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Public Member (1st District)

Southern California Chapter-American

College of Surgeons (ACS)

Southern California Public Health Assn.

Executive Director

Cathy Chidester, Director, EMS Agency

(562) 347-1604

cchidester@dhs.lacounty.gov

Commission Liaison

Marilyn Rideaux

(323) 890-7392

mrideaux@dhs.lacounty.gov

**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: September 21, 2016

TIME: 1:00 – 3:00 PM

LOCATION: Los Angeles County EMS Agency

10100 Pioneer Blvd., EMSC 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/PRESENTATIONS

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

1 MINUTES

- July 20, 2016

2 CORRESPONDENCE

- 2.1 (8-18-2016) Fire Chief, Each Fire Department and CEO/President, Each Ambulance Company: Standardized Drug Formulary (Revised)
- 2.2 (8-8-2016) Chief Executive Office, Hospital Preparedness Program (HP) Participant, Non-Emergency Department Approved for Pediatrics: Pediatric Readiness – Integrating Every Day Pediatric Readiness into your Emergency Management Program
- 2.3 (7-25-2016) Each STEMI Referring Facility, Chief Executive Officer and (Each) ED Medical Director: Interfacility Transfers Utilizing 9-1-1 Transport

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. 1401.1: Mobile Medical System Deployment Summary

POLICIES – FOR YOUR INFORMATION

- 4.2 Reference No. 1308: Medical Control Guideline: Cardiac Monitoring / ECG
- 4.3 Reference No. 1304: Medical Control Guideline: Airway / Oxygenation / Ventilation
- 4.4 Reference No. 1248: Treatment Protocol: Pain Management
- 4.5 Reference No. 804: Fireline Emergency Medical Technician – Paramedic (FEMP)

5. BUSINESS

Old:

- 5.1 Community Paramedicine (*July 18, 2012*) - Attachment
- 5.2 EMSC Ad Hoc Committee (*May 20, 2015*)
- 5.3 Education Advisory Committee (*July 20, 2016*)

New:

- 5.4 EMSC Annual Report – 2015/2016 - Attachment

6. COMMISSIONERS COMMENTS/REQUESTS

7. LEGISLATION

8. EMS DIRECTOR'S REPORT

9. ADJOURNMENT

(To the meeting of November 16, 2016)

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

September 21, 2016

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For your information

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July 20, 2016

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Commission Liaison

Marilyn Rideaux

(323) 890-7392

mr Rideaux@dhs.lacounty.gov

COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
(Ab) Robert Ower	LAC Ambulance Assn	Cathy Chidester	Director, EMS Agency
☑ Robert Barnes	LAC Police Chiefs Assn	Kay Fruhwirth	Asst. Dir., EMS Agency
☑ Frank Binch	Public Member, 4 th District	Richard Tadeo	Asst. Dir, EMS Agency
* Erick H. Cheung, M.D.	So. CA Psychiatric Society	Marilyn Rideaux	Staff
☑ Robert Flashman, M.D.	L.A. County Medical Assn	Amelia Chavez	"
☑ John Hisserich	Public Member, 3 rd District	Christine Clare	"
☑ James Lott	Public Member, 2 nd District	Nichole Bosson, MD	"
☑ Clayton Kazan, M.D.	CAL/ACEP	Cathlyn Jennings	"
☑ Paul S. Rodriguez	CA State Firefighters' Assn.	Susan Mori	"
* Colin Tudor	League of California Cities		
☑ Margaret Peterson, PhD	HASC		
☑ Lt. Brian S. Bixler	Peace Officers Assn. of LAC		
☑ Nerses Sanossian, M.D.	American Heart Assn.		
☑ Carole Snyder	Emergency Nurses Assn.		
* Chief David White	LA Chapter-Fire Chiefs Association		
☑ Gary Washburn	Public Member, 5 th District		

GUESTS

Michael Murrey	Manhattan Beach FD	Jaime Garcia	HASC
Mike Hansen	Torrance Fire Dept	Laurie Mejia	Long Beach Memorial
Chad Richardson	LAFD	Josh Hogan	Long Beach Fire Dept
Al Flores	LAFD	Victor Galsan	Harbor-UCLA

(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 1:12 PM by Chairman, Clayton Kazan. A quorum was present with 12 Commissioners in attendance.

ANNOUNCEMENTS/PRESENTATIONS:

Ms. Cathy Chidester, Director, EMS Agency presented a summary of the activities on July 2, 2016, Sidewalk CPR Day in Los Angeles County and shared a video of the event's press conference held at LAC+USC Medical Center.

Consent Calendar:

Chairman Kazan called for approval of the Consent Calendar:

M/S/C: Commissioner Flashman/Rodriguez to approve the Consent Calendar.

5. OLD BUSINESS

5.1 Community Paramedicine (July 18, 2012)

The alternate sites (ALTRANS) program which allows the paramedic to transport non-emergency patients who consent to be seen at urgent care centers is progressing slowly. The Congestive Heart Failure (CHF) program is also progressing.

On Sept 22, 2016, the State EMS Authority is having a seminar in San Diego on community paramedicine and how the program is progressing throughout the state. Ms. Chidester stated that she will be one of the speakers at this seminar.

5.2 EMSC Ad Hoc Committee Report (May 20, 2015)

Chairman Kazan reported that the EMSC Ad Hoc Committee's working group on Behavioral Emergencies last met in June and is continuing to work on a draft report for consideration by the EMSC. The draft report will be distributed to the Ad Hoc Committee in August for their review and edits. A final report should be ready for presentation to the EMSC in September.

NEW BUSINESS

5.3 Education Advisory Committee

Richard Tadeo, Assistant Director, EMS Agency reported that staff has been monitoring activity of the Education Advisory Committee (EAC) reviewing the past three years meetings. Mr. Tadeo noted that the EAC meets infrequently. Most meetings are cancelled due to lack of agenda items necessitating a meeting as well as lack of committee members being able to attend the scheduled meeting. There has been very few agenda items that require action; therefore the meetings held have been strictly informational. Ms. Chidester stated that historically this committee assisted in curriculum development and education standards, however the curriculum for EMTs and paramedics is standardized across the nation with the National Registry and that EAC has not been a working committee for quite some years.

Commissioner Jim Lott recommended that conference and/or web-conferencing be considered in place of a physical meeting if the issue is low attendance by committee members.

Commissioner Binch called for development of a small working group to make recommendations to the EMSC. The workgroup should be headed by the Chair and Vice Chair of the EAC and including identified support.

Action: Notify EAC Committee Chair and Vice Chair.

Responsibility: EMS Agency

6. Commissioners Comments/Requests

Chairman Kazan stated that the Blood Bank in L.A. County reported lower than anticipated blood reserve. Everyone who can is encouraged to donate.

7. Legislation

Ms. Chidester reported that the legislative session is in recess for the summer.

8. Director's Report

- Ms. Chidester distributed a handout from the Insure the Uninsured Project (ITUP) Behavioral Health (BH) Workgroup Framework-Collaborative System Supports to Manage ED Utilization of Individuals in Behavioral Health Crisis. The purpose of the ITUP BH workgroup is to ensure the mental health patient get to the proper place initially which may not necessarily be the hospital. ITUP's BH workgroup's activities dovetail with the work the EMSC Ad Hoc Committee on Behavioral Emergencies is doing. Additional comments by Jaime Garcia, HASC.
- Dr. Nichole Bosson – Color Code Kids has been updated based on a standardized formulary. This will be rolled out in September with a training module; the Emergi-Press format is changing-moving into online updates, which will provide for more rapid updates from the Medical Director's office; Comprehensive Stroke Centers-the stroke standards have been developed and now include comprehensive stroke centers as well as primary stroke center care.

9. Adjournment

The Meeting was adjourned by Chairman Clayton Kazan at 2:22 PM. The next meeting will be held on September 21, 2016.

Next Meeting: Wednesday, September 21, 2016
EMS Agency
10100 Pioneer Blvd.
Santa Fe Springs, CA 90670

Recorded by:
Marilyn Rideaux
EMSC Liaison



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

August 18, 2016

**Los Angeles County
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Cathy Chidester
Director

Marianne Gausche-Hill, 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.

TO: Fire Chief, Each Fire Department
CEO/President, Each Ambulance Company

FROM: Marianne Gausche-Hill, MD. FACEP, FAAP
Medical Director, LA County EMS Agency

SUBJECT: STANDARDIZED DRUG FORMULARY (REVISED)

This is a follow-up to the June 18, 2016 memorandum regarding the standardization of drug formulation for the pediatric population. The implementation date has been revised for October 3, 2016. This will allow for additional training and purchasing of the new formulations.

Please note the following key changes since the initial release of the standard formulary:

- Atropine: changed from 1mg/1mL to 1mg/10mL
- Epinephrine: relabeling
 - 1:10,000 concentration to 0.1mg/1mL (IV administration)
 - 1:1,000 concentration to 1mg/1mL (IM administration or for inhalation)
- Dextrose: replace 50% with 10%

A training module will be provided in early September to assist with this transition. If you have any questions or need additional information, please do not hesitate to contact me or Richard Tadeo, Assistant Director, at (562) 347-1610.

Attachment

MGH:rt

- c. Director, EMS Agency
Assistant Medical Director, EMS Agency
Medical Director, Each EMS Provider Agency
Nurse Educator, Each EMS Provider Agency
EMS Commission



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

ATTACHMENT**DRUG FORMULATIONS:**

MEDICATION	FORMULATION
Adenosine	12mg/4mL or 6mg/2mL
Albuterol	2.5mg/3mL
Amiodarone	150mg/3mL
Atropine	1mg/10mL
Calcium Chloride	100mg/1mL
Dextrose 10%	0.1mg/1mL
Diphenhydramine	50mg/1mL
Epinephrine 0.1mg/1mL IV	1mg/10mL
Epinephrine 1mg/1mL IM	1mg/1mL
Epinephrine 1mg/1mL (for inhalation)	1mg/1mL
Fentanyl IV	50mcg/1mL
Fentanyl IN	50mcg/1mL
Glucagon	1mg/1mL
Lidocaine (IO Only)	100mg/5mL
Midazolam	5mg/1mL
Morphine Sulfate	4mg/1mL
Naloxone	1mg/1mL
Normal Saline	0.9% NaCl
Ondansetron ODT (5yrs or older)	4mg
Sodium Bicarbonate IV (dilute 1:1 for <1yr)	1mEq/1mL



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

CORRESPONDENCE 2.2

August 8, 2016

**Los Angeles County
Board of Supervisors**

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Michael D. Antonovich
Fifth District

TO: Chief Executive Officer
Hospital Preparedness Program (HPP) Participant
Non-Emergency Department Approved for Pediatrics

FROM: Marianne Gausche-Hill, MD
Medical Director

**SUBJECT: PEDIATRIC READINESS - INTEGRATING EVERY DAY
PEDIATRIC READINESS INTO YOUR EMERGENCY
MANAGEMENT PROGRAM**

Los Angeles County (LAC) Emergency Medical Services (EMS) Agency is embarking on the Los Angeles Pediatric Readiness project aimed at improving the readiness of hospitals to care for pediatric patients. The target audience is hospitals that are 9-1-1 receiving centers that do not participate in the Emergency Department Approved for Pediatrics (EDAP) program.

In 2012, a national assessment of pediatric readiness was conducted with 72 of the 73 (99%) hospitals that are 9-1-1 receiving centers in LAC participating in this assessment. The median readiness score was 70 out of 100 which was consistent with the national median score of 69. Of interest was that hospitals designated as EDAPs had a mean score of 91.8, indicating that verification of hospitals by the EMS Agency improved day-to-day readiness of hospital emergency departments to care for children.

Given the success of the EDAP program in LAC, the EMS Agency is requesting that you join us in working to improve the readiness of all hospitals for both day-to-day pediatric patients and disaster preparedness. The proposed program called the Los Angeles Pediatric Readiness Project (LA Peds Ready) will identify pediatric champions from EDAP or Pediatric Medical Center (PMC) hospitals that provide pediatric services to establish partnerships with your hospital to assist in improving your pediatric readiness. These pediatric champions will work with you and hospital staff to identify gaps in pediatric readiness. Based on this gap analysis tools and materials will be provided to assist your organization with developing pediatric policies and the program will provide training to enhance clinicians' pediatric assessment and procedural skills.

A meeting to kick-off the LA Peds Ready project is scheduled for September 29, 2016. Each hospital should designate a pediatric emergency care coordinator (an ED physician and/or nurse) to coordinate this project and they should attend this meeting, as well as, the emergency department manager and medical director.

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

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Fax: (562) 941-5835

*To ensure timely,
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Health Services
<http://ems.dhs.lacounty.gov>



The meeting details are below:

Date: September 29, 2016
Time: 09:30 a.m. to 11:30 a.m.
Location: Town Center Hall
11740 Telegraph Road
Santa Fe Springs, CA 90670

Your hospitals participation and attendance is encouraged. Please let us know who will be attending this meeting by logging on to <https://lapedsready.eventbrite.com> and registering the participants by September 22, 2016.

If you have any problems registering or questions, contact Laurie Lee- Brown, DRC Program Coordinator at (562) 347-1648 or LLee-Brown6@dhs.lacounty.gov. Regardless of the disaster, prepared healthcare systems which includes readiness to care for patients of all ages, are the cornerstone of an effective response and recovery effort.

C: Emergency Management/Disaster Planner
ED Medical Director
ED Nursing Director
Hospital Association of Southern California



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

CORRESPONDENCE 2.3

July 25, 2016

**Los Angeles County
Board of Supervisors**

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Marianne Gausche-Hill, MD
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TO: Each STEMI Referring Facility, Chief Executive Officer
Each STEMI Referring Facility, ED Medical Director

FROM: Marianne Gausche-Hill
Medical Director

SUBJECT: INTERFACILITY TRANSFERS UTILIZING 9-1-1 TRANSPORT

This letter is to provide you with data regarding interfacility transfers of patients from your facility utilizing 9-1-1 transport. Reference 513.1 'Emergency Department Interfacility Transports of Patients with ST-Elevation Myocardial Infarction' is intended to reduce delays in care for this population by allowing 911 transport for patients with **STEMI requiring emergent percutaneous coronary intervention when private ALS transport is not available within 10 minutes**. The goal is to meet the 120-minute national benchmark for first-medical-contact-to-balloon (FMC2B) time for STEMI patients requiring interfacility transfer. Patients who have cardiac ischemia or infarction not requiring emergent coronary angiography (e.g. NSTEMIs) or patients with other serious medical illness are not appropriate for 9-1-1 transport by this policy.

Establishing a written memorandum of understanding (MOU) with the closest STEMI receiving center (SRC), which delineates the transfer procedure, will help reduce delays and ensure appropriate 9-1-1 utilization. In addition, establishing agreements with private advanced life support (ALS) and critical care transport (CCT) providers is important to ensure timely transfer of patients requiring higher level care; 9-1-1 transport is limited and should be a last resort.

Only patients with true STEMI necessitating immediate percutaneous coronary intervention (PCI) are appropriate for 9-1-1 transport. Therefore, all patients who are transferred should both 1) have an indication for emergent coronary angiography and 2) be a candidate for the procedure.

We expect at least 90% of patients transferred to a STEMI receiving center via 9-1-1 to receive emergent coronary angiography.

In addition, based on national standards, **we expect 90% of patients requiring percutaneous coronary intervention to receive the intervention within 120 minutes from arrival at your facility**. Transfer patients currently incur the greatest delays to care, of which a major contributor is the door-in-door-out (DIDO) time at the transferring facility. This time should be less than 30 minutes. By meeting the DIDO goal of 30 minutes at STEMI referral facilities, we can achieve timely care for all patients with STEMI in Los Angeles County. As a system, we have set the ambitious goal of FMC2B time within 90 minutes for all STEMI patients and hope to exceed the national standard.

Confidential Quality Improvement Information: The information contained in this document is privileged and strictly confidential under State Law, including Evidence code Section 1157.



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

Interfacility Transfers Utilizing 9-1-1 Transport
July 25, 2016
Page 2

We have provided attachments with the current metrics for your facility along-side the other facilities in Los Angeles County. We have also provided a sample MOU that you may use to connect with your closest SRC. We ask that you use these materials to work toward meeting and improving upon these goals. We will look again at these metrics in 6 and 12 months and provide you with data regarding your progress.

Thank you for your support.

MGH:nb

Attachments:

Reference 513.1

Graph 1: IFT percent coronary angio complete by SRF

Graph 2: IFT time intervals by SRF

Sample MOU



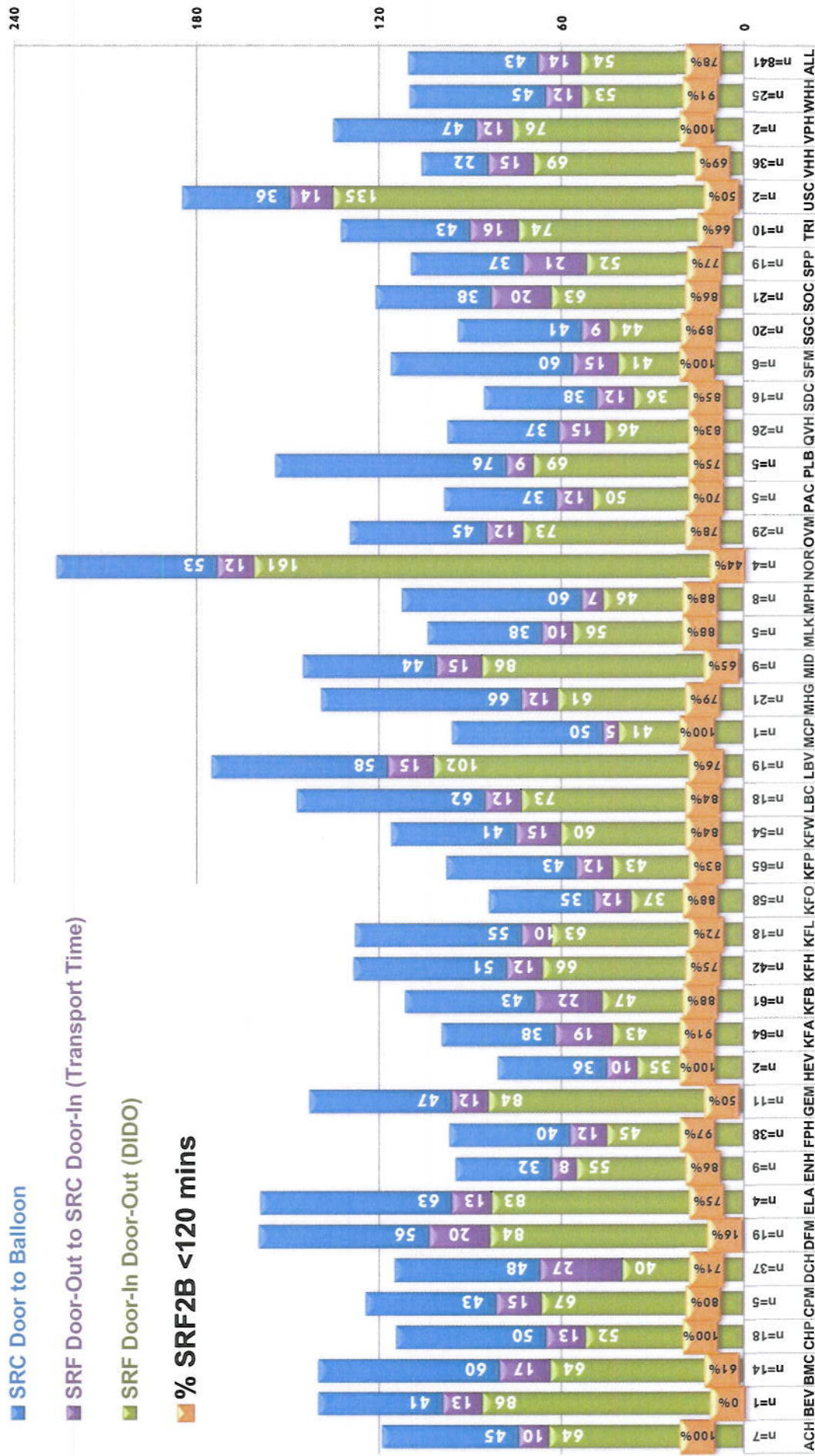
EMERGENCY MEDICAL
SERVICES AGENCY
LOS ANGELES COUNTY

STEMI IFT Median Times (in minutes)

January 1, 2014 - December 31, 2015 (2yrs)



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STEMI Referred Facility / No. of Patients with PCI



SUBJECT: **SAMPLE MEMORANDUM OF UNDERSTANDING/
AGREEMENT INTER-FACILITY TRANSFER FOR
ACUTE STEMI**

REFERENCE NO. 320.2

This Transfer Agreement (hereinafter referred to as "AGREEMENT") between _____ Medical Center and _____, bearing the effective date of _____, _____, is made and entered into as of the date of execution below, by and between

(hereinafter referred to as STEMI Receiving Center "SRC"),

and

(hereinafter referred to as STEMI Referral Facility "SRF"),

and sets forth in full, completely, and exclusive of any understandings which shall be controlling over this AGREEMENT.

This AGREEMENT is to provide for the specific transfer of ST-elevation myocardial infarction (STEMI) patients from _____, a SRF Emergency Department, to _____ Medical Center a STEMI Receiving Center (SRC) with the intent to provide **emergent** angiography for STEMI in the cardiac catheterization laboratory and primary percutaneous coronary intervention when clinically appropriate.

Prior to transfer the following is to occur:

Referral Facility (SRF) responsibilities:

- Fax the patient's STEMI ECG to ____-____-____.
- Call _____ at ____-____-____ for patient acceptance.
- Appropriate transport modality should be made in consultation with the receiving SRC.
 - It is the responsibility of the transferring facility to ensure transport at the appropriate level of care.
- Call the private ambulance for transport to the SRC confirming a response time of < 10 minutes.
If unavailable,
- Call 9-1-1 after the STEMI patient is packaged and ready for immediate transport.
 - 9-1-1 transports are reserved for STEMI patients requiring immediate PCI.
- Send any available records with the patient without a delay in transport.
 - Other information, not sent at the time of transfer, is to be readily available when requested.

EFFECTIVE:
REVISED:
SUPERSEDES:

PAGE 1 OF 2



SUBJECT: **SAMPLE MEMORANDUM OF UNDERSTANDING/
AGREEMENT INTER-FACILITY TRANSFER FOR
ACUTE STEMI**

REFERENCE NO. 320.2

STEMI Receiving Hospital (SRC) responsibilities:

- Accept the transfer as appropriate-decision is at the discretion of the ED physician/interventional cardiologist after reviewing the patient history and 12-lead ECG.
- Notify the cath lab per hospital protocol.

IN WITNESS, WHEREOF, we have executed this AGREEMENT on the dates written below:

**STEMI Referral
Facility** _____:

Print Name: _____

Title: _____

Date: _____

Signature: _____

**STEMI Receiving
Center** _____:

Print Name: _____

Title: _____

Date: _____

Signature: _____

EFFECTIVE:
REVISED:
SUPERSEDES:



EMERGENCY MEDICAL
SERVICES AGENCY
LOS ANGELES COUNTY

SRF (Referral) IFT

January 1, 2014 - December 31, 2015 (2yrs)



© copyright LA County EMS Agency

■ No Cath ■ Cath



STEMI Referral Facility (SRF)

All data are self-reported by hospitals.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMERGENCY DEPARTMENT INTERFACILITY
TRANSPORT OF PATIENTS WITH
ST - ELEVATION MYOCARDIAL INFARCTION** (ALS PROVIDERS, HOSPITALS)
REFERENCE NO. 513.1

PURPOSE: To define the transportation options available for the Emergency Department (ED) interfacility transfer of patients diagnosed with ST-elevation myocardial infarction (STEMI) and who may require emergent percutaneous coronary intervention (PCI).

AUTHORITY: Health and Safety Code 1797.220 and 1798
California Code of Regulations, Title 22, Sections 100147 and 100169
Social Security Act Section 1867(a) (EMTALA) of the United States Code, Section 42

POLICY:

- I. The ED interfacility transfer of STEMI patients shall comply with current EMTALA and Title 22 transfer laws and regulations for both sending and receiving hospitals.

Note: Transfer agreements between approved STEMI Receiving Centers (SRC) and STEMI Referral Facilities (non-approved SRCs and non-PCI capable facilities) are the optimal practice to facilitate the transfer process.

- II. Transportation arrangements are the responsibility of the STEMI Referral Facility (SRF). The appropriate transport modality (as defined in Ref. No. 517) should be made in consultation with the receiving SRC.

TRANSPORTATION OPTIONS:

1. Private Advanced Life Support (ALS) and/or Critical Care Transport (CCT) provider agencies are to be utilized when agreements are in place and the ALS transport unit is available within 10 minutes of the initial transport request.
2. The jurisdictional 9-1-1 provider agency may be contacted when it is known that a private ALS transport unit is not available within 10 minutes. Patient destination shall comply with Ref. No. 513, ST-Elevation Myocardial Infarction Patient Destination.
 - A. 9-1-1 should be accessed only when the patient is ready for immediate transport.
 - B. Patients are to be transported to the SRC as directed by the SRF physician (base hospital contact/notification guidelines apply).
 - C. Transport units may bypass the most accessible SRC to the prearranged receiving SRC within 30 minutes if the provider-based resources at the time of transport allow.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 513, **ST-Elevation Myocardial Infarction (STEMI) Patient Destination**

Ref. No. 517, **Private Provider Agency Transport/Response Guidelines**

Emergency Medical Treatment and Active Labor Act (EMTALA)

EFFECTIVE: 08-01-10

REVISED: 09-01-15

SUPERSEDES: 02-01-12

APPROVED:


Director, EMS Agency


Medical Director, EMS Agency

PAGE 1 OF 1



**EMERGENCY MEDICAL SERVICES COMMISSION
BASE HOSPITAL ADVISORY COMMITTEE
MINUTES
August 10, 2016**



REPRESENTATIVES		EMS AGENCY STAFF
<input checked="" type="checkbox"/> Carole Snyder, RN, Chair	EMS Commission	Dr. Nichole Bosson
<input type="checkbox"/> Margaret Peterson, Ph.D., Vice Chair	EMS Commission	Richard Tadeo
<input checked="" type="checkbox"/> Robert Flashman, M.D.	EMS Commission	Christine Clare
<input type="checkbox"/> Erick Cheung, Ph.D.	EMS Commission	Mark Ferguson
<input checked="" type="checkbox"/> Karyn Robinson	Northern Region	Lucy Hickey
<input type="checkbox"/>	Northern Region, Alternate	John Telmos
<input checked="" type="checkbox"/> Kristina Crews	Southern Region	Michelle Williams
<input checked="" type="checkbox"/> Samantha Verga-Gates	Southern Region	Cathy Jennings
<input type="checkbox"/> Laurie Mejia	Southern Region	Susan Mori
<input type="checkbox"/> Natalie Burciago	Southern Region, Alternate	Gary Watson
<input checked="" type="checkbox"/> Christine Farnham	Southern Region, Alternate	Dr. Ashley Sanello
* <input type="checkbox"/> Paula Rosenfield	Western Region	Jacqui Rifenburg
<input checked="" type="checkbox"/> Ryan Burgess	Western Region	Jerry Crow
<input type="checkbox"/> Rosie Romero	Western Region, Alternate	
<input type="checkbox"/> Laurie Sepke	Eastern Region	
<input checked="" type="checkbox"/> Alina Candal	Eastern Region	
<input checked="" type="checkbox"/> Jenny Van Slyke	Eastern Region, Alternate	
<input checked="" type="checkbox"/> Lila Mier	County Hospital Region	
<input checked="" type="checkbox"/> Emerson Martell	County Hospital Region	
<input type="checkbox"/> Jose Garcia	County Hospital Region, Alternate	
<input type="checkbox"/> Yvonne Elizarraraz	County Hospital Region, Alternate	
<input type="checkbox"/> Mike Hansen	Provider Agency Advisory Committee	
<input checked="" type="checkbox"/> Michael Murrey	Provider Agency Advisory Committee, Alt.	
<input checked="" type="checkbox"/> Jazmin Gonzalez	MICN Representative	
<input type="checkbox"/> Jeff Warsler	MICN Representative, Alt.	
<input checked="" type="checkbox"/> Robin Goodman	Pediatric Advisory Committee	
<input type="checkbox"/> Kerry Gold-Tsakonas	Pediatric Advisory Committee, Alt.	
PREHOSPITAL CARE COORDINATORS		GUESTS
<input type="checkbox"/> Kevin Lennox (AMH)	<input checked="" type="checkbox"/> Adrienne Roel (AMH)	Wendy Ruggeri M.D.- LAFD
<input checked="" type="checkbox"/> Courtney Derryberry (AVH)	<input type="checkbox"/> Alex Perez (CAL)	Clayton Kazan, M.D.- LACoFD
<input checked="" type="checkbox"/> Annette Cornell (HCH)	<input type="checkbox"/> Dee Phillips (HMN)	Nichole Steeneken, LACoFD
<input type="checkbox"/> Rachel Caffey (NRH)	<input checked="" type="checkbox"/> Heidi Ruff (NRH)	Victoria Hernandez, LACoFD
<input type="checkbox"/> Gloria Guerra (QVH)	<input type="checkbox"/> Nichole Havens (QVH)	
<input checked="" type="checkbox"/> Laura Leyman (SFM)	<input checked="" type="checkbox"/> Jennifer Hunt (SMM)	
<input checked="" type="checkbox"/> Lauren Spina (CSM)		

- 1. CALL TO ORDER:** The meeting was called to order at 1:03 P.M. by Carole Snyder, Chairperson.

- 2. APPROVAL OF MINUTES -** The June 8, 2016 meeting minutes were approved as written.

M/S/C (Burgess/Verga-Gates) Approve the June 8, 2016 meeting minutes as written.

- 3. INTRODUCTIONS/ANNOUNCEMENTS**

Dr. Ashely Sanello from Harbor-UCLA Medical Center and Dr. Krystal Baciak from LAC+USC Medical Center were introduced as the new EMS Fellows working with the EMS Agency for this year.

- 4. REPORTS & UPDATES**

4.1 Memorial Hospital of Gardena Service Area Pilot Project

Memorial Hospital of Gardena is continuing to evaluate.

4.2 EMS Update 2016

EMS Update 2016 is complete. Please email Richard Tadeo with any additional comments and/or topic suggestions for EMS Update 2017.

4.3 STEMI Interpretation for EMS Providers

Dr. Bosson reported the EMS had a presentation on STEMI interpretation for EMS providers. The program was seen as valuable and EMS Agency is considering using the program in the future.

5. UNFINISHED BUSINESS

5.1 Electronic Base Form Documentation

Ryan Burgess reported that the development and testing of a real-time electronic base hospital form is ready for trial with the APCC e-form workgroup. They are also in discussions with Lancet for a possible scanning option.

5.2 Los Angeles County Fire (CF) ePCR Implementation

Richard Tadeo reported that training has been completed for all providers and hospitals and CF was fully deployed as of today. Software issues are continuing to be addressed by CF with their vendor. The EMS Agency is continuing to have weekly conference calls with CF to address any issues/concerns.

Dr. Kazan apologized for difficulties with the implementation and wanted to ensure that CF is continuing to address. Stated that the issue regarding base hospitals not being able to access records on XchangER when they do not receive the patient should be resolved with the service release next week.

Ryan Burgess identified key priority for the hospitals as failure to receive EMS Report via XchangER approximately 50% of the time when patient is transported to them.

5.3 Reference No. 1304, Medical Control Guideline: Airway/Oxygenation/Ventilation

Principle 8, add language "is most accurate with proper 2-person BVM technique or advanced airway"

Guideline13, remove wording "methods for assisting" and change "should" to "shall"

M/S/C (Burgess/Van Slyke) Approve Reference No. 1304, Medical Control Guideline: Airway/Oxygenation/Ventilation with recommended changes

5.4 Reference No. 1308, Medical Control Guideline: Cardiac Monitoring/ECG

Guideline 7, remove specific ECG quality parameters and make them Principle 7 and Change wording from "computerized" to "software and paramedic"

**M/S/C (Burgess/Crews) Approve Reference No. 1308, Medical Control
Guideline: Cardiac Monitoring/ECG with recommended changes**

6. NEW BUSINESS

6.1 BHAC Representatives

Chris Clare requested a current copy of the representatives for BHAC to include region. Jessica Strange to forward a copy.

6.2 Reference No. 1140.1, Mobile Medical System (MoMS) Deployment Summary

No changes.

M/S/C (Van Slyke/Burgess)

7. OPEN DISCUSSION

Pediatric Weight Color Code

Initial roll-out was scheduled for September 1, 2016. Educational PowerPoint is completed. Members felt that voiceover was not needed if the 'notes' are included. EMS Agency to develop into a computer-based learning module that the PCCs and Nurse Educators can forward to their staff. Implementation delayed until October 1, 2016.

EmergiPress

The EMS Agency is rebranding the EmergiPress. It will include: Updates from Office of Medical Director; Cases from the Field; 12-Lead ECG interpretation; and other information thought to be useful. Please forward interesting cases to Dr. Bosson for possible inclusion.

Medical Control Guideline 1303: Cath Lab Activation Algorithm

Mission Lifeline, part of American Heart Association, is looking at LA County data to evaluate for best practice.

ENA Annual Conference

The conference is being held in LA September 15-17, 2016 and ENA is looking for volunteers to assist.

8. NEXT MEETING: October 12, 2016

9. ADJOURNMENT: The meeting was adjourned at 2:08 P.M.



**EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE
WEDNESDAY, August 10, 2016**



MEMBERSHIP / ATTENDANCE		
MEMBERS	ORGANIZATION	EMS AGENCY
* Nerses Sanossian , Chair	EMS Commissioner (MD)	Nichole Bosson
<input checked="" type="checkbox"/> John Hisserich, Vice Chair	EMS Commissioner (Community Member)	Richard Tadeo
<input type="checkbox"/> Clayton Kazan	EMS Commissioner (MD)	Christine Clare
<input type="checkbox"/> Colin Tudor	EMS Commissioner (League of CA Cities)	Michelle Williams
<input type="checkbox"/> Matt Armstrong	Ambulance Advisory Board (LACAA)	Susan Mori
<input checked="" type="checkbox"/> Trevor Stonum	Ambulance Advisory Board (alternate)	Ashley Sanello
<input checked="" type="checkbox"/> Gloria Guerra	Base Hospital Advisory Committee (BHAC) (RN)	
<input type="checkbox"/> Alina Candal	BHAC (alternate)	
<input checked="" type="checkbox"/> Ryan Burgess	Hospital Association of Southern California (HASC)	
<input type="checkbox"/> Nathan McNeil	HASC (alternate)	
<input type="checkbox"/> Joanne Dolan	Long Beach Fire Department (LBFD) (RN)	
<input type="checkbox"/> Don Gerety	LBFD (alternate)	
<input checked="" type="checkbox"/> Dan France	Los Angeles Area Fire Chiefs Association	
<input checked="" type="checkbox"/> Sean Stokes	LA Area Fire Chiefs Association (alternate)	
<input checked="" type="checkbox"/> Nicole Steeneken	Los Angeles County Fire Department (LACoFD)	
<input checked="" type="checkbox"/> Victoria Hernandez	LACoFD (alternate)	
<input checked="" type="checkbox"/> Al Flores	Los Angeles Fire Department (LAFD)	
<input checked="" type="checkbox"/> John Smith	LAFD (alternate)	
<input type="checkbox"/> Dipesh Patel	Medical Council (MD)	
<input type="checkbox"/> VACANT	Medical Council (alternate)	
* Corey Rose	Provider Agency Advisory Committee (PAAC)	
<input type="checkbox"/> VACANT	PAAC (alternate)	
<input type="checkbox"/> VACANT	Trauma Hospital Advisory Committee (THAC) (MD)	
<input type="checkbox"/> David Hanpeter	THAC (MD) (alternate)	
* Marilyn Cohen	THAC (RN)	
<input type="checkbox"/> VACANT	THAC (RN) (alternate)	
<input checked="" type="checkbox"/> Present *Excused <input type="checkbox"/> Absent		

- 1. CALL TO ORDER:** The meeting was called to order at 10:00 am by Commissioner Hisserich.
- 2. APPROVAL OF MINUTES:** The minutes of the April 13, 2016 meeting was approved as written.
- 3. INTRODUCTIONS/ANNOUNCEMENTS**

- None

4. REPORTS AND UPDATES

4.1. TEMIS Update (Michelle Williams/Richard Tadeo)

County Fire (CF) Update: Currently importing April and May 2016. No records from when they went live with their ePCR in May have been received.

Los Angeles Fire Department (CI) is working on submitting their records from mid-January 2016 onward.

The County is looking to expand the current TEMIS database from a client based to a web based product, a request for information (RFI) is being prepared.

4.2. Service Changes (Michelle Williams)

Primary Stroke Centers (PSCs)

Providence St. John's Health Center (SJH) became a PSC on July 5, 2016.

Emergency Department Approved for Pediatrics (EDAPs)

Pacifica Hospital of the Valley (PAC) is no longer an EDAP as of July 5, 2016.

ePCR

Santa Monica Fire Department (SM) went live with their ePCR, with Digital EMS as their vendor, as of August 1, 2016.

4.3 Data Verification (*Michelle Williams*)

Data verification reports were sent out to the nurse educators, paramedic coordinators, and QI coordinators of all the public providers on July 27, 2016. Any discrepancies or questions should be directed to Michelle Williams.

5. UNFINISHED BUSINESS

- None

6. NEW BUSINESS

6.1. Revised EMS Form – CEMSIS (*Richard Tadeo*)

Collection of some National EMS Information System (NEMSIS) data elements, such as provider impression and location, will begin in July 2017. The addition of these fields cannot be accomplished on the current 8.5x11 EMS Report Form so possible solutions are to increase the size of the EMS Report Form to 8.5x14 or make the Report Form 2 pages in length. There was concern voiced by the committee on both options, suggestion was made to put the primary impression codes on a separate sheet. A workgroup of all public provider agencies still utilizing paper report forms will be convened to work on a solution.

6.2 STEMI & Stroke Data Dictionary Revisions (*Richard Tadeo*)

The STEMI data dictionary has been finalized, the changes required to the database are in process.

The Stroke data dictionary is in a draft phase, a workgroup of stroke stakeholders will convene in September to finalize the details.

- 7. OPEN DISCUSSION:** Consistent lack of agenda items for the committee was discussed. As EMS data elements are determined by national databases such as NEMSIS and the data elements for the Base and Trauma databases are determined by their respective advisory groups and workgroups, suggestions were requested from the committee on what direction and role the committee should have for future data issues. There was discussion about whether the members of the committee are the appropriate individuals to make decisions regarding data transmission and system data management issues. Committee asked to think of possible solutions to bring back at the October meeting.

- 8. NEXT MEETING:** October 12, 2016 at 10:00 a.m. (EMS Agency Hearing Room – First Floor)

- 9. ADJOURNMENT:** The meeting was adjourned at 10:25 a.m. by Commissioner Hisserich



County of Los Angeles
Department of Health Services

**EMERGENCY MEDICAL SERVICES COMMISSION
EDUCATION ADVISORY COMMITTEE RECORD OF DISCUSSION**

Wednesday, August 18, 2016 (No Quorum Present)



Attendance

Members

- ☒ Frank Binch, Chair
- ☐ Gary Washburn, Vice-Chair
- ☐ Lt Andres Ramirez
- ☐ Bernard Weintraub
- ☒ Alina Candal, RN
- ☐ Tina Crews, RN
- ☐ VACANT, RN
- ☒ Joanne Dolan, RN
- ☐ Susan Hayward, RN
- ★ Sean Stokes, RN
- ☒ Adam Richards, PM
- ★ Jim Karras, EMT
- ☒ Kim Mutaw, PM
- ☐ Mark Ferguson, RN
- ☐ Jacqueline Rifenburg, RN
- ☒ Tina Ziolkowski, RN
- ☐ Kelly Sherwood, RN
- ☐ Heather Davis, PM
- ☐ Stanley Bakey, PM
- ☐ Sean Lyons, PM
- ☐ Aaron Aumann, PM
- ☐ Jeff Warstler, RN
- ☐ Jennifer Webb, RN
- ☐ Charles Drehsen, MD
- ☐ VACANT
- ☒ Ken Leasure, PM
- ☐ James Altman, PM
- ☐ Scott Buck, PM
- ☐ William Gonzales, PM
- ★ Anthony Mendoza, PM
- ☐ VACANT
- ☐ Barry Jensen, PM
- ★ Scott Jaeggi, PM
- ☐ Ryan Carey, EMT

Organization

- EMSC/Public Member 4th District
- EMSC/Public Member 5th District
- EMSC/POA LA Co
- EMSC/SCPHA
- APCC
- APCC
- APCC - alternate
- LAAFCA
- LAAFCA
- LAAFCA - alternate
- LACAA
- LACAA
- LACAA - alternate
- PTI Paramedic Education
- PTI Paramedic Education- alternate
- Mt SAC Paramedic Education
- Mt SAC Paramedic Education - alternate
- UCLA Paramedic Education
- UCLA Paramedic Education - alternate
- UAV Paramedic Education
- UAV Paramedic Education - alternate
- MICN
- MICN - alternate
- Med Council
- Med Council - alternate
- LAAFCA
- LAAFCA - alternate
- LACAA
- LACAA - alternate
- EMS Educator – Non PD
- EMS Educator – Non PD - alternate
- EMT Program Director
- EMT Program Director
- EMT Program Director - alternate

EMS Agency Staff Present

- Erika Reich, RN
- Joan Lockwood, RN
- Susan Mori, RN
- Richard Tadeo, RN
- Lucy Hockey, RN

Position

- Program Approvals
- Certification
- Systemwide QI
- Assistant Director
- Chief, Cert/Program App

Others Present

- Trevor Stonum
- David Mah

Agency/Representing

- MedCoast Ambulance
- Mt SAC

★ - Excused

1. CALL TO ORDER - An informational discussion proceeded due to a lack of a quorum.

2. APPROVAL OF MINUTES - No recommended revisions; approval pending.

3. INTRODUCTIONS AND ANNOUNCEMENTS - None

4. REPORTS & UPDATES

- 4.1 California Prehospital Program Directors (CPPD) (Ziolkowski)
No report
- 4.2 California Council of EMS Educators (C²E²) www.ccoee.net (Reich)
Next meeting is pending
- 4.3 Association of Prehospital Care Coordinators (APCC) (Candal)
No report
- 4.4 California Association of Nurses and EMS Professionals (CALNEP) (Dolan)
Met with Dr. Backer at EMSA to determine a project for the group to work on.
- 4.5 Disaster Training Unit (Eads)
Representative not present; nothing new to report
- 4.6 EMS Quality Improvement Report (Mori)
The LEMSA QI group is providing CQI training for EMS quality improvement managers. Public Safety providers are evaluating the use of waveform capnography in adult cardiac arrest patients with bag-mask-ventilation. Private providers are evaluating transfer of care vital signs and wall time for inter-facility transports.
- 4.7 EMT Program Update (Reich)
EMT regulations have been released for public comment. EMSA will receive comments until September 27th.

4.8 EMS Update (Tadeo)

Medical Director has identified several topics for the next update. The EMS Agency is currently evaluating delivery mechanisms and the frequency of the mandatory training.

5.UNFINISHED BUSINESS - None

6.NEW BUSINESS

6.1 Committee Self Review and Recommendations (Commissioner Binch)

R. Tadeo presented a summary of the Education Advisory meetings for the past two years. F. Binch presented a historical overview the EMS Commission. An anonymous survey was provided to members attending the meeting by Commissioner Binch. F. Binch asked the group if Education Advisory made a difference and if the committee should be rebuilt. K. Leasure believes Education Advisory needs have changed. F. Binch stated the direction of the committee will be determined by the Commission.

7.OPEN DISCUSSION

No Discussion

8.ADJOURNMENT - Next meeting: Wednesday, October 19, 2016 at 10:00 a.m.

ROLE OF THE L. A. COUNTY EMS COMMISSION'S
EDUCATIONAL ADVISORY COMMITTEE
QUESTIONS & ANSWERS

Q 1. What is the assigned mission of the Los Angeles County EMS Commission's Educational Advisory Committee?

A 1.

Q 2. Is that assigned mission clear, complete, relevant and appropriate?

A 2.

Q 3. Is the work of the Educational Advisory Committee fulfilling that assigned mission?

A 3.

Q 4.. Based on the answers to the questions above, what changes (if any) could lead to positive results for EMS patients and staff?

A 4.

**LOS ANGELES COUNTY EMS COMMISSION'S
EDUCATIONAL ADVISORY COMMITTEE
MEMBER SURVEY (ANONYMOUS) August 17, 2016**

	-2 <i>Strongly Disagree</i>	-2 <i>Strongly Disagree</i>	0 <i>No Opinion</i>	+1 <i>Agree</i>	+2 <i>Strongly Agree</i>	<i>Comments (optional)</i>
I am clear about what is the mission of the EMS Commission's Educational Advisory Committee						
I believe that the time I spend as a committee member is a good use of my time						
I think the Committee is effective as a whole in getting its work done						
I believe this work makes a positive difference in the quality of EMS in L.A. County						



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, August 17, 2016

MEMBERSHIP / ATTENDANCE

MEMBERS

- ☒ Dave White, Chair
- ☒ Robert Ower, Vice-Chair
- ☐ LAC Ambulance Association
- ☐ LAC Police Chiefs' Association
- ☐ Jodi Nevandro
 - ☐ Sean Stokes
- ☐ Nick Berkuta
 - ☐ Kevin Klar
 - ☒ Clayton Kazan, MD
 - ☒ Victoria Hernandez
- ☒ Ken Leasure
 - ☐ Susan Hayward
- ☒ Richard Roman
 - ☐ Mike Beeghly
- ☒ Josh Hogan
 - ☒ Joanne Dolan
- ☒ Mike Hansen
 - ☒ Michael Murrey
- ☐ Corey Rose
 - ☐ Miguel Escobedo
- ☒ Adam Richards
 - ☐ VACANT
- ☒ Jenny Van Slyke
 - ☐ Alina Chandal
- ☒ Andrew Respicio
 - ☐ James Michael
- ☒ Maurice Guillen
 - ☐ Scott Buck
- ☐ Marc Eckstein, MD
 - ☐ Stephen Shea, MD
- ☒ Diane Baker
 - ☐ Vacant

ORGANIZATION

- EMSC, Commissioner
- EMSC, Commissioner
- EMSC, Commissioner
- EMSC, Commissioner
- Area A
- Area A Alt (Rep to Med Council, Alt)
- Area B
- Area B, Alt.
- Area B, Alt.
- Area B Alt. (Rep to Med Council)
- Area C
- Area C, Alt
- Area E
- Area E, Alt.
- Area F
- Area F, Alt.
- Area G (Rep to BHAC)
- Area G, Alt. (Rep to BHAC, Alt.)
- Area H (Rep to DAC)
- Area H, Alt.
- Employed EMT-P Coordinator (LACAA)
- Employed EMT-P Coordinator, Alt. (LACAA)
- Prehospital Care Coordinator (BHAC)
- Prehospital Care Coordinator, Alt. (BHAC)
- Public Sector Paramedic (LAAFCFA)
- Public Sector Paramedic, Alt. (LAAFCFA)
- Private Sector EMT-P (LACAA)
- Private Sector EMT-P, Alt. (LACAA)
- Provider Agency Medical Director (Med Council)
- Provider Agency Medical Director, Alt. (Med Council)
- Private Sector Nurse Staffed Ambulance Program (LACAA)
- Private Sector Nurse Staffed Ambulance Program, Alt (LACAA)

EMS AGENCY STAFF PRESENT

- Marianne Gausche-Hill, MD
- Nichole Bosson, MD
- Susan Mori
- John Telmos
- Christine Zaiser
- Gary Watson
- Richard Tadeo
- Christy Preston
- David Wells
- Jerry Crow

OTHER ATTENDEES

- Kim Mutaw
- Roger Braum
- Drew Bernard
- Margie Chidley
- B. Grock
- Trevor Stonum
- Sandra Isnasious
- Angelica McParthin
- Nicole Steeneken
- Mike Barilla
- Gerold Shepphard, MD
- AMR Ambulance
- Culver City FD
- Emergency Amb
- LACoFD
- LACoFD
- MedCoast Amb
- Harbor-UCLA Med Ctr
- Harbor-UCLA Med Ctr
- LACoFD
- Pasadena FD
- Compton FD

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

CALL TO ORDER: Chair, Commissioner Dave White called meeting to order at 1:00 p.m.

1. APPROVAL OF MINUTES: (Hernandez/Leasure) June 15, 2016 minutes were approved as written.

2. INTRODUCTIONS / ANNOUNCEMENTS

2.1 New Committee Memberships

- Adam Richards (American Medical Response Ambulance) replacing Brandon Greene as Employed Paramedic Coordinator.
- Andrew Respicio (Monterey Park Fire Department) replacing Todd Tucker as Public Sector Paramedic.

3. REPORTS & UPDATES

3.1 Revised EMS Form – CEMSIS (*Richard Tadeo*)

- In effort to move towards being CEMSIS (California EMS Information System) and NEMSIS (National EMS Information System) compliant, a work group will be formed to address additional data elements to the paper patient care record (PCR).
- Two data elements being considered include provider impression and location codes.
- Currently, there are four public providers that are still utilizing paper PCRs. These providers will be asked to participate in the work group.
- Implementation date of the new form is July 1, 2017.

3.2 EMS Update 2016 (*Richard Tadeo*)

- The EMS Agency will be forming a work group to develop next year's EMS Update.
- Suggestions and/or comments regarding this year's update or future update topics can be directed to Mark Ferguson or Richard Tadeo.

Restructuring EMERGI-PRESS (*Marianne Gausche-Hill, MD*)

- The EMS Agency is currently rebranding the Emergi-Press. It will be housed in the EMS Agency's webpage beginning in September 2016.
- This not only contain the newsletters but will be expanded to include all medical issues that will be addressed by the EMS Agency. Topics will include "Cases from the Field", "Updates from the Medical Director" and "ECG of the Month".
- Long term goal for the Emergi-Press is to develop an interactive site where continuing education such as the EMS Update can be provided.

3.3 Los Angeles County Fire Department – ePCR Implementation (*Clayton Kazan, MD*)

- LACoFD has completely transitioned to an electronic PCR system, utilizing Physio Control (previously Sansio).
- While issues are being addressed, LACoFD asked for patience during this transition.
- Providers who are interested in learning more about the Physio Control ePCR product, may contact LACoFD.

3.4 Fireline Medic (*Nichole Bosson, MD*)

- EMS Agency is in the process of revising Reference No. 804, Fireline Emergency Medical Technician – Paramedic policy, to clarify the following:
 - Diphenhydramine will still be available for the Fireline EMT-Paramedic for treatment of hives and itching.
 - Epinephrine (1:1000) can be administered for anaphylaxis and will be allowed to repeat doses prior to base contact.
- Reminder – When Fireline EMT-Paramedic(s) are activated with a strike team and respond out of County, please notify the Medical Alert Center (MAC) at (562) 347-1789.

3.5 Innovations in EMS (*Marianne Gausche-Hill, MD*)

- The EMS Agency is developing an ad hoc Committee to discuss possible innovative programs that can be introduced into the Los Angeles County EMS system.
- Previous Los Angeles County programs include the Fast Response Vehicles, Prehospital Nurse Practitioner program, Community Paramedicine program and Rapid Medic Deployment program.
- Those interested in participating in this ad hoc Committee and discussing possible future innovative EMS programs, please contact Richard Tadeo or Gary Watson.

3.6 ALS Unit Staffing (*John Telmos*)

- There has been growing interest from providers to develop an ALS resource, modeled after LAFD's Fast Response Vehicle, in which an ALS unit is manned and placed into service for 8, 10, or 12 hours; instead of the required 24-hour ALS unit.

- The EMS Agency brought the following to the table and was agreed upon by this Committee:
 - A public provider may place into service an ALS unit that functions less than 24 hours per day as long as the base number of 24-hour ALS units are not replaced by the part-time ALS model.
- The base number of 24-hour ALS units are determined by the EMS Agency's ALS unit tracking system that is already in place. This tracking system is maintained in collaboration with providers during the annual program review.

3.7 Pediatric Color Code (*Richard Tadeo*)

- New implementation date is October 3, 2016. Training material will be distributed in September 2016.
- Additional changes since last discussion include Atropine formulation changed from 1mg/mL to 1mg/10mL, Epinephrine relabeling by the manufacturers - 1:10,000 is now 0.1mg/mL and 1:1,000 is now 1mg/mL, and replacing D50 with D10.

4. UNFINISHED BUSINESS

4.1 Reference No. 1304, Medical Control Guideline: Airway Oxygenation / Ventilation (*Richard Tadeo*)

Policy reviewed and approved as presented.

M/S/C (Van Slyke/Hernandez): Approve Reference No. 1304, Medical Control Guideline: Airway Oxygenation / Ventilation.

5. NEW BUSINESS

5.1 Reference No. 1140.1, Mobile Medical System Deployment Summary (*Jerry Crow*)

Policy reviewed and approved as presented.

M/S/C (Hernandez/Baker): Approve Reference No. 1140.1, Mobile Medical System Deployment Summary.

6. OPEN DISCUSSION:

6.1 EMS Update 2016 Reminders (*Marianne Gausche-Hill, MD*)

- Although paramedics are NOT being directed to Comprehensive Stroke Centers at this time, paramedics are encouraged to document and report the Los Angeles Motor Score (LAMS).

6.2 Quality Improvement Training Course (*Susan Mori*)

- In collaboration with the California EMS Authority, there will be a QI Training Program on November 17-18, 2016, at the Los Angeles County EMS Agency.
- Information was distributed to providers via email. Questions can be directed to Susan Mori (sumori@dhs.lacounty.gov).

7. NEXT MEETING: October 19, 2016

8. ADJOURNMENT: Meeting adjourned at 1:55 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **MOBILE MEDICAL SYSTEM DEPLOYMENT
SUMMARY**

(EMT, PARAMEDIC, HOSPITAL)
REFERENCE NO. 1140.1

Purpose

To provide surge capacity when existing hospital resources are overwhelmed or incapacitated.

Description

The Mobile Medical System consists of the following equipment:

1. Tractor/trailer facility; (2) 53 ft. tractor/trailers:
 - a. (1) Treatment trailer: 11 exam beds (4 monitored); 2 monitored procedure room surgical beds. All beds have suction, oxygen, blood pressure cuff and otoscope/ophthalmoscope.
 - b. (1) Support trailer: contains equipment used in treatment trailer (e.g., exam beds, portable digital x-ray, ramps, IV supplies, bandages, splints, PPE, O₂ masks, etc.).
2. Tent facility; (4) 32 ft. trailers each containing (1) 25 person tent facility: heating, AC, lighting, (2) O₂ concentrators: 120 liters/min. each), empty medical supply carts, 30 bed central monitoring station, bedside commode.

Note: Each facility is self-contained and can be deployed independently of each other, either as a stand-alone facility or at an existing treatment site such as a hospital.

Footprint

Equipment	Travel Mode	Operational Mode
Tractor/support trailer	79 ft. long, 102" wide	95 ft. long (ramp open)
Tractor/treatment trailer	79 ft. long, 102" wide	110 ft. long, 20 ft. wide (slide outs and patient ramp)
Tent facility with F350 truck	50 ft. long	
(1) 25-person tent		125 ft. x 75 ft. (with 20 ft. buffer zone for access)
(2) 100-person tent		60,000 sq. ft. (approx. size of a football field) May require stakes into asphalt.
Full set-up (100 person tent with treatment and support trailer)		70,000 sq. ft.

Accessibility

Deployment site requirements:

1. Must be accessible to large commercial vehicles.
2. Overhang or bridge height must be greater than 14 ft. 6 in.
3. Parking surface must be hard asphalt or concrete (no grass or bare earth foundations).
4. Parked vehicles must be removed from area.

Requesting Resources

A resource request must be submitted to the EMS Agency to obtain the MoMS or any portion thereof. Within 3 days of the MoMS site assessment, the requesting facility must sign an MOU with the County regarding

EFFECTIVE: x-x-xx

PAGE 1 OF 3

REVISED:

SUPERSEDES:

APPROVED: _____

Director, EMS Agency

Medical Director, EMS Agency

deliverables, indemnification, and insurance. The EMS Agency provides logistical support only for a MoMS deployment. This includes a team for initial set-up with one specialist provided to monitor mechanical systems 24 hrs. /day during the operational period. The requesting facility is responsible for providing the following:

1. A list of required equipment (specify which components of MoMS are being requested).
2. Medical and ancillary staff. Necessary staff that cannot be provided by the requesting facility may be obtained through a resource request.

Wrap-Around Services

The requesting facility must provide or contract for the following resources and services:

1. Fuel (diesel) – Treatment/support trailers, 300 gallons diesel: burn rate 6 gal./hr.; Tent generators (one per 25-person tent): burn rate 1.5 gal./hr.
2. Water – Treatment trailer 400 gal. fresh water (hand washing); Support trailer 100 gal. fresh water (sink, restroom, shower). Fresh water tanks can be filled using garden hose.
3. Food service for patients and staff.
4. Linen/housekeeping – MoMS provides 1,000 disposable blankets, sheets, pillows for the tent cots. Linen is not provided for the exam beds in the treatment trailer.
5. Waste management – Grey water: Treatment trailer, 200 gal.; Support trailer 40 gal.; Black water: Treatment trailer 200 gal.; Support trailer 60 gal. Sharps and biohazards will be managed by requesting facility.

Response Time from Initial Resource Request

The MoMS is not an immediate response asset (e.g., an ambulance).

Within 6 hours: Upon receipt of a resource request to the DHS DOC, an “Advance Team” will be dispatched to assess the needs of the requesting facility and inspect the deployment location. This team may consist of an administrator, physician, and a class “A” driver. This assessment should take no longer than 2 hours, after which the team may identify issues that need to be addressed or requirements that must be met.

Within 8 hours: The MoMS will be activated and deployed to requested location if determined to meet deployment site requirements (driving time to facility is additional).

Set-Up Time

Treatment and Support trailers: 2 hours with 5 people.

25-person tent: 12 hours with 5-6 people.

MoMS Equipment/Supplies

The MoMS will deploy with a limited amount of supplies and medical equipment. The following are carried with the intent to support an initial start-up for an alternate care site:

1. Monitors: (30) Welch Allyn central monitor station, (3) Philips Heartstart MRX monitor/defibrillators.
2. IV pumps: (6) Hospira Plum A+ pumps with approx. (100) IV cartridges.
3. Pharmaceuticals: (1) Local pharmaceutical cache (see Ref. 1106.1 of the Prehospital Care Policy Manual).
4. Laboratory: (3) i-STAT handheld bedside testing devices.
5. Oxygen: Treatment trailer: (7) H tanks, liquid oxygen capable; Tent facility: (2) O₂ concentrators (120 L/min. each).

6. X-ray: (1) MinXray portable digital x-ray machine with developer.
7. Ultrasound machine.
8. Patient beds: Treatment trailer (11 exam beds, 2 OR beds); tent facility (100) cots, (4) cribs, (1) gurney.
9. Suction: Treatment trailer: (1) at each bedside; Tent facility: (20) Laerdal suction units.
10. Miscellaneous: Bandages, splints, IV start equip. with NS, O₂ masks, suction, gloves, etc.
11. Generators for heat and air conditioning.

Electrical/Power

1. Treatment trailer – Self-contained, 100 kW diesel generator located on each Volvo tractor.
2. Support trailer – Self-contained, 50 kW diesel generator on board.
3. Tent facility – 25 kW portable diesel generator with each 25 person tent.

Cost and Reimbursement

1. Approximate cost of a complete MoMS trailer and tent facility deployment is \$15,000/day.
2. Reimbursement should be sought at the local level and will be pursued through State and Federal programs at the County level after all costs and disaster related expenses have been calculated and documented.

Terms of Use

The requesting facility will operate and maintain the MoMS as if it is part of their existing system. This includes organizational and functional areas such as scheduling workers, ordering supplies/equipment, running tests, and maintaining a clean and hazard free patient care environment.

The EMS Agency and requesting facility will have input with and provide coordination for the demobilization and recovery aspects early in the deployment planning process.

If there are multiple requests for the MoMS unit, the EMS Agency will work through the EOC to prioritize the location of deployment.

Procedure

1. Deployment within Los Angeles County: contact EMS Agency through Medical Alert Center or ReddiNet.
Deployment outside of Los Angeles County: use resource request process specified in CDPH/EMSA EOM.
2. Indicate current facility status and capability.
3. Specify resource needs using an approved Resource Request form.
4. Provide name, call back number, and location for advance team meeting.
5. Any additional requests for resources during the operational period shall be made through the facility's hospital command center (HCC) if within Los Angeles County, and through the MHOAC/RDMHC programs if outside of Los Angeles County.

SUBJECT: SUMMARY OF COMMENTS RECEIVED

Reference No. 1140.1, Mobile Medical System Deployment Summary

SECTION	COMMITTEE/ DATE	COMMENT	RESPONSE
N/A	(BHAC) August 10, 2016	No changes recommended	Approved as written
N/A	(PAAC) August 17, 2016	No changes recommended	Approved as written

MEDICAL CONTROL GUIDELINE : CARDIAC MONITORING / ECG

PRINCIPLES:

1. Continuous cardiac monitoring is a key component of a thorough patient assessment and treatment in the prehospital setting.
2. Continuous observation of a patient's cardiac rhythm ensures early identification of potentially lethal dysrhythmias and provides other information about the patient's condition to guide treatment and destination decisions.
3. Complete and accurate ECG documentation is essential for patient care and quality improvement purposes.
4. The 12-lead electrocardiogram (ECG) in the prehospital care setting plays a key role in determining the most appropriate treatment and destination for patients with suspected cardiac symptoms.
5. Prehospital identification and communication of ST-elevation myocardial infarction (STEMI) can reduce critical "door-to-intervention" times for STEMI patients.
6. When a 12-lead ECG is indicated, it should be obtained early in the assessment so necessary medical treatment is not delayed in order to obtain an ECG on the unstable patient.
7. A good quality 12-lead ECG is a key component of a thorough patient assessment. A good quality 12-lead ECG includes the presence of all 12-leads on the ECG tracing and absence of artifacts and/or wavy baseline.

GUIDELINES:

1. Once cardiac monitoring is determined to be necessary, observe the rhythm continuously and leave the monitor in place until care has been transferred to appropriate hospital personnel or as directed by the base hospital.
2. Document the ECG interpretation on the appropriate section in the EMS Report Form or Electronic Patient Care Report (ePCR). If a dysrhythmia is identified, provide an ECG strip labeled with the patient's name, sequence number, date and time to the receiving facility (in either paper or electronic format) as part of the patient's prehospital medical record. Retain a copy per the provider agency's departmental policy.
3. Perform a prehospital 12-lead ECG on patients with any of the following:
 - a. Chest pain/discomfort/symptoms of suspected cardiac etiology
 - b. Medical history with high risk of acute cardiac event
 - c. New onset dysrhythmia
 - d. Return of spontaneous circulation (ROSC) after a cardiac arrest, if able
4. Treat symptoms and rhythms identified according to applicable treatment protocols.

5. Maintain the patient's privacy and dignity while performing the 12-lead ECG.
6. Contact the SRC if the 12-lead ECG tracing has greater than 1mm ST-segment elevation in 2 or more contiguous leads and/or if computer analysis indicates "Acute MI" (or manufacturer's equivalent). Transmit the ECG tracing to the SRC receiving the patient. Discuss with receiving SRC ED physician.
7. Report to the Base Hospital shall include the software interpretation, paramedic interpretation, any quality issues and if there is an underlying paced rhythm of the 12-lead ECG.

MEDICAL CONTROL GUIDELINE: AIRWAY / OXYGENATION / VENTILATION

DEFINITIONS:

Advanced Airway Maneuvers: Use of a cuffed endotracheal tube or King LTS-D to facilitate ventilation and/or oxygenation in a patient who is unable to protect his/her own airway or maintain spontaneous respiration.

Basic Airway Maneuvers: Manual airway positioning, obstructed airway maneuvers, bag-mask-ventilation (BMV), and/or use of airway adjuncts (nasopharyngeal or oropharyngeal airways) to provide ventilation and/or to facilitate oxygenation in a patient who is unable to maintain adequate spontaneous ventilation.

Hypoxia: Lower than normal oxygen (O₂) concentration in the blood resulting in diminished availability of O₂ to the body tissues.

Hypoventilation: Ventilation that is inadequate to support gas exchange in the lung.

Manageable Airway: Ventilation is effective, such that one of the following holds true:

- Patient is breathing adequately through a patent airway.
- Patient is mechanically ventilated effectively via bag-mask-ventilation (BMV), King LTS-D or endotracheal tube (ET).

Unmanageable Airway: The patient is not able to breathe adequately and EMS personnel are not able to maintain the patient's airway and/or cannot ventilate the patient effectively via BMV, King LTS-D or ET.

Unprotected Airway: The patient is not able to protect his/her airway from the risk of aspiration and is not being ventilated via a cuffed ET in the trachea. Ventilation may be effective with BMV or with insertion of a King LTS-D, but the airway is not fully protected from risk of aspiration.

PRINCIPLES:

1. Signs and symptoms of hypoxia may include O₂ saturation (SpO₂) less than 94% with respiratory distress, altered mental status or changes in skin signs.
2. Providing O₂ to emergency medical services (EMS) patients may be a lifesaving procedure. Both hypoxia and hyperoxia are potentially harmful; therefore, O₂ should be treated like any other drug and administered when indicated.
3. Hypoventilation results in high arterial carbon dioxide (CO₂). In general, this results in an end-tidal CO₂ greater than 45mmHg on capnography, but end-tidal CO₂ may not reflect arterial CO₂ when lung disease and/or increased dead space are present.
4. Basic airway maneuvers should be performed prior to advanced airway maneuvers on patients with hypoventilation.
5. Techniques and procedures utilized for airway management may vary based on operational environment, patient condition and the EMS personnel's level of training and expertise.
6. Unmanageable airway shall be transported to the most accessible receiving facility.

7. Advanced airway tube placement must be verified and continually monitored.
 - a. In Los Angeles County, Endotracheal intubation (ETI) is considered a definitive airway.
 - b. King LTS-D tubes may not protect the patient from aspiration. It is recommended that this be used when prehospital personnel are unable to secure a definitive airway (ETI) or when patient's medical condition or anatomy predicts likely failure of ETI.
8. Pulse oximetry and capnography are essential tools for monitoring the effectiveness of airway management. While pulse oximetry monitors oxygenation, it does not assess adequacy of ventilation. Capnography is necessary to monitor ventilation. Capnography is most accurate with proper two-person BMV technique or advanced airway.

GUIDELINES:

1. If pulse oximetry is not available (BLS Unit) and the patient is in mild or moderate respiratory distress, provide O₂ with nasal cannula at 2-6 liters per minute.
2. When available, use pulse oximetry to guide oxygen therapy. The desired SpO₂ for most non-critical patients is 94 – 98%. Document pulse oximetry reading.
3. Initiate O₂ therapy and titrate as follows:
 - a. Stable patients with mild hypoxia (SpO₂ less than 94%) – start O₂ with nasal cannula at 2-6 liters per minute or basic mask at 8-10 liters per minute
 - b. Patients unable to tolerate nasal cannula or basic mask – use blow-by technique with O₂ flowing at 15 liters per minute:
 - c. Start O₂ using the appropriate O₂ delivery system based on the patient's condition:
 - Non-rebreather mask – 12-15 liters per minute
 - BMV with reservoir – 15 liters per minute
 - Endotracheal tube – 15 liters per minute
 - King LTS-D airway – 15 liters per minute
 - CPAP – Refer to Ref. No. 1312
 - d. Indications for immediate high-flow O₂ include:
 - Respiratory Arrest
 - Cardiac Arrest
 - Shock/Poor Perfusion
 - Anaphylaxis
 - Traumatic Brain Injury
 - Carbon Monoxide Poisoning
 - Suspected Pneumothorax
 - e. Special Considerations:
 - Chronic Obstructive Pulmonary Disease (COPD) – goal SpO₂ is 88 – 92%
 - Newborns in need of positive-pressure ventilation – ventilate for 90 seconds with room air, if heart rate remains less than 100 beats per minute, start O₂ at 15 liters per minute
 - Pediatric Congenital Heart Disease – use O₂ with caution if known history of low baseline O₂ saturation
4. Continue O₂ therapy until transfer of patient care.



5. Monitor and document the SpO₂, O₂ delivery system used, and the liters per minute administered.
6. If suctioning is required, pre-oxygenate prior to suctioning and do not suction longer than 10 seconds per occurrence. For tracheal suctioning, maintain sterile procedures.
7. Considerations for oropharyngeal airway:
 - Unresponsive requiring BMV
8. Considerations for nasopharyngeal airway:
 - Spontaneously breathing patients who require assistance in maintaining a patent airway (e.g., seizure patient, intoxication)
 - Unresponsive patients requiring BMV in whom an oropharyngeal airway cannot be inserted
9. Considerations for BMV:
 - Apnea or agonal respirations
 - Altered level of consciousness with hypoventilation or hypoxia despite maximal supplemental O₂
10. Considerations for endotracheal intubation:
Adults or Pediatrics 12 years or greater, or longer than the length-based resuscitation tape (e.g., Broselow Tape)
 - Ineffective ventilation with BMV
 - Prolonged transport time
 - Unprotected airway
11. Considerations for rescue airway (King LTS-D)
Adults or Pediatrics 12 years or greater, and longer than the length-based resuscitation tape (e.g., Broselow Tape)
 - Unsuccessful attempts (maximum three attempts) at endotracheal intubation (with or without the use of a flexible introducer guide)
 - Suspected difficult airway based on assessment and anatomical features

Height	Size	Air
Between 4 feet to 5 feet	3	40-55mL
Between 5 feet to 6 feet	4	50-70mL
6 feet or greater	6	60-80mL

12. Verify endotracheal tube or rescue airway placement utilizing capnography. In case of device failure, use an End-tidal CO₂ detector or an Esophageal Detector Device (EDD). Document the method used for placement verification.
13. Additional confirmation of endotracheal tube placement shall include **all** of the following:
 - Bilateral lung sounds
 - Bilateral chest rise
 - Absent gastric sounds
 - Pulse oximetry

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

TREATMENT PROTOCOL: PAIN MANAGEMENT *

1. Basic airway
2. Spinal immobilization prn
3. Pulse oximetry
4. Oxygen prn
5. Cardiac monitor prn: document rhythm and attach ECG strip if dysrhythmia identified
6. Control bleeding prn
7. Venous access prn
8. Non-invasive pain management
 - Splint injured extremity and elevate
 - Reposition patient
 - Ice pack
 - Distracting measures
 - Reassurance
9. Assess patient for an infusion device and/or transdermal patches for narcotics; if present, report to base hospital
10. For burn injury, refer to Ref. No. 1271, Burns
11. For isolated extremity injury and other trauma, refer to Ref. No. 1275, General Trauma
12. For chest pain, refer to Ref. No. 1244, Chest Pain
13. For the patient who is at least 20wks pregnant, refer to Ref. No. 1261, Emergency Childbirth (Mother)
14. **CONTINUE SFTP or BASE CONTACT**
15. For other non-traumatic pain, including non-traumatic abdominal pain, consider:
 - Fentanyl ①②③**
 - 50-100mcg slow IV/IO push, titrate to pain relief
 - May repeat every 5min, maximum adult dose 200mcg
 - 50-100mcg IM/IN one time
 -  **Pediatric:** 1mcg/kg slow IV/IO push, titrate to pain relief
 - May repeat every 5 minutes
 - 1mcg/kg IM one time
 - 1.5mcg/kg IN one time
 - See Color Code Drug Doses/L.A. County Kids ④
 - Morphine ①②③**
 - 2-12mg slow IV push, titrate to pain relief
 - May repeat every 5min, maximum total adult dose 20mg
 -  **Pediatric:** 0.1mg/kg slow IV push
 - See Color Code Drug Doses/L.A. County Kids ④
 - Do not repeat dose, maximum pediatric dose 4mg

SPECIAL CONSIDERATIONS

- ① 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
- ② Contraindications: Absolute: respiratory rate less than 12 breaths/min, hypersensitivity or allergy. Relative: use with caution in altered LOC.
- ③ Ondansetron, 4mg IV, IM or ODT may be administered one time prior to fentanyl or morphine administration to reduce potential for nausea/vomiting
- ④ If the child is off the Broselow™ and adult size, move to the Adult protocol and adult dosing

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **FIRELINE EMERGENCY MEDICAL
TECHNICIAN – PARAMEDIC (FEMP)**

(PARAMEDIC)
REFERENCE NO. 804

PURPOSE: To establish procedures for Fireline paramedic response from and to agencies within or outside Los Angeles County EMS Agency jurisdiction when requested through the statewide Fire and Rescue Mutual Aid System, to respond to and provide Advance Life Support (ALS) care on large scale incidents.

AUTHORITY: California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220
California Code of Regulations, Title 22, Division 9, Sections 100166 and 100167
California Fire Service and Rescue Emergency Mutual Aid System, Mutual Aid Plan, (3-2002).

DEFINITIONS:

Fireline Emergency Medical Technician-P (FEMP): A paramedic who meets all pre-requisites established by FIRESCOPE and is authorized by their department to provide ALS treatment on the fireline.

PRINCIPLES:

1. When authorized by the Incident Commander or designee at an incident a paramedic may utilize the scope of practice for which they are trained and accredited according to the policies and procedures established by their accrediting local EMS agency.
2. These guidelines are not intended to replace existing regional EMS policies or circumvent the established response of EMS in the local County.
3. Upon initial request by an agency for FEMP support, the sending provider agency shall notify the EMS Agency by contacting the Medical Alert Center (MAC) at (562) 347-1739 to provide the MAC operator with the following information: First and last name of the paramedic, State paramedic number, local accreditation number, name and location of the incident where they are being sent. Upon assignment completion, the provider agency shall also notify the MAC of the FEMP's return.
4. Upon arrival the FEMP is expected to check in and obtain a briefing from the Logistics Section Chief, or the Medical Unit Leader or Incident Commander.

POLICY:

- I. Under the authority of State regulations, a paramedic may render ALS care during emergency operations as long as the following conditions are met:
 - A. The paramedic is currently licensed by the State of California and is accredited by a County EMS Agency within California.

EFFECTIVE: 12-1-09
REVISED: 09-25-16
SUPERSEDES: 06-30-15

PAGE 1 OF 3

APPROVED: Cathy Chidester Marianne Puzos-Hillman
Director, EMS Agency Medical Director, EMS Agency

- B. The paramedic is currently employed and on duty with an approved ALS provider and possesses the requisite wildland fireline skills and equipment.
 - C. The paramedic does not exceed the scope of practice or medical control policies from their county of origin.
- II. The Los Angeles County FEMP will function within Reference No. 806.1, Procedures Prior to Base Contact, Treatment Protocols. When communication capability is available, the Medical Alert Center (MAC) shall be contacted at (562) 347-1789 for the EMS Agency Medical Director or designee approval for all procedures. In addition to the treatments outlined in Ref. No. 806.1, the FEMP may provide the following treatment(s):
- A. Additional doses of morphine sulfate may be administered to patients with a pain level of seven (7) or greater as follows: if respiratory rate >10 per minute and SBP>100mmHg, 2mg slow intravenous (IV) push. May repeat every 5 minutes to a maximum total dose of 20mg.
 - B. Additional doses of fentanyl may be administered to patients with a pain level of seven (7) or greater as follows: if respiratory rate > 10 per minute and SBP > 100 mmHg, 50-100 mcg titrate to pain relief to a maximum adult dose of 200mcg.
FOR APPROVED PROVIDERS ONLY.
 - C. Additional dose(s) of midazolam may be administered to actively seizing patients: 2-5mg slow IV push until the seizure stops or to a maximum total dose of 10mg.
 - D. Additional doses of epinephrine 0.5mg IM may be administered to patients with anaphylaxis, whose symptoms persist or recur, repeat every 20 minutes to a maximum of 3 doses.
 - E. Diphenhydramine can be administered to those patients with hives and itching due to an allergic reaction and have adequate perfusion. It may be given as 50mg slow IV push or deep IM.
 - F. A two-liter fluid challenge of normal saline may be administered as needed for dehydration or shock (with the exception of cardiogenic shock). May repeat once as needed.
 - G. An additional dose of ondansetron may be administered for nausea and/or vomiting, 4mg IV or IM or ODT (Orally Disintegrating Tablet). The 4mg dose may be repeated one time after 10 minutes if initial dose not effective.
- III. Controlled drugs will be obtained, secured and inventoried as per Reference No. 702, Controlled Drugs Carried on ALS Units.

Note: Controlled drugs shall be inventoried by two paramedics at least daily and anytime there is a change in staff as soon as a second paramedic is available to co-sign.

A. Controlled Drug Resupply through a County Pharmacy:

Provider FEMPs who procure controlled drugs through Los Angeles County pharmacies shall contact the EMS Agency for a letter of authorization. After business hours the provider shall contact the MAC at (562) 347-1700 and ask for the administrator on call.

B Controlled Drug Replacement through a Non-County Supplier:

Providers who procure narcotics through their own Medical Director/Drug Authorizing Physician shall follow the policies and procedures of their agency.

- IV. Documentation of patient care will be completed as per Reference No. 606, Documentation of Prehospital Care. A legible copy of the Patient Care Record (PCR) will be forwarded to the LA County EMS Agency (independent of the normal daily PCRs), Attention: Medical Director and to the incident's jurisdictional EMS Agency.
- V. Upon arrival at the incident the FEMP shall present their credentials (paramedic license and department identification) to the Medical Unit Leader, who will forward the information (deployment date and location) to the local EMS Agency as soon as possible.
- VI. County accredited paramedics shall respond with the ALS/BLS inventory as per Ref. No. 719, Fireline Paramedic ALS Pack Inventory as a minimum standard in their pack while on the fireline. The inventory shall be supplied by the FEMP Provider Agency. (Based on FEMP operation assignments the inventory may be adjusted at the discretion of the Incident Medical Unit Leader).

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 606, **Documentation of Prehospital Care**

Ref. No. 702, **Controlled Drugs Carried on ALS Units**

Ref. No. 806.1, **Procedures Prior to Base Contact - Treatment Protocols**

Ref. No. 719, **Fireline Paramedic ALS Pack Inventory**

Ref. No. 1006, **Paramedic Accreditation**

FIRESCOPE



CITY OF GLENDALE, CALIFORNIA
Glendale Fire Department
OFFICE OF THE FIRE CHIEF

421 Oak Street
Glendale, California 91204-1298
(818) 548-4814 Fax (818) 547-1031
www.ci.glendale.ca.us

August 17, 2016

State EMS Authority,

The Glendale Fire Department has been privileged to have been part of Community Paramedic Pilot and Alternate Destination Pilot this past year. It has been an outstanding partnership with all agencies involved as we work together to find an avenue to enhance patient care and operational efficiency. Our agency, as well as our community, has benefited through the training of three Community Paramedics.

We regret to inform you that the Glendale Fire Department will not be continuing with the Community Paramedic Pilot and Alternate Transport Destination Pilot. We are unable to continue to fund these projects with our current budget. On September 1st, 2016, Gilberto Mejia will be reassigned to the Operations Section.

Again, please accept my sincere appreciation for allowing us to participate in these programs.

Sincerely,

A handwritten signature in black ink, appearing to read "Greg Fish".

Greg Fish
Fire Chief

**ANNUAL REPORT
TO THE
BOARD OF SUPERVISORS**



EMERGENCY MEDICAL SERVICES COMMISSION

JULY 1, 2015 – JUNE 30, 2016

INTRODUCTION

The Emergency Medical Services (EMS) Commission was established by the Board of Supervisors in October 1979 under Ordinance No. 12332 of the County Code, Chapter 3.20. The EMS Commission performs the functions of the Emergency Medical Care Committee as defined in the Health and Safety Code, Section 1797.270, et seq.

The EMS Commission acts in an advisory capacity to the Board of Supervisors and the Director of Health Services regarding County policies, programs, and standards for emergency medical services, including paramedic services throughout Los Angeles County.

The EMS Commission is comprised of 19 members appointed by the Board of Supervisors of which five members are public members representing each of the County Supervisorial Districts. Each of these 19 members serves a four year term at the pleasure of the Board of Supervisors and may not serve more than two consecutive four-year terms as stipulated in the EMS Commission Bylaws. The Board of Supervisors can authorize a commissioner to serve beyond the two-consecutive terms upon request.

The EMS Commission meetings are held on the third Wednesday of each odd month at 1:00 PM in the EMS Commission Hearing Room, 10100 Pioneer Boulevard, 1st Floor, Santa Fe Springs, CA 90670 and are open to the public. The EMS Agency is conveniently located in the same building on the 2nd Floor.

DUTIES

The Commission performs the functions of the Emergency Medical Care Committee as defined in Sections 1750 et seq. of the Health and Safety Code and shall have the following duties:

- Act in an advisory capacity to the Board of Supervisors and the Director of Health Services regarding County policies, programs, and standards for emergency medical care services throughout the County, including paramedic services.
- Establish appropriate criteria for evaluation and conduct continuous evaluations on the basis of these criteria of the impact and quality of emergency medical care services throughout Los Angeles County.
- Conduct studies of particular elements of the emergency medical care system as requested by the Board of Supervisors, the Director of Health Services or on its own initiative; delineate problems and deficiencies and to recommend appropriate solutions.
- Acquire and analyze the information necessary for measuring the impact and the quality of emergency medical care services.
- Report its findings, conclusions and recommendations to the Board of Supervisors at least every twelve months.
- Review and comment on plans and proposals for emergency medical care services prepared by County departments.
- Recommend, when the need arises, that Los Angeles County engage Independent contractors for the performance of specialized, temporary, or occasional services to the Commission which cannot be performed by members of the classified service, and for which the County otherwise has the authority to contract.
- Advise the Director and the Department of Health Services on the Policies, procedures, and standards to control the certification of mobile intensive care nurses and

paramedics. Proposals of any public or private organization to initiate or modify a program of paramedic services or training

EMERGENCY MEDICAL SERVICES COMMISSIONERS



**Clayton Kazan,
M.D.**



**Erick H.
Cheung, M.D.,
Vice Chair**



**Chief Robert E.
Barnes**



**Mr. Frank
Binch**

No
photo

**Lt. Brian S.
Rivler**



**Robert
Flachman**



**John C.
Hisserich, Dr.**



**James Lott,
Psv.D.**

No
photo

**FF/Paramedic
Paul Rodriguez**

No
photo

**Margaret
Peterson Ph.D**



**Nerses Sanossian,
MD FAHA**



**Carole A.
Snyder, RN**

No
photo

**Fire Chief David
White**



**Mr. Colin
Tudor**



**Mr. Gary
Washburn**



**Ms. Cathy
Chidester**



**Ms. Marilyn
Bidlow**

VANCANCIES

Public Member, First Supervisorial
District

Vacancies

Public Member, First Supervisorial District
Southern California Chapter-American College of Surgeons
Southern California Public Health Association

New Appointments

Mr. Robert Ower (12/15/2015)	L. A. County Ambulance Association
Lt. Brian Scott Bixler (2/23/2016)	Peace Officers Association of LA
County	
Chief David White (1/19/2016)	L.A. Area Fire Chiefs' Association
FF/Paramedic Paul S. Rodriguez (4/5/2016)	CA State Firefighters' Association

Re-Appointments

Mr. Frank Binch
Erick H. Cheung, M.D.
John Hisserich, Dr. PH.
James Lott, PsyD., MBA
Margaret Peterson, PH.D.
Nerses Sanossian, M.D.
Carole Snyder, RN

Resignations

Mr. David Austin (11/19/2015)	L. A. County Ambulance Association
Lt. Andres Ramirez (11/19/2015)	Peace Officers Association of LA
County	
Chief Jon Thompson (11/19/2015)	L.A. Area Fire Chiefs' Association
Chief Raymond Mosack (1/20/2016)	CA State Firefighters' Association
Mr. Bernard Weintraub (4/1/2016)	So CA Public Health Association

Elected Officers

Clayton Kazan, M.D., Chair	1/21/2015 – Present
Erick Cheung, M.D., Vice Chair	1/21/2015 – Present

Areas of Discussion

- Community Paramedicine Pilot Project in the County (ongoing)
- 1+1 Paramedic Staffing Model
- Physician Services for Indigent Program – Proposed increase of the reimbursement rate for Fiscal Year 2015-2016
- Transport of 5150 Patients: The EMSC recommended that an ad hoc committee be identified to develop a blueprint for addressing behavioral emergencies in the prehospital setting. Meeting have been ongoing throughout the year. (ongoing)
- Active legislation of interest to EMS

Accomplishments

- The Los Angeles Surgical Society which is represented on the EMS Commission ceased to exist. The EMS Agency drafted an ordinance change to the Board of Supervisors to fill the vacancy with a practicing trauma surgeon affiliated with the Southern California

Chapter of the American College of Surgeons (ACS). The Ordinance change was adopted by the Board of Supervisors on February 11, 2016.

- A mandatory public hearing was held in conjunction with the September 16, 2015 regular meeting of the EMS Commission to discuss a proposed Physician Services for Indigent Program (PSIP) increase of the reimbursement rate for Fiscal Year 2015-2016
- Approved the 2014-2015 Annual Report of the EMS Commission at the September 16, 2015 meeting
- Recognized key players in the Community Paramedicine pilot project at the November 18, 2015 meeting; also upon his departure from the EMS Commission, Commissioner David Austin, representing the Los Angeles County Ambulance Association was honored for his many years of service to the EMS Commission and the EMS community
- The Commission approved development of an Ad Hoc Committee on November 18, 2015, to address the Prehospital Care of Mental Health and Substance Use. The Ad Hoc Committee has been meeting and working on a report that will provide a *blue print* for management of behavioral emergencies in a prehospital setting.

Recommendations

- The Commission recommended that the EMS Agency work with the Chairman and Vice Chairman of the EMS Commission to identify proper stakeholders to serve on an ad hoc committee to develop recommendations for management of behavioral emergencies in the prehospital setting.

Policies Approved by the Commission

The Commission approved 35 Prehospital Care Policies between July 1, 2015 and May 31, 2016.

Advisory Committees to the EMS Commission

Base Hospital Advisory Committee

MISSION:

The Base Hospital Advisory Committee is responsible for all matters regarding MICN certification and policy development pertinent to the practice, operation and administration of prehospital care.

2015 Commissioners

Carole Snyder- Chair
James Lott- Vice Chair

2016 Commissioners

Carole Snyder- Chair
Margaret Peterson, Ph.D. - Vice Chair

Meetings

August 10, 2015 - Meeting Canceled
October 12, 2015
December 14, 2015
February 10, 2016
April 13, 2016
June 8, 2016

SUMMARY OF COMMITTEE ACTIVITIES

Prehospital Care Policies/Treatment Protocols/Medical Control Guidelines Activity

During this fiscal year, the Base Hospital Advisory Committee (BHAC) reviewed and took action on 34 prehospital care policies. Thirty-three policies were approved and one policy was deleted.

EMS Update 2016

EMS Update 2016 was an instructor-based module.

The final topics compiled by the EMS Update 2016 Work Group included:

- Provider Impression
- Anaphylaxis
- Comprehensive Stroke Centers
- Documentation
- Pediatric Resuscitation
- Ventricular Assist Device
- Hypertension in Pregnancy
- Emerging Infectious Diseases
- Surge Plans
- Hemostatic Agents
- Needle Thoracostomy
- 911 Re-Triage

Stroke Program Update

Revised stroke standards were developed, to include specific standards for Comprehensive Stroke Centers. As of June 30, 2016 there were 43 Primary Stroke Centers approved for transportation of 9-1-1 patients with stroke symptoms, three of which are located outside of Los Angeles County.

Data Advisory Committee

MISSION:

The Data Advisory Committee is responsible for all matters regarding quality of prehospital data, report generation, prehospital research and policy development impacting TEMIS.

2015 Commissioners

Robert Flashman –Chair
Ray Mosack – Vice Chair

2016 Commissioners

Nerses Sanossian – Chair
John Hisserich – Vice Chair

Membership Changes

- New Medical Council representative Dipesh Patel, MD effective July 2015
- New Provider Agency Advisory Committee representative Corey Rose, effective December 2015
- New Hospital Association of Southern California (HASC) representative Ryan Burgess, effective June 2015 and new HASC alternate Nathan McNeil, effective June 2015
- Base Hospital Advisory Committee representative Mark Baltau resigned position, replaced by Gloria Guerra, effective June 2016

Meetings

August 12, 2015
October 14, 2015
December 9, 2015
February 10, 2016
April 13, 2016
June 8, 2016 – Cancelled due to lack of agenda items

SUMMARY OF COMMITTEE ACTIVITIES

Prehospital Care Policies Activity

Reference No. 622-622.5 *Data Requests* and *Data Use Agreement* reviewed

Data submission verification and cleanup

Developed data reports that will be sent to the public providers on a quarterly basis to assist with data verification and cleanup

Education Advisory Committee

MISSION:

The Education Advisory committee is responsible for all matters regarding issues and policies pertinent to EMS curriculum and program development, implementation and evaluation.

2015 Commissioners

Andres Ramirez - Chair
Frank Binch - Vice-Chair
Gary Washburn – Commissioner
Bernard Weintraub -Commissioner

2016 Commissioners

Frank Binch - Chair
Gary Washburn – Vice Chair
Bernard Weintraub -Commissioner

Meetings:

August 19, 2015 – meeting canceled due to lack of agenda items
October 21, 2015
December 16, 2015 – meeting canceled due to lack of agenda items
February 17, 2017 - meeting canceled due to lack of agenda items
April 20, 2016 - meeting canceled due to lack of agenda items
June 15, 2016 – no quorum

SUMMARY OF COMMITTEE ACTIVITIES

Nothing to report. The Education Advisory committee is responsible for issues and policies pertinent to EMS curriculum implementation and evaluation. This advisory committee is scheduled to meet every other month on the even months. In Fiscal Year 2015-2016, the committee met once. Four meetings were canceled due to a lack of agenda items. The June 2016 meeting was scheduled but failed to obtain a quorum. The committee received updates on EMS Update, system-wide QI studies and the California EMS System Core Measures report.

Provider Agency Advisory Committee

MISSION:

The Provider Agency Advisory Committee is responsible for all matters regarding prehospital licensure, certification/accreditation, and policy development (and revision) pertinent to the practice, operation and administration of prehospital care.

2015 Commissioners

Dave Austin - Chair
Robert Barnes - Vice Chair
Jon Thompson - Commissioner
Clayton Kazan, MD - Commissioner

2016 Commissioners

Dave Austin - Chair
Robert Ower – Vice Chair

During the fiscal year, this Committee included six different Commissioners; representatives from each major fire department and the seven public geographic regions. Membership also included one currently employed paramedic coordinator, one prehospital care coordinator; one public sector paramedic; one private sector paramedic; one provider agency Medical Director and one critical care transport nurse coordinator.

Meetings

August 19, 2015
October 21, 2015
December 16, 2015
February 17, 2016
April 20, 2016
June 15, 2016

SUMMARY OF COMMITTEE ACTIVITIES

Prehospital Care Policies/Treatment Protocols/Medical Control Guidelines Activity

During this fiscal year, the Provider Agency Advisory Committee reviewed and took action on 42 prehospital care policies. Forty policies were approved, one policy was deleted and currently, one policy is tabled.

Topics of discussion included issues related to the Middle Eastern Respiratory Syndrome (MERS); Community Paramedicine programs; and the implementation of Comprehensive Stroke Centers within Los Angeles County. This Committee also said good bye to the EMS Agency's Medical Director, William Koenig, MD and welcomed the new Medical Director, Marianne Gausche-Hill, MD.