May 20, 2019

Esam El-Morshedy
EMS Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670

Re: Title 22. Social Security, Division 9. Prehospital emergency medical services
Chapter 4. Paramedic - Notice published on April 5, 2019

To Whom It May Concern:

The California Medical Association (CMA) respectfully submits the following comments for consideration related to Emergency Medical Services Authority's (EMSA) proposed regulations to implement, interpret, or make specific Section 1797.116, 1797.172, and 1797.194 of the Health and Safety Code.

The California Medical Association is an advocacy organization that represents more than 45,000 California physicians. Dedicated to the health of Californians, CMA is active in the legal, legislative, reimbursement and regulatory areas on behalf of California physicians and their patients.

CMA's concerns with the proposed regulations pertain to the amendments that establish requirements for prehospital triage and transportation of patients who are assessed and determined to have a non-emergency condition to an alternative destination for treatment under the medical control of a LEMSA medical director. The proposed amendments expand the paramedic scope of practice to make medical decisions regarding where to transport a patient beyond what is allowed under current state law. We disagree that it is within EMSA's current authority to establish prehospital triage protocols as proposed in these regulations. We urge EMSA to withdraw subsection (a)(7) to Article 7. System Requirements, § 100170. Medical Control relating to the development of prehospital triage protocols and transport to destinations other than a general acute care hospital operating an emergency department.

Background

The proposed amendments add subsection (a)(7) to Article 7. System Requirements, § 100170. Medical Control, to state that written medical policies and procedures should be developed which delineate the requirements to be followed for prehospital triage of patients who are assessed and determined to have a non-emergency condition. As proposed, these requirements may include procedures for:
• Patients that are frequent users of the EMS system that require referral;
• Patients that require transport to an alternative destination other than a Hospital with a Basic emergency permit for further treatment, or
• Patients who require assessment in an emergency situation.

These requirements include but shall not be limited to:

(A) Policies, procedures, and protocols for medical control and quality of care.

(B) Use of advanced life support skills, advanced screening tools and point-of-care testing to evaluate patient severity.

(C) Documentation of assessment and evaluation in an electronic health record for each patient evaluated.

(D) Completion of additional training and competency testing based upon standardized curriculum approved by the authority.

(E) Authorization of personnel by the local EMS agency medical director.

(F) Designation of alternative receiving facilities, with medical staffing to consist of at least one registered nurse, that includes:

1. Hospitals with a standby emergency department permit or a hospital operated by the Veterans Administration, or

2. Authorized mental health facilities as defined in Subdivision (n) of Section 5008 of the Welfare and Institutions Code, or

3. Authorized sobering centers that are either a federally qualified health center or a clinic as described in Section 1211 of the Health and Safety Code.

The Notice of Proposed Rulemaking states that the regulations propose the adoption of specific requirements for training, protocols, documentation, and consideration for establishing alternative destinations when paramedics assess and determine that a patient is in a “non-emergency” condition. EMSA states that the proposed amendments are intended to establish requirements for prehospital triage of patients who are assessed and determined to have a non-emergency condition to an alternative destination for treatment under the medical control of a LEMSA medical director.

CMA Comments

Assessment of Non-Emergent Medical Conditions and Transfer to Destinations Other Than General Acute Care Hospitals Exceeds Paramedic’s Legal Scope of Practice. Under the proposed regulations, LEMSAs would establish protocols under which paramedics would
perform patient assessments to determine if a patient is experiencing an emergency situation and if the patient is determined not to be experiencing an emergency, the paramedic would transport the patient to an alternate destination that includes mental health facilities or sobering centers. According to the Office of Statewide Health Planning and Development (OSHPD) and EMSA:

Paramedics are presently trained to provide advanced life support services in an emergency setting or during inter-facility transfers. Currently, California Health and Safety Code (HSC 1797.52, 1797.218), limits paramedic scope of practice to emergency care in the pre-hospital environment. Moreover, patients under the care of a paramedic are required to be delivered to a general acute care hospital emergency department. The paramedic scope of practice in California is somewhat unique compared to other licensed health professionals in that the statute refers to both a set of authorized skills/activities that emergency medical personnel may perform and the places and circumstances in which those skills/activities may be performed... Paramedics are required to operate under medical control or protocol at all times.¹

Under existing state law, paramedic scope of practice is limited to advanced life support services in an emergency setting and does not include diagnosis of medical conditions or decisions about appropriate medical treatment of medical conditions and the environments in which those treatments should be delivered. Paramedics are responsible for providing care to stabilize a patient's condition to allow transport to a general acute care hospital with an emergency department where the patient can be assessed, triaged, treated and, if appropriate, discharged from the hospital's care. Emergency departments in California are required to meet specified staffing and facility requirements that allow them to be the entity responsible for determining if a patient's condition is stable enough to be discharged for care outside of a general acute care hospital.

EMT-Paramedics are trained to provide advanced life support services in emergency settings or during inter-facility transfers. California Health and Safety Code Division 2.5, Emergency Medical Services:

a) Limits the EMT-Paramedics scope of practice to emergency care in the pre-hospital environment
b) Requires that patients under the care of an EMT-Paramedic be transported to a general acute hospital that has a basic or comprehensive emergency department permit (Health and Safety Code Section 1797.52, 1797.218)
c) Requires emergency medical services to transport a patient to the closest and most appropriate facility (Health and Safety Code Section 1797.114).

¹ Office of Statewide Health Planning and Development, Community Paramedicine Pilot Project Application, HWPP #173, February 16, 2014.
HSC makes no reference to paramedics providing non-emergency care and clearly specifies that patients must be transported to a general acute care hospital. While patients reserve the right to decline transportation to a hospital emergency department, this does not affirmatively allow paramedics to make decisions regarding transport to other locations.

**EMSA Lacks Authority to Allow Transfers to Destinations Other Than General Acute Care Hospitals.** These regulations propose the adoption of specific requirements for training, protocols, documentation, and consideration for establishing alternative destinations when paramedics assess and determine that a patient is in a “non-emergency” condition. According to the Notice of Proposed Rulemaking, the authority to promulgate regulations on prehospital triage protocols is based on the EMS Administrators Association of California (EMSAAC) and EMS Medical Directors Association of California (EMDAC) position paper positing that once paramedics arrive at an emergency patient, the paramedics may assess and determine that a patient is in a “non-emergency” condition. According to the position paper, at that point, a local EMS agency (LEMSA) Medical Director has broad medical control authority to authorize a patient to be transported to any destination, unrestricted by existing statutes, because the patient is not in an “emergency” condition. The paper asserts that the Medical Director of a LEMSA has broad authority to make medical decisions regarding patient destination from the scene of an emergency and while in transport, pursuant to HSC Sections 1797.220 and 1798.

1797.220. The local EMS agency, using state minimum standards, shall establish policies and procedures approved by the medical director of the local EMS agency to assure medical control of the EMS system. The policies and procedures approved by the medical director may require basic life support emergency medical transportation services to meet any medical control requirements including dispatch, patient destination policies, patient care guidelines, and quality assurance requirements.

1798. (a) The medical direction and management of an emergency medical services system shall be under the medical control of the medical director of the local EMS agency. This medical control shall be maintained in accordance with standards for medical control established by the authority.

The Notice states that “though existing regulations do not require patient transport, and specifically recognize nontransport as an option, there is much confusion regarding the assessment and transport of patients to alternative destinations by paramedics.” We disagree and believe there is ample support in law, past statements and actions by EMSA that EMSA clearly does not have the legal authority to promulgate regulations to allow patient transfers to destinations other than general acute care hospitals with a standby emergency department. In 2014, EMSA applied to establish a Health Workforce Pilot Project (HWPP) through the Office of Statewide Planning and Development (OSHPD) to allow for the temporary waiver of sections of the Health and Safety code (HSC 1797.52, 1797.218) that
limit the destination of patients transported by paramedics and that specify the limited emergency settings and situations where paramedics can provide services. Application for temporary waiver of HSC sections governing paramedic scope and transfer clearly indicates that the specified HSC sections limited EMSA’s authority to expand the type of care provided by paramedics and where those patients can be transferred.

In addition, there have been legislative attempts to expand EMSA’s ability to allow paramedics to transport patients to alternate destinations. SB 944 (Hertzberg, 2018), AB 1795 (Gipson, 2018), AB 3115 (Gipson, 2018) have all sought to allow EMTs to divert patients to sobering centers or mental health facilities or to make permanent the community paramedicine pilot programs authorized by OSHPD. Most recently, AB 1544 (Gipson, 2019) seeks to establish the Community Paramedicine or Triage to Alternate Destination Act of 2020 to establish state guidelines to govern the implementation of community paramedicine programs (CPP) or triage to alternate destination programs (TADP) by local LEMSAs in California. The repeated introduction of this legislation would indicate that EMSA and LEMSA medical directors do not already have the statutory authority to promulgate regulations on this subject.

**Expanded Paramedic Scope of Practice and Transportation to Destinations Other than General Acute Care Hospitals Risks Patient Safety.** Patients call for emergency services with the expectation that they will be transported to a hospital and thoroughly examined and treated for their condition. CMA is concerned that the proposed regulations would rely on paramedics to evaluate and make determinations regarding the nature and acuity of a patient’s condition. Licensed physicians are the most qualified to diagnose a patient’s condition, based on their education, training and experience. Even in an emergency room setting, patients must be evaluated by a physician before being discharged. A physician cannot rely on an assessment performed by the paramedic or other allied health professional.

While a paramedic is trained to assess symptoms and stabilize a patient for transport to the emergency room, they are not trained to make a determination regarding the root cause of potentially broad symptoms. For example, a 911 caller might present with shoulder pain which could be a physical injury or could be the first sign of a heart attack. It is also possible that patients could be diverted to an urgent care setting, only to be transported to a hospital after being diagnosed with a more acute condition by physicians at the urgent care center. This could result in additional costs to the patient and delays in care that could impact patient safety.

Properly diagnosing conditions, knowing the likely course of treatment and directing patients to the appropriate location where they can receive appropriate care is a significant responsibility that requires specialized education and training. Physicians attend medical school for four years and then complete three to seven years of residency training, during which they become experienced in evaluation and diagnosis. This experience cannot be
distilled into a protocol or checklist that can be administered by an allied health professional with substantially less training and education.

A 2019 evaluation of the OSHPD Health Workforce Pilot Project, funded by the California Healthcare Foundation found that pilot programs participating in alternate destination transfers to mental health facilities and sobering centers generated cost savings to participating counties (due to diversion from treatment at emergency departments); however, there is limited information regarding whether there were improvements in quality of care. The pilot projects also included alternate destination transfers to urgent care centers and the evaluation found that urgent care centers were often closed or declined to accept the patients, and in a few cases the patients had to be rerouted from the urgent care clinic to the emergency department causing a delay in care.

In conclusion, CMA supports improving access to care for underserved patients and the more efficient use of EMSA resources. However, we have significant concerns regarding these proposed regulations and the ability of the programs to meet these objectives while ensuring patient safety. We urge EMSA to withdraw the sections of the proposed regulations related to prehospital triage procedures pending the granting of statutory authority from the Legislature to expand the authority of EMSA and the paramedic scope of practice to allow this action.

Thank you in advance for your consideration of our comments on the proposed regulations.

Sincerely,

Yvonne Choong
Vice President, Center for Health Policy
California Medical Association