HEALTHCARE REFORM (HCR) AND EMERGENCY MEDICAL SERVICES (EMS)
By Cathy Chidester, Director

You may be hearing a lot about HCR and wondering how this will affect you both personally and professionally. Basically, you may be thinking, “doesn’t it mean healthcare insurance for everyone? How could that be a cause for concern?” I trust this article will answer some of those questions.

Think of HCR as a snowball rolling down a steep slope. It is coming at us faster and faster, while getting larger by the minute. EMS needs to make some changes to not get bowled over and we need to change fast.

Over the years there has been governmental intervention to maintain healthcare cost and improve the quality of care. Consider government as the largest payer of healthcare through Medicare and MediCal. Even with intervention, the United States spends more money on healthcare than any other country. The estimate is 2.6 trillion dollars or $8,600 per person. Yet, we rank 37th in overall performance.

Healthcare today is delivered by a disconnected system of insurance such as Medicare, MediCal, Blue Cross, HealthNet, Kaiser, etc.; providers such as physicians, nurses, and allied health (including paramedics and EMTs); hospitals, skilled nursing facilities, clinics, and outpatient services, etc. So we have many parties interested and influencing the medical care of confused patients trying to navigate a complex system.

We have been moving toward a more organized system of healthcare for many years. Some healthcare organizations, such as Kaiser, have been developing a system of care and are well positioned for HCR. Others are playing catch up and putting systems in place. HCR will be enacted in stages and will significantly increase the number of people covered by insurance. The unknown factor is what, exactly, will happen when the majority of the population is insured? Many predictions are based on the Massachusetts experience with the universal healthcare

LASD & MAC PARTICIPATE IN MARITIME DRILL
By Christine Bender

Over thirty local, state, federal, and private sector emergency response and management organizations participated in the June 2012 Coastal Trident exercise, including the Los Angeles Sheriff’s Department (LASD) and the EMS Agency’s Medical Alert Center (MAC). The purpose of the drill was to improve response to potential maritime emergencies and test how LASD and local emergency responders would handle a biological or chemical terrorist attack offshore.

LASD’s Ocean Rescue 2, equipped with electronic sniffers to detect chemical and biological agents, identified a vessel off the coast of Malibu contaminated with a mustard agent that armed “terrorists” (role players) were planning to bring ashore. Before that...

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fter two years of planning, the Los Angeles (LA) County Pediatric Surge Plan is finally completed. The plan, developed in collaboration with Children’s Hospital Los Angeles (CHLA), has the potential to double the number of available pediatric acute care (PAC) beds and increase the number of pediatric intensive care unit (PICU) beds by 140% during an emergency (Table 1).

Table 1

<table>
<thead>
<tr>
<th>Bed Type</th>
<th>Current Staffed Beds</th>
<th>Surge Beds</th>
<th>Total Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Acute Care (PAC)</td>
<td>806</td>
<td>800</td>
<td>1606</td>
</tr>
<tr>
<td>Pediatric ICU</td>
<td>141</td>
<td>200</td>
<td>341</td>
</tr>
</tbody>
</table>

Table 1

Background

The 2009 H1N1 influenza pandemic disproportionately affected the pediatric population and stressed the hospital system’s pediatric intensive care units capacity during the peak of the outbreak. A Centers for Disease Control and Prevention (CDC) study found that “the overall attack rate was highest among children aged 5-14 years (147 per 100,000 population), which was 14 times higher than for adults older than 60 years of age. A total of 205 (13%) patients were hospitalized, with the highest rate observed among children aged 0-4 years (25 per 100,000), followed by children aged 5-14 years (11 per 100,000).” The 2009 H1N1 Pandemic: Summary Highlights (CDC, June 2010).

Recognizing that LA County needed to plan for such events, the EMS Agency initiated the Pediatric Surge Program to meet the medical needs of children during a disaster, specifically when the pediatric population is disproportionately impacted such as the 2009 H1N1 pandemic or a school shooting.

Gap Analysis

The initial step in developing the surge plan was identifying the existing gaps. To do this CHLA conducted a countywide assessment of the current status of pediatric services and identified the following:

1. Limited pediatric bed capacity on a daily basis – LA County is home to 2.8 million children ages 18 and under (2010 U.S. Census) but only has 171 licensed PICU beds (141 staffed PICU beds) and 1,044 licensed PAC beds (806 staffed PAC beds). There was no data available to determine the occupancy rate of the pediatric beds but based on the H1N1 pandemic experience, the number of pediatric beds in LA County is limited and capacity was an issue even in a mild pandemic.

2. Geographic variability of pediatric bed capacity – Based on 2009 Office of Statewide Health and Planning and Development (OSHPD) data, the majority of pediatric beds in LA County are located in downtown LA Metro Area (31%) followed by the South Bay area (20%). The Antelope Valley, with a pediatric population of 113,511 children is served by 22 licensed PAC beds and the South service planning area of the county has 14 licensed PAC beds serving 340,370 children. Neither of these areas do not have licensed PICU beds (Table 2)

Table 2

<table>
<thead>
<tr>
<th>Service Planning Area (SPA)</th>
<th>Peds Pop</th>
<th>Licensed PICU beds</th>
<th>Licensed PAC beds</th>
<th>Licensed beds per 1000 children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antelope Valley</td>
<td>113,511</td>
<td>0</td>
<td>22</td>
<td>0.19</td>
</tr>
<tr>
<td>East</td>
<td>379,976</td>
<td>0</td>
<td>137</td>
<td>0.36</td>
</tr>
<tr>
<td>Afton</td>
<td>282,977</td>
<td>97</td>
<td>466</td>
<td>1.65</td>
</tr>
<tr>
<td>San Fernando</td>
<td>532,864</td>
<td>11</td>
<td>123</td>
<td>0.23</td>
</tr>
<tr>
<td>San Gabriel</td>
<td>459,786</td>
<td>8</td>
<td>126</td>
<td>0.27</td>
</tr>
<tr>
<td>South</td>
<td>340,370</td>
<td>0</td>
<td>14</td>
<td>0.04</td>
</tr>
<tr>
<td>South Bay</td>
<td>388,105</td>
<td>30</td>
<td>212</td>
<td>0.55</td>
</tr>
<tr>
<td>West</td>
<td>107,961</td>
<td>24</td>
<td>57</td>
<td>0.52</td>
</tr>
</tbody>
</table>

Table 2

3. Limited pediatric specialty physician resources in hospitals – Forty-one percent of responding hospitals reported that they have a physician available 24/7 to admit pediatric patients into their facility. Fifty percent reported that they have contracts with pediatric general surgeons; however, these contracts are not necessarily exclusive so an individual surgeon may have existing contracts with multiple hospitals leading to an overestimation of available pediatric surgeons. Twenty-three percent of hospitals have pediatric anesthesiologists (20/87). Of the 87 hospital survey respondents, 15 hospitals have pediatric emergency medicine departments (17%). Of these 15 dedicated pediatric emergency medicine departments, only nine have dedicated pediatric emergency physicians.

4. Varying availability of staff with pediatric training – Thirty-one percent (6,557/21,175) of hospital nursing staff and 55% of respiratory therapists are Pediatric Advanced Life Support (PALS) certified while only 2% of the nursing staff have taken the Emergency Nursing Pediatric Course.
5. Availability of pediatric critical care supplies – Eighty-eight percent of hospitals reported having pediatric resuscitation equipment and supplies; however only 67% have routine (EDAP) pediatric equipment and supplies and 68% of the facilities have pediatric critical care equipment and supplies.

The Plan

As part of the plan development, each hospital participating in the Hospital Preparedness Program (HPP) was assigned to a tier based on the type of pediatric service they currently provide. Each hospital tier was then assigned a surge target to increase the county’s available pediatric beds during a disaster. The tiers are designated as follows (Table 3):

<table>
<thead>
<tr>
<th>Tier</th>
<th>Tier Criteria</th>
<th>Types of patients recommended for the tier</th>
<th># of Hospitals</th>
<th>Existing # of licensed beds for potential pediatric care</th>
<th>Proposed Surge Capacity</th>
<th>Surge Capacity Increase Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Full pediatric complement – PICU, Peds Acute and NICU</td>
<td>All patients and services (Triage level - Immediate)</td>
<td>14</td>
<td>678 pediatric acute beds 136 PICU beds 484 NICU beds</td>
<td>Expand PICU and pediatric acute capacity for medical and trauma scenarios</td>
<td>170 PICU 210 Peds Acute</td>
</tr>
<tr>
<td>2</td>
<td>Adult Trauma Centers (all Level 2)</td>
<td>All patients and services (Triage level - Immediate)</td>
<td>6</td>
<td>168 adult ICU 64pediatric acute 133 ICU beds</td>
<td>Use for a trauma surge event and overflow for intensive care</td>
<td>30 ICU 90 Peds Acute</td>
</tr>
<tr>
<td>3</td>
<td>Pediatric acute beds (4 non EDAP)</td>
<td>All patients and services, but would be used following Tiers 1 and 2</td>
<td>16</td>
<td>276 pediatric acute beds 374 adult ICU beds 304 NICU beds</td>
<td>Expand pediatric acute care.</td>
<td>240 Peds Acute</td>
</tr>
<tr>
<td>4</td>
<td>EDAP with no pediatric acute or PICU care</td>
<td>Possibly respiratory, simple fractures, surgery – older children in adult and possibly increase age for NICU; ideally children under age 8</td>
<td>15</td>
<td>276 adult ICU 136 NICU beds</td>
<td>Adult med / surg and or ICU beds carved out in a specific area</td>
<td>150 Peds acute</td>
</tr>
<tr>
<td>5</td>
<td>Not EDAP and no Pediatric inpatient care</td>
<td>Stable patients older than age 8</td>
<td>22</td>
<td>364 adult ICU beds 61. NICU beds</td>
<td>Adult med / surg and or ICU beds carved out in a specific area</td>
<td>110 Peds acute</td>
</tr>
<tr>
<td>6</td>
<td>No emergency services and/or Specialty Type -Hospitals</td>
<td>Use as a specialty resource</td>
<td>14</td>
<td>115 pediatric acute beds 129 adult ICU</td>
<td>Transfer patients based on specialty for specialty hospitals</td>
<td>As needed</td>
</tr>
</tbody>
</table>

Each hospital will determine what surge strategies to implement to meet the surge of pediatric patients based on their facility’s bed capacity and capabilities. Licensed adult acute care resources may need to be re-allocated to manage pediatric patients. Some hospitals may choose to use areas of the NICU if they are available and isolated from other patient populations, whereas some may elect to use their PACU or adult ICU to care for pediatric patients.

In the event this plan is operationalized, prehospital care providers may be directed to transport pediatric patients to non-EDAP receiving facilities as well as adult-only trauma centers. The EMS Agency will coordinate patient destination and secondary transfers when warranted.

Plan Implementation

The EMS Agency, again in collaboration with CHLA, will be providing six pediatric surge training classes December 2012 through March 2013. These classes are targeted for hospital emergency preparedness planners as well as hospital clinical staff who may need to manage pediatric patients during a disaster. These training classes will provide an overview of the pediatric surge plan but will mainly focus on updating the pediatric management skills of clinical staff to enable them to manage pediatric patients. Training for prehospital personnel (paramedics and mobile intensive care nurses) will be provided through EMS Update 2013.

Table 3

Each hospital will use existing methods for caring for children during a surge situation. Hospitals that routinely care for children and have PICU capability will be requested to increase capacity for intensive care beds so that more stable patients can be cared for at other facilities. Additionally, children under the age of eight (8) should be cared for at facilities accustomed to caring for children. This is based on physical age of development when a typical 8 year old’s anatomy is more similar to an adult.
Have You Checked All Their Vitals?
By Gary Watson

Recently the EMS Agency received an email from the California EMS Authority asking all local EMS providers to help in a campaign to reduce homelessness among veterans. Every day firefighters, EMTs, paramedics and ER nurses are provided with unique opportunities to help those who have protected our land and fought for our freedom.

In 2011, there were an estimated 67,495 homeless veterans in the United States; approximately 7,400 live in Los Angeles County. Many of these homeless veterans are not aware of the free resources that are available to them through the United States Department of Veteran’s Affairs (VA); resources that include health care, mental health services, employment/job training and housing assistance.

Of the 88,000 U.S. troops in Afghanistan, 20,000 will be returning home this fall and the plan is for all troops to return by 2014. Although the homeless veteran population has declined over recent years, this number could soon drastically increase as the troops return home.

When soldiers return home, adjustment back to civilian life is often difficult. Some find themselves lost in an unfamiliar world and unable to find their place in society. As an EMS provider you may find yourself interacting with veterans in situations that are reversible and preventable. The next time you are assessing a homeless patient, ask if they are a veteran. If they are, provide them with information that could turn their life around. Remember…complete all their vital signs!

1-877-4AID-VET
(1-877-424-3838)

“Those who have served this nation as Veterans should never find themselves on the streets, living without care and without hope.”
Eric Shinseki, U.S. Department of Veterans Affairs Secretary

For more information on the homeless veteran project, visit the U.S. Department of Veterans Affairs at http://www.va.gov/HOMELESS/index.asp
For information on how to obtain free informational products, contact: Gary Watson, Los Angeles County EMS Agency at gwatson@dhs.lacounty.gov

Dr. Badday
By William Koenig M.D.

It was a routine call for Squad 101; a 9-1-1 summons to a patient at a rehab hospital with complaints of dizziness, nausea and hypotension.

It’s never a routine event for the patient; especially if you are accustomed to treating patients, not being the patient. Dr. Jalal Badday, a staff physician at Pomona Valley Hospital Medical Center (PVC) was making his rounds at a rehab hospital when he felt dizzy. Despite this, Dr. Badday continued to work. His symptoms increased, though, and while at the nursing station he began to sweat profusely and slipped to the floor. He immediately asked the nurses to check his blood pressure (roughly 68/30), and administer aspirin and oxygen. One nurse called 9-1-1 while another started an intravenous line and a third ordered a stat ECG.

Dr. Badday already suspected what the ECG confirmed: he was having an ST-elevation myocardial infarction (STEMI). Amazingly, Dr. Badday continued to direct his own care, asking the rehab nurses to notify the PVC emergency department and alert them of his imminent arrival. Just as the paramedics showed up, so did the chest pain. Dr. Badday’s blood pressure, already low, dropped even further. Squad 101 immediately got enroute, continued to treat the physician in the back of the ambulance, and shortly thereafter rolled into PVC’s ambulance bay where the Medical Director of the Cardiac Cath Lab was waiting.

Rapid treatment in the Cath Lab left Dr. Badday feeling like “a monkey had cleared from my chest, instantly”. Total time from the squad’s arrival on scene to completion of the angiogram in the Cath Lab? An incredible 51 minutes. As Dr. Badday said, “The artery was opened before my wife even arrived!”

Since that day, Dr. Badday has recovered well, lost 22 pounds and joined the Cardiac Rehab Program at PVC. He continues to “thank God for life and the gift of life that I have with every breath.” He expressed his gratitude to the responding paramedics of Los Angeles County Fire Squad 101 and the staff members of PVC’s emergency department, Cardiac Cath Lab, and ICU.

Four months later, PVC hosted a breakfast to thank the EMS providers for their dedication to heart attack and
stroke victims. “With the excellent emergency care and attention to detail by EMS personnel and their cooperative partnership and teamwork with PVC, together we save lives,” said Deborah Keasler, Director of PVC’s Heart and Vascular Center. Dr. Badday, thanks to his own quick thinking and that of his EMS partners and hospital staff, is one of those valuable lives.

Healthcare reform (from on pg.1)

coverage implemented after the 2006 healthcare reforms.

Predictions include:
- increased number of Emergency Department (ED) visits due to a shortage of primary care physicians and medical homes
- backlog of clinic and physician appointments
- increased patient visits seeking care for minor problems or early visits for medical conditions
- continued population of uninsured patients (homeless, undocumented)
- efforts to ensure healthcare professionals are working at the top of their license
- increase in the number of alternate care sites
- increased reliance on the internet and technology
- increased monitoring and oversight of limited resources (e.g., money, hospital beds, physicians)
- changes to reimbursement increasing the focus on managed care, reimbursement for quality, and demonstrated benefit to patients
- pressure on healthcare systems to keep patients out of the hospital, document the benefits of care, decrease errors and decrease or eliminate re-adoptions
- shifting of payment sources; moving the uninsured to MediCal
- capped payments or payments made only when necessity and quality are documented

Is EMS part of the healthcare system? Yes! We are a key player in the healthcare system but, unfortunately, we have not told anyone. We not only save lives on a daily basis; we improve patient outcome and shorten hospital length of stay with appropriate treatment and transport to facilities such as Trauma Centers, STEMI Centers, Stroke Centers and EDAPS. One of the biggest issues facing the healthcare system is “resource management” and that includes EMS resources. The questions for us include: How can EMS effectively manage our resources to the benefit of our patients? How does EMS fit into HCR? Does EMS have a product to offer Accountable Care Organizations (hospital systems of care), insurers, and patients as part of the healthcare system?

We need to be considering our resources and start the conversation about resource management. This includes tiered dispatch, patient education, alternate care sites, treat and release, and connecting patients to community resources. There are programs on the horizon and things we can get started with today in preparation for that snowball. For example, policy makers are looking at the Health and Safety Code regulations and developing a paper addressing the regulations governing the paramedic scope of practice. The State EMS Authority is preparing to convene a task force to help define the Community Paramedic for California. Several regulatory changes will be necessary to allow paramedics in California to implement some of the practices listed above and change as needed with thoughtful consideration for the outcome.

There are things that you and your department can do without regulatory changes. At the top of the list is improved data collection. Data not only needs to be accurate but timely, and it should provide the necessary information to demonstrate the effect of any system changes. Without a robust data system (most likely electronic) we cannot act and react to system changes and demonstrate the benefit of new programs. It is all about documented benefits. Know your community resources, meet with your local hospitals and find out how they are preparing for HCR. Agencies should evaluate their calls, identify repeat callers, and develop an understanding of the reasons for the calls. Can some of the calls be prevented by ensuring the patient has a primary care physician and access to community resources? Develop a local brochure for patients to access help. Examine your agency’s data to identify the frequency of preventable injury and illness in your system, and then develop a prevention program.

Paramedics and EMTs access people’s homes and know when a person or family needs assistance. I have been told that we have the most educated workforce in the history of our nation and I know our paramedics and EMTs have great ideas on how to improve the management of our patients and resources. I welcome your comments and suggestions. Call or e-mail me at any time to discuss your ideas for HCR.

The EMS Agency will be addressing changes from HCR with the fire departments and ambulance companies. We are in a unique position to benefit from HCR but if we do not respond quickly in a thoughtful and collaborative manner, we are going to get BOWLED OVER by that oncoming snowball!
Fireline Emergency Medical Technician-Paramedic

By John Telmos and Captain Dan France, FEMP

With the wildland fire season off and running (although many say that fire season is now year-round), the Los Angeles County area Fireline Paramedics (FEMPs) are ready to respond.

In August 2009, Firescope officially added FEMP to their Incident Command System (ICS) Position Manual. This position was created to ensure that firefighters injured on the fireline would be assessed and treated by paramedic personnel as quickly as possible on the fireline as opposed to only providing BLS level care and either transporting the firefighter back to the Medical Unit at base camp or to a local emergency department.

Following Firescope’s lead, Los Angeles County Emergency Medical Services (EMS) Agency staff and FEMP subject matter experts developed policies, procedures, and a standardized equipment list for the Los Angeles County Fireline EMT and FEMPs. Ref. No. 804, Fireline Emergency Medical Technician-Paramedic (FEMP) and Ref. No. 719, Fireline Emergency Medical Technician-Paramedic Inventory were finalized and effective as of December 2009. Sponsoring provider agencies are responsible to make available and maintain all equipment/supplies and necessary personnel training.

FEMPs working the fireline function utilizing Ref. No. 806.1, Procedures Prior to Base Contact Field Reference. Additionally, Ref. No. 804 allows the FEMP to administer additional treatments not included in Ref. No. 806.1 (fluid challenge for heat related injuries, additional doses of morphine sulfate for pain control, etc.). Contact must be made (as soon as capable) to the EMS Agency medical director via the Medical Alert Center for authorization of ALS level treatment. All medical care provided by the FEMP must be documented on their local EMS agency report form. Historically, most firefighter injuries encountered at wildland fires are minor in nature and include chief complaints such as extremity injuries, smoke inhalation and landscape-associated dermatological complaints.

The FEMP can respond from and to agencies within or outside Los Angeles County EMS Agency jurisdiction when requested through the statewide Fire and Rescue Mutual Aid System. Los Angeles County Fire (CF) Command and Control is the “clearinghouse” agency that maintains the list of qualified personnel for Region One Operational Area (includes Los Angeles and five surrounding counties). Once the call for assistance is received, CF Command and Control checks the Resource Ordering and Status System (ROSS) for available FEMPs. Once availability is determined, the FEMPs’ sponsoring fire department is notified and personnel are deployed.

Upon arrival to the wildland fire, incident coordination takes place in accordance with the ICS component of the National Incident Management System (NIMS). The FEMP initially reports to the Check-in Unit Leader, if established, or the Logistics Section Chief at the base camp. The FEMP must provide a picture ID, driver’s license, County accreditation card and the California Incident Command Certification System Qualification Card (Red Card). The Red Card validates experience, training and qualifications to function as a FEMP.

After check-in, the FEMP receives a briefing and assignment from the Logistics Section Chief or the Medical Unit Leader including current incident situation, fire weather report, anticipated medical needs, and local emergency medical system orientation. The FEMP is normally paired with either a Fireline EMT or another FEMP. The team is provided the current Incident Action Plan (IAP) for the operational period which includes ICS Form 206, Medical Plan. The 206 contains, among other items, the physical location of ground transport units, medevac resources, surrounding hospitals and specialty centers.

Upon arrival to the assigned location, the FEMP establishes and maintains contact with assigned personnel.
Defibrillation Stats for 2011
By Dana Scala

The EMS Agency developed the Annual Defibrillation Report based on summaries submitted by AED providers in March 2012. AED usage data for 2011 is depicted in the table below. Twenty agencies out of the 90 approved AED programs in Los Angeles County performed defibrillation with an AED on a total of 684 patients. This is a 3.8% decrease from 2010 usage despite a 1% increase in the number of AED providers for 2011. Unfortunately, it is very difficult for providers to follow these patients through their hospital stay to obtain outcome data, which may not accurately reflect survival rates. It is believed that the actual survival rates are much higher. AEDs are vital tools in the care of patients who suffer cardiac arrest and continue to save lives.

Special thanks to all AED Providers who submitted their annual report in a timely manner. As a reminder, the State and Los Angeles County require all AED Providers to submit an annual report every March. AED usage reports and forms are located on the EMS Agency website at http://ems.dhs.lacounty.gov

Defibrillation Report for Los Angeles County Calendar Year 2011

1. Total patients defibrillated by EMT/Public Safety Personnel: 684
2. Persons who suffered a witnessed (seen or heard) cardiac arrest and whose final monitored rhythm was ventricular tachycardia or ventricular fibrillation: 548
3. Defibrillated patients who survived cardiac arrest and were discharged from the hospital: 4
4. Defibrillated patients in witnessed cardiac arrest who survived to hospital discharge: 0
5. Basic life support personnel qualified to perform defibrillation: 11,578
6. Public Safety personnel (as defined in CCR Chapter 1.5) qualified to perform defibrillation: 3,181
7. Non-licensed or non-certified (lay public) persons trained to perform defibrillation by AED Providers: 3,438

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could happen, the chemical started to leak on the vessel. Deputies on an inflatable boat, armed with assault rifles and hazmat suits, drew up to the suspect boat and boarded. “We had suspects who were injured,” said Sheriff’s Sgt. Mick Kelleher, whose specialty is dealing with hazardous materials. “We had to decontaminate them before we brought them on Ocean Rescue 2 to be treated by paramedics.” LASD paramedics treated the moulaged blisters on the “terrorists” arms and legs while samples of the suspicious substance were tested by HazMat members.

As part of the exercise, the MAC was contacted by LASD paramedics and advised that several “terrorists” were arrested at sea in possession of a mustard agent and were suffering from mustard agent injuries. The MAC arranged air transport of the “terrorists” to the Ronald Reagan UCLA Medical Center and made countywide notifications of the on-going terrorist/medical event.

While the exercise scenario was not based on any known threats to the Port of Los Angeles or the region, it was designed to address the increasing frequency of seaborne criminal activity along the Southern California coastline. Coastal Trident 2012 provided valuable opportunities for participants to validate tactics, techniques, and procedures to counter potential threats in the port and maritime environments, as well as evaluate the coordination among and between emergency response personnel and the EMS Agency.