STATE OF CALIFORNIA
COMMISSION ON EMERGENCY MEDICAL SERVICES
June 20, 2018
10:00 A.M.
(Meeting will end at the completion of all agenda items)
Doubletree Suites by Hilton
Sacramento – Rancho Cordova
11260 Point East Drive
Rancho Cordova, CA 95742
Reservations 916-638-4141

1. Call to Order and Pledge of Allegiance

2. Review and Approval of March 21, 2018 Minutes

3. Director's Report
- A. EMSA Program Updates Disaster Personnel Systems
- B. Legislative Report

4. Consent Calendar
- A. Administrative and Personnel Report
- B. Legal Report
- C. Enforcement Report
- D. POLST eRegistry Update
- E. Community Paramedicine Update

Regular Calendar

5. EMS Administration
- A. Regulations Update

6. EMS Personnel
- A. Trial Studies
  1. Ketamine Trial Studies

7. EMS Systems
- A. Wireless 911 Routing Status

8. Items for Next Agenda

9. Public Comment

Break 15 Minutes

10. Call to Order

11. Kern EMS Plan Appeal

A. Attachment - ALJ Proposed Decision

Kern County EMS Agency's Appeal of the Denial of its EMS Plan(s), Office of Administrative Hearings Case Nos. 2016100453, 2017010313

A. Review of Legal Authorities:
   1. Section 1797.105, Health and Safety Code, Division 2.5
   2. EMS System Regulations, Chapter 13, Division 9, Title 22, California Code of Regulations.
B. Presentation by the Kern County EMS Agency – 10 minutes
C. Presentation by the EMS Authority – 10 minutes
D. Public Comment – 30 minutes, 2 minutes maximum per speaker
E. Commissioner Discussion and Deliberation
F. Vote Concerning Administrative Law Judge's Proposed Decision. Commissioners present shall vote for one of the following (decision shall be by majority vote):
   1. Adopt the Administrative Law Judge's Proposed Decision
   2. Not Adopt the Administrative Law Judge's Proposed Decision
   3. Return the Proposed Decision for Rehearing

12. Adjournment

A full agenda packet will not be provided at the meeting; however, you can print a full packet, including the agenda from the Department's website at www.emsa.ca.gov. This event will be held in an accessible facility. Individuals with disabilities requiring auxiliary aids or services to ensure accessibility such as language interpreting, assisted listening device, materials in alternate formats or other accommodations, should contact Sandra Baker at (916) 431-3701, no less than 7 days prior to the meeting.

STATE OF CALIFORNIA
COMMISSION ON EMS
Wednesday, March 21, 2018
Sheraton Park Hotel Anaheim Resort
1855 South Harbor Blvd.
Anaheim, 92802

MINUTES

COMMISSIONERS PRESENT:
Steve Barrow, Dan Burch, Steve Drewniany, James Dunford, M.D., Nancy Gordon, Mark Hartwig, James Hinsdale, M.D., Richard O. Johnson, M.D., Daniel Margulies, M.D., David Rose, Eric Rudnick, M.D., Jane Smith, Carole Snyder, Lewis Stone, Atilla Uner, M.D., Susan Webb

COMMISSIONERS ABSENT:
Jaison Chand, Brent Stangeland

EMS AUTHORITY STAFF PRESENT:
Howard Backer, M.D., Daniel R. Smiley, Craig Johnson, Jennifer Lim, Tom McGinnis, Sean Trask, Adrianne Winuck, Sandra Baker

AUDIENCE PRESENT (partial list):
Ross Elliott, California Ambulance Association
Marc Gautreau, Life Flight
Todd Klingensmith, California Paramedic Foundation
Kristy Koenig, M.D., EMS Medical Directors Association of California
Dave Magnino, Sacramento County Emergency Medical Services
Ray Ramirez, Cal Chiefs
Daniel Shepherd, M.D., Ventura County Public Health
Reza Vaezazizi, Inland Counties Emergency Medical Agency

1. CALL TO ORDER AND PLEDGE OF ALLEGIANCE

Chair Dan Burch called the meeting to order at 10:00 a.m. Sixteen Commissioners were present. Commissioner Rose led the Pledge of Allegiance.

Chair Burch tabled Item 7A, approval of the 2018 Core Measures Guidelines, to the next Commission meeting.

2. REVIEW AND APPROVAL OF DECEMBER 6, 2017, MINUTES

Commissioner Stone referred to Item 3B of the minutes from September 13th, 2017, and asked to change “the Commission had some concern” to “staff had some concern.”

Action: Commissioner Rudnick moved approval of the December 6, 2017, Commission on Emergency Medical Services Meeting Minutes as presented.

Commissioner Hinsdale seconded. Motion carried unanimously with Commissioner Gordon abstaining.

3. DIRECTOR'S REPORT

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

A. EMSA Program Updates

Budget

The budget is approximately $37 million with 70 permanent positions. Of this amount, $16 million is delegated to state operations and $21 million is delegated to local assistance.

Uncertainty remains at the federal budget with regards to the Public Health Block Grant, which supports the EMS Systems Division.

There has been a four percent cut in the Hospital Preparedness Program Grant (HPP), which funds the EMS Disaster Division. This grant has been run by the Centers for Disease Control (CDC) but will be moving to the Health and Human Services Office of the Assistant Secretary for Preparedness and Response (ASPR).

Data

Staff is seeking data analytic partners to help look at California EMS Information System (CEMSIS), EMS patient care, and ambulance patient offload time (APOT) data and other data. EMSA does not have the fiscal resources currently for commercial partners. An alternative may be partnering with the National Collaborative for Bio-Preparedness (NCBP), which is a partnership with the Office of Health Affairs at the Federal Department of Homeland Security and the University of North Carolina that is interested in EMS data for bio-surveillance purposes. The NCBP sees an advantage in the National EMS Information System (NEMSIS) data that is submitted to perform syndromic surveillance.

In exchange for receiving that data, the NCBP will provide data analytic support for the state, help develop various dashboards, and help link with other potential databases to explore other issues outside of bio-preparedness, such as naloxone use for the opioid crisis or many other types of data analysis.

Value in the data that 80 percent of the local EMS agencies (LEMSAs) provide needs to be shown to encourage the rest of the LEMSAs to submit their data.

Staff is also in discussion with sister departments within the California Health and Human Services Agency (CHHS) that have much greater analytic capacity to see if they can help manage and display data, such as ambulance patient offload time (APOT) data.

Staff is in the process of seeking matching funds from the Centers for Medicaid and Medicare (CMS) with a nine-to-one matching grant. The Department of Health Care Services (DHCS) has incorporated the project request into their state plan. They are

currently reviewing an advanced planning document to submit to the CMS for final approval.

Staff is also seeking matching funds from foundations and other sources of funding for the LEMSAs to fund development of health information exchange and related data support to link information transfer in EMS. Staff is working with the Department of Finance (DOF) on the appropriate means of budgeting these funds.

EMDAC Meeting

Dr. Backer asked the Commission to provide feedback on the following discussions from yesterday's EMS Medical Directors Association of California (EMDAC) meeting:

Emergency Medical Responder

There has been confusion among several agencies around the difference between training standards and the scope of practice of the Emergency Medical Responder (EMR). A scope of practice for the EMR category has never been incorporated into the EMS system in California; however, there is a training standard for EMR.

The California Highway Patrol (CHP) has been training to the EMR training standard but they cannot use the EMR scope of practice. The CHP has sent letters to EMS administrators requesting their approval for the CHP to carry oxygen and airway adjuncts for use in the field. The CHP training standards have always incorporated these.

Volunteer search and rescue teams are also asking if they could perform the scope of practice if they train to EMR.

Statewide Policy for Non-Transported Patients

Dr. Backer tasked medical directors with working on a statewide policy for non-transported patients, who are some of the highest risk patients for EMS. The challenge is separating out the low-risk patients from the high-risk patients. Non-transported patients account for a significant number of emergency calls; yet, the group is difficult to define clearly. Developing a consistent statewide policy will help LEMSAs create medical protocols for these patients at the local level.

Dr. Backer suggested that the statewide policy should include an evaluation and a record generated on every patient before leaving them in the field. This will allow quality improvement evaluation on these patients to help define this population. Insurers are beginning to pay for non-transport, which will create a larger issue in the future.

Drug Shortages

Many LEMSAs are running out of narcotics and cannot get restocked. Narcotics are a key part of the EMS formulary. One reason for drug shortages is pharmaceutical company decisions that have huge consequences EMS. Hospitals are first to get drugs, then healthcare providers. By the time it gets down to EMS, there is not much left.

One option to address drug shortages is to use expired medications. The federal government has found that almost all medications maintain potency for many years past

their expirations dates. The worst thing that can happen to an expired narcotic is that it may be slightly less potent.

Another option to address drug shortages is to use alternative drugs. There is an approved optional scope of practice to use IV Tylenol (acetaminophen) which studies show is quite effective. Ketamine in small doses is another alternative for pain control. It has been used extensively by the military in the field for many years. Ketamine trial studies will be discussed later in today's agenda.

Air Medical Scope of Practice

EMDAC continues to work on the air medical scope of practice. There is a bundled request for six different items to be included, including pediatric intubation which has been removed from the scope of ground transport EMS providers. A working group made up of medical directors and administrators has developed recommendations on the criteria for air medical to continue to do this procedure, and an associated procedure of rapid sequence intubation to facilitate both pediatric intubation and adult intubation more readily. These include a host of standards, including training, certification, and maintenance of skills, as well as a nurse-paramedic staff configuration on an air ambulance, which is the most common configuration for air medical services.

The recommendations will go out for final approval within the next quarter. Because EMSA has asked that they cease doing pediatric intubation by July 1st, an extension may be necessary for uninterrupted use of the procedure while air medical brings their standards up to the required levels.

Trauma Summit

The Trauma Summit will be held in San Diego on May 8th and 9th. The agenda will include a panel on concussion, repetitive head injury, and chronic traumatic encephalitis. Other discussions will include military medicine, pediatric trauma, secondary transfers, and various case studies.

Bill Tracking

There are currently two community paramedicine bills. One of them is an alternate destination bill which allows or enables the current projects that are taking patients to mental health facilities or sobering centers. The other one is a spot bill that will include all of the current projects that EMSA is testing. These bills do not assure funding for these programs but reflect the degree of safety and acceptance around the country for the community paramedicine programs.

Questions and Discussion

Commissioner Barrow suggested a discussion at a future meeting about the integration of trauma data and EMR data or a presentation from the California Department of Public Health (CDPH)-based Epi Center about data sharing, where hospital data on trauma is captured for policy development.

Daniel Smiley, EMSA Chief Deputy Director, stated staff attend a monthly meeting with the DHCS, OSHPD, the CDPH, Epi Center, and others with the goal of integrating all data sources. The group is examining the possibility of the DHCS leading the way with a

Health Information Hub that would do exactly what Commissioner Barrow described, and then bringing in the CDPH.

Commissioner Dunford stated he has been participating in meetings at the Substance Abuse and Mental Health Services Administration (SAMHSA). There is a strong interest in the value of EMS and fire data to inform a program that the White House created called the Data-Driven Justice System, which seeks to move individuals out of incarceration by identifying low-level offenders who have primary mental health and substance abuse issues who would be better served by being treated rather than incarcerated. SAMHSA has been pulling together large communities around the country to analyze how data streams can be shared to identify individuals and intercept them before they ever become arrested. Commissioner Dunford suggested that EMSA strategically align with this effort to connect data.

Commissioner Dunford stated nitrous oxide is used in ambulances in the United Kingdom for early, timely treatment for acute pain. It may be worth looking into the safety profile of that drug. Dr. Backer stated it is on the optional scope and is available.

Commissioner Margulies asked if the cost of IV Tylenol was discussed in yesterday's EMDAC meeting. It is expensive if used frequently. Dr. Backer stated the cost was brought up more than once.

Commissioner Webb asked about turnaround time for CEMSIS data reporting by the LEMSAs. Dr. Backer stated NEMSIS 3.4 is designed for immediate transmittal. There is a spectrum in the timeliness of those records ranging from same day to quarterly. Some LEMSAs allow the data to flow through to EMSA the same day, others hold and batch the data, and still others hold it and review it prior to submittal. The goal is to push that up to get it at least within a couple of days, optimally within a day.

Commissioner Smith asked when community paramedic will no longer be considered a pilot. Dr. Backer stated it requires legislation to no longer be considered a pilot. The current pilots are authorized until mid-November of this year and OSHPD has signaled that they are hesitant to keep extending these but may be convinced to extend them for one more year.

Public Comment

Kristi Koenig, M.D., EMS Medical Director, San Diego County, and past Commissioner, stated San Diego County has been working on drug shortage issues and appreciates EMSA support. She stated the county's extensive research on this topic has shown that nitrous oxide and ketamine are in short supply at this time, and IV acetaminophen is approximately $35 a dose which is 1,000 times more than a tablet at three cents.

B. Legislative Report

Jennifer Lim, EMSA Deputy Director, Policy, Legislative, and External Affairs, reviewed the Legislative Activity Report of the bills currently being tracked and analyzed by staff, which was included in the meeting packet and posted on the website. She stated staff has been working with the authors and sponsors of these bills for a number of months,

but the Commission has not taken an official position on any of the bills. She noted that staff is tracking animal bills for the first time. She summarized the following bills:

- AB 1776 (Steinorth), emergency medical transportation: transport of police dogs

The Vet Board heard this bill in February. They have concerns but have yet to take a position. The next hearing is in May.

- SB 1305 (Glazer), emergency pre-veterinary services: immunity

The Vet Board will hear this bill in May. They have questions about the treatment of animals by EMS professionals.

- AB 1795 (Gipson), emergency medical services: behavioral health facilities and sobering centers

This is an alternate destination bill. The Assembly Health Committee will hear this bill on April 10th. Amendments have not yet been made public.

- SB 944 (Hertzberg), Community Paramedicine Act of 2018

This is a spot bill and may incorporate other themes and topics besides alternate destination. Amended language is expected soon.

- AB 2293 (Reyes), EMT certification: conservation camps

Staff will continue to watch this bill.

- AB 2280 (Chen), emergency medical services: nonstandard patient offload time

Staff will continue to watch this bill.

- AB 2961 (O'Donnell), emergency medical services: APOT

Staff will continue to watch this bill.

- AB 2370 (Holden), lead exposure: child day care facilities

Staff will continue to watch this bill.

- SB 1158 (McGuire), specialized license plates: "Have a Heart, Be a Star, Help Our Kids" license plate program

Commissioner Barrow is one of the subject matter experts for this bill.

<u>Questions and Discussion</u>

Commissioner Rudnick stated AB 2293 poses potential danger to the health, safety, and welfare of the public because it is broad and does not contain prescriptive language. He stated his concern about giving convicted felons, regardless of the offense, the ability to enter individuals' homes when they are at their weakest and most vulnerable. It is dangerous unless done correctly.

Commissioner Johnson asked if SB 944 could bridge the gap between the approvals for the pilot programs that are approved by OSHPD through November, or if other legislation would be required to have those programs carry on. Ms. Lim stated the current language does not permit that. She stated the hope that the community

paramedicine program would be permitted through amendment of the legislation to bridge that gap.

Commissioner Barrow discussed AB 1776 and SB 1305. He stated his concern about the use of EMS resources for animal transport and asked if this has ever come up before. Dr. Backer stated it has not. He stated he shared Commissioner Barrow's concerns.

Commissioner Barrow spoke in opposition to SB 2370. It is a bad proposal in how it is drafted, it would add a layer of unnecessary tests, and it would impact EMSA regulations and training resources.

Dr. Backer stated the Commission cannot take a position on legislation. Commissioners who feel strongly about a bill can speak with their representative groups to take an oppose or support position.

Public Comment

Ray Ramirez, California Fire Chiefs Association (CalChiefs), discussed AB 1776 and SB 1305. He stated it is not uncommon for firefighters in the field to pull out and try to resuscitate family pets when there are no humans who need medical care. EMS cannot do that under the existing law. That is what this legislation is trying to say, because many animals are resuscitated simply by ventilating them.

Mr. Ramirez stated the transport is confined to police dogs. These are highly-trained animals that need care and transportation to the vet when injured in the line of duty. This cannot be done under existing law. It may be helpful to discuss the transport issue with law enforcement to help inform the Commission.

Commissioner Uner stated, in his experience with search and rescue dogs, the dog handlers are much better at caring for and transporting their animals than EMS will ever be.

4. CONSENT CALENDAR

- **A. Administrative and Personnel Report**
- **B. Legal Report**
- **C. Enforcement Report**
- **D. POLST eRegistry Update**
- **E. National Registry of EMTs Examination Results**

Action: Commissioner Rudnick moved approval of the consent calendar. Commissioner Hinsdale seconded. Motion carried unanimously. The item was noted and filed.

REGULAR CALENDAR

5. EMS ADMINISTRATION

- **A. Regulations Update**

Ms. Lim stated the Stroke and STEMI Regulations have been reviewed and approved by the DOF and will be sent to the Office of Administrative Law on the 27th.

Public comment on the Emergency Medical Services for Children Regulations will end on April 30th, at which time there will be an in-person hearing opportunity for public comment at the EMSA in Rancho Cordova. She welcomed Commissioners to participate.

Questions and Discussion

Commissioner Dunford stated value-based care drives change. STEMI Regulations and Stroke Regulations will improve the systems of care in the state of California. The Federal Government should reward states that design systems of care, which are linked with better outcomes at a lower cost. The National Quality Forum in Washington, D.C., creates the standards and defines the metrics of quality. Commissioner Dunford stated he will be meeting with the President and CEO of the National Quality Forum next week to discuss this topic.

6. EMS PERSONNEL

A. Trial Studies

1. Ventura County EMS Agency's 36-Month Air-Q Trial Study Report

Sean Trask, Chief of the EMS Personnel Division, stated Ventura County presented their 18-month air-Q supraglottic airway device trial study report at the December 2016 meeting. The Commission recommendation was to continue the trial study another 18 months. Since that time, medical directors and EMSA have supported the use of other supraglottic airway devices such as the i-gel as a local optional scope for paramedics for pediatric to adult sizes.

Mr. Trask asked Dr. Shepherd to report on Ventura County's trial study.

Daniel Shepherd, M.D., Medical Director, Ventura County EMS, presented his 36-month report, which was included in the meeting packet. He stated the trial study ran from December 2014 to December 2017. Providers completed a questionnaire about their experience with the air-Q supraglottic airway device after each attempted insertion.

The two primary concerns with the device were regurgitation of gastric contents and securing the device for transport. An improved securing device, similar to a standard endotracheal tube holder, is now available and has worked well. The manufacturer recently began shipping a more effective suction mechanism to address regurgitation.

The air-Q was initially made the primary airway device but, approximately six months after initiation of the trial study, the airway treatment protocol was altered so the air-Q was considered if bag-valve-mask ventilation was inadequate.

Questions and Discussion

Commissioner Dunford stated his concern that the trial was extended in 2016 due to the lack of sufficient data to draw a conclusion but, during the 18-month extension period,

the air-Q was only used four times. He asked why providers preferred not to use what was considered an easy rescue device. Dr. Shepherd stated he shared Commissioner Dunford's concern. He stated all four cases were successful with no complications and no air leaks. Intubation is a rare event. He surmised that, when faced with the opportunity, providers chose to proceed to endotracheal intubation.

Commissioner Uner asked for more information on the 53 cases that were not successful. Dr. Shepherd stated there were 9 failures to insert the device and 44 noted a large air leak or inability to ventilate.

Commissioner Uner asked if an 80 percent success rate is considered sufficient for an airway method. Dr. Shepherd stated endotracheal intubation has a success rate of 60 to 70 percent.

Commissioner Uner asked if it is possible that paramedics reverted to endotracheal intubation simply because it is the better airway method in their minds. Dr. Shepherd stated these devices are helpful and appropriate in the pre-hospital setting. As pre-hospital providers gain familiarity with these types of devices, the frequency of use will increase.

Commissioner Uner stated he was satisfied with neither a 60 nor an 80 percent success rate. Dr. Shepherd agreed.

Commissioner Rudnick thanked Dr. Salvucci and Dr. Shepherd for doing the study. It will help pave the way for statewide metrics and data that can be further analyzed.

Commissioner Dunford asked if there were concerns that Ventura County is proposing that the Commission adopt a device that has not yet been tested. He stated the manufacturer is only now shipping a more effective suction mechanism to address regurgitation, although the study showed that vomiting was an issue a year and a half ago. The Commission can assume the modification will prevent the problem, but it may cause other logistical issues. The modified device is untested.

Public Comment

Todd Klingensmith, Executive Director, California Paramedic Foundation, stated it has been a concern to find alternative airways since the withdrawal of pediatric intubation. The protocol in San Diego is bag-value-mask ventilation with a secondary airway of endotracheal intubation. The current protocol remains open-ended with no solution to manage the bag-valve-mask-ventilated patients who are unable to effectively ventilate. He requested that the Commission put together a good secondary airway for pediatrics.

Commissioner Rudnick stated there are multiple supraglottic airway devices available as an alternative for LEMSA medical directors.

Chair Burch stated the Commission does not have to approve a specific device at the Commission level by trial study because supraglottic airway devices are already a part of the optional local scope of practice.

Action: Commissioner Stone moved to receive information on the status of current trial studies and the preliminary 36-month trial study report on the Ventura County EMS Agency's air-Q airway device, and close Ventura County

EMS Agency's 36-month trial study. Commissioner Margulies seconded. Motion carried unanimously with no abstentions.

2. ICEMA and Riverside County EMS Agencies Combined 36-Month Tranexamic Acid Trial Study Report and Approve Recommendation

Mr. Trask stated the next trial study is the 36-month tranexamic acid (TXA) multisystem trial study from the Inland Counties EMS Agencies (ICEMA), Riverside County, and Alameda County.

Mr. Trask asked Dr. Vaezazizi to report on ICEMA and Riverside and Alameda Counties' trial study.

Dr. Vaezazizi stated ICEMA and Riverside and Alameda Counties presented their 18-month TXA trial study report at the December 2016 meeting. The Commission recommendation was to continue the trial study another 18 months. He presented his 36-month report, which was included in the meeting packet. He stated the trial study ran from 2015 to July of 2017.

Dr. Vaezazizi stated the trial study was the largest North American study of TXA in the pre-hospital setting to date. The study looked at traumatic injuries and hemorrhagic shock due to traumatic mechanism.

Questions and Discussion

Commissioner Margulies stated there was a statistically-significant 28-day mortality benefit for the use of TXA. He asked if patients with head injuries were part of the study. Mr. Vaezazizi stated some patients with head injuries were inadvertently included in the study and have since been separated, since that was an exclusion criteria. There are conversations about using that data as a subgroup analysis for potential future discussion.

Commissioner Margulies asked if there was any difference in the amount of blood transfusion requirements in the hospital between the groups. Dr. Vaezazizi stated the TXA group had a trend towards using significantly less blood transfusion. However, the study was too small to show statistical significance. The average mean time to receive TXA was quicker than that of the crash study, where there was little difference in the transfusion requirements. The more critical the injury, the bigger the value of TXA seems to be. The trial also demonstrates that sooner use of TXA is better.

Commissioner Margulies asked if there was data on whether patients received the appropriate continuation of TXA as recommended once they were in the hospital. Dr. Vaezazizi stated that subgroup has not yet been analyzed. The protocol was designed for EMS to screen patients for candidacy for TXA administration in the field; the same screening would then take place in the hospital to determine if patients qualify for a second dose.

Commissioner Dunford asked if approval would also approve optional scope of TXA only for blunt trauma. Dr. Backer stated the approval brings the trial study to termination and makes a recommendation to add it to local optional scope. The Scope of Practice

Committee will make a recommendation on the details and protocols for the local optional scope.

Dr. Backer commended the LEMSAs for taking up the trial studies. It speaks to the ability and willingness of EMS providers to participate in these studies, and it supports the contention that paramedics are capable of making triage and destination decisions.

Commissioner Margulies asked if there was any increase in complications in hospitalization between the groups, despite the improvement in mortality. Dr. Vaezazizi stated the control and treatment groups had the same complication rate. There were two cases of DVT per group; there were also two cases with neurologic issues, two ischemic stroke cases, and two critically injured patients. Detailed analysis determined that the ischemic strokes were the result of injury. He stated the highest rate of selection problems occurred at the beginning of the study. All of the cases were reviewed real-time, which improved the percentage of inappropriate selection. He stated paramedics can easily and safely identify patients who are candidates for TXA administration.

Commissioner Dunford asked if the TXA was administered intravenously and if any patients were excluded for a lack of ability to establish an IV. Mr. Vaezazizi stated the TXA was administered intravenously, but he was not aware of any candidates who did not receive TXA due to lack of IV access.

Staff recommendation was:

- Receive the combined 36-month trial study report from the Riverside County, Alameda County, and Inland Counties EMS Agencies TXA.
- Approve the addition of TXA to the paramedic local optional scope.

Action: Commissioner Margulies moved the staff recommendation as presented. Commissioner Dunford seconded. Motion carried unanimously with no abstentions.

3. Information on the Status of Other Current Trial Studies

Mr. Trask summarized current trial studies, which will be updated to take Ventura and Santa Barbara Counties off of supraglottic airway and TXA studies. If Napa and Yolo Counties continue using TXA, they will have to provide an application for local optional scope approval.

Mr. Trask stated the Mountain Valley, Inland Counties, and Riverside County LEMSAs are using ketamine for analgesia. There have been discussions on whether ketamine should be a trial study or a local optional scope item; the outcome of the discussion was to have the three LEMSAs report to the Commission on the next agenda.

B. Community Paramedicine Pilot Project Report

Mr. Trask stated the OSHPD has extended approval for the Community Paramedicine Project through November of 2018 and may be willing to make one more extension. A number of sites are still operating on different concepts, four new sites have applied to operate on a combination of the same concepts, and four sites have put their pilots on hold pending the outcome of this legislative session.

C. Pediatric Endotracheal Intubation for Paramedics

Mr. Trask stated there has been discussion among medical directors and LEMSA administrators, who have formed a committee, on exempting flight medics and critical care paramedics within the EMS systems. The committee has agreed upon a number of items included in the report, such as competency, accreditation, training requirements, and scope of practice. The committee hopes to have a recommendation for the Commission at the June meeting.

Public Comment

Mr. Klingensmith asked if significant local optional issues like pediatric intubation could be opened up for public discussion periods. He also noted that there was a lack of data from areas in California that use pediatric intubation.

Marc Gautreau, Clinical Associate Professor and Director of EMS, Life Flight, Stanford University, asked about the requirement for a nurse-paramedic flight crew rather than two paramedics. Dr. Backer stated the nurse is required for the performance of rapid sequence intubation. As this was primarily for the bundled air medical request, flight and critical care nurses have the necessary expertise.

David Magnino, Administrator, Sacramento County EMS Agency, stated, although this is an optional scope item, it will rely upon the approval of the LEMSAs.

7. EMS SYSTEMS

A. Approval of 2018 Core Measures Guidelines

This agenda item was tabled to the next Commission meeting.

B. Ambulance Patient Offload Time Reporting

Adrian Winnick, Manager, Data and Quality Improvement Division, stated fifteen LEMSAs have reported at least one quarter's worth of APOT data and eight have reported a year's worth. EMSA staff is in the process of determining the best way to display this data and working on developing a repository.

Questions and Discussion

Commissioner Barrow suggested having a discussion or presentation on hospitals with low APOT to determine common characteristics. Dr. Backer stated this would require a sophisticated statistical analysis. The preliminary Data have been presented to the Commission.

Commissioner Webb stated the results should not be posted on the website. The data would misrepresent California jurisdictions.

C. EMS Plan Appeal Update

Tom McGinnis, Chief, EMS Systems Division, stated there are three local EMS agencies who have appealed EMS plans: Santa Clara County, who will withdraw their plan appeal; El Dorado County, who is waiting to set hearing dates; and Kern County,

who has had a plan appeal hearing, wherein the administrative law judge requested briefs.

8. DISASTER MEDICAL SERVICES DIVISION

A. Ambulance Strike Team Program Utilization

Craig Johnson, Chief of the Disaster Medical Services Division, stated staff is considering enhancing the program by working with local partners, the counties, and the region for reimbursement guidelines for Ambulance Strike Team deployments. The reimbursement guidelines must first be established. Participation in the program, including from the public sector, must increase. Staff is looking into establishing an Ambulance Strike Team Train the Trainer Program to meet needs for leader training.

Questions and Comments

Commissioner Johnson asked for an estimate of the number of non-affiliated Ambulance Strike Teams. Mr. Johnson stated there has not been a count.

Commissioner Stone asked how many affiliated teams are private and how the Strike Teams are ordered to deploy. Mr. Johnson stated all of the teams are private. Local medical health coordinators can order their county Strike Teams to respond without requiring state approval; however, when counties are overwhelmed, the Regional Disaster Medical Health Coordination Program can provide support for scaled regional responses.

9. ELECTION OF COMMISSION OFFICERS FOR 2018

Chair Burch stated his term is up and, as Immediate Past Chairman, he automatically will serve on the Administrative Committee. He reminded Commissioners of the officer nominations from the December meeting:

- Commissioner Drewniany was nominated for Chair.
- Commissioner Hartwig was nominated for Vice Chair.
- Commissioners Chand and Stone were nominated for membership in the Administrative Committee.

Chair

Chair Burch entertained additional nominations for the position of the EMSA Chair.

Commissioner Johnson nominated Commissioner Rudnick as Chair.

Action: Commissioner Stone moved to close nominations for Chair of the EMSA for March of 2018 to March of 2019. Commissioner Dunford seconded. Motion carried unanimously.

Action: Commissioner Rudnick nominated Steve Drewniany as Chair of the EMSA for March of 2018 to March of 2019. Five members of the Commission voted aye.

Action: Commissioner Johnson nominated Eric Rudnick, M.D., as Chair of the EMSA for March of 2018 to March of 2019. Six members of the Commission voted aye.

Vice Chair

Chair Burch entertained additional nominations for the position of the EMSA Vice Chair. No additional nominations were offered. Commissioner Hartwig ran for Vice Chair unopposed.

Action: Commissioner Stone moved to close nominations for Vice Chair of the EMSA for March of 2018 to March of 2019. Commissioner Margulies seconded. Motion carried unanimously.

Action: Commissioner Rudnick nominated Mark Hartwig as Vice Chair of the EMSA for March of 2018 to March of 2019. Motion carried unanimously.

Administrative Committee

Chair Burch removed Commissioner Chand's name from the ballot since his term on the Commission will be ending. He asked for nominations for members of the Administrative Committee.

Vice Chair Drewniany nominated Commissioner Stone to serve on the Administrative Committee.

Commissioner Stone nominated Commissioner Johnson to serve on the Administrative Committee.

Action: Commissioner Uner moved to close nominations for service on the Administrative Committee for March of 2018 to March of 2019. Commissioner Smith seconded. Motion carried unanimously.

Action: Vice Chair Drewniany nominated Lewis Stone to serve on the Administrative Committee from March of 2018 to March of 2019. Motion carried unanimously.

Action: Commissioner Stone nominated Richard Johnson, M.D., to serve on the Administrative Committee from March of 2018 to March of 2019. Motion carried unanimously.

2018 Officers

- Chair of the EMSA for 2018 is Eric Rudnick, M.D.
- Vice Chair of the EMSA for 2018 is Mark Hartwig
- Richard Johnson, M.D., and Lewis Stone are part of the Administrative Committee as representatives of the EMSA and Dan Burch is Member Emeritus, as past Chair.

Immediate Past Chair Burch deferred to Chair Rudnick to run the remainder of the meeting.

10. ITEMS FOR NEXT AGENDA

Chair Rudnick suggested an update on wireless 9-1-1 at the June meeting.

11. PUBLIC COMMENT

There were no questions or comments from the public.

12. ADJOURNMENT

Chair Rudnick adjourned the meeting at 12:24 p.m.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
June 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
1. Ambulance Strike Team (AST) – Medical Task Force (MTF)	Michael Frenn, ext. 435	AST/MTF Leader Trainings are conducted on an ongoing basis, as requested. There was significant utilization in the Program for the Oroville Dam incident, the Santa Rosa/Napa Fires and the recent Southern California Fires. Recent activity has resulted in a noticeable increase in interest for Strike Team Leader training. Two training classes were conducted in May (San Diego and Sacramento), another class is scheduled for June (San Bernardino), and another is pending for Kern County. Use of ASTs over the past two years has also revealed issues with reimbursement, particularly with regards to standardization. EMSA-DMS is working with stakeholders in pursuit of a standardized rate that counties will be able to use for reimbursing ASTs. The Disaster Medical Support Units (DMSU), which support and have affiliated ASTs, 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	Hiring by EMSA-DMS for persons interested in participating in the CAL-MAT program continues, and program membership is growing. The first successful deployment of CAL-MAT personnel, including hiring and compensation using the new Emergency Hire process, occurred during the Santa Rosa/Napa fire response. Initial recruitment has been targeted at existing federal Disaster Medical Assistance Team (DMAT) members (Phase I). Two Unit has been officially “stood up (San Diego and San Francisco Bay Area). The Sacramento unit will be stood up within a month. This will permit implementation of the Phase II hiring process; persons not already affiliated with DMAT may not apply to the program.
3. CAL-MAT Cache	Markell Pierce, ext. 1443	EMSA is currently working on the second bi-annual inventory and resupply of the (3) CAL-MAT Medical supply caches for the 2017-2018 fiscal period. This ensures that all medical supplies are 100% accounted for, to date, and ready for immediate deployment. The revised CAL-MAT pharmacy formulary has been completed, approved, and implemented to include new medications.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
June 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
4. California Public Health and Medical Emergency Operations Manual (EOM)	Craig Johnson, ext. 4171	The Regional Disaster Medical and Health Specialists (RDMHS) conduct EOM training on an ongoing basis. The EOM Workgroup is currently in the process of revising the EOM based on lessons learned since the initial 2011 release. Additional Function Specific topics are being added to the EOM.
5. California Crisis Care Operations Guidelines	Bill Campbell, ext. 728	EMSA is working with CDPH to acquire funding to develop a Crisis Care/Scarce Resources guidance document.
6. 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 23,700 volunteers registered. There are over 21,000 healthcare occupations filled by registered volunteers. All 58 counties have trained DHV System Administrators in their MHOAC Programs. EMSA provides routine training and system drill opportunities for all DHV System Administrators. Over 9,300 of the 23,700 plus DHV registered responders are Medical Reserve Corps (MRC) members. EMSA trains and supports DHV System Administrators in each of the 36 participating MRC units. DHV System Administrator training, DHV user group webinars, and quarterly DHV drills are ongoing. On, April 4, 2018, EMSA conducted a quarterly DHV drill for System Administrators. On April 11, 2018, EMSA conducted a quarterly DHV User Group webinar. EMSA publishes the "DHV Journal" newsletter for all volunteers on a tri-annual basis. The most recent issue was released on January 29, 2018. The "DHV Journal" is available on the DHV webpage of the EMSA webpage: http://www.emsa.ca.gov/disaster_healthcare_volunteers_journal_page. The DHV website is: https://www.healthcarevolunteers.ca.gov.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
June 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
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)		Medical Health Operations Center Support Activities (MHOCSA) Training Classes were held in Region I, Region II and Region VI in May 2018. Region V will be offering a class this summer, and several other classes are in the early stages of planning times and locations.
7. 2018 Statewide Medical and Health Exercise (2018 SWMHE)	Theresa Gonzales, ext. 1766	The 2018 Statewide Medical and Health Exercise (SWMHE) is tentatively scheduled for November 5th through November 9th and November 13th through November 16th, 2018. The Emergency Medical Services Authority in conjunction with the California Department of Public Health and emergency management partners continue to plan for the annual exercise. The exercise is designed as a multiphase exercise program for statewide participants to exercise response to an infectious disease incident. Focusing on Region IV. Also, the exercise will include objectives for Ambulance Services, Behavioral Health, Community Clinics, Emergency Medical Services Agencies, Fire Services, Hospitals, Law Enforcement, Long Term Care Facilities, Medical Examiners/Coroners, Offices of Emergency Management, and Public Health. The jurisdiction-specific objectives are designed to help enhance participants' exercise play.
8. Hospital Available Beds for Emergencies and Disasters (HAvBED)	Nirmala Badhan, ext. 1826	Federal requirements for HAvBED reporting have been discontinued. However, EMSA is working with the California Department of Public Health (CDPH) and other partners to determine how to continue to integrate hospital data collection for California use.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
June 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
9. Hospital Incident Command System (HICS)	Patrick Lynch, ext. 467 hics@emsa.ca.gov	The Hospital Incident Command System (HICS) activities are sponsored by the California Emergency Medical Services Authority (EMSA). EMSA has assembled a National HICS Advisory Committee to assist with matters relating to the HICS Program. This committee will serve as technical advisers on the development, implementation, and maintenance of EMSA's HICS program and activities. The HICS National Advisory Committee will be convened via webinar in July 2018 to discuss HICS competencies for HICS implementation and training. The Fifth Edition of HICS, Frequently Asked Questions (FAQ), and additional program information are available on the recently revised EMSA website: http://www.emsa.ca.gov/disaster_medical_services_division_hospital_incident_command_system_resources.
10. Mission Support Team (MST) System Development	Michael Frenn, ext. 435	Position Duty Statements developed as part of the CAL-MAT program also included positions needed to staff MSTs, which would be needed to support EMSA's Mobile Medical Assets when deployed to major events. EMSA-DMS is recruiting persons interested in filling these positions as part of the recruitment for the CAL-MAT Program.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
June 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
11. Response Resources	Markell Pierce, ext. 1443	The bi-annual inventory maintenance of the Mission Support Team (MST) caches was completed in December 2017. The MST caches are constantly being refined based on After Action Reports following exercises and real-world deployments. The Response Resources Unit (RRU) has implemented new I.T. and telecommunications equipment to improve MST networking infrastructure and Internet functionality in the field. The RRU continued audits on the 41 Disaster Medical Support Unit (DMSU) vehicles located around the State. During the audits, EMSA verified that all the DMSU vehicles are being properly maintained and utilized according to written agreements. New audits are in progress focusing on Region 2 & 3. Annual servicing of the biomedical equipment for the California Medical Assistance Teams (CAL-MAT) caches was completed in January 2018. Currently, the CAL-MAT cache resupply process is underway for 2017/18. All our portable generators have been inspected and permitted by the Sacramento Metropolitan Air Quality Management District. Routine maintenance for generators, forklifts, and fleet vehicles is ongoing. There are currently no major problems.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
June 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
12. Information Technology	Rick Stricklin, ext. 1445	Identification and inventory of IT equipment to be surveyed is in-progress and near completion. Working thru the process of replacing failed wireless access point equipment. Continue to perform analysis of Station 1 network connectivity and type of Services current and future providers can provide including redundancy during a disaster response. Work includes continued evaluation of the Meraki wireless system to provide field connectivity for data (Cellular, VSAT, wired) and video capabilities during field deployments. Annual servicing of Disaster Medical Support Unit (DMSU) radio systems by Cal OES Public Safety Communications (PSCO) is being planned, and the building of the Kenwood TK 980 800 MHz frequency re-banding load is expected to be completed 3rd quarter 2018. The EMSA Station 1 vehicle fleet will also be included in the annual servicing. Work continues with the C3 communications vehicle to identify outdated technology and discover new technologies to increase its capabilities and functionality in the field.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
June 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
13. Mobile Medical Shelter Program (MMSP)	Bill Hartley, ext. 1802	Working with other state agencies, and within existing resources, the EMS Authority has redesigned the Mobile Field Hospital (MFH) program into the California Mobile Medical Shelter program. The purpose of the redesign is to modify and expand the potential uses of the equipment into general staging, stabilization and shelter capacity. 1. The structures and durable equipment of the first MFH stored at the EMS Authority have been separated by like items for ease of deployment to meet the mission requirements of the Mobile Medical Shelter program. 2. The EMS Authority has reconfigured the 2nd MFH into six (6) multiuse modules to distribute to local partners. We are working with the RDMHSs and LEMSAs to locate one module in each Cal OES Mutual Aid Region. The modules will include the shelters, infrastructure equipment, and durable equipment, but will **not** include biomedical equipment and medical supplies. This redistribution of the MFH would allow local partners to deploy this resource rapidly. Potential uses include field sites for Local/Regional incidents, triage/treatment during flu season surge, medical clinic, medical shelter, emergency operations center, staff quarters, disaster exercise, and any other use that requires a field facility. Deployment would be at the discretion of the locals without requiring a state resource request. Modules have been placed in Long Beach, Riverside, and Santa Cruz. Module placement in San Mateo and Sacramento will be completed soon. We are targeting Northern Sacramento valley for the placement of the sixth module. 3. The third MFH was transferred on September 8, 2016, to the State Military Department for use by the California National Guard.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
June 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
14. Regional Disaster Medical/Health Specialists (RDMHS) Program and Medical Mutual Aid System	Nirmala Badhan, ext. 1826	The RDMHS program works with EMSA and California Department of Public Health (CDPH) staff to support major disaster planning activities in addition to supporting information management processes. The RDMHSs have been instrumental in response to 2017 California wildfires which included Ambulance Strikes Teams for patient evacuations and MRC participation in shelter support.
15. Medical Reserve Corps (MRC)	Lauran Capps, ext. 466	36 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 9,300 plus of the DHV Program's 23,700 plus volunteers are Medical Reserve Corps volunteers. EMSA sponsored a 1 ½ day MRC Coordinators Statewide Training Workshop on May 30 & 31 in Rancho Cordova, CA. The workshop provided an opportunity for California's MRCs to strategize on the incorporation of MRCs into local emergency plans and to highlight daily best practices for sustainability, standardized training, and real situation experiences when responding to public health emergencies or disasters.
16. Statewide Emergency Plan (SEP) Update	Jody Durden, ext. 702	The California Governor's Office of Emergency Services (Cal OES) released the updated in October 2017. The updated version is located at: http://caloes.ca.gov/PlanningPreparednessSite/Documents/California_State_Emergency_Plan_2017.pdf. This version includes a brief description of the Public Health and Medical Mutual Aid System.
17. Southern California Catastrophic Earthquake Response Plan	Theresa Gonzales, ext. 755	The California Governor's Office of Emergency Services (Cal OES) is currently leading the revision of the Southern California Catastrophic Earthquake Plan. The Emergency Medical Services Authority continues to work with the Regional Disaster Medical Health Specialists, Medical Health Operational Area Coordinator, Emergency Support Functions, Cal OES, California Department of Public Health, California Department of Healthcare Services, Assistance Secretary of Preparedness and Response, and the Federal Emergency Management Agency to update the Public Health and Medical Fact Sheet, Survivor Movement plan, Mass Care Plan and Shelter Fact Sheet.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
June 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
18. Patient Movement Plan	Bill Campbell, ext. 728	EMSA is currently incorporating comments received during the public comment period. The release of the California Statewide Patient Movement Plan will be summer 2018.
19. Bay Area Catastrophic Earthquake Plan	Bill Campbell, ext. 728	EMSA participated in the Medical Planning Group for the Bay Area Catastrophic Earthquake Plan revision. EMSA continues to participate in the socialization of the plan.
20. Northern California Catastrophic Flood Response Plan	Nirmala Badhan, ext. 1826	EMSA is working with the Governor's Office of Emergency Services (Cal OES) for the development of the Northern California Catastrophic Response Plan. EMSA worked closely with the California Department of Public Health to develop a Public Health and Medical Information Analysis Brief. This document is the basis of the Public Health and Medical section of the response plan. The draft plan was presented to Cal OES Executive leadership on May 31, 2017 and is now in the final stages of editing.

Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
June 20, 2018

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
1. First Aid Practices for School Bus Drivers	Mark Olivas, ext. 445	There are nine (9) School Bus Driver training programs currently approved and one (1) pending review. Technical assistance to school staff and school bus drivers is ongoing. The EMSA Child Care Training website is updated monthly.
2. Child Care Provider First Aid/CPR Training Programs	Mark Olivas, ext. 445	There are currently 17 approved First Aid/CPR programs. Staff is reviewing one (1) program renewal. 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. EMSA is continuing work to revise the Chapter 1.1 Training Standards for Child Care Providers, which includes First Aid and CPR training standards.
3. Child Care Preventive Health Training Programs	Lucy Chaidez, ext. 434	There are 26 preventive health and safety practices training programs approved. There are eight (8) programs in the review process. EMSA will host the Child Care Regulatory Workgroup quarterly meeting in June. EMSA Preventive Health sticker sales are ongoing.
4. Child Care Training Provider Quality Improvement/Enforcement	Mark Olivas, ext. 445 and Lucy Chaidez, ext. 434	EMSA is continuing its work to revise the Chapter 1.1 Training Standards for Child Care Providers, including First Aid, CPR, and Preventive Health training standards. Technical assistance and education regarding compliance issues is provided to approved training programs, child care providers, DSS community care licensing, and child care resource and referral staff. Review of rosters as an auditing tool, is ongoing. There are no open complaint cases involving any EMSA-approved training program. EMSA is participating in both the statewide Child Care Regulatory Workgroup and the CDPH Early Childhood Nutrition workgroup. We completed the CDC MiniCollN project to reduce childhood obesity. EMSA has been asked to participate in a campaign to provide a unified message to child care providers regarding new CDSS Licensing infant safe sleep regulations that are on the horizon.

Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
June 20, 2018

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
5. Automated External Defibrillator (AED) Requirements for EMT's, Public Safety and Layperson	Betsy Slavensky, ext. 461	Ongoing technical support and clarification is provided to public safety agencies, LEMSA's and the general public regarding all AED statutes and regulations. EMSA plans to develop a webpage to provide information regarding AED statutes for clarification. Review and approval of public safety and EMT AED service provider programs continue. There are different requirements for these programs found in Chapter 1.5 Section 100021 and Chapter 2 Section 100063.1. CHP, CAL FIRE and State Parks have updated/reapproved public safety AED programs. CAL FIRE and Parks are currently in the process of review/re-approval of their EMT AED service provider programs.
6. BLS Training and Certification Issues	Betsy Slavensky, ext. 461	EMSA provides ongoing support and technical assistance to EMTs, prospective EMTs and 71 Certifying Entities. EMSA continues to assist all certifying entities with questions and clarification on the EMT regulations that were effective July 1, 2017. EMSA fields calls/questions about Emergency Medical Responders (EMR) processes and relays that there are no regulations specific to EMR, but program approval and scope for public safety EMRs falls under Chapter 1.5. All other questions are directed to the local EMS agency to respond.

Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
June 20, 2018

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
7. State Public Safety Program Monitoring	Betsy Slavensky, ext. 461	EMSA provides ongoing review, approval & monitoring of EMSA approved Public Safety First Aid/CPR, EMR, EMT and CE programs for statutory and regulatory compliance. The BLS Coordinator provides support and clarification to LEMSAs and all statewide public safety agencies regarding the Chapter 1.5 regulations and approval requirements. EMSA approved public safety first aid/CPR courses in 2017 for POST, California State Parks & Recreation and Cal Fire. In 2018, EMSA approved CHP's public safety first aid program and California Firefighters Joint Apprenticeship Committee (CAL JAC) EMT training program. In current review at EMSA are CAL FIRE and CA Parks' EMT training programs. The training program database has been updated to allow the addition of public safety programs that are approved by EMSA and the LEMSAs. Optional scope for the above programs are noted in the comment section for the approved program in the database. Parks & Recreation and Cal Fire will be submitting CE Programs for re-approval this year. EMSA did a site visit to CAL JAC's EMT training program in April 2018. Future site visits to state wide public safety agency programs are pending fiscal approval and staffing.
8. My License Office/ EMT Central Registry Audit	Betsy Slavensky, ext. 461	EMSA monitors the EMT Central Registry to verify that the 73 certifying entities are in compliance with the California Code of Regulations regarding data entry, including background checks and disciplinary notification for all EMT personnel. Correspondence is maintained via Newsletter, email, phone, and LEMSA Coordinator meetings with certifying entities to share updates, changes and corrections. Ongoing development and updates of discipline and certification procedures support central registry processes and reduce time spent on technical support. Certifying entities continue to work with EMSA staff to find and correct erroneous certifications in the Registry.
9. Epinephrine Auto-injector Training and Certification	Nicole Mixon, ext. 420	On January 1, 2016 the EMS Authority began accepting applications for training programs to provide training and certification for the administration of epinephrine auto-injectors to the general public and off-duty EMS personnel. EMSA has approved 14 training programs and has issued 717 lay rescuer certification cards.

Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
June 20, 2018

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
10. Hemostatic Dressings	Lucy Chaidez, ext. 434	The EMS Authority is responsible for approving hemostatic dressings for use in the prehospital setting. EMSA has approved three (3) hemostatic dressings.
11. Paramedic Licensure	Kim Lew, ext. 427	The EMS Authority is responsible for receiving, processing, and auditing paramedic license applications for approval in compliance with the California Code of Regulations. During the past three (3) months, EMSA has approved the following: 183 Initial In-State applications, 28 Initial Out-of-State applications, 1,590 Renewal applications, and 78 Reinstatement applications.
12. eGov Online Licensure Project	Kim Lew, ext. 427	On March 26, 2018 the EMS Authority procured an online licensure application system, MyLicense eGov. Project activities began in late April. The estimated timeline for project completion is approximately five (5) months. Upon completion, paramedic training program graduates and paramedics requiring licensure renewal will be able to apply online.

Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
June 20, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
1. Trauma	Elizabeth Winward ext. 460	State Trauma Advisory Committee (STAC): The STAC held an in-person meeting on May 9, 2018 in San Diego. EMSA staff briefed STAC members on the status of CA-TQIP, PIPS Guidelines, Re-triage Guidelines and next steps planned for opening the trauma regulations. STAC discussed the use of tranexamic acid in the pre-hospital setting as well as developments of EMTALA-related guidance for trauma centers. The next meeting will be in-person in Southern California in late July or early August. 2018 Trauma Summit: The Trauma Summit took place at the Holiday Inn Bayside, San Diego on May 8 and May 9, 2018. Approximately 140 trauma professionals attended the Summit, most of which were surgeons or RNs. CEs and CMEs were available to MDs, MSNs, RNs, EMT-Ps, and EMTs. Attendees provided overall excellent ratings for presentations and commented on the summit being well-organized and informative. The 2019 Trauma Summit will be held in Northern California. The dates and location will be finalized in early July. Regional Trauma Coordinating Committees (RTCC) 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. The EMSA Trauma Coordinator participates in monthly RTCC teleconferences, as invited, and presented at the Bay Area RTCC meetings on April 9, 2018. Performance Improvement and Patient Safety (PIPS) Plan The PIPS plan is being revised by EMSA staff to meet the current needs of California's Trauma System. Once revisions are complete, the PIPS plan will be sent out for public comment. This should take place by mid-summer. Regional Trauma Network for Re-Triage Subcommittee The Regional Trauma Network for Re-Triage guidance document is being finalized and will be submitted for Commission review in September 2018.

Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
June 20, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
2. STEMI/Stroke Systems of Care	Farid Nasr, ext. 424	STEMI and Stroke Regulations EMSA has opened the rulemaking process with the Office of Administrative Law for the Stroke and STEMI regulations. The public was invited to submit written comments on the proposed regulations during the 45-day public comment period from April 6, 2018, through May 21, 2018. At the end of the public comment period, EMSA held a public hearing on May 21, 2018, beginning at 9:00 am and ending at 11:00 am to go over the regulations with any member of the public who had questions. The comments received during the comment periods will be reviewed against the draft regulations and considerations for change will be made. Should substantive changes be indicated, EMSA will engage the working group who helped develop the regulations prior to an additional comment period.
3. EMS System, Standards, and Guidelines	Lisa Galindo, ext. 423	<u>EMS Plan Automation</u> The EMS Authority has plans to develop an automated system for Local EMS Agencies (LEMSA) to submit EMS Plan submissions. This will also permit EMSA and the LEMSAs to run various reports. The EMS Authority is working with the Department of Technology on the development of a Stage 1 Business Analysis. <u>EMS Authority Guidelines</u> Proposed changes to EMS System Standards and Guidelines #101 (June 1993) and #103 (June 1994) have been developed, and are on hold pending finalization of the EMS Plan automation.

Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
June 20, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
4. EMS Transportation	Laura Little, ext. 412	EMS Systems Regulations Work Group / Chapter 13 Task Force: On hiatus, pending outcome of litigation, related to the subject matter involved in the regulation draft. Request for Proposals: Request for Proposals (RFPs) for Exclusive Operating Areas continue to go through a dual review process, to ensure that they meet Federal and State statutory requirements, that there is no bid rigging, collusion, bid chilling, as well as address EMSA Guideline #141 "Competitive Process for Creating Exclusive Operating Areas". EMSA continues to provide technical assistance to LEMSAs by in-person meetings, email, phone, and mail in order to help them create a RFP that meets all required criteria. EMS Plan Appeals Review past EMS Plan submissions, correspondence, conduct public records requests, further historical documentation to map out the issue under appeal, and attend appeal hearings. Complaints/Allegations Conduct an initial investigation into any allegations involving violations of Federal and State laws, including but not limited to Sherman Act Violations. If allegations are proven to be true, a formal investigation is conducted and action is taken. Website Updates EMS System webpages are updated monthly, or daily depending on the topic, to ensure that the most up-to-date information is available to the public and our constituents. Technical Assistance: Provide daily technical assistance to public and providers on exclusive operating areas, interpretation of statute and regulations, EMS provider information and direction on who to contact outside of EMSA for further information.

Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
June 20, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
5. Poison Center Program	Lisa Galindo, ext. 423	The California Poison Control System (CPCS) is one of the largest single providers of poison control services in the U.S. The CPCS is made up of four designated Poison Control Centers. The CPCS receives approximately 330,000 calls a year from both public and health professionals through a toll-free hotline that is accessible 24-hours a day, 7 days a week. Quarterly Report The Quarterly Report consists of data and narrative reports. The data report for the 3rd quarter, January 1, 2018 - March 31, 2018, was received on April 12, 2018, and the narrative report was received on April 16, 2018. Both were reviewed for consistency with contractual objectives. There were no areas of concern. Contract The current contract with the CPCS expires on June 30, 2018. The EMS Authority is in the process of developing a new contract with the CPCS for Fiscal Year 2018/2019. Request for Offer (RFO)/Contract In March 2018, the EMS Authority entered into contract with Sjoberg Evashenk Consulting, Inc., through December 31, 2018, to conduct a Fiscal Management Evaluation and Program Performance Review of the CPCS for the period of July 1, 2016, through June 30, 2017.
6. EMS Plans	Lisa Galindo, ext. 423	Review The EMS Authority continues to review EMS Plans and annual Plan Updates as they are submitted by Local EMS Agencies (LEMSA). A bi-weekly update is provided to management on the staff review of EMS Plan submissions. Technical Assistance Technical assistance is provided to the LEMSAs, as needed, on the EMS Plan development and submission process. Electronic reminders to the LEMSAs are provided in advance of their scheduled submissions.

Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
June 20, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
7. EMS for Children Program	Heidi Wilkening, ext. 556	Regulations: The EMS for Children regulations completed the 45-day public comment period on Friday, April 27, 2018. The public hearing was held on Monday, April 30, 2018. NO members of the public appeared at the hearing to discuss the EMSC regulations draft. Revisions to the draft EMSC regulatins are being considered baased on the comments received dureing the first comment period. EMSA is engaging the EMSC TAC to assist us with revision considerations. Upon the completion of the revisions, a second comment period will be held. Educational Forum: The 21st Annual EMS for Children Educational Forum will be held on Friday, November 9, 2018 in Fairfield, CA. The venue has changed to the NorthBay HealthCare Administration Center. Speakers and vendors/sponsors are being recruited for the forum. NEDARC Survey: The EMSC Program survey of California hospitals for Performance Measures EMSC 06 and 07 will be conducted May – August 2018. This survey will pertain to EMSC Interfacility Transfer Guidelines and Agreements of pediatric patients.

Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
June 20, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
8. CEMSIS EMS Data	Adrienne Kim, ext. 742	CEMSIS now has 27 LEMSAs participating at some level in the submission of EMS data. On January 1, 2017, many LEMSAs transitioned to NEMSIS V3.4 and EMSA is providing technical assistance and guidance to LEMSAs that are still in the process of transitioning to NEMSIS Version 3.4 consistent with AB 1129 which implemented HSC 1797.227. There are three LEMSAs that are currently in the testing stage. <u>Reports:</u> The annual EMS report for CY 2015 and 2016 was completed and published in April of 2018. A comparison study for CEMSIS data is currently being developed.
9. CEMSIS – Trauma Data	Elizabeth Winward, ext. 460	There are 27 Local EMS agencies (LEMSA) with designated Trauma Centers. Trauma Centers are physically located in 38 of the 58 counties. All 27 LEMSAs are submitting data into CEMISIS-representing 79 of the 80 designated Trauma Centers.
10. Communications	Heidi Wilkening, ext. 556	EMSA personnel is working on attending various California communications meetings to learn more on public concerns on issues related to Wireless 9-1-1. This position is currently vacant.
11. Core Measures	Adam Davis, ext. 409	An ad hoc committee met in November of 2017 to review and assess each Core Quality Measure, as well as those developed through the National EMS Compass Initiative. The ad hoc committee was comprised of representatives from the Emergency Medical Services Administrators' Association of California (EMSAAC), Emergency Medical Directors Association of California, (EMDAC), local EMS data managers, and local EMS quality improvement staff. After analysis and discussion of each measure, the committee's recommendations were provided to the Core Quality Measures Task Force group for technical review. Recommendations included retiring some measures, revising others, and incorporating some of the National Compass Measures. 2017 was still a time of

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		transition to NEMSIS 3.4 for many EMS providers and LEMSAs, and since the new measures will be applied retrospectively to 2017 data, EMSA will consider 2017 data as a test year for the new measures. This will allow time to identify and finalize additional technical revisions and for the LEMSAs, providers, and vendors to gain experience and evaluate these measures. Data reports for 2017 will not identify individual agencies. 2017 calendar year data using the new measures are to be reported by June 30, 2018.
12. Grant Activity/Coordination	Lori O'Brien, ext 401	<u>Office of Traffic Safety (OTS) Grants:</u> EMS Systems Division has two OTS grants in process. 1. The **CEMSIS** project continues to improve the data traffic profile within the EMS and Trauma data that is collected in CEMSIS. Second quarter reporting and claims were completed and submitted to OTS on April 30, 2018. 2. The **TQIP** grant has been canceled by OTS. Due to issues with contracting and delays from the American College of Surgeons, EMSA consulted OTS on a process to move forward with this project. However due to timing of the grant, it was decided to cancel this grant as the objectives were not obtainable by the end of the grant period on September 30, 2018. EMSA will consider other opportunities to fund a statewide TQIP collaborative in the future. 3. <u>Health Resource Services Administration (HRSA) Grant:</u> EMSA was awarded the 2018 EMSC Partnership Grant on March 20, 2018. As a result of the federal government's continuing resolution status, the initial Notice of Award reflected a reduced level of funding. The funding level for FFY 2018 for the one-year budget period of 4/1/2018 – 3/31/2019 is 47.35% of $130,000.00 or $61,555.00 Staff continues the work associated with the Health Resources Services Administration (HRSA) grant in furthering the integration of the Emergency Medical Services for Children (EMSC) into the State EMS system <u>Preventive Health and Health Services Block Grant (PHHSBG):</u>

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		EMSA staff remains continually involved in the Preventive Health and Health Services Block Grant. The State Plan for FFY 2018 was submitted to CDPH in February, 2018, and is expected to be accepted by the Technical Advisory Committee in June, 2018.
13. Office Support	Tiffany Pierce ext. 900	<u>Kern County Appeal:</u> -Participated in meetings to take notes and edit/update information. -Spreadsheets were created to be included as exhibits in the Kern County Appeal hearing. -Prepared thumb-drives containing all pertinent hearing documents -Created binders with all exhibits submitted by Kern County EMS -Coordinated with Legal staff to gather required supplies for the hearing. -Set up flight and hotel reservations; worked directly with hotel to reserve a meeting room for EMSA staff attending the Kern County Appeal hearing. <u>Documents and Letters:</u> Processed Systems Division letters and documents including the following: 1. RFP letters for Alameda, San Diego, and Solano County 2. EMS Plan Disapproval and PRA response for Santa Clara County 3. EMS Plan Updates for Santa Clara, Tuolumne, and Mountain Valley 4. STAC appointment letters 5. Two non-EMSA Travel Expense Claims <u>Trauma Summit:</u> Tiffany Pierce met with the Trauma System Coordinator to establish an efficient course of action to prepare for the 2018 Trauma Summit. 1. Ordered supplies 2. Designed new folder labels 3. Assembled folders and name badges for summit attendees 4. Attended Trauma Summit to assist the Trauma System Coordinator with room set-up and attendee registration

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

DATE: June 20, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Jennifer Lim
Deputy Director, Policy, Legislative & External Affairs

SUBJECT: Legislative Report

RECOMMENDED ACTION:

Receive information regarding current bills potentially affecting EMS.

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 June 20, 2018.

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

DATE: June 20, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Rick Trussell, Chief
Fiscal and Administration Unit

SUBJECT: Administrative and Personnel Report

RECOMMENDED ACTION:

Information Only

FISCAL IMPACT:

None

DISCUSSION:

Emergency Medical Services Authority (EMSA) Budget:

2017-18

The 2017-18 enacted California State budget includes departmental expenditure authority in the amount of $37.2 million and 69 permanent positions. Of this amount, $16.3 million is delegated for State operations and $20.9 million is delegated to local assistance.

As of May 15, 2018, accounting records indicate that the Department has expended and/or encumbered $26.6 million or 71.5% of available expenditure authority. Of this amount, $9.9 million or 60.8% of State Operations expenditure authority has been expended and/or encumbered and $16.7 million or 79.7% of local assistance expenditure authority has been expended and/or encumbered.

The Department is in the process of month-end closing (MEC) accounting activities and 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.

2018-19

The Governor's May Revise Budget for 2018-19 released in May 2018 includes expenditure authority in the amount of $37.4 million and 69.9 permanent positions. Of this amount, $16.4 million is delegated for State operations and $21 million is delegated to local assistance. The following workload budget adjustments are included in the proposed budget:

- **Increased Information Technology Security Resources:** EMSA is requesting one 1.0 permanent position and a $356,000 General Fund augmentation which includes one-time funding of $196,000 for Information Technology (IT) infrastructure improvements. The additional resources will be utilized to strengthen the department's IT infrastructure and provide adequate staffing levels to ensure compliance with State policy and procedural requirements.

EMSA Staffing Levels:

As of May 15, 2018, the Department is authorized 69 positions and also has 11.3 temporary (blanket positions and retired annuitants) positions for an overall staffing level of 80.3. Of the 80.3 positions, 6 positions are vacant at this time.

	Division				
	Admin/Exec	**DMS**	**EMSP**	**EMS**	**Total**
Authorized	18.0	20.0	22.0	9.0	69.0
Temporary Staff	3.5	1.5	1.3	5.0	11.3
Staffing Level	**21.5**	**21.5**	**23.3**	**14.0**	**80.3**
Authorized (Vacant)	0.0	-3.0	-2.0	0.0	-5.0
Temporary (Vacant)	0.0	0.0	0.0	-1.0	-1.0
Current Staffing Level	**21.5**	**18.5**	**21.3**	**13.0**	**74.3**

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

DATE: June 20, 2018

TO: Commission on EMS

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

PREPARED BY: Steven A. McGee, Administrative Adviser

SUBJECT: Legal Report

RECOMMENDED ACTION:

Receive information on Legal Office Activities.

FISCAL IMPACT:

None

DISCUSSION:

Disciplinary Cases:

From February 16, 2018, to May 18, 2018, the Authority issued twenty-two new Accusations against existing paramedic licenses, one temporary suspension order, issued one administrative fine, and issued decisions on five petitions for reduction of penalties. Of the newly issued actions, four of the Respondents have requested that an administrative hearing be set. There are currently seven hearings scheduled, and one waiting to be scheduled. There are currently thirty-three open active disciplinary cases in the legal office.

Litigation:

Tagliere v. Backer, Los Angeles County Superior Court #BS1707101, Writ of Administrative Mandamus. Plaintiff has filed a writ seeking to overturn the revocation of his license subsequent to an administrative hearing. Hearing set for October 2018.

Americare Medservices, Inc.v. City of Anaheim, et al., Appeal from the United States District Court for the Central District of California, No. 8:16-cv-01703-JLS. The Authority has filed an amicus brief asking the court to certify the matter to the California Supreme Court for an interpretation of Health and Safety Code 1797.201. The case is being considered for oral arguments, dates to be scheduled in August or October.

Kern County EMS v. EMSA, OAH #'s 2016100453, 2017010313. Appeal of a denial of local EMS plans. A hearing was held on March 13-15 In Bakersfield. Closing and reply briefs

were filed. The Administrative Law Judge's proposed decision for the Commission is due on May 24.

Calchiefs v. EMSA and Alameda County EMS, Alameda County Superior Court, Case No. RG18890846. From the lawsuit: "This Petition seeks to set aside a request for proposal ("RFP") for the provision of ambulance and emergency medical services ("EMS") issued by Respondent and Defendant Alameda County Emergency Medical Services District ("ALCO EMS") and approved by Respondent and Defendant California Emergency Medical Services Authority ("EMSA")." The Court ruled that EMSA was to meet and confer with Alameda County regarding changes to the RFP. The Authority met with Alameda County who submitted new RFP language, which was approved by the Authority.

Warren v. EMSA and Howard Backer, Sacramento County Superior Court, Case No. 34-2018-00225194. Mr. Warren is suing both EMSA and Sacramento County as he desires to have Sacramento County EMS hospital destination transportation protocols changed. EMSA has stated that changing the transportation protocol is governed by the LEMSA. Sacramento County EMS has stated, through counsel, that revising the local protocol is a state responsibility. The lawsuit seeks to determine which entity is responsible and compel them to change the protocol. The Authority has retained the Attorney General's office and has responded to the suit.

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RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

DATE: June 20, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

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

SUBJECT: Enforcement Report

RECOMMENDED ACTION:

Receive information on Enforcement Unit activities.

FISCAL IMPACT:

None

DISCUSSION:

Unit Staffing:

As of May 1, 2018, the Enforcement Unit is budgeted for 5 full-time Special Investigators: one Special Investigator position is temporarily vacant due to maternity leave, the Associate Government Program Analyst (AGPA-Probation Monitor) position is vacant due to salary savings mandates, and a retired annuitant Special Investigator position is vacant while awaiting approval to hire. One of the Special Investigator positions has been temporarily realigned to fulfill the primary functions of case management and probation monitoring.

Investigative Workload:

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

Cases opened since January 1, 2018, including:

Cases opened:	73
Cases completed and/or closed:	70
EMT-Paramedics on Probation:	220

In 2017:

Cases opened:	282
Cases completed and/or closed:	307
EMT-Paramedics on Probation:	230

Status of Current Cases:

The Enforcement Unit currently has 104 cases in “open” status.

As of May 1, 2018, there are 42 cases that have been in “open” status for 180 days or longer: three (3) Fire Fighters’ Bill of Rights (FFBOR) cases and eight (8) cases waiting for California Society of Addiction Medicine (CSAM) evaluations. Respondents are directed to a physician who specializes in addition medicine for an examination/review in cases involving alcohol or other substance abuse.

Those 42 cases are divided among 3 Special Investigators and are in various stages of the investigative process. These stages include 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.

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

DATE: June 20, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Priscilla Rivera, Manager
Personnel Standards Unit

Lou Meyer
EMSA POLST eRegistry Coordinator

SUBJECT: POLST eRegistry Update

RECOMMENDED ACTION:

Receive information regarding POLST eRegistry Pilot Project.

FISCAL IMPACT:

The California Health Care Foundation has granted up to $3 million to fund the different aspects of the POLST eRegistry Pilot Project that includes, but is not limited to, the local pilot sites, the technology vendor, independent evaluator, project director, project consultant.

DISCUSSION:

Decisions on end of life care for oneself and for that of loved ones are difficult for anyone to make. The Physician Orders for Life-Sustaining Treatment (POLST) is a process that encourages open and thoughtful discussion between physicians, and their patients regarding end of life care. To address some of the current limitations with the accessibility to the POLST information, SB 19 (Wolk Chapter 504, 2015) was signed by the California Governor authorizing a POLST electronic registry (eRegistry) pilot project under the aegis of the EMS Authority (EMSA).

Multi Agency Coordination Activity (MAC)

As a member of the MAC, EMSA's POLST eRegistry Coordinator, with the support of other members of the EMSA leadership team continues to participate in weekly as well as needed MAC Conference Calls and in person meetings throughout the last quarter.

Report to the Legislature

The “Report to the Legislature” has been submitted as required by SB 19 (Wolk).

Pilot Site Update

The pilot site in Contra Costa County being led by the Alameda-Contra Costa Medical Association (ACCMA), has gone live with Sutter Delta and the Sutter Health System in Contra Costa County. ACCMA continues to work with their other hospital stakeholders to ensure their active participation within the POLST eRegistry.

Additionally, Vynca the technology vendor collaborated with Contra Costa County EMS, Contra Costa Fire and American Medical Response (AMR) and the POLST eRegistry has also gone live for use by EMS Field personnel on April 10, 2018.

The Contra Costa County EMS Agency’s Workgroup has reported that they had a successful launch. The field personnel find the platform very intuitive to date. Systems are in place to capture real patient successes and challenges using EMS Events reporting. The main dilemma is sustaining field query activity given that queries typically do not yield results given the quantity of the POLST Forms currently available for query.

Successful strategies to sustain engagement of field personnel will be important to fully test the value of the system.

The pilot site in the City of San Diego is being led by San Diego Health Connect (SDHC). They are also continuing to work with their hospital stakeholders to ensure active participation within the POLST eRegistry.

Additionally, SDHC has collaborated with the San Diego County EMS Agency, City of San Diego Fire, and American Medical Response (AMR). The POLST eRegistry is live for use by EMS Field personnel within the SDHC HIE capture area.

Over 800 Fire and paramedics will attend refresher/update training in June that will include the new POLST eRegistry functionality, as well as a refresher about Search, Alert, File, and Reconcile and the Health Information Exchange.

Unlike Contra Costa County where the Paramedic needs to make a POLST Form query, the SDHC process currently in place will automatically advise the Paramedic if a POLST Form is on file as soon as the patients name is entered into their Field Tablet.

SDHC is continuing to manually upload POLST Forms to meet certain contractual milestone requirements, with the anticipation of having an electronic upload option in place in the near future.

Stella Technology, the technology vendor for the SDHC project, is collaborating appropriately with all parties at this time.

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

DATE: June 20, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Priscilla Rivera, Manager
Personnel Standards Unit

Lou Meyer
Community Paramedicine Pilot Project Manager

SUBJECT: Community Paramedicine Update

RECOMMENDED ACTION:

Receive information regarding the Community Paramedicine Pilot.

FISCAL IMPACT:

The Community Paramedicine Project Manager and the Independent Evaluator are funded by the California HealthCare Foundation. Local pilot site providers participate with in-kind contributions and any local grants or reimbursement.

DISCUSSION:

Strong progress continues with the Community Paramedicine Projects. The data, as well as the independent evaluator's public report continues to show these projects have improved patient care as well as having reduced hospital re-admissions and visits to emergency departments.

Independent Evaluation:

The Health Workforce Pilot Project (HWPP) regulations require organizations that sponsor pilot projects to retain an independent evaluator to assess trainee performance, patient acceptance, and cost effectiveness. A team of evaluators at the Philip R. Lee Institute for Health Policy Studies and the Center for the Health Professions at the University of California, San Francisco continue to serve as the independent evaluators for the HWPP #173.

The UCSF's Healthforce Center issued an update Evaluation Report in February 2018, containing their findings for the first 28 months of the project, (*see link below*) which in summary states:

"The evaluation found that community paramedics are collaborating successfully with physicians, nurses, behavioral health professionals, and social workers to fill gaps in the health and social services safety net. The evaluation has yielded consistent findings for six of the seven community paramedicine concepts tested. All of the post-discharge, frequent 911 users, tuberculosis, hospice, and alternate destination – mental health projects have been in operation for 21 or more months and have improved patients' well-being. In most cases, they have yielded savings for payers and other parts of the health care system. Preliminary findings regarding the sixth concept, alternate destination – sobering center, suggest that this project is also benefitting patients and the health care system."

The following links contain the UCSF February 2018 Evaluation Report as well a Research Highlight Document:

https://healthforce.ucsf.edu/publications/evaluation-california-s-community-paramedicine-pilot-program

https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Community%20Paramedicine%20Research%20Highlight.pdf

Patient Safety:

There were no patient safety issues reported to the EMSA Pilot Project Manager or discovered by the independent evaluator during this reporting period.

Additional Pilot Sites:

In accordance with the California Code of Regulations (22 CCR §92604), EMSA submitted and OSHPD approved Applications from the following healthcare agencies and/or EMS providers in collaboration with a local EMS Agency (LEMSA) to become additional Pilot Sites within the HWPP#173 Pilot Project to run thru November 13, 2018.

The following is a status update on the additional Pilot Projects

Local EMS Agency	Sponsor	Concepts	Status
Santa Clara County	Santa Clara County EMS Agency	Alt Destination Behavioral Health	CORE and Site-specific training has been completed, an IRB has been approved for this Pilot Project.

		Alt Destination Sobering Center	OSHPD implementation approval is pending.
Sierra Sacramento Valley	Dignity Health	Post Discharge	CORE and Site-specific training and an approved IRB are pending.
El Dorado County	Cal Tahoe JPA	Alt Destination Behavioral Health Post Discharge	This project has withdrawn due to lack of JPA Board approval and funding.
Marin County EMS Agency		Frequent 911 User	CORE and Site-specific Training and an approved IRB are pending, awaiting the outcome of the Legislative process.
City & County of San Francisco	San Francisco Fire Department	Frequent 911 User Alt Destination – Behavioral Health Post Discharge	Site-specific Training and an approved updated IRB are pending.
Central California EMS Agency	Central California EMS Agency	Alt Destination - Behavioral	CORE and Site-specific Training has been completed. Currently awaiting an approved IRB

Community Paramedicine Legislation

There are currently two (2) pieces of Legislation making their way through the legislative process which would enable the ability for EMSA and the Local EMS Agencies to approve Community Paramedicine and/or Alternate Destination to Mental Health Facilities or Sobering Centers programs throughout the State of California.

AB 1795 (Gipson)
(Sponsored by California Hospital Association (CHA) & Los Angeles County)

Allows a local emergency medical services agency (LEMSA) to submit, as part of its emergency medical services (EMS) plan, a plan to transport specified patients who meet triage criteria to a behavioral health facility or a sobering center. This bill authorizes a city, county, or city and county to designate, and contract with, a sobering center to receive patients, and would establish sobering center standards. Specifies the

training requirements for paramedics to transport individuals to behavioral health facilities. Requires the Emergency Medical Services Authority (EMSA) to adopt guidelines for the triage criteria and assessment procedures by July 1, 2020 and requires EMSA to annually analyze administration of local plans and issue a report.

SB 944 (Hertzberg)

This Bill is sponsored by the California Professional Firefighters (CPF)

The Bill would enact the Community Paramedicine Act of 2018. This bill would create the statutory authority to transition community paramedicine (CP) from the Health Workforce Pilot Project #173 to a statewide program. The bill would authorize local EMS agencies to develop a community paramedicine program that is consistent with regulations that would be developed by the Emergency Medical Services Authority (EMSA), in consultation with the Community Paramedicine Medical Oversight Committee, which would be formed by this bill. Community paramedicine programs would provide services in one or more of the following five roles: (1) providing short-term post discharge follow up; (2) providing directly observed tuberculosis therapy; (3) providing case management services to frequent emergency medical services users; (4) providing hospice services in coordination with hospice nurses to treat patients in their homes; and, (5) providing patients with transport to an alternate destination, which can either be an authorized mental health facility or an authorized sobering center.

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

DATE: June 20, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Jennifer Lim, Deputy Director
Legislative, Regulatory, and External Affairs

SUBJECT: Regulations Update

RECOMMENDED ACTION:

For information only.

FISCAL IMPACT:

There is no fiscal impact.

DISCUSSION:

The following information is an update to the regulation rulemaking calendar approved by the Commission on EMS on December 6, 2017. In accordance with Health and Safety Code Section 1797.107, the Emergency Medical Services Authority (EMSA) is promulgating the following regulations:

	Chapter	Status
1.1	Training Standards for Child Care Providers	Under review by EMSA
4	Paramedic	Under review by the California Health and Human Services Agency
7.1	ST-Elevation Myocardial Infarction (STEMI) Systems of Care	Public comment closed May 21, 2018. Comments under review by EMSA
7.2	Stroke Systems of Care	Public comment closed May 21, 2018. Comments under review by EMSA
10	California Emergency Medical Technician Central Registry	Under review by EMSA
12	Emergency Medical Services System Quality Improvement	Under review by EMSA
14	Emergency Medical Services for Children	First public comment period completed. Comments under review by EMSA

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DATE: June 20, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Sean Trask, Chief
EMS Personnel Division

SUBJECT: Trial Studies - Move Ketamine from Trial Study to Local Optional Scope

RECOMMENDED ACTION(S):

Recommend termination of the ketamine trial studies and move ketamine to the paramedic local optional scope of practice.

FISCAL IMPACT:

No fiscal impact.

DISCUSSION:

Morphine and fentanyl are part of the paramedic basic scope of practice and generally part of the local EMS agencies approved protocols for analgesia. Prehospital providers are running low on supplies of morphine and fenantyl due to drug shortages of opioid analgesics.

Because ketamine is not in the paramedic basic or local optional scopes of practice in California, three local EMS agencies applied for trial study approval to determine the safety and efficacy of administering ketamine for analgesia. Those local EMS agencies with approved trial studies are:

1. Mountain Valley EMS Agency
2. Riverside County EMS Agency
3. Inland Counties EMS Agency

See attached interim report that includes data from all three trial study sites.

Under the current trial studies, the indications and contraindications for the administration of ketamine for analgesia are:

Indications:

1. Acute traumatic injury or acute burn injury with pain score of 5 or higher on a scale of 1 - 10.
2. 15 years of age or older
3. Glascow Coma Scale Score of 15

Contraindications:

1. GCS 14 or less
2. Known or suspected pregnancy
3. Known allergy to Ketamine
4. Known or suspected alcohol or drug intoxication
5. Having received narcotic analgesia in any form within 6 hours of planned Ketamine administration
6. Pain score less than 5 prior to first dose of Ketamine

Other States Information

Ketamine is used in the prehospital setting in four other states:

1. San Antonio, TX – uses ketamine for sedation for rapid sequence intubation, analgesia, excited delirium, sedation for intubated patients, and severe respiratory failure from asthma/COPD.
2. New York uses ketamine for analgesia, procedural sedation, and excited delirium.
3. Milwaukee, WI uses ketamine for analgesia
4. Seattle, WA uses ketamine for analgesia, excited delirium, and procedural sedation for endotracheal intubation.

Attached is the current table of trial studies.

Attachments: Ketamine Pilot Project Interim Report
Table of Current Trial Studies

Ketamine Pilot Project Interim Report
February 1 – May 27, 2018

- **Total enrollment = 79 patients**
- **Age range 17 - 93 years**
- **Weight range 40 – 190 kg**
- **Chief Compliant in order most to least**
  - **Extremity trauma**
  - **Multi-trauma**
  - **Thoracic trauma**
  - **Pelvis/Hip trauma**
  - **Burn**
- **Initial systolic BP range: 70 – 210 mmHg (Median 140 mmHg)**
- **Final systolic BP range: 90 – 205 mmHg (Median 140 mmHg)**
- **Initial pulse range: 50 – 126 beats per minute**
- **Initial pain scores (scale 0 – 10 with 10 being the worst)**
  - **86% had pain scores 8, 9 or 10**
  - **57% had 10/10 pain**
- **Average pain reduction = 5 points**
  - **44 patients dropped from 10/10 to 0/10 (over half of the patients)**
- **One patient reported increased pain from 9/10 to 10/10**
- **Complications**
  - **Nausea (4), Dysphoria (2), Dizziness (1), Headache (1)**
- **Number of patients handed off to a second provider = 4**
- **Protocol Violations**
  - **Not documenting ENDING pain score = 4**
  - **Not placing a wrist band = 1**
  - **Administering Ketamine after taking a pain medicine = 1**
  - **Non-traumatic pain = 2**
  - **Dosing error = 1**
- **No untoward effects in any patients with a protocol violation**

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STATE OF CALIFORNIA

EMERGENCY MEDICAL SERVICES AUTHORITY

CURRENT TRIAL STUDIES
as of 3/22/2018

Local EMS Agency	Study Title	EMS Agency Medical Director and Primary Investigator	Date of Initiation of Trial Study	Commission Notified	18 Mo. Report Due	Commission Action	36 Mo. Report Due / Patients Enrolled	Disposition of Study
Mountain Valley EMS Agency	Ketamine	Katherine Shafer, MD	2/1/18	3/21/18	8/1/19			Approved 11/28/17
Riverside County EMS Agency	Ketamine	Reza Vaezazizi, MD	4/1/18	3/21/18	10/1/19			Approved 12/11/17
ICEMA EMS Agency	Ketamine	Reza Vaezazizi, MD	4/1/18	3/21/18	10/1/19			Approved 12/11/17

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

DATE: June 20, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

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

SUBJECT: Wireless 911 Routing Status

RECOMMENDED ACTION:

Receive information on Wireless 911 Routing.

FISCAL IMPACT:

None known at this time.

DISCUSSION:

The EMS Authority continues to engage stakeholders in issues related to the wireless 911 system.

Paul Troxel, ENP, 9-1-1 Program Management Division Chief from the Office of Emergency Services (OES) is scheduled to be in attendance today to provide updates on this topic.

We will keep the Commission informed on progress of review of wireless 9-1-1 system activities.

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RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

DATE: June 20, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

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

SUBJECT: Kern EMS Plan Appeal

RECOMMENDED ACTION:

Review and vote on the Administrative Law Judge's Proposed Decision and Order related to EMSA's denial of the Kern County EMS Plans for 2012 and 2015.

FISCAL IMPACT:

None known at this time.

DISCUSSION:

A hearing was conducted before the Office of Administrative Hearings on March 13-15, 2018, pertaining to the appeal of EMSA's denial of the 2012 and 2015 Kern County EMS Plans. A Proposed Decision and Order was made on May 18, 2018, by Judge Reyes of the Office of Administrative Hearings (OAH), and received on May 21, 2018. The Commission on EMS is required to review the ALJ's proposed decision pertaining to the EMSA denial of the Kern County EMS plans and vote to adopt or not adopt it as the Commission's decision in the matter following the California Code of Regulations, Title 22, Division 9, Chapter 13.

On September 17, 2014, the EMS Commission adopted the Administrative Procedures Act (APA) as the process to be employed for local EMS plan appeals. The APA method requires a hearing to be held before an Administrative Law Judge (ALJ). The administrative appeal process allows for the review of the factual basis, receipt of evidence including the examination of witnesses, the submission of motions and briefs, oral arguments, and rebuttal. This procedure closely follows the same process as a civil hearing.

In this case, the Kern County local EMS agency filed appeals of EMSA's denial of the transportation portion of the 2012 and 2015 EMS plans. The denial was primarily concerning the designation of exclusive operating areas for ambulance services. An appeal hearing was scheduled with the Office of Administrative Hearings (OAH). A public hearing was held on

March 13-15, 2018. Both parties presented evidence and argued their case before the ALJ. On May 18, 2018, the ALJ submitted a proposed Decision and Order which was within 30 days of the case being submitted to the ALJ. The recommendations in the Proposed Decision and Order are not binding on the Commission, but the Commission may adopt the recommendation as its decision in the matter.

The ALJ's proposed decision before the Commission requires the Commission to vote based upon the regulations adopted by the Commission when hearing an appeal (CCR, Title 22, Div 9, Ch 13)

The applicable statues and regulation sections are listed below:

- Health & Safety Code (HSC), Section 1797.105(b) gives the EMS Authority the authority to approve or not approve a local EMS plan.
- *HSC Section 1797.105(c) A local EMS agency may appeal a determination of the authority pursuant to subdivision (b) to the commission.*
- *HSC Section 1797.105(d) In an appeal pursuant to subdivision (c), the commission may sustain the determination of the authority or overrule and permit local implementation of a plan, and the decision of the commission is final.*
- *California Code of Regulations, Title 22, Div 9, Chapter 13 EMS Systems Regulations, 100450.100:*
  (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 rehearing.
  (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.

The agenda presented below is consistent with the statutory and regulatory requirement for the Commission on EMS to consider and vote on an ALJ proposed decision, subsequent to a hearing by the Office of Administrative Hearings:

Kern County EMS Agency's Appeal of the Denial of its EMS Plan(s),
Office of Administrative,
OAH Case Nos. 2016100453, 2017010313

Commission on EMS Determination Agenda
June 20, 2018

A. Review of Legal Authorities:
   1. Section 1797.105, Health and Safety Code, Division 2.5
   2. EMS System Regulations, Chapter 13, Division 9, Title 22, California Code of Regulations.

B. Presentation by the Kern County EMS Agency – 10 minutes

C. Presentation by the EMS Authority – 10 minutes

D. Public Comment – 30 minutes, 2 minutes maximum per speaker

E. Commissioner Discussion and Deliberation

F. Vote Concerning Administrative Law Judge's Proposed Decision. Commissioners present shall vote for one of the following (decision shall be by majority vote):
   1. Adopt the Administrative Law Judge's Proposed Decision
   2. Not Adopt the Administrative Law Judge's Proposed Decision
   3. Return the Proposed Decision for Rehearing

BEFORE THE
COMMISSION ON EMERGENCY MEDICAL SERVICES
STATE OF CALIFORNIA

In the Matter of the Statement of Issues of: KERN COUNTY EMERGENCY MEDICAL SERVICES AGENCY, Respondent,	Case Nos. 16-001A and 17-001A OAH Case Nos. 2016100453 and 2017010313

PROPOSED DECISION

These consolidated matters regularly came before Samuel D. Reyes, Administrative Law Judge, Office of Administrative Hearings, in Bakersfield, California, on March 13, 14, and 15, 2018.

Steven A. McGee, Administrative Adviser and Counsel, Emergency Medical Services (EMS) Authority (EMSA or Authority), and Stephen J. Egan, Senior Staff Counsel, represented Tom McGinnis (Complainant), Chief, EMS Systems Division.

Gurujodha S. Khalsa, Chief Deputy, Office of the County Counsel, County of Kern, represented Kern County EMS Agency (Respondent).

Craig J. Cannizzo, Attorney at Law, filed an *amicus curiae* brief on behalf of Hall Ambulance Service, Inc. (Hall), Delano Ambulance Service, Inc. (Delano), and Progressive Ambulance, Inc. doing business as Liberty Ambulance (Liberty), providers of ground ambulance services in Kern County.

This case arises pursuant to the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (Act), Health and Safety Code section 1797 et seq.[1] Pursuant to the requirements of the Act, Respondent, a local EMS agency within the meaning of the Act, is required to submit annual plans for the implementation of emergency medical services and trauma care systems within its jurisdiction for Authority approval. At issue in case 16-001A, OAH Case 2016100453, is the 2012 Plan Update (2012 Plan), and at issue in case 17-001A, OAH Case 2017010313, is the 2015 Plan Update (2015 Plan). In each case, and essentially for the same reasons, the Authority declined to approve the Ground Transportation component of the respective plans. In brief, the Authority concluded that Respondent had improperly designated exclusive providers for ambulance services in multiple operating areas or service zones within Kern County.

[1] Unless otherwise stated, all statutory references are to the Health and Safety Code.

The Act permits designation of exclusive ambulance service providers in one of two ways, by a competitive bidding process or by "grandfathering" an existing provider. The following language in section 1797.224 permits grandfathering an existing provider: "[N]o competitive process is required if the local EMS agency develops or implements a local plan that continues the use of existing providers operating within a local EMS area in the manner and scope in which the services have been provided without interruption since January 1, 1981. . . ."

The Authority concluded that Respondent could not grant exclusivity to the three providers in question, Hall, Delano, and Liberty, because they had not been operating ambulance service in the operating areas "in the manner and scope in which the services have been provided without interruption since January 1, 1981." The Authority cites to changes in the identity of the providers, non-exclusivity in the areas of operation, changes in operating areas, and Respondent's failure to provide pertinent materials to establish the required provider continuity as the primary bases for its rejection of the transportation components of the plans. In addition, it rejected the portion of the plan that provided for the selection of a provider through a competitive bidding process because it had not previously approved the selection process.

Respondent urges adoption of the plans. It argues that the Authority has not adopted valid guidelines or regulations to define the "manner and scope" of the services in question and, absent such guidelines or regulations, the Authority cannot make the requisite statutory determinations. It challenges the Authority's interpretation of the statutory language, and urges that a proper construction of the statute leads to approval of the Plans. It maintains that Hall, Delano, and Liberty have been continuously providing services in the requisite manner and scope since January 1, 1981, and that Hall was selected as the exclusive provider through a valid competitive bidding process in one of the areas at issue. Respondent argues that any operating area boundary changes were not significant and did not materially affect provision of services, and that, despite changes in structure or ownership, the existing ambulance companies are the same ones or the successors of those that were providing the services at the start of 1981. Moreover, the Plans effectively meet the needs of the persons served.

As more fully set forth below, the Authority's rejection of the plans is upheld with respect to three of the operating areas and not upheld with respect to seven of the operating areas. Because the regulation governing appeals such as this one requires adoption or rejection of an entire plan, the Plans must be rejected because of the deficiencies in the three operating areas.

Oral and documentary evidence was received at the hearing. The record was left open for the submission of written closing argument. On April 6, 2018, Complainant and Respondent filed initial closing briefs. Also on April 6, 2018, Delano, Hall, and Liberty filed an *amicus curiae* brief. Complainant and Respondent filed reply briefs on April 23, 2018. The matter was submitted for decision on April 23, 2018.

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FACTUAL FINDINGS

Parties and Jurisdiction

1. Complainant filed the Statement of Issues in his official capacity.

2. Respondent is the local EMS agency for the County of Kern.

3. The County of Kern is large and geographically diverse. It has urban areas, by far the largest of which is the Bakersfield area, and it has many rural areas. It has mountainous areas and desert areas which are lightly populated. For the purpose of providing ambulance service, the County is divided into 10 operating areas or service zones. The operating areas, with a geographic references associated with the area served, are as follows: Operating Area 1 (City of Wasco), Operating Area 2 (City of Shafter), Operating Area 3 (Cities of Delano and McFarland), Operating Areas 4 and 5 (City of Bakersfield and environs), Operating Area 6 (Kernville, Lake Isabella and other mountain communities), Operating Area 7 (City of Ridgecrest and other northern county desert communities), Operating Area 8 (Cities of Arvin, Lamont, Tehachapi, and Frazier Park), Operating Area 9 (Cities of Taft and Maricopa), and Operating Area 11 (California City, City of Mojave and other southern county desert communities). Former Operating Area 10 merged into Operating Area 11 in 1992.

4. Ambulance services are divided into several components, including, as pertinent to this proceeding, 911 Response, Seven-Digit Response, and Non-Emergency Response. These services are differentiated in part by the manner in which calls are received by the ambulance service providers and the urgency required in the response. 911 Response calls are received from the central 911 dispatchers and typically involve emergencies. Seven-Digit Response calls are those made in response to direct calls from individuals and may involve emergency services. The Non-Emergency Response calls do not require immediate response and typically involve transfers from or to medical facilities or care facilities, such as nursing homes.

The 2012 Plan

5. The only component of the plan not approved by the Authority, and thus at issue is this case, is the ground transportation component. In the 2012 Plan, Respondent designated Hall as the exclusive provider of 911 Response, Seven-Digit Response, and Non-Emergency Response services in Operating Areas 1, 2, 4, 5, 8, 9, and 11. The plan designated Delano as the provider of all three services in Operating Area 3 and Liberty as the provider of all three services in Operating Areas 6 and 7. With the exception of Operating Area 11, in which a contract had been awarded through competitive bidding, Respondent determined exclusivity through the grandfathering method.

6. By letter dated June 24, 2014, the Authority declined to approve the ground transportation component of the 2012 Plan. It concluded that due to changes in ownership,

changes in operating area boundaries, and multiple operators in the areas claimed to be exclusive, none of the operating areas could be treated as exclusive to the proposed providers absent a competitive bidding process. The Authority also concluded that a new competitive bidding process and a schedule for periodic competitive bidding intervals were required for Operating Area 11 before an exclusive provider could be selected.

The 2015 Plan

7. The 2015 Plan is similar to the 2012 Plan in all material respects pertinent to the transportation component.

8. By letter dated September 26, 2016, the Authority declined to approve the ground transportation component of the 2015 Plan, essentially for the same reasons it had declined to approve the 2012 Plan.

Ambulance Services in Kern County

9. On February 22, 2005, the County of Kern Board of Supervisors enacted Resolution 2005-065, setting forth the following criteria for determining if an ambulance provider could be deemed a grandfathered ambulance services provider pursuant to section 1797.224:

"(a) The existing provider is the same service provider since January 1, 1981 without interruption of service. A successor to a previously existing emergency services provider shall qualify as an existing provider if the successor has continued uninterrupted the emergency ambulance transportation service previously supplied by the prior provider; and

"(b) The existing provider is the sole contracted ground ambulance service provider authorized to provide emergency ambulance service, or emergency and non-emergency ambulance service for the operating area; and

"(c) Any changes to the operating area boundaries since January 1, 1981 have not significantly reduced the level of care to the communities being served by the provider; and

"(d) There have been only minor alterations in the level of life support personnel or equipment, such that it does not significantly reduce the level of care available since January 1, 1981." (Exh. A, at pp. 2-3.)[2]

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[2] Respondent relied on this ordinance in creating exclusive operating areas, and Complainant argues that the ordinance is preempted by State law and must be declared void. Declaring a county ordinance void is not necessary for resolution of the matter and the invitation to do so is declined.

10. Respondent thereafter concluded that existing providers of ambulance services in Operating Areas 1, 2, 3, 4, 5, 6, 7, 8, 9, and 11 met the legal requirements to be designated exclusive providers in their respective service zones, and recommended approval of contracts with the providers. With the exception of Operating Area 11, where a competitive bidding had been used, the providers for all other zones were designated exclusive through the process of grandfathering. Kern Ambulance Service was chosen as the exclusive provider in Operating Area 1; Hall was chosen for Operating Areas 2, 4, 5, 8, 9, and 11; Delano was chosen for Operating Area 3; Community Ambulance Service, Inc., doing business as CARE Ambulance Service (CARE Ambulance) was chosen for Operating Area 6; and Liberty was chosen for Operating Area 7. Respondent entered into contracts with the chosen entities for the provision of ambulance services, which contracts were subsequently amended to substitute successor entities, such as Liberty for Operating Area 6 and Moses as the new owner of Delano.

11. Several individuals with knowledge and experience with ambulance services in Kern County testified at the hearing. Their testimony was generally consistent and uncontroverted. Complainant, the Authority's Chief of the EMS Systems Division, worked for eight years for Shafter Ambulance, from 1991 to 1998, and for eight years for Hall, from 1999 to 2008. Peter William Brandon III (Brandon) first worked providing emergency services in 1975, for Flynn Ambulance; he worked for Golden Empire Ambulance from 1980 until 1999, when he became the chief executive officer of Liberty, a position he still held at the time of the hearing. Dora Gatlin (Gatlin), worked as a paramedic from 1982 until 2003, and helped her father run Shafter Ambulance. Aaron Moses (Moses), the owner of Delano since 2009, worked as a paramedic in Kern County in the late 1990s. Michael Parent (Parent) worked as a paramedic and director of operations for Golden Empire Ambulance from December 1992 until August 2005.

12. As established by the testimonies of Complainant, Gatlin, and Parent, with partial corroboration from Brandon and Moses, over the years, at least since 1981, and continuing through the present, ambulance service providers were given primary responsibility for one or more specific geographic zones, i.e., the primary operating area, but were not expressly prohibited from providing services in another provider's primary zone. Some of the ambulance companies, notably Golden Empire Ambulance and Hall, distributed literature in convalescent homes and medical facilities so clients could call them directly for non-emergency transfers. As detailed below, at times, the services were irregularly provided into a particular operating area by ambulances based outside the particular zone, or what witnesses referred to as ambulances "running calls." In other instances, providers primarily based in other operating areas or seeking to commence operations in Kern County established facilities from which to provide services in the operating area in question, temporarily resulting in more than one provider in a particular operating area. The fact that each ambulance service provider had to submit detailed logs regarding their operations to Respondent establishes that Respondent was aware of the ambulance companies' practices.

Ambulance Services in Operating Area 1

13. Wasco Ambulance was providing 911, Seven-Digit, and Non-Emergency Response services in Operating Area 1 since at least January 1, 1981. The company changed ownership in 1984. Wasco Ambulance continued to provide services until it was sold to Kern Ambulance in 1999.

14. Kern Ambulance Service provided all three types of services from facilities located in the operating area, starting in 1987. In 2003, ownership of Kern Ambulance Service changed. On March 24, 2014, Hall entered into an Asset Purchase Agreement with Kern Ambulance Service, in which Hall agreed to purchase all assets used in the operations of the ambulance business. The agreement made reference to the companies' designations in their respective areas as exclusive providers of ambulance services.[3]

15. Hall has been the sole provider of ambulance services in Operating Area 1 from March 24, 2014, to the present. Jacqueline Att (Att), Hall's Secretary/Treasurer testified, without contradiction, that the level of services did not decrease as a result of Hall's purchase of Kern Ambulance.

16. North Kern Ambulance provided all three types of services from 1983 until 1987, when it was sold to WestWorld Healthcare. WestWorld Healthcare ceased providing services later in 1987, when it filed for bankruptcy.

17. Shafter Ambulance provided Seven-Digit and Non-Emergency Response services in Operating Area 1 from 1995 to 1998.

18. As set forth in factual finding numbers 13, 14, 16 and 17, at least two, and for brief periods three, ambulance companies regularly provided services in Operating Area 1 at the same time during the 1983 to 1999 period. The existing provider, Hall, has not been providing ambulance services in Operating Area 1 in the manner and scope in which the services have been provided without interruption since January 1, 1981, either in its own capacity or as the successor of a prior provider. While Respondent correctly argues that Hall

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[3] At the time it reviewed the 2012 and 2015 Plans, the Authority did not have some or all of the documents evidencing terms of sale in the Kern Ambulance Service-Hall transaction, as well as those of other transactions discussed below, namely the CARE Ambulance-Liberty, and Taft Ambulance-Hall transactions. The Authority cited the lack of documentation in its decision not to approve the plans. Respondent asserts that all pertinent documents were provided, but did not persuasively controvert the Authority's contemporaneous statements regarding the lack of documents. Nevertheless, the documents were received in evidence and have been considered in order to resolve the matter on its merits.

is the surviving entity through acquisition of the company that provided services on January 1, 1981, Wasco Ambulance, the manner and scope of ambulance services changed in 1999 when Kern Ambulance Services acquired Wasco Ambulance. In 1999, one of the two competing providers was removed from the market, reducing consumer choice and potentially reducing the level of service.

Ambulance Services in Operating Area 2

19. Shafter Ambulance was providing 911, Seven-Digit, and Non-Emergency Response services in Operating Area 2 since at least January 1, 1981. Shafter Ambulance continued to provide the services until 1999, when it was purchased by Hall. Hall has continuously provided all three services since the purchase, and Att testified, without contradiction, that the level of ambulance services did not decrease in the operating area following Hall's purchase of Shafter.

20. a. The purchase of Shafter Ambulance was accomplished through an Asset Purchase Agreement executed on March 19, 1999, in which Hall agreed to purchase all assets used in the operations of the ambulance business, with the exception of the name "Schaefer's Shafter Ambulance Service."

b. Complainant concluded that the purchase of Shafter Ambulance did not constitute a change in the manner or scope of services because it constituted a complete transfer of assets and operations from one provider to another. This conclusion is consistent with the evidence presented at the hearing and is accepted.

21. Kern Ambulance rented space in Shafter for less than one month in 1985, and provided all three types of services in Operating Area 2. During the period of 1981 to the present, other ambulance providers, including Delano and Kern Ambulance, also provided Seven-Digit and Non-Emergency Response services in Operating Area 2 from facilities located outside the operating area.

Ambulance Services in Operating Area 3

22. Delano was providing 911, Seven-Digit, and Non-Emergency Response services in Operating Area 3 since at least January 1, 1981. It has continued to provide such services to the present.

23. On October 1, 2009, Moses signed a Stock Purchase Agreement to buy all the stock of Delano. The agreement contained the following provision: "Purchaser acknowledges and understands that the Company is currently conducting an active business, and that Purchaser, in acquiring the Stock, is agreeing that the Company's business will continue to be conducted in a manner consistent with the manner in which the Business has been operated."

(Exh. V., at p. 2.) Certain assets of the company, which did not include those used to provide ambulance service, were transferred to the seller before the sale of the stock.

24. Moses testified without contradiction that the level of ambulance services did not stop or decrease after the transfer of ownership. On the contrary, Delano has purchased three new ambulances, and four new heart monitors and other equipment.

25. The acquisition of Delano by Moses constituted a complete transfer of ownership of the existing ambulance service provider, and Delano, under Moses's ownership, continued to provide, and in fact improve, existing services.

26. Kern Ambulance maintained an ambulance facility in McFarland from 1985 until 1987, and provided Seven-Digit and Non-Emergency Response services. During the period of 1981 to the present, other ambulance providers, including Delano, Kern Ambulance, and Shafter Ambulance also provided Non-Emergency Response services in Operating Area 3 from facilities located outside the area.

Ambulance Services in Operating Areas 4 and 5

27. Operating Areas 4 and 5 were created out of one area in 1989, but ambulance companies continued to operate in the combined area after 1989.

28. Hall has been providing 911, Seven-Digit, and Non-Emergency Response services in Operating Areas 4 and 5 since at least January 1, 1981, and continues to do so at present.

29. Golden Empire Ambulance provided 911, Seven-Digit, and Non-Emergency Response services in Operating Areas 4 and 5 since at least January 1, 1981, until 1999, when it was purchased by Hall. Hall continues to operate some ambulances under the Golden Empire Ambulance name.

30. a. Hall purchased Golden Empire on April 14, 1999 through the execution of an Asset Purchase Option Agreement, in which Hall obtained an option to purchase all assets used in the operations of the ambulance business.

b. Complainant concluded that the purchase of Golden Empire did not constitute a change in the manner or scope of services because it constituted a complete transfer of assets and operations from one provider to another. This conclusion is consistent with the evidence presented at the hearing and is accepted.

31. Att testified without contradiction that the level of ambulance services provided by Hall did not decrease over the years.

32. Golden Empire Medical Transportation provided Non-Emergency Response services in Operating Areas 4 and 5 from 2003 to 2006. Other companies, including Delano, Kern Ambulance, and Shafter Ambulance have also been providing Non-Emergency Response services in the operating areas from January 1, 1981, to the present.

33. Complainant concluded that the statutory criteria for grandfathering Hall had been met with respect to the two services it has exclusively provided, 911 and Seven-Digit Emergency services.

Ambulance Services in Operating Area 6

34. CARE Ambulance provided 911, Seven-Digit, and Non-Emergency Response services in Operating Area 6 at least since January 1, 1981, through 2011, when it was purchased by Liberty.

35. CARE Ambulance did not provide services for a brief period in 1982, while it corrected issues related to its licensure, as directed by the California Highway Patrol. In part based on his contemporaneous conversations with the owner of CARE Ambulance, Brandon estimated that the gap in CARE Ambulance service lasted approximately 72 hours. Hall provided ambulance services in Operating Area 6 during CARE Ambulance's absence. The temporary and limited interruption of service by CARE Ambulance did not constitute an interruption of service and did not materially alter the manner or scope in which ambulance services were provided in 1982 in Operating Area 6.

36. On June 21, 2011, Liberty and CARE Ambulance executed a Stock Purchase and Sale Agreement, in which Liberty purchased all stock issued by CARE Ambulance. The agreement stated that CARE Ambulance had been designated by the County of Kern as a provider of ground ambulance and medical transportation in an exclusive operating area as part of a plan created pursuant to the Act. (Exh. EE, at pp. 1 and 2.) The agreement constituted a complete transfer of ownership of the existing ambulance service provider, and Liberty continued to provide existing services.

37. Brandon testified without contradiction that the purchase of CARE Ambulance did not result in any decrease in services in Operating Area 6. Rather, Liberty brought in an additional ambulance to provide services in the area.

38. During the period of 1981 to the present, other ambulance providers also provided Seven-Digit and Non-Emergency Response services in Operating Area 6.

Ambulance Services in Operating Area 7

39. Operating Area 7 encompasses the City of Ridgecrest and smaller desert

communities in the northeastern section of the County. Tri-County Ambulance provided services in the area at least since January 1, 1981. In 1982, Tri-County Ambulance sold some of its assets to another company, Trans-Med Ambulance, which also provided ambulance services in the area until 1985, when Tri-County's re-acquired the assets. In 1983, Tri-County Ambulance changed its name to Liberty.

40. In 1992, the south and southwestern sections of the area were severed from Operating Area 7 to form Operating Area 11. In 1992, Liberty was designated as the primary provider in Operating Area 7, and has continued to provide 911, Seven-Digit, and Non-Emergency Response services in the area to the present.

41. Despite the presence of Liberty, multiple ambulance providers have made runs into the area to provide 911, Seven-Digit, and Non-Emergency Response services in Operating Area 7 to the present.

Ambulance Services in Operating Area 8

42. Hall has been continuously providing 911, Seven-Digit, and Non-Emergency Response services in Operating Area 8 since at least January 1, 1981.

43. Golden Empire Ambulance provided all three services from 1981 to 1983. During the period of 1981 to the present, other ambulance providers, including Liberty, West Star Ambulance, and Tri-County Ambulance also provided Non-Emergency Response services in Operating Area 8.

Ambulance Services in Operating Area 9

44. Taft Ambulance provided 911, Seven-Digit, and Non-Emergency Response services in Operating Area 9 since at least January 1, 1981, through 1995, when it was purchased by Hall.

45. Hall purchased Taft Ambulance on March 6, 1995, pursuant to an Agreement of Purchase and Sale of Assets, through which Hall purchased all assets used in the operations of the ambulance business. The agreement constituted a complete transfer of ownership of the existing ambulance service provider, and Hall continued to provide existing services.

46. Hall has been continuously providing services since its purchase of Taft Ambulance, and Att testified without contradiction that the level of ambulance services provided by Hall did not decrease after the purchase.

47. Tommy's Taft Ambulance had facilities in the area and provided all three services in 1983 and 1984.

48. Golden Empire Ambulance had facilities in the area and provided all three services in 1983.

Ambulance Services in Operating Area 10

49. Boron Volunteer Emergency Services provided 911, Seven-Digit, and Non-Emergency Response services in Operating Area 10 since at least January 1, 1981, through 1992.

50. In 1992, the area of Zone 10 was added to Zone 11, and Zone 10 ceased to exist as a separate service area.

Ambulance Services in Operating Area 11

51. In 1992, when Operating Area 11 was created, the County conducted a competitive bidding process to award the ambulance services contract. No details of the competitive bidding process were provided at the hearing, and Respondent did not submit the bidding process to the Authority for prior approval. Hall was selected as the exclusive provider, and entered into a contract with Respondent to provide of 911, Seven-Digit, and Non-Emergency Response services in Operating Area 11.

52. On September 21, 2006, Respondent and Hall entered into a new contract that expired on June 30, 2013. No evidence was presented at the hearing that a competitive bidding process was undertaken before execution of the new contract.

53. Respondent and Hall entered into a new contract that is set to expire on June 30, 2023. No evidence was presented at the hearing that a competitive bidding process was undertaken before execution of the new contract.

54. The Authority denied its approval with respect to operating area 11 for the following reasons: "[A] competitive process was successfully completed for this operational area in 1994. Based on the lack of periodic interval as required criteria in [section] 1797.224, a competitive process needs to be completed for this operational area to reestablish exclusivity. The EMS Authority has not approved a competitive process or an EMS Transportation Plan Update with a periodic interval listed and has determined this zone to be non-exclusive." (Exh. L, at p. 8.)

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LEGAL CONCLUSIONS

1. Respondent seeks to have its EMS plans approved and to establish exclusive operating areas for the provision of emergency ambulance services within each plan. It therefore bears the burden of proof in this proceeding because it seeks "A hearing to determine whether a right, authority, license, or privilege should be granted, issued, or renewed . . . ." (Gov. Code, § 11504.) (*Coffin v. Department of Alcoholic Beverage Control* (2006) 139 Cal.App.4th 471, 476-477; see also: *Martin v. Alcoholic Beverage Control Appeals Board* (1959) 52 Cal.2d 259, 266; *Breakzone Billiards v. City of Torrance* (2000) 81 Cal.App.4th 1205, 1224.)

2. The Act created "a two-tier system 'governing virtually every aspect of prehospital emergency medical services.' (*County of San Bernardino v. City of San Bernardino* (1997) 15 Cal.4th 909, 915, 64 Cal.Rptr.2d 814, 938 P.2d 876 (hereafter *County of San Bernardino*).) The first tier is occupied by [the Authority], a division of the Health and Welfare Agency, 'which is responsible for the coordination and integration of all state activities concerning emergency medical services.' (§§ 1797.1, 1797.100.) The second tier of governance is a 'local EMS agency' (§ 1797.200), which is responsible for, among other things, '(1) planning, implementing, and evaluating an emergency medical services system 'consisting of an organized pattern of readiness and response services based on public and private agreements and operational procedures' (§ 1797.204); (2) developing a formal plan for the system in accordance with the Authority's guidelines and submitting the plan to the Authority on an annual basis (§§ 1797.250, 1797.254); [and] (3) 'consistent with such plan, coordinat[ing] and otherwise facilitate[ing] arrangements necessary to develop the emergency medical services system' (§ 1797.252).' (*County of San Bernardino, supra*, 15 Cal.4th at p. 916, 64 Cal.Rptr.2d 814, 938 P.2d 876.)." (*County of Butte v. California Emergency Medical Services Authority* (2010) 187 Cal.App.4th 1175, 1181-1182 (*Butte*).)

3. Section 1797.105, which provides for submission of EMS plans and sets forth the appeal process of Authority determinations, provides:

"(a) The authority shall receive plans for the implementation of emergency medical services and trauma care systems from local EMS agencies.

"(b) After the applicable guidelines or regulations are established by the authority, a local EMS agency may implement a local plan developed pursuant to Section 1797.250, 1797.254, 1797.257, or 1797.258 unless the authority determines that the plan does not effectively meet the needs of the persons served 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.

"(c) A local EMS agency may appeal a determination of the authority pursuant to subdivision (b) to the commission.

"(d) In an appeal pursuant to subdivision (c), the commission may sustain the determination of the authority or overrule and permit local implementation of a plan, and the decision of the commission is final."

4. As required by section 1797.105, subdivision (b), the Authority enacted the following Guidelines: EMS System Standards and Guidelines (June 1993) (EMSA Publication #101); EMS System Guidelines Part II Implementation Resource (March 1994) (EMSA Publication #102); EMS System Guidelines Part III EMS System Planning Guidelines (June 1994) (EMSA Publication #103); and Competitive Process for Creating Exclusive Operating Areas (EMSA Publication #141).

5. At issue in these cases is the Authority's decision to reject the 2012 and 2015 Plans because Respondent did not establish that the exclusive ambulance service providers were selected in compliance with statutory requirements. The provision governing the creation of exclusive operating areas, section 1797.224, states:

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

6. The parties disagree about the meaning of the statutory language in section 1797.224. Principles of statutory construction are useful in analyzing the language in dispute. Thus, statutes must be interpreted in such a manner as to ascertain and effectuate the legislative intent. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 775; *California Teachers Assn. v. Governing Bd. of Rialto Unified School District* (1997) 14 Cal.4th 627, 632; *People v. Hull* (1991) 1 Cal.4th 266, 271; *Steketee v. Lintz, Williams & Rothberg* (1985) 38 Cal.3d 46, 51-52.) The first step in determining legislative intent is to scrutinize the actual words of the statute, giving them a plain and commonsense meaning. (*Hughes v. Board of Architectural Examiners*, *supra* at p. 775; *California Teachers Assn. v. Governing Bd. of Rialto Unified School District,* supra at p. 633; *Steketee v. Lintz, Williams & Rothberg*, *supra* at p. 51.) "Ordinarily, if the statutory language is clear and unambiguous, there is no need for judicial construction." (*Hughes v. Board of Architectural Examiners*, *supra* at 775, citing *California School Employees Assn. v. Governing Board* (1994) 8 Cal.4th 333, 340.) In addition, each and every word in the statute must be given meaning to accomplish a result consistent with the legislative purpose. (*Hughes v. Board of Architectural Examiners*, *supra* at 775; *California Teachers Assn. v. Governing Bd. of Rialto Unified*

School District, *supra* at 634.) "A statute must be construed in the context of the entire statutory system of which it is a part, in order to achieve harmony among the parts [Citations]." (*People v. Hull*, *supra* at p. 272.)

7. Dictionaries are often used to assist in deriving the plain meaning of words. The Merriam-Webster Online Dictionary defines "manner" as a "characteristic or customary mode of acting." (Merriam-Webster.com.) The same source defines "scope" as the "extent of treatment, activity, or influence." (*Ibid.*)

8. In *Butte*, the court addressed the exclusive operating area provisions of section 1797.224 and the Authority's interpretation of the statute. The Authority had rejected a local EMS agency plan because it concluded that the local agency had not provided sufficient information to demonstrate that the providers in question had been providing services in the same manner or scope for the requisite period. As here, the Authority pointed to changes in provider ownership and to changes in boundaries as the basis for its conclusion.

Initially, the court construed the Act to require Authority approval of local EMS agencies' designation of exclusive operating areas in connection with the Authority's annual review of EMS plans. In this regard, the court noted: "We thus conclude that the Authority has the statutory authority to review a local EMS agency's creation of an [Exclusive Operating Area] as part of the transportation portion of the local EMS plan, regardless of whether the [Exclusive Operating Area] was created through a competitive process or grandfathering, and then to reject the local EMS plan if it is not 'concordant and consistent with applicable guidelines or regulations, established by the [A]uthority.' (§ 1797.105, subds. (a) & (b).)." (*Butte*, *supra*, 187 Cal.App.4th at p.1199.)

In rejecting the plan in question, the Authority relied on a list of factors, set forth in a declaration before the court, which stated, in part: "A change in the manner and scope, defeating a county's ability to grandfather existing providers into [Exclusive Operating Area]s, may occur in the following instances: (1) where there is a change in the number of providers in the area; (2) where there are interruptions in the services provided by one or more providers in that area; (3) where there is a change in the economic distribution of calls between providers in the area; (4) where there is a change in ownership of one of the providers in the area; (5) where there is a change in the geographical boundaries of the area; (6) where areas or subareas are combined or splintered; and (7) where there is approval by the local EMS agency of a new provider in the area. . . ." (*Butte*, *supra*, 187 Cal.App.4th at p. 1201.) The court determined that the list of factors was, in effect, a regulation. Because the regulation had not undergone the rulemaking process contained in the Administrative Procedure Act, the court concluded that the factors did not warrant deference.

The court nevertheless upheld the Authority's determination because the Authority had the power to interpret the statute. In doing so, the court stated the following regarding statutory construction: "There can be no doubt that a change in the manner and scope under section

1797.224 can occur when one provider ceases operations and another provider begins operations in its place; nor do we have any trouble concluding that a change in manner and scope can occur when there is a significant boundary change between areas of operation." (*Butte, supra*, 187 Cal.App.4th at p. 1204.) In upholding the Authority's construction of the statute in another respect, the court stated that reading the phrase "no competitive process is required if the local EMS agency develops or implements a local plan that continues the existing providers operating within a local EMS area in the [*same*] manner and scope in which the services have been provided" to include the highlighted word "same" is the "only reasonable interpretation of this provision" and thus appropriate. (*Butte, supra*, 187 Cal.App.4th at pp.1201.)

The court concluded: "We need not determine whether the changes in ownership and boundary change in this case amounted to a change in manner and scope. We simply conclude that the Authority did not abuse its discretion by rejecting the designation of [Exclusive Operating Area]s based on a lack of information provided by Nor-Cal EMS. Assuming Butte County chooses to retain Nor-Cal EMS as its local EMS agency, nothing in this opinion should be construed as preventing Nor-Cal EMS from submitting for the Authority's consideration a revised local EMS plan incorporating the [Exclusive Operating Area]s, with the documentation requested by the Authority." (*Butte, supra*, 187 Cal.App.4th at p. 1204.)

9. The Authority has not promulgated regulations pertaining to the interpretation of "manner and scope" in section 1797.224.

10. Taking the principles of statutory construction discussed above and the *Butte* court's guidance leads to the following construction of section 1797.224. In agreement with the *Butte* court's conclusions, significant changes in boundaries can lead to a change in the manner and scope in which services are provided. An area roughly equivalent to two thirds of former operating area 7 was removed from the area to form Operating Area 11, and another operating area, number 10, was merged into Operating Zone 11. These are significant changes in boundaries which changed the manner and scope in which services are being provided. The existing service provider in Operating Area 7 lost a significant number of potential customers, and an entirely new provider had to be selected for Operating Area 11.

11. As the *Butte* court also concluded, a change in the method and scope in which services are provided *can* occur when one provider ceases operations and another provider begins operations in its place. Implicit in this conclusion is the fact that not all changes in ownership necessarily result in a change in the manner or scope in which services are provided. Complainant recognizes, as set forth in factual finding numbers 20 and 30, that transactions which lead to a complete transfer of ownership do not change the manner or scope in which the services are provided. Moreover, sole focus on the word "provider" in the key phrase in section 1797.224 would ignore references to the word "services," which is also found in the sentence. We must therefore look to whether a change in ownership changes the mode or extent in which the services are provided.

All of the material purchases in this case, those involving the purchase of Shafter Ambulance by Hall (factual finding number 20), the purchase of Delano by Moses (factual finding number 23), the purchase of Golden Empire by Hall (factual finding number 30), the purchase of CARE Ambulance by Liberty (factual finding number 36), and the purchase of Taft Ambulance by Hall (factual finding number 45), involved the complete transfer of ownership and did not alter the mode or extent in which the services were provided after the transactions.

12. In rejecting the 2012 and 2015 Plans, Complainant construed section 1797.224 as requiring "exclusivity" of providers for the entire pertinent period of time. However, the word "exclusive" only precedes "operating areas" in the statute and does not modify "existing providers." Complainant's construction would therefore require the addition of the word "exclusive" or one of its variants, something which the canons of statutory construction warn against doing. Thus, the plain language of the statute requires that the existing ambulance companies have provided the services in the same manner and scope they have done so since January 1, 1981, but does not say anything about other providers who may have also provided some services. Moreover, the fact that other providers may have intermittently or temporarily also provided services in the area in question does not necessarily mean that the services provided by the existing ambulance companies were diminished or changed as a result. Complainant's construction of section 1797.224 to require exclusivity of existing providers is not supported by the plain language of the statute.

Rejection of Complainant's construction regarding exclusivity of providers therefore removes the impediments to Respondent's designation of exclusive providers for operating area numbers 2, 3, 4, 5, 6, 8, and 9.

13. Accordingly, Respondent established that the 2012 Plan and the 2015 Plan continue the use of the existing providers operating in Operating Areas 2, 3, 4, 5, 6, 8, and 9 in the manner and scope in which the services have been provided without interruption since January 1, 1981, by reason of factual finding numbers 1 through 12, 19 through 38, and 42 through 48, and legal conclusion numbers 1 through 9, 11, and 12.

14. Respondent failed to meet its burden with respect to Operating Area 1 because its designated provider, Hall, has not been providing ambulance services in the area in the manner and scope in which the services have been provided without interruption since January 1, 1981, either in its own capacity or as the successor of a prior provider, by reason of factual finding numbers 1 through 18, and legal conclusion numbers 1 through 9.

15. Respondent failed to meet its burden with respect to Operating Area 7 because a significant change in the boundaries of the operating area led to a change in the manner and scope in which services were provided, by reason of factual finding numbers 1 through 12, 39 through 41, and legal conclusion numbers 1 through 10.

16. As noted above, in the event a competitive process for selecting exclusive providers is chosen, section 1797.224 requires the EMS plans to "include provisions for a competitive process held at periodic intervals" and that the plans containing such provisions be submitted to the Authority for approval. Respondent failed to meet its burden with respect to Operating Area 11 because it failed to demonstrate that Hall had been selected pursuant to a competitive bidding setting forth periodic intervals for the selection of a provider or pursuant to a process approved by the Authority, by reason of factual finding numbers 1 through 12 and 51 through 54, and legal conclusion numbers 1 through 9.

17. The Authority may reject the 2012 and 2015 Plans because the plans designate exclusive operating areas in Operating Areas 1, 7, and 11, in violation of section 1797.224, as set forth in factual finding numbers 1 through 18, 39 through 41, and 51 through 54, and legal conclusion numbers 1 through 10, 14, 15, and 16.

18. In containing exclusive Operating Areas 1, 7, and 11, which designations violate section 1797.224, the 2012 and 2015 Plans do not effectively meet the needs of the persons served and are not consistent with coordinating activities in the geographic areas served, as required by section 1797.105, subdivision (b), as set forth in factual finding numbers 1 through 18, 39 through 41, and 51 through 54, and legal conclusion numbers 1 through 10, 14, 15, and 16. The Authority may, therefore, reject the 2012 and 2015 Plans on this independent ground.

19. Respondent and *amicus curiae* argue that the Authority may not reject either of the plans because it has not developed regulations pursuant to the APA to define "manner and scope" in section 1797.224. In addition, it argues that failure to enact guidelines or regulations in this subject area precludes the Authority from concluding, as required by section 1797.105, subdivision (b), that the plans are not "concordant or consistent with applicable guidelines or regulations." These arguments are unpersuasive, as they ignore the holding of *Butte*. The court in *Butte* faced a similar situation. Rather than rejecting the plan before it, the court declined to give deference to the non-APA-compliant regulations used to evaluate the plan, independently reviewed the requirements of section 1797.224, and concluded that the Authority had not abused its discretion in rejecting the plan. A similar course of action is appropriate in this case. With respect to the section 1797.105, subdivision (b), argument, the statute also permits rejection of a plan that "does not effectively meet the needs of the persons served" independently of whether the plan violates any published guidelines or regulations.

20. California Code of Regulations, title 22, section 100450.100, subdivision (c), provides: "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." In light of these options, immediate implementation of a plan that contains deficiencies will not be recommended. Rather, it will be recommended that the Commission sustain the determination of the Authority consistent with this Proposed Decision and permit partial implementation of the plans.

ORDER

1. Respondent's appeal is sustained in part and denied in part, as set forth in this Proposed Decision.

2. The Authority's determinations to reject the 2012 Plan and the 2015 Plan are sustained, as set forth in this Proposed Decision.

3. It is recommended that the Commission sustain the determinations of the Authority with respect to the 2012 Plan and 2015 Plan consistent with this Proposed Decision and permit partial implementation of the plans.

DATED: May 18, 2018

DocuSigned by:

SAMUEL D. REYES
Administrative Law Judge
Office of Administrative Hearings