STATE OF CALIFORNIA
COMMISSION ON EMERGENCY MEDICAL SERVICES
December 13, 2023
10:00 A.M. – 1:00 P.M.

Location
Marines' Memorial Hotel
609 Sutter Street
San Francisco, CA 94102

AGENDA

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

2. **Review and Approval of September 20, 2023, Minutes**

3. **Consent Calendar**
   A. Administrative and Personnel Report
   B. Legal Report
   C. Enforcement Report
   D. PDRB Report

Regular Calendar

4. **EMS Administration**
   A. Legislative Report
   B. Regulations Update

5. **EMS Systems**
   A. APOT report
   B. EMTALA Discussion
      Lois Richardson, CHA's VP Legal Counsel

Lois Richardson is vice president and legal counsel at the California Hospital Association. She advises CHA staff on proposed legislation and regulations that impact hospitals, develops public policy positions and strategy, and advocates for hospitals before legislative and regulatory bodies. Lois is also responsible for writing and updating CHA legal publications on topics such as hospital licensing and certification, patient consent, health information privacy, EMTALA, and mental health.

6. **EMS Personnel**
   A. Statewide Paramedic License report

B. EMT Denial Report
C. Opioid Crisis and Buprenorphine Presentation
D. Trial Study- ICEMA Point of Care Ultrasound

7. DMS
A. APEC Report

8. Nominations of Officers (March 2024-March 2025)
A. Chairperson
B. Vice-chairperson
C. Two Administrative Committee representatives

9. Approval of Commission dates for 2025

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 j.mcginnis@emsa.ca.gov, no less than 7 days prior to the meeting.

STATE OF CALIFORNIA
COMMISSION ON EMS
September 20, 2023
Holiday Inn Bayside – San Diego
4875 North Harbor Drive
San Diego, CA 92106

MINUTES

COMMISSIONERS PRESENT:
Sean Burrows, Chair, Marc Gautreau, M.D., Vice Chair, Steve Barrow, David Ghilarducci, M.D., Thomas Giandomenico, Nancy Gordon, Travis Kusman, Ken Miller, M.D., Ph.D., Lori Morgan, M.D., Jodie Pierce, Paul Rodriguez, Carole Snyder, Kristin Thompson, Atilla Uner, M.D., and Todd Valeri

COMMISSIONERS ABSENT:
Curtis Brown, Lydia Lam, M.D., and Masaru “Rusty” Oshita, M.D.

EMS AUTHORITY STAFF PRESENT:
Elizabeth Basnett, Director
Brian Aiello, Chief Deputy Director
Hernando Garzon, M.D., Acting Medical Director
Kim Lew, Chief, EMS Personnel Division
Julie McGinnis, HIE Grant Program Analyst
Tom McGinnis, Chief, EMS Systems Division
Ashley Williams, Deputy Director of Legislative and External Affairs

PUBLIC COMMENTORS AND PRESENTERS:
Pamela Allen, Redlands Community Hospital
Roger Braum, Culver City Fire Department
Mary Chiesa
Rose Colangelo, Sutter Roseville Medical Center
Brian Henricksen, Global Medical Response
Sheree Lowe, California Hospital Association
David Magnino, National EMS Memorial Bike Ride Foundation
Bernie Molloy, Murrieta Fire and Rescue
Tressa Naik, MD, Cosumnes Fire Department
David Parsons, Oceanside Fire Department
Nate Pearson, Carlsbad Fire Department
Ray Ramirez, speaking as an individual
Darrell Roberts, Chula Vista Fire Department
Amanda Ward, Crafton Hills College and California Association of EMS Educators
Steve Wells, Corona Fire Department

1. CALL TO ORDER AND PLEDGE OF ALLEGIANCE

Chair Sean Burrows called the meeting to order at 10:00 a.m. Fifteen Commissioners were present. He led the Pledge of Allegiance and reviewed the meeting protocols and meeting agenda.

Chair Burrows announced that Elizabeth Basnett has been appointed as the Director of the EMS Authority. He welcomed Director Basnett to her new position on behalf of the Commission.

2. REVIEW AND APPROVAL OF JUNE 14, 2023, MINUTES

Commissioner Uner asked to remove the word "teleconference," since it was not a teleconference meeting.

Vice Chair Gautreau asked to correct the spelling of his first name.

Action: Commissioner Morgan made a motion, seconded by Commissioner Thompson, that:

- *The Commission approves the June 14, 2023, Commission on Emergency Medical Services (EMS) Meeting Minutes as amended.*

Motion carried 12 yes, 0 no, and 3 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Giandomenico, Kusman, Miller, Morgan, Pierce, Rodriguez, Snyder, Thompson, Uner, and Valeri, Vice Chair Gautreau, and Chair Burrows.

The following Commissioners abstained: Commissioners Barrow, Ghilarducci, and Gordon.

3. DIRECTOR'S REPORT

Elizabeth Basnett, Director, stated she is honored to have been appointed as Director of the EMSA. She stated she is committed to ensuring that the EMSA will remain patient-centered in all its work.

Update on EMSA Goals for 2023

Director Basnett provided an update on the three priority areas for the EMSA:

- Implementation of the Strategic Plan: The California EMS System Strategic Plan was published in June of 2023 and posted to the website. The EMSA is developing an implementation design to operationalize the strategic plan priorities and objectives. Staff is working with partners statewide to outline strategies to accomplish short-term objectives, with a significant focus on equity.
- Data and Technology: Data is the foundation of the EMS. Data is necessary to support policy decision-making. The EMSA has funded the initial planning phases and consulting support to transform and modernize the EMSA's licensing and training management systems.
    - The EMSA is well underway in standing up an electronic physician order for life-sustaining treatment (ePOLST) registry. The electronic registry will allow

providers in the field to access this information in real-time to honor medical decisions made between a patient and their primary provider.

- The EMSA has brought on a consultant to provide an initial strategy for data integration in California's health information exchange.

- Partnerships and Service Orientation: Work is ongoing to build partnerships, improve collaborations, and better orient toward being a patient-centered service organization.
  - The EMSA is organizing listening sessions with partners to gain their perspectives on Chapter 13, a key set of regulations to move the EMS system forward.
  - The EMSA has identified a series of additional regulations that will require an update in coordination with partners statewide. This will be a priority over the next 24 months.

There were no questions from Commissioners and no public comment.

4. CONSENT CALENDAR

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

Chair Burrows noted that Items 4B and 4C were identified as information items in the meeting packet, when they are Consent Calendar items.

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

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

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

The following Commissioners voted "Yes": Commissioners Barrow, Ghilarducci, Giandomenico, Gordon, Kusman, Miller, Morgan, Pierce, Rodriguez, Snyder, Thompson, Uner, and Valeri, Vice Chair Gautreau, and Chair Burrows.

The item was noted and filed.

D. PDRB Report

Director Basnett stated the regular Paramedic Disciplinary Review Board (PDRB or Board) quarterly meetings have been scheduled to meet on the Thursdays prior to Commission meetings. At the July meeting, Governor appointee David Konieczny was elected as PDRB Chair, and the Board received training from the Board attorney on Class C violations.

Director Basnett stated the Board will work on Class C violations and establish updated regulations, policies, procedures, and bylaws at the next PDRB meeting in December.

Discussion

Chair Burrows asked how determinations were made at the July meeting without the updated regulations, policies, procedures, and bylaws.

Director Basnett stated current regulations were utilized to make those decisions.

Public Comment

There was no public comment.

REGULAR CALENDAR

5. EMS ADMINISTRATION

A. Legislative Report

Ashley Williams, Deputy Director of Legislation and External Affairs, reviewed the EMSA Legislative Update of the bills currently being tracked and analyzed by staff, which was included in the meeting materials and posted on the website.

There were no questions from Commissioners and no public comment.

B. Regulations Update

Deputy Director Williams reviewed the Regulations Update Report of the regulations being promulgated, which was included in the meeting materials.

Discussion

Commissioner Barrow asked for further details on the upcoming Chapter 13 listening sessions.

Deputy Director Williams stated the listening sessions are internal administrative advisement meetings made prior to the rulemaking process and not subject to the Bagley-Keene Open Meeting Act.

Chair Burrows asked about the Senate Bill (SB) 438 regulations that were not included in the meeting materials.

Director Basnett stated approximately 25 regulations are outstanding. The regulations listed in the meeting materials are actively in process. She stated she would be happy to provide the full list of regulations to Commissioners.

Commissioner Morgan asked about the medication policy for ketamine for pain management. She noted that a slightly greater dose will cause the patient to lose consciousness.

Dr. Garzon agreed and stated these medications have been available for use through the local optional scope application process, where the applications include the protocols that are being used. They are reviewed and approved by the Scope of Practice Committee, which is made up of physicians from the EMS community, and then ultimately approved by Dr. Garzon and Director Basnett. Once they are in basic scope, it is at the discretion of the medical director when writing local policies to determine indications, contraindications, route, dosing, and so on.

Commissioner Morgan asked, if a local agency wanted to use ketamine for sedation and not for pain management, whether this precludes that.

Dr. Garzon stated, once in basic scope, it does not go back to the regulation for specific language.

Commissioner Miller stated, as chair of the Scope of Practice Committee, this language is in the specified regulation. All doses the Scope of Practice Committee has approved so far for ketamine, either as an adjunct or alternative to opiates in pain management, have been sub-dissociative.

Commissioner Ghilarducci stated his local EMS agencies (LEMSAs) were recently approved for use of ketamine for analgesia only, which is an important distinction. He expressed concern over scope creep. He asked Dr. Garzon whether there are any policy statements through EMDAC to control usage, such as limiting use to analgesia, even though those statements may not be in the regulations.

Dr. Garzon stated a consensus from EMDAC or the Scope of Practice Committee is one way to do it, since they are subject matter experts on clinical practice. Another way is to revisit regulations and consider doing more than listing which medications are allowed. This is the reason local medical direction is critical: to provide direction on what is safe for patients locally.

Commissioner Ghilarducci stated, with regard to other medications, LEMSAs tend to look to each other for standard of practice. However, it is more sensitive with this particular drug. He stated this will need to be discussed in EMDAC going forward.

Dr. Garzon stated these four medications were approved at the December Commission meeting. The reason they are brought back is because there were technical issues with the way the packet was presented to the OAL. The subsequent revisions triggered a new public comment period and new approval by the Commission, but nothing has changed that has any impact on the clinical use of the medications. It is back for a vote for technical reasons.

Public Comment

There was no public comment.

B.1 Regulations Medication Update – 22 CCR 100146 Scope of Practice of Paramedic Additional Medications to Administer

Deputy Director Williams reviewed the Staff Memo on the proposed medications to add to the list under Subsection (c)(1)(R), which was included in the meeting materials.

Discussion

Chair Burrows asked for a motion to approve the staff recommendation.

Action: Commissioner Ghilarducci made a motion, seconded by Commissioner Uner, that:

- *The Commission approves adding tranexamic acid, ketamine, ketorolac, and acetaminophen IV to the list of medications under Subsection (c)(1)(R).*

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

The following Commissioners voted “Yes”: Commissioners Barrow, Ghilarducci, Giandomenico, Gordon, Kusman, Miller, Morgan, Pierce, Rodriguez, Snyder, Thompson, Uner, and Valeri, Vice Chair Gautreau, and Chair Burrows.

Discussion, continued

Commissioner Thompson asked about the process for making a motion for a possible advisory committee to the EMSA to add NARCAN and flu vaccinations to basic scope.

Chair Burrows deferred to the experts on the Scope of Practice Committee and asked whether they would need direction from the Commission.

Commissioner Miller stated the Scope of Practice Committee, being advisory to the EMSA, would look at such a proposal and make a recommendation for the EMSA. Additionally, as a committee of EMDAC, any LEMSA can bring local optional scope proposals to the Scope of Practice Committee.

Dr. Garzon stated this is a local conversation, since local medical directors must approve implementation of basic scope, as well. Almost all LEMSAs have a three-year local optional scope approval to give vaccinations. The issue is that paramedics cannot give vaccinations without a governor’s emergency order, even if they are technically allowed to do so by the scope. This is more of a statutory regulation issue. However, the Scope of Practice Committee is open to considering anything brought by LEMSA medical directors.

Commissioner Morgan reiterated the issue of NARCAN and stated EMS personnel are more than capable of administering it.

Commissioner Barrow stated teenagers have been carrying NARCAN since they have been in situations where they have had to use it, or where their friends have died because nobody had it available.

Dr. Garzon stated the medical directors have been discussing this for several meetings and it is the intent of the Scope of Practice Committee to pull out regulations. At present, it is allowed for paramedics to administer NARCAN. The intent is to add it as a scope for public safety and first aid classifications. It is a matter of updating the regulations in the prioritization package. In the meantime, since it is currently allowed under local optional scope, local medical directors can approve the administration of NARCAN by EMTs at the LEMSA level without any approval from the EMSA. The majority of LEMSAs have already allowed NARCAN usage at public safety and first aid levels under local optional scope.

6. EMS SYSTEMS

A. NEMSIS Transition from 3.4 to 3.5

Tom McGinnis, Chief of the EMS Systems Division, stated, on February 14, 2023, the California EMS Information System (CEMSIS) was determined compliant with the National EMS Information System (NEMSIS) version 3.5 by the University of Utah. The EMSA will accept both V3.4 and V3.5 data until December 31, 2023. Beginning

January 1, 2024, V3.4 will sunset and the EMSA will only be able to accept NEMSIS V3.5 data.

Chief McGinnis stated the goal is for all entities submitting data to CEMSIS to be NEMSIS V3.5 compliant data by October 1, 2023. He noted that transition target rates and goals are significantly behind. Staff is working hard with providers and LEMSAs to get everyone up and running. The EMSA has scheduled workshops for August 16, September 27, and October 18, of 2023, to review changes from V3.4 to V3.5, ambulance patient offload time, and core quality measures, and to answer questions.

Chief McGinnis stated the federal government has many reasons for these changes but the main reason for this mandated transition has to do with the disposition of patients. The single item that captured where a patient went after EMS response has now been split into four to five items to report patient disposition more accurately to locations such as community paramedicine, transport to alternate destination, and healthcare information exchange environments. It is important that all entities work with the same standard.

Chair McGinnis stated the most pressing issue is the ambulance patient offload time that is being collected in two separate formats, which causes challenges. As of January 1, 2024, only V3.5 will be available and V3.4-collected data will be lost.

Discussion

Commissioner Barrow stated there have been complaints in the past that the EMSA is trying to break into CEMSIS with incident site information from first responders; however, EMSA is focused on children, teens, and youth. Unintentional injury is the leading cause of death and hospitalization for people up to the age of 24. SB 855 was passed to create pilot programs, but it has only been used to fund development of an electronic system that first responders and police use after they are finished with taking care of a patient. Collecting detailed information about what is going on during the incident is necessary for policy to address unintentional injury of children. This is not intended to interfere with CEMSIS or NEMSIS, but is something else. There must be a way to connect with first responders for more data while allowing them ease of use in reporting.

Commissioner Morgan asked about barriers.

Chief McGinnis stated barriers include the size of the organizations involved, software vendors, and training.

Commissioner Morgan asked if Los Angeles County is a big part of the 50 percent.

Chief McGinnis stated Los Angeles County is one entity within the 34 local EMS agencies.

Commissioner Morgan asked what Commissioners can do to alleviate burdens.

Chief McGinnis stated Commissioners who are provider-based and work with LEMSAs can try to help LEMSAs work with software vendors, the EMSA, and each other to aid in the transition. This data standard change is the more complicated one that NEMSIS has put up. Engagement between counties is the best way to share lessons learned.

Commissioner Kusman stated the deadline has not yet passed; therefore, although only a short time remains, 100 percent compliance is not yet expected.

B. Ambulance Patient Offload Time (APOT)

Chair Burrows stated there was a request at the June Commission meeting for a discussion on the downstream impacts of APOT and the status of hospital systems today. Staff has put together two panels to present today – a panel made up of hospital association members and a panel made up of public and private providers. He introduced the members of Panel 1 and asked them to give their presentations.

Panel 1: California Hospital Association

- **Sheree Lowe, California Hospital Association**
- **Pamela Allen, Redlands Community Hospital**
- **Rose Colangelo, Sutter Health**

California Hospital Association

Sheree Lowe, Vice President of Policy, California Hospital Association (CHA), stated the Panel 1 slide presentation is full of information and rich in data. She noted that her data sources are identified on her last slide. She began the Panel 1 slide presentation with an overview of the members and demographics of the CHA, healthcare utilization emergency departments (EDs), workforce and other challenges, factors impacting APOT, and solutions to APOT delay. She noted that there are less than 100 beds for children under the age of 12 who have an acute need for psychiatric inpatient treatment, one of the populations with long wait times in EDs. She also pointed out that more than half of the hospitals are struggling financially.

Ms. Lowe suggested increasing local collaboration and use of technology and telemedicine, a 911/988 interface, and developing mutually agreeable standards. She stated offload delays are a delivery system problem not just a hospital or EMS provider problem. She suggested moving from being reactive to proactive and making APOT about the patient.

Redlands Community Hospital

Pamela Allen, Director of Emergency Services, Redlands Community Hospital (RCH), continued the slide presentation and discussed the background, licensed beds, and emergency services of the RCH, ED challenges and solutions, hospital challenges for discharging patients to Skilled Nursing Facilities (SNF), and solutions to expedite in-patient and ED discharges. She stated the need to continue to work on ambulance bed delay.

Sutter Health

Rose Colangelo, Director of Emergency Services at Sutter Roseville Medical Center (SRMC), stated she was on the panel representing Sutter Health. She continued the slide presentation and discussed the background, demographics, and departments of Sutter Health, systemwide APOT committee, ambulance workflow, the A3 process to

identify problems and achieve goals, and the Sutter Health Hospital Over Capacity Scale (SHHOCS) Tool and capacity management policy.

Ms. Colangelo stated Sutter Health implemented a Situation, Background, Assessment, and Recommendation (SBAR) for APOT to identify gaps and measure success. Sutter Health created the internal EPIC Turnover of Care Time dashboard to help measure APOT. Everyone needs to work together to do what is right for all patients in the ED. She stated Sutter Health has monthly APOT meetings to report out on data and improvements and to share best practices.

Discussion

Vice Chair Gautreau asked, if the 77 percent of ambulance patients who are nonemergent are sent to the waiting room, whether the patients being potentially held are the 20 percent listed as emergent.

Ms. Allen stated the patients who are coming are usually the ones being held – those from SNFs and assisted living, who need a cardiac monitor, and so on. If a patient comes in with, for example, an ESI, they will be sent to the waiting room with a provider there to see them. Critical patients are not held.

Vice Chair Gautreau asked which strategies for having monitored beds available have been employed, such as sending discharges awaiting instructions to the waiting room, sending patients awaiting results to the waiting room, or boarding patients on inpatient floors.

Ms. Colangelo stated Sutter Health has discharge areas in different departments to free up beds and put ambulatory patients into wheelchairs instead of beds. Boarding patients are pulled out to a hallway bed if they do not need monitors. Recess rooms have been converted.

Vice Chair Gautreau stated having a number of beds available helps to avoid APOT, since discharges open a bed every four minutes, which is sufficient time to offload an ambulance.

Ms. Colangelo agreed, but stated beds may be taken by boarders or psychiatric or inpatient, and patients may come in more frequently than beds open.

Vice Chair Gautreau asked if hospitals believe that their Emergency Medical Treatment and Labor Act (EMTALA) obligations are not their responsibility until patients are turned over to ED staff or reports are given.

Ms. Lowe stated EMTALA is a complex, 30-year-old law. If the Commission requested it, an expert in the EMTALA space could be available at a future meeting.

Vice Chair Gautreau asked if hospitals are aware of a statement by the Centers for Medicare and Medicaid Services that states hospitals cannot delay their EMTALA obligations by deliberately delaying a patient’s transfer from EMS to the ED, which ties up EMS equipment and personnel and is in violation of 42 CFR 482.55, the Hospital Condition of Participation for Emergency Services.

Ms. Lowe stated no hospital questions that patients become the responsibility of the hospital once they are on its property.

Ms. Colangelo stated hospitals are responsible for every patient who arrives in the ED, whether by EMS or by self-transport. There are more people who need services than there are available resources, so the issue is how to best provide those services.

Commissioner Ghilarducci stated there is a tendency for hospitals to confine their activity to the ED; however, patient satisfaction, safety, and mortality are all improved by boarding on the floor rather than in the ED.

Commissioner Morgan thanked the EMSA for having this presentation on request. She stated hospitals do care about patients; this is a system problem of not having enough space or resources for different types of patients.

Commissioner Barrow stated the loss of several rural hospitals creates a lot of problems in the rural area. Between rural and urban hospitals, there is a discrepancy of agreement on the data. He asked for comment on this. He also asked about the groups trying to figure out the APOT issue.

Ms. Colangelo stated manually collecting data causes challenges, such as that the worst data is captured from the patients who are the sickest. Sutter Health is looking at other opportunities for data collection through technological advances.

Ms. Allen stated ambulances in San Bernardino County that have been held too long have the option to put the hospital on redirect; this will change in January once the hospital is able to place those ambulances. RCH is strategizing with the supervisor of the ambulance service and with environmental services, as well as using ImageTrend and FirstWatch.

Ms. Colangelo stated some counties have APOT committees; it is important to have APOT committees in all counties.

Ms. Lowe stated police and health plans are not represented at the APOT local tables. This is a system problem, so all of the representatives from the system need to be at the table.

Commissioner Uner encouraged publishing measures of spread in average length of stay. Whether patients can be triaged to the waiting room depends on factors other than acuity. He asked about the rate of absenteeism in hospitals and whether beds are unavailable because they are not staffed.

Ms. Allen stated one of the daily huddles discusses staffing. If they are short, other personnel will take on assignments.

Ms. Colangelo added that there is a replacement factor to average LOAs and sick calls and hire and staff above that number.

Commissioner Uner asked why Ms. Allen’s hospital closed its inpatient psychiatric unit.

Ms. Allen stated it was mainly for financial reasons.

Commissioner Valeri stated local collaboration and tailored approaches informed by accurate data are effective solutions.

Commissioner Miller asked, on average, at what level ESI triage is used in the waiting room.

Ms. Colangelo stated a patient brought by EMS will take a bed before walk-ins. As far as waiting room triage, they do threes, fours, and fives on the emergency severity index.

Commissioner Miller asked if the CHA is willing to accept broader interpretation of community paramedicine and alternate destinations.

Ms. Lowe stated the CHA has always supported community paramedicine and alternate destinations.

Commissioner Thompson stated the data is different because EMS documents scene time as well as patient contact time. She pointed out that nonemergent patients who have not been offloaded are tying up EMS resources that are.

Ms. Colangelo stated the internal time in health care had to be standardized, which means arrival time is different, but this is not used to measure success in APOT, only improvement internally. System data received from LEMSAs is the driving factor for overall success.

Commissioner Snyder stated appreciation for the presentation and agreed that a collaborative team, including law enforcement, needs to be at the table.

Commissioner Pierce asked what measures are being taken with throughput in skilled nursing facilities.

Ms. Lowe stated this has been an ongoing statewide issue at the Association. It has not been successful in getting the attention of health plans or legislators. After the survey results come in, there will be quantifiable data as a starting place for more traction.

Chair Burrows recommended having someone speak to EMS personnel on the wall to let them know what is being done to help them go home.

Panel 2: Provider Perspective on APOT

- **Brian Henricksen, Global Medical Response**
- **Darrell Roberts, Chula Vista Fire**
- **Public Sector Admin - Roger Braum, EMS Battalion Chief, Culver City**
- **Public Sector Physician – Tressa Naik, Cosumnes Fire**

Chair Burrows introduced the members of Panel 2 and asked them to give their presentations.

<u>Global Medical Response</u>

Brian Henricksen, Senior Regional Director, Global Medical Response, and Director of the California Ambulance Association, provided an overview, with a slide presentation, of the impacts of APOT delays on ambulance services, caregivers, and patients. He

stated solutions include hospital accountability, the APOT Committee recommendations, and 911 system utilization.

Public Sector Admin

Public Sector Admin - Roger Braum, Assistant Fire Chief, Culver City Fire Department, stated the members of Panel 2 will discuss the impacts of APOT delays from the perspective of fire management, fire-based EMS medical directors, and fire-based paramedics and EMTs in the field. He provided an overview, with a slide presentation, of the background, causes of APOT delays such as staffing shortages, increased call volumes, and extended hospital wait times, optimal deployment, and solution strategies.

Mr. Braum noted that fire-based EMS is the largest provider of EMS services in the state. Many times, fire personnel are first on-scene and meet the recommended arrival time; however, transport to the ER is dependent on ambulance arrival times, and ambulances are often delayed due to extended waits at hospitals. Not only are transport units, both BLS and ALS, out of service holding the wall, but many times fire apparatus like engines and trucks are rendered out of service as they are required to remain at the hospital with the patient. When fire-based units are delayed by extended hospital wait times, critical and time sensitive emergencies are left waiting for service.

Public Sector Physician

Public Sector Physician – Dr. Tressa Naik, Medical Director, Cosumnes Fire Department, and the Sacramento Regional Fire EMS Communication Center, stated she is an emergency physician at Kaiser South Sacramento, which is a Level 2 Trauma Center. She continued the slide presentation and discussed patient safety and outcomes, increased diversion, working relationships, prolonged dispatch, and interfacility transports.

Dr. Naik stated the APOT issue affects working relationships between medics and nurses and creates a hostile working environment. This is an unfortunate byproduct created by the APOT issue. It should not happen. Hospitals, nurses, and medics need to work together to provide the best care for the patient.

Chula Vista Fire

Darrell Roberts, Chula Vista Fire Department, and First District Vice President for the California Professional Firefighters, continued the slide presentation and discussed the increased response time, morale, alternate transport, working relationships, and scene and hallway stress. He stated the primary mission and objective of fire-based paramedics and EMTs is patient outcomes. Extended APOT wall times mean increased response times, which equate to negative patient outcomes. He stated the need for collaborative solutions to help fire-based paramedics and EMTs to get back into the field.

Discussion

Commissioner Barrow stated this has been a problem as far back as the 1970s. This is a systemwide problem. He asked who is missing from the table. He also asked how other countries approach APOT problems.

Dr. Naik stated health plans and insurances must come to the table, first and foremost, because they ultimately approve patients to be discharged. She thanked everyone who has been involved in the work that has already been done.

Dr. Naik stated standardized meanings of APOT times are specifically designed in LEMSA protocol, but it should be something to discuss.

Mr. Henricksen stated the question is also what is missing – innovation, technology, and adaptation of EMS systems. He agreed that insurers and health plans are important to bring to the table.

Commissioner Uner stated EMS providers are not credentialed in hospitals. They cannot watch patients. He acknowledged all hospital and EMS workers for their labor and risk of burnout, but stated only EMS is forced to hold over after shift and through breaks.

Vice Chair Gautreau stated ED staff is facing significant challenges. However, in many hospitals, the EDs' problems remain in the ED. He stated, in one hospital out of state, one of the ways APOT was avoided was by declaring a disaster several times a week and forcing hospital administration to stay in the building, which created attention and incentive to find solutions. Outpatient clinic personnel are not expected to hold the wall because that would involve financial pain on the part of the institution, but if it were to happen, perhaps a solution would be found more quickly. Sometimes, individual revenue concerns must be sacrificed to get the system working better.

Commissioner Snyder stated ER physician groups should be at the table. They are usually not owned by the hospital, and they staff few people and see few patients per hour due to money factors. They are part of the system problem. Additional staff members would be helpful in increasing speed.

Dr. Naik stated the private company she worked for had an on-call doctor to help during busy times; there are emergency medicine groups with the ability to call people in. At Kaiser, the busiest times have 30 providers on shift who sometimes must wait to see patients.

Commissioner Pierce stated there needs to be more infrastructure in technology. However, everyone is on the same side to find solutions and serve their important role.

Commissioner Ghilarducci stated the larger issue is the throughput factors outside hospitals' control due to the legislature, whose attempts to fix behavioral health and homelessness issues have laid a burden on hospitals they were never intended to bear. What is needed is a more holistic solution to address all issues without stressing one area to alleviate stress on another.

Commissioner Morgan stated moral injury is experienced by both EMS and hospital personnel, who are all in this together. The behavioral health and homelessness people are missing at the table, as well. Over half of the hospitals in California are in the red, so this is not about revenue; it is about time that hospital personnel need to work to save patients' lives being lost. It is easy to blame someone but that will not help to find any solutions. Outside factors are making these problems worse now than ever before.

Working together and going to the people who have control over those factors are crucial.

Commissioner Rodriguez stated APOT has been a huge issue that has been going on for a long time. The people who are missing from the table do need to be brought to the table. He stated concern about not having this conversation, since not only patients but providers are suffering and the longer there are no solutions, the bigger the problem becomes.

Chair Burrows stated appreciation for the engagement from the Commission. This is another step in the right direction.

Public Comment

Ray Ramirez, Deputy Chief, City of Ontario Fire Department, and California Fire Chiefs Association (CalChiefs), speaking as an individual, stated the California Fire Service's strategic reserve is being impacted by this issue, which draws resources to specific counties rather than where they are needed to fight fires. EMTALA is a complaint-driven process. EMS personnel who leave the hospital are not abandoning patients.

Bernie Molloy, Fire Chief, Murrieta Fire and Rescue, agreed that this problem is getting much worse and stated one opportunity that is not being taken advantage of is that nonemergent patients must be moved out of the emergency room to make room for emergent patients.

Steve Wells, Corona Fire, stated a nurse is also a social worker who links patients with resources over time, and recommended emphasizing that portion of community medicine and paramedicine in training. Many providers want to alleviate the burden on the healthcare system; helping patients who do not know how to access health care outside of emergency rooms to connect with social services will be impactful.

Nate Pearson, Carlsbad Fire, stated EMS-hospital teams are starting to break down, and asked the Commission to recognize the broad nature of the services providers are able to deliver and support novel deployments for EMS throughout the state.

David Parsons, Fire Chief, City of Oceanside, agreed that it is a system problem but stated the percentage of ER visits from the EMS system are the core business of that system. The reason EMS personnel are passionate about this problem is that it affects their job and their patients' wellbeing.

7. EMS PERSONNEL

A. Human Trafficking – Update on PM Training, Scope of the Issue in CA

Kim Lew, Chief of the EMS Personnel Division, reviewed the Staff Memo on the background and current training on issues relating to human trafficking, which was included in the meeting materials. She stated the EMSA will collaborate with LEMSAs and community groups to develop training standards that equip EMS personnel with the necessary knowledge and skills to recognize and report potential human trafficking incidents.

Discussion

Commissioner Barrow stated it is good for the EMSA to have a refresh on its opportunities to create continuing education units and online training as issues evolve, but 20 minutes is short.

Dr. Garzon stated many of the LEMSAs have done this training and cover this topic locally.

Commissioner Rodriguez asked if there is a curriculum for the 20 minutes, and what the schools are.

Chief Lew stated there is no legislative requirement for specific curriculum. That is why the EMSA wants to involve subject matter experts to establish a definition of human trafficking, which is ever-evolving. A lot of human trafficking training is not designed for EMS, so the EMSA will be looking at what might be useful for emergency medical service responders in relation to local jurisdiction needs and issues.

Commissioner Thompson stated there is also a lot of training that is specific to EMS providers that has been offered for a few years by multiple departments and counties across the state – it just needs to be shared.

Public Comment

Amanda Ward, Paramedic Program Director of Crafton Hills College, and the California Association of EMS Educators, stated there is education that is already being presented at Crafton College using recently-published textbooks. She stated the college is waiting for further guidelines from the state on how to ensure that everything is covered.

8. ITEMS FOR NEXT AGENDA

- **Opioid Crisis**
- **Behavioral Health**
- **Buprenorphine**

Chair Burrows asked Commissioners for additional suggestions for the next agenda.

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

- *The Commission approves inviting an EMTALA legal expert to present at the December meeting.*

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

The following Commissioners voted “Yes”: Commissioners Barrow, Ghilarducci, Giandomenico, Gordon, Kusman, Miller, Morgan, Pierce, Rodriguez, Snyder, Thompson, Uner, and Valeri, Vice Chair Gautreau, and Chair Burrows.

9. PUBLIC COMMENT

Dave Magnino, Administrator, Sacramento County EMS Agency, and Member of the National EMS Memorial Bike Ride Board of Directors, stated the sixth and final ride of this year's event is being held from Reno to San Francisco over six days. He asked

everyone to pause sometime next week to think about the 113 individuals being honored this year.

Mary Chiesa asked how to add equipment from the EMS equipment checkoff list to ambulances for patient safety and who to contact for that list.

Chair Burrows asked staff to respond to Ms. Chiesa's question.

Dr. Garzon stated there is a statewide list of generic items that does not include brand names. Medical equipment is generally determined by each LEMSA.

Chief McGinnis stated the State Highway Patrol has a mandated list for all ambulances that are in service. The State Highway Patrol is the entity that initially licenses ambulances in the state of California as a basic life support (BLS) unit. When they go to the LEMSA for advanced life support (ALS) certification, the ALS pieces are then controlled by the LEMSA. The State Highway Patrol list is limited to the more basic things that are needed in the basic scope of practice for an EMT so the ambulance is functional, such as oxygen cannula, adult and pediatric masks, four by fours, and traction splints.

Ms. Chiesa asked who she should contact to get something added. She stated concern that, although an OB kit is required on ambulances, safely transporting the newborn, reducing the risk of hypothermia or postpartum hemorrhage, and ensuring that the newborn can stay with the mother are not addressed.

Vice Chair Gautreau suggested that Ms. Chiesa contact the medical director at her LEMSA to share her concerns. The medical director can then bring her concerns to the Emergency Medical Directors' Association of California (EMDAC) and Scope of Practice Committee.

Director Basnett asked Ms. Chiesa to contact her offline so staff can follow up with her on this issue.

Ray Ramirez, speaking as an individual, asked for clarification on the scope of practice. There are limitations for trial studies, local optional scope, and EMS Authority-initiated processes. Once a medication goes to defined scope, it goes to the medical director unless a limitation is imposed through the regulations. He stated many individuals may not understand that process.

10. ADJOURNMENT

Chair Burrows thanked staff for their assistance and everyone for their participation. He asked for a motion to adjourn.

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

There being no further business, the meeting was adjourned at 1:00 p.m.

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13, 2023 **ITEM NUMBER: 3A**

SUBJECT: Administrative and Personnel Report

PRESENTER: Rick Trussell, Chief of Administration Unit

CONSENT: _X_ ACTION: ___ INFORMATION: ___

FISCAL IMPACT

None

DISCUSSION

Emergency Medical Services Authority (EMSA) Budget:

2023-24

The 2023-24 California State Budget includes expenditure authority of $60.5 million and 119 permanent positions. Of this amount, $37.3 million, or 61%, is delegated for State operations, and $23.2 million, or 39%, to Local Assistance. Of note is the increase in Local Assistance expenditure authority by $745,000 pursuant to Senate Bill (SB) 104 (Ch. 189, Statutes of 2023). This funding will be distributed to local entities to support critically needed emergency medical equipment at four West Marin volunteer stations and to fund weekend ambulance services for an area that covers Southern Humboldt and Trinity Counties for a service area of 1,250 sq miles.

As of November 27, 2023, accounting records indicate that the Department has expended or encumbered $13.1 million, or 21.7% of all available expenditure authority. Of this amount, $9.9 million, or 27% of State Operations expenditure authority, has been expended or encumbered, and $3.3 million, or 13.7% 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. An updated report will be distributed prior to the next Commission meeting.

EMSA Staffing Levels:

The Department staffing level includes 119 permanent positions and 13 temporary (blanket and retired annuitant) positions. Of the 132 positions, 33 positions are vacant as of November 28, 2023.

	Department				
	Admin	**DMS**	**EMS**	**EMSP**	**Total**
Authorized	47.0	34.0	20.0	18.0	119.0
Temporary Staff	9.0	2.0	2.0	0.0	13.0
Staffing Level	**56.0**	**36.0**	**22.0**	**18.0**	**132.0**
Authorized (Vacant)	-7.0	-16.0	-6.0	-3.0	-32.0
Temporary (Vacant)	0.0	-1.0	0.0	0.0	-1.0
Current Staffing Level	**49.0**	**19.0**	**16.0**	**15.0**	**99.0**

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13, 2023 **ITEM NUMBER: 3B**

SUBJECT: Legal Report

PRESENTER:

CONSENT: _X__ ACTION: ____ INFORMATION: ___

FISCAL IMPACT

No fiscal impact.

DISCUSSION

NOTE: Since the start of 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 August 26, 2023, to November 27, 2023, the Authority has issued ten new Accusations against existing paramedic licenses and three new Statements of Issues against applicants for licensure. The Authority has issued three decisions on petition for reduction of penalty. The Authority has issued one administrative fine which resulted from a Proposed Decision being adopted by the Paramedic Disciplinary Review Board (PDRB). The Authority has issued one denial letter and has closed seventeen matters without action. Of the newly issued actions, eight of the Respondents requested that an administrative hearing be set. One action has resolved as pre-Accusation agreements for surrender and one action has resolved through a Stipulated Settlement Agreement for probation. There is currently one hearing scheduled with the Office of Administrative Hearings. There are currently fifty-seven open active disciplinary cases in the legal office.

An administrative hearing has been held in one case resulting in a proposed decision that was not adopted by the PDRB. That matter is pending a hearing before the PDRB.

Litigation:

EMSA vs. Orange County Partnership Regional Health Information Org: Orange County Superior Court #30-2023-01310464-CU-BC-NJC, Breach of Contract, Unjust Enrichment, Fraud and Deceit, Negligent Misrepresentation, and Alter Ego Liability. Action filed March 1, 2023. Defendants have been granted an extension of time to answer the Complaint. Answers are currently due by November 29, 2023.

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13, 2023 **ITEM NUMBER: 3C**

SUBJECT: ENFORCEMENT REPORT

PRESENTER: Alexander Bourdaniotis, Chief Investigator

CONSENT: ___ ACTION: ___ INFORMATION: __x_

RECOMMENDATION

Receive information on Enforcement Unit activities.

FISCAL IMPACT

None

BACKGROUND

Unit Staffing:

The Enforcement Unit is budgeted for five full-time Special Investigators and one full-time Associate Government Program Analyst (AGPA-Probation Monitor). As of May 5, 2023, one full time Special Investigator has left the Enforcement Unit to join the CHP Academy. The unit is not currently fully staffed.

Investigative Workload:

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

Cases opened since January 1, 2023, including:

Cases opened:	279
Cases completed and/or closed:	167
EMT-Paramedics on Probation:	179

In 2022:

Cases opened:	346
Cases completed and/or closed:	246
EMT-Paramedics on Probation:	235

Status of Current Cases:

The Enforcement Unit currently has 261 cases in "open" status.

As of November 1, 2023, there are 109 cases that have been in "open" status for 180 days or longer, including: 22 Firefighters' Bill of Rights (FFBOR) cases and 5 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 109 cases are divided among four special investigators and are in various stages of the investigative process. These stages include awaiting documents, preparing for and/or setting up interviews, report writing and corrections to be made, awaiting action by local law enforcement jurisdictions, the courts, etc.

Delays in the interview process are common due to unforeseen difficulties in obtaining certified copies of documents, court records, availability of witnesses and/or the subject(s) of an investigation due to medical action/disability issues, on-going investigations for FFBOR staff or on-going criminal investigations, court actions, plus the routine requirement for two or more follow-up interviews.

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13, 2023 **ITEM NUMBER: 3D**

SUBJECT: Paramedic Disciplinary Review Board

PRESENTER: Elizabeth Basnett, EMSA Director

CONSENT: __X_ ACTION: ____ INFORMATION: ___

BACKGROUND
AB 450 Chapter 463, approved by the Governor and Chaptered by Secretary of State on October 4, 2021, created the Paramedic Disciplinary Review Board (PDRB) to act on appeals regarding the Emergency Medical Services Authority (EMSA) denial of licensure and decision to impose licensure action on and after January 1, 2023. The Board had their first meeting on July 13, 2023.

SUMMARY
The Board elected a Board Chairperson, David Konieczny, at the September meeting. The board attorney provided training on the AB 450 Mandates, Violations Subject to Discipline, and the Disciplinary Guidelines. The Board began its review of the progressive discipline set forth in the Recommended Guidelines for Disciplinary Orders, and Conditions of Probation, dated July 26, 2008, for violations set forth in Health and Safety Code 1798.200(c) at the September meeting. The Board made decisions on all but four violations and will review the remaining progressive discipline and the fine structure at the upcoming December meeting.

The PDRB reviewed one (1) case during the September meeting in which they did not adopt the Administrative Law Judge's decision. The Board will make a determination regarding the case at the upcoming December meeting.

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13, 2023 **ITEM NUMBER: 4A**

SUBJECT: Legislative Report

PRESENTER: Ashley Williams
Deputy Director of Legislation and External Affairs

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: December 13, 2023 **ITEM NUMBER: 4B**

SUBJECT: Regulations Update

PRESENTER: Ashley Williams
Deputy Director of Legislation and External Affairs

CONSENT: ___ ACTION: ____ INFORMATION: _X__

BACKGROUND
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:

➢ Renumbering Chapters
- ▪ Status: EMSA is drafting a Section 100 to renumber the chapters. This is a non-substantive change.
- ▪ Purpose: Better align regulations with the chapters.

➢ Administered Medications (Ch. 4 § 100146)
- ▪ Status: Approved with Office of Administrative Law, effective January 1, 2024.
- ▪ Purpose: Add new medications to list under subsection (c)(1)(R)

➢ EMS Administration (Ch. 13)
- ▪ Status: Listening Sessions are being held with partners statewide. The purpose of the listening sessions is to:
  1) understand the history of Chapter 13 with the partner organization
  2) hear key ideas the partner organization believes should be included within Chapter 13 regulations
  3) discuss benefits, risks, and cascading impacts to the ideas discussed.

▪ Purpose: Provide new and updated regulations for annual EMS plans, requests for proposal (RFP) and general EMS administration required by statute.

➢ Trauma Care Systems (Ch. 7)

▪ Status: Work group meetings are complete. EMSA is currently reviewing the draft and working on documentation for notification of rulemaking process to OAL. Following the notification to OAL, the regulations will move to public comment.

▪ Purpose: General update.

➢ Training Standards for Childcare Providers & Merger of Chapters 1.1 and 1.2.

▪ Status: The draft is completed and EMSA is working on documentation for notification of the rulemaking process to OAL. Following the notification to OAL, the regulations will move to public comment.

▪ Purpose: General update to include fee increase.

➢ Lay Rescuer Epinephrine Auto-Injector Training Certificate Standards (Ch. 1.9)

▪ Status: The draft is completed and EMSA is working on documentation for notification of the rulemaking process to OAL. Following the notification to OAL, the regulations will move to public comment.

▪ Purpose: Updates, including required form.

➢ EMS System Data Collection, Evaluation, and Quality Improvement (Ch. 12)

▪ Status: Under review and draft development.

▪ Purpose: General update.

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13, 2023 **ITEM NUMBER: 5A**

SUBJECT: Ambulance Patient Offload Time (APOT)

PRESENTER: Tom McGinnis

CONSENT: ___ ACTION: ____ INFORMATION: _X_

RECOMMENDATION

No Action Recommended.

FISCAL IMPACT

No Fiscal Impact.

DISCUSSION

The EMS Authority is monitoring APOT using the California EMS Information System (CEMSIS) run data in 2023 for all participating LEMSAs. LEMSAs with limited CEMSIS participation are requested to provide the EMS Authority with quarterly reports until their CEMSIS participation is deemed sufficient to calculate APOT.

Since January 2023, the EMS Authority has been running monthly APOT reports sourced from CEMSIS for all participating LEMSAs using the updated APOT specifications from Fall 2022. Following internal EMS Authority review, each LEMSA has been receiving monthly APOT reports outlining their APOT representation in CEMSIS. LEMSAs are encouraged to continue to monitor APOT locally and engage the EMS Authority if they identify any discrepancies in their CEMSIS representation. The EMS Authority is also in the process in updating the APOT specification using the NEMSIS 3.5 data dictionary. The EMS Authority will continue to run monthly APOT reports using LEMSAs NEMSIS 3.4 for all of 2023.

With the passing of Assembly Bill (AB) 40, the EMS Authority has developed an implementation timeline/plan and is moving forward to comply with the requirements of AB 40.

ATTACHMENT(S)

December 2023 Report to Commission: Ambulance Patient Offload Delays

Report to Commission: Ambulance Patient Offload Delays

Emergency Medical Services Authority

California Health and Human Services Agency

December 2023

Elizabeth Basnett, Director

ACKNOWLEDGEMENTS

This report was prepared by the California Emergency Medical Services Authority Staff:

Adam Davis, Ambulance Patient Offload Time Research Data Specialist

Adrienne Kim, Data and Quality Improvement Unit Manager

This report was reviewed and approved by the California Emergency Medical Services Authority Executives:

Elizabeth Basnett, Director

Dr. Hernando Garzon, Acting Medical Director

Brian Aiello, Chief Deputy Director

Tom McGinnis, EMS Systems Chief

If you have any questions or comments about this report, please contact:

APOT@emsa.ca.gov

Table of Contents

Ambulance Patient Offload Time (APOT) Specifications

This report was generated using California Emergency Medical Services Information System (CEMSIS) records meeting the ambulance patient offload time specification described below.

The APOT Specifications outlined below can be found in full detail at https://emsa.ca.gov/apot/. The APOT qualifying record population for a given timeframe, for both APOT-1 and APOT-2, is defined as emergency medical services (EMS) records which meet the following National Emergency Medical Services Information System (NEMSIS) 3.4 criteria:

• All events for which eResponse.05 "Type of Service Requested" with the value of 2205001 "911 Response (Scene)"; **AND**
• All events in eDisposition.12 "Incident/Patient Disposition" with the value of 4212033, "Patient Treated, Transported by this EMS Unit"; **AND**
• All events in eDisposition.21 "Type of Destination" with the value of 4221003, "Hospital-Emergency Department"; **AND**
• eTimes.11 "Patient Arrived at Destination Date/Time" values are logical and present **AND**
• eTimes.12 "Destination Patient Transfer of Care Date/Time" values are logical and present

APOT-1 identifies the count of offloads meeting the APOT specification criteria and, based on those same records, the 90th percentile APOT time for a given time frame. APOT-1 is reported by general acute care facility or aggregated at a LEMSA level.

APOT-2 identifies the count of offloads meeting the same APOT specification criteria as APOT-1 and based on those same records, counts the number of records found within the five time intervals for a given time frame. The time intervals are as follows:

2.1: What count of patients transported by EMS personnel experience a transfer of care within 20 minutes of arrival at the Hospital Emergency Department?
2.2: What count of patients transported by EMS personnel experience a transfer of care between 20:01-60 minutes of arrival at the Hospital Emergency Department?
2.3: What count of patients transported by EMS personnel experience a transfer of care between 60:01-120 minutes after arrival at the Hospital Emergency Department?
2.4: What count of patients transported by EMS personnel experience a transfer of care between 120:01-180 minutes after arrival at the Hospital Emergency

Department?
2.5: What count of patients transported by EMS personnel experience a transfer of care more than 180:01 minutes after arrival at the Hospital Emergency Department?

Qualifying Record Exclusion Criteria:

EMS records which meet the APOT specification criteria and have a negative calculated time between eTimes.11 and eTimes.12 do not qualify as being part of the APOT record population and have been excluded from this report.

EMS records which meet the APOT specification criteria and have a eDisposition.02 "Destination Code" (CEMSIS Facility ID) recorded for as "Blank, Not Recorded, Not Reported, Not Available, or Null" do not qualify as being part of the APOT record population and have been excluded from this report.

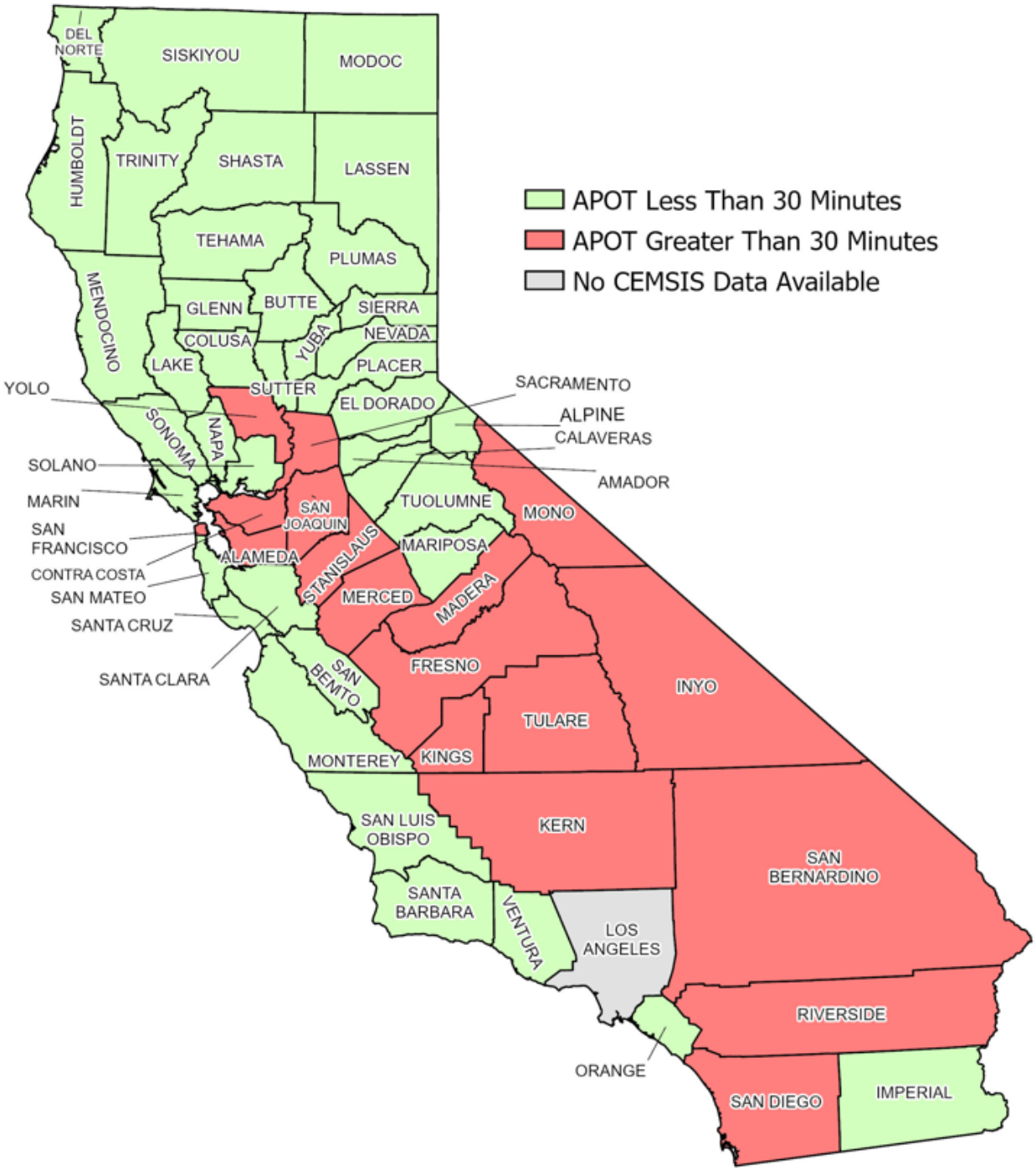
EMS records represented in this report are based on the specifications which may include duplicate records, records with offload times exceeding 24 hours, records from non-transport providers, and facilities which are not general acute care hospitals or do not have an emergency department. These records which fall into one of the above categories are included in this report due to provider documentation, a limitation of the NEMSIS Data Standards, or as a limitation of the APOT Specifications used for this report.

Report Notes and Transition to NEMSIS 3.5:

All APOT record counts and times are associated with EMS providers operating within the listed LEMSA and include transport to facilities both within and outside of a LEMSA's jurisdiction. There is no hospital-level or hospitals specific information contained in this report.

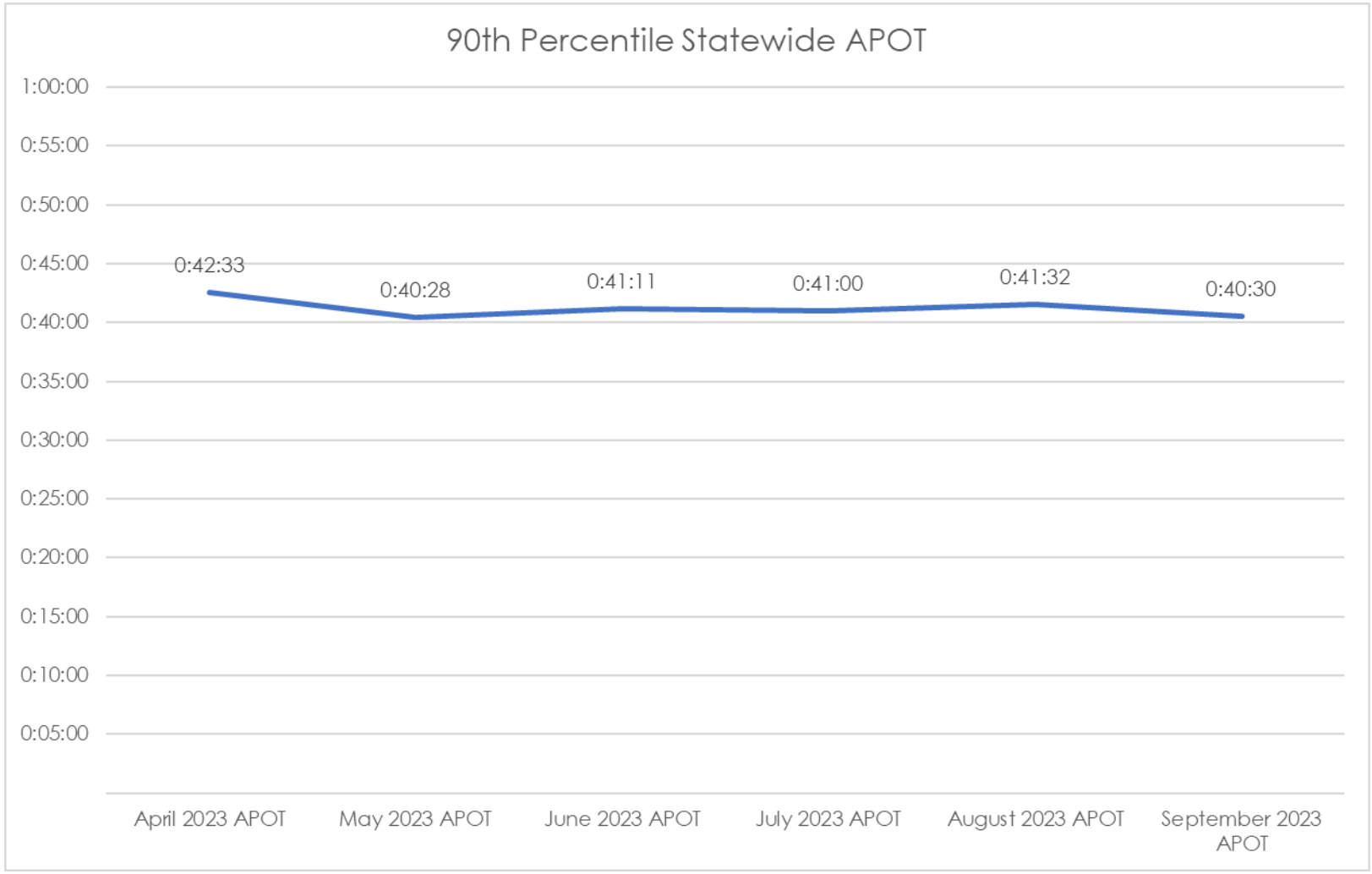
This report includes only records submitted using the NEMSIS 3.4 standard. During the time period analyzed in this report, some LEMSAs began transitioning to the NEMSIS 3.5 data standard and will have decreased APOT record representation in this document. 33 of 34 LEMSAs are represented in all components of this report, however their representation may be limited as a result of their transition status.

California Counties with a LEMSA 90th Percentile APOT Greater than 30 minutes over A 6-Month Period (April – September 2023)



All data represented in this report is sourced from CEMSIS with a run date of October 14, 2023. CEMSIS records are populated by participating EMS providers documented care in the pre-hospital setting through direct transmission into CEMSIS or passed through their local EMS Agency (LEMSA). Not all EMS providers in all LEMSAs are CEMSIS participants, therefore this report does not reflect 100% of EMS interactions and records meeting APOT criteria.

CEMSIS Sourced Statewide APOT Trend Graph (April – September 2023)



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CEMSIS Sourced APOT 1 (April – September): LEMSA Count of Offloads and 90th Percentile Offload Times

Local EMS Agency (LEMSA)	April 2023 Count	April 2023 APOT	May 2023 Count	May 2023 APOT	June 2023 Count	June 2023 APOT	July 2023 Count	July 2023 APOT	August 2023 Count	August 2023 APOT	September 2023 Count	September 2023 APOT
Alameda	7192	0:48:00	8971	0:48:00	8394	0:49:20	8995	0:50:00	8798	0:51:39	8242	0:50:33
Central California	11371	0:43:40	14297	0:44:05	13759	0:44:25	14383	0:46:42	14762	0:50:13	13411	0:50:57
Coastal Valleys	3116	0:18:00	3803	0:19:31	3527	0:19:05	3824	0:22:07	3781	0:20:15	3566	0:22:39
Contra Costa	5771	0:49:23	7102	0:48:37	6642	0:49:22	7028	0:45:11	7083	0:45:18	5194	0:43:11
El Dorado	1074	0:17:17	1108	0:22:49	1054	0:24:25	1245	0:20:24	1111	0:22:26	1005	0:20:11
Imperial	369	0:26:25	16	0:12:53	13	0:10:42	10	0:16:56	0		15	0:07:00
Inland Counties	12399	0:47:05	14790	0:46:33	14382	0:46:37	15730	0:45:10	15961	0:45:37	14726	0:42:11
Kern	4911	0:53:00	6459	0:52:55	6177	0:52:26	6726	0:55:15	6673	0:59:23	6095	0:52:44
Los Angeles												
Marin	954	0:13:01	1247	0:13:36	2	0:10:56	820	0:13:15	1326	0:13:54	1358	0:14:03
Merced	1554	0:44:19	1838	0:46:14	421	0:39:56	1814	0:44:09	1814	0:46:01	1612	0:49:55
Monterey	1862	0:21:00	2250	0:22:44	2190	0:21:00	2216	0:19:13	2283	0:20:22	2289	0:20:37
Mountain Valley	967	0:21:00	1357	0:19:00	1244	0:19:37	945	0:17:00	788	0:16:00	820	0:15:00
Napa	800	0:15:46	981	0:16:00	901	0:17:43	958	0:17:01	1046	0:16:19	1032	0:14:16
Northern California	298	0:07:18	417	0:07:12	281	0:08:00	475	0:10:00	466	0:09:00	376	0:07:00
North Coast	1454	0:07:24	1691	0:06:34	1592	0:07:21	1647	0:07:18	1617	0:07:50	1279	0:09:11
Orange	16018	0:30:45	19119	0:27:02	18181	0:28:33	19307	0:29:29	19979	0:29:00	19135	0:29:22
Riverside	12891	0:49:49	15068	0:43:13	14737	0:42:49	15963	0:38:43	15788	0:42:12	14565	0:41:45
Sacramento	9132	1:07:46	11024	1:04:13	8085	1:09:08	10723	1:06:07	11156	1:01:41	9565	0:55:30
San Benito	178	0:11:28	212	0:10:32	75	0:13:43	4	0:16:42	0		9	0:24:46
San Diego	5451	0:52:43	6619	0:45:00	5769	0:51:17	7082	0:47:39	6992	0:46:48	6619	0:43:17
San Francisco	5786	0:44:27	6789	0:40:27	6743	0:39:30	6870	0:38:50	6305	0:41:30	6652	0:41:52
San Joaquin	4174	0:46:39	5060	0:40:33	4681	0:42:50	5715	0:42:49	5051	0:39:51	3059	0:43:40
San Luis Obispo	1224	0:12:32	1630	0:12:21	1572	0:11:59	1617	0:13:26	1543	0:12:24	1408	0:12:31
San Mateo	2987	0:18:02	3537	0:17:39	3417	0:15:45	3612	0:16:00	3721	0:17:23	3327	0:16:50
Santa Barbara	1883	0:13:34	2213	0:13:01	2201	0:12:55	2154	0:13:03	2442	0:12:51	1800	0:12:40
Santa Clara	6824	0:27:42	8547	0:27:20	7985	0:26:52	8457	0:26:19	8512	0:27:58	7806	0:28:15
Santa Cruz	1087	0:19:42	1346	0:17:51	1288	0:19:28	1345	0:19:59	1299	0:19:05	1393	0:19:21
Sierra-Sacramento Valley	7936	0:29:34	8693	0:27:40	6072	0:31:02	3746	0:26:44	2481	0:18:00	711	0:11:29
Solano	1	0:05:48	1782	0:23:05	2020	0:24:09	2614	0:24:02	2510	0:25:21	2535	0:24:12
Stanislaus County	246	0:46:13	286	0:39:14	269	0:33:00	836	0:34:28	753	0:32:35	602	0:28:55
Tuolumne	335	0:10:00	432	0:09:00	467	0:13:00	474	0:13:00	419	0:12:42	428	0:13:00
Ventura	3138	0:22:51	3892	0:21:43	3753	0:23:02	4021	0:22:24	4097	0:21:41	3992	0:22:42
Yolo	1111	0:42:00	1367	0:40:34	1308	0:40:58	468	0:36:20	0		1	0:03:00
Statewide Total	134494	0:42:33	163943	0:40:28	149202	0:41:11	161824	0:41:00	160557	0:41:32	144627	0:40:30

During the time period analyzed in this report, some LEMSAs began transitioning to the NEMSIS 3.5 data standard and will have decreased APOT record representation in this table.

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CEMSIS Sourced APOT 2 (April – September): Aggregate Count of Offloads by APOT-2 Time Intervals

Local EMS Agency (LEMSA)	<=20 Minute Offload	20:01-60 Minute Offload	60:01-120 Minute Offload	120:01-180 Minute Offload	>180 Minute Offload	Total Offloads
Alameda	24,549	22,946	2,750	296	51	50,592
Central California	39,213	39,303	3,277	145	45	81,983
Coastal Valleys	19,450	1,950	200	13	4	21,617
Contra Costa	17,515	19,289	1,743	218	55	38,820
El Dorado	5,880	618	83	15	1	6,597
Imperial	348	73	1		1	423
Inland Counties	46,551	37,597	3,634	178	28	87,988
Kern	12,218	22,043	2,491	228	61	37,041
Los Angeles						
Marin	5,591	113	1		2	5,707
Merced	4,530	4,136	352	28	7	9,053
Monterey	11,708	1,297	81	3	1	13,090
Mountain Valley	5,633	413	62	5	8	6,121
Napa	5,376	336	5	1		5,718
Northern California	2,274	33	5		1	2,313
North Coast	9,152	96	18	3	11	9,280
Orange	90,766	18,557	2,163	222	31	111,739
Riverside	56,964	27,413	3,746	646	243	89,012
Sacramento	28,024	24,926	5,380	997	358	59,685
San Benito	466	11	1			478
San Diego	22,451	13,763	1,992	240	86	38,532
San Francisco	23,020	14,636	1,274	169	46	39,145
San Joaquin	16,037	10,567	943	100	93	27,740
San Luis Obispo	8,728	258	5	1	2	8,994
San Mateo	19,229	1,330	34	4	4	20,601
Santa Barbara	12,444	242	5	1	1	12,693
Santa Clara	38,857	8,337	811	95	31	48,131
Santa Cruz	7,077	670	9	1	1	7,758
Sierra-Sacramento Valley	24,686	4,201	642	83	27	29,639
Solano	9,067	2,357	27	1	10	11,462
Stanislaus County	2,269	619	88	7	9	2,992
Tuolumne	2,451	93	10	1		2,555
Ventura	19,864	2,844	123	10	52	22,893
Yolo	2,945	1,111	153	33	13	4,255
Statewide Total	595,333	282,178	32,109	3,744	1,283	914,647

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CEMSIS Sourced Statewide APOT "Heat" Table (April – September)

Local EMS Agency (LEMSA)	April 2023 APOT	May 2023 APOT	June 2023 APOT	July 2023 APOT	August 2023 APOT	September 2023 APOT
Alameda	0:48:00	0:48:00	0:49:20	0:50:00	0:51:39	0:50:33
Central California	0:43:40	0:44:05	0:44:25	0:46:42	0:50:13	0:50:57
Coastal Valleys	0:18:00	0:19:31	0:19:05	0:22:07	0:20:15	0:22:39
Contra Costa	0:49:23	0:48:37	0:49:22	0:45:11	0:45:18	0:43:11
El Dorado	0:17:17	0:22:49	0:24:25	0:20:24	0:22:26	0:20:11
Imperial	0:26:25	0:12:53	0:10:42	0:16:56		0:07:00
Inland Counties	0:47:05	0:46:33	0:46:37	0:45:10	0:45:37	0:42:11
Kern	0:53:00	0:52:55	0:52:26	0:55:15	0:59:23	0:52:44
Los Angeles						
Marin	0:13:01	0:13:36	0:10:56	0:13:15	0:13:54	0:14:03
Merced	0:44:19	0:46:14	0:39:56	0:44:09	0:46:01	0:49:55
Monterey	0:21:00	0:22:44	0:21:00	0:19:13	0:20:22	0:20:37
Mountain Valley	0:21:00	0:19:00	0:19:37	0:17:00	0:16:00	0:15:00
Napa	0:15:46	0:16:00	0:17:43	0:17:01	0:16:19	0:14:16
Northern California	0:07:18	0:07:12	0:08:00	0:10:00	0:09:00	0:07:00
North Coast	0:07:24	0:06:34	0:07:21	0:07:18	0:07:50	0:09:11
Orange	0:30:45	0:27:02	0:28:33	0:29:29	0:29:00	0:29:22
Riverside	0:49:49	0:43:13	0:42:49	0:38:43	0:42:12	0:41:45
Sacramento	1:07:46	1:04:13	1:09:08	1:06:07	1:01:41	0:55:30
San Benito	0:11:28	0:10:32	0:13:43	0:16:42		0:24:46
San Diego	0:52:43	0:45:00	0:51:17	0:47:39	0:46:48	0:43:17
San Francisco	0:44:27	0:40:27	0:39:30	0:38:50	0:41:30	0:41:52
San Joaquin	0:46:39	0:40:33	0:42:50	0:42:49	0:39:51	0:43:40
San Luis Obispo	0:12:32	0:12:21	0:11:59	0:13:26	0:12:24	0:12:31
San Mateo	0:18:02	0:17:39	0:15:45	0:16:00	0:17:23	0:16:50
Santa Barbara	0:13:34	0:13:01	0:12:55	0:13:03	0:12:51	0:12:40
Santa Clara	0:27:42	0:27:20	0:26:52	0:26:19	0:27:58	0:28:15
Santa Cruz	0:19:42	0:17:51	0:19:28	0:19:59	0:19:05	0:19:21
Sierra-Sacramento Valley	0:29:34	0:27:40	0:31:02	0:26:44	0:18:00	0:11:29
Solano	0:05:48	0:23:05	0:24:09	0:24:02	0:25:21	0:24:12
Stanislaus County	0:46:13	0:39:14	0:33:00	0:34:28	0:32:35	0:28:55
Tuolumne	0:10:00	0:09:00	0:13:00	0:13:00	0:12:42	0:13:00
Ventura	0:22:51	0:21:43	0:23:02	0:22:24	0:21:41	0:22:42
Yolo	0:42:00	0:40:34	0:40:58	0:36:20		0:03:00
Statewide Total	0:42:33	0:40:28	0:41:11	0:41:00	0:41:32	0:40:30

LEMSAs with red text and a red highlighted cell had a 90th Percentile APOT greater than 30 minutes for the month listed. The Statewide 90th Percentile APOT for each month between April 2023 and September 2023 exceeded 40 minutes.

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CEMSIS Sourced Cumulative APOT Greater than 30 minutes by LEMSA for April 2023 through September 2023 (6 Months)

Local EMS Agency (LEMSA)	Count of Records > 30 Minutes	Percent of Total Records > 30 Minutes	Total Hours, Minutes and Seconds of Delay > 30 minutes
Alameda	12,719	25.1%	4997:50:13
Central California	19,111	23.3%	5644:02:54
Coastal Valleys	830	3.8%	379:06:54
Contra Costa	10,105	26.0%	3465:49:19
El Dorado	342	5.2%	142:28:26
Imperial	23	5.4%	7:37:22
Inland Counties	19,232	21.9%	6032:11:35
Kern	12,940	34.9%	4401:48:18
Los Angeles			
Marin	19	0.3%	30:00:20
Merced	1,919	21.2%	683:38:54
Monterey	463	3.5%	140:50:52
Mountain Valley	209	3.4%	237:42:02
Napa	101	1.8%	17:11:21
Northern California	22	1.0%	30:01:12
North Coast	48	0.5%	255:01:06
Orange	8,865	7.9%	3341:59:49
Riverside	14,605	16.4%	7758:19:32
Sacramento	17,398	29.1%	9976:49:10
San Benito	2	0.4%	0:04:10
San Diego	7,822	20.3%	3770:31:45
San Francisco	6,668	17.0%	2735:54:09
San Joaquin	5,294	19.1%	3285:13:28
San Luis Obispo	90	1.0%	65:26:06
San Mateo	321	1.6%	90:57:05
Santa Barbara	50	0.4%	13:55:02
Santa Clara	3,300	6.9%	1440:26:07
Santa Cruz	166	2.1%	58:06:01
Sierra-Sacramento Valley	2,563	8.6%	1186:16:01
Solano	389	3.4%	3127:05:29
Stanislaus County	322	10.8%	235:19:11
Tuolumne	39	1.5%	11:59:43
Ventura	918	4.0%	1391:28:15
Yolo	722	17.0%	326:02:08
Statewide Total	147,617	16.1%	65281:13:59

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CEMSIS Sourced Cumulative APOT Greater than 30 minutes by LEMSA (April 2023)

Local EMS Agency (LEMSA)	Count of Records > 30 Minutes	Percent of Total Records > 30 Minutes	Total Hours, Minutes and Seconds of Delay > 30 minutes
Alameda	2,060	28.6%	631:34:36
Central California	2,859	25.1%	730:54:17
Coastal Valleys	113	3.6%	32:55:29
Contra Costa	1,883	32.6%	616:18:36
El Dorado	47	4.4%	19:49:45
Imperial	23	6.2%	7:37:22
Inland Counties	3,373	27.2%	1029:53:08
Kern	1,887	38.4%	597:56:37
Los Angeles			
Marin	3	0.3%	0:23:57
Merced	390	25.1%	99:57:09
Monterey	82	4.4%	22:10:53
Mountain Valley	61	6.3%	45:23:07
Napa	7	0.9%	0:50:31
Northern California	1	0.3%	0:04:00
North Coast	8	0.6%	49:12:25
Orange	1,665	10.4%	662:44:59
Riverside	2,887	22.4%	1506:50:10
Sacramento	3,121	34.2%	1789:24:16
San Benito	2	1.1%	0:04:10
San Diego	1,447	26.5%	829:03:43
San Francisco	1,325	22.9%	446:08:39
San Joaquin	1,025	24.6%	527:42:04
San Luis Obispo	23	1.9%	6:43:23
San Mateo	59	2.0%	20:38:10
Santa Barbara	8	0.4%	2:58:24
Santa Clara	576	8.4%	258:15:57
Santa Cruz	35	3.2%	7:56:35
Sierra-Sacramento Valley	759	9.6%	356:02:43
Solano	0	0.0%	0:00:00
Stanislaus County	50	20.3%	52:51:56
Tuolumne	2	0.6%	0:12:30
Ventura	175	5.6%	221:57:38
Yolo	211	19.0%	91:04:10
Statewide Total	26,167	19.5%	10665:41:19

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CEMSIS Sourced Cumulative APOT Greater than 30 minutes by LEMSA (May 2023)

Local EMS Agency (LEMSA)	Count of Records > 30 Minutes	Percent of Total Records > 30 Minutes	Total Hours, Minutes and Seconds of Delay > 30 minutes
Alameda	2,587	28.8%	867:47:05
Central California	3,696	25.9%	927:25:17
Coastal Valleys	154	4.0%	46:05:51
Contra Costa	2,215	31.2%	763:54:26
El Dorado	66	6.0%	28:16:46
Imperial	0	0.0%	0:00:00
Inland Counties	3,956	26.7%	1157:34:54
Kern	2,593	40.1%	851:41:55
Los Angeles			
Marin	5	0.4%	24:03:22
Merced	469	25.5%	139:55:09
Monterey	125	5.6%	51:40:24
Mountain Valley	36	2.7%	43:25:16
Napa	13	1.3%	2:17:04
Northern California	3	0.7%	0:57:17
North Coast	6	0.4%	2:20:03
Orange	1,574	8.2%	551:39:28
Riverside	3,029	20.1%	1300:44:32
Sacramento	3,620	32.8%	2108:48:49
San Benito	0	0.0%	0:00:00
San Diego	1,442	21.8%	545:28:26
San Francisco	1,390	20.5%	434:38:15
San Joaquin	1,067	21.1%	797:52:20
San Luis Obispo	15	0.9%	26:24:10
San Mateo	72	2.0%	19:39:21
Santa Barbara	7	0.3%	0:52:37
Santa Clara	689	8.1%	264:20:46
Santa Cruz	32	2.4%	6:22:16
Sierra-Sacramento Valley	744	8.6%	350:26:45
Solano	59	3.3%	60:39:20
Stanislaus County	48	16.8%	18:26:29
Tuolumne	3	0.7%	0:53:00
Ventura	159	4.1%	261:08:13
Yolo	227	16.6%	103:33:41
Statewide Total	30,101	18.4%	11759:23:17

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CEMSIS Sourced Cumulative APOT Greater than 30 minutes by LEMSA (June 2023)

Local EMS Agency (LEMSA)	Count of Records > 30 Minutes	Percent of Total Records > 30 Minutes	Total Hours, Minutes and Seconds of Delay > 30 minutes
Alameda	2,460	29.3%	1167:43:58
Central California	3,516	25.6%	951:50:25
Coastal Valleys	129	3.7%	60:29:27
Contra Costa	2,068	31.1%	668:38:46
El Dorado	84	8.0%	30:10:56
Imperial	0	0.0%	0:00:00
Inland Counties	3,750	26.1%	1094:11:40
Kern	2,625	42.5%	765:31:36
Los Angeles			
Marin	0	0.0%	0:00:00
Merced	87	20.7%	21:37:38
Monterey	85	3.9%	23:17:33
Mountain Valley	57	4.6%	21:14:31
Napa	26	2.9%	4:53:30
Northern California	3	1.1%	1:06:08
North Coast	9	0.6%	13:46:12
Orange	1,682	9.3%	574:03:43
Riverside	2,850	19.3%	1155:30:56
Sacramento	2,965	36.7%	1624:35:45
San Benito	0	0.0%	0:00:00
San Diego	1,443	25.0%	737:42:21
San Francisco	1,269	18.8%	559:19:34
San Joaquin	992	21.2%	636:03:16
San Luis Obispo	13	0.8%	2:42:06
San Mateo	44	1.3%	6:27:38
Santa Barbara	12	0.5%	4:08:37
Santa Clara	635	8.0%	276:44:19
Santa Cruz	35	2.7%	7:07:44
Sierra-Sacramento Valley	639	10.5%	264:47:12
Solano	77	3.8%	25:24:22
Stanislaus County	31	11.5%	11:14:38
Tuolumne	10	2.1%	4:10:05
Ventura	192	5.1%	218:14:44
Yolo	216	16.5%	109:44:57
Statewide Total	28,004	18.8%	11042:34:17

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CEMSIS Sourced Cumulative APOT Greater than 30 minutes by LEMSA (July 2023)

Local EMS Agency (LEMSA)	Count of Records > 30 Minutes	Percent of Total Records > 30 Minutes	Total Hours, Minutes and Seconds of Delay > 30 minutes
Alameda	2,626	29%	975:38:46
Central California	4,132	29%	1164:06:47
Coastal Valleys	228	6%	102:41:22
Contra Costa	1,960	28%	618:27:26
El Dorado	60	5%	30:00:21
Imperial	0	0.0%	0:00:00
Inland Counties	3,942	25%	1372:22:54
Kern	2,838	42%	872:24:49
Los Angeles			
Marin	6	1%	0:35:44
Merced	467	26%	120:25:03
Monterey	72	3%	14:44:29
Mountain Valley	34	4%	58:24:08
Napa	20	2%	2:46:21
Northern California	7	1%	2:47:47
North Coast	13	1%	69:33:35
Orange	1,870	10%	643:03:20
Riverside	2,562	16%	1750:27:47
Sacramento	3,577	33%	1912:39:40
San Benito	0	0.0%	0:00:00
San Diego	1,658	23%	736:22:45
San Francisco	1,291	19%	417:06:57
San Joaquin	1,157	20%	873:59:22
San Luis Obispo	21	1%	25:57:49
San Mateo	61	2%	23:45:56
Santa Barbara	11	1%	0:47:08
Santa Clara	618	7%	271:57:03
Santa Cruz	38	3%	8:12:49
Sierra-Sacramento Valley	306	8%	130:24:06
Solano	115	4%	2976:05:01
Stanislaus County	101	12%	83:10:19
Tuolumne	12	3%	4:21:57
Ventura	200	5%	295:16:33
Yolo	68	15%	21:39:20
Statewide Total	30,071	18.6%	15580:17:24

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CEMSIS Sourced Cumulative APOT Greater than 30 minutes by LEMSA (August 2023)

Local EMS Agency (LEMSA)	Count of Records > 30 Minutes	Percent of Total Records > 30 Minutes	Total Hours, Minutes and Seconds of Delay > 30 minutes
Alameda	2,701	30.7%	984:28:17
Central California	4,609	31.2%	1489:34:18
Coastal Valleys	177	4.7%	56:07:17
Contra Costa	1,887	26.6%	594:08:08
El Dorado	75	6.8%	20:47:03
Imperial			
Inland Counties	4,041	25.3%	1194:42:41
Kern	2,779	41.6%	1023:35:33
Los Angeles			
Marin	4	0.3%	0:26:17
Merced	461	25.4%	212:08:06
Monterey	93	4.1%	22:14:28
Mountain Valley	18	2.3%	31:38:00
Napa	35	3.3%	6:23:55
Northern California	8	1.7%	25:06:00
North Coast	9	0.6%	71:35:08
Orange	1,865	9.3%	659:41:11
Riverside	2,799	17.7%	1344:53:09
Sacramento	3,628	32.5%	1791:21:03
San Benito			
San Diego	1,678	24.0%	701:16:00
San Francisco	1,248	19.8%	519:30:09
San Joaquin	991	19.6%	338:06:08
San Luis Obispo	18	1.2%	3:38:38
San Mateo	83	2.2%	18:38:00
Santa Barbara	11	0.5%	2:41:35
Santa Clara	711	8.4%	231:03:05
Santa Cruz	25	1.9%	4:46:48
Sierra-Sacramento Valley	113	4.6%	82:14:27
Solano	134	5.3%	37:53:40
Stanislaus County	84	11.2%	34:55:29
Tuolumne	12	2.9%	2:22:11
Ventura	172	4.2%	218:16:38
Yolo			
Statewide Total	30,469	19.0%	11724:13:22

All data represented in this report is sourced from CEMSIS with a run date of October 14, 2023. CEMSIS records are populated by participating EMS providers documented care in the pre-hospital setting through direct transmission into CEMSIS or passed through their local EMS Agency (LEMSA). Not all EMS providers in all LEMSAs are CEMSIS participants, therefore this report does not reflect 100% of EMS interactions and records meeting APOT criteria.

CEMSIS Sourced Cumulative APOT Greater than 30 minutes by LEMSA (September 2023)

Local EMS Agency (LEMSA)	Count of Records > 30 Minutes	Percent of Total Records > 30 Minutes	Total Hours, Minutes and Seconds of Delay > 30 minutes
Alameda	2,578	31.3%	890:40:31
Central California	4,453	33.2%	1356:19:30
Coastal Valleys	225	6.3%	127:48:31
Contra Costa	1,302	25.1%	437:08:18
El Dorado	53	5.3%	21:58:52
Imperial	1	6.7%	0:20:07
Inland Counties	3,312	22.5%	851:00:20
Kern	2,196	36.0%	728:47:43
Los Angeles			
Marin	5	0.4%	5:41:30
Merced	474	29.4%	189:48:37
Monterey	103	4.5%	25:08:29
Mountain Valley	17	2.1%	41:28:00
Napa	11	1.1%	1:03:31
Northern California	1	0.3%	0:07:00
North Coast	12	0.9%	49:32:41
Orange	1,819	9.5%	621:18:15
Riverside	2,510	17.2%	1188:14:55
Sacramento	2,780	29.1%	1317:16:20
San Benito	1	11.1%	0:35:00
San Diego	1,328	20.1%	504:05:33
San Francisco	1,388	20.9%	618:52:48
San Joaquin	614	20.1%	241:01:29
San Luis Obispo	14	1.0%	2:16:36
San Mateo	60	1.8%	10:41:20
Santa Barbara	4	0.2%	2:38:17
Santa Clara	671	8.6%	255:54:42
Santa Cruz	38	2.7%	28:54:07
Sierra-Sacramento Valley	17	2.4%	6:56:36
Solano	121	4.8%	44:03:27
Stanislaus County	56	9.3%	44:14:07
Tuolumne	12	2.8%	3:01:20
Ventura	197	4.9%	213:55:41
Yolo	0	0.0%	0:00:00
Statewide Total	26,373	18.2%	9830:54:13

All data represented in this report is sourced from CEMSIS with a run date of October 14, 2023. CEMSIS records are populated by participating EMS providers documented care in the pre-hospital setting through direct transmission into CEMSIS or passed through their local EMS Agency (LEMSA). Not all EMS providers in all LEMSAs are CEMSIS participants, therefore this report does not reflect 100% of EMS interactions and records meeting APOT criteria.

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13, 2023 **ITEM NUMBER: 5B**

SUBJECT: EMTALA Discussion

PRESENTER: Lois Richardson, CHA's VP Legal Counsel

CONSENT: ___ ACTION: ____ INFORMATION: _X__

RECOMMENDATION
Receive information related to EMTALA and APOT.

FISCAL IMPACT
No fiscal impact.

DISCUSSION
Lois Richardson, CHA's VP Legal Counsel
Lois Richardson is vice president and legal counsel at the California Hospital Association. She advises CHA staff on proposed legislation and regulations that impact hospitals, develops public policy positions and strategy, and advocates for hospitals before legislative and regulatory bodies. Lois is also responsible for writing and updating CHA legal publications on topics such as hospital licensing and certification, patient consent, health information privacy, EMTALA, and mental health.

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 14, 2023 **ITEM NUMBER:** 6A

SUBJECT: Licensure and Certification Trend Report

PRESENTER: Laura Little, Paramedic Licensure Manager
Kim Lew, EMS Personnel Division Chief

CONSENT: ___ ACTION: ____ INFORMATION: X

RECOMMENDATION

None. Information only.

FISCAL IMPACT

None.

BACKGROUND

In accordance with Health and Safety Code Section (HSC) §1797.172, the Emergency Medical Services Authority (EMSA) is responsible for licensing Paramedics to practice in the State of California. The EMSA has delegated authority to sixty-four (64) certifying entities (CEs), to include thirty-four (34) local emergency medical service agencies (LEMSAs), to certify Emergency Medical Technicians (EMTs) and Advanced Emergency Medical Technicians (AEMTs). By utilizing an EMSA certification and licensing record system, the Central Registry, EMSA can monitor, collect, and report on EMT, AEMT, and Paramedic certification and licensure data.

On September 20, 2023, the Commission on EMS requested EMSA to provide a report on EMT, AEMT, and Paramedic certification and licensure trends based on initial, renewal, and reinstatement application and expired certification/licenses (credential) information collected during the State Fiscal Years (SFY) 2018-2019 through 2022-2023. The SFY begins on July 1 and ends June 30th of the following year.

SUMMARY

Utilizing Central Registry system collected data, EMSA found a 3% increase in the overall number of EMS professional credentials during the five-year period, SFY 2018-19 through SFY 2022-23. The total number of EMS professional active credentials has increased 3%. The key drivers of this growth are an increase in Paramedic and EMT credentials, with an average annual growth rate of 2% and 1%, respectively. AEMT credentials, though nominal in population by comparison, declined by 18%.

DISCUSSION

Although there was an overall increase in EMT certifications and Paramedic licenses over the five-year period, a marked decrease in EMT and Paramedic initial and reinstatement credentials occurred during the SFY 2019-20 and 2020-21. During that same period, Paramedic initial licenses decreased by 6% and reinstatements decreased by 18%.

These decreases may be attributed to the onset of the COVID-19 pandemic. Pursuant to Governor Newsom Executive Orders, EMSA waived EMS personnel credentialling requirements to include the waiver of out-of-state EMS personnel certification and licensure and the extension of certification and licensure expiration dates by an additional 6 months. As such, annual EMS credential initial, renewal, and reinstatement actions were delayed.

ATTACHMENT(S)

Annual Data Trends – California EMS Personnel Certification and Licensure

Annual Data Trends – California EMS Personnel Certification and Licensure

Emergency Medical Services Authority
California Health and Human Services Agency

December 2023

Elizabeth Basnett, Director

EXECUTIVE SUMMARY:
In accordance with Health and Safety Code Section (HSC) §1797.172, the Emergency Medical Services Authority (EMSA) is responsible for licensing Paramedics to practice in the State of California. The EMSA has delegated authority to sixty-four (64) certifying entities (CEs), to include thirty-four (34) local emergency medical service agencies (LEMSAs), to certify Emergency Medical Technicians (EMTs) and Advanced Emergency Medical Technicians (AEMTs). By utilizing an EMSA certification and licensing record system, the Central Registry, EMSA can monitor, collect, and report on EMT, AEMT, and Paramedic certification and licensure data.

On September 20, 2023, the Commission on EMS requested EMSA provide a report on EMT, AEMT, and Paramedic certification and licensure trends. EMSA collected initial, renewal, and reinstatement application and expired certification/license (credential) information from the State Fiscal Years (SFY) 2018-2019 through 2022-2023. The SFY begins on July 1 and ends June 30th of the following year.

An initial applicant may be one of the following:

- **In-State applicant**: an applicant who graduated from a California state approved emergency medical services (EMS) training program, or
- **Out-of-State applicant**: an applicant who graduated from any other government or military oversight approved EMS training program, or
- **Challenge applicant**: an applicant who graduated from a higher medical training program than EMS or is licensed in a higher medical profession and would like to substitute the required EMS didactic (classroom) training with their education or experience.

Renewal applicants are licensed or certified persons due to renew their credentials to practice no later than the last day of the month every 2-years from the initial certification or license date.

Reinstatement applicants are persons whose certification or license has lapsed past their require 2-year renewal period and are required to take additional continuing education and other steps to reinstate (or restore) their credentials to a valid and active status.

Utilizing Central Registry system collected data, EMSA found a 3% increase in the overall number of EMS professional credentials during the five-year period, SFY 2018-19 through SFY 2022-23. The total number of EMS professional active credentials has increased 3%. The key drivers of this growth are an increase in Paramedic and EMT credentials, with an average annual growth rate of 2% and 1%, respectively. AEMT credentials, though nominal in population by comparison, declined by 18% (See Appendix A).

ANALYSIS:

Although there was an overall increase in EMT certifications and Paramedic licenses over the five-year period, a marked decrease in EMT and Paramedic initial and reinstatement credentials occurred during the SFY 2019-20 and 2020-21. During that same period, Paramedic initial licenses decreased by 6% and reinstatements decreased by 18% (See Appendix B).

These decreases may be attributed to the onset of the COVID-19 pandemic. Pursuant to Governor Newsom Executive Orders, EMSA waived EMS personnel credentialling requirements to include the waiver of out-of-state EMS personnel certification and licensure and the extension of certification and licensure expiration dates by an additional 6 months. As such, annual EMS credential initial, renewal, and reinstatement actions were delayed.

Over the five-year period, 6,760 certified EMTs applied for Paramedic licensure. Of those who applied, 6,711 (99%) were approved. As of November 30th, 2023, 5,184 of these licensees continue to maintain an active paramedic license (See Appendix C).

As of November 30th, 2023, the total number of active EMS Personnel credentials includes 24,953 active Paramedic licenses, 65,447 active EMT certifications, and 101 active AEMTs. Currently, 3,453 personnel hold both an EMT certification and a Paramedic license (See Appendix C).

Credentialed EMS Personnel Population Trend

The total of currently active Paramedic, EMT and AEMT credentials during the five-year-period shows the following trends:

- Paramedic workforce: 6% overall growth, or an annual average increase of 1%.
- EMT workforce: 2% overall growth, or an annual average increase of half a percent.
- AEMT workforce: *18% decrease*, or an annual loss of 4.6% of the workforce.

The average number of individuals entering and reentering the workforce during the five-year period, indicated by the average of initial and reinstatement applications received for each credential type, includes:

- Paramedic: 1,323 initial and 319 reinstatement applications per year.
- EMT: 8,854 initial and 4,085 reinstatement applications per year.
- AEMT: 15 initial and 14 reinstatement applications per year.

The number of individuals remaining in the workforce each year is indicated by the following credential renewal data:

- Paramedic: average of 11,111 renewals per year.
- EMT: average of 19,257 renewals per year.
- AEMT: average of 24 renewals per year.

LIMITATIONS

The Central Registry credential system has limited reporting capabilities. Although real-time and static data is available, complex relation and correlation data between types of applications is minimal. For example, EMSA analyzed specific credential records of those with EMT certifications who also obtained paramedic licenses, but system data correlation and analysis capabilities are limited.

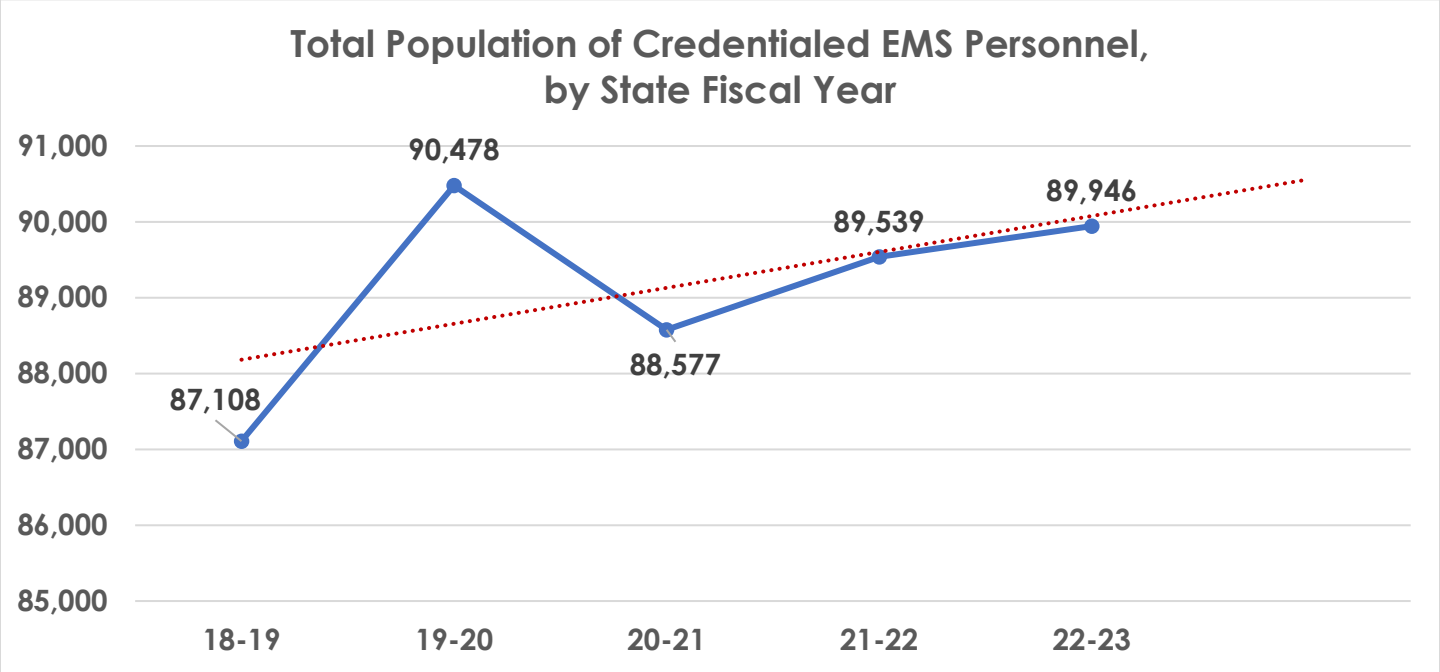
The impact of the COVID-19 pandemic may have contributed to outlier data during the SFY 2019-20 and 2021-22 period. EMS professional credential extensions and waivers were authorized foregoing standard credential processing activities in the Central Registry system.

CONCLUSION

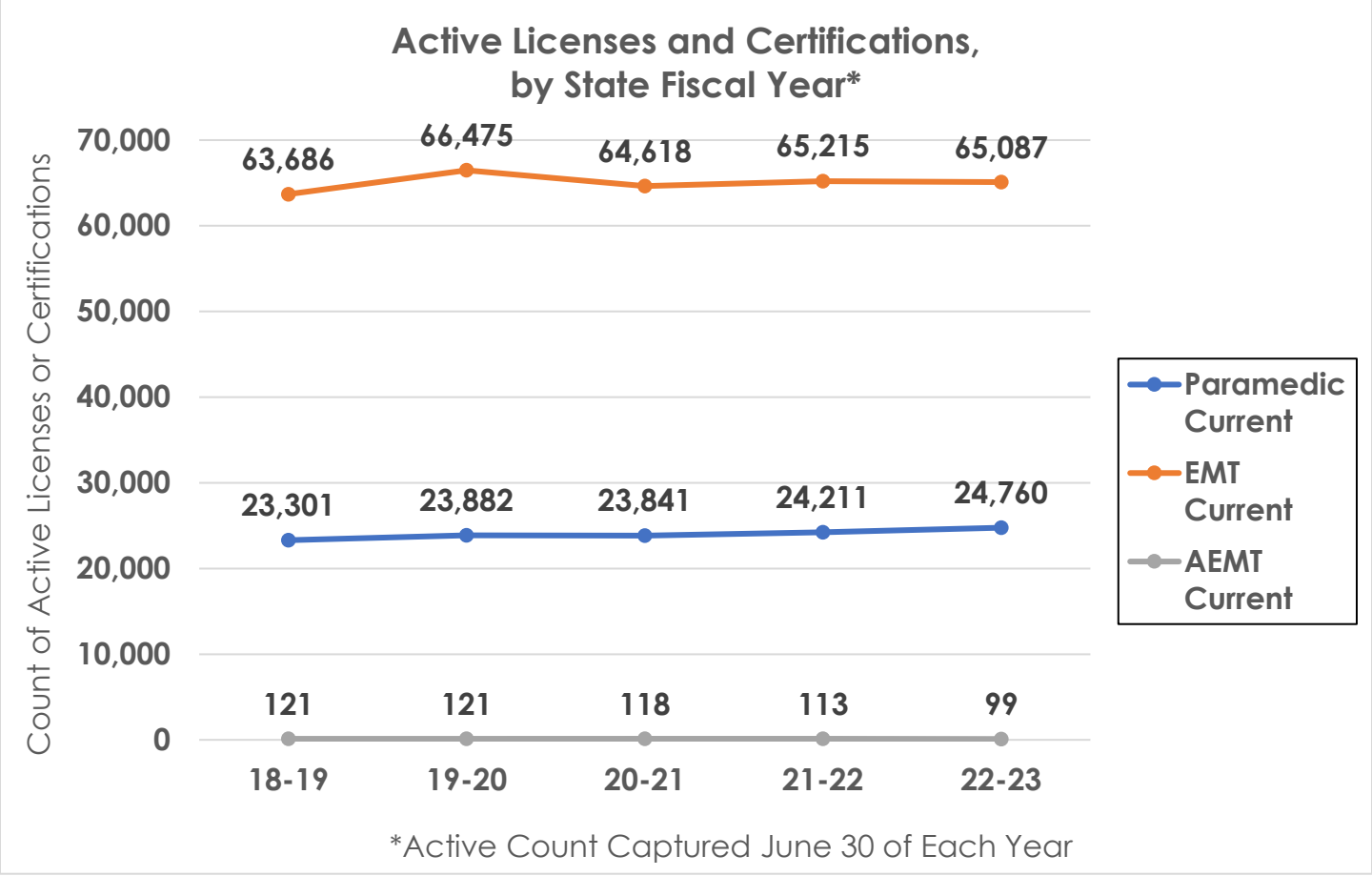
An overall increase in EMT certification and Paramedic licensure is evident based on the SFY 2018-19 and 2022-23 years. Although the COVID-19 pandemic may have contributed to a decrease in certified and licensed EMS personnel, data suggests initial and/or reentering EMS personnel are increasing post-pandemic. Further data collection and analysis is necessary to expand on certification and licensure trends moving forward post-pandemic.

Appendix A: EMS Personnel, Data Sets

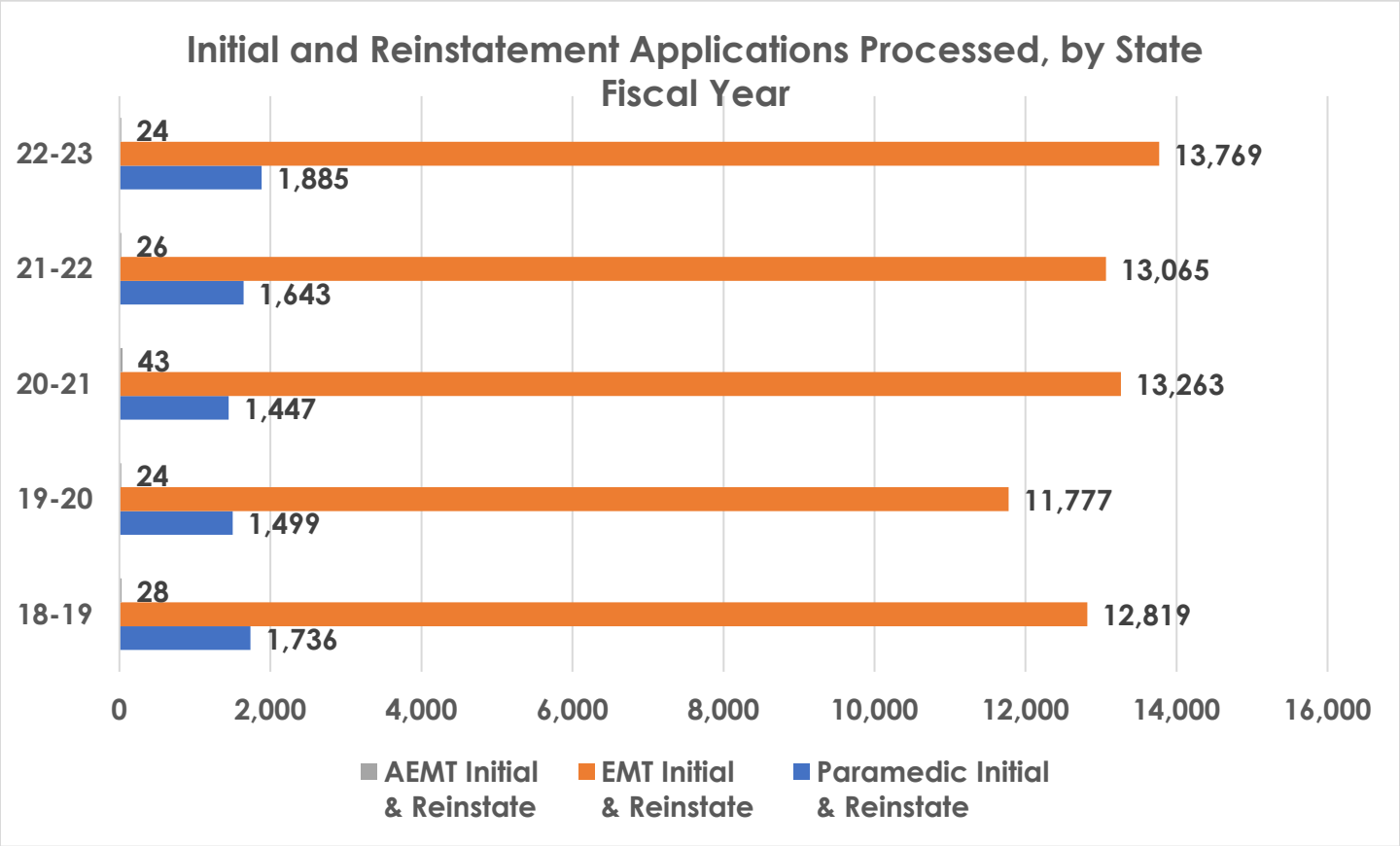
Graph 1.



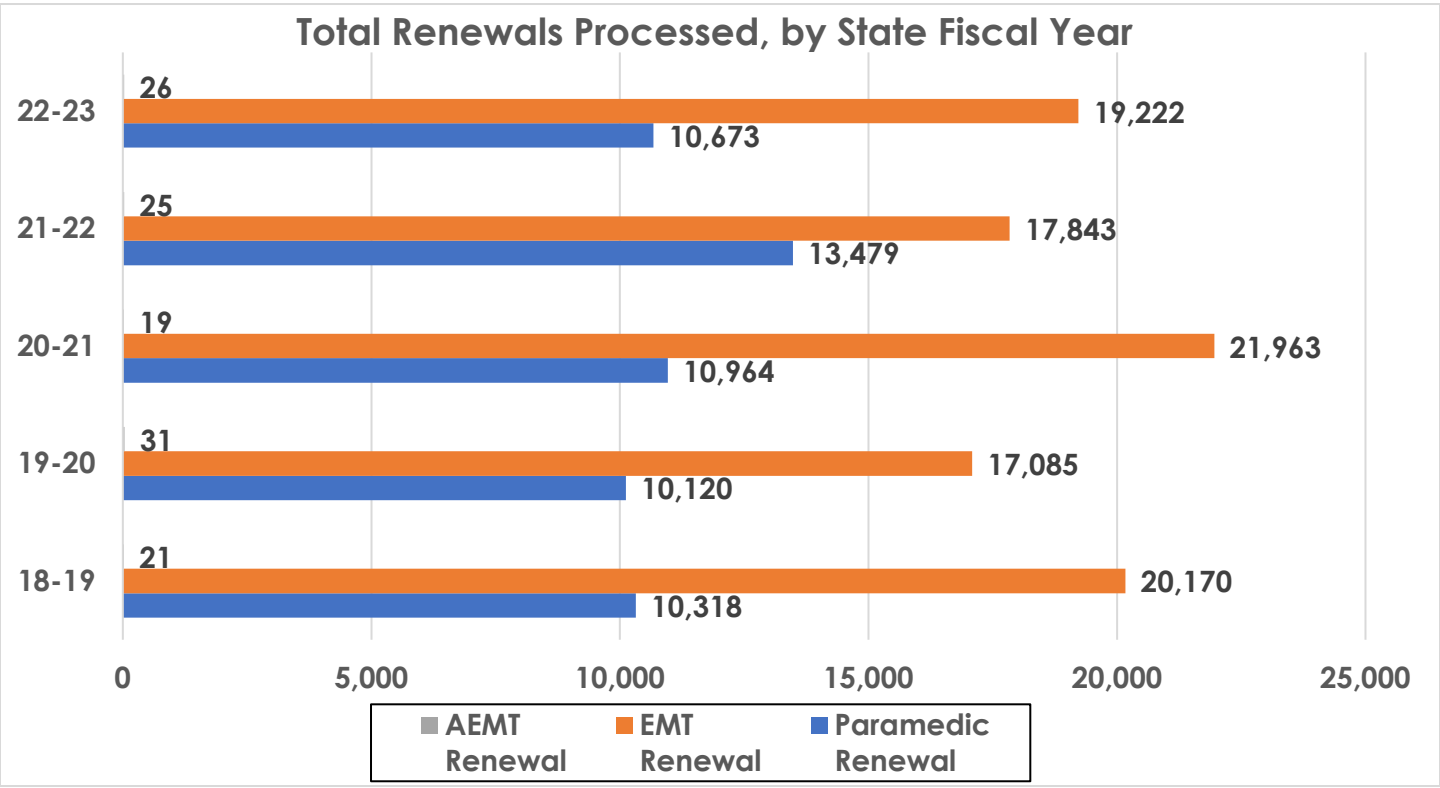
Graph 2.



Graph 3.



Graph 4.



Appendix B. EMS Personnel Data, Five-Year Averages

Table 1.

2018-2023 Fiscal-Year Summary Data, Paramedic				
Year	Paramedic Renewal	Paramedic Reinstate	Paramedic Initials	Paramedic Current
2018	10,318	369	1,367	23,301
2019	10,120	261	1,238	23,882
2020	10,964	304	1,143	23,841
2021	13,479	317	1,326	24,211
2022	10,673	342	1,543	24,760
Average	**11,111**	**319**	**1,323**	**23,999**

Table 2.

2018-2023 Fiscal-Year Summary Data, EMT				
Year	EMT Renewal	EMT Reinstate	EMT Initials	EMT Current
2018	20,170	4,077	8,742	63,686
2019	17,085	3,455	8,322	66,475
2020	21,963	4,394	8,869	64,618
2021	17,843	4,245	8,820	65,215
2022	19,222	4,254	9,515	65,087
Average	**19,257**	**4,085**	**8,854**	**6,5016**

Table 3.

2018-2023 Fiscal-Year Summary Data, AEMT				
Year	AEMT Renewal	AEMT Reinstate	AEMT Initials	AEMT Current
2018	21	15	13	121
2019	31	13	11	121
2020	19	20	23	118
2021	25	12	14	113
2022	26	12	12	99
Average	**24**	**14**	**15**	**114**

Appendix C. EMS Personnel Transition Data

Graph 1.

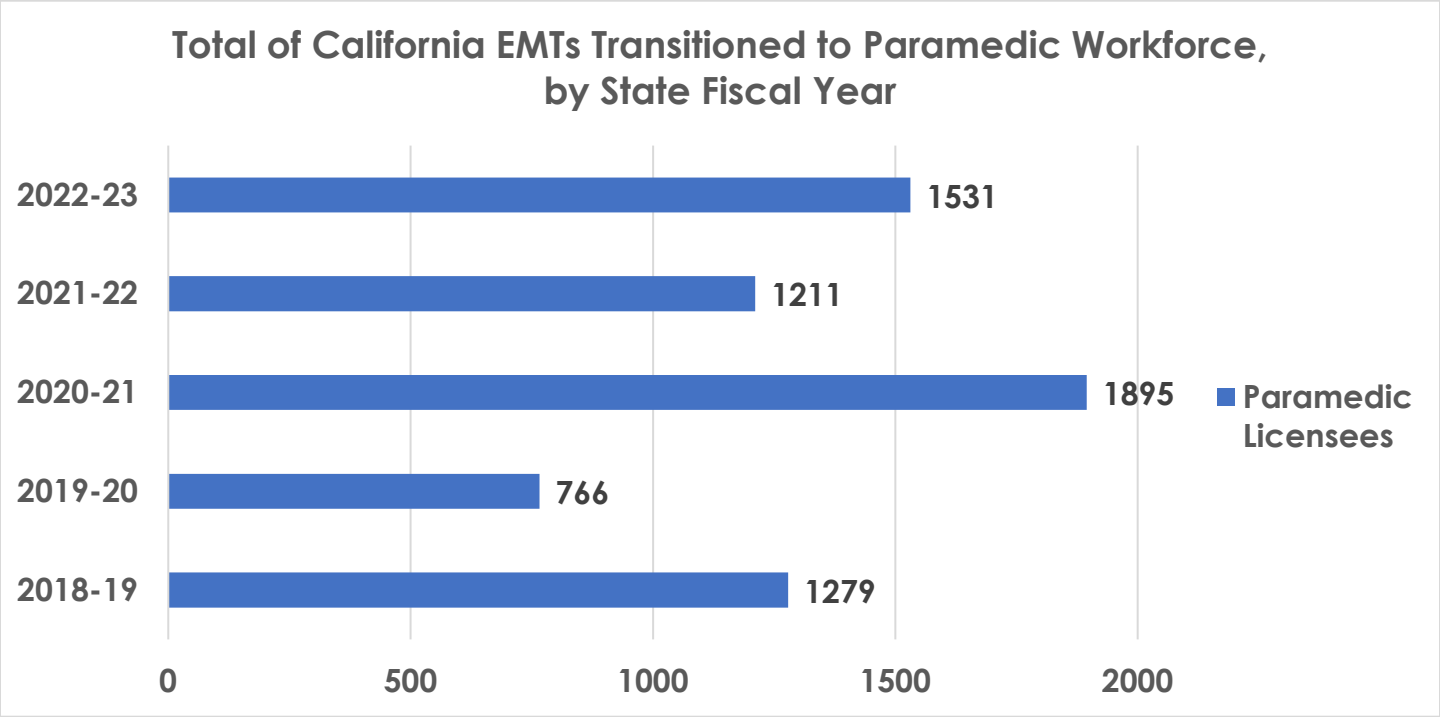


Table 1.

Paramedic Status of EMTs with Certification Lapsed SFY 2018-19 - 2022-23						
Paramedic Status	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**5-Year TOTAL**
Active (all)	907	616	1451	985	1225	**5184**
Lapsed/Inactive	372	150	444	226	306	**1498**
Revoke/Suspend	11	3	7	4	4	**29**
Withdrawn	4	3	20	7	8	**42**
Pend/Deleted	1	1	2	1	2	**7**
Total	**1295**	**773**	**1924**	**1223**	**1545**	**6760**

Table 2.

Current EMS Personnel Workforce, as-of 11/30/2023						
Personnel Type	**Active**	**Active-PROBATION**	**TOTAL ACTIVE**	**Lapsed**	**Lapsed-PROBATION**	**TOTAL LAPSED**
Advanced EMT	100	1	101	163	0	163
EMT	65184	263	65447	107150	627	107777
Paramedic	24860	93	24953	10343	69	10412
Total	**90144**	**357**	**90501**	**117656**	**696**	**118352**

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13, 2023 **ITEM NUMBER:** 6B

SUBJECT: AB 2293 EMT Denial Report Update

PRESENTER: Nicole Mixon

CONSENT: ___ ACTION: ____ INFORMATION: X

RECOMMENDATION

Receive information on the EMT Certification Denial Report required by Assembly Bill 2293.

FISCAL IMPACT

The Emergency Medical Services Authority (EMSA) received General Fund support for a fulltime, permanent associate government program analyst to collect, analyze, and prepare the annual report.

BACKGROUND

Effective January 1, 2019, the HSC 1797.229, states that each local EMS Agency (LEMSA) and other Certifying Entities shall submit to the EMSA data on EMT I (EMT) or EMT-II (AEMT) applicant and certification approvals, denials, and approvals with restrictions from the preceding calendar year annually. Reporting for calendar year 2022 was due to EMSA by July 1, 2023.

EMSA shall report annually to the EMS Commission and Legislature the extent to which prior criminal history may be an obstacle to EMT and AEMT certification based on the submitted data. Reporting shall continue through July 1, 2024.

SUMMARY

In accordance with Health and Safety Code Section (HSC) 1797.229, the Emergency Medical Services Authority (EMSA) collected Emergency Medical Technician (EMT) and Advanced Emergency Medical Technician (AEMT) initial certification applicant criminal history, gender, age, race, and ethnicity data from 64 certifying entities (CEs) during the 2022 calendar year to determine the extent to which prior criminal history may be an obstacle to certification. Sixty-four (64) CEs reported data on 9,191 initial certification applications, including criminal histories, denials, and approvals. The EMSA found prior criminal history does not appear to represent an obstacle to certification as an EMT or AEMT in California.

Data analysis shows 367 applicants were found to have pending charges or confirmed conviction history in their background, which represents four percent (4%) of all applicants. Of those applicants with reported criminal history, 329 (90%) received approved certifications, including 36 applicants approved with restrictions (probation). The remaining 12 (3%) were denied due to criminal history, including seven (7) applicants denied according to California Code of Regulations (CCR) Title 22, §100214.3 and five (5) applicants denied according to HSC §1798.200(c). The remaining 26 (7%) applications are currently pending due to open investigations or incomplete application requirements.

Data gathered from 2019 through 2022 shows an average of 8,965 EMT and AEMT applications are received per year. An annual average of 398 (4.4%) applicants are identified as having criminal history reports. Of those applicants, an average of 373 (93.7%) are approved and 15 (3.8%) applicants are denied per year.

DISCUSSION

After reviewing and analyzing the EMT and AEMT certification data collected from 64 certifying entities for 2022, EMSA found that prior criminal history is not an obstacle to certification. A summary of 2019 – 2022 data shows no significant outliers in population totals, indicating reliability in its overall consistency. Over the past four (4) years, EMSA has approved, on average, 96% of all applicants with criminal history. The remaining 4% of applicants with criminal history were denied certification in accordance with the requirements specified in CCR TITLE 22, §100214.3 and HSC §1798.200(c).

ATTACHMENT(S)

Criminal History Impact on EMT Certification 2022

Criminal History Impact on EMT Certification 2022

Emergency Medical Services Authority
California Health and Human Services Agency

October 2023

Elizabeth Basnett, Director

EXECUTIVE SUMMARY:

In accordance with Health and Safety Code Section (HSC) 1797.229, the Emergency Medical Services Authority (EMSA) collected Emergency Medical Technician (EMT) and Advanced Emergency Medical Technician (AEMT) initial certification applicant data from 64 certifying entities (CEs) during the 2022 calendar year to determine the extent to which prior criminal history may be an obstacle to certification. The sixty-four (64) CEs reported criminal history, gender, age, race, ethnicity, and certification action data on 9,191 initial certification applications. The EMSA found prior criminal history does not appear to represent an obstacle to certification as an EMT or AEMT in California.

Data analysis shows 367 applicants were found to have pending charges or confirmed conviction history in their background, which represents four percent (4%) of all applicants. Of those applicants with reported criminal history, 329 (90%) received approved certifications, including 36 applicants approved with restrictions (probation). Only 12 (3%) were denied due to criminal history, including seven (7) applicants denied according to California Code of Regulations (CCR) Title 22, §100214.3 and five (5) applicants denied according to HSC §1798.200(c). The remaining 26 (7%) applications are currently pending due to open investigations or incomplete application requirements.

Data gathered from 2019 through 2022 shows an average of 8,965 EMT and AEMT applications are received per year. An annual average of 398 (4.4%) applicants are identified as having criminal history reports. Of those applicants, an average of 373 (93.7%) are approved and 15 (3.8%) applicants are denied per year.

BACKGROUND:

Effective January 1, 2019, the HSC 1797.229, states that each local EMS Agency (LEMSA) and other CEs shall submit to the EMSA data on EMT I (EMT) or EMT-II (AEMT) applicant and certification approvals, denials, and approvals with restrictions from the preceding calendar year annually. Reporting for calendar year 2022 was due to EMSA by July 1, 2023.

The EMSA shall report annually to the EMS Commission and Legislature the extent to which prior criminal history may be an obstacle to EMT and AEMT certification based on the submitted data. Reporting shall continue through July 1, 2024.

SCOPE & METHODOLOGY:

The EMSA, in collaboration with the LEMSAs, developed a standardized Excel table to be used as the reporting tool. The EMSA aggregated and analyzed the data to assess whether applicant prior criminal history was an obstacle to certification. Demographic data of denied applicants was also collected and reviewed.

During the 2022 calendar year, five (5) of the 68 agencies confirmed deactivation in the Central Registry and transfer of their EMT and AEMT certifications to other, active agencies. A new agency also began operation. In 2022, 64 active agencies submitted data utilizing the provided reporting tool, meeting data reporting statutory requirements. The data collected was compiled and analyzed by the EMSA and is included in this report.

ANALYSIS:
The EMSA received initial EMT certification data on 9,191 applications. Among those received, 367 (4%) applicants reported criminal history in their background checks, including 365 convictions and two applicants with pending charges. A total of 341 applications were fully processed. The CE's approved a total of 329 (89.7%) applicants, including 36 applicants approved with restrictions (probation) and 293 without restrictions. The balance of 12 (3%) processed applications were denied due to criminal history record information. Of those denials, seven (7) were denied pursuant to CCR Title 22, §100214.3, requiring a "shall deny" action. The remaining five (5) were denied pursuant to HSC §1798.200(c), which states, "[a]ny of the following actions shall be considered evidence of a threat to the public health and safety and may result in the denial..." . The remaining 26, pending applications include 14 (4%) incomplete applications and 12 (3%) applications with ongoing investigations.

Demographic Data of Applicants Reporting Criminal History & Denials

Of the data submitted in a format allowing stratification, most applicants that were denied certification due to criminal history, identified themselves as male.

Of the 341 applicants with criminal history information, the data indicates:
- 83.3% identified as male
- 14.7% identified as female
- 2.1% chose not to disclose their gender

Of the twelve applicants denied due to criminal history, the data indicates:
- 10 applicants (83%) identified as male
- one applicant (8.3%) identified as female
- one applicant (8.3%) chose not to disclose their gender.

Applicants 31 to 40 years of age had the highest number of criminal history reports, followed closely by applicants 30 years of age or younger. Of the 12 applicants denied certification due to criminal history, the data indicates:
- seven applicants (58.3%) were age 30 or younger
- four applicants (33.3%) were between 31 and 40 years of age
- one applicant (8.3%) was between 41 and 50 years of age

Of the demographic data collected for the race or ethnicity of applicants, "White/Caucasian" applicants had the highest number of criminal history reports. The data indicates:
- 43.1% of applicants with criminal history identified themselves as "White/Caucasian"
- 29.% identified as "Hispanic or Latino"
- 11.1% chose not to identify their race/ethnicity
- 5.6% identified as "Black/African American"
- 4.4% identified as "Asian
- 2.9% identified as "American Indian or Alaskan Native"
- 2.3% identified as "Other"
- 1.5% identified as "Native Hawaiian or Pacific Islander"

Of the 12 applicants denied due to criminal history, the data indicates:

- six applicants (50%) identified as "Hispanic or Latino"
- four applicants (33.3%) identified as "White/Caucasian"
- one applicant (8.3%) identified as "Black/African American"
- one applicant (8.3%) chose not to identify their race/ethnicity

Aggregate of 2019 - 2022 Annual Population Summary Data

The population summary data gathered for calendar years 2019 through 2022 are free of outlier values for all population categories, to include:

- Total Applicants (z-range = -1.69 - .89)
- Applicants disclosing criminal history (z-range = -1.32 – 1.49)
- Applicants approved, no criminal history (z-range = -1.69 – .90)
- Applicants approved with criminal history (z-range = -1.62 – 1.07)
- Applicants approved and placed on probation (z-range = -1.51 – 1.24)
- Applicants denied (z-range = -1.42 - .94)

All z-scores, or standard[1] scores, fall within range $-2 < x < 2$. This indicates the number of applicants, and the pattern of approval, probation, and denial are free of outliers. The greatest variation in population data appeared in 2020, in the sum of applicants (8277 count, z-score = -1.69) and the sum of applicants certified with no criminal history (8254, z-score = -1.69). In all other years, standard scores fall within a range of .24-.9, so the variation found in calendar year 2020 appears to be atypical. The timing of the variation correlates with the onset of COVID-19 pandemic; however, the EMSA was unable to determine specific causal factors.

LIMITATIONS:

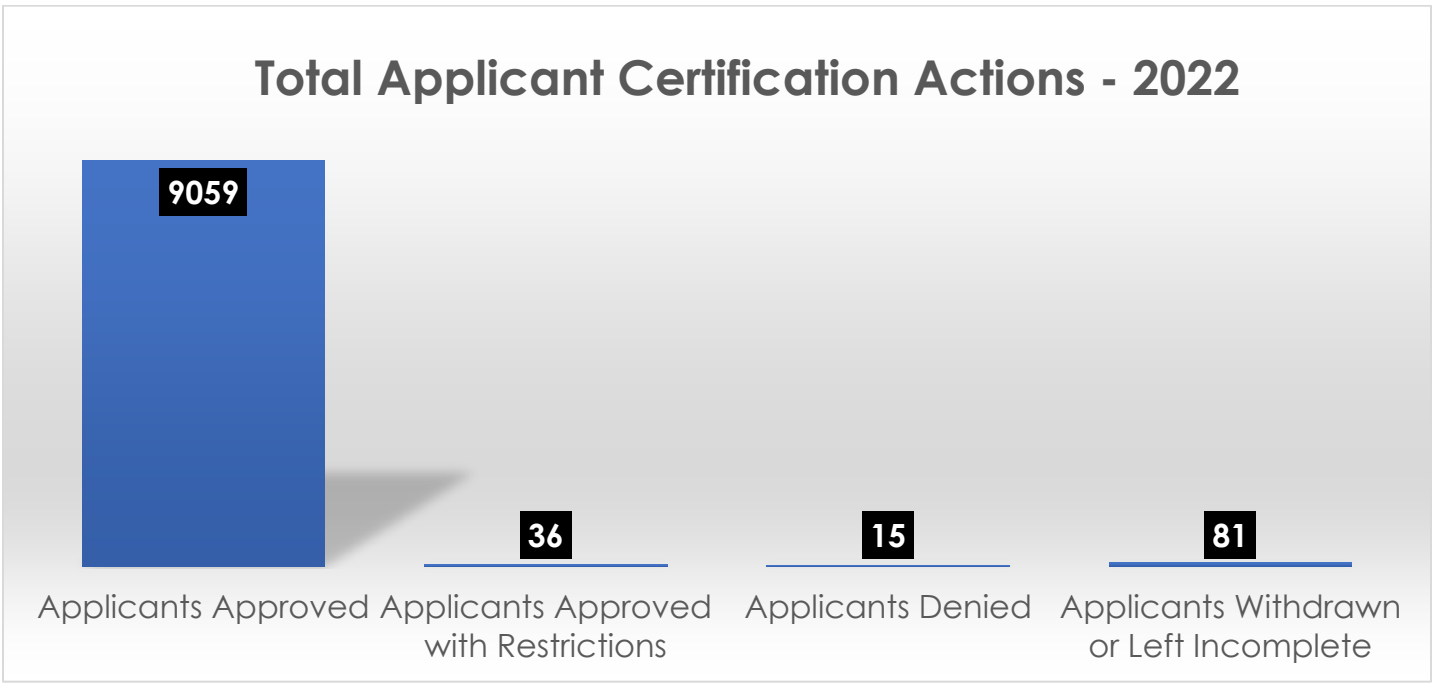
Complete data collection was hindered by some unresolved discrepancies and incomplete data which affects the efficacy of this analysis.

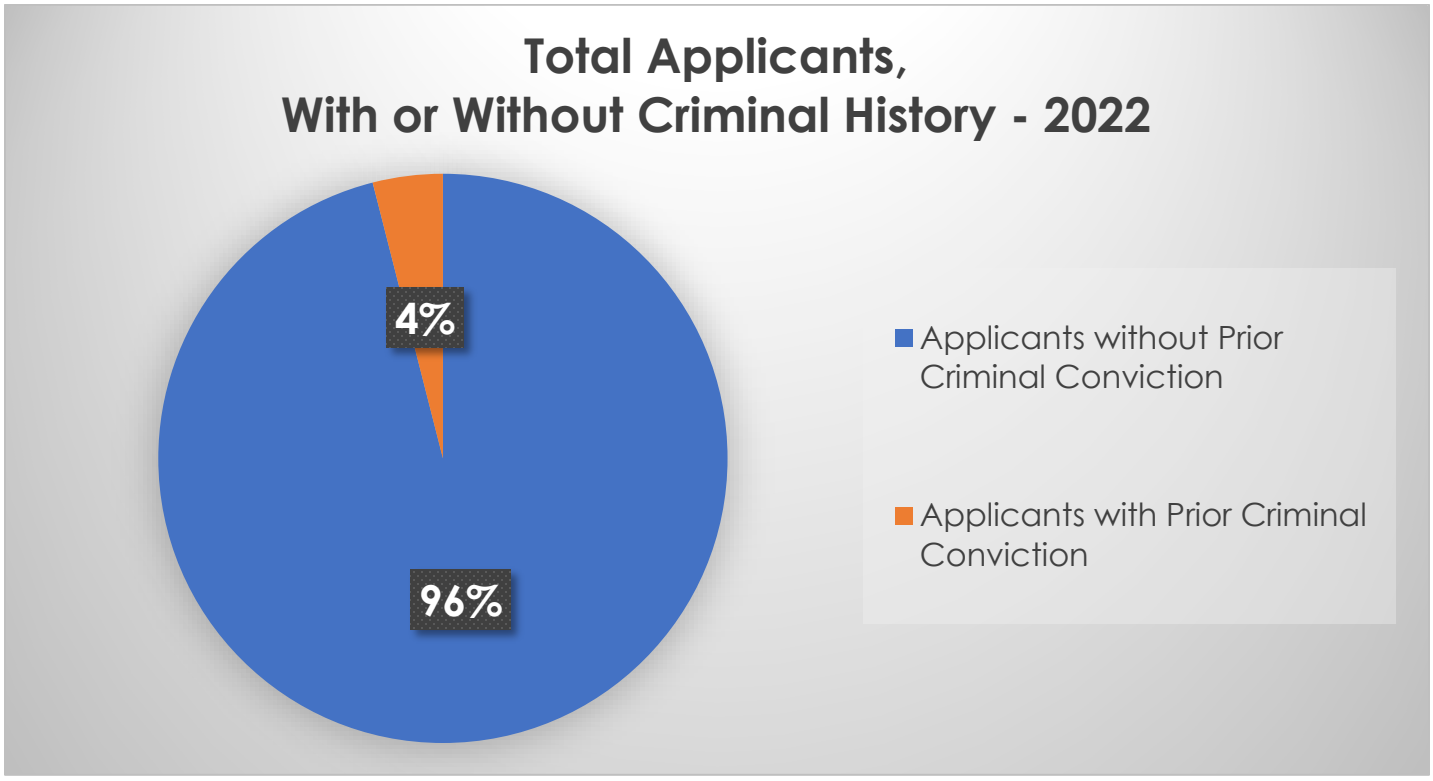
CONCLUSION:

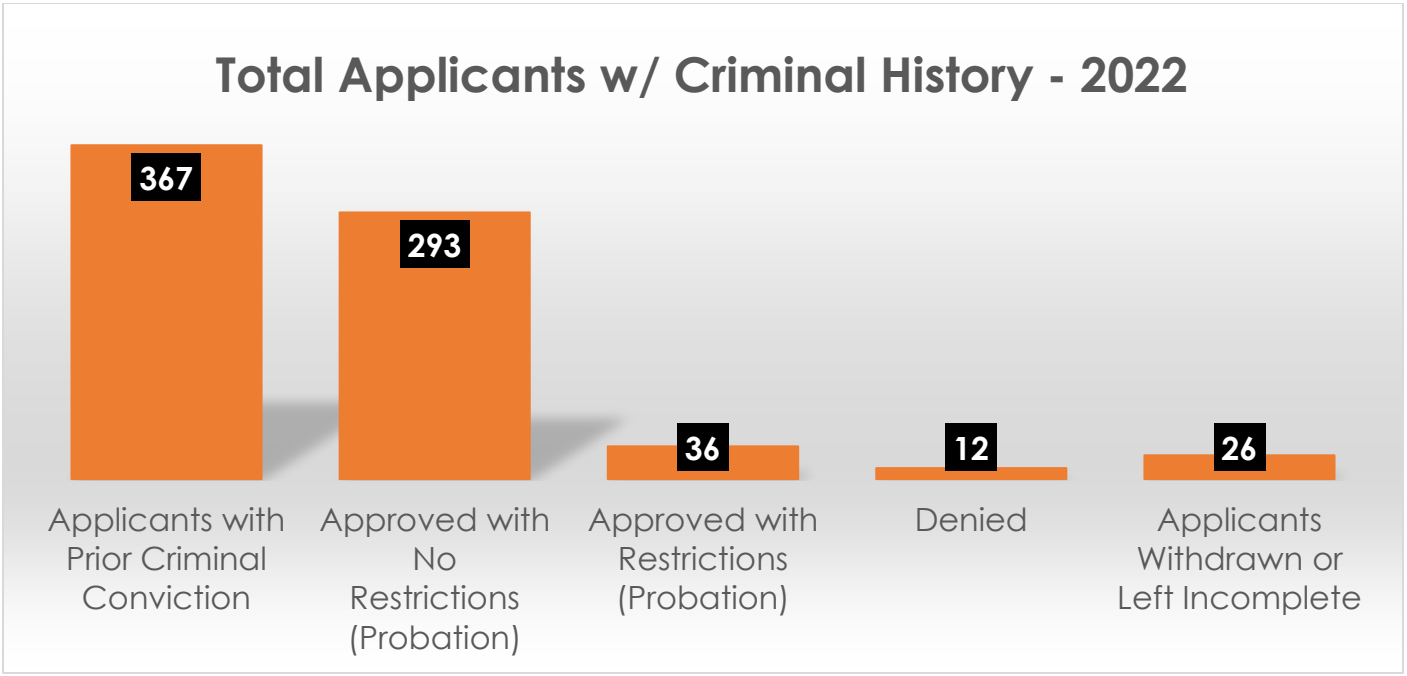
After reviewing and analyzing the EMT and AEMT certification data collected from 64 certifying entities for 2022, the EMSA found prior criminal history is not an obstacle to certification. A summary of 2019 – 2022 data shows no significant outliers in population totals, indicating reliability in its overall consistency. Over the past four (4) years, the EMSA has approved, on average, 96% of all applicants with criminal history. The remaining 4% of applicants with criminal history were denied certification in accordance with the requirements specified in CCR TITLE 22, §100214.3 and HSC §1798.200(c).

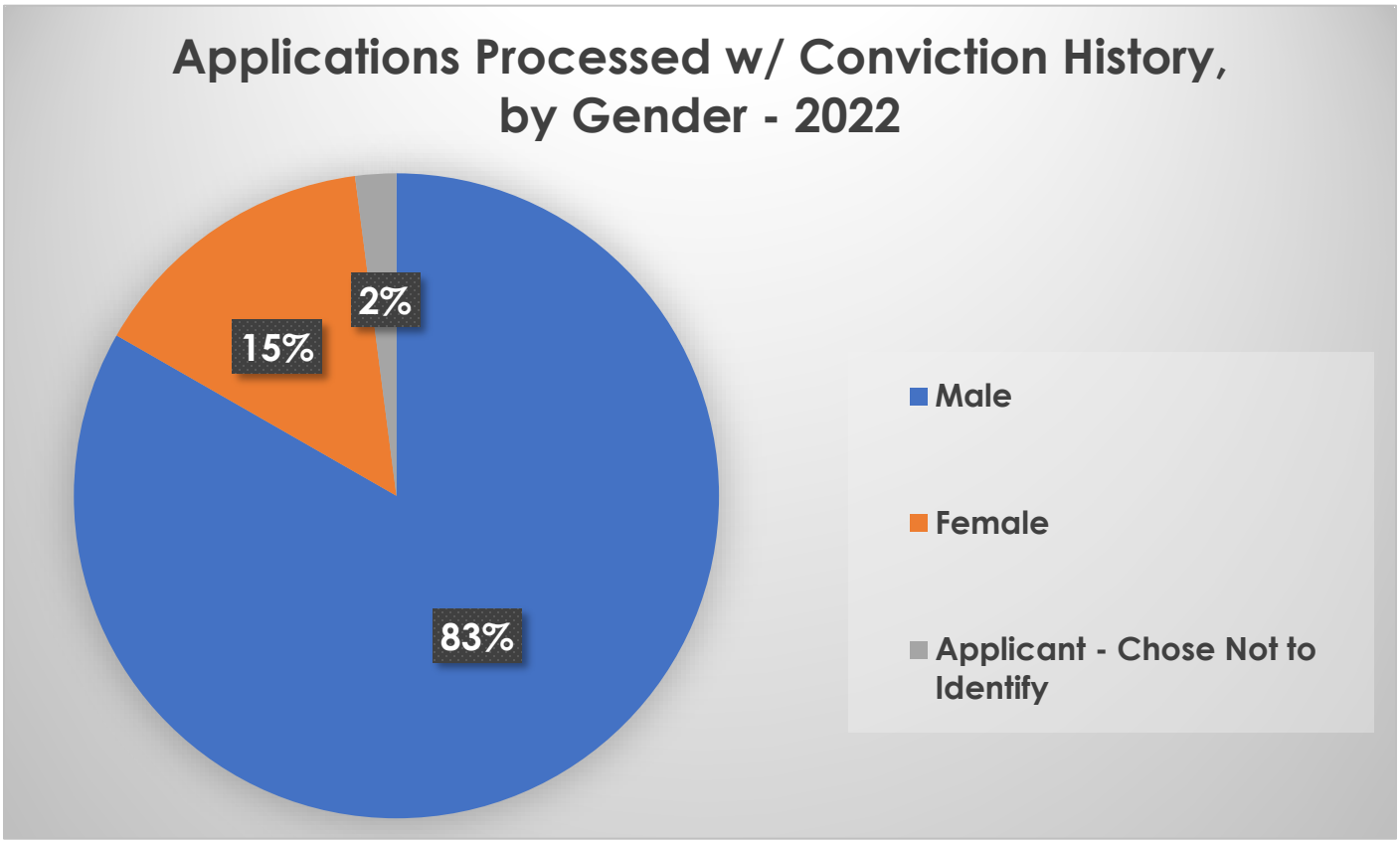
[1] Standard Score: an individual test score expressed as the deviation from the mean score of the group in units of standard deviation

Appendix A: Applicants, Aggregate Data Sets

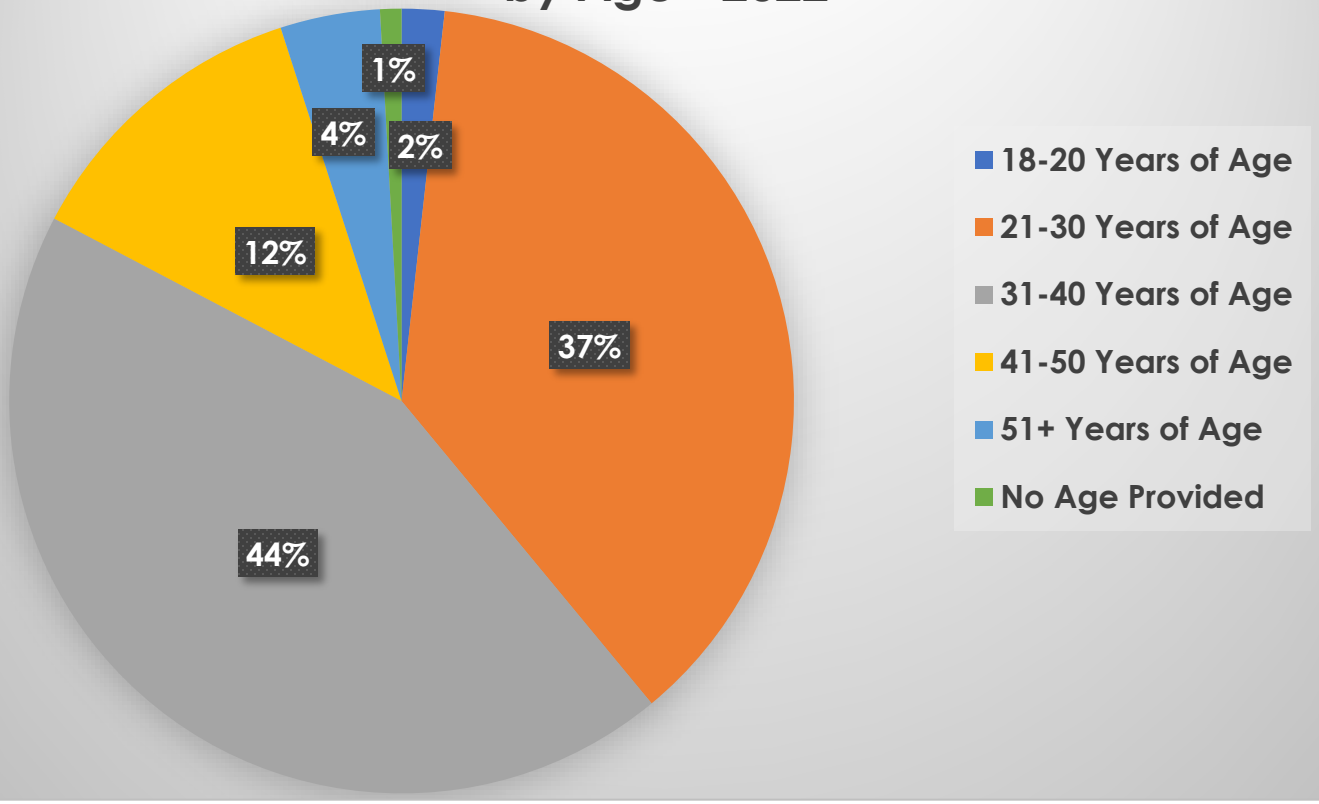




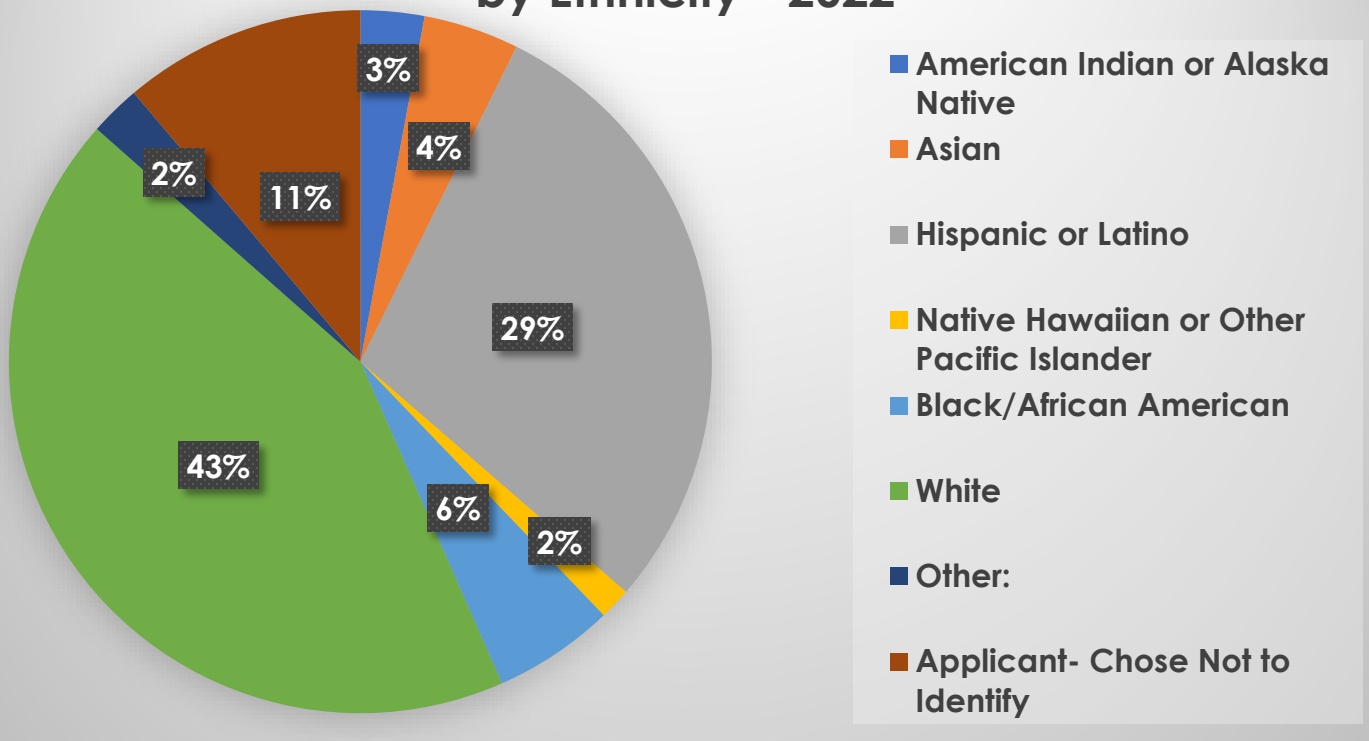

Total Applicants w/ Criminal History - 2022
367
293
36
12
26
Applicants with Prior Criminal Conviction
Approved with No Restrictions (Probation)
Approved with Restrictions (Probation)
Denied
Applicants Withdrawn or Left Incomplete


Applications Processed w/ Conviction History, by Gender - 2022
2%
15%
83%
Male
Female
Applicant - Chose Not to Identify

Applications Processed w/ Conviction History, by Age - 2022



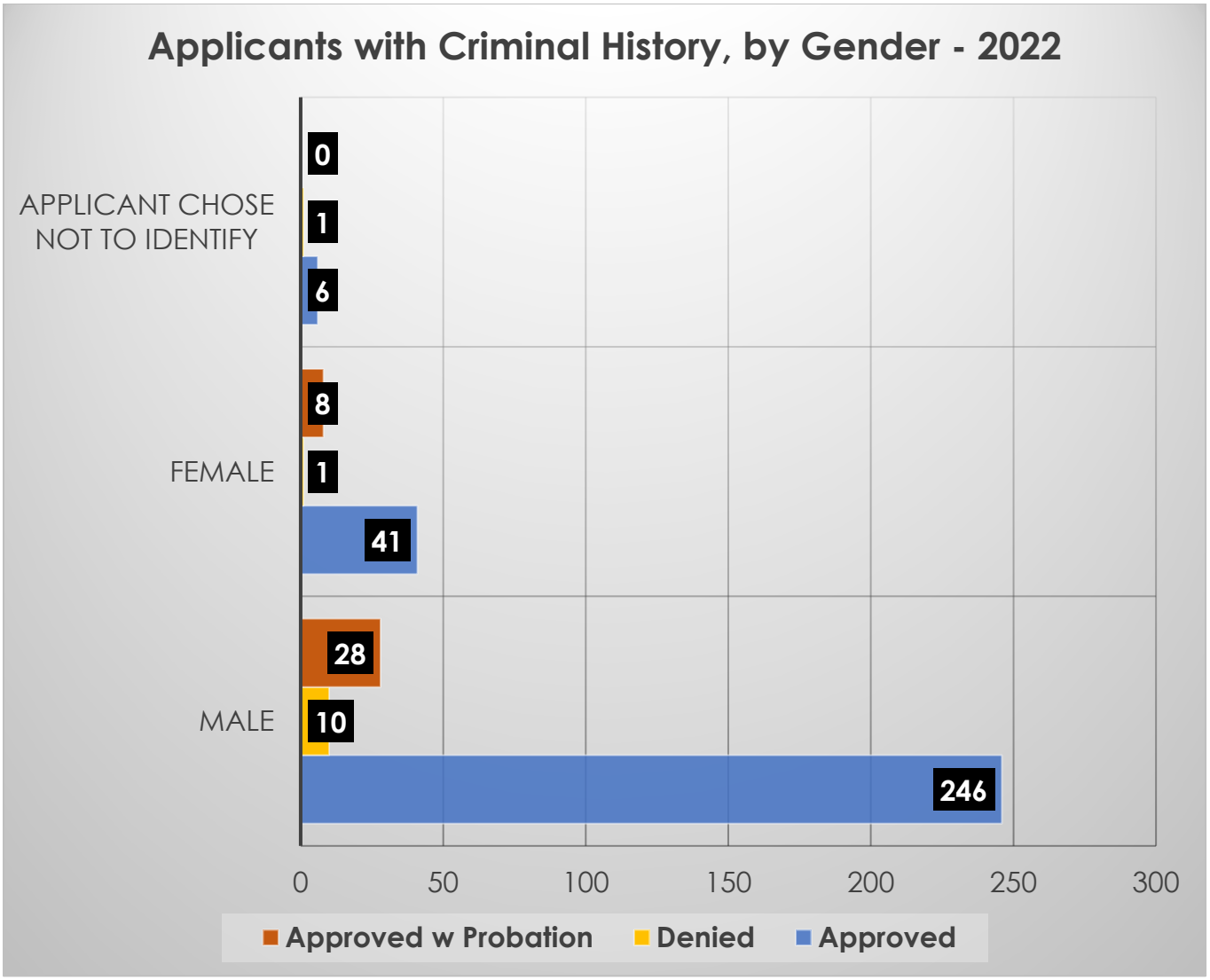
Applications Processed w/ Conviction History, by Ethnicity - 2022

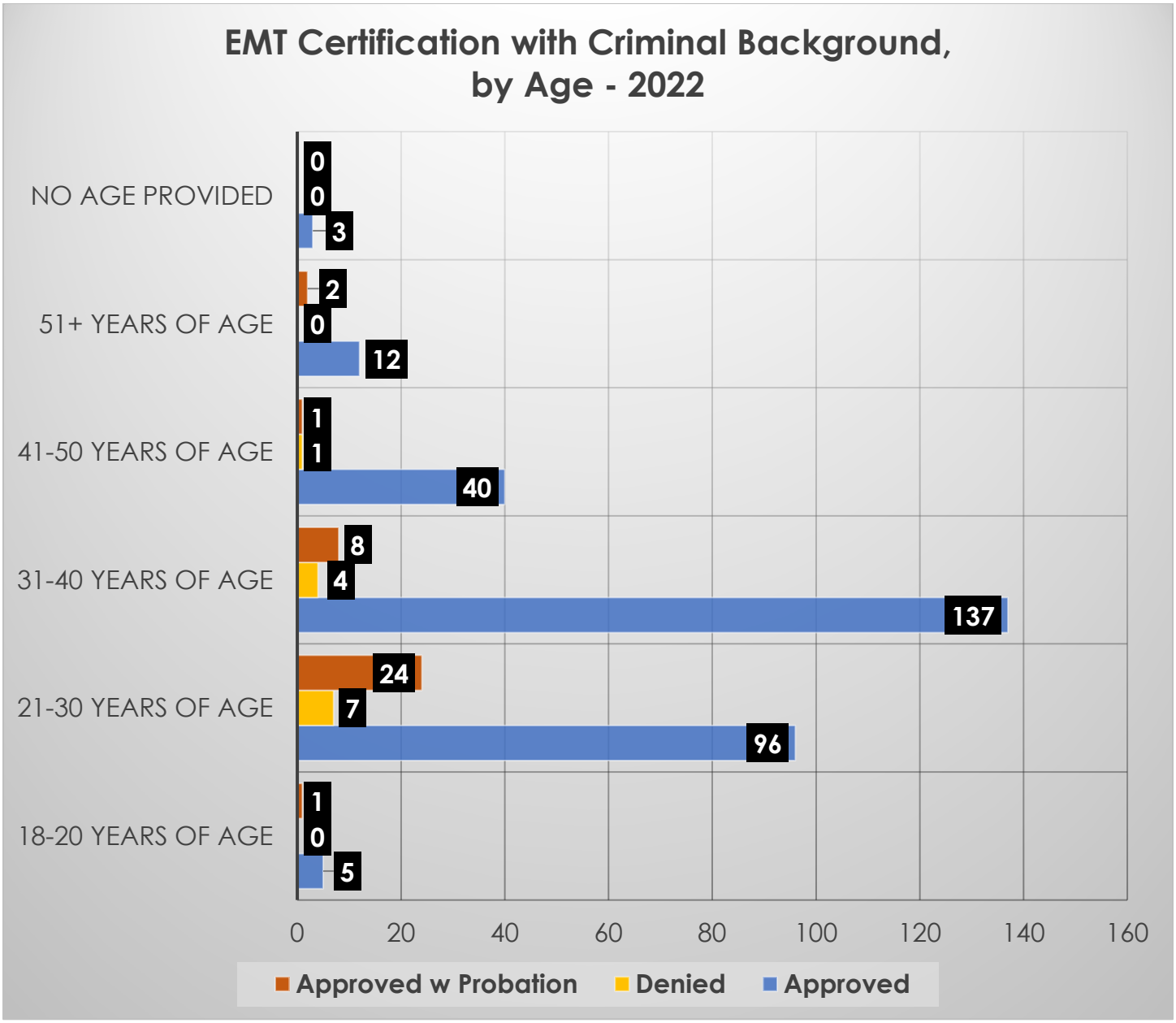


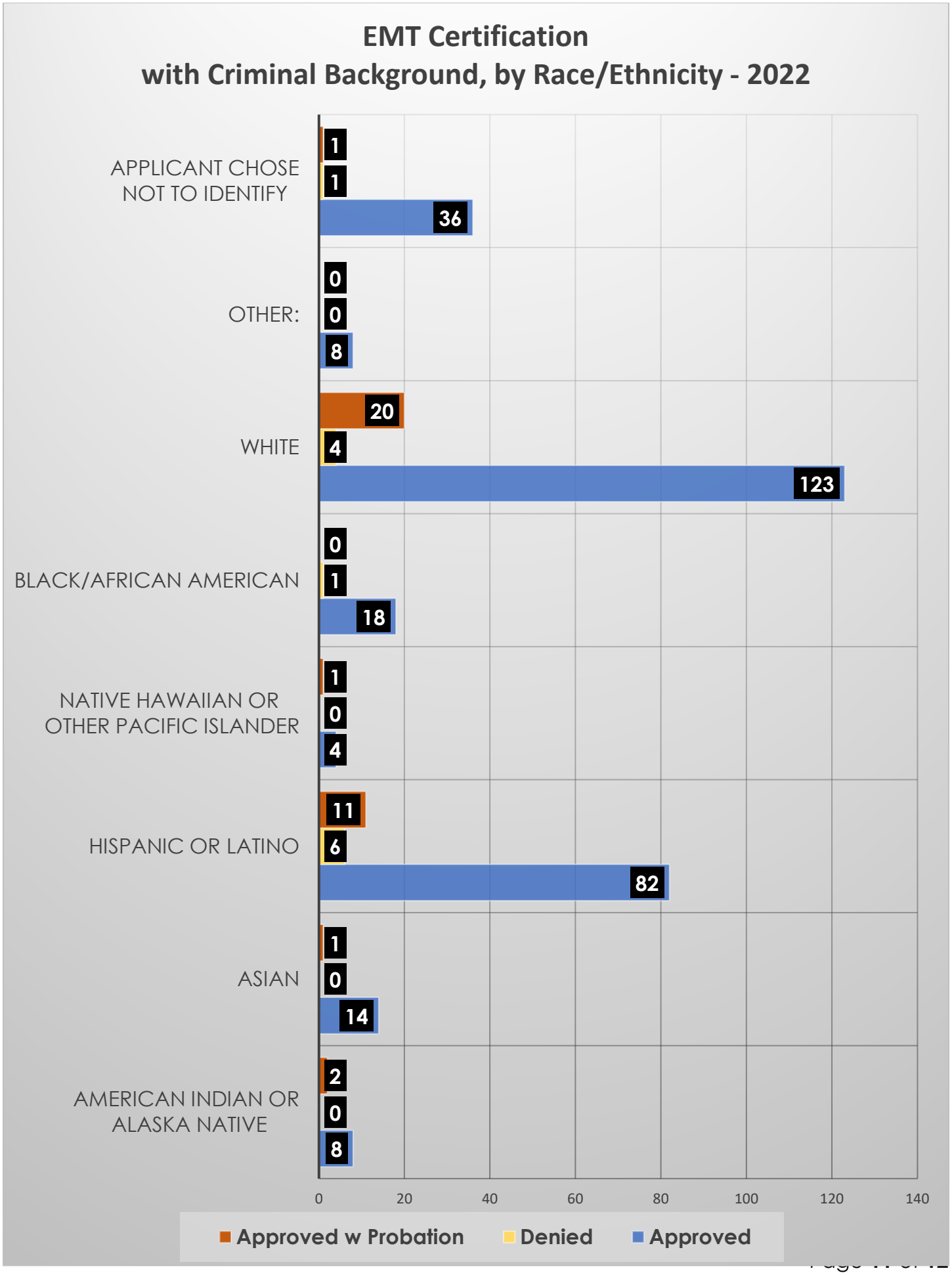
Appendix B: Applicants with Criminal History, Data Sets

SECTION	REASONS FOR DENIAL DUE TO CRIMINAL HISTORY	TOTAL
CCR §100214.3(c)	**The medical director shall deny or revoke an EMT or AEMT certificate if any of the following apply to the applicant:**	**7**
§100214.3(c)(5)	Has Been Convicted and Released from Incarceration for Said Offense During the Preceding Fifteen (15) Years for the Crime of Manslaughter or Involuntary Manslaughter.	1
§100214.3(c)(6)	Has been convicted and released from incarceration for said offense during the preceding ten (10) years for any offense punishable as a felony.	1
§100214.3(c)(7)	Has Been Convicted of Two (2) or More Misdemeanors Within the Preceding Five (5) Years for Any Offense Relating to the Use, Sale, Possession, or Transportation of Narcotics or Addictive or Dangerous Drugs.	1
§100214.3(c)(9)	Has been convicted within the preceding five (5) years of any theft related misdemeanor.	1
§100214.3(d)(1)	Has Committed Any Act Involving Fraud or Intentional Dishonesty for Personal Gain Within the Preceding Seven (7) Years.	3
HSC §1798.200(c)**	**Any of the following actions shall be considered evidence of a threat to the public health and safety and may result in the denial, suspension, or revocation of a certificate or license issued under this division, or in the placement on probation of a certificate holder or license holder under this division:**	**29**
§1798.200(c)(1)	Fraud in the procurement of any certificate or license under this division.	4
§1798.200(c)(5)	The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel.	3
§1798.200(c)(6)	Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction or a certified copy of the record shall be conclusive evidence of the conviction.	6
§1798.200(c)(7)	Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.	3
§1798.200(c)(8)	Violating or attempting to violate any federal or state statute or regulation that regulates narcotics, dangerous drugs, or controlled substances.	1
§1798.200(c)(9)	Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.	11
§1798.200(c)(11)	Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired.	1

**HSC §1798.200(c): Some denial data cited multiple actions for a single individual under the "may" deny categories.


Applicants with Criminal History, by Gender - 2022
APPLICANT CHOSE NOT TO IDENTIFY
FEMALE
MALE
0
1
6
8
1
41
28
10
246
0
50
100
150
200
250
300
Approved w Probation
Denied
Approved


EMT Certification with Criminal Background, by Age - 2022
NO AGE PROVIDED
0
0
3
51+ YEARS OF AGE
2
0
12
41-50 YEARS OF AGE
1
1
40
31-40 YEARS OF AGE
8
4
137
21-30 YEARS OF AGE
24
7
96
18-20 YEARS OF AGE
1
0
5
0
20
40
60
80
100
120
140
160
Approved w Probation
Denied
Approved


EMT Certification
with Criminal Background, by Race/Ethnicity - 2022
APPLICANT CHOSE NOT TO IDENTIFY
1
1
36
OTHER:
0
0
8
WHITE
20
4
123
BLACK/AFRICAN AMERICAN
0
1
18
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
1
0
4
HISPANIC OR LATINO
11
6
82
ASIAN
1
0
14
AMERICAN INDIAN OR ALASKA NATIVE
2
0
8
0
20
40
60
80
100
120
140
Approved w Probation
Denied
Approved

Aggregation of 2019-2022 Calendar-Year Summary Data						
Year	Applied	Disclosed History	Certified, No History Disclosed	Approved with History	Approved with Probation (with or without History)	Denied due to Conviction History
2019	9062	433	9026	347	56	17
2020	8277	393	8254	327	46	17
2021	9328	399	9231	335	50	14
2022	9191	367	9059	293	36	12
Average	**8965**	**398**	**8893**	**326**	**47**	**15**

Z-Score (Any Z-Score Value >2.0 indicates the datapoint is an outlier)						
Year	Applied	Disclosed History	Certified, No History Disclosed	Approved with History	Approved with Probation (with or without History)	Denied due to Conviction History
2019	0.24	1.49	0.35	1.07	1.24	0.94
2020	-1.69	-0.21	-1.69	0.07	-0.14	0.94
2021	0.89	0.04	0.90	0.47	0.41	-0.47
2022	0.56	-1.32	0.44	-1.62	-1.51	-1.42
Standard Deviation:	**407.92**	**23.52**	**377.55**	**20.07**	**7.28**	**2.12**

EMERGENCY MEDICAL SERVICES AUTHORITY
11120 INTERNATIONAL DR., SUITE 200
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13, 2023 **ITEM NUMBER: 6C**

SUBJECT: Opioid Crisis and Buprenorphine Presentation

PRESENTER: Hernando Garzon, MD

CONSENT: ___ ACTION: ____ INFORMATION: _X__

RECOMMENDATION: Receive information on the Opioid crisis and Buprenorphine

FISCAL IMPACT: No fiscal impact.

Attachments: Opioid Crisis and Buprenorphine Presentation

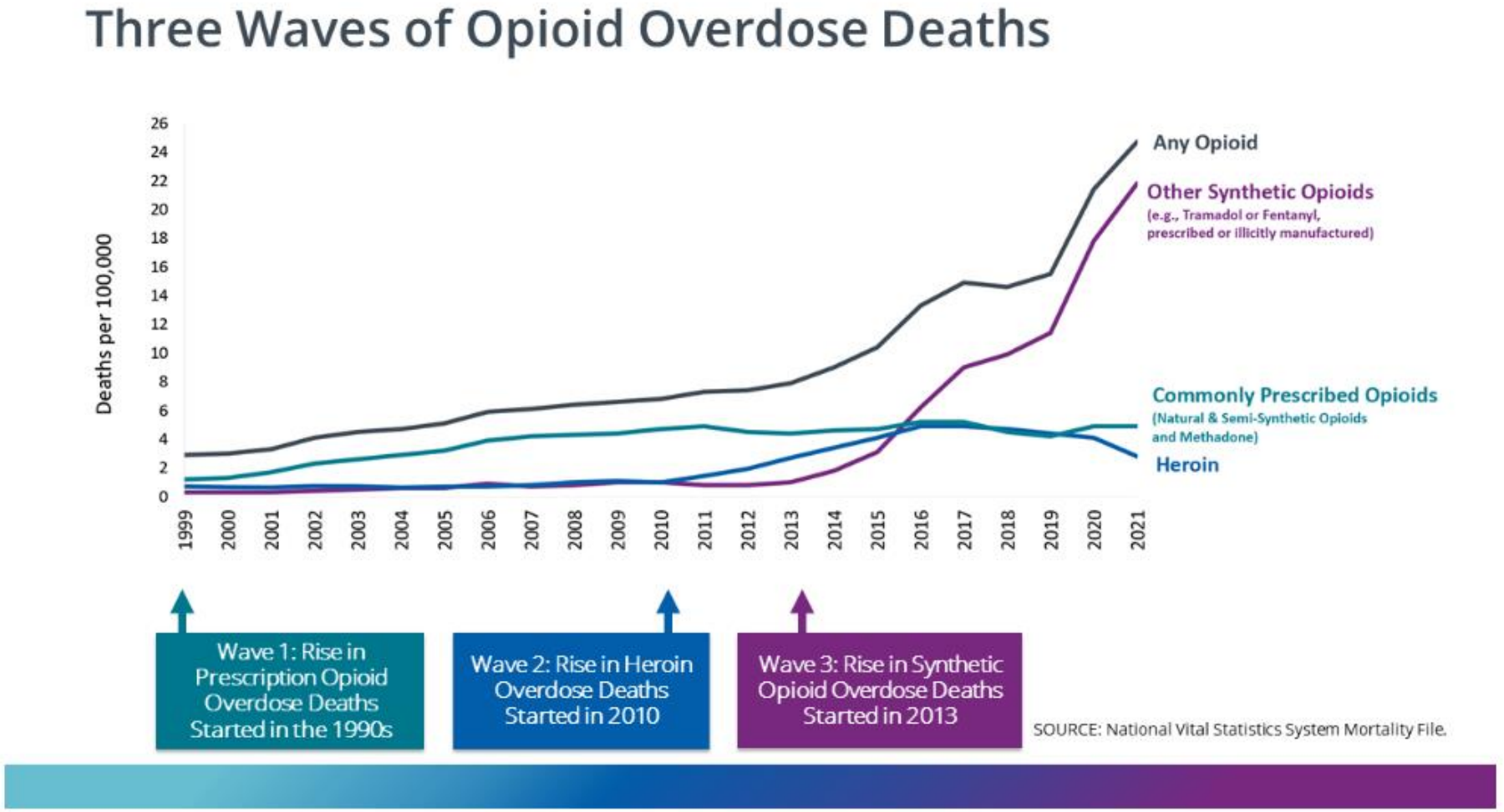
The Opiate Crisis and EMS

Hernando Garzon, MD
Acting Chief Medical Officer, EMSA
EMS Commission
December 13, 2023

Overview

- The Opiate Crisis – background and national stats
- The Opiate Crisis - California
- The Health System response
- CA Behavioral Health Initiatives
- EMS Leave Behind Naloxone Programs
- Bridge Program
- Buprenorphine administration by EMS

Three Waves of Opioid Overdose Deaths



From 1999-2021, nearly 645,000 people died from an overdose involving any opioid, including prescription and illicit opioids[1].

Source: Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2021. Available at http://wonder.cdc.gov.

Deadliest “Events” in US History

- 1. COVID-19 (1,127,000)
- 2. Civil War (750,000)
- 3. 1918 Flu (675,000)
- 4. Opiate OD s 1999-2021 (645,000)
- 5. HIV/AIDS (608,000)

The Opiate Crisis - National

- The number of people who died from a drug overdose in 2021 was over six times the number in 1999.
- The number of drug overdose deaths increased more than 16% from 2020 to 2021.
- Over 75% of the nearly 107,000 drug overdose deaths in 2021 involved an opioid.
- From 2020 to 2021:
  - Opioid-involved death rates increased by over 15%.
  - Prescription opioid-involved death rates remained the same.
  - Heroin-involved death rates decreased nearly 32%.
  - Synthetic opioid-involved death rates (excluding methadone) increased over 22%[1].

Source: Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2021. Available at http://wonder.cdc.gov.

8 Florida indictments charged Chinese companies and nationals with fentanyl crimes: DOJ

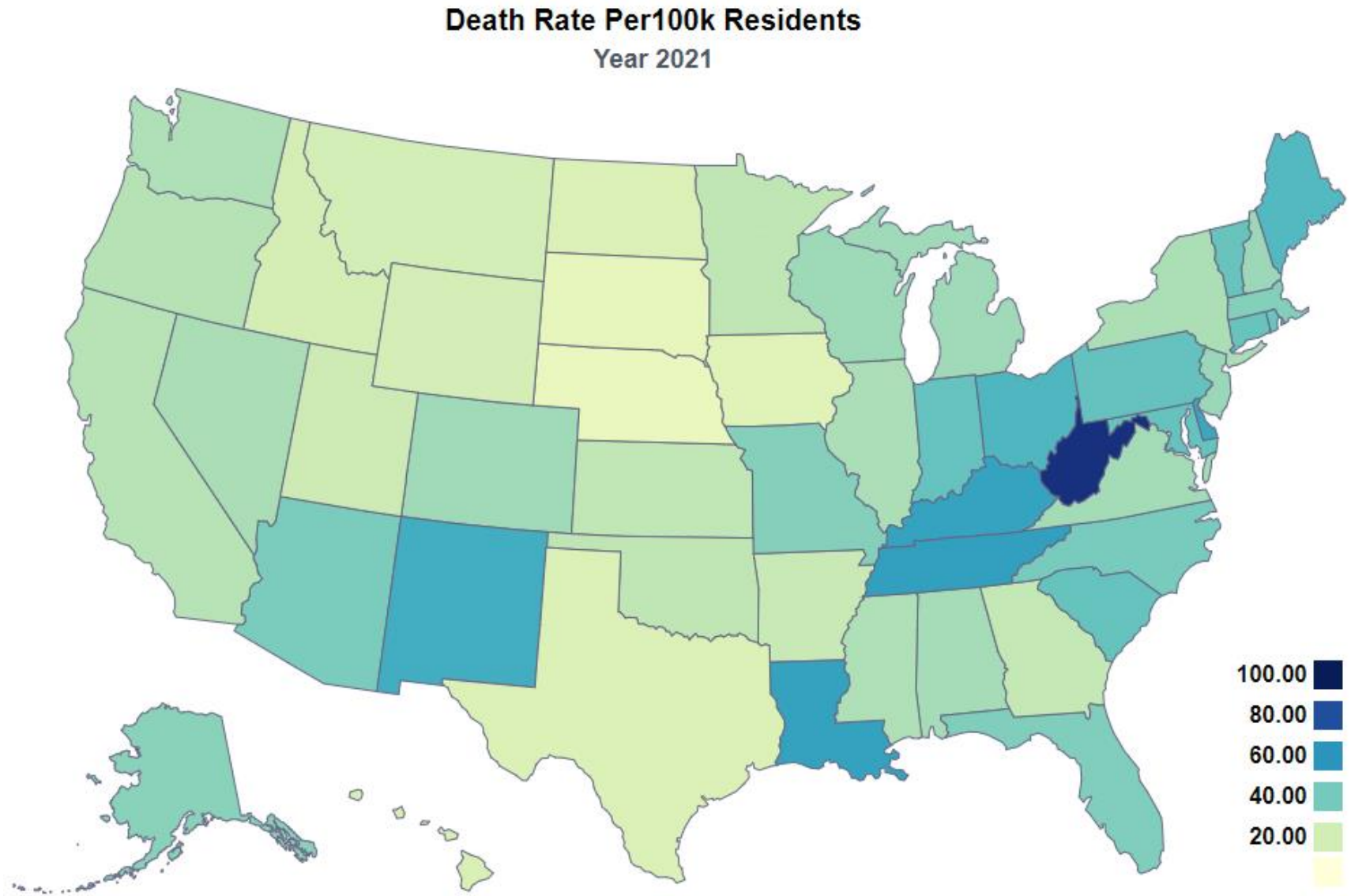
The latest charges build on prosecutions against Chinese-based chemical manufacturing companies and their executives for producing chemicals used to make fentanyl.

Bart Jansen
USA TODAY

Published 2:24 p.m. ET Oct. 3, 2023 | **Updated 2:50 p.m. ET Oct. 3, 2023**

Three indictments in the southern district of Florida charged three Chinese companies and four officers and employees with fentanyl trafficking, synthetic opioid trafficking, precursor chemical importation, defrauding the U.S. Postal Service, and making and using counterfeit postage.

“The international dimension to the deadly scourge of fentanyl requires the all-of-government response that we are delivering today,” Homeland Security Secretary Alejandro Mayorkas said in a statement.



Source: [Drug Overdose Mortality by State - Centers for Disease Control and Prevention]

Non-Fatal Opioid Overdose Surveillance Dashboard

September 11, 2022 – September 10, 2023

EMS Data Updated On: September 30, 2023

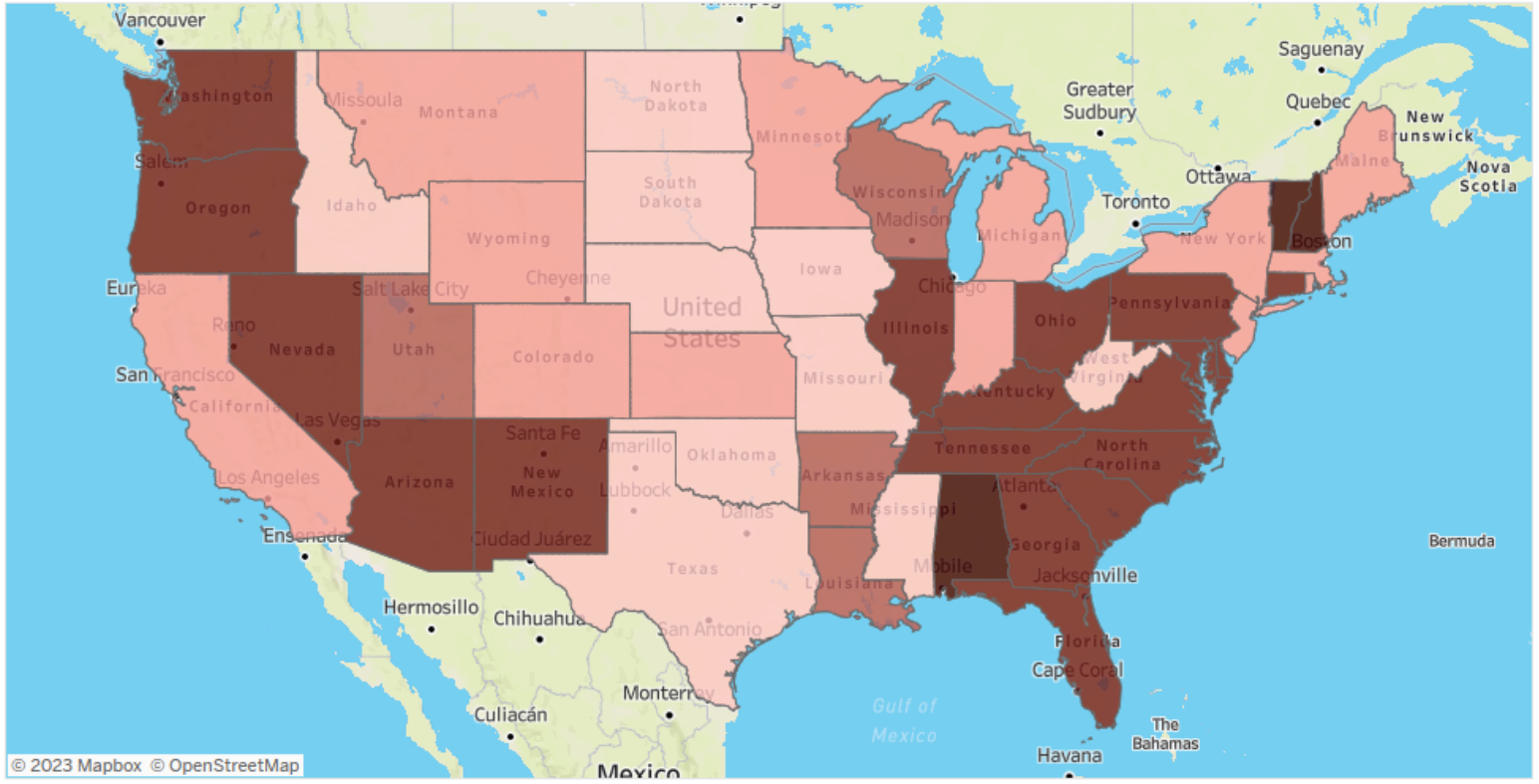
Select Time Period: Rolling 365 Days | Select Jurisdiction: (All) | Select Level of Geographic Detail: States | Select an Overdose Measure: Rate of Nonfatal Opioid Overdose | MVC-Related Non-Fatal Opioid Overdoses 2,656

Average EMS Time to Patient		Number of Opioid Overdoses		Rate of Nonfatal Opioid Overdose per 100k Population		Average Number of Naloxone Administrations per Overdose		Patients Not Transported to a Medical Facility	
Rolling 365 Days	% Change	Rolling 365 Days	% Change	Rolling 365 Days	% Change	Rolling 365 Days	% Change	Rolling 365 Days	% Change
9.9 minutes	+1.5%	213,845	-1.3%	64.9	-1.3%	1.0	+1.0%	22.2%	+5.2%

Top Jurisdictions

Rate of Nonfatal Opioid Overdose

1. District of Columbia
2. New Hampshire
3. Vermont
4. Alabama
5. New Mexico
6. Oregon
7. Connecticut
8. Washington
9. North Carolina
10. Illinois



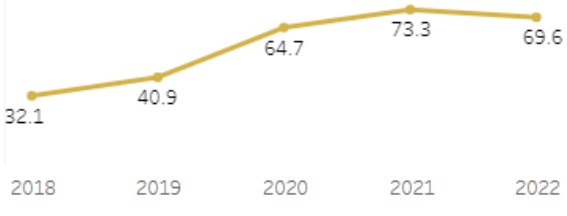
No/Limited Data Available
Zero or Much Lower Than Average
Lower than Average
Near National Average
Higher than Average
Much Higher than Average

Top Counties

Rate of Nonfatal Opioid Overdose

1. Menominee, Wisconsin
2. Roanoke (city), Virginia
3. Walker, Alabama
4. Portsmouth (city), Virginia
5. Mahnomen, Minnesota
6. Jasper, South Carolina
7. Rowan, North Carolina
8. Harmon, Oklahoma
9. Campbell, Tennessee
10. Philadelphia, Pennsylvania

National Rate of Nonfatal Opioid Overdose



Non-Fatal Opioid Overdose Surveillance Dashboard

September 11, 2022 – September 10, 2023

EMS Data Updated On: September 30, 2023

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- West Virginia
- Maryland
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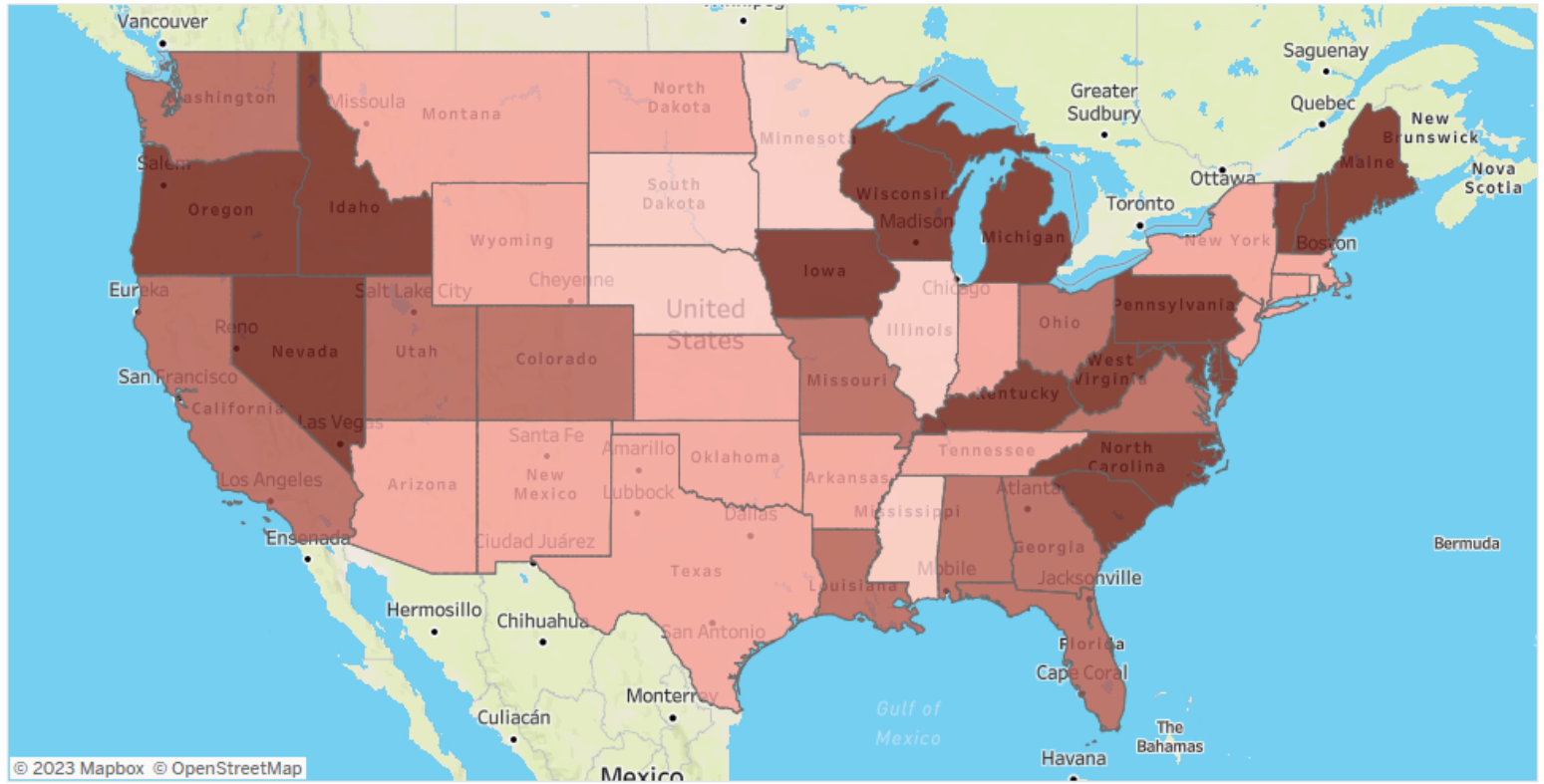


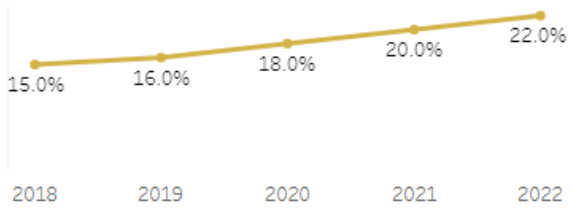
No/Limited Data Available
Zero or Much Lower Than Average
Lower than Average
Near National Average
Higher than Average
Much Higher than Average

Top Counties

Percent Not Transported to a Medical Facility

- Valdez-Cordova (CA), Alaska
- Cleburne, Arkansas
- Howard, Arkansas
- Nevada, Arkansas
- Crowley, Colorado
- Elbert, Colorado
- Grand, Colorado
- Gunnison, Colorado
- Teller, Colorado
- Lafayette, Florida

National Percent Not Transported to a Medical Facility



Non-Fatal Opioid Overdose Surveillance Dashboard

September 11, 2022 – September 10, 2023

EMS Data Updated On: September 30, 2023

Select Time Period: Rolling 365 Days | Select Jurisdiction: California | Select Level of Geographic Detail: Counties | Select an Overdose Measure: Rate of Nonfatal Opioid Overdose | MVC-Related Non-Fatal Opioid Overdoses 2,656

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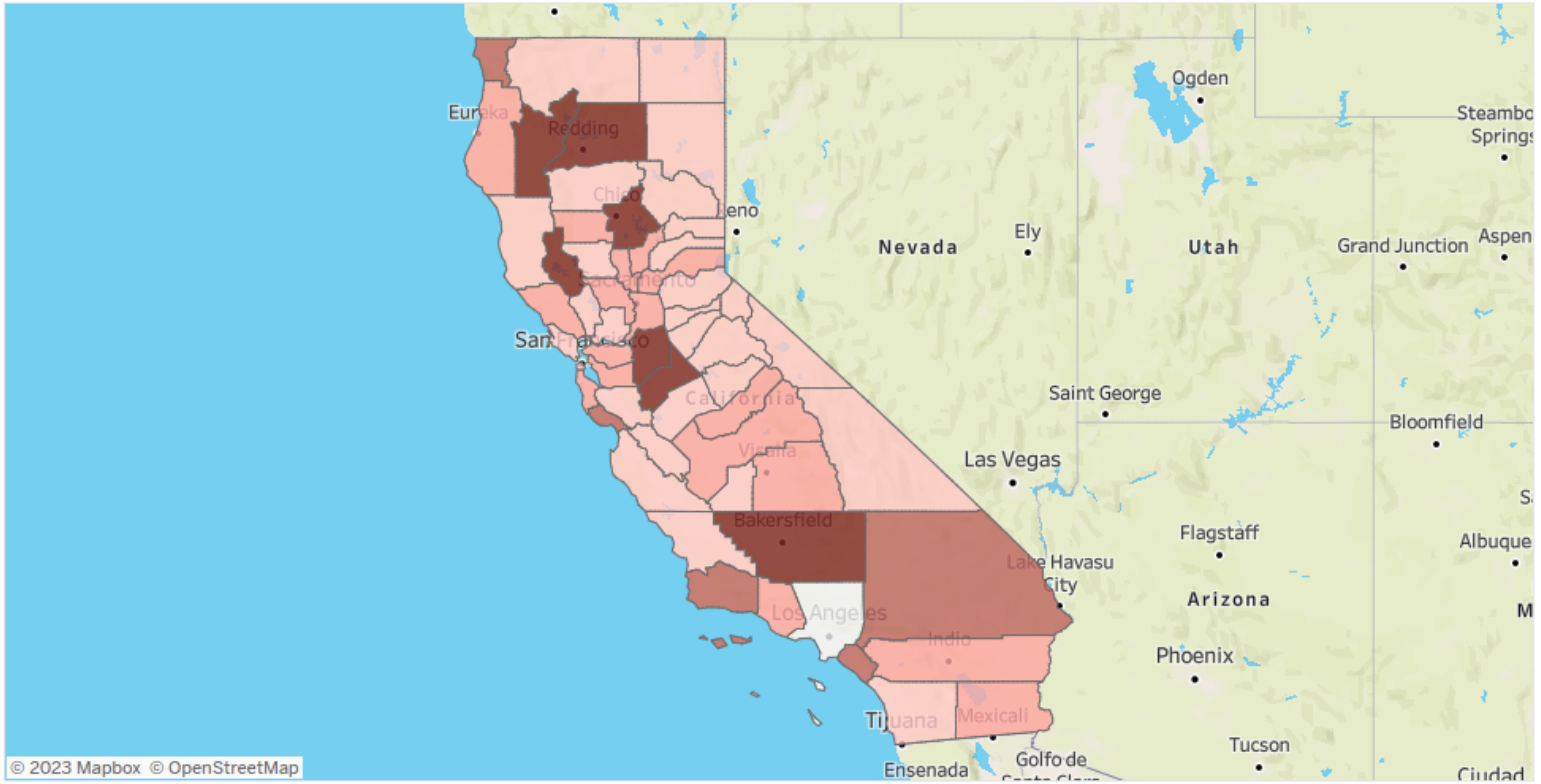

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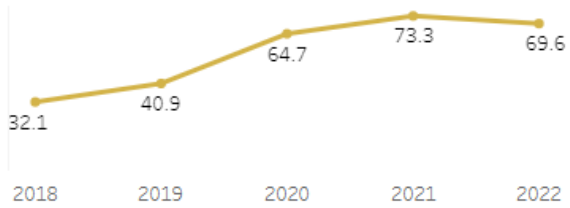
National Rate of Nonfatal Opioid Overdose



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September 11, 2022 – September 10, 2023

EMS Data Updated On: September 30, 2023

Select Time Period: Rolling 365 Days | Select Jurisdiction: California | Select Level of Geographic Detail: Counties | Select an Overdose Measure: Percent Not Transported to a Medical Facility | MVC-Related Non-Fatal Opioid Overdoses 2,656

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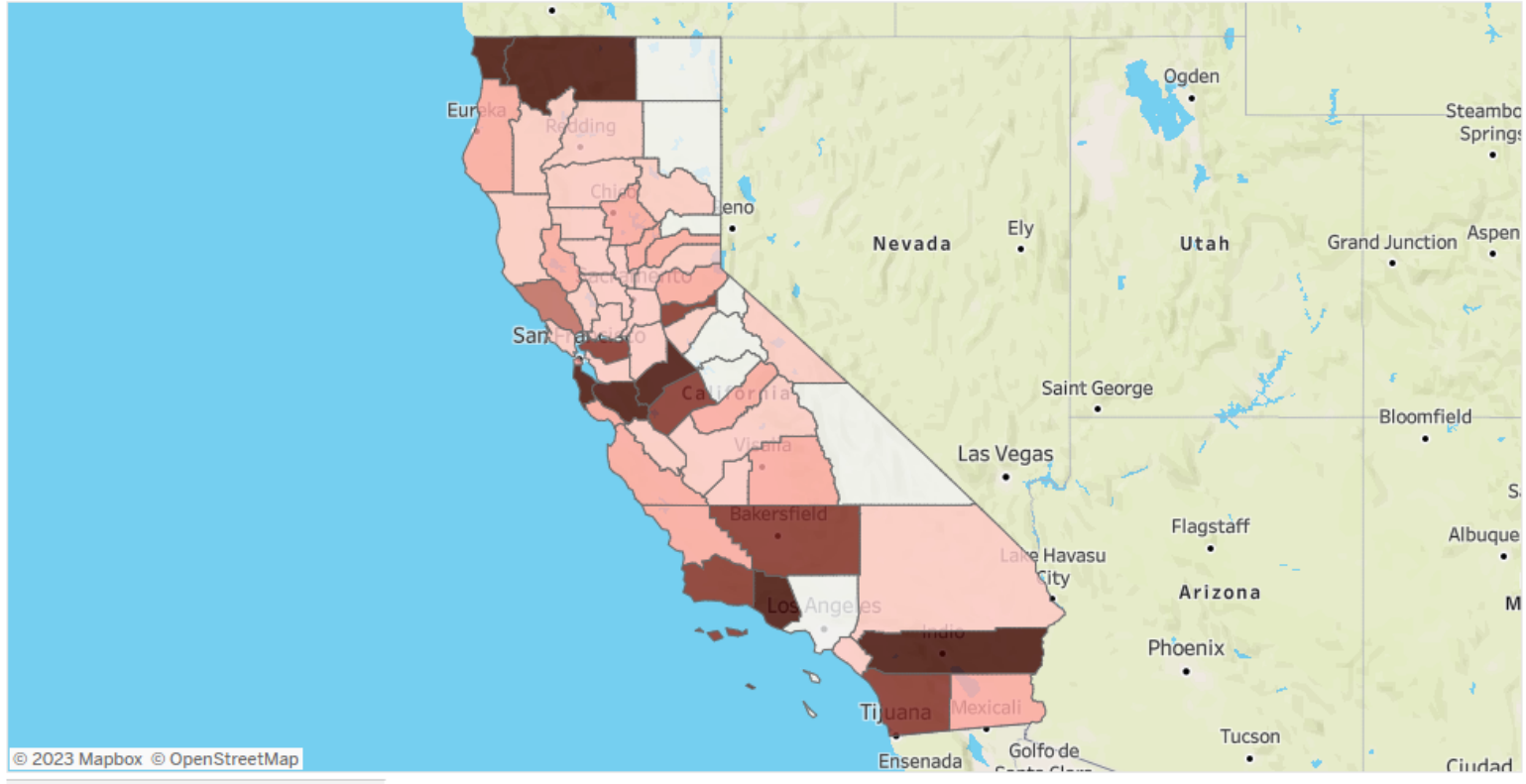
- Idaho
- North Carolina
- West Virginia
- Maryland
- South Carolina



- No/Limited Data Available
- Zero or Much Lower Than Average
- Lower than Average
- Near National Average
- Higher than Average
- Much Higher than Average

Top Counties

Percent Not Transported to a Medical Facility

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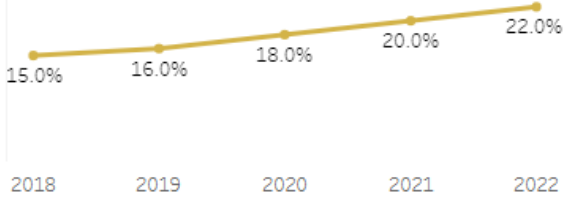
- Cleburne, Arkansas
- Howard, Arkansas
- Nevada, Arkansas
- Crowley, Colorado
- Elbert, Colorado
- Grand, Colorado
- Gunnison, Colorado
- Teller, Colorado
- Lafayette, Florida

National Percent Not Transported to a Medical Facility



The Health System Response – It takes a Village

Health Legislation and Funding

Behavioral Health Workforce
Care Economy Workforce: $1.4 billion for Care Economy Workforce investments, including funding to recruit and train 25,000 new community health workers as well as additional psychiatric providers.

Opioid Settlements Funds: $86 million to support opioid abatement programs, including, but not limited to, distribution of naloxone to homeless service providers, operation of a web-based statewide addiction treatment locator platform, support of vocational rehabilitation employment services, provider training on opioid treatment, and education and outreach campaigns.

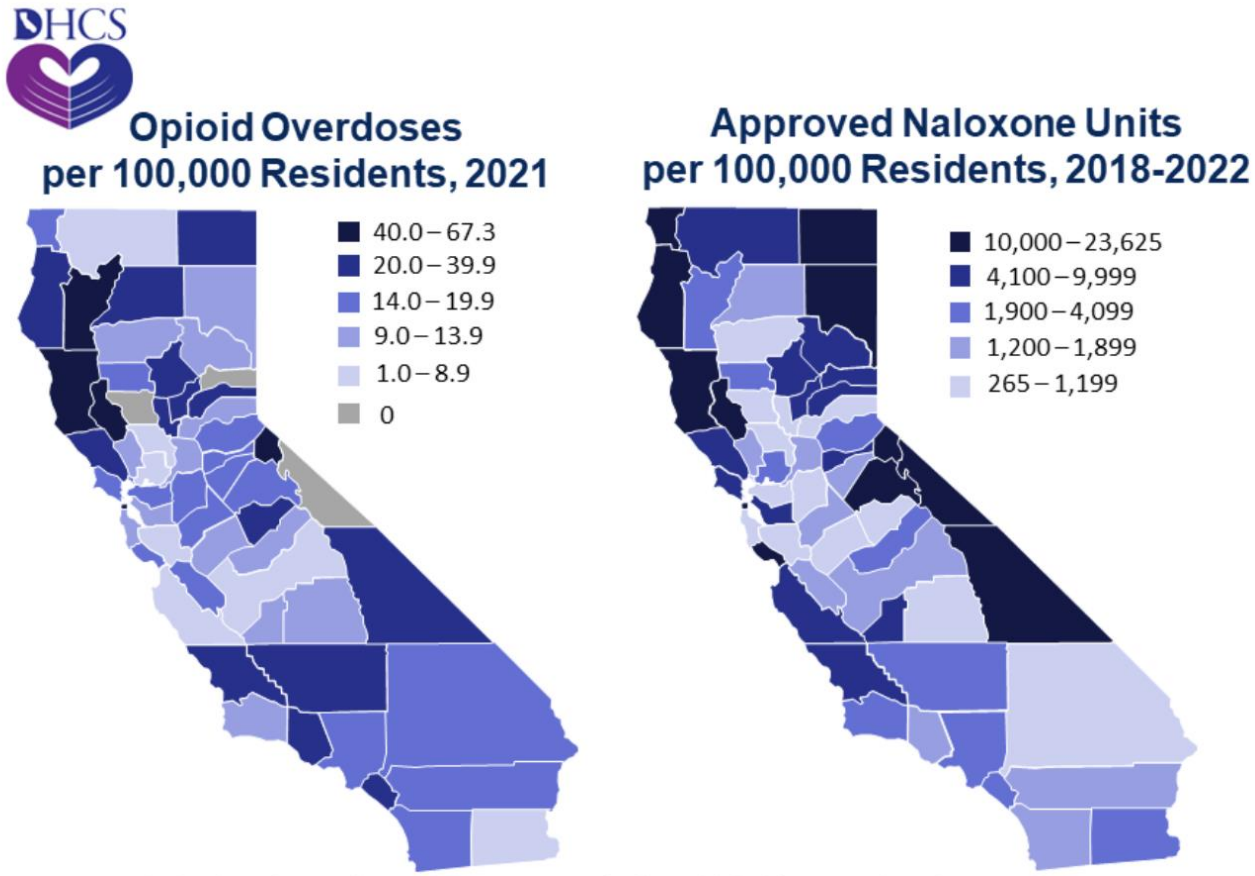
Medi-Cal Mobile Crisis Benefit: $1.4 billion to add qualifying community-based mobile crisis intervention services as a Medi-Cal covered benefit available to eligible Medi-Cal beneficiaries exclusively through the Medi-Cal behavioral health delivery system. Qualifying community-based mobile crisis intervention services will be available 24 hours a day, 7 days a week, and provided by a multidisciplinary mobile crisis team to Medi-Cal beneficiaries in the community.

DHCS Naloxone Distribution Project

- In 2018, DHCS created the Naloxone Distribution Project (NDP) using Substance Abuse and Mental Health Services Administration (SAMHSA) funding
- The NDP provides free naloxone *directly* to applicants to remove barriers in redistribution, avoid duplication and to track reported overdose reversals
- Since 2018, the NDP has spent $104,079,360 on naloxone for distribution to communities in California with **over 100,000 reported overdose reversals**
- Eligible Organization Type:
  - First responders, fire, EMS
  - Law enforcement, courts, & criminal justice partners
  - Community organizations, Harm reduction organizations, homeless programs, veteran organizations, religious organizations
  - Schools, universities, libraries
  - County public health or behavioral health agencies
  - Substance Use Recovery Facilities
  - Hospitals and Emergency Departments

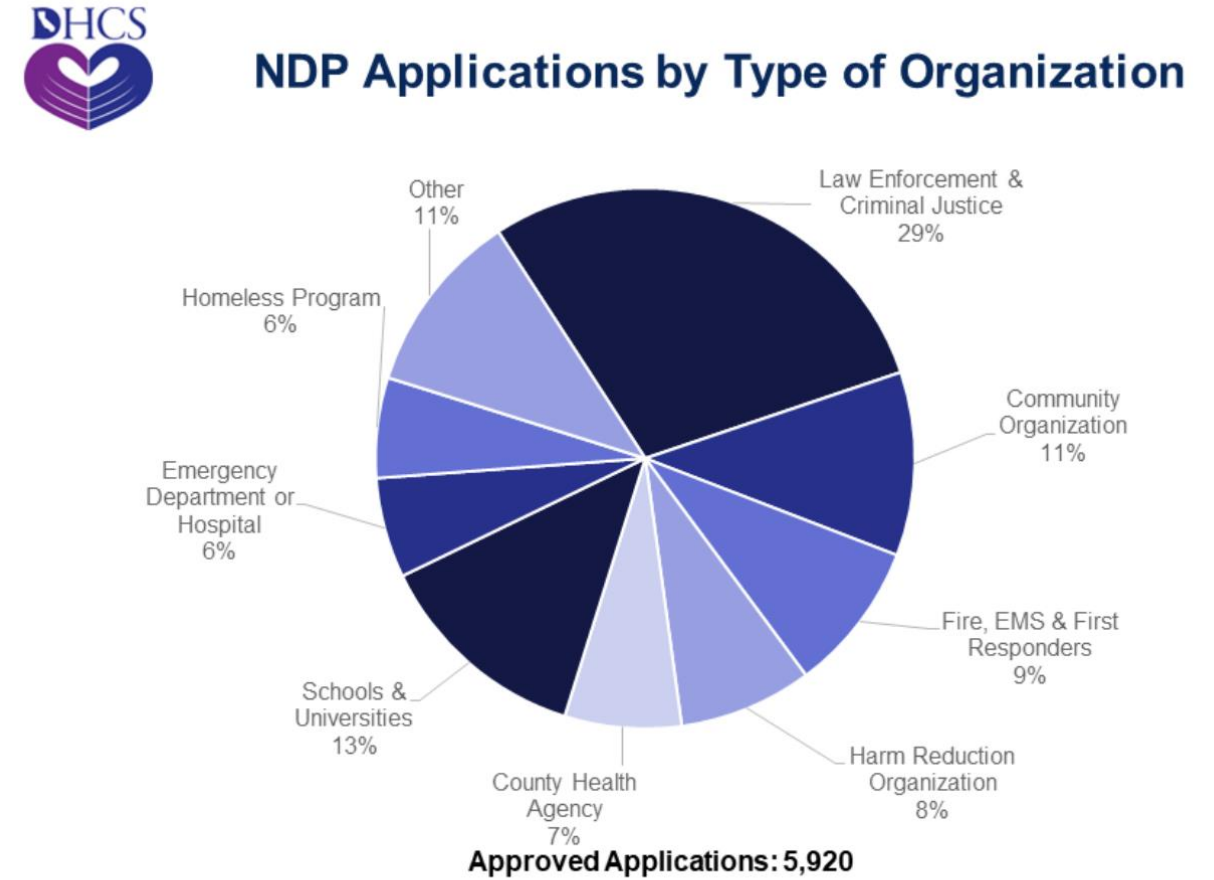
https://www.dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx

Opioid Overdoses and Approved Naloxone by County



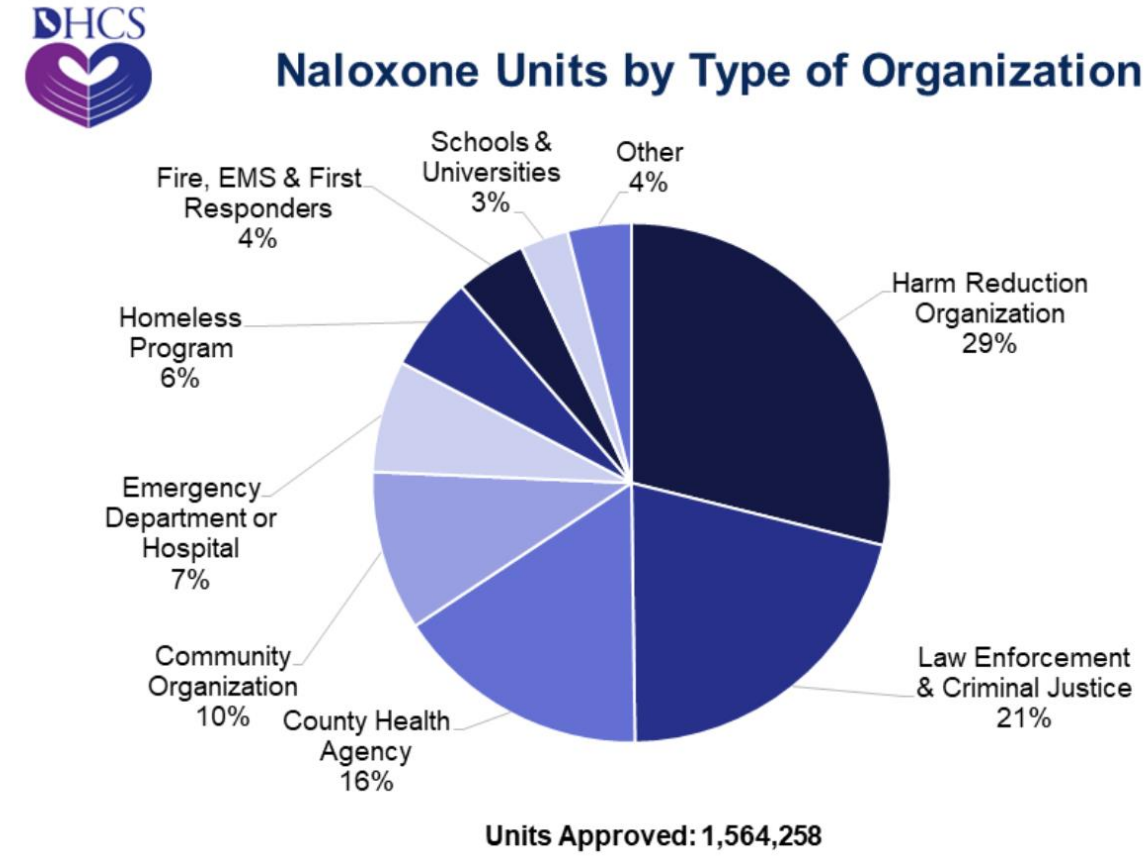
SOURCES: Any Opioid-Related Overdose Deaths – California Department of Public Health, "California Opioid Overdose Surveillance Dashboard"; accessed October 2022. Population data - State of California Department of Finance, "E-1 Cities, Counties, and the State Population Estimates with Annual Percent Change – January 1, 2021 and 2022"; accessed October 2022. Naloxone units as of November 4, 2022.

NDP Applications by Type of Organization



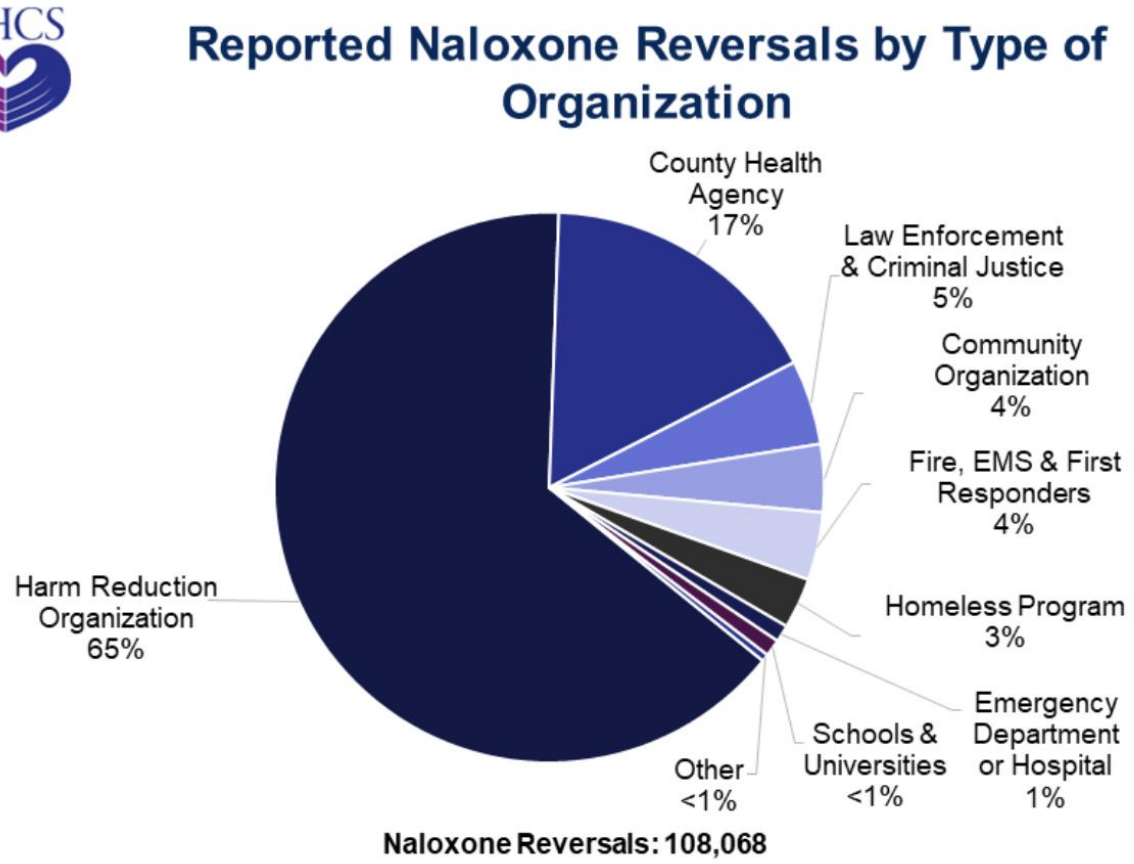
NOTE: Approved applications as of November 4, 2022.
Other category includes: Tribal entities, SUD treatment facilities, libraries, veteran's organizations, religious entities, and state agencies.

Naloxone Units by Type of Organization



NOTE: Naloxone units as of November 4, 2022.
Other category includes: SUD treatment facilities, libraries, veteran's organizations, religious entities, and state agencies.

Reported Naloxone Reversal by Type of Organization



NOTE: Reported naloxone reversals as of November 4, 2022.
Other category includes: SUD treatment facilities, libraries, veteran's organizations, religious entities, and state agencies.

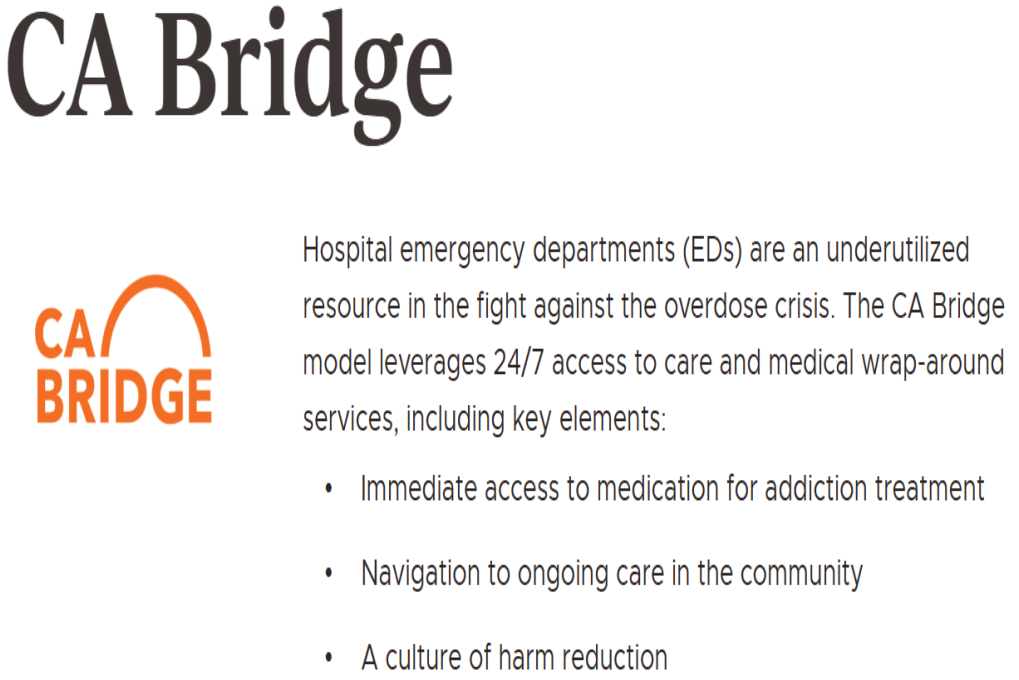
EMS Leave Behind Naloxone Programs

- LEMSA Survey 9/29/2023 – 15 responses
- In Use:
  - LA, Marin, Alameda, Contra Costa, ICEMA (San Bernardino), Riverside, Sacramento, Ventura, Kern, San Francisco, San Diego
- Developing or considering:
  - Imperial, Santa Clara, Santa Barbara
- Does Not Have:
  - Napa, Merced

Naloxone Administration by PSFA

- All LEMSAs have created policies to promote/support administration of Naloxone by Public Safety / First Aid personnel – Law enforcement, Fire Fighters, Lifeguards, Parks Department Personnel.

Bridge - bridgetotreatment.org



- "We fund and support providers to build on our country's guarantee of 24/7 emergency care to offer treatment where people are, promote equity, and connect patients to ongoing care."
  - CA Bridge
  - EMS Bridge
  - National Bridge Network

EMS Bridge

We engage EMS in the treatment of Opioid Use Disorder

To save lives and improve patient outcomes, we engage EMS agencies and personnel in the treatment of opioid use disorder (OUD) and the prevention of opioid overdose. Under our EMS Bridge model, eligible patients are treated with buprenorphine from the ambulance. Paramedics use motivational interviewing to engage patients and encourage them to be seen at a nearby Emergency Department that treats OUD. All patients receive follow-up from a patient navigator who connects them to ongoing substance use disorder care. Paramedics also distribute naloxone to patients and their friends and family to prevent future overdose deaths.

We provide resources to help EMS agencies launch their own pilots to prevent overdose and treat OUD.

1. Naloxone Distribution
2. Treating opioid use disorder with buprenorphine in the field
3. Engaging patients through motivational interviewing

Buprenorphine

- For opioid use disorder, it is typically started when withdrawal symptoms have begun and for the first two days of treatment under direct observation of a health-care provider
- In the treatment of opioid use disorder buprenorphine is an agonist/antagonist - it relieves withdrawal symptoms from other opioids and induces some euphoria, but also blocks the ability for many other opioids, including heroin, to cause an effect
- EMS administration is intended to relieve withdrawal symptoms and encourages the patient to accept transport to the ED where they can be started on treatment and connected with services
- First started as a trial study in Contra Costa, and in December 2022 EMS Commission voted to add it to Optional Scope
- Now optional scope in 11 LEMSAs (2023)

PREHOSPITAL EMERGENCY CARE
https://doi.org/10.1080/10903127.2022.2061661

Taylor & Francis
Taylor & Francis Group

Prehospital Buprenorphine Treatment for Opioid Use Disorder by Paramedics: First Year Results of the EMS Buprenorphine Use Pilot

H. Gene Hern[a], Vanessa Lara[b], David Goldstein[c], M. Kalmin[d], S. Kidane[c], S. Shoptaw[d], Ori Tzvieli[e], and Andrew A. Herring[a]

[a]EMS Project Director, CA Bridge, Emergency Medicine, Alameda Health System – Highland Hospital, Oakland, California; [b]CA Bridge, Emergency Medical Services Division, Oakland, California; [c]Emergency Medical Services, Contra Costa County, Martinez, California; [d]UCLA Center for Behavioral and Addiction Medicine, Los Angeles, California; [e]Public Health Agency, Contra Costa County, Martinez, California

ABSTRACT

Background: Prehospital initiation of buprenorphine treatment for Opioid Use Disorder (OUD) by paramedics is an emerging potential intervention to reach patients at greatest risk for opioid-related death. Emergency medical services (EMS) patients who are at high risk for overdose deaths may never engage in treatment as they frequently refuse transport to the hospital after naloxone reversal. The potentially important role of EMS as the initiator for medication for opioid use disorder (MOUD) in the most high-risk patients has not been well described.

Setting: This project relies on four interventions: a public access naloxone distribution program, an electronic trigger and data sharing program, an "Overdose Receiving Center," and a paramedic-initiated buprenorphine treatment. For the final intervention, paramedics followed a protocol-based pilot that had an EMS physician consultation prior to administration.

Results: There were 36 patients enrolled in the trial study in the first year who received buprenorphine. Of those patients receiving buprenorphine, only one patient signed out against medical advice on scene. All other patients were transported to an emergency department and their clinical outcome and 7 and 30 day follow ups were determined by the substance use navigator (SUN). Thirty-six of 36 patients had follow up data obtained in the short term and none experienced any precipitated withdrawal or other adverse outcomes. Patients had a 50% (18/36) rate of treatment retention at 7 days and 36% (14/36) were in treatment at 30 days.

Conclusion: In this small pilot project, paramedic-initiated buprenorphine in the setting of data sharing and linkage with treatment appears to be a safe intervention with a high rate of ongoing outpatient treatment for risk of fatal opioid overdoses.

ARTICLE HISTORY
Received 8 February 2022
Revised 14 March 2022
Accepted 15 March 2022

Buprenorphine LOSOP			
LEMSA	Date LOSOP Approved	Doses Given 2022	Doses Given 2023 (to 10/31/2023)
Alameda	Jun-23		5
Contra Costa	Jan-21	45	16
Inland Counties	Jun-23		
Kern	Dec-22		
Monterey	Dec-22		7
Riverside	Jun-23		
San Benito	Dec-22		1
San Diego	Dec-22		0
San Francisco	Dec-22		12
Santa Cruz	Dec-22		6
Yolo	Dec-22		0

It Takes A Village
Thank you!
Questions?

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13,2023 **ITEM NUMBER: 6D**

SUBJECT: ICEMA Trail study report

PRESENTER: Kim Lew

CONSENT: ___ ACTION: ____ INFORMATION: __X_

DISCUSSION:

The Commission shall review the attached ICEMA trial study report within two (2) meetings and **advise** the Authority to do one of the following:

(1) Recommend termination of the study if there are adverse effects or no benefit from the study is shown.
(2) Recommend continuation of the study for a maximum of eighteen (18) additional months if potential but inconclusive benefit is shown.
(3) Recommend the procedure, or medication, be added to the paramedic basic or local optional scope of practice (LOSOP).

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ATTACHMENT(S)7D1

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October 7, 2021

Reza Vaezazizi, MD
EMS Medical Director
Inland Counties Emergency Medical Services
1425 South "D" Street
San Bernardino, CA 92415-0060

Dear Dr. Vaezazizi:

The purpose of this letter is to advise you that your request for approval of a trial study on the use of Point of Care Ultrasound (POCUS) in the prehospital setting is approved.

Your request was reviewed in consultation with the members of the Emergency Medical Directors Association (EMDAC) on October 7, 2021. The recommendation from the group, and I concur, was to approve your request.

Please advise the Emergency Medical Services Authority (EMSA) via email, scopeofpractice@emsa.ca.gov, of the date that the trial study will begin enrolling students and, 18-months from the start date, a trial study report 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 POCUS to the paramedic basic or local optional scope of practice.

If you have questions, please contacted Laura Little of my staff by phone at (916) 431-3677 or by email at ScopeofPractice@emsa.ca.gov.

Sincerely,

Dave Duncan, MD
Director

cc: Tom Lynch, EMS Administrator, Inland Counties EMS Agency

PARAMEDIC PREHOSPITAL UTILIZATION OF ULTRASOUND (TRIAL STUDY)

I. PURPOSE

To establish authority and parameters for the prehospital use of Prehospital Point of Care Ultrasound (POCUS) as part of a trial study.

II. INCLUSION CRITERIA

Paramedic application of POCUS should be considered to help guide treatment during any of the following conditions.

- Suspected Tension Pneumothorax as a result of blunt or traumatic injury
  - absent or decreased breath sounds and
  - signs of hemodynamic compromise (shock).
- Persistent cardiac arrest with fine ventricular fibrillation, asystole, or PEA.
- Confirm placement of endotracheal tube.in conjunction with $EtCO_2$
- Placement of vascular access when impeded by patient condition

III. CONTRAINDICATIONS

Any circumstance where application of POCUS, or interpretation of the study findings may delay patient care or transportation to the emergency department.

IV. PROCEDURE

Paramedics participating in the study must evaluate each patient to determine whether they meet criteria and indications for performing POCUS. This assessment is not intended to replace clinical judgement or currently employed techniques for treatment. It is intended to augment the paramedic's diagnostic tools and verify or eliminate differential diagnoses considered.

Only paramedics meeting the following criteria may utilize the POCUS

- May only use the Butterfly IQ Handheld Ultrasound Device approved for use in the trial study.
- Be authorized by an EMS Provider who is participating in the study and has purchased the trial study equipment and supplies.
- Received training in use of the Butterfly IQ handheld ultrasound device and meets all trial study requirements.

V. DOCUMENTATION REQUIREMENTS

- ICEMA requirements for documentation and collection and submission of EMS data must be followed.
- All images captured by POCUS must be archived in the "cloud" for review.

- The IRB, Trauma Center involved in the care of the transported patient, ICEMA, and Medical Director for the agency involved in the patient care must be advised, and the PI must be informed within 24 hours if either of the following occur:

  - Needle decompression in setting of normal lung sliding
  - Termination of resuscitation efforts in the setting of fine v-fib mistaken for asystole.

V. Quality Assurance

- EMS Providers, participating in the Trial Study, must review 100% of the uses for quality of imaging and proper application of the device and by verifying use it is within the approved IRB guidelines and ICEMA Policy.

- The investigation team will review a sample of each agency's studies obtained and verify the quality is adequate for the purposes of the trial study.

Update on the Implementation of Prehospital Ultrasound Educational Program for Paramedics

Inland Counties Emergency Medical Agency (ICEMA)
Riverside county EMS Agency (REMSA)

Ricardo Padilla, M.D. Austin Toole BS, EMPT, Steven Wells EMPT, Carly Crews RN, Kevin Deardon EMPT, Deepak Chandowani MD, Troy Pennington DO, MS, Reza Vaizazizi MD, Stephen Patterson MD, Rodney Borger MD, Fanglong Dong PhD, Michael M. Neeki DO, MS

Objective

- Demonstrate that paramedics can safely use ultrasound in the prehospital environment with an improvement in certain critical patients without delay in the transport time to the designated hospital.

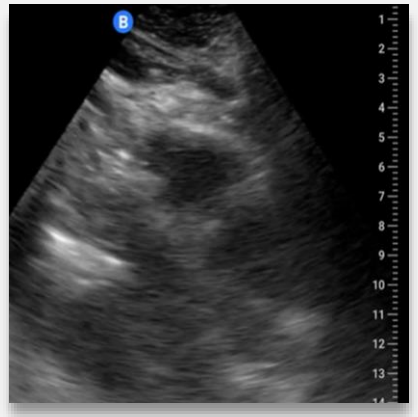


Image I: : A limited transthoracic cardiac view performed by a paramedics in the prehospital setting on a 72-year-old female with witnessed cardiac arrest. On EMS arrival, ACLS measures were initiated. The cardiac monitor indicated ventricular fibrillation, in turn, the patient was defibrillated. Patient received two doses of epinephrine and amiodarone. The monitor showed sinus tachycardia, however, no palpable pulses were detected. The portable ultrasound revealed sufficient cardiac activity leading to transfer to cardiac center for cardiac catheterization.

Methods: Prospective Observational

Phase 1: Training

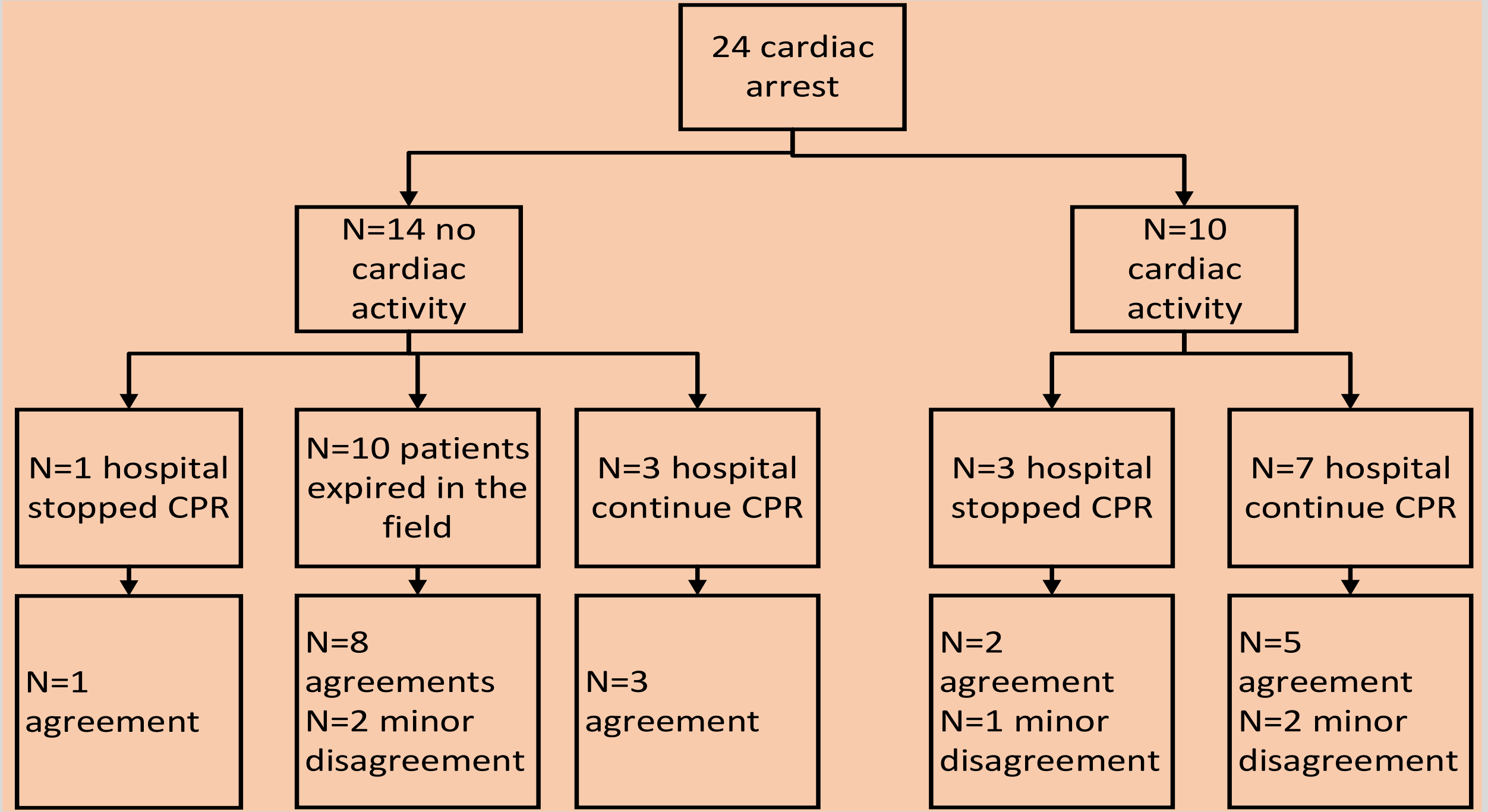
- **Initial didactic session**
- **Prove competency with an exam**

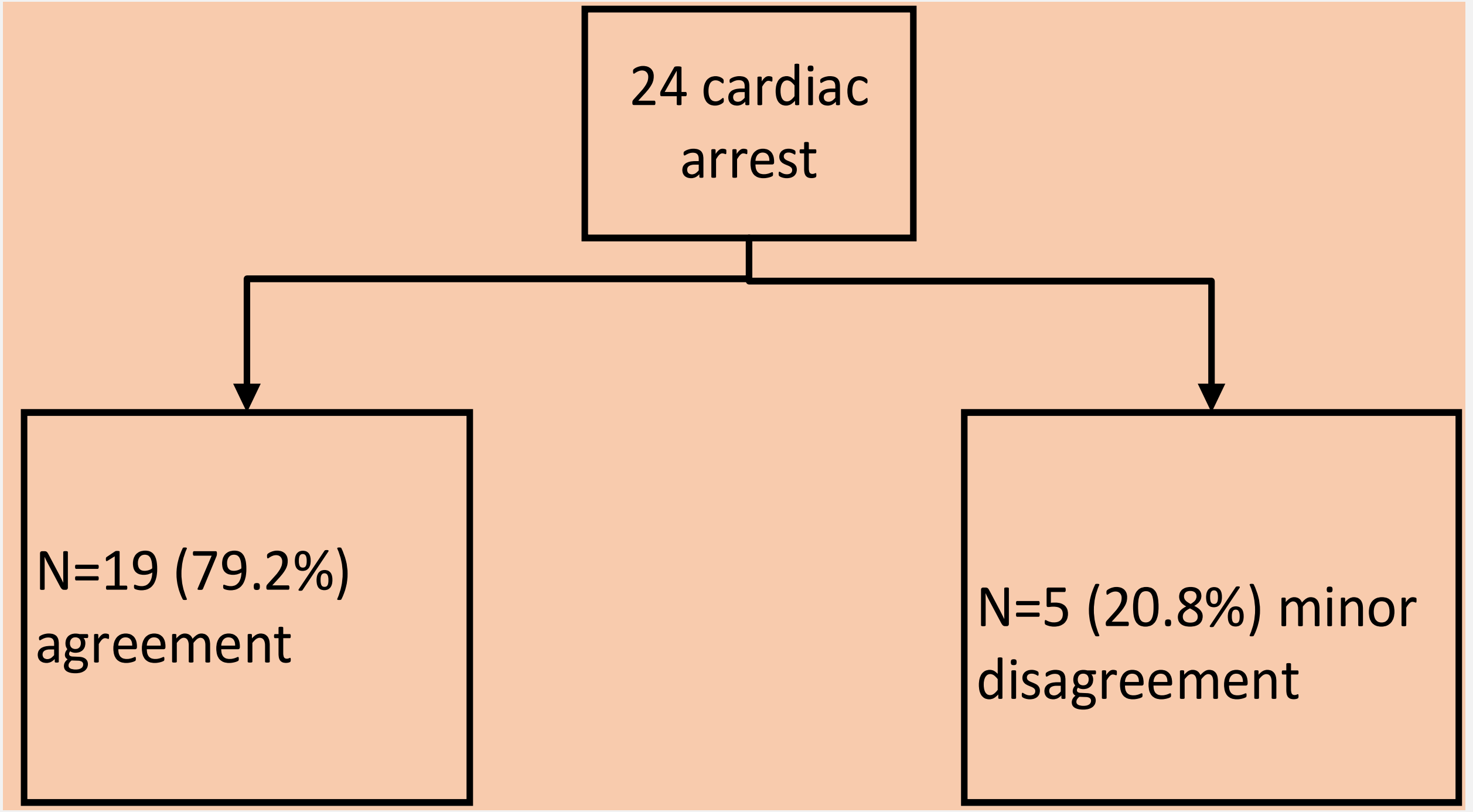
Phase 2: Deployment

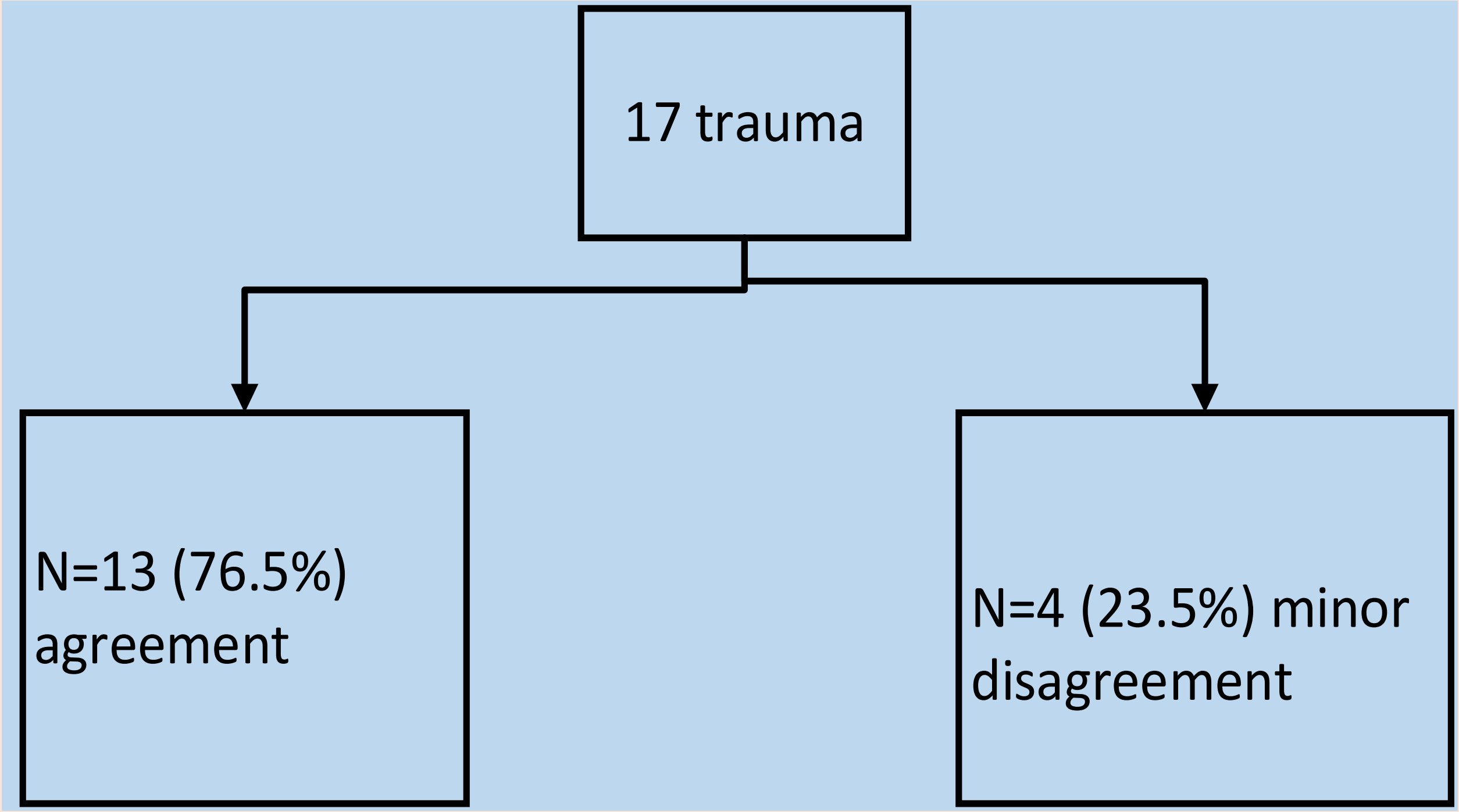
- **Ultrasound used by paramedics to evaluate**
  - **Pneumothorax**
  - **Intra-abdominal bleeding**
  - **Cardiac arrest**
- **Paramedics upload images to a secure cloud server and complete a survey that is matched up to each study creating a data point.**
- **Data evaluation**
  - **Agreement between paramedics & two physicians (EM Boarded, US fellowship trained)**

Results (Inclusion dates 3/8/22-2/26/23)

- **EMS Agencies are still loading images after the initial data analysis period.**
- **33 images were excluded because of missing data.**
- **A total of 41 patients were included in the analysis.**
- **More than half (65.9%, n=27) were males.**
- **The average age of the patients was 62.7 ± 13.4 years. (Range 27-95 years old).**
- **There are 24 cardiac arrests and 17 trauma events.**
- **Agreement between paramedic and physician's interpretation of each case was reached in 32 out of the 41 patients and included in the final analysis.**
- **The nine disagreements were minor, meaning there was no change in the outcome of the patient as result of the disagreement.**


24 cardiac arrest
N=14 no cardiac activity
N=10 cardiac activity
N=1 hospital stopped CPR
N=10 patients expired in the field
N=3 hospital continue CPR
N=3 hospital stopped CPR
N=7 hospital continue CPR
N=1 agreement
N=8 agreements N=2 minor disagreement
N=3 agreement
N=2 agreement N=1 minor disagreement
N=5 agreement N=2 minor disagreement


24 cardiac arrest
N=19 (79.2%) agreement
N=5 (20.8%) minor disagreement


17 trauma
N=13 (76.5%) agreement
N=4 (23.5%) minor disagreement

Disagreements

Do you agree with the paramedic's interpretation of the image?	Comments by physicians:
No	Cardiac activity present
No	Negative RUQ
N0	RUQ positive
Good quality, No Medic interpretation was provided	No interpretation
Poor quality study	Rib shadow
Poor quality study	Rib shadow
Poor quality study	Rib shadow, lung scan too deep
Poor quality study	Good window, no video filled
Poor quality study	Rib shadow
Poor quality study	Lung scan too deep
Poor quality study	Kidney not seen
Poor quality study	Rib shadow

Conclusions

- Paramedics can be adequately trained to safely utilize ultrasound in the prehospital environment with feasible benefits to patients with critical conditions.
- The ultrasound technology present a unique opportunity to improve quality of critical care in the prehospital arena.

Scan me!

Suggestions & Recommendations

- **US is safe tool to be added to the paramedic toolbox.**
- **Non-invasive**
- **Requires minimal training at the start but need to have active participation and frequent practice to maintain the skills.**
- **Need direct EMS coordinator and medical director involvement both in maintenance of the training and design of the QI program for each participating agencies.**
- **Recommend to be a part of local scope of practice program to allow expansion by those agencies that can commit funding and education.**
- **Expansion of the use in various clinical setting based on the direct supervision of the medical director.**

Presentations

- Submitted to ICEMA MAC committee 6/22.

- Padilla R, Toole A, Wells S, Crews C, Deardon K, Chandowani D, Pennington T, Vaezazizi R, Patterson S, Borger R, Dong F, **Neeki MM.** Implementation of Prehospital Ultrasound Educational Program for Paramedics. Update from The Field. Submitted to the annual NEMSP meeting 2024.
- Padilla R, Toole A, Wells S, Crews C, Deardon K, Chandowani D, Pennington T, Vaezazizi R, Patterson S, Borger R, Dong F, **Neeki MM.** Implementation of Prehospital Ultrasound Educational Program for Paramedics. Update from The Field. 17th Annual Arrowhead Regional Medical Center Research Day. Colton CA. May 28, 2023. Abstract published, and poster presented.
- Padilla R, Toole A, Wells S, Crews C, Deardon K, Chandowani D, Pennington T, Vaezazizi R, Patterson S, Borger R, Dong F, **Neeki MM.** Implementation of Prehospital Ultrasound Educational Program for Paramedics. Update from The Field. 5th Annual California University of Science and Medicine Research & Scholarly Activity Symposium. April 28, 2023. Colton, CA. Abstract published, and poster presented.

References

- 1. Eadie, L., Mulhern, J., Regan, L., Mort, A., Shannon, H., Macaden, A., & Wilson, P. (2018). Remotely supported prehospital ultrasound: A feasibility study of real-time image transmission and expert guidance to aid diagnosis in remote and rural communities. Journal of Telemedicine and Telecare, 24(9), 616-622 doi: 10.1177/1357633X17731444 2. Butterfly Network (2020) Butterfly iQ Personal Ultrasound System User Manual. Butterfly Network Inc. Guilford. 7-12 3. Levine, R. A., McCurdy, T., M., Zubrow, T. M., Papali, A., Mallemat, A. H., & Verceles, C. A. (2015). Tele-intensivists can instruct non-physicians to acquire high-quality ultrasound images. Journal of Critical Care, 30(5), 871-875. http://dx.doi.org/10.1016/j.jcrc.2015.05.030 0883-9441 4. Ronaldson J, Moultrie CEJ, Corfield AR, McElhinney E. Can non-physician advanced retrieval practitioners (ARP) acquire and interpret diagnostic views of the lungs with sufficient quality to aid in the diagnosis of pneumothorax in the pre-hospital and retrieval environment?. Scand J Trauma Resusc Emerg Med. 2020;28(1):102. Published 2020 Oct 16. doi:10.1186/s13049-020-00797-8 5. Ketelaars, R., Reijnders, G., van Geffen, G. J., Scheffer, G. J., & Hoogerwerf, N. (2018). ABCDE of prehospital ultrasonography: A narrative review. Critical Ultrasound Journal, 10(1), 17. doi:10.1186/s13089-018-0099-y 6. Boutros, S. M., Nassef, A. M., & Ghany-Abdel, G. A. (2016) Blunt abdominal trauma: The role of focused abdominal sonography in assessment of organ injury and reducing the need for CT. Alexandria Journal of Medicine, 52(1), 35-41. https://doi.org/10.1016/j.ajme.2015.02.00

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13, 2023 **ITEM NUMBER: 7**

SUBJECT: 2023 Asia Pacific Economic Cooperation (APEC) Summit Update

PRESENTER: Tim Reed EMT-P, DMS Division Chief

CONSENT: ___ ACTION: ____ INFORMATION: _X__

RECOMMENDATION
Receive information regarding the States response to recent disasters.

FISCAL IMPACT
No fiscal impact.

BACKGROUND
The Asia Pacific Economic Cooperation (APEC) is the leading economic forum for the 21 Member Economies of the Asia-Pacific region, facilitating trade and investment, economic growth, and regional cooperation. San Francisco was the host location for the APEC Economic Leaders' Week. APEC attendees included Heads of State/Government, dignitaries, officials, and economic/business leaders. Several other events related to APEC (meetings at Moscone Center) and unrelated to APEC (multiple Golden State Warriors games) took place simultaneously during the operational period. On November 2, 2023, the Emergency Medical Services Authority (EMSA) entered into a Memorandum of Understanding (MOU) with the City and County of San Francisco Local Emergency Medical Services (EMS) Agency to provide three (3) Advanced Life Support (ALS) Ambulance Strike Teams (AST) each with an AST Leader and Assistant ASTL to support the 9-1-1 system in San Francisco during the APEC Summit.

SUMMARY
Due to the complexity of APEC, several EMS resources were utilized in support of APEC and non-APEC response during the operation periods. The focus of the AST was EMS Mutual Aid in support of non-APEC response (911 EMS System) and contingency support of APEC. On November 2, 2023, EMSA entered into an MOU with the City and County of San Francisco Local EMS Agency to provide AST support. EMSA coordinated three (3) Advanced Life Support (ALS) Ambulance Strike Teams (AST),

each with an AST Leader (15 Ambulances in total) to support the 9-1-1 system in San Francisco during the APEC Summit. The California Medical Assistant Team (CAL-MAT) was deployed to the Mass Arrest Point (MAP) to provide medical evaluations and minor treatment for subjects brought in by law enforcement. Both AST and CAL-MAT were operational from November 14 -18, 2023. The AST worked three different shifts of 14-hours, and CAL-MAT worked 12-hour shifts, as needed. During the summit, the AST units responded to 278 calls and transported 148 patients. San Francisco brought 81 persons into the MAP/ Of those, CAL-MAT examined one client and requested transportation to the emergency room for one patient.

AST Response Breakdown

AST Data	11/14	11/15	11/16	11/17	11/18	Totals
Total EMS Incidents	309	368	371	386	340	1774
Total EMS Transports	179	210	221	249	209	1068
AST Responses	15	81	88	89	5	278
AST Transports	8	41	43	53	3	148
Total call percentage by AST	5%	22%	24%	23%	1%	16%
Percentage AST Transport	4%	20%	19%	21%	1%	14%

AST Regional Resource Breakdown

Region 3
1 ALS - Mount Shasta Ambulance
3 ALS - Dignity Health
1 ALS - Side Trax
1 ASTL – Side Trax
1 ASTL – Dignity Health

Region 4
1 ALS - Cal-Tahoe EMS
2 ALS - Manteca District Ambulance
2 ALS - American Medical Response
2 ASTL – American Medical Response

Region 5
5 ALS - American Ambulance
2 ASTL – American Ambulance

CAL-MAT Resource Breakdown

3 – EMT (2 Sacramento Valley Unit and 1 San Francisco Bay Area Unit)
1 – Physician (East Bay Unit)
1 – Physician Assistant (San Francisco Bay Area Unit)
3 – Registered Nurses (2 San Francisco Bay Area Unit and 1 East Bay Unit)

DISCUSSION

None.

ATTACHMENT(S)

None

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13, 2023 **ITEM NUMBER: 8**

SUBJECT: Open Nominations for Election of Officers (March 2024 – March 2025)

PRESENTER: Commission Chair Sean Burrows

CONSENT: ___ ACTION: __X__ INFORMATION: ___

RECOMMENDATION: Open nominations for Commission Officers for March 2024 – March 2025.

FISCAL IMPACT: No fiscal impact.

DISCUSSION: Nominations for Commission Officers are opened at the last Commission meeting of the year, and the election is held at the first meeting of the following year. Per the Commission on EMS By-Laws, the Chair can only serve two consecutive one-year terms. Per the Commission on EMS By-Laws, all Commission Officers are eligible for reelection except the immediate past chair who is automatically a member of the Administrative Committee.

Current Commission Officers: Chair, Sean Burrows Vice Chair, Marc Gautreau Administrative Committee, Atilla Uner, MD, Paul Rodriguez and Ken Miller, MD

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COMMISSION ON EMERGENCY MEDICAL SERVICES

QUARTERLY MEETING

MEETING DATE: December 13, 2023 **ITEM NUMBER: 9**

SUBJECT: Approval of 2025 meeting dates

PRESENTER: Director Basnett

CONSENT: ___ ACTION: __X__ INFORMATION: ___

RECOMMENDATION: Approve the proposed meeting dated for Calendar Year 2025.
FISCAL IMPACT: The estimated cost of four in-person meetings per year is approximately $58,000.

DISCUSSION: The 2025 meeting dates are scheduled to be held in person. The following meeting dates and locations need to be approved for calendar year 2025:
March 19, 2025, in Garden Grove
June 18, 2025, in Sacramento
September 17, 2025, in San Diego
December 10, 2023, in Bay Area