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: **July 15, 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
- March 18, 2015
- May 20, 2015

2 CORRESPONDENCE
- 2.1 July 1, 2015, Howard Backer, M.D., Director, Emergency Medical Services Authority: Appointment of Dr. Marianne Gausche-Hill to the position of Medical Director for the Los Angeles County EMS Agency
- 2.2 June 30, 2015, Fire Chief, Each 9-1-1 Paramedic Provider Agency: Updates for Deployment of Fireline Emergency Medical Technician-Paramedic and Strike Team Assessment Units
- 2.3 June 16, 2015, Daryl Osby, Fire Chief, Los Angeles County Fire Department: Memorandum of Understanding (MOU H-702098), Measure B Funds allocated for lease of helicopter stationed in East San Gabriel Valley (ESGV)
- 2.4 June 16, 2015, Andrew Leeka, Chief Executive Officer, Good Samaritan Hospital: Approved Stroke Center Agreement
- 2.5 June 15, 2015, James Theiring, Chief Executive Officer, Mission Community Hospital: Approved Stroke Center Agreement
- 2.6 May 26, 2015, Distribution: Cath Lab Activation Algorithm
- 2.7 May 18, 2015, Distribution: Designation of Approved Stroke Centers
- 2.8 May 18, 2015, Lieutenant Robert Lamborghini, Medical Program Coordinator, Glendora Police Department: Approval to utilize intranasal naloxone for patients with a suspected opiate overdose

(Correspondence-continued)

2.9 May 11, 2015, To whom it may concern: Letter of support for a pilot project by the Los Angeles Fire Department to participate in the Centers for Disease Control and Prevention (CDC) sponsored Cardiac Arrest Registry to Enhance Survival (CARES) registry

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. 806.1, Procedures Prior to Base Contact
4.2 Reference No. 808, Base Hospital Contact and Transport Criteria
4.3 Reference No. 808.1, Base Hospital Contact and Transport Criteria Field Reference
4.4 Reference No. 1202, Treatment Protocol: General ALS*
4.5 Reference No. 1210, Treatment Protocol: Non-Traumatic Cardiac Arrest (Adult)*
4.6 Reference No. 1275, Treatment Protocol: General Trauma*

5. BUSINESS

Old:

5.1 Community Paramedicine *(July 18, 2012)*
5.2 1+1 Paramedic Staffing Model *(November 21, 2012)*
5.3 Public Hearing – Transport of 5150 Patients *(March 18, 2015)*
5.4 Los Angeles Surgical Society *(May 20, 2015)*

New:

(None)

6. COMMISSIONERS COMMENTS/REQUESTS

7. LEGISLATION - Cathy Chidester

8. EMS DIRECTOR'S REPORT - Cathy Chidester

9. ADJOURNMENT

(To the meeting of September 16, 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
July 15, 2015

1. **MINUTES**
   - March 18, 2015
   - May 20, 2015

2. **CORRESPONDENCE**
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4. **POLICIES**
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   - 4.6 Reference No. 1275, Treatment Protocol: General Trauma*

Executive Director
Cathy Chidester
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MARCH 18, 2015
(Revised: 5/20/2015)

	COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
☑	David Austin (1:32 pm)	LAC Ambulance Assn	Cathy Chidester	Director, EMS Agency
☑	Robert Barnes	LAC Police Chiefs Assn	Kay Fruhwirth	Asst. Dir, EMS Agency
☑	Frank Binch	Public Member, 4th District	Richard Tadeo	Asst. Dir, EMS Agency
☑	Erick H. Cheung, M.D.	So. CA Psychiatric Society	Bill Koenig, MD	Med. Dir., EMS Agency
*	Robert Flashman, M.D.	L.A. County Medical Assn	Roel Amara	Asst. Dir., EMS Agency
*	James Lott	Public Member, 2nd District	Marilyn Rideaux	EMSC Liaison
☑	Clayton Kazan, M.D.	CAL/ACEP	Lucy Hickey	EMS Agency
*	Ray Mosack	CA State Firefighters' Assn.	John Telmos	"
	(VACANT)	League of California Cities	Jacqueline Rifenburg	"
☑	Margaret Peterson, Ph.D.	HASC	Brett Rosen, M.D.	"
☑	Andres Ramirez	Peace Officers Assn. of LAC	Susan Mori	"
☑	Nerses Sanossian, M.D.	American Heart Assn.	Michelle Williams	"
☑	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	Richard Espinosa	4th Supervisorial District
Richard Roman	Compton Fire Dept.	Victoria Hernandez	LAC Fire Dept.
Rita Murray	NAMI, LACC/Whittier	Dwayne Preston	Long Beach Fire Dept.
Mike Barilla	Pasadena Fire Dept.	Jamie Garcia	HASC
Robert Ower	LACAA	Todd LeGassick	UCLA
Tim Ernst	LAFD	Doug Zabilski	LAFD
Michael Silk	Intermedix		

(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, Clayton Kazan. A quorum was declared.

INTRODUCTIONS/ANNOUNCEMENTS:

- Chairman Kazan introduced a new Commissioner, Mr. John Hisserich, representing Supervisor Sheila Kuehl, Third District.

CONSENT CALENDAR:

Chairman Kazan called for approval of the Consent Calendar. Commissioner Binch requested that Consent Calendar item 4.3 be held for discussion.

M/S/C: Commissioners Washburn/Snyder to approve the Consent Calendar excluding Consent Calendar item 4.3

Commissioner Binch referred to a statement of background he had distributed for discussion on Reference 834 (item 4.3 on the Consent Calendar).

Motion by Commissioner Binch/Ramirez that:

1) **Item 4.3 be continued;**

2) **and scheduled for consideration as one component of a future widely advertised and centrally-located public hearing on the future role of Los Angeles County EMS in serving patients with behavioral complaints;**

3) **That EMS Agency be asked to prepare, distribute and post on its internet home page, at least 30 days before this hearing, a complete proposed blueprint and recommendations (including pre-hospital care policy changes) on the present and proposed future role of EMS in serving Behavioral Emergency patients.**

Commissioner Binch referred to the redlined copy of Reference No. 834, Patient Refusal of Treatment or Transport, distributed by the EMS Agency as being inaccurate. He then distributed a (historical) document from 2009 where the EMSC forwarded a letter to the Board of Supervisors stating that it did not agree, in most cases, that transport of 5150 holds via law enforcement vehicle was in the best interest of the detainee. In addition, the Board was requested to convene a study group to determine the most appropriate mechanism of transport for persons detained on a 5150 hold by peace officers. He stated that in 2010, on Motion by Supervisor Knabe, the Board of Supervisors approved establishment of a study to improve the transport of 5150 detainees and report back in 120 days.

Commissioner Binch stated that it was his opinion that the EMS Agency has opposed the use of EMS ambulance resources in responding to behavioral emergencies. He pointed out that more than 21,000 transports in 2013 were of a behavioral nature according the EMS data reports. He proposed a public hearing to discuss the future role of L.A. County EMS in serving patients with behavioral emergencies and how it can better interact with Mental Health and law enforcement, and how this would impact fire agencies.

Richard Tadeo, EMS Assistant Director, provided an explanation on the changes of Reference No. 834. In addressing the educational needs of EMS personnel it was

identified that paramedics were having difficulty with the word “competent” and that determining whether a person is competent is more of a legal term. In an effort to address this issue, it was proposed by the Prehospital Care Coordinators to revise Reference No. 834 and remove the term “competent” and replace it with “decision-making capacity.” Based on this suggestion the definition for competent was deleted and the definition for decision-making capacity was added and the rest of Reference No. 834 was revised to reflect this new terminology. Mr. Tadeo stated that the omission of the definition of “5150 Hold” was an unintentional error.

Chairman Kazan: I’m not sure I understand where this concern is headed and I need some clarification. Is your concern that the Sheriff’s Department will transport a large percentage of behavioral health patients themselves and not utilize our contracted EMS services?

Commissioner Binch: I would be willing to provide details but probably in a closed session. 1) There has been concerted effort by EMS Agency staff, a multi-year effort involving hundreds of staff hours to secure support for no connection between using the EMS Agency Emergency Transportation agreement and the Sheriff’s use of ambulance services; 2) In meetings that involved Counsel that I have attended in an advisory capacity, it’s been imminently clear that the Agency’s management strongly opposes the use of EMS for behavioral emergencies. We were also assured that that there was very little of that care which made the October data report an enlightening surprise because it turns out to be a substantial component of what EMS does. I already knew from a case standpoint that some fire departments are pretty aggressive and very skilled in handling behavioral emergencies. I did not realize the volume until the data report came out. This is a big area and at a time when there is a concerted effort on the part of Cathy’s boss, the Director of Health Services, to obtain a closer integration of services between DHS, Mental Health and Public Health. I am suggesting that we get proactive on that issue and it is a good issue. Those of us who deal a lot with response to psychiatric emergencies, on the hospital and analytical level, have a chance to see how many opportunities there are for improving the quality of service by appropriating a version of service. Let’s get a vision in place and move on that issue. The problem that led us to hang our hat on Policy 834 looks minor but really is not. It simply gives us an option to do it the right way. Where is EMS’ role? What shall it be in handling behavioral emergencies and especially how does it integrate with law enforcement, hospitals, and mental health?

Cathy Chidester: The EMS Commission did send a letter to the Board of Supervisors stating that it felt that transport of 5150 holds would be better accomplished by ambulance. There were multiple meeting with the CEOs office regarding the issue. The question as to whether the Sheriff’s Department should be part of the 9-1-1 emergency ambulance transport agreements has been addressed with County Fire, the CEO’s office, County Counsel and Sheriff’s office. The decision was made not to include the transport of Sheriff detainees in the 9-1-1 ambulance EOA RFP. There was also discussion regarding Sheriff’s having a pilot project, contracting directly with ambulance companies to transport 5150 detainees. Department of Mental Health has their own agreements with ambulance companies to do transport of patients who are

experiencing psychiatric issues and being placed on 5150 hold. The issue is complex and there are multiple reasons that it was a policy decision of the CEO's office, County Counsel, and the Department of Health Services that the 9-1-1 emergency ambulance transport agreements were not necessarily appropriate for the Sheriff's Department transports. EMS supports the Sheriff's doing a pilot project for transport of 5150 detainees. EMS is very interested in behavioral health because it has a great impact on our emergency departments and the EMS system. The EMS Agency is also supportive of emergency departments and concerned about patient's rights. I apologize for the misunderstanding of the policy. Yes, a great number of patients may present with behavioral health issues, but they are not necessarily 5150s. They may be only acting out or under the influence of drugs or alcohol. We are working to capture the data better so we have a better understanding of what patients make up the group of behavioral emergencies. Only law enforcement can impose a 5150 hold and if the Sheriff's wants a 5150 detainee transported by ambulance or determine they need assistance from a medical perspective, they always have the option to call County Fire or the jurisdictional provider for involvement from an EMS perspective and assistance with transport.

Commissioner Binch: Why is Reference No. 834 being revised after only one year? Does anyone here think the system works just fine? Could it stand some improvement?

Richard Tadeo explained that the policy revision was at the request of the Prehospital Care Coordinators. Based on an identified educational need the topic of Patient Refusal of Treatment or Transport was being incorporated into the EMS Update 2015. In order for our training to be consistent with the policy, the policy needed to be updated.

Chairman Kazan: Feels that the system is not broken and agrees with Cathy Chidester that a vast majority of EMS behavioral emergency patients are not 5150. Yes, the system could stand to be streamlined and there may be opportunity for improvement. The question is how do we bridge the gap between law enforcement and EMS? The Chair is willing to support a public hearing.

Commissioner Cheung: Psychiatric mental health is a medical condition that should be treated by medical personnel, however, law enforcement personal are usually the first responders in a scene so I would support an effort to investigate how we could best optimize the system.

Commissioner Hisserich: There is a three component motion on the Floor. How do we handle the issue of meeting and blue print?

The meeting was opened for Public Comment on this issue:

Richard Espinosa, Health Deputy, Fourth Supervisorial District: Stated he was terribly surprised that this has come up and that it was a good thing that the EMS Commission had not support this consent item because it would have changed the 5150 issue. It would make Dr. Katz someone who does not tell the truth because he told the

BOS and public and behavioral health advocates who are concerned about the integration of health and mental health services that he did think the Department could do that simply because there was a question in terms of what the history has been doing in dealing with integral health issues. It's a totally different world and we don't want to get our hands messed up. I cannot believe what I heard that this agency has been particularly supportive of efforts in the past including the Sheriff's efforts to do a pilot project which is in our District which our District pushed. I believe that the Agency did all that it could to stop it to the point where Dr. Katz had to write a letter of apology saying the action taken to stop this pilot from going on does not reflect his thinking nor of that of the Department.

What I'm now hearing is contrary to what Dr. Katz has said to the Board, the public and advocates. This agency has been unsupportive in the past and we have reason to believe that EMS has not been doing their job. The process would require stakeholder involvement but seems that EMS selects the stakeholders and other interested were never consulted. There will be a meeting next week with Dr. Katz and from what I can see we have a problem.

Rita Murray, NAMI LACC/Whittier, cannot attend all official meetings and would like to see a system of being notified of important agenda issues that affect stakeholders.

Commissioner Hisserich expressed concern of dealing with the complexity of the Motion on the floor. He stated he felt confident to deal with one or two of the components but not necessarily the entire Motion as a whole.

Commissioner Peterson asked for clarification. Commissioner Binch responded that Reference No. 834 was intended to provide coordination of care by agencies involved in the process of transport of 5150 patients. Unless there is an urgency to approve Reference No. 834, it should be held over for further discussion until the mental health community has had the opportunity to give input.

Amendment to the Motion by Commissioner Binch, Second by Commissioner Ramirez to retain the modification until the definition change that was previously omitted and delete all other changes pending a public hearing.

Commissioner Snyder stated that she disagrees with Commissioner Binch regarding his statement that Reference No. 834 was being pushed through fast. The policy was vetted through the proper groups and while policies may be reviewed on a scheduled basis, when an issue is identified and in addressing that issue it is identified that a policy needs a revision, the policy goes for redraft and this is the situation here. It was not the intent to omit the 5150 definition.

Chairman Kazan asked Commissioner Binch if he would be comfortable with the policy revision of changing the term "competent" to "decision making capacity" and restating the 5150 definition. Commissioner Binch stated that he would be comfortable with making changes that are essential and deferring any other changes specific to 5150.

Motion by Commissioner Binch, second by Commissioner Ramirez to replace his original motion with the following substitute motion:

1) ***Approve item 4.3 with amendment to restore the deleted definition headed, "5150 hold."***
2) ***EMS Agency be asked to prepare a complete proposed blueprint and recommendations (including pre-hospital care policy changes) on the present and proposed future role of EMS in serving Behavioral Emergency patients, to distribute and post on its' internet home page, at least 30 days before a public hearing on the blueprint."***
3) ***EMS Commission hold and widely advertise a centrally-located public hearing on the proposed future role of L.A. County EMS in serving patients with behavioral complaints."***

Also, in subsequent paragraphs on that page, replace the term "5150" with "behavioral emergency."

MSC: Commissioner Binch/Ramirez to approve Reference 834 with the reinsertion of the definition of behavioral emergency.

5.1 Community Paramedicine

Todd Lagassick, UCLA, gave an update and presentation on the education process of the Community Paramedicine Pilot Project in Los Angeles (L.A) County. There were 13 Community Paramedicine pilot projects approved in the State. Two of the projects are in L.A. County. The County's projects deal with alternate transport destinations of low acuity patients, and post discharge follow-up of CHF patients. UCLA's role is to bring all involved entities together, monitor, evaluate and develop the training programs.

Commissioner Austin commended Dr. Baxter Larmon and Todd Lagassick for putting long and hard hours in developing the program.

5.2 Wall Time

Cathy Chidester reported that the State committee addressing wall time met last month and had completed a tool kit for hospital use and a standard wall time definition. The EMS Agency will be working with the Data Advisory Committee, hospitals and providers to gather the wall time data based on the standard wall time definition (arrival at ED to patient offload unto hospital gurney) so that all data collected is comparable. Once data points are analyzed, we will be able to share the information with each 9-1-1 receiving hospitals and work with hospitals that have long wall times to reduce their waits.

5.3 1+1 Paramedic Staffing Model

Richard Tadeo reported that Long Beach Fire submitted a letter dated March 12, 2015 to the EMS Commission by request of Commissioner Lott explaining why it is not economically feasible to add multiple Advanced Life Support capable rescue units to the Long Beach system.
Mr. Tadeo also reported that there has been no change in the percent compliance of two paramedics arriving on scene within 3 minutes of each other. Long Beach's paramedic arrival time is consistent with what was reported in January.
Commissioner Binch wanted to know if Risk Management had been consulted regarding liability factors considering Long Beach has chronically not been able to meeting the standard established in the policy (Reference No.407).

5.4 9-1-1 EMS Provider Ebola Virus Disease (EVD) Patient Assessment and Transportation Guidelines

Roel Amara reported that Los Angeles County continues to coordinate preparedness activities with Public Health and the Office of Emergency Management, along with the California Department of Public Health. L.A. County currently has two Ebola Treatment Hospitals with one bed capacity each and is working to establish two additional assessment centers.

6. Commissioners Comments/Requests

Chairman Kazan reported that Prime Healthcare has withdrawn their offer to purchase the Daughter of Charity Health System California hospitals, which has two hospitals in L.A. County (St. Francis Medical Center and St. Vincent Medical Center).

7. Legislation

Cathy Chidester reported on current Legislation under watch by L.A. County and EMSAAC.

8. Director's Report

- The annual Sidewalk CPR will be held on June 4. Each year more individuals are participating in the training process. Los Angeles County Fire has added "Pulse Point" to their computer aided dispatch system which allows the public to download a mobile application which alerts the individual when there is a patient in cardiac arrest nearby. Additionally, Supervisor Mark Ridley-Thomas made a motion that was approved by the Board of Supervisors that all L.A. County employees (there are over 100,000 County employees) be trained in Hands-Only CPR.

- Dr. William Koenig, long time EMS Medical Director, will retire in May 2015.

- Chief Jeff Elder, L.A. City Fire announced that Assistant Chief Tim Ernst would be taking Greg Reynar's position with the Fire Department in the EMS Division.

9. Adjournment

The Meeting was adjourned by Chairman Kazan at 2:40 PM. The next meeting will be held on May 20, 2015.

Next Meeting: **Wednesday, May 20, 2015**
EMS Agency
10100 Pioneer Blvd.
Santa Fe Springs, CA 90670

Recorded by:
Marilyn E. Rideaux
EMS Agency

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MAY 20, 2015

COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
* David Austin	LAC Ambulance Assn	Cathy Chidester	Director, EMS Agency
☑ Robert Barnes	LAC Police Chiefs Assn	Kay Fruhwirth	Asst. Dir, EMS Agency
☑ Frank Binch	Public Member, 4th District	Richard Tadeo	Asst. Dir, EMS Agency
☑ Erick H. Cheung, M.D.	So. CA Psychiatric Society	Marilyn Rideaux	EMSC Liaison
☑ Robert Flashman, M.D.	L.A. County Medical Assn	John Telmos	EMS Agency Staff
☑ John Hisserich	Public Member, 3rd District	Jacqueline Rifenburg	"
* James Lott	Public Member, 2nd District	Susan Mori	"
☑ Clayton Kazan, M.D.	CAL/ACEP	Christy Preston	"
☑ Ray Mosack	CA State Firefighters' Assn.	Michelle Williams	"
(VACANT)	League of California Cities		
* Margaret Peterson, Ph.D.	HASC		
☑ Andres Ramirez	Peace Officers Assn. of LAC		
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* Bernard Weintraub	S. CA Public Health Assn.		
GUESTS			
Mike Sargeant	Long Beach Fire Dept.	Robert Ower	LACAA
Samantha Verga-Gates	APCC-LA County & LBMMC	Alfred Flores	LAFD-EMS QI
Jamie Garcia	HASC		

(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 1:09 PM by Chairman, Clayton Kazan. A quorum was present.

INTRODUCTIONS/ANNOUNCEMENTS:

- Chairman Kazan announced that it was EMS Week and in recognition of the occasion, EMS Agency provided a cake to acknowledge following the meeting.
- Chairman Kazan recognized Dr. Bosson (EMS Agency) and Dr. Uner (UCLA Medical Center and Antelope Valley Hospital) members of the Los Angeles County Urban Search and Rescue Team on a successful mission in Nepal.

CONSENT CALENDAR:

Chairman Kazan called for approval of the Minutes of the March 18, 2015 meeting. Commissioner Binch requested that the Minutes of the meeting be held for later discussion in conjunction with 5.5.

5. OLD BUSINESS

5.1 Community Paramedicine

Cathy Chidester, Director, EMS Agency reported that L.A. County continues to move forward with the approved community paramedicine pilot projects with an estimated start date of early August. The focus of the two projects is alternate patient destination and post discharge follow up on patients with CHF. Some details still need to be worked out and the project will continue to move forward.

5.2 Wall Time

Cathy Chidester reported that hospitals have received the State toolkit and are currently reviewing 'wall time.' She recommended that this item be removed from the EMSC agenda for now pending development of the methodology for measuring wall time at all 9-1-1 receiving hospitals. The definition published by the State workgroup regarding wall time will be incorporated into LAC EMS Agency data collection and once collected the agencies plan is to report it similar to diversion data.

Another issue related to wall-time is AB 1223, introduced by O'Donnel, Emergency medical services; ambulance transportation is currently under review by the State Assembly. This bill would authorize the local EMS agencies to regulate ambulance patient offload time, and a statewide standard will be developed for calculating and reporting ambulance patient offload time by local EMS agencies.

5.3 1+1 Paramedic Staffing Model

Richard Tadeo, Assistant Director, EMS Agency reported that based on data available, there does not seem to be any degradation of patient care under Long Beach Fire Department's Rapid Medic Deployment pilot project. The Data Safety Monitoring Board is scheduled to meet on May 27 and will make final recommendations to the EMS Agency, based on their analysis of the clinical data.

The EMS Agency continues to review the progress of the project and will be reviewing all the requirements for the pilot project. Based on the overall analysis a recommendation on whether to continue or discontinue the pilot project and next steps will be brought back to the commission in a future meeting.

Q. How often is the Data Safety Monitoring Board reviewing data?
A. Monthly

5.4 9-1-1 EMS Provider Ebola Virus Disease (EVD) Patient Assessment and Transportation Guidelines

Kay Fruhwirth, Assistant Director, EMS Agency, stated that there was not much to report but Liberia is being considered as one of the countries to remove from the traveler screening process. CDC, through local health departments continues to monitor travelers from that country, as well as Sierra Leone and Guinea. The field assessment protocol for Ebola will be updated when the official word is received from CDC that Liberia is Ebola free. EMS continues to work with Public Health on response plans.

5.5 Public Hearing – Transport of 5150 Patients

Earlier in the meeting, Commissioner Binch requested that the Minutes of the March 18, 2015 EMS Commission meeting be held for discussion in conjunction with this agenda item.

Commissioner Binch requested that the March 18, 2015 minutes be amended to replace the first four paragraphs of page 6 with the following:

Motion by Commissioner Binch, second by Commissioner Ramirez to replace his original motion with the following substitute motion:

1) ***Approve item 4.3 with amendment to restore the deleted definition headed, "5150 hold."***
2) ***EMS Agency be asked to prepare a complete proposed blueprint and recommendations (including pre-hospital care policy changes) on the present and proposed future role of EMS in serving Behavioral Emergency patients, to distribute and post on its' internet home page, at least 30 days before a public hearing on the blueprint."***
3) ***EMS Commission hold and widely advertise a centrally-located public hearing on the proposed future role of L.A. County EMS in serving patients with behavioral complaints."***

Also, in subsequent paragraphs on that page, replace the term "5150" with "behavioral emergency."

M/S/C: Commissioner Binch/Ramirez to approve Reference 834 with the reinsertion of the definition of behavioral emergency.

Ms. Chidester advised that the concept of a blueprint in relation to the hearing was unclear and asked for clarity from the commission. Mr. Binch replied that a blueprint would be developed and posted on the EMS Agency web site and widely published for 30 days prior to the hearing. Mr. Binch suggested that perhaps the commission could form an ad hoc committee to provide guidance to the EMS Agency staff.

Commissioner Flashman asked for clarification regarding Reference 834 and what the actual issues are. Commissioner Binch responded that in 2010 a

recommendation was made by Supervisor Knabe via Board motion to transport 5150 patients by ambulance instead of by law enforcement vehicle, unless contraindicated. EMS, Department of Mental Health and law enforcement response depends on who gets the initial call. All agencies should work with and talk to each other.

5.6 Measure B Funds – Request for One-Time Allocation to Reimburse Purchase or Upgrade of Electronic Patient Care Record System

The EMS Agency has been working with provider agencies who have expressed interest in obtaining or upgrading an existing electronic Patient Care Record (ePCR) systems to obtain funding through the Prehospital Emergency Medical Care Enhancement Program. This funding is coming from Measure B, so a Board Letter was submitted to obtain Board of Supervisor approval to use Measure B for this project. The letter has been held, not specific to this project but because there is a lot of interest and questions from the Board offices regarding the use and allocation of Measure B funds.

Ms. Chidester explained that there was a State Audit, two years ago, focusing on the use of Measure B funding related to the issue of there not being a trauma center in the East San Gabriel Valley. Since that time, the EMS Agency has been communicating with Queen of the Valley and Pomona Valley Hospital to award a trauma contract. It was announced at a previous EMSC meeting that Pomona Valley Hospital was selected and will begin the pre-designation process towards trauma center designation.

Also related to Measure B funding, a letter was sent to County Fire regarding East San Gabriel Valley helicopter transports regarding the impact of designation of a trauma center in the East San Gabriel Valley and the potential for them receiving decreased or no Measure B funding in the future.

Additionally, Antelope Valley Hospital has expressed disappointment in the distribution of Measure B funds for trauma. They do not feel that they are receiving a proper allocation. Dr. Katz, Director, DHS, and Ms. Chidester met with Antelope Valley Hospital a few weeks go to discuss allocation of Measure B funds for trauma.

There is a meeting with the Board of Supervisor Health Deputies next week to discuss Measure B funding allocation and we are optimistic that the ePCR Board letter will move forward and be approved.

NEW BUSINESS:

5.7 Los Angeles Surgical Society

Ms. Chidester reported that the Los Angeles Surgical Society has disbanded so Commissioner Areti Tillou is no longer able to participate on the EMS Commission. The EMS Agency will be working to change the EMSC ordinance to replace this position on the EMSC. Ms. Chidester asked for recommendations -should the

incumbent be a trauma surgeon or any surgical position? Chairman Kazan recommended that it be a trauma surgeon. It was recommended that in the meantime, THAC should be approached for a recommendation of a trauma specialist to sit in on the meetings (as a non-voting member) until the position is approved to be filled.

6. Commissioners Comments/Requests

Commissioner Sanossian expressed concern regarding stroke patient destination and the variance in the timeframe of symptom onset to transport to a Stroke Center throughout the State. He stated that there were 36 hospitals in Los Angeles County that can receive stroke patients and would like the Commission approval to prepare a presentation for review at the next EMSC meeting. This was referred to Medical Council and the Stroke Hospital group as these are medical care issues.

7. Legislation

Cathy Chidester pointed out specific Legislative bills under watch by the Emergency Medical Services Administrators' Association of California.

8. Director's Report

- With Dr. Koenig's retirement approaching approximately May 27 or 28, the position of EMS Medical Director has been offered to Dr. Marianne Gausche-Hill.
- Ms. Chidester addressed Agenda correspondence 2.3, a letter to Glendora Police Department regarding approval for EMTs to use intranasal naloxone in the emergency treatment of patients with suspected opiate overdose; correspondence 2.5, a letter to San Marino Fire Department regarding utilization of QuikClot® Combat Gauze™ in certain traumatic hemorrhage cases; 2.9, regarding St. Vincent Medical Center approval as a 9-1-1 receiving facility.

9. Adjournment

The Meeting was adjourned by Chairman Kazan at 2:17 PM. The next meeting will be held on July 15, 2015.

Next Meeting: **Wednesday, July 15, 2015**
EMS Agency
10100 Pioneer Blvd.
Santa Fe Springs, CA 90670

Recorded by:
Marilyn E. Rideaux
EMS Agency

CORRESPONDENCE 2.1

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Cathy Chidester
Director

Nichole Bosson, MD
Interim 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.

July 1, 2015

Howard Backer, MD
Director
Emergency Medical Services Authority
10901 Gold Center Dr., Suite 400
Rancho Cordova, CA 95670

Dear Dr. Backer:

I am pleased to be able to inform you of the appointment of Dr. Marianne Gausche-Hill to the position of Medical Director for the Los Angele County EMS Agency. Dr. Gausche-Hill replaces Dr. William Koenig, who has recently retired from County Service.

Dr. Gausche-Hill is a graduate of the UCLA School of Medicine and has worked for the County at Harbor General-UCLA since 1989. She has held several distinguished positions in the Department of Emergency Medicine, including Base Hospital Medical Director, Chief of the Division of Pediatric Emergency Medicine, and Vice Chair, Department of Emergency Medicine. She has also been active with the Paramedic Training Institute and of course she is nationally recognized for her extensive work with pediatric emergency medicine.

I am certain that Dr. Gausche-Hill's experience, passion for emergency medicine and vision will be an asset to our local EMS Agency and State committees.

You may contact Dr. Gaushe-Hill at (562) 347-1600 or MGausche-Hill@dhs.lacounty.gov if you have any questions.

Sincerely,

Cathy Chidester
Director

c: Director, Department of Health Services
Chief Medical Officer, Department of Health Services
EMS Commission
LA Area Fire Chiefs
Los Angeles Ambulance Association
APCC
EMDAC

CORRESPONDENCE 2.2

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.

June 30, 2015

TO: Fire Chief, Each 9-1-1 Paramedic Provider Agency

FROM: Cathy Chidester
Director

SUBJECT: **UPDATES FOR DEPLOYMENT OF FIRELINE EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC AND STRIKE TEAM ASSESSMENT UNITS**

With the fire season rapidly approaching, the Emergency Medical Services (EMS) Agency, in conjunction with subject matter expert representation, convened a meeting to review/revise EMS Agency policies that address FireLine Paramedic/EMT deployment. Based on this meeting, new language for out-of-county Assessment Unit (AU) Strike Team deployment has been added to the applicable policies (attached).

- Ref. No. 416, Assessment Unit
- Ref. No. 719, Fireline Emergency Medical Technician-Paramedic (FEMP) Inventory
- Ref. No. 804, Fireline Emergency Medical Technician-Paramedic (FEMP)

If you are a sponsoring agency of FIRESCOPE approved FEMPs/FEMTs or deploy AU Strike Teams, please carefully review the attached policies with your agencies personnel.

As a reminder, it is vital that the EMS Agency be notified when your agency depolys an FEMP/FEMT or AU Strike Team to an incident and upon demobilization. Notification should be made by contacting the Medical Alert Center (MAC) at (562) 347-1739 and provide the following information:

- First and last name of the FEMP/FEMT or AU Paramedic
- State paramedic number
- Local accreditation number
- Name of the deployment location
- Incident and order number
- Deployment date/demobilization date

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.

June 16, 2015

Daryl Osby
Fire Chief
Los Angeles County Fire Department
1320 N. Eastern Avenue
Los Angeles, CA 90063

Dear Chief Osby:

This is to inform you that effective July 1, 2015 Los Angeles County Fire Department (County Fire) will no longer receive $880,000 annually in Measure B funds towards the lease payment of the helicopter that is stationed in East San Gabriel Valley (ESGV).

The Memorandum of Understanding (MOU H-702098) entered by and between the Department of Health Services (DHS) and County Fire included an annual allocation not to exceed $880,000 for a period not to exceed ten years beginning with Fiscal Year (FY) 2005-06. This ten year period ends with FY 2014-15 and no new provisions have been made to provide Measure B funding beyond this date. County Fire will continue to receive $642,000 annually in Measure B funds to offset the costs associated with the paramedic air squad assigned to the ESGV.

If additional Measure B funding is needed, beyond the $642,000 that is allocated on an annual basis, County Fire will need to make a formal request to Mitch Katz, M.D., Director DHS. Any request for Measure B funding would require final approval by the Board of Supervisors.

Please contact me if you have any questions.

Very truly yours,

Cathy Chidester
Director

CC:kf

c: Director, DHS
Chief Financial Officer, DHS
Administrative Deputy, DHS
Acting Deputy Chief, Fire District EMS Bureau
Senior EMS Program Head, Fire District Administration

CORRESPONDENCE 2.4

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

10100 Pioneer, 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

June 15, 2015

Andrew Leeka
Chief Executive Officer
Good Samaritan Hospital
1225 Wilshire Blvd.
Los Angeles, CA 90017

Dear Mr. Leeka:

The Emergency Medical Services (EMS) Agency is pleased to announce that Good Samaritan Hospital (GSH) has met all Approved Stroke Center (ASC) requirements.

Enclosed is your ASC Confirmation Agreement. Your signature on the Agreement indicates GSH's intent to comply with the all applicable policies, standards, and data submission requirements – and to allow the EMS Agency to perform scheduled site visits and/or request additional data if deemed necessary to monitor compliance. Please complete and return the attached Confirmation Agreement within 15 days – upon receipt, the EMS Agency will sign the Agreement and return the original to your facility.

Congratulations and thank you again for your commitment to the ASC program. If you have any questions, please feel free to contact Carolyn Naylor, Hospital/Stroke Center Coordinator at (562) 347-1655.

Very truly yours,

Cathy Chidester for NB

Nichole Bosson, M.D.
Interim Medical Director

NB:cn
06-02

Enclosure

c: Director, EMS Agency
Emergency Medical Services Commission
Medical Director Stroke Program, GSH
Stroke Program Coordinator, GSH

CORRESPONDENCE 2.5

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

10100 Pioneer, 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

June 15, 2015

James Theiring
Chief Executive Officer
Mission Community Hospital
14850 Roscoe Blvd.
Panorama City, CA 91402

Dear Mr. Theiring:

The Emergency Medical Services (EMS) Agency is pleased to announce that Mission Community Hospital (MCP) has met all Approved Stroke Center (ASC) requirements.

Enclosed is your ASC Confirmation Agreement. Your signature on the Agreement indicates MCP's intent to comply with the all applicable policies, standards, and data submission requirements – and to allow the EMS Agency to perform scheduled site visits and/or request additional data if deemed necessary to monitor compliance. Please complete and return the attached Confirmation Agreement within 15 days – upon receipt, the EMS Agency will sign the Agreement and return the original to your facility.

Congratulations and thank you again for your commitment to the ASC program. If you have any questions, please feel free to contact me at (562) 347-1600 or Carolyn Naylor, Hospital/Stroke Center Coordinator at (562) 347-1655.

Very truly yours,

Cathy Chidester for NB

Nichole Bosson, M.D.
Interim Medical Director

NB:cn
06-01

Enclosure

c: Director, EMS Agency
Emergency Medical Services Commission
Medical Director Stroke Program, MCP
Stroke Program Coordinator, MCP

CORRESPONDENCE 2.6

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

May 26, 2015

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.

TO: Distribution

FROM: William Koenig M.D.
Medical Director

SUBJECT: CATH LAB ACTIVATION ALGORITHM

Los Angeles County is recognized nationally for its excellent ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) program. Since its inception 8 years ago, over 20,000 STEMI patients have been triaged by paramedics to SRCs - more than in any other EMS system nationwide. Working together with our cardiology community, care provided for our STEMI patients has consistently surpassed national American Heart Association (AHA)/American College of Cardiology Foundation (ACCF) benchmarks for quality. These achievements require significant collaboration and resource commitments by our prehospital providers, emergency and cardiology personnel, and hospitals.

Since the onset of our program, the triage tool used by paramedics to determine destination for suspected myocardial infarction patients is the computerized algorithmic interpretation printed on the 12-Lead electrocardiogram (ECG). This method cost substantially less than additional ECG interpretation training and continuing education for paramedics, yet has resulted in cath lab cancellation rates of over 50%. False positive activation is recognized by the AHA as an issue in many EMS Systems nationally.

Some SRCs have individualized their approach to cath lab activation to reduce false positives. Methods include:

- Waiting to activate the cath lab until the ECG interpretation can be confirmed in the ED
- Activating only when an ECG is transmitted and read by a physician
- Activating only when a paramedic can confirm that the ECG meets certain criteria (e.g. not a paced rhythm, no atrial fibrillation, no rapid heart rate, etc.)
- Providing immediate relevant feedback to paramedics through an established QI process
- Some combination of the above

While over 80% of our paramedics have the capability to transmit ECGs, SRCs report only 35% are transmitted.

In collaboration with the AHA, Los Angeles County EMS Agency has developed an algorithm intended to reduce inappropriate field activations (attached). Prospective evaluation indicates use of the algorithm could reduce the number of false positive activations by over 80%.

Distribution
May 26, 2015

PRINCIPLES OF THE ALGORITHM:

- The algorithm pertains to FIELD cath lab activation
- Paramedics will perform the ECG according to EMS Ref. No. 1302: 12-Lead Electrocardiogram *(no change)*
- All identified STEMI patients will continue to be triaged to an SRC *(no change)*
- ECG transmission should occur for every ECG with 1mm of ST-Elevation or STEMI, but should not delay transport
- The paramedic and the SRC ED Physician will have a direct discussion regarding the patient and findings
    - Attempts to contact the physician should not delay transport
- This communication should result in a **Field Activation** of the cath lab, or an **Expedited ED Exam** upon patient's arrival
- Application of the algorithm could eliminate over 80% of false positive activations

Paramedic Responsibilities:

- If 12-Lead ECG, shows 1mm ST-Elevation in 2 contiguous leads, AND/OR positive software interpretation of STEMI, then:
    - Initiate transmission of ECG and begin transport
    - Contact Base hospital for medical orders per EMS treatment protocols
    - Contact SRC physician to discuss Cath Lab Activation Criteria
    - Proceed to ED bed or cath lab, as directed by SRC physician

SRC ED Physician Responsibilities:

- Respond to the paramedic call
- Determine if field activation is appropriate
- Do not re-route paramedics if ECG is determined not to be a STEMI
- Follow hospital protocols for cath lab activation
- If all criteria for field activation are not met, perform an expedited ED exam upon patient's arrival, and activate the cath lab if appropriate

IMPLEMENTATION:

Training of paramedics and MICNs started May 1, 2015, with an anticipated launch date of September 1, 2015. A web-based video for SRC ED physicians is currently under development.

If you or your staff have any questions or require further information, please contact Paula Rashi, RN, STEMI Receiving Center Programs Manager, at prashi@dhs.lacounty.gov or (562) 347-1656.

WK:pr
05-45

c. Medical Director, EMS Agency
SRC Director, Each SRC
ED Medical Director, Each SRC
ED Director, Each SRC
EMS Director, Each Fire Department
Prehospital Care Coordinators

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

May 18, 2015

TO: Distribution **VIA FAX/EMAIL**

FROM: William Koenig, MD
Medical Director

SUBJECT: DESIGNATION OF APPROVED STROKE CENTERS

The Emergency Medical Services Agency is pleased to announce that effective Tuesday, May 19, 2015 the following 40 facilities are now designated as Approved Stroke Centers (ASC):

NEWLY APPROVED:

Mission Community Hospital (MCP)

PREVIOUSLY APPROVED:

- Antelope Valley Hospital
- California Hospital Medical Center
- Cedars Sinai Medical Center
- Citrus Valley Medical Center – Queen of the Valley Campus (QVH)
- Garfield Medical Center
- Glendale Adventist Medical Center
- Good Samaritan Hospital
- Henry Mayo Newhall Memorial Hospital
- Hollywood Presbyterian Medical Center
- Huntington Memorial Medical Center
- Kaiser Foundation Hospital – Baldwin Park Medical Center
- Kaiser Foundation Hospital – Downey Medical Center
- Kaiser Foundation Hospital – Los Angeles Medical Center
- Kaiser Foundation Hospital – Panorama City
- Kaiser Foundation Hospital – West Los Angeles
- Kaiser Foundation Hospital – Woodland Hills
- Lakewood Regional Medical Center
- Long Beach Memorial Medical Center
- Los Alamitos Medical Center (Orange County)
- Los Robles Hospital & Medical Center
- Methodist Hospital of Southern California (AMH)
- Northridge Hospital Medical Center
- PIH Health Hospital - Whittier
- Pomona Valley Hospital Medical Center
- Providence Holy Cross Medical Center

- Providence Little Company of Mary Medical Center – San Pedro
- Providence Little Company of Mary Medical Center- Torrance
- Providence Saint Joseph Medical Center
- Providence Tarzana Medical Center
- Ronald Reagan UCLA Medical Center
- Saint Francis Medical Center
- Saint Jude Medical Center (Orange County)
- Saint Mary Medical Center
- San Gabriel Valley Medical Center
- Torrance Memorial Medical Center
- USC Verdugo Hills Hospital
- Valley Presbyterian Hospital
- West Hills Hospital & Medical Center
- White Memorial Medical Center

Please visit the EMS Agency website at http://ems.dhs.lacounty.gov for the most current information about the new ASCs and a map showing the approved hospitals. If you have any questions, please feel free to contact me at (562) 347-1600, or Carolyn Naylor, Hospital Programs at (562) 347-1655.

WK:cn

c: Director, EMS Agency
Fire Chief, Each Fire Department
Paramedic Coordinator, Each Provider Agency
Prehospital Care Coordinator, Each Base Hospital
Nurse Educator, Each Fire Department
ASC Coordinator, Each Approved Stroke Center

CORRESPONDENCE 2.8

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.

May 18, 2015

Lieutenant Robert Lamborghini
Medical Program Coordinator
Glendora Police Department
150 South Glendora Avenue
Glendora, CA 91741-3498

Dear Lt. Lamborghini:

The Emergency Medical Services (EMS) Agency has approved Glendora Police Department (PD) for the utilization of intranasal naloxone for patients with a suspected opiate overdose. At this time, Glendora PD is electing to limit the naloxone training and application to the Glendora PD Emergency Medical Technicians (EMT). Pease inform the EMS Agency in writing should you decide to include all sworn Officers in the naloxone program.

As part of the quality improvement process required for implementation, Glendora PD will submit quarterly data to the Susan Mori, EMS Agency System Quality Improvement Coordinator for purposes of evaluating and aggregate reporting on systemwide utilization of naloxone.

Additionally, Glendora PD EMTs may utilize oxygen as described in the California Code of Regulations, EMT Basic Scope of Practice in accordance with the Los Angeles County EMS Agency prehospital care polices, Medical Control Guidelines and Treatment Protocols.

Please contact me at (562) 347-1600 or Susan Mori at (562) 347-1609 for any questions or concerns.

Very truly yours,

William J. Koenig

William Koenig, MD
Medical Director

WK:sm
05-18

c: Director, EMS Agency
Assistant Director, EMS Agency
Timothy Staab, Chief of Police Glendora PD
Augusto Cigliano, MD, Medical Director, Glendora PD

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.

May 11, 2015

To whom it may concern:

The Los Angeles County Emergency Medical Services (EMS) Agency is writing to support a pilot project by the Los Angeles Fire Department (LAFD) to participate in the Centers for Disease Control and Prevention (CDC) sponsored Cardiac Arrest Registry to Enhance Survival (CARES) registry. Collaborating with LAFD would allow hospitals to link EMS data and Hospital data to obtain Cardiac Arrest outcomes information from area hospitals. CARES will allow benchmarking with other communities nationally, providing confidential comparisons for participating hospitals and our EMS system.

Benefits of the CARES registry include:

- Minimal burden for data entry (often only one question if patient not admitted, 4 additional if they are admitted)
- Hospital gets confidential bench marked reports
- Community gets survival data to improve the chain of survival
- No cost to hospitals
- Can be used with Joint Commission as an example of community partnership and QA

A standardized population based system linking EMS and hospital outcomes in a secure data base will help yield meaningful outcome comparisons and benefit our patients.

This pilot project is has the potential to improve the care of patients with out-of-hospital cardiac arrest, and we encourage your organization to participate.

Very truly yours,

William Koenig, MD, FACEP
Medical Director

Nichole Bosson, MD, MPH
Assistant Medical Director

COMMITTEE REPORTS 3.2

EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE
WEDNESDAY, JUNE 10, 2015

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

MEMBERSHIP / ATTENDANCE		
MEMBERS	ORGANIZATION	EMS AGENCY
* Robert Flashman, Chair	EMS Commissioner (MD)	Richard Tadeo
☒ Raymond Mosack, Vice-Chair	EMS Commissioner (Asst. Fire Chief)	Deidre Gorospe
☒ Nerses Sanossian	EMS Commissioner (MD)	Michelle Williams
☒ John Hisserich	EMS Commissioner (DrPH)	Susan Mori
□ Matt Armstrong	Ambulance Advisory Board (LACAA)	
* Trevor Stonum	Ambulance Advisory Board (alternate)	
☒ Mark Baltau	Base Hospital Advisory Committee (BHAC) (RN)	
□ Alina Candal	BHAC (alternate)	
□ VACANT	Hospital Association of Southern California (HASC)	
□ VACANT	HASC (alternate)	
□ Joanne Dolan	Long Beach Fire Department (LBFD) (RN)	OTHERS
□ Don Gerety	LBFD (alternate)	Brenda Sadler- LBFD Representative for Joanne Dolan
☒ Dan France	Los Angeles Area Fire Chiefs Association	
☒ Sean Stokes	LA Area Fire Chiefs Association (alternate)	
☒ Nicole Steeneken	Los Angeles County Fire Department (LACoFD)	
☒ Victoria Hernandez	LACoFD (alternate)	
☒ Al Flores	Los Angeles Fire Department (LAFD)	
□ John Smith	LAFD (alternate)	
☒ Nicole Bosson	Medical Council (MD)	
□ VACANT	Medical Council (alternate)	
□ VACANT	Provider Agency Advisory Committee (PAAC)	
□ VACANT	PAAC (alternate)	
* Howard Belzberg	Trauma Hospital Advisory Committee (THAC) (MD)	
□ David Hanpeter	THAC (MD) (alternate)	
* Marilyn Cohen	THAC (RN)	
□ VACANT	THAC (RN) (alternate)	
☒ Present *Excused □ Absent		

1. **CALL TO ORDER:** The meeting was called to order at 10:04 am by Commissioner Sanossian.

2. **APPROVAL OF MINUTES:** The minutes of the April 8, 2015 were approved as written.

3. **INTRODUCTIONS**

4. **REPORTS AND UPDATES**

4.1 TEMIS Update:

4.1 a. County Fire (CF) Update (Michelle Williams)

CF records for 2011 and 2012 continue to be imported.

4.1 b. Termination of Resuscitation (TOR) Documentation (Michelle Williams)

An example from the Base Hospital and EMS Report Forms were provided on how to properly document TOR in the field.

4.1 c. MLK Update (Richard Tadeo)

MLK is scheduled to open their ER to walk-in patients on July 7, 2015. The hospital has to have 30 admits and discharges before the Joint Commission will come out for a survey, as of June 9th they had 13. MLK will be using a trauma re-triage protocol for any non-EMS trauma patients that present to the ER, adult trauma patients will be transported to Saint Francis and pediatric trauma patients will be transported to LAC-Harbor UCLA.

4.2 Electronic Data Systems (Michelle Williams)

Redondo Beach Fire went live with their ePCR on May 11th.

4.3 Service Changes (Michelle Williams)

Approved Stroke Centers (ASCs)
Mission Community Hospital became an ASC on May 19, 2015

Emergency Department Approved for Pediatrics (EDAP)
Southern California Hospital at Culver City is no longer an EDAP as of May 1, 2015.

4.4 System Wide Data Reports (Michelle Williams)

Report on "Run Type=No Patient or Cancelled on Scene with Patient Information for 2013-April 2015" for all providers was presented.

5. UNFINISHED BUSINESS:

5.1 Standardized TEMIS Reports (Michelle Williams, Deidre Gorospe)

Ideas for future reports were discussed, 3 report possibilities are:

- Wall Time
- Scene Time for Critical Trauma Patients
- Psych Patient Destination

It was also suggested that next year the Core Measures be reviewed by the committee before being submitted to the State.

6. NEW BUSINESS:

6.1 MCI Documentation (Richard Tadeo)

Capturing data on multi-casualty incidents (MCIs) is difficult therefore a task force is needed to look at the documentation of MCIs. Nicole Steeneken from CF and Al Flores from LAFD offered to assist with this project.

6.2 Patient Tracking System (Richard Tadeo)

A request for proposal (RFP) was sent out for a patient tracking system to be used during MCIs – approximately five bids were received, but none met the requirements so the RFP was recalled. Currently the County is looking at the possibility of partnering with Reddinet and Lancet Technology, Inc. to develop a system that can fulfill all of the requirements.

7. OPEN DISCUSSION:

Richard Tadeo informed the committee that the State Paramedic Curriculum is changing to focus on paramedic impression rather than chief complaint – data collection within the County will need to be revised accordingly.

8. NEXT MEETING: August 12, 2015 at 10:00 a.m. (EMS Agency Hearing Room – First Floor)

9. ADJOURNMENT: The meeting was adjourned at 10:53 a.m. by Commissioner Mosack.

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION
10100 Pioneer Blvd, Suite 200 Santa Fe Springs, CA 90670
(562) 347-1500 FAX (562) 941-5835

EDUCATION ADVISORY COMMITTEE

MEETING CANCELATION NOTICE

DATE: June 11, 2015

TO: Education Advisory Committee Members

SUBJECT: CANCELATION OF MEETING

Due to a lack of agenda items, the Education Advisory Committee meeting scheduled for June 17, 2015 is canceled.

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, June 17, 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 (Rep to Med Council, Alt)
☐ Jon O'Brien	Area B
☐ Kevin Klar	Area B, Alt.
☐ Victoria Hernandez	Area B Alt. (Rep to Med Council)
☐ 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.
☑ Brian Hudson	Area G (Rep to BHAC)
☐ Michael Murrey	Area G, Alt. (Rep to BHAC, Alt.)
☑ Jeffrey Elder	Area H (Rep to DAC)
☑ 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)

EMS AGENCY STAFF PRESENT	
Richard Tadeo	Michelle Williams
Carolyn Naylor	Jacqueline Rifenburg
Stephanie Raby	Lucy Hickey
Deidre Gorospe	Cathlyn Jennings
Christy Preston	Mark Ferguson
David Wells	Karen Rodgers
Gary Watson	

OTHER ATTENDEES	
Clayton Kazan, MD	LA Co FD
Nicole Steeneken	LA Co FD
Michael Barilla	Pasadena FD
Phil Tibbs	Sierra Madre FD
Monica Bradley	Culver City FD
Alfred Flores	LAFD
Michael Beeghly	Santa Fe Springs FD
Robert Grounds	Downey FD
Dan France	Montebello FD
Ian Wilson	PRN Ambulance
Gonzalo Casas	Med Response Amb
Chad Brewster	Gentle Ride Amb
Tisha Hamilton	Bowers Amb
Rocky Allen	Mercy Air Amb
Michael Neiberger	Impulse Amb
Sean Grimes	Royalty Amb
Trevor Stonum	Med Coast Amb
Robert Ower	RSI 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: Vice-Chair, Commissioner Jon Thompson called meeting to order at 1:05 p.m.

1. **APPROVAL OF MINUTES (Preston/Elder)** February 18, 2015 minutes were approved.
(There was no meeting on April 15, 2015)

2. INTRODUCTIONS / ANNOUNCEMENTS

2.1 General Public Ambulance Rates *(Gary Watson)*

Annual adjustments to the General Public Ambulance Rates go into effect July 1, 2015. Announcement letter with the adjusted rates were available during this meeting and is posted on the EMS Agency webpage.

2.2 Committee Representatives *(Jon Thompson)*

Former non-voting Committee member, Laurie Lee-Brown, has been hired by the EMS Agency and unable to represent this Committee at Medical Council and Data Advisory Committee. Members were appointed to represent the following Committees:

- Medical Council – Victoria Hernandez, Primary representative
  Sean Stokes, Alternate representative
- Data Advisory – Jeffrey Elder, Primary representative

2.3 Disaster Training Day *(Stephanie Raby)*

- The EMS Agency will be hosting a private ambulance provider, disaster training day on August 27, 2015.
- This workshop is open to LA County licensed ambulance companies only.
- There will be lectures in the morning and, hands-on training in the afternoon.
- Space is limited to 50 participants. Those interested in participating need to register through Event Brite, at: https://emsadisastertrainingday.eventbrite.com.
- For more information, contact Elaine Forsyth at (562) 347-1647 or eforsyth@dhs.lacounty.gov.

2.4 EMS Update 2015 *(Lucy Hickey)*

- Training has started for EMS Update 2015; deadline for completion is August 31, 2015.
- Rosters are to be submitted to the EMS Agency, either by FAX or email.
- Providers can e-mail their rosters to Nicholas Todd at ntodd@dhs.lacounty.gov.
- For those who complete the training through the UCLA Training Center (internet based), the EMS Agency receives monthly lists of those who have completed the training.
- July 6, 2015 - the EMS Agency will begin sending first notice letters to the providers, listing paramedic personnel who have not completed the required training.
- September 10, 2015 - Suspension notices will be sent out and suspensions will become effective on September 23, 2015.
- Further information may be obtained by contacting Nicholas Todd at (562) 347-1632.

3. REPORTS & UPDATES

3.1 EMS Report Form Changes *(Michelle Williams)*

The revised patient care record (PCR) began in circulation last month. A list of revisions were distributed to the Committee.

3.2 East San Gabriel Valley Trauma *(Christy Preston)*

Pomona Valley Hospital Medical Center (PVC) has been selected to become the next Trauma Center in Los Angeles County. The completion process will take approximately 12-18 months before PVH begins its official designation as a Trauma Center.

3.3 9-1-1 Trauma Re-Triage *(Christy Preston)*

- Concept: Non-trauma center hospitals utilizing 9-1-1 to transfer patients needing immediate transportation to a trauma center.
- LA County EMS Agency will be developing guidelines and most likely implement this concept as a pilot program with Martin Luther King Community Hospital (upon re-opening) and with St. Francis Medical Center.
- After the Trauma Hospital Advisory Committee reviews the draft policy, it will be circulated through the Committees for further recommendations.

4. UNFINISHED BUSINESS

4.1 Reference No. 1244, Treatment Protocol: Chest Pain

Policy remains tabled. There was no discussion.

Tabled Reference No. 1244, Treatment Protocol: Chest Pain

5. NEW BUSINESS

5.1 Reference No. 416, Assessment Unit *(Richard Tadeo)*

Policy reviewed and approved with the following recommendations:

- Policy III. A. add "for ALS patient responses"
- Policy III, C. to read: "An ALS Unit should never be canceled by an Assessment Unit if the patient meets Ref. No. 808**,** Base Hospital Contact and Transport Criteria, **Section I, or** appears to need ALS intervention, or if ALS intervention has been initiated."

M/S/C (Preston/Hudson): Approve Reference No. 416, Assessment Unit, with the above recommendations

5.2 Reference No. 719, Fireline Emergency Medical Technician – Paramedic (FEMP) Inventory *(Richard Tadeo)*

Policy reviewed and approved with the following recommendations:

- Page 2 of 3, NOTE:
  - Add clarification that unit can only carry either Morphine Sulfate or Fentanyl (not both).
  - Remove "sufficient quantities" and replace with "maximum allowed quantities" of either Morphine Sulfate or Fentanyl.

M/S/C (Elder/Preston): Approved Reference No. 719, Fireline Emergency Medical Technician – Paramedic (FEMP) Inventory, with the above recommendations

5.3 Reference No. 804, Fireline Emergency Medical Technician – Paramedic (FEMP) *(Richard Tadeo)*

Policy reviewed and approved as presented.

M/S/C (Hudson/Nevandro): Approve Reference No. 804, Fireline Emergency Medical Technician – Paramedic (FEMP)

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

Policy reviewed and approved as presented. Policy will return to Committee after Medical Council reviews the administration of Amiodarone, listed under the treatment section of Cardiopulmonary Arrest.

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

5.5 Reference No. 808, Base Hospital Contact and Transport Criteria *(Jacqueline Rifenburg)*

Policy reviewed and approved as presented.

M/S/C (Tucker/Elder): Approve Reference No. 808, Base Hospital Contact and Transport Criteria

5.6 Reference No. 808.1, Base Hospital Contact and Transport Criteria – Field Reference *(Jacqueline Rifenburg)*

Policy reviewed and approved as presented.

M/S/C (Nevandro/Greene)): Approve Reference No. 808.1, Base Hospital Contact and Transport Criteria – Field Reference

5.7 Reference No. 1202, Treatment Protocol: General ALS *(Jacqueline Rifenburg)*

Policy was reviewed and approved as presented.

M/S/C (Elder/Tucker): Approve Reference No. 1202, Treatment Protocol: General ALS

5.8 Reference No. 1210, Treatment Protocol: Non-Traumatic Cardiac Arrest (Adult) *(Jacqueline Rifenburg)*

Policy tabled until reviewed by Medical Council.

Tabled Reference No. 1210, Treatment Protocol: Non-Traumatic Cardiac Arrest (Adult)

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

Policy reviewed and approved as presented.

M/S/C (Hudson/Preston): Approve Reference No. 1275, Treatment Protocol: General Trauma

6. OPEN DISCUSSION

6.1 EMS Agency Medical Director / Pediatric Protocols *(Richard Tadeo)*

- Marianne Gausche Hill, M.D., has been selected as the new Los Angeles County EMS Agency Medical Director. Her duties will be July 1, 2015.
- Pediatric Advisory Committee has recommended the development of separate protocols that specifically addresses the treatment of pediatric patients. A work group will be formed.

6.2 EMS Bureau – Los Angeles Fire Department *(Jeffrey Elder, BC)*

The new Los Angeles Fire Chief is expanding the EMS Division into an EMS Bureau; which will incorporate all sections related to EMS, under one Bureau.

6.3 Community Para-Medicine Program *(Todd Tucker)*

Beginning July 2015, Glendale Fire Department will begin training for the following programs, with an expected implementation date of August 1, 2015:

- Alternate Transport Destinations for Communities in Los Angeles County (ALTrans)
- Community Paramedic Effectiveness Strategies for Congestive Heart Failure (COMPARE)

Santa Monica Fire Department is also participating in the ALTrans program.

7. NEXT MEETING: August 19, 2015

8. ADJOURNMENT: Meeting adjourned at 2:28 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 806.1

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
General ALS	Medical Advisory	#3 addition of 250ml fluid challenge prn	Addition made
Pain Management	Medical Advisory	#3 addition of max. of 8mg to Morphine dose	Addition made
Chest Pain	Base Advisory 6/10/15	#4 change dose of Aspirin from 162-325mg to 325mg	Change not made. Due to provider inventory
Pain Management	Base Advisory 6/10/15	Removal of "Isolated Extremity Injury" and move "Burn" to read "Crush Injury/Burns	Change made. MAC agreed
Cardiopulmonary Arrest	Base Advisory 6/10/15	#1 addition of capnography	Change made. MAC agreed
Cardiopulmonary Arrest	Base Advisory 6/101/5	Multiple changes suggested regarding medications and times medications are given	Suggestions on hold, MAC will review and comment
All above sections	Provider Advisory 6/17/15	No comments	Approved

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; 250ml fluid challenge 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
2. Traction/splints/dressings prn
3. **Morphine** for moderate to severe pain
   2-4mg slow IVP, titrate to pain relief; max. of 8mg
   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/BURN

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/capnography/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. 808

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Policy Section I Item J	Medical Advisory	Addition of ≥ 20 weeks gestation	Changes made
Policy Section I Item P	Medical Advisory	Removal of (i.e., blurred vision, weak and dizzy, numbness, etc.) replace with (stroke symptoms)	Changes made
Policy Section I Item J	Base Advisory	No comments	approved
Policy Section I Item P	Base Advisory	Request the addition of suspected signs and symptoms prior to stroke and removal of symptoms	Approved changes made
Both above items	Provider Advisory	No comments	Approved

DEPARTMENT OF HEALTH SERVICES

COUNTY OF LOS ANGELES

SUBJECT: **BASE HOSPITAL CONTACT AND TRANSPORT CRITERIA** (EMT, PARAMEDIC, MICN) REFERENCE NO. 808

PURPOSE: To identify the signs, symptoms, chief complaints, or special circumstances of patients for whom base hospital contact is required for medical direction and/or patient destination. This policy delineates when transport to an appropriate and approved facility is indicated.

AUTHORITY: California Health and Safety Code, Division 2.5, Section 1798 et seq.,
California Code of Regulations, Title 22, Section 100169
California Welfare and Institution Code, Section 5008(h)(1)

PRINCIPLES:

1. Paramedics should contact their assigned base hospital.

2. In situations not described in this policy, paramedics and EMTs should exercise their clinical judgment as to whether ALS intervention, base hospital contact and/or transport is anticipated or indicated.

3. Children ≤ 36 months of age require base hospital contact and/or transport in accordance with this policy.

4. When base hospital contact and/or transport are not performed in accordance with this policy, appropriate explanation and documentation shall be recorded on the EMS Report Form. **This does not apply to patients ≤ 36 months of age.**

5. Circumstances may dictate that transport be undertaken immediately with attempts to contact the base hospital enroute.

6. In situations where EMTs arrive on scene prior to the paramedics, EMTs shall not cancel the paramedic response if a patient meets any criteria outlined in Section I of this policy. An ALS unit shall be requested if one has not been dispatched, unless Principle 7 applies.

7. In life-threatening situations in which the estimated time of arrival (ETA) of the paramedics exceeds the ETA to the most accessible receiving facility (MAR), EMTs should exercise their clinical judgment as to whether it is in the patient's best interest to be transported prior to the arrival of paramedics. EMTs shall make every effort to notify the MAR via the VMED28, telephone, dispatch, or other appropriate means of communication when exercising this principle.

8. Paramedics shall contact their designated receiving trauma center on all injured patients meeting trauma triage criteria and/or guidelines or if, in the paramedics' judgment, it is in

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

the patient's best interest to be transported to a trauma center. When the receiving trauma center is not a base hospital (only applies to Children's Hospital Los Angeles), paramedics shall contact their assigned base hospital.

9. A paramedic team may transfer care of a patient to an EMT team in cases where, in the paramedics' judgment, the patient does not require ALS level care. If the patient's condition meets base hospital contact criteria, the base hospital must approve the EMT transport.

POLICY:

I. Paramedics shall make base hospital contact for medical direction and/or patient destination on all patients meeting one or more of the following criteria:

A. Signs or symptoms of shock

B. Cardiopulmonary arrest (excluding patients defined in Ref. Nos. 814 and 815)

C. Chest pain or discomfort

D. Shortness of breath and/or tachypnea

E. Pediatric Medical Care (PMC) guidelines as defined in Ref. No. 510

F. Situations involving five or more patients who require transport (Contacting the Medical Alert Center constitutes base hospital contact)

G. Altered level of consciousness as defined in the Medical Control Guidelines

H. Suspected ingestion of potentially poisonous substances

I. Exposure to hazardous materials with a medical complaint

J. Abdominal pain in a pregnant or in a suspected pregnant patient ≥ 20 weeks gestation

K. Childbirth or signs of labor

L. Suspected femur fracture

M. Facial, neck, electrical, or extensive burns:

1. 20% or greater BSA in adults

2. 15% or greater BSA in children

3. 10% or greater BSA in infants

N. Trauma Triage Criteria and Guidelines as defined in Ref. No. 506

O. Traumatic Crush Syndrome

P. Syncope or loss of consciousness, or acute neurological symptoms (suspected signs and symptoms of stroke) prior to or upon EMS personnel arrival.

Q. A patient meeting any criteria in Section I who refuses transport against medical advice (AMA). Base contact is required prior to the patient leaving the scene.

II. EMT or paramedic personnel shall transport all patients meeting one or more of the following criteria:

A. Abdominal pain

B. Suspected isolated fracture of the hip

C. Abnormal vaginal bleeding

D. Suspected allergic reaction

E. Asymptomatic exposure to hazardous material known to have delayed symptoms

F. Gastrointestinal bleeding

G. Near drowning

H. Patients who are gravely disabled or a danger to themselves or others.

III. Prehospital personnel shall manage pediatric patients $\leq$ 36 months of age as follows:

A. All children $\leq$ twelve (12) months of age shall be transported, regardless of chief complaint and/or mechanism of injury **unless** the child meets the criteria outlined in Reference No. 814, Determination/Pronouncement of Death in the Field, e.g., rigor mortis, post-mortem lividity, evisceration of the heart, lung or brain, etc.

B. All children thirteen (13) months to thirty-six (36) months of age require base hospital contact and/or transport, except in isolated minor extremity injury.

C. If a parent or legal guardian refuses transport (AMA), base contact is required prior to the patient leaving the scene.

IV. Paramedics utilizing Standing Field Treatment Protocols (SFTPs) shall make base hospital contact for medical direction and/or patient destination on all patients meeting one or more of the following criteria:

A. If indicated in the SFTPs

B. For any criteria listed in Section I of this policy that is not addressed by SFTPs

C. Anytime consultation with the base hospital is indicated

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 411, **Provider Agency Medical Director**
Ref. No. 502, **Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 515, **Air Ambulance Trauma Transport**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 802, **Emergency Medical Technician Scope of Practice**
Ref. No. 813, **Standing Field Treatment Protocols**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**
Ref. No. 815, **Honoring Prehospital DNR Orders**
Ref. No. 816, **Physician at Scene**
Ref. No. 832, **Treatment/Transport of Minors**
Ref. No. 834, **Patient Refusal of Treatment or Transport**

Medical Control Guidelines

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 808.1

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Section I	Medical Advisory	Addition of ≥ 20 weeks gestation	Change made
Section I	Base Advisory 6/10/15	No comments regarding above change. Wanted same language from 808 added to 808.1 Suspected s/sx of stroke)	Approved and changes made
Section I	Provider Advisory 6/17/15	No comments	Approved

Los Angeles County EMS Agency
Ref. No. 808.1 - BASE HOSPITAL CONTACT AND TRANSPORT CRITERIA
Field Reference

PRINCIPLES:

1. Contact assigned base whenever possible.
2. Clinical judgment should be exercised in situations not described in this policy.
3. Children under three years of age require base hospital contact and/or transport in accordance with this policy.
4. Thorough documentation is essential, especially if contact/transport is not performed in accordance with this policy **(* EXCEPTION, See SECTION III).**
5. Circumstances may dictate immediate transport with base contact en route.
6. EMTs shall not cancel a paramedic response if a patient meets any criteria in Section I; an ALS Unit shall be requested if one has not been dispatched.
7. In life threatening situations, consider BLS transport if ALS arrival is longer than transport time.
8. Contact shall be made with the area's trauma center, when it is also a base hospital, on all injured patients meeting Trauma Criteria and/or Guidelines.

SECTION I – BASE CONTACT REQUIRED

- Signs or symptoms of shock
- Cardiopulmonary arrest (excluding those meeting Ref. No. 814, 815 & 821)
- Chest pain or discomfort
- Shortness of breath/ tachypnea
- PMC/PTC Criteria/Guidelines (Ref. No. 510)
- 5 or more patients requiring transport (contacting MAC constitutes base contact)
- Altered level of consciousness as defined in the Medical Control Guidelines
- Suspected ingestion of poisonous substance
- Exposure to hazardous materials with a medical complaint
- Abdominal pain pregnancy or suspected pregnancy ≥ 20 weeks gestation
- Childbirth or signs of labor
- Suspected femur fracture
- Facial, neck, electrical, or extensive burns:
  20% or > in adults
  15% or > in children
  10% or > in infants
- Trauma Criteria/Guidelines (Ref. No. 506)
- Traumatic crush syndrome
- Syncope, loss of consciousness, acute neurological symptoms (Suspected s/sx of stroke)
- Refusal of transport (AMA), if meeting any criteria in Section I

SECTION II – TRANSPORT REQUIRED

- Abdominal pain
- Suspected isolated fracture of the hip
- Abnormal vaginal bleeding
- Suspected allergic reaction
- Asymptomatic exposure to hazardous material (If known to have delayed symptoms)
- GI bleeding
- Near drowning
- Patients who are gravely disabled or a danger to themselves or others

SECTION III – PEDIATRIC PATIENTS

- Infants ≤ 12 months of age shall be transported, regardless of chief complaint and/or mechanism of injury

  EXCEPTION: Infants ≤ 12 months of age who meet Ref. No. 814, Determination/Pronouncement of Death in the Field, Section I.
- Children 13-36 months of age require base hospital contact and/or transport except isolated minor extremity injury
- If a parent or legal guardian refuses transport (AMA), base contact is required prior to leaving the scene

  EXCEPTION: Ref. No. 808, Principle 4 does not apply to patients ≤ 36 months of age.

SECTION IV – REQUIRED BASE CONTACT CRITERIA FOR SFTPs

- If indicated in the SFTPs
- For any criteria listed in Section I that is not addressed by SFTPs
- Whenever consultation with the base hospital is Indicated

Revised x-x-15
Supersedes 1-1-13

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 1202

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
#8	Medical Advisory	Addition of 250ml fluid challenge prn	Changes made
#8	Base Advisory 6/10/15	No comments	Approved
#8	Provider Advisory 6/171/5	No comments	Approved

TREATMENT PROTOCOL: GENERAL ALS *

1. Basic airway
2. Spinal immobilization prn
3. Control major bleeding prn
4. Pulse oximetry
5. Oxygen prn
6. Advanced airway prn
   - **Pediatric**: ETT 12 years of age or older or height greater than the length of the pediatric resuscitation tape
7. Cardiac monitor prn: document rhythm, attach ECG strip if dysrhythmia identified and refer to appropriate treatment protocol
8. Venous access prn; 250ml fluid challenge prn
9. Perform blood glucose test prn, if blood glucose less than 60mg/dl:
   Consider oral glucose preparation if patient awake and alert
10. If indicated, **Dextrose**
    50% 50ml slow IV push
    - **Pediatric:** See Color Code Drug Doses/L.A. County Kids
      1month-less than 2yrs of age: Dextrose 25% 2ml/kg slow IV push
      2yrs of age and older: Dextrose 50**%** 1ml/kg slow IV push up to 50ml
11. If nausea/vomiting/morphine administration
    Ondansetron
    4mg slow IV push, IM or ODT (Orally Disintegrating Tablet)
    - **Pediatric:**
      4yrs of age and older: 4mg ODT one time
      Do not administer to children less than 4yrs of age
      Maximum pediatric dose 4mg
12. **CONTINUE SFTP or BASE CONTACT**
13. If blood glucose remains less than 60mg/dl:
    Dextrose
    50% 50ml slow IV push
    - **Pediatric:** If blood glucose remains less than 60mg/dl and symptomatic:
      See Color Code Drug Doses/L.A. County Kids
      1month- less than 2yrs of age: Dextrose 25% 2ml/kg slow IV push one time
      2yrs of age and older: Dextrose 50**%** 1ml/kg slow IV push up to 50ml one time
13. Reassess for deterioration and refer to the appropriate treatment protocol, if applicable
14. If fluid challenge is indicated, obtain base hospital order
15. If nausea and/or vomiting persists 10 minutes after initial dose:
    Ondansetron
    4mg slow IV push, IM or ODT
    Maximum adult dose 8mg all routes

This protocol includes, but is not limited to, vague complaints such as:

- **General weakness/dizziness**
- **Nausea and vomiting**
- **Palpitations without dysrhythmia**
- **Vaginal bleeding (less than 20wks gestation, no pain, normal vital signs)**
- **Malaise**
- **Near syncope**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 1210

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
Special Considerations	EMS Internal Policy Review (Drs. Koenig & Bosson)	Addition of special considerations #8 & 9	Change made
#1	Base Advisory 6/10/15	Addition of capnography	Change made
Below #5	Base Advisory 6/10/15	Multiple suggested changes to medications and times of medications to be given	Hold and to go to MAC for review & discussion
Special Considerations	Base Advisory 6/10/15	No comments	Approved
All above	Provider Advisory 6/17/15	No Comments	Approved

TREATMENT PROTOCOL: NON-TRAUMATIC CARDIAC ARREST (ADULT) *

1. Basic airway/capnography
2. If arrest not witnessed by EMS:
   CPR for 2min at a compression rate of at least 100/min, minimize interruptions to chest compressions
3. Cardiac monitor: document rhythm and attach ECG strip
4. If asystole, confirm in more than one lead
5. If fine V-Fib is suspected, treat with V-Fib/Pulseless V-Tach

ASYSTOLE / PEA

6. If confirmed PEA, consider causes ❶
7. Venous access, if unable:
   place IO (if available)
8. **Epinephrine** (1:10,000) ❹
   1mg IV or IO
9. Consider advanced airway ❷,
   capnography
10. If narrow complex and heart rate greater than 60bpm:
    Normal saline fluid challenge
    10ml/kg IV or IO at 250ml increments
11. CPR for 2min
12. **CONTINUE SFTP or BASE CONTACT**
13. **Epinephrine** (1:10,000)
    1mg IVP or IO
    May repeat every 3-5min
14. If down time greater than 20min:
    Sodium bicarbonate
    1mEq/kg IV push
    May repeat 0.5mEq/kg every 10-15min
15. If resuscitative efforts are successful:
    Perform 12-lead ECG ❽❾
16. If resuscitative efforts are unsuccessful:
    contact the base hospital to consider pronouncement ❼
    CONTINUE SFTP or BASE CONTACT

V-FIB / PULSELESS V-TACH

6. Defibrillate ❺❻
   Biphasic at 120-200J (typically)
   Monophasic at 360J
7. CPR for 2min
8. Venous access, if unable:
   place IO (if available)
9. Check rhythm ❸, and if indicated:
   Defibrillate
   Biphasic at 200J, monophasic at 360J
10. CPR for 2min
11. **Epinephrine** (1:10,000) ❹
    1mg IVP or IO
12. Consider advanced airway ❷,
    capnography
13. Check rhythm, and if indicated:
    Defibrillate
    Biphasic at 200J, monophasic at 360J
14. **CONTINUE SFTP or BASE CONTACT**
15. CPR for 2min
16. Check rhythm, and if indicated:
    Defibrillate
    Biphasic at 200J, monophasic at 360J
17. **Epinephrine** (1:10,000)
    1mg IVP or IO
    May repeat every 3-5min
18. CPR for 2min
19. Check rhythm, and if indicated:
    Defibrillate
    Biphasic at 200J, monophasic at 360J
20. **Amiodarone**
    150mg IV or IO
    Maximum total dose 450mg
21. CPR for 2min
22. Check rhythm, and if indicated:
    Defibrillate
    Biphasic at 200J, monophasic at 360J
25. If resuscitative efforts are successful:
    Perform 12-lead ECG ❽❾
26. If resuscitative efforts are unsuccessful:
    contact the base hospital to consider pronouncement ❼

TREATMENT PROTOCOL: NON-TRAUMATIC CARDIAC ARREST (ADULT) *

SPECIAL CONSIDERATIONS

❶ Consider causes of PEA: acidosis; cardiac tamponade; drug overdose; hyperkalemia; hypothermia; hypovolemia; hypoxia; massive MI; pulmonary embolus; or tension pneumothorax

Drugs to consider for specific suspected causes:

If hypoglycemia is suspected:
DEXTROSE (50%)
50ml IV or IO

If narcotic overdose is suspected:
NARCAN (naloxone)
0.8-2mg IV or IO
2mg IN or IM

If dialysis patient:
CALCIUM CHLORIDE - BASE CONTACT REQUIRED
1gm IV or IO

SODIUM BICARBONATE – BASE CONTACT REQUIRED
1mEq/kg IV or IO

If tricyclic overdose suspected:
SODIUM BICARBONATE – BASE CONTACT REQUIRED
1mEq/kg IV or IO

If calcium channel blocker overdose suspected:
CALCIUM CHLORIDE – BASE CONTACT REQUIRED
1gm IV or IO

❷ Attempt to limit interruptions in CPR to no more than 10sec with advanced airway. Should utilize end tidal CO_2 monitoring for advanced airway and monitoring ROSC.

❸ Pulse check if a change in ECG rhythm, take no longer than 10sec to check for a pulse. If no pulse is detected within 10sec, resume chest compressions.

❹ If hypothermia is suspected, administer only one dose of epinephrine and **no other medications** until the patient is re-warmed

❺ Biphasic defibrillator settings may vary; refer to manufacturer's guidelines. If unknown, use 200J for biphasic, 360J for monophasic

❻ If hypothermia is suspected, defibrillate only once until the patient is re-warmed

❼ If hypothermia is suspected, resuscitation efforts should not be abandoned until the patient is re-warmed, or the base hospital orders termination of resuscitative efforts

❽ A 12-lead ECG shall be acquired on patients who complain of chest pain/discomfort of suspected cardiac etiology, non-traumatic post cardiac arrest patients with a return of spontaneous circulation (ROSC) and/or patients who the paramedics suspect are experiencing an acute cardiac event.

❾ Post cardiac arrest patients with ROSC, with or without a 12 lead ECG analysis equivalent to "Acute MI", shall be transported to the most accessible open SRC if ground transport is 30 minutes or less regardless of service agreement rules and/or considerations. Transmission of 12-Lead ECG shall be sent to the receiving SRC.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REFERENCE NO 202.1

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 1275

SECTION	COMMITTEE/DATE	COMMENT	RESPONSE
#15	Medical Advisory	Addition of 8mg to maximum dose of Morphine	Change made
#18	Medical Advisory/Trauma Advisory	Remove "Wide open" and add in 250ml increments after IV fluid administration	Change made
#17	Internal EMS Policy Review	Addition of IM/IN dosing for Fentanyl to make consistent with other policies	Changes made
Above items	Base Advisory 6/10/15	No comments	Approved
#15	Base Advisory 6/10/15	Removal of "isolated extremity injury" following Pain Management. Addition of IM/IN dosing for Fentanyl for consistency Move "Normal Saline" from #15 to #9	Changes made Approved
Above items	Provider Advisory 6/17/15	No Comments	Approved

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 ❽
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
   Poor perfusion:
   Normal Saline Fluid Challenge
   250ml one time
   Pediatric: 20ml/kg IV
   See Color Code Drug Doses/L.A. County Kids ❼
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:
    Fentanyl ❷❸❻
    50mcg slow IVP, titrate for pain relief, do not repeat
    50-100mcg IM/IN one time
    Pediatric: 1mcg/kg slow IV push, do not repeat
    1mcg/kg IM one time
    1.5mcg/kg IN one time
    Morphine ❷❸❻
    2-4mg slow IV push, titrated to pain relief maximum 8mg
    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
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
    50-100mcg IM/IN one time
    Pediatric: 1mcg/kg slow IV push (over 2 minutes)
    May repeat every 5min, maximum pediatric dose 50mcg
    1mcg/kg IM one time
    1.5mcg/kg IN one time See Color Code Drug Doses/L.A. County Kids ❼

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
IV fluid administration in 250ml increments 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

Los Angeles County EMS Agency

EMS Commission Ad Hoc Committee for development of Blue Print for Behavior Emergencies

Membership suggestions:

1. EMS Agency staff
2. Chair of EMS Commission
3. EMS Commission member
4. Sheriff's Office
5. Los Angeles County Fire
6. Los Angeles Area Fire Chiefs Association
7. Los Angeles Police Chiefs Association
8. Department of Mental Health
9. Los Angeles Ambulance Association
10. Hospital Association of Southern California
11. EMS Agency Medical Director
12. Southern California Psychiatric Society