



A Summary of Issues Related to H&SC § 1797.201

For

**“.201 Today and Tomorrow:  
A Workshop on EMS System Coordination”**

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**Emergency Medical Services Administrators’  
Association of California**

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Bruce Barton, Riverside County EMS

Chuck Baucom, Merced County EMS

Dan Burch, San Joaquin County EMS

Cathy Chidester, Los Angeles County EMS

Ross Elliott, Kern County EMS

Virginia Hastings, Inland Counties EMS (Chair)

Miles Julihn, Marin County EMS

Larry Karsteadt, North Coast EMS

Nancy Lapolla, Santa Barbara County EMS

Jan Ogar, San Mateo County EMS

Vickie Pinette, Sierra Sacramento EMS

## Introduction

The EMS Administrators' Association of California (EMSAAC) is a professional organization that represents the interests of 31 local EMS agencies in California. Our mission is to provide EMS system leadership within the state and to foster excellence in all aspects of emergency specialty care services. We are a leading advocate for the development and maintenance of safe, effective, patient-oriented, community-based EMS systems.

EMSAAC is pleased to be an invited participant in a statewide workshop hosted by the EMS Authority to discuss the views of various stakeholders regarding 1797.201, a sometimes controversial section of California's Health and Safety Code, Division 2.5, now 30 years old. This summary document represents a consensus view held by local EMS agencies regarding the relevance of 1797.201 today.

## Background

Progressive in its time, California's first comprehensive statute for emergency medical services was enacted in 1980 and continues to guide the development of our local EMS systems. Amended by subsequent legislation nearly 100 times since, the "Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act" continues to provide the statutory framework for EMS in California.

The task of legislating an organized system of EMS in California into reality had to take into account the many EMS providers who were already engaged in delivering BLS and ALS services across the state. Cities and fire districts in Los Angeles, San Diego, Orange and other counties in California had been developing resources since the 1960s to provide emergency medical services within their jurisdiction. A number of different delivery models flourished, creating a variety of existing services that would have to be integrated into newly-formed local EMS systems for the vision of Senator John Garamendi's bill, known as SB 125, to be realized.

## The Role of the Local EMS Agency

The EMS Act clearly intended to create a two-tiered model of governance for EMS in California. The EMS Authority was established by the Act to carry out the State's oversight role in governance, and the local EMS agency (LEMSA) was authorized as the county or regional entity responsible to "*plan, implement and evaluate an emergency medical services system*" (1797.204).

Within the highly diverse and varied State of California, the EMS Act ensured that the LEMSA was the single, publicly accountable local entity with the over-arching authority for coordinating and evaluating the medical operations of all EMS system participants that provide emergency medical patient care

throughout the LEMSAs jurisdiction. This unique county or regional responsibility was established to optimize the systematic approach to patient care, and the effectiveness of this approach has been repeatedly demonstrated in peer-reviewed medical journals that verify the life-saving value of organized EMS systems.

In addition, the local EMS agency medical director was further authorized to “provide medical control and assure medical accountability throughout the planning, implementation and evaluation of the EMS system” (1797.202). While medical control is defined in the statute, the courts have interpreted the scope of this oversight by the LEMSA medical director as being broad.

Subsequent regulations approved and chaptered in *Title 22, Division 9* of the *California Code of Regulations* have since specified additional regulatory responsibility for local EMS agencies through the creation of no fewer than twelve separate chapters.

EMSAAC believes the EMS Act intended to create a statutory framework for local EMS agency coordination and oversight of EMS systems in California, and that it intended to accommodate existing EMS providers by creating a transitional pathway for integration into each local EMS system in 1797.201.

### **Health & Safety Code 1797.201**

To accommodate the transition of existing prehospital EMS services into an integrated local EMS system, the new statute contained language to address the status of these pre-existing services, 1797.201:

*Upon the request of a city or fire district that contracted for or provided, as of June 1, 1980, prehospital emergency medical services, a county shall enter into a written agreement with the city or fire district regarding the provision of prehospital emergency medical services for that city or fire district. Until such time that an agreement is reached, prehospital emergency medical services shall be continued at not less than the existing level, and the administration of prehospital EMS by cities and fire districts presently providing such services shall be retained by those cities and fire districts, except the level of prehospital EMS may be reduced where the city council, or the governing body of a fire district, pursuant to a public hearing, determines that the reduction is necessary. Notwithstanding any provision of this section the provisions of Chapter 5 (commencing with Section 1798) shall apply.*

The Act created specific statutory authority for these entities to continue providing prehospital EMS until local integration could be achieved. Once counties had established their own local EMS agency as authorized in the statute, the law makers believed these experienced providers would simply request to be integrated into the new local EMS system by a written

agreement that included how the services for that .201-eligible city or fire district would be delivered. But in many cases it didn't exactly turn out that way.

How it turned out largely determined how your local EMS system operates today...

### **The "Sand Box" Model**

For some local EMS systems it has become like playing in a sand box. No big deal. These local EMS agencies and .201 entities have worked it out so existing providers continued to deliver services to their jurisdictions as before under the required medical direction provided by the LEMSA Medical Director. Everyone has a place to play in the sand box, and each gets along pretty well with the others.

Exclusive Operating Areas, Expanded Scope of Practice, Quality Improvement Programs, Model Disciplinary Orders and other system enhancements would come later, but even with these new challenges, "Sand Box" systems continue to generally work and play pretty well together.

### **The "Partnership" Model**

Perhaps the most highly evolved model for local EMS systems in California is one where mutual respect and cooperation are the norm. In such a system the local EMS agency and stakeholders are essential partners in providing quality emergency medical patient care. Slightly different from the "sand box" model, the participants in a partnership model not only play in the same sand box, they work together in an organized EMS system that validates performance according to national and state standards. In this model, collaborative processes are consistently used to develop EMS policies and the EMS Plan, ensure accountability of all participants, and implement coordinated quality improvement efforts. Decision-making is often shared, and the litmus test used is how the decision will impact patient care and improve patient outcomes.

### **Where Do We Sometimes Disagree?**

#### *The Scope of Medical Control.*

As previously discussed, "Medical Control" is defined broadly in the EMS Act and assigned to the local EMS agency Medical Director:

- **1797.90.** *"Medical control" means the medical management of the emergency medical services system pursuant to the provisions of Chapter 5 (commencing with Section 1798).*

- **1797.202 (a).** *Every LEMSA shall have a... Medical Director... to provide medical control and assure medical accountability throughout the planning, implementation and evaluation of the EMS system.*
- **1798. (a)** *The medical direction and management of an emergency medical services system shall be under the medical control of the medical director of the local EMS agency. This medical control shall be maintained in accordance with standards for medical control established by the authority.*

Although medical control is defined in the statute, this definition has not always been helpful when it comes to specific issues. In the 1997 California Supreme Court decision regarding *County of San Bernardino v. City of San Bernardino*, the Court opined that dispatch protocols imposed by the County related directly to *“the provision of emergency medical care, affecting the speed and effectiveness of response to medical emergencies.”* The Court concluded this was within the scope of medical control intended by the EMS Act.

While the courts have added some clarity on this issue, system stakeholders may still disagree on the far-reaching scope of this authority for the local EMS Medical Director.

#### Administration of Prehospital EMS.

This term is not defined in the statute and is used only in 1797.201. It is however, the tip of the spear for many .201 cities and fire districts. This language seems to suggest these providers retain the administrative oversight required to maintain their existing services until they can be integrated with the local EMS system by written agreement. The EMS Act clearly intended to preserve these pre-existing services in a steady state while the new model for a locally-integrated EMS system could be developed by a county or EMS region. It is likely the legislature also anticipated that this integration would become desirable for existing providers, and thus placed unilateral responsibility to request such an agreement on each individual .201 provider. This language also precluded a county from abdicating its responsibility for EMS by making it mandatory for the County to enter into such an agreement upon request.

#### Written Agreements.

The use of written agreements between LEMSAs and providers is clearly anticipated in both the statute and regulations:

#### **Health & Safety Code, Div. 2.5**

*1797.204. The local EMS agency shall plan, implement, and evaluate an emergency medical services system, in accordance with the provisions of this part, consisting of an organized pattern of readiness and response*

*services based on public and private agreements, the EMS Plan and operational procedures.*

**Title 22. Division 9. Chapter 4. (EMT-P Regs)**

*100167. Paramedic Service Provider*

*(b) An approved paramedic service provider shall:*

*(4) Have a written agreement with the local EMS agency to participate in the EMS system and to comply with all applicable State regulations and local policies and procedures, including participation in the local EMS agency's Quality Improvement Plan (QIP) as specified in Chapter 12 of this Division.*

EMSAAC concurs with the Authority that the language of 1797.201 was included to promote an orderly transition and the eventual integration of pre-existing services into a newly-formed local EMS system. We believe this intended integration has been largely accomplished in all areas of the state both with and without agreements between the local EMS agency and the .201 entity. Integration can be clearly demonstrated by a .201 entity's compliance with local EMS agency clinical protocols, participation in EMS system quality improvement efforts, and adherence to triage and destination policies for trauma and other specialty care.

However, there are substantial benefits for using agreements to enhance system integration. First of all, the use of written agreements is how local government normally does business. Counties, cities and fire districts all make use of this tool to carry out their statutory roles and responsibilities. Agreements carefully define the expectations of the parties and can include remedies to invoke if a party fails to meet its legal obligations. Long-term agreements can also mitigate an unfavorable succession in administrative staff by either party that could lead to arbitrary new requirements being imposed in the absence of an existing written agreement.

**Is it all about "control"?**

In some local EMS systems a "tug of war" continues between medical control by the LEMSA and administrative control by .201 cities and fire districts. But it is not as simple as just a battle of wills to decide who has more "pull". A more accurate metaphor might be a rugby match where two teams form a large huddle, or "scrum" around the ball. The object is for the massed players to push the scrum around until the ball can be snatched away into play by one of the teams. In reality there are multiple forces that influence the direction of a local EMS system. Politics, contracts, personalities, EMS Plan, legal opinions, court decisions, fiscal issues, payer mix and a host of other factors can cause our EMS systems to get pushed around like a scrum in a rugby match.

## Recommendations

EMSAAC offers the following suggested strategies for moving forward:

1. Promote a “partnership model” for your local EMS system.
2. Acknowledge each stakeholder as essential to the delivery of quality patient care in your EMS system.
3. Commit to effective conflict resolution with EMS participants.
4. Consider the use of written agreements as a tool to clarify matters of local control, authority and system integration.
5. Ensure that all local stakeholders are invited to participate in the process to develop LEMSA policies, protocols and plans.
6. Let the courts interpret the law.

