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EMS SYSTEM COORDINATION AND HS 1797.201 IN 2010



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EMS SYSTEM COORDINATION AND HS 1797.201 IN 2010

SECTION I: INTRODUCTION

The California Emergency Medical Services Authority (EMSA) is the State agency responsible for the development and coordination of emergency medical services statewide. The primary goal of the current scheme for regulating emergency medical services (EMS) in California is to achieve a coordinated system that serves the public with effective and efficient EMS services.

The fire service has presented a position paper regarding their role in a coordinated and integrated EMS system. As a result of disputes between some local EMS agencies (LEMSA) and some cities and fire districts, a singular provision in the Health and Safety code is being presented as a rationale by the fire service for their independence in a coordinated and integrated local EMS system.

These issues give EMSA the opportunity to carefully discuss and respond to the important questions raised now 30 years after passage of the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (EMS Act) in 1980. EMSA has further reviewed the California Health and Safety Code¹, the California Code of Regulations² and various clarifying court cases.

The issues related to EMS System coordination and the impact of Health and Safety Code 1797.201 appear to have been already substantially answered by the California Supreme Court in its opinions contained in the cases of County of San Bernardino v. City of San Bernardino, 15 Cal. 4th 909 (1997)³ (the "*San Bernardino* decision"), and Valley Medical Transport v. Apple Valley Fire Protection District, 17 Cal. 4th 747 (1998)⁴ (the "*Apple Valley* decision"). Additionally, the Appellate Court decision in City of Petaluma v. County of Sonoma, 12 Cal. App. 4th 1239 (1993)⁵ (the "*Petaluma* decision") is illustrative. In this document, EMSA relies extensively upon the clarification given in these decisions.

This document further will identify some limited solutions to the ongoing discussion related to the application of section 1797.201 in light of the overarching legislative intent to have a coordinated and integrated EMS system in 2010.

Three specific recommendations will be identified for consideration as part of this document:

1. Agreements should be reached between a local EMS agency and an eligible city or fire district under 1797.201, for those areas that have not already done so, that specify and clearly articulate the type of service and role in the EMS system.
2. Local EMS plans should include a review and verification of what constitutes a section 1797.201 city or fire district, and at what type of prehospital EMS service, as part of an EMS plan that is submitted to EMSA for approval.
3. A local Emergency Medical Care Committee should be required at the local EMS level to ensure meaningful involvement by EMS system participants.

Agreements continue to form the basis of the development of an effective and efficient EMS system, and those agreements should clearly identify the role of a city or fire district. These agreements which are mutually satisfactory can serve to decrease future conflict if certain rights can be clearly articulated.

On its surface, the issue now presented appears to be a fairly isolated issue. EMSA is unaware of substantial service disagreements between the fire service and local EMS Agencies in the area of the provision of paramedic services or ambulance services.

Our observation that the core issue today is related to dispatch, and whether HS 1797.201 contemplated “dispatch” as a prehospital type of service and to what extent medical control impacts the decision about who may perform emergency medical dispatch as part of an EMS system.

Meaningful involvement by all EMS system participants in the EMS planning process will assist in building trust and collaboration.

SECTION II: ORGANIZATION OF EMS COORDINATION IN CALIFORNIA

The proper starting point for discussion of these issues is an understanding of the EMS Act. As the Court in *Apple Valley* reiterated from the *San Bernardino* case, "the EMS Act contain[s] 100 different provisions in 9 separate chapters and create[s] a comprehensive system governing virtually every aspect of prehospital emergency medical services.⁶ The Legislature's desire to achieve coordination and integration is evident throughout. The EMS Act accomplishes this integration through what is essentially a "two-tiered system of regulation."

California's "Two Tiered System of Regulation"

The two tiers of regulatory oversight consist of a state Authority, which "performs a number of different functions relating to the coordination of EMS throughout the state", and an EMS agency established by a county, or a joint powers agency of counties or counties and cities, which plans, implements, and evaluates emergency medical service systems on a countywide or multicounty basis, and which maintains " '[t]he medical [control] and management of an emergency medical services system.' "⁷

As the court viewed the EMS Act, the statute and relevant regulations "broadly mandate that the local EMS agency formulate medically related policies and procedures to govern EMS providers."⁸

What is EMSA'S role?

Emergency medical services in California began with the passage of the Wedworth-Townsend Pilot Paramedic act in 1970.⁹ The Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (EMS Act) was passed in 1980 to institutionalize the provision of emergency medical services.¹⁰ Consequently, EMSA was established as a mechanism to form a statewide EMS system.

It is headed by a physician director who has substantial experience in emergency medicine.¹¹ The mission of the California Emergency Medical Services Authority (EMSA) is to ensure quality patient care by administering an effective, statewide system of coordinated emergency medical care, injury prevention, and disaster medical response. Both Health and Safety code 1797.1 and 1797.78 articulate the critical nature of coordination and integration for EMS services.

1797.1. The Legislature finds and declares that it is the intent of this act to provide the state with a statewide system for emergency medical services by establishing within the Health and Welfare Agency the Emergency Medical Services Authority, which is responsible for the coordination and integration of all state activities concerning emergency medical services.

1797.78. "Emergency medical services system" or "system" means a specially organized arrangement which provides for the personnel, facilities, and equipment for the effective and coordinated delivery in an EMS area of medical care services under emergency conditions.

In performing these duties, the EMS Authority utilizes statutes, regulations, and guidelines as a basis for its oversight of the EMS system in California as directed in Health and Safety code 1797.103 and 1797.107. EMSA's duties include the development and implementation of standards and guidelines for EMS systems and reviewing and approving local emergency medical services plans submitted by local emergency medical services agencies (LEMSAs) based on these standards and guidelines as required in Health and Safety code 1797.250 and 1797.254.

1797.103. The authority shall develop planning and implementation guidelines for emergency medical services systems which address the following components:

- (a) Manpower and training.
- (b) Communications.
- (c) Transportation.
- (d) Assessment of hospitals and critical care centers.
- (e) System organization and management.
- (f) Data collection and evaluation.
- (g) Public information and education.
- (h) Disaster response.

As part of the methodology to ensure a coordinated EMS system, EMSA may create regulations to clarify any part of the EMS Act.

1797.107. The authority shall adopt, amend, or repeal, after approval by the commission and in accordance with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, such rules and regulations as may be reasonable and proper to carry out the purposes and intent of this division and to enable the authority to exercise the powers and perform the duties conferred upon it by this division not inconsistent with any of the provisions of any statute of this state.

Statewide coordination is accomplished through the participation of an eighteen (18) member Commission on EMS as identified in Health and Safety Code 1799.¹² Their role is to “review and approve regulations, standards, and guidelines to be developed by the authority for implementation of this division.”

What is the role of a local EMS agency?

Local EMS agencies (LEMSA) are required, by Health and Safety Code Section 1797.204 to plan, implement, and evaluate an emergency medical services system, consisting of an organized pattern of readiness and response services based on public and private agreements and operational procedures. The importance of 1797.204 is made abundantly clear in the *San Bernardino* decision as the court articulated in multiple references that one of the key provisions of the entire EMS act is 1797.204.

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 and operational procedures.

The court in *San Bernardino* noted that one of the key provisions of the act is section 1797.204, which requires the local EMS agency to “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 and operational procedures.”¹³

It should be noted that the legislative intent of 1797.204 is for both the LEMSA and cities to work cooperatively to provide quality care for patients, and typically agreements are the mechanism to ensure all parties are aware of, understand, and agree to comply with, local policies. The section indicates the need for public and private agreements which are reflected in the California Code of Regulations (CCR) Section 100167(b)(4).

What is the role of medical control?

One of the overarching concepts in the regulatory scheme is the requirement for medical direction and medical control of the EMS system. Two statutes are important in this construct.

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.

(b) Medical control shall be within an EMS system which complies with the minimum standards adopted by the authority, and which is established and implemented by the local EMS agency.

(c) In the event a medical director of a base station questions the medical effect of a policy of a local EMS agency, the medical director of the base station shall submit a written statement to the medical director of the local EMS agency requesting a review by a panel of medical directors of other base stations. Upon receipt of the request, the medical director of a local EMS agency shall promptly convene a panel of medical directors of base stations to evaluate the written statement. The panel shall be composed of all the medical directors of the base stations in the region, except that the local EMS medical director may limit the panel to five members.

This subdivision shall remain in effect only until the authority adopts more comprehensive regulations that supersede this subdivision. [Amended by SB 1124 (CH 1391) 1984.]

1797.220. The local EMS agency, using state minimum standards, shall establish policies and procedures approved by the medical director of the local EMS agency to assure medical control of the EMS system. The policies and procedures approved by the medical director may require basic life support emergency medical transportation services to meet any medical control requirements including dispatch, patient destination policies, patient care guidelines, and quality assurance requirements. [Amended by AB 3269 (CH 1390) 1988.]

Health and Safety code 1797.220 addresses issues related to medical control. The local EMS agency is required to develop policies and procedures that are approved by the medical director. These policies and procedures may require basic life support emergency medical transportation services to meet any medical control requirements including dispatch, patient destination policies, patient care guidelines, and quality assurance requirements. It is important to note that 1797.204 and 1797.220 do not address the same topics. 1797.204 states that the local EMS agency has the responsibility to plan, implement, and evaluate the EMS system while 1797.220 addresses items related to policy and procedure aspects of the EMS system.

The court here also noted that “the term ‘medical control’ was not intended to be confined strictly to such higher level policy matters as the establishment of certification standards and training programs for paramedics, or emergency treatment procedures implemented by base hospitals.”¹⁴

What are the roles of EMS providers?

The roles of providers of EMS services, both public and private, are a critical part of the EMS infrastructure. Both public and private EMS providers respond to emergency and non-emergency requests for medical assistance and transportation. However, they are not regulatory bodies within the context of a coordinated and integrated EMS system.

As part of the EMS planning effort, all providers should be incorporated in the planning process to ensure meaningful participation in the local EMS system. This will enable a greater degree of coordination and integration to ensure that an effective and efficient EMS system can be achieved consistent with the goals of the EMS Act.

Local EMS agencies employ a variety of methodologies to provide for meaningful participation in an EMS system. One mechanism is the use of a local Emergency Medical Care Committee or similar participatory structure.

The requirement for a local Emergency Medical Care Committee was eliminated in 1993 as part of a reduction in County mandates. However, a local Emergency Medical Care Committee may be established to ensure meaningful participation in the local EMS system planning process. The following statutes, beginning with Health and Safety code 1797.270, are often used by local EMS agencies to assist in local EMS planning:

1797.270. An emergency medical care committee may be established in each county in this state. Nothing in this division should be construed to prevent two or more adjacent counties from establishing a single committee for review of emergency medical care in these counties.

[Formerly H & S Code Section 1751. Amended by SB 627 (CH 64) 1993.]

1797.272. The county board of supervisors shall prescribe the membership, and appoint the members, of the emergency medical care committee. If two or more adjacent counties establish a committee, the county boards of supervisors shall jointly prescribe the membership, and appoint the members of the committee.

[Formerly H & S Code Section 1752.]

1797.274. The emergency medical care committee shall, at least annually, review the operations of each of the following:

- (a) Ambulance services operating within the county.
- (b) Emergency medical care offered within the county, including programs for training large numbers of people in cardiopulmonary resuscitation and lifesaving first aid techniques.
- (c) First aid practices in the county. [Formerly H & S Code Section 1755.]

1797.276. Every emergency medical care committee shall, at least annually, report to the authority, and the local EMS agency its observations and recommendations relative to its review of the ambulance services, emergency medical care, and first aid practices, and programs for training people in cardiopulmonary resuscitation and lifesaving first aid techniques, and public participation in such programs in that county. The emergency medical care committee shall submit its observations and recommendations to the county board or boards of supervisors which it serves and shall act in an advisory capacity to the county board or boards of supervisors which it serves, and to the local EMS agency, on all matters relating to emergency medical services as directed by the board or boards of supervisors. [Formerly H & S Code Section 1756. Amended by AB 1119 (CH 260) 1988.]

Although Health and Safety Code 1797.270 was amended in 1993 to be an optional provision, consideration should be given to requiring formation of a local Emergency Medical systems committee as part of the local planning process to ensure meaningful participation by EMS system participants.

**SECTION III:
HEALTH AND SAFETY CODE 1797.201 – WHAT DOES IT MEAN in 2010?**

Almost 30 years after the implementation of the statute, the issue of the rights or obligations of cities or fire districts under section 1797.201 seems moot given the widespread integration of EMS services throughout California. Those services that had ALS, LALS, or ambulance services in 1980, and wished to continue them, have generally retained that type of service.

The *San Bernardino* decision notes “As we have seen, the EMS Act aims to achieve integration and coordination among various government agencies and EMS providers, and the Legislature likely contemplated that 1797.201 cities and fire districts would eventually be integrated into local EMS agencies.”¹⁵

Health and Safety Code Section 1797.201 reads:

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.

Is HS 1797.201 the symptom or the cause of conflict?

The court in *San Bernardino* observed that “Only when a county or local EMS agency attempts to assert its authority in a manner that is contrary to the perceived interests of cities and fire districts would these latter agencies have the occasion to decide whether they wish to formally assert against a county their section 1797.201 rights.”¹⁶

The statutes do not specify exactly what a .201 city or fire district is. Moreover, it does not provide a separate agency or body to determine if a city or fire district has those specific rights. As a result, the only way to adjudicate any disagreements is through the courts.

Section 1797.201 allows existing cities and fire districts that provided care prior to June 1, 1980, to continue services and retain administration of those prehospital services under very specific parameters until formal integration through an agreement between the city or fire district and a local emergency medical services agency (LEMSA) occurs. H&S Code Section 1797.201 sets forth the specific obligation for cities and fire districts that meet the criteria in this section to continue providing service until such time as they requested to enter into a written agreement with the county.

Importantly, the court in the *San Bernardino* decision noted that "...1797.201 is 'transitional' in the sense that there is a manifest legislative expectation that cities and counties will eventually come to an agreement with regard to the provision of emergency medical services"¹⁷

The court here also noted a "pre-agreement period". The pre-agreement period of 1797.201 requires that a city or county which performed prehospital emergency medical services as of June 1, 1980, to continue doing so until such time as an agreement is reached with the county. In the "post agreement period" of an implementation, the city or county is considered an integrated part of the local EMS system pursuant to the terms of the agreement. The *San Bernardino* decision states that "Nothing in this reference to 1797.201 suggests that cities or fire districts are to be allowed to expand their services, or to create their own exclusive operating areas."¹⁸

It is also recognized that until such time as an agreement is reached, the authorization for LALS or ALS as noted in 1797.178 is derived statutorily, provided medical control is maintained. Therefore, a written agreement cannot be compelled for those entities falling under the provision of 1797.201 that have yet to enter into an agreement with the county. The legislative intent for 1797.201 is clear that the "pre-agreement period" would be a temporary, transitional period of time. However, 30 years after the implementation of this section, there are cities and fire districts that have not entered into a written agreement to integrate into the local EMS system.

The court noted that in the "pre-agreement period", there is no provision that provides for any "grandfathering" of cities or fire districts in section 1797.201. Section 1797.201 does not grant exclusivity for ALS, LALS, or ambulance services. However, an eligible "1797.201" city may qualify for "grandfathering" under the provisions of 1797.224, if the criteria found there are fully met, subsequent to entering into a written agreement for integration and coordination into the local EMS system.

EMSA has concerns that the use of the wording of "grandfathering" in relation to section 1797.201 entities is erroneous and potentially confusing. Section 1797.201 does not grant, by itself, any rights for grandfathering nor exclusivity. Additionally, the word "grandfathering" is not used anywhere in the EMS Act.

What exactly are the “rights and obligations” under section 1797.201?

Consistent with the *Apple Valley* decision, EMSA believes that “.201 rights” should more properly be characterized as “.201 rights and obligations”. The rights and obligations under section .201 are that a city or fire district must provide prehospital EMS, during the transitional period of time before an agreement to integrate into the local EMS system is reached.

The city or fire district’s “obligation” under 1797.201 is fairly limited. A city or fire district must maintain the level of service that was in place as of June 1, 1980, until an agreement for service is reached with the county. Alternatively, the services may be decreased after a public hearing.

Unfortunately, section 1797.201 does not definitively specify any discrete right or set of rights. However, the courts have specifically clarified that two types of prehospital EMS services may be continued: Paramedic services and ambulance services.

May a City or Fire District reclaim section 1797.201 rights?

A common misperception seems to be that if a city or fire district had an agreement with a LEMSA at one time, and then that agreement was subsequently terminated, the city or fire district would then revert to the state of having their original .201 rights and obligations. This is not correct. The Court in *Apple Valley* concluded that section 1797.201 does not give a right of resumption to a city or fire district.

Plainly stated, a city or fire district that has previously signed an agreement can no longer rely upon HS 1797.201, as it is no longer applicable. The court said that “Health & Saf. Code 1797.201, is not a broad recognition or authorization of autonomy in the administration of EMS for cities and fire districts. When a city or fire district ceases to be involved in the administration of some distinct part of EMS and allows the local EMS agency to assume that authority, it no longer has the prerogative to unilaterally resume control of that part of the EMS operation.”¹⁹

What is and who is a section 1797.201 City or Fire District?

There are several criteria that must be examined when applying this provision. Previously, EMSA was requested to by Los Angeles County Fire Chiefs’ Association to ensure eligible .201 agencies receive a determination within the EMS plan.²⁰ Buried in this request is the imperative for EMSA to either determine directly, or set criteria for the evaluation of, whether or not a city or fire district claiming that they are a “.201” entity meets specific requirements for that eligibility. Currently, there is no determination made as part of the EMS plan.

When considering the applicability of 1797.201 in relation to 1797.204, it is important to understand what constitutes an eligible “.201” city or fire district. Not all cities and fire districts are eligible entities.

The specific 1797.201 eligibility criteria that a city or fire district must meet include, but are not limited to, all of the following:

- Be a City or Fire District that existed on June 1, 1980.
- Be the same entity that existed on the date of the “1797.201” eligibility evaluation.
- Provided service on June 1, 1980, at one of these types: ALS, LALS, or emergency ambulance services.
- Operated, or directly contracted for the same type of service continuously since June 1, 1980.
- Has never entered into a written agreement with LEMSA for the type of service they were providing in 1980, including ALS, LALS, or emergency ambulance services.

An eligible 1797.201 agency is entitled to retain, but not change (diminish or expand), their type of service. If they wish to change the type of service provided, an agreement must be entered into with the local EMS agency.

After an agreement is reached with the local EMS agency (“post-agreement period”), the entity is considered “integrated and coordinated” into the local EMS system. Authorization for ALS under 1797.178 is then derived from the local EMS agency. After an agreement is reached, an agency may not reclaim “1797.201” pre-agreement status.

Are agreements required?

Under 1797.201, a county must enter into a written agreement with a city or fire district that requests an agreement with the county for the provision of EMS. With the transitional legislative intent of 1797.201, it is reasonable that a city or fire district that entered into an agreement for EMS after June 1, 1980, is said to have done so consistent with the language in 1797.201. Prior to the execution of any type of agreement between a city or fire district and a LEMSA, both parties should carefully consider the ramifications of entering into that agreement. Since section 1797.201 has been in place since June 1, 1980, local EMS agencies and city and fire districts should understand that an agreement would serve to fulfill the legislative intent to integrate into the EMS system.

The EMS Authority does not see that there is, or has been, any incentive to deny or otherwise restrict a city or fire district from providing services it has provided since June 1, 1980, if no written agreement with the county has been entered into. As previously stated, 1797.201 is not a right but rather a responsibility of the city or fire district to continue providing EMS at the same level it did on June 1, 1980.

Is there a conflict between the EMS Act and the Regulations concerning the requirement for agreements?

No conflict exists between existing statutes and the regulatory requirement for a written agreement, due to the nature of 1797.201 and the significance placed on the integration and coordination of EMS found in 1797.204. Although the *San Bernardino* decision makes clear that cities and fire districts must be integrated by agreement, there is no statutory deadline imposed for requesting or reaching such an agreement.

The statute clearly intends that regardless whether or not an entity meets the requirements of H&S Section 1797.201 for the provision of EMS, the entity and the LEMSA must work together to formally coordinate the provision of medical control generally under Section 1798.

California Code of Regulations, Title 22, Division 9, Chapter 4, Article 7, further defines medical control responsibilities of a LEMSA:

- Section 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....
- Section 100169. Medical Control. The medical director of the local EMS agency shall establish and maintain control in the following manner:
 - (a) Prospectively by assuring the development of written medical policies and procedures, to include at minimum:
 - (1) Treatment protocols that encompass the paramedic scope of practice,
 - (3) Criteria for initiating specified emergency medical treatments or standing orders for use in the event of communication failure...
 - (4) Criteria for initiating specified emergency treatments prior to voice contact...

In EMSA's previously expressed opinion regarding "Standing Field Treatment Protocols" (SFTP's) in Los Angeles County, EMSA determined that SFTP's are functionally a method to achieve "prospective" or "off-line" medical direction.²¹ Hence, provided an eligible ".201" agency complies with the medical control requirement, there is no reason that a formal written agreement be required in order to provide this patient-oriented care.

In the event there is no formal written agreement, in order to achieve the medical control requirement, mechanisms for accountability and quality control must still be in place to ensure that EMS provider agencies adhere to all of the policies, procedures, medical controls and protocols of the Local EMS system.

Provided the entity is an eligible “.201” entity, the derivation of its authorization for advanced life support (ALS) is from H&S 1797.178 as a paramedic agency under the Wedworth-Townsend Paramedic Act. It is interesting to note that the Wedworth-Townsend Paramedic Act did not address limited advanced life support (LALS) [EMT-II], nor did it address emergency ambulance service. This gives further credence to the limiting nature of HS 1797.201.

1797.178. No person or organization shall provide advanced life support or limited advanced life support unless that person or organization is an authorized part of the emergency medical services system of the local EMS agency or of a pilot program operated pursuant to the Wedworth-Townsend Paramedic Act, Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2.

To remove the requirement for agreements from the Regulations would deviate from the legislative intent of 1797.204. However, EMSA will recognize that a LEMSA has met the minimum standards as part of their EMS plan, without written agreements, based upon the statutory authorization of an eligible “.201” agency.

As noted earlier, an agreement between the LEMSA and a pre-agreement, eligible 1797.201 entity should meet the general criteria of intent to be integrated into and coordinated within an EMS system.

In a previous interpretation from EMSA, the Authority stated that an agreement under Los Angeles County’s SFTP Program with the cities posited that it would “not affect the rights of a H&S Section 1797.201 city”. The concern of the cities is that the renewal of the same agreement would jeopardize their “1797.201” eligibility. Whether or not signing a narrowly worded SFTP agreement that solely impacts medical control actually affects H&S Section 1797.201 rights and responsibilities, is beyond the scope of this document.

Can a LEMSA withdraw paramedic authorization unilaterally from a City or Fire District after an agreement has been signed?

Although this has not been specifically addressed in the courts or in statute, it seems logical that once an agreement is signed, that city or fire district may continue to provide those paramedic services as set forth in the agreement. Although medical control is still required, withdrawal of paramedic services by the local EMS agency should only be done for significant cause and with due process.

Additionally, unless the provisions of exclusivity as defined under Section 1797.85 and 1797.224 have been followed, the restriction of those types of services may not be possible.

EMSA encourages all parties to move forward and work collaboratively for the development of an integrated and coordinated EMS system. EMSA has concerns that a general call for refusal to sign any agreement, unless it preserves ambiguous 1797.201 rights, will only serve to prolong a non-productive discussion.

Because the only mechanism to resolve a disagreement over 1797.201 rights or responsibilities lies in the courts, it is predictable that some situations will escalate to a point where legal action is chosen as the method of dispute resolution. This observation is an important one when evaluating possible solutions to the problems. A potential solution could be through a review process as part of the approval of a local EMS plan by EMSA.

EMSA still questions whether a written agreement can specifically exempt the provisions of 1797.201, while still receiving the same benefits or consideration afforded an agency that has formally integrated and coordinated its services within the EMS system.

Additionally, a question exists if there is a threshold limit for “non-201” agreements, coupled with integrative behavior, before it appears manifest that an eligible “1797.201” agency has “integrated” into the system.

SECTION IV: PREHOSPITAL EMS--TYPE AND LEVEL OF SERVICE

Prehospital emergency medical services, as used in HS 1797.201 in 1980, contemplated two types of discrete and severable service levels that were able to be continued at not less than the existing level: Paramedic services and ambulance services.

What is the difference between level and type of service?

EMSA notes clarification from the courts regarding the types and levels of service. The *Petaluma* decision, reinforced and clarified later by the Supreme Court in the *San Bernardino* decision, identifies that levels of services refer “to such matters as the quantity of available staff, vehicles, equipment, etc.”, and types of service “as constituting basic, advanced, or limited advanced life support”.²² The court in *San Bernardino* also clearly added ambulance services as a type of emergency medical services.

The *Petaluma* decision defined the “types” of emergency medical services as “BLS, LALS, (and) ALS”, rather than as levels. Basic Life Support (BLS) is a statutorily defined term; there is nothing in the *San Bernardino* decision that further defines it. The use of “first responder” or “advanced first aid” as either a level or a type of service is also not found in the court’s opinion. Therefore, in this instance of evaluating 1797.201, BLS was likely seen as a type of service rather than a level of service. However, the provision of BLS is also not limited in statute, which means that anyone can provide it, and it is reasonable to believe that any provider can increase the training of their personnel within the general area of BLS. Consequently, it is unlikely that the continuation of BLS as a type of service was specifically contemplated in 1797.201. In the case of a 1797.201 city or fire district that was providing BLS (in some form) in 1980, moving from a BLS type of service to another type of service (i.e. ALS, LALS, or emergency ambulance service) would not be permitted without authorization from the local EMS agency.

Reconciling this construct, it is reasonable to also consider prehospital EMS types as “ALS, LALS, and emergency ambulance services” as being consistent with H&S 1797.85. In this example, ALS and LALS may be provided by non-transport services. This allows for consistency with the “grandfathering” provisions contemplated in 1797.224. As both 1797.85 and 1797.224 were chaptered after 1797.201, it provides a clear mechanism for integration of the system and receiving the benefits of that coordination and integration under a written agreement.

The *San Bernardino* decision confirms this interpretation, “Thus, construing section 1797.201 in light of section 1797.224 and the system of EOA’s that it envisions, we conclude section 1797.201 was designed to confine EMS operations by cities and fire districts to those types in which they were historically engaged as of June 1, 1980.”²³

Additionally, any position that levels of prehospital emergency medical services include first responder, advanced first aid, BLS, LALS, or ALS, cannot be found or confirmed anywhere in statute or within the intent of the EMS Act. This interpretation would allow an eligible section 1797.201 entity to freely move through these levels at its own discretion, and neither the *San Bernardino* nor *Apple Valley* decisions support this.

What are the different types of exclusivity?

There is a distinct difference between type and level of service (or scope of operations) when considering ambulance zone exclusivity. “Type of service” refers to specified characteristics that distinguish a provider, while “level of service” refers to a provider’s relative position in terms of the quantity or scope of services provided. “Type of service” is expressly related to exclusive operating areas under 1797.85 and is not referenced in 1797.201.

When reconciling these terms, it is apparent that the types of service that may be created as exclusive types are defined in 1797.85 and are limited to the following:

- Emergency Ambulance Services
- Advanced Life Support
- Limited Advanced Life Support

Is dispatch a type of prehospital EMS that was contemplated as part of HS 1797.201?

Dispatch of emergency medical services units continues to be a topic of discussion, especially as it relates to who may perform the dispatch of EMS providers. The question is; “when does medical control and oversight begin in relation to a call for medical assistance?”

From a historical perspective, emergency medical dispatch was not present in the United States until around 1979.²⁴ Additionally, it was not adopted widely in California until the mid to late 1980s after EMSA published EMD training guidelines in 1986. It is therefore unlikely that dispatch was contemplated at a type of service under 1797.201.

The *San Bernardino* decision rejected dispatch as a type of prehospital EMS service contemplated under section 1797.201. The provision of dispatch services is not a “type of service”, but rather a “coordination function” under medical control. Medical control in section 1797.220 is a function of the medical director of the local EMS agency to assure medical oversight of the EMS system.

The *San Bernardino* decision states that the EMS act views dispatch as a coordination function of the local EMS agencies that have medical control related to “affecting the speed and effectiveness of the response to medical emergencies”.²⁵ The Court further identified that the dispatch as part of administrative control in section 1797.201 only referred to “internal” dispatch policies for that city or fire district. Although dispatch could be seen as a non-severable part of the “internal” dispatch of a type of apparatus, it would still be dependent upon the type of service provided by a 1797.201 city or fire district in 1980--either ambulance service or paramedic services. Unfortunately, this would answer neither the fundamental question of who gets dispatched “first” nor the question of who decides where emergency medical dispatch occurs.

The court in *San Bernardino* noted that the dispatch protocol is also confirmed by section 1797.220, and by the overriding purpose of the EMS Act to afford some measure of coordination and [929*] integration to the provision of emergency medical services.” The court held that the “City is obliged, under section 1797.201, to follow them.”²⁶

A 2003 Attorney General opinion concluded also that “Emergency medical dispatch services are subject to the review and approval of the local emergency medical services agency even when the services are developed, implemented, and operated in accordance with state guidelines.”²⁷

The EMS Authority considers dispatch to be a part of the EMS system, and therefore it falls within the control of the local EMS agency to plan, implement and evaluate that aspect of EMS under HS 1797.204. The application of dispatch to EMS is not singularly a city or fire district’s internal administrative function, but rather it is a part of the overall EMS system and is included in the required coordination and integration to ensure medical control of the system.

SECTION V: AMBULANCE ZONE EXCLUSIVITY

The creation of exclusive operating areas is expressly permitted in Health and Safety Code 1797.6, 1797.85, and 1797.224.²⁸ These statutes continue the “two-tiered” local and State regulatory scheme. The court in *San Bernardino* noted that “a local EMS agency may create one or more exclusive operating areas in the development of a local [EMS] plan”²⁹

1797.6. (a) It is the policy of the State of California to ensure the provision of effective and efficient emergency medical care. The Legislature finds and declares that achieving this policy has been hindered by the confusion and concern in the 58 counties resulting from the United States Supreme Court's holding in *Community Communications Company, Inc. v. City of Boulder*, Colorado, 455 U.S. 40, 70 L. Ed.2d810, 102 S. Ct. 835, regarding local governmental liability under federal antitrust laws.

(b) It is the intent of the Legislature in enacting this section and Sections 1797.85 and 1797.224 to prescribe and exercise the degree of state direction and supervision over emergency medical services as will provide for state action immunity under federal antitrust laws for activities undertaken by local governmental entities in carrying out their prescribed functions under this division. [Added by AB 3153 (CH 1349) 1984.]

1797.85. "Exclusive operating area" means an EMS area or subarea defined by the emergency medical services plan for which a local EMS agency, upon the recommendation of a county, restricts operations to one or more emergency ambulance services or providers of limited advanced life support or advanced life support. [Added by AB 3153 (CH 1349) 1984.]

1797.224. A local EMS agency may create one or more exclusive operating areas in the development of a local plan, if a competitive process is utilized to select the provider or providers of the services pursuant to the plan. No competitive process is required if the local EMS agency develops or implements a local plan that continues the use of existing providers operating within a local EMS area in the manner and scope in which the services have been provided without interruption since January 1, 1981. A local EMS agency which elects to create one or more exclusive operating areas in the development of a local plan shall develop and submit for approval to the authority, as part of the local EMS plan, its competitive process for selecting providers and determining the scope of their operations. This plan shall include provisions for a competitive process held at periodic intervals. Nothing in this section supersedes Section 1797.201. [Added by AB 3153 (CH 1349) 1984.]

The court in *San Bernardino* noted that “The ability to create EOA’s recognized in section 1797.224 would be rendered largely futile, however, if cities or fire districts that had no history of operating ambulance services were able to at any time to expand into those services, thereby partially nullifying an existing EOA. Thus, construing section 1797.201 in light of section 1797.224 and the system of EOA’s that it envisions, we conclude that section 1797.201 was designed to confine EMS operations by cities and fire districts to those types in which they were historically engaged as of June 1, 1980.”³⁰

The court also answers some important points:

- First, “the ability to create EOA’s in section 1797.224 is made expressly subject to 1797.201 and therefore would not permit a county or EMS agency to unilaterally displace a city or fire district continuing to operate emergency medical services.”³¹
- Second, “nothing in section 1797.224 prevents a local EMS agency from assigning an EOA within the borders of a city or fire district to a private provider, if the city or fire district ceases to offer a certain type of emergency medical service.”³²
- Third, “nothing in either section 1797.201 or section 1797.224 suggests that once a city or fire district has abandoned emergency medical services and allowed another entity, pursuant to an EOA, to provide such services, it has the right to nullify the EOA by resuming control of these operations.”³³

By extension of the second point above, a local EMS agency may assign non-exclusive status to an area, including a city or fire district that claims certain rights under 1797.201, if that area does not qualify for the continuation of exclusivity without a competitive process. Alternatively, a local EMS agency may identify that the area is non-exclusive until such time as an agreement is reached to continue the area under the provisions of section 1797.224, if that area qualifies for that continuation of exclusivity.

Can a City or Fire District establish an EOA?

The court in *San Bernardino* said that it is important to note that “section 1797.224 speaks only of local EMS agencies, not cities or fire districts, creating an emergency operating area (EOA).”³⁴

If an eligible 1797.201 City or Fire District is providing ambulance services, does that automatically make the ambulance zone exclusive?

Section 1797.201 does not grant exclusivity for emergency ambulance, advanced life support or limited advanced life support services. An eligible 1797.201 city or fire district may qualify for exclusivity without a competitive process, if the criteria in 1797.224 are fully met after entering into an agreement for integration and coordination into the local EMS system.

It is important to clarify that 1797.201 does not grant any rights for a city or fire district to ambulance zone exclusivity without a competitive process. 1797.201 only provides for the right to service the boundaries of that city or fire district, as clarified in the *Petaluma* decision.³⁵

Can an eligible 1797.201 City or Fire District have their ambulance zone become exclusive without a competitive process?

The court noted that “Section 1797.224 makes clear that a city or fire district that has provided emergency medical services ‘without interruption since January 1, 1981,’ can be assigned exclusive operating areas without going through a competitive bidding process.”³⁶

A provider agency may be “grandfathered” into an exclusive operating area if qualified in concordance with 1797.224, if there was no change in the manner and scope, after a written agreement with the local EMS agency is secured.

Are there financial incentives involved in the creation of exclusive operating areas?

As part of the responsibility for indigent care under California Welfare and Institutions code section 17000, a county has a responsibility to ensure that services are available and payment is made to ensure critical services as a “payer of last resort”.

In the “Lomita I” decision the court noted that it is the “statutory duty of a County to provide hospital and medical services to all indigent County residents. (County of San Diego v. Vilorio, 276 Cal.App.2d 350, 352--353 [80 Cal.Rptr. 869 (1969)]. When an emergency occurs anywhere in the county which requires hospitalization, it necessarily follows that the duty to provide medical care includes the duty to provide emergency transportation from the place where the indigent is to the hospital where he can receive care. The cost of providing that service is, by statute, a proper county charge (Gov. Code, § 29606; Health & Saf. Code, § 1444.)”³⁷

As it relates to ambulance services, the “Lomita II” decision confirmed that the county had financial responsibility.³⁸ The county, or its local EMS agency, may organize the EMS system with this responsibility in mind. It specifically gave four options for the County:

“The county's duty to such persons may be fulfilled in any one of four different ways or by any combination of such services.

(1) The county may create a separate county department to provide emergency ambulance service, equipping such department with the necessary vehicles and other equipment, as well as personnel in such department and pay the expenses of operating such department as it staffs and operates other county departments.

(2) It may assign the duty of providing emergency ambulance service to residents of the county to such existing county department as it may choose and provide that department with the necessary equipment and trained personnel. [*482]

(3) It may contract with the cities or local agencies located within the county to provide necessary emergency ambulance service to the residents of the county found within such city or cities; or,

(4) It may contract with private ambulance companies.”

These options remain at the discretion of the county to fulfill their financial obligation.

With respect to ambulance service exclusivity, a City or Fire District cannot claim to both hold 1797.201 rights, and also simultaneously receive the benefits of exclusivity under 1797.224, as an integrated part of an EMS system.

SECTION VI: OBSERVATIONS AND CONSIDERATIONS

What are EMSA's observations?

Coordination and integration of the EMS System is the primary goal for emergency medical services in California. This system coordination is achieved by a “two tiered” system of regulation at the State and local EMS agency levels. Within this structure, medical control is broad and must be maintained. The methodology to achieve an effective and efficient system is through the use of agreements to achieve EMS system coordination. Both public and private EMS providers should be engaged as part of a local planning process to ensure meaningful involvement by all system participants.

The goal of the legislature when considering EMS systems was for cities and fire districts to be integrated into an organized EMS system and to sign agreements. Section 1797.201 was seen as a transitional part of the EMS Act. Unfortunately, there is no required date to enter into agreements under 1797.201. Consequently, section 1797.201 is being cited as authority for a city or fire district to remain free from local EMS agency oversight. At this time, it is unclear what discrete 1797.201 rights exist, if any, beyond the provision of paramedic services and emergency ambulance services. However, the predominant issue under discussion is the provision of dispatch of emergency medical assets and whether that is included as a right under in section 1797.201.

There is presently no independent authority for review and verification of what constitutes a section 1797.201 city or fire district. This means that every disagreement has the potential to be resolved through the court system. Although in many cases agreements in various forms have been entered into, there is now some disagreement as to what specific terms an agreement must contain and the form it may take. The courts seem to be clear that a city or fire district may not avail itself of the use of 1797.201 after an agreement has been reached, if there is an interruption of service, or upon the termination of an existing agreement.

At its time of inception, it seems clear that section 1797.201 only contemplated two (2) types of service for continuation—paramedic service and emergency ambulance service. Dispatch was not a prehospital EMS service or type under 1797.201, especially since emergency medical dispatch was not widely known at the time the law was written. Under section 1797.201, cities and fire districts are required to maintain services at not less than the level they were providing it in 1980. They may adjust the level of service upward in the areas of quantity of available staff, vehicles, equipment, etc. but a city or fire district may not enter into new types of services.

Ambulance services provided by cities or fire districts do not obtain exclusivity from section 1797.201. However, ambulance services may be grandfathered under section 1797.224 if they qualify and are part of the local EMS system through an agreement.

What are some considerations for resolution?

Three specific recommendations are identified for discussion as part of this document. The following considerations reflect some limited solutions to the ongoing discussion related to the application of section 1797.201 in light of the overarching legislative intent to have a coordinated and integrated EMS system in 2010:

1. Agreements should be reached between a local EMS agency and an eligible city or fire district under 1797.201, for those areas that have not already done so, that specify and clearly articulate the type of service and role in the EMS system.
2. Local EMS plans should include a review and verification of what constitutes a section 1797.201 city or fire district, and what type of prehospital EMS service that entity provides, as part of an EMS plan that is submitted to EMSA for approval.
3. A local Emergency Medical Care Committee should be required at the local EMS level to ensure meaningful involvement by EMS system participants.

ENDNOTES

¹ California Health and Safety Code, Division 2.5, Section 1797 et seq. Initially passed as SB 125 (Statutes of 1980).

² California Code of Regulations, Title 22, Division 9.

³ County of San Bernardino v. City of San Bernardino, 15 Cal. 4th 909 (1997)

⁴ Valley Medical Transport v. Apple Valley Fire Protection District, 17 Cal.4th 747 (1998)

⁵ City of Petaluma v. County of Sonoma, 12 Cal. App.4th 1239 (1993).

⁶ Apple Valley at 754.

⁷ Apple Valley at 754.

⁸ County of San Bernardino at 927.

⁹ Wedworth-Townsend Pilot Paramedic Act, SB 772 (Statutes of 1970).

¹⁰ Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (EMS Act), SB 125 (Statutes of 1980).

¹¹ California Health and Safety Code 1797.101.

¹² California Health and Safety Code 1799.

¹³ County of San Bernardino at 931.

¹⁴ County of San Bernardino at 909.

¹⁵ County of San Bernardino at 925.

¹⁶ County of San Bernardino at 924.

¹⁷ County of San Bernardino at 922.

¹⁸ County of San Bernardino at 932.

¹⁹ Apple Valley at 749.

²⁰ Letter to EMSA from Jim Hone, Los Angeles Area Fire Chiefs' Association, dated April 8, 2008.

²¹ Letter to Jim Hone Los Angeles Area Fire Chiefs' Association, and Cathy Chidester, Los Angeles County EMS Agency, from EMSA dated October 23, 2008.

²² City of Petaluma v. County of Sonoma, 12 Cal. App.4th 1239 (1993).

²³ County of San Bernardino at 932.

²⁴ Clawson J. and Dernocoeur K. *Principles of Emergency Medical Dispatch*. Englewood Cliffs, New Jersey: Brady/Prentice Hall (1988).

²⁵ County of San Bernardino at 927.

²⁶ Valley Medical Transport v. Apple Valley Fire Protection District, 17 Cal.4th 747 (1998).

²⁷ Bill Lockyer, Attorney General Opinion No. 03-316, September 5, 2003.

²⁸ Added by AB 3153, Bronzan (Statutes of 1984).

²⁹ County of San Bernardino at 931.

³⁰ County of San Bernardino at 932.

³¹ Apple Valley at 759.

³² Apple Valley at 759.

³³ Apple Valley at 759.

³⁴ County of San Bernardino at 931.

³⁵ City of Petaluma v. County of Sonoma, 12 Cal. App.4th 1239 (1993).

³⁶ Apple Valley at 761.

³⁷ City of Lomita v. County of Los Angeles, 148 Cal. App. 3d 671 (1983).

³⁸ City of Lomita v. Superior Court of Los Angeles, County of Los Angeles, 186 Cal. App. 3d 479 (1986).

