

STATE OF CALIFORNIA
COMMISSION ON EMERGENCY MEDICAL SERVICES
December 4, 2019
09:00 A.M. – 11:30 A.M.
(Meeting may end early at the completion of all agenda items)
Marines' Memorial Club and Hotel
609 Sutter Street
San Francisco, CA 94102
(415) 673-6672

- 1. Call to Order and Pledge of Allegiance**
- 2. Review and Approval of September 18, 2019 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. EMS Plan and Critical Care Plans Update

Regular Calendar

- 5. EMS Administration**
 - A. Approval of Paramedic Regulation Revisions
- 6. EMS Personnel**
 - A. Community Paramedicine Pilot Project Status
- 7. Disaster Medical Services Division**
 - A. Ambulance Strike Team Program Update
- 8. Open Nominations for Election of Officers (March 2020 – March 2021)**
- 9. Approval of 2021 Meeting Dates**
- 10. Items for Next Agenda**
- 11. Public Comment**
- 12. Adjournment**

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

**STATE OF CALIFORNIA
COMMISSION ON EMS
Wednesday, September 18, 2019
Holiday Inn Bayside San Diego
4875 North Harbor Drive
San Diego, CA 92106**

MINUTES

COMMISSIONERS PRESENT:

Steve Barrow, Dan Burch, Sean Burrows, James Dunford, M.D., Nancy Gordon, Mark Hartwig, Ken Miller, M.D., Ph.D., Carole Snyder, Brent Stangeland, Jim Suver, Atilla Uner, M.D., Todd Valeri

COMMISSIONERS ABSENT:

Thomas Giandomenico, James Hinsdale, M.D., Daniel Margulies, M.D., Karen Relucio, M.D., Jane Smith

EMS AUTHORITY STAFF PRESENT:

David Duncan, M.D., Daniel R. Smiley, Craig Johnson, Jennifer Lim, Lou Meyer, Sean Trask, Sandra Baker

AUDIENCE PRESENT (partial list):

BJ Bartleson, California Hospital Association
Todd, Klingensmith, California Paramedic Foundation
Kristi Koenig, MD, County of San Diego EMS
Dave Magnino, Sacramento County EMS Agency
Kristin Thompson, Newport Beach Fire Department

1. CALL TO ORDER AND PLEDGE OF ALLEGIANCE

Chair James Dunford, M.D., called the meeting to order at 10:02 a.m. Twelve Commissioners were present. Commissioner Stangeland led the Pledge of Allegiance. Chair Dunford welcomed new appointed EMSA Medical Director David Duncan, M.D. Dr. Duncan introduced himself.

2. REVIEW AND APPROVAL OF JUNE 19, 2019, MINUTES

Commissioner Barrow referred to his comment on page 8 and asked to change “registries do not work until they are mandated” to “registries cannot be fully populated until they are mandated.”

Action: Commissioner Uner made a motion, seconded by Commissioner Snyder, that:
The Commission approves the June 19, 2019, Meeting Minutes as revised.

Motion carried 12 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Barrow, Burrows, Gordon, Hartwig, Miller, Snyder, Stangeland, Suver, Uner, and Valeri, Vice Chair Burch, and Chair Dunford.

3. DIRECTOR’S REPORT

Daniel R. Smiley, EMSA Chief Deputy Director, presented the Director’s Report.

A. EMSA Program Updates

- Objectives to work towards, based on the priorities of the Governor and the Secretary of the California Health and Human Services Agency (CHHS), are the following:
 - To ensure that EMS is connected to local health departments that are working to manage vulnerable populations.
 - To have relevant, timely data and information to support emerging issues.
 - To distribute funding to help build infrastructure to the Health Information Exchange to allow EMS and hospitals to securely exchange electronic patient health care information.
 - This is critical to drive better clinical decisions, improve transitions of care, and ultimately improve outcome data.
 - To support the gradual shift in culture of EMS for improved education and professional development at the clinical, educational, and managerial levels.
- The Paramedic Regulations are included in today’s agenda as an information item only.
 - EMSA recognized the need to provide clarity concerning confusing terminology and differing interpretations on alternate destination in the pre-hospital care setting.
 - The Community Paramedicine Pilot Project Program has been studying the effectiveness of community paramedicine and alternate destinations for mental health and sobering center patients.
 - The Paramedic Regulations are expected to be presented at the December Commission meeting for approval without the alternate destination piece, which requires further discussion.
- Stroke, STEMI, and EMS for Children Regulations have gone into effect since the last Commission meeting. Staff will be working with the local EMS agencies (LEMSAs) to incorporate them into EMS plans.

Questions and Discussion

Commissioner Uner asked how the removal of alternate destination from the Paramedic Regulations will affect current or planned alternate destination projects.

Mr. Smiley stated the Office of Statewide Health Planning and Development (OSHPD) has granted a one-year extension through November of 2020.

Commissioner Suver asked to include the California Hospital Association (CHA) in the alternate destination discussion.

B. Legislative Report

Jennifer Lim, EMSA Deputy Director, Legislative, Regulatory, and External Affairs, summarized the EMSA Legislative Report of the bills currently being tracked and analyzed by staff, which was included in the meeting packet and posted on the website.

4. CONSENT CALENDAR

A. Administrative and Personnel Report

B. Legal Report

C. Enforcement Report

Action: Vice Chair Burch made a motion, seconded by Commissioner Barrow, that:

The Commission approves the Consent Calendar as presented.

Motion carried 12 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Barrow, Burrows, Gordon, Hartwig, Miller, Snyder, Stangeland, Suver, Uner, and Valeri, Vice Chair Burch, and Chair Dunford. The item was noted and filed.

REGULAR CALENDAR

5. PARAMEDIC REGULATIONS REVISION

Sean Trask, Division Chief, EMS Personnel Division, stated the Director’s Report updated the Commission on the Paramedic Regulations Revision. He noted that the Paramedic Regulations are in the fourth 15-day public comment period and are expected to be presented at the December Commission meeting for approval.

Questions and Discussion

Commissioner Uner stated the additional four hours required for tactical medicine can be a burden for private students who pay out-of-pocket or for private or public entities who send them.

Commissioner Barrow respectfully disagreed. He spoke in support of the added training hours and increased fees due to the complicated work.

Public Comment

Kristi Koenig, M.D., EMS Medical Director, San Diego County, and former Commissioner, spoke in support of the new four-hour tactical training requirement. She asked about the anticipated timeline to re-look at adding alternate destination language

into the regulations. Mr. Smiley stated a collaborative solution is expected within this next year to address both the community paramedicine and alternate destination issues.

6. EMS PERSONNEL

A. Community Paramedicine Pilot Project Status Update

Lou Meyer, EMSA Community Paramedicine Project Manager, summarized comments given by OSHPD in their Community Paramedicine Pilot Project extension approval letter.

- No patient safety or non-compliance issues were reported during the past year.
- The extension will allow EMSA to collect additional data, particularly for those community paramedicine sites that have recently become operational.
 - Los Angeles City Fire has two new pilot projects: behavioral health and alternate destination to a sobering center.

The independent evaluator from the University of California San Francisco has filed their fifth public update to the community paramedicine program.

- Findings from the evaluation indicate that California has benefited from these innovative models of health care that leverage an existing work force operating under medical control, either directly or by protocols developed by physicians experienced in EMS and emergency care.
- No health professionals were displaced. The pilot projects have demonstrated that community paramedics can partner with physicians, nurses, behavioral health professionals, and social service workers to fill gaps in the health and social services safety net.
- No adverse patient outcomes are attributable to the pilot projects.

Mr. Meyer stated the pilot projects have answered many questions over the past five years and have added credibility to the work that the field paramedic can do to fill gaps in the health care system of care. The Pilot Project Manager and Independent Evaluator contracts expire on November 30th. The next step, now that the OSHPD approval has been secured, is to ask the California Health Care Foundation to continue the funding.

Questions and Discussion

Commissioner Barrow stated one of the complaints he keeps hearing is that the quality of care for patients is not good and that the data is skewed. This is what policy makers hear. He stated, if there are issues, they should be brought up so they can be corrected.

Mr. Meyer stated, in his forty-plus years of experience in EMS, he has not seen higher scrutiny of patient Electronic Patient Care Reporting (ePCR) charts and the care given to patients. He stated every ePCR is audited and there are high accountability and quality review processes throughout the program.

Commissioner Barrow asked about triggers for community paramedicine use for post-discharge. Mr. Meyer stated it is triggered by the hospital, most often through the post-discharge or the discharge planners.

Public Comment

BJ Bartleson, Vice President, Nursing and Clinical Services, CHA, thanked EMSA and the LEMSAs that have been involved with the Community Paramedicine Pilot Projects. She particularly thanked Mr. Meyer for his continued assistance in helping the CHA better understand the need.

Ms. Bartleson stated the need to publicly challenge the individuals who are criticizing or are concerned about the data and scope of practice. Nurses, physicians, and paramedics are beginning to overlap in the new era of health care. Conversations should be held openly with civility to talk about differences.

Todd Klingensmith, Executive Director, California Paramedic Foundation, expressed his hope and excitement over community paramedicine and how it can lift the profession in new directions. He encouraged the Commission to impact current legislation and to collaborate with legislators and stakeholders to develop guidance with clinical excellence and patient-centric concern for community paramedicine. He stated collaboration is integral to moving the profession forward.

7. EMS SYSTEMS

A. EMS Plan and Critical Care Plans Update

Mr. Smiley stated he will give the report for Tom McGinnis, Chief of the EMS Systems Division, who was unable to be attendance. Mr. Smiley provided an overview of current EMS Plan appeals and LEMSAs plan submissions as of August 12, 2019, which were included in the meeting packet. He stated the Commission will work with the LEMSAs over the next few months to bring them into statutory compliance with the National EMS Information System (NEMSIS) plan submittal format for standardized data.

Questions and Discussion

Chair Dunford asked about the percentage of the LEMSAs that are NEMSIS-compliant. Mr. Smiley stated data is being received from 32 of the 33 LEMSAs. This question is complex; the answer depends on how a provider is defined. He stated he will report on this at the December meeting.

Commissioner Barrow asked for common reasons why counties are overdue and what EMSA is doing to support them. Mr. Smiley stated there are staffing issues in many cases. EMSA assists counties whenever possible. The new Data/CEMSIS Program Coordinator Adrienne Kim is planning to meet with LEMSAs individually to try to better understand the issues and how EMSA can help.

8. DISASTER MEDICAL SERVICES DIVISION

A. Ridgecrest Earthquake Response

Craig Johnson, Chief of the Disaster Medical Services Division, provided an overview of the impacts, successes, and lessons learned from the 6.4 and 7.1 magnitude earthquakes on July 4th and 5th in the Ridgecrest, California area. Governor Newsom declared a state of emergency following the July 4th earthquake. Mr. Johnson stated the cities of Ridgecrest and Trona suffered the most damage, necessitating significant local- and regional-level support and limited state-level support. The EMSA's role in this response was primarily support and coordination. Although the response was effective, communication gaps were seen. Along with improvements in communication, the county is developing training for hospitals on the resource-requesting process and types of resources that are available.

Comments and Discussion

Commissioner Barrow asked for further details on the communication gaps. Mr. Johnson stated communication gaps were seen between coordinators and other individuals at the local and county levels, such as around resource requesting, resource timelines, and utilization of ambulances.

Commissioner Stangeland stated it is important to continue to improve those gaps to break down the communication barriers.

Commissioner Suver stated he is the CEO at Ridgecrest Regional Hospital. He stated his appreciation for Mr. Smiley and his crew whose response was effective, competent, timely, and supportive. Mr. Smiley acknowledged Commissioner Suver for his outstanding leadership and excellent team.

9. STATUS OF EMS GUIDELINES

Mr. Smiley summarized the staff memo on the status update of the EMS Guidelines and the three petitions filed by the California Fire Chiefs Association in February asking for clarification from the Office of Administrative Law, which was included in the meeting packet. These petitions made clear that EMSA needs to clarify what is a best practice, what is a guideline, what is enforceable, and what is a recommendation or a consideration for LEMSAs or providers in developing their systems. These petitions also made clear that guidelines need to be updated and guidelines posted on the website must be Americans with Disabilities Act (ADA) compliant.

Comments and Discussion

Commissioner Burrows stated the need for clear guidance and transparency for innovative system development so that the agencies that are trying to bring forward an effective system into an agency and into a LEMSA are working collaboratively with that LEMSA and the EMSA.

10. ITEMS FOR NEXT AGENDA

Mr. Smiley stated the December meeting is scheduled in San Francisco at 9:00 a.m. and will be followed by an award ceremony.

Commissioner Barrow suggested an update on the Ambulance Patient Offload Time (APOT) at a future meeting.

Commissioner Uner suggested a discussion at a future meeting on the EMSA and LEMSA process when procedures or medications are added to or deleted from the scope of practice for paramedics.

Chair Dunford suggested a presentation at a future meeting about the vulnerabilities of existing EMS technology.

Chair Dunford suggested a presentation about funding from the federal government to the state and ideas from a statewide perspective to deal with the opioid epidemic.

Commissioner Barrow announced a two-day conference on unintentional injury prevention to be scheduled in the fall of 2020.

11. PUBLIC COMMENT

Kristin Thompson, EMS Division Chief, Newport Beach Fire Department, stated the core measures due in September are inaccurate. She gave the example of “trauma,” which measures scene time. The term “scene time” is unclear whether transport time should be included and does not take into consideration extrication or other operational issues with those trauma patients. Also “aspirin for chest pain” should be straightforward but it does not take into consideration contraindications for aspirin. The same for scene time and STEMI patients and with 12-lead acquisition. She cautioned that the ePCR is not an accurate reflection of the patient care that is being delivered by paramedics in the state.

Dave Magnino, Administrator, Sacramento County EMS Agency, spoke as a member of the Muddy Angels, a group of bike riders who ride at five different fundraising-type bike rides throughout the nation to honor the EMS personnel who have given their lives to EMS. The West Coast EMS Memorial Bike Ride is a six-day ride from Reno to San Francisco and is happening at the end of September. He stated anyone who would like to support the bike ride by riding, being one of the support vehicles, or donating to the foundation can go to muddyangels.org.

Mr. Klingensmith stated his excitement about the broad consensus for community paramedicine from all stakeholders. He stated the need for participation to be maximized so that all stakeholders have a role in forming the guidelines for the new community paramedicine programs, that all players be allowed to participate in the development and the governance, and that it would be a transparent process.

12. ADJOURNMENT

Chair Dunford adjourned the meeting at 11:43 a.m.

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
1. Ambulance Strike Team (AST) – Medical Task Force (MTF)	Michael Frenn, ext. 435	<p>Development of a standardized rate schedule for AST reimbursement was facilitated by EMSA's AST Program with assistance from the California Ambulance Association (CAA), American Medical Response (AMR), and the Disaster Subcommittee of the EMS Administrators Association of California (EMSAAC). At its regular meeting in March 2019, EMSAAC formally adopted the rate schedule for utilization statewide. The schedule is being incorporated into the draft statewide Cooperative Assistance Agreement.</p> <p>There has been significant utilization of the AST Program over the past several years, beginning notably with the Oroville Dam Incident, the 2017 North Bay and Southern California wildfires, the 2018 Carr and Mendocino Complex wildfires, the Camp Fire Incident, the Ridgecrest Earthquake, and the Kincadee Fires, in addition to numerous smaller events occurring throughout the State. Lessons learned from these deployments have spurred the EMSA AST Program to reconvene the AST Advisory Committee (which developed the original curriculum) to address needed improvements to the Program, including a refresh of the course materials, development of a communications plan, and incorporating the concept of an Incident Support Team (IST) to assist Operational Areas (OAs) with large-scale deployments. The Committee will operate as a workgroup with tasks divvied out to various members.</p> <p>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 appropriate operational parameters. A key component to this is an electronic review document created via "Formstack" which AST Leaders will complete post-deployment.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>2. California Medical Assistance Teams (CAL-MAT) Program</p>	<p>Michael Frenn, ext. 435</p>	<p>The CAL-MAT Program is modeled after the federal Disaster Medical Assistance Team (DMAT) program and is designed to provide additional capability at the State level to mitigate major medical disaster situations. CAL-MAT had two significant deployments in 2018: The Carr Fire (Shasta County) and the Camp Fire (Butte County). In both situations CAL-MAT was used to provide medical support to shelters housing evacuees. CAL-MAT deployed 135 personnel to the Camp Fire, including personnel from organized Health Care Systems and was activated for nearly three months. Four Units have now been officially “organized” (San Diego, San Francisco Bay Area, Orange County and Sacramento) and a fifth Unit is presently being organized in the Central Valley, which will be based in the Bakersfield area.</p> <p>Two exercises were conducted, one in mid-June in concert with Urban Search and Rescue (USAR); the three-day exercise was at Moffett Field in Sunnyvale. The following month (mid-July), there was another three-day exercise at the Los Alamitos California Army National Guard Joint Forces Training Base.</p> <p>Last spring, CAL-FIRE approached EMSA to provide CAL-MAT response for fire base camp medical support and a 3-year contract was executed with CAL-FIRE in September 2018. CAL-MAT has recently since filled three requests from Cal-Fire: The Red Bank Fire in September, and the Kincade and Ventura County fires in late October, early November. CAL-MAT set up 24/7 operations with nurses, physicians, EMT-Ps, Nurse Practitioners, Physician Assistants and EMT-Is to treat firefighters and vendors in the two base camps. The Kincade fire alone had over 5000 personnel assigned or affiliated with the response.</p> <p>In addition to and simultaneous with the Kincade Fire, a 37-member CAL-MAT was sent to the Marin County Fair Grounds to manage a general population shelter with an initial residency of nearly 500 displaced persons.</p> <p>There are over 170 members in CAL-MAT at present and recruitment efforts continue.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
3. CAL-MAT Cache	Markell Pierce, ext. 1443	After a robust reconstitution by EMSA in early 2019, the three CAL-MAT Caches are resupplied, 100% accounted for, and deployment ready. The diverse caches of medical supplies, biomedical equipment, pharmacy and shelter systems have been reassessed and prepared, with lessons learned from the Camp Fire deployment in mind. Subsequent resupplies will follow the pre-established bi-annual schedule.
4. California Public Health and Medical Emergency Operations Manual (EOM)	Kelly Coleman, ext. 726	<p>CDPH and EMSA have released new content for the California Public Health and Medical Emergency Operations Manual (EOM). The EOM Workgroup, subject matter experts, and many reviewers collaborated to develop the new materials, which include:</p> <ul style="list-style-type: none"> • New chapter on Disaster Behavioral Health • New Resource Typing Tools for Disaster Behavioral Health personnel • New chapter on BioWatch • New chapter on Risk Communication • New chapter on Biological Hazards • New chapter on Drinking Water (updated to reflect movement of Drinking Water Program from CDPH to Cal EPA) <p>The materials are posted on the EMSA website at https://emsa.ca.gov/plans/.</p> <p>The Regional Disaster Medical and Health Specialists (RDMHS) continue to conduct EOM training on an ongoing basis.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
5. California Crisis Care Operations Guidelines	Kelly Coleman, ext. 726	EMSA and CDPH recognize the importance of this guidance document, but development is on hold until funding is made available.
6. Disaster Healthcare Volunteers (DHV) of California (California's ESAR-VHP program): Registering, Credentialing & Mobilizing Health Care Personnel	Todd Frandsen, ext. 4168	<p>The DHV Program has over 25,000 volunteers registered. There are 49 healthcare occupations filled by registered volunteers. Over 9,400 of the 25,000 plus DHV registered responders are Medical Reserve Corps (MRC) members. EMSA trains and supports DHV System Administrators in each of the 35 participating MRC units.</p> <p>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 on a quarterly basis.</p> <p>DHV System Administrator training, DHV user group webinars, and quarterly DHV drills are ongoing. On June 18-19, 2019, EMSA conducted a quarterly DHV drill for System Administrators. There were 19 local DHV county and 13 MRC organizations that participated in this drill. On July 25, 2019, EMSA conducted a quarterly DHV User Group webinar.</p> <p>June 12-14, 2019 DHV MRC Units (9 MRC Units / 28 MRC members) participated in a State CAL-MAT full-scale exercise at Moffett Field with EMSA RPU support.</p> <p>July 17-19, 2019 DHV MRC Units (3 MRC Units / 9 MRC members) participated in a State CAL-MAT full-scale exercise at Los Alamitos with EMSA RPU support.</p> <p>EMSA publishes the "DHV Journal" newsletter for all volunteers on a tri-annual basis. The latest issue was released July 23, 2019. The "DHV Journal" is available on the DHV webpage of the EMSA webpage: https://emsa.ca.gov/disaster-healthcare-volunteers-journal-page.</p> <p>The DHV website is: https://healthcarevolunteers.ca.gov.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
7. Training Weapons of Mass Destruction (WMD) Medical Health Operations Center Support Activities (MHOCSA)	Markell Pierce, ext. 1443 Kelly Coleman, ext. 726	<p>The California Emergency Medical Response to Weapons of Mass Destruction Incidents (with Med-Plus) course is offered on a continuous basis, requiring a minimum enrollment of 12 students. In the first quarter of 2019 three courses taught at Glendora Community Hospital and Desert Valley Medical Center, and Azusa Pacific University.</p> <p>Medical Health Operations Center Support Activities (MHOCSA) Training Classes were conducted in Region IV and Region V in January 2019. Two (2) MHOCSA classes were conducted in May at EMSA Station 1 and Del Norte County, CA. Two (2) additional courses are scheduled for August and September in RII and III.</p>
8. 2019 Statewide Medical and Health Exercise (2019 SWMHE)	Kelly Coleman, ext. 726	<p>The 2019 Statewide Medical and Health Exercise will be hosted November 18 to November 22. This scenario is a local flood scenario. The website https://www.cdph.ca.gov/Programs/EPO/Pages/swmhe.aspx includes customizable templates for counties to use for their exercise. This year, EMSA and CDPH are planning to activate the MHCC to support local exercise play with a focus on Region V.</p>
9. Hospital Available Beds for Emergencies and Disasters (HAvBED)	Kelly Coleman, ext. 726	<p>The United States Health and Human Services discontinued funding the national HAvBED program in 2016. 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.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
10. Hospital Incident Command System (HICS) hics@emsa.ca.gov	Craig Johnson, ext. 4171	<p>The Hospital Incident Command System (HICS) is sponsored by the California Emergency Medical Services Authority (EMSA).</p> <p>EMSA has assembled a HICS National Advisory Committee to assist with activities relating to the HICS Program. The committee members serve as technical advisers on the development, implementation, and maintenance of EMSA's HICS program and activities.</p> <p>The HICS National Advisory Committee will be holding the third quarter meeting on September 12, 2019. The newly formed subcommittees will be reporting on their proposed activities.</p> <p>The Fifth Edition of HICS, Frequently Asked Questions (FAQ), and additional program information are available on the recently revised EMSA website: https://emsa.ca.gov/disaster-medical-services-division-hospital-incident-command-system-resources/.</p>
11. Mission Support Team (MST) System Development	Michael Frenn, ext. 435	<p>Activated by EMSA, the MST functions under the Medical/Health Branch of the Medical Health Coordination Center (MHCC), EMSA Department Operational Center (DOC) or Regional Emergency Operational Center (REOC) depending upon the nature of the event and the origin of the resources it supports. The MST provides the management oversight and logistical support for state deployed medical and health teams that may be assigned to the deployment.</p> <p>EMSA is working to increase participation of CAL-MAT members as Mission Support Team (MST) members. Three field level Mission Support Teams plus an overhead MST operating out of the Department Operations Center in Sacramento were stood up to support CAL-MAT at the Kincade and Ventura County Fires, and the Marin general population shelter.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
12. Response Resources	Markell Pierce, ext. 1443	<p>The Mission Support Team (MST) caches have been completed and refined based on after-action findings from the recent Camp Fire deployment. The California Medical Assistance Teams (CAL-MAT) caches are complete.</p> <p>The Response Resources Unit (RRU) continues to integrate and update IT and telecommunications equipment to improve MST/CAL-MAT networking infrastructure.</p> <p>The RRU is continuing its audits on the 42 Disaster Medical Support Unit (DMSU) vehicles located within the State. During these audits, EMSA is verifying all DMSU vehicles are being properly maintained and utilized according to written Memorandum of Understanding agreements. New audits are in progress, focusing on Regions 1, Region 2, and Region 3.</p> <p>Pharmacy full inventory and replacement of expired items is completed monthly. Two additional CAL-MAT pharmaceutical caches have been created for the Cal-Fire Base of Operations wild fire contract deliverables and are deployment ready.</p>
13. Information Technology	Rick Stricklin, ext. 1445	<p>EMSA continues to address key shortfalls within the EMSA Department Operations Center (DOC). IT & Communications upgrades and response configurations are being implemented to provide full disaster response functionality during activations. EMSA is continuing to design and expand the Meraki system to provide connectivity for data (Cellular, VSAT, wired) and video capabilities during field deployments and incident response.</p> <p>EMSA has enhanced the use of the Mobile Ready Office (MRO) units to support field data operations during field training and incident response. This in conjunction with the use of the ACU-M, interoperability for Radio Over IP Communications, for cross-patching of radio frequencies.</p> <p>EMSA continues to develop new relationships with allied agencies and NGO, to improve radio interoperability. Research and development continue with the C3 communications vehicle to upgrade and implement new technologies to increase its capabilities and functionality in the field.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
14. Mobile Medical Shelter Program (MMSP)	Bill Hartley, ext. 1802	<p>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.</p> <ol style="list-style-type: none"> 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 with further plans to configure into six modules. 2. The EMS Authority has reconfigured the 2nd MFH into six (6) multiuse modules to distribute to local partners. 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, San Mateo and Santa Cruz. We are targeting Northern Sacramento valley for the placement of the sixth module. 3. The third MFH was transferred on September 8, 2016, to the State Military Department for use by the California National Guard. <p>The program was recently utilized during the Camp Fire response to support shelter sites by providing patient isolation shelters to control infectious disease outbreaks.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
15. Regional Disaster Medical/Health Specialists (RDMHS) Program and Medical Mutual Aid System	Jody Durden, ext. 702	<p>The RDMHS program is a critical component of the Medical and Health Disaster Response System. The functions of the RDMHS are to manage and improve the regional medical and health mutual aid and cooperation systems; coordinate medical and health resources; support development of the Operational Area Medical and Health Disaster Response System; and, support the State medical and health response system through the development of information and emergency management systems. The RDMHS' work closely 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 RDMHSs continue to be instrumental in coordination and support of regional major events and disasters as seen with the recent response to the 2019 wildfires and activities related to the Public Safety Power Shutoffs.</p>
16. Medical Reserve Corps (MRC)	Lauran Molina, ext. 466	<p>35 MRC units are in the Disaster Healthcare Volunteers (DHV) System and have trained System Administrators. These MRCs are regular users of the DHV system and active participants in quarterly DHV drills and DHV user group webinars. 9,448 of the 25,000 volunteers are MRC unit members.</p> <p>The 2019 MRC Coordinators Statewide Training Workshop was on May 29th and 30th, 2019. There were 35 MRC Coordinators/designees representing 21 MRC units.</p>
17. Statewide Emergency Plan (SEP) Update	Brad Gates, ext 4728	<p>The California Governor's Office of Emergency Services (Cal OES) released the update 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. A review and rewrite of the ESF8 annex was conducted in 9/2019. The rewrite is in its final review and will be published soon.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
18. Southern California Catastrophic Earthquake Response Plan	Brad Gates, ext. 4728	The California Governor's Office of Emergency Services (Cal OES) is currently leading the refresh 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, Assistant 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. The plan is in its final review with a brief due to Southern California Senior Leadership on 11/13/19 and is set to be published 4/2020
19. Patient Movement Plan	Kelly Coleman, ext. 726	The California Patient Movement Plan has been released and can be found at https://emsa.ca.gov/plans/ . EMSA Plans and Training Unit are now working on socializing the plan and rolling out training statewide for key stakeholders. Executive briefs have been completed in Regions II, III and V. Additional briefs are scheduled for Regions I and VI.
20. Bay Area Catastrophic Earthquake Plan	Kelly Coleman, ext. 726	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	Kelly Coleman, ext. 726	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 is now posted on the Cal OES website.

**Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
1. First Aid Practices for School Bus Drivers	Joseph Bejarano	There are nine (9) School Bus Driver training programs currently approved and no (0) pending reviews. Technical assistance to school staff, school bus drivers, California Highway Patrol, and California Department of Education is ongoing.
2. Child Care Provider First Aid/CPR Training Programs	Joseph Bejarano	There are fifteen (15) approved First Aid/CPR programs. Staff is currently reviewing three (3) program renewal. Technical assistance is being provided to child care training program instructors and directors, licensing staff, child care providers, and other training entities. 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	There are twenty-two (22) preventive health and safety practices training programs approved. There are nine (9) programs in the review process. EMSA Preventive Health sticker sales are ongoing. Technical assistance is provided to the Department of Social Services Community Care Licensing, California Department of Public Health, and California Department of Education. Training standards for the program are being revised.
4. Child Care Training Provider Quality Improvement/Enforcement	Lucy Chaidez	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, Department of Social Services Community Care Licensing, and child care resource and referral staff. Review of rosters as an auditing tool, is ongoing. There are no open complaint cases involving EMSA-approved training programs.
5. Automated External Defibrillator (AED) Requirements for EMT's, Public Safety and Layperson	Austin Trujillo	Ongoing technical support and clarification is provided to public safety agencies, LEMSAs and the general public regarding AED statutes and regulations. There are different requirements for AED programs found in the Public Safety Regulations [Chapter 1.5 Section 100021] and the EMT Regulations [Chapter 2 Section 100063.1]. CAL FIRE, CHP, and State Parks have approved public safety AED programs and approved EMT AED service provider programs. CDCR has a public safety AED program that was approved in July 2019.

**Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
6. BLS Training and Certification Issues	Austin Trujillo	EMSA provides ongoing support and technical assistance to EMTs, AEMTs, prospective EMTs, and 68 Certifying Entities (Garden Grove FD recently merged with Orange County Fire Authority – effective 8/16/19). EMSA continues to assist all certifying entities with questions and clarification on the EMT, AEMT, and Central Registry regulations. EMSA fields calls/questions about enforcement issues, training programs, skills competency verification, new training (i.e. epi, naloxone, glucometer required after first renewal 7/1/19), NREMT examination processes, and Emergency Medical Responders (EMR) options. There are currently no regulations specific to EMR, but program approval and scope for public safety EMRs falls under the Public Safety Regulations, Chapter 1.5. Calls are referred to the appropriate LEMSA for further information.
7. State Public Safety Program Monitoring	Austin Trujillo	EMSA provides ongoing review, approval, and monitoring of EMSA approved Public Safety First Aid/CPR, EMR, EMT and continuing education (CE) programs for statutory and regulatory compliance. The Health Program Specialist I provides support and clarification to LEMSAs and all statewide public safety agencies regarding the Public Safety Regulations and approval requirements. EMSA-approved public safety first aid/CPR courses include POST, CA State Parks, Cal Fire, CHP, and CDCR, some of which include optional skills training. EMSA-approved EMT training programs include: California Joint Apprenticeship Committee (CAL JAC) and CA State Parks. EMSA-approved EMT Refresher programs include CAL FIRE and CHP – both programs include epinephrine auto-injector, naloxone, glucometer, and tactical topics. EMSA approved CE Provider programs include CHP, CAL FIRE, CE Solutions (Burnet, TX) and CDCR.

**Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
8. My License Office/ EMT Central Registry Audit	Betsy Slavensky	EMSA monitors the EMT Central Registry to verify that the 68 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 conducted via email, phone, and at LEMSA Coordinator meetings with certifying entities to share updates, changes and corrections. The Personnel Standards newsletter remains on hold during new staff transition/training. Ongoing development and updates of discipline and certification procedures (found on EMSA's website) support central registry processes and reduce time spent on technical support. Certifying entities work with EMSA staff to find and correct erroneous certifications in the Central Registry. EMSA alerts certifying entities that have missing requirements (such as EMT applications) or need to correct erroneous live scan forms and update DOJ contracts to be compliant with regulation.
9. Epinephrine Auto-injector Training and Certification	Jeffrey Hayes, & Austin Trujillo	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 19 training programs and has issued 1,420 lay rescuer certification cards.
10. Hemostatic Dressings	Lucy Chaidez,	EMSA is responsible for approving hemostatic dressings for use in the prehospital setting. EMSA has approved three (3) hemostatic dressings which are listed on the EMS Authority's web site.
11. Paramedic Licensure	Nicole Mixon	EMSA 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: 290 Initial In-State applications, 31 Initial Out-of-State applications, 2,590 Renewal applications, and 59 Reinstatement applications. Of those applications, 54% (1,608) were received through the new online licensing system that began on March 1, 2019.
13. Administrative Actions Reporting System (AARS)	Nicole Mixon	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 continues to meet bi-weekly to assist in system improvements. User acceptance testing continues.

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
1. Trauma	Elizabeth Winward ext. 460	<p><u>State Trauma Advisory Committee (STAC):</u> The STAC will be meeting on December 11, 2019 by teleconference. Agenda items will include an update on the status of trauma regulations revisions, discussion on the timeline for release of the first annual trauma report, introduction of new STAC members, and the status of the 2020 Trauma Summit program.</p> <p><u>2020 Trauma Summit</u> The 11th annual Trauma Summit will focus on injury prevention and take place May 12-13 at the Holiday Inn San Diego Bayside hotel. Professor Ian Roberts is confirmed to provide presentations on his work with Crash-3, an international, multicenter, randomized, double-blind, placebo-controlled trial to quantify effects of early administration of TXA on patients with traumatic brain injury. EMSA staff will distribute a new "Save the Date" electronic postcard to announce this special guest. David Marcozzi, MD, is confirmed to provide a presentation on Zero Preventable Deaths.</p> <p><u>Annual Trauma Plan Status Updates</u> 29 of 33 LEMSAs have submitted trauma plan status updates within the past 12 months. EMSA staff are sending 60-day written notices to all LEMSAs with overdue trauma plan updates to let them know their trauma system status is in jeopardy unless they provide EMSA with a trauma system status update.</p> <p><u>Trauma Regulations</u> The Regulations Revisions committee continues to meet monthly to collaborate on a draft of regulations revisions by late 2020. A subgroup has formed to determine revisions for certain sections and will provide suggested edits to the larger workgroup on December 17, 2019.</p> <p><u>Regional Trauma Coordinating Committees (RTCC)</u> Each Regional Trauma Coordinating Committee representative provides regional activity updates at the STAC meeting and provides documents approved by the RTCC and available for statewide use. The EMS Authority Trauma Coordinator provided presentations to the SE RTCC, the North RTCC, and the Bay Area RTCC either in-person or via teleconference during August, September, and October quarterly meetings.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
2. STEMI/Stroke Systems of Care	Farid Nasr, ext. 424	<p><u>STEMI and Stroke Programs</u> The EMS Authority is continuing providing technical assistance to LEMSAs working on their plan development for STEMI and Stroke. EMSA has received 15 plans for review as November 11, 2019. The LEMSAs that had a Stroke and/or STEMI program prior to the implementation of the new regulations or are choosing to implement a new Stroke and/or STEMI program have until December 31, 2019 to provide EMSA with their updated plan for these programs.</p> <p>EMSA is working on scheduling the official kick-off meeting for the STEMI and Stroke Technical Advisory Committee sometime after the first of the year. This committee will be made of system stakeholders who can assist EMSA with the implementation of the Stroke and STEMI regulations and systems in the state.</p>
3. EMS Transportation	Laura Little, ext. 412	<p><u>Competitive Processes for Ambulance Zones</u> Competitive Processes for Exclusive Operating Areas continue to go through a review process consistent with Health and Safety Code Section 1797.224, to ensure that they meet Federal and State statutory requirements, that there is no bid rigging, collusion, or bid chilling. EMSA continues to provide technical assistance to LEMSAs in order to help them create a RFP that meets statutes, regulations, and case law.</p> <p><u>EMS Plan Appeals</u> Review past EMS Plan submissions, correspondence, conduct public records requests, further historical documentation to map out the issue under appeal, and attend appeal hearings.</p> <p><u>Complaints/Allegations</u> 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.</p> <p><u>Technical Assistance</u> Technical assistance is provided, via phone, email, or face to face, regarding matters concerning transportation queries.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
4. Poison Center Program	Lisa Galindo, ext. 423	<p>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. Calls are received from the public and health professionals through a toll-free hotline, accessible 24-hours a day, 7 days a week. The CPCS manages more than 200,000 poison cases each year, and 51% of poisonings involve children under age six.</p> <p><u>Budget Change Proposal</u> In July 2019, a Budget Change Proposal was submitted requesting a Local Assistance augmentation to the General Funds received to ensure continued stable funding for day-to-day operations of the CPCS.</p> <p><u>Quarterly Report</u> The Quarterly Report consists of data and narrative reports. The 1st quarter report, July 1, 2019 - September 30, 2019, was received on October 15, 2019. The report is in the process of being reviewed.</p> <p><u>Contract</u> The proposed contract for Fiscal Year 2019/2020 is undergoing review and it is anticipated the contract will be executed in November 2019.</p> <p><u>Site Visits</u> At least one site visit (Fresno or San Francisco) is anticipated to be conducted during Fiscal Year 2019/2020.</p>
5. EMS Plans	Lisa Galindo, ext. 423	<p><u>Review</u> The EMS Authority continues to review EMS Plans/annual updates as they are submitted by Local EMS Agencies (LEMSA). In 2019, ten EMS Plans have been approved. Ten EMS Plans are currently within the EMS Authority for review.</p> <p><u>Technical Assistance</u> Technical assistance is provided to LEMSAs, as needed, on the EMS Plan development and submission process.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
6. EMS for Children Program	Heidi Wilkening, ext. 556	<p><u>Regulations</u> Following the July 1, 2019 effective date of the EMS for Children regulations, the EMS for Children technical advisory committee is continuing to work on an implementation toolkit for the local EMS agencies that choose to have an EMS for Children program in their jurisdiction. The LEMSAs that had an EMSC program prior to the implementation of the new regulations or are choosing to implement a new EMSC program have until December 31, 2019 to provide EMSA with their plan to include EMSC.</p> <p><u>Educational Forum</u> The 22nd Annual EMS for Children Educational Forum was held on Friday, November 8, 2019 in Fairfield, CA. Topics include pediatric trauma, human trafficking, infectious diseases and the recent Camp Fire. We are still currently receiving registrations.</p>
7. CEMSIS Trauma	Elizabeth Winward, ext. 460	<p>There are 27 Local EMS agencies (LEMSA) with designated trauma centers. Trauma Centers are physically located in 38 of the 58 counties. Currently, 2 out of 33 LEMSAs are not transmitting data in some form to CEMSIS. EMSA staff have sent a 60-day request for compliance to submit data.</p> <p>2019 trauma data submissions for quarter 1 have increased but 12 of 27 LEMSAs who have not submitted any 2019 trauma data. EMSA staff are in the process of sending letters to these LEMSAs to request 2019 data submission.</p>
8. CEMSIS RDS I	Victoria Lupinetti, ext. 622	Started the first steps of the pilot project matching trauma and EMS data for patients admitted to UC Davis Medical Center (UCDMC) by partnering with Sacramento County EMS Agency for assistance on data linkage and trauma registrars at UCDMC.

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
9. CEMSIS EMS Data	Ashley Stewart, ext. 910	<p>CEMSIS has 32 LEMSAs participating at some level in the submission of EMS data.</p> <p>As of November 2019, CEMSIS has over 3.7 million records for 2018 and over 3.2 million records for 2019 in Version 3.4. Once the final LEMSA begins submitting data, CEMSIS will have approximately around 6 million records each year.</p> <p><u>Reports</u> The CY 2017 and 2018 Annual EMS Reports are currently developed and is under review.</p> <p>The outline for the CY 2018 Annual Trauma Report is in the process of being developed and drafted.</p>
10. Communications	Heidi Wilkening, ext. 556	<p>EMSA personnel continues to attend various California communications meetings to learn more on public concerns on issues related to NextGen 9-1-1. The Statewide EMS Operations and Communications Manual has been revised and is awaiting EMSA management approval to post on the EMSA website.</p>
11. Core Measures	Adam Davis, ext. 409	<p>EMSA received responses from 23 LEMSAs reporting 2018 Core Measures data. Multiple factors contributed to the limited participation in this year's reporting of Core Measures including updated guidance to strictly adherence to the core measure specifications. It was reported that this cause some confusion and resulted in limited reporting. Some LEMSAs provided detailed feedback on their experience in running the measure set. EMSA is working with LEMSAs to revise the standardized specifications to more accurately measure EMS activities and encourage increased participation in future core measures reporting.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
12. Grant Activity/Coordination/ Maddy EMS Fund report	Lori O'Brien, ext. 401	<p><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 annual Non-competing Continuation Performance Report was submitted on September 16, 2019.</p> <p><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 annual report for the FFY 2019 grant year will be completed and submitted to CDPH on 11/15/2019. Success stories will be completed and submitted on 11/21/2018. EMSA staff remains continually involved in the Preventive Health and Health Services Block Grant.</p> <p><u>Maddy EMS Fund Reporting</u> The report to the Legislature for SFY 16/17 was approved by the California Health and Human Services agency and forwarded to the appropriate members of the Legislature as statutorily required on September 20, 2019. A copy was posted to the EMSA website the same day. The SFY 17/18 Maddy EMS Fund report has been completed and is in the second stage of the review process. After approval by EMSA Executive Staff, it will be forwarded to the California Health and Human Services agency for approval before forwarding to the appropriate members of the Legislature. The SFY 18/19 Maddy EMS Fund reporting template has been updated and approved for posting to the EMSA website.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 4, 2019**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
13. Ambulance Patient Offload Time (APOT)	Adam Davis, ext. 409	<p>On July 17, 2019, EMSA issued a Memo alerting all LEMSAs to the new APOT reporting requirements pursuant to Health and Safety Code 1797.225. In this memo, EMSA called for 2019 Quarter 3 APOT information to be submitted no later than November 1, 2019. As of November 4th, 24 LEMSAs responded, representing 47 of 58 Counties, including information on 279 non-unique Hospitals. EMSA will be reaching out to all non-compliant LEMSAs ensure reporting expectations and requirements are met. EMSA staff is compiling APOT submissions for analysis and reporting to the Commission on EMS. EMSA will be working with each LEMSA to ensure accurate reporting and will be conducting a comparison to APOT information found in CEMSIS.</p> <p>Reporting of 2019 Q4 will be due to EMSA January 31st, 2020.</p>

EMERGENCY MEDICAL SERVICES AUTHORITY

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



DATE: December 4, 2019

TO: Commission on EMS

FROM: Dave Duncan MD
Director

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

SUBJECT: Legislative Report

RECOMMENDED ACTION:

Receive information regarding the 2019 Legislative year affecting EMS.

FISCAL IMPACT:

None

DISCUSSION:**AB 1 (Cooper) Youth athletics: California Youth Football Act.**

Status: 7/31/2019-Approved by the Governor. Chaptered by Secretary of State - Chapter 158, Statutes of 2019.

Summary: Expresses legislative findings and declarations relating to youth football and specifically relating to player safety. The bill, on and after January 1, 2021, requires a youth sports organization, as defined, that conducts a tackle football program to comply with certain requirements.

AB 453 (Chau) Emergency medical services: training.

Status: 7/12/2019-Approved by the Governor. Chaptered by Secretary of State - Chapter 88, Statutes of 2019.

Summary: Under current law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, the Emergency Medical Services Authority is responsible for establishing minimum standards and promulgating regulations for the training and scope of practice for an Emergency Medical Technician-I (EMT-I), Emergency Medical Technician-II (EMT-II), and Emergency Medical Technician-Paramedic (EMT-P). This bill requires EMT-I, EMT-II, and EMT-P standards established pursuant to the above provision to include a training component on how to interact effectively with persons with dementia and their caregivers.

AB 1116 (Grayson) Firefighters: peer support.

Status: 10/1/2019-Approved by the Governor. Chaptered by Secretary of State - Chapter 388, Statutes of 2019.

Summary: Enacts the California Firefighter Peer Support and Crisis Referral Services Act. The bill authorizes the state or a local or regional public fire agency to establish a Peer Support and Crisis Referral Program to provide an agency-wide network of peer representatives available to aid fellow employees on emotional or professional issues. The bill, for purposes of the act, defines a “peer support team” as a team composed of emergency service personnel, as defined, hospital staff, clergy, and educators who have completed a peer support training course, as specified.

AB 1227 (Obernolte) Health and human services: information sharing: administrative actions.

Status: 9/27/2019-Vetoed by Governor.

Summary: Current law, in order to protect the health and safety of persons receiving care or services from individuals or facilities licensed by the state or from individuals certified or approved by a foster family agency, authorizes the California Department of Aging, the State Department of Public Health, the State Department of Health Care Services, the State Department of Social Services, and the Emergency Medical Services Authority to share information with respect to applicants, licensees, certificate holders, or individuals who have been the subject of any administrative action, as defined, resulting in one of specified actions, including, among others, the denial of a license, permit, or certificate of approval. Current law also authorizes, for the same purpose, the State Department of Social Services and county child welfare agencies to share those same types of information. This bill would have required the above-described agencies to share the information relating to administrative actions under the two respective provisions.

AB 1544 (Gipson) Community Paramedicine or Triage to Alternate Destination Act.

Status: 9/15/2019-Failed Deadline pursuant to Rule 61(a)(15). (Last location was INACTIVE FILE on 9/10/2019) (May be acted upon Jan 2020)

Summary: Would establish within the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act until January 1, 2030, the Community Paramedicine or Triage to Alternate Destination Act of 2019. The bill would authorize a local EMS agency to develop a community paramedicine or triage to alternate destination program, as defined, to provide specified community paramedicine services. The bill would require the authority to develop regulations to establish minimum standards for a program and would further require the Commission on Emergency Medical Services to review and approve those regulations.

SB 438 (Hertzberg) Emergency medical services: dispatch.

Status: 10/1/2019-Approved by the Governor. Chaptered by Secretary of State. Chapter 389, Statutes of 2019.

Summary: Prohibits a public agency from delegating, assigning, or contracting for “911” emergency call processing services for the dispatch of emergency response resources unless the delegation or assignment is to, or the contract or agreement is with, another public agency. The bill exempts from that prohibition a public agency that is a joint powers authority that delegated, assigned, or contracted for “911” call processing services on or before January 1, 2019, under certain conditions.

EMERGENCY MEDICAL SERVICES AUTHORITY

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



DATE: December 4, 2019

TO: Commission on EMS

FROM: David Duncan MD
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:****2019-20**

The 2019-20 enacted California State budget includes expenditure authority in the amount of \$35.1 million and 78 permanent positions. Of this amount, \$16.2 million is delegated for State operations and \$18.9 million is delegated to local assistance.

As of November 8, 2019, accounting records indicate that the Department has expended and/or encumbered \$5.76 million or 16.4% of available expenditure authority. Of this amount, \$3.95 million or 24.5% of State Operations expenditure authority has been expended and/or encumbered and \$1.81 million or 11% of local assistance expenditure authority has been expended and/or encumbered.

2018-19

The 2018-19 enacted California State budget includes expenditure authority in the amount of \$46.45 million and 70 permanent positions. Of this amount, \$18.10 million is delegated for State operations and \$28.35 million is delegated to local assistance.

As of November 8, 2019, accounting records indicate that the Department has expended and/or encumbered \$28.90 million or 62.2% of available expenditure authority. Of this amount, \$13.67 million or 75.5% of State Operations expenditure authority has been expended and/or encumbered and \$15.23 million or 53.7% of local assistance expenditure authority has been expended and/or encumbered.

The Department is still in the midst of the fiscal year-end closing process and an updated report will be distributed prior to the next Commission meeting.

EMSA Staffing Levels:

As of November 8, 2019 the Department is authorized 78 positions and also has 13 temporary (blanket positions and retired annuitants) positions for an overall staffing level of 91. Of the 91 positions, 9 positions are vacant at this time.

	Division				Total
	Admin/Exec	DMS	EMSP	EMS	
Authorized	24.0	18.0	22.0	14.0	78.0
Temporary Staff	9.0	2.0	1.0	1.0	13.0
Staffing Level	33.0	20.0	23.0	15.0	91.0
Authorized (Vacant)	-1.0	-4.0	-1.0	-2.0	-8.0
Temporary (Vacant)	0.0	-1.0	0.0	0.0	-1.0
Current Staffing Level	32.0	15.0	22.0	13.0	82.0

EMERGENCY MEDICAL SERVICES AUTHORITY

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



DATE: December 4, 2019

TO: Commission on EMS

FROM: Dave Duncan MD
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 August 16, 2019, to November 12, 2019, the Authority issued twenty-one new accusations against existing paramedic licenses, four statements of issues, four administrative fines, five temporary suspension orders and accusations, three accusations and petitions to terminate probation, and six decisions on petitions for reduction of penalties and license reinstatements. Of the newly issued actions, four of the Respondents have requested that an administrative hearing be set. There are currently fifteen hearings scheduled. There are currently forty-nine open active disciplinary cases in the legal office.

Litigation:

Tagliere v. Backer: Los Angeles County Superior Court #BS1707101, Writ of Administrative Mandamus. Plaintiff filed a writ seeking to overturn the revocation of his license subsequent to an administrative hearing. A hearing was held on February 14, 2019. The superior court remanded the matter back to OAH for a new hearing; hearing to be scheduled.

Contra Costa County EMS v. EMSA: The Authority is currently working to determine hearing dates and request a hearing through OAH for the appeal of a denial of a local EMS plan.

California Fire Chiefs Association, Inc. v. EMSA: Sacramento Superior Court Case No. 34-2019-80003163, filed June 7, 2019. California Fire Chiefs Association, Inc. (CalChiefs) filed 3 petitions with the Office of Administrative Law (OAL) seeking a determination that EMSA Publications #141 (approved by the Commission), draft 141-B, and 310 were alleged underground regulations. Pursuant to CCR Title 1 Section 280, the Authority certified that it would not use or enforce those publications. CalChiefs has filed suit against EMSA, alleging that “Despite its Section 280 Certification, EMSA has continued to use, enforce, or attempt to enforce the alleged underground regulations in CalChiefs’ petitions and rebuffed CalChiefs’ demands that it comply with its certification.” Hearing set for January 10, 2020.

EMERGENCY MEDICAL SERVICES AUTHORITY

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



DATE: December 4, 2019

TO: Commission on EMS

FROM: Dave Duncan, MD
Director

PREPARED BY: Alexander Bourdaniotis, 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 November 1, 2019, the Enforcement Unit is budgeted for 5 full-time Special Investigators, 1 part-time Retired Annuitant Special Investigator and 1 full-time Associate Government Program Analyst (AGPA-Probation Monitor). Two Special Investigator positions were filled on January 16, 2019. Mike Smith, the Supervising Special Investigator retired on April 1, 2019. Alexander Bourdaniotis replaced Mr. Smith as of August 30, 2019. Mr. Bourdaniotis comes to the EMS Authority from the California Dental Board and brings over 10 years of investigative experience to the EMS Authority.

Investigative Workload:

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

Cases opened since January 1, 2019, including:

Cases opened:	296
Cases completed and/or closed:	272
EMT-Paramedics on Probation:	215

In 2018:

Cases opened:	272
Cases completed and/or closed:	265
EMT-Paramedics on Probation:	220

Status of Current Cases:

The Enforcement Unit currently has 129 cases in “open” status.

As of November 1, 2019, there are 52 cases that have been in “open” status for 180 days or longer, including: 4 Firefighters’ Bill of Rights (FFBOR) cases and 2 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 52 cases are divided among 6 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.

EMERGENCY MEDICAL SERVICES AUTHORITY

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



DATE: December 4, 2019

TO: Commission on EMS

FROM: Tom McGinnis
Chief, EMS Systems Division

PREPARED BY: Lisa Galindo
EMS Plans Coordinator

SUBJECT: EMS Plan and Critical Care Plans Update

RECOMMENDED ACTION:

Receive updated information on the status of Emergency Medical Services (EMS) Plan appeals and submission activity related to EMS, Quality Improvement (QI), and Critical Care (Trauma, ST-Elevation Myocardial Infarction [STEMI], Stroke, and EMS for Children [EMSC]) Plans.

FISCAL IMPACT:

None

DISCUSSION:

Local EMS Agencies (LEMSA) must submit an EMS Plan annually to the EMS Authority, in accordance with Health and Safety Code (HSC) § 1797.254. An EMS Plan is a plan for the delivery of EMS consistent with HSC § 1797.103 that addresses the following components:

- | | |
|---------------------------------------|--|
| 1. System Organization and Management | 5. Facilities and Critical Care Centers |
| 2. Staffing and Training | 6. Data Collection and System Evaluation |
| 3. Communications | 7. Public Information and Education |
| 4. Response and Transportation | 8. Disaster Medical Response |

The information contained in an EMS Plan is used to ensure compliance with all applicable laws and to be able to assess the functionality of an EMS system to ensure safety and quality EMS to the public. The EMS Authority is responsible for the review of EMS, QI, Trauma, STEMI, Stroke, and EMSC Plans and for making a determination on the approval or disapproval of the plans, based on compliance with statute, regulations, and case law, consistent with HSC § 1797.105(b), HSC § 1797.257, HSC § 1797.258, and Chapters 7, 7.1, 7.2, 12, and 14 of California Code of Regulations (CCR), Title 22, Division 9.

EMS Plan Appeal:

In accordance with CCR § 100450.100, LEMSAs maintain the ability to appeal an EMS Plan disapproval to the Commission on EMS. The following EMS Plan appeal is currently in progress:

LEMSA	EMS Plan	Disapproval	Appeal Hearing
Contra Costa County	2016	4/13/18	Awaiting dates of availability

Submission Status:

Attached is a statewide activity report on LEMSA submissions related to EMS, QI, Trauma, STEMI, Stroke, and EMSC Plans. The activity report identifies LEMSAs who are current, under review, and overdue in submissions to the EMS Authority.

Below is a statewide summary of the plan submission compliance as of October 28, 2019:

Plan Submission	Number of LEMSAs	Percentage Compliance
EMS	24/33	73%
QI	24/33	73%
Trauma	26/33	79%
STEMI	7/33	N/A*
Stroke	7/33	N/A*
EMSC	0/33	N/A*

* STEMI, Stroke, and EMSC regulations became effective July 2019. These plans are due to the EMS Authority as part of the LEMSA's next EMS Plan submission, or by December 31, 2019, whichever is sooner. Annual submissions are required thereafter, as part of the annual EMS Plan submission.

There may be LEMSAs out of compliance due to a variety of factors, including but not limited to LEMSA fiscal year close-out, limited staffing or staff turnover, or critical EMS matters such as a natural disaster. Each LEMSA is unique and has dynamic factors impacting their ability to submit timely plans.

The EMS Authority will continue to keep the Commission apprised of the activity involving EMS, QI, Trauma, STEMI, Stroke, and EMSC Plans.

Attachment



Status of Local EMS Agency Plan/Update As of October 28, 2019



EMS AGENCY	EMS PLAN	QI	TRAUMA	STEMI	STROKE	EMSC
Alameda	Overdue	Current	Current	Current	Current	
Central California	Under Review	Overdue	Current			
Coastal Valleys	Current	Current	Current			
Contra Costa *	Current	Current	Current			
El Dorado	Overdue	Current	Current			
Imperial	Overdue	Overdue	Overdue			
Inland Counties	Under Review	Current	Current			
Kern	Current	Current	Current			
Los Angeles	Under Review	Under Review	Current			
Marin	Under Review	Current	Current		Current	
Merced	Current	Current	Overdue			
Monterey	Current	Current	Current			
Mountain-Valley	Current	Current	Current			
Napa	Under Review	Under Review	Current	Under Review	Under Review	
North Coast	Current	Current	Current			
Northern California	Current	Current	Current			
Orange	Current	Current	Overdue			
Riverside	Current	Current	Current	Current		
Sacramento	Under Review	Current	Current			
San Benito	Current	Current	Current			
San Diego	Under Review	Overdue	Current			
San Francisco	Overdue	Overdue	Overdue			
San Joaquin	Under Review	Current	Current	Under Review	Under Review	
San Luis Obispo	Current	Current	Current			
San Mateo	Current	Current	Current			
Santa Barbara	Overdue	Overdue	Current			
Santa Clara	Overdue	Overdue	Overdue			
Santa Cruz	Overdue	Overdue	Overdue			
Sierra-Sac Valley	Under Review	Overdue	Current	Under Review	Under Review	
Solano	Overdue	Current	Current			
Tuolumne	Overdue	Overdue	Overdue			
Ventura	Under Review	Current	Current	Under Review	Under Review	
Yolo	Current	Current	Current	Current	Current	

* EMS Plan Appeal in Progress
Current plan on file
Pending submission
No current plan on file
Due December 31, 2019

EMERGENCY MEDICAL SERVICES AUTHORITY

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



DATE: December 4, 2019

TO: Commission on EMS

FROM: Dave Duncan MD
Director

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

SUBJECT: Approval of Paramedic Regulation Revisions

RECOMMENDED ACTION:

Approve revisions to the Emergency Medical Technician-Paramedic regulations, Chapter 4, Division 9, Title 22 of the California Code of Regulations.

FISCAL IMPACT:

The proposed regulations will increase paramedic license fees by \$50, to be phased in over two, staggered years: \$25 in 2020-21 and \$25 in 2021-2022. Following an evaluation of the current paramedic licensure fees, it was determined by the Emergency Medical Services (EMS) Authority that a fee increase is necessary to fund the actual costs of EMSA's paramedic program sufficiently. Paramedic license fees are assessed directly to the individual applicant, though some public agencies cover fees for the licensed paramedics they employ through an employment contract or union agreement.

The proposed regulations will also require paramedic training programs to increase their hours of training from the current minimum of 1090 hours to the proposed minimum of 1094 hours to include additional training in tactical casualty care (TCC) principles. The proposed changes will impact local government paramedic training programs, which include 20 community colleges, one (1) University of California, one (1) California State University, and three (3) governmental agencies.

Community colleges and state universities may be able to recoup any potential costs to paramedic training programs impacted by the additional curriculum through tuition. Specific costs to local government(s) are unknown, though based on input received during stakeholder workgroup meetings and discussions with various state agencies providing training to EMS personnel, these regulations are not likely to result in an adverse economic impact.

This rulemaking may also impact statewide public safety agencies through the implementation of a \$2,500 fee for approval and reapproval of a continuing education (CE) provider. Existing regulations (Chapter 11, Title 22) specify that the EMS Authority is the

agency responsible for approving CE providers for statewide public safety agencies and CE providers whose headquarters are located out of state and require CE providers to permit the EMS Authority to make site visits to individual classes, courses, or activities of the CE provider.

In order to carry out these responsibilities, and in the best interest of the health and safety of the public, the EMS Authority believes that these programs should be periodically reviewed and audited. However, the EMS Authority has been unable to perform reviews and audits of its CE provider programs due to a lack of available resources. The EMS Authority has determined that a fee increase for all Authority-approved CE providers is necessary to cover costs necessary to review and audit statewide public safety and out-of-state programs.

These regulations are not likely to result in an adverse economic impact on any business. The cost increase for CE providers will be \$2,500 every four years, or \$625 annually. Each public safety agency is charged one fee for all of its sites and will only be required to pay this fee upon renewal, which occurs every four years. Following stakeholder discussions, the EMS Authority believes that this minimal cost can be absorbed by the programs.

DISCUSSION:

The regulations proposed in this rulemaking action intend to clarify and make specific the methods for training program reviews, approvals, and accreditation requirements, update the paramedic licensure applications and processes, and add curriculum content for tactical casualty care (TCC) principles to the required paramedic training course content.

The EMS Authority submitted a Notice of Proposed Regulatory Action and initial rulemaking documents to the Office of Administrative Law (OAL) on March 26, 2019. The 45-day public comment period began on April 5 and concluded on May 20, 2019. Upon completion of the comment period, the EMS Authority reviewed all comments submitted by the public and made additional modifications to the proposed regulation text accordingly. Those changes were noticed during a 15-day public comment period, which concluded June 26, 2019.

The EMS Authority made additional modifications based on comments received and held additional 15-day public comment periods from July 30 to August 14, 2019, and August 19 to September 3, 2019, respectively. A fourth 15-day public comment period was noticed on Thursday, September 12, and will close on September 27, 2019.

Following completion of the fourth 15-day public comment period, the EMS Authority determined that no additional modifications to the proposed rulemaking action are necessary at this time. The EMS Authority supports moving these regulations forward to the Office of Administrative Law and respectfully requests the Commission's approval.

California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 4. Paramedic

1 **ARTICLE 1. DEFINITIONS**

2
3 **§ 100137. Paramedic Training Program Approving Authority.**

4 (a) "Paramedic training program approving authority" means an agency or person
5 authorized by this Chapter to approve a Paramedic training program and/or a Critical
6 Care Paramedic (CCP) training program, as follows:

7
8 (1) A paramedic training program and/or a CCP training program conducted by a
9 qualified statewide public safety agency shall be approved by the director of the
10 Authority.

11
12 (2) Any other paramedic training program and/or a CCP training program not included in
13 subsection (1) shall be approved by the local EMS agency (LEMSA) that has jurisdiction
14 in the county where the training program is located.

15
16 Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
17 Reference: Sections 1797.172, 1797.200 and 1797.208, Health and Safety Code.

18
19 **§ 100140. Psychomotor Skills Examination.**

20 "Psychomotor Skills examination" " means the National Registry of Emergency Medical
21 Technicians (NREMT) Paramedic Psychomotor Skills Examination to test the skills of
22 an individual applying for licensure as a paramedic

23
24 Note: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194,
25 Health and Safety Code. Reference: Sections 1797.172, 1797.175, 1797.185 and
26 1797.194, Health and Safety Code.

27
28 **§ 100141. Cognitive Written Examination.**

29 "Cognitive Written Examination" means the NREMT Paramedic Cognitive Written
30 Examination to test an individual applying for licensure as a paramedic.

31
32 Note: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194,
33 Health and Safety Code. Reference: Sections 1797.63, 1797.172, 1797.175, 1797.185,
34 1797.194 and 1797.210, Health and Safety Code.

35
36 **§ 100141.1. High Fidelity Simulation**

37 High Fidelity Simulation means using computerized manikins, monitors, and similar
38 devices or augmented virtual reality environments that are operated by a technologist
39 from another location to produce audible sounds and to alter and manage physiological

changes within the manikin to include, but not be limited to, altering the heart rate, respirations, chest sounds, and saturation of oxygen.

Note: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code. Reference: Sections 1797.63, 1797.172, 1797.175, 1797.185, 1797.194 and 1797.210, Health and Safety Code.

§ 100143.1. Electronic Health Record

“Electronic health record” or EHR, or electronic patient care record or ePCR means real time, patient-centered records that make information available securely to authorized users in a digital format capable of being shared with other providers across more than one health care organization.

Note: Authority cited: Sections 1797.107, 1797.122 and 1797.227 Health and Safety Code. Reference: Sections 1797.107, 1797.122 and 1797.227, Health and Safety Code.

§ 100144. Critical Care Paramedic.

A “Critical Care Paramedic” (CCP) or is an individual who is educated and trained in critical care transport, whose scope of practice is in accordance to the standards prescribed by this Chapter, has completed a training program as specified in Section 100155(c), holds a current certification as a CCP by the International Board of Specialty Certification (IBSC), Board for Critical Care Transport Paramedic Certification (BCCTPC), who has a valid license issued pursuant to this Chapter, and is accredited by a LEMSA in which their paramedic service provider is based.

Note: Authority cited: Sections 1797.107, 1797.172 and 1797.194, Health and Safety Code. Reference: Sections 1797.84, 1797.172, 1797.185 and 1797.194, Health and Safety Code.

§ 100144.1. Flight Paramedic.

A “Flight Paramedic” (FP) is an individual who is educated and trained in critical care transport, whose scope of practice is in accordance to the standards prescribed by this Chapter, has completed a training program as specified in Section 100155(c), holds a current certification as a FP by the International Board of Specialty Certification (IBSC), Board for Critical Care Transport Paramedic Certification (BCCTPC), who has a valid license issued pursuant to this Chapter, and is accredited by a LEMSA in which their paramedic service provider is based.

Note: Authority cited: Sections 1797.107, 1797.172 and 1797.194, Health and Safety Code. Reference: Sections 1797.84, 1797.172, 1797.185 and 1797.194, Health and Safety Code.

ARTICLE 2. GENERAL PROVISIONS

§ 100146. Scope of Practice of Paramedic.

(a) A paramedic may perform any activity identified in the scope of practice of an EMT in Chapter 2 of this Division, or any activity identified in the scope of practice of an Advanced EMT (AEMT) in Chapter 3 of this Division without requiring a separate certification.

(b) A licensed paramedic shall be affiliated with an approved paramedic service provider in order to perform the scope of practice specified in this Chapter.

(c) A paramedic student or a licensed paramedic, as part of an organized EMS system, while caring for patients in a hospital as part of his/her training or continuing education (CE) under the direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, or while working in a small and rural hospital pursuant to Section 1797.195 of the Health and Safety Code, may perform the following procedures or administer the following medications when such are approved by the medical director of the LEMSA and are included in the written policies and procedures of the LEMSA.

(1) Basic Scope of Practice:

(A) Utilize electrocardiographic devices and monitor electrocardiograms, including 12-lead electrocardiograms (ECG).

(B) Perform defibrillation, synchronized cardioversion, and external cardiac pacing.

(C) Visualize the airway by use of the laryngoscope and remove foreign body(ies) with Magill forceps.

(D) Perform pulmonary ventilation by use of lower airway multi-lumen adjuncts, the esophageal airway, perilaryngeal airways, stomal intubation, and adult oral endotracheal intubation.

(E) Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP)/bi-level positive airway pressure (BPAP) and positive end expiratory pressure (PEEP) in the spontaneously breathing patient.

(F) Institute intravenous (IV) catheters, saline locks, needles, or other cannulae (IV lines), in peripheral veins and monitor and administer medications through pre-existing vascular access.

(G) Institute intraosseous (IO) needles or catheters.

(H) Administer IV or IO glucose solutions or isotonic balanced salt solutions, including Ringer's lactate solution.

(I) Obtain venous blood samples.

CLEAN COPY

(J) Use laboratory devices, including point of care testing, for pre-hospital screening use to measure lab values including, but not limited to: glucose, capnometry, capnography, and carbon monoxide when appropriate authorization is obtained from State and Federal agencies, including from the Centers for Medicare and Medicaid Services pursuant to the Clinical Laboratory Improvement Amendments (CLIA).

(K) Utilize Valsalva maneuver.

(L) Perform percutaneous needle cricothyroidotomy.

(M) Perform needle thoracostomy.

(N) Perform nasogastric and orogastric tube insertion and suction.

(O) Monitor thoracostomy tubes.

(P) Monitor and adjust IV solutions containing potassium, equal to or less than 40 mEq/L.

(Q) Administer approved medications by the following routes: IV, IO, intramuscular, subcutaneous, inhalation, transcutaneous, rectal, sublingual, endotracheal, intranasal, oral or topical.

(R) Administer, using prepackaged products when available, the following medications:

1. 10%, 25% and 50% dextrose;
2. activated charcoal;
3. adenosine;
4. aerosolized or nebulized beta-2 specific bronchodilators;
5. amiodarone;
6. aspirin;
7. atropine sulfate;
8. pralidoxime chloride;
9. calcium chloride;
10. diazepam;
11. diphenhydramine hydrochloride;

12. dopamine hydrochloride;

13. epinephrine;

14. fentanyl;

15. glucagon;

16. ipratropium bromide;

17. lorazepam;

18. midazolam;

19. lidocaine hydrochloride;

20. magnesium sulfate;

21. morphine sulfate;

22. naloxone hydrochloride;

23. nitroglycerine preparations, except IV, unless permitted under (c)(2)(A) of this section;

24. ondansetron;

25. sodium bicarbonate.

(S) In addition to the approved paramedic scope of practice, the CCP or FP may perform the following procedures and administer medications, as part of the basic scope of practice for interfacility transports when approved by the LEMSA medical director.

1. set up and maintain thoracic drainage systems;

2. set up and maintain mechanical ventilators;

3. set up and maintain IV fluid delivery pumps and devices;

4. blood and blood products;

5. glycoprotein IIB/IIIA inhibitors;

6. heparin IV;

1 7. nitroglycerin IV;

2
3 8. norepinephrine;

4
5 9. thrombolytic agents;

6
7 10. maintain total parenteral nutrition;

8
9 (2) Local Optional Scope of Practice:

10
11 (A) Perform or monitor other procedure(s) or administer any other medication(s)
12 determined to be appropriate for paramedic use by the medical director of the LEMSA,
13 that have been approved by the Director of the Authority. Paramedics shall demonstrate
14 competency in performing these procedures and administering these medications
15 through training and successful testing.

16
17 (B) The medical director of the LEMSA shall submit a written request, Form #EMSA-
18 0391, revised 01/17, incorporated herein by reference, to the Director of the Authority
19 for approval of any procedures or medications proposed for use in accordance with
20 Section 1797.172(b) of the Health and Safety Code prior to implementation.

21
22 (C) The Authority shall, within fourteen (14) days of receiving Form #EMSA-0391,
23 revised 01/17, notify the medical director of the LEMSA that the form has been received
24 and shall specify what information, if any, is missing.

25
26 (D) The Director of the Authority, in consultation with the Emergency Medical Services
27 Medical Directors Association of California's (EMDAC) Scope of Practice Committee,
28 shall approve or disapprove the request for additional procedures and/or administration
29 of medications and notify the LEMSA medical director of the decision within ninety (90)
30 days of receipt of the completed request. An approved status shall be in effect for a
31 period of three (3) years. An approved status may be renewed for another three (3) year
32 period, upon the authority's receipt of a written request that includes, but is not limited
33 to, the following information: the utilization of the procedure(s) or medication(s),
34 beneficial effects, adverse reactions or complications, statistical evaluation, and general
35 conclusion.

36
37 (E) The Director of the Authority, in consultation with the EMDAC Scope of Practice
38 Committee may suspend or revoke approval of any previously approved additional
39 procedure(s) or medication(s) for cause.

40
41 (d) The medical director of the LEMSA may develop policies and procedures or
42 establish standing orders allowing the paramedic to initiate any paramedic activity in the
43 approved scope of practice without voice contact for medical direction from a physician,
44 authorized registered nurse, or mobile intensive care nurse (MICN), provided that an
45 EMSQIP is in place as specified in Chapter 12 of this Division.

Note: Authority cited: Sections 1797.107, 1797.172, 1797.185, 1797.192, 1797.195 and 1797.214, Health and Safety Code. Reference: Sections 1797.56, 1797.172, 1797.178 and 1797.185, Health and Safety Code.

§ 100148. Responsibility of the LEMSA.

(a) The LEMSA that authorizes an ALS program shall establish policies and procedures approved by the medical director of the LEMSA that shall include:

(1) Approval, denial, revocation of approval, suspension, and monitoring of the ALS components of the EMS System such as training programs, base hospitals or alternative base stations, and paramedic service providers.

(2) Assurance of compliance with provisions of this Chapter.

(b) The LEMSA shall submit to the Authority, along with any changes to, the following paramedic training program information:

(1) Name of program director and/or program contact;

(2) Program address, phone number, email address, website address, and facsimile number;

(3) Date of program approval, date classes will begin, and date of program expiration.

(4) Date of Commission on Accreditation of Allied Health Education Programs (CAAHEP) approval;

(5) Date of Bureau of Private Post-Secondary Education (BPPE) approval for private post-secondary educational institutions;

(6) Issue date of Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) letter of review (LoR).

(c) Development or approval, implementation and enforcement of policies for medical control, medical accountability, and an EMSQIP of the paramedic services, including:

(1) Treatment and triage protocols.

(2) Patient care record and reporting requirements.

(3) Medical care audit system.

(4) Role and responsibility of the base hospital and paramedic service provider.

(d) System data collection and evaluation.

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Sections 1797.172, 1797.178, 1797.200, 1797.202, 1797.204, 1797.208, 1797.220, 1797.218 1798 and 1798.100, Health and Safety Code.

ARTICLE 3. PROGRAM REQUIREMENTS FOR PARAMEDIC TRAINING PROGRAMS

§ 100149. Approved Training Programs.

(a) An approved paramedic training program or an institution eligible for paramedic training program approval, as defined in Section 100149(j) of this Chapter, may provide CCP training upon approval by the paramedic training program approving authority. The purpose of a paramedic training program shall be:

(1) to prepare individuals to render prehospital ALS within an organized EMS system; and

(2) to prepare individuals to render critical care transport within an organized EMS system

(b) All approved paramedic training programs shall be accredited and shall maintain current accreditation, or be in the process of receiving accreditation approval by CAAHEP upon the recommendation of CoAEMSP in order to operate as an approved paramedic training program.

(c) All approved paramedic training programs shall:

(1) Receive a Letter of Review (LoR) from CoAEMSP prior to starting classes; and

(2) Submit their application, fee, and Initial Self-Study Report (ISSR) to CoAEMSP for accreditation within six (6) months of the first class' graduation; and

(3) Receive and maintain CAAHEP accreditation no later than two (2) years from the date of the ISSR submission to CoAEMSP for accreditation.

(d) Paramedic training programs approved according to the provisions of this Chapter shall provide the following information in writing to all their paramedic training program applicants prior to the applicants' enrollment in the paramedic training program:

(1) The date the paramedic training program must submit their CAAHEP Request for Accreditation Services (RAS) form and ISSR or the date their application for accreditation renewal was sent to CoAEMSP.

(2) The date the paramedic training program must be initially accredited or the date its accreditation must be renewed by CAAHEP.

(e) Failure of the paramedic training program to maintain its LoR, submit their RAS form and ISSR to CoAEMSP, or obtain and maintain its accreditation with CAAHEP, as described in 100149(c), by the date specified shall result in withdrawal of program approval as specified in Section 100162 of this Chapter.

(f) Students graduating from a paramedic training program that fail to apply, receive, or maintain CAAHEP accreditation by the dates required will not be eligible for state licensure as a paramedic.

(g) Paramedic training programs shall submit to their respective paramedic training program approving authority all documents submitted to, and received from, CoAEMSP and CAAHEP for accreditation, including but not limited to, the RAS form, ISSR, and documents required for maintaining accreditation.

(h) Paramedic training programs shall submit to the Authority the date their initial RAS form was submitted to CoAEMSP and copies of documentation received from CoAEMSP and/or CAAHEP verifying accreditation.

(i) Approved paramedic training programs shall participate in the EMSQIP of their respective paramedic training program approving authority.

(j) Eligibility for program approval shall be limited to the following institutions:

(1) Accredited universities, colleges, including junior and community colleges, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau for Private Postsecondary Education.

(2) Medical training units of the United States Armed Forces or Coast Guard

(3) Licensed general acute care hospitals which meet the following criteria:

(A) Hold a special permit to operate a basic or comprehensive emergency medical service pursuant to the provisions of Division 5;

(B) Provide continuing education (CE) to other health care professionals; and

(C) are accredited by a Centers for Medicare and Medicaid Services with deeming authority.

(4) Agencies of government.

Note: Authority cited: Sections 1797.107, 1797.172 and 1797.173, Health and Safety Code. Reference: Sections 1797.172, 1797.173, 1797.208 and 1797.213, Health and Safety Code.

§ 100150. Teaching Staff.

(a) Each training program shall have a program medical director who is a physician currently licensed in the State of California, has experience in emergency medicine and has education or experience in methods of instruction. Duties of the program medical director shall include, but not be limited to the following:

(1) Review and approve educational content of the program curriculum, including training objectives for the clinical and field instruction, to certify its ongoing appropriateness and medical accuracy.

(2) Review and approve the quality of medical instruction, supervision, and evaluation of the students in all areas of the program.

(3) Approval of hospital clinical and field internship experience provisions.

(4) Approval of principal instructor(s).

(b) Each training program shall have a program director who is either a California licensed physician, a registered nurse who has a baccalaureate degree, or a paramedic who has a baccalaureate degree, or an individual who holds a baccalaureate degree in a related health field or in education. The program director shall be qualified by education and experience in methods, materials, and evaluation of instruction, and shall have a minimum of one (1) year experience in an administrative or management level position, and have a minimum of three (3) years academic or clinical experience in prehospital care education. Duties of the program director shall include, but not be limited to the following:

(1) Administration, organization and supervision of the educational program.

(2) In coordination with the program medical director, approve the principal instructor(s), teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate the development of curriculum, including instructional objectives, and approve all methods of evaluation.

(3) Ensure training program compliance with this chapter and other related laws.

(4) Sign all course completion records.

(5) Ensure the preceptor(s) are trained according to the curriculum in subsection (e)(4).

(c) Each training program shall have a principal instructor(s), who is responsible for areas including, but not limited to, curriculum development, course coordination, and instruction and shall meet the following criteria:

(1) Be a physician, registered nurse, physician assistant, or paramedic, currently certified or licensed in the State of California.

CLEAN COPY

(2) Be knowledgeable in the course content of the January 2009 United States Department of Transportation (U.S. DOT) National Emergency Medical Services Education Standards DOT HS 811 077 E, herein incorporated by reference; and

(3) Have six (6) years of experience in an allied health field and an associate degree or two (2) years of experience in an allied health field and a baccalaureate degree.

(4) Be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.

(5) A Principal Instructor may also be the program medical director or program director.

(d) Each CCP training program shall have a principal instructor(s) who is either licensed in California as a physician with knowledge in the subject matter, a registered nurse knowledgeable in the subject matter, or a paramedic with current CCP certification or a flight paramedic (FP) certification from the International Board of Specialty Certification (IBSC) Board for Critical Care Transport Paramedic Certification (BCCTPC).

(e) Each training program may have a teaching assistant(s) who has training and experience to assist with teaching the course. The teaching assistant(s) shall be supervised by a principal instructor, the program director and/or the program medical director.

(f) Each training program may have a clinical coordinator(s) who is either a Physician, Registered Nurse, Physician Assistant, or a Paramedic currently licensed in California, and who shall have two (2) years of academic or clinical experience in emergency medicine or prehospital care. Duties of the program clinical coordinator shall include, but not be limited to, the following:

(1) The coordination and scheduling of students with qualified clinical preceptors in approved clinical settings as described in Section 100152.

(2) Ensuring adequate clinical resources exist for student exposure to the minimum number and type of patient contacts established by the program as required for continued CAAHEP accreditation.

(3) The tracking of student internship evaluation and terminal competency documents.

(g) Each paramedic training program shall have a field preceptor(s) who meets the following criteria:

(1) Be a certified or licensed paramedic; and

(2) Be working in the field as a certified or licensed paramedic for the last two (2) years; and

(3) Be under the supervision of a principal instructor, the program director and/or the program medical director; and

(4) Have completed a field preceptor training program approved by the LEMSA in accordance with CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions (2015). Training shall include curriculum that will result in preceptor competency in the evaluation of paramedic students during the internship phase of the training program and the completion of the following:

(A) Conduct a daily field evaluation of students.

(B) Conduct cumulative and final field evaluations of all students.

(C) Rate students for evaluation using written field criteria.

(D) Identify ALS contacts and requirements for graduation.

(E) Identify the importance of documenting student performance.

(F) Review the field preceptor requirements contained in this Chapter.

(G) Assess student behaviors using cognitive, psychomotor, and affective domains.

(H) Create a positive and supportive learning environment.

(I) Measure students against the standards of entry level paramedics.

(J) Identify appropriate student progress.

(K) Counsel the student who is not progressing.

(L) Identify training program support services available to the student and the preceptor.

(M) Provide guidance and procedures to address student injuries or exposure to illness, communicable disease or hazardous material.

(h) Each training program shall have a hospital clinical preceptor(s) who shall meet the following criteria:

(1) Be a physician, registered nurse or physician assistant currently licensed in the State of California.

(2) Have worked in emergency medical care services or areas of medical specialization for the last two (2) years.

(3) Be under the supervision of a principal instructor, the program director, and/or the program medical director.

(4) Receive training in the evaluation of paramedic students in clinical settings. Instructional tools may include, but not be limited to, educational brochures, orientation, training programs, or training videos. Training shall include the following components of instruction:

(A) Evaluate a student's ability to safely administer medications and perform assessments.

(B) Document a student's performance.

(C) Review clinical preceptor requirements contained in this Chapter.

(D) Assess student behaviors using cognitive, psychomotor, and affective domains.

(E) Create a positive and supportive learning environment.

(F) Identify appropriate student progress.

(G) Counsel the student who is not progressing.

(H) Provide guidance and procedures for addressing student injuries or exposure to illness, communicable disease or hazardous material.

(i) Instructors of tactical casualty care (TCC) topics shall be qualified by education and experience in TCC methods, materials, and evaluation of instruction,

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Sections 1797.172 and 1797.208, Health and Safety Code.

§ 100153. Field Internship.

(a) A field internship shall provide emergency medical care training and experience to paramedic students under continuous supervision, instruction, and evaluation by an authorized preceptor and shall promote student competency in medical procedures, techniques, and the administration of medications as specified in Section 100146, in the prehospital emergency setting within an organized EMS system.

(b) An approved paramedic training program shall enter into a written agreement with a paramedic service provider(s) that provide field internship services to students. This agreement shall include provisions to ensure compliance of this Chapter.

(c) The medical director of the LEMSA where the internship is located shall have medical control over the paramedic intern.

(d) The assignment of a student to a field preceptor shall be a collaborative effort between the training program and the provider agency.

(1) The assignment of a student to a field preceptor shall be limited to duties associated with the student's training or the student training program.

(e) If the paramedic service provider is located outside the jurisdiction of the paramedic training program approving authority, the paramedic training program shall do the following:

(1) Ensure the student receives orientation in collaboration with the LEMSA where the field internship will occur. The orientation shall include that LEMSA's local policies, procedures, and treatment protocols,

(2) Report to the LEMSA, where the field internship will occur, the name of the paramedic intern, the name of the field internship provider, and the name of the preceptor.

(3) Ensure the field preceptor has the experience and training as required in Section 100150(g)(1) (4).

(f) The paramedic training program shall enroll only the number of students it is able to place in field internships within ninety (90) days of completion of their hospital clinical education and training phase of the training program. The training program director and student may agree to start the field internship at a later date, in the event of special circumstances (e.g., student or preceptor illness or injury, student's military duty, etc.). This agreement shall be in writing.

(g) The internship, regardless of the location, shall be monitored by the training program staff, in collaboration with the assigned field preceptor.

(h) Training program staff shall, upon receiving input from the assigned field preceptor, document the progress of the student. Documentation shall include the identification of student deficiencies and strengths and any training program obstacles encountered by, or with, the student.

(i) Training program staff shall provide documentation reflecting student progress to the student at least twice during the student's internship.

(j) No more than one (1) trainee, of any level, shall be assigned to a response vehicle at any one time during the paramedic student's field internship.

Note: Authority cited: Sections 1797.107, 1797.172 and 1797.173, Health and Safety Code. Reference: Sections 1797.172, 1797.173 and 1797.208, Health and Safety Code.

1 **§ 100154. Required Course Hours.**

2 (a) The total paramedic training program shall consist of not less than one thousand and
3 ninety-four (1094) hours. These training hours shall be divided into:

4
5 (1) A minimum of four-hundred and fifty-four (454) hours of didactic instruction and skills
6 laboratories that shall include not less than four (4) hours of training in tactical casualty
7 care principles as provided in Section 100155(b);

8
9 (2) The hospital clinical training shall consist of no less than one-hundred and sixty
10 (160) hours;

11
12 (3) The field internship shall consist of no less than four-hundred and eighty (480)
13 hours.

14
15 (b) The student shall have a minimum of forty (40) documented ALS patient contacts
16 during the field internship as specified in Section 100153. An ALS patient contact shall
17 be defined as the student performance of one or more ALS skills, except cardiac
18 monitoring and CPR, on a patient.

19
20 (1) When available, up to ten (10) of the required ALS patient contacts may be satisfied
21 through the use of high fidelity adult simulation patient contacts as defined in Section
22 100141.1.

23
24 (2) Students shall document patient contacts utilizing an EHR system under supervision
25 of the preceptor.

26
27 (c) The student shall have a minimum of twenty (20) documented experiences
28 performing the role of team lead during the field internship. A team lead shall be defined
29 as a student who, with minimal to no prompting by the preceptor, successfully takes
30 charge of EMS operation in the field including, but not limited to, the following:

31
32 (1) Lead coordination of field personnel,

33
34 (2) Formulation of field impression,

35
36 (3) Comprehensively assessing patient conditions and acuity.

37
38 (4) Directing and implementing patient treatment,

39
40 (5) Determining patient disposition, and

41
42 (6) Leading the packaging and movement of the patient.

43
44 (d) The minimum hours shall not include the following:
45

(1) Course material designed to teach or test exclusively EMT knowledge or skills including CPR.

(2) Examination for student eligibility.

(3) The teaching of any material not prescribed in Section 100155 of this Chapter.

(4) Examination for paramedic licensure.

(e) The total CCP training program shall consist of not less than two-hundred and two (202) hours. These training hours shall be divided into:

(1) A minimum of one-hundred and eight (108) hours of didactic and skills laboratories; and

(2) No less than ninety-four (94) hours of hospital clinical training as prescribed in Section 100152(b) of this Chapter.

(f) For at least half of the ALS patient contacts specified in Section 100154(b) the paramedic student shall be required to provide the full continuum of care of the patient beginning with the initial contact with the patient upon arrival at the scene through transfer of care to hospital personnel.

Note: Authority cited: Sections 1797.107, 1797.172, and 1797.173, Health and Safety Code. Reference: Section 1797.172 and 1797.173, Health and Safety Code.

§ 100155. Required Course Content.

(a) The content of a paramedic course shall meet the objectives contained in the January 2009 U.S. Department of Transportation (DOT) National Emergency Medical Services Education Standards, DOT HS 811 077E, and be consistent with the paramedic basic scope of practice specified in Section 100146(a) of this Chapter. The DOT HS 811 077 E can be accessed through the U.S. DOT National Highway Traffic Safety Administration at the National Highway Traffic Safety Administration: <http://www.nhtsa.gov/>.

(b) In addition to the above, the content of the training course shall include a minimum of four (4) hours of tactical casualty care (TCC) principles applied to violent circumstances with at least the following topics and skills and shall be competency based:

(1) History and Background of Tactical Casualty Care

(A) Demonstrate knowledge of tactical casualty care

1. History of active shooter and domestic terrorism incidents

CLEAN COPY

- 1 2. Define roles and responsibilities of first responders including Law Enforcement, Fire
2 and EMS.
- 3
- 4 3. Review of local active shooter policies
- 5
- 6 4. Scope of Practice and Authorized Skills and procedures by level of training,
7 certification, and licensure zone
- 8
- 9 (2) Terminology and definitions
- 10
- 11 (A) Demonstrate knowledge of terminology
- 12
- 13 1. Hot zone/warm zone/cold zone
- 14
- 15 2. Casualty collection point
- 16
- 17 3. Rescue task force
- 18
- 19 4. Cover/concealment
- 20
- 21 (3) Coordination, Command and Control
- 22
- 23 (A) Demonstrate knowledge of Incident Command and how agencies are integrated into
24 tactical operations.
- 25
- 26 1. Demonstrate knowledge of team command, control and communication
- 27
- 28 a. Incident Command System (ICS) /National Incident Management System (NIMS)
- 29
- 30 b. Mutual Aid considerations
- 31
- 32 c. Unified Command
- 33
- 34 d. Communications, including radio interoperability
- 35
- 36 e. Command post
- 37
- 38 f. Staging areas
- 39
- 40 g. Ingress/egress
- 41
- 42 h. Managing priorities
- 43
- 44 (4) Tactical and Rescue Operations
- 45
- 46 (A) Demonstrate knowledge of tactical and rescue operations

1
2 1. Tactical Operations – Law Enforcement

3
4 a. The priority is to mitigate the threat

5
6 b. Contact Team

7
8 c. Rescue Team

9
10 2. Rescue Operations – Law Enforcement/EMS/Fire

11
12 a. The priority is to provide life-saving interventions to injured parties

13
14 b. Formation of Rescue Task Force (RTF)

15
16 c. Casualty collection points

17
18 (5) Basic Tactical Casualty Care and Evacuation

19
20 (A) Demonstrate appropriate casualty care at your scope of practice and certification

21
22 1. Demonstrate knowledge of the components of the Individual First Aid Kit (IFAK)
23 and/or medical kit.

24
25 2. Understand the priorities of Tactical Casualty Care as applied by zone.

26
27 3. Demonstrate competency through practical testing of the following medical treatment
28 skills:

29
30 a. Bleeding control

31
32 b. Apply Tourniquet

33
34 i. Self-Application

35
36 ii. Application on others

37
38 c. Apply Direct Pressure

39
40 d. Apply Pressure Dressing

41
42 e. Apply Hemostatic Dressing with Wound Packing, utilizing California EMSA-approved
43 products

44
45 2. Airway and Respiratory management

- a. Perform Chin Lift/Jaw Thrust Maneuver
- b. Recovery position
- c. Position of comfort
- d. Airway adjuncts
3. Chest/torso wounds
 - a. Apply Chest Seals, vented preferred
4. Demonstrate competency in patient movement and evacuation.
 - a. Drags and lifts.
 - b. Carries
5. Demonstrate knowledge of local multi-casualty/mass casualty incident protocols.
 - a. Triage procedures (START or SALT).
 - b. Casualty Collection Point.
 - c. Triage, Treatment and Transport.
- (6) Threat Assessment.
 - (A) Demonstrate knowledge in threat assessment.
 1. Understand and demonstrate knowledge of situational awareness
 2. Pre-assessment of community risks and threats.
 3. Pre-incident planning and coordination
 4. Medical resources available.
 - (c) The content of the CCP course shall include:

* * * * *
 - (d) Training programs in operation prior to the effective date of these regulations shall submit evidence of compliance with this Chapter to the appropriate approving authority as specified in Section 100137 of this Chapter within twelve (12) months after the effective date of these regulations.

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Sections 1797.172, 1797.173, 1797.185 and 1797.213, Health and Safety Code.

§ 100156. Required Testing.

(a) Approved paramedic and CCP training programs shall include a minimum of two (2) formative examinations and one (1) final comprehensive competency-based examinations to test the knowledge and skills specified in this Chapter.

(b) Documentation of successful student clinical and field internship performance shall be required prior to course completion.

Note: Authority cited: Sections 1797.107, 1797.172 and 1797.185, Health and Safety Code. Reference: Sections 1797.172, 1797.185, 1797.208, 1797.210 and 1797.213, Health and Safety Code.

§ 100157. Course Completion Record.

(a) A tamper resistant course completion record shall be issued to each person who has successfully completed the paramedic training program and/or CCP training program. The course completion record shall be issued no later than ten (10) working days from the date the student successfully completes the paramedic and/or CCP training program.

(b) The course completion record shall contain the following:

(1) The name of the individual.

(2) The date of completion.

(3) The following statement:

(A) "The individual named on this record has successfully completed an approved paramedic training program", or

(B) "The individual named on this record has successfully completed an approved Critical Care Paramedic training program."

(4) The name of the training program approving authority.

(5) The signature of the program director.

(6) The name and location of the training program issuing the record.

(7) The following statement in bold print: "This is not a paramedic license."

(8) For paramedic training, a list of the approved optional scope of practice procedures and/or medications taught in the course pursuant to subsection (c)(2)(A)-(D) of Section 100146.

(9) For CCP training, a list of the approved procedures and medications taught in the course pursuant to subsection (c)(1)(S)(1-10) of Section 100146.

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Section 1797.172, Health and Safety Code.

§ 100158. Student Eligibility.

(a) To be eligible to enter a paramedic training program an individual shall meet the following requirements:

(1) Possess a high school diploma or general education equivalent; and

(2) possess a current basic cardiac life support (CPR) card equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level; and

(3) possess a current EMT certificate or NREMT-Basic registration; or

(4) possess a current AEMT certificate in the State of California; or

(5) be currently registered as an Advanced-EMT with the NREMT.

(b) To be eligible to enter a CCP training program an individual shall be currently licensed, and accredited, in California as a paramedic with three (3) years of basic paramedic practice.

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Sections 1797.172 and 1797.208, Health and Safety Code.

§ 100159. Procedure for Training Program Approval.

(a) Eligible training institutions, as defined in Section 100149(j), shall submit a written request for training program approval to the paramedic training program approving authority

(b) The paramedic training program approving authority shall receive and review the following documentation prior to program approval:

(1) A statement verifying that the course content meets the requirements contained in the U.S. DOT National Education Standards DOT HS 811 077 E January 2009.

(2) An outline of course objectives.

1 (3) Performance objectives for each skill.

2
3 (4) The names and qualifications of the training program director, program medical
4 director, and principal instructors.

5
6 (5) Provisions for supervised hospital clinical training including student evaluation
7 criteria and standardized forms for evaluating paramedic students; and monitoring of
8 preceptors by the training program.

9
10 (6) Provisions for supervised field internship including student evaluation criteria and
11 standardized forms for evaluating paramedic students; and monitoring of preceptors by
12 the training program.

13
14 (7) The location at which the courses are to be offered and their proposed dates.

15
16 (8) Written agreements between the paramedic training program and a hospital(s) and
17 other clinical setting(s), if applicable, for student placement for clinical education and
18 training.

19
20 (9) Written contracts or agreements between the paramedic training program and a
21 provider agency (ies) for student placement for field internship training.

22
23 (10) A copy of an approved CoAEMSP LoR issued to the training institution applying for
24 approval or documentation of current CAAHEP accreditation.

25
26 (11) Samples of written and skills examinations administered by the training program.

27
28 (12) Samples of a final written examination administered by the training program.

29
30 (13) Evidence of adequate training program facilities, equipment, examination securities
31 and student record keeping.

32
33 (14) CCP programs shall submit a statement verifying the CCP training program course
34 content complies with the requirements of subsection 100155(c) of this Chapter and
35 documentation listed in subsections (b)(2)(B)(C)(D)(E)(G) and (H) of this Section, If
36 applicable.

37
38 (c) The paramedic training program approving authority shall submit to the Authority an
39 outline of program objectives and eligibility on each training program being proposed for
40 approval in order to allow the Authority to make the determination required by section
41 1797.173 of the Health and Safety Code. Upon request by the Authority, any or all
42 materials submitted by the training program shall be submitted to the Authority.

43
44 (d) Paramedic training programs will be approved by meeting all requirements in
45 subsection (b) of this section. Notification of program approval or deficiencies with the
46 application shall be made in writing by the paramedic training program approving

1 authority to the requesting training program in a time period not to exceed ninety (90)
2 days.

3
4 (e) The paramedic training program approving authority shall establish the effective date
5 of program approval in writing upon the satisfactory documentation of compliance with
6 all program requirements.

7
8 (f) Paramedic training program approval shall be valid for four (4) years ending on the
9 last day of the month in which it was issued and may be renewed every four (4) years
10 subject to the procedure for program approval specified in Section 100159(b).

11
12 Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
13 Reference: Sections 1797.172, 1797.173 and 1797.208, Health and Safety Code; and
14 Section 15376, Government Code.

15
16 **§ 100160. Program Review and Reporting.**

17 (a) All program materials specified in this Chapter shall be subject to review by the
18 paramedic training program approving authority and shall also be made available for
19 review upon request by the Authority.

20
21 (b) All programs shall be subject to on-site evaluation by the paramedic approving
22 authority and may also be evaluated by the Authority.

23
24 (c) Any person or agency, conducting a training program shall provide written
25 notification of changes to the paramedic training program approving authority of course
26 objectives, hours of instruction, program director, program medical director, principal
27 instructor, provisions for hospital clinical experience, or field internship. Written
28 notification shall be provided in advance, when possible, and no later than thirty (30)
29 days after a change(s) has been identified.

30
31 Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
32 Reference: Sections 1797.172, 1797.173 and 1797.208, Health and Safety Code.

33
34 **§ 100162. Withdrawal of Program Approval.**

35 (a) Failure to comply with the provisions of this Chapter may result in denial, probation,
36 suspension or revocation of program approval by the paramedic training program
37 approving authority.

38
39 (b) The requirements for training program noncompliance notification and actions are as
40 follows:

41
42 (1) A paramedic training program approving authority shall provide written notification of
43 noncompliance with this Chapter to the paramedic training program provider found in
44 violation. The notification shall be in writing and sent by certified mail to the paramedic
45 training program director.

CLEAN COPY

(2) Within fifteen (15) days from receipt of the noncompliance notification the approved training program shall submit in writing, by certified mail, to the paramedic training program approving authority one of the following:

(A) Evidence of compliance with the provisions of this Chapter, or

(B) A plan to comply with the provisions of this Chapter within sixty (60) days from the day of receipt of the notification of noncompliance.

(3) Within fifteen (15) days from receipt of the approved training program's response, or within thirty (30) days from the mailing date of the noncompliance notification, if no response is received from the approved paramedic training program, the paramedic training program approving authority shall issue a decision letter by certified mail to the Authority and the approved paramedic training program. The letter shall identify the paramedic training program approving authority's decision to take one or more of the following actions:

(A) Accept the evidence of compliance provided.

(B) Accept the plan for meeting compliance provided.

(C) Place the training program on probation.

(D) Suspend or revoke the training program approval.

(4) The decision letter shall also include, but not be limited to, the following information:

(A) Date of the program training approval authority's decision;

(B) Specific provisions found noncompliant by the training approval authority, if applicable;

(C) The probation or suspension effective and ending date, if applicable;

(D) The terms and conditions of the probation or suspension, if applicable;

(E) The revocation effective date, if applicable;

(5) The paramedic training program approving authority shall establish the probation, suspension, or revocation effective dates no sooner than sixty (60) days after the date of the decision letter, as described in subsection (3) of this Section.

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Sections 1797.172, 1797.208 and 1798.202, Health and Safety Code.

ARTICLE 4. APPLICATIONS AND EXAMINATIONS

§ 100163. Cognitive Written and Psychomotor Skills Examination.

(a) Applicants shall comply with the procedures for examination established by the Authority and the NREMT and shall not violate or breach the security of the examination. Applicants found to have violated the security of the examination or examination process as specified in Section 1798.207 of the Health and Safety Code, shall be subject to the penalties specified therein.

(b) Students enrolled in an accredited paramedic training program, or a paramedic training program with a current Letter of Review on file with the NREMT, shall be eligible to take the psychomotor skills examination specified in Section 100140 of this chapter upon successful completion of didactic and skills laboratory. Students shall be eligible to take the cognitive written examination specified in Section 100141 when they have successfully completed the didactic, clinical, and field training and have met all the provisions of the approved paramedic training program.

Note: Authority cited: Sections 1797.7, 1797.107, 1797.172, 1797.174 and 1797.185, Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, 1797.214 and 1798.207, Health and Safety Code.

§ 100164. Date and Filing of Applications.

(a) The Authority shall notify the applicant within forty-five (45) calendar days of receipt of the state application that the application was received and shall specify what information, if any, is missing. The types of applications, which the applicant may be required to submit to the Authority, are as follows:

(1) Initial In-State Paramedic License Application, (California Graduate), Form #L-01, revised 03/2019 herein incorporated by reference, for California paramedic program graduates.

(2) Initial Out-of-State Paramedic License Application Form #L-01A revised 03/2019, herein incorporated by reference, for Out-of-State applicants who are registered with the National Registry of Emergency Medical Technicians as a paramedic.

(3) Initial Challenge Paramedic License Application, Form #CL-01A revised 03/2019, herein incorporated by reference.

(4) Renewal Paramedic License Form #RL-01, revised 03/2019, herein incorporated by reference.

(5) Audit Renewal Paramedic License Application, Form #AR-01, revised 03/2019, herein incorporated by reference.

(6) Reinstatement Paramedic License Applications(s):

CLEAN COPY

1 (A) Reinstatement Paramedic License Application Lapsed Less than One Year, Form
2 #RLL-01A, revised 03/2019, herein incorporated by reference.

3
4 (B) Reinstatement Paramedic License Application Lapsed One Year or More, Form
5 #RLL-01B, revised 03/2019, herein incorporated by reference.

6
7 (7) Applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service
8 Form, BCII 8016 (Rev 05/2018), submitted to the California Department of Justice
9 (DOJ), for a state and federal criminal history report provided by the Department of
10 Justice in accordance with the provisions of section 11105 et seq. of the Penal Code.

11
12 (8) Request for Licensure/Certification Verification, Form #VL-01, revised 03/2019.

13
14 (b) Applications for renewal of license shall be complete and postmarked, hand
15 delivered, or otherwise received by the Authority at least thirty (30) calendar days prior
16 to the expiration date of the current license. Applications postmarked, hand delivered or
17 otherwise received by the Authority less than thirty (30) calendar days prior to the
18 expiration date of the current license will require the applicant to pay a \$50 late fee, as
19 specified in Section 100172(b)(4) of this Chapter.

20
21 (c) Eligible out-of-state applicants as defined in section 100165() (a)(2) and eligible
22 applicants as defined in section 100165 (a)(3) of this Chapter who have applied to
23 challenge the paramedic licensure training requirements shall be notified by the
24 Authority within forty-five (45) calendar days of receiving the application. Notification
25 shall advise the applicant that the application has been received, and shall specify what
26 information, if any, is missing.

27
28 (d) An application shall be denied without prejudice when an applicant does not
29 complete the application, furnish additional information or documents requested by the
30 Authority or fails to pay any required fees. An applicant shall be deemed to have
31 abandoned an application if the applicant does not complete the requirements for
32 licensure within one (1) year from the date on which the application was filed. An
33 application submitted subsequent to an abandoned application shall be treated as a
34 new application.

35
36 (e) A complete state application is a signed application submitted to the Authority that
37 provides all the requested information and is accompanied by the appropriate
38 application fee(s). All statements submitted by or on behalf of an applicant shall be
39 made under penalty of perjury.

40
41 Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
42 Reference: Section 1797.172, Health and Safety Code.

43 44 **ARTICLE 5. LICENSURE**

45 46 **§ 100165. Licensure.**

CLEAN COPY

1 (a) In order to be eligible for initial paramedic licensure an applicant shall meet at least
2 one of the following requirements:

3
4 (1) Provide documentation of a California paramedic training program course
5 completion record as specified in Section 100157 of this Chapter or other documented
6 proof of successful completion of a California approved paramedic training program and
7 shall meet the following requirements:

8
9 (A) Complete and submit the appropriate Initial In-State Paramedic License application
10 form as specified in Section 100164.

11
12 (B) Provide documentation of successful completion of the paramedic licensure
13 cognitive written and psychomotor skills examinations within the previous two (2) years
14 as specified in sections 100140 and 100141, or possess a current NREMT paramedic
15 registration.

16
17 (C) Submit to the California DOJ, an applicant fingerprint card, FD-258 dated 5/11/99 or
18 a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Revised
19 05/2018), for a state criminal history record provided by the DOJ in accordance with the
20 provisions of Section 11105 et seq. of the Penal Code.

21
22 (D) Pay the established fees pursuant to Section 100172.

23
24 (2) Provide documentation of a paramedic license or a paramedic training program
25 course completion issued from an approved training program outside the State of
26 California and meet the following requirements:

27
28 (A) Complete and submit the Initial Out-of-State Paramedic License application form as
29 specified in Section 100164.

30
31 (B) Provide documentation of a current paramedic NREMT registration or proof of
32 passing the paramedic licensure cognitive written and psychomotor skills exams within
33 the last two (2) years.

34
35 (C) Provide documentation of successful completion of an approved paramedic field
36 internship, provided by an approved paramedic program director, consisting of no less
37 than 40 advanced life support patient contacts as defined in Section 100153(a), or a
38 letter on official letterhead by an applicant's employer, training program director, or
39 medical director verifying applicant's successful completion of 40 ALS patient contacts.

40
41 (D) An individual who is currently or was previously paramedic certified/licensed out-of-
42 state shall submit a completed Request for License/Certification Verification, Form # VL-
43 01 03/2019.

44
45 (E) Submit to the California DOJ, an applicant fingerprint card, FD-258 dated 5/11/99 or
46 a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Revised

CLEAN COPY

05/2018), for a state criminal history record provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code

(F) Pay the established fees pursuant to Section 100172.

(3) A physician, authorized registered nurse, mobile intensive care nurse (MICN), or physician assistant currently licensed shall be eligible to challenge the required paramedic training for initial paramedic licensure upon meeting the following requirements:

(A) If licensed as a physician, authorized registered nurse, MICN or physician assistant outside the state of California, provide documentation that their training is equivalent to the DOT HS 811 077 E specified in Section 100155,

(B) If licensed as a physician, authorized registered nurse, MICN or physician assistant in the state of California, provide a copy of their current license, or

(C) Complete and submit the Initial Challenge Paramedic License application form as specified in Section 100164.

(D) Provide documentation of successful completion of no less than 40 advanced life support patient contacts during an approved paramedic training program field internship, as specified in Section 100153(a), or a letter on official letterhead by a paramedic employer, training program director, or medical director verifying applicant's successful completion of 40 ALS patient contacts in an approved paramedic service provider field environment.

(E) Pay the established fees pursuant to Section 100172.

(F) Submit a completed Request for Licensure/Certification Verification Form # VL-01 03/2019, if applicable.

(G) Provide documentation of a current paramedic NREMT registration or proof of passing the paramedic licensure cognitive written and psychomotor skills exams within the last two (2) years.

1. If a letter of support is required by the NREMT to take the paramedic licensure cognitive written or psychomotor skills exams, the applicant shall notify the Authority. The Authority shall review an applicant's completed and signed application for eligibility to provide a letter of support to NREMT.

(H) Submit to the California DOJ, an applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Revised 05/2018), for a state criminal history record provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code.

1 (b) If a letter of support is required by the NREMT to take the paramedic licensure
2 cognitive written or psychomotor skills exams, the applicant shall be required to submit
3 the appropriate application as identified in section 100165(a) and at least one of the
4 following to the Authority:

5
6 (1) Documentation showing the applicant is currently licensed as an out-of-state
7 paramedic.

8
9 (2) Documentation showing proof of completion of a state, or country, approved or
10 CAAHEP accredited paramedic training program within the past two (2) years.

11
12 (3) Documentation showing applicants training program course content is equivalent or
13 surpasses the content and hours of the January 2009 United States Department of
14 Transportation (U.S. DOT) National Emergency Medical Services Education Standards
15 DOT HS 811 077E.”

16
17 (c) All documentation submitted in a language other than English shall be accompanied
18 by a translation into English certified by a translator who is in the business of providing
19 certified translations and who shall attest to the accuracy of such translation under
20 penalty of perjury.

21
22 (d) The Authority shall issue within forty-five (45) calendar days of receipt of a
23 completed application as specified in Section 100164(e) a wallet-sized license to eligible
24 individuals who apply for a license and successfully complete the licensure
25 requirements.

26
27 (e) The initial paramedic licenses’ effective date shall be the day the license is issued.
28 The license shall be valid for a period of two (2) years; beginning on the effective date
29 through the last day of the approval month in the second year.

30
31 (f) The paramedic shall be responsible for notifying the Authority of her/his proper and
32 current mailing address and shall notify the Authority in writing within thirty (30) calendar
33 days of any and all changes of the mailing address, giving both the old and the new
34 address, and paramedic license number.

35
36 (g) A paramedic may request a duplicate license if the individual submits a request in
37 writing certifying to the loss or destruction of the original license, or the individual has
38 changed his/her name. If the request for a duplicate card is due to a name change, the
39 request shall also include documentation of the name change. The duplicate license
40 shall bear the same number and date of expiration as the replaced license.

41
42 (h) An individual currently licensed as a paramedic by the provision of this section may
43 function as an EMT and/or an AEMT, except when the paramedic license is under
44 suspension, with no further testing or certification process required. If a separate EMT
45 or AEMT certificate is sought the certifying entity shall follow the EMT, or AEMT
46 certification/recertification provisions as specified in Chapters 2 and 3 of this Division.

(i) An individual currently licensed as a paramedic by the provisions of this section may voluntarily deactivate his/her paramedic license if the individual is not under investigation or disciplinary action by the Authority for violations of Health and Safety Code Section 1798.200. If a paramedic license is voluntarily deactivated, the individual shall not engage in any practice for which a paramedic license is required, shall return his/her paramedic license to the Authority, and shall notify any LEMSA with which he/she is accredited as a paramedic or with which he/she is certified as an EMT or AEMT that the paramedic license is no longer valid. Reactivation of the paramedic license shall be done in accordance with the provisions of Section 100167(b) of this Chapter.

Note: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185, 1797.194, 1798.200 and 1798.202, Health and Safety Code. Reference: Sections 1797.56, 1797.63, 1797.172, 1797.175, 1797.177, 1797.185, 1797.194 and 1798.200, Health and Safety Code; and Section 15376, Government Code.

ARTICLE 6. LICENSE RENEWALS, LICENSE AUDIT RENEWALS and LICENSE REINSTATEMENTS.

§ 100167. License Renewal, License Audit Renewal, and License Reinstatement

(a) In order to be eligible for renewal of a non-lapsed paramedic license, an individual shall comply with the following requirements:

(1) Possess a current paramedic license issued in California.

(2) Complete forty-eight (48) hours of CE pursuant to the provisions of Chapter 11 of this Division.

(3) Complete and submit the Renewal Paramedic License Application, Form #RL-01, revised 03/2019.

(4) If applicant is selected for audit, submit to the Authority a signed and completed Audit Renewal Paramedic License Application, Form #AR-01, revised 03/2019.

(A) Applicants selected for audit shall submit documentation of forty-eight (48) hours of CE completion, as specified in (a)(2) of this section.

(5) Pay the appropriate fees as specified on the application in accordance with Section 100172 of this Chapter.

(6) EMSA will send a renewal reminder notification by mail to the paramedic, approximately five (5) months prior to their paramedic license expiration date.

(b) In order for an individual whose license has lapsed to be eligible for license reinstatement, the following requirements shall apply:

CLEAN COPY

(1) For a license lapsed less than six (6) months, the individual shall submit:

(A) Forty-eight (48) hours of CE pursuant to the provisions of Chapter 11 of this Division with copies of the CE Certificates.

(B) Pay the appropriate fees as specified on the application in accordance with Section 100172 of this Chapter.

(C) Submit a signed and completed Reinstatement Paramedic License Application, Lapsed Less than 1 year, specified in Section 100164(a)(6)(A),

(D) If an applicant is or was certified/licensed in another state or country, a signed and completed Licensure/Certification Verification, Form #VL-01, 03/2019, shall be submitted to the Authority for each state or country the applicant was licensed/certified.

(2) For a license lapsed six (6) months or more, but less than twelve (12) months, the individual shall:

(A) Submit sixty (60) hours of CE pursuant to the provisions of Chapter 11 of this Division, with copies of the CE Certificates.

(B) Pay the appropriate fees as specified on the application in accordance with Section 100172 of this Chapter.

(C) Submit a signed and completed Reinstatement Paramedic License Application, Lapsed less than 1 year, as specified in Section 100164(a)(6)(A).

(D) If an applicant is or was certified/licensed in another state or country, a signed and completed Licensure/Certification Verification, Form #VL-01, 03/2019, shall be submitted to the Authority for each state or country the applicant was licensed/certified.

(3) For a license lapsed twelve (12) months or more, but less than twenty-four (24) months, the individual shall:

(A) Provide documentation of passing the licensure examinations within the past two (2) years as specified in Sections 100140 and 100141 or provide documentation of a current paramedic registration issued by the NREMT,

(B) Submit seventy-two (72) hours of CE pursuant to the provisions of Chapter 11 of this Division, with copies of the CE Certificates.

(C) Pay the appropriate fees as specified on the application in accordance with Section 100172 of this Chapter,

CLEAN COPY

(D) Submit to the California DOJ, an applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Revised 05/2018), for a state criminal history record provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code

(E) Submit a signed and completed Reinstatement Paramedic License Application, Lapsed 1 year or more, specified in Section 100164(a)(6)(B),

(F) If an applicant is or was certified/licensed in another state or country, a signed and completed Licensure/Certification Verification, Form #VL-01, 03/2019, shall be submitted to the Authority for each state or country the applicant was licensed/certified.

(4) For a lapse of twenty-four (24) months or more, the individual shall:

(A) Provide documentation of passing the licensure examinations within the past two (2) years as specified in Sections 100140 and 100141 or provide documentation of a current paramedic registration issued by the NREMT.

(B) Pay the appropriate fees as specified on the application in accordance with Section 100172 of this Chapter.

(C) Submit to the California DOJ an applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Rev 05/2018), for a state criminal history record provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code.

(D) Submit a signed and completed Reinstatement Paramedic License Application, lapsed 1 year or More, specified in Section 100164(a)(6)(B).

(E) Documentation of seventy-two (72) hours of CE that shall include completion of the following courses, or their equivalent:

(1) Advanced Cardiac Life Support,

(2) Pediatric Advanced Life Support,

(3) Prehospital Trauma Life Support or International Trauma Life Support,

(4) CPR.

(F) If an applicant is or was certified/licensed in another state or country, a signed and completed Licensure/Certification Verification, Form #VL-01, 03/2019, shall be submitted to the Authority for each state or country the applicant was licensed/certified.

(c) Renewal of a license shall be for two (2) years. If the renewal requirements are met within six (6) months prior to the expiration date of the current license, the effective date

1 of licensure shall be the first day after the expiration of the current license. This applies
2 only to individuals who have not had a lapse in licensure.

3
4 (d) Reinstated licenses shall be valid for a period of two (2) years; beginning on the date
5 of issuance through the last day of the approved month in the second year.

6
7 (e) Within forty-five (45) calendar days of receiving the application, the Authority shall
8 notify the applicant that the application has been approved or specify what information,
9 if any, is missing.

10
11 (f) An individual, who is a member of the Armed Forces of the United States, whose
12 paramedic license expires during the time the individual is on active duty or license
13 expires less than six (6) months from the date the individual is deactivated/released
14 from active duty, has an additional six (6) months to comply with the following CE
15 requirements and the late renewal fee is waived upon compliance with the following
16 provisions:

17
18 (1) Provide documentation from the respective branch of the Armed Forces of the
19 United States verifying the individual's dates of activation and deactivation/release from
20 active duty.

21
22 (2) Meet the requirements of Section 100167(a)(2) through (a)(4) of this Chapter, except
23 the individual will not be subject to the \$50 late renewal application fee specified in
24 Section 100172(b)(4).

25
26 (3) Provide documentation showing the CEs were received no sooner than 30 days
27 prior to the effective date of the individual's paramedic license that was valid when the
28 individual was activated for active duty and not later than six months from the date of
29 deactivation/release from active duty.

30
31 (A) Individuals whose active duty required them to use their paramedic skills, credit may
32 be given for documented training that meets the requirements of Chapter 11, EMS
33 Continuing Education Regulations (California Code of Regulations, Title 22, Division 9).
34 The documentation shall include verification from the individual's Commanding Officer
35 attesting to the classes attended.

36
37 Note: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194,
38 Health and Safety Code. Reference: Sections 1797.63, 1797.172, 1797.175, 1797.185,
39 1797.194 and 1797.210, Health and Safety Code; and Section 101, Chapter 1, Part 1,
40 Subtitle A, Title 10, United States Code.

41 42 **ARTICLE 7. SYSTEM REQUIREMENTS**

43 44 **§ 100170. Medical Control.**

45 The medical director of the LEMSA shall establish and maintain medical control in the
46 following manner:

- 1
2 (a) Prospectively, by assuring the development of written medical policies and
3 procedures, to include at a minimum:
4
5 (1) Treatment protocols that encompass the paramedic scope of practice.
6
7 (2) Local medical control policies and procedures as they pertain to the paramedic base
8 hospitals, alternative base stations, paramedic service providers, paramedic personnel,
9 patient destination, and the LEMSA.
10
11 (3) Criteria for initiating specified emergency treatments on standing orders or for use in
12 the event of communication failure that is consistent with this Chapter.
13
14 (4) Criteria for initiating specified emergency treatments, prior to voice contact, that are
15 consistent with this Chapter.
16
17 (5) Requirements to be followed when it is determined that the patient will not require
18 transport to the hospital by ambulance, is treated on scene without transport, or when
19 the patient refuses care or transport.
20
21 (6) Requirements for the initiation, completion, review, evaluation, and retention of an
22 electronic health record (EHR) as specified in this Chapter. These requirements shall
23 address but not be limited to:
24
25 (A) Initiation of an electronic health record for every patient response.
26
27 (B) Responsibilities for record completion.
28
29 (C) Record distribution to include LEMSA, receiving hospital, paramedic base hospital,
30 alternative base station, and paramedic service provider.
31
32 (D) Responsibilities for record review and evaluation.
33
34 (E) Responsibilities for record retention.
35
36 (b) Establish policies which provide for direct voice communication between a
37 paramedic and a base hospital physician, authorized registered nurse, or MICN, as
38 needed.
39
40 (c) Retrospectively, by providing for organized evaluation and CE for paramedic
41 personnel. This shall include, but not be limited to:
42
43 (1) Review by a base hospital physician, authorized registered nurse, or MICN of the
44 appropriateness and adequacy of paramedic procedures initiated and decisions
45 regarding transport.
46

(2) Maintenance of records of communications between the service provider(s) and the base hospital through tape recordings and through emergency department communication logs sufficient to allow for medical control and CE of the paramedic.

(3) Organized field care audit(s).

(4) Organized opportunities for CE including maintenance and proficiency of skills as specified in this Chapter.

(5) Ensuring the EMSQIP methods of evaluation are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process and recognize excellence in performance and delivery of care, pursuant to the provisions of Chapter 12 of this Division.

(d) In circumstances where use of a base hospital as defined in Section 100169 is precluded, alternative arrangements for complying with the requirements of this Section may be instituted by the medical director of the LEMSA if approved by the Authority.

Note: Authority cited: Sections 1797.106, 1797.107, 1797.172 and 1797.176, Health and Safety Code. Reference: Sections 1204, 1206, 1797.56, 1797.90, 1797.114, 1797.172, 1797.202, 1797.220, 1797.227, 1798, 1798.2, 1798.3, 1798.101 and 1798.105, Health and Safety Code; and Section 5404 of the Welfare and Institutions Code.

ARTICLE 8. RECORD KEEPING AND FEES

§ 100171. Record Keeping.

(a) Each paramedic approving authority shall maintain a record of approved training programs within its jurisdiction and annually provide the Authority with the name, address, and program director of each approved program. The Authority shall be notified of any changes in the list of approved training programs.

(b) Each paramedic approving authority shall maintain a list of current paramedic program medical directors, program directors, and principal instructors within its jurisdiction.

(c) The Authority shall maintain a record of approved training programs.

(d) Each LEMSA shall, at a minimum, maintain a list of all paramedics accredited by them in the preceding five (5) years.

(e) The paramedic is responsible for accurately completing, in a timely manner, the electronic health record referenced in Section 100170(a)(6) compliant with the current versions of the National EMS Information System and the California EMS Information

System, which shall contain, but not be limited to, the following information when such information is available to the paramedic:

- (1) The date and estimated time of incident.
 - (2) The time of receipt of the call (available through dispatch records).
 - (3) The time of dispatch to the scene.
 - (4) The time of arrival at the scene.
 - (5) The location of the incident.
 - (6) The patient's:
 - (A) Name;
 - (B) Age or date of birth;
 - (C) Gender;
 - (D) Weight, if necessary for treatment;
 - (E) Address;
 - (F) Chief complaint; and
 - (G) Vital signs.
 - (7) Appropriate physical assessment.
 - (8) Primary Provider Impression.
 - (9) The emergency care rendered and the patient's response to such treatment.
 - (10) Patient disposition.
 - (11) The time of departure from scene.
 - (12) The time of arrival at receiving facility (if transported).
 - (13) Time patient care was transferred to receiving facility.
 - (14) The name of receiving facility (if transported).
 - (15) The name(s) and unique identifier number(s) of the paramedics.
 - (16) Signature(s) of the paramedic(s).
- (f) A LEMSA shall establish policies for the collection, utilization, storage and secure transmission of interoperable electronic health records.
- (g) The paramedic service provider shall submit electronic health records to the LEMSA according to the LEMSA's policies and procedures.
- (h) The LEMSA shall submit the electronic health record data to the Authority within seventy-two (72) hours after completion of the patient encounter, or at longer intervals if established by written agreement between the LEMSA and the Authority.

Note: Authority cited: Sections 1797.107, 1797.172 and 1797.185, Health and Safety Code. Reference: Sections 1797.172, 1797.173, 1797.185, 1797.200, 1797.227, 1797.204 and 1797.208, Health and Safety Code.

§ 100172. Fees.

(a) A LEMSA may establish a schedule of fees for paramedic training program review and approval, CE provider approval, and paramedic accreditation in an amount sufficient to cover the reasonable cost of complying with the provisions of this Chapter.

CLEAN COPY

(b) The following are the nonrefundable licensing fees established by the Authority:

(1) The Initial In-State Paramedic License application fee shall be two hundred fifty (\$250) dollars.

(A) Effective July 1, 2020 through June 30, 2021, the Initial In-State Paramedic License application fee shall be two hundred seventy-five (\$275) dollars.

(B) Effective July 1, 2021 and thereafter the Initial In-State Paramedic License application fee shall be three hundred (\$300) dollars.

(2) The the Initial Out-of-State Paramedic License application fee shall be three hundred (\$300) dollars.

(A) Effective July 1, 2020 through June 30, 2021, the Initial Out-of-State Paramedic License application fee shall be three hundred twenty-five (\$325) dollars.

(B) Effective July 1, 2021 and thereafter the Initial Out-of-State Paramedic License application fee shall be three hundred fifty (\$350) dollars.

(3) The the Renewal Paramedic License application fee received at least thirty (30) days prior to expiration of the current license, as specified in 100164(b) of this Chapter, shall be two hundred dollars (\$200)

(A) Effective July 1, 2020 through June 30, 2021, the Renewal Paramedic License application fee received at least thirty (30) days prior to expiration of the current license, as specified in 100164(b) of this Chapter, shall be two hundred twenty-five (\$225) dollars.

(B) Effective July 1, 2021 and thereafter the Renewal Paramedic License application fee received at least thirty (30) days prior to expiration of the current license, as specified in 100164(b) of this Chapter, shall be two hundred fifty (\$250) dollars.

(4) The fee for failing to submit a complete application for renewal, as specified in Section 100164(e), within the timeframe specified in Section 100164(b) shall be a late fee in the amount of fifty dollars (\$50.00).

(5) The fee for state and criminal history records shall be in accordance with the schedule of fees established by the California DOJ and the Federal Bureau of Investigations.

(6) The fee for a duplicate or replacement of a license shall be ten dollars (\$10).

(7) The fee for approval and re-approval of a CE provider shall be two thousand five hundred (\$2,500) dollars.

CLEAN COPY

1
2 (8) The fee for administration of the provisions of Section 17520 of the Family Code
3 shall be five dollars (\$5); which is incorporated into the fees specified commencing with
4 Section 100172(b)(1).

5
6 (9) The Reinstatement Paramedic License Application fee shall be two hundred fifty
7 dollars (\$250).

8
9 (A) Effective July 1, 2020 through June 30, 2021, the Reinstatement Paramedic License
10 Application fee shall be two hundred seventy-five (\$275) dollars.

11
12 (B) Effective July 1, 2021 and thereafter the Reinstatement Paramedic License
13 Application fee shall be three hundred (\$300) dollars.

14
15 (10) The Initial Challenge Paramedic License Application fee shall be three hundred
16 dollars (\$300).

17
18 (A) Effective July 1, 2020 through June 30, 2021, the Initial Challenge Paramedic
19 License Application fee shall be three hundred twenty-five (\$325) dollars.

20
21 (B) Effective July 1, 2021 and thereafter the Initial Challenge Paramedic License
22 Application fee shall be three hundred fifty (\$350) dollars.

23
24 (11) The fee for dishonored checks shall be twenty-five dollars (\$25).

25
26 Note: Authority cited: Sections 1797.107, 1797.112, 1797.172, 1797.185 and 1797.212,
27 Health and Safety Code. Reference: Sections 1797.172, 1797.185 and 1797.212,
28 Health and Safety Code; and Section 11105, Penal Code; and Section 1719, Civil
29 Code.
30

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

The Emergency Medical Services Authority has illustrated changes to the original text in the following manner:

- Additions to the original text from 45-day comment period are shown underlined.
- Deletions to the original text from 45-day comment period are shown in Strikeout
 - Omitted text is indicated by (* * * *)

The Emergency Medical Services Authority has illustrated changes to the modified text from the 15-day comment period in the following manner:

- Additions to the modified text are shown in double underline.
- Deletions to the modified text are shown in ~~double strikeout~~.

The Emergency Medical Services Authority has illustrated changes to the modified text from the second 15-day comment period in the following manner:

- Additions to the modified text are shown in **bolded double underline**.
- Deletions to the modified text are shown in ~~**bolded double strikeout**~~.

The Emergency Medical Services Authority has illustrated changes to the modified text from the third 15-day comment period in the following manner:

- Additions to the modified text are shown in ***bolded italics double underline***.
- Deletions to the modified text are shown in ~~***bolded italics double strikeout***~~.

The Emergency Medical Services Authority has illustrated changes to the modified text from the fourth 15-day comment period in the following manner:

- Additions to the modified text are shown in ***highlighted bolded italics double underline***.
- Deletions to the modified text are shown in ~~***highlighted bolded italics double strikeout***~~.

California Code of Regulations Title 22. Social Security Division 9. Prehospital Emergency Medical Services Chapter 4. Paramedic

ARTICLE 1. DEFINITIONS

§ 100137. Paramedic Training Program Approving Authority.

(a) "Paramedic training program approving authority" means an agency or person authorized by this Chapter to approve a Paramedic training program and/or a Critical Care Paramedic (CCP) training program, as follows:

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

(a) ~~(1)~~ The approving authority for a A paramedic Paramedic training program and/or a Critical Care Paramedic (CCP) training program conducted by a ~~qualified~~ qualified statewide public safety agency shall be approved by the director of the Authority.

(b) ~~(2)~~ The approving authority for any Any other paramedic Paramedic training program and/or a Critical Care Paramedic (CCP) training program not included in subsection (1) ~~(a)~~ shall be approved by the local EMS agency (LEMSA) ~~which~~ that has jurisdiction in the ~~area in which~~ county where the training program is located. ~~headquartered~~.

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Sections 1797.172, 1797.200 and 1797.208, Health and Safety Code.

§ 100140. Licensure Psychomotor Skills Examination.

"Psychomotor Skills examination" or practical examination means the National Registry of Emergency Medical Technicians (NREMT) EMT-Paramedic Practical Psychomotor Skills Examination to test the skills of an individual applying for licensure as a paramedic. ~~Examination results shall be valid for application purposes for two (2) years from the date of examination.~~

Note: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code. Reference: Sections 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code.

§ 100141. Licensure Cognitive Written Examination.

"Licensure Cognitive Written Examination" means the NREMT EMT-Paramedic Written Cognitive Written Examination to test an individual applying for licensure as a paramedic. ~~Examination results shall be valid for application purposes for two (2) years from date of examination.~~

Note: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code. Reference: Sections 1797.63, 1797.172, 1797.175, 1797.185, 1797.194 and 1797.210, Health and Safety Code.

§ 100141.1. High Fidelity Simulation

High Fidelity Simulation means using computerized manikins, monitors, and similar devices or augmented virtual reality environments that are operated by a technologist from another location to produce audible sounds and to alter and manage physiological changes within the manikin to include, but not be limited to, altering the heart rate, respirations, chest sounds, and saturation of oxygen.

Note: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code. Reference: Sections 1797.63, 1797.172, 1797.175, 1797.185, 1797.194 and 1797.210, Health and Safety Code.

§ 100143.1 Electronic Health Record

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

1 “Electronic health record” or EHR, or electronic patient care record or ePCR means real
2 time, patient-centered records that make information available securely to authorized
3 users in a digital format capable of being shared with other providers across more than
4 one health care organization.

5
6 Note: Authority cited: Sections 1797.107, 1797.122 and 1797.227 Health and Safety
7 Code. Reference: Sections 1797.107, 1797.122 and 1797.227, Health and Safety Code.
8

9 **§ 100144. Critical Care Paramedic.**

10 A “Critical Care Paramedic” (CCP) or ~~Flight Paramedic (FP)~~ is an individual who is
11 educated and trained in critical care transport, whose scope of practice is in accordance
12 to the standards prescribed by this Chapter, has completed a training program as
13 specified in Section 100155(c), holds a current certification as a CCP by the
14 International Board of Specialty Certification (IBSC), Board for Critical Care Transport
15 Paramedic Certification (BCCTPC), who has a valid license issued pursuant to this
16 Chapter, and is accredited by a LEMSA in which their paramedic service provider is
17 based.

18
19 Note: Authority cited: Sections 1797.107, 1797.172 and 1797.194, Health and Safety
20 Code. Reference: Sections 1797.84, 1797.172, 1797.185 and 1797.194, Health and
21 Safety Code.

22 **§ 100144.1. Flight Paramedic.**

23 A “Flight Paramedic” (FP) is an individual who is educated and trained in critical care
24 transport, whose scope of practice is in accordance to the standards prescribed by this
25 Chapter, has completed a training program as specified in Section 100155(c), holds a
26 current certification as a FP by the International Board of Specialty Certification (IBSC),
27 Board for Critical Care Transport Paramedic Certification (BCCTPC), who has a valid
28 license issued pursuant to this Chapter, and is accredited by a LEMSA in which their
29 paramedic service provider is based.

30
31
32 Note: Authority cited: Sections 1797.107, 1797.172 and 1797.194, Health and Safety
33 Code. Reference: Sections 1797.84, 1797.172, 1797.185 and 1797.194, Health and
34 Safety Code.

35 **ARTICLE 2. GENERAL PROVISIONS**

36 **§ 100146. Scope of Practice of Paramedic.**

37
38 (a) A paramedic may perform any activity identified in the scope of practice of an EMT
39 in Chapter 2 of this Division, or any activity identified in the scope of practice of an
40 Advanced EMT (AEMT) in Chapter 3 of this Division without requiring a separate
41 certification.

42
43
44 (b) A licensed paramedic shall be affiliated with an approved paramedic service provider
45 in order to perform the scope of practice specified in this Chapter.
46

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

(c) A paramedic student or a licensed paramedic, as part of an organized EMS system, while caring for patients in a hospital as part of his/her training or continuing education (CE) under the direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, or while working in a small and rural hospital pursuant to Section 1797.195 of the Health and Safety Code, may perform the following procedures or administer the following medications when such are approved by the medical director of the LEMSA and are included in the written policies and procedures of the LEMSA.

(1) Basic Scope of Practice:

(A) Utilize electrocardiographic devices and monitor electrocardiograms, including 12-lead electrocardiograms (ECG).

(B) Perform defibrillation, synchronized cardioversion, and external cardiac pacing.

(C) Visualize the airway by use of the laryngoscope and remove foreign body(ies) with Magill forceps.

(D) Perform pulmonary ventilation by use of lower airway multi-lumen adjuncts, the esophageal airway, perilaryngeal airways, stomal intubation, and adult oral endotracheal intubation.

(E) Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP)/bi-level positive airway pressure (BPAP) and positive end expiratory pressure (PEEP) in the spontaneously breathing patient.

(F) Institute intravenous (IV) catheters, saline locks, needles, or other cannulae (IV lines), in peripheral veins and monitor and administer medications through pre-existing vascular access.

(G) Institute intraosseous (IO) needles or catheters.

(H) Administer IV or IO glucose solutions or isotonic balanced salt solutions, including Ringer's lactate solution.

(I) Obtain venous blood samples.

(J) Use laboratory devices, including point of care testing, for pre-hospital screening use to measure lab values including, but not limited to: glucose, capnometry, capnography, and carbon monoxide when appropriate authorization is obtained from State and Federal agencies, including from the Centers for Medicare and Medicaid Services pursuant to the Clinical Laboratory Improvement Amendments (CLIA).

(K) Utilize Valsalva maneuver.

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

1 (L) Perform percutaneous needle cricothyroidotomy.

2
3 (M) Perform needle thoracostomy.

4
5 (N) Perform nasogastric and orogastric tube insertion and suction.

6
7 (O) Monitor thoracostomy tubes.

8
9 (P) Monitor and adjust IV solutions containing potassium, equal to or less than 40
10 mEq/L.

11
12 (Q) Administer approved medications by the following routes: IV, IO, intramuscular,
13 subcutaneous, inhalation, transcutaneous, rectal, sublingual, endotracheal, intranasal,
14 oral or topical.

15
16 (R) Administer, using prepackaged products when available, the following medications:

17
18 1. 10%, 25% and 50% dextrose;

19
20 2. activated charcoal;

21
22 3. adenosine;

23
24 4. aerosolized or nebulized beta-2 specific bronchodilators;

25
26 5. amiodarone;

27
28 6. aspirin;

29
30 7. atropine sulfate;

31
32 8. pralidoxime chloride;

33
34 9. calcium chloride;

35
36 10. diazepam;

37
38 11. diphenhydramine hydrochloride;

39
40 12. dopamine hydrochloride;

41
42 13. epinephrine;

43
44 14. fentanyl;

45
46 15. glucagon;

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

16. ipratropium bromide;

17. lorazepam;

18. midazolam;

19. lidocaine hydrochloride;

20. magnesium sulfate;

21. morphine sulfate;

22. naloxone hydrochloride;

23. nitroglycerine preparations, except IV, unless permitted under (c)(2)(A) of this section;

24. ondansetron;

25. sodium bicarbonate.

(S) In addition to the approved paramedic scope of practice, the CCP or FP may perform the following procedures and administer medications, as part of the basic scope of practice for interfacility transports when approved by the LEMSA medical director.
~~when a licensed and accredited paramedic has completed a Critical Care Paramedic (CCP) training program as specified in Section 100160(b) and successfully completed competency testing, holds a current certification as a CCP from the BCCTPC, and other requirements as determined by the medical director of the LEMSA.~~

1. set up and maintain thoracic drainage systems;

2. set up and maintain mechanical ventilators;

3. set up and maintain IV fluid delivery pumps and devices;

4. blood and blood products;

5. glycoprotein IIB/IIIA inhibitors;

6. heparin IV;

7. nitroglycerin IV;

8. norepinephrine;

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

9. thrombolytic agents;

10. maintain total parenteral nutrition;

(2) Local Optional Scope of Practice:

(A) Perform or monitor other procedure(s) or administer any other medication(s) determined to be appropriate for paramedic use, ~~in the professional judgment of the by the~~ medical director of the LEMSA, that have been approved by the Director of the Authority. Paramedics shall demonstrate competency in performing these procedures and administering these medications through training and successful testing. when the paramedic has been trained and tested to demonstrate competence in performing the additional procedures and administering the additional medications.

(B) The medical director of the LEMSA shall submit a written request, Form #EMSA-0391, revised 01/17, Revised 03/18/03 incorporated herein by reference, to, and obtain approval from, the Director of the Authority for approval of any procedures or medications proposed for use in accordance with Section 1797.172(b) of the Health and Safety Code ~~for any procedures or medications proposed for use pursuant to this subsection prior to implementation, of these medication(s) and or procedure(s).~~

(C) The Authority shall, within fourteen (14) days of receiving Form #EMSA-0391, revised 01/17, ~~the request,~~ notify the medical director of the LEMSA submitting request Form #EMSA-0391 that the request form has been received and shall specify what information, if any, is missing.

(D) The Director of the Authority, in consultation with the Emergency Medical Services Medical Directors Association of California's (EMDAC) Scope of Practice Committee, shall approve or disapprove the request for additional procedures and/or administration of medications and notify the LEMSA medical director of the decision within ninety (90) days of receipt of the completed request. Approval is for a three (3) year period and An approved status shall be in effect for a period of three (3) years. An approved status may be renewed for another three (3) year period, based on evidence from upon the authority's receipt of a written request that includes, but is not limited to, the following information: at a minimum the utilization of the procedure(s) or medication(s), beneficial effects, adverse reactions or complications, appropriate statistical evaluation, and general conclusion.

(E) The Director of the Authority, in consultation with the EMDAC Scope of Practice Committee ~~a committee of the LEMSA medical directors named by the EMDAC Emergency Medical Directors Association of California,~~ may suspend or revoke approval of any previously approved additional procedure(s) or medication(s) for cause.

(d) The medical director of the LEMSA may develop policies and procedures or establish standing orders allowing the paramedic to initiate any paramedic activity in the approved scope of practice without voice contact for medical direction from a physician.

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

1 authorized registered nurse, or mobile intensive care nurse (MICN), provided that an
2 EMSQIP, ~~as specified in Chapter 12 of this Division~~, is in place: as specified in Chapter
3 12 of this Division.

4
5 Note: Authority cited: Sections 1797.107, 1797.172, 1797.185, 1797.192, 1797.195 and
6 1797.214, Health and Safety Code. Reference: Sections 1797.56, 1797.172, 1797.178
7 and 1797.185, Health and Safety Code.

8 9 **§ 100148. Responsibility of the LEMSA.**

10 (a) The LEMSA that authorizes an ALS program shall establish policies and procedures
11 approved by the medical director of the LEMSA that shall include:

12
13 ~~(a)~~ (1) Approval, denial, revocation of approval, suspension, and monitoring of the ALS
14 components of the EMS System such as training programs, base hospitals or
15 alternative base stations, and paramedic service providers.

16
17 ~~(b)~~ (2) Assurance of compliance with provisions of this Chapter. ~~Chapter by the~~
18 ~~paramedic program and the EMS system.~~

19
20 ~~(c)~~ (b) ~~Submission to the Authority, as changes occur, of the following information on~~
21 ~~the approved paramedic training programs: The LEMSA shall submit to the Authority,~~
22 along with any changes to, the following paramedic training program information:

23
24 (1) Name of program director and/or program contact;

25
26 (2) Program address Address, phone number, email address, website address, and
27 facsimile number;

28
29 (3) Date of program approval, date classes will ~~initially~~ begin, and date of program
30 expiration.

31
32 (4) Date of Commission on Accreditation of Allied Health Education Programs
33 (CAAHEP) approval;

34
35 (5) Date of Bureau of Private Post-Secondary Education (BPPE) approval for private
36 post-secondary educational institutions;

37
38 (6) Issue date of Committee on Accreditation of Educational Programs for the
39 Emergency Medical Services Professions (CoAEMSP) letter of review (LoR).

40
41 ~~(d)~~ (c) Development or approval, implementation and enforcement of policies for
42 medical control, medical accountability, and an EMSQIP of the paramedic services,
43 including:

44
45 (1) Treatment and triage protocols.
46

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

(2) Patient care record and reporting requirements.

(3) Medical care audit system.

(4) Role and responsibility of the base hospital and paramedic service provider.

~~(e)~~ (d) System data collection and evaluation.

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Sections 1797.172, 1797.178, 1797.200, 1797.202, 1797.204, 1797.208,
1797.220, 1797.218 1798 and 1798.100, Health and Safety Code.

**ARTICLE 3. PROGRAM REQUIREMENTS FOR PARAMEDIC TRAINING
PROGRAMS**

§ 100149. Approved Training Programs.

(a) An approved paramedic training program or an institution eligible for paramedic training program approval, as defined in Section 100149~~(j)~~(i) of this Chapter, may provide CCP training upon approval by the paramedic training program approving authority. The purpose of a paramedic training program shall be:

~~The purpose of a paramedic training program shall be:~~

(1) to prepare individuals to render prehospital ALS within an organized EMS system;
and

(2) to prepare individuals to render critical care transport within an organized EMS system

~~(b) By January 1, 2004, all approved paramedic training programs approved by a paramedic training program approving authority prior to January 1, 2000, shall be accredited and shall maintain current accreditation, or be in the process of receiving accreditation approval by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), CAAHEP upon the recommendation of CoAEMSP the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP), in order to continue to operate as an approved paramedic training program.~~

~~(c) All approved paramedic training programs shall: approved by a paramedic training program approving authority January 1, 2000, or thereafter shall submit their application, fee, and self-study to CoAEMSP for accreditation within twelve (12) months of the startup of classes and receive and maintain CAAHEP accreditation no later than two (2) years from the date of application to CoAEMSP for accreditation in order to continue to operate as an approved paramedic training program.~~

(1) Receive a Letter of Review (LoR) from CoAEMSP prior to starting classes; and

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

1 (2) Submit their application, fee, and Initial Self-Study Report (ISSR) to CoAEMSP for
2 accreditation within six (6) months of the first class' graduation; and
3

4 (3) Receive and maintain CAAHEP accreditation no later than two (2) years from the
5 date of the ISSR submission to CoAEMSP for accreditation.
6

7 (d) Paramedic training programs approved according to the provisions of this Chapter
8 shall provide the following information in writing to all their paramedic training program
9 applicants prior to the applicants' enrollment in the paramedic training program:
10

11 (1) The date ~~by which~~ the paramedic training program must submit their CAAHEP
12 Request for Accreditation Services (RAS) form and ISSR application and self-study for
13 initial accreditation or the date their application for accreditation renewal was sent to
14 CoAEMSP.
15

16 (2) The date ~~by which~~ the paramedic training program must be initially accredited or the
17 date have their its accreditation must be renewed by CAAHEP.
18

19 ~~(3) (e) Failure of the paramedic training program to maintain its LoR, submit their RAS~~
20 ~~form application and ISSR to CoAEMSP, self-study or obtain and maintain its their~~
21 ~~accreditation renewal to CoAEMSP with CAAHEP, as described in 100149(c), by the~~
22 ~~date specified will shall result in withdrawal of program approval as specified in Section~~
23 ~~100162 of this Chapter. closure of the paramedic training program by their respective~~
24 ~~paramedic training program approving authority, unless the paramedic training program~~
25 ~~approving authority has approved a plan for meeting compliance as provided in Section~~
26 ~~100157 of this Chapter. When a paramedic training program approval is revoked under~~
27 ~~this provision, the paramedic training program course director must demonstrate to the~~
28 ~~satisfaction of their respective paramedic training program approving authority that the~~
29 ~~deficiency for which the paramedic training program approval was revoked has been~~
30 ~~rectified before submitting a new application for paramedic training program approval.~~
31

32 ~~(4) Failure of the paramedic training program to obtain or maintain CAAHEP~~
33 ~~accreditation by the required date will result in closure of the paramedic training~~
34 ~~program by their respective paramedic training program approving authority, unless the~~
35 ~~paramedic training program approving authority has approved a plan for meeting~~
36 ~~compliance as provided in Section 100157 of this Chapter. When a paramedic training~~
37 ~~program approval has been revoked under this provision, the paramedic training~~
38 ~~program course director must demonstrate to the satisfaction of their respective~~
39 ~~paramedic training program approving authority that the deficiency for which the~~
40 ~~paramedic training program approval was revoked has been rectified before submitting~~
41 ~~a new application for paramedic training program approval.~~
42

43 ~~(5) (f) Students graduating from a paramedic training program that fail to apply, receive,~~
44 ~~for accreditation with, receive accreditation from, or maintain CAAHEP accreditation~~
45 ~~with, CAAHEP by the dates required will not be eligible for state licensure as a~~
46 ~~paramedic.~~

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

~~(e)~~ (g) Paramedic training programs shall submit to their respective paramedic training program approving authority all documents submitted to, and received from, CoAEMSP and CAAHEP for accreditation, including but not limited to, the RAS form, ISSR, and initial application and self-study for accreditation and the documents required for maintaining accreditation.

~~(f)~~ (h) Paramedic training programs shall submit to the Authority the date their initial RAS form application was submitted to CoAEMSP and copies of documentation received from CoAEMSP and/or CAAHEP verifying accreditation.

~~(g)~~ Paramedic training program approving authorities shall revoke approval, in accordance with Section 100162 of this Chapter, of any paramedic training program which fails to comply with subsections (b) through (e) of this Section.

~~(h)~~ (i) Approved paramedic training programs shall participate in the EMSQIP of their respective paramedic training program approving authority. ~~In addition, an approved paramedic training program, which is conducting a paramedic training program outside the jurisdiction of their approving authority, shall also agree to participate in the EMSQIP of the LEMSA which has jurisdiction where the paramedic training program is being conducted.~~

~~(i)~~ (j) Eligibility for program approval shall be limited to the following institutions:

(1) Accredited universities, colleges, including junior and community colleges, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, and Bureau for Private Postsecondary Education.

(2) Medical training units of a branch of the United States Armed Forces or Coast Guard ~~of the United States.~~

(3) Licensed general acute care hospitals which meet the following criteria:

(A) Hold a special permit to operate a basic or comprehensive emergency medical service pursuant to the provisions of Division 5;

(B) Provide continuing education (CE) to other health care professionals; and

(C) are accredited by a Centers for Medicare and Medicaid Services approved with deeming authority.

(4) Agencies of government.

Note: Authority cited: Sections 1797.107, 1797.172 and 1797.173, Health and Safety Code. Reference: Sections 1797.172, 1797.173, 1797.208 and 1797.213, Health and Safety Code.

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

§ 100150. Teaching Staff.

(a) Each training program shall have ~~an approved a~~ program medical director who shall ~~be is~~ a physician currently licensed in the State of California, ~~who has two (2) years'~~ experience in emergency medicine ~~prehospital care in the last five (5) years, and who is~~ qualified by has education or experience in methods of instruction. Duties of the program medical director shall include, but not be limited to the following:

(1) Review and approve educational content of the program curriculum, including training objectives for the clinical and field instruction, to certify its ongoing appropriateness and medical accuracy.

(2) Review and approve the quality of medical instruction, supervision, and evaluation of the students in all areas of the program.

(3) Approval of hospital clinical and field internship experience provisions. ~~provision for hospital clinical and field internship experiences.~~

(4) Approval of principal instructor(s).

(b) Each training program shall have ~~an approved a~~ course program director who shall ~~be licensed in California as a physician, is either a California licensed physician, a~~ registered nurse who has a baccalaureate degree, or a paramedic who has a baccalaureate degree, or ~~shall be~~ an individual who holds a baccalaureate degree in a related health field or in field or in education ~~field~~. The course program director shall be qualified by education and experience in methods, materials, and evaluation of instruction, and shall have a minimum of one (1) year experience in an administrative or management level position, and have a minimum of three (3) years academic or clinical experience in prehospital care education. ~~within the last five (5) years.~~ Duties of the course program director shall include, but not be limited to the following:

(1) Administration, organization and supervision of the educational program.

(2) In coordination with the program medical director, approve the principal instructor(s), teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate the development of curriculum, including instructional objectives, and approve all methods of evaluation.

(3) Ensure training program compliance with this chapter and other related laws.

(4) Sign all course completion records.

(5) Ensure ~~that~~ the preceptor(s) are trained according to the curriculum in subsection (e)(4).

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

(c) Each training program shall have a principal instructor(s), who is responsible for areas including, but not limited to, curriculum development, course coordination, and instruction and shall meet the following criteria: ~~may also be the program medical director or course director if the qualifications in subsections (a) and (b) are met, who shall:~~

(1) Be a physician, registered nurse, physician assistant, or paramedic, currently certified or licensed in the State of California.

(2) Be knowledgeable in the course content of the January 2009 United States Department of Transportation (U.S. DOT) National Emergency Medical Services Education Standards DOT HS 811 077 EA, ~~January 2009~~, herein incorporated by reference; and

(3) Have six (6) years of experience in an allied health field and an associate degree or two (2) years of experience in an allied health field and a baccalaureate degree.

~~(4) Instructors of tactical casualty care (TCC) topics shall be qualified by education and experience in TCC methods, materials, and evaluation of instruction.~~

~~(4) Be responsible for areas including, but not limited to, curriculum development, course coordination, and instruction.~~

~~(5)~~ (4) Be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction. ~~in methods, materials, and evaluation of instruction, which shall be documented by at least forty (40) hours of instruction in teaching methodology. Following, but not limited to, are examples of courses that meet the required instruction in teaching methodology:~~

(A) California State Fire Marshal (CSFM) "Training Instructor 1A, 1B, and 1C";

(B) National Fire Academy (NFA) "Fire Service Instructional Methodology" course; and

(C) A course that meets the U. S. Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors, such as the National Association of EMS Educators' EMS Educator Course.

~~(6)~~ (5) A Principal Instructor may also be the program medical director or program director.

(d) Each CCP training program shall have a principal instructor(s) who ~~shall be~~ is either licensed in California as a physician and with knowledgeable in the subject matter, a registered nurse knowledgeable in the subject matter, or a paramedic with current CCP certification or a flight paramedic (FP) ~~FP certification from the BCCTPC~~ International

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

Board of Specialty Certification (IBSC) Board for Critical Care Transport Paramedic Certification (BCCTPC).

(e) Each training program may have a teaching assistant(s) who ~~shall be an individual(s) qualified by~~ has training and experience to assist with teaching of the course. A The teaching assistant(s) shall be supervised by a principal instructor, the ~~course~~ program director and/or the program medical director.

(f) Each training program may have a clinical coordinator(s) who is either a Physician, Registered Nurse, Physician Assistant, or a Paramedic currently licensed in California, and who shall have two (2) years of academic or clinical experience in emergency medicine or prehospital care. Duties of the program clinical coordinator shall include, but not be limited to, the following:

(1) The coordination and scheduling of students with qualified clinical preceptors in approved clinical settings as described in Section 100152.

(2) Ensuring adequate clinical resources exist for student exposure to the minimum number and type of patient contacts established by the program as required for continued CAAHEP accreditation.

(3) The tracking of student internship evaluation and terminal competency documents.

~~(f)-(g)~~ Each paramedic training program shall have a field preceptor(s) who meets the following criteria: ~~shall:~~

(1) Be a certified or licensed paramedic; and

(2) Be working in the field as a certified or licensed paramedic for the last two (2) years; and

(3) Be under the supervision of a principal instructor, the ~~course~~ program director and/or the program medical director; ~~and director.~~

(4) Have completed a field preceptor training program approved by the LEMSA and/or comply one that complies with the field preceptor guidelines approved by the LEMSA in accordance with CoAEMSP guidelines **CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions (2015)**. Training shall include a curriculum that will result in the preceptor competency in the evaluation of paramedic students during the internship phase of the training program and the completion of the following: ~~being competent to evaluate the paramedic student during the internship phase of the training program, and how to do the following in cooperation with the paramedic training program:~~

(A) Conduct a daily field evaluation of students.

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

- 1 (B) Conduct cumulative and final field evaluations of all students.
2
3 (C) Rate students for evaluation using written field criteria.
4
5 (D) Identify ALS contacts and requirements for graduation.
6
7 (E) Identify the importance of documenting student performance.
8
9 (F) Review the field preceptor requirements contained in this Chapter.
10
11 (G) Assess student behaviors using cognitive, psychomotor, and affective domains.
12
13 (H) Create a positive and supportive learning environment.
14
15 (I) Measure students against the standardss of entry level paramedics.
16
17 (J) Identify appropriate student progress.
18
19 (K) Counsel the student who is not progressing.
20
21 (L) Identify training program support services available to the student and the preceptor.
22
23 (M) Provide guidance and applicable procedures to address student injuries or for
24 ~~dealing with an injured student or student who has had an exposure to illness,~~
25 communicable disease or hazardous material.
26
27 ~~(g)~~ (h) Each training program shall have a hospital clinical preceptor(s) who shall meet
28 the following criteria:
29
30 (1) Be a physician, registered nurse or physician assistant currently licensed in the
31 State of California.
32
33 (2) Have worked in emergency medical care services or areas of medical specialization
34 for the last two (2) years.
35
36 (3) Be under the supervision of a principal instructor, the **course-program** director,
37 and/or the program medical director.
38
39 (4) Receive training ~~instruction in the evaluation of~~ evaluating paramedic students in the
40 clinical settings. ~~Means of instruction~~ Instructional tools may include, but need not be
41 limited to, educational brochures, orientation, training programs, or training videos, and
42 Training shall include the following components of instruction: ~~how to do the following in~~
43 ~~cooperation with the paramedic training program:~~
44
45 (A) Evaluate a student's ability to safely administer medications and perform
46 assessments.

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

(B) Document a student's performance.

(C) Review clinical preceptor requirements contained in this Chapter.

(D) Assess student behaviors using cognitive, psychomotor, and affective domains.

(E) Create a positive and supportive learning environment.

(F) Identify appropriate student progress.

(G) Counsel the student who is not progressing.

(H) Provide guidance and ~~applicable~~ procedures for addressing student injuries or dealing with an injured student or student who has had an exposure to illness, communicable disease or hazardous material.

(i) Instructors of tactical casualty care (TCC) topics shall be qualified by education and experience in TCC methods, materials, and evaluation of instruction.

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.

Reference: Sections 1797.172 and 1797.208, Health and Safety Code.

§ 100153. Field Internship.

(a) A field internship shall provide emergency medical care training and experience to paramedic students under continuous supervision, instruction, and evaluation by an authorized preceptor and shall promote student competency in medical procedures, techniques, and the administration of medications as supervised at all times by an authorized field preceptor to result in the paramedic student being competent to provide the medical procedures, techniques, and medications specified in Section 100146, in the prehospital emergency setting within an organized EMS system.

(b) An approved paramedic training program shall enter into a written agreement with a paramedic service provider(s) that provide field internship services to students. to provide for field internship, as well as for a field preceptor(s) to directly supervise, instruct, and evaluate the students. The assignment of a student to a field preceptor shall be a collaborative effort between the training program and the provider agency. If the paramedic service provider is located outside the jurisdiction of the paramedic training program approving authority, then the training program shall do the following: This agreement shall include provisions to ensure compliance of this Chapter.

(c) The medical director of the LEMSA where the internship is located shall have medical control over the paramedic intern.

(d) The assignment of a student to a field preceptor shall be a collaborative effort between the training program and the provider agency.

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

1
2 (1) The assignment of a student to a field preceptor shall be limited to duties associated
3 with the student's training or the student training program.

4
5 (e) If the paramedic service provider is located outside the jurisdiction of the paramedic
6 training program approving authority, the paramedic training program shall do the
7 following:

8
9 (1) Ensure the student intern receives orientation in collaboration with the LEMSA in
10 which where the field internship will occur, ensure that the student has been oriented
11 to that LEMSA, The orientation shall includeing that LEMSA's local policies, and
12 procedures, and treatment protocols,

13
14 (2) contact the LEMSA where the paramedic service provider is located and r Report to
15 that the LEMSA, where the field internship will occur, the name of the paramedic intern
16 in their jurisdiction, the name of the EMS field internship provider, and the name of the
17 preceptor. The paramedic intern shall be under the medical control of the medical
18 director of the LEMSA in which the internship occurs.

19
20 (c) (3) The training program shall be responsible for ensuring that the filed Ensure the
21 field preceptor has the experience and training as required in Section 100150(g)(1) -(4).

22
23 (d) (f) The paramedic training program shall not enroll any more students than the
24 training program can commit to providing a filed internship to begin no later than ninety
25 (90) days after a student's completion of the hospital clinical education and training
26 portion of the training program. enroll only the number of students it is able to place in
27 field internships within ninety (90) days of completion of their hospital clinical education
28 and training phase of the training program. The training program director and a student
29 may mutually agree to start the field internship at a later date, for the filed internship to
30 begin in the event of special circumstances (e.g., student or preceptor illness or injury,
31 student's military duty, etc.). This agreement shall be in writing.

32
33 (e) For at least half of the ALS patient contacts specified in Section 100154(b) the
34 paramedic student shall be required to provide the full continuum of care of the patient
35 beginning with the initial contact with the patient upon arrival at the scene through
36 release of the patient to a receiving hospital or medical care facility.

37
38 (f) (g) All interns, The internship, regardless of the location, shall be continuously
39 monitored by the training program staff, in collaboration with the assigned field
40 preceptor, regardless of the location of the internship, as described in written
41 agreements between the training program and the internship provider. The training
42 program shall document a student's progress, based on the assigned field preceptor's
43 input, and identify specific weaknesses of the student, if any, and/or problems
44 encountered by, or with, the student. Documentation of the student's progress, including
45 any identified weaknesses or problems, shall be provided to the student at least twice
46 during the student's field internship.

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

1
2 (h) Training program staff shall, upon receiving input from the assigned field preceptor,
3 document the progress of the student. Documentation shall include the identification of
4 student deficiencies and strengths and any training program obstacles encountered by,
5 or with, the student.

6
7 (i) Training program staff shall provide documentation reflecting student progress to the
8 student at least twice during the student's internship.

9
10 ~~(g)~~ (j) No more than one (1) EMT-trainee, of any level, shall be assigned to a response
11 vehicle at any one time during the paramedic student's field internship.

12
13 Note: Authority cited: Sections 1797.107, 1797.172 and 1797.173, Health and Safety
14 Code. Reference: Sections 1797.172, 1797.173 and 1797.208, Health and Safety Code.

15
16 **§100154. Required Course Hours.**

17 (a) The total paramedic training program shall consist of not less than ~~one thousand and~~
18 ~~ninety (1090)~~ one thousand and ninety-four (1094) hours. These training hours shall be
19 divided into:

20
21 (1) A minimum of four-hundred and fifty-four ~~(454)~~ (450) hours of didactic instruction
22 and skills laboratories that shall include not less than four (4) hours of training in tactical
23 casualty care principles as provided in Section 100155(b);

24
25 (2) The hospital clinical training shall consist of no less than one-hundred and sixty
26 (160) hours; ~~and the field internship shall consist of no less than four-hundred and~~
27 ~~eighty (480) hours.~~

28
29 (3) The field internship shall consist of no less than four-hundred and eighty (480)
30 hours.

31
32 (b) The student shall have a minimum of forty (40) documented ALS patient contacts
33 during the field internship as specified in Section 100153. An ALS patient contact shall
34 be defined as the student performance of one or more ALS skills, except cardiac
35 monitoring and CPR, on a patient.

36
37 (1) When available, up to ten (10) of the required ALS patient contacts may be satisfied
38 through the use of high fidelity adult simulation patient contacts as defined in Section
39 100141.1.

40
41 (2) Students shall document patient contacts utilizing an EHR system under supervision
42 of the preceptor.

43
44 (c) The student shall have a minimum of ~~ten (10)~~ twenty (20) documented experiences
45 performing the role of team lead during the field internship. A team lead shall be defined

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

as a student who, with minimal to no prompting by the preceptor, successfully takes charge of EMS operation in the field including, but not limited to, the following:

(1) Lead coordination of field personnel,

(2) Formulation of field impression,

(3) Comprehensively assessing patient conditions and acuity.

(4) Directing and implementing patient treatment,

(5) Determining patient disposition, and

(6) Leading the packaging and movement of the patient.

(d) The minimum hours shall not include the following:

(1) Course material designed to teach or test exclusively EMT knowledge or skills including CPR.

(2) Examination for student eligibility.

(3) The teaching of any material not prescribed in Section 100155 ~~400160~~ of this Chapter.

(4) Examination for paramedic licensure.

(e) The total CCP training program shall consist of not less than two-hundred and two (202) hours. These training hours shall be divided into:

(1) A minimum of one-hundred and eight (108) hours of didactic and skills laboratories; and

(2) No less than ninety-four (94) hours of hospital clinical training as prescribed in Section 100152(b) of this Chapter.

(f) For at least half of the ALS patient contacts specified in Section 100154(b) the paramedic student shall be required to provide the full continuum of care of the patient beginning with the initial contact with the patient upon arrival at the scene through transfer of care to hospital personnel.

Note: Authority cited: Sections 1797.107 ~~and~~, 1797.172, and 1797.173, Health and Safety Code. Reference: Section 1797.172 and 1797.173, Health and Safety Code.

§ 100155 Required Course Content.

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

(a) The content of a paramedic course shall meet the objectives contained in the January 2009 U.S. Department of Transportation (DOT) National Emergency Medical Services Education Standards, DOT HS 811 077 EA, January 2009, ~~to result in the and be consistent with paramedic being competent in the paramedic basic scope of practice specified in Section 100146(a) of this Chapter. The DOT HS 811 077 EA can be accessed through the U.S. DOT National Highway Traffic Safety Administration at the following National Highway Traffic Safety Administration website address:~~
~~<http://www.ems.gov/education/nationalstandardsnecs.html>~~
~~<http://www.nhtsa.gov/>~~ <http://www.nhtsa.gov/>

(b) In addition to the above, the content of the training course shall include a minimum of four (4) hours of tactical casualty care (TCC) principles applied to violent circumstances with at least the following topics and skills and shall be competency based:

(1) History and Background of Tactical Casualty Care

(A) Demonstrate knowledge of tactical casualty care

1. History of active shooter and domestic terrorism incidents

2. Define roles and responsibilities of first responders including Law Enforcement, Fire and EMS.

3. Review of local active shooter policies

4. Scope of Practice and Authorized Skills and procedures by level of training, certification, and licensure zone

(2) Terminology and definitions

(A) Demonstrate knowledge of terminology

1. Hot zone/warm zone/cold zone

2. Casualty collection point

3. Rescue task force

4. Cover/concealment

(3) Coordination, Command and Control

(A) Demonstrate knowledge of Incident Command and how agencies are integrated into tactical operations.

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

1. Demonstrate knowledge of team command, control and communication
- a. Incident Command System (ICS) /National Incident Management System (NIMS)
 - b. Mutual Aid considerations
 - c. Unified Command
 - d. Communications, including radio interoperability
 - e. Command post
 - f. Staging areas
 - g. Ingress/egress
 - h. Managing priorities
- (4) Tactical and Rescue Operations
- (A) Demonstrate knowledge of tactical and rescue operations
1. Tactical Operations – Law Enforcement
 - a. The priority is to mitigate the threat
 - b. Contact Team
 - c. Rescue Team
 2. Rescue Operations – Law Enforcement/EMS/Fire
 - a. The priority is to provide life-saving interventions to injured parties
 - b. Formation of Rescue Task Force (RTF)
 - c. Casualty collection points
- (5) Basic Tactical Casualty Care and Evacuation
- (A) Demonstrate appropriate casualty care at your scope of practice and certification
1. Demonstrate knowledge of the components of the Individual First Aid Kit (IFAK) and/or medical kit.
 2. Understand the priorities of Tactical Casualty Care as applied by zone.

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

3. Demonstrate competency through practical testing of the following medical treatment skills:

a. Bleeding control

b. Apply Tourniquet

i. Self-Application

ii. Application on others

c. Apply Direct Pressure

d. Apply Pressure Dressing

e. Apply Hemostatic Dressing with Wound Packing, utilizing California EMSA-approved products

2. Airway and Respiratory management

a. Perform Chin Lift/Jaw Thrust Maneuver

b. Recovery position

c. Position of comfort

d. Airway adjuncts

3. Chest/torso wounds

a. Apply Chest Seals, vented preferred

4. Demonstrate competency in patient movement and evacuation.

a. Drags and lifts.

b. Carries

5. Demonstrate knowledge of local multi-casualty/mass casualty incident protocols.

a. Triage procedures (START or SALT).

b. Casualty Collection Point.

c. Triage, Treatment and Transport.

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

(6) Threat Assessment.

(A) Demonstrate knowledge in threat assessment.

1. Understand and demonstrate knowledge of situational awareness

2. Pre-assessment of community risks and threats.

3. Pre-incident planning and coordination

4. Medical resources available.

~~(b)~~(c) The content of the CCP course shall include:

* * * * *

(d) Training programs in operation prior to the effective date of these regulations shall submit evidence of compliance with this Chapter to the appropriate approving authority as specified in Section 100137 of this Chapter within twelve (12) months after the effective date of these regulations.

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Sections 1797.172, 1797.173, 1797.185 and 1797.213, Health and Safety Code.

§ 100156. Required Testing.

(a) Approved paramedic and CCP training programs shall include ~~periodic~~ a minimum of two (2) formative examinations and one (1) final comprehensive competency-based examinations to test the knowledge and skills specified in this Chapter.

(b) Documentation of § successful student clinical and field internship performance ~~in the clinical and field setting~~ shall be required prior to course completion.

Note: Authority cited: Sections 1797.107, 1797.172 and 1797.185, Health and Safety Code. Reference: Sections 1797.172, 1797.185, 1797.208, 1797.210 and 1797.213, Health and Safety Code.

§ 100157. Course Completion Record.

(a) ~~Approved paramedic training program and/or CCP training program shall issue a~~ A tamper resistant course completion record shall be issued to each person who has successfully completed the paramedic training program and/or CCP training program. The course completion record shall be issued no later than ten (10) working days from the date of the student's ~~successfully completion of~~ completes the paramedic and/or CCP training program.

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

(b) The course completion record shall contain the following:

(1) The name of the individual.

(2) The date of completion.

(3) The following statement:

(A) "The individual named on this record has successfully completed an approved paramedic training program", or

(B) "The individual named on this record has successfully completed an approved Critical Care Paramedic training program."

(4) The name of the ~~paramedic training program or CCP training program~~ approving authority, ~~depending on the training program being taught.~~

(5) The signature of the ~~course~~program director.

(6) The name and location of the training program issuing the record.

(7) The following statement in bold print: "This is not a paramedic license."

(8) For paramedic training, a list of the approved optional scope of practice procedures and/or medications taught in the course ~~approved~~ pursuant to subsection (c)(2)(A)-(D) of Section 100146. ~~taught in the course.~~

(9) For CCP training, a list of the approved procedures and medications taught in the course ~~approved~~ pursuant to subsection (c)(1)(S)(1-10) of Section 100146. ~~taught in the course.~~

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Section 1797.172, Health and Safety Code.

§ 100158. Student Eligibility.

(a) To be eligible to enter a paramedic training program an individual shall meet the following requirements:

(1) Possess a high school diploma or general education equivalent; and

(2) possess a current basic cardiac life support (CPR) card equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level; and

(3) possess a current EMT certificate or NREMT-Basic registration; or

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

(4) possess a current AEMT certificate in the State of California; or

(5) be currently registered as an Advanced EMT-Intermediate with the NREMT.

~~(b) Starting January 1, 2021, the following prerequisites shall be met:~~

~~(1) A college level course in introductory human anatomy and physiology with lab, and~~

~~(2) A college level course in introductory psychology.~~

~~(b)(c)(b)~~ To be eligible to enter a CCP training program an individual shall be currently licensed, and accredited, in California as a paramedic with three (3) years of basic paramedic practice.

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.

Reference: Sections 1797.172 and 1797.208, Health and Safety Code.

§ 100159. Procedure for Training Program Approval.

(a) Eligible training institutions, as defined in Section 100149(j), shall submit a written request for training program approval to the paramedic training program approving authority. ~~A paramedic training program approving authority may deem a training program approved that has been accredited by the CAAHEP upon submission of proof of such accreditation, without requiring the paramedic training program to submit for review the information required in subsections (b) and (c) of this section.~~

(b) The paramedic training program approving authority shall receive and review the following documentation prior to program approval:

(1) A statement verifying that the course content meets the requirements contained in the U.S. DOT National Education Standards DOT HS 811 077 EA January 2009.

~~(2) A statement verifying that the CCP training program course content meets the requirements contained in Section 100160(b) of this Chapter. The CCP training program must also verify compliance with Subsections (b)(3)-(b)(6) and (b)(8)-(b)(9) of this Section.~~

~~(3)~~ (2) An outline of course objectives.

~~(4)~~ (3) Performance objectives for each skill.

~~(5)~~ (4) The names and qualifications of the training program ~~course~~ director, program medical director, and principal instructors.

~~(6)~~ (5) Provisions for supervised hospital clinical training including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

~~(7)~~ (6) Provisions for supervised field internship including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.

~~(8)~~ (7) The location at which the courses are to be offered and their proposed dates.

~~(9)~~ (8) Written agreements between the paramedic training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.

~~(10)~~ (9) Written contracts or agreements between the paramedic training program and a provider agency (ies) for student placement for field internship training.

~~(11)~~ (10) A copy of an approved CoAEMSP LoR issued to the training institution applying for approval or documentation of current CAAHEP accreditation.

~~(c) The paramedic training program approving authority shall review the following prior to program approval:~~

~~(1)~~ (11) Samples of written and skills examinations administered by the training program, for periodic testing.

~~(2)~~ (12) Samples of a A final written examination administered by the training program.

~~(3)~~ (13) Evidence that the training program provides of adequate training program facilities, equipment, examination securities security and student record keeping.

~~(14)~~ CCP programs shall submit a statement verifying the CCP training program course content complies with the requirements of subsection 100155(c) of this Chapter and documentation listed in subsections (b)(2)(B)(C)(D)(E)(G) and (H) of this Section, If applicable.

~~(d)~~ (c) The paramedic training program approving authority shall submit to the Authority an outline of program objectives and eligibility on each training program being proposed for approval in order to allow the Authority to make the determination required by section 1797.173 of the Health and Safety Code. Upon request by the Authority, any or all materials submitted by the training program shall be submitted to the Authority.

~~(d)~~ Paramedic training programs will be approved by meeting all requirements in subsection (b) of this section. Notification of program approval or deficiencies with the application shall be made in writing by the paramedic training program approving authority to the requesting training program in a time period not to exceed ninety (90) days.

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

1 (e) The paramedic training program approving authority shall establish the effective date
2 of program approval in writing upon the satisfactory documentation of compliance with
3 all program requirements.

4
5 (f) Paramedic training program approval shall be valid for four (4) years ending on the
6 last day of the month in which it was issued and may be renewed every four (4) years
7 subject to the procedure for program approval specified in Section 100159(b).

8
9 Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
10 Reference: Sections 1797.172, 1797.173 and 1797.208, Health and Safety Code; and
11 Section 15376, Government Code.

12 13 **§ 100160. Program Review and Reporting.**

14 (a) All program materials specified in this Chapter shall be subject to ~~periodic~~ review by
15 the paramedic training program approving authority and ~~may~~ shall also be made
16 available for review ~~reviewed~~ upon request by the Authority.

17
18 (b) All programs shall be subject to ~~periodic~~ on-site evaluation by the paramedic
19 approving authority and may also be evaluated by the Authority.

20
21 (c) Any person or agency, conducting a training program shall provide written
22 notification of changes to ~~notify~~ the paramedic training program approving authority ~~in~~
23 ~~writing, in advance when possible, and in all cases within thirty (30) days of any change~~
24 ~~in~~ of course objectives, hours of instruction, ~~course~~ program director, program medical
25 director, principal instructor, provisions for hospital clinical experience, or field
26 internship. Written notification shall be provided in advance, when possible, and no later
27 than thirty (30) days after a change(s) has been identified.

28
29 Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
30 Reference: Sections 1797.172, 1797.173 and 1797.208, Health and Safety Code.

31 32 **§ 100161. Paramedic Training Program Approval.**

33 ~~(a) The paramedic training program approving authority shall, within thirty (30) working~~
34 ~~days of receiving a request for training program approval, notify the requesting training~~
35 ~~program that the request has been received, and shall specify what information, if any,~~
36 ~~is missing.~~

37
38 ~~(b) Paramedic training program approval or disapproval shall be made in writing by the~~
39 ~~paramedic training program approving authority to the requesting training program after~~
40 ~~receipt of all required documentation. This time period shall not exceed three (3)~~
41 ~~months.~~

42
43 ~~(c) The paramedic training program approving authority shall establish the effective date~~
44 ~~of program approval in writing upon the satisfactory documentation of compliance with~~
45 ~~all program requirements.~~

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

(d) ~~Paramedic training program approval shall be for four (4) years following the effective date of approval and may be renewed every four (4) years subject to the procedure for program approval specified in this chapter.~~

Note: Authority cited: ~~Sections 1797.107 and 1797.172, Health and Safety Code.~~
Reference: ~~Sections 1797.172, 1797.173 and 1797.208, Health and Safety Code; and Section 15376, Government Code.~~

§ 100162. Withdrawal of Program Approval.

(a) ~~Noncompliance with any criterion required for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable Failure to comply with the provisions of this Chapter may result in denial, probation, suspension or revocation of program approval by the paramedic training program approving authority. Notification of noncompliance and action to place on probation, suspend or revoke shall be done as follows:~~

(b) The requirements for training program noncompliance notification and actions are as follows:

(1) A paramedic training program approving authority shall provide written notification of noncompliance ~~notify the approved training program course director in writing, by certified mail, of the provisions of~~ with this Chapter with which to the paramedic training program provider found in violation. The notification shall be in writing and sent by certified mail to the paramedic training program course director. ~~is not in compliance.~~

(2) Within fifteen (15) days ~~of~~ from receipt of the noncompliance ~~notification of noncompliance~~, the approved training program shall submit in writing, by certified mail, to the paramedic training program approving authority one of the following:

(A) Evidence of compliance with the provisions of this Chapter, or

(B) A plan ~~for meeting compliance with~~ to comply with the provisions of this Chapter within sixty (60) days from the day of receipt of the notification of noncompliance.

(3) Within fifteen (15) days ~~of~~ from receipt of the ~~response from the~~ approved training program's response, or within thirty (30) days from the mailing date of the noncompliance notification, if no response is received from the approved paramedic training program, the paramedic training program approving authority shall issue a decision letter by certified mail to notify the Authority and the approved paramedic training program. ~~in writing, by certified mail, of the~~ The letter shall identify the paramedic training program approving authority's decision to take one or more of the following actions: accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the training program approval.

(A) Accept the evidence of compliance provided.

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

1 (B) Accept the plan for meeting compliance provided.

2
3 (C) Place the training program on probation.

4
5 (D) Suspend or revoke the training program approval.

6
7 (4) The decision letter shall also include, but not be limited to, the following information:

8
9 (A) Date of the program training approval authority's decision;

10
11 (B) Specific provisions found noncompliant by the training approval authority, if
12 applicable;

13
14 (C) The probation or suspension effective and ending date, if applicable;

15
16 (D) The terms and conditions of the probation or suspension, if applicable;

17
18 (E) The revocation effective date, if applicable;

19
20 (4) (5) The paramedic training program approving authority shall establish the probation,
21 suspension, or revocation effective dates no sooner than sixty (60) days after the date
22 of the decision letter, as described in subsection (3) of this Section. If the paramedic
23 training program approving authority decides to suspend or revoke the training program
24 approval, the notification specified in subsection (a)(3) of this section shall include the
25 beginning and ending dates of the probation or suspension and the terms and
26 conditions for lifting of the probation or suspension or the effective date of the
27 revocation, which may not be less than sixty (60) days from the date of the paramedic
28 training program approving authority's letter of decision to the Authority and the training
29 program.

30
31 Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
32 Reference: Sections 1797.172, 1797.208 and 1798.202, Health and Safety Code.

33 34 **ARTICLE 4. APPLICATIONS AND EXAMINATIONS**

35 36 **§ 100163 ~~Written and~~ Cognitive Written and Psychomotor Skills Examination.**

37 (a) Applicants shall comply with the procedures for examination established by the
38 Authority and the NREMT and shall not violate or breach the security of the
39 examination. Applicants found to have violated the security of the examination or
40 examination process as specified in Section 1798.207 of the Health and Safety Code,
41 shall be subject to the penalties specified therein.

42
43 (b) Students enrolled in an accredited paramedic training program, or a paramedic
44 training program with a current Letter of Review on file with the NREMT, shall be eligible
45 to take the practical psychomotor skills examination specified in Section 100140 of this
46 chapter upon successful completion of didactic and skills laboratory, and Students shall

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

be eligible to take the cognitive written examination specified in Section 100141 when they have successfully completed the didactic, clinical, and field training and have met all the provisions of the approved paramedic training program.

Note: Authority cited: Sections 1797.7, 1797.107, 1797.172, 1797.174 and 1797.185, Health and Safety Code. Reference: Sections 1797.7, 1797.172, 1797.185, 1797.214 and 1798.207, Health and Safety Code.

§ 100164. Date and Filing of Applications.

(a) The Authority shall notify the applicant within forty-five (45) calendar ~~thirty (30)~~ days of receipt of the state application that the application was received and shall specify what information, if any, is missing. The types of applications, which the applicant may be required to be submitted to the Authority, by the applicant are as follows:

(1) Initial In-State Paramedic License Application, for Initial License (California Graduate), Form #L-01, revised 03/2019 Revised (7/2011) herein incorporated by reference, for California paramedic program graduates, herein incorporated by reference.

(2) Application for Initial License of Out-of-State Paramedic License Application Form #L-01A revised 03/2019, herein incorporated by reference, for Out-of-State applicants Candidates who are registered with the National Registry of Emergency Medical Technicians as a paramedic., Form #L-01A, Revised 7/2011, herein incorporated by reference.

(3) Initial Challenge Paramedic License Application, Form #CL-01A revised 03/2019, herein incorporated by reference.

(3) (4) Application for License Renewal, Renewal Paramedic License Form #RL-01, revised 03/2019, Revised 6/2011, herein incorporated by reference.

(5) Audit Renewal Paramedic License Application, Form #AR-01, revised 03/2019, herein incorporated by reference.

(6) (4) Application for Lapsed License Reinstatement: Paramedic License Applications(s):

(A) Reinstatement Paramedic License Application Lapsed Less than One Year, Form #RLL-01A, revised 03/2019 Revised 06/2012, herein incorporated by reference.

(B) Reinstatement Paramedic License Application Lapsed of One Year or More, Form #RLL-01B, revised 03/2019 Revised 06/2012, herein incorporated by reference.

(5) Application for Challenge, Form #C L-01A, revised 06/2012, herein incorporated by reference.

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

(7) Applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Rev ~~06/09~~05/2018), submitted to the California Department of Justice (DOJ), for a state and federal criminal history report summary provided by the Department of Justice in accordance with the provisions of section 11105 et seq. of the Penal Code.

~~(8) Statement of Citizenship, Alienage, and Immigration Status for State Paramedic License Application /Renewal Form IS-01 (8/11), herein incorporated by reference.~~

(8) Request for Licensure/Certification Verification, Form #VL-01, revised 03/2019.

(b) Applications for renewal of license shall be complete and postmarked, hand delivered, or otherwise received by the Authority at least thirty (30) calendar days prior to the expiration date of the current license. Applications postmarked, hand delivered or otherwise received by the Authority less than thirty (30) calendar days prior to the expiration date of the current license ~~will not cause the license to lapse but~~ will require the applicant to pay a \$50 late fee, as specified in Section 100172(b)(4) of this Chapter.

(c) Eligible out-of-state applicants as defined in section 100165(b) ~~(a)(2)~~ and eligible applicants as defined in section 100165~~(c)~~ ~~(a)(3)~~ of this Chapter who have applied to challenge the paramedic licensure training requirements ~~process~~ shall be notified by the Authority within forty-five (45) calendar ~~working~~ days of receiving the application. Notification shall advise the applicant that the application has been received, and shall specify what information, if any, is missing.

(d) An application shall be denied without prejudice when an applicant does not complete the application, furnish additional information or documents requested by the Authority or fails to pay any required fees. An applicant shall be deemed to have abandoned an application if the applicant does not complete the requirements for licensure within one (1) year from the date on which the application was filed. An application submitted subsequent to an abandoned application shall be treated as a new application.

(e) A complete state application is a signed application submitted to the Authority that provides all the requested information and is accompanied by the appropriate application fee(s). All statements submitted by or on behalf of an applicant shall be made under penalty of perjury.

Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code.
Reference: Section 1797.172, Health and Safety Code.

ARTICLE 5. LICENSURE

§ 100165. Licensure.

(a) In order to be eligible for initial paramedic licensure an ~~individual~~ applicant shall meet at least one of the following requirements:-

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

1
2 (1) ~~Have a~~ Provide documentation of a California paramedic training program course
3 completion record as specified in Section 100157 of this Chapter or other documented
4 proof of successful completion of an a California approved paramedic training program
5 within the last two years from the date of application to the Authority for paramedic
6 licensure. and shall meet the following requirements:

7
8 (2)(A) Complete and submit the appropriate state Initial In-State Paramedic License
9 application form forms as specified in Section 100164.

10
11 (3)(B) Provide documentation of successful completion of the paramedic licensure
12 cognitive written and psychomotor practical skills examinations within the previous two
13 (2) years as specified in sections 100140, and 100141, and 100163, or possess a
14 current NREMT paramedic registration.

15
16 (C) Submit to the California DOJ, an applicant fingerprint card, FD-258 dated 5/11/99 or
17 a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Revised
18 05/2018), for a state criminal history record provided by the DOJ in accordance with the
19 provisions of Section 11105 et seq. of the Penal Code.

20
21 (4)(E)(D) Pay the established fees pursuant to Section 100172.

22
23 (b) ~~An individual who possesses a current paramedic registration issued by the NREMT~~
24 ~~shall be eligible for licensure when that individual fulfills the requirements of subsection~~
25 ~~(a)(2) and (4) of this section and successfully completes a field internship as defined in~~
26 ~~Sections 100153 and 1001589(b)~~

27
28 (c) ~~A physician, registered nurse or physician assistant currently licensed shall be~~
29 ~~eligible for paramedic licensure upon:~~

30
31 (1) ~~providing documentation that their training is equivalent to the DOT HS 811-077A~~
32 ~~specified in Section 100160;~~

33
34 (2) ~~successfully completing a field internship as defined in Sections 100153(a) and~~
35 ~~100159(b); and,~~

36
37 (3) ~~fulfilling the requirements of subsection (a)(2) through (a)(4) of this section.~~

38
39 (2) Provide documentation of a paramedic license or a paramedic training program
40 course completion issued from an approved training program outside the State of
41 California and meet the following requirements:

42
43 (A) Complete and submit the Initial Out-of-State Paramedic License application form as
44 specified in Section 100164.

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

1 (B) Provide documentation of a current paramedic NREMT registration or proof of
2 passing the paramedic licensure cognitive written and psychomotor skills exams within
3 the last two (2) years.

4
5 (C) Provide documentation of successful completion of an approved paramedic field
6 internship, provided by an approved paramedic program director, consisting of no less
7 than 40 advanced life support patient contacts as defined in Section 100153(a), or a
8 letter on official letterhead by an applicant's employer, training program director, or
9 medical director verifying applicant's successful completion of 40 ALS patient contacts.

10
11 (D) An individual who is currently or was previously paramedic certified/licensed out-of-
12 state shall submit a completed Request for License/Certification Verification, Form # VL-
13 01 03/2019.

14
15 (E) Submit to the California DOJ, an applicant fingerprint card, FD-258 dated 5/11/99 or
16 a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Revised
17 05/2018), for a state criminal history record provided by the DOJ in accordance with the
18 provisions of Section 11105 et seq. of the Penal Code

19
20 (F) Pay the established fees pursuant to Section 100172.

21
22 (3) A physician, authorized registered nurse, mobile intensive care nurse (MICN), or
23 physician assistant currently licensed shall be eligible to challenge the required
24 paramedic training for initial paramedic licensure upon meeting the following
25 requirements:

26
27 (A) If licensed as a physician, authorized registered nurse, MICN or physician assistant
28 outside the state of California, provide documentation that their training is equivalent to
29 the DOT HS 811 077 E specified in Section 100155,

30
31 (B) If licensed as a physician, authorized registered nurse, MICN or physician assistant
32 in the state of California, provide a copy of their current license, or

33
34 (C) Complete and submit the Initial Challenge Paramedic License application form as
35 specified in Section 100164.

36
37 (D) Provide documentation of successful completion of no less than 40 advanced life
38 support patient contacts during an approved paramedic training program field
39 internship, as specified in Section 100153(a), or a letter on official letterhead by a
40 paramedic employer, training program director, or medical director verifying applicant's
41 successful completion of 40 ALS patient contacts in an approved paramedic service
42 provider field environment.

43
44 (E) Pay the established fees pursuant to Section 100172.

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

1 (F) Submit a completed Request for Licensure/Certification Verification Form # VL-01
2 03/2019, if applicable.

3
4 (G) Provide documentation of a current paramedic NREMT registration or proof of
5 passing the paramedic licensure cognitive written and psychomotor skills exams within
6 the last two (2) years.

7
8 1. If a letter of support is required by the NREMT to take the paramedic licensure
9 cognitive written or psychomotor skills exams, the applicant shall notify the Authority.
10 The Authority shall review an applicant's completed and signed application for eligibility
11 to provide a letter of support to NREMT.

12
13 (H) Submit to the California DOJ, an applicant fingerprint card, FD-258 dated 5/11/99 or
14 a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Revised
15 05/2018), for a state criminal history record provided by the DOJ in accordance with the
16 provisions of Section 11105 et seq. of the Penal Code

17
18 (b) If a letter of support is required by the NREMT to take the paramedic licensure
19 cognitive written or psychomotor skills exams, the applicant shall be required to submit
20 the appropriate application as identified in section 100165(a) and at least one of the
21 following to the Authority:

22
23 (1) Documentation showing the applicant is currently licensed as an out-of-state
24 paramedic.

25
26 (2) Documentation showing proof of completion of a state, or country, approved or
27 CAAHEP accredited paramedic training program within the past two (2) years.

28
29 (3) Documentation showing applicants training program course content is equivalent or
30 surpasses the content and hours of the January 2009 United States Department of
31 Transportation (U.S. DOT) National Emergency Medical Services Education Standards
32 DOT HS 811 077E."

33
34 ~~(d)~~(c) All documentation submitted in a language other than English shall be
35 accompanied by a translation into English certified by a translator who is in the business
36 of providing certified translations and who shall attest to the accuracy of such translation
37 under penalty of perjury.

38
39 ~~(e)~~(d) The Authority shall issue within forty-five (45) calendar days of receipt of a
40 completed application as specified in Section 100164(e) a wallet-sized license to eligible
41 individuals who apply for a license and successfully complete the licensure
42 requirements.

43
44 ~~(f)~~(e) The initial paramedic licenses' effective date of the initial license shall be the day
45 the license is issued. The license shall be valid for a period of two (2) years; beginning

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

on the effective date through ~~from~~ the last day of the approval month in the second
year. ~~which it was issued.~~

~~(g)~~(f) The paramedic shall be responsible for notifying the Authority of her/his proper and current mailing address and shall notify the Authority in writing within thirty (30) calendar days of any and all changes of the mailing address, giving both the old and the new address, and paramedic license number.

~~(h)~~(g) A paramedic may request a duplicate license if the individual submits a request in writing certifying to the loss or destruction of the original license, or the individual has changed his/her name. If the request for a duplicate card is due to a name change, the request shall also include documentation of the name change. The duplicate license shall bear the same number and date of expiration as the replaced license.

~~(i)~~(h) An individual currently licensed as a paramedic by the provision of this section is ~~deemed to be certified~~ may function as an EMT and/or an AEMT, except when the paramedic license is under suspension, with no further testing or certification process required. ~~If certificates are issued, the expiration date of the EMT or AEMT certification shall be the same expiration date as the paramedic license, unless the individual~~ If a separate EMT or AEMT certificate is sought the certifying entity shall follows the EMT, or AEMT certification/recertification process provisions as specified in Chapters 2 and 3 of this Division.

~~(j)~~(i) An individual currently licensed as a paramedic by the provisions of this section may voluntarily deactivate his/her paramedic license if the individual is not under investigation or disciplinary action by the Authority for violations of Health and Safety Code Section 1798.200. If a paramedic license is voluntarily deactivated, the individual shall not engage in any practice for which a paramedic license is required, shall return his/her paramedic license to the Authority, and shall notify any LEMSA with which he/she is accredited as a paramedic or with which he/she is certified as an EMT or AEMT that the paramedic license is no longer valid. Reactivation of the paramedic license shall be done in accordance with the provisions of Section 100167(b) of this Chapter.

Note: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185, 1797.194, 1798.200 and 1798.202, Health and Safety Code. Reference: Sections 1797.56, 1797.63, 1797.172, 1797.175, 1797.177, 1797.185, 1797.194 and 1798.200, Health and Safety Code; and Section 15376, Government Code.

ARTICLE 6. LICENSE RENEWALS, LICENSE AUDIT RENEWALS and LICENSE REINSTATEMENTS.

§ 100167. License Renewal, License Audit Renewal, and License Reinstatement

(a) In order to be eligible for renewal of a non-lapsed paramedic license, an individual shall comply with the following requirements:

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

(1) Possess a current paramedic license issued in California.

(2) Complete forty-eight (48) hours of CE pursuant to the provisions of Chapter 11 of this Division.

(3) Complete and submit the state Renewal Paramedic License Application for License Renewal, Form #RL-01, revised 03/2019. ~~Revised 07/2011 including the Statement of Continuing Education located on the back of the license renewal application. EMSA will notify the paramedic, by mail, approximately six (6) months prior to their paramedic license expiration date on how to renew their license.~~

(4) If applicant is selected for audit, submit to the Authority a signed and completed Audit Renewal Paramedic License Application, Form #AR-01, revised 03/2019.

(A) Applicants selected for audit shall submit documentation of forty-eight (48) hours of CE completion, as specified in (a)(2) of this section.

~~(4)(5)~~ Pay the appropriate fees as specified on the application in accordance with Section 100172 of this Chapter.

(6) EMSA will send a renewal reminder notification by mail to the paramedic, approximately five (5) months prior to their paramedic license expiration date.

(b) In order for an individual whose license has lapsed to be eligible for license renewal reinstatement, the following requirements shall apply:

~~(1) For a license lapsed of less than six (6) months, the individual shall submit: comply with (a)(2), and (a)(4) of this section, and complete and submit the state Paramedic Application specified in Section 100163(a)(4), including the Statement of Continuing Education located on the back of the lapsed license renewal application.~~

(A) Forty-eight (48) hours of CE pursuant to the provisions of Chapter 11 of this Division with copies of the CE Certificates.

(B) Pay the appropriate fees as specified on the application in accordance with Section 100172 of this Chapter.

(C) Submit a signed and completed Reinstatement Paramedic License Application, Lapsed Less than 1 year, specified in Section 100164(a)(6)(A),

(D) If an applicant is or was certified/licensed in another state or country, a signed and completed Licensure/Certification Verification, Form #VL-01, 03/2019, shall be submitted to the Authority for each state or country the applicant was licensed/certified.

~~(2) For a license lapsed of six (6) months or more, but less than twelve (12) months, the individual shall: comply with (a)(2), and (a)(4) of this section, complete an additional~~

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

~~twelve (12) hours of CE, for a total of sixty (60) hours of CE, and complete and submit the state Paramedic Application specified in Section 100163(a)(4), including the Statement of Continuing Education located on the back of the lapsed license renewal application.~~

(A) Submit sixty (60) hours of CE pursuant to the provisions of Chapter 11 of this Division, with copies of the CE Certificates.

(B) Pay the appropriate fees as specified on the application in accordance with Section 100172 of this Chapter.

(C) Submit a signed and completed Reinstatement Paramedic License Application, Lapsed less than 1 year, as specified in Section 100164(a)(6)(A).

(D) If an applicant is or was certified/licensed in another state or country, a signed and completed Licensure/Certification Verification, Form #VL-01, 03/2019, shall be submitted to the Authority for each state or country the applicant was licensed/certified.

~~(3) For a license lapsed of twelve (12) months or more, but less than twenty-four (24) months, the individual shall: pass the licensure examination specified in Sections 100140, 100141, and 100164 or possess a current paramedic registration issued by the NREMT, comply with (a)(2) and (a)(4) of this section, submit to the California DOJ an applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Rev 03/07), for a state summary criminal history provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code, complete an additional twenty-four (24) hours of CE, for a total of seventy-two (72) hours of CE and complete and submit a state Paramedic Application specified in Section 100163(a)(4), including the Statement of Continuing Education located on the back of the lapsed license renewal application.~~

(A) Provide documentation of passing the licensure examinations within the past two (2) years as specified in Sections 100140 and 100141 or provide documentation of a current paramedic registration issued by the NREMT,

(B) Submit seventy-two (72) hours of CE pursuant to the provisions of Chapter 11 of this Division, with copies of the CE Certificates.

(C) Pay the appropriate fees as specified on the application in accordance with Section 100172 of this Chapter,

(D) Submit to the California DOJ, an applicant fingerprint card, FD-258 dated 5/11/99 or a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Revised 05/2018), for a state criminal history record provided by the DOJ in accordance with the provisions of Section 11105 et seq. of the Penal Code

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

1 (E) Submit a signed and completed Reinstatement Paramedic License Application,
2 Lapsed 1 year or more, specified in Section 100164(a)(6)(B).

3
4 (F) If an applicant is or was certified/licensed in another state or country, a signed and
5 completed Licensure/Certification Verification, Form #VL-01, 03/2019, shall be
6 submitted to the Authority for each state or country the applicant was licensed/certified.

7
8 ~~(4) For a lapse of twenty-four (24) months or more, the individual shall: comply with~~
9 ~~(a)(2) and (a)(4) and (b)(3) of this section. Documentation of the seventy-two (72) hours~~
10 ~~of CE shall include completion of the following courses, or their equivalent:~~

11
12 (A) Provide documentation of passing the licensure examinations within the past two (2)
13 years as specified in Sections 100140 and 100141 or provide documentation of a
14 current paramedic registration issued by the NREMT.

15
16 (B) Pay the appropriate fees as specified on the application in accordance with Section
17 100172 of this Chapter.

18
19 (C) Submit to the California DOJ an applicant fingerprint card, FD-258 dated 5/11/99 or
20 a Request for Live Scan Service Applicant Submission Form, BCII 8016 (Rev 05/2018),
21 for a state criminal history record provided by the DOJ in accordance with the provisions
22 of Section 11105 et seq. of the Penal Code.

23
24 (D) Submit a signed and completed Reinstatement Paramedic License Application,
25 lapsed 1 year or More, specified in Section 100164(a)(6)(B).

26
27 (E) Documentation of seventy-two (72) hours of CE that shall include completion of the
28 following courses, or their equivalent:

29
30 (1) Advanced Cardiac Life Support,

31
32 (2) Pediatric Advanced Life Support,

33
34 (3) Prehospital Trauma Life Support or International Trauma Life Support,

35
36 (4) CPR.

37
38 (F) If an applicant is or was certified/licensed in another state or country, a signed and
39 completed Licensure/Certification Verification, Form #VL-01, 03/2019, shall be
40 submitted to the Authority for each state or country the applicant was licensed/certified.

41
42 (c) Renewal of a license shall be for two (2) years. If the renewal requirements are met
43 within six (6) months prior to the expiration date of the current license, the effective date
44 of licensure shall be the first day after the expiration of the current license. This applies
45 only to individuals who have not had a lapse in licensure.

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

(d) ~~For individuals whose Reinstated licenses has lapsed, the licensure cycle shall be valid for a period of two (2) years; beginning on the date of issuance through the last day of the approved month in the second year. from the last day of the month in which all licensure requirements are completed and the license was issued.~~

(e) ~~The Authority shall notify the applicant for license renewal within thirty (30) Within forty-five (45) calendar working days of receiving the application, the Authority shall notify the applicant that the application has been received approved or and shall specify what information, if any, is missing.~~

(f) ~~An individual, who is a member of the reserves and is deployed for active duty with a branch of the Armed Forces of the United States, whose paramedic license expires during the time the individual is on active duty or license expires less than six (6) months from the date the individual is deactivated/released from active duty, has an additional six (6) months to comply with the following CE requirements and the late renewal fee is waived upon compliance with the following provisions:~~

(1) ~~Provide documentation from the respective branch of the Armed Forces of the United States verifying the individual's dates of activation and deactivation/release from active duty.~~

(2) ~~Meet the requirements of Section 100167(a)(2) through (a)(4) of this Chapter, except the individual will not be subject to the \$50 late renewal application fee specified in Section 100172(b)(4).~~

(3) ~~Provide documentation showing that the CEs activities submitted for the license renewal period were received no sooner taken not earlier than 30 days prior to the effective date of the individual's paramedic license that was valid when the individual was activated for active duty and not later than six months from the date of deactivation/release from active duty.~~

(A) ~~For an individual~~ Individuals ~~whose active duty required him/her them to use his/her their paramedic skills, credit may be given for documented training that meets the requirements of Chapter 11, EMS Continuing Education Regulations (California Code of Regulations, Title 22, Division 9). The documentation shall include verification from the individual's Commanding Officer attesting to the classes attended.~~

Note: Authority cited: Sections 1797.107, 1797.172, 1797.175, 1797.185 and 1797.194, Health and Safety Code. Reference: Sections 1797.63, 1797.172, 1797.175, 1797.185, 1797.194 and 1797.210, Health and Safety Code; and Section 101, Chapter 1, Part 1, Subtitle A, Title 10, United States Code.

ARTICLE 7. SYSTEM REQUIREMENTS

§ 100170. Medical Control.

The medical director of the LEMSA shall establish and maintain medical control in the

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

following manner:

(a) Prospectively, by assuring the development of written medical policies and procedures, to include at a minimum:

(1) Treatment protocols that encompass the paramedic scope of practice.

(2) Local medical control policies and procedures as they pertain to the paramedic base hospitals, alternative base stations, paramedic service providers, paramedic personnel, patient destination, and the LEMSA.

(3) Criteria for initiating specified emergency treatments on standing orders or for use in the event of communication failure that is consistent with this Chapter.

(4) Criteria for initiating specified emergency treatments, prior to voice contact, that are consistent with this Chapter.

(5) Requirements to be followed when it is determined that the patient will not require transport to the hospital by ambulance, is treated in place on scene without transport, or when the patient refuses care or transport.

(6) Requirements for the initiation, completion, review, evaluation, and retention of an electronic health record (EHR) patient care record as specified in this Chapter. These requirements shall address but not be limited to:

(A) Initiation of a-an electronic health record for every patient response.

(B) Responsibilities for record completion.

(C) Record distribution to include LEMSA, receiving hospital, paramedic base hospital, alternative base station, and paramedic service provider.

(D) Responsibilities for record review and evaluation.

(E) Responsibilities for record retention.

~~(7) Requirements to be followed for prehospital triage of patients who are assessed and determined to have a non-emergency condition. These requirements may include procedures for patients that are frequent users of the EMS system that require referral, or for patients that require transport to an alternative/alternate destination, other than a Hhospital with a Bbasic emergency permit, for further treatment, or for patients who require assessment in an emergency situation. These requirements include but shall not be limited to:~~

~~(A) Policies, procedures, and protocols for medical control and quality of care.~~

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

~~(B) Use of advanced life support skills, advanced screening tools and point-of-care testing to evaluate severity of patient severity medical condition.~~

~~(C) Documentation of assessment and evaluation in an electronic health record for each patient evaluated.~~

~~(D) Completion of additional training and competency testing based upon standardized curriculum approved by the authority.~~

~~(E) Authorization of EMS personnel by the local EMS agency medical director.~~

~~(F) Designation of alternative alternate receiving facilities, with medical staffing to consist of at least one registered nurse, that includes:~~

~~1. Hospitals with a standby emergency department permit or a hospital operated by the Veterans Administration, or~~

~~2. LEMSA-designated Authorized authorized m Mental health facilities as defined in approved pursuant to Subdivision (n) of Section 50085404 of the Welfare and Institutions Code, or~~

~~a. Licensed 24-hour health care facilities, hospital based outpatient programs, or provider sites certified by a county Mental Health Plan or by the Department of Health Care Services to provide Medi-Cal crisis stabilization services consistent with and pursuant to sections, 1810.210, 1810.435, 1840.338, 1840.348 under Chapter 11, Title 9 of the California Code of Regulations.~~

~~3. Authorized s Soboring centers that are either a federally qualified health center or a clinic as described in Sections 12111204 and 1206 of the Health and Safety Code.~~

~~(G) Secure, bi-directional exchange of electronic patient health care information between treating providers by no later than January 1, 2023.~~

~~(H) Retrospective review of records and quality measures by the receiving facility as determined by the LEMSA.~~

(b) Establish policies which provide for direct voice communication between a paramedic and a base hospital physician, authorized registered nurse, or MICN, as needed.

(c) Retrospectively, by providing for organized evaluation and CE for paramedic personnel. This shall include, but not be limited to:

ALL MODIFICATIONS TO EXISTING REGULATION TEXT

(1) Review by a base hospital physician, authorized registered nurse, or MICN of the appropriateness and adequacy of paramedic procedures initiated and decisions regarding transport.

(2) Maintenance of records of communications between the service provider(s) and the base hospital through tape recordings and through emergency department communication logs sufficient to allow for medical control and CE of the paramedic.

(3) Organized field care audit(s).

(4) Organized opportunities for CE including maintenance and proficiency of skills as specified in this Chapter.

(5) Ensuring the EMSQIP methods of evaluation are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process and recognize excellence in performance and delivery of care, pursuant to the provisions of Chapter 12 of this Division.

(d) In circumstances where use of a base hospital as defined in Section 100169 is precluded, alternative arrangements for complying with the requirements of this Section may be instituted by the medical director of the LEMSA if approved by the Authority.

Note: Authority cited: Sections 1797.106, 1797.107, 1797.172 and 1797.176, Health and Safety Code. Reference: Sections 1204, 1206, 1797.56, 1797.90, 1797.114, 1797.172, 1797.202, 1797.220, 1797.227, 1798, 1798.2, 1798.3, 1798.101 and 1798.105, Health and Safety Code; and Section 5404 of the Welfare and Institutions Code.

ARTICLE 8. RECORD KEEPING AND FEES

§ 100171. Record Keeping.

(a) Each paramedic approving authority shall maintain a record of approved training programs within its jurisdiction and annually provide the Authority with the name, address, and course-program director of each approved program. The Authority shall be notified of any changes in the list of approved training programs.

(b) Each paramedic approving authority shall maintain a list of current paramedic program medical directors, course-program directors, and principal instructors within its jurisdiction.

(c) The Authority shall maintain a record of approved training programs.

(d) Each LEMSA shall, at a minimum, maintain a list of all paramedics accredited by

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

1 them in the preceding five (5) years.

2
3 (e) The paramedic is responsible for accurately completing, in a timely manner, the
4 electronic health record ~~patient care record~~ referenced in Section 100170(a)(6)
5 compliant with the current versions of the National EMS Information System and the
6 California EMS Information System, which shall contain, but not be limited to, the
7 following information when such information is available to the paramedic:

- 8
9 (1) The date and estimated time of incident.
10 (2) The time of receipt of the call (available through dispatch records).
11 (3) The time of dispatch to the scene.
12 (4) The time of arrival at the scene.
13 (5) The location of the incident.
14 (6) The patient's:
15 (A) Name;
16 (B) Age or date of birth;
17 (C) Gender;
18 (D) Weight, if necessary for treatment;
19 (E) Address;
20 (F) ~~Chief complaint~~Primary Provider Impression~~Chief complaint~~; and
21 (G) Vital signs.

- 22
23 (7) Appropriate physical assessment.
24 (8) Primary Provider Impression.
25 ~~(9)(9)~~ The emergency care rendered and the patient's response to such treatment.
26 ~~(9)(10)~~ Patient disposition.
27 ~~(10)(11)~~ The time of departure from scene.
28 ~~(11)(12)~~ The time of arrival at receiving facility (if transported).
29 ~~(12)(13)~~ Time patient care was transferred to receiving facility.
30 ~~(123)(14)~~ The name of receiving facility (if transported).
31 ~~(134)(15)~~ The name(s) and unique identifier number(s) of the paramedics.
32 ~~(145)(16)~~ Signature(s) of the paramedic(s).

33
34 (f) ~~A LEMSA utilizing computer or other electronic means of collecting and storing the~~
35 ~~information specified in subsection (e) of this section shall in consultation with EMS~~
36 ~~providers establish policies for the collection, utilization, and storage and secure~~
37 transmission of interoperable electronic health records. ~~of such data.~~

38
39 (g) The paramedic service provider shall submit electronic health records to the LEMSA
40 according to the LEMSA's policies and procedures.

41
42 (h) The LEMSA shall submit the electronic health record data to the Authority ~~in no~~
43 ~~greater than quarterly intervals~~ within seventy-two (72) hours after completion of the
44 patient encounter, or at longer intervals if established by written agreement between the
45 LEMSA and the Authority.
46

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

Note: Authority cited: Sections 1797.107, 1797.172 and 1797.185, Health and Safety Code. Reference: Sections 1797.172, 1797.173, 1797.185, 1797.200, 1797.227, 1797.204 and 1797.208, Health and Safety Code.

§ 100172. Fees.

(a) A LEMSA may establish a schedule of fees for paramedic training program review and approval, CE provider approval, and paramedic accreditation in an amount sufficient to cover the reasonable cost of complying with the provisions of this Chapter.

(b) The following are the nonrefundable licensing fees established by the Authority:

(1) ~~The fee for initial~~ Initial In-State Paramedic License application fee shall be two hundred fifty (\$250) dollars. ~~for paramedic licensure for individuals who have completed training in California through an approved paramedic training program shall be \$50.00.~~

(A) Effective July 1, 2020 through June 30, 2021, the Initial In-State Paramedic License application fee shall be two hundred seventy-five (\$275) dollars.

(B) Effective July 1, 202~~2~~1 and thereafter the Initial In-State Paramedic License application fee shall be three hundred (\$300) dollars.

(2) ~~The fee for initial~~ the Initial Out-of-State Paramedic License application fee shall be three hundred (\$300) dollars. ~~For paramedic licensure for individuals who have completed out-of-state paramedic training, as specified in Section 100165(b), or for individuals specified in Section 100165(c), shall be \$100.00.~~

(A) Effective July 1, 2020 through June 30, 2021, the Initial Out-of-State Paramedic License application fee shall be three hundred twenty-five (\$325) dollars.

(B) Effective July 1, 202~~2~~1 and thereafter the Initial Out-of-State Paramedic License application fee shall be three hundred fifty (\$350) dollars.

(3) ~~The fee for licensure or licensure renewal as a paramedic~~ the Renewal Paramedic License application fee received at least thirty (30) days prior to expiration of the current license, as specified in 100164(b) of this Chapter, shall be two hundred dollars (\$200) ~~\$195.00.~~

(A) Effective July 1, 2020 through June 30, 2021, the Renewal Paramedic License application fee received at least thirty (30) days prior to expiration of the current license, as specified in 100164(b) of this Chapter, shall be two hundred twenty-five (\$225) dollars.

(B) Effective July 1, 202~~2~~1 and thereafter the Renewal Paramedic License application fee received at least thirty (30) days prior to expiration of the current license, as specified in 100164(b) of this Chapter, shall be two hundred fifty (\$250) dollars.

**ALL MODIFICATIONS TO EXISTING
REGULATION TEXT**

(4) The fee for failing to submit ~~an a complete~~ application for renewal, as specified in Section 100164(e), within the timeframe specified in Section 100164(b) ~~or for an~~ individual whose license has lapsed, as specified in Section 100167(b)(1), (2), (3) and (4) shall be a late fee in the amount of fifty dollars (\$50.00).

(5) The fee for state ~~summary~~ and criminal history ~~records~~ shall be in accordance with the schedule of fees established by the California DOJ- and the Federal Bureau of Investigations.

(6) The fee for a duplicate or replacement of a license shall be ten dollars (\$10.00).

(7) The fee for approval and re-approval of ~~an out-of-state~~ a CE provider shall be two thousand five hundred (\$2,500) dollars. ~~\$200.00~~.

(8) The fee for administration of the provisions of Section 17520 of the Family Code shall be five dollars (\$5.00); which is incorporated into the fees specified commencing with Section 100172(b)(1).

(9) The Reinstatement Paramedic License Application fee shall be two hundred fifty dollars (\$250).

(A) Effective July 1, 2020 through June 30, 2021, the Reinstatement Paramedic License Application fee shall be two hundred seventy-five (\$275) dollars.

(B) Effective July 1, 202~~21~~ and thereafter the Reinstatement Paramedic License Application fee shall be three hundred (\$300) dollars.

(10) The Initial Challenge Paramedic License Application fee shall be three hundred dollars (\$300).

(A) Effective July 1, 2020 through June 30, 2021, the Initial Challenge Paramedic License Application fee shall be three hundred twenty-five (\$325) dollars.

(B) Effective July 1, 202~~21~~ and thereafter the Initial Challenge Paramedic License Application fee shall be three hundred fifty (\$350) dollars.

(11) The fee for dishonored checks shall be twenty-five dollars (\$25).

Note: Authority cited: Sections 1797.107, 1797.112, 1797.172, 1797.185 and 1797.212, Health and Safety Code. Reference: Sections 1797.172, 1797.185 and 1797.212, Health and Safety Code; and Section 11105, Penal Code; and Section 1719, Civil Code.

Comments on the Proposed Paramedic Regulations
Chapter 4, Division 9, Title 22, California Code of Regulations
45-day Public Comment Period – **ALL COMMENTS**
April 5, 2019 through May 20, 2019

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
1		Kristi L. Koenig, MD, Medical Director Emergency Medical Services County of San Diego Health & Human Services Agency	Please change “alternative destination” to “alternate destination” in each instance (avoids confusion with “complimentary” or “alternative” medicine such as acupuncture).	Comment accepted. EMSA has revised all references to “alternative destination” to state “alternate destination” throughout the proposed regulations. This language is consistent with the terms commonly used on EMSA’s website and in proposed legislation, and in the Office of Statewide Health Planning and Development (OSHPD) Health Workforce Pilot Project #173, which identifies alternate destination as a concept for transporting patients to care sites appropriate to meet their needs. The changes are located in subsections 100170 (a)(7) and (a)(7)(F).
2	Section 100137 Page 1 Lines 8-10, 12-15	Lena Rohrbaugh NCTI	It states in the proposed regulation that a Statewide Public Service Agency with a paramedic training program shall be approved by the Director of the Authority. Would this include a Statewide contracted public service provider?	Comment accepted. To answer the commenter’s question, no it does not. Existing statute only authorizes EMSA to approve California statewide public service agencies. An approved training program must meet all of the requirements. This definition was modified to improve clarity. This change is necessary because the term “qualified” identifies that the statewide public safety agency meets all requirements for conducting a paramedic training program.
3	Section 100141.1 Page 2 Lines 5-9	Tom O'Connor Ventura College	The definition of high fidelity simulation in this section does not take into account the use of standardized patients with wearable devices or augmented/virtual reality which is also capable of delivering extremely	Comment accepted in part and rejected in part. EMSA is rejecting the commenter’s

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>realistic experiences. The NREMT Psychomotor Skills examination currently utilizes standardized patients during the Integrated Out of Hospital Scenario to increase the fidelity of the simulation.</p> <p>Limiting High-fidelity simulation to the use of computerized manikins does not allow for emerging technologies to be utilized in conjunction with these standardized patients or augmented/virtual reality environments to create more realistic simulation opportunities than a computerized manikin can provide.</p> <p>There are simulation monitors capable of displaying various ECG rhythms, allows the adjustment of heart rate, blood pressure, SPO2 levels, and ETCO2 readings with waveform. All of these can be adjusted by the technician to provide accurate readings displayed on the monitoring device screen without the requirement of a computerized manikin.</p> <p>The Society for Simulation in Healthcare has defined this in the Healthcare Simulation Dictionary linked below. https://www.ssih.org/Portals/48/Docs/Dictionary/simdictionary.pdf page 14 Definition • In healthcare simulation, high-fidelity refers to simulation experiences that are extremely realistic and provide a high level of interactivity and realism for the learner (INACSL, 2013); Can apply to any mode or method of simulation; for example: human, manikin, task trainer, or virtual reality.</p> <p>Please consider revision of the definition to match that of the Society of Simulation in Healthcare listed above.</p>	<p>suggestion to use the Society for Simulation in Healthcare definition because it is overly broad and not recognized as an industry standard in emergency medical services (EMS).</p> <p>EMSA is accepting the commenter's recommendation to revise the definition. EMSA has modified this definition to be consistent with the Committee on Accreditation of EMS Professionals' (CoAEMSP) and the Commission on Accreditation of Allied Health Education Programs' (CAAHEP) simulation standards. CoAEMSP and CAAHEP are the national reviewing and accrediting bodies for paramedic education programs. This change is necessary to clarify that the intent is not to limit high fidelity simulation to the use of computerized manikins only.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
4	Section 100144 Page 2 Line 25	Lee Siegel	Again, I strongly support adding FPs to this.	Comment accepted. EMSA acknowledges the commenter's support for defining Flight Paramedics (FPs) in this regulatory proposal.
5	Section 100144 Page 2 Line 25	San Joaquin County EMS Agency	Delete "Flight Paramedic (FP)" from the definition of Critical Care Paramedic (CCP). The terms are not synonymous. It is not practical or even likely that every paramedic employed by an air ambulance provider will achieve CCP standards.	Comment accepted. EMSA acknowledges the commenters concerns and has added a separate definition for Flight Paramedic to improve clarity. The proposed text was revised to include a new definition for "Flight Paramedic." This change is necessary to ensure that all levels of EMS providers are clearly defined and covered by the standards and protections found within the respective regulations and statutes.
6	Section 100144 Page 2 Line 26	John Clark International Board of Specialty Certification (IBSC)	Add "or FP" after CCP	Comment rejected. EMSA is rejecting this comment because FP is being removed from the definition for Critical Care Paramedic (CCP). Based on a comment by San Joaquin County EMS Agency, EMSA has added a separate definition for Flight Paramedic to improve clarity. This change is necessary to specify FP certification separate from CCP certification because they are not interchangeable.
7	Section 100144 Page 2 Line 27	John Clark/IBSC	Change "Board for Critical Care Transport Paramedic Certification (BCCTPC)" to the board new name of International Board of Specialty Certification (IBSC)	Comment accepted in part and rejected in part. EMSA accepts the commenter's suggestion to revise this definition. This change is necessary to accurately reflect

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				<p>the full title of the certification board.</p> <p>EMSA is rejecting the commenter's suggestion to replace BCCTPC with IBSC because it is inaccurate. The Board for Critical Care Transport Paramedic Certification (BCCTPC) is a subsidiary of International Board of Specialty Certification (IBSC).</p>
8	Section 100144 Page 2 Line 29	San Joaquin County EMS Agency	<p>Change "valid license issued pursuant to this Chapter, and is accredited by a LEMSA" to read as: "valid license issued pursuant to this Chapter, and is accredited by a LEMSA in which their paramedic service provider is based."</p> <p>Health and Safety Code, Division 2.5, Section 1797.194(f) states that: "Nothing in this section shall be construed to alter or interfere with the local EMS agency's ability to locally accredit licensed EMT-P's."</p> <p>EMSA may not issue regulations recognizing quasi statewide paramedic accreditation.</p>	<p>Comment accepted and rejected in part.</p> <p>EMSA accepts the suggested revision and has modified the definition according. This change is necessary to improve clarity and consistency with the rest of Chapter 4.</p> <p>The commenter's statement regarding "recognizing quasi statewide paramedic accreditation" is being rejected. Health and Safety Code (HSC) Section 1797.185 specifically states that "all future regulations for EMT-P personnel adopted by the authority shall, where relevant, include provisions for statewide recognition of certification or authorization for the scope of practice of those personnel."</p>
9	Section 100146 (c)(1)(j) Page 3 Lines 37-41	ICEMA	Permits use of laboratory devices (capnography and CO) but conditions it on approval from state and federal agencies. Suggest "...and carbon monoxide when <u>approved by the LEMSA Medical Director and</u> appropriate authorization is obtained...."	<p>Comment rejected.</p> <p>EMSA is rejecting this suggestion because the proposed language is redundant and unnecessary. The element of local EMS agency (LEMSA) Medical Director approval is already stated in subsection 100146(c).</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
10	Section 100146 Subsection (c)(1)(S) Page 5 lines 21 -27	Lee Siegel	With my 7 years of CCP ambulance experience and now 8 years as an ALCO LEMSA EMS Coordinator, I strongly support all the language changes regarding CCPs and FPs. This is a common sense approach since CCPs and FPs have a similar training and skills competencies.	Comment accepted. EMSA acknowledges the commenter's support for the addition of FP to the scope of practice for paramedics.
11	Section 100146 Subsection (c)(1)(S) Page 5 Line 21	San Joaquin County EMS Agency	Delete "FP". See comment above for section 100144, Page 2, Line 25	Comment rejected. Please see response to comment #6.
12	Section 100146 Subsection (c)(1)(S) Page 5 Line 23	ICEMA	Change "when approved by the LEMSA medical director" to <u>when such are approved by the medical director of the LEMSA and are included in the written policies and procedures of the LEMSA.</u>	Comment rejected. Please see response to comment #9.
13	Section 100146 Subsection (c)(2)(A) Page 6 Line 9	ICEMA	...and successful trusting	Comment rejected. EMSA is rejecting this comment because it is unclear what the commenter is recommending. EMSA has determined that the proposed language is appropriate, and no change is necessary.
14	Section 100146 Subsection (d) Page 6 Line 45	San Joaquin County EMS Agency	Beginning with its first use here replace "mobile intensive care nurse (MICN)" with the correct term "authorized registered nurse" to be consistent with Health and Safety Code, Division 2.5, Section 1797.56.	Comment rejected. The term "mobile intensive care nurse (MICN)" cannot be replaced, as it is consistent with the authorizing statute. EMSA has modified language throughout the regulations to include "authorized registered nurse" next to all references to "mobile intensive care nurse." This change is necessary to improve clarity.
15	Section 100148 Subsection (b)(2) Page 7 Line 23	San Joaquin County EMS Agency	Remove facsimile number and replace with website address.	Comment accepted in part and rejected in part. EMSA is rejecting the recommendation to

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				<p>delete “facsimile” because, although less frequently used, removing the term would be unnecessarily limiting for the purposes of this requirement.</p> <p>EMSA accepts the commenter's suggestion to add “website address” and has modified the text accordingly. Adding “website address” is necessary to ensure that common, frequently-used paramedic training program information be provided by the LEMSA.</p>
16	Section 100149 Page 8	Brian K Rice President CPF	<p>Eligibility for program approval should include the CFF-JAC. Health and Safety Code Section 1797.109 identifies specific types of agencies that are eligible emergency medical services technician that can be approved per the request of the agency. While the proposed regulation references “agencies of government” in paragraph (4) of subdivision (j) of Section 100149, a clarification is necessary to identify the agencies authorized by statute (Amended by Stats. 2000 Ch. 157, Sec. 1, effective January 1, 2001). Section 100149(j)(4) of the regulation should be amended to include those agencies identified in the statute as follows:</p> <p><u>“(4) Agencies of government, <i>including but not limited to, the Department of the California Highway Patrol, Department of Forestry and Fire Protection, California Fire Fighter Joint Apprenticeship Committee, and other public safety agency personnel, upon the request of, and as deemed appropriate by, the director for the particular agency.</i></u></p>	<p>Comment rejected.</p> <p>EMSA is rejecting the commenter's suggested revision because it is not authorized by existing statute. HSC Section 1797.109 refers to EMT training programs. In contrast, Article 3 of Chapter 4 specifically addresses program requirements for paramedic training programs.</p>
17	Section 100149 Subsection [new] Page 10	San Joaquin County EMS Agency	Add section (k). The draft regulations omit any reference to Health and Safety Code “1797.173. (Training Program Locations) The authority shall	<p>Comment rejected.</p> <p>EMSA is rejecting the commenter's</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Line 40		<p>assure that all training programs for EMT-I, EMT-II, and EMT-P are located in an approved licensed hospital or an educational institution operated with written agreements with an acute care hospital, including a public safety agency that has been approved by the local emergency medical services agency to provide training. The authority shall also assure that each training program has a competency-based curriculum.</p> <p>The requirements should be included in regulation.</p>	<p>recommendation because adding the suggested language in regulation would be duplicative and unnecessary.</p> <p>The types of institutions that may house a paramedic training program are listed under subsection 100149(j) which is consistent with HSC section 1797.173. The statute is contained in this section's reference citations.</p>
18	Section 100150 Page 10 Lines 45 To Page 12 (whole section)	Tom O'Connor Ventura College	<p>Each of the Teaching Staff positions listed has some similarity to the CAAHEP standards and guidelines, but there are differences in terminology.</p> <p>As each training program is required to be in the process of becoming accredited or currently accredited, the terminology for each position title, responsibilities, and qualifications should match the CAAHEP documentation or link to the current version of the CAAHEP standards section B Personnel.</p> <p>Below are the titles, responsibilities, and qualification listed in the CAAHEP Standards and Guidelines updated in 2015</p> <ul style="list-style-type: none"> • Program Director <ol style="list-style-type: none"> Responsibilities The program director must be responsible for all aspects of the program, including, but not limited to: <ol style="list-style-type: none"> 1) the administration, organization, and supervision of the educational program, 2) the continuous quality review and improvement of the educational program, 3) long range planning and ongoing development of the program, 4) the effectiveness of the program, including instruction and faculty, with systems in place to 	<p>Comment rejected.</p> <p>The recommendation to adopt the same terminology used in the CAAHEP standards and guidelines is being rejected because HSC 1797.172 authorizes EMSA to develop and adopt paramedic training program approval criteria, including establishing personnel criteria. The personnel criteria was previously vetted when it was added through a regular rulemaking action.</p> <p>Revising the titles, responsibilities, and qualifications for all paramedic training program personnel criteria requirements would go beyond the scope of what was noticed for this regulatory proposal. In addition, replacing the entire existing personnel criteria with that of CAAHEP standards and guidelines would require a working group comprised of representatives of training programs, LEMSAs, and other key California stakeholders. EMSA acknowledges the commenters suggestion, and such revisions may be pursued in a future</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>demonstrate the effectiveness of the program, 5) cooperative involvement with the medical director, 6) the orientation/training and supervision of clinical and field internship preceptors 7) the effectiveness and quality of fulfillment of responsibilities delegated to another qualified individual.</p> <p>b. Qualifications: The program director must: 1) possess a minimum of a Bachelor's degree to direct a Paramedic program and a minimum of an Associate's degree to direct an Advanced Emergency Medical Technician program, from an accredited institution of higher education. Program Directors should have a minimum of a Master's degree. 2) have appropriate medical or allied health education, training, and experience, 3) be knowledgeable about methods of instruction, testing and evaluation of students, 4) have field experience in the delivery of out-of-hospital emergency care, 5) have academic training and preparation related to emergency medical services at least equivalent to that of a paramedic, 6) be knowledgeable about the current versions of the National EMS Scope of Practice and National EMS Education Standards, and about evidenced-informed clinical practice. For most programs, the program director should be a full-time position.</p> <p>• Medical Director Responsibilities: The medical director must be responsible for medical oversight of the program, and must: 1) review and approve the educational content of the program curriculum for appropriateness, medical accuracy, and reflection of current evidence-</p>	regulatory proposal.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>informed prehospital or emergency care practice. 2) review and approve the required minimum numbers for each of the required patient contacts and procedures listed in these Standards.</p> <p>3) review and approve the instruments and processes used to evaluate students in didactic, laboratory, clinical, and field internship,</p> <p>4) review the progress of each student throughout the program, and assist in the determination of appropriate corrective measures, when necessary. Corrective measures should occur in the cases of adverse outcomes, failing academic performance, and disciplinary action.</p> <p>5) ensure the competence of each graduate of the program in the cognitive, psychomotor, and affective domains,</p> <p>6) engage in cooperative involvement with the program director,</p> <p>7) ensure the effectiveness and quality of any Medical Director responsibilities delegated to another qualified physician.</p> <p>8) ensure educational interaction of physicians with students.</p> <p>The Medical Director interaction should be in a variety of settings, such as lecture, laboratory, clinical, field internship. Interaction may be by synchronous electronic methods.</p> <p>b. Qualifications: The Medical Director must:</p> <p>1) be a physician currently licensed and authorized to practice in the location of the program, with experience and current knowledge of emergency care of acutely ill and injured patients,</p> <p>2) have adequate training or experience in the delivery of out-of-hospital emergency care, including the proper care and transport of patients, medical direction, and quality improvement in out-of-hospital care,</p> <p>3) be an active member of the local medical</p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>community and participate in professional activities related to out-of-hospital care, 4) be knowledgeable about the education of the Emergency Medical Services Professions, including professional, legislative and regulatory</p> <ul style="list-style-type: none"> • Associate Medical Director: When the program Medical Director delegates specified responsibilities, the program must designate one or more Associate Medical Directors. <ul style="list-style-type: none"> a. Responsibilities <ul style="list-style-type: none"> 1) Fulfill responsibilities as delegated by the program Medical Director b. Qualifications: The Associate Medical Director must: <ul style="list-style-type: none"> 1) be a physician currently licensed and authorized to practice in the location of the program, with experience and current knowledge of emergency care of acutely ill and injured patients, For a distance education program, the location of program is the mailing address of the sponsor. 2) have adequate training or experience in the delivery of out-of-hospital emergency care, including the proper care and transport of patients, medical direction, and quality improvement in out-of-hospital care, 3) be an active member of the local medical community and participate in professional activities related to out-of-hospital care, 4) be knowledgeable about the education of the Emergency Medical Services Professions, including professional, legislative and regulatory issues regarding the education of the Emergency Medical Services Professions. • Assistant Medical Director: When the program Medical Director or Associate Medical Director cannot legally provide supervision for out-of-state location(s) of the educational activities of the 	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>program, the sponsor must appoint an Assistant Medical Director.</p> <p>a. Responsibilities</p> <p>1) Medical supervision and oversight of students participating in field experience and/or field internship</p> <p>b. Qualifications:</p> <p>1) be a physician currently licensed and authorized to practice in the jurisdiction of the location of the student(s) , with experience and current knowledge of emergency care of acutely ill and injured patients,</p> <p>2) have adequate training or experience in the delivery of out-of-hospital emergency care, including the proper care and transport of patients, medical direction, and quality improvement in out-of-hospital care,</p> <p>3) be an active member of the local medical community and participate in professional activities related to out-of-hospital care,</p> <p>4) be knowledgeable about the education of the Emergency Medical Services Professions, including professional, legislative and regulatory is</p> <p>• Faculty/Instructional Staff</p> <p>a. Responsibilities: In each location where students are assigned for didactic or clinical instruction or supervised practice, there must be instructional faculty designated to coordinate supervision and provide frequent assessments of the students' progress in achieving acceptable program requirements.</p> <p>b. Qualifications: The faculty must be knowledgeable in course content and effective in teaching their assigned subjects, and capable through academic preparation, training and experience to teach the courses or topics to which they are assigned. For most programs, there should be a faculty member to assist in teaching and/or clinical coordination in addition to the program director.</p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>The faculty member should be certified by a nationally recognized certifying organization at an equal or higher level of professional training than the Emergency Medical Services Profession(s) for which training is being offered.</p> <ul style="list-style-type: none"> • Lead Instructor: When the Program Director delegates specified responsibilities to a lead instructor, that individual must: <ul style="list-style-type: none"> a. Responsibilities: Perform duties assigned under the direction and delegation of the program director. The Lead Instructor duties may include teaching paramedic or AEMT course(s) and/or assisting in coordination of the didactic, lab, clinical and/or field internship instruction. b. Qualifications: The Lead Instructor must possess <ol style="list-style-type: none"> 1) a minimum of an associate degree 2) professional healthcare credential(s) 3) experience in emergency medicine / prehospital care, 4) knowledge of instructional methods, and 5) teaching experience to deliver content, skills instruction, and remediation. <p>Lead Instructors should have a bachelor's degree. The Lead Instructor role may also include providing leadership for course coordination and supervision of adjunct faculty/instructors. The program director may serve as the lead instructor</p>	
19	Section 100150 Subsection (c)(2) Page 12 Line 7	Lena Rohrbaugh NCTI	<p>Be knowledgeable in the course content of the January 2009 United States 8 Department of Transportation (U.S. DOT) National Emergency Medical Services 9 Education Standards DOT HS 811 077 EA, January 2009, herein incorporated by 10 reference;</p> <p>The Ed Standards are being revised and set to release in 2020. Recommend Inaguga modification</p>	<p>Comment rejected.</p> <p>The requirements for incorporation by reference of another document, pursuant to Section 20 of Title of the CCR, requires the regulation text to state that the document is being "incorporated by reference and identifies the document by title and date of publication or issuance."</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			to "current Education Standards" or similar.	The exception to this rule does not apply in this situation because no "authorizing California statute or other applicable law requires the adoption or enforcement of the incorporated provisions of the document...[.]"
20	Section 100150 Subsection (c)(2) Page 12 line 7: (2)	Arthur Hsieh	<p>Be knowledgeable in the course content of the January 2009 United States 8 Department of Transportation (U.S. DOT) National Emergency Medical Services 9 Education Standards DOT HS 811 077 EA, January 2009, herein incorporated by 10 reference;</p> <p>The National EMS Education Standards are currently being revised through a task force led by the National Association of EMS Educators and the RedFlash group. These standards are due to be published in late 202 or early 2021. <u>Suggestion: Revise statement to most the "January 2009" reference and include the phrase, "most current iteration" or similar.</u></p>	<p>Comment rejected.</p> <p>EMSA is rejecting this commenter's suggestion because the Administrative Procedure Act does not allow regulations to reference to a guideline that does not currently exist. Adding the proposed language would create confusion and result in varied interpretations of required competency for principal instructors.</p>
21	Section 100150 Subsection (c)(3) Page 12 lines 12-13	Lena Rohrabough NCTI	Proposed principal instructor degree requirements do not mirror CoAEMSP. CoAEMSP requires all principal instructors to hold an associate's degree. The CoAEMSP lead instructor appears to be an equivalent to the principal instructor in title 22. As CoAEMSP accreditation is a requirement for operating paramedic training in the state, recommendation is to mirror the CoAEMSP requirement and not allow 6 years of experience in lieu of the associate degree.	<p>Comment rejected.</p> <p>EMSA is authorized to establish paramedic training program approval criteria in California pursuant to HSC 1797.172, including establishing principal instructor criteria.</p> <p>The proposed regulations require an Associate's-level degree at a minimum and does not permit 6 years of experience in lieu of that degree.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
22	Section 100150 Subsection (c)(4) Page 12 Line 15 and 16	San Joaquin County EMS Agency	Remove reference to TCC as this issue is properly addressed in EMT curriculum.	<p>Comment rejected.</p> <p>EMSA is rejecting this comment because it is necessary for paramedic training to include TCC curriculum to ensure patients treated by paramedics receive the highest level of care that is appropriate and informed by up-to-date training principles.</p> <p>Not all EMTs in the state have received TCC training, in part because it was only recently introduced to EMT training program standards in 2017 (2017-0329-03S, Emergency Medical Technical (EMT) Regulations). In addition, those who do receive TCC training within EMT training program curriculum may not pursue their paramedic training until many years later, when TCC curriculum standards and practices may differ.</p>
23	Section 100150 Subsection (c)(4) Page 12 Lines 15 and 16	Los Angeles County EMS Agency	(4) The requirement for Tactical Casualty Care (TCC) instructors is under the Principle Instructor, but more than likely an instructor for TCC would be a Subject Matter Expert and not necessarily a Principal Instructor. Therefore, it should not be a requirement. The TCC instructors should meet qualifications by education and experience in TCC methods. We suggest you move this under Teaching Assistants.	<p>Comment rejected.</p> <p>EMSA acknowledges the commenter's recommendation and has removed it from subsection (c). The requirement was renumbered to a new subsection (i). This change is necessary because the intent is for the requirement to apply to any instructor who teaches the topic of TCC, not limited to the principal instructor only.</p>
24	Section 100150 Subsection (c)(4) Page 12 Line 15-16	Orange County EMS Agency	We believe that an instructor for TTC should be a subject matter expert. A principal instructor might not necessarily have the needed qualifications to adequately present the material.	<p>Comment accepted.</p> <p>Please see response to comment #23.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
25	Section 100150 Subsection (c)(4) Page 12 Line 16	Los Angeles County EMS Agency	Clarify what “experience in evaluation of instruction” means related to the TCC instructor being qualified to teach this topic.	Comment accepted. It is the program director's responsibility to ensure instructors have adequate experience and are appropriately qualified to provide instruction. The duties of a program director are specified in subsection (b) and include approval of a program's teaching staff.
26	Section 100150 Subsection (d) Page 12 Line 40	John Clark/IBSC	Change “Board for Critical Care Transport Paramedic Certification (BCCTPC)” to the board new name of International Board of Specialty Certification (IBSC)	Comment accepted in part and rejected in part. Please see response to comment #7.
27	Section 100150 Subsection (g)(2) Page 13 line 24	Lena Rohrbaugh NCTI	Recommend eliminating number of years working in the field as a licenses paramedic. We believe it should be up to the agency and educational institution to identify competency of a preceptor.	Comment rejected. This requirement was previously vetted and found to be lawful when it was added through regular rulemaking action. Field paramedic experience is necessary to ensure field preceptors are qualified to fulfill an integral role in hands-on paramedic training. Requiring field experience is necessary to ensure field preceptors are able to provide knowledgeable, safe, and qualified supervision, evaluation, and security of students for optimum student success and patient outcomes.
28	Section 100150 Subsection (g)(4) Page 13 Lines 30-31	Orange County EMS Agency	We do not believe this is the LEMSAs responsibility. The approved paramedic training program/school should be responsible for creation of their preceptor guidelines based on CoAEMSP criteria	Comment accepted / rejected in part. This section pertains to paramedic training program approval, not creation of preceptor guidelines. It is the LEMSAs responsibility to ensure training programs

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				<p>meet requirements and approval of all components of training programs including field internships. This section pertains to approval not the development of preceptor guidelines. Field preceptor training guideline approval is done under the program approval process.</p> <p>EMSA accepts the commenter's suggestion that preceptor guidelines be based on CoAEMSP criteria. The subsection was revised to clarify that preceptor training program must be in accordance with CoAEMSP guidelines.</p>
29	Section 100150 Subsection (g)(4) Page 13 Lines 30 and 31	San Joaquin County EMS Agency	<p>Amend to read as follows:</p> <p>"Have completed a field preceptor training program approved by the LEMSA. and/or 31-comply one that complies with the field preceptor guidelines approved by the LEMSA.</p> <p>EMSA does not have statutory authority for medical control of the local EMS system or for authorizing ALS service providers in a local EMS system.</p>	<p>Comment accepted.</p> <p>This subsection has been revised to clarify that preceptor training program must be in accordance with CoAEMSP guidelines.</p>
30	Section 100150 Subsection (h)(2) Page 14 Line 26	Bakersfield College	<p>Suggest revising to read: "Have worked in <u>area of specialization</u> for the last two (2) years."</p> <p>Reason: Many paramedic students perform clinical rotations throughout the clinical training portion of the course. Students may be placed in labor and delivery, pediatrics, psychiatric care and operating rooms in addition to emergency room experience for more specialized training and experiences. The current language is prohibitive of placing students in specialized areas by only having clinical preceptors with "emergency medical care services" experience.</p>	<p>Comment accepted and rejected in part.</p> <p>EMSA agree with commenters rationale that paramedic students, and preceptors in the student training environment, may possess relevant medical experience outside of an emergency medical care environment. The requirement was revised accordingly.</p> <p>EMSA is rejecting the commenter's language suggested because it is unclear and further specificity is necessary for this</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				requirement.
31	Section 100153 Subsection (a) Page 15 Line 19	ICEMA	Specified in Section 100146 <u>when approved by the medical director of the LEMSA and are included in the written policies and procedures of the LEMSA,</u> in the prehospital...	Comment rejected. EMSA has determined that the existing reference to section 100146 is sufficient and is rejecting the commenter's recommendation. The suggested language is a direct quotation from subsection 100146 (c). Inserting it into the text would be duplicative and unnecessary.
32	Section 100153 Subsection (d) Page 15 Lines 34 and 35	Los Angeles County EMS Agency	(D) Some agencies precepting their own employees tend to use the student in other capacities in addition to the intern role. Suggested language to address this - add the following at the end of sentence,-line 35. <i>The intern shall remain solely in the student paramedic role during internship and will not be assigned other duties.</i>	Comment accepted. EMSA acknowledges the commenter's concerns and has modified this section by adding subsection (d)(1) to clarify that the student shall not be assigned other duties typically held by employees in a non-student role.
33	Section 100153 Subsection (d) Page 15 Lines 34-35	Orange County EMS Agency	We agree with this change and know that this is also a CoAEMSP concern. Please consider adding language to clarify that the student/intern is not to be counted as part of the regular crew configuration during internship hours	Comment accepted. Please see response to comment #32.
34	Section 100153 Subsection (e) Page 15 Line 41	ICEMA	Add under (e) <u>Obtain written permission from the LEMSA where the field internship is proposed to occur prior to contacting the field internship provider and/or the preceptor.</u>	Comment rejected. Adding the commenter's proposed requirement would put undo strain on the training programs by requiring unnecessary contracts with the LEMSAs. It is up to the field internship provider to determine its ability to take on additional students and have a contract with the county.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
35	Section 100153 Subsection (f) Page 16 Line 18	San Joaquin County EMS Agency	Add the following language to read as: "This agreement shall be in writing <u>with a copy provided to the LEMSA.</u> "	Comment rejected. EMSA is rejecting the commenter's proposed language because adding it to this section would be redundant and unnecessary. Section 100153 requires notification and reporting to a LEMSA, and there is a requirement that training programs provide such documentation in subsection 100149 (d).
36	Section 100153 Subsection (e) [struck] Page 16 line 20	Lena Rohrbaugh NCTI	Recommend replacing the struck verbiage on full continuum of care to align with the CoAEMSP standard III.C.3. <i>To be counted as a Team Lead the Paramedic student must conduct a comprehensive assessment, establish a field impression, determine patient acuity, formulate a treatment plan, direct the treatment, and direct and participate in the transport of the patient to a medical facility, transfer of care to a higher level of medical authority, or termination of care in the field. For the capstone field internship to meet the breadth of the paramedic profession, team leads must include transport to a medical facility and may occasionally include calls involving transfer of care to an equal level or higher level of medical authority, termination of care in the field, or patient refusal of care. Capstone field internship team leads cannot be accomplished with simulation.</i>	Comment accepted in part and rejected in part. EMSA is accepting the commenter's recommendation to unstrike the language. The intent of this amendment was to place the ALS patient contact requirement in the correct section, which outlines coursework duration requirements, and delete it from section 100153, which pertains to establishing a paramedic field internship program. The initial proposed text struck subsection 100153 (e) but the language was not re-inserted in the correct section. The requirement has been moved to section 100154 accordingly. This change is necessary to improve clarity and consistency. EMSA is rejecting the commenter's suggesting that the language be replaced with the CoAESMP standard because this proposal does not seek to repeal existing course content requirements and adopt the CoAEMSP standards in place of those requirements, which EMSA established pursuant to HSC 1797.172.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				Such significant regulatory changes would require EMSA to facilitate working group comprised of representatives of training programs, LEMSAs, and other key stakeholders. EMSA acknowledges the commenters suggestion, and revisions may be pursued in a future regulatory proposal.
37	Section 100153 Subsection (e) Page 15 Line 37 (e)	Douglas J. Boileau, MBA, EMT-P College of Redwoods	Paramedics should be expected to function in the most common work environments immediately upon licensure and accreditation. The most common environment for new paramedics is working on an ALS ambulance. The elimination of this requirement eliminates any mandated exposure to attend a patient in the back of an ambulance, or to deliver a patient to a hospital. Paramedics that complete their internship only on a first response ALS vehicle will not be adequately prepared for work on an ambulance. I recommend retaining the current language.	Comment accepted. Please see response to comment #36.
38	Section 100153 Subsection (e) Page 16 line 20	Arthur Hsieh	(e) For at least half of the ALS patient contacts specified in Section 100154(b) the paramedic student shall be required to provide the full continuum of care of the patient 22 beginning with the initial contact with the patient upon arrival at the scene through 23 release of the patient to a receiving hospital or medical care facility. CPPD strongly disagrees with this change. While this may be an anticipatory step in the future of paramedic education, it will currently allow paramedic students to conduct their entire paramedic internship aboard a first responder, i.e. paramedic fire engine. The experience gained by the paramedic student during the transportation and	Comment accepted. Please see response to comment #36.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			transfer phases of an EMS incident is an absolute necessity in th preparation of the paramedic. In fact, the national examination process is moving toward an all-scenario based testing model, where the interaction between candidate and patient is evaluated during a transport phase. <u>Suggestion: Remove strikeout and keep current language in place.</u>	
39	Section 100153 Subsection (j) Page 16 Line 43	ICEMA	EMT trainee, of any level, shall be...	Comment accepted. EMSA is removing the term “EMT” as suggested. The trainee could be a nurse, physician, LEMSA medical director, or other medical professional. This change is necessary because “EMT trainee” is too limiting.
40	Section 100153 Page 16 Line 45	Arthur Hsieh	In keeping with CoAEMSP standards, expressly state that the paramedic intern must be in “third person” mode, not as a operational member of a team.	Comment rejected. A student may be an operational member of the team. An intern needs to be “operational” to get hands-on experience. “Third person” infers an observation only role. EMSA acknowledges the commenter’s concerns and has modified this section by adding subsection (d)(1) to clarify that the student shall not be assigned other duties typically held by employees in a non-student role.
41	Section 100154 Subsection (b)(2) Page 17 Line 29	North Coast EMS	Drop the EHR requirement. The EHR system as defined in § 100143.1 does not currently exist. Although the goal to utilize such a system may be valid, it should not be required until it is widely available. Requiring instead the use of an e PCR program would be a reasonable first step but a simulated ePCR program should also be permitted	Comment rejected. Current statute does not permit this requirement to be removed. HSC 1797.227 requires any EMS provider to use an electronic health record (EHR) system that is in a format compliant with

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			since some providers do not allow students to write the actual report. Requiring it may lead to the decreased availability of internship opportunities.	the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards, and that shall be interactable with the local EMS agency's data system. EMSA has revised the requirement to clarify that student documentation of patient contact shall be under supervision of the preceptor.
42	Section 100154 Subsection (b)(2) Page 17 Line 29	Douglas J. Boileau, MBA, EMT-P College of Redwoods	The EHR system as defined in § 100143.1 does not currently exist. Although the goal to utilize such a system may be valid, it should not be required until it is widely available. Requiring instead the use of an electronic PCR program would be a reasonable first step, but a simulated ePCR program should also be permitted since some providers do not allow students to write the actual report. Requiring it may lead to the decreased availability of internship opportunities.	Comment rejected. Please see above response to comment #41.
43	Section 100154 Subsection(a) Page 17 Lines 5-11	San Joaquin County EMS Agency	Remove reference to TCC as this issue is properly addressed in EMT curriculum.	Comment rejected. Please see above response to comment #22.
44	Section 100154 Subsection (a)(3) Page 17 Lines 17-18	Tom O'Connor Ventura College	Measuring students by the number of hours engaged in a clinical practicum or field internship is not the best method for determining clinical competency. Advisory committees for each program determine the minimum number of patient contact experiences required for a candidate to complete the paramedic training. During our program's last accreditation site visit, the evaluators commented on the disparity of	Comment rejected. The proposed modification is a nonsubstantive change made for formatting purposes to improve clarity. EMSA does not have data necessary to determine the minimum number of patient contacts that can replace 480 hours, a field internship and allow for competency. In addition, CoAEMPS does not establish a minimum patient contact count; only a

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>experiences between students in various parts of the county for their Field Internship Capstone work. Two students in the comparison completed with the 480 hours minimum requirement and successfully passed the NREMT exams on the first attempt. One student had a total of 78 patient contacts while the other had 237 patients during the same time period.</p> <p>Requiring only a number of hours does not provide an accurate measurement of entry-level competency given the differences in call volume from area to area. Some candidates working in busy areas could reach entry-level competencies much sooner than 480 hours. Surveying the data for over 250 graduates from our program, the average field internship contact number was 110 patients.</p> <p>I would propose the addition of a minimum patient contact count or the 480 hours as the requirement.</p> <p>The NREMT 2015 Paramedic Psychomotor Competency Portfolio, Appendix A (page 27) lists that a student must complete 18 out of the last 20 patient contacts successfully on an ALS unit responsible for responding to critical and emergent patients who access the emergency medical system. A candidate that reaches the 18 out of the last 20 competency marker prior to 480 hours could be cleared as long as the minimum patient contact target is reached. Where our program has an average of 110 patient contacts, I would suggest that 125 be the proposed patient minimum needed to complete prior to 480 hours.</p> <p>This section would read as follows: The field internship shall consist of no less than one-hundred and twenty-five (125) patient contacts OR</p>	<p>minimum count per type of patient contact.</p> <p>The suggestion language proposed by the commenter, as written, could allow hours in lieu of any patient contacts. Such significant regulatory changes would require EMSA to facilitate working group comprised of representatives of training programs, LEMSAs, and other key stakeholders. EMSA acknowledges the commenters concerns, and revisions may be pursued in a future regulatory proposal.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			four-hundred and eighty (480) hours.	
45	Section 100154 Subsection (b) Page 17 Line 20	Arthur Hsieh	<p>The student shall have a minimum of forty (40) documented ALS patient contacts during the field internship as specified in Section 100153. An ALS patient contact shall be defined as the student performance of one or more ALS skills, except cardiac monitoring and CPR, on a patient.</p> <p>This is antiquated and no longer valid. As EMT scope enlarges, does this mean now that providing naloxone IM or IN on an opioid overdose is no longer an ALS contact? In reality, the paramedic student does not turn off that portion of their training just because the patient does not require so called ALS intervention. They are evaluating ALL patients through the paramedic lens. Suggestion: <u>Eliminate this language. Since CoA requires team leads and does not differentiate between ALS and BLS patients, replace current language with The student shall have a minimum of at least 20 Team Leads as defined by the COAEMSP during the capstone phase of the field internship as specified in Section 100153.</u></p>	<p>Comment Rejected.</p> <p>Advanced Life Support (ALS) is still a recognized term for field internship by CoAEMSP. CoAEMSP defines Field Internship as, "Planned, scheduled, educational student time on an advanced life support (ALS) unit responsible for responding to critical and emergent patients who access the emergency medical system to develop and evaluate team leading skills."¹</p>
46	Section 100154 Subsection (b) Page 17 line 20-23	Lena Rohrbaugh NCTI	Recommend removing the 40 ALS contact requirement and mirror the CoAEMSP requirement for successful completion of the program to include minimum patient experience in the identified patient populations and conditions ensuring the provider has competency in handling a wide breath of emergency medicine.	<p>Comment rejected.</p> <p>Please see above response to comment #45.</p>
47	Section 100154 Subsection (b)(1) Page 17 Line 25		Use of high fidelity simulation is not an appropriate replacement for actual ALS contacts. Allowing simulation to replace actual patient contact should be removed. Students may be exposed to simulation	<p>Comment rejected.</p> <p>The intent of this proposal is not to allow high fidelity simulation to replace true</p>

¹ <https://coaemsp.org/ems-caahep-accreditation-glossary-of-terms>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			during their didactic training.	patient contacts as a whole. The proposed language is consist with CoAEMSP and CAAHEP and is necessary to provide alternatives for areas with low volume or restricted field internship exposure to complex, advance emergency medical responses. Additionally, students are still required to obtain 30 ALS patient contacts during field internship.
48	Section 100154 Subsection (b)(1) Page 17 line 25-27	Lena Rohrbaugh NCTI	Follow CoAEMSP patient simulation limitations, pediatric simulations are only allowed during the didactic phase and must be live encounters during clinical and field.	Comment accepted. EMSA agrees with the commenter's recommendation and has revised the requirement accordingly. This change is necessary to be consist with CoAEMSP accreditation standards.
49	Section 100154 Subsection (b)(1) Page 17 Lines 25-27	Dr. Grant Goold American River College	Would suggest a range between 10 and 20 high fidelity simulations contacts be available for use against the 40 ALS requirement. In addition, if we recognize the value and rigor of high fidelity simulation in student learning, then why would we also not allow the time spent in preparation, execution, and reflection of each high fidelity simulation encounter to count towards the total hours of a field internship? Many health care sectors are moving towards higher than 25% of total required patient encounters. Let us take the lead and push the envelope a bit higher. In the end, the safeguard towards minimum competency includes preceptor evaluation, medical director/program director validation, and ultimately NREMT skills and cognitive assessments. By shifting more responsibility on the program staff we can help secure sustainable funding for the simulation technology as well as continue research on the impact high fidelity simulation has on student outcomes. This shift could	Comment rejected. Simulation is provided as an alternative for areas with low volume or restricted field internship exposure to complex, advance emergency medical responses. However, the intent of this proposal is not to allow high fidelity simulation to replace true patient contacts as a whole. Currently no accepted industry standard exists for translation of simulation to hours in the field.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			also significantly impact the field internship challenges that many programs/student experience. Delays to the field could be lessened and employer demands more quickly addressed.	
50	Section 100154 Subsection (b)(2) Page 17 Line 29	ICEMA	Students should not be permitted to finalize/complete or transmit the ePCR	Comment accepted. Please see above response to comment #40.
51	Section 100154 Subsection (b)(2) Page 17 Line 29	ICEMA	Students should have ePCR training during didactic training and prior to field internship.	Comment rejected. This would place an undue burden on the training programs because different providers utilize different EHR systems. Therefore, it falls on the field internship preceptor to conduct that training. Additionally, the national standards for paramedic training (incorporated by reference in section 100155) include training on patient contact documentation.
52	Section 100154 Subsection (b)(2) Page 17 Line 29	Lena Rohrabough NCTI	The EHR system as defined in § 100143.1 does not currently exist. A simulated program should also be permitted, as some providers do not allow students access to their EHR system. Requiring the use of EHR could limit the availability of internship opportunities and in result negatively impact workforce pipeline.	Comment rejected. Please see above response to comment #41 and #51.
53	Section 100154 Subsection (b)(2) Page 17 Line 29	Dr. Grant Goold American River College	The EHR system as defined in § 100143.1 does not currently exist. A simulated program should also be permitted, as some providers do not allow students access to their EHR system. Requiring the use of EHR could limit the availability of internship opportunities and in result negatively impact workforce pipeline.	Comment rejected. Please see above response to comment #41 and #51.
54	Section 100154 Subsection (b)(2)	ICEMA	Students shall document patient contacts utilizing an EHR System <u>according to the policies of LEMSA in</u>	Comment rejected.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Page 17 Line 29		<u>which they are conducting their field internship.</u>	The commenter's suggested language is redundant with statute and is not necessary to restate in regulation. HSC 1797.227 requires all providers to be using an EHR that can be integrated with the LEMSA's data system.
55	Section 100154 Subsection (b)(2) Page 17 Line 29	Arthur Hsieh	Students shall document patient contacts utilizing an EHR system. This may be cost prohibitive depending on the LEMSA or region involved, that do not allow students to complete EHRs. However CPPD agree that patient documentation is a critical skill and is a required element of paramedic competency. <u>Suggest: Remove "utilizing an EHR system".</u>	Comment rejected. Please see above response to comment #41.
56	Section 100154 Subsection (c) Page 17 Line 31	Arthur Hsieh	The student shall have a minimum of ten (10) documented experiences performing the role of team lead during the field internship. A team lead shall be defined as a student who, with minimal to no prompting by the preceptor, successfully takes charge of EMS operation in the field including, but not limited to, the following: CoAEMSP requires twenty team leads. <u>Suggest: Change to twenty team leads.</u>	Comment accepted. This requirement has been revised according to the commenter's recommendation. This change is necessary to ensure paramedic training program course content is consistent with CoAEMSP, the reviewing/accrediting body's standards, which requires twenty team leads per student.
57	Section 100154 Subsection (c) Page 17 line 31-34	Lena Rohrabough NCTI	Recommend adopting National Registry/CoAEMSP definition of a team lead.	Comment rejected. Please see above response to comment #36.
58	Section 100155 Subsection (a) Page 18 Line 34	San Joaquin County EMS Agency	Correct the website address removing http://www.nhtsa.gov/ and replacing with https://www.ems.gov/	Comment rejected. Previously https://www.ems.gov/ was used in regulation text, however that web address has not proven to be consistently

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				accessible over the course of implementation of prior regulations, and through the development of this proposal. The language has been modified to clarify the location of the document online rather than use of a web address that may not be accessible in the future. This change is necessary to eliminate confusion.
59	Section 100155 Subsection (b) Pages 18-21 Line 37 through 40	Bakersfield College	<p>Suggest removing outline of TCC required content and replace with reference to <u>California Tactical Casualty Care Training Guidelines</u> (2017) for requirements of training.</p> <p>Reason: To ensure consistency with language and training content. Any updates in training materials of TCC would require CCR changes. By incorporating the document by reference (similar to the DOT incorporation for required course content) any changes can be made to one document and then be applicable to CCR Chapters 2 and 4. California Tactical Casualty Care Training Guidelines (2017) was developed in coordination with P.O.S.T. Any variances between CCR and the Guideline document would not be in a collaborative development of course content. Furthermore, any variances between the Guideline document and CCR would create confusion for Training Programs as to which one to follow.</p>	<p>Comment rejected.</p> <p>EMSA's EMT regulations specified the topic areas rather than referenced the guidelines. The specific purpose of this added language is to enumerate requirements for TCC to the course content of paramedics and CCPs that is consistent with public safety and EMT regulations under Title 22, Division 9 of the CCR. This is why the proposed changes specify all relevant TCC topic areas rather than referencing EMSA TCC guidelines.</p>
60	Section 100155 Subsection (b) Page 18 Line 37 through Page 21 Line 39	Tom O'Connor Ventura College	<p>These items are listed as requirements under the EMT Course Content regulations and does not list any advanced level training for the paramedic. These items would require a paramedic training program to duplicate training that was completed during an EMT training program.</p>	<p>Comment rejected.</p> <p>Please see above response to comment #22.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
61	Section 100155 Subsection (b) Page 18-22 Line 27 et seq	San Joaquin County EMS Agency	Remove reference to TCC as this issue is properly addressed in EMT curriculum.	Comment rejected. Please see above response to comment #22.
62	Section 100157 Subsection (b)(5) Page 22 Line 45	Bakersfield College	Revise to read: "The signature of the <u>program</u> director." Reason: Maintain consistency with other changes suggested throughout chapter.	Comment accepted. This requirement has been revised according to the commenter's recommendation to improve consistency with terms used throughout the chapter.
63	Section 100158 Subsection (b) Page 23	Kristin Thompson, EMS Division Chief City of Newport Beach, Fire Department	While I agree fundamentally that adding these classes to paramedic training requirements improves their knowledge base and is key to paramedicine, adding them as a prerequisite could hinder the process significantly for sending firefighter EMT's to school to become paramedics. As you know, many fire agencies handpick and send already hired firefighters to paramedic school to become paramedics for their fire department. It is a significant investment of time and costs to a municipality or jurisdiction, but one we take on to ensure we have good paramedics in our agency. Adding hours to training to incorporate A & P and Psych (Behavioral Health) would be preferable in my opinion. Many times fire agencies send internal firefighter EMT's to school with only a few months or less of preplanning due to circumstances, finances and dept needs beyond our control. If this process were in place, it would significantly impact the time a fighter would be ready to actually care for patients in the field as a licensed, locally accredited paramedic. At least one - two semesters of school for pre-preqs. Another long semester in school, clinicals, precepting, National Registry, State Lic and local accred could easily interpret to over a year until that firefighter is ready. There would also be additional costs to agencies, as they would have to pay for the	Comment rejected. EMSA has deleted these proposed education requirements based on comments suggesting that they are cost-prohibitive, time-prohibited, and a lack of available anatomy and physiology, and psychology courses throughout the state at this time. EMSA acknowledges the importance of these topics and the NHTSA EMS Educational Standards reference to these topics. Proposed revisions to the standards appear to emphasize these as well in the future.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			time as well as the classes. I am not sure how attending the college prerequ classes would look on a shift schedule either. To further add to the process, A & P are often impacted with Allied Health students and difficult to get into as well as are prereqs met. Please reconsider adding this as a pre-req (160-200 hours?) and look at adding hours to the training. We staff, budget and plan for time at medic school, adding time there would be far easier to accommodate.	
64	Section 100158 Subsection (b) Page 23 Line 29	Los Angeles County EMS Agency	Add " <i>or A-EMT</i> " after EMT-Intermediate.	Comment accepted and rejected in part. EMSA is accepting the commenter's suggestion to revise the language, as EMT-Intermediate is no longer a frequently used term. EMSA rejected the commenter's recommendation because the requirement has been revised to state Advanced EMT (A-EMT) in place of Intermediate EMT. This change is necessary to avoid confusion and varied interpretations of what registration level is required to be eligible to enter a paramedic training program.
65	Section 100158 Subsection (b) Page 23 Line 29	San Joaquin County EMS Agency	Add " <i>or A-EMT</i> " after EMT-Intermediate	Comment Rejected. Please see the above response to comment #64.
66	Section 100158 Subsection (b) Page 23 Lines 31 - 35	North Coast EMS	Drop the addition of the prerequisites "(1) A college level course in human anatomy and physiology with lab, and (2) A college level course in introductory psychology". These additions are likely to result in the elimination of paramedic programs in rural areas. The local program at College of the Redwoods (CR) draws students from six surrounding counties because it is structured in such a way as to allow students to commute long distances and continue to	Comment rejected. EMSA has removed this requirement. Please see the above response to comment #63.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>work full time. Requiring additional courses as prerequisites would eliminate the ability for many prospective students to participate, resulting in a decrease in qualified applicants to the point that the program may no longer be financially viable. There is already a shortage of paramedics in California and in the North Coast EMS region. Attracting and retaining paramedics in rural areas is even more difficult. It is critical that training opportunities are available in rural areas or the paramedic level of service may no longer be available.</p> <p>Paramedics have been trained in California for over 50 years without a mandate for A&P prerequisites at most programs. At a time when EMS is focused on evidence based practices it seems that that standard should be applied to required education as well. We are not aware of evidence demonstrating that paramedics trained in programs without these prerequisites are less prepared than those coming from programs that do. While having taken an A&P class should make the paramedic program easier for the student, we don't believe that there is any demonstrated correlation to success in the field.</p>	
67	Section 100158 Subsection (b) Page 23 Lines 31-35	Orange County EMS Agency	<p>We support the concept of preparation in the areas of anatomy, physiology and psychosocial content prior to the program but believe that this language is too restrictive. Lab courses at the college level are above and beyond what an EMT would need and, as others have mentioned, are often difficult to get into. We would like to see "paramedic prep" courses, designed for EMTs entering into programs to facilitate necessary education in A&P, pathophysiology and psychosocial issues. These courses should be designed for teaching by paramedic training programs/institutes and incorporated into their curriculum, and not require enrollment in 2 or 4 year colleges</p>	<p>Comment rejected.</p> <p>EMSA has removed this requirement. Please see the above response to comment #63.</p> <p>Additionally, adding "paramedic prep courses" would be discretionary on the training program (permissive) but current statute does not authorize EMSA to mandate that in regulation.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
68	Section 100158 Subsection (b) Page 23 Lines 31-35	Bakersfield College	<p>Suggest removal of language/ prerequisites.</p> <p>Reason: Adding in the prerequisite will have an unintended consequence of impacting student applicants to existing paramedic training programs. The courses suggested are already severely impacted in local community colleges. Students will have difficulty in obtaining said courses and because of impact at the community college level, student applicants to training programs will fall.</p> <p>Within the Notice of Proposed Rulemaking published on April 5, 2019 the section <i>Informative Digest/ Policy Statement Overview</i> makes no mention of the addition of prerequisites to paramedic training program student eligibility. In the <i>Disclosures Regarding The Proposed Action</i> section EMSA has determined that there is no mandate on school districts, no cost or savings to any state agency, etc... This determination is incorrect. Community college districts will have an additional impact to the courses suggested. The districts will either have to increase the number of sections which will require the hiring of additional faculty, or increase the class sizes. The college districts will have a financial impact associated with the hiring of additional faculty or additional lab materials to accommodate students. These proposed courses are already required as prerequisites in other allied health fields and because of that it will be difficult for paramedic students to obtain these courses timely for admission into paramedic training programs. The State Chancellor's Office has revised the funding formula for community colleges which may have a significant impact on a district's ability to add course sections or additional seats to a course. Has EMSA consulted with the Chancellor's Office and/or the Academic Senate for California Community Colleges with</p>	<p>Comment accepted.</p> <p>EMSA has removed this requirement. Please see the above response to comment #63.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>regard to potential impact for college districts? Furthermore, the section titled <i>Results of the Economic Impact Analysis/Assessment</i> states: “unlikely that the proposal will eliminate any jobs or training programs” may also be incorrect. If prerequisite classes are impacted and paramedic students are unable to take courses for an extended period of time, then enrollment into paramedic training programs will decline. When low enrollment levels are sustained, programs will be closed as low student enrollment will not offset to cost of operating said programs.</p> <p>With regard to the Initial Statement of Reasons (ISOR) the justification for the addition of the prerequisite courses is anecdotal at best. EMSA has failed to describe how a lack of these proposed courses is necessary to protect the health and safety of the public. There are many current paramedics that have not taken the proposed courses and are safely and appropriately providing prehospital care at highly competent levels. Is EMSA suggesting that all current paramedics that have not taken these particular courses are a threat to the health and safety of the public? The standard DOT curriculum that is mandated by EMSA for training programs to adhere already provide information and training in anatomy and physiology as well as behavioral and psychiatric fundamentals. The necessity that EMSA insists that “providing a paramedic student with a basic overview of the anatomy of the human body and the physiological functioning thereof” is already provided to paramedic students in a consistent manner as mandated currently. EMSA surmises that “the course work will provide the paramedic with the necessary foundation for improved clinical decision making” is anecdotal. Is there evidence regarding clinical decision making capabilities of paramedics with the additional course work vs. those without?</p>	<p>EMSA has not consulted with the Chancellor's Office or the Academic Senate for California Community Colleges.</p> <p>EMSA is not making this suggestion. The intentions of this rulemaking proposal were clearly stated in the Notice of Proposed Regulatory Action.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				EMSA is not aware of evidence that either supports, nor evidence that contradicts that the proposed coursework would provide paramedics with a foundation for improved clinical decision making.
69	Section 100158 Subsection (b) Page 23 line 33-35	Lena Rohrbaugh NCTI	Prerequisite for eligibility for A&P with lab and a Psychology course will inhibit the ability and eligibility of students to enter a paramedic program. These prerequisites would exacerbate staffing issues with agencies and departments in the future. Availability of A&P courses and Psychology courses at the local colleges is limited and will impact enrollment, delay paramedic program enrollment and in result negatively impact workforce pipeline.	Comment accepted. EMSA has removed this requirement. Please see the above response to comment #63.
70	Section 100158 Subsection (b) Page 23 Lines 33 and 35	San Joaquin County EMS Agency	<p>We have concerns about the new requirements for a college level course in “introductory human anatomy and physiology with lab” and an “introductory psychology” course. While we understand the reason behind adding these requirements, the additional coursework will be onerous on future paramedic students and are very likely to inhibit access to paramedic school for many potential students.</p> <p>At many colleges, the proposed courses come with substantial prerequisites themselves, making it more difficult for these students to meet the requirements. The proposed courses may require multiple semesters of coursework before the prerequisite classes can be taken. Additionally, registration for</p>	<p>Comment accepted.</p> <p>EMSA has removed this requirement. Please see the above response to comment #63.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>these courses at some Community Colleges is restricted to students who are attending the school on a "nursing track". These changes could potentially limit the accessibility of paramedic training, leaving students with limited time and resources without this viable career path. Limiting access to paramedic training creates strain on EMS systems that are already facing personnel shortages.</p> <p>We would encourage EMSA to establish a stakeholder group consisting of LEMSAs, EMS providers, and EMS educational programs to explore this issue and work toward consensus on the approach to expanding prerequisites to paramedic training.</p>	<p>EMSA accepts the commenter's recommendation to establish a stakeholder group to explore any issues surrounding amending existing regulations to add requirements for anatomy and physiology, and psychology courses to the paramedic training program student eligibility criteria.</p>
71	Section 100158 Subsection (b) Page 23 Line 31-35	North Coast EMS	<p>Retain the requirement to require 50% of field contacts including full continuum of care. Paramedics should be expected to function in the most common work environments immediately upon licensure and accreditation. The most common environment for new paramedics is working on an ALS ambulance. The elimination of this requirement eliminates any mandated exposure to attend a patient in the back of an ambulance, or to deliver a patient to a hospital. Paramedics that complete their internship only on a first response ALS vehicle will not be adequately prepared for work on an ambulance.</p>	<p>Comment accepted.</p> <p>Comments don't match section referenced by commenter. Please see the above response to comment #36.</p>
72	Section 100158 Subsection (b) Page 23 Lines 31-35	Douglas J. Boileau, MBA, EMT-P College of	<p>Our program at College of the Redwoods (CR) draws students from six surrounding counties because it is structured in such a way as to allow students to commute long distances and</p>	<p>Comment accepted.</p> <p>EMSA has removed this requirement. Please see the above response to</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		Redwoods	<p>continue to work full time. Requiring additional courses as prerequisites would eliminate the ability for many prospective students to participate, resulting in a decrease in qualified applicants to the point that the program may no longer be financially viable. Our A&P course are currently heavily impacted and require prerequisites themselves thus delaying entry into the paramedic program by at least three semesters.</p> <p>There is already a shortage of paramedics in California and in the country. Attracting and retaining paramedics in rural areas is even more difficult. It is critical that training opportunities are available in rural areas or the paramedic level of service may no longer be available.</p> <p>Paramedics have been trained in California for over 50 years without a mandate for A&P prerequisites at most programs. At a time when EMS is focused on evidence based practices it seems logical that that standard should be applied to required education as well. I am aware of no evidence demonstrating that para medics trained in programs without these prerequisites are less prepared than those coming from programs that do</p>	comment #63.
73	Section 100158 Subsection (b) Page 23 Line 33	Los Angeles County EMS Agency	Recommend deletion of college level Anatomy and Physiology based on concern that this requirement is unsubstantiated and difficult to obtain. This requirement adds the burden to potential students for increased cost and time to be accepted into a college level program. It is our understanding that there is limited availability of <i>Anatomy and Physiology with lab</i> courses. It is common practice for preference of enrollment to be given to full-time students currently attending the college and nursing	<p>Comment accepted.</p> <p>EMSA has removed this requirement. Please see the above response to comment #63.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>students, and veterans are also competing for class space and receive priority. Many colleges require Chemistry as a pre-requisite to enroll in Anatomy and Physiology, causing further delays and decreasing the number of potential paramedic students. In Los Angeles County, the majority of paramedic students are fire department employees with various levels of education. This requirement will place a burden on the departments and tax payers by increasing the length of time required for the EMT to qualify for paramedic training. We feel this requirement will not improve the quality of the paramedic graduate and further exacerbate the paramedic shortage. This requirement has the potential to limit the accessibility of paramedic training so that students with limited time and resources would not have access to this viable career path.</p> <p>We support further education of paramedics and encourage positive mechanisms to accomplish this goal such as giving Continuing Education Credits for college courses that qualify toward a degree, decrease in licensing fees with proof of enrollment in advance training, etc.</p>	
74	Section 100158 Subsection (b) Page 23 Line 33	ICEMA	Suggest separate college level courses in human anatomy and physiology with lab	<p>Comment rejected.</p> <p>EMSA has deleted these proposed education requirements based on comments suggesting that they are cost-prohibitive, time-prohibited, and a lack of available anatomy and physiology, and psychology courses throughout the state at this time.</p> <p>EMSA acknowledges the importance of these topics and may establish a stakeholder group to explore any issues surrounding amending existing</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				regulations to add requirements for anatomy and physiology, and psychology courses to the paramedic training program student eligibility criteria.
75	Section 100158 Subsection (b)(1) Page 23 Line 33	Arthur Hsieh	A college level course in introductory human anatomy and physiology with lab Program directors strongly support an introductory course. However the inclusion of a lab can be onerous for education institutions to implement due to cost and configuration requirements. Suggestion: Strike "with lab".	Comment rejected. Please see above response to comment #74.
76	Section 100158 Subsection (b)(2) Page 23 Line 35	Arthur Hsieh	A college level course in introductory psychology. Program directors indicated that while this would be helpful in expanding a paramedic's knowledge base, more essential education is needed in basic writing and communication techniques. Suggestion: <u>Strike introductory psychology and replace with an introductory English course with an emphasis in developing writing skills.</u>	Comment rejected. Please see the above response to comment #74.
77	Section 100158 Subsection (b) Page 23 Lines 33-35	(missing commenter)	Prerequisite for eligibility for A&P with lab and a Psychology course will inhibit the ability and eligibility of students to enter a paramedic program. These prerequisites would exacerbate staffing issues with agencies and departments in the future. Availability of A&P courses and Psychology courses at the local colleges is limited and will impact enrollment, delay paramedic program enrollment and in result negatively impact workforce pipeline.	Comment accepted. EMSA has removed this requirement. Please see the above response to comment #63.
78	Section 100158 Subsection (b) Page 23 Lines 33 and 35	Brian Henricksen, Napa County EMS Agency	The Napa County EMS Agency has concerns about the new requirements for a college level course in "introductory human anatomy and physiology with lab" and an "introductory psychology" course. While we understand the reason behind adding these requirements, the additional	Comment accepted. EMSA has removed this requirement. Please see the above response to comment #63.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>coursework will be onerous on future paramedic students and are very likely to inhibit access to paramedic school for many potential students.</p> <p>Our local community college has noted that the proposed courses come with substantial prerequisites, making it more difficult for these students to meet the requirements. The proposed courses may require multiple semesters of coursework before the prerequisite classes can be taken. Additionally, registration for these courses at our local community college is impacted by students attending the college on a “nursing track”. These changes could potentially limit the accessibility of paramedic training, leaving students with limited time and resources without this viable career path. Limiting access to paramedic training may create a strain on our EMS system due to staffing shortages.</p> <p>The Napa County EMS Agency would encourage EMSA to establish a stakeholder group consisting of LEMSAs, EMS providers, and EMS educational programs to explore this issue and work toward consensus on the approach to expanding prerequisites to paramedic training.</p>	
79	Section 100158 Subsection (b) Page 23 Lines 33 and 35	Emergency Medical Services Administrators' Association of California	<p>EMSAAC has concerns about the new requirements for a college level course in “introductory human anatomy and physiology with lab” and an “introductory psychology” course. While we understand the reason behind adding these requirements, the additional coursework will be onerous on future paramedic students and are very likely to inhibit access to paramedic school for many potential students.</p> <p>At many colleges, the proposed courses come with substantial prerequisites themselves, making it more difficult for these students to meet the requirements. The proposed courses may require multiple semesters of coursework before the prerequisite classes can be taken. Additionally, registration for these courses at some Community</p>	<p>Comment accepted.</p> <p>EMSA has removed this requirement. Please see the above response to comment #63.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>Colleges is restricted to students who are attending the school on a "nursing track". These changes could potentially limit the accessibility of paramedic training, leaving students with limited time and resources without this viable career path. Limiting access to paramedic training creates strain on EMS systems that are already facing personnel shortages.</p> <p>EMSAAC would encourage EMSA to establish a stakeholder group consisting of LEMSAs, EMS providers, and EMS educational programs to explore this issue and work toward consensus on the approach to expanding prerequisites to paramedic training.</p>	
80	Section 100158 Subsection (b) Page 23 Lines 33 and 35	Central California EMS Agency	<p>Recommend the removing college level anatomy and physiology and psychology due to the following:</p> <ul style="list-style-type: none"> • Paramedic Shortage By requiring college level anatomy and physiology with lab and psychology, we will be increasing the current paramedic shortage that we are experiencing in our EMS region in Central California. • Limited Availability College level anatomy and physiology is a course the is very impacted in every higher education institution in our region. Part-time students that are not following a specific scope and sequence within the educational institution (i.e. registered nursing, respiratory therapy, etc.) are usually put on waiting list and are seen as low priority in the registration process. • Conflict with Adult Learning Theory The concept of introducing anatomy and physiology and psychology as a prerequisite for primary paramedic training conflicts with the principles of adult learning theory (andragogy). More specifically, adult learners are most interested in learning subjects that have immediate relevance and impact 	<p>Comment accepted.</p> <p>EMSA has removed this requirement. Please see the above response to comment #63.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>to their personal life and career. College level anatomy and physiology and psychology does not translate into immediate relevance to personal life and career in that it would not be tied directly to patient assessment and treatment at the college level. Most instructors and teaching assistants are not patient care providers and are frequently unable to make the appropriate connections to assessment and treatment of patients.</p> <ul style="list-style-type: none"> • Time Delay By requiring college level anatomy and physiology and psychology, paramedic students going through the Fresno County Paramedic Program could possibly double the time to complete the program (1 year to 2 years). Ninety-eight percent (98%) of the students that go through Fresno County's Paramedic Program work full-time schedules while attending paramedic school. To add another year of intense schedule management appears to be excessive for what we are training students to master. • Economics By increasing the program length, students will most likely see that the economics do not make sense. More students may be drawn to other health education programs (RN, RT, Surgical Tech, etc.) due to the fact that these careers pay more at an entry level. By closing the time gap between paramedic training and those other career paths, we would continue to contribute to the paramedic shortage. • Discriminatory Barriers Prospective students may not be in the position to pay for one, possibly two semesters in addition to the cost of primary paramedic training. We feel this creates an unnecessary economic barrier to entry into the paramedic profession. 	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<ul style="list-style-type: none"> Evidence-based Shortfalls <p>With EMS developing into an evidence-based profession, there is not any data that directly shows that students who complete college level anatomy and physiology and psychology become more competent paramedics.</p>	
81	Section 100158 Subsection (b) Page 23 Line 35	Dr. Grant Goold American River College	For both the A&P prerequisite and the Psychology prerequisite, who will validate "college level"? Can this be done by the program alone? I say it is college level and so it is? Will the validation take the form of a college transcript? What are the minimum qualifications for the faculty teaching a college level psych and A&P course? Does the A&P course require a wet or virtual lab? Could we consider the Psych course as a corequisite? I get the A&P as a prerequisite but it seems perhaps more pedagogically sound to have the students taking the psych course while they are being exposed to patients in simulation or in the clinical practice. As a corequisite the student could complete during any one of the phases of the program prior to course completion.	Comment accepted. EMSA has removed this requirement. Please see the above response to comment #63.
82	Section 100158 Subsection (b) Page 23 Line 35	Los Angeles County EMS Agency	Though all education is positive, we do not see the relevance of an introductory psychology course. We recommend deleting due to increasing the burden on the potential student and any agency supporting EMTs through the training process to become paramedics.	Comment accepted. EMSA has removed this requirement. Please see the above response to comment #63.
83	Section 100159 Subsection (b)(4) Page 24 Line 21	Bakersfield College	Remove word "course" Reason: Language consistency throughout document with proposed revisions.	Comment accepted. EMSA accepts the commenter's recommendation and has removed the word "course" from the program director title. This change is necessary to improve consistency with terms used throughout the regulations.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
84	Section 100159 Subsection (f) Page 25 Line 30	San Joaquin County EMS Agency	<p>Add clarifying language stating that approval is for a maximum of four (4) years. Suggest as follows:</p> <p>(f) Paramedic training program approval shall be valid for a maximum of four (4) years ending on the last day of the month in which it was issued and may be renewed every four (4) years subject to the procedure for program approval specified in Section 100159(b).</p>	<p>Comment rejected.</p> <p>EMSA is rejecting the commenter's recommendation because this timeframe is consistent with other program approval periods. One of the main purposes of this proposal is to create consistency with EMT sections including training program approval periods, as many programs provide both EMT and Paramedic training. Requiring separate timeframes for review would place an undue burden on the programs for compliance. As noted in the Initial Statement of Reasons, this proposal repeals section 100161 and relocates this requirement to section 100159 without making any substantive changes to it.</p>
85	Section 100159 Subsection (f) Page 25 line 30-32	Lena Rohrbaugh NCTI	Recommend moving approval cycle to align with CoAEMSP accreditation cycle.	<p>Comment rejected.</p> <p>Please see the above response to comment #84.</p>
86	Section 100160 Subsection (c) Page 26 Line 4	Bakersfield College	<p>Replace "course" with "program" in reference to the director.</p> <p>Reason: Language consistency throughout document with proposed revisions.</p>	<p>Comment accepted.</p> <p>This change is necessary to ensure consistency with terms used throughout the regulations.</p>
87	Section 100162 Subsection (b)(1) Page 27 Line 5	Bakersfield College	<p>Replace "course" with "program" in reference to the director.</p> <p>Reason: Language consistency throughout document with proposed revisions.</p>	<p>Comment accepted.</p> <p>Please see the above response to comment #86.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
88	Section 100165 Subsection (a)(3) Page 32 Lines 4 - 23	San Joaquin County EMS Agency	Replace registered nurse and mobile intensive care nurse with "authorized registered nurse" to be consistent with Health and Safety Code, Division 2.5, Section 1797.56.	Comment rejected. Please see above response to comment #14.
89	Section 100170 Page 38	North Coast EMS	The addition of the alternate destination and treat in place language is critically important and we applaud the EMSA for including it.	Comment accepted. EMSA acknowledges the commenter's support for the proposed addition.
90	Section 100170 Subsection (a)(5) Page 38 Line 45	Orange County EMS Agency	Please clarify re "treated in place". Is this a mandate? Or can the LEMSA write a policy saying this is not allowed?	Comment accepted. This requirement was revised to clarify that "treated in place" is intended to mean treatment that takes place "on scene without transport." This change is necessary to improve clarity. Section 100170 references the LEMSA medical director as responsible for establishing these criteria. Determining whether to allow prehospital triage of patients who are assessed and determined to have a non-emergency condition falls under the LEMSA medical director's responsibilities in maintaining medical control of the respective EMS system.
91	Section 100170 Subsection (a)(5) Page 38 Line 45	ICEMA	Add to "is treated in place" <u>and released.</u>	Comment rejected. ESMA acknowledges the commenters recommendation and need for further specificity to clarify intent of this subsection. While EMSA is rejecting the specific language suggested, the requirement has been revised to improve clarity.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
92	Section 100170 Subsection (a)(5) Page 38 Line 45-46	ICEMA	Add to "or when the patient refuses <u>care or</u> transport"	Comment accepted. EMSA has revised this requirement according to the commenter's recommendation. This change is necessary to improve clarity.
93	Section 100170 Subsection (a)(7) Page 39 Line 17	Whitney Lopez	<p>I believe this is a horrible idea for 911 paramedics. Especially those who work in busy systems and are already running 10 + calls, working 24 hour shifts, etc. I believe this will only dramatically increase the burden of work load on paramedics and eventually deter EMT's from furthering their education to become a paramedic, thus worsening the shortage of paramedics that we are already having. This will allow for more abuse of the 911 system and taking 911 ambulance out of service when it is completely unnecessary. It is almost like turning ambulance companies into taxi services. Here is a scenario that would maybe put this into perspective.</p> <p>You wake up, 5 am... you notice your infant hasn't woken you up with cries to notify you that it is feeding time. You go to the crib and find you infant lifeless and without a pulse. You call 911. The paramedic ambulance responding to your call has been up all night, transporting people to halfway houses and sober centers all night and has been up for a total of 21 hours without sleep. This is the paramedic who will be attempting to resuscitate your infant. Would you be willing to gamble with the safety of citizens and their children by allowing 911 ambulance to transport to sobering centers?</p> <p>There are dozens of ways to transport these people. Uber, Lyft, BLS, PERT (psychiatric emergency response team), bus, train, taxi... this list goes ON AND ON AND ON.</p> <p>However, if this was strictly for community</p>	<p>Comment accepted.</p> <p>EMSA acknowledges the commenters concerns, however it is unclear whether the comment is proposing specific recommendations as it relates to the proposed changes to section 100170. The commenter provides no evidence to support the position that the changes proposed by this regulatory action shall jeopardize the safety of California citizens and their children.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			paramedics, then this is a fantastic idea, but do not further extend this burden onto paramedics of the 911 system.	
94	Section 100170 Subsection (a)(6)(A) Page 39 Line 6	San Joaquin County EMS Agency	Replace “response” with “contact” to read as: (A) Initiation of a an electronic health record for every patient <u>contact</u> response.	Comment rejected The intent of this requirement is to capture the EHR for all calls. In practice, there can be a lot of variance in what is considered a “patient contact.” Requiring EHR for every patient “response,” will allow a LEMSA to gather records for all calls, for all calls, including situations where there is only a record of dispatch, when a dispatch is canceled in route, or in other situations. etc.
95	Section 100170 Subsection (a)(6)(A) Page 39 Line 6	Los Angeles County EMS Agency	We recommend deleting the word <i>response</i> at the end of the sentence. There is not a clear definition. If more than one response vehicle responds to a single patient, this will generate more than one record for the patient. There should only be one electronic health record generated for each patient encounter.	Comment rejected. Please see above response to comment #94. Additionally, determining whether more than one response vehicle responds or is dispatched to a single patient falls under medical control and are best qualified at the local level, where policies for allocation of resources are developed and implemented.
96	Section 100170 Subsection (a)(6)(A) Page 39 Line 6	ICEMA	Add to “Initiation of an electronic health record for every patient response” <u>by each responding paramedic service provider</u>	Comment rejected. Please see above responses to comments #94 and #95.
97	Section 100170 Subsection (a)(6)(A) Page 39 Line 6	Orange County EMS Agency	This practice is commonplace throughout the nation. Agencies often reconcile the dispatch record with the response, whether it is determined to be an actual patient or not. Perhaps use the terminology “EMS response” rather than “patient response”	Comment rejected. Please see above responses to comments #94 and #95.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
98	Section 100170 Subsection (a)(7) Page 39 Line 17 et seq.	Kris Mangano San Benito County EMS Agency, Coordinator	San Benito County EMS Agency is supportive of the alternative destination language proposed by EMSA. These changes will provide consistent requirements for local EMS Agencies to safely implement these programs and for appropriate oversight by local EMS Agency Medical Directors.	Comment accepted. EMSA acknowledges the commenter's support for the alternate destination language proposed by this regulatory action.
99	Section 100170 Subsection (a)(7) Page 39 Line 17 et seq.	San Joaquin County EMS Agency	We support the alternate destination language proposed by EMSA. These changes will provide consistent requirements for local EMS agencies to safely implement these programs and for appropriate medical control oversight by LEMSA medical director.	Comment accepted. Please see above response to comment #98.
100	Section 100170 Subsection (a)(7) Page 39 Line 17 et seq.	Emergency Medical Services Administrators' Association of California	EMSAAC is supportive of the alternate destination language proposed by EMSA. These changes will provide consistent requirements for local EMS agencies to safely implement these programs and for appropriate oversight by local EMS agency medical directors.	Comment accepted. Please see above response to comment #98.
101	Section 100170 Subsection (a)(7) Page 39 Line 17 et seq.	Brian Henricksen, Napa County EMS Agency	The Napa County EMS Agency is supportive of the alternate destination language proposed by EMSA. These changes will provide consistent requirements for our agency to safely implement these programs and for appropriate oversight by our local EMS agency Medical Director.	Comment accepted. Please see above response to comment #98.
102	Section 100170 Subsection (a)(7) Page 39 Line 17 et seq.	Orange County EMS Agency	Please clarify the language.	Comment rejected. EMSA is rejecting this recommendation because the commenter has not identified which aspect(s) or language within proposed subsection (a)(7) need clarification.
103	Section 100170 Subsection (a)(7) Page 39 Line 17 et seq.	Chad Henry San Mateo County EMS Agency	Our LEMSA is supportive of the alternate destination language proposed by EMSA. These changes will provide consistent requirements for LEMSAs to safely implement these programs and for appropriate oversight by LEMSA Medical Directors.	Comment accepted. Please see above response to comment #98.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
104	Section 100170 Subsection (a)(7)(A) Page 39 Line 24	CHA	<p>Page 39, line 24, Policies, procedures, and protocols for medical controls, <u>base station</u> and quality of care, <u>as mutually agreed upon by LEMSA, alternate destination and GACH providers</u></p> <p><u>Hospitals are concerned with the growing responsibilities of BASE Station responsibilities, including quality assurance and continuing education requirements. While in full agreement for alternate destination sites, some hospitals may choose not to be a base station for these sites which would include unfunded QA and educational requirements by the GACH providers</u></p>	<p>Comment rejected.</p> <p>EMSA is rejecting the recommendation because it is unnecessary. Functionally, base stations are contracted with local EMS agencies pursuant to HSC section 1798.100. The concerns the commenter has raised are addressed between the local EMS agency, hospital(s), and alternate destination facility(ies) in local policy development and contract agreements.</p> <p>Additionally, a general acute care hospital (GACH) is not authorized to determine designation; that authority is under the purview of the LEMSA's establishment of medical control.</p>
105	Section 100170 Subsection (a)(7)(B) Page 39 Lines 26-27	ICEMA	<p>Patient severity is vague. Consider changing to <u>severity of patient medical condition</u></p>	<p>Comment accepted.</p> <p>EMSA acknowledges the commenters concerns regarding vagueness of "patient severity." This requirement has been revised according to the recommended language in order to improve clarity.</p>
106	Section 100170 Subsection (a)(7)(E) Page 39 Line 35	Orange County EMS Agency	<p>What personnel? Are you meaning field personnel? Or the personnel at the destination?</p>	<p>Comment accepted.</p> <p>This requirement is specific to EMS personnel. EMSA has modified the requirement to improve clarity.</p>
107	Section 100170 Subsection (a)(7)(F) Page 39	ICEMA	<p>Does this include clinics and/or other healthcare facilities?</p>	<p>Comment accepted.</p> <p>EMSA acknowledges the commenter's question regarding what types of facilities</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Line 37			may receive prehospital patients who are assessed and determined to have a non-emergency condition. Designated alternate received facilities are limited to those specified under subsection (a)(7)(F).
108	Section 100170 Subsection (a)(7)(F)(2) Page 39 Lines 43 and 44	Los Angeles County EMS Agency	Change wording to "LEMSA Designated" mental health facility. Referenced Subdivision (n) of Section 5008 of the Welfare and Institutions Code refers to Section 1250 of the Health and Safety Code in which definitions are not applicable to mental health urgent cares or clinics. Section 1250 refers to "general acute care hospital" or "an acute psychiatric hospital".	Comment accepted. 'LEMSA designated" was added to clarify that a mental health facility receiving triaged prehospital patients must be designated by a local EMS agency. Subsection (a)(7)(F)(2) was modified reference the correct statute that defines these types of facilities.
109	Section 100170 Subsection (a)(7)(F) Page 39 Lines 17-22, 37-44, Page 40 Lines 1-2	ICEMA	Line 17 appears to allow procedures for transport to alternative destinations (shall not be limited to) and then in line 37-38 appears to limit it to "alternative receiving facilities with medical staffing to consist of at least one registered nurse, that includes"... Under these criteria, would transport to medical clinics or other healthcare facilities be permissible?	Comment rejected. Under this criteria transport would be limited to facilities specified under subsection (a)(7)(F). Please see above response to comment #107.
110	Section 100170 Subsection (a)(7)(F)(3) Page 40 Line 1	CHA	Page 40, line 1, Authorized Sobering Centers that are either a federally qualified health center or a clinic as described in Section 1211 of the Health and Safety Code. means a noncorrectional facility that provides a safe, supportive environment for intoxicated individuals to become sober that meets one of the following requirements: (a) the facility is a federally qualified health center, including a clinic described in subdivision (b) or (d) Section 1206. (b) the facility is certified by the Department of Health Care Services, Substance Use Disorder Compliance Division, to prove outpatient, non-residential	Comment accepted in part and rejected in part. EMSA is accepting the commenter's recommendation to revise this subsection in order to reference the correct sections of the Health and Safety Code. Subsection (a)(7)(F)(3) was modified reference HSC section 1204 and 1206, the correct statutes that defines these types of facilities that may qualify as a sobering center authorized to receive

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			detoxification services, (c) the facility has been accredited as a sobering center under the standards developed by the National Sobering Center collaborative. Facilities granted approval for operation by OSHPD before November 28, 2017, under the Health Workforce Pilot Project #173, or otherwise providing sobering center services as of December 31, 2019, are authorized to continue operation until twelve months after the National Sobering Collaborative accreditation becomes available.	<p>patients that have been assessed and determined to have a non-emergency condition.</p> <p>EMSA is rejecting the specific language provided by the commenter because the Department of Health Care Services does not certify sobering centers, only outpatient and treatment centers. In addition, the National Sobering Collaborative is a non-profit, non-governmental entity. The Collaborative's accreditation standards do not currently exist, therefore EMSA cannot put them in regulations under APA guidelines.</p>
111	Section 100170 Subsection (a)(7)(F)(3) Page 40 Lines 1 and 2	Los Angeles County EMS Agency	Change wording to "LEMSA Designated" sobering centers. Very few are Federally qualified and the referenced Health and Safety Code Section 1211 is not applicable since it refers to a licensed clinic operating in shared clinic space with an exempt clinic.	<p>Comment accepted in part and rejected in part.</p> <p>Please see above responses to comments #108 and #110.</p> <p>Modified based on input from CDPH.</p>
112	Section 100170 Subsection (a)(7)(G) Page 40 Line 4	Orange County EMS Agency	We believe this fits better to be F under 6, not G under 7	<p>Comment rejected.</p> <p>EMSA has modified the requirement to state that initiation of an EHR shall be in accordance with subsection (a)(6)(A) of this section.</p>
113	Section 100170 Subsection (a)(7)(G) Page 40 Lines 4 and 5	Los Angeles County EMS Agency	(G) Should match the definition for Electronic Health Record that is on page 2, line 15. While having a bi-directional exchange of electronic patient health care information is a goal, it is not realistic or achievable at this time. Counties across California are just beginning their work on health information exchanges.	<p>Comment rejected.</p> <p>EMSA has modified the requirement to state that initiation of an EHR shall be in accordance with subsection (a)(6) of this section.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
114	Section 100170 Subsection (a)(7)(g) Page 40 Line 4 and 5	San Joaquin County EMS Agency	G should match the definition for Electronic Health Record that is on page 2, line 15. While having a bi-directional exchange of electronic patient health care information is a goal it isn't realistic or achievable at this time. Counties across California are just beginning their work on health information exchanges.	Comment accepted. EMSA has modified the requirement to allow for delayed implementation of bi-directional exchange of electronic patient health care information.
115	Section 100170 Subsection (b) Page 40 Line 9-10	Sacramento Prehospital Workgroup Members	<p><i>"Establish policies which provide for direct voice communication between a paramedic and a base hospital physician or MICN, as needed."</i></p> <p>This is appropriate for patients who are being transported to an approved Emergency Department (as in current practice).</p> <p>This is not appropriate for patients who will be transported to an alternate destination. Field crews requiring direct voice communication for patients who will be transported to an alternate destination will need to contact an alternate resource such as the alternate destination itself or a representative from the LEMSA. The hospitals do not have the resources available to pick up this additional responsibility. Wording should clarify that this item does not pertain to patients being transported to alternate destinations.</p>	<p>Comment rejected.</p> <p>This decision-making falls under the LEMSA medical control pursuant to HSC 1798 and 1798.100. The term "as needed" allows the LEMSA medical director to determine whether this type of communication is necessary, which may include communication with alternate destinations.</p>
116	Section 100170 Subsection (c)(1) Page 40 Line 15-16	Sacramento Prehospital Workgroup Members	<p><i>"Review by a base hospital physician or MICN of the appropriateness and adequacy of paramedic procedures initiated and decisions regarding transport."</i></p> <p>This is appropriate for patients who are being transported to the approved Base Hospital Emergency Department (as in current practice).</p> <p>Wording should clarify that this item does not pertain to patients being transported to alternate destinations. Review of EMS patients that are transported to non-base hospitals (receiving</p>	<p>Comment rejected.</p> <p>It is not the intent of this proposal to put alternate destination review under the responsibility of the base hospital(s).</p> <p>A local EMS agency is responsible for retrospective review of alternate destination transport as specified in subsection (a)(7)(H) of this section. Subsection (a)(7)(H) has been modified to relieve the base hospital of the</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>facilities) does not happen in our area however, transports to receiving facilities are often brought to light when there has been a sentinel event, complaint or adverse outcome. This has been a critical oversight of our EMS System for many years as we do not have system data regarding procedures initiated and decisions regarding transport for those patients who are transported to receiving hospitals. Receiving hospitals simply do not have a staffing matrix that clearly identifies an EMS Liaison who performs this level of auditing with a closed loop communication process. In areas where the EMS Agency is lacking in terms of staffing, accountability and oversight, these patient cases go without review at the LEMSA level as well and put quality of care at risk.</p> <p>The assessment of appropriateness and adequacy in regards to patients transported to alternate destinations will succumb to the same misfortune. Unfortunately, lack of auditing and oversight to an alternate destination has a much higher risk for significant complications and poor outcomes. It is not appropriate to hand off the responsibility of auditing and oversight to base hospital physicians / MICN's. In addition to not having the staffing nor resources to manage this level of assessment, there is no infrastructure in place to reduce risk and liability of over-the-phone consults which rely on accuracy of verbal reports and clinical assessments of field providers.</p> <p>In addition, many Base Hospitals utilize the MICN primarily for consults and orders and only call on a physician when protocol dictates. Because California never created 1) standardized curriculum, 2) testing and 3) minimum competencies, we see MICN programs in California ranging from 8 hours in length to over 50 hours in length with huge variations in</p>	responsibility specific to prehospital triage of patients.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>content. There is no way to ensure that the MICN has the skill set to assess for appropriateness and adequacy of this potentially highly sensitive population. It is not reasonable to ask Base Hospital Physicians at these hospitals to change work practices to accommodate for the lack of standardized, comprehensive MICN education. Therefore, training to this specific subject is absent or at best unknown.</p> <p>It is with great concern that we ask all auditing and oversight of alternate destination transports be the responsibility of the LEMSA without the option to delegate these duties to Base Hospitals. In addition it should be noted that LEMSA's should not be allowed to make Specialty System of Care designations (ie. Trauma, STEMI, Stroke and EMSC) dependent on maintaining Base Hospital status and / or providing alternate destination audits/ oversight through contractual bindings. This type of contractual binding is an avenue for LEMSA's to continuously delegate out the very responsibilities that they are held to preform and at a costly expense to either the hospital or the community it serves.</p> <p>Additional options aside of a LEMSA staff member for assessing for appropriateness / accuracy / auditing and oversight could include third party vendors or a trained representative from the alternate destination itself.</p>	<p>Comment rejected.</p> <p>Subsection (a)(7)(H) states that review of records and quality measures are the responsibility of the LEMSA. Modifying the language of this subsection would go beyond the scope of what was noticed for this regulatory proposal. EMSA acknowledges the commenter's concerns but is rejecting the recommended changes related to specialty care system designations because they fall outside of the scope of what was noticed for this regulatory proposal. EMSA may pursue such regulatory changes in the future after assembling a workgroup comprised of key stakeholders to determine impacts to the overall system brought on by such amendments to subsection 100170 (c)(1).</p>
117	Section 100170 Subsection (c)(2) Page 40 Line 18-20	Sacramento Prehospital Workgroup Members	<p><i>"Maintenance of records of communications between the service provider(s) and the base hospital through tape recordings and through emergency department communication logs sufficient to allow for medical control and CE of the paramedic."</i></p> <p>This is appropriate for patients who are being transported to the approved Base Hospital Emergency Department (as in current practice).</p>	<p>Comment rejected.</p> <p>Medical oversight must be determined by the local EMS agency pursuant to HSC section 1798 and 1798.100. If policy requires communication with the base hospital, those records need to be maintained.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>Again, wording should clarify that this item does not pertain to patients being transported to alternate destinations. Patients who are being transported by EMS to an alternate destination should be contacting the most appropriate medical oversight designee which is not the existing Base Hospitals. The amount of responsibility that the Base Hospitals currently maintain is more than can be efficiently managed. There is a significant increased demand placed on the Emergency Departments as a result of lack of public health resources. Field transports of the homeless populations, mental health populations, and substance abuse populations have magnified the need for additional help in the ED to ensure quality of care related to EMS transports. Assuming any additional responsibility, especially maintaining communications, documentation and logs of patients in which the Base Hospital does not receive, (such as with alternate destination patients) is not feasible, not realistic and will likely result in hospitals opting out of Base Hospital designation.</p> <p>Wording here should be changed to make clear that in regards to alternate destinations, it is referencing the most appropriate medical oversight which is designated by the LEMSA however is not the existing Base Hospitals.</p>	Please see the modifications described in response to comment 116.
118	Section 100170 Subsection (c)(3) Page 40 Line 22	Sacramento Prehospital Workgroup Members	<p><i>“Organized field care audits.”</i></p> <p>Please add wording to clarify that this is the responsibility of the LEMSA Medical Director because there are other items in this section that currently describe responsibilities of the Base Hospital which could provide for inappropriate interpretation of this particular item. Please include wording to ensure that Base Hospitals are not tasked with performing organized field care audits of</p>	<p>Comment rejected.</p> <p>Subsection (c)(3) does not identify this as a responsibility of the base hospital. Additionally, a base hospital may need to be involved in audits of alternate destinations if a patient is transported to base hospital upon determination that an alternate destination facility is not appropriate for patient care, or other</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			patients whom are transported by EMS to an alternate destination.	circumstances.
119	Section 100170 Subsection (c)(4) Page 40 Line 24-25 Number (4)	Sacramento Prehospital Workgroup Members	<p><i>“Organized opportunities for CE including maintenance and proficiency of skills as specified in this chapter.”</i></p> <p>Please add wording to clarify that this is the responsibility of the LEMSA Medical Director because there are other items in this section that currently describe responsibilities of the Base Hospital which could provide for inappropriate interpretation of this particular item. Please include wording to ensure that Base Hospitals are not tasked with providing organized opportunities for CE including maintenance and proficiency of skills. This is an employer responsibility and most employers meet these requirements with on-line training modules while employees are on duty and at work. Hospitals may elect to provide training for CE, especially training specific to specialty systems of care however it should not be required unless there is a requirement for EMS provider attendance as well.</p>	<p>Comment Rejected.</p> <p>This subsection is under medical control, it is part of the CE process – existing regulatory language does not apply that responsibility to the base hospital.</p>
120	Section 100170 Subsection (c)(5) Page 40 Line 27-31	Sacramento Prehospital Workgroup Members	<p><i>“Ensuring the EMSQIP methods of evaluation are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes and take steps to correct the process and recognize excellence in performance and delivery of care, pursuant to the provisions of Chapter 12 of this Division.”</i></p> <p>Please add wording to clarify that this is the responsibility of the LEMSA Medical Director because there are other items in this section that currently describe responsibilities of the Base Hospital which could provide for inappropriate interpretation of this particular item.</p>	<p>Comment rejected.</p> <p>See above response to comment #119.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
121	Section 100169 Page 40 Line 33	ICEMA	100169 does not appear in the draft. It appears that 100168 Paramedic Service Provider and 100169 Paramedic Base Hospital were removed without notation from Article 7 in the draft.	Comment rejected. Sections 100168 and 100169 were not removed from regulations. The sections are not being amended or repealed as part of this regulatory proposal.
122	Section 100170 Subsection (d) Page 40 Line 35	ICEMA	...may be instituted by the medical director of the LEMSA if approved by the Authority.	Comment rejected. This existing requirement is not being amended by this proposal and is consistent with statute. Where the use of a base hospital is precluded, alternative arrangements must be approved by the Emergency Medical Services Authority pursuant to HSC 1798.101 (a)(2).
123	Section 100171 Subsection (e) Page 41 Line 13	ICEMA	...completing, in a timely manner <u>and in compliance with LEMSA policies and procedures,</u>	Comment rejected. This change is unnecessary because it is redundant because section 100146 of this chapter already specifies that an operating paramedic must be part of an EMS system. Additionally, subsection 100170(a)(6) outlines LEMSA medical director requirements for initiating, completing, reviewing electronic health records.
124	Section 100171 Subsection (e)(6)(F) Page 41 Line 29	Orange County EMS Agency	We do not believe that "chief complaint" should be eliminated from required documentation – it is still a NEMSIS field. We support the addition of Primary Impression.	Comment accepted. This subsection has been revised according to the commenter's recommendation. This change is necessary to ensure compliancy with NEMSIS/CEMSIS.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
125	Section 100171 Subsection (e)(12) Page 41 Line 36	Orange County EMS Agency	We believe that this language should match the NEMSIS/CEMSIS data element to ensure compliance with APOT	Comment accepted. EMSA acknowledges the commenter's suggestion and has confirmed that the language for this requirement is consistent with CEMSIS/NEMSIS. (Tom looked it up!)
126	Section 100170 Subsection (e)(12) Page 41 After Line 36	Los Angeles County EMS Agency	You need to add "Facility Equipment Time" to capture Ambulance Patient Offload Time to be consistent with the definition of APOT.	Comment rejected. The recommended data field is not consistent with CEMSIS/NEMSIS. Pursuant to HSC 1797.227 all data fields must be compliant with CEMSIS/NEMSIS.
127	Section 100171 Subsection (g) Page 42 Lines 1-2	North Coast EMS	Increase flexibility in Section (g). It states that the paramedic service provider shall submit the EHR data to the LEMSA per policy and the LEMSA shall submit data to EMSA at quarterly intervals. In the North Coast EMS region, each provider directly submits EHR data to the EMSA repository and we currently do not receive it at all. Rather, our IT mines the state database. We suggest allowing this kind of local flexibility but requiring that EHR data be submit to EMSA by either the provider or the LEMSA.	Comment rejected. Local EMS agency can determine guidelines for submission locally, but are required to ensure complete and timely submission per HSC 1797.227.
128	Section 100171 Subsection (g) Page 42 Lines 1-2	Raymond Ramirez Jr., EMT-P, J.D.	Suggested modifying 100171(g) to read, or language to the effect: (g) The paramedic service provider shall submit electronic health records to the LEMSA according to the LEMSA's policies and procedures, <u>subject to subsection (1) of this section.</u> (1) <u>The LEMSA shall not mandate that a paramedic service provider shall use a specific electronic health record system to collect and share data with the LEMSA; however, this restriction shall not modify or affect a written contract or agreement executed</u>	Comment rejected. This revision is unnecessary because it is clearly stated in the authorizing statute, HSC 1797.227, which is being added to the reference citations for this section under this proposal. EMSA has determined that it is unnecessary for this language to be added to the regulation text because it is clearly stated in the authorizing statute, which is referencing in the citations for

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p><u>before January 1, 2016, between a local EMS agency and an emergency medical care provider.</u></p> <p>AB 1129, Burke (2015) added H&SC § 1797.227 and was specifically enacted to limit a LEMSA's medical control authority to require that any "emergency medical care provider" shall use a <u>specific</u> electronic health care record system. The EMS Authority's ISOR recognizes that changes to subsection (e) are necessary for compliance with AB 1129. As written, the proposed changes impermissibly-narrow AB 1129's application and intent. Alternatively, amending CCR 100171(f) or 100170(a)(6) to include the above statutory intent would be satisfactory.</p>	this section. Adding the language in regulation would be duplicative.
129	Section 100171 Subsection (g) Page 42 lines 1-2	Kristin Thompson, EMS Division Chief City of Newport Beach, Fire Department	<p>Modify 100171(g) to read, or language to the effect:</p> <p>(g) The paramedic service provider shall submit electronic health records to the LEMSA according to the LEMSA's policies and procedures, <u>subject to subsection (1) of this section.</u></p> <p><u>(1) The LEMSA shall not mandate that a paramedic service provider shall use a specific electronic health record system to collect and share data with the LEMSA; however, this restriction shall not modify or affect a written contract or agreement executed before January 1, 2016, between a local EMS agency and an emergency medical care provider.</u></p> <p>AB 1129, Burke (2015) added H&SC § 1797.227 and was specifically enacted to limit a LEMSA's medical control authority to require that any "emergency medical care provider" shall use a <u>specific</u> electronic health care record system. The EMS Authority's ISOR recognizes that changes to subsection (e) are necessary for compliance with AB 1129. As written, the proposed changes impermissibly-narrow AB 1129's application and intent. Alternatively, amending CCR 100171(f) or 100170(a)(6) to include</p>	<p>Comment rejected.</p> <p>Please see above response to comment 128.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			the above statutory intent would be satisfactory.	
130	Section 100171 Subsection (h) Page 42 Line 4	San Joaquin County EMS Agency	Revise to read: (h) The LEMSA shall submit the electronic health record data to the Authority quarterly as follows: January, February, March data due by May 31; April, May, June data due by August 31; July, August, September data due by November 30; and October, November, December data due by February 28.	Comment rejected. EMSA has determined that a need for further specification does not exist. Preference is for real time data or that EHR data be submitted as frequently as possible. However, the regulations establish minimum standards; consistency is necessary.
131	Section 100170 Subsection (h) Page 42 Line 4	Los Angeles County EMS Agency	The term no greater is confusing - does that mean we can't send it any more frequently than quarterly? Rewrite this sentence and define when quarterly data is due. Example: eHR data is due to Authority within 60 days of the end of each calendar quarter, specifically Quarter I data is due no later than May 31, Quarter II data is due no later than August 30, Quarter III data is due no later than November 30 and Quarter IV data is due no later than March 2, of the following year.	Comment accepted. EMSA acknowledges the commenter's concerns and does not intend to limit submission to no more frequently than quarterly. The language has been revised to clarify that providers are required to submit EHR data in a timely manner that is more appropriate, and provides flexibility by allowing for a LEMSA to establish a different frequency if agreed upon with EMSA.
132	Section 100170 Subsection (h) Page 42 Lines 4-5	Orange County EMS Agency	It might be more clear to say "no less frequently than quarterly"	Comment rejected. EMSA acknowledges the commenter's concerns and has modified the language to improve clarity.
133	Section 100172 Page 42 Line 11 et seq.	John Spooner	The fee increase is absurd. The existing fee is already burdensome to EMS providers. CA has one of the highest licensure fees in the country and it is actually discouraging people from obtaining and renewing their licensure in the state. Additionally, having higher out of state application fees ensures that the net flow of EMS providers into the state will	Comment Rejected. The fee increased that have been proposed are necessary to cover increasing cost associated with review, approval, and oversight of providers. (restate problem from ISOR, cite statutory authority).

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>remain negative.</p> <p>Consider reducing this fee (not increasing) and finding g alternative means for funding. Do not place it on the providers. Consider than many jurisdictions have additional licencing fees and requirments (Los Angeles City for example.)</p>	
134	Section 100172 Subsection (a) Page 42 Line 12-14	San Joaquin County EMS Agency	Add "paramedic service providers" to the list of entities to be consistent with application of this provision of the regulations.	<p>Comment rejected.</p> <p>Local EMS agencies are authorized to collect fees as specified in subsection (a) pursuant to HSC section 1797.212. No statutory authority exists to allow for providers to establish a fee schedule for paramedic training programs for paramedic service providers.</p> <p>EMSA does not have the authority to mandate that fee, however, it may be established through local ordinance as determined by the LEMSA.</p>
135	Section 100172 Subsection (b)(7) Page 43 Line 17	ICEMA	The fee for approval and re-approval of a CE provider <u>that is approved by the Authority</u> shall be...	<p>ST/KL: Comment Rejected.</p> <p>Adding this language is redundant, unnecessary.</p> <p>Subsection 100172(b) establishes this is an Authority established schedule of fees.</p>
136		Graham Pierce Chairman International Board of Specialty Certification (IBSC)	<ul style="list-style-type: none"> • The IBSC supports the concept of a defined level of education and suggest that the curriculum be based on or reference the detailed content outlines (DCO) that the FP-C and CCP-C exams are built around. The DCOs for both exams are attached to this correspondence. • The IBSC also supports the idea that the entry level 	<p>Comment accepted. EMSA acknowledges the commenters support.</p> <p>Comment rejected. The content outlines references were designed for CCP training program development. California currently does not have any CCP training programs. Updating this curriculum is</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>(basic) paramedic benefits from experience learned in both the clinical and didactic arenas as a paramedic prior to attempting specifically certification.</p> <ul style="list-style-type: none"> • The IBSC recognizes that recent changes in the fabric of American society, and support the need for specialized training and validation of the related body of knowledge through specialized certification to include flight paramedics, critical care paramedics, community paramedics and tactical paramedics and responder. <p>The IBSC's mission is to improve the quality of the care delivered by paramedics whom are functioning in a specialty environment using a board certification model. We accomplish this goal by providing a family of specialty certification exams that are an objective, fair, and honest validation of a unique domain of knowledge that provide validation of the best practices in care and creates a de facto National and International standard for critical care transport, flight paramedic, tactical paramedic and community paramedic practitioner. The IBSC is accredited by the National Commission for Certifying Agencies (NCCA), the accreditation body of the Institute for Credentialing Excellence (ICE). The NCCA Standards were developed to help ensure the health, welfare, and safety of the public and highlight the essential elements of a high-quality program.</p>	<p>outside the scope of this proposal.</p> <p>Comment accepted. EMSA acknowledges the commenters support.</p> <p>Comment accepted. EMSA acknowledges the commenters support.</p>
137		ELENA LOPEZ-GUSMAN Executive Director California American College of Emergency Physicians	Comments below	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		Cal-ACEP		
	<p>These proposed regulations attempt to alter the statutory requirement which requires patients to be transported to emergency departments and instead seek to allow patients to be transported to alternate destinations. EMSA lacks authority to make this change.</p> <p>Current Scope of Practice Statute Requires Transport to an Emergency Department</p> <p>In the informative digest/policy statement overview of the Notice of Proposed Rulemaking, EMSA acknowledges that existing statutes require transport of a patient to a General Acute Care Hospital. Current law does not allow transport of a patient to alternate destinations.</p> <p>EMSA acknowledged this fact in its February 16, 2014 Community Paramedicine Pilot Project HWPP #173 application on page 12 where it stated “The paramedic scope of practice in California is somewhat unique compared to other licensed health professionals in that the statute refers to both a set of authorized skills/activities that emergency medical personnel may perform and the places and circumstances in which those skills/activities may be performed.” EMSA went on to say, “The establishment of a Health Workforce Pilot Project (HWPP) through the Office of Statewide Planning and Development (OSHDP) will allow for the temporary waiver of sections of the Health and Safety Code (HSC 1797.52, 1797.218) that limit the destination of patients transported by paramedics and that specify the limited emergency settings and situations where paramedics can provide services.”</p> <p>The Legislature has not Delegated Scope of Practice Changes to EMSA</p> <p>The Legislature has not delegated the authority to expand this scope of practice to EMSA. In fact, the Legislature has been debating numerous proposals to make changes to scope of practice for the past several years now, none of which has been signed into law. EMSA does not have authority to circumvent the legislative process.</p> <p>EMSA cites an EMSAAC and EMDAC Joint Position Paper as “Documents Relied Upon” for this regulation. That document states: Recent experience with legislation attempting to address alternate destination using the community paramedicine model have been disappointing, highlighting the difficulty of working through the legislative process with its myriad of special interest groups that do not understand the history of EMS systems in California and the role of the LEMSAs medical director in ensuring medical control. Senate Bill 944/Hertzberg, the only existing legislative vehicle for keeping community paramedicine projects operating, placed local EMS agencies in an untenable situation. It is unclear if any LEMSAs would even consider enacting a community</p>			<p>Comment rejected.</p> <p>EMSA is rejecting this comment and asserts that existing regulations allow paramedics to not transport a patient and recognizes the authority of the local EMS agency (LEMSA) medical director to set medical control standards.</p> <p>There are three clear statutory references that provide authority for the use of regulations to clarify medical control and patient destinations as described in HSC 1797.114, 1797.176, and 1797.220. There are no clear prohibitions regarding alternate destinations. Change of existing statutes is unnecessary in order to clarify the role of medical control and destination decisions in a local EMS system as part of the regulatory process outlined in HSC 1797.107.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>paramedicine program if the legislation passes as written.</p> <p>In fact, they acknowledge “Senate Bill 944/Hertzberg, <i>the only existing legislative vehicle for keeping community paramedicine projects operating</i>, placed local EMS agencies in an untenable situation.” (emphasis added) The fact that EMSAAC and EMDAC find the legislative process disappointing and that it may not lead to their desired policy outcome, does not bestow rulemaking authority on EMSA.</p> <p>EMSA Lacks Authority to Approve Transport of Patients with Non-Emergency Conditions to Alternate Destinations</p> <p>In the informative digest/policy statement overview of the Notice of Proposed Rulemaking for these regulations, EMSA states “Though existing regulations do not require patient transport, and specifically recognize non-transport as an option, there is much confusion regarding the assessment and transport of patients to alternative destinations by paramedics.”</p> <p>There is a significant distinction between non-transport and transport to alternate destinations. Health and Safety Codes section 1797.52 is clear that scope of practice applies “at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.” It clearly does not apply during transport to any other destination.</p> <p>Proposed Regulations Lack Clarity and Apply to Patients with Emergency Conditions</p> <p>In the informative digest/policy statement overview of the Notice of Proposed Rulemaking for these regulations, EMSA states “The regulations proposed in this rulemaking action intend to... establish requirements for prehospital triage of patients who are assessed and determined to have a non-emergency condition to an alternative destination for treatment under the medical control of a LEMSAs medical director.”</p> <p>EMSA argues that the alternate destination provisions of these regulations apply only to patients with non-emergency conditions and therefore do not run afoul of current statute. We disagree.</p> <p>Even if EMSA had authority to promulgate regulations allowing transport of patients who are assessed and determined to have a non-emergency condition to an alternative destination, these proposed regulations apply to patients with emergency conditions and therefore still exceed EMSA's authority.</p> <p>Article 7, Section 100170(a)(7) of the proposed regulation found on page 39, states:</p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>Requirements to be followed for prehospital triage of patients who are assessed and determined to have a non-emergency condition. These requirements may include procedures for patients that are frequent users of the EMS system that require referral, for patients that require transport to an alternative destination other than a Hospital with a Basic emergency permit for further treatment, or for patients who require assessment in an emergency situation. (emphasis added)</p> <p>On its face the regulation applies to patients with emergency conditions.</p> <p>Similarly, Article 7, Section 100170(a)(7)(F)(2) of the proposed regulation allows transport of patients with psychiatric conditions to mental health facilities including licensed psychiatric hospitals, licensed psychiatric health facilities, and certified crisis stabilization units. It is well settled law in California that psychiatric conditions have parity with other medical conditions and constitute medical emergencies (Health and Safety Code Section 1371.1(a)(2)(B)). EMSA may not authorize transport to alternate destinations for behavioral health patients simply because their emergency condition is psychiatric.</p> <p>Additionally, these regulations must be read in the context of the previous 5-years of history around efforts to allow transport to alternate destinations. This history includes EMSA's application to OSHPD under the Community Paramedicine Pilot Project HWPP #173, as well as multiple legislative efforts to allow those pilots to continue and to permanently allow transport to alternate destinations. The behavioral health pilots authorized by OSHPD under the Community Paramedicine Pilot Project HWPP #173 are transporting patients with psychiatric emergencies to alternate destinations. That transport was planned and outlined in the pilot applications and protocols and was included in their ongoing reporting to OSHPD. To believe that these proposed regulations do not intend to do the same thing, particularly when the proposed regulations authorize transport to the same facilities included in the pilots, strains logic. Doing so would apply to patients with emergency conditions and exceed EMSA's authority.</p> <p>For the reasons described above, EMSA lacks authority to promulgate these regulations and we must oppose their adoption. This scope of practice change must be made within the proper purview of the Legislature. If you have any questions about these comments, please contact our office at (916) 325-5455.</p>	
138		Yvonne Choong VP California	Comments below	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		Medical Association (CMA)		
	<p>Assessment of Non-Emergent Medical Conditions and Transfer to Destinations Other Than General Acute Care Hospitals Exceeds Paramedic's Legal Scope of Practice.</p> <p>Under the proposed regulations, LEMSAs would establish protocols under which paramedics would perform patient assessments to determine if a patient is experiencing an emergency situation and if the patient is determined not to be experiencing an emergency, the paramedic would transport the patient to an alternate destination that includes mental health facilities or sobering centers. According to the Office of Statewide Health Planning and Development (OSHPD) and EMSA:</p> <p><i>Paramedics are presently trained to provide advanced life support services in an emergency setting or during inter-facility transfers. Currently, California Health and Safety Code (HSC 1797.52, 1797.218), limits paramedic scope of practice to emergency care in the pre-hospital environment. Moreover, patients under the care of a paramedic are required to be delivered to a general acute care hospital emergency department. The paramedic scope of practice in California is somewhat unique compared to other licensed health professionals in that the statute refers to both a set of authorized skills/activities that emergency medical personnel may perform and the places and circumstances in which those skills/activities may be performed... Paramedics are required to operate under medical control or protocol at all times.</i></p> <p>Under existing state law, paramedic scope of practice is limited to advanced life support services in an emergency setting and does not include diagnosis of medical conditions or decisions about appropriate medical treatment of medical conditions and the environments in which those treatments should be delivered. Paramedics are responsible for providing care to stabilize a patient's condition to allow transport to a general acute care hospital with an emergency department where the patient can be assessed, triaged, treated and, if appropriate, discharged from the hospital's care. Emergency departments in California are required to meet specified staffing and facility requirements that allow them to be the entity responsible for determining if a patient's condition is stable enough to be discharged for care outside of a general acute care hospital.</p> <p>EMT-Paramedics are trained to provide advanced life support services in emergency settings or during inter-facility transfers. California Health and Safety Code Division 2.5, Emergency Medical Services:</p>			<p>Comment rejected.</p> <p>EMSA is rejecting this comment and asserts that existing regulations allow paramedics to not transport a patient and recognizes the authority of the local EMS agency (LEMSA) medical director to set medical control standards.</p> <p>There are three clear statutory references that provide authority for the use of regulations to clarify medical control and patient destinations as described in HSC 1797.114, 1797.176, and 1797.220. There are no clear prohibitions regarding alternate destinations. Change of existing statutes is unnecessary in order to clarify the role of medical control and destination decisions in a local EMS system as part of the regulatory process outlined in HSC 1797.107.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>a) Limits the EMT-Paramedics scope of practice to emergency care in the pre-hospital environment</p> <p>b) Requires that patients under the care of an EMT-Paramedic be transported to a general acute hospital that has a basic or comprehensive emergency department permit (Health and Safety Code Section 1797.52, 1797.218)</p> <p>c) Requires emergency medical services to transport a patient to the closest and most appropriate facility (Health and Safety Code Section 1797.114).</p> <p>HSC makes no reference to paramedics providing non-emergency care and clearly specifies that patients must be transported to a general acute care hospital. While patients reserve the right to decline transportation to a hospital emergency department, this does not affirmatively allow paramedics to make decisions regarding transport to other locations.</p> <p>EMSA Lacks Authority to Allow Transfers to Destinations Other Than General Acute Care Hospitals. These regulations propose the adoption of specific requirements for training, protocols, documentation, and consideration for establishing alternative destinations when paramedics assess and determine that a patient is in a “non-emergency” condition. According to the Notice of Proposed Rulemaking, the authority to promulgate regulations on prehospital triage protocols is based on the EMS Administrators Association of California (EMSAAAC) and EMS Medical Directors Association of California (EMDAC) position paper positing that once paramedics arrive at an emergency patient, the paramedics may assess and determine that a patient is in a “non-emergency” condition. According to the position paper, at that point, a local EMS agency (LEMSA) Medical Director has broad medical control authority to authorize a patient to be transported to any destination, unrestricted by existing statutes, because the patient is not in an “emergency” condition. The paper asserts that the Medical Director of a LEMSAs has broad authority to make medical decisions regarding patient destination from the scene of an emergency and while in transport, pursuant to HSC Sections 1797.220 and 1798.</p> <p><i>1797.220. The local EMS agency, using state minimum standards, shall establish policies and procedures approved by the medical director of the local EMS agency to assure medical control of the EMS system. The policies and procedures approved by the medical director may require basic life support emergency medical transportation services to meet any medical control requirements including dispatch, patient destination policies, patient care guidelines, and quality assurance requirements.</i></p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p><i>1798. (a) The medical direction and management of an emergency medical services system shall be under the medical control of the medical director of the local EMS agency. This medical control shall be maintained in accordance with standards for medical control established by the authority.</i></p> <p>The Notice states that “though existing regulations do not require patient transport, and specifically recognize nontransport as an option, there is much confusion regarding the assessment and transport of patients to alternative destinations by paramedics.” We disagree and believe there is ample support in law, past statements and actions by EMSA that EMSA clearly does not have the legal authority to promulgate regulations to allow patient transfers to destinations other than general acute care hospitals with a standby emergency department. In 2014, EMSA applied to establish a Health Workforce Pilot Project (HWPP) through the Office of Statewide Planning and Development (OSHDP) to allow for the temporary waiver of sections of the Health and Safety code (HSC 1797.52, 1797.218) that limit the destination of patients transported by paramedics and that specify the limited emergency settings and situations where paramedics can provide services. Application for temporary waiver of HSC sections governing paramedic scope and transfer clearly indicates that the specified HSC sections limited EMSA’s authority to expand the type of care provided by paramedics and where those patients can be transferred.</p> <p>In addition, there have been legislative attempts to expand EMSA’s ability to allow paramedics to transport patients to alternate destinations. SB 944 (Hertzberg, 2018), AB 1795 (Gipson, 2018), AB 3115 (Gipson, 2018) have all sought to allow EMTs to divert patients to sobering centers or mental health facilities or to make permanent the community paramedicine pilot programs authorized by OSHPD. Most recently, AB 1544 (Gipson, 2019) seeks to establish the Community Paramedicine or Triage to Alternate Destination Act of 2020 to establish state guidelines to govern the implementation of community paramedicine programs (CPP) or triage to alternate destination programs (TADP) by local LEMSAs in California. The repeated introduction of this legislation would indicate that EMSA and LEMSAs medical directors do not already have the statutory authority to promulgate regulations on this subject.</p> <p>Expanded Paramedic Scope of Practice and Transportation to Destinations Other than General Acute Care Hospitals Risks Patient Safety. Patients call for emergency services with the expectation that they will be transported to a hospital and thoroughly examined and treated for their condition. CMA is concerned that the proposed regulations would rely on paramedics to evaluate and make determinations regarding the nature and acuity of a patient's condition. Licensed physicians are the most qualified to diagnose a patient's condition, based on their education, training and experience. Even in an emergency room setting, patients must</p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>be evaluated by a physician before being discharged. A physician cannot rely on an assessment performed by the paramedic or other allied health professional.</p> <p>While a paramedic is trained to assess symptoms and stabilize a patient for transport to the emergency room, they are not trained to make a determination regarding the root cause of potentially broad symptoms. For example, a 911 caller might present with shoulder pain which could be a physical injury or could be the first sign of a heart attack. It is also possible that patients could be diverted to an urgent care setting, only to be transported to a hospital after being diagnosed with a more acute condition by physicians at the urgent care center. This could result in additional costs to the patient and delays in care that could impact patient safety.</p> <p>Properly diagnosing conditions, knowing the likely course of treatment and directing patients to the appropriate location where they can receive appropriate care is a significant responsibility that requires specialized education and training. Physicians attend medical school for four years and then complete three to seven years of residency training, during which they become experienced in evaluation and diagnosis. This experience cannot be distilled into a protocol or checklist that can be administered by an allied health professional with substantially less training and education.</p> <p>A 2019 evaluation of the OSHPD Health Workforce Pilot Project, funded by the California Healthcare Foundation found that pilot programs participating in alternate destination transfers to mental health facilities and sobering centers generated cost savings to participating counties (due to diversion from treatment at emergency departments); however, there is limited information regarding whether there were improvements in quality of care. The pilot projects also included alternate destination transfers to urgent care centers and the evaluation found that urgent care centers were often closed or declined to accept the patients, and in a few cases the patients had to be rerouted from the urgent care clinic to the emergency department causing a delay in care.</p> <p>In conclusion, CMA supports improving access to care for underserved patients and the more efficient use of EMSA resources. However, we have significant concerns regarding these proposed regulations and the ability of the programs to meet these objectives while ensuring patient safety. We urge EMSA to withdraw the sections of the proposed regulations related to prehospital triage procedures pending the granting of statutory authority from the Legislature to expand the authority of EMSA and the paramedic scope of practice to allow this action.</p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	BRIAN K. RICE President California Professional Firefighters		Comments below	
139	Article 7 Section 100168	<p>Written agreements with Paramedic Service Providers. While the proposed regulations appear to be a substantial rewrite of Chapter 4, studiously omitted from the rulemaking notice is CCR Section 100168. This Section clarifies and makes specific the requirements of paramedic service provider and the associated requirement to enter into a written agreement to provide such services. The “written agreement” requirement has generated substantial litigation with respect to how the requirements of this Section may interact with the grandfathered rights provided to cities and fire districts under Section 1797.201. Given the history around the inconsistent application of this rule in various local EMS agency jurisdictions, it is some-what perplexing that the Emergency Medical Services Authority (EMSA) would pass on an opportunity to clarify the rule consistent with supreme court decisional law to avoid future disputes. We recommend the following change to paragraph (4) of subdivision (b) of Section 100168:</p> <p>(b)(4) Have a written agreement with the LEMSA to participate in the EMS system and to comply with all applicable State regulations and local policies and procedures, including participation in the LEMSA’s EMSQIP as specified in Chapter 12 of this Division. <u>Notwithstanding the foregoing, a city or fire district operating pursuant to Section 1797.201 of the Health & Safety is not required to comply with the provisions of this subparagraph except that city or fire district shall be subject to a local EMS agency’s medical control.</u></p>		<p>Comment rejected.</p> <p>EMSA acknowledges the commenters concerns and clarifies that Section 100168 of title 22 is not being amended or repealed by this proposal. Any modification to section 100168 would exceed the scope of this regulatory action as provided int the notice of proposed regulatory action.</p>
140	Article 7 Section 100170	<p>Current Scope of Practice Statute Requires Transport to An Emergency Department. The changes proposed through the addition of paragraph (7) and subparagraphs (A)-(H) to subdivision (a) of Section 100170 represent an inappropriate expansion of a paramedic’s scope of practice without statutory authorization. These proposed regulations alter the statutory requirement that patients be transported to emergency departments and instead, through regulation, seek to allow patients to be transported to an alternate destination other than the emergency department. EMSA lacks the statutory authorization to propose such a change through regulation.</p>		<p>Comment rejected.</p> <p>EMSA is rejecting this comment and asserts that existing regulations allow paramedics to not transport a patient and recognizes the authority of the local EMS agency (LEMSA) medical director to set medical control standards.</p> <p>There are three clear statutory references</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>In the informative digest/policy statement overview of the Notice of Proposed Rulemaking, EMSA acknowledges that existing statutes require transport of a patient to a General Acute Care Hospital. Current law does NOT allow transport of a patient from the scene of an emergency to alternate destinations.</p> <p>The proposed regulations must be considered in the context of the last several years and related efforts to allow transport to alternate destinations, including the EMSA's own application in 2014 to the Office of Statewide Health Planning and Development (OSHDP) under the Health Workforce Pilot Project (HWPP) #173, a pilot project to test seven different concepts for the practice of community paramedicine in ten geographic areas across California. In short, HWPP #173 was designed to test and study community paramedicine in the field and was adopted under existing OSHPD authority and among those concepts was the transportation of a patient to an alternate destination.</p> <p>Notably, on page 12 of EMSA's application it stated "The paramedic scope of practice in California is somewhat unique compared to other licensed health professionals in that the statute refers to both a set of authorized skills/activities that emergency medical service personnel may perform and the places and circumstances in which those skills/activities may be performed." EMSA went on to say, "The establishment of a Health Workforce Pilot Project (HWPP) through the Office of Statewide Planning and Development (OSHDP) will allow for the <u>temporary waiver of sections of the Health and Safety Code (HSC 1797.52, 1797.218) that limit the destination of patients transported by paramedics and that specify the limited emergency settings and situations where paramedics can provide services.</u> (emphasis added).</p> <p>The Legislature has not Delegated Scope of Practice Changes to EMSA. The Legislature, to date, has not delegated the authority to expand this scope of practice to EMSA, In fact, as EMSA is aware, a handful of community paramedicine and alternate destination bills have moved through stages of the legislative process in the last several years. To date, however, none have been signed into law. Legislative efforts since the evolution of</p>	<p>that provide authority for the use of regulations to clarify medical control and patient destinations as described in HSC 1797.114, 1797.176, and 1797.220.</p> <p>There are no clear prohibitions regarding alternate destinations. Change of existing statutes is unnecessary in order to clarify the role of medical control and destination decisions in a local EMS system as part of the regulatory process outlined in HSC 1797.107.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>these pilots have aimed to authorize such programs statewide, including the authorization for a paramedic to allow transport to alternate destinations.</p> <p>OSHPD's authority to continue the HWPP #173 have received several extensions and are authorized to continue operating per Governor Brown's veto message of AB 3115 (2018). However, unless legislation is enacted to extend or make them permanent, the existing pilots will sunset on November 14, 2019, which is why CPF is sponsoring AB 1544 this year. AB 1544 is currently making its way through the Legislature.</p> <p>In "Documents Relied Upon" for these proposed regulations, EMSA cites a joint EMSAAC and EMDAC letter, which was written in response to CPF's sponsored bill, SB 944 (2018). In pertinent part, the joint letter asserts: Senate Bill 944/Hertzberg, the only existing legislative vehicle for keeping community paramedicine projects operating, placed local EMS agencies in an untenable situation.</p> <p>While EMSAAC and EMDAC may be disappointed in the legislative process and not agree with the Legislature's policy proposals, such a view does not confer rulemaking authority on EMSA. Conversely, EMSA does not retain the authority to circumvent the legislative process and unilaterally authorize transport to alternate destinations under a local emergency medical services agency's existing law medical control authority.</p> <p>EMSA Lacks Authority to Approve Transport of Patients with Non-Emergency Conditions to Alternate Destinations. EMSA incorrectly suggests that the alternate destination provisions of these proposed regulations apply only to patients with non-emergency conditions and therefore, they do not conflict with existing statute.</p> <p>In the informative digest/policy statement overview of the Notice of Proposed Rulemaking for these regulations, EMSA states "Though existing regulations do not require patient transport, and specifically recognize non-transport as an option, there is much confusion regarding assessment and transport of patients to alternative destinations by paramedics."</p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>Health & Safety Code section 1797.52 is clear that scope of practice applies “at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.” It clearly does not apply during transport to any other destination.</p> <p>The Proposed Regulations Apply to Patients with Emergency Conditions. In the informative digest/policy statement overview of the Notice of Proposed Rulemaking for these regulations, EMSA states “The regulations proposed in this rulemaking action intend to...establish requirements for prehospital triage of patients who are assessed and determined to have a non-emergency condition to an alternative destination for treatment under the medical control of a LEMSA medical director.” Current law requires transport to an emergency department. Even if EMSA had authority to issue regulations allowing for the transport of patients who are assessed and determined to have a nonemergency condition to an alternative destination, these regulations, as proposed, apply to patients with emergency conditions and as such, exceed EMSA’s authority.</p> <p>Similarly, these regulations attempt to allow transport of patients with psychiatric conditions to mental health facilities including licensed psychiatric hospitals, licensed psychiatric health facilities, and certified crisis stabilization units. It is well settled law in California that psychiatric conditions have parity with other medical conditions and constitute medical emergencies (Health & Safety Code Section 1317.1(a)(2)(B) which states in reference to emergency care: “The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or to an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, pursuant to subdivision (k).”</p> <p>To repeat, the history around efforts to allow transport to alternate destinations must be considered when reviewing these proposed regulations. This history includes EMSA’s application to OSHPD under the Community Paramedicine Pilot Project HWPP #173, as well as</p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>multiple legislative efforts to allow those pilots to continue and to permanently allow transport to alternate destinations. The behavioral health pilots authorized by OSHPD under the Community Paramedicine Pilot Project HWPP #173 are transporting patients with psychiatric emergencies to alternate destinations. That transport was planned and outlined in the pilot applications and protocols and was included in their ongoing reporting to OSPHD. To believe that these proposed regulations do not intend to do the same thing, particularly when the proposed regulations authorize transport to the same facilities included in the pilots, is misguided.</p> <p><u>Therefore, paragraph (7) of subdivision (a) of Section 100170 of the proposal must be deleted.</u></p>	
141	Article 8 Section 100171		<p>The Proposed Regulation Fails to Incorporate limitations Explicitly Specified in the Authorizing Statute. Health & Safety Code Section 1797.227, subdivision (b) states:</p> <p>“(b) A local EMS agency shall not mandate that a provider use a specific electronic health record system to collect and share data with the local EMS agency.”</p> <p>Recordkeeping requirements are a proper medical control function (CCR Section 100170(a)(6)), however, subdivision (b) of Section 1797.227 as noted above was enacted specifically to impose statutory limitations on the medical control authority with respect to this recordkeeping requirement. For clarity, this exception to the mandate should likewise be referenced in the regulation by adding subdivision (i) to Section 100171 as follows:</p> <p><u>“(i) The LEMSA shall not mandate that a paramedic provider use a specific electronic health record system to collect and share data with the LEMSA.”</u></p>	<p>Comment rejected.</p> <p>Please see response to comment #128.</p>
142	Article 8 Section 100172		<p>Proposed Continuing Education (CE) Provider and Paramedic Licensure Fee Increases are unsubstantiated. In the informative digest/policy statement overview of the Notice of Proposed Rulemaking for these regulations, EMSA is silent with respect to the proposed increases in paramedic CE provider approval fees and paramedic licensure fees. The CPF questions the reasonableness of a tenfold increase in CE</p>	<p>Comment rejected.</p> <p>Statutory authority provides that fees be appropriate for maintaining the program. Therefore, as detailed in the Fiscal and Economic impact statement analysis,</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>provider fees. Additionally, such an increase is unjustifiable and only serves as a barrier to entry for those individuals seeking jobs that require paramedic licensure or CE to maintain a license. As proposed in these regulations, the initial licensure fee for a paramedic is proposed to be \$200 but will subsequently increase to \$300 by 2022. The initial approval and re-approval fee of a paramedic continuing education provider rises from \$200 to \$2500.</p> <p>The Legislature retains the proper authority to either authorize or confer authority to EMSA for scope of practice changes. Because EMSA lacks the appropriate authority to do so, we respectfully submit the forgoing comments and recommend deletion of noted provisions in the regulations and reconsideration of others prior to the adoption of these proposed regulations.</p>	<p>which was approved by the Department of Finance, EMSA has determined that the proposed fee increases are appropriate and necessary.</p>
143	100166*	San Joaquin County EMS Agency	<p>Section 100166 – Accreditation to Practice is missing from the draft regulations. If it EMSA’s intention to remove existing section 100166 then SJCEMSA objects to its removal.</p> <p>As noted earlier, Health and Safety Code, Division 2.5, Section 1797.194(f) states that: “Nothing in this section shall be construed to alter or interfere with the local EMS agency’s ability to locally accredit licensed EMT-P’s.”</p>	<p>Comment rejected.</p> <p>Section 100166, Title 22 of the CCR is not being amended by this proposal.</p>
144	Grant Colfax MD, Director San Francisco Department of Public Health		<p>On behalf of the City and County of San Francisco, The San Francisco Department of Public Health is writing to express our strong support for the proposed changes to California Code of Regulations, Division 9, Title 22, Chapter 4. Emergency Medical Technician-Paramedic. The changes will allow San Francisco to continue to provide our services to safely transport patients to authorized alternate destination, as well as continue provide case management services for frequent emergency medical services users in collaboration with and by providing referral to existing appropriate community resources.</p> <p>In 2003, the City and County of San Francisco developed the Sobering Center, a specialty care site designed to address the needs of chronic inebriates and reduce unnecessary hospital transports. This program is</p>	<p>Comment accepted.</p> <p>EMSA acknowledges the commenter’s support for this proposed regulatory action and agrees with the assertion that providing non-emergency patients with triage to an alternate destination facility will reduce unnecessary impacts on emergency departments and improve the health of the community.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>designed to safely observe intoxicated persons, but also to connect at-risk individuals with a system of addiction treatment, medical and behavioral health care to better serve their needs. Acute and chronic alcohol use is a significant issue in San Francisco and impacts some of the City's most vulnerable residents. The rate of emergency department visits due to acute or chronic alcohol use is 61% higher in San Francisco than in California overall (71.0 vs 44.2 per 10,000 adults). Directing at-risk individuals with alcohol use disorder to behavioral health care services like the Sobering Center, instead of the emergency department, is an important strategy for ensuring individuals receive the care they need while reducing unnecessary emergency department visits and overcrowding.</p> <p>EMS transport to a designated sobering center has been safe and effective for our community. Alternate destinations such as the SF Sobering Center are being studied as part of the State EMS Authority's Community Paramedicine Pilot Projects. Between 2012 and 2015 alone, the SF Sobering center successfully cared for intoxicated patients in more than 12,000 encounters, including 4,300 who avoided an unnecessary emergency department stay. Through our local pilot program, all paramedics participated in an eight-hour training to effectively triage patients to the sobering center or if needed the local Emergency Department.</p> <p>As an approved Community Paramedicine Pilot Project, EMS 66 team in collaboration between the Department of Public Health, Department of Homelessness and Supportive Housing, and the San Francisco Fire Department. EMS-6 aims to support vulnerable patients in the 911 system. The team responds to frequent 911 users and links patients with primary care, behavioral health and social support services. With California's large population of individuals experiencing chronic homelessness and stress on the emergency care system we believe that it is vital to preserve the ability for EMS systems to adapt and create programs that will meet the specific unmet needs of its patients.</p> <p>In our city, the impact of this program has been dramatic. In 2018, 19.75% of the 911 medical incidents in our community were the result of responding to 2.5% of the patients. By stabilizing patients and referring to non-emergency resources, the EMS-6 program decreased monthly</p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>calls due to individual frequent users by an average of 44%. These patients are often struggling with complex medical and social needs. The care coordination that the EMS-6 team provides can be the difference between stability and continued, ineffective cycling through the emergency care system.</p> <p>Solutions such as San Francisco's sobering Center and EMS-6 team are necessary to improve care in our changing healthcare environment. It is imperative that our local EMS systems are empowered to develop and nurture these programs to meet their own unique patient's needs. The proposed revision to the regulations would provide the tools for caring for our most vulnerable patients while also retaining the necessary flexibility for innovation.</p> <p>The City and County of San Francisco is committed to supporting community paramedicine thorough medical oversight of the EMS system, continuing quality improvement, and rigorous analysis based on medical practice. Thank you for your leadership in developing these proposed changes that will improve the health of our community.</p>	

Comments on the Proposed Paramedic Regulations
Chapter 4, Division 9, Title 22, California Code of Regulations
15-day Public Comment Period – **ALL COMMENTS**
June 11, 2019 through June 26, 2019

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
1	(All)	Saskia Kim California Nurses Association	Importantly, none of the modified text changes address any of CAN's previously stated comments and concerns. In fact, the changes made in this 15-Day Modified Text create additional confusion because the Initial Statement of Reasons has not been updated to explain the necessity for the changes made in the modified text. Furthermore, notwithstanding our fundamental position that EMSA lacks the authority to make the changes proposed in §100170, CAN also believes the proposed changes in the modified text conflict with existing statutes and regulations, create confusion, and continue to lack clarity.	Comment rejected. EMSA shall respond to any written comments regarding changes proposed in the final statement of reasons pursuant to Government Code section 11346.8.
2	Section: 100137 Subsection: New Page: 1 Line: New	Ray Ramirez, EMT-P	Consider adding section 100137.1 to state: “Counting Education (CE) Provider Program Approval” which then references Chapter 11 for related authorities; this will be consistent with CCR 100172(a) which authorizes LEMSA fees for such approval.	Comment rejected. EMSA is rejecting this comment because the section of text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time. Further, the approval process for Continuing Education (CE) Providers is contained within the Chapter 11 as referenced in the commenter's suggested language. Adding that information in this chapter would be redundant and unnecessary.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
3	Section: 100144.1 Page: 3 Line: 4	Patrick Powers	Why is this a .1 to section 100144, which defines CCP? Make this definition it's own section like 100146, and incorporate my above comment regarding 100145.	<p>Comment accepted in part and rejected in part.</p> <p>EMSA accepts the commenter's question. The numbering of this section does not make it a subdivision or subsection of section 100144.</p> <p>EMSA is rejecting the commenters recommendation to revise the numbering to 100145 because that is an existing section number under Article 2 of this chapter.</p>
4	Section: 100144 Subsection: Page: 2 Line: 39-41	San Joaquin County EMS Agency	<p>Remove requirement for to hold current certification as a CCP by International Board of Specialty Certification (IBSC), Board for Critical Care Transport Paramedic Certification (BCCTPC).</p> <p>This is an independent private party board with no government oversight. It adds additional cost to the paramedic. If the paramedic has successfully completed the CCT training that should be sufficient. LEMSA should be given the option to test the CCT paramedics for competency based on their local system needs.</p>	<p>Comment rejected.</p> <p>EMSA is rejecting this comment because the changes to section 100144 regarding International Board of Specialty Certification (IBSC), Board for Critical Care Transport Paramedic Certification (BCCTPC) are non-substantive. Existing regulations already required a critical care paramedic to hold a current certification with the Board for Critical Care Transport Paramedic Certification, or BCCTPC. These changes were necessary to fully identify the title of the board that certifies critical care (CCPs).</p> <p>Flight Paramedics perform critical care transports similar to Paramedics (EMT-P). As such, FP curriculum shall be substantively similar to that of paramedics. In addition, authorizing LEMSAs to individually test critical</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				care transport paramedics through regulation may create an unfunded state mandate. Nothing in the regulations prohibits a LEMSA from administering a CCT test as part of local accreditation requirements. For these reasons, EMSA has determined that no change is necessary at this time.
5	Section: 100144.1 Subsection: Page: 3 Line: 4-15	San Joaquin County EMS Agency	Remove this section. If Flight Paramedic (FP) are required to have the same training standards as a Critical Care Paramedic, they should not be identified as something different. See comment above regarding private party certification requirement. Nothing was added to § 100166. Accreditation to Practice for FP accreditation.	Comment rejected. While the requirements for the ability to perform these functions are the same, they are used in different capacities and settings. It is necessary to define terms in the regulations that are utilized throughout the nation to specify a certain type of paramedic. EMSA provides better clarity to these specialty paramedics as a result.
6	Section: 100145 (new) Page: 3 Line: n/a	Patrick Powers	Let's just go ahead and define the community paramedic. The certification is the same from the IBSC. Let's not go on denying it exist.	Comment rejected. The commenter's recommendation falls outside of the scope of this regulatory proposal. The purpose of this proposal is to is stated in the Notice of Proposed Regulatory Action. Nowhere in that document, the regulation text or any other supplemental documentation is the term "community paramedic" used, nor is the intention to define or establish the role of a "community paramedic" stated.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
7	Section: 100146 Subsection: (a) Page: 3 Line: 22-23	Ray Ramirez, EMT-P	Support this change clarifying that no additional certifications are required.	Comment accepted. EMSA acknowledges the commenter's statement in support of the specified changes.
8	Section: 100146 Subsection: (b) Page: 3 Line: 26	Patrick Powers	Please consider adding a statement to this subsection that the affiliation may also be with EMSA as a Cal MAT member. Otherwise, I recommend reviewing the term "approved paramedic service provider" from the context of community paramedic providers that are non-traditional and not just ambulance and 911. EMSA should consider defining approved service provider types and requiring recognition of those types in the annual EMS plan submission by the LEMSAS. Examples are Ambulance transport, 911 EMS providers, Mobile Integrated Healthcare, Disaster and Emergency Responders.	Comment rejected. The commenter's recommendation falls outside of the scope of this regulatory proposal. In addition, pursuing such a change in regulation may only be possible if the legislature were to amend Health and Safety Code section (HSC) 1797.178, which states that no person may provide advanced life support unless that person is authorized to do is an authorized part of a local emergency medical services (EMS) agency's EMS system. At this time, EMSA is not aware of any legislative proposal to amend or repeal this section.
9	Section: 100146 Subsection: (c) S Page: 6 Line: 4	San Joaquin County EMS Agency	Remove FP. See comment above for section 100144.1.	Comment rejected. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time. By adding "Flight Paramedic (FP)" to this section, EMSA is clarifying the type of specialty paramedic being utilized in the field rather than lumping them into one inaccurate category. Defining FP and critical care paramedic (CCP) improves clarity by eliminating varied interpretations of the two specialties.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
10	Section: 100146 Subsection: (c)(2)(B)-(E) Page: 6-7 Line: 42-45; 1-24	Ray Ramirez, EMT-P	Support clarification of the optional-scope approval process.	Comment rejected. This comment is being rejected because the subsections of text referenced by the commenter have not been modified as part of the 15-day public comment period that ended on June 26, 2019.
11	Section: 100148 Subsection: (a)(1) Page: 7 Line: 41-43	Ray Ramirez, EMT-P	Recommend adding “ continuing education providers ” to list of LEMSA responsibilities; this will be consistent with CCR 100172(a) which authorizes LEMSA fees for such approval.	Comment rejected. This comment is being rejected because the text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019. For additional clarification, see the response above for comment #2 regarding section 100137.
12	Section: 100148 Subsection: (a)(1) Page: 7 Line: 43	Patrick Powers	The term Paramedic service providers needs to be further defined by EMSA and recognized at the LEMSA level. Even if a LEMSA doesn't recognize a specific level such as CCP, there needs to be standardization of what “Paramedic Service Providers” may be at the State level. Example, Both Orange and Riverside Counties have struggled to define IFT-ALS because they have always only known 911-ALS. Don't leave the LEMSAS to their own local politics but help them define types of providers in a regulatory structure. Community based EMS providers are coming, let's define them	Comment rejected. This comment is being rejected because the text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time.
13	Section: 100149 Subsection: Page: Line:	San Joaquin County EMS Agency	The draft regulations omit any reference to Health and Safety Code “1797.173. (Training Program Locations) The authority shall assure that all training programs for EMT-I, EMT-II, and EMT-P are located in an	Comment rejected. This comment is being rejected because the section referenced by the

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>approved licensed hospital or an educational institution operated <u>with written agreements with an acute care hospital</u>, including a public safety agency that has been approved by the local emergency medical services agency to provide training. The authority shall also assure that each training program has a competency-based curriculum.”</p> <p>The requirements should be included in regulation and added to this section.</p>	commenter has not been modified as part of the 15-day public comment period that ended on June 26, 2019. These comments are substantively identical to comments previously submitted by San Joaquin County EMS Agency during the 45-day public comment period.
14	Section: 100150 Subsection: (d) Page: 13 Line: 26-28	San Joaquin County EMS Agency	<p>Remove “CCP certification or a flight paramedic (FP) certification from the International Board of Specialty Certification (IBSC) Board for Critical Care Transport Paramedic Certification (BCCTPC).”</p> <p>This is an independent private party board with no government oversight. It adds additional cost to the paramedic. If the paramedic has successfully completed the CCT training that should be sufficient. LEMSA should be given the option to test the CCT paramedics for competency based on their local system needs.</p>	<p>Comment rejected.</p> <p>EMSA is rejecting this comment because the modifications to subsection 100150 (d) were non-substantive. Existing regulations already required critical care paramedics to hold a current certification with the Board for Critical Care Transport Paramedic Certification, or BCCTPC. These changes were necessary to fully identify the title of the board that certifies critical care and flight paramedics (CCPs and FPs).</p> <p>Please see the above response to the comment #4.</p>
15	Section: 100150 Subsection: (g)(4) Page: 14 Line: 15-17	Los Angeles County EMS Agency	We are unable to locate any CoAEMPS guidelines on preceptorship so should not be included in this section or reference where these guidelines are in the CoAEMPS documents.	<p>Comment accepted and rejected in part.</p> <p>EMSA accepts the comment regarding a lack of CoAEMSP guidelines on preceptorship and has amended this requirement to correctly incorporate by reference the CAAHEP Standards and Guidelines for the Accreditation of</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				Educations Programs in the Emergency Medical Services Profession. The previous draft of the regulations incorrectly referenced CoAEMSP guidelines, which only exist as interpretations of the CAAHEP standards and guidelines.
16	Section: 100150 Subsection: (i) Page: 15 Line: 43-45	San Joaquin County EMS Agency	Remove reference to TCC instructor as this issue is properly addressed in the EMT curriculum.	<p>Comment rejected.</p> <p>This comment is being rejected because the section referenced by the commenter has not been modified as part of the 15-day public comment period that ended on June 26, 2019.</p> <p>These comments are substantively identical to comments previously submitted by San Joaquin County EMS Agency during the 45-day public comment period.</p>
17	100153 (d) Page: 16 Line: 8	Orange County EMS	We feel strongly that the language should clarify that the intern shall remain solely in the student role during internship and that if the student is an employee of the precepting agency, they should not be assigned other duties while serving as a student/intern	<p>Comment rejected.</p> <p>EMSA is rejecting this comment because the subsection referenced by the commenter has not been modified as part of the 15-day public comment period that ended on June 26, 2019.</p> <p>EMSA acknowledges the commenter's concerns. After receiving similar comments during the 45-day public comment period, EMSA addressed the need for additional clarification through the addition of subsection 100153 (d)(1).</p>
18	Section: 100153	San Joaquin	Add the following language to read as: "This	Comment rejected.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Subsection: (f) Page: 17 Line: 12	County EMS Agency	agreement shall be in writing <u>with a copy provided to the LEMSA where the field internship is occurring.</u> "	EMSA is rejecting the commenter's suggestion because the additional language is unnecessary. As the approving authority, a LEMSA that has approved the training program may request documentation at any time. In addition, oversight of the training program is the responsibility of the LEMSA where the training program is located, not where the field internship is occurring. Furthermore, the agreement referenced is for the extension of time <i>before</i> a location is set. Without a set field internship location this requirement would be unenforceable.
19	Section: 100154 Subsection: (a) (1) Page: 18 Line: 3-4	San Joaquin County EMS Agency	Remove TCC training requirement as this issue is properly addressed in the EMT curriculum.	Comment rejected. This comment is being rejected because the section referenced by the commenter has not been modified as part of the 15-day public comment period that ended on June 26, 2019. These comments are substantively identical to comments previously submitted by San Joaquin County EMS Agency during the 45-day public comment period.
20	Section: 100155 Subsection: (b) Page: 19-22 Line: 36-46: 1-37	San Joaquin County EMS Agency	Remove TCC training requirement as this issue is properly addressed in the EMT curriculum.	Comment rejected. This comment is being rejected because the section referenced by the commenter has not been modified as part of the 15-day public comment

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				<p>period that ended on June 26, 2019.</p> <p>These comments are substantively identical to comments previously submitted by San Joaquin County EMS Agency during the 45-day public comment period.</p>
21	Section: 100155 Subsection: (c) Page: 22 Line: 39-42	San Joaquin County EMS Agency	Omitted text. Unable to evaluate the requirements of other sections that reference this requirement because the text has been omitted.	<p>Comment rejected.</p> <p>EMSA is rejecting this comment because the subsection referenced by the commenter has not been modified as part of the 15-day public comment period that ended on June 26, 2019.</p> <p>The text was omitted because those requirements have not changed from the current regulations which already went through a public comment period prior to adoption. At the top of the original proposed regulatory text, as well as the modified text, EMSA noted that omitted text is indicated by “* * *”.</p> <p>Title 22, Division, in its entirety, including all existing subdivisions of section 100155, are readily available to the public online and on EMSA’s website, and can made available upon request, as well.</p>
22	100158 (a)(2)-(3) Page: 24 Line: 20-22	Jonathan L. Epstein, MEMS, NRP Senior Director - Science American Red	This language should be changed as it gives a perception of a restriction of trade by citing a specific organizations program and guidelines. While equivalency language is included, the perception in the marketplace is that the card must be from the American Heart Association. The American Red	<p>Comment rejected.</p> <p>EMSA is rejecting this comment because subsections (a)(2) and (a)(3) have not been modified as part of the 15-day public comment period that</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		Cross	<p>Cross also develops and promulgates CPR Guidelines based on the same scientific recommendations from the International Liaison Committee of Resuscitation (ILCOR) Consensus on Science with Treatment Recommendations (CoSTR) as the American Heart Association. Treatment recommendations between the two organizations are consistent with each other. I suggest either adding the American Red Cross to the language or striking the AHA language and create language for a program based on ILCOR Science that includes psychomotor skills assessment and testing.</p> <p>Here is a sample of the Commonwealth of Massachusetts regulations CMR 170.000 et al . This language that would preferred:</p> <p>...(C) (1) Successful completion of a course provided by a nationally recognized organization and reflecting current cardiopulmonary resuscitation (CPR) and emergency cardiac care resuscitation science and treatment recommendations issued by the International Liaison Committee on Resuscitation (ILCOR)'s International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations (CoSTR) or successor body, as documented by a current training certificate, renewed biennially, in Basic Cardiac Life Support health care professional CPR. CPR training must be obtained through an instructor-led program or blended learning experience with an in-person hands-on skills evaluation, and must include a cognitive examination; and ...</p> <p>or</p> <p>(2) possess a current basic cardiac life support (CPR) card equivalent to the current American Heart</p>	<p>ended on June 26, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary.</p> <p>This requirement was previously vetted and found to be lawful when it was added through regular rulemaking action. Modifying preexisting student eligibility requirements would go beyond the scope of what was noticed for this regulatory proposal. EMSA would need to assemble a workgroup comprised of key stakeholders to determine the overall impacts of modifying the existing requirements before pursuing amendments through a regulatory action.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			Association's or American Red Cross Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level; and	
23	Section: 100158 Subsection: (b) Page: 24 Line: 36-38	San Joaquin County EMS Agency	<p>Remove this section or update language to include having 3 years of EMT or Advance EMT practice (basic paramedic practice is the same as EMT practice). How will this be verified by a training program? And 3 years full-time or 3 years with the license or certification?</p> <p>Unless the intention was for 3 years of ALS paramedic practice, then it should be re-worded to reflect it.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the subsection referenced by the commenter has not been substantively modified, only renumbered, as part of the 15-day public comment period that ended on June 26, 2019.</p> <p>Pursuant to section 100 of Title 1 of the California Code of Regulations, renumbering/reordering constitutes a non-substantive modification because it does not "materially alter any requirement, right, responsibility, condition, prescription or other regulatory element of any California Code of Regulations provision."</p>
24	Section: 100159 Subsection: (f) Page: 26 Line: 30-32	San Joaquin County EMS Agency	<p>Add clarifying language stating that approval is for a maximum of four (4) years. Suggest as follows:</p> <p>(f) Paramedic training program approval shall be valid for a maximum of four (4) years ending on the last day of the month in which it was issued and may be renewed every four (4) years subject to the procedure for program approval specified in Section 100159(b).</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019. EMSA acknowledges the commenter's recommendation but has determined that no additional modification is necessary.</p>
25	Section: 100166 Subsection: Page:	San Joaquin County EMS Agency	Section 100166 – Accreditation to Practice is missing from the draft regulations. If it EMSA's intention to remove existing section 100166 then SJCEMSA	<p>Comment rejected.</p> <p>This comment is being rejected</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Line:		<p>objects to its removal.</p> <p>Health and Safety Code, Division 2.5, Section 1797.194(f) states that: "Nothing in this section shall be construed to alter or interfere with the local EMS agency's ability to locally accredit licensed EMT-P's."</p>	<p>because the text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019.</p> <p>Section 100166 was not included in the proposed text because this proposal does not seek to amend or repeal any of the requirements therein, and, therefore, is not open for public comment at this time.</p>
26	100167 (b)(4)(E)(1) Page: 38 Line: 10	Jonathan L. Epstein, MEMS, NRP Senior Director - Science American Red Cross	The term for a course as "ACLS" or Advanced Cardiac Life Support is no longer an all-inclusive term for this type of program. The American Red Cross titles this course Advanced Life Support or "ALS" because the nature of the program is greater than just cardiac in terms of resuscitation (Respiratory, Shock and other etiologies). The United States Defense Health Agency and Military Training Network have adopted the ALS program as well as the new NFPA 451 guidelines to adjust to this evolving situation. It would be preferred to list ACLS and ALS together to avoid the perception that the title must be ACLS. This creates a possible perception problem leading to a restriction of trade.	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019.</p> <p>EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time. Subsection 100167 (b)(4)(E) states that documentation of continuing education (CE) hours shall include completion of certain specified courses or their equivalent. As stated, this requirement allows for what the commenter is requesting.</p>
27	Section: 100170 Subsection: (a)(5) Page: 39 Line: 44	Saskia Kim California Nurses Association	<p>EMSA Does Not Have the Authority To Expand Paramedics' Role To Allow Them To Treat On Scene Without Transport</p> <p>In our previous comments, CNA expressed concern that EMSA did not have the authority to expand the role of paramedics to allow them to treat patients "in place," as proposed in the initial rulemaking. While</p>	<p>Comment rejected.</p> <p>EMSA is rejecting this comment and asserts that existing regulations allow paramedics to not transport a patient and recognizes the authority of the local EMS agency (LEMSA) medical director to set medical control</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			that language has been changed in the 15-Day Modified Text to instead allow paramedics to treat patients "on scene without transport," our concerns remain. Again, we struggled to identify statutory or regulatory authority which would support EMSA's authority to expand paramedics' role in this way. And the HWPP #173 Pilot Projects demonstrated that treat without transport in response to a 9-1-1 call required statutory change before the pilot project skills could become permanent. Because the 15-Day Modified Text has not address our concerns to this point, please refer to our initial comments for more complete discussion.	standards. There are three clear statutory references that provide authority for the use of regulations to clarify medical control and patient destinations as described in HSC 1797.114, 1797.176, and 1797.220. There are no clear prohibitions regarding alternate destinations. Change of existing statutes is unnecessary in order to clarify the role of medical control and destination decisions in a local EMS system as part of the regulatory process outlined in HSC 1797.107.
28	Section: 100170 Subsection: (a)(6)(A) Page: 40 Line: 6	San Joaquin County EMS Agency	Replace "response" with "contact" to read as: (A) Initiation of an electronic health record for every patient contact response.	Comment rejected. EMSA is rejecting this comment because the intent of this requirement is to capture the electronic health record (EHR) for all calls. In practice, there can be a lot of variance in what is considered a "patient contact." By requiring an EHR for all responses we can maintain a record of all calls, including situations where there is only a record of dispatch, like when a call is canceled in route, for example.
29	Section 100170 Subsection (a)(7)(F) Page: 40-41	Jacey Cooper Senior Advisor - Health Care Programs Department of Health Care Services	DHCS had provided TA regarding allowable mental health facilities for such regulations. When reviewing the draft regulations recently posted, we wanted to note our concern with the current language around sobering centers. To be clear, DHCS is supportive of sobering centers, as many have been propped up via Whole Person Care funding and we are proposing sobering centers as In-Lieu of Service (ILOS) via the new waiver. However, the way the language is	Comment accepted in part and rejected in part. EMSA accepts the commenter's concerns regarding the language used to qualify a sobering center as a designated alternate receiving facility. EMSA has removed the term "authorized" because operationally,

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>currently written, we have concerns no one would meet the definition of “authorized sobering centers that are either a federally qualified health center or a clinic...”</p> <p>First, it is our understanding that no state statute exists for the “authorization” of sobering centers, whether at a FQHC or clinic. Furthermore, sobering center costs in themselves would not be allowed as part of the FQHC costs when establishing a PPS rate and no change of scope would be required for a FQHC that has a sobering center because the costs are not allowable due to it not being a Medi-Cal Benefit. We want to be clear about this so FQHCs do not think such services are allowable. However, we would note that to the extent the FQHC is allowed to provide medical or behavioral health (BH) services, the FQHC could be reimbursed for any face-to-face medical or BH visits that took place at a sobering center located at a FQHC.</p> <p>Regarding the changes for mental health facilities. The training content requirements for paramedics (pages 19-22) does not include anything related to dealing with a person with a mental health condition, training in de-escalation techniques or crisis intervention, and we think it should. We apologize for not flagging that previously.</p> <p>Lastly, it appears that the crisis stabilization facilities and LPS facilities receiving these triage patients may have some LEMSAs requirements that they would have to meet, such as the review of records and quality measures described in subparagraph (H). These documentation requirements would be different than what is required by DHCS. This is not a concern, but we are flagging it as there would be some joint oversight and potential for overlapping requirements (the facilities would have to meet</p>	<p>sobering centers authorization does not exist. This change is necessary to eliminate confusion and ensure a qualified sobering center is able to obtain designation as a alternate destination facility.</p> <p>EMSA acknowledges the commenter's concerns regarding federally qualified health center (FQHC) costs and services offered but has determined that no change is necessary. Designation of facilities operating within an EMS system and oversight of the services offered by those facilities falls under medical control of a local EMS agency medical director.</p> <p>EMSA rejects the notion that the training content for paramedics does not include anything related to dealing with persons with mental health condition, de-escalation techniques, or crisis intervention. The National EMS Education Standards for Paramedics referenced in section 100155 (Required Course Content) includes content on the assessment of patients with specific behavioral/psychiatric disorders and providing empathetic and respectful management, including, but not limited to, communication techniques and crisis intervention skills.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			whichever standard is higher).	
30	100170 (a)(7) Page: 40 Line: 17	Emergency Medical Services Administrators' Association of California	EMSAAC continues to strongly support the alternate destination language proposed by EMSA. These changes will provide consistent requirements for local EMS agencies to safely implement these programs and for appropriate oversight by local EMS agency Medical Directors.	Comment accepted. EMSA accepts the commenter's statement in support of the specified changes.
31	100170 (a)(7) Page: 40-41 Lines: 17-46 and 1-14	California ACEP	<p>Even if EMSA had authority to promulgate regulations allowing transport of patients who are assessed and determined to have a non-emergency condition to an alternative destination, these proposed regulations apply to patients with emergency conditions and therefore still exceed EMSA's authority.</p> <p>Article 7, Section 100170(a)(7) of the proposed regulation found on page 39, states: Requirements to be followed for prehospital triage of patients who are assessed and determined to have a non-emergency condition. These requirements may include procedures for patients that are frequent users of the EMS system that require referral, for patients that require transport to an alternative destination other than a Hospital with a Basic emergency permit for further treatment, or for patients who require assessment in an emergency situation. (emphasis added)</p> <p>On its face the regulation applies to patients with emergency conditions.</p>	<p>Comment accepted in part and rejected in part.</p> <p>EMSA is rejecting the commenter's assertion regarding EMSA's authority to promulgate regulations allowing transport of patients who are assessed and determined to have a non-emergency condition to an alternative destination. There are three clear statutory references that provide authority for the use of regulations to clarify medical control and patient destinations as described in HSC 1797.114, 1797.176, and 1797.220. There are no clear prohibitions regarding alternate destinations. Change of existing statutes is unnecessary in order to clarify the role of medical control and destination decisions in a local EMS system as part of the regulatory process outlined in HSC 1797.107.</p> <p>EMSA accepts the commenter's statement regarding conflicting language that identifies patients with emergency conditions. The intent of the requirement under subsection 100170 (a)(7) is for it to apply to</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				patients that have been assessed and determined <u>not</u> to have an emergency condition or be in an emergency situation. EMSA has amended subsection (a)(7) to improve clarity and eliminate varied interpretations.
32	100170 (a)(7)(F) Page: 40-41	Saskia Kim California Nurses Association	<p>Existing Law Authorizes Counties, Not LEMSAs, To Designate Mental Health Facilities as 72-Hour Evaluation and Treatment Facilities</p> <p>In its initial regulatory draft, EMSA proposed §100170(a)(7)(F)2 to allow for the transport of a 9-1-1 call patient, determined by the responding paramedic to have a “non-emergency condition,” to a designated facility pursuant to Section 5008(n) of the Welfare and Institutions Code instead of a receiving facility that is not a general acute care hospital with a basic emergency department (GACH ED).</p> <p>The 15-day Modified Text proposed to amend the alternate receiving facilities with medical staffing of at least one registered nurse [§100170(a)(7)(F)] to instead include, among other things, LEMSAs-<i>designated</i> mental health facilities approved pursuant to Welfare & Institutions Code 5404. These county-designated facilities under 5404 are mental health facilities that provide 72-hour evaluation and treatment and 14-day intensive treatment of mentally ill patients but that are not hospitals or clinics. These facilities may admit patients on a voluntary or involuntary basis for treatment of acute mental illness. The Legislature specifically authorized counties to “designate” such facilities and not LEMSAs.</p>	<p>Comment rejected.</p> <p>This does not remove the counties ability to approve mental health facility. The designation referenced in this regulation means for participation in alternate destination policies. Not all facilities will participate or be approved to received EMS transports.</p> <p>LEMSA’s policies and procedures as noted in (F) allow for LEMSAs designation for the purpose of receiving triaged patients, which differs from facility approval or designation done at the county level.</p>
33	100170 (a)(7)(F)(2) Page: 40 Line: 44-45	Saskia Kim California Nurses Association	Licensed 24-Hour Healthcare Facilities Not Appropriate Alternate Destinations Under Existing Law	Comment rejected.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>The new amendments to 22 CCR 100170(a)(7)(F)2 includes licensed 24-hour health care facilities as alternate destinations. Health and Safety Code (H&S Code) Division 2.5 Emergency Medical Services does not define "Licensed 24-hour health care facilities." However, health facilities that provide 24-hour care are defined under 1250 of the H&S Code.</p> <p>As used in this chapter, "health facility" means a facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer, and includes the following types:</p> <ul style="list-style-type: none"> • General acute care hospital • Acute psychiatric hospital • <i>Skilled nursing facility</i> • Intermediate care facility • Intermediate care facility/developmentally disabled habilitative facility • Special hospital • Intermediate care facility/developmentally disabled • Intermediate care facility/developmentally disabled nursing • Congregative living facility • <i>Correctional treatment center</i> • Nursing facility • Intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN) • <i>Hospice Facility</i>* (*emphasis added 1250.2 and 1250.3 include psychiatric health facilities and chemical dependency recover hospitals as health facilities that provide 24-hour care.) 	<p>Section 100170 (a)(7)(F)(2) specifically allows for transport to a licensed 24-hour health care facility that has been certified by a county mental health plan or the state (DHCS) to provide crisis stabilization services, specifically Medi-Cal specialty mental health services.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>Proposed 22 CCR 100170(a)(7)(F)2 conflicts with H&S Code Section 1262.7 which provides that skilled nursing facility (SNF) shall admit a patient only upon a physician's order. Nowhere in that section does it say that a 9-1-1 call patient could be admitted based on an assessment by a paramedic that the patient could be transported to an alternate destination SNF 24-hour health facility rather than a GACH ED. In addition the 24-hour health facility that is licensed as a correctional treatment center only provides health care services to the inmate population. Finally, hospice facilities that provide 24-hour inpatient care require physician certification that the patient has a terminal illness under Section 418.110 of Title 42 of the Code of Federal Regulations.</p> <p>Other than GACH from which patients would be diverted to an alternate destination under these proposed regulations, none of the health facilities that provide 24-hour care, as defined in the H&S Code, could directly admit 9-1-1 call patients from a GACH ED, the modified text has failed to provide a definition of licensed 24-hour health facilities that could function as alternate destination receiving facilities.</p> <p>GACH ED Ambulance Diversion To Hospital Based Outpatient Programs May Violate EMTALA Requirements</p> <p>The proposed 15-day Modified Text would add "hospital based outpatient programs" to the list of facilities that could be considered alternate receiving facilities.</p> <p>GACHs risk violating EMTALA requirements if a 9-1-1 call patient is transported to the hospital campus by ambulance and then diverted from a GACH ED to a hospital based outpatient program, a "distinct part"</p>	<p>EMTALA requirements are an important consideration, however, this is beyond the scope of these regulations.</p> <p>The focus is on mental health facilities with these capabilities. Concerns regarding EMTALA fall on the LEMSA when designating the appropriate facility based on local needs and</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>(d/p) SNF, a d/p Intermediate Care facility, a d/p chemical dependency recovery hospital, or a psychiatric health facility on the campus of a GACH. 42 CFR 413.65 defines the "campus" of a hospital subject to EMTALA requirements as the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 2050 yards of the main buildings, and any other areas determined on an individual case basis, by the CMDS regional office, to be part of the provider's campus. Although d/p facilities themselves are not subject to EMTALA requirements, the diversion from the GACH ED to an alternate destination on the hospital campus, would conflict with the EMTALA hospital requirements for a minimum of medical screening examination by an ED physician or other qualified medical person which, based on a hospital's written policy, may include a nurse practitioner or physician assistant.</p> <p>Moreover, assuming for the same of argument that EMSA had the authority to alter the setting in which paramedics could apply their ALS skills to determine that 9-1-1 call patients had a non-emergency condition and could, therefore, be diverted from a GACH ED to an alternate receiving facility,</p> <p><i>Patients who present off hospital grounds and are transports by a hospital owned or operated ambulance are considered to have presented to the hospital's emergency department and must undergo routine medical screening examination and stabilization as outlined by EMTALA regulations. Before 2003, EMS systems that were owned and operated by a hospital were required under EMTALA laws to transport all patients to their specific hospital to discourage the practice of only carrying insured patients to that hospital. However, given the possibility that the hospital tied with the hospital-based EMS</i></p>	resources.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>system may not have specialty services that may be required to stabilize and treat the patient, an EMTALA revision was implemented that allowed hospital-based EMS systems to transport a patient <i>to a different hospital if the area protocols require transport to another hospital.</i></p> <p>EMTALA requirements do not allow for the transport of 9-1-1 call patients who are transported by hospital owned and operated ambulances to alternate destinations based only on a paramedic's assessment in the field.</p> <p>Proposed Regulations for Minimum Staffing Requirements Of At Least One Registered Nurse Conflict With Existing Law's Crisis Stabilization Service Staffing Standards</p> <p>The 15-day Modified Text proposes to add the following to 100170(a)(7)(F)2: "<u>...or provider sites certified by a county Mental Health plan or by the Department of Health Care Services to provide Medi-Cal crisis stabilization services consistent with and pursuant to sections, 1810.210, 1810.435, 1840.338, 1840.348 under Chapter 11, Title 9 of the California Code of Regulations.</u>"</p> <p>The Crisis Stabilization Staffing Requirement in 9 CCR 1840.348 states that there shall be a minimum of one Registered Nurse, Psychiatric Technician, or Licensed Vocational Nurse on site at all times patients are present. Since the proposed regulations under this rulemaking would require an alternate destination receiving facility to staff with a minimum of one registered nurse, existing law's minimum staffing standard allowing only a Psychiatric Technician or a Licensed Vocational Nurse would not meet the proposed medical standard for an alternate destination receiving facility.</p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
34	100170 (a)(7)(F)(2) Page: 40 Line: 44-45	California ACEP	Similarly, Article 7, Section 100170(a)(7)(F)(2) of the proposed regulation allows transport of patients with psychiatric conditions to mental health facilities including licensed psychiatric hospitals, licensed psychiatric health facilities, and certified crisis stabilization units. It is well settled law in California that psychiatric conditions have parity with other medical conditions and constitute medical emergencies (Health and Safety Code Section 1371.1(a)(2)(B)). EMSA may not authorize transport to alternate destinations for behavioral health patients simply because their emergency condition is psychiatric.	<p>Comment rejected.</p> <p>Determination of patient destination is a medical control discussion based on prehospital assessment following protocols determined by the LEMSA.</p> <p>And why a nurse must be present at the receiving facility – to provide a higher level of care. This is also why secure, bi-directional exchange of patient information is essential.</p>
35	100170 (a)(7)(F)(3) Page: 41 Line: 7-8	Saskia Kim California Nurses Association	<p>Poorly Drafted Modified Text Expands Authorized Sobering Centers to Include Alternative Birth Centers, Chronic Dialysis Clinics, Surgical Clinics, Physical Rehabilitation Clinics and Clinics Exempt from Clinic Licensure.</p> <p>The proposed 15-day Modified Text would revise 100170(a)(7)(F)3 to read: <u>Authorized sobering centers that are either a federally qualified health center or a clinic as described in Sections 12441204 and 1206 of the Health and Safety Code.</u> It is not clear why these two new cross references have been inserted into the text. As noted above, EMSA has not provided an updated explanation for the changes it is proposing. Also, the substance of these code sections simply does not make sense in the context of the proposed alternate destination regulations.</p> <p>First, Health and Safety Code 1204 pertains to surgical clinics, chronic dialysis clinics, rehabilitation clinics, and alternative birth centers. As a result, it appears that EMSA is proposing to include these clinics as “authorized sobering center.” While it strains</p>	<p>Comment rejected.</p> <p>Comment rejected.</p> <p>Modifications to the initial proposed language were based on comments and consultations from or recommendations made by the Department of Health Care Services (DHCS), the state regulatory body that licenses these types of facilities. In addition, the health centers must be deemed an sobering center in order to be designated by a LEMSA to receive patients for the purposes outline.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>credulity to presume that EMSA is proposing to authorize Sobering Centers in Alternative Birth Centers, without an explanation of these proposed changes, we are left to speculate as to both the reason for the change as well as – more fundamentally – the substance of the actual change.</p> <p>Second, the modified text also expands Sobering Centers to include a clinic as described in Section 1206 of the Health and Safety Code. Section 1206, as written, actually lists clinics that are not subject to the licensure requirements of Chapter 1, Clinics of Division 2 Licensing Provision of the Health and Safety Code. Specifically, Section 1206 provides:</p> <p style="text-align: center;"><i>(quotation of entire section 1206)</i></p> <p>In sum, the use of this entire section to, instead, describe clinics that could serve as Sobering Center receiving facilities is inexplicable. And, it is difficult to assume that EMSA is proposing to authorize Sobering Centers in student health centers, speech and hearing centers or in clinics performing in vivo diagnostic procedure by magnetic resonance imaging. The lack of clarity in the modified text reference to clinics found in these code sections is concerning. But, as noted earlier, EMSA has not provided an amended or updated explanation for the 15-Day Modified Text changes so it is impossible to understand the Authority's intent in making these changes.</p> <p>Moreover, because there is no explanation for these changes, 100170(a)(7)(F)3 could conceivably be read to allow for alternate destination transport to any of the clinics described in Health and Safety Codes 1204 and 1206. Surely, alternate destination transportation to, for example, alternative birth centers, chronic dialysis clinics, and student health centers, would be unprecedented.</p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
36	100170 (d) Page: 41 Line: 42	ICEMA	References 100169 which is missing from the draft. 100168 Paramedic Service Provider and 100169 Paramedic Base Hospital were removed in the 15-Day Public Comment draft	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time.</p> <p>This section was not amended and thus not open for public comment. It still exists in regulations.</p>
37	100171 (e)(13) Page: 43 Line: 4	Sandy Griffin, BSN EMS Administrator Rancho Cucamonga Fire District	<p>Page 43 line 4 change to Time patient care was transferred.</p> <p>We are a non-transport agency so we often transfer care on scene. If the patient is pronounced the patient does not get transported but transfer of care may be to the PD.</p>	<p>Comment rejected.</p> <p>EMSA acknowledges the commenters concerns and has determined that no change is necessary. Subsection (e) says a patient's electronic health record shall contain the items specified, including the time patient care was transferred, "when such information is available to the paramedic."</p>
38	100171 (g) Page: 43 Line: 14	Kim Roderick Palo Alto Fire	<p><i>"The paramedic service provider shall submit electronic health records to the LEMSA according to the LEMSA's policy and procedures."</i></p> <p>This doesn't address if agencies have different EHR. Currently we are having vendor wars that won't or delay interfacing data into the server. This sets the agencies up for non-compliance to this directive. Also, if the LEMSA requires a specific vendor, how would</p>	<p>Comment not accepted.</p> <p>Current statute prohibits EMSA or a LEMSA from requiring a specific EHR vendor. It does, however, required EMS providers to use an EHR systems that exports data in a format that is CEMSIS- and NEMSIS-compliant.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			the agencies comply if they have a comparable system? This would conflict with the regulation that you can't require a specific EHR system. Policies and procedures are too easy to change. I think there should be some sort of agreement on how the data is shared.	
39	Section: 100171 Subsection: (g) Page: 43 Line: 14-15	Ray Ramirez, EMT-P	<p>Recommending modifying 100171(g) to read, or language to the effect:</p> <p>(g) The paramedic service provider shall submit electronic health records to the LEMSA according to the LEMSA's policies and procedures, <u>subject to subsection (1) of this section.</u></p> <p><u>(1) The LEMSA shall not mandate that a provider shall use a specific electronic health record system to collect and share data with the LEMSA; however, this restriction shall not modify or affect a written contract or agreement executed before January 1, 2016, between a local EMS agency and an emergency medical care provider.</u></p> <p>AB 1129, Burke (2015) added H&SC § 1797.227 to the EMS Act and was specifically enacted to limit a LEMSA's medical control authority to require that any "emergency medical care provider" shall use a <u>specific</u> electronic health care record system. The EMS Authority's ISOR recognizes that changes to subsection (e) are necessary for compliance with AB 1129. Once again, as written, the proposed changes impermissibly-narrow AB 1129's application and intent. Alternatively, amending CCR 100171(f) or 100170(a)(6) to include the above statutory intent would be satisfactory.</p> <p>In describing AB 1129, the Legislative Counsel's Digest stated: "<i>The bill would prohibit a local EMS agency from mandating that a provider use a specific</i></p>	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time.</p> <p>These comments are substantively identical to comments previously submitted by Raymond Ramirez Jr., EMT-P, J.D., during the 45-day public comment period. EMSA's response to the comments is in 45-day public comments #128.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<i>electronic health record system to collect and share data with the agency.</i> ” Many providers look to the regulations for clarification on certain practices. I urge the EMS Authority to reflect these necessary clarifications in the proposed regulations.	
40	Section: 100171 Subsection: (h) Page: 43 Line: 17-20	San Joaquin County EMS Agency	Revise as: The LEMSA shall submit the electronic health record data to the Authority quarterly as follows: January, February, March data due by May 31; April, May, June data due by August 31; July, August, September data due by November 30; and October, November, December data due by February 28.	Comment rejected. EMSA has determined that this timeframe is reasonable. Because EHR data is readily available; many LEMSAs are submitting real time data. The regulations absolutely allow for longer submission intervals if this is not feasible. For those that need a longer interval, the modified text states that is permissible, including quarterly, upon agreement.
41	100171 (h) Page: 43 Line: 17-20	Los Angeles County EMS Agency	Submitting records within 72 hours of patient encounter is not feasible. We suggest retaining the previous concept of quarterly submission. Trauma which has less records to submit is required on a quarterly basis. The proposed language should be replaced with: (h) The LEMSA shall submit electronic health record data to the Authority, at minimum, on a quarterly basis.	Comment rejected. Please see above response to comment #40.
42	100171 (h) Page: 43 Line: 18	Emergency Medical Services Administrators' Association of California	Local EMS agencies have concerns about new requirements for electronic health record submission within seventy-two (72) hours of completion of the patient encounter. The language originally proposed during the 45 day comment period allow for submission at “no greater than quarterly intervals”. EMSAAC is supportive of efforts to reduce time to completion of records at the local level as EMS systems work to implement Health Information Exchange, but do not believe that most systems are ready for such a short window to submit these	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			records. EMSAAC recommends changing this requirement back to “no greater than quarterly intervals.”	
43	Section: 100172 Subsection: (a) Page: 43 Line: 26-29	Ray Ramirez, EMT-P	<p>Consider adding subsection 100172(a)(1) to state:</p> <p>(1) No fees shall be charged for paramedic, critical care paramedic or flight paramedic reaccreditation, which includes any reverification fees.</p> <p>This language and intent are consistent with CCR 100166(h) which prohibits fees for “paramedic reaccreditation,” which is continuous so long as no lapse in licensure occurs. There is appears to substantial confusion amongst the various LEMSA’s on this issue as some continue to assess non-allowable fees for reaccreditation under the guise of a “reverification fee”; regulatory clarification is therefore necessary.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019.</p> <p>Accreditation requirements are outlined in section 100166. Amending that section or adding the commenter’s recommended language to section 100172 would fall outside the scope of this regulatory proposal. Such significant changes would require EMSA to facilitate working group comprised of representatives of training programs, LEMSAs, and other key California stakeholders. EMSA acknowledges the commenters suggestion, and such revisions may be pursued in a future regulatory proposal.</p>
44	Section: 100172 Subsection: (a) Page: 43 Line: 26-29	Ray Ramirez, EMT-P	The CCR’s specify the allowable fees that the EMS Authority and respective LEMSA’s may charge under medical control under Division 9’s controlling Chapters. For LEMSA’s, a primary fee authority statute is H&SC Section 1797.212, which the governing CCR’s interpret. CCR 100172(a) (Paramedic Fees) currently describes the allowable scope of fees a LEMSA may charge individuals and/or Provider agencies. Specifically, CCR 100172(a) provides for PM Training Program Approval fees, PM	<p>Comment rejected.</p> <p>Statutory authority provides that fees be appropriate for maintaining the program. Therefore, as detailed in the Fiscal and Economic impact statement analysis, which was approved by the Department of Finance, EMSA has determined that the proposed fee increases are appropriate and</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>CE Provider Approval fees and PM Accreditation fees. Currently, many LEMSA's are creating additional program fees (Provider Approval fees, Medical Control fees, etc.) which are not the specified allowable fees; and may conflict with Government Code Section 6103's limitations on allowable fees for official services between political subdivisions. Moreover, the EMS Act and the CCR's evidences an intent for uniformity in the governing fee structure; and in some instances, impose limitations on allowable fees which the Authority and/or LEMSA's may levy.</p> <p>I am asking the EMS Authority to clarify whether additional fees not specified by these regulations (CCR's) are allowable fees under Chapter 4 for paramedic Provider agencies.</p>	necessary.
45	Section: 100172 Subsection: (a) Page: 43 Line: 27-29	San Joaquin County EMS Agency	Add "paramedic service providers" to the list of entities to be consistent with application of this provision of the regulations.	<p>Comment rejected.</p> <p>Local EMS agencies are authorized to collect fees as specified in subsection (a) pursuant to HSC section 1797.212. No statutory authority exists to allow for providers to establish a fee schedule for paramedic training programs for paramedic service providers.</p> <p>EMSA does not have the authority to mandate that fee, however, it may be established through local ordinance as determined by the LEMSA.</p>
46	Section: 100172 Subsection: (b)(1)(A)(B) Page: 43 Line: 37-41	Ray Ramirez, EMT-P	<p>I observe that a fee authority gap exists between July 1, 2021 and June 30, 2022. The effect of this gap would to be an absence of EMSA fee authority for a one-year period.</p> <p>Recommend correcting with appropriate dates.</p>	<p>Comment accepted.</p> <p>EMSA is accepting the commenter's recommended changes because EMSA did not intent to create a gap in the fee dates. This change is</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				necessary to eliminate confusion.
47	Section: 100172 Subsection: (b)(A)(B) Page: 44 Line: 2-6	Ray Ramirez, EMT-P	I observe that a fee authority gap exists between July 1, 2021 and June 30, 2022 . The effect of this gap would to be an absence of EMSA fee authority for a one-year period. Recommend correcting with appropriate dates.	Comment accepted. Please see the above response to comment #46.
48	Section: 100172 Subsection: (b)(3)(A)(B) Page: 44 Line: 13-20	Ray Ramirez, EMT-P	I observe that a fee authority gap exists between July 1, 2021 and June 30, 2022 . The effect of this gap would to be an absence of EMSA fee authority for a one-year period. Recommend correcting with appropriate dates.	Comment accepted. Please see the above response to comment #46.
49 (last)	Section: (b) Subsection: (7) Page: 44 Line: 33-34	Ray Ramirez, EMT-P	CCR 100390.5(d) specifies that the Authority shall be the CE Provider approval body for “statewide public safety agencies” and specified “out-of-state providers,” which are otherwise not authorized by CCR 100309.5(a)(b). After reviewing applicable regulations, I observe that this fee currently applies to only “out-of-state providers” and not “statewide public safety agency” CE Providers. By deleting “ an out-of-state ” in CCR 100172(b)(7), this fee proposed action implements a new CE Provider approval/reapproval fee for statewide public safety agencies; which is likely contrary to Government Code Section 6103, which appears to suggest that specific statutory authorization may be necessary to implement such fees. Last, I observe that the referencing authority in Chapter 11 (EMS Continuing Education) for EMSA CE-approval related fees, CCR 100393(a)(1), incorrectly references “ CCR Section 100172(b)(7) ” as “ CCR Section 100171(b)(7) .”	Comment rejected. Existing regulations (Chapter 11, Title 22) specify that the EMS Authority is the agency responsible for approving CE providers for statewide public safety agencies and CE providers whose headquarters are located out of state and require CE providers to permit the EMS Authority to make site visits to individual classes, courses, or activities of the CE provider. In order to carry out these responsibilities, and in the best interest to the health and safety of the public, the EMS Authority believes that these programs should be periodically reviewed and audited. However, the EMS Authority has been unable to perform reviews and audits of its CE provider programs due to lack of

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				available resources. The EMS Authority has determined that a fee increase for all EMS Authority-approved CE providers is necessary to cover costs necessary to review and audit statewide public safety and out-of-state programs.

Comments on the Proposed Paramedic Regulations
Chapter 4, Division 9, Title 22, California Code of Regulations
Second 15-day Public Comment Period – **ALL COMMENTS**
July 30, 2019 through August 14, 2019

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
1	General Comment	Monterey County EMS Agency	The Monterey County EMS Agency commends the California EMS Authority for proposing these logical and well thought changes to Title 22, Chapter 4. Nice job!!	Comment accepted. EMSA acknowledges the commenter's support for the proposed changes to this section.
2	General Comment	Jeremy Palmitier, Paramedic	<p>I am a paramedic provider and wish to provide public comment regarding the flight paramedic expanded scope of practice.</p> <p>I wish to see the State EMSA withhold LEMSA exemption from expanded scope. Meaning, the scope should be available to departments regardless of LEMSA approval. Air medical providers already have protocols that have been in place and approved by their medical directors. The flight paramedic crews receive initial and ongoing training and oversight allowing for proper CQI practices. There should be no reason a LEMSA medical director should feel the need to withhold practices approved by another medical director who's signed off a flight paramedic to provide care as they feel necessary to run an efficient flight program. This model is often referred to as Delegated Scope of Care and is a successful model of medical direction run in numerous states with far more progressive prehospital care. When looked at in a simple Span of Control model it is clear a flight programs medical director providing oversight to maybe 15 crews at a base level can have far better CQI than a medical director of a LEMSA with up to 1000 paramedics.</p> <p>It's time this State takes a leap forward with prehospital care. We've been stuck in the same</p>	<p>Comment rejected.</p> <p>EMSA is rejecting the commenter's recommendation because providing air medical providers with the authority to set the scope of practice for a flight paramedic would require a statutory change. Chapter 4 of Division 2.5 of the Health and Safety Code (commencing with section 1797.200) delegates medical control for all emergency medical services (EMS), including air medical, to the local EMS agency (LEMSA) medical director and not the provider medical directors. LEMSAs maintain medical control in order to ensuring consistent levels of care throughout the system no matter which provider responds.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			model since it's inception.	
3	Section: 100137 – 100144.1 Subsection: Page: 1-3 Line: 1-20; 1-46; and 1-20	MVEMSA	Please consider listing definitions in alphabetical order for ease in finding a given definition.	Comment rejected. EMSA acknowledges the commenter's request and has determined that reordering the sections in Article 1 is not necessary. EMSA may consider utilizing a section 100 processes later to better organize the definitions.
4	Section: 100146 Subsection: (c)(1)(D) Page: 4 Line: 6-8	Kathie Dunn Reach Medical Holdings, LLC	<ul style="list-style-type: none"> • please clarify term “multi-lumen adjuncts” • only includes Adult? Contingency for Pedi intubation? 	Comment rejected. EMSA acknowledges the commenter's questions, however, the proposed regulatory action does not include modifications to this existing language. In addition, no modifications were made to this section in the last draft of the regulations text and it is not currently open for public comment.
5	Section: 100146 Subsection: (c)(1)(E) Page: 4 Line: 10-12	Kathie Dunn Reach Medical Holdings, LLC	<ul style="list-style-type: none"> • mechanical ventilation for CPAP, BPAP, PEEP in spont breathing patient only? <ul style="list-style-type: none"> ○ The term PEEP is used when patient is on a ventilator dialed rate so it's confusing to see PEEP mentioned but not ability to set/ adjust rate ○ What about the patient who is not spontaneously breathing? EBP Literature supports patients on ventilator asap vs BVM or BVT • consider adding: medic can set and adjust the inspiratory pressure, pressure support, 	Comment rejected. EMSA acknowledges the commenter's questions, however, the proposed regulatory action does not include modifications to this existing language. In addition, no modifications were made to this section in the last draft of the regulations text and it is not currently open for public comment.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			inspiratory time and rate?	
6	Section: 100150 Subsection: (b) Page: 12 Line: 13-14	Jamie Hirsch, Chief Paramedic Program Director Mt. San Antonio College	<p>This in the proposed Title 22 revisions, states that the Paramedic Program Director shall hold a baccalaureate degree in a related health education field. The requirement that the degree be in a health education field is not in CAAHEP standards.</p> <p>This language would, and could negatively impact all California accredited programs. As you know, the primary delivery of pre-hospital care is through the fire service. An individual coming to a paramedic program director position, from the fire service, would probably have a degree in emergency management, organizational leadership, or public administration.</p> <p>I have been the Paramedic Program Director at Mt. San Antonio College for 3 years. If this restrictive language remains in place, I would not meet the minimum qualifications, even though I was a paramedic for 30 years, and retired from the fire service as a Deputy Chief. My baccalaureate degree is in Vocational Education and not the "health education field".</p> <p>I am requesting that the language be changed to the following:</p> <p><i>The program director must:</i></p> <ol style="list-style-type: none"> (1) possess a minimum of a Bachelor's degree, from an accredited institution of higher education. (Master's degree preferred) (2) have appropriate medical or allied health education, training, and experience, (3) be knowledgeable about methods of instruction, testing and evaluation of students, (4) have field experience in the delivery of out-of- 	<p>Comment accepted and rejected in part.</p> <p>EMSA is accepting the commenter's statements regarding the revisions to the minimum education qualifications for a paramedic training program's program director.</p> <p>EMSA has determined that the it would be exceedingly limiting to narrow the requirement to "health related education" fields of study. Given the lack of degrees that would qualify as "health related education", individuals operating as a program director for a paramedic training program may be excluded from performing that role even if previously qualified for having a degree in a "health related" or "education" field. While the initial intend to amend this requirement was to specify that the education background qualification for a program director may be satisfied by a degree in a "qualified health education field," rather than in any education field, EMSA did not intend to exclude existing program directors who have met or exceeded existing qualifications. EMSA has revised subsection (b) to revert this education qualification to the previous "health field or education field" language.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<i>hospital emergency care, (5) have academic training and preparation related to emergency medical services at least equivalent to that of a paramedic, (6) be knowledgeable about the current versions of the National EMS Scope of Practice and National EMS Education Standards, and about evidenced-informed clinical practice.</i>	The commenter's recommended language is being rejected because it introduces new criteria not based on stakeholder input and is redundant. Subsection (b) also states that a program director must be qualified by both education and experience, including in methods of instruction, and have specific experience related to course direction.
7	Section: 100150 Subsection: (g)(4) Page: 14 Line: 24-32	Jacey Cooper Senior Advisor – Health Care Programs Department of Health Care Services (DHCS)	Section 100150(g)(4) was amended to require that each paramedic training program have a field preceptor that has completed a preceptor training program the complies with CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions (2015). EMSA provided a soft copy of the CAAHEP curriculum, which includes the following topics: medicine (including psychiatric), clinical behavior/judgment (including therapeutic communication and cultural competency), pharmacology, and assessment. DHCS recommended in its previous response to EMSA during the first round of revisions for public comment that the training include topics related to dealing with a person with a mental health condition and training in de-escalation techniques or crisis intervention. <u>These revisions were not made and DHCS continues to recommend that these provisions are added to the regulations.</u>	Comment rejected. CAAHEP standards speak to accreditation of education programs, whereas course content references the National EMS Educations Standards. The National EMS Education Standards for Paramedics referenced in section 100155 (Required Course Content) includes content on the assessment of patients with specific behavioral/psychiatric disorders and providing empathetic and respectful management, including, but not limited to, communication techniques and crisis intervention skills.
8	Section: 100155 Subsection: (b)4 Page: 20 Line: 17	MVEMSA	Please clarify what is a licensure zone? Is this correct terminology or insert appropriate terminology.	Comment accepted. EMSA accepts the commenter's question. "Licensure zone" means the area where the paramedic is accredited to work.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
9	Section: 100155 Subsection: (b)(3)(A)1 Page: 20 Line: 37	Jeff Smeenk, Captain Stockton Fire Department	On page 20 line 37 uses the term " team command." This is not a standardized term of ICS- unified command is the standardized term according to ICS 300, March 2018. We should all be using the same terminology to communicate clearly, that is one of the main ideas of page 20 line 37.	Comment rejected. This comment is being rejected because the section of text referenced has not been modified as part of the second 15-day public comment period that ended on August 14, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time. The topics listed are based on the EMSA TCC guidelines which were vetted by stakeholder groups and approved by the Commission on EMS.
10	Section: 100155 Subsection: Page: 23 Line: 5	MVEMSA	Please clarify if the "*****" placed in the middle of the page is appropriate or denotes missing information?	Comment accepted. The formatting notations the commenter is referencing indicates omitted information as denoted on page 1. Subsection (c) of section 100155 is not being amended by this proposal. As such, EMSA omitted the contents of that subsection from the proposed regulation text to limit the amount of irrelevant language in the text.
11	Section: 100158 Subsection: (a) (5) (b) (1) Page: 24 Line: 43	Kreig Harmon, Paramedic, EMS Coordinator, Alameda County EMS	A college level course in introductory human anatomy and physiology with lab is critical and essential to the success of paramedic training program candidates and for their personal development as a healthcare provider. For these	Comment rejected. This comment is being rejected because the section of text referenced has not been modified

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			reasons, I believe this requirement should remain in place.	as part of the second 15-day public comment period that ended on August 14, 2019. The revisions removing the college level course in introductory human anatomy and physiology was made due to comments EMSA received regarding these requirements during the 45-day public comment period. EMSA determined that the requirements need further input and review from key stakeholders before they may be added to the individual requirements to enter a paramedic training program.
12	Section: 100165 Subsection: (a)(2)(C) Page: 32 Line: 41-45	MVEMSA	Please insert the word "training" between the word's paramedic and program on line 42. Please delete the word "director" on line 42. Please delete the verbiage "applicant's employer." An employer should not have the ability to approve a field internship that is conducted through a paramedic training program. Please add the words "paramedic training" in front of the word medical on line 45.	Comment rejected. This comment is being rejected because the section of text referenced has not been modified as part of the second 15-day public comment period that ended on August 14, 2019.
13	Section: 100165 Subsection: (a)(3)(D) Page: 33 Line: 27-32	MVEMSA	Please delete the words "paramedic employer" from line 30. An employer should not have the ability to approve a field internship that is conducted through a paramedic training program. Please add the words "paramedic training" in front of the word medical on line 30.	Comment rejected. This comment is being rejected because the section of text referenced has not been modified as part of the second 15-day public comment period that ended on August 14, 2019.
14	Section: 100167 Subsection: (f)(3) Page: 39 Line: 17	Kristopher Lyon, MD EMDAC President	The EMS Medical Directors Association of California (EMDAC) supports the proposed amendment to transport patients to alternate destinations based on local medical control and the standards set in	Comment accepted. EMSA acknowledges the commenter's support for the

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			regulation.	proposed changes to this section.
15	Section: 100168 - 1001069 Subsection: Page: Line:	Ron Holk ICEMA	<p>We've added this comment to prior comments but it doesn't seem to get fixed. If section 100169 was purposefully left out of the draft regulations then shouldn't the references to it also be changed? There is no notation in the draft proposed chapter 14 that shows that it was to be deleted. The text goes from 100167 to 100170 omitting 100168 and 100169. Or are we missing something.</p> <p>Thanks for the clarity. It will keep us from having to repeat the comment.</p>	<p>Comment accepted.</p> <p>EMSA has omitted the two sections from the proposed text because neither are being modified, amended, or repealed by this proposed regulatory action, as noticed to the public on April 5, 2019.</p>
16	Section: 100170 Medical Control Subsection: (a) (7) Page: 38 Lines: 27 – 46 and Page 39 lines 1 - 25	Orange County EMS	The Orange County EMS Agency strongly supports vesting medical control of all aspects of prehospital care in the LEMSA medical director. This supervision must specifically encompass prehospital triage and treatment of patients who are assessed and determined to have a non-emergency condition and include policies and procedures for patients that require transport to an alternate destination other than a hospital (a) (7). In addition, medical control by the LEMSA medical director must extend to designation of alternate receiving facilities to include but not limited to sobering centers and mental health crisis stabilization facilities.	<p>Comment accepted.</p> <p>Please see the above response to comment #14.</p>
17	Section: 100170 Page: 40 Line: 27	Central California EMS Agency	The Central California EMS Agency strongly supports the proposed alternate destination language in this section. Our Community Paramedic Project in Fresno County has proven the safe and appropriate treatment and transport of patients to an alternate destination. The use of the alternate destination has diverted 42% of behavioral health patients (approx. 400 per month) directly to a crisis stabilization unit and allows the patient to get needed care immediately. It also avoids taking these patients	<p>Comment accepted.</p> <p>Please see the above response to comment #14.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			to overcrowded emergency departments. The proposed language regarding alternate destination will provide consistent requirements for local EMS agencies to continue the safe implementation of these programs under the appropriate oversight by local EMS agency Medical Directors.	
18	Section: 100170 Page: 40 Line: 27	North Coast EMS	North Coast EMS strongly supports the proposed alternate destination language. The use of alternate destinations for non-emergent patients has been safely occurring in California for many years. Alternate destination programs are proven to help EMS agencies provide services in the patient's best interest, by getting them directly to the definitive care they need. These programs have been proven to be safe and also improve the efficiency of EMS services, reducing emergency department overcrowding and ambulance delays. The proposed language regarding alternate destination will provide consistent requirements for local EMS agencies to continue the safe implementation of these programs under the appropriate oversight by local EMS agency Medical Directors.	Comment accepted. Please see the above response to comment #14.
19	Section: 100170 Page: 40 Line: 27	Napa County EMS Agency	The Napa County EMS Agency continues to strongly support the proposed alternate destination language. The use of alternate destinations for non-emergent patients has been safely occurring in California for many years. Alternate destination programs are proven to help EMS agencies provide services in the patient's best interest, by getting them directly to the definitive care they need. These programs have been proven to be safe and also improve the efficiency of EMS services, reducing emergency department overcrowding and ambulance delays. The proposed language regarding alternate destination will provide consistent requirements for local EMS agencies to continue the safe implementation of these programs under the	Comment accepted. Please see the above response to comment #14.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			appropriate oversight by local EMS agency Medical Directors.	
20	Section: 100170 Page: 40 Line: 27	Emergency Medical Services Administrators' Association of California	EMSAAC continues to strongly support the proposed alternate destination language. The use of alternate destinations for non-emergent patients has been safely occurring in California for many years. Alternate destination programs are proven to help EMS agencies provide services in the patient's best interest, by getting them directly to the definitive care they need. These programs have been proven to be safe and also improve the efficiency of EMS services, reducing emergency department overcrowding and ambulance delays. The proposed language regarding alternate destination will provide consistent requirements for local EMS agencies to continue the safe implementation of these programs under the appropriate oversight by local EMS agency Medical Directors.	Comment accepted. Please see the above response to comment #14.
21	Section: 100170 Page: 40 Line: 27	Coastal Valleys EMS Agency	CVEMSA continues to strongly support the proposed alternate destination language. The use of alternate destinations for non-emergent patients has been safely occurring in California for many years. Alternate destination programs are proven to help EMS agencies provide services in the patient's best interest, by getting them directly to the definitive care they need. These programs have been proven to be safe and also improve the efficiency of EMS services, reducing emergency department overcrowding and ambulance delays. The proposed language regarding alternate destination will provide consistent requirements for local EMS agencies to continue the safe implementation of these programs under the appropriate oversight by local EMS agency Medical Directors.	Comment accepted. Please see the above response to comment #14.
22	Section: 100170	David Magnino,	Sacramento County strongly support the proposed	Comment accepted.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Page: 40 Line: 27	EMS Administrator, Sacramento county EMS Agency	alternate destination language. Alternate destination programs are proven to help EMS agencies provide services in the patient's best interest, by getting them directly to the definitive care. The use of alternate destinations for non-emergent patients has been safely occurring in California for many years. These programs have proven to be safe and improve the efficiency of EMS services, reducing emergency department overcrowding and ambulance delays. The proposed language regarding alternate destination will provide consistent requirements for local EMS agencies to continue the safe implementation of these programs under the appropriate oversight by local EMS agency Medical Directors.	Please see the above response to comment #14.
23	Section: 100170 Page: 40 Line: 27	Monterey County EMS Agency	The Monterey County EMS Agency supports the inclusion of the proposed alternate destination language to improve EMS system effectiveness and efficiency. Providing allowance for directing and/or transporting non-emergent patients to an appropriate destination other than an ED is right for both the patient and EMS system. This is a rational approach to help reduce emergency department overcrowding and ambulance delays while getting the patient the care they need. We support having regulations to provide consistent requirements for implementation of a safe and effective system to manage these patients under medical director oversight.	Comment accepted. Please see the above response to comment #14.
24	Section: 100170 Page: 40 Line: 27	San Joaquin County EMS Agency	San Joaquin County supports the proposed alternate destination language. Local EMS agencies have demonstrated that the use of alternate destinations are safe and effective in meeting the needs of patients. The transport of patients directly to sobering and psychiatric facilities under LEMSA medical control policies allows patients to receive the specific type of services required to meet their needs while reducing unnecessary emergency department	Comment accepted. Please see the above response to comment #14.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			utilization. Adding these specifications in regulation will ensure statewide consistency and the safe implementation of these programs under the appropriate oversight by LEMSA medical director.	
25	Section: 100170 Subsection: (a)(7) Page: 40 Line: 27	James Salvante, Emergency Medical Services Coordinator Coastal Valley EMS Agency	Comment to express support for reinforcing medical control at the local level with the LEMSA medical director. LEMSA medical directors are responsible for the assessment and triage criteria required to direct patient destination. Such criteria must take into account the capabilities and capacity of any alternate destination facility as well as the qualifications of the EMS responders acting under medical control when making patient destination choices. To protect the safety of patients, designation of such facilities, and the ability to qualify responders to make patient destination decisions, must remain a LEMSA function as part of the local coordinated EMS system.	Comment accepted. EMSA acknowledges the commenter's support for the proposed regulations, specifically the establishment of alternate destination policies under the medical control of a local EMS agency medical director.
26	Section: 100170 Subsection: (a)(7) Page: 40 Line: 27-33	Sierra – Sacramento Valley EMS Agency	The Sierra-Sacramento Valley EMS Agency strongly supports vesting medical control of all aspects of prehospital care in the LEMSA medical director. This supervision must specifically encompass prehospital triage and treatment of patients who are assessed and determined to have a non-emergency condition and include policies and procedures for patients that require transport to an alternate destination other than a hospital (a) (7). In addition, medical control by the LEMSA medical director must extend to designation of alternate receiving facilities to include but not limited to sobering centers and mental health crisis stabilization facilities.	Comment accepted. Please see the above response to comment #14.
27	Section: 100170 Subsection: (a)(7)(A)-(F) Page: 40	Lauri McFadden, Director Alameda County EMS District	Alameda County supports the alternate destination provisions outlined in Article 7, § 100170 Medical Control. These provisions ensure flexibility and authority for Local Emergency Medical Services Authorities (LEMSA) to administer and oversee safe	Comment accepted. EMSA acknowledges the commenter's support for the proposed regulations, specifically

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>and effective alternate destination programs in their counties. Specifically, the provisions in 7(A) through 7(F) should be maintained as written to allow LEMSAs to administer their programs according to the population needs of their individual counties.</p> <p>Current law only allows paramedics to transport to hospital emergency rooms, which can be a costly and inefficient way to provide care in non-emergency situations. The State has authorized various alternate destination pilots, which allow paramedics to transport to non-emergency destinations, such as psychiatric facilities or sobering centers instead. These pilots have proven to be safe for patients, and to increase efficiency in the system of care through reduced ambulance turnaround times, reduced crowding in emergency departments, and ensuring the appropriate level of care for patients.</p> <p>According to a 2010 study by the RAND Corporation, between 14% and 27% of all emergency department visits are for non-urgent care and could take place in a different setting, such as a doctor's office, after-hours clinic or retail clinic, resulting in a potential cost savings of \$4.4 billion annually.</p> <p>Alameda County has adopted Vision 2026 as our path to creating vibrant, resilient and safe communities across our county. We support policies that promote innovation and flexibility for our local EMS authority and this issue is among our legislative priorities for 2019-2020. We urge the Emergency Medical Services Authority to adopt the alternate destination language within Article 7, § 100170 Medical Control as published in the Second 15-Day Public Comment Period, Modified Text.</p>	<p>the establishment of alternate destination policies under the medical control of a local EMS agency medical director.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
28	Section: 100170 Subsection: (a)(7)(F)(2) Page: 41 Line: 8	Jacey Cooper Senior Advisor – Health Care Programs Department of Health Care Services (DHCS)	DHCS has provided input several times indicating that use of the word “authorized” to describe LPS designated facilities in the proposed section 100170(a)(7)(F)(2) creates confusion. The most recent revisions puts the word “authorized” back into the definition, specifically these facilities would now be described as: “LEMSA-designated authorized (sic) mental health facilities approved pursuant to Section 5404 of the Welfare and Institutions Code.” <u>The addition of the word “authorized” may cause confusion since it appears that the facility must have 1) LEMSA designation, 2) approval pursuant to 5404, and 3) “authorization.” DHCS and counties do not “authorize” the facilities that receive involuntarily detained patients and the term is not defined in the EMSA regulations, as such we recommend deleting the term “authorized” from the regulation.</u>	Comment accepted. EMSA accepts the commenter’s recommendation and has revised the language to improve clarity and eliminate confusion regarding the requirements a facility must meet in order to operate as a sobering center facility capable of receiving patients that have been assessed and determined not to have an emergency condition.
29	Section: 100170 Subsection: (a)(7)(G) Page: 41 Line: 21-22	Ray Ramirez, EMT-P	As written, proposed CCR Section 100170(a)(7)(G) appears to require a “bi-directional exchange of electronic health care information” between all “treating providers.” H&SC § 1797.222(a)(1) allows a defined health facility to conditionally release “patient-identifiable medical information” information to an “EMS Provider.” Section 1797.222(c) further empowers EMSA to make regulations for “system operation, patient outcome, and performance quality improvement.” AB1129 (2015, Burke), now H&SC § 1797.227, requires that an emergency medical care provider have an electronic healthcare record system which can be integrated with the LEMSA data system, for the exchange of defined data. Taken together, EMSA appears to have authority to make regulations concerning the exchange of select “electronic healthcare” data elements between defined health facilities and EMS Providers, and	Comment rejected. This comment is being rejected because the section of text referenced has not been modified as part of the second 15-day public comment period that ended on August 14, 2019. The intent of the requirement is not to require bi-directional exchange between all treating healthcare facilities and between all treating EMS providers. Subdivision (G) falls under subsection (a)(7), which specifies the requirements to be followed for prehospital triage of patients who are assessed and determined to have a non-emergency condition. Given the numbering used, the term

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>between LEMSAs and EMS Providers; but no direct authority to make mandatory bi-directional (two-way) electronic health care data requirements between all treating EMS Providers (e.g. between treating health care facilities & between treating healthcare facilities and all treating EMS Providers)</p> <p>Please clarify the scope of this proposed regulation, which as implemented, will impose unfunded mandated costs upon all treating EMS providers, by the specified date. Moreover, absent a federally mandated universal electronic health care information system, this requirement is cost prohibitive and technically infeasible. Last, has EMSA conducted a cost study to evaluate the fiscal impact of this proposed revision?</p>	<p>“treatment providers” can be reasonably understood to mean those who are providing treatment to patients who are assessed and determined to have a non-emergency condition.</p>
30	<p>Section: 100171 Subsection: (g) Page: 43 Line: 14-15</p>	Ray Ramirez, EMT-P	<p>Once again, recommend modifying 100171(g) to read, or language to the effect:</p> <p>(g) The paramedic service provider shall submit electronic health records to the LEMSA according to the LEMSA’s policies and procedures, <u>subject to subsection (1) of this section.</u></p> <p><u>(1) The LEMSA shall not mandate that a provider shall use a specific electronic health record system to collect and share data with the LEMSA; however, this restriction shall not modify or affect a written contract or agreement executed before January 1, 2016, between a local EMS agency and an emergency medical care provider.</u></p> <p>AB 1129, Burke (2015) added H&SC § 1797.227 to the EMS Act and was specifically enacted to limit a LEMSA’s medical control authority to require that any “emergency medical care provider” shall use a <u>specific</u> electronic health care record system. The</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019.</p> <p>These comments are substantively identical to comments previously submitted by Raymond Ramirez Jr., EMT-P, J.D., during both the 45-day and first 15-day public comment period. EMSA’s response to the comments is located in responses to the comments from the initial 45-day comment period, comment #128.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>EMS Authority's ISOR recognizes that changes to subsection (e) are necessary for compliance with AB 1129. Once again, as written, the proposed changes impermissibly-narrow AB 1129's application and intent. Alternatively, amending CCR 100171(f) or 100170(a)(6) to include the above statutory intent would be satisfactory.</p> <p>In describing AB 1129, the Legislative Counsel's Digest stated: "<i>The bill would prohibit a local EMS agency from mandating that a provider use a specific electronic health record system to collect and share data with the agency.</i>" Many providers look to the regulations for clarification on certain practices. I urge the EMS Authority to reflect these necessary clarifications in the proposed regulations.</p>	
31	Section: 100171 Subsection: h Page: 43 Line: 27	Los Angeles County EMS Agency	<p>Submitting records within 72 hours of patient encounter is not feasible. This timeline is not sufficient for validation and verification to ensure data integrity and accuracy. Data cleanup is an essential process to ensure data supports system monitoring and policy decisions.</p> <p>We recommend retaining the previous concept of quarterly submission. This affords time for local systems to process data based on their local data systems and workflow. Additionally, many data systems used for regionalized systems of care provide realistic timelines to adequately collect, process and manage data. The proposed language should be replaced with: (h) The LEMSA shall submit electronic health record data to the Authority, at minimum, on a quarterly basis.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019.</p> <p>These comments are substantively identical to comments previously submitted by the Los Angeles County EMS Agency during the first 15-day public comment period. EMSA's response to the comment is located in the responses from the first 15-day comment period, comment #40.</p>
32	Section: 100171 Subsection: h Page: 43 Line: 27-30	MVEMSA	Due to disparate ePCR systems submitting closed PCR data to the State database through a variety of interfaces, the LEMSA has NO visibility nor ability to monitor individual record submission held to a 72	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>hour standard. This is an unreasonable request by the State. Furthermore; the LEMSA has no contractual leverage on individual software companies as in many cases the service and support contract is between the provider and software vendor.</p> <p>Nor does the LEMSA have the technical access or ability to rectify technology issues.</p>	<p>been modified as part of the 15-day public comment period that ended on June 26, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time. The requirements provides flexibility by allowing for a LEMSA to establish a different frequency for submission of electronic health record data if agreed upon with EMSA.</p>
33	<p>Section: 100172 Subsection: (a) Page: 43 Line: 37-39</p>	Ray Ramirez, EMT-P	<p>Once again, consider adding subsection 100172(a)(1) to state:</p> <p>(1) No additional fees shall be charged for paramedic, critical care paramedic or flight paramedic accreditation, so long as the initial license requiring accreditation has not lapsed.</p> <p>The above is consistent with CCR 100166(h) prohibiting fees for PM reaccreditation, which is continuous so long as no licensure lapse occurs. There is substantial confusion amongst some LEMSA's concerning fee authority, and some continue assessing non-allowable fees for "reaccreditation" under the guise of a "reverification fee," regulatory clarification is necessary. I incorporate by reference California Attorney General Opinion (CAAG) No. 94-408 (October 21, 1997) (attached) into my comments.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time.</p> <p>Accreditation requirements are outlined in section 100166. Amending that section or adding the commenter's recommended language to section 100172 would fall outside the scope of this regulatory proposal. Such significant changes would require EMSA to facilitate working group comprised of representatives of training programs, LEMSAs, and other key California stakeholders. EMSA acknowledges the commenters suggestion, and such revisions may</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				be pursued in a future regulatory proposal.
34	Section: 100172 Subsection: (a) Page: 43 Line: 37-39	Ray Ramirez, EMT-P	<p>H&SC § 1798(a)(b) restricts LEMSA medical control authority to the standards established by EMSA (using established rule-making procedures); and H&SC § 1797.185 contains additional restrictions. In turn, the Division 9 CCR's specify the allowable fees EMSA and respective LEMSA's may charge under medical control. For LEMSA's, the primary fee authority statute is H&SC § 1797.212, which the governing CCR's interpret. CCR 100172(a) (Paramedic Fees) currently describes the allowable scope of fees a LEMSA may charge individuals/provider agencies.</p> <p>Specifically, CCR 100172(a) provides for PM Training Program Approval fees, PM CE Provider Approval fees and PM Accreditation fees. Many LEMSA's are now creating additional fees ("provider approval" fees, "medical control" fees, etc.) which are not the specified allowable fees; and may conflict with Government Code Section 6103's limitations on allowable fees for official services between political subdivisions. Moreover, the EMS Act and the CCR's evidences an intent for uniformity in the governing fee structure; and in some instances, impose limitations on allowable fees which the Authority and/or LEMSA's may levy (<u>See</u> CAAG No. 94-408).</p> <p>I am asking the EMS Authority to clarify whether additional fees not specified by these regulations (CCR's) are allowable fees under Chapter 4 for paramedic Provider agencies.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the 15-day public comment period that ended on June 26, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time. In addition, the language in question under subsection 100172 (a) has not been modified by this proposed regulatory action in any way.</p> <p>Regarding the commenter's question, section 100172 authorizes a LEMSA to establish fees for the specific purposes described in this section.</p>
35	Section: 100172 Subsection: (b)(7) Page: 44 Line: 43-44	Ray Ramirez, EMT-P	CCR 100390.5(d) specifies that the Authority shall be the CE Provider approval body for "statewide public safety agencies" and specified "out-of-state providers," which are otherwise not authorized by	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>CCR 100390.5(a)(b). CCR 100390.5(d) empowers EMSA as the CE Provider Approval authority for “<i>statewide public safety agencies</i>” and “<i>CE providers whose headquarters are located out-of-state,</i>” subject to defined exceptions.</p> <p>After reviewing applicable regulations (including Title 22, Division 9, Chapter 11), I observe that currently a CE Provider approval fee applies to only “out-of-state providers” not otherwise excepted, and not “statewide public safety agency” CE Providers. By deleting the language “an out-of-state” in CCR 100172(b)(7), this proposed fee action <i>implements</i> a new CE Provider approval/reapproval fee for statewide public safety agencies; which is likely contrary to Government Code Section 6103, which appears to suggest that specific statutory authorization may be necessary to implement such fees. Moreover, it is not the necessity or reasonableness of the proposed fee, which is in question, but the direct statutory authority to require such fee in the first instance. As noted above, allowing such a fee may lead to new non-allowable EMSA fees for public safety statewide agencies.</p> <p>Last, I observe that the referencing authority in Chapter 11 (EMS Continuing Education) for EMSA CE-approval related fees, CCR 100393(a)(1), incorrectly references “CCR Section 100172(b)(7)” as “CCR Section 100171(b)(7).”</p>	<p>been modified as part of the 15-day public comment period that ended on June 26, 2019.</p> <p>These comments are substantively identical to comments previously submitted by Ray Ramirez, EMT-P, during the first 15-day public comment period. EMSA’s response to the comments is located in responses to the comments from the initial 15-day comment period, comment #49.</p>
36 (last)	Elena Lopez-Gusman Executive Director California ACEP	<p>While these proposed regulations have been revised a second time, the changes do not address the fundamental flaw that EMSA lacks authority to alter the statutory requirement which requires patients to be transported to emergency departments and instead seek to allow patients to be transported to alternate destinations.</p> <p>Current Scope of Practice Statute Requires Transport to an Emergency Department</p>		<p>Comment rejected.</p> <p>These comments are substantively identical to comments previously submitted by Elena Lopez-Gusman of California ACEP during both the 45-day and first 15-day public comment period. EMSA’s response</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>In the informative digest/policy statement overview of the Notice of Proposed Rulemaking, EMSA acknowledges that existing statutes require transport of a patient to a General Acute Care Hospital. Current law does not allow transport of a patient to alternate destinations.</p> <p>EMSA acknowledged this fact in its February 16, 2014 Community Paramedicine Pilot Project HWPP #173 application on page 12 where it stated "The paramedic scope of practice in California is somewhat unique compared to other licensed health professionals in that the statute refers to both a set of authorized skills/activities that emergency medical personnel may perform <u>and</u> the places and circumstances in which those skills/activities may be performed." EMSA went on to say, "The establishment of a Health Workforce Pilot Project (HWPP) through the Office of Statewide Planning and Development (OSHDP) will allow for the temporary waiver of sections of the Health and Safety Code (HSC 1797.52, 1797.218) that limit the destination of patients transported by paramedics and that specify the limited emergency settings and situations where paramedics can provide services."</p> <p>The Legislature has not Delegated Destination Scope of Practice Changes to EMSA</p> <p>The Legislature has not delegated the authority to alter this scope of practice to EMSA. In fact, the Legislature has been debating numerous proposals to make changes to scope of practice for the past several years now, none of which has been signed into law. EMSA does not have authority to circumvent the legislative process.</p> <p>EMSA cites an EMSAAC and EMDAC Joint Position Paper as "Documents Relied Upon" for this regulation. That document states: Recent experience with legislation attempting to address alternate destination using the community paramedicine model have been disappointing, highlighting the difficulty of working through the legislative process with its myriad of special interest groups that do not understand the history of EMS systems in California and the role of the LEMSA medical director in ensuring medical control. Senate Bill 944/Hertzberg, the only existing legislative vehicle for keeping community paramedicine projects operating, placed local EMS agencies in an untenable situation. It is unclear if any LEMSA would even consider enacting a community paramedicine program</p>	<p>to the comments is located in responses to the comments from the initial 45-day comment period, comment #137.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>if the legislation passes as written.</p> <p>In fact, they acknowledge “Senate Bill 944/Hertzberg, <i>the only existing legislative vehicle for keeping community paramedicine projects operating</i>, placed local EMS agencies in an untenable situation.” (emphasis added) The fact that EMSAAC and EMDAC find the legislative process disappointing and that it may not lead to their desired policy outcome, does not bestow rulemaking authority on EMSA.</p> <p>EMSA Lacks Authority to Approve Transport of Patients with Non-Emergency Conditions to Alternate Destinations</p> <p>In the informative digest/policy statement overview of the Notice of Proposed Rulemaking for these regulations, EMSA states “Though existing regulations do not require patient transport, and specifically recognize non-transport as an option, there is much confusion regarding the assessment and transport of patients to alternative destinations by paramedics.”</p> <p>There is a significant distinction between non-transport and transport to alternate destinations. Health and Safety Codes section 1797.52 is clear that scope of practice applies “at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.” It clearly does not apply during transport to any other destination.</p> <p>Proposed Regulations Lack Clarity and Apply to Patients with Emergency Conditions</p> <p>In the informative digest/policy statement overview of the Notice of Proposed Rulemaking for these regulations, EMSA states “The regulations proposed in this rulemaking action intend to... establish requirements for prehospital triage of patients who are assessed and determined to have a non-emergency condition to an alternative destination for treatment under the medical control of a LEMSA medical director.”</p> <p>EMSA argues that the alternate destination provisions of these regulations apply only to patients with non-emergency conditions and therefore do not run afoul of current statute. We disagree.</p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>Even if EMSA had authority to promulgate regulations allowing transport of patients who are assessed and determined to have a non-emergency condition to an alternative destination, these proposed regulations apply to patients with emergency conditions and therefore still exceed EMSA's authority.</p> <p>Article 7, Section 100170(a)(7) of the proposed regulation found on page 39, states:</p> <p>Requirements to be followed for prehospital triage of patients who are assessed and determined to have a non-emergency condition. These requirements may include procedures for patients that are frequent users of the EMS system that require referral, for patients that require transport to an alternative destination other than a Hospital with a Basic emergency permit for further treatment, <i>or for patients who require assessment in an emergency situation.</i> (emphasis added)</p> <p>On its face the regulation applies to patients with emergency conditions.</p> <p>Similarly, Article 7, Section 100170(a)(7)(F)(2) of the proposed regulation allows transport of patients with psychiatric conditions to mental health facilities including licensed psychiatric hospitals, licensed psychiatric health facilities, and certified crisis stabilization units. It is well settled law in California that psychiatric conditions have parity with other medical conditions and constitute medical emergencies (Health and Safety Code Section 1371.1(a)(2)(B)). EMSA may not authorize transport to alternate destinations for behavioral health patients simply because their emergency condition is psychiatric.</p> <p>Additionally, these regulations must be read in the context of the previous 5-years of history around efforts to allow transport to alternate destinations. This history includes EMSA's application to OSHPD under the Community Paramedicine Pilot Project HWPP #173, as well as multiple legislative efforts to allow those pilots to continue and to permanently allow transport to alternate destinations. The behavioral health pilots authorized by OSHPD under the Community Paramedicine Pilot Project HWPP #173 are transporting patients with psychiatric emergencies to alternate destinations. That transport was planned and</p>	

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>outlined in the pilot applications and protocols and was included in their ongoing reporting to OSPHD. To believe that these proposed regulations do not intend to do the same thing, particularly when the proposed regulations authorize transport to the same facilities included in the pilots, strains logic. Doing so would apply to patients with emergency conditions and exceed EMSA's authority.</p> <p>For the reasons described above, EMSA lacks authority to promulgate these regulations and we must oppose their adoption. This scope of practice change must be made within the proper purview of the Legislature. If you have any questions about these comments, please contact our office at (916) 325-5455.</p>	

Comments on the Proposed Paramedic Regulations
Chapter 4, Division 9, Title 22, California Code of Regulations
Third 15-day Public Comment Period – **ALL COMMENTS**
August 19, 2019 through September 3, 2019

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
1	Section: 100137 Subsection: a Page: 1 Line: 8-10	Contra Costa County EMS Agency	Is the language in these lines designed to address specifically paramedic, or all training programs? Additionally subsection 2 references subsection 1.	Comment accepted. The language in question is located within the definition for "Paramedic Training Program Approving Authority" and is not intended to address other training programs regulated by the Emergency Medical Services Authority (EMSA) under Division 9, Title 22 of the California Code of Regulations (CCR).
2	Section: 100140 Subsection: Page: 1 Line: 21 & 23	Contra Costa County EMS Agency	"examination" changes from capitalized to not capitalized. Remove language: "to test the skills of an individual applying for licensure as a paramedic"	Comment rejected. This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period that ended on September 3, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time.
3	Section: 100414 Subsection: Page: 2 Line: 6-9	Contra Costa County EMS Agency	Suggestion to modify language as below: "Cognitive Written Examination means the NREMT Paramedic Cognitive Written Examination." Remove language: "to test an individual applying for licensure as a paramedic"	Comment rejected. This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period that ended on September 3, 2019. EMSA

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				acknowledges the commenter's concerns and has determined that no change is necessary at this time.
4	Section: 100143 Subsection: Page: 2 Line: 27-30	Contra Costa County EMS Agency	Suggestion to modify language as below: "Electronic health record or (EHR), or electronic patient care record, or ePCR means real time, patient-centered records... "	Comment rejected. This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period that ended on September 3, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time.
5	Section: 100144 Subsection: Page: 2 Line: 39-41	Contra Costa County EMS Agency	the International Board of Specialty Certification (IBSC) and Board for Critical Care Transport Paramedic Certification (BCCTPC), Line 41: and who has a valid license...	Comment rejected. This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period that ended on September 3, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time.
6	Section: 100144.1 Subsection: Page: 3 Line: 5-11	Contra Costa County EMS Agency	the International Board of Specialty Certification (IBSC) and Board for Critical Care Transport Paramedic Certification (BCCTPC), Line 9: and who has a valid license...	Comment rejected. This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period that ended on

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				September 3, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time.
7	Section: 100150 Subsection: (b) Page: 12 Line: 23	Sebastian Wong Paramedic Program Director Las Positas College	<p>The accrediting body for Paramedic Training Programs (CAAHEP) in it's own standards and guidelines does not specify an area of study or award for the program director's baccalaureate degree. In the interpretation document, CAAHEP states the following: "The Bachelor's degree must be awarded by an academic institution that is accredited by an institutional accrediting agency that is recognized by the United States Department of Education (USDE). The Bachelor's degree may be in any major. (02/05/2011).</p> <p>In addition, the current number of baccalaureate degrees in Health related fields is minimal due to the fact that the California State University and the University of California system does not offer or award a baccalaureate degree in health (clinical areas such as a paramedic or EMS) and the Health Sciences degrees awarded are for Health Administration.</p> <p>Efforts to propose a baccalaureate degree program in CTE and Allied Health Fields such as Paramedic in a Pilot Program for Community Colleges to award the degree was struck down by the Chancellor of Community College system.</p> <p>You cannot mandate a standard that does not exist and a standard that will not exist until the State's institutions of higher learning allow the award of said degree/standard.</p> <p>I propose that the language stipulating a baccalaureate degree be modified to reflect that of the accrediting organization for paramedic programs.</p>	<p>Comment rejected.</p> <p>In the previous comment period, EMSA received comments from a paramedic training program director that raised concerns with previous iteration of this requirement. The commenter suggested that "health related field," was too limiting and would potentially disqualify existing paramedic training program directors from serving in that role in the future. As a result, EMSA revised subsection (b) to utilize existing regulation language regarding training program director educational requirements.</p> <p>HSC 1797.172 authorizes EMSA to develop and adopt paramedic training program approval criteria, including establishing personnel criteria. EMSA considered CAAHEP accreditation guidelines when it developed the requirements to serve as a paramedic training program director. The requirements were previously vetted through a regular rulemaking action and do not conflict with CAAHEP standards.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
8	Section: 100150 Subsection: (b) Page: 12 Line: 19-28	Matthew Jewett, President CFTDA	<p>Upon reviewing the proposed revisions to Title 22, Division 9 Chapter 4 Paramedic, we have observed the language in the proposed regulations specifies the program director possess a degree in a related health field or education. More specifically;</p> <p><i>“an individual who holds a baccalaureate degree in a related health field or in education.”</i></p> <p>We have concerns that this language will have a detrimental effect on the ability of Paramedic programs to retain qualified individuals. With many covered within the Fire programs, it is not uncommon for the directors to have Fire related degrees. In addition, with a high turnover rate of directors in community college paramedic programs, this language would prohibit a large number of qualified candidates from meeting the MQ's for the position and ultimately hurt our programs.</p> <p>To that end, we fully agree that a program director needs to hold a baccalaureate degree, however; we would like to see the language on this issue mirror national standards.</p>	<p>Comment rejected.</p> <p>Please see the above response to comment # 7.</p>
9	Section: 100150 Subsection: (b) Page: 12 Line: 19-28	Marc Cohen MD, Medical Director, Mt. San Antonio College Paramedic Academy	<p>I am writing to request a change in the language of proposed revisions to Title 22 Chapter 4. I ask that the Paramedic Program Director minimum qualification requirements align with Commission on Accreditation of Allied Health Education Programs (CAAHEP) requirements.</p> <p>The proposed language requires that t11e Program Director hold a baccalaureate degree in a health education field. That the degree is in education does not conform to CAAHEP standards and in fact excludes many highly qualified paramedic instructors from consideration for these positions. Individuals coming from the fire service, who are the main talent pool for these</p>	<p>Comment rejected.</p> <p>These comments are substantively identical to comments previously submitted by Tom O'Connor, Ventura College, during the 45-day public comment period.</p> <p>EMSA's response to the comments is located in the table of comments from the first 15-day comment period, comment #18.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>roles, would be more likely to have a degree in emergency management, organizational leadership, or public administration.</p> <p>I would recommend that the language be changed to something akin to the following:</p> <p>The program director must:</p> <ol style="list-style-type: none"> 1. Possess a minimum of a Bachelor's degree from an accredited institution of higher learning (Master's degree preferred). 2. Have appropriate medical or allied health education, training, and experience. 3. Be knowledgeable about methods of instruction, testing, and evaluation of students. 4. Have field experience in the delivery of out-of-hospital emergency care. 5. Have academic training and preparation related to Emergency Medical Services at least equivalent to that of a paramedic. 6. Be knowledgeable about the current version of the National EMS Scope of Practice and National EMS Education Standards, and about evidence-informed clinical practice. 	
10	Section: 100158 Subsection: (a)(2) Page: 24 Line: 36-38	David Markenson, MD American Red Cross	<p>§ 100158. Student Eligibility. (2) possess a current basic cardiac life support (CPR) card equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level; and</p> <p>We respectfully this be changed to</p> <p>§ 100158. Student Eligibility. (2) possess a current basic cardiac life support (CPR) card equivalent to the current American Heart Association's or American Red Cross' Guidelines at the healthcare provider level; and</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period that ended on September 3, 2019. EMSA acknowledges the commenter's concerns and has determined that no change is necessary at this time.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			As both the American Red Cross and American Heart Association provide BLS (CPR) courses at the healthcare level that are scientifically based, educationally valid and based on the standards established by ILCOR, they are equivalent. <u>As equivalent national programs that set the standard, it is appropriate and needed that both are listed in a governmental regulation.</u> In the alternate, if the EMS authority would wish to not list both agencies then it would be incumbent on the authority to list neither organization and instead list basic cardiac life support (CPR) card from a program based on the ILCOR guidelines.	Please see EMSA's response to a similar comment from Johnathan L. Epstein, American Red Cross, submitted during the first 15-day public comment period. EMSA's response to the comments is located in the table of comments from the first 15-day comment period, comment #22.
11	Section: 100170 Subsection: (a)(7)(F) Page: 39 Line: 17	Kristopher Lyon, MD EMDAC President	The EMS Medical Directors Association of California (EMDAC) supports the proposed amendment to transport patients to alternate destinations based on local medical control and the standards set in regulation.	Comment accepted. EMSA acknowledges the commenter's support for the proposed changes to this section.
12	Section: Article 7 Subsection: 100170 Page: 40 Line: 35	Sacramento County Emergency Medical Service Agency	Sacramento County Emergency Medical Services Agency continues to strongly support the proposed alternate destination language. The use of alternate destinations for non-emergent patients has been safely occurring in California for many years. Alternate destination programs are proven to help EMS agencies provide services in the patient's best interest, by getting them directly to the definitive care they need. These programs have been proven to be safe and also improve the efficiency of EMS services, reducing emergency department overcrowding and ambulance delays. The proposed language regarding alternate destination will provide consistent requirements for local EMS agencies to continue the safe implementation of these programs under the appropriate oversight by local EMS agency Medical Directors.	Comment accepted. EMSA acknowledges the commenter's support for the proposed changes to this section.
13	Section: Article 7	Napa County	The Napa County EMS Agency continues to strongly	Comment accepted.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Subsection: 100170 Page: 40 Line: 35	EMS Agency	support the proposed alternate destination language. The use of alternate destinations for non-emergent patients has been safely occurring in California for many years. Alternate destination programs are proven to help EMS agencies provide services in the patient's best interest, by getting them directly to the definitive care they need. These programs have been proven to be safe and also improve the efficiency of EMS services, reducing emergency department overcrowding and ambulance delays. The proposed language regarding alternate destination will provide consistent requirements for local EMS agencies to continue the safe implementation of these programs under the appropriate oversight by local EMS agency Medical Directors.	EMSA acknowledges the commenter's support for the proposed changes to this section.
14	Section: Article 7 Subsection: 100170 Page: 40 Line: 35	Emergency Medical Services Administrators' Association of California	EMSAAC continues to strongly support the proposed alternate destination language. The use of alternate destinations for non-emergent patients has been safely occurring in California for many years. Alternate destination programs are proven to help EMS agencies provide services in the patient's best interest, by getting them directly to the definitive care they need. These programs have been proven to be safe and also improve the efficiency of EMS services, reducing emergency department overcrowding and ambulance delays. The proposed language regarding alternate destination will provide consistent requirements for local EMS agencies to continue the safe implementation of these programs under the appropriate oversight by local EMS agency Medical Directors.	Comment accepted. EMSA acknowledges the commenter's support for the proposed changes to this section.
15	Section: Article 7 Subsection: 100170 Page: 40 Line: 35	Central California EMS Agency	The Central California EMS Agency strongly supports the proposed alternate destination language in this section. Our Community Paramedic Project in Fresno County has proven to be safe and appropriate treatment and transport of patients to an alternate destination. The use of the alternate destination has diverted 42% of behavioral health patients (approx. 400 per month) directly to a crisis stabilization unit and allows the patient	Comment accepted. EMSA acknowledges the commenter's support for the proposed changes to this section.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			to get needed care immediately. It also avoids taking these patients to overcrowded emergency departments. The proposed language regarding alternate destination will provide consistent requirements for local EMS agencies to continue the safe implementation of these programs under the appropriate oversight by local EMS agency Medical Directors.	
16	Section: 100170 Subsection: (a)(7)(F)(2) Page: 41 Line: 18-19	Los Angeles County EMS Agency	Recommend that Sobering Centers are designated by the Local EMS Agency. This section should be revised to read: 3.LEMSA-designated authorized sobering centers that provide a safe, supportive environment for intoxicated individuals to become sober.	Comment rejected. EMSA is rejecting this commenter's recommendation because adding the suggested language would be duplicative and redundant. Section 100170 outlines requirements that must be followed in order to maintain medical control; everything in the section falls under the responsibility of the LEMSAs, including (a)(7)(F), designation of alternate receiving facilities. The facility designation requirements were revised based on comments received during the first and second 15-day public comment period indicating a lack of clarity and potential conflicts with the proposed language.
17	Section: 100170 Subsection: (a)(7)(F) Page: 41 Line: 10-27	Barbara Hewitt Jones Tenet Healthcare	Tenet appreciated the inclusion of crisis stabilization centers (CSU) and other psychiatric care facilities regardless of county designation. However, Section (F) Designation of alternate receiving facilities states that medical staffing must consist of at least one registered nurse. As noted below, regulations require specific staffing in a CSU, but that is not necessarily a registered nurse. (see §1840.348, Title 9, CCR). It is important to recognize that mental health services	Comment rejected. EMSA acknowledges the commenter's concerns and, upon review, has determined that existing language related to alternate destination facility staffing requirements is sufficient no change is necessary at this time.

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			use professions other than registered nurses in providing care. The use of CSUs have proven to be effective under the current pilot program, without noting needs for staffing changes.	
18	Section: Record Keeping and Fees Subsection: Record Keeping Page: 43 Line: 27-30	Los Angeles County EMS Agency	<p>Submitting records within 72 hours of patient encounter is not feasible. This timeline is not sufficient for validation and verification to ensure data integrity and accuracy. Data cleanup is an essential process to ensure data supports system monitoring and policy decisions.</p> <p>We recommend retaining the previous concept of quarterly submission. This affords time for local systems to process data based on their local data systems and workflow. Additionally, many data systems used for regionalized systems of care provide realistic timelines to adequately collect, process and manage data. The proposed language should be replaced with: (h) The LEMSA shall submit electronic health record data to the Authority, at minimum, on a quarterly basis.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the third 15-day public comment period that ended on September 3, 2019.</p> <p>These comments are substantively identical to comments previously submitted by the Los Angeles County EMS Agency during the first 15-day public comment period. EMSA's response to the comment is located in the responses from the first 15-day comment period.</p> <p>EMSA has determined that this timeframe is reasonable because EHR data is readily available and many LEMSAs are submitting real time data. For those that need a longer interval, the modified text states that is permissible, including quarterly, upon agreement.</p> <p>Necessity: Collection of this information on a frequent basis as a result of opioid or infectious disease surveillance, patient information is necessary to be received in a timely manner. The regulations absolutely allow for longer submission intervals if this is</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
				not feasible, but we are aiming to collect as much real time data as possible to improve patient safety and reduce morbidity statewide.
19	Section: 100170 Subsection: (a)(7)(G) Page: 41 Line: 29-30	Ray Ramirez, EMT-P	<p>As written, proposed CCR Section 100170(a)(7)(G) appears to require a “bi-directional exchange of electronic health care information” between <i>all</i> “treating providers.”</p> <p>H&SC § 1797.222(a)(1) allows a defined health facility to conditionally release “patient-identifiable medical information” information to an “EMS Provider.” Section 1797.222(c) further empowers EMSA to make regulations for “system operation, patient outcome, and performance quality improvement.” AB1129 (2015, Burke), now H&SC § 1797.227, requires that an emergency medical care provider have an electronic healthcare record system which can be integrated with the LEMSA data system, for the exchange of defined data.</p> <p>Taken together, EMSA appears to have authority to make regulations concerning the exchange of select “electronic healthcare” data elements between defined health facilities and EMS Providers, and between LEMSAs and EMS Providers; but no direct authority to make mandatory <i>bi-directional</i> (two-way) electronic health care data requirements between <i>all</i> treating EMS Providers (e.g. between treating health care facilities & between treating healthcare facilities and all treating EMS Providers)</p> <p>Please clarify the scope of this proposed regulation, which as implemented, will impose unfunded mandated costs upon all treating EMS providers, by the specified date. Moreover, absent a federally mandated universal electronic health care information system, this requirement is cost prohibitive and technically infeasible.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period that ended on September 3, 2019.</p> <p>The intent of the requirement is not to require bi-directional exchange between all treating healthcare facilities and between all treating EMS providers. Subdivision (G) falls under subsection (a)(7), which specifies the requirements to be followed for prehospital triage of patients who are assessed and determined to have a non-emergency condition. Given the numbering used, the term “treatment providers” can be reasonably understood to mean those who are providing treatment to patients who are assessed and determined to have a non-emergency condition.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			Last, has EMSA conducted a cost study to evaluate the fiscal impact of this proposed revision?	
20	Section: 100171 Subsection: (g) Page: 43 Line: 32-33	Ray Ramirez, EMT-P	<p>Once again, recommend modifying 100171(g) to read, or language to the effect, to state:</p> <p>(g) The paramedic service provider shall submit electronic health records to the LEMSA according to the LEMSA's policies and procedures, <u>subject to subsection (1) of this section.</u></p> <p>(1) <u>The LEMSA shall not mandate that a provider shall use a specific electronic health record system to collect and share data with the LEMSA; however, this restriction shall not modify or affect a written contract or agreement executed before January 1, 2016, between a local EMS agency and an emergency medical care provider.</u></p> <p>AB 1129, <i>Burke</i> (2015) added H&SC § 1797.227 to the EMS Act and was <i>specifically</i> enacted to limit a LEMSA's medical control authority to require that any "emergency medical care provider" shall use a <u>specific</u> electronic health care record system. The EMS Authority's ISOR recognizes that changes to subsection (e) are necessary for compliance with AB 1129 (p. 29). Once again, as written, the proposed changes impermissibly-narrow AB 1129's <i>substantive</i> application and intent. Alternatively, amending CCR 100171(f) or 100170(a)(6) to include the above statutory intent would be satisfactory.</p> <p>In describing AB 1129, the Legislative Counsel's Digest stated: "<i>The bill would prohibit a local EMS agency from mandating that a provider use a specific electronic health record system to collect and share data with the agency.</i>" Many providers look to the regulations for clarification on certain practices. I urge the EMS Authority to reflect these necessary clarifications in the proposed</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the third 15-day public comment period that ended on September 3, 2019.</p> <p>These comments are substantively identical to comments previously submitted by Raymond Ramirez Jr., EMT-P, J.D., during both the 45-day and first 15-day public comment period. EMSA's response to the comments is located in the table of comments from the initial 45-day comment period, comment #128.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>regulations.</p> <p>In sum, the current proposed PM regulation revision defeats both the Legislature's purpose of enacting AB 1129 and the EMS Authority's stated purpose of implementing "clear requirements for compliance with AB 1129 (Burke, Chapter 337, Statutes of 2015)."</p>	
21	Section: 100172 Subsection: (a) Page: 43-44 Line: 44; 1-3	Ray Ramirez, EMT-P	<p>Once again, consider adding subsection 100172(a)(1) to state:</p> <p>(1) No additional fees shall be charged for paramedic, critical care paramedic or flight paramedic accreditation, so long as the initial license requiring accreditation has not lapsed.</p> <p>The above is consistent with CCR 100166(h) prohibiting fees for PM reaccreditation, which is continuous so long as no licensure lapse occurs. There is substantial confusion amongst some LEMSA's concerning fee authority, and some continue assessing non-allowable fees for "reaccreditation" under the guise of a "reverification fee," regulatory clarification is necessary. I incorporate by reference California Attorney General Opinion (CAAG) No. 94-408 (October 21, 1997) (attached) into my comments.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the third 15-day public comment period that ended on September 3, 2019. EMSA acknowledged similar comments during the first 15-day public comment period, comment #15.</p>
22	Section: 100172 Subsection: (a) Page: 43-44 Line: 44; 1-3	Ray Ramirez, EMT-P	<p>H&SC § 1798(a)(b) restricts LEMSA medical control authority to the standards established by EMSA (using established rule-making procedures); and H&SC § 1797.185 contains additional restrictions. In turn, the Division 9 CCR's specify the allowable fees EMSA and respective LEMSA's may charge under medical control. For LEMSA's, the primary fee authority statute is H&SC § 1797.212, which the governing CCR's interpret. CCR 100172(a) (Paramedic Fees) currently describes the <i>allowable scope of fees</i> a LEMSA may charge individuals/provider agencies.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the third 15-day public comment period that ended on September 3, 2019. EMSA acknowledged similar comments during the first 15-day public comment period, comment #44.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			Specifically, CCR 100172(a) provides for PM Training Program Approval fees, PM CE Provider Approval fees and PM Accreditation fees. Many LEMSA's are now creating additional fees ("provider approval" fees, "medical control" fees, etc.) which are not the specified allowable fees; and may conflict with Government Code Section 6103's limitations on allowable fees for official services between political subdivisions. Moreover, the EMS Act and the CCR's evidences an intent for uniformity in the governing fee structure; and in some instances, impose limitations on allowable fees which the Authority and/or LEMSA's may levy (<u>See</u> CAAG No. 94-408). I am asking the EMS Authority to clarify whether additional fees not specified by these regulations (CCR's) are allowable fees under Chapter 4 for Paramedic Provider agencies.	
23	Section: 100172 Subsection: (b)(7) Page: 45 Line: 7-8	Ray Ramirez, EMT-P	<p>CCR 100390.5(d) specifies that the Authority shall be the CE Provider approval body for "statewide public safety agencies" and specified "out-of-state providers," which are otherwise not authorized by CCR 100390.5(a)(b). CCR 100390.5(d) empowers EMSA as the CE Provider Approval authority for "<i>statewide public safety agencies</i>" and "<i>CE providers whose headquarters are located out-of-state</i>," subject to defined exceptions.</p> <p>After reviewing applicable regulations (including Title 22, Division 9, Chapter 11), I observe that currently a CE Provider approval fee applies to only "out-of-state providers" not otherwise excepted, and not "statewide public safety agency" CE Providers. By deleting the language "an out-of-state" in CCR 100172(b)(7), this proposed fee action <i>implements a new</i> CE Provider approval/reapproval fee for statewide public safety agencies; which is likely contrary to Government Code Section 6103, which appears to suggest that specific statutory authorization may be necessary to implement such fees. Moreover, and importantly, it is not the necessity or reasonableness of the proposed fee, which</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the text referenced has not been modified as part of the third 15-day public comment period that ended on September 3, 2019.</p> <p>These comments are substantively identical to comments previously submitted by Ray Ramirez, EMT-P, during the first 15-day public comment period. EMSA's response to the comments is located in responses to the comments from the first 15-day comment period, comment #49.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>is in question, but the EMS Authority's direct statutory authority to require such fees in the first instance, for official services between government entities. As noted above, allowing such a fee may lead to new non-allowable EMSA fees for public safety statewide agencies. Perhaps a general fund increase is the appropriate means for securing any necessary funding which the EMS Authority references in the Proposed PM Regulation's ISOR (p. 32).</p> <p>Last, I observe that the referencing authority in Chapter 11 (EMS Continuing Education) for EMSA CE-approval related fees, CCR 100393(a)(1), incorrectly references "CCR Section 100172(b)(7)" as "CCR Section 100171(b)(7)." Please not this discrepancy in the next Chapter 11 revision.</p>	

Comments on the Proposed Paramedic Regulations
Chapter 4, Division 9, Title 22, California Code of Regulations
Fourth 15-Day Public Comment Period – **ALL COMMENTS**
September 13, 2019 through September 28, 2019

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
1	Section: 100149 Subsection: (j)(3)(C) Page: 11 Line: 39	California Hospital Association	<p>Change (j)(3)(C) from “are accredited by a Centers for Medicare and Medicaid Services with deeming authority” to “are certified by the Centers for Medicare & Medicaid Services.”</p> <p>There are two ways a hospital may be certified to participate in the Medicare and Medicaid (Medi-Cal) programs: either by being certified directly by the Centers for Medicare & Medicaid Services (CMS), or by being accredited by an organization that has been granted deeming authority by CMS. The EMSA regulations should be clear that either method of being certified by CMS is acceptable.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period that ended on September 28, 2019.</p>
2	Section: 100149 Subsection: (j)(4) Page: 11 Line: 42	Brian Rice, President California Professional Firefighters	<p>Eligibility for program approval should include the California Fire Fighter Joint Apprenticeship Committee (CFF-JAC). Health and Safety Code Section 1797.109 identifies specific types of agencies that are eligible emergency medical services technician that can be approved per the request of the agency. While the proposed regulation references “agencies of government” in paragraph (4) of subdivision (j) of Section 100149, a clarification is necessary to identify the agencies authorized by statute (Amended by Stats. 2000 Ch. 157, Sec. 1, effective January 1, 2001). Section 100149(j)(4) of the regulation should be amended to include those agencies identified in the statute as follows:</p> <p><u>“(4) Agencies of government, including but not limited to, the Department of the California Highway Patrol, Department of Forestry and Fire Protection, California Fire Fighter Joint Apprenticeship Committee, and other public safety agency personnel, upon the request of, and as deemed appropriate by, the director</u></p>	<p>Comment rejected.</p> <p>This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period that ended on September 28, 2019.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<u>for the particular agency.</u>	
3	Section: 100170 Subsection: (a)(2) Page: 40 Line: 8	California Hospital Association	<p>Change (a)(2) from “Local medical control policies and procedures as they pertain to the paramedic base hospitals, alternative base stations, paramedic service providers, paramedic personnel, patient destination, and the LEMSA” to “Local medical control policies and procedures as they pertain to the paramedic base hospitals, alternative base stations, paramedic service providers, paramedic personnel, patient destination, and the LEMSA as mutually agreed upon by the LEMSA, alternate destination and general acute care hospital (GACH) providers.”</p> <p>Hospitals want more involvement in policies driving GACH base station activities.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period that ended on September 28, 2019.</p>
4	Section: 100170 Subsection: (a)(7) Page: 40 Line: 37 (et seq)	Yvonne Choong, Vice President California Medical Association	<p>CMA supports the deletion of proposed subsection (a)(7) to Article 7. System Requirements, § 100170. Medical Control relating to the development of prehospital triage protocols and transport to destinations other than a general acute care hospital operating an emergency department. The deletion of this proposed section addresses the concerns expressed in our original comment letter dated May 20, 2019 regarding the inappropriate expansion of the paramedic scope of practice to make medical decisions regarding where to transport a patient beyond what is allowed under current state law. In that letter we stated our opinion that it is not within EMSA’s current authority to establish prehospital triage protocols as proposed in these regulations. Withdrawing sections of the proposed regulations related to prehospital triage procedures until the necessary statutory authority is granted by the Legislature to expand the authority of EMSA and the paramedic scope of practice is appropriate.</p> <p>CMA supports improving access to care for underserved patients and the more efficient use of EMSA resources.</p>	<p>Comment accepted in part / rejected in part.</p> <p>EMSA accepts the comments acknowledging change to subsection (a)(7).</p> <p>EMSA rejects the notion that the deletion was based on comments submitted by the California Medical Association.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			We appreciate that EMSA reviewed, considered and agreed with comments from CMA and other stakeholders regarding our concerns with the original proposed language.	
5	Section: 100170 Subsection: (a)(7)(A) Page: 40 Line: 45	California Hospital Association	<p>Change (a)(7)(A) from “Policies, procedures, and protocols for medical control and quality of care” to “Policies, procedures and protocols for medical control, base station and quality of care, as mutually agreed upon by LEMSA, alternate destination and GACH providers.”</p> <p>As above, hospitals want more involvement in policies driving GACH Base Station activities</p>	<p>Comment rejected.</p> <p>Subsection (a)(7) has been deleted. EMSA determined that this course of action was necessary in order to give a new EMSA Director the opportunity to work with stakeholders and collaborate on a path forward for both alternate destinations and community paramedicine.</p>
6	Section: 100170 Subsection: (a)(7) Page: 40 Line: 37	Brian Rice, President California Professional Firefighters	We support the deletion of paragraph (7) of subdivision (a) of Section 100170 of the proposal, as was recommended in our comments from May 17, 2019. The changes proposed in this section represented an inappropriate expansion of a paramedic's scope of practice, as the Legislature has not delegated the authority to expand scope of practice to EMSA. The previously proposed regulations altered the statutory requirement that patients be transported to emergency departments and instead, through regulation, sought to allow patients to be transported to an alternate destination other than the emergency department. EMSA lacks the statutory authorization to propose such a change through regulation.	<p>Comment accepted in part / rejected in part.</p> <p>EMSA accepts the comments acknowledging change to subsection (a)(7).</p> <p>EMSA rejects the notion that the deleted language sought to alter existing statutory authority.</p>
7	Section: 100170 Subsection: (a)(7)(F)3. Page: 41 Line: 28	California Hospital Association	Change (a)(7)(F) 3. from “Authorized Sobering Centers that are either a federally qualified health center or a clinic as described in Section 1211 of the Health and Safety Code” to “ Authorized sobering centers that are non-correctional facilities that provide a safe, supportive	<p>Comment rejected.</p> <p>Subsection (a)(7) has been deleted. EMSA</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>environment for intoxicated individuals to become sober that meet one of the following requirements: (a) the facility is a federally qualified health center, including a clinic described in subdivision (b) or (d) Section 1206; (b) the facility is certified by the Department of Health Care Services, Substance Use Disorder Compliance Division, to provide outpatient, non-residential detoxification services; (c) the facility has been accredited as a sobering center under the standards developed by the National Sobering Center collaborative; or (d) the facility is a hospital-based outpatient department. Facilities granted approval for operation by OSHPD before November 28, 2017, under the Health Workforce Pilot Project #173, or otherwise providing sobering center services as of December 31, 2019, are authorized to continue operation until twelve months after the National Sobering Collaborative accreditation becomes available.</p> <p>This language will be broad enough to encompass all 13 active sobering centers plus those who could additionally be accredited through the National Sobering Center Collaborative.</p>	determined that this course of action was necessary in order to give a new EMSA Director the opportunity to work with stakeholders and collaborate on a path forward for both alternate destinations and community paramedicine.
8	Section: 100170 Subsection: (a)(7)(G) Page: 37-45 Line: 29-30; 1-36	Ray Ramirez, EMT-P	Concur with deletions highlighted in yellow.	<p>Comment accepted.</p> <p>EMSA accepts the comments acknowledging change to subsection (a)(7).</p>
9	Section: 100171 Subsection: (g) Page: 43 Line: 39-40	Ray Ramirez, EMT-P	<p>Once again, recommend modifying 100171(g) to read, or language to the effect, to state:</p> <p>(g) The paramedic service provider shall submit electronic health records to the LEMSA according to the LEMSA's policies and procedures, <u>subject to subsection (1) of this section.</u></p>	<p>Comment rejected.</p> <p>This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			<p>(1) <u>The LEMSA shall not mandate that a provider shall use a specific electronic health record system to collect and share data with the LEMSA; however, this restriction shall not modify or affect a written contract or agreement executed before January 1, 2016, between a local EMS agency and an emergency medical care provider.</u></p> <p>AB 1129, <i>Burke</i> (2015) added H&SC § 1797.227 to the EMS Act and was <i>specifically</i> enacted to limit a LEMSA's medical control authority to require that any "emergency medical care provider" shall use a <u>specific</u> electronic health care record system. The EMS Authority's ISOR recognizes that changes to subsection (e) are necessary for compliance with AB 1129 (p. 29). Once again, as written, the proposed changes impermissibly-narrow AB 1129's <i>substantive</i> application and intent. Alternatively, amending CCR 100171(f) or 100170(a)(6) to include the above statutory intent would be satisfactory.</p> <p>In describing AB 1129, the Legislative Counsel's Digest stated: "<i>The bill would prohibit a local EMS agency from mandating that a provider use a specific electronic health record system to collect and share data with the agency.</i>" Many providers look to the regulations for clarification on certain practices. I urge the EMS Authority to reflect these necessary clarifications in the proposed regulations.</p> <p>In sum, the current proposed PM regulation revision defeats both the Legislature's purpose of enacting AB 1129 and the EMS Authority's stated purpose of implementing "clear requirements for compliance with AB 1129 (<i>Burke</i>, Chapter 337, Statutes of 2015)."</p>	that ended on September 28, 2019.
10	Section: 100172 Subsection: (a) Page: 44 Line: 5-8	Ray Ramirez, EMT-P	<p>Once again, consider adding subsection 100172(a)(1) to state:</p> <p>(1) No additional fees shall be charged for paramedic, critical care paramedic or flight paramedic accreditation, so long as the initial license requiring accreditation has not lapsed.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			The above is consistent with CCR 100166(h) prohibiting fees for PM reaccreditation, which is continuous so long as no licensure lapse occurs. There is substantial confusion amongst some LEMSA's concerning fee authority, and some continue assessing non-allowable fees for "reaccreditation" under the guise of a "reverification fee," regulatory clarification is necessary. I incorporate by reference California Attorney General Opinion (CAAG) No. 94-408 (October 21, 1997) (attached) into my comments.	public comment period that ended on September 28, 2019.
11	Section: 100172 Subsection: (a) Page: 44 Line: 5-8	Ray Ramirez, EMT-P	<p>H&SC § 1798(a)(b) restricts LEMSA medical control authority to the standards established by EMSA (using established rule-making procedures); and H&SC § 1797.185 contains additional restrictions. In turn, the Division 9 CCR's specify the allowable fees EMSA and respective LEMSA's may charge under medical control. For LEMSA's, the primary fee authority statute is H&SC § 1797.212, which the governing CCR's interpret. CCR 100172(a) (Paramedic Fees) currently describes the <i>allowable</i> scope of fees a LEMSA may charge individuals/provider agencies.</p> <p>Specifically, CCR 100172(a) provides for PM Training Program Approval fees, PM CE Provider Approval fees and PM Accreditation fees. Many LEMSA's are now creating additional fees ("provider approval" fees, "medical control" fees, etc.) which are not the specified allowable fees; and may conflict with Government Code Section 6103's limitations on allowable fees for official services between political subdivisions. Moreover, the EMS Act and the CCR's evidences an intent for uniformity in the governing fee structure; and in some instances, impose limitations on allowable fees which the Authority and/or LEMSA's may levy (<u>See</u> CAAG No. 94-408). I am asking the EMS Authority to clarify whether additional fees not specified by these regulations (CCR's) are allowable fees under Chapter 4 for Paramedic Provider agencies.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period that ended on September 28, 2019.</p>

#	Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
11	Section: 100172 Subsection: (b)(7) Page: 45 Line: 12-13	Ray Ramirez, EMT-P	<p>CCR 100390.5(d) specifies that the Authority shall be the CE Provider approval body for “statewide public safety agencies” and specified “out-of-state providers,” which are otherwise not authorized by CCR 100390.5(a)(b). CCR 100390.5(d) empowers EMSA as the CE Provider Approval authority for “<i>statewide public safety agencies</i>” and “<i>CE providers whose headquarters are located out-of-state</i>,” subject to defined exceptions.</p> <p>After reviewing applicable regulations (including Title 22, Division 9, Chapter 11), I observe that currently a CE Provider approval fee applies to only “out-of-state providers” not otherwise excepted, and not “statewide public safety agency” CE Providers. By deleting the language “an out-of-state” in CCR 100172(b)(7), this proposed fee action <i>implements a new</i> CE Provider approval/reapproval fee for statewide public safety agencies; which is likely contrary to Government Code Section 6103, which appears to suggest that specific statutory authorization may be necessary to implement such fees. Moreover, and importantly, it is not the necessity or reasonableness of the proposed fee, which is in question, but the EMS Authority’s direct statutory authority to require such fees in the first instance, for official services between government entities. As noted above, allowing such a fee may lead to new non-allowable EMSA fees for public safety statewide agencies. Perhaps a general fund increase is the appropriate means for securing any necessary funding which the EMS Authority references in the Proposed PM Regulation’s ISOR (p. 32).</p> <p>Last, I observe that the referencing authority in Chapter 11 (EMS Continuing Education) for EMSA CE-approval related fees, CCR 100393(a)(1), incorrectly references “CCR Section 100172(b)(7)” as “CCR Section 100171(b)(7).” Please not this discrepancy in the next Chapter 11 revision.</p>	<p>Comment rejected.</p> <p>This comment is being rejected because the section of text referenced has not been modified as part of the third 15-day public comment period that ended on September 28, 2019.</p>

EMERGENCY MEDICAL SERVICES AUTHORITY

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



DATE: December 4, 2019

TO: Commission on EMS

FROM: Dave Duncan, MD
Director

PREPARED BY: Priscilla Rivera, Manager
Personnel Standards Unit

Lou Meyer
Community Paramedicine Pilot Project Manager

SUBJECT: Community Paramedicine Pilot Project Status

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 (CHCF). 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, 2017, and 2018. OSHPD's current authorization will expire on November 14, 2019. EMSA submitted a request for an additional one-year extension on August 27, 2019, which was approved by OSHPD on September 17, 2019 extending the Pilot Projects through November 14, 2020. The community paramedicine HWPP has encompassed 17 projects in 13 communities across California that have tested seven different community paramedicine concepts.

The data provided by the current community paramedicine projects, as well as the independent evaluator's quarterly reports and public report, continues to show these projects safely improve patient care as well as reducing hospital re-admissions and unnecessary visits to emergency departments.

Independent Evaluation:

The 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.

On October 1, 2019, UCSF submitted its 2nd Quarter 2019, Data Update Report to EMSA and OSHPD.

Additional Pilot Sites Status:

The Los Angeles County City Fire Department Alternate Destination Pilot programs listed below were approved by OSHPD and EMSA to become additional projects and launched their program on July 1, 2019. Site visits by EMSA and UCSF took place on November 13, 2019.

Local EMS Agency	Sponsor	Concepts	Status
Los Angeles County EMS Agency	Los Angeles City Fire Department	Alt Destination Behavioral Health	Received OSHPD, EMSA and LA County LEMSA approval to implement on June 21, 2019
Los Angeles County EMS Agency	Los Angeles City Fire Department	Alt Destination Sobering Center	Received OSHPD, EMSA and LA County LEMSA approval to implement on June 21, 2019.

Community Paramedicine Concept	Lead Agency	Partner Agencies	Date Implemented	Total Patients Enrolled	Notes
Post-Discharge – Short-Term Follow-Up	Alameda City EMS	Alameda City Fire Alameda City Hosp	June 1, 2015	132	
Post-Discharge – Short-Term Follow-Up	Butte County EMS	Butte EMS Enloe Hospital	July 1, 2015	1,001	Ceased enrolling patients on November 14, 2018
Post-Discharge – Short-Term Follow-Up	San Bernardino County and Rialto Fire Depts.	San Bernardino & Rialto Fire Arrowhead Medical Center	August 13, 2015	228	

Community Paramedicine Pilot Project Status

December 4, 2019

Page 3

Post-Discharge – Short-Term Follow-Up	UCLA Center for Prehospital Care	Glendale Fire & Glendale Hospital	September 1, 2015	154	Ceased enrolling patients on August 31, 2017
Post-Discharge – Short-Term Follow-Up	Medic Ambulance Solano	North Bay Medical Center	September 15, 2015	257	
All Post-Discharge – Short-Term Follow-Up Projects				1,772	
Frequent EMS User	Alameda City EMS	Alameda City Fire Alameda City Hosp	July 1, 2015	81	
Frequent EMS User	City of San Diego	San Diego City Fire & American Medical Response	October 12, 2015	46	Ceased enrolling new patients in December 2016, Re-engaged July 2019
Frequent EMS User	San Francisco Fire Dept.	SF Fire Department	September 12, 2018	168	
All Frequent EMS User Projects				295	
Directly Observed Therapy for Tuberculosis	Ventura County EMS	Ventura Public Health Department and American Medical Response	June 1, 2015	51	
Hospice	Ventura County EMS	Mission Hospice and American Medical Response	August 1, 2015	371	
Community Paramedicine Concept	Lead Agency	Partner Agencies	Date Implemented	Total Patients Enrolled	Notes
Alternate Destination – Mental Health	Mountain Valley – Stanislaus EMS	Stanislaus County Behavioral Health & American Medical Response	September 25, 2015	406	
Alternate Destination – Mental Health	Santa Clara County EMS	Gilroy Fire Department and American Medical Response	June 6, 2018	74	
Alternate Destination – Mental Health	Central California EMS	American Ambulance of Fresno	July 30, 2018	2,125	
Alternate Destination – Mental Health	Los Angeles County EMS	Los Angeles City Fire Department & Exodus	July 1, 2019	Pending	
All Alternate Dest. – Mental Health Projects				2,605	

Community Paramedicine Pilot Project Status

December 4, 2019

Page 4

Alternate Destination – Urgent Care	UCLA Center for Prehospital Care	Glendale Fire & Santa Monica Fire Departments	September 8, 2015	12	Ceased enrolling patients on May 31, 2017
Alternate Destination – Urgent Care	Orange County Fire Chiefs	Huntington Beach, Newport Beach & Fountain Valley Fire	September 14, 2015	34	Ceased enrolling patients on November 13, 2017
Alternate Destination – Urgent Care	Carlsbad Fire Dept.	Carlsbad Fire Department	October 9, 2015	2	Ceased enrolling patients on November 13, 2017
All Alternate Dest. – Urgent Care Projects				48	
Alternate Destination – Sobering Center	San Francisco Fire Dept.	SF Fire Department	February 1, 2017	1,909	
Alternate Destination – Sobering Center	Santa Clara County EMS	Gilroy Fire Department and American Medical Response	June 6, 2018	0	
Alternate Destination – Sobering Center	Los Angeles County EMS	Los Angeles City Fire Department & Exodus	July 1, 2019	Pending	
All Alternate Dest. – Sobering Center Projects				1,909	
15 Active Pilots				7,051	

Legislative Status:

AB 1544 (Gipson) *Community Paramedicine or Triage to Alternate Destination Act*, was introduced on February 22, 2019, and is currently a two-year bill that must clear the Senate by January 2020. This bill would permit local emergency medical services agencies (LEMSAs), with approval by EMSA, to develop programs to provide community paramedic or triage to alternate destination services in one of the following specialties:

- (1) providing directly observed tuberculosis therapy;
- (2) providing case management services to frequent emergency medical services (EMS) users;
- (3) providing hospice services to treat patients in their homes; and,
- (4) providing patients with transport to an alternate destination, which can either be an authorized mental health facility, or an authorized sobering center.

The bill requires changes to the structure of the Commission on EMS and multiple data reporting requirements. As drafted, this bill would sunset on January 1, 2030.

As amended on July 11, 2019, AB 1544 removes the provision of providing short-term post-discharge follow-up from the authorized community paramedicine services, thereby eliminating a core element of a community paramedic program.

EMERGENCY MEDICAL SERVICES AUTHORITY

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



DATE: December 4, 2019

TO: Commission on EMS

FROM: Dave Duncan MD
Director

PREPARED BY: Craig Johnson, Chief
Disaster Medical Services Division

SUBJECT: Ambulance Strike Team (AST) Program Updates

RECOMMENDED ACTION:

Receive information regarding the EMS Authority's Ambulance Strike Team/Medical Task Force (AST/MTF) Program.

FISCAL IMPACT:

None

DISCUSSION:

The AST/MTF Program is an essential component of the mobile medical assets utilized by EMSA to respond to and mitigate mass casualty and other significant disaster events in California. This program was originally approved by the Commission in June 2003 (EMSA Publication #215) and is modeled after concepts for strikes teams developed by FIREScope (5 like capable resources and a Strike Team Leader in a separate vehicle with common communications). The Disaster Medical Support Unit (DMSU) is designed to provide extended logistical support and serve as the AST leader vehicle.

The AST Program, created by EMSA and the first in the nation, dates back to 2001, and was intended to provide "...a rapid, coordinated, EMS operational response to disaster situations, with an ability to provide field triage, treatment, and transportation..." ASTs may also be used for medical and health support in various settings, including first aid sites, shelters, and command posts." The program was created in part due to the great flood of 1997 in Sutter and Yuba counties where there was a haphazard and chaotic ambulance response to the evacuation needs. Further urgency for the program came as a result of hurricane Katrina. The first Ambulance Strike Team Leader (ASTL) training was held in January 2002.

Ambulance strike teams have been used extensively over the past several years, supporting the major incidents which struck California during that time. The potential failure of the

Oroville Dam in February 2017; severe wildfires in Santa Rosa and Napa; equally devastating fires in Ventura, Los Angeles, and San Diego Counties; major mudslides in Montecito, the Ridgecrest earthquake, and most recently the Kincade fire in Sonoma County were all supported by the use of ASTs. These responses have provided significant data to EMSA on various aspects of the program which has illuminated areas warranting review.

Ambulance Strike Team Advisory Workgroup:

Recognizing the need for review and improvement, EMSA is organizing a workgroup to assist in advancing the AST Program. In developing the AST program nearly two decades ago, EMS utilized the expertise of the Ambulance Strike Team Advisory Workgroup. The workgroup was comprised of subject matter experts from various disciplines and stakeholder groups; this body was key in creating a program that has become an essential component of disaster response to any incident requiring the movement of substantial numbers of patients. The new workgroup will have several of the original committee members as well as multiple new members with recent experience in the deployment and utilization of ASTs.

Several areas of primary focus for the AST Advisory Workgroup include:

- Enhancing the AST resource requesting process
- Development, in collaboration with EMSAAC, an AST Overhead Team
- Implementing a Standardized Communications Plan
- Revamping the AST Leader Course and Red Card certification process
 - Include on-line training tools and a train-the-trainer program
- Improving the integration and utilization of the Disaster Medical Support Units
- Increasing provider participation statewide

Ambulance Strike Team/Medical Task Force State Reimbursement Schedule:

At the program's inception, little consideration was given to reimbursement for AST requests. Following the Oroville Dam incident, the reimbursement process was substantially delayed because there was a wide variation in the bills submitted. The wide variation in costs was also true during the Lake County fires. Seeing this, EMSA took the initiative, and working with the California Ambulance Association (CAA), American Medical Response (AMR) and the EMS Administrators Association of California (EMSAAC), crafted a proposed Statewide Rate for AST Reimbursement (Exhibit "A"), creating certainty for both the "buyer and seller" of services. While not compulsory, the rate structure was approved and adopted by EMSAAC and incorporated as an integral component of the newly proposed Statewide Cooperative Assistance Agreement.

EMERGENCY MEDICAL SERVICES AUTHORITY

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

**ATTACHMENT "A"**

**AMBULANCE STRIKE TEAM/MEDICAL TASK FORCE
 STATE REIMBURSEMENT SCHEDULE**

Effective 03/25/2019

Entities who provide (or participate as a member of) an Ambulance Strike Team/Medical Task Force in response to a State request shall be reimbursed in accordance to the schedule below. Reimbursement shall be "portal to portal," that is, from time of dispatch to return to home base.

If the incident is likely to be eligible for FEMA reimbursement, billing for transport or other costs (except as noted) is discouraged as they are covered in the rates below. FEMA will reduce (and potentially delay) reimbursement by any amounts collected through direct billing.

All personnel costs are paid on an hourly basis and no overtime rates shall be applied.

Resource	Hourly Rate¹	BLS (24 Hr.)	ALS (24 Hr.)	Total BLS (EMT-I + EMT-I)/24 Hr.	Total ALS (EMT-P + EMT-I)/24 Hr.
Ambulance (Vehicle)	40.50	972.00	972.00	972.00	972.00
EMT-I (Per Person)	42.00	1008.00		2016.00	1008.00
EMT-P	72.45		1738.80		1738.80
Per Diem/Person	3.50	84.00	84.00	168.00	168.00
Supplies	10.00/BLS 18.00/ALS	240.00	432.00	240.00	432.00
Cost/Unit/24 Hrs.				3396.00	4318.80
Leader Cost					
Leader Vehicle ²	31.00	744.00	744.00	744.00	744.00
AST/MTF Leader	89.50	2148.00	2148.00	2148.00	2148.00
Leader Support Staff ³		1008.00	1008.00	1008.00	1008.00
Per Diem/Person	3.50	84.00	168.00	168.00	168.00
Cost/Leader/24 Hours			4068.00	4068.00	4068.00
AST/MTF Leader				4068.00	4068.00
Ambulances (5)				16980.00	21594.00
Strike Team, Total Cost				21048.00	25662.00

¹ AST Rates are computed hourly and assessed "portal to portal".

² If a DMSU is used as the Leader Vehicle, no vehicle cost shall be assessed. Fuel receipts may be submitted.

³ While the AST Program does not *require* staff support for the AST Leader, it is highly *recommended*.

EMERGENCY MEDICAL SERVICES AUTHORITY

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



DATE: December 4, 2019

TO: Commission on EMS

FROM: Dave Duncan, MD
Director

PREPARED BY: Sean Trask, Chief
EMS Personnel Division

SUBJECT: Open Nominations for Election of Officers (March 2020 – March 2021)

RECOMMENDED ACTION:

Open nominations for Commission Officers for 2020 - 2021.

FISCAL IMPACT:

No fiscal impact.

DISCUSSION:

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

Per the Commission on EMS By-Laws, all Commission Officers are eligible for re-election.

Current Commission Officers:

Chair	James Dunford, MD
Vice Chair	Dan Burch
Administrative Committee	Dan Marguliese, MD
	Brent Stangeland
	Atilla Uner, MD

EMERGENCY MEDICAL SERVICES AUTHORITY

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



DATE: December 4, 2019

TO: Commission on EMS

FROM: Dave Duncan, MD
Director

PREPARED BY: Sean Trask/Sandi Baker
EMS Personnel Division

SUBJECT: Approval of 2021 Meeting Dates

RECOMMENDED ACTION:

Select a meeting date for September 2021 and approve the proposed meeting dates for Calendar Year 2021.

FISCAL IMPACT:

The estimated cost of four meetings per year is approximately \$58,000.

DISCUSSION:

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

The following meeting dates and locations were approved on December 5, 2018 for calendar year 2020:

Calendar Year 2020:

March 18, 2020, in Garden Grove
June 17, 2020, in Sacramento
September 16, 2020, in San Diego
December 9, 2020, in San Francisco

The proposed meeting dates and locations for Calendar Year 2021 are:

Calendar Year 2021:

March 17, 2021, in Garden Grove
June 16, 2021, in Sacramento
September TBD in San Diego
December 8, 2021, in San Francisco

Typically the Commission on EMS meetings are held on the third Wednesday of the month, which would place the September 2021 meeting on the 15th. There are potential conflicts with holding the Commission meeting on two of the five Wednesdays in September. Rosh Hashanah starts on the evening of Monday, September 6th, and ends on the evening of Wednesday, September 8th. Yom Kippur starts on the evening of Wednesday, September 15th, and ends on the evening of Thursday, September 16th. These holidays may impact individuals attending the Commission meeting if it is held on September 8th or 15th 2021.

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

The EMS Authority has not contracted for meeting rooms for the 2021 Commission meetings. The Commission is requested to select a date for the September meeting.

Because September 2021 may contain other potential conflicts with personal and meeting schedules, the EMS Authority has listed the options, along with the advantages and disadvantages in keeping with a Wednesday meeting schedule:

1. September 1, 2021
Advantage – Does not interfere with the Labor Day Holiday on September 6, 2021.
Disadvantage – Ten weeks after the June 16, 2021 Commission meeting.
2. September 8, 2021
Advantage – Eleven weeks after the June 16, 2021 meeting.
Disadvantage – Rosh Hashanah ends the evening of September 8th which may impact attendance at the EMDAC, EMSAAC, and Commission meetings. This may also interfere with the Labor Day holiday on September 6, 2021.
3. September 15, 2021
Advantage – 12 weeks after the June 16, 2021 Commission meeting.
Disadvantage – Yom Kippur begins the evening of September 15th and ends on the evening of September 16th which may impact attendance at the Commission, EMDAC and EMSAAC meetings.
4. September 22, 2021
Advantage – 13 weeks after the June 16, 2021 Commission meeting.
Disadvantage – Only 11 weeks until the December 8, 2021 Commission meeting.
5. September 29, 2021
Advantage – 14 weeks after the June 16, 2021 Commission meeting.
Disadvantage – Only 10 weeks until the December 8, 2021 Commission meeting.