STATE OF CALIFORNIA
COMMISSION ON EMERGENCY MEDICAL SERVICES
September 21, 2022
10:00 A.M. – 1:00 P.M.

Participate In Person:

Holiday Inn San Diego Bayside
4875 North Harbor Drive
San Diego, CA 92106

Participate via Webinar/Teleconference:

The meeting will be live streamed through the web link below. To provide public comment during the meeting, please join at the in-person location or submit written comments to WebMeeting@emsa.ca.gov during the meeting.

Live Stream Link: https://youtu.be/NNqaxOHHKd4

AGENDA

1. **Call to Order and Pledge of Allegiance**

2. **Review and Approval of June 15, 2022 Minutes**

3. **Director's Report**

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
      a. Community Paramedicine Regulations Package Update

C. Strategic Planning Update

6. EMS Systems

A. Ambulance Patient Offload Time (APOT)
   a. APOT Committee
   b. Quarterly APOT Data Submission
   c. APOT Reporting Memo

B. Community Paramedicine Pilot Project Update
   a. Community Paramedicine Implementation Plan

C. Cessation of 180-Day Extensions for the Submission of Local Emergency Medical Services Agency Annual Plans Memo

7. EMS Response to Behavioral Health Patients

8. EMS Personnel

A. Contra Costa Buprenorphine Trial Study

B. NREMT Exam Pass Rates

9. Disaster Medical Services Division

A. State Medical Response Update

10. Items for Next Agenda

11. Public Comment

12. Adjournment

A full agenda packet will not be provided at the meeting; however, you can print a full packet, including the agenda from the Department's website at www.emsa.ca.gov. This event will be held in an accessible facility. Individuals with disabilities requiring auxiliary aids or services to ensure accessibility such as language interpreting, assisted listening device, materials in alternate formats or other accommodation, should contact Zoë Jones at executive.assistant@emsa.ca.gov or (916) 591-1298 no less than 7 days prior to the meeting.

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **ITEM NUMBER: 2**

SUBJECT: Review and Approval of June 15, 2022 Minutes

PRESENTER: Atilla Uner
Chair, Commission on EMS

CONSENT: ___ ACTION: X INFORMATION: ___

RECOMMENDATION

Approve the meeting minutes from the June 15, 2022, Commission on Emergency Medical Services (EMS) Meeting.

FISCAL IMPACT

No fiscal impact.

SUMMARY

The prior meeting of the Commission on EMS occurred June 15, 2022. 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, June 15, 2022.

STATE OF CALIFORNIA
COMMISSION ON EMS
Wednesday, June 15, 2022
Hilton Sacramento Arden West
2200 Harvard Street
Sacramento, 95815

MINUTES

COMMISSIONERS PRESENT:
Steve Barrow, Sean Burrows, James Dunford, M.D., Thomas Giandomenico, Travis Kusman, Lydia Lam, M.D., Ken Miller, M.D., Ph.D., Masaru "Rusty" Oshita, M.D., Jodie Pierce, Karen Relucio, M.D., Paul Rodriguez, Carole Snyder, Jim Suver, Kristin Thompson, Atilla Uner, M.D., and Todd Valeri

COMMISSIONERS ABSENT:
Curtis Brown, Marc Gautreau, M.D., and Nancy Gordon

EMS AUTHORITY STAFF PRESENT:
Elizabeth Basnett, Louis Bruhnke, Hernando Garzon, M.D., Zoë Jones, Kim Lew, Tom McGinnis, and Lou Meyer

PUBLIC SPEAKERS AND PRESENTERS:
Tanir Ami, CARESTAR Foundation
Nichole Bosson, M.D., Los Angeles County EMS Agency
Ray Gayk, President, California Fire Chiefs Association
Kevin Greene, EMS Health and Safety Director, California Professional Firefighters
Dave Magnino, National EMS Memorial Bike Ride Foundation/Muddy Angels
Stephanie Welch, MSW, Deputy Secretary of Behavioral Health, California Health and Human Services Agency (CalHHS)

1. CALL TO ORDER AND PLEDGE OF ALLEGIANCE

Chair Atilla Uner, M.D., called the teleconference meeting to order at 10:00 a.m. Sixteen Commissioners were present. He led the Pledge of Allegiance and reviewed the meeting protocols and meeting agenda.

Chair Uner introduced new Commissioners Travis Kusman, representing the Emergency Medical Services Administrators' Association of California (EMSAAC), and Masaru "Rusty" Oshita, M.D., representing the California Medical Association (CMA).

Chair Uner stated Commissioners James Hinsdale, M.D., and Kristin Weivoda have termed out. He thanked them for their many years of service.

2. REVIEW AND APPROVAL OF MARCH 16, 2022, MINUTES

Commissioner Relucio referred to her comment in the last paragraph on page 8 and asked to change "he" to "she."

Chair Uner referred to the list of 2022 Officers at the top of page 10 and asked to change Atilla Uner to James Dunford as Member Emeritus on the Administrative Committee.

Action: Vice Chair Burrows made a motion, seconded by Commissioner Snyder, that:

- *The Commission approves the March 16, 2022, Commission on Emergency Medical Services (EMS) Teleconference Meeting Minutes as revised.*

Motion carried 13 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Dunford, Giandomenico, Lam, Miller, Pierce, Relucio, Rodriguez, Snyder, Suver, Thompson, and Valeri, Vice Chair Burrows, and Chair Uner.

The following Commissioners abstained: Commissioners Kusman and Oshita.

3. DIRECTOR'S REPORT

A. In-Depth Overview of CA EMS Strategic Planning Subcommittee

Elizabeth Basnett, Acting Director, thanked everyone, especially the Commissioners, for their resilience and dedication through ongoing issues such as COVID response, drought, infant formula shortage, wildfire season, and many others. She emphasized her intention for the Emergency Medical Services Authority (EMSA) and the California Emergency Medical Services (EMS) System to stay patient-centered in all their efforts and decisions.

Acting Director Basnett reviewed EMSA's three focus areas: data and technology, strategic planning, and partnerships and service orientation. She provided an overview, with a slide presentation, of the background, makeup, four working groups, goals, and timeline of the California EMS Strategic Planning Advisory Committee. She reviewed the slide presentation and questions that will be part of tomorrow's four-hour Advisory Committee kickoff meeting and were part of today's meeting materials. The Advisory Committee will continue to meet over the next ten months as part of the strategic planning process.

Acting Director Basnett stated Working Group development will be discussed at the next Advisory Committee meeting with an emphasis on guidelines, boundaries, and goals. The four Working Groups are Equity and Transparency, Innovation and Data, Real-Time Data, and Administration and Resilience.

Acting Director Basnett stated EMSA is in the process of adopting a new mission statement, vision, and values as part of its internal strategic planning process for the Department. She noted that EMSA will move into alignment with the parent organization, the California Health and Human Services Agency (CalHHS), and their new strategic plan.

Discussion

Commissioner Barrow stated the US Secretary of Transportation released the new US Road Strategic Safety Plan in January, which calls for zero traffic fatalities by a certain

date, and asked all states to consider the role of their EMS Systems in helping to reach that goal. Commissioner Barrow asked to include this in the strategic plan. He also suggested including a section in the strategic plan about the EMS System's role in advancing prevention in California.

Commissioner Relucio suggested not only looking at retrospective equity and transparency data but considering prospective changes in data collection so it will truly measure equity.

Acting Director Basnett agreed and stated input on these points will be gathered from the Advisory Committee.

Commissioner Relucio asked if the California Department of Public Health (CDPH) is involved in this conversation.

Acting Director Basnett stated Susan Fanelli, the Chief Deputy Director of the CDPH, is a member of the Advisory Committee.

Commissioner Thompson thanked EMS staff for their work on this long-overdue issue and for their dedication to including all interested parties in the process.

Commissioner Barrow stated the data shows that the leading cause of death in children and youth of color in California is unintentional injury. He stated the need for communities of color to be well-represented on the Advisory Committee and during the strategic planning process.

Public Comment

No public comment.

4. CONSENT CALENDAR

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

Discussion

Chair Uner asked staff if the EMSA has the financial means to conduct business appropriately.

Acting Director Basnett stated Budget Change Proposals have been submitted for the upcoming Fiscal Year 2023-24.

Commissioner Thompson asked about the mandated responsibilities required in the $2 million allocation for multicounty local EMS agencies (LEMSAs).

Louis Bruhnke, Chief Deputy Director, stated multicounty LEMSAs are LEMSAs of three or more counties that are eligible to receive funding annually as multicounty LEMSAs. As this funding has remained essentially stagnant since 2000, the Budget Change Proposal will provide additional funding for those multicounty LEMSAs.

Public Comment

No public comment.

Action: Commissioner Relucio made a motion, seconded by Commissioner Barrow, that:

- *The Commission approves all items on the Consent Calendar as presented.*

Motion carried 16 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Barrow, Dunford, Giandomenico, Kusman, Lam, Miller, Oshita, Pierce, Relucio, Rodriguez, Snyder, Suver, Thompson, and Valeri, Vice Chair Burrows, and Chair Uner.

The item was noted and filed.

REGULAR CALENDAR

5. EMS ADMINISTRATION

A. Legislative Report

Chief Deputy Director Bruhnke summarized the EMSA 2022 Legislative Summary of the bills currently being tracked and analyzed by staff, which was included in the meeting materials and posted on the website.

B. Regulations Update

Chief Deputy Director Bruhnke reviewed the Regulations Update of the regulations being promulgated, which was included in the meeting materials. He asked to defer discussion on the proposed community paramedicine text to the next agenda item.

Discussion

Vice Chair Burrows asked about the status of the Chapter 13 draft regulations, since it has been more than one year since the subcommittee last met.

Acting Director Basnett stated the fourth working group for the Strategic Planning Advisory Committee, Administration and Resilience, will discuss the Request for Proposals, EMS Plans, and main themes in Chapter 13 in the first quarter of next year. Members of the Chapter 13 Subcommittee will be a part of the Administration and Resilience Working Group. The idea is to be closer to a consensus among members of the group prior to beginning the rulemaking process for greater success.

Vice Chair Burrows suggested that the Regulations Update reflect that Chapter 13 will be addressed as part of the Strategic Planning Process.

Commissioner Thompson asked for a status update on Senate Bill (SB) 438, the dispatch bill, and why it is still pending.

Tom McGinnis, Chief of the EMS Systems Division, stated SB 438 tasked EMSA with developing a set of regulations regarding changes to statute associated with the passage of that bill. The COVID-19 pandemic stalled forward progress, but EMSA has now hired the required staff person and will begin the interested party engagement process to help develop the required set of regulations.

Public Comment

No public comment.

a. Approval of Community Paramedicine and Transport to Alternate Destination Proposed Regulations

Acting Director Basnett thanked Lou Meyer, Community Paramedicine Program Manager Consultant, for the work he has done over the years for community paramedicine and his outstanding dedication to this project. She deferred to Mr. Meyer to make his presentation and to request Commission approval of the proposed regulations.

Mr. Meyer stated the California Office of Statewide Health Planning and Development (OSHPD) approved a health workforce pilot project sponsored by the EMSA on November 14, 2014, to test multiple community paramedicine concepts. Seven community paramedicine concepts were tested as part of the pilot project: post-discharge, frequent emergency medical services users, direct observation of therapy for tuberculosis patients in collaboration with the Public Health Department, hospice support, alternate destination for mental health patients, alternate destination urgent care, and alternate destination to sobering centers. He noted that Assembly Bill (AB) 1544 does not include post-discharge as one of the concepts that can be implemented.

Mr. Meyer stated the pilot project was required to have an independent evaluation. It is the opinion of the University of California San Francisco independent evaluators, particularly Dr. Janet Coffman, that the community paramedicine pilot projects have demonstrated that specially trained paramedics can provide services beyond their traditional and current statutory scope of practice in California and no adverse outcome is attributable to any of these pilot projects. The projects enhance patients' wellbeing, improve the integration and efficiency of health services in the community, and reduce ambulance transports, emergency department visits, and hospital readmissions.

Mr. Meyer stated, based in part on the success and outcomes of the pilot project, the proposed regulations are being promulgated as required by AB 1544, which was approved by the Governor on September 25, 2020. The Community Paramedicine or Triage to Alternate Destination Act of 2020 authorizes a local EMS agency to develop community paramedicine or triage to alternate destinations programs, and requires the EMSA to develop and adopt regulations and to establish minimum standards for the development of these programs.

Mr. Meyer stated the proposal provides for approving and renewing LEMSA programs, approving training programs, community paramedicine providers, triage to alternate destination providers and facilities, training requirements for paramedics to become accredited to participate in these programs, and procedures for obtaining, renewing, and reinstating official accreditation as well as procedures for actions taken against the various approvals and accreditations.

Mr. Meyer asked the Commission to consider approval of the proposed regulations, which will allow the successful pilot projects authorized by LEMSAs to implement additional programs and to have these programs throughout the state of California.

Discussion

Commissioner Barrow asked for clarification on the medical personnel who receive the community paramedicine patient.

Mr. Meyer stated AB 1544 and the regulations specify that there be at least one registered nurse in mental health facilities and sobering centers. The regulations do not address the qualifications of the registered nurse; however, the pilot projects had a collaboration between the sobering centers and the providers throughout the entire process. He stated he expected that to be the normal protocol.

Commissioner Dunford stated the community paramedicine program is part of the process moving forward in the state of California to redefine the roles and responsibilities in taking care of marginalized people.

Vice Chair Burrows asked about the negative impacts of Section 100183(8), which states a LEMSA may exclude an existing advanced life support (ALS) provider if they determine that the participation would negatively impact patient care.

Hernando Garzon, M.D., Acting Medical Director, stated this regulation contains similar language to the bill upon which it was based. The reason the regulation is not more prescriptive is to allow LEMSAs to administer their system locally.

Vice Chair Burrows stated it creates ambiguity as to why a provider would be excluded from the program. He suggested including some level of definition to add clarity.

Commissioner Thompson stated the hope that these regulations will be fine-turned to community needs for better adaptation and to address concerns. She suggested having an ongoing Q&A to help answer the many questions on implementation of this regulation.

Commissioner Pierce stated concern about the implementation of the training requirements for individuals who will be instituting these programs and agreed with Commission Thompson about the need to fine-tune these regulations to better meet community need.

Chair Uner asked about the sunset date.

Mr. Meyer stated the sunset date is January 1, 2024. He stated this provides approximately one year to make adjustments to those areas that AB 1544 may not have made clear.

Commissioner Thompson thanked everyone who had a part in bringing these draft regulations forward and especially Mr. Meyer for his work and dedication in making this momentous moment possible that was eight years in the making.

Mr. Meyer acknowledged the California Health Care Foundation, particularly Sandra Shewry, the Vice President of External Affairs, who helped fund the startup and evaluation of not only the training program but the data collection process, and the CARESTAR Foundation that assisted with funding.

Public Comment

Kevin Greene, EMS Health and Safety Director, California Professional Firefighters (CPF), spoke in support of the proposed regulations. He stated, consistent with Commissioner comments, the CPF continues to have concerns, including providing greater clarity for specific training requirements, review withdrawal and revocation of a program, and when a LEMSA can exclude an existing ALS provider.

Ray Gayk, President, California Fire Chiefs Association (Cal Chiefs), spoke in support of the proposed regulations. He echoed the concerns voiced by the previous speaker.

Chair Uner asked for a motion to approve the proposed regulations.

Commissioner Suver made a motion to approve the proposed regulations.

Commissioner Rodriguez seconded.

Action: Commissioner Suver made a motion, seconded by Commissioner Rodriguez, that:

- *The Commission approves the proposed text for Community Paramedicine Regulations, Chapter 5, Division 9, Title 22 of the California Code of Regulations, as presented.*

Motion carried 15 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Barrow, Dunford, Giandomenico, Kusman, Lam, Miller, Pierce, Relucio, Rodriguez, Snyder, Suver, Thompson, and Valeri, Vice Chair Burrows, and Chair Uner.

The following Commissioner abstained: Commissioner Oshita.

6. EMS SYSTEMS

A. Ambulance Patient Offload Time (APOT) Report

Tom McGinnis, Chief of the EMS Systems Division, provided an overview of the APOT Report, which was included in the meeting materials. He stated AB 2961 required that LEMSAs submit APOT reports quarterly to the EMS Authority effective July 1, 2019. The bill also required the EMS Authority to calculate APOT times provided by the LEMSAs and provide biannual reports to EMS Commission. This report is the first report for the 2022 calendar year.

Discussion

Commissioner Barrow asked about APOT differences between urban and rural counties.

Chief McGinnis stated the data is fairly consistent in urban areas because their population level varies little, while rural areas tend to be inconsistent depending on the time of year. Rural areas with a higher tourism volume often experience more instances of an offload situation during tourist season.

B. Ambulance Patient Offload Time Committee Update

Acting Director Basnett stated the Ambulance Patient Offload Time Committee was created seven months ago with the purpose of developing recommendations to reduce ambulance patient offload delays. The Committee continues to move toward the goal of developing two sets of recommendations: one set for the Emergency Medical Services System and one set for the Hospital System. This committee will conclude by June 30, 2022, and will bring recommendations for Commission approval at a future meeting.

C. After-Action Reporting Presentation: Ambulance Patient Offload Times Teams

Acting Medical Director Garzon reported on APOT during the Omicron Surge and the response to support hospitals, emergency departments, and the EMS. He reviewed the background, purpose, methodology, conclusion, and next steps of the APOT Deployment Survey, as provided in the staff memo for this agenda item in the meeting materials. He stated the feedback received from the survey confirmed that a sizable difference was seen in decreasing wall times, releasing ambulances back to service, and supporting emergency departments in their operations, especially during COVID surges.

Discussion

Commissioner Dunford asked about services provided to expedite a reduction in APOT times.

Acting Medical Director Garzon stated 52 percent served as nurse extenders. The original concept of the APOT team was doctors, mid-level providers, nurses, and paramedics to help support and staff the emergency department. Having more hands to do the work has an indirect benefit on emergency department throughput. Getting to the work quicker theoretically decreases wall times. Later, assigning paramedics specifically to take transfer of care meant that the transporting medics can return to the field.

Commissioner Dunford suggested looking at the reduction in APOT times for those teams.

Acting Medical Director Garzon agreed that that would be beneficial. It is a potential strategy in managing APOT going forward.

Commissioner Snyder asked about the cost of these teams.

Acting Medical Director Garzon stated he will follow up with Commissioner Snyder on that figure.

D. Community Paramedicine Pilot Project Update

Mr. Meyer reviewed the fiscal impact, background, and enrollment in the Community Paramedicine Pilot Project, as provided in the staff memo for this agenda item in the meeting materials. He stated the pilot project enrolled 14,754 patients into the program as of the end of May and serviced those patients throughout the program, the majority of those being in the alternate destination mental health followed by the alternate destination sobering center. The data shows that there have been no adverse effects or outcomes in relationship to the pilot projects. The pilot projects have one year from the

date of the promulgation of these regulations to comply with the regulations as set forth today.

7. EMS RESPONSE TO BEHAVIORAL HEALTH PATIENTS

A. Review of Behavioral Health Practices Across Local EMS Agencies

Commissioner Miller, the EMS Medical Directors' Association of California (EMDAC) representative to the Commission and the Chair of the Scope of Practice Committee, stated there was a conversation at the last Commission meeting about where EMS is in trying to manage the seemingly ever-increasing interaction with patients in behavioral crisis. He stated he asked EMDAC about behavioral health practices across LEMSAs and received responses from rural to dense urban areas accounting for three-quarters of the population of California. He highlighted a statement in one of the behavioral health policies received on how to approach a patient in crisis: begin to make contact, make a visual assessment, and then begin to engage.

Commissioner Miller stated the first approach is through de-escalation. Many times, if not most times, de-escalation will be successful. When it is not is when it gets more complicated. He continued his presentation under the assumption that de-escalation was not successful. He suggested that Commissioners review a position paper from the National Association of EMS Physicians (NAEMSP), published in October of 2020, and a review published in the Emergency Medicine Clinics of North America Journal from May of 2022 for detailed information on this issue.

Commissioner Miller provided an overview, with a slide presentation, of the terms and definitions, uniform policies and practices, and opportunities for alternative means to find help for patients in crisis. He noted that different pathologies require different approaches. He noted that EMS personnel do not diagnose. Any new onset of psychosis is a medical problem until proven otherwise.

Commissioner Miller stated the need for a term that describes a syndrome to practitioners that goes to a measurable mortality rate. He stated what emerged in looking at these various protocols is that the distinction between protocols for agitated delirium versus those of sedation alone also includes resuscitation.

Commissioner Miller stated the Commission’s approval today of the updated Community Paramedicine Regulation text regarding AB 1544 will help with capacity issues in acute care hospitals for 5150 holds by allowing individual EMS systems to assess to what degree triage in the field can be enacted to deliver patients to the best place the first time.

Discussion

Chair Uner asked about the number of substance abuse mental health protocols recently rewritten by the LEMSAs that were recent versus long-standing policies.

Commissioner Miller stated these were probably mostly legacy policies. This is an issue LEMSAs have wrestled with for a long time.

Commissioner Barrow asked about the interactions with and receptivity of law enforcement on this issue.

Commissioner Miller stated these policies were written for patient care and not intended to assist with incarceration.

Commissioner Oshita referred to the patient disposition presentation chart and asked if it is true that the majority of patients are discharged to self. He asked for clarification on the second graph of patients who were hospitalized and whether there are identifiers, particularly related to AB 1544, that could help pre-hospital personnel.

Commissioner Miller stated this pilot project was designed with an a priori endpoint that was to have 5% or fewer patients transferred to an emergency department within 12 hours. The percentage on the presentation slide met that objective; however, those patients were transferred after discharge from the psychiatric facility, as opposed to upon presentation or during evaluation. All of those patients were transferred for existing chronic conditions that were not comorbidities for the presenting behavioral crisis.

Commissioner Dunford stated this important issue will be an agendized topic for the next three to four Commission meetings. He suggested asking the LEMSAs that did not yet submit a response to do so, especially about their legacy protocols.

Commissioner Dunford stated the NAEMSP and the National Association of Emergency Medical Technicians (NAEMT) included recommendations in the Kupa paper that these concepts should be embedded in all programs. He stated quality assurance processes should be considered for psychiatric emergencies. Questions asked were about the number of counties that have a process that triggers a quality assurance review in individuals who are physically restrained and receive chemical sedation, and about the processes used to monitor their vital signs. These issues are critical.

Commissioner Dunford suggested a New York Times review about the definition of excited delirium that was published last December. It is controversial as to whether excited delirium even exists as a syndrome. He suggested asking EMDAC colleagues to come forward with a statement that excited delirium is real, what it is, and what should be taught to providers to help these patients.

Commissioner Barrow asked if the EMDAC has been presented with these findings.

Commissioner Miller stated today is the first presentation of these findings. He suggested beginning at the EMDAC's Scope of Practice Committee to offer suggestions on common practices and attempts toward standardization across LEMSAs by choosing the best policies.

Vice Chair Burrows asked about protocols with respect to law enforcement body-worn cameras and HIPAA.

Commissioner Miller stated there is nothing that addresses body-worn cameras in EMS policies.

Vice Chair Burrows suggested discussing this policy in collaboration with law enforcement partners.

Commissioner Kusman stated the Emergency Medical Services Administrators' Association of California (EMSAAC) was not included in the data request. He stated EMSAAC is willing to partner with EMDAC to bolster the response rate.

Commissioner Miller asked the Commission and EMDAC if they would be willing to increase the survey response rate by including members of EMSAAC.

Chair Uner stated the Commission will consider this proposal.

Public Comment

Tanir Ami, CEO, CARESTAR Foundation, stated the CARESTAR Foundation had commissioned a piece of research specifically on pediatrics and chemical and physical restraint, looking at the differential based on race. Preliminary data indicates that there is a significant difference in the rate and frequency with which Black and brown children are chemically and physically restrained. She suggested including racial disparities and reviewing the preliminary research data, which is soon to be publicized, to consider how to further integrate those concepts and themes into the way this is looked at in the future.

B. 988 Behavioral Health Hotline Initiative Presentation

Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency (CalHHS), provided an overview, with a slide presentation, of the background, goals and objectives, building out the capacity of the 13 crisis call centers, current trends and issues, robust crisis response system to address these issues, expanded mobile crisis infrastructure, Crisis Care Mobile Units Project, post-crisis wraparound, stabilization services, Behavioral Infrastructure Program to help build more crisis stabilization facilities, partnerships across the continuum, advancing equity, activities, and key components of the 988 Behavioral Health Hotline Initiative.

Ms. Welch stated the initiative provides an unprecedented opportunity to transform the way crisis care is provided in California and is aligned with the Governor’s behavioral health transformation goals. She stated approximately 90 percent of crises can be resolved through crisis centers. The ideal would be to match individual callers to mobile crisis response teams that can ultimately transport the individual to a crisis stabilization unit or other crisis facility.

Ms. Welch stated CalHHS has implemented the Medi-Cal Mobile Crisis Services, an expanded mobile crisis Medi-Cal benefit through the Department of Health Care Services (DHCS), to draw down federal financial participation for co-responder mobile crisis.

Ms. Welch stated the need to create a comprehensive plan that looks at and does an inventory of the connections between programs that focus on preventing crisis, such as hotlines, peer support services, family response units, and family support services. The

988 Mental Health Call Centers will soon become Behavioral Health Call Centers to help individuals with mental health crisis and crisis from substance misuse or abuse.

Ms. Welch discussed the blueprint that CalHHS has committed to working on in developing recommendations for the state.

- Outline the vision for what a full set of services is.
- Articulate statewide minimum standards and metrics.
- Define models and prototypes.
- Provide a high-level overview of the resources necessary to fully achieve this vision.
- Outline a governance model.
- Create a roadmap of targets.

Ms. Welch stated a draft plan will be in place by the end of this calendar year that takes input from stakeholders from diverse perspectives and uses the CalHHS Behavioral Health Taskforce to provide a forum for more public vetting from consumers and family members around the state.

Discussion

Chair Uner stated one of the benchmarks is that 80 percent of individuals should have access to rapid response and community-based care by 2025. He asked if this benchmark has a built-in favoritism toward densely-populated cities over rural areas.

Ms. Welch stated the intent is not to favor cities over rural areas. She stated one of the questions for the state going forward is whether the state will support communities that do not have the capacity or resources to do what larger communities can.

Commissioner Barrow stated rural areas often have metropolitan islands, which need to be treated like urban areas. Rural areas have the same issues as other areas. Even though county demographics are smaller in rural areas, a much higher rate of suicide in children and youth of color is seen. The issue often is that rural areas have no mental health programs to help children and youth who reach out for help.

Commissioner Barrow asked for more detail at a future meeting on the interaction between 988 and 911, the interaction between 988 and the Health Information Exchange (HIE), and whether 988 is a helpful component for the community paramedicine projects. This will be critical for rural areas.

Commissioner Relucio asked where CARE Court comes in or if it is separate. She noted that only a small amount of funding is dedicated to this issue. She asked how this will roll out.

Ms. Welch stated one of the main reasons CalHHS considered how to design CARE Court was to prevent people being forced to go through a 5150 to access care. They are aligned in the larger picture, but CalHHS is still designing the details.

Commissioner Kusman stated the interface between 988 and 911 is exceedingly important. Resources are scarce and need is huge. The coordination to deliver the right resources and care at the right time is tremendously important in order to achieve the right outcomes the first time. He noted that one of the challenges today is that mobile crisis teams have limited hours of operation; outside of those hours, the responsibility falls back on the 911 system.

Public Comment

No public comment.

8. EMS PERSONNEL

A. Trial Studies Update

Kim Lew, Chief of the EMS Personnel Division, stated EMSA has approved five LEMSA-requested trial studies. She reviewed the summary table describing the details, which was included in the meeting packet. She stated the only remaining active pilot project is the Contra Costa Buprenorphine Pilot Project. They have submitted their status report, which will be presented to the Commission for review and approval at the next Commission meeting.

Discussion

Commissioner Dunford asked whether the two buprenorphine protocols are similar enough that the data could be combined for a larger sample size.

Chief Lew stated the two new protocols from Alameda and San Francisco piggyback off of the pilot project already in place in Contra Costa, which does the California bridge concept with slight deviations. The data may be comparable.

Acting Medical Director Garzon stated, unlike many other medications, this provides an opportunity to offer treatment and counseling to patients who do not often access the health care system for help. The benefit in the EMS setting would be based on how many of those patients stay engaged in the program. Even if there are variations on protocol across LEMSAs, success based on continued enrollment in treatment programs is comparable.

Public Comment

No public comment.

9. ITEMS FOR NEXT AGENDA

Chair Uner asked Commissioners for suggestions for the next agenda.

Commissioner Barrow suggested a discussion on how prevention of injury and illness can be incorporated into EMS.

Commissioner Miller stated, at the EMDAC meeting yesterday, there was conversation about the local optional scope of practice for paramedic vaccination provision and for selected viral testing. Those local optional scopes remain in effect. However, when the

governor's declaration of emergency expires on June 30, the location in which those local optional scopes can be executed reverts back to statute for EMTs and paramedics. While likely unintentional, that limits the intent and the locations where that practice can happen. He suggested including a discussion on the options available to provide local optional scopes as intended, without limiting locations where they can be administered, because this is a statute that cannot easily be changed.

Chair Uner agreed that this plays into the report about the deployment of EMS resources to stationary facilities during the COVID crisis.

10. PUBLIC COMMENT

Tanir Ami, CEO, CARESTAR Foundation, stated CARESTAR is partnering with EMSA staff to inspire the transformation of the state through upcoming training programs and funding:

- CARESTAR plans to hold a seminar after the San Diego Commission meeting, another in-person meeting in the north during autumn, and two virtual meetings.
- CARESTAR is offering $100,000 in autumn to inspire LEMSAs to work on their applications. The first half will be awarded for submitting an application and the second half will be awarded after the application is approved. This funding will be on a first-come, first-served basis.
- CARESTAR will be in touch with pilot programs regarding other available funding.

Nichole Bosson, Assistant Medical Director, Los Angeles County EMS Agency, stated the local optional scope of practice for paramedics and EMTs to perform vaccination and testing for COVID-19 and flu was approved by Dr. Duncan last year for most LEMSAs and will continue for three years; however, the understanding from the medical directors is that this will cease to be authorized in non-emergency settings when the Governor’s Executive Order expires on June 30th.

Dr. Bosson read a comment from Dr. Kristi Koenig, the Medical Director for San Diego County EMS, that highlights the urgent need for EMTs and paramedics to continue to vaccinate and test, especially in rural areas. EMS professionals are trusted entities who can promote health equity and decrease hesitancy regarding vaccination and testing, and who can also vaccinate each other to increase safety. San Diego County EMS professionals have provided nearly 64,000 COVID-19 vaccinations for first responders, the general public, and hard-to-reach populations such as homebound seniors, and have performed nearly 100,000 tests. This program was also valuable in reaching marginalized communities during the 2020 influenza season and addressing the at-risk homeless population during the 2017 hepatitis A outbreak. Dr. Koenig urged EMSA to advocate for an interim patient-centered solution in addition to agendizing this topic in September. Dr. Bosson stated this program has been valuable in Los Angeles County, as well, and added the county’s strong support of Dr. Koenig’s recommendations.

Dave Magnino, Administrator, Sacramento County EMS Agency, representing the board of directors for the National EMS Memorial Bike Ride Foundation, spoke as a member of the Muddy Angels, a group of bike riders who ride at six different fundraising-type bike rides throughout the nation to honor the EMS personnel who have given their lives to EMS and to raise funding to support families of deceased EMS personnel.

Mr. Magnino stated the West Coast EMS Memorial Bike Ride is a six-day ride from Reno to San Francisco at the end of September. He asked everyone to nominate honorees and to register to support the bike ride by riding, working from one of the support vehicles, or donating to the foundation at muddyangels.org.

Ray Gayk, President, California Fire Chiefs, encouraged EMSA to consider allowing paramedics and EMTs to do vaccinations and testing as a long-term option rather than an emergency declaration. This and other successful measures during the COVID-19 pandemic provide opportunities that he recommended the Commission examine for the future.

11. ADJOURNMENT

Action: Commissioner Barrow moved to adjourn the meeting. Commissioner Pierce seconded. Motion carried unanimously.

Chair Uner adjourned the meeting at 1:02 p.m.

EMERGENCY MEDICAL SERVICES AUTHORITY
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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **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:

2022-23

The 2022-23 California State Budget includes expenditure authority of $181.1 million and 114 permanent positions. Of this amount, $158.4 million, or 88.45%, is delegated for State operations, and $22.7 million, or 12.55%, to Local Assistance.

State Operations ($158.4 million)

1. $100 million in reimbursement authority to assist in recovering expenses associated with medical surge staff deployments to California medical facilities during the ongoing COVID-19 pandemic.
2. $38.4 million from multiple funding sources for EMSA State Operations.
3. $10 million General Fund to continue and complete the project planning process for the California Emergency Medical Services (EMS) Data Resource System (CEDRS) and to connect and increase interoperable health information exchange between EMS providers and EMS Receiving Hospitals via Health Information Exchange Organizations.

4. $10 million General Fund to establish a statewide electronic registry system to collect a patient's Physician Orders for Life Sustaining Treatment (POLST) information and share it with authorized healthcare providers.

Local Assistance ($22.7 million)

1. $16.1 million in General Fund and reimbursement authority to support the California Poison Control System.
2. $4.2 million in General Fund to support Multi-County Local Emergency Medical Services Agencies (LEMSA).
3. $1.4 million in General Fund and reimbursement authority to support the Regional Disaster Medical Health Specialist (RDMHS) program.
4. $671 thousand in Federal funding to support the California Emergency Medical Services Information System (CEMSIS).
5. $300 thousand in Emergency Medical Technician Fund Revenue to reimburse LEMSAs for expenses incurred if an Emergency Medical Technician (EMT) certificate holder requests an appeal of disciplinary action.

Accounting data for the new fiscal year is not yet available. We continue to monitor and adjust state operations and local assistance budgets to meet changing program priorities and will provide an updated report before the next Commission meeting.

2021-22

The 2021-22 California State budget included expenditure authority of $85.7 million and 110 permanent positions. Of this amount, $20 million was dedicated to CEDRS and ePOLST but was not utilized and is still available for expenditure through June 30, 2024. The remaining funding of $65.7 million is delegated to State Operations ($46 million) and Local Assistance ($19.7 million).

As of August 28, 2022, accounting records indicate that the Department has expended or encumbered $53.2 million, or 81% of all available expenditure authority. Of this amount, $35.4 million, or 76.9% of State Operations expenditure authority, has been expended or encumbered, and $17.8 million, or 90.5% of local assistance expenditure authority, has been expended or encumbered.

We continue to monitor and adjust state operations and local assistance budgets to meet changing program priorities and will provide an updated report before the next Commission meeting.

EMSA Staffing Levels:

The Department staffing level includes 114 permanent positions and 11 temporary (blanket and retired annuitant) positions. Of the 117 positions, 37 positions are vacant as of August 28, 2022.

	Department					
	Admin	**DMS**	**EMS**	**EMSP**	**HITEMS**	**Total**
Authorized	36.0	35.0	15.5	26.5	1.0	114.0
Temporary Staff	6.0	1.0	0.0	1.0	3.0	11.0
Staffing Level	**42.0**	**36.0**	**15.5**	**27.5**	**4.0**	**125.0**
Authorized (Vacant)	-13.0	-15.0	-1.0	-5.0	0.0	-34.0
Temporary (Vacant)	0.0	0.0	0.0	0.0	-3.0	-3.0
Current Staffing Level	**29.0**	**21.0**	**14.5**	**22.5**	**1.0**	**88.0**

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **ITEM NUMBER: 4B**

SUBJECT: Legal Report

PRESENTER: Erin Brennan
Attorney, Interim Counsel

CONSENT: X ACTION: ___ INFORMATION: ___

FISCAL IMPACT

No fiscal impact.

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 11, 2021, to May 13, 2022, the Authority issued eleven new accusations against existing paramedic licenses, five statements of issues, eleven administrative fines, issued four temporary suspension orders, and issued five decisions on petitions for reduction of penalties and license reinstatements. Of the newly issued actions, four of the Respondents have requested that an administrative hearing be set. There are currently nine hearings scheduled with the Office of Administrative Hearings. There are currently forty-five open active disciplinary cases in the legal office.

Litigation:

Tagliere v. Director of EMSA: Los Angeles County Superior Court #22STCP00253, Writ of Administrative Mandamus. Plaintiff filed a writ seeking to overturn the revocation of his license subsequent to an administrative hearing. This is second

writ of mandate filed by this individual. Briefing is complete. Hearing is set for set for September 15, 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 that dismissal and the court re-instated the suit. The United States Court of Appeals for the Ninth Circuit heard oral argument and asked for supplemental briefing. On June 9, 2022, the Court affirmed the District Court's decision. Plaintiff-appellant has petitioned for rehearing. Awaiting direction from the Ninth Circuit.

Waters v. EMSA: Sonoma County Superior Court #SCV-268267, Writ of Administrative Mandamus. Plaintiff filed a writ seeking to overturn the revocation of her license subsequent to her violation of a "last chance" agreement for testing positive on a random drug/alcohol test. Hearing is set for January 25, 2023.

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **ITEM NUMBER: 4C**

SUBJECT: Enforcement Report

PRESENTER: Alexander Bourdaniotis
Supervising Special Investigator

CONSENT: X ACTION: ___ INFORMATION: ___

RECOMMENDATION

Receive information on Enforcement Unit activities.

FISCAL IMPACT

No fiscal impact.

BACKGROUND

Unit Staffing:

The Enforcement Unit is budgeted for one full-time Supervising Special Investigator, five full-time Special Investigators, one retired annuitant Staff Services Manager I (Specialist), and one full-time Associate Government Program Analyst (AGPA-Probation Monitor). The unit is currently fully staffed.

Investigative Workload:

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

Cases opened since January 1, 2022, including:

Cases opened:	223
Cases completed and/or closed:	213
EMT-Paramedics on Probation:	234

In 2021:

Cases opened:	309
Cases completed and/or closed:	282
EMT-Paramedics on Probation:	242

Status of Current Cases:

The Enforcement Unit currently has 123 cases in "open" status.

As of August 1, 2022, there are 51 cases that have been in "open" status for 180 days or longer, including: 3 Firefighters' Bill of Rights (FFBOR) cases and 10 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 51 cases are divided among five Special Investigators and one Staff Services Manager I (Specialist) 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: September 21, 2022 **ITEM NUMBER: 5A**

SUBJECT: Legislative Report

PRESENTER: Kent Gray
Regulations Manager

CONSENT: ___ ACTION: ___ INFORMATION: X

RECOMMENDATION

Receive information regarding current bills potentially affecting EMS.

FISCAL IMPACT

No fiscal impact.

DISCUSSION

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

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **ITEM NUMBER: 5B**

SUBJECT: Regulations Update

PRESENTER: Kent Gray
Regulations Manager

CONSENT: ___ ACTION: ___ INFORMATION: X

FISCAL IMPACT

No fiscal impact.

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:

- Training Standards for Child Care Providers & Merger of Chapters 1.1 and 1.2.
  - Status: Hold
  - Purpose: General update.
- Public Safety First Aid (Ch. 1.5)
  - Status: Agency
  - 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.
- Paramedic Fees (Ch 4)
  - Status: Under review by EMSA
  - Purpose: Fee increase based on costs from AB 450.

- Administered Medications (Ch. 4 § 100146)
  - Status: In development.
  - Purpose: Add new medications to list under subsection (c)(1)(R)
- Community Paramedicine and Alternate Destination (Ch. 5)
  - Status: Regulations withdrawn from the Office of Administrative Law
  - Purpose: Implement AB 1544 (Statutes of 2020)
- Trauma Care Systems (Ch. 7)
  - Status: Work group meetings continue
  - Purpose: General update.
- Emergency Medical Services System Quality Improvement (Ch. 12)
  - Status: Hold
  - Purpose: General update.
- EMS Plans (Ch. 13)
  - Status: Review and redraft
  - Purpose: Provide new and updated regulations for annual EMS plans required by statute.
- Dispatch
  - Status: Pending
  - Purpose: Implement SB 438 (Statutes of 2019)

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **ITEM NUMBER: 5C**

SUBJECT: Strategic Planning Update

PRESENTER: Elizabeth Basnett
Acting Director

CONSENT: ___ ACTION: ___ INFORMATION: X

RECOMMENDATION

Receive information on the California EMS System Strategic Planning Advisory Committee

FISCAL IMPACT

No fiscal impact.

SUMMARY

EMSA invited 14 organizations to participate in the California EMS System Strategic Planning Advisory Committee. Together, this committee will advise EMSA and its Director on the mission, vision, values, and guiding principles of California's EMS system and help codify a written strategic plan to guide our state into the future. Through this advisory committee we will retrospectively examine our lessons learned, collate our best practices, and envision the future of EMS over an 8 – 10 month planning process. Additionally, the overarching advisory committee will spend time determining the mission, vision, values, guiding principles and goals for four sub-working groups of the committee. These working groups will think through objectives and tasks in accomplishing the put forth goals focused specifically on equity and transparency, innovation and data, operational management, and administration and resilience.

DISCUSSION

The California EMS Strategic Planning Advisory Committee met on June 16th for a kickoff meeting in Sacramento, CA, at the EMSA Headquarters. This initial meeting sparked collaborative conversation as committee members worked together to solidify the mission, vision, values, and guiding principles of the strategic planning agenda. The Committee convened a second time on July 21st in Alameda, CA, to discuss and finalize the guiding principles of the four sub-working groups scheduled to meet later in the fall. The third meeting of the Committee is scheduled for October 11th in Ontario, CA. Committee members will come together to discuss the progress of each working group.

The four working groups of the Committee will meet for the first time on September 9th to begin discussions on equity and transparency, innovation and retrospective data, operational management, and administration and resilience. Members of each working group will collaborate on ways to accomplish the short-, intermediate-, and long-term objectives and overarching goals set forth by the Advisory Committee. These working groups will conclude in December of this year.

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **ITEM NUMBER: 6A**

SUBJECT: Ambulance Patient Offload Time (APOT)

PRESENTER: Tom McGinnis
Chief, EMS Systems Division

CONSENT: ___ ACTION: ___ INFORMATION: X

RECOMMENDATION

No recommended action.

FISCAL IMPACT

No fiscal impact.

BACKGROUND

In 2018, AB 2961(O'Donnell, Chapter 656) required that Local Emergency Medical Services Agencies (LEMSAs) submit APOT reports quarterly to the Emergency Medical Services (EMS) Authority effective July 1, 2019. The bill also required the EMS Authority to calculate APOT times provided by the LEMSAs and provide biannual reports to EMS Commission and a legislative report on or by December 1, 2020.

DISCUSSION

6A(a). APOT Committee

The Ambulance Patient Offload Time (APOT) Committee met to develop advisory recommendations related to APOT in the State. The recommendations developed by the Committee were submitted to the California Health and Human Services (CHHS) Agency for review. The Committee concluded in June

2022. The Commission will be kept informed on the progress of the APOT Committee recommendations.

6A(b). Quarterly APOT Data Submission

EMSA continues to collect and analyze APOT submissions from participating LEMSAs. The current submission status beginning Q3 2019 through Quarter 2 of 2022 for each LEMSA can be found below.

	2019		2020				2021				2022	
LEMSA	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Alameda	11/5/2019	1/2/2020	4/23/2020	7/13/2020	10/16/2020	3/2/2021	4/2/2021	7/2/2021	10/5/2021	1/5/2022	4/11/2022	7/6/2022
Central California	10/21/2019	1/28/2020	12/9/2020	12/9/2020	12/9/2020	1/5/2021	4/26/2021	7/27/2021	10/28/2021	1/20/2022	4/19/2022	7/19/2022
Coastal Valleys	11/27/2019	3/22/2022	3/22/2022	3/22/2022	3/22/2022	3/22/2022	3/22/2022	3/22/2022	3/22/2022	3/22/2022	4/28/2022	8/11/2022
Contra Costa	10/30/2019	2/3/2020	8/12/2020	8/12/2020	10/7/2020	7/7/2021	7/7/2021	7/7/2021	1/5/2022	1/5/2022	4/27/2022	8/8/2022
El Dorado	11/1/2019	1/15/2020	12/6/2021	12/6/2021	12/6/2021	12/6/2021	11/23/2021	11/23/2021	11/23/2021	1/21/2022	4/20/2022	7/27/2022
Imperial									11/1/2021	2/1/2022	4/22/2022	7/26/2022
Inland Counties	10/18/2019	7/21/2020	7/21/2020	7/16/2020	10/7/2020	1/13/2021	9/10/2021	9/10/2021	2/9/2022	2/9/2022	4/22/2022	8/16/2022
Kern	10/21/2019	1/22/2020	4/23/2020	8/3/2020	10/5/2020	1/7/2021	4/12/2021	7/13/2021	10/4/2021	1/18/2022	4/8/2022	7/12/2022
Los Angeles	12/16/2019	4/28/2020	6/25/2020	9/23/2020	2/8/2021	2/23/2022	2/23/2022	3/3/2022	3/17/2022	3/25/2022	5/11/2022	8/3/2022
Marin	11/19/2019	11/1/2021	11/1/2021	11/1/2021	11/1/2021	11/1/2021	11/1/2021	11/1/2021	1/31/2022	1/31/2022	5/11/2022	7/13/2022
Merced	10/4/2019	1/16/2020	4/14/2020	7/2/2020	11/16/2020		4/12/2021	10/14/2021	10/14/2021	1/27/2022	4/14/2022	7/5/2022
Monterey	10/31/2019	1/30/2020	6/11/2020	7/30/2020	1/21/2021	1/21/2021	4/9/2021	7/19/2021	10/7/2021	1/14/2022	6/15/2022	7/12/2022
Mountain Valley	11/1/2019	6/17/2020	6/17/2020	7/13/2020	11/5/2020	1/14/2021	7/13/2021	7/13/2021	10/4/2021	1/3/2022	5/10/2022	7/8/2022
Napa	10/30/2019	1/18/2020	9/15/2020	9/15/2020	11/11/2020	7/20/2022	5/4/2021	8/23/2021	10/31/2021	1/26/2022	6/13/2022	7/19/2022
Northern Cal	10/23/2019	1/15/2020	4/30/2020	7/29/2020	10/27/2020	1/13/2021	4/19/2021	7/7/2021	10/13/2021	3/23/2022	4/4/2022	7/12/2022
North Coast	10/31/2019	1/15/2020		8/30/2020		1/19/2021	4/14/2021	10/6/2021	10/5/2021	1/7/2022	5/10/2022	7/13/2022
Orange	10/8/2019	1/8/2020	4/20/2020	7/7/2020	10/7/2020	1/6/2021	4/8/2021	7/8/2021	10/12/2021	1/6/2022	4/12/2022	7/12/2022
Riverside	10/22/2019	1/16/2020	4/7/2020	12/10/2020	10/9/2020	1/8/2021	5/12/2021	9/21/2021	10/25/2021	1/25/2022	4/12/2022	7/15/2022
Sacramento	10/10/2019	1/8/2020	5/7/2020	7/7/2020	10/9/2020	1/7/2021	4/8/2021	7/7/2021	12/8/2021	1/10/2022	4/11/2022	7/13/2022
San Benito	10/31/2019	1/9/2020	4/7/2020	7/9/2020	10/12/2020		4/13/2021	7/14/2021	10/11/2021	1/10/2022	4/5/2022	7/12/2022
San Diego	10/10/2019	1/15/2020	8/14/2020	8/12/2020	10/16/2020	1/12/2021	4/12/2021	7/19/2021	10/14/2021	1/14/2022	4/20/2022	7/13/2022
San Francisco	11/19/2019	3/16/2020	6/18/2020	8/3/2020	10/23/2020	1/19/2021	7/2/2021	1/26/2022	1/26/2022	1/26/2022	4/4/2022	7/12/2022
San Joaquin	10/10/2019	1/6/2020	4/10/2020	7/13/2020	10/9/2020	1/8/2021	4/9/2021	7/6/2021	10/14/2021	1/24/2022	4/5/2022	7/5/2022
San Luis Obispo	10/24/2019	1/22/2020					5/19/2021	9/13/2021	3/15/2022	1/28/2022	4/13/2022	7/8/2022
San Mateo	10/7/2019	1/2/2020	5/4/2020	7/2/2020	10/5/2020	1/4/2021	4/5/2021	7/5/2021	10/4/2021	1/3/2022	4/1/2022	7/12/2022
Santa Barbara	11/13/2019	2/11/2020	12/8/2020	12/8/2020	12/8/2020		5/24/2021	8/2/2021	10/13/2021	1/3/2022	4/4/2022	8/11/2022
Santa Clara	10/30/2019	1/29/2020	4/2/2020	7/29/2020	10/27/2020	2/25/2021	4/22/2021	8/25/2021	3/28/2021	3/15/2022	4/6/2022	7/14/2022
Santa Cruz	10/30/2019	2/11/2020	4/10/2020	7/7/2020	11/4/2020	1/5/2021	4/6/2021	8/4/2021	10/12/2021	1/26/2022	4/6/2022	7/12/2022
Sierra-Sac Valley	10/7/2019	1/5/2020	4/3/2020	7/23/2020	10/7/2020	1/11/2021	4/2/2021	7/8/2021	2/8/2022	2/8/2022	4/5/2022	8/11/2022
Solano	12/20/2019	1/13/2020	4/23/2020	7/28/2020	10/23/2020	1/21/2021	4/27/2021	8/4/2021	10/27/2021	3/23/2022	4/27/2022	7/28/2022
Tuolumne	12/26/2019						11/2/2021	11/2/2021	11/2/2021	1/14/2022	4/11/2022	7/6/2022
Ventura	12/3/2019	1/3/2020	4/7/2020	7/13/2020	10/7/2020	7/29/2021	7/30/2021	8/2/2021	10/6/2021	1/19/2022	4/22/2022	7/19/2022
Yolo	10/30/2019	1/7/2020	9/1/2021	9/1/2021	9/1/2021	9/1/2021	9/1/2021	9/1/2021	12/8/2021	2/3/2022	5/11/2022	7/14/2022

6A(c). APOT Reporting Memo

Starting January 1, 2023, EMSA will be running all APOT reports through the California Emergency Medical Services Information System (CEMSIS). LEMSAs have been encouraged to review their quarterly CEMSIS comparison reports to ensure their data is accurately represented. Notification to the LEMSAs was sent out on July 20, 2022.

ATTACHMENT(S)

APOT Submission Memo 7.20.2022

CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY
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(916) 322-4336 FAX (916) 322-1441

DATE: July 20, 2022

TO: LEMSA Administrators and LEMSA Medical Directors

FROM: Elizabeth Basnett
Acting Director
California EMS Authority

SUBJECT: Ambulance Patient Offload Time (APOT) Reporting

Since July 2019, the EMS Authority has been collecting APOT data from the LEMSAs and has been creating APOT Comparison Reports from the LEMSA's submitted APOT data and CEMSIS data. These comparisons have been created and sent to each LEMSA who submits both APOT data and CEMSIS since 2019.

The EMS Authority will begin solely using CEMSIS data to run APOT reports starting January 1, 2023.

The EMS Authority will continue running quarterly comparison reports for quarter three (3) and quarter four (4) of 2022 and will send to all LEMSAs for data validation and quality assurance.

The APOT Tool Kit specifications, template and information is located on the EMS Authority's website: https://emsa.ca.gov/apot/.

Please contact Tom McGinnis by email at Tom.McGinnis@emsa.ca.gov if you have any questions or comments.

Elizabeth Basnett, EMEDM
Acting Director
Emergency Medical Services Authority

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **ITEM NUMBER: 6B**

SUBJECT: Community Paramedicine Pilot Project Update

PRESENTER: Lou Meyer
Community Paramedicine Pilot Project Manager

CONSENT: ___ ACTION: ___ INFORMATION: X

RECOMMENDATION

Receive information regarding the Community Paramedicine Pilot Project.

FISCAL IMPACT

EMSA has entered into consultant contracts for both the project manager consultant and the independent evaluator. Local pilot site providers participate with in-kind contributions and any local grants or reimbursement.

BACKGROUND

On November 14, 2014, the Office of Statewide Health Planning and Development (OSHPD) approved Health Workforce Pilot Project (HWPP) #173, a pilot project to test different concepts for the practice of community paramedicine (CP). Each site chose the concept(s) it would test based on local needs and interests. The concepts currently being tested are:

- Case management services for people who frequently use emergency medical services (EMS)
- Short-term, home-based follow-up care to people recently discharged from a hospital due to a chronic condition
- Directly observed therapy for tuberculosis
- Collaboration with hospice agency nurses, patients, and family members to treat patients in their homes according to their wishes instead of transporting them to an ED

- Offering people who have mental health needs, but no acute medical needs, transport directly to a mental health crisis center instead of to an ED
- Offering people who are inebriated transport to a sobering center instead of to an ED

SUMMARY

Community Paramedicine Pilot Project Enrollment

		Enrolled for the First Time			Total Enrolled			Cumulative Enrolled*
Project No.	**Concept**	**Jan - 22**	**Feb-22**	**Mar - 22**	**Jan - 22**	**Feb-22**	**Mar - 22**	
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	0	0	0	1	1	1	56
CP006	Hospice	20	16	20	-	-	-	729
CP007A	Frequent EMS Users	0	0	0	0	0	0	85
CP007B	Post-Discharge	Closed November 2020						140
CP008	Post-Discharge	-	-	-	-	-	-	228
CP009	Alternate Destination – Urgent Care	Closed in November 2017						2
CP010	Frequent EMS Users	0	0	1	25	25	26	72
CP012	Alternate Destination – Mental Health	1	0	4	-	-	-	533
CP013	Post-Discharge	2	0	2	2	0	2	307
CP014	Alternate Destination – Sobering Center	32	33	40	-	-	-	3,543
CP015A	Alternate Destination – Sobering Center	-	-	-	-	-	-	0
CP015B	Alternate Destination – Mental Health	0	3	3	-	-	-	142
CP018	Alternate Destination - Mental Health	0	2	2	-	-	-	122
CP019	Alternate Destination - Sobering Center	0	0	0	-	-	-	96
CP021	Frequent EMS Users	14	18	14	140	116	127	563
CP022	Alternate Destination – Mental Health	123	118	114	-	-	-	6,945

Total	**192**	**190**	**200**	**168**	**142**	**156**	**14,764**

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 January 20, 2022, and completed 30-day period on February 19, 2022).

DISCUSSION

The Community Paramedicine Pilot Project Manager/Consultant has devoted significant time working with the EMSA Regulatory Workgroup and EMSA Executive Team in the development of the Community Paramedicine & Triage to Alternate Destination regulations Final Statement of Reason which was submitted to OAL and the Department of Finance (DOF) on July 19, 2022. EMSA received DOF's approval on August 2, 2022. The Office of Administrative Law determined the need for EMSA to further revise the proposed regulations to address technical issues they identified during their review. Upon receiving this OAL notification, EMSA withdrew the Community Paramedicine & Triage to Alternate Destination regulations. A 15-day public comment period for review of the modified proposed regulatory text will be scheduled in the near future. EMSA will release details of this 15-day public comment period once we have finalized the modifications.

6B(a). Community Paramedicine Implementation Plan

The Community Paramedicine Pilot Project Manager/Consultant is working with the EMSA team in the preparation of a workshop to assist LEMSA's and Providers with Community Paramedicine & Triage to Alternate Destination implementation. These workshops, sponsored by the CARESTAR Foundation, are scheduled for December 8, 2022, in San Diego and December 15, 2022, in Berkley.

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

COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **ITEM NUMBER: 6C**

SUBJECT: Cessation of 180-Day Extensions for the Submission of Local Emergency Medical Services Agency Annual Plans Memo

PRESENTER: Tom McGinnis
Chief, EMS Systems Division

CONSENT: ___ ACTION: ___ INFORMATION: _X_

RECOMMENDATION

Receive information on distributed memorandums regarding local EMS plans.

FISCAL IMPACT

No fiscal impact.

BACKGROUND

On December 14, 2020, the EMS Authority issued a memorandum to all Local Emergency Services Agencies (LEMSAs) clarifying the extension provided for the submission of annual local EMS plans. Due to the ongoing COVID-19* pandemic and the significant response efforts of LEMSAs, the EMS Authority granted an extension of 180-day beginning on the cessation of the State's declared emergency on the coronavirus pandemic.

On July 13, 2022, the EMS Authority issued a memorandum to all LEMSAs rescinding the 180-day extension beginning August 1, 2022. The memorandum clarified all LEMSAs who are past due in the submission of their annual EMS plan must submit an EMS plan to the EMS Authority for review on or before January 31, 2023.

SUMMARY

The EMS Authority will keep the Commission on EMS appraised on all efforts made towards gaining LEMSA compliance with the statutory requirement that all local EMS plans be submitted annually.

ATTACHMENT(S)

December 14, 2020 EMS Plans Memo

July 13, 2022 EMS Plans Memo

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY GAVIN NEWSOM, *Governor*

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

DATE: December 14, 2020

TO: Local Emergency Medical Services Agencies

FROM: Dave Duncan MD, Director
Emergency Medical Services Authority

SUBJECT: **Local Emergency Medical Services Plan Extensions – Rescission of Prior Memo of August 18, 2020 and Issuance of New Memo**

On August 18, 2020, the Emergency Medical Services Authority (EMSA) issued a memo regarding an extension for the submission of local emergency medical services (EMS) Plans. Due to confusion regarding the scope of the extension covered by that document, that memo is withdrawn, effective immediately, and is replaced by the following:

Due to the ongoing COVID-19 pandemic and the significant response efforts of local emergency medical services agencies (LEMSAs) during this time, EMSA is aware of the difficulty in preparing and submitting the annually required local EMS plans. Therefore, effective immediately, all LEMSAs are granted an extension for the submission of EMS plans as follows:

1. **180-day extension for the submission of local EMS plans**. All LEMSAs are granted a 180-day extension for the submission of their regular annual local EMS plan. The beginning date for this 180-day extension shall be the date of cessation of the State's declared emergency on the coronavirus pandemic.
2. **Local EMS plan requirements contained in statute and regulation are not suspended**. The extension provided in #1 above pertains only to the timing of when local EMS plans are due to EMSA. All other requirements contained in statute and regulation pertaining to what must be included in a local EMS plan must still be met and are not waived. All new plans must be submitted to EMSA for approval prior to implementation, pursuant to Health and Safety Code §1797.105. The plan submission must address all normal requirements, including, but not limited to, trauma centers, system planning, agreements with ALS providers, and prior EMSA review of competitive processes for ambulance zone exclusive operating areas. Plans that do not follow statutory and regulatory requirements will not be approved. Continue to implement your last approved local EMS plan until your new plan is submitted and approved.
3. **Previously submitted plans may be subject to delays in review**. Plans that have already been submitted to EMSA for approval will continue through the

review process, but, due to EMSA's COVID-19 response efforts, the plans may require additional time for review and approval.

If you have any questions, please contact Angela Wise, Assistant Chief of the EMS Systems Division, at angela.wise@emsa.ca.gov or (916) 431-3708.

Dave Duncan MD
Director

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY EDMUND G. BROWN JR., *Governor*

EMERGENCY MEDICAL SERVICES AUTHORITY
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DATE: July 13, 2022

TO: Local Emergency Medical Services Agency Administrators
Local Emergency Medical Services Agency Medical Directors

FROM: Elizabeth Basnett, EMEDM, Acting Director
Emergency Medical Services Authority

SUBJECT: **Cessation of 180 day extensions for the submission of Local Emergency Medical Services Agency annual plans**

On December 14, 2020, the Emergency Medical Services Authority (EMSA) issued a memo (see attached) pertaining to a 180-day submission extension of local emergency medical services agency (LEMSA) plans. The memo stated that*, all LEMSAs are granted a 180-day extension for the submission of the regular annual EMS plan and the beginning date for this extension shall be the date of the cessation of the Governor's declaration of emergency of the Coronavirus Pandemic (Proclamation of State of Emergency, March 2, 2020)*.

The purpose of this memo is to inform all local EMS agencies that the 180-day extension outlined in the December 14, 2020 memo will be rescinded on August 1, 2022.

All local EMS agencies that are currently past due in the submission of their annual local plan must submit their local EMS plan to the Authority for review on or before January 31st, 2023. Additionally, all regular EMS Plans reporting will resume February 1st, 2023.

Should you have any questions please contact Tom McGinnis, Chief of EMS Systems at tom.mcginnis@emsa.ca.gov.

Elizabeth Basnett, EMEDM
Acting Director
Emergency Medical Services Authority

Attachments: December 14, 2020, memo from Dr. Dave Duncan, Director

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **ITEM NUMBER: 7**

SUBJECT: EMS Response to Behavioral Health Patients

PRESENTER: Atilla Uner, M.D.
Chair, Commission on EMS

CONSENT: ___ ACTION: ___ INFORMATION: _X_

BACKGROUND

This is a standing agenda item for the Commission on EMS to discuss the topic of EMS response to behavioral health patients.

SUMMARY

There is nothing to report for this agenda item.

EMERGENCY MEDICAL SERVICES AUTHORITY
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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **ITEM NUMBER: 8A**

SUBJECT: Contra Costa Buprenorphine Trial Study

PRESENTER: Kim Lew
Chief, EMS Personnel Division

CONSENT: ___ ACTION: _X_ INFORMATION: ___

RECOMMENDATION

Recommend continuation of the study for a maximum of eighteen (18) additional months to provide Contra Costa EMS Agency time to provide additional data.

FISCAL IMPACT

No fiscal impact.

BACKGROUND

On June 18, 2020, the EMS Authority (EMSA), in consultation with the members of the Emergency Medical Directors Association, approved a trial study request from the Contra Costa County EMS Agency to study the use of Buprenorphine for opioid withdrawal in the prehospital setting. The first 18-month report was due to the EMSA on February 15, 2022 and is being presented to the Commission on EMS for review and provide the EMSA with a recommendation pursuant to California Code of Regulations, §100147.

SUMMARY

In September 2020, Contra Costa County EMS Agency began a pilot trial study project using paramedics to initiate Medication Assisted Treatment (MAT), for patients that contact the 9-1-1 system with an Opioid Use Disorder (OUD), by administering Buprenorphine. This project was incorporated into a multi-agency

initiative with the California Department of Public Health and the California Bridge program to provide MAT rapidly and early, share OUD electronic health record data, leave Naloxone behind with friends and family on scene, and utilize an EMS designated Contra Costa Regional Medical Center as the Opioid Overdose Receiving Center.

Contra Costa EMS Agency submitted a written report to EMSA for the EMS Commission within eighteen (18) months of initiating the utilization of this medication and program. Due to the COVID-19 statewide pandemic, the EMSA was delayed in presenting it to the EMS Commission until this month. As a result, six additional months have passed prolonging the study.

DISCUSSION

Contra Costa County EMS Agency found Buprenorphine inductions successful for patients who called 9-1-1 for primary withdrawal and patients who were reversed with Naloxone. At the time of the report which includes 16 months of data, 48 patient received Buprenorphine by EMS (an average of 3 per month) and 29% of patients who received Buprenorphine in the field continued MAT at 30 days (#14). Furthermore, none of their patients experienced adverse reactions.

It is unclear from the report, whether the trial study hypothesis that EMS Buprenorphine administration to patients experiencing opioid withdrawal in a pre-hospital setting will increase patient access and long-term intervention to treat opioid addiction. Further collection of measurable data outcomes and analytics are needed. While the CA Bridge model has shown emergency department therapy and the provision of resources to patients not transported can dramatically lower barriers to patient treatment, provide immediate patient relief from withdrawal, and stabilize the patient to engage in long-term treatment solutions[1], this study does not clearly define the benefits of early utilization of Buprenorphine by EMS personnel. For instance, the report does not include the following desired data:

- Number of patients that received Buprenorphine who enrolled in a drug treatment program.
- Number of patients who enrolled in a drug treatment program that met the research standard of 90 days compliance[2] in the program,

[1] CA Bridge Program model (2021).Contra Costa EMS Agency Trial Study application packet.
[2] Tkacz, J., Severt, J ., Cacciola, J. & Ruetsch, C.*Compliance with Buprenorphine Medication-Assisted Treatment and Relapse to Opioid Use*.The American Journal on Addictions. (PDF) Compliance with Buprenorphine Medication-Assisted Treatment and Relapse to Opioid Use (researchgate.net)

- Data to suggest EMS Buprenorphine administration to patients experiencing opioid withdrawal in a pre-hospital setting improves or is comparable to therapy provided by Emergency Department personnel or resources to patients who are not transported.
- Cause/reason why the 27 of the 48 patients who received Buprenorphine by EMS did not get a prescription.

Although this study presents promising outcomes, the EMSA requests, at a minimum, the following information and consideration:

- Additional patient data to increase study sample size.
- 90-day compliance follow up (instead of the 30-day compliance follow up reported in the study) on the 14 patients noted to have remained in therapy at 30 days, and for any new patients successfully enrolled in Buprenorphine treatment.
- 90-day follow up on patients treated with Buprenorphine in the field but who did not complete their medical care with a prescription for Buprenorphine.
- Larger sample size.

ATTACHMENT(S)

- Contra Costa EMS Buprenorphine Field Induction Trial Study 18-Month Review
- Originally approved Contra Costa Buprenorphine Trial Study application packet

ANNA M. ROTH, RN, MS, MPH
HEALTH DIRECTOR

MARSHALL BENNETT
EMS DIRECTOR

SENAI KIDANE, MD
EMS MEDICAL DIRECTOR

CONTRA COSTA
HEALTH SERVICES

EMERGENCY MEDICAL
SERVICES AGENCY

777 Arnold Drive, Suite 110
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Local Optional Scope of Practice

EMS Buprenorphine Field Induction

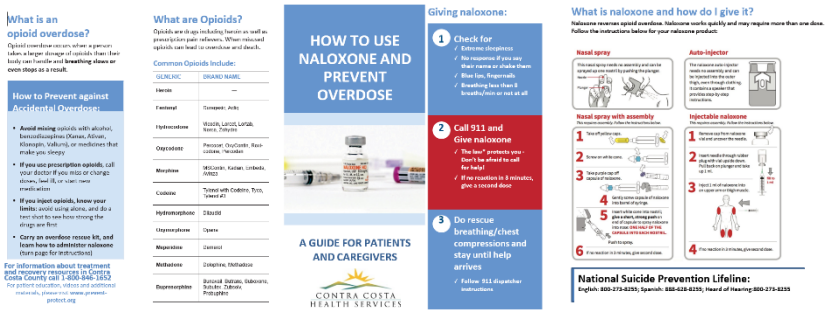
18-Month Review

Purpose

In September of 2020, Contra Costa County EMS began a pilot using paramedics to initiate Medication Assisted Treatment (MAT) for patients that contact the 9-1-1 system with an Opioid Use Disorder (OUD) by administering Buprenorphine.

The Buprenorphine pilot has been incorporated into a multi-agency initiative in which Contra Costa EMS, Public Health, CDPH and the California Bridge program are working together to support OUD patients in our communities. There are 4 pillars to the Opioid Multi-Agency Response Initiative (OMRI).

1) EMS Buprenorphine Induction pilot – to initiate MAT treatment rapidly and early. In some cases, we were able to get patients into a rehab program within hours of near-death overdoses.
2) EMS Data Sharing – Electronic Health Record data for OUD patients is shared with Contra Costa Regional Medical Center to connect their Substance Use Navigators with OUD patients that contact EMS. The Substance Use Navigators try to connect with the patients in real time, either in the emergency room or via phone to offer treatment options.
3) Leave Behind Naloxone – EMS is leaving naloxone with friends and family on scene to have on hand for possible future overdoses. The double-sided card below is attached to every box.

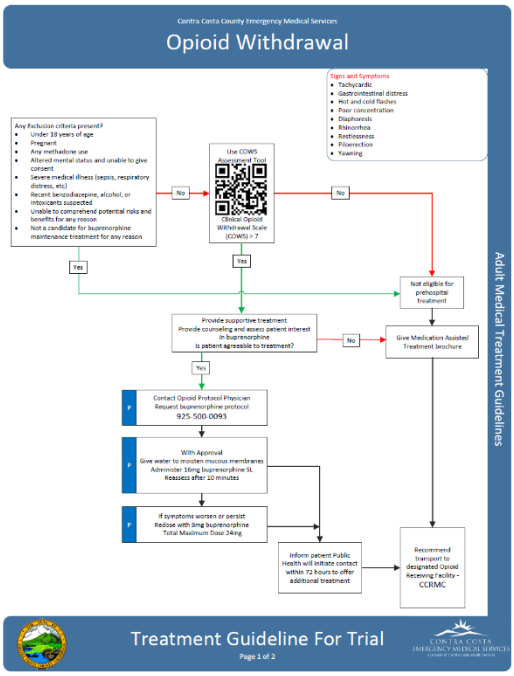


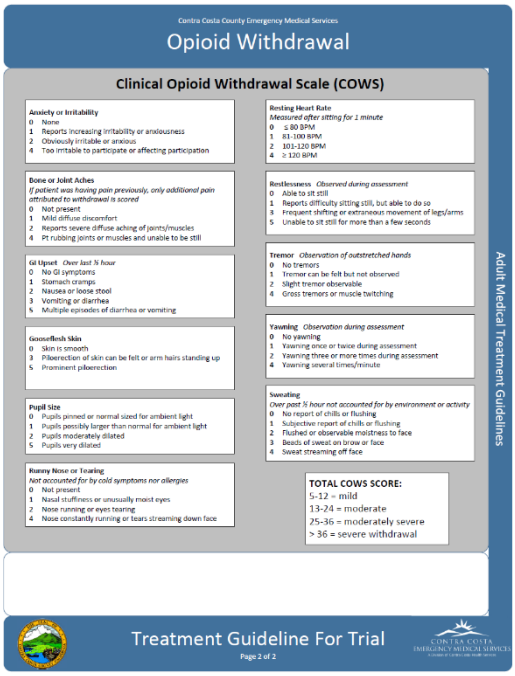
4) Opioid Overdose Receiving Center – EMS designated Contra Costa Regional Medical Center as the Opioid OD Receiving Center within the county. A whitepaper creating a specification for an Opioid OD Receiving Center is being authored through this work. An article authored by some in this group can be found here.

The ORMI group meets twice a month for Buprenorphine case review and to discuss the other pillars of the program. All Buprenorphine administrations, missed opportunities, and authorization declinations are reviewed amongst this multi-disciplinary team. Cases are reviewed from 9-1-1 activation, through the ED course of care, and onto long-term treatment referrals. An overview of the program can be found on the CA Bridge Site. Our model is gathering momentum, and we are getting interest from other EMS agencies in the state and beyond. We are currently working with Falck Ambulance in Alameda County and with San Francisco County on sharing our training materials from our Buprenorphine pilot with them to get their pilots off the ground.

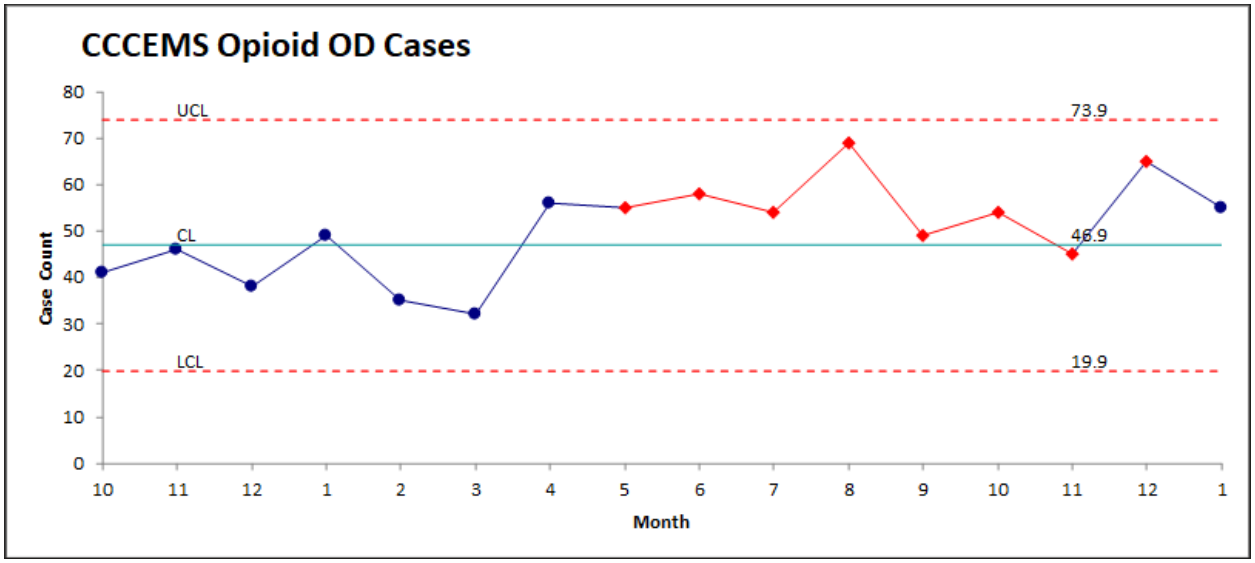
Process

Prior to initiation of the pilot, American Medical Response (our primary transport provider) Paramedics were trained in Buprenorphine induction, motivational interviewing techniques, and unconscious bias. Initial rollout in September 2020 was restricted to the east part of the county until the beginning of 2021, when the rest of the fleet was stocked with Buprenorphine, and all AMR paramedics were trained. A pool of X-waivered doctors was recruited to provide 24-7 on-call coverage to review and approve administration in real-time. The treatment protocol that CCCEMSA had developed for the pilot, is below for review.





Data Review



The above chart is EMS contacts for possible OUD by month in the Contra Costa County EMS system

Pilot Study at a Glance	
EMS Encounters for possible OUD	809
Total number of patients with identified Opioid withdrawal (qualifying for pilot study)	104
Total number of on-call MD consults	68
Total number of patients given Buprenorphine by EMS	48
Total number of patients where Buprenorphine administration denied by MD	14
Adverse reactions or complications	0
Patients admitted post ED course following EMS Bup administration (1)	7
Total number of patients given a Buprenorphine prescription at ED discharge	21
Total number of patients that continued MAT at 7 days	22
Total number of patients that continued MAT at 30 days	14

(1) Patients experienced severe opioid withdrawal symptoms or had other complications not related to Bup administration.

Outcome Results

29% % Patients who received Bup by EMS and had continued MAT at 30 days.

% Of Patients who received Bup from identified withdrawal patients 46%

General Conclusions

In the last 18 months, we've learned a great deal from this pilot and the patients we sought to help. We've found Buprenorphine inductions to be successful in treating patients who called 9-1-1 for primary withdrawal and patients who were reversed with naloxone, many who would have previously signed out AMA or declined transport to the hospital. Given the high-risk nature of the individuals that EMS interfaces with, it is incredible that nearly 30% of individuals who received Buprenorphine in the field continued MAT at 30 days and likely beyond. To date, we've had no adverse reactions in any of the cases. We've had a handful of repeat patients who were aware that the ambulances had Buprenorphine and called 9-1-1 specifically for that treatment. We believe we are changing the perceptual stigma amongst EMS providers associated with OUD and are surveying paramedics so we can learn about cultural change In EMS through their experiences. In conclusion, there is overwhelming support in our EMS community for this new treatment. We believe EMS prehospital administration of Buprenorphine is safe and effective for OUD patients in opioid withdrawal and are eager to continue our pilot and sharing our experiences.

Request for Approval of Undefined Scope of Practice

Buprenorphine Administration in the Prehospital Setting Trial Study

1. **Description of the procedure or medication requested:**

   See attached Medication Review

2. **Description of the medical condition for which the procedure/medication will be utilized:**

   Opioid withdrawal is a syndrome of distressing physical and psychological symptoms that can occur after stopping opioids or prescription opioid medication. Symptoms are painful and very unpleasant, often leading patients to relapse. Buprenorphine administration in the prehospital setting provides relief from withdrawal symptoms and establishes a pathway for the patient to receive medication assisted treatment through a designated Bridge program.

3. **Patient population that will benefit:**

   Patients in the prehospital setting that are experiencing suspected opioid withdrawal symptoms.

4. **Description of proposed study design including the scope of the study, research question, method of evaluating the effectiveness of the procedures and expected outcome.**

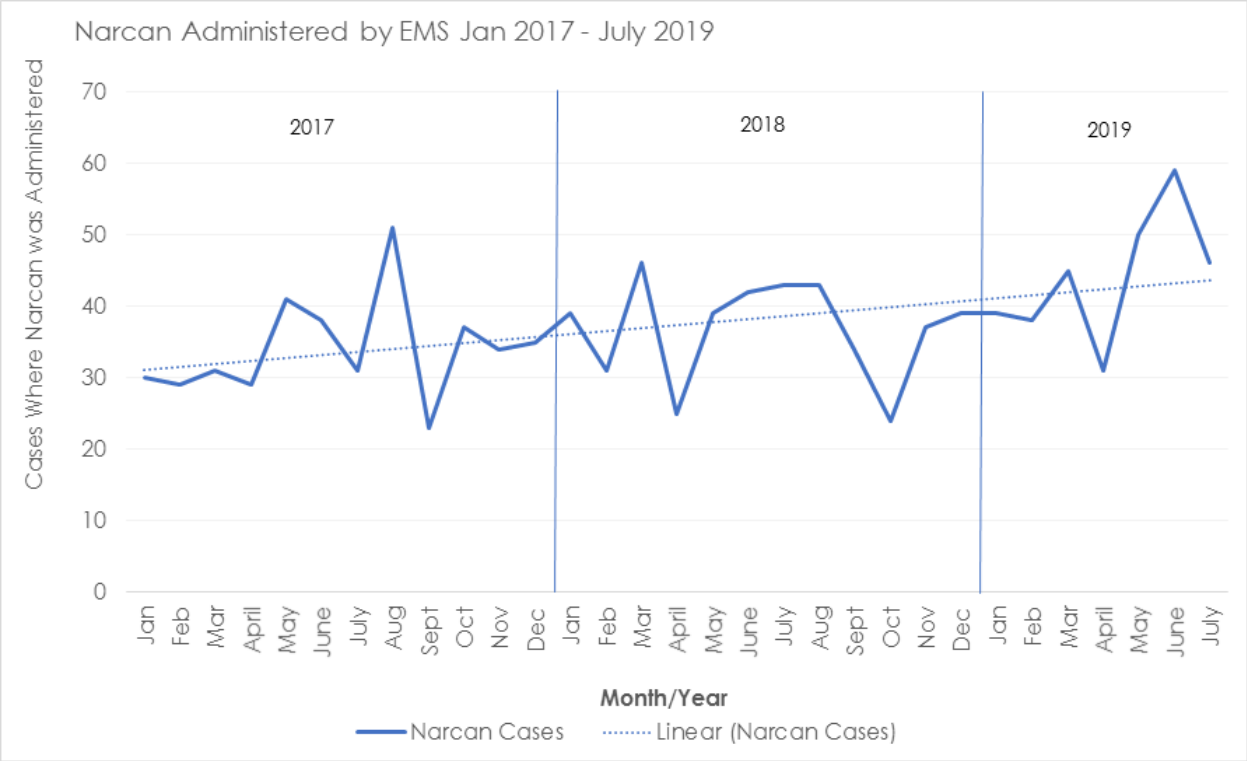
   See attached Overview of Bridge Program

5. **Alternatives (Please describe any alternate therapy(ies) considered for the same conditions and any advantages and disadvantages:**

   See attached Medication Review

6. **Estimated frequency of utilization:**

   Narcan administrations in the prehospital setting have increased steadily for the past two years. From 1/1/2018 to 9/1/2019, there were 667 patients that received Narcan and 616 patients transported. On average there are approximately 31 patients a month that receive Narcan. A subset of those may be eligible for Trial enrollment. The actual number of patients presenting with withdrawal symptoms is unknown. There are currently no Primary or Secondary impressions for suspected opioid withdrawal.



7. Other factors or exceptional circumstances:

- The LEMSA is designating a Bridge ED site as the Opiate Overdose and Withdrawal Receiving Center with a new destination policy.
- The LEMSA is sharing all overdose and withdrawal patient's contact information with our Dept of Public Health using First Pass. Public Health is initiating timely outreach to enroll these patients in MAT programs run by the county or if they have private insurance, by the appropriate provider. This allows guaranteed timely access to any patient who wants MAT (Buprenorphine) regardless of ability to pay or type of insurance coverage.
- The Alliance/AMR is implementing Leave at Scene Narcan under LEMSA Treatment Guideline and Medical Direction
- The LEMSA is proposing a Trail Study to EMSA to offer Buprenorphine in the Field by 911 EMS under online control of x waivered physicians via an alternative base arrangement. This will be for patient's in the 911 system suffering acute opiate withdrawal symptoms.

8. Any supporting data, including relevant studies and medical literature:

See Medication Review

9. Recommended policies/procedures to be instituted regarding:

1. Use – See treatment protocols
2. Medical Control – X-waived physician and virtual base will field calls from paramedics that have assessed and meet the enrollment criteria.
3. Treatment Protocols – See attached.
4. Quality assurance of the procedure or medication – See attached Data Collection Tool.

10. Description of the training and competency testing required to implement the procedure or medication: See attached lesson plan.

11. Copy of the local EMS System Evaluation and Quality Improvement Program for this request: The Contra Costa County EMS Quality Improvement Plan, approved by the State EMSA, is located on our website.
https://cchealth.org/ems/pdf/eqip_plan.pdf

12. Make up of local medical advisory committee, appointed by the Medical Director to assist with the evaluation of the trial study: Medical Advisory Committee consists of the following people:

Contra Costa County LEMSA Medical Director – Dr. David Goldstein
Contra Costa County LEMSA Assistant Medical Director – Dr. Senai Kidane
American Medical Response Medical Director – Dr. Gene Hern
Contra Costa County Public Health Medical Director – Dr. Ori Tzvieli
American Medical Response Clinical Education Team
Maria Fairbanks MSN, RN – Contra Costa County LEMSA
Joanny All RN – Contra Costa County LEMSA
Marissa Elliott RN, PHN, MSN, CNL – Public Health Nurse Program Manager – Choosing Change
Geoff Martin EMT-P – Contra Costa County LEMSA
Regina Gunderson – Substance Use Navigator, ED-Bridge Program

Medication Review: Buprenorphine

Contra Costa County EMS

A. 1-page Medication Overview:

Buprenorphine

Buprenorphine is a high-affinity partial opioid agonist as well as an antagonist of the kappa-opioid receptor and an agonist of the opioid like-1 receptor (Kleber, 2007). As a partial agonist, buprenorphine does not fully substitute for other opioids on the mu receptor (e.g., heroin, codeine, and oxycodone). Like methadone, buprenorphine can bring relief to a patient in opioid withdrawal. Through its partial agonist effect, it can also reduce the rewarding effect if the patient uses opioids while taking buprenorphine. Because it is a partial agonist, buprenorphine also has less of an effect on respiratory depression, so it has a lower risk of overdose than methadone and other opioids (Dahan et al., 2006).

The most widely available forms of buprenorphine in the United States are tablets or films that are absorbed under the tongue. In these formulations, buprenorphine is combined with the opioid antagonist naloxone to discourage injection, because naloxone is not well absorbed sublingually but will rapidly reduce the rewarding effect if the product is injected. Buprenorphine is also available in implantable and extended-release subcutaneous formulations, which are more difficult to divert1 and theoretically increase adherence to treatment.

In the United States, buprenorphine can also be provided at an OTP, but it is most commonly prescribed in an office-based setting (e.g., a primary care clinic) to patients who fill the prescription at regular pharmacies. Patients can then administer buprenorphine sublingually to themselves, as with most other medications for chronic disease. Patients are often seen by providers frequently at first, but as the treatment progresses patients who do not use other opioids are usually able to reduce the frequency of the required office visits (Fiellin et al., 2006). In order to treat OUD with buprenorphine, prescribers in the United States must undergo additional training and obtain a waiver from the Drug Enforcement Administration. Only a limited number of providers pursue these waivers. In fact, only 2 to 3 percent of physicians in the United States are waivered to provide buprenorphine, most of whom are based in urban areas (Jones et al., 2015). In 2017 nurse practitioners and physician assistants became eligible to apply for training to obtain waivers (ASAM, 2016).

As with methadone, buprenorphine sustains opioid tolerance and physical dependence in patients, so discontinuation can lead to withdrawal—although buprenorphine's withdrawal syndrome may be less severe. The most prominent risk of buprenorphine to patients with OUD is precipitation of non-life-threatening opioid withdrawal at first dose. The risk of opioid overdose death declines immediately when patients with OUD initiate buprenorphine treatment (Sordo et al., 2017).

A. **An analysis of existing peer-reviewed literature which determines whether the medication meets the standard for inclusion:**
   - **The Class of Recommendation 2A for use in the prehospital environment (Is it reasonable, Can be useful/effective/beneficial, Treatment/strategy A is probably recommended/indicated in preference to treatment B, It is reasonable to choose treatment A over treatment B),**
   - **The Level of Evidence B-NR for use in the prehospital environment (Moderate-quality evidence‡ from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies, Meta-analyses of such studies).**

In this instance, there is really no comparable medications that both successfully manage the effect of opiate withdrawal and prevent medium-term opiate overdose in these patients.

The comparative treatments for direct observed therapy to bridge the time between a patient seeking recovery services and availability of recovery services would be A. "go to where the patient is" vs. B. "have the patient come to the hospital." Because opiate addicted patients have an entire spectrum of issues which prevent timely and responsible behavior, we believe that delivering the medication to them will be more effective.

The comparative treatment for treating opiate overdose patients who have been given naloxone but who are refusing transport to the hospital are A. "provide a rescue medication that will reduce withdrawal symptoms and reduce the patient's ability to get high for the next 24 hours" vs. B. "leave the patient in opiate withdrawal."

In Contra Costa County, we believe that in both settings, it is reasonable to choose treatment A over treatment B, particularly when treatment A is combined with referral to treatment.

Regarding the level of evidence, to quote the National Academies of Science. Medications for Opioid Use Disorder Save Lives:

"*Treatment using agonist medication is estimated to reduce mortality by up to 50 percent among people with OUD (Cicero et al., 2014; Schuckit, 2016). Both methadone and buprenorphine treatment retention have been linked to substantially decreased risks of both all-cause and overdose-related mortality among people with OUD (Schuckit, 2016), and both medications reduce the number of opioid overdose deaths in the community (Pierce et al., 2016; Schwartz et al., 2013). Expanding access to these medications reduces the number of deaths due to opioid overdose (Cicero et al., 2014; Larochelle et al., 2017; Sordo et al., 2017). Studies of extended-release naltrexone have not had sufficient power or duration of follow-up to detect a mortality benefit (Jarvis et al., 2018).*

Treatment with methadone or buprenorphine is also associated with lower rates of other opioid use (Kakko et al., 2003; Mattick et al., 2009, 2014; Thomas et al., 2014), improved social functioning (Bart, 2012), decreased injection drug use (Woody et al., 2014), reduced HIV transmission risk behaviors (Gowing et al., 2011), reduced risk of HIV diagnosis (MacArthur et al., 2012), reduced risk of hepatitis C virus (HCV) infection (Peles et al., 2011), and better quality of life compared to individuals with OUD not in treatment (Ponizovsky and Grinshpoon, 2007). Methadone is also associated with reduced levels of criminality for individuals with OUD (Bukten et al., 2012; Gearing, 1974; Schwartz et al., 2009, 2011; Sun et al., 2015). Limited evidence suggests that, compared with a placebo, extended-release naltrexone may be associated with reduced opioid use, but more rigorous studies are needed (Jarvis et al., 2018).

Compared with a placebo, both buprenorphine alone and buprenorphine in combination with naloxone administered in office-based treatment settings significantly reduced opioid use and opioid cravings (Fudala et al., 2003). In women who are pregnant, buprenorphine treatment has been linked to improved maternal and fetal outcomes; infants also tend to have less severe symptoms of neonatal abstinence syndrome when their mothers were treated with buprenorphine during pregnancy (Thomas et al., 2014)."

We believe that the weight of evidence regarding the impact of buprenorphine on opioid use disorder patients is very compelling compared to the existing treatment methodology. Further, the weight of evidence in both the emergency department setting and community environments compared to the existing treatment methodology is also compelling, and both are somewhat analogous to the prehospital setting. As a result, we are requesting a trial to apply this methodology in the prehospital setting.

B. **Bibliography and copies of the peer-reviewed articles.**

Berg, M.L.. Evaluation of the use of buprenorphine for opioid withdrawal in an emergency department. Drug and Alcohol Dependence 86 (2007) 239–244. Available at: https://www.gacguidelines.ca/site/GAC_Guidelines/assets/pdf/97_Berg_2007.pdf?origin=publication_detail

California American College of Emergency Physicians. BUPRENORPHINE GUIDE AUGUST 2018. Available at: https://acep.org/patient-care/bupe/

California American College of Emergency Physicians. BUPRENORPHINE ALGORITHM AUGUST 2018. Available at: https://acep.org/patient-care/bupe/

D'Onofrio, Gail, et. al.. Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence-A Randomized Clinical Trial. JAMA. 2015;313(16):1636-1644. Available at: https://jamanetwork.com/journals/jama/fullarticle/2279713

National Academies of Science. Medications for Opioid Use Disorder Save Lives. 2019. Available at: https://www.nap.edu/catalog/25310/medications-for-opioid-use-disorder-save-lives

Rosado, James, et. al.. Sublingual Buprenorphine/Naloxone Precipitated Withdrawal in Subjects Maintained on 100 mg of Daily Methadone. Drug Alcohol Depend. 2007 Oct 8; 90(2-3): 261–269. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2094723/

Samuels, Elizabeth A.. A Quality Framework for Emergency Department Treatment of Opioid Use Disorder. Annals of Emergency Medicine Volume 73, Issue 3, March 2019, Pages 237-247. Available at: https://www.acep.org/globalassets/sites/acep/media/equal-documents/primary_lsamuelsetal2018.pdf

CALIFORNIA BRIDGE PROGRAM OVERVIEW

The CA Bridge model dramatically lowers barriers to treatment by eliminating medically unnecessary barriers and quickly providing patients with what they are seeking—immediate relief from withdrawal. We've designed a process that meets patients where they are and works in the real world of busy hospitals. Once patients are stabilized, they are better equipped to engage in conversation about long-term treatment, which they do with a Substance Use Navigator (SUN) – a peer from the community, often with lived experience. Based on a harm reduction perspective, we emphasize rapid, patient-centered care and human connections. Our goal is to transform the way people who use drugs get help by ensuring that every hospital in California provides 24/7 access to evidence-based treatment.

To advance this goal, we are rapidly building capacity to:

- Expand medication for addiction treatment (MAT) in California hospitals by raising awareness of the benefits to patients and providers.
- Help hospitals implement the CA Bridge MAT model of *treatment*, *culture*, and *connection* with resources, training, and technical support.
- Demonstrate the impact of hospital-based MAT programs and improve quality of care through research and evaluation.
- Promote sustainability of hospital-based MAT programs through policy and systems change.
- Help EMS agencies to initiate MAT for patients they encounter in partnership with local CA Bridge hospitals.

Core Elements of the CA Bridge Model

CA Bridge is advancing the use of evidence-based medications for addiction treatment (MAT), most commonly buprenorphine, which has been shown to reduce relapse among people suffering from opioid use disorder. Recently, a number of hospitals across the country have started providing MAT in their emergency rooms, but many use restrictive protocols in which patients must undergo multiple lab tests, psychosocial assessments, and paperwork before receiving any treatment.

The CA Bridge model dramatically lowers barriers to treatment by eliminating medically unnecessary tests and quickly providing patients in withdrawal with what they are seeking—immediate relief from withdrawal symptoms. By simplifying the process, the CA Bridge model works in the real world of busy hospital emergency rooms. Once patients are stabilized, they are better equipped to engage in conversation about long-term treatment, which they do with a Substance Use Navigator (SUN). The SUN is a peer who comes from the community and is often in recovery him or herself. The CA Bridge model is based on a harm reduction perspective that emphasizes rapid, patient-centered care and human connections.

The EMS component of this CA Bridge model allows EMS providers to initiate MAT with the direct consultation of a physician for patients encountering the medical system via EMS. The EMS providers will then recommend the patients be taken to the local ED Bridge site. This component is starting as a pilot project but is designed to expand to other EMS systems across the state.

Evaluation

CA Bridge has an extensive evaluation conducted in partnership with the University of California, Los Angeles. All 52 CA Bridge sites are reporting performance indicators on a monthly basis, including the number of patients identified with OUD, administered buprenorphine, accepted referral for ongoing MAT and attend at least one follow visit for treatment after ED or hospital discharge. In addition, six sites with mature MAT programs will participate in an in-depth study of a cohort of 400 randomly selected patients. This study will collect in-depth sociodemographic, substance use, overdose history, treatment history, and infectious disease risk assessments at baseline, 7- and 30-days following baseline.

We will also be assessing the status and quality of implementation at each of our sites through a tool being developed by UCLA in conjunction with several outside experts based on the IMAT (Integrated Medication Assisted Treatment), an existing tool used to assess the status of integration of MAT in specialty care practices. Finally, UCLA will be conducting interviews with patients and nursing staff at selected hospitals to generate insights into how the CA Bridge program has affected hospital culture and ED operations as well as patient experience.

Future Directions

We are actively raising funds to sustain and grow CA Bridge as a leader at both the state and national levels in high quality SUD treatment in hospitals. Our future directions include:

- Leveraging one-time state funding for substance use navigators available to every California hospital with an emergency department in 2020.
- Engagement of a third cohort of hospitals to launch the CA Bridge MAT model, pending availability of federal funds.
- Continued support for hospitals with existing MAT programs.
- Expansion of outreach, training and technical assistance to reach more hospitals and cover a wider range of SUDs, building on successful experience with treatment of opioid use disorder.
- Expansion of our EMS pilot project to include more EMS agencies and broaden the California EMS integration.
- Support for health systems seeking to develop system wide implementation of MAT across multiple hospital sites.
- Development of a statewide database on patients with SUD treated in California hospitals, with potential to be the largest such database in the country.
- Strengthening our voice as a champion for policy and system changes at the federal, state and health plan levels to establish MAT as the standard of care in hospitals.
- Pioneering special projects to innovate and test new approaches to SUD treatment that bring hospitals together with emergency medical services (EMS), correctional system health services, patient advocates, and harm reduction services.

Contra Costa County Emergency Medical Services

Opioid Withdrawal

Signs and Symptoms

- Tachycardic
- Gastrointestinal distress
- Hot and cold flashes
- Poor concentration
- Diaphoresis
- Rhinorrhea
- Restlessness
- Piloerection
- Yawning

Any Exclusion criteria present?

- Under 18 years of age
- Pregnant
- Any methadone use
- Altered mental status and unable to give consent
- Severe medical illness (sepsis, respiratory distress, etc)
- Recent benzodiazepine, alcohol, or intoxicants suspected
- Unable to comprehend potential risks and benefits for any reason
- Not a candidate for buprenorphine maintenance treatment for any reason

Yes

No

Clinical Opioid Withdrawal Scale (COWS) > 7

Yes

No

Not eligible for prehospital treatment

Provide supportive treatment
Provide counseling and assess patient interest in buprenorphine
Is patient agreeable to treatment?

No

Give Medication Assisted Treatment brochure

Yes

P Contact Opioid Protocol Physician
Request buprenorphine protocol

P **With Approval**
Give water to moisten mucous membranes
Administer 16mg buprenorphine SL
Reassess after 10 minutes

P **If symptoms worsen or persist**
Redose with 8mg buprenorphine
Total Maximum Dose 24mg

Inform patient Public Health will initiate contact within 72 hours to offer additional treatment

Recommend transport to designated Opioid Receiving Facility

Adult Medical Treatment Guidelines

CONTRA COSTA EMERGENCY MEDICAL SERVICES
A Division of Contra Costa Health Services

Opioid Withdrawal

Clinical Opioid Withdrawal Scale (COWS)

Anxiety or Irritability
0 None
1 Reports increasing irritability or anxiousness
2 Obviously irritable or anxious
4 Too irritable to participate or affecting participation

Bone or Joint Aches
If patient was having pain previously, only additional pain attributed to withdrawal is scored
0 Not present
1 Mild diffuse discomfort
2 Reports severe diffuse aching of joints/muscles
4 Pt rubbing joints or muscles and unable to be still

GI Upset *Over last ½ hour*
0 No GI symptoms
1 Stomach cramps
2 Nausea or loose stool
3 Vomiting or diarrhea
5 Multiple episodes of diarrhea or vomiting

Gooseflesh Skin
0 Skin is smooth
3 Piloerection of skin can be felt or arm hairs standing up
5 Prominent piloerection

Pupil Size
0 Pupils pinned or normal sized for ambient light
1 Pupils possibly larger than normal for ambient light
2 Pupils moderately dilated
5 Pupils very dilated

Runny Nose or Tearing
Not accounted for by cold symptoms nor allergies
0 Not present
1 Nasal stuffiness or unusually moist eyes
2 Nose running or eyes tearing
4 Nose constantly running or tears streaming down face

Resting Heart Rate
Measured after sitting for 1 minute
0 ≤ 80 BPM
1 81-100 BPM
2 101-120 BPM
4 ≥ 120 BPM

Restlessness *Observed during assessment*
0 Able to sit still
1 Reports difficulty sitting still, but able to do so
3 Frequent shifting or extraneous movement of legs/arms
5 Unable to sit still for more than a few seconds

Tremor *Observation of outstretched hands*
0 No tremors
1 Tremor can be felt but not observed
2 Slight tremor observable
4 Gross tremors or muscle twitching

Yawning *Observation during assessment*
0 No yawning
1 Yawning once or twice during assessment
2 Yawning three or more times during assessment
4 Yawning several times/minute

Sweating
Over past ½ hour not accounted for by environment or activity
0 No report of chills or flushing
1 Subjective report of chills or flushing
2 Flushed or observable moistness to face
3 Beads of sweat on brow or face
4 Sweat streaming off face

TOTAL COWS SCORE:
5-12 = mild
13-24 = moderate
25-36 = moderately severe
> 36 = severe withdrawal

Adult Medical Treatment Guidelines

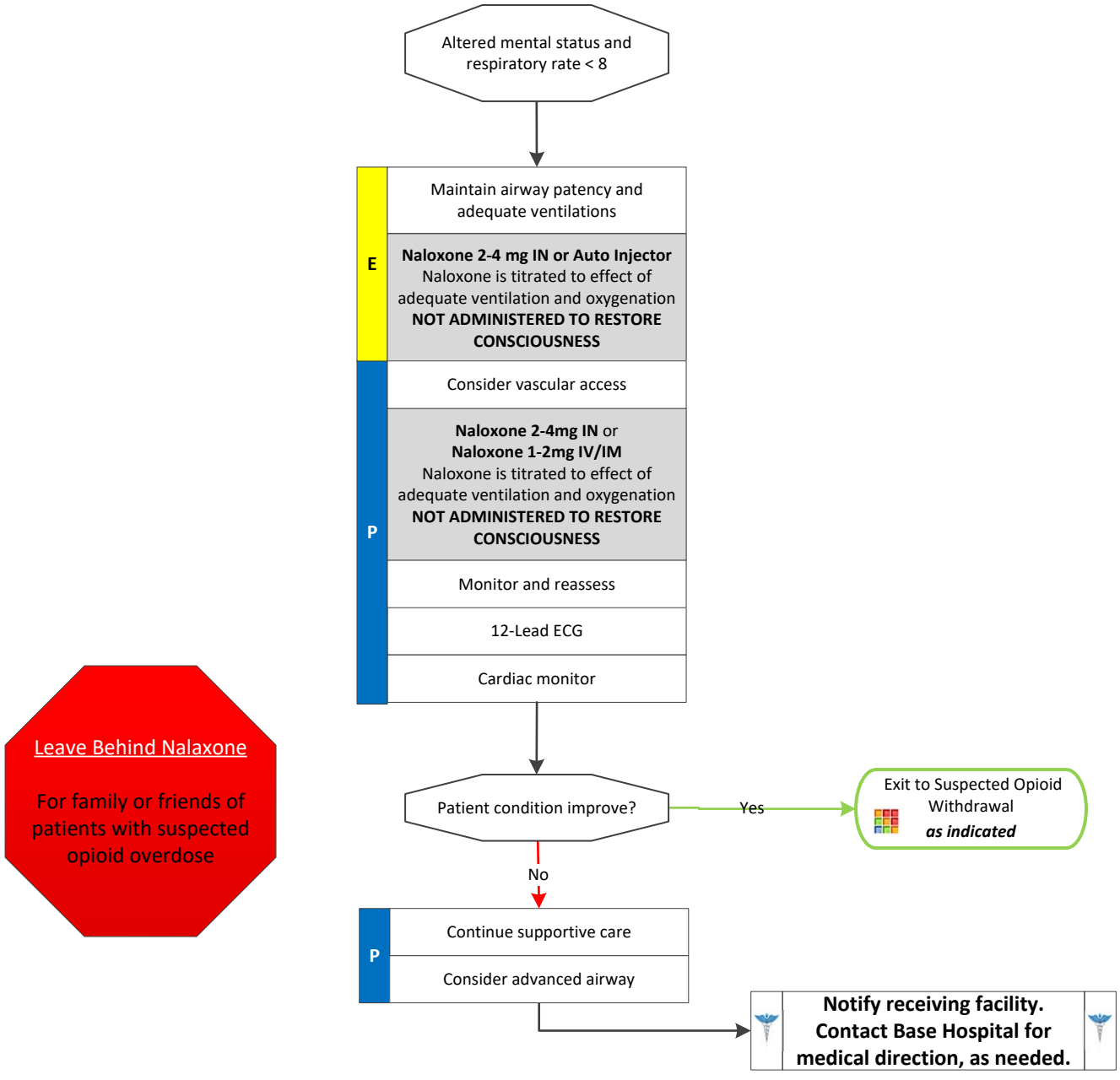
PEARLS

Suspected Opioid Overdose

History
- Hx of recent opioid drug use
- Hx of chronic opioid drug use
- Narcotic prescriptions in the household
- Evidence of illicit drug use (needles, paraphernalia)
- Hx of chronic medical conditions requiring opioid medication

Signs and Symptoms
- Altered mental status
- Depressed respiratory drive
- Pin point pupils
- Track marks
- Unconsciousness

Differential
- Diabetic emergency
- Stroke
- Neurologic disorder
- Non-opioid overdose
- Traumatic injury



Adult Medical Treatment Guidelines

EMS Buprenorphine Training

Daily Lesson Plan – Day 1 of 1

Topic: EMS Buprenorphine Training	**Intended Learners:** Paramedic Cohort Identified for authorization to administer Buprenorphine in the EMS setting
Class Facilitator(s): CCEMSA Buprenorphine Trial Lead PHCC	**Time Allotment: TBD**

Needs Assessment

1. CCEMSA is developing a trial study for Paramedics to administer Buprenorphine in the EMS setting. The trial is an effort to create a pathway for treatment of opioid use disorder by managing withdrawal symptoms and connecting to available resources for recovery. Other components of the system include:
    - Identifying persons at risk for overdose and providing "Leave Behind Narcan" kits.
    - Identifying persons who can help someone at risk for overdose and providing "Leave Behind Narcan" kits.
    - Identifying persons who show signs and symptoms of opioid use disorder or withdrawal symptoms and offering a directed destination to the only identified Bridge Program Opioid Use Disorder treatment receiving center (Contra Costa Regional Medical Center) in Contra Costa County.

Student Prerequisites: Paramedics identified to participate in this training will be eligible by meeting the following criteria:

- Active Licensed Paramedic 2+ years full time experience
- Current Contra Costa County Accreditation
- No documented Operational disciplines level of written warning or greater
- No documented Clinical inquiries that are as a result of deviation from clinical treatment guidelines and administrative policies, or failure to follow standard of care procedures.

Resource Materials, Handouts, Classroom Environment

A/V Equipment Needs: ▪ Projector w/screen, sound system and computer for PP presentation	**Room Setup:** ▪ Rectangle Closed Center
Teaching Resources/Supplies/Equipment: ▪ Class Roster – Make sure signed by all ▪ Class Evaluation – (Digital ?)	**References for Educators:** ▪ **See Attached Medication Review for references**

Handouts:

- CCEMSA Opioid Withdrawal Treatment Guideline
- CCEMSA Buprenorphine Drug Reference
- CCEMSA Administration of Buprenorphine Scenarios worksheet
- CCEMSA COWS Reference Sheet

Education Standards being addressed:

Complex depth, comprehensive breadth of Opioid toxidrome

- Anatomy
- Physiology

- Epidemiology
- Pathophysiology
- Psychosocial impact
- Presentations
- Prognosis
- Management

Integrates comprehensive knowledge of Buprenorphine to formulate treatment plan intended to mitigate emergencies and improve overall health of the patient.

Complex depth, comprehensive breadth in principles of pharmacology for Buprenorphine

- Medication safety
- Naming
- Classification
- Pharmacokinetics
- Storage and security
- Autonomic pharmacology
- Metabolism and excretion
- Mechanism of action
- Phases of medication activity
- Medication response relationships
- Medication interactions
- Toxicity

Complex depth, comprehensive breadth of administration of Buprenorphine

- Routes of administration
- Indications
- Contraindications
- Complications
- Side effects
- Interactions
- Dosages

Applies fundamental knowledge of principles of public health and epidemiology including the current public health emergency of Opioid Use Disorder in Contra Costa County.

Applies fundamental knowledge of principles of Opioid Use Disorder Bridge Program to include:

- Participants
- Benefits
- Resources Available
- Eligibility Requirements

Complex depth, comprehensive breadth of Treatment Guideline for Opioid Withdrawal in Contra Costa County

Integrates comprehensive knowledge of Clinical Opiate Withdrawal Scale (COWS) in EMS setting and utilizes the tool to identify common signs and symptoms of Opioid withdrawal.

Essential Questions and Enduring Understandings

- Participants will be able to integrate knowledge of the Opioid Toxidromes, pharmacology of Buprenorphine, results of the COWS assessment and principles of the Opioid Use Disorder Bridge

EMS Buprenorphine Training

Daily Lesson Plan – Day 1 of 1

program to determine patient eligibility for EMS administration of Buprenorphine with referral to Opioid Use Disorder Bridge and "Leave Behind Narcan" programs.

Objectives

At the conclusion of this course:

- **Cognitive**
  1. Participant will define and describe Opioid Toxidromes to include anatomy and physiology, pathophysiology, presentations and management.
  2. Participants will use information described in this course to evaluate and perform an assessment of a patient with Opioid Use disorder by utilizing C.O.W.S.
  3. Participants will define and describe the following of Buprenorphine: Indications, Contraindications, Dosage, Route, Side Effects
  4. Discuss how to use the Contra Costa Treatment Guideline Opioid Withdrawal to determine eligibility for Opioid Use Disorder Bridge Program.
  5. Define eligibility for "Leave Behind Narcan" Program.
- **Psycho-Motor**
  1. Participants will be able to prepare and administer Buprenorphine in the EMS setting.
  2. Participants will demonstrate on a simulated patient assessment utilizing COWS.
  3. Participants will evaluate eligibility requirements for Opioid Use Disorder Bridge Program and "Leave Behind Narcan" program on a simulated patient.
  4. Participants will demonstrate procedure for "Leave Behind Narcan" kit on a simulated patient.
  5. Participants will demonstrate procedure for documentation of evaluation for and administration of Buprenorphine.
- **Affective**
  1. Participant will defend the need to evaluate and provide Buprenorphine to a patient demonstrating withdrawal symptoms.
  2. Participant will appreciate the importance of Opioid Use Disorder Bridge Program and "Leave Behind Narcan" program as interventions to decrease risk of death from overdose.

General Class Content/Activities	Instructional Method	Time
Instructional set: **Introductions:** https://www.youtube.com/watch?v=aBlFgZI2e5M A video titled "Treating Opioid Addiction in the Emergency Department" depicting a Highland Hospital ER MD speaking to the use of Buprenorphine in the ED and the potential to alter the trajectory of the epidemic.	You Tube video- need internet connection	**TBD**
Background: Opioid Use Disorder	Lecture PPT slide	**TBD**
History of Treatment		**TBD**
MAT (methadone)		**TBD**
Move to Bridge Program (Buprenorphine)		**TBD**
Opioid Use Disorder Bridge Program: Description (What does the bridge program do?)		**TBD**
Participants (Who are the players?)		**TBD**
Eligibility Requirements (What it includes and who is eligible?)		**TBD**
Naloxone Distribution ("Leave Behind Narcan Program")		**TBD**
"Leave Behind Narcan" program: Description (What does the program do?)		**TBD**
Participants (Who are the players?)		**TBD**

EMS Buprenorphine Training

Daily Lesson Plan – Day 1 of 1

Eligibility Requirements (What it includes and who is eligible?)		**TBD**
Buprenorphine Pharmacology Pharmacokinetics (Mechanism of Action, Metabolism and Excretion)		**TBD**
Indications (6 Rights of Medication Administration)		**TBD**
Contraindications		**TBD**
Dosage and Route		**TBD**
Side Effects and Interactions		**TBD**
Opioid Withdrawal Treatment Guideline Review CCEMSA Opioid Withdrawal Treatment Guideline	Handout Instructor Led-Discussion	**TBD**
Clinical Opiate Withdrawal Scale (C.O.W.S.)	Lecture	**TBD**
Perform Assessment: Tabletop Scenarios	Instructor Led Discussion	**TBD**
Documentation Standards for CQI	Lecture	**TBD**
Activity (Proctor Led activity to reinforce this lesson) Clinical Scenarios - Patient Assessment- Medical with signs and symptoms of Opioid withdrawals COWS Assessment Performance Preparation for and Administration of Buprenorphine Reassessment of Patient	Break Out Groups	**TBD**
Verification (Checks for understanding) Successful completion of skills check-off for Patient Assessment, COWS Assessment performance, Preparation for and administration of Buprenorphine, and Reassessment of Patient.		**TBD**
Closure Emphasize the importance of Opioid Use Disorder Bridge Program and "Leave Behind Narcan" Program as interventions to decrease risk for death from overdose.		**TBD**
Application: Bridge the learning – Ask questions that will foster understanding, inquiry and transfer of learning for each major point.		
Evaluation: (How will achievement of objectives be measured?)		
25 Question test and skills evaluation (COWS)		
Independent Practice: In-class, independent activity, or homework assignment where students apply the information without the aid of an instructor or other students		
Reflection/notes (what went well, what should be changed?) Sent to all educators.		

CA Bridge Essential Engagement Form

Who are they and how are you going to stay in touch with them?

NAME:
DOB:
MRN:
DATE OF INTAKE:

Arrival TIme:_____ Discharge Time:_____

Gender: ❑ Male ❑ Female ❑ Transgender MTF ❑ Transgender FTM
❑ Gender non Binary ❑ Declined to Answer

Race/Ethnicity:
❑ White ❑ Black/African American
❑ Hispanic/Latinx ❑ Native American/American Indian
❑ Asian/Pacific Islander ❑ Other/mixed

Cell #: ( ) _____- _____ 2nd Cell #: ( ) _____- _____ Name of place they are staying _____ Phone #: ( ) _____- _____

Are they living outside? ❑ Yes ❑ No If yes then what are the cross streets? _____ and _____

Do you have a partner to help this person should they need extra assistance? (staff person, friend, relative, doctor?) _____

Who initially identified pt with SUD?:
❑ ED Clinician ❑ Inpatient Clinician ❑ EMS
❑ SUN or other staff (nurse, registration, social worker, etc.)

SUN made contact during initial ED/IP visit? ❑ Yes ❑ No
If no, reason: ❑ After hours referral ❑ SUN unavailable
❑ other_____

Insurance Status: *Did they need help with insurance* ❑ *Yes* ❑ *No*
❑ Private ❑ Kaiser
❑ Medi-Cal ❑ Medicare
❑ Military (e.g.Tricare, VA) ❑ Indian Health Service
❑ Unknown ❑ No insurance

Housing status: *"Where are you going to sleep tonight?"*
❑ Housed (apartment/house)
❑ Marginally housed (e.g. couchsurfing, motel, boarding house)
❑ Shelter
❑ Street or vehicle
❑ Sobering center/ Detox Facility (e.g. Cherry Hill)
❑ Sober living environment/halfway house
❑ In custody/Incarcerated
❑ Other:_____

Were housing/shelter resources offered? ❑ Yes ❑ No

Accepted referral to treatment (or already accessing treatment)?
❑ Yes ❑ No
If yes, plan for follow-up treatment:
❑ Primary care based clinic
❑ OTP (methadone or buprenorphine)
❑ Addiction specialty clinic
❑ Street program
❑ Bridge Clinic
If in custody:
❑ MAT available and will be continued
❑ MAT unavailable, plan to resume MAT after release (patient made aware bup prescriptions valid for 6 months)

If no, reason _____

Reason for ED/IP visit or hospitalization: *check all that apply*
OPIOID-RELATED::
❑ Opioid withdrawal
❑ Recent Opioid Use/ "High"
❑ Opioid overdose
❑ Seeking detox or addiction treatment (MAT):
❑ MAT start ❑ MAT restart ❑ MAT lapse prevention
❑ Other opioid use related reason:
❑ abscess, ❑ cellulitis, ❑ endocarditis, ❑ osteomyelitis,
❑ seeking opioid pain med refill ❑ Other:_____
OTHER SUBSTANCE-RELATED:
❑ Meth/crystal use ❑ cocaine/crack
❑ psychiatric crisis? ❑ High? ❑ withdrawing?
❑ CHF ❑ heart attack ❑ breathing problem
❑ stroke ❑ renal failure ❑ other_____?
❑ Alcohol use disorder
❑ Other substance intoxicated (etoh, stimulants)
❑ Other substance withdrawal (etoh, stimulants)
OTHER:
❑ Non-opioid related reason (appendicitis, trauma, stroke, etc):
❑ Unknown
❑ Other: _____

Past complications to drug use
❑ Abscesses/Skin infections
❑ Spinal abscesses
❑ blood infection
❑ bone infection (osteomyelitis)
❑ heart infection (endocarditis)
❑ brain infection (meningitis)

Did they receive Buprenorphine today?
❑ Yes. ❑ No
If yes, **where**: ❑ ED ❑ Inpatient ❑ EMS
If yes: **total amount administered** today (ED/Inpatient/EMS):
≤4 8 10 12 16 18 20 24 28 32 ≥40 mg

If no, reason: ❑ too soon ❑ methadone ❑ Intoxicated
❑ Altered or too sick ❑ Clinician declined_____

Harm Reduction kit dispensed? ❑ Yes ❑ No

DISCHARGE & CARE LINKAGE
Follow up date/time: _____
Where?: _____
Partner Staff Contact Info_____
Was an appointment available within 72hrs? ❑ Yes ❑ No

Meds prescribed?
Bup: Daily dose: ❑ 16 mg ❑ other: _____mg
Other meds:_____

Trusted Pharmacy: _____
Address_____
Phone_____
Any issues related to pharmacy?

PATIENT FOLLOW UP
Did a SUN make contact within 10 days?
❑ Yes
❑ No
❑ Attempted - unable to contact
❑ No contact info available

Did the patient attend their follow-up appointment?
❑ Yes ❑ No ❑ Unknown
If yes, date (if known)?: _____
If no did SUN attempt to re-engage the patient? ❑ Yes ❑ No

Pt engaged with followup treatment? ❑ At 1 mo ❑ At any time

Deeper Dive. The more you know the more you can help.

Get a detailed understanding of their experience with drugs and special needs they may have.

SUBSTANCE USE

Current opioid use:

❑ Heroin **How much per day**? ❑<1 gm ❑ 1-2gm ❑ 2-3gm ❑ >3gm
Route: ❑ Inject ❑ Snort ❑ Smoke ❑ Oral ❑ Other

❑ Fentanyl **How much per day**? ❑<1 gm ❑ 1-2gm ❑ 2-3gm ❑ >3g
Route: ❑ Inject ❑ Snort ❑ Smoke ❑ Oral ❑ Other

❑ Street pain pills: ❑ Prescribed pain pills:
Type: ❑ Oxy ❑ Norco/vicodin ❑ morphine ❑ other_____
How much per day? ❑ ≤ 40mg ❑40-99mg ❑100-299 ❑300+
Route: ❑ Inject ❑ Snort ❑ Smoke ❑ Oral ❑ Other

Opioid Use History

Age of patient when they first used ANY opioid for ANY reason?
❑ <17 ❑ 18-25 ❑ 26-44 ❑ 45-64 ❑ ≥ 65

What was the first opioid used?
❑ pain medication (prescribed) ❑ opium ❑ fentanyl
❑ pain medication (not-prescribed) ❑ heroin

On the heaviest use day ever, what was the <u>maximum</u> used?
Heroin/fentanyl ❑<1 gm ❑ 1-2gm ❑ 2-3gm ❑ >3gm
Pills ❑ ≤ 40mg ❑40-99mg ❑100-299 ❑300+
Route: ❑ Inject ❑ Snort ❑ Smoke ❑ Oral ❑ Other

Other substance use *(note any heavy usage)*
❑ ETOH
❑ Tobacco/Cigarette
❑ Meth/crystal
❑ Cocaine/Crack
❑ Benzos/Xanax
❑ Other:
Route(s): ❑ Inject ❑ Snort ❑ Smoke ❑ Oral ❑ Other

Has the patient ever been put on a psych hold / 5150 after meth/crystal use? ❑ Yes ❑ No ❑ Unknown

OPIOID OVERDOSE HISTORY

Has the patient ever Overdosed on opioids?
❑ Yes How Many times? Date of last OD:
❑ No

Have they ever overdosed more than once in a 7 day period?
❑Yes ❑ No

The <u>last</u> time they overdosed, can they explain why it happened?
❑ Intended to harm
❑ Took too much or too quickly
❑ Drug was stronger than thought
❑ Tried fentanyl
❑ Used stimulants containing unexpected fentanyl
❑ Mixed opioid with another drug
❑alcohol ❑benzo ❑meth ❑other

The last time they overdosed were they:
❑ Given narcan by friend/bystander but EMS was not called
❑ Given narcan by friend/bystander with EMS called
❑ Had EMS called and was given narcan by EMS

Were you taken to the hospital?
❑Yes ❑ No

If yes what happened at the hospital
❑ Given take home naloxone in hand?
❑ Administered Buprenorphine
❑ Given a prescription for buprenorphine
❑ Administered methadone
❑ Given a referral for methadone clinic
❑ None of the above/other

The last time they overdosed what did they do in the <u>48 hours</u> after narcan administration?
❑ returned to using opioids
❑ started on Bup
❑ started on methadone
❑ stopped using opioids for at least 48 hours

PREVIOUS MAT

Has the patient ever taken buprenorphine?: ❑ Yes ❑ No
If yes: ❑ prescribed/hospital ❑ street/friend (illicit)

Previous methadone: ❑ Yes ❑ No
If yes where did they first try methadone?
❑ prescribed/hospital ❑ street (illicit)

Special Situations (current visit): *check all that apply*
❑ Pregnant ❑ On psych hold (5150) ❑ In Custody
❑ Domestic Violence (DV) ❑ Sexual Assault (261)

Treatment Challenges Regarding SUD Treatment
Check all that apply.
❑ Transportation: *Can't get to appointments, no transportation*
❑ Housing: *Homeless, unstable housing*
❑ Incarcerated: *arrested, being put in jail, or incarceration*
❑ Not welcomed: *Unfriendly or mean staff who do not care*
❑ Financial: *Cannot afford to pay for medications*
❑ Insurance: *No insurance*
❑ Time/flexible appt: *Can't take time off work, no evening appts*

Are there health needs you could help address to promote wellbeing and safety?

Mental Health History *"This is a self reported answer. Do you feel that you have any mental health issues?" or "Do you want assistance with mental health issues?"*
❑ Yes ❑ No
❑ Anxiety ❑ Depression
❑ PTSD ❑ Schizophrenia
❑ Bi-Polar ❑ Other / not specified

"Have you ever been to a locked psychiatric facility or put on a hold (5150)?"
❑ Yes ❑ No

Does the patient report or is there documentation of them every attempting suicide?
❑ Yes ❑ No

Hep C/ HIV testing *"Do you have or do you feel that you are at risk for Hep C and or HIV?"*
❑ Yes ❑ No ❑ Unknown

"Would you like to be tested today?"
❑ Yes ❑ No

Was the patient tested during this visit?
❑ Yes (Hep C) ❑ No
❑ Yes (HIV)

"Would you like to be linked to possible Hep C or HIV treatment?"
❑ Yes (Hep C) ❑ No
❑ Yes (HIV)

Medical History (if known)
❑ Hypertension ❑ Stroke
❑ COPD ❑ Hep C
❑ Diabetes ❑ HIV
❑ Asthma

Chronic Pain *"Do you feel that you have any chronic pain? What I mean by that is every day pain you wake up with or experience daily."*
❑ Yes ❑ No
"Have you ever used an opioid because of pain related to trauma?"
❑ Gunshot wound
❑ Other assault, stab wound etc
❑ MVC ❑ Fall
❑ Athletic Injury

EMS Deeper Dive/Data Questions (for patients brought in by EMS)

Dispatch Code for EMS call: _____
Primary Impression from Paramedic: _____
Sign out AMA? Time:_____
Time at Patient: _____ Time at Facility: _____Off Load time at Destination: _____

Pain scale in field prior to Bup admin?
Initial:_____ After Bup: _____ at ____ min after dose

Medications in field:
Total amount of Narcan given by EMS if any:_____mg Route: IN IM IV
Total amount of Bup given by EMS if any: 0 ≤4 8 10 12 16 18 20 24 28 32 ≥40 **mg**
Other: _____

What was the EMS COWS score prior to Bup? _____

Notes:

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY GAVIN NEWSOM, *Governor*

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

June 18, 2020

David Goldstein, MD
EMS Medical Director
Contra Costa County Emergency Medical Services
777 Arnold Drive, Suite 110
Martinez, CA 94553

Dear Dr. Goldstein:

The purpose of this letter is to advise you that your request for approval of a trial study on the use of buprenorphine for opioid withdrawal in the prehospital setting is approved.

Your request was reviewed in consultation with the members of the Emergency Medical Directors Association (EMDAC) on June 16, 2020. The recommendation from the group, and I concur, was to approve your request.

Please advise Austin Trujillo, of the EMS Personnel Division of the EMS Authority, of the date that the trial study will begin enrolling patients. A report will be due to the EMS Authority 18-months from the start date. This report will be presented to the Commission on EMS for review and recommendation to continue the trial study for one more 18-month period, end the trial study, or add buprenorphine to the paramedic basic or local optional scope of practice.

If you have questions, please contacted Austin Trujillo of my staff by phone at (916) 431-3727 or by email at Austin.Trujillo@emsa.ca.gov.

Sincerely,

Dave Duncan, MD
Director

cc: Mike Williams, EMS Director, Contra Costa County Emergency Medical Services

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

COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **ITEM NUMBER: 8B**

SUBJECT: NREMT Exam Pass Rates

PRESENTER: Kim Lew
Chief, EMS Personnel Division

CONSENT: ___ ACTION: ____ INFORMATION: _X_

RECOMMENDATION

Receive information on the National Registry of EMTs (NREMT) paramedic and EMT examination pass rates in California.

FISCAL IMPACT

No fiscal impact.

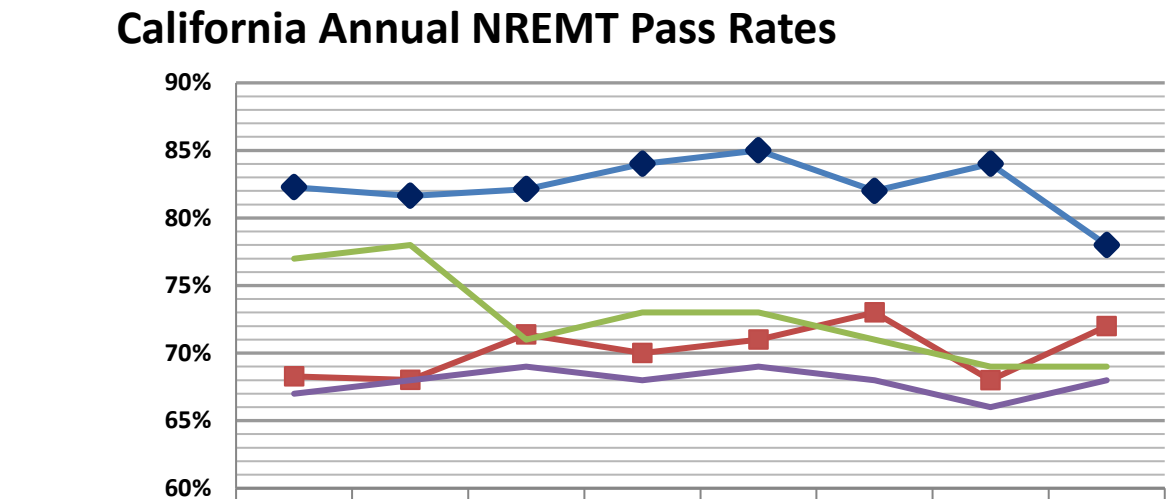
BACKGROUND

Local EMS agencies approve most EMT, AEMT, and paramedic training programs; however, the EMS Authority approves statewide public safety agency EMT training programs, which include the California Highway Patrol, CAL FIRE, and the State Department of Parks and Recreation. California has adopted the NREMT to provide EMS training program graduates cognitive (written) and psychomotor (skills) examinations as proof of competency for licensure/certification in California.

SUMMARY

The state of California continues to have the highest number of NREMT certified EMS professionals nationwide. As of September 7, 2022, there are 40,463 NREMT certified EMTs, AEMTs, and paramedics in California.

California paramedic and EMT program graduate first time pass rates continue to exceed the national averages. California paramedic graduate pass rates decreased while EMT graduate pass rates increased over the past year.



	2014	2015	2016	2017	2018	2019	2020	2021
CA Paramedic	82%	82%	82%	84%	85%	82%	84%	78%
California EMT	68%	68%	71%	70%	71%	73%	68%	72%
National	77%	78%	71%	73%	73%	71%	69%	69%
State	67%	68%	69%	68%	69%	68%	66%	68%

Attached are data from the NREMT that list the first attempt pass rate results of paramedics and EMTs affiliated with California approved training programs.

DISCUSSION

None.

ATTACHMENT(S)

2020 and 2021 California EMT Pass Rates by LEMSA and Program
2020 and 2021 California Paramedic Pass Rates by LEMSA and Program

California National Registry of EMTs, Paramedic Pass Rates
Effective 09/07/2022

		2017		2018		2019		2020		2021	
California - State NREMT EMT Pass Rate		**70%**		**71%**		**73%**		**68%**		**72%**	
National - NREMT Pass Rate										68%	
CA EMT Training Program Name	NREMT Program #	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt
Alameda County EMS Agency											
ALCO EMS Corps EMT Program	CA-01031	26	62%	35	80%	12	50%	22	82%	14	71%
American Health Education	CA-01009	119	67%	117	70%	122	86%	209	75%	220	81%
Bay Area Youth EMT Program	CA-01033									12	100%
Bay Area Training Academy	CA-01030	41	68%	103	81%	197	80%	334	85%	540	86%
Bear EMT Program	CA-01028	56	64%	83	73%	52	79%	38	89%	9	89%
Berkeley STEP	CA-01029	4	75%	7	86%	5	40%	1	100%	5	100%
Chabot College	CA-01014	31	55%	31	58%	41	71%	42	88%	34	62%
Las Positas College	CA-01001	47	83%	42	69%	70	79%	48	79%	34	65%
Merritt College/Alameda County	CA-01022	59	61%	68	53%	61	64%	12	58%	28	50%
NCTI- Bay Area (Livermore)	CA-65032	43	81%	55	87%	115	79%	29	76%	28	79%
Project Heartbeat EMS Academy	CA-01032					71	68%	237	86%	207	86%
Unitek College	CA-01003	299	76%	279	70%	71	68%				
LEMSA TOTALS & AVERAGE %		**725**	**69%**	**820**	**73%**	**817**	**69%**	**972**	**82%**	**1131**	**79%**
Central California EMS Agency											
Alert Medical Training	CA-61027	55	71%	87	68%	94	62%	122	75%	138	84%
American Ambulance	CA-61005	54	74%								
California State University Fresno	CA-61006	3	33%	8	50%	6	0%	10	50%	5	40%
College of the Sequoias	CA-61019	30	33%	26	46%	32	28%	28	50%	27	22%
Fresno City College Fire Academy	CA-61008	35	49%	70	59%	64	23%	63	30%	97	42%
Valley ROP	CA-61042	26	31%	61	16%	105	31%	52	33%	78	37%
Hume Lake Fire Department	CA-61037	1	100%	4	100%	3	67%	1	100%		
Madera Adult School	CA-61017	6	67%	13	46%	11	45%			12	33%
Minarets Adult Education EMT-Basic	CA-61032	9	78%	21	67%	15	60%			5	80%
Orange Cove Fire Department	CA-61013	14	36%	18	28%	18	33%	9	22%	25	52%
Porterville Community College	CA-61024	10	60%	34	50%	52	44%	29	55%	30	50%
Selma Fire Department	CA-61003	20	0%					1	100%		
Tulare Co. Fire Department	CA-6023					4	50%	4	0%	2	50%
West Hills College	CA-61004	14	36%	29	69%	31	74%	29	52%	29	52%
LEMSA TOTALS & AVERAGE %		**277**	**51%**	**371**	**54%**	**435**	**43%**	**348**	**52%**	**448**	**49%**

California National Registry of EMTs, Paramedic Pass Rates
Effective 09/07/2022

		2017		2018		2019		2020		2021	
California - State NREMT EMT Pass Rate		**70%**		**71%**		**73%**		**68%**		**72%**	
National - NREMT Pass Rate										68%	
CA EMT Training Program Name	NREMT Program #	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt
Coastal Valleys EMS Agency											
Coast Life Support District	CA-66017					10	60%	1	100%	16	50%
Mendocino College Mendocino County	CA-66006	35	66%	31	61%	53	55%	21	81%	30	73%
Mendocino County Office of Education ROP	CA-66005	7	71%	4	75%						
Santa Rosa Junior College	CA-66001	95	96%	125	93%	123	96%	120	92%	135	94%
LEMSA TOTALS & AVERAGE %		**137**	**78%**	**160**	**76%**	**176**	**70%**	**142**	**91%**	**181**	**72%**
Contra Costa County EMS Agency											
Contra Costa College	CA-07001	4	25%	23	57%	43	58%	47	66%	44	84%
Los Medanos Community College	CA-07003	144	72%	80	54%	60	30%	67	28%	44	27%
Mt Diablo Adult Education	CA-07002	14	29%	27	74%	13	62%	4	75%	22	55%
LEMSA TOTALS & AVERAGE %		**162**	**42%**	**130**	**62%**	**116**	**50%**	**118**	**56%**	**110**	**55%**
El Dorado County EMS Agency											
El Dorado County Training Officer's Assn	CA-09002	17	100%	31	71%	35	94%				
Lake Tahoe Community College	CA-09001	43	72%	36	78%	44	68%	33	61%	37	73%
LEMSA TOTALS & AVERAGE %		**60**	**86%**	**67**	**75%**	**79**	**81%**	**33**	**61%**	**33**	**73%**
Imperial County EMS Agency											
Bureau of Land Management	CA-13004	2	100%					3	100%		
Central Union Adult School	CA-13005					5	0%	2	50%	11	45%
Imperial Community College	CA-13002	1	100%			46	50%				
Imperial Valley College	CA-13001	45	71%			36	47%	50	36%	50	62%
LEMSA TOTALS & AVERAGE %		**48**	**90%**	**0**		**87**	**32%**	**55**	**62%**	**55**	**54%**

California National Registry of EMTs, Paramedic Pass Rates
Effective 09/07/2022

		2017		2018		2019		2020		2021	
California - State NREMT EMT Pass Rate		**70%**		**71%**		**73%**		**68%**		**72%**	
National - NREMT Pass Rate										68%	
CA EMT Training Program Name	NREMT Program #	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt
Inland Counties EMS Agency											
American EMT Academy	CA- 62042							112	56%	121	65%
Barstow Community College	CA-62001	14	79%	8	50%	6	67%	9	44%	4	50%
Cerro Coso Community College	CA-15007	40	75%	46	78%	37	78%	57	61%	39	79%
Chaffey College	CA-62022	36	64%	56	39%	76	59%	53	57%	29	41%
Copper Mountain College	CA-62003	33	79%	18	94%	15	67%	16	75%	20	55%
CPR and More	CA-62042	84	77%	71	65%	93	55%				
Crafton Hills College	CA-62008	115	64%	103	65%	146	55%	108	56%	73	71%
Fire Future LLC	CA-62047							81	67%	77	64%
High Desert EMT	CA-62048									21	62%
Inland Empire Healthcare Training Institute	CA-62041	11	82%	17	65%	13	23%				
Lone Pine Unified School District	CA-62010										
Mono County EMS EMT Training Program	CA-62029	14	86%								
Montclair Fire Department	CA-62023	70	74%	68	75%						
San Bernardino Co. Fire Department	CA-62025	8	50%	1	100%					5	40%
San Bernardino Co. Fire	CA-94027	9	22%	6	67%						
San Bernardino Co. Superintendent of Schools ROP	CA-62045					9	44%	3	0%		
So Cal EMT Fire Training	CA-62024	50	70%								
So Cal EMT Fire Training - Oct 2017	CA-62030	3	100%	65	77%	108	66%	108	82%	124	82%
Southern Cascades Community Services District	CA-64027							4	50%	5	80%
Southern Inyo Fire Protection District	CA-62027	5	60%	5	40%	7	57%				
US Colleges- San Bernardino	CA-62044					21	33%	14	21%	23	13%
Victor Valley Community College	CA-62006	128	46%	143	60%	132	64%	138	65%	116	59%
LEMSA TOTALS & AVERAGE %		**620**	**69%**	**607**	**67%**	**663**	**56%**	**267**	**53%**	**273**	**59%**
Kern County EMS Agency											
Bakersfield College Allied Health	CA-15012	162	64%	146	62%	116	45%	115	55%	104	57%
Taft College	CA-15011	14	79%			14	86%	12	50%	9	56%
LEMSA TOTALS & AVERAGE %		**176**	**72%**	**146**	**62%**	**130**	**66%**	**127**	**53%**	**113**	**57%**

California National Registry of EMTs, Paramedic Pass Rates
Effective 09/07/2022

		2017		2018		2019		2020		2021	
California - State NREMT EMT Pass Rate		**70%**		**71%**		**73%**		**68%**		**72%**	
National - NREMT Pass Rate										68%	
CA EMT Training Program Name	NREMT Program #	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt
Los Angeles County EMS Agency											
Alhambra Unified School District	CA-19067	2	100%	5	40%	4	75%				
Antelope Valley College	CA-19019	10	70%	9	67%	16	63%	13	83%	25	48%
Antelope Valley High School District ROP	CA-19014	23	83%	23	96%	25	84%	13	100%	11	82%
California Advancing Pathways for Students (CalAPS)	CA-19071									2	50%
California Institute of EMT	CA-19054	532	89%	502	90%	388	89%	204	90%	262	96%
Charter College - LA	CA-19066	8	13%								
Citrus Community College	CA-19002	51	78%	59	90%	44	89%			27	93%
College of the Canyons	CA-19017	115	82%	118	86%	113	82%	70	76%	57	81%
CSU Dominguez Hills	CA-19073							9	100%		
CSU Long Beach	CA-19062	74	61%	72	64%	66	74%	22	82%	51	76%
Downey Adult School	CA-19064	23	48%	42	48%	55	49%	49	53%	54	50%
East Los Angeles College	CA-19030	28	57%	18	61%	26	62%	31	55%	22	41%
East San Gabriel Valley ROP	CA-19031	18	61%	14	64%	26	58%	11	27%		
El Camino College	CA-19003	129	78%	153	75%	186	74%	17	59%	160	60%
Glendale Community College	CA-19004	61	85%	52	58%	63	62%	34	47%	42	48%
Long Beach City College	CA-19006	12	75%	12	75%	21	29%	25	48%	29	52%
Long Beach Fire Department	CA-19035	13	69%								
Los Angeles County Fire Department	CA-19007	16	100%	54	85%	14	71%				
Los Angeles County Sheriff's Department	CA-19009	5	100%								
Los Angeles Harbor College	CA-19036	7	57%	9	67%	3	67%			5	20%
Los Angeles Valley College	CA-19010	88	66%	69	77%	58	91%	58	83%	60	90%
Mt. San Antonio College	CA-19011	53	60%	56	98%	142	82%	17	82%	66	85%
North Valley Occupational Center	CA-19039	31	48%	37	49%	28	64%	7	57%	45	47%
Pasadena City College	CA-19040	98	61%	104	95%	183	76%	45	73%	149	79%
Professional Career Development Center	CA-19068	1	100%								
ProTech Life Safety Services	CA-30022	59	64%	139	58%	178	66%	239	65%	275	69%
West Coast EMT- Redondo Beach	CA-19070	38	95%	133	90%	193	82%	58	81%	227	85%
Rio Hondo College Fire Academy	CA-19058	104	64%	115	74%	119	69%	92	63%	87	74%
Southern California ROC	CA-19050	29	62%	21	90%	21	86%	20	80%	21	90%
UCLA Center for Prehospital Care	CA-19013	564	97%	615	97%	636	92%	587	95%	661	91%
University of Antelope Valley	CA-19001	113	53%	143	57%	106	49%	51	53%	64	45%
LEMSA TOTALS & AVERAGE %		**2305**	**70%**	**2574**	**74%**	**2714**	**71%**	**1672**	**71%**	**2402**	**67%**
Marin County EMS Agency											
College of Marin	CA-21001	16	94%	19	89%	23	74%	17	71%	26	81%
LEMSA TOTALS & AVERAGE %		**16**	**94%**	**19**	**89%**	**23**	**74%**	**17**	**71%**	**26**	**81%**

California National Registry of EMTs, Paramedic Pass Rates
Effective 09/07/2022

		2017		2018		2019		2020		2021	
California - State NREMT EMT Pass Rate		**70%**		**71%**		**73%**		**68%**		**72%**	
National - NREMT Pass Rate										68%	
CA EMT Training Program Name	NREMT Program #	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt
Merced County EMS Agency											
Merced Community College	CA-24001	31	77%	44	86%	46	63%	20	65%	25	60%
LEMSA TOTALS & AVERAGE %		**31**	**77%**	**44**	**86%**	**46**	**63%**	**20**	**65%**	**25**	**60%**
Monterey County EMS Agency											
Hartnell Community College	CA-27001	28	43%	38	32%	52	21%	45	38%	50	58%
Monterey Peninsula College	CA-27002	45	73%	35	86%	53	79%	29	93%	57	72%
Monterey Peninsula ROP	CA-27004			1	0%						
LEMSA TOTALS & AVERAGE %		**73**	**58%**	**74**	**39%**	**105**	**50%**	**74**	**66%**	**107**	**65%**
Mountain Valley EMS Agency											
Academy for Profesional Development	CA-60027	18	22%	35	54%	33	45%	54	48%	40	38%
Abrams College	CA-60003	114	42%	81	44%	99	52%	117	47%	77	48%
Ceres Unified Adult Education	CA-60002	24	33%	25	80%	41	56%	40	53%	16	50%
First Lady Permanente	CA-60028	15	33%	66	44%	60	53%	61	48%	76	59%
Ione Fire Department	CA- 60026	33	24%	16	31%	13	8%			18	61%
Mariposa County Adult Education	CA-60008							14	43%	7	71%
Modesto Junior College	CA-60001	63	84%	59	93%	66	88%	36	72%	33	85%
Murphys Fire Protection District	CA-60013	18	72%	15	67%	21	62%	34	62%	25	60%
LEMSA TOTALS & AVERAGE %		**285**	**44%**	**297**	**59%**	**333**	**52%**	**356**	**53%**	**292**	**59%**
Napa County EMS Agency											
Napa Valley College	CA-67002	42	57%	33	85%	38	55%	31	52%	23	48%
Pacific Union College	CA-67003	9	67%	8	63%	7	57%	9	44%	2	50%
LEMSA TOTALS & AVERAGE %		**51**	**62%**	**41**	**74%**	**45**	**56%**	**39**	**48%**	**39**	**49%**
North Coast EMS Agency											
College of the Redwoods	CA-63003	41	85%	44	82%	43	56%	42	79%	35	71%
Del Norte Fire Training Consortium	CA-63005	22	77%			24	46%			13	69%
Humboldt State University	CA-63007	17	47%	24	67%	28	71%				
Lake Co. Fire Protection District	CA-63001	7	57%								
LEMSA TOTALS & AVERAGE %		**87**	**67%**	**68**	**75%**	**95**	**58%**	**42**	**79%**	**42**	**70%**

California National Registry of EMTs, Paramedic Pass Rates
Effective 09/07/2022

		2017		2018		2019		2020		2021	
California - State NREMT EMT Pass Rate		**70%**		**71%**		**73%**		**68%**		**72%**	
National - NREMT Pass Rate										68%	
CA EMT Training Program Name	NREMT Program #	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt
Nor Cal EMS Agency											
College of the Siskiyous	CA-65026	28	68%	32	84%	27	70%	15	87%	27	44%
Downieville Fire Protection District	CA-64026	12	100%			6	83%	8	63%	4	50%
Feather River College	CA-64007	6	50%	6	83%	11	45%	6	67%	6	50%
Lassen Community College	CA-64005	7	71%	9	44%	4	100%	6	33%	8	63%
Modoc Medical Center	CA-64019	7	71%	4	75%	13	38%	4	0%	3	67%
Plumas District Hospital	CA-64029									9	89%
Shasta Community College	CA-65022	64	66%	72	60%	105	59%	52	63%	63	67%
STAR/KZVFD EMT Program	CA-64020					2	0%	2	0%	1	0%
Trinity County Life Support EMT Program	CA-64024	3	100%	3	100%	4	100%				
LEMSA TOTALS & AVERAGE %		**127**	**75%**	**126**	**74%**	**172**	**62%**	**93**	**45%**	**121**	**54%**
Orange County EMS Agency											
Central County ROP CTE Partnership	CA-30008	1	0%			4	50%				
Coastline Regional Occupational Program	CA-30002	60	62%	53	81%	51	65%	47	36%	21	67%
College and Career Advantage	CA-30024					15	47%	32	38%	32	50%
North Orange County ROP	CA-30003	11	55%	5	0%	11	36%	13	23%	14	36%
Orange Coast College	CA-30004	32	84%	52	85%	48	88%	59	80%	30	83%
Orange County CPR	CA-30015	142	59%	2	50%	2	100%				
Orange County EMT	CA-30020	65	66%	209	76%	177	75%	365	81%	270	82%
Saddleback College	CA-30005	92	85%	98	77%	108	82%	89	67%	72	42%
Santa Ana College	CA-30006	95	81%	140	79%	132	82%	123	52%	129	56%
South Coast ROP	CA-30001	18	44%	7	57%						
West Coast EMT - Orange	CA-30019	544	77%	566	78%	553	85%	964	64%	542	89%
LEMSA TOTALS & AVERAGE %		**1060**	**61%**	**1132**	**65%**	**1101**	**71%**	**1692**	**55%**	**1110**	**63%**

California National Registry of EMTs, Paramedic Pass Rates
Effective 09/07/2022

		2017		2018		2019		2020		2021	
California - State NREMT EMT Pass Rate		**70%**		**71%**		**73%**		**68%**		**72%**	
National - NREMT Pass Rate										68%	
CA EMT Training Program Name	NREMT Program #	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt
Riverside County EMS Agency											
College of the Desert	CA-33004	34	88%	30	83%	52	69%	25	64%	20	85%
Health Pro EMT Training	CA-33013	15	67%	26	58%	18	50%	93	65%	160	56%
Moreno Valley College	CA-33002	137	83%	126	90%	147	86%	113	88%	114	82%
Mt San Jacinto College	CA-33005	48	63%	56	64%	48	69%	65	37%	31	42%
NCTI-Riverside	CA-65034					65	94%	6	83%	18	72%
Palo Verde College	CA-33001										
Riverside Couty Fire (Cal Fire)	CA-33006					1	100%	1	100%		
Riverside County Office of Education ROP	CA-33007	9	22%	17	24%	20	15%	13	38%	3	67%
Southern California EMS Training Institute	CA-33010	78	78%	155	75%	125	66%	218	65%	189	59%
West Coast EMT-Riverside	CA-33011	267	78%	301	77%	370	84%	371	63%	309	87%
LEMSA TOTALS & AVERAGE %		**588**	**68%**	**711**	**67%**	**846**	**70%**	**905**	**67%**	**844**	**69%**
Sacramento County EMS Agency											
American River College	CA-34001	128	91%	101	83%	92	77%	68	93%	84	93%
California Regional Fire Academy	CA-34018					41	80%	26	92%		
CA State Univ. Sac., Pre-Hospital Education	CA-34006	158	76%	169	80%	174	82%	105	83%	149	87%
Cosumnes River College	CA-34002	66	100%	76	92%	71	92%	19	89%	32	81%
Folsom Lake College	CA-09003									27	78%
Herald Fire District	CA-94032										
Project Heartbeat LLC	CA-01032							237	86%	207	86%
Walnut Grove Fire District	CA-34020	7	57%	5	0%			1	0%	7	57%
LEMSA TOTALS & AVERAGE %		**359**	**81%**	**351**	**64%**	**378**	**83%**	**456**	**74%**	**506**	**80%**
San Diego County EMS Agency											
EMSTA Inc.	CA-37007	290	76%	265	74%	209	77%	227	59%	242	60%
Grossmont Health Occupations Center	CA-37003	18	56%	34	76%	37	68%	18	61%	25	48%
Healthcare Academy of California	CA-37028	71	48%	104	78%	90	81%	159	58%	97	75%
Institute of Healthcare, Inc.	CA-37031							109	61%	170	65%
Miramar College	CA-37005	402	88%	395	83%	416	78%	245	75%	252	76%
Pala Fire Dept. EMT Training										2	50%
Palomar Community College	CA-37001	301	82%	265	77%	267	74%	166	74%	166	76%
Point Loma Nazarene University	CA-37032							12	92%	10	90%
Southwestern Community College	CA-37006					63	75%	77	45%	60	80%
US Colleges- San Diego	CA-37030					17	53%	36	58%	47	51%
WestCoast EMT- San Diego	CA-37033							1	0%	115	86%
LEMSA TOTALS & AVERAGE %		**1082**	**70%**	**1063**	**78%**	**1099**	**72%**	**1050**	**58%**	**1186**	**69%**

California National Registry of EMTs, Paramedic Pass Rates
Effective 09/07/2022

		2017		2018		2019		2020		2021	
California - State NREMT EMT Pass Rate		**70%**		**71%**		**73%**		**68%**		**72%**	
National - NREMT Pass Rate										68%	
CA EMT Training Program Name	NREMT Program #	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt
San Francisco EMS Agency											
City College of San Francisco	CA-38001	91	67%	111	74%	104	77%	71	76%	133	71%
University of San Francisco	CA-38008	37	95%	54	91%	22	95%				
LEMSA TOTALS & AVERAGE %		**128**	**81%**	**165**	**83%**	**126**	**86%**	**71**	**76%**	**71**	**71%**
San Joaquin County EMS Agency											
Bradford College of Nursing	CA-39010							56	64%	115	72%
Ripon Fire Department	CA-39003	1	100%								
LEMSA TOTALS & AVERAGE %		**1**	100%	**0**		**0**		**56**	**64%**	**115**	**72%**
San Luis Obispo County EMS Agency											
Cuesta College Allied Health-EMT	CA-40003	64	75%	79	77%	104	75%	72	69%	82	77%
LEMSA TOTALS & AVERAGE %		**64**	75%	**79**	77%	**104**	**75%**	**72**	**69%**	**72**	**77%**
San Mateo County EMS Agency											
College of San Mateo	CA-41004	41	98%	31	87%	44	86%	20	90%	29	97%
Skyline College	CA-41002	55	78%	62	75%	67	67%	29	79%	33	82%
LEMSA TOTALS & AVERAGE %		**96**	**88%**	**93**	**81%**	**111**	**77%**	**49**	**85%**	**62**	**90%**
Santa Barbara County EMS Agency											
Allan Hancock College	CA-42001	33	58%	40	35%	37	54%	35	40%	45	64%
NCTI-Santa Barbara	CA-65035	32	94%	16	100%	110	66%				
Santa Barbara City College	CA-42002	64	84%	92	86%	**37**		70	73%	72	79%
UCSB Extension	CA-42006							72	92%	79	76%
LEMSA TOTALS & AVERAGE %		**129**	**79%**	**148**	**74%**	**184**	**60%**	**105**	**68%**	**196**	**73%**
Santa Clara County EMS Agency											
Foothill College	CA-43003	4	75%	35	69%	86	73%	65	68%	54	61%
Foothill Community College	CA-43008	106	86%	62	77%	92	48%				
Mission College	CA-43005	71	73%	74	73%	374	63%	66	53%	60	37%
National University	CA-37026	163	64%	256	65%	29	76%	361	61%	371	44%
San Jose City College	CA-43002	33	79%	39	62%	53	66%	39	62%	36	72%
Silicon Valley Ambulance/ACE EMT Academy	CA-43012	17	65%	24	79%	26	46%	60	70%	8	63%
South Bay Regional Public Safety Training	CA-43015	20	55%	25	56%	25	100%	15	93%	43	77%
Stanford University	CA-43009	23	100%	20	100%	2	100%	19	100%	16	81%
Sunnyvale Department of Public Safety	CA-43013	15	73%	13	100%			9	100%	11	91%
LEMSA TOTALS & AVERAGE %		**452**	**74%**	**548**	**76%**	**687**	**72%**	**634**	**76%**	**599**	**66%**

California National Registry of EMTs, Paramedic Pass Rates
Effective 09/07/2022

		2017		2018		2019		2020		2021	
California - State NREMT EMT Pass Rate		**70%**		**71%**		**73%**		**68%**		**72%**	
National - NREMT Pass Rate										68%	
CA EMT Training Program Name	NREMT Program #	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt
Santa Cruz County EMS Agency											
Cabrillo College	CA-44002	66	76%	49	63%	127	87%	48	58%	29	66%
Defib This EMT Program	CA-44004	143	86%	136	68%	125	86%	146	88%	195	89%
LEMSA TOTALS & AVERAGE %		**209**	**81%**	**185**	**66%**	**252**	**87%**	**194**	**73%**	**224**	**78%**
Sierra-Sac Valley EMS Agency											
Absolute Safety Training EMT Program	CA-64004	24	46%	27	48%	24	58%				
Absolute Safety Training - Oroville Adult	CA-65021							30	73%	11	55%
Burney Fire Protection District	CA-65036	7	14%	7	71%	87	68%				
Butte Community College	CA-65025	60	80%	75	81%			74	59%	80	79%
Institute of Technology	CA-65024	6	50%								
Karuk Tribe	CA-65039	1	0%			52	85%				
NCTI-Roseville	CA-65003	74	80%	70	91%			59	86%	78	97%
NOLS Wilderness Medicine at COS	CA-65028	110	93%	103	87%	249	78%	47	87%	87	97%
Sierra Community College	CA-65002	173	79%	285	72%	19	74%	190	60%	260	65%
Sierra County Schools for Adults	CA-64031									1	100%
Woodland Community College EMT Program	CA-65029	14	93%	20	90%	48	60%	28	86%	32	75%
Yuba Community College District	CA-65004	26	88%	44	64%	479		28	50%	54	63%
LEMSA TOTALS & AVERAGE %		**495**	**62%**	**631**	**76%**	**958**	**71%**	**456**	**72%**	**603**	**79%**
Solano County EMS Agency											
National Institute for Healthcare Education	CA-48002					79	68%				
Solano Community College	CA-48001	34	53%	43	65%	21	43%	51	59%	37	49%
Vallejo Regional Education Center	CA-48006	1	0%	5	20%	**16**	50%	36	46%	34	26%
LEMSA TOTALS & AVERAGE %		**35**	**27%**	**48**	**43%**	**116**	**54%**	**87**	**53%**	**71**	**38%**
Tuolumne County EMS Agency											
Columbia College	CA-55001	13	85%	18	83%	**30**	80%	7	86%	4	50%
LEMSA TOTALS & AVERAGE %		**13**	**85%**	**18**	**83%**	**30**	**80%**	**7**	**86%**	**4**	**50%**

California National Registry of EMTs, Paramedic Pass Rates
Effective 09/07/2022

		2017		2018		2019		2020		2021	
California - State NREMT EMT Pass Rate		**70%**		**71%**		**73%**		**68%**		**72%**	
National - NREMT Pass Rate										68%	
CA EMT Training Program Name	NREMT Program #	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt	# Taken	% Pass 1st Attempt
Ventura County EMS Agency											
Conejo Valley Adult School	CA-56007	37	78%	31	65%			13	31%	14	57%
Charter College	CA-56015	14	57%								
EMS Training Institute Inc.	CA-56006	11	82%			45	58%				
Moorpark College	CA-56001	49	80%	61	70%	121	51%	45	93%	52	90%
Oxnard College	CA-56002	87	60%	104	58%	68	60%	113	49%	146	60%
Simi Valley Adult School	CA-56003	60	68%	64	61%	79	67%	49	76%	20	65%
Ventura College	CA-56004	60	82%	74	57%	**313**		44	55%	69	74%
LEMSA TOTALS & AVERAGE %		**318**	**72%**	**334**	**62%**	**626**	**59%**	**264**	**61%**	**301**	**69%**
Yolo County EMS Agency											
On-Site Medical Service-EMT-B-Training	CA-65023	65	88%			42	79%	13	69%	11	73%
UC Davis Fire EMT Program	CA-57002					112	96%	123	93%	132	95%
LEMSA TOTALS & AVERAGE %		**65**	**88%**	**0**		**154**	**88%**	**136**	**81%**	**143**	**84%**
EMS Authority											
Mott Training Center (CA Parks & Recreation)	CA-96001	30	100%			23	100%			1	100%
California State Parks	CA-96002					17	100%			25	96%
CALJAC Academy	CA-94033										
Butte College Fire Academy	CA-94010	32	88%	43	88%	3	100%	44	84%	20	70%
LEMSA TOTALS & AVERAGE %		**62**	**94%**	**43**	**88%**	**43**	**100%**	**44**	**84%**	**46**	**89%**
Exceeds the CA State Pass Rate											

		2017		2018		2019		2020		2021	
California - Paramedic NREMT Exam Pass Rate		**72%**		**74%**		**83%**		**84%**		**78%**	
National - Paramedic NREMT Pass Rate		72%		74%		73%		69%		69%	
CA Paramedic Training Program Name		**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**
ALAMEDA COUNTY EMS AGENCY											
Fast Response School of Health	n/a										
Las Positas College	CA-01001	16	100%	12	83%	13	77%	11	82%	12	100%
NCTI- Bay Area (Livermore)	CA-65032	85	80%	96	78%	56	86%	70	86%	93	78%
LEMSA TOTAL and Average %		**101**	**90%**	**108**	**81%**	**69**	**82%**	**81**	**84%**	**105**	**89%**
CENTRAL CALIFORNIA EMS AGENCY											
Fresno County Dept. of Health	CA-61002	20	75%	31	84%	40	70%	37	73%	38	92%
West Hills College	CA-61004	15	67%	8	63%	12	50%	16	44%	29	38%
WestMed College-Fresno	n/a										
LEMSA TOTAL and Average %		**35**	**71%**	**39**	**74%**	**52**	**60%**	**53**	**59%**	**67**	**65%**
COASTAL VALLEY EMS AGENCY											
Santa Rosa Junior College	CA-66001	14	93%	21	90%	15	100%	12	83%	20	95%
LEMSA TOTAL and Average %		**14**	**93%**	**21**	**90%**	**15**	**100%**	**12**	**83%**	**20**	**95%**
CONTRA COSTA COUNTY EMS AGENCY											
Contra Costa College	CA-6354							3	67%	2	100%
LEMSA TOTAL and Average %								**3**	**67%**	**2**	**100%**
EL DORADO COUNTY EMS AGENCY											
n/a											
LEMSA TOTAL and Average %											
IMPERIAL COUNTY EMS AGENCY											
Imperial Valley College	CA-13001	1	0%	9	89%			12	42%	1	0%
LEMSA TOTAL and Average %		**1**	**0%**	**9**	**89%**	**0**		**12**	**42%**	**1**	**0%**
INLAND COUNTY EMS AGENCY											
Crafton Hills College	CA-62009	31	84%	37	81%	34	85%	38	82%	42	79%
Victor Valley Community College	CA-62006	43	81%	62	84%	42	64%	41	68%	54	61%
LEMSA TOTAL and Average %		**74**	**83%**	**99**	**83%**	**76**	**75%**	**79**	**75%**	**96**	**70%**

		2017		2018		2019		2020		2021	
California - Paramedic NREMT Exam Pass Rate		**72%**		**74%**		**83%**		**84%**		**78%**	
National - Paramedic NREMT Pass Rate		72%		74%		73%		69%		69%	
CA Paramedic Training Program Name		**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**
KERN COUNTY EMS AGENCY											
Antelope Valley College	n/a										
Bakersfield College ParamedicProgram	CA-15004	20	90%	11	100%	19	84%	16	69%	33	85%
LEMSA TOTAL and Average %		**20**	**90%**	**11**	**100%**	**19**	**84%**	**16**	**69%**	**33**	**85%**
LOS ANGELES COUNTY EMS AGENCY											
Los Angeles County ParamedicTraining	CA-19008	66	86%	96	86%	94	89%	73	88%	41	68%
Mt. San Antonio College	CA-19011	13	100%	35	94%	32	88%	11	100%	24	92%
UCLA Paramedic Education Program	CA-19012	105	90%	105	87%	128	79%	119	92%	135	82%
University of Antelope Valley	CA-19001	19	84%	29	79%	37	68%	13	92%	22	59%
LEMSA TOTAL and Average %		**203**	**90%**	**265**	**87%**	**291**	**81%**	**216**	**93%**	**222**	**75%**
MARIN COUNTY EMS AGENCY											
n/a	n/a										
LEMSA TOTAL and Average %											
MERCED COUNTY EMS AGENCY											
n/a	n/a										
LEMSA TOTAL and Average %											
MONTEREY COUNTY EMS AGENCY											
n/a	n/a										
LEMSA TOTAL and Average %											
MOUNTAIN VALLEY EMS AGENCY											
n/a	n/a										
LEMSA TOTAL and Average %											
NAPA COUNTY EMS AGENCY											
Napa Valley College	CA-66009	8	88%	23	83%	12	100%	18	78%	19	68%
LEMSA TOTAL and Average %		**8**	**88%**	**23**	**83%**	**12**	**100%**	**18**	**78%**	**19**	**68%**
NORTHERN CALIFORNIA EMS AGENCY											
Absolute Safety Training Inc.	n/a	10	30%								
LEMSA TOTAL and Average %		**10**	**30%**								

		2017		2018		2019		2020		2021	
California - Paramedic NREMT Exam Pass Rate		**72%**		**74%**		**83%**		**84%**		**78%**	
National - Paramedic NREMT Pass Rate		72%		74%		73%		69%		69%	
CA Paramedic Training Program Name		**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**
NORTH COAST EMS AGENCY											
North Coast EMS	CA-63002	16	75%	18	83%	13	69%	19	63%	24	79%
LEMSA TOTAL and Average %		**16**	**75%**	**18**	**83%**	**13**	**69%**	**19**	**63%**	**24**	**79%**
ORANGE COUNTY EMS AGENCY											
Orange County EMT (OCEMT Corp)	CA-30020							34	85%	69	86%
Saddleback College	CA-30005	50	74%	23	70%	52	83%	18	78%	34	44%
LEMSA TOTAL and Average %		**50**	**74%**	**23**	**70%**	**52**	**83%**	**52**	**82%**	**103**	**65%**
RIVERSIDE COUNTY EMS AGENCY											
Moreno Valley College	CA-33002	22	95%	23	83%	18	89%	22	82%	24	83%
NCTI- Riverside	CA-65034	100	75%	106	74%	81	75%	63	86%	52	75%
LEMSA TOTAL and Average %		**122**	**85%**	**129**	**79%**	**99**	**82%**	**85**	**84%**	**76**	**79%**
SACRAMENTO COUNTY EMS AGENCY											
American River College	CA-34001	9	100%	12	92%	21	90%	16	75%	18	100%
CA State Univ. Sacramento, PreHospital Education	CA-34006	57	81%	72	79%	70	76%	61	80%	64	77%
LEMSA TOTAL and Average %		**66**	**91%**	**84**	**86%**	**91**	**83%**	**77**	**78%**	**82**	**89%**
SAN DIEGO COUNTY EMS AGENCY											
EMSTA Inc.	CA-37007	43	86%	36	94%	42	83%	48	90%	24	58%
Palomar Community College	CA-37001	64	84%	54	89%	43	91%	26	88%	44	82%
San Diego Fire-Rescue Dept. Paramedic	CA-37029			17	94%	18	94%	13	92%	15	80%
Southwestern Community College	CA-37006	16	100%	11	100%	9	100%	10	100%	24	92%
LEMSA TOTAL and Average %		**123**	**90%**	**118**	**94%**	**112**	**92%**	**97**	**93%**	**107**	**78%**
SAN FRANCISCO EMS AGENCY											
City College of San Francisco	CA-38001	24	100%	24	88%	17	88%	4	75%	18	94%
LEMSA TOTAL and Average %		**24**	**100%**	**24**	**88%**	**17**	**88%**	**4**	**75%**	**18**	**94%**
SAN LUIS OBISPO COUNTY EMS AGENCY											
Cuesta College-CCPP	CA-40001	14	79%	14	79%	13	85%	6	83%	16	88%
LEMSA TOTAL and Average %		**14**	**79%**	**14**	**79%**	**13**	**85%**	**6**	**83%**	**16**	**88%**

		2017		2018		2019		2020		2021	
California - Paramedic NREMT Exam Pass Rate		**72%**		**74%**		**83%**		**84%**		**78%**	
National - Paramedic NREMT Pass Rate		72%		74%		73%		69%		69%	
CA Paramedic Training Program Name		**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**
SAN MATEO COUNTY EMS AGENCY											
n/a	n/a										
LEMSA TOTAL and Average %											
SANTA BARBARA COUNTY EMS AGENCY											
NCTI- Santa Barbara	n/a					1	0%				
LEMSA TOTAL and Average %						**1**	**0%**				
SANTA CLARA COUNTY EMS AGENCY											
Foothill College	CA-43003	29	97%	41	100%	43	91%	22	100%	28	93%
WestMed College - San Jose	CA-43014	22	82%	12	75%	3	100%				
LEMSA TOTAL and Average %		29	**97%**	**41**	**100%**	**43**	**91%**	**22**	**100%**	**28**	**93%**
SANTA CRUZ COUNTY EMS AGENCY											
n/a	n/a										
LEMSA TOTAL and Average %											
SIERRA-SAC VALLEY EMS AGENCY											
Butte Community College	CA-65025	9	100%	20	90%	81	96%	15	93%	16	75%
NCTI-Roseville	CA-65003	73	90%	65	83%	56	86%	78	94%	75	84%
College of the Siskiyous	CA-65026	17	100%	18	89%	13	92%	10	100%	13	92%
LEMSA TOTAL and Average %		**99**	**97%**	**103**	**87%**	**150**	**91%**	**88**	**96%**	**104**	**84%**
SOLANO COUNTY EMS AGENCY											
n/a	n/a										
LEMSA TOTAL and Average %											
STANISLAUS COUNTY EMS AGENCY											
n/a	n/a										
LEMSA TOTAL and Average %											
TUOLUMNE COUNTY EMS AGENCY											
n/a	n/a										
LEMSA TOTAL and Average %											

		2017		2018		2019		2020		2021	
California - Paramedic NREMT Exam Pass Rate		**72%**		**74%**		**83%**		**84%**		**78%**	
National - Paramedic NREMT Pass Rate		72%		74%		73%		69%		69%	
CA Paramedic Training Program Name		**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**	**# Taken**	**% Pass 1st Attempt**
VENTURA COUNTY EMS AGENCY											
Ventura College	CA-56004	23	83%	15	87%	20	70%	25	88%	18	67%
LEMSA TOTAL and Average %		**23**	**83%**	**15**	**87%**	**20**	**70%**	**25**	**88%**	**18**	**67%**
YOLO COUNTY EMS AGENCY											
n/a	n/a										
LEMSA TOTAL and Average %											
Exceeds the CA State Pass Rate											

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: September 21, 2022 **ITEM NUMBER: 9A**

SUBJECT: State Medical Response Update

PRESENTER: Craig Johnson
Chief, Disaster Medical Services Division

CONSENT: ___ ACTION: ___ INFORMATION: X

FISCAL IMPACT

No fiscal impact.

BACKGROUND

Beginning in March 2020, EMSA provided statewide medical support for the COVID-19 Pandemic and 2020/21 Wildfires. EMSA's support continued through four significant COVID surges and two fire seasons. EMSA expanded all Mobile Medical Assets programs, increased warehouse space, logistics operations, and bolstered staffing levels for state medical teams to unprecedented levels to meet the substantial statewide needs. EMSA support extended to Alternate Care Sites (ACS), Federal Medical Stations, medical strike teams for Long-term Care Facilities, shelters, Migrant Hubs to support border communities, vaccinations clinics, and Monoclonal Antibody Infusion Centers. EMSA also established a mobile field hospital in Southern California on multiple occasions and supported the build-out of hospitals across the State to increase bed capacity.

SUMMARY

Although EMSA continues to provide support for Monoclonal Antibody Infusion Centers and migrant hubs located in Southern California, our focus has shifted primarily to recovery of medical assets and After-Action Reporting. Over the past few months, EMSA conducted three After-Action Conferences in Southern California, Sacramento, and virtually with the California Medical Assistance

Team (CAL-MAT) leads. During the meetings, we discussed lessons learned and best practices. Below is a summary of our findings.

DISCUSSION

Key COVID Medical Response After-Action Items and Improvement Plan:

1. Statewide Patient Movement:

    a. The patient Movement Plan succeeded overall but did not contemplate the slow-moving MCI of a pandemic with hundreds of Inter-Facility Transports (IFT) over a period of months. EMSA implemented a hybrid approach using the IFT process and the medical health mutual aid system to facilitate effective patient movement. The hybrid approach worked well. However, limited bed capacity across the State and patient placement remained challenging throughout the response.

    b. Contracting with private EMS transfer centers for statewide COVID transfers was a necessary and effective method of moving hundreds of patients during the peaks of COVID and this innovation provided regionally based patient movement coordination.

    c. The lack of a statewide bed polling system was a considerable challenge. Real-time bed polling data was not available. Instead, bed polls were conducted on a continuous basis, and the data was outdated almost immediately. Information about patient movement did not consistently and reliably reach the Medical Health Operational Area Coordinator (MHOAC) level in some cases, especially early in the response.

    d. The Public Health Order for level-loading helped to encourage hospitals to accept COVID patients. Although, the number of successful out-of-county patient placements remained low due to limited capacity.

    Improvement Plan Items:

        1. Update the California Patient Movement Plan to include IFT Intensive Care Unit (ICU) patient transports, level-loading considerations, the process for regional coordination using transfer centers, and pandemic response considerations. This will be done in coordination with the CA EMS Strategic Planning Process.

2. Continue to investigate better methods for real-time statewide bed polling.
3. Strengthen communications at all levels, including hospitals, MHOACs, transfer centers, regional, and state Emergency Support Function 8 partners.

2. State-Level Medical Staffing:

   a. The CAL-MAT program experienced rapid growth and, despite growing pains, was universally appreciated and respected throughout the State. Many lessons were learned that will lead to future improvements. As a result, EMSA is embarking on a redesign of the program, currently named CAL-MAT 2.0. Organizational structure, policies and procedures, training, recruitment, and compensations are being addressed.

   b. The State utilized the long-established Disaster Healthcare Volunteer (DHV) system to recruit and coordinate the new Health Corps program. Early in the response, this conflicted with the local medical coordinators' use of the DHV system to coordinate local volunteers. EMSA provided updates and workarounds to the DHV system to improve local use. However, the recruitment of Health Corps continued to negatively impact DHV volunteers throughout the COVID response.

   c. EMSA approved and processed over 68,000 out-of-state medical personnel to support medical facilities across the State. Although contract staffing proved hugely successful, there was some confusion statewide regarding state-contracted rates vs. locally negotiated rates and who was paying for the staffing.

   d. The use of contracted EMS personnel, Guard, and Federal medical teams was successful, but these personnel became increasingly scarce as the pandemic wore on.

   e. Ambulance Patient Offload Time (APOT) teams provided to support hospitals and reduce wall time proved successful.

Improvement Plan Items:

1. Continue to improve EMSA response capabilities with CAL-MAT 2.0 reorganization. Establish a workgroup to address gaps and build on lessons learned.
2. Provide more transparency and guidance around the use of paid contract medical staff and on the allocation of paid contract medical staff.
3. Work to make the APOT team concept a permanent solution to long ER bed delays in busy 911 systems.
4. Include local DHV/MRC coordinators early when making significant changes to the DHV system.
5. Define the Health Corps as state-level medical staffing support and differentiate it from local volunteer programs.

3. Healthcare Surge:

a. Hospital surge buildouts were successful and helped to decompress facilities. The decision to build out hospitals and move away from the ACS proved the more effective approach.

b. State-run ACSs were a good tool in certain circumstances but were underutilized and were poorly located to support surge and decompression. For example, the Imperial ACS was critical in managing the surge in Imperial County. However, the Porterville and Sleep Train ACSs were underutilized due to location and the admission criteria.

c. Training for medical staff at the ACS was lacking. Just-in-time training helped ensure effective patient care but created treatment delays early in the operation.

d. The approved LEMSA Optional Scope of Practice (LOSOP) for paramedics was viewed as a success and best practice and should be memorialized for future use in healthcare surge. Some of the best practices include:

- Providing care in non-EMS settings during the worst COVID surges to support at ACS's, SNF, and other healthcare facilities.
- Allowing EMT's and Paramedics to administer COVID vaccinations.
- Supporting EMS Vaccination Task Forces to provide vaccines to immobile and underserved populations.

- Allowed Paramedics to staff APOT teams in hospital ERs to decompress back-logs in the 911 system.

Improvement Plan Items:

1. Include local representatives early in the decision-making process when deciding which facilities to build-out for State supported medical surge.
2. While ACSs are a valuable tool, they should be placed strategically in collaboration with local jurisdictions.
3. Consider ways to broaden the admittance criteria to be effective at mitigating healthcare system decompression.
4. Add the LOSOP into future pandemic planning as a best practice.
5. Re-initiate state-led Crisis Standards of Care planning.

4. Medical Equipment and Supplies:

a. There were lengthy logistics delays early in the response due to the lack of staffing, training, and tracking systems. Also, warehouse space to house ACS caches and 15,000+ ventilators and associated biomedical equipment was extremely limited. EMSA recruited emergency hires to support logistics operations and acquired additional warehouse space to meet statewide needs. EMSA expanded from having approximately 30,000 square feet of warehouse space to 250,000 square feet of space.

b. Supply chain issues created competition for scarce resources at all response levels. The establishment of the State Multi-Agency Coordination (MAC) group to adjudicate scarce resources and prioritize fulfillment helped with supporting medical supply needs. However, the supply chain issues remained a critical concern for most of the COVID response.

c. Subsequent attempts to reestablish the MAC group during the Delta and Omicron surges were less successful. Per local partners, communication out of the MAC group was lacking, and the process for distributing resources was not clearly understood.

d. Implementing the statewide Salesforce system for resource requesting created some communication shortfalls. Local jurisdictions could not

connect existing systems with Salesforce, therefore forcing them to forgo local systems and adopt Salesforce. Despite the disconnects, Salesforce did help to streamline the resource requesting process and created much needed statewide standardization. The majority expressed overall positive reviews of using one standard system.

e. EMSA received very positive feedback regarding Biomedical Equipment distribution and tracking statewide, including oxygen systems, ventilators, hospital beds, and IV pumps. Concern was expressed about the State's funding and ability to maintain and deploy these moving into the future.

Improvement Plan Items:

1. Develop a process for improved inter-agency communication and coordination regarding scarce resource allocation. Maintain consistent procedures for resource allocation when activating and reactivating the MAC group.
2. Implement a medical logistics inventory management system encompassing OES, CDPH, and EMSA.
3. Recruit permanent EMSA staff to support the added state-level medical response capabilities.
4. Continue to improve Salesforce to make it workable post-COVID for all Medical and Health resource needs.

5. <u>Overall State Medical Response (Medical/Health System):</u>

a. Regional Disaster Medical Health Specialist (RDMHS) and MHOAC programs proved critical and effective. Adding a second RDMHS in each of the six Cal OES Mutual Aid Regions during the COVID response significantly improved regional resource coordination. However, coordination of resources at the MHOAC level struggled to keep pace with some Operational Areas' identified needs. It was noted that the MHOAC program is inadequately staffed and needs funding to bolster program effectiveness.

Improvement Plan Items:

1. Provide more training and exercise opportunities to improve the standards in the MHOAC programs statewide.

2. Seek funding opportunities to support the MHOAC program. Presently, many MHOACs wear multiple hats and do not have the resources to support the program entirely.
3. Reestablish the CA Public Health and Medical Emergency Operations Manual workgroup to provide plan updates based on lessons learned.

Overall, the statewide medical response for COVID proved extremely effective with countless lives saved. EMSA will continue to advance all response programs based on lessons learned and memorialize the best practices put in place over the past couple of years.