**STATE OF CALIFORNIA**
**COMMISSION ON EMERGENCY MEDICAL SERVICES**
**September 2, 2015**
**10:00 A.M. – 4:30 P.M.**
**(Meeting may end early at the completion of all agenda items)**
**Holiday Inn Bayside San Diego**
**4875 North Harbor Drive**
**San Diego, CA 92106**
**Reservations: 800-662-8899 or 619-224-3621**

**1. Call to Order and Pledge of Allegiance**

**2. Review and Approval of June 17, 2015 Minutes**

**3. Director's Report**
- A. EMSA Budget Status
- B. EMSA Program Updates [DMS] [Personnel] [Systems]

**4. Consent Calendar**
- A. Legislative Report
- B. Administrative and Personnel Report
- C. Legal Report
- D. Enforcement Report
- E. Wireless 9-1-1 Routing Status
- F. EMS Systems Regulations Workgroup Update

**Regular Calendar**

**5. EMS Personnel**
- A. Epinephrine Auto-Injector Regulations
- B. Community Paramedicine Pilot Project Status
- C. EMT Regulation Revisions
- D. First Aid, CPR, and Preventive Health Training Standards for Child Care Providers, Legislative Changes and Regulation Impact
- E. Physician Orders For Life Sustaining Treatment (POLST) Form

**6. EMS Systems**
- A. EMS Plan Appeal Regulations
- B. EMS Plan Review Process
- C EMSC Inter-facility Transport Guidelines, EMSA #181

**7. Disaster Medical Services Division**
- A. Medical and Health Operations Center Support Activities

**8. Items for Next Agenda**

## 9. Public Comment

## 10. 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 externalaffairs@emsa.ca.gov or (916) 431-3700, no less than 7 days prior to the meeting.

**STATE OF CALIFORNIA**
**COMMISSION ON EMS**
**WEDNESDAY, JUNE 17, 2015**
**COURTYARD BY MARRIOTT SACRAMENTO CAL EXPO HOTEL**
**1782 TRIBUTE ROAD**
**SACRAMENTO, CA 95815**
**800-605-6578 – 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, Eric Rudnick, MD, Jane Smith, Lew Stone, Dave Teter

**COMMISSIONERS ABSENT:**
Aaron Hamilton, Kathleen Stevenson, Joy P. Stovell

**EMS AUTHORITY STAFF PRESENT:**
Reba Anderson, Howard Backer, MD, Daniel R. Smiley, Jody Durden, Corrine Fishman, Virginia Fowler, Bill Hartley, Adrienne Kim, Jennifer Lim, Laura Little, Kim Lew, Steven McGee, Tom McGinnis, Shona Merl, Lou Meyer, June Iljana, Priscilla Rivera, Lisa Schoenthal, Jeff Schultz, Betsy Slavensky, Sean Trask, Rick Trussell, Adam Willoughby

**AUDIENCE PRESENT:**
Marco Mijic, Assistant Secretary, California Health and Human Services Agency (CHHS)
Karen Wong, Assistant Director of Public Safety Communications, California Office of Emergency Services (Cal OES)

## 1. CALL TO ORDER AND PLEDGE OF ALLEGIANCE

Chairman Lew Stone called the meeting to order at 10:02 a.m. Fifteen Commissioners were present. He asked Commissioner Richard Johnson to lead the Pledge of Allegiance and it was recited.

## 2. REVIEW AND APPROVAL OF MARCH 18, 2015, MINUTES

**Action: Commissioner Rudnick made the motion to approve. Moved (Rudnick). Second (Rose). Motion was passed. Minutes were approved.**

## 3. DIRECTOR'S REPORT

Rick Trussell, Chief of the Fiscal, Administration, and Information Technology Division, presented the budget report:

## EMSA Budget Status

The 2014-15 budget included $13.1 million for state operations and $17.6 million for local assistance.

As of March 31st, approximately $22.8 million or 74.3 percent of the budget has been expended or encumbered – $8.1 million for state operations and $14.7 million for local assistance.

For 2015-16, the governor's budget proposes an expenditure authority of $32.2 million and 71.2 permanent positions – $13.9 million for state operations and $18.3 million for local assistance. Workload and policy adjustments include a general fund augmentation of $500,000 and two permanent positions to support existing disaster medical preparedness programs, and a special fund augmentation of $366,000 and one permanent full-time office technician to address increased workload associated with the document imaging of paramedic licensure and enforcement files.

EMSA staffing levels are 86.2 positions – 65 permanent and 21 temporary.

Howard Backer, M.D., director of EMSA, presented his report:

## Bill Tracking

- AB 503 – hospital outcome data. This bill may help EMS agencies obtain outcome data from hospitals, but the impact will need to be evaluated after a year because of the language, "may" provide outcome information versus "shall."
- AB 1223 – a "wall time" bill. This bill provides a standard definition and methodology to measure ambulance patient offload delays. While it encourages measurement, it allows LEMSAs to set their own time standards.
- AB 1129 – relates to ambulance providers and electronic health record systems. Issues include whether systems must be NEMSIS 3 compliant or compatible and whether LEMSAs can specify which system must be used.
- SB 19 – a POLST registry. The bill would establish a pilot program to create a POLST registry in California without using state funds. The final solution will be to incorporate the POLST form into an electronic medical record that all providers can access.

## Trauma Plan

- Two trauma summits were held in the past two months, one in Southern and in one in Northern California. Both were considered very successful.
- The draft trauma plan is undergoing some final revisions and will be submitted to the California Health and Human Services Agency (CHHS).

- The current Local and regional Trauma Systems are supported by a committed group of experts who donate their time to improve the system.
- There is good trauma data

Geographic gaps in trauma coverage have been filled in recent years by new trauma centers coming online

- Areas for Improvement:
  - Broader regional coordination
  - Quality improvement across the system
  - Better protocols and means to monitor secondary transfers
  - Funding for system development
  - Data linkage with EMS and other data sources to do better research

The state plans an overall system review by the American College of Surgeons next year.

**Narcotic Management**

There is naloxone legislation to allow law enforcement and the public to administer naloxone to suspected narcotic overdose patients.

EMSA has an opportunity to make changes in the Board of Pharmacy statute or regulations related to EMS narcotic management:

- Create narcotic management protocols for provider agencies and medical directors
- Make state statute more consistent with EMS practice
- Allow storage and dispensing units, like Pyxis units, to be used by EMS agencies
- Incorporate EMS into state Pharmacy Board statute where appropriate
- Delineate who can receive, distribute, and monitor narcotics

There is also a drive by national emergency organizations to change federal statute, not just regulations to incorporate language that supports EMS for the Drug Enforcement Administration (DEA)

**Medical Transportation**

Paratransit and medical transportation services are largely unlicensed and unregulated areas. Dr. Backer recommended learning more about this issue, since EMS is considered the overseer of medical transportation.

**Appeals Regulations**

The public comment period has been extended, so the Commission will be unable to take any action on this issue today. Only a few comments have been received.

**Preparedness Hearing**

During the preparedness hearing, legislators expressed concern and disbelief that there are mobile field hospitals mothballed in Sacramento, when California faces a constant risk of large earthquakes.

## Ebola

Liberia has been declared Ebola-free. The Centers for Disease Control (CDC) has recommended a change in policy and procedure for monitoring, and the California Department of Public Health (CDPH) has followed suit. (Since this time, new cases have been diagnosed in Liberia.)

- Self-observation has replaced active monitoring of travelers from Liberia, even though Liberia borders Sierra Leone and Guinea, which still have active outbreaks.
- Travelers are not required to alert authorities if they develop symptoms but are instructed to see their usual provider.
- Travelers will be given a flyer from CDC and told to monitor themselves and, if they have symptoms, to call a number; each state is allowed only one number.
    - The number for California will be the Office of Emergency Services Warning Center, which will contact the CDPH duty office and their on-call Ebola consultant. The provider needs to be included in the notification and the CDPH plans to intervene.

Dr. Backer stated there may be confusion to EMS and providers that one out of the three countries is cleared, but there is a need to maintain vigilance and protocols and be ready to deal with patients that are under investigation.

Commissioner Koenig stated the need to look more broadly than just Ebola and prepare for other serious infectious diseases like the Middle East Respiratory Syndrome (MERS).

## EMS Compass

EMS Compass is the new name for the Performance Improvement Project, funded by the Department of Transportation and National Highway Traffic Safety Administration, led by the National Association of EMS Officials and the CHHS.

More than four hundred suggestions of measures were submitted across ten domains of measures, during the open public submission period. EMSA submitted our Core Measures, which focus on interventions with a strong evidence base of improving patient outcomes.

There is still no plan for implementation. The performance measures are the future for EMS, but it will be at least another year for the initial measures to be completed.

## Air Ambulance

The Federal Aviation Administration (FAA) has further clarified its rules about medical regulation of air ambulance.

EMS oversees anything medical, such as staff, equipment, and protocols, but cannot regulate price or routes – that is the purview of the FAA.

EMSA interprets this to mean that local jurisdictions cannot create exclusive operating areas for air ambulance; however, dispatching air medical transport remains under medical control.

Tom McGinnis, the Chief of the EMS Systems Division, provided additional details: the Department of Transportation (DOT) issued the Guidelines for Use and Availability of Helicopter Emergency Transport (HEMS), in April of 2015, related to Airline Deregulation Act Section 41713. The DOT stated they believe, when a vehicle leaves the ground, they have regulatory control, including the the aspects of flight – the rates, route, and services provided. However, they support EMS control of the staff and medical equipment within the vehicle.

Commissioner Rudnick asked Mr. McGinnis to send the document to Commissioners.

**Introductions**

Dr. Backer introduced Marco Mijic, the new assistant secretary at CHHS.

He asked EMSA staff in attendance to introduce themselves.

## 4. CONSENT CALENDAR

**Action: Commissioner Teter made the motion to approve the consent calendar. Moved (Teter). Second (Hartwig). Motion carried. The item was noted and filed.**

## REGULAR CALENDAR

## 5. EMS PERSONNEL

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

**Community Paramedic**

Mr. Meyer showed Commissioners the dashboard that he sends to Dr. Backer and OSHPD monthly. OSHPD authorized three pilot sites to implement on the first of June: Butte County with the Post-Discharge Pilot Project, Ventura County with the TB Directly-Observed Treatment Protocols, and Alameda County with the Alameda City Fire Department Post-Discharge Project.

UCSF has filed the Baseline Data Report with OSHPD. All core training has been completed, and that report has also been filed with OSHPD and with the California Health Care Foundation (CHCF). The dashboard also shows pilot projects that are pending approval. Site-specific training is in progress in the UCLA, San Diego, and Solano County projects. Six IRBs have been approved; another six are waiting for the data collection implementation tool. Pilot project 12 in Stanislaus County is in the process of resolving a perceived EMTALA issue.

Mr. Meyer hoped to implement two more pilot projects by the first of July, and the remainder in August.

Commissioner Lieser asked if projects 4, 5, and 7 are OSHPD-approved. Mr. Meyer confirmed that those projects have been implemented. Project 4 has approval to move forward.

Sean Trask, the chief of the EMS Personnel Division, presented his report:

## Trial Studies

There have been three additional trial studies since the March Commission meeting. Santa Barbara County is studying the efficacy of a supraglottic airway, called the Air-Q, in a pre-hospital setting. Ventura County has begun to enroll patients.

The Inland Counties started their tranexamic acid (TXA) trial study and started enrolling patients in March 2015, and Riverside and Alameda are expanding the trial study into their jurisdictions. The TXA will be administered to patients who have signs and symptoms of hemorrhagic shock, and who also meet trauma triage criteria.

## Epinephrine Auto-injector Regulations

EMSA has convened a work group and drafted regulations to allow for training and certification for laypersons to obtain an epi auto-injector for use on the public. The draft regulations are out for the third public comment period.

## EMT Regulation Revisions

- The EMS Authority has convened a working group to assist with revising the EMT Regulations. The working group has come up with some creative ideas on which Mr. Trask would like to hear feedback from the Commission.
- The major highlights to this revision are:
    - Remove the skills competency form and require six hours of skills related continuing education to be included in the 24 hours of continuing education required for recertification. The EMS Authority is hearing concerns from local EMS agencies that EMTs are not being evaluated in required skills performance.
    - Incorporate mandatory training in the administration of naloxone as required in SB 1438. The working group suggests mandatory training in the use of epinephrine auto-injectors and drawing up the correct dose of epinephrine from vials, as well as mandatory training in the use of glucometers.
    - The administration of naloxone and epinephrine and the use of a glucometer would require local EMS agency approval.
    - Substituting 25% of EMT clinical training hours with high fidelity simulation, where available. The operators of these simulation labs are able to create various scenarios and complications that provide valuable training. EMT students would still be required to complete 18 hours of clinical training, even if a simulation lab is available.

Commissioner Johnson stated, while he is not opposed to epinephrine auto-injectors, he is opposed to members of the public drawing epinephrine from a vial because it is produced in different concentrations and usually given under stressful situations.

Commissioner Rudnick agreed. He asked how high fidelity sim labs can be standardized. There is value in live patient evaluation. He spoke in opposition to the removal of the skills sign-off form and stated that EMTs need to be evaluated in their skills.

The EMS Authority anticipates releasing the proposed changes to the EMT Regulations by July 1st

## 6. EMS SYSTEMS

### Wireless 9-1-1 Routing Status

Karen Wong, the Assistant Director of Public Safety Communications with Cal OES, stated Public Safety Answering Points (PSAPs) cannot always locate the 9-1-1 cellular phone caller. Ms. Wong reviewed the current technology limitations, the need for improved location accuracy, which is currently at 50 percent, the FCC's regulatory responsibility to resolve this issue, the FCC's solution to give wireless carriers eight years to correct the problem, and Cal OES's determination to find a better solution.

**Next Generation 9-1-1**

- Improves location accuracy
- Calls go to the nearest responding agency within jurisdictional boundaries
- Location accuracy pilot project
    - Prior project identified potential savings of 100 hours in six months of transfer time

Commissioner Rudnick asked about the timeline. Ms. Wong clarified that it meant that, in those 100 hours, the calls to the responding agencies had location accuracy.

Commissioner Rudnick asked when Next Generation will be available to Californians. Ms. Wong stated it will take five years to roll Next Generation out to the 451 PSAPs.

Commissioner Koenig stated the Commission is extremely concerned about this unacceptable situation. She suggested that the individuals and organizations that have solution options present their ideas to the Commission for input. Ms. Wong agreed and welcomed all input. She suggested that Commissioners attend the 9-1-1 Advisory Board meetings in person or by webinar to give public comment.

Ms. Wong stated a second issue is the cellular 9-1-1 calls that go directly to the CHP instead of the primary PSAPs. There are 278,000 cell sectors and 130 cell towers in California. Within a cell sector with more than one jurisdiction, only one PSAP can be selected to take the 9-1-1 calls. Under the Public Utilities Code, the CHP answers all wireless 9-1-1 calls not accepted by PSAPs. A statewide call data system called ECATS has been put in place to instead route 9-1-1 calls to the closest PSAP.

ECATS includes reporting devices to monitor the number of transfers at any cell sector. If the CHP is transferring more calls than they are responding to, the CHP may change the cell sector over to the local PSAP. Within the last two months, 200 of the 400 cell sectors that have been reviewed have been transferred to local PSAPs.

Commissioner Koenig asked what happens to a call that never gets through to be transferred. Ms. Wong stated the ECATS data shows all unanswered calls, as well. The 2007 project led to a decrease in unanswered calls from 42 percent to 1 percent. As far as looking at cell sectors, the 451 PSAPs will be able to access that data in addition to the CHP, leading to a statewide solution.

Commissioner Rudnick asked how long it takes the CHP to examine cell sectors, as 400 out of 300,000 is a small percentage. Ms. Wong stated it took 45 days to look at 400 cell sectors. It will take less than a year to evaluate every sector.

Commissioner Margulies asked how the Commission can help. Ms. Wong suggested increasing outreach to wireless carriers and partnering with the 9-1-1 community. ECATS will lessen the number of PSAPs that have transferred calls, but eliminating this issue will require changing technology.

Chairman Stone asked for information on a point person for Verizon and AT&T to invite to present at an EMSA meeting. He asked if the EMS community is represented on the 9-1-1 Advisory Board. Ms. Wong stated, since the Board is identified through the state, there is no EMS representative, but there is a fire chief. Legislation would need to be changed in order to require EMS representation.

**Action: Commissioner Koenig made the motion that the EMS Commission request a regular report from the OES at each Commission meeting on the status of wireless 9-1-1 call routing and that the Commission be given the opportunity to review and provide input on proposals for solutions at the next EMS Commission meeting. Moved (Koenig). Second (Smith). Motion carried.**

**Monthly reports were suggested, but Dr Backer said that this was not feasible or reasonable, since little changes that quickly. In addition, EMSA could not ask Karen Wong to travel to all the Commission meetings. Dr Backer will discuss the request with Ms Wong.**

Tom McGinnis, the chief of the EMS Systems Division, presented his report:

**EMSA Plan Appeal Process – Emergency Regulations**

The public comment period has been extended. This issue will be brought before the Commission for approval in the September meeting.

**EMS Systems Regulations (Chapter 13 Workgroup)**

The work group continues to go through the complicated issues in this set of regulations.

**EMS Plan Submission, EMSA #101 Exemption Request**

Mr. McGinnis suggested that the five-year-plan requirement only apply to EMS agencies that have not submitted annual plans to EMSA or to newly formed LEMSAs. He suggested streamlining the process for efficiency for EMSA and EMS agencies by exempting that section for EMS agencies that already submit their annual plans to EMSA.

Staff's recommendation is to approve exception to EMSA #101, EMS Systems Guidelines Part III, EMS Planning, June 1994 edition.

**Action: Commissioner Burch moved approval of the staff recommendation. Commissioner Rudnick seconded. Motion passed unanimously.**

## 7. DISASTER MEDICAL SERVICES DIVISION

Lisa Schoenthal, chief of the Disaster Medical Services Division, presented her report:

### Disaster Healthcare Volunteer Program

Ms. Schoenthal provided an overview of the role, number, and affiliations of the verified licensed professions of the volunteers in the Disaster Healthcare Volunteers Program.

EMSA held field exercises with the Disaster Health Care Volunteers and Medical Reserve Corps units in 2012 and 2013 through the use of competitive grants. These grants are no longer available, which has created a gap in the program. The program was named a national model by the DHHS.

### Disaster Medical Response Training and Exercises

Most of the exercises held this year were tabletop or emergency operation center exercises, with the exception of the national Urban Search and Rescue (US&R) exercise that was held at Moffett Field June 3rd through 5th. This is the third consecutive year that the California Medical Assistance Team (CAL-MAT) unit was at the exercises to support US&R activities.

The incident commander announced to the over 200 representatives present that, of all the state medical assistance teams that they interface with around the country, they have the most positive working relationship with CAL-MAT, which substantiates the need to stabilize this program. Ms. Schoenthal stated she received support at the legislative hearing to restore the full-scale field exercise of the Mobile Medical Assets Program with the use of Homeland Security grant funds.

## 8. BYLAWS UPDATE

Mr. Trask suggested that this item be tabled until the appeal regulations are approved. He asked Commissioners to email comments on the draft bylaws to staff.

## 9. ITEMS FOR NEXT AGENDA

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

## 10. PUBLIC COMMENT

There were no questions or comments from the public.

## 11. ADJOURNMENT

Chairman Stone thanked Robin Robinson on behalf of the Commission for her work as the executive assistant to the director. He wished her well in her new position working with Mr.Trask.

**Action: Commissioner Rudnick moved to adjourn the meeting. Commissioner Haskins seconded. Motion passed unanimously.**

Chairman Stone adjourned the meeting at 12:02 p.m.

**Emergency Medical Services Authority**
**Disaster Medical Services Division**
**Major Program Activities**
**September 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 | 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. Information regarding the AST Program can be found at: http://www.emsa.ca.gov/Ambulance_Strike_Team.<br><br>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. |
| **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. 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 a bi-annual inventory maintenance on all three CAL-MAT caches and is currently in the process of acquiring contract services to perform annual maintenance on the biomedical equipment. 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)** | Lisa Schoenthal, ext. 463 | 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**
**September 2015**

| Activity & Description | Primary Contact EMSA (916) 322-4336 | Updates |
|---|---|---|
| **7. Disaster Healthcare Volunteers (DHV) of California (California's ESAR-VHP program): Registering, Credentialing & Mobilizing Health Care Personnel** | Patrick Lynch, ext. 467 | The DHV Program has over 21,000 volunteers registered. Over 18,500 of these registered volunteers are in healthcare occupations.<br><br>All 58 counties have trained System Administrators. EMSA provides routine training and system drill opportunities for all DHV System Administrators.<br><br>Over 8,000 of the 21,000 DHV registered responders are Medical Reserve Corps (MRC) members. EMSA trains and supports DHV System Administrators in each of the 39 participating MRC units.<br><br>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.<br><br>DHV System Administrator training, DHV user group webinars, and quarterly DHV drills are ongoing.<br><br>EMSA publishes the "DHV Journal" newsletter for all volunteers on a tri-annual basis. The most recent issue was released on May 11, 2015.<br><br>The DHV website is: https://www.healthcarevolunteers.ca.gov.<br><br>The DHV Deployment Operations Manual (DOM) is available on the EMSA webpage: http://www.emsa.ca.gov/Media/Default/PDF/DHV_DOMRevisionFebruary21-2012.pdf.<br><br>The "DHV Journal" is available on the DHV webpage of the EMSA webpage: http://www.emsa.ca.gov/disaster_healthcare_volunteers_journal_page. |

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

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| **8. Exercises and Training** | | |
| • **Weapons of Mass Destruction (WMD)** | Bill Campbell, ext. 728 | 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. |
| • **Medical Health Operations Center Support Activities (MHOCSA)** | Bill Campbell, ext. 728 | 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 late 2015. |
| **Statewide Exercises:**<br>• **California Capstone 2015 - 2016** | Bill Campbell, ext. 728 | California Capstone 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 After Action Report is currently in process. |
| • **2015 Statewide Medical and Health Exercise (2015 SWMHE)** | Nirmala Badhan, ext. 1826 | 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. |
| **9. Hospital Available Beds for Emergencies and Disasters (HAvBED)** | Nirmala Badhan, ext. 1826 | EMSA continues working with the California Department of Public Health (CDPH) and other partners to integrate hospital data collection that meets federal HavBED requirements. |

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| **10. Hospital Incident Command System (HICS)** | hics@emsa.ca.gov | 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.<br><br>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.<br><br>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. |
| **11. Medical Sheltering** | Bill Campbell, ext. 728 | 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." |
| **12. Mission Support Team (MST) System Development** | Michael Frenn, ext. 435 | 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 use of their employees when deployed by EMSA on an MST. |

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

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| **13. Response Resources** | Craig Johnson, ext. 4171 | 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. The RRU has begun conducting audits on the 41 DMSU vehicles located around the State. During the audit, EMSA will verify that all the DMSU vehicles are being properly maintained and utilized according to written agreements. The biomedical equipment for the California Medical Assistance Teams (CAL-MAT) caches are due to be serviced. The RRU is currently working to elicit contractor support and will begin the work this quarter. General annual maintenance for generators and fleet vehicles are underway. |
| **14. Regional Disaster Medical/Health Specialists (RDMHS) Program and Medical Mutual Aid System** | Nirmala Badhan, ext. 1826 | 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 wildfires throughout California. |
| **15. Mobile Field Hospital (MFH) Program** | Craig Johnson, ext. 4171 | Three 200-bed MFHs are being stored in Sacramento, California. Due to a loss in program funding the MFHs are no longer considered 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 rsources. Although the MFH program is without funding, EMSA continues to try to identify alternatives to sustain this valuable program without stressing the State budget. |
| **16. Medical Reserve Corps (MRC)** | Sheila Martin, ext. 465 | 39 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 8,000 of the DHV Program's 21,000 volunteers are Medical Reserve Corps volunteers. 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. |

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

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|---|---|---|
| **17. Statewide Emergency Plan (SEP) Update** | Lisa Schoenthal, ext. 463 | 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 is 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** | Jody Durden, ext. 702 | The Statewide Patient Movement Workgroup met on July 22, 2015. Task groups have been collecting and providing information specific to the disciplines they represent, such as MHOACs, RDMHSs, hospitals, LEMSAs, and EMS providers. The consultant has moved forward from the research phase of the plan to the writing phase with the expectation of a completed draft plan for the workgroup to review by October 2015. |
| **21. Bay Area Catastrophic Earthquake Plan** | Bill Campbell, ext. 728 | EMSA is participating as part of the Medical Planning Group for this plan revision. |
| **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. |

| ACTIVITY | PRIMARY CONTACT | STATUS/COMMENT |
|---|---|---|
| 1. First Aid Practices for School Bus Drivers | Lucy Chaidez Extension 434 | There are 10 school bus driver programs currently approved. Renewal reviews are ongoing. |
| 2. Child Care Provider First Aid/CPR Training Programs | Lucy Chaidez | There are 26 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 | There are 25 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 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 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 | 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 3 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. There is one Layperson AED program reviewed and in approval process currently. AED bill recently analyzed and in Assembly-In Floor Process-Third Reading |
| 6. BLS Training and Certification Issues | Betsy Slavensky | Providing ongoing daily support and technical assistance. EMSA has convened a regulatory workgroup to revise the EMT regulations, implementing SB 1438 which requires the addition of naloxone training and scope of practice addition for all EMTs. Clarification of the certification and recertification process is being addressed in revising the regulations to assist certifying entities and reduce time spent on technical support. EMSA has recently approved three online NREMT Transition courses that have been publicized on the website, via email to Central Registry users, LEMSA Administrators and Coordinators. |
| 7. State Public Safety Program | Betsy Slavensky | Provide ongoing monitoring of State Public Safety EMSA approved Public Safety First |

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| Monitoring | | Aid, EMR, and EMT programs for statutory and regulatory compliance. Follow up correspondence regarding upcoming expiration dates and expired programs. These include reference to the new PSFA regulations effective 4/1/2015 and required implementation (with prior program approval) by 4/1/2017. |
| 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. Databases have been created to track and pull stats for certification & discipline issues or non-compliance. Procedures are being developed in relation to certification and discipline. A Procedures workgroup was formed recently consisting of representatives from certifying entities volunteering to assist in procedure review prior to implementation. Procedures, and support material are posted on the website, in the Newsletter and sent via email to all Registry users and LEMSA Coordinators. |
| 9. Epinephrine Auto-injector Training and Certification | Corrine Fishman Extension 927 | EMSA developed draft regulations establishing training standards and certification for lay rescuers in the use and administration of epinephrine auto-injectors. The public comment period has been completed and the regulation text will be presented to the EMS Commission at the September 2, 2015 meeting for approval. Upon Commission approval the regulations will be sent to the Office of Administrative Law for review and approval. EMSA is anticipating a January 2016 effective date. |

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| 1. Trauma: | Bonnie Sinz<br>Extension<br>460 | <u>State Trauma Advisory Committee (STAC):</u><br>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.<br><br><u>Regional Trauma Coordinating Committees (RTCC)</u><br>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 <u>www.emsa.ca.gov</u><br><br><u>Performance Improvement and Patient Safety (PIPS) Subcommittee</u><br>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 CEMSIS. 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.<br><br><u>Regional Trauma Network for Re-Triage Subcommittee</u><br>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.<br><br><u>Trauma Centers</u><br>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 |

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| | | 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 are working on the STEMI and Stroke drafts of regulations and responding to the comments from the Regulations taskforce members and match the language with the latest edition of California Rulemaking Law. Next step is submission to the OAL, estimated in 3rd quarter of 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. |
| 4. EMS Transportation | Laura Little Extension 412 | <u>EMS Systems Regulations Work Group / Chapter 13 Task Force :</u><br>Since July of 2012, the EMS Authority meets monthly with individuals who have specific knowledge of HSC 17977.224/201 and the AB1387. The Chapter 13 work group 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.<br><br><u>Request for Proposals</u>:<br>Request for Proposals (RFPs) for Exclusive Operating Areas are going 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 is providing technical assistance to LEMSAs by email, phone, and mail in order to help them create a RFP that meets all required criteria.<br><br><u>Bi-Annual Statewide Public Safety Air Rescue Inspections</u>:<br>At the beginning of 2015 the California National Guard began the accreditation/approval process to be a California recognized and Sacramento County approved ALS Rescue provider. The inspections of medical equipment took place on May 8, and June 15, 2015. |

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| | | On May 12, 2015, EMSA conducted their first inspections of the CAL FIRE helicopters, in Hemet and Columbia. EMSA is attempting 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 | The EMS Authority continues to review EMS Plans and annual updates that have been submitted by the LEMSA's. In July the EMS Systems Division contacted each LEMSA to advise them of the 5 –year 'Full Plan' submission exemption approved by the EMS Commission in June 2015 and continues to make itself available for technical assistance and general questions regarding EMS Plans.<br><br>The EMS Authority recognizes that the submission and development of EMS plans can be difficult at times. We are working on considerations for revising the entire EMS plan process and will be engaging EMSAAC in the coming months to assist us in this effort. |
| 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. |

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| | | 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.<br><br>The next EMS for Children Educational Forum in northern California is scheduled for November 5, 2015 in Sacramento at the Doubletree by Hilton Hotel. |
| 8. CEMSIS-EMS Data | Maria Alisangco Extension 742 | 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. |
| 9. CEMSIS – Trauma Data | Bonnie Sinz Extension 460 | 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. |
| 10. Grant Activity Coordination | Kim Lew Extension 415 | On 07/01/15, the Grant Coordinator submitted grant agreements for the following two OTS grant funded projects: GIS System and Data NEMSIS Transition. On 07/08/15, the grant coordinator, along with several other EMSA personnel, met with OTS to discuss current OTS grant funded project activities as part of their Grantee Performance Review (GPR). In July, the Grant Coordinator submitted the FFY15 3rd quarter progress report to OTS. EMSA OTS funded programs continue to meet the objectives of the grant. |

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| | | On 07/01/15, the Grant Coordinator submitted the required SFY 15/16 PHHFBG semi-annual progress report to CDPH that summarized all high-level grant program, and LEMSA grant funded project, activities for the past six (6) month reporting period. With only three (3) months left in the current federal fiscal year, EMSA Systems division program grant objectives have been met.<br><br>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.<br><br>The Grant Coordinator attended specialized Grant Management training on 07/22/15 – 07/23/15 hosted by the CDHCS.<br><br>EMSA has recently filled the position of a limited-term, full-time Grant Coordinator. The Grant Coordinator is responsible for the research, acquisition, coordination, and monitoring of grant- funded projects and programs. The three (3) major grants currently funding EMSA System programs are: the US Health & Human Services/ Prevention & Public Health Fund (PPHF), CA. Office of Traffic Safety (OTS), and the US Health Resources and Services Admin. (HRSA).<br>Over the past 4 months, the Grant Coordinator has accomplished the following:<br>- submitted 2 FFY15 grant applications to the CA. Office of Traffic Safety (OTS)<br>- submitted 1 FFY15 grant application to the U.S. Health & Human Services/ Prevention & Public Health Fund (PPHF)<br>- -completed 1 FFY14 annual report to OTS<br>- completed 1 FFY14 annual report to PHHF<br>- completed 1 FFY14 semi-annual report to PHHF<br>- submitted 8 FFY14 program success stories for publishing consideration to PHHF<br>- reviewed 8 LEMSA grant proposals for local EMS program pilot projects funded by PHHF<br>- developed 5 contract agreements w/LEMSAs to conduct the pilot projects (KL, |

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| | | 02/04/15)<br><br>The grant coordinator is currently reviewing mid-term progress reports received from the four local EMS Agencies that received Prevention & Public Health Funding (PPHF) for QI, Data, or HIE projects and are in the process of completing revisions to the SFY 15/16 (FFY 15) PPHF State Work Plan for submission to the Department of Public Health (CDPH).<br><br>The grant coordinator has submitted the 2nd quarter Office of Traffic Safety (OTS) progress report to OTS and will be participating in a Grantee Performance Review (GPR) meeting or conference with OTS soon. |
| 11. Communications | Kim Lew<br>Extension 415 | The Communications Coordinator reviewed five (5) LEMSA Communication plan submissions. The Coordinator provided letters of support to two (2) local EMS providers for the use of emergency medical radio frequencies.<br><br>California EMS Authority personnel attended the FirstNet, First Responder Network Authority, regional consultation workshop Monday, July 28th, 2015 – July 30th, 2015 in Sacramento, California.<br><br>This program was recently assigned to a new EMSA staff member. EMSA staff attended the Northern California Chapter of the Association of Public-Safety Communications Officials (NAPCO) meetings on January 8th and February 12th, 2015. Due to significant advancements in communication technologies, EMSA recognizes the need to update its EMS Communications Plan and Emergency Medical Services Dispatch Program Guidelines. As a result, the Coordinator is reviewing both documents to develop draft recommendations for revisions.(KL, 02/04/15)<br><br>Recent inquiries and interest in wireless 9-1-1 routing location accuracy has developed resulting in EMSA staff attendance at a Joint Legislative Committee on Emergency Management Hearing on 04/09/15. EMSA personnel are working with the Office of Emergency Services (OES) to address public concerns and will |

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| | | be developing a presentation regarding the matter for the Commission.<br><br>The EMSA Communications Coordinator has completed an initial review of the EMSA Emergency Medical Services Dispatch Program guidelines in preparation for revisions.<br><br>The communications coordinator attended the Western Regional Association of Public Safety Communications Officials (NAPCO) conference April 8-10th, 2015. |
| 12. Core Measures | Adam Davis Extension 409 | EMSA has received core measure reports from the participating LEMSAs and has begun to consolidate the information submitted. Similar to years prior, EMSA will develop this information into a report containing summary tables and charts for each of the clinical measures. The document will include commentary on the challenges and barriers to success faced by the EMS Providers, LEMSAs, and EMSA during this year's project. The report will be shared with the LEMSAs and will be published on EMSA's website no later than July 15, 2015.<br><br>Due to late submissions of Core Measure Reports from LEMSAs, the development and publishing of the 2014 data report has been pushed back. EMSA has developed a draft report for internal review and will be sharing the document with the LEMSAs prior to publishing on EMSA's website. |
| 13. HIE | Kathy Bissell Extension 464 | The 2014 EMSA HIE Summit November 17th – 19th, 2014 is moving forward as planned. The event will include several national level speakers as well as a pre-summit "Boot Camp" that is an introductory course to HIE. EMSA staff have begun planning and publicizing the "HIE in EMS" summit and pre-summit informational meeting. Information related to HIE activities, including the "HIE in EMS Summit" can be found at: http://www.emsa.ca.gov/HIE. |
| 14. EMS Plan Appeal Regulations | Teri Harness Extension 462 | The appeal regulations were amended based on public comments received during the 45-day comment period and the April 27, 2015 public hearing. A 15-day public comment period was held based on the changes. All comments have been addressed and the regulations are ready for Commission review and |

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| | | approval. |

**COMMISSION ON EMERGENCY MEDICAL SERVICES**
10901 GOLD CENTER DRIVE, SUITE 400
SACRAMENTO, CA 95670-6073
(916) 322-4336 FAX (916) 324-2875

**DATE:** September 2, 2015

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP
Director

**PREPARED BY:** Jennifer Lim, Deputy Director

**SUBJECT:** Legislative Report

## RECOMMENDED ACTION:

Receive information regarding EMS-related legislation.

## FISCAL IMPACT:

None.

## DISCUSSION:

Due to the dynamic nature of the legislative process, the Legislative Report to the Commission on EMS will be posted on the EMSA website at http://www.emsa.ca.gov/current_legislation. Copies of the printed Legislative Report will also be available at the Commission Meeting on September 2, 2015.

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

**DATE:** September 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**

**2015/16**

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. Workload budget adjustments and policy adjustments enacted include the following items:

- A General Fund augmentation of $500,000 and 2.0 permanent positions to stabilize disaster medical preparedness resources to respond to a moderate incident and initially respond to a catastrophic incident. The additional funding and new positions will be utilized to reestablish the southern California component of the California Medical Assistance Team (CAL-MAT), support existing disaster medical preparedness programs [Ambulance Strike Team (AST) Program, CAL-MAT Program, Training and Exercise Program], and coordinate joint activities with the California Department of Public Health's Emergency Preparedness Office (EPO), including Catastrophic Event Planning, and Emergency Operations Center (EOC) planning and development.

- A Special Fund (EMS Personnel Fund) budget authority augmentation of $366,000 and one permanent full time Office Technician (OT). The additional budget authority and new position will be utilized to address increased workload associated with the document imaging of paramedic licensure and enforcement files. There exists sufficient revenue within the EMS Personnel Fund to fund this request while still maintaining a 5% reserve as required by statute.

On July 7, 2015, the Department received a preliminary allocation letter and is awaiting 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 Health Information Exchange (HIE), EMS system data and quality improvement, Ambulance Exclusive Operating Area evaluations, and trauma system, planning, and enforcement activities.

On July 28, 2015, the Department received a NOGA in the amount of $2.75 million from the Office of National Coordinator for HIT (ONC) to implement HIE in day to day EMS plus disasters. The project includes three (3) major milestones: Adoption, Interoperability, and Exchange.

Accounting data for the new Fiscal Year is not yet available as the Department is migrating to the new statewide Financial Information System for California (FI$Cal Project) which will house all Accounting, Budget, and Procurement functions. We are continuing to monitor and adjust both State Operations and Local Assistance budgets to meet changing program priorities. An updated report will be distributed prior to the next Commission meeting.

**2014/15**

As of June 30, 2015, the EMS Authority has expended and/or encumbered $20.5 million or 67.3% of available budget authority. Currently, program expenditures and encumbrances are being adjusted and updated due to year-end closing. When revised expenditure data is received and analyzed, an updated report will be compiled and distributed prior to the next Commission meeting.

## EMS Authority Staffing Levels

The EMS Authority is authorized 71 positions and also has 19 temporary (blanket positions and retired annuitants) positions for an overall staffing level of 90. Of the 90 positions, 3 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 | 14.0 | 21.0 | 27.0 | 9.0 | 71.0 |
| Salary Savings | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Authorized Total** | **14.0** | **21.0** | **27.0** | **9.0** | **71.0** |
| Temporary Staff | 7.0 | 3.0 | 4.0 | 5.0 | 19.0 |
| **Overall Staffing Level** | **21.0** | **24.0** | **31.0** | **14.0** | **90.0** |
| Vacant | 0.0 | -2.0 | -1.0 | 0.0 | -3.0 |
| **Current Staffing Level** | **21.0** | **22.0** | **30.0** | **14.0** | **87.0** |

Enclosures

*Emergency Medical Services Authority*
*FY 2014/15 - as of June 30, 2015*
*Note: 100% of the FY has elapsed*

## Budget Authority: Expenditure Analysis

| | Budget Authority | Program Expenditures: Expended | Program Expenditures: Encumbered | Program Expenditures: Total | Balance of Authority | % Expended |
|---|---|---|---|---|---|---|
| ***Department*** | **$ 31,533,000** | **$ (19,615,000)** | **$ (1,604,000)** | **$ (21,219,000)** | **$ 10,314,000** | **67.3%** |
| ***State Operations*** | **$ 13,927,000** | **$ (10,024,000)** | **$ (782,000)** | **$ (10,806,000)** | **$ 3,121,000** | **77.6%** |
| **EMS Personnel Fund (0312)** | $ 1,992,000 | $ (1,909,000) | $ (83,000) | $ (1,992,000) | $ - | 100.0% |
| **EMT Certification Fund (3137)** | $ 1,315,000 | $ (1,224,000) | $ (19,000) | $ (1,243,000) | $ 72,000 | 94.5% |
| **Federal Trust (0890)** | $ 2,761,000 | $ (1,964,000) | $ (393,000) | $ (2,357,000) | $ 404,000 | 85.4% |
| **General Fund (0001)** | $ 1,213,000 | $ (481,000) | $ (97,000) | $ (578,000) | $ 635,000 | 47.7% |
| **Specialized First Aid Training Program Approval Fund (3256)** | $ 135,000 | $ (75,000) | $ (2,000) | $ (77,000) | $ 58,000 | 57.0% |
| **Reimbursements (0995)** | $ 6,121,000 | $ (4,066,000) | $ (183,000) | $ (4,249,000) | $ 1,872,000 | 69.4% |
| **Training Program Approval Fund (0194)** | $ 390,000 | $ (305,000) | $ (5,000) | $ (310,000) | $ 80,000 | 79.5% |
| **Local Assistance** | **$ 17,606,000** | **$ (9,591,000)** | **$ (822,000)** | **$ (10,413,000)** | **$ 7,193,000** | **59.1%** |
| **EMS Personnel Fund (0312)** | $ - | $ - | $ - | $ - | $ - | 0.0% |
| **EMT Certification Fund (3137)** | $ 300,000 | $ (159,000) | $ (47,000) | $ (206,000) | $ 94,000 | 68.7% |
| **Federal Trust (0890)** | $ 704,000 | $ (38,000) | $ (116,000) | $ (154,000) | $ 550,000 | 21.9% |
| **General Fund (0001)** | $ 6,385,000 | $ (4,269,000) | $ (659,000) | $ (4,928,000) | $ 1,457,000 | 77.2% |
| **Specialized First Aid Training Program Approval Fund (3256)** | $ - | $ - | $ - | $ - | | 0.0% |
| **Reimbursements (0995)** | $ 10,217,000 | $ (5,125,000) | $ - | $ (5,125,000) | $ 5,092,000 | 50.2% |
| **Training Program Approval Fund (0194)** | $ - | $ - | $ - | $ - | $ - | 0.0% |

***Note: Figures are rounded. Figures in red and in paranthesis denote negative numbers.***

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

**DATE:** September 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 May 8, 2015, to August 12, 2015, the Authority issued thirty new Accusations against existing paramedic licenses, issued six Statement of Issues denying an unrestricted license, issued thirteen notices of Administrative Fine, and three Temporary Suspension Orders. Of the newly issued actions, two of the Respondents have requested that an administrative hearing be set. There are currently 20 hearings scheduled, and there are two cases awaiting a proposed decision from an administrative law judge. 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 72 active disciplinary cases in the legal office.

## LITIGATION:

The Authority is not currently involved in any litigation.

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

**DATE:** September 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 August 10, 2015, the Enforcement Unit has 5 full-time Special Investigators and 2 Retired Annuitants working as Special Investigators.

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

Cases opened since January 1, 2015, including:

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| Cases opened: | 224 |
| Cases completed and/or closed: | 220 |
| EMT-Paramedics on Probation: | 227 |

In 2014:

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

Status of Current Cases:

The Enforcement Unit currently has 110 cases in “open” status.

As of August 10, 2015, there are 32 cases that have been in “open” status for 180 days or longer; 3 Fire Fighters’ Bill of Rights (FFBOR) cases and 11 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 32 cases are divided among 7 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**
10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

**DATE:** September 2, 2015

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP
Director

**PREPARED BY:** Kim Lew
Analyst, EMS Systems Division

**SUBJECT:** Wireless 9-1-1 Routing

## RECOMMENDED ACTION:

None.

## FISCAL IMPACT:

Unknown.

## DISCUSSION:

The California Office of Emergency Services (Cal OES), Public Safety Communications division is charged with providing oversight of the California public safety 9-1-1 system. On June 17th, 2015, Cal OES Public Safety Communications Assistant Director, Karen Wong, presented a status update to the Commission on EMS 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. In response to concerns expressed by Commission members, Director Wong agreed to provide regularly scheduled status updates regarding this matter to the Committee on EMS and to the EMS Authority.

In an effort to address this issue, Assembly Bill 510, *Emergency Telephone User Surcharge* (formerly titled "*Emergency Services: 9-1-1 Emergency Communication System*"), was written requiring Cal OES to conduct a comprehensive review of the 9-1-1 emergency communications system and provide a report of its findings to the Legislature by January 1, 2017. The report shall include statewide information on the public safety answering points, available technology, funding, and equipment limitations. The bill content has been revised extensively; however, the Cal OES mandate to complete the aforementioned report remains intact. The bill is currently active in the Committee pending its first hearing. EMS Authority personnel are monitoring the status of the bill.

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

**DATE:** September 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 EMS Authority is continuing to develop a set of draft EMS systems regulations, by using a small work group of subject matter experts on California's EMS system. In late September 2014, the draft EMS Systems Regulation, Chapter 13 was sent out to the work group member's leadership for review and comment to their respective members. The last meetings were held on January 12, 2015, February 25, 2015, March 16, 2015, and a one day meeting on June 16, 2015. The subject matter expert workgroup last met on July 22, 2015.

The group is making progress on very complex issues in a positive and collaborative environment in the development of these draft regulations. 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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(916) 322-4336 FAX (916) 324-2875

**DATE:** September 2, 2015

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP
Director

**PREPARED BY:** Corrine Fishman, Program Analyst

**SUBJECT:** Epinephrine Auto-Injector Regulations

## RECOMMENDED ACTION:

Please review and approve proposed regulations regarding lay rescuer epinephrine auto-injector training certification standards for submission to the Office of Administrative Law (OAL).

## 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) has been charged with promulgating regulations providing lay rescuer epinephrine auto-injector training standards, including CPR and AED training. The regulations also authorize the EMSA to review and approve training programs that will train the lay public in the use and administration of an epinephrine auto-injector.

With this rulemaking, the EMS Authority is proposing to:

1. Specify the procedures that enable the lay person to receive certification in the use and administration of an epinephrine auto-injector to a member of the general public who is suffering from a severe allergic emergency, while also providing civil liability protection.

2. Implement, interpret and make specific Section 1797.197a of the Health and Safety Code with the addition of Chapter 1.9 of Division 9, Title 22.

Attached for your review is the final text of the regulations and public comment tables with responses from the following public comment periods.

**PUBLIC COMMENT PERIODS AND NEXT STEPS**

| | |
|---|---|
| March 6 - April 20, 2015 | Opened public comment period |
| May 16 – 30, 2015 | 15-day public comment period |
| June 10 – 24, 2015 | 2nd 15-day public comment period |
| July 1 – 15, 2015 | 3rd 15-day public comment period – no comments received |
| September 2, 2015 | Proposed regulations submitted to Commission on EMS for approval |
| October 2015 | Office of Administrative Law reviews and approves regulations |
| January 1, 2016 | Regulations become effective |

Attachments: Proposed Text of Regulations
Comment Tables

**California Code of Regulations**
**Title 22. Social Security**
**Division 9. Prehospital Emergency Medical Services**
**Chapter 1.9. Lay Rescuer Epinephrine Auto-injector Training Certification Standards**

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## Article 1. Definitions.

**§ 100044 Anaphylaxis.**
"Anaphylaxis" means a potentially life-threatening hypersensitivity or allergic reaction.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

**§ 100044.1. Approved Training Program.**
"Approved training program" means a training program that is approved by the EMS Authority to provide epinephrine auto-injector training.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

**§ 100044.2. Authorized Health Care Provider**.
"Authorized Health Care Provider" means a currently licensed health care professional who is legally authorized in California to issue a prescription for or dispense an epinephrine auto-injector to an individual who meets the requirements of Section 100046 of this Chapter.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

**§ 100044.3. Authorized Training Provider.**
"Authorized training provider" or "instructor" means an individual who is authorized by an approved training program to provide epinephrine auto-injector training as approved by the EMS Authority and who meets the requirements set forth in Section 100050 of this Chapter.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

**§ 100044.4. Automated External Defibrillator.**
"Automated external defibrillator" or "AED" means an external defibrillator capable of cardiac rhythm analysis which will charge and deliver a shock either automatically or by

user interaction after electronically detecting and assessing ventricular fibrillation or rapid ventricular tachycardia.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.5, 1797.190, 1797.196, 1797.197 and 1797.197a, Health and Safety Code and Section 1714.23, Civil Code.

**§ 100044.5. Cardiopulmonary Resuscitation.**
"Cardiopulmonary resuscitation" (CPR) means ensuring adequate circulation either spontaneously or by means of closed chest cardiac compression, establishing and maintaining an open airway, and ensuring adequate ventilation equivalent to current standards promulgated by the American Heart Association's (AHA) Guidelines for CPR and Emergency Cardiovascular Care (ECC) or the American Red Cross.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code; and Section 1714.23, Civil Code.

**§ 100044.6. Certification of Training.**
"Certification of training" means the certification card issued by the EMS Authority to an individual who satisfies the requirements outlined in Section 100046.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

**§ 100044.7. Epinephrine Auto-injector.**
"Epinephrine auto-injector" means a disposable drug delivery system with a spring-activated needle that is designed for emergency administration of epinephrine to provide rapid, convenient first aid for persons suffering from anaphylaxis.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a and Section 1714.23, Civil Code.

**§ 100044.8. Lay Rescuer.**
"Lay rescuer" means any person who has met the training standards and other requirements of this section but who is not otherwise licensed or certified to use an epinephrine auto-injector on another person.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code; and Section 1714.23, Civil Code.

**§ 100044.9. Prehospital Emergency Medical Care Person.**
"Prehospital emergency medical care person" means any of the following: authorized registered nurse, mobile intensive care nurse, nurse practitioner, nurse midwives, clinical nurse specialist, nurse anesthetists, physician assistant, emergency medical technician, advanced emergency medical technician, paramedic, lifeguard, firefighter, peace officer, or a physician and surgeon who provides prehospital emergency medical care or rescue services.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.56, 1797.80, 1797.82, 1797.84, 1797.182, 1797.183, 1797.189, 1797.197 and 1797.197a, Health and Safety Code; and Section 1714.23, Civil Code.

**§ 100044.10. Training Program Director.**

"Training program director" means the person who is designated in the application as the director and who provides oversight of the approved training program as set forth in Section 100049 of this Chapter.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

## Article 2. Certification Requirements.

**§ 100045. Application and Scope.**

(a) Upon certification by the EMS Authority as defined in Section 100044.6 a lay rescuer, or off-duty prehospital emergency medical care personnel are authorized to administer an epinephrine auto-injector to treat a person who is suffering or reasonably believed to be suffering from anaphylaxis under the following conditions:

(1) The epinephrine auto-injector is legally obtained by prescription from an authorized health care provider who may issue a prescription for an epinephrine auto-injector to a person described in this subdivision for the purpose of rendering emergency care to another person upon presentation of current and valid certification card issued by the EMS Authority, and

(2) The epinephrine auto-injector is used on an individual, with the express or implied consent of that person, to treat anaphylaxis, and

(3) The epinephrine auto-injector is stored and maintained as directed by the manufacturer's instructions for that product, and

(4) The emergency medical services system is activated as soon as practical when an epinephrine auto-injector is used.

(b) Certified persons shall make, maintain, and make available to EMSA upon request a record for five years reflecting:

(1) Dates of receipt, use and destruction of each auto-injector dispensed, and

(2) The name of any person to whom epinephrine was administered by using an auto-injector, and

(3) The circumstances and manner of disposal of any auto-injectors.

(c) The training standards prescribed by this Chapter shall apply to lay rescuers and off duty prehospital emergency medical care personnel.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code, 4119.3 of the Business and Professions Code.

**§ 100046. Certification Requirements.**

(a) An individual who meets all of the following criteria shall be eligible for certification by the EMS Authority:

(1) Successful completion of training from an epinephrine auto-injector training program approved pursuant to Section 100047 of this Chapter, and
(2) Course completion document provided by the training program and signed by the class instructor and,
(3) Current certification in CPR and AED for infants, children and adults equivalent to the current standards of the American Red Cross and/or the AHA Guidelines for CPR and ECC and,
(4) Payment of all fees pursuant to Section 100054 of this Chapter and,
(5) Submit Application for Epinephrine Auto-injector Certification form #1.9app (6/2015).
(b) Currently licensed California health care professionals including physician assistants, registered nurses, nurse practitioners, nurse midwives , clinical nurse specialists, nurse anesthetists, mobile intensive care nurses and currently licensed or certified California paramedics and advanced emergency medical technicians (AEMTs) shall be deemed to have met the requirement for training and are eligible for certification under this Chapter and may apply to the EMS Authority for a certification card using form # 1.9app (6/2015) herein incorporated by reference.
(c) California emergency medical technicians, lifeguards, firefighters and peace officers in this state who have current documentation of successfully completed training in the administration of epinephrine by auto-injector, approved by a local EMS agency or the EMS Authority, are eligible for certification under this Chapter and may apply to the EMS Authority for a certification card using form # 1.9app (6/2015).
(d) The effective date of the certification shall be the day the certification is issued by the EMS Authority.
(e) The certification card shall be valid for two (2) years from the last day of the month in which it was issued.
(f) The requirements and process for renewal of the certification are the same as that for the initial certification as described in Section 100046 (a)(1)-(5),(b) and (c).
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

## Article 3. Training Program Requirements.

### § 100047. Procedures for Training Program Approval.

(a) Prospective training programs shall submit a written request for training program approval to the EMS Authority.
(b) The EMS Authority shall receive and review the following prior to program approval:
(1) A statement verifying that the course content meets the requirements set forth in Section 100048 of this Chapter, and
(2) An outline of course objectives, and
(3) A final written and skills competency examination, and
(4) The name and qualifications of the program director, and
(5) The training program address and phone number, and
(6) A copy of the training course curriculum including any workbooks, videos, textbooks, or handouts if used in the course, and

(7) The required fees for program review, and
(8) A copy of a course completion document to be provided to students who successfully complete training which shall contain all of the following elements:
(A) The name of the training program, and
(B) The name of the individual completing the course, and
(C) The course completion date, and
(D) A signature line for the class instructor, and
(E) Course name.
(c) All program materials and student records specified in this chapter shall be subject to periodic review, evaluation and monitoring by the EMS Authority.
(d) Any person or agency conducting a training program shall notify the EMS Authority in writing within thirty (30) calendar days of any change in program director, instructor, and change of address, phone number, and contact person.
(e) Any change to the curriculum once approved, shall be submitted for review and approval by the EMS Authority and shall include the requirements of Section 100048 Subsections (a) and (b) (1)-(12) and subsection (a)(2) of Section 100054
(f) The EMS Authority may request additional materials or documentation as a condition of course approval.
(g) The requirements and process for renewal of approval are the same as that for the initial approval.
(1) The training program shall submit an application for renewal at least sixty (60) calendar days before the expiration date of their approval in order to maintain continuous approval.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

**§ 100048. Course Content Requirements.**
(a) Training in the administration of epinephrine shall result in the lay rescuer demonstrating competency in the assessment, management and administration of epinephrine to an individual suspected of having an anaphylactic reaction.
(b) The following topics and skills shall be included in the training:
(1) Common causative agents,
(2) Recognition of symptoms of anaphylaxis,
(3) Recognition of signs of anaphylaxis,
(4) Acquisition and disposal of epinephrine auto-injectors,
(5) Maintenance and quality assessment of epinephrine auto-injectors,
(6) Emergency use of an epinephrine auto-injector
(A) Indications,
(B) Contraindications,
(C) Adverse effects,
(D) Administration by auto-injector,
(E) Dosing,
(F) Drug actions,
(G) Proper storage, handling and disposal of used/or expired injectors,

(7) Consent law,
(8) Good Samaritan law,
(9) Emergency Care Plans,
(10) Activation of the EMS system by calling 9-1-1,
(11) Commonly available models of epinephrine auto-injectors,
(12) Record keeping requirement as specified in Section 100045(b).
(c) At the completion of training, the student shall successfully complete a competency based written and skills examination which shall include all the course content requirements listed in subsection (b) of this Section.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

**§ 100049. Director Requirements.**
(a) Each training program shall have a program director that shall be qualified by education and experience in methods, materials, and evaluation of instruction.
(b) Duties of the program director shall include but not be limited to:
(1) Administering the training program, and
(2) Approving course content, and
(3) Approving all written examinations and the final skills examination, and
(4) Approving all instructor(s), and
(5) Assuring all aspects of the training program are in compliance with this Chapter and other related laws.
(6) Provide to the EMS Authority a list of all instructors at least every thirty (30) calendar days or,
(7) Notify the EMS Authority of any changes to the approved instructor list within fifteen (15) calendar days.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

**§ 100050. Instructor Requirements.**
(a) Each instructor shall:
(1) Be authorized by an approved training program, and
(2) Be approved by the training program director as qualified to teach by education and experience in methods, materials, and evaluation of instruction, and
(3) Possess current certification in first aid, CPR and AED.
(b) Upon completion of each epinephrine auto-injector course the instructor shall provide the individual with a signed course completion document.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

**§ 100051. Notification of Program Approval.**
(a) The EMS Authority shall notify the training program within twenty-one (21) working days of receiving its request that:
(1) The request has been received, and

(2) The request contains or does not contain the information requested in Section 100047 of this Chapter, and
(3) What information, if any, is missing from the request.
(b) Program approval or disapproval shall be made in writing by the EMS Authority to the applying training program within sixty (60) days of receiving all application information. The training program shall complete all modifications to an application or program required by the EMS Authority before approval can be given.
(c) The EMS Authority shall establish the effective date of training program approval in writing once the training program is reviewed and found in compliance with all program requirements. The EMS Authority shall issue a certificate of approval to the training program with the effective date and an expiration date.
(d) Program approval shall be for four (4) years from the last day of the month in which the approval is given and shall be reviewed by the EMS Authority for approval every four (4) years or sooner at the discretion of the EMS Authority.
(e) Approved training programs shall notify the EMS Authority in writing, and within thirty (30) calendar days of any change in name, address, phone number, hours of instruction, or program director.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

**§ 100052. Withdrawal of Program Approval.**
(a) Failure to comply with any requirement for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provision of this Chapter may result in probation, suspension, revocation, or denial of renewal of program approval by the EMS Authority.
(b) Notification of noncompliance and action to place on probation, suspend, or revoke shall be done as follows:
(1) The EMS Authority shall notify the approved training program course director in writing, by registered mail, of the provisions of this Chapter with which the training program is not in compliance.
(2) Within fifteen (15) working days of receipt of the notification of noncompliance, the approved training program shall submit in writing, by registered mail, to the EMS Authority one of the following:
(A) Evidence of compliance with this Chapter, or
(B) A plan for meeting compliance with the provisions of this Chapter within sixty (60) calendar days from the day of receipt of the notification of noncompliance.
(3) Within thirty (30) calendar days from the mailing date of the noncompliance notification the EMS Authority shall notify the approved training program in writing, by registered mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the training program approval.
(4) If the EMS Authority decides to suspend, revoke, or place a training program on probation the notification specified in the subsection (b) (3) of this Section shall include the beginning and ending dates of the probation or suspension and the terms and

conditions for lifting of the probation or suspension or the effective date of the revocation which shall not be less than sixty (60) calendar days from the date of the EMS Authority's letter of decision to the approved training program.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

**§ 100053. Certification Card.**
(a) The EMS Authority shall issue a certification card to each individual who satisfies the requirements of Section 100046
(b) The certification card shall contain all of the following:
(1) The name of the individual completing the course
(3) The course completion date
(4) Certification expiration date
(5) Certification number
(6) The title of the card shall be listed as: Epinephrine Auto-injector Certification.
(7) The signature of the certified Section 1797.197a Responder, affirming the statement: "I understand the scope of my authority and responsibilities as a trained Section 1797.197a Responder, and will possess and only employ epinephrine consistent with that 1797.197a training and applicable law, including activation of the Emergency Medical Services System and record keeping."
Note: Authority cited: Sections 1797.107, Health and Safety Code. Reference: Sections, 1797.197 and 1797.197a, Health and Safety Code.

## Article 4. Fees.

**§ 100054. Fees.**
(a) Each epinephrine training program submitting an application for program approval shall include a fee of:
(1) Five hundred ($500) dollars for approval and re-approval of a training program.
(2) Two hundred and fifty ($250) dollars for any changes in the course content or curriculum occurring outside of the renewal period.
(b) Each individual submitting an application for certification, recertification, or request for a replacement card shall include a fee of:
(1) Fifteen ($15) dollars.
(c) All fees are nonrefundable.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

Comments on Proposed Epinephrine Auto-Injector Training Certification Standards
Chapter 1.9, Division 9, Title 22, California Code of Regulations
45-Day Public Comment Period
March 6, 2015 through April 20, 2015

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
|---|---|---|---|
| General | Karen M. Tait, M.D | I believe that if the development process for proposed regulations has not researched the legal considerations or invited the input of stakeholders, such as the medical, nursing and pharmacy boards, then the regulation development process is incomplete. I would like the assurance that these technical questions have been thoroughly addressed to assure that there is not conflict with existing statute or regulation. As a physician, I would want to be certain that prescribing epinephrine under these regulations would not be interpreted as negligent medical practice. For that reason, I would like to submit the questions below and this commentary as public comment. | Comment acknowledged.<br>No change.<br>We agree that the regulation development process should include broad stakeholder input. The Emergency Medical Services Authority convened a workgroup comprised of subject matter experts including, but not limited to, the California Medical Association, Emergency Nurses Association, California School Nurses Organization, and Conference of California BAR Association.<br>We have also separately reached out to the medical, nursing and pharmacy boards to solicit their input on the proposed regulations. |
| General | Karen M. Tait, M.D | What is the stance of the Medical Board of California regarding "good faith examination" requirement of prescribing physicians as it would apply when the prescribed epinephrine is administered by an unlicensed layperson? | Comment acknowledged.<br>No change.<br>According to the legal department of the Medical Board of California; a "good faith examination" is not required in order to prescribe an epinephrine auto-injector under Business and Professions Code section 4119.3(a)(1). A physician and surgeon may issue the prescription upon the presentation of a current certificate demonstrating that the person is |

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| | | | trained and qualified under Health and Safety Code section 1797.197a to administer an epinephrine auto-injector to another person in an emergency situation." |
| General | Karen M. Tait, M.D | What is the stance of the Boards of Registered and Licensed Vocational Nursing regarding these provisions that would allow delegation of prescribing authority to a layperson even though an LVN cannot be similarly authorized to assess a patient and initiate treatment under protocol without direct supervision from an RN? | Comment acknowledged.<br>No change.<br>Under the proposed regulations, a layperson is not delegated prescribing authority. Upon completion of a training program a layperson will receive a certification card to take to their physician where they will obtain a prescription for an epinephrine auto-injector. Health and Safety Code Section 1797.197a authorizes a layperson to administer the specified medication after completion of training and certification. |
| General | Karen M. Tait, M.D | What are the implications of this precedent that blurs the lines regarding scope of practice and use of prescription drugs? Are there clear criteria for when and how this flexibility would apply in other situations? | Comment acknowledged.<br>No change.<br>Health and Safety Code section 1797.197a differentiates between on duty and off duty medical personnel to avoid blurring scope of practice authorization and off-duty medication administration. The proposed regulations describe the requirements for lay persons and off-duty medical personnel to administer epinephrine. |

| Section/Page/Line | Commenter's Name | Comments/<br>Suggested Revisions | Response |
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| General | Gina Knight | This proposed legislation does not address the many problems that the bill has produced for many of the school nurses in California. The biggest concern is that the doctors have no indemnification and many of the doctors have refused to sign and allow the school nurses to get prescriptions for the EpiPens. Nurse practitioner and Physician Assistants can write prescriptions but I don't understand why they cannot write the scripts, it would make the process easier and give us a larger pool of people to get the prescription from. As far as the training standards go there was a group of nurses and doctors that wrote the training standards, however the Ca department of education has not adopted those standards nor will they return phone calls or emails. | Comment acknowledged.<br>No change.<br>These concerns relate to Assembly Bill 1266 which pertains to the stocking of epinephrine auto-injectors in schools and allows training by school nurses. AB 1266 is being implemented by the California Department of Education within Section 49414 of the Education Code.<br><br>Per Section 1797.197a (e) "This section shall not apply to a school district or county office of education, or its personnel, that provided and utilizes epinephrine auto-injectors to provide emergency medical aid pursuant to Section 49414 of the Education Code." |
| General | Pamela Kahn, MPH,BS,RN | There are statements in the Notice of Proposed Rulemaking that this legislation will not have a mandate on schools, but I am wondering how "lay rescuers" will be defined; could this be construed to be teachers and other unlicensed persons that are trained within the school system currently? What about the credentialed school nurses who currently train the unlicensed assistive personnel in schools – will the school nurses need to go through some certification per this proposed law?<br>There are associated costs for training | Comment acknowledged.<br>No change.<br>The lay rescuer is defined in Section 100051 of the proposed regulations as "any person who has met the training standards and other requirements of this section but who is not otherwise licensed or certified to use an epinephrine auto-injector on another person."<br>These regulations allow for any layperson to receive training and become certified to assist a member of the general public who |

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
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| | | per this law, and I would like to make sure that these do not extend to training school personnel to meet the requirements of California Education Code 49414.7, which governs the use of epinephrine auto-injectors at school sites/school related functions. | is suffering from anaphylaxis while providing civil liability protection.<br>Per Health and Safety Code Section 1797.197a (e) "This section shall not apply to a school district or county office of education, or its personnel, that provided and utilizes epinephrine auto-injectors to provide emergency medical aid pursuant to Section 49414 of the Education Code."<br>Teachers and assistive school personnel may be trained by school nurses to use an epinephrine auto-injector pursuant with the requirements of the California Department of Education. |
| General | Shana Tarter | Many training organizations have course delivery areas within and outside of California, the American Heart Association and the American Red Cross are examples. If the EMS Authority approves a training provider who operates and delivers this curriculum content within and outside of California, how will the EMS authority respond to requests for epinephrine certification if the approved training was delivered outside of California? | Comment acknowledged.<br>No change.<br>The authorizing statute is specific to California, therefore training program approval and certification is only valid in California. |
| General | Brian Morr, EMT | If a licensed health care professional needs to use an epi-auto injector to save a life, but has not applied to state | Comment acknowledged.<br>Suggestion will be adopted.<br>EMSA will revise the proposed |

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
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| | | EMS authority for the $15 card, that professional has broken the law. Breaking the law now places them in a different legal category should their actions be called into question. | regulations to eliminate the requirement and $15 fee for licensed physicians. Physician assistants, Nurse practitioners, nurse midwives and registered nurses will still be required to purchase and carry a certification card in order to obtain a prescription and have civil liability protection although additional training will not be required. Paramedics, Advanced EMTs (AEMTs) and EMTs will also still be required to purchase and carry a certification card although additional training will not be required so long as they can provide documentation of prior completion. An epinephrine auto-injector must be legally obtained by prescription from an authorized health care provider to receive civil liability protection pursuant to Health and Safety Code 1797.197a (b)(1) and Civil Code 1714.23 (b) |
| General | Brian Morr, EMT | Most professionals will probably not think to fill out the separate application and pay the $15. This working group should not place those professionals in the position of wishing they had filed the paper work and paid the $15 after the fact. | Comment acknowledged. Suggestion will be adopted. EMSA will revise the proposed regulations to eliminate the requirement and $15 fee for licensed physicians. Physician assistants, Nurse practitioners, nurse midwives and registered nurses will still be required to purchase |

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| | | | and carry a certification card in order to obtain a prescription and have civil liability protection although additional training will not be required.<br>Paramedics, Advanced EMTs (AEMTs) and EMTs will also still be required to purchase and carry a certification card although additional training will not be required so long as they can provide documentation of prior completion.<br>An epinephrine auto-injector must be legally obtained by prescription from an authorized health care provider to receive civil liability protection pursuant to Health and Safety Code 1797.197a (b)(1) and Civil Code 1714.23 (b) |
| 100055<br>Page 3, Lines 37-42<br><br>100063<br>Page 8, lines 25-28 | Brian Morr, EMT | Why should a physician licensed in the state of California need a $15 card from the state EMS Authority to carry an epi-auto injector in their "black bag" if they choose to do so? | Comment acknowledged. Suggestion will be adopted. EMSA will revise the proposed regulations to eliminate the requirement and $15 fee for licensed physicians. The proposed regulations state that the "authorized health care provider" can only provide a prescription upon presentation of a certification card. Therefore, Physician assistants,<br>Nurse practitioners, nurse midwives and registered nurses will still be required to purchase and carry a certification card in order to obtain a prescription and |

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| | | | have civil liability protection although additional training will not be required.<br>Paramedics, Advanced EMTs (AEMTs) and EMTs will also still be required to purchase and carry a certification card although additional training will not be required so long as they can provide documentation of prior completion.<br>An epinephrine auto-injector must be legally obtained by prescription from an authorized health care provider to receive civil liability protection pursuant to Health and Safety Code 1797.197a (b)(1) and Civil Code 1714.23 (b) |
| General | Brian Morr, EMT | If the physician who supervises a PA, NP, RN, Paramedic, or EMT-Advanced prescribes an epi-auto injector for emergency use, why is a $15 card from the state necessary? | Comment acknowledged. Suggestion will be adopted. EMSA will revise the proposed regulations to eliminate the requirement and $15 fee for licensed physicians.<br>The proposed regulations state that the "authorized health care provider" can only provide a prescription upon presentation of a certification card. Therefore Physician assistants,<br>Nurse practitioners, nurse midwives and registered nurses will still be required to purchase and carry a certification card in order to obtain a prescription and have civil liability protection. However, additional training will |

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| | | | not be required.<br>Paramedics, Advanced EMTs (AEMTs) and EMTs will also be required to purchase and carry a certification card although additional training will not be required so long as they can provide documentation of prior completion.<br>An epinephrine auto-injector must be legally obtained by prescription from an authorized health care provider to receive civil liability protection pursuant to Health and Safety Code 1797.197a (b)(1) and Civil Code 1714.23 (b) |
| General | Brian Morr, EMT | AED use data from airports was instrumental in showing the effectiveness of AEDs. This same data showed that off duty health professionals used the AEDs at a much higher rate than would be expected based on the population of visitors at the airports. The regulations regarding Epi Auto-Injectors should be crafted in such a way that off duty health professionals can feel as comfortable and secure in administering an Epi Auto-Injector as they feel about using an AED. | Comment acknowledged. Suggestion will be adopted. EMSA will revise the proposed regulations to eliminate the requirement and $15 fee for licensed physician. The proposed regulations state that the "authorized health care provider" can only provide a prescription upon presentation of a certification card. Therefore, Physician assistants, nurse practitioner, nurse midwives and registered nurses will still be required to purchase and carry a certification card in order to obtain a prescription and have civil liability protection. However, additional training will not be required.<br>Paramedics, Advanced EMTs |

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| | | | (AEMTs) and EMTs will still be required to purchase and carry a certification card although additional training will not be required so long as they can provide documentation of prior completion. |
| Section 100048. Cardiopulmonary Resuscitation, page 2, lines 1-6. | California Nurses Association | "the Highlights of the 2010 American Heart Association Guidelines for CPR and ECC recommend a change in the BLS sequence for A-B-C (Airway, Breathing, Chest compressions) to C-A-B (Chest compressions, Airway, and Breathing) for adults, children and infants. This fundamental change in CPR sequence will require reeducation of everyone who has ever learned CPR, but the consensus of the authors and experts involved in the creation of the 2010 AHA Guidelines for CPR and ECC is that the benefit will justify the effort"<br>It's important for the current standards to be reflected in this document since it is specifically referenced in Section 100048. In addition, "ventilation" rather than "respiration" is the accurate term for what is performed in CPR. CNA recommends the following change:<br><br>"Cardiopulmonary resuscitation" (CPR) means ~~establishing and maintaining an open airway, ensuring adequate respiration, and~~ ensuring adequate circulation either spontaneously or by means of closed | Comment acknowledged. Suggestion will be adopted. |

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| | | chest cardiac compression, establishing and maintaining an open airway, and ensuring adequate ventilation equivalent to current standards promulgated by the American Heart Association's (AHA) Emergency Cardiovascular Care (ECC) Guidelines or the American Red Cross. | |
| 100051/2/23-28 | Bruce Hayes, San Diego EMS<br>San Diego EMS | Does this apply to family and parents? should not | Comment acknowledged.<br>No change.<br>Anyone issued an epinephrine auto-injector for themselves or an immediate family member such as a child is not required to take the training or be certified. However, without certification a person may not use the epinephrine auto-injector on anyone other than the person for whom it has been prescribed. |
| 100052.<br>Page 2,<br>line 31 | California Emergency Nurses Association | Eliminate the word "authorized" | Comment acknowledged.<br>No change.<br>Under this definition the term "authorized" is specific to the prehospital environment and is defined in Health and Safety Code Section 1798.189 |
| 100052.<br>Page 2,<br>Line 34 | California Emergency Nurses Association | Eliminate "and surgeon" | Comment acknowledged.<br>No change.<br>According to the California Medical Board, physician and surgeon is the proper title. |
| 3/2/43 | Shana Tarter | Suggest including Wilderness First Aid | Comment acknowledged. |

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| 100055<br>Page 3<br>Line 43 | | (16 hours), Wilderness Advanced First Aid (40 hours) and Wilderness First Responder (80 hours) graduates. These certifications prepare graduates to provide pre-hospital emergency medical care or rescue services and have more training hours than some of the listed titles. | No change.<br>While wilderness training may include training related to allergies and anaphylaxis it does not include a certification or scope of practice and there is no state or national training standard for wilderness medicine. Because of the lack of a consistent standard, it is not possible to accept wilderness training as meeting the training standards described in the proposed regulations. |
| 3/2/43<br><br>100055.<br>Page 3<br>Line 43 and<br>Page 4<br>Line 1-2 | Shana Tarter | Strongly advocate for a system that allows all graduates of an approved epinephrine training course to apply directly to the EMS Authority for a certification card. This allows for people who take an approved epinephrine course independent of a CPR course to submit verification of both.<br>The fee could be increased for individual processing.<br>By requiring epinephrine training providers to submit entire rosters puts an unrealistic burden on the epinephrine training provider to collect CPR certifications from epinephrine training participants, some of whom may not be interested in obtaining the epinephrine certification. The collection of such certifications is difficult and might delay the submission of a roster beyond the allotted time frame. | Comment acknowledged.<br>Suggestion will be adopted. |

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| 1/2/30<br><br>100052<br>Page 2<br>Line 30 | Shana Tarter | Suggest broadening definition of pre-hospital emergency care person to include Wilderness First Aid (16 hours), Wilderness Advanced First Aid (40 hours) and Wilderness First Responder (80 hours) graduates. These certifications prepare graduates to provide pre-hospital emergency medical care or rescue services and have more training hours than some of the listed titles. | Comment acknowledged.<br>No change.<br>While the wilderness training may include training related to allergies and anaphylaxis it does not include a certification or scope of practice and there is no state or national training standard for wilderness medicine. Because of the lack of a consistent standard, it is not possible to accept wilderness training as meeting the training standards described in the proposed regulations. |
| 100054.<br>Page 3,<br>Lines 19 and 22 | California Emergency Nurses Association | destruction and disposal of auto-injector seems redundant.<br>Recommend stating it once in line 22 as proper disposal of auto-injector | Comment acknowledged.<br>No change.<br>Line 19 requires the date of destruction while line 22 requires the circumstances and manner of disposal. These requirements are found in Section 4119.3 of the Business and Professions Code. |
| 100055.<br>Page 3<br>line 45 | California Emergency Nurses Association | This gives the Local EMS agency authorization for approval but doesn't clarify this process throughout the rest of the regulations. Should this be further clarified? | Comment acknowledged.<br>No change.<br>The local EMS agency is authorized to approve the training and administration of epinephrine for public safety personnel in Chapter 1.5 and for EMTs in Chapter 2, of the California Code of Regulations Title 22. |
| Section 100054(a)(1)<br>Page 3<br>Line 10 | LA County EMS Agency | Insert after "health care provider"<br><br>"who may issue a prescription for an epinephrine auto-injector to a person described in this subdivision for the | Comment acknowledged.<br>Suggestion will be adopted. |

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| | | purpose of rendering emergency care to another person"…<br><br>This would clarify the process of how an individual would obtain the prescription and assist physicians with the change in issuance of a prescription for epinephrine auto-injectors in California.<br>HSC 1797.197a(b)(1) | |
| 2/3/9 | Shana Tarter | What consideration should be given to a provider certified to give epinephrine under this program that uses personal epinephrine or other available epinephrine not obtained by prescription with their certification card? | Comment acknowledged.<br>No change.<br>As long as the epinephrine auto-injector is legally obtained by prescription from an authorized health care provider there is civil liability protection pursuant to Health and Safety Code 1797.197a (b)(1) and Civil Code 1714.23 (b) |
| 2/3/33 | Shana Tarter | It is not clear whether the required CPR certification is at the Heart saver level or the Healthcare Provider level-both offer the stated content. Suggest Heart saver. | Comment acknowledged.<br>No change.<br>All levels of CPR/AED certification meet the requirements of the proposed regulations. |
| Section 100054<br>Page 3, Line 18 | Bruce Haynes, San Diego EMS | This should be able to delegate to provider if there is one | Comment acknowledged.<br>No change.<br>The requirement for the prehospital emergency medical personnel or lay rescuer to maintain records in the proposed regulations follows the requirements outlined in Section 4119.3 of the Business and Professions Code. |

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| Section 100055<br>Page 3, Line 37 | Bruce Haynes, San Diego EMS | Physicians are legal prescribers/users. This does not apply to them. | Comment acknowledged.<br>Suggestion adopted.<br>Physicians will not be required to obtain a certification card or pay the $15.00 fee. |
| Section 100055<br>Page 3, Line 45 | San Diego EMS | Why does a RN need a certification card? | Comment acknowledged.<br>No change<br>A physician cannot write a prescription for an epinephrine auto-injector pursuant to H&S Code 1797.197a unless an individual presents a certification card. Therefore registered nurses are required to purchase and carry a certification card in order to obtain a prescription and have civil liability protection. However, additional training will not be required. |
| Section 100055<br>Page 3, Lines 45 | San Diego EMS | It seems excessive to ask for certification if personnel is part of approved provider | Comment acknowledged.<br>No change<br>The intent of this section specific to trained EMS personnel is to verify that public safety personnel or EMTs have had training to recognize anaphylaxis and use of an epinephrine auto-injector. A physician cannot write a prescription for an epinephrine auto-injector pursuant to H&S Code 1797.197a unless an individual presents a certification card. Therefore this section of regulations permits trained individuals to bypass the training requirements and still obtain a |

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| | | | certification card. |
| Section 100055<br>Page 3, Lines 37-42 | Brian Morr, EMT | Include the following language in the regulation:<br>In the interest of public health, Physicians, Physician Assistants, Registered Nurses, Paramedics, and Advance EMTs are explicitly authorized to utilize epinephrine auto-injectors while off duty | Comment acknowledged.<br>No change.<br>The proposed regulations describe the circumstances under which off-duty prehospital emergency medical care personnel may utilize epinephrine auto-injectors. The suggested language would not add further clarity. |
| Section 100055<br>Page 3, Lines 43-45<br>Page 4, Lines1-2 | Brian Morr, EMT | Include the following language in the regulation:<br>In the interest of public health, EMTs, lifeguards, firefighters, and peace officers who have successfully completed training in the administration of epinephrine by auto-injector approved by the local EMS agency or the state EMS authority are explicitly authorized to utilize epinephrine auto-injectors while off duty. | Comment acknowledged.<br>No change.<br>The proposed regulations describe the circumstances under which off-duty personnel may utilize epinephrine auto-injectors. The suggested language would not add further clarity |
| 100055<br>Page 3 | Brian Morr, EMT | Include the following language in the regulation:<br><br>Nothing in this policy shall require the above reference professional to use a epinephrine auto-injector off duty. | Comment acknowledged.<br>No change.<br>The proposed regulations are permissive and do not create a mandate for any individual including medical professionals to carry or administer epinephrine off duty. |

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| 100055<br>Page 3, Lines 43-45<br>Page 4 Lines 1-2 | Brian Morr, EMT | Make the State EMS Authority issued epinephrine auto-injector cards optional for licensed professionals for those professionals that need the documentation to obtain an epinephrine auto-injector from a pharmacist. | Comment acknowledged.<br>No change<br>EMSA will revise the proposed regulations to eliminate the requirement and $15 fee for licensed physicians. However, the proposed regulations state that the "authorized health care provider" can only provide a prescription upon presentation of a certification card. Therefore, Physician assistants,<br>Nurse practitioners, nurse midwives and registered nurses will still be required to purchase and carry a certification card although additional training will not be required.<br>Paramedics, Advanced EMTs (AEMTs) and EMTs will also still be required to purchase and carry a certification card although additional training will not be required so long as they can provide documentation of current training. |
| 100055. Page 4, lines 7-8 | California Nurses Association | This section would seem to require that lay persons must repeat the initial course requirements every two years along with re-certification of CPR and AED training. It would be clearer, if that is the intent to state as follows:<br>(f) the requirements and process for renewal of the certification are the same as that for the initial certification <u>including evidence of successful completion of re-training from an</u> | Comment acknowledged.<br>Suggestion will be adopted. |

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| | | epinephrine auto-injector training program approved pursuant to Section 100056 of this Chapter and current certification in CPR and AED for infant, children and adults equivalent to the current standards of the American Red Cross and/or the American Heart Association Guidelines for CPR and ECC. | |
| 100055(f)<br>Page 4<br>Lines 7-8 | San Diego EMS | Does person have to repeat class each renewal? | Comment acknowledged.<br>No change.<br>Yes, a certification card is good for two years after which the training program must be retaken prior to renewal of certification. |
| 100057<br>Page 5,<br>Lines 6-7 | California Emergency Nurses Association | Would recommend combining signs and symptoms. | Comment acknowledged.<br>No change.<br>The suggestion does not add clarity to the existing proposed language. |
| 100058(b)<br>Page 5<br>Lines 43-44 | San Diego EMS | The 30 day interval is excessive and should be lengthened. | Comment acknowledged.<br>No change.<br>The specified time frame is necessary for EMSA to ensure that all instructors are qualified and approved to issue course completion documents. This will ensure that students that have completed the training will receive certification cards in a timely manner. |
| 3/5/23<br><br>100057<br>Page 5<br>Line 23 | Shana Tarter | Suggest the EMS Authority develop standard assessment tools to be used by all training providers | Comment acknowledged.<br>No change.<br>EMSA's role is to establish training standards upon which training programs develop their |

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| | | | curriculum and assessment tools. |
| 3/5/23<br><br>Section 100057<br>Page 5<br>Line 23 | Shana Tarter | Must students demonstrate competency in all models of auto-injectors? | Comment acknowledged.<br>No change.<br>Per 1797.197a (a)(2) the epinephrine auto-injector model must be a disposable drug delivery system with a spring activated concealed needle. |
| 3/5/29<br><br>100057<br>Page 5<br>Line 29 | Shana Tarter | Suggest the EMS Authority develop curriculum for the record keeping requirements and provide it to recipients with the certification cards. | Comment acknowledged.<br>No change.<br>Record keeping requirements are part of the course content. |
| 3/5/43<br><br>100058<br>Page 5<br>Line 43 | Shana Tarter | Providing updated instructor lists every 30 days seems excessive and burdensome on both the training program and the EMS Authority. Suggest changing to every 6 or 12 months, or creating an online register where changes can be made as needed. | Comment acknowledged.<br>No change.<br>The specified time frame is necessary for EMSA to ensure that all instructors are qualified and approved to issue course completion documents. This will ensure that students that have completed the training will receive certification cards in a timely manner. |
| 100059<br>Page 6,<br>Lines 10-17 | California Nurses Association | According to this proposal a person can qualify as an instructor for the administration of epinephrine by auto-injector with only approval by the training program and current CPR and AED certification. The instructor is expected to know and communicate the course content requirements listed in Section 100057 to a lay person despite no evidence that the person | Comment acknowledged.<br>Suggestion will be adopted. |

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| | | instructing the course has any more preparation than the layperson taking the course. Approval by the training program does not provide assurance that the individual has the knowledge and skills to be an instructor.<br>Current licensure as an AEMT, paramedics or someone with a higher level of training would have knowledge to impart course information and clinical expertise to supervise the lay person skills examination. Neither CPR nor AED certification prepares the instructor for training in the administration of epinephrine. At some point in time, all EMT's will be trained in the administration of epinephrine and opioid antagonist. Until such time, an EMT allowed to be an instructor should have evidence of completion of the training in administration of epinephrine in order to teach the class as well as current certification in CPR and AED. Every instructor should have current certification in CPR and AED as a minimum requirement but should also be a currently licensed EMT with evidence of having completed training for the administration of epinephrine, an AEMT with current licensure, a paramedic with current licensure, or a licensed individual with a higher level of medical training.<br>We know that EMSA wants a high level of training commensurate with the responsibility for the administration of a life-saving parenteral drug by | |

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| | | laypersons in response to anaphylaxis. Without this clear standard, it is not evident how EMSA would identify the "unqualified teaching personnel" that would result in withdrawal of program approval in Section 100061. The bar would be set so low that the meaning of "unqualified' would be limited to a layperson without first aid, CPR and AED certification. | |
| 3/6/1<br><br>100058<br>Page 6<br>Line 1 | Shana Tarter | Suggest extending the submission window from 30 to 60 days. Suggest allowing programs the option of submitting rosters or providing individual course participants with verification of training and allowing the individual participants to apply themselves if they are interested in obtaining the epinephrine certification. | Comment acknowledged.<br>Suggestion will be adopted. |
| 3/6/19<br><br>100059<br>Page 6<br>Line 19 | Shana Tarter | The roster element references year of birth, is there a minimum age requirement for certification? | Comment acknowledged.<br>Based on comments received we are eliminating the requirement for a roster. |
| 3/6/23<br><br>100059<br>Page 6<br>Line 23 | Shana Tarter | It is not clear whether the required CPR certification is at the Heartsaver level or the Healthcare Provider level- both offer the stated content. Suggest Heartsaver. | Comment acknowledged.<br>No change.<br>All levels of certification meet the requirements of this chapter. |
| 3/6/23<br><br>100059<br>Page 6<br>Line 23 | Shana Tarter | What consideration is being made for individuals with a CPR expiration date different than the epinephrine certification expiration date? For instance, will an applicant who has a valid CPR certification with one year | Comment acknowledged.<br>No change.<br>The requirement in the proposed regulations is that an individual must have a valid CPR card at the time of application to EMSA |

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| | | remaining who takes an epinephrine training valid for two years need to provide the EMS Authority a copy of a renewed CPR certification midway through their epinephrine certification cycle? | for certification. |
| 100060.<br>Page 7, Lines 1<br>and<br>Page 8 line 18 | California Emergency Nurses Association | Most training programs are approved for a period of five years. This seems more reasonable for a cost of $500 | Comment acknowledged.<br>Based on this comment and considering the established time frames for other programs approved by the EMSA we will change the approval period to four years. |
| 100062<br>Page 8,<br>Lines 5-9 | Brian Morr, EMT | Place whatever language is proposed to appear on the Epinephrine Auto-Injector Certification Card on the license card already issued to Physicians, PA's, RNs, and Paramedics. | Comment acknowledged.<br>No change.<br>Physicians will not be required to carry a certification card.<br>PA's, RNs, Paramedics, AEMTs and EMTs will be required to carry a certification card to avoid confusion between their authorized scope of practice within the EMS system and their off-duty certification. |
| 100062<br>Page 8,<br>Lines 5-9 | Brian Morr, EMT | Place whatever language is proposed to appear on the Epinephrine Auto-injector Certification Card on the certification card issued by the local EMS agency, and issued to EMTs, lifeguards, firefighters, and peace officers. | Comment acknowledged.<br>No change.<br>EMTs and public safety personnel will be required to carry a certification card to avoid confusion between their authorized scope of practice within the EMS system and their off-duty certification. |

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| 4/8/18<br><br>100063<br>Page 8<br>Line 18 | Shana Tarter | $500 may be burdensome for small training providers or well-meaning perhaps unpaid volunteer individuals attempting to serve audiences in need | Comment acknowledged.<br>Based on this comment and considering the established time frames for other programs approved by the EMSA we will change the approval period to four years which will reduce the financial burden. |
| 4/8/21<br><br>100063<br>Page 8<br>Line 21 | Shana Tarter | Suggest increasing the $15 fee to allow for processing of individual applications in lieu of course rosters. This may allow for a lesser program approval fee. | Comment acknowledged.<br>No change.<br>We feel the fee is sufficient to cover our anticipated work load and staffing costs.<br>EMSA reserves the right to increase fees based on the level of interest for this program and staffing needs. |
| 100063<br>Page8<br>Lines 25-30 | San Diego EMS | Can't apply to physician. Should not apply to an RN or person working as part of approved EMS provider. | Comment acknowledged.<br>Suggestion will be adopted to remove the need for the physician to pay a fee for a certification card.<br>RNs, EMTs, AEMTs and paramedics who have had training are not required to complete the training outlined in this chapter but must submit the fee for certification card as a prerequisite to obtain a prescription for an epinephrine auto-injector. |

Comments on Proposed Epinephrine Auto-Injector Training Certification Standards
Chapter 1.9, Division 9, Title 22, California Code of Regulations
15-Day Public Comment Period
May 16, 2015 through May 30, 2015

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| General | Brian Morr, BS,MICP | Request:<br>Please allow RN's, Paramedics and AEMTs to use epinephrine in any form. The current price of auto injectors is exorbitant. RNs, Paramedics, and AEMTs are already trained in the use of and should be allowed to carry and use: a vial of epinephrine, needle, syringe, and alcohol wipe. (cost, less than $10) | Comment acknowledged.<br>No change.<br>Per 1797.197a (a)(2) of the Health and Safety Code the epinephrine auto-injector model must be a disposable drug delivery system with a spring activated concealed needle. |
| § 100045. Authorized Health Care Provider and § 100055. Certification Requirements. | Connie Green | "Authorized Health Care Provider" means a currently licensed health care professional who is legally authorized in California to issue a prescription for or dispense an epinephrine auto-injector to an individual who meets the requirements of Section 100055 of this Chapter.<br>This definition is confusing, because it implies there are two different kinds of healthcare providers – those that can write scripts, and those that can also write scripts for the purposes layed out in these regulations.<br>This is obviously not the case. Either a provider may write a script by law, or they may not. Perhaps something like: "Authorized Health Care Provider" means a currently licensed health care professional who is legally authorized in California to issue a prescription for or dispense an epinephrine auto- | Comment acknowledged<br>No change<br>The definition suggested does not provide any more clarity then the current definition in the proposed regulations. |

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| | | injector, may provide a prescription to an individual who meets the requirements of Section 100055 of this Chapter.<br>The problem repeated in section 10055, with this confusing statement "(1) The epinephrine auto-injector is legally obtained by prescription from an<br>authorized health care provider who may issue a prescription for an epinephrine auto-injector to a person described in this subdivision for the purpose of rendering emergency care to" Perhaps 10055 should just say :" )<br>The epinephrine auto-injector is legally obtained by prescription from an authorized health care provider as defined in 100045" | |
| 100048.<br>Page 2 | California Nurses Association | Thank you for incorporating our recommendations into the modified text. This section is now compliant with the AHA Guidelines for CPR and Emergency Cardiovascular Care | General comment |
| Section 100052<br>Page 2<br>Lines 41-44 | LA County EMS Agency | Add "Physician Assistant, Nurse Practitioner and Nurse Midwife" to the definition. | Comment acknowledged<br>Suggestion will be adopted |
| 5/16/15<br>100054 (1) | Brian Morr, BS,MICP | Question:<br>Does the regulation apply to all legally obtained auto injectors? If Suzie is having an anaphylactic reaction, will the certification card allow me to use Billy's auto injector on her? (This is a real life need, as there are 4 girls in my daughter's girl scout troop with auto injectors.)(my daughters' school | Comment acknowledged.<br>These regulations allow for any layperson to receive training and become certified to use an epinephrine auto-injector on a member of the general public who is suffering from anaphylaxis while providing civil liability protection. |

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| | | has 40+ children with auto injectors) | As long as the epinephrine auto-injector is legally obtained by prescription from an authorized health care provider there is civil liability protection pursuant to Health and Safety Code 1797.197a (b)(1) and Civil Code 1714.23 (b)(c).<br>Without certification a person may only assist and may not use the epinephrine auto-injector on anyone other than the person for whom it has been prescribed. |
| Section 100052 and Section 100055 | Janette Wackerly, MBA, RN Board of Registered Nursing | The Board of Registered Nursing request where RNs are identified in the proposed Chapter 1.9 Lay Rescuer Epinephrine Auto-injector Training Certification Standards that added nurse practitioner and certified nurse midwives in the original 45 day comment period. Please add to this 15 day comment period clinical nurse specialists, and nurse anesthetists to the appropriate sections.<br><br>Business and Professions Code Section 2725 identifies RN and Business and Professions Code Section 2725.5 advanced practice registered nurse defined: means a registered nurse with BRN certification as a nurse practitioner, nurse-midwives, clinical nurse specialist, and nurse anesthetist. | Comment acknowledge<br>Suggestion will be adopted |

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| Section 100055(c)<br>Page 4<br>Line 20 | LA County EMS Agency | Add "California" prior to Emergency medical technicians.<br><br>Maintain consistency within the regulation as California is required for paramedics, registered nurses and AEMTs. | Comment acknowledged<br>Suggestion will be adopted |
| 100055.<br>Page3-4 | California Nurses Association | Thank you for incorporating our recommendations into the modified text clarifying EMSA's intent that all requirements for re-certification are the same as for initial certification and includes re-taking an approved training course. | General Comment |
| § 100055. | Connie Green | How will the trainee be able to show their CPR/AED training to the instructor? | Comment acknowledged<br>The trainee is not required to show their CPR/AED card to the instructor. A copy of a current CPR/AED card must be included with the application and other documentation sent to EMSA in order to be eligible to receive a certification card. Upon receipt of all required documentation, including proof of current CPR/AED training, EMSA will issue the individual a certification card. |
| § 100055.<br>Certification Requirements. | Connie Green | c) Emergency medical technicians, lifeguards, firefighters and peace officers in this state who have current documentation of successfully completed training in the administration of epinephrine by auto-injector, approved by a local EMS agency or the EMS Authority,<br>Is a local EMS agency allowed to have | Comment acknowledged<br>The minimum course content for training in the administration of epinephrine by auto-injector is established in regulation. EMSA does not approve the training; this is the responsibility of a local EMS agency. Although the training will not be exactly the |

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| | | potentially different training standards to those that are required by course providers? | same it will be equivalent as EMTs and public safety personnel receive more training then the lay rescuer. |
| § 100055. Certification Requirements. | Connie Green | (c) Emergency medical technicians, lifeguards, firefighters and peace officers in this state who have current documentation of successfully completed training in the administration of epinephrine by auto-injector, approved by a local EMS agency or the EMS Authority, Why are life guards considered similar to EMTs with respect to training requirements? Do they have the same qualifications? | Comment acknowledged<br>No change<br>Lifeguards are considered prehospital personnel according to Section 1797.189 of the Health and Safety Code and fall under the Public Safety First Aid and CPR regulations (Chapter 1.5, Title 22 Division 9, CCR) Lifeguards are trained at a lower level than EMTs but are part of the local EMS System. |
| 100055/page 4/line 15 | Shana Tarter | Include EMTs (formerly EMT Basic) with paramedics and AEMTs in the groups who have met the requirements for training. For more than 20 years EMTs have been trained to use auto-injectors.<br><br>In the1994 Department of Transportation EMT Basic National Standard Curriculum, EMTs were expected to have the cognitive, affective and psychomotor competencies to administer epinephrine via auto-injector.<br>The 2011 National EMS Education Standards document entitled EMT Instructional Guidelines includes the following:<br>VI. Epinephrine as a Treatment for Allergic Reaction | Comment acknowledged<br>No change<br>As long as EMTs are able to provide current documentation of having met the requirements for training they may receive a certification card. |

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
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| | | A. Indications – Severe Allergic Reaction or Hypersensitivity to Exposed Substance<br><br>B. Contraindications – Not Patient's Drug, Expired, or Discolored<br><br>C. Actions – Slows Allergic Response, Raises B/P, Dilates the Bronchioles<br><br>D. Side Effects – Increased Pulse Rate and B/P, Anxiety, Cardiac Arrhythmias<br><br>E. Auto injection Systems<br><br>1. Physician order<br><br>2. Expiration date and patient prescription<br><br>3. Prep site, remove needle cover<br><br>4. Lateral thigh; push against thigh; hold until drug fully injected<br><br>5. Monitor patient | |

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
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| | | response<br><br>6. Dispose properly | |
| 100056.<br>Page 4 | Eileen Johnson, BSN,RN,PHN | Suggest standardizing the course hours to maintain high level of training. Add to Article 3 Training Program Requirements: <u>The course shall at a minimum consist of not less than (8 hrs).</u> | Comment acknowledged.<br>No change.<br>EMSA's role is to establish training standards upon which training programs develop their curriculum and assessment tools. EMSA is moving toward an emphasis on competency based knowledge and skills rather than a number of required hours. Requiring the individual to complete a competency based written and skills examination is a more accurate way to ensure the individual is properly trained in the use and administration of epinephrine. |
| § 100056.<br>Procedures for Training Program Approval. | Connie Green | When or if best practices for responding to Anaphylaxis change, how long do the training programs have to switch to the new standards?<br><br>When a new autoinjector device is released, how long do the training programs have to update their programs? Can a person who owns an autoinjector not discussed under an approved training program be used to save a person's life under these regulations? | Comment acknowledged<br>As long as minimum course content is met, training programs may incorporate new course materials into their curriculum within the established standards once the changes have been reviewed and approved by EMSA.<br><br>Per 1797.197a (a)(2) of the Health and Safety Code the only epinephrine auto-injector model that may be used must be a "disposable drug delivery system with a spring activated concealed needle…" As long as the auto-injector device meets this |

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| | | | requirement it may be used. |
| 100057. | Lauren Dietrich Chavez | EMSA should approve the course content of the epi training and instructor training process. | Comment acknowledged<br>No change<br>EMSA's role is to establish training standards upon which training programs develop their own curriculum and assessment tools. As long as minimum course content is met, training programs may incorporate new course materials into their curriculum within the established standards once the changes have been reviewed and approved by EMSA. |
| § 100057. Course Content Requirements. | Connie Green | Please add a section on storing the Epinephrine injectors. e.g. 100057 (b) (7) Storage requirements of Epinephrine injectors should include both keeping the medication and unit stored as per the manufacturer instructions, and also to keep the unit in a location that is not easily accessible by children and people not authorized to use the unit. | Comment acknowledged<br>No change<br>EMSA's role is to establish training standards upon which training programs develop their own curriculum and assessment tools. The course content requirements under Section 100057 include the "Proper storage, handling and disposal of used/or expired injectors" for the training program to expand upon within their own curriculum. |
| 100057<br>Page 5 | Eileen Johnson, BSN,RN,PHN | Suggest this verbiage to allow for new course materials as they evolve.<br>Course Requirements<br>(b) the following topics and skills shall include, but need not be limited to the following: | Comment acknowledged.<br>No change.<br>As long as minimum course content is met, training programs may incorporate new course materials into their curriculum within the established standards |

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| | | | once the changes have been reviewed and approved by EMSA. |
| 100057. Page 5 | Kenta Takamori | EMSA should approve the course content of the epi training and instructor training process. | Comment acknowledged<br>No change<br>Sections 100058 and 100059 of the proposed regulations establish the instructor requirements and requires the training program director to approve the instructors. |
| 100058/6/29 | Kevin Mackey | A list of instructors every 30 days is redundant and will lead to poor compliance over time. Suggest a comprehensive list every 6 months, and updates on additional instructors monthly | Comment acknowledged.<br>Based on the comments received EMSA will modify instructor list requirements.<br>A specified time frame is necessary for EMSA to ensure that all instructors are qualified and approved to issue course completion documents and that students have completed the training with a qualified and approved instructor. This will allow the students to receive certification cards in a timely manner. |
| 100058/page 6/line 29 | Shana Tarter | Providing updated instructor lists every 30 days seems excessive and burdensome on both the training program and the EMS Authority. Suggest changing to every 6 or 12 months, or creating an online register where changes can be made as needed. If these are lists of instructor names and an organization has 50 instructors it is an onerous task to | Comment acknowledged.<br>Based on the comments received EMSA will modify instructor list requirements.<br>A specified time frame is necessary for EMSA to ensure that all instructors are qualified and approved to issue course completion documents and that students have completed the |

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| | | review person by person to look for changes. Why not require a complete list every 12 months and changes within 30 days of a change? | training with a qualified and approved instructor. This will allow the students to receive certification cards in a timely manner. |
| 100059<br>Page 6 | California Nurses Association | Thank you for incorporating our recommendations into the modified text enhancing the instructor requirements. The requirements now ensure qualified instructors and provide EMSA with a baseline evaluation of instructors authorized by approved training programs. | Comment acknowledged<br>Based on numerous comments received EMSA will not limit training instructors to the level of an EMT or higher. EMSA recognizes there are those qualified to teach the required skills through education and/or experience and by limiting instructors to an EMT or higher level will reduce the number of qualified instructors which in turn would restrict the number of classes available. EMSA feels this is against the original intent of this law, which is to make training in the use and administration of an epinephrine auto-injector easily available to the lay person. |
| 100059.<br>Page 7<br>Line 2 | Lauren Dietrich Chavez | Suggest EMSA remove the A-EMT minimum for teaching. | Comment acknowledged<br>Suggestion will be adopted<br>Based on numerous comments received EMSA will not limit training instructors to the level of an EMT or higher. EMSA recognizes there are those qualified to teach the required skills through education and/or experience and by limiting instructors to an EMT or higher |

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| | | | level will reduce the number of qualified instructors which in turn would restrict the number of classes available. EMSA feels this is against the original intent of this law, which is to make training in the use and administration of an epinephrine auto-injector easily available to the lay person. |
| 100059. | Lauren Dietrich Chavez | Individual programs should be relied upon to establish teaching competency. | Comment acknowledged Suggestion will be adopted Based on numerous comments received EMSA will not limit training instructors to the level of an EMT or higher. EMSA recognizes there are those qualified to teach the required skills through education and/or experience and by limiting instructors to an EMT or higher level will reduce the number of qualified instructors which in turn would restrict the number of classes available. EMSA feels this is against the original intent of this law, which is to make training in the use and administration of an epinephrine auto-injector easily available to the lay person. |

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| 100059.<br>Page 6, line 2 | David Yacubian, EMT | I would like to suggest removing the A-EMT minimum requirement for teaching. As an EMT-B and an educator for over 15 years I know that I am more than qualified to lead the proposed training. I also know that the educators I hire (who are medical professionals are as well) are qualified. I know firsthand that training level does not translate to teaching competency- limiting the training to A-EMTs and above will disqualify qualified individuals and will limit available training for this important initiative. I would suggest that the individual programs be relied upon to establish teaching competency. | Comment acknowledged<br>Suggestion will be adopted<br>Based on numerous comments received EMSA will not limit training instructors to the level of an EMT or higher. EMSA recognizes there are those qualified to teach the required skills through education and/or experience and by limiting instructors to an EMT or higher level will reduce the number of qualified instructors which in turn would restrict the number of classes available. EMSA feels this is against the original intent of this law, which is to make training in the use and administration of an epinephrine auto-injector easily available to the lay person. |
| 100059/page 7/lines 1-6 | Shana Tarter | Strongly disagree with the comments made in the first comment period that only Advanced EMTs and other healthcare professionals or EMTs who have taken the training are qualified to deliver this training. I have worked in healthcare education for 25 years and believe it is a mistake to equate a practitioner's credential (or lack there of) to their ability to teach others. For example, most pharmaceutical reps are not healthcare practitioners, yet they are able to teach the administration of new medications, techniques, and tools to practitioners. Many physicians are excellent practitioners but not good educators. | Comment acknowledged<br>Suggestion will be adopted<br>Based on numerous comments received EMSA will not limit training instructors to the level of an EMT or higher. EMSA recognizes there are those qualified to teach the required skills through education and/or experience and by limiting instructors to an EMT or higher level will reduce the number of qualified instructors which in turn would restrict the number of classes available. EMSA feels this is against the original intent of this law, which is to make training |

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| | | CPR training has been successful largely because of its widespread availability. Training organizations are charged with developing strategies for quality assurance in the content delivery and establishing instructor training standards. The EMS Authority should judge a training program on its approach to curriculum development and delivery and its instructor training program. There are many potential instructors with great capacity to teach this topic who do not hold the listed credential. There are many examples of epinephrine laws in other states that establish minimum training guidelines but delegate the oversight, including qualifications and training, of instructors to the training agencies themselves. Colorado And Alaska are two examples.<br><br>I propose the language revert to the original wording or drop instructor qualifications altogether and put the burden on approved training organizations. | in the use and administration of an epinephrine auto-injector easily available to the lay person. |
| 100059.<br>Page 7<br>Line 2 | Kenta Takamori | I support removing the A-EMT minimum for teaching epi pen training. | Comment acknowledged<br>Suggestion will be adopted<br>Based on numerous comments received EMSA will not limit training instructors to the level of an EMT or higher. EMSA recognizes there are those qualified to teach the required skills through education and/or |

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| | | | experience and by limiting instructors to an EMT or higher level will reduce the number of qualified instructors which in turn would restrict the number of classes available. EMSA feels this is against the original intent of this law, which is to make training in the use and administration of an epinephrine auto-injector easily available to the lay person. |
| 100059. | Kenta Takamori | Individual programs should be relied upon to establish teaching competency. | Comment acknowledged Suggestion will be adopted Based on numerous comments received EMSA will not limit training instructors to the level of an EMT or higher. EMSA recognizes there are those qualified to teach the required skills through education and/or experience and by limiting instructors to an EMT or higher level will reduce the number of qualified instructors which in turn would restrict the number of classes available. EMSA feels this is against the original intent of this law, which is to make training in the use and administration of an epinephrine auto-injector easily available to the lay person. |
| 100059.<br>Page 7<br>Line 2 | Kenta Takamori | By limiting it to A-EMTs, EMSA will unnecessarily limit the available training opportunities and thus the reach of people available to support this public health initiative. | Comment acknowledged Suggestion will be adopted Based on numerous comments received EMSA will not limit training instructors to the level of an EMT or higher. EMSA |

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| | | | recognizes there are those qualified to teach the required skills through education and/or experience and by limiting instructors to an EMT or higher level will reduce the number of qualified instructors which in turn would restrict the number of classes available. EMSA feels this is against the original intent of this law, which is to make training in the use and administration of an epinephrine auto-injector easily available to the lay person. |
| § 100059. Instructor Requirements. | Connie Green | (2) Meet ~~one of~~ the following requirements:<br>Why are all requirements now needed to be an instructor?<br>Similarly, why was this clause removed? ~~"(B) Experience in instructing first aid and CPR courses, and/or"~~ Are the Instructor requirements for this class the same as those needed to be a CPR/AED instructor?<br>Or otherwise stated - Does this class have the additional requirement that an instructor must be or have been EMTs or higher grade EMS personnel?<br><br>If course instructors for CPR/AED are **not** required to currently be, or have previously been EMTs, imposing this restriction on this class is unreasonable. | Comment acknowledged<br>Suggestion will be adopted<br>Based on numerous comments received EMSA will not limit training instructors to the level of an EMT or higher. EMSA recognizes there are those qualified to teach the required skills through education and/or experience and by limiting instructors to an EMT or higher level will reduce the number of qualified instructors which in turn would restrict the number of classes available. EMSA feels this is against the original intent of this law, which is to make training in the use and administration of an epinephrine auto-injector easily available to the lay person. |

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| | | It will have the effect of unnecessarily reducing the number of instructors able to teach this class, and so restrict the number of classes available for people to take. I believe this is against the original intent of this law, which is to make auto-injectors easily available to trained laypeople. | |
| § 100060. Notification of Program Approval. | Connie Green | Does the EMSA have a way of notifying all training program managers of any changes in Anaphylaxis response guidelines?<br><br>When or if best practices for responding to Anaphylaxis change, how long do the training programs have to switch to the new standards?<br><br>Will the program approval be revoked if the program does not update it's material? | Comment acknowledged<br>EMSA will have contact information for all training programs and will disseminate information that way.<br><br>As long as minimum course content is met, training programs may incorporate new course materials into their curriculum within the established standards at any time once the changes have been reviewed and approved by EMSA.<br><br>Only if minimum course requirements are not met. |
| 100062.<br>Page 8 | Brian Morr, BS,MICP | Place whatever language is proposed to appear on the Certification card on the back of the license card already issued to RNs, Paramedics, and EMTAs. This will save staff time and reduce cost because CPR, eligibility and standing are already checked as part of the relicensure process. | Comment acknowledged.<br>No change.<br>RNs, Paramedics, and AEMTs will be required to carry a separate epinephrine auto-injector certification card to avoid confusion between their authorized scope of practice within the EMS system and their off-duty certification. |

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| § 100062. Certification Card. | Connie Green | Information specified to be required in the certification card in § 100062. Certification Card. does not mention the instructor signature, which is required in § 100056.<br>Will the instructor name or trainer-identification number be on the card or just the signature? | Comment acknowledged<br>Section 100056 (b)(8)(D) requires the training program to provide EMSA with a copy of their course completion document which must have a signature line for the instructor, as part of the approval process.<br>In Section 100059 (b) the instructor is required to provide the individual with a signed course completion document as proof of successful completion of the epinephrine class.<br>This document is sent to EMSA as part of the package to receive a certification card.<br>Only the individuals name will be on the certification card and only the individual is required to sign the certification card. |
| Whole Document | Connie Green | People will have questions related to how the laws apply. This was discussed twice in the meetings. Please provide a FAQ for the authorized healthcare providers, the pharmacists, and the trainees. | Comment acknowledged<br>No change<br>A frequently asked questions (FAQ) section is not part of a regulation package however; EMSA may include an FAQ on its website upon approval and implementation of the regulations. |
| **Application for Epinephrine Auto-injector Certification** | Shana Tarter | Allow for email submission of the application and supporting documentation | Comment acknowledged<br>Suggestion will be adopted with the exception of fees via email as email is not secure. |
| **Application for Epinephrine Auto-** | Shana Tarter | Consider a minimum age for training and certification | Comment acknowledged<br>No change |

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
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| **injector Certification** | | | Death from anaphylaxis has become a pervasive yet preventable problem in the community. A minimum age requirement does not meet the intent of the statute which is to create a process for the lay public to receive training to assist a member of the general public who is suffering from anaphylaxis while also being provided civil liability protection. |
| **<u>Application for</u> Epinephrine Auto-injector Certification** | Shana Tarter | Include EMTs (formerly EMT Basic) with paramedics and AEMTs in the groups who have met the requirements for training. For more than 20 years EMTs have been trained to use auto-injectors.<br><br>In the1994 Department of Transportation EMT Basic National Standard Curriculum, EMTs were expected to have the cognitive, affective and psychomotor competencies to administer epinephrine via auto-injector.<br><br>The 2011 National EMS Education Standards document entitled EMT Instructional Guidelines includes the following:<br>VII. Epinephrine as a Treatment for Allergic Reaction<br><br>A. Indications – Severe Allergic Reaction or Hypersensitivity to | Comment acknowledged<br>No change<br>As long as EMTs are able to provide current documentation of having met the requirements for training they may receive a certification card. |

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
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| | | Exposed Substance<br><br>B. Contraindications – Not Patient's Drug, Expired, or Discolored<br><br>C. Actions – Slows Allergic Response, Raises B/P, Dilates the Bronchioles<br><br>D. Side Effects – Increased Pulse Rate and B/P, Anxiety, Cardiac Arrhythmias<br><br>E. Auto injection Systems<br><br>1. Physician order<br><br>2. Expiration date and patient prescription<br><br>3. Prep site, remove needle cover<br><br>4. Lateral thigh; push against thigh; hold until drug fully injected<br><br>5. Monitor patient response | |

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| | | 6. Dispose properly | |
| Form# 1.9app (5/2015) Certification Eligibility (1) | LA County EMS Agency | Add "Physician Assistant, Registered Nurse, Nurse Practitioner and Nurse Midwife" to the certification eligibility section of the application. | Comment acknowledge<br>Suggestion will be adopted |
| Form# 1.9app (5/2015) Basis of Eligibility | LA County EMS Agency | Add "Physician Assistant, Registered Nurse, Nurse Practitioner and Nurse Midwife" to the basis of eligibility section of the application. | Comment acknowledged<br>Suggestion will be adopted |

Comments on Proposed Epinephrine Auto-Injector Training Certification Standards
Chapter 1.9, Division 9, Title 22, California Code of Regulations
2nd 15-Day Public Comment Period
June 10, 2015 through June 24, 2015

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
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| General | Jennifer Jobrack, Senior National Director of Advocacy, Food Allergy Research & Education | FARE, the nation's largest food allergy patient advocacy group, supports the work of EMSA to establish training standards for certification of off-duty prehospital emergency medical care persons and lay rescuers in the use and administration of epinephrine auto injectors (EAIs).<br>We support the wide availability of epinephrine and appreciate your agency's efforts toward that end. | Comment acknowledged |
| Section 100055<br>Page 4<br>Lines 12-14 | Jennifer Jobrack, Senior National Director of Advocacy, Food Allergy Research & Education | We do not endorse the language in § 100055. Certification Requirements such that current certification in CPR and AED for infants, children and adults equivalent to the current standards of the American Red Cross and/or the AHA Guidelines for CPR and ECC are required to be certified in EAI use. As evinced by the recently released study of EAI use in U.S. schools, lay persons trained in EAI administration do not need to know CPR or other first aid measures in order to successfully administer an EAI. We strongly urge a change in the EAI certification requirements such that CPR certification is not a prerequisite. | Comment acknowledged<br>No change<br>The requirement for certification in CPR/AED for a layperson to obtain an epinephrine auto-injector is required per Health and Safety Code 1797.197a (c)(2)(F) |

Comments on Proposed Epinephrine Auto-Injector Training Certification Standards
Chapter 1.9, Division 9, Title 22, California Code of Regulations
3rd 15-Day Public Comment Period
July 1, 2015 through July 15, 2015

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
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| | | No comments received | |
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**EMERGENCY MEDICAL SERVICES AUTHORITY**
10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

**DATE:** September 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 as the Community Paramedicine Project moves toward implementation. The discussion that follows will provide an update on the progress of the Pilot.

### Training

Site specific training has been completed by 11 of the 12 approved pilot project sites, with the final one expected to conclude on August 24, 2015.

### 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 the efficacy of the Community Paramedicine concept.

Based upon the recommendations of the Community Paramedicine Advisory Committee to collect additional data points from the projects during implementation of the pilot, as well as to overcome some of the challenges encountered during the Baseline Data Collection process, 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 submitted the necessary applications to their IRB's. Seven projects have received IRB approval at this time. The remaining projects are in the process of working with their IRB's and providing additional information or clarification.

Implementation

Beginning June 1, 2015 implementation for the project sites has been staggered based upon the readiness of each project site to move forward. All Project sites have received OSHPD approval of their Medical Protocols & Procedures. The seven projects that have received their IRB approvals have been approved by OSHPD to enter Phase III Implementation. The remaining five projects are prepared to implement as soon as they receive their IRB approvals. (*See attached Readiness Dashboard*)

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

# Community Paramedicine Pilot Project
## Readiness Dashboard
### As of August 12, 2015

| Project # | Pilot Concept | EMS Providers | Baseline Data | CORE Training | Updated Medical Protocols | Site Specific Training | IRB Approval | Phase III Start Date |
|---|---|---|---|---|---|---|---|---|
| CP001 | Alt Trans Destinations | UCLA, Santa Monica, Glendale | | | | | | **Pending** |
| CP002 | Post Discharge (CHF) | UCLA - Glendale Fire | | | | | | **Pending** |
| CP003 | Alt Trans Destinations | Orange County | | | | | | 8/24/15 |
| CP004 | Post Discharge Follow Up | Butte County EMS | | | | | | 7/1/15 |
| CP005 | Directly Observed TB | AMR Ventura | | | | | | 6/1/15 |
| CP006 | Hospice Support | AMR Ventura | | | | | | 8/1/15 |
| CP007 | Post Disch Feq 911 | Alameda City Fire | | | | | | 6/1/15<br>7/1/15 |
| CP008 | Post Discharge Follow up | San Bernardino County Fire | | | | | | 8/13/15 |
| CP009 | Alt Destinations | Carlsbad Fire Department | | | | | | 8/17/15 |
| CP 010 | Frequent 911 | City of San | | | | | | **Pending** |
| CP012 | Alt Destinations | AMR Stanislaus | | | | | | **Pending** |
| CP 013 | Post Discharge Follow Up | Medic Ambulance | | | | | | **Pending** |

**In Process**

**Complete**

**OSHPD Approved**

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

**DATE:** September 2, 2015

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP
Director

**REPARED BY:** Corrine Fishman, Analyst

**SUBJECT:** EMT Regulation Revisions

## RECOMMENDED ACTION:

Receive information regarding implementation plan for Senate Bill (SB) 1438 Controlled Substances: Opioid Antagonists.

## 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. Remove the skills based competency verification form and replace it with 6 hours of skills based continuing education.

4. Increase the required course hours from 160 to 166 to include Naloxone, epinephrine and glucometer training.
5. Move the monitoring of preexisting vascular access devises and intravenous lines delivering fluids with additional medications from a basic skill to an optional skill to clarify this is a local optional request.
6. Provide clarity and consistency with the NREMT registration requirements.
7. 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 Chapter 2 EMT regulations. Formal rulemaking through the Office of Administrative Law (OAL) is anticipated to commence in August 2015, offering the opportunity to receive public comments.

We anticipate having the proposed regulations submitted to the Commission on EMS for approval at the December 2015 meeting.

## IMPLEMENTATION STEPS AND TIMELINE

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

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

**DATE:** September 2, 2015

**TO:** Commission on EMS

**FROM:** Howard Backer, M.D.
Director

**PREPARED BY:** Lucy Chaidez
Associate Governmental Program Analyst

**SUBJECT:** First Aid, CPR, and Preventive Health Training Standards for Child Care Providers, Legislative Changes and Regulation Impact

## RECOMMENDED ACTION

Receive information.

## FISCAL IMPACT

No fiscal impact to the Authority is expected. However, the state's training businesses may see increased revenue from the extra hour of training they will be providing.

## DISCUSSION

The Governor signed AB 290 into law in October 2013 (Assembly Bill AB 290, Alejo, Chapter 734, Statutes of 2013). AB 290 adds one hour of childhood nutrition training to health and safety prevention training for some of the state's licensed child care providers. Beginning January 1, 2016, child care providers must receive an hour of basic child nutrition training as a condition of their licensure. The training adds one hour to the current 7 hours of prevention training that child care providers receive once in a lifetime as a condition of licensure. (Not all child care providers are required to take the prevention training; only one child care provider with the training must be on the child care center premises at all times children are present.) Approximately 80,000 of the state's child care providers receive the prevention training annually.

The new law authorized the EMS Authority to establish standards for the training, and issue the standards by director's bulletin until regulations could be adopted. The standards were developed by a task force of children's nutrition experts who met from spring to fall of 2014, and the director's bulletin (http://www.emsa.ca.gov/Media/Default/PDF/Nutrition_Bulletin_January2015.pdf) was issued to training program directors on January 16, 2015. The new modules are being developed by the Authority's approved child care provider training programs, according to standard practice for the development of training curricula in the Authority's

program. The training programs are the businesses throughout the state that provide the training to child care providers. The first drafts of the modules have been submitted to the Authority, reviewed by staff, and are in the process of modifications. All modifications must be completed, with programs approved and the new modules ready to proceed, by the end of October 2015, although training in the new module will not begin until January 1, 2016.

Concurrently, the Authority's child care unit is working to incorporate the nutrition standards into the full child care provider training regulations (***California Code of Regulations; Title 22; Social Security; Division 9 Prehospital Emergency Medical Services; Chapter 1.1 Training Standards for Child Care Providers***). The Authority convened a task force of child care health and safety experts in April 2015 to revise the regulations. The task force will complete their work in October 2015. It is estimated that the Authority will submit the regulations revision package to the Commission in December 2015, and to Office of Administrative Law in January 2016. Please see the timeline for the regulations revision plan below.

## Implementation Steps and Timeline for Regulations Revision

| | |
|---|---|
| April - October 2015 | Workgroup meets to assist EMSA with developing a new first aid training module whose focus is prevention, honing the training topics, and reviewing the suggested amendments to the regulations |
| December 2015 | Proposed revisions to regulations to the Commission for approval |
| January 2016 | Submit the rulemaking file to the Office of Administrative Law for review and approval |
| January 2017 | Regulations become effective |

Attachment Director's Bulletin

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

**DATE:** January 16, 2015

**TO:** All Preventive Health and Safety Training Program Directors

**FROM:** Howard Backer, MD, MPH, FACEP
Director

**SUBJECT:** Preventive Health and Safety Training Course Content Changes: Nutrition Training Standards

The Emergency Medical Services Authority (EMSA) has developed child care nutrition training standards as required by Assembly Bill (AB) 290 (Alejo, Chapter 734, Statutes of 2013). The law adds one (1) hour of nutrition training to the current seven (7) hour preventive health and safety practices course for a total of eight (8) hours of preventive health and safety training required for licensees of child care homes and centers.

Program directors are required to develop child care nutrition curriculum based on the EMSA child care nutrition training standards. The standards contained in this bulletin are also available on the EMSA website (www.emsa.ca.gov/childcare_nutrition), along with a sample curriculum and additional resources to enhance the nutrition curriculum.

The new training will educate child care providers on the importance of childhood nutrition and the benefits of the federal nutrition program, the Child and Adult Care Food Program (CACFP). This training is an important step for California's children in child care to receive healthy meals and snacks.

Along with all existing course curricula, the child care nutrition training component must be submitted to EMSA for review and approval prior to training child care providers.

Program directors must:

- Revise preventive health and safety curriculum to include one-hour of nutrition training based upon the EMSA child care nutrition training standards.
- Submit an application and fee for preventive health and safety course review.
    - Applications for course review can be submitted beginning January 16, 2015.
    - Applications for course review *must be submitted no later than July 1, 2015.*

Beginning January 1, 2016 and thereafter, all preventive health and safety courses must include an additional one-hour of nutrition training based upon the standards developed and approved by EMSA.

## EMSA Child Care Nutrition Training Standards

### I. Course Requirements

The child care nutrition course shall:
(a) Consist of no less than one (1) hour of training in children's nutrition for child care providers.

(b) Provide basic information about the USDA's Child and Adult Care Food Program (CACFP): how to access the program and how to obtain information on CACFP eligibility, enrollment, and reimbursement rates by contacting the CACFP Unit of the California Department of Education (CDE) Nutrition Services Division. The training shall provide California CACFP program contact information.

(c) Refer trainees to the California Emergency Medical Services Authority (EMSA) Child Care Nutrition Training webpage for resources and additional information about children's nutrition. Inform child care providers that more in-depth information about the topics in the nutrition training can be found on the EMSA Child Care Nutrition Training webpage (www.emsa.ca.gov/childcare_nutrition).

(d) Only contain content that is consistent with current *Dietary Guidelines for Americans*.

(e) Provide trainees with an opportunity to ask questions or ask for clarification of topics.

### II. Required Course Content for Child Care Nutrition Training

The course content shall include the following topics:
(a) A brief overview of the positive effects of healthy nutrition on the developing child and on the overall health of children ages 12 and younger.

(b) Basic information about California's Healthy Beverages in Child Care Law (AB 2084, 2010) that includes the following:

(1) Clean and safe drinking water must be readily available throughout the day, including at all meal, snack, and play times.

(2) Serve only fat-free or low-fat (1%) unsweetened, plain milk for children two years of age or older.

(3) Provide no more than one serving (4-6 ounces) per day of 100 percent juice.

(4) Beverages with added sweeteners, either natural or artificial, are prohibited (not including infant formula or complete balanced nutritional products designed for children).

(c) Best practices for feeding infants and toddlers including breast milk, iron fortified formula, and introducing first foods.

(d) Overview of how to serve age appropriate healthy foods at each snack and meal that are based on the standards of the current Dietary Guidelines for Americans.

(e) Ways to cut back on foods high in solid fats, added sugars, and salt.

(f) Explanation of how to use food labels to help identify healthy choices.

(g) Best practices for building healthy eating habits in children, including the division of responsibility in feeding, based upon the current standards of the American Academy of Pediatrics and *Caring for Our Children*.

The information for this topic shall include:

1. The child care provider is the role model for healthy eating while children are in the child care environment.

2. The division of responsibility: the child care provider chooses which healthy foods to prepare and offer to children, when and where to provide the food; children choose *what* and *how much* they will eat from the foods offered.

3. Allow children to serve themselves: they choose what they want from what you serve, they choose what portions to put on their plates, and they decide when they are "full."

4. Child care providers eat with the children at a communal table.

5. Offer a variety of foods from each of the food groups (fruits and vegetables, meat and meat alternatives, grains including mainly whole grains, and dairy products). Colorful foods with varying textures appeal to children's palates.

6. Encourage children to taste a new food, but do not force or reward children to eat or to clean their plates. It is normal for children to dislike some foods and favor others.

7. Children may need to be introduced to a new food 10 to 20 times before they accept it.

8. Planning menus helps to provide a healthy variety of foods to children, and can help save money.

(h) The benefits of developing written nutrition policies for the child care setting.

1. Refer to the EMSA Child Care Nutrition Training webpage (www.emsa.ca.gov/childcare_nutrition) for samples and further guidance regarding policy writing.

(i) Overview of information regarding food allergies and food safety on the EMSA Child Care Nutrition Training webpage.

For questions regarding the nutrition training standard requirements within this letter, please contact Lucy Chaidez by phone at (916) 431-3678, or by email at lucy.chaidez@emsa.ca.gov.

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

**DATE:** September 2, 2015

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP
Director

**PREPARED BY:** Sean Trask, Chief
EMS Personnel Division

**SUBJECT:** Revisions to the Physician's Order for Life Sustaining Treatment Form

## RECOMMENDED ACTION:

Receive information on pending changes to the POLST Form.

## FISCAL IMPACT:

There is no fiscal impact.

## DISCUSSION:

### Background:

AB 3000 (Wolk, Chapter 266, Statutes of 2008) introduced a new do not resuscitate (DNR) form to the Probate Code, the Physician's Order for Life Sustaining Treatment (POLST). AB 3000 also named the EMS Authority (EMSA) as the department responsible for approving the POLST form (Form).

The Commission approved the current version of the form at the June 19, 2013 meeting and the Statewide DNR Guidelines at the December 4, 2013 meeting.

### Assembly Bill (AB) 637

AB 637 (Campos) was introduced to amend the probate code to add nurse practitioners and physician assistants as individuals who may sign a completed Form while acting under the supervision of the physician and within the scope of practice authorized by law. AB 637 was enrolled on August 3, 2015 and as of August 12, 2015 was not signed.

Assuming AB 637 becomes law, the California Coalition for Compassionate Care (CCCC) will make the necessary changes to the Form. The CCCC has advised the EMS Authority that the revised draft of the Form will be ready for the December 2015 Commission on EMS meeting for approval.

**Impacts to EMS**

The change from AB 637 to the Form is substantive and will require the EMS Authority's DNR Guidelines to be revised to reflect the additional signature lines and will require approval by the Commission on EMS. The EMS Authority will have the revised DNR Guidelines ready for approval at the December 2015 Commission on EMS meeting.

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

**DATE:** September 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:

At the December 2014 Commission on EMS meeting, the Commission requested that the EMS Authority prepare emergency regulations for a process for local EMS agencies to appeal EMS plan determinations made by the EMS Authority.

In February 2015, the EMS Authority sent a notice of proposed emergency rulemaking to all stakeholders and submitted an emergency rulemaking file to the Office of Administrative Law. The emergency regulations were subsequently withdrawn from OAL to pursue the rulemaking action through the standard (non-emergency) rulemaking process.

The EMS Authority has completed two public comment periods on the EMS plan appeal regulations. A 45-day public comment period was conducted from March 13, 2015 – April 27, 2015, and changes were made to the regulations based on the public comments received. A second public comment period was conducted from May 14, 2015 – June 15, 2015 to allow stakeholders to review the changes made from the first public comment period. No public comment was received that warranted additional changes to the regulations.

All written and verbal comments have been considered and responses have been provided in a matrix developed by the EMS Authority.

The regulations are being presented to the Commission on EMS for consideration. Upon approval by the Commission, the EMS Authority will continue the rulemaking process and submit the regulations and rulemaking record to the Office of Administrative Law for review.

The Commission will be kept informed on our progress with the rulemaking process.

**California Code of Regulations**

**TITLE 22. SOCIAL SECURITY**

**DIVISION 9. PRE-HOSPITAL EMERGENCY MEDICAL SERVICES**

**CHAPTER 13. EMS System Regulations**

**Adopt Section 100450.100 to read:**

**§ 100450.100 . Appeal Proceedings to the Commission**

(a) Any proceeding by the Commission to hear an appeal of a local emergency medical services agency's (LEMSA) emergency medical services (EMS) plan, pursuant to Health and Safety Code §1797.105, shall be conducted in accordance with the provisions of the Administrative Procedure Act, Government Code Section 11500 et seq, and its associated regulations as contained in Title 1 of the California Code of Regulations.

(b) The Office of Administrative Hearings, using an administrative law judge, shall hold a public hearing and receive evidence according to the Administrative Procedures Act.

(c) The administrative law judge, in making a proposed decision to the Commission, shall only make a recommendation as described in Section 1797.105(d) of Division 2.5 of the Health and Safety Code to:

(1) sustain the determination of the authority, or

(2) overrule the determination of the authority and permit local implementation of the plan.

(d) Upon receipt of the Proposed Decision and Order from the Office of Administrative Hearings, the Commission shall calendar a discussion and vote regarding the proposed decision at the next regularly scheduled Commission meeting.

(e) The Commission shall permit public comment concerning the proposed decision pursuant to the Bagley-Keene Open Meeting Act.

(f) The Commission's vote on the proposed decision is limited to the following:

(1) adopt the administrative law judge's proposed decision, or

(2) not adopt the administrative law judges proposed decision, or

(3) return the proposed decision to the Office of Administrative Hearings for re-hearing.

(g) The decision by the Commission shall be by simple majority vote of a quorum of those members present at the meeting where the proposed decision is scheduled as an agenda item.

(h) Costs of the administrative hearing shall be borne equally by the parties. Costs shall not include attorney's fees.

Authority: Section 1797.107 of the Health and Safety Code

Reference: Sections 1797.105 and 254

**COMMENTS for APPEALS PROCEEDINGS TO THE COMMISSION REGULATIONS, CHAPTER 13, Section 100450.100**
**Comment Period: March 13, 2015 – April 27, 2015**

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
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| General Comment | County of Kern | The County…objects to portions of the proposed emergency regulations and requests modifications, as outlined, to ensure a fair administrative review process and the opportunity for judicial review, as required by applicable statutes and regulations. | Comment acknowledged. This regulatory packet is no longer classified as "emergency" in nature. |
| General Comment | El Dorado County EMS Agency | Objection to Rulemaking Process: Allowing the opposing party on an appeal to unilaterally adopt appeal procedures for the hearing body is a denial of due process. | Comment acknowledged. No change made. |
| General Comment | El Dorado County EMS Agency | The appeal regulations must be proposed and adopted by the Commission, not the Authority. | Comment acknowledged. No change made. Pursuant to Health & Safety Code, Section 1797.107, the EMS Authority has been given the statutory responsibility to promulgate regulations. The Commission on EMS has the statutory responsibility to approve rules and regulations created by the EMS Authority. |
| General Comment | EMS Administrators' Association of California (EMSAAC) | While EMSAAC supports the adoption of procedural rules for LEMSA appeals of EMSA's refusal to approve local EMS plans, it requests that portions of the proposed Section 100450.100 be revised to insure that: 1) evidence may be presented at public administrative hearings; 2) the decisions resulting from such hearings serve only to exhaust administrative remedies, and not preclude further recourse to the courts; and 3) that all parties to | Comment acknowledged. EMSA has modified the proposed regulation to be consistent with the provisions of the APA. |

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
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| | | administrative appeals bear their own costs. | |
| General Comment | Sacramento County EMS Agency (SCEMSA) | While SCEMSA supports the adoption of procedural rules for LEMSA appeals of EMSA's refusal to approve local EMS plans, it requests that portions of the proposed Section 100450.100 be revised to insure that: 1) evidence may be presented at public administrative hearings; 2) the decisions resulting from such hearings serve only to exhaust administrative remedies, and not preclude further recourse to the courts; and 3) that all parties to administrative appeals bear their own costs. | Comment acknowledged. EMSA has modified the proposed regulation to be consistent with the provisions of the APA. |
| 100450.100<br>Pages 1-2<br>Lines 7-42 | El Dorado County EMS Agency | The proposed regulations do not meet the APA clarity standard (GC § 11349.1) See comments below. | Comment acknowledged. |
| 100450.100(a)<br>Page 1<br>Lines 9-14 | El Dorado County EMS Agency | Proposed regulations 100450.100(a) states that any appeal shall be conducted in accordance with the APA, GC §11500 et seq. and associated regulations in Title 1 of the CCRs; however, this conflicts with Proposed regulation 100450.100(f) which changes the parameters of GC §11517 relating to allowed Commission action on the proposed decision submitted by the ALJ. | Comment acknowledged. All the decision parameters of GC 11517 relating to actions that may be taken on a proposed decision are not available to the Commission on EMS due to the constraints contained in HSC 1797.105. |
| 100450.100(b)<br>Page 1<br>Lines 15-16 | California Ambulance Association | Revise as follows:<br>*The Office of Administrative Hearings, using an administrative law judge, shall hold a hearing, receive testimony and evidence presented by the parties, and evaluate all information submitted by the Authority and the* | Comment acknowledged. EMSA has modified the proposed regulation to be consistent with the provisions of the APA. |

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| | | *local EMS agency.*<br><br>This additional language was included in the draft emergency regulations, but seems to have been omitted in this version. It must be clear that a hearing will be held and parties will be allowed to present evidence and testimony. | |
| 100450.100(b)<br>Page 1<br>Lines 15-16 | EMS Administrators' Association of California (EMSAAC) | Revise to read: "The Office of Administrative Hearings, using an administrative law judge, shall *hold a public hearing, receive such evidence as may be presented by the parties, and* evaluate all information submitted by the Authority and the Local EMS Agency." (Please attached letter for further explanation of requested changes.)<br><br>With regard to subsection (b), concern exists whether EMSA may seek to limit introduction of evidence or testimony at administrative hearings through a strict interpretation of its "evaluate all information" language, and limit appeals simply to the briefs submitted by the parties. Such a limitation would prevent a full and complete hearing of the dispute, and unnecessarily limit the administrative law judge's ability to fully analyze the issues. EMSAAC therefore proposes the addition of the following language to subsection (b):<br><br>(b) The Office of Administrative Hearings, using an administrative | Comment acknowledged. EMSA has modified the proposed regulation to be consistent with the provisions of the APA. |

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
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| | | law judge, shall *hold a public hearing, receive such evidence as may be presented by the parties, and* evaluate all information submitted by the Authority and the Local EMS Agency. | |
| 100450.100(b)<br>Page 1<br>Lines 15-16 | County of Kern | The County requests that subdivision (b) be deleted. See comments in attached letter.<br><br>The County objects to subdivision (b) of Section 100450.100, which states that "The Office of Administrative Hearings, using an administrative law judge, shall evaluate all information submitted by the Authority and the local EMS agency."<br><br>Under subdivision (a), proceedings shall be conducted in accordance with the Administrative Procedures Act, Government Code section 11500 et seq., and associated regulations. Under Government Code 11512 (b), the administrative law judge has the authority to determine what information they will evaluate; they may choose not to evaluate all information submitted by EMSA and the local EMS agency.<br><br>Therefore, the County requests that subdivision (b) be deleted. | Comment acknowledged. Section not deleted but language modified to be consistent with the APA.<br><br>Comment acknowledged, language has been modified to be consistent with the APA.<br><br>Comment acknowledged.<br><br>Comment acknowledged. Section not deleted but language modified to be consistent with the APA. |

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| 100450.100(b)<br>Page 1<br>Lines 15-16 | El Dorado County EMS Agency | Subsection (b) states that the administrative law judge shall evaluate "all information submitted" by the Authority and the LEMSA. "All information" should be clarified to include written briefs, oral testimony and such other evidence as may be presented by the parties. The concern is whether or not the Authority would seek to limit introduction of evidence or testimony at the administrative hearings through its interpretation of "all information." The following change is proposed"<br><br>(b) The Office of Administrative Hearings, using an administrative law judge, shall hold a public hearing, receive written briefs, oral testimony and argument and such other evidence as may be presented by the parties, and evaluated all information submitted by the Authority and the Local EMS Agency. | Comment acknowledged. EMSA has modified the proposed regulation to be consistent with the APA. |
| 100450.100(b)<br>Page 1<br>Lines 15-16 | Monterey County Regional Fire District (MCRFD) & San Ramon Valley Fire Protection District (SRVFPD) | Subsection (b) of Section 100450.100 addresses the evidence to be heard by the administrative law judge. Because EMS Plans have important effects on public safety and health, the regulations should expressly allow for evidence at the hearing before the administrative law judge ("ALJ"). Maximizing the scope of relevant evidence that may be submitted will assist the ALJ's ability to make a well-informed recommendation based on the most current evidence, as well as | Comment acknowledged. |

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| | | adequately granting due process to the involved parties and all potentially involved public stakeholders impacted by the EMS Plan.<br><br>It is requested that Subsection (b) be amended with the underlined language so as to read:<br><br>(b) The Office of Administrative Hearings, using an administrative law judge, <u>shall hold a hearing, receive such relevant testimony and evidence presented by the parties</u>, and evaluate all information submitted by the Authority and the Local EMS Agency. | Comment acknowledged. EMSA has modified the proposed section to be consistent with the APA. |
| 100450.100(b)<br>Page 1<br>Lines 15-16 | Sacramento County EMS Agency (SCEMSA) | With regard to subsection (b), concern exists whether EMSA may seek to limit introduction of evidence or testimony at administrative hearings through a strict interpretation of its "evaluate all information" language, and limit appeals simply to the briefs submitted by the parties. Such a limitation would prevent a full and complete hearing of the dispute, and unnecessarily limit the administrative law judge's ability to fully analyze the issues. SCEMSA therefore proposes the addition of the following language to subsection (b):<br><br>(b) The Office of Administrative Hearings, using an administrative law judge, shall *hold a public hearing, receive such evidence as may be presented by the parties, and* evaluate | Comment Acknowledged. |

| Section/Page/Line | Commenter's Name | Comments/<br>Suggested Revisions | Response |
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| | | all information submitted by the Authority and the Local EMS Agency.<br><br>As written, this section limits the appeals simply to the briefs submitted to the Office of Administrative Hearings (OAH), by the parties. SCEMSA recommends the Section be **amended** to read: 'The OAH, using an ALJ, shall *hold a public hearing, receive such evidence as may be presented by the parties, and* evaluate all information submitted by the Authority and the Local EMS Agency'. | Comment acknowledged. EMSA has modified the proposed section to be consistent with the APA. |
| 100450.100(b)<br>Page 1, lines 15-16 | County of Marin<br>and<br>ICEMA | With regard to subsection (b), concern exists whether EMSA may seek to limit introduction of evidence or testimony at administrative hearings through a strict interpretation of its "evaluate all information" language, and limit appeals simply to the briefs submitted by the parties. Such a limitation would prevent a full and complete hearing of the dispute, and unnecessarily limit the administrative law judge's ability to fully analyze the issues. County of Marin and ICEMA therefore proposes the addition of the following language to subsection (b):<br><br>Revise to read: "The Office of Administrative Hearings, using an administrative law judge, shall hold a public hearing, receive such evidence as may be presented by the parties, and evaluate all information submitted by the Authority and the Local EMS | Comment acknowledged. EMSA has modified the proposed section to be consistent with the APA. |

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| | | Agency." | |
| 100450.100(c)<br>Page 1<br>Lines 17-22 | County of Kern | The County requests that subdivision (c) be modified to provide: "The administrative law judge, in make a proposed decision to the Commission shall make and articulate findings of fact and conclusions of law, and either grant the appeal, approving the local EMS plan as submitted to the Authority, or deny the appeal, disapproving the local EMS plan as submitted to the Authority, consistent with California Health and Safety Code section 10197.105 (d)." See comments in attached letter.<br><br>The proposed regulations do not address whether the administrative law judge would be required to provide a written explanation for a decision. The relevant statute, Government Code section 11517(c)(1), provides that the administrative law judge shall prepare a proposed decision "in a form that may be adopted by the agency as the final decision in the case." There is no particular format specified by statute.<br><br>In other contexts, however, regulations require an administrative law judge to provide written reasons for a decision. For instance, in child support hearings, the decision must specify the reasons for the decision and must identify supporting evidence and law. 22 | Comment acknowledged. No change made to proposed language.<br><br>Comment acknowledged.<br><br>Comment acknowledged. |

| Section/Page/Line | Commenter's Name | Comments/ Suggested Revisions | Response |
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| | | C.C.R. § 120216. In Gambling Control Commission hearings, the administrative law judge must include written findings of fact, 4 C.C.R. § 12554. Generally in quasi-judicial administrative proceedings, the quasi-judicial body must state findings in its decision. *Topanga Association v. County of Los Angeles* (1974) 11 Cal.3d 506; City of Fairfield v. Superior Court (1975) 14 Cal.3d 768.<br><br>EMSA has not proposed any regulations or guidelines dictating the format of the administrative law judge's decision. However, the judge must make a factual and legal determination under the statute that "the plan does not effectively meet the needs of the persons and is not consistent with coordinating activities in the geographical area served, or that the plan is not concordant and consistent with applicable guidelines or regulations, or both the guidelines and regulations, established by the authority." H& S § 1797.105(b). A written decision including findings of fact and conclusions of law would assist the Commission in making the final determination and provide clarity to EMSA and the local EMS agency regarding the areas of any plan that are inadequate.<br><br>Permitting the administrative law judge to approve or disapprove EMSA's | Comment acknowledged. |

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| | | decision without providing reasoning would abrogate the purpose of involving the administrative law judge in the first place, and it would prevent the Commission from relaying on facts and conclusions articulated by a neutral third party in making decisions.<br><br>Therefore, the County proposes the following modification to subdivision (c):<br><br>(c) be modified to provide: "The administrative law judge, in make a proposed decision to the Commission shall make and articulate findings of fact and conclusions of law, and either grant the appeal, approving the local EMS plan as submitted to the Authority, or deny the appeal, disapproving the local EMS plan as submitted to the Authority, consistent with California Health and Safety Code section 10197.105 (d)." | Comment acknowledged.<br><br>Comment acknowledged. No change to language necessary. OAH provides a written decision with findings of fact and law in all matters. |
| 100450.100(d)<br>Page 1<br>Lines 23-25 | County of Kern | The County requests that subdivision (d) be modified to provide: "Upon receipt of the Proposed Decision and Order from the Office of Administrative Hearings, the Commission shall calendar a discussion and vote of the proposed decision at the next regularly scheduled Commission meeting not less than 30 days from receipt of the Proposed Decision Order." See comments in attached letter.<br><br>Subdivision (d) provides that the | Comment acknowledged.<br><br>Comment acknowledged. |

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| | | Commission shall calendar a discussion and vote on the proposed decision at the next regularly scheduled meeting after receipt of the proposed decision and order. In the event the next regularly scheduled meeting is only a short time after the Commission receives the proposed decision, there will be insufficient time for the Commission and local EMS agency to consider the proposed decision fully.<br><br>Therefore, the County proposes the following modification to subdivision (d):<br><br>(d) Upon receipt of the Proposed Decision and Order from the Office of Administrative Hearings, the Commission shall calendar a discussion and vote of the proposed decision at the next regularly scheduled Commission meeting <u>not less than 30 days from receipt of the Proposed Decision Order</u>. | Comment acknowledged. No change to proposed language. The commission on EMS has regularly scheduled meetings approximately every 90 days. In order to be considered as an agenda item pursuant to the Bagley-Keene open meetings act, a proposed decision must be received at least 10 days prior to a regularly scheduled meeting. If a proposed decision is received within 10 days prior to a regularly scheduled meeting, it will be calendared as an agenda item at the next meeting. This proposed regulatory framework will allow all decisions to be heard within the 100 day time limit imposed by the APA for adoption of proposed decisions. Commissioners will therefore have a minimum of 10 |

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| | | | and a maximum of 100 days to review a proposed decision. |
| 100450.100(d)<br>Page 1<br>Lines 23-25 | El Dorado County EMS Agency | Proposed regulation 100450.100(d) states that "upon receipt of the Proposed Decision and Order from the Office of Administrative Hearings, the Commission shall calendar a discussion and vote of [sic] the proposed decision at the next regularly scheduled Commission meeting." There are time limits for Commission review of the ALJ decision pursuant to GC 11517 (within 100 days); however, the Commission only meets quarterly. Depending when an ALJ decision is received by the Commission, there could be scheduling problems both for the Commission and the LEMSA's since the Commission meetings are held at various locations throughout the state (i.e. San Diego, Sacramento, San Francisco, Los Angeles). Special meetings may be required. | Comment acknowledged. No change to proposed language. The commission on EMS has regularly scheduled meetings approximately every 90 days. In order to be considered as an agenda item pursuant to the Bagley-Keene open meetings act, a proposed decision must be received at least 10 days prior to a regularly scheduled meeting. If a proposed decision is received within 10 days prior to a regularly scheduled meeting, it will be calendared as an agenda item at the next meeting. This proposed regulatory framework will allow all decisions to be heard within the 100 day time limit imposed by the APA for adoption of proposed decisions. Commissioners will therefore have a minimum of 10 and a maximum of 100 days to review a proposed decision. |
| 100450.100(d)<br>Page 1<br>Line 24 | California Ambulance Association | Correct typo as follows:<br><br>*Upon receipt of the Proposed Decision and Order from the Office of Administrative Hearings, the Commission shall calendar a discussion and vote ~~of~~ on the proposed decision at the next regularly scheduled Commission meeting.* | Comment acknowledged. Proposed language has been changed. |

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| 100450.100(e)<br>Page 2<br>Lines 26-28 | California Ambulance Association | Revise as follows:<br>*The Commission shall not accept new evidence at the meeting. However, the Commission shall permit public comment pursuant to the Bagley-Keene Open Meeting act, and such public comment may be considered by the Commission in rendering its decision.*<br><br>~~*The Commission shall permit Public comment pursuant to the Bagley-Keene Open Meeting act. The Commission shall not accept new evidence at the meeting, but shall rely solely on the evidence of record at the administrative hearing.*~~<br><br>The CAA agrees with the concept that no new formal evidence should be allowed, to prevent volumes of new material being submitted to the Commissioners. But, the language needs to be clarified so that it is clear the Commission may consider and weigh any public testimony it receives at its hearing on this matter. | Comment acknowledged. EMSA has modified the proposed regulation in response to comments to specifically allow public comment pursuant to statute. |
| 100450.100(e)<br>Page | Patrick Powers | Request that public comments permitted at the Commission meeting pursuant to the Bagley-Keene Open Meeting act are afforded consideration by the Commission. The reasoning is that if pursuant to subsection b of the proposed regulation, the administrative law judge (ALJ) shall evaluate all information submitted by the Authority and the local EMS | Comment acknowledged. EMSA has modified the proposed regulation to specifically allow public comment pursuant to statute. |

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| | | agency, there is no allowance of the ALJ to consider public comment. LEMSAS have a tendency to device EMS plans outside of the purview of their EMS system stakeholders, and do not necessarily want local public comment on their plans. The public should be able to be heard and comments considered by either the ALJ or the Commission | |
| 100450.100(f)<br>Page 2<br>Lines 29-33 | El Dorado County EMS Agency | Proposed regulations 100450.100(a) states that any appeal shall be conducted in accordance with the APA, GC §11500 et seq. and associated regulations in Title 1 of the CCRs; however, this conflicts with Proposed regulation 100450.100(f) which changes the parameters of GC §11517 relating to allowed Commission action on the proposed decision submitted by the ALJ.<br><br>Proposed regulation 100450.100(f) states that the Commission's vote on the proposed decision is limited either 1) adopting the ALJ's proposed decision, or 2) not adopting the ALJ's proposed decision, or 3) returning the proposed decision to the OAH for rehearing if the proposed decision is inconsistent with "this article or statute or regulations." This deviates from GC §11517 decision options.<br><br>Questions: Is the Commission required to adopt the ALJ decision without changes? (i.e. not technical or | Comment acknowledged.<br><br>Comment acknowledged. All the decision parameters of GC 11517 relating to actions that may be taken on a proposed decision are not available to the Commission on EMS due to the constraints contained in HSC 1797.105.<br><br>Comment acknowledged. Pursuant to GC 11517, the Commission on EMS may adopt |

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| | | minor changes or clarifications that do not affect the factual or legal basis of the proposed decision?) | as its decision the ALJ's opinion in the proposed decision. The Commission may not modify the proposed decision, as it is constrained by the provisions of HSC 1797.105(d). |
| | | If the Commission votes to "not adopt" the ALJ's proposed decision then is the final decision the opposing decision by default and without any changes? | Comment acknowledged. If the Commission on EMS does not adopt as its decision the ALJ's opinion in the proposed decision, then the opposite conclusion is adopted. Ex: If an ALJ's proposed decision is to uphold the Authority's denial of the local plan, and the Commission votes to not adopt that decision, then the determination of the Authority is deemed overruled pursuant to HSC 1797.105(d). |
| | | If the Commission decided to return the proposed decision for rehearing, what does "inconsistent with this article, or statute or regulations" mean?<br><br>What article, statute or regulations? | Comment acknowledged. EMSA has modified the language of the proposed regulation in response to comments. |
| 100450.100(f)(3)<br>Page 2<br>Lines 32-33 | California Ambulance Association | Revise as follows:<br>*(3) return the proposed decision to the office of Administrative Hearings for re-hearing if the proposed decision is inconsistent with this article or statute or regulations, or the Commission determines that another basis exists for return of the decision to the administrative law judge.* | Comment acknowledged. EMSA has modified the proposed language of the regulation in response to comments. |

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| | | The Commission should have the discretion to return the ALJ decision for other compelling reasons beyond solely "inconsistencies". | |
| 100450.100(f)(3)<br>Page 2<br>Lines 32-33 | County of Kern | The County requests that subdivision (f)(3) be modified to provide that the Commission may "reject the proposed decision and refer the case to the same administrative law judge if reasonably available, otherwise to another administrative law judge, to take additional evidence." See comments in attached letter.<br><br>Subdivision (f)(3) provides that the Commission may veto to "return the proposed decision to the office of Administrative Hearings for re-hearing if the proposed decision is inconsistent with this article or statute or regulations." This regulation is vague as well as inconsistent with the Administrative Procedures Act.<br><br>The County therefore requests that subdivision (f)(3) be modified in accordance with Government Code 11517(c)(2)(D) to provide that the Commission may "reject the proposed decision and refer the case to the same administrative law judge if reasonably available, otherwise to another administrative law judge, to take additional evidence." | Comment acknowledged. EMSA has modified the proposed language of the regulation in response to comments.<br><br>Comment acknowledged.<br><br>Comment acknowledged. EMSA has modified the proposed language of the regulation in response to comments. |
| 100450.100(f)(3)<br>Page 2 | MCRFD & SRVFPD | Subsections (f)((1)-(3) provide the Commission with the option of either | Comment acknowledged. |

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| Line 37 | | adopting or not adopting the ALJ's proposed decision, or returning the decision to the office of Administrative Hearings for re-hearing "if the proposed decision is inconsistent with this article or statute or regulations."<br><br>It is respectfully requested that the just referenced language be deleted, thereby granting the Commission with wider latitude to return the matter for additional hearings, such as in the event that new evidence or changed circumstances exist that would materially impact the judge's recommendation or the Commission's review of the issues. Subsection (f)(3) should read:<br><br>(3) return the proposed decision to the office of AdministrativeHearings for re-hearing. | Comment acknowledged. EMSA has modified the proposed language of the regulation in response to comments. |
| 100450.100(h)<br>Page 2<br>Line 37 | California Ambulance Association | Delete this section:<br>~~(h) The decision of the Commission is final.~~<br><br>Health and Safety Code, Section 1797.105(d) clearly states that the Commission's decision is final. It is not necessary to re-state that fact in these regulations. | Comment acknowledged. EMSA has deleted the requested language. |
| 100450.100(h)<br>Page 2<br>Line 37 | County of Kern | The County requests that subdivision (h) be modified to provide: "The decision of the Commission shall be | Comment acknowledged. |

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| | | deemed an exhaustion of administrative remedies." See comments in attached letter.<br><br>The County objects to subdivision (h) of Section 100450, which provides that the "decision of the Commission is final." This subdivision may be interpreted to bar judicial recourse after an adverse administrative decision. The County requests that the subdivision be modified, as recommended by the Emergency Medical Services Administrators' Association of California ("EMSAAC") in their letter of March 4, 2015, as follows:<br><br>(h) The decision of the Commission shall be deemed an exhaustion of administrative remedies. | Comment acknowledged. EMSA has deleted the proposed section in response to comments.<br><br>Comment acknowledged. EMSA has deleted the proposed section in response to comments. |
| 100450.100(h)<br>Page 2<br>Line 37 | El Dorado County EMS Agency | A final decision by the Commission should be deemed an exhaustion of administrative remedies. This request is being made out of concern that the Authority and/or the Commission may attempt to interpret proposed subdivision (h) of Section 100450.100 as a bar to judicial recourse by a LEMSA following an adverse administrative decision. The following change is proposed:<br><br>(h) The final decision of the Commission shall be deemed an exhausting of administrative remedies. | Comment acknowledged. EMSA has deleted the proposed section in response to comments. |

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| 100450.100(h)<br>Page 2<br>Line 37 | EMS Administrators' Association of California (EMSAAC) | Revise to read: "The decision of the Commission *shall be deemed an exhaustion of administrative remedies*." (Please attached letter for further explanation of requested changes.)<br><br>Likewise, out of concern that EMSA may attempt to interpret its proposed subdivision (h) of Section 100450.100 as a bar to judicial recourse by a LEMSA following an adverse administrative decision, EMSAAC proposes the following change to that subdivision:<br><br>(h) The decision of the Commission *shall be deemed an exhaustion of administrative remedies*. | Comment acknowledged.<br><br>Comment acknowledged. EMSA has deleted the proposed section in response to comments. |
| 100450.100(h)<br>Page 2<br>Line 37 | MCRFD & SRVFPD | As currently worded, Subsection (h) could be read to bar a judicial challenge of the Commission decision. Specifying that the Commission decision constitutes only an exhaustion of the parties' administrative remedies would avoid procedural due process concerns. Therefore, the following underlining language is proposed for addition to Subsection (h):<br><br>(h) The decision of the Commission <u>constitutes an exhaustion of administrative remedies</u>. | Comment acknowledged.<br><br>Comment acknowledged. EMSA has deleted the proposed section in response to comments. |
| 100450.100(h)<br>Page 2 | Sacramento County EMS Agency (SCEMSA) | Likewise, out of concern that EMSA may attempt to interpret its proposed | Comment acknowledged. |

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| Line 37 | | subdivision (h) of Section 100450.100 as a bar to judicial recourse by a LEMSA following an adverse administrative decision, SCEMSA proposes the following change to that subdivision:<br><br>(h) The decision of the Commission *shall be deemed an exhaustion of administrative remedies*.<br><br>As written, this section may limit and bar a judicial recourse by a Local EMS Agency following an adverse administrative decision.<br>SCEMSA recommends the Section be **amended** to read: 'The decision of the Commission *shall be deemed an exhaustion of administrative remedies.*' | Comment acknowledged. EMSA has deleted the proposed section in response to comments. |
| 100450.100(h)<br>Page 2, line 37 | County of Marin<br>and<br>ICEMA | Out of concern that EMSA may attempt to interpret its proposed subdivision (h) of Section 100450.100 as a bar to judicial recourse by a LEMSA following an adverse administrative decision, County of Marin and ICEMA proposes the following change to that subdivision:<br><br>(h) The decision of the Commission shall be deemed an exhaustion of administrative remedies. | Comment acknowledged. EMSA has deleted the proposed section in response to comments. |
| 100450.100 (i)<br>Page 2<br>Lines 38-39 | California Ambulance Association | Revise as follows:<br>*(i) ~~Pursuant to~~ California Code of Regulations Title 1, Section 1042 – Cost Recovery~~, the prevailing party may recover costs~~ shall not be* | Comment acknowledged. EMSA has modified the proposed regulation in response to comments. Costs of the administrative hearing will be |

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| | | *applicable to this appeal process*.<br><br>Parties in the dispute should be responsible for their own costs in the appeal process. Knowing that there will be costs regardless of the outcome may serve as an incentive to minimize filing of any frivolous appeals. Costs of the ALJ hearing should be split among the parties of the appeal. | shared equally by all the parties. Cost shall not include attorney's fees. |
| 100450.100 (i)<br>Page 2<br>Lines 38-39 | County of Kern | The County requests that subdivision (i) be deleted. See comments in attached letter.<br><br>The County objects to EMSA's inclusion of cost recovery to the prevailing party in subdivision (i) of Section 100450. While California Code of Regulations Title 1, Section 1042 permits the recovery of costs by a prevailing party, it also requires the prevailing party to cite "the applicable cost recovery statute or regulation." Section 1042 does not, in itself, create an entitlement to recovery of costs.<br><br>The EMS Act (Health & Safety § 1797 et seq.), particularly Section 1979.105, does not authorize cost recovery in connection with a local EMS agency's appeal of EMSA's refusal to approve a local EMS plan. Code of Regulations Title 22, Division 9 pertaining to prehospital emergency medical services likewise does not provide for cost recovery. | Comment acknowledged.<br><br>Comment acknowledged.<br><br>Comment acknowledged. |

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| | | The County objects to the attempt to enable the prevailing party to recover costs because such a measure would be punitive and would discharge a local EMS agency from appealing an arbitrary EMSA decision. | Comment acknowledged. EMSA has modified the proposed regulations in response to comments. Title 1, Section 1042(a) specifically says: "(a) An agency shall allege in its pleading any request for costs, citing the applicable cost recovery statute **or regulation**."(emphasis added) As this is a proposed enabling regulation, the proposed language will allow for the recovery of costs. The proposed regulation has been modified to state that costs of the administrative hearing will be shared equally by all parties. Costs do not include attorney's fees. |
| 100450.100(i)<br>Page 2<br>Lines 38-39 | El Dorado County EMS Agency | Proposed regulation 100450.100(i) states that the prevailing party may recover costs pursuant to 1 CCR 1042. 1 CCR 1042 is not self-implementing and requires the agency requesting costs to cite the applicable cost recovery statute or regulation.<br><br>What statute or regulation is applicable to recovery in an appeal by a LEMSA of an Authority decision on an EMS Plan? El Dorado County EMS Agency objects to the Authority's attempt to include cost recovery in a regulation because it appears punitive in nature and an attempt to discourage the LEMSAs from exercising their | Comment acknowledged. EMSA has modified the proposed regulations in response to comments. Title 1, Section 1042(a) specifically says: "(a) An agency shall allege in its pleading any request for costs, citing the applicable cost recovery statute **or regulation**."(emphasis added) As this is a proposed enabling regulation, the proposed language will allow for the recovery of costs. The proposed regulation has been modified to state that costs of the administrative hearing will be shared equally by all parties. |

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| | | statutory right to an appeal. This section should be deleted in its entirety. | Costs do not include attorney's fees. |
| 100450.100 (i)<br>Page 2<br>Lines 38-39 | EMS Administrators' Association of California (EMSAAC) | Delete subsection in its entirety. (Please attached letter for further explanation of requested changes.) | Comment acknowledged. |
| | | EMSAAC objects to EMSA's attempt to include cost recovery by the prevailing party. While Title 1, Section 1042 permits the recovery of costs by a prevailing party, subsection (a) of that provision requires the prevailing party to cite "the applicable cost recovery statute or regulation." Section 1042 does not, in itself, create an entitlement to recovery of costs. | Comment acknowledged. |
| | | Viewing the EMS Act (Health & Saf. Code, §1797, et seq.), and Section 1797.105 in particular, nowhere is the recovery of costs authorized or even mentioned in connection with a LEMSA's appeal of EMSA's refusal to approve a local EMS plan. Similarly, Title 22 of Division 9 of the Code of Regulations pertaining to prehospital emergency medical services is devoid of any cost recovery measures. | Comment acknowledged. |
| | | The attempt to enable the prevailing party to recover costs is objectionable as it appears punitive in nature, and would serve to potentially discourage a LEMSA from appealing what it may deem to be an arbitrary decision of the | Comment acknowledged. EMSA has modified the proposed regulations in response to comments. Title 1, Section 1042(a) specifically says: "(a) An agency shall allege in its pleading |

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| | | EMSA. EMSAAC urges that references to cost recovery be deleted from the proposed Section 100450.100 of Title 22. | any request for costs, citing the applicable cost recovery statute **or regulation**."(emphasis added) As this is a proposed enabling regulation, the proposed language will allow for the recovery of costs. The proposed regulation has been modified to state that costs of the administrative hearing will be shared equally by all parties. Costs do not include attorney's fees. |
| 100450.100 (i)<br>Page 2<br>Lines 38-39 | MCRFD & SRVFPD | Subsection (i) is ambiguous and poses potential consequences, and should be revised to specify that each party is to bear they own costs.<br><br>First, it is noted that 1 CCR 1042 does not, by itself authorize a prevailing party to recover its costs. Rather it requires that an agency cite "cit[e] the applicable cost recovery statute or regulation." That is recovery of costs must be otherwise authorized by law.<br><br>Second, it is unclear whether as used in Subsection (i), the term "costs" include attorney's fees.<br><br>Thirdly, it is unclear whether the term "prevailing party" means. That is, who is the "prevailing party" in situations where the Commission does not adopt the ALJ's recommendation? For | Comment acknowledged.<br><br>Comment acknowledged. No change requested.<br><br>Comment acknowledged.<br><br>Comment acknowledged. EMSA has modified the proposed regulations in response to comments. Title 1, Section 1042(a) specifically says: "(a) An |

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| | | example, assume the ALJ's proposed order is in favor of a Local EMS Agency, by the Commission determines to not adopt the judge's decision. Should the "prevailing party" be ultimately determined by Commission vote, the Commission itself is then in perilous position of controlling who is to bear costs: its own agency or a Local EMS Agency. | agency shall allege in its pleading any request for costs, citing the applicable cost recovery statute **or regulation**."(emphasis added) As an enabling regulation, the proposed language will allow for the recovery of costs. The proposed regulation has been modified to state that costs of the administrative hearing will be shared equally by all parties. Costs do not include attorney's fees. |
| 100450.100 (i)<br>Page 2<br>Lines 38-39 | Sacramento County EMS Agency (SCEMSA) | As written, this section appears to be punitive in nature, and would serve to potentially discourage a Local EMS Agency from appealing what it deem to be an arbitrary decision of the Authority. The Authority has not cited 'the applicable cost recovery statute or regulation' that Section 1042 (a) Title 1 requires.<br><br>SCEMSA recommends this Section be **DELETED** and all parties to the administrative appeals bear their own costs.<br>SCEMSA objects to EMSA's attempt to include cost recovery by the prevailing party. While Title 1, Section 1042 permits the recovery of costs by a prevailing party, subsection (a) of that provision requires the prevailing party to cite "the applicable cost recovery statute or regulation." Section 1042 does not, in itself, create an | Comment acknowledged.<br><br>Comment acknowledged. |

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| | | entitlement to recovery of costs.<br><br>Viewing the EMS Act (Health & Safety Code, §1797, et seq.), and Section 1797.105 in particular, nowhere is the recovery of costs authorized or even mentioned in connection with a LEMSA's appeal of EMSA's refusal to approve a local EMS plan. Similarly, Title 22 of Division 9 of the Code of Regulations pertaining to prehospital emergency medical services is devoid of any cost recovery measures.<br><br>The attempt to enable the prevailing party to recover costs is objectionable as it appears punitive in nature, and would serve to potentially discourage a LEMSA from appealing what it may deem to be an arbitrary decision of the EMSA. SCEMS urges that references to cost recovery be deleted from the proposed Section 100450.100 of Title 22. | Comment acknowledged. EMSA has modified the proposed regulations in response to comments. Title 1, Section 1042(a) specifically says: "(a) An agency shall allege in its pleading any request for costs, citing the applicable cost recovery statute **or regulation**."(emphasis added) As this is a proposed enabling regulation, the proposed language will allow for the recovery of costs. The proposed regulation has been modified to state that costs of the administrative hearing will be shared equally by all parties. Costs do not include attorney's fees. |
| 100450.100 (i)<br>Page 2<br>Lines 38-39 | County of Marin<br>And<br>ICEMA | County of Marin and ICEMA objects to EMSAs attempt to include cost recovery by the prevailing party. While Title 1, Section 1042 permits the recovery of costs by a prevailing party, subsection (a) of that provision requires the prevailing party to cite "the applicable cost recovery statute or regulation." Section 1042 does not, in itself, create an entitlement to recovery of costs. | Comment acknowledged. |

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| | | Viewing the EMS Act (H&SC 1797, et seq.), and 1797.105 in particular, nowhere is the recovery of costs authorized or even mentioned in connection with a LEMSAs appeal of EMSAs refusal to approve a local EMS plan. Similarly, Title 22 of Division 9 of the CCR pertaining to prehospital emergency medical services is devoid of any cost recovery measures.<br><br>The attempt to enable the prevailing party to recover costs is objectionable as it appears punitive in nature, and would serve to potentially discourage a LEMSA from appealing what it may deem to be an arbitrary decision of the EMSA. Marin/ICEMA urges that references to cost recovery be deleted from the proposed Section 100.450.11 of Title 22.<br><br>While Marin/ICEMA supports adoption of procedural rules for LEMSA appeals of EMSAs refusal to approve local EMS plans, it requests that portions of the proposed Section 100450.100 be revised to insure that: 1) evidence may be presented at public administrative hearings; 2) the decisions resulting from such hearings serve only to exhaust administrative remedies, and not preclude further recourse to the courts; and 3) that all parties to administrative appeals bear their own | Comment acknowledged. EMSA has modified the proposed regulations in response to comments. Title 1, Section 1042(a) specifically says: "(a) An agency shall allege in its pleading any request for costs, citing the applicable cost recovery statute **or regulation**."(emphasis added) As this is a proposed enabling regulation, the proposed language will allow for the recovery of costs. The proposed regulation has been modified to state that costs of the administrative hearing will be shared equally by all parties. Costs do not include attorney's fees.<br><br>Comment acknowledged. |

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| | | costs. | |

**COMMENTS for MODIFIED APPEALS PROCEEDINGS TO THE COMMISSION REGULATIONS, CHAPTER 13, Section 100450.100 Comment Period: May 14, 2015 – June 15, 2015**

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| General Comment | Inland Counties Emergency Medical Agency (ICEMA) | ICEMA agrees with the May 14, 2015, revisions to the proposed appeal regulation, and supports adoption of the regulation in its present form. | Comment acknowledged. |
| General Comment | El Dorado County EMS Agency | Objection to Rulemaking Process: Allowing the opposing party on an appeal to unilaterally adopt appeal procedures for the hearing body is a denial of due process. | Comment acknowledged. |
| General Comment | El Dorado County EMS Agency | The appeal regulations must be proposed and adopted by the Commission, not the Authority. | Comment acknowledged. No change made. Pursuant to Health & Safety Code, Section 1797.107, the EMS Authority has been given the statutory responsibility to promulgate regulations. The Commission on EMS has the statutory responsibility to approve rules and regulations created by the EMS Authority. |
| 100450.100 | El Dorado County EMS Agency | The proposed regulations do not meet the APA clarity standard (GC § 11349.1) See comments below. | Comment acknowledged. |
| 100450.100 (a), (f) | El Dorado County EMS Agency | The internal ambiguity has not been resolved. The Authority has created an inherent conflict by stating that the appeal will be conducted in accordance with the APA procedures without exception and then changed the procedures in a later provision. Proposed regulation 100450.100(a) states that any appeal shall be conducted in accordance with the APA, GC § 11500 et seq. and associated regulations in Title 1 of the | Comment acknowledged. |

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| | | CCRs; however this conflicts with Proposed regulation 100450(f) which changes the parameters of GC § 11517 relating to allowed Commission action on the proposed decision submitted by the ALJ. | |
| 100450.100 (c)<br>Page 1<br>Lines 17-22 | County of Kern | The County renews its request that subdivision (c) be modified to provide: "The administrative law judge, in making a proposed decision to the Commission shall make and articulate findings of fact and conclusions of law, and either grant the appeal, approving the local EMS plan as submitted to the Authority, or deny the appeal, disapproving the local EMS plan as submitted to the Authority, consistent with California Health and Safety Code section 10197.105 (d)."<br><br>EMSA has not proposed any regulations or guidelines dictating the format of the administrative law judge's decision. The judge must make a factual and legal determination under the statute that "the plan does not effectively meet the needs of the persons and is not consistent with coordinating activities in the geographical area served, or that the plan is not concordant and consistent with applicable guidelines or regulations, or both the guidelines and regulations, established by the authority." H& S § 1797.105(b). A written decision including findings of fact and conclusions of law would | Comment acknowledged. No change to language necessary. OAH provides a written decision with findings of fact and law in all matters. |

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| | | assist the Commission in making the final determination and provide clarity to EMSA and the local EMS agency regarding the areas of any plan that are inadequate.<br><br>Therefore, the County proposes the following modification to subdivision (c) to specifically instruct the ALJ and provide regulatory clarity:<br><br>(c) be modified to provide: "The administrative law judge, in make a proposed decision to the Commission shall make and articulate findings of fact and conclusions of law, and either grant the appeal, approving the local EMS plan as submitted to the Authority, or deny the appeal, disapproving the local EMS plan as submitted to the Authority, consistent with California Health and Safety Code section 10197.105 (d)." | |
| 100450.100 (d)<br>Page 1<br>Lines 23-25 | County of Kern | The County renews its request that subdivision (d) be modified to provide: "Upon receipt of the Proposed Decision and Order from the Office of Administrative Hearings, the Commission shall calendar a discussion and vote of the proposed decision at the next regularly scheduled Commission meeting not less than 30 days from receipt of the Proposed Decision Order." See comments in attached letter. | Comment acknowledged. No change to proposed language. The commission on EMS has regularly scheduled meetings approximately every 90 days. In order to be considered as an agenda item pursuant to the Bagley-Keene open meetings act, a proposed decision must be received at least 10 days prior to a regularly scheduled meeting. If a proposed decision is received within 10 days prior to a regularly |

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| | | Subdivision (d) provides that the Commission shall calendar a discussion and vote on the proposed decision at the next regularly scheduled meeting after receipt of the proposed decision and order. In the event the next regularly scheduled meeting is only a short time after the Commission receives the proposed decision, there will be insufficient time for the Commission and local EMS agency to consider the proposed decision fully. It is neither prudent or appropriate to rely on the vagaries of agenda publication as a calendaring standard for Commission rulings related to appeals<br><br>Therefore, the County proposes again the following modification to subdivision (d):<br><br>(d) Upon receipt of the Proposed Decision and Order from the Office of Administrative Hearings, the Commission shall calendar a discussion and vote of the proposed decision at the next regularly scheduled Commission meeting <u>not less than 30 days from receipt of the Proposed Decision Order</u>.<br>County has read and considered EMSA's comments but without clarity in the actual appeals process rules calendaring of the discussion process is open to discretion, abuse and or | scheduled meeting, it will be calendared as an agenda item at the next meeting. This proposed regulatory framework will allow all decisions to be heard within the 100 day time limit imposed by the APA for adoption of proposed decisions. Commissioners will therefore have a minimum of 10 and a maximum of 100 days to review a proposed decision. |

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| | | unnecessary delay. | |
| 100450.100 (d) | El Dorado County EMS Agency | It is a denial of due process if the LEMSAs are only given 10 days notice of the hearing before the Commission. Proposed regulation 100450.100(d) states that "upon receipt of the Proposed Decision and Order form the Office of Administrative Hearings, the Commission shall calendar a discussion and vote regarding the proposed decision at the next regularly scheduled Commission meeting." The Authority has indicated that under the current provision, the Commission will have a minimum of 10 days and a maximum of 100 days to review a proposed decision. This does not take into account procedural due process for the LEMSAs. Pursuant to Gov. Code 11517, 30 days after receipt of the proposed decision, the Commission is required to file the | Comment acknowledged. |

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| | | proposed decision on each party and its attorney. This also does not take into account the time needed to prepare a transcript of the administrative hearing, if necessary. The LEMSAs are entitled to sufficient time to read the proposed decision and to prepare oral or written arguments for the Commission hearing on the proposed decision. Giving the LEMSAs' 10 days notice of a hearing that may be conducted in another part of the state from where the LEMSA is located, without regard to the calendars of the necessary parties, without regard to the cost to the LEMSAs and without allowing the LEMSAs sufficient time to prepare oral and written arguments, if necessary, is a denial of due process. Commission meetings are held at locations throughout the state (i.e. San Diego, Sacramento, San Francisco, and Los Angeles). Special meetings may be required.<br><br>Additionally, the proposed appeal regulations, as written, are a denial of due process in that the decision to "not adopt" the proposed ALJ decision does not provide for due process during the Commission's reconsideration of the appeal as required by GC 11517. | |
| 100450.100 (f) | El Dorado County EMS Agency | The ambiguity has not been resolved. Proposed regulations 100450.100(a) states that any appeal shall be | Comment acknowledged. |

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| | | conducted in accordance with the APA, GC § 11500 et seq. and associated regulations in Title 1 of the CCRs; however, this conflicts with Proposed regulation 100450.100(f) which changes the parameters of GC § 11517 relating to allowed Commission action on the proposed decision submitted by the ALJ.<br><br>Proposed regulation 100450.100(f) states that the Commission's vote on the proposed decision is limited to either 1) adopting the ALJ's proposed decision, 2) "not adopting" the ALJ's proposed decision, or 3) returning the proposed decision to the OAH for rehearing. This deviates from GC § 11517 decision options. The Authority responded that all of the decision parameters of GC 11517 relating to actions that may be taken on a proposed decision are "not available" to the Commission due to constraints contained in HSC 1797.5.<br><br>Solely for the sake of argument, if the Commission is actually constrained by H&S 1797.105 then having the ALJ hear the appeal alone is not an option for the Commission and the Commission is required to hear the appeal itself so that it directly makes the decision to either approve or reject the decision of the Authority. Any decision by the Commission requires that due process be afforded to the | |

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| | | parties which includes the opportunity to be heard and that the Commission issue written findings of fact and conclusions of law. (GC 11425.50 and GC 11517)<br><br>LEMSA asked whether the Commission was required to adopt the ALJ decision without change? (i.e. no technical or minor changes or clarifications that do not affect the factual of legal basis of the proposed decision.) The Authority responded that no changes or modifications are allowed. If that is true, then minor changes or clarifications that do not affect the factual or legal basis of the proposed decision will require the Commission to refer the proposed decision back to the ALJ for revision, return of the revised proposed decision to the Commission, service on the LEMSA and its attorney, another hearing before the Commission and then a final decision. This is a complete waste of time and money.<br><br>LEMSA asked whether a Commission vote to "not adopt" the ALJ's proposed decision would result in the opposite decision by default. The Authority responded that a vote to "not adopt" a proposed decision is the adoption of the opposite conclusion. In order for the Commission to "not adopt" the ALJ decision, the Commission will have to | |

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| | | consider the record and make findings and legal conclusions of its own.<br><br>After the ALJ's issues the proposed decision there is a second level of decision making in which the Commission decides whether to adopt the proposed decision, the Commission is by default also making a decision to decide the appeal itself and such reconsideration requires the due process procedures set forth in Government Code 11517(c)(2)(E). The Commission cannot merely "not adopt" (reject) the proposed decision without reconsidering/deciding the appeal itself. Merely rejecting the ALJ decision without more, results in there being no disposition of the appeal and no decision for judicial review. If the Commission elects to "not adopt" (reject) the proposed ALJ decision then the Commission must review the record, accept oral or written argument and issue its own written decision setting forth the factual and legal basis for the decision. Without a written decision setting forth the factual and legal basis for the decision, judicial review is impossible and the LEMSA's would be denied due process.<br><br>This adoption by default is a denial of due process to the LEMSA if the ALJ rejects the EMSA disapproval and the Commission votes to "not adopt" the decision of the ALJ (disapprove the | |

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| | | EMS Plan). Adoption by default is a denial of due process to the Authority would also need a written decision from the Commission explaining the factual and legal basis for rejecting a decision for future guidance and reference.<br><br>If the Commission is not required to follow due process procedural safeguards as set forth in the APA in making a contrary decision then the proposed Commission appeal procedures are unconstitutional. As stated in *Yanke v State Department of Public Health* 162 Cal.App.2d 600, 602-603, "The board may adopt the hearing officer's proposed decision (Gov Code § 11517, subd, (b)) and may do so without reading the transcript of the hearing. (*Hohreiter v. Garrison*, 81 Ca.App.2d 384, 396, et seq. [184 P.2d 323].) However, if the proposed decision is not adopted, the board, before it can render a contrary decision, must read the record and afford the parties the opportunity for argument. (Gov. Code § 11517, subd, (c)), *Hohreiter v. Garrison*, supra, p.396)" Under the proposed Commission appeal regulations, there is only the option to "not adopt" the proposed ALJ decision without any Commission review of the record, no opportunity for argument form the parties and no requirement for a written decision setting forth the | |

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| | | factual and legal basis for the contrary decision. This is a denial of due process. | |
| 100450.100 (h)<br>Page 2<br>Line 37 | County of Kern | The County renews its request that subdivision (h) be modified to provide: "The decision of the Commission shall be deemed an exhaustion of administrative remedies." See comments in attached letter.<br><br>The County objects to the deletion of subdivision (h) of Section 100450. The County requests that the subdivision read instead:<br><br>(h) The decision of the Commission shall be deemed an exhaustion of administrative remedies. | Comment acknowledged. Proposed current language is consistent with HSC 1797.105. |
| 100450.100 (h) | El Dorado County EMS Agency | A final decision by the Commission should be deemed an exhausting of administrative remedies. The following change is proposed:<br><br>(h) The final decision of the Commission shall be deemed an exhaustion of administrative remedies. | Comment acknowledged. Proposed current language is consistent with HSC 1797.105. |
| 100450.100 (i) | El Dorado County EMS Agency | Proposed regulation 100450.100(h) states that "Costs of the administrative hearing shall be borne equally by the parties. Costs shall not include attorney's fees."<br><br>What is specifically included in "costs of administrative hearing"? The cost of the services of the Office of | Comment acknowledged. |

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| | | Administrative Hearings (OAH) is borne by the state agency to which the services are provided. (Government Code §11370.4) Under common law, the services of a judge are publicly funded.<br><br>The amended regulation penalizes a LEMSA for exercising its right to due process (appeal). HSC 1797.105 gives the LEMSAs the statutory right to appeal a decision of the Authority to the Commission. There is nothing in the appeal statute that requires the LEMSA to pay for the costs of the administrative hearing.<br><br>The amended regulation penalizes a LEMSA for exercising its right to due process (appeal). HSC 1797.105 gives the LEMSAs the statutory right to appeal a decision of the Authority to the Commission. There is nothing in the appeal statute that requires the LEMSA to pay the costs of the administrative hearing. Under the proposed regulations, a LEMSA can only appeal a decision of the Authority if the LEMSA is willing to bear half the costs of the "administrative hearing" whether the LEMSA wins or loses (in whole or in part) and regardless of the merits of the appeal. The Commission has a statutory duty to hear appeals of an Authority denial of a LEMSA EMS Plan. This regulation imposes a monetary penalty on the actual | |

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| | | exercise of the right to a hearing. This regulation has a chilling effect on the LEMSA's statutory right to appeal and has no real or substantial relation to a proper legislative goal.<br><br>Cost recovery in administrative proceedings is frequently related to professional licensing or regulatory enforcement wherein an agency only recovers costs for investigation and enforcement costs up to the start of the hearing. This is not a regulatory or enforcement situation, it is a determination by the Authority as to whether or not an EMS Plan conforms to the requirements of the EMS Act. No one loses a license and no one gets shut down. As noted by the Authority, if a plan is disapproved by the Authority, the LEMSA allowed to operate under the last approved plan.<br><br>El Dorado County EMS Agency objects to the Authority's attempt to include cost recovery in a regulation because it appears punitive in nature and an attempt to discourage the LEMSAs from exercising their statutory right to an appeal. This section should be deleted in its entirety. | |

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

**DATE:** September 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 time frames and recent activity.

## FISCAL IMPACT:

None

## DISCUSSION:

At the 2014 Commission on EMS meeting a discussion was held on the submission of EMS Plans by the Local EMS Agencies to the EMS Authority. The EMS Authority was requested to provide information that outlined the activities related to review of EMS Plans from both the LEMSA and EMSA perspective.

As a background, pursuant to Health and Safety Code Section 1797.254, each LEMSA shall annually submit an emergency medical services plan for the EMS area to the authority, according to EMS Systems, Standards, and Guidelines established by the authority. Once submitted, these plans are reviewed in the EMS Systems Division supervised by the EMS Plans Coordinator, under direction of the Division Chief.

Once submitted to EMSA, EMS Plans undergo an initial review to confirm all required components have been included. If the plans are found to missing a required component the LEMSA is contacted to update their submission. Once the plan contains all required components it is disseminated to staff members with primary program responsibilities (Trauma, Transportation, Quality Improvement, Communications, etc.) as part of the 'Subject Matter Expert' review portion. Comments from the SME's are then compiled and reviewed by the EMS Plan Coordinator.

If it is deemed that additional information or further clarification is needed on any part(s) of the plan, a request is made to the LEMSA. Once that request is fulfilled, or if no additional clarification is required, the plan is considered complete and a determination is made. Once the determination is made by the EMS Authority, the LEMSA is advised in writing of the decision. Upon approval the LEMSA is provided any pertinent observations made by EMSA during the review as well as a due date for their next plan submission. If the plan submission is disapproved, the LEMSA then has the option of submitting a revised plan or requesting an appeal of the determination.

The EMS Authority has been working with EMS stakeholders, through the Chapter 13 Workgroup and other outreaches, to identify a clearer, more concise EMS Plan submission and review process that would be beneficial to both EMSA and the LEMSA's. Areas of focus include a more streamlined submission process and defined timelines throughout the process resulting in a more timely determination.

The Commission on EMS has requested that the EMS Authority provide a regular progress report on current submission activity. For the Commission's consideration, the EMS Authority has created a visual representation depicting:

- Current overall status of all 33 LEMSA's as related to EMS Plan submissions.
- Overview of all plan review activity for past calendar year.
- Status of all EMS Plans currently in the possession of the EMS Authority.
- Overview of time each current submission has spent in various review phases.
- Types of information and/or clarification being requested of LEMSA's during process.

It is the intention of the EMS Authority to keep this information updated and available for presentation to the Commission of EMS on a quarterly basis. Should the Commission wish to see additional or different information the presentation can be adjusted appropriately.

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

**DATE:** September 2, 2015

**TO:** Commission on EMS

**FROM:** Howard Backer, MD, MPH, FACEP
Director

**PREPARED BY:** Bonnie Sinz, RN
Interim EMSC Coordinator

**SUBJECT:** Approval of Revision to Guidelines for Pediatric Interfacility Transport Program, EMSA #181

## RECOMMENDED ACTION:

Approve EMSA #181 – Guidelines for Pediatric Interfacility Transport Program.

## FISCAL IMPACT:

None.

## DISCUSSION:

The EMS Authority, in conjunction with the EMS for Children Technical Advisory Committee (TAC) and the EMS for Children Coordinators Group, has revised the "Guidelines for Pediatric Interfacility Transport Program. The original Interfacility Transport Program document was developed in February 1994. The original document was circulated and reviewed by the EMSC TAC and Coordinators with revisions being recommended based on current practices around the State.

The guideline was redrafted and sent out for a total of three public comment periods - August through September 2011; September through October 2012; and July through August 5, 2014. Revisions to the document were made based on comments received.

Once approved by the Commission on EMS, the document will be provided to each LEMSA and placed on the EMSA website.

The EMS Authority recommends the Commission on EMS approve of the revision to Guidelines for Pediatric Interfacility Transport Program, EMSA #181.

# Guidelines for Pediatric Interfacility Transport Program

Emergency Medical Services Authority
California Health and Human Services Agency

EMSA #181
Revised 2015

# Guidelines for Pediatric Interfacility Transport Program

**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**

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# Table of Contents

# GUIDELINES FOR PEDIATRIC INTERFACILITY TRANSPORT PROGRAMS IN CALIFORNIA

## Introduction

Safe and effective emergency transport of pediatric patients between health care facilities and specialized pediatric centers (e.g. Pediatric Critical Care Centers, Pediatric Trauma Centers, and Trauma Centers) is an essential component of organized systems of care for critically ill and injured children. Assuring access and appropriate linkage to such specialized centers should be part of local and regional EMS for Children (EMSC) programs.

Specialized centers for neonatal and pediatric emergency and critical care developed rapidly in the early 1990's in California. Neonates and critically ill and injured children are being transported from community health facilities, including emergency departments, to centers with specialized pediatric personnel and services. Prompt referral of such patients has been shown to improve outcomes. Specialized interfacilty transport programs have also evolved to improve access to these centers and to facilitate earlier delivery of specialized critical care services. Ideally all pediatric interfacility transports should occur rapidly and safely by qualified interfacility pediatric transport programs functioning with prospectively developed operational guidelines, consultation agreements and transfer agreements.

The purpose of this publication is to provide uniform guidelines within the state for pediatric interfacility transport programs to assure quality of care, cost efficiency, coordination of transports, and adherence to state and federal regulations.

In 1986, a statewide California Pediatric Critical Care Coalition was formed to develop recommendations for improving services for critically ill and injured children. A committee of the Coalition developed recommendations for pediatric interfacility transport services. This committee of the Coalition was composed of members of the Advisory Committee of the Northern California Perinatal Dispatch Center, the Pediatric Intensive Care Networks of Northern and Central California and the ad hoc Committee on Pediatric Interfacility Transport Services in California. In 1992, representatives of the Coalition's committee were appointed to the Pediatric Interfacility Transport Program Subcommittee of the California EMSC Project. This subcommittee developed the first state guidelines. This publication is a revision of the original guidelines to reflect current practices. Earlier drafts of these guidelines were used in the development of Guidelines for Air and Ground Transport of Neonatal and Pediatric Patients published by the American Academy of Pediatrics.

Pediatric interfacility transport programs, like other components of pediatric emergency and critical care systems, must be tailored to the special needs and resources of each region. These guidelines are intended to apply to both hospital-based and non-hospital-based programs that *regularly* provide pediatric interfacility transport services.

**Introduction** (continued)

Prehospital care providers are currently involved in the interfacility transport of pediatric patients. If such transport services are rendered routine, as part of a prehospital care provider service plan or contract, it is recommended the provider follow these guidelines. Determination of the level of capability of the transporting service, whether an ambulance provider or an organized pediatric interfacility transport program, is the responsibility of both the transferring and receiving physicians. When ambulance providers predominantly involved in prehospital care conduct pediatric interfacility transfers, the appropriateness of such transports and quality of care provided should be reviewed and monitored by the local EMS agency in concert with pre-hospital care providers. This review should be included in the local Emergency Medical Services agencies and provider agencies Quality Improvement plan.

## I. DEFINITIONS:

Advanced Emergency Medical Technician (Title 22, Division 9, Chapter 3, Section 100103) or “AEMT” or “EMT-II” means (a) a California certified EMT with additional training in limited advanced life support (LALS) according to the standards prescribed by Chapter 3, and who has a valid Advanced EMT wallet-sized certificate card issued pursuant to Chapter 3, or (b) an individual who was certified as an EMT-II prior to the effective date of this chapter, whose scope of practice includes the LEMSA approved Advanced EMT Scope of Practice as well as the Local Optional Scope of Practice, and who was part of an EMT-II program in effect on January 1, 1994.

Ambulance Provider means an organization employing certified EMT-I, certified EMT-II or licensed paramedic personnel who provides air or ground ambulance services.

Emergency Medical Technician (Title 22, Division 9, Chapter 2, Section 100060) or “EMT-I” or “EMT-Basic” means a person who has successfully completed an EMT-I course which meets the requirements of Chapter 2, has passed all required tests, and who has been certified by the EMT-I certifying authority.

Emergency Medical Technician-Paramedic (Title 22, Division 9, Chapter 4, Section 100139) or "EMT-P" or "paramedic" or "mobile intensive care paramedic" means an individual who is educated and trained in all elements of prehospital advanced life support (ALS); whose scope of practice to provide ALS is in accordance with the standards prescribed by Chapter 4, and who has a valid license issued pursuant to Chapter 4.

Local EMS Agency (LEMSA) (Health & Safety Code, Chapter 4, Article 1, Section 1797.200) means a designated agency, department, or office having primary responsibility for administration of emergency medical services in a county or city.

Medical Control Physician means the physician who is responsible for directing the medical care of the patient during transport which includes standing field treatment protocols.

Pediatric means neonates, infants, children and adolescents. For data collection purposes pediatric is defined as less than 15 years of age (as per California Children Services). Some facilities may extend the pediatric age to 21 years old.

Pediatric Interfacility Transport means the transport of ill or injured pediatric patients between health care facilities.

Pediatric Interfacility Transport Program means a transport program organized to provide pediatric interfacility transport on a regular basis. This program may be

hospital-based or non-hospital-based.

Prehospital Care Providers means an EMS provider approved by the local EMS agency.

Qualified Specialist. (Title 22, Division 9, Chapter 7, Section 100242) "Qualified Specialist" or "qualified surgical specialist" or "qualified non-surgical specialist means a physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.

A non-board certified physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a trauma center if:

(1) the physician can demonstrate to the appropriate hospital body, and the hospital is able to document, that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada;
(2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and
(3) the physician has successfully completed a residency program.

Regional Interfacility Pediatric Transport Program means an organized program that provides pediatric transport services for multiple facilities in a geographic area.

Referring Physician means the physician at the sending facility.

Transport Team means a medical team composed of a minimum of two healthcare professionals responsible for providing clinical care and monitoring of a patient during transport.

Transport Team Nurse means a registered nurse who provides clinical care for a patient, during transport, and within the scope of the licensure and training.

Transport Team Physician means the physician providing clinical care for a patient during transport.

Transport Team Respiratory Therapist means a respiratory therapist or a respiratory care practitioner providing clinical care for a patient during transport within the scope of licensure and training.

## II. STRUCTURE

A. All transport programs should have, at a minimum, the following components included in their systems.

1. Organization and Personnel

2. Operational Agreement with Ambulance Providers

3. Affiliated Hospital Agreement

4. Continuous Quality Improvement Program

5. Information Management

6. Pediatric Interfacility Transport Equipment and Supplies

## III. ORGANIZATION AND PERSONNEL

All transport programs should have sufficient personnel, staff and resources to facilitate and provide appropriate support of all aspects of the transport program, including but not limited to:

A. Administrative Director of Pediatric Interfacility Transport Program

1. Qualifications

   a. Training and experience in transport administration

2. Responsibilities

   a. Oversight of structure, administration, operational components, fiscal management, information management and a quality improvement mechanism for the pediatric transport program.
   b. Assurance that the transport program and personnel meet all applicable, federal, state and local laws, regulations, and licensure requirements.
   c. Implement and develop safety programs in conjunction with the Medical Director.
   d. Provides for continuing education to maintain and enhance necessary skills in conjunction with the medical director.
   e. Notification of transport team members about insurance coverage and medicolegal implications of being transport team members.
   f. Established liaison with local EMS agencies and other involved public and private agencies.

B. Medical Director

1. Qualifications

a. Specialized training, experience, or expertise in pediatric transport medicine.
b. Qualified specialist in pediatric emergency medicine, pediatric critical care, neonatal, or emergency medicine.
c. If the medical director does not meet the requirements of 1(b) there must be an associate medical director with these qualifications.

2. Responsibilities

a. Concurrent service as administrative director if individual meets qualifications in Section III.A.(1) and Section III.B.(1).
b. Authority over transport utilization.
c. Coordination of specialists and services required in the transport of patients.
d. Establishment of guidelines for transport team composition and mode of transportation.
e. Appointment and assurance of competence of medical control physicians and transport team physicians and the development of appropriate orientation, training, and continuing education programs for these physicians.
f. Appointment of associate medical director(s) as necessary.
    (1)The associate medical director(s) should have specialized training, experience and expertise in pediatric transport and pediatric critical care, including advanced skills in monitoring and life support techniques.
    (2) When a medical director is unavailable, an associate medical director should be designated to function as medical director.

C. Transport Team Coordinator

1. Qualifications

a. Registered nurse, respiratory therapist, paramedic, or physician.
b. At least 2 years of clinical experience in pediatric transport.
c. Advanced skills and knowledge of the standards of practice in pediatric monitoring and life support techniques. Advanced skills training (i.e., Pediatric Advanced Life Support, Pediatric Education for Prehospital Professionals, Prehospital Trauma Life Support, etc.) is determined by the medical director.
d. A minimum of 3 years of clinical experience in pediatric critical care, neonatal intensive care or pediatric emergency services.

2. Responsibilities

a. Concurrent service as the administrative director if individual meets qualifications on Section III.A.(1) and Section III.C.(1).
b. Appointment and assurance of competence of transport team members and development of appropriate orientation, training and continuing education programs.

D. Joint Responsibilities of the Administrative and Medical Directors

1. Collaborative responsibilities of the administrative and medical directors include, but are not limited to, the following:

a. Implementation of these guidelines for the pediatric interfacility transport program.
b. Development, implementation and annual review of policies protocols, and standards for the transport program, including policies and procedures for patient care.
c. Collection and analysis of data necessary for evaluation of the safety and effectiveness of the transport program.
d. Integration of orientation, training and continuing education programs for personnel involved in the transport program.
e. Selection and periodic evaluation of competency and performance of personnel involved in the transport program.
f. Implementation of an organized quality improvement program which is integrated with the local EMS agency.
g. Development of the program budget.
h. Appropriate interface with the local EMS agency.
i. Development of outreach education related to the pediatric interfacility transport program.

E. Medical Control Physician

1. Qualifications

a. Qualified specialist in at least one of the following: pediatrics, pediatric emergency medicine, emergency medicine, pediatric anesthesiology or pediatric critical care.
b. Specialized training, experience, or expertise in pediatric transport medicine.

2. Responsibilities

a. Oversight of medical care delivered during individual transports.
b. Attendance at regular meetings of the transport program staff.

c. Communicates with transport team and referral services.
d. Verification of acceptance and disposition of the patient.
e. Determination of the transport team composition, the mode of transport and direction of the clinical care for an individual transport.
f. Delegation of specific responsibilities for the medical care of an individual patient to another physician who has special training in the medical care required; however, the medical control physician retains overall medical responsibility for the transport.

F. Transport Team Personnel

1. Qualifications

a. A combination of at least two of the following personnel based on the level of need for the patient, and scope of the health care provider: Physician, registered nurse, respiratory care practitioner (RCP), EMT, AEMT, paramedic as determined by the medical control physician.
b. Training and experience in pediatric transport and pediatric or neonatal critical care as determined by the medical director.
c. Transport team personnel who are responsible for the stabilization and transport of ill or injured pediatric patients should collectively possess the skills and knowledge within their scope of practice to provide a level of care commensurate with the specific and anticipated clinical needs of the patient, as determined by the referring physician in collaboration with the medical control physician.

2. Responsibilities

a. Stabilization and care during transport of ill or injured pediatric patients.
b. The transport team leader should:
(1) Be assigned by the medical control physician for each transport team.
(2) Be responsible for patient care under the direction of the medical control physician.
(3) Coordinate, supervise and/or participate in the patient care delivered.
(4) Maintain communications with the medical control physician and the receiving and referring health care personnel.
(5) Be responsible for obtaining consent required for the transport and for admission to the receiving hospital
(6) Attend formal orientation and education programs as required by the transport program.
(7) Mobilize the transport team as soon as possible.

G. Communication Center

1. The Pediatric Interfacility Transport Program should have a transport communication center or special location where transport requests are received and processed. Essential components and elements are:
   a. Communication and dispatch protocols.
   b. Dedicated telecommunication capability between all components of the transport program.
   c. Contact list of hospitals and ambulance providers serviced by the program.
   d. Policy for Document Action Requirements for all transport referrals.
2. Communication personnel should be trained and skilled in the expeditious handling of transport referrals.
3. All communications for individual transports should be documented.
4. A contact list should be maintained and should include regional information pertinent to pediatric interfacility transport, including hospitals, ambulance providers, airports, interfacility distances, interfacility transport times by the various ambulance providers, and other essential information stored in a manner which allows immediate accessibility.
5. The transport program should provide a communications system that facilitates communications between the transport team, the communication center personnel, the medical control physician, and the referring and receiving facilities.

## IV. OPERATIONAL AGREEMENTS WITH AMBULANCE PROVIDERS

Pediatric Interfacility Transport Programs should have written operational agreements with ground and air ambulance providers used by the program for emergency and/or non-emergency transports.

A. Agreements should include, but are not limited to:

1. Responsibilities for patient care
2. Process for recording and transferring appropriate information and records including digital imaging
3. Financial and indemnification provisions
4. Response time standards
5. Term of agreement

## V. AFFILIATED HOSPITAL AGREEMENTS

A. Pediatric Interfacility Transport Programs should have written agreements with referring and receiving hospitals that routinely utilize the program.

B. Agreements should specify the roles and responsibilities of the transport program and the hospitals including:

1. Agreement to transfer and receive appropriate pediatric patients when indicated.
2. Policies and procedures for evaluating, transferring or receiving pediatric patients.
3. Responsibilities for patient care before, during, and after transport.
4. Private physician and family involvement.
5. Recording and transferring appropriate information and records.
6. Financial and indemnification provisions.
7. Terms of agreement.

C. Agreements should include provisions for educational programs related to pediatric transport, evaluation and stabilization of critically ill and injured pediatric patients, and availability of pediatric critical care consultation and other pediatric critical care services.

## VI. CONTINUOUS QUALITY IMPROVEMENT PROGRAM

Pediatric Interfacility Transport Program should have an organized multidisciplinary quality improvement program including participation from the facilities, prehospital providers, physicians, etc. This quality improvement program will at a minimum:

1. Establish, maintain, support and document evidence of a planned, systematic quality improvement program.
2. Assure appropriate and adequate response to findings from quality improvement activities, including the identification of opportunities to improve patient care and pediatric transport programs.
3. Assure appropriate and efficient use of the transport programs and resources.
4. Utilize concurrent review, generic screens and focused studies to monitor pediatric care provided by the Pediatric Interfacility Transport Program.

A. The quality improvement program should address the following:

1. Safety
   a. Patient safety
   b. Transport team safety
   c. Equipment safety, including records of equipment used, maintenance, testing of function, and critical failures.
   d. Untoward events

2. Expediency
   a. Record and review response times for each component of the transport program.

3. Resource allocation
    a. Monitoring and review of appropriate utilization of the transport program, transport personnel, equipment, supplies, and mode of transport.
    b. Monitoring and review of transport costs.

4. Triage
    a. Evaluation of the flow of information, prioritization of resource allocation, selection of ambulance provider, and selection of receiving facility.

5. Patient Care and Management
    a. Evaluation of patient care and management in terms of patient outcome.

B. Components of the plan should include an interface with the prehospital provider, local EMS agency, emergency department, trauma services, inpatient pediatric services, and pediatric critical care quality improvement activities.

## VII. INFORMATION MANAGEMENT

Accurate and current records should be maintained on all components of the Pediatric Interfacility Transport Program.

A. As available, facilities should receive data from each transport program.
B. Data should be collected and reviewed on a regular basis for planning, evaluation, and quality improvement.
C. Programs should cooperate in the development, analysis, and distribution of data.

## VIII. PEDIATRIC INTERFACILITY TRANSPORT EQUIPMENT AND SUPPLIES

All interfacility transport units should have equipment and supplies in accordance with the local EMS agency and state policies.

A. The following equipment and supplies should be available and maintained in proper operating condition for use by the Pediatric Interfacility Transport Program.
    1. Transport gurney/Isolette should:
        a. Be capable of providing a neutral thermal environment and should allow for continuous intensive care at all times.
        b. Be capable of being loaded into an ambulance by the ambulance personnel and safely secured within the ambulance.
        c. Utilize child passenger restraints systems, (e.g. car seats) as medically appropriate and commercially available.

2. Portable patient equipment
   a. Portable patient monitoring equipment should be capable of monitoring the patient in a moving environment. (See Appendix A)
   b. Transport equipment should have independent battery power with a secondary back-up power or charging system available.

3. Transport oxygen/air systems
   a. The primary transport oxygen/air system should have the capability of blending air and oxygen and providing a precise oxygen concentration from 21% to 100% at the discretion of medical control.
   b. Oxygen/air systems should have the capability to operate for twice the anticipated duration of the transport as estimated by the transport program.
   c. The transport equipment should be capable of direct connection to ambulance oxygen/air and power supplies to include:
      (1) Oxygen and air connections.
      (2) Oxygen/air flow meters capable of delivery of up to 15 liters/minute continuously.

4. Ambulance Power Requirements
   a. Inverter (12V DC/120V AC outlet) adequate to power the transport equipment
   b. Built-in Suction Device, Engine Vacuum or Electrically Powered

5. All transport equipment and supplies should be checked and secured to ensure that it will maintain physical and functional integrity when subjected to sudden deceleration or impact.

B. Operation and Maintenance

1. All medical equipment and supplies should meet applicable federal and state requirements, including hazardous material regulations.
2. All equipment should be maintained in working order and be ready for use on transport.

C. Other Equipment

Specialty equipment as determined by the provider to care for patients being transported.

## APPENDIX A

The following equipment, medication and supplies should be stocked and readily available for transport. Selection for the individual transport should be based on the patient's needs as determined by the medical control physician and the referring physician. Additional equipment, medications and supplies may be needed for certain specialized pediatric transports. All equipment and supplies must be appropriately sized for pediatrics.

a. Monitoring Equipment

1. Stethoscope
2. Cardiac-respiratory monitor
3. Invasive pressure monitors, able to monitor at least 2 channels
4. Blood pressure cuffs (automatic and manual) neonatal, infant, child, and adult
5. ECG monitor/defibrillator (5-360 Joules capacity, or biphasic equivalent) with pediatric and adult sized pads and pacing capability.
6. Pulse oximeter
7. Continuous End Tidal $CO_2$
8. Inspired oxygen concentration ($FiO_2$) monitor
9. Patient thermometer/probes able to measure core temperatures.
10. Point of care device: minimum blood glucose. Prefer point of care blood gas and electrolytes analysis

b. Respiratory Equipment

1. Oxygen delivery (50 psi with alarm system)
2. Flowmeter -15 L/minute
3. Portable air and oxygen cylinders
4. Oxygen delivery devices (i.e. nasal cannulas, nonrebreather masks) in infant, pediatric and adult sizes
5. Suction devices:
    (a) Bulb syringe
    (b) Stand-alone battery powered suction unit
6. Suction catheters (tracheal and pharyngeal) (infant, child, adult sizes)
7. Nebulizer
8. Oral airways (0-5)
9. Nasopharyngeal airways (infant, child, adult)
10. Bag valve mask (BVM) device, self-inflating (neonatal/pediatric size 500 ml and adult size 1000 ml).
11. Clear facemasks for BVM (infant, child, and adult sizes)
12. Laryngoscope and blades (curved 2, 3, 4; straight 0, 1, 2, 3, 4), spare light bulbs and batteries
13. Endotracheal tubes (uncuffed 2.5-5.0 and cuffed 3.0-8.0)
14. Endotracheal tube Stylettes (pediatric and adult)
    Magill forceps (pediatric and adult)
15. Transport mechanical ventilator capable of delivering pressure-

control breaths and measuring tidal volumes from 50 ml-750 ml, inspiratory times as low as 0.3 seconds, flows as low as 5 liters/minute, rates up to 60 breaths/minute, PEEP up to 20 cm $H_2O$. Inspired gas should be humidified.

16. Chest tubes, placement equipment and Heimlich Valve
17. Naso/orogastric tubes (infant, child, adult sizes)

c. Vascular Access

1. Peripheral Intravenous (PIV) catheters from 24 Gauge through 14 Gauge
2. IV tubing
3. Intraosseous access device
4. Central lines 3, 4, 5, and 7 French (optional)
5. Umbilical Arterial Catheter (UAC), Umbilical Venous Catheter (UVC), placement and monitoring equipment
6. Infusion pump(s) – prefer "Smart Pump" technology

d. Other Equipment

1. Adhesive tape
2. Urinary bladder catheters (infant, child, adult sizes)
3. Blood culture and laboratory specimen tubes (optional)
4. Penlight/flashlight
5. Warming devices, insulated blanket
6. Cooling devices
7. Pediatric backboard
8. Cervical collars
9. Lower extremity traction devices

e. Resource materials

1. Size-based methods for determining appropriate medication dosing and equipment sizing for children.
2. Pediatric pain assessment tool
3. Treatment protocol handbook

f. Medications

*The following is a list of suggested medications; additional medications may be needed for certain pediatric transports*.
Drug doses should minimize the amount of calculations and preferably be determined by a weight-length based tool such as a color coded tape.
<u>Cardiovascular Medications</u>

- Epinephrine 1:1000 (0.1 mg/ml) and 1:10 000 (1 mg/ml)
- Adenosine
- Amiodarone

- Lidocaine hydrochloride
- Atropine

Vasopressors
- Dopamine
- Dobutamine

Respiratory medications
- Albuterol sulfate nebulizer solution
- Ipratropium Bromide nebulizer solution
- Racemic Epinephrine nebulizer solution (may use l-Epinephrine)
- Magnesium Sulfate (IV)

Anaphylaxis medications
- Diphenhydramine Hydrochloride
- Glucocorticosteroid (solumedrol or Decadron)
- Preloaded Epinephrine syringes

Analgesics and sedatives
- Opiates (Morphine, Fentanyl)
- Midazolam or Diazepam

Anticonvulsants
- Phenytoin sodium or Fosphenytoin sodium
- Phenobarbital
- Lorazepam, ,Midazolam, or Diazepam

Rapid sequence intubation
- Succinylcholine
- Vecuronium
- Rocuronium
- Etomidate

Other
- Dextrose include: 50% in water (D50) and 25% in water (D25)
- Sodium Bicarbonate (8.4% & 4.2%)
- Glucagon
- Naloxone hydrochloride
- Prostaglandin E – (for ALS neonatal transports)
- Calcium chloride
- Furosemide
- 3% Sodium Chloride or Hypertonic Saline)
- Mannitol

g. IV Fluids

1. Dextrose 5% 0.45 Normal Saline (D5 ½ NS)
2. Dextrose 10% in Water (D10W)
3. Normal Saline 0.9 (NS)

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# Acknowledgements

## EMS for Children Technical Advisory Committee

Art Andres, EMT-P
Ontario Fire Department

Howard Backer, MD, MPH
State of CA
EMS Authority

B.J. Bartleson, RN
California Hospital Association

Donna Black
State of CA
Office of Traffic Safety

Louis Bruhnke, EMT/P
North Coast EMS Agency

Patrice Christensen, RN
San Mateo County EMS Agency

Bernard Dannenberg, MD, FAAP, FACEP
Lucile Packard Children's Hospital

Ronald Dieckmann, MD
Pediatric & Emergency Medicine

Robert Dimand, MD
State of CA
Children Services

Erin Dorsey, RN, BSN, PHN
Huntington Beach Unified High School District

Jan Fredrickson, RN, MSN
CA State Emergency Nurses Association

Pat Frost, RN, MSN, PNP
Contra Costa EMS Agency

Marianne Gausche-Hill, MD, FACEP, FAAP
Harbor UCLA Medical Center

Jim Harley, MD, MPH
Rady Children's Hospital San Diego

Debra Henes
Family Representative
Public Member

Ramon Johnson, MD, FACEP, FAAP
Emergency Medicine Associates

James Marcin, MD, MPH
UC Davis Medical Center
Pediatric Critical Care

Anne Marcotte, RN
Public Member

Tammi McConnell, RN
Orange County
EMS Agency

Tom McGinnis, EMT-P
State of CA
EMS Authority

Nancy McGrath, RN, CPNP
Harbor UCLA
Medical Center

Farid Nasr, MD
State of CA
EMS Authority

Shira Schlesinger, MD, MPH
UCI Department of Emergency Medicine

Bonnie Sinz, RN
State of CA
EMS Authority

Sam Stratton, MD, MPH
Orange County EMS Agency

Tonya Thomas
EMSC Program Coordinator
EMS Authority

Richard Watson
Public Member

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

**DATE:** September 2, 2015

**TO:** Commission on EMS

**FROM:** Dr. Howard Backer, Director

**PREPARED BY:** Jody Durden, Plans and Training Unit Manager
Disaster Medical Services Division

**SUBJECT:** Disaster Medical Services Training and Exercises Update

## RECOMMENDED ACTION:

Receive updated information on the EMS Authority's Medical and Health Operations Center Support Activities (M/HOCSA) course.

## FISCAL IMPACT:

None

## DISCUSSION:

The EMS Authority has long recognized that in the event of a moderate or catastrophic event, additional personnel will be needed to staff emergency operations centers (EOCs) at all levels of government. In order to meet this potential need, the EMS Authority's Disaster Medical Services Division has worked with the California Specialized Training Institute (CSTI) to develop a course that will prepare individuals to serve in EOCs, representing the public health and medical system.

The development of this course has taken many forms over the last seven years, when it was first conceived. The course was first titled "Disaster Medical Managers." Initially developed in 2008 and mentioned in the California Disaster Medical Operations Manual, the course focused on training individuals to support the medical functions in an EOC at each level of the Standardized Emergency Management System (SEMS). At the pilot course in November 2008, the EMS Authority's partners provided significant feedback indicating the course should include additional information.

The EMS Authority reconvened the course development team, along with CSTI, and revised the course based on the feedback received. The second pilot, then named

Medical Health Operations Center Support Activities (MOCSA) was held in early 2010. The delay in offering the second pilot was due to an extended activation in 2009 to respond to H1N1 Influenza. Also in 2009, the Interim California Disaster Health Operations Manual was released by the California Department of Public Health and the EMS Authority. Since this document had not been incorporated into the course curriculum, the EMS Authority once again needed to revise the content.

Due to fiscal constraints and a reduction in staff, there were not sufficient staff resources to dedicate to quickly moving the project forward. The primary planning focus at the time was the California Public Health and Medical Emergency Operations Manual (EOM), which builds a common operational framework for California's public health and medical system to rapidly and effectively respond to emergencies. This document was released in July 2011. Following the release of the EOM, feedback received by the EMS Authority indicated that public health should also be included in the course content.

The EMS Authority received additional funds through the Homeland Security Grant Program to revise the course. Another pilot of the course was held in January 2012. Following this and the feedback received by the EMS Authority regarding including public health, the course was renamed Medical and Health Operations Center Support Activities (M/HOCSA).

The EMS Authority continued to work with CSTI to revise the course. However, due to continued staffing constraints, competing priorities, and time required for the EMS Authority's partners to review and comment on the course content, the project moved forward slowly.

In May 2015, the EMS Authority participated in California Capstone, an exercise sponsored by the Federal Emergency Management Agency, the U.S. Department of Health and Human Services, the Office of the Assistant Secretary for Preparedness and Response and the California Governor's Office of Emergency Services. The purpose of the 2015 Capstone exercise was to test portions of the Southern California Catastrophic Earthquake Response Plan. This exercise identified gaps and the need for additional staffing to assist in EOCs at all levels of SEMS, particularly in a catastrophic event.

Following that exercise, completion of the M/HOCSA course was prioritized. Staff members in the EMS Authority's Disaster Medical Services Division have completed a review and provided suggested revisions to the current course content, ensuring that public health has now been included. The course packet will now be sent back to CSTI for formatting and Federal approval.

The EMS Authority anticipates that the M/HOCSA course will be offered through CSTI, in conjunction with the EMS Authority, in early 2016.