

STATE OF CALIFORNIA
COMMISSION ON EMERGENCY MEDICAL SERVICES
March 17, 2021
10:00 A.M. – 1:00 P.M.

This meeting will be conducted pursuant to Governor Newsom's [Executive Order N-29-20](#) issued on March 17, 2020, which suspended certain provisions of the Bagley-Keene Open Meeting Act during the declared State of Emergency response to the COVID-19 pandemic.

Consistent with the Executive Order, in order to promote and maximize social distancing and public health and safety, this meeting will be conducted by Zoom and teleconference only. The locations from which Commissioners will participate are not listed on the agenda and are not open to the public. All members of the public shall have the right to offer comment at this public meeting as described in the Notice.

Zoom:

<https://zoom.us/j/99767263694>

Teleconference number:

1-669-900-6833

Webinar ID:

997 6726 3694

AGENDA

- 1. Call to Order and Pledge of Allegiance**
- 2. Review and Approval of December 9, 2020 Minutes**
- 3. Director's Report**
 - A. EMSA Program Updates – DMS / HIE / Personnel / Systems
- 4. Consent Calendar**
 - A. Administrative and Personnel Report
 - B. Legal Report
 - C. Enforcement Report

Regular Calendar

- 5. EMS Administration**
 - A. Legislative Report
 - B. Regulations Update

6. EMS Personnel

- A. Community Paramedicine Pilot Project Status Update
- B. Clinical Care and Restraint of Agitative or Combative Patients

7. EMS Systems

- A. Core Measures Report and Project Update

8. Disaster Medical Services Division

- A. State Medical Response Update

9. Election of Officers

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 Caitlyn Cranfill at (916) 431-3701, no less than 7 days prior to the meeting.

**STATE OF CALIFORNIA
COMMISSION ON EMS**

**Minutes of Teleconference Meeting
Wednesday, December 9, 2020
Zoom**

Call-In Number 669-900-6833; Code 947 8421 0226

COMMISSIONERS PRESENT:

Steve Barrow, Dan Burch, Sean Burrows, James Dunford, M.D.,
Thomas Giandomenico, Nancy Gordon, Mark Hartwig, James Hinsdale, M.D.,
Lydia Lam, M.D., Ken Miller, M.D., Ph.D., Karen Relucio, M.D., Paul Rodriguez,
Jane Smith, Carole Snyder, Brent Stangeland, Jim Suver, Atilla Uner, M.D., Todd Valeri

EMS AUTHORITY STAFF PRESENT:

David Duncan, M.D., Louis Bruhnke, Caitlyn Cranfill, Sergy El-Morshedy, Kent Gray,
Craig Johnson, Adrienne Kim, Jennifer Lim, Lou Meyer, Sean Trask

AUDIENCE PRESENT (partial list):

Tanir Ami, CARESTAR Foundation
BJ Bartleson, California Hospital Association
Nichole Bosson, M.D., Los Angeles County EMS Agency
Ken Johnson, Stockton Fire Department and North Branch Director, Cal Chiefs EMS
Section
Clayton Kazan, M.D., Los Angeles County Fire Department
Kristi Koenig, EMS Medical Director, San Diego County
Noele Richmond
Kristin Thompson, Newport Beach Fire

1. CALL TO ORDER AND PLEDGE OF ALLEGIANCE

Chair James Dunford, M.D., called the teleconference meeting to order at 10:18 a.m. Eighteen Commissioners were present. He led the Pledge of Allegiance and reviewed the meeting protocols and meeting agenda.

2. REVIEW AND APPROVAL OF SEPTEMBER 16, 2020, MINUTES

Action: Commissioner Hartwig moved approval of the September 16, 2020, Commission on Emergency Medical Services Meeting Minutes as presented. Commissioner Barrow seconded. Motion carried unanimously with two abstentions by Commissioners Gordon and Lam.

3. DIRECTOR'S REPORT

A. EMSA Program Updates – DMS / HIE / Personnel / Systems

David Duncan, M.D., EMSA Medical Director, shared his screen and provided a high-level update on current numbers and projections of the third surge of the COVID-19 pandemic. He stated new Stay-at-Home Orders from the Governor based on the metric of ICU availability went into effect last week due to the impressive incline upward with no bend yet seen in the curve. The regions of greatest concern are the Central Valley and Southern California.

Dr. Duncan stated the question is how to manage this surge when ICUs are already stressed. Alternative locations for additional bed space are being prepared. EMSA is also working to expand the health care workforce through a multi-pronged approach: expanding the existing health care personnel scope and practice, reaching out through four staffing agencies at the state level, and reaching out to federal partners to assist in staffing alternate care sites and skilled nursing facilities.

Dr. Duncan stated many hospitals have requested hospital patient ratio waivers while others have yet to do so. The California Department of Public Health (CDPH) is currently working on a uniform waiver to be available to counties that meet certain criteria. It is expected to become available next week.

Dr. Duncan stated new Centers for Disease Control and Prevention (CDC) guidance allows a quarantine limit of 7 days, as opposed to 14, with a negative PCR test. He stated, despite COVID-19 fatigue, non-pharmaceutical interventions (NPIs) need to be maximized in order to see this curve bend down.

Questions and Discussion

Commissioner Suer stated there are no hospitals with the capacity to offer tertiary services. Patients are being held from transfer for dozens of hours, which will result in negative health care outcomes. This is not due to COVID-19 patients; it is the inability to fully utilize the health care network. While more ICU beds are helpful, appropriate staffing and safety measures are more critical issues.

Commissioner Barrow stated another troubling issue during this time is unintentional injuries in children. The number of unintentional injuries in children have been off the charts during COVID-19. The CDPH had restricted some of the safety and young child unintentional injury prevention activities due to COVID-19, but they have reopened some safety programs since.

Commissioner Relucio asked for clarification that, during times of hospital overflow, skilled nursing level patients would be transferred to regional, rather than local, alternate care sites.

Dr. Duncan stated a better way to think about the alternate care site development is they, like everything else, are limited by the number of health care personnel. However, counties are reaching out as well. Some counties have their own alternate care sites, and the state has its appointed alternate care sites. The goal is to transition towards opening up as many as are required based on the metrics and the requests from counties.

Commissioner Relucio asked if there is an overall strategy that will be given to operational areas for guidance.

Dr. Duncan stated the highest-level priority demonstrates and dictates that, when these health care personnel can be utilized in hospitals, larger numbers of beds and higher levels of care are also delivered. Increasing the number of hospital beds is priority one and alternate care sites are priority two behind that. However, catchment for some of the other facilities, particularly skilled nursing facilities, et cetera, is necessary.

Chair Dunford asked where the military comes in.

Dr. Duncan stated the California National Guard remains closely involved. Currently, there are three national guard teams that are considered skilled nursing facility strike teams in conjunction with CAL-MAT skilled nursing facility strike teams. Additional responsibilities include contributing to mobile testing teams. They will soon be included in vaccination team portfolios along with EMS providers to deliver vaccines in California.

Commissioner Suver agreed with providing more staff in hospitals. The criteria for alternative sites has been fairly restrictive thus far.

Public Comment

Ms. Lim read a comment from Dr. Kristi Koenig, EMS Medical Director, San Diego County and former Commissioner, from the Chat section. Dr. Koenig noticed an increase in pediatric drownings in San Diego County and collaborated with the California Paramedic Foundation for outreach and education that created a one-minute PSA. Dr. Koenig provided a link to the PSA.

4. CONSENT CALENDAR

- A. Administrative and Personnel Report**
- B. Legal Report**
- C. Enforcement Report**

Action: Commissioner Gordon moved approval of all items on the consent calendar. Commissioner Barrow seconded. Motion carried unanimously. The item was noted and filed.

REGULAR CALENDAR

5. EMS ADMINISTRATION

- A. Legislative Report**

Sergy El-Morshedy, Legislative Coordinator, summarized the Legislative Report of the bills currently being tracked and analyzed by staff, which was included in the meeting materials and posted on the website.

Questions and Discussion

Commissioner Barrow asked about the types of criminal background violations of the 400 applicants that were approved for licensure or certification in the report.

Mr. El-Morshedy stated Assembly Bill (AB) 2292, the catalyst for this study, focused mainly on whether criminal backgrounds impacted the licensure or certification process rather than the specific types of violations.

Sean Trask, Chief of the EMS Personnel Division, added that the bill specified the number of denials with prior criminal convictions and the reasons stated for denying the applicant with a prior criminal conviction.

Commissioner Barrow asked if specific types of violations can be studied in the future. Many individuals have criminal backgrounds for violations that have since been decriminalized, such as marijuana as a drug offense.

Mr. Trask agreed that it would be helpful to know the nature of the criminal activity. Unfortunately, the bill did not go into that level of detail.

Commissioner Burrows asked for an update on AB 1544 and the development of the oversight advisory committee.

Mr. Trask stated staff is putting together a contact list for the organizations that were listed in the bill to participate in the advisory committee. An invitation letter has been drafted and will be sent to those organizations shortly.

B. Regulations Update

Kent Gray, Regulations Manager, reviewed the Regulations Update, which was included in the meeting materials.

Questions and Discussion

Commissioner Hartwig expressed concern that EMSA is taking arguably the most controversial issues related to the EMS Act of 1980, creating regulations in an inconceivably challenging time for communication and collaboration, and placing restrictions on the stakeholder representation on the Chapter 13 task force. The solution requires conversation that is not happening.

Commissioner Barrow stated concern over the arguments about who could serve on this panel. People who represent the organizations on the front lines have a global view, while lobbyists will push a narrow agenda.

Vice Chair Uner asked about the repeal of noncitizen application status and the noncitizens who are applying for it.

Mr. Gray stated Chapter 5 provides an extra set of questions for noncitizens to answer and the statutory change prevented any requirement that included disseminating their immigration status. It was part of a large bill passed in 2018 that covered a great number of professional licenses. It clearly provides that these questions of immigration status cannot be asked, and all that Chapter 5 addressed were areas of immigration.

Vice Chair Uner asked if these are applicants for EMT or paramedic licenses.

Mr. Trask stated it was for paramedics.

Commissioner Rodriguez emphasized the importance of having all the players with significant institutional knowledge about Chapter 13 over the years at the table to help in

this discussion. The people who were left off the task force will be missed in later discussions. He stated the hope that they will be able to provide input moving forward as the evaluation of Chapter 13 is done carefully and thoroughly.

Public Comment

Ms. Lim read a comment from Clayton Kazan, M.D., Los Angeles County Fire Department, from the Chat section. Dr. Kazan wrote that the EMS system has been operating within the current statute for the past 40 years. The fact that EMSA is pushing this through now during the pandemic is extremely frustrating.

Kristin Thompson, Newport Beach Fire, supported comments made that Chapter 13 has continued to progress during these unprecedented times, not only with the COVID-19 pandemic but with the wildfires experienced again this year. The speaker stated disappointment that the anticipated collaboration and communication that was going to be the hallmark of a new era with EMSA and the fire service has not happened.

Dr. Duncan stated the perspective from EMSA is that this is not a rushed process. Agency asked that it be done with a deliverable in six months. The work group was able to pause as COVID-19 surged. The pause can be continued if it is necessary, as this process will not be forced without appropriate input. He stated non-member stakeholders were disallowed early in the process; there is an additional category to allow them to participate under Observer status. The ability to submit comments from the work group in writing has been added to increase the ability to participate.

Ken Johnson, Stockton Fire Department and North Branch Director for Cal Chiefs EMS Section, stated appreciation for the work the EMS agency is doing. The speaker echoed comments from Commissioners Hartwig, Barrow, and Rodriguez about collaboration and bringing more stakeholders into this conversation. It is important to have the people who are at the tip of the spear in these conversations so they can echo the issues that are facing the California EMS system. The speaker encouraged looking at who those stakeholders are to ensure that the best decisions are being made.

6. EMS PERSONNEL

A. AB 2293 EMT Denial Report

Mr. Trask stated AB 2293 went into effect in 2019 and requires the EMS Authority to collect initial EMT and advanced EMT certification, gender, ethnicity, and disciplinary data from California's 68 certifying entities. The bill also requires the EMS Authority to annually report to the Commission and the Legislature the extent to which prior criminal history may be an obstacle to certification as an EMT or advanced EMT.

Mr. Trask provided an overview of the first report to the Commission and Legislature, which was included in the meeting materials. He stated the conclusion from this first report is that prior criminal history does not appear to represent an obstacle to EMT certification.

Questions and Discussion

Commissioner Barrow suggested a discussion at a future meeting about the criminal record information included in the application to help inform personnel decisions.

Chair Dunford stated data was provided by the local EMS agencies (LEMSAs). He asked about a uniform reporting tool for all LEMSAs to use.

Mr. Trask stated the EMS Authority was asked early on by the LEMSAs to provide them with a tool. An Excel spreadsheet was created for uniformity and was distributed to all certifying entities. Unfortunately, the bill did not go into the level of detail to require specific criminal record information.

Commissioner Smith stated the need for information about what is preventing people from entering EMS due to criminal backgrounds so they will not be let into the system in the beginning when signing up for a class to keep students from spending time and money when they are unable to be certified.

Mr. Trask stated Chapter 6 of the regulations reviews the denial or revocation standards to help with EMT or paramedic training programs.

B. Emergency Regulations

Mr. Trask reviewed the proposed emergency EMT, AEMT, and paramedic regulations, which were included in the meeting materials. He stated once the COVID-19 emergency is lifted, training modifications cease immediately and there is no grace period for a training program to transition back to pre-COVID operations. These emergency regulations would allow training programs to continue with these modified measures for at least a six-month period to allow them an opportunity to transition back to pre-COVID operations. Each separate emergency regulation package must be approved by the Commission.

- a. EMT**
- b. AEMT**
- c. Paramedic**

Questions and Discussion

Commissioner Stangeland stated, although appropriate, this will create a tracking nightmare. He stated the need to ensure that EMSA feels confident in the process of being able to track these individuals as they go through and that that was taken into consideration.

Mr. Trask stated tracking can be done in coordination with LEMSAs that are approving the local training programs.

Commissioner Miller asked if there is a way to ensure that training programs do not resort to minimal standards for cost and time savings that are too low to be effective. For example, high-fidelity simulation has value in current and future EMS education.

Mr. Trask stated there are checks and balances in the programs. The programs go through an approving authority to ensure that measures are acceptable and student pass rates on the certifying examination ensure that students are being properly educated.

Vice Chair Uner agreed with Commissioner Miller for the need to ensure that programs do not take this as an opportunity to provide lesser education.

Commissioner Burrows asked if there are concerns with the 50 percent threshold regarding the emergency regulations for paramedics that can be met using substitute levels of training, including high-fidelity and documented ALS contacts and team leads, for an additional 90 days after the six-month period of continuing that training in a simulated scenario versus a hands-on, face-to-face patient/provider type of training situation with a preceptor guiding.

Mr. Trask stated the use of high-fidelity simulation by paramedic training programs was added as an option, although the use of high-fidelity simulation for ALS contacts in the emergency regulations is only for 20 of the 40 field internship contacts that are currently in the regulations. Once the emergency regulations expire, it will go back to 10 of the 40-contacts in the field.

Action: Commissioner Stangeland moved approval of the proposed emergency regulations for EMTs. Commissioner Barrow seconded. Motion carried unanimously.

Action: Vice Chair Uner moved approval of the proposed emergency regulations for AEMTs. Commissioner Hinsdale seconded. Motion carried unanimously.

Action: Commissioner Gordon moved approval of the proposed emergency regulations for paramedics. Commissioner Snyder seconded. Motion carried unanimously.

C. LA County EMS Stroke Trial Study

Mr. Trask stated the EMS Authority notified the Commission in June of 2019 of their approval of a trial study request from the LA County EMS agency to study the effectiveness of paramedics administering the neuroprotective agent Trans Sodium Crocetin (TSC) for the acute stroke patient. Enrollment of patients began in January of 2020. On September 10th, the EMS Authority was notified that the trial study was suspended because Diffusion Pharmaceuticals opted to devote resources to COVID-19 therapeutics. He invited Dr. Bosson, a member of the research team, to comment.

Nichole Bosson, M.D., Assistant Medical Director, Los Angeles County EMS Agency, stated the double-blind, randomized, placebo-controlled trial of TSC in stroke patients was ongoing from February to August. There were no serious adverse events in the six patients enrolled, and the target appeared to be well-designed with the majority of patients having the disease of interest.

Public Comment

Caitlyn Cranfill, EMS Authority, read a comment from Noele Richmond from the Chat section. Noele Richmond stated this information cannot be asked because it violates Penal Code. Background check information can only be shared by the requesting agency to the individual it directly affects.

D. Community Paramedicine Pilot Project Status Update

Lou Meyer, Project Manager for the Community Paramedicine Project, provided an overview of the background, implementation report, AB 1544 implementation plan, and training curriculum development, which was included in the meeting materials. The California Health Care Foundation Board of Directors, which has been funding Mr. Meyer's position for approximately six years, has approved the funding to extend Mr. Meyer's agreement through June 30 of next year, after which his position will be picked up under the state budget.

Commissioner Hartwig recognized the efforts undertaken by Lou Meyer for the Community Paramedicine Pilot Project. He stated the people in the state of California are better off because of Mr. Meyer's efforts and undying commitment.

Commissioners and members of the public joined in the appreciation for Lou Meyer's work.

7. DISASTER MEDICAL SERVICES DIVISION

A. COVID-19 Response Update

Craig Johnson, Chief of the Disaster Medical Services Division for the EMS Authority, reviewed the COVID-19 response and the California wildfire response updates, which were included in the meeting materials.

Public comment

Ms. Cranfill read an anonymous question from the Chat section asking how EMS will be a part of the first tier of COVID-19 vaccine when most counties indicate that shipments are going to hospitals that will not likely include EMS in the same priority as their own workers.

Dr. Duncan stated the vaccine distribution plan includes a joint venture between state and local health departments. Although hospitals are the receiving subsidiary for the vaccines, they do not determine the priority levels. The hospitals will deliver the vaccine as delineated in Schedule 1A per local health departments.

8. EMS SYSTEMS

A. Ambulance Patient Off-Load Time (APOT) Report

Adrienne Kim, Manager for the Data and QI Unit for EMS Systems Division, reviewed the APOT Report, which was included in the meeting materials. She stated the legislative report was submitted yesterday. Information will continue to be gathered from stakeholders to better understand APOT delay issues.

Questions and Discussion

Commissioner Barrow asked about the toolkit mentioned in the report.

Louis Bruhnke, Chief Deputy Director for EMSA, stated the toolkit was a joint venture of EMSA and the California Hospital Association and was published in 2014. The intent of the toolkit was to assist hospitals and other stakeholders to apply metrics to the

questions surrounding APOT. That report and collaboration contributed ultimately to the legislation that provided for measuring APOT statewide.

Commissioner Valeri stated APOT delays are severely impacting providers throughout the state, both private and public sectors. The report is inadequate with respect to providing recommendations to reduce or eliminate APOT. Most people in the industry who deal with these issues firsthand have implemented the guidance and it still continues to be a severe problem. He suggested creating another stakeholder group, including a representative from the California Ambulance Association, to develop a better toolkit.

Commissioner Suver agreed and emphasized the importance of stakeholders. He stated the danger of presenting data in averages, while hospitals that are drastically outside of the average need to be examined. Complete data is as important as stakeholder collaboration.

Commissioner Burrows asked about the possibility of loading the APOT data quarterly onto the EMSA website.

Ms. Kim stated it is possible to load the aggregates of APOT-1 and -2.

Commissioner Burrows noted that there are a number of EMS agencies in the report that are not compliant and some have not submitted any data. He asked staff to respond offline about what EMSA is doing to hold them accountable for the APOT data.

Commissioner Burrows stated there are a number of factors that are suppressing ambulance service delivery, and those trickle down into the public sector, fire department, paramedic, and EMS delivery services as well. There must be efforts to solve this issue beyond just the data collection component.

Commissioner Barrow supported Commissioner Valeri's and Burrows' comments but questioned why there is not another task force or appointed committee of stakeholders.

Chair Dunford asked staff to recruit volunteers and assemble a representative sample of stakeholders to serve on the APOT Task Force.

Vice Chair Uner suggested convening the APOT Task Force soon due to the urgency of this issue.

Chair Dunford agreed that the APOT Task Force should meet at least once prior to the next meeting.

Ms. Lim read a comment from Commissioner Snyder from the Chat section. Commissioner Snyder wrote that ENA is a vital stakeholder in the APOT conversation. Commissioner Snyder volunteered to be a part of the APOT Task Force.

Public Comment

Ms. Lim read a comment from Dr. Kazan from the Chat section asking to include provider agencies in this group.

BJ Bartleson, California Hospital Association (CHA), suggested a group collaboration including new partners to update the ambulance patient toolkit written in 2014. In

addition to hospitals and EMS pre-hospital providers, the collaboration should include such partners as counties, state government, payers, the Department of Health Care Services, the Department of Managed Care, and stakeholders in the public health system to bring new perspectives and authorities to address systemic issues facing society. The speaker offered to share the data collected by the CHA.

Dr. Kazan supported BJ Bartleson's statement that hospitals and the EMS system require the collaboration of other stakeholder groups to solve the issues faced. The speaker stated the EMS is especially burdened with these issues and urged the EMS Commission to consider the most affected provider agencies when developing the stakeholder groups. The speaker suggested keeping the focus on taking immediate action to alleviate APOT delays rather than seeking to solve larger health care issues and proposed EMS take responsibility for deciding patient destination as it does in other cities such as London, England.

Kristin Thompson, Newport Beach Fire, supported the preceding comments and requested action be taken quickly to resolve the issues that are directly affecting service to emergency patients.

Ms. Lim stated comments in the Chat section indicate that the California American College of Emergency Physicians (CalACEP) and the California Association of Professional Firefighters (CAPF) volunteer to serve on the APOT committee.

9. CLINICAL CARE AND RESTRAINT OF AGITATIVE OR COMBATIVE PATIENTS

Chair Dunford tabled this item to the next meeting.

10. OPEN NOMINATIONS FOR ELECTION OF OFFICERS (MARCH 2021 – MARCH 2022)

Chair Dunford asked for nominations for Chair of the EMSA for March of 2021 to March of 2022.

Commissioner Barrow nominated Chair Dunford, Vice Chair Uner, and the two Administrative Committee positions held by Commissioners Burrows and Stangeland for another term.

Commissioner Burch nominated Commissioner Valeri as Vice Chair.

Commissioner Rodriguez nominated Commissioner Burrows as Vice Chair.

Chair Dunford closed the nominations and stated the votes will be taken at the March meeting.

11. APPROVAL OF 2022 MEETING DATES

Action: Commissioner Barrow moved approval of the 2022 meeting dates. Commissioner Rodriguez seconded. Motion carried unanimously.

12. ITEMS FOR NEXT AGENDA

No next agenda items were offered.

13. PUBLIC COMMENT

Mr. El-Morshedy read a comment from Tanir Ami, CEO of the CARESTAR Foundation, from the Chat section. Tanir Ami thanked Lou Meyer on behalf of the CARESTAR Foundation for his hard work on the community paramedicine program and stated the CARESTAR Foundation plans to help support the spread of the community paramedicine model across the state in the years to come.

14. ADJOURNMENT

Commissioner Hartwig urged the Director to reengage the stakeholders that are not part of the process in order to develop the right regulations under Chapter 13.

Commissioner Smith stated appreciation for Sean Trask's service and that he will be missed.

Chair Dunford congratulated Mr. Trask on his retirement and wished him the best on behalf of the Commission.

There being no further business, the meeting was adjourned at 1:30 p.m.

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 March 2021 – Item #3A**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>1. Ambulance Strike Team (AST) – Medical Task Force (MTF)</p>	<p>Michael Frenn, ext. 435</p>	<p>EMSA manages the statewide AST program and collaborates with local EMS Agencies and ambulance providers to support California during emergencies. To advance the program, EMSA has convened an AST workgroup to help EMSA develop appropriate revisions to the program. The modifications include further development of the AST Leader program and curriculum, effective utilization of the Disaster Medical Support Units (AST resupply and Leader vehicle), command and control during deployments, and overall program updates. The workgroup began work in late 2019 but has since been on hold due to the COVID response.</p> <p>The AST program proved critical during the 2020 COVID and Wildfires response. ASTs were heavily engaged with COVID patient movement, fire evacuations, and support for CAL Fire operations. To date, 17 ASTs were utilized to support response activities in 2020.</p>

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 March 2021 – Item #3A**

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 significant medical disaster situations. Five Units have now been stood up: San Diego, San Francisco Bay Area, Orange County, Sacramento, and Central California. Efforts to stand up a unit in Los Angeles are underway.</p> <p>CAL-MAT supported the COVID-19 activities beginning in March. EMSA deployed over 800 CAL-MAT members, some multiple times (2,500 individual member deployments) to support 89 missions throughout the State, including 1 quarantine site, 4 ACS, 2 FMS, 1 medical shelter, 57 Long-term Care Facilities, and 24 Cal Fire Base Camps.</p> <p>To meet the statewide needs in 2020, EMSA expanded the program from less than 200 members to over 1,000 members. Additionally, there are approximately 1,500 potential members that EMSA is currently vetting for CAL-MAT membership. However, with the program growth, EMSA is faced with many new challenges to maintain the program effectively. Some of the challenges include having the resources (funding and staffing) to effectively manage the program, provide continuing training for members, and update equipment and supply caches to support the expanded program and new statewide expectations.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
March 2021 – Item #3A**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
3. CAL-MAT Cache	Markell Pierce, ext. 1443	The three CAL-MAT Caches were all deployed for the COVID-19 response and utilized Statewide to support 89 CAL-MAT missions. One CAL-MAT cache has been 100% accounted for and redeployed to support a new COVID-19 surge in Imperial County. The two remaining caches are currently undergoing resupply. The various caches of medical supplies, biomedical equipment, and pharmacy are being refined with future disaster deployments in mind. Procurements of new medical technologies continue to be implemented to update the CAL-MAT cache response capabilities. Subsequent resupplies will continue to follow the pre-established bi-annual schedule.
4. California Public Health and Medical Emergency Operations Manual (EOM)	Kelly Coleman, ext. 726	All EOM materials are posted on the EMSA website at https://emsa.ca.gov/plans/ . The Regional Disaster Medical and Health Specialists (RDMHS) continue to conduct EOM training on an ongoing basis. The EOM workgroup meetings have been postponed throughout 2020 due to COVID-19 response.
5. California Crisis Care Operations Guidelines	Kelly Coleman, ext. 726	Development is on hold until funding is made available.

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 March 2021 – Item #3A**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>6. Disaster Healthcare Volunteers (DHV) of California (California’s ESAR-VHP program): Registering, Credentialing, & Mobilizing Health Care Personnel</p>	<p>Lauran Molina, ext. 466</p>	<p>The DHV System has over 102,000 volunteers/personnel registered. The number of volunteers has nearly quadrupled since the COVID-19 pandemic began. At the direction of the CA Governor’s Office, the DHV System was temporarily redirected for mass hiring of paid medical professionals to support California’s response efforts to the COVID-19 pandemic. On March 30, 2020, the Governor gave a press release discussing the mass hiring of medical professionals to the California Health Corps. Health Corps hires are paid positions by the State of California. There are over 62,000 personnel registered in the California Health Corps within the DHV System. All personnel registered for the California Health Corps were provided the opportunity to join the DHV County Unit, Medical Reserve Corps (MRC) Unit, and California Medical Assistance Team (CAL-MAT).</p> <p>There are 49 healthcare occupations filled by registered responders. Over 20,000 of the 102,000 plus DHV registered responders are accepted/pending Medical Reserve Corps (MRC) members. EMSA trains and supports DHV System Administrators in each of the 30 participating MRC units.</p> <p>All 58 counties have trained DHV System Administrators in their MHOAC Programs. EMSA provides routine training, DHV User Group Webinars, and system drill opportunities for all DHV System Administrators every quarter. However, some of these items are on hold due to the COVID-19 pandemic.</p> <p>EMSA publishes the “DHV Journal” newsletter for all volunteers on a tri-annual basis. The Winter DHV journal is scheduled to be released March 2021. 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
 March 2021 – Item #3A**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>7. Training</p> <p>Weapons of Mass Destruction (WMD)</p> <p>Medical Health Operations Center Support Activities (MHOCSA)</p>	<p>Markell Pierce, ext. 1443</p> <p>Kelly Coleman, ext. 726</p>	<p>The WMD course is currently on hold due to the COVID-19 response. EMSA plans to continue offering the course in 2022.</p> <p>The course will be offered on a continuous basis, requiring a minimum enrollment of 12 students.</p> <p>Medical Health Operations Center Support Activities (MHOCSA) training classes were conducted in early 2020. However, since March 2020, due to COVID-19 response, no additional MHOCSA courses have been conducted.</p>
<p>8. 2019 Statewide Medical and Health Exercise (2019 SWMHE)</p>	<p>Kelly Coleman, ext. 726</p>	<p>The 2020 Statewide Medical and Health Exercise (SWMHE) was canceled due to COVID-19 response. The exercise planned for 2021 is still to be determined.</p>
<p>9. Hospital Available Beds for Emergencies and Disasters (HAvBED)</p>	<p>Kelly Coleman, ext. 726</p>	<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 continue integrating hospital data collection for California use.</p>

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 March 2021 – Item #3A**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>10. Hospital Incident Command System (HICS) hics@emsa.ca.gov</p>	<p>Craig Johnson, ext. 4171</p>	<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 developing, implementing, and maintaining EMSA's HICS program and activities.</p> <p>The HICS National Advisory Committee did not meet in 2020 due to the COVID response. EMSA is hoping to resume activities late 2021. The focus moving forward is to identify best practices and lessons learned from hospital utilization during the COVID response. Additionally, EMSA will work with the committee to increase statewide HICS participation.</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>
<p>11. Mission Support Team (MST) System Development</p>	<p>Michael Frenn, ext. 435</p>	<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>The MST program was utilized heavily during the COVID response. The effectiveness of the program enabled critical field logistical support for the deployed EMSA medical teams. To date, the program supported 89 medical missions to support the COVID-19 and 2020 wildfire responses. EMSA also grew the program membership during the COVID response to meet statewide needs. EMSA added hundreds of new members and established just-in-time training programs. Moving forward, EMSA will focus on program improvements from lessons learned and identified gaps.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
12. Response Resources	Markell Pierce, ext. 1443	<p>The Mission Support Team (MST) caches and the California Medical Assistance Teams (CAL-MAT) caches were deployed for the COVID-19 pandemic response and are undergoing resupply and modification.</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 of 24 DMSUs were conducted during this time. EMSA plans to complete the remaining DMSU audits by the end of the year.</p> <p>Inventory of the pharmacy caches and replacement of expired items is completed monthly. The caches were used heavily during the COVID-19 and 2020 Wildfire response and have been revamped based on lessons learned.</p>
13. Information Technology	Rick Stricklin, ext. 1445	<p>EMSA continues to address key shortfalls within the EMSA Department Operations Center (DOC) and the newly acquired EMSA Station 4. IT and communications upgrades and response configurations are being implemented to provide full disaster response functionality during activations.</p> <p>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. EMSA has completed the upgrade of VSAT on the C3.</p> <p>EMSA continues to develop relationships with allied agencies and NGO to improve radio interoperability to include the implementation of the Shared Resources High Frequency Radio Program (SHARES) and California Radio Interoperability System (CRIS). Procurements of critical information technology and communications equipment for 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)
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>14. Mobile Medical Shelter Program (MMSP)</p>	<p>Bill Hartley, ext. 1802</p>	<p>Working with other state agencies and within existing resources, EMSA 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> <p>During the COVID response, EMSA deployed 40 mobile medical structures to support medical surge at hospitals and other treatment sites. Also, EMSA worked with Local EMS Agencies to deploy four of the six Mobile Medical Shelter Modules (each module includes six structures plus durable equipment) EMSA placed strategically around the State with local partners. EMSA also provided just-in-time training for local partners on set-up, utilization, and teardown of the structures.</p> <p>The previous MFH structures, now configured for sheltering and other multiuse support, proved extremely beneficial during the 2020 COVID response. EMSA will continue to maintain the structures for future use.</p>

**Emergency Medical Services Authority
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>15. Regional Disaster Medical/Health Specialists (RDMHS) Program and Medical Mutual Aid System</p>	<p>Jody Durden, ext. 702</p>	<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.</p> <p>EMSA and CDPH conducted the RDMHS quarterly meeting in October 2020. During the meeting, we discussed current COVID and Wildfire response efforts and identified program strengths and weaknesses. The addition of one RDMHS per mutual aid region was lauded as a huge success. We also focused on ideas to improve communications around situation reporting and resource requesting.</p>
<p>16. Medical Reserve Corps (MRC)</p>	<p>Lauran Molina, ext. 466</p>	<p>Thirty (30) 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 are active participants in quarterly DHV Drills and DHV User Group webinars. Over 20,000 of the 102,000 plus DHV registered responders are accepted/pending Medical Reserve Corps (MRC) members.</p> <p>The MRCs have been crucial in California’s COVID-19 response efforts There has been over 1,000 individual MRC volunteers deployed for COVID-19 pandemic response and medical support across the state. MRCs have deployed in approximately 20 counties, volunteering their time and skills in COVID-19 vaccination clinics, COVID-19 testing sites, COVID-19 hotlines, contact tracing, patient care, alternate care site support, operation center support., etc. MRCs are comprised of Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Licensed Vocational Nurses, Emergency Medical Technicians, Paramedics, Medical Assistants, retired medical personnel, non-medical support staff, etc. During the COVID-19 pandemic, California MRC Units have more than doubled in size. MRC’s continue to support California’s healthcare and emergency response systems as urgent needs arise across the state.</p>

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
17. Statewide Emergency Plan (SEP) Update	Brad Gates, ext. 4728	The California Governor’s Office of Emergency Services (Cal OES) released the SEP 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 were conducted in September 2019. The rewrite is in its final review and will be published soon. Cal OES came back with edits to the Public Health / Medical annex; these edits are under review pending final approval by CDPH and EMSA.

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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 (RDMHS), Medical Health Operational Area Coordinator (MHOAC), Emergency Support Functions, Cal OES, California Department of Public Health (CDPH), California Department of Healthcare Services (CDHS), the Assistant Secretary for Preparedness and Response (ASPR), and the Federal Emergency Management Agency (FEMA) to update the Public Health and Medical Fact Sheet, Survivor Movement plan, Mass Care Plan, Shelter Fact Sheet and Course of Action. Final review and approval is on hold due to the COVID response.
19. Patient Movement Plan	Kelly Coleman, ext. 726	The California Patient Movement Plan was released in November 2018 and can be found at https://emsa.ca.gov/plans/ . The Plan was utilized extensively during the COVID response (over 5,700 patient transports). In particular, the Plan proved beneficial in providing direction as EMSA worked with local partners to transport 650 COVID patients out of Imperial County. Moving forward, EMSA will work with partners to update the Plan based on lessons learned from the current response.
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. There have been no Plan activities in 2020 due to the COVID response. EMSA will continue to socialize the Plan in 2021.
21. Northern California Catastrophic Flood Response Plan	Kelly Coleman, ext. 726	EMSA worked with the Governor’s Office of Emergency Services (Cal OES) to develop 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. The Plan is posted on the Cal OES website. There have been no Plan activities in 2020 due to the COVID response. EMSA will continue to socialize the Plan in 2021.

**Emergency Medical Services Authority
Office of Health Information Exchange (OHIE)
Major Program Activities
March 17, 2021 – Item #3A**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
HITEMS Grant	Leslie Witten-Rood	<p>On July 1, 2018, EMSA was awarded Federal funding through an Interagency Agreement with the California Department of Public Health (CDPH) for the development of health information exchange and interoperability for +EMS SAFR and PULSE. EMSA was awarded up to \$36 million in federal funding, which requires \$4 million in the Non-Federal match. On February 27, 2020, EMSA was awarded additional matching funds for \$1.5 million from CARESTAR Foundation on February 27, 2020. This brings EMSA matching fund total to \$3,665,000 million enabling EMSA to draw down \$33 million of federal funding, which provides EMSA expenditure authority for \$36,665,000 for the HITEMS Project to be spent by September 30, 2021.</p> <p>Matching Fund Source:</p> <ul style="list-style-type: none"> • CARESTAR Foundation \$2.5 million • EMSA General Fund \$1 million • San Mateo County Special Funds \$100,000.00 • Santa Cruz County Special Funds \$40,000.00 • California Health Care Foundation (CHCF) \$25,000
+EMS SAFR	Leslie Witten-Rood	There are five (5) +EMS Awardees who have been granted a total of \$14 million and will conclude their contract 9/30/2021. All Awardees are on target with their milestones.
PULSE	Leslie Witten-Rood	<p>In March of 2020, EMSA deployed the Office of Health Information Exchange (OHIE) PULSE Team to train CAL-MAT medical staff deployed at multiple Field Medical Stations in California. The OHIE staff traveled to Riverside, Imperial, San Mateo, Tulare, Orange, and Sacramento Counties, where EMSA Medical Teams CAL-MAT and Health Corps were treating COVID Patients. HIE staff created innovative solutions to train medical staff on PULSE while ensuring social distancing and other safety measures were used. A just-in-time training was designed and posted on the EMSA website so that medical providers could have access to the training and user guide 24/7. The training was also conducted for providers virtually by the HIE Staff. EMSA has trained an additional 250 medical providers in person on PULSE during the Pandemic. EMSA deployed PULSE on August 9, 2020, in response to the California Wildfires. PULSE was deployed at one medical shelter staffed by CAL-MAT in Santa Cruz County at the Watsonville Fairgrounds. During the deployment, OHIE</p>

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Office of Health Information Exchange (OHIE)
Major Program Activities
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>Team was asked to train CAL-MAT Teams supporting the firebase camps on the PULSE system. Onsite training was conducted at three fire camps — Monterey County in Salinas, Santa Cruz County in Scotts Valley, and in Santa Clara County at the Pleasanton Fairgrounds. The fire camps supported by EMSA provide care for firefighters working the fires in our state. PULSE was instrumental in delivering our CAL-MAT teams with past medical histories of the firefighters who were receiving medical care from CAL-MAT teams. PULSE was instrumental in providing history on the patients' medication and allergies that were essential in treating multiple cases of severe poison oak exposure that many firefighters were struggling with. During this 2-day deployment, the OHIE team trained an additional 30 medical providers on PULSE.</p>
POLST	Leslie Witten-Rood	<p>EMSA awarded all applicants who request funding to add an POLST Alert and POLST Registry connection to a +EMS SAFR System. The following received awards: Manifest Medex (\$278,240.00), San Diego Health Connect (\$379,300.00), and San Mateo County (\$189,150.00).</p>

**Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
March 17, 2021 – Item #3A**

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
1. First Aid Practices for School Bus Drivers	Joseph Bejarano	<ul style="list-style-type: none"> • EMSA approved nine (9) School Bus Driver training programs. • EMSA is currently reviewing one (1) program. • EMSA continues to provide technical assistance to school staff, school bus drivers, the CHP, and the California Department of Education.
2. Child Care Provider First Aid/CPR Training Programs	Joseph Bejarano	<ul style="list-style-type: none"> • EMSA approved sixteen (16) First Aid/CPR programs. • EMSA is reviewing six (6) programs. • EMSA continues to provide technical assistance to training program instructors and directors, licensing staff, childcare providers, and other training entities. • Course completion sticker sales are ongoing. • In response to COVID-19, EMSA is allowing programs to provide the lecture portions of the training through a virtual classroom setting that has real-time interactions with the instructor.
3. Child Care Preventive Health Training Programs	Lucy Chaidez	<ul style="list-style-type: none"> • EMSA approved thirty-seven (37) preventive health and safety practices training programs. • EMSA is reviewing seven (7) programs. • EMSA continues to sell course completion stickers. • EMSA continues to provide technical assistance to the public and the Department of Social Services Community Care Licensing, California Department of Public Health, and California Department of Education.
4. Child Care Training Provider Quality Improvement/Enforcement	Lucy Chaidez	<ul style="list-style-type: none"> • EMSA continues to revise Chapter 1.1. • EMSA has no complaint cases involving EMSA-approved training programs at this time.

**Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
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Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
5. Automated External Defibrillator (AED) Requirements for EMT's, Public Safety and Layperson	Austin Trujillo	<ul style="list-style-type: none"> • EMSA approved four (4) public safety AED programs. • EMSA approved three (3) EMT AED services provider programs. • EMSA provides ongoing technical support and clarification to public safety agencies, LEMSAs, and the general public regarding AED statutes and regulations.
6. BLS Training and Certification Issues	Austin Trujillo	<ul style="list-style-type: none"> • EMSA continues to support and provide technical assistance to EMTs, AEMTs, EMS applicants, and 68 certifying entities on topics including but not limited to: <ul style="list-style-type: none"> • EMT, AEMT, and central registry regulations. • EMT enforcement processes. • Training program approvals. • EMR vs public safety clarifications.
7. State Public Safety Program Monitoring	Austin Trujillo	<ul style="list-style-type: none"> • EMSA approved four (4) public safety first aid/CPR training programs. • EMSA approved two (2) EMT training programs. • EMSA approved two (2) EMT refresher training programs. • EMSA approved six (6) continuing education provider programs. • 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. • EMSA provides ongoing support and technical assistance to the LEMSAs and all statewide public safety agencies.

**Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
March 17, 2021 – Item 3A**

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
8. My License Office/ EMT Central Registry Audit	Betsy Slavensky	<ul style="list-style-type: none"> • EMSA monitors the EMT Central Registry to verify that the 68 certifying entities are in compliance with the California Code of Regulations regarding: <ul style="list-style-type: none"> • Data entry requirements. • Correct certification processes. • EMSA continues to provide ongoing support and technical assistance to certifying entities on the Central Registry and application of regulations. • In response to COVID-19, EMSA has released a number of policies addressing the Governor’s Executive Orders. These policies: <ul style="list-style-type: none"> • Guide the continued training and certifications of all levels of EMS personnel. • Are located on EMSA’s COVID-19 webpage.
9. Epinephrine Auto-injector Certification	Jeffrey Hayes	<ul style="list-style-type: none"> • EMSA processed and issued twenty-four (24) applications for epinephrine certification. • EMSA continues to provide technical assistance to the general public interested in certification.
10. Epinephrine Auto-injector Training	Austin Trujillo	<ul style="list-style-type: none"> • EMSA approved seventeen (17) training programs. • EMSA continues to provide technical assistance, renew training program certifications, and monitor training programs to ensure regulatory compliance.
11. Hemostatic Dressings	Lucy Chaidez	<ul style="list-style-type: none"> • EMSA approved three (3) hemostatic dressings for use in the prehospital setting.

**Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
March 17, 2021 – Item 3A**

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
12. Paramedic Licensure	Kim Lew	<p>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:</p> <ul style="list-style-type: none"> • 259 Initial In-State applications, • 27 Initial Out-of-State applications, • 2,698 Renewal applications, • 59 Reinstatement applications. • EMSA received sixty-five (65)% of the applications through the online licensing system. <p>EMSA has issued a total of 127 Active-restricted paramedic licenses (35 in the past quarter) for paramedic program graduates completing the NREMT psychomotor exam at a delayed date due to the COVID-19 pandemic. 52 remain in Active-Restricted status. These licensees have until 06/30/21 to provide EMSA with proof of successfully passing the exam.</p>
13. Dept. of Child Support Services (DCSS) System	Kim Lew	DCSS temporarily discontinued use of its State License Match System (SLMS) for reporting and requesting EMSA licensure action against licensees in arrears for child support during the COVID-19 pandemic.

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
March 17, 2021**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
1. Trauma	Elizabeth Winward ext. 460	<p><u>State Trauma Advisory Committee (STAC):</u> The State Trauma Advisory Committee met through video conferencing on February 9, 2021. STAC members provided updates on the effects of COVID-19 on regional trauma systems and provided direction to EMSA on holding a 2021 Trauma Summit with Zoom as the platform. The next STAC meeting is being scheduled for May 2021.</p> <p><u>2021 Trauma Summit</u> Due to the COVID-19 Pandemic, EMSA will not hold an in-person Trauma Summit in 2021. EMSA staff are in the process of identifying a date for an online Trauma Summit. Topics and presenters will be identified and vetted through the STAC.</p> <p><u>Annual Trauma Plan Status Updates</u> Several LEMSAs are overdue for submission of trauma plan status updates due to the COVID-19 emergency response efforts in their counties. LEMSAs are being accommodated in their requests for extensions due to COVID-19.</p> <p><u>Trauma Regulations</u> The workgroup meeting scheduled for December 15, 2020 was cancelled due to the surge in COVID-19 cases across California. The workgroup will resume meeting once COVID-19 cases decrease and workgroup members are able to participate.</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. Zoom/teleconference meetings are scheduled through 2021.</p>
2. STEMI/Stroke Systems of Care	Farid Nasr, ext. 424	<p><u>STEMI and Stroke Programs Plan Submission</u> EMSA staff continues to provide technical assistance to LEMSAs for either updating their annual plan or developing an initial Stroke and STEMI system of care plan for submission. There has been a delay in LEMSAs annual plan update submissions for the STEMI and Stroke system due to the COVID-19 pandemic.</p>

**Emergency Medical Services Authority
EMS Systems Division
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p><u>STEMI and Stroke Technical Advisory Committee</u> The Stroke and STEMI Technical Advisory Committee resumed work on their projects and meet on a regular basis via Zoom. EMSA is planning to conduct the first State STEMI and Stroke Summit virtually on June 8 - 9, 2021. This will provide education on current trends for optimal care, newest technology, and best practice on both aspects of clinical and system management of care for STEMI and Stroke patients with the purpose of increasing the level of care and reducing morbidity and mortality for STEMI and Stroke patients. EMSA is planning and organizing the Summit with the help of STEMI and Stroke TAC Summit Subcommittee.</p>
3. EMS Transportation	Laura Little, ext. 412	<p><u>Competitive Processes for Ambulance Zones</u> Consistent with Health & Safety Code Section 1797.224, competitive processes for Exclusive Operating Areas continue to go through a state review process to ensure they meet Federal and Statutory requirements.</p> <p><u>EMS Plan Review</u> EMS response and transportation data is submitted with each LEMSA's EMS plan. When EMS plans are submitted, the transportation data is compared with data submitted from the prior years. The data from each LEMSA EMS Plan is captured as a snapshot of EMS delivery in California and placed on EMSA's website for public viewing.</p> <p><u>EMS Plan Appeals</u> Continue to review previous EMS Plan submissions, correspondence, conduct public records requests, review historical documentation to map out issues under appeal, and attend appeal hearings for support.</p> <p><u>Technical Assistance</u> The EMS Transportation Coordinator continues to handle all calls and queries related to competitive processes, statutes, regulations, operating areas (exclusive and non-exclusive), prehospital aeromedical vehicles, and EMS transportation.</p>
4. Poison Center Program	Lisa Galindo, ext. 423	<p><u>Contract</u> An executed contract between EMSA and CPCS is in effect from July 1, 2019 through June 30, 2021. The following contract is in development.</p>

**Emergency Medical Services Authority
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p><u>Quarterly Report</u> The CPCS Quarterly Report consists of data and narrative reports, including a summary of activities that have been accomplished during the quarter. The 2nd quarter report, October 1 – December 31, 2020, was received and no concerns were identified.</p> <p><u>Site Visits</u> Site visits have been postponed due to the COVID-19 pandemic.</p>
5. EMS Plans	Lisa Galindo, ext. 423	<p><u>EMS Plan Review</u> EMSA continues to review EMS Plans as they are submitted by LEMSAs; 10 EMS Plans are currently under review. In 2020, 13 EMS Plans were approved and 2 EMS Plans were denied.</p> <p><u>Technical Assistance</u> Technical assistance is provided to LEMSAs, as needed, on the EMS Plan development and submission process.</p> <p><u>Contract</u> Executed contracts are in effect with six multicounty EMS agencies for Fiscal Year July 1, 2020 through June 30, 2021. State General Fund assistance is provided to assist these LEMSAs in the planning, organization, implementation, and maintenance of their EMS systems.</p> <p><u>Quarterly Report</u> Multicounty Quarterly Reports consist of a detailed description of work performed, the duties of all parties, and a summary of activities that have been accomplished during the quarter relevant to the eight EMS system components identified in statute. The 2nd quarter reports, October 1 - December 31, 2020, were received from six LEMSAs and no concerns were identified.</p> <p><u>Site Visit</u> Site visits have been postponed due to the COVID-19 pandemic.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
6. EMS for Children Program	Heidi Wilkening, ext. 556	<p><u>Educational Forum</u> Following a successful 2020 virtual EMSC Educational Forum, EMSA has decided to continue the virtual platform. The next event is tentatively scheduled for November 4, 2021 via Zoom, and EMSA is also planning smaller virtual trainings throughout the year.</p> <p><u>EMSC Surveys</u> The 2021 EMSC survey opened on January 6, 2021 and will close mid-March 2021. Currently, California has a 4.2% response rate. The low response rate was expected due to COVID-19 activities throughout California.</p> <p>The NPRP Assessment that was scheduled to open June 2020 is still anticipated to launch the week of May 3, 2021 and anticipated to close the week of July 26, 2021.</p>
Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
7. CEMSIS Trauma	Elizabeth Winward, ext. 460	<p>There are 27 LEMSAs with designated trauma centers. Trauma Centers are physically located in 38 of the 58 counties. One LEMSA is not transmitting data in any form to CEMSIS.</p> <p>All but two LEMSAs have submitted trauma data for 2019. Several LEMSAs have not completed submissions of 2020 trauma data. EMSA staff are providing technical assistance to any LEMSA experiencing difficulties with data submissions.</p>
8. CEMSIS RDS I	Victoria Lupinetti, ext. 622	<p>The pilot project for matching trauma and EMS data for patients admitted to UC Davis Medical Center (UCDMC) has been published on EMSA's website. EMSA is attempting to increase the patient match rate for records in CEMSIS and the ImageTrend Patient Registry by validating and reviewing the records for accuracy and completeness. The successful match rate for UCDMC records for June 2019 is roughly 58% with a goal of at least 75-90% in current and future data linkage attempts. Efforts have now shifted to matching EMS data to trauma data for the first half of 2019 (January 1 to June 30, 2019) for Riverside Community Hospital.</p>

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		<p>Currently, the successful match rate is roughly 64%. EMSA is also attempting to link EMS patient records from data platforms (i.e. SWITRS, OTS, Biospatial), which will add more robust data to the analyses.</p> <p><u>Reports</u> Currently conducting weekly trend reports related to statewide COVID-19 respiratory symptoms in the CEMSIS database. Concurrently conducting monthly reports on other primary symptoms such as shortness of breath, fever, fatigue, cough, etc. Additional reports on the success of EMS and trauma patient record matching is in development, but progress is impacted by COVID-19 activities. Reports include: submission rates by EMS agencies, patient demographics, geographic indicators, response times, and an overview of the study methodology. Recently, we acquired SAS licenses and will be creating more in-depth statistical analyses pertaining to COVID-19 and various other health and EMS-related situations.</p>
9. CEMSIS EMS Data	Ashley Stewart, ext. 910	<p>As of February 2021, CEMSIS has received over 3.7 million records for 2018, over four million records for 2019, almost four million records for 2020, and already over four hundred thousand for 2021 in Version 3.4. Once the final LEMSA onboards and all 911 EMS providers submit data, CEMSIS will have approximately 6 million records each year.</p> <p><u>Reports</u> The CY 2019 EMS Annual report is currently in its final approval stage, and the CY 18/19 Trauma Report is currently in development; however, both the annual report and the trauma report will be delayed due to COVID-19.</p>
10. Communications	Heidi Wilkening, ext. 556	<p>Due to COVID-19 response activities, EMSA personnel are still attending virtual meetings. Applications for the communications coordinator position have been collected and interviews are expected to occur soon.</p>
11. Core Quality Measures	Michelle McEuen, ext. 1925	<p>EMSA released the 2019 California Core Quality Measures Instruction Manual on August 3, 2020. All 33 Local EMS Agencies (LEMAs) were contacted to provide core quality measure information to EMSA by October 9, 2020. 26 of the 33 LEMAs provided a formal response and reported data for at least one measure for the 2019 reporting calendar year. Most participating LEMAs (24 of 26) reported data for 10 of</p>

**Emergency Medical Services Authority
EMS Systems Division
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>the 10 measures. The remaining LEMSAs failed to provide any response to the request.</p> <p>The annual Core Quality Measures Report for 2019 has been drafted and is currently pending review for publication. The Core Quality Measures workgroup met via Zoom on January 28, 2021, to discuss project improvements and revisions to the measure specifications sheets. EMSA is currently in the process of compiling the recommendations and incorporating the changes into the instruction manual for 2020 reporting.</p>
<p>12. Grant Activity/Coordination/ Maddy EMS Fund report</p>	<p>Lori O'Brien, ext. 3679</p>	<p><u>Health Resource Services Administration (HRSA) Grant:</u> The annual Non Competing Continuation Progress Report was submitted on December 16, 2020.</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. Work on the SFY 21/22 State Plan is in progress using the new national Healthy People 2030 objectives.</p> <p><u>Maddy EMS Fund Reporting</u> SFY 18/19 Maddy EMS Fund report submissions have been received from 32 counties to date. Due to the COVID-19 Pandemic, all counties were given an extension of the deadline for report submission. Reports are now due 45 days after the end of the declared state of emergency. Because of this extension, 19 counties have not yet submitted their reports for SFY 18/19, and subsequently the report to the legislature has not yet been developed.</p>

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March 17, 2021**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>13. Ambulance Patient Offload Time (APOT)</p>	<p>Adam Davis, ext. 409</p>	<p>In July 2019, EMSA notified all LEMSAs of the new APOT reporting requirements pursuant to Health and Safety Code 1797.225. EMSA received APOT 1 and APOT 2 submissions from 32 of 33 LEMSAs, and one LEMSAs failed to provide any submissions. 29 of 33 LEMSAs provided a submission for quarter four of 2019. As anticipated, COVID-19 has significantly impacted APOT reporting for quarter one and two of 2020. To date, only 26 LEMSAs provided a submission for quarter one of 2020. 27 LEMSAs have provided a submission for quarter two of 2020. Only 25 LEMSAs have provided a submission for quarter three of 2020. Only 17 LEMSAs have provided a submission for quarter four of 2020. EMSA continues to develop CEMSIS comparison reports for LEMSAs who provide submissions to EMSA and who are participating in CEMSIS.</p> <p>EMSA staff continue to monitor the impact of COVID-19 on local EMS systems through the analysis of CEMSIS data related to APOT.</p> <p>Pursuant to Health and Safety Code 1797.123, EMSA has fulfilled both statutory requirements to report bi-yearly to the EMS Commission and submit a legislative report on or before December 1, 2020. The legislative report is the product of a year-long collaborative effort by EMSA and LEMSAs to understand factors impacting APOT and to develop recommendations on how best to decrease delays statewide.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
March 17, 2021**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
Management Services (Office Support)	John Skarr	<p><u>Support in Out of State Medical Licensure in State of Emergency</u></p> <ol style="list-style-type: none"> 1. Assisted personnel team in approving and denying requested temporary out of state medical license. <p><u>Support Personnel in Licensure</u></p> <ol style="list-style-type: none"> 1. Send approval letters & license cards to paramedics and EMTs 2. Send deficiency letters to individuals who need further documentation to become approved in the State of California <p><u>Support Manager in the Hiring of a Communications Coordinator</u></p> <ol style="list-style-type: none"> 1. Review candidates' applications utilizing a screening tool to score their applications <p><u>Support EMSA DOC operations</u></p> <ol style="list-style-type: none"> 1. Acted as Planning Coordinator 2. Participated in Logistics of EMSA Materials 3. Assisted in sending Ventilators to sites throughout the State & New York <p><u>Support Administrative Division in onboarding new members for the Health Corps Program</u></p> <ol style="list-style-type: none"> 1. Deliver materials to different sites 2. Check-in individuals as they arrive 3. Complete medical scan of individuals 4. Obtain documentation 5. Provide assistance to HR staff in the on-boarding procedures 6. Clean and organize materials for secondary sight <p><u>Support Management in communications with LEMSAs</u></p> <ol style="list-style-type: none"> 1. Scribe meetings as necessary 2. Take notes on actionable information 3. Learn how to effectively work with EMS Stakeholders <p>Supported all Systems staff as needed daily</p>

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DATE: March 17, 2021 **Item #4A**

TO: Commission on EMS

FROM: Dave 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:****2021-22**

The Governor's Proposed Budget for 2021-22, released in January of this year, includes expenditure authority in the amount of \$37.4 million and 74.8 permanent positions. Of this amount, \$17.7 million, or 47.3%, is delegated for State operations and \$19.7 million, or 52.7%, is delegated to local assistance. The following budget adjustments are included in the proposed budget:

- EMSA is requesting ongoing \$365,000 local assistance General Fund to improve regional disaster medical and health mitigation, preparedness, response, and recovery by funding three additional Regional Disaster Medical Health Specialists (RDMHS) within the six Cal OES Mutual Aid Regions.
- EMSA is requesting \$286,000 General Fund ongoing and two permanent positions to meet the increased workload within the Office of Legislative, Regulatory, and External Affairs (LEA) and the Legal Office associated with mandated reporting tasks, AB 434 compliance, and creation of content and ongoing workload associated with implementation of EMSA's intranet.
- EMSA is requesting \$2.3 million General Fund over three years beginning in 2021-22 to implement Chapter 138, Statutes of 2020 (AB 1554). AB 1544

creates the Community Paramedicine or Triage to Alternate Destination Act of 2020, which would authorize a local emergency medical services agency (LEMSA) to develop and seek approval for a program that provides the various community paramedic or triage paramedic services.

2020-21

The 2020-21 California State budget includes expenditure authority in the amount of \$89.4 million and 79 permanent positions. Of this amount, \$70.1 million is delegated for State operations and \$19.3 million to local assistance. State operations funding was increased \$53.3 million to provide critical Statewide emergency medical staffing and support during the COVID-19 pandemic.

As of February 16, 2021, accounting records indicate that the Department has expended and/or encumbered \$63.4 million, or 70.9%, of available expenditure authority. Of this amount, \$48.4 million, or 69%, of State Operations expenditure authority has been expended and/or encumbered and \$15 million, or 77.5%, of local assistance expenditure authority has been expended and/or encumbered.

We are continuing to monitor and adjust both State operations and local assistance budgets to meet changing program priorities. An updated report will be distributed prior to the next meeting of the Commission on EMS.

EMSA Staffing Levels:

The Department staffing level includes 79 permanent positions and 19 temporary (blanket and retired annuitant) positions. Of the 98 positions, 10 positions are vacant as of February 16, 2021.

	Division				
	Admin/Exec	DMS	EMSP	EMS	Total
Authorized	25.0	18.0	22.0	14.0	79.0
Temporary Staff	14.0	3.0	0.0	2.0	19.0
Staffing Level	39.0	21.0	22.0	16.0	98.0
Authorized (Vacant)	0.0	-3.0	-2.0	-1.0	-6.0
Temporary (Vacant)	-4.0	0.0	0.0	0.0	-4.0
Current Staffing Level	35.0	18.0	20.0	15.0	88.0

Additionally, EMSA, through the emergency hiring process, has hired and deployed approximately 439 California Health Corps members and 800 California Medical Assistance Team (CAL-MAT) members to assist with California’s COVID-19 response activities since March 9, 2020. These emergency hires have been deployed to field medical sites, alternate care sites, skilled nursing facilities, hospitals, and other locations throughout the State to provide both medical and logistical support.

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DATE: March 17, 2021 **Item #4B**

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:

*NOTE: Due to the COVID-19 pandemic, the Office of Administrative Hearings (OAH) and most courts in the state are conducting hearings only remotely through services such as Zoom, Microsoft Teams, etc.

Disciplinary Cases:

From November 5, 2020, to February 12, 2021, EMSA issued eleven new accusations against existing paramedic licenses, four statements of issues, three administrative fines, accepted five license surrenders in lieu of legal action, and issued six decisions on petitions for reduction of penalties and license reinstatements. Of the newly issued actions, three of the Respondents have requested that an administrative hearing be set. There are currently seven hearings scheduled with the Office of Administrative Hearings. There are currently twenty-two 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 has been scheduled for July 7 and 8, 2021.

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

Gurrola v. Duncan: United States District Court, Eastern District, 2:20-CV-01238-JAM-DMC Plaintiff sued for a violation of his constitutional rights, alleging a violation for being precluded under the regulations from receiving an EMT certificate due to two felony convictions. The complaint was amended to add another individual with similar claims. On February 10, 2021, the Court granted EMSA's motion to dismiss the complaint and found that the regulations barring certification to someone with two felony convictions are rationally related to the State's interest in protecting the public's health and safety.

Sacramento County EMS v. EMSA: Denial of local EMS plan that included ALS providers without ALS agreements, as is required by the regulations. EMSA has issued a Statement of Issues and is currently working to request a hearing through OAH for the appeal.

Inland Counties Emergency Medical Agency v. EMSA: Denial of local EMS plan that included ALS providers without ALS agreements, as is required by the regulations. EMSA has issued a Statement of Issues and is currently working to request a hearing through OAH for the appeal.

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DATE: March 17, 2021

Item #4C

TO: Commission on EMS

FROM: Dave Duncan MD
 Director

PREPARED BY: Alexander Bourdaniotis, Chief Investigator
 Paramedic Enforcement Unit

SUBJECT: Enforcement Report

RECOMMENDED ACTION:

Receive information on Enforcement Unit activities.

FISCAL IMPACT:

None

DISCUSSION:

Unit Staffing:

The Enforcement Unit is budgeted for five full-time Special Investigators and one full-time Associate Governmental Program Analyst (AGPA-Probation Monitor). As of January 19, 2021, the Enforcement Unit is fully staffed.

Investigative Workload:

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

Cases opened since January 1, 2021, including:

Cases opened:	28
Cases completed and/or closed:	13
EMT-Paramedics on Probation:	226

In 2020:

Cases opened:	297
Cases completed and/or closed:	292
EMT-Paramedics on Probation:	226

Status of Current Cases:

The Enforcement Unit currently has 127 cases in “open” status.

As of January 31, 2021, there are 64 cases that have been in “open” status for 180 days or longer, including 13 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 64 cases are divided among five 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. The COVID pandemic has significantly delayed the ability for Enforcement to complete cases mainly due to court closures and police department clerical staff working from home and unable to respond to subpoenas.

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DATE: March 17, 2021

TO: Commission on EMS

FROM: Dave Duncan MD
Director

PREPARED BY: Sergy (Esam) El-Morshedy
Legislative Coordinator

SUBJECT: Legislative Report

Item #5A**RECOMMENDED ACTION:**

Receive information regarding current bills potentially affecting EMS.

FISCAL IMPACT:

None

DISCUSSION:

Due to the dynamic nature of the legislative process, the Legislative Report to the Commission on EMS will be posted on the EMSA website at https://emsa.ca.gov/legislative_activity/. Copies of the printed Legislative Report will also be available at the Commission Meeting on March 17, 2021.

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DATE: March 17, 2021

TO: Commission on EMS

FROM: Dave Duncan MD
 Director

PREPARED BY: Kent Gray
 Regulations Manager

SUBJECT: Regulations Update

Item #5B**RECOMMENDED ACTION:**

Receive information regarding the status of EMS regulations.

FISCAL IMPACT:

None

DISCUSSION:

The following information is an update to the Emergency Medical Services Authority rulemaking. In accordance with Health and Safety Code Section 1797.107, the Emergency Medical Services Authority is promulgating the following regulations:

	Chapter	Status
1.1	Training Standards for Child Care Providers & Merge Chapter 1.2	Under review by the Emergency Medical Services Authority
1.5	Public Safety Personnel	Developing text and package
1.9	Lay Rescuer Epinephrine Auto-Injector Training Certificate Standards	Under review by the Emergency Medical Services Authority
4	Community Paramedicine and Alternate Destination (AB 1544)	Emergency Medical Services Authority has begun the development process.
5	Noncitizen Application Process	OAL approved. Chapter 5 is repealed.
7	Trauma Care Systems	Under review by the Emergency Medical Services Authority
10	California Emergency Medical Technician Central Registry	Under review by the Emergency Medical Services Authority
12	Emergency Medical Services System Quality Improvement	Under review by the Emergency Medical Services Authority
13	Emergency Medical Services System Regulations	Receiving input from Workgroup.
TBD	SB 438	Development to begin soon.

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DATE: March 17, 2021 **Item #6A**

TO: Commission on EMS

FROM: Dave Duncan MD
Director

PREPARED BY: Lou Meyer
Community Paramedicine Pilot Project Manager

SUBJECT: Community Paramedicine Pilot Project Status Update

RECOMMENDED ACTION:

Receive information regarding the Community Paramedicine Pilot.

FISCAL IMPACT:

The community paramedicine project manager and the independent evaluator are funded by the California Health Care Foundation (CHCF). Local pilot site providers participate with in-kind contributions and any local grants or reimbursement.

DISCUSSION:

The community paramedicine HWPP #173 has encompassed 20 projects in 14 communities across California, testing seven different community paramedicine concepts. Fourteen (14) projects are currently enrolling patients, five (5) of the projects launched in 2015 have closed for various reasons, and one (1) project has suspended operations.

Status of Pilot Projects:

With the passage of Assembly Bill 1544 (Gibson), all the active Community Paramedicine Pilot Projects have transitioned to Community Paramedicine or Triage to Alternate Destination Programs, in accordance with Division 2.5 of the Health and Safety Code, commencing with Section 1800, effective January 1, 2021.

Community Paramedicine Pilot Project Concepts and Enrollment:

- The pilot projects enrolled 10,855 persons through third quarter 2020 (see Table 1).

Community Paramedicine Pilot Project Status Update

March 17, 2021

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- Thirteen (13) pilot projects were launched from June through October of 2015.
- Seven (7) additional projects began enrolling patients in 2017, 2018, and 2019.

Five projects closed, and one suspended operation. Two post-discharge – short-term follow-up projects closed due to lack of local resources, and one suspended operation. The three alternate destination – urgent care projects closed.

Table 1. Pilot Sites, Community Paramedicine Concepts, and Enrollment through Third Quarter 2020

Community Paramedicine Concept	Lead Agency	Date Implemented	Total Patients Enrolled
Post-Discharge – Short-Term Follow-Up	Alameda City EMS	June 1, 2015	140
Post-Discharge – Short-Term Follow-Up	Butte County EMS	July 1, 2015*	1,001
Post-Discharge – Short-Term Follow-Up	San Bernardino County and Rialto Fire Depts.	August 13, 2015†	228
Post-Discharge – Short-Term Follow-Up	UCLA Center for Prehospital Care	September 1, 2015‡	154
Post-Discharge – Short-Term Follow-Up	Medic Ambulance Solano	September 15, 2015	291
All Post-Discharge –Follow-Up Projects			1,814
Frequent EMS User	Alameda City EMS	July 1, 2015	85
Frequent EMS User	City of San Diego	October 12, 2015	65
Frequent EMS User	San Francisco Fire Dept.	September 12, 2018	331
All Frequent EMS User Projects			481
Directly Observed Therapy for Tuberculosis	Ventura County EMS	June 1, 2015	52
Hospice	Ventura County EMS	August 1, 2015	422
Alternate Destination – Mental Health	Mountain Valley – Stanislaus EMS	September 25, 2015	476
Alternate Destination – Mental Health	Santa Clara County EMS	June 6, 2018	104
Alternate Destination – Mental Health	Central California EMS	July 30, 2018	4,427
Alternate Destination – Mental Health	Los Angeles Fire Dept.	June 21, 2019	86
All Alternate Dest. – Mental Health Projects			5,093
Alternate Destination – Urgent Care	UCLA Center for Prehospital Care	September 8, 2015§	12
Alternate Destination – Urgent Care	Orange County Fire Chiefs	September 14, 2015	34
Alternate Destination – Urgent Care	Carlsbad Fire Dept.	October 9, 2015	2
All Alternate Dest. – Urgent Care Projects			48
Community Paramedicine Concepts	Lead Agency	Date Implemented	Total Patients Enrolled
Alternate Destination – Sobering Center	San Francisco Fire Dept.	February 1, 2017	2,849

Community Paramedicine Pilot Project Status Update

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Alternate Destination – Sobering Center	Santa Clara County EMS	June 6, 2018	0
Alternate Destination – Sobering Center	Los Angeles Fire Dept.	June 21, 2019	96
All Alternate Dest. – Sobering Center Projects			2,945
All Projects			10,855

*Ceased enrolling patients on November 14, 2018.

†Suspended operations on September 30, 2019, due to lack of referrals from partner hospital.

‡Ceased enrolling patients on August 31, 2017.

§Ceased enrolling patients on May 31, 2017.

||Ceased enrolling patients on November 13, 2017.

Work Force Development - Community Paramedics:

One of the goals of an Office of Statewide Health Planning and Development (OSHPD) pilot project is to enhance the opportunity for growth within the health care workforce. This goal was met through the successful graduation of 143 community paramedics.

The first cohort of community paramedics consisted of 79 paramedics who were enrolled in the core curriculum and site-specific coursework during the first quarter of 2015. Two of the 79 paramedics were unable to complete the training for nonacademic reasons. All 77 paramedics who completed the core curriculum passed a written final examination, a simulated patient scenario examination, and an oral examination by the pilot site’s medical director. Since then, three sites (Solano, Stanislaus, and Ventura) have trained 12 additional community paramedics to expand their programs or replace paramedics who have left their agencies or were promoted to other positions. San Francisco trained 10 community paramedics prior to the launch of its alternate destination – sobering center pilot project in February 2017. These same 10 community paramedics serve patients enrolled in San Francisco’s frequent EMS user project, which launched in September 2018. San Francisco trained 10 additional paramedics in early 2020. Fresno and Santa Clara each trained 10 community paramedics prior to launching their pilot projects in 2018. The City of Los Angeles Fire Department trained 14 community paramedics prior to launching its two pilot projects in June 2019 (see Table 2).

Community Paramedicine Pilot Project Status Update

March 17, 2021

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Table 2. Number of Paramedics Completing Full Community Paramedic Training

Lead Agency	Community Paramedicine Concept(s)	# CPs Trained During Initial Training	# CPs Trained During Subsequent Trainings	Total # CPs Trained
Alameda City EMS	Post-Discharge – Short-Term Follow-Up and Frequent EMS User	5		5
Butte County EMS	Post-Discharge – Short-Term Follow-Up	10		10
Carlsbad Fire Dept.	Alternate Destination – Urgent Care	2		2
Central California EMS/American Ambulance	Alternate Destination – Mental Health		10	10
Los Angeles Fire Dept.	Alternate Destination – Mental Health and Alternate Destination – Sobering Center		14	14
Medic Ambulance Solano	Post-Discharge – Short-Term Follow-Up	6	12*	?
Mountain Valley – Stanislaus EMS/AMR	Alternate Destination – Mental Health	7	12*	?
Orange County Fire Chiefs	Alternate Destination – Urgent Care	4		4
San Bernardino County and Rialto Fire Depts.	Post-Discharge – Short-Term Follow-Up	14		14
City of San Diego	Frequent EMS User	8		8
San Francisco Fire Dept.	Frequent EMS User and Alternate Destination – Sobering Center		20	20
Santa Clara County EMS	Alternate Destination – Mental Health and Alternate Destination – Sobering Center		10	10
UCLA Center for Prehospital Care/Glendale & Santa Monica Fire Depts.	Post-Discharge – Short-Term Follow-Up and Alternate Destination – Urgent Care	7		7
Ventura County EMS/AMR	Directly Observed Therapy for Tuberculosis and Hospice	14	12*	?
All Sites and Projects		77	66	143

Community Paramedicine Program Effectiveness:

The community paramedicine pilot projects have demonstrated that specially trained paramedics can provide services beyond their traditional and current statutory scope of practice in California. No adverse outcome is attributable to any of these pilot projects. The projects are enhancing patients' well-being by improving the coordination of medical, behavioral health, and social services, and reducing ambulance transports, ED visits, and hospital readmissions. Most of the potential savings associated with these pilot projects accrued to Medicare and Medi-Cal and hospitals that care for Medicare and Medi-Cal beneficiaries because Medicare and Medi-Cal beneficiaries accounted for the largest share of persons enrolled in the pilot projects.

These pilot projects integrate with existing health care resources and utilize the unique skills of paramedics and their availability 24 hours per day, 7 days per week. The pilot projects have not displaced any other health professionals. Instead, they have demonstrated that community paramedics can collaborate with physicians, nurses, behavioral health professionals, and social services workers to fill gaps in the health and social services safety net. Several projects are playing important roles in their communities' response to the COVID-19 pandemic by expanding their services to include assisting with the staffing of skilled nursing facilities and hospital emergency departments as well as participating in the administration of the COVID-19 vaccine or pivoting to serve different populations. The community paramedics always operate under medical control – either directly or by protocols developed by physicians experienced in EMS and emergency care.

Research conducted to date indicates that community paramedicine programs are improving the effectiveness and efficiency of the health care system. Findings from this research also suggest that the benefits of community paramedicine programs grow as they mature, solidify partnerships, and find their optimal structure and niche within a community. The evaluation of HWPP #173 yielded consistent findings for six of the seven community paramedicine concepts tested. The post-discharge – short-term follow-up, frequent EMS user, directly observed therapy for tuberculosis, hospice, alternate destination – mental health and alternate destination – sobering center projects have improved patients' well-being and, in most cases, have potentially increased health care value by yielding potential savings for payers and other parts of the health care system. The seventh concept, alternate destination – urgent care, shows potential, but further research involving a larger volume of patients transported to urgent care centers with wider ranges of services and expanded hours is needed to draw definitive conclusions.

According to the University of California San Francisco (UCSF) Independent Evaluators, the current EMS system design is well-suited to utilize the results of these pilot projects to optimize the design and implementation of proposed programs and to ensure

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

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: March 17, 2021 **Item #6B**

TO: Commission on EMS

FROM: Dave Duncan MD
Director

PREPARED BY: Caitlyn Cranfill
Executive Division

SUBJECT: Clinical Care and Restraint of Agitative or Combative Patients

RECOMMENDED ACTION:

Discuss the clinical care and restraint of agitative or combative patients.

FISCAL IMPACT:

No fiscal impact.

DISCUSSION:

During the September 16, 2020 Commission on EMS Meeting, it was requested that discussion be held regarding excited delirium in EMS. The National Association of EMS Physicians (NAEMSP) published an article entitled Clinical Care and Restraint of Agitated or Combative Patients by Emergency Medical Services Practitioners.



National Association of EMS Physicians®

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Clinical Care and Restraint of Agitated or Combative Patients by Emergency Medical Services Practitioners

Douglas F. Kupas, MD, Gerald C. Wydro, MD, David K. Tan, MD, Richard Kamin, MD, Andrew J. Harrell IV, MD, Alvin Wang, DO

POSITION

The National Association of EMS Physicians (NAEMSP) has had a position statement on patient restraint since 2002(1), which was updated in 2017(2). This document updates and replaces these previous statements and is now a joint position statement with the National Association of State EMS Officials (NASEMSO), National EMS Management Association (NEMSMA), National Association of Emergency Medical Technicians (NAEMT) and the American Paramedic Association (APA).

The NAEMSP, NASEMSO, NEMSMA, NAEMT and APA recognize that emergency medical services (EMS) personnel frequently care for agitated, combative, or violent patients, who require clinical treatment and transportation. These situations are often complicated by alcohol use, substance use, or mental health illness. When clinical monitoring and treatment are indicated, these become health care issues.

When such encounters occur, patients, the public, and all emergency responders are at risk for injury. Furthermore, excited delirium is associated with continued patient agitation or struggling, with or without physical restraint, and is associated with hyperthermia, hyperkalemia, rhabdomyolysis, and cardiac arrest. In these severely impaired patients, rapid pharmacologic management/ sedation may prevent these adverse and life-threatening conditions and maximize patient safety.

Concerning the care of these patients, the NAEMSP, NASEMSO, NEMSMA, NAEMT and APA believe that:

- **Primary Goal:** It is of paramount importance to protect agitated, combative, or violent patients from injuring themselves while simultaneously protecting the public and emergency responders from injury.
- **Agency Protocol:** Every EMS agency should have specific protocols for dealing with an agitated, violent, or combative individual. Such protocols may be developed in consultation with EMS system administrators, EMS practitioners, legal counsel, community stakeholders, and local law enforcement representatives, but ultimately this patient-centered clinical protocol must be overseen and approved by the agency's EMS medical director. Note: The term "protocol" is used throughout this document to define a written form of oversight provided by the medical director to direct patient assessment and treatment, realizing that in some systems terms such as guidelines, standing orders, policies or procedures are used.
- **Assessment/ Clinical Treatment:** EMS practitioners must quickly evaluate the situation and resources available, often with limited information available to them. EMS practitioners must perform an appropriate patient assessment to identify and manage clinical conditions that may be contributing to a patient's agitated, combative, or violent behavior. EMS agencies should consider using an agitation score, like the Richmond Agitation Sedation Scale (RASS), as part of the assessment and reassessment of agitated patients. Agitated, combative, or violent behavior has varying presentations on a spectrum from agitated but cooperative to excited delirium with a dangerous inability to understand the situation or the dangers of their behavior. Assessment should be thorough to identify conditions causing this behavior including, hypoxia, hypoglycemia, alcohol or substance intoxication, stroke, seizure, traumatic brain injury, and excited delirium. Clinical treatment of some of these conditions may decrease agitation. EMS practitioners should consider early use of high-flow oxygen by mask as it serves to treat hypoxia in patients who are too agitated to assess pulse oximetry and preoxygenation is beneficial if the patient is sedated.

- **Patient Dignity:** Persons who lack decision-making capacity are assessed and treated with implied consent. EMS practitioners must maintain the patient's dignity to the extent possible, including use of the least restrictive method of restraint that protects the patient, the public, and emergency responders from harm. The use of appropriate de-escalation techniques should take precedence over physical restraint or pharmacologic management whenever possible.
- **Unique EMS Environment:** Compared with the controlled setting of a hospital, EMS practitioners face higher risks when caring for patients in the confined space of an ambulance or with limited resources in the field. These differences may require the use of restraint techniques and thresholds for the implementation of restraint techniques that are specifically intended for the out-of-hospital environment. These may differ from those used by health care providers within a hospital.
- **Education/Credentialing:** EMS agencies must ensure that their EMS practitioners have received education on how to identify and treat the clinical spectrum of conditions that are associated with agitated, combative, or violent behavior and that their EMS practitioners are trained to implement the principles and devices of the agency's restraint protocol during patient care. EMS practitioners should also be educated about patient reassessment. The EMS agency medical director should credential the agency's practitioners as competent in these skills.
- **Indications for Restraint:** Physical restraint and pharmacologic management/ sedation when providing EMS care are only indicated to protect a patient, the public, and emergency responders from further injury, facilitate assessment, or allow for treatment of life-threatening injury or illness. Restraint protocols should describe the clinical indications for restraining a patient. Although EMS practitioners work closely in the field with co-responders and frequently assist or are assisted by law enforcement officers, EMS practitioners must not administer sedating medications to an individual to facilitate arrest or to assist law enforcement to take the individual into custody. EMS practitioners should use the least restrictive restraint techniques to facilitate clinical patient assessment, medically indicated treatment, and safe transport to a hospital. In all circumstances, the decision about using pharmacologic management is a health care decision that must be made by the EMS practitioner with oversight by an EMS medical director.
- **Strategies and Techniques:** Restraint protocols must address the strategies, devices and techniques that will be used (verbal de-escalation, physical restraint, and/ or pharmacologic management), when each will be used, who can apply them, and if direct medical oversight must be involved. EMS agencies should ensure that all practitioners are competent in the use of any devices, techniques or medications used for restraint. Agencies should ensure that practitioners also have training in techniques of verbal and environmental de-escalation and in communication with individuals who are agitated or have a behavioral illness. Preplanning in conjunction with law enforcement agencies can facilitate appropriate and safe management of these incidents.
- **Physical Restraint:** Restraint protocols should address the type of physical restraints and techniques that are permissible for use by EMS practitioners. Any physical restraint device used must allow for rapid removal if the patient's airway, breathing, or circulation becomes compromised. Rigid restraints, such as handcuffs, should not be used by EMS providers. If the patient is handcuffed by law enforcement officers, consideration should be made to transition to the least restrictive restraints that are safe for the patient and responders. Physical restraint devices that are easily removed by practitioners without a key are preferred. However, if a patient is restrained in devices that require a key, the key must accompany the patient during treatment and transportation.
- **Prohibited Techniques:** Restraint protocols should identify restraint techniques that are expressly prohibited for use by EMS practitioners. Patients must not be restrained in a position with hands and feet tied together behind their back or restrained with techniques that compromise the airway or constrict the neck or chest. During transport on a stretcher or other transport device, patients must not be restrained in a prone position nor under backboards or mattresses. EMS practitioners must not use weapons as adjuncts in the restraint of a patient.

- **Pharmacologic Management/ Sedation:** Pharmacologic management, usually with a dissociative agent (ketamine), a benzodiazepine (for example, midazolam), butyrophenone (for example, droperidol), or a combination of these medications, is an effective method of protecting the violent or combative patient from self-injury. When pharmacologic management is required due to excited delirium or risk of serious self-injury, a medication with rapid onset is preferred to reduce the risk as quickly as possible. Neuromuscular blocking agents that paralyze individuals are not acceptable for restraint, unless they are also clinically indicated to treat an underlying medical or traumatic condition by EMS practitioners in agencies that otherwise use these agents. Medications used for pharmacologic management may cause respiratory depression, and every individual who receives pharmacologic management must be continuously monitored and treated by EMS providers. These individuals must be transported to a hospital for additional clinical assessment and treatment.
- **Reassessment:** After patient physical restraint and/or pharmacologic management, physiologic monitoring and clinical assessment/reassessment of respiratory and hemodynamic status as well as neurovascular status of all restrained extremities must be done as soon as possible and at recurring intervals.
- **Documentation:** EMS patient care reports must be completed for all patients assessed or treated by EMS practitioners. Documentation should include details of patient behavior, patient assessment, clinical indication for restraint, type of restraint intervention(s) attempted or applied, frequency of reassessment and associated exam findings, and additional care provided during transport. If an agitation score is used by the agency, the initial and repeat scores should be documented.
- **Direct Medical Oversight:** In some systems, direct medical oversight of interventions performed by EMS practitioners may be required for combative patients who refuse treatment, as well as for orders to restrain a patient (before or immediately after restraint) or for orders for pharmacologic management (before or after medication is administered). If required, EMS medical directors should determine the point at which EMS practitioners are expected to contact a physician in these situations. Clinicians providing direct medical oversight through a base station should be educated to EMS protocols and their options.
- **Quality Assurance:** Every case of physical restraint or pharmacologic management by EMS practitioners should undergo quality assurance review, with specific filters for the appropriateness of restraint for the patient, the type of restraint(s) used, the quality and frequency of physiologic monitoring, protocol compliance, and documentation compliance. States are encouraged to develop a method of tracking the use of medications for the purpose of pharmacologic management of agitated patients and to consider a statewide quality improvement plan to ensure the appropriateness of their use.
- **Scene Safety Considerations:** Law enforcement officers, whenever available, should be involved in all cases in which a patient poses a threat to themselves, the public, or emergency responders. If the practitioners are in danger of harm they should retreat to a safe place and await the arrival of law enforcement. If there is no safe option for retreat, EMS practitioners who are being physically attacked may defend themselves as permitted by local law.
- **EMS and Law Enforcement Techniques Differ:** EMS restraint protocols and interventions will differ from those of law enforcement. All agencies should recognize their roles and work cooperatively and proactively to ensure the safe care of patients assessed or treated by EMS. EMS practitioners who are legally authorized to function in a law enforcement capacity or vice versa must be particularly cognizant of their role in the encounter and ensure that their actions are commensurate to their role.
- **Assessment of Patients Restrained by Law Enforcement:** In some situations, it may be necessary for law enforcement to apply restraint techniques or technologies to individuals which are not sanctioned by EMS protocols. These individuals may also need, or may develop a need for, EMS assessment or patient care. In these cases, a law enforcement officer must remain immediately available while the EMS practitioner assesses and manages the patient based upon the EMS agency's clinical protocols. At all times, the EMS practitioner must act as an advocate for the safety, medical monitoring, and clinical care of the patient.

- **Patients in Custody:** If a law enforcement-based restraint intervention (for example handcuffs, flex cuffs) which are not sanctioned for use by EMS practitioners must be continued during patient care and transport by EMS, a law enforcement officer should either accompany the patient during transport by ambulance or the law enforcement-based restraint intervention should, when appropriate, be discontinued in favor of a sanctioned EMS-based restraint intervention. Patients who are in law enforcement custody or who are under arrest, must always have a law enforcement officer present or immediately available during EMS transport.
1. Kupas DF, Wydro GC. Patient restrain in emergency medical services systems. [Position Statement] *Prehosp Emerg Care.* 2002;6:340-345.
 2. Patient restraint in emergency medical services [Position Statement]. *Prehosp Emerg Care.* 2017;21(3):395-396.

Statement endorsed by the following organizations:



EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: March 17, 2021 **Item #7A**

TO: Commission on EMS

FROM: Dave Duncan MD
Director

PREPARED BY: Michelle McEuen
Quality Improvement Coordinator

SUBJECT: Core Quality Measures Report and Project Update

RECOMMENDED ACTION:

Receive information and updates on the Core Quality Measures Project.

FISCAL IMPACT:

None.

DISCUSSION:**Core Quality Measures Report:**

The Emergency Medical Services Authority (EMSA) engaged members from various local EMS agencies (LEMSAs) to assist in a review and revision process of the 2019 Core Quality Measures for the annual report. The workgroup currently consists of members from EMSA and Emergency Medical Services Administrators' Association of California (EMSAAC). Three workgroup meetings took place in person and virtually. EMSA compiled the recommendations from the workgroup and incorporated pertinent changes into the Core Quality Measures Instruction Manual for the 2019 reporting calendar year. Three measures were retired from the 2019 measure set due to feasibility issues, thus yielding a measure set of 10 performance indicators for systemwide measurement. For the 2019 reporting year, all 33 LEMSAs were contacted to provide core quality measure information to EMSA by a set date. 79% (26 of 33) of LEMSAs participated in the 2019 report by providing data for at least one measure. 92% (24 of 26) of participating LEMSAs reported data for 10 of the 10 measures. Participation in the annual report increased by 21% from the 2018 to 2019 reporting year. Non-reporting LEMSAs did not indicate why they were unable to report information on the measures. The 2019 Annual Core Measures report will be published in spring 2021. The workgroup will continue to meet to review and refine the Core Quality Measure set.

LEMSA Responses for the 2019 Core Quality Measures Annual Report	
Alameda County EMS	Provided a response for 10 of 10 measures.
Central California EMS	Provided a response for 10 of 10 measures.
Coastal Valleys EMS	No formal response provided.
Contra Costa County EMS	No formal response provided.
El Dorado County EMS	Provided a response for 10 of 10 measures.
Imperial County EMS	No formal response provided.
Inland Counties EMS	Provided a response for 10 of 10 measures.
Kern County EMS	Provided a response for 10 of 10 measures.
Los Angeles County EMS	Provided a response for 10 of 10 measures.
Marin County EMS	Unable to provide data by the deadline.
Merced County EMS	Provided a response for 10 of 10 measures.
Monterey County EMS	Provided a response for 10 of 10 measures.
Mountain-Valley EMS	Provided a response for 10 of 10 measures.
Napa County EMS	Provided a response for 10 of 10 measures.
North Coast EMS	Provided a response for 10 of 10 measures.
Northern California EMS	Provided a response for 10 of 10 measures.
Orange County EMS	Provided a response for 3 of 10 measures.
Riverside County EMS	Provided a response for 10 of 10 measures.
Sacramento County EMS	Provided a response for 10 of 10 measures.
San Benito County EMS	Provided a response for 10 of 10 measures.
San Diego County EMS	Provided a response for 8 of 10 measures.
San Francisco EMS	Provided a response for 10 of 10 measures.
San Joaquin County EMS	Provided a response for 10 of 10 measures.
San Luis Obispo County EMS	No formal response provided.
San Mateo County EMS	Provided a response for 10 of 10 measures.
Santa Barbara County EMS	No formal response provided.
Santa Clara County EMS	Provided a response for 10 of 10 measures.
Santa Cruz County EMS	Provided a response for 10 of 10 measures.
Sierra-Sacramento Valley EMS	Provided a response for 10 of 10 measures.
Solano County EMS	Provided a response for 10 of 10 measures.
Tuolumne County EMS	No formal response provided.
Ventura County EMS	Provided a response for 10 of 10 measures.
Yolo County EMS	Provided a response for 10 of 10 measures.

CEMSIS:

The LEMSAs run core quality measure reports from their local database and submit aggregate results to EMSA. Since each of the 33 LEMSAs maintains their own EMS database and each is dependent on their EMS provider agencies to submit data, there is variability in their capability to report core quality measures and some intrinsic variation in the results exists. In future years, system improvements will facilitate data collection and more accurate reporting. Improvements include: California Emergency Medical Services Information System (CEMSIS) accumulating sufficient records to generate reports on core quality measures from patient-level data and data validation between CEMSIS and LEMSA data. These advancements should improve data validity

and decrease variability related to documentation and measure specifications. This should also allow EMSA to run the annual reports reliably on behalf of each LEMSA.

Biospatial:

In December 2019, all LEMSAs were given access to their specific EMS data on Biospatial. This data was input directly from CEMSIS. Biospatial is an EMS data platform that uses EMS and health-related data sources that provide timely, national-scale syndromic detection and anomalies, and monitor real-time trends and alerts that are critical to ensuring the nation's health and safety. Utilizing EMS data, the platform computes aggregate clinical and operational performance. More specifically, Biospatial implemented the EMS Compass measures as well as state- and institution-specific clinical and performance measures, including the California EMS System Core Quality Measures. The measures can be aggregated, sorted, and filtered to provide reports that are beneficial to EMSA and LEMSAs for overall improved EMS quality and patient outcomes. Access to the Biospatial database and analytical clinical performance dashboards comes at no cost to EMSA or the LEMSAs and is an opportunity for LEMSAs to analyze their own data submitted into CEMSIS.

The Commission on EMS will be kept informed on the progress of the Core Quality Measures project.

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DATE: March 17, 2021 **Item #8A**

TO: Commission on EMS

FROM: Dave Duncan MD
Director

PREPARED BY: Craig Johnson
Chief, Disaster Medical Services Division

SUBJECT: State Medical Response Update

RECOMMENDED ACTION:

Receive information on the progression of DMS capabilities in support of COVID-19 and 2020 Wildfires.

FISCAL IMPACT:

None

DISCUSSION:

For the past two decades, EMSA DMS has developed and maintained the Mobile Medical Assets (MMA) Program to support local response needs throughout the state in times of significant disaster medical events. The MMA program is comprised of the Ambulance Strike Team/Medical Task Force (AST/MTF) and Disaster Medical Support Unit (DMSU) Programs (1998), the California Medical Assistance Team (CAL-MAT) Program (2005), the Mobile Medical Shelter (formerly Mobile Field Hospital) Program (2007), and the Mission Support Team (MST) Program (2005).

Approximately seven years ago, California began to experience a series of unprecedented disasters. These disasters began with wildfires in 2014 (San Diego and Northern California) and continued with more record-setting wildfires each year. Torrential rains and flooding (similar to events in 1997 and 2007) followed, including the near collapse of the Oroville dam crisis in early 2017. The Thomas fire in late 2017 ultimately contributed to the Montecito mudslide in early 2018, and that year was capped off with the horrific Camp Fire. California continued to experience severe wildfires in 2019, including the Kincadee and other fires. In 2020, the COVID-19 virus arrived, taxing the health care system at levels not even experienced during the H1N1 pandemic of 2009. Wildfires raged in the summer of 2020, many ignited by unusual and surprisingly intense thunderstorms in the San Francisco bay area.

Over the past year, the MMA programs in EMSA-DMS Division continued to grow, expand, and adapt. The severity and intensity of the Camp fire was considered a bell-weather event, resulting in considerable momentum toward expanding the capabilities of the MMA programs. However, the combined events of 2020 – the COVID-19 pandemic and the massive (and multiple) wildfires – served to push EMSA’s capabilities further than anything previously contemplated. Below is a synopsis of the growth of the various programs.

Response Personnel:

Out-of-State Medical Professionals: To support the statewide critical medical facility staffing shortages, EMSA has processed over 23,000 out-of-state medical professionals to work in California. Currently, more than 4,200 out-of-state medical personnel are supporting 255 medical facilities across the state. EMSA staff, along with newly recruited emergency hires, continue to process out-of-state approvals daily.

CA Health Corps: The program was created to recruit licensed medical professionals, including retirees, using the DHV system to support the COVID-19 response. Since the inception of the Governor’s initiative program, EMSA has registered approximately 80,000 volunteers in the DHV system and onboarded 1,256 Health Corps clinical professionals for immediate deployment. Currently, Health Corps personnel have filled about 3,500 shifts within medical facilities to support COVID-19 response. The vast pool of registrants also served to bolster DHV, MRC, and CAL-MAT memberships as Health Corps registrants were redirected to support programs based on their skills and interests.

CAL-MAT: Before COVID-19, the CAL-MAT Program had approximately 200 members. To meet the statewide need for medical support during the COVID-19 response, EMSA grew the program to over 2,100 members. To date, EMSA has deployed over 800 CAL-MAT members on 2,500 individual deployments to support 89 medical missions during the COVID-19 and 2020 Wildfires response. Also, CAL-MAT members are now being utilized to support statewide COVID-19 vaccination clinics.

Disaster Healthcare Volunteers (DHV): EMSA manages the DHV Program in collaboration with locally assigned DHV/MRC coordinators. The system is designed for local use to support local responses to emergencies. One year ago, there were 17,352 registered volunteers. Currently, there are approximately 100,000 volunteers registered in the DHV system. During the COVID-19 response, nearly 1,500 DHV and MRC volunteers were deployed to support local response efforts.

Medical Reserve Corps (MRC): MRC members are volunteers who train together and provide disaster response as a formalized team locally or to other jurisdictions as requested. EMSA provides personnel registration coordination to local jurisdictions through the DHV system. Like DHV, MRC numbers have swelled significantly. Prior to COVID-19, there were 9,618 MRC members; there are now nearly 19,000 members.

Response Resources:

Warehouse Space: Before the COVID-19 response, EMSA-DMS ran all operations out of one 30,000 sq. ft warehouse. Three warehouses now support response efforts with a combined space of 190,000 sq. ft. to house our greatly expanded resources and serve as the state repository for ventilators and associated respiratory equipment. EMSA deployed 1,684 ventilators to local counties and maintains nearly 13,000 in ready status (up from an inventory of 100).

Equipment & Supply Caches: The COVID-19 response required EMSA to expand all response caches (CAL-MAT, pharmacy, fire, Mission Support Team, and IT & communication) by three to four times the previous amounts and maintain large amounts of medical supplies to support the Alternate Care Sites. EMSA went from managing a moderate operation with a few trucks to statewide distribution of supplies to support 89 medical missions. Additionally, the management of the multiple Alternate Care Sites required a robust distribution plan and daily delivery of supplies to ensure medical needs were being met. This expansion significantly stressed capabilities but led to massive improvements in EMSA's ability to support statewide operations.

EMSA also deployed 40 medical structures to support hospital surge, including setting up a mobile hospital in Imperial County. The structures were formerly part of the Mobile Field Hospital program, which transitioned to the Mobile Medical Shelter program in 2016.

Ambulance Strike Team (AST) Program:

The AST program proved invaluable during the COVID-19 and 2020 Wildfire response. Activities included statewide support for patient movement, evacuation of the Grand Princess Cruise Ship, support to Imperial County to help move over 650 patients out of the County to decompress hospitals, and the evacuation of over 400 patients due to the wildfires. AST personnel were required to transport persons known or suspected to be COVID-19 positive, often with very strict Personal Protective Equipment (PPE) requirements. Their duties and skills went well beyond that planned for ASTs. The teams augmented nursing personnel in Alternative Care Sites, provided support at vaccination sites, and supported fire basecamp operations. There have been many lessons learned regarding patient movement and the AST Program. EMSA plans to continue leading the AST Advisory Workgroup to build on the lessons learned and advance the AST Program.

EMSA-DMS remains vigilant as the response begins to lessen and we transition to vaccination support. We recognize the threat from variants of the virus remains unknown. EMSA moves forward with increased capacity, capability, and skillsets. The experience gained over the past 12 months has proven invaluable.

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DATE: March 17, 2021

TO: Commission on EMS

FROM: Dave Duncan MD
 Director

PREPARED BY: Caitlyn Cranfill
 Executive Division

SUBJECT: Election of Officers

Item #9**RECOMMENDED ACTION:**

Close the nominations for Chair, Vice Chair, and Administrative Committee, and hold the election.

FISCAL IMPACT:

None

DISCUSSION:

Per the Commission on EMS By-Laws, all Commission Officers are eligible for re-election except the immediate past chair who is automatically a member of the Administrative Committee. Chair Dunford has served two consecutive terms as Chair of the Commission on EMS; he was first elected in March of 2019 and was re-elected the following year. Chair Dunford will serve on the Administrative Committee, and at least one new nomination for Chair must be made prior to elections.

The following individuals were nominated for Commission Officers at the December 9, 2020 Commission meeting:

Chair: James Dunford (Immediate Past Chair)

Vice Chair: Atilla Uner
 Todd Valeri
 Sean Burrows

Administrative Committee: Sean Burrows
 Brent Stangeland