COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 347-1604 FAX (562) 941-5835
http://.ems.dhs.lacounty.gov/

DATE: **March 18, 2015**

TIME: **1:00 – 3:00 pm**

LOCATION: **Los Angeles County EMS Agency**
10100 Pioneer Blvd.
EMS Commission Hearing Room – 1st Floor
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 Commission Chair as time permits.
NOTE: Please SIGN IN if you would like to address the Commission.

AGENDA

CALL TO ORDER – Clayton Kazan, M.D., Chairman

INTRODUCTIONS/ANNOUNCEMENTS

CONSENT CALENDAR (Commissioners/Public may request that an item be held for discussion.)

1 MINUTES
- January 21, 2015

2 CORRESPONDENCE
- 2.1 March 4, 2015, fire Chief/Chief Executive Officer, Each 9-1-1 Provider Agency and Each 9-1-1 EOA Provider Agency: Request For Application For Emergency Medical Care Enhancement Program
- 2.2 February 18, 2015, Distribution: Countywide Sidewalk Cardiac Resuscitation Day – June 4, 2015
- 2.3 February 9, 2015, Doug Cain, President, Antelope Ambulance: Approval Letter ALS Unit RA 125
- 2.4 February 5, 2015, Chief Executive Officer 9-1-1 Receiving Hospital: Emergency Department Impact Survey (Request for 2014 Data)
- 2.5 February 5, 2015, California Emergency Medical Services Authority: State California Initiative to enable secure access to medical information by medical professionals and first responders following a natural or manmade disaster
- 2.6 February 5, 2015, William Racowschi, Fire Chief, Torrance Fire Department: New Unit Authorization – RA 91 and RA 93
- 2.7 January 29, 2015, Kelvin Carlisle, President, Liberty Ambulance: New ALS Unit Approval

(Correspondence continued)

2.8 January 29, 2015, Antonio Liu, M.D., Stroke Medical Director, White Memorial Medical Center: Reference Number 521, Stroke Patient Destination
2.9 January 15, 2015, Ziba Chavoshi, M.D., Medical Director, Gentle Ride, Inc.: Request for Variation in Reference No. 713, Respiratory Care Practitioner Staffed Critical Care Unit Inventory

3. COMMITTEE REPORTS
3.1 Base Hospital Advisory Committee
3.2 Data Advisory Committee
3.3 Education Advisory Committee
3.4 Provider Agency Advisory Committee

4. POLICIES
4.1 Reference No. 519-Management of Multi Casualty Incidents
4.2 Reference No. 806.1-Procedures Prior to Base Contact (Field Reference)
4.3 Reference No. 834-Patient Refusal of Treatment or Transport
4.4 Reference No. 1200-General Instructions for Treatment Protocols
4.5 Reference No. 1251-Treatment Protocol: Stroke/Acute Neurological Deficits **(Info)**
4.6 Reference No. 1275-Treatment Protocol: General Trauma
4.7 Reference No. 1314-Medical Control Guideline: Traumatic Hemorrhage Control

5. BUSINESS
Old:
5.1 Community Paramedicine *(July 18, 2012) - Todd Lagassick, UCLA*
5.2 Wall Time *(July 17, 2013) (Attachment) - Cathy Chidester, EMS Agency*
5.3 1+1 Paramedic Staffing Model *(November 21, 2012) - Cathy Chidester*
5.4 911 EMS Provider Ebola Virus Disease (EVD) Patient Assessment and Transportation Guidelines *(November 19, 2014 - Roel Amara, EMS Agency*

6. COMMISSIONERS COMMENTS/REQUESTS

7. LEGISLATION - Cathy Chidester

8. EMS DIRECTOR'S REPORT - Cathy Chidester

9. ADJOURNMENT
(To the meeting of May 20, 2015)

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 noncompliance exists.

CONSENT CALENDAR
March 18, 2015

1. **MINUTES**
   - January 21, 2015

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3. **COMMITTEE REPORTS**

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   3.2 Data Advisory Committee
   3.3 Education Advisory Committee
   3.4 Provider Agency Advisory Committee

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Los Angeles County
Board of Supervisors

Gloria Molina
First District
Mark Ridley-Thomas
Second District
Zev Yaroslavsky
Third District
Don Knabe
Fourth District
Michael D. Antonovich
Fifth District

Commissioners
Mr. David Austin
LA County Ambulance Association
Chief Robert E. Barnes
Los Angeles County Police Chiefs Assn.
Mr. Frank Binch
Public Member (4th District)
Erick H. Cheung, M.D., Vice Chair
Southern CA Psychiatric Society
Robert Flashman, M.D.
LA County Medical Association
Clayton Kazan, M.D., Chair
California Chapter-American College of Emergency Physicians (CAL-ACEP)
James Lott
Public Member (2nd District)
Chief Raymond A. Mosack
CA State Firefighters' Association
Mr. Daryl Parrish
League of Calif. Cities/LA County Division
Margaret Peterson, Ph.D.
Hospital Association of Southern CA
Capt. Andres Ramirez
Peace Officers Association of LA County
Nerses Sanossian, MD, FAHA
American Heart Association Western States Affiliate
Carole A. Snyder, RN
Emergency Nurses Association
Chief Jon D. Thompson
LA Chapter-Fire Chiefs Association
Areti Tillou, M.D.
LA Surgical Society
Mr. Gary Washburn
Public Member (5th District)
Mr. Bernard S. Weintraub
Southern California Public Health Assn.
VACANT
Public Member (1st District)
Public Member (3rd District)

Executive Director
Cathy Chidester
(562) 347-1604
cchidester@dhs.lacounty.gov

Commission Liaison
Marilyn Rideaux
(323) 890-7392
mrideaux@dhs.lacounty.gov

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EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
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MINUTES
JANUARY 21, 2015

COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
* David Austin	LAC Ambulance Assn	Richard Tadeo	Asst. Dir, EMS Agency
☑ Robert Barnes	LAC Police Chiefs Assn	Marilyn Rideaux	EMSC Liaison
* Frank Binch	Public Member, 4th District	Bill Koenig, MD	Med. Dir., EMS Agency
☑ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Lucy Hickey	Staff, EMS Agency
* Robert Flashman, M.D.	L.A. County Medical Assn	John Telmos	"
☑ James Lott	Public Member, 2nd District	Jacqueline Rifenburg	"
☑ Clayton Kazan, M.D.	CAL/ACEP		
☑ Ray Mosack	CA State Firefighters' Assn.		
* Daryl Parrish	League of California Cities		
☑ Margaret Peterson, Ph.D.	HASC		
☑ Andres Ramirez	Peace Officers Assn. of LAC		
* Nerses Sanossian, M.D.	American Heart Assn.		
☑ Carole Snyder	Emergency Nurses Assn.		
* Jon Thompson	LA Chapter/Fire Chiefs Assn		
☑ Areti Tillou, M.D.	L.A. Surgical Society		
☑ Gary Washburn	Public Member, 5th District		
* Bernard Weintraub	S. CA Public Health Assn.		

GUESTS

Mike Sargeant	Long Beach Fire Dept.	Jeff Elder	Los Angeles Fire Dept.
Samantha Verga-Gates	APCC-LA County & LBMMC	David Segura	Long Beach Fire Dept.
Richard Roman	Compton Fire Dept.	Victoria Hernandez	LAC Fire Dept.
Lilian Russell	L.A. County Counsel	Dwayne Preston	Long Beach Fire Dept.
Mike Barilla	Pasadena Fire Dept.	Dave Molyneux	Trans Life Ambulance

(Ab) = Absent; (*) = Excused Absence

CALL TO ORDER:

The Emergency Medical Services Commission (EMSC) meeting was held in the EMS Commission Hearing Room, 10100 Pioneer Blvd, Santa Fe Springs, 90670. The meeting was called to order at 1:07 PM by Chairman, Raymond Mosack. A quorum was declared.

INTRODUCTIONS/ANNOUNCEMENTS:

- Chairman Mosack introduced a new Commissioner representing the Hospital Association of Southern California, Margaret R. Peterson, Ph.D.

- Dr. William Koenig, Medical Director, EMS Agency, announced his upcoming retirement from Los Angeles County. Dr. Koenig stated that Dr. Nicole Bosson, an EMS Fellow, will be the Assistant Medical Director for the time being until the position of EMS Medical Director is filled. Commissioner Lott expressed gratitude for Dr. Koenig's 25 years plus service to the County.

CONSENT CALENDAR:

Chairman Mosack called for a Motion to approve the Consent Calendar.

Motion by Commissioner Kazan/Snyder to approve the Consent Calendar with no exclusions. Motion carried unanimously

5. BUSINESS (Old Business)

5.1 Nominating Committee Report

The Nominating Committee consisted of Commissioner Robert Barnes and Commissioner Daryl Parrish. Commissioner Barnes reported that the Committee met and recommends Commissioner Clayton Kazan for Chairman and Commissioner Erick Cheung for Vice Chairman for the 2015 year. Chairman Mosack called for any additional nominations from the Floor. There were none.

Motion by Commissioner Barnes/Washburn to accept the recommendations of the Nominating Committee. Motion carried unanimously.

Commissioner Ray Mosack then vacated the Chair's seat and newly elected Chairman Clayton Kazan took over the meeting.

5.2 Community Paramedicine

Richard Tadeo, Assistant Director-EMS, reported that the training of paramedics for this approved pilot project should start by the end of January. The steering committee is still meeting monthly to hash out the details of the program.

Q. (Commissioner Lott): What is the process for this project?
A. (Richard Tadeo): There are two pilot projects approved for L.A. County, Alternate Care Destinations (urgent care centers) and Cardiac Heart Failure Patients – follow-up evaluation by paramedics. The project is expected to last two years.

Action: Commissioner Snyder commented that the EMSC had requested that CLA give an update on the training curriculum at its last meeting.
Responsibility: EMS Agency

Q. (Commissioner Peterson): Does the grant cover the cost of training in its entirety?
A. (Richard Tadeo): No. UCLA has been soliciting for funding.

5.3 Wall Time

Richard Tadeo reported that last steering committee meeting was cancelled so there was no update. The committee is scheduled to meet in March.

Q. (Commissioner Lott): What is the objective of the Wall Time committee?
A. (Richard Tadeo): A statewide steering committee was formed to discuss and define wall time, specifically when it starts and ends.

Q. (Commissioner Peterson): Are all the providers required to buy a standard electronic system because it will be challenging if there is no standardized tool to capture this data.
A. It will be challenging

5.4 Active Shooter

Richard Tadeo reported that the Statewide Committee met today to determine the educational component. A report will be provided at the next meeting.

Q. (Commissioner Lott): What will the Statewide Committee be working on and what are we expecting to happen?
A. (Richard Tadeo): The State Committee was formulated to provide a forum for stake holders to collaborate in further defining Tactical EMS activities in the State.

Commissioner Lott requested additional information and background on the standing agenda items listed under Old Business to better understand what has gone on historically and the goal of having these items on the EMSC agenda.

5.5 1 + 1 Paramedic Staffing Model

Richard Tadeo reported that Long Beach Fire Department is now in the 7th month of the pilot project. Prior to the November 2014 meeting, the EMS Agency had requested corrective action from Long Beach because they had not met one of Reference 407 requirements related to the time lapse between first paramedic arrival and second paramedic arrival on scene. LB submitted a corrective action plan by adding three basic life support units. In October they were at 76% and then in November, 82% of the time meeting the standard. Data received by the EMS Agency yesterday indicates they were only compliant 84.6% of the time. The policy requires that the second paramedic arrive on-scene within three minutes of the first paramedic's arrival 95% of the time.

Q. (Commissioner Tillou): How much time will lapse before we say they have had enough time to correct the standard?
A. (Richard Tadeo): There is no timeline established at this time.

Q. (Commissioner Kazan): How does the use of BLS units improve ALS response?
A. (Chief Mike Sargeant-LBFD): Responded that Long Beach was trying to keep ALS units available for ALS calls by adding more BLS units. He stated that in the two years Reference 407 was being reviewed, the standard about the three minute arrival on scene of the second paramedic was not stipulated in the draft policy and that it was not included until the final draft came out. He went on to say that there is no basis for the requirement and no other provider is held to the requirement. He also stated that there is no provider in Los Angeles County that could meet the requirement. He added that Long Beach Fire will never meet the 95% requirement as stated in Reference 407. There will have to be a rescue in every corner to meet this requirement. Before the pilot project started, half of the units were PAUs (paramedic assessment units) and during the pilot project all the units are PAUs. "We are getting paramedics on scene 50 seconds faster than prior to the study." He reported that there was an average of under two minute variance between arrival of the first and second paramedic on scene. He also reported that there has been an increase in the ROCS (return of spontaneous circulation) since the start of the pilot project.

Q. (Commissioner Peterson): How long is the pilot project and is there any preliminary data?
A. (Chief Sargeant): The pilot is for two years and the data has been provided to the DSMB.

For the benefit of the new Commissioners, Richard Tadeo explained the difference between a paramedic assessment unit (PAU) as opposed to the RMD proposed by Long Beach Fire, gave an overview of Governance Committee, explained the three minute standard of Reference No. 407 that was being debated, and the function of the Data Safety Monitoring Board.

Q. (Commissioner Peterson): Does Long Beach face a termination of the study based on Reference 407?
A. The EMS Agency will continue to monitor the impact of the corrective action plan.

Q. (Commissioner Peterson): What is the purpose of the two vehicles?
A. (Chief Sargeant): It increased the number of rescues from 8 to 11 and put a paramedic on every engine company to get ALS level care sooner by spreading the paramedic resources throughout the city.

Commission Kazan stated that although the 3 minute requirement is not based on literature it is in the policy and the Commission needs to address it when it is not being met.

Dr. Koenig reminded the Commission that the pilot study is not going to change much of the medical outcome but there certainly is a perception by the public that two paramedics are better than one. If only one paramedic is initially sent then it is important on how soon the second paramedic gets there. The Union also had issues on going from two to one paramedic. Dr. Koenig also addressed Commissioner Binch's prior request to conduct a literature search on the impact of a 3 minute time frame. There are no studies that address this issue.

Commissioner Lott commented that it is the perception that bothers him. He stated that it is a Union issue and wants the ability to talk openly about the issue. He wants the EMS Agency to provide a staff report without couching the language because of concerns about the Union and provide data on the issues.

Dr. Koenig also elaborated on the plan to conduct a post study interview to identify issues related to worker satisfaction.

Q. (Commissioner Kazan): Long Beach has indicated that they will never reach the 95% standard, what impact does this have on whether the study continues or not? Who makes that decision?

A. (Richard Tadeo): Cathy Chidester and Dr. Koenig are the final decision makers on whether the study should continue. The Data Safety Monitoring Board has advised the EMS Agency that there is no degradation in patient care and indicated that there is no reason to stop the project at this time. In order to maintain the integrity of the study, the EMS Agency was also advised not to release any preliminary data.

Q. (Commissioner Lott): Asked Chief Sargeant what he would recommend as substitute to the three-minute arrival standard.

A. (Chief Sargeant): Consider the average variance time between arrival of first and second unit, whether there is any degradation in the overall patient care, and how soon the first unit arrives.

Commissioner Lott asked if the EMS Agency and the EMSC could address this issue. Richard Tadeo stated that the EMSC had already revised the standard in Reference No. 407, which requires patient data to be captured electronically and now Long Beach is asking that the policy be revised again to eliminate the three minute standard between first and second paramedic arrival. Commissioners Lott, Snyder, and Tillou indicated being in favor of eliminating this standard if there was not threat to patient safety. Commissioner Barnes and Peterson felt that the standard should not be removed. Chief Sargeant stated that Long Beach Fire would continue to strive to increase its percentage of time the second unit arrives within three minutes although they do not expect to meet the Reference No. 407 standard of 95% compliance. Commissioner Lott asked why

Long Beach did not believe it could meet the standard. Chief Sargeant replied that Long Beach would have to radically increase the number of units and that is not economically possible. Commissioner Lott stated that he did not accept that response and wanted to see some budget data from Long Beach Fire to substantiate not being able to add more units.

Motion by Commissioner Lott, Second by Commissioner Snyder to defer any penalties imposed on the non-compliance of Long Beach Fire Department in meeting the requirement that One-Plus-One staffed ALS units arriving at the scene of an incident within three minutes of each other 95% of the time and that LBFD report back with calculated budget driven data as to why they cannot provide more units.

5.6 9-1-1 EMS Provider Ebola Virus Disease (EVD) Patient Assessment and Transportation Guidelines

The EMS Agency worked with Public Health and the 9-1-1 providers to develop a patient assessment algorithm as well as transport guidelines for potential Ebola patients. The information has been published and distributed to provider agencies. Each 9-1-1 EOA ambulance provider has identified an appropriate vehicle for transport of potential Ebola patients resulting in seven designated vehicles. Los Angeles City has also designated vehicles for Ebola patient transport.

Q. (Commissioner Snyder): Has there been any further discussion/decision regarding the destination of Ebola patients?
A. (Dr. Koenig): Although there is not specific policy in place to have paramedics transport Ebola patients to designated centers, Public Health is currently making the determination on patient destination based on the patient history and risk for having Ebola.

Q. (Commissioner Lott): What is the difference between California and Federal Government guidelines policy on designation centers?
A. (Dr. Koenig): We don't have an answer for that.

Commissioner Peterson stated that the algorithm was confusing because patients are being picked up by paramedics, delivered to the nearest hospital and then the hospital is responsible for contacting Public Health for a designation center for the patient. Dr. Koenig stated that the CDC requires every hospital to be able to do the initial evaluation of these patients. Commissioner Lott recommended that the EMSC send a letter to the Board of Supervisors asking them to urge the State to establish a clear line of communication with the Federal Government on directives related to dealing with potential Ebola patients.

M/S/C: Commissioner Lott/Washburn to send a letter to the Board of Supervisors to request that they ask the State and Federal governments to supply clear protocols for transporting and handling of possible Ebola patients that arrive at the ER.

Action: Draft a letter to the Board of Supervisors
Responsibility: EMS Agency

5.7 The Brown Act - Conducting Public Meetings Update

Marilyn Rideaux reported that a conference call was held between Ms. Lillian Russell, Deputy County Counsel, Cathy Chidester, EMS Director, and herself to discuss Brown Act when there is no quorum. During the conference call, Ms. Russell explained the options available when there is no quorum present. The options are to delay the meeting (via recess) to allow for establishing a quorum of Commissioners, to allow for exchange of information as long as the discussion does not lead to a decision or consensus of the members present, or adjourn the meeting.

Ms. Russell addressed the issue of conducting an informational meeting due to absence of a quorum. She advised that any issue that requires an assessment or decision of the Commission should not be discussed when a quorum is not present.

NEW BUSINESS:

5.8 Ratification of Committee Appointments for 2015

(No discussion)

M/S/C: Commissioner Lott/Washburn to approve the Sub-Committee appointments for 2015.

6. COMMISSIONERS' COMMENTS/REQUESTS

(No discussion)

7. LEGISLATION

(*No report)*

8. EMS DIRECTOR'S REPORT

- Several years ago the EMS Agency requested an Attorney General opinion asking for clarification on Health and Safety Code 201 Rights. Recently, an opinion was rendered and below are the questions asked by the County and the answers from the Attorney General:
    1. Does a LEMSA have to have an agreement with independent cities and fire districts and would it impact their 201 Rights? No

2. Does a contract between a LEMSA and independent cities and fire districts for medical equipment affect 201 Rights? No
3. Does a contractual agreement between a LEMSA and provider agency for medical oversight affect 201 Rights? No

- Update on the sale of St. Francis/St. Vincent hospital – the Attorney General conducted a public hearing on January 5, 2015 related to the sale of St. Francis Medical Center. Dr. Mitch Katz, DHS Director, was on hand to give testimony. The County has requested that one of the requirements of the sale be that current trauma services must be maintained by the buyer. According the Commissioner Lott, that requirement applies to emergency department services only.

  Action: Provide each Commissioner with a copy of Dr. Katz' January 8, 2015 letter and his testimony at the Hearing.
  Responsibility: EMS Agency

- The EMS Agency is in the process of reviewing applications received from the San Gabriel Valley hospitals expressing interest in becoming a trauma center. There were two applications received. The evaluation and scoring of the proposals and recommendations are due to be completed in late February. DHS has received a thirty day assignment from the Board of Supervisors to report on this matter.

- The County will hold a celebration of the 125 years of continuous operation of Health Services Ambulance Services on February 12, 2015 at the Disaster Staging Facility located on Slusher Avenue in Santa Fe Springs. The Ambulance Services section will be recognized with a scroll by the Board of Supervisors at the February 3, 2015 Board meeting.

9. ADJOURNMENT

The Meeting was adjourned by Chairman Kazan at 2:40 PM. The next meeting will be held on March 18, 2015.

Next Meeting: Wednesday, March 18, 2015
EMS Agency
10100 Pioneer Blvd.
Santa Fe Springs, CA 90670

Recorded by:
Marilyn E. Rideaux
Richard Tadeo
EMS Agency

CORRESPONDENCE 2.1

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

William Koenig, MD
Medical Director

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

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely, compassionate and quality emergency and disaster medical services.

March 4, 2015

TO: Fire Chief/Chief Executive Officer
Each 9-1-1 Provider Agency
Each 9-1-1 EOA Provider Agency

FROM: Cathy Chidester
Director

SUBJECT: **REQUEST FOR APPLICATIONS FOR EMERGENCY MEDICAL CARE ENHANCEMENT PROGRAM**

In March 2014, the Emergency Medical Services (EMS) Commission requested $3.0 million in one-time Measure B funding to assist EMS provider agencies in implementing or upgrading their electronic Patient Care Record (ePCR) System.

The EMS Agency is happy to announce the solicitation of applications for the Emergency Medical Care Enhancement Program (Program). Attached is the Request for Applications (RFA) with instructions for preparing and submitting applications, required forms, and agreement specifications. Project applications should focus on, but not be limited to, the purchase or upgrade of the hardware, software, computers, printers, mobile hand-held devices, annual licensing fees, record retention and storage fees, or on-site technical assistance fees for the selected ePCR system. The Provider Agency must match the funding amount they are requesting, for example if the project proposal costs total $100,000 the provider would request $50,000 in Measure B funding and would have to demonstrate that they contributed the remaining $50,000. Approved projects must be completed within 12 months of the award and will require the provider agency entering into a Program Agreement with the County.

To apply, please review the attached RFA and submit your Application to Ruth Guerrero, Department of Health Services, Contracts and Grants Division, 313 North Figueroa Street, 6th Floor-East, Los Angeles, California 90012 **no later than 3 p.m. on March 20, 2015.** If you have any questions, please submit those in writing to Ruth Guerrero at rguerrero@dhs.lacounty.gov **no later than 3 p.m. on March 11, 2015.** Questions and Answers will be released by DHS via e-mail on March 14, 2015. All applications will be reviewed by an evaluation committee including EMS Agency personnel. Depending on the number and total dollar amount of the submitted applications some projects may be only partially funded. Award recipients will be notified with appropriate details once a decision has been made regarding whether your project will be funded.

CC:kf

Attachment

CORRESPONDENCE 2.2

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

William Koenig, MD
Medical Director

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

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely, compassionate and quality emergency and disaster medical services.

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

February 18, 2015

Distribution

FROM: Cathy Chidester
Director

SUBJECT: COUNTYWIDE SIDEWALK CARDIAC RESUSCITATION DAY – JUNE 4, 2015

Los Angeles (LA) County Emergency Medical Services (EMS) Agency, in collaboration with the American Heart Association (AHA), is coordinating a countywide SideWalk Cardio Pulmonary Resuscitation (CPR) public education event on Thursday **June 4, 2015**. The week of June 1 is designated as National CPR Week and provides a perfect opportunity for public education on this vital skill.

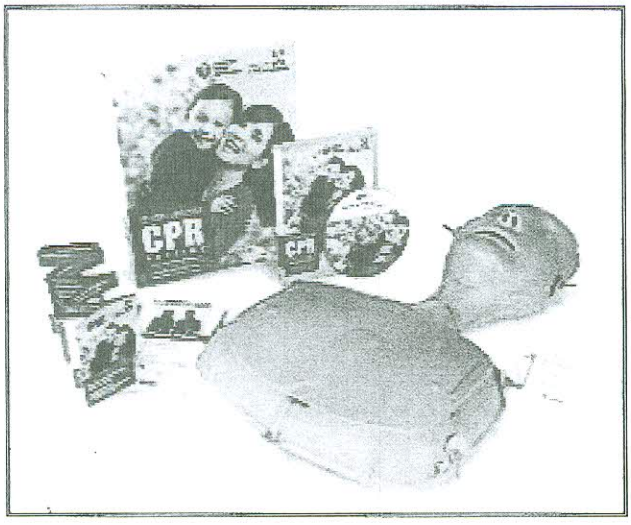
We would like to invite your facility/agency to participate in this exciting campaign. The EMS Agency will coordinate the participation through pre-registration (Attached). Registration provides a contact for us to distribute the basic curriculum, sample press release, program ideas, and rosters/sign-in sheets to track the number of persons trained for the day. Early registration allows us to list your training site on our informational web page for press coverage and community information.

The EMS Agency and AHA will coordinate press releases, but each participating entity will also need to publicize the time and location for their training to the local community. You may choose to have one or more CPR training stations and utilize an area in or close to your facility. Instructors do not need a CPR instructor card, but will need to be comfortable performing CPR and utilize the curriculum provided by the EMS Agency. CPR Anytime Kits (Attachment) are available for purchase through the AHA at the cost of $34.95 if your facility does not have manikins available.

Training sites may choose their hours of operation. At the end of the day, the number of people trained at each site will be reported to the EMS Agency. The EMS Agency will tabulate the total number of people trained in LA County and report back to the AHA and interested parties. Last year approximately 7,000 people in LA County were trained in one day.

We hope that you will choose to participate in the LA County Sidewalk CPR event. Please complete the attached registration form and return it to the EMS Agency by May 25, 2015.

Attachment


CPR

CORRESPONDENCE 2.3

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely, compassionate, and quality emergency and disaster medical services.

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

February 9, 2015

Doug Cain, President
Antelope Ambulance
169 W. Avenue J-5, Suite A
Lancaster, California 93534

Dear Mr. Cain:

APPROVAL LETTER ALS UNIT RA 125

On February 3, 2015, the EMS Agency performed an inventory inspection of Antelope Ambulance's (AN) new Advanced Life Support (ALS) unit Reserve RA 125. RA 125 met the requirements of Reference No. 703, ALS Unit Inventory.

Fentanyl and midazolam were stocked on the unit in accordance to Reference No. 702, Controlled Drugs Carried on ALS Units.

This unit should be designated on the EMS Report Forms as RA 125 with a provider code of AN. Antelope Valley Medical Center (AVH) is the assigned base hospital for this unit. Verbal authorization was given to place this new unit into service as of February 2, 2015.

If you or your staff have any questions, please contact Cathlyn Jennings, Prehospital Programs Coordinator, at (562) 347-1680.

Very truly yours,

Cathy Chidester
Director

CC:cj
02-08

c. Paramedic Coordinator, AN
PCC, AVH

CORRESPONDENCE 2.4

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

Tel: (562) 347-1500
Fax: (562) 941-5835

February 5, 2015

TO: Chief Executive Officer
9-1-1 Receiving Hospital

FROM: Cathy Chidester, Director
Los Angeles County EMS Agency

SUBJECT: EMERGENCY DEPARTMENT IMPACT SURVEY (REQUEST FOR 2014 DATA)

The Health and Safety Code, Section 1300(c) requires each county to have a policy which specifies the criteria it will consider when conducting an impact evaluation for hospitals considering downgrading or closing emergency services. The Los Angeles County Emergency Medical Services (EMS) Agency maintains a database of each 9-1-1 receiving hospital in order to complete meaningful impact evaluations when requested or required. To ensure currency of our database, it is of utmost importance that the attached survey is completed accurately and returned to the EMS Agency no later than **May 1, 2015.**

Thank you for your attention to this matter. Should you have any questions, please call Michelle Williams at (562) 347-1653 or email at michwilliams@dhs.lacounty.gov.

CC:rt

Attachment

c: Emergency Department Director

LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES AGENCY
9-1-1 RECEIVING HOSPITAL DATABASE

Name of Facility: _____

Name and Title of Person Completing Form: _____

Telephone Number: _____

DATA SHOULD REFLECT THE PERIOD JANUARY 1 - DECEMBER 31, 2014

TREATMENT STATIONS

Number of Emergency Department Treatment Bays (do not include Fast Track beds): _____

Does your facility have a Fast Track treatment area: _____ YES _____ NO

If "YES", what is the number of Treatment Bays: _____

Total Facility ED and Fast Track Treatment Bays: _____

VOLUME in 2014

1. _____ # of critical* patients treated in ED
2. _____ # of urgent* patients treated in ED
3. _____ # of non-urgent* patients treated in ED

Total of lines 1., 2., and 3. _____

* Refer to the attached definitions in the Hospital Impact Evaluation Glossary

ADMISSIONS in 2014

_____ # of adult admissions from ED to non-ICU area

_____ # of adult admissions from ED to ICU

_____ # of adult admissions from ED to Observation

_____ # of pediatric patients (14 years of age or younger) treated in ED

BEHAVIORAL HEALTH VOLUME in 2014 (include substance abuse and mental health conditions)

_____ # of behavioral health visits in ED

_____ # of behavioral health admissions from ED

_____ # of behavioral health transfers from ED

_____ # of behavioral health visits in ED for patients aged 5 to 12 years

_____ # of behavioral health visits in ED for patients aged 13 to 17 years

Circle Appropriate Response:

YES	NO	Hospital has 24/7 Neurosurgical Call Panel
YES	NO	Hospital maintains obstetrical services
YES	NO	Hospital has a Neonatal Intensive Care Unit
YES	NO	Hospital has a licensed helipad
YES	NO	Hospital is a designated 5150 LPS facility

Please return this form by **May 1, 2015** to:

Los Angeles County Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Attn: Michelle Williams
FAX: (562) 941-2306
Email: michwilliams@dhs.lacounty.gov

HOSPITAL IMPACT EVALUATION GLOSSARY

Emergency Department (ED) Treatment Station:

This is a specific place within the ED adequate to treat one patient at a time. Holding or observation beds are not included.

Emergency Department Visits:

Visits made during the year to the ED divided into the following categories:

Critical – a patient presents an acute injury or illness that could result in permanent damage, injury or death (head injury, vehicular accident, a shooting). Applicable CPT codes for this level of service would be 99284 (detailed history, detailed physical, and medical decision making of moderate complexity) or 99285 (medical decision making of high complexity) or 99291 (critical care, evaluation and management).

Urgent – patient with an acute injury or illness, loss of life or limb is not an immediate threat to their well-being, or a patient who needs a timely evaluation (fracture or laceration). Applicable CPT codes for this level of service would be 99282 (medical decision making of low complexity) or 99283 (medical decision making of moderate complexity).

Non-Urgent – a patient with a non-emergent injury, illness, or condition; sometimes chronic; that can be treated in a non-emergency setting and not necessarily on the same day they are seen in the ED (pregnancy tests, toothache, minor cold, ingrown toenail). An applicable CPT code for this level of services would be 99281 (straight forward medical decision making).

Behavioral Health – a patient with abnormal behavior associated with mental or emotional origin, includes substance abuse and mental health conditions. Applicable ICD codes for this category include 290 through 319.

CORRESPONDENCE 2.5

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

William Koenig, MD
Medical Director

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

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely, compassionate and quality emergency and disaster medical services.

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

February 5, 2015

California Emergency Medical Services Authority
10901 Gold Center Drive, 4th Floor
Rancho Cordova, CA 95670

Dear Dr. Cothren and Mr. Smiley:

The Los Angeles County Emergency medical Services (EMS) Agency is pleased to express its interest in participating in the State of California's initiative to enable secure access to medical information by medical professionals and first responders following a natural or manmade disaster. We agree that California, and our country more broadly, must pursue significant improvements in our ability to ensure an individual's health information is available to those caring for them during disaster situations. We also agree that California is an excellent environment to pilot test an approach to disaster response that might be adopted in other areas across the country.

As the nation has moved towards the digitization of patient's health information, many stakeholders have explored how best to exchange that data, but few efforts have made significant progress with the intent of supporting disaster-based scenarios. We understand that the California Emergency Medical Services Authority (Cal-EMSA) and the California Association of Health Information Exchanges (CAHIE) have partnered with the Office of the National Coordinator (ONC) and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to pursue the PULSE program, and that discussions have already started with stakeholders including other state agencies, local emergency management services agencies, health systems, and health information exchange organizations. [Your organization's name] believes that having the federal support of ONC and ASPR is critical to the success of PULSE.

We understand that this letter of interest will be followed by more detailed discussions between Los Angeles County EMS Agency and CalEMSA regarding implementation.

We look forward to partnering with CAHIE, Cal-EMSA, and the other partners on this important initiative for Californians and for the country.

Very truly yours,

Cathy Chidester
Director

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

Tel: (562) 347-1500
Fax: (562) 941-5835

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

February 5, 2015

William Racowschi, Fire Chief
Torrance Fire Department
1701 Crenshaw Boulevard
Torrance, CA 90501

Dear Chief Racowschi:

NEW UNIT AUTHORIZATION - RA 91 and RA 93

On January 30, 2015, Emergency Medical Services (EMS) Agency representative performed an inventory inspection of Torrance Fire Department's (TF) newly purchased Rescue Ambulances (RAs) 91 and 93. Both units meet the requirements of Reference No. 703, ALS Unit Inventory with the following exception:

- Needle Thoracostomy Kits: Expired as of June 2014.

Your request to place these two ALS units into service is authorized with the understanding that the above expired equipment is to be replaced prior to going into service.

Once RAs 91 and 93 are placed into service, TF is authorized to downgrade the current frontline units (RS 91 and RS 93) to reserve status.

Documentation on the EMS Report Form should indicate the provider code "TF" and a Unit Designation of either "RA 91" or "RA 93", if unit is utilized as the transporting unit; and "RS 91" or "RS 93", if unit is NOT utilized as the transporting unit. Base hospital assignment for these units is Providence Little Company of Mary Medical Center Torrance (LCM).

If you have any questions, please contact Gary Watson, Provider Agency / SFTP Program Coordinator, at (562) 347-1679.

Very truly yours,

Cathy Chidester
Director

CC:gw
2-10

c: Paramedic Coordinator, Torrance Fire Department

CORRESPONDENCE 2.7

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely, compassionate, and quality emergency and disaster medical services.

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

January 29, 2015

Kelvin Carlisle, President
Liberty Ambulance
9441 Washburn Street
Downey, California 90242

Dear Mr. Carlisle:

NEW ALS UNIT APPROVAL

On January 22, 2015, the Emergency Medical Services (EMS) Agency performed an inventory inspection of Liberty Ambulance's (LI) new Advanced Life Support (ALS) unit RA 379. RA 379 met the requirements of Reference No. 703, ALS Inventory.

This unit should be designated on EMS Report Forms as RA 379 with a provider code of LI. Providence Little Company of Mary Medical Center-Torrance is the assigned base hospital for this unit. Verbal authorization was given to place this new unit into service as of January 22, 2015.

If you or your staff have any questions, please contact Cathlyn Jennings, Prehospital Programs Coordinator, at (562) 347-1680.

Very truly yours,

Richard Tadeo for CC

Cathy Chidester
Director

CC:cj
01-25

c. Paramedic Coordinator, LI
PCC, LCM

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely, compassionate, and quality emergency and disaster medical services.

January 29, 2015

Antonio Liu, M.D.
Stroke Medical Director
White Memorial Medical Center
1720 Cesar Chavez Avenue
Los Angeles, CA 90033

Dear Dr. Liu:

This is in response to your letter dated July 29, 2014 to the Emergency Medical Services (EMS) Agency requesting assistance with obtaining contact information of family/witnesses of potential stroke victims in the prehospital setting as a means to facilitate acute stroke care. After careful consideration and discussion in the relevant EMS Commission subcommittees, Reference No. 521, Stroke Patient Destination, was revised to reflect this important aspect of prehospital stroke care.

Thank you for notifying the EMS Agency of this issue. Your dedication and commitment to the EMS community providing stroke care is greatly appreciated.

William J. Koenig, M.D.
Medical Director

WJK:cn
01/08

Attachments

c: Director, EMS Agency

CORRESPONDENCE 2.9

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

William Koenig, MD
Medical Director

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

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely, compassionate and quality emergency and disaster medical services.

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

January 15, 2014

Ziba Chavoshi, M.D., Medical Director
Gentle Ride, Inc.
710 Ruberta Avenue
Glendale, CA 91201

CERITIFED

Dear Dr. Chavoshi:

REQUEST FOR VARIATION IN REFERENCE NO. 713, RESPIRATORY CARE PRACTITIONER STAFFED CRITICAL CARE UNIT INVENTORY

On December 18, 2014, the Emergency Medical Services (EMS) Agency received a request from you requesting a variation in the inventory required by Reference No. 713, Respiratory Care Practitioner Staffed Critical Care Transport Unit Inventory on behalf of Gentle Ride, Inc (GR). Your request to not maintain intubation equipment for neonate, pediatric and adult patients has been denied.

In May 2011, the EMS Agency convened a task force comprised of representatives of Los Angeles County approved critical care transport providers to develop a respiratory care practitioner (RCP) inventory. At the committee's suggestion, Reference No. 713 was developed and it was recommended that this policy include a minimum inventory for all RCP providers. The EMS Agency believes that making variations in the inventory for specific providers can compromise care and therefore complicate the overall system, as a result your request was denied.

If you or your staff have questions, please contact Cathlyn Jennings, Prehospital Program Coordinator, at (562) 347-1680.

Very truly yours,

William J. Koenig

William Koenig, M.D.
Medical Director

WK:cj
12-26

Attachments

c. Critical Care Coordinator, Gentle Ride Ambulance
President, Gentle Ride Ambulance

EMERGENCY MEDICAL SERVICES COMMISSION
BASE HOSPITAL ADVISORY COMMITTEE

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

February 11, 2015 meeting
Minutes were not available at time of mailing.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

William Koenig, MD
Medical Director

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

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Health Services
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EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE

MEETING NOTICE

Date & Time: Wednesday, February 11, 2015 10:00 A.M.
Location: EMS Agency, First Floor Hearing Room
10100 Pioneer Boulevard
Santa Fe Springs, 90670-3736

DATA ADVISORY COMMITTEE
DARK FOR FEBRUARY 2015

County of Los Angeles
Department of Health Services

EMERGENCY MEDICAL SERVICES COMMISSION
EDUCATION ADVISORY COMMITTEE MINUTES

Wednesday, February 18, 2015

Attendance

Members	Organization	EMS Agency Staff Present	Position
☒ Lt Andres Ramirez, Chair	EMSC/POA LA Co	David Wells	Program Approvals
❑ Frank Binch, Vice-Chair	EMSC/Public Member 4th District	Erika Reich	Program Approvals
❑ Gary Washburn	EMSC/Public Member 5th District	Susan Mori	Systemwide QI
❑ Bernard Weintraub	EMSC/SCPHA	Lucy Hickey	Chief, Program Approvals
☒ Alina Candal, RN	APCC	Richard Tadeo	Assistant Director
❑ Tina Crews, RN	APCC		
❑ Jennifer Pickard, RN	APCC - alternate		
❑ Joanne Dolan, RN	LAAFCA		
☒ Susan Hayward, RN	LAAFCA		
☒ Sean Stokes, RN	LAAFCA - alternate		
☒ Jesus Cardoza, PM	LACAA	**Others Present**	**Agency/Representing**
☒ Jim Karras, EMT	LACAA	Gary Cevello	AMR
❑ Kim Mutaw, EMT	LACAA - alternate	Robin Goodman	PAC
☒ Mark Ferguson, RN	PTI	Trevor Stonum	MedCoast Ambulance
❑ VACANT	PTI - alternate		
❑ Tina Ziolkowski, RN	Mt SAC		
❑ Kelly Sherwood, RN	Mt SAC - alternate		
❑ Heather Davis, PM	UCLA Paramedic Education		
☒ Nanci Medina, PM	UCLA Paramedic Education - alternate		
☒ Jeff Warstler, RN	MICN		
❑ Jennifer Webb, RN	MICN - alternate		
❑ Charles Drehsen, MD	Med Council		
❑ VACANT	Med Council - alternate		
☒ Ken Leasure, PM	LAAFCA		
★ James Altman, PM	LAAFCA - alternate		
❑ Ernie Foster, PM	LACAA		
❑ VACANT	LACAA - alternate		
❑ Anthony Mendoza, PM	EMS Educator – Non PD		
❑ VACANT	EMS Educator – Non PD - alternate		
❑ Karin Reynoso, RN	EMT Program Director		
❑ Barry Jensen, PM	EMT Program Director		
❑ Cliff Hadsell, PM	EMT Program Director - alternate		★ - Excused

1. CALL TO ORDER - A. Ramirez, Chair called the meeting to order at 10:08 a.m.

2. APPROVAL OF MINUTES - Motion to approve August 20, 2014 minutes by K. Leasure; second by A. Candal. Minutes approved by committee.

3. INTRODUCTIONS AND ANNOUNCEMENTS

3.1 EMS Agency Staff Changes (Tadeo)
Mark Ferguson has been appointed as Interim Program Director for PTI. Terry Crammer has been promoted to Senior EMS Program Head for the Disaster Section. Gary Chambers (Disaster) is retiring this summer.

4. REPORTS & UPDATES

4.1 California Prehospital Program Directors (CPPD) (Medina)
No report

4.2 California Council of EMS Educators (C^2E^2) (Reich)
Next meeting is scheduled for Thursday, February 19th at 10:00 a.m. at the EMS Agency in Room 247.

4.3 Association of Prehospital Care Coordinators (APCC) (Candal)
No report

4.4 California Association of Nurses and EMS Professionals (CALNEP) (Hayward)
No report

4.5 Disaster Training Unit (Ferguson)
Disaster Section is conducting a Healthcare Business Continuity Workshop on February 25, 2015, with the assistance of a contracted vendor. The workshop will provide strategies to assist healthcare providers in recovery and reimbursement after a disaster response.

4.6 EMS Quality Improvement Report (Mori)
The data for the 2014 Core Measures from the local EMS Agencies (LEMSA) are now due to the EMS Authority. The LEMSA QI group is working on a QI template to be utilized statewide. The LEMSA group is developing statewide standardized QI training. Funding is required to provide training and implement both projects.

4.7 EMT Program Update (Reich)
EMT Preceptor Train-the-Trainer program was provided in December. The Skills Development committee will continue to meet on the 4th Thursday of the month. The EMT Training Program workgroup is on hold.

4.8 EMS Update 2015 (Tadeo)
EMS Update 2015 Train-the-Trainer program is scheduled for April 20th and 23rd. The update will include STEMI activation, 12-lead EKG recognition, Legal Challenges, and Excellence in EMS. The program will be available for instructional delivery via online and dvd.

5. UNFINISHED BUSINESS

6. NEW BUSINESS

7. OPEN DISCUSSION

7.1 UCLA Paramedic Program (Medina)
The program is moving to a new location in July. The address will be provided in the near future. Hybrid (online/traditional combination) Paramedic program students are performing on par with the students in the traditional program.

8. ADJOURNMENT - The meeting adjourned at 10:31 a.m. Next meeting: Wednesday, April 15, 2015 at 10:00 a.m.

County of Los Angeles
Department of Health Services

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES COMMISSION

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, February 18, 2015

MEMBERSHIP / ATTENDANCE

MEMBERS	ORGANIZATION
☑ David Austin, Chair	EMSC, Commissioner
☐ Robert Barnes, Vice-Chair	EMSC, Commissioner
☐ Jon Thompson, Commissioner	EMSC, Commissioner
☐ Clayton Kazan, MD, Commissioner	EMSC, Commissioner
☐ Jodi Nevandro	Area A
☑ Sean Stokes	Area A Alt
☑ Jon O'Brien	Area B
☐ Kevin Klar	Area B, Alt.
☐ Victoria Hernandez	Area B Alt.
☑ Ken Leasure	Area C
☑ Susan Hayward	Area C Alt
☐ Bob Yellen	Area E
☑ Richard Roman	Area E Alt.
☑ Dwayne Preston	Area F
☐ Joanne Dolan	Area F Alt.
☑ Steve Treskes	Area G (PAAC Rep to BHAC)
☐ Michael Murrey	Area G Alt. (PAAC Rep to BHAC, Alt.)
☑ Jeffrey Elder	Area H
☑ Douglas Zabilski	Area H Alt.
☐ Brandon Greene	Employed EMT-P Coordinator (LACAA)
☐ Matthew Chelette	Employed EMT-P Coordinator, Alt. (LACAA)
☑ Ryan Burgess	Prehospital Care Coordinator (BHAC)
☐ Alina Chandal	Prehospital Care Coordinator, Alt. (BHAC)
☐ Todd Tucker	Public Sector Paramedic (LAAFCA)
☑ James Michael	Public Sector Paramedic, Alt. (LAAFCA)
☑ Maurice Guillen	Private Sector EMT-P (LACAA)
☐ Ernie Foster	Private Sector EMT-P, Alt. (LACAA)
☐ Marc Eckstein, MD	Provider Agency Medical Director (Med Council)
☐ Stephen Shea, MD	Provider Agency Medical Director, Alt. (Med Council)
☑ Diane Baker	Private Sector Nurse Staffed Ambulance Program (LACAA)
☐ Vacant	Private Sector Nurse Staffed Ambulance Program, Alt (LACAA)
☐ Laurie Lee-Brown	Representative to Medical Council and Representative to Data Advisory Committee

EMS AGENCY STAFF PRESENT

William Koenig, MD	Cathy Chidester
Richard Tadeo	Jacqueline Rifenburg
Stephanie Raby	Nichole Bosson, MD
John Telmos	Cathlyn Jennings
Paula Rashi	Michelle Williams
Deidre Gorospie	Susan Mori
David Wells	Phillip Santos
Lynne An	Gary Watson

OTHER ATTENDEES

David Baumann	LA Co FD
Michael Jones	LA Co FD
Nicole Steeneken	LA Co FD
Margie Chidley	LA Co FD
Evie Anguiano	LA Co FD
Greg Reynar	Los Angeles FD
Mike Beeghly	Santa Fe Springs FD
Issac Yang	Redondo Beach FD
Tisha Hamilton	Bowers Ambulance
Ian Wilson	PRN Ambulance
Robert Camarena	Gentle Care Ambulance
Trevor Stonum	MedCoast Ambulance
Jeff Telmore	Care Ambulance
Rocky Allen	Mercy Air Ambulance

LACAA – *Los Angeles County Ambulance Association* * LAAFCA – *Los Angeles Area Fire Chiefs Association* * BHAC – *Base Hospital Advisory Committee* * DAC – *Data Advisory Committee*

CALL TO ORDER: Commissioner, David Austin called meeting to order at 1:03 p.m.

1. APPROVAL OF MINUTES (Preston/Leasure) December 17, 2014 minutes were approved.

2. INTRODUCTIONS / ANNOUNCEMENTS

2.1 Committee Membership Changes

Committee Chair, David Austin announced that Commissioner Clayton Kazan, MD, will be joining the Committee for 2015.

2.2 Pediatric Triage Training – Computer Based *(John Telmos)*

Bridget Berg, Trauma Surge Coordinator, Children's Hospital Los Angeles (CHLA), introduced a new web-based platform for a disaster triage program, entitle "Surge World". This web-based computer program is to provide training in pediatric triage skills. Currently, CHLA is requesting assistance from providers to test this training program and provide feedback to the computer program designers. A sign-up sheet was distributed to Committee members. Those interested in volunteering may also contact Ms. Berg at (323) 361-7159 or email at bberg@chla.usc.edu

2.3 EMS Agency Medical Director *(William Koenig, MD)*

Dr. Koenig, EMS Agency Medical Director, announced his plan to retire in the late Spring of 2015. , There is a National search to fill this position. Nichole Bosson, MD, will be filling this role as Medical Director until permanent replacement is found.

2.4 Los Angeles Fire Department – Change to EMS Leadership *(Jeffrey Elder)*

Gregory Reynard, Assistant Chief, Los Angeles Fire Department, has been reassigned and will be leaving LAFD's EMS Division on March 15, 2015. Assistant Chief, Timothy Ernst will will be assigned to the EMS division.

2.5 EMS Agency Staff Changes *(Richard Tadeo)*

- Michele Hanley has left the EMS Agency. In the interim, Mark Ferguson will fill the role as Director of Paramedic Training Institute.
- Terry Cramer has been promoted to Chief, Disaster Medical Services; replacing Roel Amara, who has recently been promoted to Assistant Director, EMS Agency.

3. REPORTS & UPDATES

3.1 Pleuritic Chest Pain *(Richard Tadeo)*

The EMS Agency is planning to realign current data elements to meet National Emergency Medical Services Association (NEMSA) requirements. This realignment would be more of a provider recognized complaint rather than a patient complaint format. In the future, the EMS Agency will be looking into adding these components into paramedic training and EMS Update.

3.2 EMS Update 2015 *(Richard Tadeo)*

- Train-the-Trainer classes for EMS Update 2015, is scheduled for April 20 and April 23, 2015. Informational letters have been distributed to all providers.
- Training formats will include computer-based education; as well as a CD for classroom training.

3.3 Public Safety Personnel (Firefighter) – Medical Training *(John Telmos)*

- California Code of Regulations, Title 22, Division 9, Chapter 1.5, First Aid Standards for Public Safety Personnel and the Health and Safety Code, Section 1797.182, state that every California firefighter is to be trained as an Emergency Medical Technician (or first-aid), and to include current training in Cardio-pulmonary Resuscitation (CPR).
- Beginning July 2015, during annual paramedic program reviews, all public providers will be audited to verify that the required medical training of firefighter personnel is maintained.
- Providers should have a method of tracking the expiration dates of these firefighter certifications.

3.4 Data Element – Added *(Richard Tadeo)*

State EMS Authority released a definition for ambulance "Wall Time". The EMS Agency's Data Committee is reviewing this and will be adding a data element(s) to the EMS Report form that would reflect this time.

4. UNFINISHED BUSINESS

There was no Unfinished Business.

5. NEW BUSINESS

5.1 Reference No. 519, Management of Multiple Casualty Incidents *(Richard Tadeo)*

Policy reviewed as information only. No action taken.

5.2 Reference No. 1251, Treatment Protocol: Stroke/Acute Neurological Deficits *(Deidre Gorospe)*

Policy reviewed as information only. No action taken.

5.3 Reference No. 834, Patient Refusal of Treatment or Transport *(Richard Tadeo)*

Policy reviewed and approved with the following recommendation:

- Principles 3, second sentence: Remove the word "significantly". Sentence to read:

  "Mental illness, drugs, alcohol intoxication, or physical/mental impairment may impair a patient's decision-making capacity."

M/S/C (Burgess/Leasure): Approve Reference No. 834, Patient Refusal of Treatment or Transport, with above recommendation

5.4 Reference No. 814, Determination/Pronouncement of Death in the Field *(Nichole Bosson, MD)*

Policy reviewed and approved with the following recommendations (in bold):

- Policy II, D.: to read:

  "Patients in asystole after 20 minutes of quality **cardio-pulmonary resuscitation** on scene, who meet **all** the following criteria:"

M/S/C (Leasure/Burgess): Approve Reference No. 814, Determination/Pronouncement of Death in the Field, with above recommendation.

5.5 Reference No. 806.1, Procedures Prior to Base Contact *(Jacqueline Rifenburg)*

Policy reviewed and approved as presented.

M/S/C (Preston/Burgess): Approve Reference No. 806.1, Procedures Prior to Base Contact

5.6 Reference No. 1200, Treatment Protocols *(Jacqueline Rifenburg)*

Policy reviewed and approved with the following recommendation:

- Page 5 of 9, Airway/Pulse Oximetry/Oxygen Therapy: add a definition of "Secure Airway".

M/S/C (O'Brien/Leasure): Approve Reference No. 1200, Treatment Protocols, with above recommendation.

5.7 Reference No. 1244, Treatment Protocol: Chest Pain *(Jacqueline Rifenburg)*

Policy was reviewed. Committee made the following recommendation:

- Incorporate item number 7 (Perform a 12-lead ECG) with number 4 (Cardiac monitor)

Upon further review, Dr. Koenig requested this policy be Tabled until further review by the EMS Agency staff.

TABLED: Reference No. 1244, Treatment Protocol: Chest Pain

5.8 Reference No. 1275, Treatment Protocol: General Trauma *(Jacqueline Rifenburg)*

Policy reviewed and approved as presented.

M/S/C (Elder/O'Brien): Approve Reference No. 1275, Treatment Protocol: General Trauma

5.9 Reference No. 1314, Medical Control Guideline: Traumatic Hemorrhage Control *(Jacqueline Rifenburg)*

Policy reviewed and approved as presented.

M/S/C (Preston/Leasure): Approve Reference No. 1314, Medical Control Guideline: Traumatic Hemorrhage Control

6. OPEN DISCUSSION

6.1 Comprehensive Stroke Centers *(William Koenig, MD)*

- International Stoke Conference was held last week.
- There was interest of having patients who meet specific stroke criteria, transferred to Comprehensive Stroke Centers (CSC). Neurologists may be accessing the 9-1-1 system in order to have these patients transferred from non-CSC to hospital that are designated as CSC.
- This has the potential to increase 9-1-1 call volume; therefore, providers are encouraged to participate in future discussions on this topic.

7. NEXT MEETING: April 15, 2015

8. ADJOURNMENT: Meeting adjourned at 2:02 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 519, Management of Multiple Casualty Incidents

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Section IV, Role of the Receiving Facility, B & C	THAC 01-28-2015	Deleted the following, “that involve 20 victims or more” from letters B & C. Approved	
	BHAC 02-11-2015	Approved	
	PAC 02-18-2015	Approved	

SUBJECT: **MANAGEMENT OF MULTIPLE CASUALTY INCIDENTS** (EMT, PARAMEDIC, MICN) REFERENCE NO. 519

PURPOSE: To provide guidelines for the efficient management of multiple casualty incidents (MCI) through coordination between prehospital care personnel, receiving facilities and the Medical Alert Center (MAC) to allow for maximum resource allocation, patient distribution and to prevent unnecessary delays in patient care and transport.

To provide guidelines for transition from a MCI response to a Mass Casualty Incident Management Response.

This policy defines the roles of the provider agency, MAC, base hospital and receiving facilities during an MCI.

DEFINITIONS : Refer to Reference No. 519.1, MCI – Definitions.

PRINCIPLES:

1. The Incident Command System (ICS) should be utilized at all MCI's.

2. Terminology is standardized.

3. Expedient and accurate documentation is essential.

4. The MAC is equipped to communicate with multiple receiving facilities simultaneously and can rapidly assess system wide emergency department bed status, hospital and ambulance resources.

5. Request for hospital diversion status should be considered when determining patient destination; however, if appropriate, patients may be directed to hospitals requesting diversion (Exception: Internal Disaster).

6. Patients requiring Advanced Life Support (ALS) treatment or procedures should be transported by paramedics whenever possible; however, these patients may be transported by Basic Life Support (BLS) units based on available resources during the MCI. BLS units may transport to other than the Most Accessible Receiving (MAR) facility if the patient meets specialty care center criteria and based on available system resources.

7. The EMS Agency will facilitate a post-incident debriefing of large scale incidents to include all affected agencies.

8. To maintain system readiness, provider agencies, hospitals, MAC and other disaster response teams should carry out regularly scheduled MCI, disaster drills and monthly VMED28 radio checks.

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

9. On any MCI in which the need for air transport is identified, early notification to air operations providers is essential in order to ensure rapid access to medical care and preserve life.

POLICY:

I. Role of the Provider Agency

A. Institute ICS as necessary.

B. Implement MCI Triage Guidelines (modified START & Jump START) as necessary (see Ref. No. 519.2).

C. Establish early communication with either the:

1. MAC for 5 or more patients (via VMED28 when possible) for hospital bed availability, authorization of Procedures Prior to Base Contact (Ref. No. 806.1), lifting of trauma catchment and service areas; or

2. Base hospital for the purpose of patient destination and/or medical direction.

D. If the need for additional BLS transport units exceeds the jurisdictional provider agency's capability, additional transport resources may be requested by the jurisdictional dispatch center or the Fire Operational Area Coordinator (FOAC) as per Ref. No. 519.3, Multiple Casualty Incident Transportation Management.

E. Request hospital based medical resources from the MAC as outlined in Ref. No. 817, Hospital Emergency Response Team (HERT) if necessary.

F. Provide the following scene information to the MAC or base hospital:

1. Nature of incident

2. Location of incident

3. Medical Communications Coordinator (Med Com) provider unit and agency

4. Agency in charge of incident

5. Total number of estimated immediate, delayed, minor and deceased patients. If indicated, include total number and category of pediatric patients

6. Nearest receiving facilities including trauma centers, PMCs, PTCs and EDAPs

7. Transporting provider, unit number and destination

8. Type of hazardous material, contamination, level of decontamination completed, if indicated

G. Document the following patient information on the appropriate EMS Report Form:

1. Patient name

2. Chief complaint

3. Mechanism of injury

4. Age

5. Sex

6. Brief patient assessment

7. Brief description of treatment provided

8. Sequence number

9. Transporting provider, unit number and destination

H. Reassess situational status to identify available resources and resource needs. If the anticipated resource needs exceed available local and mutual aid resources, contact the FOAC. Additional resources beyond the operational area shall be requested through the Regional Disaster Medical and Health Coordinator (RDMHC).

I. Whenever departmental resources allow, the paramedic provider should consider assigning a provider agency representative to report to the MAC to assist with communications and coordination of patient destination.

II. Role of the Medical Alert Center

A. Provide prehospital care personnel with emergency department bed availability and diversion status as indicated by the ReddiNet poll.

B. Assist prehospital care personnel as necessary with patient destinations.

C. Arrange for additional ambulance transport units as requested by the FOAC or RDMHC.

D. Coordinate activation of HERT as requested.

E. Notify receiving facilities of incoming patients immediately via the ReddiNet.

F. Document, under the authority of the MAC Medical Officer on Duty (MOD) the implementation of Procedures Prior to Base Contact (Ref. No. 806.1). Lifting of trauma catchment and service areas is an EMS Administrator on Duty (AOD) function.

G. Maintain an “open MCI victim list” via the ReddiNet for 72 hours.

H. Complete a written report to include a summary of the incident and final disposition of all patients involved as indicated.

I. Notify the EMS AOD per MAC policies and procedures.

J. The EMS Agency, as the Medical and Health Operational Area Coordinator (MHOAC) for the County of Los Angeles, will assess the situational status and evaluate available resources and resource needs. If the anticipated resource needs exceed the available resources the EMS Agency, via its role as the RDMHC, will request resources from surrounding counties.

K. Maintain a paramedic provider agency Medical/Health Resource Directory and assist paramedic providers with MCI resource management when requested.

III. Role of the Base Hospital

A. Notify the MAC of the MCI as soon as possible, especially for newsworthy events, HAZMAT, multi-jurisdictional response and potential terrorism incidents.

B. Provide prehospital care personnel with emergency department bed availability and diversion status.

C. Assist prehospital care personnel as needed with patient destination.

D. Provide medical direction as needed.

E. Notify receiving facilities of incoming patients.

IV. Role of the Receiving Facility

A. Provide the MAC or base hospital with emergency department bed availability upon request.

B. Level I Trauma Centers are automatically designated to accept 6 Immediate patients from MCIs.

C. Level II Trauma Centers are automatically designated to accept 3 Immediate patients from MCIs.

D. When activated by the EMS Agency, Burn Resource Centers (BRC) can accept up to 12 critically burned patients.

E. Accept MCI patients with minimal patient information.

F. Monitor the VMED 28 and ReddiNet.

G. Provide the MAC or base hospital with patient disposition information, sequence numbers and/or triage tags when requested and enter information into the ReddiNet.

H. Maintain the “Receiving Facility” copy of the EMS Report Form and/or triage tag as part of the patient’s medical record.

I. Ensure that requested patient information is entered as soon as possible into the ReddiNet “MCI victim list” for all patients received from the MCI. The “MCI victim list” will remain open for 72 hours after the incident.

J. Notify the MAC if resource needs exceed available resources.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 201, **Medical Direction of Prehospital Care**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 506, **Trauma Triage**
Ref. No. 510 **Pediatric Patient Destination**
Ref. No. 511, **Perinatal Patient Destination**
Ref. No. 519.1, **MCI Definitions**
Ref. No. 519.2, **MCI Triage Guidelines**
Ref. No. 519.3 **Multiple Casualty Incident Transportation Management**
Ref. No. 519.4, **MCI Transport Priority Guidelines**
Ref. No. 519.5, **MCI Field Decontamination Guidelines**
Ref. No. 519.6, **Regional MCI Maps and Bed Availability Worksheets**
Ref. No. 803, **Paramedic Scope of Practice**
Ref. No. 806.1, **Procedures Prior to Base Contact Field Reference**
Ref. No. 807, **Medical Control During Hazardous Material Exposure**
Ref. No. 808, **Base Hospital Contact and Transport Criteria**
Ref. No. 814, **Determination/Pronouncement of Death**
Ref. No. 817, **Hospital Emergency Response Team (HERT)**
Ref. No. 842, **Mass Gathering Interface with Emergency Medical Services**

FIRESCOPE’s Field Operations Guide ICS 420-1. December 2012

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: SUMMARY OF COMMENTS RECEIVED REFERENCE NO 202.1

Reference No. 806.1

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
SHOCK	BHAC – 2/11/15	Approve addition of #4 under SHOCK	
	PAAC – 2/18/15	Approve addition of #4 under SHOCK	

Los Angeles County EMS Agency

POLICY REVIEW SUMMARY BY COMMITTEE

Reference No. 806.1, Procedures Prior to Base Contact – Field Reference

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	02/05/15	02/18/15	Y
	Base Hospital Advisory Committee	02/02/15	02/11/15	Y
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

***** See attached **Summary of Comments Received**

COUNTY OF LOS ANGELES – EMS AGENCY

PROCEDURES PRIOR TO BASE CONTACT - REFERENCE NO. 806.1

Prior to base hospital contact, paramedics may utilize the following treatment protocols:

GENERAL ALS

1. Basic airway/O_2 prn
   BVM & advanced airway prn
2. Cardiac monitor/document rhythm prn
3. Venous access prn
4. If indicated, blood glucose test; if <60mg/dl administer:
   Dextrose 50% 50ml slow IVP
   Pediatric:
   1month-<2yrs of age: 25% 2ml/kg slow IVP
   ≥2yrs age: 50% 1ml/kg slow IVP up to 50 ml
5. Pediatric resuscitation tape prn
6. **Ondansetron:** may give 4mg IV, IM or ODT one time for nausea/vomiting/morphine administration

RESPIRATORY DISTRESS

1. General ALS

ARREST/HYPOVENTILATION (RR< 8/MIN):

2. If suspected narcotic OD with hypoventilation,
   Naloxone 2mg IM/IN prior to venous access or advanced airway
   Adult: 0.8-2mg IVP, titrate to adequate RR/TV or 2mg IM/IN
   Pediatric: 0.1mg/kg IV/IM/IN
3. May repeat PRN

BRONCHOSPASM/WHEEZING

2. **Albuterol**
   Adult: 5mg via hand-held nebulizer
   Pediatric: age <1yr=2.5mg
   age ≥1yr=5.0mg
3. May repeat one time prn

BASILAR RALES – CARDIAC ORIGIN (ADULTS ONLY)

2. **Nitroglycerin** (NTG) SL:
   SBP ≥ 100=0.4mg (1 puff or 1 tablet)
   SBP ≥ 150=0.8mg (2 puffs or 2 tablets)
   SBP ≥ 200=1.2mg (3 puffs or 3 tablets)
3. May repeat two times in 3-5min based on repeat BP
4. Albuterol 5mg via hand-held nebulizer if wheezing
5. Consider CPAP if available; max pressure 10cmH_20

CHEST PAIN (Adult)

1. General ALS
2. 12-lead ECG for suspected acute cardiac event
   Transport to MAR if ECG=no MI
   Transport to SRC if ECG=suspected acute MI
3. **NTG** 0.4mg SL, may repeat 2 times every 3-5min if SBP>100mmHg
4. **Aspirin** 162-325mg, chewable

ACTIVE SEIZURE

1. General ALS
2. **Midazolam****
   Adult: 2-5mg slow IVP, titrate to control seizure activity; if unable to establish IV, 5mg IN/IM**
   Pediatric: Up to 0.1mg/kg IVP titrate to control seizure activity; if unable to establish IV, 0.1mg/kg IM/IN
3. May repeat one time in 5min. Maximum adult dose10mg all routes, max pediatric dose 5mg all routes

Controlled substances are **NOT in the Assessment Unit Inventory

ALTERED LOC

1. General ALS
2. If blood glucose <60mg/dl and unable to obtain IV,
   Glucagon 1mg IM
   If narcotic overdose, **Naloxone** 2mg IM/IN prior to venous access or advanced airway
   Adult: 0.8-2mg IVP, titrate to adequate RR/TV or 2mg IM/IN
   Pediatric: 0.1mg/kg IV/IM/IN

SHOCK

1. General ALS
2. Normal saline fluid challenge. If basilar rales or cardiogenic shock suspected, reduce rate to TKO
   Adult: 10ml/kg, assess lung sounds frequently
   Pediatric: 20ml/kg
3. Perform needle thoracostomy enroute if suspected tension pneumothorax with SBP≤80mmHg
4. If uncontrollable traumatic hemorrhage utilize tourniquets and/or hemostatic agents *If an approved provider

ANAPHYLAXIS

1. General ALS

ADEQUATE PERFUSION

2. **Epinephrine:**
   Adult: 0.3mg (1:1,000) IM
   Pediatric: 0.01mg/kg (1:1,000) IM, maximum single dose 0.3mg for weight 30kg or greater
3. **Albuterol,** if wheezing:
   Adult: 5mg via hand-held nebulizer
   Pediatric: age <1yr=2.5mg
   age ≥1yr=5.0mg

POOR PERFUSION

2. **Epinephrine**
   Adult: 0.1mg (1:10,000) slow IVP. If unable to obtain IV, 0.5mg (1:1,000) IM
   Pediatric: 0.01mg/kg (1:1,000) IM, maximum single dose 0.3mg for weight 30kg or greater
3. Normal saline fluid challenge if lungs are clear.
   Adult: 10ml/kg, assess lung sounds frequently
   Pediatric: 20ml/kg

PAIN MANAGEMENT

1. General ALS

ISOLATED EXTREMITY INJURY/BURN

2. Traction/splints/dressings prn
3. **Morphine** for moderate to severe pain
   2-4mg slow IVP, titrate to pain relief; MR one time
   Pediatric: 0.1mg/kg slow IVP; do not repeat
   OR
   Fentanyl for moderate to severe pain
   50mcg slow IVP, titrate to pain relief; do not repeat
   Pediatric: 1mcg/kg slow IVP; do not repeat pediatric dose; maximum

CRUSH INJURY

2. **Morphine** 2-12mg slow IVP, titrate to pain relief; maximum total adult dose 20mg
   Pediatric: 0.1mg/kg slow IVP; do not repeat pediatric dose; maximum total dose 4mg
   OR
   Fentanyl see above for dosing.

Base hospital contact shall be made following each of the treatment protocols. If communication cannot be established, base contact shall be made with a full patient report prior to leaving the receiving facility.

SYMPTOMATIC BRADYCARDIA

1. General ALS

ADULT: HR < 40/MINUTE AND SBP <80MMHG:

2. **Atropine** 0.5mg IVP
3. If suspected hyperkalemia, **Albuterol** 5mg via continuous mask nebulization two times
4. If no improvement, TCP; follow department guidelines

PEDIATRIC: HR <60/MINUTE:

2. Assist respirations with BVM prn
   Rescue airway: King LTs-D if ≥12yrs and 4ft. tall
3. Advanced airway prn.
4. CPR if ≤8yrs and HR <60bpm after effective ventilations

SUPRAVENTRICULAR TACHYCARDIA NARROW QRS ≥150bpm

1. General ALS

ADEQUATE PERFUSION

Adult:

2. Valsalva maneuver

If no conversion, **Adenosine** 6mg rapid IVP immediately followed by a 10-20ml NS bolus

4. If no conversion, **Adenosine** 12mg rapid IVP immediately followed by a 10-20ml NS bolus

Pediatric (infant HR>220bpm, child HR >180bpm):

5. Rapid transport. Monitor closely.

POOR PERFUSION

Adult:

2. If IV access, **Adenosine** 12mg rapid IVP immediately followed by a 10-20ml rapid IV flush. If no conversion, may repeat one time in 1-2min
3. Synchronized cardioversion❖ May repeat one time.

Pediatric:

4. NS fluid challenge 20ml/kg IV

SUPRAVENTRICULAR TACHYCARDIA WIDE QRS

1. General ALS

ADEQUATE PERFUSION >150BPM

Adult:

2. **Adenosine** 6mg rapid IVP immediately followed by a 10-20ml NS bolus
3. If no conversion, **Adenosine** 12mg rapid IVP immediately followed by a 10-20ml NS bolus.

Pediatric

4. Rapid transport. Monitor closely.

POOR PERFUSION

Adult:

2. Synchronized cardioversion, may repeat one time❖

Pediatric:

3. Synchronized cardioversion 0.5-1J/kg mono- or biphasic
4. If no conversion, synchronized cardioversion 2J/kg
5. Rapid transport

❖Adult biphasic: administer according to departmental or manufacturer's recommendations. If unknown, use highest setting.

CARDIOPULMONARY ARREST

Non-Traumatic

1. BCLS/cardiac monitor

IF V-FIB/PULSELESS V-TACH:

Unwitnessed: 2min CPR at 100/min or greater then defibrillate, minimize interruptions to CPR and immediately resume CPR for 2min
Witnessed: CPR while charging monitor; defibrillate

2. Defibrillation
   Adult: biphasic,120-200J❖ monophasic 360J
   Pediatric: 2J/kg monophasic or biphasic❖
3. Venous access; if unable, place IO*
   If hypovolemia, NS fluid challenge:
   Adult: 10ml/kg rapid IV/IO*
   Pediatric: 20ml/kg IV/IO*
4. Defibrillation
   Adult: biphasic❖ monophasic 360J
   Pediatric: 4J/kg monophasic or biphasic❖
5. **Epinephrine** (1:10,000) (indicated for all pulseless rhythms)
   Adult: 1mg IV/IO*
   Pediatric: 0.01mg/kg IV/IO*
6. If no conversion, defibrillate and immediately resume CPR for 2min
   Adult: biphasic❖ monophasic 360J
   Pediatric: 4 J/kg monophasic or biphasic❖
7. If no conversion, immediately resume CPR for 2min

ASYSTOLE OR PEA

2. Venous access, if unable, place IO*
3. **Adult: Epinephrine** (1:10,000) 1mg IV or IO*
   Pediatric: 0.01mg/kg IV/IO*
4. If narrow complex and HR >60bpm: NS fluid challenge 10ml/kg IV or IO* in 250cc increments
5. Advanced airway prn

Traumatic

1. BCLS - do not delay transport for treatment, maintain spinal immobilization if indicated
2. Cardiac monitor
   If V-Fib/Pulseless V-Tach:
3. Defibrillation
   Adult: biphasic 120-200J❖ monophasic 360J
   Pediatric: 2J/kg monophasic or biphasic
4. Perform needle thoracostomy enroute if suspected tension pneumothorax
5. Advanced airway prn.
6. Venous access en route. If unable to establish IV, place IO*

Adult: 10ml/kg rapid IV/IO*
Pediatric: 20ml/kg IV/IO*

* If IO is available

HAZARDOUS MATERIAL

1. General ALS
2. If base contact cannot be established, refer to Ref. No. 1225, Nerve Agent Exposure, and Ref. No. 1235, Radiological Exposure.

Base hospital contact shall be made following each treatment protocol. If communication cannot be established, base contact shall be made with a full patient report prior to leaving the facility.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 834, Patient Refusal of Treatment or Transport

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Definition of Decision-Making Capacity	Base Hospital Advisory Committee	Add "rationale explanation of their" so it reads "Relate the above information to their personal values, and then make and convey a rational explanation of their decision."	Change made
		Delete "…determined because the ability is:" so it reads "Lack of decision-making capacity may be:"	Change made
		Add language to "Never existed" category "…those who are deemed by the Courts as incompetent or a person under conservatorship"	Change made
Definition of Decision-Making Capacity, Never Existed	Provider Agency Advisory Committee	Replace "mental retardation" with "neurodevelopmental disorder"	Change made
Principle 3	Base Hospital Advisory Committee	Delete "…intoxication"	Change made
		Add "…but are not sufficient to eliminate decision-making capacity" so it reads "Mental illness, drugs, alcohol, or physical/mental impairment may significantly impair a patient's decision-making capacity but are not sufficient to eliminate decision-making capacity."	Change made
		Add "…or a patient's report of ingesting drugs/alcohol..." so it reads "Diagnosed mental illness alone or a patient's report of ingesting drugs/alcohol does not justify a determination of lace of decision-making capacity.	Change made
	Provider Agency Advisory Committee	Delete "…significantly"	Change made

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy I	Base Hospital Advisory Committee	Restate title to read “Adult With Decision-Making Capacity or Minor (Not Requiring Parental Consent)	Change made
Policy II	Base Hospital Advisory Committee	Restate title to read “Individual Lacking Decision-Making Capacity or Minor (Requiring Parental Consent)	Change made

Los Angeles County EMS Agency

POLICY REVIEW SUMMARY BY COMMITTEE

Reference No. 834, Patient Refusal of Treatment or Transport

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	02/05/15	02/18/15	Y
	Base Hospital Advisory Committee	02/02/15	02/11/15	Y
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

***** See attached **Summary of Comments Received**

DEPARTMENT OF HEALTH SERVICES

COUNTY OF LOS ANGELES

(EMT/PARAMEDIC/MICN)

SUBJECT: **PATIENT REFUSAL OF TREATMENT OR TRANSPORT** REFERENCE NO. 834

PURPOSE: To provide procedures for EMS personnel to follow when patients, parents, or legal representatives refuse medical treatment and/or ambulance transportation.

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

DEFINITIONS:

Adult: A person at least eighteen years of age.

Minor: A person less than eighteen years of age.

Minor Not Requiring Parental Consent is a person who:

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

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

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

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

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

APPROVED: _____ _____

Director, EMS Agency Medical Director, EMS Agency

Lack of decision-making capacity may be:

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

Emergency: A condition or situation in which an individual has an immediate need for medical attention, whether actual or perceived.

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

"Patient Not Requiring Transport" or "Release at Scene": A patient who, after a complete assessment by EMS personnel, does not meet any criteria listed in Ref. No. 808 and does not appear to require immediate treatment and/or transportation.

Refusing Care Against Medical Advice (AMA): A patient or a legal representative of a patient who has the capacity to refuses treatment and/or transport. This includes patients who meet any criteria listed in Ref. No. 808, or appear to require immediate treatment and/or transportation.

PRINCIPLES:

1. An adult or emancipated minor who has decision-making capacity has the right to determine the course of their medical care including the refusal of care. These patients must be advised of the risks and consequences resulting from refusal of medical care.

2. A patient less than eighteen (18) years of age, with the exception of minors not requiring parental consent, must have a parent or legal representative to refuse evaluation, treatment, and/or transport for an emergency condition.

3. A patient determined by EMS personnel or the base hospital to lack decision-making capacity may not refuse care AMA or be released at scene. Mental illness, drugs, alcohol, or physical/mental impairment may impair a patient's decision-making capacity but are not sufficient to eliminate decision-making capacity. Patients who have attempted suicide, verbalized suicidal intent, or if other factors lead EMS personnel to suspect suicidal intent, should be regarded as lacking the decision-making capacity. Diagnosed mental illness alone or a patient's report of ingesting drugs/alcohol does not justify a determination of lack of decision-making capacity. Capacity determinations are specific only to the particular decision that needs to be made.

4. At no time are EMS personnel to put themselves in danger by attempting to treat and/or transport a patient who refuses care.

POLICY:

I. Adult With Decision-Making Capacity or Minor (Not Requiring Parental Consent)

A. EMS personnel shall advise the patient of the risks and consequences which may result from refusal of treatment and/or transport. The patient should be advised to seek immediate medical care.

B. If the patient's condition meets any criteria for base hospital contact and a BLS unit is alone on scene, an ALS unit should be requested.

C. When base hospital contact is made, contact should be made prior to the patient leaving the scene. Paramedics shall advise the base hospital of all the circumstances including care, transportation, reasons for refusal, and the patient's plans for follow-up care.

D. Paramedics shall have the patient or their legal representative, as appropriate, sign the release (AMA) section of the EMS Report Form. The signature shall be witnessed, preferably by a family member.

E. A patient’s refusal to sign the AMA section should be documented on the EMS Report Form.

II. Individual Lacking Decision-Making Capacity or a Minor (Requiring Parental Consent)

A. The patient should be transported to an appropriate receiving facility under implied consent. A 5150 hold is not required.

B. If EMS personnel or the base hospital determines it is necessary to transport the patient against their will and the patient resists, or the EMS personnel believe the patient will resist, assistance from law enforcement should be requested in transporting the patient. Law enforcement may consider the placement of a 5150 hold on the patient but this is not required for transport.

C. Law enforcement should be involved whenever EMS personnel believe a parent or other legal representative of the patient is acting unreasonably in refusing immediate care and/or transport.

III. Patients Released at Scene

A. EMS personnel shall advise the patient to seek follow-up treatment or immediate medical care, including re-contacting 9-1-1 if they develop symptoms at a later time. The advice given should be documented on the EMS Report Form.

B. EMS personnel should not require patients released at scene to sign the release (AMA) section of the EMS Report Form, as this implies that the patient is at significant risk by not utilizing the EMS system for treatment and/or transportation.

IV. Documentation:

An EMS Report Form must be completed for each incident of patient refusal of emergency medical evaluation, care and/or transportation. EMS personnel shall ensure that documentation includes, at a minimum, the following:

A. Patient history and assessment
B. Description of the patient which clearly indicates their decision-making capacity
C. What the patient is refusing (i.e., medical care, transport)
D. Why the patient is refusing care
E. Risk and consequences of refusing care
F. Statement that the patient understands the risks and consequences of refusing care
G. Signature of patient or legal representative refusing care
H. Patient's plan for follow-up care

CROSS REFERENCE:

Prehospital Care Manual

Ref. No. 808, **Base Hospital Contact and Transport Criteria**
Ref. No. 832, **Treatment/Transport of Minors**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: SUMMARY OF COMMENTS RECEIVED REFERENCE NO 202.1

Reference No. 1200

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Airway/Pulse Oximetry/Oxygen Therapy (pg 5/9)	BHAC – 2/11/15	Approved new definitions of "Unprotected/unsecure airway" and "Unmanageable airway" (with grammar & typo corrections)	Corrections made
	PAAC – 2/18/15	Approved new definitions and requested an additional definition of "secured airway"	Addition made

Los Angeles County EMS Agency

POLICY REVIEW SUMMARY BY COMMITTEE

Reference No. 1200, Treatment Protocols

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	02/05/15	02/18/15	Y
	Base Hospital Advisory Committee	02/02/15	02/11/15	Y
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

***** See attached **Summary of Comments Received**

GENERAL INSTRUCTIONS FOR TREATMENT PROTOCOLS

The Treatment Protocols were developed by combining the Base Hospital Treatment Guidelines (BHTG) and the Standing Field Treatment Protocols (SFTP). The foundations for the revised guidelines are the paramedic scope of practice, medical research, and community standards in medical practice. A sign/symptom orientation to treating the prehospital care patient has been retained.

GENERAL INFORMATION

1. Patients with the same disease may have differing complaints and presentations, and conversely, patients with similar signs and symptoms may have very different diagnoses.

2. The Treatment Protocols guide treatment of “classic” presentations based on evidence-based practice. Base hospital physicians, mobile intensive care nurses (MICNs) and paramedics must utilize their medical knowledge, expertise and critical thinking to determine appropriate treatments for each patient.

3. The protocols were not developed with the intent that all therapies be done on scene. Transport of patients with treatment en route is left to the discretion of the base hospital and the field unit.

PROTOCOL FORMAT

1. Pharmacologic agents are in **bold** typeface.

2. Pediatric treatments are preceded by the Los Angeles County Emergency Department Approved for Pediatrics (EDAP) teddy bear symbol. 

3. Paramedics must measure all pediatric patients using a pediatric resuscitation tape and report the identified color code. The color is documented on the EMS Report Form in the patient weight section. Medication dosages are then determined by correlating the pediatric resuscitation tape color with the appropriate range on the Color Code Drug Doses/L.A. County Kids chart or the pediatric doses in the Drug Administration section.

4. The **Special Considerations** section has additional helpful information specific to the chief complaint and/or specific patient population.

APPROVED:

Director, EMS Agency

Medical Director, EMS Agency

USING THE TREATMENT PROTOCOLS

Determine the patient's chief complaint or problem and then identify the protocol that best meets their needs.

1. Follow each treatment protocol in sequence as written.

2. If more than one treatment protocol applies, begin by using the one most closely associated with the patient's primary complaint. Utilize Reference No. 806.1,

   Procedures Prior to Base Contact, as indicated and refer to other treatment protocols as needed.

3. If the patient's status changes, a different treatment protocol might be needed. Select the new treatment protocol by taking into account the treatments already performed.

4. Not all the treatment protocols have an SFTP component. Some have only procedures that can be done under Ref. No. 806.1 and then base contact is required. Report the treatment protocol number or name when making base contact such as, "we have a crush injury and are utilizing Ref. No. 1277" or "we are using the crush injury treatment protocol".

5. All treatment protocols will be located in Section 1200 of the Prehospital Care Manual; therefore, each protocol will be identified by a four-digit number starting with "12". The 4-digit protocol number should be documented if the Base Hospital Report Form or EMS Report Form has adequate space. If the form does not allow for four digits, document the last three digits of the protocol.

6. The treatment protocols replace the former SFTPs; therefore, all protocols that have designations with an alpha character and a number (M4, T2, P1, etc.) have been deleted.

7. The SFTP portion of the treatment protocols can only be used by approved SFTP provider agencies.

CONTACT THE BASE HOSPITAL WHEN:

1. Indicated by the protocol

2. ALS intervention is performed and the provider agency is not an authorized SFTP provider

3. Additional or unlisted treatments are required

4. Consultation with the base hospital would be helpful

5. ST Elevation Myocardial Infarction (STEMI) notification and destination are required

6. Stroke notification, last known well date and time, and destination are required

Once base contact is made for medical control, all subsequent treatments listed in the protocol require a base hospital order.

Airway/Pulse Oximetry/Oxygen Therapy

Providing oxygen to emergency medical services (EMS) patients may be a lifesaving procedure. In particular, patients in acute respiratory distress should receive aggressive oxygenation, including patients who have a history of chronic lung disease.

Oxygen should be treated like any other drug and administered only when indicated for signs and/or symptoms of hypoxia such as: oxygen saturation (SpO_2) less than 94% with respiratory distress, altered mental status or changes in skin signs.
Basic airway maneuvers: establishing and maintaining an open airway with positioning, obstructed airway maneuvers, airway adjuncts and suctioning should be performed prior to advanced airway maneuvers: direct laryngoscopy for foreign body removal, endotracheal intubation or King LTs-D (Disposable Supraglottic Airway device).

1. If pulse oximetry is not available (BLS Unit) and the patient is in mild or moderate respiratory distress, provide oxygen (O_2) with nasal cannula at 2-6 liters per minute.

2. When available, use pulse oximetry and document reading to guide oxygen therapy. The desired oxygen saturation (SpO_2) for most non-critical patients is 94 – 98%.

3. Initiate oxygen O_2 therapy and titrate as follows:

   a. Stable patients with mild hypoxia (SpO_2 less than 94%) – start O_2 with nasal cannula at 2-6 liters per minute or basic mask at 8-10 liters per minute

   b. Patients unable to tolerate nasal cannula or basic mask – use blow-by technique using the following:

      - Adult – 10-15 liters per minute
      - Infant/Child – 6-10 liters per minute
      - Newborn – 5 liters per minute

   c. Critical patients (those with impending or actual respiratory or cardiopulmonary arrest) – **O_2 should not be withheld in any critical patient**, start O_2 using the appropriate O_2 delivery system based on the patient's condition:

      - Non-rebreather mask – 12-15 liters per minute
      - BVM with reservoir – 15 liters per minute
      - Endotracheal tube – 15 liters per minute
      - King LTS-D airway – 15 liters per minute
      - CPAP – Refer to Ref. No. 1312

d. Special Considerations:
- Chronic Obstructive Pulmonary Disease (COPD) – goal SpO_2 is 88 – 92%
- Carbon Monoxide Poisoning – goal SpO_2 is 100%
- Newborn in need of positive-pressure ventilation – ventilate for 90 seconds with room air, if heart rate remains less than 100 beats per minute, start O_2 at 15 liters per minute
- Traumatic Brain Injury - goal SpO_2 is 100%

4. Continue oxygen therapy until transfer of patient care.

5. Monitor and document the SpO_2, oxygen delivery system used and the liters per minute administered.

6. If suctioning is required, pre-oxygenate prior to suctioning. Maintain sterile procedures and do not suction longer than 10 seconds per occurrence.

7. Considerations for oropharyngeal airway:
- Unconscious
- Absent gag reflex

8. Considerations for nasopharyngeal airway:
- Oropharyngeal airway cannot be inserted
- Spontaneously breathing patients who require assistance in maintaining a patent airway

9. Considerations for bag-valve-mask (BVM) ventilation:
- Apnea or agonal respirations
- Compromised ventilatory effort

10. Considerations for endotracheal intubation
Adults or Pediatrics 12 years of age or older **or** height greater than the length of the pediatric resuscitation tape with:
- Ineffective ventilation with BVM
- Prolonged transport time
- Unprotected airway

11. Considerations for rescue airway (King LTS-D)
- Unsuccessful attempts (maximum three attempts) at endotracheal intubation
- Suspected difficult airway based on assessment and anatomical features

Small adult: Size 3 for 12yrs of age or older **and** height between 4'-5'
Adult: Size 4 for 12yrs of age or older **and** height between 5'-6'
Large adult: Size 5 for 12yrs of age or older **and** height greater or equal to 6'

12. Verify endotracheal tube or rescue airway placement. Document the methods used for placement verification which should include a combination of:
- Capnography
- End-tidal CO_2 detector
- Bilateral lung sounds
- Bilateral chest rise

- Absent gastric sounds
- Esophageal detector device (EDD)

13. Continuously assess ventilation status and monitor waveform capnography of all patients requiring bag-valve-mask ventilation or advanced airway placement. Report capnography reading to the base hospital and document capnography reading as follows:
    - Every five minutes during transport
    - After any patient movement
    - Upon transfer of care
    - Change in patient condition

Protected/secured airway: Ventilation is effective and risk of aspiration is minimized, such that one of the following hold true:

1. Patient is breathing adequately and able to protect his/her own airway.
2. Patient is mechanically ventilated effectively through a cuffed tube in the trachea.

Unprotected/unsecure airway: The patient is not able to protect his/her airway and is not being ventilated via an endotracheal tube secured in the trachea. Ventilation is effective, either spontaneous or via BVM or King tube.

Unmanageable airway: The patient is not able to maintain his/her airway, is not breathing adequately, and cannot be ventilated via BVM, King or endotracheal tube.

Perfusion Status

Perfusion status is determined by a **combination** of parameters that includes heart rate, blood pressure, tissue color and mentation.

1. **Adequate Perfusion:** adequate circulation of blood through organs and tissues, manifested by normal pulse, tissue color, level of consciousness and blood pressure.

2. **Poor Perfusion:** Bradycardia, tachycardia, and/or altered mental status (includes anxiety, restlessness, lethargy, altered level of consciousness) associated with other symptoms of poor perfusion (hypotension, shortness of breath, chest pain and/or poor tissue color).

3. Base hospital contact should be initiated on hypotensive patients or if perfusion status is poor.

GUIDELINES FOR DETERMINATION OF POOR PERFUSION:

<u>Adults:</u>

1. Systolic blood pressure (SBP) less than 100mmHg, many medications are not administered if the SBP is less than 100mmHg.

2. Bradycardia, tachycardia, and/or altered mental status (includes anxiety, restlessness, lethargy, altered level of consciousness) associated with other

symptoms of poor perfusion (hypotension, shortness of breath, chest pain and/or poor tissue color).

3. Poor pulse quality (weak/thready)

4. Increased respiratory effort and/or rate greater than 24 per minute in conjunction with other parameters

5. Delayed capillary refill time (greater than 2 seconds)

6. History of current chief complaint with potential for rapid deterioration

Pediatrics:

1. SBP less than 60mmHg in conjunction with other parameters

2. Heart rate less than 60bpm or greater than 180bpm in conjunction with other parameters

3. Labored respirations (retractions, grunting, nasal flaring) in conjunction with other parameters

4. Tissue color (i.e., pallor, cyanosis, mottling) is considered a sign of poor perfusion

5. Altered mental status (includes anxiety, restlessness, lethargy, or altered level of consciousness)

6. Delayed capillary refill time (greater than 2 seconds) in conjunction with other parameters

7. History of current chief complaint with potential for rapid deterioration

Venous Access

Venous access is a catheter inserted into a vein and attached to either an intravenous (IV) line of normal saline or a saline lock.

1. Saline lock: intermittent IV device used for patients with stable vital signs or patients who do not require volume replacement but may need limited IV medications

2. To keep open (TKO): slowest drip rate (approx. 30gtts/min); used for patients who might need fluid replacement or multiple intravenous medications

3. Fluid challenge: 10ml/kg rapid IV fluid administration with reassessment at 250ml increments

Pediatrics: 20ml/kg, reassess after initial fluid challenge

4. Fluid resuscitate: wide open intravenous fluid administration through large lumen tubing, preferably using two sites

Pediatrics: 20ml/kg, may repeat two times, reassess after each fluid challenge

5. Pre-existing vascular access device: paramedics may access external venous access devices for patients who are in extremis or if directed by the base hospital

ECG Documentation

Complete and accurate ECG documentation is essential for patient care and quality improvement purposes.

1. Document the ECG interpretation on the front of the EMS Report Form in the ECG Section. If a dysrhythmia is identified, a six-second strip must accompany the following:

   a. Receiving Hospital copy for continuation of patient care.

   b. Provider Agency copy as the official medical record.

2. The patient's name and/or sequence number should be written on the ECG strip. If only one segment of the ECG is available (i.e., run of V-tach), attach to the Receiving Hospital copy and, if possible, photocopy and attach to the Provider Agency copy.

2. 12-Lead ECG documentation: document the computer ECG interpretation of STEMI on the EMS Report Form with the time noted. Write the sequence number on the 12-lead tracing and distribute the copies as follows:

   a. Hand the original directly to the nursing staff at the ST Elevation Myocardial Infarction Receiving Center (SRC).

   b. Retain a copy per the provider agency's departmental policy.

Pediatric Patients

Separate pediatric guidelines were not developed for every sign and symptom. For guidelines not developed expressly for pediatrics, treatments specific to pediatrics are referenced under Drug Administration and/or Special Considerations and are preceded by a teddy bear symbol for easy identification.

Medication Orders and Administration

Base hospitals must provide complete medication orders to include:

1. Name of the medication
2. Dose
3. Route of administration
    a. Intravenous (IV)
    b. Intravenous Piggy-Back (IVPB)
    c. Intramuscular (IM)
    d. Intranasal (IN)
    e. Intraosseous (IO)
    f. Per Os (PO)
    g. Sublingual (SL)
4. Frequency of administration, if applicable

Paramedics are to repeat complete orders back to the base hospital.

*Standing Field Treatment Protocol (SFTP) Providers

Additional treatments that can be performed by an approved SFTP provider prior to base contact are identified by **"Continue SFTP or Base Contact".** All subsequent treatments may be performed until the paramedic reaches the notation **"Establish Base Contact"**. Once **"Establish Base Contact All**" appears, all ensuing treatments require an order from the base hospital.

The following dysrhythmias require establishing base hospital contact:

- Symptomatic Bradycardia
- Supraventricular Tachycardia (SVT)
- Ventricular Tachycardia (contact not required if utilizing Cardiac Arrest protocol and no pulse is present)
- Ventricular Fibrillation

- Second and Third Degree Heart Blocks
- Symptomatic Atrial Fibrillation/Atrial Flutter

If base hospital contact is made to obtain patient care orders, a full patient report will be given. If the patient meets trauma guidelines but is being transported to a non-trauma hospital, a full patient report must be given.

It is the expectation when providing receiving hospital report for patient notification only, the following minimal patient information will be provided:

All Patients
Provider Code/Unit #
Sequence Number
Location (if 9-1-1 transfer)
Chief complaint
Age and units
Gender
Level of distress
Name of the protocol (number optional)
Glasgow Coma Scale (GCS), if altered
Airway adjuncts utilized, if applicable
Destination/ETA

Additional information if:
Trauma Complaint and transporting to a trauma center
Mechanism of injury
Location of injuries/pertinent information (flail segment, rigid abdomen, evisceration, etc.)
Complete vital signs and GCS

Pediatric
Pediatric Weight (in kg from weight-based tape) and Color Code (if applicable)

STEMI
12-Lead ECG rhythm/interpretation if the 12-lead ECG indicates STEMI, to include quality of tracing

If mLAPSS (modified Los Angeles Stroke Screen) performed:
If positive/met
Last known well date and time
Blood glucose

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC, MICN)
REFERENCE NO. 1251

TREATMENT PROTOCOL: STROKE / ACUTE NEUROLOGICAL DEFICITS *

1. Basic airway
2. Spinal immobilization prn
3. Pulse oximetry
4. Oxygen prn
5. Advanced airway prn
6. If shock, treat by Ref. No. 1246, Non-Traumatic HypotensionTreatment Protocol
7. Cardiac monitor: document rhythm and attach ECG strip if dysrhythmia identified
8. Venous access prn
9. Perform blood glucose test, if blood glucose is less than 60mg/dl:
   Consider oral glucose preparation if patient is awake and alert
   Dextrose
   50% 50ml slow IV push
   Pediatric: See Color Code Drug Doses/L.A. County Kids
   Less than 2yrs of age: Dextrose 25% 2ml/kg slow IV push
   2yrs of age or older: Dextrose 50% 1ml/kg slow IV push up to 50ml
   Caution in administering to alert patients with acute focal neurological deficits
   If unable to obtain venous access:
   Glucagon
   1mg IM
   Pediatric: See Color Code Drug Doses/L.A. County Kids
10. **CONTINUE SFTP or BASE CONTACT**
11. SFTP providers are responsible for assuring the Approved Stroke Center (ASC) is notified of the patient's pending arrival and contacting the base hospital to provide minimal patient information, including the results of the mLAPPS, last known well date and time, and patient destination (may be done after transfer of care)
12. If unable to obtain venous access and blood glucose remains less than 60mg/dl:
    Glucagon
    1mg IM
    May be repeated every 20min two times
    Pediatric: See Color Code Drug Doses/L.A. County Kids

SPECIAL CONSIDERATIONS

Document time of symptom onset

In order to ensure that proper consent for treatment can be obtained by hospital personnel, if possible, document the name and contact information of the family member, caregiver, or witness who can help verify the patient's last known well time in the Comments area of the EMS Report Form or ePCR. When practical, transport the witness with the patient.

Transport the patient to the nearest ASC if mLAPSS screening criteria are met and transport time is equal to or less than 30minutes regardless of service area rules or considerations

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: SUMMARY OF COMMENTS RECEIVED REFERENCE NO 202.1

Reference No. 1275

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
#3	BHAC – 2/11/15	Approved the addition of Control bleeding – with direct pressure, if unsuccessful, utilize tourniquets and/or hemostatic agents. Approved the addition of footnote #8 – Hemostatic agents are for use by approved providers only.	
	PAAC – 2/18/15	Approved as above	

Los Angeles County EMS Agency

POLICY REVIEW SUMMARY BY COMMITTEE

Reference No. 1275, Treatment Protocol: General Trauma

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	02/05/15	02/18/15	Y
	Base Hospital Advisory Committee	02/02/15	02/11/15	Y
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

***** See attached **Summary of Comments Received**

TREATMENT PROTOCOL: GENERAL TRAUMA *

1. Basic airway
2. Spinal immobilization prn: do not delay transport of hypotensive patients with penetrating torso trauma in order to apply spinal immobilization.
3. Control bleeding – with direct pressure, if unsuccessful, utilize tourniquets and/or hemostatic agents ❸
4. Pulse oximetry
5. Oxygen prn
6. Advanced airway prn
7. Apply 3-sided dressing to sucking chest wounds if indicated
8. If tension pneumothorax suspected and systolic blood pressure less than 80mmHg, remove dressing and consider needle thoracostomy ❶
9. Venous access en route
10. Blood glucose prn
11. Cardiac monitor prn: document rhythm and attach ECG strip if dysrhythmia identified, treat dysthythmias by the appropriate protocol
12. Splints/dressings prn, treatment for specific extremity injuries:
    - Poor neurovascular status – realign and stabilize long bones
    - Joint injury – splint as lies
    - Midshaft femur – splint with traction
13. Consider other protocols for altered level of consciousness with possible medical origin: Ref. No. 1243, Altered Level of Consciousness; Ref. No. 1247, Overdose/Poisoning (Suspected)
14. If evisceration of organs is present, apply moist saline and non-adhering dressing, do not attempt to return to body cavity
15. For pain management of isolated extremity injury:

Fentanyl ❷❸❻

50-100mcg slow IV push, titrate to pain relief
May repeat every 5min, maximum total adult dose 200mcg

Pediatric: 1mcg/kg slow IV push (over 2 minutes)
See Color Code Drug Doses/L.A. County Kids ❼
May repeat every 5min, maximum pediatric dose 50mcg

Morphine ❷❸❻

2-4mg slow IV push, titrated to pain relief
May repeat one time

Pediatric: 0.1mg/kg slow IV push
See Color Code Drug Doses/L.A. County Kids ❼
Do not repeat pediatric dose, maximum pediatric dose 4mg

Poor perfusion:

Normal Saline Fluid Challenge

10ml/kg IV

Pediatric: 20ml/kg IV
See Color Code Drug Doses/L.A. County Kids ❼

16. **CONTINUE SFTP or BASE CONTACT ❹❺**
17. If pain unrelieved,

Fentanyl ❷❸❻

50-100mcg slow IV push, titrate to pain relief
May repeat every 5min, maximum total adult dose 200mcg

Pediatric: 1mcg/kg slow IV push (over 2 minutes)
See Color Code Drug Doses/L.A. County Kids ❼
May repeat every 5min, maximum pediatric dose 50mcg

TREATMENT PROTOCOL: GENERAL TRAUMA *

Morphine ❷❸
2-12mg slow IV push, titrate to pain relief
May repeat every 5min, maximum total adult dose 20mg

18. If continued poor perfusion:
Normal Saline Fluid resuscitate
Wide open IV fluid administration until SBP is equal to or greater than 90mmHg or signs of improved perfusion
Pediatric: 20ml/kg IV
See Color Code Drug Doses/L.A. County Kids ❼

SPECIAL CONSIDERATIONS

❶ Indications for needle thoracostomy include unilateral breath sounds and profound hypotension (SBP equal to or less than 80mmHg) with one or more of the following:
- Altered mental status
- Severe respiratory distress
- Cyanosis
- Shock
- Cool, pale, moist skin

❷ Use with caution: in elderly; if SBP less than 100mmHg; sudden onset acute headache; suspected drug/alcohol intoxication; suspected active labor; nausea/vomiting; respiratory failure or worsening respiratory status

❸ Absolute contraindications: Altered LOC, respiratory rate less than 12 breaths/min, hypersensitivity or allergy

❹ Base hospital contact must be established for all patients who meet trauma criteria and/or guidelines; generally, this is the designated trauma center. SFTP providers may call the trauma center directly or establish base contact if transporting the patient to a non-trauma hospital.

❺ Receiving Hospital Report
Provider Code/Unit #
Sequence Number
Age/Gender
Level of distress
Mechanism of Injury/Chief Complaint
Location of injuries
Destination/ETA
If patient meets trauma criteria/guidelines/judgment:
Regions of the body affected
Complete vital signs/Glasgow Coma Scale (GCS)
Airway adjuncts utilized
Pertinent information (flail segment, rigid abdomen, evisceration)

❻ Ondansetron 4mg IV, IM or ODT may be administered prior to fentanyl or morphine administration to reduce potential for nausea/vomiting

❼ If the child is off the Pediatric Resuscitation tape and adult size, move to the Adult protocol and Adult dosing

❽ Hemostatic agents are for use by approved providers only

TREATMENT PROTOCOL: GENERAL TRAUMA *

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: SUMMARY OF COMMENTS RECEIVED REFERENCE NO 202.1

Reference No. 1314

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Principles #5	BHAC – 2/11/15	Remove – Reference No. 1248, Pain Management or.	Removed
Principles #6		Remove – approved for usage by SWAT and replace with	Removed
	PAAC – 2/18/15	Above approved	

Los Angeles County EMS Agency

POLICY REVIEW SUMMARY BY COMMITTEE

Reference No. 1314, Medical Control Guideline: Traumatic Hemorrhage Control

	Committee/Group	Date Assigned	Approval Date	Comments* (Y if yes)
EMS ADVISORY COMMITTEES	Provider Agency Advisory Committee	02/05/15	02/18/15	Y
	Base Hospital Advisory Committee	02/02/15	02/11/15	Y
	Data Advisory Committee			
	Education Advisory Committee			
OTHER COMMITTEES/RESOURCES	Medical Council			
	Trauma Hospital Advisory Committee			
	Ambulance Advisory Board			
	EMS QI Committee			
	Hospital Association of So California			
	County Counsel			
	Other:			

***** See attached **Summary of Comments Received**

MEDICAL CONTROL GUIDELINE: TRAUMATIC HEMORRHAGE CONTROL

PRINCIPLES:

1. Tourniquets have been demonstrated to be safe and effective when used appropriately and can be lifesaving.

2. A hemorrhage control tourniquet should be used if external bleeding from an extremity cannot be controlled by direct pressure.

3. Poorly perfusing patients with an isolated penetrating extremity injury and those with amputations or mangled extremities should have a tourniquet applied even if minimal to no visible bleeding.

4. Tourniquet application may be the initial method to control extremity bleeding when scene safety concerns or resource limitations preclude direct pressure application.

5. Tourniquet application frequently results in severe pain. Consider pain management as necessary. Refer to Reference No. 1275, General Trauma.

6. Hemostatic Agents are only to be utilized by approved providers.

GUIDELINES:

1. Explain usage of tourniquet to patient.

2. Follow manufacturer's instructions for application of the tourniquet.

3. Apply tourniquet 2-3 inches proximal to the bleeding site but not over a joint or the hemorrhaging injury.

4. Ensure that bleeding is stopped and distal pulses are absent after the application of the tourniquet.

5. Once a tourniquet is applied, the patient should be reassessed at least every 5 minutes for continued absence of distal pulse and/or bleeding.

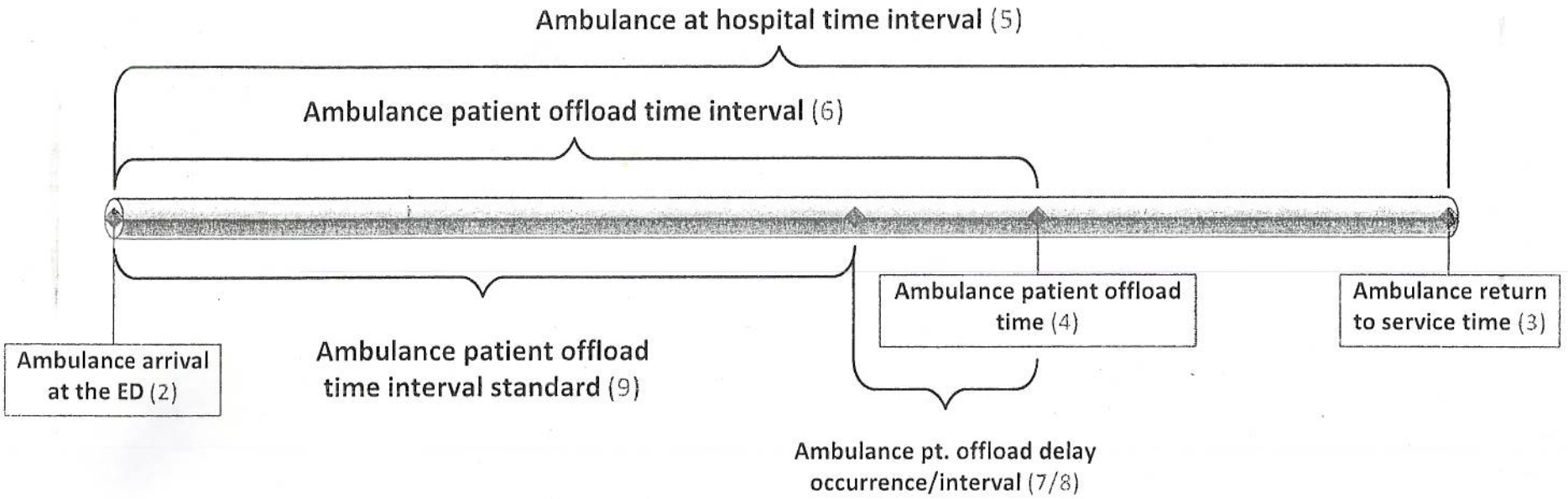
6. If bleeding is not controlled with one tourniquet, a second tourniquet may be applied proximal to the first tourniquet. Do not remove the first tourniquet after applying the second tourniquet.

7. Once a tourniquet is applied it should not be loosened or removed without physician approval.

8. Paramedics shall make base hospital contact and transport in accordance with Reference No. 808, Base Hospital Contact and Transport, and Reference No. 502, Patient Destination.

9. Paramedic shall document the time tourniquet applied on the tourniquet and on the EMS Report Form. Remaining patient documentation will be in accordance with Reference No. 606, Documentation of Prehospital Care.

Ambulance Patient Offload Delay
Draft Definitions and Nomenclature for Metric Development
February 2014



1. **Ambulance transport** – is defined as the transport of a patient from the prehospital EMS system by emergency ambulance to an approved EMS receiving hospital
2. **Ambulance arrival at the ED** - is defined as the time ambulance stops (actual wheel stop) at the location outside the hospital ED where the patient is unloaded from the ambulance.
3. **Ambulance return to service time** – is defined as the time the ambulance is response ready after transporting a patient to a hospital ED.
4. **Ambulance patient offload time** – is defined as the time the patient is physically removed from the ambulance gurney to hospital equipment.
5. **Ambulance at hospital time interval** – defined as the period of time between ambulance arrival at the hospital ED and ambulance return to service time.
6. **Ambulance patient offload time interval** (commonly referred to as ambulance wait time or wall time) – is defined as the period of time between ambulance arrival at the ED and ambulance patient offload time.
7. **Ambulance patent offload delay interval** – is the resulting period of time produced when the ambulance patient offload time interval exceeds the established ambulance patient offload time interval standard. That is to say it is the time accumulated when a patient remains on the ambulance gurney in excess of the offload time interval standard.
8. **Ambulance patient offload delay occurrence –** the occurrence of an ambulance patient remaining on the ambulance gurney beyond the ambulance patient offload time interval standard.
9. **Ambulance patient offload time interval standard** – is the established system performance standard for the period of time between ambulance arrival at the ED and ambulance patient offload time.

BUSINESS 5.2