STATE OF CALIFORNIA
COMMISSION ON EMERGENCY MEDICAL SERVICES
September 12, 2018
10:00 A.M. – 1:00 P.M.
(Meeting may end early at the completion of all agenda items)
Holiday Inn Bayside San Diego
4875 North Harbor Drive
San Diego, CA 92106
Reservations: 800-662-8899 or 619-224-3621

1. Call to Order and Pledge of Allegiance

2. Review and Approval of June 20, 2018 Minutes

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

4. Consent Calendar
- A. Administrative and Personnel Report
- B. Legal Report
- C. Enforcement Report
- D. POLST eRegistry Update
- E. Overview of Ambulance Zone Exclusivity

Regular Calendar

5. Recognition of EMS Personnel Licensure Interstate CompAct Presentation

6. EMS Administration
- A. Regulations Update
- B. STEMI Regulations
- C. Stroke Regulations

7. EMS Personnel
- A. Community Paramedicine Pilot Project Status Update
- B. Medication Shortages Presentation by EMDAC

8. EMS Systems
- A. EMS Quality Core Measures Guidelines
- B. Ambulance Patient Offload Time Update
- C. California Unintentional Injuries Preventive Strategic Plan Project Presentation

9. Disaster Medical Services Division

A. Disaster Healthcare Volunteers/Medical Reserve Corps Program Update

10. Items for Next Agenda

11. Public Comment

12. Adjournment

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

STATE OF CALIFORNIA
COMMISSION ON EMS
Wednesday, June 20, 2018
Doubletree Suites by Hilton
Sacramento - Rancho Cordova
11260 Point East Drive
Rancho Cordova, 95742

MINUTES

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

COMMISSIONERS ABSENT:
Steve Drewniany, Daniel Margulies, M.D.

EMS AUTHORITY STAFF PRESENT:
Howard Backer, M.D., Daniel R. Smiley, Jennifer Lim, Steven McGee, Tom McGinnis, Sean Trask, Sandra Baker

AUDIENCE PRESENT (partial list):
B.J. Bartleson, Vice President, Nursing and Clinical Services, California Hospital Association (CHA)
Craig Cannizzo, Kern County Ambulance Service Providers
Jenny Farah, M.D., University of California San Diego
Brian Hartley, Bound Tree Medical, LLC
Chris Kahn, M.D., San Diego Fire-Rescue Department
Gurujodha Singh Khalsa, Chief Deputy County Counsel, County of Kern, Office of the County Counsel
Kristi Koenig, M.D., County of San Diego EMS
Ray Ramirez, California Fire Chiefs Association (Cal Chiefs)
Kathy Staats, M.D., Imperial County EMS Agency
Kristin Thompson, EMS Division Chief, Newport Beach Fire Department
Paul Troxel, 911 Program Management Division Chief, California Office of Emergency Services (Cal OES)
Reza Vaezazizi, M.D., Inland Counties EMS Agency/Riverside EMS Agency

1. CALL TO ORDER AND PLEDGE OF ALLEGIANCE

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

2. REVIEW AND APPROVAL OF MARCH 21, 2018, MINUTES

Action: Commissioner Barrow moved approval of the March 21, 2018, Commission on Emergency Medical Services Meeting Minutes as presented. Commissioner Dunford seconded. Motion carried unanimously with no abstentions.

3. DIRECTOR'S REPORT

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

A. EMSA Program Updates

- The Office of Traffic Safety will no longer fund the California EMS Information System (CEMSIS). EMSA will reprioritize internal funding to focus on EMS and local EMSA agencies' data to maintain statewide functionality and meet data information mandates and the core functionality of CEMSIS.
- Regulation updates will soon go out for the second round of public comment. Staff has been challenged with balancing specificity versus flexibility in the regulations and may develop supplemental guidelines to support local EMS agencies (LEMSAs) that do not have the expertise or staff to develop their own.
- The California Department of Public Health (CDPH) issued naloxone standing orders targeted to community services that do not have medical directors. Dr. Backer met with Dr. Karen Smith, the State Public Health Officer, who assured him that the standing orders will not impact EMSA regulations related to public safety/first aid and will not supersede medical director or LEMSA authority.
- EMSA's international Hospital Incident Command System (HICS) publication is now being translated into Chinese. A publisher in Taiwan has agreed to distribute the publication as a public service to the hospitals in Taiwan.
- More than 14 states have joined the Recognition EMS Personnel Licensure Interstate CompAct (REPLICA), a national interstate compact for EMS mutual aid. The National Association of State EMS Officials (NASEMSO) has been invited to present at the next Commission meeting. NASEMSO has signaled that, when a critical mass of signatories has been achieved, those states would no longer accept EMS personnel to practice from states that are not members, which may affect California in the future.
- The End of Life Act was struck down by the Riverside County Superior Court then recently reinstated by a California Appeals Court while a legal challenge is pending. This is likely to end up at the Supreme Court. The legal issue used to strike it down was that it was passed during a special session of the Legislature. The claim is that it is not an appropriate use of a special session.
- The EMS Medical Directors' Association of California (EMDAC) Scope of Practice Committee met yesterday.
    - The work continues for a unified air medical scope of practice. It has been designed as a standardized application and six individual procedures. The

standardized application will be simplified so that it will have all the materials necessary for implementation. A LEMSA medical director will simply need to sign the standardized application. Only the medical directors with an air base in their jurisdiction would need to sign to implement this for air medical statewide. Until the standardized application is approved and for six months after approval, the Scope of Practice Committee recommended that the practice of pediatric intubation for the Commission on Air Medical Transport Systems (CAMTS) accreditation be extended.

- Several jurisdictions have applied for supraglottic airways in their local optional scope of practice. Discussion focused on the requirements for that. The Scope of Practice Committee agreed to allow the use of colorimetric capnography monitoring for basic life support (BLS) rather than waveform monitoring, which is an expensive technology with complex interpretation.
- The Scope of Practice Committee had previously agreed to phase out nasotracheal intubation, a procedure known and used by older paramedic providers. A one-year deadline was given to end the practice. Younger paramedics do not learn the procedure because there are other types of adjuncts for achieving intubation.
- Several more jurisdictions applied for prehospital use of tranexamic acid (TXA) through local optional scope. Members of the State Trauma Advisory Committee (STAC) suggested minor modifications on the clinical criteria to assure that TXA was used only in cases of hemorrhagic shock.
- Alameda County will begin using an anti-psychotic medication, olanzapine, in the field for safety of the patient and crew since these patients have an extremely long wait in the emergency department for psychiatric evaluation. The LEMSA will monitor this practice.
- More jurisdictions have applied for intravenous (IV) acetaminophen, which is (Tylenol), although the cost of this drug is becoming prohibitive. The oral form of Tylenol is pennies per dose while the IV form has increased to approximately $40 per dose. Several jurisdictions want this pain management tool because of the recent shortages of narcotics, although, according to the supplier, the narcotic shortage seems to be easing.
- The Scope of Practice Committee will soon finalize patient non-transport policy suggestions to guide local jurisdictions in their development of policy and protocols regarding EMS calls that do not result in transport. This is being driven by an impending policy by one insurer to begin reimbursement for certain patients who are not transported.
- The key debate and the difficult issue of the non-transport policy is the concept of a person versus a patient and who does not require evaluation or documentation. The issue is the individuals at the scene who refuse to be evaluated and EMS providers have minimal interaction or no contact with

them. This needs to be under medical control with quality assurance on patients who are not transported.

Public Comment

Kristi Koenig, M.D., County of San Diego EMS, stated the national opiod shortage is still affecting EMS. She stated she is encouraged that manufacturers may be saying they currently can meet demand but, on the ground, accessing multiple types of opiods - for example, morphine and fentanyl - continues to be a challenge.

Dr. Backer asked Brian Hartley to respond to Dr. Koenig's concerns.

Brian Hartley, Bound Tree Medical, retired paramedic, stated his warehouses currently have fentanyl in stock while morphine continues to have many back-orders. He stated many counties support their use of narcotics in the field by having acetaminophen as an alternative to pain management when morphine is unavailable. He encouraged providers to place their orders a minimum of 45 to 60 days out prior to expiration.

Chris Kahn, M.D., EMS Medical Director, San Diego Fire-Rescue Department, stated obtaining fentanyl in the field continues to be a significant problem. He stated he has tried to get fentanyl for six to seven months with no success through multiple distributors.

B.J. Bartleson, California Hospital Association (CHA), stated the CHA has been working closely with Senator Feinstein and the Drug Enforcement Agency to change their quotas for narcotic release, and with the Board of Pharmacy on allocating more manufacturers for narcotics.

Commissioner Barrow stated expired narcotics are still useful. He requested a report at the next Commission meeting on the use of expired medications.

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 summarized the following bills:

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

This bill died on suspense in the Assembly and is no longer active.

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

This bill has moved to the second house and will be heard next Tuesday. Staff continues to relay their concerns to the author and sponsor but remains supportive of continuing the community paramedicine initiative in California.

- AB 1812 (Ting), public safety omnibus

This is a trailer bill that allows the California Department of Forestry and Fire Protection (CAL FIRE), to grant statewide certification to an individual as an Emergency Medical Responder (EMR) regardless of whether they committed specified crimes, unless the

action was committed after the person received certification. The bill will be effective immediately upon signature of the Governor and will require an update to the regulations.

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

This bill revises the criteria that an employer or a LEMSA can consider in certifying, licensing, and taking disciplinary action against an Emergency Medical Technician (EMT)-I and an EMT-II. The paramedic licensure has been dropped in this version of the bill. The bill allows individuals with criminal backgrounds to gain certification as an EMT-I and an EMT-II. Staff will address concerns with the author of the bill.

- An initiative that pertains to California Ambulance Employees Paid On-Call Breaks, Training, and Mental Health Services has gained the required 25 percent signatures and will be on the November 6th ballot.

Questions and Discussion

Commissioner Barrow asked about the core concerns of the EMS community with SB 944. Ms. Lim stated EMSA would like all providers to have an opportunity to participate in this program under medical control. Chair Rudnick stated the concern of the EMS community is that the bill undermines medical control. Dr. Backer added that the bill departs from the pilot model.

Commissioner Hinsdale asked for additional detail on AB 2293. Ms. Lim stated this bill has a number of sponsors that are anti-recidivism groups and provides an opportunity for individuals with prior convictions to secure EMT certification.

Commissioner Burch stated the hearing for AB 2293 is set for this Wednesday. He stated one objection EMS administrators and medical directors have is that it is poorly written such that certifications to pedophiles who are Penal Code 290 registrants would be undeniable. The author has rejected assistance in crafting the language for this bill, and it has been unable to be stopped through the legislative process. Commissioner Burch asked Commissioners to contact their constituencies before Wednesday. This bill is not the vehicle for stances on recidivism and removing employment barriers. It is a dangerous bill that will threaten public safety and tie EMS up in courts for years.

Chair Rudnick agreed that it endangers public safety and puts vulnerable individuals at risk.

Commissioner Hinsdale asked if it is appropriate for this Commission to weigh in on that publicly. Chair Rudnick stated it may be better for Commissioners to contact their respective organizations.

Commissioner Barrow disagreed. The governor is more likely to listen to the concerns of agencies such as EMSA that have authority in this area. Dr. Backer stated the Commission has not issued letters of support or opposition to specific legislation in the past because it is not statutorily mandated.

Commissioner Barrow asked what EMSA's official position is, since it oversees the training and qualifications of EMS personnel. Ms. Lim stated EMSA does not currently

have an approved position to share. Dr. Backer clarified that EMSA is not the certifying agent.

4. CONSENT CALENDAR

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

Action: Commissioner Snyder 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 initial comment period for the Emergency Medical Services for Children and the Stroke and STEMI Regulations have been completed. Staff is preparing responses to those comments and will soon issue a second public comment period. A report will be presented at the next Commission meeting.

The Paramedic Regulations are currently in review by the control agencies.

6. EMS PERSONNEL

A. Trial Studies

1. Ketamine Trial Studies

Sean Trask, Chief of the EMS Personnel Division, provided an overview of the Issue Memo, which was included in the meeting packet, that generally explains the ketamine trial studies and preliminary data from the three trial study locations.

The action items to consider are to discontinue the trial study and recommend moving ketamine to local optional scope for paramedics, continue the trial studies and receive a report when the 18-month reports are due in August of 2019, or terminate the trial studies altogether.

Public Comment

Dr. Koenig spoke in support of the staff recommendation to move ketamine into the local optional scope of practice.

Jenny Farah, M.D., EMS Fellow, University of California San Diego, stated it can be difficult to discern the results of studies in the literature that has been published on the

use of ketamine. Studies and news stories tend to refer to ketamine for agitated delirium, which requires higher doses than for analgesia. The dose for pain control is safer and has more predictable absorption and patient response. Dr. Farah recommended an article in *Prehospital Emergency Care* last month that compares ketamine and fentanyl.

Dr. Kahn discussed the practical difficulties and considerations regarding local optional scope of practice versus trial studies. He stated trial studies are more appropriate for something that is truly experimental rather than something that is as safe and has such a long history as ketamine.

Kathy Staats, M.D., Interim Medical Director, Imperial County EMS Agency, stated Imperial County applied for IV Toradol because of the opiate shortage, which is significantly impacting the county. IV ketamine in pain control dosing is more effective than both IV acetaminophen and IV ketorolac. Ketamine is a safe medication. With the recent chronic rotating shortages in the United States, it would be a good choice to have in California as an extra medication.

Reza Vaezazizi, M.D., Medical Director of Riverside and Inland Counties, two of the ketamine trial study jurisdictions, stated the ketamine shortage delayed the implementation of the trial study by four to six weeks. There have been over 250 administrations of ketamine in those counties as part of the trial study. Although the data has yet to be fully analyzed, he stated the general experience is that ketamine has been very effective.

Questions and Discussion

Commissioner Dunford asked if there will be a uniform method of training for the CEMSIS database or if each LEMSA will be required to develop its own. He asked about the use of ketamine in children and how it will be defined. Chair Rudnick stated it should be a uniform method of training because there is no point in reinventing the wheel. He stated he has not seen poor outcomes with children and noted that several providers are supportive of ketamine with children. Dr. Backer suggested requiring consistent protocols statewide for new local optional scope for him to sign off on.

Chair Rudnick stated ketamine will initially be administered intravenously, but the Scope of Practice Committee recommended ketorolac/Torodol be administered intramuscularly (IM). Dr. Koenig added that it can also be administered intranasally. She stated the military has vast experience with that and can be looked to to provide expertise and dosing.

Action: Commissioner Uner made a motion to discontinue the trial study and recommend moving ketamine to the paramedic local optional scope of practice. Commissioner Johnson seconded. Motion carried unanimously.

7. EMS SYSTEMS

A. Wireless 911 Routing Status

Tom McGinnis, Chief of the EMS Systems Division, deferred to Paul Troxel to present this agenda item.

Paul Troxel, 911 Program Management Division Chief, California Office of Emergency Services (Cal OES), updated the Commission on the current status of 911 in California.

Cal OES continues to work on Next Generation 911 (NextGen 911). Current issues are funding and procurement. Cal OES has been working with the California Department of Technology to build a NextGen 911 Request for Proposal, which is expected to go out in July. A $14 million to $18 million shortfall next year is expected if the funding is not corrected. SB 870 and AB 1836 will change the funding structure to provide a surcharge on all access lines including text messages and any future applications that may be developed.

First Responder Network Authority (FirstNet) was signed in by President Obama in 2012 and created the nationwide standard of a public safety broadband wireless network. This guaranteed that Spectrum 14 would be available for priority preemption in a dedicated platform for public safety to ride on so if an event happened they would have the bandwidth and the signal to be able to perform their job. AT&T won that contract nationwide.

In December of this year, Governor Brown opted in to AT&T's contract. Each state had to either opt in to FirstNet or opt out and build their own public safety broadband network. The state of California looked at the cost, labor, and manpower to be able to do that; it was not feasible, so California opted in to the FirstNet contract.

Mr. Troxel stated he will send his PowerPoint slide presentation to staff.

Questions and Discussion

Commissioner Barrow asked about the progress with rural counties. Mr. Troxel stated Cal OES is currently working with all 58 county coordinators. NextGen 911 will increase accuracy with wireless calls. Issues are still expected and some locations may not transfer properly, but Cal OES is committed to ensuring that all calls are routed the best as is possible.

Commissioner Dunford stated one of the biggest issues confronted in cardiac arrest is 10 percent reduction in survival per minute. He asked about the average length of time it takes each of the 58 regions from the first attempt to call 911 to the delivery of that call to the public safety answering point (PSAP) and if Cal OES has a connection metric goal. Mr. Troxel stated he does not have the statistic pinpointing cardiac arrest specifically, but it is possible to circle back from the time a person in the community dials 911 until the time it hits the PSAP.

Commissioner Dunford stated the importance that calls hit the correct PSAP the first time. Mr. Troxel admitted that is problem number one. 80 percent of the time, calls do not arrive with accurate location immediately. Accurate location can follow 1 to 30 seconds later.

Commissioner Dunford stated 20 percent of the calls are still landline and there are three years to achieve this. He asked, from a public safety point of view, if individuals

should be educated to use a landline instead of a cell phone because the landline is guaranteed to connect to the correct PSAP the first time. Mr. Troxel stated Cal OES recommends using a landline when available.

Commissioner Uner asked if new infrastructure will need to be built, such as new cell phone towers, and if that may delay the project. Mr. Troxel stated the current 911 infrastructure is being decommissioned and new 911 trunks will be commissioned.

8. ITEMS FOR NEXT AGENDA

Chair Rudnick suggested an update on using expired medications and an update in general about medical shortages.

Commissioner Barrow suggested a presentation on the California Unintentional Injuries Prevention Strategic Plan Project.

Commissioner Gordon suggested a presentation on REPLICA and the California initiative on paramedic work conditions.

Commissioner Dunford suggested that the Commission consider the use of paramedics for vaccines and for other immediate conditions such as a hepatitis or H7N9 virus outbreak. He stated the need to assure that Dr. Backer can issue whatever is necessary as quickly as possible. Dr. Backer stated it currently does not fit within the paramedic scope of practice and it is not within the power of the Commission to approve that as it would require a change in statute. The ability to respond quickly is dependent upon a Declaration of Emergency from the governor.

Dr. Koenig stated the county of San Diego accomplished their quick response to the recent hepatitis outbreak under the local optional scope of practice application with a local health emergency declaration. She thanked Dr. Backer and EMSA Chief Deputy Director Daniel Smiley for their quick approval of the application.

9. PUBLIC COMMENT

Kristin Thompson, EMS Division Chief, Newport Beach Fire Department, stated Newport Fire supports the core measures but there are inconsistencies that need to be clarified that will affect the data sent to EMSA. Newport Fire has not had a chance to train on them.

Dr. Backer stated EMSA welcomes feedback on the core measures and understands that adjustments will need to be made as this is the first year of reporting. All numbers posted will need to be re-identified. He encouraged any LEMSA or provider agency that feels the data does not reflect their practice to choose a measure or two each year and validate it.

BREAK 15 MINUTES

10. CALL TO ORDER

Chair Rudnick reconvened the meeting at 11:46 a.m.

11. KERN EMS PLAN APPEAL

Chair Rudnick stated the Kern County appeal is the first appeal that the Commission will have heard. It is based on the California Code of Regulations, Title 22, Division 9, Chapter 13.

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

Gurujodha Singh Khalsa, Chief Deputy County Counsel, County of Kern, Office of the County Counsel, stated Kern County requests that EMSA fully adopt the Hearing Officer's Proposed Decision. He gave an overview of the history of the legal legitimacy of Kern County’s ambulance exclusive operating areas and subsequent litigation. Positive outcomes included the creation of a new hearing process.

Judge Samuel D. Reyes, Administrative Law Judge (ALJ), submitted a Proposed Decision to the Commission rejecting the Authority's construction of Health and Safety Code Section 1797.224, which sets forth the requirements for exclusivity without a competitive process or grandfathering, and agreeing with Kern County that other providers having temporarily provided services in the area in question does not diminish the existing ambulance companies. Judge Reyes determined that the majority of Kern's exclusive operating areas met the statutory requirements for grandfathering.

Judge Reyes made his findings and recommendations after both parties presented substantial documentary evidence, witness testimony, and oral argument over the three-day period of the hearing. He also requested, received, and considered pre- and post-hearing briefs by both parties along with an amicus brief filed by separate counsel for Kern County's ambulance providers.

Kern County encouraged the Commission to verify and endorse the newly-minted fair hearing process and to adopt Judge Reyes' Proposed Decision, which includes ordering the implementation of Kern County's plan for Exclusive Operating Areas 2, 3, 4, 5, 6, 8, and 9 and allowing the county to work with the Authority with respect to 1, 7, and 11.

C. Presentation by the EMS Authority

Steven McGee, EMSA Administrative Advisor, Counsel, stated the Commission can adopt the ALJ Proposed Decision as written, not adopt, or send the case back to the ALJ for rehearing. The EMS Authority requests that the Commission adopt the ALJ Proposed Decision as its own fair decision in the matter. That would mean the 2012 and 2015 Kern EMS Plans as submitted are not adopted by the Authority.

D. Public Comment

Craig Cannizzo, Counsel, Kern County Ambulance Service Providers, disagreed with the characterization provided by counsel for the Authority's last comment that the ALJ's Decision does not permit implementation of the plan. The ALJ specifically identified the majority of the areas as eligible for partial implementation of exclusivity. He urged EMSA to clarify that it will adopt partial implementation of the plan.

Ray Ramirez, California Fire Chiefs Association (Cal Chiefs), agreed that at the end of the Decision it is clear that certain exclusive operating areas have been approved. The county's responsibility is to provide ambulance service and clarifying this decision will allow Kern County to continue ambulance services in the area. It is important to bring this to a quick resolution.

E. Commission Discussion and Deliberation

Commissioner Barrow asked if there is any disagreement with partial implementation of the plan. Chair Rudnick clarified that the Decision allows for partial implementation.

Commissioner Uner asked for clarification of the implication that an ambulance provider that has provided continuous services since 1981 may do so in perpetuity without bidding or competition. Commissioner Burch stated each county may choose whether to take an area out to bid. Chair Rudnick stated Butte County made that decision with NORCAL Ambulance.

Commissioner Chand asked for clarification that affirming the ALJ Decision will result in partial implementation of the plan. Mr. Smiley stated, according to Health and Safety Code 1797.105(d), the Commission may sustain the determination of the Authority or overrule and permit local implementation of a plan. The decision of the Commission is final. If the Commission chooses to adopt the Proposed Decision, part of it is to deny the 2012 and 2015 plans. EMSA would then ask Kern County for a new EMS plan that is consistent with the Proposed Decision.

Commissioner Barrow asked about the definition of and the Commission’s future with grandfathering. Chair Rudnick stated that would require changing statute. He suggested asking Dr. Backer or Mr. Smiley what type of forum would be appropriate for that issue, however, September’s agenda may allow for a discussion on the definition.

Vice Chair Hartwig made a motion to sustain the determinations of the Authority with respect to the 2012 and 2015 plans consistent with the Proposed Decision and to permit partial implementation of the plans. Commissioner Barrow seconded.

Commissioner Burch asked Commissioners to reject the proposed motion as it deviates from the lawful authority of the Commission. Chair Rudnick agreed.

Commissioner Hinsdale asked how this motion differs from the motion on the agenda to adopt the Proposed Decision. Chair Rudnick stated this motion adds editorialization. The ruling must be to accept, to reject, or to send back.

Commissioner Barrow clarified that his second was intended to open a discussion. He asked if the motion means adoption. Chair Rudnick stated the language in the motion adds stipulation.

Vice Chair Hartwig stated Chapter 13 was written pursuant to statute. Statute regulation cannot contradict and/or overrule statute. The statute, 1797.105(d), states in an appeal the Commission may sustain the determination of the Authority or overrule and permit local implementation of a plan.

Commissioner Burch asked if the motion is to sustain or overrule. Vice Chair Hartwig stated both parties are in agreement. The Commission is currently extending the process. He stated the belief that 1797.105(d) gives the Commission the authority to allow implementation of a plan. Commissioner Burch stated allowing local implementation of the plan as submitted requires rejecting the ALJ Decision.

Commissioner Chand stated the concern that the current motion violates the Commission's rules set up four years ago. By rejecting this, the Authority and Kern County will be able to handle a plan resubmission quickly. Commissioner Dunford agreed that adopting or not adopting are the best choices.

Commissioner Stone asked Vice Chair Hartwig to withdraw the motion. Vice Chair Hartwig stated the motion that the ALJ Decision allows for the Authority and Kern County to implement consistent with the ALJ's Decision.

Commissioner Barrow stated the argument seems to be that the motion editorialized the Proposed Decision, which he felt it did not. Chair Rudnick disagreed and stated it is best left to the two parties.

F. <u>Vote Concerning Administrative Law Judge's Proposed Decision</u>

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**

Action: Vice Chair Hartwig made a motion to sustain the determinations of the Authority with respect to the 2012 and 2015 plans consistent with the Proposed Decision and to permit partial implementation of the plans. Commissioner Barrow seconded. Motion failed.

Action: Commissioner Burch made a motion to adopt the Administrative Law Judge's Proposed Decision. Several Commissioners seconded. Motion carried unanimously.

12. ADJOURNMENT

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

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
September 12, 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 as well as the for the Carr and Mendocino Fires. Recent activity has resulted in a noticeable increase in interest for Strike Team Leader training. Classes were conducted in May (San Diego and Sacramento), and June (San Bernardino). Multiple requests for classes have been received in the past few months. 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 and is pursuing statewide adoption of same. A standardized post review process is being implemented to capture data after each deployment. This information will be utilized to modify and improve the curricula and establish operational parameters. 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. Initial recruitment has been targeted at existing federal Disaster Medical Assistance Team (DMAT) members (Phase I) and two Units have been officially “stood up” (San Diego and San Francisco Bay Area). The Sacramento unit should be stood up soon. A Team was recently deployed to Redding (Carr Fire) to support medical needs at multiple shelters. The recent CAL-MAT deployment and intense fire activity has generated significant interest in the program with more and more inquiries about the program. The Phase II hiring process (non-DMAT members is gradually being implemented.). CAL-FIRE approached EMSA to provide CAL-MAT for fire base camp medical support. A contract for those services should be completed very soon.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
3. CAL-MAT Cache	Markell Pierce, ext. 1443	EMSA is currently working on the first bi-annual inventory and resupply of the (3) CAL-MAT Medical supply caches for the 2018-2019 fiscal period. This ensures that all medical supplies are 100% accounted for, to date, and ready for immediate deployment. CAL-MAT resupply order was received July 2018.
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	Jody Durden, ext. 702	Development of a Crisis Care/Scarce Resources guidance document is on hold until funding is made available. EMSA and CDPH recognize the importance of the guidance document so will keep this on our radar.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
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 24,000 volunteers registered. There are 49 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 9,100 of the 24,000 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. The DHV Program deployed Medical Reserve Corps volunteers for shelter medical support in Lake County during the Mendocino Complex Wildfires, and for animal care needs in Shasta County with the CA Veterinary Medical Reserve Corps during the Carr Fire. 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
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
7. Training		
Weapons of Mass Destruction (WMD)	Markell Pierce, ext. 1443	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. Next training courses are scheduled for October – December 2018.
Medical Health Operations Center Support Activities (MHOCSA)	Jody Durden, ext. 702	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.
8. 2018 Statewide Medical and Health Exercise (2018 SWMHE)	Theresa Gonzales, ext. 1766	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.
9. 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
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
10. 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 convene via webinar/in-person meeting in September 2018 to discuss next steps for HICS implementation and training. EMSA has also collaborated with stakeholders in Taiwan, the Republic of China for HICS Guidebook translation into Mandarin. 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.
11. 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. Several CAL-MAT members were deployed as MST personnel during the Carr wildfire to support the CAL-MAT mission to Redding.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
12. Response Resources	Markell Pierce, ext. 1443	The bi-annual inventory maintenance of the Mission Support Team (MST) caches was completed in June 2018. The MST caches are constantly being refined based on After Action Reports following exercises and real-world deployments. The Response Resources Unit (RRU) continues to integrate newly purchased I.T. and telecommunications equipment to improve MST networking infrastructure. 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 1 & 6. 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 2018/19. Pharmacy full inventory and resupply of expired items completed in July 2018.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
13. Information Technology	Rick Stricklin, ext. 1445	The identification and inventory of IT equipment to be surveyed has been finalized and disposal is near completion. The fiber optic cabling to replace existing DSL and T1 circuit has been connected and the installation of Cisco Meraki network appliance is completed. The design & implementation for the Meraki wireless system to provide connectivity for data (Cellular, VSAT, wired) and video capabilities during field deployments is completed. EMSA Station 1 received [2] Mobile Ready Office (MRO) units and continues to refine the MRO configuration and connectivity to other devices. The annual servicing of Disaster Medical Support Unit (DMSU) radio systems by Cal OES Public Safety Communications (PSCO) has been completed. Collaboration with CAL OES PSCO to refine the VHF Kenwood TK 5710 radio load, to include the CALFIRE Group 3 load is in process. The EMSA Station 1 vehicle fleet annual radio servicing has been completed. Research and development continues with the C3 communications vehicle to identify outdated technology and discover new technologies to increase its capabilities and functionality in the field. Preventative maintenance\service was performed on C3 communication vehicle VSAT antenna and is completed. EMSA is working with vendors to identify proper interoperability communication device[s], to allow communications with other partnering agencies. Planning has begun on the installation of Meraki wireless access points, to provide better Wi-Fi coverage at station 1. Received new technology desktop computers for the Department Operations Center to replace older obsolete laptops. New desktop computers are currently being configured to replace older desktop units.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
14. 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 include the shelters, infrastructure equipment, and durable equipment, but does **not** include biomedical equipment and medical supplies. This redistribution of the MFH allows 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 is at the discretion of the locals without requiring a state resource request. Modules have been placed in Long Beach, Riverside, Sacramento and Santa Cruz. Module placement in San Mateo will be completed in early October. We are targeting Northern Sacramento valley for the placement of the sixth module have an interested partner we are discussing details with. 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
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
15. 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 coordination of medical/health resources during an emergency response. The RDMHS have been instrumental in response to 2017 & 2018 California wildfires which included coordination of Ambulance Strikes Teams for patient evacuations and DHV/MRC participation in shelter operations for medical/health needs.
16. Medical Reserve Corps (MRC)	Patrick Lynch, ext. 467	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 9,100 plus of the DHV Program's 24,000 plus volunteers are Medical Reserve Corps volunteers. Medical Reserve Corps volunteers deployed to Lake County for medical support to shelter operations during the Mendocino Complex Wildfires. The California Veterinary Medical Reserve Corps deployed in two locations in Shasta County in support of animal care needs during the Carr Fire.
17. 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.
18. 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, Shelter Fact Sheet, and Course of Action.

Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
19. Patient Movement Plan	Craig Johnson, ext. 4171	The California Patient Movement Plan is in final draft and will be released once approved by Agency. EMSA plans to coordinate with EMSAAC for final recommendations and Commission review/approval.
20. Bay Area Catastrophic Earthquake Plan	Jody Durden, 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.
21. Northern California Catastrophic Flood Response Plan	Nirmala Badhan, ext. 1826	EMSA worked with the Governor's Office of Emergency Services (Cal OES) for the development of the Northern California Catastrophic Flood 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 Plan has been signed and will be posted on Cal OES website once ADA compliancy work is completed.

Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
September 12, 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 no (0) 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 19 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 three (3) programs in the review process. EMSA will host the Child Care Regulatory Workgroup quarterly meeting in September. EMSA Preventive Health sticker sales are ongoing. Training standards for the program are being revised.
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 2 open complaint cases involving EMSA-approved training program.
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, LEMSAs and the general public regarding AED statutes and regulations. 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. Los Padres and Sierra National Forest have programs that have been contacted to update to current regulation. CAL FIRE, State Parks and CHP have recently reviewed/approved EMT AED service provider programs.

Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
6. BLS Training and Certification Issues	Betsy Slavensky, ext. 461	EMSA provides ongoing support and technical assistance to EMTs, prospective EMTs and 69 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.
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, CA State Parks and Cal Fire. In early 2018, EMSA approved CHP's public safety first aid program and California Firefighters Joint Apprenticeship Committee (CAL JAC) new EMT training program. In June 2018, EMSA approved CA State Parks EMT training program. In July 2018, EMSA approved CAL FIRE's EMT Refresher training program and their CE Provider program. EMSA reviewed and filed additional training (epi, naloxone, glucometer) added to CHP's EMT Refresher program that expires in 2019. CA State Parks CE Provider program expired 5/31/18 and they plan to renew it this year. CA State Parks submitted an EMR program for review in July 2018. Site visits to state wide public safety agency programs are pending fiscal approval and staffing.

Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
8. My License Office/ EMT Central Registry Audit	Betsy Slavensky, ext. 461	EMSA monitors the EMT Central Registry to verify that the 69 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 email, phone, and LEMSA Coordinator meetings with certifying entities to share updates, changes and corrections. The Personnel Standards newsletter has been put on hold pending increased staff support. Ongoing development and updates of discipline and certification procedures support central registry processes and reduce time spent on technical support. Updates to the Central Registry software continue to enhance processes and reduce errors. 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	EMSA processes applications for Epinephrine training programs and certification for the administration of epinephrine auto-injectors to the general public and off-duty EMS personnel. EMSA has approved 12 training programs and has issued 873 lay rescuer certification cards.
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. A new hemostatic dressing application has been received and is currently under review.
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: 308 Initial In-State applications, 49 Initial Out-of-State applications, 2,508 Renewal applications, and 80 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 six (6) months. Upon completion, paramedic training program graduates and paramedics requiring initial or renewal licensure will be able to apply online.

Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
13. Administrative Actions Reporting System (AARS)	Kim Lew, ext. 427	On August 1, 2018, the EMS Authority began participation in a statewide project to enhance the current AARS system. Under the direction of the system vendor and the CA. Dept. of Social Services, the EMS Authority will be meeting bi-weekly over the course of a year to assist in system improvements.

Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
September 12, 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 September. 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
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
2. STEMI/Stroke Systems of Care	Farid Nasr, ext. 424	STEMI and Stroke Regulations Rulemaking efforts for the STEMI and Stroke draft regulations with the Office of Administrative Law have continued. EMSA has reviewed and responded to the comments received during the 45-day public comment periods April 6, 2018 through May 21, 2018. After review of the comments received, changes to the draft regulations were completed and a 15-day public comment period starting July 10-July 25, 2018. EMSA is current reviewing the most recent comments received during the second comment period and will be making changes to the draft regulations. A third comment period will take place beginning the week of August 13, 2018.
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 (S1BA). The S1BA has been drafted and is being reviewed by Agency. On August 15, 2018, the S1BA is scheduled to be presented to the Agency Investment Review Committee. <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
September 12, 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. 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
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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. <u>Quarterly Report</u> The Quarterly Report consists of data and narrative reports. The data report for the 4th quarter, April 1, 2018 - June 30, 2018, was received on July 12, 2018, and the narrative report was received on July 13, 2018. Both were reviewed for consistency with contractual objectives; there were no areas of concern. <u>Contract</u> The contract with the CPCS expired on June 30, 2018. The EMS Authority has developed a new contract with the CPCS for Fiscal Year 2018/2019, which is currently being reviewed by the CPCS. <u>External Audit</u> 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. Sjoberg Evashenk Consulting, Inc. has submitted three monthly status reports to date outlining progress on the project. <u>Site Visits</u> The EMS Authority conducted two Poison Control Center (PCC) site visits with Sjoberg Evashenk Consulting, Inc. On May 22, 2018, the San Diego PCC was visited, and on May 24, 2018, the Sacramento PCC was visited. The site visits consisted of a tour of the facility, a walk-through of processes, observations of hotline staff, and interviews with management.

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EMS Systems Division
Major Program Activities
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
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). The EMS Authority has reviewed/approved 13 EMS Plans in 2018. 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.
7. EMS for Children Program	Heidi Wilkening, ext. 556	Regulations: The EMS for Children regulations were put out for a 15-day public comment period of July 25. The public comment period will close on August 9, 2018. It is expected the EMSC regulations will be presented at the September Commission meeting for the Commission's approval. 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 topics have been scheduled for this one day event. NEDARC Survey: The EMSC Program survey of California hospitals for Performance Measures EMSC 06 and 07 opened in May and will close on August 17, 2018. This survey will pertain to EMSC Interfacility Transfer Guidelines and Agreements of pediatric patients. As of July 30, 2018, California has reached 59.2% of the required 80% response rate.

Emergency Medical Services Authority
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
8. CEMSIS EMS Data	Adrienne Kim, ext. 742	CEMSIS now has 31 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 two LEMSAs that are currently in the testing stage. The Office of Traffic Safety has cut funding for CEMSIS in May 2018. EMSA is looking for alternatives to long-term funding sources for CEMSIS. <u>Reports:</u> The CY 2017 Annual EMS Report is currently being developed. The comparison reports have been developed and will be testing with several LEMSAs.
9. CEMSIS – Trauma Data	Tom McGinnis, ext. 695	There are 27 Local EMS agencies (LEMSA) with designated Trauma Centers. Trauma Centers are physically located in 37 of the 58 counties. Currently, 26 LEMSAs are transmitting into CEMSIS-Trauma representing 77 of the 79 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. The Statewide EMS Operations and Communications Manual is in the process of being revised to be posted on the EMSA website. 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.

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		Recommendations included retiring some measures, revising others, and incorporating some of the National Compass Measures. 2017 was still a time of 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. 19 of 33 LEMSAs met the June 30th, 2018 deadline. LEMSAs who did not meet this deadline were provided an extension to participate. EMSA will be reviewing the submission of Core Measures Information as well as comments and recommendations for improvement with the Core Measures Task Force in the Fall to implements appropriate changes prior to the end of 2018.
12. Grant Activity/Coordination	Lori O'Brien, ext 401	<u>Office of Traffic Safety (OTS) Grants:</u> Both the CEMSIS and TQIP Grants were closed by OTS on 5/9/2018. <u>Health Resource Services Administration (HRSA) Grant:</u> 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. The first EMSC Performance Report will be submitted at the end of September. <u>Preventive Health and Health Services Block Grant (PHHSBG):</u> EMSA staff remains continually involved in the Preventive Health and Health Services Block Grant. The State Plan for FFY 2018 (SFY 18/19) was accepted by the Technical Advisory Committee in June, 2018. The MOU was received in July, 2018. Semi-annual reporting for SFY 17/18 was completed and submitted to CDPH on 8/2/2018.

Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
September 12, 2018

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
13. Office Support	Tiffany Pierce ext. 900	<u>Documents and Letters:</u> Processed Systems Division letters and documents including the following: 1. RFP letter for San Mateo 2. EMS Plan Updates for Central California, San Diego, and Los Angeles The entire electronic and hard copy tracking systems were completely updated on 7/23/18. <u>Trauma Summit:</u> Tiffany Pierce helped to facilitate the Trauma Summit by assisting with the following: • preparation • planning • set-up • registration • hotel contract liaison • collecting and properly storing last-minute registration payments • etc. <u>Travel Expense Claims:</u> Tiffany Pierce processed at least 10 TEC's and coordinated with the Administration Unit to ensure completion of additional TECs submitted.

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

DATE: September 12, 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 September 12, 2018.

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

DATE: September 12, 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:

2018-19

The 2018-19 enacted California State budget 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:

Accounting data for the new fiscal year is not yet available 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.

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 June 30, 2018, accounting records indicate that the Department has expended and/or encumbered $28.3 million or 75.8% of available expenditure authority. Of this amount, $12.1 million or 74.2% of State Operations expenditure authority has been expended and/or encumbered and $16.2 million or 77.1% of local assistance expenditure authority has been expended and/or encumbered.

The Department is in the process of year-end closing (MEC) accounting activities and we are continuing to monitor and adjust both State operations and local assistance. An updated report will be distributed prior to the next Commission meeting.

EMSA Staffing Levels:

As of June 30, 2018, the Department is authorized 69 positions and also has 8.8 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	2.0	1.5	1.3	5.0	9.8
Staffing Level	**20.0**	**21.5**	**23.3**	**14.0**	**78.8**
Authorized (Vacant)	-1.0	-3.0	-2.0	0.0	-6.0
Temporary (Vacant)	0.0	0.0	0.0	-2.0	-2.0
Current Staffing Level	**19.0**	**18.5**	**21.3**	**12.0**	**70.8**

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

DATE: September 12, 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 May 18, 2018, to August 10, 2018, the Authority issued twenty-one new Accusations against existing paramedic licenses, one temporary suspension order, 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 eight hearings scheduled, and twelve waiting to be scheduled. There are currently forty 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 to the 9th Circuit court of Appeals from a dismissal in the United States District Court for the Central District of California, No. 8:16-cv-01703-JLS. The Authority filed an amicus brief asking the 9th Circuit court to certify the matter to the California Supreme Court for an interpretation of Health and Safety Code 1797.201. Oral Arguments were heard in Pasadena on August 7, 2018. On August 27, 2018, the court upheld the dismissal of Americare's appeal. Americare has until September 10, 2018 to petition for a rehearing.

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 retained the Attorney General's office and the Authority was dismissed from the lawsuit by the court.

Local EMS Agency Plan Denial Appeals:

Contra Costa County EMS v. EMSA. The Authority is currently undertaking the process to determine hearing dates and request a hearing through OAH.

El Dorado County EMS v. EMSA. The Authority is waiting for a statement from El Dorado County of their basis for appeal and available hearing dates in order to undertaking the process to request a hearing through OAH.

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DATE: September 12, 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 August 1, 2018, the Enforcement Unit is budgeted for 5 full-time Special Investigators and 1 retired annuitant Special Investigator. The Associate Government Program Analyst (AGPA-Probation Monitor) 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:	150
Cases completed and/or closed:	127
EMT-Paramedics on Probation:	215

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 121 cases in “open” status.

As of August 1, 2018, there are 49 cases that have been in “open” status for 180 days or longer: three (6) 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 addiction medicine for an examination/review in cases involving alcohol or other substance abuse.

Those 49 cases are divided among 4 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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DATE: September 12, 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.

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 and that there are systems are in place to capture real patient successes and challenges using EMS Events reporting.

During an in person meeting with the MAC, representatives from the Contra Costa County EMS Agency and American Medical Response reported that the main difficulty being experienced from the field, is that they are unable to make access to the POLST eRegisty from the patients residence if the ambulance which contains the WiFi Hotspot is more then 30 feet away. An earlier decision by Contra Costa County to not support the use of a Back Up Call Center has been revisited and steps are underway to set up access to a Back Up Call Center for the times that WiFi Connectivitiy can not be established from within the patient's residence.

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 attended refresher/update training in June 2018 that included the new POLST eRegistry functionality, as well as a refresher about Search, Alert, File, and Reconcile and the Health Information Exchange.

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DATE: September 12, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

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

SUBJECT: Overview of Ambulance Zone Exclusivity

RECOMMENDED ACTION:

Receive information on Health and Safety Code Section 1797.224 and Ambulance Zone Exclusivity.

FISCAL IMPACT:

None known at this time.

DISCUSSION:

This informational document is provided to the Commission as an overview of ambulance zone exclusivity and the general manner in which an ambulance zone can be determined exclusively. The information provided is a basic overview of what is a very complicated process that involves many factors at both the state and local levels.

A few high-level items for consideration:

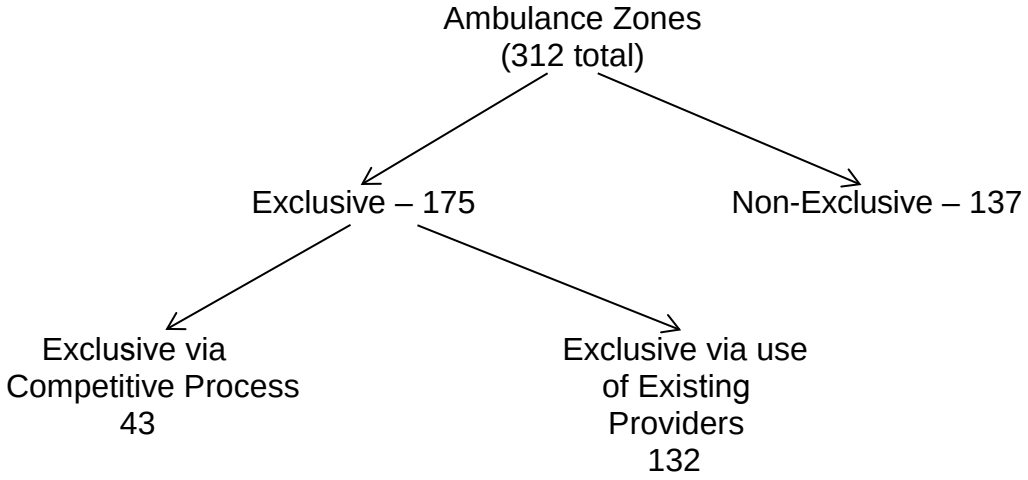
1) California is divided, by 33 local EMS agencies (LEMSAs), into 312 ambulance zones for a primary emergency medical response,
2) Selection of the provider is in the purview of the LEMSA given various statutory constraints,
3) The default position is that an ambulance zone is non-exclusive. Any otherwise qualified provider may serve the area or sub-area upon application,
4) Some LEMSAs wish to limit competition in some ambulance zones,
5) Both private and public ambulance providers have exclusive operating areas,
6) The role of Health and Safety Code 1797.201 remains a controversial provision.

If a LEMSA chooses to restrict competition, consistent with Health and Safety Code (HSC) Sections 1797.6, 1797.85 and 1797.224, the EMS Authority provides the degree of state direction and supervision over emergency medical services as will provide for state action

immunity under federal antitrust laws for activities. These sections specifically relate to ambulance zone exclusivity and their designation in a LEMSA's EMS Plan. The plan is subsequently reviewed and an approval determination made by the EMS Authority.

Ambulance zones can achieve exclusively using one of two methods. The first is where a provider is selected through the LEMSA doing a competitive process and selecting a provider from the bids they receive. The second method is achieved by a LEMSA using existing providers operating in the local EMS area or subarea in the same manner and scope in which the services have been provided without interruption since January 1981. As noted earlier, if neither method is selected to determine and ambulance zone exclusive, the default position is that the ambulance zone is non-exclusive and open to any otherwise qualified provider in that EMS area or sub-area.

An area is defined as the borders of an entire county while a sub-area is a unique portion of the overall county area. Sub-areas vary in size LEMSA to LEMSA. As of July 16, 2018, there are 312 EMS areas and/or sub-areas as noted in the chart below:



The text of the applicable statutes that define the state policy on the creation of exclusive operating areas is listed below:

1797.6: *(Legislative Intent: Antitrust Immunity)*
(a) It is the policy of the State of California to ensure the provision of effective and efficient emergency medical care. The Legislature finds and declares that achieving this policy has been hindered by the confusion and concern in the 58 counties resulting from the United States Supreme Court's holding in Community Communications Company, Inc. v. City of Boulder, Colorado, 455 U.S. 40, 70 L. Ed. 2d 810, 102 S. Ct. 835, regarding local governmental liability under federal antitrust laws.
(b) It is the intent of the Legislature in enacting this section and Sections 1797.85 and 1797.224 to prescribe and exercise the degree of state direction and supervision over emergency medical services as will provide for state action immunity under federal antitrust laws for activities undertaken by local governmental entities in carrying out their prescribed functions under this division. (Added by Stats. 1984, Ch. 1349, Sec. 1.)

1797.85: *(Exclusive Operating Area)*

"Exclusive operating area" means an EMS area or subarea defined by the emergency medical services plan for which a local EMS agency, upon the recommendation of a county, restricts operations to one or more emergency ambulance services or providers of limited advanced life support or advanced life support. (Added by Stats. 1984, Ch. 1349, Sec. 2.)

1797.224: *(Creation of Exclusive Operating Areas)*
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 Statutes in Effect as of January 1, 2016 ● 72 process for selecting providers and determining the scope of their operations. This plan shall include provisions for a competitive process held at periodic intervals. Nothing in this section supersedes Section 1797.201. (Added by Stats. 1984, Ch. 1349, Sec. 3.)

EMERGENCY MEDICAL SERVICES AUTHORITY
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DATE: September 12, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Howard Backer, MD, MPH, FACEP
Director

SUBJECT: Recognition of EMS Personnel Licensure Interstate CompAct Presentation (REPLICA)

RECOMMENDED ACTION:

Presentation on Recognition of EMS Personnel Licensure Interstate CompAct.

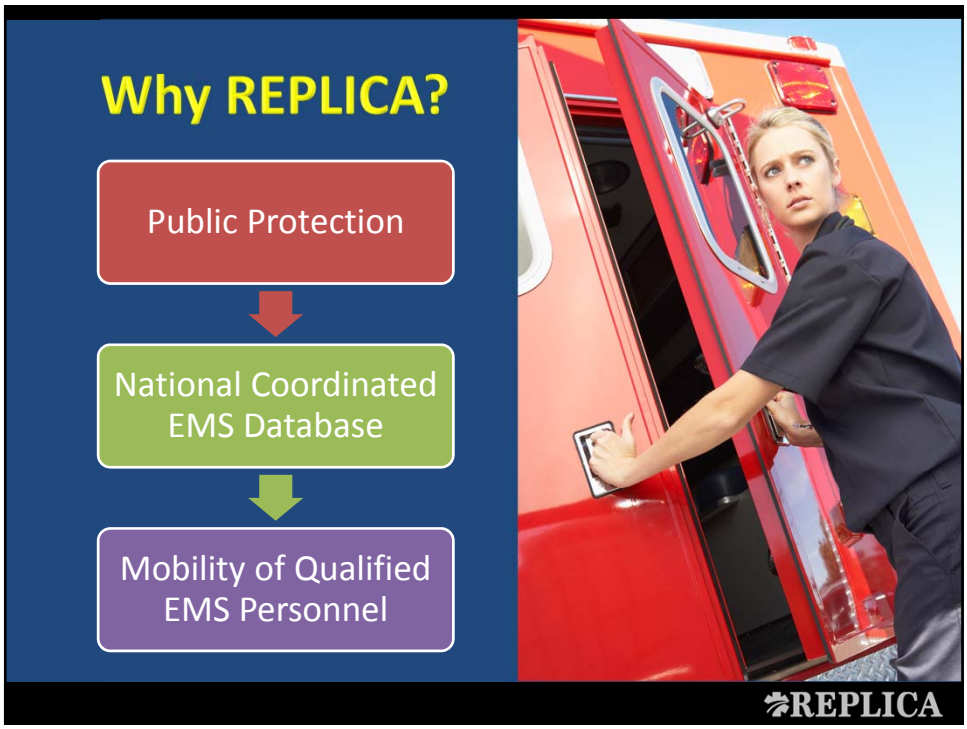
FISCAL IMPACT:

None

DISCUSSION:

Dan Manz will give a brief presentation on the Recognition of EMS Personnel Licensure Interstate CompAct Project.


REPLICA
Recognition of EMS Personnel
Licensure Interstate CompAct
REPLICA


Why REPLICA?
Public Protection
National Coordinated EMS Database
Mobility of Qualified EMS Personnel
REPLICA

WHY REPLICA?

- Allows EMS *personnel* to do their job
- Protects the public though proper screening of EMS personnel crossing state lines
- Assures EMS personnel meet a uniform, national 'fitness to practice'

REPLICA

Brief History of Compacts

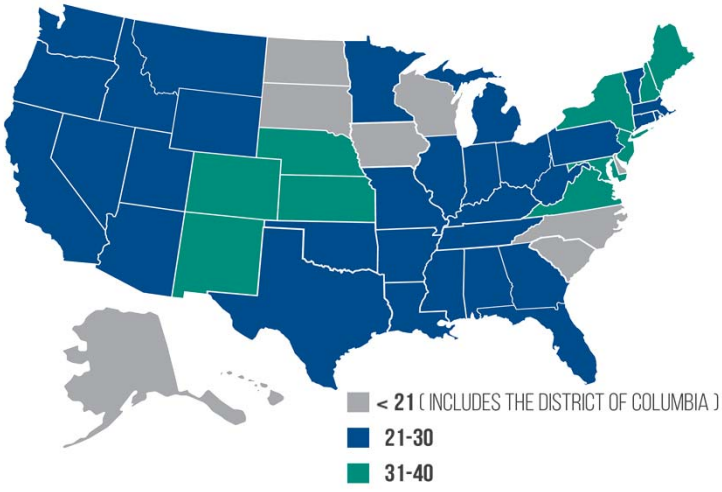
- Colonial days, solve state border disputes
- Time-tested, flexible
- Self governing entity for the purposes specified in Compact
- Allows states to retain and maintain their **sovereignty**

REPLICA

Interstate Compacts

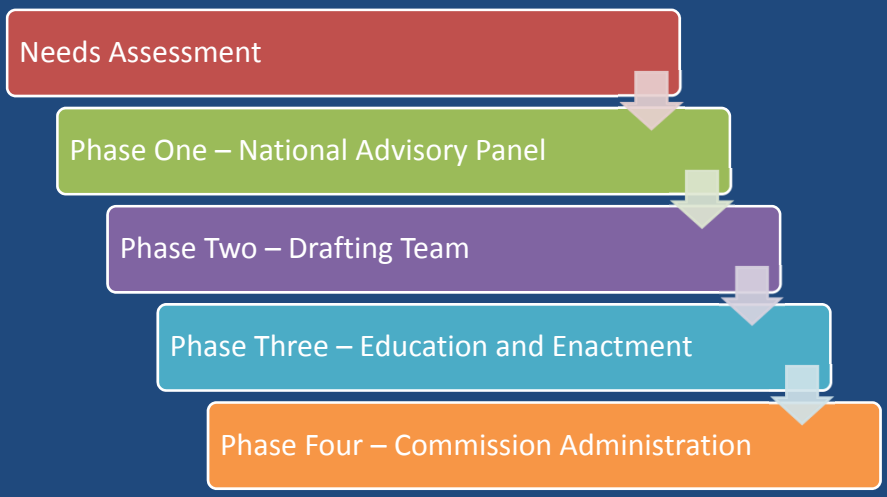
REPLICA

STATE-BY-STATE INTERSTATE COMPACT MEMBERSHIP



REPLICA

2012 to Today



REPLICA

Phase I – National Advisory Panel

- American Ambulance Association
- American College of Emergency Physicians
- Association of Air Medical Services
- Association of Critical Care Transport
- Bureau of Land Management
- EMS Labor Alliance
- Federal Bureau of Investigation
- Federation of State Medical Boards
- Int'l Association of EMS Chiefs
- Int'l Association of Fire Chiefs
- Int'l Association of Fire Fighters
- International Association of Flight & Critical Care Paramedics
- International Paramedic
- National Association of EMS Educators
- National Association of EMS Physicians
- National Association of EMTs
- National EMS Management Association
- National Governors Association
- National Registry of EMTs
- National Volunteer Fire Council
- USDA Forest Service
- US DOI National Park Service

REPLICA

NAP Decisions

- Go forward with a compact: Preserve state sovereignty and collective control
- Create a system of self-regulation by the states whereby national policy can be put into place and data can be exchanged but remain flexible enough to change as change continues to occur in the EMS industry
- Work closely with CSG's National Center for Interstate Compacts

REPLICA

Phase 2: Compact Drafting Team

- NASEMSO (five state officials)
- CSG National Center for Interstate Compacts
- AAMS
- IAFCCP
- IAFF
- NEMSMA
- NAEMT
- Vedder Price Law Firm

REPLICA

The Results:

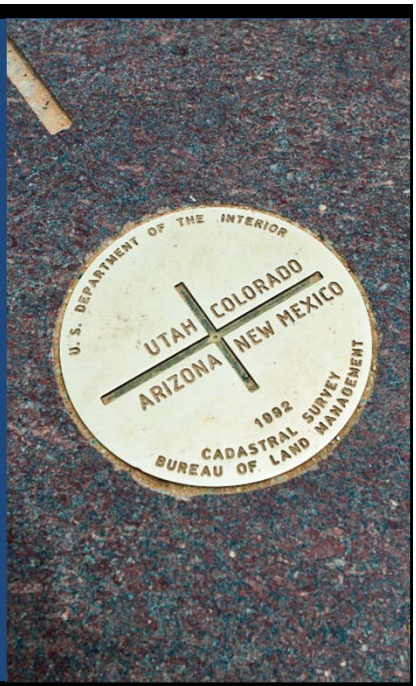
REPLICA

Recognition of EMS Personnel Licensure Interstate CompAct

REPLICA

REPLICA Framework

- National Coordinated EMS Licensure Database
- Privilege To Practice in other compact states
- Interstate Compact
- Compact Commission - Cross Border Management
- Veteran & Spouse Expedited Processing



REPLICA

REPLICA State Eligibility

NREMT
- Utilize the NREMT exam at the EMT and Paramedic levels for initial licensure

FBI
- Utilize FBI compliant background check with biometric data (e.g. fingerprints) within 5 years of Compact activation

Process
- Have a process to receive, investigate, and resolve complaints; and share information with other Compact states as necessary

Law
- Enact the model REPLICA legislation

REPLICA

Individual Eligibility

- **Licensed** in a Home State as an EMT, AEMT* or Paramedic
- Practicing in **good standing** in their home state
- Under the supervision of an EMS Medical Director
- At least **18** years of age

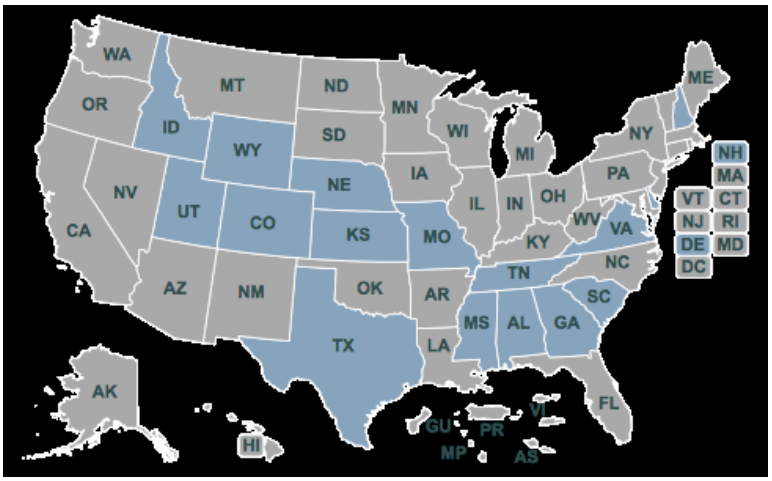
* Or at a lever between EMT and Paramedic

REPLICA

What REPLICA Does Not Do

- Does not provide a multi-state license
- Does not create automatic reciprocity
- Does not have authority over EMS/Ambulance agency licensure
- Reach into state EMS operations in unrelated jurisdictions

REPLICA States



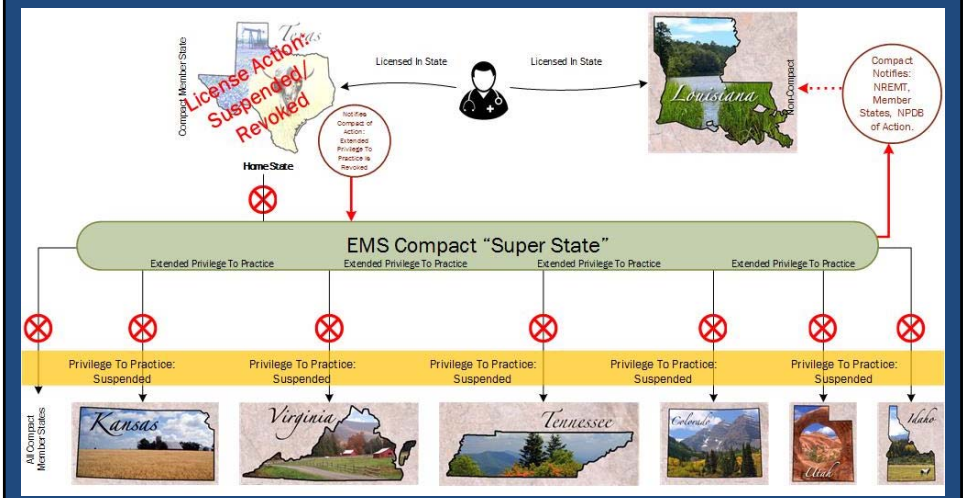
As of August 2018

REPLICA

Discipline & Adverse Actions

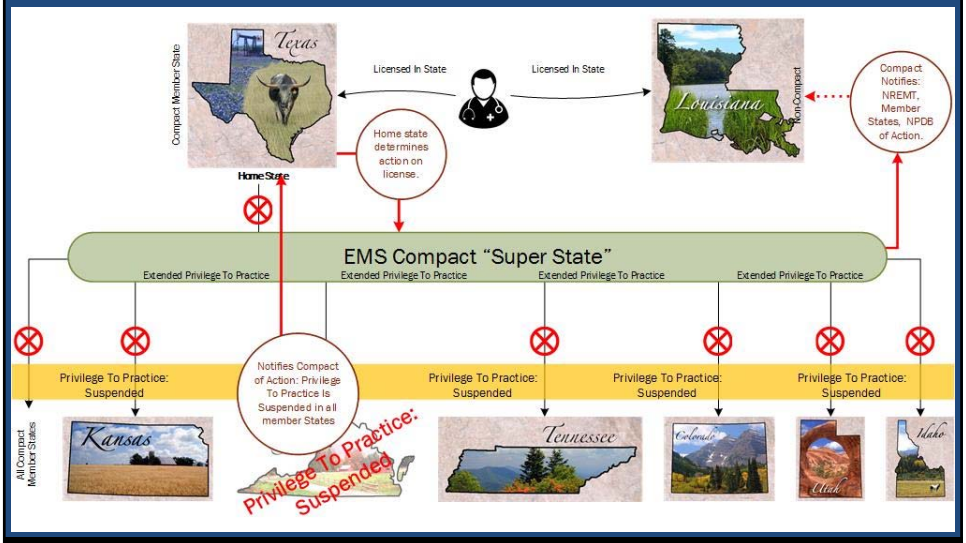
REPLICA

"Home State" Discipline



REPLICA

Remote State Discipline



REPLICA

Alternative Programs

- Option for a state to require participation in an alternative program is preserved
- Shall remain non-public if required by the member state's laws.
- Individuals who enter any alternative programs must agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state

REPLICA

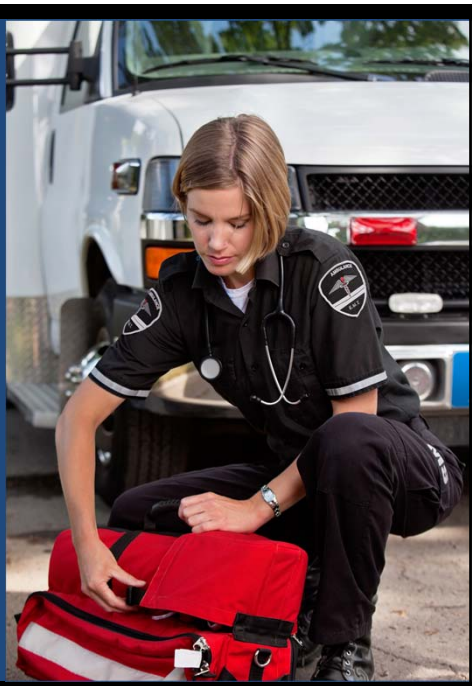
Relationship to the Emergency Management Assistance Compact

Once a Governor declares a disaster and EMAC is activated, EMAC applies and no terms or provisions of REPLICA shall supersede the terms of EMAC with respect to any individual practicing in the remote state in response to such declaration

REPLICA

National Database

- Legal authorization provided by REPLICA
- State EMS Office Can:
  - View complete (multiple state) license history of individuals
  - Share real-time significant investigatory information
  - Share License Discipline History
  - Receive cross-border notifications of out of state adverse actions



REPLICA

Who is paying for REPLICA?

- Homeland Security already paid for the development of REPLICA
- The National Registry of EMTs is currently supporting development of the REPLICA coordinated database
- The compact provides authorization for the commission to raise money or have states pay costs of operations
- The good news is- this compact is fairly inexpensive to maintain

REPLICA

Next Steps

- More states to pass REPLICA Legislation
- REPLICA Commission to enact rules

REPLICA

Why is REPLICA good for California?

- The state gets much better control (transparency) for personnel in adjacent states coming into CA.
- CA EMS personnel get a privilege to practice in other REPLICA states
- CA gets a seat on the REPLICA Commission and a voice in REPLICA rule making
- Expedited pathway for qualified military veterans and spouses to enter EMS

REPLICA

Next steps for California?

CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY

- Identify and gather advocates within the state
- Identify sponsor(s) for REPLICA legislation
- Educate, educate, educate!

REPLICA

For More Information..

REPLICA

Recognition of EMS Personnel Licensure Interstate CompAct

- 201 Park Washington Court
- Falls Church, VA 22046
- (802) 316-2126
- manz@emsreplica.org
- www.emsreplica.org

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

DATE: September 12, 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 is promulgating the following regulations:

	Chapter	Status
1.1	Training Standards for Child Care Providers	Under review by the Emergency Medical Services Authority
4	Paramedic	Under review by the Department of Finance
7.1	ST-Elevation Myocardial Infarction (STEMI) Systems of Care	Submitted to the Commission on EMS Sept 12, 2018, for review/approval
7.2	Stroke Systems of Care	Submitted to the Commission on EMS Sept 12, 2018, for review/approval
10	California Emergency Medical Technician Central Registry	Under review by the Emergency Medical Services Authority
12	Emergency Medical Services System Quality Improvement	Under review by the Emergency Medical Services Authority
14	Emergency Medical Services for Children	Open for 15-day public comment period Jul 25 – Aug 9, 2018

EMERGENCY MEDICAL SERVICES AUTHORITY
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DATE: September 12, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Sergy El-Morshedy, Legislative Analyst
Legislative, Regulatory, and External Affairs

SUBJECT: STEMI Critical Care System Regulations Approval

RECOMMENDED ACTION:

Review and approve ST-Elevation Myocardial Infarction (STEMI) Critical Care System Regulations.

FISCAL IMPACT:

No fiscal impact exists, as this regulation does not impose a mandate for any local program or entity, state agency or program, and does not affect any federally funded State agency or program.

DISCUSSION:

The EMS Authority requests approval for the adoption of Chapter 7.1. ST-Elevation Myocardial Infarction (STEMI) Critical Care System, to Division 9, Title 22 of the California Code of Regulations.

The EMS Authority submitted a Notice of Proposed Regulatory Action and initial rulemaking documents for STEMI Critical Care System regulations to the Office of Administrative Law (OAL) on March 27, 2018. The 45-day public comment period concluded on May 21, 2018. Upon completion of the comment period, the EMS Authority reviewed all comments submitted by the public and revised the STEMI draft regulations accordingly.

Based on amendments to the draft STEMI regulations, the EMS Authority held a 15-day public comment period, which concluded July 25, 2018. The EMS Authority made additional revisions based on comments received during the first 15-day public comment period and held a second 15-day public comment period, which concluded August 28, 2018.

The one-year rulemaking timeline for the proposed STEMI regulations will conclude April 6, 2019. The EMS Authority supports moving these STEMI Critical Care System regulations forward to OAL at this time and respectfully request the Commission's approval.

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DATE: September 12, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Sergy El-Morshedy, Legislative Analyst
Legislative, Regulatory, and External Affairs

SUBJECT: Stroke Critical Care System Regulations Approval

RECOMMENDED ACTION:

Review and approve Stroke Critical Care System Regulations.

FISCAL IMPACT:

No fiscal impact exists, as this regulation does not impose a mandate for any local program or entity, state agency or program, and does not affect any federally funded State agency or program.

DISCUSSION:

The EMS Authority requests approval for the adoption of Chapter 7.2. Stroke Critical Care System, to Division 9, Title 22 of the California Code of Regulations.

The EMS Authority submitted a Notice of Proposed Regulatory Action and initial rulemaking documents for Stroke Critical Care System regulations to the Office of Administrative Law (OAL) on March 27, 2018. The 45-day public comment period concluded on May 21, 2018. Upon completion of the comment period, the EMS Authority reviewed all comments submitted by the public and revised the Stroke draft regulations accordingly.

Based on amendments to the draft Stroke regulations, the EMS Authority held a 15-day public comment period, which concluded July 25, 2018. The EMS Authority made additional revisions based on comments received during the first 15-day public comment period and held a second 15-day public comment period, which concluded September 1, 2018.

The one-year rulemaking timeline for the Stroke regulations package will conclude April 6, 2019. The EMS Authority supports moving these Stroke Critical Care System regulations forward to OAL at this time and respectfully requests the Commission's approval.

EMERGENCY MEDICAL SERVICES AUTHORITY
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(916) 322-4336 FAX (916) 324-2875

DATE: September 12, 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 Pilot Project Status 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 Health Care Foundation. Local pilot site providers participate with in-kind contributions and any local grants or reimbursement.

DISCUSSION:

On November 14, 2014, the California Office of Statewide Health Planning and Development (OSHPD) approved an application from the California Emergency Medical Services Authority (EMSA) to establish a Health Workforce Pilot Project (HWPP) to test multiple community paramedicine concepts. OSHPD has since renewed the HWPP for one-year periods in 2015, 2016, and 2017. The community paramedicine HWPP has encompassed 17 projects in 13 communities across California that have tested seven different community paramedicine concepts. Eleven projects are currently enrolling patients. Eight projects launched in 2015, one launched in 2017, and two additional projects launched in 2018 (Santa Clara & Fresno).

Five of the initial projects have closed due to various challenges.

Strong progress continues with the remaining 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 UCSF Healthforce Center, San Francisco continue to serve as the independent evaluators for the HWPP #173.

The UCSF's Healthforce Center issued an update Evaluation Report in July 11, 2018 which presents a summary of major findings from the evaluation for policymakers. All data submitted by project sites are reported to OSHPD on a quarterly basis. The report presents findings from the time the initial group of pilot projects began enrolling patients (June 2015 to October 2015) through March 2018, for nine of the eleven community paramedicine projects that are currently enrolling patients and the five projects that have closed. The tenth and eleventh projects that are currently enrolling patients, Santa Clara County EMS's alternate destination - mental health project and its alternate destination - sobering center project, are not included because they did not begin enrolling patients until June 2018.

In summary the report states that *"Research conducted to date indicates that community paramedicine programs are improving the effectiveness and efficiency of the health care system. Findings from this research also suggest that the benefits of community paramedicine programs grow as they mature, solidify partnerships, and find their optimal structure and niche within a community. The evaluation of HWPP #173 yields consistent findings for six of the seven community paramedicine concepts tested. All of the post-discharge, frequent 911 users, DOT for TB, hospice, and alternate destination – mental health projects have been in operation for at least two and a half years and have improved patients' well-being and, in most cases, have potentially increased health care value by yielding potential savings for payers and other parts of the health care system."*

"Findings regarding outcomes of a project testing the sixth concept, alternate destination – sobering center, suggest that this project is also benefitting patients and the health care system over the course of its first 14 months. The seventh concept, alternate destination – urgent care, shows potential but further research involving a larger volume of patients transported to urgent care centers with wider ranges of services and expanded hours is needed to draw definitive conclusions. If California implements community paramedicine on a broader scale, the current EMS system design is well suited to utilize the results of these pilot programs to optimize the design

and implementation of proposed programs and to assure effectiveness and patient safety.

The two-tiered system enables cities and counties to design and administer community paramedicine programs to meet local needs while both local and state oversight and regulation ensure patient safety."

The link to the Updated Evaluation Report is:
https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Update-Community%20Paramedicine%20Pilot%20Program_0.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 current additional Pilot Projects

Local EMS Agency	Sponsor	Concepts	Status
Santa Clara County	Santa Clara County EMS Agency	Alt Destination Behavioral Health Alt Destination Sobering Center	Implemented June 1, 2018
Sierra Sacramento Valley	Dignity Health	Post Discharge	This project has withdrawn due to the loss of a major Hospital Providers participation.
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	Site-specific Training has been completed and current awaits an approved updated IRB are pending.
Central California EMS Agency	Central California EMS Agency	Alt Destination - Behavioral	Implemented July 26, 2018

Community Paramedicine Legislation

There were two pieces of Legislation introduced that would have enabled Community Paramedicine Programs to be implemented throughout California. Both AB 1795 and SB 944 did not receive hearings within the Assembly Appropriations Committee and therefore died.

AB 1795 (Meinchien) Would have allowed 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 would have authorized 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. Would have required the Emergency Medical Services Authority (EMSA) to adopt guidelines for the triage criteria and assessment procedures by July 1, 2020 and require EMSA to annually analyze administration of local plans and issue a report.

SB 944 (Hertzberg) This Bill would have created the Community Paramedicine Act of 2018. This bill would have created the statutory authority to transition community paramedicine (CP) from the Health Workforce Pilot Project #173 to a statewide program. The bill would authorize LEMSAs to develop a community paramedicine program that is consistent with regulations that would be developed by 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.

The EMS Authority will be submitting a request to extend the HWPP#173 Pilot Project to OSHPD for one more year to seek legislation to authorize community paramedicine projects throughout the state.

Project #	Local EMS Agency	Sponsor	Concepts	Partners	Area	Status
CP 001	Los Angeles County EMS	UCLA	Post Discharge	Glendale Hospital Glendale Fire Department	City of Glendale	Discontinued
CP 002	Los Angeles County EMS	UCLA	Alternate Destination Urgent Care Centers	Glendale Fire Dept Santa Monica Fire Dept	Glendale & Santa Monica	Discontinued
CP 003	Orange County EMS	Orange County Fire Department	Alternate Destination Urgent Care Centers	Fountain Valley Fire Huntington Beach Fire Newport Beach Fire	Fountain Valley, Huntington Beach & Newport Beach	Discontinued
CP 004 Private	SSV EMS Agency	Butte EMS	Post Discharge	Enloe Hospital	Butte County	Active
CP 005 Private	Ventura County EMS Agency	American Medical Response	Hospice Support	Mission Hospice – Ventura	Ventura County	Active
CP 006 Private	Ventura County EMS Agency	American Medical Response	Directly Observed TB Treatment	Ventura County Health Department	Ventura County	Active
CP 007 A Public CP 007 B Public	Alameda County EMS Agency Alameda County EMS Agency	Alameda City Fire Alameda City Fire	Post Discharge Frequent 911 User	Alameda City Hospital Alameda County EMS	Alameda City Alameda City	Active Active
CP 008 Public	ICEMA	San Bernardino Fire Department	Post Discharge	Arrowhead Medical Center	City and County of San Bernardino	Active
CP 010 Public	San Diego EMS Agency	City of San Diego Fire	Frequent 911 User	City of San Diego	City of San Diego	Discontinued
CP 012 Private	Mountain Valley EMS Agency	American Medical Response	Alternate Destination – Behavioral Health	Stanislaus Behavioral Health Department	Stanislaus County	Active
CP 013 Private	Solano County EMS Agency	Medic Ambulance – Solano	Post Discharge	North Bay Medical Center	Solano County	Active
CP 014 Public	City & County of San Francisco EMS Agency	City & County of San Francisco Fire Department	Alternate Destination – Sobering Center	San Francisco Sobering Center	City & County of San Francisco	Active

CP 015 Public	Santa Clara County	Santa Clara County EMS Agency	Alt Destination Behavioral Health Alt Destination Sobering Center	EMS Agency Santa Clara County Behavioral Health Services Gilroy Fire Department Gilroy Police Dept American Medical Response Saint Louise Hospital	City of Gilroy Santa Clara County	Active
CP 016 Private	Sierra Sacramento Valley	Dignity Health	Post Discharge	Dignity Health Home Health American Medical Response Mercy Medical Center Mt. Shasta	Redding Shasta County	Withdrawn
CP 017 Public	El Dorado County	Cal Tahoe JPA	Alt Destination Behavioral Health Post Discharge	Telecare El Dorado County Psychiatric Facility - Placerville Barton Memorial Hospital	Greater South Lake Tahoe area (East El Dorado County)	Withdrawn
CP 018 Public	Los Angeles County EMS Agency	Los Angeles City Fire Department	Alt Destination - Behavioral Health	Exodus Recover Center	City of Los Angeles	Withdrawn
CP 019 Public	Los Angeles County EMS Agency	Los Angeles City Fire Department	Alt Destination – Sobering Center	Dr. L Murphy Sobering Center	City of Los Angeles	Withdrawn
CP 020 Public	Marin County EMS Agency	Marin County EMS Agency	Post Discharge	Marin Community Clinics Marin County Department of Health & Human Services Marin General Hospital Novato Fire Protection District San Rafael Fire Department	Marin	Pending outcome of enabling Legislation
CP 021 Public	City & County of San Francisco	San Francisco Fire Department	Frequent 911 User Alt Destination – Behavioral Health	San Francisco Department of Health San Francisco Department of Homelessness and Supportive Housing	City and County of San Francisco	Pending IRB

CP 022 Private	Central California EMS Agency	Central California EMS Agency American Ambulance	Alt Destination – Behavioral Health	Central California EMS Agency American Ambulance Fresno County Behavioral Health and Public Health Departments	Fresno County	Active

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DATE: September 12, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Sean Trask, Chief
EMS Personnel Division

SUBJECT: Medication Shortages Presentation by EMDAC

RECOMMENDED ACTION:

Receive information regarding medication shortages impacting EMS providers.

FISCAL IMPACT:

EMS providers may incur additional costs associated with tighter medication inventory control and just in time training for alternative medications.

DISCUSSION:

Sixteen of the thirty-two medications in the California paramedic basic and optional scopes of practice are listed as “Currently in Shortage” on the Food and Drug Administration’s (FDA’s) website[1]. Adding to the problem is that hospitals and pharmacies are a higher priority for drug distributors leaving EMS as a low priority.

To mitigate the shortage in opioids in California the Commission on EMS discontinued three ketamine trial studies and recommended it be added to the paramedic local optional scope of practice. Some EMS agencies have received local optional scope approval for other alternative pain medications such as acetaminophen and ketorolac. Unfortunately, ketamine and ketorolac are on the FDA’s “Currently in Shortage” list. Other strategies are to look for alternative medications for the same indications such as epinephrine as a vasopressor to substitute for dopamine which is in short supply.

Background:

Drug shortages pose a significant threat to public health resulting in delaying or denying needed care to patients or prescribing alternative therapies that may be less effective.

[1] https://www.accessdata.fda.gov/scripts/drugshortages/

In most cases, a shortage is preceded by a production disruption (i.e., a discontinuance or interruption in manufacturing). Once a manufacturer experiences a discontinuance or interruption in manufacturing, a shortage will occur if there is no other manufacturer is able to fill the gap in supply, or if other manufacturers cannot increase production quickly enough to make up the loss.

A production disruption can be triggered by several factors, including natural disasters (Hurricanes Harvey, Irma, and Maria) or other unexpected event outside of a manufacturer's control, or a business decision to permanently discontinue production of a drug (e.g., because the product is no longer profitable or is less profitable than other products that could be produced with the limited production capacity available to the firm).

Mitigation:

State Level Responses:

Pennsylvania, Oregon, and Utah have enacted rules for EMS providers to administer medications for up to six months past their expiration date when shortages were documented.

Arizona and Tennessee waive certain medications from their required medication inventories for those medications that are in short supply.

EMS agencies and providers in other states have also implemented various strategies to address medication shortages that include:

1. Active inventory management – focus on medications on the shortage list and be prepared to substitute with alternative medications.
2. Protocol changes – be prepared for a just in time protocol changes for alternative medications to substitute one that is in short supply.
3. Point of care support and education – being prepared to offer education quickly for medication and protocol changes.
4. Packaging (using color coding) – color code medication packages to reduce the possibility of medication errors.
5. Incident management team and action plan – incorporate the Incident Command System as a strategy to mitigate drug shortages.

Next Steps:

The EMS Authority along with our various stakeholder groups will continue to explore strategies to address shortages of medications.

An Overview of EMS Drug Shortages

KEN MILLER MD PHD

SANTA CLARA COUNTY EMS

Drug Shortage Causes for Generic Sterile Injectable Drugs

- Limited number of manufacturers
  - Low profit margin compared to branded drugs
  - Manufacturer consolidation
- Production disruptions
  - Natural disasters (e.g. Hurricane Maria 2017 in Puerto Rico)
  - Pharmaceutical active ingredient/raw material shortage (rare cause)
  - Quality-related failure in finished dosage form (frequent cause)
    - Microbial contamination, metal or glass particulates
  - Delays and capacity problems (frequent cause)
  - Other manufacturers unable to meet demand

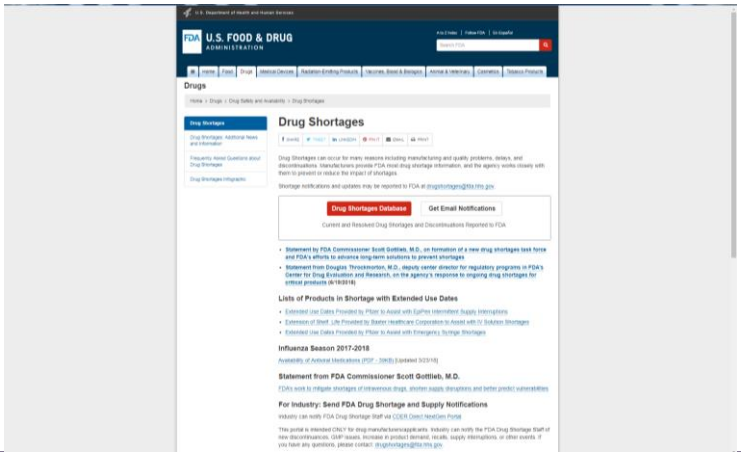
Additional Causes of Shortage Generic Sterile Injectable Drugs

- Regulatory actions
- Insufficient investment in quality
  - Aging production facilities
  - More profitable production opportunities
- Contracting practices
    - Quality management and oversight at contracted manufacturing facilities
    - Overcommitted
- Economic downturn
- Increased price competition

EMS System Mitigation of Drug Shortages

- EMS is a small market for generic sterile injectable drugs with very little direct influence on the greater issue of drug shortages
- Individual solutions are drug specific
- Contracts or purchase orders with multiple distributors
  - Shortages can be both temporal and geographic
  - Maintain a strong relationship with a distributor point of contact

EMS System Mitigation of Drug Shortages



EMS System Mitigation of Drug Shortages: Conserve available inventory

- Redistribute field inventory based upon individual unit utilization history
  - Focus inventory on high utilization units
  - Reduce or eliminate station/post inventory storage
- Reduce par to requirements of policy
- Temporarily reduce par below the requirement of policy
- Patient selection to optimize outcome and reduce less effective use
  - IV saline lock rather than IV fluid infusion for standby venous access or bolus drug therapy
  - Objective, measureable acuity-based parameters
- Optimize non-pharmacologic alternative therapies
  - e.g. non-pharmacologic pain management (splinting, cold packs, position of comfort)

EMS System Mitigation of Drug Shortages: Change presentation

- Change drug presentation (a common mitigation)
  - Single dose vials
  - Multidose vials
  - Prefilled syringes
  - Carpujects™
  - Ampules with filtering needle
  - Orally dissolving tablets (ODT vs. IV ondansetron, olanzaspine)

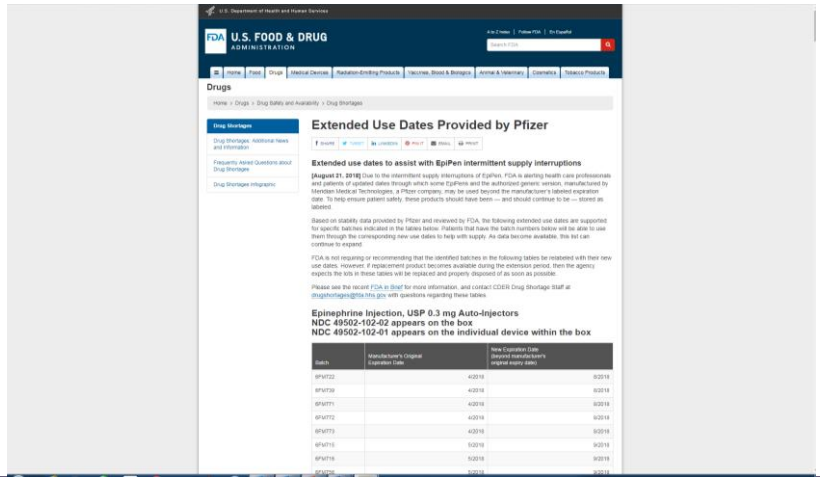
EMS System Mitigation of Drug Shortages: Change concentration

- Change in drug concentration (common mitigation; introduces risk)
  - IM (higher concentration) vs. IV (lower concentration) route of administration
  - Cohort same concentrations on individual units--reducing risk of dosing errors
    - Lower concentration than usual dosage form when possible (may not be)
    - Avoid different concentration on same unit
    - Clear labelling, separate packaging, color differences
    - EMS provider education
    - Proactive monitoring for dosing errors

EMS System Mitigation of Drug Shortages: Expiration date extension

- FDA and manufacturer
  - Specific manufacturer, product, lot number
  - Expiration date extensions can paradoxically contribute to further shortages
- Use of drugs post-expiration date (without FDA authorization)
  - Literature, legalities, ethics, patient disclosure, state law (illegal in FL)
  - A last mitigation if not treating patients is the only remaining option

EMS System Mitigation of Drug Shortages



EMS System Mitigation of Drug Shortages:Drug substitution

- Regulatory limitations
  - State EMS regulations
  - LEMSA LOSOP
- Within a drug class or new drug class
  - 0.9% sodium chloride
    - 250ml, 500ml, 1000ml
    - Ringers lactate, sodium acetate

EMS System Mitigation of Drug Shortages: Drug substitution

- Within a drug class or new drug class
  - Benzodiazepines
  - Vasopressors
    - Dopamine, bolus dose epinephrine, LOSOP norepinephrine
  - Narcotic analgesics
    - Morphine (IM, IV), fentanyl (IM, IN, IV)
  - Non-narcotic analgesics
    - Acetaminophen IV
    - Subdissociative dose ketamine (IV)
    - Ketorolac (IM, IV)
  - Sodium bicarbonate vs. TRIS (tris-hydroxymethyaminomethane)

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DATE: September 12, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Adam Davis
Quality Improvement Coordinator, EMS Systems Division

SUBJECT: EMS Quality Core Measures Guidelines

RECOMMENDED ACTION:

Approval of revisions to EMS Core Quality Measures to accommodate the NEMSIS version 3 data standard.

FISCAL IMPACT:

None

DISCUSSION OF REPORTING:

EMSA has revised the Core Quality Measures program to accommodate the NEMSIS Version 3 data standard. EMSA convened an ad-hoc workgroup comprised of EMS stakeholders to enhance the existing Core Quality Measure set. This group, which met on November 2, 2017, reviewed each of the California Core Quality Measures as well as those developed through the National Association of State EMS Officials (NASEMSO) EMS Compass Initiative. The recommendations from the ad-hoc group were discussed and reviewed by the Core Measures Task Force on November 28, 2017.

EMSA took the recommendations of these workgroups and retired some measures while also incorporating some nationally recommended measures from the NASEMO, EMS Compass Project. This effort yielded a set of 16 indicators for system-wide measurement utilizing the NEMSIS version 3 data dictionary. As of August 1, 2018, 19 of 33 LEMSAs have submitted Core Quality Measures data for the 2017 calendar year.

EMSA will solicit feedback on the revised Core Quality Measures set with the Core Quality Measures Task Force to address comments and recommendations for future improvement. The following chart outlines and identifies the changes to NEMSIS version 2 measures, versus NEMSIS version 3 measures:

Previous "NEMSIS 2" Set (20 Measures) **Updated "NEMSIS 3" Set (16 Measures)**

DETAILED SUMMARY OF CHANGES

NEMSIS v.2 California Core Measure Set			NEMSIS v.3 California Core Measure Set	
ID	**Description**	**Status**	**ID** *= EMS Compass Measure	**Description**
TRA-1	Scene time for trauma patients	Same-Updated for v.3	TRA-1	Scene time for trauma patients
TRA-2	Direct transport to trauma center for trauma patients	Same-Updated to Compass	*TRA-2	Patients meeting CDC Step 1 or 2 or 3 criteria originating from a 911 request who were transported to a trauma center
		New-Added for Compass	*TRA-3	Measurement of patients with a pain scale value present
		New-Added for Compass	*TRA-4	Measurement of patients with two or more pain scale values present
		New-Added for Compass	*TRA-5	Measurement of patients with a decrease in their pain scale compared to initial pain scale
ACS-1	Aspirin administration for chest pain/discomfort	Same-Updated for v.3	ACS-1	Aspirin administration for chest pain/discomfort
ACS-2	12 lead EKG performance	Retired-Replaced w/ ACS-6		
ACS-3	Scene time for suspected heart attack patients	Same-Updated for v.3	ACS-3	Scene time for suspected heart attack patients
		New	ACS-4	Advance hospital notification for suspected STEMI patients
ACS-5	Direct transport to PCI center for suspected ACS patients meeting criteria	Retired		
		New	ACS-6	Time to EKG
CAR-2	Out-of-hospital cardiac arrests return of spontaneous circulation	Retired - Transition to CARES		

CAR-3	Out-of-hospital cardiac arrests survival to emergency department discharge	Retired - Transition to CARES		
CAR-4	Out-of-hospital cardiac arrests survival to hospital discharge	Retired - Transition to CARES		
		New- Added for Compass	*HYP-1	Treatment administered for hypoglycemia
		New- Added for Compass	*STR-1	Suspected Stroke Patient Receiving Prehospital Screening
STR-2	Glucose testing for suspected stroke patients	Same- Updated for v.3	STR-2	Glucose testing for suspected stroke patients
STR-3	Scene time for suspected stroke patients	Retired		
		New	STR-4	Advance hospital notification for suspected stroke patients
STR-5	Direct transport to stroke center for suspected stroke patients meeting criteria	Retired		
RES-2	Beta2 agonist administration	Retired		
	Pediatric asthma patients receiving bronchodilators	Retired		
		New- Added for Compass	*PED-3	Pediatric Respiratory Assessment
PAI-1	Pain intervention	Retired		
SKL-1	Endotracheal intubation success rate	Retired		
SKL-2	End-tidal CO2 performed on any endotracheal intubation	Retired		
RST-1	Ambulance response time by ambulance zone (Emergency)	Retired		
RST-2	Ambulance response time by ambulance zone (Non-Emergency)	Retired		
RST-3	Transport of patients to hospital	Retired		
		New- Added for Compass	*RST-4	Rate of emergency lights and sirens responses to include each vehicle responding to an incident
		New- Added for Compass	*RST-5	Rate of emergency lights and sirens transports to include each vehicle transporting from incidents with one or more patients

California EMS System Core Quality Measures Updated for NEMSIS Version 3 Data Standard

Emergency Medical Services Authority
California Health and Human Services Agency

EMSA #166 - Appendix E (7th Edition)
EMS System Quality Improvement Program Guidelines

HOWARD BACKER, MD, MPH, FACEP
DIRECTOR

DANIEL R. SMILEY
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CHIEF, EMS SYSTEMS DIVISION

EMSA #166 – Appendix E
Released – January 2013 (1st Edition)
Updated – January 2014 (2nd Edition)
Updated – January 2015 (3rd Edition)
Updated – January 2016 (4th Edition)
Updated – January 2017 (5th Edition)
Updated – February 2018 (6th Edition)
Updated – August 2018 (7th Edition)

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EMS System Core Quality Measures Project

Core Quality Measures Specification Sheets

STATUTORY AUTHORITY

The California EMS Authority (EMSA or authority) is charged with creating a “statewide system for emergency medical services” and the responsibility for the “coordination and integration of all state activities concerning emergency medical services (HS 1797.1)”. Moreover, the authority is required to assess each EMS area or the system’s service area, utilizing regional and local information, for “the purpose of determining the need for additional emergency medical services, coordination of emergency medical services and the effectiveness of emergency medical services” (HS1797.102). Local EMS agencies are required to plan, implement, and evaluate an EMS system (HS 1797.204).

Health and Safety Code 1797.103 identifies one of the required elements of an EMS system as data collection and evaluation. Additionally, the development of quality improvement guidelines must be established (HS 1797.174). As a result of this statutory mandate, EMSA has developed regulations requiring the system data collection and evaluation of prehospital care reports (CCR, Title 22, Division 9, Chapter 4, Section 100147, 100169, 100170).

Additionally, EMS system quality improvement regulations have been established (CCR, Title 22, Division 9, Chapter 12) that define the requirements for local EMS agencies, EMS service providers, and base hospitals in their role as part of the EMS system. These requirements include, but are not limited to, the implementation of an EMS Quality Improvement program (EMS QI) and the use of defined indicators to assess the local EMS system as found in EMSA #166, Appendix E. EMSA’s aim with the Core Quality Measures Project is to develop appropriate indicators to reflect on-going LEMSA efforts at quality improvement aimed at clinical and transport activities that are reflective of Quality Improvement activities at the local level.

To evaluate system impact on patients, the continuum of care from dispatch to pre-hospital to hospital disposition must be connected. In addition, we need to report on performance measures such as those included in Core Quality Measures. By using the data we can begin to understand how care provided by EMS personnel translates to improved outcomes and system effectiveness.

PROJECT HISTORY

The purpose of the EMS system Core Quality Measures project is to increase the accessibility and accuracy of pre-hospital data for public, policy, academic and research purposes to facilitate EMS system evaluation and improvement. This program was originally developed in 2012 through a grant from the California Health Care Foundation (CHCF). Ultimately, the project highlights opportunities to improve the quality of patient care delivered within an EMS system.

During the 1 year period, from July 31, 2013 to June 30, 2014, The California EMS Authority (EMSA) performed the following activities to deliver a set of publicly available data reports:

1. Created a formal data system profile and written analysis to identify areas for data quality improvement and inform an action plan to address the issues.

2. Worked to reveal opportunities for both short-term and long-term data improvement plans.

3. Focused on achieving reliable measures that are high value and feasible within a short-term time frame.

4. Refined and published Core Quality Measure sets that describe the coordination and effectiveness of EMS utilizing regional and local information for California. This project focuses on the following Core Quality Measures sets:

    - Trauma
    - Acute Coronary Syndrome/Heart Attack
    - Cardiac Arrest
    - Stroke
    - Respiratory
    - Pain Intervention
    - Pediatric
    - Skill Performance by EMS Providers
    - EMS Response and Transport
    - Public Education Bystander CPR

5. Conducted data workshops for local EMS agencies across the state to implement improved data collection and reporting practices with those Local EMS Agencies who participate in California Emergency Medical Services Information System.

EMSA has continued to utilize the EMS system Core Quality Measures project to collect information on an annual basis (calendar year 2012, 2013, 2014, 2015, 2016, 2017) while maintaining similar direction and goals to the objectives stated above.

WHAT ARE CORE QUALITY MEASURES?

Core Quality Measures are a set of standardized performance measures that are intended to examine an EMS system or treatment of an identified patient condition.

CORE QUALITY MEASURES DEFINITION

The California Core Quality Measures are about processes and interventions that have some evidence of patient benefit for a condition or illness. These measures help emergency medical services systems improve the quality of patient care. Measure benchmarks include the following: the performance of EMS systems, performance of recommended treatments determined to get the best results for patients with certain medical conditions and transport of patients to the most appropriate hospital. The data most closely focused on system performance is contained in the following data pieces:

- Arrival at the scene in a timely manner;
- Timely, focused patient assessment;
- Delivery of time-sensitive pre-hospital therapy; and
- Transport to a hospital capable of providing necessary care

Information about these treatments is taken from the pre-hospital care reports.

DEMONSTRATING PERFORMANCE

The preliminary California EMS Core Quality Measures were derived largely from a set of quality indicators developed through a project by the National Quality Forum and the National Association of State EMS Officials (NASEMSO) EMS Compass Project. Emergency medical services systems across the state are measured on their performance in these Core Quality Measures and can compare their results to other similar LEMSAs. There is a delay between when data are reported from EMS systems and when they are available for review because EMSA allows time for data to be compiled before it posts quality data for a given period. EMS providers can utilize these Core Quality Measures to assist in quality assurance and continuous quality improvement activities.

CORE QUALITY MEASURES PURPOSE

The primary purpose of the Core Quality Measures Project is to develop a mechanism to reflect as accurately as possible the local EMS activity so that EMSA can better fulfill its obligation to assess the effectiveness of emergency medical services and provide quality improvement information. The collection of the 16 clinical measures and those selected by the Core Quality Measures Task Force provide the best mechanism for EMSA to do this. The data will become even more useful when all LEMSAs in California participate fully in the project. EMSA looks forward to more robust project participation.

EMSA has made data quality and analysis a priority over the past 4 years and has recently formed a data advisory group consisting of representatives from local EMS

agency administrators and medical directors to help determine a cooperative strategy for improving EMS data and enhancing data quality efforts.

ESSENTIAL ELEMENTS

The table below lists all 27 essential elements found in this instruction manual. Each element plays a vital role in the ability to collect and report the California Core Quality Measures. EMS providers and LEMSAs should ensure that these elements are appropriately captured and populated in every patient care record.

Element Description	Element Name
Incident/Patient Disposition	eDisposition.12
Additional Transport Mode Descriptors	eDisposition.18
Hospital Capability	eDisposition.23
Destination Team Pre-Arrival Alert or Activation	eDisposition.24
Date/Time of Destination Prearrival Alert or Activation	eDisposition.25
Mechanism of Injury	eInjury.02
Trauma Center Criteria	eInjury.03
Vehicular, Pedestrian, or Other Injury Risk Factor	eInjury.04
Medication Given	eMedications.03
Patient Age	ePatient.15
Date/Time Procedure Performed	eProcedure.01
Procedure	eProcedure.03
Patient Care Report Number	eRecord.01
Type of Service Requested	eResponse.05
Additional Response Mode Descriptors	eResponse.24
Possible Injury	eSituation.02
Provider Primary Impression	eSituation.11
Provider Secondary Impression	eSituation.12
Arrived at Patient Date/Time	eTimes.07
Unit Left Scene Date/Time	eTimes.09
Cardiac Rhythm / Electrocardiography (ECG)	eVitals.03
Pulse Oximetry	eVitals.12
Respiratory Rate	eVitals.14
Blood Glucose Level	eVitals.18
Pain Scale Score	eVitals.27
Stroke Scale Score	eVitals.29
Stroke Scale Type	eVitals.30

UPDATES TO CORE QUALITY MEASURES

EMS system Core Quality Measures have been modified to reflect NEMSIS 3 dataset, which is mandatory for the collection of EMS data as of January 1, 2017. EMSA, along with the Core Quality Measures Task Force reviewed each of the measures and enhanced the set using the updated NEMSIS 3 dataset. Additionally, EMSA retired some measures while replacing others with those developed by the National Association of State EMS Officials' EMS Compass Project. In total, the new measure set included in this instruction manual is comprised of 16 indicators. Updates to the California Core Quality Measures set can be found on page 6 and 7.

NEMSIS v.2 California Core Quality Measure Set			NEMSIS v.3 California Core Quality Measure Set		
ID	**Description**	**Status**	**ID** *= EMS Compass Measure	**Description**	CCR Title 22, Division 9, Chapter 12
TRA-1	Scene time for trauma patients	Same-Updated for v.3	TRA-1	Scene time for trauma patients	D: Clinical Care and Patient Outcome
TRA-2	Direct transport to trauma center for trauma patients	Same-Updated to Compass	*TRA-2	Patients meeting CDC Step 1 or 2 or 3 criteria originating from a 911 request who were transported to a trauma center	
		New-Added for Compass	*TRA-3	Measurement of patients with a pain scale value present	
		New-Added for Compass	*TRA-4	Measurement of patients with two or more pain scale values present	
		New-Added for Compass	*TRA-5	Measurement of patients with a decrease in their pain scale compared to initial pain scale	
ACS-1	Aspirin administration for chest pain/discomfort	Same-Updated for v.3	ACS-1	Aspirin administration for chest pain/discomfort	
ACS-2	12 lead EKG performance	Retired-Replaced w/ ACS-6			
ACS-3	Scene time for suspected heart attack patients	Same-Updated for v.3	ACS-3	Scene time for suspected heart attack patients	
		New	ACS-4	Advance hospital notification for suspected STEMI patients	
ACS-5	Direct transport to PCI center for suspected ACS patients meeting criteria	Retired			
		New	ACS-6	Time to EKG	
CAR-2	Out-of-hospital cardiac arrests return of spontaneous circulation	Retired - Transition to CARES			
CAR-3	Out-of-hospital cardiac arrests survival to emergency department discharge	Retired - Transition to CARES			
CAR-4	Out-of-hospital cardiac arrests survival to hospital discharge	Retired - Transition to CARES			

		New-Added for Compass	*HYP-1	Treatment administered for hypoglycemia	
		New-Added for Compass	*STR-1	Suspected Stroke Patient Receiving Prehospital Screening	
STR-2	Glucose testing for suspected stroke patients	Same-Updated for v.3	STR-2	Glucose testing for suspected stroke patients	
STR-3	Scene time for suspected stroke patients	Retired			
		New	STR-4	Advance hospital notification for suspected stroke patients	
STR-5	Direct transport to stroke center for suspected stroke patients meeting criteria	Retired			
RES-2	Beta2 agonist administration	Retired			
PED-1	Pediatric asthma patients receiving bronchodilators	Retired			
		New-Added for Compass	*PED-3	Pediatric Respiratory Assessment	
PAI-1	Pain intervention	Retired			
SKL-1	Endotracheal intubation success rate	Retired			
SKL-2	End-tidal CO2 performed on any endotracheal intubation	Retired			
RST-1	Ambulance response time by ambulance zone (Emergency)	Retired			
RST-2	Ambulance response time by ambulance zone (Non-Emergency)	Retired			
RST-3	Transport of patients to hospital	Retired			
		New-Added for Compass	*RST-4	Rate of emergency lights and sirens responses to include each vehicle responding to an incident	F: Transport and Facilities
		New-Added for Compass	*RST-5	Rate of emergency lights and sirens transports to include each vehicle transporting from incidents with one or more patients	

QUALIFYING DATA FOR NEMSIS VERSION 3 REPORTING

The data for NEMSIS 3 standard was utilized as measurement specifications are designed for NEMSIS 3. For consistency, only data from this version of NEMSIS should be reported to EMSA.

CORE QUALITY MEASURES TASK FORCE

A task force makes recommendations and reviews the Core Quality Measures. The task force consists of key data and quality leaders from local EMS agencies, medical directors, hospitals, and pre-hospital EMS providers that continue to provide clarity and insight into the data elements.

REFERENCE INFORMATION

The California EMS System Core Quality Measures contains various references and coding from other documents. All data elements and values referenced in the Core Quality Measures are coded using NEMSIS. Please refer to the following documents regarding the codes found in each measure:

NEMSIS 3.4.0 Data Dictionary – Updated 7/13/2016
(https://nemsis.org/media/nemsis_v3/release-3.4.0/DataDictionary/PDFHTML/DEMEMS/NEMSISDataDictionary.pdf)

National Association of State EMS Officials – EMS Compass Project
https://www.nasemso.org/Projects/EMSCompass/index.asp

NHTSA: Emergency Medical Services Performance Measures – Updated 12/2009
(www.ems.gov/pdf/811211.pdf)

INSTRUCTIONS FOR RUNNING CORE QUALITY MEASURE REPORTS

Run each Core Quality Measures exactly as specified on each Core Quality Measure specification sheet.

If the Core Quality Measure cannot be run as specified, run the measure based on the intent of the Core Quality Measure according to the question provided in the description box on the specification sheet.

If a Core Quality Measure is run based on intent (as described above), the LEMSA must indicate in the “Measure Run Exactly As Written” column on the reporting spreadsheet and provide the data elements that were used, including all relevant values, as well as inclusion and exclusion criteria, to achieve a value for the Core Quality Measure. This information must be provided when submitting the report to EMSA.

LEGISLATION ENACTED

State legislation is driving changes in EMS data systems related to data quality and data accuracy. Specifically, four bills were enacted in 2015 and became effective January 2016.

- AB 1129 requires each EMS provider to utilize electronic health record systems that are compliant with the "current version of NEMSIS" to collect EMS data;
- AB 503 authorizes a health facility to share patient-identifiable information with EMSA or other appropriate EMS entities for the purposes of addressing quality improvement;
- AB 1223 requires EMSA to adopt standards related to data collection for ambulance patient off-load time; and
- SB 19 requires EMSA to establish a pilot project to be known as the California POLST eRegistry for the purpose of collecting information received from a physician or their designee.

Each of these new laws have some impact on Core Quality Measures reporting, particularly AB 1129 and AB 1223.

Core Quality Measures Specification Sheets

SCENE TIME FOR TRAUMA PATIENTS TRANSPORTED TO A TRAUMA CENTER

MEASURE SET	Trauma	
SET MEASURE ID #	TRA - 1	
PERFORMANCE MEASURE NAME	Scene Time for trauma patients transported to a Trauma Center	
Description	What is the 90th percentile scene time, beginning at the time of patient contact until the patient arrived at a trauma center, for trauma patients, originating from a 911 response?	
Type of Measure	Process	
Reporting Value and Units	Time (Minutes and Seconds)	
Continuous Variable Statement (Population)	Time (in minutes) from time EMS personnel arrival at the patient side until the patient arrives at a trauma center, originating from a 911 Response	
Inclusion Criteria	**Criteria**	**Data Elements**
	• (eInjury.02 = Logical and Present OR • eInjury.03 = 2903001, 2903003, 2903005, 2903007, 2903009, 2903011, 2903013, 2903015, 2903017, 2903019, 2903021 OR • eInjury.04 = 2904001, 2904003, 2904005, 2904007, 2904009, 2904011, 2904013, 2904015) • eResponse.05 = 2205001 “911 Response (Scene)” WHERE eTimes.09 – eTimes.07	• Type of Service Requested (eResponse.05) • Mechanism of Injury (eInjury.02) • Trauma Center Criteria (eInjury.03) • Vehicular, Pedestrian, or Other Injury Risk Factor (eInjury.04) • Arrived at Patient Date/Time (eTimes.07) • Unit Left Scene Date/Time (eTimes.09)
Exclusion Criteria	**Criteria**	**Data Elements**
	eInjury.02 = Not Null, 7701001, 7701003, 7701005	
Indicator Formula Numeric Expression	The formula is the 90th Percentile of the given numbers or distribution in their ascending order.	

Example of Final Reporting Value (number and units)	19 minutes, 34 seconds (19:34)
Sampling	Yes
Aggregation	Yes
Blinded	Yes
Minimum Data Values	30
Data Collection Approach	☐ Retrospective data sources for required data elements include administrative data and pre-hospital care records. ☐ Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.
Suggested Display Format & Frequency	Process control or run chart by month
Suggested Statistical Measures	90th Percentile Measurement. Aggregate measure of central tendency and quantile (fractile) measurement to determine the span of frequency distributions.
Trending Analysis	Yes
Benchmark Analysis	(TBD)

TRANSPORT OF SUSPECTED TRAUMA PATIENTS TO A TRAUMA CENTER

MEASURE SET	Trauma	
SET MEASURE ID #	TRA - 2	
PERFORMANCE MEASURE NAME	Measurement of suspected trauma patients transported to a trauma center	
Description	What percent of suspected trauma patients meeting CDC Step 1 or 2 or 3 criteria were transported to a trauma center?	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	Number of suspected trauma patients meeting CDC Step 1 or 2 or 3 criteria from a 911 response	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	• eInjury.02 = Logical and Present • (eInjury.03 = 2903001, 2903003, 2903005, 2903007, 2903009, 2903011, 2903013, 2903015, 2903017, 2903019, 2903021 **Or** • eInjury.04 = 2904001, 2904003, 2904005, 2904007, 2904009, 2904011, 2904013, 2904015) • eResponse.05 = 2205001 "911 Response (Scene)"	• Type of Service Requested (eResponse.05) • Mechanism of Injury (eInjury.02) • Trauma Center Criteria (eInjury.03) • Vehicular, Pedestrian, or Other Injury Risk Factor (eInjury.04)
Exclusion Criteria	**Criteria**	**Data Elements**
	• eInjury.02 = Not Null, 7701001, 7701003, 7701005	• Mechanism of Injury (eInjury.02)

Numerator Statement (sub-population)	Number of suspected trauma patients meeting CDC Step 1 or 2 or 3 criteria who were transported to a trauma center from a 911 response	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**
	• eDisposition.23 **=** 9908021, 9908023, 9908025, 9908027, 99808025 • eInjury.02 = Logical and Present **OR** • (eInjury.03 = 2903001, 2903003, 2903005, 2903007, 2903009, 2903011, 2903013, 2903015, 2903017, 2903019, 2903021) **OR** • eInjury.04 = 2904001, 2904003, 2904005, 2904007, 2904009, 2904011, 2904013, 2904015) • eResponse.05 = 2205001 “911 Response (Scene)”	• Hospital Capability (eDisposition.23) • Type of Service Requested (eResponse.05) • Mechanism of Injury (eInjury.02) • Trauma Center Criteria (eInjury.03) • Vehicular, Pedestrian, or Other Injury Risk Factor (eInjury.04)
Exclusion Criteria	**Criteria**	**Data Elements**
	eInjury.02 = Not Null, 7701001, 7701003, 7701005	
Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%	

Example of Final Reporting Value (number and units)	15%	
Sampling	No	
Aggregation	Yes	
Blinded	Yes	
Minimum Data Values	30	
Data Collection Approach	• Retrospective data sources for required data elements include administrative data and pre-hospital care records. • Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	

PAIN ASSESSMENT FOR INJURED PATIENTS

MEASURE SET	Trauma	
SET MEASURE ID #	TRA - 3	
PERFORMANCE MEASURE NAME	Pain Assessment for Injured Patients	
Description	What percent of patients received a pain assessment from a 911 response?	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	Number of 911 responses	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 "911 Response (Scene)" • eSituation.02 = 9922005	• Type of Service Requested (eResponse.05) • Possible Injury (eSituation.02)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Numerator Statement (sub-population)	Number of patients who received a pain scale originating from a 911 Request	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 "911 Response (Scene)" • eSituation.02 = 9922005 **AND** • eVitals.27 = Not Null	• Type of Service Requested (eResponse.05) • Pain Scale Score (eVitals.27) • Possible Injury (eSituation.02)
Exclusion Criteria	**Criteria**	**Data Elements**

	eVitals.27 = 8801019, 8801023	• Pain Scale Score (eVitals.27)
Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%	
Example of Final Reporting Value (number and units)	15%	
Sampling	No	
Aggregation	Yes	
Blinded	Yes	
Minimum Data Values	30	
Data Collection Approach	• Retrospective data sources for required data elements include administrative data and pre-hospital care records. • Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	

MULTIPLE PAIN ASSESSMENTS FOR INJURED PATIENTS

MEASURE SET	Trauma	
SET MEASURE ID #	TRA - 4	
PERFORMANCE MEASURE NAME	Multiple Pain Assessments for Injured Patients	
Description	What percent of patients received 2 or more pain scale assessment from a 911 response?	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	Number of patients who received a pain scale from a 911 response	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 "911 Response (Scene)" • eVitals.27 has a value > 0 • eSituation.02 = 9922005	• Type of Service Requested (eResponse.05) • Pain Scale Score (eVitals.27) • Possible Injury (eSituation.02)
Exclusion Criteria	**Criteria**	**Data Elements**
Numerator Statement (sub-population)	Number of patients who received more than one pain scale originating from a 911 response	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**
	Pseudocode as follows: eRecord.01 IN (SELECT * FROM eVitals WHERE e.Vitals.27 = NOT NULL *GROUP BY* eRecord.01 *HAVING* Count(*) >1	• Type of Service Requested (eResponse.05) • Pain Scale Score (eVitals.27) • Possible Injury (eSituation.02) • Patient Care Report Number (eRecord.01)

	) *WHERE* [eSituation.02] = 9922005 AND [eVitals.27] > 0 *WHERE* eResponse.05 = 2205001 “911 Response (Scene)”	
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%	
Example of Final Reporting Value (number and units)	15%	
Sampling	No	
Aggregation	Yes	
Blinded	Yes	
Minimum Data Values	30	
Data Collection Approach	• Retrospective data sources for required data elements include administrative data and pre-hospital care records. • Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	

PAIN RELIEF FOR INJURED PATIENTS

MEASURE SET	Trauma	
SET MEASURE ID #	TRA - 5	
PERFORMANCE MEASURE NAME	Measurement of patients with a decrease in their pain scale compared to initial pain scale	
Description	What percent of patients who received 2 or more pain scale assessments, had a decrease in their pain scale compared to their initial pain scale originating from a 911 response?	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	Number of patients who received two pain scales from a 911 response	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	Pseudocode as follows: eRecord.01 IN (SELECT * FROM eVitals WHERE e.Vitals.27 = NOT NULL GROUP BY eRecord.01 HAVING Count(*) >1) WHERE [eSituation.02] = 9922005 AND [eVitals.27] > 0 WHERE eResponse.05 = 2205001 “911 Response (Scene)”	• Type of Service Requested (eResponse.05) • Pain Scale Score (eVitals.27) • Patient Care Report Number (eRecord.01) • Possible Injury (eSituation.02)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	

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Numerator Statement (sub-population)	Patients with a decrease in their pain scale compared to initial pain scale	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**
	Pseudocode as follows: *MAX*([eVitals.27]) – *LAST*([eVitals.27)] > 0 *WHERE* [eSituation.02] = 9922005 AND [eVitals.27] > 0 and eRecord.01 *IN* (*SELECT* * *FROM* eVitals *WHERE* e.Vitals.27 = NOT NULL *GROUP BY* eRecord.01 *HAVING* count(*) >1) *WHERE* eResponse.05 = 2205001 “911 Response (Scene)”	• Type of Service Requested (eResponse.05) • Pain Scale Score (eVitals.27) • Patient Care Report Number (eRecord.01) • Possible Injury (eSituation.02)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%	
Example of Final Reporting Value (number and units)	15%	
Sampling	No	
Aggregation	Yes	

Blinded	Yes	
Minimum Data Values	30	
Data Collection Approach	• Retrospective data sources for required data elements include administrative data and pre-hospital care records. • Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	

ASPIRIN ADMINISTRATION FOR CHEST PAIN/DISCOMFORT

MEASURE SET	Acute Coronary Syndrome	
SET MEASURE ID #	ACS - 1	
PERFORMANCE MEASURE NAME	Aspirin Administration for Chest Pain/Discomfort	
Description	What percent of patients with chest pain/discomfort were administered aspirin from EMS personnel originating from a 911 response?	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	Number of patients who had a primary or secondary impression of chest pain/discomfort originating from a 911 response.	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 "911 Response (Scene)" • (eSituation.11 = I20.9 "Chest Pain - Suspected Cardiac" OR • eSituation.12 = I20.9 "Chest Pain - Suspected Cardiac")	• Type of Service Requested (eResponse.05) • Provider Primary Impression (eSituation.11) • Provider Secondary Impression (eSituation.12)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Numerator Statement (sub-population)	Number of patients who had a primary or secondary impression of chest pain/discomfort originating from a 911 response who also received aspirin from EMS personnel	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 "911 Response (Scene)" • (eSituation.11 = I20.9 "Chest Pain - Suspected Cardiac" OR	• Type of Service Requested (eResponse.05) • Provider Primary Impression (eSituation.11)

	• eSituation.12 = I20.9 “Chest Pain - Suspected Cardiac”) AND • eMedications.03 = 1191 “Aspirin”	• Provider Secondary Impression (eSituation.12) • Medication Given (eMedications.03)
Exclusion Criteria	**Criteria**	**Data Elements**
	eMedications.03 = 8801001, 8801003, 8801007, 8801009, 8801019, 8801023 “Pertinent Negatives”	• Medication Given (eMedications.03)
Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%	
Example of Final Reporting Value (number and units)	15%	
Sampling	No	
Aggregation	Yes	
Blinded	Yes	
Minimum Data Values	30	
Data Collection Approach	• Retrospective data sources for required data elements include administrative data and pre-hospital care records. • Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	

SCENE TIME FOR STEMI PATIENTS

MEASURE SET	Acute Coronary Syndrome	
SET MEASURE ID #	ACS - 3	
PERFORMANCE MEASURE NAME	Scene Time for STEMI Patients	
Description	For STEMI patients, what is the 90th Percentile scene time originating from a 911 Response?	
Type of Measure	Process	
Reporting Value and Units	Time (Minutes)	
Continuous Variable Statement (Population)	Time (in minutes) from time EMS personnel arrival at the patient side until the patient arrives at a STEMI center, originating from a 911 response	
Inclusion Criteria	**Criteria**	**Data Elements**
	• eResponse.05 = 2205001 "911 Response (Scene)" • eProcedure.01 = Not Null • eProcedure.03 = 268400002 "12 Lead ECG Obtained" • eVitals.03 = 9901051, 9901053, 9901055, 9901057 "STEMI Anterior Ischemia, STEMI Inferior Ischemia, STEMI Lateral Ischemia, STEMI Posterior Ischemia" • eTimes.07 = Logical and Present • eTimes.09 = Logical and Present • eResponse.05 = 2205001 "911 Response (Scene)") WHERE eTimes.09 – eTimes.07	• Type of Service Requested (eResponse.05) • Date/Time Procedure Performed (eProcedure.01) • Procedure (eProcedure.03) • Cardiac Rhythm / Electrocardiography (ECG) (eVitals.03) • Arrived at Patient Date/Time (eTimes.07) • Unit Left Scene Date/Time (eTimes.09)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Indicator Formula Numeric Expression	The formula is the 90th Percentile of the given numbers or distribution in their ascending order.	

Example of Final Reporting Value (number and units)	19 minutes, 34 seconds (19:34)
Sampling	Yes
Aggregation	Yes
Blinded	Yes
Minimum Data Values	30
Data Collection Approach	☐ Retrospective data sources for required data elements include administrative data and pre-hospital care records. ☐ Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.
Suggested Display Format & Frequency	Process control or run chart by month
Suggested Statistical Measures	90^{th} Percentile Measurement. Aggregate measure of central tendency and quantile (fractile) measurement to determine the span of frequency distributions.
Trending Analysis	Yes
Benchmark Analysis	(TBD)

ADVANCED HOSPITAL NOTIFICATION FOR STEMI PATIENTS

MEASURE SET	Acute Coronary Syndrome	
SET MEASURE ID #	ACS - 4	
PERFORMANCE MEASURE NAME	Advance Hospital Notification for STEMI Patients	
Description	What percent of STEMI patients transported by ground ambulance included an advance hospital notification or pre-arrival alert?	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	Number of patients who received a 12 Lead ECG and yielded a positive STEMI measurement.	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 “911 Response (Scene)” • eProcedure.01 = Not Null • eProcedure.03 = 268400002 “12 Lead ECG Obtained” • eVitals.03 = 9901051, 9901053, 9901055, 9901057 “STEMI Anterior Ischemia, STEMI Inferior Ischemia, STEMI Lateral Ischemia, STEMI Posterior Ischemia”	• Type of Service Requested (eResponse.05) • Date/Time Procedure Performed (eProcedure.01) • Procedure (eProcedure.03) • Cardiac Rhythm / Electrocardiography (ECG) (eVitals.03)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Numerator Statement (sub-population)	Number of patients who received a 12 Lead ECG and yielded a positive STEMI measurement which resulted in a documented advance hospital notification or pre-arrival alert	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**

	All events where: • eResponse.05 = 2205001 “911 Response (Scene)” • **(**eSituation.11 = I20.9 “Chest Pain - Suspected Cardiac” **OR** • eSituation.12 = I20.9 “Chest Pain - Suspected Cardiac”**)** **AND** • (eDisposition.24 = 4224013 “Yes-STEMI” **OR** • eDisposition.25 = NOT NULL)	• Type of Service Requested (eResponse.05) • Date/Time Procedure Performed (eProcedure.01) • Procedure (eProcedure.03) • Cardiac Rhythm / Electrocardiography (ECG) (eVitals.03) • Destination Team Pre-Arrival Alert or Activation (eDisposition.24) • Date/Time of Destination Prearrival Alert or Activation (eDisposition.25)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%	
Example of Final Reporting Value (number and units)	15%	
Sampling	No	
Aggregation	Yes	
Blinded	Yes	
Minimum Data Values	30	

TIME TO EKG

MEASURE SET	Acute Coronary Syndrome	
SET MEASURE ID #	ACS - 6	
PERFORMANCE MEASURE NAME	Time to EKG	
Description	For STEMI patients, what amount of time, reported at the 90th percentile, transpired from EMS personnel arrival on scene until an EKG measurement with a positive STEMI was recorded?	
Type of Measure	Process	
Reporting Value and Units	Time (Minutes and Seconds)	
Continuous Variable Statement (Population)	Time (in minutes and seconds) from time EMS personnel arrived at the patient side until an EKG was applied, originating from a 911 Response	
Inclusion Criteria	**Criteria**	**Data Elements**
	• (eSituation.11 = I20.9 "Chest Pain - Suspected Cardiac" OR • eSituation.12 = I20.9 "Chest Pain - Suspected Cardiac") • eMedications.03 = 1191 "Aspirin" • (eProcedure.03 = 268400002 "12 Lead ECG Obtained" AND • eVitals.03 = 9901051, 9901053, 9901055, 9901057 "STEMI Anterior Ischemia, STEMI Inferior Ischemia, STEMI Lateral Ischemia, STEMI Posterior Ischemia") • eResponse.05 = 2205001 "911 Response (Scene)" WHERE eProcedure.01 - eTimes.07	• Type of Service Requested (eResponse.05) • Provider Primary Impression (eSituation.11) • Provider Secondary Impression (eSituation.12) • Medication Given (eMedication.03) • Procedure (eProcedure.03) • Date/Time Procedure Performed (eProcedure.01) • Arrived at Patient Date/Time (eTimes.07)
Exclusion Criteria	**Criteria**	**Data Elements**
	eMedications.03 = 8801001, 8801003, 8801007, 8801009,	

	8801019, 8801023 “Pertinent Negatives”	
Indicator Formula Numeric Expression	The formula is the 90th Percentile of the given numbers or distribution in their ascending order.	
Example of Final Reporting Value (number and units)	19 minutes, 34 seconds (19:34)	
Sampling	Yes	
Aggregation	Yes	
Blinded	Yes	
Minimum Data Values	30	
Data Collection Approach	☐ Retrospective data sources for required data elements include administrative data and pre-hospital care records. ☐ Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	
Suggested Display Format & Frequency	Process control or run chart by month	
Suggested Statistical Measures	90th Percentile Measurement. Aggregate measure of central tendency and quantile (fractile) measurement to determine the span of frequency distributions.	
Trending Analysis	Yes	
Benchmark Analysis	(TBD)	

TREATMENT ADMINISTERED FOR HYPOGLYCEMIA

MEASURE SET	Hypoglycemia	
SET MEASURE ID #	HYP - 1	
PERFORMANCE MEASURE NAME	Treatment administered for hypoglycemia	
Description	What percent of patients received treatment to correct their hypoglycemia originating from a 911 response?	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	Number of patients with a blood glucose level indicating hypoglycemia	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 "911 Response (Scene)" • eVitals.18 = score/value < 60	• Type of Service Requested (eResponse.05) • Blood Glucose Level (eVitals.18)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Numerator Statement (sub-population)	Number of patients who received treatment to correct their hypoglycemia originating from a 911 response	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 "911 Response (Scene)" • eVitals.18 = score/value < 60 AND • eMedications.03 = 1795480, 1795477, 260258, 309778, 237653, 4832, 377980	• Type of Service Requested (eResponse.05) • Blood Glucose Level (eVitals.18) • Medication Given (eMedications.03)

Exclusion Criteria	**Criteria**	**Data Elements**
	• eMedications.03 = 8801001, 8801003, 8801007, 8801009, 8801019, 8801023 “Pertinent Negatives”	• Medication Given (eMedications.03)
Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%	
Example of Final Reporting Value (number and units)	15%	
Sampling	No	
Aggregation	Yes	
Blinded	Yes	
Minimum Data Values	30	
Data Collection Approach	• Retrospective data sources for required data elements include administrative data and pre-hospital care records. • Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	

PREHOSPITAL SCREENING FOR SUSPECTED STROKE PATIENTS

MEASURE SET	Stroke	
SET MEASURE ID #	STR - 1	
PERFORMANCE MEASURE NAME	Prehospital Screening for Suspected Stroke Patients	
Description	What percent of suspected stroke patients received a prehospital stroke screening originating from a 911 response?	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	Number of patients with a provider primary or secondary impression of stroke	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 “911 Response (Scene)” • (eSituation.11 = I63.9 OR • eSituation.12 = I63.9)	• Type of Service Requested (eResponse.05) • Provider Primary Impression (eSituation.11) • Provider Secondary Impression (eSituation.12)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Numerator Statement (sub-population)	Number of patients with a provider primary or secondary impression of stroke and yielding a documented stroke assessment	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 “911 Response (Scene)” • (eSituation.11 = I63.9 OR • eSituation.12 = I63.9)	• Type of Service Requested (eResponse.05) • Provider Primary Impression (eSituation.11)

	AND • (eVitals.29 = 3329001 “Negative”, 3329003 “Non-Conclusive”, 3329005 “Positive” OR • eVitals.30 = 3330001 “Cincinnati”, 3330003 “Los Angeles”, 3330005 “Massachusetts, 3330007 “Miami Emergency Neurologic Deficit”, 3330009 “NIH”, 3330013 “F.A.S.T. Exam”)	• Provider Secondary Impression (eSituation.12) • Stroke Scale Score (eVitals.29) • Stroke Scale Type (eVitals.30)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%	
Example of Final Reporting Value (number and units)	15%	
Sampling	No	
Aggregation	Yes	
Blinded	Yes	
Minimum Data Values	30	
Data Collection Approach	• Retrospective data sources for required data elements include administrative data and pre-hospital care records. • Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	

GLUCOSE TESTING FOR SUSPECTED STROKE PATIENTS

MEASURE SET	Stroke	
SET MEASURE ID #	STR-2	
PERFORMANCE MEASURE NAME	Glucose Testing for Suspected Stroke patients	
Description	Patients with suspected stroke have assessment of blood glucose level originating from a 911 response	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	All Suspected Stroke patients	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	• eResponse.05 = 2205001 “911 Response (Scene)” • (eSituation.11 = I63.9 “Stroke / CVA / TIA” OR • eSituation.12 = I63.9 “Stroke / CVA / TIA”)	• Type of Service Requested (eResponse.05) • Provider Primary Impression (eSituation.11) • Provider Secondary Impression (eSituation.12)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Numerator Statement (sub-population)	Glucose level checked on all suspected stroke patients	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**
	• eResponse.05 = 2205001 “911 Response (Scene)” • ((eSituation.11 = I63.9 “Stroke / CVA / TIA” OR • eSituation.12 = I63.9 “Stroke / CVA / TIA”) And • eVitals.18 = Logical and Present	• Provider Primary Impression (eSituation.11) • Provider Secondary Impression (eSituation.12) • Procedure (eProcedure.03)
Exclusion Criteria	**Criteria**	**Data Elements**
	eVitals.18 = 7701001, 7701003 “Not Values” eVtials.18 = 8801019, 8801023 “Pertinent Negatives”	• Blood Glucose Level (eVitals.18)

Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%
Example of Final Reporting Value (number and units)	90%
Sampling	Yes
Aggregation	Yes
Blinded	Yes
Minimum Data Values	30
Data Collection Approach	☐ Retrospective data sources for required data elements include administrative data and pre-hospital care records. ☐ Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.
Suggested Display Format & Frequency	Process control or run chart by month
Suggested Statistical Measures	Mean (x); Mode (m)
Trending Analysis	Yes
Benchmark Analysis	(TBD)
Rationale for Data	☐ ☐

ADVANCE HOSPITAL NOTIFICATION FOR STROKE PATIENTS

MEASURE SET	Stroke	
SET MEASURE ID #	STR - 4	
PERFORMANCE MEASURE NAME	Advance Hospital Notification for Stroke Patients	
Description	What percent of stroke patients transported by ground ambulance included an advance hospital notification or pre-arrival alert?	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	Number of patients who received a stroke scale and yielded a positive stroke measurement.	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 "911 Response (Scene)" • eVitals.29 = 3329005 "Positive"	• Type of Service Requested (eResponse.05) • Stroke Scale Score (eVitals.29)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Numerator Statement (sub-population)	Number of patients who received a stroke scale and yielded a positive stroke measurement which resulted in a documented advance hospital notification or pre-arrival alert	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 "911 Response (Scene)" • eVitals.29 = 3329005 "Positive" AND	• Type of Service Requested (eResponse.05) • Stroke Scale Score (eVitals.29) • Destination Team Pre-Arrival Alert or Activation (eDisposition.24) • Date/Time of Destination Pre-Arrival Alert or Activation (eDisposition.25)

	• (eDisposition.24 = 4224015 "Yes-Stroke" OR • eDisposition.25 = NOT NULL)	
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%	
Example of Final Reporting Value (number and units)	15%	
Sampling	No	
Aggregation	Yes	
Blinded	Yes	
Minimum Data Values	30	
Data Collection Approach	• Retrospective data sources for required data elements include administrative data and pre-hospital care records. • Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	

RESPIRATORY ASSESSMENT FOR PEDIATRIC PATIENTS

MEASURE SET	Pediatric	
SET MEASURE ID #	PED - 3	
PERFORMANCE MEASURE NAME	Respiratory Assessment for Pediatric Patients	
Description	What percent of pediatric patients with a provider primary or secondary impression of patients received a documented respiratory assessment originating from a 911 response?	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	Number of pediatric patients with a provider primary or secondary impression of respiratory distress	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 "911 Response (Scene)" • ePatient.15 = <15 "Patient Age" • (eSituation.11 = J98.01 OR • eSituation.12 = J98.01)	• Type of Service Requested (eResponse.05) • Patient Age (ePatient.15) • Provider Primary Impression (eSituation.11) • Provider Secondary Impression (eSituation.12)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Numerator Statement (sub-population)	Number of pediatric patients with a provider primary or secondary impression of respiratory distress and yielding a documented respiratory assessment	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**
	All events where: • eResponse.05 = 2205001 "911 Response (Scene)" • ePatient.15 = <=15 "Patient Age" • (eSituation.11 = J98.01 OR • eSituation.12 = J98.01)	• Type of Service Requested (eResponse.05) • Patient Age (ePatient.15) • Provider Primary Impression (eSituation.11)

	AND • (eVtials.12 = Logical and Present OR • eVitals.14 = Logical and Present)	• Provider Secondary Impression (eSituation.12) • Pulse Oximetry (eVitals.12) • Respiratory Rate (eVitals.14)
Exclusion Criteria	**Criteria**	**Data Elements**
	eVitals.12 = 7701001, 7701003, 8801005, 8801019, 8801023 eVitals.14= 7701001, 7701003, 8801005, 8801019, 8801023	• Pulse Oximetry (eVitals.12) • Respiratory Rate (eVitals.14)
Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%	
Example of Final Reporting Value (number and units)	15%	
Sampling	No	
Aggregation	Yes	
Minimum Data Values	30	
Data Collection Approach	• Retrospective data sources for required data elements include administrative data and pre-hospital care records. • Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	

911 REQUESTS FOR SERVICES THAT INCLUDE A LIGHT AND/OR SIREN RESPONSE

MEASURE SET	Response and Transport	
SET MEASURE ID #	RST - 4	
PERFORMANCE MEASURE NAME	911 requests for services that include a lights and/or siren response	
Description	What percent of 911 requests for services that include a lights and/or siren response?	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	Number of 911 requests for services	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	• eResponse.05 = 2205001 "911 Response (Scene)"	• Type of Service Requested (eResponse.05)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Numerator Statement (sub-population)	Number of 911 requests for services that include a lights and/or siren response	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**
	• eResponse.24 = 2224015, 2224017, 2224021, 2224023 • eResponse.05 = 2205001 "911 Response (Scene)"	• Additional Response Mode Descriptors (eResponse.24) • Type of Service Requested (eResponse.05)

Exclusion Criteria	Criteria	Data Elements
	None	
Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%	
Example of Final Reporting Value (number and units)	15%	
Sampling	No	
Aggregation	Yes	
Blinded	Yes	
Minimum Data Values	30	
Data Collection Approach	• Retrospective data sources for required data elements include administrative data and pre-hospital care records. • Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	

LIGHT AND/OR SIREN TRANSPORT RATE

MEASURE SET	Response and Transport	
SET MEASURE ID #	RST - 5	
PERFORMANCE MEASURE NAME	Lights and/or Siren Transport Rate	
Description	What percent of 911 requests for services that include a lights and/or siren transport?	
Type of Measure	Process	
Reporting Value and Units	(%) Percentage	
Denominator Statement (population)	Number of 911 requests for services which included a patient transport	
Denominator Inclusion Criteria	**Criteria**	**Data Elements**
	• eResponse.05 = 2205001 "911 Response (Scene)" • eDisposition.12 = 4212033 "Patient Treated, Transported by this EMS Unit"	• Type of Service Requested (eResponse.05) • Incident/Patient Disposition (eDisposition.12)
Exclusion Criteria	**Criteria**	**Data Elements**
	None	
Numerator Statement (sub-population)	Number of 911 Requests for services that include a lights and/or siren patient transport	
Numerator Inclusion Criteria	**Criteria**	**Data Elements**
	• eResponse.05 = 2205001 "911 Response (Scene)" • eDisposition.12 = 4212033 "Patient Treated, Transported by this EMS Unit" • eDisposition.18 = 4218011, 4218013, 4218017, 4218019	• Type of Service Requested (eResponse.05) • Incident/Patient Disposition (eDisposition.12) • Additional Transport Mode Descriptors (eDisposition.18)

Exclusion Criteria	Criteria	Data Elements
	None	
Indicator Formula Numeric Expression	The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =%	
Example of Final Reporting Value (number and units)	15%	
Sampling	No	
Aggregation	Yes	
Blinded	Yes	
Minimum Data Values	30	
Data Collection Approach	• Retrospective data sources for required data elements include administrative data and pre-hospital care records. • Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency.	

California EMS System Core Quality Measures

Edmund G. Brown Jr.
Governor
State of California

Michael Wilkening
Secretary
Health and Human Services Agency

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

EMSA Publication #166 – Appendix E
Released January 2013
Updated August 2018
www.emsa.ca.gov

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

DATE: September 12, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Adam Davis
Quality Improvement Coordinator, EMS Systems Division

SUBJECT: Ambulance Patient Offload Time Update

RECOMMENDED ACTION:

Receive information regarding Ambulance Patient Offload Time (APOT).

FISCAL IMPACT:

None

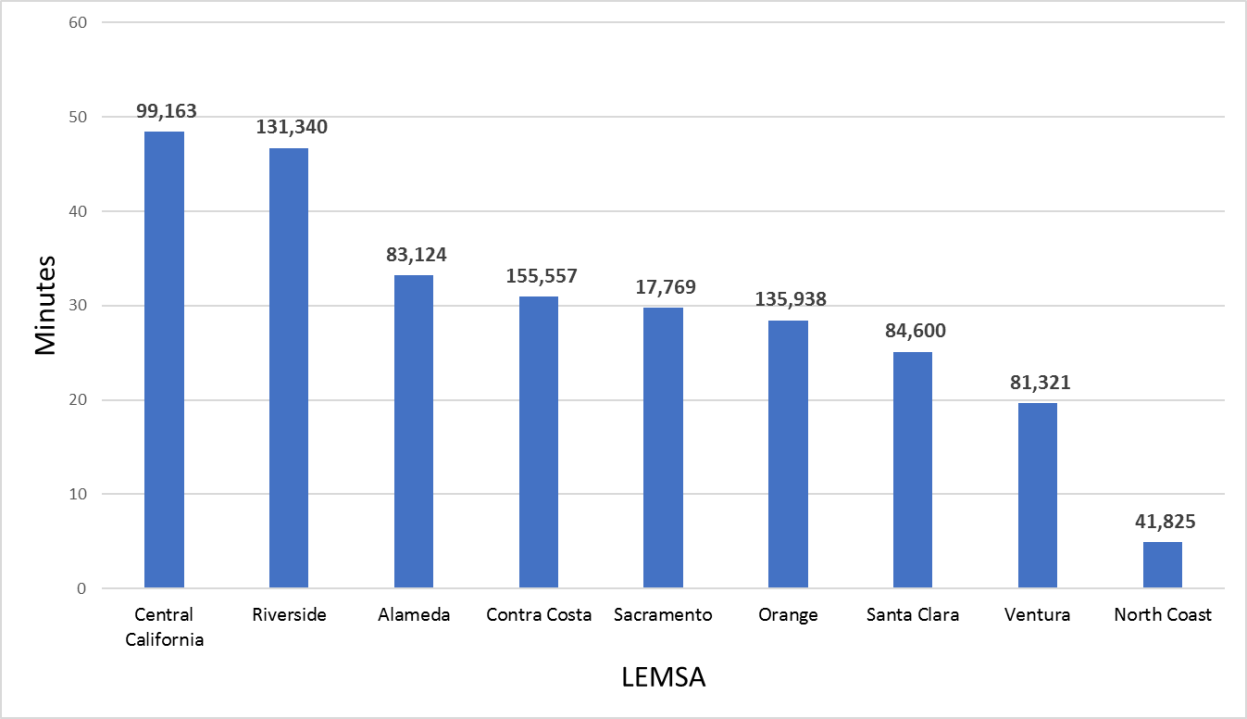
DISCUSSION:

Ambulance Patient Offload Times (APOT) continue to be submitted quarterly to EMSA. To date, 18 of the 33 LEMSAs have provided at least one quarter's worth of APOT data for 2017, while 17 of the 33 LEMSAs have provided at least one quarter's worth of APOT data for 2018. Additionally, 11 LEMSAs provided data for all four quarters of 2017. The 2018 data submitted represents 223 hospitals.

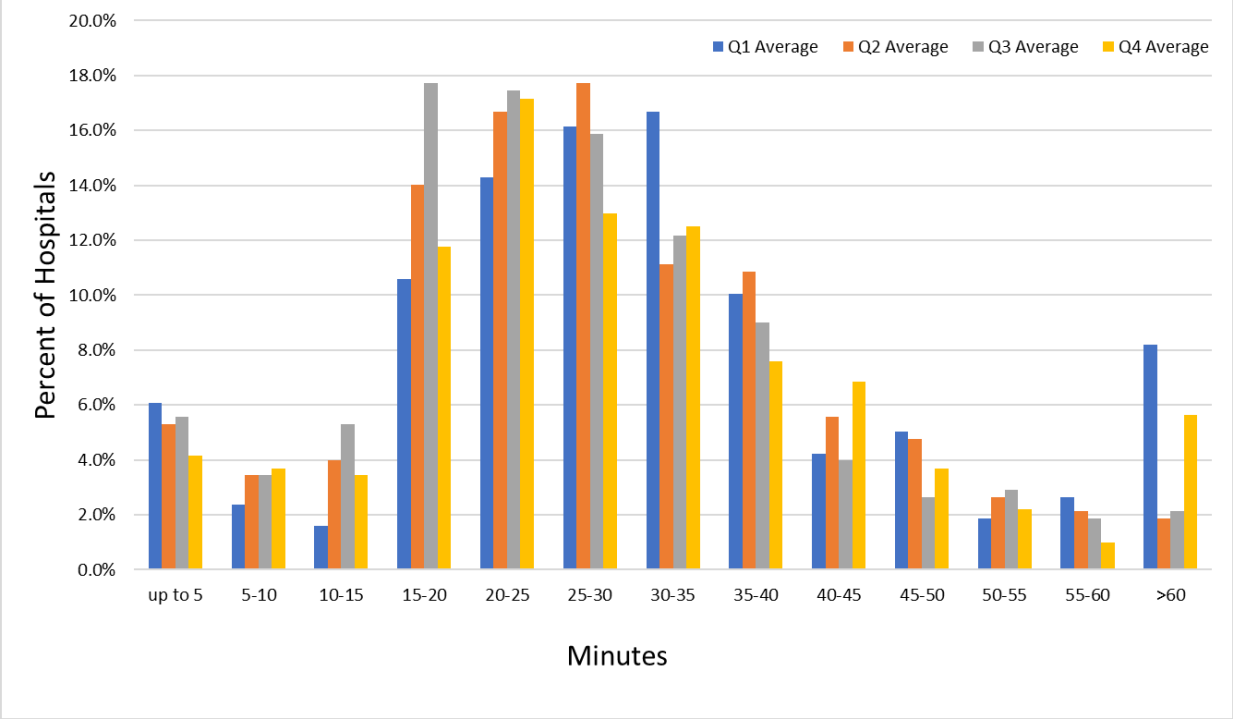
EMSA intends to provide ongoing analysis and report annually on APOT data received. LEMSAs are encouraged to continue quarterly submissions of APOT data to EMSA and continue to monitor and analyze local APOT data to help identify and implement quality improvement where needed.

Dr. Karl Sporer reached out to EMSA to request APOT information for a medical journal submission. EMSA provided analysis from 9 LEMSAs who submitted all four quarters of 2017 data. The paper, titled "Statewide Method of Measuring Ambulance Patient Offload Times," will not identify hospitals. The graphs provided to Dr. Sporer can be found on the following pages:

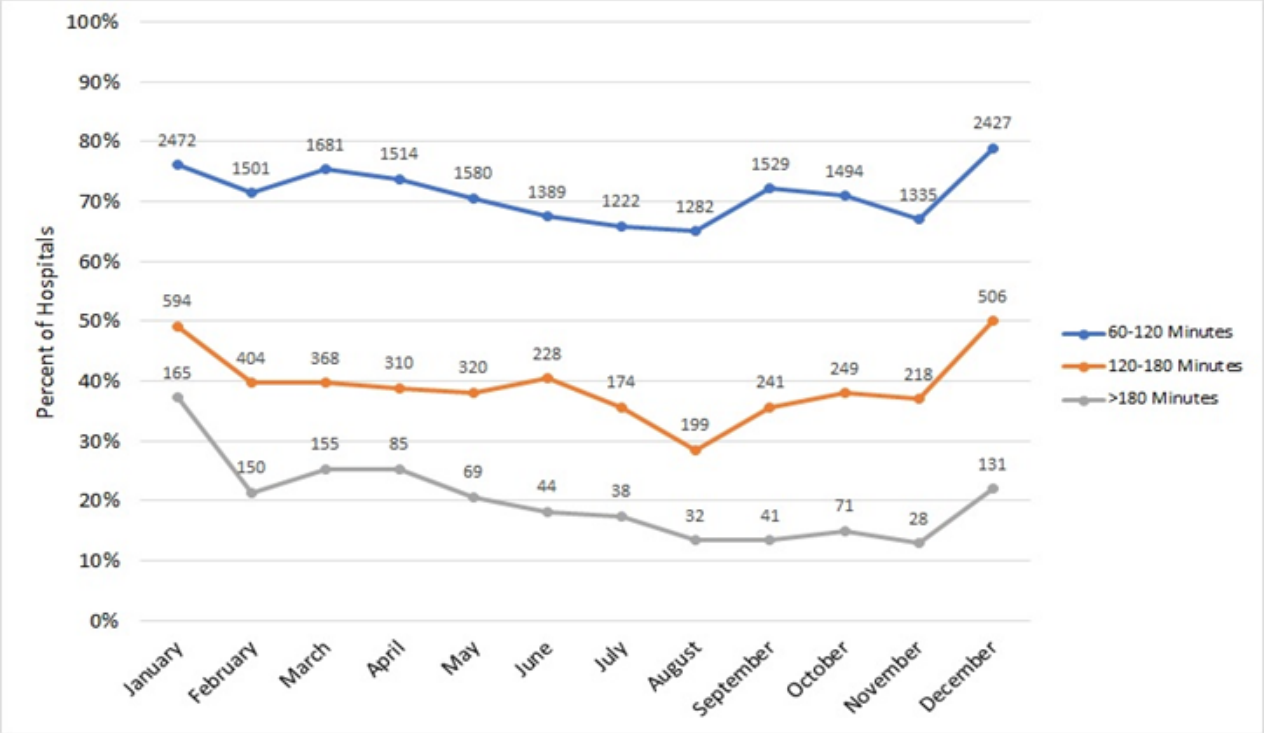
APOT 1 (90th percentile) of offload times by local EMS agency, 2017, with number of runs.



Percent of Hospitals (n=126) in 5 minute intervals for 90th fractile of APOT 1 by quarter for 2017.



Count of runs greater than 1 hour offload delay and percent of hospitals with at least one delay of this length, by month, for 2017.



Total hours of delay greater than 20 minutes and financial cost of APOD by local EMS agency per month and total for 2017. Cost estimate uses an average unit hour cost of $156.

	Alameda	Central California	Contra Costa	Orange	North Coast	Riverside	Sacramento	Santa Clara	Ventura	Monthly Systemwide Cost for Hours of Delay for 2017
Jan	1,884.0	3,922.5	1,302.0	668.0	1,258.5	2,742.5	1,225.5	940.5	147.0	$ 2,198,118
Feb	1,117.5	2,912.5	1,015.5	392.5	972.0	2,492.5	991.5	501.5	161.5	$ 1,646,892
March	1,265.5	3,091.5	1,005.0	482.0	1,147.0	2,887.5	843.5	553.5	161.5	$ 1,784,172
April	1,321.0	2,690.5	1,033.5	602.5	1,108.5	2,566.5	1,000.0	486.5	156.5	$ 1,710,618
May	1,325.0	3,010.0	899.0	440.5	1,125.5	2,521.5	1,423.0	577.0	153.5	$ 1,790,100
June	1,204.0	2,445.0	787.5	332.0	892.0	2,743.0	1,214.5	576.5	129.5	$ 1,610,544
July	1,071.0	2,348.5	807.0	400.0	968.0	2,601.5	961.0	532.0	121.5	$ 1,530,438
Aug	1,027.0	2,349.0	791.0	356.0	923.0	3,085.0	941.0	540.0	102.5	$ 1,577,862
Sept	1,102.5	2,817.5	873.0	359.0	973.5	3,007.5	1,099.5	553.0	103.0	$ 1,698,606
Oct	1,145.5	2,922.5	922.0	361.0	914.0	3,054.0	990.5	541.5	142.5	$ 1,714,986
Nov	1,043.0	2,764.0	919.5	365.0	849.5	2,736.0	954.0	459.5	139.0	$ 1,595,802
Dec	1,398.0	3,396.5	1,408.5	647.5	1,191.5	4,419.5	1,388.5	813.0	232.0	$ 2,323,620
2017 Total Hours	14,904.0	34,670.0	11,763.5	5,406.0	12,323.0	34,857.0	13,032.5	7,074.5	1,750.0	
Cost Totals ($156/hr)	$2,325,024	$ 5,408,520	$ 1,835,106	$843,336	$1,922,388	$5,437,692	$2,033,070	$ 1,103,622	$273,000	$ 21,181,758.00

Current submission status of APOT information for 2018 data.

	2018			
LEMSA	Q1	Q2	Q3	Q4
Alameda	4/2/2018	7/2/2018		
Central California	4/17/2018			
Coastal Valleys				
Contra Costa	4/2/2018	7/3/2018		
El Dorado				
Imperial				
Inland Counties	8/1/2018			
Kern	6/18/2018			
Los Angeles				
Marin				
Merced	7/10/2018	7/10/2018		
Monterey				
Mountain Valley				
Napa				
Northern Cal				
North Coast	6/19/2018			
Orange	4/11/2018	7/23/2018		
Riverside	4/17/2018	7/15/2018		
Sacramento	4/23/2018	7/12/2018		
San Benito		8/8/2018		
San Diego	4/12/2018	7/25/2018		
San Francisco				
San Joaquin	4/20/2018	7/12/2018		
San Luis Obispo				
San Mateo				
Santa Barbara				
Santa Clara	6/20/2018	8/7/2018		
Santa Cruz				
Sierra-Sac Valley	4/16/2018	7/2/2018		
Solano				
Tuolumne				
Ventura	6/19/2018	7/16/2018		
Yolo	5/25/2018			

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

DATE: September 12, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

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

SUBJECT: California Unintentional Injuries Prevention Strategic Plan Project

RECOMMENDED ACTION:

Presentation on California Unintentional Injuries Prevention Strategic Plan Project.

FISCAL IMPACT:

None

DISCUSSION:

EMS Commissioner Steve Barrow will give a brief presentation on the California Unintentional Injuries Prevention Strategic Plan Project.

CA Unintentional Injury Prevention Strategic Plan Project

Overview

for EMS Commission
September 12, 2018

By
EMS Commissioner Barrow,
Project State Co-Chair & Program Director
CA Coalition for Children's Safety and Health
scbarrow88@gmail.com

Goals of this Presentation

Increase EMS Commissioners and EMS Community

- **Big picture knowledge about childhood unintentional injury in CA**
- **Knowledge about what is going on statewide to prevent childhood unintentional injury**
- **Engagement in childhood unintentional injury prevention**

Presentation Overview –

- Project Vision and Goals
- Why Unintentional Injury focused on children and youth
- How project is organized
- Who are the project stakeholders
- Eight leading Unintentional Injury Issue areas of focus
- Why important for EMS Commissioners and EMSA
- Examples of Project activities
  - Traffic, Non-Traffic, Drowning, Suffocation, Poisoning, Falls, Burns and Sports Related unintentional injury
- Outcome measurable metrics and data sources
- Accomplishments
- Where help is needed
- Contact information

Why Unintentional Injury is Focused on Children and Youth
Incident numbers

- According to Center for Disease Control Injury Prevention and California's Dept of Public Health EPICenter
  - Unintentional injuries are the leading cause of death and hospitalizations for children and youth ages 1-19 and leading cause of injury-related death for infants under the age of 1.
  - Between 2003-2013 unintentional injuries caused the death of nearly 10,000 CA children and youth – at a pace of around 1,000 child deaths per year
  - The annual death rate is equivalent to the death of every child in three averaged sized elementary schools each year
  - Every ten years in CA more than 240,000 children and youth are hospitalized, and another 4+ million are sent to the emergency room
  - The annual hospitalization rate is equivalent to sending every child from 65 elementary schools to the hospital every year.

All of this is Preventable

Goals of the Project

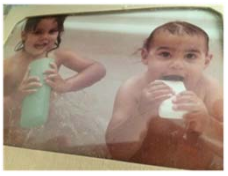
- **Save kids lives** and protect them from harm
- **End unintentional injuries long reign** as leading cause of death and hospitalization for CA's children and youth
- **Elevate unintentional injury back onto the table of important issues** for our policymakers, foundations, media, community leaders and parents
- Create **sustainable collaboration** between not only unintentional injury prevention groups and leaders, but also with organizations working on other important health and well-being of children and youth issues – especially children and youth from underserved communities.

Why Unintentional Injury Project is Focused on Children and Youth
Cost

- Unintentional injuries are a preventable expense to our state's health care system
  - According to California's Dept of Public Health EPICenter data child and youth unintentional injuries costs our state's healthcare system more than $1.6 billion in initial hospital costs 2003-2013
- Brain injuries is the leading severe type of injury
  - A child with a brain injury costs around $5 million in initial hospital costs
- On-going major costs
  - Example: The CA Dept of Developmental Services has more than 700 near-drowning clients, representing one of the leading sources for being a client of DDS
  - Example: One month's institutional care for a child with brain damage due to near drowning is in the $30,000 per month range.
- Unintentional injury annual medical and wage loss cost is $3.4 billion dollars
  - With wage loss associated with parents taking time off work caring for an injured child or to plan a funeral

Why We Do This
Unintentional Injury Prevention Strategic Plan Project

Why We Do This



- **samira and JJ.**

Samira was two years old and JJ just 14 months old the day they slipped through a sliding door and out of sight of their babysitter. A few minutes later the babysitter found both of the children floating face down in the backyard pool. A neighbor helped provide CPR until the fire department arrived. Samira had no life signs and was not able to be resuscitated. JJ had a slight heart beat! He was resuscitated, but too late. JJ's mom recently held a 40th birthday party at the institution where he is cared for. He is the oldest living near-drowning victim cared for by CA's Department of Developmental Services. He has not walked or spoken since that fateful day. Multiple barriers would of kept Samira and JJ from gaining access to the pool and/or warned the sitter they were accessing the pool area.

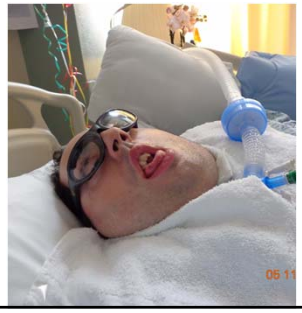
Drowning Prevention Foundation

Samira and JJ Riggsbee/ Ages 2 and 14 months/ Bay Area CA (www.DPF.Org – need DPF

- Backyard pool

Why We Do This

Why we Do This



Why We Do This

nicky.

On Father's Day, June 20, 2010, 5 year old Nicky, his sister, and their friends were playing outside. The older kids got bored and eventually wondered inside to play games and watch a movie. Unknown to Nicky's father, Nicky a neighbor friend went to her house where her mother was asleep. Somehow they ventured past a locked sliding door and a door alarm that was not connected and into the unprotected swimming pool without supervision. After a brief search, Nicky's father knocked on the neighbor's door and the little girl answered the door saying "Nicky went swimming and I think he drowned." He was pulled from the swimming pool by his father after an unknown time in the water. CPR was performed by another neighbor who heard all the screaming for help. First responders transported Nicky to the hospital, but he never regained consciousness. His parents' lives have never been the same.

Nicholas Joseph Norman/ Age 5 /
San Diego CA

- **Backyard pool**

WHY WE DO THIS

JJ's story as a near drowning victim

JJ drowned in a backyard pool alongside his sister Samira when she was 2 and he was 14 months old. JJ survived. Samira did not.

The photo was taken at JJ's 40th birthday party this last May 11, 2017. In the picture with JJ are his Mom, Nadina, and his caregivers. JJ is California's oldest living near-drowning victim under the care of the CA Department of Developmental Services.

According to CA's EPICenter injury data from 2010 to 2014 more than 160 California children ages 1 to 4 died due to drowning. Most of these drowning incidents occurred in backyard pools. For every one drowning fatality there are another 4 to 5 children who drown, but survive, and many of these children have permanent brain damage.

During a five year period, from 2010 to 2015 more than 740 California children aged 1 to 4 years old were hospitalized due to a near-drowning incident. As of December 2016, CA's Department of Developmental Services is currently providing care to 755 near-drowning victims with brain damage.

For the parents and families of children who have suffered a near-drowning caused brain injury, the drowning incident is just the start of a long difficult and expensive journey through hospitalizations, rehabilitation, around the clock care, special education, and other issues that impact the whole family.

For the last 14 years JJ has been institutionalized in a round the clock care facility at a monthly cost of $30,000.

Because of JJ's brain injury due to drowning, JJ's two younger brothers never got to run and play with their older brother.

This is the other side of the drowning story for far too many California children.

Drowning is preventable.

Why We Do This

A survey of more than 4,000 first responders found that 6.6 percent had attempted suicide, which is more than 10 times the rate in the general population, according to a 2015 article published in the Journal of Emergency Medical Services.

Who is Involved, Who are the Project Stakeholders

Project was designed by more than 70 initial stakeholders - Example & partial list of stakeholders:

- Injury prevention and safety groups including by not limited to: Safe Kids International & CA, CA Coalition for Children's Safety and Health, Drowning Prevention Foundation, Children's Safety Network, Safety Belt Safe USA, KidAndCars.org, Impact Teen Drivers, National Safety Council, Advocates for Highway and Auto Safety, etc.
- Children's Hospitals: Los Angeles, Oakland, L. Packard, Central CA, LA, Shriners
- Insurance associations: Assoc CA Life Health Ins Co (ACLHIC), CA Assoc Health Plans, Personal Insurance Federation of CA, CA Health Plan Association
- State agencies: Emergency Med Services Authority, CA Department Public Health Safe and Active Communities, Office of Traffic Safety
- Federal agency: Consumer Product Safety Commission
- Healthcare: American Academy of Pediatricians – CA
- Public Health: Health Officers Association of CA

How the Project is Organized

- Working subcommittees are organized around eight leading causes of Unintentional Injury
- Subcommittee rosters made up of over 50 experienced national, state and local safety experts
- Project housed under 501c3 CA Coalition for Children's Safety and Health (CCCSH)
- Admin and staffing through CCCSH

Project is Focused on Eight leading Unintentional Injury Issues Involving Children and Youth Up Through Age 19

- Traffic related – teen driver safety, safety seats, pedestrian and bicycle
- Non-Traffic vehicle related – kids left in cars, backovers & frontovers
- Poisoning – primarily inappropriate use of prescription meds
- Suffocation – primarily sleep suffocation infants and babies & ingestion small objects
- Drowning – residential pools and open bodies of water
- Burns – primarily home and kitchen fires
- Falls – primarily window fall prevention
- Sports related – concussion, cardiac arrest, spinal injury

How the Project is Organized – Stakeholder Capabilities

Linked to

- National and state **data sources**
- National and state **policy experts** – private and public sectors
- Local and regional **community level safety coalitions**
- State and federal level organizations **experts in legislative process**
- Linked to **experts in coalition building, collaboration, and partnership development**

Why is this statewide unintentional injury prevention project Important to EMS community

- Prevention is one of the EMSA and EMS communities responsibilities
- EMS is in the business of saving lives and keeping children from harm
- Front line first responders are trusted members of the community, and involvement in unintentional injury prevention elevates the integrity of the issue statewide and in our communities
- Running **Code Three is dangerous** – Reducing unintentional injury incidents has a positive impact on the safety of first responders, and the finances of local EMS
- Suicide rate – mental health PTSD impact dealing with childhood death and severe injuries takes a toll on first responders

How can EMS community
Be involved in the UI Prevention statewide project

EMSA continued involvement in the project's leadership team and the eight working subcommittees

LEMSA representatives become formal members of the state level leadership team, and working subcommittees

LEMSA representatives formally participate in **local unintentional injury prevention coalition** – leadership team, strategic planning, fund development, data and evaluation

Current Project Objectives
What the Project is focused on and Is not focused on

The CA Unintentional Injury Prevention Strategic Plan Project is focused on supporting:

- Creation and growth of collaboration and cooperation between organizations, proactive in civic engagement, and advocating for the development of best practice policies, laws, programs and funding that support unintentional injury prevention statewide
- Institutionalize best practices that are proven, effective and can be replicated
- Passage of new and updating existing unintentional injury focused laws based on best practices
- Increase resources to help sustain and grow to capacity local and regional "hands on" safety programs, organizations and projects

The CA Unintentional Injury Prevention Strategic Plan Project was not created to provide hands on local safety and prevention services, unless working with Project stakeholders to support pilot program(s) to test a hypothesis toward advancing unintentional injury prevention

END

Planned EMS Commission Presentation

Questions?

Current Project Objectives
related issue current Priorities — Traffic

- Teen driver safety – Implement national recommendation GDL age change from 18 y/o to 21 y/o – cover 18, 19, and 20 year old new drivers with GDL – 2019 legislation
- Safety Seat Technicians – Create statewide safety seat technician goals and strategic plan, increase number of sustainable certification training courses and number of local safety seat technicians
- Revamp CA's bicycle helmet law citation to be fix-it-ticket rather than only a $197 punitive citation -- allow local law enforcement or other local jurisdiction waive ticket if parent or guardian shows the child has successfully completed a bicycle safety program, and has an appropriate safety helmet to wear
- Increase sustainable support for local and regional school and community-based hands-on bicycle and pedestrian safety programs
- Increase collaboration, cooperation and communications between local and state agencies responsible for road and intersection design, maintenance and revamp, with focus on "hotspots" where multiple vehicle, bicycle and pedestrian crashes occur

Below are examples of the specific actions identified
to help address each of the eight leading causes of unintentional injury

Current Project Objectives
Kids left in cars, backovers and frontovers — Non-Traffic –

- Increase support in underserved communities around non-traffic issues and prevention actions that need to be taken by parents, caregivers, children and community leaders, regarding kids left in cars, backovers and frontovers
- Support development of technologies to help prevent infants and children being left in vehicles (Ex: Congressional bill "Hot Car NHTSA Regulations")
- Increase public awareness regarding backovers and access to affordable rearview vehicle cameras
- Reform incident reporting of kids left in cars, backovers and frontovers, to increase accurate picture of these issues in CA

Current Project Objectives
Drowning prevention

- Implementation of legislation updating CA's 1996 Pool Safety Act law – SB 442 (Newman)
- Ensure drowning prevention concepts are included in school, hospital discharge, parent training, swimming lessons and Pediatrician safety lessons and curriculums
  - Core concepts are: all water comes with risk and understanding water risks; maintain safety barriers on residential pools and spas; ***active adult supervision*** of children around water; and having a strategic safety plan, including rescue, in place before accessing water

Current Project Objectives
Falls Prevention

- The main **child fall focus** is currently on institutionalizing best practice window fall prevention, with a primary focus on multistory residential buildings. The best practice window fall prevention strategy is to institutionalize the New York best practice window fall ordinance onto the California landscape. New York was able to nearly eradicate its child window fall public health problem, reducing fall incidents there by more than 90%.
- Comment on **senior falls**: Falls create one of the largest numbers of unintentional injuries for children and seniors. For children common falls on the same surface are less of a major unintentional injury issue. For seniors common falls can be deadly or a contributor to decline in health. The Project will - where appropriate - support information exchange about senior falls. So many of California's children in underserved communities depend on grandparents/grand uncles, aunts for care, losing these guardians and caregivers impact stability of children's lives.

Current Project Objectives
Suffocation Prevention

- Suffocation prevention is primarily focused on sleep suffocation, which is by far and away the leading cause of suffocation-injury and death to infants and babies in CA
  - Support the development of, refining and defining of the attributes associated with best practice local sleep suffocation prevention programs
  - Increase sustainable support to underpin ongoing access to local best practice sleep suffocation prevention programs
  - Institutionalize sleep suffocation prevention policies and protocols at all California hospitals regarding parent and caregiver sleep suffocation prevention knowledge and support upon the discharge of a baby or infant from the hospital
- Institutionalize suffocation education for parents, caregivers and families about preventing babies, infants and young children from ingesting small objects – working with hospital leadership, child care councils, EMSA primary health and safety training course curriculum review for licensed child care providers

Current Project Objectives
Burns Prevention

A lot has been accomplished over the years in California through building code requirements, technology, state of the art fire departments, and better building materials. There are still too many home and kitchen fires resulting in death and severe injury.

- Re-instate fire department personnel positions in all areas of the state, with an expertise in community engagement, safety, prevention and unintentional injury prevention education
- Ensure all local hands on burn prevention and safety programs have access to free long term (10 year battery) smoke alarms, to install as a priority in homes where children live or are cared for
- Institutionalize safety inspection support and remediation programs for all local housing where children live, deemed to be at risk of fire dangers, including kitchen fire dangers, due to the age, design, kitchen or safety equipment, and status of building maintenance.

Current Project Objectives
Poisoning Prevention

- Support the retention of Poison Control Centers in the CA state and federal budgets
- Institutionalize best practices prescription med drop off policies and protocols for all pharmacies, to prevent children and youth access to unused prescription medication

Current Project Objectives
Sports Related

- Implementation of recently passed sports concussion safety protocols for all community sports programs (AB 2007 Chapter 516 of 2016)
- Institutionalize community-based sports program coaches training and parent and player education about sports related heat stroke, cardiac arrest and spinal injury prevention, and action steps when these unintentional injuries occur.

Outcomes - Measurable Metrics

Examples of outcomes data that can be tracked

There are dozens of types of data that can be tracked with existing data systems. Here are a few examples:

- Number of and types of injuries due to teenage driver involved crashes, and cause of the crash – especially distracted driving underlying causes
- Number of vehicle crashes resulting in death or injury involving children required to be in safety seats
- Number and outcome residential pool and open body of water drownings
- Number of death and injuries due to sleep suffocation
- Number of head injuries associated with bicycle crashes
- Number of burn deaths and injuries due to home and kitchen fires
- Number of poisonings due to misuse of Rx medications
- Number and severity of sports related concussions
- Number of children harmed – fatal and non-fatal - due to being left in vehicles unattended, backover or frontover incidents

Accomplishments To Date (1)

- Launched the project
- Created collaboration of wide array of private and public stakeholders supporting project and specific objectives under the project
- Developed and supported eight working subcommittees to guide project Top Ten Issues action plan
- Provided technical support CA DPH Kids Plate grant program on unintentional injury issues
- Considered a type of national model for moving unintentional injury issues forward at state level
- Project stakeholders are sponsoring legislation addressing: teen driver safety, pool drowning prevention, bicycle helmet law update, window fall prevention, updating Kids Plate Child Health and Safety Fund formula and focus

National Examples of Data Sources

Nationally unintentional injury data sources

- CDC WISQUR http://www.cdc.gov/injury/wisqars/index.html (Web-based Injury Statistics Query and Reporting System)
- Children's Safety Network https://www.childrenssafetynetwork.org/
- KidsSafe
- KidsAndCars.org
- Children's Hosp of Philadelphia Center for Injury Research and Prevention
- Consumer Product Safety Commission
- National Highway Traffic Safety Administration
- Insurance Institute

Accomplishments to Date (continued)

- Development of the Top Ten Issues action plan
- Brought Kids Plates funding back to DPH
- Supported CA DPH Kids Plate grant program, which in the last two years has funded more than $1 million of safety equipment (safety seats, bicycle helmets, smoke alarms and life vests) and statewide effort to strengthen local coalition development
- Set up collaborative statewide initiatives on:
  - Supporting CA Department of Education reinstating age appropriate child safety education in all school districts
  - Developing state strategic plan for optimal level of safety seat technicians
  - Developing project addressing brain injury impact on domestic violence, substance abuse and behavioral health issues

State Examples of Data Sources

State level settings that track detailed unintentional injury data collected from hospitals, first responders and public health community

- CA Dept of Public Health "EPICenter" http://epicenter.cdph.ca.gov/
- CA Highway Patrol SWITRS
- County Health and Public Health Agencies
- CA state and local Child Death review data
- CA Emergency Medical Services Authority Trauma Data and CEMSIS

Questions?

Contact Information

CA Unintentional Injury Prevention Strategic Plan Project

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DATE: September 12, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Craig Johnson
Chief, Disaster Medical Services Division

SUBJECT: Disaster Healthcare Volunteers/Medical Reserve Corps Program Update

RECOMMENDED ACTION:

Receive information regarding the Disaster Healthcare Volunteers (DHV) Program.

FISCAL IMPACT:

None

DISCUSSION:

Disaster Healthcare Volunteers (DHV) is a statewide program administered by the California Emergency Medical Services Authority and operates in coordination with county operational areas to recruit, register, credential, track, identify, deploy, and maintain currently licensed volunteer healthcare professionals for response to emergencies, disasters, and terrorist incidents in California and throughout the nation. The DHV Program is California's model for the federally mandated Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP).

At the local level, DHV volunteers are coordinated by County (Operational Area) Medical/Health DHV System Administrators as well as Medical Reserve Corps (MRC) Unit Coordinators. All DHV volunteer healthcare professionals are local volunteers available to their communities in time of need.

DHV System Administrator training has been provided to all 58 counties as well as 36 MRC Units. Currently there are over 24,041 active volunteers registered on the system. DHV electronically verifies the license and certification status of 49 types of health care professionals every 24 hours via the licensing/certifying department/agency.

Since the last update to the EMS Commission, EMSA DHV Program staff and DHV and MRC volunteers participated in numerous activities and deployments including:

- Statewide MRC Coordinator Workshops, 2017 and 2018
- CAL-MAT USAR Full Scale Exercise, 2018
- Bay Area UASI Shelter Care Workshop, 2018
- Southern California MRC Coordinators Alliance Workshop and Drill, 2017
- Urban Shield Exercise, 2017
- Fleet Week Mobile Medical Demonstrations, 2017
- Continuum of Care Homeless Count Event, 2017
- Vaccination Clinics (Influenza and Hepatitis A), 2017
- First Aid Stations, 2017
- Hospital Replacement Wing Patient Transfer Event, 2017
- Community Fairs, 2017

More significantly, over the past year both County DHV and MRC volunteers were utilized heavily to support the response to the California wildfires that impacted many of our communities.

A total of thirteen DHV and MRC Units deployed 364 volunteers for the 2017 Northern California October Wildfires. The primary response activity was providing medical support for shelter operations and veterinary support.

Two Medical Reserve Corps Units (98 members) deployed during the 2017 December Wildfires in Southern California. The teams provided medical support to shelters, assisted with Point of Distribution (POD) sites distributing N95 Masks and information to the communities, and provided Emergency Operations Center medical hotline support.

During the 2018 Carr and Mendocino Complex Wildfires, approximately 180 DHV and MRC volunteers deployed from multiple regions to support Shasta, Trinity, and Lake Counties for various medical and veterinary missions. The primary medical mission was supporting medical needs in shelters.

A challenge we are facing, considering the recent multi-regional events, is the ability to identify medical staffing availability and deploy quickly to meet urgent requests. We are finding that the existing process for DHV resource requesting needs to be streamlined. EMSA is working with DHV/MRC Unit Coordinators to develop a solution. In addition, EMSA is beginning discussions with stakeholders to better manage the reception and support for volunteers at the deployment sites.

Considering the growing utilization and viability of DHV resources over the past few years, EMSA is making efforts to increase the number of registered volunteers. We have seen a steady slow growth since the program inception but desire to have a much larger resource pool to support California.