SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 2041
AUTHOR: Carrillo
VERSION: May 18, 2026
HEARING DATE: June 10, 2026
CONSULTANT: Vincent D. Marchand

SUBJECT: Emergency medical services

SUMMARY: Requires a public safety agency that provides 911 call processing services for emergency medical response, but was not providing prearrival instructions to 911 callers requiring medical assistance before January 1, 2026, to report to their local emergency medical services agency on the status of their compliance with a new requirement to provide prearrival instructions.

Existing law:

1) Establishes the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (EMS Act) to provide for a statewide system for emergency medical services (EMS), and establishes the Emergency Medical Services Authority (EMSA), which is responsible for the coordination and integration of all state activities concerning EMS, including the establishment of minimum standards, policies, and procedures. [HSC §1797, et seq.]

2) Authorizes counties to develop an EMS program and designate a local EMS agency (LEMSA) responsible for planning and implementing an EMS system, which includes day-to-day EMS system operations. [HSC §1797.200, et seq.]

3) Requires every LEMSA to have a licensed physician as medical director, to assure medical accountability throughout the planning, implementation, and evaluation of the EMS system. Requires the medical direction and management of an EMS system to be under the medical control of the medical director [HSC §1797.202 and HSC §1798]

4) Establishes the Warren-911-Emergency Assistance Act, which requires every public agency to have in operation a telephone service, which automatically connects a person dialing the digits "911" to an established public safety answering point. Defines "public agency" to include the state, any city or county, or any public district that provides or has authority to provide firefighting, police, ambulance, or other emergency services. Prohibits these provisions of law from prohibiting or discouraging the formation of multijurisdictional or regional systems. [GOV §53100, et seq.]

5) Requires every 911 system to include police, firefighting, and emergency medical and ambulance services. Requires every 911 system, in those areas in which a public safety agency provides ambulance emergency services, to include such public safety agencies. Permits 911 systems to incorporate private ambulance services. [GOV §53110(a)]

6) Prohibits a public agency from delegating, assigning, or entering into a contract for 911 call processing services for the dispatch of emergency response resources unless it is with another public agency, with the exception of a delegation, assignment, or contract entered into on or before January 1, 2019, subject to certain limitations. [GOV §53110(b) and (c)]

7) Requires a public safety agency implementing an emergency medical dispatch program to be subject to the review and approval of the LEMSA, and to perform 911 call processing services and operate the program in accordance with applicable state guidelines and regulations, and the policies adopted by the LEMSA. [HSC §1797.223(c)]

8) Prohibits medical control by a LEMSA medical director, or medical direction and management of an EMS system, from being construed to limit, supplant, prohibit, or otherwise alter a public safety agency's authority to directly receive and process requests for assistance originating with the public safety agency's territorial jurisdiction through the emergency 911 system, but specifies that this provision does not supersede the LEMSA's authority to adopt and implement emergency life-saving instructions or emergency medical dispatch pre-arrival instructions. [HSC §1798.8]

9) Requires, by January 1, 2027, a public safety agency that provides 911 call processing services for emergency medical response to provide prearrival instructions to 911 callers requiring medical assistance. Permits a public safety agency to satisfy this requirement by contracting with another public safety agency that provides prearrival medical instructions. Requires the prearrival medical instructions to include, at a minimum, all of the following:
   a) Airway and choking medical instructions for infants, children, and adults;
   b) AED and CPR instructions for children and adults;
   c) Childbirth;
   d) Bleeding control and hemorrhage;
   e) Administration of epinephrine by auto-injector for suspected anaphylaxis; and,
   f) Administration of naloxone for suspected narcotics overdoses. [HSC §1797.161(a)]

10) Requires the prearrival medical instructions required in 9) above to be approved by the local EMS agency medical director and implemented consistent with medical protocols and procedures adopted by the public safety agency. [HSC §1797.161(c)]

This bill: Requires a public safety agency that provides 911 call processing services for emergency medical response, but was not providing prearrival instructions to 911 callers requiring medical assistance before January 1, 2026, to report to their LEMSA, by January 31, 2027, on the status of their compliance with the requirement to provide prearrival instructions.

FISCAL EFFECT: The current version of this bill has not been analyzed by a fiscal committee.

PRIOR VOTES:

Assembly Floor:	70 - 1
Assembly Appropriations Committee:	12 - 0
Assembly Emergency Management	7 - 0
Assembly Communications and Conveyance Committee:	8 - 0

COMMENTS:

1) *Author's statement.* According to the author, in medical emergencies such as cardiac arrest or choking, immediate bystander intervention before first responders arrive can mean the difference between life and death. The American Heart Association reports that prompt CPR can double or even triple a person's chances of survival following cardiac arrest. Bystander

intervention also significantly increases when individuals receive pre-arrival medical instructions and verbal guidance provided from 9-1-1 dispatchers at a public agency. This bill aims to ensure public safety agencies are training first responders to provide these lifesaving pre-arrival medical instructions by requiring any previously non-complying agency to report their status of compliance to their local EMS agency. By investing in these proven, lifesaving practices, we can equip everyday Californians with the guidance they need to act in those first critical moments of medical need.

2) *Background on EMS and the 911 system.* While EMSA is the lead agency and centralized resource to oversee emergency and disaster medical services, day-to-day EMS system management is the responsibility of the local and regional EMS agencies. California has 34 LEMSA systems that provide EMS for California's 58 counties. Regional systems are usually comprised of small, more rural, less-populated counties and single-county systems generally exist in the larger and more urban counties. There are seven regional EMS agencies comprised of 31 counties and 27 single-county LEMSAs. The EMS Act comprehensively regulates emergency medical care in California. Enacted in 1980, the EMS Act provides for the creation of emergency medical procedures and protocols, certification of emergency medical personnel, and coordination of emergency responses by fire departments, ambulance services, hospitals, specialty care centers, and other providers within the local EMS system.

   The Warren 911 Act authorizes cities and counties to form contracts regulating the implementation of a 911 system. The basic structure of the 911 system is designed to ensure that when a person dials 911, a law enforcement agency serving as a primary Public Safety Answering Point (PSAP) receives 911 requests from the area where the person is calling. If a 911 caller requests emergency medical assistance, the primary PSAP may retain the caller if it directly provides EMS dispatch, or may transfer the caller to a secondary PSAP for emergency medical response. The medical secondary PSAP can be a public agency, public/private partnership, or private EMS provider designated or recognized by the LEMSA as serving the entire EMS area or portion of the EMS area. However, under SB 438 (Hertzberg, Chapter 389, Statutes of 2019), a public agency is prohibited from delegating, assigning, or entering into a contract for 911 call processing services regarding the dispatch of emergency response resources unless it is with another public agency, with certain exceptions, including contracts entered into before January 1, 2019 if the public safety agencies agree to continue those contracts.

3) *Pre-arrival EMS instructions.* This bill is a follow-up to AB 645 (Carillo, Chapter 273, Statutes of 2025), which established the requirement to provide prearrival instructions to 911 callers requesting medical assistance, effective January 1, 2027. According to information provided by the author last year, the rationale for AB 645 was that while most agencies already provide pre-arrival instructions to 911 callers to help them with emergency situations until emergency medical personnel arrive on scene, it is not universal, and there are some areas in the state where 911 callers are not provided with pre-arrival instructions.

   According to a September 2019 article published in *StatPearls*, nearly any circumstance resulting in a 911 call involves a stressed or alarmed caller seeking help. The person responsible for answering that call is assigned the crucial task of rapidly identifying the nature of the emergency, its severity, and the necessary resources to deploy, all while keeping the caller calm enough to answer the right questions. When specific life-threatening emergencies are identified, the following actions by the caller and recipient can be the difference between survival and death. “Pre-arrival instruction” refers to specific instructions

or guidance provided by 911 dispatchers or public safety answering point call-takers to the individuals making the emergency call. According to this article, the first organized effort to provide pre-arrival instructions was implemented in Phoenix, Arizona in 1974. As of 1988, emergency medical dispatch's use of pre-arrival instructions has been the standard recommendation of the National Association of Emergency Management Service Physicians. A study published in 2000 revealed that 97% of community members surveyed would call 911 in an emergency, and 67% of respondents expected that calling 911 should result in receiving pre-arrival instructions for choking, a person not breathing, bleeding, and childbirth, when appropriate. At the time, however, many answering points were noted not to provide such instructions. The greatest challenge to providing pre-arrival instructions is determining how to apply life-saving and hands-on interventions through the caller without visual aids, all in seconds. Dispatchers can most effectively provide pre-arrival instructions by following scripts and practicing possible scenarios. Scripted instructions are written clearly for any non-medical person to comprehend and perform. While few studies have addressed the provision or efficacy of pre-arrival instructions for bleeding control, choking, respiratory arrest, and childbirth, the most studied emergency for pre-arrival instructions is sudden cardiac arrest. A study in 2008 revealed that even when dispatchers gave 911 callers standard CPR instructions, the majority of calls did not result in cardiac arrest victims receiving proper chest compressions. The recommendations for out-of-hospital bystander resuscitation changed significantly after this study, and shifted to "hands-only CPR" without airway or breathing intervention. In sudden cardiac arrest, pre-arrival instruction for dispatch-assisted CPR is now considered the standard of care, though a 2015 survey of public safety answering points concluded that nearly 50% of systems did not offer dispatcher-assisted instructions for CPR.

In discussions over AB 645 in 2025, stakeholders all agreed that the vast majority of 911 emergency medical response dispatching agencies in California already provide pre-arrival instructions. Regarding this bill, the author stated that there are concerns that public safety agencies that are not currently providing pre-arrival instructions are not working toward this goal, and that this bill will help ensure that dispatchers that were not in compliance last year are taking steps to implement AB 645.

4) *EMSA planning on promulgating regulations on emergency medical dispatch.* An earlier version of AB 645 would have focused on establishing minimum standards for the training of emergency medical dispatchers, which generated some controversy from a number of stakeholders. In the context of a version that would have potentially established training requirements, EMSA provided some considerations that it believed was important for the Legislature to consider, including that medical care does not begin when field providers arrive, but it begins at the first point of medical contact, which is often the 911 call. EMSA stated that patient outcomes are directly impacted by the accuracy of call triage and the quality of pre-arrival medical instructions provided by dispatchers. As such, oversight of these functions, and of training and oversight, must remain within the clinical and regulatory framework of medical control. EMSA also stated that ensuring an equitable standard in the delivery of quality care from the moment of first medical contact requires consistent statewide standards, and that EMSA is best positioned to define those standards, with LEMSAs implementing and overseeing them within their jurisdictions under medical direction.

   According to EMSA, it continues to recognize emergency medical dispatch as an important area for future regulatory consideration, and anticipates addressing it through a future

rulemaking effort. AB 645 included a provision prohibiting anything in that bill from being construed to either expand or limit EMSA's ability, under existing law, to adopt guidelines or regulations for emergency medical dispatch, including dispatcher training.

5) *Prior legislation.* AB 645 (Carrillo, Chapter 273, Statutes of 2025) requires a public safety agency that processes 911 calls for emergency medical response, commencing January 1, 2027, to provide pre-arrival medical instructions to 911 callers requiring medical assistance, including airway and choking instructions, automatic external defibrillator and CPR instructions, childbirth, bleeding control and hemorrhage, administration of epinephrine auto-injectors, and administration of naloxone for suspected overdoses. Requires pre-arrival medical instructions to be approved by the medical director of the local emergency medical services agency.

   SB 438 (Hertzberg, Chapter 389, Statutes of 2019), among other provisions, prohibits a public agency from delegating, assigning, or entering into a contract for 911 call process services regarding the dispatch of emergency medical response resources unless it is with another public agency, with certain exceptions, including allowing contracts in existence at the time to be renewed if public agencies do not object.

6) *Support.* This bill is sponsored by the California Ambulance Association (CAA), which states that this bill strengthens the effectiveness and level of compliance with last year's AB 645 by requiring public dispatching agencies who have not yet implemented pre-arrival instructions into their systems to report the status of their implementation.

SUPPORT AND OPPOSITION:

Support: California Ambulance Association (sponsor)
AmWest Ambulance
Del Norte Ambulance
LifeWest Ambulance
Medic Ambulance
NorCal Ambulance
Pro Transport-1 Ambulance
Royal Ambulance, Inc.
Southern California Ambulance Association

Oppose: None received

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