Date of Hearing: April 17, 2023

ASSEMBLY COMMITTEE ON EMERGENCY MANAGEMENT
Freddie Rodriguez, Chair
AB 379 (Rodriguez) – As Amended March 23, 2023

SUBJECT: Emergency medical services

SUMMARY: Would require the California Emergency Medical Services Authority (EMSA) and Local Emergency Medical Services Authorities (LEMSAs) to post approved annual plans on their respective public websites. The bill would also require that LEMSAs adopt a procedure for calculating and reporting their ambulance patient offload times (APOT). Specifically, **this bill**:

1) Requires local emergency medical services agencies to adopt policies and procedures for calculating and reporting ambulance patient offload time, as defined.

2) Requires the local EMS agency, in each designated EMS area, to develop and submit a plan to the authority for an emergency medical services system according to EMSA guidelines.

3) Requires each local EMS agency to make EMS system plans accessible on the agency's internet website within 30 days of approval by the authority.

4) Requires EMSA to make each local EMS agency's EMS system plan accessible on EMSA's internet website within 30 days of approving such plans.

EXISTING LAW:

1) Allows local emergency medical services (EMS) agencies to adopt policies and procedures for calculating and reporting ambulance patient offload time, as defined. (Health and Safety Code Section 1797.225)

2) Requires local EMS agencies that adopt such policies and procedures to, use the statewide standard methodology for calculating and reporting ambulance patient offload time developed by the authority and establish criteria for the reporting of, and quality assurance followup for, a nonstandard patient offload time. (Health and Safety Code Section 1797.225)

3) Allows a local EMS agency, in each designated EMS area, to develop and submit a plan to the authority for an emergency medical services system according to EMSA guidelines. (Health and Safety Code Section 1797.250)

4) Requires EMSA to develop planning and implementation guidelines for emergency medical services systems which address the following components: manpower and training; communications, transportation; assessment of hospitals and critical care centers; system organization and management; data collection and evaluation; public information and education; and disaster response. (Health and Safety Code Section 1797.103)

5) Requires local EMS agencies to annually submit an emergency medical services plan for the EMS area to the authority, according to EMS Systems, Standards, and Guidelines established by EMSA. (Health and Safety Code Section 1797.254)

FISCAL EFFECT: Unknown.

COMMENTS:

Purpose of the bill: According to the author, "Local Emergency Medical Services Authorities are responsible for planning, coordinating, and improving local emergency and medical response systems. LEMSAs mainly work to organize prehospital services. Local EMS plans lay out policies for system organization and management, staffing and training, communication, response and transportation for emergency services, facilities and critical care, data collection and system evaluation, public information and education, disaster medical response, and more."

The author adds, "Maintaining timely 911 response times and efficient APOT is essential to ensuring that residents receive the medical care they need in a timely manner. By requiring LEMSAs and EMSA to post approved plans on their websites, we can increase transparency for policymakers, stakeholders and residents who want to see how their emergency management officials are planning for their care."

"Current law states that LEMSAs may establish policies and procedures for calculating and reporting APOT, but does not require it. Because APOT plays a pivotal role in how quickly EMS workers are able to respond to a 911 call, requiring LEMSAs to establish these metrics is a critical component of emergency planning," the author concludes.

Equity Impact: According to the author's staff, "the lack of available emergency medical services resources in the community often leads to longer response times. Unfortunately, the most vulnerable are often times disproportionally impacted by a lack of response resources in a community. Greater transparency of local EMS plans will help those who seek to mitigate inequities in local EMS systems."

The Emergency Medical Services Authority (EMSA): EMSA is charged with providing leadership in developing and implementing EMS systems throughout California and setting standards for the training and scope of practice of various levels of EMS personnel. The EMS Authority also has responsibility for promoting disaster medical preparedness throughout the state, and, when required, coordinating and supporting the state's medical response to major disasters. According to EMSA, emergency and disaster medical services in California are rooted in the skills and commitment of the first responders, EMTs, nurses, physicians, and administrators who deliver care to the public and operate the system.

In California, day-to-day EMS system management is the responsibility of the local and regional EMS agencies. It is principally through these agencies that the EMS Authority works to promote quality EMS services statewide. EMS Authority staff also work closely with many local, state and federal agencies and private enterprises with emergency and/or disaster medical services roles and responsibilities.

Local EMS Agencies (LEMSAs): California's EMS Act authorizes each county to develop an EMS program and to designate a LEMSA that oversees the delivery of EMS within that geographic area. This level of governance allows for local control of emergency medical services that is desirable in a state as large and diverse as California. Essential functions performed by local EMS agencies include, among other things: planning, implementing, evaluating, and continually improving local EMS systems including prehospital services and relevant hospital services such as trauma and pediatrics; collaborating with other health officials to ensure a unified, coordinated approach in the delivery of health care; carrying out regulations relative to EMS systems; certifying, accrediting, and authorizing EMS field personnel; developing medical treatment protocols and policies for local EMS service providers (EMTs, paramedics, dispatchers); and designating trauma centers and other specialty care centers.

According to EMSA, "All 33 LEMSAs (single county or multi county regions) have developed an EMS system and plan, implement, and evaluate their EMS systems in accordance with HSC 1797.204. The LEMSAs submit their EMS plans to the Authority for approval. The LEMSAs, upon request, evaluate cities and fire districts for compliance with HSC 1797.201, and create exclusive operating areas pursuant to HSC 1797.224 where applicable. The procedures and provisions for carrying out the responsibilities noted above have been specified in state guidelines and county policies and procedures, and adhered to voluntarily over the years.

Status of EMSA planning and implementation guidelines: As noted above, Health and Safety Code 1797.103 requires EMSA to develop planning and implementation guidelines for EMS systems which address the following eight components: manpower and training; communications; transportation; assessment of hospitals and critical care centers; system organization and management; data collection and evaluation; public information and education; and disaster response.

In 1985, the Authority developed, and the Commission approved, EMS System Standards and Guidelines to provide guidance to LEMSAs in the planning, organization, management, and evaluation of local EMS systems, and to provide an evaluation and education mechanism for the Authority, elected officials, and interested parties. These standards and guidelines were revised over the ensuing years with input from EMS stakeholders and received approval from the Commission, but were never formally adopted as regulations. In 2012, EMSA formed a committee and invited affected stakeholder organizations to appoint a member to begin the process of updating the standards and drafting proposed regulations. Due to a lawsuit, the work of this Committee was suspended in 2015, but resumed again in late 2016.

In 2019, petitions were filed with the Office of Administrative Law asking for a determination as to whether three of EMSA's documents related to Exclusive Operating Areas amounted to underground regulations. In response, the Authority certified and agreed that it would not use or enforce the documents. The Authority subsequently began the process of promulgating regulations to cover the guidelines authorized and required in accordance with Health and Safety Code Section 1797.103.

According to EMSA, "these regulations will provide clarity and specificity in the implementation of the EMS system standards and guidelines. The regulations will assist local governments in the implementation and maintenance of their EMS systems by providing clear and enforceable standards. The regulations will also provide the necessary resources for EMSA to effectively evaluate the local EMS systems in California in order to carry out its

responsibilities for oversight of the EMS System to ensure protection of the public health and safety (HSC 1797.103)."

At the March 15, 2023 meeting of the California EMS Commission, EMSA reported that it was reviewing previously submitted comments and developing a new draft of updated regulations for annual EMS plans.

Annual LEMSA plans: Based upon information available on EMSA's and LEMSA's internet websites, many EMS plans are not being updated on an annual basis and there are several instances of EMSA taking an unduly amount of time to approve such plans. For example, according to EMSA:

1. Alameda County's most recent EMS Plan for 2018 was submitted on November 18, 2019 and approved by EMSA on January 2, 2020. The next plan update was due on January 31, 2020.

2. Central California's most recent EMS Plan for 2019 was submitted on September 12, 2019 and approved on February 1, 2022. The next plan update was due on December 31, 2022.

3. Los Angeles's most recent EMS Plan for 2017 was submitted on June 27, 2018 and approved on July 23, 2018. The next plan update was due on July 31, 2019.

4. Riverside's most recent EMS Plan for 2018 was submitted on November 28, 2018 and approved on March 7, 2019. The next plan update was due on March 31, 2020.

5. San Diego's most recent EMS Plan for 2018 was submitted on June 28, 2019 and approved on October 14, 2021. The next plan update was due on October 14, 2022.

6. Solano's most recent EMS Plan update for 2011 was approved on February 1, 2013. It was unclear on when this plan was originally submitted for approval, but the next update of the plan was due on February 1, 2014.

In letters approving local EMS plans, EMSA includes the following information:

1. When EMSA received the last full plan approval from the local EMS agency;

2. The years in which EMSA has previously received EMS Plan submissions;

3. A reminder of "Health and Safety Code (HSC) § 1797.254 states: "Local EMS agencies shall **annually** (emphasis added) submit an emergency medical services plan for the EMS area to the authority, according to EMS Systems, Standards, and Guidelines established by the authority"

4. The following statement: "The EMS Authority is responsible for the review of EMS Plans and for making a determination on the approval or disapproval of the plan, based on compliance with statute, regulations, and case law, consistent with HSC § 1797.105(b)."

Defining Ambulance Patient Offload Time (APOT) and Ambulance Patient Offload Delay (APOD): The Ambulance Patient Offload Time for each transported 9-1-1 patient is defined as the "interval between the arrival of an ambulance at an ED and the time that the patient is transferred to an ED gurney, bed, chair or other acceptable location and the ED assumes responsibility for care of the patient." The Ambulance Patient Offload Delay is anything past the 20 minute guideline recommendation for APOT as provided by Emergency Medical Services Authority (EMSA). APOT is most commonly captured electronically in the patient care record from the recorded time on arrival at the hospital (defined as wheel stop at the location where the patient is off-loaded), to the time of the electronic signature of the triage nurse after the physical removal of the patient from the ambulance gurney.

Scope of the Problem: Ambulance patient offload delays have been a concern in the health care community for some time due to the potential impact on patient safety and quality of care. According to EMSA, each year, roughly 70,000 Californians wait over an hour on an ambulance gurney once they arrive at the hospital and before their care is assumed by emergency department staff and moved to a hospital bed.

In a 2020 report to the Legislature, EMSA notes that the number of transports to a given hospital seems to directly correlate to their APOT. More transport typically means longer wait times. Generally, rural counties and their hospitals have significantly lower APOT than urban counties and their hospitals.

During the COVID-19 pandemic, almost all local EMS agencies experienced less transport overall but saw an increase in APOT compared to the prior year as hospitals saw an increased number of patients being admitted. With stakeholder input, EMSA targeted 20 minutes as a maximum APOT, but concluded that, with only two years of data derived from disparate sources, it is still premature to draw conclusions about what corrective measures are most practical and acceptable.

Impact on Patient Care and Experience: When pre-hospital providers must wait to transfer care to the ED staff, it creates issues of patient safety. The paramedics or emergency medical technicians (EMTs) must continue to care for the patient they brought to the ED, rather than transferring the patient to the higher level of care within a hospital ED.

Waiting for an open ED bed may lead to delays in medication administration and failure to meet standard of care for various treatments. Delays in patient throughput in the ED decreases hospital cost efficacy and increases subsequent hospital stays, both of which are of concern to hospital and have negative financial impact.

According to the National Association of EMS Physicians (NAEMSP), offload delays lead to delays to definitive care, poor pain control, delayed time to antibiotics, increased morbidity, and possibly even mortality. Ultimately, there is a reasonable concern that ambulance offload delay will compromise patient safety.

During last year's Emergency Management Committee hearing on wall times, a representative from the Sacramento Fire Department testified about an incident where a fire department paramedic was performing CPR on a patient with two ambulances at a hospital around the corner waiting to transfer patient care for more than an hour. The Fire Department ultimately needed an ambulance from a neighboring jurisdiction to respond from eight miles away and three cities

over, because other resources weren't available. The ambulance sent to the scene was the 20th pick in terms of distance but was the closest available resource.

Impact on EMS Systems: The ambulance unit and staff that are delayed in the ED are effectively out of service, decreasing advanced life support coverage in the community, which can increase response time for subsequent critical cases, including cardiac arrest and major trauma. ED delays of the EMS professionals back up the entire system; dispatch centers have increased task times and EMS supervisors spend their time in the hospital attempting to make their units available.

The compilation of these additional non-productive unit-hours are costly to the company and to the community, since readiness accounts for a large portion of the cost associated with ambulance coverage in a community, and ambulance contracts mandate maximal response times to critical calls.

Related legislation: AB 40 (Rodriguez) of this Session. Would require EMSA to, among other things, to adopt emergency regulations to develop an electronic signature for use between emergency department and emergency medical personnel, a statewide 20 minute standard for patient offload times, and an audit tool to improve the accuracy of such data. (Set to be heard in the Assembly Health Committee on April 18, 2023)

AB 55 (Rodriguez) of this Session. Would increase the Medi-Cal fee-for-service reimbursement rate for emergency medical transports, as specified. (Set to be heard in the Assembly Health Committee on April 18, 2023)

AB 296 (Rodriguez) of this Session. Establishes a 911 public education campaign within the California Office of Emergency Services. (Set to be heard by the Assembly Committee on Communications and Conveyance on April 19, 2023)

Prior legislation: AB 1770 (Rodriguez) of the 2021-2022 Session. Would have required the Emergency Medical Services Authority (EMSA), in collaboration with the California Office of Emergency Services (Cal OES), California Department of Public Health (CDPH), and other entities as specified, to establish several policies to reduce ambulance patient offload delays and protect patients from unnecessary and life-threatening impacts to their overall health outcomes. (Died in the Assembly Health Committee)

AB 1229 (Rodriguez) of the 2021-2022 Session. Would have required the Director of the California Emergency Services Authority (EMSA) to establish a task force to address ambulance patient offload delays. (Held in the Assembly Committee on Appropriations.)

AB 2961 (O'Donnell), Chapter 656, Statutes of 2018. Requires a local EMS agency to submit quarterly data to EMSA. Also required EMSA to submit a report to the Legislature on ambulance patient offload time and recommendations to reduce or eliminate ambulance patient offload time.

AB 503 (Rodriguez), Chapter 362, Statutes of 2015. Authorizes health facilities to release patient-identifiable medical information to an EMS provider and LEMSA when specific data elements are requested for the purpose of quality assessment and improvement.

AB 1129 (Burke), Chapter 377, Statutes of 2015, requires an emergency medical care provider, when submitting data to a LEMSA, to use an electronic health record system that is compatible with specified standards, and that includes those data elements that are required by the LEMSA.

AB 1223 (O'Donnell), Chapter 379, Statutes of 2015. Authorizes a local EMS agency to adopt policies and procedures relating to ambulance patient offload time, as defined. Requires the authority to develop a statewide standard methodology for the calculation and reporting by a local EMS agency of ambulance patient offload times.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file.

Opposition

None on file.

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