectiveness is pending evaluation. Additionally, because this QI initiative focused specifically on assessing current clinical practices to develop new guidance and policy, it did not include the patient or family perspective. Fully understanding the patient experience within the 911 and EMS systems is critical and warrants further study.

Finally, regional 911 systems may consider increasing mobile mental health crisis team availability, as they provide a distinct advantage of having specialized mental health clinicians for suicide risk screening and assessment and the authority to place an IPH. However, these teams face challenges in providing 24/7 coverage and scaling across LAC's vast geography. Regardless of future developments, EMS is expected to continue to remain a cornerstone of the 911 response for patients with SIB.

Conclusion

LAC-EMSA's quality improvement initiative analyzed the current state of the evaluation and management of patients with SIB, identified targets for improvement, and resulted in the development of new policy and procedures for EMS in a large urban metropolis.

Electronic Supplementary Material

The following electronic supplementary material is available at https://doi.org/10.1027/0227-5910/a001074

ESM 1. Survey of EMS providers experiences and perspectives on the evaluation of patients at risk for suicide.

ESM 2. Committee review of suicide risk screening instruments for potential EMS use.

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validation. Richard Tadeo: project administration, validation. Denise Whitfield: writing – original draft, writing – review & editing, investigation, supervision.
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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

September 17, 2026

VIA-EMAIL

TO: Distribution

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

SUBJECT: **STEMI AND PEDIATRIC REFERRAL HOSPITAL REQUIREMENTS EFFECTIVE OCTOBER 1, 2026**

Effective October 1, 2026, general acute care hospitals that are not locally designated as specialty receiving centers must meet the applicable requirements of the California Code of Regulations, Title 22, Division 9, Chapter 6, Critical and Specialty Care Programs. These requirements are outlined in §100147.01, STEMI Referring Hospitals and §100159.01, General Acute Care Hospitals Not Designated as a Pediatric Receiving Center (PedRC).

Details are available on the California Emergency Medical Services Authority's regulations webpage at https://www.emsa.ca.gov/caemsa?id=regulations.

To emphasize timely STEMI care, STEMI Referral Hospitals should prioritize rapid transfer to a STEMI Receiving Center for primary percutaneous coronary intervention (PCI) within 120 minutes and have transfer agreements to support this goal. When this timeframe cannot be achieved, hospitals should consider thrombolytic therapy for qualifying patients and have established policies and procedures.

To support hospitals in meeting EMS system expectations, the Los Angeles County Emergency Medical Services (EMS) Agency initiated Technical Assistance Surveys this year. These surveys introduce the EMS Agency team, establish reliable points of contact with key emergency department (ED) personnel, share available EMS system resources, and review hospital processes to ensure alignment with EMS Agency policies.

The EMS Agency will continue conducting Technical Assistance Surveys every three years and will incorporate verification of compliance with these new state requirements into the survey process.

For more information, please contact Ami Boonjaluksa, Chief Hospital Programs at ABoonjaluksa2@dhs.lacounty.gov or (562) 378-1596.

NB:jr:ab

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

September 21, 2026

TO: Distribution **VIA E-MAIL**

FROM: Richard Tadeo
Director

SUBJECT: RONALD REAGAN UCLA DESIGNATED HYPERBARIC CHAMBER

Ronald Reagan UCLA Medical Center's (UCL) hyperbaric chamber is approved to receive patients with onshore decompression emergencies or when the Catalina Hyperbaric Chamber is offline. Effective **October 1, 2026**, patients with suspected decompression emergencies may be transported to UCL. Attached is Reference No. 518, *Decompression Emergencies / Patient Destination*, for additional information.

For questions, please contact Ami Boonjaluksa, Chief of Hospital Programs at (562) 378-1596.

Attachment

Distribution: Medical Director, EMS Agency
Fire Chief, Each Fire Department
Paramedic Coordinator, Each Provider Agency
Prehospital Care Coordinator, Each Base Hospital
Base Hospital Medical Director, Each Base Hospital
Nurse Educator, Each Fire Department
Medical Alert Center
EMS Commission
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RT:ab:jr

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

COUNTY OF LOS ANGELES
Public Health

September 28, 2026

TO: Los Angeles County Skilled Nursing and Subacute Care Facilities

FROM: Richard Tadeo, RN
Director, Emergency Medical Services Agency

Muntu Davis, MD, MPH
Los Angeles County Health Officer

RE: LOS ANGELES COUNTY LONG TERM CARE MUTUAL AID PROGRAM (LTC-MAP) FOR EVACUATION AND RESOURCES/ASSETS

Los Angeles County is partnering with skilled nursing and subacute care facilities to help strengthen emergency preparedness and response capabilities through the Long-Term Care Mutual Aid Program (LTC-MAP). This initiative, which is being coordinated by the Los Angeles County Department of Public Health and Emergency Medical Services (EMS) Agency, in partnership with the California Association of Health Facilities (CAHF), LeadingAge California, and the County's Long-Term Care Ombudsman Program is designed to help skilled nursing facilities protect residents and staff, maintain continuity of operations, and coordinate effectively during emergencies and disasters.

Emergencies place sudden demands on long-term care facilities. We strongly encourage every facility to participate in this important project. Participation helps facilities prepare for these operational demands before an incident occurs and establishes a coordinated system for mutual assistance when normal resources are insufficient and strengthens the overall long-term care response.

Action Step: Please identify an administrator, emergency preparedness coordinator, or clinical leader who will serve as your facility's primary contact for LTC-MAP activities and respond promptly when outreach begins.

PREPAREDNESS SITE VISITS

Over the next two months, an additional thirty skilled nursing facilities will receive site visits focused on emergency plans, evacuation and shelter-in-place procedures, resident movement, transportation needs, communications, staffing, resource management, and continuity of operations. These visits will identify practical actions to improve readiness for both facility-specific emergencies and large-scale incidents affecting multiple long-term care providers and provide actionable steps to enhance preparedness. Additional funding is being pursued to extend onsite assistance, tools, training, and exercises to all 371 facilities in Los Angeles County.

COORDINATED EMERGENCY RESPONSE

A LTC Coordination Group has been established and is being trained to support information sharing and operational coordination across the long-term care sector during emergencies. This Group includes long-term care representatives, professional associations, the Ombudsman's Office, and partner agencies and will coordinate with the Los Angeles County Medical and Health Operational Area Coordinator (MHOAC) to help identify affected facilities, prioritize unmet needs, coordinate available resources, and support resident evacuation and placement.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

COUNTY OF LOS ANGELES
Public Health

FACILITY ENGAGEMENT AND SCHEDULING

The County has engaged Global Readiness Partners and Jensen Hughes to support program design and conduct the site visits. Their teams have experience developing and implementing long-term care mutual aid programs and will work directly with participating facilities to assess readiness and strengthen response procedures. Jensen Hughes may contact your facility by email or telephone to schedule a visit. Please ensure your designated administrator, emergency preparedness coordinator, or clinical leader responds promptly and participates in the onsite review.

READINESS AND REGULATORY ALIGNMENT

LTC-MAP supports the core capabilities required for effective emergency preparedness – planning, policies and procedures, communications, training, testing, and coordinated response. While participation may also support compliance with applicable elements of the Centers for Medicare & Medicaid Services Emergency Preparedness Rule, it is not a replacement for individual facility emergency plan or compliance with regulatory responsibilities. This pilot is designed to strengthen these efforts by connecting individual facility plans to a broader system of mutual aid and countywide coordination.

Your active participation is essential to building a reliable long-term care emergency response network. By preparing together before the next emergency, we can improve coordination, reduce delays, preserve continuity of operations, and help protect residents and staff throughout Los Angeles County. Participation reinforces a coordinated countywide approach that benefits all facilities.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

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First District

Holly J. Mitchell
Second District

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Third District

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Fourth District

Kathryn Barger
Fifth District

Richard Tadeo
Director

Nichole Bosson, MD, MPH
Medical Director

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

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

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

October 8, 2026

TO: Distribution **VIA-EMAIL**

FROM: Richard Tadeo
Director

SUBJECT: **NAME UPDATE FOR CATALINA ISLAND MEDICAL CENTER**

Effective Monday, **October 19, 2026 at 0700,** Catalina Island Medical Center name will be updated to **Catalina Island Health** in Reddinet® and all EMS Agency databases. The 3-letter hospital identification code will remain as AHM.

Please update all systems and ensure personnel are notified of the name update.

If you have any questions, please contact Ami Boonjaluksa, Chief Hospital Programs at (562) 378-1596 or ABoonjaluksa2@dhs.lacounty.gov.

RT:jr:ab
10-05

Distribution:
Medical Director, EMS Agency
Fire Chief, All Public Provider EMS Agencies
Paramedic Coordinators, All Public Provider EMS Agencies
Nurse Educators, All Public Provider EMS Agencies
CEO, All Licensed Private Ambulance Providers
Paramedic Coordinator, All Licensed Private Ambulance Providers
CEO, All 9-1-1 Receiving Hospitals
ED Medical Director, All 9-1-1 Receiving Hospitals
ED Clinical Director, All 9-1-1 Receiving Hospitals
Medical Director, All Paramedic Base Hospitals
Prehospital Care Coordinators, All Paramedic Base Hospitals
Medical Alert Center
ReddiNet®
Hospital Association of Southern California
EMS Commission

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
(562) 378-1500

Richard Tadeo, RN
Director

Nichole Bosson, MD
Medical Director

November 4, 2026

BY EMAIL

TO: Distribution

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

SUBJECT: EXPANSION OF LA-DROP PILOT TO EL MONTE

This is to notify you that Los Angeles County Fire Department (LACoFD), in collaboration with Pomona Valley Medical Center and LA General Medical Center, will be expanding units participating in the Los Angeles Development & Rapid Operationalization of Prehospital Blood (LA-DROP) Pilot effective immediately.

Squad 167 joins the previously participating LACoFD participating units and other provider agencies listed below. 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 10	s167
LA County Fire Battalion 20	s14, s171, s172, s173
Compton Fire	All Units
Pasadena 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 over 90 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 is 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 additional background on the LA County prehospital blood transfusion pilot, including the training program and its rationale, please view this video https://vimeo.com/1062996337 and refer to the attached Facts and Questions for further details.

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; and 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
Director of Operations, EOA Provider Agencies
Medical Director, Paramedic Base Hospitals
Prehospital Care Coordinator, Paramedic Base Hospitals
Chief Executive Officers, 9-1-1 Receiving Hospitals
ED Managers, 9-1-1 Receiving Centers
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

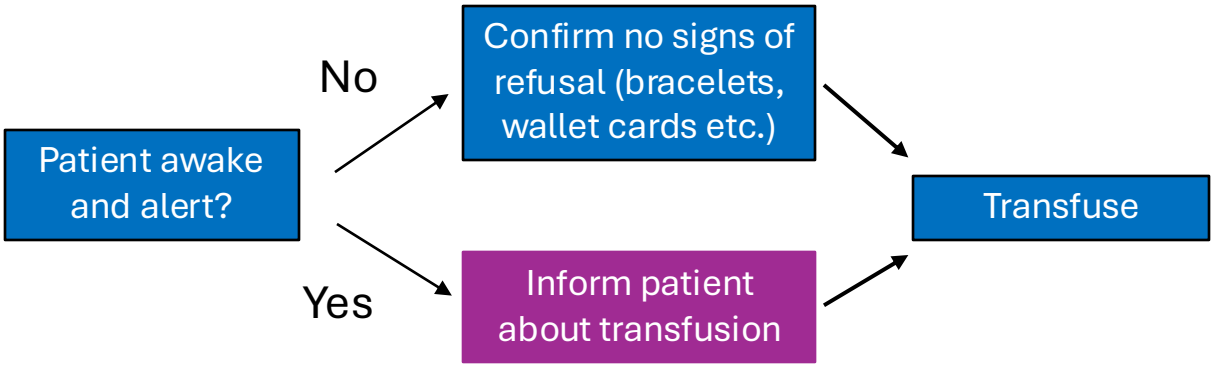
Pediatric patient (≤14 years or on length-based tape)
Traumatic arrest not witnessed by EMS
Isolated head injury and/or ground level falls
Patient refusal

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