EMERGENCY MEDICAL SERVICES AUTHORITY
11120 INTERNATIONAL DR., SUITE 200
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

October 4, 2024

Richard Tadeo, EMS Director
Los Angeles County Emergency Medical Services Agency
10100 Pioneer Blvd., Suite 200
Santa Fe Springs, CA 90670

Dear Richard Tadeo,

This letter is in response to Los Angeles County Emergency Medical Service (EMS) Agency's 2018 - 2023 EMS, Triage to Alternate Destination (TAD), Trauma, St-Elevation Myocardial Infarction (STEMI), Stroke, Quality Improvement (QI), and EMS for Children (EMSC) plan submissions to Emergency Medical Service Authority (EMSA).

EMSA has reviewed the EMS plan based on compliance with statutes, regulations, and case law. It has been determined that the plan meets EMS system components identified in Health and Safety Code (HSC) § 1797.103 and is approved for implementation pursuant to HSC § 1797.105(b). Based on the transportation documentation provided, please find the enclosed EMS area/subarea status, compiled by EMSA.

California Health and Safety Code 1797.227 requires emergency medical care providers to use Electronic Health Records (EHR) and submit to the local EMS agency (LEMSA) in accordance with LEMSA policies and procedures. Additionally, and California Code of Regulations Title 22, Division 9, Chapter 4, Article 8, Section 100171 requires providers of advanced life support to submit the EHR data to the EMSA within 72 hours of the patient encounter. The following interfacility providers do not have such an EHR system:

- All Town Ambulance, LLC
- Ambulnz Health, LLC
- AmbuServe, Inc.
- American Professional Ambulance, Corp.
- Amwest Ambulance
- Antelope Ambulance Service, Inc.
- California Medical Response, Inc.
- Cal-Med Ambulance
- Firstmed Ambulance Services, Inc.
- Guardian Ambulance Service
- Liberty Ambulance, LLC
- Eastwestproto, Inc. dba: Lifeline Ambulance
- Mauran Ambulance Service
- Rescue Services International, Ltd. Dba: Medic-1 Ambulance
- PRN Ambulance, Inc.
- Royalty Ambulance Services, Inc.
- Symons Emergency Specialties, Inc. dba:

R. Tadeo
2018 – 2023 EMS Plan

Please submit a plan to the EMSA by January 3, 2025, outlining a process for the identified providers to become compliant with statue and regulations related to EHRs. The providers listed shall be compliant with statute and regulation by January 1, 2027. The submitted plan needs to include a timeline for compliance. Failure to adhere to the submitted timeline or to achieve compliance for the interfacility providers by the date indicated may result in adverse action to future EMS plan submissions.

EMSA has also reviewed the TAD, Trauma, STEMI, Stroke, QI plans, and EMSC based on compliance with Chapters 5, 7, 7.1, 7.2, 12, and 14 of the California Code of Regulations, Title 22, Division 9, and has been approved for implementation.

Per HSC § 1797.254, local EMS agencies must annually submit EMS plans to EMSA. Los Angeles County EMS Agency will only be considered current if an EMS plan is submitted each year.

Your 2024 EMS plan will be due on or before October 2, 2025. Concurrently with the EMS plan, please submit an annual TAD, Trauma, STEMI, Stroke, QI, and EMSC plan.

If you have any questions regarding the EMS plan review, please contact Roxanna Delao, EMS Plans Coordinator, at (916) 903-3260 or roxanna.delao@emsa.ca.gov.

Sincerely,

Tom McGinnis

Tom McGinnis, MHA, EMT-P
Chief, EMS Quality and Planning Division

Enclosure:
AW: rd

EMERGENCY MEDICAL SERVICES AUTHORITY
11120 INTERNATIONAL DR., SUITE 200
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

Los Angeles County EMS Agency 2018-2023 EMS Areas and Subareas	Non-Exclusive	Exclusive	Method to Achieve Exclusivity	Emergency Ambulance	ALS	LALS	All Emergency Ambulance Services	9-1-1 Emergency Response	7-digit Emergency Response	ALS Ambulance	All CCT/ALS Ambulance Services	Critical Care Transport	Standby Service with Transport Authorization
Area/Subarea Name	**EXCLUSIVITY**			**TYPE**			**LEVEL**						
Los Angeles County													
EOA 1		X	Competitive	X				X					
EOA 2		X	Competitive	X				X					
EOA 3		X	Competitive	X				X					
EOA 4		X	Competitive	X				X					
EOA 5		X	Competitive	X				X					
EOA 6		X	Competitive	X				X					
EOA 7		X	Competitive	X				X					
EOA 8		X	Competitive	X				X					
EOA 9		X	Competitive	X				X					
City of Alhambra		X	Non-Competitive	X				X					
City of Arcadia		X	Non-Competitive	X				X					
City of Avalon		X	Non-Competitive	X				X					
City of Beverly Hills		X	Non-Competitive	X				X					
City of Burbank		X	Non-Competitive	X				X					
City of Culver City		X	Non-Competitive	X				X					
City of Downey		X	Non-Competitive	X				X					

City of El Segundo		X	Non-Competitive	X				X					
City of Glendale		X	Non-Competitive	X				X					
City of Hermosa Beach		X	Non-Competitive	X				X					
City of La Verne		X	Non-Competitive	X				X					
City of Long Beach		X	Non-Competitive	X				X					
City of Los Angeles		X	Non-Competitive	X				X					
City of Manhattan Beach		X	Non-Competitive	X				X					
City of Monterey Park		X	Non-Competitive	X				X					
City of Pasadena		X	Non-Competitive	X				X					
City of San Fernando		X	Non-Competitive	X				X					
City of San Gabriel		X	Non-Competitive	X				X					
City of San Marino		X	Non-Competitive	X				X					
City of Santa Monica		X	Non-Competitive	X				X					
City of Sierra Madre		X	Non-Competitive	X				X					
City of South Pasadena		X	Non-Competitive	X				X					
City of Torrance		X	Non-Competitive	X				X					
City of West Covina		X	Non-Competitive	X				X					
City of Vernon	X	Exp. 2020											

ANNUAL
EMERGENCY MEDICAL SERVICE PLAN
2022-2023

County of Los Angeles
Department of Health Services

Emergency Medical Services Agency
10100 Pioneer Blvd., Suite 200
Santa Fe Springs, California 90670

EMS PLAN FY 22-23 (July 1, 2022 – June 30, 2023) Participating Members:

Executive Summary

Communications:	Adam Martinez/Lipin Tan
EMS System Data Reports:	Sara Rasnake
SideWalk CPR:	Natalie Greco/David Wells
EOA for 911 Transportation:	Christopher Rossetti
LA County Disaster Health Care Coalition:	Terry Cramer/Kellyn Pak
Annual EMS Update:	Mark Ferguson
Facility/Alternate Destination Changes:	Ami Boonjaluksa
Provider Changes:	Christopher Rossetti
Table 1 – Minimum Standards:	Chris Clare

Changes Made to Standards

2.04 Dispatch Training:	Greg Klein
3.01 Communications Plan:	Adam Martinez/Lipin Tan
EMS Annual Data Report	Chris Clare

Table 2 – System Organization:	Adrian Romero
Table 3 – Staffing/Training:	Jennifer Calderon
Table 4 – Communications:	Greg Klein
Table 5 – Response/Transportation:	Gary Watson

Verdugo Dispatch – Gor Galstyan GGalstyan@glendaleca.gov
LAFD – David Hahn David.hahn@lacity.org
Long Beach FD – Andrew Reno Andrew.reno@longbeach.gov
LACoFD – Yun Son Kim yunson.kim@fire.lacounty.gov

Table 6 – System Resources and Operations (Facility/Critical Care):	Lorrie Perez
Table 7 – System Resources and Operations (Disaster Medical):	Terry Cramer/Kellyn Pak
Table 8 – Resource Directory (Response/Transportation/Providers):	Gary Watson – Public Providers
	Christopher Rossetti – Pvt Providers
Table 9 – Resource Directory (Facilities):	Ami Boonjaluksa
Table 10 – Resource Directory (Approved Training Programs):	Jennifer Calderon
Table 11 – Resource Directory (Public Dispatch Agencies):	Greg Klein
Table 12 – Ambulance Zone Summary, EOA Map:	Christopher Rossetti
Table 13 – LA County EMS Agency/QI Plan 2021-2022:	Gerard Waworundeng
Table 14 – Specialty Care System Program:	Ami Boonjaluksa

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

Hilda L. Solis
First District

Holly J. Mitchell
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Richard Tadeo
Director

Nichole Bosson, MD
Medical Director

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

Tel: (562) 378-1500
Fax: (562) 941-5835

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

May 6, 2024

Elizabeth Basnett
Director
Emergency Medical Services Authority
11120 International Drive, Suite 200
Rancho Cordova, California 95670

LOS ANGELES COUNTY EMS PLAN 2022-2023 SUBMISSION

Dear Ms. Basnett:

In accordance with Section 1797.254 of the Health and Safety Code, I am pleased to forward the Los Angeles County Fiscal Year 2022-2023 Annual EMS Plan to the Emergency Medical Services Authority.

If you have any questions regarding the plan, please contact me, at (562) 378-1610 or Lily Choi, Hospital Programs Manager, SRC, Pediatric and SART, at (562) 378-1652.

Sincerely,

Richard Tadeo
Director

RT:lc

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

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES

ANNUAL EMS PLAN UPDATE

(Fiscal Year 2022-2023)

EXECUTIVE SUMMARY

Health and Safety Code, Division 2.5, Section 1797.254, requires the Emergency Medical Services (EMS) Agency to submit an EMS Plan to the State EMS Authority and follow it with annual updates thereafter. Attached is the Los Angeles County Fiscal Year (FY) 2022-2023 Annual Update which provides the required information on the status of our system and the EMS Agency's progress toward meeting long-range goals.

Communications:

The EMS Agency continues to be an active participant and voting member of the governing body of the Los Angeles Regional Interoperable Communications System (LA-RICS) Board of Directors. LA-RICS' mission is to provide the finest mission-critical communication system with unwavering focus on the needs of the public safety professional. It is being designed and built to serve law enforcement and fire service first responders, along with health service professionals throughout Los Angeles County.

With over 80 public safety agencies with approximately 34,000 first responders and encompassing a sprawling terrain of over 4,060 square miles that approximately 10 million people call home, the Los Angeles region seeks a modern interoperable public safety broadband network that allows multiple agencies to respond to the widest possible variety of emergencies. LA-RICS has transferred operation and ownership of its 700MHz broadband network to ATT/First-Net, which is based on 4G/5G wireless data technology. The network would enable computer-aided dispatch, rapid law-enforcement queries, real-time video streaming, medical telemetry, patient tracking, geographic information systems services for first responders, and many other broadband-specific applications.

LA-RICS is partnered with AT&T/First-Net, a nationwide first responder network authority to ensure coordination with the broadband network on a national level for public safety and first responders.

EMS System Data Report:

Efforts to incorporate the STEMI and Stroke databases into a combined database with the three (3) core EMS Agency databases (EMS, Base Hospital, and Trauma Center) continue. To further enhance reporting and access capability, the EMS Agency continues to explore opportunities to improve TEMIS, such as a web-based solution.

Of the ~800,000 EMS responses in the County, 100% of patient care records from public EMS providers are collected through an electronic patient care report (ePCR) and all ePCR vendors are NEMSIS 3.5 compliant.

Los Angeles County Fire District – (36% of system data) and City of Los Angeles Fire Department – (41% of system data) utilize ImageTrend.
Cities of Torrance and Redondo Beach Fire Department's (2% of system data) – utilize W.A.T.E.R.
Remaining 25 Fire Departments (21% of system data) utilize Digital EMS.

During FY 2022-2023, the EMS Agency submitted 100% records for the 15 designated trauma centers to CEMSIS-Trauma.

On October 1, 2023, LA County began submitting NEMSIS 3.5 compliant EMS records to CEMSIS for all 9-1-1 providers.

Sidewalk CPR:

The EMS Agency Sidewalk CPR annual program is held during National CPR and AED Awareness Week. The theme this year was "Take a Minute to Save a Life." On June 5, 2023, in collaboration with the American Heart Association, the Los Angeles County Fire Department, and community partners, over 3,300 citizens received training on "hands-only" cardiopulmonary resuscitation (CPR). Participation in this system-wide community effort included fire departments, hospitals, and ambulance companies within the County providing valuable public education in this life-saving technique to improve bystander CPR response for victims of sudden cardiac arrest.

The EMS Agency and its partners continued to raise awareness about the importance of knowing "hands-only" CPR by maintaining an instructional hands-only CPR video https://youtu.be/jHaicno95sk. This training video is posted on our website and shared with community partners to allow for a broader distribution.

Exclusive Operating Areas (EOA) for 9-1-1 Transportation:

There were no changes to the following nine (9) Los Angeles County EOA providers that provide 9-1-1 transportation services:

- **EOA 1**: Santa Clarita Valley, Antelope Valley (3 cities, 46 unincorporated areas)
  American Medical Response, Inc. (AR) as Agreement #H-707043

- **EOA 2**: City of Monrovia
  Falck Mobile Healthcare, dba Care Ambulance Service (CA) as Agreement #H-707291

- **EOA 3**: East County, Pomona Valley (11 incorporated cities, 10 unincorporated areas)
  Falck Mobile Healthcare, dba Care Ambulance Service (CA) as Agreement #H-707284

- **EOA 4**: San Gabriel Valley (10 incorporated cities, 10 unincorporated areas)
  Falck Mobile Healthcare, dba Care Ambulance Service (CA) as Agreement #H-707284

- **EOA 5**: Southeast County, Gateway Cities (19 cities, 12 unincorporated areas)
  Falck Mobile Healthcare, dba Care Ambulance Service (CA) as Agreement #H-707284

- **EOA 6**: City of Compton
  Westmed/McCormick Ambulance (WM) as Agreement #H-707042

- **EOA 7**: South Bay Cities (9 incorporated cities, 12 unincorporated areas)
  Westmed/McCormick Ambulance (WM) as Agreement #H-707042

- **EOA 8**: City of Redondo Beach
  Westmed/McCormick Ambulance (WM) as Agreement #H-707042

- **EOA 9:** West County (10 incorporated cities, 31 unincorporated areas)
  Westmed/McCormick Ambulance (WM) as Agreement #H-707042

Los Angeles County Disaster Health Care Coalition (HCC):

The HCC was established in October 2013 to coordinate strategic planning activities amongst healthcare facilities in various healthcare delivery sectors, public health agencies, other government entities and community partners to prepare for, respond to, and recover from emergencies and other incidents that impact the public's health.

Los Angeles County's HCC has an advisory committee with representatives from acute care hospitals, community health centers, long-term care facilities, dialysis centers, ambulatory surgery centers, home health/hospice agencies, EMS providers, volunteer organizations, and government agencies that support Emergency Support Function 8 (ESF 8) functions. The advisory committee is co-chaired by the Los Angeles County Emergency Medical Services Agency and Department of Public Health and meets three times per year to facilitate:

- Strategic planning
- Identification of gaps and mitigation strategies
- Operational planning and response
- Information sharing for improved situational awareness
- Resource coordination and management

In FY 2022-2023, Los Angeles County's overall HCC membership was comprised of:

Acute Care Hospitals	95
Behavioral Health	4
Dialysis Centers	232
Emergency Management Organizations	2
EMS Providers	50
Federal Facilities	5
Home Health Agencies	346
Medical Reserve Corps (ESAR-VHP)	3

Non-Governmental Organizations	2
Infrastructure Companies	2
Outpatient Health Care Centers (Ambulatory Care, Clinics, FQHC, Urgent Care)	589
Professional Healthcare Trade Organizations	4
Public Health Departments	3
Skilled Nursing Facilities	480

Annual EMS Update:

The EMS Agency provided the annual EMS Update Training for 2023 through a learning management system. Training included the following:

- Introduction and History of LA County EMS
- TXA and Blood Products
- Professional Expectations and Accountability
- Just Culture
- Policy Updates
- Patient Handoffs
- Death Notification
- Burnout

We also continued to provide our monthly education to all pre-hospital personnel through our EmergiPress educational newsletter.

Facility / Provider Changes:

Facility Changes:

On December 8, 2022, the following facility withdrew from the Stroke Center Program as a Comprehensive Stroke Center and has been updated in Table 9, Resource Directory – Facilities:

PIH Good Samaritan Hospital (GSH)
1225 Wilshire Blvd.
Los Angeles, California 90017

On March 20, 2023, the following facility was upgraded from a Primary Stroke Center to a Thrombectomy Capable Stroke Center (CSC II) and has been updated in Table 9, Resource Directory – Facilities:

Dignity Health – Glendale Memorial Hospital and Health Center
1420 S. Central Avenue
Glendale, California 91204

On March 20, 2023, the following facility withdrew as an Emergency Department Approved for Pediatrics and has been updated in Table 9, Resource Director – Facilities:

Beverly Hospital
309 W. Beverly Boulevard
Montebello, California 90640

On April 5, 2023, the following facility was removed from the Stroke Center Program as a Primary Stroke Center and has been updated in Table 9, Resource Directory – Facilities:

Coast Plaza Hospital (CPM)
13100 Studebaker Road
Norwalk, California 90650p

Alternate Destination Changes:

No changes

Provider Changes:

On January 25, 2023, The EMS Agency executed a Jurisdictional Advanced Life Support and EMS Provider Agreement with Sierra Madre Fire Department (see attached) and is reflected within Table 8, Resource Directory-Response/Transportation/Providers.

The following changes were made to the Licensed Ambulance Operators within Los Angeles County during FY 2022-2023:

Addition: (1)

MedResponse, Inc. (MI) based in the City of South El Monte was licensed as a new private Basic Life Support ambulance provider on June 12, 2023. MI obtained new ownership.

Deletions (3):

- Ambulnz Health, Inc. (AZ) based in the City of Torrance, discontinued all ambulance services on March 21, 2023.
- Go Green Ambulance Corporation (GG) based in the City of Los Angeles (Wilmington) discontinued all ambulance services on April 13, 2023.

TABLE 1: MINIMUM STANDARDS

A. SYSTEM ORGANIZATION AND MANAGEMENT

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Agency Administration:					
1.01 LEMSA Structure		X			
1.02 LEMSA Mission		X			
1.03 Public Input		X			
1.04 Medical Director		X			
Planning Activities:					
1.05 System Plan		X			
1.06 Annual Plan Update		X			
1.07 Trauma Planning*		X			
1.08 ALS Planning*		X			
1.09 Inventory of Resources		X			
1.10 Special Populations		X			
1.11 System Participants		X			
Regulatory Activities:					
1.12 Review & Monitoring		X			
1.13 Coordination		X			
1.14 Policy & Procedures Manual		X			
1.15 Compliance w/Policies		X			
System Finances:					
1.16 Funding Mechanism		X			
Medical Direction:					
1.17 Medical Direction*		X			
1.18 QA/QI		X			
1.19 Policies, Procedures, Protocols		X			

TABLE 1: MINIMUM STANDARDS

A. SYSTEM ORGANIZATION AND MANAGEMENT (continued)

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
1.20 DNR Policy		X			
1.21 Determination of Death		X			
1.22 Reporting of Abuse		X			
1.23 Interfacility Transfer		X			
Enhanced Level: Advanced Life Support					
1.24 ALS Systems		X			
1.25 On-Line Medical Direction		X			
Enhanced Level: Trauma Care System:					
1.26 Trauma System Plan		X			
Enhanced Level: Pediatric Emergency Medical and Critical Care System:					
1.27 Pediatric System Plan		X			
Enhanced Level: Exclusive Operating Areas:					
1.28 EOA Plan		X			

B. STAFFING/TRAINING

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Local EMS Agency:					
2.01 Assessment of Needs		X			
2.02 Approval of Training		X			
2.03 Personnel		X			
Dispatchers:					
2.04 Dispatch Training		X			
First Responders (non-transporting):					
2.05 First Responder Training		X			
2.06 Response		X			
2.07 Medical Control		X			

TABLE 1: MINIMUM STANDARDS

Transporting Personnel:						
2.08	EMT-I Training		X			
Hospital:						
2.09	CPR Training		X			
2.10	Advanced Life Support		X			
Enhanced Level: Advanced Life Support:						
2.11	Accreditation Process		X			
2.12	Early Defibrillation		X			
2.13	Base Hospital Personnel		X			

C. COMMUNICATIONS

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Communications Equipment:						
3.01	Communication Plan*		X			
3.02	Radios		X			
3.03	Interfacility Transfer*		X			
3.04	Dispatch Center		X			
3.05	Hospitals		X			
3.06	MCI/Disasters		X			
Public Access:						
3.07	9-1-1 Planning/ Coordination		X			
3.08	9-1-1 Public Education		X			
Resource Management:						
3.09	Dispatch Triage		X			
3.10	Integrated Dispatch		X			

TABLE 1: MINIMUM STANDARDS

D. RESPONSE/TRANSPORTATION

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Universal Level:					
4.01 Service Area Boundaries*		X			
4.02 Monitoring		X			
4.03 Classifying Medical Requests		X			
4.04 Prescheduled Responses		X			
4.05 Response Time*		X			
4.06 Staffing		X			
4.07 First Responder Agencies		X			
4.08 Medical & Rescue Aircraft*		X			
4.09 Air Dispatch Center		X			
4.10 Aircraft Availability*		X			
4.11 Specialty Vehicles*		X			
4.12 Disaster Response		X			
4.13 Intercounty Response*		X			
4.14 Incident Command System		X			
4.15 MCI Plans		X			
Enhanced Level: Advanced Life Support:					
4.16 ALS Staffing		X			
4.17 ALS Equipment		X			
Enhanced Level: Ambulance Regulation:					
4.18 Compliance		X			
Enhanced Level: Exclusive Operating Permits:					
4.19 Transportation Plan		X			
4.20 “Grandfathering”		X			
4.21 Compliance		X			
4.22 Evaluation		X			

TABLE 1: MINIMUM STANDARDS

E. FACILITIES/CRITICAL CARE

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Universal Level:					
5.01 Assessment of Capabilities		X			
5.02 Triage & Transfer Protocols*		X			
5.03 Transfer Guidelines*		X			
5.04 Specialty Care Facilities*		X			
5.05 Mass Casualty Management		X			
5.06 Hospital Evacuation*		X			
Enhanced Level: Advanced Life Support:					
5.07 Base Hospital Designation*		X			
Enhanced Level: Trauma Care System:					
5.08 Trauma System Design		X			
5.09 Public Input		X			
Enhanced Level: Pediatric Emergency Medical and Critical Care System:					
5.10 Pediatric System Design		X			
5.11 Emergency Departments		X			
5.12 Public Input		X			
Enhanced Level: Other Specialty Care Systems:					
5.13 Specialty System Design		X			
5.14 Public Input		X			

TABLE 1: MINIMUM STANDARDS

F. DATA COLLECTION/SYSTEM EVALUATION

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Universal Level:					
6.01 QA/QI Program		X			
6.02 Prehospital Records		X			
6.03 Prehospital Care Audits		X			
6.04 Medical Dispatch		X			
6.05 Data Management System*		X			
6.06 System Design Evaluation		X			
6.07 Provider Participation		X			
6.08 Reporting		X			
Enhanced Level: Advanced Life Support:					
6.09 ALS Audit		X			
Enhanced Level: Trauma Care System:					
6.10 Trauma System Evaluation		X			
6.11 Trauma Center Data		X			

G. PUBLIC INFORMATION AND EDUCATION

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Universal Level:					
7.01 Public Information Materials		X			
7.02 Injury Control		X			
7.03 Disaster Preparedness		X			
7.04 First Aid & CPR Training		X			

TABLE 1: MINIMUM STANDARDS

H. DISASTER MEDICAL RESPONSE

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
Universal Level:					
8.01 Disaster Medical Planning*		X			
8.02 Response Plans		X			
8.03 HazMat Training		X			
8.04 Incident Command System		X			
8.05 Distribution of Casualties*		X			
8.06 Needs Assessment		X			
8.07 Disaster Communications*		X			
8.08 Inventory of Resources		X			
8.09 DMAT Teams		X			
8.10 Mutual Aid Agreements*		X			
8.11 CCP Designation*		X			
8.12 Establishment of CCPs		X			
8.13 Disaster Medical Training		X			
8.14 Hospital Plans		X			
8.15 Interhospital Communications		X			
8.16 Prehospital Agency Plans		X			
Enhanced Level: Advanced Life Support:					
8.17 ALS Policies		X			
Enhanced Level: Specialty Care Systems:					
8.18 Specialty Center Roles		X			
Enhanced Level: Exclusive Operating Areas/Ambulance Regulations:					
8.19 Waiving Exclusivity		X			

Los Angeles County – Department of Health Services
EMERGENCY MEDICAL SERVICES

ANNUAL EMS PLAN UPDATE
(Fiscal Year 2022-2023)

Table 1 – STANDARDS – Changes Made on a Standard

EMS System: **Los Angeles County**

Standard	Minimum Standards	Meets Minimum Requirement	Short Range (one year or less)	Long Range (more than one year)	Progress	Objective
2.04 Dispatch Training	Public safety answering point (PSAP) operators with medical responsibility shall have emergency medicine orientation and all medical dispatch personnel (both public and private) shall receive emergency medical dispatch training in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines. **RECOMMENDED GUIDELINES:** Public safety answering point PSAP operators with medical dispatch responsibilities and all medical dispatch personnel (both public and private) should be trained and tested in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines.		X		Approximately 95% of the Fire Departments providing Emergency Medical Services are dispatched by centers that provides pre-arrival instructions. 9-1-1 calls are routinely transferred from the PSAP to Fire Dispatch. .	One Fire Department utilizes a police dispatch to either approved pre-arrival instructions or will transition to a fire-based dispatch center with existing pre-arrival instructions. The LEMSA has begun routine (semi-annually at a minimum) meeting with the 9-1-1 dispatching centers. The LEMSA has begun annual site surveys within its jurisdiction for 9-1-1 dispatch to monitor compliance with mandated

Table 1 – Standards – Changes Made on a Standard

Standard	Minimum Standards	Meets Minimum Requirement	Short Range (one year or less)	Long Range (more than one year)	Progress	Objective
						policies and standards

EMERGENCY MEDICAL SERVICES AGENCY

DATA FACTS

LOS ANGELES COUNTY EMS SYSTEM REPORT

DECEMBER 1, 2023

ISSUE 12

Message from the Director and Medical Director

We are dedicating this 12th year issue of the EMS System Report to Dr. Marianne Gausche-Hill. Dr. Gausche-Hill served as the EMS Agency Medical Director from 2015-2023 and through her inspirational leadership has left a lasting positive impact on the Los Angeles County EMS System. She is recognized nationwide as an industry leader in the advancement of emergency and pediatric medicine and disaster preparedness.

Richard Tadeo
Director

Dr. Gausche-Hill has over 40 years of dedicated service to the LA County EMS System as the Base Medical Director at Harbor -UCLA Medical Center, the Medical Director for the Paramedic Training Institute, and for the past 8 years, the Medical Director of the EMS Agency. During her tenure at the EMS Agency, Dr. Gausche-Hill was instrumental in leading the efforts for the County to participate in the Cardiac Arrest Registry to Enhance Survival (CARES), which has allowed comprehensive evaluation of the prehospital treatment of patients experiencing cardiac arrest. Data from CARES is a new addition to this year's report.

Dr. Gausche-Hill spearheaded the efforts for all Emergency Departments Approved for Pediatrics and Pediatric Medical Centers to participate in the National Pediatric Readiness Program. This demonstrated that our pediatric emergency departments and medical centers are well prepared to evaluate and treat our pediatric patients, and provides essential tools for their continued growth. She also led efforts to establish our Data Collaboratives for the Specialty Systems of Care, including STEMI and Cardiac Arrest, Stroke, Trauma, and Pediatrics, which paved the way for multiple research and publications regarding system performance. She also served as the President for the American Board of Emergency Medicine.

Prior to her retirement, Dr. Gausche-Hill launched the Pediatric Dose Optimization for Seizures in EMS (PediDOSE) trial to evaluate the optimal dosing of medication to treat pediatric patients with active seizures and laid the groundwork for the Pediatric Prehospital Airway Resuscitation Trial (Pedi-PART), which will determine the best approach to prehospital pediatric airway management.

Dr. Nichole Bosson
Medical Director

Despite her retirement from County service, Dr. Gausche-Hill continues to participate in these research efforts to improve emergency and pediatric care. Her unwavering dedication to the medical care and health of the citizens of Los Angeles County continues in her new roles as the Interim CEO for The Lundquist Institute and serving on the Board of Directors for CARES. We extend our best wishes and a prosperous retirement.

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SPECIAL POINTS OF INTEREST:

- Emergency Severity Index (page 11)
- Trauma Mechanism of Injury (page 13)
- OHCA Overall Survival (pages 18-22)
- Paramedic Base Hospital Contact Volume (page 24)

2023 System Demographics

69 9-1-1 Receiving Hospitals

- 37 EDAP (Emergency Department Approved for Pediatrics)
- 8 Pediatric Medical Centers
- 7 Pediatric Trauma Centers
- 15 Trauma Centers
- 21 Paramedic Base Hospitals
- 34 STEMI Receiving Centers
- 24 Comprehensive Stroke Centers
- 28 Primary Stroke Centers
- 43 Perinatal Centers
- 40 Hospitals with Neonatal ICU
- 13 SART (Sexual Assault Response Team)
- 13 Disaster Resource Centers

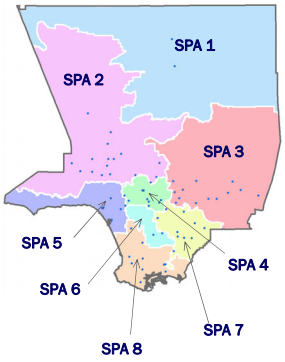
EMS Provider Agencies

- 31 Public Safety EMS Provider Agencies
- 34 Licensed Basic Life Support Ambulance Operators
- 17 Licensed Advanced Life Support Ambulance Operators
- 18 Licensed Critical Care Transport Ambulance Operators
- 5 Licensed Ambulette Operators

EMS Practitioners

- 4,503 Accredited Paramedics
- 8,457 Certified EMTs by LA Co EMS Agency
- 763 Certified Mobile Intensive Care Nurses

ADULT EMS PROVIDER IMPRESSION by Service Planning Area (SPA)



Year	Total Population	SPA1	SPA2	SPA3	SPA4	SPA5	SPA6	SPA7	SPA8
2014	10,069,036	392,730	2,190,391	1,783,041	1,149,691	652,160	1,033,672	1,312,015	1,555,336
2023	9,792,167	413,966	2,154,399	1,720,799	1,090,182	648,902	991,811	1,258,726	1,513,402
%Change	-3%	5%	-2%	-3%	-5%	-0.5%	-4%	-4%	-3%

COUNTYWIDE TOP 10 ADULT EMS PROVIDER IMPRESSIONS	2018		2019		2020		2021		2022	
	No.	%	No.	%	No.	%	No.	%	No.	%
Traumatic Injury	118,549	15%	120,909	15%	102,560	13%	121,487	15%	122,029	16%
Behavioral/Psychiatric	57,027	7%	59,891	7%	58,136	8%	60,619	8%	54,836	7%
Weakness - General	54,752	7%	54,632	7%	53,409	7%	55,368	7%	50,983	7%
No Medical Complaint	47,525	6%	47,142	6%	41,110	5%	35,163	4%	45,399	6%
Body Pain-Non Traumatic	39,563	5%	40,428	5%	36,832	5%	38,506	5%	40,401	5%
Abdominal Pain	38,725	5%	40,365	5%	35,688	5%	41,024	5%	33,466	4%
Respiratory Distress	32,120	4%	32,702	4%	34,205	5%	34,679	4%	31,682	4%
Altered Level of Consciousness	35,373	4%	29,465	4%	24,820	3%	24,544	3%	26,177	3%
Chest Pain - Suspected Cardiac	21,125	3%	21,812	3%	19,320	3%	21,880	3%	22,690	3%
Syncope/Near Syncope	25,396	3%	24,447	3%	18,333	2%	21,125	3%	20,331	3%
Total Adult EMS Responses	791,900		801,661		759,972		787,420		775,516	

	Top 10 Adult EMS Provider Impressions	2018		2019		2020		2021		2022	
		No.	%	No.	%	No.	%	No.	%	No.	%
SPA 1	Traumatic Injury	7,151	14%	9,788	17%	5,932	11%	6,995	13%	4,943	10%
	Body Pain-Non Traumatic	4,085	8%	4,464	8%	3,492	6%	3,462	6%	3,174	6%
	Abdominal Pain	3,235	6%	3,201	6%	2,952	5%	3,169	6%	2,958	6%
	Weakness - General	2,784	5%	2,475	4%	2,952	5%	3,151	6%	2,792	6%
	Behavioral/Psychiatric	4,062	8%	4,007	7%	3,443	6%	3,858	7%	2,727	5%
	Respiratory Distress	1,860	4%	2,179	4%	2,019	4%	2,401	4%	2,041	4%
	Chest Pain - Suspected Cardiac	1,554	3%	1,767	3%	1,428	3%	1,682	3%	1,581	3%
	Cold/Flu	1,175	2%	1,138	2%	1,533	3%	1,357	2%	1,383	3%
	Altered Level of Consciousness	1,857	4%	1,669	3%	1,395	3%	1,518	3%	1,376	3%
	Nausea/Vomiting	1,281	2%	1,586	3%	1,087	2%	1,390	3%	1,200	2%
Total SPA 1 Adult EMS Responses		51,368		56,824		54,767		55,367		50,680	

	EMS Provider Impressions	No.	%	No.	%	No.	%	No.	%	No.	%
SPA 2	Traumatic Injury	18,981	14%	18,247	13%	18,243	14%	21,791	15%	25,593	18%
	Weakness - General	11,077	8%	11,030	8%	11,012	8%	11,707	8%	10,843	8%
	Behavioral/Psychiatric	9,163	7%	9,707	7%	10,249	8%	10,265	7%	9,215	6%
	No Medical Complaint	9,131	7%	9,087	7%	8,109	6%	7,865	6%	8,789	6%
	Abdominal Pain	5,584	4%	5,685	4%	6,350	5%	7,613	5%	7,844	5%
	Respiratory Distress	6,389	5%	6,620	5%	7,040	5%	6,990	5%	6,377	4%
	Body Pain - Non-Traumatic	5,429	4%	5,395	4%	5,154	4%	5,945	4%	6,153	4%
	Syncope/Near Syncope	4,786	4%	5,054	4%	3,867	3%	4,738	3%	4,892	3%
	Chest Pain - Suspected Cardiac	3,939	3%	4,043	3%	3,911	3%	4,482	3%	4,368	3%
	Altered Level of Consciousness	6,493	3%	6,683	5%	4,921	4%	4,710	3%	3,974	3%
Total SPA 2 Adult EMS Responses		135,030		136,833		132,977		141,562		142,691	

	EMS Provider Impressions	No.	%	No.	%	No.	%	No.	%	No.	%
SPA 3	Traumatic Injury	22,151	17%	24,900	19%	18,207	15%	21,730	18%	20,445	17%
	Weakness - General	8,328	6%	7,594	6%	7,531	6%	7,952	6%	7,753	7%
	Behavioral/Psychiatric	9,108	7%	8,975	7%	8,412	7%	8,876	7%	7,116	6%
	Body Pain - Non-Traumatic	7,932	6%	8,008	6%	6,139	5%	5,929	5%	6,237	5%
	Abdominal Pain	6,411	5%	6,124	5%	5,382	4%	5,899	5%	5,891	5%
	Respiratory Distress	5,110	4%	5,461	4%	5,508	4%	5,471	4%	4,514	4%
	No Medical Complaint	7,398	6%	6,999	5%	5,601	5%	5,683	5%	4,466	4%
	Syncope/Near Syncope	4,348	3%	4,465	3%	3,322	3%	3,664	3%	3,749	3%
	Chest Pain - Suspected Cardiac	3,102	2%	3,614	3%	3,198	3%	3,445	3%	3,369	3%
	Altered Level of Consciousness	5,515	4%	4,571	3%	3,960	3%	3,821	3%	2,866	2%
Total SPA 3 Adult EMS Responses		129,597		131,879		123,464		123,688		117,854	

	Top 10 Adult EMS Provider Impressions	2018 No.	%	2019 No.	%	2020 No.	%	2021 No.	%	2022 No.	%
SPA 4	Traumatic Injury	11,649	12%	10,331	11%	10,951	12%	13,366	14%	15,184	15%
	Behavioral/Psychiatric	7,098	7%	7,767	8%	7,800	9%	8,346	9%	7,469	8%
	Weakness - General	7,059	7%	7,373	8%	7,239	8%	7,710	8%	7,270	7%
	No Medical Complaint	6,343	7%	6,604	7%	6,169	7%	5,752	6%	6,048	6%
	Abdominal Pain	3,895	4%	4,515	5%	3,915	4%	4,919	5%	4,780	5%
	Overdose/Poisoning	2,308	2%	2,920	3%	3,315	4%	4,578	5%	4,694	5%
	Body Pain - Non-Traumatic	3,444	4%	4,073	4%	3,954	4%	4,524	5%	5,026	5%
	Respiratory Distress	3,401	4%	3,423	4%	4,399	5%	4,118	4%	4,081	4%
	Altered Level of Consciousness	4,653	5%	3,688	4%	3,275	4%	3,230	3%	2,794	3%
	Seizure	2,835	3%	2,989	3%	2,478	3%	2,473	3%	2,665	3%
Total SPA 4 Adult EMS Responses		95,524		95,477		91,353		97,424		98,954	

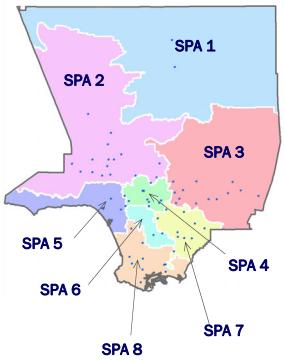
	EMS Provider Impressions	No.	%	No.	%	No.	%	No.	%	No.	%
SPA 5	Traumatic Injury	10,797	18%	9,190	16%	8,179	17%	9,931	19%	10,497	19%
	Behavioral/Psychiatric	3,933	7%	3,981	7%	4,014	8%	4,367	8%	4,114	8%
	No Medical Complaint	4,977	8%	4,074	7%	3,352	7%	3,710	7%	3,876	7%
	Weakness - General	4,185	7%	3,995	7%	3,352	7%	3,710	7%	3,813	7%
	Abdominal Pain	2,011	3%	2,252	4%	1,858	4%	2,280	4%	2,395	4%
	Body Pain - Non-Traumatic	1,698	3%	2,119	4%	1,771	4%	2,104	4%	2,285	4%
	Syncope/Near Syncope	2,582	4%	2,498	4%	1,537	3%	1,860	4%	2,154	4%
	Respiratory Distress	1,945	3%	1,944	3%	1,858	4%	1,961	4%	1,973	4%
	Altered Level of Consciousness	2,493	4%	1,949	3%	1,769	4%	1,683	3%	1,593	3%
	Nausea/Vomiting	1,666	3%	1,684	3%	1,230	3%	1,327	3%	1,416	3%
Total SPA 5 Adult EMS Responses		59,682		56,379		48,224		52,677		54,183	

	EMS Provider Impressions	No.	%	No.	%	No.	%	No.	%	No.	%
SPA 6	Traumatic Injury	14,742	13%	13,758	12%	13,788	12%	15,121	14%	14,501	14%
	Behavioral/Psychiatric	8,089	7%	8,892	8%	9,225	8%	8,737	8%	7,632	7%
	Weakness - General	7,638	7%	8,160	7%	9,046	8%	8,115	7%	7,436	7%
	Abdominal Pain	6,591	6%	7,143	6%	6,378	6%	7,037	6%	6,605	6%
	Body Pain - Non-Traumatic	6,585	6%	6,967	6%	6,462	6%	6,378	6%	6,274	6%
	No Medical Complaint	6,929	6%	6,954	6%	6,803	6%	6,210	6%	5,183	5%
	Respiratory Distress	5,016	4%	5,158	5%	5,550	5%	5,239	5%	4,941	5%
	Seizure	3,695	3%	3,950	4%	3,529	3%	3,437	3%	3,490	3%
	Cold/Flu	3,609	3%	3,707	3%	4,339	4%	3,239	3%	3,481	3%
	Altered Level of Consciousness	4,395	4%	3,346	3%	2,955	3%	2,746	2%	2,518	2%
Total SPA 6 Adult EMS Responses		111,500		111,695		112,044		110,085		105,165	

	EMS Provider Impressions	No.	%	No.	%	No.	%	No.	%	No.	%
SPA 7	Traumatic Injury	13,581	15%	14,608	16%	10,740	13%	12,645	16%	11,043	14%
	Behavioral/Psychiatric	6,458	7%	7,193	8%	6,397	8%	6,412	8%	5,312	7%
	Weakness - General	5,853	7%	5,386	6%	3,340	4%	5,155	6%	5,183	7%
	Body Pain - Non-Traumatic	5,773	7%	6,136	7%	4,519	6%	4,124	5%	4,278	5%
	Abdominal Pain	4,387	5%	4,194	5%	3,566	4%	3,982	5%	4,248	5%
	Respiratory Distress	3,276	4%	3,067	3%	3,071	4%	3,388	4%	2,916	4%
	Chest Pain - Suspected Cardiac	2,463	3%	2,526	3%	2,083	3%	2,313	3%	2,407	3%
	Altered Level of Consciousness	3,654	4%	2,712	3%	2,343	3%	2,411	3%	2,328	3%
	Syncope/Near Syncope	2,664	3%	2,554	3%	2,060	3%	2,111	3%	2,071	3%
	Seizure	2,262	3%	2,382	3%	1,857	2%	1,945	2%	2,071	3%
Total SPA 7 Adult EMS Responses		88,437		89,297		80,058		79,913		77,964	

	EMS Provider Impressions	No.	%	No.	%	No.	%	No.	%	No.	%
SPA 8	Traumatic Injury	19,497	16%	20,087	16%	16,919	14%	19,908	16%	19,823	15%
	Behavioral/Psychiatric	8,841	7%	8,898	7%	8,839	7%	9,758	8%	8,539	7%
	Weakness - General	8,040	7%	8,086	7%	7,696	6%	7,868	6%	7,929	6%
	Body Pain - Non-Traumatic	5,699	5%	6,609	5%	5,532	5%	6,040	5%	6,837	5%
	Abdominal Pain	6,092	5%	6,142	5%	5,433	5%	6,125	5%	6,242	5%
	No Medical Complaint	7,156	6%	6,997	6%	5,871	5%	6,360	5%	5,456	4%
	Respiratory Distress	5,123	4%	4,850	4%	4,903	4%	5,111	4%	4,954	4%
	Altered Level of Consciousness	6,313	5%	4,847	4%	4,275	4%	4,425	3%	4,281	3%
	Syncope/Near Syncope	4,070	3%	3,821	3%	3,010	3%	3,348	3%	3,638	3%
	Chest Pain - Suspected Cardiac	3,385	3%	3,289	3%	2,930	2%	3,369	3%	3,621	3%
Total SPA 8 Adult EMS Responses		120,762		123,277		120,090		126,704		128,025	

PEDIATRIC EMS PROVIDER IMPRESSION by Service Planning Area (SPA)



COUNTYWIDE TOP 10 PEDIATRIC EMS PROVIDER IMPRESSIONS	2018 No.	2018 %	2019 No.	2019 %	2020 No.	2020 %	2021 No.	2021 %	2022 No.	2022 %
Traumatic Injury	8,440	23%	8,641	23%	5,736	22%	6,655	25%	6,719	23%
No Medical Complaint	5,150	14%	4,746	13%	3,155	12%	2,846	11%	5,203	18%
Seizure	4,904	14%	5,609	15%	3,502	14%	3,218	12%	2,408	8%
Behavioral/Psychiatric	1,894	5%	1,709	5%	1,351	5%	1,448	5%	1,816	6%
Respiratory Distress	1,987	6%	2,140	6%	1,015	4%	1,379	5%	1,637	6%
Cold/Flu	1,390	4%	1,453	4%	1,000	4%	1,004	4%	1,368	5%
Fever	1,695	5%	1,751	5%	1,083	4%	861	3%	1,267	4%
Nausea/Vomiting	865	2%	917	2%	570	2%	847	3%	949	3%
Syncope/Near Syncope	956	3%	1,025	3%	564	2%	784	3%	847	3%
Weakness - General	675	2%	886	2%	614	2%	607	2%	746	3%
Total Pediatric Responses	36,117		36,945		25,675		26,984		29,457	

	Top 10 Pediatric EMS Provider Impressions	2018 No.	2018 %	2019 No.	2019 %	2020 No.	2020 %	2021 No.	2021 %	2022 No.	2022 %
SPA 1	Traumatic Injury	699	21%	830	24%	534	22%	555	22%	394	19%
	Seizure	420	13%	475	14%	270	11%	257	10%	466	22%
	Respiratory Distress	197	6%	229	7%	106	4%	155	6%	217	10%
	Cold/Flu	169	5%	141	4%	119	5%	109	4%	115	5%
	Behavioral/Psychiatric	286	9%	245	7%	155	6%	154	6%	103	5%
	Fever	109	3%	119	3%	84	3%	63	3%	73	3%
	Syncope/Near Syncope	64	2%	83	2%	97	4%	57	2%	73	3%
	Choking	42	1%	78	2%	97	4%	87	4%	42	2%
	Nausea/Vomiting	74	2%	72	2%	32	1%	73	3%	41	2%
	No Medical Complaint	531	6%	504	6%	284	4%	243	3%	64	1%
Total SPA 1 Pediatric EMS Responses		3,298		3,457		2,425		2,470		2,118	

	EMS Provider Impressions	No.	%	No.	%	No.	%	No.	%	No.	%
SPA 2	Traumatic Injury	926	23%	1,019	19%	844	21%	1,059	23%	1,261	24%
	Seizure	566	14%	898	17%	620	15%	565	12%	868	17%
	No Medical Complaint	469	12%	688	13%	496	12%	475	10%	381	7%
	Cold/Flu	158	4%	307	6%	170	4%	192	4%	304	6%
	Respiratory Distress	210	5%	348	6%	201	5%	235	5%	300	6%
	Fever	167	4%	282	5%	245	6%	242	5%	300	6%
	Behavioral/Psychiatric	252	6%	241	4%	210	5%	242	5%	266	5%
	Syncope/Near Syncope	150	4%	183	3%	100	2%	178	4%	186	4%
	Allergic Reaction	110	3%	183	3%	139	3%	158	3%	170	3%
	Nausea/Vomiting	84	2%	170	3%	101	2%	163	4%	123	2%
Total SPA 2 Pediatric EMS Responses		3,967		5,385		4,069		4,655		5,221	

	EMS Provider Impressions	No.	%	No.	%	No.	%	No.	%	No.	%
SPA 3	Traumatic Injury	1,611	25%	1,792	28%	961	24%	1,184	28%	1,221	26%
	Seizure	865	13%	911	14%	593	15%	513	12%	788	17%
	No Medical Complaint	936	14%	737	12%	428	10%	353	8%	309	7%
	Respiratory Distress	322	5%	343	5%	122	3%	176	4%	246	5%
	Behavioral/Psychiatric	341	5%	179	3%	206	5%	232	5%	226	5%
	Syncope/Near Syncope	201	3%	203	3%	108	3%	162	4%	163	4%
	Fever	209	3%	225	4%	180	4%	121	3%	149	3%
	Allergic Reaction	161	2%	150	2%	104	3%	110	3%	129	3%
	Choking	130	2%	171	3%	159	4%	175	4%	124	3%
	Nausea/Vomiting	134	2%	133	2%	159	4%	124	3%	124	3%
Total SPA 3 Pediatric EMS Responses		6,516		6,333		4,077		4,253		4,652	

	Top 10 Pediatric EMS Provider Impressions	2018 No.	%	2019 No.	%	2020 No.	%	2021 No.	%	2022 No.	%
SPA 4	Traumatic Injury	503	19%	476	18%	361	19%	459	22%	479	19%
	Seizure	392	15%	471	17%	284	15%	256	12%	406	16%
	No Medical Complaint	399	15%	360	13%	238	13%	285	13%	212	9%
	Cold/Flu	162	6%	148	5%	81	4%	95	4%	158	6%
	Respiratory Distress	147	5%	142	5%	57	3%	111	5%	156	6%
	Fever	152	6%	102	4%	87	5%	67	3%	122	5%
	Behavioral/Psychiatric	111	4%	141	5%	100	5%	106	5%	115	5%
	Allergic Reaction	60	2%	78	3%	66	4%	65	3%	87	4%
	Weakness - General	71	3%	70	3%	43	2%	82	4%	70	3%
	Nausea/Vomiting	70	3%	70	3%	43	2%	74	3%	69	3%
Total SPA 4 Pediatric EMS Responses		2,701		2,705		1,860		2,124		2,472	

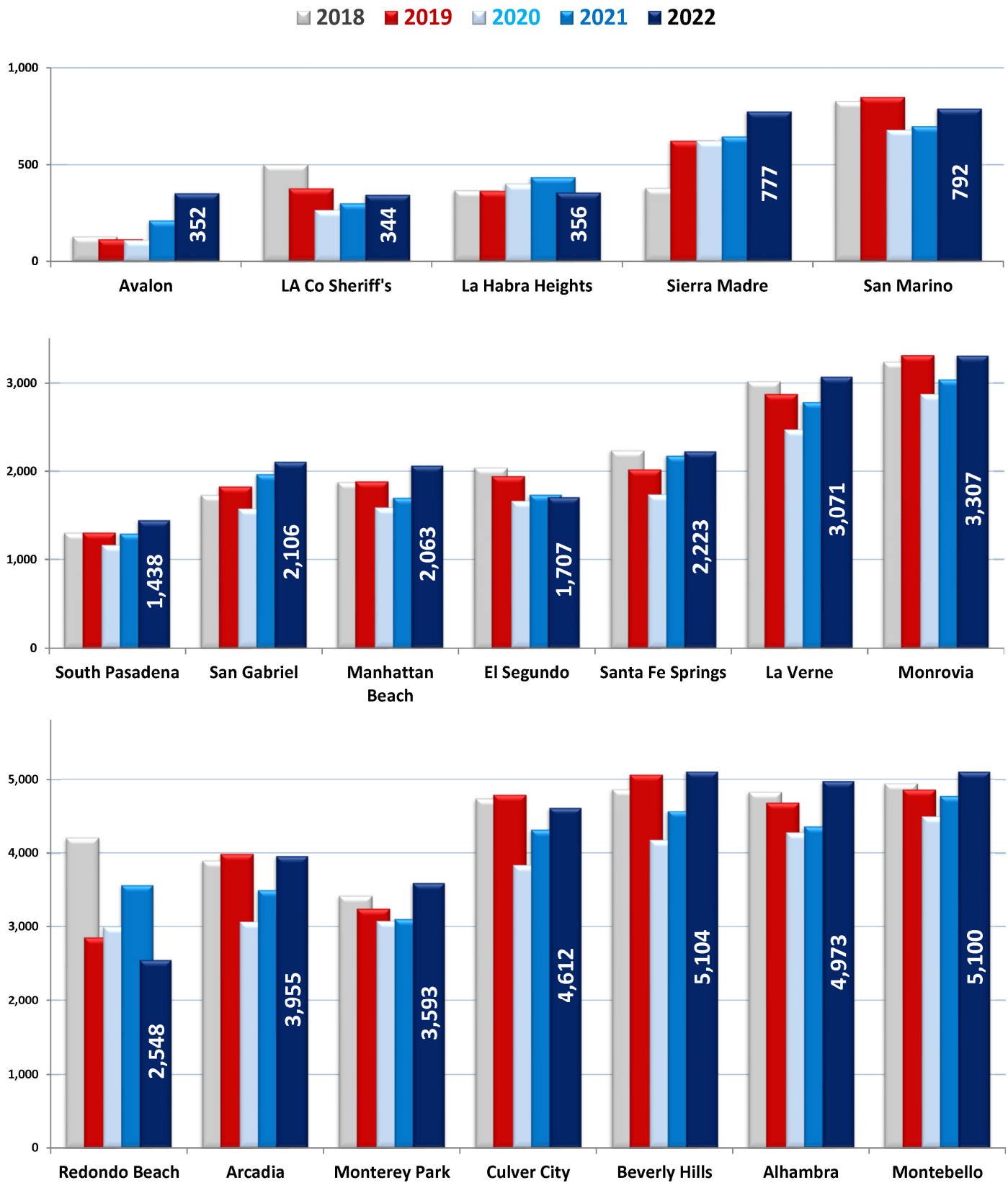
	EMS Provider Impressions	No.	%	No.	%	No.	%	No.	%	No.	%
SPA 5	Traumatic Injury	643	30%	473	24%	356	27%	381	28%	368	25%
	No Medical Complaint	258	12%	209	11%	137	10%	137	10%	131	9%
	Seizure	213	10%	192	10%	134	10%	113	8%	209	14%
	Respiratory Distress	139	6%	93	5%	45	3%	67	5%	93	6%
	Allergic Reaction	102	5%	76	4%	31	2%	68	5%	85	6%
	Cold/Flu	84	4%	79	4%	31	2%	45	3%	83	6%
	Fever	78	4%	47	2%	44	3%	35	3%	81	5%
	Nausea/Vomiting	75	3%	84	4%	32	2%	55	4%	68	5%
	Syncope/Near Syncope	66	3%	74	4%	27	2%	57	4%	66	4%
	Behavioral/Psychiatric	72	3%	61	3%	67	5%	61	4%	49	3%
Total SPA 5 Pediatric EMS Responses		2,175		1,941		1,338		1,360		1,491	

	EMS Provider Impressions	No.	%	No.	%	No.	%	No.	%	No.	%
SPA 6	Traumatic Injury	1,350	20%	1,308	20%	1,014	21%	1,115	23%	1,153	21%
	Seizure	884	13%	1,032	16%	622	13%	582	12%	922	17%
	Cold/Flu	497	7%	510	8%	260	5%	249	5%	524	10%
	No Medical Complaint	1,001	15%	970	15%	734	15%	662	13%	460	8%
	Respiratory Distress	422	6%	400	6%	225	5%	282	6%	361	7%
	Fever	330	5%	328	5%	210	4%	166	3%	274	5%
	Behavior/Psychiatric	296	4%	310	5%	248	5%	287	6%	247	4%
	Nausea/Vomiting	198	3%	172	3%	122	3%	163	3%	168	3%
	Weakness -General	151	2%	192	3%	172	4%	136	3%	156	3%
	Abdominal Pain	119	2%	124	2%	100	2%	95	2%	111	2%
Total SPA 6 Pediatric EMS Responses		6,647		6,649		4,865		4,952		5,491	

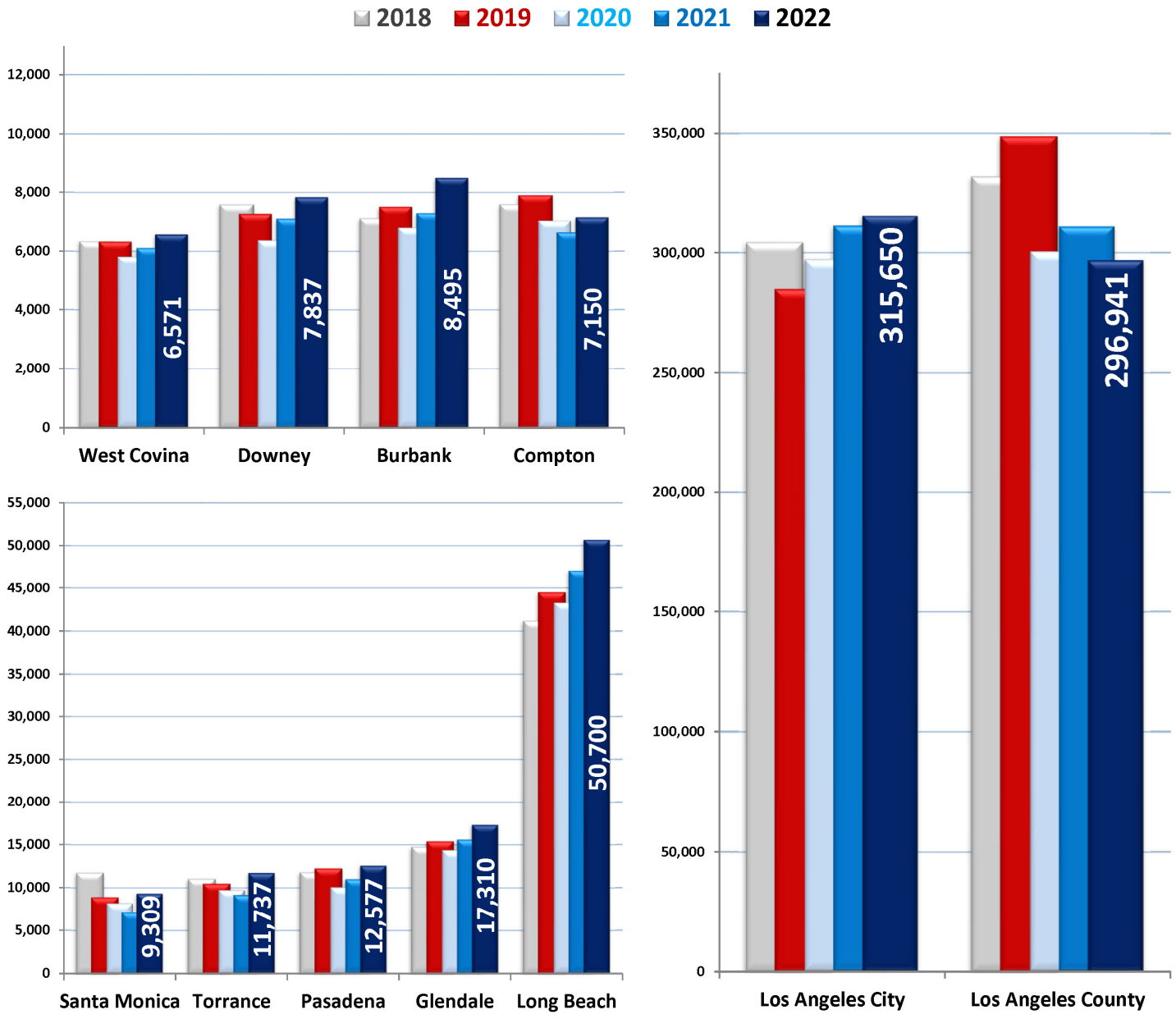
	EMS Provider Impressions	No.	%	No.	%	No.	%	No.	%	No.	%
SPA 7	Seizure	767	15%	801	16%	512	15%	447	14%	761	22%
	Traumatic Injury	1,153	22%	1,256	24%	722	22%	790	25%	720	21%
	Respiratory Distress	226	4%	291	6%	105	3%	152	5%	229	7%
	Cold/Flu	174	3%	195	4%	105	3%	77	2%	160	5%
	Behavioral/Psychiatric	256	5%	284	6%	186	6%	148	5%	156	5%
	Fever	171	3%	185	4%	112	3%	64	2%	138	4%
	No Medical Complaint	817	16%	670	13%	369	11%	277	9%	132	4%
	Syncope/Near Syncope	178	3%	160	3%	88	3%	80	3%	125	4%
	Overdose/Poisoning	73	1%	90	2%	89	2%	72	2%	89	3%
	Choking	91	2%	143	3%	136	4%	139	4%	87	3%
Total SPA 7 Pediatric EMS Responses		5,150		5,152		3,339		3,126		3,424	

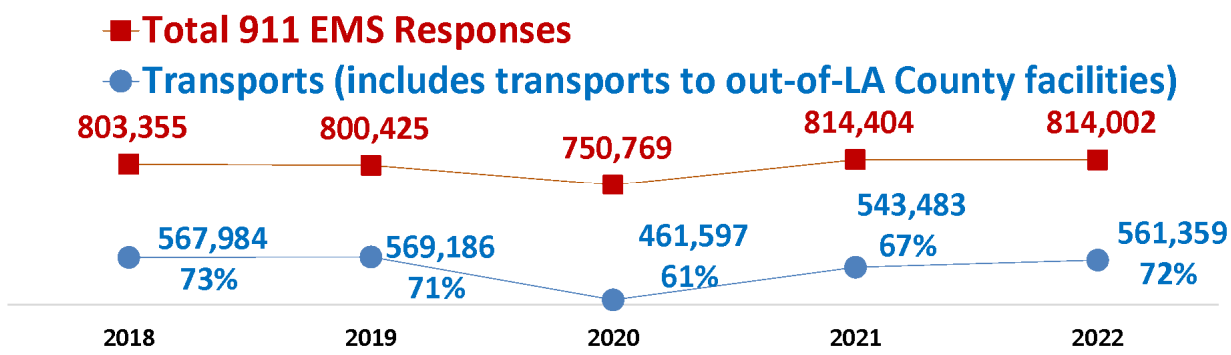
	EMS Provider Impressions	No.	%	No.	%	No.	%	No.	%	No.	%
SPA 8	Traumatic Injury	1,555	27%	1,487	28%	976	25%	1,112	27%	1,082	24%
	Seizure	797	14%	829	16%	501	13%	485	12%	902	20%
	Respiratory Distress	324	6%	294	6%	166	4%	201	5%	327	7%
	No Medical Complaint	739	13%	608	11%	488	13%	414	10%	280	6%
	Cold/Flu	197	3%	230	4%	131	3%	148	4%	250	5%
	Behavioral/Psychiatric	280	5%	248	5%	190	5%	218	5%	215	5%
	Fever	183	3%	168	3%	128	3%	103	3%	204	4%
	Syncope/Near Syncope	152	3%	138	3%	96	2%	117	3%	144	3%
	Choking	134	2%	124	2%	161	4%	160	4%	131	3%
	Allergic Reaction	122	2%	134	3%	86	2%	119	3%	119	3%
Total SPA 8 Pediatric EMS Responses		5,663		5,323		3,883		4,044		4,588	

EMS Responses by 9-1-1 Jurisdictional Provider Agency



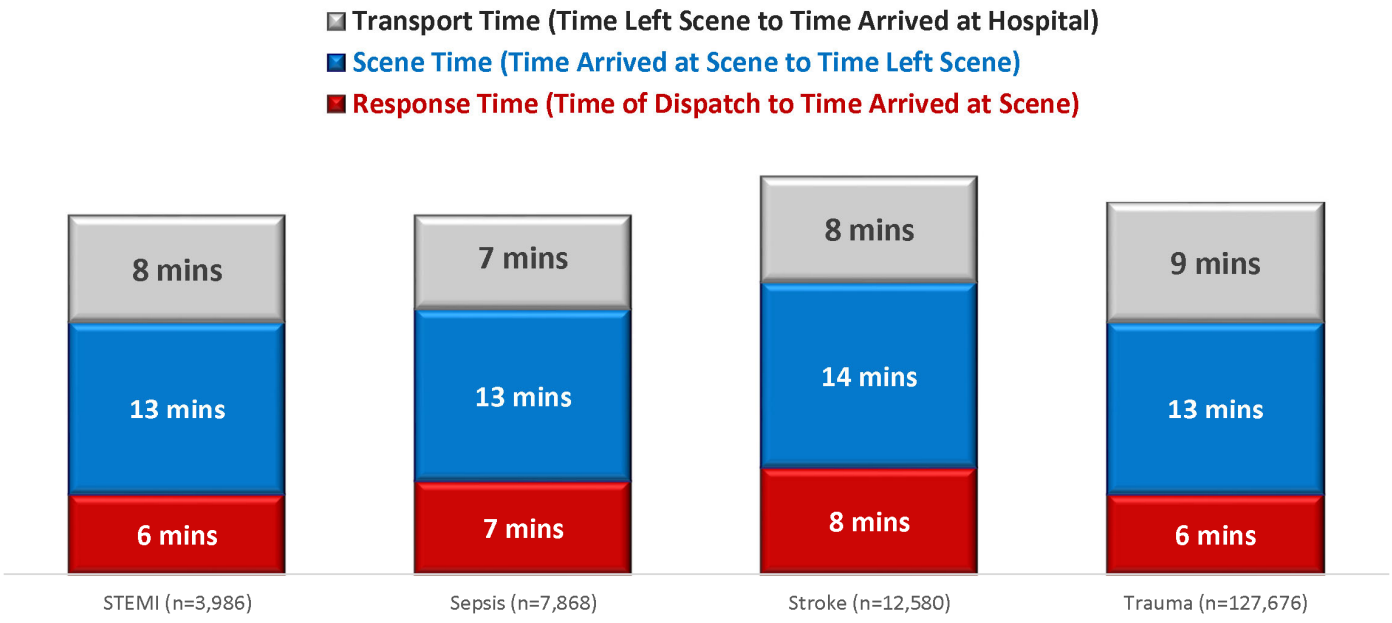
EMS Responses by 9-1-1 Jurisdictional Provider Agency



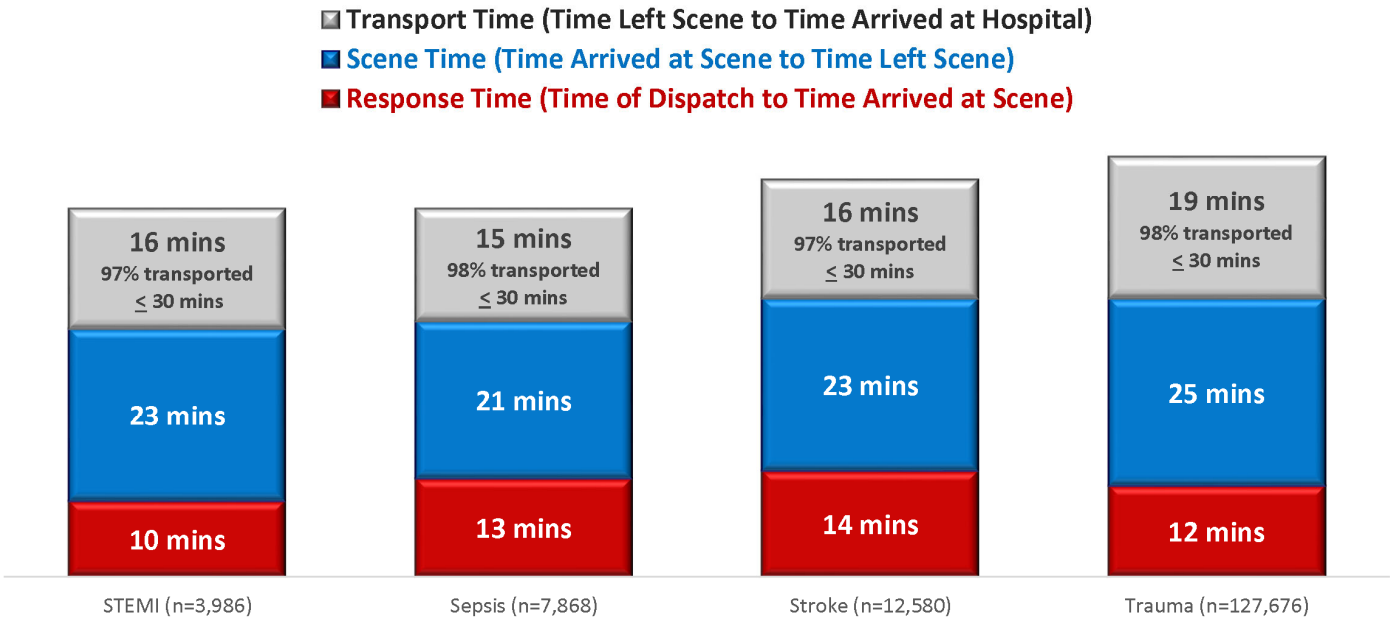


2022 EMS Times: Adult (Median)

LA County EMS Transport Time of ADULT Patients with Provider Impressions STEMI, Stroke, Sepsis and Traumatic Injuries

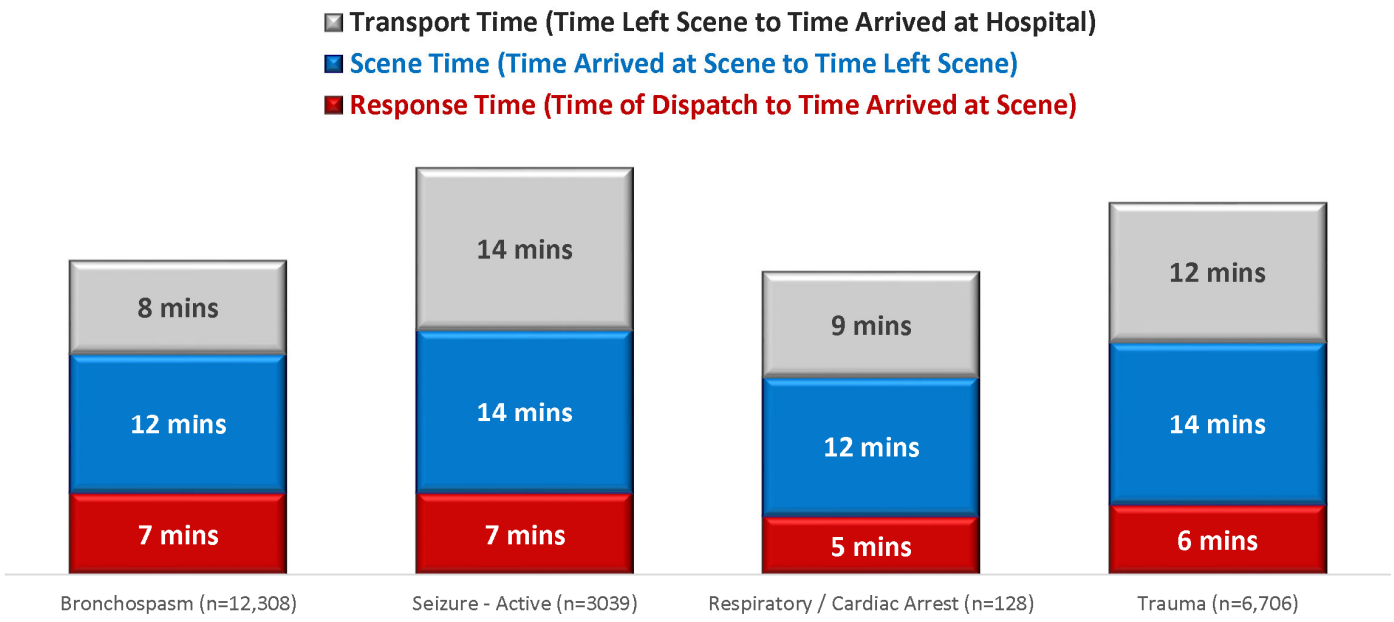


2022 EMS Times (90th Percentile)

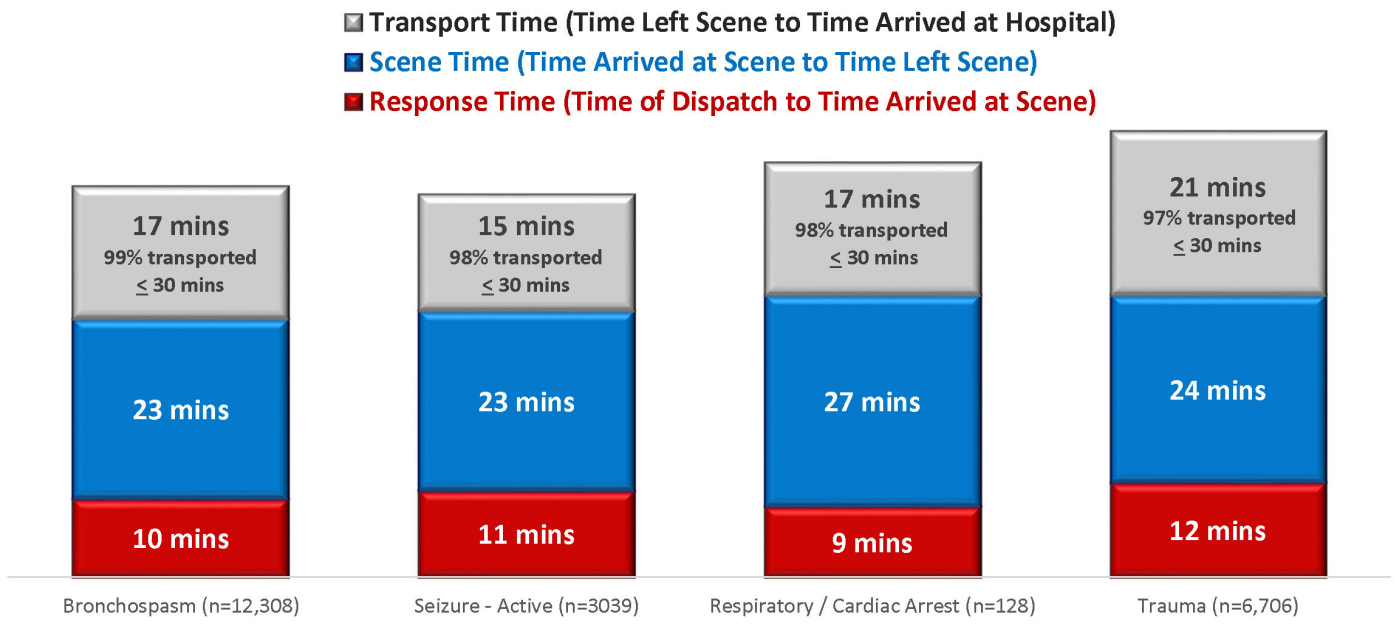


2022 EMS Times: Pediatric (Median)

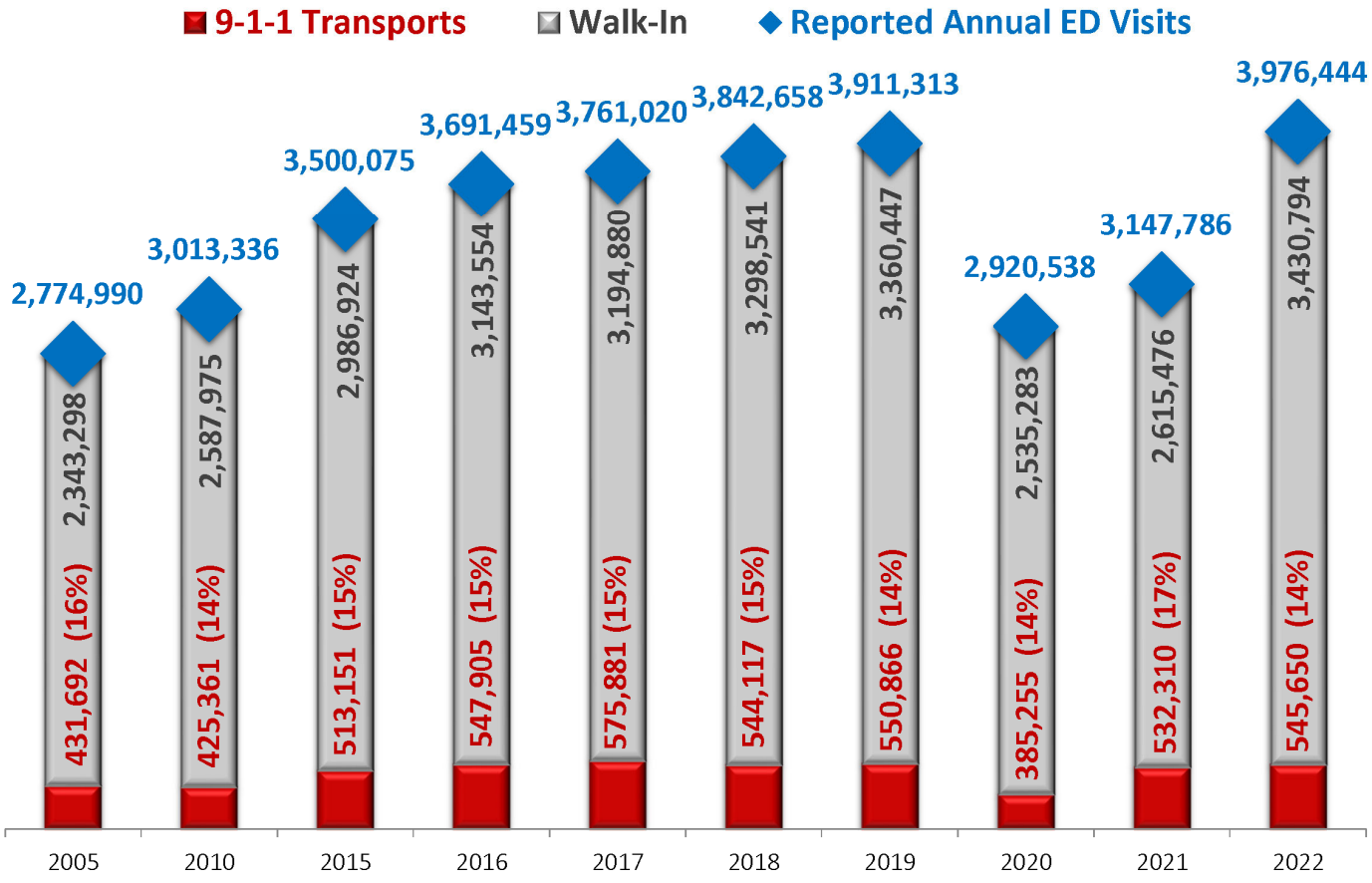
LA County EMS Transport Time PEDIATRIC Patients with Provider Impressions Bronchospasm, Seizure, Respiratory/Cardiac Arrest and Traumatic Injuries

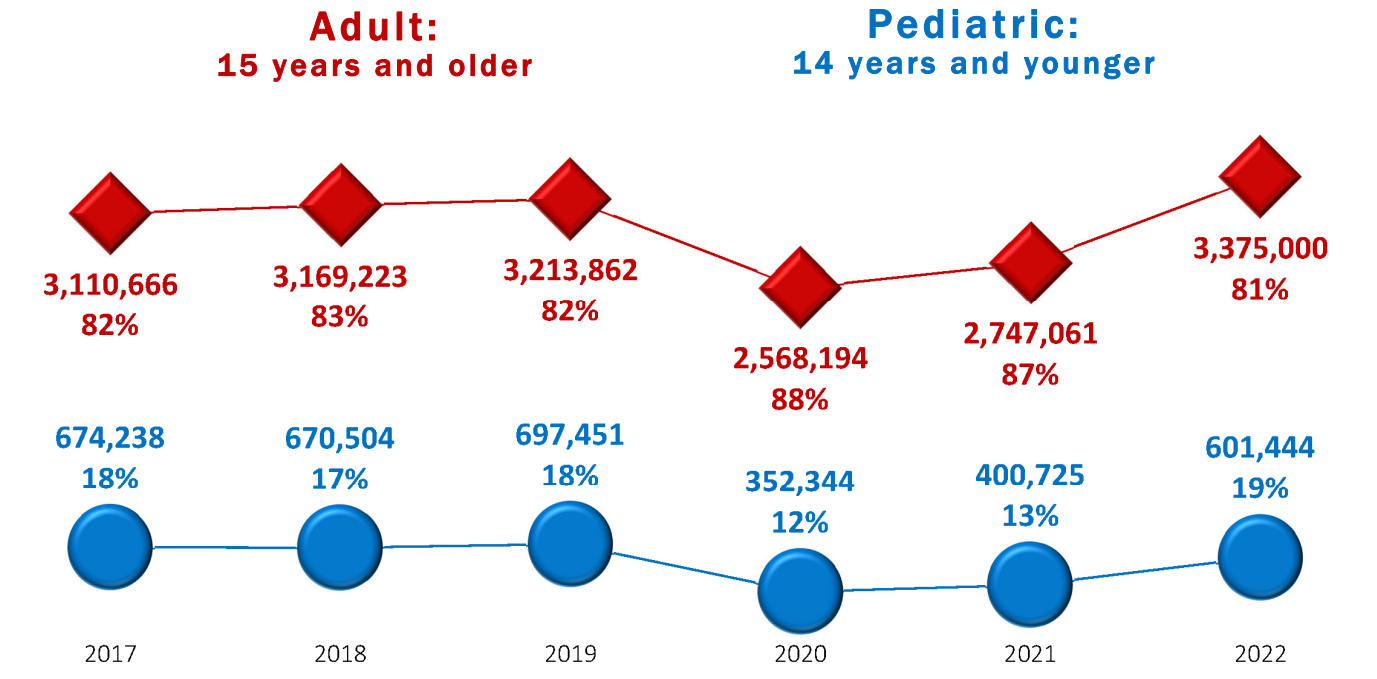


2022 EMS Times: Pediatric (90th Percentile)

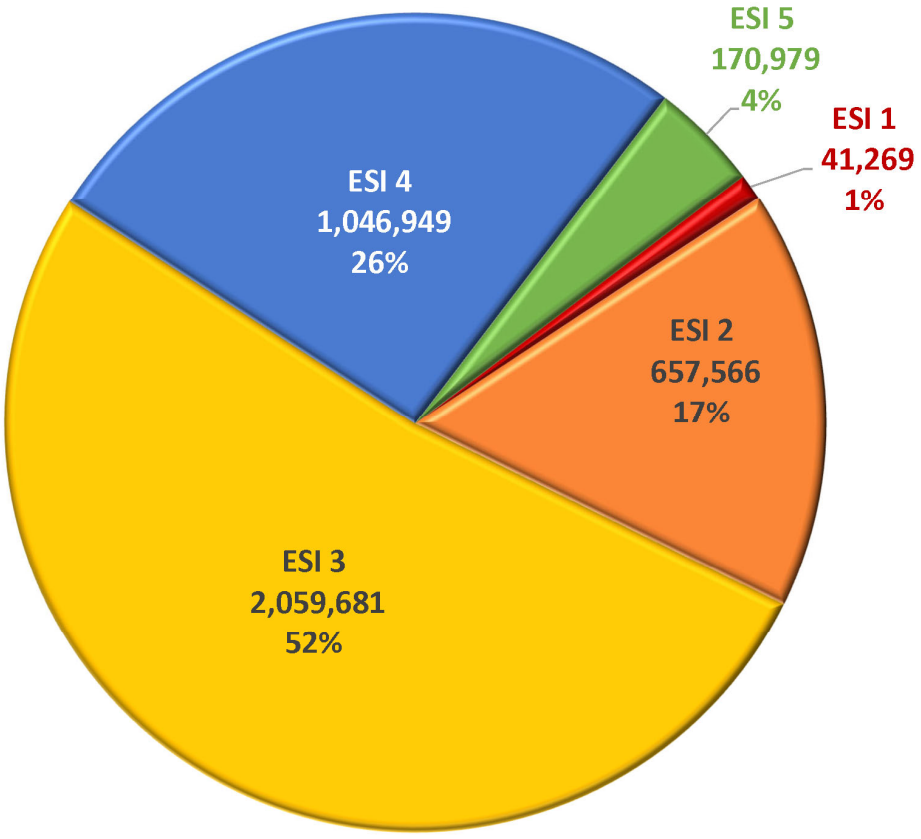


Emergency Department Volume





Emergency Severity Index (ESI)



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

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

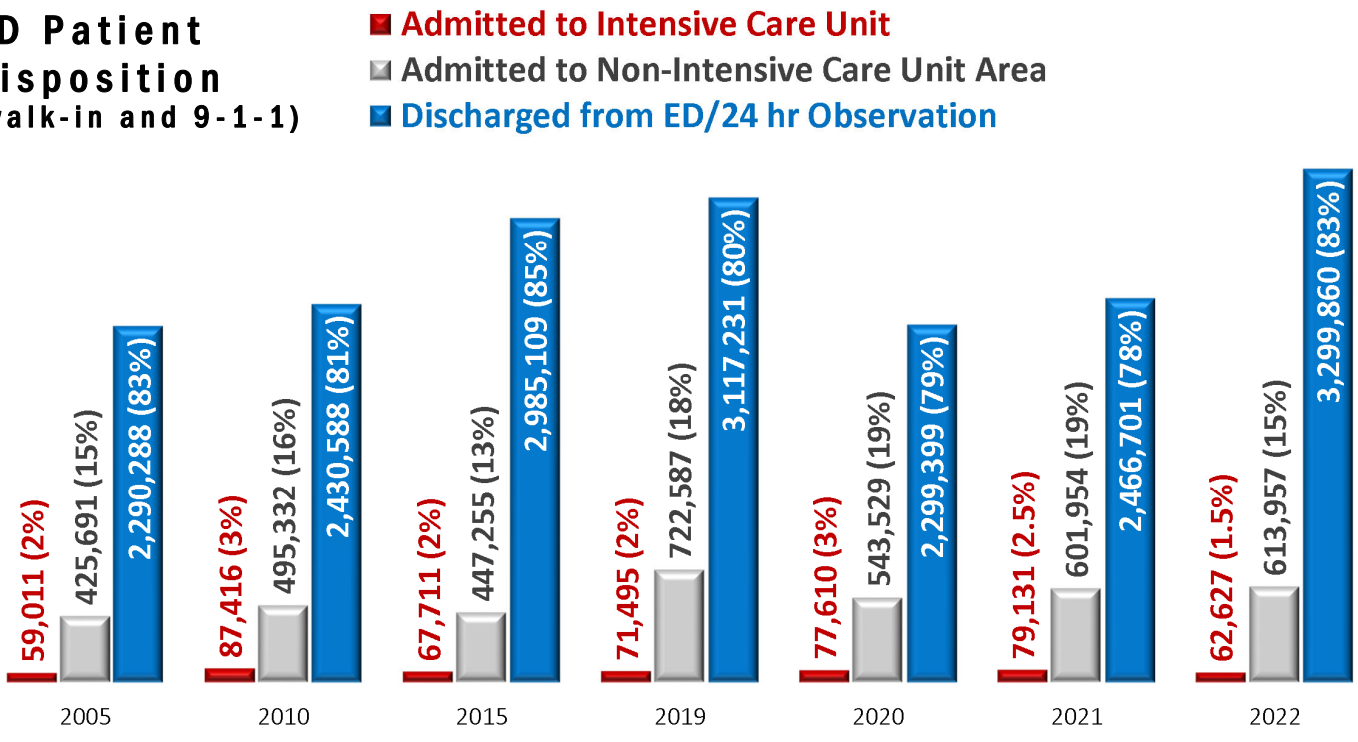
ESI 3—Patient is currently stable but requires multiple different types of resources* to diagnose or treat condition (e.g., diagnostic tests and procedures).

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

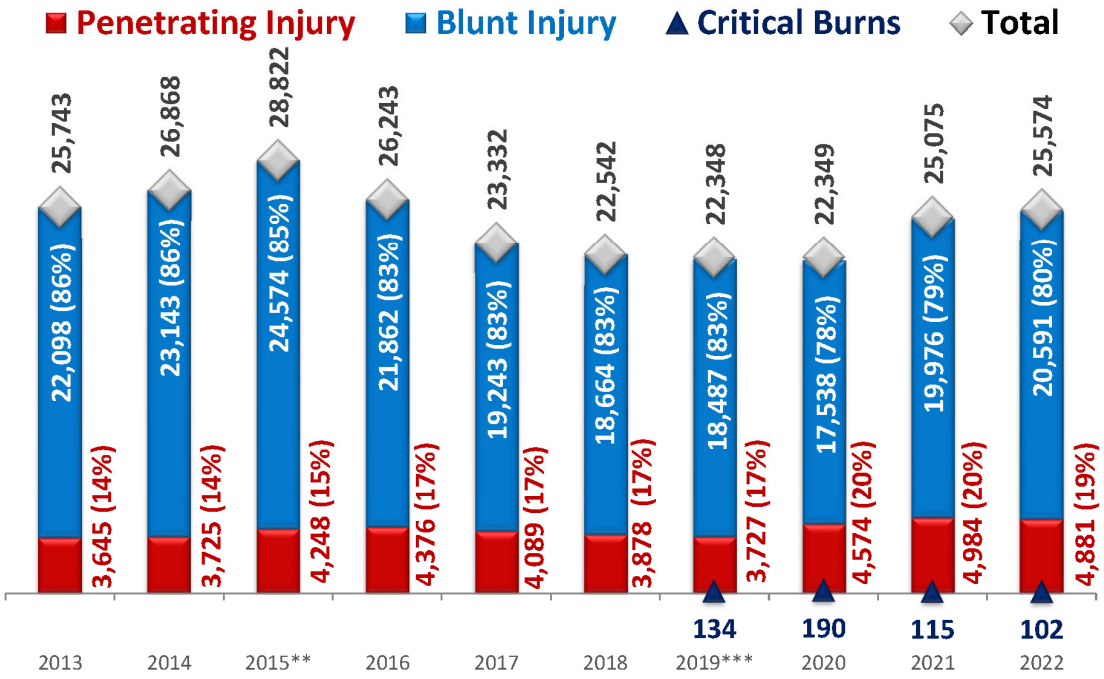
ESI 5—A patient not needing any resources*.

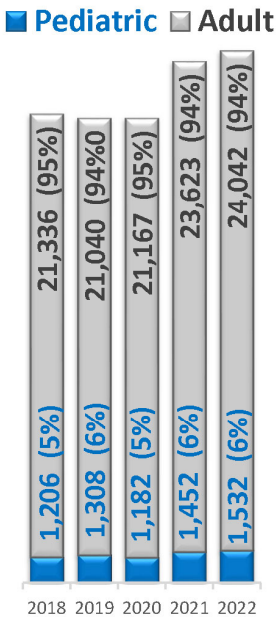
*The following are not considered resources: simple would care-dressing/recheck; sling, PO medications, saline lock, history and physical-including a pelvic exam; point of care testing; tetanus immunization; prescription refills, crutches; splint

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



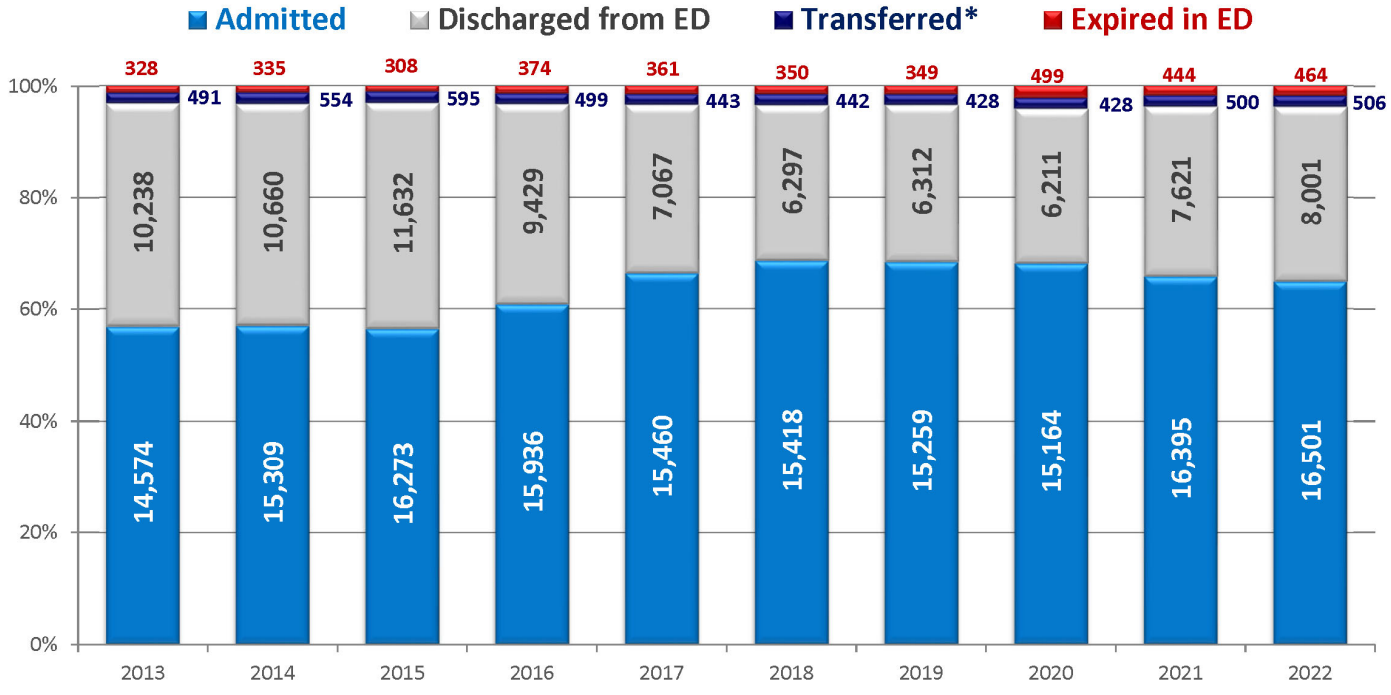
Trauma Center Volume (includes EMS transports and Walk-In patients who met trauma center criteria/guidelines)





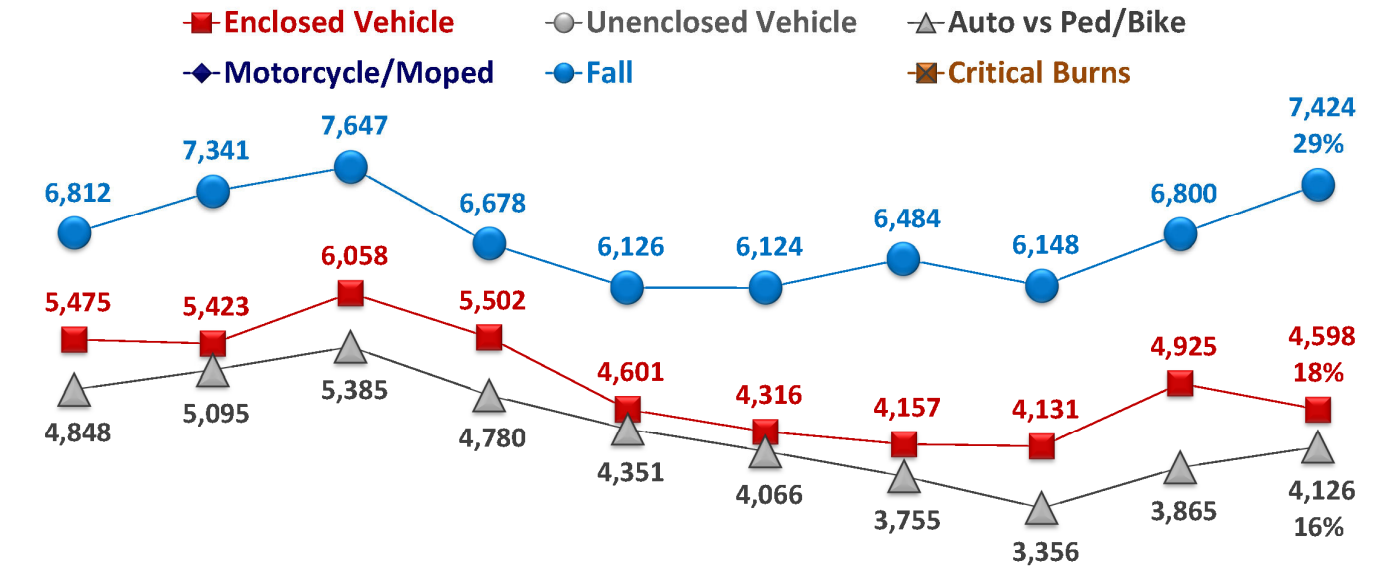
*2015 : Trauma Center Registry inclusion criteria was revised.
**2019: Critical Burns added as a Trauma Center Criteria

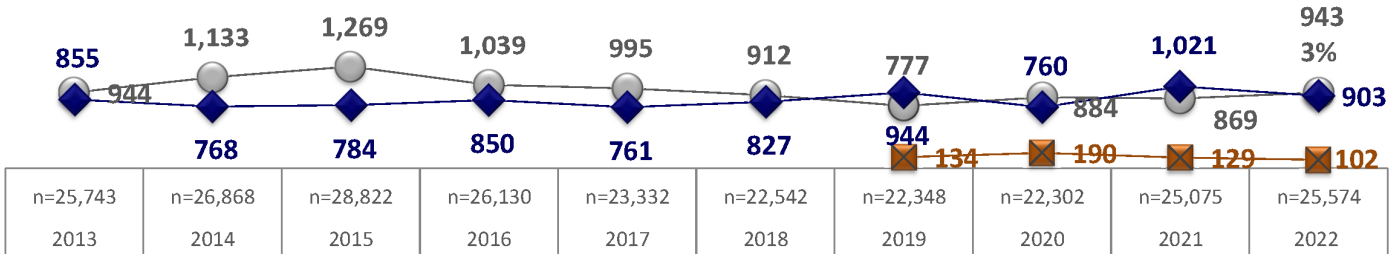
Patient Disposition of Trauma Center Patients



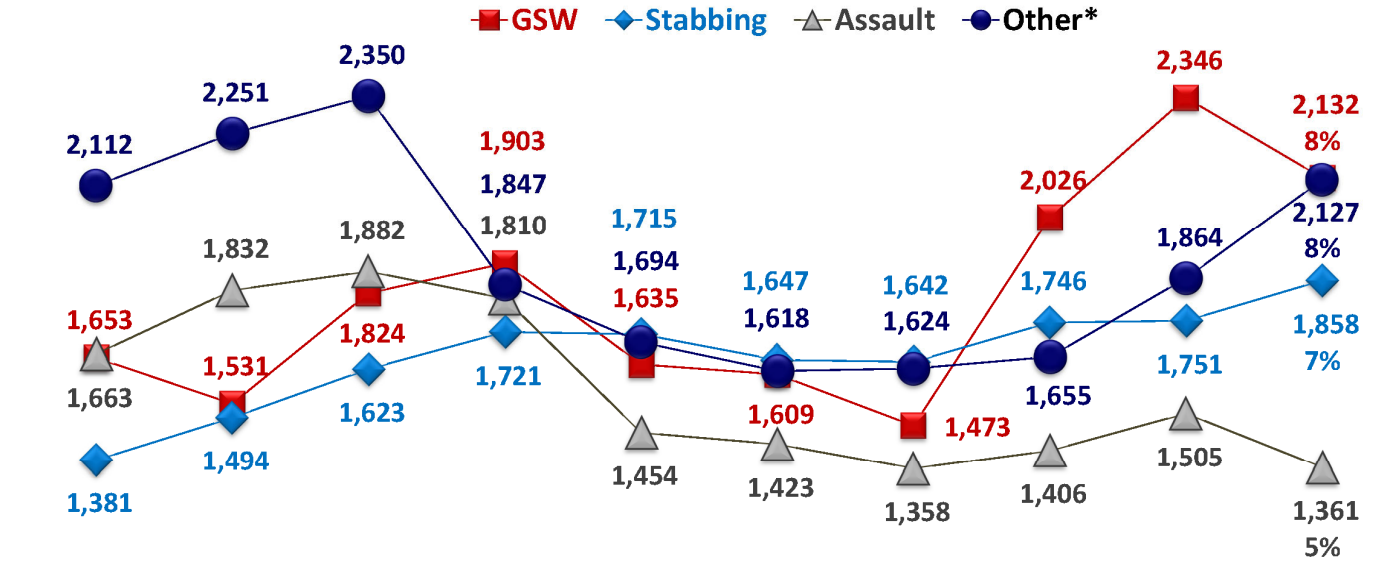
* Transferred to another health facility

Mechanism of Injury: Patients Transported to Trauma Centers





n=25,743	n=26,868	n=28,822	n=26,130	n=23,332	n=22,542	n=22,348	n=22,302	n=25,075	n=25,574
2013	2014	2015	2016	2017	2018	2019	2020	2021	2022

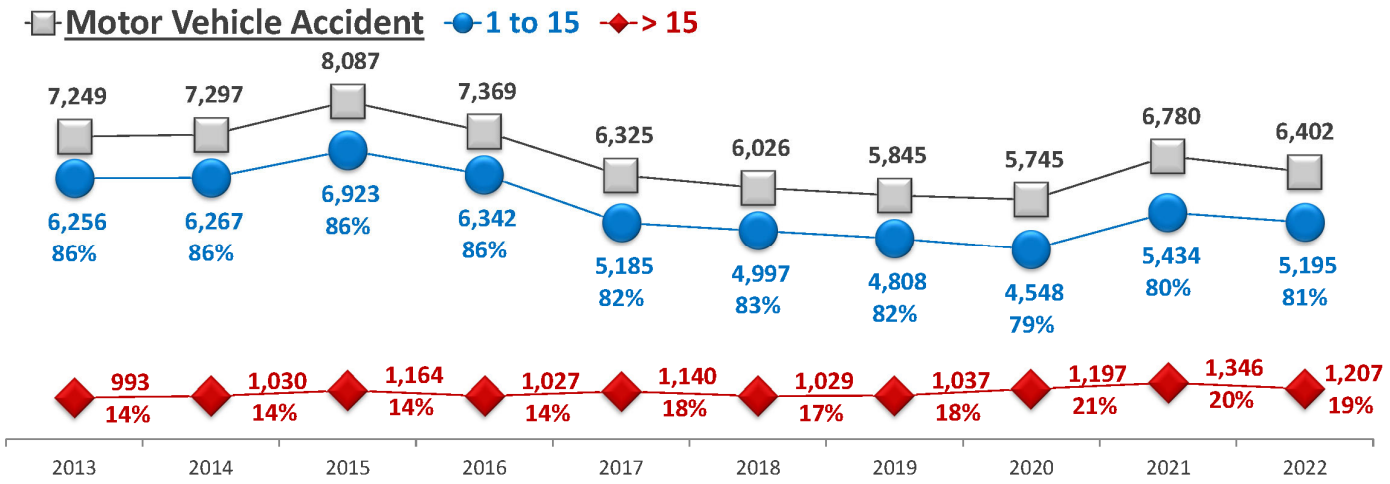


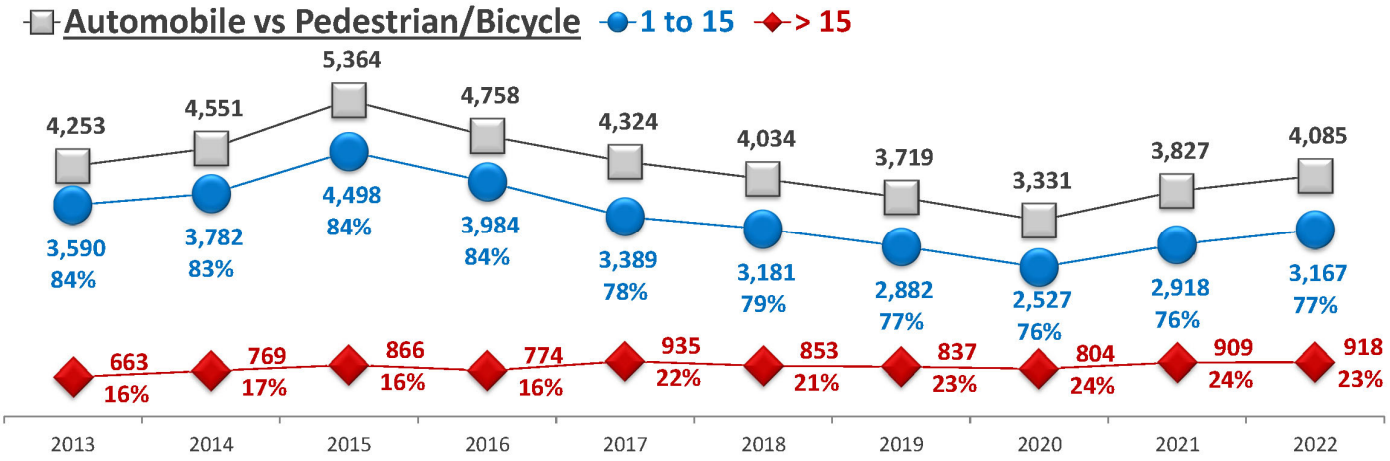
n=25,743	n=26,868	n=28,822	n=26,130	n=23,332	n=22,542	n=22,348	n=22,302	n=25,075	n=25,574
2013	2014	2015	2016	2017	2018	2019	2020	2021	2022

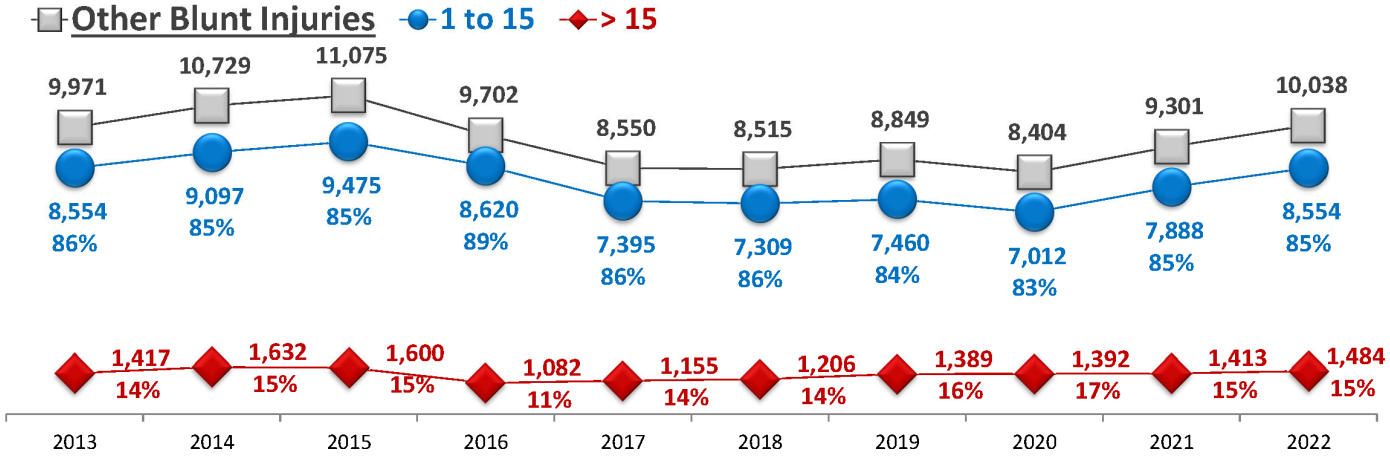
* Other: includes Sports, Work Related, Self-Inflicted, Unknown

Injury Severity Score by Mechanism of Injury

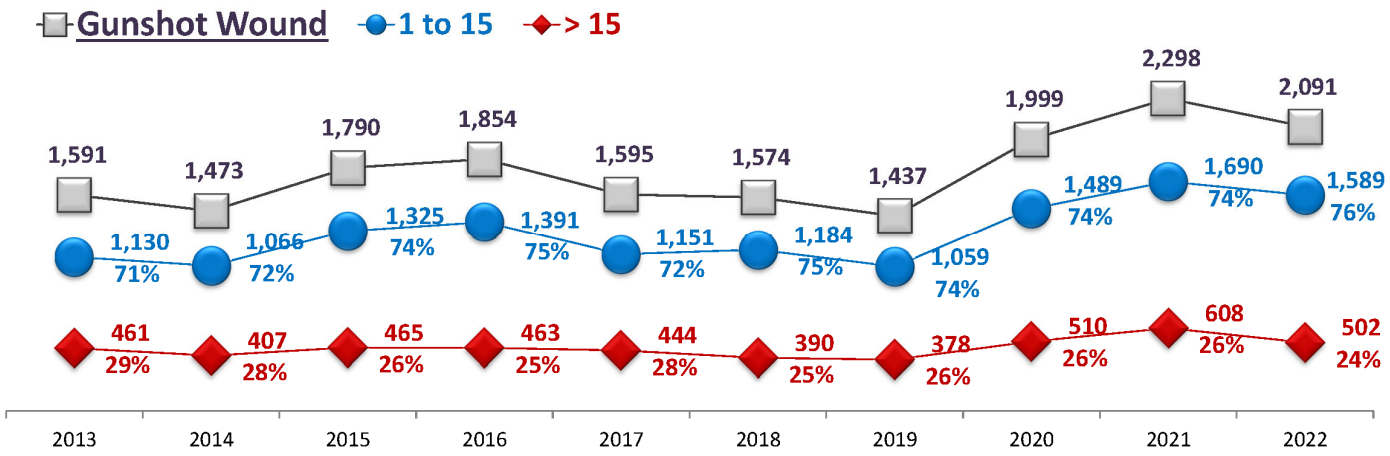
Injury Severity Score (ISS): Is an established medical score to assess trauma severity. It correlates with mortality, morbidity and hospitalization time after trauma. It is used to define the term major trauma. A major trauma (or polytrauma) is defined as the ISS being greater than 15.

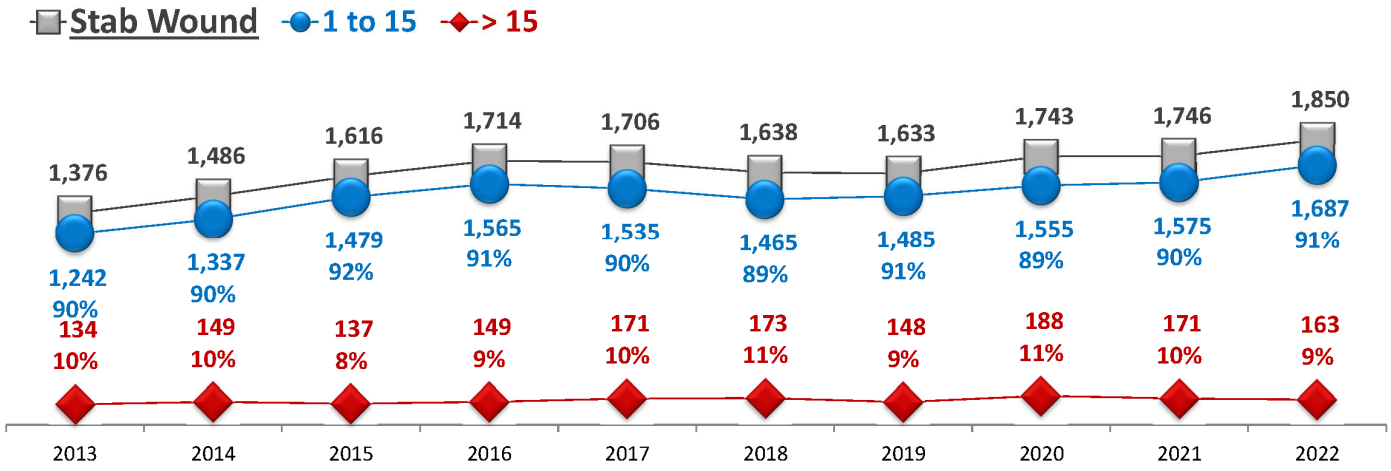


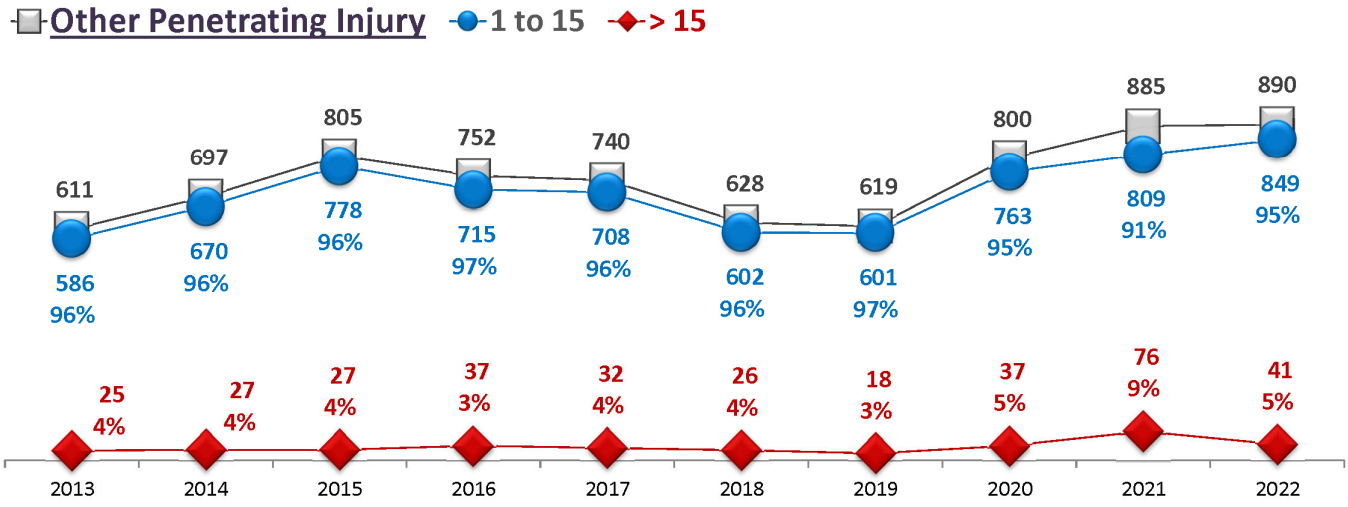




Injury Severity Score by Mechanism of Injury



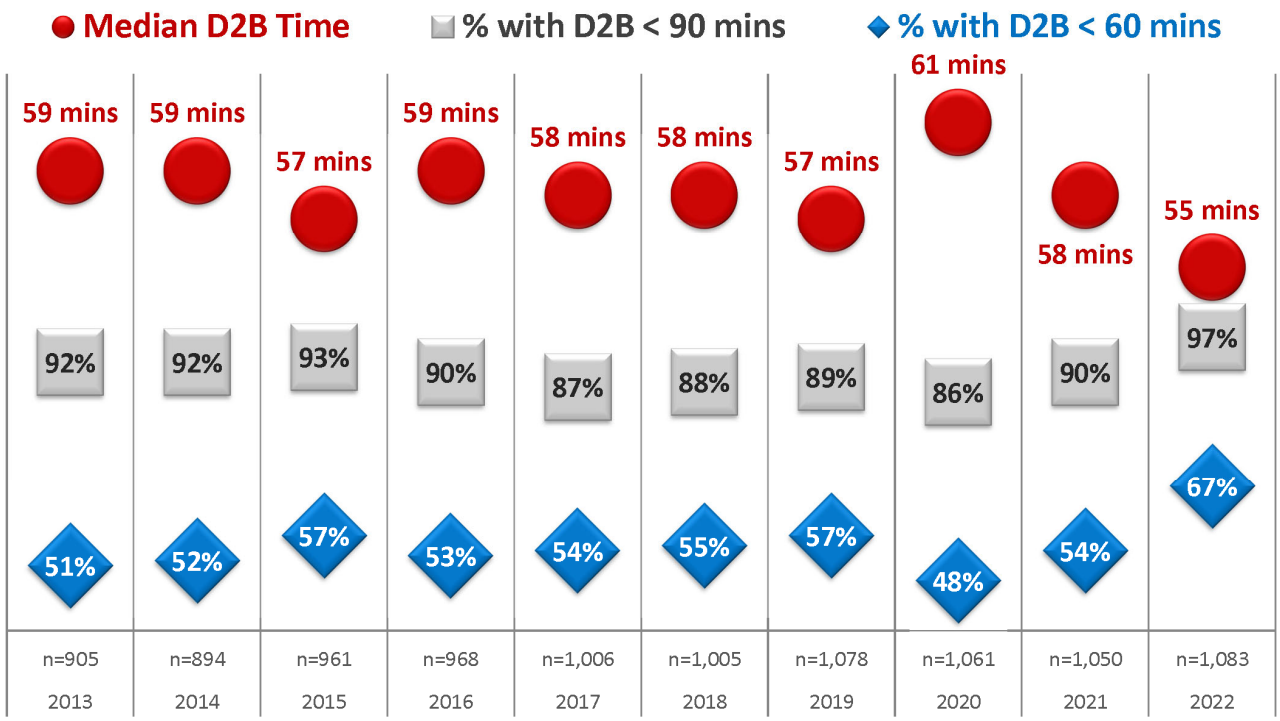




ST-Elevation Myocardial Infarction (STEMI)

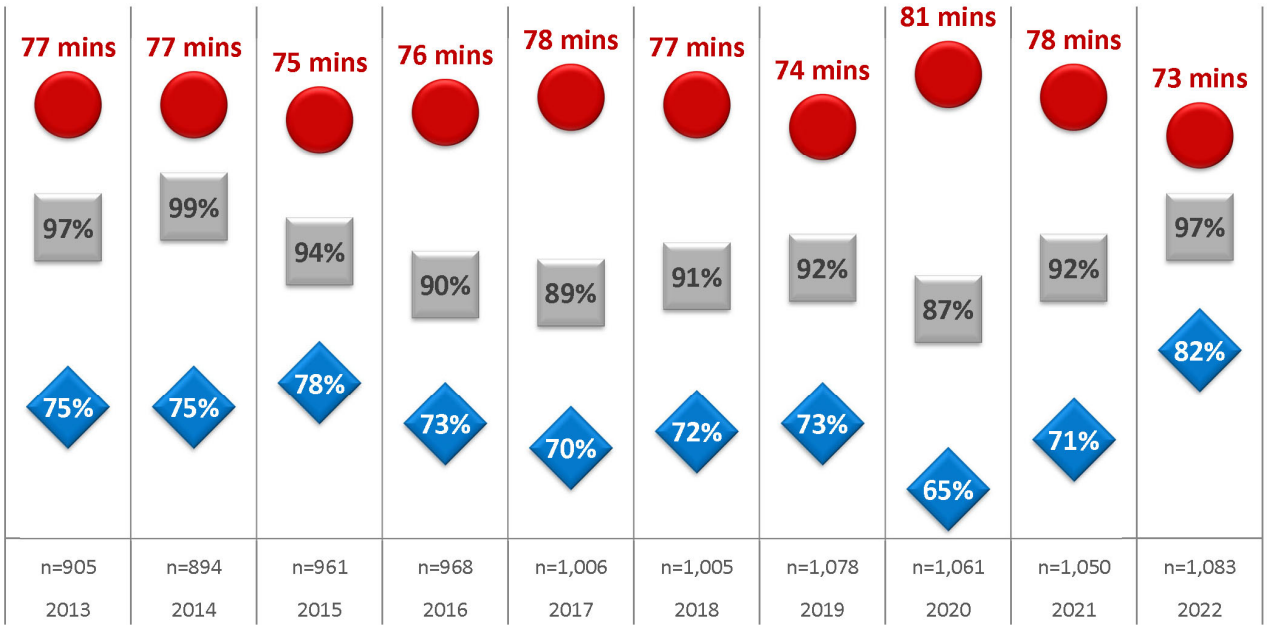
STEMI Receiving Center: Door-to-Device (D2B) Time

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



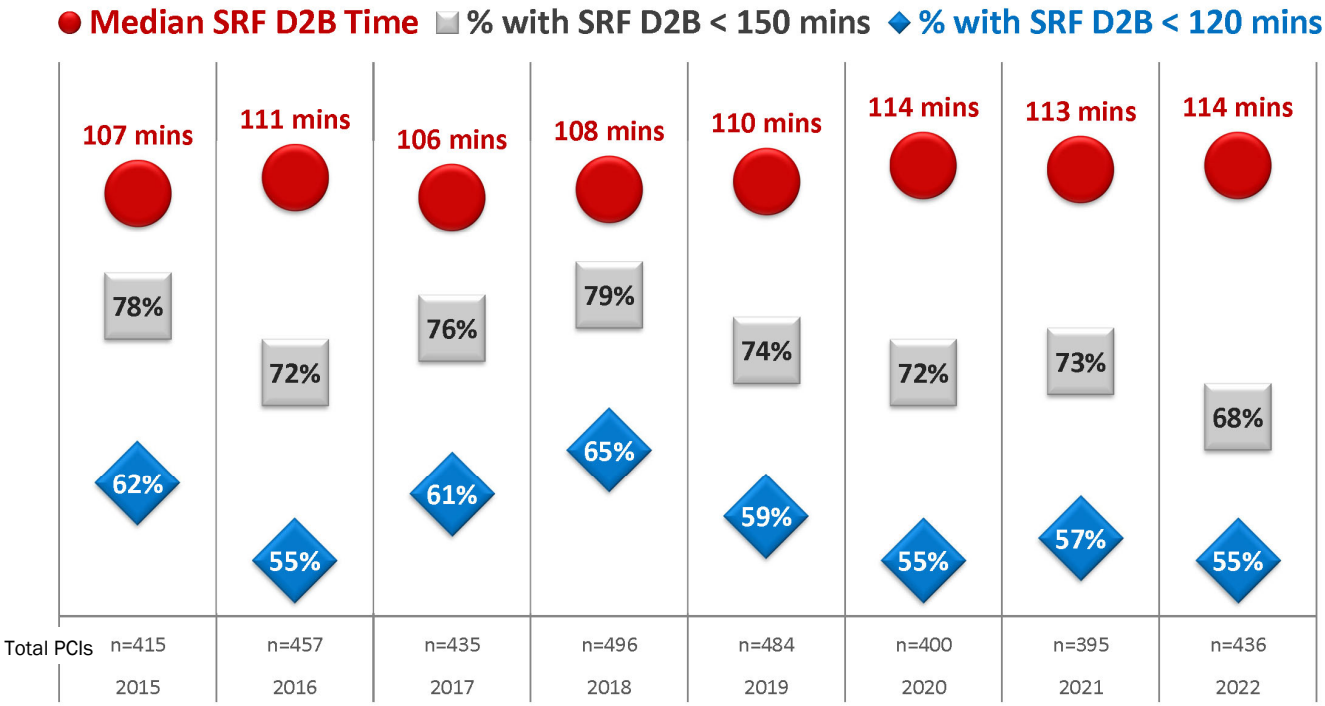
STEMI Receiving Center: EMS Medical Contact-to-Device (E2B) Time

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



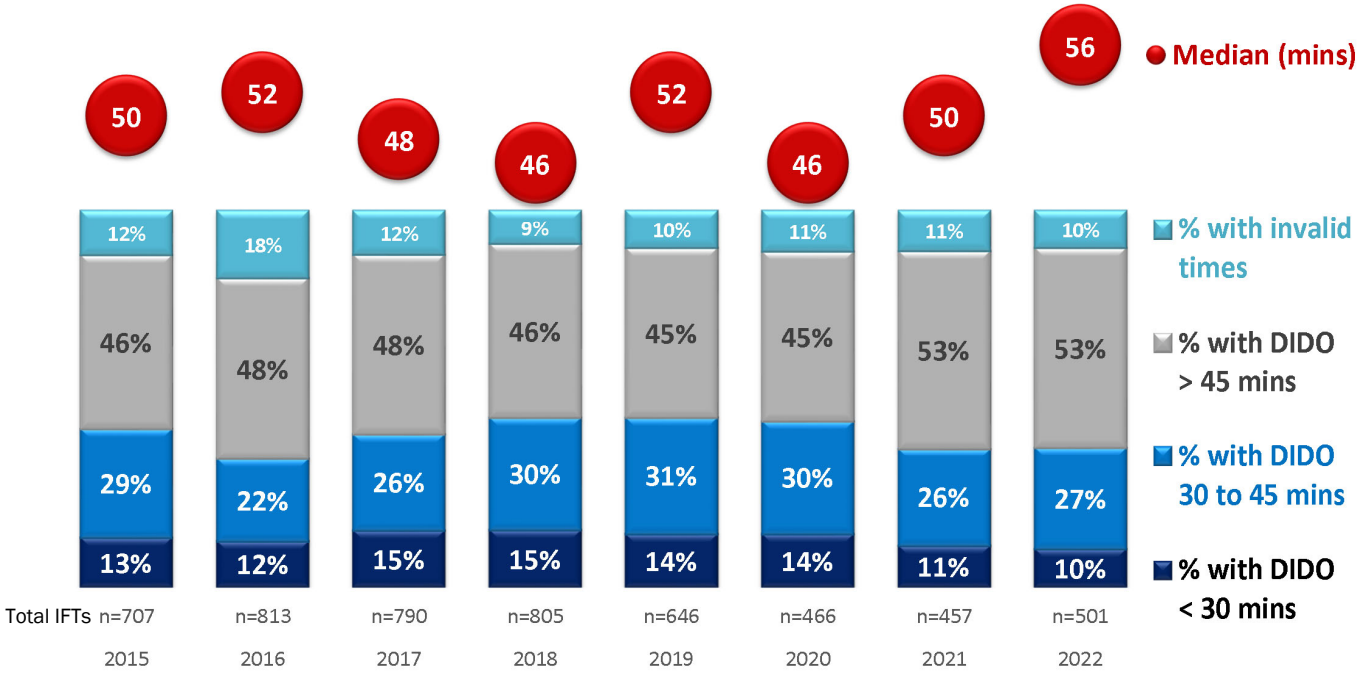
STEMI Referral Facility: Door-to-Device (D2B) Time

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



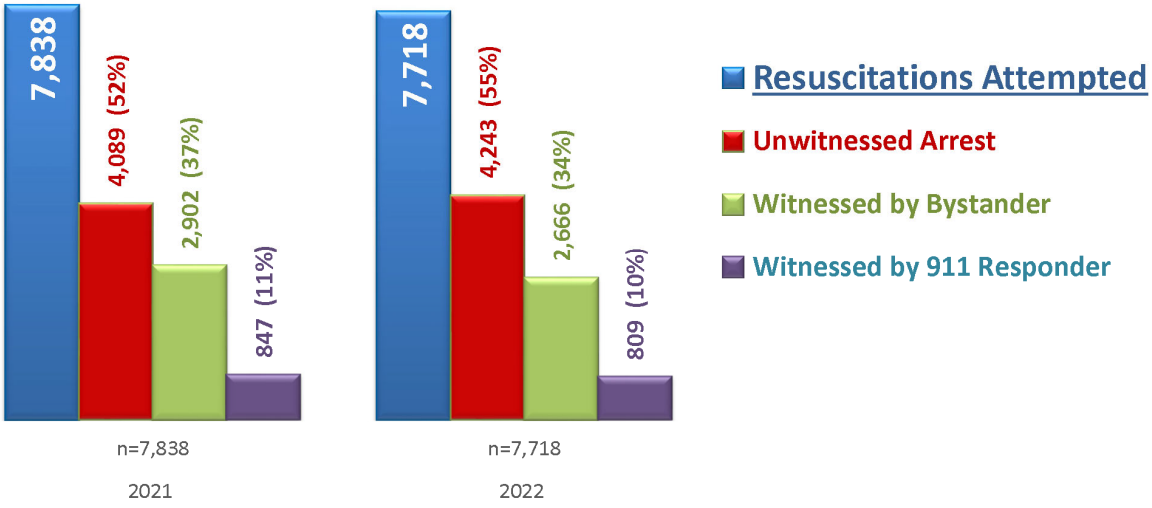
STEMI Referral Facility: Door-in Door-out (DIDO) Time

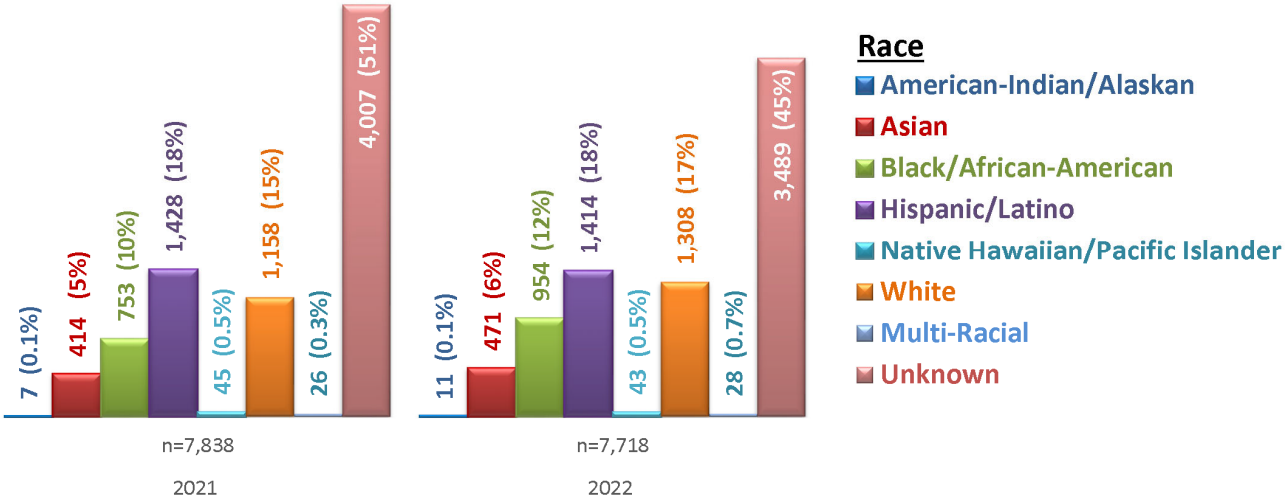
LA County Target: < 30 minutes

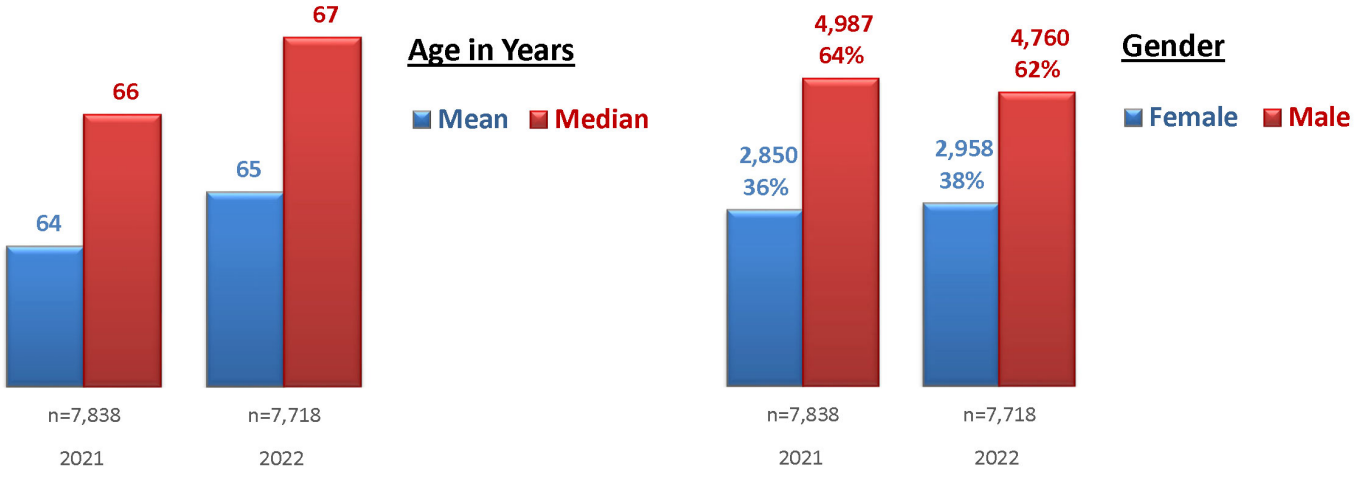


Out of Hospital Cardiac Arrest (OHCA)

Non-Traumatic Etiology

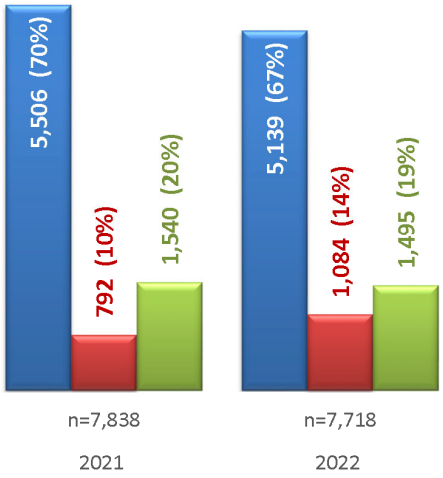




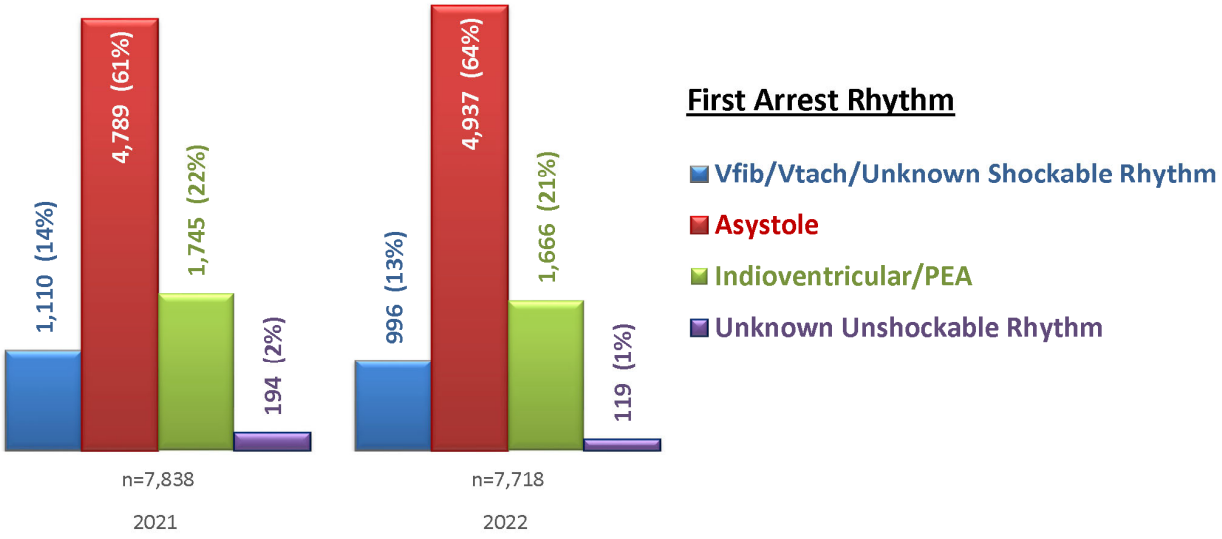


Data Source: Cardiac Arrest Registry to Enhance Survival

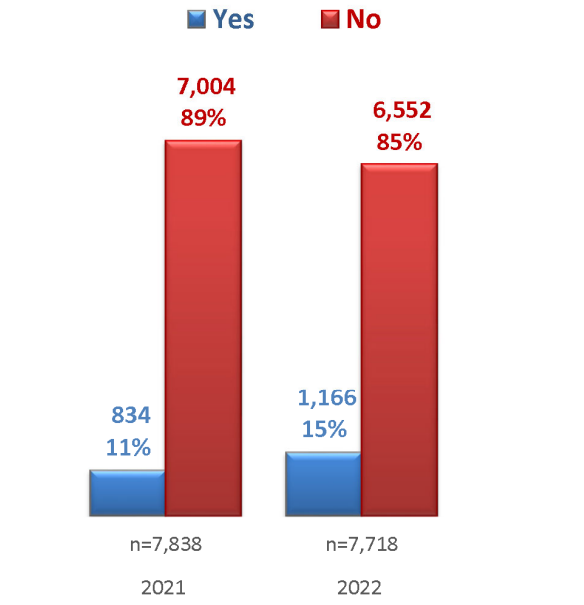
Arrest Location



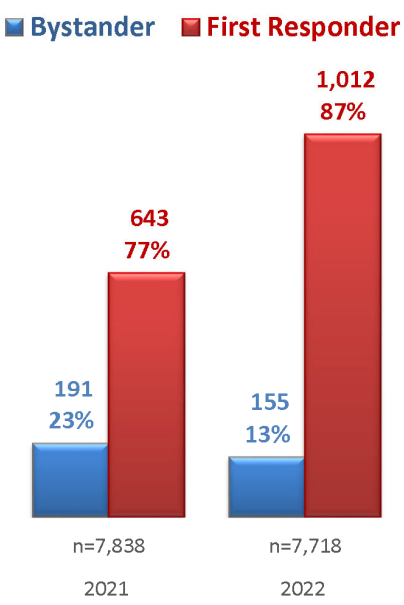
First Arrest Rhythm



Was an AED Applied prior to EMS Arrival?



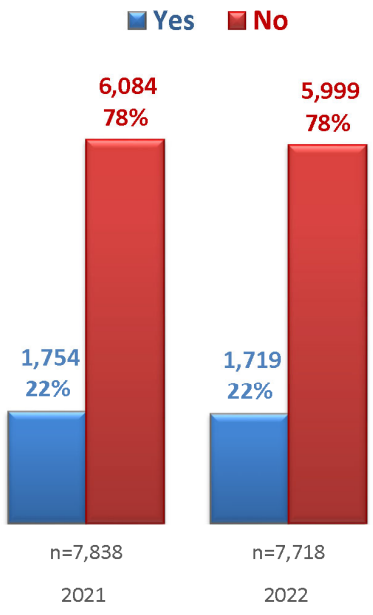
Who First Applied AED?



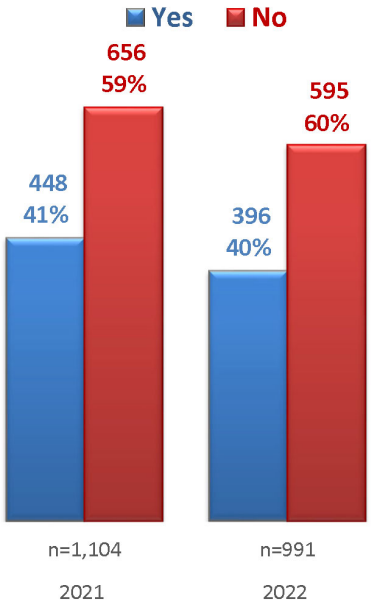
Out of Hospital Cardiac Arrest (OHCA)
Return of Spontaneous Circulation (ROSC)

Who Initiated CPR?

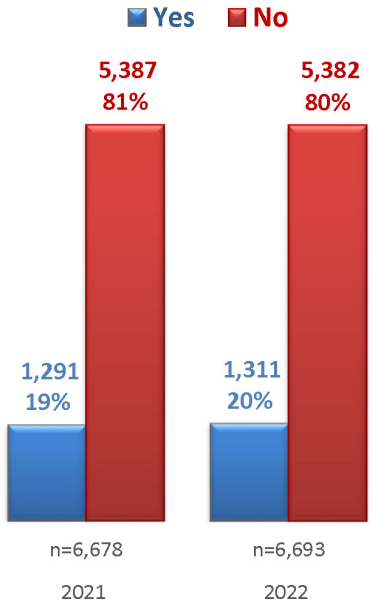
Sustained ROSC All Patients



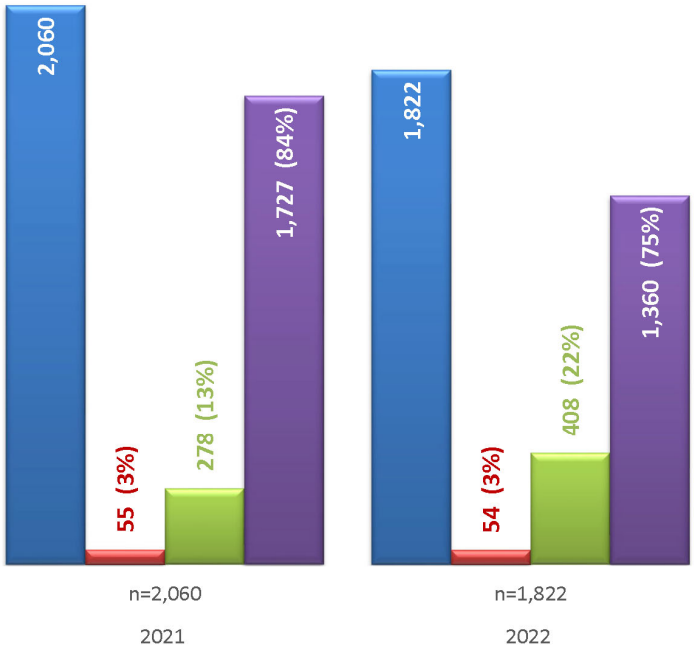
Sustained ROSC Shockable Rhythm



Sustained ROSC Non-Shockable Rhythm

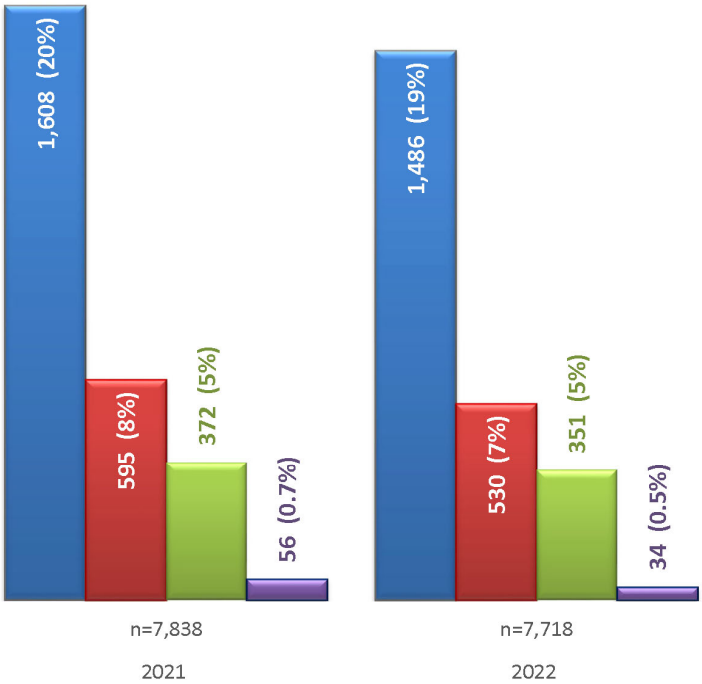


Data Source: Cardiac Arrest Registry to Enhance Survival



Who First Defibrillated the Patient?

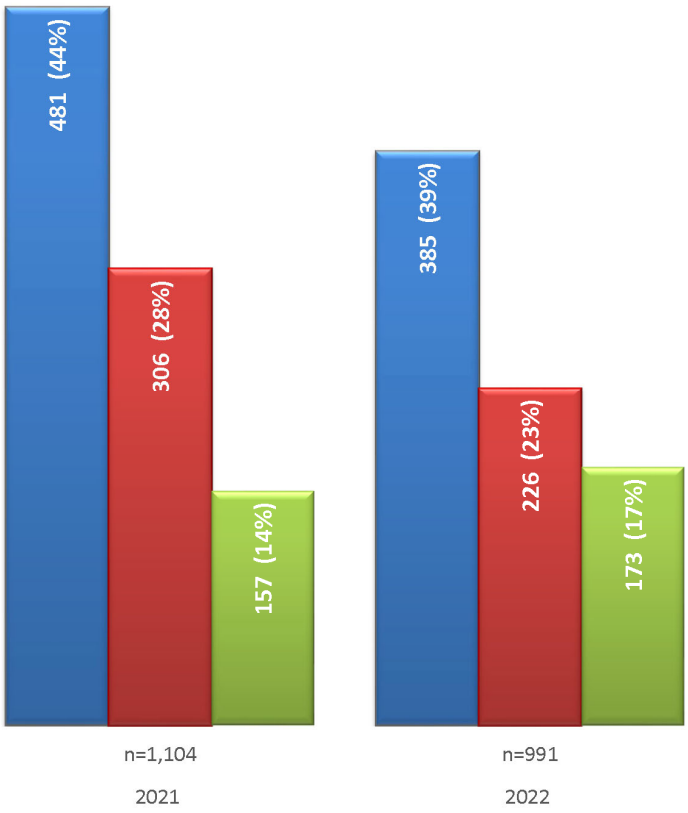
- Patients Defibrillated
- Bystander
- First Responder
- Responding EMS Personnel



Cardiac Arrest Outcome

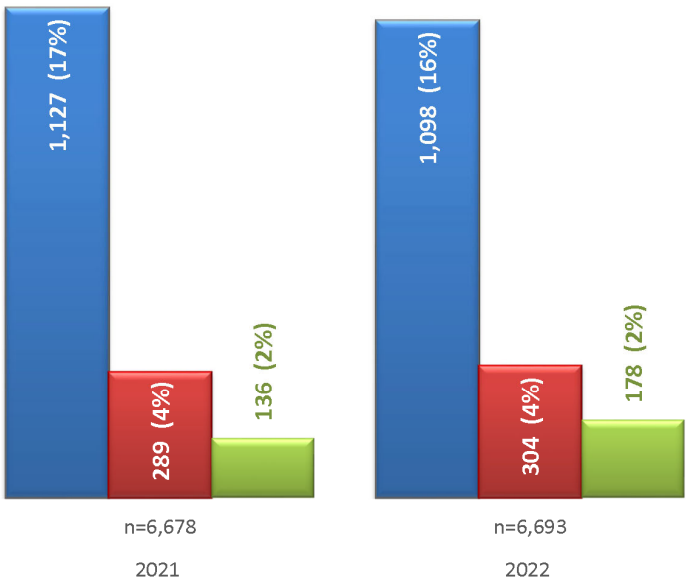
- Overall Survival to Hospital Admission
- Overall Survival to Hospital Discharge
- With Good or Moderate Cerebral Performance (CPC 1 or 2)
- Missing Hospital Outcome

Out of Hospital Cardiac Arrest (OHCA)



Cardiac Arrest Outcome: Shockable Rhythm

- Overall Survival to Hospital Admission
- Overall Survival to Hospital Discharge
- With Good or Moderate Cerebral Performance (CPC 1 or 2)

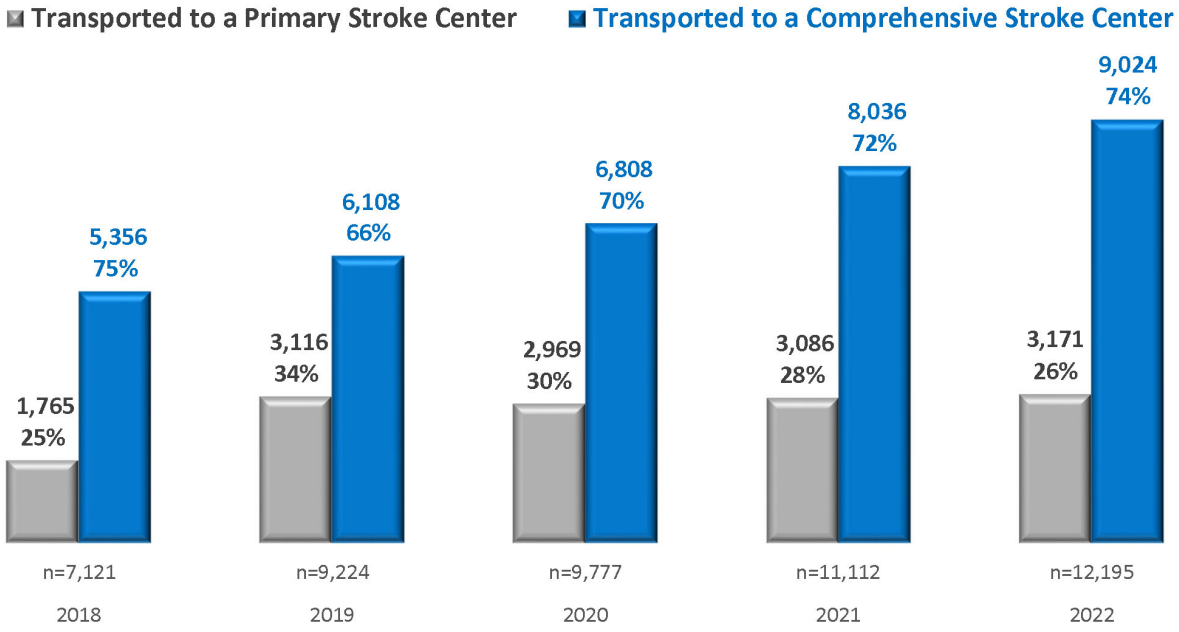


Cardiac Arrest Outcome: Non-Shockable Rhythm

- Overall Survival to Hospital Admission
- Overall Survival to Hospital Discharge
- With Good or Moderate Cerebral Performance (CPC 1 or 2)

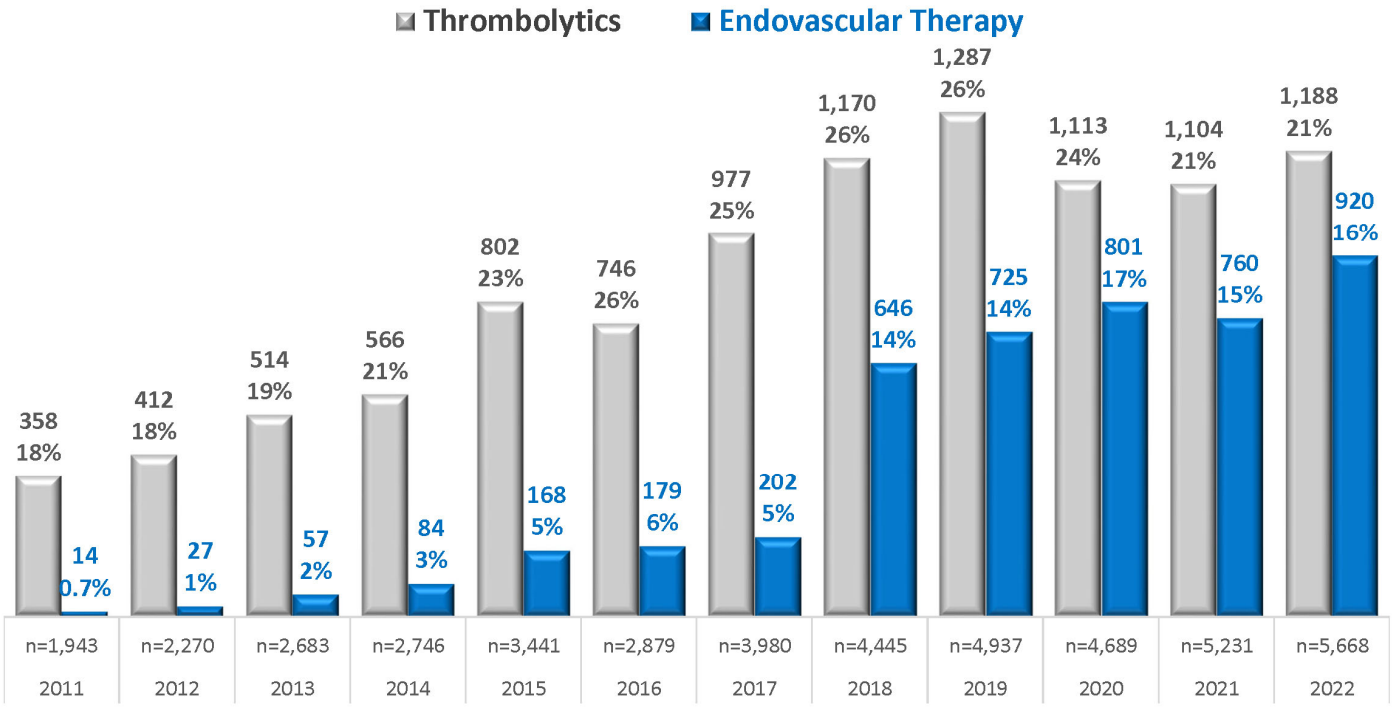
Suspected Stroke Patient Destination

The routing of suspected stroke patients with large vessel occlusions based on a Los Angeles Motor Scale (LAMS) score of 4 or 5 to designated Comprehensive Stroke Centers began on January 8, 2018.

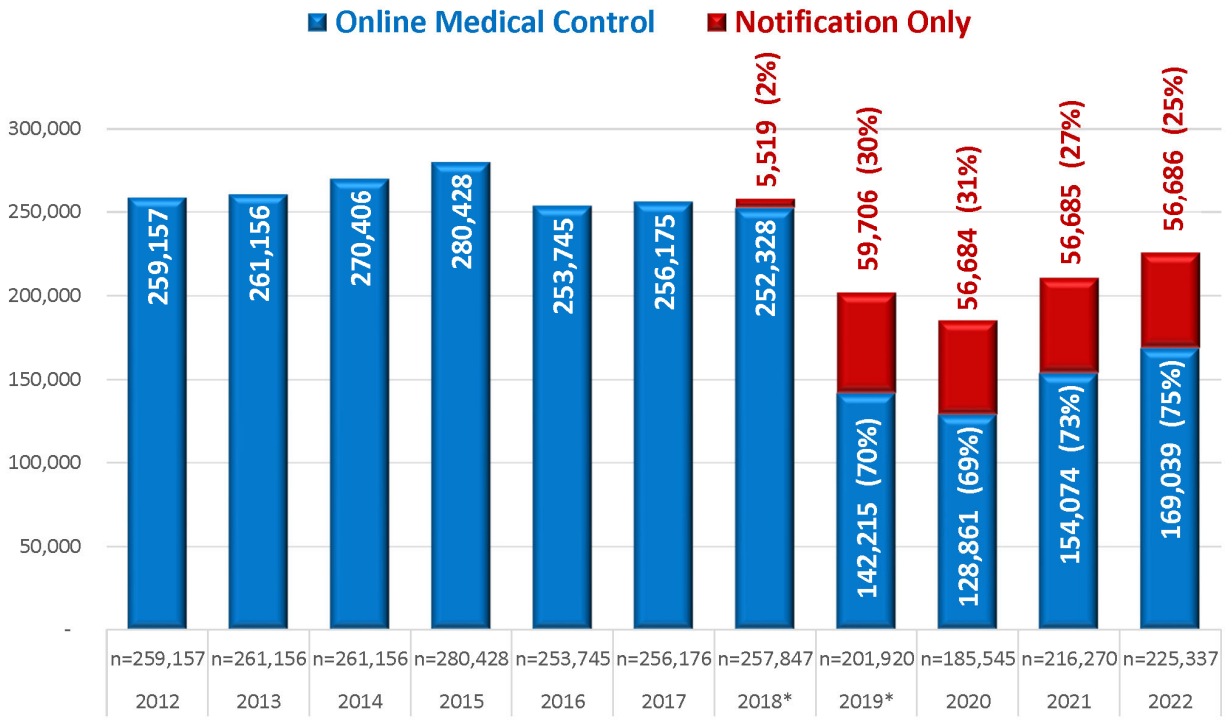


This chart is based on the Stroke Center Designation of the receiving facility, regardless of routing criteria.

Treatment—All Ischemic Stroke



Paramedic Base Hospital Contact



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

EMS AGENCY

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

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TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT

Reporting Year: **FISCAL YEAR 2022-2023**

NOTE: Number (1) below is to be completed for each county. The balance of Table 2 refers to each agency.

1. Percentage of population served by each level of care by county:
(Identify for the maximum level of service offered; the total of a, b, and c should equal 100 %.)

County: Los Angeles County

A.	Basic Life Support (BLS)	N/A %
B.	Limited Advanced Life Support (LALS)	N/A %
C.	Advanced Life Support (ALS)	100 %

2. Type of agency
   a) Public Health Department
   b) County Health Services Agency
   c) Other (non-health) County Department
   d) Joint Powers Agency
   e) Private Non-Profit Entity
   f) Other: _____

3. The person responsible for day-to-day activities of the EMS agency reports to
   a) Public Health Officer
   b) Health Services Agency Director/Administrator
   c) Board of Directors
   d) Other: _____

4. Indicate the non-required functions which are performed by the agency:

Implementation of exclusive operating areas (ambulance franchising)	X
Designation of trauma centers/trauma care system planning	X
Designation/approval of pediatric facilities	X
Designation of other critical care centers	X
Development of transfer agreements	X
Enforcement of local ambulance ordinance	X
Enforcement of ambulance service contracts	X
Operation of ambulance service	X
Continuing education	X
Personnel training	X
Operation of oversight of EMS dispatch center	
Non-medical disaster planning	
Administration of critical incident stress debriefing team (CISD)	

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)

Administration of disaster medical assistance team (DMAT)	
Administration of EMS Fund [Senate Bill (SB) 12/612]	X
Other: RDMHS	X
Other:	
Other:	

5. EXPENSES

Salaries and benefits (All but contract personnel)	$ 29,749,472
Contract Services (e.g. medical director)	
Operations (e.g. copying, postage, facilities)	
Travel (included in S&S expense)	
Fixed assets	976,634
Indirect expenses (overhead)	
Ambulance subsidy	
EMS Fund payments to physicians/hospital	9,116,408
Dispatch center operations (non-staff)	
Training program operations	
Other: S&S expense (includes Travel expense)	13,244,989
Other: S&S expense AIA	233,317
Other:	

**estimate final report not completed at time of this submission*

TOTAL EXPENSES	$ 53,320,820

6. SOURCES OF REVENUE

Special project grant(s) [from EMSA] *RDMHS*	$ 240,000
Preventive Health and Health Services (PHHS) Block Grant	
Office of Traffic Safety (OTS)	
State general fund	
County general fund	23,400,208
Other local tax funds (e.g., EMS district)	
County contracts (e.g. multi-county agencies)	
Certification fees	713,578
Training program approval fees	
Training program tuition/Average daily attendance funds (ADA)	341,942
Job Training Partnership ACT (JTPA) funds/other payments	
Base hospital application fees	

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)

Trauma center application fees	_____
Trauma center designation fees	_____
Pediatric facility approval fees	_____
Pediatric facility designation fees	_____
Other critical care center application fees	111,811
Type: Base Hospital	
Other critical care center designation fees	_____
Type: Comprehensive Stroke Center	
Other critical care center designation fees	647,784
Type: STEMI Receiving Center	1,069,188
Ambulance service/Vehicle fees	1,070,104
Contributions	_____
EMS Fund (SB 12/612 & SB 1773)	9,116,408
Other grants: Homeland Security, HPP, RDMHS	_____
Other fees: Various Other Revenue/Intrafund Transfer	7,972,191
Other (specify): HPP	8,637,606
TOTAL REVENUE	$ 53,320,820

TOTAL REVENUE SHOULD EQUAL TOTAL EXPENSES.
IF THEY DON'T, PLEASE EXPLAIN.

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)

7. Fee structure

_____ We do not charge any fees

__X___ Our fee structure is:

First responder certification	$ _____
EMS dispatcher certification	_____
EMT certification	190
EMT recertification	190
EMT-defibrillation certification	_____
EMT-defibrillation recertification	_____
AEMT certification	_____
AEMT recertification	_____
EMT-P accreditation	155
EMT-P re-accreditation	155
Mobile Intensive Care Nurse/Authorized Registered Nurse certification	142
MICN/ARN recertification	96
EMT training program approval	_____
AEMT training program approval	_____
EMT-P training program approval	_____
MICN/ARN training program approval	_____
Base hospital application	_____
Base hospital designation	15,973
Trauma center application	_____
Trauma center designation	_____
Pediatric facility approval	_____
Pediatric facility designation	_____
Other critical care center application	
Type: Comprehensive Stroke Center Fee	26,991
Other critical care center designation	
Type: STEMI Receiving Center Fee	31,066
Ambulance service license - New	4,846.17
Ambulance service license - Renewal	2,923.43
Ambulance vehicle permit - New	373.86
Ambulance vehicle permit - Renewal	339.55
Other: Ambulette Operator - New	4,846.17
Other: Ambulette Operator - Renewal	2,923.43
Other: Ambulette Vehicle Permit - New	361.72
Other: Ambulette Vehicle Permit - Renewal	327.41

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)

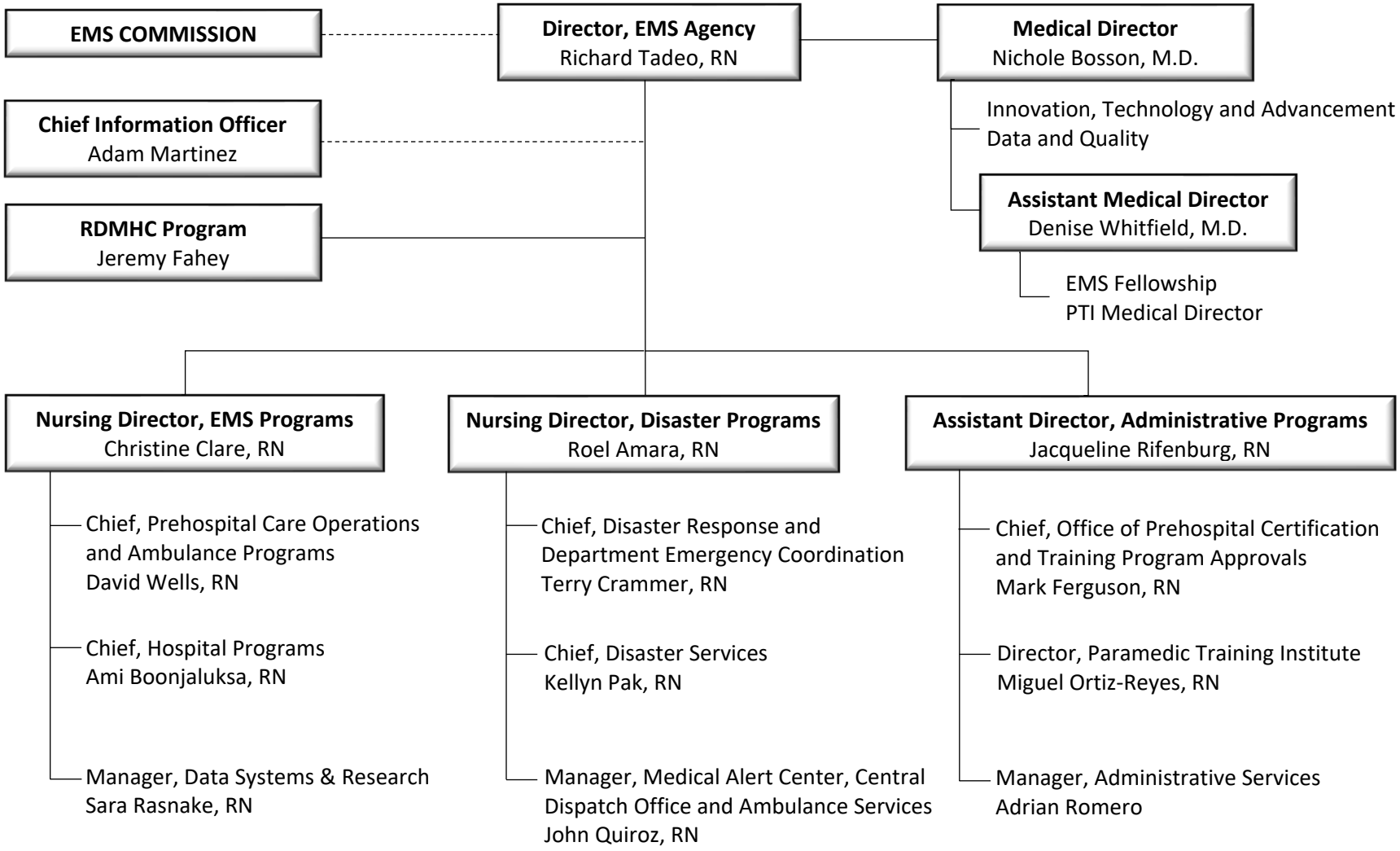
CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	BENEFITS (51.55 %of Salary)	COMMENTS
EMS Admin./Coord./Director	EMERGENCY MEDICAL SERVICES DIRECTOR	1	106.97	75.61	
Asst. Admin./Admin. Asst./Admin. Mgr.	EMERGENCY MEDICAL SERVICES ASSISTANT DIRECTOR	1	94.23	66.61	
ALS Coord./Field Coord./Trng Coordinator	NURSING DIRECTOR, ADMINISTRATION ASSISTANT NURSING DIRECTOR ADMINISTRATION	1 1	104.36 77.59	73.77 54.85	
Program Coordinator/Field Liaison (Non-clinical)	ASSISTANT NURSING DIRECTOR, ADMINISTRATION	1	77.59	54.85	
Trauma Coordinator	SENIOR NURSING INSTRUCTOR	1	89.43	63.29	
Medical Director	MEDICAL DIRECTOR II	1	238.88	168.86	
Other MD/Medical Consult/Training Medical Director	CHIEF PHYSICIAN, ASSISTANT MEDICAL DIRECTOR	1	198.78	140.51	
Disaster Medical Planner	SENIOR PHYSICIAN EMERGENCY MEDICINE NURSING DIRECTOR, ADMINISTRATION	2	199.66 104.36	141.14 75.11	Dr. Whitfield Roel Amara

TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)

Dispatch Supervisor	PATIENT TRANSPORTATION SUPERVISOR	1	106.26	75.11	
Medical Planner (not applicable)					
Data Evaluator/Analyst	NURSE MANAGER	1	72.77	51.44	
QA/QI Coordinator	SENIOR NURSING INSTRUCTOR	1	88.12	62.29	
Public Info. & Education Coordinator	ASSISTANT NURSING DIRECTOR, ADMINISTRATION	1	83.04	56.46	
Executive Secretary	MANAGEMENT SECRETARY III	1	42.23	29.85	
Other Clerical	SENIOR CLERK; INTERMEDIATE CLERK; INTERMEDIATE TYPIST CLERK	6	27.36	19.34	
Data Entry Clerk	INTERMEDIATE TYPIST-CLERK	2	23.54	16.01	
Other	VARIOUS	180	VARIOUS	VARIOUS	

Include an organizational chart of the local EMS agency and a county organization chart(s) indicating how the LEMSA fits within the county/multi-county structure.

LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES AGENCY
ORGANIZATIONAL CHART
August 30, 2023



Approved by: Richard Tadeo _____
Director, EMS Agency

DEPARTMENT OF HEALTH SERVICES
Organizational Chart

Health Services
LOS ANGELES COUNTY

Director
Department of Health Services
Christina R. Ghaly, MD

- Chief Deputy Director, Clinical Affairs — ***Hal F. Yee, Jr, MD, PhD***
  - Associate Chief Medical Officer — ***Paul Giboney, MD***
  - Director Medical Affairs — ***Michael Owens, MD***
  - Chief Health Information Officer — ***Phillip Gruber, MD***
  - Chief Pharmacy Officer — ***Jean Pallares, PharmD***
  - Chief Academic Officer — ***Darrell Harrington, MD***
  - Director Pediatric Services — ***Shannon Thyne, MD***
  - System Chief Nursing Officer — ***Aries Limbaga, DNP, MBA***
  - Director Emergency Medical Services — ***Richard Tadeo, RN***
  - Director Pt. Safety and Clinical Risk Management — ***Arun Patel, MD***
  - Medical Director Radiology Services — ***Jack Brunner, MD***
  - Director Strategy and Operations, Diagnostic Services — ***Mala Nanda, MBA***
  - Director Specialty Mental Health Services — ***Jacqueline Yu***
- Chief Information Officer — ***Kevin Lynch***
  - Associate Chief Information Officer — ***Susan Aintablian***
  - Chief Information Security Officer — ***Jeff Zito***
  - Chief Technology Officer — ***Jeff Bowlick***
  - Chief Enterprise Clinical Services — ***Arsalan Rahmanian***
  - Chief IT Administration and Enterprise Projects — ***Laura Williams***
  - Facility and Program CIOs
- Director Patient Access — ***Shari Doi***
  - Director Language Access and Inclusion — ***Erika Flores Uribe, MD***
  - Manager Central Contact Center — ****Rony Tanchez***
  - Director Medical Management and Transfer Center — ***Peter Balingit, MD***
  - Director, Patient Engagement and Medical Director, Nurse Advice Line — ***Anshu Abhat, MD***
  - Chief Patient Financial Services — ****Sofia Hurtado***
  - Director PAC Strategic Development — ***Vanna Tran***
  - Facility Patient Access Center Directors
- Director EDIA — ***Danielle M. Gautt***
  - Chief Wellness Officer — ****Vacant***
  - Facility Chief Engagement and Equity Officers
- Director Community Programs — ***Clemens Hong, MD***
  - Director Housing for Health — ***Sarah Mahin***
  - Director Office of Diversion and Re-entry — ****Clemens Hong, MD***
  - Chief Operating Officer Community Programs — ***Anna Gorman***
- Chief Deputy Director Population Health — ***Nina J. Park, MD***
  - Director Patient and Social Support Services — ***Charmaine Dorsey, MSW, LCSW***
  - Chief Analytics Officer — ***Trisha Mitra-Nedic***
  - Director Primary Care — ****Nina J. Park, MD***
    - Facility Primary Care Directors
  - Chief Nursing Officer Population Health and Outpatient Services — ***Debra Duran, RN***
  - Director Care Delivery Transformation — ***Belinda Waltman, MD***
  - Director Plan Partnerships and Payer Strategies — ***Maria Calleros***
- Chief Financial Officer — ***Allan Wecker***
  - Associate Chief Financial Officer — ***Roza Sakzlyan***
  - Chief Financial Strategy — ****Vacant***
  - Chief Financial Planning and Programs — ***Ferris Ling***
  - Clinical Project Manager — ***Roger J. Lewis, MD***
- Administrative Deputy — ***Elizabeth Jacobi***
  - Director Communications — ***Coral Itzcalli***
  - Director Contracts and Grants — ***Julio C. Alvarado***
  - Chief Supply Chain Network — ***Jason Ginsberg***
  - Director Capital Projects — ***Stephen Scott***
  - Director Security Coordination — **** Catherine Mathers***
  - Director Facilities Operations — **** Stephen Scott***
  - Director Human Resources Operations — ***Marilyn Hawkins***
  - Director Organizational Development — ***Joshua Rutkoff***
  - Director Competency — ***Karen Wunch, RN***
  - Director Risk Management — ***Catherine Mathers***
  - Provost College of Nursing and Allied Health — ***Vivian Branchick, RN***
  - Assistant County Counsel and Chief Legal Advisor — ***Sharon Reichman***

Ambulatory Care Network CEO — ***Quentin O'Brien***	Director Correctional Health Services — ***Timothy G. Belavich, PhD***	Harbor-UCLA MC CEO — ***Andrea Turner***	LA General MC CEO — ***Jorge Orozco, PT***	OV-UCLA MC CEO — ***Konita Wilks, DDS***	Rancho Los Amigos NRC CEO — ***Aries Limbaga, DNP, MBA***
CMO — ***Margarita Pereyda, MD***	CMO — ***Sean Henderson, MD***	CMO — ***Griselda Gutierrez, MD***	CMO — ***Brad Spellberg, MD***	CMO — ***Benjamin Waterman, MD***	CMO — ***Barry Jordan, MD***
CNO — ***Armenui Telliyan, RN***	CNO — ***Edward W. Matzen, RN***	CNO — ***Jason Black, RN***	CNO — ***Nancy Blake, PhD, RN***	CNO — ***Kimmalo Wright, RN***	CNO — ***Michelle Sterling, RN***
COO — ***Valerie Ojeda***	COO — ***Rhonda Bean***	COO — ***Azar Kattan***	COO — ***Edgar Solis, RN***	COO — ***Jessica Kuo, PharmD***	COO — ***Ben Ovando***
CFO — **** Efrain Muñoz***		CFO — ***Rosita Banuelos***	CFO — ***Efrain Muñoz***	CFO — ***Dave Young***	CFO — **** Rocio Calderon***

Christina R. Ghaly, MD
Director

Date

**** Acting/Interim***
**** Vacant***

Los Angeles County-Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN 2023
(Fiscal Year 2022-2023)

TABLE 3: STAFFING/TRAINING

NOTE: Table 3 is to be reported by agency.

	EMT	AEMT	Paramedic	MICN
Total Certified	8136	Not Applicable	Not Applicable	829
Number newly certified this year	1591	Not Applicable	Not Applicable	93
Number recertified this year	2078	Not Applicable	Not Applicable	278
Total number of accredited personnel on July 1 of the reporting year	N/A	Not Applicable	4489	Not Applicable
Number of certification reviews resulting in:				
a) formal investigations	79	Not Applicable	N/A	0
b) probation	7	Not Applicable	0	0
c) suspensions	0	Not Applicable	0	0
d) revocations	4	Not Applicable	N/A	0
e) denials	2	Not Applicable	N/A	0
f) denials of renewal	0	Not Applicable	N/A	0
g) no action taken	44	Not Applicable	0	0

1. Early defibrillation:
   a) Number of EMTs authorized to use AEDs 13,084
   b) Number of public safety AED service provider personnel (non-EMT) 4,393

2. Do you have an EMR training program No

Los Angeles County – Department of Health Services
EMERGENCY MEDICAL SERVICES
ANNUAL EMS PLAN UPDATE
(Fiscal Year 2022-2023)

TABLE 4: COMMUNICATIONS

Note: Table 4 is to be answered for each county.

1. Number of primary Public Service Answering Points (PSAP)	**96**
2. Number of secondary PSAPs	**6**
3. Number of dispatch centers directly dispatching ambulances	**36 Private** **11 Public**
4. Number of EMS dispatch agencies utilizing EMD guidelines	**10**
5. Number of designated dispatch centers for EMS Aircraft	**3**
6. Who is your primary dispatch agency for day-to-day emergencies? Department on origin of call: • **Beverly Hills Police Department** • **Downey Fire Communication** • **Los Angeles County Fire** • **Long Beach Fire Department** • **Los Angeles Fire Department** • **Redondo Beach Police Department** • **Santa Monica Fire Department** • **South Bay Regional Public Communication Authority** • **Torrance Police Department** • **Verdugo Fire Communication** • **West Covina Police Department**	
7. Who is your primary dispatch agency for a disaster? **Los Angeles County Fire District is the Fire Operations Area Coordinator**	
8. Do you have an operational area disaster communication system? a. Radio primary frequency **155.340 MHz** b. Other methods **Landline, cell phones, Internet ReddiNet, satellite phones and amateur radio (HAM)**	☑ Yes ☐ No

c. Can all medical response units communicate on the same disaster communications system?	☑ Yes ☐ No
d. Do you participate in the Operational Area Satellite Information System (OASIS)?	☐ Yes ☑ No
e. Do you have a plan to utilize the Radio Amateur Civil Emergency Services (RACES) as a back-up communication system?	☑ Yes ☐ No
1) Within the operational area?	☑ Yes ☐ No
2) Between operation area and the region and/or state?	☑ Yes ☐ No

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES
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TABLE 5: RESPONSE/TRANSPORTATION (Reported by the provider agency)

Early Defibrillation Providers

1. Number of EMT-Defibrillation providers Not reported

SYSTEM STANDARD RESPONSE TIMES (90TH PERCENTILE)

The following table lists dispatch information for **Verdugo Dispatch Center** who dispatches the following providers: **Alhambra, Arcadia, Burbank, Glendale, Monrovia, Montebello, Monterey Park, Pasadena, San Gabriel, San Marino, Sierra Madre, and South Pasadena.**

	METRO/URBAN	SUBURBAN/ RURAL	WILDERNESS	SYSTEMWIDE
BLS and CPR capable first responder	6:52 min.	Not Applicable	Not Applicable	
Early defibrillation responder	6:52 min.	Not Applicable	Not Applicable	
Advanced life support responder	6:57 min.	Not Applicable	Not Applicable	
Transport Ambulance	7:12 min.	Not Applicable	Not Applicable	

The following table lists dispatch data for **Los Angeles Fire Department:**

	METRO/URBAN	SUBURBAN/ RURAL	WILDERNESS	SYSTEMWIDE
BLS and CPR capable first responder	9:01 min.	Not Applicable	Not Applicable	
Early defibrillation responder	9:01 min.	Not Applicable	Not Applicable	
Advanced life support responder	8:32 min.	Not Applicable	Not Applicable	
Transport Ambulance	9:52 min.	Not Applicable	Not Applicable	

The following table list dispatch data for **Long Beach Fire Department:**

	METRO/URBAN	SUBURBAN/ RURAL	WILDERNESS	SYSTEMWIDE
BLS and CPR capable first responder	10:07 min.	Not Applicable	Not Applicable	
Early defibrillation responder	10:07 min.	Not Applicable	Not Applicable	
Advanced life support responder	10:01 min.	Not Applicable	Not Applicable	
Transport Ambulance	15:44 min.	Not Applicable	Not Applicable	

The following table lists dispatch data for **Los Angeles County Fire Department** (also dispatches La Habra Heights Fire Department, and Los Angeles County Sheriff)

	METRO/URBAN	SUBURBAN/ RURAL	WILDERNESS	SYSTEMWIDE
BLS and CPR capable first responder	8:21 min.	Not Applicable	Not Applicable	
Early defibrillation responder	8:18 min.	Not Applicable	Not Applicable	
Advanced life support responder	8:14 min.	Not Applicable	Not Applicable	
Transport Ambulance	Not Applicable	Not Applicable	Not Applicable	

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES
ANNUAL EMS PLAN UPDATE
(Fiscal Year 2022-2023)

TABLE 6: SYSTEM RESOURCES AND OPERATIONS - Facilities/Critical Care

NOTE: Table 6 is to be reported by agency.

Trauma

Trauma Patients:

1. Number of patients meeting trauma triage criteria	**24,970**
2. Number of major trauma victims transported directly to a trauma center by ambulance	**21,007**
3. Number of major trauma patients transferred to a trauma center	**1,620**
4. Number of patients meeting trauma triage criteria who weren't treated at a trauma center	**1,752**

Emergency Departments

Total number of emergency departments	**69**
1. Number of referral emergency services	**0**
2. Number of standby emergency services	**1**
3. Number of basic emergency services	**67**
4. Number of comprehensive emergency services	**2**

(Los Angeles General Medical Center and Ronald Reagan UCLA Medical Center)

Receiving Hospitals

1. Number of receiving hospitals with written agreements	**69**
2. Number of base hospitals with written agreements	**21**

TABLE 7: SYSTEM RESOURCES AND OPERATIONS - Disaster Medical

SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
   a. Where are your CCPs located?
      Fire Department establishes field treatment sites near the incident.
   b. How are they staffed?
      Prehospital Care Personnel.
   c. Do you have a supply system for supporting them for 72 hours? **Yes** No

2. CISD –
   Do you have a CISD provider with 24-hour capability? Yes **No**

   NOTE: The EMS Agency will coordinate with LA County Department of Mental Health to address mental health and behavioral issues related to disasters.

3. Medical Response Team*
   a. Do you have any team medical response capability Yes **No** NKA
   b. For each team, are they incorporated into your local response plan? Yes No **NKA**
   c. Are they available for statewide response? Yes No **NKA**
   d. Are they part of a formal out-of-state response system? Yes No **NKA**

4. Hazardous Materials
   a. Do you have any HazMat trained medical response teams? **Yes** No
   b. At what HazMat level are they trained? **LA County has fire department HazMat teams trained at the technician and specialist levels and are able to operate in Level A, B and C. Hospital decontamination teams are first receivers and can operate in level C PAPRs**.
   c. Do you have the ability to do decontamination in an emergency room? **Yes** No
   d. Do you have the ability to do decontamination in the field? **Yes** No

OPERATIONS

1.	Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure?	**Yes**	No
2.	What is the maximum number of local jurisdictions EOCs you will need to interact with in a disaster?	1	
3.	Have you tested your MCI Plan this year in a:	**Yes**	No
	a. real event?	**Yes**	No
	b. exercise?	**Yes**	No
4.	List all counties with which you have a written medical mutual aid agreement. *(Region I-Orange, Ventura, Santa Barbara, San Luis Obispo, and Region VI-Inyo, Mono, San Bernardino, Imperial and San Diego counties).*		
5.	Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response?	**Yes**	No
6.	Do you have formal agreements with community clinics in your operational areas to participate in disaster planning and response?	**Yes**	No
7.	Are you part of a multi-county EMS system for disaster response?	Yes	**No**
8.	Are you a separate department or agency?	Yes	**No**
9.	If not, to whom do you report? **LA County Department of Health Services (DHS)**		
10.	If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department?	**Yes**	No

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

ANNUAL UPDATE 2023
(Fiscal Year 2022-2023)

Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Alhambra Fire Department **Response Zone:** Alhambra

Address: 301 North First Street
Alhambra, CA 91801

Phone Number: 626-570-5190

Number of Ambulance Vehicles in Fleet: 3

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 2

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

5,075	Total number of responses	3,902	Total number of transports
5,037	Number of emergency responses	3,788	Number of emergency transports
38	Number of non-emergency responses	114	Number of non-emergency transports

Air Ambulance Services

N/A	Total number of responses	N/A	Total number of transports
N/A	Number of emergency responses	N/A	Number of emergency transports
N/A	Number of non-emergency responses	N/A	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** All Town Ambulance, LLC **Response Zone:** Countywide (Non-9-1-1)

Address: 7755 Haskell Avenue
Van Nuys (City of Los Angeles) CA 91406

Phone Number: (877) 599-4282

Number of Ambulance Vehicles in Fleet: 40

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 35

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

36192	Total number of responses
20	Number of emergency responses
36172	Number of non-emergency responses

35107	Total number of transports
18	Number of emergency transports
35089	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Ambulife Ambulance, Inc. **Response Zone:** Countywide (Non-9-1-1)

Address: 6644 Van Nuys Boulevard #B
Van Nuys (City of Los Angeles) CA 91405

Phone Number: (877) 557-7888

Number of Ambulance Vehicles in Fleet: 12

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 8

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

12680	Total number of responses	12295	Total number of transports
76	Number of emergency responses	76	Number of emergency transports
12604	Number of non-emergency responses	12219	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Ambulnz Health, LLC **Response Zone:** Countywide (Non-9-1-1)

Address: 1907 Border Avenue
Torrance 90501

Phone Number: (877) 311-5555

Number of Ambulance Vehicles in Fleet: 10

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 0

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

4359	Total number of responses	4229	Total number of transports
0	Number of emergency responses	0	Number of emergency transports
4359	Number of non-emergency responses	4229	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Ambuserve, Inc. **Response Zone:** Countywide (Non-9-1-1)

Address: 15105 South Broadway Avenue
Gardena (Unincorporated Rosewood) 90248

Number of Ambulance Vehicles in Fleet: 23

Phone Number: (310) 664-0500

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 16

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

15780	Total number of responses	15307	Total number of transports
65	Number of emergency responses	59	Number of emergency transports
15715	Number of non-emergency responses	15248	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles

Provider: American Medical Response, Inc.

Response Zone: EOA 1
(North County)
3 incorporated cities
47 unincorporated areas

Address: 12634 Saticoy Street South
North Hollywood (City of Los Angeles) 91605

Phone Number: (626) 636-4612

Number of Ambulance Vehicles in Fleet: 119

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 75

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

79915	Total number of responses	51684	Total number of transports
76464	Number of emergency responses	48336	Number of emergency transports
3451	Number of non-emergency responses	3348	Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** American Professional Ambulance, Corp. **Response Zone:** Countywide (Non-9-1-1)

Address: 16945 Sherman Way
Van Nuys (City of Los Angeles) CA 90746

Phone Number: (818) 996-2200

Number of Ambulance Vehicles in Fleet: 33

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 22

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

30924	Total number of responses	29927	Total number of transports
12	Number of emergency responses	12	Number of emergency transports
30912	Number of non-emergency responses	29915	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Amwest Ambulance **Response Zone:** Countywide (Non-9-1-1)

Address: 13257 Saticoy Street
North Hollywood (City of Los Angeles) 91605

Number of Ambulance Vehicles in Fleet: 33

Phone Number: (818) 859-7999

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 23

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

31183	Total number of responses	30248	Total number of transports
22	Number of emergency responses	20	Number of emergency transports
31161	Number of non-emergency responses	30228	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Antelope Ambulance Service, Inc. **Response Zone:** Countywide (Non-9-1-1)

Address: 42540 North 6th Street East
Lancaster, CA 93535

Phone Number: (661) 951-1988

Number of Ambulance Vehicles in Fleet: 9

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 6

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

12984	Total number of responses
3360	Number of emergency responses
9624	Number of non-emergency responses

12595	Total number of transports
2520	Number of emergency transports
10075	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Arcadia Fire Department **Response Zone:** City of Arcadia

Address: 710 S Santa Anita Ave
Arcadia CA 91006

Number of Ambulance Vehicles in Fleet: 3

Phone Number: (626)574-5100

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 2

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

4132	Total number of responses	3143	Total number of transports
4132	Number of emergency responses	3133	Number of emergency transports
0	Number of non-emergency responses	10	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Beverly Hills Fire Department **Response Zone:** City of Beverly Hills

Address: 445 North Rexford Drive
Beverly Hills CA 90210

Phone Number: (310) 281-2733

Number of Ambulance Vehicles in Fleet: 6 (5 ALS + 1 BLS)

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 5

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport; ☒ ALS ☒ BLS ☐ LALS; ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT; ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

5466	Total number of responses	2812	Total number of transports
5466	Number of emergency responses	2812	Number of emergency transports
0	Number of non-emergency responses	0	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Burbank Fire Department **Response Zone:** City of Burbank

Address: 311 E. Orange Grove Avenue
Burbank CA 91502

Phone Number: (818) 238-3473

Number of Ambulance Vehicles in Fleet: 3 Frontline and 3 Reserve

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 3

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

13,006	Total number of responses	6116	Total number of transports
9,021	Number of emergency responses	3072	Number of emergency transports
3,985	Number of non-emergency responses	3044	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** California Medical Response, Inc. Cal-Med Ambulance **Response Zone:** Countywide (Non-9-1-1)

Address: 1557 South Santa Anita Avenue, South El Monte, 91733

Number of Ambulance Vehicles in Fleet: 22

Phone Number: (562) 968-1818

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 16

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport; ☒ ALS ☒ BLS ☐ LALS; ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT; ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

14622	Total number of responses	14184	Total number of transports
134	Number of emergency responses	86	Number of emergency transports
14488	Number of non-emergency responses	14098	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles

Provider: Falck Mobile Healthcare, dba Care Ambulance Service, Inc.

Response Zone: EOA 2, 3, 4 and 5 (Eastern/Southern County) 41 cities 32 unincorporated areas

Address: 13257 Mora Drive
Santa Fe Springs 91605

Phone Number: (562) 531-7100

Number of Ambulance Vehicles in Fleet: 139

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 125

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

166752	Total number of responses	115908	Total number of transports
166752	Number of emergency responses	115908	Number of emergency transports
0	Number of non-emergency responses	0	Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** College Coastal Care, LLC **Response Zone:** Countywide (Non-9-1-1)

Address: 1754 Pacific Avenue
Long Beach, 90806

Phone Number: (562) 997-2020

Number of Ambulance Vehicles in Fleet: 3

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 2

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

4901	Total number of responses	4754	Total number of transports
0	Number of emergency responses	0	Number of emergency transports
4901	Number of non-emergency responses	4754	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Compton Fire Department **Response Zone:** City of Compton

Address: 201 South Acacia Avenue
Compton, Ca 90220

Phone Number: (310) 605-5670

Number of Ambulance Vehicles in Fleet: 1 (NON TRANSPORT)

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 0

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Transport ☒ ALS ☒ 9-1-1 ☒ Ground ☒ Non-Transport ☐ BLS ☐ 7-Digit ☐ Air ☐ LALS ☐ CCT ☐ Water ☐ IFT

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

8024	Total number of responses	0	Total number of transports
7828	Number of emergency responses		Number of emergency transports
196	Number of non-emergency responses		Number of non-emergency transports

Air Ambulance Services

0	Total number of responses	0	Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Culver City Fire Department **Response Zone:** City of Culver City

Address: 9770 Culver Blvd. 3rd Floor
Culver City, CA 90232

Phone Number: (310) 253-5900

Number of Ambulance Vehicles in Fleet: 3

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 3

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport; ☒ ALS ☐ BLS ☐ LALS; ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT; ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

4883	Total number of responses
1850	Number of emergency responses
1459	Number of non-emergency responses

3092	Total number of transports
2810	Number of emergency transports
282	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Downey Fire Department **Response Zone:** City of Downey

Address: 11111 Brookshire Ave.
Downey, CA 90241

Number of Ambulance Vehicles in Fleet: 4

Phone Number: (562) 904-7344

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 4

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

8523	Total number of responses	6335	Total number of transports
4246	Number of emergency responses	3084	Number of emergency transports
4277	Number of non-emergency responses	3251	Number of non-emergency transports

Air Ambulance Services

0	Total number of responses	0	Total number of transports
0	Number of emergency responses	0	Number of emergency transports
0	Number of non-emergency responses	0	Number of non-emergency transports

Los Angeles County – Department of Health Services

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** El Segundo Fire Department **Response Zone:** City of El Segundo

Address: 314 Main Street
El Segundo, Ca 90245

Phone Number: (310) 524-2269

Number of Ambulance Vehicles in Fleet: 3

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 2

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

3266	Total number of responses	987	Total number of transports
2718	Number of emergency responses	987	Number of emergency transports
548	Number of non-emergency responses	0	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Emergency Ambulance Service, Inc. **Response Zone:** Countywide (Non-9-1-1)

Address: 3200 East Birch Street
Brea, (Orange County) 90221

Phone Number: (800) 700-9344

Number of Ambulance Vehicles in Fleet: 11

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 8

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

622	Total number of responses
0	Number of emergency responses
622	Number of non-emergency responses

601	Total number of transports
0	Number of emergency transports
601	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Explorer-1 Ambulance, LLC **Response Zone:** Countywide (Non-9-1-1)

Address: 1040 East Compton Boulevard
Compton, CA 90221

Number of Ambulance Vehicles in Fleet: 3

Phone Number: (800) 700-9344

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 1

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

1215	Total number of responses
5	Number of emergency responses
1210	Number of non-emergency responses

1201	Total number of transports
5	Number of emergency transports
1196	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

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EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** First Rescue Ambulance, Inc. **Response Zone:** Countywide (Non-9-1-1)

Address: 5365 Arrow Highway, #2
Irwindale, CA 91706

Phone Number: (626) 338-2273

Number of Ambulance Vehicles in Fleet: 15

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 12

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

7221	Total number of responses
12	Number of emergency responses
7209	Number of non-emergency responses

7005	Total number of transports
8	Number of emergency transports
6997	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

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EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Firstmed Ambulance Services, Inc. **Response Zone:** Countywide (Non-9-1-1)

Address: 8630 Tamarack Avenue
Sun Valley (City of Los Angeles), CA 91352

Number of Ambulance Vehicles in Fleet: 39

Phone Number: (818) 982-8333

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 29

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

19234	Total number of responses	19122	Total number of transports
234	Number of emergency responses	156	Number of emergency transports
19000	Number of non-emergency responses	18966	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Glendale Fire Department **Response Zone:** City of Glendale

Address: 421 Oak Street
Glendale, CA 91204

Phone Number: (818) 548-6471

Number of Ambulance Vehicles in Fleet: 12

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 6

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

19385	Total number of responses
19385	Number of emergency responses
	Number of non-emergency responses

11397	Total number of transports
5274	Number of emergency transports
6123	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Go Green Ambulance, Corp. **Response Zone:** Countywide (Non-9-1-1)

Address: 1001 Wilmington Boulevard
Wilmington (City of Los Angeles), CA 90774

Number of Ambulance Vehicles in Fleet: 3

Phone Number: (818) 600-2579

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 1

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

582	Total number of responses
0	Number of emergency responses
582	Number of non-emergency responses

582	Total number of transports
0	Number of emergency transports
582	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Guardian Ambulance Service **Response Zone:** Countywide (Non-9-1-1)

Address: 12121 Barringer Street
South El Monte, CA 91733

Number of Ambulance Vehicles in Fleet: 11

Phone Number: (626) 405-8848

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 7

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

4102	Total number of responses	3630	Total number of transports
1368	Number of emergency responses	978	Number of emergency transports
2734	Number of non-emergency responses	2652	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Heart Ambulance, Corporation **Response Zone:** Countywide (Non-9-1-1)

Address: 11629 Clark Street, Suite 201
Arcadia, CA 91006

Number of Ambulance Vehicles in Fleet: 5

Phone Number: (562) 741-6230

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 4

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

5672	Total number of responses
10	Number of emergency responses
5662	Number of non-emergency responses

5478	Total number of transports
8	Number of emergency transports
5470	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles

Provider: Journey via Gurney, LLC. dba Journey Ambulance

Response Zone: Countywide (Non-9-1-1)

Address: 8116 Byron Road, Suite C
Whittier, CA 90606

Phone Number: (887) 262-4838

Number of Ambulance Vehicles in Fleet: 7

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 4

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

1067	Total number of responses
0	Number of emergency responses
1067	Number of non-emergency responses

1027	Total number of transports
0	Number of emergency transports
1027	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Los Angeles County Sheriff **Response Zone:** Los Angeles County

Address: 1060 N. Eastern Ave.
Los Angeles, CA 90063

Number of Ambulance Vehicles in Fleet: 2 Helicopters 3 Ambulances 2 Boats

Phone Number: (323) 881-7810

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 1 Helicopter

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☒ Air ☒ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☐ Fire ☒ Law ☐ Other Explain:	☐ City ☒ County ☐ State ☐ District ☐ Federal	☒ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☒ ALS Rescue ☐ BLS Rescue

Transporting Agencies

131	Total number of responses	0	Total number of transports
122	Number of emergency responses	0	Number of emergency transports
9	Number of non-emergency responses	0	Number of non-emergency transports

Air Ambulance Services

290	Total number of responses	167	Total number of transports
246	Number of emergency responses	131	Number of emergency transports
44	Number of non-emergency responses	36	Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** La Habra Heights Fire Department **Response Zone:** City of La Habra Heights

Address: 1245 N. Hacienda Road
La Habra Heights, CA 90631

Phone Number: (562) 694-8283

Number of Ambulance Vehicles in Fleet: 0

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 0

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Transport ☒ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

728	Total number of responses	NA	Total number of transports
633	Number of emergency responses	NA	Number of emergency transports
95	Number of non-emergency responses	NA	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** La Verne Fire Department **Response Zone:** City of La Verne

Address: 2061 Third St
La Verne, CA 91750

Phone Number: (909) 596-5991

Number of Ambulance Vehicles in Fleet: 2

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 1

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

4310	Total number of responses	2441	Total number of transports
4155	Number of emergency responses	1231	Number of emergency transports
155	Number of non-emergency responses	1210	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Liberty Ambulance, LLC **Response Zone:** Countywide (Non-9-1-1)

Address: 9441 Washburn Road
Downey, CA 90242

Phone Number: (562) 741-6230

Number of Ambulance Vehicles in Fleet: 29

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 22

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

4856	Total number of responses
56	Number of emergency responses
4800	Number of non-emergency responses

4801	Total number of transports
34	Number of emergency transports
4767	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles

Provider: Eastwestproto, Inc.
dba: Lifeline Ambulance

Response Zone: Countywide (Non-9-1-1)

Address: 6605 East Washington Boulevard
City of Commerce, CA 90040

Phone Number: (800) 700-9344

Number of Ambulance Vehicles in Fleet: 71

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 60

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

77152	Total number of responses	76896	Total number of transports
56	Number of emergency responses	43	Number of emergency transports
77096	Number of non-emergency responses	76853	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Long Beach Fire Department **Response Zone:** City of Long Beach

Address: 3205 N. Lakewood Blvd
Long Beach, CA 90808

Phone Number: (562) 570-2500

Number of Ambulance Vehicles in Fleet: **ALS Units**: 9 **BLS Units**: 5

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 14

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☒ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

67,118	Total number of responses	29,787	Total number of transports
63,607	Number of emergency responses	29,762	Number of emergency transports
3,511	Number of non-emergency responses	25	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** County of Los Angeles Fire Dept. **Response Zone:** Los Angeles County

Address: 1320 N Eastern Ave
Los Angeles, CA 90063-3294

Phone Number: (213) 267-7000

Number of Ambulance Vehicles in Fleet: 10 (Air Ambulance Only)

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 3

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Transport ☒ ALS ☒ 9-1-1 ☒ Ground ☒ Non-Transport ☒ BLS ☐ 7-Digit ☒ Air ☐ LALS ☐ CCT ☒ Water ☐ IFT

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☐ City ☒ County ☐ State ☐ District ☐ Federal	☒ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☒ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

392,417	Total number of responses	N/A	Total number of transports
392,417	Number of emergency responses	N/A	Number of emergency transports
N/A	Number of non-emergency responses	N/A	Number of non-emergency transports

Air Ambulance Services

921	Total number of responses	548	Total number of transports
921	Number of emergency responses	548	Number of emergency transports
N/A	Number of non-emergency responses	N/A	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Los Angeles City Fire Department **Response Zone:** City of Los Angeles

Address: 200 N Main St
Los Angeles, CA 90012

Number of Ambulance Vehicles in Fleet: 135

Phone Number:

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 135

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport; ☒ ALS ☒ BLS ☐ LALS; ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT; ☒ Ground ☒ Air ☒ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☒ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☒ Air Ambulance ☒ ALS Rescue ☐ BLS Rescue

Transporting Agencies

439248	Total number of responses	228332	Total number of transports
414720	Number of emergency responses	220648	Number of emergency transports
24528	Number of non-emergency responses	7684	Number of non-emergency transports

Air Ambulance Services

1372	Total number of responses	66	Total number of transports
8	Number of emergency responses	66	Number of emergency transports
1380	Number of non-emergency responses	0	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Filyn Corporation, dba: Lynch EMS **Response Zone:** Countywide (Non-9-1-1)

Address: 2950 East La Jolla Street
Anaheim (Orange County), CA 92806

Number of Ambulance Vehicles in Fleet: 29

Phone Number: (800) 347-3262

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 20

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

2967	Total number of responses
23	Number of emergency responses
2944	Number of non-emergency responses
2890	Total number of transports
20	Number of emergency transports
2870	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses
	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Manhattan Beach Fire Dept. **Response Zone:** City of Manhattan Beach

Address: 400 15TH Street
Manhattan Beach, CA. 90266

Number of Ambulance Vehicles in Fleet: 2

Phone Number: (310) 802-5203

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 1

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☒ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

2052	Total number of responses	1493	Total number of transports
2052	Number of emergency responses	728	Number of emergency transports
0	Number of non-emergency responses	765	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Mauran Ambulance Service **Response Zone:** Countywide (Non-9-1-1)

Address: 1211 1st Street
San Fernando, CA 91340

Phone Number: (818) 365-3182

Number of Ambulance Vehicles in Fleet: 9

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 7

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

5760	Total number of responses
12	Number of emergency responses
5748	Number of non-emergency responses
5712	Total number of transports
12	Number of emergency transports
5700	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses
	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles

Provider: Westmed, Inc.
dba: McCormick Ambulance

Response Zone: EOA 6, 7, 8 and 9
(Western County)
21 cities
39 unincorporated areas

Address: 2020 South Central Avenue
Compton, CA 90220

Phone Number: (888) 349-8994

Number of Ambulance Vehicles in Fleet: 98

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 80

Written Contract:	**Medical Director:**	**System Available 24 Hours:**	**Level of Service:**
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	**If Public:**	**If Public:**	**If Air:**	**Air Classification:**
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

10380	Total number of responses	7862	Total number of transports
9813	Number of emergency responses	7360	Number of emergency transports
567	Number of non-emergency responses	502	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Medcoast Ambulance Service **Response Zone:** Countywide (Non-9-1-1)

Address: 9033 Washington Boulevard
Pico Rivera, CA 90660

Phone Number: (866) 626-9900

Number of Ambulance Vehicles in Fleet: 1

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 1

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

567	Total number of responses
0	Number of emergency responses
567	Number of non-emergency responses

567	Total number of transports
0	Number of emergency transports
567	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles

Provider: Rescue Services International, Ltd. Dba: Medic-1 Ambulance

Response Zone: Countywide (Non-9-1-1)

Address: 12806 Schabarum Avenue #A
Irwindale, CA 91706

Phone Number: (888) 214-5263

Number of Ambulance Vehicles in Fleet: 25

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 20

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

17527	Total number of responses	17234	Total number of transports
123	Number of emergency responses	89	Number of emergency transports
17404	Number of non-emergency responses	17145	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** MedResponse, Inc. **Response Zone:** Countywide (Non-9-1-1)

Address: 1907 Border Avenue
Torrance, CA 90501

Phone Number: (818) 989-3000

Number of Ambulance Vehicles in Fleet: 2

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 0

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

0	Total number of responses	0	Total number of transports
0	Number of emergency responses	0	Number of emergency transports
0	Number of non-emergency responses	0	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Medtrans, Inc. **Response Zone:** Countywide (Non-9-1-1)

Address: 345 South Woods Avenue
Unincorporated East Los Angeles, 91340

Phone Number: (818) 365-3182

Number of Ambulance Vehicles in Fleet: 17

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 10

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

624	Total number of responses
0	Number of emergency responses
624	Number of non-emergency responses

620	Total number of transports
0	Number of emergency transports
620	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Monrovia Fire & Rescue **Response Zone:** City of Monrovia

Address: 141 E. Lemon Ave
Monrovia CA 91016

Number of Ambulance Vehicles in Fleet: 0

Phone Number: (626) 256-8181

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 0

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Transport ☒ Non-Transport; ☒ ALS ☐ BLS ☐ LALS; ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT; ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

4425	Total number of responses	NA	Total number of transports
4419	Number of emergency responses	NA	Number of emergency transports
6	Number of non-emergency responses	NA	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Montebello Fire Department **Response Zone:** City of Montebello

Address: 1600 W. Beverly Blvd.
Montebello Ca. 90640

Number of Ambulance Vehicles in Fleet: 0

Phone Number: (323) 887-4510

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 0

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Transport ☒ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

6,581	Total number of responses	N/A	Total number of transports
5,501	Number of emergency responses	N/A	Number of emergency transports
117	Number of non-emergency responses	N/A	Number of non-emergency transports

Air Ambulance Services

N/A	Total number of responses	N/A	Total number of transports
N/A	Number of emergency responses	N/A	Number of emergency transports
N/A	Number of non-emergency responses	N/A	Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Monterey Park Fire Department **Response Zone:** City of Monterey Park

Address: 350 W. Newmark Ave.
Monterey Park, Ca 91754

Phone Number: (626) 307-1262

Number of Ambulance Vehicles in Fleet: 2

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 2

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport; ☒ ALS ☐ BLS ☐ LALS; ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT; ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

5535	Total number of responses	2958	Total number of transports
5535	Number of emergency responses	2958	Number of emergency transports
0	Number of non-emergency responses	0	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Pasadena Fire Department **Response Zone:** City of Pasadena

Address: 215 N. Marengo Avenue #195
Pasadena, CA, 91101

Number of Ambulance Vehicles in Fleet: 12

Phone Number: (626) 744-7189

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 6

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

13,258	Total number of responses	9,553	Total number of transports
13,137	Number of emergency responses	3,082	Number of emergency transports
121	Number of non-emergency responses	6,471	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** PRN Ambulance **Response Zone:** Countywide (Non-9-1-1)

Address: 8928 Sepulveda Boulevard
North Hills (Los Angeles), CA 91343

Phone Number: (818) 810-3600

Number of Ambulance Vehicles in Fleet Serving LA County: 95

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day Serving LA County: 80

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

63024	Total number of responses	62896	Total number of transports
223	Number of emergency responses	180	Number of emergency transports
62801	Number of non-emergency responses	62716	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** REACH Air Medical Services, LLC **Response Zone:** Countywide (Non-9-1-1)

Address: 8880 Cal Center Drive, Suite 125
Sacramento (Sacramento County) 95826

Number of Helicopters in Fleet: 4

Phone Number: (916) 921-4000

Average Number of Helicopters on Duty At 12:00 p.m. (noon) on Any Given Day: 4

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☐ Yes ☒ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☐ Ground ☒ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☒ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☒ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

_____ Total number of responses	_____ Total number of transports
_____ Number of emergency responses	_____ Number of emergency transports
_____ Number of non-emergency responses	_____ Number of non-emergency transports

Air Ambulance Services

225 Total number of responses	140 Total number of transports
225 Number of emergency responses	140 Number of emergency transports
0 Number of non-emergency responses	0 Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Redondo Beach Fire Department **Response Zone:** City of Redondo Beach

Address: 401 S. Broadway
Redondo Beach, CA 90277

Number of Ambulance Vehicles in Fleet: 1 (reserve ambulance)

Phone Number: (310) 318-0663

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 0

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Transport ☒ Non-Transport; ☒ ALS ☐ BLS ☐ LALS; ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT; ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

5089	Total number of responses	0	Total number of transports
5089	Number of emergency responses	0	Number of emergency transports
0	Number of non-emergency responses	0	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Royalty Ambulance Services, Inc. **Response Zone:** Countywide (Non-9-1-1)

Address: 3235 North San Fernando Road, Building 6
Glassell Park (City of Los Angeles) 90065

Number of Ambulance Vehicles in Fleet: 18

Phone Number: (818) 550-5833

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 12

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

8604	Total number of responses
1820	Number of emergency responses
6784	Number of non-emergency responses

8074	Total number of transports
1340	Number of emergency transports
6734	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

ANNUAL UPDATE 2023
(Fiscal Year 2022-2023)

Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** San Gabriel Fire Department **Response Zone:** City of San Gabriel

Address: 1303 S. Del Mar Ave
San Gabriel, CA 91776

Number of Ambulance Vehicles in Fleet: 2

Phone Number: (626) 308-2885

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 1

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport; ☒ ALS ☐ BLS ☐ LALS; ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT; ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

3178	Total number of responses
3178	Number of emergency responses
	Number of non-emergency responses
1709	Total number of transports
1709	Number of emergency transports
	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses
	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

ANNUAL UPDATE 2023
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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** San Marino Fire Department **Response Zone:** City of San Marino

Address: 2200 Huntington Drive
San Marino, CA 91108

Number of Ambulance Vehicles in Fleet: 2

Phone Number: (626) 300-0735

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 1

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

1872	Total number of responses	1248	Total number of transports
1872	Number of emergency responses	1248	Number of emergency transports
0	Number of non-emergency responses	0	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Santa Fe Springs Fire Rescue **Response Zone:** City of Santa Fe Springs

Address: 11300 Greenstone Avenue
Santa Fe Springs, CA 90670

Phone Number: (562) 944-9713

Number of Ambulance Vehicles in Fleet: 0

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 0

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Transport ☒ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

2225	Total number of responses	0	Total number of transports
2225	Number of emergency responses	0	Number of emergency transports
0	Number of non-emergency responses	0	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Santa Monica Fire Department **Response Zone:** City of Santa Monica

Address: 333 Olympic Dr
Santa Monica, Ca 90401

Number of Ambulance Vehicles in Fleet: Reserve SMFD RAs – 4

Phone Number: (310) 458-8652

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 0

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport; ☒ ALS ☒ BLS ☐ LALS; ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT; ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

12,983	Total number of responses	8,189	Total number of transports
12,983	Number of emergency responses	3,362	Number of emergency transports
0	Number of non-emergency responses	4,827	Number of non-emergency transports

Air Ambulance Services

N/A	Total number of responses	N/A	Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Sierra Madre Fire Department **Response Zone:** City of Sierra Madre

Address: 242 W Sierra Madre Blvd
Sierra Madre, CA 91024

Number of Ambulance Vehicles in Fleet: 2

Phone Number: (626) 355-3611

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 1

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

1429	Total number of responses	872	Total number of transports
1429	Number of emergency responses	872	Number of emergency transports
0	Number of non-emergency responses	0	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

ANNUAL UPDATE 2023
(Fiscal Year 2022-2023)

Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** South Pasadena Fire Department **Response Zone:** City of South Pasadena

Address: 817 Mound Ave.
South Pasadena, Ca 9103

Number of Ambulance Vehicles in Fleet: 1

Phone Number: (626) 403-7300

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 1

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

2717	Total number of responses	1050	Total number of transports
2717	Number of emergency responses	1050	Number of emergency transports
0	Number of non-emergency responses	0	Number of non-emergency transports

Air Ambulance Services

N/A	Total number of responses	N/A	Total number of transports
N/A	Number of emergency responses	N/A	Number of emergency transports
N/A	Number of non-emergency responses	N/A	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Dibiassi, Inc. dba: Symbiosis **Response Zone:** Countywide (Non-9-1-1)

Address: 1801 Orange Tree Lane
Redlands (Riverside County), CA 92374

Phone Number: (909) 880-8911

Number of Ambulance Vehicles in Fleet: 1

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 1

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

0	Total number of responses	0	Total number of transports
0	Number of emergency responses	0	Number of emergency transports
0	Number of non-emergency responses	0	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Symons Emergency Specialties, Inc. dba: Symbiosis **Response Zone:** Countywide (Non-9-1-1)

Address: 1801 Orange Tree Lane, Redlands (Riverside County), CA 92374

Number of Ambulance Vehicles in Fleet: 22

Phone Number: (909) 880-2979

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 16

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport; ☒ ALS ☒ BLS ☐ LALS; ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT; ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

9876	Total number of responses	9786	Total number of transports
123	Number of emergency responses	97	Number of emergency transports
9753	Number of non-emergency responses	9689	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

ANNUAL UPDATE 2023
(Fiscal Year 2022-2023)

Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Torrance Fire Department **Response Zone:** City of Torrance

Address: 1701 Crenshaw Blvd.
Torrance, CA 90504

Number of Ambulance Vehicles in Fleet: 11

Phone Number: (310) 781-7000

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 9

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☒ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

10284	Total number of responses	9169	Total number of transports
10284	Number of emergency responses	9169	Number of emergency transports
0	Number of non-emergency responses	0	Number of non-emergency transports

Air Ambulance Services

N/A	Total number of responses	N/A	Total number of transports
N/A	Number of emergency responses	N/A	Number of emergency transports
N/A	Number of non-emergency responses	N/A	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

ANNUAL UPDATE 2023
(Fiscal Year 2022-2023)

Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Viewpoint Ambulance, Inc. **Response Zone:** Countywide (Non-9-1-1)

Address: 1341 North Miller Street, Suite 209
Anaheim (Orange County), CA 92806

Number of Ambulance Vehicles in Fleet: 18

Phone Number: (888) 202-6500

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 12

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

7017	Total number of responses	6987	Total number of transports
0	Number of emergency responses	0	Number of emergency transports
7017	Number of non-emergency responses	6987	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

ANNUAL UPDATE 2023
(Fiscal Year 2022-2023)

Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Vital Care Ambulance, Inc. **Response Zone:** Countywide (Non-9-1-1)

Address: 4509 Alger Street
Atwater Village (City of Los Angeles) 90039

Number of Ambulance Vehicles in Fleet: 15

Phone Number: (323) 747-1072

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 11

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

9576	Total number of responses
0	Number of emergency responses
9576	Number of non-emergency responses

9521	Total number of transports
0	Number of emergency transports
9521	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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(Fiscal Year 2022-2023)

Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** Skori, Inc. dba: West Coast Ambulance **Response Zone:** Countywide (Non-9-1-1)

Address: 123 South Victory Boulevard
Burbank, CA 91502

Phone Number: (888) 880-0556

Number of Ambulance Vehicles in Fleet: 8

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 7

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☒ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

12932	Total number of responses
69	Number of emergency responses
12863	Number of non-emergency responses

11233	Total number of transports
60	Number of emergency transports
11173	Number of non-emergency transports

Air Ambulance Services

	Total number of responses
	Number of emergency responses
	Number of non-emergency responses

	Total number of transports
	Number of emergency transports
	Number of non-emergency transports

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles **Provider:** West Covina Fire Department **Response Zone:** City of West Covina

Address: 1444 W. Garvey Ave South
West Covina, CA 91790

Number of Ambulance Vehicles in Fleet: 3 + (3 Reserves)

Phone Number: (626) 939 - 8824

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 3

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☒ ALS ☐ BLS ☐ LALS ☒ 9-1-1 ☐ 7-Digit ☐ CCT ☐ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☒ Public ☐ Private	☒ Fire ☐ Law ☐ Other Explain:	☒ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

6822	Total number of responses	3896	Total number of transports
6822	Number of emergency responses	2180	Number of emergency transports
0	Number of non-emergency responses	1716	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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EMERGENCY MEDICAL SERVICES PLAN

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Table 8 – RESOURCE DIRECTORY – Response/Transportation/Providers

County: Los Angeles

Provider: Solartricity, dba: Zoom Medical Transportation

Response Zone: Countywide (Non-9-1-1)

Address: 1315 North Bullis Road, #16
Compton, CA 90220

Phone Number: (323) 617-2620

Number of Ambulance Vehicles in Fleet: 4

Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 3

Written Contract:	Medical Director:	System Available 24 Hours:	Level of Service:
☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Transport ☐ Non-Transport ☐ ALS ☒ BLS ☐ LALS ☐ 9-1-1 ☐ 7-Digit ☐ CCT ☒ IFT ☒ Ground ☐ Air ☐ Water

Ownership:	If Public:	If Public:	If Air:	Air Classification:
☐ Public ☒ Private	☐ Fire ☐ Law ☐ Other Explain:	☐ City ☐ County ☐ State ☐ District ☐ Federal	☐ Rotary ☐ Fixed Wing	☐ Auxiliary Rescue ☐ Air Ambulance ☐ ALS Rescue ☐ BLS Rescue

Transporting Agencies

4032	Total number of responses	3976	Total number of transports
22	Number of emergency responses	22	Number of emergency transports
4010	Number of non-emergency responses	3954	Number of non-emergency transports

Air Ambulance Services

	Total number of responses		Total number of transports
	Number of emergency responses		Number of emergency transports
	Number of non-emergency responses		Number of non-emergency transports

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Table 9 – RESOURCE DIRECTORY – Facilities

EMS System: **Los Angeles County** Reporting Year: **Fiscal Years 2022-2023**

Facility: Adventist Health – Glendale **Telephone Number:** (818) 409-8000
Address: 1509 East Wilson Terrace
Glendale, CA 91206

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

Pediatric Critical Care Center[1] ❒ Yes ☑ No **EDAP**[2] ☑ Yes ❒ No **PICU**[3] ❒ Yes ☑ No	**Trauma Center:** ❒ Yes ☑ No	**If Trauma Center what level:** ❒ Level I ❒ Level II ❒ Level III ❒ Level IV	

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[1] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[2] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[3] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Adventist Health – White Memorial **Telephone Number:** (323) 268-5000
Address: 1720 Cesar Chavez Avenue
Los Angeles, CA 90033

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[4]	❒ Yes ☑ No		
EDAP[5]	☑ Yes ❒ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[6]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[4] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[5] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[6] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Alhambra Hospital **Telephone Number:** (626) 570-1606
Address: 100 South Raymond Avenue
Alhambra, CA 91801

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[7]	❒ Yes ☑ No		
EDAP[8]	❒ Yes ☑ No		
PICU[9]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[7] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[8] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[9] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Antelope Valley Hospital **Telephone Number:** (661) 949-5000
Address: 1600 West Avenue J
Lancaster, CA 93534

Written Contract:	Service:	Base Hospital:	Burn Center:
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	If Trauma Center what level:
Pediatric Critical Care Center[10]	❒ Yes ☑ No	☑ Yes ❒ No	❒ Level I ☑ Level II ❒ Level III ❒ Level IV
EDAP[11]	☑ Yes ❒ No		
PICU[12]	❒ Yes ☑ No		

STEMI Center:	Stroke Center:
☑ Yes ❒ No	☑ Yes ❒ No

[10] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[11] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[12] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Beverly Hospital **Telephone Number:** (323) 726-1222
Address: 309 West Beverly Boulevard
Montebello, CA 90640

Written Contract:	Service:	Base Hospital:	Burn Center:
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	If Trauma Center what level:
Pediatric Critical Care Center[13]	❒ Yes ☑ No		
EDAP[14]	❒ Yes ☑ No		
PICU[15]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	Stroke Center:
❒ Yes ☑ No	☑ Yes ❒ No

[13] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[14] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[15] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Catalina Island Medical Center **Telephone Number:** (310) 510-0700
Address: 100 Falls Canyon Road
Avalon, CA 90704

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ☑ Standby Emergency ❒ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[16]	❒ Yes ☑ No		
EDAP[17]	❒ Yes ☑ No		
PICU[18]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[16] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[17] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[18] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Cedars Sinai Medical Center **Telephone Number:** (310) 855-5000
Address: 8700 Beverly Medical Center
Los Angeles, CA 90048

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[19]	☑ Yes ❒ No	☑ Yes ❒ No	☑ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[20]	☑ Yes ❒ No		
PICU[21]	☑ Yes ❒ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[19] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[20] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[21] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Cedars-Sinai Marina Del Rey Hospital **Telephone Number:** (310) 823-8911
Address: 4650 Lincoln Boulevard
Marina Del Rey, CA 90291

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[22]	❒ Yes ☑ No		
EDAP[23]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[24]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[22] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[23] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[24] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Centinela Hospital Medical Center **Telephone Number:** (310) 673-4660
Address: 555 East Hardy Street
Inglewood, CA 90301

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

Pediatric Critical Care Center[25]	❒ Yes ☑ No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[26]	☑ Yes ❒ No		
PICU[27]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[25] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[26] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[27] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Children's Hospital Los Angeles **Telephone Number:** (323) 660-2450
Address: 4650 Sunset Boulevard
Los Angeles, CA 90027

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[28]	☑ Yes ❒ No	☑ Yes ❒ No	☑ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[29]	☑ Yes ❒ No		
PICU[30]	☑ Yes ❒ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[28] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[29] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[30] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Coast Plaza Doctors Hospital **Telephone Number:** (562) 868-3751
Address: 13100 Studebaker Road
Norwalk, CA 90650

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[31]	❒ Yes ☑ No		
EDAP[32]	❒ Yes ☑ No		
PICU[33]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[31] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[32] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[33] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: College Medical Center **Telephone Number:** (562) 595-1911
Address: 2776 Pacific Avenue
Long Beach, CA 90806

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[34]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[35]	❒ Yes ☑ No		
PICU[36]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[34] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[35] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[36] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Community Hospital of Huntington Park **Telephone Number:** (323) 538-1931
Address: 2623 E. Slauson Ave
Huntington Park, CA 90023

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[37]	❒ Yes ☑ No		
EDAP[38]	❒ Yes ☑ No		
PICU[39]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[37] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[38] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[39] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility:	Dignity Health-California Hospital Medical Center	**Telephone Number:**	(213) 748-2411
Address:	1401 South Grand Avenue Los Angeles, CA 90015		

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[40]	❒ Yes ☑ No	☑ Yes ❒ No	❒ Level I ☑ Level II ❒ Level III ❒ Level IV
EDAP[41]	☑ Yes ❒ No		
PICU[42]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[40] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[41] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[42] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility:	Dignity Health-Glendale Memorial Hospital and Health Center	**Telephone Number:**	(818) 502-1900
Address:	1420 South Central Avenue Glendale, CA 91204		

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[43]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[44]	☑ Yes ❒ No		
PICU[45]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[43] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[44] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[45] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility:	Dignity Health-Northridge Hospital Medical Center	**Telephone Number:**	(818) 885-8500
Address:	18300 Roscoe Boulevard Northridge, CA 91328		

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[46]	☑ Yes ❒ No	☑ Yes ❒ No	❒ Level I ☑ Level II ❒ Level III ❒ Level IV
EDAP[47]	☑ Yes ❒ No		
PICU[48]	☑ Yes ❒ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[46] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[47] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[48] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Dignity Health-St. Mary Medical Center **Telephone Number:** (562) 491-9000
Address: 1050 Linden Avenue
Long Beach, CA 90813

Written Contract:	Service:	Base Hospital:	Burn Center:
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	If Trauma Center what level:
Pediatric Critical Care Center[49]	❒ Yes ☑ No	☑ Yes ❒ No	❒ Level I ☑ Level II ❒ Level III ❒ Level IV
EDAP[50]	☑ Yes ❒ No		
PICU[51]	❒ Yes ☑ No		

STEMI Center:	Stroke Center:
☑ Yes ❒ No	☑ Yes ❒ No

[49] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[50] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[51] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: East Los Angeles Doctors Hospital **Telephone Number:** (323) 268-5514
Address: 4060 East Whittier Boulevard
Los Angeles, CA 90023

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[52]	❒ Yes ☑ No		
EDAP[53]	❒ Yes ☑ No		
PICU[54]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[52] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[53] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[54] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility:	Emanate Health – Foothill Presbyterian Hospital	**Telephone Number:**	(626) 963-8411
Address:	250 South Grand Avenue Glendora, CA 91749		

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[55]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[56]	❒ Yes ☑ No		
PICU[57]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[55] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[56] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[57] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Emanate Health Inter-Community Hospital **Telephone Number:** (626) 331-7331
Address: 210 West San Bernardino Road
Covina, CA 91723

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[58]	❒ Yes ☑ No		
EDAP[59]	❒ Yes ☑ No		
PICU[60]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	❒ Yes ☑ No

[58] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[59] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[60] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Emanate Health Queen of the Valley Hospital
Telephone Number: (626) 962-4011
Address: 1115 South Sunset Avenue
West Covina, CA 91790

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[61]	❒ Yes ☑ No		
EDAP[62]	☑ Yes ❒ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[63]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[61] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[62] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[63] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Encino Hospital Medical Center **Telephone Number:** (818) 995-5000
Address: 16237 Ventura Boulevard
Encino, CA 91436

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[64]	❒ Yes ☑ No		
EDAP[65]	☑ Yes ❒ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[66]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[64] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[65] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[66] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Garfield Medical Center **Telephone Number:** (626) 573-2222
Address: 525 North Garfield Avenue
Monterey Park, CA 91754

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[67]	❒ Yes ☑ No		
EDAP[68]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[69]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[67] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[68] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[69] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Greater El Monte Community Hospital **Telephone Number:** (626) 579-7777
Address: 1701 Santa Anita Avenue
South El Monte, CA 91733

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[70]	❒ Yes ☑ No		
EDAP[71]	❒ Yes ☑ No		
PICU[72]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[70] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[71] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[72] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Harbor-UCLA Medical Center **Telephone Number:** (310) 222-2345
Address: 1000 West Carson Street
Torrance, Ca 90502

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

Pediatric Critical Care Center[73]	☑ Yes ❒ No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[74]	☑ Yes ❒ No	☑ Yes ❒ No	☑ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[75]	☑ Yes ❒ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	❒ Yes ☑ No

[73] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[74] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[75] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Henry Mayo Newhall Hospital **Telephone Number:** (661) 253-8000
Address: 23845 West McBean Parkway
Valencia, CA 91355

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

Pediatric Critical Care Center[76]	❒ Yes ☑ No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[77]	☑ Yes ❒ No	☑ Yes ❒ No	❒ Level I ☑ Level II ❒ Level III ❒ Level IV
PICU[78]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[76] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[77] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[78] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Hollywood Presbyterian Medical Center **Telephone Number:** (323) 413-3000
Address: 1300 North Vermont Avenue
Los Angeles, CA 90027

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[79]	❒ Yes ☑ No		
EDAP[80]	❒ Yes ☑ No		
PICU[81]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[79] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[80] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[81] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Huntington Hospital **Telephone Number:** (626) 397-5000
Address: 100 West California Boulevard
Pasadena, CA 91105

Written Contract:	Service:	Base Hospital:	Burn Center:
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	If Trauma Center what level:
Pediatric Critical Care Center[82]	❒ Yes ☑ No	☑ Yes ❒ No	❒ Level I ☑ Level II ❒ Level III ❒ Level IV
EDAP[83]	☑ Yes ❒ No		
PICU[84]	❒ Yes ☑ No		

STEMI Center:	Stroke Center:
☑ Yes ❒ No	☑ Yes ❒ No

[82] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[83] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[84] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Kaiser Foundation-Baldwin Park **Telephone Number:** (626) 851-1011
Address: 1011 Baldwin Park Boulevard
Baldwin Park, CA 91706

Written Contract:	Service:	Base Hospital:	Burn Center:
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	If Trauma Center what level:
Pediatric Critical Care Center[85]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[86]	❒ Yes ☑ No		
PICU[87]	❒ Yes ☑ No		

STEMI Center:	Stroke Center:
❒ Yes ☑ No	☑ Yes ❒ No

[85] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[86] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[87] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Kaiser Downey Medical Center **Telephone Number:** (562) 920-3023
Address: 9333 Imperial Highway
Downey, CA 90242

Written Contract:	Service:	Base Hospital:	Burn Center:
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	If Trauma Center what level:
Pediatric Critical Care Center[88]	❒ Yes ☑ No		
EDAP[89]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[90]	❒ Yes ☑ No		

STEMI Center:	Stroke Center:
❒ Yes ☑ No	☑ Yes ❒ No

[88] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[89] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[90] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Kaiser Foundation-Los Angeles **Telephone Number:** (323) 783-4011
Address: 4867 Sunset Boulevard
Los Angeles, CA 90027

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[91]	❒ Yes ☑ No		
EDAP[92]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[93]	☑ Yes ❒ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[91] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[92] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[93] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Kaiser Foundation-Panorama City **Telephone Number:** (818) 375-2000
Address: 13652 Cantara Street
Panorama City, CA 91402

Written Contract:	Service:	Base Hospital:	Burn Center:
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	If Trauma Center what level:
Pediatric Critical Care Center[94]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[95]	❒ Yes ☑ No		
PICU[96]	❒ Yes ☑ No		

STEMI Center:	Stroke Center:
❒ Yes ☑ No	☑ Yes ❒ No

[94] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[95] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[96] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Kaiser Foundation-South Bay **Telephone Number:** (310) 325-5111
Address: 25825 South Vermont Avenue
Harbor City, CA 90710

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[97]	❒ Yes ☑ No		
EDAP[98]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[99]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[97] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[98] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[99] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Kaiser Foundation-West Los Angeles **Telephone Number:** **(323) 857-2000**
Address: 6041 Cadillac Avenue
Los Angeles, CA 90034

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[100]	❒ Yes ☑ No		
EDAP[101]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[102]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[100] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[101] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[102] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Kaiser Foundation-Woodland Hills **Telephone Number:** (818) 719-2000
Address: 5601 De Soto Avenue
Woodland Hills

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ❒ Basic Emergency ☑ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[103]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[104]	❒ Yes ☑ No		
PICU[105]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[103] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[104] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[105] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Los Angeles Community Hospital at Norwalk **Telephone Number:** (562) 863-4763
Address: 13222 Bloomfield Avenue
Norwalk, CA 90650

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[106]	❒ Yes ☑ No		
EDAP[107]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[108]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[106] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[107] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[108] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Los Angeles General Medical Center **Telephone Number:** (310) 226-2600
Address: 1200 North State Street
Los Angeles, CA 90033

Written Contract:	Service:	Base Hospital:	Burn Center:
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ❒ Basic Emergency ☑ Comprehensive Emergency	☑ Yes ❒ No	☑ Yes ❒ No

		Trauma Center:	If Trauma Center what level:
Pediatric Critical Care Center[109]	☑ Yes ❒ No	☑ Yes ❒ No	☑ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[110]	☑ Yes ❒ No		
PICU[111]	☑ Yes ❒ No		

STEMI Center:	Stroke Center:
☑ Yes ❒ No	☑ Yes ❒ No

[109] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[110] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[111] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Martin Luther King Jr Community Hospital **Telephone Number:** (424) 388-8000
Address: 1680 East 120th Street
Los Angeles, CA 90059

Written Contract:	Service:	Base Hospital:	Burn Center:
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	If Trauma Center what level:
Pediatric Critical Care Center[112]	❒ Yes ☑ No		
EDAP[113]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[114]	❒ Yes ☑ No		

STEMI Center:	Stroke Center:
❒ Yes ☑ No	❒ Yes ☑ No

[112] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[113] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[114] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Memorial Hospital of Gardena **Telephone Number:** (310) 532-4200
Address: 1145 West Redondo Beach Boulevard
Gardena, CA 90247

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[115]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[116]	❒ Yes ☑ No		
PICU[117]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[115] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[116] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[117] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility:	MemorialCare Long Beach Medical Center	**Telephone Number:**	(562) 933-2000
Address:	2801 Atlantic Avenue Long Beach, CA 90806		

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[118]	☑ Yes ❒ No	☑ Yes ❒ No	❒ Level I ☑ Level II ❒ Level III ❒ Level IV
EDAP[119]	☑ Yes ❒ No		
PICU[120]	☑ Yes ❒ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[118] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[119] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[120] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Mission Community Hospital **Telephone Number:** (818) 787-2222
Address: 14850 Roscoe Boulevard
Panorama City, CA 91402

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[121]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[122]	❒ Yes ☑ No		
PICU[123]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[121] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[122] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[123] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Monterey Park Hospital **Telephone Number:** (626) 570-9000
Address: 900 South Atlantic Boulevard
Monterey Park, CA 91754

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[124]	❒ Yes ☑ No		
EDAP[125]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[126]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[124] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[125] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[126] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Olive View Medical Center **Telephone Number:** (818) 364-1555
Address: 14445 Olive View Drive
Sylmar, CA 91342

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[127]	❒ Yes ☑ No		
EDAP[128]	☑ Yes ❒ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[129]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[127] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[128] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[129] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Pacifica Hospital of the Valley **Telephone Number:** (818) 767-3310
Address: 9449 San Fernando Road
Sun Valley, CA 91352

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[130]	❒ Yes ☑ No		
EDAP[131]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[132]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[130] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[131] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[132] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Palmdale Regional Medical Center **Telephone Number:** (661) 940-1498
Address: 38600 Medical Center Drive
Palmdale, CA 93551

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[133]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[134]	❒ Yes ☑ No		
PICU[135]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[133] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[134] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[135] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: PIH Health Hospital-Downey **Telephone Number:** (562) 904-5000
Address: 11500 Brookshire Avenue
Downey, CA 90241

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[136]	❒ Yes ☑ No		
EDAP[137]	☑ Yes ❒ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[138]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[136] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[137] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[138] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: PIH Health - Good Samaritan Hospital **Telephone Number:** (213) 977-2121
Address: 1225 Wilshire Blvd
Los Angeles, CA 90017

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[139]	❒ Yes ☑ No		
EDAP[140]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[141]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	❒ Yes ☑ No

[139] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[140] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[141] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: PIH Health Hospital-Whittier **Telephone Number:** (562) 698-0811
Address: 12401 East Washington Boulevard
Whittier, CA 90602

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[142]	❒ Yes ☑ No		
EDAP[143]	☑ Yes ❒ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[144]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[142] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[143] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[144] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Pomona Valley Hospital Medical Center **Telephone Number:** (909) 623-8715
Address: 1768 North Garey Avenue
Pomona, CA 91767

Written Contract:	Service:	Base Hospital:	Burn Center:
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	If Trauma Center what level:
Pediatric Critical Care Center[145]	❒ Yes ☑ No	☑ Yes ❒ No	❒ Level I ☑ Level II ❒ Level III ❒ Level IV
EDAP[146]	☑ Yes ❒ No		
PICU[147]	❒ Yes ☑ No		

STEMI Center:	Stroke Center:
☑ Yes ❒ No	☑ Yes ❒ No

[145] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[146] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[147] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility:	Providence Cedars-Sinai Tarzana Medical Center	**Telephone Number:**	(818) 881-0800
Address:	18321 Clark Street Tarzana, CA 91356		

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[148]	☑ Yes ❒ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[149]	☑ Yes ❒ No		
PICU[150]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[148] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[149] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[150] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Providence Holy Cross Medical Center **Telephone Number:** (818) 365-8051
Address: 15031 Rinaldi Street
Mission Hills, CA 91345

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[151]	❒ Yes ☑ No	☑ Yes ❒ No	❒ Level I ☑ Level II ❒ Level III ❒ Level IV
EDAP[152]	☑ Yes ❒ No		
PICU[153]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[151] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[152] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[153] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Providence Little Company of Mary Medical Center – San Pedro
Telephone Number: (310) 832-3311
Address: 1300 West Seventh Street
San Pedro, CA 90732

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[154]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[155]	☑ Yes ❒ No		
PICU[156]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[154] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[155] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[156] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility:	Providence Little Company of Mary Medical Center – Torrance	**Telephone Number:**	(310) 540-7676
Address:	4101 Torrance Boulevard Torrance, CA 90503		

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[157]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[158]	☑ Yes ❒ No		
PICU[159]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[157] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[158] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[159] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Providence Saint John's Health Center **Telephone Number:** (310) 829-5511
Address: 2121 Santa Monica Boulevard
Santa Monica, CA 90404

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[160]	❒ Yes ☑ No		
EDAP[161]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[162]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[160] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[161] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[162] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Providence Saint Joseph Medical Center **Telephone Number:** (818) 843-5111
Address: 501 South Buena Vista Street
Burbank, CA 91505

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

Pediatric Critical Care Center[163]	❒ Yes ☑ No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[164]	☑ Yes ❒ No		
PICU[165]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[163] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[164] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[165] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Ronald Regan UCLA Medical Center **Telephone Number:** (310) 825-9111
Address: 757 Westwood Plaza
Los Angeles, CA 90095

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ❒ Basic Emergency ☑ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[166]	☑ Yes ❒ No	☑ Yes ❒ No	☑ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[167]	☑ Yes ❒ No		
PICU[168]	☑ Yes ❒ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[166] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[167] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[168] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: San Dimas Community Hospital **Telephone Number:** (909) 599-6811
Address: 1350 West Covina Boulevard
San Dimas, CA 91773

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[169]	❒ Yes ☑ No		
EDAP[170]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[171]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[169] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[170] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[171] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: San Gabriel Valley Medical Center Telephone Number: (626) 289-5454
Address: 438 West La Tunas Drive
San Gabriel, CA 91776

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒Yes ☑ No

Pediatric Critical Care Center[172]	❒ Yes ☑ No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[173]	❒ Yes ☑ No		
PICU[174]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[172] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[173] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[174] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Santa Monica-UCLA Medical Center Telephone Number: (310) 319-4000
Address: 1250 16th Street
Santa Monica, CA 90404

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

Pediatric Critical Care Center[175]	❒ Yes ☑ No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[176]	☑ Yes ❒ No		
PICU[177]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[175] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[176] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[177] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Sherman Oaks Hospital **Telephone Number:** (818) 981-7111
Address: 4929 Van Nuys Boulevard
Sherman Oaks, CA 91403

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[178]	❒ Yes ☑ No		
EDAP[179]	☑ Yes ❒ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[180]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[178] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[179] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[180] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Southern California Hospital at Culver City **Telephone Number:** (310) 836-7000
Address: 3828 Delmar Terrace
Culver City, CA 90231

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[181]	❒ Yes ☑ No		
EDAP[182]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[183]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[181] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[182] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[183] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: St. Francis Medical Center **Telephone Number:** (310) 900-8900
Address: 3630 East Imperial Highway
Lynwood, CA 90262

Written Contract:	Service:	Base Hospital:	Burn Center:
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

		Trauma Center:	If Trauma Center what level:
Pediatric Critical Care Center[184]	❒ Yes ☑ No	☑ Yes ❒ No	❒ Level I ☑ Level II ❒ Level III ❒ Level IV
EDAP[185]	☑ Yes ❒ No		
PICU[186]	❒ Yes ☑ No		

STEMI Center:	Stroke Center:
☑ Yes ❒ No	☑ Yes ❒ No

[184] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[185] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[186] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Torrance Memorial Medical Center **Telephone Number:** (310) 325-9110
Address: 3330 West Lomita Boulevard
Torrance, CA 90505

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	☑ Yes ❒ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[187]	❒ Yes ☑ No		
EDAP[188]	☑ Yes ❒ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[189]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[187] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[188] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[189] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: USC Arcadia Hospital **Telephone Number:** (626) 898-8000
Address: 300 West Huntington Drive
Arcadia, CA 91007

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	☑ Yes ❒ No	❒ Yes ☑ No

Pediatric Critical Care Center[190]	❒ Yes ☑ No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[191]	☑ Yes ❒ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[192]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[190] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[191] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[192] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: USC Verdugo Hills Hospital **Telephone Number:** (818) 790-7100
Address: 1812 Verdugo Boulevard
Glendale, CA 91208

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[193]	❒ Yes ☑ No		
EDAP[194]	☑ Yes ❒ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[195]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	☑ Yes ❒ No

[193] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[194] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[195] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Valley Presbyterian Hospital **Telephone Number:** (818) 782-6600
Address: 15107 Vanowen Street
Van Nuys, CA 91405

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[196]	☑ Yes ❒ No		
EDAP[197]	☑ Yes ❒ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
PICU[198]	☑ Yes ❒ No		

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[196] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[197] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[198] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: West Hills Hospital and Medical Center **Telephone Number:** (818) 676-4000
Address: 7300 Medical Center Drive
West Hills, CA 91307

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	☑ Yes ❒ No

Pediatric Critical Care Center[199]	❒ Yes ☑ No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[200]	☑ Yes ❒ No		
PICU[201]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
☑ Yes ❒ No	☑ Yes ❒ No

[199] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[200] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[201] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Whittier Hospital Medical Center **Telephone Number:** (562) 945-3561
Address: 9080 Colima Road
Whittier, CA 90605

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☑ Basic Emergency ❒ Comprehensive Emergency	❒ Yes ☑ No	❒ Yes ☑ No

Pediatric Critical Care Center[202]	❒ Yes ☑ No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[203]	❒ Yes ☑ No		
PICU[204]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[202] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[203] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[204] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: David L. Murphy Sobering Center **Telephone Number:** (213) 395-7702
Address: 640 Maple Ave.
Los Angeles, CA 90014

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☐ Basic Emergency ❒ Comprehensive Emergency ❒ Behavior Health Center ☑ Sobering Center	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[205]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[206]	❒ Yes ☑ No		
PICU[207]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

TABLE 9: FACILITIES

[205] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[206] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[207] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

Facility:	Exodus – Recovery, Inc. Eastside Urgent Care Center	**Telephone Number:**	(323) 276-6400
Address:	1920 Marengo Street Los Angeles, CA 90033		

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☐ Basic Emergency ❒ Comprehensive Emergency ☑ Behavior Health Center	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[208]	❒ Yes ☑ No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[209]	❒ Yes ☑ No		
PICU[210]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[208] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[209] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[210] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Exodus Recovery, Inc. Harbor **Telephone Number:** (424) 405-5888
Address: 1000 W. Carson Street, Bldg. 2 South
Torrance, CA 90509

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☐ Basic Emergency ❒ Comprehensive Emergency ☑ Behavior Health Center	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[211]	❒ Yes ☑ No		
EDAP[212]	❒ Yes ☑ No		
PICU[213]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[211] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[212] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[213] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Exodus Recovery, Inc. MLK - Martin Luther King, Jr.
Telephone Number: (562) 295-4617
Address: 12021 Wilmington Avenue, Bldg 10, Lot B
Los Angeles, CA 90059

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☐ Basic Emergency ❒ Comprehensive Emergency ☑ Behavior Health Center	❒ Yes ☑ No	❒ Yes ☑ No

Pediatric Critical Care Center[214]	❒ Yes ☑ No	**Trauma Center:**	**If Trauma Center what level:**
EDAP[215]	❒ Yes ☑ No		
PICU[216]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[214] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[215] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[216] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Exodus Recovery Center – Westside **Telephone Number:** (310) 253-9494
Address: 11444 W. Washington Blvd
Culver City, CA 90066

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☐ Basic Emergency ❒ Comprehensive Emergency ☑ Behavior Health Center	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[217]	❒ Yes ☑ No		
EDAP[218]	❒ Yes ☑ No		
PICU[219]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[217] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[218] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[219] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility:	Star Behavioral Health Urgent Care Center – City of Industry	**Telephone Number:**	(626) 626-4997
Address:	18501 Gale Avenue, Suite 100 City of Industry, CA 91748		

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☐ Basic Emergency ❒ Comprehensive Emergency ☑ Behavior Health Center	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[220]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[221]	❒ Yes ☑ No		
PICU[222]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[220] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[221] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[222] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility:	Star Behavioral Health Urgent Care Center – High Desert	**Telephone Number:**	(661) 522-6770
Address:	415 East Avenue I Lancaster, CA 93535		

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☐ Basic Emergency ❒ Comprehensive Emergency ☑ Behavior Health Center	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[223]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[224]	❒ Yes ☑ No		
PICU[225]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[223] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[224] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[225] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

TABLE 9: FACILITIES

Facility: Star Behavioral Health Urgent Care Center – Long Beach
Telephone Number: (562) 548-6500
Address: 3210 Long Beach Blvd.
Long Beach, CA 90807

Written Contract:	**Service:**	**Base Hospital:**	**Burn Center:**
☑ Yes ❒ No	❒ Referral Emergency ❒ Standby Emergency ☐ Basic Emergency ❒ Comprehensive Emergency ☑ Sobering Center	❒ Yes ☑ No	❒ Yes ☑ No

		Trauma Center:	**If Trauma Center what level:**
Pediatric Critical Care Center[226]	❒ Yes ☑ No	❒ Yes ☑ No	❒ Level I ❒ Level II ❒ Level III ❒ Level IV
EDAP[227]	❒ Yes ☑ No		
PICU[228]	❒ Yes ☑ No		

STEMI Center:	**Stroke Center:**
❒ Yes ☑ No	❒ Yes ☑ No

[226] Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*
[227] Meets EMSA Emergency Departments Approved for Pediatrics (EDAP) Standards
[228] Meets California Children Services (CCS) Pediatric Intensive Care Unit (PICU) Standards

Los Angeles County – Department of Health Services
EMERGENCY MEDICAL SERVICES PLAN
ANNUAL EMS PLAN UPDATE
(Fiscal Year 2022-2023)

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**	
American EMT Academy 345 S. Woods Avenue Los Angeles, CA 90022	Name: Chris Siska Office: 800.477.6193 Fax: e-mail: chris@cprnmore.com	
Student Eligibility: Open to the public	Cost of Program: Basic: $1000 Refresher: n/a	Program Level: EMT Number of students completing training per year: Initial training: 7 Refresher: n/a Expiration date: 2/28/2026 Number of courses:1 Initial training: 1 Refresher: n/a

Training Institution Name/Address	**Program Director/Telephone Number**	
Alhambra Unified School District (USD) 1515 W. Mission Road Alhambra, CA 91803	Name: Leann Huang, Ed.D. Office: 626.943.6994 Fax: e-mail: hung_leann@ausd.us	
Student Eligibility: Must be an Alhambra USD Students	Cost of Program: Basic: No cost to students Refresher: n/a	Program Level: EMT Number of students completing training per year: Initial training: 0 Refresher: n/a Expiration date: 10/31/2026 Number of courses: 0 Initial training: 0 Refresher: n/a

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**
Antelope Valley (AV) College 3041 West Avenue K Lancaster, CA 93536	Name: Darren Watters Office: 661.722.6300 x6890 Fax: e-mail: darren.watters@avc.edu

Student Eligibility: Open to AV College students	Cost of Program: Basic: $322 Refresher: n/a	Program Level: EMT Number of students completing training per year: Initial training: 70 Refresher: n/a Expiration date: 12/31/2025 Number of courses: 4 Initial training: 4 Refresher: n/a

Training Institution Name/Address	**Program Director/Telephone Number**
Antelope Valley Unified High School District (AVUSD) CTE 39055 25th St West Palmdale, CA 93551	Name: Christy Chacon Office: 661.538.0304 x336 Fax: 661.538.0405 e-mail: cchacon@avhsd.org

Student Eligibility: Must be a High School Senior student within AVUSD. Must have a BLS CPR card.	Cost of Program: Basic: No cost to students Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 80 Refresher: n/a Expiration date: 8/31/2026 Number of courses: 2 Initial training: 2 Refresher: n/a

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**
Burbank Fire Department 311 E. Orange Grove Avenue Burbank, CA 91502	Name: Britney Alton Office: 818.238.3453 Fax: e-mail: balton@burbankca.gov

Student Eligibility: Restricted to Burbank Fire Department (BFD) personnel and already hold an EMT Certification.	Cost of Program: Basic: n/a Refresher: $0	Program Level: EMT Refresher Only Number of students completing training per year: Initial training: n/a Refresher: 0 Expiration date: 5/31/2025 Number of courses: 0 Initial training: n/a Refresher: 0

Training Institution Name/Address	**Program Director/Telephone Number**
California Advancing Pathways for Students (CalAPS) 16703 S Clark Avenue Bellflower, CA 90706	Name: Lisa Azevedo Office: 562.866.9011 x2184 Fax: n/a e-mail: lazaevedo@busd.k12.ca.us

Student Eligibility: Must be a High School Senior student within Bellflower, Paramount, or Lynwood school districts.	Cost of Program: Basic: No cost to Students Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 5-20 Refresher: n/a Expiration date: 8/31/2026 Number of courses: 1 Initial training: 1 Refresher: n/a

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**
California Institute of EMT (CIEMT) 2669 Myrtle Avenue, #201 Signal Hill, CA 90755	Name: Matthew Goodman Office: 562.989.1520 Fax: e-mail: admin@ciemt.com

Student Eligibility: Open to the public	Cost of Program: Basic: $1200 Hybrid $1295 Refresher: n/a	Program Level: EMT Basic and Hybrid Number of students completing training per year: Initial training: 200-300 Refresher: n/a Expiration date: 2/28/2025 Number of courses: 27 Initial training: 27 Refresher: n/a

Training Institution Name/Address	**Program Director/Telephone Number**
California State University – Dominguez Hills College of Extended and Internal Education 1000 E. Victoria Street Carson, CA 90815	Name: Lynda Wilson, PhD Office: 310.243.3737 Fax: e-mail: lwilson@csudh.edu

Student Eligibility: Open to the public	Cost of Program: Basic: $1495 Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 19 Refresher: n/a Expiration date: 05/31/2027 Number of courses: 3 Initial training: 3 Refresher: n/a

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**
California State University – Long Beach / CPaCE 6300 State University Drive, Foundation Suite 104 Long Beach, CA 90815	Name: Dr. Peter Kreysa Office: 562.985.8111 Fax: 562.985.8449 e-mail: peter.kreysa@csulb.edu

Student Eligibility: Open to the public	Cost of Program: Basic: $1495.00 Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 29 Refresher: n/a Expiration date: 9/30/2027 Number of courses: 2 Initial training: 2 Refresher: n/a

Cedars-Sinai EMT 127 S. San Vicente Blvd. Suite A1300 Los Angeles CA 90048	Name: Russell Metcalfe-Smith Office: 323-352-4443 Fax: e-mail: Russell.metcalfesmith@csmc.edu

Student Eligibility:* Open to the public High School Diploma or equivalency Must be at least 18 years old	Cost of Program: Basic: $ 2500 **Includes:** Background check, book and online material, uniform, boots, voucher to take the National Registry EMT exam, basic equipment (PPE pouch, trauma shears, blood pressure cuff, and a stethoscope). Refresher: n/a	Program Level: EMT Hybrid Number of students completing training per year: Initial training: 4 Refresher: n/a Expiration date: 6/30/2027 Number of courses: 1 Initial training: 1 Refresher: n/a

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**	
Citrus College 1000 West Foothill Blvd Glendora, CA 91741	Name: Al Laicans Office: 626.914.8755 Fax: 626.914.8724 e-mail: alaicans@citruscollege.edu	
Student Eligibility: Open to Citrus College students	Cost of Program: Basic: $1000 Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 19 Refresher: n/a Expiration date: 12/31/2025 Number of courses: 2 Initial training: 2 Refresher: n/a

Training Institution Name/Address	**Program Director/Telephone Number**	
College of the Canyons 26455 Rockwell Canyon Road Santa Clarita, CA 91355	Name: SB Tucker Office: 661.362.3745 Fax: 661.362.5438 e-mail: SB.Tucker@canyons.edu	
Student Eligibility: Open to College of the Canyon students	Cost of Program: Basic: $437+fees Refresher: $69	Program Level: EMT Basic and Refresher Number of students completing training per year: Initial training: 85 Refresher: 15 Expiration date: 3/31/2026 Number of courses: 9 Initial training: 8 Refresher: 1

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**
Compton College (CC)-EMT 1111 E. Artesia Blvd Compton, CA 90221	Name: Alex Rodrigues Office: 310.347.5718 Fax: N/A e-mail: arodrigues@compton.edu

Student Eligibility: Open to CC students	Cost of Program: Basic: ~$800 Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 4 Refresher: n/a Expiration date: 9/30/2026 Number of courses: 1 Initial training: 1 Refresher: n/a

Training Institution Name/Address	**Program Director/Telephone Number**
Downey Adult School 12340 Woodruff Avenue Downey, CA 90241	Name: Mariana Pacheco Office: 562.940.6277 Fax: 562-940-6221 e-mail: mpacheco@dusd.edu

Student Eligibility: Open to the public Must be at least 18 years old High School Diploma	Cost of Program: Basic: $1,299 Refresher: $45	Program Level: EMT Basic and Refresher Number of students completing training per year: Initial training: 27 Refresher: 1 Expiration date: 1/31/2028 Number of courses: 5 Initial training: 3 Refresher: 2

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**	
East Los Angeles College (ELAC) Fire Technology/EMT Program 1301 Avenida Cesar Chavez Monterey Park, CA 91754	Name: Jason Hosea Office: 323.415.5080 Fax: 323.265.8619 e-mail: hoseajb@elac.edu	
Student Eligibility: Open to ELACC students	Cost of Program: Basic: $368 Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 60 Refresher: n/a Expiration date: 1/31/2028 Number of courses: 4 Initial training: 4 Refresher: n/a

Training Institution Name/Address	**Program Director/Telephone Number**	
El Camino College (ECC) 16007 Crenshaw Blvd. Torrance, CA 90506	Name: Ryan Carey Office: 626.272.9392 Fax: 310.660.3106 e-mail: rcarey@elcamino.edu	
Student Eligibility: Open to ECC students	Cost of Program: Basic: $ 980 Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 196 Refresher: n/a Expiration date: 1/31/2028 Number of courses: 13 Initial training: 13 Refresher: n/a

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**	
Glendale Community College (GCC) 1500 N. Verdugo Road Glendale, CA 91208	Name: Abraham Baca Office: 818.240.1000 x3090 Fax: e-mail: abaca@glendale.edu	
Student Eligibility: Open to GCC students	Cost of Program: Basic: $368 Refresher: $368	Program Level: EMT Basic and Refresher Number of students completing training per year: Initial training: 80 Refresher: 0 Expiration date: 1/31/2028 Number of courses: 2 Initial training: 2 Refresher: 0

Training Institution Name/Address	**Program Director/Telephone Number**	
Long Beach City College 4901 East Carson St. Long Beach, CA 90808	Name: Andy Reno Office: 213.503.7170 Fax: 562.570.2556 e-mail: Andrew.reno@longbeach.gov	
Student Eligibility: Open to LBCC students	Cost of Program: Basic: $200 (approx.) Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 70 Refresher: n/a Expiration date: 7/31/2027 Number of courses: 2 Initial training: 2 Refresher: n/a

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**
Long Beach Fire Department 3205 N. Lakewood Blvd Long Beach, CA 90808	Name: Andrew Reno Office: 562.570.2547 Fax: 562.570.2556 e-mail: andrew.reno@longbeach.gov

Student Eligibility: Restricted to Long Beach City Fire Personnel Only	Cost of Program: Basic: $ 0 Refresher: $ 0	Program Level: EMT Basic and Refresher Number of students completing training per year: 26 Initial training: 0 Refresher: 26 Expiration date: 11/30/2027 Number of courses: 1 Initial training: 0 Refresher: 1

Training Institution Name/Address	**Program Director/Telephone Number**
Los Angeles City Fire Department (LAFD)-EMS Training Unit 1700 Stadium Way Los Angeles, CA 90012	Name: Laurie Stolp Captain 1/Paramedic Office: 213.893.9877, 213.893.9869 Fax: e-mail: lafd.emstraining@lacity.org / laurie.stolp@lacity.org

Student Eligibility: Restricted to LAFD recruit or LAFD personnel	Cost of Program: Basic: n/a Refresher: $0	Program Level: EMT Refresher only Number of students completing training per year: Initial training: n/a Refresher: 2093 Expiration date: 10/31/2027 Number of courses: 1 Initial training: n/a Refresher: 1

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**
Los Angeles County Fire Department – EMS Section 1255 Corporate Center Dr Monterey Park, CA 91754	Name: Paula LaFarge Office: 323.267.7173 Fax: e-mail: paula.lafarge@fire.lacounty.gov

Student Eligibility: Restricted to Los Angeles County Fire Department personnel	Cost of Program: Basic: $0 Refresher: $0	Program Level: EMT Basic and Refresher Number of students completing training per year: Initial training: 0 Refresher: 81 Expiration date: 3/31/2024 Number of courses: 3 Initial training: 0 Refresher: 3

Training Institution Name/Address	**Program Director/Telephone Number**
Los Angeles County Sheriff's Department 4700 Ramona Blvd, Room 234 Monterey Park, CA 91754	Name: Janet Henderson Office: 818.219.7581 Fax: e-mail: janhende@yahoo.com

Student Eligibility: Los Angeles County Sheriff Department employees	Cost of Program: Basic: n/a Refresher: $0	Program Level: EMT Refresher Number of students completing training per year: Initial training: n/a Refresher: 55 Expiration date: 3/31/2027 Number of courses: 5 Initial training: n/a Refresher: 5

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**
Los Angeles Harbor College (LAHC) Division of Nursing and Health Sciences 1111 Figueroa Place Wilmington, CA 90744-2397	Name: Lynn Yamakawa Office: 310.233.4361 Fax: 310.602.7382 e-mail: yamakalm@laccd.edu

Student Eligibility: Open to the LAHC students	Cost of Program: Basic: $400.00 Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 5 Refresher: n/a Expiration date: 9/30/2026 Number of courses: 1 Initial training: 1 Refresher: n/a

Training Institution Name/Address	**Program Director/Telephone Number**
Los Angeles Valley College (LAVC) 5800 Fulton Avenue Valley Glen, CA 91401	Name: Alan R. Cowen Office: 818.947.2982 Fax: e-mail: cowenar@lavc.edu

Student Eligibility: Open to the LAVC students	Cost of Program: Basic: $368 Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 75 Refresher: n/a Expiration date: 11/30/2024 Number of courses: 4 Initial training: 4 Refresher: n/a

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**
Mt. San Antonio College (MT.SAC) 1100 North Grand Avenue Walnut, CA 91789	Name: Benjamin Vu Office: 909.274.5778 Fax: e-mail: bvu8@mtsac.edu

Student Eligibility: Open to MT. SAC students	Cost of Program: Basic: $0 Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 100 Refresher: n/a Expiration date: 12/31/2024 Number of courses: 6 Initial training: 6 Refresher: n/a

Training Institution Name/Address	**Program Director/Telephone Number**
Mt. San Antonio College (MT.SAC) 1100 North Grand Avenue Walnut, CA 91789	Name: Scott Atkinson Office: 909.274 5834 Fax: e-mail: satkinson5@mtsac.edu

Student Eligibility:* Open to MT.SAC students	Cost of Program: Basic: $4500.00 Refresher: n/a	Program Level: Paramedic Number of students completing training per year: Initial training: 50 Refresher: n/a Expiration date: 12/31/2024 Number of courses: 2 Initial training: 2 Refresher: n/a

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**
North Valley Occupational Center 11450 Sharp Avenue Mission Hills, CA 91345	Name: Patrick Wickham Office: 818.256 1325 Fax: 818.365.2695 e-mail: ross.wickham@lasd.net

Student Eligibility: Open to the public or restricted to certain personnel only	Cost of Program: Basic: $ 0 Refresher: $ 0	Program Level: EMT Basic and Refresher Number of students completing training per year: Initial training: 22 Refresher: 19 Expiration date: 10/31/2026 Number of courses: 4 Initial training: 1 Refresher: 3

Training Institution Name/Address	**Program Director/Telephone Number**
Los Angeles County EMS Agency - Paramedic Training Institute 10100 Pioneer Blvd, Suite 200 Santa Fe Springs, CA 90670	Name: Miguel Ortiz-Reyes Office: 562.378.1571 Fax: 562.944.6091 e-mail: meortiz@dhs.lacounty.gov

Student Eligibility: Open to the public Must be enrolled at El Camino College	Cost of Program: Basic: $1751.00 (Books and materials for Paramedic Training Institute-PTI)) $1518.00 (El Camino College Tuition) Refresher: n/a	Program Level: Paramedic Number of students completing training per year: Initial training: 59 Refresher: n/a Expiration date: 12/31/2026 Number of courses: 3 Initial training: 3 Refresher: n/a

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**	
Pasadena City College (PCC) Health Sciences Division EMS Academy 3035 E Foothill Blvd, B-6 Pasadena, CA 91107	Name: Barry Jensen Office: 626.585.3378 Fax: n/a e-mail: bjensen4@pasadena.edu	
Student Eligibility: Open to PCC students	Cost of Program: Basic: $460 plus books and materials Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 184 Refresher: n/a Expiration date: 04/30/2024 Number of courses: 12 Initial training: 12 Refresher: n/a

Training Institution Name/Address	**Program Director/Telephone Number**	
Rio Hondo Community College (RHCC) 11400 Greenstone Avenue Santa Fe Springs, CA 90670	Name: Scott Jaeggi Office: 562.941.4082 Fax: e-mail: sjaeggi@riohondo.edu	
Student Eligibility: Open to the RHCC students	Cost of Program: Basic: $1,600 Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 127 Refresher: n/a Expiration date: 3/31/2026 Number of courses: 8 Initial training: 8 Refresher: n/a

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**
Santa Monica Fire Department 333 Olympic Drive Santa Monica, CA 90401	Name: Catherine Borman Office: 310-458-4929 Fax: e-mail: Catherine.borman

Student Eligibility: Restricted to Santa Monica Fire Department personnel	Cost of Program: Basic: n/a Refresher: $0	Program Level: EMT Refresher Number of students completing training per year: Initial training: n/a Refresher: 0 Expiration date: 3/30/2026 Number of courses: 0 Initial training: n/a Refresher: 0

Training Institution Name/Address	**Program Director/Telephone Number**
Southern California Regional Occupational Center (SCROC) 2300 Crenshaw Blvd Torrance, CA 90501	Name: Dr. Atlas Helaire Office: 310.224.4200 x216 Fax: e-mail: drhelaire@scroc.k12.ca.us

Student Eligibility: Open to: **General Public:** 1) Proof of age (18+) 2) Proof of HS diploma or GED 3) Proof of AHA BLS Card 4) Proof of negative Mantoux test or chest x-ray (tuberculosis) **High School Prerequisites:** • Be a second semester high school Senior • Be 18 years old by the end of the course	Cost of Program: Basic: $1100.00 Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 11 Refresher: n/a Expiration date: 12/31/2024 Number of courses: 2 Initial training: 2 Refresher: n/a

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

• Complete Emergency Medical/First Responder course with a Certificate of Competency • "C" or better in Math, English & Science		

Training Institution Name/Address		**Program Director/Telephone Number**
University of Antelope Valley 44055 Sierra Hwy Lancaster, CA 93534		Name: William Barrett Office: 661.726.1911 x164 Fax: 661.726.5251 e-mail: bill.barrett@uav.edu
Student Eligibility: • BLS (AHA) must be submitted within 7 days after course start date. • At time of course completion must be a minimum of 18 years of age. • Felony convictions may prohibit graduate from receiving employment and/or licensure. • High school diploma/GED required	Cost of Program: Basic: $2400 Refresher: $165	Program Level: EMT Basic and Refresher Number of students completing training per year: Initial training: 97 Refresher: 62 Expiration date: 7/31/2024 Number of courses: 13 Initial training: 7 Refresher: 6

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

<table>
<tr><th colspan="2">Training Institution Name/Address</th><th>Program Director/Telephone Number</th></tr>
<tr><td colspan="2">University of Antelope Valley
44055 Sierra Hwy
Lancaster, CA 93534</td><td>Name: William Barrett
Office: 661.726.1911 x164
Fax: 661.951.5158
e-mail: bill.barrett@uav.edu</td></tr>
<tr><td>Student Eligibility:
• Valid state-issued driver's license or identification card.
• Social Security Number
• Proof of High School Diploma or GED
• Current state issued or NREMT EMT certification (must remain current throughout the program)
• Current resume outlining EMT experience
Minimum of:
6 months full-time experience as an EMT (720 hrs.) OR 12 months part-time experience as an EMT (720 hrs.)</td><td>Cost of Program:

Basic: $24,338

Refresher: n/a</td><td>Program Level: Paramedic
Number of students completing training per year:
Initial training: 30
Refresher: n/a
Expiration date: 7/31/2024

Number of courses: 3
Initial training: 3
Refresher: n/a</td></tr>
</table>

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address	**Program Director/Telephone Number**
UCLA Center for Prehospital Care 1100 Glendon Ave., Suite 1200 Los Angeles, Ca 90024	Name: Michael Kaduce Office: 310.339-6142 Fax: e-mail: mkaduce@mednet.ucla.edu

Student Eligibility: Open to the public Must be at least 18 years old AHA/ARC BLS CPR card	Cost of Program: Basic: $1595 tuition, $349.46 materials Refresher: $245 tuition, $22.50 materials	Program Level: EMT Basic and Refresher Number of students completing training per year: Initial training: 718 Refresher: 386 Expiration date: 10/31/26 Number of courses: 29 Initial training: 16 Refresher: 13

Training Institution Name/Address	**Program Director/Telephone Number**
UCLA Paramedic Education 5220 Pacific Concourse Drive, Suite 135 Los Angeles, CA 90045	Name: David Filipp Office: 310.339.7473 Fax: N/A e-mail: dfilipp@mednet.ucla.edu

Student Eligibility: Open to the public	Cost of Program: Basic: $10,500.00 Refresher: $395.00	Program Level: Paramedic and Refresher Number of students completing training per year: Initial training: 130 Refresher: 60 Expiration date: 10/31/2025 Number of courses: 6 Initial training: 4 Refresher: 2

Table 10 – RESOURCE DIRECTORY – Approved Training Programs

Training Institution Name/Address		**Program Director/Telephone Number**
West Coast EMT 19750 South Vermont Avenue, #160 Torrance, CA 90502		Name: Matt Horan Office: 714-509-0126 Fax: n/a e-mail: matt@westcoastemt.com
Student Eligibility: Open to the public	Cost of Program: Basic: $950 Refresher: n/a	Program Level: EMT Basic Number of students completing training per year: Initial training: 268 Refresher: n/a Expiration date: 7/31/2025 Number of courses: 20 Initial training: 20 Refresher: n/a

Table 11 – RESOURCE DIRECTORY – Public Dispatch Agencies

Note: Complete information for each facility by County.

<table>
<tr><td colspan="3">Name & Address: OPERATED by LA County Fire
Avalon Fire Department
P.O. Box 707
Avalon, CA 90704</td><td>Primary Contact & Phone Number:
Michael Alegria
Fire Chief
310.510.0203 x205</td></tr>
<tr><td>Written Contract:
☒ yes
☐ no</td><td rowspan="2">Medical Director:
☒ yes
☐ no</td><td>☒ Day-to-day
☒ Disaster</td><td>Number of Personnel Providing Services:
____93___ EMD ___14___ EMT-D _____ ALS
_____ BLS _____ LALS _____ Other</td></tr>
<tr><td>Ownership:
☒ Public
☐ Private</td><td>If Public:
☒ Fire
☐ Law
☐ Other explain:___</td><td>If Public:
☒ City ☐ County ☐ State
☐ Fire District ☐ Federal</td></tr>
</table>

Table 11 – Resource Directory – Dispatch Agencies

Name & Address: Beverly Hills Police Department 464 North Rexford Drive Beverly Hills CA 90210			**Primary Contact & Phone Number:** Patricia Tachias Communications Manager 310.288.2634 ptachias@beverlyhills.org
Written Contract: ☐ yes ☒ no	Medical Director: ☐ yes ☐ no *(Note: BHPD Dispatch utilizes PowerPhone as its EMS product and receives oversight through Dr Angelique Campen.)*	☒ Day-to-day ☒ Disaster	Number of Personnel Providing Services: 4 EMD _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: ☒ Public ☐ Private		If Public: ☒ Fire ☒ Law ☐ Other explain:___	If Public: ☒ City ☐ County ☐ State ☒ Fire District ☐ Federal

Name & Address: Downey Fire Dispatch Center, "Downey Dispatch" 12222 Paramount Blvd. Downey, CA 90242			**Primary Contact & Phone Number:** Patrick Hunter Fire Communication Supervisor 562.299.5413 Pat.Hunter@areaefire.org
Written Contract: ☐ yes ☒ no	Medical Director: ☒ yes ☐ no	☒ Day-to-day ☒ Disaster	Number of Personnel Providing Services: 9 EMD _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: ☒ Public ☐ Private		If Public: ☒ Fire ☐ Law ☐ Other explain:___	If Public: ☒ City ☐ County ☐ State ☐ Fire District ☐ Federal

Table 11 – Resource Directory – Dispatch Agencies

Name & Address: Los Angeles County Fire Department 1320 N. Eastern Avenue Los Angeles, CA 90063			**Primary Contact & Phone Number:** Frank Forman Assistant Fire Chief 323.881.2370 frank.forman@fire.lacounty.gov
Written Contract: ☐ yes ☒ no	Medical Director: ☒ yes ☐ no	☒ Day-to-day ☒ Disaster	Number of Personnel Providing Services: 78 EMD 14 EMT-D ___ ALS ___ BLS ___ LALS ___ Other
Ownership: ☒ Public ☐ Private		If Public: ☒ Fire ☐ Law ☐ Other explain:___	If Public: ☐ City ☒ County ☐ State ☐ Fire District ☐ Federal

Name & Address: Los Angeles Fire Department – Metro Fire Communications 500 E. Temple Street Los Angeles, CA 90012			**Primary Contact & Phone Number:** Carlos Calvillo Assistant Fire Chief 213.576.8900 Carlos.Calvillo@lacity.org
Written Contract: ☐ yes ☒ no	Medical Director: ☒ yes ☐ no	☒ Day-to-day ☒ Disaster	Number of Personnel Providing Services: 80 EMD ___ EMT-D 33 ALS 53 BLS ___ LALS ___ Other
Ownership: ☒ Public ☐ Private		If Public: ☒ Fire ☐ Law ☐ Other explain:___	If Public: ☒ City ☐ County ☐ State ☐ Fire District ☐ Federal

Table 11 – Resource Directory – Dispatch Agencies

Name & Address: Long Beach Fire Disaster Prep Communications 2990 Redondo Avenue Long Beach, CA 90808			**Primary Contact & Phone Number:** Melina Runnels, Manager 562.570.9470 Melina.Runnels@longbeach.gov
Written Contract: ☐ yes ☒ no	Medical Director: ☒ yes ☐ no	☒ Day-to-day ☒ Disaster	Number of Personnel Providing Services: 20 EMD _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: ☒ Public ☐ Private		If Public: ☒ Fire ☒ Law ☐ Other explain:___	If Public: ☒ City ☐ Fire District If Public: ☐ City ☐ Fire District If Public: ☐ City ☐ Fire District

Name & Address: Redondo Beach Police/Fire Communications Center 401 Diamond Street Redondo Beach, CA 90277 310-379-2477			**Primary Contact & Phone Number:** Jason Kilpatrick Communications Manager 310.379-2477 EX 2289 Jason.Kilpatrick@redondo.org
Written Contract: ☐ yes ☒ no	Medical Director: ☐ yes ☒ no	☒ Day-to-day ☒ Disaster	Number of Personnel Providing Services: _____ EMD _____ EMT-D _____ ALS _____ BLS _____ LALS 6 Other
Ownership: ☒ Public ☐ Private		If Public: ☒ Fire ☒ Law ☐ Other explain:___	If Public: ☒ City ☐ Fire District If Public: ☐ City ☐ Fire District If Public: ☐ City ☐ Fire District

Table 11 – Resource Directory – Dispatch Agencies

Name & Address: Santa Monica Public Safety Communications 333 Olympic Drive, 2nd Floor Santa Monica, CA 90401			**Primary Contact & Phone Number:** Leticia Elder Chief Resilience Officer 310.458-2245 Leticia,Elder@santamonica.gov
Written Contract: ☐ yes ☒ no	Medical Director: ☒ yes ☐ no	☒ Day-to-day ☒ Disaster	Number of Personnel Providing Services: 15 EMD 4 EMT-D ___ ALS __3__ BLS ___ LALS __6__ Other
Ownership: ☒ Public ☐ Private		If Public: ☒ Fire ☒ Law ☐ Other explain:___	If Public: ☒ City ☐ Fire District If Public: ☐ City ☐ Fire District If Public: ☐ City ☐ Fire District

Name & Address: South Bay Regional Public Communications Authority 4440 W. Broadway Hawthorne, CA 90250			**Primary Contact & Phone Number:** Shannon Kauffman 310.973.1802 x102 skauffman@rcc911.gov
Written Contract: ☐ yes ☒ no	Medical Director: ☒ yes ☐ no	☒ Day-to-day ☒ Disaster	Number of Personnel Providing Services: 25 EMD ___ EMT-D ___ ALS ___ BLS ___ LALS __8__ Other
Ownership: ☒ Public ☐ Private		If Public: ☒ Fire ☒ Law ☐ Other explain:___	If Public: ☒ City ☐ Fire District If Public: ☐ City ☐ Fire District If Public: ☐ City ☐ Fire District

Table 11 – Resource Directory – Dispatch Agencies

Name & Address: Torrance Police Department 3300 Civic Center Drive Torrance, CA 90503			**Primary Contact & Phone Number:** Karen Farmer 310.618.5673 Kfarmer@torranceca.gov
Written Contract: ☐ yes ☒ no	Medical Director: ☒ yes ☐ no	☒ Day-to-day ☒ Disaster	Number of Personnel Providing Services: 11 EMD _____ EMT-D _____ ALS _____ BLS _____ LALS 14 Other
Ownership: ☒ Public ☐ Private		If Public: ☒ Fire ☒ Law ☐ Other explain:___	If Public: ☒ City ☐ Fire District If Public: ☐ City ☐ Fire District If Public: ☐ City ☐ Fire District

Name & Address: Verdugo Fire Communications Center 421 Oak Street Glendale, CA 91204			**Primary Contact & Phone Number:** Battalion Chief Phil Ambrose 818.548.5668 pambrose@glendaleca.gov
Written Contract: ☐ yes ☒ no	Medical Director: ☒ yes ☐ no	☒ Day-to-day ☒ Disaster	Number of Personnel Providing Services: 13 EMD _____ EMT-D _____ ALS _____ BLS _____ LALS _____ Other
Ownership: ☒ Public ☐ Private		If Public: ☒ Fire ☐ Law ☐ Other explain:___	If Public: ☒ City ☐ Fire District If Public: ☐ City ☐ Fire District If Public: ☐ City ☐ Fire District

Table 11 – Resource Directory – Dispatch Agencies

<table>
<tr><td colspan="3">Name & Address:
West Covina Fire Department
1444 W. Garvey Avenue
West Covina, CA 91790</td><td colspan="3">Primary Contact & Phone Number:
Mary Rodriguez
626.939.8519
Mary.Rodriguez@wcpd.org</td></tr>
<tr><td>Written Contract:
☐ yes
☒ no</td><td rowspan="2">Medical Director:
☐ yes
☒ no</td><td>☒ Day-to-day
☒ Disaster</td><td colspan="3">Number of Personnel Providing Services:
___7___ EMD _____ EMT-D ____ ALS
____ BLS _____ LALS _____ Other</td></tr>
<tr><td>Ownership:
☒ Public
☐ Private</td><td>If Public:
☒ Fire
☒ Law
☐ Other explain:___
Uses Powerphone and their medical director</td><td>If Public:
☒ City
☐ Fire District</td><td>If Public:
☐ City
☐ Fire District</td><td>If Public:
☐ City
☐ Fire District</td></tr>
</table>

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES
(Fiscal Year 2022-2023)
Table 12 – AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

Emergency Operating Area 1: Santa Clarita Valley, Antelope Valley
(3 incorporated cities, 46 Unincorporated areas).

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

American Medical Response of Southern California

Area or subarea (Zone) Geographic Description:

Contains urban, rural and wilderness areas. See Attached Map.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

Following a Request For Proposal process, Los Angeles County entered into an Emergency Ambulance Transportation Service Agreement with American Medical Response of Southern California on January 1, 2017 for the provision emergency ambulance transportation services in Emergency Operating Area 1. EOA 1 was a non-contested zone and the EMS Authority approved implementing this zone effective January 1, 2017. In order to have all 9 EOA Agreements expire on the same ten year cycle (contested EOAs were approved as of July 1, 2017), the EMS Authority authorized amending the term of EOA 1 allowing for an effective date of July 1, 2017 – June 30, 2027.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Request for Proposal, competitive bidding process was utilized to award EOAs. The Emergency Ambulance Transportation Services Agreement is effective from January 1, 2017 and amended to July 1, 2017 through June 30, 2027.

Los Angeles County – Department of Health Services

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

Emergency Operating Area 2: (City of Monrovia)

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Falck Mobile Healthcare Inc. dba Care Ambulance Service

Area or subarea (Zone) Geographic Description:

Contains urban and rural areas. See Attached Map.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

After Schaefer Ambulance Services, Inc. filed for bankruptcy in 2019 and defaulted on the Agreement. Care Ambulance Service was assigned area due to proximity and needs with permission from the California Emergency Medical Services Authority for the provision of emergency ambulance transportation services in Emergency Operating Area 2. In 2022, the corporate name of Care Ambulance Service, Inc. was changed to Falck Mobile Healthcare, Inc. dba Care Ambulance Service in a Los Angeles County corporate director change process.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Request for Proposal, competitive bidding process was utilized to award EOAs. The Emergency Ambulance Transportation Services Agreement is effective from July 1, 2017 through June 30, 2027.

Los Angeles County – Department of Health Services

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

Emergency Operating Area 3: East County, Pomona Valley
(11 incorporated cities, 10 unincorporated areas).

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Falck Mobile Healthcare Inc. dba Care Ambulance Service

Area or subarea (Zone) Geographic Description:

Contains urban, rural and wilderness areas. See Attached Map.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.

Following a Request For Proposal process, Los Angeles County entered into an Emergency Ambulance Transportation Service Agreement with Care Ambulance Service on July 1, 2017 for the provision of emergency ambulance transportation services in Emergency Operating Area 3. In 2022, the corporate name of Care Ambulance Service, Inc. was changed to Falck Mobile Healthcare, Inc. dba Care Ambulance Service in a Los Angeles County corporate director change process.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Request for Proposal, competitive bidding process was utilized to award EOAs. The Emergency Ambulance Transportation Services Agreement is effective from July 1, 2017 through June 30, 2027.

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES
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Table 12 – AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

Emergency Operating Area 4: San Gabriel Valley
(10 incorporated cities, 10 unincorporated areas).

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Falck Mobile Healthcare Inc. dba Care Ambulance Service

Area or subarea (Zone) Geographic Description:

Contains urban areas only. See Attached Map.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.

Following a Request For Proposal process, Los Angeles County entered into an Emergency Ambulance Transportation Service Agreement with Care Ambulance Service on July 1, 2017 for the provision of emergency ambulance transportation services in Emergency Operating Area 4. In 2022, the corporate name of Care Ambulance Service, Inc. was changed to Falck Mobile Healthcare, Inc. dba Care Ambulance Service in a Los Angeles County corporate director change process.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Request for Proposal, competitive bidding process was utilized to award EOAs. The Emergency Ambulance Transportation Services Agreement is effective from July 1, 2017 through June 30, 2027.

Los Angeles County – Department of Health Services

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Table 12 – AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

Emergency Operating Area 5: Southeast County, Gateway Cities
(19 incorporated cities, 12 unincorporated areas).

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Falck Mobile Healthcare Inc. dba Care Ambulance Service

Area or subarea (Zone) Geographic Description:

Contains urban and rural areas only. See Attached Map.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.

Following a Request For Proposal process, Los Angeles County entered into an Emergency Ambulance Transportation Service Agreement with Care Ambulance Service on July 1, 2017 for the provision of emergency ambulance transportation services in Emergency Operating Area 5. In 2022, the corporate name of Care Ambulance Service, Inc. was changed to Falck Mobile Healthcare, Inc. dba Care Ambulance Service in a Los Angeles County corporate director change process.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Request for Proposal, competitive bidding process was utilized to award EOAs. The Emergency Ambulance Transportation Services Agreement is effective from July 1, 2017 through June 30, 2027.

Los Angeles County – Department of Health Services

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

Emergency Operating Area 6 (City of Compton)

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Westmed/McCormick Ambulance Service

Area or subarea (Zone) Geographic Description:

Contains Urban area only. See Attached Map.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

Following a Request for Proposal process, Los Angeles County entered into an Emergency Ambulance Transportation Service Agreement with Westmed/McCormick Ambulance Service on July 1, 2017 for the provision of emergency ambulance transportation services in Emergency Operating Area 6.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Request for Proposal, competitive bidding process was utilized to award EOAs. The Emergency Ambulance Transportation Services Agreement is effective from January 1, 2017 and amended to July 1, 2017 through June 30, 2027.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

Emergency Operating Area 7: South Bay Cities
(9 incorporated cities, 12 unincorporated areas).

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Westmed/McCormick Ambulance Service

Area or subarea (Zone) Geographic Description:

Contains urban area only. See Attached Map.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.

Following a Request for Proposal process, Los Angeles County entered into an Emergency Ambulance Transportation Service Agreement with Westmed/McCormick Ambulance Service on July 1, 2017 for the provision of emergency ambulance transportation services in Emergency Operating Area 7.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Request for Proposal, competitive bidding process was utilized to award EOAs. The Emergency Ambulance Transportation Services Agreement is effective from January 1, 2017 and amended to July 1, 2017 through June 30, 2027.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

Emergency Operating Area 8 (City of Redondo Beach)

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Westmed/McCormick Ambulance Service

Area or subarea (Zone) Geographic Description:

Contains urban area only. See Attached Map.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

Following a Request for Proposal process, Los Angeles County entered into an Emergency Ambulance Transportation Service Agreement with Westmed/McCormick Ambulance Service on July 1, 2017 for the provision of emergency ambulance transportation services in Emergency Operating Area 8.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Request for Proposal, competitive bidding process was utilized to award EOAs. The Emergency Ambulance Transportation Services Agreement is effective from January 1, 2017 and amended to July 1, 2017 through June 30, 2027.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

Emergency Operating Area 9: West County
(10 incorporated cities, 31 unincorporated areas).

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Westmed/McCormick Ambulance Service

Area or subarea (Zone) Geographic Description:

Contains urban area only. See Attached Map.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

Following a Request for Proposal process, Los Angeles County entered into an Emergency Ambulance Transportation Service Agreement with Westmed/McCormick Ambulance Service on July 1, 2017 for the provision of emergency ambulance transportation services in Emergency Operating Area 9.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Request for Proposal, competitive bidding process was utilized to award EOAs. The Emergency Ambulance Transportation Services Agreement is effective from January 1, 2017 and amended to July 1, 2017 through June 30, 2027.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Alhambra

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Alhambra Fire Department
Length of operation prior to1981

Area or subarea (Zone) Geographic Description:

Alhambra has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

City of Alhambra had provided continuous emergency ambulance services prior to 1981. On April 30, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Alhambra Fire Department has provided service without a change in scope or manner since prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Arcadia

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Arcadia Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

Arcadia has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

City of Arcadia had provided continuous emergency ambulance services prior to 1981. On May 16, 1992 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Arcadia Fire Department has provided service without a change in scope or manner since prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Avalon

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Avalon Fire Department
Length of service prior to 1981

Area or subarea (Zone) Geographic Description:

Avalon has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of Avalon entered into an agreement for the provision of ambulance services with LA County prior to 1981. They have since entered into an *Evergreen Agreement* with LA County for the continued provision of ambulance services for the City of Avalon as well as the unincorporated area of Catalina Island.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Avalon Fire Department has provided service without a change in scope or manner prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Beverly Hills

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Beverly Hills Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

Beverly Hills has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

City of Beverly Hills City of Arcadia had provided continuous emergency ambulance services prior to 1981. On April 2, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Beverly Hills Fire Department has provided service without a change in scope or manner since prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Burbank

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Burbank Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

Burbank has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

City of Burbank had provided continuous emergency ambulance services prior to 1981. On May 30, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Burbank Fire Department has provided service without a change in scope or manner since prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Culver City

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Culver City Fire Department

Area or subarea (Zone) Geographic Description:

Culver City has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

City of Culver City had provided continuous emergency ambulance services prior to 1981. On April 30, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Culver City Fire Department has provided service without a change in scope or manner since prior to 1981.

Los Angeles County – Department of Health Services

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Downey

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Downey Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

Downey has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

City of Downey had provided continuous emergency ambulance services prior to 1981. On January 8, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Downey Fire Department has provided service without a change in scope or manner since prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of El Segundo

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

El Segundo Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

El Segundo has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

City of El Segundo had provided continuous emergency ambulance services prior to 1981. On September 3, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of El Segundo Fire Department has provided service without a change in scope or manner since prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Glendale

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Glendale Fire Department
Length of service prior to 1981

Area or subarea (Zone) Geographic Description:

Glendale has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of Glendale had provided continuous emergency ambulance services prior to 1981. On March 16, 1993 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ender. The agreement is applicable under Health and safety Code 1797.224, as the City of Glendale Fire Department has provided service without a change in scope or manner since prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Hermosa Beach

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Hermosa Beach Fire Department
Length of operation prior to 1981
Hermosa Beach entered into an agreement with Los Angeles County Fire Department as of January 1, 2018, for fire protection and ALS services. The City of Hermosa Beach maintained their emergency ambulance transportation service through an agreement with McCormick Ambulance.

Area or subarea (Zone) Geographic Description:

Hermosa Beach has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

City of Hermosa Beach had provided continuous emergency ambulance services prior to 1981. On June 19, 1991, they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits. The City subcontracted with McCormick Ambulance Services to provide emergency ambulance transportation on January 1, 2018.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Hermosa Beach Fire Department has provided service without a change in scope or manner since prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of La Verne

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

La Verne Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

La Verne has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

City of La Verne had provided continuous emergency ambulance services prior to 1981. On August 27, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of La Verne Fire Department has provided service without a change in scope or manner since prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Long Beach

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Long Beach Fire Department
Length of service prior to 1981

Area or subarea (Zone) Geographic Description:

Long Beach has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

City of Long Beach had provided continuous emergency ambulance services prior to 1981. On July 3, 1990 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Long Beach Fire Department has provided service without a change in scope or manner since prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Los Angeles

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Los Angeles City Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

Los Angeles has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.

City of Los Angeles had provided continuous emergency ambulance services prior to 1981. On August 23, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Los Angeles Fire Department has provided service without a change in scope or manner since prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Manhattan Beach

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Manhattan Beach Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

Manhattan Beach has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

Manhattan Beach had provided continuous emergency ambulance services prior to 1981. On April 30, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Manhattan Beach Fire Department has provided service without a change in scope or manner since prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Monterey Park

Name of Current Provider(s):
Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Monterey Park Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

Monterey Park has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):
Include intent of local EMS agency and Board action.

The City of Monterey Park had provided continuous emergency ambulance services prior to 1981. In 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):
Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):
If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code Section 1797.224, as the City of Monterey Park Fire Department has provided service without a change in scope or manner prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Pasadena

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

Pasadena Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

Pasadena has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of Pasadena had provided continuous emergency ambulance services prior to 1981. On April 23, 1993 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Pasadena has provided service without a change in scope or manner prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of San Fernando

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

City of Los Angeles Fire Department
Length of service prior to 1981

Area or subarea (Zone) Geographic Description:

San Fernando has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of San Fernando entered into an agreement for the provision of emergency ambulance service with LA City prior to 1981. They have since entered into an *Evergreen Agreement* with LA City covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Agreement is applicable under Health and Safety Code 1797.224, as the City of Los Angeles has provided service without a change in scope or manner since prior to 1981. The Agreement is automatically renewed for five-year periods until either party gives the other a least six months notice prior to the termination date of its desire to terminate or amend the Agreement.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of San Gabriel

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

City of San Gabriel Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

San Gabriel has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of San Gabriel had provided continuous emergency ambulance services prior to 1981. On August 20, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of San Gabriel Fire Department has provided service without a change in scope of manner prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of San Marino

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

City of San Marino Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

San Marino has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of San Marino had provided continuous emergency ambulance services prior to 1981. On July 23, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of San Marino Fire Department has provided service without a change in scope of manner prior to 1981.

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In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Santa Monica

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

City of Santa Monica Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

Santa Monica has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of Santa Monica had provided continuous emergency ambulance services prior to 1981. On March 16, 1993 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Santa Monica Fire Department has provided service without a change in scope or manner prior to 1981.

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES
(Fiscal Year 2022-2023)
Table 12 – AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Sierra Madre

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

City of Sierra Madre Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

Contains urban, rural and wilderness areas.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of Sierra Madre had provided continuous emergency ambulance services prior to 1981. On December 17, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Sierra Madre Fire Department has provided service without a change in scope or manner prior to 1981.

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES
(Fiscal Year 2022-2023)
Table 12 – AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of South Pasadena

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

City of South Pasadena Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

South Pasadena has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of South Pasadena had provided continuous emergency ambulance services prior to 1981. On July 25, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of South Pasadena Fire Department has provided service without a change in scope or manner prior to 1981.

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES
(Fiscal Year 2022-2023)
Table 12 – AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Torrance

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

City of Torrance Fire Department
Length of operation prior to 1981

Area or subarea (Zone) Geographic Description:

Torrance has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of Torrance had provided continuous emergency ambulance services prior to 1981. On August 27, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Torrance Fire Department has provided service without a change in scope or manner prior to 1981.

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES
(Fiscal Year 2022-2023)
Table 12 – AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Vernon

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

City of Vernon Fire Department prior to October 21, 2020.
On October 21, 2020, the City of Vernon entered into an agreement with the Los Angeles County Fire Department to provide fire protection and ALS services. Los Angeles County Fire utilizes Exclusive Operating Area #5 for transportation in the City of Vernon which is operated by Falck Mobile Healthcare, Inc. dba Care Ambulance Service.

Area or subarea (Zone) Geographic Description:

Vernon has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of Vernon had provided continuous emergency ambulance services prior to 1981. On November 26, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits. On October 21, 2020, ALS services were given to the Los Angeles County Fire Department and the City of Vernon relinquished their rights under the Health and Safety Code 1797.224; Falck Mobile Healthcare, Inc. dba Care Ambulance Service was temporarily assigned to provide transportation services until an RFP can be conducted.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of Vernon has provided service without a change in scope or manner since prior to 1981 and ended on October 21, 2020.

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES
(Fiscal Year 2022-2023)
Table 12 – AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of West Covina

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

City of West Covina Fire Department
Length of service prior to 1981

Area or subarea (Zone) Geographic Description:

West Covina has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of West Covina had provided continuous emergency ambulance services prior to 1981. On July 23, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Exclusivity covers "Emergency Ambulance" 9-1-1 calls only.

Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

The Emergency Ambulance Service Agreement was achieved by grandfathering and is open-ended. The agreement is applicable under Health and Safety Code 1797.224, as the City of West Covina has provided service without a change in scope or manner since prior to 1981.

Los Angeles County – Department of Health Services

EMERGENCY MEDICAL SERVICES
(Fiscal Year 2022-2023)
Table 12 – AMBULANCE ZONE SUMMARY FORM

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

Local EMS Agency or County Name:

Los Angeles County

Area or subarea (Zone) Name or Title:

City of Vernon

Name of Current Provider(s):

Include company name(s) and length of operation (uninterrupted) in specified area or subarea.

City of Vernon Fire Department provided continuous emergency ambulance transportation prior to October 21, 2020. On October 21, 2020, the City of Vernon entered into an agreement with the Los Angeles County Fire Department to provide fire protection and ALS services. Los Angeles County Fire utilizes Exclusive Operating Area #5 for transportation in areas surrounding the City of Vernon which is operated by Falck Mobile Healthcare, Inc. dba Care Ambulance Service.

Area or subarea (Zone) Geographic Description:

Vernon has urban area only.

Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):

Include intent of local EMS agency and Board action.

The City of Vernon had provided continuous emergency ambulance services prior to 1981. On November 26, 1991 they entered into an *Evergreen Agreement* with LA County covering the City's continued provision of emergency ambulance service within its corporate limits. On October 21, 2020, ALS services were contracted with the Los Angeles County Fire Department and the City of Vernon relinquished their rights under the Health and Safety Code 1797.224; Falck Mobile Healthcare, Inc. dba Care Ambulance Service was temporarily assigned to provide transportation services until an RFP can be conducted.

Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):

Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.).

Non-exclusive.

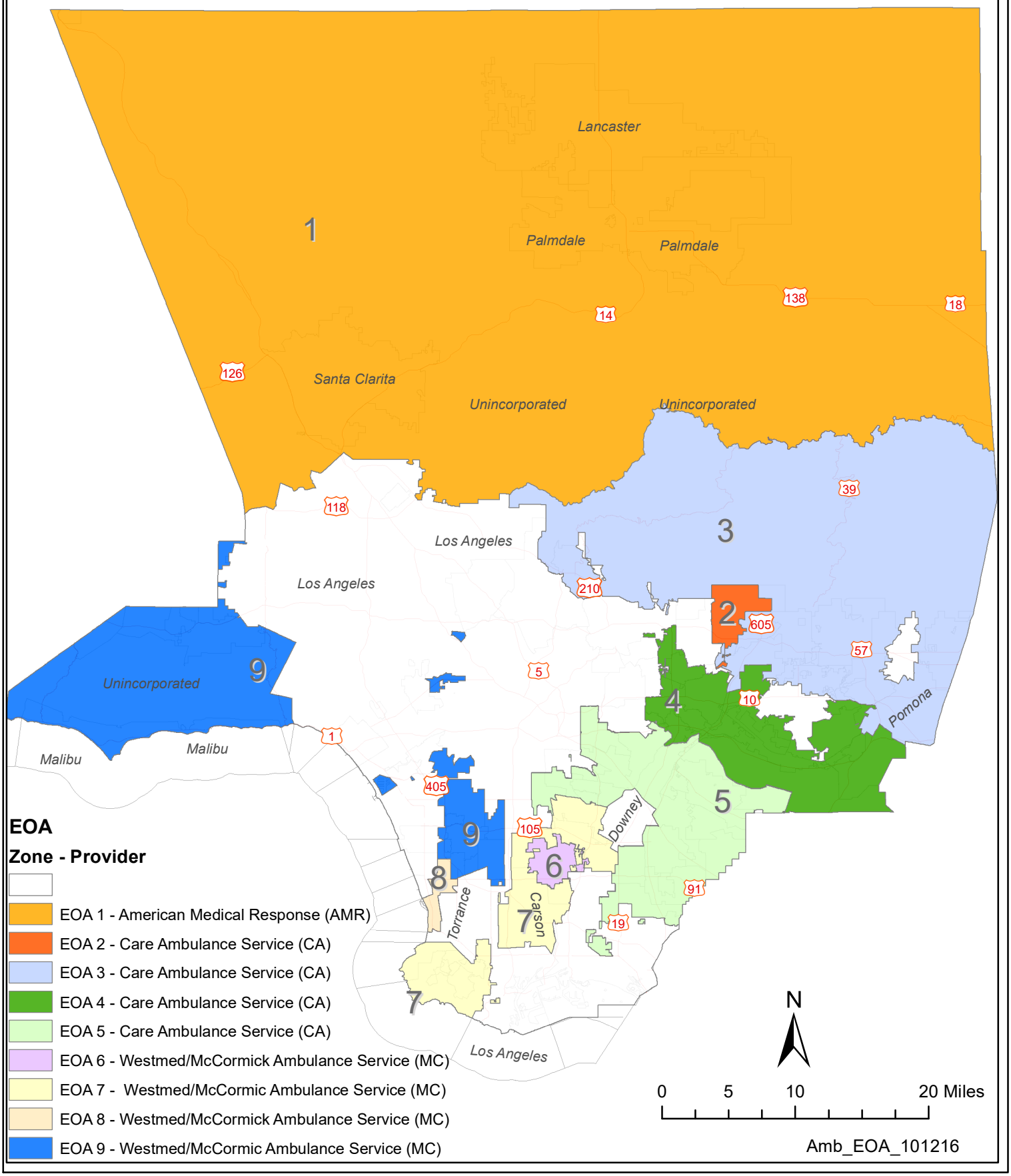
Method to achieve Exclusivity, if applicable (HS 1797.224):

If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.

If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.

Not applicable.

LOS ANGELES COUNTY
9-1-1 AMBULANCE EXCLUSIVE OPERATING AREAS 2016



Los Angeles County
Emergency Medical Services Agency
Quality Improvement Plan
2022-2023

I. Introduction

Los Angeles County EMS Agency Mission Statement

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

The Los Angeles (L.A.) County Emergency Medical Services (EMS) Agency is responsible for monitoring and implementing regulatory oversight over for one of the largest multijurisdictional EMS systems in the nation. The LAC system utilizes more than 18,000 certified EMS personnel employed by public and private organizations, fire departments, ambulance companies, hospitals, and law enforcement agencies to provide emergency and non-emergency prehospital care to over 10 million residents and visitors.

The EMS Agency requires a comprehensive quality improvement (QI) program to provide ongoingsystem evaluation to maintain quality in day-to-day operations. This program includes the implementation of process improvement strategies to advance patient care delivery that are consistent with best practices and evidence-based medicine. The QI plan provides the written framework for the QI program.

Our system utilizes a multidisciplinary collaborative approach to drive improvement. It is designed to be educational rather than punitive to encourage the exchange of information which enhances patient safety and minimizes adverse events. Quality patient care delivery is maintained through ongoing evaluation, timely system feedback, adaptive education, and the acknowledgement of performance excellence within the system.

The EMS Agency and QI program supports the California EMS Authority (EMSA) in the development, implementation, and reporting of statewide core measures.

The L.A. County EMS QI plan is written in accordance with the California Code of Regulations,Title 22, Division 9, Chapter 12: *Emergency Medical Services System Quality Improvement* and is consistent with the State of California *Emergency Medical Services System Quality Improvement Program Model Guidelines* and *EMSA 166, Appendix E, EMS Core Quality Measures.*

II. Structure and Organizational Description

A. Organizational Chart – https://dhs.lacounty.gov/emergency-medical-services-agency/home/who-we-are/organizational-chart/

B. QI Structure – The EMS Agency's QI Program utilizes an integrated process that incorporates all EMS system stakeholders to develop, implement, and support QI activities. The committees described below are the structure that supports the QI Program.

1. **EMS Agency QI Team** – The EMS QI Team is the guiding body for EMS QI Program activities. The EMS Agency QI Team meetings are convened as needed to support the QI system needs. Members include, but are not limited to, the following representatives:

   EMS Agency Medical Director
   EMS Agency Director
   EMS Agency Assistant Medical Director
   EMS Agency Nursing Director
   EMS Agency Assistant Director
   EMS Agency Director, Education and Innovation
   EMS System QI Manager
   Chief Prehospital Operations
   Chief Hospital Programs
   Data Systems and Research Programs Manager
   Additional EMS Agency staff, when needed

   Responsibilities of the EMS Agency QI Team include the following:
   - Cooperate with EMSA in carrying out the responsibilities of the EMS QI Program in accordance with the Quality Improvement Program Model Guidelines and EMS Core Quality Measures.
   - Collaborate with EMSA in the development and implementation of statewide EMS performance indicators.
   - Maintain and support local QI/Advisory committees to incorporate input from EMS system participants for the development, implementation, evaluation, and monitoring of local and statewide measures.
   - Facilitate and support the development of training and educational programs as they relate to action plans and other QI activities.
   - Convene and facilitate research collaborative committees to assist with evaluating performance and developing strategies to improve regionalized specialty care programs.
   - Make recommendations for the development and revision of EMS Agency policies and Treatment Protocols that are consistent with best practices and evidence-based medicine.
   - Serve as a resource to support QI among all programs and EMS community stakeholder groups.
   - Publish an annual data report and provide ongoing reports to the EMS community.
   - Review and update the L. A. County EMS QI Program as needed.

2. **Base Hospital / 9-1-1 Provider Agency QI Committee**
   Meetings are held quarterly; members include, but are not limited to:

   EMS Agency Medical Director
   EMS Agency Director or Nursing Director
   EMS Agency Assistant Medical Director
   EMS Agency Director, Education and Innovation
   EMS Agency EMS System QI Manager
   Chief Prehospital Operations
   Designated EMS Agency staff
   Prehospital Care Coordinators from each Base Hospital
   Paramedic Coordinator and /or Fire Department Nurse Educator from each 9-1-1 Provider Agency
   Ad hoc members/representatives:
      Pediatric Liaison Nurse from EDAP
      Air Operations Provider Agency
      Emergency Medical Dispatch
      Private (non-911) Provider Agency QI Committee

3. **Private Non 9-1-1 Provider Agency QI Committee**
   Meetings are held every four months; members include, but are not limited to:

   EMS Agency Medical Director or Assistant Medical Director
   EMS Agency Director or Nursing Director
   EMS Agency Director, Education and Innovation
   EMS Agency EMS System QI Manager
   Chief Prehospital Operations
   Designated EMS Agency staff
   Non 9-1-1 BLS/ALS provider agencies
   Ad hoc members/representatives:
      Approved paramedic training programs
      Approved EMT training programs
      Specialty Care Transport provider
      9-1-1 Provider Agency
      Emergency Medical Dispatch

4. **Trauma Hospital Advisory Committee (THAC) - QI Sub-Committee**
   Meetings are held every other month to address trauma care in LAC. For QI meeting purposes, THAC QI is divided into three sub-committees each covering a region of the county. The QI sub-committees meet quarterly and report back to THAC. Members include, but are not limited to:

   EMS Agency Medical Director
   EMS Agency Director and/or Assistant Director
   EMS Agency Assistant Medical Director
   EMS Agency Director, Education and Innovation
   EMS Agency Trauma Program Manager and designated staff
   Trauma Medical Director (surgeon) from each designated Trauma Center
   Trauma Center Program Manager (RN) from each designated Trauma Center
   Technical Advisory Group (TAG) members, as needed

5. **Medical Advisory Council (MAC)**
   Meetings are held quarterly to assist the EMS Agency Medical Director in carrying out regulatory responsibilities, provide recommendations on written treatment guidelines, policies and procedures that are consistent with best practices and evidence-base medicine. Members include, but are not limited to:

   EMS Agency Medical Director
   EMS Agency Director and/or Nursing Director
   EMS Agency Assistant Medical Director
   EMS Agency Director, Education and Innovation
   Paramedic Training Institute Medical Director
   EMS Agency Physician Specialist(s)
   EMS Agency EMS System QI Manager
   Chief Prehospital Operations
   Designated EMS Agency staff
   Medical Directors from each Base Hospital
   Medical Directors from each Provider Agency
   Representatives:
   Trauma Hospital physician
   Association Prehospital Care Coordinators
   9-1-1- Receiving Hospital physician

6. **ST Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) Advisory Committee**
   SRC/ROSC program QI meetings areheld biannually, at a minimum, to maintain and improve program quality appropriate to the SRC system. Members include, but are not limited to:

   EMS Agency Medical Director
   EMS Agency Director/Assistant Director
   EMS Agency Assistant Medical Director
   Paramedic Training Institute Medical Director
   EMS Agency SRC Program Manager
   Chief Hospital Programs
   Designated EMS Agency staff
   Medical Director from each SRC
   SRC Program Manager from
   each SRC
   9-1-1 Provider Agency Paramedic

7. **Stroke Center Advisory/QI Committee**
   Stroke program meetings are held biannually, at minimum, to maintain and improve quality of stroke care delivery. The EMS Agency implemented Comprehensive Stroke Center (CSC) designation in early 2018. CSC hospital designation includes Thrombectomy Capable Stroke Centers (TSC) and CSCs. Members include, but are not limited to:

   EMS Agency Medical Director
   EMS Agency Director/Nursing Director

EMS Agency Assistant Medical Director
EMS Agency Physician Specialist
EMS Agency Stroke Program Coordinator
Chief Hospital Programs
Designated EMS Agency Staff
Medical Directors from each designated stroke center
Stroke Coordinators from each designated stroke center

8. **Pediatric Advisory Committee (PedAC)**
Meets quarterly to provide expert oversight and address QI needsspecific to pediatric patients. Members include, but are not limited to:

EMS Agency Medical Director
EMS Agency Director/Nursing Director
EMS Agency Assistant Medical Director
EMS Agency Pediatric Physician Specialist
EMS Agency EDAP Program Manager
Chief Hospital Programs
Designated EMS Agency staff
Pediatric Liaison Nurse from each region
Emergency Department Approved for Pediatrics (EDAP) Medical Director from each EDAP region
Pediatric Medical Center (PMC) Medical Director from each PMC region
PMC Coordinator from each PMC
Medical Director and a Program Manager from a Pediatric Trauma Center

9. **Data Collaborative/Research Collaborative**
The data collaborative workgroup members include physician specialists, program medical directors and managers, designated program representatives, and other subject matter experts as needed. The primary purpose is to utilize the EMS Agency data to evaluate, provide recommendations, and develop quality initiatives to improve the delivery of care within our local regional programs and support EMS research through publication. The current Data Collaborative/Research Collaborative include STEMI, Stroke, Trauma, and Pediatric. https://dhs.lacounty.gov/emergency-medical-services-agency/home/resources-ems/ems-system-publications/

10. **EMS Commission Advisory Committees**
The advisory committee meetings are held every other month. Each advisory committee's membership represents the constituent groups as outlined in the EMS Commission bylaws. The EMS Commission Advisory Committee membership includes the following:

Base Hospital Advisory Committee (BHAC)
Provider Agency Advisory Committee (PAAC)

11. **Innovation, Technology and Advancement Committee (ITAC)**
ITAC is designed to evaluate innovative technologies and provide recommendations to the EMS Agency Medical Director and Director regarding implementation and oversight on new or novel products, pharmacological

interventions, and equipment. ITAC recommendations are shared with EMS system stakeholders and published on the EMS Agency website.

Link to Ref. No. 205, ITAC Policy
https://file.lacounty.gov/SDSInter/dhs/1055023_205-ITACommittee.pdf
Link to Ref. No. 205, ITAC Recommendations
https://file.lacounty.gov/SDSInter/dhs/1063374_205.1-ITACRecommendations.pdf

Meetings will be held quarterly or as directed by the Chair; members include, but are not limited to:

EMS Agency Director of Education and Innovation
Medical Advisory Council, three (3) Physician Representatives
PAAC Representative/Alternate
BHAC Representative/Alternate
PedAC Representative/Alternate
Primary Training Program, Paramedic and EMT
EMS Agency staff
Subject matter experts, as needed

III. Data Management

A. Data Collection

The EMS Agency obtains information through a variety of methods that include the following: electronic data exchange, hard copy review, internal and external customer surveys, and program reviews (audits). Data collection is primarily conducted via the Trauma and Emergency Medicine Information System (TEMIS), Lancet Technology Innovative Data Solutions by ESO. The TEMIS database assists the EMS Agency in evaluating, monitoring, and coordinating all EMS system components, as well as meet state data collection requirements.

All public 9-1-1 and Exclusive Operating Area provider agencies utilize an electronic patient care record (ePCR) platform. Paramedic base hospitals and trauma centers utilizing paper PCR capture the required data elements using an approved electronic platform and standard paper forms (EMS Report Form, Base Hospital Form and Trauma Patient Summary Form). All paramedic base hospitals and trauma centers conduct data entry on site. The data is uploaded automatically to a dedicated File Transfer Protocol (FTP) site every 24 hours. Many of the private (non-911) private provider agencies have transitioned from paper to an ePCR with the remainder utilizing paper PCR.

Other mechanisms by which the EMS Agency obtain data include direct data input to the LA STEMI and LA Stroke databases by the designated SRC and stroke hospitals. Stroke data is also downloaded from the *Get With The Guidelines (GWTG)* Patient Management Tool. Helicopter EMS (HEMS) data is submitted to the EMS Agency on a quarterly basis from the three HEMS providers in LA County. The EMS Agency continues to work on the process of

incorporating the STEMI, Stroke and HEMS data into TEMIS. Systemwide data collection on hospital diversion, bed availability, and surge capacity are collected via ReddiNet.

The Public Safety Agency Data Registry allows public safety agencies approved for naloxone administration to enter data directly into the data registry. Each public safety agency may utilize the data registry to generate reports on their own agency to assist in the quality improvement process required for program approval. The EMS Agency oversees the data and is able to provide aggregate system reports.

B. **Data Validation**

Data submitted to the EMS Agency databases undergoes an extensive data quality review and clean up through the following mechanisms:

1. EMS provider agencies utilizing electronic data collection are required to validate their data using the EMS Agency's published EMS Data Validator before submission to the FTP site. The EMS Agency conducts a secondary validation before final upload to TEMIS. Data that fails validation is rejected and sent back to the EMS Provider for correction.

2. Annual data audits are conducted by the EMS Agency for each EMS Provider Agency. A corrective action plan is required for data elements that fall below a 90% compliance rate for accuracy and completeness.

3. Data clean up reports are generated by the EMS Agency for Paramedic Base Hospitals and Trauma Centers. In general, a corrective action plan is required for data elements that fall below a 90%compliance rate for accuracy and completeness.

4. Documentation reports are routinely developed and disseminated in the quality improvement committees for evaluation and education on the application of the data dictionary and data standards to improve reliability.

C. **Data Submission**

1. The EMS Agency ensures timely data collection and submission from paramedic base, trauma, SRC and stroke hospitals through written agreements.

2. Data collection requirements for other specialty care centers are prescribed in the specific specialty care center Standards and local policies.

3. EMS provider agency data collection requirements are governed by local policies. Submission of required data to the EMS Agency is highly dependent upon organizational resources (method of data collection/ ePCR vendor) and size (personnel/volume of EMS responses). The EMS

Agency has established policies and procedures specific to submission of ePCR data. However, provider agencies can experience vendor-related problems that can cause significant delays in data submission. The EMS Agency and EMS community continue to work together on improving

data collection and submission as the system transitions to CEMSIS data requirements.

4. The LA County Trauma Center Programs participate in the American College of Surgeons Trauma Quality Improvement Program (TQIP) and are members of the LA County TQIP Collaborative. Collaborative system-level TQIP reports allow us to compare our system performance to national results and impart opportunities for systemwide QI projects.
5. EMS providers may be required to submit self-reported data utilizing Excel spreadsheets for the following reasons:
    a. Non-911 (interfacility) transports which are not entered into TEMIS.
    b. Base hospitals and public 911 provider agencies may be required to submit self-reported data on prospective QI projects when the required data cannot be accessed through the EMS Agency databases.
    c. Provider agencies approved for pilot projects requiring data submission not captured in the EMS Agency databases.

D. **Data Utilization**

1. The EMS Agency utilizes the TEMIS, LA STEMI, LA Stroke, and GWTG databases for both statewide core measures and local system reports. The local reports are utilized for daily operations such as performance and contract monitoring, system audits, policy revision, and QI activities. The databases are also used to provide the information needed to analyze the potential impact of hospital diversions and closures.
2. Self-reported data utilizing Excel spreadsheets for private non-9-1-1 provider agency and when needed, 9-1-1 provider agency QI activities aimed at evaluating performance and ensuring safety when implementing new medications, treatment and/or devices into the system.
3. The Public Safety Data Registry was implemented in May 2020 to allow for public safety agencies with approved naloxone programs to enter their data. Each agency can only view and download reports on their data. The EMS Agency anticipates expanding the registry in the future to collect additional data regarding other field care provided by public safety personnel (i.e., tourniquet application and AED).

E. Limitations

1. Separate Databases: The existence of multiple databases is not ideal for timely reporting. Multiple data entry and data abstraction are conducted on the same patient. Data analysis is resource-intensive when data elements are found in the various databases.

2. Multiple System Participants: Data validation and transmission is complex due to multiple electronic PCR software applications. Changes to the reporting standards often require additional time and expense.

3. Data Quality: Current methods of data capture require extensive data audits. Cleanup is needed to ensure valid and reliable data.

IV. Quality Measures

A. Utilization of Provider Impression/Treatment Protocols

The EMS Public 9-1-1 Provider Agency and Base Hospital QI Committee assisted the EMS Agency in systemwide evaluation of the high-risk Treatment Protocols (TP) and Provider Impressions (PI) from 2020 through 2022 utilizing Reference No. 1373 as the standard for determining fallouts. The TPs and PIs will continue to be evaluated as part of the QI process using a combination of the EMS Agency databases and self-reported data to ensure appropriate utilization. Link to Reference No. 1373, MCG: Treatment Protocol QI Fallout Data Dictionary: https://file.lacounty.gov/SDSInter/dhs/1040527_1373-TPQIFalloutDataDictionary.pdf

B. Ambulance Patient Offload Time (APOT)

The EMS Agency continues to work with system participants to collect data using the standardize methods for collecting and reporting APOT data adopted bythe EMS Authority. 9-1-1 APOT reports are generated quarterly and are provided to EMS providers and hospitals. For hospitals the continually have extended APOT and/or extensive utilization of ED diversion, a corrective action plan is requested to include monthly reporting as needed. Additionally, the non-911 provider agencies collect and submit APOT data to the EMS Agency on interfacility (non-911) transports to the emergency department and in-patient hospital in an effort to track and improve time to transfer of care.

C. EMSA Core Quality Measures

The EMS Agency historically has participated in statewide data submission to CEMSIS and continues to actively participate in statewide data collection through the submission of core measure data outlined in EMSA #166 – Appendix E. To ensure reliable and valid data, the EMS Agency updates the data dictionary and provides training/feedback to EMS personnel on documentation of the core

measure data elements with the exception of ambulance response times by zones. The L.A.COunty EMS system is not designed to collect data by zones. Alternatively, systemwide ambulance response times are collected and reported. Data is available upon request.

D. **Pediatric Readiness Project – LA Peds Ready**

The National Pediatric Readiness Project (NPRP) is a multi-phase quality improvement initiative to ensure all emergency departments have the essential resources in place to provide effective emergency care to sick and injured children. The NPRP is partnership with the federal EMS for Children program, American Academy of Pediatrics, American College of Emergency Physicians, and Emergency Nurses Association.
LA Peds Ready was developed to assist L. A. County emergency departments with access to the NPRP assessment tools, resources, and on-line educational activities designed to improve the delivery of pediatric emergency care in our system. Participation in the NPRP assessment has been added to the Los Angeles County EDAP standards.

E. **Local Performance Indicators**

Category	Reporting Frequency	Indicator Summary	Method of Collection	EMS Agency Section Responsible
Personnel	Continuous	Number of Emergency Medical Technician (EMT) certifications that result in disciplinary action, ongoing tracking for variance	Prehospital Emergency Personnel System Information (PEPSI)	Certification and Program Approvals
Documentation	Continuous	Number of base hospitals compliant with mandatory data fields documented Link to Base Hospital Documentation Manual	TEMIS Base Database	Hospital Programs/ Data Management
Clinical Care and Patient Outcomes	Quarterly & Annually	Percentage of time from STEMI Referral Center door to PCI at the SRC for STEMI- identified patients < 120 min	STEMI/SRC DB	SRC/ROSC Program

Category	Reporting Frequency	Indicator Summary	Method of Collection	EMS Agency Section Responsible
Clinical Care and Patient Outcomes	Quarterly & Annually	Percentage of out-of-hospital cardiac arrest transported to the STEMI Receiving Center % to cath-lab % received PCI	STEMI/SRC Database	SRC/ROSC Program
		Percentage of suspected stroke patients transported to the Primary Stroke Center and Comprehensive Stroke Center Percentage of ischemic strokes patients received thrombolytic and endovascular care	Stroke Database	Stroke Program
		12-lead ECG and ASA administration for patients with PI = CPMI and CPSC Average time to first albuterol for PI = SOBB in patients 14 years or younger Hypotensive (SBP ≤ 90) adult patients with a blunt traumatic mechanism to chest/abdomen that received fluids Average field time for penetrating head, chest or abdomen with SBP ≤ 100 and GCS <15 Adult patients (age ≥ 15 years) with PI = TRMA and GCS = 15 with pain assessed	TEMIS EMS Database	Prehospital Care Operations/ System QI

Category	Reporting Frequency	Indicator Summary	Method of Collection	EMS Agency Section Responsible
Skills Competency	Biannually	Utilization of Provider Impressions	TEMIS EMS & TEMIS Base Databases	Prehospital Operations/ System QI
Transportation/ Facilities	Annually	Number of patients transported to the trauma center % penetrating injury % blunt injury	Trauma & TEMIS EMS Database	Data Management
Public Education and Prevention	Annually	Percentage of cardiac arrest 9-1-1 responsesthat receive bystanderCPR Number of citizens trained during the annual Sidewalk "hands-only" CPR Program	CARES TEMIS EMS Database	Data Management Prehospital Care Operations/ System QI
Risk Management	Quarterly	Percentage of compliance with Ref. 834, "treat and release" on scene by public 9-1-1provider agencies (future) Percentage of 9-1-1 calls not transported and 9-1-1 EMS re-contacted within 24-48 hours (future)	TEMIS EMS Database *Self-reported	Prehospital Care Operations/ System QI

***Self-reported using a standardized reporting method.**

V. Prehospital Research

Research provides an evidence base to support prehospital medical treatments and interventions. The EMS Agency actively supports prehospital research through the Research Data Collaboratives. Link to EMS System Publications: https://dhs.lacounty.gov/emergency-medical-services-agency/home/resources-ems/ems-system-publications/

VI. Evaluation of System Indicators

A. The System EMS QI Coordinator and designated staff prepare reports on system performance indicators to be utilized by the QI Team, advisory committees (Medical Advisory Council, Base Hospital Advisory, and Provider Agency Advisory) and specialty care committees (STEMI, stroke, trauma, pediatric) to ensure proper systemwide evaluation.

B. Under the direction of the EMS Agency Medical Director, the EMS Agency QI Team will analyze system reports generated by each EMS Agency section responsible for collecting and reporting on current performance indicators, including the EMSA Core Measures.

C. Presentations on performance indicators will be prepared in the most appropriate format to allow for ease of interpretation of data. Formats most commonly utilized include line charts, bar graphs, flowcharts, and data tables.

VII. Action to Improve

A. The EMS Agency, under the direction of the Los Angeles County Department of Health Services, utilizes the FOCUS PDSA model for performance improvement.

1. **F**ind a process to improve—improvement needs are identified by the EMS QI Team in collaboration with the TAG, QI and Advisory groups.
2. **O**rganize the process utilizing the team most familiar with the process related to the system process identified.
   Clarify current knowledge of the process by collecting information and reviewing current trends.

3. **U**nderstand capabilities and causes for variations in processes by utilizing brainstorming techniques and fishbone diagrams or flowcharts.
4. **S**elect a strategy or process for improvement that will most likely reduce or eliminate the causes for variation in performance.
5. **P**lan—determine objectives and develop a plan in agreement with systemparticipants.
6. **D**o—carry out the action according to established plan.
7. **S**tudy findings—the EMS QI Team with system input will analyze the findings,compare with hypothesis, and prepare a summary for a trend report.
8. **A**ct on findings—the EMS QI Team in collaboration with the TAG, QI and Advisory groups will determine performance improvement needs. A Quality Task Force may be chartered if needed, to carry out specific performance improvement plans.

VIII. Training and Education

A. The effectiveness of the QI process is related to the efficacy of training and educational activities. Due to the size and complexity of our system, training andeducation is accomplished through a variety of mechanisms:

1. **Quality Improvement Committees/Advisory Meetings**
   Information needed for improving local system and statewide performance is disseminated to committee members for training and education of providers responsible for direct patient care.

2. **EMS Update**
   Under the direction of Dr. Denise Whitfield, the EMS Agency staff, Paramedic Training Institute, and system stakeholders develop and implement the mandatory annual EMS Update that address educational and training needs related to performance improvement. The format was changed to an on-line training utilizing a learningmanagement system 2020.

3. **EMS Data Report**
   The EMS Agency publishes an annual data report that provides valuable feedback to the EMS community and citizens of Los Angeles on system demographics and performance.

4. EMERGIPRESS

   The Emergi-Press is a web-based EMS educational forum located on the EMS Agency website. It serves as an educational program for providers and stakeholders to integrate into their learning management systems while giving EMS personnel the opportunity to earn continuing education credit. Educational material includes ECG of the month video learning modules, and cases from the field. Content is developed quarterly. Additionally, Emergi-Press utilizes updates from the Medical Director to communicate pertinent information regarding system issues. Emergi-Press link

B. The EMS Agency QI Team and other advisory groups review policies and procedures to ensure consistency with the EMSA and LAC EMS QI plan.

C. Once a performance improvement plan has been successfully implemented, the EMS Agency will post all policies and system updates to its website to allow timely access by all EMS participants.

VIII. **Update/Summary**

The QI plan was updated to reflect the changes in our plan and performance measures. As the COVID pandemic winds down, COVID-related indicators are no longer being tracked. As far as clinical care and patient outcome indicators, the EMS Agency continues to track aspirin administration in patients with suspected cardiac chest pain as there continues to be much room for improvement across our system. New clinical care indicators for 2022–2023 include the time to albuterol for pediatric patients with bronchospasms, fluid administration for hypotensive trauma patients with a blunt mechanism to the chest/abdomen, time on-scene for hypotensive trauma patients with a penetrating mechanism to the head/chest/abdomen, and pain assessments in trauma patients. The QI plan is submitted to EMSA for review and published on the EMS Agency website for review by the EMS participants and system stakeholders.

Indicators Monitored	Findings/Issues Identified	Action Needed	Responsible Entity
Percentage of EMT certifications that result in disciplinary action	Number of EMT certifications that result in disciplinary action annually. See LAC EMS Plan for report.	Continue to monitor for variance	Office of Certification and Accreditation
Number of 9-1-1 provider agencies compliant with documentation of mandatory data fields **Number of base hospitals compliant with documentation of mandatory data fields**	In addition to the mandatory fields,the EMS Agency continues to workwith the base hospitals and provider agencies on core measure data documentation through education, ongoing programs reviews and data audits. Data available upon request	Continue to monitor and provide feedback	Hospital and Prehospital Programs/ Data Management
90th percentile for time from STEMI Referral Center door to PCI at the SRC for STEMI-identified patients < 120 minutes	Ongoing collaboration with system partners to reduce STEMI Referral Center door-in door-out. Data available upon request	Continue to monitor and provide feedback to system partners	SRC/ROSC Program

Indicators Monitored	Findings/Issues Identified	Action Needed	Responsible Entity
Percentage of suspected stroke patients transported to Primary and Comprehensive Stroke Centers	Data available upon request	Continue to monitor, plan to add evaluation of LAMS and stroke destination	Stroke Program
Volume of patients transported by 9-1-1 from acute care hospitals by PI	Data available upon request	Continue to monitor	Data Management
12-lead ECG and ASA administration for patients with PI = CPMI and CPSC	Excellent compliance with 12-lead ECG at 99%. Aspirin administration rates—72% for PI = CPSC; 63% for PI = CPMI. Goal of 90% not met.	Educational plan centered around ASA for cardiac chest pain	Prehospital Care Operations/ System QI
Average time to first albuterol for PI = SOBB in patients 14 years or younger	Average time to first albuterol administration is 8 minutes. Wide variability among departments.	Continue to monitor	Prehospital Care Operations/ System QI
Hypotensive (SBP ≤ 90) adult patients with a blunt traumatic mechanism to chest/abdomen that received fluids	Fluid administration rate for these specific blunt trauma patients very low at 45%.	Educational plan centered around hypotensive trauma patients	Prehospital Care Operations/ System QI
Average field time for penetrating head, chest or abdomen with SBP ≤ 100 and GCS <15	Average time on-scene for these hypotensive trauma patients is 9 minutes.	Continue to monitor	Prehospital Care Operations/ System QI
Adult patients (age ≥ 15 years) with PI = TRMA and GCS = 15 with pain assessed	Rate of pain assessment for this group of trauma patients is 70%. Rate of pain reassessment if numeric pain score ≥ 7 is 74%.	Educational plan centered around pain assessment and pain management	Prehospital Care Operations/ System QI

EMS PLAN UPDATE FISCAL YEAR 2022 – 2023
SPECIALTY CARE SYSTEM PROGRAM

As required by the California Code of Regulations, Title 22, Division 9, Chapter 7.1, Article 2, §100270.122, Chapter 7.2, Article 2 §100270.221, and Chapter 14, Article 2, §1001450.217, the Los Angeles County Emergency Medical Services Agency is submitting the required Annual EMS System Plan Updates for the specialty care system programs for Los Angeles County for fiscal year 2022 – 2023:

- STEMI Critical Care System – Exhibit 1
- Stroke Critical Care System – Exhibit 2
- Emergency Medical Services for Children – Exhibit 3
- Trauma System Plan – Exhibit 4

For FY 22-23, there were no changes to the STEMI system. A map of our current STEMI Centers is included for reference (Attachment A)

Changes since the previous plan was submitted and approved include:

- List of Designated STEMI Centers and Agreement Expiration Dates (Attachment B)
- Reference No. 320, ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) Standards – Revised 01-01-2023 (Attachment C)
- Reference No. 320.1, Target Temperature Management (TTM) Guideline – Revised 01-01-2023 (Attachment D)
- Reference No. 320.2, Sample Memorandum of Understanding Agreement Inter-Facility Transfer for Acute STEMI – Revised 01-01-2023 (Attachment E)
- Reference No. 320.3, SRC Performance Measures – Revised 01-01-2023 (Attachment F)
- Reference No. 513, ST-Elevation Myocardial Infarction (STEMI) Patient Destination – Revised 01-01-2023 (Attachment G)
- Reference No. 606, Retention and Disposition of Prehospital Patient Care Records – Revised 01-01-2023 (Attachment H)
- Reference No. 612, Release of Emergency Medical Services (EMS) Records – Revised 01-01-2023 (Attachment I)
- Reference No. 621, Notification of Personnel Change – Revised 01-01-2023 (Attachment J)
- Reference No. 624, STEMI Receiving Center Advisory – Quality Improvement Committee (SRCA-QIC) – Revised 01-01-2023 (Attachment K)
- Reference No. 1210, Treatment Protocol: Cardiac Arrest – Revised 07-01-2022 (Attachment L)
- Reference No. 1212, Treatment Protocol: Dysrhythmia Bradycardia – Revised 07-01-2022 (Attachment M)
- Reference No. 1213, Treatment Protocol: Dysrhythmia Tachycardia – Revised 7-01-2022 (Attachment N)

The STEMI Receiving Center Data Dictionary is updated annually. Due to its size, Reference No. 648, SRC Data Dictionary 2023 is not included but available upon request or can be accessed on our Los Angeles EMS Agency website. The SRC Data Dictionary Summary of Changes 2023 is attached and details all the changes made. (Attachment O)

EmergiPress Topics included:

- Evolving STEMI
- ECG of the Month – SVT
- ECG of the Month – Pediatric ECG
- ECG of the Month – QT Prolongation

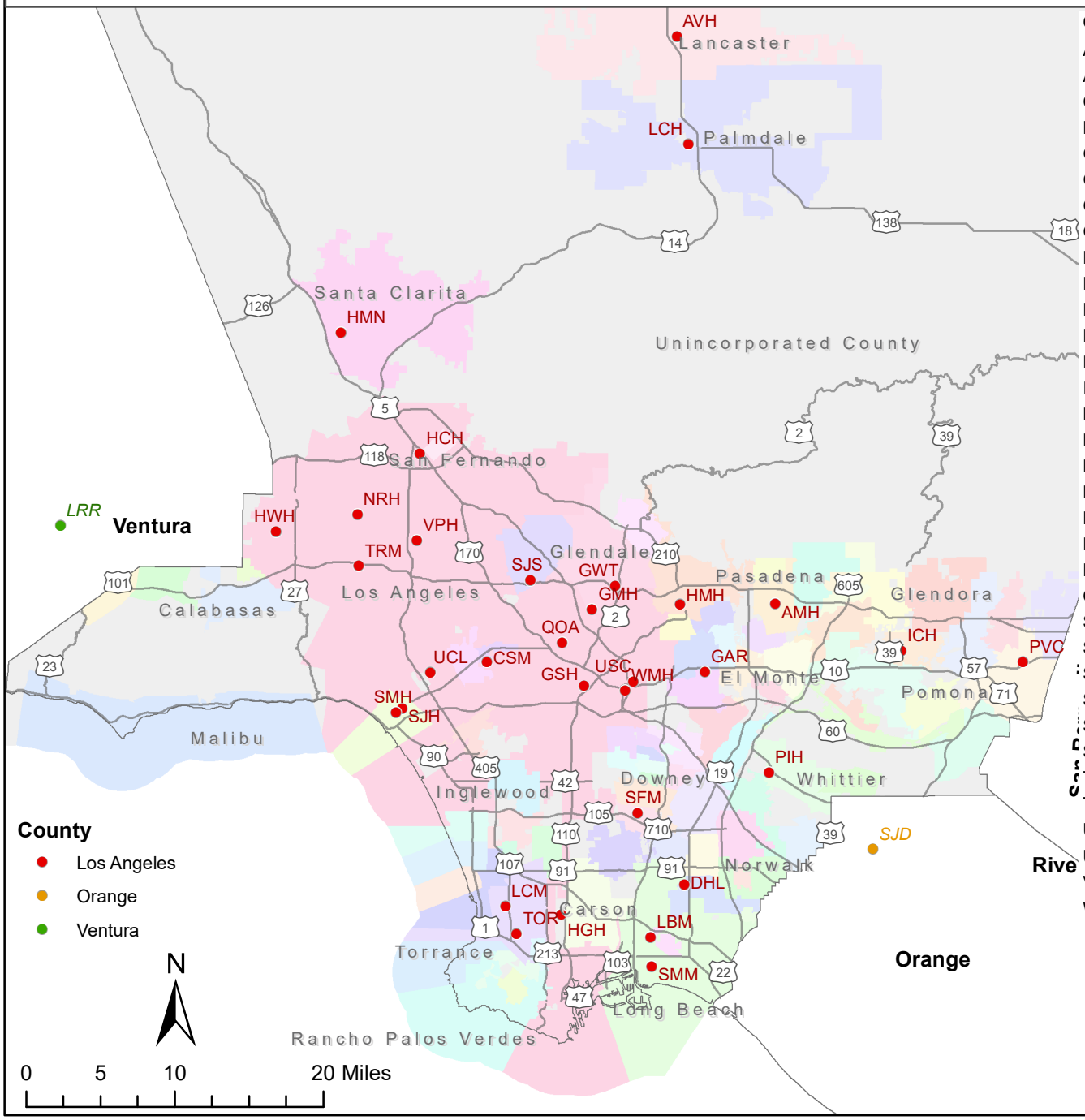
The STEMI Center Advisory/QI Committee met on October 18, 2022 and April 18, 2023. Topics included:

- STEMI/ROSC system-wide data reports
- STEMI Receiving Center Program updates

- Cardiac Arrest Registry to Enhance Survival (CARES) data update
- EMCO Study Pilot Program update
- Stay on Scene Trial (SOS)
- I-gel Implementation
- Sidewalk CPR
- SRC Data Collaborative project updates
- SRC standards/policy updates – Reference No. 320, ST-Elevation Myocardial Infarction Receiving Center Standards
- Inclusion criteria changes

LOS ANGELES COUNTY

ST ELEVATION MYOCARDIAL INFARCTION APPROVED RECEIVING CENTERS



Code	STEMI As of 04/2023
AMH	USC Arcadia Hospital
AVH	Antelope Valley Hospital
CSM	Cedars Sinai Medical Center
DHL	Lakew ood Regional Medical Center
GAR	Garfield Medical Center
GMH	Dignity Health-Glendale Memorial Hospital and Health Center
GSH	PIH Health Good Samaritan Hospital
GWT	Adventist Health - Glendale
HCH	Providence Holy Cross Medical Center
HGH	LAC Harbor-UCLA Medical Center
HMH	Huntington Hospital
HMN	Henry Mayo New hall Hospital
HWH	West Hills Hospital and Medical Center
ICH	Emanate Health Inter-Community Hospital
LBM	MemorialCare Long Beach Medical Center
LCH	Palmdale Regional Medical Center
LCM	Providence Little Company of Mary Medical Center-Torrance
LRR	Los Robles Regional Medical Center
NRH	Dignity Health-Northridge Hospital Medical Center
PIH	PIH Health Whittier Hospital
PVC	Pomona Valley Hospital Medical Center
QOA	Hollyw ood Presbyterian Medical Center
SFM	St. Francis Medical Center
SJD	St. Jude Medical Center
SJH	Providence Saint John's Health Center
SJS	Providence Saint Joseph Medical Center
SMH	Santa Monica-UCLA Medical Center
SMM	Dignity Health-St. Mary Medical Center
TOR	Torrance Memorial Medical Center
TRM	Providence Cedars-Sinai Tarzana Medical Center
UCL	Ronald Reagan UCLA Medical Center
USC	LAC+USC Medical Center
VPH	Valley Presbyterian Hospital
WMH	Adventist Health - White Memorial

Source: SRC_11012021

List of Designated STEMI Centers and Agreement Expiration Dates as of June 30, 2023

STEMI Receiving Centers	Agreement Expiration Date
Adventist Health - Glendale	June 30, 2025
Adventist Health – White Memorial	June 30, 2026
Antelope Valley Hospital	February 28, 2024
Beverly Hospital	September 30, 2022
Cedars Sinai Medical Center	September 30, 2024
Dignity Health – Glendale Memorial Hospital and Health Center	July 31, 2026
Dignity Health – Northridge Hospital Medical Center	April 30, 2025
Dignity Health – Saint Mary Medical Center	August 31, 2024
Emanate Health Intercommunity Hospital	November 30, 2022^
Garfield Medical Center	December 31, 2024
Henry Mayo Newhall Hospital	September 31, 2026
Hollywood Presbyterian Medical Center	March 31, 2026
Huntington Hospital	October 31, 2026
LAC Harbor UCLA Medical Center	January 31, 2025
LAC+USC Medical Center	February 29, 2024
Lakewood Regional Medical Center	May 31, 2025
Los Robles Medical Center (Ventura County)	March 31, 2025
MemorialCare Long Beach Medical Center	August 31, 2025
Palmdale Regional Medical Center	May 31, 2026
PIH Health – Downey	October 31, 2024
PIH Health – Good Samaritan	March 31, 2025
PIH Health – Whittier	May 31, 2024
Pomona Valley Hospital Medical Center	March 31, 2025
Providence Cedars-Sinai Tarzana Medical Center	June 30, 2026
Providence Holy Cross Hospital Medical Center	May 31, 2026
Providence Little Company Mary Medical Center Torrance	October 31, 2022^
Providence Saint John's Health Center	January 31, 2026
Providence Saint Joseph Medical Center	April 30, 2025
Ronald Reagan UCLA Medical Center	March 31, 2025
Santa Monica UCLA Medical Center	January 31, 2026
St. Francis Medical Center	February 28, 2026
St. Jude Medical Center (Orange County)	March 31, 2025
Torrance Memorial Medical Center	April 30, 2025
USC Arcadia Hospital	November 30, 2025
Valley Presbyterian Hospital	March 31, 2026
West Hills Hospital & Medical Center	January 31, 2024

^Pending action items

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **ST-ELEVATION MYOCARDIAL INFARCTION (STEMI) RECEIVING CENTER (SRC) STANDARDS** REFERENCE NO. 320

PURPOSE: To establish minimum standards for the designation of a ST-Elevation Myocardial Infarction Receiving Center (SRC) to ensure that patients transported by the 9-1-1 system in Los Angeles County who exhibit ST-elevation myocardial infarction (STEMI) and/or non-traumatic out-of-hospital cardiac arrest (OHCA), are transported to a hospital appropriate to their needs.

AUTHORITY: California Code of Regulations (CCR), Title 22, Division 9, Chapter 7.1

DEFINITIONS:

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialists (ABMS) or American Osteopathic Association (AOA) including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in a particular specialty.

Board Eligible (BE): Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA for a specific specialty.

Interventional Cardiologist: Physician who has completed a residency in internal medicine, or fellowship in cardiology and/or interventional cardiology, and is BC or BE, and has privileges to perform percutaneous interventions.

Out-of-Hospital Non-traumatic Cardiac Arrest (OHCA): Sudden, sometimes temporary cessation of function of the heart not due to a traumatic cause.

Percutaneous Coronary Intervention (PCI): A procedure used to open or widen a narrowed or blocked coronary artery to restore blood flow supplying the heart.

Promptly Available: Able to be physically present in the emergency department (ED) within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, should not have a measurable harmful effect on the course of the patient management or outcome. Hospital guidelines shall be established that address response time for on-call physicians, usually 30 minutes or less.

Qualified Specialist: A physician licensed in the State of California who has become BC or BE in the corresponding specialty by American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).

Return of Spontaneous Circulation (ROSC): Following cardiopulmonary arrest, ROSC is the restoration of a spontaneous perfusing rhythm. Signs include: palpable pulse, breathing (more than an occasional gasp), a measurable blood pressure and/or a sudden rise in capnography to a normal/high reading.

APPROVED: Director, EMS Agency — Medical Director, EMS Agency

SUBJECT: **ST-ELEVATION MYOCARDIAL INFARCTION (STEMI) RECEIVING CENTER (SRC) STANDARDS** REFERENCE NO. 320

SRC Medical Director: A physician licensed in the State of California and Board Certified in Interventional Cardiology, privileged by the hospital and active in performing PCI.

SRC Program Manager: A Registered Nurse currently licensed to practice in the State of California and appointed by the hospital to monitor, coordinate and evaluate the SRC Program.

ST- Elevation Myocardial Infarction (STEMI): A myocardial infarction that generates ST-segment elevation on a 12-lead ECG.

STEMI Receiving Center (SRC): A licensed general acute care facility that meets the minimum hospital STEMI care requirements pursuant to CCR Section 100270.124 and is able to perform PCI, manage cardiac arrest and post-resuscitation care, and is designated as a SRC by the Los Angeles County EMS Agency.

STEMI Referral Facility (SRF): A non-PCI capable hospital that transfers a STEMI patient requiring emergency cardiac intervention to a designated SRC.

Targeted Temperature Management (TTM): Maintaining body temperature at a target between 32 and 37.5 degrees Celsius in a person for a specific duration of time for the purpose of preserving neurological function post cardiac arrest.

POLICY:

I. SRC Designation / Re-Designation

A. SRC initial designation and re-designation is granted for up to three years based on maintenance of these standards and after a satisfactory review and approval by the EMS Agency.

B. The EMS Agency reserves the right to perform a scheduled on-site survey or request additional data at any time.

C. The SRC shall immediately provide written notice to the Medical Director of the EMS Agency if unable to adhere to any of the provisions set forth in these SRC Standards.

D. The SRC shall provide a 90-day, written notice to the EMS Agency Medical Director of intent to withdraw from the SRC program.

E. The SRC shall notify the EMS Agency, in writing, of any change in status of the SRC Medical Director, SRC Program Manager, or data entry personnel by submitting Reference No. 621.2, Notification of Personnel Change Form.

F. Prior to designation, the SRC shall meet the performance measures, for a minimum of six months, listed in Ref. No. 320.3 and ensure quality improvement processes are in place. Performance measures shall be consistently achieved to maintain SRC designation.

II. General Hospital Requirements

A. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and:

1. Have a special permit for Basic or Comprehensive Emergency Medical Service

2. Accredited by a Centers for Medicare and Medicaid Services (CMS) recognized Hospital Accreditation Organization

3. Have a special permit to provide cardiac catheterization laboratory (cath lab) and cardiovascular surgery services pursuant to the provisions of Title 22, Division 5, California Code of Regulations.

B. Appoint a SRC Medical Director and SRC Program Manager who shall be responsible for meeting the SRC Program requirements and allocate non-clinical time such that they can meet the requirements of the SRC standards.

C. Have a fully executed Specialty Care Center SRC Designation Agreement with the EMS Agency.

D. Have the capability to receive transmitted 12-Lead ECG from EMS providers through a process that is agnostic to monitor type and optimizes efficiency, and includes the following:

1. An alert when hospital receives ECG transmission

2. A process to ensure that firewalls do not block the transmission and distribution of the transmitted ECGs.

E. Establish a Memorandum of Understanding (Ref. No. 320.2 MOU IFT for Acute STEMI) for the timely transfer of STEMI patients for emergent PCI from the regional SRFs to the SRC.

III. SRC Leadership Requirements

A. SRC Medical Director

1. Responsibilities:

a. Medical oversight and ongoing performance of the STEMI and OHCA quality improvement (QI) programs

b. Participate in the hospital Cardiology Committee or equivalent and other committees associated with STEMI, cardiac arrest, and post-resuscitation care

c. Collaborate with the SRC Program Manager to ensure adherence to these Standards

d. Liaison with hospital administration, SRC Program Manager, medical and clinical staff across the STEMI and OHCA patient's continuums of care

e. Attend 100% of the EMS Agency's SRC QI Meetings onsite or via video conference. Fifty percent (50%) of meetings may be attended by an alternate interventional cardiologist from the same SRC.

B. SRC Program Manager

1. Qualifications:

a. Currently assigned in the cath lab (if duties are shared with another RN(s), one RN must be assigned to the cath lab)

b. Knowledgeable in critical care and interventional cardiac procedures

c. Able to facilitate internal hospital policy and procedure development and implementation

2. Responsibilities:

a. Collaborate with the ED Medical and Clinical Directors regarding STEMI, cardiac arrest, and post-resuscitation care

b. Collaborate with the SRC Medical Director to ensure adherence to these Standards

c. Maintain and monitor STEMI and OHCA QI programs

d. Participate in the hospital Cardiology Committee or equivalent and other committees associated with STEMI, cardiac arrest, and post-resuscitation care

e. Ensure hospital policies are consistent with these Standards

f. Liaison with hospital administration, SRC Medical Director, medical and clinical staff across the STEMI and OHCA patient's continuums of care

g. Liaison with prehospital cardiac monitor vendors and EMS Provider Agencies to ensure successful ECG transmission

h. Attend 100% of the EMS Agency's SRC QI Meetings on site or via video conference. Fifty percent (50%) of meetings may be attended by an alternate cath lab RN from the same SRC.

i. Ensure processes are in place to identify and track patients transported to the SRC by EMS providers, including patients transferred from other acute care hospitals

j. Provide oversight of accurate and timely data collection and submission

k. Develop relationships and collaborate with the surrounding SRFs to meet specified time metrics

l. Ensures SRC diversion is consistent with EMS policies and processes are in place to minimize the need for diversion

IV. SRC Program Physician Participants

A. Hospital shall maintain a cardiac catheterization team and cardiothoracic surgery on-call panel 24 hours per day/7 days per week/365 days per year.

B. All physicians attending in the ED shall be BC or BE in Emergency Medicine.

C. Interventional Cardiologists performing emergent percutaneous interventions must:

1. Maintain current board certification or, board eligibility, in interventional cardiology with privileges in PCI procedures, and credentialed by the hospital;

OR

2. Maintain current board certification in internal medicine or cardiovascular disease with privileges in PCI procedures and credentialed by the hospital.

D. On-call interventionalists may only be on-call for **one** facility at a time.

E. Surgeons performing coronary artery bypass grafting (CABG), must maintain current BC , or is BE in Cardiovascular/Cardiothoracic surgery with specific privileges in CABG and credentialed by the hospital.

F. On-call physicians should be promptly available, not to exceed 30 minutes, for a cath lab activation.

V. SRC Program Plan

The hospital shall develop and maintain a SRC Program Plan pertaining to the care of the STEMI and/or OHCA patient. The plan shall be reviewed annually and approved by the appropriate committee(s) every three years. The SRC Program should include, at minimum, the following:

A. Job descriptions and organization structure clarifying the relationship between the SRC Medical Director, SRC Program Manager and the cardiac catheterization team

B. Cath lab activation guidelines with the ability to track the activation and/or cancelation

C. Procedures for triage, diagnosis and cardiac catheterization team activation following EMS notification of impending arrival of a STEMI/OHCA patient, which shall include, at minimum, the following:

1. A process for immediate notification of the emergency physician and/or interventional cardiologist upon EMS notification of a STEMI patient transport

2. A protocol for physician review of patient data, including ECG if available, to determine if activation from the field is appropriate

3. A single call activation system to directly activate the cardiac catheterization team

4. A process for the triage and treatment of simultaneously arriving STEMI/OHCA patients

5. Post resuscitation care, including initiation of TTM

6. A process for direct feedback to the transporting paramedics on the patient's presumed diagnosis and ED disposition

D. A process to administer fibrinolytics, move other cath lab patients, or transfer a STEMI patient to another SRC when there is a mechanical issue in the cath lab, or the hospital is on internal disaster

E. Mechanisms to ensure SRC diversion is consistent with EMS policies and processes are in place to minimize the need for diversion

F. A process to collaborate with EMS providers and 12-Lead ECG vendors to integrate electronic prehospital patient care (ePCR) records into the hospital electronic medical record

G. SRC Program Manager shall ensure review and recommend revisions to the SRC Program Plan, policies and procedures to maintain compliance with SRC Standards.

VI. Data Collection and Submission Requirements

A. Ensure adequate data entry personnel, collaborate with ED personnel to ensure capture and entry of patients meeting inclusion criteria into the Los Angeles County EMS Agency STEMI Receiving Center Database on an ongoing basis. Back-up data entry personnel should be identified and trained in the event primary data personnel is unable to meet the data entry requirements.

B. Participate in the data collection process established by the EMS Agency.

C. Maintain an Emergency Department (ED) Log to capture patients who are transported to the ED due to SRC designation.

D. Submit data to the EMS Agency, within 45 days of patient's discharge, which shall include all patients who meet data inclusion criteria and all applicable data elements listed in Ref. No. 648, STEMI Receiving Center Data Dictionary.

E. Maintain a minimum 90% compliance for:

1. Capture of patients meeting the data inclusion criteria

2. Data field completion

3. Data field accuracy

4. Timely data entry

VII. Quality Improvement (QI)

A. SRC Program must include a comprehensive-multidisciplinary SRC QI Meeting.

1. Meeting participation should include the SRC Medical Director, SRC Program Manager, EMS providers and educators, interventional cardiologists, ED physicians, ED and cath lab personnel, other associated healthcare providers, as well as other healthcare specialties including neurology, thoracic surgery or TTM specialists when applicable.

2. Meeting to be held quarterly, at a minimum.

3. Meeting minutes and roster must be maintained for each meeting and available for review.

4. SRCs that are also a Base Hospital are encouraged to provide periodic SRC Base Hospital education with the collaboration of the SRC Program Manager.

B. Pertinent aspects of care should be tracked and trended with the identification of areas requiring improvement and the action(s) necessary to improve care.

C. The SRC QI program shall:

1. Track and trend performance measures as per Ref. No. 320.3, SRC Performance Measures

2. Review the care and outcome on, but not limited to, the following patients:

a. In-hospital STEMI deaths

b. Coronary angiography complicated by intra-procedure or post-procedure bleeding requiring transfusion

c. Coronary angiography complicated by intra-procedural or post-procedural stroke

d. Any delays in care

e. All patients with OHCA with sustained ROSC – to include whether TTM and PCI were performed when indicated

3. Collaborate with SRF(s) to evaluate care of transfer patients, to include:

a. Door-in to door-out time (DIDO) at SRF (Goal <30 minutes)

b. Proportion of 9-1-1 IFTs for STEMI who went for emergency coronary angiogram (goal $\geq$90%)

c. Use of 9-1-1 for non-STEMI transfers

d. Quality of care issues and delays

4. Address other issues, processes or personnel trends identified from hospital specific data (i.e., increase in fallouts over time, proportion of patients transported to the cath lab found not to have a STEMI).

5. SRC shall have a mechanism to provide feedback to EMS Providers and SRFs (i.e., encrypted/secure e-mail). The feedback shall be provided within one (1) week of patient arrival at the SRC. Feedback shall include, but be not limited to, the following:

   a. Date of service, sequence number, provider unit, patient age and gender, whether the patient received coronary angiogram and/or PCI, and positive feedback when a job was well done.

   b. Rationale for not performing angiogram, which may be in the following three categories:

      i. Patient factor (e.g., patient refusal, contraindication to angiogram)

      ii. ECG quality (e.g., poor quality field ECG which led to misinterpretation)

      iii. Non-ischemic ST elevation (e.g., early repolarization, bundle branch blocks, hyperkalemia)

3. Any quality-of-care concerns

XI. Public Education

SRC shall participate in the annual Los Angeles County EMS Agency sponsored Side-Walk CPR public education programs or annually provide a minimum of one public education class on CPR. Sign-in rosters need to be maintained. Classes may be in collaboration with other health care providers/organizations.

CROSS REFERENCE

Prehospital Care Manual

Ref. No. 320.1, **Target Temperature Management Guidelines**
Ref. No. 320.2, **Interfacility Transfer Memorandum of Understanding for Acute STEMI**
Ref. No. 320,3, **SRC Performance Measures**
Ref. No. 321.2, **Notification of Personnel Change Form**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**
Ref. No. 513, **S-T Elevation Myocardial Infarction (STEMI) Patient Destination**
Ref. No. 513.1, **Interfacility Transfer of Patients with STEMI**
Ref. No. 516, **Cardiac Arrest Patient Destination**
Ref. No. 624, **STEMI Receiving Center QI Committee**
Ref. No. 1303, **Medical Control Guideline: Algorithm for Cath Lab Activation**
Ref. No. 1308, **Medical Control Guideline: Cardiac Monitoring / 12-Lead ECG**

2020 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

SUBJECT: **ST-ELEVATION MYOCARDIAL INFARCTION (STEMI) RECEIVING CENTER (SRC) STANDARDS** REFERENCE NO. 320

ACKNOWLEDGEMENTS:

The input of the Hospital Association of Southern California's (HASC) Emergency Health Services Committee and the Cardiac Technical Advisory Group (TAG) was essential in the initial development of these standards. The TAG was composed of a cardiologist from the American Heart Association; Emergency Department physicians from teaching and community hospitals; an EMS Commissioner; nurse managers from emergency departments and catheterization labs; members of the Association of Prehospital Care Coordinators; a Paramedic Nurse Educator; and the Emergency Medical Services (EMS) Agency. Additional contributions were made by the Medical Council of the EMS Agency, the Commission, the American Heart Association and the Los Angeles County Medical Association.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **TARGETED TEMPERATURE MANAGEMENT GUIDELINE**

REFERENCE NO. 320.1

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 7.1

PRINCIPLES:

1. Targeted temperature management (TTM) preserves cerebral function in patients resuscitated after cardiac arrest. This occurs through decreasing cellular metabolism and oxygen demand, reducing production of excitatory neurotransmitters, minimizing disruption of ion homeostasis, and reducing free radicals.

2. Previously referred to as “therapeutic hypothermia”, the term TTM has been adopted to refer to either induced hypothermia or strict temperature control at a target core temperature at or below normothermia (32-37.5ºC) for at least 24 hours.

3. Current guidelines recommend that all comatose adult patients with return of spontaneous circulation (ROSC) after cardiac arrest have TTM for both shockable and non-shockable rhythms.

4. While there are no data demonstrating a benefit of therapeutic hypothermia in children who remain comatose after out-of-hospital cardiac arrest, these children with ROSC may benefit from TTM with target temperatures between 36 and 37.5°C.

5. Initiating hypothermia in the prehospital setting has **not** improved survival or neurologic outcomes. Currently there is no role for prehospital cooling.

6. Fever in the post-cardiac arrest patient is associated with poor outcome.

7. TTM is the only intervention demonstrated to improve neurological recovery after cardiac arrest. TTM should not affect the decision to perform percutaneous coronary intervention (PCI). Concurrent PCI and TTM are reported to be feasibly safe.

GUIDELINES:

1. Fever should be avoided in all comatose post-cardiac arrest pediatric and adult patients.

2. Comatose adult (greater than 14 years of age) patients with ROSC after cardiac arrest should receive TTM.

3. There are no absolute contraindications for TTM; however, it is reasonable to withhold TTM in the following scenarios:

   a. Known wishes for limitations in resuscitation and/or a Do Not Resuscitate (DNR) order

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Medical Director, EMS Agency

b. Known comorbid disease making 180 days survival unlikely

c. Preceding poor neurologic function (Pre-arrest Cerebral Performance Category of 3 or 4)

d. Temperature on admission <30°C

4. A temperature between 32°C and 37.5°C should be selected and maintained for **at least 24 hours** once target temperature is achieved. Core temperature should be monitored. Axillary or oral temperatures are inadequate for measurement of core temperature.

5. Targets below 36°C should typically be avoided for the following conditions:

   a. Pregnancy

   b. Known intrinsic bleeding diathesis (e.g. Hemophilia or Von Willebrand)

   c. Acute intracranial bleeding and/or major head trauma

   d. Active significant bleeding

   e. Suspected or confirmed acute stroke

   f. Systolic blood pressure <80 mm Hg despite fluid resuscitation, vasopressor(s) and possibly including inotropic medication and/or intra-aortic balloon pump

   g. Delays longer than 6 hours from ROSC to cooling

6. TTM may be achieved and maintained using:

   a. Intravenous Normal Saline 4°C

   b. Ice packs (axillae, groin, neck)

   c. Cooling blankets

   d. Cooling vests

   e. Intravascular devices (including extracorporeal membrane oxygenation)

CROSS REFERENCE:

2020 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

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 _____ Medical Center,

bearing the effective date of _____/_____/_____ is made and entered into as of the date

of execution below, by and between

_____ the ST-Elevation Myocardial Infarction

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

_____ the STEMI Referral Facility (SRF)

(hereinafter referred to as "SRF"), and sets forth in full, completely, and exclusively of any

understandings which shall be controlling over this AGREEMENT.

This AGREEMENT is to provide for the specific transfer of STEMI patients from

_____, a SRF, to _____, a SRC

with the intent to provide emergency angiography for STEMI in the cardiac catheterization

laboratory (cath lab) and primary percutaneous coronary intervention (PCI) when clinically

appropriate.

The following is to occur prior to transfer:

SRF Responsibilities:

- Email or 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 SRF to ensure the appropriate level of transport.
- Call the private ambulance company for transport to the SRC confirming a response time of less than 10 minutes.

If private ambulance is not available:

- Call 9-1-1 after the STEMI patient is packaged and ready for immediate transport – 9-1-1 transports are reserved for **Emergency Department** STEMI patients requiring emergent PCI.
- Send any available records with the patient without delaying transport – other information, not sent at the time of transfer may be sent at a later time.

SRC Responsibilities:

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

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

STEMI *Referral Facility*: _____

Signature: _____

Print Name: _____

Title: _____

Date: _____

STEMI *Receiving Center*: _____

Signature: _____

Print Name: _____

Title: _____

Date: _____

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

SUBJECT: **SRC PERFORMANCE MEASURES** REFERENCE NO. 320.3

PURPOSE: To provide standardized quantifiable indicators to assess and evaluate the performance, quality of care and program management of designated STEMI Receiving Centers (SRC).

DEFINITIONS:

Cerebral Performance Category (CPC) Score: A tool used to assess neurologic outcome following cardiac arrest.

Door to Balloon Time (D2B): A time measurement that starts with the patient's arrival in the emergency department and ends when the first device (excluding guidewire) intervened at the culprit lesion during the first percutaneous coronary intervention.

Electrocardiogram (ECG) Time: Time 12-Lead ECG was obtained.

Emergency Department (ED) Door Time: Time of patient arrival at the ED.

Percutaneous Coronary Intervention (PCI): A procedure used to open or widen a narrowed or blocked coronary artery to restore blood flow supplying the heart.

Return of Spontaneous Circulation (ROSC): Following cardiopulmonary arrest, ROSC is the restoration of a spontaneous perfusing rhythm. Signs of ROSC include: palpable pulse, breathing (more than an occasional gasp), a measurable blood pressure and/or a sudden rise in capnography to a normal/high reading.

STEMI Referral Facility (SRF) Time: Time of patient arrival at the ED of the STEMI Referral Facility

Targeted Temperature Management (TTM): Maintaining body temperature at a target between 32 and 37.5 degrees Celsius in a person for a specific duration of time for the purpose of preserving neurological function post cardiac arrest.

POLICY:

I. The SRC shall meet compliance threshold on all performance measures to maintain SRC Designation.

II. The EMS Agency may terminate SRC designation at any time if an SRC's non-compliance with the Performance Measures are deemed significant enough to result in poor patient outcomes.

III. Performance Measures:

A. Receipt of notification of transmission of prehospital ECG to MD ECG review is within 5 minutes 90% of the time

B. ED Door Time to ED ECG obtained time, when a confirmation ECG is required, is within 10 minutes 90% of the time

C. Prehospital ECG Time to PCI is within 120 minutes 90% of the time and 90 minutes 75% of the time

D. D2B for EMS (9-1-1) Transports: within 90 minutes 90% of the time and 60 minutes 75% of the time

E. SRF Door to PCI is within 150 minutes 90% of the time and 120 minutes 75% of the time

F. Prehospital/ED cardiac arrest patients who achieve ROSC with STEMI to cath lab is within 6 hours 90% of the time

G. TTM for patients who meet inclusion criteria is applied 90% of the time

H. Cerebral Performance Category (CPC) Score is documented upon discharge on cardiac arrest patients 90% of the time

IV. Procedure for Non-Compliance with Performance Measures

Month	Action 1	Compliance Result	Action 2
1st	SRC provides care to STEMI and OHCA Patients		
2nd	SRC starts data collection and electronic data collection for patients who meet inclusion criteria		
3rd	EMS Agency reviews SRC's 1st month compliance with all performance measures	SRC does not meet 90% compliance in any one of the performance measures Significant Improvement	EMS Agency notifies SRC's Medical Director and Program Manger via e-mail or telephone, of non-compliance and request corrective action plan and assist in determining solutions. Monitor
4th	EMS Agency reviews SRC's 2nd month compliance with all performance measures	No significant improvement Significant improvement	EMS Agency sends a written notice to SRC's Medical Director and Program Manager notifying of compliance results and continued non-compliance. Monitor
5th	EMS Agency reviews SRC's 3rd month compliance with all performance measures	No significant improvement Significant improvement	EMS Agency notifies SRC's Medical Director and Program Manager in writing of compliance results and request to submit within 15 calendar days a plan to correct deficiency. Monitor

Month	Action 1	Compliance Result	Action 2
6th	EMS Agency reviews SRC's 4th month compliance with all performance measures	No significant improvement Significant improvement	Within 15 days of EMS Agency's receipt of SRC's corrective action plan, the EMS Agency will provide SRC a written approval or request additional modification to SRC's corrective action plan. Monitor
7th	EMS Agency reviews SRC's 5th month compliance with all performance measures	No significant improvement Improvement based on approved corrective action plan	EMS Agency notifies SRC's Medical Director and Program Manager in writing of compliance results and request modification to SRC's corrective action plan. Monitor
8th	EMS Agency reviews SRC's 6th month compliance with all performance measures	No significant improvement Improvement based on approved corrective action plan	EMS Agency notifies SRC's Chief Executive Officer or President in writing of compliance results and continued failure to meet performance measures. SRC is place on a 3-month provisional status. Monitor
9th	EMS Agency reviews SRC's 7th month compliance with all performance measures	No significant improvement Improvement based on approved corrective action plan	EMS Agency will notify SRC of continued non-compliance Monitor
10th	EMS Agency reviews SRC's 8th month compliance with all performance measures	No significant improvement Improvement based on approved corrective action plan	EMS Agency will notify SRC of continued non-compliance Monitor
11th	EMS Agency reviews SRC's 9th month compliance with all performance measures	No significant improvement Improvement based on approved corrective action plan	EMS Agency notifies SRC's Chief Executive Officer or President in writing that continued noncompliance may result in revocation of SRC designation. Monitor
12th	EMS Agency reviews SRC's 10th month compliance with all performance measures	No significant improvement	EMS Agency will notify SRC's Chief Executive Officer or President in writing of revocation of hospital's SRC designation.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC, MICN)

SUBJECT: **ST-ELEVATION MYOCARDIAL INFARCTION (STEMI) PATIENT DESTINATION**

REFERENCE NO. 513

PURPOSE: To ensure that 9-1-1 patients with ST-elevation myocardial infarction (STEMI) are transported to the most appropriate facility that is staffed, equipped, and prepared to administer emergency and/or definitive care appropriate to the needs of a STEMI patient.

AUTHORITY: Health & Safety Code, Division 2.5, Sections, 1798

DEFINITIONS:

ST-Elevation Myocardial Infarction (STEMI): An acute myocardial infarction that generates ST-segment elevation on the prehospital 12-lead electrocardiogram (ECG).

STEMI Receiving Center (SRC): A facility licensed for a cardiac catheterization laboratory and cardiovascular surgery by the Department of Public Health, Health Facilities Inspection Division, and approved by the Los Angeles County EMS Agency as a SRC.

PRINCIPLES:

1. The 12-lead ECG in the prehospital care setting plays a key role in determining the most appropriate treatment and destination for patients with suspected cardiac symptoms.

2. In all cases, the health and wellbeing of the patient is the overriding consideration in determining patient destination. Factors to be considered include: clinical presentation, severity, and stability of the patient's condition; current status of the SRC; anticipation of transport time; and request by the patient, family, guardian, or physician.

3. Prehospital identification and communication of STEMI can reduce critical "door-to-intervention" times for STEMI patients.

POLICY:

I. A prehospital 12-lead ECG should be performed in accordance with the Ref. No. 1308, Cardiac Monitoring/12-lead ECG Medical Control Guideline.

II. If the 12-lead ECG demonstrates STEMI (or manufacturer's equivalent), transmit the 12-lead ECG to the receiving SRC.

III. For any patient with a software interpretation of STEMI on the 12-lead ECG where the paramedic provider impression differs, base contact should be established to clarify the provider impression and to determine the destination.

IV. Paramedics shall notify the receiving SRC and discuss catherization (cath) lab activation criteria for all patients with a provider impression of Chest Pain – STEMI, including 9-1-1

APPROVED:

Director, EMS Agency

Medical Director, EMS Agency

interfacility transports of patients with a STEMI 12-lead ECG from a non-SRC ED to an SRC.

V. In general, patients with a STEMI 12-lead ECG, (including hypotensive patients with signs and symptoms consistent with cardiogenic shock) shall be transported to the most accessible open SRC if ground transport is 30 minutes or less regardless of service area boundaries.

VI. Provide properly labeled, at a minimum patient name and sequence number, 12-lead ECGs to the receiving facility (in either paper or electronic format) as part of the patient's prehospital medical record.

VII. Document the findings of the 12-lead ECG on the Patient Care Record.

VIII. STEMI patients should be transported to the most accessible SRC regardless of **ED Diversion** status.

IX. If ground transport time to **any** SRC is greater than 30 minutes, the patient shall be transported to the most accessible receiving facility.

X. If the closest SRC has requested **SRC Diversion** (as per Ref. No. 503), STEMI patients should be transported to the **next** most accessible **open** SRC if ground transport time is less than 30 minutes.

XI. Interfacility Transfer of STEMI patients from a STEMI Referral Facility (SRF) Emergency Department to a SRC via the 9-1-1 system: SRFs are strongly encouraged to enter into interfacility transfer agreements with the most accessible SRC (See Ref. No. 320.2).

A. Patients are to be transported to the SRC as directed by the SRF physician (base hospital contact/notification guidelines apply).

B. Transport units may bypass the most accessible SRC to the prearranged receiving SRC within 30 minutes, if the EMS provider resources at the time of transport allow.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 506, **Trauma Triage**
Ref. No. 513.1, **Interfacility Transport of the ST-Elevation Myocardial Infarction Patient**
Ref. No. 516, **Cardiac Arrest Patient Destination**
Ref. No. 517, **Private Provider Agency Transport/Response Guidelines**
Ref. No. 1210, **Cardiac Arrest**
Ref. No. 1211, **Cardiac Chest Pain**
Ref. No. 1212, **Cardiac Dysrhythmia – Bradycardia**
Ref. No. 1213, **Cardiac Dysrhythmia – Tachycardia**
Ref. No. 1303, **Cath Lab Activation Algorithm**
Ref. No. 1308, **Cardiac Monitoring/12-Lead ECG**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **RETENTION AND DISPOSITION OF PREHOSPITAL PATIENT CARE RECORDS** (EMT, PARAMEDIC, MICN) REFERENCE NO. 608

PURPOSE: To outline the appropriate procedure for retention and disposition of Prehospital Patient Care Records which includes but is not limited to the following formats: electronic patient care record (ePCR), EMS Report form, Base Hospital Form, Multiple Casualty Incident (MCI) Base Hospital Form, Base Hospital Form Page 2, Advanced Life Support (ALS) Continuation Form, Triage Tags, base hospital radio contact logs, base hospital medical control audio recordings, and private provider agency patient care records.

AUTHORITY: California Code of Regulations, Title 22, Sections 100128, 100170
California Welfare and Institutions Code Section 14124.1
California Health and Safety Code section 1797.98(e)
Health Insurance Portability and Accountability Act of 1996

PRINCIPLES:

1. Prehospital patient care records contain patient information which is protected under the Health Insurance Portability and Accountability Act (HIPAA) and shall be maintained in accordance with HIPAA regulations.

2. Prehospital care providers and base hospitals have an obligation to ensure the security of confidential patient information.

3. Personnel responsible for all aspects of prehospital patient care record maintenance (including data entry personnel) shall receive appropriate training related to patient care record confidentiality.

4. Prehospital patient care records shall be maintained in a secure location with access limited to authorized personnel.

5. Provider agencies and base hospitals are responsible for maintaining the original copy of prehospital patient care records.

6. Original patient care records of all patients shall be retained for a minimum of seven years. Original patient care records of minors shall be kept for at least one year after such minors have reached the age of 18, but in no event less than seven years following the provision of service.

7. Records shall be accessible for audit review by EMS Agency personnel.

8. All records related to either suspected or pending litigation shall be retained indefinitely.

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill
Medical Director, EMS Agency

SUBJECT: **RETENTION AND DISPOSITION OF PREHOSPITAL CARE RECORDS** REFERENCE NO. 608

POLICY:

I. Provider Agency Prehospital Patient Care Records:

A. ePCR, EMS Report Form, and ALS Continuation Forms are utilized as applicable for all 9-1-1 patients (ALS and BLS) and for private provider transports where base contact is made for medical control and are distributed as follows:

1. White (Original) - Retained by the EMS Provider Agency that initiates the form.

2. Red (Receiving Hospital) - Left with the receiving facility for transported patients. This copy becomes part of the patient's medical record at the receiving facility. If the patient is not transported, disposition is at the discretion of the EMS Provider Agency that initiates the form.

3. Yellow (EMS Agency) - Sent to the EMS Agency within 30 days of the last day of the preceding month. The EMS Agency shall retain until the data has been entered into the Trauma Emergency Medical Information System (TEMIS) database.

B. Private provider agency-specific, non-9-1-1 prehospital patient care records are completed for all patients and are distributed as follows:

1. Original copy - Retained by the private provider agency that initiates the form.

2. Duplicate copy – Left with the receiving facility for patients transported to a healthcare facility. This copy becomes part of the patient's medical record at the receiving facility. If patient is not transported to a healthcare facility, disposition is at the discretion of the private provider agency that initiates the form.

C. Triage Tags - In the event of a multiple casualty incident where triage tags are utilized, the original triage tag will remain with the patient, if transported, the triage tag should become part of the patient's medical record at the receiving facility. If the patient is not transported, the triage tag is to be retained as the original patient care record.

II. Base Hospital Records: Base Hospital Form, MCI Base Hospital Form, and Base Hospital Form Page 2 are utilized, as applicable, for all patients requiring base hospital contact and are distributed as follows:

A. White (Original) - Retained by the Base Hospital that initiates the form.

B. Red (Complimentary) - Used at the discretion of the Base Hospital.

C. Black (Complimentary) - Used at the discretion of the Base Hospital.

III. Maintenance of Prehospital Care Patient Records

A. Prehospital patient care records shall be delivered to the EMS Agency in a manner that ensures form security and patient confidentiality.

B. Prehospital patient care records in paper format, may be stored electronically upon written approval by the EMS Agency.

IV. Destruction of Prehospital Care Patient Records

A. Prehospital patient care records that are eligible for destruction shall be disposed of in accordance with all applicable laws.

B. Complimentary and supplemental copies of prehospital patient care records shall be disposed of in accordance with all applicable laws.

CROSS REFERENCES:

Prehospital Care Policy Manual:
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **RELEASE OF EMERGENCY MEDICAL SERVICES (EMS) RECORDS** REFERENCE NO. 612

PURPOSE: To establish a procedure for release of EMS patient care records which contain protected health information.

AUTHORITY: Health & Safety Code, Sections 123100 – 123149.5
American Hospital Association, A Patient's Bill of Rights
Healthcare Information Portability and Accountability Act of 1996 (HIPAA)
Health Information Technology for Economic and Clinical Health (HITECH) Act

DEFINITIONS:

Protected Health Information (PHI): Individually identifiable health information that is held or transmitted in any form or media, whether electronic, written, spoken, printed, digital, recorded, or photographic, which can be linked to an individual, or there is reasonable basis to believe it can be used to identify an individual.

Emergency Medical Services (EMS) Records: EMS records exist in different formats and include those on which written, printed, spoken or digital information is recorded or preserved. For purposes of this policy, EMS records consist of the Base Hospital Forms and EMS Report Forms which include but are not limited to: Base Hospital Page 2s, Base Hospital Multiple Casualty Incident (MCI) Forms, Advanced Life Support (ALS) Continuation Forms, and Triage Tags.

PRINCIPLES:

1. Patients have the right to communicate with healthcare providers in confidence and to have the confidentiality of their PHI maintained.

2. Patients have the right to review and receive a copy their own medical records upon presenting to the healthcare provider a written request specifying the records to be copied.

3. Attorneys may request EMS records in accordance with the law.

POLICY:

Individual's requesting the release of an EMS record shall be directed in the following order:

I. Hospital

   A. The requesting individual will be referred to the Medical Records Department of the healthcare facility where the patient was transported.

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Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

B. If available, the facility's procedure for releasing medical records shall be followed.

II. Provider Agency

A. If the receiving hospital does not have a copy of the EMS record or if the patient was not transported, the individual may request the provider agency to release the document.

B. The provider agency's policy or procedure for releasing medical records shall be followed and the report shall be released only upon receipt of a:

1. Subpoena Duces Tecum, or

2. An authorization form signed by the patient or patient's representative such as a Release of Medical Records, Request for Patient Access to Health Information, or the provider agency's own form to ensure proper release of medical information.

III. EMS Agency

A. If neither the hospital nor the provider agency is able to provide the requested EMS record, the EMS Agency may be asked to release the document.

B. If the records are available, they shall be released only upon receipt of a:

1. Subpoena Duces Tecum, or

2. An authorization form for Release of Medical Records, Request for Patient Access to Health Information or similar form signed by the patient or patient's representative.

AND

3. The EMS Agency shall require reasonable verification of identity, such as photo identification, prior to permitting inspection or copying of the EMS records.

CROSS REFERENCE

Prehospital Care Manual:
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 622, **Release of EMS Data**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **NOTIFICATION OF PERSONNEL CHANGE** REFERENCE NO. 621

PURPOSE: To inform the EMS Agency of all pertinent staffing, address, telephone, and electronic mail changes within the EMS community to facilitate the flow of information between organizations.

POLICY: All EMS related organizations shall complete and forward Ref. No. 621.1, Notification of Personnel Change Form Provider Agency & Training Programs or 621.2, Notification of Personnel Change Hospital Programs, whenever there is an address, telephone, or personnel staffing change of one of the following positions:

A. Provider Agency (Ref. No. 621.1):

1. Fire Chief/Chief Executive Officer
2. Paramedic Coordinator
3. Medical Director
4. EMS Educator
5. SCT Coordinator (RN/RCP)
6. AED Program Coordinator
7. Quality Improvement Coordinator
8. General Manager/Operations Manager or Equivalent
9. Professional Standards Manager or Equivalent
10. Other Manager

B. Approved Training Programs: (EMT/Paramedic/MICN/Expanded Scope/Skills and CE) (Ref. No. 621.1):

1. Medical Director - (Paramedic only)
2. Program Director
3. Clinical Director/Coordinator
4. Principal Instructor - (EMT only)

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Marianne Gausche-Hill
Medical Director, EMS Agency

C. Hospitals (Ref. No. 621.2):

1. Chief Executive Officer
2. Emergency Department Medical Director
3. Emergency Department Nurse Manager
4. Base Hospital Medical Director
5. Prehospital Care Coordinator
6. Trauma Medical Director
7. Trauma Program Manager
8. EDAP Medical Director
9. Pediatric Liaison Nurse
10. EDAP Pediatric Consultant
11. PMC Medical Director
12. PMC Nurse Coordinator
13. PICU Nurse Manager
14. Disaster Coordinator/Emergency Management Officer (EMO)
15. Trauma/Burn Surge Coordinator
16. Stroke Center Medical Director
17. Stroke Center Program Manager
18. SRC Medical Director
19. SRC Program Manager
20. SART Program Director
21. SART Program Medical Director
22. SART Program Nurse Coordinator

FORWARD TO:

Los Angeles County Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Attention: Prehospital Care Programs (621.1)
Attention: Hospital Programs (621.2)

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **STEMI RECEIVING CENTER ADVISORY - QUALITY IMPROVEMENT COMMITTEE (SRCA-QIC)**

REFERENCE NO. 624

PURPOSE: The ST Elevation Myocardial Infarction Receiving Center (SRC) Advisory – Quality Improvement Committee (SRCA–QIC) through a system-wide approach and peer review, will monitor, evaluate, and facilitate the quality improvement process for the STEMI and non-traumatic out of hospital cardiac arrest (OHCA) Receiving Center program.

AUTHORITY: Health and Safety Code Division 2.5
California Code of Regulations, Title 22, Division 9
California Evidence Code, Section 1157.7
California Civil Code, Part 2.6, Section 56.

PRINCIPLES:

1. The proceedings of the of the SRCA-QIC shall be free from disclosure and discovery (Section 1157.7, California Evidence Code) and held as a confidential peer review meeting with all communications deemed part of the peer review process.

2. Care of the patient with a ST-Elevation Myocardial Infarction (STEMI) and/or OHCA requires a system-wide approach to ensure delivery of the highest standard of care.

POLICY:

I. The SRCA-QIC shall:

   A. Review the SRC Quality Improvement Program from a system perspective.

   B. Develop current system-wide standards.

   C. Identify system issues, developing a plan for improvement, and monitoring results of the SRC system-wide quality improvement program.

   D. Meet biannually, at a minimum

II. The SRCA-QI membership shall consist of the following:

   A. SRC Medical Program Director from each SRC.

   B. SRC Clinical Program Director from each SRC.

   C. EMS Agency Medical Director and designated staff.

   D. Other individuals, invited as Ad Hoc members, whose presence is germane to the SRC system and quality assurance/improvement process.

APPROVED: Director, EMS Agency

Medical Director, EMS Agency

SUBJECT: **STEMI RECEIVING CENTER ADVISORY - QUALITY IMPROVEMENT COMMITTEE (SRCA-QIC)** REFERENCE NO. 624

III. The EMS Agency shall:

A. Perform periodic evaluation of the SRC program, including hospital-specific programs.

B. Provide system-wide reports and analysis of SRC program data to the committee.

C. Provide meeting notifications, attendance rosters, agendas, and minutes.

D. Maintain all records in a confidential manner.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 320, **ST Elevation Myocardial Infarction Receiving Center Standards**
Ref. No. 513, **ST Elevation Myocardial Infarction Patient Destination**
Ref. No. 618, **EMS Quality Improvement Program Committees**
Ref. No. 620, **EMS Quality Improvement Program**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: CARDIAC ARREST **Ref. No. 1210**

Base Hospital Contact: Required prior to transport for all cardiac arrest patients who do not meet criteria for determination of death per *Ref. 814*.

1. For patients meeting *Ref. 814* Section I criteria for determination of death in the field – document Provider Impression as *DOA – Obvious Death*

2. Resuscitate cardiac arrest patients on scene ❶

3. Initiate chest compressions at a rate of 100-120 per min, depth 2 inches or 5 cm ❷
   Minimize interruptions in chest compressions

4. Assess airway and initiate bag-mask-ventilation; escalate to advanced airway prn ❸❹ *(MCG 1302)*
   Supraglottic airway is the preferred advanced airway when indicated ❺
   Monitor waveform capnography throughout resuscitation ❻

5. Administer high-flow **Oxygen** (15L/min) *(MCG 1302)*

6. Initiate cardiac monitoring *(MCG 1308)*
   Briefly assess rhythm every 2 minutes, minimizing pauses, or continuously via rhythm display technology ❼

<u>V-FIB/PULSELESS V-TACH</u>: ❽

7. **Defibrillate biphasic at 200J** immediately or per manufacturer's instructions
   Repeat at each 2-minute cycle as indicated

8. Establish vascular access *(MCG 1375)*
   Establish IO if any delay in obtaining IV access

9. Begin **Epinephrine** after defibrillation x2:
   Epinephrine (0.1mg/mL) administer 1mg (10mL) IV/IO
   Repeat every 5 min x2 additional doses; maximum total dose 3mg ❾

   <u>CONTACT BASE</u> to discuss additional epinephrine doses in cases where it may be indicated due to recurrent arrest or conversion to PEA

10. After defibrillation x3 (for refractory or recurrent V-Fib/V-Tach without pulses):
    Amiodarone 300mg (6mL) IV/IO
    Repeat **Amiodarone 150mg (3mL) IV/IO** x1 prn after additional defibrillation x2, maximum total dose 450mg

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Treatment Protocol: CARDIAC ARREST **Ref. No. 1210**

ASYSTOLE/PEA:

11. **Epinephrine (0.1mg/mL) administer 1mg (10mL) IV/IO**
    Repeat every 5 min x2; administer first dose as early as possible; maximum total dose 3mg ❾

    CONTACT BASE to discuss additional epinephrine doses in cases where it may be indicated due to refractory PEA or recurrent arrest

12. Consider and treat potential causes ❿

13. **Normal Saline 1L IV/IO rapid infusion**
    Repeat x1 for persistent cardiac arrest
    For suspected hypovolemia, administer both liters simultaneously

14. For patients with renal failure or other suspected hyperkalemia: ⓫
    Calcium Chloride 1gm (10mL) IV/IO
    Sodium Bicarbonate 50mEq (50mL) IV/IO

TERMINATION OF RESUSCITATION:

15. If resuscitative efforts are unsuccessful and the patient does not meet ALL criteria for Termination of Resuscitation in *Ref. 814, Section II.A.*, **CONTACT BASE** to consult with Base Physician ❽

RETURN OF SPONTANEOUS CIRCULATION (ROSC): ⓬⓭

16. Initiate post-resuscitation care immediately to stabilize the patient prior to transport ⓮
17. Establish advanced airway prn if not placed prior ❺
18. Raise head of stretcher to 30 degrees if blood pressure allows, otherwise maintain supine
19. Continue low volume ventilations at 10 per minute ⓯
20. Immediately resume CPR if patient re-arrests
21. For SBP < 90 mmHg:
    Normal Saline 1L IV/IO rapid infusion

    If no response after **Normal Saline 250mL,** or worsening hypotension and/or bradycardia:

    Push-dose Epinephrine – mix 9mL Normal Saline with 1mL Epinephrine 0.1mg/mL (IV formulation) in a 10mL syringe. Administer **Push-dose Epinephrine (0.01mg/mL) 1mL IV/IO** every 1-5 minutes as needed to maintain SBP > 90mmHg ⓱
    CONTACT BASE concurrent with initial dose of **Push-dose Epinephrine**

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22. Perform 12-lead ECG and transmit to the SRC ⑯

23. Check blood glucose
    For blood glucose < 60mg/dL
    Dextrose 10% 125mL IV and reassess
    If glucose remains < 60mg/dL, repeat 125 mL for a total of 250 mL

24. For suspected narcotic overdose: ⑱
    Naloxone 2-4mg (2-4mL) IV/IO/IM/IN (For IN, 1mg per nostril or 4mg/0.1mL IN if formulation available)
    Maximum dose all routes 8 mg

25. Contact **Public Health 213-989-7140** for all submersion incidents involving pools or spas after transfer of patient care in the emergency department or upon termination of resuscitation in the field (this requirement is effective 10/1/21). ⑲

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Treatment Protocol: CARDIAC ARREST **Ref. No. 1210**

SPECIAL CONSIDERATIONS

❶ Maintaining perfusion with high-quality CPR throughout resuscitation is essential to ensuring good patient outcome. Transporting the patient in cardiac arrest causes interruptions in CPR and reduces CPR quality. Patients who are resuscitated until ROSC on scene have higher neurologically intact survival.

❷ Chest compressions are the most important aspect of cardiac arrest resuscitation. Maintaining continuous chest compressions should take priority over any medication administration or transport.

❸ Hyperventilation reduces venous return and worsens patient outcomes. Both continuous and interrupted (30:2) compressions/ventilations are acceptable. Regardless of ventilation method used, ventilations should be no more frequent than 10 per minute with a volume of 400-600mL depending on patient size, just enough to see chest rise. Care should be taken to avoid hyperventilation, especially with an advanced airway in place.

❹ Bag-mask ventilation (BMV) with a viral filter is the preferred initial method of airway management. BMV in cardiac arrest has been associated with improved patient outcomes. Supraglottic airway (SGA) placement should be performed if BMV is ineffective and otherwise deferred until initial resuscitation priorities are complete (i.e., at least 2 defibrillations for shockable rhythms and first dose of epinephrine IV for nonshockable rhythms). Intubation should not be performed until after return of spontaneous circulation (ROSC) unless ventilation with BMV and SGA is ineffective and/or contraindicated. For all patients, consider placement of an advanced airway prior to transport to facilitate ventilations en route and during patient transfers.

❺ SGA is the preferred advanced airway unless specifically contraindicated given studies showing improved outcomes compared to endotracheal intubation. SGAs are more rapid to place without interruption in chest compressions. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality.

❻ $ETCO_2$ should be > 10 with a “box-shaped” waveform during effective CPR. A flat or wavy waveform or $ETCO_2$ < 10 may indicate ineffective compressions or airway obstruction. A sudden increase in $ETCO_2$ is suggestive of ROSC. The waveform can also be used to confirm ventilation rate if an advanced airway or asynchronous ventilation with continuous compressions is used.

❼ If you are able to observe the underlying rhythm during compressions via rhythm display technology, do not pause for the rhythm check. In order to minimize pauses in chest compressions, pulse checks should only be performed during rhythm checks when there is an organized rhythm with signs of ROSC, such as normal capnography or sudden rise in capnography.

❽ Patients in persistent cardiac arrest with refractory V-Fib (persistent V-Fib after 3 unsuccessful shocks) or EMS-witnessed arrest of presumed cardiac etiology may have a good outcome despite prolonged resuscitation. For these patients, resuscitation may be continued on scene for up to 40 minutes, as long as resources allow, in order to maximize the chances for field ROSC, which is strongly associated with improved survival with good neurologic outcome. Earlier transport may be initiated for providers using a mechanical compression device who are transporting a patient to a STEMI Receiving Center (SRC) for extracorporeal membrane oxygenation (ECMO) initiation.

❾ Epinephrine may improve outcomes if given early in non-shockable rhythms, but can worsen outcomes

early in shockable rhythms, where defibrillation is the preferred initial treatment. Epinephrine is most likely to be effective if it is given early and after chest compressions have begun. The likelihood of meaningful survival declines after three (3) doses of epinephrine. Resuscitation should continue focused on quality CPR, defibrillation, and identifying reversible causes. Additional doses of epinephrine should only be administered with Base order.

⑩ Potential causes that can be treated in the field include hypoxia, hypovolemia, hyperkalemia, hypothermia, toxins, and tension pneumothorax. Hypoglycemia is a very rare cause of cardiac arrest and should not be assessed until after ROSC. If environmental hypothermia is suspected, resuscitation efforts should not be abandoned until the patient is re-warmed, or after consultation with the Base Physician.

⑪ Treat suspected hyperkalemia with calcium and sodium bicarbonate as soon as possible. The sooner it is administered, the more likely it is to be effective. Flush the line between medication administration.

⑫ Post cardiac arrest patients are at high risk for re-arrest during transport. Fluid resuscitation, vasopressor support, and avoidance of hyperventilation are recommended to decrease the risk of re-arrest.

⑬ All cardiac arrest patients, with or without ROSC, shall be transported to the most accessible open SRC if ground transport is 30 minutes or less, as initiation of targeted temperature management and early coronary angiography in a specialty center have been shown to improve outcomes.

⑭ Approximately 50% of patients will re-arrest shortly after ROSC. Anticipate this decline as the epinephrine administered during the resuscitation begins to lose effect. Initiating post-resuscitation care, including fluids and preparing push-dose epinephrine for use as needed, can prevent re-arrest. These steps should be initiated immediately after ROSC to stabilize the patient for approximately 5 minutes prior to transport to reduce chances of re-arrest en route.

⑮ $ETCO_2$ can help guide your ventilation rate; target $ETCO_2$ 35-45 mmHg. Just after ROSC, the $ETCO_2$ may be transiently elevated. This will decrease appropriately with ventilation and does not require hyperventilation to normalize. Persistently elevated $ETCO_2$ and/or “sharkfin” waveform may indicate respiratory failure as cause of the cardiac arrest. Falsely low $ETCO_2$ measurements can occur if there is a leak with BMV or shock.

⑯ An ECG with STEMI after ROSC requires notification of ECG findings to the SRC.

⑰ **Push-dose Epinephrine** is appropriate for non-traumatic shock including cardiogenic shock. Additional doses beyond 10mL may need to be prepared for prolonged transports.

⑱ Narcotic overdose should be suspected in cases where there is drug paraphernalia on scene or there is a witness report. Pinpoint pupils may be present, but hypoxia during cardiac arrest can cause mydriasis (dilated pupils) instead.

⑲ EMS is assisting the Department of Public Health (DPH) in promptly investigating fatal or nonfatal drownings at public pools or spas in order to ensure safety can be verified before reopening. Contacting the on-call DPH officer will allow timely investigation of these incidents and prevent future incidents.

DEPARTMENT OF HEALTH SERVICES
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Treatment Protocol: CARDIAC DYSRHYTHMIA - BRADYCARDIA **Ref. No. 1212**

Base Hospital Contact: Required for all patients with symptomatic bradycardia.

1. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*

2. Administer **Oxygen** prn *(MCG 1302)*

3. Initiate cardiac monitoring *(MCG 1308)*
   Assess cardiac rhythm and obtain 12-lead ECG

4. If cardiac chest pain/STEMI suspected as cause of bradycardia, treat in conjunction with *TP 1211, Cardiac Chest Pain*

5. Maintain supine for patients with signs of poor perfusion, if respiratory status allows

6. Establish vascular access *(MCG 1375)*
   Do not delay transcutaneous pacing (TCP) if indicated for vascular access

7. For suspected hyperkalemia ❹
   Calcium Chloride 1gm (10mL) slow IV/IO push, may repeat x1 for persistent symptoms
   Albuterol 5mg (6mL) via neb, repeat continuously until hospital arrival
   CONTACT BASE to obtain order for **Sodium Bicarbonate 50mEq (50mL) slow IVP** ❺

8. For poor perfusion:
   Atropine 1mg (10mL) IV/IO push, repeat every 3-5 min prn, maximum total dose 3mg
   If IV cannot be rapidly established or if HR ≤ 40bpm in 2nd degree type II or 3rd degree heart block, proceed immediately to transcutaneous pacing ❶
   If no improvement after initial dose of **Atropine**, proceed to TCP

9. **TCP** for HR ≤ 40 with continued poor perfusion *(MCG 1365)*
   Recommended initial settings: rate 70bpm/0mA, slowly increase mAs until capture is achieved ❷
   CONTACT BASE concurrent with initiation of TCP

   If TCP will be utilized for the awake patient, consider sedation and analgesia
   For sedation:
   Midazolam 5mg (1mL) slow IV/IO push or IM/IN
   May repeat in 5 min prn x1, maximum total dose prior to Base contact 10mg
   For pain management: refer to *MCG 1345, Pain Management*

   CONTACT BASE for additional sedation and/or pain management after maximum dose administered: May repeat as above to a maximum dose of Midazolam 20 mg, and Fentanyl 250mcg or Morphine 20mg

10. For signs of poor perfusion with HR > 40:
    CONTACT BASE to discuss appropriateness of TCP

11. For persistent poor perfusion after initiating TCP:
    CONTACT BASE to obtain order for **Normal Saline 1L IV/IO rapid infusion** and/or **Push-dose Epinephrine**

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Treatment Protocol: CARDIAC DYSRHYTHMIA - BRADYCARDIA **Ref. No. 1212**

While infusing **Normal Saline**, reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

Push-dose Epinephrine – mix 9mL Normal Saline with 1mL Epinephrine 0.1mg/mL (IV formulation) in a 10mL syringe. Administer **Push-dose Epinephrine (0.01mg/mL) 1mL IV/IO** every 1-5 min as needed to maintain SBP > 90mmHg ❸

12. For suspected overdose, treat in conjunction with *TP 1241, Overdose/Poisoning/Ingestion*

13. For nausea or vomiting:
Ondansetron 4mg ODT/IV/IM, may repeat x1 in 15 min prn ❻

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COUNTY OF LOS ANGELES

Treatment Protocol: CARDIAC DYSRHYTHMIA - BRADYCARDIA **Ref. No. 1212**

SPECIAL CONSIDERATIONS

❶ In patients with 2nd degree type II or 3rd degree heart block, atropine is unlikely to produce clinical improvement, therefore TCP should not be delayed for atropine administration.

❷ Electrical capture can occur without mechanical capture. Assess for electrical capture by reviewing the rhythm strip for a QRS complex and a T wave after each pacer spike. Assess for mechanical capture by palpating a pulse with each QRS complex.

❸ **Push-dose Epinephrine** is appropriate for non-traumatic shock including cardiogenic shock. Additional doses beyond 10mL may need to be prepared for prolonged transports.

❹ Patients at increased risk for hyperkalemia include those with history or clinical evidence of renal failure, missed dialysis or patients taking potassium-sparing diuretics such as spironolactone. ECG signs of hyperkalemia included peaked T-waves, wide QRS, bradycardia, long PR interval and absent P-waves.

❺ Sodium Bicarbonate is another rapid-acting treatment for suspected hyperkalemia. Due to the risk of pulmonary edema, contact Base to discuss administration.

❻ Nausea and vomiting cause vagal stimulation, which can worsen bradycardia. Ondansetron may be administered to reduce potential for nausea or vomiting.

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Treatment Protocol: CARDIAC DYSRHYTHMIA - TACHYCARDIA **Ref. No. 1213**

Base Hospital Contact: Required for all patients with wide complex tachycardia.

1. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*
2. Administer **Oxygen** prn *(MCG 1302)*
3. Initiate cardiac monitoring *(MCG 1308)*
   Assess cardiac rhythm and obtain 12-lead ECG
4. If cardiac chest pain/STEMI suspected, treat in conjunction with *TP 1211, Cardiac Chest Pain*
5. Maintain supine for patients with signs of poor perfusion, if respiratory status allows
6. Establish vascular access prn *(MCG 1375)*
7. Advanced airway prn *(MCG 1302)*

SINUS TACHYCARDIA ❶

8. Consider possible underlying cause and treat as per applicable protocol ❷
9. For sinus tachycardia of unclear etiology and suspected hypovolemia or signs of poor perfusion:
   Normal Saline 1L IV/IO rapid infusion
   Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

   For persistent poor perfusion, treat in conjunction with *TP 1207, Shock/Hypotension*

   Continue to assess for underlying cause ❷

SVT – NARROW COMPLEX ≥ 150bpm ❸

10. For adequate perfusion:
    Attempt **Valsalva maneuver**

    Adenosine 6 or 12mg (2 or 4mL) rapid IV push ❹
    Immediately follow with Normal Saline rapid IV flush

    If no conversion
    Adenosine 12mg (4mL) rapid IV push ❹
    Immediately follow with Normal Saline rapid IV flush

11. For alert patients with poor perfusion:
    Adenosine 12mg (4mL) rapid IV push ❹
    Immediately follow with Normal Saline rapid IV flush, may repeat x1 if persistent SVT

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Treatment Protocol: CARDIAC DYSRHYTHMIA - TACHYCARDIA **Ref. No. 1213**

CONTACT BASE if no conversion after adenosine or if adenosine contraindicated to discuss order for **Synchronized Cardioversion at 120J**

12. For poor perfusion with ALOC: ❼
Synchronized Cardioversion at 120J, may repeat x2 with escalating doses of 150J followed by 200J, or per manufacturer's guidelines
CONTACT BASE concurrent with initial cardioversion

Consider sedation prior to cardioversion:
Midazolam 5mg (1mL) slow IV/IO push or IM/IN
May repeat in 5min prn x1, maximum total dose prior to Base contact 10mg

CONTACT BASE for additional sedation after maximum dose administered
May repeat as above to a maximum total dose of Midazolam 20mg

ATRIAL FIBRILLATION

13. Consider possible underlying cause and treat as per applicable protocol ❷

14. For poor perfusion:
CONTACT BASE for treatment guidance ❺

WIDE COMPLEX – REGULAR/MONOMORPHIC

15. For adequate perfusion:
Adenosine 6 or 12mg (2 or 4mL) rapid IV push ❹ ❻
Immediately follow with Normal Saline rapid IV flush

If WCT persists:
Adenosine 12mg (4mL) rapid IV push ❹ ❻
Immediately follow with Normal Saline rapid IV flush

16. For alert patients with poor perfusion:
If vascular access available, **Adenosine 12mg (4mL) rapid IV push ❹ ❻**
Immediately follow with Normal Saline rapid IV flush
May repeat x1 for persistent WCT if mental status normal, or proceed directly to cardioversion

If no vascular access or no conversion with adenosine**:**
Synchronized Cardioversion at 120J, may repeat x2 with escalating doses of 150J followed by 200J, or per manufacturer's guidelines
CONTACT BASE concurrent with cardioversion

Consider sedation prior to cardioversion:
Midazolam 5mg (1mL) slow IV/IO push or IM/IN
May repeat in 5min prn x1, maximum total dose prior to Base contact 10mg

CONTACT BASE for additional sedation after maximum dose administered
May repeat as above to a maximum total dose of Midazolam 20mg

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Treatment Protocol: CARDIAC DYSRHYTHMIA - TACHYCARDIA **Ref. No. 1213**

17. For poor perfusion with ALOC: ❼

    Synchronized Cardioversion at 120J, may repeat x2 with escalating doses of 150J followed by 200J, or per manufacturer's guidelines
    CONTACT BASE concurrent with cardioversion

    Consider sedation prior to cardioversion:
    Midazolam 5mg (1mL) slow IV/IO push or IM/IN
    May repeat in 5min prn x1, maximum total dose prior to Base contact 10mg

    CONTACT BASE for additional sedation after maximum dose administered
    May repeat as above to a maximum total dose of Midazolam 20mg

WIDE-COMPLEX – IRREGULAR

18. For adequate perfusion:
    CONTACT BASE for treatment guidance ❻

19. For poor perfusion:
    Synchronized Cardioversion at 120J, may repeat x2 with escalating doses of 150J followed by 200J, or per manufacturer's guidelines
    CONTACT BASE concurrent with cardioversion ❻

    Consider sedation prior to cardioversion:
    Midazolam 5mg (1mL) slow IV/IO push or IM/IN
    May repeat in 5min prn x1, maximum total dose prior to Base contact 10mg

    CONTACT BASE for additional sedation after maximum dose administered
    May repeat as above to a maximum total dose of Midazolam 20mg

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Treatment Protocol: CARDIAC DYSRHYTHMIA - TACHYCARDIA **Ref. No. 1213**

SPECIAL CONSIDERATIONS

❶ Treatment of sinus tachycardia should be directed at the underlying cause. Sinus tachycardia due to conditions such as hypovolemia, sepsis, or GI bleed can present as a wide complex tachycardia in patients with left or right bundle branch blocks. P waves should be visible before each QRS and a typical bundle branch block pattern noted on the ECG.

❷ Tachycardia is often a response to an underlying illness including but not limited to: sepsis, GI bleeding, respiratory distress, anaphylaxis, hyperthermia, and toxic ingestions. Sinus tachycardia may be a manifestation of pain and/or anxiety, but these should not be considered until other, more dangerous etiologies, are evaluated.

❸ Sinus tachycardia can occur at a rate above 150 bpm. Sinus tachycardia does not respond to Adenosine, so it should not be administered, and treatment should be directed at the underlying cause.

❹ Adenosine is contraindicated in patients with history of Wolf-Parkinson-White (WPW) Syndrome and atrial fibrillation, Sick Sinus Syndrome, or heart transplant; or if the patient's medications include carbamazepine (Tegretol) for seizure disorder. In these patients, adenosine may cause degeneration to a fatal dysrhythmia.

❺ Patients with atrial fibrillation (or flutter) have abnormal impulses generated by the atria. Adenosine is not effective to slow or terminate the rhythm and, in the presence of Wolf-Parkinson-White (WPW) Syndrome, can cause ventricular fibrillation. Further, these rhythms cause abnormal contraction of the atria that can lead to clot formation. Cardioversion increases the risk for stroke as these clots can be forced out of the atria into circulation after cardioversion. Consider and treat underlying causes of rapid atrial fibrillation (e.g. dehydration, sepsis) prior to cardioversion. Cardioversion is appropriate for cases of acute onset (<48 hours) atrial fibrillation with hemodynamic instability and without other apparent cause.

❻ Regular monomorphic wide complex tachycardia may be supraventricular rhythm with a bundle branch block or aberrancy. In this case, Adenosine may convert the rhythm to sinus and AHA guidelines recommend its use for regular monomorphic wide complex tachycardia. Adenosine should not be used for irregular wide complex tachycardia, because this may represent atrial fibrillation with WPW and lead to degeneration to a fatal dysrhythmia (see ❹ above).

❼ Altered level of consciousness (ALOC) refers to a decreased or depressed level of consciousness compared to the patient's baseline (secondary to shock or hypoperfusion).

Summary of SRC Database Changes November 2022

Date	Change	Section	Reason For Change
8/2022	Included language 'Patients from the age of 15 years and older should be entered into the SRC Database'	Data Dictionary Definition—Inclusion Criteria	Rule exists in SRC Database allows entry of patients 15 years and older. Add to the Data Dictionary 'Inclusion Criteria' that ages 15 years and older are to be entered into the SRC Database to align with EMS Agency definition of adult patients.
8/2022	Included language specifying that 'Cardiac Arrest due to hanging and drowning are considered asphyxiation NOT traumatic cardiac arrest and should be entered into the SRC Database'	Data Dictionary Definition—Inclusion Criteria	Clarification of the SRC Database entry requirement of the cardiac arrest by hanging or drowning.
8/2022	Inclusion Criteria changed to 'Patients with STEMI identified by prehospital by: Provider Impression of CPMI' and 'Patients with OCHA identified by prehospital by: Provider Impression of CANT	Data Dictionary Definition—Inclusion Criteria	Aligning Inclusion Criteria to the Provider Impression used for STEMI; CPMI-Chest Pain—STEMI and Provider Impression used for OHCA; CANT-Cardiac Arrest Non Traumatic
8/2022	Added Field Value 'HE-Heart Ambulance Corporation'	Data Dictionary/Database—Gen Info/Provider	Revised to reflect new providers approved to operate within LA County
8/2022	Added Field Value 'MD-MedTrans, Inc.'	Data Dictionary/Database—Gen Info/Provider	Revised to reflect new providers approved to operate within LA County
9/2022	Added Field Value 'ZM-Solartricity dba Zoom Medical Transportation'	Data Dictionary/Database—Gen Info/Provider	Revised to reflect new providers approved to operate within LA County
8/2022	Expanded Field to capture 5 digits and allow alphabetical and numerical entry.	Data Dictionary/Database—Gen Info/ALS Unit #	Aligning with EMS Data Dictionary to capture ALS Units that include alphabetical entry
8/2022	Changed to a select all that apply Field	Data Dictionary/Database—Gen Info/Race/Ethnicity	Revised to capture multiple Race/Ethnicity options
8/2022	Changed Field Value 'ALRX-Allergic Reaction (X)' to 'ALRX-Allergic Reaction'	Database—Gen Info/ Provider Impression	Revised to remove '(X)' which is no longer needed

Summary of SRC Database Changes November 2022

Date	Change	Section	Reason For Change
8/2022	Changed Field Value 'DYRX-Dystonic Reaction (X)' to 'DYRX-Dystonic Reaction'	Database—Gen Info/ Provider Impression	Revised to remove '(X)' which is no longer needed
8/2022	Changed Field Value 'ENTP-ENT/Dental Problem-Unspecified' to 'ENTP-ENT/Dental Emergencies'	Data Dictionary/Database—Gen Info/Provider Impression	Revised to update 'Provider Impression' title to align with current revision
8/2022	Changed Field Value 'WEAK-General Weakness' to 'WEAK-Weakness-General'	Data Dictionary/Database—Gen Info/Provider Impression	Revised to update 'Provider Impression' title to align with current revision
8/2022	Changed Field Value 'GUDO Genitourinary Disorder' to 'GUDO-Genitourinary Weakness-Unspecified'	Data Dictionary/Database—Gen Info/Provider Impression	Revised to update 'Provider Impression' title to align with current revision
8/2022	Changed Field Value 'HEAT-Hyperthermia-Environmental' to 'HEAT-Hyperthermia'	Data Dictionary/Database—Gen Info/Provider Impression	Revised to update 'Provider Impression' title to align with current revision
8/2022	Changed Field Value 'FAIL-Medical Device Malfunction' to 'FAIL-Medical Device Malfunction-Fail'	Data Dictionary/Database—Gen Info/Provider Impression	Revised to update 'Provider Impression' title to align with current revision
8/2022	Changed Field Value 'SOBB-Shortness of Breath-Bronchospasm' to 'SOBB-Resp. Distress/Bronchospasm'	Data Dictionary/Database—Gen Info/Provider Impression	Revised to update 'Provider Impression' title to align with current revision
8/2022	Added Field Value 'OT-Other' to Field Values and added a free text field after 'OT-Other' with a rule to require entry	Data Dictionary/Database—Gen Info/Comorbidities	Revised to capture comorbidities that are not listed in the current Field Values
8/2022	Added Field 'Was Pt Already Vaccinated? 'AFTER 'COVID-19 PCR Test During Hospitalization?' with Field Values of 'Yes' and 'No'	Data Dictionary/Database—Gen Info/COVID19 PCR Test During Hospitalization?	Revised to capture COVID-19 vaccination status
8/2022	Removed field "Date Test Performed"	Data Dictionary/Database—Gen Info/Date Test Performed	Revised to remove COVID test date prior to
8/2022	Removed the word 'positive' from the definition description in SRC Data Dictionary	Data Dictionary—COVID19 PCR Test During Hospitalization?	Revised to capture status of hospital PCR tests performed regardless of the negative or positive result.

Summary of SRC Database Changes November 2022

Date	Change	Section	Reason For Change
8/2022	Changed 'Hospice: Hospice' to 'Hospice: Hospice Facility'	Data Dictionary/Database— Gen Info/Hospital Disposition	Revised to align with CARES database definition
8/2022	If 'Acute-Other Acute Care Facility' is selected, add a Field titled ‘Transfer to’ AFTER the Field ‘Hospital Disposition’ that has picklist with the names of all hospitals listed in the ‘Transferring Facility’ field	Data Dictionary/Database— Gen Info/Hospital Disposition	Revised to align with CARES database collection to track the Facility name of where the patient was transported
8/2022	Added rule that if Field ‘Hospital Disposition’= ‘Morgue: Morgue/Mortuary’, than CPC field automatically enters ‘5’	Database— Gen Info/Hospital Disposition	Revised to reduce data entry errors in the ‘CPC Scale at Discharge ‘field
8/2022	Added to Additional Information: 'If a patient was residing in an Extended/Skilled Nursing Facility prior to hospital arrival and is discharged back to the same Extended/Skilled Nursing Facility, enter 'Home'	Data Dictionary— Hospital Disposition	Revised to clarify that if a patient is discharged home and was residing in an Extended/Skilled Nursing Facility prior to hospital arrival and is discharged back to the same Extended/Skilled Nursing Facility, value for this field should be ‘Home’
8/2022	Added rule 'if Transfer=Yes, then 'PH ECG performed' and '1st PH ECG date/time' grey out	Database— SRC/Transfer	Revised to reduce data entry errors
8/2022	Added 'HBC-Hyperbaric Chamber' to ‘Field Values’	Data Dictionary/Database— SRC/Transferring Facility	Revised to reflect hospitals that are 9-1-1 Receiving Centers
8/2022	Removed LBC-Community Hospital Long Beach from Field Values	Data Dictionary/Database— SRC/Transferring Facility	Revised to reflect hospitals that are no longer 9-1-1 Receiving Centers
8/2022	Added to ‘Definition’: Checkbox indicating whether an ECG was performed by EMS Personnel, Physician’s Office, Clinic, or Urgent Care prior to the patient’s arrival at the SRC.	Data Dictionary— Prehospital ECG Performed	Revised to provide clarification that the Prehospital ECG Performed refers to EMS Personnel, Physician’s Office, or Clinic, not the SRF ECG
8/2022	Added to ‘Definition’: Date of the 1st ECG performed by EMS Personnel, Physician’s	Data Dictionary— 1st Prehospital ECG Date	Revised to provide clarification that the Prehospital ECG Performed refers

Summary of SRC Database Changes November 2022

Date	Change	Section	Reason For Change
	Office, Clinic, or Urgent Care prior to the patient's arrival at the SRC.		to EMS Personnel, Physician's Office, or Clinic, not the SRF ECG
8/2022	Added to 'Definition': Time of day of the first ECG performed by EMS Personnel, Physician's Office, Clinic or Urgent Care prior to the patient's arrival at the SRC.	Data Dictionary— 1st Prehospital ECG Time	Revised to provide clarification that the Prehospital ECG Performed refers to EMS Personnel, Physician's Office, or Clinic, not the SRF ECG
3/2022	Removed the rule on 'Peak Troponin Value' to allow values >100	Database— SRC/Peak Troponin Value	Revised to capture high sensitivity troponin values
8/2022	Added unit Field after 'Peak Troponin Value' with Field Values of 'ng/mL', 'ng/L' and "pg/mL"	Data Dictionary/Database— SRC/Peak Troponin Value	Added to capture the units of measurement for Peak Troponin Values including High Sensitivity Troponin measurements
8/2022	Added Field AFTER 'PCI Performed?' titled 'PCI Procedure Performed' with Field Values of 'Wire-Guidewire','Thrombectomy-Surgical Thrombectomy', 'Balloon-Balloon Angioplasty' and 'Stent-Cardiac Stent Placed' and 'OT-Other'	Data Dictionary/Data Base— CL/PCI Procedure Performed	Added to capture the procedures performed when Percutaneous Coronary Intervention is needed.
8/2030	Changed Field Value of 'CABG/IABP: Candidate for CABG/IABP' to 'CABG: Candidate for CABG'	Data Dictionary/Database— CL/Reason PCI Not Performed	Revised to remove IABP from the CABG field value
8/2022	Added Field Values 'EC: ECMO', 'IA: Intra Aortic Balloon Pump (IABP)', 'IM: Impella'	Data Dictionary/Database— CL/Delays to PCI	Revised to capture the hemodynamic devices used prior to PCI
8/2022	Added to 'Additional Information' the language 'If there is a change in approach, select 'Access-Difficulty Obtaining Vascular Access'	Data Dictionary— CL/Delays to PCI	Added to capture changes in PCI approach
8/2022	Changed field value of 'IA: IABP' to 'IA: Intra Aortic Balloon Pump (IABP)'	Data Dictionary/Database— CL/If Yes, What Type of Device?	Revised to give definition of IABP acronym

Summary of SRC Database Changes November 2022

Date	Change	Section	Reason For Change
11/2022	Added rule ‘if ‘Was a Hemodynamic Support Device Used?’ Field=Yes, then Fields ‘If Yes, What Type of Device?’ and ‘When was Hemodynamic Support Device Placed?’ should be mandatory entry fields	Data Dictionary/Database—CL/Was a Hemodynamic Support Device Used?	Added to capture the type of hemodynamic support device and the time that the device was placed in the CL
11/2022	Added field “When was hemodynamic support device placed?” with field values of ‘BP: Before PCI Procedure’, and ‘AP: After PCI Procedure’ AFTER field ‘If Yes, What Type of Device?’	Database/Data Dictionary—CL/new field ‘When was hemodynamic support device placed?’	Current clinical practice is changing. Hemodynamic support devices are being placed pre, intra and post procedure versus only post procedure.
8/2022	Added Field AFTER 'Init. Cardiac Arrest CPR Init By' titled 'CPR Method' with field values of 'Manual: Manual CPR only', 'Manual to Mechanical: Manual CPR to Mechanical CPR', 'Mechanical: Mechanical CPR only', and 'ND: Not Documented'	Database/Data Dictionary—Cardiac Arrest/CPR Method	Added to capture the method of CPR administered to the cardiac arrest patient
8/2022	Added Field AFTER 'CPR Method' titled 'CPR Mechanical Device' with Field Values of 'LU: LUCAS', 'AP: AutoPulse', ‘NO: No Mechanical Device Used’ and 'OT:Other' with the Field Value of 'OT:Other' having a free text line with rule for mandatory entry into the free text line	Data Dictionary/Database—Cardiac Arrest/CPR Mechanical Device	Added to capture the type of mechanical device used in cardiac resuscitation
8/2022	Added rule: "if '1st Lactate Value Upon ROSC'=ND, then the Field 'Lactate Value Units' should gray out and autofill with NA"	Database—Cardiac Arrest/1st Lactate Value Upon ROSC	Revised to reduce documentation errors
8/2022	Added under 'Additional Information' for lactate 'if a lactic acid or formal lactate level is not drawn, ok to enter lactate level from POCT'	Data Dictionary—1st Lactate Value Upon ROSC	Revised to give option to use POCT results if formal lactate level is not drawn
8/2022	Added rule: ‘if 'CPC Scale at Discharge' is blank, then create a pop-up screen stating, ‘this is a required field’ and do not allow further	Database—Cardiac Arrest/CPC Scale At Discharge	Revised to capture all CPC scores

Summary of SRC Database Changes November 2022

Date	Change	Section	Reason For Change
	data entry until field is completed. (Make this field a mandatory field)		
8/2022	Removed ‘ND: Not Documented’ from Field Values	Data Dictionary/Database—Cardiac Arrest/CPC Scale At Discharge	Revised to capture all CPC scores
8/2022	Changed temperature range from ’32-36’ to ‘32-37.5’	Data Dictionary—TTM Initiated?	Revised to expand temperature range to include normothermia
11/2022	Added field ‘TTM Approach’ with field values of ‘NT: Normothermia’ and ‘IH: Induced Hypothermia’ AFTER field ‘TTM Initiated?’	Data Dictionary/Database—TTM/new field ‘TTM Approach’	Added to determine whether normothermia or hypothermia TTM was used on the ROSC patient.
8/2022	Changed language in second bullet under 'Additional Information' to ‘Pre-existing coma refers to being in a comatose state prior to cardiac arrest due to a pre-existing condition, neurologic dysfunction (pre-arrest CPC score of 3 or 4), or severe dementia.	Data Dictionary—Contraindications to TTM	Revised to clarify neurologic dysfunction CPC score
8/2022	Changed wording of Field Value 'BD: Known Intrinsic Bleeding Diathesis' to 'BD: Known Intrinsic Bleeding Diathesis (e.g. hemophilia or Von Willebrand)	Data Dictionary—Contraindications to TTM	Revised to clarify bleeding diathesis disorders
8/2022	Remove '14: Age <15 yrs' Field Value	Data Dictionary/Database—TTM/Contraindications to TTM	Removed because a rule exists in the database to exclude the entries of ≤15 years old
8/2022	Add Field Value '37 degrees Celsius' Add Field Value '37.5 degrees Celsius'	Data Dictionary/Database—TTM/Target Temperature	Revised to include normothermia temperatures
12/2021	Changed five-digit numeric value to seven-digit numeric value	Target Temperature Range	Revised to expand temperature range to include normothermia temperatures

For FY 22-23, two facilities were added to the Stroke Center Program as Primary Stroke Centers and one facility upgraded from Primary Stroke Center designation to Comprehensive Stroke Center designation. A map of our Stroke Centers is included for reference (Attachment A).

Changes since the previous plan was submitted and approved include:

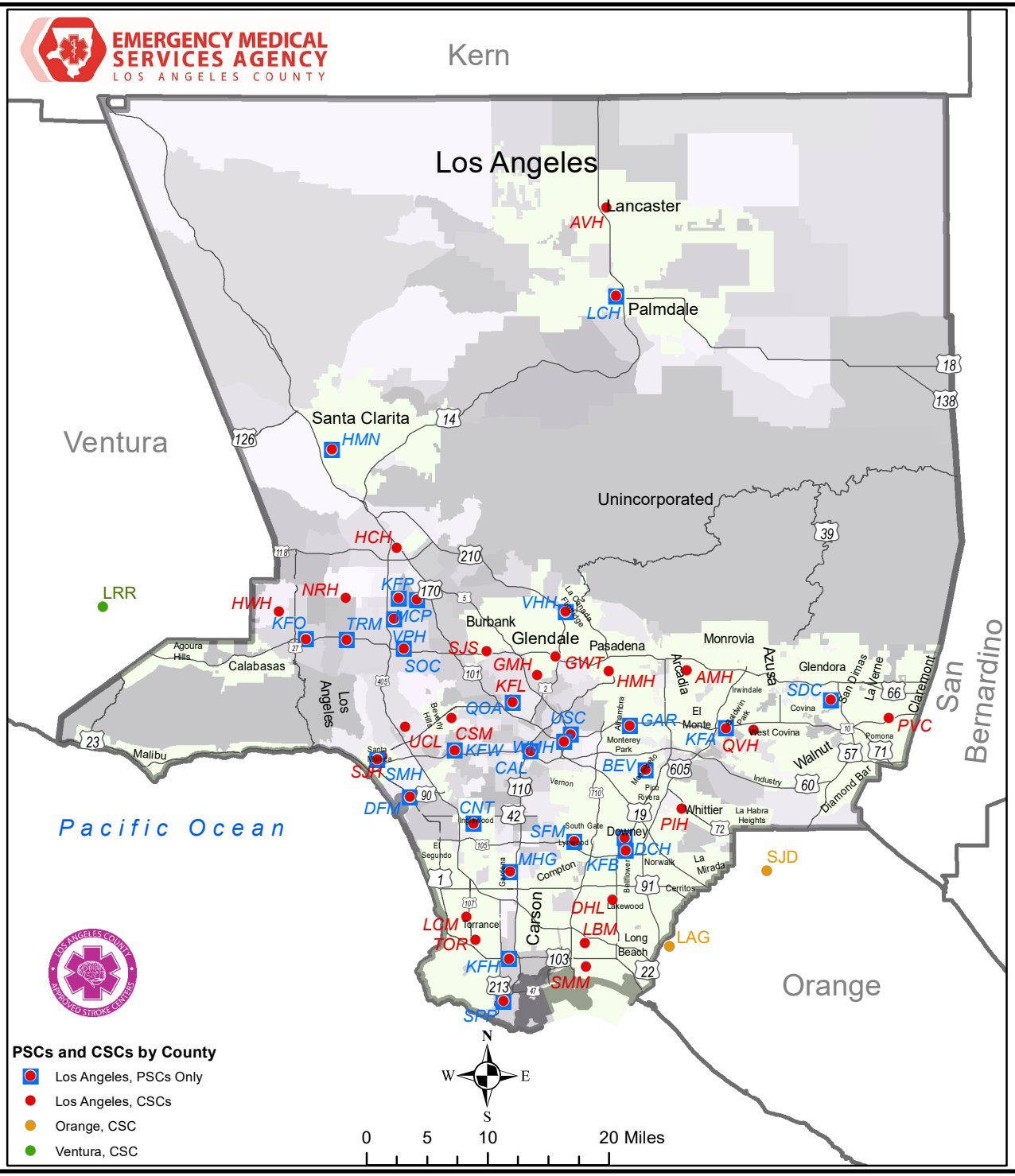
- List of Designated Stroke Centers and Agreement Expiration Dates (Attachment B)
- Reference No. 521, Stroke Patient Destination – Revised 07-01-2022 (Attachment C)

EmergiPress Topics Included:

- Acute Aphasia

The Stroke Advisory/QI Committee met on August 15 2022 and February 27, 2023. Topics included:

- Stroke system update
- Get with the Guidelines update
- Stroke data collaborative report
- Performance measures
- Mobile Stroke Unit expansion update
- Stroke center data reports



Code	Stroke Centers As of April 6, 2023
AMH	USC Arcadia Hospital
AVH	Antelope Valley Hospital
BEV	Beverly Hospital
CAL	Dignity Health-California Hospital Medical Center
CNT	Centinela Hospital Medical Center
CSM	Cedars-Sinai Medical Center
DCH	PIH Health Downey Hospital
DFM	Cedars-Sinai Marina Del Rey Hospital
DHL	Lakewood Regional Medical Center
GAR	Garfield Medical Center
GMH	Dignity Health-Glendale Memorial Hospital and Health Center
GWT	Adventist Health - Glendale
HCH	Providence Holy Cross Medical Center
HMH	Huntington Hospital
HMN	Henry Mayo Newhall Hospital
HWH	West Hills Hospital and Medical Center
KFA	Kaiser Foundation Hospital - Baldwin Park
KFB	Kaiser Foundation Hospital - Downey
KFH	Kaiser Foundation Hospital - South Bay
KFL	Kaiser Foundation Hospital - Sunset (Los Angeles)
KFO	Kaiser Foundation Hospital - Woodland Hills
KFP	Kaiser Foundation Hospital - Panorama City
KFW	Kaiser Foundation Hospital - West Los Angeles
LAG	Los Alamitos Medical Center
LBM	MemorialCare Long Beach Medical Center
LCH	Palmdale Regional Medical Center
LCM	Providence Little Company of Mary Medical Center-Torrance
LRR	Los Robles Regional Medical Center
MCP	Mission Community Hospital
MHG	Memorial Hospital of Gardena
NRH	Dignity Health-Northridge Hospital Medical Center
PIH	PIH Health Whittier Hospital
PVC	Pomona Valley Hospital Medical Center
QOA	Hollywood Presbyterian Medical Center
QVH	Emanate Health Queen of the Valley Hospital
SDC	San Dimas Community Hospital
SFM	St. Francis Medical Center
SJD	St. Jude Medical Center
SJH	Providence Saint John's Health Center
SJS	Providence Saint Joseph Medical Center
SMH	Santa Monica-UCLA Medical Center
SMM	Dignity Health-St. Mary Medical Center
SOC	Sherman Oaks Hospital
SPP	Providence Little Company of Mary Medical Center-San Pedro
TOR	Torrance Memorial Medical Center
TRM	Providence Cedars-Sinai Tarzana Medical Center
UCL	Ronald Reagan UCLA Medical Center
USC	LAC+USC Medical Center
VHH	USC Verdugo Hills Hospital
VPH	Valley Presbyterian Hospital
WMH	Adventist Health - White Memorial

File:Stroke040623

List of Designated Stroke Centers and Agreement Expiration Dates as of June 30, 2023

Stroke Center	Designation Level	Agreement Expiration Date
Adventist Health - Glendale	Comprehensive	August 31, 2024
Adventist Health – White Memorial	Primary	March 31, 2024
Antelope Valley Hospital	Primary	December 31, 2024
Beverly Hospital	Primary	October 31, 2023
Cedars Sinai Medical Center	Comprehensive	December 31, 2023
Centinela Hospital Medical Center	Primary	November 30, 2023
Coast Plaza Doctors Hospital	Primary	Suspended as of April 5, 2023
Dignity Health – California Hospital Medical Center	Primary	April 30, 2025
Dignity Health – Glendale Memorial Hospital and Health Center	Primary	October 31, 2024
Dignity Health – Northridge Hospital Medical Center	Comprehensive	December 31, 2025
Dignity Health – Saint Mary Medical Center	Comprehensive	December 31, 2023
Emanate Health Queen of the Valley	Comprehensive	October 31, 2023
Encino Hospital Medical Center	Primary	March 31, 2025
Garfield Medical Center	Primary	October 31, 2023
Henry Mayo Newhall Hospital	Primary	November 30, 2025
Hollywood Presbyterian Medical Center	Primary	February 28, 2024
Huntington Hospital	Comprehensive	September 30, 2023
Kaiser Foundation Hospital – Baldwin Park Medical Center	Primary	October 31, 2024
Kaiser Foundation Hospital – Downey Medical Center	Primary	October 31, 2025
Kaiser Foundation Hospital – Los Angeles Medical Center	Comprehensive	February 28, 2024
Kaiser Foundation Hospital – Panorama City	Primary	December 31, 2025
Kaiser Foundation Hospital – South Bay	Primary	December 31, 2024
Kaiser Foundation Hospital – West Los Angeles	Primary	November 30, 2024
Kaiser Foundation Hospital – Woodland Hills	Primary	July 31, 2025
LAC+USC Medical Center	Primary	November 30, 2025
Lakewood Regional Medical Center	Comprehensive	October 31, 2025
Los Alamitos Medical Center (Orange County)	Comprehensive	November 30, 2023
Los Robles Medical Center (Ventura County)	Comprehensive	September 30, 2024
MemorialCare Long Beach Medical Center	Comprehensive	December 31, 2025
Memorial Hospital of Gardena	Primary	October 31, 2023
Mission Community Hospital	Primary	November 30, 2023
Palmdale Regional Medical Center	Primary	December 31, 2025
PIH Health – Downey	Primary	December 31, 2025

PIH Health – Good Samaritan	Comprehensive	December 31, 2025
PIH Health – Whittier	Comprehensive	October 31, 2023
Pomona Valley Hospital Medical Center	Comprehensive	August 31, 2023
Providence Cedars-Sinai Tarzana Medical Center	Primary	October 31, 2024
Providence Holy Cross Hospital Medical Center	Comprehensive	October 31, 2024
Providence Little Company Mary Medical Center San Pedro	Primary	December 31, 2023
Providence Little Company Mary Medical Center Torrance	Comprehensive	November 30, 2025
Providence Saint John's Health Center	Comprehensive	December 31, 2024
Providence Saint Joseph Medical Center	Comprehensive	January 31, 2024
Ronald Reagan UCLA Medical Center	Comprehensive	October 31, 2023
San Dimas Community Hospital	Primary	June 30, 2025
Santa Monica UCLA Medical Center	Primary	May 31, 2024
Sherman Oaks Hospital	Primary	May 31, 2025
St. Francis Medical Center	Primary	May 31, 2026
St. Jude Medical Center (Orange County)	Comprehensive	December 31, 2023
Torrance Memorial Medical Center	Comprehensive	December 31, 2025
USC Arcadia Hospital	Comprehensive	May 31, 2024
USC Verdugo Hills Hospital	Primary	March 31, 2025
Valley Presbyterian Hospital	Primary	July 31, 2025
West Hills Hospital & Medical Center	Comprehensive	October 31, 2025

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **STROKE PATIENT DESTINATION** REFERENCE NO. 521

PURPOSE: To provide guidelines for transporting suspected stroke patients to the most accessible facility appropriate to their needs.

AUTHORITY: Health & Safety Code, Division 2.5, Section 1798

DEFINITIONS:

Primary Stroke Center (PSC): A 9-1-1 receiving hospital that has met the standards of a Center for Medicaid & Medicare Services (CMS) approved accreditation body as a Primary Stroke Center and has been approved as a Stroke Center by the Los Angeles (LA) County Emergency Medical Services (EMS) Agency.

Comprehensive Stroke Center (CSC): A 9-1-1 receiving hospital that has met the standards of a CMS approved accreditation body as a Comprehensive (Level I CSC) or Thrombectomy Capable Stroke Center (Level II CSC) and has been approved as a Comprehensive Stroke Center by the LA County EMS Agency. CSCs have subspecialty neurology and neurointerventional physicians available 24 hours a day and 7 days a week who can perform clot-removing procedures (i.e., thrombectomy).

Last Known Well Time: The **time** (military time) at which the patient was **last known** to be without the signs and symptoms of the current stroke or at his or her prior baseline.

Local Neurological Signs: Signs and symptoms that may indicate a dysfunction in the nervous system such as a stroke or mass lesion. These signs include: speech and language disturbances, altered level of consciousness, unilateral weakness, unilateral numbness, new onset seizures, dizziness, and visual disturbances.

Modified Los Angeles Prehospital Stroke Screen (mLAPSS): A screening tool utilized by prehospital care providers to assist in identifying patients who may be having a stroke.

Los Angeles Motor Score (LAMS): A scoring tool utilized by prehospital care providers to determine the severity of stroke on patients with suspected stroke. A large vessel involvement is suspected if the total LAMS score from the three categories is 4 or greater.

Mobile Stroke Unit (MSU): Mobile specialized stroke unit as approved by the LA County EMS Agency and defined in Ref. No. 817, Regional Mobile Response Teams.

PRINCIPLES:

1. Patients experiencing a stroke should be transported to the most accessible facility appropriate to their needs. This determination will be made by the base hospital physician, Mobile Intensive Care Nurse or MSU physician after consideration of the guidelines established in this policy.

APPROVED: Director, EMS Agency

Medical Director, EMS Agency

2. Basic Life Support units shall call an Advanced Life Support unit for suspected stroke patients.

3. In all cases, the health and well-being of the patient is the overriding consideration in determining patient destination. Factors to be considered include: severity and stability of the patient's condition; anticipation of transport time; available transport resources; and request by the patient, family, guardian, or physician.

4. Service area rules and/or considerations do not apply to suspected stroke patients.

5. Patients with a history of previous stroke with new or worsening deficits should be routed to the Stroke Center according to this policy.

POLICY:

I. Responsibility of the Provider Agency

A. Perform mLAPSS on all patients exhibiting neurological signs. The mLAPSS is positive if all of the following criteria are met:

1. No history of seizures or epilepsy

2. Age 40 years or older

3. At baseline, patient is not wheelchair bound or bedridden

4. Blood glucose between 60 and 400 mg/dL

5. Obvious asymmetry-unilateral weakness with any of the following motor exams:
   a. Facial Smile/Grimace
   b. Grip
   c. Arm Strength

B. Perform LAMS on ALL patients with suspected stroke

1. Facial droop — Total Possible Score = 1
   a. Absent = 0
   b. Present = 1

2. Arm drift — Total Possible Score = 2
   a. Absent = 0
   b. Drifts down = 1
   c. Falls rapidly = 2

3. Grip strength — Total Possible Score = 2
   a. Normal = 0
   b. Weak grip = 1
   c. No grip = 2

C. Transport the patient to the most appropriate stroke center in accordance with base hospital direction or section III of this policy.

D. Document the results of mLAPSS, LAMS, and last known well date and time in the designated areas on the Patient Care Record.

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

II. Responsibility of the Base Hospital

A. Provide medical direction and destination for all patients who meet mLAPSS criteria or have symptoms strongly suggestive of a stroke.

B. Determine patient destination based on stroke center status via the ReddiNet® system and section IV of this policy.

C. Notify the receiving stroke center if the base hospital is not the patient's destination.

D. Document the results of mLAPSS, LAMS, and last known well date and time in the designated areas on the Base Hospital Form.

E. Prompt prehospital care personnel to obtain and document witness contact information on the Patient Care Record.

III. Destination of Stroke Patients assessed and treated by EMS providers:

A. All patients who have a positive mLAPSS and LKWT within 24 hours or a provider impression of stroke shall be transported to a LA County EMS Agency designated stroke center as follows:

1. Patients with a LAMS of 3 or less shall be transported to the <u>closest</u> stroke center (PSC, or CSC).

2. Patients with suspected acute onset stroke symptoms and a LAMS of 4 or greater shall be transported to the closest Level I or II CSC. If transport time to the CSC is greater than 30 minutes, the patient shall be transported to the most accessible PSC.

IV. Destination of Stroke Patients assessed and treated by a Mobile Stroke Unit (MSU):

A. Ischemic stroke patients with CT imaging demonstrating a large vessel occlusion shall be transported to the closest Level I or II CSC.

B. The following patients shall be transported to the closest Level I CSC:

1. <u>Hemorrhagic Stroke</u>
2. Intraparenchymal or subarachnoid hemorrhage demonstrated on non-contrast CT
3. Subdural or epidural hemorrhage
4. Pathology needing emergency neurosurgical intervention

2. If transport time to the CSC is greater than 30 minutes, the patient shall be transported to the most accessible PSC.

C. Destination for patients with a positive mLAPSS whose LKWT is greater than 24 hours will be determined by the base hospital (i.e., consider stroke center destination if patient may benefit from stroke evaluation and management).

D. If there are no stroke centers (PSC or CSC) that are accessible by transport within the maximum allowable time of 30 minutes, the patient shall be transported to the most accessible receiving facility.

E. Ground transport is the preferred method of transport. Considerations for **dispatching** air ambulance transport shall include, but not limited to, the following:

1. Geographic isolation of incident location (e.g., Antelope Valley, Malibu, Gorman, Catalina Island)
2. Immediate availability of air ambulance
3. Accessibility of a fully licensed and permitted helipad at the stroke center
4. Transport capability from helipad to the emergency department of the stroke center

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 322, **Stroke Receiving Center Standards**
Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No, 517, **Regional Mobile Response Teams**
Ref. No. 1200, **Treatment Protocols**
Ref. No. 1251, **Stroke/Acute Neurological Deficits**

For FY 22-23, there were no changes to the emergency medical system for pediatrics. A map of our hospitals with children's services is included for reference (Attachment A)

Changes since the previous plan was submitted and approved include:

- List of Designated EDAP and PMCs with Agreement Expiration Dates (Attachment B)
- Reference No. 316, EDAP Standards – Revised 01-01-2023 (Attachment C)
- Reference No. 510, Pediatric Patient Destination – Revised 01-01-2023 (Attachment D)
- Reference No. 703, ALS Unit Inventory – Revised 10-01-2022 (Attachment E)
- Reference No. 703.1, Private Provider Interfacility Transfer ALS Unit Inventory – Revised 10-01-2022 (Attachment F)
- Reference No. 704, Assessment Unit Inventory – Revised 10-01-2022 (Attachment G)
- Reference No. 706, ALS EMS Aircraft Inventory – Revised 10-01-2022 (Attachment H)
- Reference No. 710, BLS Ambulance Equipment – Revised 10-01-2022 (Attachment I)
- Reference No. 712, Nurse Staffed Specialty Care Transport Unit Inventory – Revised 10-01-2022 (Attachment J)
- Reference No. 713, Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory – Revised 10-01-2022 (Attachment K)
- Reference No. 719, Fireline Emergency Technician Paramedic Inventory – Revised 10-01-2022 (Attachment L)
- Reference No. 822, Suspected Child Abuse/Neglect Reporting Guidelines – Revised 01-01-2023 (Attachment M)
- Reference No. 822.1, Guide to Suspected Child Abuse Reporting – Revised 01-01-2023 (Attachment N)
- Reference No. 832, Treatment/Transport of Minors – Revised 01-01-2023 (Attachment O)
- Reference No. 834, Patient Refusal of Treatment/Transport and Treat and Release at Scene – Revised 01-01-2023 (Attachment P)
- Reference No. 1208-P, Treatment Protocol: Agitated Delirium – Revised 10-01-2022 (Attachment Q)
- Reference No. 1209-P, Treatment Protocol: Behavioral/Psychiatric Crisis – Revised 10-01-2022 (Attachment R)
- Reference No. 1210-P, Treatment Protocol: Cardiac Arrest – Revised 07-01-2022 (Attachment S)
- Reference No. 1212-P, Treatment Protocol: Dysrhythmia Bradycardia – Revised 07-01-2022 (Attachment T)
- Reference No. 1213-P, Treatment Protocol: Dysrhythmia Tachycardia – Revised 07-01-2022 (Attachment U)
- Reference No. 1216-P, Treatment Protocol: Newborn/Neonatal Resuscitation – Revised 07-01-2022 (Attachment V)
- Reference No. 1219-P, Treatment Protocol: Allergy – Revised 01-01-2023 (Attachment W)
- Reference No. 1231-P, Treatment Protocol: Seizure – Revised 07-01-2022 (Attachment X)
- Reference No. 1234-P, Treatment Protocol: Airway Obstruction – Revised 07-01-2022 (Attachment Y)
- Reference No. 1237-P, Treatment Protocol: Respiratory Distress – Revised 07-01-2022 (Attachment Z)

- Reference No. 1241-P, Treatment Protocol: Overdose/Poisoning/Ingestion – Revised 01-01-2023 (Attachment AA)
- Reference No. 1243-P, Treatment Protocol: Traumatic Arrest – Revised 07-01-2022 (Attachment AB)
- Reference No. 1244-P, Treatment Protocol: Traumatic Injury – Revised 07-01-2022 (Attachment AC)
- Reference No. 1350, Medical Control Guidelines: Pediatric Patients – Revised 07-01-2022 (Attachment AD)

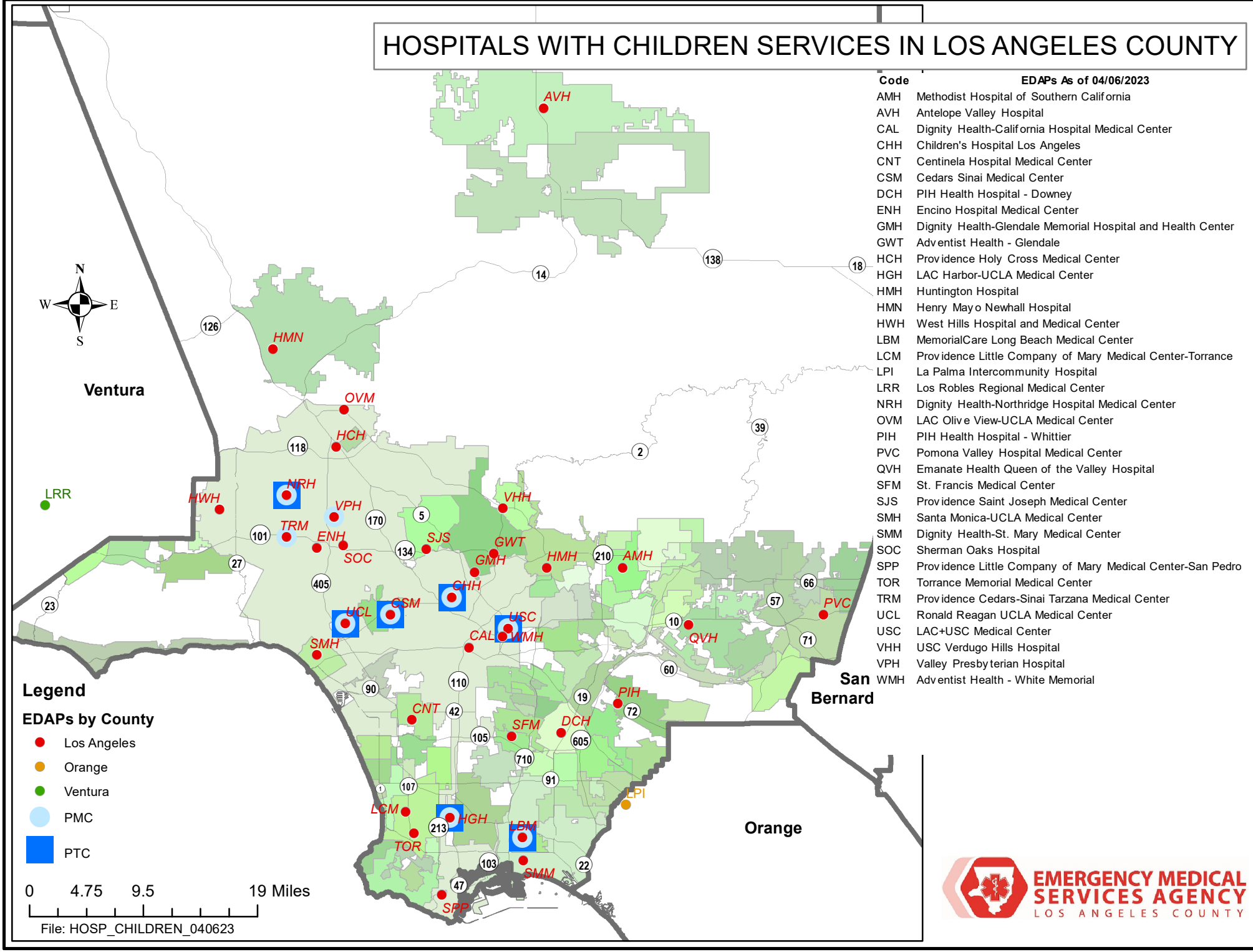
Pediatric EMS Update and EmergiPress Topics Included:

- Principles for consent for the treatment of minors, including implied consent for emergency medical conditions
- Understanding Brief Resolved Unexplained Event (BRUE)
- Pediatric asthma
- ECG of the Month – Pediatric ECG

The Pediatric Advisory/QI Committee met quarterly on September 6, 2022, December 4, 2022, March 21, 2023, and June 6, 2023. Topics included:

- EDAP/PDLN System-Wide QI Indicators and Quarterly Reports
- Pediatric Out of Hospital Cardiac Arrest (OHCA) for Cardiac Arrest Registry for Enhanced Survival (CARES) database update
- Innovation, Technology, and Advancement Committee Updates
- Pediatric Data Collaboratives Update – BRUE, PECARN, & Pedi-Dose
- PsySTART ED Boarders Tracking Study Update
- EnergiPress Update
- EDAP Standards revision
- No Hit Zone public service campaign
- AAP Infant Fever Guidelines recommendation for revisions
- Pediatric viral illness surge
- Pediatric stroke project
- Neonate <29 Days with Fever chart review template
- EDAP track and trend quality indicators
- National Pediatric Quality Improvement Collaborative and System-Wide QI project

HOSPITALS WITH CHILDREN SERVICES IN LOS ANGELES COUNTY



Legend

EDAPs by County

- Los Angeles
- Orange
- Ventura
- PMC
- PTC

Code	EDAPs As of 04/06/2023
AMH	Methodist Hospital of Southern California
AVH	Antelope Valley Hospital
CAL	Dignity Health-California Hospital Medical Center
CHH	Children's Hospital Los Angeles
CNT	Centinela Hospital Medical Center
CSM	Cedars Sinai Medical Center
DCH	PIH Health Hospital - Downey
ENH	Encino Hospital Medical Center
GMH	Dignity Health-Glendale Memorial Hospital and Health Center
GWT	Adventist Health - Glendale
HCH	Providence Holy Cross Medical Center
HGH	LAC Harbor-UCLA Medical Center
HMH	Huntington Hospital
HMN	Henry Mayo Newhall Hospital
HWH	West Hills Hospital and Medical Center
LBM	MemorialCare Long Beach Medical Center
LCM	Providence Little Company of Mary Medical Center-Torrance
LPI	La Palma Intercommunity Hospital
LRR	Los Robles Regional Medical Center
NRH	Dignity Health-Northridge Hospital Medical Center
OVM	LAC Olive View-UCLA Medical Center
PIH	PIH Health Hospital - Whittier
PVC	Pomona Valley Hospital Medical Center
QVH	Emanate Health Queen of the Valley Hospital
SFM	St. Francis Medical Center
SJS	Providence Saint Joseph Medical Center
SMH	Santa Monica-UCLA Medical Center
SMM	Dignity Health-St. Mary Medical Center
SOC	Sherman Oaks Hospital
SPP	Providence Little Company of Mary Medical Center-San Pedro
TOR	Torrance Memorial Medical Center
TRM	Providence Cedars-Sinai Tarzana Medical Center
UCL	Ronald Reagan UCLA Medical Center
USC	LAC+USC Medical Center
VHH	USC Verdugo Hills Hospital
VPH	Valley Presbyterian Hospital
WMH	Adventist Health - White Memorial

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

List of Pediatric Care Services with Agreement Expiration Dates as of June 30, 2023

Pediatric Hospitals	Designation Level	Agreement Expiration Date
Adventist Health - Glendale	EDAP	October 31, 2023
Adventist Health – White Memorial	EDAP	September 30, 2023
Antelope Valley Hospital	EDAP	October 31, 2025
Beverly Hospital	EDAP	Withdrew on March 20, 2023
Cedars Sinai Medical Center	PMC EDAP	July 31, 2026 September 30, 2024
Centinela Hospital Medical Center	EDAP	July 31, 2024
Children's Hospital Los Angeles	EDAP PMC	March 31, 2026 February 28, 2023*
Dignity Health – California Hospital Medical Center	EDAP	July 31, 2023^
Dignity Health – Glendale Memorial Hospital and Health Center	EDAP	September 30, 2023
Dignity Health – Northridge Hospital Medical Center	EDAP PMC	March 31, 2026 January 31, 2024*
Dignity Health – Saint Mary Medical Center	EDAP	May 31, 2025
Emanate Health Queen of the Valley	EDAP	June 30, 2025
Encino Hospital Medical Center	EDAP	October 31, 2023
Henry Mayo Newhall Hospital	EDAP	June 30, 2024*
Huntington Hospital	EDAP	February 28, 2024
LAC Harbor UCLA Medical Center	EDAP PMC	January 31, 2025 February 28, 2025
LAC Olive View-UCLA Medical Center	EDAP	August 31, 2023
La Palma Intercommunity Hospital	EDAP	May 31, 2026
Los Angeles General Medical Center	EDAP PMC	September 30, 2023 April 30, 2026
Los Robles Medical Center (Ventura County)	EDAP	August 31, 2025
MemorialCare Long Beach Medical Center	EDAP PMC	August 31, 2023^ August 31, 2024
PIH Health – Downey	EDAP	January 31, 2025
PIH Health – Whittier	EDAP	October 31, 2023
Pomona Valley Hospital Medical Center	EDAP	September 30, 2025
Providence Cedars-Sinai Tarzana Medical Center	EDAP PMC	July 31, 2025 December 31, 2023
Providence Holy Cross Hospital Medical Center	EDAP	June 30, 2026
Providence Little Company Mary Medical Center San Pedro	EDAP	June 30, 2025

Providence Little Company Mary Medical Center Torrance	EDAP	September 30, 2025
Providence Saint Joseph Medical Center	EDAP	September 30, 2024
Ronald Reagan UCLA Medical Center	EDAP PMC	October 31, 2025 March 31, 2026
Santa Monica UCLA Medical Center	EDAP	April 30, 2024
Sherman Oaks Hospital	EDAP	October 31, 2023
St. Francis Medical Center	EDAP	January 31, 2024
Torrance Memorial Medical Center	EDAP	September 30, 2025
USC Arcadia Hospital	EDAP	July 31, 2025
USC Verdugo Hills Hospital	EDAP	July 31, 2023^
Valley Presbyterian Hospital	EDAP PMC	December 31, 2026 October 31, 2025
West Hills Hospital & Medical Center	EDAP	February 28, 2025

*Deferred to the following year
^Pending corrective action

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMERGENCY DEPARTMENT APPROVED FOR PEDIATRIC (EDAP) STANDARDS**

REFERENCE NO. 316

PURPOSE: To establish minimum standards for the designation of Emergency Departments Approved for Pediatrics (EDAP). These Emergency Departments (ED) provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 14

DEFINITIONS:

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA), including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in a particular specialty.

Board Eligible (BE): Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA.

Department of Children and Family Services (DCFS): A mandated component of Emergency Response Services, administered by the Los Angeles County Department of Children and Family Services. The Child Protection Hotline (CPH), 800-540-4000, intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect, or exploitation to determine whether an in-person investigation and consultation is required.

Designated Pediatric Consultant: a qualified specialist in pediatrics and/or pediatric subspecialty.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic or comprehensive ED that is designated by the Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system. These EDs provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

EDAP Medical Director: A qualified specialist in Emergency Medicine (EM) or Pediatric Emergency Medicine (PEM), also referred to as the Physician Pediatric Emergency Care Coordinator.

Emergency Nursing Pediatric Course (ENPC): Two-day course developed by the Emergency Nurses Association (ENA) that provides core-level pediatric knowledge and psychomotor skills needed to care for pediatric patients in the emergency care setting.

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill
Medical Director, EMS Agency

Pediatric Advanced Life Support (PALS): Pediatric resuscitation course that is recognized by the EMS Agency and valid for two years (e.g., American Heart Association, American Red Cross).

Pediatric Advisory Committee (PedAC): Acts in an advisory capacity to the EMS Agency and is responsible for all matters regarding pediatric care and policy development pertinent to the practice, operation, and administration of prehospital care, emergency departments, and pediatric intensive care units (PICU). Committee reviews, evaluates, and makes recommendations on EMS issues impacting the pediatric population.

Pediatric Emergency Course (PEC): Two-day course, with topics pre-approved by the EMS Agency, that provides knowledge about the acutely ill and injured child, and a minimum of 14 hours of Board of Registered Nursing (BRN) approved continuing education.

Pediatric Intensivist: A qualified specialist in Pediatric Critical Care.

Pediatric Liaison Nurse (PdLN): A Registered Nurse currently licensed to practice in the State of California and appointed by the hospital to coordinate pediatric emergency care, also referred to as Nurse Pediatric Emergency Care Coordinator.

Pediatric Medical Center (PMC): A licensed acute care hospital that is designated by the EMS Agency to receive **critically ill** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 510, Pediatric Patient Destination.

Pediatric Patient: In the prehospital setting, is a child who is 14 years of age or younger.

Pediatric Trauma Center (**PTC):** A licensed acute care hospital that is designated by the EMS Agency to receive **injured** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 506, Trauma Triage. These centers provide tertiary pediatric care and serve as referral centers for critically injured pediatric patients.

Promptly Available: Able to be physically present in the ED within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, should not have a measurable harmful effect on the course of patient management or outcome. Hospital guidelines shall be established that address response time for on-call physicians.

Qualified Specialist: A physician licensed in the State of California who has become BC or BE in the corresponding specialty by ABMS or AOA.

Sexual Assault Response Team (SART) Centers: A center specializing in forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 120 hours), which has the capabilities of providing comprehensive medical and psychological forensic examinations and consist of a knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards.

Telehealth: The remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone media.

POLICY:

I. EDAP Designation / Re-Designation

A. EDAP initial designation and EDAP re-designation is granted for a period of three years after a satisfactory review by the EMS Agency.

B. The EMS Agency reserves the right to perform scheduled site visits or request additional data of the EDAP at any time.

C. The EDAP shall immediately provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the EDAP Standards, including structural changes, relocation of ED and change in pediatric inpatient resources.

D. The EDAP shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the EDAP program.

E. The EDAP shall notify the EMS Agency within 15 days, in writing of any change in status of the EDAP Medical Director, ED Nurse Manager/Director, Designated Pediatric Consultant, or Pediatric Liaison Nurse (PdLN) by submitting the Notification of Personnel Change Form (Ref. No. 621.2).

F. Execute and maintain a Specialty Care Center EDAP Designation Agreement with the EMS Agency.

II. General Hospital Requirements

A. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and maintain:

1. A special permit for Basic or Comprehensive Emergency Medical Service; and

2. Accreditation from a Centers for Medicare & Medicaid Services (CMS) recognized Hospital Accreditation Organization.

B. Appoint an EDAP Medical Director.

C. Appoint a PdLN and provide non-clinical time to perform duties based upon the ED's annual pediatric volume:

1.	Low	<1,800
2.	Medium	1,800 – 4,999
3.	Medium-High	5,000 – 9,999
4.	High	>10,000 (highly recommend 1 full time equivalent)

D. Hospital shall have a mechanism to track and monitor pediatric continuing education, including PALS, of pertinent staff.

E. Pediatric Interfacility Transfer

Establish and maintain a written Interfacility Consultation and Transfer Agreement for tertiary or specialty care, which shall include, at a minimum, the

following:

1. A plan for subspecialty consultation (telehealth or on-site) 24 hours per day.

2. Identification of transferring and receiving hospitals' responsibilities in accordance with Emergency Medical Treatment and Active Labor Act (EMTALA).

3. A process for selecting the appropriately staffed transport service to match the patient's acuity level.

III. EDAP Leadership Requirements

A. EDAP Medical Director

1. Responsibilities:

a. Oversee EDAP quality improvement (QI) program and monitor to ensure adherence to the EDAP standards.

b. Promote and verify adequate skills and current knowledge of ED staff physicians and mid-level practitioners in pediatric emergency care and resuscitation.

c. Participate in a multidisciplinary ED and pediatric committees (if applicable) to ensure that pediatric care needs are addressed and communicated across disciplines.

d. Liaison with PMCs, PTCs, other hospitals, prehospital care providers, and the EMS Agency to ensure pediatric care needs are addressed.

e. Collaborate with the ED Nurse Manager/Director and the PdLN to ensure adherence to the EDAP standards for staffing, medication, equipment, supplies, and other resources for children in the ED.

f. Participate in EMS Agency activities and meetings and attend a minimum of two (2) PedAC meetings per year.

B. Designated Pediatric Consultant

1. Responsibilities:

a. Promptly available for consultation

b. Participate in the development and monitoring of pediatric QI program, and pediatric policies and procedures

c. Collaborate with the EDAP Medical Director and PdLN as needed

d. May also be the EDAP Medical Director

C. ED Nurse Manager/Director

Responsibility: provide organizational support to meet EDAP requirements and initiatives

D. Pediatric Liaison Nurse (PdLN)

1. Qualifications:

a. At least two years of experience working in pediatrics, or in an ED that provides care for pediatric patients, within the previous five years; and currently working for the ED.

b. Current PALS provider or instructor certification.

c. Completion of a two-day PEC or ENPC every four years.

d. Completion of seven hours of BRN approved pediatric continuing education (CE) every two years.

2. Responsibilities:

a. Collaborate with the EDAP Medical Director, ED Nurse Manager/Director, and Designated Pediatric Consultant to ensure compliance with the EDAP Standards, and policies and procedures established by the EMS Agency.

b. Implement, maintain, and monitor the EDAP QI program.

c. Serve as a liaison and maintain effective lines of communication with:

1) ED management, physicians, and personnel
2) Hospital pediatric management, physicians, and personnel
3) System PdLNs
4) Other EDAPs and PMCs
5) Prehospital care coordinators (PCCs), as needed, to follow up with pediatric treatment/transport concerns
6) EMS providers as needed, to follow up with pediatric treatment and/or transport concerns
7) EMS Agency

d. Serve as a contact person for the EMS Agency and be available upon request to respond to County business.

e. Ensure pediatric ED continuing education and competency evaluation in pediatrics for ED staff.

f. Participate in EMS Agency activities and meetings and attend a minimum of two (2) PedAC meetings per year.

IV. Personnel Requirements

A. ED Physicians

1. 75% of the physicians attending in the ED shall be BC, or BE in EM, or PEM. 100% of the physicians attending in the ED shall be BC, or BE in EM, or PEM is recommended.

2. ED Physicians who are not EM, or PEM BC, or BE shall have current PALS provider or instructor certification.

3. ED Physicians who are not EM, or PEM BC, or BE shall have an affidavit signed by the EDAP Medical Director and Chief Medical Officer verifying competency in caring for pediatric patients, within the past two years.

B. Pediatricians (applies to EDAPs with associated pediatric admission unit)

There shall be a call panel for telephone consultation and a qualified specialist in pediatrics to be available to the ED twenty-four hours per day.

C. Pediatric Subspecialty Services

Pediatric subspecialty physicians, to include pediatric intensivist, shall be available through in-house call panel, telehealth, or transfer agreements.

D. Advanced Practice Providers (Physician Assistants and Nurse Practitioners)

1. Advanced Practice Providers shall be licensed in the State of California.

2. Advanced Practice Providers assigned to the ED caring for pediatric patients must have PALS provider or instructor certification.

E. Registered Nurses

1. All RN staff in the ED caring for pediatric patients must have a current PALS provider or instructor certification.

2. All nurses assigned to the ED shall attend at least 14 hours of BRN-approved pediatric emergency education (not including PALS) every four years (e.g., PEC or ENPC).

3. At least one RN per shift shall have completed a two-day PEC within the last 4 years and be available for patient care. It is highly recommended that all nurses regularly assigned to the ED complete this course.

V. Two-Day PEC – Continuing Education

A. May be completed in-house or off-site.

B. The interval between Day/Part 1 and Day/Part 2 must be completed within a six-month period. If the interval between Day/Part 1 and Day/Part 2 is greater than six months, this will only fulfill the 14-hour requirement in Section IV.E.2 above.

C. Curriculum should be selected from this broad spectrum of pediatric topics which

have been pre-approved by the EMS Agency:

1. Airway management
2. Brief Resolved Unexplained Event (BRUE)
3. Burns
4. Child maltreatment (suspected child abuse, neglect, and sexual assault) to include the mandated reporting process
5. Coordination of care with a SART Center for an acute suspected sexual assault victim requiring a forensic examination
6. Death
7. Disaster preparedness
8. Fever
9. Female presenting with signs & symptoms of recent delivery and no history of giving birth / newborn abandonment
10. Human trafficking
11. Injury prevention
12. Medical conditions (e.g., diabetic ketoacidosis, inborn errors of metabolism, etc.)
13. Medication safety
14. Neonatal resuscitation
15. Pain management
16. Disaster management
17. Poisonings / overdose
18. Procedural sedation
19. Respiratory emergencies
20. Resuscitation
21. Seizures
22. Sepsis
23. Shock / hypotension
24. SIDS/SUID
25. Special health care needs
26. Submersions
27. Surgical emergencies
28. Trauma
29. Triage

D. A copy of the course flyer, with agenda, shall be sent electronically to the EMS Agency Pediatric Program Coordinator no later than eight weeks before the scheduled course.

VI. Ancillary Services

A. Respiratory Care Practitioners (RCP)

1. At least one RCP shall be in-house twenty-four hours per day to respond to the ED.

2. All RCPs that work or respond to the ED shall have a PALS provider or instructor certification.

B. Radiology

1. The radiology department shall have pediatric-specific policies and

procedures pertaining to imaging studies of children and reducing radiation exposure.

2. Qualified specialist in radiology must be on-call and promptly available twenty-four hours per day.

3. Radiology technician must be in-house twenty-four hours per day.

4. Provide the following services 24 hours per day/seven days per week:

   a. Computerized tomography (CT)

   b. Ultrasonography

   c. Magnetic resonance Imaging (MRI)

C. Laboratory

Laboratory service shall have pediatric-specific policies and procedures pertaining to laboratory studies of children including, but not limited to, obtaining samples, and microtechnique for small or limited sample sizes.

VII. Policies and Procedures

The hospital shall develop and maintain, at minimum, the following policies and procedures pertaining to the emergency care of children. Multiple required elements may be incorporated into one policy (e.g., Care of the Pediatric Patient in the ED).

A. Weight and Vital Sign Measurement:

1. Vital signs shall be obtained and recorded at triage for all children. The policy shall include age-appropriate methods to obtain temperature, heart rate, respiratory rate, and pain scale.

2. Blood pressure and pulse oximetry monitoring shall be available for children of all ages. Optimally, blood pressure and pulse oximetry should be assessed on all children and shall be measured on all children requiring admission or transfer. Exceptions must be addressed in policy and monitored.

3. All pediatric weights shall be obtained and recorded in kilograms upon arrival to the ED:

   a. For children who require emergency stabilization or those who cannot be safely weighed, a standardized length-based resuscitation tape, approved by the EMS Agency (e.g., Broselow 2011A or newer), may be used to estimate weight in kilograms. The weight shall be recorded in a prominent place on the medical record.

   b. Scales used to weigh children must be configured to display weights only in kilograms.

c. Electronic medical records shall only allow for weight entries in kilograms.

B. Pediatric patient safety in the ED

C. Immunization assessment and management of the under immunized patient

D. Mandated reporting of child maltreatment (suspected child abuse, neglect, and sexual assault) to include:

1. An immediate, or as soon as practically possible, verbal telephone report to the Child Protection Hotline (CPH) and/or law enforcement and a Suspected Child Abuse Report (SCAR) #8572 report shall be submitted to the DCFS within 36 hours. https://mandreptla.org/cars.web/CallType. The case number or referral number shall be documented in the patient's medical record. If the SCAR report is filed electronically, the electronic tracking number must also be documented in the patient's medical record.

   a. To expedite reporting to CPH, press * and wait to be prompted to enter code **3237** (DCFS). Choose from the following options for reports:

      i. Press 1 for Safely Surrendered baby
      ii. Press 2 for Substance exposed infant
      iii. Press 3 for child fatality or critical condition
      iv. Press 4 for all other inquiries (Child report – medical queue)

2. Collaborative discussion with Social Worker, ED Physician, and RN prior to patient being discharged, to ensure patient is discharged to the appropriate location or with the appropriate services.

E. Coordination of care with a SART Center for an acute (defined as occurring with the last 120 hours) suspected sexual assault patient/victim who may require a forensic evidentiary examination or appropriate referral, the policy/procedure shall include the following (may be incorporated into the policy/procedure above):

1. ED nurse or physician shall notify the law enforcement agency in the appropriate jurisdiction where the crime occurred.

   a. Collaborate with law enforcement to determine plan of care and/or forensic evidentiary examination and document the officer's identification, department, and badge number in the medical record

   b. The ED may also contact the forensic nurse for consultation or clarification regarding patient care as it relates to evidence preservation.

2. Appropriate discharge and referral include the name of the SART Center(s), location address, and hotline telephone number(s).

F. Pediatric assessment and reassessment include identification of abnormal vital

signs according to the age of the patient. If abnormal values are obtained, include a plan/process for physician notification.

G. Pain assessment, treatment, and reassessment, utilizing developmentally appropriate pain scales (include a description of the tools used for all age levels)

H. Consent and assent for emergency treatment, include situations in which a parent/legal guardian is not immediately available

I. Do Not Resuscitate (DNR) orders/Advanced Health Care Directives (AHCD)

J. Death of the child in the ED and care of the grieving family

K. Care and safety for the pediatric patient with mental and/or behavioral health emergencies

L. Physical and chemical restraint of patients

M. Procedural sedation

N. Safe surrender of newborns

O. Daily verification of proper location and function of equipment and supplies for the pediatric crash cart, with a list and description of items in each drawer

P. Family Centered Care, include the following:

1. Supporting appropriate family presence during all aspects of care to include invasive procedures and resuscitation

2. Education of the patient, family, and regular caregivers

3. Discharge planning and instructions

4. Culturally and linguistically appropriate services

Q. Communication with patient’s medical home or primary provider based on illness and severity (e.g., aftercare instructions, x-ray results, laboratory studies, as appropriate)

R. Transfer from the ED to another facility

S. Disaster preparedness addressing the following pediatric issues:

1. Minimizing parent-child separation, and methods for reuniting separated children with their families

2. Pediatric surge capacity for both injured and non-injured children

3. Medical and mental health therapies, and social services for children in the event of a disaster

4. Disaster drills that include a pediatric mass casualty incident at least once

every two years

5. Decontamination

6. Surge plan for back-up personnel (MD and nursing) in the ED

T. Medication safety addressing the following pediatric issues:

1. Medication orders should be written clearly in milligrams per kilogram and should specify the total dose.

2. Processes for prescribing, safe medication storage, and delivery should be established. Include the use of pre-calculated dosing guidelines for children of all ages.

3. Involve the patient and family in the medication safety process to ensure accurate patient identification. Include patient and family education as to the rationale for the medication.

VIII. Equipment, Supplies, and Medications

A. Pediatric equipment, supplies, and medications shall be easily accessible, labeled, and logically organized. A mobile pediatric crash cart shall be utilized.

B. A locator chart or grid identifying the locations of all required equipment and supplies shall be developed and maintained in order for staff to easily identify location of all items.

C. Required EDAP equipment, supplies, and medications

1. General Equipment

a. Weight scale measuring only in kilograms for both infants and children

b. Standardized length-base resuscitation tape, approved by the EMS Agency (e.g., Broselow 2011A or newer), or other standardized method to estimate pediatric weights in kilograms

c. Pediatric drug dosage reference material with dosages calculated in milligrams, micrograms, milliequivalents, etc. per kilogram (either posted or readily available)

d. Developmentally appropriate pain scale assessment tools for infants and children

e. Blood and IV fluid warmer (Rapid infuser)

f. Warming and cooling system with appropriate disposable blankets

g. Restraints in various sizes

2. Monitoring Equipment

a. Blood pressure cuffs

1) Neonatal
2) Infant
3) Child
4) Adult arm
5) Adult thigh

b. Vascular Doppler device (handheld)

c. ECG monitor/defibrillator

1) ECG electrodes in pediatric and adult sizes
2) Defibrillator paddles in pediatric and adult sizes, and/or; Hands-free defibrillation device
3) External pacing capability
4) Multifunction pads in pediatric and adult sizes

d. Thermometer with hypothermia capability

3. Airway Management

a. Bag-Mask-Ventilation (BMV) device with self-inflating bag

1) Infant (minimum 450ml)
2) Child
3) Adult

b. BMV clear masks

1) Neonate
2) Infant
3) Child
4) Adult

c. Laryngoscope handle

1) Pediatric
2) Adult

d. Laryngoscope Blades

1) Macintosh/curved: 2, 3
2) Miller/straight: 00, 0, 1, 2, 3

e. Endotracheal Tubes

1) Uncuffed: size mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5
2) Cuffed: size mm 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0

f. Stylets for endotracheal tubes

1) Pediatric
2) Adult

g. Magill Forceps

1) Pediatric
2) Adult

h. Continuous end-tidal CO2 monitoring device for pediatric and adult patients (preferred). If not available, colorimetric CO2 detector may be utilized.

i. Pulse oximeter unit with sensors

1) Infant
2) Pediatric
3) Adult

j. Nasopharyngeal Airways

1) Infant (sizes 12-14)
2) Child (sizes 18-28)
3) Adult (sizes 30-36)

k. Oropharyngeal Airways

1) Infant (size 00)
2) Child (size 0-2)
3) Adult (sizes 3-5)

l. Clear oxygen masks

1) Infant
2) Child
3) Adult

m. Non-rebreather masks

1) Infant (partial non-rebreather)
2) Child
3) Adult

n. Nasal cannulas

1) Infant
2) Child
3) Adult

o. Suction catheters

6, 8, 10, 12 Fr

p. Yankauer suction tips

q. Feeding tubes

5, 8 Fr

r. Nasogastric Tubes

5, 8, 10, 12, 14, 16, 18 Fr

s. Supraglottic Airway Devices

1) Neonatal
2) Infant
3) Child
4) Adult

t. Difficult Airway Kit

u. Tracheostomy trays: optional for EDAP, required for PMC

1) Pediatric
2) Adult

v. Tracheostomy Tubes: optional for EDAP, required for PMC

1) Neonatal: size mm 2.0, 2.5, 3.0, 3.5, 4.0, 4.5
2) Pediatric: size mm 3.0, 3.5, 4.0, 5.0, 5.5, 6.0

4. Vascular Access Equipment

a. Arm boards

1) Infant
2) Child
3) Adult

b. IV administration sets with calibrated chambers

c. IV catheters

16, 18, 20, 22, 24 gauge

d. 3-way stopcocks

e. Device or needle to achieve intraosseous (IO) vascular access, to include needles in the appropriate sizes for pediatric and adult patients

f. IV solutions, 250ml and/or 500ml bags

1) 0.9 NS
2) D5.45NS

3) D5NS
4) D10W

5. Fracture Management Devices

a. Splinting supplies for long bone fractures

b. Cervical spine motion restriction equipment (e.g., cervical collar)

1) Pediatric
2) Adult

c. Spinal board with the appropriate straps

6. Specialized Trays or Kits

a. Newborn delivery kit to include:

1) Bulb syringe
2) Umbilical clamps
3) Towels
4) Scissors

b. Newborn initial resuscitation equipment should be readily available, include:

1) Radiant warmer or warming mattress
2) BMV device with self-inflating bag and clear mask for newborns
3) Umbilical vein catheters, or 5.0 Fr feeding tube

c. Thoracostomy tray

d. Chest drainage system

e. Chest tubes (at least one in each size range)

1) Required for EDAP: (10 – 12) (16 – 24) (28 – 40) Fr
2) Required for PMC: 8, 12, 16, 20, 24, 28, 36 Fr

f. Lumbar Puncture trays and spinal needles

1) 22 g, 3 inch
2) 22-25 g, 1½ inch

g. Urinary catheterization sets and indwelling urinary catheters

5, 8, 10, 12, 14, 16 Fr

7. Pediatric-Specific Resuscitation

a. Immediately available drug calculation resources

b. The following medications must be immediately available:

1) Adenosine
2) Albuterol
3) Amiodarone
4) Atropine
5) Calcium chloride
6) Dobutamine
7) Dopamine
8) Epinephrine 0.1mg/mL **(IV administration**)
9) Epinephrine 1mg/mL (**IM administration**)
10) Epinephrine for inhalation
11) Fentanyl
12) Ipratropium bromide (Atrovent)
13) Ketamine
14) Lidocaine
15) Mannitol or hypertonic saline
16) Naloxone
17) Norepinephrine
18) Neuromuscular blocking agent
19) Procainamide
20) Sedative agent
21) Sodium Bicarbonate 4.2% (or a process to obtain the drug in an emergency situation)
22) Sodium Bicarbonate 8.4%

IX. Quality Improvement (QI) Program Requirements

A QI program shall be developed as per Ref. No. 620, EMS Quality Improvement Program, and monitored by the EDAP Medical Director, ED Nurse Manager/Director, and PdLN, with input as needed from the Designated Pediatric Consultant.

A. Develop a methodology to easily identify pediatric (14 years of age and under) visits to the ED that can clearly delineate between 9-1-1 transport and self-transport.

B. Identification and trending of important aspects of pediatric care requiring improvement, shall include:

1. 100% medical record review by physician and PdLN to include physician reviewer signature(s) and date(s) of the reviews:

a. Deaths in the ED

b. Child Maltreatment (suspected child abuse, neglect, and sexual assault) to include the mandated reporting process

c. Transfers to higher level of care

d. Unscheduled/unplanned return visits to the ED within 48 hours and are admitted or transferred for continued acute care

2. System-wide QI projects selected by the EMS Agency and endorsed by the PedAC

3. Track and trend two (2) EMS Agency-approved indicators and one (1) additional indicator (important aspects of patient care) identified by the Medical Director and PdLN

4. Quarterly QI review of all suspected child maltreatment cases shall be conducted by Social Services and the ED to ensure the appropriate recognition and reporting of processes have been completed. A checklist may be utilized to ensure complete documentation and facilitate the review

C. Maintain written QI plan, trending and analysis reports, agenda, minutes, and attendance rosters. Upon request records shall be readily available to the EMS Agency for review.

D. Complete the National Pediatric Readiness Project (NPRP) assessment annually https://www.pedsready.org/, and submit a copy of the NPRP Assessment Gap Analysis to the EMS Agency upon request.

E. Submit data as requested by the EMS Agency for quality improvement purposes to include physician-specific reviews of EMS Agency identified important aspects of care.

X. Data Collection Requirements

A. Participate in the data collection process established the EMS Agency.

B. Submit data to the EMS Agency, within 45 days of patient discharge, which shall include data elements listed in Ref. No. 652, EDAP and PMC Data Dictionary.

CROSS REFERENCE:

Prehospital Care Policy Manual

Ref, No. 216, **Pediatric Advisory Committee (PedAC)**
Ref. No. 318, **Pediatric Medical Center (PMC) Standards**
Ref. No. 324, **SART Center Standards**
Ref. No. 506, **Trauma Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 621.2, **Notification of Personnel Change Form**
Ref. No. 652, **EDAP and PMC Data Dictionary**
Ref. No. 822, **Suspected Child Abuse/Neglect Reporting Guidelines**
Ref. No. 822.2, **Suspected Child Abuse Report (SCAR) #8572**

California Penal Code 11166
Emergency Nursing Pediatric Course (ENPC)
National Pediatric Readiness Project (NPRP)

ACKNOWLEDGEMENTS

The EMS Agency EDAP Standards were first developed by the Committee on Pediatric Emergency Medicine (COPEM), which is made up of representatives from the following organizations: Los Angeles Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of the American College of Emergency Physicians (ACEP), National Emergency Medical Services for Children (EMSC) Resource Alliance, American Academy of Pediatrics (AAP)-California Chapter 2, Emergency Nurses Association (ENA), American College of Surgeons (ACS), and the EMS Agency.

The EDAP Standards have since been revised, endorsed by The Hospital Association of Southern California, and now meet or exceed the 2009 Joint Policy Statement: Guidelines for Care of Children in the Emergency Department which was ratified by the AAP, ACEP, and the ENA.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT-I, PARAMEDIC, MICN)

SUBJECT: **PEDIATRIC PATIENT DESTINATION** REFERENCE NO. 510

PURPOSE: To ensure that 9-1-1 pediatric patients are transported to the most appropriate facility that is staffed, equipped, and prepared to administer emergency and/or definitive care appropriate to the needs of the pediatric patient.

AUTHORITY: Health and Safety Code, Division 2.5, Section 1797.220
California Code of Regulations, Title 13, Section 1105 C

DEFINITIONS:

Brief Resolved Unexplained Event (BRUE): A brief episode characterized by any one of the following (for children 12 months of age or younger): absent, decreased, or irregular breathing; color change (usually cyanosis or pallor); marked change in muscle tone (usually limpness or hypotonia, may also include hypertonia); and/or altered level of responsiveness.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic or comprehensive emergency department that is designated by the Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system.

Newly Born: Refers to patients from birth to two hours after birth.

Pediatric Medical Center (PMC): A licensed acute care hospital that is designated by the EMS Agency to receive critically **ill** pediatric patients via the 9-1-1 system based on guidelines outlined in this policy. These centers also provide referral services for critically ill pediatric patients.

Pediatric Patient: Children 14 years of age or younger.

Pediatric Trauma Center (PTC): A licensed acute care hospital that is designated by the EMS Agency to receive critically **injured** pediatric patients via the 9-1-1 system based on guidelines outlined in this policy. These centers provide tertiary-level pediatric care and serve as referral centers for critically injured pediatric patients.

PRINCIPLE:

In all cases, the health and well-being of the patient is the overriding consideration in determining patient destination. Factors to be considered include severity and stability of the patient's illness or injury; current status of the pediatric receiving facility; anticipated transport time; request by the patient, family, guardian or physician; and EMS personnel and base hospital judgment.

POLICY:

I. Guidelines for transporting pediatric patients to a specialty care center (i.e., EDAP, PMC, PTC, Perinatal, Sexual Assault Response Team Center, or Trauma Center):

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

A. Patients who require transport, and do not meet guidelines for transport to a PMC or PTC should be transported to the most accessible EDAP.

1. Newly born patient requiring assisted ventilation and/or chest compression should be transported to the most accessible EDAP that is also a Perinatal Center with a NICU.

2. Newly born patient without distress should be transported to the nearest EDAP that is also a Perinatal Center.

B. BLS units shall call for an ALS unit on pediatric patients who meet criteria for Base Hospital Contact and ALS Transport as listed in Ref. No. 1200.1, Treatment Protocols General Instructions.

C. BLS units shall transport pediatric patients not requiring ALS unit response to the most accessible EDAP unless criteria are met for Treat and Refer as outlined in Ref. No. 834, Patient Refusal of Treatment/Transportation and Treat and Release at Scene.

D. Patients meeting conditions listed in Section II:

1. Should be transported to the most accessible PMC if ground transport is ≤30 minutes.

2. If ground transport time to a PMC is >30 minutes, the patient may be transported to the most accessible EDAP.

Patients meeting trauma criteria/guidelines as per Ref. No. 506, Trauma Triage:

3. Should be transported to the most accessible PTC if the transport time is ≤30 minutes.

4. If a PTC cannot be accessed but a trauma center can be accessed under the parameter in (E.1), the patient may be transported to the trauma center.

5. If a PTC or trauma center cannot be accessed as specified above, the patient may be transported to the most accessible PMC, or if >30 minutes to the closet EDAP.

E. Pediatric patients who have an uncontrollable, life-threatening situation (e.g., unmanageable airway or uncontrollable hemorrhage) should be transported to the most accessible EDAP.

F. Pediatric patients may be transported to a non-EDAP provided all of the following are met:

1. The patient, family, or private physician requests transport to a non-EDAP facility.

2. The patient, family, or private physician is made aware that the receiving facility is not an EDAP and may not meet current EDAP standards.

3. The base hospital concurs and contacts the requested facility and ensures that the facility has agreed to accept the patient.

4. All of the above shall be documented on the Patient Care Record.

II. Critically **ill** pediatric patients exhibiting conditions listed below should be transported to a PMC:

A. Cardiac dysrhythmia

B. Severe respiratory distress

C. Cyanosis

D. Altered mental status without signs of improvement

E. Status epilepticus

F. Brief Resolved Unexplained Event (BRUE) ≤12 months of age

G. Focal neurologic signs not associated with trauma (e.g.; pediatric stroke, atypical migraine, petit mal seizures)

H. Post cardiopulmonary arrest in whom return of spontaneous circulation (ROSC) is achieved

IV: For multi-casualty incidents see Ref. No. 519, Management of Multiple Casualty Incidents, for destination.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 316, **EDAP Standards**
Ref. No. 318, **Pediatric Medical Care (PMC) Standards**
Ref. No. 324, **Sexual Assault Response Team (SART) Standards**
Ref. No. 501, **9-1-1 Receiving Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 508.1, **SART Center Roster**
Ref. No. 511, **Perinatal Patient Destination**
Ref. No. 512, **Burn Patient Destination**
Ref. No. 516, **Cardiac Arrest Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 816, **Physician at Scene**
Ref. No. 832, **Treatment/Transport of Minors**
Ref. No. 834, **Patient Refusal of Treatment/Transport and Treat and Release at Scene**
Ref. No. 1200.1, **Treatment Protocols General Instructions**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **ALS UNIT INVENTORY** REFERENCE NO. 703

PURPOSE: To provide a standardized minimum inventory on all Advanced Life Support (ALS) Units.

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

POLICY:

I. Providers may only carry one narcotic analgesic on the ALS units. Provider Agency Medical Directors may request approval from the Emergency Medical Services (EMS) Agency's Medical Director to carry Fentanyl.

II. ALS Units shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied according to the Department of the California Highway Patrol, California Administrative Code, Title 13.

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

MEDICATIONS			
Adenosine	**24mgs**	Glucagon	**1mg**
Albuterol (pre-mixed w/ NS)	**20mgs**	Ketorolac 15mg/mL **OR**	**4**
Amiodarone	**900mgs**	Ketorolac 30mg/2mL	**2**
Aspirin (chewable 81mg)	**648mgs**	Lidocaine 2% [4]	**200mgs**
Atropine sulfate (1mg/10mL)	**3mgs**	Midazolam [5]	**20mgs**
Calcium chloride	**1gm**	Morphine sulfate [6]	**20mgs**
Dextrose 10% / Water 250mL	**3 bags**	Naloxone	**4mgs**
Dextrose - glucose paste/gel	**45gms**	Normal saline (for injection)	**2 vials**
Diphenhydramine	**100mgs**	Nitroglycerin (SL) spray, tablets, or single dose powder packets	**1 pump/ bottle/ or 36 packets**
Disaster Cache [1]	**1**	Olanzapine 10mg ODT	**40mgs**
Epinephrine (1mg/mL)	**5mgs**	Ondansetron 4mg ODT	**16mgs**
Epinephrine (0.1mg/mL)	**7mgs**	Ondansetron 4mg IV	**16mgs**
Fentanyl [2, 3]	**500mcgs**	Sodium bicarbonate	**50mLs**
INTRAVENOUS FLUIDS			
Normal saline 1000 mL	**6 bags**	Normal saline 250 or 500 mL	**2 bags**

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill
Medical Director, EMS Agency

SUBJECT: **ALS UNIT INVENTORY** REFERENCE NO. 703

SUPPLIES			
Adhesive dressing (Band-Aids®)	**1 box**	Color Code Drug Doses, Ref. No. 1309	**1**
Airways – Nasopharyngeal:		Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5” 14G	**2**
Large (34-36)	**1**	Contaminated needle container	**1**
Medium (26-28)	**1**	Continuous Positive Airway Pressure (CPAP) device: [3]	
Small (20-22)	**1**	Small	**1**
Airways – Oropharyngeal:		Medium	**1**
Large	**1**	Large	**1**
Medium	**1**	Endotracheal tubes w/ stylets Sizes 6.0-8.0	**2 each**
Small Adult/Child	**1**	Tube introducer	**2**
Infant	**1**	End Tidal CO2 Detector or Aspirator (Adult)	**1**
Neonate	**1**	Extrication device or short board	**1**
Alcohol prep pads	**1 box**	Filter, viral HEPA [11]	**2**
Backboards	**2**	Flashlight or penlight	**1**
Bag-Mask-Ventilation (BMV) device w/ O_2 inlet & reservoir:		Gauze bandages	**6**
Bag Volume 650-1000 mL[7]	**1**	Gauze sponges 4x4 (sterile)	**12**
Bag Volume 400-700 mL[7]	**1**	Gloves, sterile	**2 pair**
Bag Volume 200-450 mL[7]	**1**	Gloves, unsterile	**1 box**
Bag-Mask-Ventilation (BMV) Masks:		Glucometer w/ strips	**1**
Large	**1**	Lancets (automatic retractable)	**5**
Medium	**1**	Hand-held nebulizer pack	**2**
Small Adult/Child	**1**	Hemostats, padded	**1**
Toddler	**1**	Intraosseous device: [3]	
Infant	**1**	Adult	**1**
Neonate	**1**	Pediatric	**1**
Burn pack or burn sheet	**1**	Intravenous catheters: Sizes 16G - 22G	**5 each**
Cervical collars (rigid):		Intravenous tubing - Macrodrip	**12**
Adult (adjustable)	**4**	i-gel (Disposable Supraglottic Airway):	
Pediatric	**2**	Neonate (size 1)	**1**
Cardiac Monitor-Defibrillator w/ oscilloscope	**1**	Infant (size 1.5)	**1**
Defibrillator pads or paste (including pediatric)	**2 each**	Small pediatric (size 2)	**1**
ECG electrodes:		Large pediatric (size 2.5)	**1**
Adult	**6**	Small adult (size 3)	**1**
Pediatric	**6**	Medium Adult (size 4)	**1**
Pulse oximeter	**1**	Large adult+ (size 5)	**1**
Transcutaneous pacing	**1**	Laryngoscope blades:	
Waveform capnography	**1**	Adult: curved & straight	**1 each**
ECG, 12-lead & transmission capable	**1**	Pediatric: Miller #1 & #2	**1 each**

SUBJECT: **ALS UNIT INVENTORY** REFERENCE NO. 703

SUPPLIES (continued)			
Laryngoscope handle:		Saline locks	**4**
Adult (compatible w/ pediatric blades)	1	Scissors	**1**
Magill forceps:		Sphygmomanometer:	
Adult	**1**	Thigh	**1**
Pediatric	**1**	Adult	**1**
Mucosal Atomization Device (MAD)	**3**	Pediatric	**1**
Needle, filtered-5micron [8]	**2**	Infant	**1**
Normal saline for irrigation	**1 bottle**	Splints:	
OB pack & bulb syringe [9]	**1**	Long	**2**
Oxygen cannulas:		Short	**2**
Adult	**3**	Splints – traction:	
Pediatric	**3**	Adult	**1**
Oxygen masks – (non-rebreather):		Pediatric	**1**
Adult	**4**	Stethoscope	**1**
Pediatric	**2**	Suction unit (portable) w/adapter	**1**
Infant	**2**	Suction catheters:	
Oxygen masks – (simple):		Size 8Fr.	**1**
Adult	**2**	Size 10Fr.	**2**
Pediatric	**2**	Size 12Fr.	**4**
Infant	**2**	Tonsillar tip	**1**
Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	**1**	Syringes sizes: 1mL – 60mL w/ luer adapter	**assorted**
Personal Protective Equipment:		Tape (various types, must include cloth)	**1**
Mask	**1 per provider**	Thermometer (Oral or axillary)	**1**
Gown	**1 per provider**	Tourniquets (IV)	**2**
Eye protection	**1 per provider**	Tourniquets (commercial for bleeding control)	**2**
Radio transmitter receiver (Hand-Held) [10]	**1**	Vaseline gauze	**2**

APPROVED OPTIONAL EQUIPMENT	
Hemostatic dressings–EMS Authority approved dressings only	Pediatric laryngoscope handle FDA-Approved
Intravenous tubing, blood	Resuscitator w/ positive pressure demand valve (flow rate not to exceed 40L/min)
Mechanical CPR device [3]	Albuterol / Metered Dose Inhaler (MDI) [12]
Metered-Dose-Inhaler (MDI) Spacer [12]	Metered-Dose-Inhaler (MDI) Mask [12]

[1] Disaster Cache minimum contents include: (9) DuoDote kits or equivalent;
And when available: (6) AtroPen Auto Injector 1.0mg
(6) AtroPen Auto Injector 0.5mg – Pediatric Use
[2] Fentanyl carried on ALS Unit is not to exceed 1500mcgs.
[3] Requires EMS Agency approval, which includes an approved training program & QI method prior to implementation.
[4] Utilized w/ infusions through IO access.
[5] Midazolam carried on ALS Unit is not to exceed 40mgs.
[6] Morphine sulfate carried on ALS Unit is not to exceed 60mgs.
[7] Device volume, not delivered volume.
[8] Optional, if not utilizing glass ampules.

[9] OB kits w/ clamps / scissors (no scalpels).
[10] Los Angeles County Department of Communications, Spec. No. 2029/2031/2033.
[11] As supply allows.
[12] All required if using Albuterol / Metered Dose Inhaler.

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

CROSS REFERENCES:

Prehospital Care Manual:

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC, MICN)

SUBJECT: **PRIVATE PROVIDER INTERFACILITY TRANSFER ALS UNIT INVENTORY**

REFERENCE NO. 703.1

PURPOSE: To provide a standardized minimum inventory for private provider agencies approved for Advanced Life Support (ALS) interfacility transfers.

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

POLICY:

I. Providers may only carry one narcotic analgesic on the ALS units. Provider Agency Medical Directors may request approval from the EMS Agency's Medical Director to carry Fentanyl.

II. ALS Units shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied according to the Department of the California Highway Patrol, California Administrative Code, Title 13.

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

MEDICATIONS			
Adenosine	**24mgs**	Fentanyl [1, 2]	**500mcgs**
Albuterol (pre-mixed w/ NS)	**10mgs**	Ketorolac 15mg/mL **OR** Ketorolac 30mg/2mL	**4** / **2**
Amiodarone	**450mgs**	Midazolam [3]	**20mgs**
Aspirin (chewable 81mg)	**648mgs**	Morphine sulfate [4]	**20mgs**
Atropine sulfate (1mg/10mL)	**3mgs**	Naloxone	**4mgs**
Calcium chloride	**1gm**	Normal saline (for injection)	**2 vials**
Dextrose 10% / Water 250mL	**2 bags**	Nitroglycerin (SL) spray, tablets, or single dose powder packets	**1 pump/ bottle/ or 10 packets**
Dextrose - glucose paste/gel	**45gms**	Olanzapine 10mg ODT	**20mgs**
Diphenhydramine	**50mgs**	Ondansetron 4mg ODT	**16mgs**
Epinephrine (1mg/mL)	**5mgs**	Ondansetron 4mg IV	**16mgs**
Epinephrine (0.1mg/mL)	**5mgs**		
INTRAVENOUS FLUIDS			
Normal saline 1000 mL	**4 bags**	Normal saline 250 or 500 mL	**2 bags**

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill
Medical Director, EMS Agency

SUBJECT: **PRIVATE PROVIDER INTERFACILITY TRANSFER ALS UNIT INVENTORY**

REFERENCE NO. 703.1

SUPPLIES			
Adhesive dressing (Band-Aids®)	**1 box**	Contaminated needle container	**1**
Airways – Nasopharyngeal:		Endotracheal tubes w/ stylets Sizes 6.0-8.0	**1 each**
Large (34-36)	**1**	Tube introducer	**2**
Medium (26-28)	**1**	End Tidal CO2 Detector or Aspirator (Adult)	**1**
Small (20-22)	**1**	Extrication device or short board	**1**
Airways – Oropharyngeal:		Filter, viral HEPA [10]	**2**
Large	**1**	Flashlight or penlight	**1**
Medium	**1**	Gauze bandages	**6**
Small Adult/Child	**1**	Gauze sponges 4x4 (sterile)	**12**
Infant	**1**	Gloves, sterile	**2 pair**
Neonate	**1**	Gloves, unsterile	**1 box**
Alcohol prep pads	**1 box**	Glucometer w/ strips	**1**
Backboards	**2**	Lancets (automatic retractable)	**5**
Bag-Mask-Ventilation (BMV) device w/ O_2 inlet & reservoir:		Hand-held nebulizer pack	**2**
Bag Volume 200-450 mL[11]	**1**	Hemostats, padded	**1**
Bag Volume 400-700 mL[11]	**1**	Intravenous catheters: Sizes 16G - 22G	**5 each**
Bag Volume 650-1000 mL[11]	**1**	Intravenous tubing - Macrodrip	**6**
Bag-Mask-Ventilation (BMV) Masks:		i-gel (Disposable Supraglottic Airway)	
Large	**1**	Neonate (size 1)	**1**
Medium	**1**	Infant (size 1.5)	**1**
Small Adult/Child	**1**	Small pediatric (size 2)	**1**
Toddler	**1**	Large pediatric (size 2.5)	**1**
Infant	**1**	Small adult (size 3)	**1**
Neonate	**1**	Medium adult (size 4)	**1**
Burn pack or burn sheet	**1**	Large adult+ (size 5)	**1**
Cervical collars (rigid):		Laryngoscope blades:	
Adult (adjustable)	**4**	Adult: curved & straight	**1 each**
Pediatric	**2**	Pediatric: Miller #1 & #2	**1 each**
Cardiac Monitor-Defibrillator w/ oscilloscope	**1**	Laryngoscope handle:	
Defibrillator pads or paste (including pediatric)	**2 each**	Adult (compatible w/ pediatric blades)	**1**
ECG electrodes:		Magill forceps:	
Adult	**6**	Adult	**1**
Pediatric	**6**	Pediatric	**1**
Pulse oximeter	**1**	Mucosal Atomization Device (MAD)	**2**
Color Code Drug Doses, Ref. No. 1309	**1**	Needle, filtered-5micron [6]	**2**
Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5” 14G	**2**		

SUBJECT: **PRIVATE PROVIDER INTERFACILITY TRANSFER ALS UNIT INVENTORY**

REFERENCE NO. 703.1

SUPPLIES (continued)			
OB pack & bulb syringe [7]	**1**	Normal saline for irrigation	**1 bottle**
Oxygen cannulas:		Splints:	
Adult	**3**	Long	**2**
Pediatric	**3**	Short	**2**
Oxygen masks – (non-rebreather):		Splints – traction:	
Adult	**4**	Adult	**1**
Pediatric	**2**	Pediatric	**1**
Infant	**2**		
Oxygen masks – (simple):		Stethoscope	**1**
Adult	**2**	Suction unit (portable) w/adapter	**1**
Pediatric	**2**	Suction catheters:	
Infant	**2**	Size 8Fr.	**1**
Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	**1**	Size 10Fr.	**2**
		Size 12Fr.	**4**
Personal Protective Equipment:		Tonsillar tip	**1**
Mask	1 per provider	Syringes sizes: 1mL – 60mL w/ luer adapter	**assorted**
Gown	1 per provider	Tape (various types, must include cloth)	**1**
Eye Protection	1 per provider	Thermometer (Oral or axillary)	**1**
Radio transmitter receiver (Hand-Held) [8]	**1**	Tourniquets (IV)	**2**
Saline locks	**4**	Tourniquets (commercial for bleeding control)	**2**
Scissors	**1**	Vaseline gauze	**2**
Sphygmomanometer:			
Thigh	**1**		
Adult	**1**		
Pediatric	**1**		
Infant	**1**		

APPROVED OPTIONAL EQUIPMENT	
Albuterol / Metered Dose Inhaler (MDI) [12]	Metered-Dose-Inhaler (MDI) Mask [12]
Continuous Positive Airway Pressure (CPAP) Device [2]	Metered-Dose-Inhaler (MDI) Spacer [12]
Glucagon	Pediatric Laryngoscope Handle FDA-Approved
Hemostatic Dressings	Resuscitator with positive pressure demand valve (flow rate not to exceed 40L/min)
Impedance Threshold Device [2]	Sodium Bicarbonate
Intraosseous Device [2]	Transcutaneous Pacing [2]
Lidocaine 2% [2, 9]	Waveform Capnography
Mechanical CPR Device [2]	

SUBJECT: **PRIVATE PROVIDER INTERFACILITY TRANSFER ALS UNIT INVENTORY** REFERENCE NO. 703.1

[1] Fentanyl carried on ALS Unit is not to exceed 1500mcgs.
[2] Requires EMS Agency approval, which includes an approved training program and QI method prior to implementation.
[3] Midazolam carried on ALS Unit is not to exceed 40mgs.
[4] Morphine sulfate carried on ALS Unit is not to exceed 60mgs.
[6] Optional, if not utilizing glass ampules.
[7] OB Kits with clamps / scissors (no scalpels.)
[8] Los Angeles County Department of Communications, Spec. No. 2029/2031/2033.
[9] Utilized with infusions through IO access.
[10] As supply allows.
[11] Device volume, not delivered volume.
[12] All required if using Albuterol / Metered Dose Inhaler.

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

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**
Ref. No. 710, **Basic Life Support Ambulance Equipment**
Ref. No. 712, **Nurse Staffed Specialty Care Transport (CCT) Unit Inventory**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(PARAMEDIC, MICN)

SUBJECT: **ASSESSMENT UNIT INVENTORY** REFERENCE NO. 704

PURPOSE: To provide a standardized minimum inventory on all Assessment Units.

PRINCIPLE:

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

2. The minimum required amounts may be augmented according to anticipated needs in consultation with the Provider Agency Medical Director and the Medical Director of the Emergency Medical Services Agency

POLICY:

I. Assessment Units shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency.

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

MEDICATIONS*			
Adenosine	**6mgs**	Glucagon	**1mg**
Albuterol (pre-mixed with NS)	**5mgs**	Ketorolac 15mgs/mL **OR** Ketorolac 30mgs/2mL	**4**
			2
Aspirin (chewable 81 mg)	**648mgs**	Naloxone	**2mgs**
Atropine sulfate (1mg/10ml)	**1mg**	Normal saline (for injection)	**2 vials**
Dextrose 10% / Water 250mL	**1**	Nitroglycerin (SL) spray, tablets, or single dose powder packets	**1 pump/ bottle/ or 36 packets**
Dextrose - glucose paste/gel	**90gms**	Olanzapine 10mg ODT	**20mgs**
Epinephrine (1mg/mL)	**1mg**	Ondansetron 4mg ODT	**16mgs**
Epinephrine (0.1mg/mL)	**2mgs**	Ondansetron 4mg IV	**16mgs**
		Sodium bicarbonate	**50mls**
INTRAVENOUS FLUIDS			
Normal saline 250 or 500 mL	**2 bags**		
SUPPLIES*			
Airways – Oropharyngeal:		Bag-Mask Ventilation (BMV) – Masks:	
Large	**1**	Large	**1**
Medium	**1**	Medium	**1**
Small Adult/Child	**1**	Small Adult/Child	**1**
Infant	**1**	Infant	**1**
Neonate	**1**	Neonate	**1**

APPROVED: Director, EMS Agency

Medical Director, EMS Agency

SUBJECT: **ASSESSMENT UNIT INVENTORY** REFERENCE NO. 704

SUPPLIES*(continued)			
Adhesive dressing (Band-Aids®)	**5**	Tube Introducer	**2**
Alcohol prep pads	**5**	Magill Forceps:	
Bag-Mask-Ventilation (BMV) device w/O_2 inlet & reservoir:		Adult	**1**
Bag Volume 200-450 mL[6]	**1**	Pediatric	**1**
Bag Volume 400-700 mL[6]	**1**	Mucosal Atomization Device (MAD)	**2**
Bag Volume 650-1000 mL[6]	**1**	Needle, filtered-5micron [1]	**1**
Burn pack or burn sheets	**1**	Normal saline for irrigation	**1 bottle**
Cardiac Monitor-Defibrillator w/ oscilloscope	**1**	OB pack and bulb syringe [7]	**1**
Defibrillator pads or paste (including pediatric)	**2**	Oxygen cannula:	
ECG Electrodes:		Adult	**1**
Adult	**6**	Pediatric	**1**
Pediatric	**6**	Oxygen Masks (non-rebreather):	
Cervical collars (rigid):		Adult	**1**
Adult (adjustable)	**1**	Pediatric	**1**
Pediatric	**1**	Infant	**1**
Color Code Drug Doses, Ref. No. 1309	**1**	Oxygen Masks (simple):	
Contaminated needle container	**1**	Adult	**1**
Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5” 14G	**2**	Pediatric	**1**
		Infant	**1**
Endotracheal tubes with stylets Sizes: 6.5-7.5	**1 each**	Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	**1**
End Tidal CO_2 Detector or Aspirator (Adult)	**1**	Personal Protective Equipment	
Filter, viral HEPA [5]	**2**	Mask	**1 per provider**
Flashlight or Penlight	**1**	Gown	**1 per provider**
Gauze sponges 4x4 (sterile)	**4**	Eye protection	**1 per provider**
Gauze bandages	**2**	Radio transmitter receiver (Hand-Held) [4]	**1**
Gloves, unsterile	**6 pairs**	Saline locks	**2**
Glucometer with strips	**1**	Scissors	**1**
Lancets (automatic retractable)	**2**	Sphygmomanometer:	
Hand-held nebulizer pack	**1**	Thigh	**1**
Intravenous catheters: Sizes 16G - 22G	**2 each**	Adult	**1**
Intravenous Tubing	**2**	Pediatric	**1**
Laryngoscope Blades:		Infant	**1**
Adult, curved and straight	**1 each**	Stethoscope	**1**
Pediatric, Miller #1 & #2	**1 each**	Tape (various types, must include cloth)	**1**
Laryngoscope Handle: Adult (compatible w/ pediatric blades)	**1**		

SUBJECT: **ASSESSMENT UNIT INVENTORY** REFERENCE NO. 704

SUPPLIES*(continued)			
i-gel (Disposable Supraglottic Airway):		Suction catheters:	
Neonate (size 1)	**1**	Size 8Fr.	**1**
Infant (size 1.5)	**1**	Size 10Fr.	**2**
Small pediatric (size 2)	**1**	Size 12Fr.	**4**
Large pediatric (size 2.5)	**1**	Tonsillar Tip	**1**
Small adult (size 3)	**1**	Syringes sizes: 1ml – 60ml w/ luer adapter	**assorted**
Medium adult (size 4)	**1**	Thermometer (Oral or axillary)	**1**
Large adult+ (size 5)	**1**	Tourniquets (IV)	**2**
Suction Unit (portable) w/adapter	**1**	Tourniquets (commercial for bleeding control)	**2**
		Vaseline gauze	**2**

APPROVED OPTIONAL EQUIPMENT	
Albuterol MDI (Metered Dose Inhaler) [8]	MDI Mask [8]
Continuous Positive Airway Pressure (CPAP) Device [2]	MDI Spacer [8]
Hemostatic Dressings	Splints: Long & Short
Intraosseous Device: [2] Adult & Pediatric	Splints - traction: Long & Short
Lidocaine 2% [3]	

[1] Optional, if not utilizing glass ampules.
[2] Requires EMS Agency approval, which includes an approved training program and QI method prior to implementation.
[3] Utilized with infusions through IO access.
[4] Los Angeles County Department of Communications, Spec. No. 2029/2031/2033.
[5] As supply allows.
[6] Device volume, not delivered volume.
[7] OB kits w/ clamps / scissors (no scalpels).
[8] All required if using Albuterol / Metered Dose Inhaler.

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

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 416, **Assessment Units**
Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

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

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

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

POLICY:

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

II. ALS EMS aircraft shall have sufficient space to carry the following minimum medical equipment and supplies. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency.

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

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

MEDICATIONS			
Adenosine	**18mgs**	Glucagon	**1mg**
Albuterol (pre-mixed w/ NS)	**20mgs**	Ketorolac 15mg/mL	**4**
Amiodarone	**600mgs**	**OR** Ketorolac 30mg/2mLs	**2**
Aspirin (chewable 81mg)	**648mgs**	Lidocaine 2% [4]	**200mg**
Atropine sulfate (1mg/10mL)	**3mgs**	Midazolam [5]	**15mgs**
Calcium chloride	**2gms**	Morphine sulfate [6]	**20mgs**
Dextrose 10% / Water 250mL	**2 bags**	Naloxone	**2mgs**
Dextrose - glucose paste/gel	**45gms**	Normal saline (for injection)	**3 vials**
Diphenhydramine	**100mgs**	Nitroglycerin (SL) spray, tablets, or single dose powder packets	**1 pump/ bottle/ or 36 packets**
Epinephrine (1mg/mL)	**7mgs**	Olanzapine 10mg ODT	**20mgs**
Epinephrine (0.1mg/mL)	**6mgs**	Ondansetron 4mg ODT	**16mgs**
Fentanyl [2, 3]	**500mcgs**	Ondansetron 4mg IV	**16mgs**
		Sodium bicarbonate	**100mLs**
INTRAVENOUS FLUIDS			
Normal saline 1000 mL	**6 bags**	Normal saline 250 or 500 mL	**2 bags**

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Laucher-Hillmon
Medical Director, EMS Agency

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

SUPPLIES			
Adhesive dressing (Band-Aids®)	**1 box**	Color Code Drug Doses, Ref. No. 1309	**1**
Airways – Nasopharyngeal:		Commercial Catheter-Over-Needle Chest Decompression Needles 3.0-3.5" 14G	**2**
Large (34-36)	**1**	Contaminated needle container	**1**
Medium (26-28)	**1**	Continuous Positive Airway Pressure (CPAP) device: [3, 7]	
Small (20-22)	**1**	Small	**1**
Airways – Oropharyngeal:		Medium	**1**
Large	**1**	Large	**1**
Medium	**1**	Endotracheal tubes w/ stylets Sizes 6.0-8.0	**2 each**
Small Adult/Child	**1**	Tube introducer	**2**
Infant	**1**	End Tidal CO2 Detector or Aspirator (Adult)	**1**
Neonate	**1**	Extrication device or short board	**1**
Alcohol prep pads	**20**	Filter, viral HEPA [11]	**2**
Backboard	**1**	Flashlight or Penlight	**1**
Bag-Mask-Ventilation (BMV) device w/ O_2 inlet & reservoir:		Gauze bandages	**6**
Bag Volume 200-450 mL [12]	**1**	Gauze sponges 4x4 (sterile)	**12**
Bag Volume 400-700 mL [12]	**1**	Gloves, sterile	**2 pair**
Bag Volume 650-1000 mL [12]	**1**	Gloves, unsterile	**1 box**
Bag-Mask-Ventilation (BMV) Masks:		Glucometer w/ strips	**1**
Large	**1**	Lancets (automatic retractable)	**5**
Medium	**1**	Hand-held nebulizer pack	**2**
Small Adult/Child	**1**	Intraosseous device: [3, 7]	
Toddler	**1**	Adult	**1**
Infant	**1**	Pediatric	**1**
Neonate	**1**	Intravenous catheters: Sizes 16G - 22G	**4 each**
Burn pack or burn sheet	**1**	Intravenous tubing - Macrodrip	**5**
Cervical collars (rigid):		i-gel (Disposable Supraglottic Airway):	
Adult (adjustable)	**1**	Neonate (size 1)	**1**
Pediatric	**1**	Infant (size 1.5)	**1**
Cardiac Monitor-Defibrillator w/ oscilloscope	**1**	Small pediatric (size 2)	**1**
Defibrillator pads or paste (including pediatric)	**2 each**	Large pediatric (size 2.5)	**1**
ECG electrodes:		Small adult (size 3)	**1**
Adult (multi-use)	**8-10**	Medium Adult (size 4)	**1**
Pediatric (multi-use)	**8-10**	Large adult+ (size 5)	**1**
ECG, 12-lead & transmission capable	**1**	Laryngoscope blades:	
Noninvasive blood pressure monitor	**1**	Adult: curved & straight	**1 each**
Pulse oximeter	**1**	Pediatric: Miller #1 & #2	**1 each**
Transcutaneous pacing	**1**	Laryngoscope handle:	
Waveform capnography	**1**	Adult (compatible w/ pediatric blades)	**1**

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

SUPPLIES (continued)			
Magill forceps:		Scissors	**1**
Adult	**1**	Syringes 1mL – 60mL w/ luer adapter	**Assorted**
Pediatric	**1**	Sphygmomanometer:	
Mucosal Atomization Device (MAD)	**2**	Thigh	**1**
Needle, filtered-5micron [8]	**2**	Adult	**1**
Normal saline for irrigation	**1 bottle**	Pediatric	**1**
OB pack & bulb syringe [9]	**2**	Infant	**1**
Oxygen cannulas:		Splints:	
Adult	**2**	Long	**2**
Pediatric	**2**	Short	**2**
Oxygen masks – (non-rebreather):		Splints – traction:	
Adult	**2**	Adult	**1**
Pediatric	**2**	Pediatric	**1**
Infant	**2**	Stethoscope	**1**
Oxygen masks – (simple):		Suction unit (portable) w/adapter	**1**
Adult	**2**	Suction catheters:	
Pediatric	**1**	Size 8Fr.	**1**
Infant	**1**	Size 10Fr.	**2**
Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	**1**	Size 12Fr.	**4**
		Tonsillar tip	**1**
Personal Protective Equipment:		Tape (various types, must include cloth)	**1**
Mask	**1 per provider**	Thermometer (Oral or axillary)	**1**
Gown	**1 per provider**	Tourniquets (IV)	**2**
Eye protection	**1 per provider**	Tourniquets (commercial for bleeding control)	**2**
Radio transmitter receiver (Hand-Held) [10]	**1**	Vaseline gauze	**2**
Saline locks	**4**		

APPROVED OPTIONAL EQUIPMENT	
Albuterol / Metered Dose Inhaler (MDI) [13]	Metered-Dose-Inhaler (MDI) Mask [13]
Dextrose 25%	Metered-Dose-Inhaler (MDI) Spacer [13]
Hemostatic dressings	Resuscitator w/ positive pressure demand valve (flow rate not to exceed 40L/min)

[1] Disaster Cache minimum contents include: (9) DuoDote kits or equivalent;
And when available: (6) AtroPen Auto Injector 1.0mg
(6) AtroPen Auto Injector 0.5mg – Pediatric Use
[2] Fentanyl carried on ALS Unit is not to exceed 1500mcgs.
[3] Requires EMS Agency approval, which includes an approved training program & QI method prior to implementation.
[4] Utilized w/ infusions through IO access.
[5] Midazolam carried on ALS Unit is not to exceed 40mgs.
[6] Morphine sulfate carried on ALS Unit is not to exceed 60mgs.
[7] Mandatory for providers that respond to medical emergencies via the 9-1-1 system.
[8] Optional, if not utilizing glass ampules.
[9] OB kits w/ clamps / scissors (no scalpels).

[10] Los Angeles County Department of Communications, Spec. No. 2029/2031/2033.
[11] As supply allows.
[12] Device volume, not delivered volume.
[13] All required if using Albuterol / Metered Dose Inhaler (MDI)

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

CROSS REFERENCES:

Prehospital Care Manual:

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

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC)

SUBJECT: **BASIC LIFE SUPPORT AMBULANCE EQUIPMENT** REFERENCE NO. 710

PURPOSE: To provide minimum equipment standards for private basic life support (BLS) ambulance providers and to ensure a system wide standardized inventory of supplies and equipment to promote safety, readiness, and the ability to meet the requirements of an "all hazards" disaster response in the event of a declared emergency.

AUTHORITY: California Administrative Code, Title 13, Section 1103
California Highway Patrol (CHP) Handbook 82.4, Chapter 4.5: Recommended Ambulance Equipment
California Vehicle Code Section 2418.5
Health and Safety Code 1797.220 and 1798
Senate Bill 409

DEFINITIONS:

Personal Protective Equipment: For the purpose of this policy, personal protective equipment (PPE) is garments/equipment designed to protect/minimize hazardous exposure to prehospital care responders.

PRINCIPLES:

1. Ambulances shall be maintained in good mechanical repair and sanitary condition.

2. Any equipment carried for use in providing emergency medical care must be maintained in clean condition and good working order. Medical supplies and solutions shall be replaced prior to the expiration date.

3. All reusable medical supplies and equipment should be maintained in clean, ready-to-use condition and be disinfected or sterilized per manufacturer's recommendations.

4. Whenever a patient with a known or suspected communicable disease has been transported, the patient compartment and all interior surfaces, including fixed equipment, should be thoroughly cleansed with soap, water, and disinfectant. Supplies such as pillows, blankets, and linens should be disposable or autoclaved. * (* indicates language specific to the CHP Handbook)

5. All ambulance providers must be integrated into the disaster medical response system in order to participate in state and local disaster response or a declared emergency.

6. Ambulance personnel should not function within an operational area requiring PPE beyond their level of provision and training.

7. In any workplace where N95, or equivalent masks are necessary to protect the health of employees or whenever such masks are required by the employer, the employer shall have a written policy and provide training in the proper use and operation of the device.

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill
Medical Director, EMS Agency

NOTE: Ambulances dedicated for infant transportation or when staffed and equipped for use in conjunction with newborn intensive care nursery services as specified in Title 22, CAC, Sections 70481 – 70487, need not concurrently carry items of emergency care equipment or supplies as specified herein that would interfere with the specialized care and transportation of an infant in an incubator or isolette.

POLICY:

I. Required Vehicle Safety Equipment:

A. A siren and steady burning red warning lamp that meet requirements established by the CHP Handbook, Section 818.

B. Seat belts or equivalent restraints for every sitting position. A child or infant not secured to a gurney should be secured in an appropriate child/infant restraint device.

C. A fire extinguisher of the dry chemical or the carbon dioxide type, with a minimum 4-B:C rating, maintained as prescribed by the State Fire Marshal in Title 19, CAC, Section 597. The use of vaporizing liquid extinguishers is prohibited.

D. A portable, battery-operated light.

E. A spare wheel with inflated tire of the appropriate load rating.

F. A jack and tools for wheel changes.

G. Maps or electronic mapping device covering the areas in which the ambulance provides service.

H. Patient compartment door latches operable from inside and outside the vehicle on all emergency ambulances manufactured and first registered after January 1, 1980.

II. Personnel PPE Training

Prior to use, all personnel who may be required to utilize PPE shall receive training in accordance with OSHA requirements (Ref. 26 CFR 1910.132 [f]. At minimum, training shall consist of:

A. Identification of when and what type of PPE is necessary; how to properly don, doff, adjust, and wear PPE; the limitations of the PPE; and the proper care, maintenance, useful life, and disposal of the PPE (Ref. 29 CFR 1910.132 [f] [1] [1-5]).

B. Demonstration of the ability to use PPE properly before being allowed to perform work requiring the use of PPE (Ref. 29 CFR 1910.132 [f] [2].

C. Verification that each employee has received and understands the required training through a written certification that contains the course title, date of the training, and the name of the employee trained.

D. Proper fit testing for any respiratory protection in accordance with OSHA requirements (Ref. 29 CFR 1910.134).

III. Minimum Levels of Recommended Emergency Care Equipment and Supplies

MINIMUM INVENTORY	QUANTITIES
Adhesive tape, rolls of 1 in., 2 in. and, 3 in.	2 each
Ankle and wrist restraints. • If soft ties are used, they should be at least three inches wide (before tying) to maintain a two inch width while in use.	1 set
Bandages, 4 in. sterile compresses or equivalent	12
Bag-valve device with 0_2 inlet and reservoir • Bag Volume 400-700 mL [1] • Bag Volume 650-1000 mL [1]	1 each
Bag-valve mask • Large • Medium • Small adult/child • Toddler • Infant • Neonate	1 each
Bandages, 2 in. or 3 in. soft, rolled stretch (Kerlix or Kling type)	6
Bandages, 3 in. x 3 in. or 4 in. x 4 in. sterile gauze pads	4
Bandages, universal dressings (trauma dressings), 10 in. x 30 in or larger	2
Bandage scissors	1
Bedpan/fracture pan	1
Blood pressure manometer, cuff and stethoscope: • Thigh • Adult • Child • Infant	1 each
*Cervical Collars, rigid: • Adult • Child • Infant *2 pediatric adjustable meets infant requirement	2 each
Dextrose – glucose paste/gel	15gms
Emesis basin, disposable bags or covered containers	1
Hemostatic dressings–EMS Authority approved dressings only - **optional**	2
Immobilizer, Head: • Disposable or Reusable	2

MINIMUM INVENTORY	QUANTITIES
Obstetrical supplies, sterile, including (no scalpel): • Gloves • Umbilical cord clamps • Dressings, towels • Scissors • Bulb syringe • Clear plastic bag	1 kit or supplies as indicated
Oropharyngeal airways: • Two (2) adult • Two (2) children • One (1) infant • One (1) newborn	6
Oxygen cannulas • Adult • Child	1each
Oxygen masks, non-rebreather • Adult • Child • Infant	1 each
Oxygen masks, simple • Adult • Child • Infant	1 each
Oxygen, portable • "D" or "E" FULL cylinder with one (1) oxygen flow control regulator for use between both cylinders	1
Oxygen, vehicle (house) • "M" or "H" cylinder with a minimum of 1000 psi and one (1) oxygen flow control regulator	1
Personal Protective Equipment (PPE) (Personal Body Substance Isolation Equipment) • mask • gown • eye protection	2 each
Saline, sterile isotonic, in clearly labeled plastic liter (quart) containers	2
Spine boards, rigid, approximately 14 inches in width, and approximately 72 inches in length with straps for immobilization of suspected spinal or back injuries	2
Splints, short, medium, and long • Cardboard splints (recommended for general use) • Inflatable air splints (recommended to immobilize lower arms and lower legs) **(Optional)**	4 each
Splints, traction	1

MINIMUM INVENTORY	QUANTITIES
Stretchers: • Stretchers with wheels and the following: o mattresses should be covered with impervious plastic material or the equivalent o have the capability to elevate both the head and foot o straps to secure the patient to the stretcher, including shoulders, waist, and legs o a means of securing the stretcher in the vehicle o adjustable to four different levels	1
• Collapsible stretcher and the following: o straps to secure the patient to the stretcher and a means of securing the stretcher in the vehicle	1
• Device to secure a child or infant to the stretcher	1
Suction equipment, portable, capable of at least: • a negative pressure equivalent to 300mm of mercury • 30 liter per minute air flow rate for 30 minutes of operation.	1
Suction equipment, vehicle (house), capable of at least: • a negative pressure equivalent to 300mm of mercury • 30 liter per minute air flow rate for 30 minutes of operation	1
Suction Tubing: • Non-collapsible, plastic, semi-rigid, whistle-tipped, finger controlled type is preferred. * • Flexible catheters for tracheostomy suctioning (8Fr.-12Fr.)	1 each
Thermometer (Oral or axillary)	1
Tongue depressors	6
Tourniquets (commercial, for control of bleeding)	2
Water, sterile, (quarts)	2
Urinal	1
Chemotherapy spill kit **(Optional)**	1

PERSONAL PROTECTION EQUIPMENT (PPE)*	QUANTITIES
Escape hood **(Optional)**	2
Gloves, work (multiple use, leather)	2 pairs
Hearing protection	2 sets
Jacket, EMS, with reflective stripes	2
Rescue helmet	2
Respiratory protection mask (N95) and general purpose mask	2 each
Safety vest meeting ANSI standards or equivalent	2

* OSHA Safety & Health Information Bulletin: "CBRN Escape Respirator", provides guidance on use, selection, and training. The minimum PPE is Level D, if applicable.

AMBULANCE STRIKE TEAM ADDITIONAL SUPPLIES*	QUANTITIES
Ballistic vest, protective **(Optional – risk dependent**)**	2
Field Operations Guide (FOG)	1
Footwear covers, single use	2 pairs
Duodote (atropine 2.1mg and pralidoxime chloride 600mg) or equivalent (**Optional)**	1/person
MRE (meal ready to eat) (3 meals/day/member for 3 days)	18

*Maintained at deployment location, not required in vehicle unless deployed.
**Mandatory for deployment to areas of civil unrest.
[1] **Device volume, not delivered volume.**

CROSS REFERENCES:

OSHA Regulations:
Ref. No. 29 CFR 1910.132
Ref. No. 29 CFR 1910.134
OSHA Safety & Health Information Bulletin: "CBRN Escape Respirator"

Emergency Medical Services Authority (EMSA):
EMSA Guidelines #216

California Highway Patrol:
Ref. 299, Ambulance Inventory

Prehospital Care Manual:
Ref. No. 703, **ALS Unit Inventory**
Ref. No. 704, **Assessment Unit Inventory**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **NURSE STAFFED SPECIALTY CARE TRANSPORT UNIT INVENTORY** REFERENCE NO. 712

PURPOSE: To provide a standardized minimum inventory on all Nurse Staffed Specialty Care Transport (SCT) Units.

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

POLICY:

I. Nurse staffed SCT vehicles shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied in accordance with Ref. No. 710, Basic Life Support Ambulance Equipment.

II. Nurse staffed vehicles performing advanced life support (ALS) level transports do not require the addition of the ALS inventory; however, if nurses are utilized in lieu of respiratory care practitioners (RCPs) for the transport of ventilator patients, all medications and equipment on Reference No. 713, Respiratory Care Practitioner (RCP) SCT Unit Inventory and not included herein, must be added to the SCT unit.

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

MEDICATIONS			
Adenosine	**24mgs**	Epinephrine (0.1mg/mL)	**5mgs**
Albuterol (pre-mixed w/ NS)	**20mgs**	*Fentanyl [1]	**400mcgs**
Amiodarone	**450mgs**	Ketorolac 15 mgs/mL **OR** Ketorolac 30 mgs/2mLs	**4**
Aspirin (chewable 81mg)	**648mgs**		**2**
Atropine sulfate (1mg/10mL)	**2mgs**	Levophed [6]	**4mgs**
Calcium chloride	**1gm**	Lidocaine 2%	**200mgs**
Dextrose 10% / Water 250mL	**3 bags**	Midazolam [2]	**20mgs**
Dextrose - glucose paste/gel	**45gms**	*Morphine sulfate [3]	**12mgs**
Diphenhydramine	**100mgs**	Naloxone	**2mgs**
Epinephrine (1mg/mL)	**1mgs**	Nitroglycerin (SL) spray, tablets, or single dose powder packets	**1 pump/ bottle/ or 36 packets**

INTRAVENOUS FLUIDS			
Normal saline 1000 mL	**2 bags**	Normal saline 250 mL	**2 bags**

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

SUBJECT: **NURSE STAFFED SPECIALTY CARE TRANSPORT UNIT INVENTORY** REFERENCE NO. 712

SUPPLIES			
Adhesive dressing (Band-Aids®)	**1 box**	Contaminated sharps container	**1**
Airways – Nasopharyngeal:		Filter, viral HEPA [8]	**2**
Large (34-36)	**1**	Filter needles [5]	**2**
Medium (26-28)	**1**	Gauze Bandages	**6**
Small (20-22)	**1**	Gauze sponges 4x4 (sterile)	**4**
Airways – Oropharyngeal:		Gloves, sterile	**2 pair**
Large	**1**	Gloves, unsterile	**1 box**
Medium	**1**	Glucometer w/strips	**1**
Small Adult/Child	**1**	Lancets (retractable)	**5**
Infant	**1**	Hand-held Nebulizer pack	**2**
Neonate	**1**	Hemostats, padded	**1**
Alcohol prep pads	**1 box**	Infusion pumps **OR**	**3**
Backboards	**1**	Infusion pump w/ 3 chamber drip capability	**1**
Bag-Mask-Ventilation (BMV) device w/O_2 inlet & reservoir:		Infusion pump tubing:	
Bag Volume 200-450 mL[9]	**1**	Full sets	**2**
Bag Volume 400-700 mL[9]	**1**	Half sets	**4**
Bag Volume 650-1000 mL[9]	**1**	Intravenous catheters: Sizes: 14G-22G	**5 each**
Bag-Mask-Ventilation (BMV) Masks:		Intravenous tubing:	
Large	**1**	Macrodrip	**2**
Medium	**1**	Microdrip	**2**
Small Adult/Child	**1**	Normal saline for irrigation	**1 bottle**
Toddler	**1**	OB pack & bulb syringe [4]	**1**
Infant	**1**	Oxygen cannulas:	
Neonate	**1**	Adult	**3**
Cardiac Monitor-Defibrillator w/ Oscilloscope	**1**	Pediatric	**3**
Defibrillator pads or paste (including pediatric)	**2 each**	Oxygen masks (non-rebreather):	
ECG Electrodes: Adult & Pediatric	**6 each**	Adult	**3**
ECG, 12-lead capable	**1**	Pediatric	**3**
Pulse Oximeter	**1**	Infant	**3**
Pulse oximeter probes: Adult & Pediatric	**2 each**	Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	**1**
Transcutaneous (external) pacing	**1**		
End Tidal CO2 Detector: Adult & Pediatric	**1 each**	Power source [back-up]/Adjunct power source (invertor batteries, etc.). Second required if transporting Intra-Aortic Balloon Pump (IABP) patients.	**1**
Cellular phone (personal or company supplied)	**1**	Color Code Drug Doses, Ref. No. 1309	**1**

SUBJECT: **NURSE STAFFED SPECIALTY CARE TRANSPORT UNIT INVENTORY** REFERENCE NO. 712

SUPPLIES (continued)			
Saline locks	**4**		
Scissors	**1**	Suction unit (portable) w/ adapter (battery operated)	**1**
Sphygmomanometer:		Suction Instruments:	
Thigh	**1**	Catheters sizes: 8Fr. - 12 Fr.	**1 each**
Adult	**1**	Tonsillar Tip	**1**
Pediatric	**1**	Syringes sizes: 1mL – 10mL w/ luer adapter	**assorted**
Infant	**1**	Tape (various types, including cloth)	**1**
Stethoscope	**1**	Thermometer (Oral or axillary)	**1**

APPROVED OPTIONAL MEDICATIONS & SUPPLIES			
MEDICATIONS		**SUPPLIES**	
Albuterol MDI (Metered Dose Inhaler) [10]	**2**	High velocity oxygen delivery system (e.g. Airvo) range 2-60 L/min and associated nasal cannulas:	**1**
Dexamethasone	**20mgs**		
Dopamine premix or vials	**400mgs**	Adult	**2**
Diltiazem	**25mgs**	Pediatric	**2**
Dextrose 5% / Water 250mL [6]	**1 bag**	Intraosseous device: [7]	
Flumazenil	**1mg**	Adult	**1**
Furosemide	**100mgs**	Pediatric	**1**
Hydralazine	**20mgs**	Impedance threshold device	**1**
Levalbuterol HCL	**7.5mgs**	Metered-Dose-Inhaler (MDI) Mask [10]	**2**
Lidocaine (1gm/250mL)	**1 bag**	Metered-Dose-Inhaler (MDI) Spacer [10]	**2**
Lopressor	**20mgs**	Mucosal Atomization Device (MAD)	**2**
Lorazepam	**4mgs**	Respiratory ventilator	**1**
Magnesium Sulfate (pre-mix or vial)	**2gms**		
Olanzapine 10mg ODT	**20mgs**		
Ondansetron (orally disintegrating tablets)	**12mgs**		
Ondansetron (intravenous) 4mgs/2mLs	**12mgs**		
Sodium Bicarbonate	**50mls**		
Vasopressin	**20 units**		

[1] Fentanyl carried on SCT Unit is not to exceed 1500mcgs.
[2] Midazolam carried on SCT Unit is not to exceed 40mgs.
[3] Morphine sulfate carried on SCT Unit is not to exceed 60mgs.
[4] OB kits w/ clamps / scissors (no scalpels).
[5] Optional, if not utilizing glass ampules.
[6] Levophed 4mg/ to be administered as an infusion only.
[7] Requires EMS Agency approval, which includes an approved training program and QI method prior to implementation.
[8] As supply allows.

[9] Device volume, not delivered volume.

[10] All required if using Albuterol / Metered Dose Inhaler (MDI)

*** May stock only one narcotic, either fentanyl or morphine sulfate-refer to Ref. No. 702.**

This policy is intended as an RN SCT Unit inventory only.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 414, **Specialty Care Transport Provider**
Ref. No. 702**,** **Controlled Drugs Carried on ALS Units**
Ref. No. 710, **Basic Life Support Ambulance Equipment**
Ref. No. 713, **Respiratory Care Practitioner Staffed Specialty Care Transport Unit Inventory**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **RESPIRATORY CARE PRACTITIONER STAFFED SPECIALTY CARE TRANSPORT UNIT INVENTORY** REFERENCE NO. 713

PURPOSE: To provide a standardized minimum inventory on all Respiratory Care Practitioner (RCP) Specialty Care Transport (SCT) Units.

PRINCIPLE:

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

POLICY:

I. RCP staffed SCT vehicles shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied according to Ref. No. 710, Basic Life Support Ambulance Equipment.

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

MEDICATIONS			
Albuterol (pre-mixed w/ NS)	**30mgs**	Atrovent	**2mgs**

SUPPLIES			
Airways – Nasopharyngeal:		Bag-Mask-Ventilation (BMV) device w/ O_2 inlet &reservoir:	
Large (34-36)	**1**	Bag Volume 200-450 mL [3]	**1**
Medium (26-28)	**1**	Bag Volume 400-700 mL [3]	**1**
Small (20-22)	**1**	Bag Volume 650-1000 mL [3]	**1**
Airways – Oropharyngeal:		Bag-Mask-Ventilation (BMV) Masks:	
Large	**1**	Large	**1**
Medium	**1**	Medium	**1**
Small Adult/Child	**1**	Small Adult/Child	**1**
Infant	**1**	Toddler	**1**
Neonate	**1**	Infant	**1**
Airway guard (bite blocker)	**2**	Neonate	**1**

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

SUBJECT: **RESPIRATORY CARE PRACTITIONER STAFFED SPECIALTY CARE TRANSPORT UNIT INVENTORY** REFERENCE NO. 713

SUPPLIES (continued)

Cell phone (personal or company)	**1**
Color Code Drug Doses, Ref. No. 1309	**1**
Coupler/Quick Connect (oxygen connection)	**2**
End tidal CO_2 detector:	
Adult	**2**
Pediatric	**2**
$ETCO_2$ filter line	**6**
Filter, viral HEPA [1]	**2**
Gloves, sterile	**2**
Gloves, non-sterile	**1 box**
Nebulizer kit (including hand-held and mask)	**2 each**
Heat / Moisture Exchange (HME) Ventilator Filters:	
Adult	**4**
Pediatric	**2**

Disposable Supraglottic Airway Device (and/or) [2]		
i-gel	King LTS-D	
Neonate (size 1)	Pediatrics (size 0)	**1**
Infant (size 1.5)	Pediatrics (size 1)	**1**
Small Pediatrics (size 2)	Pediatrics (size 2)	**1**
Large Pediatrics (size 2.5)	Pediatrics (size 2.5)	**1**
Small Adult (size 3)	Adult (size 3)	**1**
Med Adult (size 4)	Adult (size 4)	**1**
Large Adult (size 5)	Adult (size 5)	**1**

Laryngoscope handle:	
Adult (compatible w/ pediatric blades)	**1**
Laryngoscope blades:	
Adult, Curved & Straight	**1 each**
Pediatric, Miller 0, 1, & Miller 2	**1 each**
Magill forceps:	
Adult	**1**
Pediatric	**1**
Normal saline pillows (ampoules/inhalant)	**10**
Penlight	**1**
Oxygen Cannulas:	
Adult	**3**
Pediatric	**3**

Oxygen masks (non-rebreather):	
Adult	**3**
Pediatric	**3**
Infant	3
Oxygen:	
Hose	**1**
Key	**2**
Regulator	**2**
Tree	**2**
Standardized Pediatric Length-Based Resuscitation Tape, approved by the EMS Agency (e.g., Broselow 2011A or newer)	**1**
PEEP valve:	
Adult	**1**
Pediatric	**1**
Personal Protective Equipment:	
Mask	**1 per provider**
Gown	**1 per provider**
Eye Protection	**1 per provider**
Portable suction (battery operated)	**1**
Pulse oximeter	**1**
Pulse oximeter probes:	
Adult	**2**
Pediatric	**2**
Sphygmomanometer:	
Thigh	**1**
Adult	**1**
Pediatric	**1**
Infant	**1**
Scissors	**1**
Stethoscope	**1**
Syringes 10mL	**2**

SUBJECT: **RESPIRATORY CARE PRACTITIONER STAFFED SPECIALTY CARE TRANSPORT UNIT INVENTORY** REFERENCE NO. 713

SUPPLIES (continued)			
Suction Catheters:		Ventilator filters	**4**
Size 8 Fr.	**1**	Ventilator (non-pneumatic or pneumatic)	**1**
Size 10 Fr.	**1**	If utilizing ventilator to fulfill non-invasive CPAP requirement, must have 1 set of the following necessary equipment:	
Size 12 Fr.	**2**		
Size 14 Fr.	**1**	Circuit	**1**
Tape (various types, must include cloth)	**1**	Mask	
Thermometer (Oral or axillary)	**1**	Small	**1**
Ventilator circuits (disposable):		Medium	**1**
Adult	**4**	Large	**1**
Pediatric	**2**	Waveform capnography	**1**
APPROVED OPTIONAL EQUIPMENT			
Albuterol Meter Dose Inhaler (MDI)	**2**	Levalbuterol	**7.5mgs**
Endotracheal tubes w/ stylets Sizes 2.0-8.0	**2 each**	Metered-Dose-Inhaler (MDI) Mask	**2**
		Metered-Dose-Inhaler (MDI) Spacer	**2**
High velocity oxygen delivery system (e.g. Airvo) range 2-60 L/min and associated nasal cannulas:	**1**	Tracheostomy mask:	
		Adult	**2**
Adult	**2**	Pediatric	**2**
Pediatric	**2**	Venturi mask	**1**
Laryngeal mask airway (sizes 0-6)[2]	**1 each**		

This policy is intended as a RCP Inventory only.
[1] As supply allows
[2] May maintain inventory and utilize i-gel, King LTS-D, and/or laryngeal mask airway
[3] Device volume, not delivered volume.
* Requires EMS Agency approved training and quality improvement program.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 414, **Specialty Care Transport Provider**
Ref. No. 710, **Basic Life Support Ambulance Equipment**
Ref. No. 712, **Nurse Staffed Specialty Care Transport Unit Inventory**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **FIRELINE EMERGENCY TECHNICIAN-PARAMEDIC (FEMP) INVENTORY** (PARAMEDIC) REFERENCE NO. 719

PURPOSE: To provide a standardized minimum inventory on all Fireline Emergency Technician Paramedic (FEMP) Units.

PRINCIPLE:

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

POLICY:

I. FEMP units shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied according to Ref. No. 710, Basic Life Support Ambulance Equipment.

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

FEMP ALS PACK INVENTORY			
ALS Airway Equipment			
ET Tubes (Cuffed), Sizes 6.0 – 8.0	**1 each**	Laryngoscope Handle:	**1**
Stylette: Adult	**1**	Miller/McIntosh blades- Adult	**1 each**
ETT holder	**1**	Magill Forceps:	
Tube Introducer	**1**	Adult	**1**
End Tidal CO2 detector or Aspirator	**1**	Needle thoracostomy kit: 3-3.5" / 14G	**1**
Hand Held Nebulizer	**2**	Suction Device, Manual or portable	**1**
i-gel (Disposable Supraglottic Airway):		Suction Catheters:	
Small adult (size 3)	**1**	Size 10Fr.	**2**
Medium adult (size 4)	**1**	Size 12Fr.	**4**
Large adult+ (size 5)	**1**	Water soluble lubricant	**5**

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill
Medical Director, EMS Agency

SUBJECT: **FIRELINE EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC (FEMP) INVENTORY** REFERENCE NO. 719

FEMP ALS PACK INVENTORY (continued)

IV and Medication Administration Supplies

Adhesive tape	**1**	Needles:	
Alcohol Preps	**6**	18G	**6**
IV Administration Set: Macro Drip	**2**	23G	**5**
IV Catheters:		Syringes:	
14G	**2**	Tuberculin	**2**
16G	**2**	5mL	**2**
20G	**2**	10mL	**2**
Saline 0.9% IV	**200ml**	Tourniquets	**2**

Miscellaneous

Antiseptic Hand Wipes	**10**	Infection Control Packs	**1**
BLS Pack	**1**	Locked Container System	**1**
Cellular Phone / Means of Communication	**1**	Numbered Controlled Substance Seals	**4**
Contaminated Needle Container	**1**	Patient Care Record	**12**
Controlled Substance Log Sheet	**1**	Red Bio-Hazard Bags	**2**
FEMP Pack Inventory Sheet	**1**	Tourniquets (Commercial, for bleeding control)	**2**

Biomedical Equipment

Glucometer	**1**	Monitor / Defibrillator **OR** Compact Semi-Automatic AED w/screen	**1**
Lancets (retractable)	**5**		**1**
EKG electrodes (disposable), Adult	**2 sets**	Monitor/AED electrode wires	**1 set**
Pulse oximeter (Optional)	**1**	Monitor/AED defibrillator patches, Adult	**2**

Medications

Adenosine	**18mg**	Ketorolac 15 mgs/mL **OR** Ketorolac 30 mgs/2mLs	**4**
Aspirin, chewable, 81mg	**1 bottle**		**2**
Albuterol Sulfate	**15mg**	Midazolam	**20mg**
Atropine Sulfate	**2mg**	Morphine Sulfate	**40mg**
Diphenhydramine	**200mg**	Naloxone	**4mg**
Epinephrine (1mg/mL)	**4mg**	Nitroglycerin spray or tablets	**1**
Epinephrine (0.1mg/mL)	**4mg**	Ondansetron IV	**16mg**
Fentanyl*	**600mcg**	Ondansetron 4mg ODT	**16mg**
Glucagon	**1mg**		

SUBJECT: **FIRELINE EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC (FEMP) INVENTORY** REFERENCE NO. 719

FEMP BLS PACK INVENTORY			
Supplies			
Airway, Nasopharyngeal:			
Medium Adult	**1**	Nasal Cannula:	
Large Adult	**1**	Adult	**1**
Airways, Oropharyngeal:		Oxygen "C" Cylinder or larger	**2**
Medium Adult	**1**	w/regulator	**1**
Large Adult	**1**	Oxygen Mask, Non-rebreather	**1**
Bag-Mask-Ventilation (BMV) device w/O_2 inlet and reservoir:		Patient Care Record	**12**
Bag Volume 650-1000 mL[1]	**1**	Pen (black or blue ink)	**1**
Bag-Mask Ventilation (BMV) Masks:		Pencil (wet environments)	**1**
Medium Adult	**2**	Penlight or Flashlight	**1**
Large Adult	**2**	Petroleum Dressing	**2**
Bandages:		Scissors	**1**
Kerlix/Kling 4.5, Sterile	**4**	Space blanket	**1**
4x4 Compress, Sterile	**6**	Sphygmomanometer:	
Triangular	**2**	Adult	**1**
Burn Sheet	**1**	Splint, Moldable	**1**
Dextrose, Oral	**1**	Stethoscope	**1**
Duct Tape	**1**	Tape, 1 Inch	**1**
Eye Wash	**1 bottle**	Thermometer (Oral or axillary)	**1**
Face-Mask (disposable), w/eye shield	**1**	Trauma Dressing 10x30	**4**
Gloves, sterile	**2 pair**	Writing Pad	**1**
Approved Optional Equipment			
Insect Sting Swabs		Moleskin	
Mask, Pocket w/O2		Pulse oximeter	
Hemostatic dressings–EMS Authority approved dressings only		Splinter kit	

[1] **Device volume, not delivered volume.**

*Requires EMS Agency approval. Provider agency may only stock fentanyl or morphine sulfate, not both controlled substances.

Additional items for re-stock should be maintained and secured in the vehicle or in the Medical Unit Trailer.

NOTE: Providers should stock maximum allowed quantities of medical supplies and medications, especially controlled substances, to avoid mid-incident restock. Incident medical units may not be capable of re-supplying controlled substances.

Controlled substances should be secured as per LA County Prehospital Care Policy Ref. No. 702 and the FEMP provider's standard operating procedures.

The FEMP should report to the incident with the full complement of EMS supplies ready to work. The incident will re-supply the FEMP to the best of its ability.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 702, **Controlled Drugs Carried on ALS Units**
Ref. No. 804, **Fireline Emergency Medical Technician- Paramedic (FEMP)**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/PARAMEDIC/MICN)

SUBJECT: **SUSPECTED CHILD ABUSE/NEGLECT REPORTING GUIDELINES**

REFERENCE NO. 822

PURPOSE: To provide guidelines and procedures for prehospital care personnel to report suspected child abuse.

AUTHORITY: California Penal Code, Chapter 916, Sections 11164-11174.3
County of Los Angeles Department of Children and Family Services

DEFINITIONS:

Agencies authorized to accept mandated reports: Any police department or sheriff's department, and the Department of Children and Family Services (DCFS) Child Protection Hotline (CPH). School district police and security departments are not authorized to accept reports.

Child: Any person less than eighteen years of age.

Mandated reporter: Any healthcare practitioner, childcare custodian, or an employee of a child protective agency. This includes EMTs and paramedics.

Neglect: The negligent treatment or maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.

Physical abuse: Physical injury or death inflicted by other than accidental means upon a child by another person.

Sexual abuse: Sexual assault or the exploitation of a minor. Sexual assault includes, but is not limited to, any intrusion by one person into the genitals; anal opening of a child; oral copulation intentional touching for the purposes of sexual arousal or gratification, or masturbation in the presence of a child. Sexual exploitation includes conduct involving matters depicting minors engaged in obscene acts; and/or prostitution.

PRINCIPLES:

1. The purpose of reporting suspected child abuse/neglect is to protect the child, prevent further abuse of the child and other children in the home, and to facilitate treatment for the entire family. The presence of abuse, rather than the degree of that abuse, is the determinant for intervention by DCFS and law enforcement.

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

2. California Penal Code, Sections 11166 and 11168, require mandated reporters to promptly report all suspected non-accidental injuries, sexual abuse, or neglect of children that they suspect, have knowledge of, or observe in their professional capacity. A verbal report shall be made to DCFS Child Protection Hotline immediately, or as soon as practically possible, and the Suspected Child Abuse Report shall be completed within 36 hours.

   In Los Angeles County, it is recommended that a report be made to local law enforcement as well.

3. It is not necessary for the mandated reporter to determine child abuse but only to suspect that it may have occurred. Law enforcement, DCFS and the courts determine whether child abuse/neglect has, in fact, occurred.

4. Current law mandates (CPC 11166) all healthcare professionals to report suspected child abuse/neglect that they know of or observe in their professional capacity. Mandated reporters are required to sign a statement acknowledging their understanding of the law (See Ref. No. 822.3, Sample Employee Acknowledgement as a Mandated Reporter). Any person who fails to report as required may be punished by a fine or imprisonment.

5. When a mandated reporter suspects or has observed child abuse/neglect, that individual is required to report by telephone to local law enforcement and/or to DCFS Child Protection Hotline.

6. When two or more mandated reporters are present at scene and jointly know or suspect an instance of child abuse/neglect, a member of the reporting team may be designated to report on behalf of the team. Any member who knows that the designated reporter failed to uphold their agreement shall thereafter make the report. If paramedics are not selected as the designated reporters, they shall document the name and agency of the designated reporting team member on the EMS Report Form.

7. Persons legally required to report suspected child abuse are immune from criminal or civil liability for reporting as required.

POLICY:

I. Reporting Procedure

A. Notify local law enforcement immediately if a child is suspected to be in imminent danger. Prehospital care providers should be aware of their local law enforcement reporting procedures and telephone numbers for notification.

B. Call the 24-hour Child Protection Hotline at **(800) 540-4000** as soon as possible to make the verbal report. (Refer to 822.1 for reporting options and instructions).

DCFS has implemented the Child Protection Hotline Priority line for Medical Providers to ensure immediate connection to the Hotline. Upon dialing the hotline number listed above, **press *** within the first 10 seconds of the call and a prompt will request a code be entered. **Enter the code 3237** (DCFS). Once the code is entered, the caller will be given options to select.

Press 1 for safely surrendered baby

Press 4 for all other inquiries (Child Report –Medical queue)

The telephone report shall include the following:

- Name of the person making the report
- Name of the child
- Present location of the child
- Nature and extent of the injury
- Information that led reporting party to suspect child abuse

The reporting party will be provided with a Referral Number (Case Number) that shall be transcribed onto Form SS8572 in the upper right hand corner under "Case Number"

Within 36 hours:

1. Compete and submit the Suspected Child Abuse Report (SS8572), that is accessible on the DCFS web site at http://dcfs.lacounty.gov

OR

2. Complete a hard copy according to the instructions on the back of the form (Ref. No. 822.2 and 822.2a, SS8572). The completed form must be mailed to local law enforcement and either mailed to DCFS (1933 S. Broadway Avenue, 5th floor, Los Angeles, CA 90007) or faxed (213) 745-1728 or (213) 745-1730

C. Document the following on the EMS Report Form

1. The name of the DCFS social worker and/or name, department and badge number of the law enforcement officer contacted.

2. Time of notification

3. Disposition of the child

CROSS REFERENCES:

Prehospital Care Manual:

Reference No. 822.1, **Guide to Suspected Child Abuse Reporting**
Reference No. 822.2, **Suspected Child Abuse Report Form SS 8572**
Reference No. 822.2a, **Definitions and General Instructions for Completion of Form SS 8572**
Reference No. 822.3, **Sample Employee Acknowledgement as a Mandated Reporter**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **GUIDE TO SUSPECTED CHILD ABUSE REPORTING** REFERENCE NO. 822.1

GUIDE TO SUSPECTED CHILD ABUSE REPORTING

1. **NOTIFY** law enforcement **IMMEDIATELY** if the child is suspected to be in imminent danger.

   - **CALL** the 24-hour Child Protection Hotline at **1 (800) 540-4000** as soon as possible to make the verbal report to the **Department of Child and Family Services (DCFS)**. To access the priority hotline for Medical Providers, **press *** within the first 10 seconds of the call and a prompt will request a code be entered. **Enter the code 3237** (DCFS). Once the code is entered, the caller will be given options to select.

     Press 1 for safely surrendered baby

     Press 4 for all other inquiries (Child Report –Medical queue)

   - You will be given a **REFERRAL NUMBER,** which is also the Case Number.

2. **COMPLETE** the **Suspected Child Abuse Report** (SCAR) form SS8572 **within 36 hours** and **submit to DCFS** via ONE of the following ways:

   - **Mail: Department of Child and Family Services (DCFS)**
     1933 S. Broadway Avenue, 5th Floor, Los Angeles, CA 90007

   - **Fax: (213) 745-1728 or (213) 745-1730**

   - **Online:**

     1. **dcfs.lacounty.gov**
     2. On the left-hand side, under RESOURCES, click on “For Mandated Reporters Only (Complete your Mandated Report Online)”
     3. Enter the REFERRAL NUMBER and proceed

   Keep a copy for yourself, and a copy to mail to local law enforcement.

3. **MAIL** (or FAX if available) a copy of the completed **Suspected Child Abuse Report** to the jurisdictional law enforcement agency.

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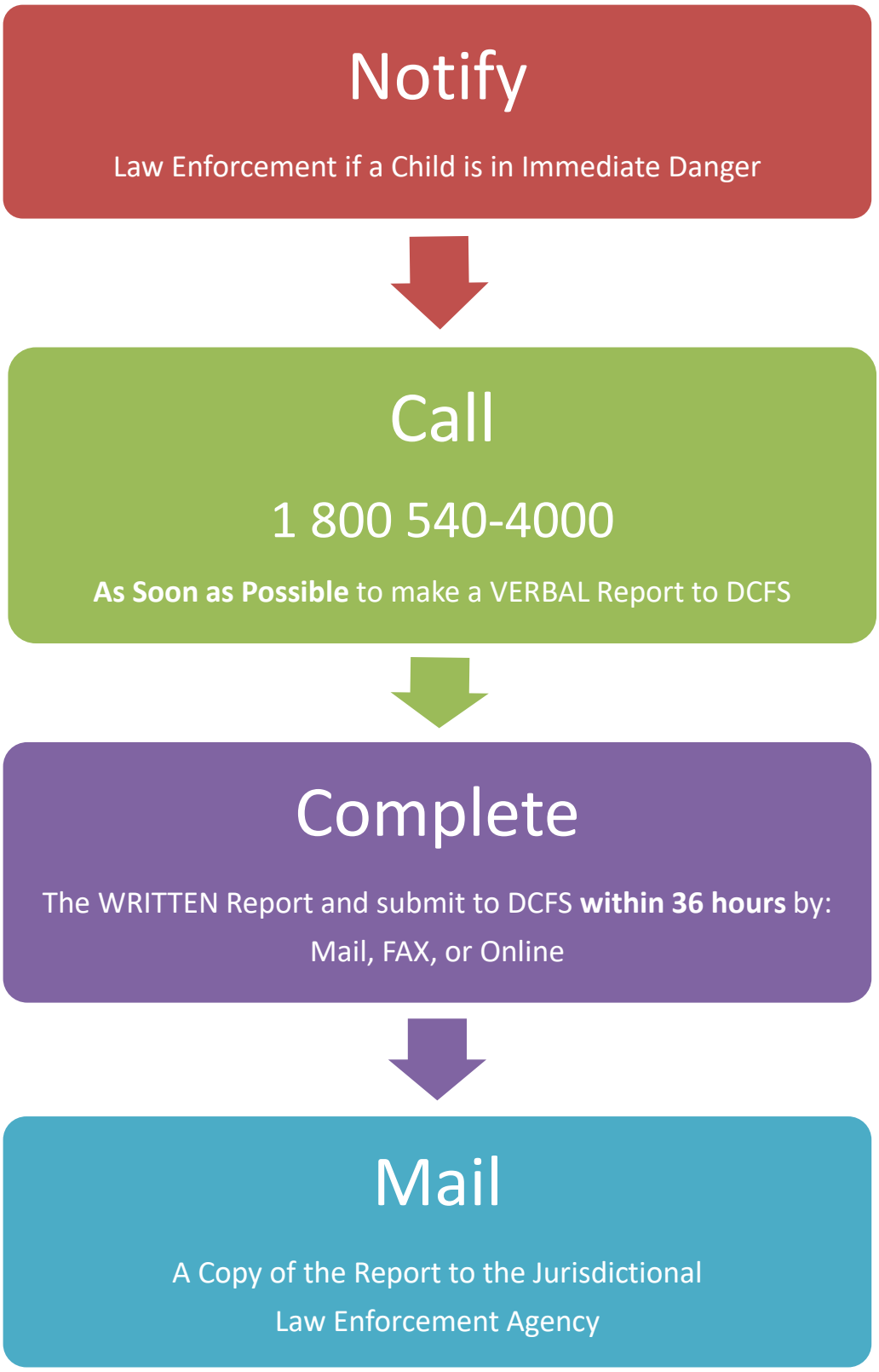
SUBJECT: **GUIDE TO SUSPECTED CHILD ABUSE REPORTING**

REFERENCE NO. 822.1



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DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT-I/EMT-P/MICN)

SUBJECT: **TREATMENT/TRANSPORT OF MINORS** REFERENCE NO. 832

PURPOSE: To describe the guidelines for treatment and/or transport of a patient under the age of eighteen.

AUTHORITY: Health and Safety Code Section 124260
California Family Code 6922, 6925, 6926, 6927, 6929, 7002, 7050, 7122, 7140
Business and Professions Code 2397

DEFINITIONS:

Emergency Medical Condition: A condition or situation in which an individual has an immediate need for medical attention. The presence of abnormal vital signs (heart rate and rhythm, respiratory rate, blood pressure – except isolated asymptomatic hypertension, oxygen saturation) are also indications of an emergency condition. Patients who meet any criteria for Base Contact or Receiving Hospital Notification are also considered to have an emergency medical condition.

Implied Consent: In the absence of a parent or legal representative, emergency treatment and/or transport of a minor may be initiated without consent.

Legal Representative: A person who is granted custody or conservatorship of another person by a court of law.

Minor: A person less than eighteen years of age.

Minor not requiring parental consent is a person who is:

1. Married or was previously married.
2. Currently or prvieously in a valid domestic partnership.
3. Not married and has an emergency medical condition and parent is not available.
4. On active duty with the Armed Forces.
5. Self-sufficient 14 years of age or older, living separate and apart from his/her parents, and managing his/her own financial affairs.
6. An emancipated minor with a declaration by the court or an identification card from the Department of Motor Vehicles.
7. Seeking care related to the treatment or prevention of pregnancy.
8. In need of care for sexual assault or rape.

APPROVED:

Director, EMS Agency

Medical Director, EMS Agency

9. Seeking care related to an abortion.

10. 12 years of age or older and in need of care for communicable reportable disease, prevention of a sexually transmitted infection (STI), alcohol or substance abuse, or outpatient mental health.

Voluntary Consent: Treatment or transport of a minor child shall be with the verbal or written consent of the parents or legal representative.

PROCEDURES:

I. Treatment/Transport of Minors

A. In the absence of a parent or legal representative, minors with an emergency medical condition shall be treated and transported to the appropriate receiving facility or a specialty care center (e.g. EDAP, PMC, PTC, SART Center, Trauma Center, etc.).

Minors should be transported using a restraint device appropriate for their size, weight, transport position, and medical condition. Restraint devices used should comply with the Federal Motor Vehicle Safety Standard (FMVSS) 213.

C. Hospital or provider agency personnel shall make every effort to inform a parent or legal representative where their child has been transported.

D. If prehospital care personnel believe a parent or other legal representative of a minor is making a decision which appears to be endangering the health and welfare of the minor by refusing indicated immediate care or transport, law enforcement authorities should be involved.

E. Infants ≤ 12 months of age shall be transported, regardless of chief complaint and /or mechanism of injury, in accordance with Ref. No. 1200.2, Treatment Protocol: Base Contact Criteria.

II. Minors **Not** Requiring Transport

A. A minor child (excluding children ≤ twelve (12) months of age) who is evaluated by EMS personnel and determined not to be injured, to have sustained only minor injuries, or to have illnesses or injuries not requiring immediate treatment or transportation, may be released to:

1. Self (consideration should be given to age, maturity, environment and other factors that may be pertinent to the situation)

2. Parent or legal representative

3. A responsible adult at the scene

4. Designated care giver

5. Law enforcement

B. Children 13 - 36 months of age require base hospital contact and/or transport, except those with no medical complaint or with isolated minor extremity injury.

C Prehospital care personnel shall document on the EMS Report Form to whom the patient was released.

CROSS REFERENCE:

Prehospital Care Manual
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 508.1, **SART Center Roster**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 822, **Suspected Child Abuse Reporting Guidelines**
Ref. No. 834, **Patient Refusal of Treatment / Transport & Treat & Release at Scene**
Ref. No. 1200.2 **Treatment Protocol: Base Contact Requirements**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/PARAMEDIC/MICN)

SUBJECT: **PATIENT REFUSAL OF TREATMENT/TRANSPORT AND TREAT AND RELEASE AT SCENE** REFERENCE NO. 834

PURPOSE: To provide guidelines for EMS personnel to determine which patients who do not wish to be transported to the hospital have decision-making capacity to refuse EMS treatment and/or transport, and to identify those who may be safely released at scene.

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

DEFINITIONS:

Adult: A person at least eighteen years of age.

Against Medical Advice (AMA): A patient or a legal representative of a patient who has decision-making capacity and who refuses treatment and/or transport for **an emergency medical condition** as advised by EMS providers, physician on scene, and/or Base personnel.

Assess, Treat, and Release: A patient who does not desire transport to the emergency department for evaluation and after an assessment and/or treatment by EMS personnel, **does not** have an ongoing emergent medical condition, a high-risk presentation, or social risk factors and is released at scene to follow-up with the patient's regular healthcare provider or a doctor's office or clinic.

Authorized Advanced Health Care Provider: An EMS physician authorized to direct EMS care on the scene or via telemedicine as per Ref. 816 – Physician at the Scene, or an advanced practiced provider who is identified by the EMS Provider Agency Medical Director to provide medical direction via telemedicine as approved by the EMS Agency Medical Director.

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

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

The lack of decision-making capacity may be:

- Temporarily lost (e.g., due to unconsciousness, influence of mind-altering substances, mental illness, or cognitive impairment)
- Permanently lost (e.g., due to irreversible coma, persistent vegetative state,

APPROVED: Director, EMS Agency; Medical Director, EMS Agency

untreatable brain injury, or dementia)
- Never existed (i.e., due to profound neurodevelopmental disorder, those who are deemed by the Court as incompetent or a person under conservatorship)

Emancipated Minor: A person under the age of 18 years is an emancipated minor if any of the following conditions are met:
- Married or previously married
- Currently or previously in a valid domestic partnership
- On active military duty
- The person has received a declaration of emancipation pursuant to Section 7122 of the California Family Code, which includes all of the following: at least fourteen (14) years of age, living separate and apart from their parents and managing their own financial affairs (may be verified by DMV Identification Card)

Emergency Medical Condition: A condition or situation in which a medical illness is suspected in a patient and there is an immediate need for medical attention. Patients with any abnormal vital signs: heart rate and rhythm, respiratory rate, blood pressure (except for isolated asymptomatic hypertension), oxygen saturation, and temperature (Ref. 1380 – Medical Control Guideline Vital Signs); and/or those who meet any criteria for Base Contact (Ref. 1200.2 – Base Contact Requirements) are considered to have an emergency medical condition.

High Risk Presentation: Features by history or presentation that are likely to be high risk for complications, progression of disease, underlying serious illness or injury, or require Base Contact. High risk chief complaints include chest pain, abdominal pain, pregnancy, gastrointestinal bleeding, syncope, neurologic symptoms (e.g., dizziness/vertigo, weakness, visual changes), and altered mental status. High risk features include:

- Patients less than 12 months of age
- Patients older than 70 years of age
- Patients with complicating comorbidities (i.e., active underlying cardiac, respiratory, kidney, liver, oncologic (cancer) or neurologic disease, or who are immunocompromised (e.g., history of HIV, chemotherapy, transplantation))

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

Lift Assist: EMS is dispatched to a scene to assist with transfer of a patient to a bed or wheelchair.

Medical Home: A team-based health care delivery model, which is led by a health care provider (i.e., primary care physician) to provide continuous, coordinated, and comprehensive medical care.

Minor: A person less than eighteen years of age.

Minor Not Requiring Parental Consent is a person who:
- Is 12 years or older and in need of care for a reportable medical condition or substance abuse
- Is pregnant and requires care related to the pregnancy

- Is in immediate danger of suspected physical or sexual abuse
- Is an emancipated minor

No Contact / No Patient: EMS is dispatched to a scene and is either cancelled prior to arriving at scene or no patient is found.

Patient: A person who seeks or appears to require medical assessment and/or medical treatment (Ref. 606, Documentation of Prehospital Care)

Person Contact / No Patient: EMS is dispatched to a scene and a person is identified as a potential patient, is alert and appropriate for situation and declines assessment by EMS.

Psychiatric Hold: A patient who is held against their will for evaluation under the authority of Welfare and Institutions Code (e.g., Section 5150, 5585 [minors]) because the patient is a danger to themselves, a danger to others, and/or gravely disabled (i.e., unable to care for self). This is a written order by law enforcement officer, County mental health worker, or a health worker certified by the County to place an individual on a psychiatric hold.

Public Assist: EMS is dispatched to a scene for assistance for nonmedical issues involving a person.

Social Risk Factors: Persons experiencing homelessness, patients in congregate living, and those who are a resident of skilled nursing facilities.

Treatment in Place: A patient who, after an assessment and treatment by EMS personnel and medical clearance by an authorized advanced healthcare provider (e.g., physician, nurse practitioner, physician assistant) on scene (Ref. 816 Physician at the Scene) or via Telemedicine, does not require ambulance transport to an emergency department. Appropriate follow-up should be arranged by the authorized advanced healthcare provider on scene or via Telemedicine.

PRINCIPLES:

1. An adult or emancipated minor who has decision-making capacity has the right to determine the course of their medical care including the refusal of care. These patients must be advised of the risks and consequences resulting from refusal of medical care. A patient less than eighteen (18) years of age, with the exception of minors not requiring parental consent, mush have a parent or legal representative to refuse evaluation, treatment, and/or transport for an emergency medical condition.

2. A patient determined by EMS personnel or the base hospital to lack decision-making capacity may not refuse care AMA or be released at scene. Mental illness, drugs, alcohol, or physical/mental impairment may impair a patient’s decision-making capacity but are not sufficient to eliminate decision-making capacity.

3. In situations where patients who have attempted suicide or expressed suicidal intent, or where other factors lead EMS personnel to suspect suicidal intent, such patients should be regarded as lacking decision-making capacity. These patients may decline treatment but cannot decline transport.

4. A patient on a psychiatric hold may not be released at scene and cannot sign-out AMA. The patient can refuse any medical treatment as long as it is not an imminent threat to

life or limb.

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

6. Patients for whom 9-1-1 is called but are not transported represent a potentially high-risk group and provider agencies should/shall have quality review programs specific to this patient population.

POLICY:

I. Adult With Decision-Making Capacity or Minor (Not Requiring Parental Consent) Refusing Transport Against Medical Advice

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

B. Base contact should be made prior to the patient leaving the scene for patients who would otherwise meet Base Contact criteria (Ref. 1200.2 – Base Contact Requirements) in order for Base personnel to have the opportunity to interview the patient and to evaluate the appropriateness of the AMA. Base personnel should be allowed to speak to the patient and/or family prior to the patient leaving the scene.

C. EMS personnel shall relay all the circumstances to the Base including assessment and care rendered, reasons for refusal, and the patient's plan for transportation and follow-up care.

D. EMS personnel shall make Base Contact prior to releasing a child at the scene with a parent or caregiver for all pediatric patients less than or equal to 12 months of age .

E. EMS personnel shall have the patient or their legal representative, as appropriate, sign the release (AMA) section of the Patient Care Record (EMS Report Form/Electronic Patient Care Record/ePCR). The signature shall be witnessed, preferably by a family member.

F. A patient's refusal to sign the AMA section should be documented on the Patient Care Record.

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

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

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

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

III. Patients Assessed, Treated, and Released

A. EMS personnel shall assess the patient for an ongoing emergency medical condition, high risk presentations, social risk factors, and assess that the patient or their legal representative has the capacity to decline transport.

B. Patients with an ongoing emergency medical condition, high risk presentation or social risk factors who do not desire transport to the emergency department shall be handled as refusing transport against medical advice (refer to Policy Section I).

C. Patients or the legal representatives of patients who contact EMS for minor complaints in order to have an assessment performed and determination made of the seriousness of the complaint and need for treatment, but later *decline transport* qualify to be assessed, treated, and released.

1. In such cases, the EMS personnel should perform an assessment including vital signs, and after the patient or patient's legal representative's states they do not wish transport, the patient may be assessed, treated, and released at the scene.

2. Patients should be instructed by EMS to follow-up with the patient's medical home or primary care physician. The advice given should be documented on the Patient Care Record. The following statement is recommended: "After our assessment, you feel that you do not wish to be transported and you do not require immediate care in the emergency department. You should seek care with your regular healthcare provider or a doctor's office or clinic within 24 hours. If you have worsening or persistent symptoms or change your mind and desire transport, recontact 9-1-1."

D. EMS personnel should not require patients who are Assessed, Treated and Released at scene to sign the release (AMA) section of the Patient Care Record, as this implies that the patient is at significant risk by not utilizing the EMS system for treatment and/or transportation.

E. If subsequent to further assessment and discussion, the patient or the patient's legal representative desires transport, EMS personnel should transport the patient to the hospital per destination policies.

IV. Documentation

A. Public Assist and Person Contact/No Patient does not require completion of a Patient Care Record. Documentation should follow the EMS provider agency's operational policy.

B. A Patient Care Record must be completed for each patient or contact encounter (i.e., Lift Assist, AMA, Assess, Treat and Release, and Treatment in Place),

including those refusing emergency medical evaluation, care and/or transportation against medical advice and those released at scene. EMS personnel shall ensure that documentation is in compliance with Ref. 606 – Documentation of Prehospital Care. Patient Care Record documentation should include:

1. AMA:

    a. Patient history and assessment, including findings of an emergency medical condition or requirement to make Base Contact

    b. Assessment by EMS that the patient or legal representative is alert and has the decision-making capacity to refuse EMS assessment

    c. What the patient is refusing (i.e., medical care, transport) and reason for refusal

    d. Risk and consequences of refusing care and/or transport, benefits of transport, and alternatives as explained to the patient or legal representative

    e. Statement that the patient understands and verbalizes the risks and consequences of refusing care and/or transport

    f. Signature of patient or legal representative

    g. Patient's plan for follow-up care

    h. Contact with Base Hospital, as applicable

    i. For Minors, the relationship of the person(s) to whom the patient is being released

2. Assess, Treat and Release:

    a. Patient history and assessment, including absence of findings of an emergency medical condition

    b. Assessment by EMS that the patient or legal representative is alert and has the capacity to make collaborative decision making with EMS to accept on-scene treatment, understand the need to have capacity for appropriate follow-up, but decline transport

    c. Discussion with patient including risks of non-transport, benefits of transport, and alternatives

    d. Plan for follow-up care including when to recall 9-1-1, seek emergency department care or follow-up with their medical home

    e. If Base contact was made (when applicable)

f. For Minors, the relationship of the person(s) to whom the patient is being released

3. Treatment in Place:

a. Document as per Assess, Treat, and Release and also include the name of the authorized advanced health care provider

V. Quality Improvement

A. Each Provider Agency shall have a quality improvement program for patients who are not transported to the ED. The quality improvement program should include but may not be limited to the following:

1. Monitor data on the frequency, percent, and type of nontransports.

2. Establish a process for review of patient care records on a percentage of nontransports to include assessment of impact on the patient's outcome, and education/training provided as indicated by this review.

3. Develop a process for evaluating rate of repeat call to 9-1-1 or "rekindles".

B. Base Hospital shall incorporate patients released at the scene into their Quality Improvement Program (Ref. 304 – Paramedic Base Hospital Standards). The quality improvement program may include but not limited to the following:

1. Review of select number of Base Hospital contacts for AMA and provide education to base personnel as appropriate from that review.

2. Inclusion of cases of patients released at the scene in Base Hospital Audio Recording Reviews.

3. Notification of EMS provider agency quality improvement staff when the base has knowledge of patients who are released at the scene and return for evaluation in the emergency department.

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 304, **Paramedic Base Hospital Standards**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 832, **Treatment/Transport of Minors**
Ref. No. 816, **Physician At The Scene**
Ref. No. 1200, **Treatment Protocols**, et al.
Ref. No. 1200.2, **Base Contact Requirements**
Ref. No. 1309, **Color Code Drug Doses**
Ref. No. 1380, **Medical Control Guidelines: Vital Signs**

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Treatment Protocol: AGITATED DELIRIUM **Ref. No. 1208-P**

Base Hospital Contact Required prior to transport.

1. Assess situation for safety; approach patient with caution and attempt verbal de-escalation *(MCG 1307)*

2. Attain law enforcement (LE) assistance for physical restraint prior to approaching a patient if a weapon is visualized or the patient threatens violence. *(MCG 1307)*

3. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*
   Continually assess patient's airway and ventilation status ❶

4. Administer **Oxygen** prn *(MCG 1302)*

5. Patients with agitated delirium have confusion and extreme agitation along with any of the following: ❶
   - Diaphoresis
   - Elevated temperature, hot or flushed skin
   - Tachycardia
   - Rapid breathing

   Agitated and/or combative patients without these sign/symptoms are not suffering agitated delirium, treat per the appropriate treatment protocol.

6. Apply physical restraints when indicated *(Ref. No. 838, Application of Patient Restraints)* ❷

7. For patients requiring medical management for agitated delirium including patients requiring physical restraint for patient or EMS personnel safety:
   Administer **Midazolam (5mg/mL) 0.2 mg/kg IM/IN**, dose per *MCG 1309*
   Repeat x1 in 5 min prn, maximum single dose 5mg, up to a total dose of 10mg prior to Base contact. ❸❹

   CONTACT BASE for additional sedation:
   With Base contact may repeat as above up to a maximum total dose of 15mg ❹

8. Evaluate for physical trauma; if present treat in conjunction with *TP-1244-P, Traumatic Injury*

9. Establish vascular access *(MCG 1375)*

10. Check blood glucose prn ❺
    If glucose < 60 mg/dL or > 250mg/dL treat in conjunction with *TP 1203-P, Diabetic Emergencies*

11. Initiate cardiac monitoring after sedation *(MCG 1308)*
    Assess for dysrhythmia or interval widening
    CONTACT BASE for QRS > 0.12 sec, QT > 500ms, or heart rate > 150 or < 50 to discuss need to administer **Sodium Bicarbonate 1mEq/kg IV** per *MCG 1309* ❻

12. **Normal saline 20mL/kg IV rapid infusion** *MCG 1309*

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Treatment Protocol: AGITATED DELIRIUM **Ref. No. 1208-P**

13. For suspected ingestions, treat in conjunction with *TP 1241-P, Overdose / Poisoning / Ingestion*

14. If patient's skin is hot to touch or has a measured fever with suspected hyperthermia (i.e., measured temperature greater than 39°C or 102°F), initiate cooling measures

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SPECIAL CONSIDERATIONS

1. Pediatric patients with Agitated Delirium / Excited Delirium are infrequently encountered by EMS personnel. These patients often are impervious to pain and have a lack response to verbal commands by EMS are at risk for sudden cardiac arrest, often preceded by a brief, abrupt period of lethargy and decreased respirations. Careful observation of patient's activity level, vital signs, and airway are essential to patient safety. If patient develops cardiac arrest, treat in conjunction with *TP 1210-P, Cardiac Arrest – Non-traumatic.*

2. Use of restraints in patients with Agitated Delirium is associated with an increased risk of sudden death. Avoid using restraints in patients who do not present a threat to self or to EMS personnel. Never transport a patient in restraints in prone position.

3. Patients who are agitated while in physical restraint and have the potential for injury due to the degree of agitation, should receive administration of medication by EMS personnel to reduce risk of self-injury. These patients should be continually monitored for respiratory depression, in accordance with *Ref. 838, Application of Patient Restraints.*

4. Midazolam onset is 2 minutes with maximum effect at 5 minutes. The IM or IN route is preferred, unless an IV has been previously established.

5. Agitation may be present after a seizure, or in the setting of hypo/hyperglycemia. Consider checking glucose early if the patient is a known diabetic, but only if safe to do so.

6. Several drugs may cause life threatening cardiac arrhythmias after intentional or accidental overdose. These arrhythmias are often preceded by prolonged ECG intervals (particularly QRS > 0.12 sec or QT interval > 500ms). Cocaine intoxication is strongly associated with Agitated Delirium and may also produce cardiac effects similar to Tricyclic antidepressant (TCA) overdose (widened QRS progressing to malignant arrhythmia). These patients may require a large dose of sodium bicarbonate to prevent sudden cardiac death. Consult Base Physician immediately to discuss administration of Sodium Bicarbonate; may repeat x1 if QRS remains > 0.12 sec after initial sodium bicarbonate. Treat in conjunction with *TP 1241-P, Overdose / Poisoning / Ingestion*

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Treatment Protocol: BEHAVIORAL / PSYCHIATRIC CRISIS **Ref. No. 1209-P**

1. Perform initial assessment of scene and patient situation for safety

2. Attain law enforcement assistance for assistance prior to approaching a patient if a weapon is visualized or the patient threatens violence or for potential assistance with application of an involuntary psychiatric hold ❶❷

3. Approach patient with caution, assess or agitation and treat accordingly including use of verbal de-escalation as needed *(MCG 1307 Care of the Psychiatric Patient with Agitation)* ❸

4. Assess airway and initiate basic and/or advanced airway maneuvers prn

5. Administer Oxygen prn *(MCG 1302)*

6. Assess for agitated delirium; treat per *TP 1208-P, Agitated Delirium*

7. Evaluate for acute medical conditions, including those that may present with psychiatric features❹

8. If ongoing agitation with safety risk to patient or EMS personnel, initiate medication management **CONTACT BASE** for orders for treatment of agitation

   If the patient is cooperative:
   Olanzapine 10mg ODT for pediatric patients longer than the length-based resuscitation tape per *MCG 1309*; *MCG 1317.32*; given once ❺❻

   If the patient is uncooperative and/or olanzapine is contraindicated:
   Midazolam (5mg/mL) 0.2 mg/kg IM/IN, dose per *MCG 1309*
   Repeat every 5 min prn; maximum single dose 5mg
   With Base orders may repeat as above to a total maximum dose of 15mg ❻❼

9. Evaluate for physical trauma; if present treat in conjunction with *TP-1244-P, Traumatic Injury*

10. Establish vascular access prn *(MCG 1375)*

    Check blood glucose prn ❽
    If glucose < 60 mg/dL or > 250 mg/dL treat in conjunction with *TP 1203-P, Diabetic Emergencies*

11. Initiate cardiac monitoring prn *(MCG 1308)*
    Assess for dysrhythmia or interval widening
    CONTACT BASE for QRS > 0.12 sec, QT > 500 ms, or heart rate > 150 or < 50 to discuss need to administer **Sodium Bicarbonate 1 meq/kg** per *MCG 1309*❾

12. Evaluate for a possible suicide attempt ❿
    For potential overdose, obtain patient and bystanders information about ingestions and treat in conjunction with *TP 1241-P, Overdose/Poisoning/Ingestion*

13. Evaluate for acute mental health and/or substance abuse crises
    Obtain relevant clinical history regarding patient's current psychiatric diagnoses, psychiatric and other medications, and any recent alcohol or recreational drug ingestions

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Obtain and document relevant third party or collateral data ⓫

14. Patients who respond to verbal de-escalation, are cooperative without medications by EMS, and have no acute medical conditions may be transported by EMS or LE to the Emergency Department, Psychiatric Urgent Care as per *Ref. No. 526 Behavioral Psychiatric Destination*

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Treatment Protocol: BEHAVIORAL / PSYCHIATRIC CRISIS **Ref. No. 1209-P**

SPECIAL CONSIDERATIONS

❶ Scene safety includes the assessment for the presence of firearms or weapons, including observations and direct inquiry with the patient and any available/relevant third parties (e.g., family, caregivers, or witnesses). If a weapon is found on the scene, EMS personnel should notify all members on the scene, and contact law enforcement (LE) immediately.

❷ Psychiatric, including mental health and substance abuse, emergencies are medical emergencies, and as such are best treated by EMS personnel. Those patients with psychiatric emergencies presenting with agitation, violence, threats of harm to self or others, or criminal activity are best managed by an EMS and LE co-response.

❸ Always attempt verbal de-escalation first and avoid applying restraints to patients who do not present a threat to self or EMS personnel *(Ref. 838, Application of Patients Restraints)*

❹ Many medical causes of psychiatric symptoms exist:

- Agitation (see *MCG 1307*)
  - Acute pain
  - Head trauma
  - Infection
  - Encephalitis or Encephalopathy
  - Exposure to environmental toxins
  - Metabolic derangement
  - Hypoxia
  - Thyroid disease or other hormone irregularity
  - Neurological disease
  - Toxic levels of medications
  - Alcohol or recreational drugs: intoxication or withdrawal
  - Exacerbation of a primary psychiatric illness
  - Autism Spectrum Disorder
- Psychosis
  - Delirium
  - Chronic neurological disease (dementia, seizures, parkinsonism, brain tumor)
  - Steroid use, other medication reactions
  - Alcohol or recreational drugs: intoxication or withdrawal
- Mania
  - Delirium
  - Thyrotoxicosis
  - Alcohol or recreational drugs: intoxication or withdrawal
- Anxiety
  - Respiratory disease
  - Cardiac disease
  - Thyroid disease
  - Toxic levels of medications
  - Alcohol or recreational drugs: intoxication or withdrawal
- Depression
  - Reaction to medication
  - Chronic disease or chronic pain
  - Hormonal variations

Subclinical / clinical hypothyroidism
Alcohol or recreational drugs: intoxication or withdrawal

❺ Olanzapine onset is 5-15 minutes with maximum effect at 45-60 minutes.

❻ Medications used for pharmacologic management of agitation may cause respiratory depression, and every individual who receives pharmacologic management should be continuously monitored and transported for additional clinical assessment and treatment.

❼ Midazolam onset is 2 minutes with maximum effect at 5 minutes. The IM or IN route is preferred unless an IV has been previously established.

❽ Agitation may be present after a seizure, or in the setting of hypo/hyperglycemia. Consider checking glucose early if the patient is a known diabetic or demonstrates clinical evidence of hypoglycemia, but only if safe to do so.

❾ Several drugs that may cause agitation and present similarly to a psychiatric crisis may also cause life threatening cardiac arrhythmias after intentional or accidental overdose. These arrhythmias are often preceded by prolonged ECG intervals (particularly QRS > 0.12 sec or QT interval > 500 ms). Cocaine intoxication is strongly associated with Agitated Delirium and may also produce cardiac effects similar to Tricyclic antidepressant (TCA) overdose (widened QRS progressing to malignant arrhythmia). These patients may require a large dose of sodium bicarbonate to prevent sudden cardiac death. Consult Base Physician immediately to discussion administration of Sodium Bicarbonate; may repeat x1 if QRS remains > 0.12 sec after initial sodium bicarbonate. Treat in conjunction with *TP 1241-P, Overdose / Poisoning / Ingestion*

❿ It is important to assess for any evidence of suicide attempt. If there is concern for overdose, ask the patient or bystanders to provide information on agents used (specifically what, when, and how much). Collect and transport any medication vials, or additional pills). This will assist in determining necessary antidote treatment and monitoring at the hospital. This information is often lost, if not obtained immediately on scene.

⓫ Patients with acute mental health or substance abuse crises may not be capable or willing to provide reliable information, therefore, it is important to obtain third party collateral information about the patient's condition (e.g., from family, caregivers, witnesses), including names and contact information for persons knowledgeable about the patient's illness, treatment and medications.

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Treatment Protocol: CARDIAC ARREST **Ref. No. 1210-P**

Base Hospital Contact Required.

1. For patients meeting *Ref. 814* Section I criteria for determination of death in the field – document *DOA – Obvious Death* ❶

2. Resuscitate cardiac arrest patients on scene ❷

3. Assess airway and initiate bag-mask ventilation; escalate to advanced airway prn *(MCG 1302; 1309)* ❸❹
   Monitor waveform capnography throughout resuscitation

4. Assist respirations with bag-mask-ventilations (BMV) with viral filter, using **high-flow Oxygen 15L/min**; squeeze bag just until chest rise and then release - state "squeeze, release, release" to avoid hyperventilation ❹

5. For advanced airway, Supraglottic airway is preferred when indicated ❸

6. For suspected foreign body (no chest rise with BMV): ❺
   Perform direct laryngoscopy and use pediatric Magill forceps to remove visible obstruction(s)

7. Initiate chest compressions at a rate of 100-120 compressions per minute with a compression to ventilation rate of 15:2 ❻

8. Initiate cardiac monitoring *(MCG 1308)*
   Briefly assess rhythm every 2 minutes, minimizing pauses, or continuously via rhythm display technology ❼❽

9. Establish vascular access *(MCG 1375)* ❾

10. **CONTACT BASE** concurrent with ongoing management

ASYSTOLE/PEA

11. **Epinephrine (0.1mg/mL) 0.01mg/kg IV/IO**, dose per *MCG 1309*
    May repeat every 5 min x2, maximum single dose 1mg ❿

    CONTACT BASE for additional epinephrine doses

12. Consider and treat potential causes ⓫

13. **Normal Saline 20mL/kg IV/IO** per *MCG 1309*
    May repeat x2

V-FIB/PULSELESS V-TACH

14. **Defibrillate at 2J/kg**, dose per *MCG 1309*
    Repeat at **4J/kg** at each 2-minute cycle as indicated

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15. **Epinephrine (0.1mg/mL) 0.01mg/kg IV/IO**, dose per *MCG 1309*
    Begin after second defibrillation
    May repeat every 5 min x2, maximum single dose 1mg ⑩

    CONTACT BASE for additional epinephrine doses

16. For persistent or recurrent V-Fib/V-Tach without pulses:
    Amiodarone (50mg/mL) 5 mg/kg IV/IO, dose per *MCG 1309*

RETURN OF SPONTANEOUS CIRCULATION ⑫⑬

17. Initiate post-resuscitation care on scene to stabilize the patient prior to transport ⑭

18. Establish advanced airway prn *(MCG 1302; 1309)* ⑮

19. Raise head of stretcher to 30 degrees if blood pressure allows, otherwise maintain supine

20. Continue ventilation at 20 breaths per minute or every 2-3 seconds

21. For SBP < 70mmHg:
    Normal Saline 20mL/kg IV/IO rapid infusion per *MCG 1309*
    Repeat x1 for persistent poor perfusion

    If no response after **Normal Saline 20mL/kg,** or worsening hypotension and/or bradycardia:
    Push-dose Epinephrine – mix 9mL Normal Saline with 1mL Epinephrine (0.1mg/mL) IV formulation in a 10mL syringe; administer **Push-dose Epinephrine (0.01mg/mL)** per *MCG 1309* every 1-5 minutes as needed to maintain SBP > 70mmHg ⑯

22. Check blood glucose
    For blood glucose < 60mg/dL
    Dextrose 10% 5mL/kg IV/IO
    ≤24kg: **Dextrose 10% in water, 5mL/kg IV in 1mL/kg** increments dose per *MCG 1309*, reassess for clinical improvement after every 1mL/kg. Administer slow IVP. May repeat as needed, maximum total dose 5mL/kg. Recheck glucose prn after 3mL/kg infused
    >24 kg: **Dextrose 10% in water, administer 125mL IVPB** and reassess, continue infusion as needed with maximum dose of 5mL/kg

23. For suspected narcotic overdose: ⑰
    Naloxone (1mg/mL) 0.1mg/kg IM/IN/IO/IV, dose per *MCG 1309*

24. Contact **Public Health 213-989-7140** for all submersion incidents involving pools or spas after transfer of patient care in the emergency department or upon termination of resuscitation in the field (this requirement is effective 10/1/21). ⑱

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SPECIAL CONSIDERATIONS

❶ EMS Personnel are mandated reporters of child abuse and neglect, and a report should be made when suspected as per *Ref. 822*. Communicate suspicion for child abuse and/or neglect to accepting ED staff when home suggests children could be at risk for harm (e.g., unkept home, evidence of drug or alcohol abuse, unsafe living conditions, known or suspected domestic violence), when the history does not match with the severity of physical findings (e.g., child posturing after a roll off the couch), when patterned injury or burns or noted (e.g., circular burns as from a cigarette, whip marks on the skin, burns of both hands or feet), or when child reports physical or sexual abuse. Children < 3 years of age and those with developmental delay are at increased risk of abuse. This must also be accompanied by notification to the Department of Children and Family Services (DCFS).

❷ Maintaining perfusion with high-quality CPR throughout resuscitation is essential to ensuring good patient outcome. Chest compressions are the most important aspect of cardiac arrest resuscitation. Maintaining chest compressions should take priority over any medication administration or transport. Transporting the patient in cardiac arrest causes interruptions in CPR and reduces CPR quality. Similar to adults in OHCA, pediatric patients who are resuscitated on scene have higher neurologically intact survival. Transport may be initiated sooner if scene safety concerns.

❸ Bag-mask ventilation (BMV) with a viral filter is the preferred initial method of airway management for pediatric patients. BMV in cardiac arrest has been associated with improved patient outcomes; the role of the supraglottic airway (SGA) in pediatric patients is still unknown. SGA placement should be performed if BMV is ineffective and otherwise deferred until initial resuscitation priorities are complete (i.e., at least 2 defibrillations for shockable rhythms and first dose of epinephrine IV for nonshockable rhythms). Sizing of the SGA per *MCG 1309*. When authorized, intubation should not be performed until after return of spontaneous circulation (ROSC) unless ventilation with BMV and SGA is ineffective and/or contraindicated.

❹ Hyperventilation reduces venous return and worsens patient outcomes. Both continuous and interrupted (15:2) compressions/ventilations are acceptable. Regardless of ventilation method used, ventilations should be no more frequent than 10 per minute with a volume just enough to see chest rise and then release the bag to allow for exhalation (“squeeze, release, release”). Once ROSC is achieved ventilation rates can increase to 20 per minute.

❺ Children < 3 years of age are at high risk for foreign body aspiration. Foreign body aspiration should be suspected if there is a history of possible aspiration or when there is no chest rise with BMV after repositioning of the airway.

❻ EMS personnel should remain on scene up to 20 minutes to establish chest compressions, vascular access and epinephrine administration for nonshockable rhythms or until return of spontaneous circulation (ROSC) is achieved; for shockable rhythms, remain on scene until 3 defibrillations or until ROSC is achieved. The best results occur when resuscitation is initiated and maintained on scene, and post ROSC care is initiated.

❼ If you are able to observe the underlying rhythm during compressions via rhythm display technology, do not pause for the rhythm check.

❽ $ETCO_2$ should be > 10 with a “box-shaped” waveform during effective CPR. A flat or wavy waveform

or $ETCO_2$ < 10 may indicate ineffective compressions or airway obstruction. A sudden increase in $ETCO_2$ is suggestive of ROSC. The waveform can also be used to confirm ventilation rate if an advanced airway or asynchronous ventilation with continuous compressions is used.

❾ Peripheral venous access may be difficult to obtain in infants and small children. Consider IO placement as primary vascular access in patients for whom venous access is unlikely to be achieved rapidly. For older children, make two attempts at venous access and, if unsuccessful, place and IO for vascular access.

❿ Epinephrine may improve outcomes if given *early* in nonshockable rhythms and should be given within 5 minutes of the resuscitation. For shockable rhythms, where defibrillation is the preferred initial treatment, epinephrine should be given after the second defibrillation. Epinephrine is most likely to be effective if it is given early and after chest compressions have begun. The likelihood of meaningful survival declines after three (3) doses of epinephrine. Resuscitation should continue focused on quality CPR, defibrillation, and identifying reversible causes. Additional doses of epinephrine should only be administered with Base order if indicated, based on the individual patient.

⓫ Potential causes that can be treated in the field include hypoxia, hypovolemia, hyperkalemia, hypothermia, toxins, and tension pneumothorax. Hypoxia and Hypovolemia are common causes of PEA arrest in children. Hypoglycemia is a very rare cause of cardiac arrest and should not be assessed until after ROSC.

⓬ Post cardiac arrest patients are at high risk for re-arrest during transport. Fluid resuscitation, vasopressor support, and avoidance of hyperventilation are recommended to decrease the risk of re-arrest.

⓭ $ETCO_2$ can help guide your ventilation rate; target $ETCO_2$ 35-45 mmHg. Just after ROSC, the $ETCO_2$ may be transiently elevated. This will decrease appropriately with ventilation and does not require hyperventilation to normalize. Persistently elevated $ETCO_2$ and/or “sharkfin” waveform may indicate respiratory failure as cause of the cardiac arrest. Falsely low $ETCO_2$ measurements can occur if there is a leak with BMV or shock.

⓮ Re-arrest shortly after ROSC is common. Anticipate this decline as the epinephrine administered during the resuscitation begins to lose effect. Consider initiating post-resuscitation care prior to transport, if the scene allows, in order to reduce chances of re-arrest en route. Considerations include suspected cause of arrest and anticipated transport time to a Pediatric Medical Center. Pediatric patients with ROSC should be transported to a Pediatric Medical Center if within 30 minutes.

⓯ Consider SGA placement if needed to facilitate effective ventilations during transport. In patients longer than the length-based resuscitation tape (e.g., Broselow tape) or > 40 kg body weight for whom intubation is also in scope of practice, SGAs are the preferred advanced airway unless specifically contraindicated. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality for pediatric patients in whom multiple modalities are authorized.

⓰ **Push-dose Epinephrine** is appropriate for non-traumatic shock including cardiogenic shock. Additional doses beyond 10mL may need to be prepared for prolonged transports. For patients < 10kg, transfer the diluted **Push-dose Epinephrine** to a smaller (1mL or 3mL) syringe in order to

administer the dose accurately.

⓱ Narcotic overdose should be suspected in cases where there is drug paraphernalia on scene or there is a witness report. Pinpoint pupils may be present, but hypoxia during cardiac arrest more often causes mydriasis (dilated pupils) instead.

⓲ EMS is assisting the Department of Public Health (DPH) in promptly investigating fatal or nonfatal drownings at public pools or spas in order to ensure safety can be verified before reopening. Contacting the on-call DPH officer will allow timely investigation of these incidents and prevent future incidents.

DEPARTMENT OF HEALTH SERVICES
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Treatment Protocol: CARDIAC DYSRHYTHMIA - BRADYCARDIA **Ref. No. 1212-P**

Base Hospital Contact: Required for all patients with symptomatic bradycardia

1. Assess patient's airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*

2. If foreign body suspected, perform direct laryngoscopy for foreign body removal and treat in conjunction with *TP 1234-P, Airway Obstruction*

3. Administer **Oxygen** prn *(MCG 1302)*
   High-flow Oxygen 15L/min for poor perfusion ❶

4. Initiate cardiac monitoring *(MCG 1308)*
   Perform 12-lead ECG if dysrhythmia suspected prn

5. For poor perfusion:
   Begin bag-mask-ventilation (BMV) ❶

6. Establish vascular access prn *(MCG 1375)*

7. Administer **Normal Saline 20mL/kg IV/IO rapid infusion** per *MCG 1309*

8. For persistent poor perfusion and alert: ❷
   Epinephrine (0.1mg/1mL) 0.01mg/kg slow IV/IO push, dose per *MCG 1309*
   Repeat every 3-5 min
   CONTACT BASE for Physician Consultation concurrent with above treatment

9. For persistent poor perfusion and ALOC: ❷
   Begin Chest compressions
   Epinephrine (0.1mg/1mL) 0.01mg/kg slow IV/IO push, dose per *MCG 1309*
   Repeat every 3-5 min
   CONTACT BASE for Physician Consultation concurrent with above treatment

10. If suspected AV Block or patient unresponsive to epinephrine: ❸
    Atropine (0.1mg/mL) 0.02 mg/kg IV/IO push, dose per *MCG 1309*
    May repeat x1 in 5 min

11. Consider **Transcutaneous Pacing (TCP)** for HR ≤ 40 with continued poor perfusion *(MCG 1365)*
    For infants and young children place pacing pads anterior and posterior chest; for older children place as per adult patients ❹
    Recommended initial settings: rate 70bpm/0mA, slowly increase mAs until capture is achieved
    CONTACT BASE concurrent with initiation of TCP

    If TCP will be utilized for the awake patient, consider sedation and analgesia
    For sedation:
    Midazolam (5mg/mL) 0.1mg/kg IV/IO or **0.2mg IM/IN**, dose per *MCG 1309*
    May repeat in 5 min prn x1 with Base order, maximum single dose 5mg
    For pain management: refer to *MCG 1345, Pain Management*
    Dose per *MCG 1309*

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12. For nausea or vomiting in patients ≥ 4 years old:
    Ondansetron 4mg ODT

13. For suspected overdose, treat in conjunction with *TP 1241-P, Overdose/Poisoning/Ingestion* ❺

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Treatment Protocol: CARDIAC DYSRHYTHMIA - BRADYCARDIA **Ref. No. 1212-P**

SPECIAL CONSIDERATIONS

❶ Management of oxygenation and ventilation is the most important aspect of treatment of bradycardia in children. Squeeze the bag mask device just until chest rise is initiated and then release; state "Squeeze, Release, Release" to prevent hyperventilation. Young athletes, typically adolescents may have normal resting heart rates < 60 bpm, treat only if signs of poor perfusion.

❷ For pediatric patients with bradycardia (HR <60 bpm) unresponsive to bag-mask ventilation and continued poor perfusion who remain alert, support perfusion with fluid resuscitation and epinephrine administration. For patients with persistent poor perfusion and ALOC, begin chest compressions, administer epinephrine and assess need for TCP. If you have concerns about initiating these therapies contact Base Physician for further guidance.

❸ Potential causes of unresponsiveness to epinephrine in children include increased intracranial pressure, beta blocker/calcium channel overdose, hypothyroidism, infection, congenital heart disease, and sleep apnea where administration of atropine could be of theoretical benefit.

❹ There is minimal data on the use of TCP in infants and children in the out-of-hospital setting. Patients unresponsive to BMV and epinephrine may be candidates. Base Physician consultation is recommended in these patients.

❺ Consider calcium channel blocker and beta blocker overdose in patients with bradycardia and hypotension. Ask about potential exposures including medications in the home. Hyperglycemia is a common finding with calcium channel blocker overdose.

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Treatment Protocol: CARDIAC DYSRHYTHMIA - TACHYCARDIA **Ref. No. 1213-P**

Base Hospital Contact: Required for all patients with wide complex tachycardia.

1. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*
2. Administer **Oxygen** prn *(MCG 1302)*
3. Initiate cardiac monitoring *(MCG 1308)*
   Document cardiac rhythm and obtain12-lead ECG if dysrhythmia suspected
4. Maintain supine for patients with signs of poor perfusion, if respiratory status allows
5. Establish vascular access prn *(MCG 1375)*

SINUS TACHYCARDIA (Infants: heart rate < 220bpm, Children: heart rate < 180bpm) ❶

6. For adequate perfusion:
   Monitor closely for potential deterioration, rapid transport
7. For poor perfusion:
   Normal Saline 20mL/kg IV per *MCG 1309*

SVT - NARROW COMPLEX (Infants: heart rate ≥ 220bpm, Children: heart rate ≥ 180bpm)

8. **Adenosine (3mg/mL) 0.1mg/kg rapid IV push**, dose per *MCG 1309*, maximum 6mg ❷
   Immediately follow with 10mL Normal Saline rapid IV flush

   If SVT persists:
   Adenosine (3mg/mL) 0.2mg/kg rapid IV push, dose per *MCG 1309*, maximum 12mg

   CONTACT BASE concurrent with adenosine treatment

9. For persistent poor perfusion after adenosine
   CONTACT BASE to discuss order for Synchronized Cardioversion
   Synchronized cardioversion 1.0J/kg, dose per *MCG 1309* ❹
   May repeat x2 at **2.0J/kg**, dose per *MCG1309*

   Consider sedation prior to cardioversion:
   Midazolam (5mg/mL) 0.1mg/kg slow IV/IO push or 0.2 mg/kg IM/IN, dose per *MCG 1309*
   May repeat in 5 min prn x1 with Base order, maximum single dose 5mg

WIDE COMPLEX (WCT) – REGULAR/MONOMORPHIC

10. For adequate perfusion:
    Adenosine (3mg/mL) 0.1mg/kg rapid IV push, dose per *MCG 1309*, maximum 6mg ❷ ❸
    Immediately follow with 10mL Normal Saline rapid IV flush

    If WCT persists:

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Treatment Protocol: CARDIAC DYSRHYTHMIA - TACHYCARDIA **Ref. No. 1213-P**

Adenosine (3mg/mL) 0.2mg/kg rapid IV push, dose per *MCG 1309*, maximum 12mg ❸

11. For poor perfusion:
    CONTACT BASE to discuss order for:
    Adenosine (3mg/mL) 0.2mg/kg rapid IV push, dose per *MCG 1309*, maximum 12mg and/or
    Synchronized cardioversion 1.0J/kg, dose per *MCG 1309* ❸ ❹
    May repeat x2 at **2.0J/kg**, dose per *MCG1309*

    Consider sedation prior to cardioversion:
    Midazolam (5mg/mL) 0.1mg/kg slow IV/IO push or 0.2 mg/kg IM/IN, dose per *MCG 1309*
    May repeat in 5 min prn x1 with Base order, maximum single dose 5mg

WIDE-COMPLEX – IRREGULAR

12. For adequate perfusion:
    CONTACT BASE and monitor closely for potential deterioration

13. For poor perfusion:
    CONTACT BASE to discuss order for synchronized cardioversion 1.0J/kg, dose per *MCG 1309* ❹
    May repeat x2 at **2.0J/kg**, dose per *MCG1309*

    Consider sedation prior to cardioversion:
    Midazolam (5mg/mL) 0.1mg/kg slow IV/IO push or 0.2 mg/kg IM/IN, dose per *MCG 1309*
    May repeat in 5 min prn x1 with Base order, maximum single dose 5mg

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Treatment Protocol: CARDIAC DYSRHYTHMIA - TACHYCARDIA **Ref. No. 1213-P**

SPECIAL CONSIDERATIONS

1. Sinus tachycardia is common and SVT is rare. Consider sinus tachycardia in patients with history of fever, volume loss (e.g., vomiting or diarrhea), or congenital heart disease. An indication of sinus tachycardia is narrow complex and beat-to-beat variability seen on the ECG. Vital signs vary by age and normal ranges can be found in *MCG 1309*. Any pediatric patient with vital signs outside the normal range for age should be considered potentially ill and transported to an EDAP or PMC if criteria are met.

2. Contraindications: 2nd and 3rd Degree Heart Blocks; history of Sick Sinus Syndrome

3. Regular monomorphic wide complex tachycardia may be a supraventricular rhythm with a bundle branch or aberrancy. In this case, Adenosine may convert the rhythm to sinus and AHA guidelines recommend its use for regular monomorphic wide complex tachycardia.

4. For failure to convert or transient conversion to normal sinus rhythm, consider expedited transport.

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Treatment Protocol: NEWBORN / NEONATAL RESUSCITATION❶ **Ref. No. 1216-P**

Base Hospital Contact required for all newborn deliveries

1. Assist delivery; if amniotic sac intact and crown is presenting part, pinch sac and twist membrane to rupture and continue with delivery. Treat mother per *TP 1215-P, Childbirth (mother)*

2. Dry, warm and stimulate newborn by drying with towel ❶

3. Assess airway and initiate basic airway management *(MCG 1302; 1309)*
   Monitor Pulse oximetry on right hand of newborn ❷
   For airway obstruction suction prn; mouth first then nostrils ❸

4. Clamp and cut cord ❹

5. If newborn is vigorous, after drying and warming with a towel place on mother's chest skin-to-skin to ensure heat transfer to the newborn; cover mother and newborn with a blanket

6. Transport newborn and mother to same facility (EDAP and Perinatal Center)

7. Reassess every 30 sec the need for assisted ventilation or CPR intervention

8. Check pulse at the precordium (auscultation), the base of the umbilical cord or at the brachial artery

9. If further resuscitation required, initiate resuscitation on scene prior to transport

IF PULSE < 100bpm OR poor respiratory rate, effort, or persistent central cyanosis ❺

10. Perform BMV with room air for 90 secs, squeeze the bag just enough to see chest rise then release; state "squeeze, release" to avoid hyperventilation

11. Recheck pulse every 30 secs
    For persistent poor respiratory rate, effort or central cyanosis, add **high flow Oxygen 15L/min** to BMV
    Assess the need for chest compressions

12. Establish vascular access *(MCG 1375)*
    If unable to obtain peripheral vascular access, place IO; should not take precedence over emergency transport ❻

IF PULSE < 60bpm ❼

13. Begin BMV with high flow oxygen and chest compressions at a rate of 120/min, maintain 3:1 compression to ventilation ratio (90 compressions to 30 ventilations per minute); continue for 2 minutes before pulse check.
    - Consider supraglottic airway in infants 3 kg or greater, if BMV ineffective or cardiac arrest despite BMV, size per MCG 1309

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Treatment Protocol: NEWBORN / NEONATAL RESUSCITATION[1] **Ref. No. 1216-P**

14. **Epinephrine (0.1mg/1mL) 0.01 mg/kg IV/IO push** dose per *MCG 1309*
    May repeat every 5 min

15. **Normal Saline 20mL/kg IV/IO rapid infusion** per *MCG 1309*
    CONTACT BASE for persistent poor perfusion to obtain order for additional **Normal Saline 20mL/kg IV/IO** per *MCG 1309*

16. Once pulse is > 60bpm, chest compressions should be discontinued

17. Transport newborn and mother to the same facility which is an EDAP or PMC and Perinatal Center with a NICU [8]

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Treatment Protocol: NEWBORN / NEONATAL RESUSCITATION❶ Ref. No. 1216-P

SPECIAL CONSIDERATIONS

❶ This protocol is be used for the newly born only; infants otherwise within the first month of life use TP 1210-P Pediatric Cardiac Arrest. The most important intervention for a resuscitation of the newly born in the field is to "Dry, Warm and Stimulate" – this allows for reversal of apnea after delivery.

❷ "Dry, Warm, and Stimulate then you have to Ventilate" – If respiratory effort poor or HR <100bpm then Ventilate using BMV. The most important signs to monitor are respiratory effort, pulse oximetry and heart rate. Measuring the pulse oximetry on the right hand provides the most accurate oxygen saturation in infants that are transitioning from fetal to normal circulation. At 60 seconds, 60% is the target with an increase of 5% every minute until 5 minutes of life when pulse oximetry is 80-85%.

Time Since Birth	Projected Increase in Pulse Oximeter Over Time
1 minute	60-65%
2 minutes	65-70%
3 minutes	70-75%
4 minutes	75-80%
5 minutes	80-85%
10 minutes	85-90%

Assessments that are used to initiate BMV and chest compressions.

Heart Rate (bpm)	Respiratory Distress/Apnea	Central Cyanosis Present	Intervention
> 100	No	Yes	Blow-by Oxygen
---	Yes	Yes/No	BMV
60-100	-	-	BMV
<60	-	-	BMV; Chest compressions

❸ Suction prior to delivery is no longer recommended for presence of meconium (thick or thin). Suctioning should occur only if there is airway obstruction present and mouth should be suctioned first followed by the nose.

❹ Delay in clamping and cutting the cord for up 30 to 60 seconds is recommended unless the newborn needs immediate resuscitation.

❺ Assessing pulse at the base of the umbilical cord is preferred, pulse rate < 100bpm is a sign of newborn distress and requires BMV.

❻ In obtaining vascular access, place an IO in a newborn use light pressure as the bone cortices are soft and the needle can easily penetrate both cortices of the bone.

❼ Chest compression should be initiated in newborns with a pulse < 60bpm and continued until the pulse increases > 60bpm.

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Treatment Protocol: NEWBORN / NEONATAL RESUSCITATION❶ **Ref. No. 1216-P**

❽ Newborns requiring field resuscitation are at high risk for complications and will require critical care by neonatologists; consider stability of both patients for destination decisions (Mother and Newborn).

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Treatment Protocol: ALLERGY **Ref. No. 1219-P**

Base Hospital Contact: Required for anaphylaxis.

1. Assess airway and initiate basic airway maneuvers *(MCG 1302)*
   Continually assess patient's airway and ventilation status

2. Administer **Oxygen** prn *(MCG 1302)*
   High-flow Oxygen 15L/min for anaphylaxis with poor perfusion or airway compromise

3. Advanced airway prn *(MCG 1302)*

4. Initiate cardiac monitoring prn *(MCG 1308)*

5. For anaphylaxis:
   Epinephrine (1mg/mL) 0.01mg/kg IM, dose per *MCG 1309*, in the lateral thigh ❶
   CONTACT BASE: Repeat **Epinephrine (1mg/mL) 0.01mg/kg IM** every 10 min x2 prn persistent symptoms, maximum total 3 doses

6. Establish vascular access prn *(MCG 1375)*
   Vascular access for all patients with anaphylaxis

7. For poor perfusion:
   Normal Saline 20mL/kg IV rapid infusion per *MCG 1309*

8. For persistent poor perfusion after initial 5mL/kg Normal Saline (anaphylactic shock):
   Continue **Normal Saline 20mL/kg IV rapid infusion**
   Push-dose Epinephrine – mix 9mL Normal Saline with 1mL Epinephrine (0.1mg/mL) IV formulation in a 10mL syringe; administer **Push-dose Epinephrine (0.01mg/mL)**, dose per *MCG 1309* every 1-5 minutes as needed to maintain SBP > 70mmHg until hospital arrival

   CONTACT BASE concurrent with initial dose of **Push-dose Epinephrine**

   Treat in conjunction with *TP 1207-P, Shock/Hypotension*

9. If wheezing: ❷
   < 4 year of age: **Albuterol 2.5mg (3mL) via neb or 2 puffs via MDI** per *MCG 1309* ❸
   ≥ 4 year of age: **Albuterol 5mg (6mL) via neb or 4 puffs via MDI** per *MCG 1309* ❸
   Repeat x2 prn, maximum 3 total doses prior to Base contact

10. For itching/hives:
    Diphenhydramine (50mg/mL) 1mg/kg slow IV push one time, dose per *MCG 1309* ❹
    If unable to obtain venous access, **Diphenhydramine (50mg/mL) 1mg/kg deep IM**, dose per *MCG 1309*

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Treatment Protocol: ALLERGY **Ref. No. 1219-P**

SPECIAL CONSIDERATIONS

1. Epinephrine is the drug of choice for allergic reactions with any one of the following: angioedema, respiratory compromise or poor perfusion. It should be given IM into a large muscle group, lateral thigh preferred or alternatively the lateral gluteus. Vital signs vary by age and normal ranges can be found in *MCG 1309*. Any pediatric patient with vital signs outside the normal range for age should be considered potentially ill and transported to an EDAP or PMC if criteria are met.

2. Patients with wheezing due to allergic reaction should be treated with Epinephrine IM. Albuterol may be administered in addition to Epinephrine IM if wheezing persists.

3. Consider blow-by to avoid agitation in pediatric patients if a mask cannot be tolerated (e.g., infants and toddlers).

4. Diphenhydramine does not treat anaphylaxis. For patients in anaphylaxis, Epinephrine administration is the first priority. Diphenhydramine may be considered once other treatments are complete or in stable patients with discomfort for isolated hives.

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Treatment Protocol: SEIZURE **Ref. No. 1231-P**

Base Hospital Contact: Required for status epilepticus or pregnant patients

1. Assess airway and initiate basic and/or airway maneuvers prn *(MCG 1302)* ❶
2. Administer **Oxygen** prn *(MCG 1302)*
3. Assess for signs of trauma
   If traumatic injury suspected, treat in conjunction with *TP 1244-P, Traumatic Injury*
4. Initiate cardiac monitoring prn *(MCG 1308)*
5. Establish vascular access prn *(MCG 1375)*
6. If seizure stops spontaneously prior to EMS arrival and no seizure witnessed by EMS:
   Document Provider Impression – *Seizure - Post*
7. For active seizure witnessed by EMS: ❷❸
   Midazolam (5mg/mL) 0.1mg/kg IV/IO, dose per *MCG 1309* or
   Midazolam (5mg/mL) 0.2mg/kg IM/IN, dose per *MCG 1309*
   Repeat x1 in 2 min prn, maximum single dose 5mg, up to a total dose of 10mg prior to Base contact ❹

   CONTACT BASE for persistent seizure and for additional medication orders: ❺
   May repeat **Midazolam** as above, maximum total dose 15mg.

   Document Provider Impression – *Seizure – Active*, even if seizure spontaneously resolves
8. For persistent seizure or persistent ALOC:
   Check blood glucose
   If < 60mg/dL or > 250mg/dL, treat in conjunction with *TP 1203-P, Diabetic Emergencies*

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Treatment Protocol: SEIZURE **Ref. No. 1231-P**

SPECIAL CONSIDERATIONS

❶ Children with seizure may develop apnea; therefore, monitor oxygenation and ventilation including continuous pulse oximetry during seizure and after treatment with midazolam. Be prepared to initiate BMV.

❷ Active seizures, including febrile seizures, may include tonic and/or clonic activity or focal seizure with altered level of consciousness. Eye deviation, clenched jaw, lip smacking or focal twitching may be subtle signs of seizure.

❸ Seizures may occur as a result of underlying medical problems or toxic ingestions. Please make every effort to obtain a medical history and determine all medications/drugs that the patient may have taken.

❹ Midazolam onset is 2 minutes with maximum effect at 5 minutes.

❺ Vital signs vary by age and normal ranges can be found in *MCG 1309*. Any pediatric patient with vital signs outside the normal range for age should be considered potentially ill and transported to an EDAP or PMC if criteria are met. Pediatric patients who continue to seize after administration of midazolam should be transported to a PMC.

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Treatment Protocol: AIRWAY OBSTRUCTION **Ref. No. 1234-P**

Base Hospital Contact: Required for patients with severe respiratory distress and/or respiratory arrest.

1. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)* ❶ ❷

2. Administer **Oxygen** prn *(MCG 1302)*
   High flow Oxygen 15L/min for all patients with impending respiratory arrest/failure ❸

3. For airway obstruction due to foreign body:
   If patient unable to speak but is conscious, perform 5 abdominal thrusts or, if <1 year, alternate 5 back blows and 5 chest thrusts
   If patient becomes unconscious lower to ground and begin chest compressions

   If patient is unconscious, initiate CPR x 2 min
   Perform direct laryngoscopy to visualize potential obstruction when indicated
   Remove visible foreign body with Magill forceps

4. If patient has an Unmanageable Airway *(MCG 1302)*:
   Initiate immediate transport to EDAP and **CONTACT BASE** en route

5. Advanced airway prn for patients of appropriate age and size *(MCG 1302)*

6. Initiate cardiac monitoring *(MCG 1308)*

7. If patient is conscious and spontaneous ventilation is adequate:
   Monitor in position of comfort

8. Consider specific presentation:
   For suspected anaphylaxis treat per *TP 1219-P, Allergy*

   For stridor concerning for croup or tracheitis:
   <1 year old: **Epinephrine (1mg/mL) 2.5mL via neb**, dose per *MCG 1309* ❸
   ≥ 1 year of age: **Epinephrine (1mg/mL) 5mL via neb,** dose per *MCG 1309* ❸
   Repeat x1 in 10 min prn, maximum 2 total doses prior to Base contact
   Prepare to manage airway if patient's condition deteriorates

   For visible airway/tongue swelling:
   Epinephrine (1mg/mL) 0.01mg/kg IM dose per *MCG 1309*
   Repeat every 10 min prn x2, maximum 3 total doses prior to Base contact

   For patients with a tracheostomy and suspected obstruction: ❹
   Attempt suctioning

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Treatment Protocol: AIRWAY OBSTRUCTION **Ref. No. 1234-P**

Remove and clean inner cannula with saline; replace if positive-pressure ventilation required ❺
If obstruction is not relieved by above maneuvers:

For children ≥ 7 years of age consider placing a 6.0mm endotracheal tube in the stoma and attempt BMV ❻

For children < 7 years of age remove entire tracheostomy tube and cover stoma and attempt BMV first via the mouth. If no chest rise attempt BMV over stoma with a small mask.

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Treatment Protocol: AIRWAY OBSTRUCTION **Ref. No. 1234-P**

SPECIAL CONSIDERATIONS

❶ In evaluation of patient with suspected airway obstruction, assessment of the airway should include the tongue and posterior oropharynx, including uvula and tonsillar pillars.

❷ Supraglottic airway placement is contraindicated for patients with upper airway obstruction.

❸ Consider blow-by to avoid agitation in pediatric patients if a mask cannot be tolerated (e.g., infants and toddlers).

❹ Common tracheostomy emergencies include obstruction of the tracheostomy tube and bleeding. There are different types of tracheostomy tubes, some with an inner cannula and/or obturator. The obturator obstructs airflow and is usually only used during insertion. The inner cannula allows for connection to a ventilator or bag mask for positive pressure ventilation. Tracheostomy tubes may be cuffed (balloon inflated in the trachea as indicated by a side port) or uncuffed. If the tracheostomy does not have a cuff, the airway is not protected against aspiration and air can leak out through the mouth during positive-pressure ventilation. If respiratory failure occurs in a patient with an uncuffed tracheostomy tube, it should be replaced with a cuffed endotracheal tube (if the appropriate size is available) if feasible in order to facilitate positive-pressure ventilation. For bleeding, direct pressure should be applied and suctioning as needed to reduce aspiration of blood.

❺ The inner cannula is required to attach a ventilator or bag mask to a tracheostomy for positive-pressure ventilation. It may become obstructed with secretions; remove, clean with saline, and replace once obstruction is relieved. If it cannot be replaced, cover the stoma with gauze and begin BMV via the mouth. If no chest rise, place a small mask over the stoma and begin stoma-mask ventilation.

❻ Removal and reinsertion of the tracheostomy tube is contraindicated if the tracheostomy is < 1 week old because the stoma has not fully formed and a false tract may be created. Once the stoma has matured, a tracheostomy can be safely removed and replaced when necessary. If a flexible intubation guide (e.g., Bougie) can be inserted, it may be used to guide the removal and reinsertion of the tracheostomy or endotracheal tube.

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Treatment Protocol: Respiratory Distress **Ref. No. 1237-P**

Base Hospital Contact: Required for respiratory failure, severe respiratory distress or hypoxia and for patients < 1 year old with moderate respiratory distress

1. Use appropriate PPE ❶
2. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302; 1309)* ❷❸❹
3. Maintain patient in position of comfort❺
4. Administer **Oxygen** prn *(MCG 1302)* ❷
   High flow Oxygen 15 L/min for all patients with impending respiratory failure, suspected pneumothorax, inhalation injury, or carbon monoxide exposure
   Use **Oxygen** with caution in patients with known congenital heart disease
5. If patient with stridor or concern for airway obstruction, treat per *TP 1234-P, Airway Obstruction*
6. If anaphylaxis suspected, treat in conjunction with *TP 1219-P, Allergy*
7. Initiate cardiac monitoring prn *(MCG 1308)*
   For suspected dysrhythmia, perform 12-lead ECG and **CONTACT BASE**
   For patients with dysrhythmias, treat per *TP 1212-P, Cardiac Dysrhythmia - Bradycardia* or *TP 1213-P, Cardiac Dysrhythmia - Tachycardia* ❻
8. For bronchospasm, wheezing or asthma exacerbation:
   < 4 years of age: **Albuterol 2.5mg (3mL) via neb or 2 puffs via MDI** per *MCG 1309* ❼
   ≥ 4 years of age: **Albuterol 5mg (6mL) via neb or 4 puffs via MDI** per *MCG 1309* ❼❽
   May repeat x2 prn wheezing
   Document Provider Impression – *Respiratory Distress / Bronchospasm*
9. For deteriorating respiratory status despite albuterol:
   Epinephrine (1mg/mL) 0.01mg/kg IM, dose per *MCG 1309*
   Consider giving initially if wheezing with poor perfusion or severe respiratory distress ❾
   CONTACT BASE concurrent with **Epinephrine**
10. Establish vascular access prn *(MCG 1375)*
11. Initiate CPAP for alert patients with moderate or severe respiratory distress with length greater than the length-based resuscitation tape (e.g., Broselow Tape™) and SBP ≥ 90mmHg
    Hold CPAP for patients with suspected pneumothorax, upper airway edema/obstruction, or other contraindications *(MCG 1315)* ❿
12. For poor perfusion:
    Normal Saline 20mL/kg IV rapid infusion per *MCG 1309*

For patients with persistent poor perfusion, treat in conjunction with *TP 1207-P, Shock/Hypotension*

13. Consider etiology ⓫
    For bronchospasm, wheezing, bronchiolitis, or asthma exacerbation document Provider Impression – *Respiratory Distress / Bronchospasm*
    For other and unknown causes of respiratory distress document Provider Impression – *Respiratory Distress / Other*

14. If sepsis suspected, treat in conjunction with *TP 1204-P, Fever/Sepsis*

15. If accidental or intentional overdose or toxic exposure is suspected, treat in conjunction with *TP 1241-P, Overdose/Poisoning/Ingestion*

16. If inhalation injury suspected, treat in conjunction with *TP 1236-P, Inhalation Injury*

17. Perform needle thoracostomy for suspected tension pneumothorax *(MCG 1335)*

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SPECIAL CONSIDERATIONS

❶ Consider wearing surgical mask when caring for patients with respiratory distress of unclear etiology, which may be infectious.

❷ Patients with cyanotic congenital heart disease may be expected to have a measured SpO2 of 75-85%. Parents/caretakers may also know the patient's "normal" SpO2 range. It is important to ask caretakers and consider this possibility, as administration of Oxygen in these patients will worsen respiratory status.

❸ Bag-mask ventilation (BMV) with a viral filter is the preferred method of airway management for pediatric patients. Initiate BMV to assess patient response. Effective BMV may improve the patient's respiratory status enough to restore adequate spontaneous respirations. Place advanced airway placement if BMV is ineffective or consider placement once assessment for rapidly reversible causes is complete as authorized per *MCG 1302*; supraglottic airway (sizing per *MCG 1309*) is preferred unless contraindicated. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality for pediatric patients in whom multiple modalities are authorized.

❹ If positive pressure ventilation is performed at any time, document Provider Impression as *Respiratory Arrest / Respiratory Failure.*

❺ Fowler's or Semi-Fowler's positioning is likely to be most comfortable for awake patients with respiratory distress. Avoid agitating children with suspected partial foreign body obstruction and/or impending airway failure. Allow parents/caretakers to handle/facilitate patient if safe to do so.

❻ In pediatric patients with respiratory distress, bradycardia is likely to represent a pre-terminal event, ensure that oxygenation and ventilation is adequate; bradycardic dysrhythmia is persistent despite adequate oxygenation and ventilation before moving to *TP 1212-P, Cardiac Dysrhythmia – Bradycardia.* Respiratory rates vary by age and normal ranges can be found in *MCG 1309*.

❼ Consider blow-by to avoid agitation in pediatric patients if a mask cannot be tolerated (e.g., infants and toddlers).

❽ Administration of albuterol via a metered-dose inhaler (MDI) with spacer is considered equivalent to nebulized albuterol; a spacer is typically required for this route to be effective in novice users. MDIs are single use and should be left with the hospital staff upon handoff of the patient.

❾ Epinephrine may be administered prior to albuterol as initial drug therapy in patients with Respiratory Failure due to bronchospasm.

❿ Contraindications to CPAP include: ALOC with inability to follow commands or hold head up independently, active vomiting, facial trauma, or inability to protect airway. While CPAP may be used in pediatric patients, current ALS equipment does not support use of CPAP in pediatric patients who are not longer than the length-based resuscitation tape (e.g., Broselow Tape™).

⓫ Etiologies of respiratory distress in pediatrics are varied; etiologies may include the following:
- Bronchospasm due to asthma, bronchiolitis, reactive airway disease or viral illness –

document Provider Impression as *Respiratory Distress / Bronchospasm*

- Pneumonia or Upper Respiratory Illness – document Provider Impression as *Respiratory Distress / Other*
- Croup or Bacterial Tracheitis – document Provider Impression as *Airway Obstruction*
- Spontaneous pneumothorax – document Provider Impression as *Respiratory Distress / Other*
- Acute Chest Syndrome in patients with Sickle Cell Disease – document Provider Impression as *Chest Pain – Not Cardiac.* For patients with history of Sickle Cell Disease presenting with chest pain, respiratory distress, and hypoxia, treat in conjunction with *TP 1202-P, General Medical.*

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Treatment Protocol: OVERDOSE / POISONING / INGESTION **Ref. No. 1241-P**

1. Assess airway and initiate basic and/or advanced airway maneuvers prn (MCG 1302)

2. Administer **Oxygen** prn *(MCG 1302)*

3. Establish vascular access prn *(MCG 1375)* ❶

4. For suspected opioid overdose with altered mental status and hypoventilation/apnea:
   Naloxone (1mg/mL) 0.1mg/kg IM/IN/IV, dose per *MCG 1309* ❶
   Maximum dose all routes 8 mg
   Titrate to adequate respiratory rate and tidal volume

5. If partial response to Naloxone and strong suspicion for opioid overdose:
   CONTACT BASE for additional doses of **Naloxone**

6. For respiratory distress, treat in conjunction with *TP 1237-P, Respiratory Distress*

7. Initiate cardiac monitoring prn *(MCG 1308)*
   For suspected cardiac ischemia or dysrhythmia, perform 12-lead ECG and **CONTACT BASE**
   For patients with dysrhythmias, treat in conjunction with *TP 1212-P, Cardiac Dysrhythmia - Bradycardia* or *TP 1213-P, Cardiac Dysrhythmia - Tachycardia*

8. Evaluate for other causes of altered level of consciousness *(MCG 1320)*

9. Assess for signs of trauma
   If traumatic injury suspected, treat in conjunction with *TP 1244-P, Traumatic Injury*

10. Check blood glucose
    If < 60mg/dL or > 250mg/dL, treat in conjunction with *TP 1203-P, Diabetic Emergencies*

11. For alcohol intoxication, document Provider Impression – *Alcohol Intoxication*
    For other intoxications, including overdose or ill affects of prescription medications and illicit substances, document Provider Impression – *Overdose/Poisoning/Ingestion*

12. For poor perfusion: ❷
    Normal Saline 20mL/kg IV rapid infusion per *MCG 1309*
    For persistent poor perfusion, treat in conjunction with *TP 1207-P, Shock/Hypotension*

13. **CONTACT BASE** to discuss antidote administration

    Calcium channel blocker overdose: **Calcium chloride (100mg/mL) 20mg/kg slow IV push**, dose per *MCG 1309* ❸
    Tricyclic antidepressant overdose: **Sodium bicarbonate (1mEq/mL) 1mEq/kg slow IV push**, dose per *MCG 1309* ❹

14. Assess for co-ingestion of other substances

15. Consider contacting the Poison Control Center (1-800-222-1222) in conjunction with Base for

assistance with identification and management of unknown medications/toxins *(Ref. 805)*

16. Bring containers of ingested substances to the emergency department with patient

17. If patient refuses treatment or transport, **CONTACT BASE**
    Patient/parent must demonstrate decision-making capacity (*Ref. 834*)
    If EMS personnel or Base Hospital determines it is necessary to transport the patient against their will and/or the will of the parent, contact law enforcement for assistance ❷

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Treatment Protocol: OVERDOSE / POISONING / INGESTION **Ref. No. 1241-P**

SPECIAL CONSIDERATIONS

❶ The first priority for apneic patients after narcotic overdose is to begin positive pressure ventilation. Once ventilations are established, naloxone should be administered with the goal of restoring spontaneous ventilations. Vascular access should not take priority over initial treatment with Naloxone (IN or IM) for patients with suspected opiate overdose. Patients who are awake and alert with normal respirations after naloxone therapy may not require IV access or additional doses of naloxone.

❷ EMS Personnel are mandated reporters of child abuse and neglect. Communicate concerns about child abuse and/or neglect to accepting ED staff when home suggests children could be at risk for harm (e.g., unkempt home, evidence of drug or alcohol abuse, unsafe living conditions, known or suspected domestic violence), when the history does not match with the severity of physical findings (e.g., child posturing after a roll off the couch), when patterned injury or burns or noted (e.g., circular burns as from a cigarette, whip marks on the skin, burns of both hands or feet), or when child reports physical or sexual abuse. Children < 3 years of age and those with developmental delay are at increased risk of abuse. This must also be accompanied by notification to Department of Children and Family Services.

❸ Signs of calcium channel overdose include bradycardia along with hypotension and hyperglycemia. Consider when the patient is taking or has access to a calcium channel blocker medication. Ask about potential exposures including medications in the home.

❹ ECG findings consistent with tricyclic overdose include wide QRS (>0.12mm) and terminal R in aVR. Consider when the patient is taking or has access to a tricyclic medication. Ask about potential exposures including medications in the home.

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Treatment Protocol: TRAUMATIC ARREST **Ref. No. 1243-P**

Base Hospital Contact: Contact the Trauma Center for patients not meeting criteria for determination of death per *Ref 814*. ❶

1. Prioritize rapid transport for patients who do not meet *Ref. 814* ❷
2. Immediately control major bleeding *(MCG 1370)*
   Apply tourniquet prn
3. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302; 1309)* ❸
   Ventilate with **high flow Oxygen 15L/min**
4. Begin chest compressions ❹
5. Perform bilateral needle thoracostomy for suspected tension pneumothorax *(MCG 1335)*
6. Initiate cardiac monitoring *(MCG 1308)*
   Assess cardiac rhythm
7. If shockable rhythm (V-Fib/V-Tach) identified:
   Defibrillate V-Fib/V-Tach, dose per *MCG 1309*

   For blunt trauma: ❺
   Initiate resuscitation on scene
   If organized rhythm is not restored after defibrillation x3 or patient converts to nonshockable rhythm
   CONTACT BASE for guidance on continued resuscitation or transport

   For penetrating trauma: ❻
   Defibrillate while prioritizing immediate transport
8. Provide spinal motion restriction (SMR) if indicated *(MCG 1360)*
   Do not delay transport for SMR ❼
9. Establish vascular access en route *(MCG 1375)*
   Establish IO if unable to establish IV access
10. **Normal Saline 20mL/kg IV/IO rapid infusion** per *MCG 1309* x2**,** maximum 2L
    Administer through two sites simultaneously if possible

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SPECIAL CONSIDERATIONS

❶ EMS Personnel are mandated reporters of child abuse and neglect, and a report should be made when suspected as per *Ref. 822*. Communicate suspicion for child abuse and/or neglect to accepting ED staff when home suggests children could be at risk for harm (e.g., unkept home, evidence of drug or alcohol abuse, unsafe living conditions, known or suspected domestic violence), when the history does not match with the severity of physical findings (e.g., child posturing after a roll off the couch), when patterned injury or burns or noted (e.g., circular burns as from a cigarette, whip marks on the skin, burns of both hands or feet), or when child reports physical or sexual abuse. Children < 3 years of age and those with developmental delay are at increased risk of abuse. This must also be accompanied by notification to the Department of Children and Family Services (DCFS).

❷ Rapid transport after hemorrhage control is the priority for all patients with severe trauma. With the exception of hemorrhage control, needle thoracostomy, and initiation of CPR, all other procedures may be deferred for immediate ambulance loading of patient and performed en route.

❸ Bag-mask ventilation (BMV) with a viral filter is the preferred initial method of airway management. An advanced airway may be placed during transport or if BMV is difficult or ineffective as authorized per *MCG 1302*; supraglottic airway (sizing per MCG 1309) is preferred unless contraindicated. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality for pediatric patients in whom multiple modalities are authorized.

❹ Manual chest compressions are recommended; automated/mechanical chest compression devices should not be used in traumatic arrest.

❺ Sudden cardiac death can result from blunt cardiac injury (commotio cordis) triggering V-fib/V-tach. Unlike major trauma resulting in hemorrhagic shock, patients with this mechanism typically have **minimal external trauma** and should be treated with immediate defibrillation on scene. Patients with multisystem blunt trauma in persistent cardiac arrest without organized rhythm should generally not be transported. If commotio cordis is the suspected mechanism with minimal external trauma and the patient remains in V-fib/V-tach after three defibrillations, contact Base to discuss timing of transport versus termination for futility.

❻ Patients with penetrating trauma should receive defibrillation while still prioritizing early transport.

❼ For patients in traumatic arrest, spinal motion restriction (SMR) using a backboard causes harmful delays in care. However, a backboard may be helpful to assist in patient movement and to support chest compressions.

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Treatment Protocol: TRAUMATIC INJURY **Ref. No. 1244-P**

Base Hospital Contact: Required for patients who meet Trauma Center criteria or guidelines. ❶❷ Notify the receiving Pediatric Trauma Center as soon as possible for all patient transports.

1. Immediately control major bleeding *(MCG 1370)*
   Apply tourniquet prn

2. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302; 1309)* ❸

3. For traumatic arrest, treat per *TP 1243-P, Traumatic Arrest*

4. Provide spinal motion restriction (SMR) if indicated *(MCG 1360)*
   For alert patients, logroll patient off the backboard (if used during extrication) and onto gurney prior to transport ❹

5. Administer **Oxygen** prn *(MCG 1302)*
   High flow Oxygen 15L/min for all patients with shock or with suspected traumatic brain injury

6. If patient has an Unmanageable Airway: *(MCG 1302)*
   Initiate immediate transport to EDAP and **CONTACT BASE** en route

7. For anticipated prolonged extrication (> 30 minutes)
   Consider activating the Hospital Emergency Response Team (HERT), *Ref. 817*

8. For crush injury, treat in conjunction with *TP 1242, Crush Injury/Syndrome*

9. Initiate cardiac monitoring prn *(MCG 1308)*

10. Establish vascular access prn *(MCG 1375)*

11. Apply blanket to keep patient warm ❺

12. Consider medical condition preceding accident and refer to appropriate treatment protocol prn ❻

MULTI-SYSTEM TRAUMA

13. Perform needle thoracostomy for suspected tension pneumothorax *(MCG 1335)*

14. For an open or sucking chest wound, cover with a commercially available vented chest seal or vented (3-sided) occlusive dressing ❼

15. For poor perfusion with hypotension:
    Normal Saline 20mL/kg IV/IO rapid infusion per *MCG 1309* ❽
    CONTACT BASE to discuss further fluid resuscitation

16. Cover eviscerated organs with a moist non-adhering dressing

17. For pain management: refer to *MCG 1345, Pain Management*
    Dose per *MCG 1309*

18. For nausea or vomiting in patients ≥ 4 years old:
    Ondansetron 4mg ODT ❾

ISOLATED HEAD INJURY

19. Administer **high flow Oxygen 15L/min** ❿
    Continually assess patient's airway and ventilation status, assist prn ⓫

20. For SBP ≤ 70mmHg:
    Normal Saline 20mL/kg IV rapid infusion per *MCG 1309* to maintain SBP > 70mmHg ⓬
    CONTACT BASE for persistent poor perfusion to obtain order for additional **Normal Saline 20mL/kg IV**

21. For nausea or vomiting in patients ≥ 4 years old: ❾
    Ondansetron 4mg ODT

22. Transport with head of gurney elevated to 30 degrees when possible ⓭

23. If patient develops seizure activity, treat in conjunction with *TP 1231-P, Seizure*

24. For pain management: refer to *MCG 1345, Pain Management*
    Dose per *MCG 1309*

ISOLATED EXTREMITY INJURY

25. For pain management: refer to *MCG 1345, Pain Management*
    Dose per *MCG 1309*

26. For poor perfusion:
    Normal Saline 20mL/kg IV rapid infusion per *MCG 1309*
    CONTACT BASE for persistent poor perfusion to obtain order for additional **Normal Saline 20mL/kg IV**

27. Splint and dress injuries prn
    For distal extremity fractures with poor neurovascular status distal to injury – realign and stabilize extremity
    Mid-shaft femur – apply traction splint per manufacturer guidelines ⓮
    All other fractures/dislocations – splint in position of comfort

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SPECIAL CONSIDERATIONS

❶ EMS Personnel are mandated reporters of child abuse and neglect, and a report should be made when suspected as per *Ref. 822*. Communicate suspicion for child abuse and/or neglect to accepting ED staff when home suggests children could be at risk for harm (e.g., unkept home, evidence of drug or alcohol abuse, unsafe living conditions, known or suspected domestic violence), when the history does not match with the severity of physical findings (e.g., child posturing after a roll off the couch), when patterned injury or burns or noted (e.g., circular burns as from a cigarette, whip marks on the skin, burns of both hands or feet), or when child reports physical or sexual abuse. Children < 3 years of age and those with developmental delay are at increased risk of abuse. This must also be accompanied by notification to the Department of children and Family Services (DCFS).

❷ For patients requiring transport to a Pediatric Trauma Center per *Ref. 506*, which is also a Base Hospital, contact receiving Pediatric Trauma Center for Base Medical Direction and notification. If the Base Hospital is contacted and the Base redirects transport to a Pediatric Trauma Center, Base personnel will notify the Pediatric Trauma Center.

❸ Transport should be prioritized over advanced airway placement unless BMV is ineffective. Advanced airway may be placed during transport as authorized per *MCG 1302*; supraglottic airway (sizing per MCG 1309) is preferred unless contraindicated. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality for pediatric patients in whom multiple modalities are authorized.

❹ A backboard is not required for spinal motion restriction (SMR) and may cause harm as well as increased pain. Patients should not be transported on a backboard for the purpose of SMR. If a backboard is used for extrication, patients who are alert should then be logrolled onto the gurney prior to transport. The backboard may be used during patient transport for splinting of multiple simultaneous extremity fractures or to assist with maneuvering the unconscious patient. In all cases, the backboard should be removed immediately if causing respiratory compromise.

❺ Infants and small children are at high risk for hypothermia due to their large surface area to body mass ratio, reduced ability to shiver, and limited body fat.

❻ Traumatic events may be due to a medical emergency, e.g. seizure.

❼ Placement of a vented dressing can prevent conversion of an open pneumothorax to a tension pneumothorax. However, tension pneumothorax may still develop in the presence of a vented dressing and should be treated with needle thoracostomy. Furthermore, needle thoracostomy in a patient with evidence of tension pneumothorax should not be delayed for placement of dressing.

❽ Fluid resuscitation increases vascular pressure and dilutes clotting factors, which may increase internal bleeding. For patients at risk of internal hemorrhage, fluids should only be administered for SBP < 70mmHg **and** other signs of poor perfusion, titrated to maintain SBP ≥ 70mmHg. In patients with penetrating trauma, permissive hypotension (withholding fluids if patient has normal mental status) is preferred to reduce ongoing blood loss. Patients with ALOC or SBP < 70mmHg should receive fluids until their mental status and SBP improve. Permissive hypotension is contraindicated in patients with possible traumatic brain injury.

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❾ Vomiting should be prevented and/or immediately treated in patients with head injury, since it increases intra-cranial pressure and can compromise the patient's airway.

❿ **Any** hypoxic episode, even brief, is associated with worse patient outcome for patients with traumatic brain injury.

⓫ Hyperventilation reduces blood flow to the brain by reducing CO_2 and is associated with worse outcomes in severe head injuries. The exception to this is presence of elevated intra-cranial pressure (ICP) with signs of impending herniation (severe ALOC without motor response or with posturing and a unilateral 'blown pupil'). In this case, **mild** hyperventilation of approximately 20-30 breaths per minute, depending on the patient's age, should be used to maintain an $ETCO_2$ of 30-35mmHg. This mild hyperventilation reduces blood flow to the brain to decrease ICP until the patient receives definitive surgical care. For patients without elevated ICP, hyperventilation is harmful.

⓬ Any hypotension increases mortality in patients with traumatic brain injury. Normal Saline should be initiated to maintain SBP ≥ 70mmHg at all times but can be withheld if the blood pressure is normal. Although <70 mmHg is used as a generic cut-off for hypotension in pediatric patients the level of systolic blood pressure varies by age and those thresholds are found in *MCG 1309* and can be used in decisions for fluid resuscitation.

⓭ A head-elevated position at about 30 degrees reduces intra-cranial pressure and improves respiratory status. Reverse Trendelenburg is an option for patients that cannot be seated. Patients who are hypotensive should be maintained supine unless airway compromise requires repositioning.

⓮ Open femur fracture is not a contraindication to apply the traction splint. If the bone is protruding and there is gross contamination, wash with saline prior to applying the splint.

Medical Control Guideline: PEDIATRIC PATIENTS

DEFINITION: Pediatric patients in the prehospital setting are defined as children 14 years of age and younger or, in the case that the is age unknown, the patient can be measured on the length-based resuscitation tape (e.g., Broselow™).

PRINCIPLES:

1. Pediatric patients require special consideration in assessment, treatment and medication administration.

2. Pediatric assessment includes: pre-arrival preparation, scene size-up for hazards to patient or providers, assessment of scene for signs of child maltreatment, the Pediatric Assessment Triangle (PAT), vital signs, focused history using SAMPLE (signs and Symptoms, Allergies, Medications, Past Medical History, Last food or liquid intake, and Events leading to illness or injury), and a detailed physical exam as dictated by the patient's presenting signs and symptoms and condition.

3. PAT is composed of three components Appearance, Work of Breathing and Circulation to the Skin (Figure 1).

    a. The PAT is a "rapid Assessment Tool" that uses only visual and auditory clues and requires no equipment.

    b. The PAT is intended to allow the EMS provider to:
        i. Establish the child's severity of illness
        ii. Determine sick or not sick
        iii. Recognize the general category of pathophysiology called the "general impression"
        iv. Determine the urgency of interventions

    c. Appearance: Recalled by the mnemonic TICLS, an abnormality in any component:
        i. **T**one
        ii. **I**nteractiveness
        iii. **C**onsolability
        iv. **L**ook/Gaze
        v. **S**peech/Cry

    d. Work of Breathing: Presence of any of the following implies abnormal work of breathing.
        i. Stridor
        ii. Wheezing
        iii. Grunting
        iv. Tripod positioning
        v. Retractions
        vi. Nasal flaring
        vii. Apnea/Gasping

e. Circulation to the Skin: Presence of any of the following indicates abnormal circulation to the skin or signs of poor perfusion.
   i. Pale
   ii. Mottled
   iii. Cyanotic

f. Combining the PAT assessment based on these components can be used to determine the general impression (i.e., what, if anything, is critically wrong with the patient in terms of pathophysiology) which will dictate immediate management priorities (Figure 2):
   i. Stable
   ii. Respiratory distress
   iii. Respiratory failure
   iv. Shock
   v. CNS/Metabolic disorder
   vi. Cardiopulmonary failure/Cardiopulmonary Arrest

4. Treatments, medication concentrations and drug dosages are weight-specific for the pediatric patient.

5. Accurate pediatric drug doses are obtained by:

   a. Measuring the patient against a pediatric length-based resuscitation tape (e.g., Broselow Tape™) to obtain the weight/color zone, and then
   b. Referring to the *MCG 1309* Color Code Drug Doses for the medication doses appropriate to that weight/color zone.

6. Brief Resolved Unexplained Events (BRUE) is defined as a brief episode characterized by any of the following (for children 12 months of age or younger):

   a. Absent, decreased or irregular breathing
   b. Color change (usually cyanosis or pallor)
   c. Marked change in muscle tone (usually limpness or hypotonia, may also include hypertonia)
   d. Altered level of consciousness

GUIDELINES:

1. Assess using the PAT and initiate immediate treatment based on your general impression (Stable, Respiratory Distress, Respiratory Failure/Arrest, Shock, Center Nervous System Disorder/Metabolic Disorder, or Cardiopulmonary Failure/Arrest).

2. Determine your Provider Impression and continue treatment per the corresponding Treatment Protocol.

3. Document findings of the PAT, your assessment, and your Provider Impression.

4. Obtain the patient's estimated weight utilizing a pediatric length-based resuscitation tape and document the corresponding weight and color zone on the EMS Report Form.

5. Pediatric Airway Management:

   a. Bag Mask Ventilation (BMV) is the preferred method of airway management.
   b. Nasopharyngeal (NP) airway and oropharyngeal (OP) airway are approved airway adjuncts to facilitate BMV.
   c. i-gel is the approved supraglottic airway for pediatric patients in whom: BMV is difficult or ineffective; in respiratory arrest after BMV initiated; in cardiac arrest once resuscitation priorities have been met. Sizing per *MCG 1309.*
   d. Endotracheal Intubation (ETI) is approved for patients 12 years of age or greater, or longer than the length of the length-based resuscitation tape and should be utilized for these pediatric patients when there is a need for advanced airway and i-gel is contraindicated.

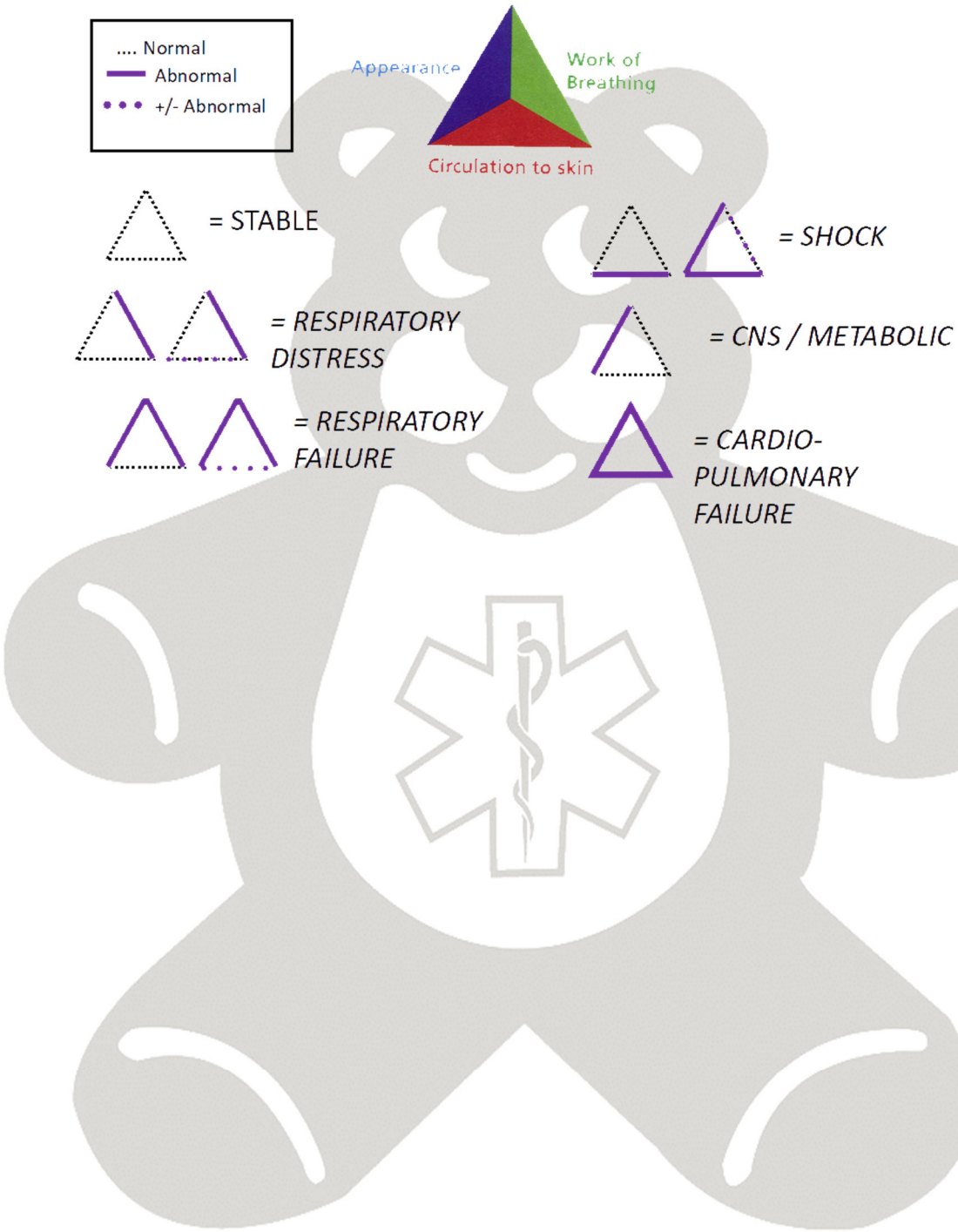
6. Pediatric Cardiopulmonary Resuscitation (CPR):

   a. Use Neonatal CPR for newborns up to 1 month of age
   b. Use Infant CPR for patients greater than one month of age to less than 13 months of age
   c. Use Child CPR for patients greater than or equal to 13 months of age to the onset of puberty

7. Automatic External Defibrillators (AED):
   Pediatric self-adhering pads or a pediatric attenuator system are recommended for infants and children younger than 8 years of age. When pediatric pads and/or a pediatric attenuator is not available, use adult AED and place front to back for infants and children

Figure 1: Pediatric Assessment Triangle

Figure 2: Using the components of the PAT to for a General Impression



A map of our current Trauma Centers is included for reference (Attachment A)

Changes since the previous plan was submitted and approved include:

- List of Designated Trauma Centers and Agreement Expiration Dates (Attachment B)
- Reference No. 504, Trauma Patient Destination – Revised 01-01-2023 (Attachment C)
- Reference No. 506, Trauma Triage – Revised 04-01-2023 (Attachment D)
- Reference No. 506.1, Trauma Triage Decision Scheme – Revised 04-01-2023 (Attachment E)
- Reference No. 1243, Treatment Protocol: Traumatic Arrest – Revised 07-01-2022 (Attachment F)
- Reference No. 1244, Treatment Protocol: Traumatic Injury – Revised 07-01-2022 (Attachment G)

Trauma Center Data Dictionary – The Trauma Center Data Dictionary (TDD) is updated annually to ensure continued compliance with the minimum data set and definitions of NTDS™ and ACS TQIP®. Due to its size, Reference No. 646, Trauma Center Data Dictionary 2023, is not included but is available upon request or on our Los Angeles County EMS Agency website. The Trauma Center Data Dictionary Summary of Changes 2023 is attached detailing the changes made. (Attachment H)

EmergiPress Topics included:

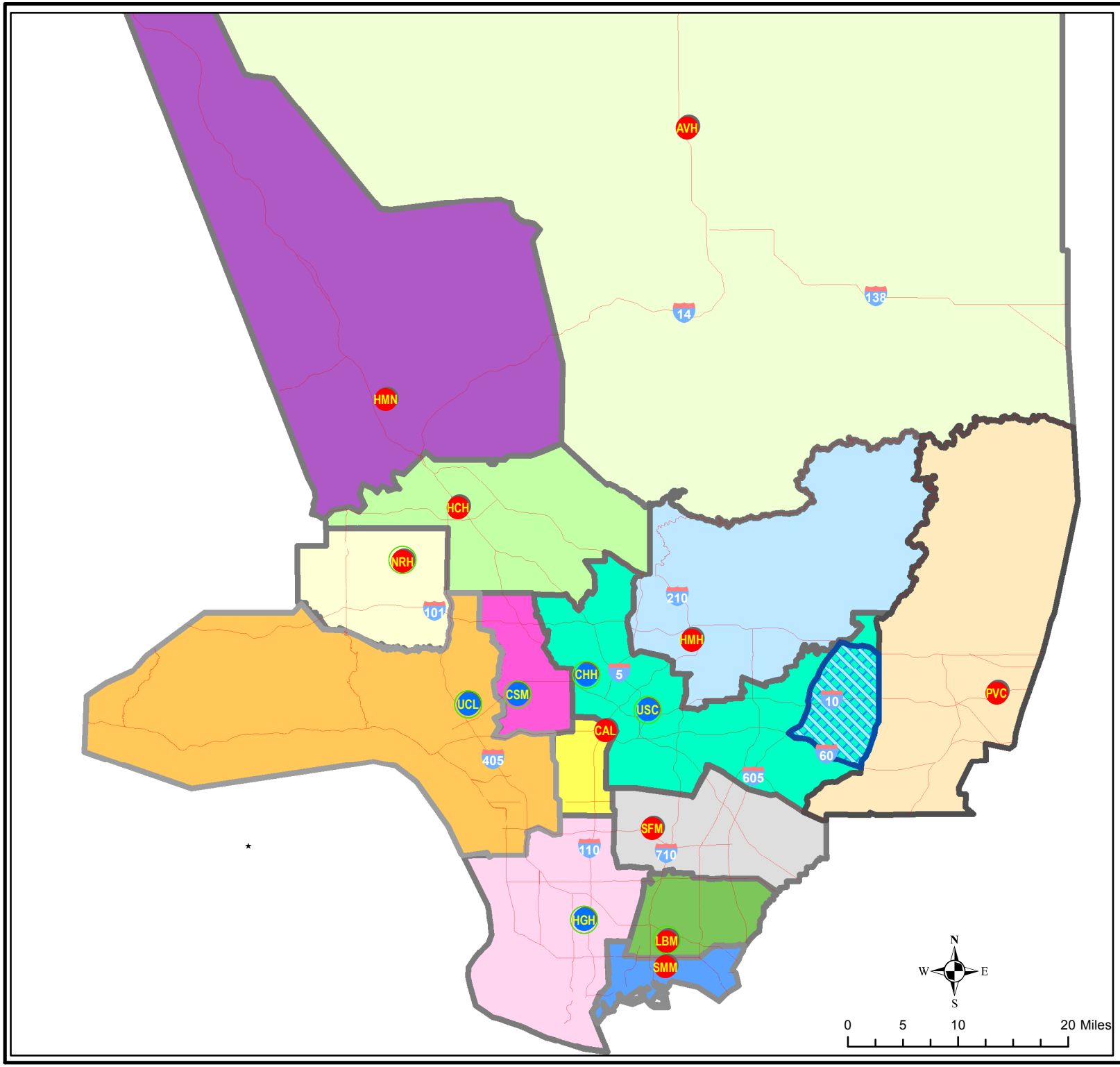
- Trauma triages updates

The Trauma Hospital Advisory Committee met on September 28, 2022, November 30, 2022, January 25, 2023, March 22, 2023, and May 24, 2023. Topics included:

- Trauma program updates
- TEMIS/THAC Data Subcommittee updates
- Quality Improvement/TQIP Subcommittee updates
- Association of Trauma Program Managers report
- American College of Surgeons Committee on Trauma report
- Southern California Trauma Consortium update
- Southwest Regional Trauma Coordinating Committee update
- State trauma regulation revision
- 9-1-1 Trauma Re-Triage
- Blood product administration
- Tranexamic acid
- National guideline field triage of injured patients
- ThoraSite pilot
- Needle thoracostomy study
- 911 EMS Provider Ebola Virus Disease Flow Chart
- Trauma Center performance metrics
- Monitoring of blood products for interfacility transfers

Los Angeles County utilizes Trauma Quality Improvement Program (TQIP) and our collaborative reports as the basis for our QI program. The Trauma QI Subcommittee meets quarterly to review TQIP reports and evaluate the need for system-wide QI indicators. Additionally, there are quarterly regional QI meetings where case reviews are presented and discussed.

Los Angeles County Trauma Centers



Trauma Centers As of 2017

Code	Name
AVH	Antelope Valley Hospital
CAL	California Hospital Medical Center
CHH	Children's Hospital Los Angeles
CSM	Cedars Sinai Medical Center
HCH	Providence Holy Cross Medical Center
HGH	LAC Harbor-UCLA Medical Center
HMH	Huntington Hospital
HMN	Henry Mayo Newhall Hospital
LBM	Long Beach Memorial Medical Center
NRH	Northridge Hospital Medical Center
PVC	Pomona Valley Hospital Medical Center
SFM	Saint Francis Medical Center
SMM	Saint Mary Medical Center
UCL	Ronald Reagan UCLA Medical Center
USC	LAC+USC Medical Center

TRAUMA012017

Trauma Centers

- LEVEL I/PTC
- LEVEL II
- LEVEL II/PTC
- PVC_USC_shared

TraumaAll_82417

List of Designated Trauma Centers as of June 30, 2023

TRAUMA CENTER	LEVEL	PTC	FISCAL YEAR FOR NEXT REVIEW
Antelope Valley Hospital	II		August 24, 2024
Cedars-Sinai Medical Center	I	X	July 2, 2025
Children's Hospital Los Angeles	I	X	May 9, 2024 *(provisional)*
Dignity Health – California Hospital Medical Center	II		May 16, 2024
Dignity Health – Northridge Hospital Medical Center	II	X	June 24, 2025
Dignity Health – Saint Mary Medical Center	II		November 9, 2023
Los Angeles General Medical Center	I	X	July 1, 2025
Harbor UCLA Medical Center	I	X	November 9, 2023
Henry Mayo Newhall Hospital	II		June 4, 2025
Huntington Hospital	II		November 9, 2024
MemorialCare Long Beach Medical Center	II	X	November 8, 2024
Pomona Valley Hospital	II		September 5, 2025
Providence Holy Cross Medical Center	II		May 15, 2024
Saint Francis Medical Center	II		May 20, 2026
Ronald Reagan UCLA Medical Center	I	X	June 12, 2026

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **TRAUMA PATIENT DESTINATION** REFERENCE NO. 504

PURPOSE: To determine the appropriate trauma patient destination with regards to the trauma center's catchment area.

AUTHORITY: California Administrative Code, Title 22, Chapter 7

DEFINITIONS:

Trauma Catchment Area: A geographical area surrounding a trauma center strictly defined by streets/freeways or other physical landmarks.

Trauma Patient: An injured patient that meets criteria and/or guidelines, or if in the provider's and/or base hospital's judgment it is in the patient's best interest to be transported to a trauma center.

PRINCIPLES:

A. Trauma patients that meet criteria, guidelines, or judgment should be transported to the designated trauma center or the designated pediatric trauma center.

B. Only the Department of Health Services may alter trauma catchment areas.

C. Patients from incident locations within the strictly defined area shall be transported to the designated trauma center.

D. To facilitate appropriate trauma team activation, direct contact with the anticipated receiving trauma center should be made whenever possible.

POLICY:

I. Responsibilities of the Paramedic:

A. Maintain current knowledge of trauma centers' catchment areas and which are pediatric trauma centers within their assigned area.

B. Paramedics shall contact their designated receiving trauma center on all injured patients meeting trauma triage criteria and/or guidelines or if in the provider's judgment it is in the patient's best interest to be transported to a trauma center. When the receiving trauma center is not a base hospital (only applies to Children's Hospital Los Angeles), paramedics shall contact their assigned base hospital.

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

II. The following table identifies trauma centers and pediatric trauma centers:

TRAUMA CENTERS	PEDIATRIC TRAUMA CENTERS
Antelope Valley Hospital	
California Hospital Medical Center	
Cedars-Sinai Medical Center	**X**
Children's Hospital Los Angeles	**X**
Henry Mayo Newhall Memorial Hospital	
Huntington Memorial Hospital	
LAC Harbor/UCLA Medical Center	**X**
LAC + USC Medical Center	**X**
Long Beach Memorial Medical Center	**X**
Northridge Hospital Medical Center	**X**
Pomona Valley Hospital Medical Center	
Providence Holy Cross Medical Center	
St. Francis Medical Center	
St. Mary Medical Center	
Ronald Reagan UCLA Medical Center	**X**

III. When the designated trauma center requests diversion to trauma, a trauma patient may be transported to:

A. The most accessible open trauma center; or

B. The designated trauma center, when the base hospital determines it is in the patient's best interest, despite the temporary request for trauma diversion.

IV. For multiple casualty incidents refer to Reference No. 519, Management of Multiple Casualty Incidents.

CROSS REFERENCES:

Prehospital Care Manual:
Reference No. 501, **Hospital Directory**
Reference No. 502, **Patient Destination**
Reference No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Reference No. 506, **Trauma Triage**
Reference No. 510, **Pediatric Patient Destination**
Reference No. 515, **Air Ambulance Trauma Transport**
Reference No. 519, **Management of Multiple Casualty Incidents**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **TRAUMA TRIAGE** REFERENCE NO. 506

PURPOSE: To establish criteria and standards which ensure that patients requiring the care of a trauma center are appropriately triaged and transported.

AUTHORITY: California Code of Regulations, Title 13, Section 1105(c) California Code of Regulations, Title 22, Section 100236 et seq. Health and Safety Code, Div. 2.5, Section 1797 et seq., and 1317.

PRINCIPLES:

1. Trauma patients should be secured and transported from the scene as quickly as possible, consistent with optimal trauma care.

2. Paramedics shall make base hospital contact to the receiving trauma center on all injured patients who meet trauma triage criteria and/or guidelines. Notification to the receiving trauma center shall be made whenever paramedic judgment determines transport to the trauma center is in the patient's best interest. Contact shall be accomplished in such a way as not to delay transport.

3. Do not delay transport of hypotensive patients with penetrating torso trauma in order to apply spinal motion restriction.

4. EMT personnel may immediately transport hypotensive patients with life-threatening, penetrating injuries to the torso to the closest trauma center, not the Most Accessible Receiving (MAR), when the transport time is less than the estimated time of paramedic arrival. The transporting unit should make every effort to contact the receiving trauma center.

5. When pediatric and adult trauma patients are transported together in one aircraft, the receiving trauma center shall be both a trauma center and a pediatric trauma center.

POLICY:

I. Trauma Criteria – Requires immediate transportation to a designated trauma center

Patients who fall into one or more of the following categories are to be transported directly to the designated trauma center, if transport time does not exceed 30 minutes.

A. Systolic blood pressure less than 90 mmHg, or less than 70 mmHg in infants age less than one year

B. Respiratory rate greater than 29 breaths/minute (sustained), less than 10 breaths/minute, less than 20 breaths/minute in infants age less than one year, or requiring ventilatory support

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Pavlo-Hill
Medical Director, EMS Agency

C. Cardiopulmonary arrest with penetrating torso trauma unless based upon the paramedic's thorough assessment is found apneic, pulseless, asystolic, and without pupillary reflexes upon arrival of EMS personnel at the scene

D. All penetrating injuries to head, neck, torso, and extremities proximal to the elbow or knee

E. Blunt head injury associated with a suspected skull fracture, altered level of consciousness (Glasgow Coma Score less than or equal to 14), seizures, unequal pupils, or focal neurological deficit

F. Injury to the spinal column associated with acute sensory or motor deficit

G. Blunt injury to chest with unstable chest wall (flail chest)

H. Diffuse abdominal tenderness

I. Suspected pelvic fracture (excluding isolated hip fracture from a ground level fall)

J. Extremity with:

1. Neurological/vascular compromise and/or crushed, degloved, or mangled extremity

2. Amputation proximal to the wrist or ankle

3. Fractures of two or more proximal (humerus/femur) long-bones

4. Bleeding not controlled by direct pressure requiring the usage of a hemorrhage control tourniquet or hemostatic agent (approved provider agencies only)

K. Fall from height > 10 feet (all patients)

L. Passenger space intrusion of greater than 12 inches into an occupied passenger space

M. Ejected from vehicles (partial or complete)

N. Auto versus pedestrian/bicyclist/motorcyclist thrown, run over, or with significant (greater than 20 mph) impact

O. Unenclosed transport crash with significant (greater than 20 mph) impact

P. Major / Critical Burn (excluding those in which the MAR is a recognized Burn Center, e.g., LAC+USC Medical Center, Torrance Memorial Medical Center, West Hills Hospital):

1. Patients 15 years of age or older with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 20% Total Body Surface Area (TBSA)

2. Patients ≤ 14 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 10% TBSA

II. Trauma Guidelines – Mechanism of injury and patient history are the most effective methods of selecting critically injured patients before unstable vital signs develop. Paramedics and base hospital personnel should consider mechanism of injury and patient history when determining patient destination. At the discretion of the base hospital, transportation to a trauma center is advisable for:

A. Passenger space intrusion of greater than 18 inches into any unoccupied passenger space

B. Automobile versus pedestrian/bicyclist/motorcyclist (impact equal to or less than 20 mph)

C. Injured victims of vehicular crashes in which a fatality occurred in the same vehicle

D. Patients requiring extrication

E. Vehicle telemetry data consistent with high risk of injury

F. Injured patients (excluding isolated minor extremity injuries):

1. on anticoagulation or antiplatelet therapy, other than aspirin-only

2. with bleeding disorders

III. Special Considerations – Consider transporting injured patients with the following to a trauma center:

A. Patients in blunt traumatic full arrest who, based on a paramedic's thorough patient assessment, was not found apneic, pulseless, and without organized ECG activity (narrow complex supraventricular rhythm) upon the arrival of EMS personnel at the scene

B. Systolic blood pressure less than 110 mmHg may represent shock after age 65 years

C. Heart rate greater than systolic blood pressure for ≥ 14 years of age

D. Child (0-9 years of age) unrestrained or in an unsecured child safety seat

E. Pregnancy greater than 20 weeks gestation

F. Prehospital judgment

IV. Extremis Patients - Requires immediate transportation to the MAR:

A. Patients with an obstructed airway or those with concern for imminent airway obstruction due to inhalation injury

B. Patients, as determined by the base hospital personnel, whose lives would be jeopardized by transportation to any destination but the MAR

V. When, for whatever reason, base hospital contact cannot be made, the destination decision for injured patients will be made by paramedics using the principles set forth above.

VI. 9-1-1 Trauma Re-Triage – This section applies to injured patients in emergency departments of non-trauma centers whose injuries were initially estimated by EMS to be less serious (under triaged) or patients who self-transported (walk-in) to a non-trauma center, and subsequently assessed by the non-trauma center physician to require immediate trauma center care. The referring facility shall utilize the procedure outlined below to expedite transfer arrangements and rapid transport to the trauma center. This process should be reserved for patients with life-threatening traumatic injuries requiring emergent surgical intervention.

A. Determine if the injured patient meets any of the following 9-1-1 Trauma Re-Triage criteria:

1. Persistent signs of poor perfusion

2. Need for immediate blood replacement therapy

3. Intubation required

4. Glasgow Coma Score less than 9

5. Glasgow Coma Score deteriorating by 2 or more points during observation

6. Penetrating injuries to head, neck and torso

7. Extremity injury with neurovascular compromise or loss of pulses

8. Patients, who in the judgement of the evaluating emergency physician, have high likelihood of requiring emergent life- or limb-saving intervention within two (2) hours.

B. Contact the designated receiving trauma center or pediatric trauma center if the patient is less than or equal to 14 years of age and transport does not exceed 30 min. Do not delay transfer by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

C. Contact 9-1-1 for transportation. The paramedic scope of practice (Ref. No. 803) does not include paralyzing agents and blood products.

D. Prepare patient and available medical records for immediate transport. Do not delay transport for medical records which could be sent at a later time.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506.1 **Trauma Triage Decision Scheme**
Ref. No. 506.2 **9-1-1 Trauma Re-Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 803, **Paramedic Scope of Practice**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGLES

REFERENCE No. 506.1 Trauma Triage Decision Scheme

Physiological Assessment

Systolic blood pressure (SBP): < 90 mmHg, or
< 70 mm Hg in infant < 1 yr.
Respiratory rate: > 29 breaths/minute (sustained),
< 10 breaths/minute,
< 20 breaths/minute in infant < 1 yr., or
requiring ventilatory support
Cardiopulmonary arrest with penetrating torso trauma

YES

Anatomical Injury Assessment

ALL penetrating injuries to head, neck, torso, and extremities above the elbow or knee
Blunt head injury associated with: suspected skull fracture, GCS ≤ 14, seizures, unequal pupils, or focal neurological deficit Spinal injury associated with acute sensory or motor deficit
Blunt chest injury with unstable chest wall (flail chest)
Diffuse abdominal tenderness
Suspected pelvic fracture (excluding isolated hip fracture from a ground level fall)
Extremity with: neuro/vascular compromise and/or crushed, degloved or mangled;
amputation proximal to the wrist or ankle; or
fractures of ≥ 2 proximal (humerus/femur) long-bones
bleeding requiring tourniquet or hemostatic agent
Major/Critical Burns: ≥15 years with 2nd or 3rd degree burns ≥ 20% TBSA
≤ 14 years with 2nd or 3rd degree burns ≥ 10% TBSA

YES

Mechanism of Injury Assessment

Falls: All patients > 10 feet
Passenger Space Intrusion: > 12 inches into an occupied passenger space
Ejected from vehicle (partial or complete)
Auto v. pedestrian/bicyclist/motorcyclist thrown, run over, or impact > 20 mph
Unenclosed transport crash with significant impact (> 20 mph)

YES → **Contact Base/Trauma Center, Immediate transport to designated Trauma Center**

Trauma Guidelines Assessment

Passenger Space Intrusion > 18 inches into an unoccupied passenger space
Auto versus pedestrian/bicyclist/motorcyclist (impact ≤ 20 mph)
Injured victims of vehicle crashes with a fatality in the same vehicle
Patients requiring extrication
Vehicle telemetry data consistent with high risk of injury
Injured patients (excluding isolated minor extremity injuries): on anticoagulation therapy other than aspirin-only; or with bleeding disorders

YES → **Consult with Trauma Center/Base Hospital, transport to designated Trauma Center is advisable**

Special Considerations Assessment

Blunt traumatic full arrest
SBP < 110 mmHg may represent shock after age 65 years
HR > SBP for age ≥ 14 years
Child (0-9 Yrs.) unrestrained or in an unsecured child safety seat
Pregnancy > 20 weeks
Prehospital judgement

YES → **Consider transport to designated Trauma Center**

EFFECTIVE: 05-01-12
REVISED: 04-01-23
SUPERSEDES: 04-01-22

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: TRAUMATIC ARREST **Ref. No. 1243**

Base Hospital Contact: Contact the Trauma Center for patients not meeting criteria for determination of death per *Ref 814*.

1. Prioritize rapid transport for patients who do not meet *Ref. 814* ❶

2. Immediately control major bleeding *(MCG 1370)*
   Apply tourniquet prn

3. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)* ❷
   Ventilate with **high flow Oxygen 15 L/min**

4. Begin chest compressions ❸

5. Perform bilateral needle thoracostomy for suspected tension pneumothorax *(MCG 1335)*

6. Initiate cardiac monitoring *(MCG 1308)*
   Assess cardiac rhythm

7. If shockable rhythm (V-Fib/V-Tach) identified:
   Defibrillate V-Fib/V-Tach at 200J or per manufacturer's instructions

   For blunt trauma: ❹
   Initiate resuscitation on scene
   If organized rhythm is not restored after defibrillation x3 or patient converts to nonshockable rhythm, refer to *Ref. No. 814* for determination of death
   CONTACT BASE if needed for guidance on continued resuscitation or transport

   For penetrating trauma: ❺
   Defibrillate while prioritizing immediate transport

8. Provide spinal motion restriction (SMR) if indicated *(MCG 1360)*
   Do not delay transport for SMR ❻

9. Establish vascular access en route *(MCG 1375)*
   Two large bore IV catheters (16 or 18 gauge) preferred
   Establish IO if unable to establish IV access

10. **Normal Saline 2L IV/IO rapid infusion**
    Administer through two sites simultaneously if possible

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: TRAUMATIC ARREST **Ref. No. 1243**

SPECIAL CONSIDERATIONS

❶ Rapid transport after hemorrhage control is the priority for all patients with severe trauma. With the exception of hemorrhage control, needle thoracostomy, and initiation of CPR, all other procedures may be deferred for immediate ambulance loading of patient and performed en route.

❷ Bag-mask ventilation (BMV) with a viral filter is the preferred initial method of airway management. An advanced airway may be placed during transport or if BMV is difficult or ineffective. Supraglottic airway is preferred unless contraindicated. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality.

❸ Manual chest compressions are recommended; automated/mechanical chest compression devices should not be used in traumatic arrest.

❹ Sudden cardiac death can result from blunt cardiac injury (commotio cordis) triggering V-fib/V-tach. Unlike major trauma resulting in hemorrhagic shock, patients with this mechanism typically have **minimal external trauma** and should be treated with immediate defibrillation on scene. Patients with multisystem blunt trauma in persistent cardiac arrest without organized rhythm should generally not be transported. If commotio cordis is the suspected mechanism with minimal external trauma and the patient remains in V-fib/V-tach after three defibrillations, contact Base to discuss timing of transport versus termination for futility.

❺ Patients with penetrating trauma should receive defibrillation while still prioritizing early transport.

❻ For patients in traumatic arrest, spinal motion restriction (SMR) using a backboard causes harmful delays in care. However, a backboard may be helpful to assist in patient movement and to support chest compressions.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: TRAUMATIC INJURY **Ref. No. 1244**

Base Hospital Contact: Required for patients who meet Trauma Center criteria or guidelines. ❶ Notify the receiving Trauma Center as soon as possible for all patient transports.

1. Immediately control major bleeding *(MCG 1370)*
   Apply tourniquet prn

2. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)* ❷

3. For traumatic arrest, treat per *TP 1243, Traumatic Arrest*

4. Provide spinal motion restriction (SMR) if indicated *(MCG 1360)*
   For alert patients, logroll off the backboard (if used during extrication) and onto gurney prior to transport ❸

5. Administer **Oxygen** prn *(MCG 1302)*
   High flow Oxygen 15 L/min for all patients with shock or with suspected traumatic brain injury

6. If patient has an Unmanageable Airway *(MCG 1302)***:**
   Initiate immediate transport to MAR and **CONTACT BASE** en route

7. For anticipated prolonged extrication (> 30 minutes)
   Consider activating the Hospital Emergency Response Team (HERT), *Ref. 817*

8. For crush injury, treat in conjunction with *TP 1242, Crush Injury/Syndrome*

9. Initiate cardiac monitoring prn *(MCG 1308)*

10. Establish vascular access prn *(MCG 1375)*

11. Apply blanket to keep patient warm

12. Consider medical condition preceding accident and refer to appropriate treatment protocol prn ❹

MULTI-SYSTEM TRAUMA

13. Perform needle thoracostomy for suspected tension pneumothorax *(MCG 1335)*

14. For an open or sucking chest wound, cover with a commercially available vented chest seal or vented (3-sided) occlusive dressing ❺

15. For poor perfusion with hypotension:
    Normal Saline 250mL IV/IO rapid infusion ❻
    CONTACT BASE to discuss further fluid resuscitation

16. Cover eviscerated organs with a moist non-adhering dressing

17. For pain management prn *(MCG 1345)*

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COUNTY OF LOS ANGELES

Fentanyl 50mcg (1mL) slow IV/IO push or IM/IN
Morphine 4mg (1mL) slow IV/IO push or IM

Ketorolac is contraindicated for multi-system trauma

CONTACT BASE for additional pain management:
May repeat as above up to maximum total dose Fentanyl 250mcg or Morphine 20mg

18. For nausea or vomiting: ❼
Ondansetron 4mg ODT/IV/IM, may repeat x1 in 15 min prn

ISOLATED HEAD INJURY

19. Administer **high flow Oxygen 15 L/min** for all patients with suspected traumatic brain injury ❽
Continually assess patient's airway and ventilation status, assist prn ❾

20. For SBP ≤ 90mmHg:
Normal Saline 1L IV/IO rapid infusion ❿
Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops
CONTACT BASE for persistent poor perfusion after **Normal Saline 1L**

21. For nausea or vomiting: ❼
Ondansetron 4mg ODT/IV/IM, may repeat x1 in 15 min prn

22. Transport with head of gurney elevated to 30 degrees when possible ⓫

23. If patient develops seizure activity, treat in conjunction with *TP 1231, Seizure*

24. For pain management prn *(MCG 1345)*

For an alert and oriented patient with GCS 15:
Fentanyl 50mcg (1mL) slow IV/IO push or IM/IN
Morphine 4mg (1mL) slow IV/IO push or IM

Ketorolac is contraindicated for head injury

CONTACT BASE for additional pain management or for initial orders if patient not alert and oriented with GCS 15
May provide or repeat as above up to maximum total dose Fentanyl 250mcg or Morphine 20mg

ISOLATED EXTREMITY INJURY

25. For pain management prn *(MCG 1345)*

26. For poor perfusion:
Normal Saline 1L IV/IO rapid infusion
Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

CONTACT BASE for persistent poor perfusion to obtain order for additional **Normal Saline 1L IV/IO**

27. Splint and dress injuries prn
    For distal extremity fractures with poor neurovascular status distal to injury – realign and stabilize extremity
    Mid-shaft femur – apply traction splint per manufacturer guidelines ⓬
    All other fractures/dislocations – splint in position of comfort
    For amputations – rinse off debris (do not manually debride), wrap with saline-moistened sterile gauze and ace wrap, then apply a splint for potential underlying fracture ⓭

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: TRAUMATIC INJURY **Ref. No. 1244**

SPECIAL CONSIDERATIONS

❶ For patients requiring transport to a Trauma Center per *Ref. 506*, contact the receiving Trauma Center for Base Medical Direction and notification. If the Base Hospital is contacted and the Base redirects transport to a Trauma Center, Base personnel will notify the Trauma Center.

❷ Transport should be prioritized over advanced airway placement unless BMV is ineffective. Advanced airway may be placed during transport; supraglottic airway is preferred unless contraindicated. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality.

❸ A backboard is not required for spinal motion restriction (SMR) and may cause harm as well as increased pain. Patients should not be transported on a backboard for the purpose of SMR. If a backboard is used for extrication, patients who are alert should then be logrolled onto the gurney prior to transport. The backboard may be used during patient transport for splinting of multiple simultaneous extremity fractures or to assist in maneuvering the unconscious patient. In all cases, the backboard should be removed immediately if causing respiratory compromise.

❹ Traumatic events may be due to a medical emergency, particularly single-vehicle accidents and unexplained falls.

❺ Placement of a vented dressing can prevent conversion of an open pneumothorax to a tension pneumothorax. However, tension pneumothorax may still develop in the presence of a vented dressing and should be treated with needle thoracostomy. Furthermore, needle thoracostomy in a patient with evidence of tension pneumothorax should not be delayed for placement of dressing.

❻ Aggressive fluid resuscitation increases vascular pressure and dilutes clotting factors, which may increase internal bleeding.
- In patients with blunt trauma and poor perfusion: administer fluids to target SBP ≥ 90mmHg.
- In patients with penetrating trauma and poor perfusion: administer fluids to target SBP ≥ 70mmHg if patient has normal mental status (permissive hypotension). Patients with ALOC or SBP < 70mmHg should receive fluids until their mental status and SBP improve.
- In patients with possible traumatic brain injury: permissive hypotension is contraindicated and SBP should be maintained ≥ 90mmHg.

❼ Vomiting should be prevented and/or immediately treated in patients with head injury, since it increases intra-cranial pressure and can compromise the patient's airway.

❽ Traumatic brain injury presents with altered mental status after head injury. Any hypoxic episode, even brief, is associated with worse patient outcome for patients with traumatic brain injury.

❾ Hyperventilation reduces blood flow to the brain by reducing CO_2 and is associated with worse outcomes in severe head injuries. The exception to this is presence of elevated intra-cranial pressure (ICP) with signs of impending herniation (severe ALOC without motor response or with posturing and a unilateral 'blown pupil'). In this case, **mild** hyperventilation of approximately 20 breaths per minute should be used to maintain an $ETCO_2$ of 30-35mmHg. This mild hyperventilation reduces blood flow to the brain to decrease ICP until the patient receives definitive surgical care. For patients without elevated ICP, hyperventilation is harmful.

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COUNTY OF LOS ANGELES

⑩ Any hypotension increases mortality in patients with traumatic brain injury. Normal Saline should be initiated to maintain SBP ≥ 90mmHg at all times but can be withheld if the blood pressure is normal.

⑪ A head-elevated position at about 30 degrees reduces intra-cranial pressure and improves respiratory status. Patients in a cervical collar may have their head elevated if there is no concern for thoracic or lumbar spine injury. Reverse Trendelenburg is another option for patients that cannot be seated. Patients who are hypotensive should be maintained supine unless airway compromise requires repositioning.

⑫ Open femur fracture is not a contraindication to apply the traction splint. If the bone is protruding and there is gross contamination, wash with saline prior to applying the splint.

⑬ If the amputated part is available, similar care should be taken to rinse off any gross debris, wrap the part with saline-moistened sterile gauze, seal in plastic and place indirectly on ice after wrapping; do not submerge in water or place directly on ice. Transport the amputated part with the patient and leave it with hospital staff.

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

Trauma Hospital Advisory Committee

TRAUMA CENTER DATA DICTIONARY
SUMMARY OF CHANGES 2023

DATA ELEMENT	ISSUE / CONCERN / ACTION
GENERAL INFORMATION	
LAST NAME	**ADDED** the following to the DD in Additional Information**:** • If the patient's name contains a suffix (Jr., Sr., etc.), include at as part of and at the end of the last name.
TRANSFERRED FROM	**NAME CHANGE** to the following hospitals: • AMH USC Arcadia Hospital • GSH PIH Health Good Samaritan Hospital • PIH PIH Health Whittier Hospital • DCH PIH Health Downey Hospital **RETIRED** • LBC Community Hospital Long Beach
PREHOSPITAL	
PROVIDER	**ADDED** the following providers to Field Values: • HE Heart Ambulance Corporation • MD MedTrans, Inc. • ZM Solartricity dba Zoom Medical Transport • BA Burbank Airport Fire **ADDED** the following provider to the DD only: • MA Mauran Ambulance Service Inc.
MECHANISM OF INJURY	**REMOVED** the following from the DD in Field Values: • PS Passenger Space Intrusion (PSI) - Unspecified
PROTECTIVE DEVICES	**ADDED** the following to DD in Additional Information: • Verbiage, "Enter the values *"SB Seatbelt – Shoulder Belt"* and *"LB Seatbelt – Lap Belt"* if a lap belt only is not specified in the EMS record, base hospital form, audio recording, or ED record."

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td>FIELD INTUBATION?</td><td>CHANGED additional information in the DD to:
Includes endotracheal tube or i-gel® placement.</td></tr>
<tr><td colspan="2">EMERGENCY DEPARTMENT (ED)/HOSPITALS</td></tr>
<tr><td>PRIMARY TRAUMA SERVICE TYPE</td><td>ADDED the data element PRIMARY TRAUMA SERVICE TYPE, following data element ED EXIT TIME.

ADDED the following Field Values:

<table>
<tr><th colspan="2">LA COUNTY</th><th colspan="2">NTDS</th></tr>
<tr><td>A</td><td>Adult</td><td>1</td><td>Adult</td></tr>
<tr><td>P</td><td>Pediatric</td><td>2</td><td>Pediatric</td></tr>
</table>

ADDED associated Additional Information, Uses, Data Source Hierarchy, and Other Associated Elements.</td></tr>
<tr><td>HEIGHT</td><td>REMOVED the following from the DD in Definition:
Verbiage, “report within 24 hours of ED/hospital arrival.”
REMOVED the following for the DD in Additional Information:
“Enter a value “Not Documented” if the patient’s height was not provided within 24 hours of ED/hospital arrival.”</td></tr>
<tr><td>HEIGHT UNITS</td><td>REMOVED the following from the DD in Definition:
Verbiage, “report within 24 hours of ED/hospital arrival.”
REMOVED the following for the DD in Additional Information:
“Enter a value “Not Documented” if the patient’s height was not provided within 24 hours of ED/hospital arrival.”</td></tr>
<tr><td>CONSULTATION SERVICE</td><td>ADDED the following Field Value:
EHT Ethicist</td></tr>
<tr><td>1ST ANTIBIOTIC ADMINISTRATION DATE</td><td>CHANGED the definition in the DD in Additional Information to:
“Open fractures as defined by the Association of Advancement of Automotive Medicine Abbreviation Injury Scale (AIS) Coding Rules and Guidelines and includes all AIS code descriptors that contain “open”</td></tr>
</table>

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td></td><td>and all AIS extremity/limb code descriptors that contain “amputation”.</td></tr>
<tr><td>1ST ANTIBIOTIC ADMINISTRATION TIME</td><td>CHANGED the definition in the DD in Additional Information to:
“Open fractures as defined by the Association of Advancement of Automotive Medicine Abbreviation Injury Scale (AIS) Coding Rules and Guidelines and includes all AIS code descriptors that contain “open” and all AIS extremity/limb code descriptors that contain “amputation”.</td></tr>
<tr><td colspan="2">RADIOLOGY/LABORATORY</td></tr>
<tr><td>ETOH/TOXICOLOGY: Substance</td><td>ADDED the following Field Value:<table><tr><th>LA COUNTY</th><th colspan="2">NTDS</th></tr><tr><td>Ethanol (ETOH)</td><td colspan="2">Alcohol Screen</td></tr><tr><td>Toxicology Screen</td><td colspan="2">Drug Screen</td></tr><tr><td>• Fentanyl</td><td>8</td><td>Opioids (OPI)</td></tr></table></td></tr>
<tr><td colspan="2">INTENSIVE CARE UNIT (ICU)/ACUTE CARE</td></tr>
<tr><td>CONSULTATION SERVICE</td><td>ADDED the following Field Value:
EHT Ethicist</td></tr>
<tr><td colspan="2">POSTHOSPITAL</td></tr>
<tr><td>TRANSFERRED/ DISCHARGED TO</td><td>ADDED the following to DD in Additional Information:
Verbiage, “For patients that report their current place of residence as “homeless”, but are discharged to a home, e.g., family member’s home, enter “Home With” or “Home W/O”.</td></tr>
<tr><td>FACILITY NAME</td><td>NAME CHANGE to the following hospitals:
AMH USC Arcadia Hospital
GSH PIH Health Good Samaritan Hospital
PIH PIH Health Whittier Hospital
DCH PIH Health Downey Hospital
ADDED the following facility to Field Values under BURN CENTERS:
UCB UCI Medical Center (Burn Center)</td></tr>
</table>

DATA ELEMENT	ISSUE / CONCERN / ACTION
	RETIRED the following hospital: • LBC Community Hospital Long Beach
DISCHARGE CAPACITY	**ADDED** the following to the DD in Additional Information: • Verbiage, "The value of "T" for Temporary Handicap may be utilized for patients transferred to another acute care hospital for higher level of trauma care.".
CO-MORBID CONDITIONS	**ADDED** the following to Field Values: • Bipolar I/II Disorder • Major Depressive Disorder • Other Mental/Personality Disorders • Post-Traumatic Stress Disorder • Schizoaffective Disorder • Schizophrenia **RETIRED** the following Field Value: • Mental/Personality Disorder
UNPLANNED READMISSION	
READMIT TRANSFERRED/DISCHARGED TO	**ADDED** the following to DD in Additional Information: • Verbiage, "For patients that report their current place of residence as "homeless", but are discharged to a home, e.g., family member's home, enter "Home With" or "Home W/O".
READMIT TRANSFER TO	**NAME CHANGE** to the following hospitals: • AMH USC Arcadia Hospital • GSH PIH Health Good Samaritan Hospital • PIH PIH Health Whittier Hospital • DCH PIH Health Downey Hospital **RETIRED** the following hospital: • LBC Community Hospital Long Beach
APPENDIX 1: REFERENCE DOCUMENTS	
MECHANISM OF INJURY REFERENCE GUIDE	
TRANSPORTATION MECHANISMS OF INJURIES QUICK REFERENCE GUIDE	**REVISED** the definition to replace "ICD-9 defines a transport accident (E800 – E848)" with "ICD-10 defines a transport accident (V00-V99)".
APPENDIX 2: GLOSSARY OF TERMS	

DATA ELEMENT	ISSUE / CONCERN / ACTION
CO-MORBID *(PRE-EXISTING)* CONDITIONS	
Alcohol Use Disorder (Alcoholism)	**REVISED** the definition to include the following: "Only report on patients ≥15 years-of-age."
Bipolar I/II Disorder	**ADDED** *Bipolar I/II Disorder.* **ADDED** the definition to include the following: "A bipolar I/II disorder diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age."
Chronic Obstructive Pulmonary Disease (COPD)	**REVISED** the definition to include the following: "Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used but are now included within the COPD diagnosis. A diagnosis of COPD must be must be documented in the patient's medical record, present prior to injury, consistent with World Health Organization (WHO), 2019. Do not include patients whose only pulmonary disease is acute asthma, and patients with diffuse interstitial fibrosis or sarcoidosis. Only report on patients ≥15 years-of-age."
Cirrhosis	**REVISED** the definition to include the following: "Cirrhosis is the replacement of normal liver tissue with non-living scar tissue related to other liver disease. A diagnosis of cirrhosis or end-stage liver disease by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record. Documentation in the medical record may include CHILD and MELD scores that support evidence of cirrhosis."
Congenital Anomalies	**REVISED** the definition to include the following: "Documentation of a cardiac, pulmonary, body wall, CNS/spinal, gastrointestinal, renal, orthopedic, or metabolic congenital anomaly, present prior to injury. A diagnosis of a Congenital Anomaly must be documented in the patient's medical record. Only report on patients <15 years-of -age."
Dementia	**REVISED** the definition to include the following: "Brain diseases that cause a long term and often gradual decrease in the ability to think and remember such that a person's daily functioning is affected, present prior to injury. A diagnosis of Dementia including Alzheimer's, Lewy Body Dementia, frontotemporal dementia (Pick's Disease) and vascular dementia must be documented in the patient's medical record."

DATA ELEMENT	ISSUE / CONCERN / ACTION
Disseminated Cancer	**REVISED** the definition to include the following: "Patients who have cancer that has spread to one or more sites in addition to the primary site AND in the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. Another term describing disseminated cancer is "metastatic cancer"."
Drug (Substance) Use Disorder	**REVISED** the definition to include the following: "Only report on patients ≥15 years-of-age."
Major Depressive Disorder	**ADDED** *Major Depressive Disorder.* **ADDED** the definition to include the following: "A major depressive disorder diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age."
Mental/Personality Disorder	**RETIRED**
Other Mental/Personality Disorders	**ADDED** *Other Mental/Personality Disorders* **ADDED** the definition to include the following: A diagnosis of any of the following documented in the medical record: • Antisocial personality disorder • Avoidant personality disorder • Borderline personality disorder • Dependent personality disorder • Generalized anxiety disorder • Histrionic personality disorder • Narcissistic personality disorder • Obsessive-compulsive disorder • Obsessive-compulsive personality disorder • Panic disorder • Paranoid personality disorder • Schizotypal personality disorder The diagnosis must be present prior to injury. Only report on patients ≥15 years-of-age.
Peripheral Arterial Disease (PAD)	**REVISED** the definition to include the following: "Only report on patients ≥15 years-of-age."
Post-Traumatic Stress Disorder	**ADDED** *Post-Traumatic Stress Disorder.* **ADDED** the definition to include the following:

DATA ELEMENT	ISSUE / CONCERN / ACTION
	"A post-traumatic stress disorder diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age."
Prematurity	**REVISED** the definition to include the following: "Babies born before 37 weeks of pregnancy are completed. A diagnosis of prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient's medical record. Only report on patients <15 years-of-age."
Schizoaffective Disorder	**ADDED** *Schizoaffective Disorder.* **ADDED** the definition to include the following: "A schizoaffective disorder diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age."
Schizophrenia	**ADDED** *Schizophrenia.* **ADDED** definition to include the following: "A schizophrenia diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age."

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County Board of Supervisors

Hilda L. Solis
First District

Holly J. Mitchell
Second District

Lindsey P. Horvath
Third District

Janice K. Hahn
Fourth District

Kathryn Barger
Fifth District

Richard Tadeo, RN
Director

Nichole Bosson, MD, MPH
Medical Director

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

Tel: (562) 378-1500
Fax: (562) 941-5835

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

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

July 18, 2024

Roxanna Delao
EMS Plan Coordinator, EMS Systems Division
Emergency Medical Services Authority
11120 International Drive, Suite 200
Rancho Cordova, California 95670

Dear Ms. Delao:

LOS ANGELES COUNTY RESPONSE – EMS PLANS 2020-2023

In response to a request from the Emergency Medical Services Authority (EMSA) on June 24, 2024, the following addresses the outstanding items identified in EMS Plans for the years of 2020 through 2023.

Transportation

EMSA: The City of Vernon – can you please send the letter from the City and if possible, the contract?

Los Angeles County Response: *The City of Vernon has been a non-exclusive operating area for emergency ambulance transportation since it started contracting with the Los Angeles County Fire Department and will be included into the next RFP for Emergency Ambulance Transportation in 2027. See Exhibit I*

Trauma

EMSA: Your 2023 Trauma System Status Report (TSSR) needs goals and objectives added to it consistent with CCR Title 22 Chapter 7 Section 100253 and 100265. Additionally, a TSSR is needed for 2022 and 2021, or the 2023 TSSR updated to include the missing years.

Los Angeles County Response: *See Exhibits II, III, IV.*

Data

EMSA: 18 ALS providers have transports listed in your EMS Plan, but there are no records in CEMSIS for them.

Los Angeles County Response: *The 18 providers listed are non-911 responders, and conduct only interfacility transports; therefore, we do not collect data from these ambulance companies.*

Communications

EMSA: If utilizing an attestation to show compliance, the below regulations need to be added/referenced in your EMS Plan.

Title 22 Chapter 4 § 100170, Medical Control
The medical director of the LEMSA shall establish and maintain medical control in the following manner:

Communications (continued)

(b) Establish policies which provide for direct voice communication between a paramedic and a base hospital physician, authorized registered nurse, or MICN, as needed.

LA County Response: *Cited in Reference No. 1200.2, Base Contact Requirements (See Exhibit V).*

EMSA: (c)(2) Maintenance of records of communications between the service providers(s) and the base hospital through tape recordings and through emergency department communication logs sufficient to allow for medical control and CE of the paramedic.

LA County Response: *Cited in Reference No. 606, Documentation of Prehospital Care (See Exhibit VI).*

EMSA: ~Title 22 Ch.8 Article 5. § 100306, Space and Equipment
(d) Communications
(1) In accordance with authorizing EMS agency policies, all EMS aircraft shall have the capability of communicating with:
(A) Designated dispatch center(s).
(B) EMS ground units at the scene of an emergency.
(C) Designated base hospitals.
(D) Receiving hospitals.
(E) Other appropriate facilities or agencies.
(2) All EMS aircraft shall utilize appropriate radio frequencies for dispatch, routing, and coordination of flights. This excludes the use of Med Channel 1-8 and VMED28 /HEAR (155.340 MHz and 155.280 MHz) for these purposes.
(3) Radio equipment may be inspected to assure compliance with the requirements of the authorizing EMS agency.

LA County Response: *Cited in Reference No. 419, Prehospital EMS Aircraft Operations Documentation of Prehospital Care (See Exhibit VII).*

Disaster

EMSA: The plan needs to list ongoing efforts to meet HSC § 1797.152 and HSC § 1797.153 specifically, who will be designated as the MHOAC and their coordination with the RDMHC Program. To show statutory compliance you could update the disaster preparedness component of your EMS Plan and do the following:

LA County Response: *See Exhibit VIII.*

Manpower and Training

EMSA: We wanted to confirm what was submitted in the EMS Plan *or* what is currently in EMSA's CE database is accurate as they do not match.

LA County Response: *EMSA's CE database is accurate.*

If you have any questions regarding this response, please contact me at (562) 378-1610, or Natalie Greco, Prehospital Program Manager at (562) 378-1680.

Sincerely,

Christine Clare for

Richard Tadeo
Director

RT:ng

Attachments

c. Director, Emergency Medical Services Authority
Assistant Chief, EMS Systems Division, Emergency Medical Services Authority

Exhibit I

City of VERNON CALIFORNIA

July 2, 2024

Richard Tadeo, RN
Director
Los Angeles County Emergency Medical Services Agency
10200 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670

Re: Emergency Ambulance Service Agreement #65658

Dear Mr. Tadeo,

This correspondence is written in response to the Los Angeles County Emergency Medical Services Agency letter dated September 2, 2020 in which the City of Vernon was notified of its options pertaining to emergency ambulance transportation services.

Since Vernon's emergency medical and fire protection and rescue services were contracted with the Consolidated Fire Protection District of Los Angeles County (LACoFire) on October 21, 2020, the City has utilized the emergency ambulance transportation services facilitated through its agreement with LACoFire via Los Angeles County licensed ambulance providers.

Vernon has not entered into a separate agreement with an ambulance provider or maintained or operated its own City emergency ambulance transportation service since its transition to LACoFire. As such, Emergency Ambulance Service Agreement #65658 between the City of Vernon and the County of Los Angeles is no longer necessary and should be terminated. The City is aware that, upon agreement termination, it is forfeiting its exclusive operating area emergency ambulance transportation rights and that the County of Los Angeles will officially assume the responsibility of providing emergency ambulance transportation services.

Thank you for bringing this unresolved matter to the City's attention. Should you have any questions, please do not hesitate to contact Diana Figueroa at dfigueroa@cityofvernon.org.

Best regards,

Daniel Calleros

Daniel Calleros
Interim City Administrator

LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES AGENCY

TRAUMA SYSTEM STATUS REPORT

FISCAL YEAR 2020-2021

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Trauma System Goals & Objectives

Goals/Objectives	Action	Schedule	Outcome
Maintain a Trauma Registry in compliance with NTDS and ACS TQIP.	In collaboration with the THAC Data Subcommittee, the Los Angeles County EMS Agency continues to review and revise the Trauma Data Dictionary (TDD) to maintain compliance with the minimum data set and definitions of NTDS and ACS TQIP.	Annually	The TDD is revised and implemented annually. Summary of changes is attached for review as Attachment D
Validate compliance with ACS standards and the Los Angeles County Specialty Care Center Designation Exhibit for Trauma Center Designation.	Attend virtual ACS verification surveys. Review the Los Angeles County Specialty Care Center Designation Exhibit for Trauma Center Designation and Los Angeles County Policies pertaining to the Trauma Centers to verify compliance.	Ongoing	Trauma centers verified during FY 2020-2021: Providence Holy Cross Medical Center, Dignity Health – California Hospital Medical Center
Utilize TQIP Collaborative reports to identify opportunities for improvement at a system level, and evaluate the need for system-wide QI indicators	Facilitate regional QI meetings with trauma centers.	Quarterly	Trauma centers present notable morbidity and mortality cases to discuss lessons learned. TQIP Collaborative reports were reviewed. There are three regions with five trauma centers per region.

EMS Plan Update FY 20-21: Trauma System Plan Update

A map of our current Trauma Centers in included for reference (Attachment A)

Trauma System Volume Overview (Attachment B)

Annual System Blunt vs. Penetrating Trauma (Attachment C)

Changes since the previous plan was submitted and approved include:

- Reference No. 506, Trauma Triage- Revised 10-01-2020 Dates (Attachment D)
- Reference No. 506.2, 9-1-1 Trauma Re-Triage- Revised 07-01-2020 (Attachment E)
- Reference No. 515, Air Ambulance Trauma Transport- Revised 07-01-2021 (Attachment F)
- Reference No. 607, Electronic Data Submission- Revised 04-01-2021 (Attachment G)
- Reference No. 618, EMS Quality Improvement Program Committees- Revised 10-01-2020 (Attachment H)
- Reference No. 1242, Treatment Protocol- Crush Injury/Syndrome- Revised 07-01-2020 (Attachment I)
- Reference No. 1242-P, Treatment Protocol- Crush Injury/Syndrome – Pediatrics- Revised 07-01-2020 (Attachment J)
- Reference No. 1244, Treatment Protocol- Traumatic Injury- Revised 10-01-2020 (Attachment K)
- Reference No. 1244-P, Treatment Protocol- Traumatic Injury – Pediatrics- Revised 07-01-2020 (Attachment L)

Trauma Center Data Dictionary – The Trauma Center Data Dictionary (TDD) is updated annually to ensure continued compliance with the minimum data set and definitions of NTDS™ and ACS TQIP®. Due to its size, Reference No. 646, Trauma Center Data Dictionary 2021, is not included but is available upon request, or on our website. However, the Trauma Center Data Dictionary Summary of Changes 2021 detailing the changes made is attached. (Attachment M)

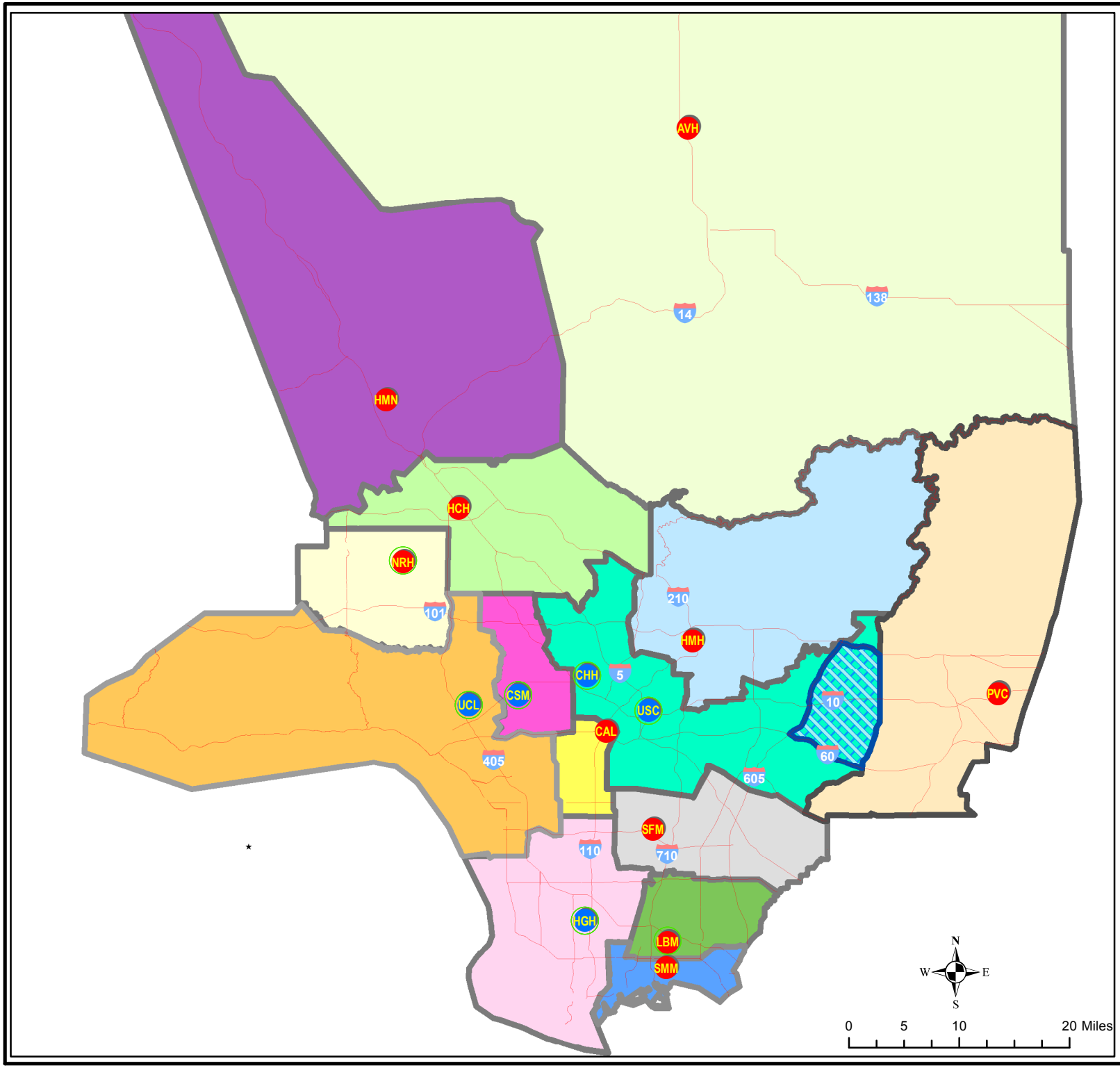
EMS Update and EmergiPress Topics included:

- Blast Injury
- Out of Hospital Cardiac Arrest –Traumatic
- Multi-System Trauma
- Commotio Cordis
- Trauma Evaluations/HERT Team
- Pain Management

Los Angeles County utilizes Trauma Quality Improvement Program (TQIP) and our collaborative reports as the basis for our QI program. The Trauma QI Subcommittee meets quarterly to review TQIP reports and evaluate the need for system-wide QI indicators. Additionally, there are quarterly regional QI meetings where case reviews are presented and discussed.

Attachment A

Los Angeles County Trauma Centers



Trauma Centers As of 2017

Code	Name
AVH	Antelope Valley Hospital
CAL	California Hospital Medical Center
CHH	Children's Hospital Los Angeles
CSM	Cedars Sinai Medical Center
HCH	Providence Holy Cross Medical Center
HGH	LAC Harbor-UCLA Medical Center
HMH	Huntington Hospital
HMN	Henry Mayo Newhall Hospital
LBM	Long Beach Memorial Medical Center
NRH	Northridge Hospital Medical Center
PVC	Pomona Valley Hospital Medical Center
SFM	Saint Francis Medical Center
SMM	Saint Mary Medical Center
UCL	Ronald Reagan UCLA Medical Center
USC	LAC+USC Medical Center

TRAUMA012017

Trauma Centers

- LEVEL I/PTC
- LEVEL II
- LEVEL II/PTC
- PVC_USC_shared

TraumaAll_82417

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Emergency Medical Services Agency

TRAUMA SYSTEM VOLUME

2000 – 2021

YEAR	NUMBER OF TRAUMA CENTERS	PATIENT VOLUME	VOLUME CHANGE	PERCENTAGE CHANGE
2000	13	16,912	1,259	8%
2001	13	18,837	1,925	11%
2002	13	19,196	359	2%
2003	13	18,150	1,046	6%
2004	14	17,134	1,016	6%
2005	13	17,680	546	3%
2006	13	18,632	952	6%
2007	13	19,481	849	5%
2008	13	19,188	293	2%
2009	13	19,173	15	0%
2010	14	19,121	52	0%
2011	14	20,242	121	6%
2012	14	23,855	3,613	16%
2013	14	25,743	1,888	8%
2014	14	26,874	1,311	5%
2015	14	28,822	1,948	7%
2016	14	26,243	2,579	9%
2017	15	23,332	2,911	12%
2018	15	22,542	790	3%
2019	15	22,348	194	0%
2020	15	22,349	1	0%

RED DENOTES DECREASE
BLUE DENOTES INCREASE

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BLUNT vs PENETRATING
2000 – 2020

YEAR	TOTAL VOLUME	BLUNT INJURIES	PERCENT BLUNT	PENETRATING INJURIES	PERCENT PENETRATING
2000	16,724	12,939	77%	3,785	23%
2001	18,824	14,854	79%	3,970	21%
2002	19,181	14,889	78%	4,292	22%
2003	18,150	14,034	77%	4,116	23%
2004	17,134	13,107	76%	4,020	23%
2005	17,680	13,367	76%	4,380	25%
2006	18,632	14,419	77%	4,205	23%
2007	19,481	15,513	80%	3,837	20%
2008	19,188	15,397	80%	3,788	20%
2009	19,173	15,703	82%	3,468	18%
2010	19,121	15,798	83%	3,314	17%
2011	20,242	17,009	84%	3,226	16%
2012	23,855	20,227	85%	3,628	15%
2013	25,743	22,085	86%	3,645	14%
2014	26,874	23,122	86%	3,720	14%
2015	28,822	24,560	85%	4,248	15%
2016	26,243	21,862	83%	4,376	17%
2017	23,332	19,242	82%	4,089	18%
2018	22,542	18,629	83%	3,878	17%
2019	22,348	18,486	83%	3,727	17%
2020	22,349	17,538	78%	4,574	20%

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **TRAUMA TRIAGE** REFERENCE NO. 506

PURPOSE: To establish criteria and standards which ensure that patients requiring the care of a trauma center are appropriately triaged and transported.

AUTHORITY: California Code of Regulations, Title 13, Section 1105(c) California Code of Regulations, Title 22, Section 100236 et seq. Health and Safety Code, Div. 2.5, Section 1797 et seq., and 1317.

PRINCIPLES:

1. Trauma patients should be secured and transported from the scene as quickly as possible, consistent with optimal trauma care.

2. Paramedics shall make base hospital contact and/or notification to the receiving trauma center on all injured patients who meet trauma triage criteria and/or guidelines, or if in the paramedic's judgment it is in the patient's best interest to be transported to a trauma center. Contact shall be accomplished in such a way as not to delay transport.

3. Do not delay transport of hypotensive patients with penetrating torso trauma in order to apply spinal motion restriction.

4. EMT personnel may immediately transport hypotensive patients with life-threatening, penetrating injuries to the torso to the closest trauma center, not the Most Accessible Receiving (MAR), when the transport time is less than the estimated time of paramedic arrival. The transporting unit should make every effort to contact the receiving trauma center.

5. When pediatric and adult trauma patients are transported together in one aircraft, the receiving trauma center shall be both a trauma center and a pediatric trauma center.

POLICY:

I. Trauma Criteria – Requires immediate transportation to a designated trauma center

Patients who fall into one or more of the following categories are to be transported directly to the designated trauma center, if transport time does not exceed 30 minutes.

A. Systolic blood pressure less than 90 mmHg, or less than 70 mmHg in infants age less than one year

B. Respiratory rate greater than 29 breaths/minute (sustained), less than 10 breaths/minute, less than 20 breaths/minute in infants age less than one year, or requiring ventilatory support

APPROVED: Cathy Chidester
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

C. Cardiopulmonary arrest with penetrating torso trauma unless based upon the paramedic's thorough assessment is found apneic, pulseless, asystolic, and without pupillary reflexes upon arrival of EMS personnel at the scene

D. All penetrating injuries to head, neck, torso, and extremities proximal to the elbow or knee

E. Blunt head injury associated with a suspected skull fracture, altered level of consciousness (Glasgow Coma Score less than or equal to 14), seizures, unequal pupils, or focal neurological deficit

F. Injury to the spinal column associated with acute sensory or motor deficit

G. Blunt injury to chest with unstable chest wall (flail chest)

H. Diffuse abdominal tenderness

I. Suspected pelvic fracture (excluding isolated hip fracture from a ground level fall)

J. Extremity with:

1. Neurological/vascular compromise and/or crushed, degloved, or mangled extremity

2. Amputation proximal to the wrist or ankle

3. Fractures of two or more proximal (humerus/femur) long-bones

4. Bleeding not controlled by direct pressure requiring the usage of a hemorrhage control tourniquet or hemostatic agent (approved provider agencies only)

K. Falls:

1. Adult patients from heights greater than 15 feet

2. Pediatric patients from heights greater than 10 feet, or greater than 3 times the height of the child

L. Passenger space intrusion of greater than 12 inches into an occupied passenger space

M. Ejected from vehicles (partial or complete)

N. Auto versus pedestrian/bicyclist/motorcyclist thrown, run over, or with significant (greater than 20 mph) impact

O. Unenclosed transport crash with significant (greater than 20 mph) impact

P. Major / Critical Burn (excluding those in which the MAR is a recognized Burn Center, e.g., LAC+USC Medical Center, Torrance Memorial Medical Center, West Hills Hospital):

1. Patients 15 years of age or older with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 20% Total Body Surface Area (TBSA)

2. Patients ≤ 14 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 10% TBSA

II. Trauma Guidelines – Mechanism of injury and patient history are the most effective methods of selecting critically injured patients before unstable vital signs develop. Paramedics and base hospital personnel should consider mechanism of injury and patient history when determining patient destination. At the discretion of the base hospital, transportation to a trauma center is advisable for:

A. Passenger space intrusion of greater than 18 inches into any unoccupied passenger space

B. Automobile versus pedestrian/bicyclist/motorcyclist (impact equal to or less than 20 mph)

C. Injured victims of vehicular crashes in which a fatality occurred in the same vehicle

D. Patients requiring extrication

E. Vehicle telemetry data consistent with high risk of injury

F. Injured patients (excluding isolated minor extremity injuries):

1. on anticoagulation or antiplatelet therapy, other than aspirin-only

2. with bleeding disorders

III. Special Considerations – Consider transporting injured patients with the following to a trauma center:

A. Patients in blunt traumatic full arrest who, based on a paramedic's thorough patient assessment, was not found apneic, pulseless, and without organized ECG activity (narrow complex supraventricular rhythm) upon the arrival of EMS personnel at the scene

B. Adults age greater than 55 years

C. Systolic blood pressure less than 110 mmHg may represent shock after age 65 years

D. Pregnancy greater than 20 weeks gestation

E. Prehospital judgment

IV. Extremis Patients - Requires immediate transportation to the MAR:

A. Patients with an obstructed airway or those with concern for imminent airway obstruction due to inhalation injury

B. Patients, as determined by the base hospital personnel, whose lives would be jeopardized by transportation to any destination but the MAR

V. When, for whatever reason, base hospital contact cannot be made, the destination decision for injured patients will be made by paramedics using the principles set forth above.

VI. 9-1-1 Trauma Re-Triage – This section applies to injured patients in emergency departments of non-trauma centers whose injuries were initially estimated by EMS to be less serious (under triaged) or patients who self-transported (walk-in) to a non-trauma center, and subsequently assessed by the non-trauma center physician to require immediate trauma center care. The referring facility shall utilize the procedure outlined below to expedite transfer arrangements and rapid transport to the trauma center. This process should be reserved for patients with life-threatening traumatic injuries requiring emergent surgical intervention.

A. Determine if the injured patient meets any of the following 9-1-1 Trauma Re-Triage criteria:

1. Persistent signs of poor perfusion

2. Need for immediate blood replacement therapy

3. Intubation required

4. Glasgow Coma Score less than 9

5. Glasgow Coma Score deteriorating by 2 or more points during observation

6. Penetrating injuries to head, neck and torso

7. Extremity injury with neurovascular compromise or loss of pulses

8. Patients, who in the judgement of the evaluating emergency physician, have high likelihood of requiring emergent life- or limb-saving intervention within two (2) hours.

B. Contact the designated receiving trauma center or pediatric trauma center if the patient is less than or equal to 14 years of age and transport does not exceed 30 min. Do not delay transfer by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

C. Contact 9-1-1 for transportation. The paramedic scope of practice (Ref. No. 803) does not include paralyzing agents and blood products.

D. Prepare patient and available medical records for immediate transport. Do not delay transport for medical records which could be sent at a later time.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506.1 **Trauma Triage Decision Scheme**
Ref. No. 506.2 **9-1-1 Trauma Re-Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 803, **Paramedic Scope of Practice**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(HOSPITAL, PARAMEDIC, MICN)

SUBJECT: **9-1-1 TRAUMA RE-TRIAGE**

REFERENCE NO. 506.2

STEP 1

Determine if patient meets 9-1-1 Trauma Re-triage Criteria:

Perfusion:
- Persistent signs of poor perfusion
- Need for immediate blood replacement therapy

Respiratory Criteria:
- Intubation required

GCS / Neurologic Criteria:
- GCS <9
- GCS deteriorating by 2 or more during observation

Anatomic Criteria:
- Penetrating injuries to head, neck, chest, or abdomen
- Extremity injury with neurovascular compromise or loss of pulses

Provider Judgment:
- Patients, who in the judgment of the evaluating emergency physician, have a high likelihood of requiring emergent life- or limb-saving intervention within 2 hours

STEP 2

Contact the designated Trauma Center for a *"9-1-1 Trauma Re-triage"*

Do NOT delay transport by initiating any diagnostic procedure that do not have direct impact on immediate resuscitative measures

Designated Trauma Center:
XXXXXXXXXXXXXXXX
Contact Number:
999.999.9999
Notify:
Transfer Center / Trauma Surgeon / Emergency Physician

STEP 3

Contact 9-1-1 for transportation

Standard Paramedic Scope does **NOT** include paralyzing agents, blood products.

STEP 4

Prepare patient, diagnostic imaging, and paperwork (to include initial EMS Report Form if applicable) for immediate transport

9-1-1 Trauma Re-triage: The movement of patients meeting specific high-acuity criteria from a non-trauma center to a trauma center for trauma care.

Trauma Transfer: The movement of other trauma patients to a trauma center that do not meet 9-1-1 Emergency Trauma Re-triage criteria.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **AIR AMBULANCE TRAUMA TRANSPORT** REFERENCE NO. 515

PURPOSE: To ensure that trauma patients are appropriately triaged to a designated trauma center when ground transport time to a designated trauma center is greater than thirty minutes.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 8, 100289.

PRINCIPLES:

1. Trauma patients should be transported to a designated trauma center as quickly as possible, consistent with optimal trauma care.

2. Appropriateness of EMS aircraft transport shall be determined by the primary EMS provider agency on scene. The first responder on scene should be responsible for the prompt request for dispatch of EMS aircraft.

POLICY:

I. Trauma patients shall be transported by air to an approved Los Angeles County trauma center with the following considerations:

   A. All patient destinations with respect to air safety factors shall be approved by the pilot in command.

   B. Trauma patients exhibiting an unmanageable airway or blunt trauma without cardiac activity (asystole or agonal rhythm) will continue to be transported to the most accessible receiving facility.

   C. Henry Mayo Newhall Memorial Hospital's northern catchment boundary is extended to Santiago Road for air ambulance trauma transports only.

   D. When pediatric and adult trauma patients are transported together in one aircraft, the receiving trauma center shall also be a pediatric trauma center.

II. Communications

   A. Base hospital contact with the anticipated receiving trauma center (except for Children's Hospital) shall be made on all trauma patients requiring air transport to an approved trauma center.

   B. In the event of communication failure with the base hospital, paramedics shall make every effort to contact the Medical Alert Center (MAC). MAC shall notify the receiving trauma center of the impending air ambulance transport.

III. Quality Improvement

APPROVED: Cathy Chidester
Director, EMS Agency

Marianne Gausche-Hill
Medical Director, EMS Agency

A. The EMS Agency, base hospitals, trauma centers, and provider agencies shall conduct regular review of all trauma related EMS aircraft responses.

B. Documentation on the EMS Report Form and Base Hospital Form should include an explanation for the use of an air ambulance (i.e., mountain rescue).

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 514, **Prehospital EMS Aircraft Operations Protocol**
Ref. No. 519, **Management of Multiple Victim Incidents**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**
Ref. No. 1302, **Airway Management and Monitoring**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **ELECTONIC SUBMISSION OF PREHOSPITAL DATA**

REFERENCE NO. 607

PURPOSE: To establish procedures for the submission of electronic data by prehospital care providers.

AUTHORITY: California Assembly Bill No. 1129
California Code of Regulations, Title 22, Chapter 4, Sections 100169, 100170
Health Insurance Portability and Accountability Act (HIPAA), 2009
Health and Safety Code, Section 130202
Health Information Technology for Economic and Clinical Health Act (HITECH)

DEFINITION:

Electronic Data: Patient Care Records submitted in electronic format (as per LA-EMS Data Dictionary) or field electronic Patient Care Records (ePCRs).

PRINCIPLES:

1. All submission of electronic personal health information (PHI) shall be in compliance with HIPPA regulations.

2. PCRs require redundant back-up and emergency down time procedures.

3. The provider agency will ensure that the electronic data is compliant with the EMS Agency's data system requirement.

4. All public and private advanced life support (ALS), specialty care transport (SCT), and exclusive operating area (EOA) provider agencies shall submit data electronically, which meets the LA-EMS or LA-EOA Data Dictionary requirements, to the EMS Agency.

5. Provider agencies cannot utilize an ePCR until their selected vendor has been approved to submit data electronically to the EMS Agency.

POLICY:

I. Provider Agency Responsibilities

A. Prior to implementation of an Electronic Data System

1. Electronic Data Submission Plan

Submit a plan, approved by the department's Fire Chief or private provider agency's Chief Executive Officer, to the EMS Agency for approval which includes:

APPROVED: Cathy Chidester
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

a. Ability to transmit data to the EMS Agency which meets the LA-EMS or LA-EOA Data Dictionary requirements.

b. A successful mechanism to provide immediate transfer of patient information to additional providers, including transporting agency (if necessary).

c. System to ensure only one Patient Care Record per patient is created, per provider agency, regardless of the number of units an individual provider responds with.

d. Process for confirming that an ePCR has been successfully generated for each patient.

e. A successful mechanism for receiving facilities to have the electronic record available upon the patient's transfer of care and any patient care related revisions made after leaving the receiving facility.

f. Back-up system available in case of system failure.

g. Staff members assigned to act as a liaison between the vendor and the EMS Agency to identify and correct data issues.

2. Notify the EMS Agency's Data Management Division Chief once a vendor has been selected and provide an estimated field implementation date.

3. Notify all hospitals that provider transports to of the intent to convert to an ePCR system and the tentative start date.

B. Implementation

1. Ensure the selected vendor contacts the EMS Agency's Data System Management Division Chief to discuss the data format, transmission procedures and obtain sequence number format.

2. Maintain a staff member to act as liaison between the vendor and the EMS Agency to identify and correct data issues.

3. Submit validated test files, meeting the LA-EMS Data Dictionary and Extensible Markup Language (XML) Schema Definition (XSD) standard, and the corresponding copies of the ePCRs in PDF format, that accurately reflect the documentation in the electronic record upon import.

C. Ongoing

1. Transmit validated data to the EMS Agency for import into the Trauma Emergency Medicine Information System (TEMIS) database within 30 days of the last day of the preceding month. Files with validation errors will be rejected and must be corrected and re-transmitted prior to import.

2. Address and correct data related issues as they arise.

3. Implement annual data field and export program changes within three months of publication.

II. EMS Agency Responsibilities

A. Review and approve the electronic data submission plan.

B. Liaison with the provider agency and receiving hospital(s) to establish a mutually agreed upon method by which the receiving hospital(s) will obtain the ePCR.

C. Meet with the provider agency and vendor to review electronic data submission plan and provide the Sequence Number formatting, LA-EMS Data Dictionary, LA- EMS XSD, LA-EMS XSD validator and LA-EMS sample XML.

D. Review validated test files, and the corresponding copies of the ePCR in PDF format, for completeness and accuracy and provide a report to the provider agency and vendor with noted deficiencies.

E. Ongoing

1. Monitor incoming data and notify the provider as issues arise and follow up with provider as needed to ensure data issues are addressed and resolved.

2. Present data field changes annually to the Provider Agency Advisory Committee.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 608, **Retention and Disposition of Prehospital Patient Care Records**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**

LA-EMS Data Dictionary
LA-EMS Extensible Markup Language (XML) Schema Definition (XSD) LA-EMS XSD Validator
LA-EMS Sample XML
LA-EOA Data Dictionary

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMS QUALITY IMPROVEMENT PROGRAM (EQIP) COMMITTEES** REFERENCE NO. 618

PURPOSE: To monitor and evaluate the quality of prehospital care within Los Angeles County. The EMS Quality Improvement Program (EQIP) Committee(s) will review and make recommendations to the Medical Director concerning system prehospital emergency medical care.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 12
Health and Safety Code Division 2.5
California Evidence Code, Section 1157
California Civil Code Part 2.6, Section 56

PRINCIPLE:

The proceedings of the EQIP Committees are confidential; any information received during these proceedings shall be considered confidential and/or privileged by the committees. Anyone providing any evidence or information to these committees shall be assured that the information is being received in confidence.

POLICY:

I. The EQIP Committees include the following:

A. Base Hospital/911 Provider Agency QI Committee

B. Private Non-911 Provider Agency QI Committee

C. Specialty Center QI Committees:

1. Trauma System QI Committee (Ad Hoc)

2. Trauma Hospital Advisory Committee-QI Subcommittee (THAC-QI)

3. Trauma Hospital Regional QI Program

4. STEMI Receiving Center Advisory Committee

5. Pediatric Advisory Committee (PedAC)

6. Stroke Advisory Committee

II. Committee member or designee responsibilities include:

A. Participate in scheduled QI committee meetings.

APPROVED: Cathy Chidester
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

B. In collaboration with the Los Angeles EMS Agency, identify prehospital care issues, provide recommendations, develop a plan for improvement, and monitor results.

C. Develop and validate system QI indicators and/or studies.

D. Participate in systemwide data collection and reporting. Each QI Committee member shall submit data to the EMS Agency on systemwide indicators, when applicable.

E. Coordinate focused studies and compile data on selected issues.

III. QI Committee membership shall include, but is not limited to, the following representative(s) or designee(s):

A. Base Hospital/9-1-1 Provider Agency QI:

1. EMS Agency Medical Director
2. EMS Agency System QI Coordinator
3. Designated EMS Agency staff
4. Prehospital Care Coordinators from each Base Hospital
5. Paramedic Coordinator and/or Fire Department Nurse Educator from each 9-1-1 Provider Agency
6. Air Operations Provider Agency, ad hoc
7. Emergency Medical Dispatch, ad hoc
8. Ad hoc members, as needed

B. Private/Non-9-1-1 Provider Agency QI:

1. EMS Agency Medical Director
2. EMS Agency System QI Coordinator
3. Designated EMS Agency staff
4. QI Coordinator from Non 9-1-1 BLS/ALS/CCT provider agencies
5. Representative(s) from approved Paramedic Training Programs
6. Representative(s) from approved EMT Training Programs
7. 9-1-1 Provider Agency member, ad hoc
8. Emergency Medical Dispatch representative, ad hoc

9. Ad hoc members, as needed

C. Specialty Center QI – see applicable policies and bylaws:

1. Trauma Program

2. STEMI Advisory Committee

3. PedAC

4. Stroke Advisory Committee

IV. EQIP Committee Responsibilities:

A. The EQIP Committees shall meet quarterly unless otherwise specified by the EMS Agency Medical Director, policy, or committee bylaws.

B. The EMS Agency is responsible for arranging the meeting location, maintaining a membership attendance roster, meeting agenda, and recording/distributing meeting minutes.

C. Significant unresolved systems issues shall be forwarded, with written recommendations, to the EMS Agency Director and/or Medical Director for further review.

CROSS REFERENCES:

Prehospital Care Policy Manual:

Ref. No. 216, **Pediatric Advisory Committee (PedAC)**
Ref. No. 218, **Trauma Hospital Advisory Committee (THAC)**
Ref. No. 320, **ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) Standards**
Ref. No. 322, **Stroke Receiving Center Standards**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 620.1 **EMS Quality Improvement Program Plan**

LA County EMS Agency, **Quality Improvement Plan**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: CRUSH INJURY / SYNDROME **Ref. No.1242**

Base Hospital Contact: Required for patients at risk for crush syndrome ❶ or prolonged entrapment > 30 minutes. ❷

1. For multi-system trauma, treat in conjunction with *TP 1244, Traumatic Injury*

2. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*

3. Provide spinal motion restriction (SMR) if indicated *(MCG 1360)*
   For alert patients, logroll patient off backboard (if used during extrication) and onto gurney prior to transport ❸

4. Administer **Oxygen** prn *(MCG 1302)*

5. For anticipated prolonged extrication (> 30 minutes)
   Consider activating the Hospital Emergency Response Team (HERT), *Ref. 817*

6. Establish vascular access immediately *(MCG 1375)*
   CONTACT BASE to discuss placement of an IO if unable to establish IV access ❹

7. **Normal Saline 1L IV/IO rapid infusion** as soon as possible and prior to release of compressive force
   Repeat x1 for a **total of 2 liters**
   Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops
   CONTACT BASE to obtain order for additional **Normal Saline** if persistent entrapment ❹

8. Initiate cardiac monitoring *(MCG 1308)*
   Assess for signs of hyperkalemia

9. Apply blanket to keep patient warm

10. If evidence of hyperkalemia (peaked T-waves in multiple leads, absent p-waves, and/or widened QRS complex) administer: ❺
    Calcium Chloride 1gm (10mL) slow IV/IO push, repeat x1 for persistent ECG abnormalities
    Sodium Bicarbonate 50mEq (50mL) slow IV/IO push, repeat x1 for persistent ECG abnormalities
    Albuterol 5mg (6mL) via neb, repeat continuously until hospital arrival
    CONTACT BASE for persistent ECG abnormalities to obtain order for additional medications ❻

11. For pain management: refer to *MCG 1345, Pain Management*

12. For CRUSH INJURY without risk of crush syndrome
    Release compression and extricate patient
    Monitor cardiac rhythm for signs of hyperkalemia

13. Consider pre-positioning a tourniquet prior to extrication in order to prevent hemorrhage upon release of compression

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: CRUSH INJURY / SYNDROME **Ref. No.1242**

14. For patients at risk for CRUSH SYNDROME ❶, administer the following medications 5 minutes prior to extrication: ❺ ❻ ❼
    Calcium Chloride 1gm (10mL) slow IV/IO push
    Sodium Bicarbonate 50mEq (50mL) slow IV/IO push
    Albuterol 5mg (6mL) via mask nebulization x2 for a total dose of 10mg

    If unable to establish vascular access while entrapped
    Place tourniquet PRIOR to extrication ❽

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: CRUSH INJURY / SYNDROME **Ref. No.1242**

SPECIAL CONSIDERATIONS

❶ Crush syndrome is a systemic illness characterized by dysrhythmias and shock. It results from toxins released from crushed muscle tissue into the blood stream. Patients are at risk for crush syndrome if they have all of the following: 1) circumferential compression causing crush injury; AND 2) involvement of a large muscle group (lower extremity including the thigh(s) and/or pelvic girdle or upper extremity including the pectoral girdle); AND 3) entrapment for at least 1 hour. The risk of crush syndrome increases with the amount of muscle involved and the duration of the entrapment.

❷ For patients requiring transport to a Trauma Center per *Ref. 506*, contact the receiving Trauma Center for Base Medical Direction and notification. If the Base Hospital is contacted and the Base redirects transport to a Trauma Center, Base personnel will notify the Trauma Center.

❸ A backboard is not required for spinal motion restriction (SMR) and may cause harm as well as increased pain. Patients should not be transported on a backboard for the purpose of SMR. If a backboard is used for extrication, patients who are alert should then be logrolled onto the gurney prior to transport. The backboard may be used during patient transport for splinting of multiple simultaneous extremity fractures or to assist with maneuvering the unconscious patient. In all cases, the backboard should be removed immediately if causing respiratory compromise.

❹ Patients with crush injury require large volumes of fluid resuscitation. Patients with prolonged entrapment will require maintenance fluids. IO access should be considered when attempts at IV access are not successful if: 1) prolonged entrapment is likely (> 30 minutes) and/or 2) there are signs of hyperkalemia and/or 3) there is risk of crush syndrome requiring medication administration.

❺ Flush the IV line with normal saline after each medication. Administration of Calcium and Bicarbonate together will cause precipitation of the medication.

❻ The duration of action of the medications is approximately 30 minutes. Contact Base to discuss re-dosing the medications if persistent signs of hyperkalemia or if the patient will not arrive at the hospital within 30 minutes.

❼ These medications should be administered prior to release of the compressive force to prevent complications from the cellular toxins that enter the circulation upon extrication of the patient. Calcium stabilizes the cardiac muscle and should be administered first.

❽ Tourniquet placement PRIOR to extrication is a last resort for patients who are at risk for crush syndrome in whom vascular access cannot be established or when transport time is anticipated to be > 30 minutes. The tourniquet must completely occlude venous and arterial flow in order to protect the patient from crush syndrome. Establish vascular access and cardiac monitoring immediately after extrication and be prepared to treat symptoms of crush syndrome.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: CRUSH INJURY/SYNDROME **Ref. No. 1242-P**

Base Hospital Contact: Required for patients at risk for crush syndrome ❶ or prolonged entrapment > 30 minutes. ❷

1. For multi-system trauma, treat in conjunction with *TP 1244-P, Traumatic Injury*

2. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*

3. Provide spinal motion restriction (SMR) if indicated *(MCG 1360)*
   For alert patients, logroll patient off backboard (if used during extrication) and onto gurney prior to transport ❸

4. Administer **Oxygen** prn *(MCG 1302)*

5. For anticipated prolonged extrication (> 30 minutes)
   Consider activating the Hospital Emergency Response Team (HERT), *Ref. 817*

6. Establish vascular access immediately *(MCG 1375)*
   CONTACT BASE to discuss placement of an IO if unable to establish IV access ❹

7. **Normal Saline 20mL/kg IV/IO rapid infusion** per *MCG 1309* as soon as possible and prior to release of compressive force
   Repeat x1 for a **total of 40mL/kg IV/IO**, maximum prior to Base contact 2L
   CONTACT BASE to obtain order for additional **Normal Saline 20 mL/kg IV/IO** if persistent entrapment ❹

8. Initiate cardiac monitoring *(MCG 1308)*
   Assess for signs of hyperkalemia

9. Apply blanket to keep patient warm ❺

10. If evidence of hyperkalemia (peaked T-waves in multiple leads, absent p-waves, and/or widened QRS complex) administer: ❻
    Calcium Chloride (100mg/mL) 20mg/kg slow IV/IO push, dose per *MCG 1309*
    Repeat x1 for persistent ECG abnormalities
    Sodium Bicarbonate (1mEq/mL) 1 mEq/kg slow IV/IO push, dose per *MCG 1309*
    Repeat x1 for persistent ECG abnormalities
    Albuterol 5mg (6mL) via neb, repeat continuously until hospital arrival ❼
    CONTACT BASE for persistent ECG abnormalities to obtain order for additional medications ❽

11. For pain management: refer to *MCG 1345, Pain Management*
    Dose per *MCG 1309*

12. For nausea or vomiting in patients ≥ 4 years old:
    Ondansetron 4mg ODT

13. For CRUSH INJURY without risk of crush syndrome
    Release compression and extricate patient
    Monitor cardiac rhythm for signs of hyperkalemia

14. Consider pre-positioning a tourniquet prior to extrication in order to prevent hemorrhage upon release of compression

15. For patients at risk for CRUSH SYNDROME ❶, administer the following medications 5 minutes prior to extrication: ❻ ❽ ❾
    Calcium Chloride (100mg/mL) 20mg/kg slow IV/IO push, dose per *MCG 1309*
    Sodium Bicarbonate (1mEq/mL) 1 mEq/kg slow IV/IO push, dose per *MCG 1309*
    Albuterol 5mg (6mL) via neb, repeat immediately x1

    If unable to establish vascular access while entrapped
    Place tourniquet PRIOR to extrication ❿

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: CRUSH INJURY/SYNDROME **Ref. No. 1242-P**

SPECIAL CONSIDERATIONS

❶ Crush syndrome is a systemic illness characterized by dysrhythmias and shock. It results from toxins released from crushed muscle tissue into the blood stream. Patients are at risk for crush syndrome if they have all of the following: 1) circumferential compression causing crush injury; AND 2) involvement of a large muscle group (lower extremity including the thigh(s) and/or pelvic girdle or upper extremity including the pectoral girdle); AND 3) entrapment for at least 1 hour. The risk of crush syndrome increases with the amount of muscle involved and the duration of the entrapment.

❷ For patients requiring transport to a Pediatric Trauma Center per *Ref. 506*, which is also a Base Hospital, contact receiving Pediatric Trauma Center for Base Medical Direction and notification. If the Base Hospital is contacted and the Base redirects transport to a Pediatric Trauma Center, Base personnel will notify the Pediatric Trauma Center.

❸ A backboard is not required for spinal motion restriction (SMR) and may cause harm as well as increased pain. Patients should not be transported on a backboard for the purpose of SMR. If a backboard is used for extrication, patients who are alert should then be logrolled onto the gurney prior to transport. The backboard may be used during patient transport for splinting of multiple simultaneous extremity fractures or to assist with maneuvering the unconscious patient. In all cases, the backboard should be removed immediately if causing respiratory compromise.

❹ Patients with crush injury require large volumes of fluid resuscitation. Patients with prolonged entrapment will require maintenance fluids. IO access should be considered when attempts at IV access are not successful if: 1) prolonged entrapment is likely (> 30 minutes) and/or 2) there are signs of hyperkalemia and/or 3) there is risk of crush syndrome requiring medication administration.

❺ Infants and small children are at high risk for hypothermia due to their large surface area to body mass ratio, reduced ability to shiver, and limited body fat.

❻ Flush the IV line with normal saline after each medication. Administration of Calcium and Bicarbonate together will cause precipitation of the medication.

❼ Dosing differs from MCG 1309; higher doses of albuterol are required to treat hyperkalemia. Consider blow-by to avoid agitation in pediatric patients if a mask cannot be tolerated (e.g., infants and toddlers).

❽ The duration of action of the medications is approximately 30 minutes. Contact Base to discuss re-dosing the medications if persistent signs of hyperkalemia or if the patient will not arrive at the hospital within 30 minutes.

❾ These medications should be administered prior to release of the compressive force to prevent complications from the cellular toxins that enter the circulation upon extrication of the patient. Calcium stabilizes the cardiac muscle and should be administered first.

❿ Tourniquet placement PRIOR to extrication is a last resort for patients who are at risk for crush syndrome in whom vascular access cannot be established or when transport time is anticipated to be > 30 minutes. The tourniquet must completely occlude venous and arterial flow in order to protect the patient from crush syndrome. Establish vascular access and cardiac monitoring immediately after extrication and be prepared to treat symptoms of crush syndrome.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: TRAUMATIC INJURY **Ref. No. 1244**

Base Hospital Contact: Required for patients who meet Trauma Center criteria or guidelines. ❶ Notify the receiving Trauma Center as soon as possible for all patient transports.

1. Immediately control major bleeding *(MCG 1370)*
   Apply tourniquet prn

2. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*

3. For traumatic arrest, treat per *TP 1243, Traumatic Arrest*

4. Provide spinal motion restriction (SMR) if indicated *(MCG 1360)*
   For alert patients, logroll off the backboard (if used during extrication) and onto gurney prior to transport ❷

5. Administer **Oxygen** prn *(MCG 1302)*
   High flow Oxygen 15 L/min for all patients with shock or with suspected traumatic brain injury

6. If patient has an Unmanageable Airway *(MCG 1302)***:**
   Initiate immediate transport to MAR and **CONTACT BASE** en route

7. For anticipated prolonged extrication (> 30 minutes)
   Consider activating the Hospital Emergency Response Team (HERT), *Ref. 817*

8. For crush injury, treat in conjunction with *TP 1242, Crush Injury/Syndrome*

9. Initiate cardiac monitoring prn *(MCG 1308)*

10. Establish vascular access prn *(MCG 1375)*

11. Apply blanket to keep patient warm

12. Consider medical condition preceding accident and refer to appropriate treatment protocol prn ❸

MULTI-SYSTEM TRAUMA

13. Perform needle thoracostomy for suspected tension pneumothorax *(MCG 1335)*

14. For an open or sucking chest wound, cover with a commercially available vented chest seal or vented (3-sided) occlusive dressing ❹

15. For poor perfusion with hypotension:
    Normal Saline 250mL IV/IO rapid infusion ❺
    CONTACT BASE to discuss further fluid resuscitation

16. Cover eviscerated organs with a moist non-adhering dressing

17. For pain management prn *(MCG 1345)*

Fentanyl 50mcg (1mL) slow IV/IO push or IM/IN
Morphine 4mg (1mL) slow IV/IO push or IM

CONTACT BASE for additional pain management:
May repeat as above up to maximum total dose Fentanyl 250mcg or Morphine 20mg

18. For nausea or vomiting: ❻
Ondansetron 4mg ODT/IV/IM, may repeat x1 in 15 min prn

ISOLATED HEAD INJURY

19. Administer **high flow Oxygen 15 L/min** for all patients with suspected traumatic brain injury ❼
Continually assess patient's airway and ventilation status, assist prn ❽

20. For SBP ≤ 90mmHg:
Normal Saline 1L IV/IO rapid infusion ❾
Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops
CONTACT BASE for persistent poor perfusion after **Normal Saline 1L**

21. For nausea or vomiting: ❺
Ondansetron 4mg ODT/IV/IM, may repeat x1 in 15 min prn

22. Transport with head of gurney elevated to 30 degrees when possible ❿

23. If patient develops seizure activity, treat in conjunction with *TP 1231, Seizure*

24. For pain management prn *(MCG 1345)*

For an alert and oriented patient with GCS 15:
Fentanyl 50mcg (1mL) slow IV/IO push or IM/IN
Morphine 4mg (1mL) slow IV/IO push or IM

CONTACT BASE for additional pain management or for initial orders if patient not alert and oriented with GCS 15
May provide or repeat as above up to maximum total dose Fentanyl 250mcg or Morphine 20mg

ISOLATED EXTREMITY INJURY

25. For pain management prn *(MCG 1345)*

26. For poor perfusion:
Normal Saline 1L IV/IO rapid infusion
Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops
CONTACT BASE for persistent poor perfusion to obtain order for additional **Normal Saline 1L IV/IO**

27. Splint and dress injuries prn

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: TRAUMATIC INJURY **Ref. No. 1244**

For distal extremity fractures with poor neurovascular status distal to injury – realign and stabilize extremity
Mid-shaft femur – apply traction splint per manufacturer guidelines ⓫
All other fractures/dislocations – splint in position of comfort

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SPECIAL CONSIDERATIONS

❶ For patients requiring transport to a Trauma Center per *Ref. 506*, contact the receiving Trauma Center for Base Medical Direction and notification. If the Base Hospital is contacted and the Base redirects transport to a Trauma Center, Base personnel will notify the Trauma Center.

❷ A backboard is not required for spinal motion restriction (SMR) and may cause harm as well as increased pain. Patients should not be transported on a backboard for the purpose of SMR. If a backboard is used for extrication, patients who are alert should then be logrolled onto the gurney prior to transport. The backboard may be used during patient transport for splinting of multiple simultaneous extremity fractures or to assist in maneuvering the unconscious patient. In all cases, the backboard should be removed immediately if causing respiratory compromise.

❸ Traumatic events may be due to a medical emergency, particularly single-vehicle accidents and unexplained falls.

❹ Placement of a vented dressing can prevent conversion of an open pneumothorax to a tension pneumothorax. However, tension pneumothorax may still develop in the presence of a vented dressing and should be treated with needle thoracostomy. Furthermore, needle thoracostomy in a patient with evidence of tension pneumothorax should not be delayed for placement of dressing.

❺ Fluid resuscitation increases vascular pressure and dilutes clotting factors, which may increase internal bleeding. For patients at risk of internal hemorrhage, fluids should only be administered for SBP < 90mmHg **and** other signs of poor perfusion, titrated to maintain SBP ≥ 90mmHg. In patients with penetrating trauma, permissive hypotension (withholding fluids for SBP ≥ 70mmHg if patient has normal mental status) is preferred to reduce ongoing blood loss. Patients with ALOC or SBP < 70mmHg should receive fluids until their mental status and SBP improve. Permissive hypotension is contraindicated in patients with possible traumatic brain injury.

❻ Vomiting should be prevented and/or immediately treated in patients with head injury, since it increases intra-cranial pressure and can compromise the patient's airway.

❼ Traumatic brain injury presents with altered mental status after head injury. Any hypoxic episode, even brief, is associated with worse patient outcome for patients with traumatic brain injury.

❽ Hyperventilation reduces blood flow to the brain by reducing CO_2 and is associated with worse outcomes in severe head injuries. The exception to this is presence of elevated intra-cranial pressure (ICP) with signs of impending herniation (severe ALOC without motor response or with posturing and a unilateral 'blown pupil'). In this case, **mild** hyperventilation of approximately 20 breaths per minute should be used to maintain an $ETCO_2$ of 30-35mmHg. This mild hyperventilation reduces blood flow to the brain to decrease ICP until the patient receives definitive surgical care. For patients without elevated ICP, hyperventilation is harmful.

❾ Any hypotension increases mortality in patients with traumatic brain injury. Normal Saline should be initiated to maintain SBP ≥ 90mmHg at all times but can be withheld if the blood pressure is normal.

❿ A head-elevated position at about 30 degrees reduces intra-cranial pressure and improves

respiratory status. Patients in a cervical collar may have their head elevated if there is no concern for thoracic or lumbar spine injury. Reverse Trendelenburg is another option for patients that cannot be seated. Patients who are hypotensive should be maintained supine unless airway compromise requires repositioning.

⓫ Open femur fracture is not a contraindication to apply the traction splint. If the bone is protruding and there is gross contamination, wash with saline prior to applying the splint.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: TRAUMATIC INJURY **Ref. No. 1244-P**

Base Hospital Contact: Required for patients who meet Trauma Center criteria or guidelines. ❶❷ Notify the receiving Pediatric Trauma Center as soon as possible for all patient transports.

1. Immediately control major bleeding *(MCG 1370)*
   Apply tourniquet prn

2. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*

3. For traumatic arrest, treat per *TP 1243-P, Traumatic Arrest*

4. Provide spinal motion restriction (SMR) if indicated *(MCG 1360)*
   For alert patients, logroll patient off the backboard (if used during extrication) and onto gurney prior to transport ❸

5. Administer **Oxygen** prn *(MCG 1302)*
   High flow Oxygen 15L/min for all patients with shock or with suspected traumatic brain injury

6. If patient has an Unmanageable Airway: *(MCG 1302)*
   Initiate immediate transport to EDAP and **CONTACT BASE** en route

7. For anticipated prolonged extrication (> 30 minutes)
   Consider activating the Hospital Emergency Response Team (HERT), *Ref. 817*

8. For crush injury, treat in conjunction with *TP 1242, Crush Injury/Syndrome*

9. Initiate cardiac monitoring prn *(MCG 1308)*

10. Establish vascular access prn *(MCG 1375)*

11. Apply blanket to keep patient warm ❹

12. Consider medical condition preceding accident and refer to appropriate treatment protocol prn ❺

MULTI-SYSTEM TRAUMA

13. Perform needle thoracostomy for suspected tension pneumothorax *(MCG 1335)*

14. For an open or sucking chest wound, cover with a commercially available vented chest seal or vented (3-sided) occlusive dressing ❻

15. For poor perfusion with hypotension:
    Normal Saline 20mL/kg IV/IO rapid infusion per *MCG 1309* ❼
    CONTACT BASE to discuss further fluid resuscitation

16. Cover eviscerated organs with a moist non-adhering dressing

17. For pain management: refer to *MCG 1345, Pain Management*
    Dose per *MCG 1309*

18. For nausea or vomiting in patients ≥ 4 years old:
    Ondansetron 4mg ODT ❽

ISOLATED HEAD INJURY

19. Administer **high flow Oxygen 15L/min** ❾
    Continually assess patient's airway and ventilation status, assist prn ❿

20. For SBP ≤ 70mmHg:
    Normal Saline 20mL/kg IV rapid infusion per *MCG 1309* to maintain SBP > 70mmHg ⓫
    CONTACT BASE for persistent poor perfusion to obtain order for additional **Normal Saline 20mL/kg IV**

21. For nausea or vomiting in patients ≥ 4 years old: ❽
    Ondansetron 4mg ODT

22. Transport with head of gurney elevated to 30 degrees when possible ⓬

23. If patient develops seizure activity, treat in conjunction with *TP 1231-P, Seizure*

24. For pain management: refer to *MCG 1345, Pain Management*
    Dose per *MCG 1309*

ISOLATED EXTREMITY INJURY

25. For pain management: refer to *MCG 1345, Pain Management*
    Dose per *MCG 1309*

26. For poor perfusion:
    Normal Saline 20mL/kg IV rapid infusion per *MCG 1309*
    CONTACT BASE for persistent poor perfusion to obtain order for additional **Normal Saline 20mL/kg IV**

27. Splint and dress injuries prn
    For distal extremity fractures with poor neurovascular status distal to injury – realign and stabilize extremity
    Mid-shaft femur – apply traction splint per manufacturer guidelines ⓭
    All other fractures/dislocations – splint in position of comfort

SPECIAL CONSIDERATIONS

❶ EMS Personnel are mandated reporters of child abuse and neglect, and a report should be made when suspected as per *Ref. 822*. Communicate suspicion for child abuse and/or neglect to accepting ED staff when home suggests children could be at risk for harm (e.g., unkept home, evidence of drug or alcohol abuse, unsafe living conditions, known or suspected domestic violence), when the history does not match with the severity of physical findings (e.g., child posturing after a roll off the couch), when patterned injury or burns or noted (e.g., circular burns as from a cigarette, whip marks on the skin, burns of both hands or feet), or when child reports physical or sexual abuse. Children < 3 years of age and those with developmental delay are at increased risk of abuse. This must also be accompanied by notification to the Department of children and Family Services (DCFS).

❷ For patients requiring transport to a Pediatric Trauma Center per *Ref. 506*, which is also a Base Hospital, contact receiving Pediatric Trauma Center for Base Medical Direction and notification. If the Base Hospital is contacted and the Base redirects transport to a Pediatric Trauma Center, Base personnel will notify the Pediatric Trauma Center.

❸ A backboard is not required for spinal motion restriction (SMR) and may cause harm as well as increased pain. Patients should not be transported on a backboard for the purpose of SMR. If a backboard is used for extrication, patients who are alert should then be logrolled onto the gurney prior to transport. The backboard may be used during patient transport for splinting of multiple simultaneous extremity fractures or to assist with maneuvering the unconscious patient. In all cases, the backboard should be removed immediately if causing respiratory compromise.

❹ Infants and small children are at high risk for hypothermia due to their large surface area to body mass ratio, reduced ability to shiver, and limited body fat.

❺ Traumatic events may be due to a medical emergency, e.g. seizure.

❻ Placement of a vented dressing can prevent conversion of an open pneumothorax to a tension pneumothorax. However, tension pneumothorax may still develop in the presence of a vented dressing and should be treated with needle thoracostomy. Furthermore, needle thoracostomy in a patient with evidence of tension pneumothorax should not be delayed for placement of dressing.

❼ Fluid resuscitation increases vascular pressure and dilutes clotting factors, which may increase internal bleeding. For patients at risk of internal hemorrhage, fluids should only be administered for SBP < 70mmHg **and** other signs of poor perfusion, titrated to maintain SBP ≥ 70mmHg. In patients with penetrating trauma, permissive hypotension (withholding fluids if patient has normal mental status) is preferred to reduce ongoing blood loss. Patients with ALOC or SBP < 70mmHg should receive fluids until their mental status and SBP improve. Permissive hypotension is contraindicated in patients with possible traumatic brain injury.

❽ Vomiting should be prevented and/or immediately treated in patients with head injury, since it increases intra-cranial pressure and can compromise the patient's airway.

❾ **Any** hypoxic episode, even brief, is associated with worse patient outcome for patients with traumatic brain injury.

⑩ Hyperventilation reduces blood flow to the brain by reducing CO_2 and is associated with worse outcomes in severe head injuries. The exception to this is presence of elevated intra-cranial pressure (ICP) with signs of impending herniation (severe ALOC without motor response or with posturing and a unilateral 'blown pupil'). In this case, **mild** hyperventilation of approximately 20-30 breaths per minute, depending on the patient's age, should be used to maintain an $ETCO_2$ of 30-35mmHg. This mild hyperventilation reduces blood flow to the brain to decrease ICP until the patient receives definitive surgical care. For patients without elevated ICP, hyperventilation is harmful.

⑪ Any hypotension increases mortality in patients with traumatic brain injury. Normal Saline should be initiated to maintain SBP ≥ 70mmHg at all times but can be withheld if the blood pressure is normal. Although <70 mmHg is used as a generic cut-off for hypotension in pediatric patients the level of systolic blood pressure varies by age and those thresholds are found in *MCG 1309* and can be used in decisions for fluid resuscitation.

⑫ A head-elevated position at about 30 degrees reduces intra-cranial pressure and improves respiratory status. Reverse Trendelenburg is an option for patients that cannot be seated. Patients who are hypotensive should be maintained supine unless airway compromise requires repositioning.

⑬ Open femur fracture is not a contraindication to apply the traction splint. If the bone is protruding and there is gross contamination, wash with saline prior to applying the splint.

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

Trauma Hospital Advisory Committee

TRAUMA DATA SUBCOMMITTEE

SUMMARY OF CHANGES 2021

DATA ELEMENT	ISSUE / CONCERN / ACTION
GENERAL INFORMATION	
DHS PATIENT?	**Added** the following bullets to the Additional Information in the Data Dictionary (DD) for DHS Patient? • Patient's with ONLY ICD-10-CM or ICD-10-CA codes "NFS", or unspecified codes resulting in an AIS severity score of 9, and therefore no ISS, should be identified as DHS=No patients. • DHS=Yes patients based upon inclusion criteria of Hospital Admission (AD), MUST be evaluated by the Trauma Surgeon in the ED. • DHS=Yes patients based upon inclusion criteria of Inclusion criteria of Transfer Higher Level of Care (TS), MUST be transferred to or from your facility, and admitted by a Trauma Surgeon for care of an injury.
TRAUMA CENTER CODE	**Revised** the following FIELD VALUE in the DD and Trauma One (TO) for TRAUMA CENTER CODE: • MemorialCare Long Beach ~~Memorial~~ Medical Center
GENDER	**Revised** the DATA ELEMENT name in the DD for SEX: GENDER **Added** the following (NTDS) FIELD VALUE in the DD for GENDER: • 3 Non-binary **Revised** the following bullet in the Additional Information in the DD for GENDER: • Nonbinary is a gender option ~~within the State of California~~ for individuals whose gender identity isn't exclusively male or female.
TRANSFERRED FROM	**Revised** the following FIELD VALUES in the DD and TO for TRANSFERRED FROM: • CPM Coast Plaza ~~Doctors~~ Hospital • DFM Cedars-Sinai Marina Del Rey Hospital • LBM MemorialCare Long Beach ~~Memorial~~ Medical Center • TRM Providence Cedars-Sinai Tarzana Medical Center • SIM Adventist Health - Simi Valley (Ventura) **Deleted** the following FIELD VALUE in the DD and TO for TRANSFERRED FROM: • ~~SVH Saint Vincent Medical Center~~

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td colspan="2">PREHOSPITAL</td></tr>
<tr><td>PROVIDER</td><td>Deleted the following FIELD VALUE in the DD and TO for PROVIDER:
~~VF Vernon Fire~~
~~UF Upland Fire~~
Revised the following FIELD VALUE in the DD for PROVIDER:
SO ~~Southern CA Ambulance~~ Symbiosis (Di Biassi)
Added the following FIELD VALUES in the DD for PROVIDER:
CO College Coastal Care, LLC
GG Go Green Ambulance
JA Journey Ambulance
VI Vital Care Ambulance</td></tr>
<tr><td>1st ON SCENE</td><td>Revised the following FIELD VALUE in the DD for 1st ON SCENE:
Use 24-hour clock</td></tr>
<tr><td>1st FIELD VS: SBP (SYSTOLIC BLOOD PRESSURE)</td><td>Deleted the following bullet from the Additional Information in the DD for 1st FIELD VS: SBP (SYSTOLIC BLOOD PRESSURE):
~~SBP in the prehospital setting will be mapped to NTDS’s initial field SBP~~.</td></tr>
<tr><td>1st FIELD VS: HR (HEART RATE)</td><td>Deleted the following bullet from the Additional Information in the DD for 1st FIELD VS: HR (HEART RATE):
~~HR in the prehospital setting will be mapped to NTDS’s initial field pulse rate.~~</td></tr>
<tr><td>1st FIELD VS: RR (RESPIRATORY RATE)</td><td>Deleted the following bullet from the Additional Information in the DD for 1st FIELD VS: RR (RESPIRATORY RATE):
~~The first recorded respiratory rate in the prehospital setting will be mapped to NTDS’s initial field respiratory rate.~~</td></tr>
<tr><td>1st FIELD VS: O2 SAT</td><td>Deleted the following bullet from the Additional Information in the DD for 1st FIELD VS: O2 SAT:
~~The first recorded oxygen saturation in the prehospital setting will be mapped to NTDS’s initial field oxygen saturation.~~</td></tr>
<tr><td>1st FIELD GSC: EYE</td><td>Deleted the NTDS mapping from the DD for 1ST FIELD GCS: EYE:<table><tr><th colspan="2">~~NTDS~~</th></tr><tr><td>~~4~~</td><td>~~Opens eyes spontaneously~~</td></tr><tr><td>~~3~~</td><td>~~Opens eyes in response to verbal stimulation~~</td></tr><tr><td>~~2~~</td><td>~~Opens eyes in response to painful stimulation~~</td></tr><tr><td>~~1~~</td><td>~~No eye movement when assessed~~</td></tr></table>Deleted the following bullet from the Additional Information in the DD for 1st FIELD GCS: EYE:
~~The first recorded GCS Eye Score in the prehospital setting will be mapped to NTDS’s initial field GCS - Eye.~~</td></tr>
</table>

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td>1st FIELD GCS: VERBAL</td><td>Deleted the NTDS mapping from the DD for 1st FIELD GCS: VERBAL:
<table>
<tr><th colspan="2">~~NTDS~~</th></tr>
<tr><th colspan="2">~~ADULT~~</th></tr>
<tr><td>5</td><td>~~Oriented~~</td></tr>
<tr><td>4</td><td>~~Confused~~</td></tr>
<tr><td>3</td><td>~~Inappropriate words~~</td></tr>
<tr><td>2</td><td>~~Incomprehensible sounds~~</td></tr>
<tr><td>1</td><td>~~No verbal response~~</td></tr>
<tr><th colspan="2">~~INFANT AND TODDLER~~</th></tr>
<tr><td>5</td><td>~~Smiles, oriented to sounds, follows objects, interacts~~</td></tr>
<tr><td>4</td><td>~~Cries but is consolable, inappropriate interactions~~</td></tr>
<tr><td>3</td><td>~~Inconsistently consolable, moaning~~</td></tr>
<tr><td>2</td><td>~~Inconsolable, agitated~~</td></tr>
<tr><td>1</td><td>~~No vocal response~~</td></tr>
</table>
Deleted the following bullet from the Additional Information in the DD for 1st FIELD GCS: VERBAL:
• ~~The first recorded GCS Verbal Score in the prehospital setting will be mapped to NTDS's initial field GCS - Verbal.~~</td></tr>
<tr><td>1st FIELD GCS: MOTOR</td><td>Deleted the NTDS mapping from the DD for 1st FIELD GCS: MOTOR:
<table>
<tr><th colspan="2">~~NTDS~~</th></tr>
<tr><td>~~6~~</td><td>~~Obeys commands/Appropriate response to stimuli~~</td></tr>
<tr><td>~~5~~</td><td>~~Localizing pain~~</td></tr>
<tr><td>~~4~~</td><td>~~Withdraws from pain~~</td></tr>
<tr><td>~~3~~</td><td>~~Flexion to pain~~</td></tr>
<tr><td>~~2~~</td><td>~~Extension to pain~~</td></tr>
<tr><td>~~1~~</td><td>~~No motor response~~</td></tr>
</table>
Deleted the following bullet from the Additional Information in the DD for 1st FIELD GCS: MOTOR:
• ~~The first recorded GCS Motor Score in the prehospital setting will be mapped to NTDS's initial field GCS - Motor.~~</td></tr>
<tr><td>1st FIELD GCS: TOTAL GCS</td><td>Deleted the following bullet from the Additional Information in the DD for 1st FIELD GCS: TOTAL GCS:
• ~~The first recorded GCS Total in the prehospital setting will be mapped to NTDS's initial field GCS - Total.~~</td></tr>
<tr><td>EXTERNAL CAUSE CODE</td><td>Revised the following FIELD VALUE in the DD for EXTERNAL CAUSE CODE:
• Relevant ICD-10-CM or ICD-10 CA code value for injury event.

Revised the following bullet in the Additional Information in the DD for EXTERNAL CAUSE CODE:
• ICD-10-CM or ICD-10-CA codes are accepted for this data element. Activity codes ~~should not be~~ are not reported ~~in this field~~ under the NTDS and should not be reported for this data element.</td></tr>
</table>

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td>ADDITIONAL CAUSE CODE</td><td>Revised the following FIELD VALUE in the DD for ADDITIONAL CAUSE CODE:
Relevant ICD-10-CM or ICD-10 CA code value for injury event code value for injury event up to six characters.
Added the following bullet to the Additional Information in the DD for ADDITIONAL CAUSE CODE:
Only ICD-10-CM or ICD-10-CA codes will be accepted for ICD-10 Additional External Cause Code.</td></tr>
<tr><td>PLACE OF OCCURRENCE CODE</td><td>Revised the following FIELD VALUE in the DD for PLACE OF OCCURRENCE CODE:
Relevant ICD-10-CM or ICD-10 CA code value for injury event
Added the following bullet to the Additional Information in the DD for PLACE OF OCCURRENCE CODE:
Only ICD-10-CM or ICD-10-CA codes are accepted for ICD-10 Place of Occurrence External Cause Code.</td></tr>
<tr><td colspan="2">EMERGENCY DEPARTMENT</td></tr>
<tr><td>CRITERIA/GUIDELINES/ SPECIAL CONSIDERATIONS MET</td><td>Deleted the NTDS mapping from the DD for CRITERIA/GUIDELINES/SPECIAL CONSIDERATIONS MET:
<table>
<tr><th colspan="2">~~NTDS (EMS Patients Only)~~</th></tr>
<tr><th colspan="2">~~Trauma Triage Criteria Steps 1 & 2 / Trauma Triage Criteria Steps 3 & 4~~</th></tr>
<tr><td>~~1~~</td><td>~~Glasgow Coma Score ≤13~~</td></tr>
<tr><td>~~1~~</td><td>~~Adult fall from heights >15 feet, or (Mapped based upon patient's age)~~</td></tr>
<tr><td>~~2~~</td><td>~~Peds from heights >10 feet, or >3 times child's height (Mapped based upon patient's age)~~</td></tr>
<tr><td>~~N/A~~</td><td></td></tr>
<tr><td>~~8~~</td><td>~~Motorcycle crash >20 mph if MOI of MM exists~~</td></tr>
<tr><td>~~2~~</td><td>~~Blood Pressure <90mmHg Systolic~~</td></tr>
<tr><td>~~2~~</td><td>~~Blood Pressure <90mmHg Systolic~~</td></tr>
<tr><td>~~3~~</td><td>~~Respiratory Rate <10/>29, <20 if <1yr. or need for ventilator support~~</td></tr>
<tr><td>~~13~~</td><td>~~Burns~~</td></tr>
<tr><td>~~14~~</td><td>~~Burns with Trauma~~</td></tr>
<tr><td>~~5~~</td><td>~~Chest wall instability or deformity (e.g., flail chest)~~</td></tr>
<tr><td>~~9~~</td><td>~~Pelvic Fracture~~</td></tr>
<tr><td>~~11~~</td><td>~~Paralysis~~</td></tr>
<tr><td>~~4~~</td><td>~~Crash ejection (partial or complete) from automobile~~</td></tr>
<tr><td>~~3~~</td><td>~~Intrusion >12 in. occupant site; 18 in. any site~~</td></tr>
<tr><td></td><td></td></tr>
<tr><td>~~7~~</td><td>~~Ped/Bicyclist Run over / Thrown / Impact >20 mph~~</td></tr>
<tr><td>~~8~~</td><td>~~Motorcycle crash >20 mph if MOI of MM exists~~</td></tr>
<tr><td>~~N/A~~</td><td></td></tr>
<tr><td>~~N/A~~</td><td></td></tr>
<tr><td>~~8~~</td><td>~~Amputation proximal to the wrist or ankle~~</td></tr>
<tr><td>~~6~~</td><td>~~Two or more proximal long-bone fractures~~</td></tr>
<tr><td>~~7~~</td><td>~~Crushed, degloved, mangled, or pulseless extremity~~</td></tr>
<tr><td>~~4~~</td><td>~~Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee~~</td></tr>
<tr><td>~~4~~</td><td>~~Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee~~</td></tr>
<tr><td>~~4~~</td><td>~~Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee~~</td></tr>
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<tr><td>~~4~~</td><td>~~Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee~~</td></tr>
<tr><td>~~8~~</td><td>~~Amputation proximal to the wrist or ankle~~</td></tr>
<tr><td>~~4~~</td><td>~~Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee~~</td></tr>
<tr><td>~~4~~</td><td>~~Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee~~</td></tr>
<tr><td>~~N/A~~</td><td></td></tr>
<tr><td>~~7~~</td><td>~~Crushed, degloved, mangled, or pulseless extremity~~</td></tr>
<tr><td>~~4~~</td><td>~~Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee~~</td></tr>
<tr><td>~~4~~</td><td>~~Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee~~</td></tr>
<tr><th colspan="2">~~Trauma Triage Criteria (Steps 3 & 4)~~</th></tr>
</table></td></tr>
</table>

DATA ELEMENT	ISSUE / CONCERN / ACTION
	<table><tr><td>~~3~~</td><td>~~Intrusion >12 inches in occupant site: 18 in. any site~~</td></tr><tr><td>~~10~~</td><td>~~Patients on anticoagulants and bleeding disorders~~</td></tr><tr><td>~~N/A~~</td><td></td></tr><tr><td>~~N/A~~</td><td></td></tr><tr><td>~~5~~</td><td>~~Crash death in same passenger compartment~~</td></tr><tr><td>~~6~~</td><td>~~Crash Vehicle telemetry data (AACN) consistent w/ high risk injury~~</td></tr><tr><td colspan="2">~~**Trauma Triage Criteria (Steps 3 & 4)**~~</td></tr><tr><td>~~N/A~~</td><td></td></tr><tr><td>~~N/A~~</td><td></td></tr><tr><td>~~9~~</td><td>~~Adults greater than 65 years of age with Systolic B/P less than 110mmHg~~</td></tr><tr><td>~~11~~</td><td>~~Pregnancy greater than 20 weeks~~</td></tr><tr><td>~~12~~</td><td>~~EMS provider judgment~~</td></tr></table> **Deleted** the following field value in the DD and TO for CRITERIA/GUIDELINES/SPECIAL CONSIDERATIONS MET: • PS Passenger Space Intrusion, unspecified **Deleted** the following bullet from the Additional Information in the DD for CRITERIA/GUIDELINES/SPECIAL CONSIDERATIONS MET: • ~~Complete on ALL patients, but will only be sent to NTDS® for patients with a Mode of Entry equal to EMS.~~
ED/HOSPITAL ARRIVAL DATE	**Added** ED/HOSPITAL ARRIVAL DATE as a data element in the DD and TO as follows: **Definition** The date the patient arrived in the ED/hospital. **Field Values** • Collected as MMDDYYYY **Additional Information** • Used to calculate Total Length of Hospital Stay. • Field value cannot be *"Not Applicable"*. • Field value cannot be left blank.
ACTIVATION DATE	**Added** ACTIVATION DATE as a data element in the DD and TO as follows: **Definition** The date the treating facility's trauma team was activated, if applicable. **Field Values** • Collected as MMDDYYYY
ACTIVATION LEVEL	**Added** the following bullet to the Additional Information in the DD for ACTIVATION LEVEL: • If the Trauma Centers' highest level of activation on file with the EMS Agency is indicated, it will be mapped to NTDB's Highest Level of Activation. To ensure continued accuracy, the EMS Agency must be notified if changes are made to the customized list.

DATA ELEMENT	ISSUE / CONCERN / ACTION
1ST ED/HOSPITAL VS: DATE	**Added** 1ST ED/HOSPITAL VS: DATE as a data element in the DD and TO as follows: **Definition** Date of the first recorded vital signs within 30 minutes of ED/hospital arrival. **Field Values** • Collected as MMDDYYYY **Additional Information** • All timed values are tied to a date and time; therefore, the 1st set of ED vitals at the ED receiving facility (Trauma Center) must be used, NOT the 1st set of documented ED vitals from the ED sending facility. Although this will result in variance in the Revised Trauma Score, vital signs that are timed prior to ED arrival at the trauma center will result in data validation issues. • Enter the null value of "*Not Documented*" if the first recorded vital signs time is not within 30 minutes of ED/hospital arrival.
1ST ED/HOSPITAL VS: RESPIRATORY RATE (RR) ASSISTED?	**Added** the following bullet to the Additional Information in the DD for 1ST ED/HOSPITAL VS: RESPIRATORY RATE (RR) ASSISTED? • Only reported if initial 1st ED/Hospital VS: Respiratory Rate (RR) is reported. **Revised** the following bullet in the Additional Information in the DD for 1ST ED/HOSPITAL VS: RESPIRATORY RATE (RR) ASSISTED? • ~~Field value cannot be~~ The null value of *"Not Applicable"* is reported if the 1st ED/Hospital VS: Respiratory Rate (RR) is *"Not Known/Not Recorded*".
LA TRAUMA DATABASE INCLUSION CRITERIA	**Revised** the following Field Value in the DD for LA TRAUMA DATABASE INCLUSION CRITERIA: • **AD** Admitted for care of an injury after ED evaluation by the Trauma ~~Service~~ Surgeon. • **TS** ~~Patient was transferred~~ Transfer Higher Level of Care to or from your facility, and **admitted** ~~to the~~ by a Trauma ~~Service~~ Surgeon for care of an injury. **Revised** the following bullet to the Additional Information in the DD for LA TRAUMA DATABASE INCLUSION CRITERIA: • The following edit checks have been applied to Trauma One®: ✓ CG - Physiological and/or Anatomical Criteria MUST exist (14, 70, 90, CB, FC, BD, BI, BR, BV, PA, PC, PF, PG, PH, PI, PK, PN, PT, PV, PX, PY, RR, SC, & SX). ✓ CG - EXCLUDES all Mechanism of Injury Criteria (12, 15, 20, EJ, ~~PS,~~ & RT), Guidelines (18, AN, EX, PB, SF, & TD), & Special Considerations (55, BP, IU, & PJ). **Added** the following bullets to the Additional Information in the DD for LA TRAUMA DATABASE INCLUSION CRITERIA:

DATA ELEMENT	ISSUE / CONCERN / ACTION
	• Inclusion criteria rationale of Hospital Admission (AD), MUST involve the evaluation of the Trauma Surgeon in the ED. • Inclusion criteria rationale of Transfer Higher Level of Care (TS), MUST be transferred to or from your facility, and admitted by a Trauma Surgeon for care of an injury.
ADMITTING SERVICE	**Revised** the following FIELD VALUE in the DD for ADMITTING SERVICE: • THO~~S~~ THORACIC SURGERY **Added** the following FIELD VALUE in the DD and TO for ADMITTING SERVICE: • INN INTERVENTIONAL NEUROLOGY
TRAUMA TEAM SERVICE	**Revised** the following FIELD VALUE in the DD for TRAUMA TEAM SERVICE: • THO~~S~~ THORACIC SURGERY **Added** the following FIELD VALUE in the DD and TO for TRAUMA TEAM SERVICE: • INN INTERVENTIONAL NEUROLOGY
REQUEST DATE *(TRAUMA TEAM)*	**Added** REQUEST DATE *(TRAUMA TEAM)* as a data element in the DD and TO as follows: **Definition** Date that trauma team physician was activated to evaluate the patient upon arrival to the ED, if applicable. **Field Values** • Collected as MMDDYYYY **Additional Information** • Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/ACUTE CARE** section.
ARRIVAL DATE *(TRAUMA TEAM)*	**Added** ARRIVAL DATE *(TRAUMA TEAM)* as a data element in the DD and TO as follows: **Definition** Date that Trauma Team physician, or services consulted during the ED phase of care, **arrived at the bedside to evaluate the injured patient** in the ED. **Field Values** • Collected as MMDDYYYY **Additional Information** • Trauma Team member equal to "TRS" will be mapped to NTDS's "Trauma Surgeon Arrival Date". • A "phone response" is NOT to be utilized as an *Arrival Date*. Physical evaluation of the patient is not possible via the phone.

DATA ELEMENT	ISSUE / CONCERN / ACTION
	• Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/ACUTE CARE** section.
ARRIVAL TIME *(TRAUMA TEAM)*	**Added** the following bullet in the DD for ARRIVAL TIME *(TRAUMA TEAM)*: • Trauma Team member equal to "TRS" will be mapped to NTDS's "Trauma Surgeon Arrival Time".
CONSULTATION SERVICE	**Revised** the following FIELD VALUE in the DD for CONSULTATION SERVICE: • THO~~S~~ THORACIC SURGERY **Added** the following FIELD VALUE in the DD and TO for CONSULTATION SERVICE: • INN INTERVENTIONAL NEUROLOGY
REQUEST DATE *(ED CONSULT)*	**Added** REQUEST DATE *(ED CONSULT)* as a data element in the DD and TO as follows: **Definition** Date that the consult services was requested to evaluate the patient in the ED phase of care, if applicable. **Field Values** • Collected as MMDDYYYY **Additional Information** • Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/ACUTE CARE** section.
ARRIVAL DATE *(ED CONSULT)*	**Added** ARRIVAL DATE *(ED CONSULT)* as a data element in the DD and TO as follows: **Definition** Date that the consulting services **arrived at the bedside to evaluate the injured patient** in the ED phase of care, if applicable. **Field Values** • Collected as MMDDYYYY **Additional Information** • **A "phone response" is NOT to be utilized as an *Arrival Time*.** Physical evaluation of the patient is not possible via the phone. • Services requested that do NOT physically evaluate the patient while in the ED should be listed in the **ICU/ACUTE CARE** section.
RADIOLOGY / LABRATORY	
WHOLE BLOOD (4 HOURS)	**Revised** the following bullets to the Additional Information in the DD for WHOLE BLOOD (4 HOURS): • Collected in ~~milliters~~ccs. • 1 unit of whole blood is equivalent to 500 ~~mls~~ccs if the actual volume of the unit is not documented.

DATA ELEMENT	ISSUE / CONCERN / ACTION
PACKED CELLS (PRBC) (4 HOURS)	**Revised** the following bullets to the Additional Information in the DD for PACKED CELLS (PRBC) (4 HOURS): • Collected in ~~milliters~~ccs. • 1 unit of PRBCs is equivalent to 350 ~~mls~~ccs if the actual volume of the unit is not documented.
PLASMA (FFP) (4 HOURS)	**Revised** the following bullets to the Additional Information in the DD for PLASMA (FFP) (4 HOURS): • Collected in ~~milliters~~ccs. • 1 unit of plasma is equivalent to 225 ~~mls~~ccs if the actual volume of the unit is not documented.
PLATELETS (4 HOURS)	**Revised** the following bullets to the Additional Information in the DD for PLATELETS (4 HOURS): • Collected in ~~milliters~~ccs. • 1 unit of Platelets is equivalent to 225 ~~mls~~ccs if the actual volume of the unit is not documented.
CRYOPRECIPITATE (4 HOURS)	**Revised** the following bullets to the Additional Information in the DD for CRYOPRECIPITATE (4 HOURS): • Collected in ~~milliters~~ccs. • 1 pack of Cryoprecipitate is equivalent to 100 ~~mls~~ccs if the actual volume of the pack is not documented.
WHOLE BLOOD (24 HOURS)	**Revised** the following bullets to the Additional Information in the DD for WHOLE BLOOD (24 HOURS): • Collected in ~~milliters~~ccs. • 1 unit of Whole Blood is equivalent to 500 ~~mls~~ccs if the actual volume of the unit is not documented.
PACKED CELLS (PRBC) (24 HOURS)	**Revised** the following bullets to the Additional Information in the DD for PACKED CELLS (PRBC) (24 HOURS): • Collected in ~~milliters~~ccs. • 1 unit of PRBCs is equivalent to 350 ~~mls~~ccs if the actual volume of the unit is not documented.
PLASMA (FFP) (24 HOURS)	**Revised** the following bullets to the Additional Information in the DD for PLASMA (FFP) (24 HOURS): • Collected in ~~milliters~~ccs. • 1 unit of plasma is equivalent to 225 ~~mls~~ccs if the actual volume of the unit is not documented.
PLATELETS (24 HOURS)	**Revised** the following bullets to the Additional Information in the DD for PLATELETS (24 HOURS): • Collected in ~~milliters~~ccs. • 1 unit of Platelets is equivalent to 225 ~~mls~~ccs if the actual volume of the unit is not documented.

DATA ELEMENT	ISSUE / CONCERN / ACTION
CRYOPRECIPITATE (24 HOURS)	**Revised** the following bullets to the Additional Information in the DD for CRYOPRECIPITATE (24 HOURS): • Collected in ~~milliters~~ccs. • 1 pack of Cryoprecipitate is equivalent to 100 ~~mls~~ccs if the actual volume of the pack is not documented.
WHOLE BLOOD (TOTAL)	**Revised** the following bullets to the Additional Information in the DD for WHOLE BLOOD (TOTAL): • Collected in ~~milliters~~ccs. • 1 unit of Whole Blood is equivalent to 500 ~~mls~~ccs if the actual volume of the unit is not documented.
PACKED CELLS (PRBC) (TOTAL)	**Revised** the following bullets to the Additional Information in the DD for PACKED CELLS (PRBC) (TOTAL): • Collected in ~~milliters~~ccs. • 1 unit of PRBCs is equivalent to 350 ~~mls~~ccs if the actual volume of the unit is not documented.
PLASMA (FFP) (TOTAL)	**Revised** the following bullets to the Additional Information in the DD for PLASMA (FFP) (TOTAL): • Collected in ~~milliters~~ccs. • 1 unit of Plasma is equivalent to 225 ~~mls~~ccs if the actual volume of the unit is not documented.
PLATELETS (TOTAL)	**Revised** the following bullets to the Additional Information in the DD for PLATELETS (TOTAL): • Collected in ~~milliters~~ccs. • 1 unit of Platelets is equivalent to 225 ~~mls~~ccs if the actual volume of the unit is not documented.
CRYOPRECIPITATE (TOTAL)	**Revised** the following bullets to the Additional Information in the DD for CRYOPRECIPITATE (TOTAL): • Collected in ~~milliters~~ccs. • 1 pack of Cryoprecipitate is equivalent to 100 ~~mls~~ccs if the actual volume of the pack is not documented.
PROCEDURES / OPERATIONS	
ICU / ACUTE CARE	
CONSULTATION SERVICE	**Revised** the following FIELD VALUE in the DD for CONSULTATION SERVICE: • THO~~S~~ THORACIC SURGERY **Added** the following FIELD VALUE in the DD and TO for CONSULTATION SERVICE: • INN INTERVENTIONAL NEUROLOGY

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td>HIGHEST GCS TOTAL</td><td>Revised the following bullet to the Additional Information in the DD for HIGHEST GCS TOTAL:
Enter the null value of “Not Applicable” for patients that do not meet the collection criteria or ~~and for~~ if the patient~~s with an ED and/or hospital discharge date~~ is discharged from your hospital prior to the next calendar day.</td></tr>
<tr><td>HIGHEST GCS MOTOR</td><td>Revised the following bullet to the Additional Information in the DD for HIGHEST GCS MOTOR:
Enter the null value of “Not Applicable” for patients that do not meet the collection criteria or ~~and for~~ if the patient~~s with an ED and/or hospital discharge date~~ is discharged from your hospital prior to the next calendar day.</td></tr>
<tr><td>QUALIFIER FOR HIGHEST GCS</td><td>Revised the following bullet to the Additional Information in the DD for QUALIFIER FOR HIGHEST GCS:
Enter the null value of “Not Applicable” for patients that do not meet the collection criteria or ~~and for~~ if the patient~~s with an ED and/or hospital discharge date~~ is discharged from your hospital prior to the next calendar day.</td></tr>
<tr><td colspan="2">POSTHOSPITAL</td></tr>
<tr><td>PHASE PRIOR TO DISCHARGE</td><td>Deleted the following bullet from the Additional Information for PHASE PRIOR TO DISCHARGE:
~~If the 23HR OBS is not a specific physical location at your facility, utilize Ward/Floor as the phase of care prior to discharge.~~</td></tr>
<tr><td>TRANSFERRED DISCHARGED TO</td><td>Added the following FIELD VALUES in the DD and TO for TRANSFERRED DISCHARGED TO, with the NTDS mapping:
<table>
<tr><th colspan="2">LA COUNTY</th><th colspan="2">NTDS</th></tr>
<tr><td>CLF</td><td>Congregate Living Facility</td><td>14</td><td>Discharged/Transferred to another type of institution not defined elsewhere</td></tr>
<tr><td>RCF</td><td>Recuperative Care Facility</td><td>14</td><td>Discharged/Transferred to another type of institution not defined elsewhere</td></tr>
</table></td></tr>
<tr><td>FACILITY NAME</td><td>Revised the following FIELD VALUES in the DD and TO for FACILITY NAME:
CPM Coast Plaza ~~Doctors~~ Hospital
DFM Cedars-Sinai Marina Del Rey Hospital
LBM MemorialCare Long Beach ~~Memorial~~ Medical Center
TRM Providence Cedars-Sinai Tarzana Medical Center
SIM Adventist Health - Simi Valley (Ventura)
Deleted the following FIELD VALUE in the DD and TO for TRANSFERRED FROM:
~~SVH Saint Vincent Medical Center~~</td></tr>
</table>

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td>TRANSFER RATIONALE</td><td>Added the following FIELD VALUE in the DD and TO for TRANSFER RATIONALE:
HO Hospice Patient transferred to hospice</td></tr>
<tr><td>DISCHARGE DIAGNOSIS – ICD-10 CODES</td><td>Revised the following bullet to the Additional Information in the DD for DISCHARGE DIAGNOSIS – ICD-10 CODES:
Injury diagnoses as defined by ICD-10-CM codes are in the range of S00-S99, T07, T14, T20-T28, and,T30-T32, and T79.A1-T79.A9, or compatible ICD-10-CA code range.
Added the following bullets to the Additional Information in the DD for DISCHARGE DIAGNOSIS – ICD-10 CODES:
ICD-10-CM codes in the range of T20-T28 and T30-T32, or compatible ICD-10-CA code range, have been removed from NTDS's inclusion criteria.
Enter the COVID-19 ICD-10 code if the patient arrives with a known positive test or a positive test is acquired while hospitalized.</td></tr>
<tr><td colspan="2">UNPLANNED READMISSION</td></tr>
<tr><td>READMIT TRANSFERRED DISCHARGED TO</td><td>Added the following FIELD VALUES in the DD and TO for READMIT TRANSFERRED DISCHARGED TO, with the NTDS mapping:
<table>
<tr><th colspan="2">LA COUNTY</th><th colspan="2">NTDS</th></tr>
<tr><td>CLF</td><td>Congregate Living Facility</td><td>14</td><td>Discharged/Transferred to another type of institution not defined elsewhere</td></tr>
<tr><td>RCF</td><td>Recuperative Care Facility</td><td>14</td><td>Discharged/Transferred to another type of institution not defined elsewhere</td></tr>
</table></td></tr>
<tr><td>READMIT TRANSFER RATIONALE</td><td>Added the following FIELD VALUE in the DD and TO for READMIT TRANSFER RATIONALE:
HO Hospice Patient transferred to hospice</td></tr>
<tr><td>READMIT TRANSFER TO</td><td>Revised the following FIELD VALUES in the DD and TO for READMIT TRANSFER TO:
CPM Coast Plaza ~~Doctors~~ Hospital
DFM Cedars-Sinai Marina Del Rey Hospital
LBM MemorialCare Long Beach ~~Memorial~~ Medical Center
TRM Providence Cedars-Sinai Tarzana Medical Center
SIM Adventist Health - Simi Valley (Ventura)
Deleted the following FIELD VALUE in the DD and TO for TRANSFERRED FROM:
~~SVH Saint Vincent Medical Center~~</td></tr>
<tr><td colspan="2">APPENDIX 1: REFERENCE DOCUMENTS</td></tr>
<tr><td>LOS ANGELES COUNTY TRAUMA DATABASE INCLUSION CRITERIA</td><td>Replaced the LOS ANGELES COUNTY TRAUMA DATABASE INCLUSION CRITERIA in the DD with the version dated January 1, 2021.

Revised the following language to Hospital Admission?:</td></tr>
</table>

DATA ELEMENT	ISSUE / CONCERN / ACTION
	• Was the patient transferred to or from your facility, and **admitted** ~~to the~~ by a Trauma ~~Service~~ Surgeon for care of an injury. **Added** the following to the to the list of EXCLUSIONS: • Injury codes that do not generate an ISS.
NATIONAL TRAUMA DATA STANDARD INCLUSION CRITERIA	**Replaced** the NATIONAL TRAUMA DATA STANDARD INCLUSION CRITERIA in the DD with the version from the NTDS Data Dictionary for 2021.
NTDS INCLUSION CRITERIA ALGORITHM	**Replaced** the NTDS INCLUSION CRITERIA ALGORITHM in the DD with the version from the NTDS Data Dictionary for 2021.
APPENDIX 2: REFERENCE GUIDES	
APPENDIX 3: GLOSSARY OF TERMS	
CO-MORBID *(PRE-EXISTING)* CONDITIONS	
Advanced Directive (limiting care)	**Revised** the definition in the DD for *Advanced Directive (limiting care)* to include the following: The patient had a Do-Not-Resuscitate (DNR) document or similar advance directive recorded prior to ~~injury~~ arrival at your center.
Alcohol Use Disorder (Alcoholism)	**Revised** the definition in the DD for *Alcohol Use Disorder (Alcoholism)* to include the following: Descriptors documented in the medical record consistent with the diagnostic criteria of alcohol use disorder OR a diagnosis of alcohol use disorder documented in the patient's medical record, consistent with American Psychiatric Association (APA) DSM 5, 2013.
Angina (Pectoris)	**Revised** the definition in the DD for *Angina (Pectoris)* to include the following: A diagnosis of Angina or Chest Pain, consistent with American Heart Association (AHA), May 2015, must be documented in the patient's medical record.
Anticoagulant Therapy	**Revised** the definition in the DD for *Anticoagulant Therapy* to include the following: Anticoagulant must be part of the patient's active medication.
Bleeding Disorder	**Revised** the definition in the DD for *Bleeding Disorder* to include the following: A Bleeding Disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willenbrand Disease, Factor V Leiden, Thrombocytopenia), consistent with American Society of Hematology, 2015.
Chronic Obstructive Pulmonary Disease (COPD)	**Revised** the definition in the DD for *Chronic Obstructive Pulmonary Disease (COPD)* as follows: ~~Lung ailment that is characterized by a persistent blockage of airflow from the lungs, present prior to injury. It is not one single disease but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow.~~ Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible.

DATA ELEMENT	ISSUE / CONCERN / ACTION
	The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis. COPD must be documented in the patient's medical record, consistent with World Health Organization (WHO), 2019. Do not include patients whose only pulmonary disease is acute asthma, and patients with diffuse interstitial fibrosis or sarcoidosis. ~~and result in any one or more of the following:~~ • ~~Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs]).~~ • ~~Hospitalization in the past for treatment of COPD.~~ • ~~Requires chronic bronchodilator therapy with oral or inhaled agents.~~ • ~~A Forced Expiratory Volume in 1 second (FEV1) of < 75% or predicted on pulmonary function testing.~~
Functionally Dependent Health Status	**Revised** the definition in the DD for *Functionally Dependent Health Status* as follows: Pre-injury functional status may be represented by the ability of the patient to complete activities of daily living (ADL) including: bathing, feeding, dressing, toileting, and walking. The patient is considered to have a Functionally Dependent Health Status if prior to injury they were partially dependent or completely dependent upon equipment, devices, or another person to complete some or all activities of daily living. ~~Formal definitions of dependency are listed below:~~ • ~~Partially dependent: The patient requires the use of equipment or devices coupled with assistance from another person for some activities of daily living. Any patient coming from a nursing home setting who is not totally dependent would fall into this category, as would any patient who requires kidney dialysis or home ventilator support that requires chronic oxygen therapy yet maintains some independent functions.~~ • ~~Totally dependent: The patient cannot perform any activities of daily living for himself/herself. This would include a patient who is totally dependent upon nursing care, or a dependent nursing home patient. All patients with psychiatric illnesses should be evaluated for their ability to function with or without assistance with ADLs just as the non-psychiatric patient.~~
Peripheral Arterial Disease (PAD)	**Revised** the definition in the DD for *Peripheral Arterial Disease (PAD)* to include the following: A diagnosis of PVD or PAD must be documented in the patient's medical record, consistent with Centers for Disease Control, 2014 Fact Sheet.
HOSPITAL *(EVENTS)* COMPLICATIONS	
Acute Kidney Injury (dialysis)	**Revised** the definition in the DD for *Acute Kidney Injury (dialysis)* to include the following: A diagnosis of AKI must be documented in the patient's medical record, that is consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.

DATA ELEMENT	ISSUE / CONCERN / ACTION
Acute Respiratory Distress Syndrome (ARDS)	**Revised** the definition in the DD for *Acute Respiratory Distress Syndrome (ARDS)* to include the following: A diagnosis of ARDS must be documented in the patient's medical record, that is consistent with the 2012 New Berlin Definition.
Alcohol Withdrawal (Syndrome)	**Revised** the definition in the DD for *Alcohol Withdrawal (Syndrome)* to include the following: Must have occurred during the patient's initial stay at your hospital, and documentation of alcohol withdrawal must be in the patient's medical record, that is consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.
Central Line-Associated Bloodstream Infection (CLABSI)	**Revised** the definition in the DD for *Central Line-Associated Bloodstream Infection (CLABSI)* to include the following: A diagnosis of CLABSI must be documented in the patient's medical record, that is consistent with the January 2016 CDC defined CLABSI.
Decubitus (Pressure) Ulcer	**Revised** the definition in the DD for *Decubitus (Pressure) Ulcer* to include the following: Documentation of Pressure Ulcer must be in the patient's medical record, consistent with the NPUAP 2014, and must have occurred during the patient's initial stay at your hospital.
Osteomyelitis	**Revised** the definition in the DD for *Osteomyelitis* to include the following: A diagnosis of osteomyelitis must be documented in the patient's medical record, that is consistent with the January 2016 CDC definition of Bone and Joint Infection.
Pulmonary Embolism (PE)	**Revised** the definition in the DD for *Pulmonary Embolism (PE)* to include the following: Exclude sub segmental PEs.
Sepsis/Severe Sepsis	**Revised** the definition in the DD for *Sepsis/Severe Sepsis* to include the following: A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CDC defined SSI, and meet the following criteria: Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)
Surgical Site Infection (SSI) (superficial)	**Revised** the definition in the DD for *Surgical Site Infection (SSI) (superficial)* to include the following: A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CDC defined SSI, and meet the following criteria: Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date
Surgical Site Infection (deep)	**Revised** the definition in the DD for *Surgical Site Infection (deep)* to include the following: A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CSC defined SSI, and must have occurred during the patient's initial stay at your hospital.
Surgical Site Infection (organ/space)	**Revised** the definition in the DD for *Surgical Site Infection (organ/space)* to include the following:

DATA ELEMENT	ISSUE / CONCERN / ACTION
	A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CSC defined SSI, and must have occurred during the patient's initial stay at your hospital.
Urinary Tract Infection Catheter-Associated (CAUTI)	**Revised** the definition in the DD for *Urinary Tract Infection Catheter-Associated (CAUTI)* as follows: A urinary tract infection (UTI) where an indwelling urinary catheter was in place for >2 calendar days on the date of event, with day of device placement being Day 1, **AND** An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for ~~>2 calendar days~~ more than 2 consecutive days in an inpatient location and then removed, the date of event for the UTI must be the day of device discontinuation or the next day for the UTI to be catheter-associated. A diagnosis of UTI must be documented in the patient's medical record that is consistent with the January 2019 CDC defined CAUTI. *Criterion 1:* • *Criterion 1:* Patient must meet 1, 2, **and** 3 below: 1. Patient has an indwelling urinary catheter that had been in place ~~for the entire day~~ more than 2 consecutive days in an inpatient location on the date of event ~~and such catheter had been in place for >2 calendar days, on that date (day of device placement – Day 1)~~ AND was either: ▪ Present for any portion of the calendar day of the event, OR ▪ Removed the day before the date of event 2. Patient has at least **one** of the following signs or symptoms: ▪ Fever (>38^{0}C): Reminder: To use fever in a patient >65 years of age, the IUC needs to be in place for more than 2 consecutive days in an inpatient location on date of event and is either still in place OR was removed the day before the DOE ▪ Suprapubic tenderness ~~with no other recognized cause~~ ▪ Costovertebral angle pain or tenderness ~~with no other recognized cause~~ ▪ Urinary urgency ▪ Urinary frequency ▪ dysuria 3. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium~~a~~ >10^5 CFU/ml. *Criterion 2:* Patient must meet 1, 2 **and** 3 below: 1. Patient is ≤1 year of age 2. Patient has at least **one** of the following signs or symptoms:

DATA ELEMENT	ISSUE / CONCERN / ACTION
	▪ fever (>38.0^{0}C) ▪ hypothermia (<36.0^{0}C) ▪ apnea ~~with no other recognized cause~~ ▪ bradycardia ~~with no other recognized cause~~ ▪ lethargy ~~with no other recognized cause~~ ▪ vomiting ~~with no other recognized cause~~ ▪ suprapubic tenderness ~~with no other recognized cause~~ 3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacterium~~a~~ of ≥10^5 CFU/ml.
Pneumonia Ventilator-Associated (VAP)	**Revised** the definition in the DD for *Pneumonia Ventilator-Associated (VAP)* to include the following: A diagnosis of pneumonia must be documented in the patient's medical record that is consistent with the January 2019 CDC defined VAP.

LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES AGENCY

TRAUMA SYSTEM STATUS REPORT

FISCAL YEAR 2021-2022

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Trauma System Goals & Objectives

Goals/Objectives	Action	Schedule	Outcome
Maintain a Trauma Registry in compliance with NTDS and ACS TQIP.	In collaboration with the THAC Data Subcommittee, the Los Angeles County EMS Agency continues to review and revise the Trauma Data Dictionary (TDD) to maintain compliance with the minimum data set and definitions of NTDS and ACS TQIP.	Annually	The TDD is revised and implemented annually. Summary of changes is attached for review as Attachment F
Validate compliance with ACS standards and the Los Angeles County Specialty Care Center Designation Exhibit for Trauma Center Designation.	Attend virtual ACS verification surveys. Review the Los Angeles County Specialty Care Center Designation Exhibit for Trauma Center Designation and Los Angeles County Policies pertaining to the Trauma Centers to verify compliance.	Ongoing	Trauma centers verified during FY 2021-2022: Antelope Valley Medical Center, Huntington Hospital, Cedars-Sinai Medical Center, Henry Mayo Newhall Hospital, Dignity Health – Northridge Medical Center, and Los Angeles General Medical Center
Utilize TQIP Collaborative reports to compare our system performance to national results, revealing opportunities to impact patient care, identify best practices and opportunities for improvement at a systems level.	Facilitate regional QI meetings with trauma centers.	Ongoing	Trauma centers present and discuss morbidity and mortality cases, share best practices and opportunities for improvement, and review TQIP Collaborative reports at Regional QI Meetings. There are three regions with five trauma centers per region.

Trauma System Summary

A map of our current Trauma Centers is included for reference (Attachment A)

List of Designated Trauma Centers and Agreement Expiration Dates (Attachment B)

Trauma System Volume Overview (Attachment C)

Annual System Blunt vs. Penetrating Trauma (Attachment D)

Changes since the previous plan was submitted and approved include:

- Reference No. 814, Determination/Pronouncement of Death in the Field – Revised 04-01-2022 (Attachment E)

Trauma Center Data Dictionary – The Trauma Center Data Dictionary (TDD) is updated annually to ensure continued compliance with the minimum data set and definitions of NTDS™ and ACS TQIP®. Due to its size, Reference No. 646, Trauma Center Data Dictionary 2022, is not included but is available upon request or on our Los Angeles County EMS Agency website. The Trauma Center Data Dictionary Summary of Changes 2022 is attached detailing the changes made. (Attachment F)

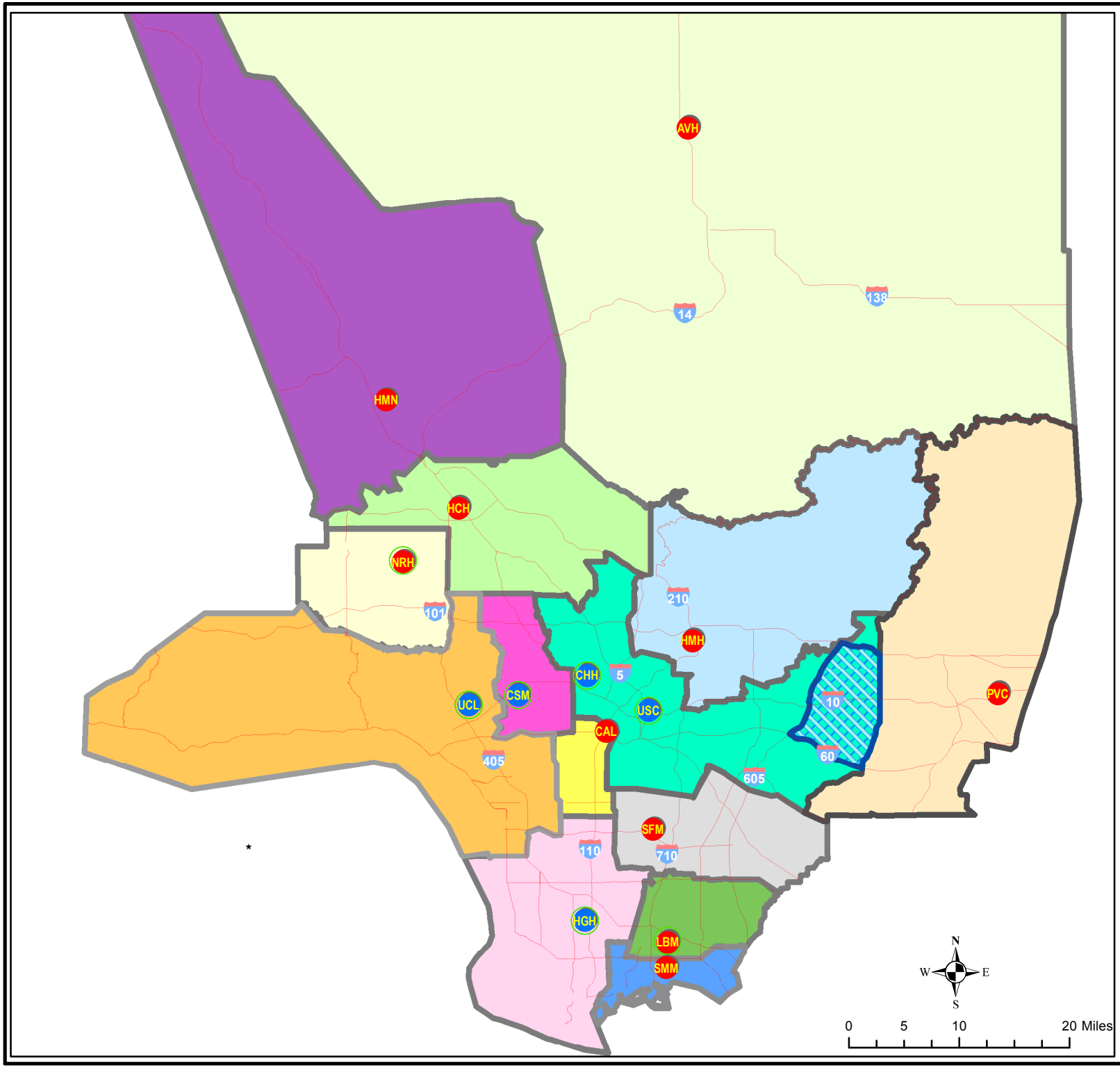
EMS Update and EmergiPress Topics included:

- Managing Epitaxis
- Diabetic Keto Acidosis
- Childbirth Emergency
- Managing a Mechanical Circulatory Support Devise Patient
- Traumatic Out of Hospital Cardiac Arrest
- Adult and Pediatric Out of Hospital Cardiac Arrest
- Neonatal Resuscitation
- Patient Refusal of Treatment and Transport, and Treat and Release at the Scence
- Needle thoracostomy update
    - Complications of needle thoracostomy
    - Locations approved for needle thoracostomy in Los Angeles County
    - Indications for needle thoracostomy
    - Needle thoracostomy placement considerations in children
- Mass casualty incidents
    - START and JumpSTART triage

Los Angeles County utilizes Trauma Quality Improvement Program (TQIP) and our collaborative reports as the basis for our QI program. The Trauma QI Subcommittee meets quarterly to review TQIP reports and evaluate the need for system-wide QI indicators. Additionally, there are quarterly regional QI meetings where case reviews are presented and discussed.

Attachment A

Los Angeles County Trauma Centers



Trauma Centers As of 2017

Code	Name
AVH	Antelope Valley Hospital
CAL	California Hospital Medical Center
CHH	Children's Hospital Los Angeles
CSM	Cedars Sinai Medical Center
HCH	Providence Holy Cross Medical Center
HGH	LAC Harbor-UCLA Medical Center
HMH	Huntington Hospital
HMN	Henry Mayo Newhall Hospital
LBM	Long Beach Memorial Medical Center
NRH	Northridge Hospital Medical Center
PVC	Pomona Valley Hospital Medical Center
SFM	Saint Francis Medical Center
SMM	Saint Mary Medical Center
UCL	Ronald Reagan UCLA Medical Center
USC	LAC+USC Medical Center

TRAUMA012017

Trauma Centers

- LEVEL I/PTC
- LEVEL II
- LEVEL II/PTC
- PVC_USC_shared

TraumaAll_82417

List of Designated Trauma Centers and Agreement Expiration Dates

TRAUMA CENTER	LEVEL	PTC	FISCAL YEAR FOR NEXT REVIEW
Antelope Valley Hospital	II		August 24, 2024
Cedars-Sinai Medical Center	I	X	July 2, 2022
Children's Hospital Los Angeles	I	X	June 11, 2023
Dignity Health – California Hospital Medical Center	II		May 16, 2024
Dignity Health – Northridge Hospital Medical Center	II	X	June 24, 2022
Dignity Health – Saint Mary Medical Center	II		November 9, 2023
LAC Harbor UCLA Medical Center	I	X	November 9, 2023
LAC+USC Medical Center	I	X	July 1, 2022
Henry Mayo Newhall Hospital	II		June 4, 2022
Huntington Hospital	II		November 9, 2021
MemorialCare Long Beach Medical Center	II	X	November 8, 2021
Pomona Valley Hospital	II		September 5, 2022
Providence Holy Cross Medical Center	II		May 15, 2024
Saint Francis Medical Center	II		November 20, 2022
Ronald Reagan UCLA Medical Center	I	X	June 12, 2023

In response to the COVID-19 pandemic, all ACS verified centers were granted an extension of one year for centers with an expiration date falling between January 2020 and December 2023. At the time the extension was granted all LA County Trauma Centers were verified except for SMM.

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

TRAUMA SYSTEM VOLUME

2000 – 2021

YEAR	NUMBER OF TRAUMA CENTERS	PATIENT VOLUME	VOLUME CHANGE	PERCENTAGE CHANGE
2000	13	16,912	1,259	8%
2001	13	18,837	1,925	11%
2002	13	19,196	359	2%
2003	13	18,150	1,046	6%
2004	14	17,134	1,016	6%
2005	13	17,680	546	3%
2006	13	18,632	952	6%
2007	13	19,481	849	5%
2008	13	19,188	293	2%
2009	13	19,173	15	0%
2010	14	19,121	52	0%
2011	14	20,242	121	6%
2012	14	23,855	3,613	16%
2013	14	25,743	1,888	8%
2014	14	26,874	1,311	5%
2015	14	28,822	1,948	7%
2016	14	26,243	2,579	9%
2017	15	23,332	2,911	12%
2018	15	22,542	790	3%
2019	15	22,348	194	0%
2020	15	22,349	1	0%
2021	15	25,075	2,726	12%

RED DENOTES DECREASE
BLUE DENOTES INCREASE

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

BLUNT vs PENETRATING

2000 – 2021

YEAR	TOTAL VOLUME	BLUNT INJURIES	PERCENT BLUNT	PENETRATING INJURIES	PERCENT PENETRATING
2000	16,724	12,939	77%	3,785	23%
2001	18,824	14,854	79%	3,970	21%
2002	19,181	14,889	78%	4,292	22%
2003	18,150	14,034	77%	4,116	23%
2004	17,134	13,107	76%	4,020	23%
2005	17,680	13,367	76%	4,380	25%
2006	18,632	14,419	77%	4,205	23%
2007	19,481	15,513	80%	3,837	20%
2008	19,188	15,397	80%	3,788	20%
2009	19,173	15,703	82%	3,468	18%
2010	19,121	15,798	83%	3,314	17%
2011	20,242	17,009	84%	3,226	16%
2012	23,855	20,227	85%	3,628	15%
2013	25,743	22,085	86%	3,645	14%
2014	26,874	23,122	86%	3,720	14%
2015	28,822	24,560	85%	4,248	15%
2016	26,243	21,862	83%	4,376	17%
2017	23,332	19,242	82%	4,089	18%
2018	22,542	18,629	83%	3,878	17%
2019	22,348	18,486	83%	3,727	17%
2020	22,349	17,538	78%	4,574	20%
2021	25,075	19,976	79%	4,984	20%

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/ PARAMEDIC/MICN)

SUBJECT: **DETERMINATION / PRONOUNCEMENT OF DEATH IN THE FIELD**

REFERENCE NO. 814

PURPOSE: This policy is intended to provide EMS personnel with parameters to determine whether or not to withhold resuscitative efforts in accordance with the patient's wishes, and to provide guidelines for base hospital physicians to discontinue resuscitative efforts and pronounce death.

AUTHORITY: California Health and Safety Code, Division 2.5
California Probate Code, Division 4.7
California Family Code, Section 297-297.5
California Health and Safety Code, Division 1, Part 1.8, Section 443 et seq.

DEFINITIONS:

Advance Health Care Directive (AHCD): A written document that allows patients who are unable to speak for themselves to provide health care instructions and/or appoint a Power-of-Attorney for Health Care. There is no one standard format for an AHCD. Examples of AHCDs include:

- Durable power of attorney for Healthcare (DPAHC)
- Healthcare proxies
- Living wills (valid in California if dated prior to 7-1-2000; advisory but not legally binding after that date)

Agent: An individual, eighteen years of age or older, designated in a durable power of attorney for health care to make health care decisions for the patient, also known as "attorney-in-fact".

Aid-in-Dying Drug: A drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to terminal illness. The prescribed drug may take effect within minutes to several days after self-administration.

Conservator: Court-appointed authority to make health care decisions for a patient.

Determination of Death: To conclude that a patient has died by conducting an assessment to confirm the absence of respiratory, cardiac, and neurologic function.

End of Life Option Act: This California state law authorizes an adult, eighteen years or older, who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease to make a request for an "aid-in-dying drug" prescribed for the purpose of ending his or her life in a humane and dignified manner.

Immediate Family: The spouse, domestic partner, parent, adult children, adult sibling(s), or family member intimately involved in the care of the patient.

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Laucche Gillmore
Medical Director, EMS Agency

Organized ECG Activity: A sinus, atrial or junctional (supraventricular) rhythm.

Pronouncement of Death: A formal declaration by a base hospital physician that life has ceased.

Standardized Patient-Designated Directives: Forms or medallions that recognize and accommodate a patient's wish to limit prehospital treatment at home, in long term care facilities, or during transport between facilities. Examples include:

- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form (Ref. No. 815.1)
- Physician Orders for Life-Sustaining Treatment (POLST, Ref. No. 815.2)
- State EMS Authority-approved DNR Medallion

PRINCIPLES:

1. Resuscitative efforts are of no benefit to patients whose physical condition precludes any possibility of successful resuscitation.

2. EMTs and paramedics may **determine** death based on specific criteria set forth in this policy.

3. Base hospital physicians may **pronounce** death based on information provided by the paramedics in the field and guidelines set forth in this policy.

4. If there is any objection or disagreement by family members or EMS personnel regarding terminating or withholding resuscitation, basic life support (BLS) resuscitation, including defibrillation, may continue or begin immediately and paramedics should contact the base hospital for further directions.

5. Aggressive resuscitation in the field to obtain the return of spontaneous circulation (ROSC) is encouraged. Transporting patients without ROSC is discouraged.

6. EMS personnel should honor valid do-not-resuscitate (DNR) orders and other patient designated end-of-life directives in the field and act in accordance with the patient's wishes when death appears imminent.

POLICY:

I. EMS personnel may determine death in the following circumstances:

   A. In addition to the absence of respiration, cardiac activity, and neurologic reflexes, one or more of the following physical or circumstantial conditions exist:

      1. Decapitation

      2. Massive crush injury

      3. Penetrating or blunt injury with evisceration of the heart, lung or brain

4. Decomposition

5. Incineration

6. Pulseless, non-breathing victims with extrication time greater than fifteen minutes, where no resuscitative measures can be performed prior to extrication.

7. Penetrating trauma patients who, based on the paramedic's thorough assessment, are found apneic, pulseless, asystolic, and without pupillary reflexes upon the arrival of EMS personnel at the scene.

8. Blunt trauma patients who, based on a paramedic's thorough patient assessment, are found apneic, pulseless, and without organized ECG activity (sinus, atrial or junctional rhythm) due to traumatic mechanism upon the arrival of EMS personnel at the scene.

    a. For patients with shockable ventricular rhythm, defibrillate as per TP 1243/1243-P in attempt to restore organized ECG activity prior to determination of death.

9. Pulseless, non-breathing victims of a multiple victim incident where insufficient medical resources preclude initiating resuscitative measures.

10. Drowning victims, when it is reasonably determined that submersion has been greater than one hour.

11. Rigor mortis (requires assessment as described in Section I, B.)

12. Post-mortem lividity (requires assessment as described in Section I, B.)

B. If the initial assessment reveals rigor mortis and/or post-mortem lividity only, EMTs and/or paramedics shall perform the following assessments (may be performed concurrently) to confirm the absence of respiratory, cardiac, and neurologic function for determination of death in the field:

1. Assessment of respiratory status:

    a. Assure that the patient has an open airway.

    b. Look, listen and feel for respirations. Auscultate the lungs for a minimum of 30 seconds to confirm apnea.

2. Assessment of cardiac status:

    a. Auscultate the apical pulse for a minimum of 60 seconds to confirm the absence of heart sounds.

    b. Adults and children: Palpate the carotid pulse for a minimum of 60 seconds to confirm the absence of a pulse.

c. Infants: Palpate the brachial pulse for a minimum of 60 seconds to confirm the absence of a pulse.

3. Assessment of neurological reflexes:

a. Check for pupillary response with a penlight or flashlight to determine if pupils are fixed and dilated.

b. Check and confirm unresponsive to pain stimuli.

C. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I. A. require immediate BLS measures to be initiated. If one or more of the following conditions is met, resuscitation may be discontinued and the patient is determined to be dead:

1. A valid standardized patient-designated directive indicating DNR.

2. A valid AHCD with written DNR instructions or the agent identified in the AHCD requesting no resuscitation.

3. Immediate family member present at scene:

a. With a patient-designated directive on scene requesting no resuscitation

b. Without said documents at scene, with full agreement of immediate family requesting no resuscitation, and EMS providers concur

4. Parent or legal guardian is required and must be present at scene to withhold or terminate resuscitation for patients less than 18 years of age.

II. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I require immediate cardiopulmonary resuscitation in accordance with Ref. No. 1210, Treatment Protocol: Cardiac Arrest. Base contact for medical direction shall be established when indicated by Ref. No. 1210.

A. EMS Personnel may determine death if a patient is in **asystole** after 20 minutes of quality cardiopulmonary resuscitation on scene and meets ALL of the following criteria:

1. Patient 18 years or greater

2. Arrest not witnessed by EMS personnel

3. No shockable rhythm identified at any time during the resuscitation

4. No ROSC at any time during the resuscitation

5. No hypothermia

B. Base Physician consultation for pronouncement is not required if Section A is

met.

C. Base Physician contact shall be established to guide resuscitation and to make decisions regarding timing of transport, if transport is indicated, for all patients in cardiopulmonary arrest who do not meet the conditions described in Section I or IIA of this policy.

D. In the event that immediate family members on scene request termination of resuscitation after resuscitation is in progress, and the patient does not meet criteria in section IIA, base physician consultation shall be made for termination and pronouncement. This does not apply to brief initiation of CPR while establishing patient/family wishes as per I.C.3.

III. Physician guidelines for transport versus termination

A. Resuscitation should be continued on-scene until one of the following:

1. ROSC is confirmed with a palpable pulse and corresponding rise in $EtCO_2$ Paramedics should stabilize the patient on scene after ROSC (for approximately 5 minutes) per TP 1210 and initiate transport once ROSC is maintained.

2. Base physician determines further resuscitative efforts are futile

B. Patients who have NOT maintained ROSC after on-scene resuscitation and stabilization should NOT be transported unless the Base physician determines transport is indicated.

1. Early transport for patients with ongoing resuscitation is NOT advised.

2. The decision to transport a patient with refractory OHCA should be based on the availability of therapies at the receiving center that are not available on scene.

IV. Crime Scene Responsibility, Including Presumed Accidental Deaths and Suspected Suicides

A. Responsibility for medical management rests with the most medically qualified person on scene.

B. Authority for crime scene management shall be vested in law enforcement. To access the patient, it may be necessary to ask law enforcement officers for assistance to create a “safe path” that minimizes scene contamination.

C. If law enforcement is not on scene, EMS personnel should attempt to create a "safe path" and secure the scene until law enforcement arrives.

V. Procedures Following Pronouncement of Death

A. The deceased should not be moved without the coroner’s authorization. Any invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient

should be left in place.

NOTE: If it is necessary to move the deceased because the scene is unsafe, the body is creating a hazard, or the body is at risk of loss through fire or flood, the EMS personnel may relocate the deceased to a safer location, or transport to the most accessible receiving facility.

B. If law enforcement or the coroner confirms that the deceased will not be a coroner's case and the personal physician is going to sign the death certificate, any invasive equipment used during the resuscitation may be removed.

C. EMS personnel should remain on scene until law enforcement arrives. During this time, when appropriate, the provider should provide grief support to family members.

VI. Required Documentation for Patients Determined Dead/Pronounced in the Field

A. The time and criteria utilized to determine death; the condition, location and position of the body, and any care provided.

B. The location and the rationale if the deceased was moved. If the coroner authorized movement of the deceased, document the coroner's case number (if available) and the coroner's representative who authorized the movement.

C. Time of pronouncement and name of the pronouncing physician if base hospital contact was initiated

D. The name of the agent identified in the AHCD or patient-designated directive or the name of the immediate family member who made the decision to withhold or withdraw resuscitative measures. Obtain their signature on the EMS Report Form.

E. If the deceased is **not** a coroner's case and their personal physician is going to sign the death certificate:

1. Document the name of the coroner's representative who authorized release of the patient, and

2. The name of the patient's personal physician signing the death certificate, and

3. Any invasive equipment removed

VII. End of Life Option Act

A. Resuscitation shall be withheld on patients in cardiopulmonary arrest who have self-administered an aid-in-dying drug (see Ref. No. 815.4, End of Life Option Field Quick Reference Guide).

B. Document the presence of a Final Attestation and attach a copy if available.

SUBJECT: **DETERMINATION / PRONOUNCEMENT OF DEATH IN THE FIELD** REFERENCE NO. 814

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 516, **Cardiac Arrest (Non-Traumatic) Patient Destination**
Ref. No. 518, **Decompression Emergencies/Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 815, **Honoring Prehospital Do Not Resuscitate Orders**
Ref. No. 815.1, **EMSA/CMA Prehospital Do Not Resuscitate (DNR) Form**
Ref. No. 815.2, **Physician Orders for Life-Sustaining Treatment (POLST) Form**
Ref. No. 815.3, **Sample - Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner**
Ref. No. 815.4, **End of Life Option Field Quick Reference Guide**
Ref. No. 819, **Organ Donor Identification**

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

Trauma Hospital Advisory Committee

TRAUMA DATA SUBCOMMITTEE

SUMMARY OF CHANGES 2022

DATA ELEMENT	ISSUE / CONCERN / ACTION
GENERAL INFORMATION	
TRANSFERRED FROM	**Added** the following FIELD VALUES in the DD and TO: • LBC Community Hospital Long Beach **Deleted** the following FIELD VALUE in the DD and TO for TRANSFERRED FROM: • ~~MID- Olympia Medical Center~~
PREHOSPITAL	
PROVIDER	**Revised** the following FIELD VALUE in the DD and TO: • FC ~~First Care~~ First Rescue Ambulance
EMERGENCY DEPARTMENT	
NEXT PHASE AFTER ED	**Added** the following FIELD VALUE in the DD: LA COUNTY: Next Phase After ED: ORR – Operating Room Recovery NTDS: ED Discharge Disposition: 7 – Operating Room
RADIOLOGY / LABORATORY	
ORGANS INJURED	**ADDED** the following FIELD VALUE in the DD and TO: PANCREAS
ORGAN GRADE – Liver	**ADDED** the following to **Additional Information:** • ORGAN GRADE – Pancreas
ORGAN GRADE – Spleen	**ADDED** the following to **Additional Information:** • ORGAN GRADE – Pancreas
ORGAN GRADE – Kidney	**ADDED** the following to **Additional Information:** • ORGAN GRADE – Pancreas

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td>ORGAN GRADE - Pancreas</td><td>
ADDED the following FIELD in the DD and TO:
Definition
Results of solid organ grading of the pancreas, if applicable.

Field Values

<table>
<tr><th colspan="3">LA COUNTY</th></tr>
<tr><td rowspan="2">Grade I</td><td>Hematoma</td><td>Minor contusion without ductal injury</td></tr>
<tr><td>Laceration</td><td>Superficial laceration without ductal injury</td></tr>
<tr><td rowspan="2">Grade II</td><td>Hematoma</td><td>Major contusion without ductal injury or tissue loss</td></tr>
<tr><td>Laceration</td><td>Major laceration without ductal injury or tissue loss</td></tr>
<tr><td>Grade III</td><td>Laceration</td><td>Distal transection or pancreatic parenchymal injury with ductal injury</td></tr>
<tr><td>Grade IV</td><td>Laceration</td><td>Proximal transection or pancreatic parenchymal injury involving the ampulla</td></tr>
<tr><td>Grade V</td><td>Laceration</td><td>Massive disruption of the pancreatic head</td></tr>
</table>
Uses
• Assists with determination of appropriate treatment.
• Provides documentation of assessment and/or care.
• System evaluation and monitoring.

Data Source Hierarchy
• Radiology Records
• ED Records

Other Associated Elements
• RADIOLOGY: Body Part/ICD-10
• RADIOLOGY: Study
• RADIOLOGY: Date
• RADIOLOGY: Time
• RADIOLOGY: Result
• RADIOLOGY: Description
• SOLID ORGAN INJURY?
• ORGANS INJURED
• ORGAN GRADE – Liver
• ORGAN GRADE - Spleen
• ORGAN GRADE – Kidney
</td></tr>
<tr><td>WHOLE BLOOD (4 HOURS)</td><td>
Added the following bullet to the Additional Information:
• EXCLUDE: Cell Saver Blood
</td></tr>
</table>

DATA ELEMENT	ISSUE / CONCERN / ACTION
PACKED CELLS (PRBC) (4 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE**: Cell Saver Blood
PLASMA (FFP) (4 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PLATELETS (4 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
CRYOPRECIPITATE (4 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
WHOLE BLOOD (24 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PACKED CELLS (PRBC) (24 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PLASMA (FFP) (24 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PLATELETS (24 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
CRYOPRECIPITATE (24 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
WHOLE BLOOD (TOTAL)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PACKED CELLS (PRBC) (TOTAL)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PLASMA (FFP) (TOTAL)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PLATELETS (TOTAL)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
CRYOPRECIPITATE (TOTAL)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PROCEDURES / OPERATIONS	
ICU / ACUTE CARE	

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td>VTE PROPHLAXIS TYPE</td><td>Added the following bullet to the Additional Information in the DD:
If patient refuses prophylaxis utilize “None”</td></tr>
<tr><td colspan="2">POSTHOSPITAL</td></tr>
<tr><td>PHASE PRIOR TO DISCHARGE</td><td>Added the following FIELD VALUE in the DD:
ORR: Operating Room Recovery</td></tr>
<tr><td>FACILITY NAME</td><td>Added the following FIELD VALUES in the DD and TO:
LBC Community Hospital Long Beach
Deleted the following FIELD VALUE in the DD and TO:
~~MID- Olympia Medical Center~~</td></tr>
<tr><td colspan="2">UNPLANNED READMISSION</td></tr>
<tr><td>READMIT TRANSFER TO</td><td>Added the following FIELD VALUES in the DD and TO:
LBC Community Hospital Long Beach
Deleted the following FIELD VALUE in the DD and TO:
~~MID- Olympia Medical Center~~</td></tr>
<tr><td colspan="2">APPENDIX 1: REFERENCE DOCUMENTS</td></tr>
<tr><td>NATIONAL TRAUMA DATA STANDARD INCLUSION CRITERIA</td><td>Replaced the NATIONAL TRAUMA DATA STANDARD INCLUSION CRITERIA in the DD with the version from the NTDS Data Dictionary for 2022.</td></tr>
<tr><td>TRANSPORTATION MECHANISMS FO INJURIES QUICK REFERENCE GUIDE</td><td>Revised the following:<table><tr><td>STRUCK BY
a moving transport, and
NOT in an enclosed vehicle</td><td>Force is equal to or less than 20mph</td></tr><tr><td>OPERATING
any transport</td><td>Transport is unenclosed, and force is EQUAL to or LESS than 20mph</td></tr></table></td></tr>
<tr><td colspan="2">APPENDIX 2: REFERENCE GUIDES</td></tr>
<tr><td colspan="2">Appendix will be deleted.</td></tr>
<tr><td colspan="2">APPENDIX 3: GLOSSARY OF TERMS</td></tr>
<tr><td colspan="2">CO-MORBID (PRE-EXISTING) CONDITIONS</td></tr>
<tr><td>Advanced Directive (limiting care)</td><td>Revised the definition:
The patient had a ~~Do-Not-Resuscitate (DNR) document or similar advance directive recorded~~ written request, signed/dated by the patient and/or his/her designee, to limit life-sustaining treatment that restricted the care for the patient during this patient care event prior to arrival at your center.</td></tr>
</table>

DATA ELEMENT	ISSUE / CONCERN / ACTION
	Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g., decompressive craniectomy, operation for hemorrhage control, angiography).
Angina (Pectoris):	**Revised** the definition: Chest pain or discomfort due to Coronary Heart Disease, present prior to injury. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men. A diagnosis of ~~Angina or Chest Pain~~ angina including microvascular angina, Prinzmetal's angina, stable angina, unstable angina, and variant angina, consistent with American Heart Association (AHA), May 2015, must be documented in the patient's medical record.
Congenital Anomalies	**Revised** the definition to include the following: Only report on patients ≤ 18 years-of -age.
Disseminated Cancer	**Revised** the definition: Patients who have cancer that: • Has spread to one site or more sites in addition to the primary site **AND** • In ~~whom~~ the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. ~~Other~~ Another term~~s~~ describing disseminated cancer is metastatic. ~~include "diffuse," "widely metastatic," "widespread," or "carcinomatosis." Common sites of metastases include major organs (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, or bone).~~
Hypertension	**Revised** the definition: History of persistent elevated blood pressure requiring antihypertensive medication.~~medical therapy,~~ present prior to injury, even if non-compliant with their prescribed antihypertensive medication. A diagnosis of Hypertension must be documented in the patient's medical record.
Prematurity	**Revised** the definition to include the following: Only report on patients ≤ 18 years-of -age.
Steroid Use	**Revised** the definition: ~~Patients that required the~~ Regular administration of oral or parenteral corticosteroid medications (e.g., Prednisone, Decadron) in the 30 days prior to injury for a chronic medical condition (e.g., COPD, asthma, rheumatologic disease, rheumatoid arthritis, inflammatory bowel disease). Do not include topical corticosteroids applied to the skin or corticosteroids administered by inhalation or rectally.

DATA ELEMENT	ISSUE / CONCERN / ACTION
HOSPITAL *(EVENTS)* COMPLICATIONS	
Acute Kidney Injury (dialysis):	**Revised** the definition: A diagnosis of AKI must be documented in the patient's medical record, that is consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline and onset of symptoms began after arrival to your ED/hospital.
Acute Respiratory Distress Syndrome (ARDS)	**Revised** the definition: A diagnosis of ARDS must be documented in the patient's medical record, that is consistent with the 2012 New Berlin Definition and onset of symptoms began after arrival to your ED/hospital.
Alcohol Withdrawal (Syndrome)	**Revised** the definition: Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption, and when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens). ~~Must have occurred during the patient's initial stay at your hospital~~ Onset of symptoms began after arrival to your ED/hospital, and documentation of alcohol withdrawal must be in the patient's medical record, that is consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.
Cardiac Arrest with CPR	**Revised** the definition: INCLUDE patients who, after arrival at your ED/hospital, have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.
Central Line-Associated Bloodstream Infection (CLABSI)	**Revised** the definition: A diagnosis of CLABSI must be documented in the patient's medical record, that is consistent with the January 2016 CDC defined CLABSI and onset of symptoms began after arrival to your ED/hospital. Criterion 1: Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). **AND** Organism cultured from blood is not related to an infection at another site **OR** Criterion 2:
Cerebral Vascular Accident (CVA)/Stroke	**Revised** the definition: A focal or global neurological deficit of rapid onset and ~~NOT present on admission~~ onset of symptoms began after arrival to your ED/hospital.

DATA ELEMENT	ISSUE / CONCERN / ACTION
Decubitus (Pressure) Ulcer	**Revised** the definition: A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and Suspected Deep Tissue Injury. Documentation of Pressure Ulcer must be in the patient's medical record, consistent with the NPUAP 2014, and ~~must have occurred during the patient's initial stay at your~~ onset of symptoms began after arrival to your ED/hospital.
Deep Vein Thrombosis (DVT)/Thrombophlebitis	**Revised** the definition to include the following: Onset of symptoms began after arrival to your ED/hospital.
Delirium	**Revised** the definition: Acute onset of behaviors ~~occurring during the patient's initial hospital stay at your~~ with an onset after arrival to your ED/hospital characterized by restlessness, illusions, and incoherence of thought and speech. Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.
Myocardial Infarction (MI)	**Revised** the definition: An acute myocardial infarction must be noted with documentation of ECG changes indicative of acute MI with onset of symptoms beginning after arrival to your ED/hospital
Osteomyelitis	**Revised** the definition: • A diagnosis of osteomyelitis must be documented in the patient's medical record, that is consistent with the January 2020 ~~2016~~ CDC definition of Bone and Joint Infection and onset of symptoms began after arrival to your ED/hospital.
Pulmonary Embolism (PE)	**Revised** the definition to include the following: Onset of symptoms began after arrival to your ED/hospital.
Sepsis/Severe Sepsis	**Revised** the definition: Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to 1 or more organs. Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation. A diagnosis of Sepsis must be documented in the patient's medical record, consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010, and ~~must have occurred during the patient's initial stay at your~~ onset of symptoms began after arrival to your ED/hospital.
Surgical Site Infection (SSI) (superficial)	**Revised** the definition: A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CDC defined SSI, onset of symptoms began after arrival to your ED/hospital, and meet the following criteria:

DATA ELEMENT	ISSUE / CONCERN / ACTION
Surgical Site Infection (deep)	**Revised** the definition: A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CSC defined SSI, and ~~must have occurred during the patient's initial stay at~~ onset of symptoms began after arrival to your ED/hospital.
Surgical Site Infection (organ/space)	**Revised** the definition: A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CDC defined SSI, and ~~must have occurred during the patient's initial stay at~~ onset of symptoms began after arrival to your ED/hospital.
Unplanned Return (admission) to the ICU	**Revised** the definition: EXCLUDE patients ~~in which the ICU care is required postoperatively for a planned surgical procedure~~ with a planned ICU stay post-operative. INCLUDE patients who required ICU care due to an event that occurred during surgery or in the PACU.
Unplanned Visit to the OR	**Revised** the definition: EXCLUDE non-urgent tracheostomy and percutaneous endoscopic gastrostomy; pre-planned, staged and/or procedures for incidental findings; and operative management related to a procedure that was initially performed prior to arrival at your center.
Urinary Tract Infection Catheter-Associated (CAUTI)	**Revised** the definition: A diagnosis of UTI must be documented in the patient's medical record that is consistent with the January 2019 CDC defined CAUTI and onset of symptoms began after arrival to your ED/hospital.
Pneumonia Ventilator-Associated (VAP)	**Revised** the definition: A diagnosis of pneumonia must be documented in the patient's medical record that is consistent with the January 2019 CDC defined VAP and onset of symptoms began after arrival to your ED/hospital.

LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES AGENCY

TRAUMA SYSTEM STATUS REPORT

FISCAL YEAR 2022-2023

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Trauma System Goals & Objectives

Goals/Objectives	Action	Schedule	Outcome
Maintain a Trauma Registry in compliance with NTDS and ACS TQIP.	In collaboration with the THAC Data Subcommittee, the Los Angeles County EMS Agency continues to review and revise the Trauma Data Dictionary (TDD) to maintain compliance with the minimum data set and definitions of NTDS and ACS TQIP.	Annually	The TDD is revised and implemented annually. Summary of changes is attached for review as Attachment J
Validate compliance with ACS standards and the Los Angeles County Specialty Care Center Designation Exhibit for Trauma Center Designation.	Attend virtual ACS verification surveys.	Ongoing	Trauma centers verified during FY 2022-2023: MemorialCare Long Beach Medical Center, Pomona Valley Medical Center, St. Francis Medical Center, Children's Hospital Los Angeles, and Ronald Reagan UCLA Medical Center
Review TQIP Collaborative reports to evaluate the need for system-wide QI indicators	Facilitate regional QI meetings with trauma centers.	Quarterly	Trauma centers present notable morbidity and mortality cases to discuss lessons learned. TQIP Collaborative reports are reviewed. There are three regions with five trauma centers per region.
Begin planning for the Los Angeles County's 40th year of its trauma system for 2023.	Form a planning committee with participation from trauma centers, determine date, time, and place, and begin soliciting donations from vendors to help support the event.	Monthly for initial planning phases and as needed thereafter.	Initial planning for the 40th Trauma Anniversary celebration began in October 2022.

Trauma System Summary

A map of our current Trauma Centers is included for reference (Attachment A)

List of Designated Trauma Centers and Agreement Expiration Dates (Attachment B)

Trauma System Volume Overview (Attachment C)

Annual System Blunt vs. Penetrating Trauma (Attachment D)

Changes since the previous plan was submitted and approved include:

- Reference No. 504, Trauma Patient Destination – Revised 01-01-2023 (Attachment E)
- Reference No. 506, Trauma Triage – Revised 04-01-2023 (Attachment F)
- Reference No. 506.1, Trauma Triage Decision Scheme – Revised 04-01-2023 (Attachment G)
- Reference No. 1243, Treatment Protocol: Traumatic Arrest – Revised 07-01-2022 (Attachment H)
- Reference No. 1244, Treatment Protocol: Traumatic Injury – Revised 07-01-2022 (Attachment I)

Trauma Center Data Dictionary – The Trauma Center Data Dictionary (TDD) is updated annually to ensure continued compliance with the minimum data set and definitions of NTDS™ and ACS TQIP®. Due to its size, Reference No. 646, Trauma Center Data Dictionary 2023, is not included but is available upon request or on our Los Angeles County EMS Agency website. The Trauma Center Data Dictionary Summary of Changes 2023 is attached detailing the changes made. (Attachment J)

EmergiPress Topics included:

- Trauma triages updates

The Trauma Hospital Advisory Committee met on September 28, 2022, November 30, 2022, January 25, 2023, March 22, 2023, and May 24, 2023. Topics included:

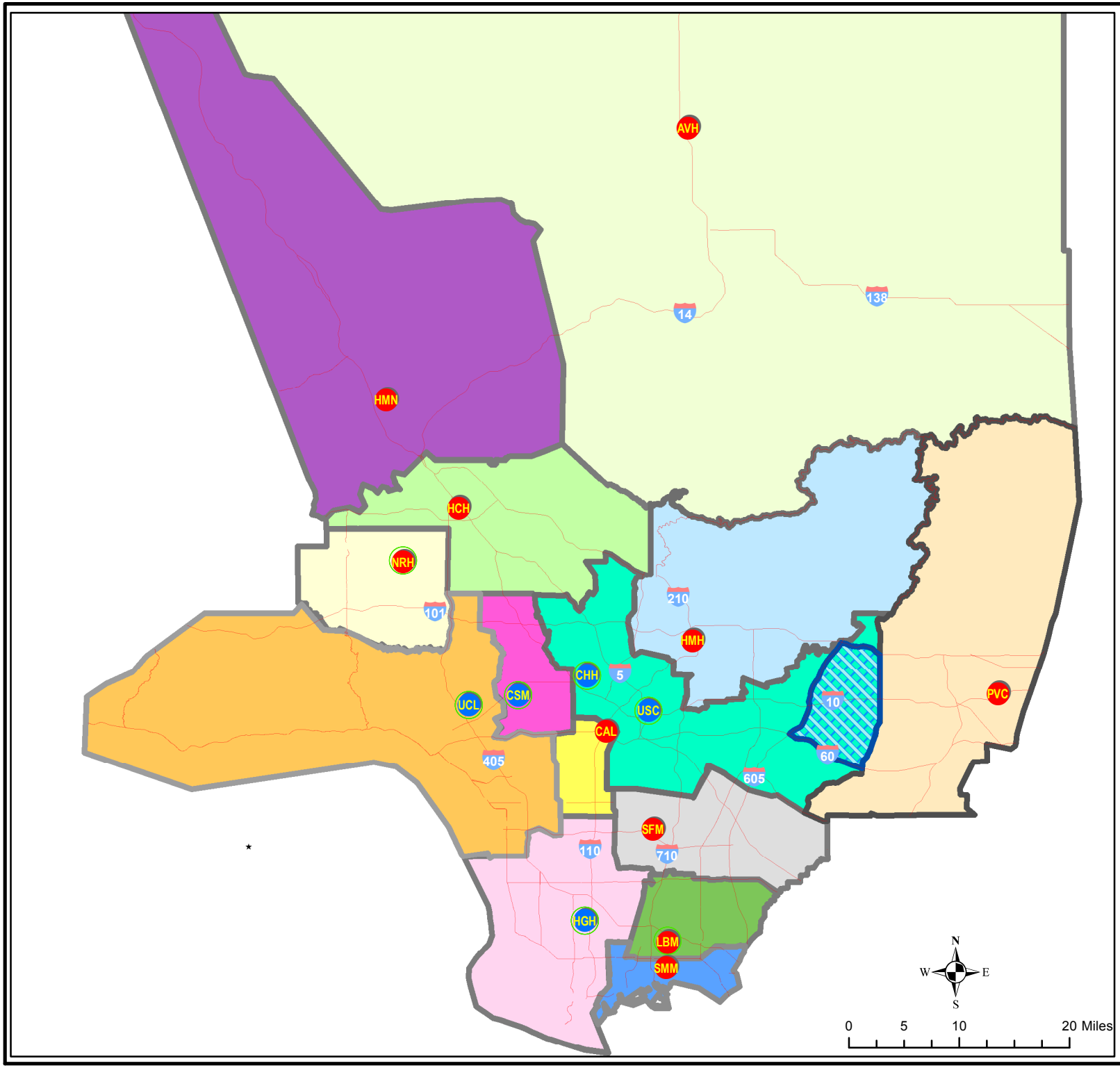
- Trauma program updates
- TEMIS/THAC Data Subcommittee updates
- Quality Improvement/TQIP Subcommittee updates
- Association of Trauma Program Managers report
- American College of Surgeons Committee on Trauma report
- Southern California Trauma Consortium update
- Southwest Regional Trauma Coordinating Committee update
- State trauma regulation revision
- 9-1-1 Trauma Re-Triage
- Blood product administration
- Tranexamic acid
- National guideline field triage of injured patients
- ThoraSite pilot
- Needle thoracostomy study
- 911 EMS Provider Ebola Virus Disease Flow Chart

- Trauma Center performance metrics
- Monitoring of blood products for interfacility transfers

Los Angeles County utilizes Trauma Quality Improvement Program (TQIP) and our collaborative reports as the basis for our QI program. The Trauma QI Subcommittee meets quarterly to review TQIP reports and evaluate the need for system-wide QI indicators. Additionally, there are quarterly regional QI meetings where case reviews are presented and discussed

Attachment A

Los Angeles County Trauma Centers



Trauma Centers As of 2017

Code	Name
AVH	Antelope Valley Hospital
CAL	California Hospital Medical Center
CHH	Children's Hospital Los Angeles
CSM	Cedars Sinai Medical Center
HCH	Providence Holy Cross Medical Center
HGH	LAC Harbor-UCLA Medical Center
HMH	Huntington Hospital
HMN	Henry Mayo Newhall Hospital
LBM	Long Beach Memorial Medical Center
NRH	Northridge Hospital Medical Center
PVC	Pomona Valley Hospital Medical Center
SFM	Saint Francis Medical Center
SMM	Saint Mary Medical Center
UCL	Ronald Reagan UCLA Medical Center
USC	LAC+USC Medical Center

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Trauma Centers

- LEVEL I/PTC
- LEVEL II
- LEVEL II/PTC
- PVC_USC_shared

TraumaAll_82417

List of Designated Trauma Centers and Agreement Expiration Dates

TRAUMA CENTER	LEVEL	PTC	FISCAL YEAR FOR NEXT REVIEW
Antelope Valley Hospital	II		August 24, 2024
Cedars-Sinai Medical Center	I	X	July 2, 2025
Children's Hospital Los Angeles	I	X	May 9, 2024 *(provisional)*
Dignity Health – California Hospital Medical Center	II		May 16, 2024
Dignity Health – Northridge Hospital Medical Center	II	X	June 24, 2025
Dignity Health – Saint Mary Medical Center	II		November 9, 2023
Los Angeles General Medical Center	I	X	July 1, 2025
Harbor UCLA Medical Center	I	X	November 9, 2023
Henry Mayo Newhall Hospital	II		June 4, 2025
Huntington Hospital	II		November 9, 2024
MemorialCare Long Beach Medical Center	II	X	November 8, 2024
Pomona Valley Hospital	II		September 5, 2025
Providence Holy Cross Medical Center	II		May 15, 2024
Saint Francis Medical Center	II		May 20, 2026
Ronald Reagan UCLA Medical Center	I	X	June 12, 2026

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Emergency Medical Services Agency

TRAUMA SYSTEM VOLUME

2000 – 2022

YEAR	NUMBER OF TRAUMA CENTERS	PATIENT VOLUME	VOLUME CHANGE	PERCENTAGE CHANGE
2000	13	16,912	1,259	8%
2001	13	18,837	1,925	11%
2002	13	19,196	359	2%
2003	13	18,150	1,046	6%
2004	14	17,134	1,016	6%
2005	13	17,680	546	3%
2006	13	18,632	952	6%
2007	13	19,481	849	5%
2008	13	19,188	293	2%
2009	13	19,173	15	0%
2010	14	19,121	52	0%
2011	14	20,242	121	6%
2012	14	23,855	3,613	16%
2013	14	25,743	1,888	8%
2014	14	26,874	1,311	5%
2015	14	28,822	1,948	7%
2016	14	26,243	2,579	9%
2017	15	23,332	2,911	12%
2018	15	22,542	790	3%
2019	15	22,348	194	0%
2020	15	22,349	1	0%
2021	15	25,075	2,726	12%
2022	15	25,574	499	2%

RED DENOTES DECREASE
BLUE DENOTES INCREASE

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

BLUNT vs PENETRATING

2000 – 2022

YEAR	TOTAL VOLUME	BLUNT INJURIES	PERCENT BLUNT	PENETRATING INJURIES	PERCENT PENETRATING
2000	16,724	12,939	77%	3,785	23%
2001	18,824	14,854	79%	3,970	21%
2002	19,181	14,889	78%	4,292	22%
2003	18,150	14,034	77%	4,116	23%
2004	17,134	13,107	76%	4,020	23%
2005	17,680	13,367	76%	4,380	25%
2006	18,632	14,419	77%	4,205	23%
2007	19,481	15,513	80%	3,837	20%
2008	19,188	15,397	80%	3,788	20%
2009	19,173	15,703	82%	3,468	18%
2010	19,121	15,798	83%	3,314	17%
2011	20,242	17,009	84%	3,226	16%
2012	23,855	20,227	85%	3,628	15%
2013	25,743	22,085	86%	3,645	14%
2014	26,874	23,122	86%	3,720	14%
2015	28,822	24,560	85%	4,248	15%
2016	26,243	21,862	83%	4,376	17%
2017	23,332	19,242	82%	4,089	18%
2018	22,542	18,629	83%	3,878	17%
2019	22,348	18,486	83%	3,727	17%
2020	22,349	17,538	78%	4,574	20%
2021	25,075	19,976	79%	4,984	20%
2022	25,574	20,591	80%	4,881	19%

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **TRAUMA PATIENT DESTINATION** REFERENCE NO. 504

PURPOSE: To determine the appropriate trauma patient destination with regards to the trauma center's catchment area.

AUTHORITY: California Administrative Code, Title 22, Chapter 7

DEFINITIONS:

Trauma Catchment Area: A geographical area surrounding a trauma center strictly defined by streets/freeways or other physical landmarks.

Trauma Patient: An injured patient that meets criteria and/or guidelines, or if in the provider's and/or base hospital's judgment it is in the patient's best interest to be transported to a trauma center.

PRINCIPLES:

A. Trauma patients that meet criteria, guidelines, or judgment should be transported to the designated trauma center or the designated pediatric trauma center.

B. Only the Department of Health Services may alter trauma catchment areas.

C. Patients from incident locations within the strictly defined area shall be transported to the designated trauma center.

D. To facilitate appropriate trauma team activation, direct contact with the anticipated receiving trauma center should be made whenever possible.

POLICY:

I. Responsibilities of the Paramedic:

A. Maintain current knowledge of trauma centers' catchment areas and which are pediatric trauma centers within their assigned area.

B. Paramedics shall contact their designated receiving trauma center on all injured patients meeting trauma triage criteria and/or guidelines or if in the provider's judgment it is in the patient's best interest to be transported to a trauma center. When the receiving trauma center is not a base hospital (only applies to Children's Hospital Los Angeles), paramedics shall contact their assigned base hospital.

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

II. The following table identifies trauma centers and pediatric trauma centers:

TRAUMA CENTERS	PEDIATRIC TRAUMA CENTERS
Antelope Valley Hospital	
California Hospital Medical Center	
Cedars-Sinai Medical Center	**X**
Children's Hospital Los Angeles	**X**
Henry Mayo Newhall Memorial Hospital	
Huntington Memorial Hospital	
LAC Harbor/UCLA Medical Center	**X**
LAC + USC Medical Center	**X**
Long Beach Memorial Medical Center	**X**
Northridge Hospital Medical Center	**X**
Pomona Valley Hospital Medical Center	
Providence Holy Cross Medical Center	
St. Francis Medical Center	
St. Mary Medical Center	
Ronald Reagan UCLA Medical Center	**X**

III. When the designated trauma center requests diversion to trauma, a trauma patient may be transported to:

A. The most accessible open trauma center; or

B. The designated trauma center, when the base hospital determines it is in the patient's best interest, despite the temporary request for trauma diversion.

IV. For multiple casualty incidents refer to Reference No. 519, Management of Multiple Casualty Incidents.

CROSS REFERENCES:

Prehospital Care Manual:
Reference No. 501, **Hospital Directory**
Reference No. 502, **Patient Destination**
Reference No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Reference No. 506, **Trauma Triage**
Reference No. 510, **Pediatric Patient Destination**
Reference No. 515, **Air Ambulance Trauma Transport**
Reference No. 519, **Management of Multiple Casualty Incidents**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **TRAUMA TRIAGE** REFERENCE NO. 506

PURPOSE: To establish criteria and standards which ensure that patients requiring the care of a trauma center are appropriately triaged and transported.

AUTHORITY: California Code of Regulations, Title 13, Section 1105(c) California Code of Regulations, Title 22, Section 100236 et seq. Health and Safety Code, Div. 2.5, Section 1797 et seq., and 1317.

PRINCIPLES:

1. Trauma patients should be secured and transported from the scene as quickly as possible, consistent with optimal trauma care.

2. Paramedics shall make base hospital contact to the receiving trauma center on all injured patients who meet trauma triage criteria and/or guidelines. Notification to the receiving trauma center shall be made whenever paramedic judgment determines transport to the trauma center is in the patient's best interest. Contact shall be accomplished in such a way as not to delay transport.

3. Do not delay transport of hypotensive patients with penetrating torso trauma in order to apply spinal motion restriction.

4. EMT personnel may immediately transport hypotensive patients with life-threatening, penetrating injuries to the torso to the closest trauma center, not the Most Accessible Receiving (MAR), when the transport time is less than the estimated time of paramedic arrival. The transporting unit should make every effort to contact the receiving trauma center.

5. When pediatric and adult trauma patients are transported together in one aircraft, the receiving trauma center shall be both a trauma center and a pediatric trauma center.

POLICY:

I. Trauma Criteria – Requires immediate transportation to a designated trauma center

Patients who fall into one or more of the following categories are to be transported directly to the designated trauma center, if transport time does not exceed 30 minutes.

A. Systolic blood pressure less than 90 mmHg, or less than 70 mmHg in infants age less than one year

B. Respiratory rate greater than 29 breaths/minute (sustained), less than 10 breaths/minute, less than 20 breaths/minute in infants age less than one year, or requiring ventilatory support

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Pavlo-Hill
Medical Director, EMS Agency

C. Cardiopulmonary arrest with penetrating torso trauma unless based upon the paramedic's thorough assessment is found apneic, pulseless, asystolic, and without pupillary reflexes upon arrival of EMS personnel at the scene

D. All penetrating injuries to head, neck, torso, and extremities proximal to the elbow or knee

E. Blunt head injury associated with a suspected skull fracture, altered level of consciousness (Glasgow Coma Score less than or equal to 14), seizures, unequal pupils, or focal neurological deficit

F. Injury to the spinal column associated with acute sensory or motor deficit

G. Blunt injury to chest with unstable chest wall (flail chest)

H. Diffuse abdominal tenderness

I. Suspected pelvic fracture (excluding isolated hip fracture from a ground level fall)

J. Extremity with:

1. Neurological/vascular compromise and/or crushed, degloved, or mangled extremity

2. Amputation proximal to the wrist or ankle

3. Fractures of two or more proximal (humerus/femur) long-bones

4. Bleeding not controlled by direct pressure requiring the usage of a hemorrhage control tourniquet or hemostatic agent (approved provider agencies only)

K. Fall from height > 10 feet (all patients)

L. Passenger space intrusion of greater than 12 inches into an occupied passenger space

M. Ejected from vehicles (partial or complete)

N. Auto versus pedestrian/bicyclist/motorcyclist thrown, run over, or with significant (greater than 20 mph) impact

O. Unenclosed transport crash with significant (greater than 20 mph) impact

P. Major / Critical Burn (excluding those in which the MAR is a recognized Burn Center, e.g., LAC+USC Medical Center, Torrance Memorial Medical Center, West Hills Hospital):

1. Patients 15 years of age or older with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 20% Total Body Surface Area (TBSA)

2. Patients ≤ 14 years of age with 2nd (partial thickness) and 3rd (full thickness) degree burns involving equal to or greater than 10% TBSA

II. Trauma Guidelines – Mechanism of injury and patient history are the most effective methods of selecting critically injured patients before unstable vital signs develop. Paramedics and base hospital personnel should consider mechanism of injury and patient history when determining patient destination. At the discretion of the base hospital, transportation to a trauma center is advisable for:

A. Passenger space intrusion of greater than 18 inches into any unoccupied passenger space

B. Automobile versus pedestrian/bicyclist/motorcyclist (impact equal to or less than 20 mph)

C. Injured victims of vehicular crashes in which a fatality occurred in the same vehicle

D. Patients requiring extrication

E. Vehicle telemetry data consistent with high risk of injury

F. Injured patients (excluding isolated minor extremity injuries):

1. on anticoagulation or antiplatelet therapy, other than aspirin-only

2. with bleeding disorders

III. Special Considerations – Consider transporting injured patients with the following to a trauma center:

A. Patients in blunt traumatic full arrest who, based on a paramedic's thorough patient assessment, was not found apneic, pulseless, and without organized ECG activity (narrow complex supraventricular rhythm) upon the arrival of EMS personnel at the scene

B. Systolic blood pressure less than 110 mmHg may represent shock after age 65 years

C. Heart rate greater than systolic blood pressure for ≥ 14 years of age

D. Child (0-9 years of age) unrestrained or in an unsecured child safety seat

E. Pregnancy greater than 20 weeks gestation

F. Prehospital judgment

IV. Extremis Patients - Requires immediate transportation to the MAR:

A. Patients with an obstructed airway or those with concern for imminent airway obstruction due to inhalation injury

B. Patients, as determined by the base hospital personnel, whose lives would be jeopardized by transportation to any destination but the MAR

V. When, for whatever reason, base hospital contact cannot be made, the destination decision for injured patients will be made by paramedics using the principles set forth above.

VI. 9-1-1 Trauma Re-Triage – This section applies to injured patients in emergency departments of non-trauma centers whose injuries were initially estimated by EMS to be less serious (under triaged) or patients who self-transported (walk-in) to a non-trauma center, and subsequently assessed by the non-trauma center physician to require immediate trauma center care. The referring facility shall utilize the procedure outlined below to expedite transfer arrangements and rapid transport to the trauma center. This process should be reserved for patients with life-threatening traumatic injuries requiring emergent surgical intervention.

A. Determine if the injured patient meets any of the following 9-1-1 Trauma Re-Triage criteria:

1. Persistent signs of poor perfusion

2. Need for immediate blood replacement therapy

3. Intubation required

4. Glasgow Coma Score less than 9

5. Glasgow Coma Score deteriorating by 2 or more points during observation

6. Penetrating injuries to head, neck and torso

7. Extremity injury with neurovascular compromise or loss of pulses

8. Patients, who in the judgement of the evaluating emergency physician, have high likelihood of requiring emergent life- or limb-saving intervention within two (2) hours.

B. Contact the designated receiving trauma center or pediatric trauma center if the patient is less than or equal to 14 years of age and transport does not exceed 30 min. Do not delay transfer by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

C. Contact 9-1-1 for transportation. The paramedic scope of practice (Ref. No. 803) does not include paralyzing agents and blood products.

D. Prepare patient and available medical records for immediate transport. Do not delay transport for medical records which could be sent at a later time.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506.1 **Trauma Triage Decision Scheme**
Ref. No. 506.2 **9-1-1 Trauma Re-Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 803, **Paramedic Scope of Practice**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGLES

REFERENCE No. 506.1 Trauma Triage Decision Scheme

Physiological Assessment

Systolic blood pressure (SBP): < 90 mmHg, or
< 70 mm Hg in infant < 1 yr.
Respiratory rate: > 29 breaths/minute (sustained),
< 10 breaths/minute,
< 20 breaths/minute in infant < 1 yr., or
requiring ventilatory support
Cardiopulmonary arrest with penetrating torso trauma

YES

Anatomical Injury Assessment

ALL penetrating injuries to head, neck, torso, and extremities above the elbow or knee
Blunt head injury associated with: suspected skull fracture, GCS ≤ 14, seizures, unequal pupils, or focal neurological deficit Spinal injury associated with acute sensory or motor deficit
Blunt chest injury with unstable chest wall (flail chest)
Diffuse abdominal tenderness
Suspected pelvic fracture (excluding isolated hip fracture from a ground level fall)
Extremity with: neuro/vascular compromise and/or crushed, degloved or mangled;
amputation proximal to the wrist or ankle; or
fractures of ≥ 2 proximal (humerus/femur) long-bones
bleeding requiring tourniquet or hemostatic agent
Major/Critical Burns: ≥15 years with 2nd or 3rd degree burns ≥ 20% TBSA
≤ 14 years with 2nd or 3rd degree burns ≥ 10% TBSA

YES

Mechanism of Injury Assessment

Falls: All patients > 10 feet
Passenger Space Intrusion: > 12 inches into an occupied passenger space
Ejected from vehicle (partial or complete)
Auto v. pedestrian/bicyclist/motorcyclist thrown, run over, or impact > 20 mph
Unenclosed transport crash with significant impact (> 20 mph)

YES → **Contact Base/Trauma Center, Immediate transport to designated Trauma Center**

Trauma Guidelines Assessment

Passenger Space Intrusion > 18 inches into an unoccupied passenger space
Auto versus pedestrian/bicyclist/motorcyclist (impact ≤ 20 mph)
Injured victims of vehicle crashes with a fatality in the same vehicle
Patients requiring extrication
Vehicle telemetry data consistent with high risk of injury
Injured patients (excluding isolated minor extremity injuries): on anticoagulation therapy other than aspirin-only; or with bleeding disorders

YES → **Consult with Trauma Center/Base Hospital, transport to designated Trauma Center is advisable**

Special Considerations Assessment

Blunt traumatic full arrest
SBP < 110 mmHg may represent shock after age 65 years
HR > SBP for age ≥ 14 years
Child (0-9 Yrs.) unrestrained or in an unsecured child safety seat
Pregnancy > 20 weeks
Prehospital judgement

YES → **Consider transport to designated Trauma Center**

EFFECTIVE: 05-01-12
REVISED: 04-01-23
SUPERSEDES: 04-01-22

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: TRAUMATIC ARREST **Ref. No. 1243**

Base Hospital Contact: Contact the Trauma Center for patients not meeting criteria for determination of death per *Ref 814*.

1. Prioritize rapid transport for patients who do not meet *Ref. 814* ❶

2. Immediately control major bleeding *(MCG 1370)*
   Apply tourniquet prn

3. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)* ❷
   Ventilate with **high flow Oxygen 15 L/min**

4. Begin chest compressions ❸

5. Perform bilateral needle thoracostomy for suspected tension pneumothorax *(MCG 1335)*

6. Initiate cardiac monitoring *(MCG 1308)*
   Assess cardiac rhythm

7. If shockable rhythm (V-Fib/V-Tach) identified:
   Defibrillate V-Fib/V-Tach at 200J or per manufacturer's instructions

   For blunt trauma: ❹
   Initiate resuscitation on scene
   If organized rhythm is not restored after defibrillation x3 or patient converts to nonshockable rhythm, refer to *Ref. No. 814* for determination of death
   CONTACT BASE if needed for guidance on continued resuscitation or transport

   For penetrating trauma: ❺
   Defibrillate while prioritizing immediate transport

8. Provide spinal motion restriction (SMR) if indicated *(MCG 1360)*
   Do not delay transport for SMR ❻

9. Establish vascular access en route *(MCG 1375)*
   Two large bore IV catheters (16 or 18 gauge) preferred
   Establish IO if unable to establish IV access

10. **Normal Saline 2L IV/IO rapid infusion**
    Administer through two sites simultaneously if possible

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: TRAUMATIC ARREST **Ref. No. 1243**

SPECIAL CONSIDERATIONS

❶ Rapid transport after hemorrhage control is the priority for all patients with severe trauma. With the exception of hemorrhage control, needle thoracostomy, and initiation of CPR, all other procedures may be deferred for immediate ambulance loading of patient and performed en route.

❷ Bag-mask ventilation (BMV) with a viral filter is the preferred initial method of airway management. An advanced airway may be placed during transport or if BMV is difficult or ineffective. Supraglottic airway is preferred unless contraindicated. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality.

❸ Manual chest compressions are recommended; automated/mechanical chest compression devices should not be used in traumatic arrest.

❹ Sudden cardiac death can result from blunt cardiac injury (commotio cordis) triggering V-fib/V-tach. Unlike major trauma resulting in hemorrhagic shock, patients with this mechanism typically have **minimal external trauma** and should be treated with immediate defibrillation on scene. Patients with multisystem blunt trauma in persistent cardiac arrest without organized rhythm should generally not be transported. If commotio cordis is the suspected mechanism with minimal external trauma and the patient remains in V-fib/V-tach after three defibrillations, contact Base to discuss timing of transport versus termination for futility.

❺ Patients with penetrating trauma should receive defibrillation while still prioritizing early transport.

❻ For patients in traumatic arrest, spinal motion restriction (SMR) using a backboard causes harmful delays in care. However, a backboard may be helpful to assist in patient movement and to support chest compressions.

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Treatment Protocol: TRAUMATIC INJURY **Ref. No. 1244**

Base Hospital Contact: Required for patients who meet Trauma Center criteria or guidelines. ❶ Notify the receiving Trauma Center as soon as possible for all patient transports.

1. Immediately control major bleeding *(MCG 1370)*
   Apply tourniquet prn

2. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)* ❷

3. For traumatic arrest, treat per *TP 1243, Traumatic Arrest*

4. Provide spinal motion restriction (SMR) if indicated *(MCG 1360)*
   For alert patients, logroll off the backboard (if used during extrication) and onto gurney prior to transport ❸

5. Administer **Oxygen** prn *(MCG 1302)*
   High flow Oxygen 15 L/min for all patients with shock or with suspected traumatic brain injury

6. If patient has an Unmanageable Airway *(MCG 1302)***:**
   Initiate immediate transport to MAR and **CONTACT BASE** en route

7. For anticipated prolonged extrication (> 30 minutes)
   Consider activating the Hospital Emergency Response Team (HERT), *Ref. 817*

8. For crush injury, treat in conjunction with *TP 1242, Crush Injury/Syndrome*

9. Initiate cardiac monitoring prn *(MCG 1308)*

10. Establish vascular access prn *(MCG 1375)*

11. Apply blanket to keep patient warm

12. Consider medical condition preceding accident and refer to appropriate treatment protocol prn ❹

MULTI-SYSTEM TRAUMA

13. Perform needle thoracostomy for suspected tension pneumothorax *(MCG 1335)*

14. For an open or sucking chest wound, cover with a commercially available vented chest seal or vented (3-sided) occlusive dressing ❺

15. For poor perfusion with hypotension:
    Normal Saline 250mL IV/IO rapid infusion ❻
    CONTACT BASE to discuss further fluid resuscitation

16. Cover eviscerated organs with a moist non-adhering dressing

17. For pain management prn *(MCG 1345)*

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Fentanyl 50mcg (1mL) slow IV/IO push or IM/IN
Morphine 4mg (1mL) slow IV/IO push or IM

Ketorolac is contraindicated for multi-system trauma

CONTACT BASE for additional pain management:
May repeat as above up to maximum total dose Fentanyl 250mcg or Morphine 20mg

18. For nausea or vomiting: ❼
Ondansetron 4mg ODT/IV/IM, may repeat x1 in 15 min prn

ISOLATED HEAD INJURY

19. Administer **high flow Oxygen 15 L/min** for all patients with suspected traumatic brain injury ❽
Continually assess patient's airway and ventilation status, assist prn ❾

20. For SBP ≤ 90mmHg:
Normal Saline 1L IV/IO rapid infusion ❿
Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops
CONTACT BASE for persistent poor perfusion after **Normal Saline 1L**

21. For nausea or vomiting: ❼
Ondansetron 4mg ODT/IV/IM, may repeat x1 in 15 min prn

22. Transport with head of gurney elevated to 30 degrees when possible ⓫

23. If patient develops seizure activity, treat in conjunction with *TP 1231, Seizure*

24. For pain management prn *(MCG 1345)*

For an alert and oriented patient with GCS 15:
Fentanyl 50mcg (1mL) slow IV/IO push or IM/IN
Morphine 4mg (1mL) slow IV/IO push or IM

Ketorolac is contraindicated for head injury

CONTACT BASE for additional pain management or for initial orders if patient not alert and oriented with GCS 15
May provide or repeat as above up to maximum total dose Fentanyl 250mcg or Morphine 20mg

ISOLATED EXTREMITY INJURY

25. For pain management prn *(MCG 1345)*

26. For poor perfusion:
Normal Saline 1L IV/IO rapid infusion
Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

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CONTACT BASE for persistent poor perfusion to obtain order for additional **Normal Saline 1L IV/IO**

27. Splint and dress injuries prn
    For distal extremity fractures with poor neurovascular status distal to injury – realign and stabilize extremity
    Mid-shaft femur – apply traction splint per manufacturer guidelines ⓬
    All other fractures/dislocations – splint in position of comfort
    For amputations – rinse off debris (do not manually debride), wrap with saline-moistened sterile gauze and ace wrap, then apply a splint for potential underlying fracture ⓭

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SPECIAL CONSIDERATIONS

❶ For patients requiring transport to a Trauma Center per *Ref. 506*, contact the receiving Trauma Center for Base Medical Direction and notification. If the Base Hospital is contacted and the Base redirects transport to a Trauma Center, Base personnel will notify the Trauma Center.

❷ Transport should be prioritized over advanced airway placement unless BMV is ineffective. Advanced airway may be placed during transport; supraglottic airway is preferred unless contraindicated. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality.

❸ A backboard is not required for spinal motion restriction (SMR) and may cause harm as well as increased pain. Patients should not be transported on a backboard for the purpose of SMR. If a backboard is used for extrication, patients who are alert should then be logrolled onto the gurney prior to transport. The backboard may be used during patient transport for splinting of multiple simultaneous extremity fractures or to assist in maneuvering the unconscious patient. In all cases, the backboard should be removed immediately if causing respiratory compromise.

❹ Traumatic events may be due to a medical emergency, particularly single-vehicle accidents and unexplained falls.

❺ Placement of a vented dressing can prevent conversion of an open pneumothorax to a tension pneumothorax. However, tension pneumothorax may still develop in the presence of a vented dressing and should be treated with needle thoracostomy. Furthermore, needle thoracostomy in a patient with evidence of tension pneumothorax should not be delayed for placement of dressing.

❻ Aggressive fluid resuscitation increases vascular pressure and dilutes clotting factors, which may increase internal bleeding.
- In patients with blunt trauma and poor perfusion: administer fluids to target SBP ≥ 90mmHg.
- In patients with penetrating trauma and poor perfusion: administer fluids to target SBP ≥ 70mmHg if patient has normal mental status (permissive hypotension). Patients with ALOC or SBP < 70mmHg should receive fluids until their mental status and SBP improve.
- In patients with possible traumatic brain injury: permissive hypotension is contraindicated and SBP should be maintained ≥ 90mmHg.

❼ Vomiting should be prevented and/or immediately treated in patients with head injury, since it increases intra-cranial pressure and can compromise the patient's airway.

❽ Traumatic brain injury presents with altered mental status after head injury. Any hypoxic episode, even brief, is associated with worse patient outcome for patients with traumatic brain injury.

❾ Hyperventilation reduces blood flow to the brain by reducing CO_2 and is associated with worse outcomes in severe head injuries. The exception to this is presence of elevated intra-cranial pressure (ICP) with signs of impending herniation (severe ALOC without motor response or with posturing and a unilateral 'blown pupil'). In this case, **mild** hyperventilation of approximately 20 breaths per minute should be used to maintain an $ETCO_2$ of 30-35mmHg. This mild hyperventilation reduces blood flow to the brain to decrease ICP until the patient receives definitive surgical care. For patients without elevated ICP, hyperventilation is harmful.

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⑩ Any hypotension increases mortality in patients with traumatic brain injury. Normal Saline should be initiated to maintain SBP ≥ 90mmHg at all times but can be withheld if the blood pressure is normal.

⑪ A head-elevated position at about 30 degrees reduces intra-cranial pressure and improves respiratory status. Patients in a cervical collar may have their head elevated if there is no concern for thoracic or lumbar spine injury. Reverse Trendelenburg is another option for patients that cannot be seated. Patients who are hypotensive should be maintained supine unless airway compromise requires repositioning.

⑫ Open femur fracture is not a contraindication to apply the traction splint. If the bone is protruding and there is gross contamination, wash with saline prior to applying the splint.

⑬ If the amputated part is available, similar care should be taken to rinse off any gross debris, wrap the part with saline-moistened sterile gauze, seal in plastic and place indirectly on ice after wrapping; do not submerge in water or place directly on ice. Transport the amputated part with the patient and leave it with hospital staff.

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

Trauma Hospital Advisory Committee

TRAUMA CENTER DATA DICTIONARY
SUMMARY OF CHANGES 2023

DATA ELEMENT	ISSUE / CONCERN / ACTION
GENERAL INFORMATION	
LAST NAME	**ADDED** the following to the DD in Additional Information**:** • If the patient's name contains a suffix (Jr., Sr., etc.), include at as part of and at the end of the last name.
TRANSFERRED FROM	**NAME CHANGE** to the following hospitals: • AMH USC Arcadia Hospital • GSH PIH Health Good Samaritan Hospital • PIH PIH Health Whittier Hospital • DCH PIH Health Downey Hospital **RETIRED** • LBC Community Hospital Long Beach
PREHOSPITAL	
PROVIDER	**ADDED** the following providers to Field Values: • HE Heart Ambulance Corporation • MD MedTrans, Inc. • ZM Solartricity dba Zoom Medical Transport • BA Burbank Airport Fire **ADDED** the following provider to the DD only: • MA Mauran Ambulance Service Inc.
MECHANISM OF INJURY	**REMOVED** the following from the DD in Field Values: • PS Passenger Space Intrusion (PSI) - Unspecified
PROTECTIVE DEVICES	**ADDED** the following to DD in Additional Information: • Verbiage, "Enter the values *"SB Seatbelt – Shoulder Belt"* and *"LB Seatbelt – Lap Belt"* if a lap belt only is not specified in the EMS record, base hospital form, audio recording, or ED record."

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td>FIELD INTUBATION?</td><td>CHANGED additional information in the DD to:
Includes endotracheal tube or i-gel® placement.</td></tr>
<tr><td colspan="2">EMERGENCY DEPARTMENT (ED)/HOSPITALS</td></tr>
<tr><td>PRIMARY TRAUMA SERVICE TYPE</td><td>ADDED the data element PRIMARY TRAUMA SERVICE TYPE, following data element ED EXIT TIME.

ADDED the following Field Values:

<table>
<tr><th colspan="2">LA COUNTY</th><th colspan="2">NTDS</th></tr>
<tr><td>A</td><td>Adult</td><td>1</td><td>Adult</td></tr>
<tr><td>P</td><td>Pediatric</td><td>2</td><td>Pediatric</td></tr>
</table>

ADDED associated Additional Information, Uses, Data Source Hierarchy, and Other Associated Elements.</td></tr>
<tr><td>HEIGHT</td><td>REMOVED the following from the DD in Definition:
Verbiage, “report within 24 hours of ED/hospital arrival.”
REMOVED the following for the DD in Additional Information:
“Enter a value “Not Documented” if the patient’s height was not provided within 24 hours of ED/hospital arrival.”</td></tr>
<tr><td>HEIGHT UNITS</td><td>REMOVED the following from the DD in Definition:
Verbiage, “report within 24 hours of ED/hospital arrival.”
REMOVED the following for the DD in Additional Information:
“Enter a value “Not Documented” if the patient’s height was not provided within 24 hours of ED/hospital arrival.”</td></tr>
<tr><td>CONSULTATION SERVICE</td><td>ADDED the following Field Value:
EHT Ethicist</td></tr>
<tr><td>1ST ANTIBIOTIC ADMINISTRATION DATE</td><td>CHANGED the definition in the DD in Additional Information to:
“Open fractures as defined by the Association of Advancement of Automotive Medicine Abbreviation Injury Scale (AIS) Coding Rules and Guidelines and includes all AIS code descriptors that contain “open”</td></tr>
</table>

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td></td><td>and all AIS extremity/limb code descriptors that contain “amputation”.</td></tr>
<tr><td>1ST ANTIBIOTIC ADMINISTRATION TIME</td><td>CHANGED the definition in the DD in Additional Information to:
“Open fractures as defined by the Association of Advancement of Automotive Medicine Abbreviation Injury Scale (AIS) Coding Rules and Guidelines and includes all AIS code descriptors that contain “open” and all AIS extremity/limb code descriptors that contain “amputation”.</td></tr>
<tr><td colspan="2">RADIOLOGY/LABORATORY</td></tr>
<tr><td>ETOH/TOXICOLOGY: Substance</td><td>ADDED the following Field Value:<table><tr><th>LA COUNTY</th><th colspan="2">NTDS</th></tr><tr><td>Ethanol (ETOH)</td><td colspan="2">Alcohol Screen</td></tr><tr><td>Toxicology Screen</td><td colspan="2">Drug Screen</td></tr><tr><td>• Fentanyl</td><td>8</td><td>Opioids (OPI)</td></tr></table></td></tr>
<tr><td colspan="2">INTENSIVE CARE UNIT (ICU)/ACUTE CARE</td></tr>
<tr><td>CONSULTATION SERVICE</td><td>ADDED the following Field Value:
EHT Ethicist</td></tr>
<tr><td colspan="2">POSTHOSPITAL</td></tr>
<tr><td>TRANSFERRED/ DISCHARGED TO</td><td>ADDED the following to DD in Additional Information:
Verbiage, “For patients that report their current place of residence as “homeless”, but are discharged to a home, e.g., family member’s home, enter “Home With” or “Home W/O”.</td></tr>
<tr><td>FACILITY NAME</td><td>NAME CHANGE to the following hospitals:
AMH USC Arcadia Hospital
GSH PIH Health Good Samaritan Hospital
PIH PIH Health Whittier Hospital
DCH PIH Health Downey Hospital
ADDED the following facility to Field Values under BURN CENTERS:
UCB UCI Medical Center (Burn Center)</td></tr>
</table>

DATA ELEMENT	ISSUE / CONCERN / ACTION
	RETIRED the following hospital: • LBC Community Hospital Long Beach
DISCHARGE CAPACITY	**ADDED** the following to the DD in Additional Information: • Verbiage, "The value of "T" for Temporary Handicap may be utilized for patients transferred to another acute care hospital for higher level of trauma care.".
CO-MORBID CONDITIONS	**ADDED** the following to Field Values: • Bipolar I/II Disorder • Major Depressive Disorder • Other Mental/Personality Disorders • Post-Traumatic Stress Disorder • Schizoaffective Disorder • Schizophrenia **RETIRED** the following Field Value: • Mental/Personality Disorder
UNPLANNED READMISSION	
READMIT TRANSFERRED/DISCHARGED TO	**ADDED** the following to DD in Additional Information: • Verbiage, "For patients that report their current place of residence as "homeless", but are discharged to a home, e.g., family member's home, enter "Home With" or "Home W/O".
READMIT TRANSFER TO	**NAME CHANGE** to the following hospitals: • AMH USC Arcadia Hospital • GSH PIH Health Good Samaritan Hospital • PIH PIH Health Whittier Hospital • DCH PIH Health Downey Hospital **RETIRED** the following hospital: • LBC Community Hospital Long Beach
APPENDIX 1: REFERENCE DOCUMENTS	
MECHANISM OF INJURY REFERENCE GUIDE	
TRANSPORTATION MECHANISMS OF INJURIES QUICK REFERENCE GUIDE	**REVISED** the definition to replace "ICD-9 defines a transport accident (E800 – E848)" with "ICD-10 defines a transport accident (V00-V99)".
APPENDIX 2: GLOSSARY OF TERMS	

DATA ELEMENT	ISSUE / CONCERN / ACTION
CO-MORBID *(PRE-EXISTING)* CONDITIONS	
Alcohol Use Disorder (Alcoholism)	**REVISED** the definition to include the following: "Only report on patients ≥15 years-of-age."
Bipolar I/II Disorder	**ADDED** *Bipolar I/II Disorder.* **ADDED** the definition to include the following: "A bipolar I/II disorder diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age."
Chronic Obstructive Pulmonary Disease (COPD)	**REVISED** the definition to include the following: "Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used but are now included within the COPD diagnosis. A diagnosis of COPD must be must be documented in the patient's medical record, present prior to injury, consistent with World Health Organization (WHO), 2019. Do not include patients whose only pulmonary disease is acute asthma, and patients with diffuse interstitial fibrosis or sarcoidosis. Only report on patients ≥15 years-of-age."
Cirrhosis	**REVISED** the definition to include the following: "Cirrhosis is the replacement of normal liver tissue with non-living scar tissue related to other liver disease. A diagnosis of cirrhosis or end-stage liver disease by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record. Documentation in the medical record may include CHILD and MELD scores that support evidence of cirrhosis."
Congenital Anomalies	**REVISED** the definition to include the following: "Documentation of a cardiac, pulmonary, body wall, CNS/spinal, gastrointestinal, renal, orthopedic, or metabolic congenital anomaly, present prior to injury. A diagnosis of a Congenital Anomaly must be documented in the patient's medical record. Only report on patients <15 years-of -age."
Dementia	**REVISED** the definition to include the following: "Brain diseases that cause a long term and often gradual decrease in the ability to think and remember such that a person's daily functioning is affected, present prior to injury. A diagnosis of Dementia including Alzheimer's, Lewy Body Dementia, frontotemporal dementia (Pick's Disease) and vascular dementia must be documented in the patient's medical record."

DATA ELEMENT	ISSUE / CONCERN / ACTION
Disseminated Cancer	**REVISED** the definition to include the following: "Patients who have cancer that has spread to one or more sites in addition to the primary site AND in the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. Another term describing disseminated cancer is "metastatic cancer"."
Drug (Substance) Use Disorder	**REVISED** the definition to include the following: "Only report on patients ≥15 years-of-age."
Major Depressive Disorder	**ADDED** *Major Depressive Disorder.* **ADDED** the definition to include the following: "A major depressive disorder diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age."
Mental/Personality Disorder	**RETIRED**
Other Mental/Personality Disorders	**ADDED** *Other Mental/Personality Disorders* **ADDED** the definition to include the following: A diagnosis of any of the following documented in the medical record: • Antisocial personality disorder • Avoidant personality disorder • Borderline personality disorder • Dependent personality disorder • Generalized anxiety disorder • Histrionic personality disorder • Narcissistic personality disorder • Obsessive-compulsive disorder • Obsessive-compulsive personality disorder • Panic disorder • Paranoid personality disorder • Schizotypal personality disorder The diagnosis must be present prior to injury. Only report on patients ≥15 years-of-age.
Peripheral Arterial Disease (PAD)	**REVISED** the definition to include the following: "Only report on patients ≥15 years-of-age."
Post-Traumatic Stress Disorder	**ADDED** *Post-Traumatic Stress Disorder.* **ADDED** the definition to include the following:

DATA ELEMENT	ISSUE / CONCERN / ACTION
	"A post-traumatic stress disorder diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age."
Prematurity	**REVISED** the definition to include the following: "Babies born before 37 weeks of pregnancy are completed. A diagnosis of prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient's medical record. Only report on patients <15 years-of-age."
Schizoaffective Disorder	**ADDED** *Schizoaffective Disorder.* **ADDED** the definition to include the following: "A schizoaffective disorder diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age."
Schizophrenia	**ADDED** *Schizophrenia.* **ADDED** definition to include the following: "A schizophrenia diagnosis documented in the medical record, present prior to injury. Only report on patients ≥15 years-of-age."

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: BASE CONTACT REQUIREMENTS **Ref. No. 1200.2**

PRINCIPLES:

1. Base Contact is made by paramedics to establish online medical direction for additional guidance on field care beyond what is contained in the offline treatment protocols.

2. Once the patient is no longer present and under the care of the paramedic medical direction is not needed. Therefore, this policy does not apply and Base Contact is not required.

3. Base Contact for all patients shall be made according to the requirements below and at the judgment of the treating paramedic. Access to online medical direction is not limited to those conditions listed below.

4. For children 13 to 36 months of age, Base Contact and/or transport is required, except those with no medical complaint or with isolated minor extremity injury.

5. Children less than or equal to 12 months of age must be transported in accordance with *Ref. No. 510*, regardless of provider impression or field treatment rendered, and if a parent or caregiver refuses transport, Base Contact shall be made prior to signing the patient out Against Medical Advice (AMA).

6. Base Contact criteria below still apply if the patient is on scene and refusing transport (AMA). This includes parents or legal guardians who refuse transport of a pediatric patient.

7. This document provides a quick reference list for Base Contact requirements; it does not replace the treatment protocols or the guidance there within, which shall be followed at all times unless otherwise directed by online medical direction.

GUIDELINES:

1. Base Contact is required when consultation with the base would be helpful such as:

    a. Patient presentation renders the provider impression and appropriate treatment protocol unclear

    b. Additional or unlisted treatments are required

2. Base Contact is required when five or more patients require transport (contacting the Medical Alert Center constitutes Base Contact).

3. Base Contact is required for children who meet transport guidelines to a Pediatric Medical Center *(Ref. 510)*

4. Base Contact is required for patients in traumatic full arrest who do not meet criteria for determination of death per *Ref. 814*. In these instances, Base Contact shall be made with the Trauma Center.

5. Base Contact is required for the following provider impressions in all patients:

a. Agitated Delirium

b. Anaphylaxis

c. Cardiac Arrest – Non-traumatic (unless patient meets determination of death by Ref. 814)

d. Childbirth

e. Dystonic Reaction

f. Hypotension

g. Respiratory Failure

h. Shock

i. Stroke / CVA / TIA

6. Additionally, Base Contact is required for the following provider impressions in pediatric patients:

    a. BRUE

    b. Chest Pain – Suspected Cardiac / Chest Pain - STEMI

    c. Pregnancy/Labor

    d. Newborn

7. Base Contact is required for the following provider impressions under the specified conditions:

    a. Airway Obstruction
        - Severe respiratory distress or respiratory arrest

    b. Altered Level of Consciousness (ALOC)
        - Persistent ALOC of unclear etiology

    c. Cardiac Dysrhythmia
        - Rapid atrial fibrillation with poor perfusion
        - Symptomatic bradycardia
        - Wide complex tachycardia

    d. Medical Device Malfunction
        - Ventricular Assist Device (VAD) malfunction

    e. Overdose / Poisoning / Ingestion
        - If signing out AMA

    f. Pregnancy Complication

- >20 weeks with vaginal bleeding

g. Respiratory Distress (of any etiology e.g. Bronchospasm, Pulmonary Edema, Other)
   - Severe respiratory distress unresponsive or not amenable to CPAP
   - Unmanageable airway

h. Seizure
   - Pregnant patient
   - Status epilepticus

i. Submersion / Drowning
   - ALOC
   - Decompression illness

j. Traumatic Injury
   - Crush syndrome
   - Prolonged entrapment >30 minutes
   - Trauma criteria or guidelines met
   - Traumatic arrest not meeting criteria for determination of death per Ref. 814

8. Base Contact is required concurrently when the following treatments are initiated:

   a. Adenosine in pediatric patients

   b. Cardioversion

   c. Push-dose epinephrine

   d. Transcutaneous pacing

9. Base Contact is required prior to initiating the following treatments:

   a. Additional dosing of normal saline or medications (e.g., midazolam, opiate analgesia) after the maximum dose is administered per protocol

   b. Calcium chloride for patients with calcium channel blocker overdose

   c. Cardioversion of a patient with adequate perfusion, or awake with a narrow complex tachycardia, or any atrial fibrillation

   d. Midazolam for treatment of agitation in a patient with behavioral/psychiatric crisis

   e. IO placement beyond the indications listed in *MCG 1375*

   f. Sodium bicarbonate for symptomatic bradycardia with suspected hyperkalemia or for dysrhythmia due to possible tricyclic antidepressant or other toxic overdose

   g. Transcutaneous pacing if HR >40

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **DOCUMENTATION OF PREHOSPITAL CARE** REFERENCE NO. 606

PURPOSE: To identify the base hospital and Emergency Medical Services (EMS) provider procedures for documentation of prehospital care.

AUTHORITY: California Code of Regulations, Title 22, Sections 100128, 100129, 100170, 100171

DEFINITIONS

EMS Response: The physical response of an EMS provider due to activation of the EMS system with a request for medical evaluation.

Multiple Casualty Incident (MCI): The combination of numbers of ill/injured patients and the type of injuries going beyond the capability of an entity's normal first response.

Patient: A person who seeks or appears to require medical assessment and/or medical treatment.

Patient Contact: An EMS response that results in an actual patient or patients.

Public Assist: EMS is dispatched to a scene for assistance for nonmedical issues.

PRINCIPLES:

1. The EMS Record and the Base Hospital Form are:

    a. Patient care records
    b. Legal documents
    c. Quality improvement instruments
    d. Billing resources (EMS Record only)
    e. Records of canceled calls, no patient found, public assist involving a person, and person contact/no patient (EMS Record only)

2. Any assessment or treatment provided to, and medical history obtained from, the patient shall be accurately and thoroughly documented on the EMS Record.

3. Any person who alters or modifies the medical record of any person, with fraudulent intent, or who, with fraudulent intent, creates any false medical record, is guilty of a misdemeanor (section 471.5 of the California Penal Code).

4. An EMS Record must be completed for every EMS response regardless of patient disposition.

POLICY:

I. EMS Record Completion – Paramedic/EMT Personnel

APPROVED: Richard Tadeo
Director, EMS Agency

Medical Director, EMS Agency

A. EMS providers shall document prehospital care according to procedures identified in the LA-EMS National Emergency Medical Services Information System (NEMSIS) Data Dictionary.

B. Electronic EMS Patient Care Record (ePCR) Completion

1. Paramedic/EMT personnel shall complete one EMS Agency approved ePCR (one for each patient) for every EMS response which includes the following:

a. Patient contact made
b. Cancelled on scene
c. Cancelled prior to arrival at scene
d. No patient contact
e. No patient found

C. Paper-Based EMS Report Form Completion

1. Paramedic/EMT personnel may document on a paper-based EMS Report Form if ePCR system failure occurs.

2. Private EMS providers shall utilize a paper-based EMS Report Form only for patients where base contact is made unless approved to electronically submit ePCR data.

D. Multiple Providers

1. In the event of an automatic or mutual aid incident when two first responding providers have each completed an EMS Record, or patient care is transferred from one ALS provider agency to another, each provider agency shall document the Original Sequence Number from the other provider's patient care record in the space designated for Original Sequence Number. If utilizing a paper EMS Report Form, document in the space designated for Second Sequence number. DO NOT cross out or line through the imprinted Sequence Number if utilizing a paper EMS Report Form.

2. The provider agency transferring patient care must have a mechanism in place to provide immediate transfer of patient information to the transporting agency.

E. Multiple Casualty Incidents (MCI)

1. One standard EMS Record must be initiated for each patient transported in an MCI. Provider agencies may use alternate means of documenting MCIs if the EMS Agency is notified prior to implementation and agrees with the proposed process.

2. Documentation should include the following, at minimum:

a. Name
b. Provider Impression
c. Chief Complaint
d. Mechanism of Injury, if applicable
e. Age and units of age

f. Gender
g. Brief patient assessment
h. Brief description of treatment provided
i. Transporting provider (provider code and unit number) and level of service (ALS, BLS or Helicopter)
j. Destination
k. Receiving facility

3. Non-transported patients should be documented on a standard EMS Record or a patient log.

4. Each provider agency should submit copies of all records and logs pertaining to an MCI to the EMS Agency within 10 business days of the incident. MCI documents should be hand carried or delivered to the EMS Agency in an envelope clearly marked with the incident date and location.

F. Completion of the EMS Record Prior to Distribution

1. EMTs and paramedics responsible for documenting prehospital care shall ensure that EMS Records are completed in their entirety prior to dissemination to the receiving facility. In most instances, this means that the record is completed at the scene or upon arrival at the receiving facility.

2. An exception to this is when a first responding agency utilizing paper-based EMS Report Forms is giving the receiving hospital (red) copy to a transporting agency. In the interest of expediting the transfer of care, it is recognized that information such as the unit times may not be documented on the receiving hospital (red) copy of the EMS Report Form.

G. Field Transfer of Care

1. When patient care has been transferred from the first responding ALS or BLS provider agency to a BLS provider agency for transport to a receiving facility, the provider agency receiving the patient should **NOT** generate an ePCR with a new Sequence Number (this will result in the same patient being entered into the ESO Repository with two different sequence numbers).

2. The provider agency that receives the BLS patient for transport to a receiving facility shall complete their agency's ePCR and document the Sequence Number generated by the first responding ALS or BLS provider agency's ePCR on their ePCR or paper-based EMS Report Form.

3. If utilizing a paper-based EMS Report Form, the receiving hospital (red) copy of the EMS Report Form, as well as the PCR from the BLS transport provider (red copy), must accompany the patient to the receiving facility where it becomes part of the patient's medical record.

4. It is the responsibility of the EMS Provider to ensure that a completed copy of the EMS Record is provided to the receiving facility upon transfer of care.

H. Completion of Advanced Life Support Continuation Form

1. If utilizing a paper-based EMS Report Form, required for each patient on whom advanced airway management is necessary.

2. Paramedics completing this form must ensure that the demographic information (patient name, date, provider code/unit, incident #) and Sequence Number are legibly and accurately transcribed from the EMS Report Form.

II. Base Hospital Form - MICN and/or Physicians

A. Base hospital personnel (MICNs and physicians) shall document prehospital care according to procedures identified in the Base Hospital Documentation Manual.

B. Base Hospital Form Completion

1. MICNs and/or physicians shall complete one EMS Agency approved Base Hospital Form (one for each patient in which medical direction is given) for every base hospital paramedic radio/telephone contact.

2. MICNs and/or physicians may document base hospital data electronically in lieu of the standard Base Hospital Form if the base hospital has received prior authorization from the EMS Agency.

C. Base Hospital Directed Multiple Casualty Incidents (MCI)

1. EMS Agency-approved MCI Base Hospital Forms may be utilized for incidents involving three or more patients.

2. Physicians and MICNs should limit requested information to **only** that which is essential to determine destination or medical management. Additional information and Sequence Numbers should be obtained after the MCI has cleared.

3. The following should be documented for MCIs involving three or more patients, when base contact is made for online medical control:

a. Date
b. Time
c. Sequence number/Triage tag number
d. Provider and unit
e. Chief complaint
f. Mechanism of injury, if applicable
g. Age and units of age
h. Gender
i. Brief patient assessment, when possible
j. Brief description of treatment provided, when possible
k. Transporting provider, method of transport (ALS, BLS or Helicopter)
l. Destination
m. Receiving Facility

4. Upon request of the EMS Agency the base hospital should submit all records pertaining to an MCI to the EMS Agency within 10 business days.

5. Provider agencies may use alternate means of reporting MCIs. Base Hospitals will be notified by the EMS Agency when alternate reporting methods will be implemented by various provider agencies.

6. MCIs involving **ONLY** BLS patients: BLS patients who are transported to a receiving facility should be documented on one Base Hospital Form in the Comments Section (provided no medical direction is given).

7. MCIs involving ALS **and** BLS Patients:

   a. One standard Base Hospital Form or one EMS Agency-approved MCI Base Hospital Form must be completed for each ALS patient.

   b. BLS patients on whom no medical direction has been given do not require a Base Hospital Form. The number and disposition of the BLS patients may be documented on the Base Hospital Form of an ALS patient in the Comments Section.

8. Alternate methods of documenting MCIs may be initiated by base hospitals with the approval of the EMS Agency.

III. Modification of Patient Care Records

A. Modifying the Patient Care Record (additions, deletions or changes) after the Patient Care Record has been completed or disseminated:

1. An audit trail of changes made to an electronic record will be included on the ePCR.

2. For paper-based EMS Report Forms, make corrections by drawing a single line through the incorrect item or narrative (the writing underneath the single line must remain readable).

   Make the changes on the original, noting the date and time the changes were made, with the signature of the individual making the changes adjacent to the correction. Ideally, changes should be made by the individual who initially completed the form. Under no circumstances should changes to either patient assessment or patient treatment documentation be made by an individual who did not participate in the response.

B. Making substantive changes (documentation of additional medications, defibrillation attempts, pertinent comments, complaints, etc.) to the EMS Record:

1. For electronic documentation systems, patient care related corrections are to be made as per provider agency policy. The provider agency shall notify its receiving hospital(s) of the mechanism by which ePCRs are updated and when an ePCR is updated. If the receiving hospital receives a printed copy of the record, a printed copy of the revised record will be provided directly to them.

2. Photocopy the paper-based EMS Report Form with the changes and send the copy, along with a cover letter, to all entities that received the original form (EMS Agency, receiving facility). The cover letter should explain the modifications and request that the modified copy be attached to the original copy.

3. Do not re-write the incident on a new paper-based EMS Report Form because this would result in a mismatch in Sequence Number. If the form requiring corrections has been mutilated or soiled and cannot be photocopied, then a new form may be used to re-write the incident provided the Sequence Number of the new form has been replaced with the Sequence Number from the original form.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 608, **Retention and Disposition of Prehospital Patient Care Records**
Ref. No. 640, **LA-EMS NEMSIS Data Dictionary**
Ref. No. 644, **Base Hospital Documentation Manual**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **PREHOSPITAL EMS AIRCRAFT OPERATIONS**

REFERENCE NO. 419

PURPOSE: To establish minimum standards for EMS aircraft operations in the County of Los Angeles.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 8, Section 100276-100306. Los Angeles County, Code of Ordinances, Title 7, Business Licenses, Division 2, Chapter 7.16 Ambulances.

DEFINITIONS:

Advanced Life Support (ALS): Definitive prehospital emergency medical care approved by the local EMS Agency, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital or Ref. No. 1200, Treatment Protocols, et al., during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the staff of that hospital.

Basic Life Support (BLS): Those procedures and skills contained in the EMT-I scope of practice, including emergency first aid and cardiopulmonary resuscitation.

Classifying and Authorizing EMS Agency: The Los Angeles County EMS Agency, which classifies EMS Aircraft into categories and approves utilization of such aircraft within its jurisdiction.

Continuation of 9-1-1 Call: In urban or other areas where helicopter landings may be unsafe, a hospital's State approved and licensed heliport or designated landing site is utilized for transfer of the patient from the ground crew to the medical flight crew for continuation of the 9-1-1 call.

Designated Dispatch Center: An agency which has been designated by the local EMS Agency for the purpose of coordinating air ambulance or rescue aircraft response to the scene of a medical or traumatic emergency within the jurisdiction of the local EMS Agency.

Emergency Medical Services (EMS) Aircraft: Any aircraft utilized for the purpose of prehospital emergency patient response and transport. EMS aircraft includes air ambulances and all categories of rescue aircraft.

Medical Flight Crew: The individual(s), excluding the pilot, specifically assigned to care for the patient during aircraft transport

Primary Provider Agency: The provider agency authorized to provide 9-1-1 emergency medical services within a city or unincorporated area of Los Angeles County by the governmental authority responsible for that geographic area.

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

PRINCIPLES:

1. The Los Angeles County EMS Agency is responsible for the integration of EMS aircraft into the Los Angeles County EMS patient transport system and for the development of policies and procedures related to the integration of this specialized resource. EMS aircraft operating in Los Angeles County must be classified and authorized by the EMS Agency in order to provide prehospital patient transport.

2. EMS aircraft providers (excluding agencies of the federal government) who provide or make available prehospital air transport or medical personnel, either directly or indirectly, or any hospital where an EMS aircraft is based, housed, or stationed permanently or temporarily, shall adhere to all federal, state, and local statutes, ordinances, policies, and procedures related to EMS aircraft operations, including qualifications of flight crews and aircraft maintenance.

3. Availability and appropriateness of EMS aircraft transport shall be determined by the primary EMS provider agency on scene. This will be based on the patient's status, ground ambulance response time, and proximity to a receiving facility staffed and equipped to meet the needs of the patient(s), i.e., trauma centers, pediatric trauma center, etc. versus the most accessible receiving facility (MAR).

4. If base hospital contact is established and directing the patient's care, the base hospital shall be the medical authority in determining patient destination and treatment in accordance with all applicable prehospital care policies.

5. No EMS aircraft shall respond to an incident without formal dispatch from a designated dispatch center or request from the primary provider agency responsible for the area in which the incident has occurred.

6. The primary provider agency requesting EMS aircraft response shall assume medical management responsibility at the scene and shall be responsible for proper protection of the emergency landing site during its use in the event that a licensed heliport is not available. This shall include, but not be limited to, fire protection, rescue services, exclusion of extraneous individuals, control of duties performed in the immediate vicinity of the aircraft (special attention will be paid to the main rotor, the tail rotor, and the effects of rotor downwash), and patient protection during landing.

7. The authority for safety of the EMS aircraft and persons associated with the EMS aircraft shall rest with the Pilot In Command (PIC). This shall include the supervision of those persons directly involved in loading/unloading patients and/or supplies.

POLICY:

I. Dispatch Criteria

Availability and appropriateness of EMS aircraft transport shall be determined by the primary provider agency on scene with regard to, but not limited to, the following:

A. The determination of ground versus air transport should be based on the time of day, incident location, weather conditions, traffic obstructions, etc.

B. An EMS aircraft should be considered for dispatch to an incident any time ground

response will result in an extended estimated time of arrival, and/or incident location is inaccessible by ground ambulance.

C. If aeromedical transport is indicated and the requested/most accessible EMS aircraft is unavailable or has declined the request due to conditions not conducive to air transport, the next most accessible EMS aircraft provider should be requested, until all resources have been exhausted. If a request for services is refused by a particular provider (e.g. weather), the reason for the flight refusal will be conveyed to any subsequent recipient of the request for service.

D. Patients meeting trauma center criteria should be transported by EMS aircraft when a trauma center cannot be accessed by ground within 30 minutes (Ref. No. 506, Trauma Triage).

E. For patients requiring ALS level care whose condition is deteriorating and transport to a 9-1-1 receiving facility is extended, transport by EMS aircraft may be considered.

F. The designated dispatch center or primary provider agency requesting/dispatching EMS aircraft responses shall notify the following facilities/agencies as early as possible, and prior to patient/EMS aircraft arrival. Examples of these facilities/agencies include, but are not limited to the following:

1. Local fire department

2. Local law enforcement for scene jurisdiction

3. Base hospital, if applicable, in accordance with established policies and procedures.

4. Receiving hospital (when possible, the receiving hospital should be notified by both the EMS Aircraft and the base hospital handling the call).

5. Medical Alert Center

G. Dispatch of EMS aircraft may not be appropriate under certain circumstances and patients may require transport to the most accessible 9-1-1 receiving facility (MAR) staffed and equipped to handle the patient in compliance with State and local EMS policies and procedures.

1. The patient has an uncontrollable life-threatening situation (e.g., obstructed airway).

2. There are conditions not conducive to air transport such as inadequate landing site, poor weather, etc.

3. Air transport is not immediately available when the patient is ready for transport and the risks of delaying transport outweigh the risks of transporting by ground.

II. Cancelation

A. When an EMS aircraft response has been requested, the decision to cancel the

EMS aircraft may be made by one or more of the following, as appropriate for the incident:

1. Primary provider EMS personnel
2. Incident commander
3. PIC of the EMS aircraft
4. Requesting personnel and/or organization
5. Base Hospital Physician

B. The designated dispatch center or primary provider agency managing the requests for an EMS aircraft shall notify all affected parties of the cancelation of an EMS aircraft.

III. Patient Destination/Landing Sites

A. The base hospital directing the patient's care shall determine patient destination in accordance with the applicable patient destination policies, provided the receiving facility has a State approved and licensed heliport or designated landing site. Hospital diversion status is also a consideration in determining patient destination. The base hospital shall contact the receiving facility and relay all pertinent information concerning the patient's condition.

B. If base hospital contact cannot be established or maintained, the decision for patient destination shall be made by the highest medical authority on scene. Hospital diversion status may be obtained from the Medical Alert Center (MAC) or via the ReddiNet system. Pertinent patient information and ETA should be relayed directly to the receiving hospital, through the MAC or the designated dispatch center.

C. All applicable destination policies will be followed for patients treated under Ref. No. 1200, Treatment Protocols, et al. Hospital diversion status and availability of a State approved, and licensed heliport or designated landing site are factors that need to be considered. Paramedics shall contact the receiving facility directly and relay all required information concerning the patient's condition. If the aircraft is unable to communicate with the receiving facility (terrain related), all efforts should be made to communicate with the receiving facility via the base hospital, dispatch center, or the MAC.

D. All patient destinations, with respect to safety factors, shall be approved by the PIC.

E. In all situations where temporary emergency landing sites are used, the PIC of each EMS aircraft will exercise primary authority and responsibility for the safe operation of the aircraft. If a hospital with a State approved and licensed heliport or designated landing site is in proximity to an incident requiring EMS aircraft transport, such heliport or landing site may be utilized for continuation of the 9-1-1 call and is not in violation of the Emergency Medical Treatment and Active Labor Act (EMTALA).

F. When pediatric and adult trauma patients are transported together in one aircraft, the receiving trauma center shall also be a pediatric trauma center.

IV. Communication/Record Keeping

A. EMS aircraft shall have the capability of communicating with each of the following:

1. Designated dispatch center

2. EMS ground units at scene of an emergency

3. Designated base hospitals

4. Receiving hospitals

5. Other appropriate facilities or agencies

6. Required FAA facilities

B. Whenever possible, direct communication should be established.

C. All EMS aircraft shall utilize appropriate radio frequencies for dispatch, routing and coordination of flights. This excludes use of Med 1-8 and Hospital Emergency Administrative Radio (V MED 28) for these purposes.

D. Each EMS aircraft shall establish base hospital contact with their assigned base hospital or the appropriate area base hospital pursuant to Ref. No. 1200, Treatment Protocols, et al., unless the call is a prearranged, specialty center, interfacility transfer.

E. When receiving a patient(s) from ground units, the medical flight crew shall ensure that, if applicable, base hospital contact has been made and/or continued. Such contact shall not unnecessarily delay patient transport.

F. In the event voice communication cannot be established or maintained with the base hospital, paramedics shall utilize Ref. No. 1200, Treatment Protocols, et al.

G. All applicable prehospital care policies and procedures related to record keeping shall apply to EMS aircraft operations. The EMS Record should be available to the receiving facility at transfer of care, or as soon as feasible.

V. Medical Control

A. All EMS policies and procedures for medical control and patient destination shall apply to the medical flight crew.

B. In situations where the medical flight crew is less medically qualified than the ground personnel from whom they receive patients, the medical flight crew may assume patient care responsibility only in accordance with policies and procedures established by the EMS Agency.

C. Medical flight crewmembers who have an expanded scope of practice (Physicians/RNs) beyond Ref. No. 803, Paramedic Scope of Practice, may only

utilize specific treatments/procedures for which they are licensed, trained and qualified. In such cases, notification to the receiving facility shall be made and base hospital medical direction is not required.

D. If a physician is aboard an EMS aircraft, under no circumstances will the presence of said physician endorse the violation of recognized limits of scope of practice of any EMT-I, paramedic, or RN aboard the aircraft.

VI. Quality Improvement

A. The EMS Agency, base hospitals, trauma centers, and provider agencies shall conduct regular review of all trauma related EMS aircraft responses.

B. Documentation on the Patient Care Report and Base Hospital Form should include an explanation for the use of an air ambulance (i.e., mountain rescue).

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 504, **Trauma Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 511, **Perinatal Patient Destination**
Ref. No. 512, **Burn Patient Destination**
Ref. No. 516**, Cardiac Arrest Patient Destination**
Ref. No. 518, **Decompression Emergencies/Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 520, **Transport of Patients from Catalina Island**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 802, **Emergency Medical Technician Scope of Practice**
Ref. No. 803, **Paramedic Scope of Practice**
Ref. Nos. 1200, **Treatment Protocols**

SYSTEM ASSESSMENT – RESPONSE/TRANSPORTATION

Universal Level

4.12 Disaster Response

STANDARD

4.12 The MHOAC in cooperation with the County Office of Emergency Management services, local public health department, the local office of environmental health, the local department of mental health, the local EMS Agency, the local fire departments, the Regional Disaster Medical and Health Coordinator (RDMHC), and the regional office of the Office of Emergency Services, shall be responsible for ensuring the development of a medical and health disaster plan for the operational area following SEMS and NIMS. This plan shall include preparedness, response, recovery, and mitigation functions consistent with the State Emergency Plan and have procedures that include the 17 MHOAC functions. In the event of a local, state, or federal declaration of emergency, the MHOAC shall assist the agency operational area coordinator in the coordination of medical and health disaster resources within the operational area and be the point of contact in that operational area, for coordination with the RDMHC, the agency, the regional office of the agency, the State Department of Public Health, and the authority.

CURRENT STATUS:

Primary provider agencies are prepared for mobilizing response and transport vehicles in a disaster and have Mutual Aid plans in place. Should additional transport vehicles be required, the EMS Agency's Medical Coordination Center is prepared to provide vehicles from the LEMSA's own fleet, from private contractors with whom contracts are in place, and from other operational areas in the Regional Disaster Medical and Health (RDMH) Region I. The LEMSA maintains agreements with other operational areas in Region I through the RDMH Coordinator for medical transportation services in a disaster. LA EMS has also actively participated in the statewide development of the Ambulance Strike Team concept.

COORDINATION WITH OTHER EMS AGENCIES:

The local EMS Agency is the Medical and Health Operational Area Coordinator (MHOAC) and the Regional Disaster Medical and Health Coordinator (RDMHC). Agreements are in place within Region I operational area.

NEED(S):

Standard met.

OBJECTIVE:

No further objective needed to meet standard.

TIMEFRAME FOR OBJECTIVE:

[ ] Short-range Plan (one year or less)
[ ] Long-range Plan (more than one year)