

STATE OF CALIFORNIA
COMMISSION ON EMERGENCY MEDICAL SERVICES
June 16, 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/96227219322>

Teleconference number:

1-669-900-6833

Webinar ID:

962 2721 9322

AGENDA

- 1. Call to Order and Pledge of Allegiance**
- 2. Review and Approval of March 17, 2021 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. Commission on EMS Subcommittee Report

7. EMS Personnel

- A. Community Paramedicine Pilot Project Status Update

8. Disaster Medical Services Division

- A. State Medical Response Update

9. Items for Next Agenda

10. Public Comment

11. 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.

EMERGENCY MEDICAL SERVICES AUTHORITY

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: June 16, 2021 **ITEM NUMBER: 2**

SUBJECT: Review and Approval of March 17, 2021 Minutes

PRESENTER: Caitlyn Cranfill, Executive Division

CONSENT: ___ ACTION: X INFORMATION: ___

RECOMMENDATION

Approve the meeting minutes from the March 17, 2021, Commission on Emergency Medical Services (EMS) Meeting.

FISCAL IMPACT

None.

SUMMARY

The prior meeting of the Commission on EMS occurred March 17, 2021. Each Commission on EMS meeting is transcribed by a third-party vendor. That vendor also drafts meeting minutes, which summarize what is said during the meeting. Those draft minutes are then edited by the Emergency Medical Services Authority (EMSA) to ensure accuracy and completion.

The Commission on EMS may request modifications to the meeting minutes or may approve the version of the minutes included in this agenda item.

ATTACHMENT(S)

Minutes of Teleconference Meeting: Wednesday, March 17, 2021

**STATE OF CALIFORNIA
COMMISSION ON EMS**

Minutes of Teleconference Meeting

Wednesday, March 17, 2021

Zoom

Call-In Number 669-900-6833; Code 997 6726 3694

COMMISSIONERS PRESENT:

Steve Barrow, 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, Kristin Weivoda

COMMISSIONERS ABSENT:

None

EMS AUTHORITY STAFF PRESENT:

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

AUDIENCE PRESENT (partial list):

Tamir Ami, CARESTAR Foundation
Saskia Kim
Kristi Koenig, M.D., County of San Diego EMS
Jodi Ravel

1. CALL TO ORDER AND PLEDGE OF ALLEGIANCE

Chair James Dunford, M.D., called the teleconference meeting to order at 10:08 a.m. Eighteen Commissioners were present. He led the Pledge of Allegiance and reviewed the meeting protocols and meeting agenda.

Chair Dunford asked Dr. Duncan to introduce the new Commissioner.

David Duncan, M.D., EMSA Medical Director, introduced Kristin Weivoda and welcomed her to the Commission.

2. REVIEW AND APPROVAL OF DECEMBER 9, 2020, MINUTES

Action: Commissioner Hartwig moved approval of the December 9, 2020, Commission on Emergency Medical Services Meeting Minutes as presented.

Commissioner Hinsdale seconded. Motion carried unanimously with one abstention by Commissioner Weivoda.

3. DIRECTOR'S REPORT

A. EMSA Program Updates

David Duncan, M.D., EMSA Medical Director, presented his report:

COVID-19 Statistics

- The case rate is at 2,400 new cases as opposed to early January, where case rates were as high as 39,000 cases.
- The number of hospitalizations has diminished 30 percent over the last two weeks and ICU bed availability is down to 17 percent and holding.
- The Blueprint for a Safer Economy Model, the color-coded tiered algorithm for California counties, is in its 28th week.
 - Over the last week, 11 counties have moved to a less restrictive tier.
 - No counties have transitioned into more affected tiers.
- Test positivity is down to 2 percent as compared to 18 percent in January, despite lower testing levels.

Vaccinations

- Approximately 12 million vaccinations have been administered in the state.
- 61 percent of individuals over 65 years of age, the most vulnerable population, have received at least their first dose.
- The vast majority of health care personnel have been vaccinated.

Variant Strains

- Staff is tracking new outbreaks worldwide, which are typically based on variant strains that have increased transmissibility.
- The Centers for Disease Control and Prevention (CDC) has recently published guidance on three categories for variants: variants of interest, concern, and high consequence. Staff will be closely tracking these while looking towards what may become a fourth surge in California. Most modeling developers assure that there will be a fourth surge likely based on a variance of some form, that the surge will be significantly lower and less impactful than the last surge seen in California, and that a demonstration of what that surge will possibly look like will occur by the end of April.

EMSA COVID Response:

- EMSA is transitioning down from the steep third surge of the COVID-19 pandemic while preparing for a possible upcoming fourth surge.

- EMSA Disaster Medical Services (DMS) have transitioned into warm status.
- A number of response pieces are being demobilized in a way that will allow a rapid redeploy within 48 to 72 hours.

Ambulance Patient Office Times (APOT)

- The Ambulance Patient Offload Report, released in December, indicated that offload delays persist and were particularly exacerbated by the COVID-19 pandemic. EMSA and CHA formed a multi-disciplinary work group nearly 10 years ago to create an APOT tool kit. EMS stakeholders will be invited to participate in a new APOT Committee that will review the APOT toolkit, which was published in 2014, and evaluate opportunities to decrease APOT. The first meeting is expected in late spring.

Questions and Discussion

Chair Dunford asked about the percent of fire and EMS personnel vaccinated to date.

Dr. Duncan stated staff is still researching the final numbers on that. He stated it is a metric that is difficult to ascertain.

Commissioner Barrow suggested doing a survey or asking the local EMS agencies to do a survey to learn the percent of fire and EMS personnel vaccinated to date. He also asked about first responders who refuse to take the vaccine.

Dr. Duncan stated there may be religious concerns or concerns about the new Messenger RNA technology in vaccination. He stated, after outreach and education efforts to EMS providers, the vaccination rate improved to approximately the same range as seen in hospitals. This may be the ultimate threshold that can be reached for health care providers, as similar thresholds are seen with influenza and other annual vaccines.

Commissioner Miller wrote in the chat section that the percent of fire and EMS personnel vaccinated in Santa Clara County is 80 percent or more.

Commissioner Barrow asked about the role EMS plays in vaccination deployment.

Dr. Duncan stated EMS is playing a huge role in vaccination deployment and has played an immense role throughout the past year as part of COVID-19 response such as rapid response, ambulance strike teams, testing, filling gaps, delivering stationary care for skilled nursing, hospitals, home care, and vaccination. All LEMSAs in California have adopted local optional scopes of practice to allow both EMTs and paramedics to administer COVID-19 vaccinations, which is a first for the State. The limiting step for vaccination still lies in supply.

Public Comment

Kristi Koenig, M.D., EMS Medical Director, San Diego County, and former Commissioner, wrote in the chat section: "Do you have any updates on the new

classification of the two California variants from the previous VOI to now be VOC, with potential for increased transmissibility?”

Dr. Duncan stated seven variants are being tracked but specific information on increased transmissibility is not yet available.

4. CONSENT CALENDAR

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

Action: Vice Chair Uner moved approval of all items on the consent calendar. Commissioner Snyder seconded. Motion carried unanimously with one abstention by Commissioner Weivoda. The item was noted and filed.

REGULAR CALENDAR

5. EMS ADMINISTRATION

A. Legislative Report

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

Questions and Discussion

Commissioner Barrow asked about the purpose of Assembly Bill (AB) 1229, since there is already a task force on APOT and Dr. Duncan already stated a need to update the toolkit.

Mr. El-Morshedy stated staff has not yet had a conversation with Assembly Member Rodriguez's office about this bill.

Commissioner Valeri suggested adding two bills to staff's bills to track and analyze: AB 662, which addresses issues of authority and liability for transport of patients on a mental health hold, and AB 1107, which addresses the financial viability and sustainability of EMS systems.

Deputy Director Lim stated that the legislative report on EMSA's website includes an additional 32 measures that EMSA is tracking along with the 11-12 bills that EMSA is formally analyzing.

B. Regulations Update

Kent Gray, Regulations Manager, reviewed the Regulations Update of the regulations being promulgated, which was included in the meeting materials.

Questions and Discussion

Commissioner Barrow referred to regulations being developed for community paramedicine and alternate destination. Commissioner Barrow asked if additional pilots and programs can be added while the regulations are in development.

Mr. Gray stated this question will be answered in the next agenda item.

Public Comment

Dr. Koenig wrote in the chat section “How many people have completed the lay rescuer epi administration training? The application fees (and cost of the epi-pens after that) would seem to be a huge barrier for most prospective participants?”

Jennifer Lim, EMSA Deputy Director, Policy, Legislative, and External Affairs, stated currently 951 individuals are active.

6. EMS PERSONNEL

A. Community Paramedicine Pilot Project Status Update

Lou Meyer, Project Manager for the Community Paramedicine Project, stated, with the passage of AB 1544, all active community paramedicine pilot projects have transitioned to a community paramedicine or triage to alternate destination program, effective January 1, 2021. All pilot projects are authorized to continue to operate as established until one year after the regulations go into effect. He noted that AB 1544 did not include post-discharge programs so the few post-discharge pilot projects that are still active can continue to operate only until June of 2024.

Mr. Meyer responded to Commissioner Barrow’s question asked in the previous agenda item by stating, until regulations go into effect, there can be no additional approved community paramedicine programs or alternate destination programs throughout the state. This puts the emphasis on getting regulations approved by July of 2022.

Mr. Meyer stated an advisory committee was created to provide oversight and guidance, as required in AB 1544. The advisory committee first met on February 19th and is scheduled to meet again on March 23rd.

Questions and Discussion

Commissioner Hartwig stated appreciation for the pilot project data, which showed the progress and improvement brought about by these pilot projects. He stated, although it was a well-documented study, the projects were not well distributed. He stated the hope that the focus on data collection and distribution will help the much-needed community paramedicine effort to be successful throughout the state.

Commissioner Barrow inquired as to the status of Lou Meyer transitioning to employment directly under the State as Mr. Meyer’s current position is funded by the California Health Care Foundation.

Jennifer Lim, EMSA Deputy Director, stated EMSA has put in a request to control agencies on how they see the projected transitioning and by the bill’s provisions. EMSA is waiting for final approval.

Chair Dunford asked if the advisory committee includes representatives from substance use treatment programs and sobering centers.

Mr. Meyer stated the 33 members include representation from every conceivable concept for community paramedicine.

Chair Dunford asked for the advisory committee member roster.

Mr. Meyer stated the list can be provided to the Commission by EMSA staff.

Commissioner Rodriguez asked about current community paramedicine training and curriculum.

Mr. Meyer stated the only training currently taking place is in the City of San Francisco Fire Department, which is using a curriculum approved through the Office of Statewide Health Planning and Development (OSHPD) process. The advisory committee plans to revise the curriculum based on learnings since 2013 on the education levels required for community paramedicine and alternate destination.

Public Comment

Saskia Kim wrote in the chat section “Could you please direct me to the public information about the community paramedicine and alternate destination advisory group?”

Ms. Lim stated staff will provide information on the advisory group, upon request.

B. Clinical Care and Restraint of Agitative or Combative Patients

Chair Dunford stated it was requested at the September meeting that discussion be held regarding excited delirium in EMS. He stated it is necessary to discuss not only the issue of managing excited delirium but the whole concept of the current behavioral health emergencies in the country. This is an EMS issue that challenges traditional approaches to mental illness and substance use disorders and that is attracting a lot of attention, particularly toward law enforcement.

Chair Dunford stated 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*, which is helpful. It endorses the concept that individuals who are suffering from disease states that put them and others at risk of injury should be dealt with as safely and with as much dignity and respect as possible.

Chair Dunford stated behavioral health disorders are different from stroke, trauma, or cardiac arrest systems in that they are owned by multiple, oftentimes siloed, entities. Neither the police nor mental health counselors, fire, or EMS can handle these cases on their own. This is a problem where the community must collectively come together and determine to jointly take on this issue in order to overcome the challenge, which is a big task.

Chair Dunford suggested that EMS take a serious look at the pieces of the puzzle they own and to demonstrate that they are doing them well. He stated the NAEMSP article

includes recommended components of quality in EMS, such as step-based protocols, measure agitation and quantify it over time, de-escalation techniques, and competency-based training. He stated the need to discuss the following:

- What is prohibited and what is allowed in each community.
- The right way to deal with pharmacologic medications.
- The right way to document.
- The definition of quality improvement when it comes to this issue.
- The role of medical online oversight.

Chair Dunford asked about the conversation on this issue at yesterday's EMS Medical Directors' Association of California (EMDAC) meeting.

Commissioner Miller stated traditionally emergency response has resulted in the placement of a hold and transport to a hospital or other location. EMDAC discussed, over multiple meetings, that the intersection between EMS and behavioral health has the potential to improve the care interface of behavioral crises and EMS entities. Many counties are working on some level of deployment of behavioral health clinicians in the field to assist law enforcement with persons presenting in behavioral crisis. That EMS interface includes clinicians who can assist law enforcement to decide if a hold is even necessary and to direct the patient to intermediate-term or next-day outpatient care to begin to mitigate the underlying causes for that behavioral crisis. This is the single most important change in the complex spectrum of behavioral crisis within an EMS system.

Commissioner Miller stated with regard to managing patients in behavioral crisis or with serious mental illness who are presenting a danger to themselves, care providers, or others, many EMS agencies have adopted or are moving toward a progressive, pharmacologic intervention through various drug choices that match the level of patient protection with the level of concern for harm. Also, alternate destinations provide more tools to work with, with protocols to assess patients in crisis, to rule out co-morbid conditions that could lead to adverse outcomes. Incorporating this decision-making spectrum, providing a thorough pre-hospital assessment, and transporting patients directly to mental health facilities will help patients more quickly receive the care they need. The intersection of EMS and behavioral health departments in finding alternative ways to manage patients in crisis is an important discussion.

Chair Dunford stated the Substance Abuse and Mental Health Services Administration (SAMHSA) is putting together a two-part national series on harmonizing health care, behavioral health, and law enforcement. He asked if Commissioners thought it would be valuable to survey communities or host a statewide conference on current protocols that pertain to some of the elements described in the NAEMSP article.

Vice Chair Uner stated it was decided at yesterday's EMDAC meeting that implementation of any kind would be at the local EMS agency level because that is where protocols are written and local EMS agencies know their local problems and

resources. He noted that there are local EMS agencies that do not have the bandwidth or the finances to address this problem.

Commissioner Hartwig suggested a standing agenda item to update Commissioners on how the local EMS agencies are addressing this issue.

Commissioner Smith stated EMS World had a 45-minute segment on this issue a couple of weeks ago with physicians throughout the country. Areas of concern brought up by the physicians were medication dosage, clarity of protocols and policies, and the need to have discussions with local police departments, politicians, and behaviorists on how to ensure that the best is being done for patients. She stated every medical director needs to be prepared on how to address these issues.

Commissioner Rodriguez stated a large component of co-response is the dispatch factor, how calls come into the system, and how to properly vet calls to ensure that the appropriate resource is being sent to individuals in need.

Chair Dunford suggested the Houston Police Department as a model. They have behavioral health experts in dispatch that help the police to triage calls for individuals with a need for mental health response.

Commissioner Valeri stated, based on his work with behavioral health transport to alternate destination community paramedic pilot projects, three areas of concern have surfaced with respect to EMS's involvement in transporting behavioral health patients, particularly those on a 5150 hold: responsibility, authority, and liability. Litigation around this issue for ambulance companies needs to be addressed.

Commissioner Valeri stated AB 662 will create an opportunity for EMS providers to address those domains of concern and have an appropriate seat at the table in caring for these behavioral health patients that currently does not exist.

Chair Dunford stated the California Crisis Intervention Training Association (CACITA) would love to partner with EMS to provide crisis training to law enforcement.

Commissioner Barrow agreed that there should be a standing agenda item on this issue. He suggested a panel presentation at the next Commission meeting about the current status and legislation on this issue. He suggested creating a working group to discuss the role of EMS. He stated trainings and programs need to be conducted differently in rural areas where there is a lack of resources so they are not left behind.

Commissioner Barrow stated there is a lack of understanding between police and EMS about authority when dealing with mental health crisis. He stated the need to clearly identify who has authority when.

Commissioner Burrows stated the information recorded by body cameras worn by law enforcement should be Health Insurance Portability and Accountability Act of 1996 (HIPAA) protected. There are patient privacy issues that need to be discussed.

Vice Chair Uner suggested that EMSA query the local EMS authorities about protocols being developed so Commissioners can get a picture of what is going on in the state.

Dr. Dave Duncan, EMSA Director, stated that EMSA would like to partner with the Commission on this topic through the creation of a subcommittee.

Commissioner Hartwig suggested the subcommittee be composed of Commissioner Weivoda, Vice Chair Uner, Chair Dunford, and Commissioner Burrows.

Action: Commissioner Hartwig moved to create a subcommittee to discuss clinical care and restraint of agitative or combative patients. Commissioner Stangeland seconded. Motion carried unanimously by roll call vote.

Public Comment

Tamir Ami wrote in the chat section “I want to fully support where Dr. Dunford is going with this conversation, both with this example and with the larger questions of measurement. CARESTAR would like to know, how can we support this work? Is creating a subcommittee something the Commissioners would consider to start talking about these issues more deeply?”

Jodi Ravel wrote in the chat section “It may be worthwhile for the Commission to take a look at AB 988 (Bauer-Kahan AB 988 – Miles Halls Lifeline Act) which proposes a new 9-8-8 number in the state specifically for Mental Health calls parallel to 9-1-1. Among other things, it says that if a law enforcement, medical, or fire response is needed, 9-8-8 and 9-1-1 operators shall coordinate the simultaneous deployment of those services with mobile crisis support teams. I believe it proposes a tax on cell phones to support it, and is being considered nationally.”

7. EMS SYSTEMS

A. Core Measures Report and Project Update

Adrienne Kim, Data and Quality Improvement Unit Manager, reviewed the Core Quality Measures Report and Project Update, which was included in the meeting materials. She stated the 2019 Annual Core Measures Report will soon be published. EMSA will work with the Core Measures Work Group to review and refine the Core Quality Measure Set.

Questions and Discussion

Chair Dunford asked about the measure of behavioral health care.

Ms. Kim stated behavioral health care is not one of the ten core measures.

8. DISASTER MEDICAL SERVICES DIVISION

A. State Medical Response Update

Craig Johnson, Chief of the Disaster Medical Services Division, reviewed the State Medical Response Update, which was included in the meeting materials. He provided information on the progression of DMS capabilities in support of COVID-19 and 2020 wildfires with an emphasis on response personnel, response resources, and the Ambulance Strike Team (AST) Program. He stated the combined events of 2020 – the

COVID-19 pandemic and the wildfires – served to push EMSA's capability further than anything previously contemplated.

Mr. Johnson reviewed the next steps of the DMS Division:

- Support the growth of the mobile medical asset programs, including right-sizing the DMS Division and EMSA.
- Integrate the Health Corps program into the mobile medical assets tiered response.
- Continue to support the AST Program.
- Rekindle the AST Advisory Work Group, which was put on hold due to the COVID-19 pandemic.
- Rekindle the Hospital Incident Command System National Advisory Work Group.

Questions and Discussion

Chair Dunford congratulated Dr. Duncan and the entire EMS Authority on their exceptional work and model response to the COVID-19 pandemic and 2020 wildfires.

Vice Chair Uner agreed and stated the entire medical system functioned at its best.

Commissioner Relucio stated the need to sustain this work and to use this experience to stay alert to be better prepared for the next disaster.

Chair Dunford agreed and stated it is unfortunate that real world problems must identify real solutions.

Dr. Duncan stated staff is working on detailed after-action reporting. EMSA is in a great place to leverage all that it has done and move it forward in a way that truly memorializes it. This is a priority for EMSA and everybody who has participated under the HHS umbrella.

9. ELECTION OF OFFICERS

Chair Dunford stated he has served two terms and, as Immediate Past Chairman, he automatically will serve on the Administrative Committee. He reminded Commissioners of the officer nominations from the December meeting:

- Commissioner 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

Chair Dunford entertained nominations for the position of the Commission on EMS Chair.

Commissioner Valeri nominated Vice Chair Uner as Chair.

Action: Commissioner Valeri nominated Vice Chair Uner as Chair of the EMSA for March of 2021 to March of 2022. Commissioner Snyder seconded. Eighteen members of the Commission voted aye.

Vice Chair

Chair Dunford entertained additional nominations for the position of the EMSA Vice Chair. No additional nominations were offered.

Action: Commissioner Hartwig moved to close nominations for Vice Chair of the EMSA for March of 2021 to March of 2022. Commissioner Hinsdale seconded. Motion carried unanimously.

Action: Commissioner Burch nominated Commissioner Valeri as Vice Chair of the EMSA for March of 2021 to March of 2022. Eight members of the Commission voted aye per roll call vote.

Action: Commissioner Rodriguez nominated Commissioner Burrows as Vice Chair of the EMSA for March of 2021 to March of 2022. Nine members of the Commission voted aye per roll call vote.

Administrative Committee

Chair Dunford stated Commissioner Burrows can no longer serve on the Administrative Committee since he was voted Vice Chair of the Commission. He asked for nominations for another member to serve with Commissioner Stangeland on the Administrative Committee.

Commissioner Hartwig nominated Commissioner Valeri to serve on the Administrative Committee. Commissioner Gordon seconded.

Action: Commissioner Hinsdale moved to close nominations for service on the Administrative Committee for March of 2021 to March of 2022. Commissioner Barrow seconded. Motion carried unanimously.

Action: Commissioner Barrow nominated Commissioner Stangeland to continue service on the Administrative Committee from March of 2021 to March of 2022. Vote carried unanimously.

Action: Commissioner Hartwig nominated Todd Valeri to serve on the Administrative Committee from March of 2021 to March of 2022. Vote carried unanimously.

2021 Officers

- Chair of the Commission on EMS for 2021-22 is Atilla Uner, M.D.
- Vice Chair of the Commission on EMS for 2021-22 is Sean Burrows.

- Brent Stangeland and Todd Valeri will serve on the Administrative Committee as representatives of the Commission on EMS and James Dunford, M.D., is Member Emeritus, as Immediate Past Chair.

10. ITEMS FOR NEXT AGENDA

No next agenda items were offered.

11. PUBLIC COMMENT

There were no questions or comments from the public.

12. ADJOURNMENT

Commissioner Smith stated the California Paramedic Foundation (CPF) will be kicking off its California Opioid Prevention by EMS (COPE) Project consisting of a two-part educational opportunity:

- An online class for EMTs and paramedics that will highlight topics such as synthetic opioids, cultural competence, and a pragmatic approach to EMS prevention programs.
- An Opioid Learning and Action Network (OpioidLAN) meeting that will begin in April with guest speakers from around the country to connect with California EMS providers and others who is interested in starting an opioid prevention program.

Commissioner Smith stated more information can be found on the CPF website.

There being no further business, the meeting was adjourned at 1:01 p.m.

**Emergency Medical Services Authority
 Disaster Medical Services (DMS) Division
 Major Program Activities
 June 16, 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. Staff have recently reached out to the sub-group leads, and it is anticipated the sub-groups will begin to meet beginning in June or July 2021.</p> <p>The AST program proved critical during the 2020 COVID and Wildfires response. ASTs were heavily engaged with COVID patient movement, fire evacuations, logistical support to various EMSA/CAL-MAT Missions, and support for Cal Fire operations. To date, 17 ASTs were utilized to support response activities.</p>
<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 units in the North State (Redding), Riverside/San Bernardino, and Los Angeles are underway.</p>

**Emergency Medical Services Authority
 Disaster Medical Services (DMS) Division
 Major Program Activities
 June 16, 2021 – Item #3A**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>CAL-MAT supported the COVID-19 activities beginning in March. EMSA deployed over 900 CAL-MAT members, some multiple times (3,700 individual member deployments) to support 133 missions throughout the State, including support for COVID quarantine sites, Alternate Care Sites, Federal medical Stations, medical shelter/clinics, Long-term Care Facilities, Vaccinations sites, and 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 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> <p>Expectations for Unit Leaders are being refined to create a more effective management arrangement. Large capability video conferencing has been provided to the Units to enable them to conduct trainings and communicate with their membership, most of which number in the hundreds.</p>

**Emergency Medical Services Authority
 Disaster Medical Services (DMS) Division
 Major Program Activities
 June 16, 2021 – Item #3A**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
3. CAL-MAT Cache	Bill Hartley, ext. 1802	<p>The three CAL-MAT Caches were all deployed for the COVID-19 response and utilized statewide to support over 100 CAL-MAT missions. In addition to the CAL-MAT caches, EMSA established multiple large caches to support the CAL-MAT missions at Alternate Care Sites and Long-term Care Facilities. All CAL-MAT caches have been returned to station 1, except supplies maintained for warm-closure at the ACSs. The three dedicated CAL-MAT caches have been resupplied for new missions. 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.</p>
4. California Public Health and Medical Emergency Operations Manual (EOM)	Kelly Coleman, ext. 726	<p>All EOM materials are posted on the EMSA website at https://emsa.ca.gov/plans/.</p> <p>The Regional Disaster Medical and Health Specialists (RDMHS) continue to conduct EOM training on an ongoing basis.</p> <p>The EOM workgroup meetings have been postponed throughout 2020 due to COVID-19 response.</p>
5. California Crisis Care Operations Guidelines	Kelly Coleman, ext. 726	<p>Development is on hold until funding is made available.</p>

**Emergency Medical Services Authority
 Disaster Medical Services (DMS) Division
 Major Program Activities
 June 16, 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 approximately 107,000 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 were over 62,000 personnel registered in the California Health Corps within the DHV System. All personnel that 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 volunteers. Approximately 22,000 of the 107,000 DHV registered volunteers are accepted/pending Medical Reserve Corps (MRC) members. EMSA trains and supports DHV System Administrators in each of the 32 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 were on hold due to the COVID-19 Pandemic. The last DHV MRC User Group webinar was held on April 29th, 2021.</p>

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 Disaster Medical Services (DMS) Division
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
9. Hospital Available Beds for Emergencies and Disasters (HAVBED)	Kelly Coleman, ext. 726	<p>The United States Health and Human Services discontinued funding the national HAVBED program in 2016. However, EMSA is working with the California Department of Public Health (CDPH) and other partners to continue integrating hospital data collection for California use.</p>
10. Hospital Incident Command System (HICS) hics@emsa.ca.gov	Craig Johnson, ext. 4171	<p>The Hospital Incident Command System (HICS) is sponsored by the California Emergency Medical Services Authority (EMSA). 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 in late 2021. The focus moving forward is to identify best practices and lessons learned from hospital utilization during the COVID response. Additionally, EMSA working with the committee will look to increase statewide HICS participation.</p> <p>The Fifth Edition of HICS, Frequently Asked Questions (FAQ), and additional program information are available on EMSA website: https://emsa.ca.gov/disaster-medical-services-division-hospital-incident-command-system-resources/.</p>

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
11. Mission Support Team (MST) System Development	Michael Frenn, ext. 435	<p>Activated by EMSA, the MST provides the management oversight and logistical support for State deployed medical and health teams.</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 over 100 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>
12. Response Resources	Bill Hartley, ext. 1802	<p>The Mission Support Team (MST), pharmaceutical, and California Medical Assistance Teams (CAL-MAT) caches were deployed for the COVID-19 Pandemic response and are resupplied.</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. Audits of all DMSUs were conducted for this fiscal year.</p> <p>EMSA is in the process of adding eight additional SUVs to the fleet to</p>

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		bolster preparedness and response capabilities.
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 infrastructure 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 NGOs, 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 High Frequency (HF) radio/data communications and antenna equipment for improving long-range interoperability communication capability.</p>
14. Mobile Medical Shelter Program (MMSP)	Bill Hartley, ext. 1802	<p>Working with other state agencies and within existing resources, the EMS Authority has redesigned the Mobile Field Hospital (MFH) program into the California Mobile Medical Shelter program. The purpose of the redesign is to modify and expand the potential uses of the equipment into general staging, stabilization, and shelter capacity.</p> <p>During the COVID response, EMSA deployed 44 mobile medical</p>

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>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>EMSA, using the mobile medical structures, established a 50-bed mobile field hospital in Imperial County to expand hospital bed capacity during the COVID surge impacting the border communities.</p> <p>The previous MFH structures, now configured for sheltering and other multi-use support, proved extremely beneficial during the 2020 COVID response. EMSA will continue to maintain the structures for future use.</p>
<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 April 2021. During the meeting, we discussed current COVID response efforts and</p>

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>identified program strengths and weaknesses. EMSA continues to work to secure ongoing funding for the addition of one RDMHS per mutual aid region, for a total of 12 RDMHSs.</p>
<p>16. Medical Reserve Corps (MRC)</p>	<p>Lauran Molina, ext. 466</p>	<p>Thirty-two (32) 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. Approximately 22,000 of the 107,000 DHV registered volunteers are accepted/pending MRC members.</p> <p>The MRC's have been crucial in California's COVID-19 response efforts. There have been approximately 3,000 individual MRC volunteers deployed for COVID-19 pandemic response and medical support across the State. 23 Medical Reserve Corps Units have deployed in California, devoting over 119,000 hours for the COVID-19 response. MRCs have volunteered their time and skills in vaccination clinics, testing sites, COVID-19 hotlines, contact tracing, patient care, Alternate Care Site support, and Emergency Operations Centers.</p> <p>Since pre-COVID, California MRC Units have more than doubled in size.</p>
<p>17. Statewide Emergency Plan (SEP) Update</p>	<p>Brad Gates, ext. 4728</p>	<p>The California Governor's Office of Emergency Services (Cal OES) released the update in October 2017. The updated version is located at http://caloes.ca.gov/PlanningPreparednessSite/Documents/California_State_Emergency_Plan_2017.pdf. This version includes a brief</p>

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		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.
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://ems.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.

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
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
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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	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

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>conducted for providers virtually by the HIE Staff. EMSA has trained an additional 250 medical providers in person on PULSE during the COVID-19 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 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 a 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>

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EMS Personnel Division
Major Program Activities
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
1. First Aid Practices for School Bus Drivers	Joseph Bejarano	<ul style="list-style-type: none"> • EMSA has nine (9) approved School Bus Driver training programs. • EMSA approved two (2) programs this quarter. • EMSA is currently reviewing one (1) renewal 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 has sixteen (16) approved First Aid/CPR programs. • EMSA approved four (4) programs this quarter. • EMSA is currently reviewing one (1) renewal and one (1) new program. • 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 has thirty-six (36) currently approved preventive health and safety practices training programs. • EMSA approved five (5) programs during the last quarter. • EMSA is reviewing seven (7) programs; 2 (two) renewals and 5 (new). • EMSA continues to sell course completion stickers. • EMSA continues to provide technical assistance to training program instructors, directors, licensing staff, childcare providers, training organizations, the public, Department of Social Services Community Care Licensing

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>Division, California Department of Public Health, and California Department of Education.</p> <ul style="list-style-type: none"> • In response to COVID-19, EMSA is allowing programs to provide the training through a virtual classroom setting that has real-time interactions with the instructor.
<p>4. Child Care Training Provider Quality Improvement/Enforcement</p>	<p>Lucy Chaidez</p>	<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.
<p>5. Automated External Defibrillator (AED) Requirements for EMT's, Public Safety and Layperson</p>	<p>Austin Trujillo</p>	<ul style="list-style-type: none"> • EMSA currently has three (3) approved public safety AED programs. • EMSA currently has three (3) approved EMT AED services provider programs. • EMSA has renewed one (1) public safety AED program this quarter. • EMSA provides ongoing technical support and clarification to public safety agencies, LEMSAs, and the general public regarding AED statutes and regulations.
<p>6. BLS Training and Certification Issues</p>	<p>Austin Trujillo</p>	<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.

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
7. State Public Safety Program Monitoring	Austin Trujillo	<ul style="list-style-type: none"> • EMSA currently has three (3) approved Public Safety First aid/CPR training programs. • EMSA currently has two (2) approved EMT training programs. • EMSA currently has two (2) approved EMT refresher training programs. • EMSA currently has six (6) approved continuing education provider programs. • EMSA is in the process of renewing one (1) public safety first aid/CPR training program this quarter. • 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.
8. My License Office/ EMT Central Registry Audit	Austin Trujillo	<p>EMS population:</p> <ul style="list-style-type: none"> • 64,709 certified EMTs (154 Active-Restricted) • 116 certified AEMTs <p>EMSA monitors the EMT Central Registry to verify that the 68 certifying entities are in compliance with the California Code of Regulations regarding:</p> <ul style="list-style-type: none"> • Data entry requirements. • Correct certification processes. <ul style="list-style-type: none"> • 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 several

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>policies addressing the Governor's Executive Orders. These policies:</p> <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 110 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 has seventeen (17) approved training programs. • EMSA is reviewing one (1) training program for renewal. • 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 has three (3) approved hemostatic dressings for use in the prehospital setting. • EMSA did not receive requests for new dressings to be considered.
12. Paramedic Licensure	Kim Lew	<p>EMS Personnel Populations:</p> <ul style="list-style-type: none"> • 23,904 licensed paramedics (44 Active-Restricted) • 916 certified epinephrine-injector lay-persons <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 during this quarter:</p>

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		<ul style="list-style-type: none"> • 159 Initial In-State applications, • 25 Initial Out-of-State applications, • 5,554 Renewal applications, • 70 Reinstatement applications. • 76% of the initial and renewal applications were received through the online licensing system. <p>EMSA issued Active-restricted paramedic licenses postponing paramedic program graduates from completing their NREMT psychomotor exam due to the COVID-19 pandemic. 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
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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 May 14, 2021. STAC members provided updates on regional trauma systems and provided direction to the Emergency Medical Services Authority (EMSA) on potential regulation. STAC members weighed in on the 2021 Virtual Trauma Summit agenda and potential speakers. The next STAC meeting is being scheduled for August 2021.</p> <p><u>2021 Trauma Summit</u> EMSA is holding a virtual Trauma Summit on October 6, 2021. Speakers and topics are being vetted through STAC and regional trauma committees. Admission for this year's summit is free and EMSA is working with Trauma partners to provide continuing education/continuing medical education.</p> <p><u>Annual Trauma Plan Status Updates</u> Due to the COVID-19 emergency response, many Local Emergency Medical Services Agencies (LEMSA)s are overdue for submission of trauma plan status updates. However, LEMSAs are beginning to submit plan status updates in alignment with their annual EMS Plan submissions.</p> <p><u>Trauma Regulations</u> The Trauma Regulations Workgroup met via Zoom on April 21, 2021, and is scheduled to meet again on June 28, 2021. EMSA anticipates holding meetings every 6-8 weeks with workgroup members until each section has been reviewed.</p>

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 EMS Systems Division
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
2. STEMI/Stroke Systems of Care	Farid Nasr, ext. 424	<p><u>ST-Elevation Myocardial Infarction (STEMI) and Stroke Programs</u> EMSA staff continues to provide technical assistance to LEMSAs on updating their annual plan or developing an initial Stroke and STEMI system of care plan for submission. Since the last Commission report, EMSA received seven annual plan updates, which were responded to promptly with the approval letter, after reviewing them to ensure they follow STEMI and Stroke Regulations. We encourage LEMSAs to submit their annual STEMI and Stroke Plan updates as part of their EMS Plan.</p> <p><u>STEMI & Stroke Summit</u> EMSA is planning to conduct its first State Stroke Summit virtually on June 8, 2021 and its first State STEMI Summit on June 9, 2021. This will provide education on current trends for optimal care, newest technology, and best practices on both aspects of clinical and system management of care for STEMI and Stroke patients. The purpose is to increase the level of care and reduce morbidity and mortality for STEMI and Stroke patients. This summit is organized with the help of the STEMI and Stroke Technical Advisory Committee. EMSA staff and the Committee actively resumed working on these two summits and met on a regular basis via Zoom. Each day of the summit provides 3.25 hours of CE credits with collaboration of the American Heart/Stroke Association for Physician, Physician Assistant, Nurse Practitioner, Nurses, and EMS personnel.</p>

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
3. EMS Transportation	Laura Little, ext. 412	<p><u>Competitive Processes for Ambulance Zones</u> The following LEMSAs submitted competitive processes for review since the last Emergency Medical Services (EMS) Commission meeting: El Dorado County EMS, Monterey County EMS, and Napa County EMS. This is consistent with Health & Safety Code Section 1797.224, which states competitive processes for Exclusive Operating Areas 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 prior years. Since the last EMS Commission meeting, Los Angeles EMS, Sacramento EMS, Mountain-Valley EMS, and San Diego EMS submitted EMS response and transportation data via the transportation component of the EMS Plan. No further EMS Plan Appeals have been received since the last EMS Commission meeting. EMSA intends to continue to review previous EMS Plan submissions and correspondence, conduct public records requests, review historical documentation to map out issues under appeal, and attend appeal hearings for support, when appeals are submitted.</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 areomedical</p>

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		vehicles, and EMS transportation. COVID-19 has slowed technical assistance inquiries.
4. Poison Center Program	Lisa Galindo, ext. 423	<p>To continue designation as California's poison control center, the California Poison Control Center (CPCS) is mandated to submit an application every four years. The application has been submitted and is currently undergoing review.</p> <p><u>Contract</u> An executed contract between EMSA and CPCS is in effect from July 1, 2019 through June 30, 2021. The contract for July 1, 2021 through June 30, 2022 is in development.</p> <p><u>Quarterly Report</u> The CPCS Quarterly Report consists of data and narrative reports, including a summary of activities accomplished during the quarter. The 3rd quarter report, January 1 –March 31, 2021, 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>

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
5. EMS Plans	Lisa Galindo, ext. 423	<p><u>EMS Plan Review</u> EMSA continues to review EMS Plans as submitted by LEMSAs; 11 EMS Plans are currently under review. Due to the ongoing COVID-19 pandemic and significant response efforts, LEMSAs have been granted a 180-day extension for their annual EMS plan submission. This year, one EMS Plan has had a plan determination.</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 (FY) July 1, 2020 through June 30, 2021. State General Fund (SGF) assistance is provided to assist these LEMSAs in the planning, organizing, implementation, and maintenance of their EMS systems. LEMSAs have been notified of their SGF assistance for FY July 1, 2021 to June 30, 2022, and are in the process of developing applications for submission to EMSA for review.</p> <p><u>Quarterly Report</u> Multicounty Quarterly Reports consist of a detailed description of work performed, duties of all parties, and a summary of activities accomplished during the quarter relevant to the eight EMS system components identified in statute. The 3rd quarter reports, January 1 - March 31, 2020, were received by six LEMSAs and no concerns were identified.</p>

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p><u>Site Visit</u> Site visits have been postponed due to the COVID-19 pandemic.</p>
<p>6. EMS for Children Program</p>	<p>Farid Nasr, ext. 424 Elizabeth Winward, ext. 460</p>	<p><u>EMS for Children (EMSC) Plan Submission</u> The COVID-19 pandemic delayed EMSC Plan submissions from LEMSAs. So far, EMSA has received four EMSC plans, which were responded to promptly with the approval letter, after reviewing to ensure they follow EMSC Regulations. We encourage LEMSAs which already have their plan approved by EMSA to submit their annual EMSC Plan update as part of their EMS Plan.</p> <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 via Zoom on November 4, 2021, and EMSA is also planning smaller virtual trainings throughout the year.</p> <p><u>EMSC Surveys</u> The National Pediatric Readiness Project (NPRP) Assessment launched the week of May 3, 2021, and is anticipated to close the week of July 26, 2021.</p>

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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. Approximately 75% of 2020 trauma data submissions have been submitted. 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 has been published on EMSA's website. EMSA is attempting to increase the patient match rate for records in California EMS Information System (CEMSIS) and the ImageTrend Patient Registry by validating and reviewing the records for accuracy and completeness. Efforts have now shifted to matching EMS data to trauma data for the first half of 2019 (January 1 to June 30) for Riverside Community Hospital. Currently, the successful match rate is roughly 64%. The subsequent report of findings is in progress. EMSA is also attempting to link EMS patient records from data platforms (i.e. Statewide Integrated Traffic Records System, Office of Traffic Safety, Biospatial), which will add robust data to the analyses. EMSA is in the process of obtaining licenses for ArcGIS software, which will aid in analyzing geospatial EMS and various health-related data on a deeper level.</p> <p><u>Reports</u> In March and April 2021 respectively, San Diego and Los Angeles counties submitted their EMS plan updates for FY 2018-2019 and both</p>

**Emergency Medical Services Authority
 EMS Systems Division
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>are compliant in data collection requirements. Weekly trend reports related to statewide COVID-19 respiratory symptoms are currently being conducted through the CEMSIS database. Concurrently, monthly reports on other primary symptoms such as shortness of breath, chills, fever, fatigue, cough, etc. are being conducted. Additional reports on the success of EMS and trauma patient record matching is continuing, but progress is impacted by COVID-19 activities. Reports include: submission rates by EMS agencies, patient demographics, geographic indicators, response times, and will eventually include traffic and collision data, and geospatial metrics.</p>
<p>9. CEMSIS EMS Data</p>	<p>Ashley Stewart, ext. 910</p>	<p>As of May 2021, CEMSIS has received 3.7 million records for 2018, over four million records for 2019, almost four million records for 2020, and has already received close to 1.4 million records 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 calendar year (CY) 2019 EMS Data report was successfully published and is available on the EMSA website. The CY 2020 EMS Data report is expected to begin development in June 2021, and the CY 2018/19 Trauma Report is currently in development.</p>

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
10. Communications	Justin Mealy, ext. 556	<p>Due to COVID-19 response activities, EMSA personnel are still attending virtual meetings. The Communications Coordinator position was filled on April 1, 2021.</p> <p>Los Angeles EMS, Mountain-Valley EMS, and San Diego EMS submitted communications data with the submission of their EMS Plans.</p> <p>Technical assistance has been provided as needed to LEMSAs, response units, and hospitals on matters related to communications infrastructure, dispatch, and interoperability.</p> <p>A LEMSA request for approval to implement alternate destination transportation protocols is being conducted to ensure compliance with statute.</p>
11. Core Quality Measures	Michelle McEuen, ext. 1925	<p>The Core Quality Measures Report for CY 2019 data was published on EMSA's website on March 22, 2021. A link to the report was shared with the EMS Administrators Association of California Quality Improvement Coordinators mailing list and provided to LEMSA directors and administrators. Additionally, LEMSA directors and administrators were provided a CEMSIS Comparison Report on March 26, 2021, for the 2019 Core Quality Measures. This document contained a comparison of data collected for the annual Core Quality Measures Report and data pulled from CEMSIS for their agency.</p> <p>The Core Quality Measures workgroup met via Zoom on March 10, 2021, to discuss project improvements and revisions to the measure specifications sheets. EMSA is currently in the process of compiling the</p>

**Emergency Medical Services Authority
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>recommendations and incorporating the changes into the instruction manual for 2020 reporting. The workgroup is scheduled to meet via Zoom on May 27, 2021, to discuss the 2022 measure specifications.</p> <p>The California Core Quality Measures Instruction Manual is currently being updated and will be sent to the LEMSAs once approved and published on EMSA's website. This will include a request for 2020 core quality measures data.</p>
<p>12. Grant Activity/Coordination/ Maddy EMS Fund report</p>	<p>Lori O'Brien, ext. 3679</p>	<p><u>Maddy EMS Fund Reporting</u> Due to the COVID-19 pandemic, on April 8, 2020, all counties were given an extension of the deadline for report submission to 45 days after the end of the declared state of emergency. It was later determined EMSA was not able to grant such extension and counties were notified on April 2, 2021, that their State Fiscal Year (SFY) 2018/19 reports would be due at the same time as the SFY 2019/20 reports, on April 15, 2021.</p> <p>Technical assistance is provided to counties, as needed, on the Maddy EMS Fund report development and submission process.</p> <p>SFY 2018/19 Maddy EMS Fund report submissions have been received from 46 of the 51 counties implementing the fund as of May 7, 2021. Of the five counties that have outstanding reports, four have been in contact and indicated they are diligently working to submit them as soon as possible; one county is non-responsive. Development of the report to the legislature summarizing the county submitted reports is ongoing.</p>

**Emergency Medical Services Authority
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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>SFY 2019/20 Maddy EMS Fund report submissions have been received from 39 of the 51 counties.</p> <p>Preventive Health and Health Services Block Grant EMSA attended the first Advisory Committee meeting for Federal Fiscal Year (FFY) 2021 held April 7, 2021. The 2021 State Plan is undergoing review by the California Department of Public Health (CDPH) and requested corrections were submitted to CDPH on April 28, 2020. EMSA's total allocation will be \$2,727,396.00. CDPH has requested ongoing identification of staff that were redirected to COVID 19 activities. The first COVID 19 redirection report (March 2020 through March 2021) was completed and submitted to CDPH on April 7, 2021. Reports will be provided monthly going forward.</p> <p>Health Resource Services Administration (HRSA) Grant EMSA has received the HRSA Notice of Award for budget period April 1, 2021 through March 31, 2022. All reporting is current. The Non-Competing Continuation Performance Report will be due July 20, 2021.</p>
13. Ambulance Patient Offload Time (APOT)	Adam Davis, ext. 409	<p>In July 2019, EMSA notified all LEMSAs of the new APOT reporting requirements pursuant to Health and Safety Code Section 1797.225. EMSA received APOT 1 and APOT 2 submissions from 32 of 33 LEMSAs, and one LEMSA failed to provide any submissions. Twenty-nine 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. Twenty-seven LEMSAs have provided a submission</p>

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>for quarter two of 2020. Only 26 LEMSAs have provided a submission for quarter three of 2020. Only 20 LEMSAs have provided a submission for quarter four of 2020. As of May 5, 2021, only 18 LEMSAs provided submissions for quarter one of 2021. EMSA continues to develop CEMISIS comparison reports for LEMSAs who provide submissions to EMSA and who are participating in CEMISIS. CEMISIS comparisons for quarter four of 2020 were distributed to participating LEMSAs on April 13, 2021.</p> <p>EMSA staff continue to monitor the impact of COVID-19 on local EMS systems through analysis of CEMISIS data related to APOT.</p> <p>EMSA staff are currently monitoring Assembly Bill 1229, a bill that would impact the APOT program by mandating EMSA to perform additional responsibilities.</p> <p>Pursuant to Health and Safety Code Section 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 Ambulance Patient Offload Delays 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. The legislative report is currently published on the EMSA website.</p>

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
Management Services (Office Support)	John Skarr	<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 applications <p><u>Develop tracking program for EMS Systems Division</u></p> <ol style="list-style-type: none"> 1. Create a database system for tracking 2. Input all applicable information 3. Maintain and update all projects and current EMS Systems progress 4. Daily, review and update with applicable information <p><u>Onboarding of New Staff Members</u></p> <ol style="list-style-type: none"> 1. Review applications for vacant EMS Systems positions 2. Utilize tools to score individuals based upon information in their applications 3. Develop a comprehensive spreadsheet all applicants 4. Provide information to management for final decision 5. Communicate with candidates to schedule interviews 6. Procure all necessary documents from individuals 7. Compile all materials for management to submit to HR for final approval 8. Prepare all necessary materials for new staff member 9. Provide relevant documents and instruction to new staff <p><u>Administrative Duties</u></p> <ol style="list-style-type: none"> 1. Complete all purchasing for EMS Systems

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Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<ol style="list-style-type: none"> 2. Develop documents for submission to procurement with necessary justifications 3. Schedule meetings for staff and management 5. Review documents for accuracy, spelling, and grammar prior to being sent 6. Order general office supplies for EMS Systems 7. Track all incoming and outgoing correspondence for EMS Systems 8. Develop binders for use by manager in special projects 9. Print, prepare, and create EMS Plan files submitted by LEMSAs 10. Send all outgoing documents for EMS Systems 11. Send correspondence for specialty care programs 12. Review language in specialty care programs letter for accuracy 13. Support all EMS Systems staff, as needed

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**COMMISSION ON EMERGENCY MEDICAL SERVICES****QUARTERLY MEETING**

MEETING DATE: June 16, 2021 **ITEM NUMBER: 4A**

SUBJECT: Administrative and Personnel Report

PRESENTER: Rick Trussell, Chief, Fiscal and Administration Unit

CONSENT: X ACTION: INFORMATION:

FISCAL IMPACT

None

DISCUSSION**Emergency Medical Services Authority (EMSA) Budget:****2021-22**

The Governor's May Revise Budget for 2021-22 includes expenditure authority in the amount of \$74.9 million and 102 permanent positions. Of this amount, \$55.2 million or 73.7% is delegated for State operations and \$19.7 million or 26.3% is delegated to local assistance. The following budget adjustments are included in the May Revise:

- \$365,000 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.
- \$286,000 General Fund 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.
- \$2.3 million General Fund over three years to implement Chapter 138, Statutes of 2020 (AB 1554). AB 1544 creates the Community

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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.

- \$8.5 million General Fund and 14 permanent positions, reducing to \$1.6 million ongoing beginning in 2024-25. The resources will maintain critical equipment and medical supplies acquired during the COVID-19 pandemic and provide lifesaving resuscitative and medical surge services to relieve suffering for disaster victims during pandemics or other catastrophic emergencies.
- \$851,000 General Fund and 5 permanent positions, reducing to \$530,000 ongoing beginning in 2024-25, to address mission critical workload associated with increased human resources workload, emergency preparedness personnel services, and to establish the human resources division within EMSA.
- \$10 million one-time General Fund and 2 permanent positions. These resources will go toward project planning for the California Emergency Medical Services (EMS) Data Resource System (CEDRS) utilizing the State's Project Approval Lifecycle (PAL) process, and to connect the remaining 17 Local Emergency Medical Services Agencies (LEMSAs) to an existing emergency medical services network. The proposed CEDRS is intended to create a link to various systems to increase data interoperability between hospitals, EMS agencies, and other healthcare organizations, ensuring continuity of care to currently uncovered areas of the state. Creating connections in these areas will also allow access to on-going Federal funding to maintain the new connections.
- \$1.4 million in General Fund in 2021-22 and six permanent positions. The resources will provide increased staffing and oversight of the Medical Staffing Surge Initiative, consisting of the California Health Corps Program, California Medical Assistance Teams program, and the Disaster Healthcare Volunteers/Medical Reserve Corps Program. The focus of these additional resources will be on Statewide recruitment efforts, on-boarding, program management, exercise and training, and deployment/management of these medical staffing surge resources both prior to and during emergency response activations.
- \$16.9 million one-time General Fund for continued medical staffing, ambulance transportation services, and related support costs to continue responding to and mitigating the impacts of the COVID-19 Pandemic.

2020-21

The 2020-21 California State budget includes expenditure authority in the amount of \$102 million and 79 permanent positions. Of this amount, \$82.7 million is delegated for State operations and \$19.3 million to local assistance. State operations funding was increased \$66 million to provide critical Statewide emergency medical staffing and support during the Covid-19 pandemic.

As of May 18, 2021, accounting records indicate that the Department has expended and/or encumbered \$85.2 million or 83.5% of available expenditure authority. Of this amount, \$69.9 million or 84.5% of State Operations expenditure authority has been expended and/or encumbered and \$15.3 million or 79% 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 Commission meeting.

EMSA Staffing Levels:

The Department staffing level includes 79 permanent positions and 26 temporary (blanket and retired annuitant) positions. Of the 105 positions, 14 positions are vacant as of May 18, 2021.

	Division				
	Admin/Exec	DMS	EMSP	EMS	Total
Authorized	24.0	18.0	22.0	15.0	79.0
Temporary Staff	16.0	9.0	0.0	1.0	26.0
Staffing Level	40.0	27.0	22.0	16.0	105.0
Authorized (Vacant)	-1.0	-3.0	-6.0	-1.0	-11.0
Temporary (Vacant)	-3.0	0.0	0.0	0.0	-3.0
Current Staffing Level	36.0	24.0	16.0	15.0	91.0

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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**COMMISSION ON EMERGENCY MEDICAL SERVICES****QUARTERLY MEETING**

MEETING DATE: June 16, 2021

ITEM NUMBER: **4B**

SUBJECT: Legal Report

PRESENTER: Steven A. McGee, Counsel

CONSENT: X ACTION: INFORMATION:

FISCAL IMPACT

None

DISCUSSION

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

Disciplinary Cases:

From February 12, 2021, to May 14, 2021, the Authority issued eighteen new accusations against existing paramedic licenses, seven statements of issues, four administrative fines, accepted five license surrenders in lieu of legal action, and issued seven decisions on petitions for reduction of penalties and license reinstatements. Of the newly issued actions, two of the Respondents have requested that an administrative hearing be set. There are currently two 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

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

Sacramento County EMS v. EMSA: The Authority denied approval of Sacramento's annual EMS plan submission because it did not comply with the regulation requiring an ALS agreement with all providers. Sacramento County subsequently produced copies of agreements with all ALS providers, and the Authority withdrew its Statement of Issues, ending the appeal.

Inland Counties Emergency Medical Agency v. EMSA: The Authority denied approval of ICEMA's annual EMS plan submission because it did not comply with the regulation requiring an ALS agreement with all providers. Hearing has been set with OAH for June 23-24, 2021.

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 the Authority'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. Gurrola appealed the dismissal and the court re-instated the suit. Briefing schedule set by the court.

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**COMMISSION ON EMERGENCY MEDICAL SERVICES
 QUARTERLY MEETING**

MEETING DATE: June 16, 2021

ITEM NUMBER: **4C**

SUBJECT: Enforcement Report

PRESENTER: Alexander Bourdaniotis, Chief Investigator

CONSENT: X ACTION: INFORMATION: **FISCAL IMPACT**

None

DISCUSSIONUnit Staffing:

The Enforcement Unit is budgeted for five full-time Special Investigators, and one full-time Associate Government Program Analyst (AGPA-Probation Monitor). However, as of April 30, 2021, one Special Investigator retired, and the position has not been filed at this time.

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:	108
Cases completed and/or closed:	75
EMT-Paramedics on Probation:	237

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 142 cases in “open” status.

As of May 5, 2021, there are 58 cases that have been in “open” status for 180 days or longer, including: two Firefighters’ Bill of Rights (FFBOR) cases and 16 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 58 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.

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**COMMISSION ON EMERGENCY MEDICAL SERVICES****QUARTERLY MEETING**

MEETING DATE: June 16, 2021

ITEM NUMBER: 5A

SUBJECT: Legislative Report

PRESENTER: Sergy (Esam) El-Morshedy
Legislative CoordinatorCONSENT: ACTION: INFORMATION: **FISCAL IMPACT**

None

DISCUSSION

Due to the dynamic nature of the legislative process, the Legislative Report to the Commission on Emergency Medical Services will be posted on the EMSA website at https://ems.ca.gov/legislative_activity/.

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**COMMISSION ON EMERGENCY MEDICAL SERVICES****QUARTERLY MEETING**

MEETING DATE: June 16, 2021

ITEM NUMBER: 5B

SUBJECT: Regulations Update

PRESENTER: Kent Gray
 Regulations Manager

CONSENT: ACTION: INFORMATION:

FISCAL IMPACT

None

DISCUSSION

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

- Public Safety First Aid (Ch. 1.5)
 - Status: In development by EMSA
 - Purpose: Updates to include volunteers.
- Lay Rescuer Epinephrine Auto-Injector Training Certificate Standards (Ch. 1.9)
 - Status: Under review by EMSA
 - Purpose: Updates, including required form.
- Community Paramedicine and Alternate Destination
 - Status: In development by EMSA with advisory group
 - Purpose: Implement AB 1544 (Statutes of 2020)
 - The full project update will be addressed under **Item 7B**
- Trauma Care Systems (Ch. 7)
 - Status: Under review by EMSA
 - Purpose: General update.
- Emergency Medical Services System Regulations (Ch. 13)
 - Status: Under review by EMSA

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- Purpose: Regulations regarding Annual EMS Plans
- Paramedic Fees (Ch. 4)
 - Status: Section 100 submitted to OAL
 - Purpose: Section 100172 fee schedule implementation.
- Training Standards for Child Care Providers & Merger of Chapters 1.1 and 1.2.
 - Status: Hold
 - Purpose: General update.
- California Emergency Medical Technician Central Registry (Ch. 10)
 - Status: Hold
 - Purpose: General update.
- Emergency Medical Services System Quality Improvement (Ch. 12)
 - Status: Hold
 - Purpose: General update.
- Dispatch
 - Status: Pending
 - Purpose: Implement SB 438 (Statutes of 2019)
- Emergency Regulations regarding training.
 - Status: Pending
 - Purpose: Transition for State of Emergency procedures to normal procedures.

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**COMMISSION ON EMERGENCY MEDICAL SERVICES****QUARTERLY MEETING**

MEETING DATE: June 16, 2021

ITEM NUMBER: 6

SUBJECT: Commission on EMS Subcommittee Report

PRESENTER: Atilla Uner, Chair, Commission on EMS

CONSENT: ___ ACTION: X INFORMATION: ___**RECOMMENDATION**

The Commission on EMS's subcommittee on behavioral health emergencies recommends the following:

1. The topic of behavioral health in emergency medical services be a standing agenda item at all future Commission on EMS meetings.
2. The Commission on EMS recommend *Clinical Care and Restraint of Agitated or Combative Patients by Emergency Medical Services Practitioners* as a guiding principle for local emergency medical services agencies (LEMSA), from which to create (or modify) policies and procedures.
3. The Commission requests EMSA to survey the LEMSAs regarding their current protocols and procedures for behavioral health responses.
 - o A report of this data is to be presented at the December 2021 Commission on EMS Meeting, and the survey is to be completed annually for three (3) consecutive years.

FISCAL IMPACT

None

BACKGROUND

At the March 17, 2021, meeting of the Commission on Emergency Medical Services (EMS), a subcommittee was created to discuss the clinical care and restraint of agitative or combative patients, as described in the 2021 National Association of EMS Physicians (NAEMSP) position paper. A virtual, public meeting of the subcommittee was held on May 4, 2021, to discuss the clinical care and

restraint of agitative or combative patients in the context of EMS. An agenda was posted to the EMSA website along with the information to join the meeting.

SUMMARY

1. The subcommittee recommends that the topic of behavioral health in EMS become a standing agenda item for discussion at Quarterly Commission on EMS Meetings. This is not to be part of the Consent Calendar.
2. The Commission on EMS should recommend the joint position paper *Clinical Care and Restraint of Agitated or Combative Patients by Emergency Medical Services Practitioners*¹ with the acknowledgement that not all information and recommendations in the statement pertain to California.
 - a. Suggested language: The Commission on Emergency Medical Services (EMS) recommends the 2021 joint position statement of the National Association of EMS Physicians (NAEMSP), National Association of State EMS Officials (NASEMSO), National EMS Management Association (NEMSMA), National Association of Emergency Medical Technicians (NAEMT), and American Paramedic Association (APA), entitled *Clinical Care and Restraint of Agitated or Combative Patients by Emergency Medical Services Practitioners*. The Commission recommends this document act as a guiding principle for local emergency medical services agencies (LEMSA), from which to create (or modify) policies and procedures. The Commission recognizes that the statement recommends transport to hospital; however, California allows alternate destination policies, so LEMSAs may decide which receiving facility they deem appropriate for each patient. Any patient who requires EMS intervention and has a patient care record must be transported to a hospital or approved alternate care destination.
3. EMSA should survey the LEMSAs regarding their current protocols and procedures for behavioral health responses, with survey responses submitted to EMSA in sufficient time for aggregate data to be reported at the December 2021 Quarterly Commission on EMS Meeting. The goal of this survey is to identify current policies and procedures for behavioral health emergencies and identify plans to modify those policies and procedures over the next 6 to 12 months.
 - a. The subcommittee recommends that EMSA repeat this query annually for three years, with EMSA providing the Commission with an aggregate, anonymized report of the results at the December meetings.

¹ Douglas F. Kupas, Gerald C. Wydro, David K. Tan, Richard Kamin, Andrew J. Harrell IV & Alvin Wang (2021) *Clinical Care and Restraint of Agitated or Combative Patients by Emergency Medical Services Practitioners*, *Prehospital Emergency Care*, DOI: [10.1080/10903127.2021.1917736](https://doi.org/10.1080/10903127.2021.1917736)

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- i. After three years, the Commission on EMS will vote to decide whether and how to continue the annual query.

ATTACHMENT(S)

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

Commission on Emergency Medical Service Subcommittee Meeting Minutes



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 restraint 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:



**STATE OF CALIFORNIA
COMMISSION ON EMERGENCY MEDICAL SERVICES
Subcommittee: EMS Response to Behavioral Health Emergencies**

**Minutes of Virtual Meeting
Tuesday, May 4, 2021
Zoom**

Commissioners Present:

Sean Burrows, James Dunford, Atilla Uner, Kristin Weivoda

Emergency Medical Services Authority (EMSA) Staff Present

Dave Duncan, Louis Bruhnke, Caitlyn Cranfill

Audience Present (Partial List)

Melissia Turpin

1. Introduction

- a. Topic: EMS Response to Behavioral Health Patients
 - i. The purpose of this discussion and recommended survey of the local emergency medical services agencies (LEMSAs) is to stimulate discussion and discern what protocols and procedures currently exist to address behavioral health emergencies.

2. Discussion

- a. Should EMS Response to Behavioral Health Patients be a standing agenda item at Commission on EMS Meetings?
 - i. Yes – The subcommittee recommends that the topic of behavioral health in EMS become a standing agenda item of the Commission with annual reports on LEMSA protocols and procedures presented at December meetings.
 1. This is not to be part of the Consent Calendar.
- b. Does the subcommittee recommend the National Association of EMS Physicians' paper (*Clinical Care and Restraint of Agitated or Combative Patients by Emergency Medical Services Practitioners*¹) as a best practice for the EMS response to behavioral health emergencies in California?
 - i. Yes, but with the acknowledgement that not all information and recommendations in the statement pertain to California.

¹ Douglas F. Kupas, Gerald C. Wydro, David K. Tan, Richard Kamin, Andrew J. Harrell IV & Alvin Wang (2021) *Clinical Care and Restraint of Agitated or Combative Patients by Emergency Medical Services Practitioners, Prehospital Emergency Care*, DOI: [10.1080/10903127.2021.1917736](https://doi.org/10.1080/10903127.2021.1917736)

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1. Suggested endorsement language:

The Commission on Emergency Medical Services (EMS) recommends the 2021 joint position statement of the National Association of EMS Physicians (NAEMSP), National Association of State EMS Officials (NASEMSO), National EMS Management Association (NEMSMA), National Association of Emergency Medical Technicians (NAEMT), and American Paramedic Association (APA), entitled *Clinical Care and Restraint of Agitated or Combative Patients by Emergency Medical Services Practitioners*.

The Commission recommends this document act as a guiding principle for local emergency medical services agencies (LEMSA), from which to create (or modify) policies and procedures. The Commission recognizes that the statement recommends transport to hospital; however, California allows alternate destination policies, so LEMSAs may decide which receiving facility they deem appropriate for each patient. Any patient who requires EMS intervention and has a patient care record must be transported to a hospital or approved alternate care destination.

ii. Additional discussion:

1. The operative agency in this discussion is the LEMSA, not the state.
 2. Dialogue is encouraged amongst the LEMSAs regarding how these principles may be applied throughout the state.
 3. LEMSAs will decide best local practices, including transportation destinations.
 4. The document is lacking in the discussion and consideration of patient privacy and HIPAA during field response.
- c. Are the local emergency medical services agencies (LEMSA) to be queried regarding their protocols and procedures for behavioral health responses?
- Yes – EMSA should survey the LEMSAs regarding their current protocols and procedures for behavioral health responses, with survey responses submitted to EMSA in sufficient time for aggregate data to be reported at the December 2021 Quarterly Commission on EMS Meeting. The goal of this survey is to identify current policies and procedures for behavioral health emergencies and identify plans to modify those policies and procedures over the next 6 to 12 months.
- i. Is such an inquiry to be repeated at regular intervals?

1. Yes – The subcommittee recommends that EMSA query the LEMSAs annually as to their current and planned protocols and procedures relating to response to behavioral health emergencies. This is to occur for 3 years, with EMSA providing the Commission with an aggregated, anonymized report of the results at the December meetings. After three years, the Commission on EMS will vote to decide whether and how to continue the annual query.
- ii. Should the Commission on EMS recommend the table created by Commissioner Dunford as a template for the inquiry?

Quality components of care (P&P)	Today
Step-based protocols	
Use of an agitation assessment tool	
Use of checklist (differential dx)	
Use of de-escalation techniques	
Competency-based training for BH emergencies	
Periodic training with law enforcement and behavioral health	
Clear definitions of prohibited techniques	
Clear protocols governing pharmacologic management	
Thorough documentation of care	
Standardized QA process for BH emergencies	
Defined role for on-line medical oversight	

1. Yes, with modifications:
 - a. Have 3 response columns:
 - i. In Effect Today
 - ii. Implementation Within 6 Months
 - iii. Implementation Within 12 Months
 - b. Add: Role of body-worn cameras by law enforcement regarding patient privacy.
 - i. Are there policies and procedures that protect the privacy rights of individuals experiencing behavioral health emergencies in the presence of body-worn cameras?
 - c. Add to Competency-based training for BH emergencies:

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- i. including de-escalation techniques
 - d. Add to Standardized QA process for BH emergencies:
 - i. To include tracking use of pharmaceuticals and patient response to pharmaceuticals during field care.
 - iii. Should the EMDAC Scope of Practice Committee be involved in surveying LEMSA protocols and procedures?
 - 1. Such a task may or may not be under the purview of the committee, but they need not become involved in the initial survey.
 - iv. Should we ask the LEMSAs to submit their existing protocols for review?
 - 1. Perhaps this could be a phase 2 request.
 - 2. The subcommittee is not seeking to provide a 'report card' to LEMSAs regarding their protocols. The LEMSAs should complete the survey to provide the Commission on EMS with information on whether or not key protocols and procedures currently exist regarding the response to behavioral health emergencies.

3. **Public Comment**

- a. None received.

4. **Adjournment**

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**COMMISSION ON EMERGENCY MEDICAL SERVICES****QUARTERLY MEETING**

MEETING DATE: June 16, 2021

ITEM NUMBER: 7A

SUBJECT: Community Paramedicine Pilot Project Update

PRESENTER: Lou Meyer, Community Paramedicine Pilot Project Manager

CONSENT: ACTION: INFORMATION: **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.

BACKGROUND

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

SUMMARY

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.

DISCUSSION

Community Paramedicine and Triage to Alternate Destination Oversight Advisory Committee

In accordance with the provisions of AB 1544 the director of the Emergency Medical Services Authority established a community paramedicine and triage to alternate destination oversight advisory committee to advise the authority on the development and oversight of community paramedicine program and triage to alternate destination program specialties. The Advisory Committee is made up of 35 Members & Alternates representing the following;

- a. Local Emergency Medical services agency administrators
- b. Local emergency medical services agency medical directors
- c. Public safety agency medical directors
- d. Physicians and surgeons, including emergency room physicians.
- e. Nurses, including nurses that specialize in treatment of substance use disorders who treat patients in authorized sobering centers
- f. Hospital administrators
- g. Public first responder paramedics
- h. Private first responder paramedics
- i. Medical Professionals specializing in;
 1. Home health care
 2. Hospice care
 3. Mental Health

Additionally, the Authority is in the process of drafting regulations that after approval of the EMS Commission will be adopted to establish minimum standards for the development of a community paramedicine or triage to alternate destination program based upon, and informed by, the Community Paramedicine Pilot Program and the protocols and operation of the pilot projects approved under the OSHPD Workforce Pilot Project No. 173 .

Community Paramedicine Pilot Project Concepts and Enrollment

- The pilot projects enrolled 11,524 persons through Fourth Quarter 2020. (see Table 1)
- Thirteen pilot projects were launched from June through October of 2015.
- Seven more 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. (see Table 2)

Table 1. Number of Persons Enrolled per Project, by Month

Project No.	Concept	Enrolled for the First Time			Total Enrolled			Cumulative Enrolled*
		Oct - 20	Nov - 20	Dec - 20	Oct - 20	Nov - 20	Dec - 20	
CP001	Alternate Destination – Urgent Care	Closed May 2017						12
CP002	Post-Discharge	Closed in August 2016						154
CP003	Alternate Destination – Urgent Care	Closed in November 2017						34
CP004	Post-Discharge	Closed in December 2018						1,001
CP005	Tuberculosis	-	-	-	-	-	-	52
CP006	Hospice	12	10	16	-	-	-	460
CP007A	Frequent EMS Users	0	0	0	11	11	11	85
CP007B	Post-Discharge	0	0	0	0	0	0	140
CP008	Post-Discharge	-	-	-	-	-	-	228
CP009	Alternate Destination – Urgent Care	Closed in November 2017						2
CP010	Frequent EMS Users	0	0	0	19	19	19	65
CP012	Alternate Destination – Mental Health	8	4	6	-	-	-	494
CP013	Post-Discharge	1	0	1	1	0	2	293
CP014	Alternate Destination – Sobering Center	35	42	37	-	-	-	2,963
CP015A	Alternate Destination – Sobering Center	-	-	-	-	-	-	0
CP015B	Alternate Destination – Mental Health	2	0	2	-	-	-	108
CP018	Alternate Destination - Mental Health	2	3	4	-	-	-	95
CP019	Alternate Destination - Sobering Center	-	-	-	-	-	-	96

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CP021	Frequent EMS Users	8	10	15	145	134	137	364
CP022	Alternate Destination – Mental Health	124	147	180	-	-	-	4,878
Total		192	216	261	176	164	169	11,524

* Cumulative enrollment differs from the cumulative sum of total enrolled patients in each month because patients enrolled in these projects are not necessarily unique from month to month. Some patients participating in frequent 911 caller and tuberculosis pilot projects receive CP services for multiple months. Some patients enrolled in post-discharge pilot projects receive CP service for a 30-day period spanning two months (e.g. enrolled on October 20, 2020, and completed 30-day period on November 19, 2020).

Table 2. Pilot Sites, Community Paramedicine Concepts

Project #	Lead Agency	Community Paramedicine Concept	Date Implemented
CP001	UCLA Center for Pre-Hospital Care	Alternate Destination – Urgent Care	Sept. 8, 2015
CP002	UCLA Center for Pre-Hospital Care	Post-Discharge	Sept. 1, 2015
CP003	Orange County	Alternate Destination – Urgent Care	Sept. 14, 2015
CP004	Butte County EMS	Post-Discharge	July 1, 2015
CP005	Ventura County EMS	Tuberculosis	June 1, 2015
CP006	Ventura County EMS	Hospice	Aug. 1, 2015
CP007A	Alameda City EMS	Frequent EMS Users	July 1, 2015
CP007B	Alameda City EMS	Post-Discharge	June 1, 2015
CP008	San Bernardino County and Rialto Fire Departments	Post-Discharge	Aug. 13, 2015
CP009	Carlsbad Fire Department	Alternate Destination - Urgent Care	Oct. 9, 2015
CP010	City of San Diego	Frequent EMS Users	Oct. 12, 2015
CP012	Mountain Valley – Stanislaus EMS	Alternate Destination – Mental Health	Sept. 25, 2015
CP013	Medic Ambulance Solano	Post-Discharge	Sept. 15, 2015

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CP014	San Francisco Fire Department	Alternate Destination – Sobering Center	Feb. 1, 2017
CP015A	Gilroy Fire Department	Alternate Destination – Sobering Center	June 6, 2018
CP015B	Gilroy Fire Department	Alternate Destination – Mental Health	June 6, 2018
CP018	Los Angeles Fire Dept. — EMS Bureau	Alternate Destination – Mental Health	June 21 2019
CP019	Los Angeles Fire Dept. — EMS Bureau	Alternate Destination – Sobering Center	June 21, 2019
CP021	San Francisco Fire Department	Frequent EMS Users	Sep. 12, 2018
CP022	American Ambulance—Fresno & Kings Counties	Alternate Destination – Mental Health	July 30, 2018

*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.

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**COMMISSION ON EMERGENCY MEDICAL SERVICES****QUARTERLY MEETING**

MEETING DATE: June 16, 2021

ITEM NUMBER: **8A**

SUBJECT: State Medical Response Update

PRESENTER: Craig Johnson, Chief, Disaster Medical Services

CONSENT: ACTION: INFORMATION: **FISCAL IMPACT**

None.

BACKGROUND

The 2020 COVID-19 Pandemic began with an outbreak of a novel Corona Virus (SARS-CoV-2) in Wuhan, Hubei Province, China in December 2019. SARS-CoV-2 quickly spread worldwide via international travel into and out of China, and by mid-January 2020, the virus had made its way to the United States. California began response operations following the activation of the Medical Health Coordination Center and State Operations Center by supporting the federal repatriation flights from China and Japan to locations within California, including March ARB, Travis AFB, and Miramar Naval Base. California experienced three significant COVID-19 surges with medical impacts throughout the State.

SUMMARY

Over the past year, EMSA, in collaboration with local, state, and federal partners, engaged in COVID-19 response activities to provide statewide medical support for victims and mitigate the impact of the multiple COVID surges.

DISCUSSION

The EMS Authority continues to support response activities for COVID-19, which began January 24, 2020, with the activation of the Medical Health Coordination Center (MHCC) and, shortly after, the State Operations Center. By mid-March

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2020, EMSA activated the DOC to support statewide medical operations and co-led the Emergency Support Function (ESF) 8 Multi-Agency Coordination (MAC) group for scarce resource allocation and policy guidance.

Response Activities to Date Include:

- Support to Federal Medical Stations, Alternate Care Sites, and Long-term Care Facilities. EMSA supported over 3,700 individual California Medical Assistance Team (CAL-MAT) member deployments to support 133 medical missions. To date, EMSA provided care for 8,654 patients.
- Staffing Support to Hospitals. EMSA Coordinated the approval of Over 32,000 out-of-state medical professionals to practice in California for the COVID-19 response. At the COVID peak, nearly 6,000 medical staff were supporting medical facilities statewide on any given day. In addition, EMSA coordinated with federal partners to deploy eight teams of 20 DOD medical professionals to support hospitals.
- Support for Hospital Medical Surge. Assisted hospitals (13) in Southern and Northern California with expanding Intensive Care Unit (ICU) capacity. EMSA also Established a 50-bed mobile hospital in the parking lot at El Centro Regional Medical Center. To support hospital oxygen shortages, EMSA established four (4) oxygen depots in Southern California consisting of H-type cylinder tanks for distribution and large oxygen concentrators for hospital use.
- Provided critical medical supplies to local hospitals and health care providers. EMSA became the central repository and hub for all State procured ventilators, IV Pumps, Hi-Flow Nasal Cannula, and BiPAP machines. We deployed approximately 2,200 ventilators to medical facilities during the response and currently have over 15,500 units ready for deployment.
- Provided COVID testing in partnership with CA National Guard. CAL-MAT performed 2,384 tests to support the Central Valley, Monterey, and Tulare County. EMSA continues to provide testing at CAL-MAT treatment sites, including migrant shelters, and for medical personnel.
- Vaccination Support. EMSA established six (6) CAL-MAT Task Force teams (six – eight member teams consisting of RNs, paramedics, and EMTs) to provide statewide assistance as requested. The teams supported 20 vaccination sites and provided approximately 42,500 vaccinations. Also, EMSA supported the medical operations at the FEMA Point of Distribution (POD) sites in Oakland and Los Angeles.

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EMSA developed a Local Optional Scope of Practice (LOSOP) for EMTs and Paramedics to administer COVID Vaccines, and it has been adopted by every LEMSA in the state, markedly expanding the pool of CA "vaccinators." EMSA also continues to work with LEMSAs to recruit and train available Paramedics, Advanced EMTs, and EMTs to support vaccination clinics by administering vaccinations.

Current Activities:

- EMSA is working with state, regional, and local medical/health partners to establish a program beginning May 2021 which will utilize EMS and Ambulance Strike Teams (ASTs) to deliver COVID Vaccines to the homebound when requested by Counties.
- EMSA is currently providing medical support (screenings, first aid, and vaccinations) at the Barbara Worth Non-Congregate Shelter in Imperial County and will begin support in May 2021 at sites in Riverside and San Diego Counties.
- EMSA continues to support the California Vaccination Campaign and has deployed staff to assist with medical coordination at the FEMA POD located at the Oakland Coliseum.
- EMSA is heavily engaged in recovery efforts, including data collection for after-action reporting, reconstituting medical equipment and caches, and leveraging funding opportunities to bolster response capabilities. EMSA is also working with the regions and counties to recover deployed biomedical equipment no longer in use throughout California.

The past year has been extremely challenging for the medical and health community and demonstrated our collective determination to overcome the difficulties of meeting statewide medical needs. Thanks to the excellent partnerships, collaboration, and team efforts, countless lives were saved. EMSA will continue to work closely with all stakeholders to build on the lessons learned and best practices to advance state-level preparedness and response capabilities.