

EMERGENCY MEDICAL DIRECTORS ASSOCIATION OF CALIFORNIA, INC.

(EMDAC)

**Los Angeles Airport Marriott
5855 West Century Blvd.
Los Angeles, CA 90045**

**March 23, 2010
9am – 4pm**

A G E N D A

- 9:00am Scope of Practice Committee Meeting (Barger)**
- a. SCOPE items presentation
 - b. Congenital Adrenal Hyperplasia
 - c. Membership vacancies
- 10:00am EMSAAC/EMDAC Joint Session; EMSA Report**
- 10:45am General Meeting**
- a. Roundtable Introductions (All)
 - b. Treasurer's Report (Lotsch) [page 2]
 - c. Legislative Update (Teufel) page 6
 - i. AB 2456 (Torrico), AB 1882
 - ii. Good Samaritan Sudden Cardiac Survival Act of 2010 [page 56]
 - d. EMS Authority Medical Director Update (Tharratt)
 - i. H1N1 Influenza: Results of Paramedic Vaccination Program
 - ii. 201 Workshop: May 4th, 2010 [page 14]
 - iii. EMT 2010- What additional resources do Medical Directors need?
- 12:00pm Lunch**
- 1:00pm Afternoon Session**
- a. EMS STEMI Registry Committee (Salvucci)
 - b. EMSA guidelines on EOAs (Goldman) [Page 16]
 - c. POLST Form comments for revision (Goldman) [Page 52]
 - d. EMDAC representative for TAC (Vaezazizi) [page 54]
 - e. AMTF Guidelines; Update (Barger; Rudnick) [page 58]
 - f. NEMIS Data Standard Update (Barger)
 - g. Review of Bylaws (Mackey) [page 93]
- 3:00pm ROUNDTABLE**
- 4:00pm ADJOURNMENT**

NEXT MEETING DATE AND LOCATION

**June 7, 2010
Crowne Plaza San Diego
2270 Hotel Circle North
San Diego, CA 92108**

EMDAC Treasurer's Report

Prepared by Richard C, Lotsch, DO, Treasurer
3/16/2010

Corporate Account: California Bank and Trust
Current Balance: \$12,559.59

Historical Account Balances:	
3/16/2010 Balance	\$12,559.59
EOY 2009	7,609.81
EOY 2008	4,345.24
EOY 2007	2,600.97
EOY 2006	3,358.68
EOY 2005	6,620.42
EOY 2004	8,111.26
EOY 2003	8,266.50
EOY 2002	5,837.75
EOY 2001	6,818.65

Membership History:		
Year	Members	Dues \$
2010	22	\$225
2009	40	\$225
2008	32.5	\$225
2007	28	\$225
2006	27	\$225
2005	29	\$150
2004	29	\$150

Income:	2010 YTD	<u>2009</u>	<u>2008</u>	<u>2007</u>	<u>2006</u>	<u>2005</u>
Dues	4950.00	9,000.00	7,390.00	6,387.00	4,350.00	4,350.00
Guest Meeting Fees	0.00	385.00				
Other	0.00					
Total Income:	4950.00	9,385.00	7,390.00	6,387.00	4,350.00	4,350.00

Expenses:	2010 YTD	<u>2009</u>	<u>2008</u>	<u>2007</u>	<u>2006</u>	<u>2005</u>	<u>2004</u>	<u>2003</u>
Annual Meeting Expenses	0	5,953.47	5,645.73	7,124.68	7,611.77	5,489.49	4,440.00	3,934.00
3/23/10 Mtg Fee Estimate	2200.00							
Total Meeting Expenses YTD	0							
\$ Difference from Prior Year		307.74	-1,478.95	-487.09	2,122.28	1,049.49	506.00	
% Difference from Prior Year		+6%	-21%	-6%	+33%	+29%	+13%	
Checks		94.98						
Stamps		2.20						
Corporation License Fee		20.00		20.00		20.00		
Member Apprec Plaques						331.35		
Late Penalty for Corp License Fee Pmt		50						
Total Expenses:		6,120.65	5,645.73	7,144.68	7,611.77	5,840.84	4,440.00	3,934.00

Income minus Expenses:	3,264.35	1,744.27	-757.68	-3,261.77	-1,490.84
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EMDAC DUES PAID FOR 2010 (22 + 1 Fellow)			
<u>2010 Dues Paid</u>	<u>Last Name</u>	<u>First Name</u>	<u>Organization & Title</u>
2/8/2010	Barger	Joe	Contra Costa Co EMS
3/7/2010	Bloom	Evan	UCSF Ems Fellow
2/8/2010	Brown	John	San Francisco County and City
2/26/2010	Chase	David	Ventura EMS and FD
2/8/2010	Falck	Troy	Sac-Sierra Valley EMS/Placer, etc
2/8/2010	Gilbert	Greg	San Mateo EMS Medical Director, Stanford ED
3/15/2010	Haynes	Bruce	San Diego Co EMS/Imperial Co EMS
11/23/2009	Kidane	Senai	EMS Fellow, Highland
2/8/2010	Koenig	Bill	LA Co EMS
2/8/2010	Lotsch	Richard	Solano Co EMS
2/8/2010	Lyon	Kristopher	SBSD Air Rescue
2/8/2010	Mackey	Kevin	Mountain Valley EMS
2/8/2010	Miller	Ken	OCEMS
2/8/2010	Ochoa	Humberto	Riverside Co EMS
2/26/2010	Ronay	Tom	SLO Co Ems
2/8/2010	Rudnick	Eric	NorCal EMS
2/26/2010	Shatz	David	UC-Davis EMS Fellow
3/7/2010	Sporer	Karl	San Francisco FD Medical Director
2/26/2010	Stiver	Ken	North Coast EMS
2/8/2010	Stubblefield	Jim	Monterey EMS
3/16/2010	Tharratt	Steve	CA EMS Authority Director
2/8/2010	Vaezazizi	Reza	ICEMA Medical Director/San Bernadino
3/7/2010	Wood	Jack	AMR/NCTI

--- Here is the current list of all subscribers:

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Total number of subscribers: 67 (67 shown here)

ASSEMBLY BILL

No. 2456

Introduced by Assembly Member Torrico

February 19, 2010

An act to amend Sections 1797.103, 1797.107, and 1797.200 of the Health and Safety Code, relating to emergency medical services.

LEGISLATIVE COUNSEL'S DIGEST

AB 2456, as introduced, Torrico. Emergency medical services: regulation.

Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, authorizes each county to designate an emergency medical services agency, for the establishment and administration of an emergency medical services program in the county. Existing law also establishes the Emergency Medical Services Authority, which, among other things, adopts regulations governing the provision of emergency medical services. Violation of these provisions is a crime.

This bill would specify that the guidelines of the authority shall include medical control, require local EMS agencies to adhere to the guidelines in all areas of administration, and would require the local EMS agencies to follow the guidelines of the authority when establishing local policies and procedures required by statute or regulation. By requiring that the local entities comply with these requirements, and by changing the definition of an existing crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

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

- 1 SECTION 1. The Legislature finds and declares all of the
- 2 following:
- 3 (a) For the purpose of administering an effective, statewide
- 4 system of coordinated emergency medical care and statewide
- 5 recognition of certification and licensure for EMT personnel, the
- 6 Emergency Medical Services Authority and the Emergency
- 7 Medical Services Commission must provide guidance to the more
- 8 than 32 local EMS agencies tasked with implementing policies
- 9 and procedures in all areas of EMS, including, but not limited to,
- 10 local accreditation of optional skills, competency tests, training
- 11 programs, demonstration of skills competency, and medical control
- 12 in order to facilitate this vital coordination and efficiency.
- 13 (b) The current statewide EMS guidelines assist in achieving
- 14 system standardization, streamlining field operations, and
- 15 continuing the authority’s commitment to comprehensive planning
- 16 for EMS statewide.
- 17 (c) The statewide EMS guidelines must be strengthened in order
- 18 to do all of the following:
- 19 (1) Link the numerous local EMS agencies together into one
- 20 coordinated statewide EMS system.
- 21 (2) Ensure safety, competence, and consistency to the public
- 22 statewide; consistent training, competence, and delivery of EMS
- 23 statewide; one standard for all EMS certified and licensed
- 24 personnel, regardless of where service is delivered; and that policies
- 25 are driven by research and consensus rather than personality of
- 26 local administrators and doctors.
- 27 (3) Support the statewide mutual aid process by providing a set
- 28 minimum level of service delivery as defined by the EMS
- 29 community.

1 (d) It is the intent of the Legislature to clarify the law with
2 respect to the authority's ability to establish guidelines for the
3 coordinated EMS delivery by the many essential EMS stakeholders
4 of this state.

5 SEC. 2. Section 1797.103 of the Health and Safety Code is
6 amended to read:

7 1797.103. The authority shall develop planning and
8 implementation guidelines for emergency medical services systems
9 ~~which~~. *Counties that establish a local EMS program pursuant to*
10 *Section 1797.200 shall adhere to the guidelines in all areas of*
11 *administration. The authority's EMS guidelines shall address all*
12 *of the following components:*

- 13 (a) Manpower and training.
- 14 (b) Communications.
- 15 (c) Transportation.
- 16 (d) Assessment of hospitals and critical care centers.
- 17 (e) System organization and management.
- 18 (f) Data collection and evaluation.
- 19 (g) Public information and education.
- 20 (h) ~~Disaster~~ *Medical disaster* response.
- 21 (i) *Medical control*.

22 SEC. 3. Section 1797.107 of the Health and Safety Code is
23 amended to read:

24 1797.107. (a) The authority shall adopt, amend, or repeal,
25 after approval by the commission and in accordance with the
26 provisions of Chapter 3.5 (commencing with Section 11340) of
27 Part 1 of Division 3 of Title 2 of the Government Code, ~~such~~ rules
28 and regulations as may be reasonable and proper to carry out the
29 purposes and intent of this division and to enable the authority to
30 exercise the powers and perform the duties conferred upon it by
31 this division not inconsistent with any ~~of the provisions of any~~
32 statute of this state.

33 (b) *The regulations shall include statewide EMS guidelines for*
34 *the coordinated delivery of emergency medical services in this*
35 *state.*

36 SEC. 4. Section 1797.200 of the Health and Safety Code is
37 amended to read:

38 1797.200. (a) Each county may develop an emergency medical
39 services program. Each county developing such a program shall
40 designate a local EMS agency which shall be the county health

1 department, an agency established and operated by the county, an
 2 entity with which the county contracts for the purposes of local
 3 emergency medical services administration, or a joint powers
 4 agency created for the administration of emergency medical
 5 services by agreement between counties or cities and counties
 6 pursuant to the provisions of Chapter 5 (commencing with Section
 7 6500) of Division 7 of Title 1 of the Government Code.

8 *(b) A local EMS agency designated pursuant to subdivision (a)*
 9 *shall follow the guidelines of the authority in establishing its*
 10 *policies and procedures required by statute or regulation.*

11 SEC. 5. No reimbursement is required by this act pursuant to
 12 Section 6 of Article XIII B of the California Constitution for certain
 13 costs that may be incurred by a local agency or school district
 14 because, in that regard, this act creates a new crime or infraction,
 15 eliminates a crime or infraction, or changes the penalty for a crime
 16 or infraction, within the meaning of Section 17556 of the
 17 Government Code, or changes the definition of a crime within the
 18 meaning of Section 6 of Article XIII B of the California
 19 Constitution.

20 However, if the Commission on State Mandates determines that
 21 this act contains other costs mandated by the state, reimbursement
 22 to local agencies and school districts for those costs shall be made
 23 pursuant to Part 7 (commencing with Section 17500) of Division
 24 4 of Title 2 of the Government Code.

AMENDED IN ASSEMBLY MARCH 10, 2010

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

ASSEMBLY BILL

No. 1882

**Introduced by Assembly Member ~~Arambula~~ *Portantino*
(~~Coauthor: Assembly Member Portantino~~)**

February 16, 2010

An act to add Section 1255.4 to the Health and Safety Code, relating to health facilities.

LEGISLATIVE COUNSEL'S DIGEST

AB 1882, as amended, ~~Arambula~~ *Portantino*. Health facilities: chilling or therapeutic hypothermia.

Existing law provides for the licensure of health facilities, including general acute care hospitals, by the State Department of Public Health. The violation of these provisions is a misdemeanor.

This bill would require each general acute care hospital with an emergency department to adopt a protocol or policy establishing a procedure for assessing patients in the emergency room who are comatose after experiencing cardiac arrest; to determine ~~if they are candidates for~~ *whether to treat these patients with* chilling or therapeutic hypothermia. ~~The bill would require the protocol or policy to establish procedures for implementing the chilling, or inducing of hypothermia, of patients who are comatose after a cardiac arrest. The bill would also impose additional requirements upon the hospital if it undertakes this treatment.~~

By creating a new crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

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

1 SECTION 1. The Legislature hereby finds and declares all of
2 the following:

3 (a) Scientific and medical journals have reported on the
4 usefulness of therapeutic hypothermia or chilling of patients who
5 have suffered heart attack, cardiac arrest, or stroke. Procedures
6 such as induced hypothermia are designed to protect endangered
7 cells, prevent tissue death and preserve organ function following
8 acute events associated with severe oxygen deprivation such as
9 stroke or cardiac arrest.

10 (b) Therapeutic hypothermia is believed to work by protecting
11 critical tissues and organs, including the brain, heart, and kidneys,
12 following ischemic or inflammatory events, by lowering
13 metabolism and preserving cellular energy stores, thereby
14 potentially stabilizing cellular structure and preventing or reducing
15 injuries at the cellular, tissue, and organ level.

16 (c) Two international clinical trials on hypothermia after cardiac
17 arrest published in the New England Journal of Medicine
18 demonstrated that induced hypothermia reduced mortality and
19 improved long-term neurological function. Based on these and
20 other results, the American Heart Association (AHA) and the
21 International Liaison Committee on Resuscitation (ILCOR) have
22 issued guidelines recommending that cardiac arrest victims be
23 treated with induced hypothermia.

24 (d) In the United States and other developed countries, an
25 estimated 1.4 million people experience cardiac arrest each year,
26 of which an increasing number, currently about 350,000, survive
27 to receive advanced care. The AHA guidelines now recommend
28 the use of therapeutic cooling as part of the critical care procedures
29 for patients with an out-of-hospital cardiac arrest following
30 ventricular fibrillation.

1 (e) Therapeutic hypothermia is used to cool a patient’s body in
2 order to reduce cell death and damage caused by acute ischemic
3 events in which blood flow to critical organs, such as the heart or
4 brain is restricted, and to prevent or reduce associated injuries such
5 as adverse neurological outcomes. Methods have been developed
6 that cool external or surface-based temperatures. There are
7 additional procedures that can be used to cool body temperatures
8 internally.

9 (f) Therapeutic hypothermia has been used to safely and
10 effectively cool patients and represents an important new tool for
11 protecting the brain from ischemia, especially in postcardiac arrest
12 patients who are at higher risk of brain tissue damage due to the
13 prolonged lack of blood flow.

14 (g) With the increase in survival of cardiac arrest victims
15 resulting from the advent of automated external defibrillators,
16 cooling patients is the next logical therapeutic approach, especially
17 in light of the large body of supporting scientific literature.
18 Guidelines issued by the AHA and ILCOR make recommendations
19 for cardiac arrest victims to be treated with induced hypothermia.

20 (h) It is the intent of the Legislature that patients that have
21 suffered cardiac arrest be assessed for the benefits of therapeutic
22 hypothermia.

23 SEC. 2. Section 1255.4 is added to the Health and Safety Code,
24 to read:

25 1255.4. (a) Each general acute care hospital with an emergency
26 center shall adopt a protocol or policy that establishes a procedure
27 for assessing a patient in the emergency center who is comatose
28 after experiencing cardiac arrest, to determine if the patient is an
29 eligible candidate for chilling or hypothermia therapy by weighing
30 the benefits of the therapy for the patient and the subsequent effect
31 upon the patient’s recovery against the risks. This protocol or
32 policy shall establish procedures for implementing the chilling, or
33 inducing of hypothermia, of a patient who becomes comatose after
34 a cardiac arrest.

35 (b) *Whenever a patient is treated with chilling or hypothermia*
36 *therapy pursuant to subdivision (a), the hospital shall note this*
37 *treatment in the patient’s record.*

38 ~~(b)~~

39 (c) The hospital shall adopt procedures that require
40 communication between the hospital emergency center and the

1 hospital intensive care unit or other units to where the patient may
2 be transferred during treatment by chilling or therapeutic
3 hypothermia pursuant to the protocol or policy described in
4 subdivision (a). The information communicated shall include the
5 length of time the patient has been in chilling or hypothermia
6 therapy, the emergency department assessment for the need for
7 this treatment, and instructions or recommendations on how long
8 the patient should continue to be treated with chilling or
9 hypothermia therapy.

10 (e)

11 (d) When a comatose, cardiac arrest patient is being treated by
12 chilling or hypothermia therapy or has been assessed by a general
13 acute care hospital to be an eligible candidate for this therapy, and
14 is subsequently transferred to the emergency room or intensive
15 care unit of any other general acute care hospital, the transferring
16 hospital shall inform that destination hospital of the ~~patient~~
17 *patient's* assessment for and treatment with therapeutic
18 hypothermia.

19 SEC. 3. No reimbursement is required by this act pursuant to
20 Section 6 of Article XIII B of the California Constitution because
21 the only costs that may be incurred by a local agency or school
22 district will be incurred because this act creates a new crime or
23 infraction, eliminates a crime or infraction, or changes the penalty
24 for a crime or infraction, within the meaning of Section 17556 of
25 the Government Code, or changes the definition of a crime within
26 the meaning of Section 6 of Article XIII B of the California
27 Constitution.

EMERGENCY MEDICAL SERVICES AUTHORITY1930 9th STREET

SACRAMENTO, CA 95811-7043

(916) 322-4336 FAX (916) 324-2875



February 22, 2010

Reza Vaezazizi MD, President
Emergency Medical Directors Association of California
515 N. Arrowhead Avenue
San Bernardino, CA 92415-0060

Dear Dr. Vaezazizi:

The EMS Authority will be holding the ".201 Today & Tomorrow: A Workshop on EMS System Coordination" on Tuesday, May 4, 2010 from 8:30am to 5:00pm at the Radisson Hotel, 500 Leisure Way, Sacramento, California 95815.

As part of this meeting, we are inviting your organization to select a representative to provide a 30 minute presentation as part of the workshop agenda. This presentation should be conducted by a member who is knowledgeable about your organizations thoughts on issues related to Health and Safety Code 1797.201 and EMS system coordination in general. Audio and visual equipment will be available for PowerPoint use. Presentations from various groups will be conducted during the morning session of the workshop and will be strictly limited to 30 minutes per group. We would like to request that you provide the name and contact information of the person who will be presenting for your organization to the EMS Authority by March 15, 2010.

In addition to the providing a presentation, we would like to request that your designated representative serve as a facilitator for a panel discussion. The panel discussions will take place in the afternoon portion of the workshop. The specific panel topics will be provided to your designated representative in advance of the meeting.

If you have any questions, please contact me or Tom McGinnis, Transportation Coordinator at (916) 322-4336, Ext 424.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Steven Tharratt".

R. Steven Tharratt, MD, MPVM
Director

ST:tm



.201 Today & Tomorrow: A Workshop on EMS System Coordination

May 4, 2010, Tuesday
8:30am to 5:00pm
Radisson Hotel
500 Leisure Lane
Sacramento, California 95815
Edgewater Room A

AGENDA

8:30-8:35	Welcome	Steven Tharratt, MD Director, EMS Authority
8:35-8:45	Workshop Outline and Process	Bonnie Sinz, RN, Chief EMS Systems Division
<u>Presentations</u>		
8:45-9:15	California Fire Service (CFS)	TBD
9:25-9:55	Emergency Medical Services Administrators Association of California (LEMSA Admin)	TBD
10:05-10:35	Private Ambulance Industry (Pvt Amb)	TBD
10:35 -10:45	BREAK	
10:45-11:15	Emergency Medical Directors Association of California (LEMSA Med Dir)	TBD
11:25-11:55	Emergency Medical Services Authority (EMSA)	Daniel Smiley Chief Deputy Director
11:55-1:30	Lunch – On Your Own	
<u>Panel Discussions</u>		
1:30-2:10	<i>What is the Relevance of .201 in 2010?</i>	Facilitator: LEMS Admin Panel Members: CFS, Pvt Amb, LEMSA Admin, LEMS Med Dir
2:20-3:00	<i>Is .201 the cause or the symptom of conflict in EMS System design?</i>	Facilitator: Pvt Amb Panel Members: CFS, Pvt Amb, LEMSA Admin, LEMS Med Dir
3:00-3:10	BREAK	
3:10-3:50	<i>What are the areas of agreement?</i>	Facilitator: CFS Panel Members: CFS, Pvt Amb, LEMSA Admin, LEMS Med Dir
4:00-4:40	<i>What are potential solutions to 201 issues and ideas for improving EMS system coordination?</i>	Facilitator: EMSA Panel Members: CFS, Pvt Amb, LEMSA Admin, LEMS Med Dir
4:40-4:50	Workshop Wrap-Up	Bonnie Sinz
4:50-5:00	Closing Comments	Steve Tharratt, MD

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REVIEW CRITERIA AND POLICY FOR TRANSPORTATION AND EXCLUSIVE OPERATING AREA COMPONENTS OF THE EMS PLAN



EMSA #141
8th Edition Draft December 1, 2009
1st Edition February 1987

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1 **I. INTRODUCTION**

2
3 **A. EMS Transportation Review Policy - Introduction**

4
5 In 1980, the Emergency Medical Services (EMS) Act granted authority to the
6 EMS Authority to provide oversight of the planning, implementation, and
7 evaluation of Local Emergency Medical Services Agency (LEMSA) systems,
8 including local transportation plans. Based on the requirement contained in
9 California Health and Safety Code Section 1797.103, the EMS Authority
10 developed the “*EMS Systems Standards and Guidelines*” (EMSA Publication
11 #101).

12
13 In 1984, prompted by the decision in *Community Communications Co., Inc. v.*
14 *City of Boulder (1982)*, 455 U.S. 40, California enacted AB 3153 (Bronzan). This
15 provided State authorization and oversight for the creation of exclusive operating
16 areas by LEMSAs. The relevant code sections are 1797.6, 1797.85, and
17 1797.224 of the Health and Safety Code (see Appendix C).

18
19 The role of the EMS Authority is defined in Health and Safety Code Sections
20 1797.6, 1797.102, 1797.103, 1797.104, 1797.105.

21
22 Since the transportation plan is an intricate portion of the EMS Plan, the EMS
23 Authority has developed the “*Review Criteria and Policy for Transportation and*
24 *Exclusive Operating Area Components of the EMS Plan.*” This document is
25 intended to provide technical assistance to LEMSAs in developing and updating
26 their EMS Transportation Plans, establishing and implementing ambulance
27 operating areas or zones, and clarifying the Health and Safety Code sections
28 relevant to EMS transportation. This document incorporates applicable
29 standards from the “*EMS Systems Standards and Guidelines*” (EMSA Publication
30 #101 – which can be found at
31 http://www.emsa.ca.gov/aboutemsa/emsa_pubs.asp), and the “*Competitive*
32 *Process for Creating Exclusive Operating Areas*” (formerly EMSA Publication
33 #141.)

34
35
36 **B. EMS Authority Statutory Oversight of EMS Transportation Systems**

37
38 Health and Safety Code Section 1797.105 calls for a LEMSA to submit its EMS
39 Plan (inclusive of the transportation plan) to the EMS Authority for approval. The
40 EMS Authority determines whether the EMS Plan effectively meets the needs of
41 the affected communities, is consistent with existing guidelines and regulations,
42 and adequately coordinates activities in the area served. In addition, Health and
43 Safety Code Section 1797.102 requires the EMS Authority, utilizing local/regional
44 information found in EMS Plans, to assess the EMS areas to determine the need
45 for, coordination of, and effectiveness of emergency medical services.

1 Therefore, the EMS Authority bears a responsibility to ensure that the local
2 transportation system adequately serves the community.

3
4 **C. LEMSA Statutory Responsibility for EMS Transportation Systems**

5
6 Under Health and Safety Code section 1797.200, each county that develops an
7 EMS program shall designate a LEMSA to administer emergency medical
8 services. Section 1797.204 requires a LEMSA to plan, implement, and evaluate
9 an emergency medical services system. Because transportation planning is an
10 integral component of an EMS system, the LEMSAs are responsible for
11 administering the transportation component of the EMS system and for ensuring
12 this component is adequately coordinated with other system components; for
13 example, trauma, disaster medical services, EMS for children, and
14 communications. Section 1797.222 authorizes the counties to adopt ordinances
15 governing patient transport and also tasks the LEMSAs with recommending the
16 adoption of such ordinances to the County Board of Supervisors. This shared
17 responsibility for developing local governance of the EMS transportation system
18 requires local officials to work cooperatively to ensure the design of the EMS
19 transportation system adequately meets the needs of the community.

20
21
22 **D. EMS Transportation System Design**

23
24 To meet its mandate of coordinating the local EMS system, and to comply with
25 the EMS Act, a LEMSA should design the local EMS transportation system to
26 ensure that all transport providers are integrated into the EMS system. A LEMSA
27 should ensure that it maintains contracts or operating agreements with all
28 emergency transport providers, including those licensed by the California
29 Highway Patrol (CHP) and any public safety agency. In addition, a LEMSA
30 should consider integrating all non-ambulance transport providers (gurney,
31 wheelchair vans, or other forms of medical transport) operating in its jurisdiction.
32 This task may be accomplished through a local ordinance under general
33 government powers of the County or the LEMSA may create a separate policy
34 defining requirements for patient transport. (See Section III – “Transportation
35 Plan Processing” for additional responsibilities).

36
37
38 **E. Restriction of Trade for Transport Providers**

39
40 Federal law governing restriction of trade is based on the Sherman Antitrust Act
41 (1890) and the Clayton Act (1984). Generally, the Sherman Antitrust Act bans
42 activities that restrain trade, and bans any monopoly, or attempt to establish a
43 monopoly, while the Clayton Act regulates practices that may inhibit fair
44 competition, such as price discrimination, mergers, and acquisitions.

1 Federal courts have determined that anticompetitive regulatory programs may
2 receive immunity from prosecution or legal action under state law (Parker v.
3 Brown 317 U.S. 341, 87 L. Ed. 315, 63 S. Ct. 307 [1943]). The federal “Boulder
4 Decision” (Community Communications Co, Inc. v. City of Boulder, Colorado, et
5 al [102 S. Ct. 835]), has limited the application of such “state action immunity” to
6 local governments. Based upon the Boulder Decision, cities and counties maybe
7 exempt for activities that are specifically authorized by the state and that are
8 subject to active state oversight. California Health and Safety Code Section
9 1797.6 (b) states: It is the intent of the Legislature in enacting this section and
10 Sections 1797.85 and 1797.224 to prescribe and exercise the degree of state
11 direction and supervision over emergency medical services as will provide for
12 state action immunity under federal antitrust laws for activities undertaken by
13 local governmental entities in carrying out their prescribed functions under this
14 division.

15
16 The only method to restrict competition in the ambulance marketplace is through
17 adherence to the provisions of the EMS Act/Health and Safety Code. For
18 example, prior to the EMS Act, counties in California adopted “need and
19 necessity” ordinances to restrict competition among providers and prevent new
20 providers from entering the market. These ordinances placed the burden on
21 potential providers to prove that their services were necessary to the community.
22

23 The rendering of the Boulder Decision and the passage of the EMS Act, in
24 addition to subsequent decisions of California courts (e.g., Schaefer's Ambulance
25 Service v County of San Bernardino, 80 Cal.Rptr.2d 385 [1998]), have
26 superseded any “need and necessity” ordinances established by the county. The
27 only method to restrict competition in the ambulance marketplace is through
28 adherence to the provisions of the EMS Act/Health and Safety Code.

1 II. DEFINITIONS

2
3 **Advanced Life Support (ALS):** Definitive pre-hospital emergency medical care
4 performed by authorized personnel who possess a valid certificate, including but not
5 limited to treatments as defined in Health and Safety Code Section 1797.52.
6

7 **ALS Ambulance Service:** A provider of emergency ambulance service whose
8 resources are staffed and equipped at the ALS level.
9

10 **Basic Life Support (BLS):** Emergency first aid and cardiopulmonary resuscitation
11 (CPR) procedures used to maintain life without invasive techniques and performed
12 by an EMT I trained in all facets as defined in Health and Safety Code Section
13 1797.60 and possess a valid certificate.
14

15 **Boundary Changes:** Any reconfiguration of the geographic borders previously
16 designated by the LEMSA for each operating area.
17

18 **Competitive Process:** The method by which a LEMSA may award an ambulance
19 operating area exclusively to one or more providers by creating a Request for
20 Proposal and establishing a contract with the selected bidder(s).
21

22 **Critical Care Transport (CCT):** Inter-facility transfer of a critically injured or ill
23 person by an emergency ambulance.
24

25 **Economic Distribution of Calls:** Based on services historically provided when
26 compared to services in place at the time of review; generally in areas serviced by
27 more than one provider where the LEMSA has determined exclusivity without a
28 competitive process. Each ambulance zone is evaluated on its own merits and
29 issues. When call distribution has changed, the percentage of change determined to
30 be relevant as a change is that used by any reasonably prudent person evaluating
31 the same data.
32

33 **Emergency Medical Services (EMS):** The services utilized in responding to a
34 medical emergency (Health and Safety Code Section 1797.72). This is inclusive of
35 any ambulance service, any ambulance, including those licensed by the California
36 Highway Patrol, irrespective of the levels of personnel, i.e. Basic Life Support (BLS),
37 Limited Advanced Life Support (LALS), Advanced Life Support (ALS), Registered
38 Nurse (RN), Doctor of Medicine (MD) or call types, i.e. code 3, Inter-facility Transport
39 (IFT), Critical Care Transport (CCT), or care provided at the scene, i.e. ALS, BLS.
40

41 **Exclusive Operating Area (EOA):** An EMS area or sub-area defined by the
42 emergency medical services plan for which a local EMS agency, upon the
43 recommendation of a county, restricts operations to one or more emergency
44 ambulance services or providers of limited advanced life support or advanced life
45 support (Health and Safety Code Section 1797.85).
46

1 **Exclusive without a Competitive Process:** Refers to creating an exclusive
2 operating area (EOA) from a non-exclusive operating area without a competitive bid
3 process. Exclusivity without a competitive process is restricted by statute to an area
4 that continues to use an existing provider that has been in continuous operations
5 within a local EMS area in the same manner and scope without interruption since
6 January 1, 1981 (Health and Safety Code Section 1797.224).
7

8 **Level of Exclusivity:** Scope of the operation defined by the EMS Plan to restrict
9 competition of area or sub-area to include, but not limited to: emergency and / or
10 non-emergency ambulance services including 9-1-1, all emergency, 9-1-1 and 7
11 digits, all emergency services, BLS, including inter-facility, and air ambulance.
12 (Health and Safety Code Section 1797.85)
13

14 **Limited Advanced Life Support (LALS):** Special service designed to
15 provide pre-hospital emergency medical care limited to techniques and procedures
16 that exceed BLS but are less than ALS and are those procedures specified to
17 Section 1797.171. (Health and Safety Code Section 1797.92).
18

19 **Local EMS Operating Area:** A geographic area or sub-area, designated with
20 boundaries, established by a LEMSA to facilitate system coordination with providers.
21 (Health and Safety Code Section 1797.85).
22

23 **Manner and Scope:** The economic distribution of the marketplace within an EMS
24 area or sub-area. Manner and scope includes consideration of geographic changes
25 to the EMS operating area or sub-area, interruption in services, free entry and exit in
26 the marketplace.
27

28 **Non-Exclusive Operating Area:** The EMS areas or sub-areas that do not have
29 restricted operations and are open to all qualified providers approved by a LEMSA.
30

31 **Periodic Interval:** The timeframe in which a LEMSA must re-address the
32 competitive process previously utilized for selecting providers and determining the
33 scope of their operations. This timeframe shall not be greater than a 10 year
34 provision, including any extensions.
35

36 **Type of Exclusivity:** Type of operations within an EMS area or sub-area as defined
37 in Health and Safety Code Section 1797.85; emergency ambulance services, LALS,
38 ALS.
39
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42

1 III. TRANSPORTATION PLAN PROCESSING

3 A. The EMS Transportation Plan

5 LEMSAs are responsible for developing a plan for the local EMS transportation
6 system to comply with its mandate for planning and implementing the local EMS
7 system, and to ensure that it conducts activities related to transportation with a
8 sufficient degree of state direction and oversight. The EMS Transportation Plan
9 is an important component of the local EMS Plan and should provide for the
10 development, coordination, and oversight of transport by providers within the
11 geographic area that a LEMSA oversees. The Transportation Plan should be
12 endorsed by the County Board of Supervisors or the LEMSA governing board
13 prior to submission. The plan can be included as a separate chapter within a
14 LEMSA's annual EMS Plan update or, if changes have occurred within the
15 transportation system after the last approval by the Authority, it is to be submitted
16 separately as an update.

17
18 The EMS Transportation Plan should incorporate the following elements:

- 19 1. Table of contents.
- 20 2. A plan summary highlighting the major sections of the plan, any changes
21 since the previous submission, and any key problems and proposed
22 solutions.
- 23 3. Description or chart of the system structure and design. The description
24 should address whether a LEMSA has established exclusive operating
25 areas or non-exclusive areas.
- 26 4. Clear plan, goals and objectives, an implementation schedule, and
27 expected outcomes.
- 28 5. Analysis of the fiscal impact of the transportation system design to the
29 system (e.g., Request for Proposal (RFP) costs for a competitive process,
30 resulting savings from changing status of an area, costs for provider
31 monitoring, etc.).
- 32 6. Inclusion of a mechanism to ensure that all ambulance services and
33 ambulances, including those licensed by the CHP, are fully integrated into
34 the EMS system. This objective can be accomplished through a county
35 ordinance requiring licensing or LEMSA policy (include copy of model
36 policy or ordinance as an appendix).
- 37 7. Description of the relationship of the transportation plan to the specific
38 components of the EMS plan, such as trauma, communications and
39 dispatch, disaster, EMS for children, etc. and how the system is integrated
40 into the EMS system as a whole.
- 41

- 1 8. Description of EOAs, if any, and how they serve the LEMSA’s mission.
2 The description must include “Ambulance Zone Summary” forms and
3 maps of sufficient detail to show the service areas.
- 4 9. Description of plan for mutual aid and a list of mutual aid providers.
- 5 10. Description of the quality improvement (QI) process specific to
6 transportation issues.
- 7 11. Description of system evaluation process and summary of periodic
8 evaluation of the transportation system.
- 9 12. Copy of RFP if a competitive process has been conducted (include as an
10 appendix).
- 11 13. Verification of provider eligibility and unchanged manner and scope of an
12 operating area under Health and Safety Code Section 1797.224 for areas
13 that are considered without a competitive process (include as an
14 appendix).
- 15 14. Contracts for exclusive providers (include as an appendix).
16

17 **B. EMS Transportation Plan Review and Approval**

18 The EMS Authority will coordinate its review of the transportation plan with the
19 submission of a completed annual EMS Plan update.
20

21 To prevent delays in the EMS Authority’s review and approval of the
22 transportation plan, a LEMSA should ensure the plan is clear, correct, and
23 complete in accordance with these guidelines. If the EMS Authority requests
24 additional information to assist in its assessment of the plan, a LEMSA should
25 submit the required information within 30 days of the request. If the EMS
26 Authority does not receive the requested information in a timely manner, the
27 approval of the plan may be delayed. EMS Authority will provide necessary
28 technical assistance to a LEMSA should there be questions or concerns
29 regarding the plan.
30

31 In the event that the EMS Authority does not approve a EMS plan, it will supply a
32 complete explanation to a LEMSA. A LEMSA should submit a revised EMS plan
33 within 60 days. A LEMSA may appeal the decision of the EMS Authority as
34 outlined in Health and Safety Code Section 1797.105.
35

36 A LEMSA must implement the transportation plan as approved by the EMS
37 Authority. The EMS Authority may withdraw approval of a transportation plan if
38 the EMS Authority determines that a LEMSA has implemented its transportation
39 plan in a manner inconsistent with the transportation plan approved by the EMS
40 Authority.
41
42

1 **C. Transportation Plan Updates**
2

3 Any changes to the transportation plan shall be submitted to the EMS Authority
4 with sufficient time for EMSA to review and approve prior to the proposed plan
5 implementation. Changes that should be submitted to the EMS Authority include
6 the following:
7

- 8 1. Intent to issue a competitive process.
9 2. A new provider begins service or a current provider terminates
10 operations.
11 3. Modifications to manner and scope of service provided in an
12 exclusive operating area, including:
13 a. Geographic areas (including combining or subdividing
14 areas).
15 b. Geographic boundaries.
16 c. Scope of operations (e.g., non-transporting to transporting,
17 ALS emergency ambulance, 9-1-1 only, interfacility
18 transport, etc.).
19 d. Level of exclusivity.
20 e. Type of exclusivity.
21 f. Provider’s ownership (asset transfer or transfer of business).
22 g. Economic distribution of calls.
23 h. Number of providers (free entry and exit).
24 i. Interruption in service.
25

26
27 Minor system changes, such as changes of address for providers, minor
28 boundary changes (e.g., to accommodate the completion of a new roadway),
29 changes in the manner and scope of service in non-exclusive operating areas, or
30 status updates of transportation related Standards and Guidelines need not be
31 submitted separately but should be submitted as part of a LEMSA’s annual EMS
32 Plan update.
33

34 **D. Changes of EMS Operating Area or Sub-area**
35

36 A LEMSA has the authority to change the status of an ambulance operating area,
37 approved in the EMS Plan, and may:
38

- 39 1. Create a non-exclusive operating area from an existing exclusive
40 operating area.

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- 2. Create an exclusive operating area from a non-exclusive operating area through competitive process.
- 3. Create an exclusive operating area without completing a competitive process from an existing non-exclusive operating area, as long as the criteria from Health and Safety Code Section 1797.224 have been met.

EXCEPTIONS: A LEMSA may **not** create an exclusive area without a competitive process if it has previously issued a competitive process with the intention of establishing the area as exclusive through the competitive process.

For changes to the status of an area, from non-exclusive to exclusive or vice versa, a LEMSA must submit the transportation plan update to the EMS Authority for review and approval prior to implementation with sufficient time for approval. Without approval, state action immunity protection may not be provided.

If the status of an area is being modified from non-exclusive to exclusive, a LEMSA cannot refuse to accept completed applications from qualified providers wishing to provide transportation services to the area during the process.

Note: The EMS Authority may post the status of exclusivity on its website.

1 **IV. OPERATING AREAS**

2
3 To facilitate system coordination in the geographic area(s) it oversees, a LEMSA
4 may elect to create ambulance operating areas that are either: non-exclusive, open
5 to all qualified providers; or exclusive, restricted to select providers. The areas
6 shall be established based on optimal service provision and patient care, not solely
7 based on geopolitical boundaries or traditional service areas.
8

9 **A. Non-Exclusive Operating Areas**

10
11 In instances where a LEMSA chooses to maintain non-exclusive ambulance
12 areas that are open to all qualified providers, a LEMSA must still ensure that the
13 providers that serve the area are fully integrated into the EMS system and
14 adhere to all requirements. A LEMSA should establish contracts or operating
15 agreements with all providers and should ensure that the calls in non-exclusive
16 areas are distributed in an optimal manner, whether through an equal rotation or
17 other method to achieve equal distribution of calls or consistent dispatch of the
18 closest unit.
19

20 Non-exclusive operating areas must be delineated in the EMS Transportation
21 Plan in the same manner as exclusive operating areas. A LEMSA should
22 address non-exclusive operating areas in its response to the relevant sections of
23 the “EMS Systems Standards and Guidelines,” complete an “Ambulance Zone
24 Summary Form” (Appendix A) for each of these providers, and ensure the
25 providers are included in the resources directory in the EMS Plan update.
26

27 **B. Exclusive Operating Areas**

28
29 A LEMSA may create one or more exclusive operating areas (EOAs) in the
30 development of the EMS Plan as outlined in Health and Safety Code Section
31 1797.224. An EOA will restrict the number of providers, public and/or private,
32 within a designated EMS area or sub-area to:
33

- 34 1. One or more emergency ambulance services; or
35 2. Providers of LALS; or
36 3. ALS
37

38 EOA types are mutually exclusive and a LEMSA may include one or more types
39 of service within a competitive process.
40
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43

1 Advantages for establishing EOAs may include: predictable EMS response
2 initiated from emergency calls received through a central dispatch; reduction of
3 LEMSA's costs; avoidance of conflict among providers jointly serving an area; an
4 increase of efficiency of the provider by minimizing direct costs; and maximizing
5 skill maintenance of certified personnel.
6

7 As outlined under Health and Safety Code, Section 1797.224, an EOA may be
8 established when existing EMS providers within these areas meet the criteria in
9 Section 1797.224 or the providers are selected through a "Competitive Process."

10 1. Criteria for Establishing an Exclusive Operating Area

11 A LEMSA may establish EOAs if ALL of the following conditions are met:

- 12
- 13
- 14 a. A LEMSA utilizes a competitive process to select the providers, OR
15 a LEMSA chooses to "continue the use of existing providers
16 operating within the manner and scope in which the services have
17 been provided without interruption since January 1, 1981."
- 18 b. A LEMSA has revised its EMS Transportation Plan to incorporate
19 EOAs into its system and received approval of the revisions from
20 the EMS Authority prior to implementation.
- 21 c. A LEMSA ensures that the transportation system meets or exceeds
22 the requirements of the Health and Safety Code, the EMS Systems
23 Standards and Guidelines, and this document. Nothing precludes a
24 LEMSA from adopting standards for providers that are more
25 stringent than those established by the EMS Authority. The policies
26 should, at minimum, address the following:
27
- 28 1. Marketing and advertising by providers.
 - 29 2. Process used to designate exclusive providers.
 - 30 3. Establishment of service areas for providers.
 - 31 4. Dispatching, including use of EMD.
 - 32 5. Communications.
 - 33 6. Coordination with exclusive and non-exclusive providers.
 - 34 7. Mutual aid.
 - 35 8. Fees, including those for application, monitoring, and
36 evaluation.
 - 37 9. Medical control and accountability.
 - 38 10. Data collection and management.
 - 39 11. Quality control and system evaluation.
 - 40 12. Rates.

1 13. Parameters of a call to avoid confusion over call origin
2 and call continuation (e.g., for inter-county or inter-area
3 calls, inter-facility transports, etc.).
4

5 14. Economic viability of the ambulance zone.

6 2. Exclusivity of Designated Exclusive Operating Areas
7

8 If a LEMSA chooses to establish EOAs that are restricted to designated
9 providers, it must do so in accordance with Health and Safety Code
10 Sections 1797.85 and 1797.224. These sections allow LEMSAs to restrict
11 operations to three types of exclusivity:
12

- 13 a. All emergency ambulance service.
- 14 b. Providers of advanced life support (ALS).
- 15 c. Providers of limited advanced life support (LALS).
- 16

17 A LEMSA can further restrict the scope of operations of the transports to
18 the following levels of exclusivity of services:
19

- 20 a. Emergency ground ambulance (9-1-1 only).
- 21 b. Emergency ground ambulance (9-1-1 and 7 digit numbers).
- 22 c. All emergency ground ambulance (this includes inter-facility
23 transfers).
- 24 d. Air Ambulance.
- 25 e. Critical Care Transport.

26 3. Inter-Facility Transports
27

28 Inter-Facility Transport (IFT) is a level of service within the emergency
29 ambulance type of exclusivity. A LEMSA may include IFTs in the services
30 restricted to select providers in establishing an EOA, or it may omit IFTs
31 from the EOA designation of services. An EOA may not be created solely
32 for IFT. See *A-1 Ambulance v County of Monterey*, 0 Fed.Rptr.3d 333 1515
33 [1996] and *Schaefer's Ambulance v County of San Bernardino*, 80
34 Cal.Rptr.2d 385 [1985].
35

36 Critical Care Transport (CCT) unit staffing can include EMT-Paramedic with
37 expanded scope of practice as approved by the LEMSA medical director for
38 authorized registered nurses or physicians. Under Health and Safety Code
39 section 1797.56, pre-hospital advanced life support staffed by authorized
40 registered nurses must be authorized by the medical director of a local EMS
41 agency. When CCT is included, it is a level of service within the emergency
42 ambulance type of exclusivity.

1 **C. Exclusivity without a Competitive Process**

2
3 Under Health and Safety Code, Section 1797.224, an EOA may be established
4 without a competitive process if the local EMS agency's EMS Plan "continues the
5 use of existing providers operating within a local EMS area in the manner and
6 scope in which the services have been provided without interruption since
7 January 1, 1981."
8

9 1. Manner and Scope Evaluation Criteria – including, but not limited to the
10 examples below:

11 a. The following are universal criteria in the assessment of manner and
12 scope:

- 13
14 1) The LEMSA has an approved EMS Plan on file with the EMS
15 Authority.
16
17 2) The EMS service provider(s) is integrated into the EMS system
18 pursuant to the EMS Plan and Health and Safety Code Section
19 1797.224.

20
21 b. The following criteria are considered for manner changes including
22 continuity of operations and economic distribution of calls:
23

- 24 1) Number of providers serving an area since January 1, 1981 (of the
25 requested *Type* of services). *An exception would be noted if a
26 provider were to purchase the business of another provider and
27 reorganize the existing entity.
- 28 2) Providers currently operating in the area or sub-areas in continuous
29 operation prior to January 1, 1981 (of the requested *Type* of
30 services). *If the service has experienced a change of ownership,
31 the transfer must be a reorganization of the existing entity, not
32 merely an assets-only sale.
- 33 3) Continuity in service for any providers serving the area since
34 January 1, 1981 (of the requested *Type* of service).
- 35 4) The economic distribution of calls (or methodology for distributing
36 calls) since January 1, 1981, if multiple providers serve (or have
37 served) an area.
- 38 5) Competitive process (Previous) in area or sub-area (of the
39 requested *Type* of services).
- 40 6) Previous non-competitive behavior, sanctioned by the LEMAS, in
41 an area or sub-area (of the requested *Type* of services).

1 7) Application from a potential provider of service to the area or sub-
2 area. *Neither a LEMSA nor the County may create unreasonable
3 requirements to prevent the timely review and approval of an
4 otherwise qualified applicant.

5 Note: Section 1797.224 allows an existing provider to subcontract with
6 another provider without jeopardizing its status, as long as the contract
7 terms do not alter the manner and scope of operations. Subcontracts
8 between providers shall be reviewed and approved by the LEMSA to
9 ensure continuity with the original contract.

10
11 c. The following criteria are considered for scope changes including
12 geography and level of services:
13

- 14 1) Geographic area of sub-area boundaries since January 1, 1981. *
15 Exception: A minor boundary change (e.g., to accommodate
16 construction of a roadway) except where the total geography or
17 population exceeds 10% cumulatively since January 1, 1981.
- 18 2) Combining multiple areas or sub-areas since January 1, 1981.
- 19 3) Separating an area or sub-area into smaller sub-areas since
20 January 1, 1981.
- 21 4) Level of services, in an area or sub-area, since January 1, 1981
22 (e.g., 9-1-1 only, emergency only, emergency ambulance with ALS,
23 etc.). *Upgrades in ambulance services from BLS to ALS may not
24 affect the eligibility of the area for existing provider exclusivity if the
25 type of exclusivity being requested is emergency ambulance
26 service.

27 2. Health and Safety Code Section 1797.226

28
29 In 1986, Health and Safety Code section 1797.226 became effective. This
30 section refers only to San Bernardino County and creates two provisions:
31 (1) A minor alteration in level of equipment and service does not
32 constitute a change in manner and scope; and (2) A provider that
33 assumes another's service shall qualify as an existing provider if it
34 continued, uninterrupted, the emergency transportation previously
35 supplied by the prior provider. This change in ownership cannot be a
36 simple assets-only transfer.
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1 3. Health and Safety Code Section 1797.201

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3 Section 1797.201 allows existing cities and fire districts that provided care
4 (transporting or non-transporting) prior to June 1, 1980, to continue
5 services at the same type, and can retain administration of care, as long
6 as a LEMSA maintains medical control of care. See, County of San
7 Bernardino v City of San Bernardino, 15 Cal.4th 909; 64 Cal.Rptr.2d 814
8 [1997].
9

10 While Section 1797.201 of the code allows cities and fire districts to
11 continue services provided prior to June 1, 1980 until such time as a
12 written agreement for provision of EMS is reached, it does not address the
13 issue of exclusivity. Exclusivity cannot be granted to any provider unless
14 the requirements established in Section 1797.224 are met.
15

16 4. EMSA Withdrawal of Approval

17
18 The EMS Authority may withdraw its prior approval of an EOA previously
19 approved by the section 1797.224 existing provider process under the
20 following conditions:
21

- 22 a. Significant boundary changes of the area.
23 b. Change of manner and scope.
24 c. Any relevant information that was not known at the time of the EMS
25 Authority decision to approve becomes available and had it been
26 known at the time would have had a significant impact on the EMS
27 Authority's decision to approve the EMS Plan.
28 d. Changes to condition of award bid.
29

30 Once the EMS Authority has withdrawn its approval, the EMS Authority
31 may not support a LEMSA involved in an EOA antitrust action.
32

33 **D. Exclusivity via the Competitive Process**

34
35 Establishing an EOA by a competitive process is a method of creating an
36 exclusive operating area. A LEMSA may choose to conduct the process itself, or
37 it may designate an awarding agency, such as the relevant county in a multi-
38 county LEMSA, or a public safety organization operating in an established area.
39 The awarding agency is responsible for conducting the process and managing
40 the contract for the selected bidder with a LEMSA's oversight and coordination.
41

42 Section 1797.224 of the Health and Safety Code requires that the EMS Authority
43 delineate a competitive process for awarding EOAs for emergency response.

1 The competitive process for awarding the area should, at a minimum, address
2 the following:

- 3
- 4 1. Formal advertising of the opportunity to compete for areas.
 - 5 2. Development of a request for proposal which sufficiently states the
6 requirements of the county and requires adequate documentation of
7 the bidders/ EMS capability and fiscal status.
 - 8 3. A bidders' conference to provide a forum for answering questions.
 - 9 4. Policies for:
 - 10 a. submission of responses;
 - 11 b. receiving responses;
 - 12 c. response evaluation by an impartial evaluation panel;
 - 13 d. response rejection;
 - 14 e. award notification;
 - 15 f. protests and appeals; and
 - 16 g. contract cancellation
- 17

18
19 A summary of the necessary steps are outlined below:

- 20
21 1) Create a competitive process that has been developed in
22 accordance with Section V, "Competitive Process for Creating
23 Exclusive Operating Areas" of this document.
 - 24 2) Submit the draft competitive process to the EMS Authority for
25 review (optional). A LEMSA should allow at least 30 days for this
26 review.
 - 27 3) Prior to conducting the competitive process, revise the EMS
28 Transportation Plan to incorporate the EOA into the plan and to
29 ensure that the "*EMS Systems Standards and Guidelines*" related
30 to the transportation system have been comprehensively
31 addressed in regard to transportation system changes. The
32 revisions should be submitted to the EMS Authority for review and
33 approval within 60 days of the initial decision to conduct the
34 competitive process and amend the local EMS Transportation Plan.
35 However, if an operating area is undergoing a repeat competitive
36 process, a LEMSA need not submit a plan revision within the 60
37 day period and may submit notice of the repeat competitive process
38 with the EMS Plan update (see Appendix D for relevant sections of
39 the standards and guidelines). In addition, the EMS Transportation
40 Plan is discussed in greater detail under Transportation Plan (see
41 Section III).
- 42
43

- 1 4) Conduct a fair and open competitive process with a transparent and
2 equitable applicant rating system. This process should include a
3 bidders' conference. A competitive process shall be conducted at
4 least every 10 years. Submit a file copy of the final competitive
5 process to the EMS Authority for its records.
- 6 5) Include with the transportation plan revisions a fully completed
7 "Ambulance Zone Summary" form for each operating area and
8 provider in the transportation plan and a map of the operating area
9 (See Appendix A).
- 10 6) Submit the plan to the EMS Authority for approval.
- 11 7) Submit verification that the county recommends the establishment
12 of the EOA (e.g., an ordinance or resolution from the County Board
13 of Supervisors) in accordance with Health and Safety Code Section
14 1797.85.

15
16 In situations where the EMS Authority requests more information or does
17 not approve the transportation plan, a LEMSA will have 30 days to respond.
18 Until the additional information is received and the status of the area
19 clarified, the Authority cannot approve the plan.

20
21 If the competitive process is taking place in a non-exclusive zone or a
22 geographic area that has not previously been designated as an ambulance
23 operating area, as stated in Section IV "Operating Areas," a LEMSA cannot
24 impose a moratorium on the receipt of completed applications to provide
25 service from qualified providers until the contract is in effect for the selected
26 provider.

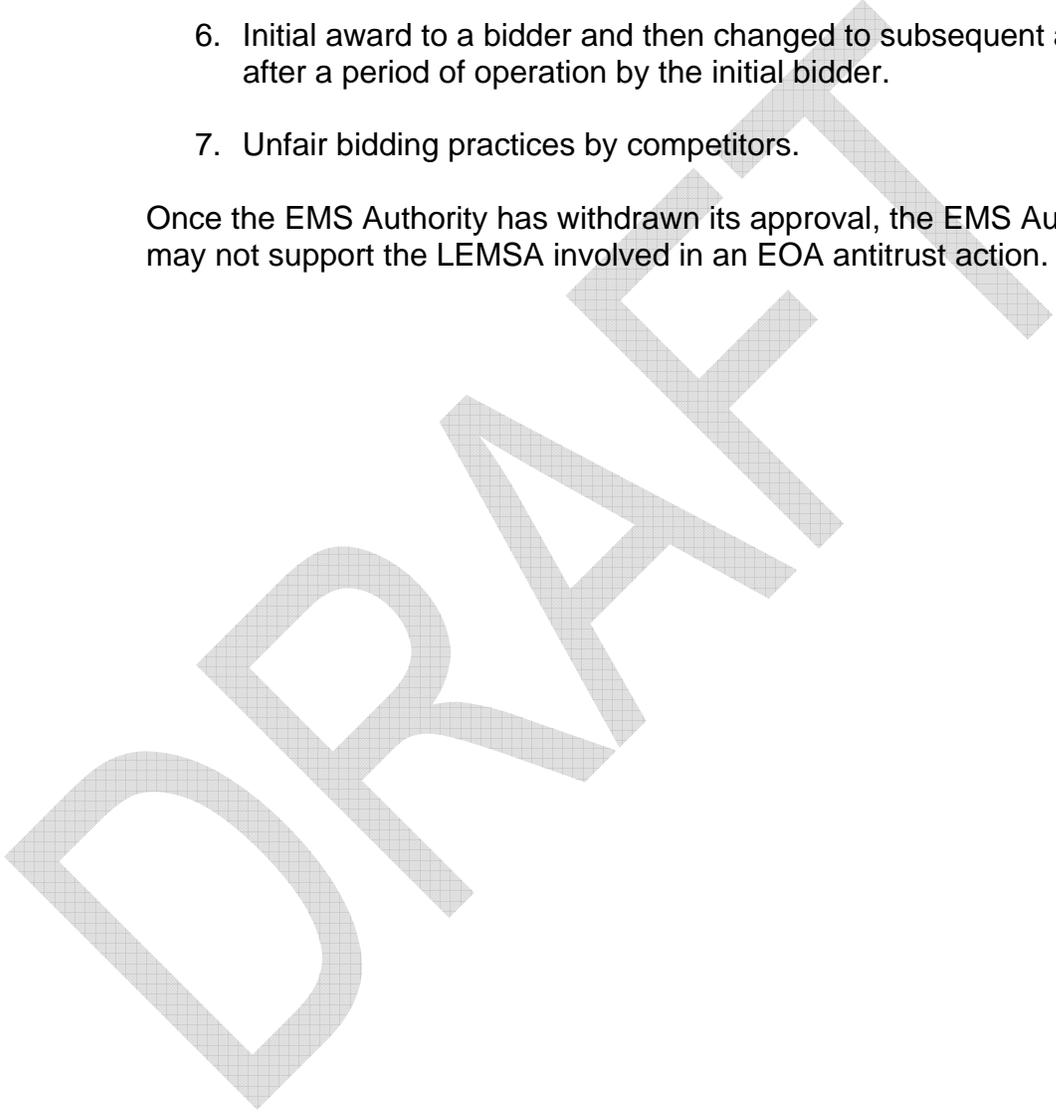
27
28 The EMS Authority may withdraw its prior approval of an EOA via the
29 "competitive" process under the following conditions:

- 30
31 1. The contract extends beyond 10 years. Without a timely
32 competitive process, the EMS Authority is unable to assure that
33 ambulance contract terms do not result in an anticompetitive
34 environment and restrict trade in a given geographic area.
35 Extending a provider contract, obtained through a competitive
36 process, beyond 10 years could be construed as allowing
37 exclusivity for an existing provider under 1797.224. A LEMSA may
38 petition the EMS Authority for limited exceptions to the 10 year
39 requirement under compelling circumstances to be evaluated on a
40 case by case basis by the EMS Authority.
- 41
42 2. After the contract has been awarded, changes are made to the
43 provisions which are significantly different than those specified in
44 the approved competitive process.

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- 3. Unfair competitive process procedures or selection (i.e. use of biased review panel).
- 4. Selection criteria as described in the competitive process was not followed.
- 5. Significant changes to the competitive process not approved by EMSA.
- 6. Initial award to a bidder and then changed to subsequent awardee after a period of operation by the initial bidder.
- 7. Unfair bidding practices by competitors.

Once the EMS Authority has withdrawn its approval, the EMS Authority may not support the LEMSA involved in an EOA antitrust action.



1 **V. COMPETITIVE PROCESS FOR CREATING EXCLUSIVE**
2 **OPERATING AREAS**
3

4 **A. Introduction**
5

6 If the local EMS agency decides to award EOAs, a competitive process shall be
7 developed. A competitive process is the awarding agency's requirements, in
8 document form, of specific services to be provided, in addition to other
9 contractual requirements. An awarding agency may be the county or any other
10 county authorized agency.
11

12 **B. Formal Advertising: Invitations**
13

14 Competitive processes should contain the applicable information enumerated
15 below and any other information necessary for proposal evaluation. The
16 competitive process should also include the eligibility and evaluation criteria
17 including the point system (if any) to be used in scoring proposals.
18

19 Competitive process information:
20

- 21 1. The identification or serial number of the competitive process.
- 22 2. Name and address of the awarding agency.
- 23 3. Date of issuance.
- 24 4. Time and place for submission of responses, including the disposition of
25 late responses and potential reasons for rejecting all responses.
- 26 5. Time and place of response opening.
- 27 6. Period of time for which response is to remain in effect.
- 28 7. Guarantee, performance and payment bond requirements.
- 29 8. Bidder's certification that all statements in the response are true. This shall
30 constitute a warranty, the falsity of which shall entitle the awarding agency
31 to pursue any remedy authorized by law, which shall include the right (at
32 the option of the awarding agency), of declaring any contract made as a
33 result thereof to be void.
- 34 9. When needed for the proposal evaluation, pre-award surveys, or
35 inspection, a requirement that bidders state the place(s), including the
36 street address from which the services will be furnished.
37
38

- 1 10. Description or specification of services to be furnished in sufficient detail
- 2 to permit open competition. The awarding agency shall obtain and
- 3 distribute information from current contractors necessary for fair
- 4 responses by all eligible providers.
- 5 11. Time, place and method of service delivery.
- 6 12. Citation of, and required bidder conformance to, all applicable provisions
- 7 of law and regulations.
- 8 13. Requirement for each bidder to submit a detailed budget and budget
- 9 narrative wherein line items are identified as yearly or contract period
- 10 costs.
- 11

12 **C. Bidders' Conference**

13 The awarding agency should conduct a bidders' conference at a pre-designated

14 time during the early stage of the process. The date and time of the conference

15 should be stated in the competitive process, or arrangements should be made for

16 contacting competitive process recipients.

17

18 The purpose of the bidders' conference is to provide a forum for answering

19 bidder's questions. The conference should be the only time that general

20 questions are answered regarding the competitive process. This will ensure that

21 all prospective bidders receive the same information. Questions and answers

22 should be put in writing, but need not be submitted prior to the conference. If a

23 written response to a question is provided then all prospective bidders must

24 receive a copy of the question and the answer.

25

26

27 **D. Proposal Contents**

- 28 1. The competitive process should require bidders to submit a statement of
- 29 experience which shall include but not be limited to the following
- 30 information:
- 31
 - 32 a. Business name and legal business status (i.e., partnership,
 - 33 corporation, etc.) of the prospective contractor.
 - 34 b. Number of years the prospective contractor has been in business
 - 35 under the present business name, as well as related prior business
 - 36 names.
 - 37 c. Number of years of experience the prospective contractor has had in
 - 38 providing the required services.
 - 39 d. Contracts completed during last five (5) years showing year, type of
 - 40 services, dollar amount of services provided, location, and contracting
 - 41 agency.

- 1 e. Details of any failures or refusals to complete a contract.
- 2 f. Whether the bidder holds a controlling interest in any other
- 3 organization, or is owned or controlled by any other organization.
- 4 g. Financial interests in any other related business.
- 5 h. Names of persons with whom the prospective contractor has been
- 6 associated in business as partners or business associates in the last
- 7 five (5) years.
- 8 i. Explanation of any litigation involving the prospective contractor or any
- 9 principal officers thereof, in connection with any contract for similar
- 10 services.
- 11 j. Explanation of experience in the service to be provided or similar
- 12 experience of principal individuals of the prospective contractor's
- 13 present organization.
- 14 k. List of major equipment to be used for the direct provision of services.
- 15 l. The awarding agency should request financial information which will
- 16 disclose the true cost of the proposed operation and the intended
- 17 source of all funding related to the provision of services as specified in
- 18 the competitive process. This may include current financial statements,
- 19 letters of credit, and guarantor letters from related entities, as well as
- 20 other materials required by the awarding agency.
- 21 m. A list of commitments, and potential commitments which may impact
- 22 assets, lines of credit, guarantor letters, or otherwise affect the bidder's
- 23 ability to perform the contract.
- 24 n. Business or professional licenses or certificates required by the nature
- 25 of the contract work to be performed and held by the bidder.
- 26 o. An agreement to provide the awarding agency with any other
- 27 information the county determines is necessary for an accurate
- 28 determination of the prospective contractor's qualifications to perform
- 29 services.
- 30 p. Agreement to right of the awarding agency to audit the prospective
- 31 contractor's financial and other records.
- 32

33 **E. Submission of Proposals**

- 34
- 35 1. Management of the proposal process should require that:
- 36
- 37 a. Proposals should be submitted so as to be received in the office
- 38 designated in the competitive process document not later than the
- 39 exact time set for submission of responses.
- 40

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- b. Proposals, with required attachments, should be submitted in the format specified by the awarding agency, and signed. The format should provide for the desired sequence of the proposal's content and a model budget.
 - c. Proposals should be filled out, executed, and submitted in accordance with the instructions which are contained in the competitive process. If the proposal is not submitted in the format specified, it may be considered only if the bidder meets and accepts all the terms and conditions of the competitive process.
2. Any proposal received at the office designated in the competitive process after the exact time specified for receipt should not be considered unless it is received before award is made and either:
- a. The awarding agency has set forth an option, to be contained in the competitive process document, for acceptance of proposals by registered or certified mail, sent prior to the date specified for the receipt of proposals.
 - b. It is determined that the late receipt was due solely to mishandling by the awarding agency after receipt at the agency.
3. Acceptable evidence to establish whether a proposal is late or meets some of the exceptions listed above may be:
- a. The date of mailing of a proposal, proposal modification, or withdrawal sent either by registered or certified mail is the U.S. Postal Service postmark on the wrapper or on the receipt from the U.S. Postal Service. If neither postmark shows a legible date, the proposal, modification, or withdrawal should be deemed to have been mailed late.
 - b. The time of receipt at the awarding agency is the time-date stamp of such agency on the proposal wrapper or other evidence of receipt.
4. Any modification or withdrawal of a proposal should be subject to the same conditions cited above.
5. A proposal may also be withdrawn in person by a bidder or an authorized representative, provided his/her identity is made known and he/she signs a receipt for the proposal, but only if the withdrawal is made prior to the exact time set for opening of proposals.

1 **F. Receipt and Evaluation of Proposals**

- 2
- 3 1. Upon receipt, each proposal should be noted with a separately identifiable
- 4 proposal number, the date and time of receipt.
- 5 2. All proposals received prior to the time set for opening should be kept
- 6 unopened and secured in a locked receptacle.
- 7 3. An agency official should decide when the time set for submission has
- 8 arrived and should declare that to those present. All proposals received
- 9 prior to the time set for opening should be publicly opened, recorded, and
- 10 read aloud to the persons present:
- 11
- 12 a. Competitive process number.
- 13 b. Submission date.
- 14 c. General description of service being procured.
- 15 d. Names of bidders.
- 16 e. Amounts proposed.
- 17 f. Any other information the awarding agency determines is necessary.
- 18
- 19 4. If the number of proposals received is less than anticipated, the awarding
- 20 agency should examine the reasons for the small number of proposals
- 21 received. The purpose of this examination is to ascertain whether the small
- 22 number of responses is attributable to an absence of any of the
- 23 prerequisites of formal advertising.
- 24
- 25 5. Should administrative difficulties be encountered after proposal opening
- 26 which may delay contract award beyond the state deadline for contract
- 27 award, the bidders should be notified before that date and the acceptance
- 28 period extended in order to avoid the need for re-advertisement.
- 29
- 30 6. Review of proposals by an impartial evaluation team.
- 31

32 **G. Rejection of Proposals**

- 33
- 34 1. Any proposal which fails to conform to the essential requirements of the
- 35 competitive process documents, such as specifications or the delivery
- 36 schedule, should be rejected as non-responsive. Proposals submitted which
- 37 do not meet the requirements regarding bidder responsibility should also be
- 38 rejected. When rejecting a proposal, the awarding agency should notify
- 39 each unsuccessful bidder that the proposal has been rejected.
- 40
- 41 2. A proposal should not be rejected when it contains a minor irregularity or
- 42 when a defect or variation is immaterial or inconsequential. A minor
- 43 irregularity means a defect or variation which is merely a matter of form and
- 44 not of substance, such as:
- 45

- 1 a. Failure of the bidder to return the required number of copies of signed
2 proposals.
- 3 b. Apparent clerical errors.
- 4
- 5 3. Immaterial or inconsequential means that the defect or variation is
6 insignificant as to price, quantity, quality, or delivery when contrasted with
7 the total costs or scope of the services being procured.
- 8
- 9 4. The awarding agency may give the bidder an opportunity to cure any
10 deficiency resulting from a minor informality or irregularity in a proposal or
11 waive such deficiency, whichever is to the advantage of the awarding
12 agency.
- 13

14 **H. Contract Periods**

- 15
- 16 1. The complete process (Requests for Proposals) must be repeated at
17 periodic intervals. The period between competitive process requests should
18 be established by local EMS agency policy based upon population, initial
19 investment in provision of service and other relevant factors but not greater
20 than ten years.
- 21
- 22 2. Contracts should be reviewed annually, at which time they may be
23 renegotiated if this option is included in the contract. A contract may be
24 renewed for a certain period, not to exceed ten total years, without a repeat
25 competitive process if this is stated in the competitive process.
- 26
- 27 3. The rate of reimbursement for additional terms under the contract should be
28 negotiated with the contractor based on the following:
29
 - 30 a. Actual expenditures by the contractor, as documented during the first
31 contract term and approved by the awarding agency.
 - 32 b. Changes in state program requirements.
 - 33 c. Other reasonable costs or increases in cost over which the contractor
34 has no control.
 - 35
- 36 4. In negotiating costs, the awarding agency should assure that these costs
37 accurately reflect current contract performance and are not inflated to
38 recover costs which may have been understated by the contractor during
39 the original competitive process.
- 40
- 41 5. The awarding agency should assure, by audit if necessary, that all cost
42 increases are reasonable and necessary to the continuation of the contract.
- 43
- 44
- 45

1 **I. Protests**

2
3 The awarding agency should consider any protest or objection regarding the
4 award of a contract, whether submitted before or after the award, provided it is
5 filed within the time period established in the competitive process. Written
6 confirmation of all protests shall be requested from the protesting parties. The
7 protesting party should be notified in writing of the awarding agency's decision on
8 the protest. The notification should explain the basis for the decision. The
9 decision of the awarding agency regarding the protest may be appealed to a
10 higher authority.

11 **J. Canceling the Procurement Process after Opening**

- 12
13 1. The procurement process may be canceled after opening, but prior to
14 award, when the contracting officer determines in writing that rejection of all
15 proposals is in the best interest of the agency for reasons such as those
16 listed below:
17
18 a. Inadequate, ambiguous, or otherwise deficient specifications were
19 cited in the competitive process.
20 b. The services are no longer required.
21 c. All otherwise acceptable proposals received exceed budgeted funds.
22 d. The proposals were not independently arrived at in open competition,
23 were collusive, or were submitted in bad faith.
24 e. No proposal is received which meets the minimum requirements of the
25 RFP.
26 f. The awarding agency determines after analysis of the proposals that
27 its needs can be satisfied by a method other than called for in the
28 proposal's requirements.
29
30 2. All bidders should be notified in writing of the specific reasons when
31 proposals are rejected.
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APPENDICES
(Appendix A – D)

DRAFT

1
 2 **Appendix B – Non-Competitive Process EOA Provider Checklist(September 2009)**

3
 4 In accordance with Health and Safety Code section 1797.224, a local EMS agency may
 5 consider allowing EOAs to providers without a competitive process. Please complete
 6 the following documentation in support of a request to grant exclusivity to a provider
 7 without a competitive process. Any missing or incomplete submissions may affect the
 8 EMS Authority’s ability to make a determination regarding eligibility.
 9
 10

1.	Operating Area Name and Description (attach map including adjacent zones):
2.	Has a competitive process ever been conducted in this area? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the provider, start date, and length of agreement:
3.	Type of Service: <input type="checkbox"/> Emergency <input type="checkbox"/> ALS <input type="checkbox"/> BLS
4.	Organization Name (include legal, fictitious, and dba):
5.	Address (headquarters and operational):
6.	Type of Organization (e.g., corporation, partnership, public agency, joint powers authority):
7.	Month/Year Service Began:
8.	List any Breaks in Service (include length of each break, reason, and how zone(s) were serviced during the break):
9.	Any changes in zone boundaries/service area since 01/01/81? If so, please: (1) Describe and include population affected: (2) Attach clearly labeled maps illustrating boundary changes: (3) Include call volume data for affected area(s) and list data source: (4) List any providers affected by the change. Include prior call volume data and projected call volume following change.

10.	<p>Any changes in ownership? For each change since 01/01/81, please:</p> <p>(1) List changes in names:</p> <p>(2) List dates of ownership changes [include a copy of contract and/or sale/transfer agreement(s)]:</p> <p>(3) Answer the following questions:</p> <p>(a) Disposition of assets: Were all assets transferred to new owner(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please explain)</p> <p>(b) Transfer of employees: Were all employees hired by new owner(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please explain)</p> <p>(c) Disposition of accounts payable and receivable: Were accounts payable and receivable transferred? <input type="checkbox"/> Yes <input type="checkbox"/> No: Please explain.</p>
11.	<p>Since 01/01/81, have any other providers served all or part of this zone? If so, please answer the following questions:</p> <p>(a) Are the providers currently in operation? Please list all providers, their level of service (emergency, ALS, BLS).</p> <p>(b) If the provider(s) no longer serves the area, please list level of service, dates of service, and reason for termination of service.</p>

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1 **Appendix C - Applicable Health and Safety Code Sections**

2
3 **1797.6.** (a) It is the policy of the State of California to ensure the provision of effective
4 and efficient emergency medical care. The Legislature finds and declares that
5 achieving this policy has been hindered by the confusion and concern in the 58 counties
6 resulting from the United States Supreme Court's holding in *Community*
7 *Communications Company, Inc. v. City of Boulder, Colorado*, 455 U.S. 40, 70 L.
8 Ed.2d810, 102 S. Ct. 835, regarding local governmental liability under federal antitrust
9 laws.

10 (b) It is the intent of the Legislature in enacting this section and Sections 1797.85
11 and 1797.224 to prescribe and exercise the degree of state direction and supervision
12 over emergency medical services as will provide for state action immunity under federal
13 antitrust laws for activities undertaken by local governmental entities in carrying out their
14 prescribed functions under this division.

15
16 **1797.85.** "Exclusive operating area" means an EMS area or sub-area defined by the
17 emergency medical services plan for which a local EMS agency, upon the
18 recommendation of a county, restricts operations to one or more emergency ambulance
19 services or providers of limited advanced life support or advanced life support.

20
21 **1797.105.** (a) The authority shall receive plans for the implementation of emergency
22 medical services and trauma care systems from EMS agencies.

23 (b) After the applicable guidelines or regulations are established by the authority, a
24 local EMS agency may implement a local plan developed pursuant to Section 1797.250,
25 1797.254, 1797.257, or 1797.258 unless the authority determines that the plan does not
26 effectively meet the needs of the persons served and is not consistent with coordinating
27 activities in the geographical area served, or that the plan is not concordant and
28 consistent with applicable guidelines or regulations, or both the guidelines and
29 regulations, established by the authority.

30 (c) A local EMS agency may appeal a determination of the authority pursuant to
31 subdivision (b) to the commission.

32 (d) In an appeal pursuant to subdivision (c), the commission may sustain the
33 determination of the authority or overrule and permit local implementation of a plan, and
34 the decision of the commission is final.

35
36 **1797.200.** Each county may develop an emergency medical services program. Each
37 county developing such a program shall designate a local EMS agency which shall be
38 the county health department, an agency established and operated by the county, an
39 entity with which the county contracts for the purposes of local emergency medical
40 services administration, or a joint powers agency created for the administration of
41 emergency medical services by agreement between counties or cities and counties
42 pursuant to the provisions of Chapter 5 (commencing with Section 6500) of Division 7
43 of Title 1 of the Government Code.

1 **1797.201.** Upon the request of a city or fire district that contracted for or provided, as of
2 June 1, 1980, pre-hospital emergency medical services, a county shall enter into a
3 written agreement with the city or fire district regarding the provision of pre-hospital
4 emergency medical services for that city or fire district. Until such time that an
5 agreement is reached, pre-hospital emergency medical services shall be continued at
6 not less than the existing level, and the administration of pre-hospital EMS by cities and
7 fire districts presently providing such services shall be retained by those cities and fire
8 districts, except the level of pre-hospital EMS may be reduced where the city council, or
9 the governing body of a fire district, pursuant to a public hearing, determines that the
10 reduction is necessary.

11
12 Notwithstanding any provision of this section the provisions of Chapter 5 (commencing
13 with Section 1798) shall apply.

14
15 **1797.204.** The local EMS agency shall plan, implement, and evaluate an emergency
16 medical services system, in accordance with the provisions of this part, consisting of an
17 organized pattern of readiness and response services based on public and private
18 agreements and operational procedures.

19
20 **1797.206.** The local EMS agency shall be responsible for implementation of advanced
21 life support systems and limited advanced life support systems and for the monitoring of
22 training programs.

23
24 **1797.220.** The local EMS agency, using state minimum standards, shall establish
25 policies and procedures approved by the medical director of the local EMS agency to
26 assure medical control of the EMS system. The policies and procedures approved by
27 the medical director may require basic life support emergency medical transportation
28 services to meet any medical control requirements including dispatch, patient
29 destination policies, patient care guidelines, and quality assurance requirements.

30
31 **1797.224.** A local EMS agency may create one or more exclusive operating areas in the
32 development of a local plan, if a competitive process is utilized to select the provider or
33 providers of the services pursuant to the plan. No competitive process is required if the
34 local EMS agency develops or implements a local plan that continues the use of
35 existing providers operating within a local EMS area in the manner and scope in which
36 the services have been provided without interruption since January 1, 1981. A local
37 EMS agency which elects to create one or more exclusive operating areas in the
38 development of a local plan shall develop and submit for approval to the authority, as
39 part of the local EMS plan, its competitive process for selecting providers and
40 determining the scope of their operations. This plan shall include provisions for a
41 competitive process held at periodic intervals. Nothing in this section supersedes
42 Section 1797.201.

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1 **1797.226.** Without altering or otherwise affecting the meaning of any portion of this
2 division as to any other county, as to San Bernardino County only, it shall be competent
3 for any local EMS agency which establishes exclusive operating areas pursuant to
4 Section 1797.224 to determine the following:

5 (a) That a minor alteration in the level of life support personnel or equipment, which
6 does not significantly reduce the level of care available, shall not constitute a change in
7 the manner and scope of providing service.

8 (b) That a successor to a previously existing emergency services provider shall qualify
9 as an existing provider if the successor has continued uninterrupted the emergency
10 transportation previously supplied by the prior provider.

11
12 **1797.254.** Local EMS agencies shall annually submit an emergency medical services
13 plan for the EMS area to the authority, according to EMS Systems, Standards, and
14 Guidelines established by the authority.
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1 **Appendix D: Relevant Sections of the EMS System Standards and Guidelines**
2 (EMSA #101, June 1993)

- 3
- 4 • Planning Activities – Section 1.09
- 5
- 6 • Enhanced Level: Exclusive Operating Areas - Section 1.28
- 7
- 8 • Response/Transportation - Sections 4.01, 4.02, 4.04, 4.05, 4.06, 4.13
- 9
- 10 • Enhanced Level: Ambulance Regulation – Section 4.18
- 11
- 12 • Enhanced Level: Exclusive Operating Permits – Section 4.19 – 4.22
- 13
- 14 • Enhanced Level: Exclusive Operating Areas/Ambulance Regulation –
- 15 Section 8.19
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EMSA #111 B
(Effective 1/1/2009)

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name	
First /Middle Name	
Date of Birth	Date Form Prepared

A **CARDIOPULMONARY RESUSCITATION (CPR):** *Person has no pulse and is not breathing.*
 Check One Attempt Resuscitation/CPR Do Not Attempt Resuscitation/DNR (Allow Natural Death)
 (Section B: Full Treatment required)
 When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B **MEDICAL INTERVENTIONS:** *Person has pulse and/or is breathing.*
 Check One **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. **Transfer** if comfort needs cannot be met in current location.
 Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
 Do Not Transfer to hospital for medical interventions. Transfer if comfort needs cannot be met in current location.
 Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. **Transfer to hospital if indicated.** Includes intensive care.
Additional Orders: _____

C **ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and desired.*
 Check One No artificial nutrition by tube. Defined trial period of artificial nutrition by tube.
 Long-term artificial nutrition by tube.
Additional Orders: _____

D **SIGNATURES AND SUMMARY OF MEDICAL CONDITION:**
 Discussed with:
 Patient Health Care Decisionmaker Parent of Minor Court Appointed Conservator Other:
Signature of Physician
 My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient, Decisionmaker, Parent of Minor or Conservator
 By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)
----------------------	--------------	--------------------------------------

Summary of Medical Condition	Office Use Only
------------------------------	-----------------

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Patient Name (last, first, middle)		Date of Birth	Gender: M F
Patient Address			
Contact Information			
Health Care Decisionmaker	Address		Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professional**Completing POLST**

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or medical treatments may prohibit a person from residing in a residential care facility for the elderly.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen “Do Not Attempt Resuscitation.”

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with “Comfort Measures Only,” should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Measures Only.”
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate “Limited Interventions” or “Full Treatment.”

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person’s health status, or
- The person’s treatment preferences change.

Modifying and Voiding POLST

- A person with capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new POLST form.
- To void POLST, draw a line through Sections A through D and write “VOID” in large letters. Sign and date this line.
- A health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual’s best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.

For more information or a copy of the form, visit www.capolst.org.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

EMERGENCY MEDICAL SERVICES AUTHORITY

1930 9th STREET
SACRAMENTO, CA 95811-7043
(916) 322-4336 FAX (916) 324-2875



January 14, 2010

Reza Vaezazizi, MD
EMDAC President
515 N. Arrowhead Avenue
San Bernardino, CA 92415-0060

Dear Dr. Vaezazizi:

The State Trauma Advisory Committee is advisory to the Director of the EMS Authority on all of California's trauma related activities. This is particularly important as the State continues trauma regionalization through Regional Trauma Coordinating Committees, moves toward establishment of a statewide trauma system, and develops a new statewide trauma plan.

I have reorganized and formalized our State Trauma Advisory Committee and would like one position to be represented by your organization. I extend an invitation to you to nominate three candidates. I ask that the nominees have the ability to represent your organization, interest in the position, and time to devote to regular participation. Your organization may choose to nominate your existing representative on the committee. Please include a curriculum vita by each candidate describing their system experience and trauma knowledge. I will appoint the position for a three year term.

The State Trauma Advisory Committee generally holds bi-monthly or quarterly meeting in San Francisco, San Diego, Los Angeles, or Sacramento, with periodic conference calls. Unfortunately, there is no funding for committee expenses at this time. I look forward to receiving your three nominations by February 15, 2010. Your existing representative may serve until replaced.

If you have any questions, please contact Johnathan Jones at (916) 322-4336, extension 415 or e-mail: Johnathan.jones@emsa.ca.gov.

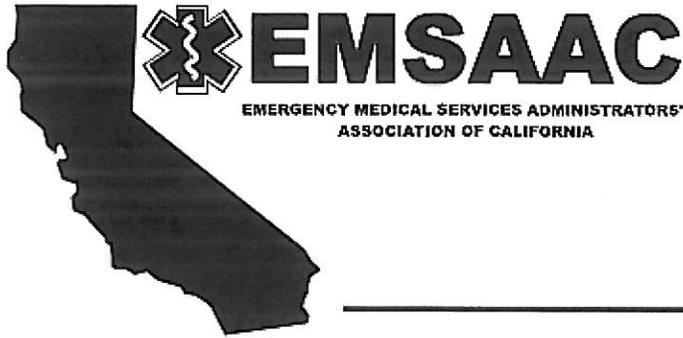
Sincerely,

A handwritten signature in black ink, appearing to read "R. Steven Tharratt".

R. Steven Tharratt, MD, MPVM
Director

JAN 21 2010

JAN 26 2010



January 15, 2010

Steve Tharratt, M.D., Director
Emergency Medical Services Authority
1930 9th Street
Sacramento, California 95814-7043

Dear Dr. Tharratt:

SUBJECT: TRAUMA ADVISORY COMMITTEE MEMBERSHIP

The Emergency Medical Services Administrators Association of California (EMSAAC) applauds the Authority's formalizing the membership of Trauma Advisory Committee (TAC). Additionally, incorporating the regional trauma advisory groups into the membership will serve to promote our support for a Statewide trauma hospital system.

The membership categories as outlined by the Authority represent a good cross section of experts; however, one very important category is missing – Local EMS Agency Medical Director. Historically, we have all used EMDAC to nominate member physicians for our committees; however, EMDAC includes some physicians who are not local EMS agency medical directors and the interests of those physicians are often varied.

EMSAAC requests that a position of local EMS agency medical director be added to the TAC membership. If you are opposed to our request, then, alternatively, we request that you ask EMDAC to appoint a local EMS agency medical director for the allocated EMDAC position.

Thank you for consideration of our request.

Very truly yours,


Miles Julihn
President

Cc: Reza Vaezazizi, MD, President, EMDAC

Good Samaritan Sudden Cardiac Survival Act of 2010

Background:

Each year, approximately 295,000 sudden cardiac arrests occur in the United States that are treated out of hospital with emergency services. Approximately 20 percent of these events occur in the presence of a witness. The key to survival is administration of bystander CPR and the use of an automated external defibrillator.

In the event of a sudden cardiac arrest, every minute counts. Statistics show that survival rates drastically increase from 10 percent to between 50 and 70 percent when a defibrillator is used within 3 to 5 minutes of a sudden cardiac arrest event. For every minute without a shock to the heart, the chance of survival decreases by 7 to 10 percent.

Problem:

Businesses are not voluntarily installing these life-saving devices because current law contains numerous barriers. Specifically, barriers include the fear of liability and extensive requirements related to training, reporting, maintenance, and development of a written plan to be followed in the case of an emergency.

Solution:

This public health bill addresses the problem by providing additional Good Samaritan immunity protections for businesses that voluntarily install AEDs. It also removes the extensive requirements placed on businesses that are mentioned above.

The bill does not provide Good Samaritan liability protections for cases involving personal injury or wrongful death that results from gross negligence or willful or wanton misconduct. Further, it leaves current law intact by not relieving a manufacturer, designer or developer, distributor, installer or supplier of an AED of any liability.

Question & Answers

1. What is Sudden Cardiac Arrest?
Sudden Cardiac Arrest (SCA) is when an abnormal heart rhythm called ventricular fibrillation causes the heart to quiver so that it cannot pump blood effectively. To return the victim's heart to a normal rhythm and allow it to begin beating again, an electrical shock must be quickly delivered via an AED.
2. What is an AED and are they easy to use?
Yes. Automatic External Defibrillators, or AEDS, are extremely accurate, user-friendly, computerized devices with audio prompts that guide the user through the steps to safely deliver both life-saving shocks and the performance of CPR. In essence AEDs offer real-time training to users.
3. How does an AED work?
A microprocessor inside the defibrillator interprets (analyzes) the victim's heart rhythm through adhesive electrodes. (Some models of AEDs require you to press an ANALYZE button). The computer analyzes the heart rhythm and advises the operator whether a shock is needed. AEDs advise a shock only for ventricular fibrillation and fast ventricular tachycardia (Fast ventricular tachycardia is a life-threatening arrhythmia in which the contractions of the heart are ineffective).

As in VF, an electrical shock can correct this condition). The electric current is delivered through the victim's chest wall through adhesive electrode pads.

4. Do AEDs improve survival rates?

Yes. AEDs strengthen the chain of survival. When a person suffers a sudden cardiac arrest, for each minute that passes without defibrillation, their chance of survival decreases by 7–10 percent increased rates.... AEDs save lives!

5. Can AEDS harm a victim of Sudden Cardiac Arrest?

AEDs are programmed to deliver a shock only when they have detected an irregular heart rhythm called ventricular fibrillation (VF) or fast ventricular tachycardia.

6. Shouldn't a Good Samaritan be trained to use an AED?

As mentioned above, AEDs are extremely accurate and user-friendly devices. The American Heart Association believes that training is important. But SCA is 100 percent fatal if not treated quickly and every willing rescuer should have the opportunity to help save a life, be enabled and encouraged to respond to SCA emergencies, regardless of formal training status. AEDs can only help SCA victims.

We believe that acquirers of AEDs will continue to participate in voluntary training programs, but meeting training and other requirements should not be tied to protection from liability. Our research shows that qualifying immunity in this manner is a barrier to increasing the availability of AEDs.

7. Why are you removing the training requirements?

The purpose of the bill is to remove barriers to the placement of AEDs. AHA believes that training is important. Lay rescuers tend to perform better under pressure if they have been trained. While it's ideal for lay rescuers to have been trained, given how easy AEDs are to use, it makes sense to have them available to people who aren't trained so they can have the opportunity to save a life. Without the use of an AED, the victim is far more likely to die.

8. Why are you removing the maintenance requirements?

With this bill we are talking about businesses that place AEDs voluntarily. Since these businesses are trying to do the right thing by installing the devices voluntarily, they are likely to keep up with the maintenance.



Prehospital EMS Aircraft Guidelines

Prepared by:

The Air Medical Task Force
And

The California Emergency Medical Services Authority

Draft
EMSA #144

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7 **Prehospital EMS Aircraft Guidelines**
8

9
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34 California Health and Human Services Agency

35
36 Arnold Schwarzenegger
37 Governor

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39 DRAFT: January 28, 2009
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Prehospital EMS Aircraft Guidelines

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II. Introduction

In 2007, the California EMS Authority held an Aeromedical Summit. The purpose of this summit was to bring the parties interested in aeromedical services in California together to discuss the overall EMS air response in our State. This event was attended by representatives from all aspects of EMS and the aeromedical industries including clinicians, private and public providers and local EMS agency representatives.

During the Aeromedical Summit, several areas of concern with respect to aeromedical services in California were identified that those in attendance felt were of significance to warrant closer evaluation. The areas listed as being significant by the Aeromedical Summit attendees included safety, communication, skill and training, fiscal issues including reimbursement, utilization and quality assurance standards within local EMS Agency (LEMSA), and oversight of registered nurses.

Based on the concerns stated by attendees of the Aeromedical Summit, EMSA decided to develop a statewide multi-jurisdictional task force to create statewide guidelines for use by providers and LEMSAs for air medical EMS. As the task force was developed, the issues to be considered grew in complexity. The task force decided to separate its resources and develop two working groups to address items that fell into either the medical or operational component of aeromedical services. Once the group assignments were established, the groups began meeting independently approximately once a month. The overall task force met approximately every other month to go over the status of the various projects each group was working on.

The meetings continued over a two year period of time with many documents being created to cover the areas of concern first brought up during the Aeromedical Summit. In 2009, the two working groups were combined back into a single task force to complete the process of placing the various individual group work pieces into one single guideline.

Once the single guideline draft was completed, EMSA administration reviewed it prior to a public comment period. Upon completion of the public comment period, the Prehospital EMS Aircraft Guidelines were presented to the Commission on EMS for approval.

The Prehospital EMS Aircraft Guideline demonstrates what can be accomplished when the EMS constituents work together collaboratively to achieve a common goal.

III. Definitions

Air Operations Branch Director: A position within the Incident Command System (ICS) system that, when assigned, is designated with responsibility for incident-related air operations. This position may be the designated ground contact. The radio designator would be: **(Incident name) Air Ops**.

Air Ambulance: Any aircraft specifically constructed, modified or equipped, and used for the primary purpose of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has a minimum of two (2) attendants certified or licensed in advanced life support.

Authorizing Agency: Local EMS agency which approves utilization of specific EMS aircraft within its jurisdiction.

Auxiliary Rescue Aircraft: Rescue aircraft which does not have a medical flight crew, or whose medical flight crew do not meet the minimum requirements established in regulations.

BRN: Board of Registered Nursing.

CAMTS: Commission on Accreditation of Medical Transport Services.

CEMSIS: California EMS Information System.

Classifying Agency: Entity which categorizes the EMS aircraft into the groups identified in California Code of Regulations Section 100300 (c)(3). This shall be the local EMS agency in the jurisdiction of origin except for aircraft operated by the California Highway Patrol, the California Department of Forestry or the California National Guard which shall be classified by the EMS Authority.

Cold Load/Fuel: Loading or fueling of aircraft with rotor blades stopped.

Emergency Landing Zone (ELZ): the term used to designate an “emergency landing site” of an EMS aircraft by a public safety official.

Emergency Landing Zone Coordinator: A position consistent with ICS protocol, when assigned, is designated with responsibility for securing an emergency landing zone (ELZ), and conducting landing, patient transfer and take-off operations. This position may be the designated ground contact. The radio designator would be: **(Incident Name) LZ Coordinator**.

EMD: Emergency Medical Dispatch

EMS Aircraft: Any aircraft utilized for the purpose of prehospital emergency patient response and transport. EMS aircraft includes air ambulances and all categories of rescue aircraft.

Flight Following: Monitoring movements of aircraft while in the air.

FOG : Firescope Field Operations Guide, ICS 420-1, June 2004

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4 **Helicopter Coordinator:** A position within the ICS system that, when assigned, is designated
5 with responsibility to coordinate tactical or logistical air operations. For the purpose of this
6 policy, the Helicopter Coordinator would typically coordinate with the Incident Medical Branch
7 during a major MCI. The Helicopter Coordinator fulfills the same function as the Ground
8 Ambulance Coordinator. This position may also be the designated ground contact. The radio
9 designator would be: **(Incident name) Helicopter Coordinator** (HLCO).

10
11 **Hot Load/Fuel:** Loading or refueling of aircraft with rotor blades turning.

12
13 **ICS:** Incident Command System.

14
15 **Incident Commander:** A position within the ICS system that is designated with overall incident
16 management responsibility. The Incident Commander (or Unified Command in multi-
17 jurisdiction operations) is responsible for ensuring the assignment of a **designated ground**
18 **contact** for EMS helicopter operations under these Guidelines. In some circumstances, the
19 I/C position may be the designated ground contact. The radio designator would be: **(Incident**
20 **name) I/C**.

21
22 **Jurisdiction of Origin:** “Jurisdiction of Origin” for the Multi-Jurisdictional Air Provider (M-JAP)
23 means the local EMS agency where the M-JAP headquarters is located in California or if a M-
24 JAP is located outside the state of California, if possible, the local EMS agency where the
25 initial base of operations was established.

26 **LEMSA:** Local emergency medical services agency.

27 **Multi-Jurisdictional Air Provider (M-JAP):** “Multi-Jurisdictional Air Service Provider”, as used
28 in these Guidelines, means an Air Medical Service Provider that operates EMS air bases
29 located in more than one local EMS agency (LEMSA) jurisdiction within California or an Air
30 Service Provider that is based outside of California but transports patients to or from multiple
31 authorizing EMS agency jurisdictions within California on a routine basis. This definition is
32 exclusive of mutual aid provider agreements.

33 **NEMESIS:** National EMS Information System.

34
35 **Private Provider:** Entity that is not owned by a public safety agency.

36
37 **Public Provider:** Entity that is operated by a public safety or other governmental agency.

38
39 **Rescue Aircraft:** An aircraft whose usual function is not prehospital emergency patient
40 transport but which may be utilized, in compliance with local EMS policy, for prehospital
41 emergency patient transport when use of an air or ground ambulance is inappropriate or
42 unavailable. Rescue aircraft includes ALS rescue aircraft, BLS rescue aircraft and auxiliary
43 rescue aircraft.
44

1 IV. Dispatch

3 **General:**

5 The utilization of EMS aircraft within EMS systems is widespread. The local
6 emergency medical services agency (LEMSA) may integrate EMS aircraft into
7 their local systems by implementing standards consistent with California Code of
8 Regulations, Title 22, Division 9, Chapter 8, Prehospital EMS Air Regulations,
9 Section 100300. A benefit from the utilization of EMS aircraft may be the time
10 saved during air transport as compared to ground transport. Other benefits are
11 achieved when aircraft are utilized to perform rescue activities or flight crews
12 perform specialized medical procedures.

14 EMS aircraft provide a mechanism to potentially reduce the amount of time that it
15 takes to deliver a patient to an appropriate medical facility. Given that saving
16 time is a key component of EMS aircraft use, it is imperative that all facets of the
17 incident be managed in a way that attempts to accomplish this goal.

19 Several time elements are created when a request is placed for an EMS aircraft.
20 These time elements are similar to those that exist for ground ambulances. The
21 request for an EMS aircraft from a dispatch center or hospital is not unlike a 9-1-
22 1 call placed by a person in need of medical attention. As soon as the request
23 for assistance is made, there is an expectation on the part of the caller that every
24 conceivable effort is being made to deliver the requested response in the most
25 expeditious manner possible.

27 **Operational Guidelines:**

29 In an effort to accomplish the aforementioned goals, the following
30 recommendations for EMS aircraft dispatch are made:

- 32 1. For incidents with an expectation that EMS aircraft will be necessary
33 (based on information secured by the call taker), it is acceptable to
34 dispatch the appropriate aircraft as soon as possible. Known as
35 "simultaneous dispatch", this practice obviates the need for first
36 responders to arrive at the scene and initiate the request.
- 38 2. For incidents that meet certain EMD criteria and occur in areas where the
39 expected ground transport time to the appropriate facility would exceed
40 the total time to deliver the patient to the Emergency Department (ED) via
41 air, the simultaneous dispatch of EMS aircraft should occur.
42 Simultaneous dispatch should also occur whenever multiple patients are
43 anticipated to exceed the capacity of ground resources. In the event air
44 resources are not dispatched with ground resources, air may be
45 requested by the responding ground units or incident commander.

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3. The use of simultaneous dispatch requires a robust continuous quality improvement process (CQI) with the appropriate medical and operational oversight. This oversight should include representation from both providers and the LEMSA. It is imperative that the immediate availability of air resources at the scene does not lead to the overuse of these resources when ground transport is appropriate.
4. EMS aircraft requests from all entities, including incident commanders, local agencies, primary Public Safety Answering Points (PSAPs) and secondary PSAPs should be directed to a single ordering point within a region / area.
5. The ordering point, communications center or emergency command center, is responsible for requesting the appropriate air resources based upon all available technologies and in coordination with local polices and procedures.
6. If a request for service is refused by a particular provider, (e.g. weather), this information will be conveyed to any subsequent recipient of the request for service.
7. EMS aircraft should initiate and maintain their status with the communications center or emergency command center until such time that their mission is complete.
8. LEMSA policy should be based on closest / most appropriate level of care.

1 V. Utilization

2
3 The decision to use EMS aircraft is complex and a number of important
4 geographical, physiological, and operational factors need to be considered.
5 Utilization is the decision to dispatch air resources and whether to use those
6 resources to transport. It is important that emergency medical services (EMS)
7 personnel utilize consistent and appropriate criteria when requesting an EMS
8 aircraft for assistance with patient care and transport. EMS aircraft utilization
9 criteria should be developed with input and approval from the LEMSA medical
10 director consistent with Health and Safety Code Section 1797.220. Review of
11 appropriate EMS aircraft utilization should be a part of EMS training, as well as a
12 component of the agency and regional level quality improvement process.

13
14 **General:**

15
16 The purpose of this section is to encourage the EMS community to actively
17 participate with the LEMSA to develop and review EMS aircraft utilization policies
18 using this document as guidance. This review should include dispatch, utilization
19 and destination policies. This document encourages multi-jurisdictional air
20 resource management and is not intended to cover every circumstance or
21 condition in which EMS aircraft may be utilized.

22
23 **Operational Guidelines:**

24
25 When utilizing EMS aircraft, a patient being transported by EMS aircraft should
26 be critically ill and/or injured (life or limb) and transport time savings to definitive
27 care must be considered. At times, special circumstances related to a particular
28 area will drive decisions related to EMS aircraft utilization. The following is an
29 outline of suggested appropriate EMS aircraft utilization:

- 30
31 1. Local policies and procedures should direct the following activities when an
32 air medical resource may be dispatched to any of the following incident
33 types:
- 34
35 A. The patient(s) meets local EMS aircraft triage criteria for trauma and
36 medical incidents. LEMSAs are encouraged to use triage criteria
37 based upon nationally recognized standards and developed by
38 organizations such as American College of Surgeons, American
39 College of Emergency Physicians, Air Medical Physician’s Association
40 and Centers for Disease Control and Prevention. These triage criteria
41 should encompass specialty care centers based on resources
42 available in their areas;
 - 43
44 B. Any agency who responds or any agency who is dispatched to the
45 scene requests the air medical resource;

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- C. A dispatch center when following expedited / simultaneous launch protocols or has information given by the reporting party would indicate a need; or
- D. Multi-casualty Incidents (MCI).

2. Utilization of EMS aircraft should be considered in situations:

- A. The use of the EMS aircraft will provide a clinically significant reduction in transport time to a receiving facility capable of providing definitive care. If the total time for air transport exceeds the ground ambulance transport time, air transport may not be indicated. Time savings must be considered when using EMS aircraft. Time frames will be influenced by a number of factors, including but not limited to, the patients' condition, the type of aircraft and current environmental conditions. These must be considered when determining whether EMS aircraft transport is appropriate.
- B. The patient is inaccessible by other means.
- C. Utilization of existing ground transport services threatens to overwhelm the local EMS system.
- D. Patient whose condition may benefit by a higher level care offered by the EMS aircraft.
- E. LEMSA policy should be based on closest / most appropriate level of care.

3. Type of air resource:

- A. The preferred EMS aircraft should be an ALS level resource as determined by LEMSA policy.
- B. Auxiliary Rescue Aircraft are primarily utilized for rescue / rendezvous purposes only and should not be used routinely for transportation to a medical facility.
- C. ALS or BLS ground providers should not be used routinely for patient transport in the aircraft. If the need for ground providers to act as flight crew is anticipated, they should be pre-trained and / or provided a pre-flight briefing prior to functioning in the aircraft.

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4. Destination / Cancellation:

- A. EMS aircraft will comply with LEMSA policy transporting patients to the closest and / or most appropriate facility.

- B. The decision to cancel a responding air medical resource is at the discretion of the incident commander. The decision should be made collaboratively with the on scene medical personnel, after assessing the scene location and patient needs.

- C. If the air medical resource pilot questions safety, they shall have the final authority in decisions to continue or cancel the response. Air Medical Resource Management / pilot in command may dictate the need to deviate from destination policy based on safety concerns.

1 VI. Helicopter Landing Zone

2
3 To provide a consistent, efficient and coordinated approach within California for
4 the setup and security of all EMS aircraft landing zones.

5
6 **General:**

7
8 Nothing in this section is intended to limit the statutory authority of a public safety
9 aircraft pilot from an “off-site” landing for the purposes of law enforcement, fire,
10 medical, or rescue operations; “off-site” landings remain under the oversight
11 authority of the Federal Aviation Administration.

12
13 This is not intended to apply to designated Helispot or Heliport facilities or EMS
14 helicopter operations from designated/approved airport facilities.

15
16 Within the ICS management of the incident rests with the Incident Commander
17 (I/C), unless the Incident Commander designates subordinate positions.

18
19 The typical designated ground contact for EMS aircraft operations in the field will
20 be either the Incident Commander (*incident name* I/C) or Incident Air Operations
21 (*incident name* Air Ops).

22
23 **Operational Guidelines:**

- 24
- 25 1. Emergency Landing Zone Setup: The designated ground contact
- 26 (referred to here as the “ELZ Coordinator”) is responsible for the
- 27 identification, selection, preparation and security of the EMS helicopter
- 28 ELZ to minimize the risk of scene response hazards.
- 29
- 30 2. Preparation for Arrival – ELZ selection should be guided by the following
- 31 considerations:
- 32
- 33 A. Size - During both day and night operations select an area of at
- 34 least 100 ft x 100 ft or 100 ft in diameter. The bigger the better.
- 35
- 36
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- 1 B. Hazards – The ELZ area should be walked by the ELZ Coordinator
2 to identify any obvious and hidden hazards. This will include any
3 loose debris, large rocks, tree stumps, etc. Many ground hazards
4 can be covered by tall grass. Ask yourself the following question:
5 Will the rotor wash cause debris (trash, plywood, garbage cans,
6 shopping carts, etc.) to be blown around by the high velocity winds?
7 Some items can be picked up by the rotor wash and be blown into
8 the rotor system causing damage to the EMS aircraft or could be
9 blown away from the EMS aircraft potentially causing harm to
10 onlookers or scene personnel.
- 11
- 12 C. Obstructions - Tall obstructions / hazards can be determined by
13 standing in the center of the ELZ and with one arm raised to a forty-
14 five (45)-degree angle anything that is noted to be in the proximity
15 of the ELZ and above the individuals arm would be identified as a
16 hazard and should be communicated to the flight crew prior to
17 landing. Wires and poles are the most common hazards along with
18 trees. The perimeter of the ELZ should be walked entirely and
19 searched for overhead wires and or poles that may indicate the
20 presence of wires. If able, park vehicles under and parallel to the
21 direction of the wires.
- 22
- 23 D. *Surface – The surface should be as firm and level as possible.*
24 *Sand, loose dirt or snow is acceptable but could cause visibility*
25 *problems (brown out or white out) during landing. Be aware that*
26 *tall grass can be okay but the underlying surface may not be flat, or*
27 *have hidden obstacles (tree stumps, fence posts). A soggy wet*
28 *field may cause the EMS aircraft wheels or skids to sink beyond a*
29 *safe point. The practice of wetting down a dusty ELZ is acceptable*
30 *in most situations and may be requested by the flight crew.*
31 *Particular attention should be made to wetting down the perimeter*
32 *of the ELZ and work toward the center. As the EMS aircraft is*
33 *making its final approach most debris / dust will initially be blown*
34 *beginning at the leeward perimeter of the ELZ.*
- 35
- 36 E. Slope – The slope of the ELZ should be no greater than ten (10)-
37 degrees. Always approach a helicopter from the downhill side,
38 never approach from the uphill side.
- 39
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- 1 F. Location - Proximity and accessibility are two important aspects of
2 every ELZ. Try to get the ELZ setup as close to the scene as
3 practical and 100 ft – 200 ft downwind. Avoid having the EMS
4 helicopter approach over the incident to minimize rotor wash on
5 scene operations. Be cognizant of areas for physical access from
6 the scene to the EMS aircraft, i.e. fences, ditches, guard rails etc.
7 The patient will have to be carried over these obstacles, so choose
8 a clear path if available.
9
- 10 G. ELZ operations on roadways and highways – ELZ operations on
11 roadways and highways, or immediately adjacent thereto, must be
12 coordinated with on-scene law enforcement. Avoid blocking traffic
13 if possible, but if landing on a road stop all traffic in both directions
14 without exception. Where law enforcement is on-scene prior to
15 designating the ELZ, the designation of the ELZ should be in
16 conjunction with the on-scene officer in charge.
17
- 18 H. Wind Direction – In most cases the EMS aircraft will land ‘*into the*
19 *wind*’ or with the wind to its nose. All reference to wind direction
20 should be made with indication of where the winds are coming
21 from.
22
- 23 I. Smoke Signaling Devices - If you have smoke devices available
24 ask the flight crew if they would like you to use it. Never use smoke
25 devices unless this action is coordinated with the pilot. When using
26 smoke, it must be non-flammable location due to the facts that the
27 canister may put out a great deal of heat and can be blown away by
28 the EMS aircraft rotor wash if not properly positioned or secured.
29
- 30 J. Night Time Landing Operations – The following apply to nighttime
31 operations:
32
- 33 1) Do not direct any light directly towards the EMS aircraft pilot
34 position.
 - 35 2) Do not use flares to mark an ELZ unless specifically
36 requested by the pilot.
 - 37 3) A helicopter should be directed into the wind for final
38 approach.
39
- 40 K. Night Time ELZ Marking – using colored lights to mark ELZ is a
41 complex operation. Care should be taken to ensure that the
42 incoming EMS aircraft is familiar with local practices regarding the
43 meaning of any colored lights being used. The ELZ Coordinator
44 should convey the meaning (red for hazard, amber for perimeter,
45 etc.) of any colored lights to the pilot prior to the EMS aircraft’s final
46 approach.

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- 1) If an ELZ kit is used, place the four (4) similarly colored lights around the perimeter of the ELZ. A fifth (5th) contrasting light should be placed along the perimeter of the ELZ to indicate wind direction as it enters the ELZ. Signaling lights should be secured as well as possible given the terrain.
- 2) Without an ELZ Kit - If vehicles are available, vehicles may be positioned at the perimeter of the ELZ with the headlights shining toward the center of the ELZ to form an "X."
- 3) NOTE: The use of colored ELZ lighting systems to designate "hazard" and/or "ELZ" locations must be carefully coordinated; extreme care must be taken to ensure that lighting systems designating "hazard" locations and "ELZ boundaries" do not conflict from jurisdiction to jurisdiction.

L. Once the EMS aircraft is in sight – When ready, the flight crew will request ELZ info. The ELZ Coordinator should report current information on wind speed and direction, hazards, obstructions / obstacles, terrain surface conditions and other special landing considerations. Hand-signals are not normally used during ELZ operations; however, within some interagency operations hand signals maybe standard practice.

M. Information to be provided to the flight crew while inbound - the ELZ Coordinator should provide:

- 1) Notification of any chemical hazards both in the area and or patient contamination issues.
- 2) Notification of multiple EMS aircraft overhead and or inbound.

3. Arrival / Ground Operations – the following should be considered during the arrival and ground operations:

A. Traffic / Crowd Control – All vehicular and pedestrian traffic must be prevented from entering the ELZ. No scene personnel should get closer than 50 ft to the perimeter of the ELZ unless approved and directed by a flight crew member. Vehicular traffic includes all scene response, police and civilian vehicles. Keep all bystanders at least 100 ft – 200 ft from the ELZ perimeter. A fenced in area will be helpful in keeping people away but, on the other hand there may be livestock that could pose a similar problem.

- 1 B. The ELZ Coordinator should stand at the upwind edge of the ELZ
2 (in proximity of the white wind direction light at night). This will
3 place the ELZ Coordinator at the far edge of the ELZ with the wind
4 at his / her back. This will also place the designated ground contact
5 away from the EMS aircraft as it makes its final approach into the
6 wind.
7
- 8 C. All other personnel or bystanders should be kept to the extreme
9 edge of the ELZ to protect them from objects that could be blown
10 by the rotor wash or downdraft.
11
- 12 D. The pilot is the final authority to accept or reject any landing zone
13 and may elect to coordinate with the ELZ Coordinator to select a
14 more suitable location if identified.
15
- 16 E. As the EMS aircraft approaches make sure that necessary
17 precautions have been taken to ensure no unauthorized entry into
18 the ELZ during final approach.
19
- 20 F. Once the EMS aircraft has made its approach to the ELZ it may
21 hover and maneuver to provide the best accessibility for the patient
22 loading.
23
- 24 G. After landing:
25
- 26 1) At no time should any ground personnel approach or return to
27 the EMS aircraft without specific crew approval, direction and
28 accompaniment.
 - 29 2) When approaching any helicopter, approach in the crouched
30 position when entering the tip path plane and remain
31 crouched until well under the rotor disc and close to the
32 helicopters fuselage.
 - 33 3) At no time should personnel be behind the horizontal tail fins
34 on a rear loading helicopter or behind the fuselage where the
35 tail booms begin on a side loading aircraft.
 - 36 4) Ground personnel should have appropriate head, hearing,
37 and eye protection if operating near the EMS aircraft and
38 have no loose objects on their person.
 - 39 5) No equipment above mid chest level when approaching a
40 running helicopter (i.e. IV poles, bags, etc.).
 - 41 6) Only EMS aircraft personnel should operate aircraft devices
42 and parts (aircraft doors, baggage compartments, cowlings,
43 litter locking devices, etc.).
44
45
46

1 H. Some patients may be declined due to:
2

- 3 1) Radioactive or chemical contamination unless proper
4 decontamination steps have been taken.
- 5 2) Patient's that are violent or combative unless they are
6 physically or chemically restrained.
- 7 3) Patient's who do not meet the weight limitations (pounds and
8 girth) of the EMS helicopter loading system/sled/gurney may
9 need a different mode of transport.

10
11 4. Departure Operations - the following should be considered during
12 departure operations:

13
14 A. During ground operations the pilot will have already formulated a
15 departure path/plan.

16
17 B. Depending on situation the departure path may be into the wind
18 passing over the windward side of the ELZ perimeter. Other times
19 the departure may mimic the approach. In any case when the EMS
20 aircraft is preparing to depart be aware of any equipment or
21 compartment doors that may be open and immediately notify the
22 crew.

23
24 C. Prior to the EMS aircraft departing:

- 25
26 1) When the pilot begins to depart be aware of flying debris
27 (you may briefly turn your back to the EMS aircraft until the
28 debris subsides).
 - 29 2) The ELZ Coordinator should look for overhead traffic (other
30 air ambulances, news helicopters, airplanes) since visibility
31 is limited above the departing EMS aircraft. The ELZ
32 Coordinator should report that the "OVERHEAD IS CLEAR
33 OF TRAFFIC" or "I HAVE TRAFFIC OVERHEAD YOUR
34 POSITION."
 - 35 3) It is recommended that the designated ground contact
36 position themselves at a 45 degree angle to the windward
37 side of the ELZ. This will prevent the potential situation of
38 the EMS aircraft departing into the wind and directly over the
39 designated ground contact's position.
 - 40 4) After the EMS aircraft departs the ELZ, the security of the
41 ELZ should be maintained until the pilot "clears the aircraft of
42 the ELZ." This is necessary in case the departing EMS
43 aircraft must emergently return due to mechanical or other
44 safety issues.
- 45

1 5. Communications – unless otherwise designated by the requesting agency,
2 the following VHF communications assignments are recommended:

3
4 A. Air-to-Ground VHF Frequencies:

- 5
6 1) Primary CALCORD (156.075).
7 2) Secondary: locally designated.
8 3) Alternate: locally designated.
9

10 B. Air-to-Ground 800 Talk Groups- the following 800 MHz talk groups
11 are common to every 800 MHz system. These national
12 interoperability talk groups should be considered in the absence of
13 a designated 800 MHz air-to-ground talk group assignment. These
14 national interoperability talk groups are generally line-of-sight and
15 are useful after the EMS aircraft arrives in the area:

- 16
17 1) Primary: I-CALL Direct.
18 2) Secondary: locally designated.
19 3) Alternate locally designated.
20

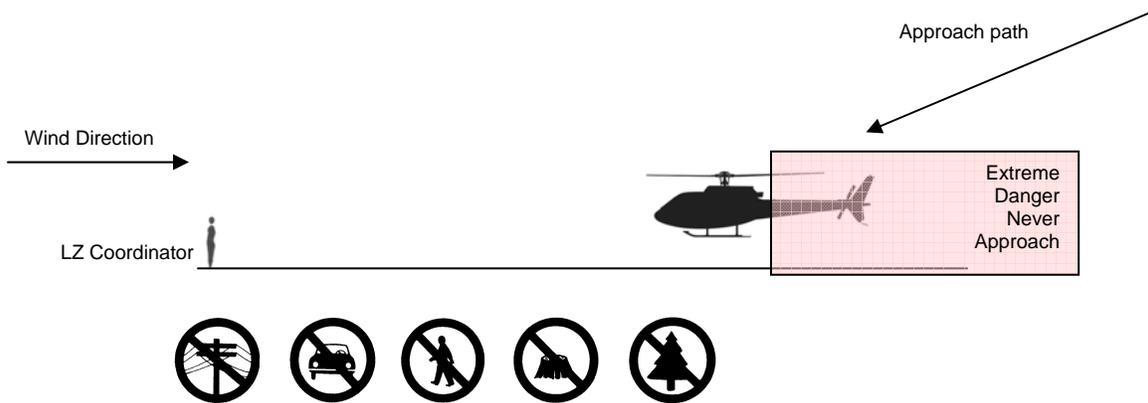
21 C. Air-to-Ground Communication Protocols- the following air-to-ground
22 communication protocols are recommended:

- 23
24 1) It is recommended that designated air-to-ground frequencies
25 should only be used for EMS helicopter-to-ELZ operations
26 whenever possible. Dual usage of frequency assignments may
27 lead to missing critical information.
28 2) Maintain “radio silence” on final approach and takeoff unless a
29 safety issue arises.
30 3) Use the words “ABORT ABORT ABORT” or “STOP STOP
31 STOP” to alert the pilot that an imminent safety condition or
32 unforeseen hazard exists during landing.
33 4) The priority of the designated ground contact during EMS
34 helicopter take-off and landing operations is ELZ safety and
35 security.
36

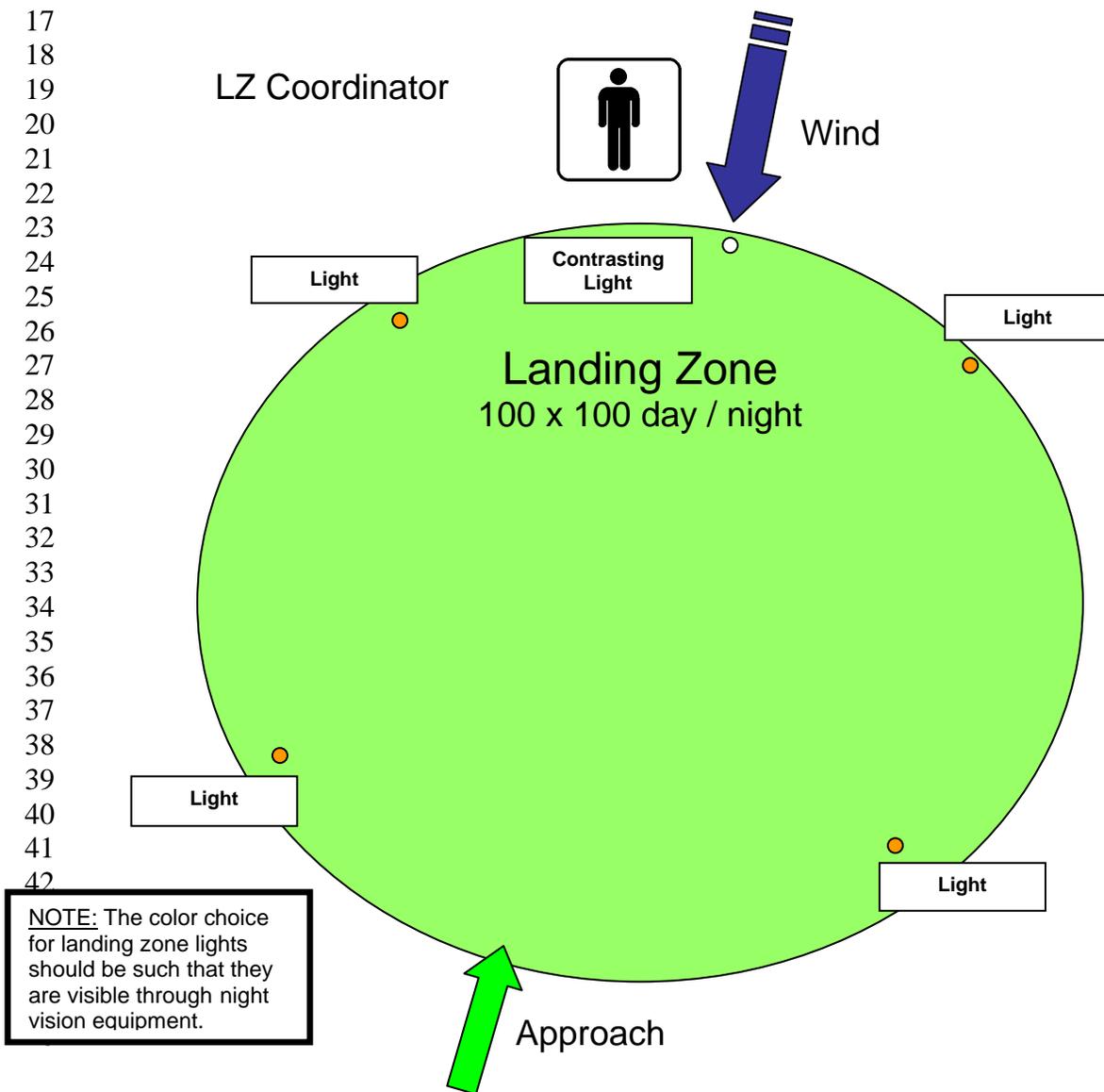
37 D. Air-to-Air Frequencies – unless otherwise designated by the
38 requesting agency, the following “air-to-air” frequency is
39 recommended:

- 40
41 1) Primary: 123.025 MHz
42
43
44
45
46

1 **Helicopter Approach Diagram**



15 **Night Time Lighting Diagram**



VII. Hospital Helipad Safety

General:

It is recommended that each local EMS agency develop policies related to helipad safety. The California Department of Transportation (Caltrans) Aeronautics Division is the approving authority for helipads in California. As part of establishing integration into their EMS system, LEMSAs shall maintain an inventory of landing sites approved by Caltrans.

Operational Guidelines:

Each local agency should tailor the criteria listed below for implementation into their system.

1. Approach and departure routes should be established in such a manner that the aircraft flies safely into and out of the helipad and provides noise abatement within the community.
2. Each helipad should have a contact frequency and phone number established in local policy.
3. Inbound and outbound aircraft considerations:
 - A. Public safety personnel should be present anytime an aircraft is arriving, departing or blades are turning on any unsecured helipad.
 - B. Communication between the aircraft and the hospital control is required for all inbound and outbound aircraft. Care should be taken to ensure that this includes all areas of the hospital and not just the emergency department.
 - C. When arriving or departing from a hospital helipad it is essential that pilots and crews remain alert, look for other traffic, and exchange traffic information when approaching or departing any landing site. To achieve the greatest degree of safety, it is essential that all aircraft transmit / receive on a common frequency identified for the purpose of LZ advisories. Use of the appropriate common frequency, combined with visual alertness and application of the following operating practices, will enhance safety of flight into and out of all such LZs. 123.025 is the accepted common frequency unless the LZ is located within the boundaries of Class B, C, or D airspace, or whenever a facility specific frequency is required.

- 1 D. For air to air communications: No less than 5 miles out; report
2 name of LZ, altitude, location relative to the LZ, landing or over
3 flight intentions, and the name of the LZ.
4
- 5 E. Inbound aircraft should notify the helipad control 15 minutes prior to
6 arrival when possible. If during the inbound leg for **that aircraft**
7 another aircraft comes up on the radio as inbound this traffic
8 information needs to be sent back out by the helipad control as a
9 radio call to the first and second aircraft.
10
- 11 F. Outbound aircraft should notify helipad control 10 minutes prior to
12 departure, again asking: **Are you showing any other traffic to**
13 **the helipad?**.
14
- 15 G. All Helipad traffic should be documented on a helipad log. This will
16 allow accurate traffic information given to all aircraft in the event
17 that several people may be charged with the responsibility of
18 answering the radio.
19
- 20 H. A helipad log should be kept by the helipad control radio and in an
21 area where the radio can be heard and monitored at all times. An
22 MICN is not required to answer the radio when communicating with
23 aircraft traffic.
24
- 25 I. Helipad control should advise all aircraft of other expected traffic to
26 or from the helipad by referencing the Helipad Log.
27
- 28 J. If not advised by helipad control the aircraft should ask if there is
29 any other expected traffic.
30
- 31 K. While a helicopter is landing or taking off, the use of artificial light is
32 not permitted for filming or photography; i.e., photo flash bulbs or
33 flood lights.
34
- 35 L. All lights on the helipad checked routinely and replaced as needed.
36
- 37 M. Helipad windsock should be checked semi-annually and replaced
38 as needed.
39
- 40 4. All personnel responding to the helipad should have initial helipad
41 orientation training and participate in annual helipad safety training.
42
- 43 5. If more than one aircraft is inbound to a single helipad, priority should be
44 given to the more critical patient. This decision should be made in
45 conjunction with the emergency department physician.
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6. The following items should be considered for general safety on all helipads:
- A. All personnel responding to the helipad should wait outside the marked safety lines until instructed to enter by the flight crew.
 - B. IV poles and gurneys should remain outside the marked safety zone until advised to bring them forward by a crew member. Ensure that the mattress pads, sheets, blankets and any other loose item is secured and will not be displaced by the rotor wash.
 - C. IV's and medical equipment should never be lifted over head height.
 - D. Always approach the helicopter from the front and within the field of vision of the pilot.
 - E. Assume a crouching position when approaching the helicopter when the blades are turning.
 - F. At no time should anyone be permitted near the tail of the aircraft. A crew member or trained public safety officer should stand guard to avert anyone walking toward an open tail rotor.
 - G. Smoking is prohibited by all personnel on the helipad.
 - H. All personnel responding to the helipad to assist with patient loading and offloading should use appropriate hearing and eye protection.
 - I. In the event of compromised vision of anyone of the helipad due to foreign body in the eyes, that person should kneel on the ground in a stationary position until assisted away from the aircraft by a member of the flight crews or public safety.
 - J. No vehicle should be driven within 50 feet of the helicopter unless under the direct supervision of a flight crew member and only when the blades have come to a stop.

VIII. Quality Improvement

This section provides local EMS agencies and air medical providers with guidelines for specific considerations for Quality Improvement (QI) programs for Air Medical Resources. Because EMS aircraft are specialized portions of the EMS system, local EMS agencies and air providers should ensure that their QI programs give consideration for the level of service provided by Air Medical Providers.

General:

Consistent with Chapter 12 of Title 22 of the California Code of Regulations, EMS air providers are to develop and implement a QI program in cooperation with other EMS system participants as defined in California Code of Regulations, Chapter 12, Section 100400.

Operational Guidelines:

1. The provider QI program should be designed to objectively, systemically and continuously monitor, access, and improve the quality and appropriateness of patient care and safety of the transport service provided. The QI program should be a written document that is approved by the provider's medical director and outlines the responsibility and accountability of the QI plan.
2. A QI flow chart diagram or comparable tool should be developed and utilized demonstrating organizational structure in the QI plan and linkage to the Safety and Risk Management Committees and facilitation of loop closure with field personnel.
3. Quality Improvement programs should include indicators, covering the areas listed in CCR Title 22, Chapter 12 of the Emergency Medical Services System Quality Improvement Program, which address, but are not limited to, the following:
 - A. Personnel
 - B. Equipment and Supplies
 - C. Documentation and Communication
 - D. Clinical Care and Patient Outcome
 - E. Skills Maintenance/Competency
 - F. Transportation/Facilities
 - G. Public Education and Prevention
 - H. Risk Management

- 1 4. The QI Program should be in accordance with the Emergency Medical
2 Services System Quality Improvement Program Model Guidelines (Rev.
3 3/04), incorporated herein by reference, and shall be approved by the
4 authorizing / local EMS agency. This is a model program which will develop
5 over time and is to be tailored to the individual organization's QI needs and is
6 to be based on available resources for the EMS QI program.
7
- 8 5. QI indicators should be tracked and trended to determine compliance with
9 their established thresholds as well as reviewed for potential issues.
10
- 11 6. The QI Program should be reviewed annually for appropriateness to the
12 operation of the EMS aircraft provider. The review should be conducted by,
13 at minimum, an internal QI committee established by the provider and the
14 provider's medical director.
15
- 16 7. Participation between the authorizing / local EMS agency and the provider's
17 EMS QI Program is encouraged. This may include, but not limited to, making
18 available mutually agreed upon relevant records for program monitoring and
19 evaluation. Participation in the local EMS QI Program may include but not be
20 limited to committee membership, policy review and trauma center QI.
21
- 22 8. Develop, in cooperation with appropriate personnel/agencies, a performance
23 improvement action plan for the air medical provider when the EMS QI
24 Program identifies a need for improvement. If the area identified as needing
25 improvement includes system clinical issues, collaboration is required with the
26 provider medical director and the authorizing / local EMS agency medical
27 director or his/her designee if the provider does not have a medical director.
28
- 29 9. Provide the authorizing / local EMS entity with an annual update, from date of
30 approval and annually thereafter, on the EMS QI Program. The update
31 should include, but not be limited to; a summary of how the air medical
32 provider's EMS QI Program addressed the program indicators.
33
- 34 10. Such programs should include indicators that are reviewed for
35 appropriateness on a quarterly basis with an annual summary of the
36 indicators performance. QI data should be considered when QI indicators are
37 developed to monitor issues found in current practices or processes. Air
38 Medical Providers may reference CAMTS to identify potential indicators they
39 may wish to implement in their system. Indicators should address, but are not
40 limited to, the following triggers:
41
- 42 A. Personnel - Continuing education/staff development should be completed
43 and documented for all Critical Care and ALS Providers. These should be
44 specific and appropriate for the mission statement and scope of care of
45 the medical transport service. Didactic continuing education should
46 include an annual review of:

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- 1) Hazardous materials recognition and response.
- 2) Crew Resource Management – Air Medical Resource Management (AMRM).
- 3) Clinical and laboratory continuing education should be developed and monitored on an annual basis and should include:
 - a. Critical care (Adult, pediatric, neonatal);
 - b. Emergency / trauma care;
 - c. Invasive procedure labs; and
 - d. Labor and delivery.

B. Equipment and Supplies - Medical transport personnel must ensure that all medical equipment is in working order and all equipment/supplies are validated through documented checklists for both the primary and secondary aircraft, if applicable. All patient equipment failures are monitored through the QA process.

- 1) Equipment must be periodically tested and inspected by a certified clinical engineer at the manufacturer's suggested intervals.
- 2) Equipment inspections and records of inspections are maintained according to the program's guidelines.

C. Documentation and Communication - A mechanism should be in place to ensure accurate, appropriate and complete documentation of, but not limited to, the following items:

- 1) Time of call (Time of request / inquiry received).
- 2) Name of requesting agency.
- 3) Age, diagnosis or mechanism of injury.
- 4) Destination airport, refueling stops (if necessary), location of transportation exchange and hours of operation.
- 5) Weather checks prior to departure and during mission as needed.
- 6) Previous turn-downs of the mission (e.g. EMS aircraft shopping)
- 7) Ground transportation coordination at sending and receiving areas.
- 8) Time of dispatch (time medical personnel notified flight is a go, post pilot OK's flight).
- 9) Time depart base (time of lift-off from base or other site).
- 10) Number and names of persons on board.
- 11) Estimated time of arrival (ETA).
- 12) Pertinent LZ information.
- 13) All times (and intervals) associated with the call.

D. Clinical Care and Patient Outcome.

- 1) Patient outcome (morbidity and mortality) at the time of arrival at destination.

- 1 | 2) Patient change in condition during transport.
- 2
- 3 | 3) Discharge summary, including date of discharge and patient
- 4 | condition. The air medical provider should work with the local EMS
- 5 | agency to obtain necessary outcome information when it is not
- 6 | readily available to the provider, including:
- 7 | a. Patients that are discharged home directly from the
- 8 | Emergency Department (ED) or discharged within 24 hours
- 9 | of admission.
- 10 | b. Patients who are transported within an intravenous (IV) line
- 11 | or Oxygen.
- 12 | c. When Cardio-Pulmonary Resuscitation (CPR) is being
- 13 | performed at the referring location.
- 14 | d. A patient who is transported more than once for the same
- 15 | illness or injury in a 24 hour period.
- 16 | e. Patients who are transported from the scene of injury with a
- 17 | trauma score of 15 or greater or fails to meet area-specific
- 18 | triage criteria for a critically injured trauma patient.
- 19 | f. Patients who are treated at the scene but not transported.
- 20 | g. Patients who are not transferred bedside to bedside by the
- 21 | flight team.
- 22 | h. Patients who are transported for continuation of care and the
- 23 | receiving facility is not a higher level of care than the
- 24 | referring facility.
- 25

26 E. Skills Maintenance/Competency.

- 27

- 28 | 1) At minimum, annual evaluations ensuring all required skills and
- 29 | operations are conducted in compliance with existing provider and /
- 30 | or LEMSA standards should be done by each discipline.
- 31 | 2) High risk, low frequency skills should also be monitored through the
- 32 | QI process. Each air medical provider should have a policy in
- 33 | place and track compliance for high risk skills and procedures.
- 34

35 F. Transportation/Facilities.

- 36

- 37 | 1) Hot / cold (rotors turning / stopped) patient load / unload policy
- 38 | including equipment and weight considerations.
- 39 | 2) Unusual / unanticipated helipad incidents.
- 40 | 3) Situations where non-assigned medical personnel are placed in
- 41 | aircraft to provide primary patient care during air medical transport.
- 42 | 4) Appropriate transport destination based on local EMS agency
- 43 | policy for the patient pick-up location.
- 44 | 5) Appropriate utilization of air medical resources based on patient
- 45 | condition in the field.
- 46 | 6) Fixed wing transport monitoring, if applicable.

1 7) Fuel issues, including situations where hot fueling (rotors turning) or
2 topping off fuel is required prior to response or during patient
3 transport.
4

5 G. Public Education and Prevention - Integration into local system
6

7 H. Risk Management - Air providers should have a policy that addresses the
8 following:
9

10 1) An annual drill is conducted to exercise the post incident / accident
11 plan (PIAP). This drill should include pilots, medical personnel,
12 communications personnel, mechanics and administrative
13 personnel. Written debriefing and critique of PIAP drills should be
14 shared with all staff members.

15 2) Fatigue.

16 3) A non-punitive system for employees to report hazards and safety
17 concerns.

18 4) A system to document, track, trend and mitigate errors or hazards.

19 5) A system to audit and review organizational policy and procedures,
20 on going safety training for all personnel (including managers), a
21 system of pro-active and reactive procedures to insure compliance.
22

23 6) Track and trend weather related previous turn downs.
24

25 11. Medical Flight Crew Training:

26 Prehospital personnel who function on an EMS aircraft shall have training in
27 air medical transportation. Medical flight crew training programs shall be
28 approved by the authorizing EMS agency consistent with CCR Title 22,
29 Division 9, Chapter 8, Section 100302, Medical Flight Crew.
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IX. Multi-Jurisdictional Air Provider

General:

The Multi-Jurisdictional Air Provider section outlines a recommended process for accrediting Multi-Jurisdictional Air Providers (M-JAP) within a local, regional, statewide, or interstate service area. The end goal is to support safety and excellence in patient care while working to minimize regulatory barriers to getting the right resource to the right patient in the right amount of time. This recommended process guideline states M-JAPs who have multiple bases throughout California to standardize their program in all aspects of medical control and patient care.

The local EMS agencies may elect to designate a single classifying EMS agency, with the end goal of minimizing regulatory barriers. This section will also address standard medical control issues and keep air operational issues, such as destination policies, “as is” within each authorizing local EMS agency’s jurisdiction.

Operational Guidelines:

1. Medical control decisions for M-JAPs should be a collaborative effort of all stakeholder medical directors involved (i.e., the medical directors of the classifying EMS agency, the authorizing EMS agency, and the M-JAP). (reference H&S 1797.202).
2. If at any point in time an authorizing EMS agency determines a change is needed in any aspect of medical control policies, procedures, or protocols, revisions may be reviewed by all stakeholder medical directors involved.
3. When a new M-JAP is established, it is required that the new air service provider undergo the classifying and authorizing process with all local EMS agencies served by the M-JAP Provider.
4. All collaboration may be established between the classifying EMS agencies through an inter-agency agreement, a memorandum of understanding (MOU), etc. with each authorizing local EMS agency where the M-JAP has a base of operations in California.
5. Multi-Jurisdictional Air Provider:
 - A. Establishes and maintains classification for all air bases in California with a LEMSA.

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- B. Establishes and maintains a provider agreement with each authorizing local EMS agency where an air base is located or where the provider is assigned primary response to a designated area within an authorizing LEMSA jurisdiction.
- C. Maintains at a minimum a physician approved by the coordinating LEMSA, who functions as the M-JAP medical director.
- D. Works in collaboration with the authorizing local medical directors to:
 - 1) Establish accreditation and authorization standards for the medical flight crew.
 - 2) Scope of practice for the paramedic flight crew member; may include expanded scope.
 - 3) Medical protocols for medical flight crew.
 - 4) Authorization of nurses by the LEMSA medical director (H&S 1797.56).
 - 5) Standardized procedures for the authorized registered nurse flight crew member (H&S 1797.56).
- E. Provides data to the classifying EMS agency in universal format consistent with CEMSIS.

6. Classifying Local EMS Agency:

- A. Should verify that an appropriate licensed physician functions as the medical director for the M-JAP.
- B. Shall establish and maintain:
 - 1) A medical flight crew accreditation and authorization process.
 - 2) A standardized drug and equipment list, based upon the scope of practice pre-determined by all the stakeholder medical directors involved.
 - 3) An approved data collection process in a universal format as identified by CEMSIS.
 - 4) Primary coordination of incident review.
 - 5) Should approve the M-JAP's Quality Improvement Plan.

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- C. Should collaborate with the M-JAP to establish the following:
 - 1) Accreditation and authorization standards for the medical flight crew.
 - 2) Scope of practice for the paramedic flight crew member
 - 3) Standardized procedures for the authorized registered nurse flight crew member (H&S 1797.56).
 - 4) Medical protocols for the medical flight crew.
 - 5) A quality improvement process.
 - 6) A data collection and submission process.
 - 7) An incident review process.
 - 8) Schedule for site visits and inspections of EMS aircraft.

*It is strongly recommended that the LEMSA establish and host a data collection point for M-JAP data based on CEMSIS. Data received from this collection shall be made available to the EMS Authority for review.

7. Authorizing EMS Agency:

- A. Establishes and maintains the following:
 - 1) A provider agreement with all M-JAP who have a base of operations within their jurisdiction or who routinely provide service from or within their jurisdiction.
 - 2) Control of LEMSA approved operational decisions for any EMS aircraft within its jurisdiction, e.g. dispatch, destination decision and policies and EMS Aircraft Utilization policies.
- B. Receives or is provided access to data for all M-JAP within their jurisdiction.
- C. Collaborates with classifying local EMS agency to establish the following:
 - 1) Accreditation and authorization standards for the medical flight crew. Shall grant reciprocity to multi-jurisdictional medical flight crew accredited or authorized by the classifying agency.
 - 2) Scope of practice for the paramedic flight crew member; may include expanded scope when approved by the authorizing LEMSA medical director within the M-JAP.
 - 3) Medical protocols for medical flight crew.
 - 4) Standardized procedures for the authorized registered nurse flight crew member (H&S 1797.56).
 - 5) A quality improvement process.

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- 6) A data collection and submission process.
- 7) An incident review process.
- 8) Schedule for site visits and inspections of EMS aircraft.

1 X. Temporary Flight Crew Authorization

2
3 **General:**

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5 This section provides LEMSAs with guidelines for the temporary authorization or
6 accreditation for medical flight crew personnel in the event that a provider is
7 temporarily unable to staff an aircraft with permanently assigned authorized or
8 accredited flight crew member. The LEMSA has authority to determine any
9 specific criteria in their area for the temporary authorization of flight crew
10 members consistent with CCR Title 22, Division 9, Chapter 8, Section 100300,
11 Application of Chapter.

12
13 **Operational Guideline:**

- 14
15 1. This is an emergency temporary process by which a LEMSA may
16 authorize or accredit a medical flight crew member who is coming from
17 another authorizing LEMSA for no more than a 90-day period of time. The
18 emergency authorization or accreditation time period may be reduced by
19 the local EMS agency based on system needs.
20
21 2. When a medical flight crew member is approved to work in another local
22 EMS region on a temporary basis, they shall:
23
24 A. Not administer medications or perform skills outside the scope of
25 practice from where they are permanently accredited or authorized.
26 The medical flight crew’s scope of practice may be limited due to
27 the medications and equipment routinely stocked on the aircraft
28 where they are temporarily working.
29
30 B. Be scheduled with another medical flight crew member who is
31 permanently authorized or accredited by the authorizing EMS
32 agency. Air transport providers normally staffed with one ALS
33 provider shall ensure any temporary flight crew members are
34 knowledgeable of the policies of the local EMS agency in which
35 they are providing service.
36

37 **Procedure:**

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39 1. In order to receive temporary authorization under this policy, the EMS
40 aircraft provider agency shall submit all of the following to the medical
41 director of the local EMS agency:
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- 1 A. A letter requesting the implementation of this emergency temporary
2 process for the medical flight crew member for approval to work in
3 that EMS region. The request shall outline the need to implement
4 this process and be signed by the EMS aircraft provider’s medical
5 director or authorized management representative and
6 administration substantiating the necessity for temporary
7 accreditation / authorization.
8 B. Documentation of the following:
9
10 1) Registered nurses: verification of a current California nursing
11 license. The Board of Registered Nurses (BRN) does not
12 recognize any form of mutual aid for nurses, except in the
13 time of a declared state of emergency by the Governor or his
14 / her designee consistent with Business and Professions
15 Code Section 2757.
16 2) EMT-Paramedics: verification of a current California
17 paramedic license.
18
19 C. Documentation demonstrating “in good standing” status within
20 another California local EMS agency; the following may be used to
21 validate this requirement where applicable:
22
23 1) Authorized registered nurses: verification of current
24 authorization.
25 2) EMT-Paramedics: verification of a current paramedic
26 accreditation card.
27
28 D. In emergency circumstances, an EMS aircraft provider can
29 temporarily fulfill requirements “1A – 1C” of this paragraph by
30 making a notification (verbal / electronic) to the LEMSA during
31 weekends / nights / holidays. The EMS aircraft provider must
32 ensure that a confirmation is received from the authorized local
33 EMS agency duty officer who the request is being made to that a
34 temporary flight crew request has been received and approved
35 within 24 hours of submission. The request may be made verbally
36 or electronically. If the request is made verbally, the local EMS
37 agency taking the request shall document the date/time of the
38 request and person/provider making the request.
39
40 2. This temporary authorization or accreditation shall not be routinely
41 renewed, but may be converted to a permanent authorization /
42 accreditation by completing remaining authorization or accreditation
43 requirements by the authorizing LEMSA. The authorizing LEMSA may
44 consider renewal of this process on a case by case basis.
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1 XII. References

- 2
- 3 1. California Code of Regulations, Title 22, Chapter 9, EMS Quality
- 4 Improvement Regulations
- 5 2. California Code of Regulations, Title 22, Chapter 8, Prehospital EMS Air
- 6 Regulations
- 7 3. Health and Safety Code Section 1797.202, 1797.56, 1797.224, 1797.201
- 8 4. Commission on Accreditation of Medical Transport Systems (CAMTS);
- 9 Accreditation Standards Version 7
- 10 5. Purtil M, Benedict K, Hernandez-Boussard T, Brundage S, Sherck J,
- 11 Garland A, Spain D. Validation of a Prehospital Trauma Triage Tool: A 10-
- 12 year Perspective. *The Journal of Trauma Injury, Infection and Critical*
- 13 *Care*. 2008;65(6):1253-1257.
- 14 6. Guidelines from the American College of Surgeons, Air Medical
- 15 Physicians Association, National Association of EMS Physicians.
- 16 NAEMSP, AAMS, AAOP 2009
- 17 7. FAA Federal Aviation Regulations 2009
- 18 8. Field Operations Guide-FOG
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BYLAWS
OF
EMERGENCY MEDICAL SERVICES
MEDICAL DIRECTORS'
ASSOCIATION OF CALIFORNIA, INC.
A California Nonprofit Public Benefit Corporation

PREAMBLE

The name of this Corporation shall be EMERGENCY MEDICAL SERVICES MEDICAL DIRECTORS' ASSOCIATION OF CALIFORNIA, INC., and may be referred to as EMDAC, Inc. The objectives and purposes of this Corporation shall be generally for public and common business purposes of improving leadership and expert opinion in the medical oversight, direction and coordination of emergency medical services for the safety and advancement of the public good for the people of the State of California within the meaning of Section 501(c) (6) of the Internal Revenue Code of 1986 or the corresponding provision of any future United States internal revenue law. More specifically, the objectives and purposes of this Corporation shall be:

1. To act in an advisory capacity to the California Emergency Medical Services Authority (EMSA) and the California Emergency Medical Services Commission (EMSC) in the establishment of goals, priorities, standards and quality assurance for the Emergency Medical Service System.
2. To provide expert medical advice and consultation to state, local, community and professional organizations involved in Emergency Medical Services.
3. To serve as a forum for the exchange of information and ideas on the medical aspect of Emergency Medical Services.
4. To improve systems' integrity, medical appropriateness and validity in statewide and local Emergency Medical Services System design and operation including all EMS Systems components: manpower, training, transportation, communications, facilities, public education, data and research and disaster medical planning and preparedness.
5. To ensure that sound medical principles are followed during the planning, implementation and evaluation of Emergency Medical Services Systems.

6. To promote the dissemination of knowledge concerning the Emergency Medical Services System and Disaster Medical Services and Preparedness.
7. To promote the fulfillment of and adherence to requirements of law, statute, local policy and procedures, and regulations by all Emergency Medical Services officials and certified personnel.
8. To promote the creation and refinement of standards for performance and quality control of Emergency Medical Services personnel, including but not limited to: field care, base hospital activities, audit and review, continuing education, training and certification, and disciplinary actions.
9. To foster relationships with other organizations and agencies involved in similar activities and to exchange information and work toward common goals.
10. To promote legislation which will accomplish the objectives and purposes of this Corporation.

ARTICLE I

OFFICES

Section 1.1 Principal Executive or Business Offices. The Board of Directors shall fix the location of the principal executive office of the Corporation. The Board of Directors is granted full power and authority to change said principal office from one location to another.

Section 1.2 Other Offices. The Board of Directors may at any time establish branch or subordinate offices at any place or places where the Corporation is qualified to do business.

ARTICLE II

MEMBERSHIP

Section 2.1 Classes of Membership. This Corporation shall have two (2) classes of membership: active and associate. These classes of membership shall have the same rights, privileges, restrictions and conditions except as otherwise set forth in these Bylaws. No person may hold more than one (1) class of membership. Only active members may vote on any issue or matter subject to a vote of the membership, including election of officers and directors. Associate members may participate fully in the activities and discussions of the Corporation.

- 1) The qualifications for active membership are:
 - a) the member shall be a physician who is directly or actively involved in the administration, development or management of an Emergency Medical Services agency, including medical directors, assistant medical directors, associate medical directors, or deputy medical directors of an organized and designated local Emergency Medical Services agency; or
 - b) the member shall be a physician acting on behalf of an Emergency Medical Services Medical Director within the meaning of Section 1797.202 of the California Health & Safety Code, and related sections, or the California Highway Patrol Emergency Medical EMT-1 and EMT-P Medical Director.

- 2) The qualifications for associate membership are:
 - a) the member shall be a physician who is a former active member; or
 - b) the member shall be a health officer with responsibility for a local Emergency Medical Services agency; or
 - c) the member shall be a base hospital medical director; or
 - d) the member shall be a medical director of training agencies and service agencies.

Section 2.2 Membership Fees, Dues & Assessments. In order for members of either class of membership to maintain membership status in good standing, with all the rights and privileges of such membership, including voting rights, all fees, dues and assessments, if applicable, must be fully paid and current. Failure to pay all fees, dues and assessments shall terminate membership. The Board of Directors shall determine the annual dues at the regular meeting prior to the annual meeting of the Board of Directors and with appropriate recommendation from the members as determined at a meeting of the membership. Any other fees or assessments shall be determined and set by the Board of Directors at a duly noticed meeting of the Board. A majority of the members entitled to vote may reverse a resolution of the Board with respect to any determination relating to dues, fees or assessments.

Section 2.3 Admission of Members. Persons desiring membership in the Corporation may present themselves at any meeting of the Board of Directors or the membership. At that time, the chair of the meeting shall direct the secretary to examine the applicant's qualifications and, if it is determined that all criteria have been met and all applicable dues, fees and assessments are paid, the

applicant shall be admitted as a member. Thereafter, the secretary shall prepare a membership certificate, if appropriate, obtain the authorized signatures thereon and deliver the same to the new member.

Section 2.4 Membership Certificate/Transferability of Memberships. The Board of Directors may authorize and adopt a Membership Certificate indicating the name of the member and the membership class that shall evidence each membership. Each membership shall be entitled to one (1) vote on all matters except as otherwise set forth in these Bylaws. Membership Certificates and memberships are not transferable.

Section 2.5 Termination of Membership. The membership of any member shall terminate upon the happening of any of the following:

- a) Death or resignation of the member;
- b) Occurrence of any event which renders such member ineligible for membership;
- c) Recommendation of the Board of Directors and a 3/5 majority of the voting membership.

Section 2.6 Place of Meetings. Meetings of members shall be held at any place designated by the Board of Directors or a majority of the membership. In the absence of a designation, members' meetings shall be held at the Corporation's principal executive office.

Section 2.7 Annual Meeting. The annual meeting of members shall be held each year on a date and at a time designated by the Board of Directors. At each annual meeting, directors and officers shall be elected and any other proper business within the power of the members may be transacted.

Section 2.8 Special Meeting. A special meeting of the members may be called at any time by the Board of Directors, by the chair of the Board, by the president or vice president, or by at least five percent (5%) of the members entitled to vote. If a special meeting is called by anyone other than the Board of Directors, the person or persons calling the meeting shall make a request in writing, delivered personally or sent by registered mail or by telegraphic, email or other facsimile transmission, to the chair of the Board or the president, vice president, or secretary, specifying the time and date of the meeting (which is not less than 10 nor more than 90 days after receipt of the request) and the general nature of the business proposed to be transacted at the special meeting. Within 20 days after receipt, the officer receiving the request shall cause notice to be given to the membership, in accordance with applicable sections of these Bylaws regarding notices, stating that a special meeting will be held at the time

requested by the person(s) calling the meeting, and stating the general nature of the business proposed to be transacted at the meeting. If notice is not given within 20 days after receipt of the request, the person or persons requesting the special meeting may give the notice. Nothing contained in this paragraph shall be construed as limiting, fixing, or affecting the time when a special meeting of members called by action of the Board may be held.

Section 2.9 Notice of Members' Meetings. All notices of meetings of members shall be sent or otherwise given in accordance with applicable sections of these Bylaws regarding manner of giving notice, not fewer than ten (10) days nor more than 90 days before the date of the meeting. Members entitled to notice shall be determined in accordance with applicable sections of these Bylaws regarding record date of ownership. The notice shall specify the place, date and hour of the meeting, and (i) in the case of a special meeting, the general nature of the business proposed to be transacted at the meeting, or (ii) in the case of the annual meeting, those matters that the Board of Directors, at the time of giving the notice, intends to present for action by the members. If directors are to be elected, the notice shall include the names of all nominees whom the Board intends, at the time of the notice, to present for election. The notice shall also state the general nature of any proposed action to be taken at the meeting to approve any of the following matters:

- a) A transaction in which a director has a financial interest, within the meaning of the California Corporations Code;
- b) An amendment of the Articles of Incorporation;
- c) A reorganization under the California Corporations Code;
- d) A voluntary dissolution the California Corporations Code; or
- e) A distribution in dissolution that requires approval of the membership under the California Corporations Code.

Section 2.10 Manner of Giving Notice; Affidavit of Notice. Notice of any members' meeting shall be given either personally or by first class mail or telegraphic, facsimile, email or other written communication, charges prepaid, addressed to the member at the address appearing on the Corporation's books or given by the member to the Corporation for purposes of notice. If no address appears on the Corporation's books or has been given as specified above, notice shall be sent by first class mail addressed to the member at the Corporation's principal executive office. Notice is deemed to have been given at the time when delivered personally or deposited in the mail or sent by other means of written communication. If any notice or report mailed to a member at the address appearing on the Corporation's books is returned marked to indicate that the United States Postal Service is unable to deliver the document to the member at that address, all future notices and reports shall be deemed to have

been duly given without further mailing if the Corporation holds the document available for the member on written demand at the Corporation's principal executive office for a period of one (1) year after the date the notice or report was given to all other members. An affidavit of the mailing or other authorized means of giving notice or delivering a document, of any notice of members' meeting, report or other document sent to the members, may be executed by the secretary of the Corporation, assistant to the secretary or transfer agent, and, if executed, shall be filed and maintained in the Minute Book of the Corporation.

Section 2.11 Quorum. The presence in person or by proxy of the holders of at least one third (1/3) of the members entitled to vote at any meeting of the members shall constitute a quorum for the transaction of business. The members present at a duly called or held meeting at which a quorum is present may continue to do business until adjournment, notwithstanding the withdrawal of enough members to leave less than a quorum, if any action taken (other than adjournment) is approved by at least a majority of the votes required to constitute a quorum.

Section 2.12 Adjourned Meeting; Notice. Any members' meeting, annual or special, whether or not a quorum is present, may be adjourned from time to time by the vote of the majority of the votes represented at that meeting, either in person or by proxy, but in the absence of a quorum, no other business may be transacted at that meeting, except as provided in these Bylaws. When any meeting of members, either annual or special, is adjourned to another time or place, notice of the adjourned meeting need not be given if the time and place are announced at the meeting at which the adjournment is taken, unless a new record date for the adjourned meeting is fixed, or unless the adjournment is for more than 45 days after the date set for the original meeting, in which case the Board of Directors shall set a new record date. Notice of any such adjourned meeting, if required, shall be given to each member of record entitled to vote at the adjourned meeting, in accordance with all applicable sections of these Bylaws. At any adjourned meeting, the members may transact any business that might have been transacted at the original meeting.

Section 2.13 Voting. The members entitled to vote at any meeting of members shall be determined in accordance with sections 2.1 and 2.2 of these Bylaws. The members' vote may be by voice vote or by ballot, provided, however, that any election for officers or directors must be by ballot if demanded by any member before voting has begun. If a quorum is present, the affirmative vote of a majority of the votes represented and voting shall be the act of the members unless the vote of a greater number or voting by classes is required by law or by the Articles of Incorporation. At a members' meeting at which officers or directors are to be elected, no member shall be entitled to cumulate votes (i.e.,

cast for any candidate a number of votes greater than the number of votes which that member normally would be entitled to cast). The candidates receiving the highest number of votes, up to the number of officers or directors to be elected, shall be elected.

Section 2.14 Voting by Mail-in Ballot. In the event the members or the Board of Directors by a majority vote determine that a mail-in ballot is necessary and appropriate for a matter to be voted on, the secretary of the Corporation shall be authorized and directed to prepare and mail a duly approved ballot setting forth the item to be voted on and instructions for voting, including the time in which to return the ballot for counting, the number of responses necessary to meet the quorum requirement and the number or percentage of positive votes necessary to pass the item. The ballot, when completed, shall be placed in an unmarked envelope and sealed, then placed in a second envelope addressed to the secretary of the Corporation, with a space for the member's signature. These envelopes must be mailed timely to the secretary or presented to the secretary within thirty (30) minutes of the scheduled commencement of the meeting at which the election is to take place and/or the ballots are to be counted. The secretary of the Corporation shall undertake counting of the mail-in ballots unless the Board of Directors designates some other person to count the ballots or unless inspectors of elections are appointed in accordance with section 2.19 of these Bylaws.

Section 2.15 Waiver of Notice or Consent by Absent Members. The transactions of any meeting of members, either annual, regular or special, however called and noticed and wherever held, shall be as valid as though they were had at a meeting duly held after regular call and notice, if a quorum is present either in person or by proxy, and if each person entitled to vote who was not present in person or by proxy, either before or after the meetings, signs a written waiver of notice or a consent to holding the meeting or an approval of the minutes of the meeting. The waiver of notice or consent need not specify either the business to be transacted or the purpose of any annual or special meeting of the members, except that if action is taken or proposed to be taken for approval of any of those matters specified in the California Corporations Code, i.e.,

- a) A transaction in which a director has a financial interest, within the meaning of the California Corporations Code;
- b) An amendment of the Articles of Incorporation;
- c) A reorganization under the California Corporations Code;
- d) A voluntary dissolution under the California Corporations Code; or
- e) A distribution in dissolution that requires approval of the membership under the California Corporations Code.

All waivers, consents, and approvals shall be filed with the corporate records or made a part of the minutes of the meeting. A member's attendance at a meeting also constitutes a waiver of notice of that meeting, unless the member at the beginning of the meeting objects to the transaction of any business on the ground that the meeting was not lawfully called or convened. In addition, attendance at a meeting does not constitute a waiver of any right to object to consideration of matters required by law to be included in the notice of the meeting which were not so included, if that objection is expressly made at the meeting.

Section 2.16 Member Action by Written Consent Without a Meeting. Any action that could be taken at an annual or special meeting of members may be taken without a meeting and without prior notice, if a consent in writing, setting forth the action so taken, is signed by the members having not less than the minimum number of votes that would be necessary to authorize or take that action at a meeting at which all members entitled to vote on that action were present and voted. Directors may be elected by written consent of the members without a meeting only if the written consents of all members entitled to vote are obtained, except that vacancies on the Board (other than vacancies created by removal) not filled by the Board may be filled by the written consent of a majority of the members entitled to vote. All consents shall be filed with the secretary of the Corporation and shall be maintained in the corporate records. Any member or other authorized person who has given a written consent may revoke it by a writing received by the secretary of the Corporation before written consents of the number of shares required to authorize the proposed action have been filed with the secretary. Unless the consents of all members entitled to vote have been solicited in writing, prompt notice shall be given of any corporate action approved by members without a meeting by less than unanimous consent, to those members entitled to vote who have not consented in writing. Notice shall be given in the manner specified in section 2.10 of these Bylaws.

Section 2.17 Record Date for Member Notice of Meeting, Voting and Giving Consent.

- a) For purposes of determining the members entitled to receive notice and/or vote at a members' meeting or give written consent to corporate action without a meeting, the Board may fix in advance a record date that is not more than 60 nor less than ten (10) days before the date of a members' meeting, or not more than 60 days before any other action.
- b) If no record date is fixed:
 - i) the record date for determining members entitled to receive notice of and vote at a members' meeting shall be the business

day next preceding the day on which notice is given, or if notice is waived as provided in section 2.15 of these Bylaws, the business day next preceding the day on which the meeting is held;

- ii) the record date for determining members entitled to give consent to corporate action in writing without a meeting, if no prior action has been taken by the Board, shall be the day on which the first written consent is given.
- c) A determination of members of record entitled to receive notice of and/or vote at a members' meeting shall apply to any adjournment of the meeting unless the Board fixes a new record date for the adjourned meeting. However, the Board shall fix a new record date if the adjournment is to a date more than 45 days after the date set for the original meeting.
- d) Only members of record on the Corporation's books at the close of business on the record date shall be entitled to any of the notice and voting rights listed in subsection a) of this section.

Section 2.18 Proxies. Every member entitled to vote for directors or on any other matter shall have the right to do so either in person or by one or more agents authorized by a written proxy signed by the member and filed with the secretary of the Corporation. A proxy shall be deemed signed if the member's name is placed on the proxy (whether by manual signature, typewriting, facsimile, telegraphic or email transmission or otherwise) by the member or the member's attorney in fact. A validly executed proxy that does not state that it is irrevocable shall continue in full force and effect unless i) revoked by the member executing it, before the vote pursuant to that proxy, by a writing delivered to the Corporation stating that the proxy is revoked, or by attendance at the meeting and voting in person by the member executing the proxy or by a subsequent proxy executed by the same member and presented at the meeting; or ii) written notice of the death or incapacity of the maker of that proxy is received by the Corporation before the vote pursuant to that proxy is counted; provided, however, that no proxy shall be valid after the expiration of 11 months from the date of the proxy, unless otherwise provided in the proxy. The revocability of a proxy that states on its face that it is irrevocable shall be governed by applicable provisions of the California Corporations Code.

ARTICLE III

DIRECTORS

Section 3.1 Powers. Subject to the provisions of the California General Corporations Law and any limitations in the Articles of Incorporation and these Bylaws relating to action required to be approved by the members, the business and affairs of the Corporation shall be managed and all corporate powers be exercised by or under the direction of the Board of Directors. Without prejudice to these general powers, and subject to the same limitations, the Board of Directors shall have to power to:

- a) Select and remove all agents and employees of the Corporation, except officers who shall be elected by the membership; prescribe any powers and duties for them that are consistent with law, with the Articles of Incorporation, and with these Bylaws; and require from them security for faithful service.
- b) Change the principal executive office or the principal business from one location to another; cause the Corporation to be qualified to do business in any other state, territory, dependency, or country and conduct business within or outside the State of California; and designate any place for holding any members' meeting or meetings, including annual meetings.
- c) Adopt, make and use a corporate seal; prescribe the forms of certificates of membership; and alter the form of the seal and certificates.
- d) Conduct, manage and control the affairs and activities of the Corporation, and to make such rules and regulations therefor not inconsistent with law, the Articles or these Bylaws, as they may deem best.
- e) Borrow money and incur indebtedness on behalf of the Corporation, and cause to be executed and delivered for the Corporation's purposes, in the corporate name, promissory notes, bonds, debentures, deeds of trust, mortgages, pledges, hypothecations and other evidences of debt and securities.

Section 3.2 Number and Qualification of Directors. The authorized number of directors shall be seven (7) until changed by a duly adopted amendment to the Bylaws of the Corporation approved by a majority of the members entitled to vote. Of the seven (7) directors, one (1) shall serve as president, one (1) shall serve as president-elect, one (1) shall be the past president and shall serve as a voting *ex officio* director, one (1) shall serve as the secretary, one (1) shall serve as the treasurer, one (1) shall be an active member and serve as a voting at-large director, and one (1) shall be an associate member and shall serve as a non-voting *ex officio* director.

Section 3.3 Election and Term of Office of Directors. Except as to the director serving as president and the director serving as president-elect, directors shall be elected at each annual meeting of the members to hold office until the next annual meeting. The director serving as president-elect automatically changes title to president at the annual meeting and the director serving as president automatically changes title to past president as *ex officio* director. Each director, including a director elected to fill a vacancy, shall hold office until the expiration of the term for which elected and until a successor has been elected and qualified.

Section 3.4 Nominating Committee. At any reasonable time prior to the time for any election of directors, the chair of the Board, or if none, the president shall appoint a Nominating Committee of at least three (3), but no more than seven (7) members, to nominate qualified candidates for election to the Board and to serve as officers subject to section 5.2 of these Bylaws. The nominating committee shall make its report at a reasonable time prior to the election, or at such time as the Board may set, and the secretary shall forward to each member , with the notice of meeting required by these Bylaws, a list of all candidates nominated by the committee.

Section 3.5 Vacancies. Subject to applicable provisions of the California Nonprofit Public Benefit Corporation Law, any director may resign effective upon giving written notice to the chair of the Board, the president, the secretary of the Board, unless the notice specifies a later time for the effectiveness of such resignation. If the resignation is effective at a future date, a successor may be selected before such time, to take office when the resignation takes effect. A vacancy in the Board of Directors shall be deemed to exist:

- a) If a director dies, resigns, fails to maintain his or her membership or is removed by a vote of a 3/5 majority of the members entitled to vote or by an appropriate court;
- b) If the Board of Directors declares vacant the office of a director who has been convicted of felony or declared of unsound mind by an order of court;
- c) If the director is found by final order of judgment to have breached the duties arising under the California Nonprofit Public Benefit Corporation Law;
- d) If the authorized number of directors is increased; or
- e) If, at any members' meeting at which one or more directors are to be elected, the members fail to elect the full authorized number of directors to be voted for at that meeting.

Except for a vacancy caused by the removal of a director, vacancies on the Board may be filled by approval of a majority of the remaining directors, or if the number of directors then in office is less than a quorum, by (i) the unanimous written consent of the directors then in office, (ii) the affirmative vote of a majority of the directors then in office at a meeting held pursuant to notice or waivers of notice complying with the California Corporations Code, or (iii) a sole remaining director. A vacancy on the Board caused by the removal of a director may be filled only by the members entitled to vote, except that a vacancy created when the Board declares the office of a director vacant as provided in subsection b) of this section of the Bylaws may be filled by the Board of Directors. The members entitled to vote may elect a director at any time to fill a vacancy not filled by the Board of Directors. The term of office of a director elected to fill a vacancy shall run until the next annual meeting of the members, and such a director shall hold office until a successor is elected and qualified.

Section 3.6 Place of Meetings; Telephone Meetings. Regular meetings of the Board of Directors may be held at any place within or outside the State of California as designated from time to time by the Board. In the absence of a designation, regular meetings shall be held at the principal executive office of the Corporation. Special meetings of the Board shall be held at any place within or outside the State of California designated in the notice of the meeting, or if the notice does not state a place, or if there is no notice, at the principal executive office of the Corporation. Any meeting, regular or special, may be held by conference telephone or similar communication equipment, provided that all directors participating can hear one another.

Section 3.7 Annual Directors' Meeting. Immediately before or after the annual members' meeting, the Board of Directors shall hold a regular meeting at the same place, or at any place that has been designated by the Board of Directors, to consider matters of organization and other business as desired or appropriate. Notice of this meeting shall not be required unless some place other than the place of the annual members' meeting has been designated.

Section 3.8 Other Regular Meetings. Other regular meetings of the Board of Directors shall be held without call at times to be fixed by the Board of Directors from time to time. Such regular meetings may be held without notice. The president-elect shall announce at the last meeting of the calendar year the regular meeting dates, places and times for the following calendar year, the year in which the president-elect shall serve as president. All members may attend regular meeting of the Board.

Section 3.9 Special Meetings. Special meetings of the Board of Directors may be called for any purpose or purposes at any time by the chair of the Board,

the president, any vice president, the secretary or any two (2) directors. Special meetings shall be held on four (4) days' notice by mail or 48 hours' notice delivered personally or by telephone, facsimile, email or telegraph. Oral notice given personally or by telephone may be transmitted either to the director or to a person at the director's office who can reasonably be expected to communicate it promptly to the director. Written notice, if used, shall be addressed to each director at the address shown on the Corporation's records. The notice need not specify the purpose of the meeting, nor need it specify the place of the meeting if the meeting is to be held at the principal executive office of the Corporation.

Section 3.10 Quorum. A majority of the voting and nonvoting directors shall constitute a quorum for the transaction of business, except to adjourn as provided in section 3.12 of these Bylaws. Every act or decision done or made by a majority of the directors present at the meeting duly held at which a quorum is present shall be regarded as the act of the Board of Directors, subject to the applicable provisions of the California Corporations Code. A meeting at which a quorum is initially present may continue to transact business, despite a withdrawal of directors, if any action taken is approved by at least a majority of the required quorum for that meeting.

Section 3.11 Waiver of Notice. The transactions of any meeting of the Board of Directors, however called and noticed or wherever held, shall be as valid as though had at a meeting duly held after regular call and notice if a quorum is present and if, either before or after the meeting, each of the directors not present signs a written waiver of notice, a consent to holding the meeting or an approval of the minutes. Notice of a meeting, although otherwise required, need not be given to any director who attends the meeting without protesting the lack of notice before or at the beginning of the meeting. Waivers of notice or consents need not specify the purpose of the meeting. All waivers, consents, and approvals of the minutes shall be filed with the corporate records or made a part of the minutes of the meeting.

Section 3.12 Adjournment to Another Time or Place. Whether or not a quorum is present, a majority of the directors present may adjourn any meeting to another time or place.

Section 3.13 Notice of Adjourned Meeting. Notice of the time and place of resuming a meeting that has been adjourned need not be given unless the adjournment is for more than 24 hours, in which case notice shall be given, before the time set for resuming the adjourned meeting, to the directors who were not present at the time of the adjournment. Notice need not be given in any case to directors who were present at the time of the adjournment.

Section 3.14 Action Without a Meeting. Any action required or permitted to be taken by the Board of Directors may be taken without a meeting if all members of the Board of Directors individually or collectively consent in writing to that action. Any action by written consent shall have the same force and effect as a unanimous vote of the Board of Directors. All written consents shall be filed with the minutes of the proceedings of the Board of Directors.

Section 3.15 Fees and Compensation of Directors. Directors and members of committees of the Board of Directors may be compensated for their services and may be reimbursed for expenses, as fixed or determined by resolution of the Board of Directors. This section shall not be construed to preclude any director from serving the Corporation in any other capacity, as an officer, agent, employee, or otherwise, or from receiving compensation for those services.

ARTICLE IV

COMMITTEES

Section 4.1 Committees of the Board. Except as otherwise set forth in these Bylaws, the Board of Directors may, by resolution adopted by a majority of the authorized number of voting directors, designate one or more committees to serve at the pleasure of the Board. The Board may designate one or more directors as members of any committee. The appointment of committee members or alternate members requires the vote of a majority of the authorized number of voting directors. A committee may be granted any or all of the powers and authority of the Board, to the extent provided in the resolution of the Board of Directors establishing the committee, except with respect to:

- a) Approving any action for which the California Nonprofit Public Benefit Corporation Law also requires the approval of the members;
- b) Filling vacancies on the Board of Directors or any committee of the Board;
- c) Fixing directors' compensation for serving on the Board or a committee of the Board;
- d) Adopting, amending or repealing Bylaws;
- e) Amending or repealing any resolution of the Board of Directors that by its express terms is not so amendable or repealable;
- f) Expenditure of any corporate funds to support a nominee for director after there are more people nominated for director than can be elected;
- g) Appointing other committees of the Board or its members; or
- h) Approval of any self-dealing transaction, as such transactions are defined in the California Nonprofit Public Benefit Corporation Law.

Section 4.2. Meetings and Action of Committees. Meetings and action of committees shall be governed by, and held and taken in accordance with, Bylaw provisions applicable to meetings and actions of the Board of Directors, with such changes in the context of those Bylaws as are necessary to substitute the committee and its members for the Board of Directors and its members, except that

- a) the time of regular meetings of committees may be determined either by resolution of the Board of Directors or by resolution of the committee;
- b) special meetings of committees may also be called by resolution of the Board of Directors; and
- c) notice of special meetings of committees shall also be given to all alternate members who shall have the right to attend all meetings of the committee.

The Board of Directors may adopt rules for the governance of any committee not inconsistent with these Bylaws.

Section 4.3 Committee Members. There shall be no limitation on the re-appointment of members to committees.

Section 4.4 Scope of Practice Committee. The Scope of Practice Committee shall be a standing committee of the Corporation. It shall have six (6) committee members to be nominated by the incoming president (the current president-elect) at the annual meeting of the members and approved by a majority vote of the members entitled to vote. The committee members shall serve for one (1) year. The chair of the Scope of Practice Committee shall be elected by the members of the committee at its first meeting. The president shall appoint one or more members of the Scope of Practice Committee to serve as compensated or uncompensated consultant(s)/advisor(s) to EMSA/EMS Commission.

Section 4.5 Legislative Committee. The Legislative Committee shall be a standing committee of the Corporation. It shall have three (3) to six (6) committee members to be nominated by the incoming president (the current president-elect) at the annual meeting of the members and approved by a majority vote of the members entitled to vote. The committee members shall serve for one (1) year. The chair of the Legislative Committee shall be elected by the members of the committee at its first meeting.

ARTICLE V

OFFICERS

Section 5.1 Officers. The officers of the Corporation shall be a president/chief executive officer, a president-elect, a secretary, and a treasurer/chief financial officer. The president and president-elect shall be active members. One person may not hold more than one (1) office; however, officers may serve up to three (3) consecutive terms.

Section 5.2 Election of Officers. The officers of the Corporation, except the president, shall be elected annually by the members entitled to vote at the annual meeting of members. The then-president-elect shall automatically assume the office of president at the annual meeting which takes place at the expiration of his or her one (1) year term as president-elect. The then-president shall automatically assume the office of immediate past-president and *ex officio* director at the annual meeting which takes place at the expiration of his or her one (1) year term as president

Section 5.3 Subordinate Officers. The Board of Directors may appoint, and may empower the president to appoint, other officers as may be required by the business of the Corporation, whose duties shall be as provided in the Bylaws, or as determined from time to time by the Board of Directors or the president.

Section 5.4 Removal and Resignation of Officers. The Board of Directors may remove any officer chosen by the Board of Directors at any time, with or without cause or notice. Subordinate officers appointed by persons other than the Board under section 5.3 of this Article may be removed at any time, with or without cause or notice, by the Board of Directors or by the officer by whom appointed. Officers may be employed for a specified term under a contract of employment if authorized by the Board of Directors; such officers may be removed from office at any time under this section, and shall have no claim against the Corporation or individual officers or Board members because of the removal except any right to monetary compensation to which the officer may be entitled under the contract of employment. Any officer may resign at any time by giving written notice to the corporation. Resignations shall take effect on the date of receipt of the notice, unless a later time is specified in the notice. Unless otherwise specified in the notice, acceptance of the resignation is not necessary to make it effective. Any resignation is without prejudice to the rights, if any, of the Corporation to monetary damages under any contract of employment to which the officer is a party.

Section 5.5 Vacancies in Offices. A vacancy in any office resulting from an officer's death, resignation, removal, disqualification, or from any other cause, shall be filled in the manner prescribed by these Bylaws for regular election or appointment to that office.

Section 5.6 Chair of the Board. The president shall serve as the chair of the Board and the president-elect shall serve as the vice-chair. In the absence of the president and president-elect, the Board of Directors may elect a chair. The chair of the Board shall in addition be the chief executive officer of the Corporation, and shall have the powers and duties as set forth in section 5.7 of this Article.

Section 5.7 President. Except to the extent that the Bylaws or the Board of Directors assign specific powers and duties to the chair of the Board (if any), the president shall be the Corporation's general manager and chief executive officer and, subject to the control of the Board of Directors, shall have general supervision, direction and control over the Corporation's business and its officers. The managerial powers and duties of the president shall include, but not be limited to, all the general powers and duties of management usually vested in the office of president of a corporation, and the president shall have other powers and duties as prescribed by the Board of Directors or the Bylaws. The president shall preside at all meetings of the members and, in the absence of the chair of the Board or if there is no chair of the Board, shall also preside at meetings of the Board of Directors.

Section 5.8 Vice President. The president-elect shall generally serve as vice president. In the absence or disability of the president, the president's duties and responsibilities shall be carried out by the president-elect. When so acting, the president-elect shall have all the powers of and be subject to all the restrictions on the president.

Section 9. The Secretary.

- a) Minutes: The secretary shall keep, or cause to be kept, minutes of all the members' meetings and of all Board meetings. If the secretary is unable to be present, the secretary or the presiding officer of the meeting shall designate another person to take the minutes of the meeting. The secretary shall keep, or cause to be kept, at the principal executive office or such other place as designated by the Board of Directors, a book of minutes of all meetings and actions of the members, of the Board of Directors, and of committees of the Board. The minutes of each meeting shall state the time and place the meeting

was held; whether it was regular or special; if special, how it was called or authorized; the names of directors present at Board or committee meetings; the number of members entitled to vote present or represented at members' meetings; an accurate account of the proceedings; and when it was adjourned.

- b) Record of Members: the secretary shall keep, or cause to be kept, at the principal executive office, a record or duplicate record of members. This record shall show the names of all members and their addresses, the class of membership held by each, the number and date of membership certificates, if any, issued to each member, and the number and date of cancellation of any certificates surrendered for cancellation.
- c) Notice of Meetings: the secretary shall give notice, or cause notice to be given, of all members' meetings, Board meetings, and meetings of committees of the Board for which notice is required by statute or by the Bylaws. If the secretary or other person authorized by the secretary to give notice fails to act, any other officer of the Corporation may give notice of any meeting.
- d) Other Duties: the secretary shall keep, or cause to be kept, the seal of the Corporation, if any, in safe custody. The secretary shall have such other powers and perform other duties as prescribed by the Board of Directors or by the Bylaws.

Section 5.10 Treasurer/Chief Financial Officer. The treasurer/chief financial officer shall keep, or cause to be kept, adequate and correct books and records of accounts of the properties and business transactions of the Corporation, including accounts of its assets, liabilities, receipts, disbursements, gains, losses, capital, retained earnings, and shares. The books of account shall at all reasonable times be open to inspection by any director. The treasurer shall (1) deposit corporate funds and other valuables in the Corporation's name and to its credit with depositories designated by the Board of Directors; (2) make disbursements of corporate funds as authorized by the Board; (3) render a statement of the Corporation's financial condition and an account of all transactions conducted as chief financial officer whenever requested by the president or the Board of Directors; and (4) have other powers and perform other duties as prescribed by the Board of Directors or the Bylaws. The chief financial officer shall be deemed to be the treasurer for purposes of giving reports or executing any certificates or other documents.

ARTICLE VI

INDEMNIFICATION OF DIRECTORS, OFFICERS,

EMPLOYEES, AND OTHER AGENTS;
LIMITATION OF LIABILITY

Section 6.1 Indemnification. The Corporation shall, to the maximum extent permitted by the California General Corporation Law, have power to indemnify each of its agents against expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred in connection with any proceeding arising by reason of the fact that any such person is or was an agent of the Corporation, and shall have power to advance to each such agent expenses incurred in defending any such proceeding to the maximum extent permitted by that law. For purposes of this Article, an “agent” of the Corporation includes any person who is or was a director, officer, employee, or other agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust or other enterprise, or was a director, officer, employee, or agent of a corporation which was a predecessor corporation of the Corporation or of another enterprise serving at the request of such predecessor corporation.

Section 6.2 Directors’ Actions. Except as otherwise set forth in the Corporations Code, a person who performs the duties of a director in accordance with the law shall have no liability based upon any alleged failure to discharge the person’s obligations as director, including, without limiting the generality of the foregoing, any actions or omissions which exceed or defeat a public or charitable purpose to which the Corporation, or assets held by it, is dedicated.

Section 6.3 No Liability to Third Parties. Except as otherwise set forth in the Corporations Code, there shall be no personal liability to a third party for monetary damages on the part of a volunteer director or volunteer executive officer caused by his or her negligent act or omission in the performance of his or her duties as a director or officer so long as such person acted in compliance with Corporations Code section 5239(a) and the Corporation has complied with its obligations under section 8.3 of these Bylaws.

ARTICLE VII

RECORDS AND REPORTS

Section 7.1 Maintenance of Membership Record and Inspection by Members. The Corporation shall keep at its principal executive office a record of the names and addresses of all members and class of membership held by each member. A member or members of the Corporation entitled to vote shall have the right to inspect and copy the record of members’ names and addresses and

classes of membership during regular business hours, on five (5) days' prior written demand on the Corporation.

Section 7.2. Maintenance and Inspection of Bylaws. The Corporation shall keep at its principal executive office, or if its principal executive office is not within the State of California, at its principal business office in this state, the original or a copy of the Bylaws as amended to date, which shall be open to inspection by the members at all reasonable times during office hours. If the principal executive office of the Corporation is outside of the State of California and the Corporation has no principal business office in this state, the secretary shall, on the written request of any member, furnish to that member a copy of the Bylaws as amended to date.

Section 7.3 Maintenance and Inspection of Minutes and Accounting Records. The minutes of proceedings of the members, Board of Directors, and committees of the Board, and the accounting books and records, shall be kept at the principal executive office of the Corporation, or at such other place or places as designated by the Board of Directors. The minutes shall be kept in written form, and the accounting books and records shall be kept either in written form or in a form capable of being converted into written form. The minutes and accounting books and records shall be open to inspection on the written demand of any member at any reasonable time during usual business hours, for a purpose reasonably related to the member's interests. The inspection may be made in person or by an agent or attorney, and shall include the right to copy and make extracts. These rights of inspection shall extend to the records of each subsidiary of the Corporation.

Section 7.4 Inspection by Directors. Every director shall have the absolute right at any reasonable time to inspect all books, records, and documents of every kind and the physical properties of the Corporation and each of its subsidiary corporations. This inspection by a director may be made in person or by an agent or attorney and the right of inspection includes the right to copy and make extracts of documents.

Section 7.5 Annual Report to Members. The Board shall cause an annual report to be sent to the members and directors within 120 days of the end of the Corporation's fiscal year. That report shall contain the following information, in appropriate detail:

- a) The assets and liabilities, including the trust funds, if any, of the Corporation as of the end of the fiscal year;
- b) The principal changes in assets and liabilities, including trust funds;

- c) The Corporation's revenue or receipts, both unrestricted and restricted to a particular purposes;
- d) The Corporation's expenses or disbursements for both general and restricted purposes;
- e) Any information required by any other section of these Bylaws or by any resolution of the Board; and
- f) An independent accountant's report or, if none, the certificate of an authorized officer of the Corporation that such statements were prepared without audit from the Corporation's books and records.

Section 7.6 Financial Statements. The Corporation shall keep a copy of each annual financial statement, quarterly or other periodic income statement, and accompanying balance sheets prepared by the Corporation on file in the Corporation's principal executive office for 12 months; these documents shall be exhibited at all reasonable times, or copies provided, to any member on demand. Quarterly income statements and balance sheets referred to in this section shall be accompanied by the report, if any, of independent accountants engaged by the Corporation or the certificate of an authorized corporate officer stating that the financial statements were prepared without audit from the Corporation's books and records.

Section 7.7 Annual Statement of General Information.

- a) Every year, during the calendar month in which the original Articles of Incorporation were filed with the California Secretary of State, or during the preceding five (5) calendar months, the Corporation shall file a statement with the Secretary of State on the prescribed form, setting forth the authorized number of directors; the names and complete business or residence addresses of all incumbent directors; the names and complete business or residence addresses of the chief executive officer, the secretary, and the chief financial officer; the street address of the Corporation's principal executive office in this state; a statement of the general type of business constituting the principal business activity of the Corporation; and a designation of the agent of the Corporation for the purpose of service of process, all in compliance with the California Corporations Code.
- b) Notwithstanding the provisions of subsection a) of this section, if there has been no change in the information in the Corporation's last annual statement on file in the Secretary of State's office, the Corporation may, in lieu of filing the annual statement described in subsection a) of this section, advise the Secretary of State, on the appropriate form, that no

changes in the required information have occurred during the applicable period.

ARTICLE VIII

GENERAL CORPORATE MATTERS

Section 8.1 Authorized Signatories for Checks. All checks, drafts, other orders for payment of money, notes, or other evidences of indebtedness issued in the name of or payable to the Corporation shall be signed or endorsed by such person or persons and in such manner authorized from time to time by resolution of the Board of Directors.

Section 8.2 Executing Corporate Contracts and Instruments. Except as otherwise provided in the Articles of Incorporation or in these Bylaws, the Board of Directors by resolution may authorize any officer, officers, agent, or agents to enter into any contract or to execute any instrument in the name of and on behalf of the Corporation. This authority may be general or it may be confined to one or more specific matters. No officer, agent, employee, or other person purporting to act on behalf of the Corporation shall have any power or authority to bind the Corporation in any way, to pledge the Corporation's credit, or to render the Corporation liable for any purpose or in any amount, unless that person was acting with the authority duly granted by the Board of Directors as provided in these Bylaws, or unless an unauthorized act was later ratified by the Corporation.

Section 8.3 General Liability Insurance. In compliance with the Corporations Code, the Board or its agent shall obtain a general liability insurance policy or a director's and officer's insurance liability policy in the name of the Corporation or it shall make all reasonable efforts in good faith to obtain available liability insurance. At minimum, the Board or its agent shall make at least one (1) inquiry per year to purchase a general liability insurance with coverage of at least \$500,000.00, unless otherwise required by applicable law.

Section 8.4 Membership Certificates. In the event the Board of Directors authorizes and adopts a Membership Certificate for members of the Corporation, a certificate representing membership in the Corporation shall be issued to each member when such membership is fully paid. All certificates shall certify the class of membership represented by the certificate. All certificates shall be signed in the name of the Corporation by the president and either the treasurer or the secretary.

Section 8.5 Lost Certificates. Except as provided in this section, no new membership certificates shall be issued to replace old certificates unless the old certificate is surrendered to the Corporation for cancellation at the same time. The Board of Directors may, in the case of certificates that have been lost, stolen, or destroyed, authorize the issuance of replacement certificates on terms and conditions as required by the Board.

Section 8.6 Rules of Procedure. Except as otherwise set forth in these Bylaws, all meetings of the members, the Board of Directors or any committees, shall be conducted using the latest edition of Robert's Rules of Order as a guide with respect to parliamentary procedures.

Section 8.7 Construction and Definitions. Unless the context requires otherwise, the general provisions, rules of construction, and definitions in the California Corporations Code shall govern the construction of these Bylaws. Without limiting the generality of this provision, the singular number includes the plural, the plural number includes the singular, and the term "person" includes both a corporation and a natural person.

ARTICLE IX

AMENDMENTS

Section 9.1 Amendment by the Members. Except as otherwise required by law or by the Articles of Incorporation, these Bylaws may be amended or repealed, and/or new Bylaws may be adopted, by the vote or written consent of a majority of the members entitled to vote.

Section 9.2 Amendment by the Directors. Except as otherwise required by law or by the Articles of Incorporation or insofar as such action would not materially and adversely affect the voting or transfer rights of the membership set forth in these Bylaws, these Bylaws may be amended or repealed, and/or new Bylaws may be adopted, by the vote or written consent of the Board of Directors.

CERTIFICATE OF SECRETARY

I, James Andrews, do hereby certify:

1. That I am the duly elected and acting Secretary of Emergency Medical Services Medical Directors' Association of California, Inc., a California nonprofit public benefit corporation ("EMDAC, Inc."); and
2. That the foregoing Bylaws of twenty-three (23) pages constitute the Bylaws of EMDAC, Inc. as duly adopted at a meeting of the Board of Directors thereof duly held on June 11, 1999.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed the seal, if any, of EMDAC, Inc. on this 11th day of June, 1999.

James Andrews