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**STATE OF CALIFORNIA
COMMISSION ON EMERGENCY MEDICAL SERVICES**

December 2, 2015

09:00 A.M. – 11:30 A.M.

(Meeting may end early at the completion of all agenda items)

Marines' Memorial Club and Hotel

609 Sutter Street

San Francisco, CA 94102

(415) 673-6672

- 1. Call to Order and Pledge of Allegiance**
- 2. Review and Approval of September 2, 2015 Minutes**
- 3. Director's Report**
 - A. EMSA Program Updates [DMS] [Personnel] [Systems]
- 4. Consent Calendar**
 - A. Legislative Report
 - B. Administrative and Personnel Report
 - C. Legal Report
 - D. Enforcement Report
 - E. Trauma System Update

Regular Calendar

- 5. EMS Personnel**
 - A. Physician Order for Life Sustaining Treatment (POLST) Form [Addendum 1, 2, 3]
 - B. Do Not Resuscitate (DNR) and Other Patient - Designated Directives
 - C. Epinephrine Auto Injector Regulations
 - D. Office of Administrative Law Rulemaking Calendar
 - E. Community Paramedicine
 - F. EMT Regulation Revisions
- 6. EMS Systems**
 - A. EMS Plan Review Process
 - B. EMS Systems Regulations Workgroup Update
 - C. Wireless 911 Routing Status
 - D. EMS Plan Appeal Regulations
 - E. CEMSIS Data Update
- 7. Disaster Medical Services Division**
 - A. Mobile Medical Assets Program Update
 - B. Hospital Incident Command System (HICS) Update

- 8. Nomination of Officers for March 2016 – March 2017**
- 9. Approval of 2017 Meeting Dates**
- 10. Items for Next Agenda**
- 11. Public Comment**
- 12. Adjournment**

A full agenda packet will not be provided at the meeting; however, you can print a full packet, including the agenda from the Department's website at www.emsa.ca.gov. This event will be held in an accessible facility. Individuals with disabilities requiring auxiliary aids or services to ensure accessibility such as language interpreting, assisted listening device, materials in alternate formats or other accommodation, should contact Jennifer Lim at (916) 431-3700, no less than 7 days prior to the meeting.

**STATE OF CALIFORNIA
COMMISSION ON EMS
WEDNESDAY, SEPTEMBER 2, 2015
HOLIDAY INN BAYSIDE SAN DIEGO
4875 NORTH HARBOR DRIVE
SAN DIEGO, CA 92106
800-662-8899 – Reservation line**

MINUTES

COMMISSIONERS PRESENT:

Linda Broyles, Dan Burch, Jaison Chand, Steve Drewniany, Mark Hartwig, Ruth Haskins, MD, Richard O. Johnson, MD, Kristi L. Koenig, MD, Alexis F. Leiser, MD, Daniel Margulies, MD, David Rose, Jane Smith, Lew Stone, Dave Teter

COMMISSIONERS ABSENT:

Aaron Hamilton, Eric Rudnick, MD, Joy P. Stovell

EMS AUTHORITY STAFF PRESENT:

Howard Backer, MD, Daniel R. Smiley, Jennifer Lim, Steven McGee, Tom McGinnis, Lou Meyer, Lisa Schoenthal, Jeff Schultz, Sean Trask

AUDIENCE PRESENT:

Gurujodha Khalsa, Kern County
Kayann Markham, El Dorado County

1. CALL TO ORDER AND PLEDGE OF ALLEGIANCE

Chairman Lew Stone called the meeting to order at 9:58 a.m. Fourteen Commissioners were present. He asked Commissioner Johnson to lead the Pledge of Allegiance and it was recited.

2. REVIEW AND APPROVAL OF JUNE 17, 2015, MINUTES

Action: Vice Chairperson Smith moved approval of the June 17, 2015, Commission on Emergency Medical Services Meeting Minutes as presented. Commissioner Margulies seconded. Motion carried unanimously.

3. DIRECTOR'S REPORT

Howard Backer, M.D., EMSA Director, presented his report:

A. EMSA Budget Status

The EMSA budget is favorable, due to several grants and no reductions in state-level funding.

B. EMSA Program Updates

Health Information Exchange

EMSA received a \$2.75 million grant for local projects to enhance EMS Health Information Exchange.

Health Information Technology

EMSA formed a work group with the Emergency Medical Services Administrators' Association of California (EMSAAC) and the EMS Medical Directors Association of California (EMDAC) to develop a strategy to improve data quality and to aggregate data at local, state, and national levels.

Specialty Care Systems

The California Department of Public Health received a grant from the Centers for Disease Control (CDC) to work with EMSA to bring a stroke registry into the EMS data system, and to use it for performance improvement..

EMSA is working with EMDAC to consider centralizing the CARES resuscitation registry at the state level.

Performance Measures

The third year of data collection for core measures has been completed with increased reporting from the LEMSAs. Funding has been secured to augment the analysis and interpretation of the core measures.

Open Data Project

The California Health and Human Services Agency (CHHS) has developed an initiative for all departments within CHHS to post data sets in a consistent format to allow exploration and analysis. Some data sets are already available; other departments, including EMSA, will begin posting data by this fall.

Trauma Plan

The EMSA Trauma Plan is currently under review by the CHHS.

The statewide consultation evaluation by the American College of Surgeons for a state-level trauma system survey will be the week of March 22nd to 25th.

Community Paramedicine

Kaiser Regional has expressed interest in the community paramedicine projects and will be an important partner.

A different model is also being initiated separately from the pilots, using nurse practitioners paired with paramedics. It remains to be seen if this will be an efficient model.

EMS Plans

EMSA will work with the LEMSAs to review the format, content, and means of submission of EMS plans.

Challenges

- Mobile field hospitals
- EMS financials
- 9-1-1 Emergency Communications
 - The Routing On Empirical Data (RED) Project data
- Drones
- Ambulance patient offload delays
- The POLST Forms

4. CONSENT CALENDAR

Commissioner Koenig suggested the removal of item (E), Wireless 9-1-1 Routing Status, from the Consent Calendar.

Action: Commissioner Johnson moved approval of the consent calendar. Vice Chairperson Smith seconded. Motion carried unanimously. The item was noted and filed.

Commissioner Koenig stated the wireless 9-1-1 routing issue was discussed at the EMDAC meeting yesterday. There continues to be concern on the management and transparency of wireless 9-1-1 and ensuring that 9-1-1 calls are both answered and routed to the correct locations, and that some or all of the RED Project data will be discarded now that the project is complete. Commissioner Koenig requested that EMSA follow up on the RED Project data.

Chairman Stone asked staff to contact Karen Wong, the Assistant Director of Public Safety Communications with the Governor's Office Emergency Services (Cal OES), to clarify what the new data is and what they plan to do with the old data, and to disseminate her response in a memorandum to all Commissioners. He also asked if Ms. Wong will attend the December EMSA meeting. Dr. Backer stated he will contact Ms. Wong.

Chairman Stone suggested inviting representatives from Verizon and AT&T to an EMSA meeting to discuss what they are doing in the wireless 9-1-1 routing area.

Dr. Backer agreed with the joint invitation, but stated the need for a point of contact. Daniel Smiley, EMSA Chief Deputy Director, suggested contacting Steve Carlson, the California Governmental Affairs Counsel for the Cellular Telephone Industries Association (CTIA).

Action: Commissioner Teter made a motion to invite Verizon and/or AT&T to present on wireless 9-1-1 routing at the next EMSA meeting or as soon as is practical for them. Commissioner Johnson seconded. Motion carried unanimously.

REGULAR CALENDAR

5. EMS PERSONNEL

A. Epinephrine Auto-Injector Regulations

Sean Trask, Chief of the EMS Personnel Division, provided an overview of the background, process, and next steps of developing the Draft Epinephrine Auto-Injector Regulations. He stated the public comment tables with responses are in the meeting packet.

- Advanced EMTs, paramedics, registered nurses, physician assistants, and nurse practitioners are not required to go through the training, as it is already part of their scope of learning, but will require an EpiPen card for an EpiPen prescription.
- The cost is approximately \$600 to \$660, including the training, the doctor's appointment, and the EpiPen. The EpiPens come in a two-pack for \$450 and have a one-year shelf life.

Action: Commissioner Drewniany moved approval of the proposed Draft Lay Rescuer Epinephrine Auto-Injector Training Certification Standards for submission to the Office of Administrative Law. Commissioner Burch seconded. Motion carried unanimously.

B. Community Paramedicine Pilot Project Status

Lou Meyer, the Project Manager for the Community Paramedicine Project, presented his report:

- The core training and site-specific training pilot projects have all completed with appropriate supporting documentation.
- The required baseline data from the pilot project sites were submitted to UCSF, the independent evaluator. UCSF has filed a report on the baseline data received to the California Office of Statewide Health Planning and Development (OSHPD).
- The OSHPD Advisory Committee recommended including additional data collection points in the baseline data. UCSF and EMSA incorporated them within the implementation data tool.
- The director of OSHPD recommended that every pilot project have Institutional Review Board (IRB) approval. Mr. Meyer stated all of the sites have received IRB approval, except for the city of San Diego and Stanislaus County, which have behavioral health components. OSHPD's authority to handle the consent issues in reference to the diminished capacity patient is currently in review.
- Implementation has been delayed in projects with a Kaiser component due to legal review and compliance questions. Mr. Meyer has met with the senior leadership of Kaiser Southern California to discuss this issue.

Mr. Meyer gave the start dates and summarized the OSHPD site visits for each pilot project.

Media

- Alameda City held a media day on August 21. Assemblymember Rob Bonta, the Chairman of the Assembly Health Committee, was in attendance and spoke in support of the Community Paramedicine Program. He stated he will do what is necessary to move the project forward.
- Multiple articles on the Community Paramedicine Program have come out this week.

Mr. Meyer played a sample of the public news radio broadcast that aired Monday for Commissioners. He stated the reporter plans to air two additional stories – one on the post-discharge scenario that’s happening in UCLA under Dr. Rottman and one in reference to AMR/Ventura’s Hospice and TB Pilot Project.

Vice Chairperson Smith stated health care cannot continue without change. She thanked Mr. Meyer and his team for the work they are doing to effect change. Mr. Meyer stated he is working with seventy-seven of the most dedicated paramedics he has seen during his forty years in EMS.

Chairman Stone thanked Mr. Meyer on behalf of the Commission for his service to the community. The medics and fire department personnel that were in attendance at a recent event were thankful that Mr. Meyer took time out of his busy schedule to participate in their local events.

Commissioner Lieser stated many of her colleagues support community paramedicine and see it as a way to make health care delivery better in this country, although some emergency physicians may be opposed to it. She thanked Mr. Meyer for his work in this area.

C. EMT Regulation Revisions

Mr. Trask presented his report on the revisions to the EMT Regulations:

- Adding training topics in the administration of naloxone and putting it in the basic scope of practice
- Adding mandatory training in the use of an epinephrine auto-injector and the use of a glucometer to check blood sugars by EMTs
- The use of naloxone, EpiPens, and glucometers still requires LEMSA approval
- Removing the school competency form that is required for recertification every two years, because it is difficult to ensure that the form is being filled out properly by an authorized person who can determine competency
- Increasing the minimum hours of EMT training from 160 to 166 hours
- Moving the scope of practice items around to make it easier to follow

- EMTs who have LEMSA approval to transport a patient with a medication drip will be moved to the optional scope
- Adding tactical casualty care training to the EMT regulations

D. First Aid, CPR, and Preventive Health Training Standards for Child Care Providers, Legislative Changes and Regulation Impact

Mr. Trask provided an overview of the background, process, and next steps of the mandated first aid, CPR, preventive health, and nutrition training programs for licensed child care facilities.

- The chapter pertaining to first aid and CPR in the regulations needs to be revised, as it has not been revised since it was implemented in 1998
- The Health and Safety Code states that refresher training in preventive health topics can be required every two years
- The preventive health topics will be added to the first aid component that is required every two years
- A fee increase will be proposed, as fees have been frozen for seventeen years for this fee-supported program while the costs have gone up

Dr. Backer stated it would be helpful before drafting the regulations to get Commissioner input on the recommendation from the Curriculum Development Advisory Committee (CDAC) to train every EMT in tactical medicine.

Commissioner Hartwig stated the concern that there are three or four different treatment models used. He stated there is value in CDAC's effort to bring all of those different disciplines under one protocol. He suggested that EMSA develop EMS standards for this by forming a governing body to work with the LEMSAs to develop the medical component of treatment and extraction.

Vice Chairperson Smith agreed and stated that finding common ground will simplify training and communication.

Commissioner Drowniany stated the legislative intent of Assembly Bill (AB) 1598 and referred to SECTION 1. (a) (2) (b) (3), which requires all of the disciplines, irrespective of their certification level, to receive training on active shooter incidents and tactical casualty care. Pursuant 1797.134 H&S the State Tactical EMS Advisory Committee, is designated to consult with POST on this training

Mr. Smiley stated AB 1598 does require the EMS Authority, as informed by the State Tactical EMS Advisory Committee, to bring forward training standards for tactical casualty care. Those training standards are out for public comment and close on September 18th.

E. Physician Orders For Life Sustaining Treatment (POLST) Form

Mr. Trask stated AB 637, which will go into effect on January 1st, added nurse practitioners and physicians' assistants to the list of individuals who can sign a POLST form. He stated the need to revise the POLST form, but also the EMSA/CMA pre-hospital DNR form and the DNR guideline document.

Staff is working with the California Coalition for Compassionate Care's Documentation Committee and CMA on the revisions to these forms. The revised documents will come back to the Commission for approval in the December EMSA meeting.

6. EMS SYSTEMS

A. EMS Plan Appeal Regulations

Tom McGinnis, Chief of the EMS Systems Division, provided an overview of the history, process, and next steps of the Draft EMS Plan Appeal Regulations.

Public Comment

Gurujodha Khalsa, Chief Deputy County Counsel for Kern County, stated the appeal regulations are the result of passionate and committed effort to develop a fair and equitable process for adjudicating appeals. He commended the Commission for a robust and thorough process of rulemaking as it concerns local EMS appeals to the Commission to establish a superior process to the prior appeals process.

The administrative law judge (ALJ) and the Commission are precluded from sustaining in part and overruling in part of determination by the Authority. It is all or nothing. This may mean that a final decision which cannot be appealed will either leave in place elements of a plan which are objectionable or result in elements of a plan which are acceptable being rejected.

Mr. Khalsa stated the hope that the Commission will remain open to changes or modifications as necessary to advance the fair and equitable tone thus established in the rulemaking process.

Kayann Markham, of El Dorado County, stated El Dorado County disagrees with the revised Initial Statement of Reasons, Section 100450.100(h), which states whatever decision the Commission agrees to is final and may not later be overturned, challenged, or appealed.

Ms. Markham stated the Initial Statement of Reasons does not indicate what is included in the administrative costs of the Office of Administrative Hearings (OAH). She asked for clarification on what "not adopt" means with regard to the Commission's ability to either adopt or not adopt the ALJ's decision.

Ms. Markham asked if the Commission received the cover letters for the comments that the LEMSAs and other interested agencies made, because the cover letters explained El Dorado County's position in more detail, and whether the cover letter will be sent to the Office of Administrative Law (OAL).

Mr. McGinnis stated, in regard to the dissemination of the cover letters from El Dorado County, cover-type documentation is not traditionally submitted to any of the parties related to the comment period in the OAL process.

Steve McGee, Counsel for the EMS Authority, stated “not adopt” is covered in the statute. The options that the Commission would have, once an ALJ decision is rendered, is to adopt, not adopt, or send back to the OAH to again hear the matter.

Commissioner Questions and Discussion:

Commissioner Hartwig stated he is concerned about the limitations placed on the ALJ, specifically through the use of the Administrative Procedures Act (APA), Chapter 13, Section 100450.100(c)(1) and (2), as compared to the options available to the ALJ according to Section 1797-105(d) Division 2.5 of the Health and Safety Code.

Commissioner Hartwig suggested striking Section 100450.100 (c)(1) and (2) and specifically referring it to the ALJ not to empower the OAL, but instead to not limit what the OAL would proceed to do in their hearing as prescribed in the APA.

Action: Commissioner Hartwig moved to strike (c)(1) and (2) specifically to not empower the OAL, but instead to not limit what the OAL would proceed to do in their hearing as prescribed in the APA. Motion died for lack of a second.

Commissioner Burch spoke in support of the regulations as written. He disagreed with empowering the ALJ with more authority than the Commission has in statute. The ALJ is asked to sit in the Commission’s place. The statute limits options of the Commission to sustain or overturn. It is not the Commission’s place to empower the ALJ to do more than what the Commission can do if it were hearing the appeal directly.

Action: Commissioner Koenig moved approval of the Draft EMS Plan Appeal Regulations as presented. Commissioner Burch seconded. Motion carried, with one objection (Hartwig).

B. EMS Plan Review Process

Mr. McGinnis provided an overview of the history, process, and next steps of the EMS Plan Review Process. He stated an update for the activities related to plans will be added to the quarterly progress report.

The EMSAAC leadership agrees that the three guideline documents that primarily outline the process related to EMS plans need to be online. He stated a small working group will be convened in the near future to begin going through the entire process to see what can be done to streamline it for both the LEMSAs and EMSA and to increase accessibility to the data.

C EMSC Inter-facility Transport Guidelines, EMSA #181

Mr. McGinnis provided the background of the EMSC Inter-facility Transport Guidelines and asked the Commission for approval to formally revise and implement it.

Action: Commissioner Rose moved approval of the revision to Guidelines for Pediatric Inter-facility Transport Program, EMSA #181, as presented. Commissioner Margulies seconded. Motion carried unanimously.

7. DISASTER MEDICAL SERVICES DIVISION

A. Medical and Health Operations Center Support Activities

Lisa Schoenthal, Chief of the Disaster Medical Services Division, provided an update on the Medical and Health Operations Center Support Activities (M/HOCSA) Training Course, which provides training for individuals to serve in Emergency Operations Centers (EOC) at all levels of the California Standardized Emergency Management System.

- The Emergency Operations Manual has been incorporated in the course through an extensive process to provide both flexibility and specificity so the course would meet the needs for all levels of EOCs.
- The health component was recently added as the course originally was developed for medical branches only.
- The California Specialized Training Institute (CSTI) of Cal OES will begin delivering this federally-approved Homeland Security course in 2016.

8. ITEMS FOR NEXT AGENDA

Chairman Stone asked Commissioners to email suggestions for next agenda items to staff.

9. PUBLIC COMMENT

There were no questions or comments from the public.

10. ADJOURNMENT

Action: Commissioner Drewniany moved to adjourn the meeting. Commissioner Teter seconded. Motion carried unanimously.

Chairman Stone adjourned the meeting at 11:41 a.m.

**Emergency Medical Services Authority
Disaster Medical Services Division
Major Program Activities
December 2015**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
1. Ambulance Strike Team (AST)/Medical Task Force (MTF) System Development	Michael Frenn, ext. 435	<p>AST/MTF Leader Trainings continue to be conducted on an ongoing basis as requested. A training was conducted on July 30, 2015 in Contra Costa County with 50+ students in attendance. Additional courses in Northern, Southern and Central California are scheduled over the next 6 months. The curriculum continues to improve. Information regarding the AST Program can be found at: http://www.emsa.ca.gov/Ambulance Strike Team.</p> <p>The Disaster Medical Support Units (DMSUs), which support and have affiliated Ambulance Strike Teams are strategically placed with local EMS Agencies and ambulance providers throughout the State. All available DMSUs have been distributed providing a total of 41 DMSUs with affiliated ASTs in the State.</p>
2. California Medical Assistance Teams (CAL-MAT) Program	Michael Frenn, ext. 435	EMSA continues its reorganization of the CAL-MAT program with a strategic focus on balancing resources with anticipated response needs. Efforts are presently focused on identifying the appropriate Civil Service route for hiring CAL-MAT personnel. A target for response readiness following reorganization has been set for January 1, 2016.
3. CAL-MAT Cache	Craig Johnson, ext. 4171	EMSA has completed bi-annual inventory maintenance on all three CAL-MAT caches. Medical supplies and pharmaceuticals are 100% accounted for and ready for immediate deployment. The biomedical equipment is currently undergoing annual maintenance. In addition, EMSA has created a CAL-MAT training cache, using expired medical supplies, to be used by team members during full scale training exercises.
4. California Public Health and Medical Emergency Operations Manual (EOM)	Jody Durden, ext. 702	The Regional Disaster Medical and Health Specialists (RDMHSs) conduct EOM training on an ongoing basis. The EOM Workgroup resumed monthly meetings in February 2015 for the purpose of revising the EOM based on lessons learned since the initial 2011 release.
5. California Crisis Care Operations Guidelines	Bill Campbell, ext. 728	This project is on hold at this time as EMSA and CDPH assess priorities due to current fiscal challenges.
6. Disaster Interest Group (DIG)	Patrick Lynch, ext. 467	The DIG has been suspended due to the re-prioritization of DMS staff projects.

**Emergency Medical Services Authority
Disaster Medical Services Division
Major Program Activities
December 2015**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>7. Disaster Healthcare Volunteers (DHV) of California (California’s ESAR-VHP program): Registering, Credentialing & Mobilizing Health Care Personnel</p>	<p>Patrick Lynch, ext. 467</p>	<p>The DHV Program has over 21,000 volunteers registered. Over 18,800 of these registered volunteers are in healthcare occupations.</p> <p>All 58 counties have trained System Administrators. EMSA provides routine training and system drill opportunities for all DHV System Administrators.</p> <p>Over 8,600 of the 21,000 DHV registered responders are Medical Reserve Corps (MRC) members. EMSA trains and supports DHV System Administrators in each of the 41 participating MRC units.</p> <p>EMSA has distributed copies of the “DHV Volunteer Handbook.” This handbook informs volunteers about the state’s DHV Program, and provides information about deploying in response to a disaster.</p> <p>DHV System Administrator training, DHV user group webinars, and quarterly DHV drills are ongoing.</p> <p>EMSA publishes the “DHV Journal” newsletter for all volunteers on a tri-annual basis. The most recent issue was released on September 11, 2015. The winter edition will be released in mid-January of 2016.</p> <p>The DHV website is: https://www.healthcarevolunteers.ca.gov.</p> <p>The DHV Deployment Operations Manual (DOM) is available on the EMSA webpage: http://www.emsa.ca.gov/Media/Default/PDF/DHV_DOMRevisionFebruary21-2012.pdf</p> <p>The “DHV Journal” is available on the DHV webpage of the EMSA webpage: http://www.emsa.ca.gov/disaster_healthcare_volunteers_journal_page.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division
Major Program Activities
December 2015**

<p>8. Exercises and Training</p> <ul style="list-style-type: none"> • Weapons of Mass Destruction (WMD) • Medical Health Operations Center Support Activities (MHOCSA) <p>Statewide Exercises:</p> <ul style="list-style-type: none"> • California Capstone 2015 - 2016 	<p>Bill Campbell, ext. 728</p> <p>Bill Campbell, ext. 728</p> <p>Bill Campbell, ext. 728</p>	<p>The California Emergency Medical Response to Weapons of Mass Destruction Incidents (with Med-Plus) course is offered on a continuous basis, requiring a minimum enrollment of 12 students.</p> <p>The Medical Health Operations Center Support Activities (MHOCSA) course is being revised and is in final review for consistency with the Public Health and Medical EOM. EMSA expects course to be offered by California Specialized Training Institute (CSTI) in Spring 2016.</p> <p>California Capstone 2015 was based on the Southern California Catastrophic Earthquake Plan Scenario and response. EMSA participated in the multi-day Emergency Operations Center (EOC) exercise in May 2015. The lessons learned in the exercise will be tested in upcoming exercises.</p>
<ul style="list-style-type: none"> • 2015 Statewide Medical and Health Exercise (2015 SWMHE) 	<p>Nirmala Badhan, ext. 1826</p>	<p>On November 19th, 2015 the EMS Authority will participate in the Statewide Medical and Health Exercise (SWMHE) in partnership with the California Department of Public Health (CDPH). The exercise is designed as a multiphase exercise program for statewide participants to exercise response to an influenza pandemic. The SWMHE will include objectives for Ambulance Services, Community Clinics, EMS Agencies, Fire Services, Hospitals, Law Enforcement, Long Term Care Facilities, Medical Examiners/Coroners, Offices of Emergency Management, and Public Health. The jurisdiction-specific objectives were designed this year to further enhance participants' exercise play.</p>
<p>9. Hospital Available Beds for Emergencies and Disasters (HAvBED)</p>	<p>Nirmala Badhan, ext. 1826</p>	<p>EMSA continues working with the California Department of Public Health (CDPH) and other partners to integrate hospital data collection that meets federal HavBED requirements.</p>

**Emergency Medical Services Authority
 Disaster Medical Services Division
 Major Program Activities
 December 2015**

<p>10. Hospital Incident Command System (HICS)</p>	<p>hics@emsa.ca.gov</p>	<p>The Fifth Edition of HICS was released in May of 2014 and is available on the EMSA website for download: http://www.emsa.ca.gov/disaster_medical_services_division_hospital_incident_command_system.</p> <p>The 2014 revision project did not include the development of education and training materials. Refer to the list of HICS Trainers to view vendors which have identified themselves as providers HICS training based on The HICS Guidebook, Fifth Edition: http://www.emsa.ca.gov/media/default/HICS/HICS_Training_2.pdf. The California Emergency Medical Services Authority does not endorse or recommend any provider. If you are a trainer that would like to be added to this list, please send a request to: hics@emsa.ca.gov along with your contact information.</p> <p>EMSA would like to receive copies of After Action Reports (AAR) and presentations on the use of HICS. This information will aid future revisions. These informative documents should be addressed to the HICS Coordinator via email: hics@emsa.ca.gov.</p>
<p>11. Medical Sheltering</p>	<p>Bill Campbell, ext. 728</p>	<p>The California Department of Public Health (CDPH) released the guidance entitled “California Guidance and Toolkit for Sheltering Persons with Medical Needs” in October 2014. This document will be used as a foundational document when EMSA has the staff resources to revise the “Emergency Medical Services Field Treatment Site (EMS FTS) Guidelines.”</p>
<p>12. Mission Support Team (MST) System Development</p>	<p>Michael Frenn, ext. 435</p>	<p>Based on lessons learned from the last two full scale exercises conducted by EMSA (Golden Guardian 2012 at Sacramento State University and Golden Guardian 2013 at Moffett Field), the MST program is being reviewed in an effort to structure it to adequately support EMSA’s Mobile Medical Assets. Inter-Governmental Employee Exchange Agreements are now being sent to local governments to permit compensating them for their employee’s participation when deployed by EMSA on an MST.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division
Major Program Activities
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<p>13. Response Resources</p>	<p>Craig Johnson, ext. 4171</p>	<p>The Mission Support Team (MST) caches are undergoing bi-annual inventory maintenance. Additional supplies are being added to the cache based on After Action Reports following the Urban Search and Rescue 2015 exercise. In addition, the RRU is currently working to add I.T. equipment to improve MST networking and Internet functionality in the field. The RRU has begun conducting audits on the 41 DMSU vehicles located around the State. During the audits, EMSA will verify that all the DMSU vehicles are being properly maintained and utilized according to written agreements. Twelve audits have been completed so far with no major problems noted. The biomedical equipment for the California Medical Assistance Teams (CAL-MAT) caches is currently being serviced. General annual maintenance for generators and fleet vehicles has been completed.</p>
<p>14. Regional Disaster Medical/Health Specialists (RDMHS) Program and Medical Mutual Aid System</p>	<p>Nirmala Badhan, ext. 1826</p>	<p>The RDMHS program continues to work with EMSA and California Department of Public Health (CDPH) staff in supporting major disaster planning activities in addition to supporting information management processes. The RDMHSs have been instrumental in the response to recent events such as the Butte and Valley Wildfires in California.</p>
<p>15. Mobile Field Hospital (MFH) Program</p>	<p>Craig Johnson, ext. 4171</p>	<p>Three 200-bed MFHs are being stored in Sacramento, California. Due to a loss in program funding the MFHs are no longer considered rapidly deployable. However, the MFH shelters remain a viable asset and can be deployed to support a response. In addition, EMSA will continue to work with the RDMHC program to pre-identify sites for a MFH deployment. The identified sites remain viable options for CAL-MAT, ACS, and other Federal resources. Although the MFH program is without funding, EMSA continues to try to identify alternatives to sustain this valuable program without stressing the State budget.</p>
<p>16. Medical Reserve Corps (MRC)</p>	<p>Sheila Martin, ext. 465</p>	<p>41 MRC units have trained Disaster Healthcare Volunteers (DHV) System Administrators. These MRCs are regular users of the DHV system and active participants in quarterly DHV drills and quarterly DHV user group webinars. Over 8,600 of the DHV Program's 21,000 volunteers are Medical Reserve Corps volunteers.</p> <p>Two Southern California MRCs (Riverside County MRC and MRC of Los Angeles County) will be key participants in the November Statewide Medical Health Exercise. Riverside County MRC will receive and distribute the Strategic National Stockpile (SNS) for the Southern California Region and LA County will have various PODs to simulate the administration of prophylaxis for the LA County area. EMSA will provide support in the DHV System for this exercise.</p>

**Emergency Medical Services Authority
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17. Statewide Emergency Plan (SEP) Update	Jody Durden, ext. 702	The Governor's Office of Emergency Services (Cal OES) updated the Statewide Emergency Plan (SEP) and is moving toward implementing Emergency Functions (EFs). EMSA is a lead participant in the development of the Public Health and Medical Emergency Function of the SEP and is supporting the development of six other EFs.
18. Emergency Medical Services Field Treatment Site (EMS FTS) Guidelines	Bill Campbell, ext. 728	The revision of this document is on hold as EMSA has insufficient staff resources to complete a review at this time.
19. Southern California Catastrophic Earthquake Response Plan	Bill Campbell, ext. 728	EMSA continues to participate in the validation of the Southern California Catastrophic Earthquake Plan. EMSA participated in the SoCal Rocks exercise that was held in March 2015. The SoCal Rocks exercise was designed to examine the processes required to establish, communicate and coordinate public health and medical resource needs. The scope of this design included the coordinated efforts of local, state, federal, and private sector partners in response to a catastrophic earthquake in Southern California.
20. Patient Movement Plan	Jody Durden, ext. 702	The Statewide Patient Movement Workgroup met on October 22, 2015. The first draft of the California Statewide Patient Movement Plan is being reviewed by the workgroup.
21. Bay Area Catastrophic Earthquake Plan	Bill Campbell, ext. 728	EMSA participated as part of the Medical Planning Group for this plan revision and anticipates that the draft plan for public comment will be released soon.
22. Northern California Catastrophic Flood Response Plan	Nirmala Badhan, ext. 1826	EMSA has provided input to Governor's Office of Emergency Services (Cal OES) for the development of the concept of operations for a catastrophic event based upon historically occurring atmospheric rivers that result in catastrophic flooding. Input was provided for "Courses of Action" based on identified response capabilities. An operational framework for the development of local flood plan annexes, training, and exercises is also a primary objective for this plan. Work on the plan will continue in 2015 and 2016.

EMS PERSONNEL DIVISION PROGRESS REPORT

December 2, 2015

ACTIVITY	PRIMARY CONTACT	STATUS/COMMENT
1. First Aid Practices for School Bus Drivers	Lucy Chaidez Extension 434	There are 11 school bus driver training programs currently approved. Renewal reviews are ongoing. Technical assistance to school staff and school bus drivers is ongoing.
2. Child Care Provider First Aid/CPR Training Programs	Adrienne Kim	There are 21 currently approved programs. Renewal reviews are ongoing. EMSA convened a work group to revise the Chapter 1.1 Training Standards for Child Care Providers; pediatric first aid and CPR training standards are a part of this work. Technical assistance is being provided to child care training program instructors and directors, licensing staff, and child care providers. EMSA First Aid and CPR sticker sales are ongoing.
3. Preventive Health Training Programs	Lucy Chaidez and Adrienne Kim	There are 24 preventive health training programs approved. Renewal reviews are ongoing. EMSA is reviewing nutrition training modules to implement AB 290, which adds the topic of nutrition to child care provider training effective January 1, 2016. EMSA has convened a workgroup to revise the Chapter 1.1 Training Standards for Child Care Providers. Part of the work to revise the regulations includes the development of a new first aid module whose focus is prevention. EMSA presented at the annual state Resource and Referral Network conference. EMSA is serving as a partner with CDE and CDSS in the plan for implementing federal laws (CCDBG) to improve child care. EMSA is serving on the Childhood Essentials leadership group led by CDPH. EMSA is serving on the state-wide Regulatory Workgroup to improve child care licensing regulations and thereby improve children's health and safety. EMSA is serving as a partner in the Disaster Child Care Work Group that is developing standards for emergency preparedness in the child care setting. The group is developing an annex to the state disaster plan that will focus on children in child care, their parents, and care providers. Technical assistance to instructors and child care providers is ongoing. EMSA Preventive Health sticker sales are ongoing.
4. Child Care Training Provider Quality Improvement/Enforcement	Adrienne Kim and Lucy Chaidez	Technical assistance and education regarding compliance issues is continually given to approved training programs, child care providers, DSS community care licensing, and child care resource and referral staff. Currently, there are 2 open complaint cases involving EMSA-approved training programs.
5. Automated External Defibrillator (AED) Requirements for EMT's, Public Safety and Layperson	Betsy Slavensky Extension 461	Ongoing technical assistance for Lay Person AED programs and Public Safety AED programs. Reviewing the current regulations for consistency with the SB 658, that was chaptered on 9/3/2015 and goes into affect 1/1/2015.
6. BLS Training and Certification Issues	Betsy Slavensky	Providing ongoing support and technical assistance. EMSA is editing and opening the EMT regulations for public comment, implementing SB 1438 which requires the addition of naloxone training and scope of practice addition for all EMTs.
7. State Public Safety Program Monitoring	Betsy Slavensky	Provide ongoing monitoring of State Public Safety EMSA approved Public Safety First Aid, First Responder, and EMT programs for statutory and regulatory compliance.
8. My License Office/ EMT Central Registry Audit	Betsy Slavensky	EMSA is continuing to monitor the EMT Central Registry to verify that the 80+ certifying entities are in compliance with the California Code of Regulations regarding data entry including background checks and disciplinary notification for all EMT personnel.

EMS PERSONNEL DIVISION PROGRESS REPORT

December 2, 2015

9. Epinephrine Auto-injector Training and Certification	Corrine Fishman Extension 927	<p>As required by Senate Bill 669 (Huff, 2013) <i>Emergency medical care: epinephrine auto-injectors</i>, The EMS Authority (EMSA) was charged with promulgating regulations providing lay rescuer epinephrine auto-injector training standards, including CPR and AED training and to review and approve training programs that will train the lay public in the use and administration of an epinephrine auto-injector.</p> <p>The proposed regulations were approved by the EMS Commission on September 2, 2015 and submitted to the Office of Administrative Law on September 4, 2015. On October 16, 2015 the EMS Authority was notified by OAL that the Lay rescuer epinephrine auto-injector training certification standard regulations have been approved and will go into effect January 1, 2016.</p>
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EMS SYSTEMS PROGRESS REPORT
December 2, 2015

<p>1. Trauma:</p>	<p>Bonnie Sinz Extension 460</p>	<p><u>State Trauma Advisory Committee (STAC):</u> The STAC has not met since the June EMS Commission meeting due to Trauma 2015: California’s Future conference planning. The next meeting is scheduled for August 11, 2015 with the agenda focusing on Trauma Regulations revision, State consultation visit from American College of Surgeons and conference evaluations.</p> <p><u>Regional Trauma Coordinating Committees (RTCC)</u> Each Regional Trauma Coordinating Committee representative provides regional activity updates at the STAC meeting and provides documents approved by the RTCC and available for statewide use. Details of current activities can be found on the EMSA website at www.emsa.ca.gov</p> <p><u>Performance Improvement and Patient Safety (PIPS) Subcommittee</u> The State PIPS Plan is on schedule to be completed by September with the next step being to test the process through the use of CEMSYS. The Plan focuses on system-wide performance issues through the use of state trauma registry data analysis and the analysis of case-based, system-related events. Specific elements of the Plan include the development and reporting of system-wide performance indicators and risk-adjusted outcomes measures.</p> <p><u>Regional Trauma Network for Re-Triage Subcommittee</u> The guidance document is being developed to provide re-triage guidelines, non-trauma center early management protocols, data collection and analysis regarding re-triage and IFT patterns throughout the state, and the identification and development of functional regional trauma networks linked by regional cooperative agreements that will reduce delays and improve communication and collaboration.</p> <p><u>Trauma Centers</u> Orchard and Oroville hospitals have dropped their Level IV Trauma Center designation. Both hospitals are located in Butte County. Mayers Memorial District Hospital dropped their Level IV Trauma Center designation and is located</p>
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EMS SYSTEMS PROGRESS REPORT
December 2, 2015

		in Shasta County. All facilities are part of Sierra-Sacramento Valley EMS Agency.
2. STEMI/Stroke Systems of Care	Farid Nasr Extension 424	EMSA staff continue to work with the STEMI Regulations Taskforce members to revise the draft STEMI regulations to bring them in compliance with Rulemaking requirements under the Administrative Procedure Act. ..The next taskforce meeting is scheduled for November 6, 2015.
3. EMS Systems, Standards, and Guidelines	Jeff Schultz Extension 423	The EMS Systems, Standards, and Guidelines are available on the EMS Authority’s website. Updates to the Standards and Guidelines will be made following the finalization of the Chapter 13 regulatory process. Meetings of the Chapter 13 workgroup continue and are currently scheduled monthly through the end of 2015.
4. EMS Transportation	Laura Little Extension 412	<p><u>EMS Systems Regulations Work Group / Chapter 13 Task Force</u> : The EMS Authority meets monthly with individuals who have specific knowledge of HSC 17977.224/201 and AB1387. The Chapter 13 task force has continued making process in the development of a draft set of regulations related to EMS systems. Once a draft set of regulations is completed, the Chapter 13 Task Force will be reengaged to review the draft regulations.</p> <p><u>Request for Proposals:</u> Request for Proposals (RFPs) for Exclusive Operating Areas continue to go through a dual review process, to ensure that they meet statutory requirements as well as address EMSA Guideline #141 “Competitive Process for Creating Exclusive Operating Areas”. The EMS Authority continues to provide technical assistance to LEMSAs by email, phone, and mail in order to help them create a RFP that meets all required criteria.</p> <p><u>Bi-Annual Statewide Public Safety Air Rescue Inspections:</u> Bi-Annual inspections of all CHP helicopters will begin in 2016, but have yet to be scheduled</p>

EMS SYSTEMS PROGRESS REPORT
December 2, 2015

		EMSA has been unable to continue conducting inspections of CAL Fire helicopters, based on the most recent fire season. EMSA is continuing to coordinate further inspections.
5. Poison Center Program	Jeff Schultz Extension 423	The University of California, San Francisco remains under contract until June 30, 2016 as the sole provider of poison control services for the State of California. The California Poison Control System (CPCS) provides poison help and information to both the public and health professionals through a toll-free hotline that is accessible 24-hours a day, 7 days a week. Quarterly and annual reports are submitted to the EMS Authority providing statistical data of CPCS activity. The reports are reviewed by the EMS Systems Division to ensure compliance with Scope of Work and contractual requirements.
6. EMS Plans	Jeff Schultz Extension 423	<p>The EMS Authority continues to review EMS Plans and annual updates that have been submitted by the LEMSA's. At the September meeting, the EMS Systems Division created a quarterly report for the Commission that reflects the progress and timelines of EMS plans submissions which will be updated and submitted prior to each meeting.</p> <p>The EMS Authority recognizes that the submission and development of EMS plans can be difficult at times. The authority has begun to actively engage EMSAAC members to create an EMS Plan workgroup. The primary focus will be the evaluation of the current plans components and processes as well as making recommendations for changes that better reflect the current and future status of EMS in California.</p>
7. EMS for Children Program	Bonnie Sinz Extension 460	EMS Authority staff has scheduled meetings in May and June 2015 to continue revisions to the EMS for Children Regulations to ensure clarity of the language. After meeting in June, staff is anticipating the proposed regulations will be finalized and the OAL process will be expected to begin in August or September 2015.

EMS SYSTEMS PROGRESS REPORT
December 2, 2015

		<p>The EMS for Children program collaborated with CFED to integrate pediatric courses into the 2015 CFED Expo in Southern California in May 2015. The EMS for Children program coordinator is scheduled to attend two of the pediatric sessions. The partnership with CFED has been a great opportunity for EMS for Children outreach within the EMS system in California.</p> <p>The next EMS for Children Educational Forum in northern California is scheduled for November 5, 2015 in Sacramento at the Doubletree by Hilton Hotel.</p>
8. CEMSIS-EMS Data	Maria Alisangco Extension 742	<p>Since November 2014 the EMS CEMSIS database has grown from 1.1 to over 2.2 million records with 17 LEMSAs participating. We are now beginning development of reports based on NEMSIS V2 data elements and will be generating simple reports from data submitted by the participating LEMSAs. Beginning February 2015, we are organizing the data submitted in the EMS plans to show the local agency data more clearly. We will be able to compare these data to data in the Image Trend application which will allow us to better review the quality of our system data.</p>
9. CEMSIS – Trauma Data	Bonnie Sinz Extension 460	<p>There are 27 Local EMS agencies (LEMSA) with designated Trauma Centers. Trauma Centers are physically located in 37 of the 58 counties. Currently 26 LEMSAs are transmitting into CEMSIS-Trauma representing 73 of the 75 designated Trauma Centers. For years 2013 through 2015 there are over 139,000 records in the CEMSIS-Trauma data system. The EMS Authority is currently developing a report for each LEMSA showing data completion compliance to be shared with their Trauma Centers.</p>
10. Grant Activity Coordination	Teri Harness Extension 462	<p>EMSA personnel have received and reviewed mid-term progress reports from each of the four (4) LEMSA's who received PHHFBG grant funds to conduct HIE and/or QI/Data projects. The LEMSA's are actively progressing as agreed and are anticipated to successfully complete their projects by the end of the FFY grant period.</p>

EMS SYSTEMS PROGRESS REPORT
December 2, 2015

		Division Chief Note: This position has recently been vacated by the prior staff member. It is anticipated a new staff member will begin operating in this position in November 2015.
11. Communications	Tom McGinnis Extension 695	EMSA personnel are working with the Office of Emergency Services (OES) to address public concerns on issues related to Wireless 9-1-1. Division Chief Note: This position has recently been vacated by the prior staff member. It is anticipated a new staff member will begin operating in this position in November 2015.
12. Core Measures	Adam Davis Extension 409	EMSA has developed the annual Core Quality Measures Report for 2014 data. The report has been reviewed and approved by the Core Measures Task Force. The document will be shared with EMSAAC prior to having it published on EMSA's webpage. The task force is scheduled to meet on December 3 rd , 2015. Agenda items include reviewing of the current measures and fine tune their aim, developing more detailed instructions for running the reports, and discussion of the shift to NEMSIS 3. The updated Core Measures Instruction Book will be distributed in late 2015 or January 2016.
13. EMS Plan Appeal Regulations	Teri Harness Extension 462	The appeal regulations were approved by the Commission at the September 2, 2015 meeting. Upon approval of the Economic and Fiscal Impact Statement by Agency and the Department of Finance, the regulations will be submitted to the Office of Administrative Law for approval.

EMERGENCY MEDICAL SERVICES AUTHORITY

10901 GOLD CENTER DRIVE, SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875



DATE: December 2, 2015

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Jennifer Lim, Deputy Director

SUBJECT: 2015 Legislative Summary

RECOMMENDED ACTION:

Receive information regarding EMS-related legislation.

FISCAL IMPACT:

None.

DISCUSSION:**AB 317 (Maienschein R) Veterinary medicine: temporary shelter.**

10/7/2015-Vetoed by the Governor

Current law requires the registration of all premises where veterinary medicine, veterinary dentistry, or veterinary surgery is being practiced. This bill would have exempted from the premises registration requirements a temporary shelter that is established to provide care and shelter to animals displaced by a state of emergency, if specified requirements are met, and would authorize the Veterinary Medical Board to inspect a temporary shelter.

AB 503 (Rodriguez D) Emergency medical services.

9/30/2015-Chaptered by Secretary of State - Chapter 362, Statutes of 2015

This bill authorizes a health facility, as defined, to release patient-identifiable medical information to a defined EMS provider, a local EMS agency, and the Emergency Medical Services Authority, to the extent specific data elements are requested for quality assessment and improvement purposes. This bill also authorizes the authority to develop minimum standards for the implementation of this data collection.

AB 637 (Campos D) Physician Orders for Life Sustaining Treatment forms.

8/17/2015-Chaptered by Secretary of State - Chapter 217, Statutes of 2015

Current law requires a physician to treat a patient in accordance with the Physician Orders for Life Sustaining Treatment form (POLST form) and specifies the criteria for creation of a POLST form, including that the form be completed by a health care provider based on patient preferences and medical indications, and signed by a physician and the patient or his or her legally recognized health care decisionmaker. This bill authorizes the signature of a nurse

practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law to create a valid POLST form.

AB 651 (Cooper D) Public safety officers and firefighters: investigations and interviews.
7/17/2015-Failed Deadline pursuant to Rule 61(a)(10). (Last location was PUB. S. on 5/21/2015)

The Firefighters Procedural Bill of Rights Act and the Public Safety Officers Procedural Bill of Rights Act grant certain rights to firefighters and public safety officers, as defined. This bill, in an investigation that focuses on matters that may result in punitive action against a firefighter or public safety officer who is not formally under investigation but is interviewed as a witness in an investigation of another firefighter or public safety officer, would have authorized the firefighter or public safety officer who is a witness to have representation in the interview, as specified.

AB 1129 (Burke D) Emergency medical services: data and information system.
9/30/2015-Chaptered by Secretary of State - Chapter 377, Statutes of 2015

This bill requires an emergency medical care provider to, when collecting and submitting data to a local EMS agency, use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards, includes those data elements required by the local EMS agency, and uses an electronic health record system that can be integrated with the local EMS agency's data system, as specified.

AB 1223 (O'Donnell D) Emergency medical services: ambulance transportation.
9/30/2015-Chaptered by Secretary of State - Chapter 379, Statutes of 2015

This bill authorizes a local EMS agency to adopt policies and procedures relating to ambulance patient offload time, as defined. The bill requires the Emergency Medical Services Authority to develop a statewide standard methodology for the calculation and reporting by a local EMS agency of ambulance patient offload time.

SB 19 (Wolk D) Physician Orders for Life Sustaining Treatment form: electronic registry pilot.

10/5/2015-Chaptered by Secretary of State - Chapter 504, Statutes of 2015

This bill enacts the California POLST eRegistry Pilot Act. The bill requires the Emergency Medical Services Authority to establish a pilot project, in consultation with stakeholders, to operate an electronic registry system on a pilot basis, to be known as the California POLST eRegistry Pilot, for the purpose of collecting POLST information received from a physician or physician's designee. The bill would require the authority to coordinate the POLST eRegistry Pilot, which would be operated by health information exchange networks, by an independent contractor, or by a combination thereof.

SB 168 (Gaines R) Unmanned aircraft systems.

10/3/2015-Vetoed by the Governor

This bill would have made it unlawful to knowingly, intentionally, or recklessly operate an unmanned aircraft or unmanned aircraft system, as defined, in a manner that prevents or

delays the extinguishment of a fire, or in any way interferes with the efforts of firefighters to control, contain, or extinguish a fire. The bill would have made a violation of this prohibition punishable by imprisonment in a county jail not to exceed 6 months, by a fine not to exceed \$5,000, or by both that fine and imprisonment. By creating a new crime, this bill would have imposed a state-mandated local program. This bill contained other related provisions and other existing laws.

SB 287 (Hueso D) Automated external defibrillators (AEDs).

10/2/2015-Chaptered by Secretary of State - Chapter 449, Statutes of 2015

This bill requires certain occupied structures that are not owned or operated by any local government entity and are constructed on or after January 1, 2017, to have an AED on the premises. The bill requires a person or entity that supplies an AED to comply with specified existing law regarding AEDs, and exempts a person or entity that acquires an AED for emergency care from liability for civil damages resulting from any acts or omissions in the rendering of emergency care if certain requirements have been met. The bill makes these provisions operative on January 1, 2017.

SB 658 (Hill D) Automated external defibrillators.

9/3/2015-Chaptered by Secretary of State - Chapter 264, Statutes of 2015

This bill provides an exemption from civil liability for a physician and surgeon or other health care professional that is involved in the selection, placement, or installation of an AED. The bill requires a person or entity, other than a health facility as defined, that acquires an AED to, among other things, comply with specified regulations for the placement of the device and ensure that the AED is maintained and tested as specified.

EMERGENCY MEDICAL SERVICES AUTHORITY

10901 GOLD CENTER DRIVE, SUITE 400
RANCHO CORDOVA, CA 95670-6073
(916) 322-4336 FAX (916) 324-2875



DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Kristi McMahon, Budget Officer
Fiscal, Administration, and Information Technology Division

SUBJECT: Fiscal and Administration

RECOMMENDED ACTION:

Information Only.

FISCAL IMPACT:

None.

DISCUSSION:**EMS Authority Budget**

The 2015/16 enacted California State budget includes expenditure authority in the amount of \$32.2 million and 71.2 permanent positions. Of this amount, \$13.9 million is delegated for State Operations and \$18.3 million is delegated to Local Assistance. On August 24, 2015, a Section 28 letter was approved through the Legislature and Department of Finance increasing current budget authority for the \$2.75 million grant from the Office of National Coordinator (ONC) to implement Health Information Exchange (HIE) in day to day EMS plus disasters. The majority of the ONC funding will be classified as Local Assistance and has been identified as contractual services while a smaller portion is allocated to State Operations. The Department is required to match \$1 for every \$3 of Federal funding expended and can be met with in-kind contributions, such as personnel. Employees are tracking personnel activity on the grant.

On August 28, 2015, the Department received a Notification of Grant Award (NOGA) for increased funding available in the Preventive Health and Health Services Block Grant to continue funding priority areas of HIE, EMS system data and quality improvement, Ambulance Exclusive Operating Area evaluations, and trauma system, planning, and enforcement activities. A Section 28 letter is under review at the Legislature to increase current year budget authority for the additional funds. We are

continuing to monitor and adjust both State Operations and Local Assistance budgets to meet changing program priorities.

Accounting data for the new Fiscal Year is not yet available as the Department migrated to the new statewide Financial Information System for California (FI\$Cal Project) on August 12, 2015, and is in the process of validating data converted both automatically and manually prior to closing the first fiscal month in the new system. An updated report will be distributed prior to the next Commission meeting.

EMS Authority Staffing Levels

The EMS Authority is authorized 71.2 positions and also has 20 temporary positions (seasonal clerks and retired annuitants) for an overall staffing level of 91.2. Of the 91.2 positions, 10 positions are vacant at this time and in the process of recruiting to fill the positions.

	Admin/Exec Division	DMS Division	EMSP Division	EMS Division	Total
Authorized	15.0	21.0	26.2	9.0	71.2
Temporary Staff	6.0	3.0	3.0	8.0	20.0
Overall Staffing Level	21.0	24.0	29.2	17.0	91.2
Vacant	-2.0	-3.0	-3.0	-2.0	-10.0
Current Staffing Level	19.0	21.0	26.2	15.0	80.2

EMERGENCY MEDICAL SERVICES AUTHORITY

10901 GOLD CENTER DRIVE, SUITE 400
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DATE: December 2, 2015
TO: Commission on EMS
FROM: Howard Backer, MD, MPH, FACEP, Director
PREPARED BY: Steven A. McGee, Administrative Adviser
SUBJECT: Update on Legal Office Activity

RECOMMENDED ACTION:

Receive the Legal Office Report.

FISCAL IMPACT:

None.

DISCIPLINARY CASES:

From August 12, 2015, to October 21, 2015, the Authority issued twenty-nine new Accusations against existing paramedic licenses, issued five Statement of Issues denying an unrestricted license, issued three notices of Administrative Fine, and two Temporary Suspension Orders. Of the newly issued actions, seven of the Respondents have requested that an administrative hearing be set. There are currently 20 hearings scheduled. The Authority currently has two cases where the administrative law judge's proposed decision was not adopted, and the Director is currently reviewing written arguments. There are currently sixty-eight open active disciplinary cases in the legal office.

LITIGATION:

The Authority is not currently involved in any litigation.

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
 Director

PREPARED BY: M.D. Smith
 Supervising Special Investigator
 Enforcement Unit

SUBJECT: Update on Enforcement Activities

RECOMMENDED ACTION:

Receive information on Enforcement Unit activities.

FISCAL IMPACT:

None

DISCUSSION:**Unit Staffing:**

As of October 20, 2015, the Enforcement Unit has 4 full-time Special Investigators, 1 Retired Annuitant working as Special Investigator and 1 vacant Special Investigator position.

Investigative Workload:

The following is a summary of currently available data extracted from the paramedic database.

Cases opened since January 1, 2015, including:

Cases opened:	284
Cases completed and/or closed:	290
EMT-Paramedics on Probation:	225

In 2014:

Cases opened:	387
Cases completed and/or closed:	374
EMT-Paramedics on Probation:	232

Status of Current Cases:

The Enforcement Unit currently has 101 cases in “open” status.

As of October 20, 2015, there are 39 cases that have been in “open” status for 180 days or longer; 6 Fire Fighters’ Bill of Rights (FFBOR) cases and 10 are California Society of Addiction Medicine (CSAM....cases where Respondents are directed to a physician who specializes in addition medicine for an examination/review) cases.

Those 39 cases are divided among 5 Special Investigators are in various stages of the investigative process, (i.e. awaiting documents, preparing for and/or setting up interviews, report writing and corrections to be made, awaiting action by local law enforcement jurisdictions, the courts, etc.).

[Delays in the interview process are common due to unforeseen difficulties in obtaining certified copies of documents, court records, availability of witnesses and/or the subject(s) of an investigation (due to medical action/disability issues, on-going investigations for FFBOR staff or on-going criminal investigations, court actions), plus the routine requirement for two or more follow-up interviews.]

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Bonnie Sinz, RN, BS
State Trauma System Specialist

SUBJECT: Trauma System Update

RECOMMENDED ACTION

Receive information regarding the Statewide Trauma System.

FISCAL IMPACT

None.

DISCUSSION**American College of Surgeons Consultation Visit**

An eight member team from the American College of Surgeons (ACS), representing surgery, emergency medicine, nursing and administration will conduct a California State Trauma System Assessment on March 22nd through March 25th, 2016. The site visit will be hosted by the EMS Authority at the Holiday Inn Bayside in San Diego.

The American College of Surgeons (Contractor) is a scientific and educational association of surgeons founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education, practice and trauma systems.

The ACS team will assess key areas of our trauma system including, but not limited to:

- Injury Epidemiology,
- Indicators as a Tool for System Assessment,
- Statutory Authority and Administrative Rules,
- System Leadership,
- Coalition Building and Community Support,
- Lead Agency and Human Resources within the Lead Agency,
- Trauma System Plan,
- System Integration,
- Financing,
- Prevention and Outreach,

- Emergency Medical Services,
- Definitive Care Facilities,
- System Coordination and Patient Flow,
- Rehabilitation,
- Disaster Preparedness,
- System-Wide Evaluation and Quality Assurance,
- Trauma Management Information Systems, and
- Research.

The assessment will be carried out using the Health Resources and Services Administration (HRSA) *Model Trauma System Planning and Evaluation* guide published in 2006 and with the template described in *Regional Trauma Systems: Optimal Elements, Integration and Assessment, Systems Consultation Guide*, published by ACS in 2008.

The EMS Authority will complete a pre-review questionnaire (PRQ) that reflects California's approach to each of the key areas by answering the provided questions. The PRQ will be supplemented with both required and other supportive documents. The ACS team will conduct the assessment based on the PRQ and any other focused questions upon request of the EMS Authority. Subject matter experts will be available to answer questions from the ACS team. On the last day of the visit the ACS team will provide a preliminary summary of its findings and recommendations. The final report will be provided in approximately sixty days.

Trauma partners and constituent groups are invited to attend any and all sessions. An invitation and agenda will be sent out at a later date.

State Trauma Advisory Committee (STAC):

The STAC schedules conference calls and face-to-face meetings. Multimedia options are made available for members who are unable to travel. The STAC's current projects include:

- The development of a State Trauma Performance Improvement and Patient Safety Program (PIPS). The development of this program is in response to State Performance Improvement Objectives found in the DRAFT State Trauma Plan.
- The Regional Network/Re-Triage document providing guidance to local EMS agencies and hospitals on the rapid transfer of critically injured patients to the appropriate level of Trauma Center. It will also provide a mapping of how non-trauma facilities partner with Trauma Centers for the transfer of these patients.
- Assisting the EMS Authority in preparing for the ACS Consultation visit.
- Providing recommendations to be included in the revision of the Trauma Regulations.

The STAC Project Subcommittee is revising the tool kit for Trauma Center and Trauma System assessment for the local EMS agencies based on the 2014 Resources for Optimal Care of the Trauma Patient published by the ACS. The subcommittee holds frequent conference calls and membership includes a Trauma System Coordinator and Trauma Center Program Coordinator from each Regional Trauma Coordinating Committee (RTCC.)

State Trauma Plan

The EMS Authority management staff has reviewed the final DRAFT of the State Trauma Plan and forwarded it to Health and Human Services Agency for approval. Minor revisions are being addressed.

EMERGENCY MEDICAL SERVICES AUTHORITY

10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875



DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Corrine Fishman, Program Analyst

SUBJECT: POLST form revisions

RECOMMENDED ACTION:

Please review and approve the revised POLST form for 2016 as recommended by the California POLST Task Force and its POLST Documentation Committee.

FISCAL IMPACT

No fiscal impact.

SUMMARY

Governor Brown recently signed two pieces of legislation related to the Physician Orders for Life Sustaining Treatment (POLST) form. The proposed form changes reflect these new laws.

On August 17, 2015 AB 637 (Campos, Chapter 217) was signed by the Governor. AB 637 authorized a “nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law” to sign a POLST form. This law goes into effect January 1, 2016.

On October 5, 2015 SB19 (Wolk, Chapter 504) was signed by the Governor and authorizes a pilot project which would enable healthcare providers to electronically submit and access a patients POLST form.

The California Coalition for Compassionate Care convened their POLST Documentation Committee, which the EMS Authority participated in, to assist with amending the form for compliance with the requirements in AB 637.

Major changes include:

1. A signature line that was added for Physician Assistant/Nurse Practitioner.
2. Language was added to clarify that a PA /NP can be consulted regarding the establishment of a decision maker.
3. A designated space was added for “NP/PA’s Supervising Physician box” to provide space for NPs and PA’s to note the name of their supervising physician.
4. A designated space was added for a registry sticker in anticipation of SB 19, the POLST eRegistry pilot program.
5. All previous form versions have been listed as valid.

Attached is the final draft of the POLST Form, a cover letter explaining the background for the amendments, and a table summarizing the changes.



October 9, 2015

Mr. Howard Backer
Director
California Emergency Medical Services Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670 United States

Dear Mr. Backer:

On behalf of the California POLST Task Force, the Coalition for Compassionate Care of California (CCCC) is pleased to submit the attached revised POLST form to EMSA for approval, with a requested effective date of January 1, 2016.

Attached, please find the following:

- 1) **Proposed revised POLST form** for approval, as recommended by the California POLST Task Force and its POLST Documentation Committee; and
- 2) **Summary of proposed changes – 2016 POLST form**

Why Changes are Needed

Governor Brown recently signed two pieces of legislation related to POLST. The proposed form changes reflect these new laws.

- Assembly Bill 637 authorizes a “nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law” to sign a POLST form. This law goes into effect January 1, 2016. Changes to the POLST form are needed to make it clear that nurse practitioners and physician assistants are legally authorized to sign the POLST form as of January 1, 2016.
- Senate Bill 19 authorizes a pilot project—to be known as the *California POLST eRegistry Pilot*—which would enable healthcare providers to electronically submit and access patients’ POLST forms. The registry will go into effect when non-state funding is secured for the pilot. As a result, CCCC is recommending adding to the form a designated “placeholder” for a future POLST registry sticker or marker.

Proposed Changes

The POLST Documentation Committee, which is a subcommittee of the California POLST Task Force, carefully considered changes needed to make the POLST form meet the requirements of AB 637. Due to the limited time between the signing of AB 637 and its implementation, the Committee made the conscious decision to limit their recommended changes to only those needed to meet the requirements of AB 637 and SB 19.

Effective Date

We are requesting 1/1/16 as the effective date for the 2016 form because that is when AB 637 goes into effect.

We have been pleased to have Corrine Fishman, Sean Trask and Jay Goldman, MD, serve on the POLST Documentation Committee and POLST Task Force.

Thank you for your consideration and please do not hesitate to contact me, or the chair of the POLST Documentation Committee, Jim Mittelberger, MD at (612) 632-5372 or james_mittelberger@optum.com, if you have any questions. We look forward to hearing the outcome of the December EMSA meeting and approval of the revised POLST form for 2016.

Sincerely,

A handwritten signature in blue ink, appearing to read "Judy Thomas". The signature is fluid and cursive, with a large loop at the beginning.

Judy Thomas, JD
Chief Executive Officer
(916) 552-7573
jthomas@coalitionccc.org



EMSA #111 B
(Effective 1/1/2016)*

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

A
Check One

CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Attempt Resuscitation/CPR (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B
Check One

MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Full Treatment – primary goal of prolonging life by all medically effective means.
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

Trial Period of Full Treatment.

Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

Request transfer to hospital only if comfort needs cannot be met in current location.

Comfort-Focused Treatment – primary goal of maximizing comfort.
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. **Request transfer to hospital only if comfort needs cannot be met in current location.**

Additional Orders: _____

C
Check One

ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

Trial period of artificial nutrition, including feeding tubes. _____

No artificial means of nutrition, including feeding tubes. _____

D

INFORMATION AND SIGNATURES:

Discussed with: Patient (Patient Has Capacity) Legally Recognized Decisionmaker

Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive:
 Advance Directive not available Name: _____
 No Advance Directive Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/NP/PA License #:
Physician/NP/PA Signature: (required)		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:	Relationship: (write self if patient)
Signature: (required)	Date:
Mailing Address (street/city/state/zip):	Phone Number:

**FOR REGISTRY
USE ONLY**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle): _____ Date of Birth: _____ Gender: M F

NP/PA's Supervising Physician

Name: _____

Preparer Name (if other than signing Physician/NP/PA)

Name/Title: _____ Phone #: _____

Additional Contact

None

Name: _____ Relationship to Patient: _____ Phone #: _____

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a **physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.**
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's **physician/NP/PA** believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by **(1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker.** Verbal orders are acceptable with follow-up signature **by physician/NP/PA** in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the **physician/NP/PA**, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit www.caPOLST.org.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Summary of Changes to the 2016 POLST Form

2014 FORM – Top Front

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY			
 EMSA #111 B (Effective 10/1/2014)*	Physician Orders for Life-Sustaining Treatment (POLST)		
	<p><u>First follow these orders, then contact physician.</u> A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.</p>		
	Patient Last Name:	Date Form Prepared:	
	Patient First Name:	Patient Date of Birth:	
	Patient Middle Name:	Medical Record #: <i>(optional)</i>	

2016 REVISION – Top Front

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY			
 EMSA #111 B (Effective 1/1/2016)*	Physician Orders for Life-Sustaining Treatment (POLST)		
	<p><u>First follow these orders, then contact Physician/ NP/ PA.</u> A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.</p>		
	Patient Last Name:	Date Form Prepared:	
	Patient First Name:	Patient Date of Birth:	
	Patient Middle Name:	Medical Record #: <i>(optional)</i>	

Summary of Changes:

Change/Addition/Deletion:	Reason:
Effective date changed from 10/1/2014 to 1/1/2016.	AB 637 and SB 19 take effect on January 1, 2016.
Top left under “First follow these orders then contact Physician,” was changed to “First follow these orders then contact Physician / NP / PA.	To comply with AB 637 and clarify to EMS personnel and other healthcare professionals that nurse practitioners and physician assistants can legally sign the form.

In signature box, changed "Print Physician Name," to "Print Physician/NP/PA Name."	To comply with AB 637 and clarify to EMS personnel and other healthcare professionals that nurse practitioners and physician assistants can legally sign the form.
Change "Physician Phone Number" box to "Physician/NP/PA Phone #:"	To comply with AB 637 and clarify to EMS personnel and other healthcare professionals that nurse practitioners and physician assistants can legally sign the form.
Change "Physician License Number:" to "Physician/NP/PA License #:"	To comply with AB 637 and clarify to EMS personnel and other healthcare professionals that nurse practitioners and physician assistants can legally sign the form.
Change "Physician Signature: (required)" to "Physician/NP/PA Signature: (required)"	To comply with AB 637 and clarify to EMS personnel and other healthcare professionals that nurse practitioners and physician assistants can legally sign the form.
In subsection under "Signature of Patient or Legally Recognized Decisionmaker", the date box was moved to the left.	This change was made to make room for a larger box at the right-hand corner.
In subsection under "Signature of Patient or Legally Recognized Decisionmaker", the "Office Use Only" box was enlarged and title was changed to "FOR REGISTRY USE ONLY."	This change was made to provide a designated space for a registry sticker in anticipation of SB 19, the POLST eRegistry pilot. Although the registry pilot is not statewide, the space was added now to minimize the need for future requests to EMSA for minor form changes.

Bottom/Front of Form

Change/Addition/Deletion:	Reason:
Changed the phrase – "*Form versions with effective dates of 1/1/2009 or 4/1/2011 are also valid." to *Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid."	This was changed to clarify to EMS personnel and other healthcare professionals that the three previous versions of the form are still valid.

2014 FORM – Back Side/Top: Additional Information

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY		
Patient Information		
Name (last, first, middle):	Date of Birth:	Gender: M F
Healthcare Provider Assisting with Form Preparation		<input type="checkbox"/> N/A if POLST is completed by signing physician
Name:	Title:	Phone Number:
Additional Contact <input type="checkbox"/> None		
Name:	Relationship to Patient:	Phone Number:

2016 REVISION – Back Side/Top: Additional Information

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY		
Patient Information		
Name (last, first, middle):	Date of Birth:	Gender: M F
NP/PA's Supervising Physician	Preparer Name (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:
Additional Contact <input type="checkbox"/> None		
Name:	Relationship to Patient:	Phone #:

Summary of Changes

Change/Addition/Deletion:	Reason:
In second row, added “NP/PA’s Supervising Physician” box.	<p>This addition was made to provide a space for NPs and PAs to note the name of their supervising physician.</p> <p>This is supported by Laws and Regulations Relating to the Practice of Physician Assistants, specifically The law governing PAs states: <i>Each time a physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient’s record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient.</i> 16 CCR 1399.546</p> <p>Since AB 637 requires NPs signing the POLST to be “acting under the supervision of a physician,” NPs were included in this box.</p>
Changed box titled: “Healthcare Provider Assisting with Form Preparation” to “Preparer Name”.	This change was made because space for text was limited by the addition of the supervising physician box.
Deleted check-box next to “N/A if POLST is completed by signing physician,”	This format change was necessary to provide space for the “NP/PAs Supervising Physician” box.
Changed text from “N/A if POLST is completed by signing physician,” to “(if other than signing Physician/NP/PA)”.	This change was made to clarify for those completing the form that the preparer’s name needed to be added only if the form was prepared by someone other than the signing physician, NP or PA.
Deleted box for title of preparer. Added Title next to name.	This format change was necessary to provide space for the “NP/PAs Supervising Physician” box.

2014 FORM – Back Side/Middle: Directions for Health Care Provider

Directions for Healthcare Provider
<p>Completing POLST</p> <ul style="list-style-type: none"> • Completing a POLST form is voluntary. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient’s preferences. • POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts. • POLST must be completed by a healthcare provider based on patient preferences and medical indications. • A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient’s physician believes best knows what is in the patient’s best interest and will make decisions in accordance with the patient’s expressed wishes and values to the extent known. • A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker’s authority is effective immediately. • POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy. • If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form. • Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient’s medical record, on Ultra Pink paper when possible.

2016 REVISION – Back Side/Middle: Directions for Health Care Provider

Directions for Health Care Provider
<p>Completing POLST</p> <ul style="list-style-type: none"> • Completing a POLST form is voluntary. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient’s preferences. • POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts. • POLST must be completed by a health care provider based on patient preferences and medical indications. • A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient’s physician/NP/PA believes best knows what is in the patient’s best interest and will make decisions in accordance with the patient’s expressed wishes and values to the extent known. • A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker’s authority is effective immediately. • To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy. • If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form. • Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient’s medical record, on Ultra Pink paper when possible.

Summary of Changes

Change/Addition/Deletion:	Reason:
Completing the POLST	
<p>First bullet, second sentence changed from “In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient’s preferences,” to “In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of a physician,”</p>	<p>This change was made comply with AB 637 and clarify to EMS personnel and other healthcare professionals that nurse practitioners and physician assistants can legally sign the form.</p>

Fourth bullet, changed "...person with whom the patient's physician believes best knows what is in the patient's best interest..." to "...person with whom the patient's physician/PA/PA believes is in the patient's best interest."	This change was made comply with AB 637 and to provide direction to EMS personnel and other healthcare professionals that nurse practitioners and physician assistants who signed the POLST can be consulted regarding establishing a decisionmaker.
Sixth bullet, changed "POLST must be signed by a physician and the patient or decisionmaker to be valid," to "To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker.	This change was made comply with AB 637 and to provide direction to EMS personnel and other healthcare professionals that nurse practitioners and physician assistants can legally sign the form. The text "acting under the supervision of a physician and within the scope of practice authorized by law," is taken directly from AB 637.
Sixth bullet, second sentence was changed from "Verbal orders are acceptable with follow-up signature by the physician in accordance with facility/company policy," to "Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy."	This change was made comply with AB 637 and to provide direction to EMS personnel and other healthcare professionals that nurse practitioners and physician assistants can legally issue verbal orders with follow up.
<i>Modifying and Voiding POLST</i>	
Second bullet: Changed "A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician" to "A legally recognized decisionmaker may modify the orders in collaboration with the physician/NP/PA".	This change was made comply with AB 637 and clarify to EMS personnel and other healthcare professionals that nurse practitioners and physician assistants can be consulted by a legally recognized decisionmaker regarding requests to modify the POLST.



Do Not Resuscitate (DNR) and Other Patient-Designated Directives

Emergency Medical Services Authority
California Health and Human Services Agency

EMSA #111

5th Revision – January 2016

EMS Personnel Guidelines Limiting Pre-Hospital Care





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CHIEF DEPUTY DIRECTOR**

**SEAN TRASK
DIVISION CHIEF**

EMSA #111

5th Revision - 2016

4th Revision – 2013

3rd Revision – 2009

2nd Revision – 1993

Released – 1990

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INTRODUCTION

These guidelines are intended to assist local emergency medical services (EMS) agencies in developing policies that honor patient-designated choices regarding unwanted resuscitation attempts and other out-of-hospital interventions. These policies allow patients to refuse resuscitation and medical interventions and ensure that a patient's rights are honored.

Local decision-making is essential in this sensitive area. When developing these policies, the local EMS agency should ensure that all stakeholders (providers, interested groups and individuals) have an opportunity to provide input during the process. Most importantly, non-EMS physicians and their patients must be aware of these policies and the ability to limit prehospital care options.

BACKGROUND

The goals of emergency medical services personnel include saving lives, preventing disability and relieving suffering. Historically, EMS systems focused on sudden cardiac death and resuscitation. Patients were treated to the fullest extent possible, and discussions about patients' wishes regarding resuscitation or the extent of treatment were reserved for medical personnel in acute care facilities.

More frequently, patients or their families resist resuscitative measures. These patients are generally, although not always, victims of terminal illnesses, and are encountered in skilled nursing facilities, private residences and other care settings. They may or may not be hospice clients. They view resuscitation attempts as lacking sufficient benefit and merely prolonging the process of dying, while causing unnecessary discomfort and emotional distress.

Historically, emergency responders were obligated to initiate full resuscitative measures and these were usually continued until arrival at a hospital. Discouraging patients from using the EMS system when they do not wish resuscitation avoids difficult problems, including identification issues, but may deny patients palliative treatment, an important obligation of all health care providers. In some cases, these patients must use the EMS system solely to obtain transportation, sometimes forcing them to accept unwanted resuscitative measures.

Despite pre-planning to decline resuscitation, family members and employees of health or long-term care facilities may activate 9-1-1 when death is imminent. Performing resuscitation against a patient's wishes in this case is inappropriate because it denies them real authority over their health care.

While it is clear that care givers should acknowledge patients' wishes in regard to resuscitation, caution is needed in the field setting since there is generally no established relationship between the patient and emergency responder. Specific procedures are needed whereby patient directives regarding limited care will be respected in the home and long term care facility and during transport. This is best

dealt with by standard requirements for DNR directives and clearly written policies and procedures for local EMS providers.

Cardiopulmonary resuscitation is similar to other medical interventions with advantages and disadvantages, risks and benefits. When possible, patients should give informed consent before resuscitation is attempted; however, in cases of sudden, unexpected cardiac arrest, treatment consent is not possible, so EMS systems operate on the principle of implied consent. Patients' rights to consent to or refuse resuscitation or other recommended medical care do not depend on the presence or absence of a terminal illness or the agreement of their physician.

The EMS system, as the extension of medical practice into the field, has the same ethical obligations to honor patient wishes regarding resuscitation. Do not resuscitate directives are a critical part of any EMS system. Patients cannot be refused their legal and ethical rights to consent to or refuse medical care simply because they are in the prehospital setting.

AUTHORITY

Health and Safety Code Section 1797.220 gives local EMS agencies the authority to establish “policies and procedures approved by the medical director of the local EMS agency to assure medical control of the EMS system”, which can include patient care guidelines.

Health and Safety Code Section 1798 states that “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”.

Section 4780 of the Probate Code defines what constitutes a "Request regarding resuscitative measures" or a DNR as well as what forms must be accepted statewide. The EMS Authority is responsible for developing a pre-hospital DNR form and for approving the POLST form.

IMPLEMENTATION PROCEDURES

All local EMS agencies shall have a policy that recognizes and accommodates a patient’s wish to limit prehospital treatment. This should apply to patients in long-term care facilities, during transport between facilities, and in patients' homes. Three instruments are used to assure standard implementation:

- The statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form
- The EMSA approved Physician Orders for Life Sustaining Treatment (POLST) Form
- A standard EMSA approved DNR medallion.

In addition to the three statewide standards mentioned above, the local EMS agency Medical Director may also approve other documents, which may include, but are not limited to the following:

- Physician's order in a patient's chart
- Physician's prescription containing the words Do Not Resuscitate, No CPR, or No Code, that contains the patient's name and is dated and signed by the physician
- Advance Health Care Directives

These other documents may not be honored outside of a particular local EMS agency's jurisdiction. If individuals want to ensure that their wishes are honored consistently throughout California, it is recommended that they utilize one of the standardized instruments mentioned above.

Patients have near-absolute authority to refuse resuscitation. The role of the physician signing the DNR directive should be to evaluate the patient for untreated or inadequately treated illness where additional treatment might change the patient's decision regarding resuscitation.

The physician should ensure that the patient understands the meaning of resuscitation and "do not resuscitate," explain the benefits and risks of a resuscitation attempt, and answer any questions the patient may have. Additionally, the physician should explain the differences in treatment protocols between the statewide EMSA/CMA approved Prehospital DNR, the EMSA approved POLST Form (which includes treatment options for patients admitted to hospitals and other healthcare facilities), and the standard DNR medallion.

The role of the base hospital should be defined. In some cases the base hospital will not be notified and all documentation will appear only on the patient care record. Other jurisdictions may wish to have the base hospital consulted.

In cases where EMS personnel question the validity of the request (e.g. DNR not identified in local DNR policy, conflicting requests by family members, etc.), EMS personnel should be allowed to temporarily disregard the DNR request and institute resuscitation measures while consulting their base hospital for assistance.

If the patient is conscious and states that they wish resuscitative measures, then the DNR Form should be ignored. In rare instances, when the patient is unable to state his or her desire and a family member is present and requests resuscitative measures for the patient, the family member's objection may call into question the validity or applicability of the DNR Form. Although the patient's wishes or instructions should remain paramount, resuscitation may be undertaken until the situation is clarified. Usually discussions with the family will make attempted resuscitation unnecessary.

Clarification may require only discussion with the family member, with explanation, reassurance, and emotional support. Assistance from a base hospital may be helpful. Again, the underlying principle is that the patient's wishes should be respected.

Local EMS agencies should have policies addressing the use of documents other than the EMSA/CMA approved Prehospital DNR Form (see Appendix A) or the EMSA approved POLST form (see Appendix B).

EMS personnel should attach a copy of the approved DNR Form to the patient care record, along with other appropriate written documentation. The DNR Form should accompany the patient so that it may be incorporated into the medical record at the receiving facility. When DNR orders are noted in medical records in licensed facilities, that fact should be recorded by the EMS provider, along with the date of the order and the physician's name. It should be noted on the patient care record that a written DNR order was present including the name of the physician, date signed and other appropriate information.

Patients who are dead at the scene should not be transported by ambulance however; local EMS agencies should consider policies for DNR patients who collapse in public locations. In these cases it may be necessary to transport the individual to a hospital even without resuscitative measures, in order to move the body to a location that provides the family with more privacy and where arrangements can be made more expeditiously. Local policies shall have the approval of the Medical Examiner/Coroner, who has the responsibility for investigating all deaths with other investigative bodies.

EMSA/CMA APPROVED PREHOSPITAL DNR FORM

1. Under the EMSA/CMA approved Prehospital DNR Form, do not resuscitate (DNR) means no chest compressions, defibrillation, endotracheal intubation, assisted ventilation, or cardiotoxic drugs.
2. The patient should receive all other care not identified above for all other medical conditions according to local protocols.
3. Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped and the patient is unconscious, ventilation should not be assisted.
4. Requests must be signed and dated by a physician. No witness to the patient's or surrogate's signature is necessary. Ensuring appropriate informed consent is the responsibility of the attending physician, not the EMS system or prehospital provider.
5. The DNR Form should be clearly posted or maintained near the patient in the home. A typical location might be in an envelope in a visible location near the patient's bed. Copies of the form are valid and will be honored. The patient or family should be encouraged to keep a copy in case the original is lost. The copy should be taken with the patient during transport.
6. In general, EMS personnel should see the written prehospital DNR Form unless the patient's physician is present and issues a DNR order.
7. Correct identification of the patient is crucial, but after a good faith attempt to identify the patient, the presumption should be that the identity is correct if

documentation is present and the circumstances are consistent. There should be a properly completed standard EMSA/CMA DNR Form available with the patient. A witness who can reliably identify the patient is valuable.

A blank sample EMSA/CMA Prehospital DNR Form is contained in Appendix A.

EMSA APPROVED POLST FORM

EMS personnel who encounter the EMSA approved POLST form in the field should be aware of the different levels of care in Sections A and B of the form (Section C does NOT apply to EMS personnel).

Section A

Section A applies only to individuals who do NOT have a pulse and are NOT breathing upon arrival of EMS personnel.

1. If an individual has checked “Attempt Resuscitation/CPR”, then EMS personnel should treat the individual to the fullest extent possible according to local protocols regardless of what may be checked in Section B. For this individual this form as filled out does NOT constitute a DNR.
2. If the individual has checked “Do Not Attempt Resuscitation/DNR”, then no attempts should be made to resuscitate the individual and the EMS personnel should follow their local policies, procedures and protocols for declaration of death.

Section B

Section B applies only to individuals who have checked “Do Not Attempt Resuscitation/DNR” in Section A AND who have a pulse and/or are breathing upon the arrival of EMS personnel.

1. If an individual has checked “Full Treatment” then they should be treated to the fullest extent possible. This includes, but is not limited to, intubation and other advanced airway interventions, mechanical ventilation and defibrillation/cardioversion.

Should the individual’s condition deteriorate after EMS personnel have arrived and they have indicated “DNR” in Section A, then resuscitation efforts should be attempted up to, but NOT including, chest compressions. Then EMS personnel should follow local protocols regarding declaration of death.

EMS personnel shall ignore the check box marked “Trial Period of Full Treatment” as it is not applicable to pre-hospital care.

2. If an individual has checked “Selective Treatment” the following care may be provided (in addition to the care outlined below):
 - Administration of IV fluids.

- May use non-invasive positive airway pressure to include: continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations according to local protocols. This does NOT include intubation.
 - EMS personnel shall ignore the subjective phrase “avoid burdensome measures” when considering treatment options for the patient. EMS personnel shall follow their local protocols, policies and procedures regarding patient treatments and if necessary contact medical control for further guidance.
 - EMS personnel shall ignore the check box marked “Request transfer to hospital only if comfort needs cannot be met in current location”. EMS personnel shall follow their local protocols, policies and procedures regarding patient transport.
3. If an individual has checked “Comfort-Focused Treatment” the following care may be provided:
- The patient should receive full palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions (includes medication by any route) according to local protocols.
 - Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped and the patient is unconscious, ventilation should not be assisted.
 - EMS personnel shall ignore the statement “Request transfer to hospital only if comfort needs cannot be met in current location”. EMS personnel shall follow their local protocols, policies and procedures regarding patient transport.
4. EMS personnel shall obtain online medical control prior to following any orders listed under “Additional Orders”.

EMSA approved POLST forms must be signed and dated by a physician, **or a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law** and the patient or legally recognized decision-maker. No witness to the patient's or legally recognized decision-maker's signature is necessary. Ensuring appropriate informed consent is the responsibility of the attending physician, not the EMS system or prehospital provider.

The EMSA approved POLST form should be clearly posted or maintained near the patient. A typical location might be in an envelope in a visible location near the patient's bed. Copies of the form are valid and will be honored. The patient or family should be encouraged to keep a copy in case the original is lost. The copy should be taken with the patient during transports.

In general, EMS personnel should see the written EMSA approved POLST form unless the patient's physician is present and issues a DNR order.

Correct identification of the patient is crucial, but after a good faith attempt to identify the patient, the presumption should be that the identity is correct if documentation is present and the circumstances are consistent. There should be a properly completed EMSA approved POLST form available with the patient. A witness who can reliably identify the patient is valuable.

A blank sample EMSA approved POLST Form is contained in [Appendix B](#).

DNR MEDALLION

1. The most accurate form of identification for patients outside of licensed facilities is a medallion or bracelet attached to the patient. Use of such a medallion should never make the patient uncomfortable and should always be optional. Every local EMS system should accept an EMSA approved DNR bracelet or medallion.
2. All EMSA approved DNR medallions must include the following information:
 - a. 24-hour, seven day a week, telephone number that is toll free to the calling party,
 - b. The words, “CALIFORNIA DO NOT RESUSCITATE – EMS”, Or; “CALIFORNIA DNR – EMS”,
 - c. An individual specific identification number to be used to identify the enrollee’s medical information on file.

Medallions should only be issued after receiving a copy of the completed EMSA/CMA approved DNR Request Form or the EMSA approved POLST Form from an individual. Should an individual use a POLST form to acquire their medallion the acronym “POLST” shall be inscribed on the medallion.

3. Should EMS personnel encounter an individual with a DNR medallion, treatment should follow as outlined by the EMSA/CMA approved Prehospital DNR form. If the individual’s medallion indicates “POLST” in addition to “DNR” then if the POLST form is available to the EMS personnel, treatment should follow as indicated on the POLST form. In the absence of a POLST form, when a DNR/POLST medallion is encountered, the EMS personnel should treat the individual in a manner consistent with that outlined by the EMSA/CMA approved DNR until the individual’s valid EMSA approved POLST form is produced.
4. The emergency medical services system must not be used simply to pronounce death in nursing home patients. This inappropriate use of EMS Personnel should be addressed by service providers and/or EMS agencies. DNR orders are aimed at patients who may suffer cardiac arrest during treatment or transfer.
5. Base hospital physicians retain authority for determining the appropriateness of resuscitation. EMS personnel in the field have the ability to contact a base hospital and advise the physician of the details of a particular case if resuscitation appears unwarranted or unwanted by the patient. While field circumstances make this type of ad hoc decision difficult as a routine procedure,

it may still apply to specific cases where patients' wishes are known and explicitly expressed.

There are currently two (2) California Approved Medallion Providers. They are the only vendors in California that are currently approved to produce Statewide approved prehospital DNR medallions. Their contact information is the following:

- MedicAlert Foundation
www.medicalert.org
1-888-633-4298
2323 Colorado Avenue
Turlock, CA 95382
- Caring Advocates
www.caringadvocates.org
1-800-647-3223
2730 Argonauta St
Carlsbad, CA 92009

BACKGROUND MATERIAL ON OTHER ADVANCE DIRECTIVES

These guidelines have focused on the standardized prehospital EMSA/CMA DNR and the EMSA approved POLST form, and physician DNR orders in licensed facilities as the preferred methods for honoring patient decisions to forego cardiac resuscitation. There are several additional written documents or instruments that may be encountered. Local EMS agencies should decide what role, if any, these written instruments play in the prehospital care system. At the very least, emergency responders and base hospital personnel must be aware that these instruments exist and may be presented to the emergency care providers by patients or their families.

There are a variety of "living wills" and advance directives available from many sources. While these may communicate to the rescuer some sense of the patient's wishes regarding resuscitation, the wide variety of these documents and the inability to confirm the legitimacy of the orders makes them unsuitable for emergency use without prior confirmation. A base hospital may, however, elect to use these in guiding a patient's therapy.

Local EMS systems may recognize advance directives. Providers may also be directed to respect the decisions made by an attorney-in-fact at the scene of an emergency when the patient is unable to make decisions for her/himself. Decisions made by the attorney-in-fact should be consistent with any written expressions of the patient's wishes. Secondly, providers may respect directions they find written in the advance directive regarding withholding or providing resuscitation. Finally, written information in the advance directive gives health care providers direction as to the patient's wishes and may be valuable in assessing whether to proceed with resuscitation.

APPENDICES

APPENDIX A- EMSA/CMA APPROVED PREHOSPITAL DNR FORM



CMA PUBLICATIONS 1(800) 892-1262 WWW.CMAHET.ORG

EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM



PURPOSE

The Prehospital Do Not Resuscitate (DNR) Form has been developed by the California Emergency Medical Services Authority, in concert with the California Medical Association and emergency medical services (EMS) providers, for the purpose of instructing EMS personnel regarding a patient's decision to forego resuscitative measures in the event of cardiopulmonary arrest. Resuscitative measures to be withheld include chest compressions, assisted ventilation, endotracheal intubation, defibrillation, and cardiotoxic drugs. This form does **not** affect the provision of life sustaining measures such as artificial nutrition or hydration or the provision of other emergency medical care, such as palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.

APPLICABILITY

This form was designed for use in **prehospital settings** --i.e., in a patient's home, in a long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals. However, hospitals are encouraged to honor the form when a patient is transported to an emergency room. California law protects any health care provider (including emergency response personnel) who honors a properly completed request regarding resuscitative measures, including a Prehospital Do Not Resuscitate Form (or an approved wrist or neck medallion), from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the provider believes in good faith that the action or decision is consistent with the law and the provider has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances. This form does not replace other DNR orders that may be required pursuant to a health care facility's own policies and procedures governing resuscitation attempts by facility personnel. Patients should be advised that their prehospital DNR instruction may not be honored in other states or jurisdictions.

INSTRUCTIONS

The Prehospital Do Not Resuscitate (DNR) Form **must** be signed by the patient or by the patient's legally recognized health care decisionmaker if the patient is unable to make or communicate informed health care decisions. The legally recognized health care decisionmaker should be the patient's legal representative, such as a health care agent as designated in a power of attorney for health care, a court-appointed conservator, or a spouse or other family member if one exists. The patient's physician **must** also sign the form, affirming that the patient/legally recognized health care decisionmaker has given informed consent to the DNR instruction.

The **white copy** of the form should be retained by the patient. *The completed form (or the approved wrist or neck medallion—see below) must be readily available to EMS personnel in order for the DNR instruction to be honored.* Resuscitation attempts may be initiated until the form (or medallion) is presented and the identity of the patient is confirmed.

The **goldenrod** copy of the form should be retained by the physician and made part of the patient's permanent medical record.

The **pink** copy of the form may be used by the patient to order an optional wrist or neck medallion inscribed with the words "DO NOT RESUSCITATE-EMS." The Medic Alert Foundation (1(888)755-1448, 2323 Colorado Avenue, Turlock, CA 95381) is an EMS Authority-approved supplier of the medallions, which will be issued only upon receipt of a properly completed Prehospital Do Not Resuscitate (DNR) Form (together with an enrollment form and the appropriate fee). Although optional, use of a wrist or neck medallion facilitates prompt identification of the patient, avoids the problem of lost or misplaced forms, and is strongly encouraged.

REVOCAATION

In the absence of knowledge to the contrary, a health care provider may presume that a request regarding resuscitative measures is valid and unrevoked. Thus, if a decision is made to revoke the DNR instruction, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with the Medic Alert Foundation or other EMS Authority-approved supplier. Medallions and associated wallet cards should also be destroyed or returned to the supplier.

Questions about implementation of the Prehospital Do Not Resuscitate (DNR) Form should be directed to the local EMS agency.



EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM



An Advance Request to Limit the Scope of Emergency Medical Care

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will **not** prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Legally Recognized Health Care Decisionmaker Signature

Date

Legally Recognized Health Care Decisionmaker's Relationship to Patient

By signing this form, the legally recognized health care decisionmaker acknowledges that this request to forego resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

I affirm that this patient/legally recognized health care decisionmaker is making an informed decision and that this directive is the expressed wish of the patient/legally recognized health care decisionmaker. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotoxic medications are to be initiated.

Physician Signature

Date

Print Name

Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

APPENDIX B- EMSA APPROVED POLST FORM

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY			
 EMSA #111 B Effective 1/1/2018	<h3 style="margin: 0;">Physician Orders for Life-Sustaining Treatment (POLST)</h3> <p style="font-size: small; margin: 0;">First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.</p>		
	Patient Last Name:	Date Form Prepared:	
	Patient First Name:	Patient Date of Birth:	
	Patient Middle Name:	Medical Record #: (optional)	
A <small>Check One</small>	CARDIOPULMONARY RESUSCITATION (CPR): <i>If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.</i>		
	<input type="checkbox"/> Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B) <input type="checkbox"/> Do Not Attempt Resuscitation/DNR (Allow Natural Death)		
B <small>Check One</small>	MEDICAL INTERVENTIONS: <i>If patient is found with a pulse and/or is breathing.</i>		
	<input type="checkbox"/> Full Treatment – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <input type="checkbox"/> Trial Period of Full Treatment. <input type="checkbox"/> Selective Treatment – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. <input type="checkbox"/> Request transfer to hospital <u>only</u> if comfort needs cannot be met in current location. <input type="checkbox"/> Comfort-Focused Treatment – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location. Additional Orders: _____		
C <small>Check One</small>	ARTIFICIALLY ADMINISTERED NUTRITION: <i>Offer food by mouth if feasible and desired.</i>		
	<input type="checkbox"/> Long-term artificial nutrition, including feeding tubes. Additional Orders: _____ <input type="checkbox"/> Trial period of artificial nutrition, including feeding tubes. _____ <input type="checkbox"/> No artificial means of nutrition, including feeding tubes. _____		
D	INFORMATION AND SIGNATURES:		
	Discussed with: <input type="checkbox"/> Patient (Patient Has Capacity) <input type="checkbox"/> Legally Recognized Decisionmaker		
	<input type="checkbox"/> Advance Directive dated _____, available and reviewed → <input type="checkbox"/> Advance Directive not available <input type="checkbox"/> No Advance Directive		Health Care Agent if named in Advance Directive: Name: _____ Phone: _____
	Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA) My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.		
	Print Physician/NP/PA Name:	Physician/NP/PA Phone#:	Physician/NP/PA License#:
	Physician/NP/PA Signature: (required)		Date:
	Signature of Patient or Legally Recognized Decisionmaker I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.		
	Print Name:		Relationship: (write self if patient)
	Signature: (required)	Date:	FOR REGISTRY USE ONLY
	Mailing Address (street/city/state/zip):	Phone Number:	
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED			

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY		
Patient Information		
Name (last, first, middle):	Date of Birth:	Gender: M F
NP/PA's Supervising Physician		Preparer Name (if other than signing Physician/NP/PA)
Name:	Name/Title:	Phone #:
Additional Contact <input type="checkbox"/> None		
Name:	Relationship to Patient:	Phone #:
Directions for Health Care Provider		
Completing POLST		
<ul style="list-style-type: none"> • Completing a POLST form is voluntary. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences. • POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts. • POLST must be completed by a health care provider based on patient preferences and medical indications. • A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known. • A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately. • To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy. • If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form. • Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible. 		
Using POLST		
<ul style="list-style-type: none"> • Any incomplete section of POLST implies full treatment for that section. <p>Section A:</p> <ul style="list-style-type: none"> • If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation." <p>Section B:</p> <ul style="list-style-type: none"> • When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). • Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations. • IV antibiotics and hydration generally are not "Comfort-Focused Treatment." • Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment." • Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel. 		
Reviewing POLST		
It is recommended that POLST be reviewed periodically. Review is recommended when:		
<ul style="list-style-type: none"> • The patient is transferred from one care setting or care level to another, or • There is a substantial change in the patient's health status, or • The patient's treatment preferences change. 		
Modifying and Voiding POLST		
<ul style="list-style-type: none"> • A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line. • A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests. 		
This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit www.caPOLST.org .		
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED		

APPENDIX C – EMSA APPROVED DNR MEDALLIONS



GUIDELINES FOR EMS PERSONNEL REGARDING DO NOT RESUSITATE (DNR) AND OTHER PATIENT-DESIGNATED DIRECTIVES LIMITING PREHOSPITAL CARE

Edmund G. Brown, Jr.
Governor
State of California

Diana S. Dooley
Secretary
Health and Human Services Agency

Howard Backer, MD, MPH, FACEP
Director
Emergency Medical Services Authority

EMSA Publication #111
Updated **January 2016**

www.emsa.ca.gov

EMERGENCY MEDICAL SERVICES AUTHORITY

10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875



DATE: December 2, 2015
TO: Commission on EMS
FROM: Howard Backer, MD, MPH, FACEP
Director
PREPARED BY: Corrine Fishman, Analyst
SUBJECT: DNR Guidelines for EMS Personnel

RECOMMENDED ACTION:

Review and approve the revised DNR Guidelines for EMS Personnel.

FISCAL IMPACT

No fiscal impact.

SUMMARY

On August 17, 2015 AB 637 (Campos, Chapter 217) was signed by the Governor. AB 637 authorized a “nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law” to sign a POLST form. This law goes into effect January 1, 2016.

Changes include:

- Added language stating the “EMSA approved POLST forms must be signed and dated by a physician, or a *nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law.*”
- Attached the revised POLST form to Appendix B of the Guidelines.
- Revision date was updated.

The revised DNR Guidelines have been provided for your review with the changes in red font.

EMERGENCY MEDICAL SERVICES AUTHORITY

10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875



DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Corrine Fishman, Program Analyst

SUBJECT: Lay Rescuer Epinephrine Auto-Injector Regulations

RECOMMENDED ACTION:

Receive information on the status of the Lay Rescuer Epinephrine Auto-Injector Regulations.

FISCAL IMPACT:

The estimated costs for an individual to obtain an epinephrine auto-injector will be approximately \$600-\$660 [\$45-\$75 for the training program plus \$45-\$75 for a CPR/AED card plus \$15 for EMSA certification card plus \$45 for a physician appointment for prescription plus \$450 for an EpiPen 2 pack].

SUMMARY

As required by Senate Bill 669 (Huff, 2013) *Emergency medical care: epinephrine auto-injectors*, The EMS Authority (EMSA) was charged with promulgating regulations providing lay rescuer epinephrine auto-injector training standards, including CPR and AED training and to review and approve training programs that will train the lay public in the use and administration of an epinephrine auto-injector.

UPDATE:

The proposed regulations were approved by the EMS Commission on September 2, 2015 and submitted to the Office of Administrative Law on September 4, 2015. On October 16, 2015 the EMS Authority was notified by OAL that the Lay rescuer epinephrine auto-injector training certification standard regulations have been approved and will go into effect January 1, 2016.

The regulations will be posted on EMSA's website as soon as they are published.

A formal announcement will be sent out to the epinephrine auto-injector workgroup participants, interested parties, EMSAC, EMDAC and the LEMSA's.

EMERGENCY MEDICAL SERVICES AUTHORITY

10901 GOLD CENTER DRIVE, SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875



DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Priscilla Rivera, Manager
Personnel Standards Unit

SUBJECT: Office of Administrative Law 2016 Rulemaking Calendar

RECOMMENDED ACTION:

Receive information and approve 2015 Rulemaking Calendar.

FISCAL IMPACT:

There is no fiscal impact.

DISCUSSION:**Background:**

Government Code section 11017.6 requires every state agency responsible for implementing a statute pursuant to the Administrative Procedure Act to prepare, by January 30, a rulemaking calendar for that year. The rulemaking calendar must be (1) prepared in accordance with the format specified by the Office of Administrative Law (OAL), (2) approved by the head of the department or, if the rulemaking agency is an entity other than a department, by the officer, board, commission, or other entity which has been delegated the authority to adopt, amend, or repeal regulations, and (3) published in the California Regulatory Notice Register (Notice Register). (Gov. Code, sec. 11017.6.)

2016 Rulemaking Calendar:

The rulemaking calendar represents an estimation by the department, of rulemaking files that may be opened during the 2016 calendar year. Rulemaking files that may be opened to implement statutes enacted in the 2015 legislative session are listed on Schedule A. Schedule B contains rulemaking files that may be opened to implement statutes enacted prior to 2015, and would likely represent revisions to existing regulations. The rulemaking calendar provides OAL with an estimate of the workload to be expected, and offers the advance notification of potential regulation amendments that may be of interest to stakeholders and the public.

Attachments

The following documents are attached and require review and approval from the Commission on EMS:

- Schedule A: Proposed Regulations Implementing Statutes Enacted During the Year 2015,
- Schedule B: Proposed Regulations Implementing Statutes Enacted Prior to the Year 2015.

Health and Human Services Agency
2016 RULEMAKING CALENDAR

SCHEDULE A: PROPOSED REGULATIONS IMPLEMENTING STATUTES ENACTED DURING THE YEAR 2015

Subject: Lay Rescuer Automated External Defibrillator Regulations		CCR Title & Sections Affected: § 100031- §100042		Statute(s) Being Implemented: Health and Safety Code sections: 1797.107, 1797.190, 1797.197a, 1797.197			
Responsible Agency Unit: Personnel Standards Unit		Contact Person & Phone Number: Corrine Fishman (916) 431-3727		Projected Dates:			
				Notice Published: February 2016	Public Hearing:	Adoption by your agency: September 2016	To OAL for review: October 2016
Subject: <i>Quality Improvement Data Requirements</i>		CCR Title & Sections Affected: <i>Title 22, Division 9, Chapter 12, Section 100406</i>		Statute(s) Being Implemented: <i>Health and Safety Code Sections 1797.227</i>			
Responsible Agency Unit: <i>Systems Division</i>		Contact Person & Phone Number: <i>Teri Harness (916) 431-3708</i>		Projected Dates:			
				Notice Published: <i>Sept 2016</i>	Public Hearing: <i>Oct 2016</i>	Adoption by your agency: <i>2017</i>	To OAL for review: <i>2017</i>
Report on the status of all uncompleted rulemaking described on previous calendars:							

Emergency Medical Services Authority
2016 RULEMAKING CALENDAR

SCHEDULE B: PROPOSED REGULATIONS IMPLEMENTING STATUTES ENACTED PRIOR TO THE YEAR 2015

Subject: Paramedic Regulations Update		CCR Title & Sections Affected: Title 22, Division 9, Chapter 4 Sections 100135-100180		Statute(s) Being Implemented: 1797.107 and 1797.172			
Responsible Agency Unit: Emergency Medical Services Authority		Contact Person & Phone Number: Corrine Fishman (916) 431-3727		Projected Dates:			
				Notice Published: 1/5/2016	Public Hearing: N/A	Adoption by your agency: 9/21/2016	To OAL for review: 10/5/2016
Report on the status of all uncompleted rulemaking described on previous calendars: <ul style="list-style-type: none"> Paramedic Regulations for Title 22, Chapter 4, was projected to be open by October 2015. This chapter was not opened and is planned to be opened with the new Rulemaking Calendar in January of 2016. 							
Subject: EMT Regulations		CCR Title & Sections Affected: Title 22, Division 9, Chapter 4 §100056 - §100083		Statute(s) Being Implemented: 1797.107, 1797.170 , 1797.182, 1797.183, 1797.197 , 1797.220, 1798			
Responsible Agency Unit: Personnel Standards		Contact Person & Phone Number: Corrine Fishman (916) 431-3727		Projected Dates:			
				Notice Published: November 2015	Public Hearing: N/A	Adoption by your agency: March, 2016	To OAL for review: April, 2016
Report on the status of all uncompleted rulemaking described on previous calendars: <ul style="list-style-type: none"> The EMT Regulations opened at the end of 2015 and are going through the public comment periods. 							
Subject: Training Standards for Child Care Providers		CCR Title & Sections Affected: Title 22, Division 9, Chapter 1.1 §100000.1 - §100000.35		Statute(s) Being Implemented: Health & Safety Codes 1596.798, 1596.865, 1596.866 and 1596.661			
Responsible Agency Unit: Personnel Standards		Contact Person & Phone Number: Lucy Chaidez (916) 431-3678		Projected Dates:			
				Notice Published: January 2016	Public Hearing: N/A	Adoption by your agency: September 2016	To OAL for review: October 2016
Report on the status of all uncompleted rulemaking described on previous calendars: <ul style="list-style-type: none"> These regulations do not have any uncomplete rulemaking on any previous calendars. 							

Subject: <i>Quality Improvement Data Requirements</i>		CCR Title & Sections Affected: <i>Title 22, Division 9, Chapter 12, Section 100406</i>		Statute(s) Being Implemented: <i>Health and Safety Code Sections 1797.103(f)</i>			
Responsible Agency Unit:		Contact Person & Phone Number:		Projected Dates:			
<i>Systems Division</i>		<i>Teri Harness (916) 431-3708</i>		Notice Published: <i>Sept 2016</i>	Public Hearing: <i>Oct 2016</i>	Adoption by your agency: <i>Jan 2017</i>	To OAL for review: <i>Feb 2017</i>
Report on the status of all uncompleted rulemaking described on previous calendars:							
Subject: <i>EMS Plan Appeal Process</i>		CCR Title & Sections Affected: <i>Title 22, Division 9, Chapter 13, Section 100450.100</i>		Statute(s) Being Implemented: <i>Health and Safety Code Sections 1797.105(c)</i>			
Responsible Agency Unit:		Contact Person & Phone Number:		Projected Dates:			
<i>Systems Division</i>		<i>Teri Harness (916) 431-3708</i>		Notice Published: <i>March 13, 2015</i>	Public Hearing: <i>April 27, 2015</i>	Adoption by your agency: <i>Dec 1, 2015</i>	To OAL for review: <i>Dec 2, 2015</i>
Report on the status of all uncompleted rulemaking described on previous calendars:							
<ul style="list-style-type: none"> • <i>The Std. 399 is currently with the Department of Health and Human Services (HHS) for approval and signature.</i> • <i>Upon approval by HHS, the Std. 399 will be sent to the Department of Finance for approval and signature.</i> • <i>Estimated date to OAL is December 2015.</i> • <i>If the December 2015 date is not reached, the regulations will continue into the 2016 calendar year.</i> 							
Subject: <i>EMS for Children</i>		CCR Title & Sections Affected: <i>Title 22, Division 9, Chapter 14, Section 100270</i>		Statute(s) Being Implemented: <i>Health and Safety Code Sections 1799.202, 204, and 205</i>			
Responsible Agency Unit:		Contact Person & Phone Number:		Projected Dates:			
<i>Systems Division</i>		<i>Teri Harness (916) 431-3708</i>		Notice Published: <i>March 2016</i>	Public Hearing: <i>April 2016</i>	Adoption by your agency: <i>July 2016</i>	To OAL for review: <i>August 2016</i>
Report on the status of all uncompleted rulemaking described on previous calendars: <i>The EMS for Children regulations are still in the draft development process.</i>							
Subject: <i>ST Elevation Myocardial Infarction (STEMI) Systems of Care</i>		CCR Title & Sections Affected: <i>Title 22, Division 9, Chapter 7.2, Sections 100270.100 – 144</i>		Statute(s) Being Implemented: <i>Health and Safety Code Sections 1797.103(d), 1797.176, 1797.220</i>			
Responsible Agency Unit:		Contact Person & Phone Number:		Projected Dates:			
<i>Systems Division</i>		<i>Teri Harness (916) 431-3708</i>		Notice Published: <i>February 2016</i>	Public Hearing: <i>March 2016</i>	Adoption by your agency: <i>July 2016</i>	To OAL for review: <i>August 2016</i>
Report on the status of all uncompleted rulemaking described on previous calendars: <i>The STEMI regulations are still in the draft development process.</i>							

Subject: <i>EMS System Requirements</i>		CCR Title & Sections Affected: <i>Title 22, Division 9, Chapter 13, Section 100450.1et seq.</i>		Statute(s) Being Implemented: <i>Health and Safety Code Sections 1797.1, 102, 103, 105, 107, 72, 74, 76, 78, 94, 250, 252, 254, 257 and 258.</i>	
Responsible Agency Unit: <i>Systems Division</i>	Contact Person & Phone Number: <i>Teri Harness (916) 431-3708</i>	Projected Dates:			
		Notice Published: <i>Dec 2016</i>	Public Hearing: <i>Dec 2016</i>	Adoption by your agency: <i>Dec 2017</i>	To OAL for review: <i>Jan 2017</i>
Report on the status of all uncompleted rulemaking described on previous calendars: <i>The regulations remain in the development phase within the EMS Systems Regulations Workgroup.</i>					

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Priscilla Rivera, Manager
Personnel Standards Unit

SUBJECT: Community Paramedicine

RECOMMENDED ACTION:

Receive information regarding Community Paramedicine Pilot

DISCUSSION:

Strong progress continues with all of the Community Paramedicine Project's now in the implementation phase. The discussion that follows will provide an update on the progress and challenges faced by the pilot project sites.

Training

All core and site specific training has been completed by the 12 sites.

OSHPD Approval

The original OSHPD approval for the project expired on November 4, 2015. The EMS Authority requested and was granted an extension of this approval through November 14, 2016. This will allow us to continue the project through the next year and collect sufficient data to evaluate the community paramedic pilot study.

Data Submission

All project site partners have submitted baseline data to OSHPD and the Philip R. Lee Institute for Health Policy Studies UCSF evaluation team. Baseline data is critical to demonstrating cost effectiveness of care provided by community paramedics during the pilot. Based upon the recommendations of the Community Paramedicine Advisory Committee to collect additional data points from the projects during implementation of the pilot, UCSF has developed a revised implementation data tool which was distributed to the projects. Implementation data will be submitted to UCSF and OSHPD on a quarterly basis.

Institutional Review Board (IRB)

Prior to implementation, each project site must receive approval from an Institutional Review Board (IRB) as a measure of ensuring patient safety and ethical treatment of human subjects during research. All project sites have received IRP approval.

Implementation

As of October 12, 2015 all sites have implemented their pilot projects and are now collecting and submitting data.

The EMS Authority will continue to keep the Commission informed on the progress of the Community Paramedicine pilot program.

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Corrine Fishman, Program Analyst

SUBJECT: EMT Regulation Revisions

RECOMMENDED ACTION:

Receive information regarding amendments to the EMT Regulations.

FISCAL IMPACT

No fiscal impact at this point.

SUMMARY

On September 19, 2014 SB 1438 (Pavley, Chapter 491) was signed by the Governor. SB 1438 expands the scope of practice for all EMT certifications through required training in the administration of naloxone hydrochloride, currently an optional skill. This bill also requires the Emergency Medical Services Agency (EMSA) to develop training and standards for all prehospital emergency care personnel in the administration of naloxone hydrochloride and other opioid antagonists by July 1, 2016.

With this rulemaking, the EMS Authority is proposing to:

1. Amend existing EMT regulations by removing naloxone hydrochloride administration as an EMT *optional skill* and include the administration of naloxone hydrochloride as a mandatory training item in the training and scope of practice for all EMT.
2. Further expand the scope of practice and required training for EMTs in the administration of epinephrine by auto-injector and the use of a glucometer at the discretion of the LEMSA.
3. Add basic tactical casualty care (TCC) principles to the required course content.
4. Remove the skills based competency verification form and replace it with 6 hours of skills based continuing education.
5. Increase the required course hours from 160 to 174 to include Naloxone, epinephrine, glucometer training and tactical casualty care.

6. Move the monitoring of preexisting vascular access devices and intravenous lines delivering fluids with additional medications from a basic skill to an optional skill to clarify this is a local optional request.
7. Provide clarity and consistency with the NREMT registration requirements.
8. Provide clarification of the initial certification pathways.

Beginning in March 2015, a stakeholder workgroup convened over a period of three months to assist in revising the EMT regulations.

Formal rulemaking through the Office of Administrative Law (OAL) is anticipated to commence in November 2015, offering the opportunity to receive public comments.

We anticipate having the proposed regulations submitted to the Commission on EMS for approval at the March 2016 meeting.

IMPLEMENTATION STEPS AND TIMELINE

March 2015	Workgroup begins meeting to assist in revising the Chapter 2 EMT regulations.
November 2015	Rulemaking file opened with Office of Administrative law; regulations must be approved within one year.
December 2015	Proposed regulations released for 45-day public comment.
February 2016	Proposed regulations released for 15-day public comment periods as needed.
March 2016	Proposed regulations submitted to Commission on EMS for approval.
April 2016	Office of Administrative Law reviews and approves regulations.
July 1, 2016	Regulations become effective.

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Jeff Schultz, EMT-P
EMS Plans Coordinator

SUBJECT: EMS Plan Review Process

RECOMMENDED ACTION:

Receive information on the EMS Plan review process and recent activity as well as a newly formed EMSA/EMSAAC EMS Plan Workgroup.

FISCAL IMPACT:

None

DISCUSSION:

Based on a Commission on EMS request, the EMS Authority created a visual progress report of all current EMS Plan activity statewide which was presented by Chief McGinnis at the September 2, 2015 meeting. At that time the Authority also indicated it would provide the Commission with updates to this information on a quarterly basis. Attached to this memo is a summary of EMS Plan activity covering 8/1/15 to 11/1/15 for review by the Commission. Topics covered in this summary report include:

- Current Overall LEMSA EMS Plan Submission Status
- EMS Plan Submission Activity (8/1/15-11/1/15)
- Status of Active Submissions
- Average Review Times of Active Submissions by Category

Additionally, in an effort to simplify the submission process, decrease review times and, most importantly, to create an improved EMS plan reporting document, EMSA has recently created an EMS Plan workgroup in collaboration with EMSAAC. Understanding that many of the current guidelines for EMS Plans were created over twenty years ago, this group will be tasked with identifying where and how the EMS Plan, and associated processes, can be improved. The members of this small group have been selected by the leadership of both EMSA and EMSAAC specifically for this challenge.

Preliminary discussions have identified many areas of possible focus including, but not limited to, updating EMSA #101 (last revised 6/93), altering the EMS Plan document to truly indicate planned activities for the coming year as well as reflecting on the preceding year and concurrent activities and migrating to an online submission process to simplify the submission and review process for both the LEMSA's and the EMS Authority. At the time of the creation of this memo, the first meeting of the EMS Plan Workgroup is pending and is projected to be accomplished prior to the end of his calendar year. The goal of the group during this initial meeting will to identify goals and objectives which can then be prioritized to provide structure for subsequent meetings.

Attachment

Current Overall LEMSA EMS Plan Submission Status	# of LEMSA's	%
On Schedule <i>(Approved Plan on File < 12 months)</i>	16	47%
Active Submissions* <i>(Currently Under Active EMSA Review)</i>	13	38%
Not Approved* <i>(Appeal Requested)</i>	2	6%
Submission Past Due <i>(No Plan submitted > 12 months)</i>	3	9%

* El Dorado County represented in multiple categories

EMS Plan Submission Activity (8/1/15-11/1/15)	# of Plans
Plans Approved	8
Plans Not Approved	0
New Plans Submitted	2

Status of Active EMS Plan Submissions	# of Plans
Under Initial EMSA Review	2
Under EMSA SME Review	1
Awaiting Info/Clarification from LEMSA	9

Average Review Times of Active Submissions	# of Days
Under Initial EMSA Review	33
Under EMSA SME Review	10
Awaiting Info/Clarification from LEMSA	146

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Laura Little, EMT
Transportation Coordinator

SUBJECT: EMS Systems Regulation Development

RECOMMENDED ACTION:

Receive information regarding the process for EMS Systems Regulations development.

FISCAL IMPACT:

None.

DISCUSSION:

The group is continuing to meet and have discussions on the very complex issues that make-up the subject matter for these regulations. At our meeting in September 2015, there was a general discussion about process and progress of the group. The members all agreed that the work of this group is valuable and support continued work on these regulations. While the process is slow in the development of the EMS Systems Regulations, the work group members have seen progress and support the continued effort towards a completed draft of the regulation.

Recent meetings for this group included a two-day meeting on October 22nd & 23rd, 2015 and November 17th, 2015.

Once these draft regulations are completed, the EMS Authority will convene the Chapter 13 Task Force to provide input to the draft regulations.

The Commission will be kept informed on our progress with these draft regulations.

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Tom McGinnis, EMT-P
Chief, EMS Systems Division

SUBJECT: Wireless 9-1-1 Routing

RECOMMENDED ACTION:

None.

FISCAL IMPACT:

Unknown.

DISCUSSION:

The EMS Authority continues to monitor issues related to wireless 9-1-1 call transfers. Specifically under review are issues regarding known delays in timely emergency medical response due to inaccurate wireless call locations, inaccurate routing of wireless calls, and limitations in wireless 9-1-1 call transfer capabilities.

The Communications position in the Systems Division at the EMS Authority has recently been vacated as the prior staff member moved on to another position. We anticipate this position being filled in early November 2015. Wireless 9-1-1 issues will be a priority for the new staff member.

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Teri Harness, Assistant Division Chief
EMS Systems Division

SUBJECT: EMS Systems Regulation Development

RECOMMENDED ACTION:

Receive information on the EMS Plan Appeal Regulations process.

FISCAL IMPACT:

Unknown specific costs to the EMS Authority and local EMS agencies who request the ability to exercise their right to appeal an EMS plan determination made by the EMS Authority.

DISCUSSION:

The EMS Plan Appeal Regulations were approved by the Commission at the September 2, 2015 meeting.

The next step in the rulemaking process is to obtain approval of the Economic and Fiscal Impact Statement (Std. 399) from the Health and Human Services Agency and the Department of Finance (DOF), respectively. The Std. 399 was provided to Agency for approval on September 28, 2015.

Upon approval from both agencies, the rulemaking file will be ready to be submitted to the Office of Administrative Law for review and approval.

The Commission will be updated on further rulemaking progress at the December 2, 2015 meeting.

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Kathy Bissell, Manager
HIE, Data and Quality Unit

SUBJECT: CEMSIS Program Update

RECOMMENDED ACTION:

Receive update information on the CEMSIS Data System

FISCAL IMPACT:

Unknown specific costs to the EMS Authority, local EMS agencies, providers and hospitals who are participants in the state data program.

DISCUSSION:

In its current format, CEMSIS has been operating since July 2013 as a pilot project funded by the Office of Traffic Safety (OTS) grants. The project was reformatted into its current iteration in order to make it more aligned with national EMS data standards and local projects being undertaken that were using EMS data.

The CEMSIS data system has two components, EMS and Trauma.

The EMS Authority has partnered with the Inland Counties Emergency Medical Agency (ICEMA) to host and organize our state level data system. We use the ImageTrend EMS software program to manager the data received into CEMSIS. The use of ImageTrend program has proven to be a good tool for us and is widely accepted by 33 of the US States as their primary data program as well.

To date, we have 20 of our 33 local EMS agencies participating at some level in the CEMSIS EMS program in the National EMS Information System (NEMSIS) Version 2 format. All trauma systems in the state are submitting data to the CEMSIS Trauma in the National Trauma Data Base (NTDB) format.

The National Highway Safety Administration (NHTSA) and University of Utah, who houses NEMSIS, have stated that the use of NEMSIS Version 2 will stop on midnight, December 31, 2016. California was the first state approved to submit data in the NEMSIS Version 3 format so we are prepared to move forward with the new data standard.

Our goal for CEMSIS submission is to have all 33 local EMS agencies submit 100% of their 9-1-1 response information to CEMSIS from transport providers.

The EMS Authority is working with the Emergency Medical Services Administrators Association of California (EMSAAC) and the Emergency Medical Directors Association of California (EMDAC) to define key elements of our state data dictionary to be used by all LEMSAs for NEMSIS Version 3 statewide. Some of the key items for consideration by this group include Primary Impression and Procedures. While the group will look at the entire NEMSIS Version 3 data dictionary, these pieces are essential to have a scale of uniformity. By having a standard base data dictionary statewide, we will have more consistent data for EMS system review. This group is meeting approximately monthly and will continue to assist the EMS Authority with development of components of the CEMSIS system.

The Commission will be kept informed on the progress of CEMSIS.

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Dr. Howard Backer, Director

PREPARED BY: Lisa Schoenthal, Chief
Disaster Medical Services Division

SUBJECT: Mobile Medical Assets Program Update

RECOMMENDED ACTION:

Receive information on the status of various components of the State's Mobile Medical Assets Program.

FISCAL IMPACT:

None.

DISCUSSION:

The Emergency Medical Services Authority (EMSA) maintains the State's Mobile Medical Assets (MMA) Program to support local response needs throughout the state in accordance with California's Standardized Emergency Management System (SEMS). The MMA Program is comprised of the Ambulance Strike Team/Medical Task Force (AST/MTF) Program, the Disaster Medical Support Unit (DMSU) Program, the California Medical Assistance Team (CAL-MAT) Program, the Mission Support Team (MST) Program, and the Mobile Field Hospital (MFH) Program.

AST/MTF Program:

This program is modeled after the Firefighting Resources Organized for Potential Emergencies (FIREScope) Strike Team approach, specifically as it pertains to the Engine Strike Teams. Each AST is comprised of 5 like capability (Advanced Life Support or Basic Life support) ambulances, plus an Ambulance Strike Team Leader (ASTL) in a separate vehicle with common communications to the members of the team. ASTLs are trained in accordance with EMSA's standards and are "Red Card qualified" in a manner similar to FIREScope. The Ambulance Strike Team Advisory Committee confers periodically to evaluate curriculum, program organization, etc. Previous revisions to the

training component made it consistent with the principles of the California Disaster Medical Operations Manual (CDMOM). Revisions are presently underway to more closely align it with the 2012 FIRESCOPE Field Operations Guide (ICS 420-1). ASTL training courses are scheduled over the next few months in Northern, Central and Southern California.

DMSU Program:

The DMSU Program supports the AST Program. DMSUs are heavy duty utility trucks sufficiently equipped to meet several objectives: serve as the command vehicle for an ASTL; provide an AST/MTF up to 72 hours of self-sufficiency; and provide supplies needed to manage multi-casualty incidents. DMSU supplies include oxygen equipment, backboards, splinting, hemorrhage control, wound treatment, etc. Advanced airway management (intubation) and IV fluid replacement equipment are also included; however, there are no other pharmaceuticals (drugs). The DMSUs are equipped with a substantial communication package with sufficient capability for an ASTL to manage their assigned team.

DMSUs were obtained utilizing federal funds from the Health Resources Services Administration (HRSA) and Homeland Security Grant Program (HSGP). There are now 41 DMSUs placed strategically throughout the State. EMSA's considerations for DMSU placement include: a) Achieve an ideal ratio of 1 DMSU per 1 million population; b) Identify providers who can field an AST/MTF on either an Immediate or Planned Need basis; c) Identify providers who can support the DMSU Program by using and maintaining the vehicle; and d) Consider isolated areas, specific high risk needs (e.g., frequent tour bus travel), etc.

All providers receiving a DMSU ("Recipients") enter into a Memorandum of Understanding with EMSA for the maintenance of the DMSU, and are committed to providing a Strike Team upon request of the State. EMSA is presently conducting field audits of all DMSUs to ensure program integrity. To date, 12 audits have been completed with the remainder expected to be completed by late Spring 2016.

CAL-MAT Program:

Modeled after the successful federal Disaster Medical Assistance Teams (DMATs), the California Medical Assistance Teams (CAL-MATs) are a group of highly trained medical professionals organized and coordinated by EMSA for rapid field medical response in times of disaster. CAL-MATs represent the State's capability to rapidly respond to mass casualty incidents and catastrophic disasters by augmenting or even replacing medical facility staff in medical surge situations. They may also respond to support communities for events such as mass gatherings or mass prophylaxis in accordance with the SEMS.

When the program is fully staffed, CAL-MAT teams may be deployed in configurations ranging from a 5 member Medical Response Team (MRT) to a 40+ person full function Team. The size and team composition are mission dependent. Teams are capable of deploying on a 24/7 basis with a response time standard of 12 hours or less from the initial activation. EMSA maintains three pharmacy caches as a component of the CAL-MAT caches.

The CAL-MAT Program has been undergoing a structural reorganization. To present, EMSA has contracted with outside entities to provide the clinical staff support needed for assembling the field teams. However, the availability of these resources is diminishing to the extent that EMSA has assessed other options to prevent a gap in CAL-MAT capacity and capability. A functional personnel acquisition model is being developed with the goal of completing this model by January 1, 2016. The success of meeting this time frame depends on the input of other State of California departments.

MFH Program:

The State retains the physical structures and equipment needed for three 200 bed Mobile Field Hospitals. One hospital is stored at EMSA's Response Station 1 in "delayed deployment" status. The other two are in donated storage at another location in the Sacramento area. EMSA does not currently maintain the biomedical equipment necessary for these facilities to begin treating patients in a guaranteed time frame.

Staffing for the hospitals is available through the health system-sponsored or "Specialized" CAL-MAT Program comprised of high level clinical personnel and Hospital Administrative Support Units (HASUs) from several hospital systems in California.

EMSA is reviewing options for the long term plan for this program in consideration of priorities and available funds.

MST Program:

The MST Program provides administrative and logistical support to the other components of the MMA Program (ASTs, CAL-MATs, MFH, etc.) and provides a liaison function with the receiving Operational Area when deployed. The MST is supported with its own cache which provides for a Base of Operations (BOO), Information Services and other support necessary for an entity with a significant logistical support role. Communications capability includes an extensive cache of public safety radios, repeaters, laptop computers, satellite phones and Broadband Global Area Networks (BGANs) and a Very Small Aperture Network (VSAT) essential for emergency communications to support the MMA.

Like the CAL-MATs, the size of the MST is determined by the mission. EMSA relies on highly skilled personnel from other entities, particularly local government, to fill many MST positions. Inter-Agency Employee Exchange Agreements are being executed with local partners to compensate employers for their employee expenses such as salaries and Workers Compensation while on deployment with EMSA.

Response Resources:

EMSA's Response Resources Unit maintains medical equipment and supplies to support the MMA described above. Biannual inventories are conducted to ensure all equipment and supplies are accounted for and meet current standards to enable an effective medical response in austere environments. Expired or recalled supplies are replaced during biannual inventory maintenance. In addition, CAL-MAT biomedical equipment is annually serviced and tagged verifying proper working status. EMSA is currently

developing an Emergency Resource Directory to improve resupply ordering during deployments.

The CAL-MAT caches have been refined by removing outdated and nonessential equipment with more progressive equipment and materials. The overall cache size has been reduced without comprising the integrity, design, and function. The caches will continue to be refined on an ongoing basis with the use of current products that are being used in the field.

Mobile Pharmacy:

During the recent wildfires in Northern California, EMSA received a request for a mobile pharmacy as a single resource to support the large numbers of displaced persons. The State does not currently possess a mobile pharmacy, and the affected Regional Disaster Medical and Health Specialist was ultimately able to identify a resource to meet this need. As an After Action issue, EMSA is assessing the feasibility of developing a mobile pharmacy by converting one of the three existing CAL-MAT pharmacies for this purpose. This pharmacy could be requested as a single resource through the SEMS.

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Dr. Howard Backer, Director

PREPARED BY: Lisa Schoenthal, Division Chief
Disaster Medical Services Division

SUBJECT: Hospital Incident Command System (HICS)

RECOMMENDED ACTION:

Receive updated information on the Hospital Incident Command System (HICS).

FISCAL IMPACT:

None.

DISCUSSION:

An EMSA “HICS Implementation Model” was developed and published as part of a HICS research article in the August 2015 edition of [Homeland Security Affairs](#). This model may be used to evaluate HICS implementation as part of an “After Action” review process or may also be used as a predictor of successful HICS implementation.

EMSA is assessing the timing of further promoting the HICS Implementation Model in consideration of priorities and existing resources. In the meantime, a request for copies of After Action Reports (AAR) and presentations on the use of HICS is posted on the EMSA web site in order to aid future revisions. These informative documents, comments, and suggestions may be sent to the HICS Coordinator via email at HICS@EMSA.CA.GOV

The Emergency Medical Services Authority (EMSA) learned in September 2015 that the Nairobi hospital that treated the greatest number of casualties after the 2013 Westgate Mall terror attack implemented HICS for their effective response. The Aga Khan University Hospital attributed their success to the HICS structure and the diligence of their staff.

International use of HICS continues to increase. EMSA personnel had a September 2015 meeting in Sacramento with representatives from Columbia who discussed

Commission on EMS
December 2, 2015

strategies to further implement HICS not only in Columbia but in other South American countries as well.

EMSA regularly receives inquiries about the availability of HICS training. The release of [*The HICS Guidebook, Fifth Edition*](#) in 2014 did not include the development of educational and training materials. A list of providers who have identified themselves as [“HICS Trainers”](#) is available on the EMSA website, but EMSA does not endorse or recommend any provider.

The lack of standards for certification and qualifications of HICS instructors remains a gap with HICS as well as the lack of standardized training materials. The development of these standards remains a goal of EMSA but requires resources such as funding. EMSA would engage broad stakeholder input for such an endeavor.

Future revisions of HICS are also dependent on available funding. Funds for the Fifth Edition were raised on an ad hoc basis and provided by the United States Department of Veterans’ Affairs and the United States Department of Health and Human Services’ Hospital Preparedness Program.

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
 Director

PREPARED BY: Sean Trask, Chief
 EMS Personnel Division

SUBJECT: Nomination of Officers for March 2016 - 2017

RECOMMENDED ACTION:

Open nominations for Commission Officers for 2016 - 2017.

FISCAL IMPACT:

No fiscal impact.

DISCUSSION:

Nominations for Commission Officers are opened at the last Commission meeting of the year, and the election is held at the first meeting of the next year.

The Commission will need to nominate a new Chair as Commissioner Stone has served two consecutive terms as the Chair. Per the Commission on EMS By-Laws, the Chair can only serve two consecutive terms.

The other officer positions are Vice Chair, Jane Smith, and Administrative Committee members Jaison Chand, and Ruth Haskins, M.D. who are all eligible for re-election to their respective positions.

Current Commission Officers:

Chair	Lew Stone
Vice Chair	Jane Smith
Administrative Committee	Ruth Haskins, M.D. Jaison Chand

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 2, 2015

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Sean Trask, Chief
EMS Personnel Division

SUBJECT: Approval of 2017 Meeting Dates

RECOMMENDED ACTION:

Review the approved meeting dates for Calendar Year 2016, and review the proposed meeting dates for Calendar Year 2017 and approve the September 2017 meeting date.

FISCAL IMPACT:

The cost of four meetings per year is approximately \$55,000 for a total of approximately \$110,000 for two years.

DISCUSSION:

At the December 6, 2006 Commission on EMS Meeting, the Commission approved scheduling the meetings two years in advance.

The following meeting dates and locations were approved on December 3, 2014 for calendar year 2016. .

Calendar Year 2016

March 16, 2016 in Los Angeles
June 15, 2016 in Sacramento
September 21, 2016 in San Diego
December 7, 2016 in San Francisco

The proposed meeting dates and locations for Calendar Year 2017 are:

Calendar Year 2017

March 15, 2017 in Los Angeles
June 21, 2017 in Sacramento
September TBD in San Diego
December 6, 2017 in San Francisco

In 2017, Rosh Hashanah, starts on the evening of Wednesday, September 20 and ends on the evening of September 22, 2017. This may impact individuals attending the Commission meeting if it is held on September 20, 2017.

The Emergency Medical Services Medical Directors Association of California (EMDAC) and the Emergency Medical Services Administrators Association of California (EMSAAC) hold their meetings the day before the Commission meetings. The Rosh Hashanah Holiday could impact attendance at these meetings as well.

The EMS Authority has not contracted for meeting rooms for the 2017 Commission meetings yet, so we would like to take this opportunity to see if the Commission is interested in rescheduling the September 20, 2017 meeting.

Because September 2017 may contain other potential conflicts with personal and meeting schedules, the EMS Authority has listed the options, along with the advantages and disadvantages in keeping with a Wednesday meeting schedule:

1. September 6, 2017
Advantage – eleven weeks from the June 21, 2017 Commission meeting.
Disadvantage – two days after the September 4, 2017 Labor Day Holiday.
2. September 13, 2017
Advantage – Twelve weeks from the June 21, 2017 meeting, no conflicts with holidays.
Disadvantage – none.
3. September 20, 2017
Advantage – 13 weeks from the June 21, 2017 Commission meeting.
Disadvantage – Rosh Hashanah begins the evening of September 20th and may impact attendance at the Commission, EMDAC and EMSAAC meetings.
4. September 27, 2017
Advantage – 14 weeks from the June 21, 2017 Commission meeting.
Disadvantage – Yom Kippur begins on the evening of September 29th and is only 9 weeks until the December 6, 2017 Commission meeting.