Meeting Attachments | Agenda | Responsible Party
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**1. Call to Order – Pledge of Allegiance** | S. Silveira

**2. Introductions** | S. Silveira

**3. Public Forum**  
*Public opportunity to speak on any matter of public interest within the committee’s jurisdiction* | S. Silveira

**4. Quorum Status Check (8 Members Required)** | S. Silveira

**5. Approval of the Agenda (Action)** | S. Silveira

**6. Approval of the October 3, 2018 EMCC Meeting Minutes (Action)** | S. Silveira

**7. Informational Items:**  
a) Public Health Officer Report | Dr. K. Bird

b) Ground Ambulance RFP/EOA Update | J. Clark

c) EMCC Membership Update | J. Clark

d) Medical Protocols Update Report | D. Murphy

e) EMS P&P Smart Device App  
Droid & iOS: [https://goo.gl/vpW7Bq](https://goo.gl/vpW7Bq)
Available on Google Play & App Store | J. Clark

f) Merced County EMS Data System | J. Clark

g) EMS Legislation: SB 1305; EMS & Dogs & Cats | J. Clark

**8. EMS Agency Reports (Info)** | S. Silveira

a) EMS Medical Director Report | Dr. AJ Singh

b) Response Time Compliance Reports | R. Duran

**9. Action Items:**  
a) None | S. Silveira

**10. Agenda Items for Next Meeting (Action)** | S. Silveira

**11. Adjournment (Action)** | S. Silveira

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All meeting materials including the Meeting Attachments A – F may be obtained by contacting:

James Clark, EMS Administrator  
Merced County EMS Agency  
260 E. 15th Street, Merced, CA 95341, PH: (209) 381-1250  
Posted March 28, 2019

Equal Opportunity Employer
Committee Members Present: Merced County Supervisor Jerry O’Banion, Dr. Tushar Patel, Memorial Hospital Los Banos ER Physician, Kraig Riggs, SEMSA, Ken Mitten, District 2, Jeremy Rahn, District 3, Jeff Cole, Merced City Fire Department, Dewayne Jones, District 5, Bryan Donnelly, Merced College, Fire Chief Mason Hurley, Los Banos Fire and Mark Lawson, Cal FIRE.

Ex-Officio Members Present: Rebecca Nanyonjo-Kemp, Public Health Director.

Ex-Officio Members Absent: Dr. Ajinder Singh, EMS Medical Director.

Committee Members Absent: Dr. David Canton, County Health Officer, Anthony Lima, Field Personnel Representative, Jeff Pate, Los Banos Memorial Hospital, John Slate, Office of Emergency Services and Jeff Butticci, CHP.

EMS Agency Staff Present: James Clark, EMS Administrator, Ron Duran, EMS Specialist, Aracely Sanchez, Health Education Specialist and Frank Romero, OAIII.

Guests Present: Bill Bullard, Abaris Group, Brian Neely, CALFIRE/Merced Co. Fire, Erik Peterson, American Ambulance, Robert Strauch, Los Banos Fire, Kevin Otterstotter, Falck NC, Kim Nausin, County Purchasing, David Murphy, SEMSA/Riggs, Mickey Brunelli, Merced City Fire Dept., Kevin Daniel, SEMSA/Riggs, Michael Williams, SEMSA, Ileisha Sanders, MCDPH, Billy Alcorn, Merced Fire, Cindy Woolston, AMR, MaryJo Quentero, Valley Children’s Hospital, Eric Rudnick, SEMSA, Steve Melander, American Ambulance, Jennifer Caposella, CALSTAR, Carly Alley, SEMSA, Adam Davenport, Falck Ambulance, Sonya Seun, SEMSA/Riggs, Kristynn Sullivan, MCDPH, Rob Smith, SEMSA, Jenna Anderson, County Counsel and Peter Hasting, AMC, Casey Comer, AMR, Heather Geske, Air Methods, DeeAnn Dion, SEMSA and Steve Crabtree, Riggs.

Call to Order: Chairman Jerry O’Banion called the meeting to order at 12:08 PM. All rose for the reciting of the Pledge of Allegiance; introductions were made and all were welcomed.

Public Forum: No comments from the public were made and the forum was closed.

Quorum Status Check (8 members required): A Quorum of EMCC voting members were present.

Approval/Additions/Deletions of the Agenda (Action): A Motion was made by Ken Mitten to accept the agenda; the motion was seconded by Kraig Riggs. The agenda was approved by unanimous vote.

Approval of the July 11, 2018 Meeting Minutes (Action): A Motion was made by Ken Mitten to accept the meeting minutes; the motion was seconded by Kraig Riggs. The meeting minutes were approved by unanimous vote.
**Informational Items:**

*Jim Clark (EMS System & RFP Kick-Off Update):* Jim introduced Bill Bullard to the committee providing the members with a brief update on the new EMS system and RFP. Bill gave a recap on the process of the new RFP and the interviews that will begin with stakeholders in the weeks to come. There were no questions from the committee.

*Jim Clark (EMCC Membership update):* Jim informed the Committee of the current EMCC membership status; the following EMCC memberships are currently vacant or need to be filled:

- One (1) E.R. Physician, Mercy Medical Center
- One (1) District 1 Representative
- One (1) District 4 Representative
- One (1) Ambulance Company Representative (separate of SEMSA which is currently represented)
- One (1) Law Enforcement Representative
- One (1) E.R. Nurse (Base Hospital)

The Following Member was Board-Appointed to the EMCC at the October 2, 2018 Board of Supervisors Meeting with a term expiring June 30, 2019:

- Mason Hurley, LBFD Fire Chief, is pending EMCC recommendation by the local Fire Chief Association and appointment by the County Board of Supervisors.

There are currently 15 appointed and active members on the Emergency Medical Care Committee; 8 members constitute a quorum.

*Jim Clark/David Murphy (Medical Protocols Update Report):* At the July 11, 2018 EMCC meeting, the following EMS policies were presented for the next Public Comment Period which occurred July 9 to August 17, 2018 becoming effective September 1, 2018:

**Adult M3 Sepsis (New)**
Sepsis is the body’s overwhelming and life-threatening response to infection. This new Medical Protocol will provide EMTs and Paramedics with guidance on how to recognize and treat Sepsis.

**Adult M8 Hyperglycemia (New)**
Elevated blood glucose levels (Hyperglycemia) can be a medical emergency. This new Medical Protocol will provide EMTs and Paramedics with guidance on how to recognize and treat Hyperglycemia.

**Adult M9 Hyperthermia (New)**
Elevated core body temperature above normal limits is usually caused by prolonged exposure to an excessive heat environment. This new Medical Protocol will provide EMTs and Paramedics with guidance on how to recognize and treat Hyperthermia.
Adult M10 Hypothermia (New)
The definition of Hypothermia is low body temperature of 95 degrees F or less. This new Medical Protocol will provide EMTs and Paramedics with guidance on how to recognize and treat Hypothermia.

Adult M11 Poisonings-Ingestions (New)
Known or suspected drug overdose, poisoning, or accidental ingestion. Common symptoms include weakness/dizziness, mild confusion, syncope, unconsciousness, bradycardia, hypotension, arrhythmias/widening QRS and seizures. This new Medical Protocol will provide EMTs and Paramedics with guidance on how to recognize and treat Poisonings and Ingestions.

Adult M12 Non-Traumatic Shock (New)
History may include: GI bleeding, vomiting, diarrhea, allergic reaction, sepsis, antihypertensive medication overdose. Physical signs may include: collapsed peripheral/neck veins, confusion, cyanosis, disorientation, thready pulse, pale/cold/clammy/mottled skin, rapid respirations, and anxiety. This new Medical Protocol will provide EMTs and Paramedics with guidance on how to recognize and treat Non-Traumatic Shock.

Supraglottic Airway Devices (SAD) (New)
The purpose of this policy is to define training standards, criteria, and procedures for the use of Supraglottic Airway Devices (SAD). This is to be utilized when BVM ventilation is not adequate. In the pediatric patient this will be used instead of endotracheal intubation. Further, if an EMT completes an approved Optional Scope training program and submits the appropriate documentation they may use a SAD on Adult (12 years or older) patients only.

- Beginning October 3, 2018, the following EMS policies are available online at the EMS Agency website for the next Public Comment Period which will occur October 3 to November 7, 2018 becoming effective November 18, 2018:

- Dave Murphy provided a brief explanation to the committee of the following:

Adult M13 Dystonic Reactions (New)
Dystonic Reaction is a reaction that occurs after ingestion of certain medications like antipsychotics, antidepressants, as well as antiemetic’s. Dystonic drug reaction causes worry in the affected people as it causes sustained muscle reactions that lead to twisting, repetitive abnormal posturing, and even pain. This condition is rarely life-threatening but needs medical attention.

Adult M14 Behavioral Emergency (New)
The vast majority of patients are non-violent, requiring only supportive care & transport. Responder & patient safety are paramount, especially when treating an aggressive or violent patient. In a known violent situation, EMS personnel should stand by until the scene is secured by Law Enforcement.

Adult M15 Envenomation-Bites-Stings (New)
Envenomation, bites or stings may present as a localized reaction with redness, pain and swelling at the site or a systemic reaction such as itchiness, flushing of skin, rash, urticaria, tachycardia, and anaphylaxis.

Adult M16 Organophosphate Exposure (New)
Organophosphate poisonings may cause bronchospasm, an increase in pulmonary and nasal secretions, constricted pupils, vomiting, diarrhea, urinary incontinence, diaphoresis, and cardiac dysrhythmias.
including both bradycardia and AV blocks. Remember the following mnemonic: **SLUDGEM** (Salivation, Lacrimation, Urination, Defecation, Gastric upset, Emesis and Miosis)

**Adult M17 OB-GYN Emergencies (New)**
Birth may be imminent if the woman is having regular contractions/low back pain, bloody show, rupture of membranes or feels like bearing down/pushing/or having a bowel movement. Attempt to provide privacy and psychosocial support.

**Adult T4 Burns (New)**
Burns are injuries to tissues caused by energy, (heat, cold, electricity, radiation, or chemicals).

**Other O-06 Pediatric Intubation (New)**
To provide for guidelines in the proper utilization and performance of advanced airway management of pediatric patients, equal to or less than 11 years in age or fits onto length based assessment tape

**Other O-07 Trauma and Burn Destination (New)**
The purpose of this policy is to identify those patients whose injuries would most benefit from the services of a trauma or burn center and provide destinations for such patients.

**Pediatric M8 Hyperglycemia (New)**
Characterized by: thirst and increased urination, confusion, dehydration, deep, and rapid respirations, nausea, vomiting, fruity odor on breath, missed insulin dose, or non-compliant with diabetic medications. Determine if patient has been diagnosed with diabetes previously.

**Pediatric M9 Hyperthermia (New)**
Elevated core body temperature above normal limits, usually caused by prolonged exposure to an excessive heat environment, in adequate fluid intake and the associated fluid loss.

**Pediatric M10 Hypothermia (New)**
The hypothermic pediatric patient is one who has a core body temperature of 95°F or less.

**Pediatric M11 Poisonings (New)**
Known or suspected drug overdose, poisoning, or accidental ingestion. Common symptoms include weakness/dizziness, mild confusion, syncope, unconsciousness, bradycardia, hypotension, arrhythmias/widening QRS and seizures.

**Pediatric M12 Non Traumatic Shock (New)**
History of the non-traumatic shock patient may include: GI bleeding, vomiting, diarrhea, allergic reaction, sepsis, antihypertensive medication overdose. Physical signs may include: collapsed peripheral/neck veins, confusion, cyanosis, disorientation, tready pulse, pale, cold, clammy, mottled skin, rapid respirations, and anxiety.

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Pediatric M15 Envenomation-Bites-Stings (New)
Envenomation, bites or stings may present as a localized reaction with redness, pain and swelling at the site or a systemic reaction such as itchiness, flushing of skin, rash, urticaria, tachycardia, and anaphylaxis.

Pediatric M16 Organophosphate Exposure (New)
Organophosphate poisonings may cause bronchospasm, an increase in pulmonary and nasal secretions, constricted pupils, vomiting, diarrhea, urinary incontinence, diaphoresis, and cardiac dysrhythmias including both bradycardia and AV blocks. Remember the following mnemonic: SLUDGEM (Salivation, Lacrimation, Urination, Defecation, Gastric upset, Emesis and Miosis)

Pediatric M17 Newborn Resuscitation (New)
Newborn resuscitation is intervention after a baby is born to help it breathe and to help its heart beat. Many babies go through this transition without needing intervention

Pediatric T4 Burns (New)
Burns are injuries to tissues caused by energy, (heat, cold, electricity, radiation, or chemicals).

Jim Clark (Merced County EMS Data System): Jim provided the committee with the following information:

It is the intent of the Local EMS Agency to begin working with all EMS providers, ALS Transport and BLS Non-Transport alike, to establish a common electronic patient care data repository. The legislative intent and goal described in the EMS Act is to have a coordinated EMS system in the state of California. The EMS Act mandates collection of data to evaluate the effectiveness of the current system, detect practices in patient care and trends in patient movement, and adjust EMS systems accordingly. LEMSAs and EMSA rely upon data and information to adequately assess and coordinate local EMS systems.

Please see the attached documents from the State Legislature and California EMS Authority regarding EMS Data Collection:

- **AB1129 (2015)** - This bill requires an emergency medical care provider, when collecting and submitting data to a local EMS agency, to use an electronic health record system that exports data in a format that is compliant with the most current version of CEMSIS and NEMSIS. The EMS provider must use an electronic health record system that can be integrated with the local EMS agency's data system.

- **New State EMS Data System Requirements (January 5, 2016)**
  AB 1129, effective January 1, 2016, requires among other provisions that:
  1. Each emergency medical care provider uses an electronic health record;
  2. The electronic record must be compliant with the current version of NEMSIS and CEMSIS.

For the purposes of this guidance, an emergency medical care provider is an entity that is authorized as part of an EMS system by the local EMS agency. At a minimum, every ambulance transport provider (both emergency and non-emergency, including BLS, LALS, and ALS) and every advanced or limited advanced life support entity would fit this definition. Some Local EMS agencies
also have specific local system design characteristics involving BLS non-transport first responder entities that also meet this definition.

- **EMSA Data Strategy Document (June 2, 2016)** - The purpose of this document is to share EMSA’s strategy on how we will collaborate with the EMS community to improve the quality of data submitted to CEMSIS.

**EMS Agency Reports:**

*Dr. Canton (Health Officer’s Report):* Not Available for report.

*Ron Duran (Response Time Compliance Report):* Ron reviewed the June, July and August ground ambulance response time compliance reports with the committee.

*Jim Clark (Thank You and Happy Retirement to Supervisor Jerry O’Banion):* Jim Clark presented Supervisor Jerry O’Banion with a plaque in recognition of many years of service to the County of Merced, members gave thanks to Supervisor O’Banion wishing him a happy retirement.

**Action Items:**

None

**Round Table (Discussion):**

*Committee Members:* Members gave thanks to Supervisor O’Banion for his many years of service.

**Adjournment (Action):** A Motion was made by Supervisor Jerry O’Banion to adjourn the meeting; the action was approved by unanimous vote. Supervisor Jerry O’Banion adjourned the meeting at 1:15 PM.

The Next EMCC meeting will be held January 3, 2019 – 12PM
April 3, 2019

To: Emergency Medical Care Committee

From: James Clark, EMS Administrator

Subject: Emergency Medical Care Committee Membership Update

The following EMCC memberships are currently vacant:

- One (1) County Health Officer
- One (1) District 1 Representative
- One (1) District 4 Representative
- One (1) E.R. Physician, Mercy Medical Center
- One (1) Ambulance Company Representative (separate of SEMSA which is currently represented)
- One (1) Law Enforcement Representative
- One (1) E.R. Nurse (Base Hospital)

There are currently 14 appointed and active members on the Emergency Medical Care Committee; currently, 8 members constitute a Quorum.

The following New EMCC Member was Board of Supervisors appointed on March 26, 2019:

- Brian Neely, Battalion Chief, was appointed to replace retired Division Chief Mark Lawson. Chief Neely will be serving as the County Fire Chief Representative (or his/her designee) and will be serving at the Pleasure of the Board (POB).
April 3, 2019

To: Emergency Medical Care Committee

From: James Clark, EMS Administrator

Subject: EMS Smart Device App

Here is the link to the new P&P web site:

https://www.acidremap.com/sites/MercedCounty/

Here is the link to download the new App for Apple iOS:

https://www.acidremap.com/customAppDownload.php?bundleID=PPPMercedCountyEMSAPP&platform=iOS

And here is the link to download the new App for Droid:


When the acidremap web site is accessed, you will receive a Promo Code that can be redeemed in the Apple Store or Google Play to download the app.
ATTACHMENT #D

April 3, 2019

To: Emergency Medical Care Committee
From: James Clark, EMS Administrator
Subject: EMS Data Collection

It is the intent of the Local EMS Agency to begin working with all EMS providers, ALS Transport and BLS Non-Transport alike, to establish a common electronic patient care data repository. ESO has been selected as the vendor to assist the EMS agency in developing the EMS Data Repository System.

The legislative intent and goal described in the EMS Act is to have a coordinated EMS system in the state of California. The EMS Act mandates collection of data to evaluate the effectiveness of the current system, detect practices in patient care and trends in patient movement, and adjust EMS systems accordingly. LEMSAs and EMSA rely upon data and information to adequately assess and coordinate local EMS systems.

Please see the attached documents from the State Legislature and California EMS Authority regarding EMS Data Collection:

- **AB1129 (2015)** - This bill requires an emergency medical care provider, when collecting and submitting data to a local EMS agency, to use an electronic health record system that exports data in a format that is compliant with the most current version of CEMSIS and NEMSIS. The EMS provider must use an electronic health record system that can be integrated with the local EMS agency's data system.

- **New State EMS Data System Requirements (January 5, 2016)**
  AB 1129, effective January 1, 2016, requires among other provisions that:
  1. Each emergency medical care provider uses an electronic health record;
  2. The electronic record must be compliant with the current version of NEMSIS and CEMSIS.

For the purposes of this guidance, an emergency medical care provider is an entity that is authorized as part of an EMS system by the local EMS agency. At a minimum, every ambulance transport provider (both emergency and non-emergency, including BLS, LALS, and ALS) and every advanced or limited advanced life support entity would fit this definition. Some Local EMS agencies also have specific local system design characteristics involving BLS non-transport first responder entities that also meet this definition.

- **EMSA Data Strategy Document (June 2, 2016)** - The purpose of this document is to share EMSA's strategy on how we will collaborate with the EMS community to improve the quality of data submitted to CEMSIS.
**+EMS Grant**

Grant Funding Opportunity for +EMS Proposals Received by EMSA

<table>
<thead>
<tr>
<th>APPLICANT AGENCY</th>
<th>AMOUNT REQUESTED</th>
<th># LEMSAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 San Mateo County EMS</td>
<td>$1,705,220</td>
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</tr>
<tr>
<td>2 SacValley Med Share</td>
<td>$3,981,425</td>
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</tr>
<tr>
<td>3 Manifest Medex</td>
<td>$5,928,838</td>
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</tr>
<tr>
<td>4 OCPRHIO</td>
<td>$2,719,541</td>
<td>5</td>
</tr>
<tr>
<td>5 San Diego Health Connect</td>
<td>$1,497,470</td>
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</tr>
<tr>
<td>6 Los Angeles County EMS</td>
<td>$2,192,841</td>
<td>1</td>
</tr>
</tbody>
</table>

**TOTAL REQUESTED** $18,025,335  16
AB 1129, Burke. Emergency medical services: data and information system.

Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems. The act establishes the Emergency Medical Services Authority, which is responsible for the coordination and integration of all state agencies concerning emergency medical services. Existing law requires a local EMS agency to plan, implement, and evaluate an emergency medical services system, as specified, and authorizes the local EMS agency to develop and submit a plan to the authority for an emergency medical services system according to prescribed guidelines that address data collection and evaluation, among other things.

This bill would require an emergency medical care provider to, when collecting and submitting data to a local EMS agency, use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards, includes those data elements required by the local EMS agency, and uses an electronic health record system that can be integrated with the local EMS agency’s data system, as specified. The bill would prohibit a local EMS agency from mandating that a provider use a specific electronic health record system to collect and share data with the agency. The bill would not modify or affect a written contract or agreement executed before January 1, 2016, between a local EMS agency and an emergency medical care provider.

The people of the State of California do enact as follows:

SECTION 1. Section 1797.227 is added to the Health and Safety Code, to read:

1797.227. (a) An emergency medical care provider shall do both of the following when collecting and submitting data to a local EMS agency:
(1) Use an electronic health record system that exports data in a format that is compliant with the current versions of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the local EMS agency.

(2) Ensure that the electronic health record system can be integrated with the local EMS agency’s data system, so that the local EMS agency may collect data from the provider.

(b) A local EMS agency shall not mandate that a provider use a specific electronic health record system to collect and share data with the local EMS agency.

(c) This section does not modify or affect a written contract or agreement executed before January 1, 2016, between a local EMS agency and an emergency medical care provider.
DATE: January 5, 2016

TO: Local EMS Administrators
    EMS Medical Directors
    EMS Providers
    Other EMS System Stakeholders

FROM: Howard Backer, MD, MPH, FACEP
      Director

SUBJECT: New State EMS Data System Requirements

Recent legislation, in addition to multiple data initiatives, is driving rapid changes in EMS data systems at the local, state, and national levels. The EMS Authority is providing this guidance to local EMS agencies, EMS providers, and other stakeholders to clarify their responsibilities related to data and quality during 2016.

EMSA has made data quality and analysis a priority over the past 3 years. Stakeholders in the EMS system recently have engaged in discussions with EMSA regarding the strategy and changes around data collection and evaluation. In addition, EMSA recently formed a data advisory group consisting of three local EMS agency administrators and an equal number of medical directors to help determine a cooperative strategy for improving EMS data and its application. The continuation of funding from the Office of Traffic Safety for local data collection efforts and movement to NEMSIS 3.x, the development of EMS performance improvement measures (Core Measures) through one-time funding from the California HealthCare Foundation (CHCF), and the recent grant from the Office of the National Coordinator for Health Information Technology (ONC) to implement local health information exchange projects (Patient Unified Lookup System for Emergencies +EMS) have enhanced data and quality efforts.

In addition, four bills were passed by the legislature and signed by the Governor during 2015 related to data, quality, and the electronic movement of health information: AB503, AB1129, AB1223, and SB19.

EMSA plans to open the California Code of Regulation, Title 22, Division 9, Chapter 12, EMS System Quality Improvement regulations for amendments to implement the newly enacted sections of AB503, AB1129, AB1223 and SB19. This revision would update the regulations to appropriately address data and quality improvement. We will reach out to EMS stakeholder groups to establish a representative task force to assist us in this effort.
While the regulatory process is lengthy, the requirements of the legislation took effect January 1, 2016. Therefore, until the regulations are revised, the following information is provided to local EMS agencies and EMS providers to support the statutory requirements.

**Implementation of AB1129 -- Health and Safety Code 1797.227**

AB 1129, effective January 1, 2016, requires among other provisions that:
1. Each emergency medical care provider uses an electronic health record;
2. The electronic record must be compliant with the current version of NEMSIS and CEMSIS.

For the purposes of this guidance, an emergency medical care provider is an entity that is authorized as part of an EMS system by the local EMS agency. At a minimum, every ambulance transport provider (both emergency and non-emergency, including BLS, LALS, and ALS) and every advanced or limited advanced life support entity would fit this definition. Some Local EMS agencies also have specific local system design characteristics involving BLS non-transport first responder entities that also meet this definition.

For the purposes of interpreting the provisions of AB1129, EMSA recognizes that “electronic health record” means electronic Patient Care Report (ePCR). An electronic health record (EHR), as defined by the Office of the National Coordinator for Health Information Technology (ONC), is a digital version of a patient’s paper chart. Further, ONC notes:

> "EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. One of the key features of an EHR is that health information can be created and managed by authorized providers in a digital format capable of being shared with other providers across more than one health care organization."

To meet this definition, the electronic health record must have the capability of mobile entry at the patient’s bedside, and incorporate workflow for real-time entry of information. This also means that all EHR systems should be interoperable with other systems, including the functionality to exchange (send and receive) electronic patient health information with other entities, including hospitals, in an HL7 format, using ONC standards. NEMSIS 3 incorporates these format standards.

AB1129 requires that, electronic health record systems must be compliant with the "current version of NEMSIS". The current version of NEMSIS is version 3.3.4 or version 3.4. The sunset date for version 3.3.4 is August 31, 2016. Compliant means a system that has been tested and certified "compliant" by NEMSIS; this certification information is posted on the NEMSIS website at [http://www.nemsis.org/v3/compliantSoftware.html](http://www.nemsis.org/v3/compliantSoftware.html).
A local EMS agency may not mandate that a provider use a specific EHR system, but the EMS provider must use a system that “can be integrated” with the LEMSA system. Therefore, the local EMS agency may require the EMS provider to demonstrate, test, and ensure that the proposed system is compatible with the local EMS agency system at the provider’s cost without a heavy reliance on mapping. The specific system mandate prohibition does not affect agreements in place by January 1, 2016.

Compliance with CEMSIS is determined by meeting any additional requirements by EMSA or California specific criteria that expand or limit the responses for any NEMSIS elements. These will be specified in a subsequent memo or guidance anticipated to be released by April 1, 2016.

**NEMSIS Version 3.4:**

All EMS systems must have a NEMSIS 3.4 compliant system in operation no later than midnight on December 31, 2016. California will use the NEMSIS Version 3.4 as our base data standard effective January 1, 2017. This will allow California to be consistent with the most current version of the national data standard and with AB1129.

The National Highway Safety Administration (NHTSA) and University of Utah have put a final sunset date on the use of NEMSIS Version 2. The submission of NEMSIS Version 2 will conclude at midnight on December 31, 2016 with no further time extension allowed.

**Implementation of AB 503 – Health and Safety Code 1797.122:**

This bill authorizes a health facility to share patient-identifiable information with a defined EMS provider, local EMS agency, and EMSA. This clarifies the California health information privacy law to be consistent with HIPAA, which already allows sharing of treatment, payment, and operations information between covered entities, and also specifies that local EMS agencies and EMSA may receive this information for quality improvement. The intent is to share outcome information on patients to support quality evaluation and performance improvement and the use of health information exchange. This will also enhance the annual EMS Core Measure reporting.

As allowed in the bill, EMSA will set the “minimum standards for the implementation of data collection, including system operation, patient outcome, and performance quality improvement.” These standards will be incorporated into revisions of Chapter 12.
Implementation of AB 1223 – Health and Safety Code 1797.120 and 1797.225:

This bill requires EMSA to adopt standards related to data collection for ambulance patient offload time.

Interim guidance will be developed by EMSA, in collaboration with local EMS agencies, on statewide standard methodology for the calculation and reporting of ambulance patient offload time. Regulation revisions will propose to incorporate the methodology found in the interim guidance.

Implementation of SB 19 – Probate Code 4788:

This bill enacts the California POLST eRegistry Pilot Act. The bill requires the Emergency Medical Services Authority to establish a pilot project, in consultation with stakeholders, to operate an electronic registry system on a pilot basis, to be known as the California POLST eRegistry Pilot, for the purpose of collecting POLST information received from a physician or physician's designee, if non-state funding is received.

The bill requires EMSA to coordinate the development of the POLST eRegistry Pilot, which would be operated by health information exchange networks, by an independent contractor, or by a combination thereof. The main model envisioned for the registry is dependent on use of electronic health records by EMS personnel (as required in AB 1129), and transition to a NEMSIS 3 platform, to link those records to electronic medical records within health systems to send, receive, find, and use POLST information.

Many individuals throughout our EMS system are excited about the potential for increased data quality and consistency, which will lead to new opportunities to evaluate, understand, and improve our EMS system at all levels.

Please contact either Tom McGinnis at Tom.mcginnis@emsa.ca.gov 916-431-3695 or Kathleen Bissell at Kathy.bissell-benabides@emsa.ca.gov 916-431-3687 with any questions concerning this memo.
DATE: June 2, 2016

TO: Local EMS Administrators
EMS Medical Directors
EMS Providers
Other EMS System Stakeholders

FROM: Howard Backer, MD, MPH, FACEP
Director

SUBJECT: EMSA Data Strategy Document

The purpose of this document is to share EMSA’s strategy on how we will collaborate with the EMS community to improve the quality of data submitted to CEMSIS.

EMSA recognizes the benefit of standardized statewide EMS data collection to successfully meet the increasing demand for quality data that describe EMS services; however, EMSA also recognizes the challenges to this goal. It is EMSA’s vision to utilize improved data quality to support the Triple Aim: improving patient health; improving health outcomes; and reducing costs. This document states EMSA’s goals that support this vision and that will position California to participate fully in national efforts to develop meaningful performance measures and data quality.

In the near term, EMSA will work collaboratively with EMS partners to standardize data and improve data quality based on electronic data systems, even without the benefit of a single data system.

EMSA’s strategy embraces the recent legislative mandates toward electronic data systems contained in AB 503, AB 1129, AB 1223, and SB 19 and supports technical assistance for LEMSA and providers.

Please contact either Tom McGinnis at Tom.mcginnis@emsa.ca.gov; 916-431-3695 or Kathleen Bissell at Kathy.bissell-benabides@emsa.ca.gov; 916-431-3687 with any questions concerning this memo.

HB/kb
EMERGENCY MEDICAL SERVICES AUTHORITY (EMSA)
STRATEGY for DATA COLLECTION, EVALUATION, and QUALITY

Emergency Medical Services Authority
And the Executive Data Advisory Group

Updated: June 2, 2016 (Ver5)

BACKGROUND AND HISTORY
EMSA and LEMSAs are currently experiencing an unprecedented convergence of opportunity and demand involving the collection and meaningful use of Emergency Medical Services (EMS) and specialty care data. Drivers include health care reform, patient outcome focused performance improvement, current and new legislation, grant and funding requirements, community expectations for efficient EMS system design, and changes in the national policy and practice of collecting EMS data. Development of a cohesive statewide EMS data collection and meaningful use strategy is urgently needed in order to position EMS in California to optimize opportunities and meet the increasing demand. This includes development of a comprehensive and integrated statewide approach to how we collect, analyze, report and utilize data.

Currently the national healthcare system is undergoing a major change driven by the need for greater economy, quality of care, and population health—all demonstrated by data. EMS will be swept along in these changes and the resulting model for healthcare. Until recently, EMS has been largely excluded from the healthcare data revolution, but there is an emerging realization that EMS plays a key role in many critical and costly medical interventions such as trauma, stroke, STEMI, and overall emergency care. Additionally, as part of the Office of the National Coordinator for Health Information Technology strategy, there is an increased emphasis on interoperability and explicit calls on EMS to be fully integrated into the healthcare information technology infrastructure. In the future, EMS will not be simply a fee-for-service transportation service; rather, EMS will be a fully integrated component in the broader challenge of community healthcare as well as the chain of emergency care.

Data played a pivotal role in the early development of EMS in the United States. In 1966 The National Academies of Science published Accidental Death and Disability: The Neglected Disease of Modern Society, which would become known as “The White Paper” presented compelling data that was widely utilized by the National Transportation and Safety Administration (NHTSA) and early EMS leaders to successfully argue for organized EMS systems. The resulting shift to a systems based approach supported by an effective governance structure led to great improvements in EMS delivery and patient care throughout the country. By all accounts this was a major

1 Members include: Bruce Barton, Ed Hill (former), Dave Magnino, Vicki Pinette (new), Joe Barger, Karl Sporer, Ken Miller, Mark Roberts; Tom McGinnis; Kathy Bissell; Howard Backer
turning point for EMS and healthcare in the United States that began with the collection, analysis and reporting of death and disability data.

Historically, EMS data collection efforts in California have been decentralized with the LEMSAs collecting, analyzing and reporting data based on local system needs. At the State level, without reliable and consistent data, EMSA has relied on the review and approval of EMS plans from local EMS agencies that provide descriptive system design and program information, current status, and planning goals, but limited system performance metrics.

Some LEMSAs have established sophisticated data collection systems; however, there is a lack of uniformity in data collection systems, varied analytic methodologies and limited success in the data reporting. This dynamic has resulted in data output variation that hamper EMSA and some LEMSA’s ability to meet their statutory mandate and key function to assess and validate the effectiveness of EMS systems in delivering care (Health and Safety Code 1797.102). This is demonstrated by the challenges faced by Core Measures reporting. Although the project is a national model for state EMS performance measurement, the completeness, comparability, and validity of the results are irregular due to the wide disparity of data systems, collection, and reporting.

As part of an EMS vision process in 2000, an EMS system stakeholder group recommended that a single data collection system be implemented statewide. However, the rapid growth of health information technology and the lack of accepted national EMS data standards made this recommendation unrealistic. The goals developed by that stakeholder group included:

1. Achieve statutory mandates at the local and State level;
2. Understand the effectiveness of EMS systems;
3. Improve the quantity and quality of pre-hospital EMS and trauma data submitted; and
4. Improve clinical care and engage in continuous quality improvement (CQI or QI) activities.

These goals are just as cogent today, but there is new opportunity to achieve them through development of a cohesive statewide EMS data collection and meaningful use strategy.

Statutory Authority and Responsibility
The legislative intent and goal described in the EMS Act is to have a coordinated EMS system in the state of California. The EMS Act mandates collection of data to evaluate the effectiveness of the current system, detect practices in patient care and trends in patient movement, and adjust EMS systems accordingly. LEMSAs and EMSA rely upon data and information to adequately assess and coordinate local EMS systems.

The local EMS agency shall plan, implement, and evaluate an emergency medical services system…(1797.204). Evaluation is one of the responsibilities specifically
assigned to the medical director: *Every local EMS agency shall have a … medical director … to provide medical control and to assure medical accountability throughout the planning, implementation and evaluation of the EMS system.* (1797.202)

Among the duties conferred on EMSA by statute (H&S code 1797.102) is to “...*assess each EMS area or the system's service area for the purpose of determining the need for additional emergency medical services, coordination of emergency medical services, and the effectiveness of emergency medical services*. The statute states “shall assess”, indicating it is a mandatory duty and further instructs that it be performed “utilizing regional and local information”.

H&S Code 1797.103 assigns additional duties to EMSA beyond assessing each EMS area. EMSA “…*shall develop planning and implementation guidelines for emergency medical services systems which address the following components:*

…

(f) *Data collection and evaluation.*

In addition, EMSA is given the responsibility “*for the coordination and integration of all state activities concerning emergency medical services*. (Section 1797.1)

EMSA, LEMSAs, and local EMS providers are all required by regulation to actively participate in a QI program. Additionally, local EMS agencies have a requirement to collect data in order to develop their local EMS plans.

Taken together, the statutes and regulations create a repeated mandate for system evaluation at the local and state levels, and the expectation that EMS providers and LEMSAs collect and submit data to EMSA to achieve the required objectives. The requirement for an evaluation of the system at the state level requires complete and reliable data from all parts of the EMS system to provide a balanced and complete picture and to understand the diversity inherent in any statewide program in California.

**CEMSIS and NEMSIS**

Currently, the California EMS Information System (CEMSIS) is based on the version 2.2 application from the National Emergency Medical Services Information System (NEMSIS) and collects EMS data from 20/33 (60%) Local Emergency Medical Service Agencies (LEMSA), representing only about one-third of EMS transports of patients who activate the 911 system. As of 2015, approximately 70% of EMS providers document patient encounters in an electronic health record (ePCR), which is necessary for competent data.

The current EMS system is being replaced by NEMSIS version 3.4.4 which is expected to improve the available data for EMS. NEMSIS Version 3 will yield better information on patient care since it is compatible with Health Level 7 (HL7) and based on International Classification of Disease (ICD) 10. EMS data reported through a NEMSIS 3.X compliant system will be the only data accepted as of January 1, 2017, but is
already the standard for EMS data nationwide and the tool for data and quality evaluation by EMS providers and the Centers for Medicare and Medicaid Services (CMS).

Other data sources and initiatives
Several other sources of data are currently or soon will be integrated with the prehospital data.
- Currently, 73 of the 78 designated Trauma Centers report data either to the LEMSA or directly to EMSA. Trauma center registrars record patient care information on pre-defined trauma patients from the time of the hospital admission to discharge.
- On behalf of local EMS agencies, EMSA will collect and aggregate data on cardiac resuscitation (CARES) within CEMSIS; much of the data is found within the EMS record.
- EMSA is partnering with CDPH on a grant from CDC to create a statewide stroke registry, which will link hospital and outcome data with the EMS data. The data will be housed with CEMSIS data and linked to prehospital data for use in performance improvement initiatives.

Performance improvement measures
In an effort to meet performance improvement goals, EMSA requests EMS Core Measures (quality measures of specific system and clinical indicators of care) reported annually from local EMS agencies on 17 clinical measures. While these are the only statewide patient care data available, they are reported as aggregate data, reflect only a small portion of the available data, and reflect non-standardized data sets in each LEMSA.

As an indication of the importance of using data for performance improvement, a national initiative is underway to develop EMS performance measures using NEMSIS 3 data (COMPASS initiative).

IMPETUS FOR CHANGE
Recent Legislation requiring EMS data collection and coordination
Several bills pertaining to EMS data were signed into law in 2015 that presume or require a leadership role by EMSA to establish data standards consistent with the statutory role to coordinate and integrate all state activities concerning emergency medical services as part of the two tiered regulatory structure.

AB 1129 (Burke) Emergency medical services: data and information system. (Chaptered-9/30/2015)
This bill requires an emergency medical care provider, when collecting and submitting data to a local EMS agency, to use an electronic health record system that exports data in a format that is compliant with the most current version of CEMSIS and NEMSIS. The EMS provider must use an electronic health record system that can be integrated with the local EMS agency’s data system.
This bill will assure the collection of electronic data at the provider level and transfer it to the local EMS agency. It will require EMSA to provide consistent definitions for NEMSIS compliance and establish standards for data collection to ensure reasonable data quality and the ability to aggregate the data at the local level. This will facilitate transmission to state and national EMS information systems and the use of data at these levels.

**AB 503** (Rodriguez) Emergency medical services. (Chaptered-9/30/2015) 
This bill authorizes a health facility to release patient-identifiable medical information to a defined EMS provider, a local EMS agency, and the authority for quality assessment and improvement purposes. Hospital outcome data is an essential component for quality improvement, and this bill is intended to relieve one barrier to reporting outcomes to EMS agencies, which was lack of explicit permission in the California privacy act. The bill also authorizes the Authority to develop minimum standards for the implementation of this data collection.

**AB 1223** (O'Donnell) Emergency medical services: ambulance transportation. (Chaptered-9/30/2015) 
This bill authorizes a local EMS agency to adopt policies and procedures relating to ambulance patient offload time. The bill requires the authority to develop a statewide standard methodology for the calculation and reporting by a local EMS agency of ambulance patient offload time, although reporting by LEMSAs is voluntary.

**SB 19** (Wolk) Physician Orders for Life Sustaining Treatment (POLST) information: electronic registry pilot. (Chaptered-10/5/2015) 
The bill requires the Emergency Medical Services Authority to establish a pilot project to operate an electronic registry system for the purpose of collecting and making available POLST information received from a physician or physician's designee. This project is dependent on use of electronic patient records by EMS personnel (as required in AB 1129), and transition to a NEMSIS 3 platform, to link those records to electronic medical records within health systems to send, receive, find, and use POLST information.

**Health Information Exchange (HIE)**
In addition to patient care data collection and aggregation, EMSA is engaged in increasing the use and value of data through the electronic movement of health information and data exchange. EMSA has received a grant from the Office of the National Coordinator to pilot HIE through two-way exchange of data between hospitals and EMS providers in the field. EMSA will also design a system to widely share patient data during a disaster between EMS personnel, other field care providers, and hospitals (Patient Unified Lookup System for Emergencies + EMS). The ePOLST registry and community paramedicine both require quality electronic data from EMS providers to exchange with other parts of the health care system.
Additional factors driving data development

- Increased emphasis on data and performance measures at the national level, including development of performance measure to justify ambulance transport reimbursement;
- Interest from the Office of Traffic Safety and the Statewide Highway Safety Program to increase funding to advance California data collection and to create linkages with EMS data programs;
- Potential for one-time Federal grant funding for local assistance grants to implement NEMSIS 3 standards and NEMSIS reporting;
- Strong request from local EMS agencies for greater EMSA leadership in standardizing data requirements to improve data quality;
- EMSA’s desire to increase our capability and capacity to meet our statutory requirements to evaluate EMS system effectiveness.

Barriers and Challenges
Despite the requirements for data, significant challenges must be addressed. These are noted, but not elaborated here.

- **Data Submission**
  At the present time, many of the most populous LEMSAs do not provide data to the state for various reasons. Some provide only aggregate data and not patient level data that are needed for any analysis. Hospitals do not universally consent to share data, allegedly out of inappropriate privacy or legal concerns that either HIPAA or the California Medical Information Act prohibits data sharing. (AB 503 was written to alleviate that concern.)

  Some providers are still using paper records, and many fire agencies use a program that is primarily for fire data and secondarily for EMS (RMS software), so is not capable of submitting data in a compatible format. But, AB 1129 now requires providers to transition to NEMSIS compliant electronic patient care reports. Until regulations are in place to define CEMSIS and NEMSIS standards, there will be a lack of compliant systems and vendors.

- **Funding**
  There are no current State General Funds allocated specifically to prehospital EMS or trauma data collection and evaluation. EMSA relies solely on year-to-year federal funding that is insufficient to address the needs in this overall data strategy. Year-to-year funding discourages EMSA from implementing a long term strategy for prehospital and trauma data.

- **Capability and Capacity to Evaluate Data and Information**
  EMSA is currently caught in a difficult situation where the local EMS agencies do not see value from EMSA and are hesitant to submit data, because they do not know what EMSA will do with it. We have developed a boilerplate data use agreement that is available for LEMSAs who require or desire it; to date, none have used it. In
order to demonstrate the value of data collection, it is critical that meaningful analytic results are returned to the local EMS agency and EMS providers. But poor data quality submitted to CEMSIS limit results of analyses. To the extent possible, any analytic results should be readily available, timely, easy to access, and pre-packaged for rapid consumption. The use of dashboards and other information tools would facilitate this and would demonstrate value from the data. This would allow them to benchmark their activities in reference to other California agencies. Currently, EMSA does only basic analysis of trauma data (our best clinical data) and develops and publishes a report on the EMS Core Measures based on the aggregate results provided by the local EMS agencies. EMSA is using available funding to improve analytic capability. Both analytic capability and data quality need to be addressed simultaneously to be successful.

- Long Term EMSA Data and Information Technology Strategy
  Currently, the mechanism in place to allow for the aggregation of local data is through the Inland Counties EMS Agency (ICEMA). This is funded as a local pilot project using Office of Traffic Safety funding. Because it is structured as a local data collection effort, EMSA must address the potential implications of pre-hospital EMS and trauma evaluation in the near future and decide our strategy to sustain data collection. Any ongoing State solution related to EMS data will require a review by California Office of Technology. The entire 4-stage process of IT development requires significant sustained resources.

GOALS AND RECOMMENDATIONS
EMSA has made data development a priority over the past 5 years. Concurrent efforts are required to meet statutory mandates, satisfy stakeholders, and position EMSA to meet its mandate to evaluate quality of care and system effectiveness. EMSA recently formed the Executive Data Advisory Group consisting of three local EMS agency administrators and an equal number of medical directors to help determine a cooperative strategy for improving EMS data and its application. This group informed and supports these recommendations.

Overarching Goals and Value Proposition
There are real benefits to improving the completeness and quality of data collected for pre-hospital, trauma and specialty emergency care when used for analysis of patient care and system performance. These benefits are consistent with the Triple Aim of improving patient satisfaction, improving population health, and lowering the cost of health care.

1. Improved data collection is critical to California’s ability to provide meaningful data describing patient care outcomes and EMS systems.
2. Improved data collection is central to achieving the need of both LEMSAs and EMSA to assess the status and quality of their EMS system and the care that it provides.
3. State-level individual patient/run data are necessary to benchmark and compare values from local agencies and providers and to evaluate the need for additional
EMSA DATA COLLECTION, EVALUATION, AND QUALITY

emergency medical services, coordination of emergency medical services, and the effectiveness of emergency medical services.

4. Quality improvement processes will help to achieve better clinical care for patients and improved population health.

5. Improved data collection and integration with HIEs will link EMS more fully to the full healthcare service spectrum.

6. Sharing critical patient information between EMS personnel in the field and the hospital through health information exchange (HIE) will allow better and more accurate care and transport to appropriate destinations with improved patient outcomes.

7. Standardization of data collection and definitions will ensure reasonable data quality.

Additional benefits include:
- Better service by EMSA to Local EMS agencies through data analysis and return of information to LEMSAAs and EMS providers for comparison purposes, including the potential of a dashboard with real-time information;
- Creating a favorable infrastructure to implement Health Information Exchange (HIE) to link EMS more fully to the full healthcare service spectrum. In turn, this would improve transitions of care with hospitals, obtain patient outcomes for quality improvement, and evaluate system effectiveness.
- Improvement of existing electronic patient care reporting processes at the LEMSA and EMS provider level;
- Efficiencies to program operations at the EMS provider level through analysis of system data;
- The ability to describe and analyze the EMS systems across the state;
- A regional view of EMS systems and better coordination between local areas in support of improved patient care;
- Inclusion of all California data to NEMSIS so that we can evaluate California within the national context.

RECOMMENDATIONS

1. Continue to rely on the Executive Data Advisory Group as a key source of consultation and expert advice, and as liaisons with EMSAAC and EMDAC.

2. Implement the other provision of AB 1129 that requires NEMSIS 3 compliant systems for all EMS providers\(^2\).
   a. Note: The preference of the data group was to use a single ePCR for all EMS providers and for aggregation and analysis of data. However, AB 1129 expressly prohibited LEMSAAs from mandating a particular ePCR for all providers.

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3. Continue to implement NEMSIS 3 and Health Information Exchange at the local level, including EMSA guidance to ensure CEMSIS and NEMSIS standards are maintained;
   a. Improve data consistency with NEMSIS 3 implementation through limiting data choice in several key fields, including primary and secondary impression, cause of injury, location type. Vendors will be required to implement these recommendations that will be drafted and approved by medical directors and the data advisory group.
   b. Per AB1129, all EMS providers must use an ePCR that is NEMSIS 3.4 compliant, a standard that is achieved only through testing by NEMSIS and cannot be achieved through data mapping from NEMSIS 2.X programs;
   c. LEMSAs must use a data platform that is also NEMSIS 3 compliant in order to aggregate and subsequently transmit data to CEMSIS
   d. LEMSAs should consider linking Computer Automated Dispatch (CAD) systems for populating NEMSIS 3 compliant dispatch and call taking data into ePCR platforms. CAD input is accommodated by NEMSIS 3.X using digital push into ePCR.

4. Work toward our federal challenge goal of receiving 100% of data from 100% of EMS providers in California.

5. Link EMS records to electronic medical records within health systems to obtain patient outcome data.

6. Improve data quality through modification to selected values of certain data elements within NEMSIS 3, such as Primary Impression and Cause of Injury.

7. EMSA will work with federal partners to maximize funds in order to support data submission and aggregation through implementation of AB 1129 and NEMSIS 3. Funds obtained will be used primarily for local assistance.

8. Regulations: There are multiple issues that require further definition through regulations. This will be done through a stakeholder task force to revise existing quality improvement regulations.
   a. Recently chaptered legislation (AB 503 and AB 1129) obligate EMSA to define CEMSIS and NEMSIS standards to assure statewide consistency. These regulations will address methods to improve quality and narrow variation in systems through clarification of data standards.
   b. Develop statewide consistency for technical data specification to define and limit data elements and subsequent values for each element. (For example, standardize appropriate choices for Primary Provider Impression).
   c. Implement NEMSIS 3.4
   d. The Executive Data Advisory Group recommends a regulatory mandate for submission of all patient level data to CEMSIS; however, the approach endorsed will be to develop support for the current statutory mandates and utilize other incentives, including funding, if available.
9. Develop **analytic capability and capacity** within EMSA and expand the Annual Statewide and local agency reports, including efforts to develop regional data.

10. Address concerns over **data security, confidentiality, and sharing**, including through data use agreements. (These were developed, reviewed by OHII legal counsel and are currently available.)

11. **Performance improvement**: In addition to improving consistency and completeness of data to use for quality improvement at the local and state level, continue EMS Core Measure reporting to provide state level measures. As national measures become available, these specifications can be incorporated into the state reporting.

12. Examine a **long term EMS Data strategy**, considering the policy options listed above.

**CONCLUSION**

EMSA and LEMSAs have an unprecedented opportunity to collaboratively improve the quality and completeness of EMS data. This is driven by both long-standing and recent statutory mandates, funding opportunities, federal data changes and expectations, and health system changes that require consistent data to measure system effectiveness and clinical quality of care at all levels of our EMS system. Moreover, we now have an opportunity to better integrate specialty care data and link to electronic health records to facilitate outcome data. EMSA, EMSAAC and EMDAC are working together to determine the best strategy and use of available resources to accomplish these goals. Development of a cohesive statewide EMS data collection and meaningful use strategy is urgently needed in order to successfully meet the increasing demand for EMS services and to position EMS in California to optimize opportunities within the healthcare system.
Senate Bill No. 1305

CHAPTER 900

An act to add Section 1799.109 to the Health and Safety Code, relating to emergency medical service providers.

[ Approved by Governor September 28, 2018. Filed with Secretary of State September 28, 201

LEGISLATIVE COUNSEL’S DIGEST

SB 1305, Glazer. Emergency medical services providers: dogs and cats.

Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personne (the act), establishes the Emergency Medical Services Authority to coordinate and integrate all state acti concerning emergency medical services, including, among other duties, establishing training standards for spe emergency services personnel. The act provides a qualified immunity for public entities and emergency re personnel providing emergency services. The act provides other exemptions from liability for specified profess rendering emergency medical services.

Existing law, the Veterinary Medicine Practice Act, governs the practice of veterinary medicine in this state makes it unlawful for any person to practice veterinary medicine in this state without a valid license issued purs to the act. For purposes of the act, the practice of veterinary medicine includes, among other things, administ a drug, appliance, or treatment for the cure or relief of a wound, fracture, or bodily injury of an animal.

This bill would authorize an emergency responder, as defined, to provide basic first aid to dogs and cats, as def to the extent that the provision of that care is not prohibited by the respondent's employer. The bill would limit liability for specified individuals who provide care to a pet or other domesticated animal during an emergenc applying existing provisions of state law. The definition of “basic first aid to dogs and cats” for purposes of t provisions would specifically include, among other acts, administering oxygen and bandaging for the purpo: stopping bleeding.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1799.109 is added to the Health and Safety Code, to read:

1799.109. (a) The Legislature finds and declares all of the following:
(1) California residents receive comfort and unconditional love on a daily basis from their household particularly dogs and cats.

(2) California residents benefit from the special support, comfort, guidance, companionship, and therapy provided by dogs and cats.

(3) Pets provide critical support to many California residents with disabilities.

(4) Pets provide assistance and aid in the official duties of military personnel, peace officers, law enforcement agencies, fire departments, and search-and-rescue agencies.

(5) Personnel of some fire districts and other first responder agencies currently provide stabilizing, life-saving emergency care to dogs and cats, which violates the Veterinary Medicine Practice Act.

(6) In enacting this section, it is the intent of the Legislature to authorize emergency responders to provide, voluntarily, basic first aid to dogs and cats without exposure to criminal prosecution or professional discipline for the unlawful practice of veterinary medicine.

(b) Notwithstanding the Veterinary Medicine Practice Act, as set forth in Chapter 11 (commencing with Section 4800) of Division 2 of the Business and Professions Code, an emergency responder may provide basic first aid to dogs and cats to the extent that the provision of that care is not prohibited by the responder's employer, and responder shall not be subject to criminal prosecution for a violation of Section 4831 of the Business and Professions Code.

(c) Civil liability for a person who provides care to a pet or other domesticated animal during an emergency governed by the following:

(1) Section 4826.1 of the Business and Professions Code governs care provided by a veterinarian.

(2) Subdivision (a) of Section 1799.102 governs care provided by an emergency responder, or law enforcement emergency personnel specified in this chapter.

(3) Subdivision (b) of Section 1799.102 governs care provided by any person other than an individual described in paragraph (1) or (2).

(d) Notwithstanding any other law, this section does not impose a duty or obligation upon an emergency responder or any other person to transport or provide care to an injured pet or other domesticated animal during an emergency.

(e) For purposes of this section, the following definitions apply:

(1) "Cat" means a small domesticated feline animal that is kept as a pet. "Cat" does not include nondomestic wild animals.

(2) "Dog" means a domesticated canine animal owned for companionship, service, therapeutic, or assist purposes.

(3) "Emergency responder" means a person who is certified or licensed to provide emergency medical services.

(4) "Employer" means an entity or organization that employs or enlists the services of an emergency responder.

(5) "Basic first aid to dogs and cats" means providing immediate medical care to a dog or cat by an emergency responder, in an emergency situation to which the emergency responder is responding, that is intended to stabilize the dog or cat so that the dog or cat can be transported by the owner as soon as practical to a veterinary treatment and which is provided through the following means:

(A) Administering oxygen.

(B) Managing ventilation by mask.
(C) Manually clearing the upper airway, not including tracheal intubation or surgical procedures.

(D) Controlling hemorrhage with direct pressure.

(E) Bandaging for the purpose of stopping bleeding.

(f) This section does not require or authorize the provision of emergency services to dogs or cats in response to a telephone call to the 911 emergency system and is not a basis for liability for the failure to provide emergency services to dogs or cats in response to a telephone call to the 911 emergency system.
September 2018
Ground
## Merced County - Riggs P1 - P4 Response Time Compliance Summary

**Period: Sep 2018**

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# Merced County - Riggs Compliance Penalty Report

**Period: Sep 2018**

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**TOTAL** $27,000
October 2018
Ground
## Merced County - Riggs P1 - P4 Response Time Compliance Summary

**Period: Oct 2018**

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<th>Gross Exceptions</th>
<th>Pending Corrections Req</th>
<th>Pending Exemptions Req</th>
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<th>Compliance Calculated Responses</th>
<th>Chargeable Late Responses</th>
<th>Compliance</th>
<th>Compliance Period Start</th>
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# Merced County - Riggs Compliance Penalty Report

**Period: Oct 2018**

## Response Time Penalty Assessment

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<th>Priority</th>
<th>Area Compliance</th>
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<th>Late Responses</th>
<th>Outlier Response Fine</th>
<th>Outlier Response Fine Credit</th>
<th>Consecutive Periods Out of Compliance</th>
<th>Out of Compliance Count for 12 Periods</th>
<th>Total Fine Assessment</th>
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<th>Responses To</th>
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**TOTAL**: $10,000
November 2018
Ground
## Merced County - Riggs P1 - P4 Response Time Compliance Summary

**Period: Nov 2018**

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<th>Gross Exceptions</th>
<th>Pending Corrections Req</th>
<th>Pending Exemptions Req</th>
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<th>Compliance Calculated Responses</th>
<th>Chargeable Late Responses</th>
<th>Compliance</th>
<th>Compliance Period Start</th>
<th>Compliance Period End</th>
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($19,750) **TOTAL**  $14,000
Quarter #3 2018
P5 (CCT)
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<th>Compliance Calculated Responses</th>
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<th>Compliance</th>
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<td>Total Inc Count</td>
<td>Late Responses</td>
<td>Outlier Response Fine</td>
<td>Outlier Response Fine Credit</td>
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## Merced County - Riggs P1 - P4 Response Time Compliance Summary

### Period: Dec 2018

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<th>Compliance Calculated Responses</th>
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## Response Time Penalty Assessment

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**TOTAL** $0
January 2019
Ground
## Merced County - Riggs P1 - P4 Response Time Compliance Summary

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February 2019
Ground
# Merced County - Riggs P1 - P4 Response Time Compliance Summary

**Period: Feb 2019**

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# Merced County - Riggs Compliance Penalty Report

**Period: Feb 2019**

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<td>0</td>
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<td>2019-02-28</td>
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<tr>
<td>P3-CODE 2</td>
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<td>496</td>
<td>16</td>
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<td>2019-02-01</td>
<td>2019-02-28</td>
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<tr>
<td><strong>CountyWide</strong></td>
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<td></td>
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<tr>
<td>P4/P6/P7</td>
<td>97.49%</td>
<td>359</td>
<td>9</td>
<td>$500</td>
<td>($500)</td>
<td>0</td>
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<td>2019-02-01</td>
<td>2019-02-28</td>
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</table>

**TOTAL**        |                      |                  |                         |                 |                |                       |                              |                                        |                                        | $23,500              |               | $0           |
Quarter #4 2018
P5 (CCT)
## Merced County - Riggs Response and Transport Summary

**Period:** 10/01/2018 thru 12/31/2018

*CCT P5 & P9*

<table>
<thead>
<tr>
<th>Area</th>
<th>Priority</th>
<th>Calls For Service</th>
<th>Calls For Service % by Area</th>
<th>Cancel Enroute</th>
<th>Cancel AtScene</th>
<th>Calls Resulting in Transport</th>
<th>% Calls Resulting in Transport</th>
<th>Transport % by Area</th>
<th>Total # Units Transporting</th>
<th>Avg Response Time</th>
<th>90th Percentile Response Time</th>
<th>Avg Call Duration Non TX</th>
<th>Avg Call Duration TX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Call Density</td>
<td></td>
<td>0.00%</td>
<td>--</td>
<td>0.00%</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>00:00:00</td>
<td>00:00:00</td>
<td>00:00:00</td>
<td>00:00:00</td>
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<tr>
<td><strong>Total Low Call Density</strong></td>
<td></td>
<td>0.00%</td>
<td>--</td>
<td>0.00%</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>00:00:00</td>
<td>00:00:00</td>
<td>00:00:00</td>
<td>00:00:00</td>
</tr>
<tr>
<td>High Call Density</td>
<td>P5-CCT TRANSFER &lt;90 MINS</td>
<td>100.00%</td>
<td>0</td>
<td>1</td>
<td>45</td>
<td>97.83%</td>
<td>100.00%</td>
<td>45</td>
<td>00:41:19</td>
<td>01:20:24</td>
<td>00:01:11</td>
<td>03:15:44</td>
<td></td>
</tr>
<tr>
<td><strong>Total High Call Density</strong></td>
<td></td>
<td>100.00%</td>
<td>0</td>
<td>1</td>
<td>45</td>
<td>97.83%</td>
<td>100.00%</td>
<td>45</td>
<td>00:41:19</td>
<td>01:20:24</td>
<td>00:01:11</td>
<td>03:15:44</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>100.00%</td>
<td>0</td>
<td>1</td>
<td>45</td>
<td>97.83%</td>
<td>100.00%</td>
<td>45</td>
<td>00:41:19</td>
<td>00:00:00</td>
<td>00:01:11</td>
<td>03:15:44</td>
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</tbody>
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Exemption Reason Count: 0
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<tr>
<th>Zone</th>
<th>Priority</th>
<th>Total Volume</th>
<th>Do Not Count</th>
<th>Adjusted Total Volume</th>
<th>Gross Exceptions</th>
<th>Exemptions Approved</th>
<th>Compliance Calculated Responses</th>
<th>Chargeable Late Responses</th>
<th>Compliance</th>
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</thead>
<tbody>
<tr>
<td>Priority-5</td>
<td>P5/P9</td>
<td>46</td>
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<td>46</td>
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<td>93.48%</td>
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</table>
### Response Time Penalty Assessment

<table>
<thead>
<tr>
<th>Area</th>
<th>Priority</th>
<th>Compliance</th>
<th>Out of Compliance Fine</th>
<th>Total Inc Count</th>
<th>Late Responses</th>
<th>Outlier Response Fine</th>
<th>Outlier Response Fine Credit</th>
<th>Total Fine Assessment</th>
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</thead>
<tbody>
<tr>
<td>Priority-5</td>
<td>P5/P9</td>
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<td></td>
<td>46</td>
<td>3</td>
<td>$1,000</td>
<td>($1,000)</td>
<td>$0</td>
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*Period: Oct 01 2018 to Dec 31 2018*
<table>
<thead>
<tr>
<th>Area</th>
<th>Priority</th>
<th>Date</th>
<th>Run #</th>
<th>Status</th>
<th>Unit</th>
<th>Threshold</th>
<th>Resp Time</th>
<th>Overage</th>
<th>Outlier Penalty</th>
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</thead>
<tbody>
<tr>
<td>High Call Density</td>
<td>P5-CCT TRANSFER &lt;90 MINS</td>
<td>2018-10-22</td>
<td>51341</td>
<td>Late After Review</td>
<td>U25</td>
<td>01:29:59</td>
<td>02:05:42</td>
<td>00:35:43</td>
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<tr>
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<td>P5-CCT TRANSFER &lt;90 MINS</td>
<td>2018-11-03</td>
<td>53591</td>
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<td>M16</td>
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<td>62265</td>
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$1,000