

# 1797.201 Stakeholders Work Group

## Outcome Paper

### 1 – Background

Since the Emergency Medical Services (EMS) Act first became law in 1980, there has been considerable debate, controversy and even litigation surrounding various interpretations of California Health and Safety Code Division 2.5, Section 1797.201 (.201) and Section 1797.224 (.224). These two sections, often referred to as the “grandfather” provisions, describe how existing EMS providers receive continuing authorization from the local emergency medical services agency (LEMSA) to provide prehospital EMS services. Section 1797.201 pertains to cities and fire districts that have continuously contracted for or provided prehospital EMS as of June 1, 1980. Section 1797.224 describes the local EMS agency’s ability to establish exclusive operating areas for providers of emergency ambulance services, limited advanced life support, and advanced life support.

Because of the complexity of the issues, numerous concerns and apparent confusion over sections .201 and .224 have persisted. Several recent events have further escalated the debate and there have been several court decisions arising out of disputes regarding the diverse interpretations and various applications of this statutory language since 1980.

In March 2010, an ad hoc 1797.201/.224 subcommittee was appointed by the California EMS Commission representing the following organizations:

- California Chapter of the American College of Emergency Physicians (CalACEP)
- California Ambulance Association (CAA)
- California Fire Chiefs Association (CFCA)
- California Professional Firefighters Association (CPF)
- Emergency Medical Services Administrators Association of California (EMSAAC)

In May 2010, the California Emergency Medical Services Authority (EMSA) hosted a one day stakeholder workshop specifically on the meaning and interpretation of .201.

In December 2010, the EMSA issued a proposed update to EMSA Document No. 141 (8th Edition Draft, December 1, 2009) titled, “Review Criteria and Policy for Transportation and Exclusive Operating Area Components of the EMS Plan.” The proposed update addressed both .201 and .224, however, was subsequently withdrawn.

On December 1, 2010, the EMS Commission ad hoc 1797.201/.224 subcommittee submitted a consensus-based report to the EMS Commission based upon its review of the issues surrounding both .201 and .224. The subcommittee developed a set of recommendations as a road map for EMSA and the EMS community at-large to strengthen the EMS Act’s legislative and regulatory

framework and to assure that all California communities have a fully integrated and coordinated EMS delivery system.

In January 2011, EMSA convened the “Chapter 13 Task Force” to provide feedback regarding new regulations associated with local EMS system management and organization, local EMS plans and transportation component requirements. EMSA formed the Chapter 13 Task Force, in part, as a result of a decision by the California Court of Appeal (Butte Decision, 2010) that the process used by EMSA in determining whether a provider qualifies for grandfathering under Section 1797.224 is best set forth in regulations, formally adopted by the EMSA under the California Administrative Procedures Act, in order to use a generally applicable policy as part of that criteria. The Chapter 13 Task Force was also intended to provide feedback for new regulations regarding both .201 and .224.

Also in early 2011, a group of statewide organizations were invited to participate as a part of the EMS Commission ad hoc subcommittee work group (“work group”). The goal of the group was to develop new statutory language which would achieve consensus-based statutory clarifications specifically regarding .201. The group used the EMS Commission’s ad hoc subcommittee initial report as a beginning template. The following statewide organizations were represented on the work group:

- American Medical Response (AMR)
- California Ambulance Association (CAA)
- California Fire Chiefs Association (CFCA)
- California Professional Firefighters Association (CPF)
- California State Association of Counties (CSAC)
- Emergency Medical Services Administrators Association of California (EMSAAC)
- League of California Cities

The work of the Chapter 13 Task Force was temporarily suspended in September 2011 to avoid duplication of efforts the work group.

The work group concluded its work in February 2012 and developed proposed next steps appearing at the end of this report which are intended to follow the recommendations of the initial EMS Commission ad hoc subcommittee.

## **2 – Achieving Consensus**

The work group defined consensus differently than a vote with a majority rule. Rather, the terms had to be acceptable to all parties. As each issue was considered, a consensus decision was reached to assure each party’s concerns were addressed, even if each party did not necessarily achieve their most desired outcome. When any party did not agree to any specific language, the party was asked to: 1) state their concern; and, 2) identify an alternative that would address their own concerns as well as the stated interests of the other stakeholders. This process was repeated

until all the parties agreed to the final language. Consensus meant that each group could support the proposed language.

All of the work group members worked diligently and in good faith to achieve consensus during dozens of meetings and conference calls over a period of nearly 12 months. The work group achieved consensus on purpose, principles and numerous key items. Ultimately, it was unanimously decided that it was not possible to achieve consensus on a number of key items. The remaining items of consensus are included in the recommendations section.

### **3 – Purpose & Principles**

Since the work group was committed to successfully achieving consensus-based legislative language to clarify 1797.201, it was important to establish a clear purpose at the beginning. The group started by identifying major tenets upon which all work group members agreed. The discussions that followed were guided by the consensus principles below.

- LEMSAs, public providers and private providers are accountable to consistent and clear standards regarding their obligations and opportunities to participate in a local EMS system.
- Objective medical oversight of all EMS system components by LEMSAs is essential to achieve quality, efficient and integrated patient care services county-wide.
- Any legislative amendments to the EMS Act related to .201/.224 issues should be consistent with previous court decisions and opinions.
- All participants in the emergency medical services system are encouraged to enter into agreements with the LEMSA as part of the county’s emergency medical services plan.
- Use of grandfathered providers as authorized under sections .201 and .224 has proven to be effective as long as existing providers can demonstrate that services are meeting the community’s needs.
- The authorizations under .201 belong to the original geographic service area (i.e., “dirt” or land) as of June 1, 1980, not to the jurisdiction (i.e., city or fire district).
- LEMSAs should sponsor a local Emergency Medical Care Committee (EMCC), or equivalent; local EMS stakeholders are encouraged to actively participate in their local EMCC (or equivalent).
- Ground interfacility transports and air ambulance services are not included within the .201 authorization.
- The statutory language in California Health and Safety Code Section 1797.224 remains unchanged.

In addition to the above, the work group established specific goals associated with the rights and obligations of eligible cities and fire districts under .201. Specifically, eligible cities and fire districts:

- May retain .201 authorization to continue to provide the existing *type* of service (*type* means either first response, dispatch or transport service that was continuously contracted for or provided, as of June 1, 1980);
- May not expand to other types of services (that were not continuously contracted for or provided, as of June 1, 1980) without LEMSA authorization;
- May increase the level of clinical care within the eligible type of service with the authorization of the LEMSA;
- May retain .201 authorization for the original geographic service area (based upon the services that were continuously contracted for or provided, as of June 1, 1980);
- Are best served when agreements entered into between a city or fire district and a LEMSA are negotiated at the local level with both parties' participation, input and concurrence with the terms of the agreement; agreement terms are specified in writing and existing entities meeting HSC 1797.201 do not necessarily waive .201 rights by signing such agreements if the agreement states that .201 rights are not waived by the .201 entity or if the agreement is limited to medical control;
- Are required to operate in accordance with LEMSA medical control policies and procedures as well as the local EMS plan;
- May not use .201 authorizations to displace an existing EMS provider which is authorized by a LEMSA.

The aforementioned principles and goals were agreed to by members of the work group and do not represent consensus or agreements by the represented professional organizations. Consensus statutory language to achieve these principles and goals was not accomplished. Those areas where consensus was reached by the work group and represented organizations are included in the final recommendations for regulatory clarification and remedy.

#### **4 – Summary of Policy Issues**

Below is a list of the policy issues which were addressed in the most recent draft of the proposed legislative clarification of Healthy and Safety Code 1797.201. The stakeholders achieved consensus on numerous key items, however, were unable to achieve consensus on a number of small but important issues. These issues are indicated in italics in the outline of items below

1. Declarations
2. New Section 1797.201
  - a. Continuing Authorization
    - i. Disqualifying Agreements*
    - ii. Written Agreements Must Recognize*
      1. Medical Control
      2. Emergency Medical Dispatch Protocols

3. Minimum EMS Performance Criteria & Reporting Standards
  4. Types and Levels of Prehospital EMS
  5. Geographical Services Areas
- b. Failure to Enter into an Agreement
  - c. *Impasse Resolution Process*
  - d. *Annexation*
  - e. LEMSA Recognition of Subcontracts
  - f. Formal Authorization Required
  - g. Local EMS Plan
  - h. Type of Prehospital EMS
    - i. First Response
    - ii. Dispatch (own resources)
    - iii. 911 Ambulance Transport
  - i. Increasing Level of Prehospital EMS
  - j. Reducing Level of Prehospital EMS
  - k. Authorization Required for New Type
  - l. Transfer to Successor Agency
3. Emergency Medical Care Committee (EMCC) – Established
  4. Emergency Medical Care Committee (EMCC) – Annually review EMS system
  5. Emergency Medical Care Committee (EMCC) – Annual report
  6. Confirm Previous Court Decisions
  7. Prohibit Displacement of Existing Authorized Providers
  8. Personnel
  9. State Mandates

## **5 – Recommendations & Next Steps**

The work group believes consensus can be achieved under existing statute on a majority of outstanding issues by establishing newly written regulations. Therefore, the work group recommends that EMSA convene a “Regulatory Work Group” to address the previously established principles of agreement and the following issues:

1. The existing two-tiered state wide EMS system with both state and local oversight provides a mechanism for local EMS system design to evolve to meet community needs.

2. All providers should be integrated into the EMS system and all providers should be included in the EMS Plan.
3. All EMS system participants are part of an approved EMS Plan; EMS Plans require demonstration of broad-based stakeholder support; EMS Plans should address all phases of the EMS response system (first response, dispatch and transport).
4. A strong EMCC (or equivalent) is imperative; EMCCs should implement formal mechanisms to demonstrate stakeholder involvement and should promote involvement of system stakeholders in the EMS system design (including public and private, first response and transport, provider and other system components).
5. Using an EMCC (or equivalent), LEMSAs should establish a stakeholder-based impasse resolution process to be included in the local EMS Plan.
6. Existing entities meeting Health and Safety Code 1797.201 should not be arbitrarily or capriciously displaced.
7. The EMS Plan should address the process for providers to advance clinical levels (i.e., from BLS to ALS) with LEMSA approval.

At the conclusion of the regulatory process, it is recommended that EMSA embark on a statewide educational program to maximize understanding of the new regulations.