COASTAL VALLEYS EMS AGENCY

EMS Stakeholder Engagement Process

CVEMSA position on Paramedic Service Provider Agreements

In a previously distributed position paper, "CVEMSA Recommendation on Sonoma County Ambulance Service Zones" The EMS Agency made recommendations regarding the process for establishing the designated service provider agency within the existing Sonoma County Ambulance Service Zones. The recommendations paper was largely concerned with the method by which a community could express a desire to change provider agencies to the LEMSA. That paper also proposed the implementation of a transparent process for entities wishing to serve an area to follow.

In the "Zones" position paper there were a few references to Paramedic Service Provider agreements as an element of any process by which the LEMSA may authorize the provision of Advanced Life Support (Paramedic) care under LEMSA medical control authority.

This paper is intended to clarify the CVEMSA understanding of the requirements for such agreements and clearly state why the LEMSA feels these agreements are limited to the provision of medical control and do not constitute agreements for the provision of services within the context and meaning of HSC 1797.201.

The California Code of Regulations (CCR) Div. 9 Title 22 § 100170 establishes the manner in which the LEMSA Medical Director must maintain medical control including the development of written policy, procedure and treatment protocols. The section mandates the LEMSA develop patient care protocols encompassing the paramedic scope of practice patient care and requirements for the documentation and review of that care.

The California Code of Regulations (CCR) Div. 9 Title 22 § 100168(b)(4), defines, in part, conditions under which a LEMSA may authorize entities to provide paramedic-level care. The section states: *"an approved paramedic service provider shall… Have a written agreement with the LEMSA to participate in the EMS system and to comply with all applicable State regulations and local policies and procedures, including participation in the LEMSA's EMSQIP as specified in Chapter 12 of this Division…."*

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The Paramedic Service Provider Agreement is the method of establishing the accountability between the LEMSA Medical Director and the employer of paramedics practicing under LEMSA medical direction.

On an individual basis paramedics must accredit in order to practice locally. Accreditation is a process in which they sign an application which requires them to agree to abide by local policy and procedure in the provision of ALS care as a condition of receiving the authorization of the EMS Agency Medical Director to practice in the system.

The Paramedic Service Provider Agreement may be viewed as analogous to the paramedic accreditation. Like the individual paramedics, the service provider agency agrees to abide by local policy and procedure in the provision of the elements of ALS care that are out of the individual paramedics' control. Such elements are the clinical and operational oversight of their paramedic employees and the logistic support of those providers with equipment and supplies in accordance with EMS system minimum standards.

The paramedic service provider agreement defines responsibilities of the service provider to abide by local policy and procedure as a condition of receiving the authorization of the EMS Agency Medical Director to provide ALS care in the system.

The Paramedic Service Provider Agreement could be renamed as the Paramedic Service Provider Accreditation and serve the same function.

Just as the Paramedic Accreditation issued by CVEMSA verifies the paramedics holding it are compliant with local medical control policies and accountable to the LEMSA Medical Director, The Paramedic Service Provider Agreement verifies the provider agency connection with the LEMSA is established in accordance with statute and regulation, and may be reported as such to any other regulator requesting that verification.

The Paramedic Service Provider Agreement also defines LEMSA responsibilities and accountability to the provider agency and the community it serves. The oversight and quality management function of the LEMSA must be incorporated into the agreement to provide clarity regarding the expectations of both LEMSA and Paramedic Service Provider. Should the LEMSA neglect those areas of the EMS System that are the LEMSA's responsibility to maintain its support of the local community, the Paramedic Service Provider Agency has the ability to hold the LEMSA accountable through the agreement.

Accountability is key for the LEMSA. Establishing and maintaining medical control of the EMS system with a high degree of system participant engagement requires staff and support. Maintaining up-to-date treatment protocols and electronic patient care reporting and data collection requires expertise and software. Staying current with EMS trends and training field providers requires outreach and consistent effort. Accountability for these activities should not be wholly internal or even limited to a state regulator. The community will be well-served only if the entire EMS system, including the local regulator responsible for system quality, is accountable back to the community itself.

With accountability comes fiscal responsibility. The LEMSA cannot engage in activities without sustainable funding. Sonoma County does not assess an EMS District tax or generate alternate funding for many of the EMS oversight duties outlined in CCR Title 22 § 100170. EMS Agency Medical Director and staff support costs must be part of the accounting around LEMSA requirements to provide oversight to system providers. One option is to study workload associated with paramedic service provider agreements and build cost recovery into the agreement. Where the funding is sourced from may differ for public and private provider agencies, but accounting for the cost is the only way to ensure the work is addressed.

The goal of CVEMSA is to ensure a compliant EMS system exists without impacting any City, District or LEMSA rights and/or obligations under HSC 1797.201. Cities and Districts that are described in 1797.201 retain the right to provide services within the city or district boundaries historically served by that provider until such time as an agreement relieving them of that obligation is reached with the County. HSC 1797.201 also affirms the Medical Control provisions of the EMS Act are applicable to all EMS providers. Ordinance language that limits emergency ambulance provider agreements to the provision of medical control would ensure all provider agencies are compliant with HSC without changing the relationship between Cities, Districts and County regarding the provision of pre-hospital care.

The intention of the LEMSA is to define the Paramedic Service Provider Agreement specifically and narrowly as the written agreement with the LEMSA required by CCR as a condition of participation in the organized EMS system. The LEMSA believes such an interpretation is appropriate given the intent that all provider agencies and the LEMSA comply with the appropriate State and local policies and procedures as a function of medical control. **Such an agreement is separate and distinct from an agreement with a County for the provision of EMS services to a given area.** CVEMSA has no intent to frame Paramedic Service Provider Agreements as altering the relationship between the LEMSA and any Cities or Districts which have or may have rights, eligibility and/or obligations related to HSC 1797.201 and or 1797.224.

The ordinance should define an emergency ambulance service provider agency agreement and address the following items:

1. The scope of provider agreements should be limited to portions of the system that fall under medical control according to relevant HSC and CCR sections.
2. The agreements should include both provider agency and LEMSA responsibilities for establishing and maintaining medical control and compliance with HSC and CCR
3. Provider agreements should include language that clearly articulates that there is no intent to modify/alter applicable provider agencies' 1797.201 rights; the agreements are to establish the basis for maintaining medical control only, and do not deprive a 1797.201 entity of the authority to provide service within the area for which they have that responsibility.
4. Paramedic Service Provider Agreements should not address geographic area covered; such information is contained in the EMS Plan and any applicable 1797.224 EOA designations.
5. LEMSA structure required to meet LEMSA responsibilities in the PSPA must be funded in some manner, either via a cost recovery tied to agreements or via another mechanism.

References:

The following are excerpts from the California Code of Regulations (CCR) Title 22, Division 9 Pre-hospital Emergency Medical Services. The entirety of the regulations are available in an online reference at:
https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I2E586D50D4C011DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)

22 CCR § 100145

§ 100145. Application of Chapter.

(a) Any LEMSA that authorizes a paramedic training program or an ALS service that provides services utilizing paramedic personnel as part of an organized EMS system, shall be responsible for approving paramedic training programs, paramedic service providers, paramedic base hospitals, and for developing and enforcing standards, regulations, policies and procedures in accordance with this chapter to provide an EMS system quality improvement program, appropriate medical control, and coordination of paramedic personnel and training program(s) within an EMS system.
(b) No person or organization shall offer a paramedic training program, or hold themselves out as offering a paramedic training program, or hold themselves out as providing ALS services utilizing paramedics for the delivery of emergency medical care unless that person or organization is authorized by the LEMSA.
(c) A paramedic who is not licensed in California may temporarily perform his/her scope of practice in California on a mutual aid response, on routine patient transports from out of state into California, or during a special event, when approved by the medical director of the LEMSA, if the following conditions are met:
(1) The paramedic is licensed or certified in another state/country or under the jurisdiction of the federal government.
(2) The paramedic restricts his/her scope of practice to that for which s/he is licensed or certified.
(3) Medical control as specified in Section 1798 of the Health and Safety Code is maintained in accordance with policies and procedures established by the medical director of the LEMSA.
Note: Authority cited: Sections 1797.107, 1797.172 and 1797.195, Health and Safety Code. Reference: Sections 1797.172, 1797.178, 1797.185, 1797.195, 1797.200, 1797.204, 1797.206, 1797.208, 1797.218, 1797.220, 1798 and 1798.100, Health and Safety Code.

22 CCR § 100168

§ 100168. Paramedic Service Provider.

(a) A LEMSA with an ALS system shall establish policies and procedures for the approval, designation, and evaluation through its EMSQIP, of all paramedic service provider(s).
(b) An approved paramedic service provider shall:

(1) Provide emergency medical service response on a continuous twenty-four (24) hours per day basis, unless otherwise specified by the LEMSA, in which case there shall be adequate justification for the exemption (e.g., lifeguards, ski patrol personnel, etc.).
(2) Utilize and maintain telecommunications as specified by the LEMSA.
(3) Maintain a drug and solution inventory as specified by the LEMSA of equipment and supplies commensurate with the basic and local optional scope of practice of the paramedic.
(A) Ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to:
1. controlled substance ordering and order tracking;
2. controlled substance receipt and accountability;
3. controlled substance master supply storage, security and documentation;
4. controlled substance labeling and tracking;
5. vehicle storage and security;
6. usage procedures and documentation;
7. reverse distribution;
8. disposal;
9. re-stocking procedures.
(B) Ensure that mechanisms for investigation and mitigation of suspected tampering or diversion are established, including, but not limited to,;
10. controlled substance testing;
11. discrepancy reporting;
12. tampering, theft and diversion prevention and detection;
13. usage audits.
(4) Have a written agreement with the LEMSA to participate in the EMS system and to comply with all applicable State regulations and local policies and procedures, including participation in the LEMSA's EMSQIP as specified in Chapter 12 of this Division.
(5) Be responsible for assessing the current knowledge of their paramedics in local policies, procedures and protocols and for assessing their paramedics' skills competency.
(6) If, through the EMSQIP the employer or medical director of the LEMSA determines that a paramedic needs additional training, observation or testing, the employer and the medical director may create a specific and targeted program of remediation based upon the identified need of the paramedic. If there is disagreement between the employer and the medical director, the decision of the medical director shall prevail.
(c) No paramedic service provider shall advertise itself as providing paramedic services unless it does, in fact, routinely provide these services on a continuous twenty-four (24) hours per day basis and meets the requirements of subsection (b) of this section.
(d) No responding unit shall advertise itself as providing paramedic services unless it does, in fact, provide these services and meets the requirements of subsection (a) of this section.
(e) The LEMSA may deny, suspend, or revoke the approval of a paramedic service provider for failure to comply with applicable policies, procedures, and regulations.
Note: Authority cited: Sections 1797.107, 1797.172 and 1798, Health and Safety Code. Reference: Sections 1797.172, 1797.178, 1797.180, 1797.204 and 1797.218, Health and Safety Code.

22 CCR § 100148

§ 100148. Responsibility of the LEMSA.

The LEMSA that authorizes an ALS program shall establish policies and procedures approved by the medical director of the LEMSA that shall include:
(a) Approval, denial, revocation of approval, suspension, and monitoring of training programs, base hospitals or alternative base stations, and paramedic service providers.
(b) Assurance of compliance with provisions of this Chapter by the paramedic program and the EMS system.
(c) Submission to the Authority, as changes occur, of the following information on the approved paramedic training programs:
(1) Name of program director and/or program contact;
(2) Address, phone number, and facsimile number;
(3) Date of approval, date classes will initially begin, and date of expiration.
(d) Development or approval, implementation and enforcement of policies for medical control, medical accountability, and an EMSQIP of the paramedic services, including:
(1) Treatment and triage protocols.
(2) Patient care record and reporting requirements.
(3) Medical care audit system.
(4) Role and responsibility of the base hospital and paramedic service provider.
(e) System data collection and evaluation.
Note: Authority cited: Sections 1797.107 and 1797.172, Health and Safety Code. Reference: Sections 1797.172, 1797.178, 1797.200, 1797.202, 1797.204, 1797.208, 1797.220, 1798 and 1798.100, Health and Safety Code.

22 CCR § 100170

§ 100170. Medical Control.

The medical director of the LEMSA shall establish and maintain medical control in the following manner:
(a) Prospectively, by assuring the development of written medical policies and procedures, to include at a minimum:
(1) Treatment protocols that encompass the paramedic scope of practice.
(2) Local medical control policies and procedures as they pertain to the paramedic base hospitals, alternative base stations, paramedic service providers, paramedic personnel, patient destination, and the LEMSA.
(3) Criteria for initiating specified emergency treatments on standing orders or for use in the event of communication failure that is consistent with this Chapter.
(4) Criteria for initiating specified emergency treatments, prior to voice contact, that are consistent with this Chapter.
(5) Requirements to be followed when it is determined that the patient will not require transport to the hospital by ambulance or when the patient refuses transport.
(6) Requirements for the initiation, completion, review, evaluation, and retention of a patient care record as specified in this Chapter. These requirements shall address but not be limited to:
(A) Initiation of a record for every patient response.
(B) Responsibilities for record completion.
(C) Record distribution to include LEMSA, receiving hospital, paramedic base hospital, alternative base station, and paramedic service provider.
(D) Responsibilities for record review and evaluation.

(E) Responsibilities for record retention.
(b) Establish policies which provide for direct voice communication between a paramedic and a base hospital physician or MICN, as needed.
(c) Retrospectively, by providing for organized evaluation and CE for paramedic personnel. This shall include, but not be limited to:
(1) Review by a base hospital physician or MICN of the appropriateness and adequacy of paramedic procedures initiated and decisions regarding transport.
(2) Maintenance of records of communications between the service provider(s) and the base hospital through tape recordings and through emergency department communication logs sufficient to allow for medical control and CE of the paramedic.
(3) Organized field care audit(s).
(4) Organized opportunities for CE including maintenance and proficiency of skills as specified in this Chapter.
(d) In circumstances where use of a base hospital as defined in Section 100169 is precluded, alternative arrangements for complying with the requirements of this Section may be instituted by the medical director of the LEMSA if approved by the Authority.
Note: Authority cited: Sections 1797.107, 1797.172 and 1797.176, Health and Safety Code. Reference: Sections 1797.90, 1797.172, 1797.202, 1797.220, 1798, 1798.2, 1798.3 and 1798.105, Health and Safety Code.