County of Santa Cruz

HEALTH SERVICES AGENCY

P.O. BOX 962, 1080 EMELINE AVENUE
SANTA CRUZ, CA 95061
(831) 454-4066 FAX: (831) 454-4770

HEALTH SERVICES AGENCY
ADMINISTRATION

April 6, 2001

AGENDA: April 24, 2001

Honorable Board of Supervisors
County of Santa Cruz
701 Ocean Street
Santa Cruz, CA 95060

Subject: Report on Hospital Restricted Status (Code Yellow/Code Red) and Emergency Department Access in Santa Cruz County

Dear Members of the Board:

Introduction

The Health Services Agency and the Emergency Medical Care Commission (EMCC) have completed a review of the issue of Emergency Medical Services system-wide access to hospital Emergency Departments in the County. The purpose of the review was to ascertain the number of times and total time that hospital Emergency Departments in the EMS system were on restricted status, and to develop a perspective on broader issues regarding Emergency Department access.

A Report on Hospital Restricted Status (Code Yellow/Code Red) and Emergency Department Access in Santa Cruz County was prepared and presented for discussion at the March 14, 2001 EMCC Meeting. The report noted that hospitals are sometimes overwhelmed by circumstances beyond their control and must request a restricted status within the EMS system in order to provide for the care and safety of all their patients. However, the total amount of time hospitals in Santa Cruz County were on restricted status was less than three days in the entire Calendar Year 2000.

Background

Code Green is a status that means the hospital is open to all ambulance traffic.

Code Yellow is a status that reflects a temporary condition that impacts the reception of certain types of patients. For example, if the Computed Tomography (CT) scanner is out of service for repair, a hospital will advise the Santa Cruz Consolidated Emergency Communication Center (SCCECC) and a medical information page will be disseminated to place the hospital on Code Yellow status. Another example of a Code Yellow condition would be a lack of intensive care or CCU beds when the hospital inpatient monitored beds are at full census. In these cases, ambulances would check with the affected hospital to determine if they should proceed to that location with patients who might require diagnostic imaging or potentially critical patients who might require an inpatient specialty unit bed.

Code Red is a status that reflects a temporary condition in which the Emergency Department (ED) is so busy that reception of an additional critical patient might adversely affect the care of patients already being treated. For example, an ED which just received several trauma victims from a multiple casualty incident motor vehicle crash might need to declare Code Red until the victims are stabilized. In this case, incoming ambulance traffic would divert to another hospital unless their patient was in extremis and required care for an immediately life-threatening condition such as cardiac and respiratory arrest or occluded airway. All hospitals receive patients in extremis at all times.

The County's EMS Program policy number 1230 details the hospital diversion procedure. This policy is undergoing review in conjunction with both hospitals in order to enhance communication between the hospitals when restricted status conditions occur and will be presented to the Prehospital Advisory Committee for review at their May 2001 meeting.

Hospital Restricted Status Review

Each month the Technical Advisory Group (TAG) reviews the Hospital Restricted Status Report prepared by the Santa Cruz Consolidated Emergency Communications Center SCCECC. In Calendar Year 2000, the total number of hours of hospital restricted status in the Santa Cruz EMS System was 71 hours and 32 minutes.

Dominican Hospital was Code Yellow on 5 occasions for a total of 27 hours and 52 minutes. Watsonville Community Hospital was Code Yellow on 3 occasions for a total of 22 hours and 53 minutes, and Code Red on 4 occasions for a total of 20 hours and 47 minutes.

The TAG further reviews the Ambulance Reroute Report prepared by the SCCECC which was designed to detect any ambulance traffic which begins to travel towards one hospital destination and which arrives at another hospital destination. No ambulance diversions were recorded by this report in Calendar Year 2000, however, the TAG recognized that this report returned imperfect data on the issue. A new procedure went into effect March 1, 2001 to flag ambulance diversions with a delay code. The TAG routinely reviews every delay code each month. Paramedic liaison nurses at each hospital also advise the EMS medical director about problems with ambulance diversions.

The results of the TAG review are reflected in the TAG minutes and are disseminated to the Board of Supervisors, the Emergency Medical Care Commission (EMCC) and the Prehospital Advisory Commission (PAC) monthly.

Hospital Emergency Medical Services

Emergency Departments (EDs) are hospital departments providing immediate initial evaluation and treatment of acutely ill or injured patients on a 24-hour basis.
EDs have evolved into the principal safety net for health care, providing universal access to emergency, acute, chronic, and episodic medical care for all persons regardless of their insurance coverage or lack of coverage.

The idea of EDs serving as a safety net derives from the philosophy of the healing professions and the societal view that emergency care is an essential public service. In addition, under state and federal law, everyone who presents to an emergency department must be provided with emergency care. The Health Maintenance Organization (HMO) model has failed to reduce the number of uninsured, and emergency medical care continues to be the health service in greatest demand by the public, insured or not. Uninsured patients are continuing to increase and use the emergency department for their primary source of medical care. Because of low bed availability in intensive care and other units, patients remain in the emergency department for longer periods of time. High acuity patients, primary care patients whose lack of routine care has exacerbated their problems into higher acuities, nursing shortages, ancillary care staff shortages, very low reimbursement rates, slow payment, and downgrading of service charges has damaged the emergency care system.

Nationwide, the result has been emergency department overcrowding, long waits, ambulance diversions, a lack of specialty physicians for on-call rosters, and facilities which downgrade services or close emergency departments.

Physician Recruitment and Specialty Physicians On-Call

Hospitals are experiencing increasing challenges recruiting physicians. As the medical staff ages and enters retirement, new physicians are not entering the area to build practices because of the cost of living and because reimbursement rates are not comparable to areas like Santa Clara County or San Francisco. The sheer volume of patients has increased demands on physicians at the same time that reimbursement has decreased and workloads have increased. Delayed or non-payment by health plans for emergency services is decreasing physician ability or desire to serve on-call. The EMS Fund (Maddy Fund) that is used to compensate physicians for care provided to the uninsured pays about 15 cents on the dollar, according to the California Medical Association.

Solutions

Santa Cruz County hospitals are meeting to promote good communication and develop contingency plans to provide hospital ED access when faced with pressures of increased patient demand and limited physician and nurse resources. The Prehospital Advisory Committee will review the EMS Program policy on hospital diversion. The Emergency Medical Care Commission and the Health Services Agency are tracking legislative efforts to improve trauma and EMS care and setting advocacy priorities.

Broader solutions to the problems of Emergency Department access must include better access to outpatient care for patients, advocacy for legislation to improve coverage for the under-insured and uninsured, increased hospital specialty bed capacities, increased numbers of

critical care nurses and increased specialty physician coverage, better reimbursement, and public education about the appropriate use of the emergency department.

As the attached letters from the EMCC, Dominican Hospital, Watsonville Community Hospital, the Santa Cruz County Medical Society, and Dr. Ira Lubell show, community facilities and providers are concerned about the need for continued Emergency Department access and care, the impact of uninsured patients on the emergency care system, and the need for support for on-call specialty physicians.

Legislative Initiatives

EMS and trauma legislation has been introduced in the California Legislature, including Assembly Bills 424 (Aroner), AB 686 (Thomson/Hertzberg), AB 687 (Thomson), AB 740 (Runner) and AB 778 (Romero), and Senate Bills 117 (Speier), SB 254 (Dunn), SB 447 (Vasconcellos) and SB 851 (Oller). Those bills which have the most specific application to the impact of uninsured patients on the emergency care system and the need for support for on-call specialty physicians are discussed below.

Senate Bill 254 (Dunn) would set forth additional requirements to existing EMS law to provide reimbursement for initial stabilizing medical services, implement a critical emergency service provider program, and establish the Critical Emergency Service Facility Fund. Existing law distributes Maddy Fund dollars to certain physicians and surgeons, and to hospitals providing disproportionate trauma and EMS services. This bill would maintain the Maddy Fund distribution to physicians and surgeons, delete the distributions to hospitals and revise the distribution formula upon funding of the critical emergency services program provided under the bill. New schedules of reimbursement would be established for Advanced Life Support (ALS) and Basic Life Support (BLS) transportation services, and for ALS and BLS initial stabilization services. These initial stabilizing medical services would also be covered benefits under Medi-Cal. The bill would appropriate $200,000,000 from the General Fund for the purposes of the critical emergency medical services program, and $100,000,000 from the General Fund to distribute to counties. The county distribution is 40% among counties with a designated critical emergency service facility and 60% according to population.

Assembly Bill 686 (Hertzberg/Thomson) would establish a Trauma Care Fund in the State Treasury to allocate unspecified General Fund dollars to local EMS agencies that operate eligible trauma care systems. Local EMS agencies would disburse funds received to agency-designated trauma centers. Both public and private hospitals designated as trauma centers would be eligible for funding. Funds would be used to maintain trauma center financial viability and to reimburse the care of uninsured patients.

Assembly Bill 687 (Thomson/Hertzberg) would create the EMS and Trauma Care Fund to pay for uncompensated care provided by trauma facilities. The funds would be an amount equal to 25.70% of the State Penalty Fund which collects $10 penalties imposed by the courts for each criminal offense.

IT IS THEREFORE RECOMMENDED THAT YOUR BOARD:

1) Accept and file the attached report, and

2) Approve and adopt the attached resolution supporting SB 254 (Dunn), AB 686 (Hertzberg/Thomson), and AB 687 (Thomson/Hertzberg).

Sincerely,

Rama Khalsa, Ph.D.
Agency Administrator

Attachments: EMCC Letter
Dominican Hospital Letter
Watsonville Community Hospital Letter
Santa Cruz County Medical Society Letter
Dr. Ira Lubell Letter
Code Yellow/Code Red Report
Resolution
Senate Bill 254 (Dunn)
Assembly Bill 686 (Hertzberg/Thomson)
Assembly Bill 687 (Thomson/Hertzberg)

RECOMMENDED

Susan A. Mauriello
County Administrative Officer

CC: County Administrative Office
County Counsel
Auditor-Controller
HSA Administration

County of Santa Cruz

0230

HEALTH SERVICES AGENCY

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EMERGENCYMEDICAL SERVICES

April 3, 2001

Rama Khalsa
HSA Administrator
1080 Emeline Ave.
Santa Cruz, CA 95060

Dear Ms. Khalsa:

This letter is in regard to the issue of Emergency Department closures or diversions in the County of Santa Cruz. As you know this issue was discussed at length at the last EMCC meeting. The issue is not an issue that can be resolved in one broad-brush stroke.

I feel the issue was explained well in your report to the Board of Supervisors. In comparison to other counties and cities in California and the United States we are incredibly fortunate in our ability to maintain open status.

The problem is far more insidious and hidden. One issue in our county is that there are over 40,000+ uninsured patients. The responsibility for the medical care of this population falls on the 2 hospitals and the medical staffs of the facilities. The County Health system or resources do not cover them. These patients usually present with larger problems and concurrent problems that drain resources and the system.

Any hospital diversion is a statement of the system for health care delivery. It is multifactorial in nature and cause. Although our county is very fortunate, it is the tip of the iceberg in regard to the unraveling of the health care system and the safety net for the population.

Both Health Care facilities in the County work extremely hard to maintain this safety net. This is accomplished by incredibly hard work on the part of the nurses and physicians that serve our population.

I would hope that the Board of Supervisors looks at the whole system with an eye to fortifying the infrastructure of the safety net for health care to our citizens.

Sincerely,

Terry B. Lapid, M.D., FACEP
Chair, Emergency Medical Care Commission

Dominican Hospital
CHW

Dominican Hospital
1555 Soquel Drive
Santa Cruz, CA 95065
83 1 462 7700 Telephone

Dominican Rehabilitation Services
610 Frederick Street
Santa Cruz, CA 95062

April 4, 2001

Rama Khalsa, Ph.D.
Santa Cruz County Health Services Agency
Administrator
1080 Emeline Avenue
Santa Cruz CA 95062

Dear Dr. Khalsa:

I would like to take this opportunity to provide you with some comments on emergency medical services in Santa Cruz County as you submit your Report on Hospital Restricted Status and Emergency Department Access in Santa Cruz County to the Board of Supervisors. As outlined in your report, the frequency of instituting Code Red/Yellow hospital restricted status in Santa Cruz County in Calendar Year 2000 was infrequent for a very small percentage of annual hours of operation. Because of ongoing commitment of resources; highly trained staff and responsive physicians, **Dominican Hospital has experienced no incidences of code red status during Calendar Year 2000.** These results are contrary to the experiences in most other counties in California including Monterey and Santa Clara Counties where ambulances are frequently on diversion.

Although the number of diversions is relatively small in Santa Cruz County, it is important to not minimize the challenges faced by hospitals and prehospital care providers when diversion status is in effect. Because of the importance of accessing timely emergency care when needed, any delays in the care process such as rerouting ambulances are serious. Following the incidences when code red diversion is in effect at Watsonville Hospital or code yellow status at either Dominican or Watsonville Hospitals, Dominican staff review the episodes to access the impact of the diversion and what actions could be taken to avoid the reliance on ambulance diversion as a solution to care delivery difficulties. A recent review of occurrences resulted in our meeting with Watsonville Hospital staff to discuss better ways to address patient volume demands and communication procedures between the two hospitals during diversions.

As you know, Dominican Hospital has a very busy emergency department providing the full service array of emergency care. We provided over 42,000 patient visits in Calendar Year 2000. All patients are treated equally regardless of health insurance status. Patients requiring admission who do not have a physician are assigned the appropriate on-call physician(s) to render services. Dominican's Emergency Department is a critical safety net for the uninsured and patients covered by County insurance programs. Last year over 40% of the ED patients were covered by Medical, MediCruz, or uninsured.

The use of ambulance diversion status is symptomatic of the growing challenges faced by hospitals in providing emergency medical services and trauma care in our communities. The provision of hospital emergency care is in trouble across California and the nation for a number of reasons, which are being felt locally to varying degrees. Some of those factors contributing to this crisis include:

- Inadequate reimbursement to cover the costs of care from both governmental and private payors.
- The rising number of uninsured needing care.
- Physicians who are unable/unwilling to meet all of the on-call demands.
- The lack of follow-up care options particularly for the uninsured and substance abuse patients.
- Workforce shortages for nurses, technicians, and other staff contributing to reduced capacity to handle the ED service demand.

Santa Cruz County is fortunate to have a coordinated, high quality EMS system of emergency care. It is Dominican Hospital's and its Medical Staffs goal to continue to maintain these high standards. However, given the fragility of the system, it is critical that all partners in EMS work together with local public policy decision makers and legislators to seek some relief from this growing crisis.

Sincerely,

Sister Julie Hyer, O.P.
President/CEO

cc. Terry Lapid, M.D., Dominican Hospital ED Medical Director; Chair, EMCC
Carol Adams, Dominican Hospital, Vice President

WATSONVILLE
COMMUNITY HOSPITAL

April 3, 2001

Rama Khalsa, Administrator
Health Services Agency
Santa Cruz County
1080 Emeline Avenue
Santa Cruz, CA 95061-0962

Dear Rama:

I would like to take this opportunity to provide some clarification to the discussion at the recent Board of Supervisors Meeting regarding Hospital Restricted Status (Code Yellow/Code Red), as well as express some concerns that I think you and the Board of Supervisorsshould be aware of that will critically impact the ability of our hospital, and I suspect other hospitals, to serve the emergency needs of our population.

First, in regard to the facts of this past year regarding Hospital Restricted Status, I believe the Emergency Medical Care Commission has documented that fact that Watsonville Community Hospital was only on a form of restricted status for less than 10 occasions and for a combined period of less than 24 hours each for Code Red and Code Yellow over the 366 days of the year. I think the County should be extremely proud of this track record as compared to most other communities and counties anywhere else in the State.

This performance has been accomplished in spite of the fact that Watsonville Community Hospital was nearly bankrupt merely three years ago, and in spite of the difficulty of recruiting qualified nursing and other clinical personnel and physicians to this community because of the high cost of housing and living expenses, as well as the high percentage of uninsured and Medi-Cal and other low-paying insurers which further exacerbates our ability to attract physicians and to provide emergency room back up coverage by the physician specialists.

At WCH, we provide two to six times the percentage of Medi-Cal, MediCruz and Charity Care as compared to the other Santa Cruz facilities, in addition to providing $0.5 million to $1.0 million of tax revenues to local governments,

I can unequivocally state that it is the policy and practice of our organization, from the Board, of Trustees level through the caregiver level, that we care for every person presenting to our emergency room regardless of any economic status, -and likewise that we not transfer any patients that we can safely and adequately care for in our own institution and community. However, some of the difficulties that have contributed to these minimal amounts of restricted. status this past year focus around our continued efforts to upgrade our facilityand equipment to accommodate additional patients.

75 NIELSON STREET . WATSONVILLE, CALIFORNIA 45076 . 831-724-4741

Specifically, when this new hospital was built (prior to its current for-profit ownership) those responsible for planning reduced the number of critical care beds from 10 at the old hospital to a mere 6 at the new hospital. This has created the most significant bottleneck that led to hospital restricted status during the past year. Community Health Systems, the current owner, identified this problem immediately upon acquisition and has been diligently pursuing a renovation project to expand the number of critical care beds. As a result, at a cost in excess of $750,000, we will begin this project to add four additional beds in our Critical Care unit that can serve as swing beds for critical care or intermediate care. We expect that to be completed by November 2001.

Similarly, our hospital is the only emergency room in the County that continues to support and provide 100% Board Certified Emergency Trained physicians for the care for our patients. We have also invested over $1 million in installing a new, upgraded cardiac cath lab that will enable us to care for a broader range of cardiac patients. We believe all of these issues will enable us to continue to receive and care for a broader base of patients during the future years-without having to have as much restricted ER status.

In spite of these additional investments, one of the bigger issues facing all the'hospitals in this area, and specifically Watsonville, is that with declining levels of reimbursement but yet tremendously escalating costs, many of the emergency back-up physicians, in the surgical specialties are dropping out of ER Call Coverage responsibilities because of the high mix of no-pay or low pay patients they are required to treat. Thus, I would like to see the County become much more of a partner with the health care providers in exploring sources of new funds to shore up the Emergency Room back-up coverage.

The physicians are expecting to be paid for some of this time and, admittedly, with less and less physicians willing to provide this service, it means-that. many of them are taking 'call every second, third, or fourth night of the year which will lead to "burnout" and attrition from this community to somewhere else where the demands are less onerous. Thus, I think we should work as partners between County Health Services and private health services to explore all State, Federal and local funding mechanisms to provide emergency physician back-up call capability.

While I am comfortable in reassuring our commitment to continue to care for all patients who present in our Emergency Room and avoiding transfer of any patients we can possibly safely treat at our facility, and while we can put new. capital and physical resources into our emergency capability, the physician and nursing/clinical personnel retention and recruitment will continue to be major challenges unless there is more funding to put into the system to ease the lifestyle vs. burnout and cost of living issues.

I hope that this has provided some insight for you to share with the Board of Supervisors and will alleviate any misinformed or misdirected concerns or challenges as to our meeting our "fair share" of caring for the under-funded patients in our community. I would be happy to make myself available to anyone to further discuss or elaborate on these issues.

Sincerely,

Barry S. Schneider
Chief Executive Officer

Santa Cruz County Medical Society

0236

March 29, 2001

Santa Cruz County Board of Supervisors
701 Ocean Street, 5th floor
Santa Cruz, CA 95060

Re: Report on Hospital Retricted Status

Dear Board Members:

You recently received a report on Hospital Restricted Status and Emergency Department Access in Santa Cruz County. The report was prepared by Vol Ranger, Emergency Medical Services (EMS) Administrator for the Emergency Medical Care Commission (EMCC). The report accurately depicts emergency department restricted status (Code Yellow/Code Red) as an uncommon event in our county. This is in keeping with our experience that the emergency departments in Santa Cruz County do an outstanding job of keeping themselves available to serve the public.

All is not well in emergency services however. The report is also accurate in the depiction of emergency departments which are overburdened, over utilized and under funded. (See sections on Hospital EMS and Emergency Department Volumes.) Physicians providing services in the emergency departments (emergency room physicians and physicians on-call to the ER) are adversely affected by these same issues. The combination of increased workload and dwindling reimbursement (or none at all) has led to increasing difficulty in recruiting physicians willing to serve on the on-call rosters for the hospitals. To quote the report:

> *. ..As the medical staff ages and enters retirement, new physicians are not entering the area to buildpractices because of the cost of living and because reimbursement rates are not comparable to areas like Santa Clara County or San Francisco. The sheer volume ofpatients have increased demands on physicians at the same time that reimbursement has decreased and workloads have increased. Delayed or nonpayment by health plans for emergency services is decreasing physician ability or desire to serve on-call. The EMS Fund (Maddy Fund) that is used to compensate physicians for care provided to the uninsuredpays about 15 cents on the dollar, according to the California Medical Association.*

19065 Portola Drive, Suite M ❖ Salinas, CA 93908 ❖ (831) 426-1137 ❖ Fax: (831) 426-1131

We are troubled and concerned about the current situation, and fear that a crisis is looming - one in which the public will no longer be able to be served by specialists and subspecialists who provide on-call services to the local emergency departments.

Senate Bill 254 (Dunn) has been introduced to help resolve the issues involving emergency on-call services. While the Santa Cruz County Medical Society supports the intent of this legislation, we have concerns that, as currently drafted, it will not fulfill its intended purpose. Some of the issues that we believe need to be further clarified include:

- SB 254 designates the county's Maddy Fund as the vehicle for reimbursing physicians. SCCMS has real concerns about the overly burdensome documentation and administrative responsibilities placed on physicians trying to access this fund.
- The bill does not obligate hospitals to use their allotted funds – in whole or in part – to compensating physicians for providing on-call emergency coverage.
- SCCMS recognizes the fact that there are two primary "problems" with physicians' providing emergency on-call services – compensation and time. SB 254 attempts to relieve just one of them – compensation. There is a great deal of personal time that every physician surrenders when he or she provides on-call coverage. As a result, physicians' quality of life suffers. The state must look at unique and creative ways to incentivize physicians to continue to provide on-call emergency coverage. Compensation is a good first step but it's only the beginning.

We remain hopeful that with work of the California Medical Association, the legislature, and the bill's author, SB 254 will be revised in such a way to alleviate our concerns.

Thank you for your concern regarding emergency medical services, and thank you for your specific attention to the issues regarding physician availability in providing emergency care.

Sincerely,

Rosalind Shorenstein

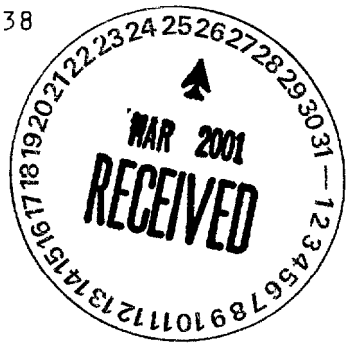
Rosalind Shorenstein, MD
President

19065 Portola Drive, Suite M ❖ Salinas, CA 93908 ❖ (831) 426-1137 ❖ Fax: (831) 426-1131

Dedicated to the Health of the Whole Community

SANTA CLARA VALLEY MEDICAL CENTER

0238



March 15, 2001

Vol Ranger
EMS Administrator
P.O. Box 962 1080 Emeline Ave.
Santa Cruz, CA 95061-0962

Dear Vol Ranger:

I am in receipt of the draft report on hospital-restricted status and emergency department access in Santa Cruz County for the past year.

Either there is an error in your calculations or Santa Cruz is doing something incredibly fantastic. I can not believe that the total time for restricted access for the calendar year 2000 was 71 hours. A year of 365 days x 24 hours per day equals 8760. This means that access was restricted for less than 0.1% of the total year. Taking into account that anything including ER decontamination after a hazmat incident, major trauma, external disaster and the like can cause this, It is incredible to me that our hospitals have been able to maintain such a high level of availability.

There are few areas in the United States that can boasts of such records. You and the entire hospital and EMS community in this county our to be congratulated.

Very truly yours,

Ira Lubell, M.D., M.P.H.
Medical Director

cc: Rama Khalsa, Ph.D.
Santa Cruz HHS
1080 Emeline Avenue
Santa Cruz, CA 9506 1

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county of Santa Cruz 0239

HEALTH SERVICES AGENCY

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EMERGENCY MEDICAL SERVICES

MEMORANDUM

Date: March 14, 200 1

To: Emergency Medical Care Commission

From: Vol Ranger VR
Santa Cruz County EMS Manager

Subject: Report on Hospital Restricted Status (Code Yellow/Code Red) and Emergency Department Access in Santa Cruz County

Introduction

The Emergency Medical Care Commission (EMCC) discussed reports of hospital restricted status at the February 14, 2001 meeting. The following information is presented for follow-up discussion at the March 14, 2001 meeting.

Hospitals are sometimes overwhelmed by circumstances beyond their control and must request a restricted status within the Emergency Medical Services (EMS) system in order to provide for the care and safety of all their patients.

Code Green is a status that means the hospital is open to all ambulance traffic.

Code Yellow is a status that reflects a temporary condition that impacts the reception of certain types of patients. For example, if the Computed Tomography (CT) scanner is out of service for repair, a hospital will advise the Santa Cruz Consolidated Emergency Communication Center (SCCECC) and a medical information page will be disseminated to place the hospital on Code Yellow status. Another example of a Code Yellow condition would be a lack of intensive care or CCU beds when the hospital inpatient monitored beds are at full census. In these cases, ambulances would check with the affected hospital to determine if they should proceed to that location with patients who might require diagnostic imaging or potentially critical patients who might require an inpatient specialty unit bed.

Code Red is a status that reflects a temporary condition in which the Emergency Department (ED) is so busy that reception of an additional critical patient might

adversely affect the care of patients already being treated. For example, an ED which just received several trauma victims from a multiple casualty incident motor vehicle crash might need to declare Code Red until the victims are stabilized. In this case, incoming ambulance traffic would divert to another hospital unless their patient was in extremis and required care for an immediately life-threatening condition such as cardiac and respiratory arrest or occluded airway. All hospitals receive patients in extremis at all times.

The County's EMS Program policy number 1230 details the hospital diversion procedure.

The SCCECC has a procedure in place to monitor Code Yellow/Code Red statuses at four hour intervals and will call the hospital to confirm that they are still on a restricted status or have resumed Code Green status if no additional information has been received four hours after the initial call.

Hospital Restricted Status Review

Each month the Technical Advisory Group (TAG) reviews the Hospital Restricted Status Report prepared by the SCCECC. In Calendar Year 2000, the total number of hours of hospital restricted status in the Santa Cruz EMS System was 71 hours and 32 minutes.

Dominican Hospital was Code Yellow on 5 occasions for a total of 27 hours and 52 minutes. Watsonville Community Hospital was Code Yellow on 3 occasions for a total of 22 hours and 53 minutes, and Code Red on 4 occasions for a total of 20 hours and 47 minutes.

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The results of the TAG review are reflected in the TAG minutes and are disseminated to the Board of Supervisors, the Emergency Medical Care Commission (EMCC) and the Prehospital Advisory Commission (PAC) monthly.

A subcommittee of the PAC held a meeting on ambulance diversion on January 20, 2000 to ensure that adequate communications protocols were in place between the two hospital EDs to assure early and consistent notification of hospital restricted status. Participants from both hospitals met again on March 2, 2001 to review the hospital diversion policy, assure good communication, brainstorm different ways to respond to pressures of decreased resources and increased demand, and to develop a contingency plan for the care and safety of all their patients.

Santa Cruz County has been fortunate not to have experienced any problems as a result of hospital restricted statuses. Other nearby counties have experienced great difficulties. At the last Monterey County Medical Advisory Committee meeting, their EMS Medical Director reminded the Monterey County hospitals that restricted status was a privilege, not a right, and that if abuse occurred he would rescind the privilege. In Santa Clara County, three hospitals have received their third and final warning about the use of hospital restricted status and are subject to peer review of plans to correct their use; if their corrective actions are not accepted by the peer review committee, they will be unable to go on restricted status for sixty days.

This year, San Francisco General Hospital has been forced to divert ambulance patients 3 1% of the time. In national settings, in November 2000, 8 Cleveland hospitals went on diversion 57 times in one month. Twenty-seven Boston EDs closed for a total of 63 1 hours in the same month. Kentucky had over 2,000 ambulance diversions last year.

Hospital Emergency Medical Services

Emergency Departments (EDs) are hospital departments providing immediate initial evaluation and treatment of acutely ill or injured patients on a 24-hour basis. EDs have evolved into the principal safety net for health care, providing universal access to emergency, acute, chronic, and episodic medical care for all persons regardless of their insurance coverage or lack of coverage.

The idea of EDs serving as a safety net derives from the philosophy of the healing professions and the societal view that emergency care is an essential public service. In addition, under state and federal law, everyone who presents to an emergency department must be provided with emergency care. The Health Maintenance Organization (HMO) model has failed to reduce the number of uninsured, and emergency medical care continues to be the health service in greatest demand by the public, insured or not. Uninsured patients are continuing to increase and use the emergency department for their primary source of medical care. Because of low bed availability in intensive care and other units, patients remain in the emergency department for longer periods of time. High acuity patients, primary care patients whose lack of routine care has exacerbated their problems into higher acuities, nursing shortages, ancillary care staff shortages, very low reimbursement rates, slow payment, and downgrading of service charges has damaged the emergency care system.

Nationwide, the result has been emergency department overcrowding, long waits, ambulance diversions, a lack of specialty physicians for on-call rosters, and facilities which downgrade services or close emergency departments.

Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA, the federal "anti-dumping" law, requires that hospitals which receive Medicare and Medicaid payments must provide a medical screening examination to all individuals seeking emergency services prior to inquiring about the means of payment. Treatment must meet minimum health care quality standards. Unstable patients can be transferred to another facility if the transfer is in the best interests of the patient, and hospitals with specialized facilities are required to receive these patients from hospitals which lack specialized capabilities.

Emergency Department Volumes

In 1999, Dominican Hospital reported 36,250 ED visits. 6600 of these ED visits were uninsured (18.21%). Dominican Hospital ED visits also included 1,682 Medi-Cal (4.64%) and 892 County indigent (2.46%) visits. The average loss per ED visit was -$51.77 for a ED total annual loss of -$1,879,769 (Source: Office of Statewide Health Planning and Development, Hospital Financial Data Disclosure Report 1998-99.)

In 1999, Watsonville Community Hospital reported 20,983 ED visits. 1704 of these ED visits were uninsured (8.12%). Watsonville Community Hospital ED visits also included 4,794 Medi-Cal (22.85%) and 2,660 County indigent (12.68%) visits. The average loss per ED visit based on OSHPOD data was -$53.18 for an ED total annual loss of -$1, 115,876 (Source: Barry Schneider amendments to incomplete Office of Statewide Health Planning and Development, Hospital Financial Data Disclosure Report 1998-99 figures which included only one quarter of data prior to the sale of Watsonville Hospital.)

Statewide, ED losses totaled -$316,576,503.

Physician Recruitment and Specialty Physicians On-Call

The purpose of the on-call roster is to ensure that the emergency department is prospectively aware of which specialty physicians are available to stabilize persons with emergency conditions. The 24hour/7 day roster includes specialists and sub-specialists represented on the medical staff.

Hospitals are experiencing increasing challenges recruiting physicians. As the medical staff ages and enters retirement, new physicians are not entering the area to build practices because of the cost of living and because reimbursement rates are not comparable to areas like Santa Clara County or San Francisco. The sheer volume of patients has increased demands on physicians at the same time that reimbursement has decreased and workloads have increased. Delayed or non-payment by health plans for emergency services is decreasing physician ability or desire to serve on-call. The EMS Fund (Maddy Fund) that is used to compensate physicians for care provided to the uninsured pays about 15 cents on the dollar, according to the California Medical Association.

Policy for Hospital Services Downgrade or Closure

The EMCC approved the Santa Cruz County "Impact Evaluation Regarding Hospital Emergency Services Downgrade or Closure Policy" at its October 11, 2000 meeting. This policy is required by the state Health and Safety Code Section 1300 (c) and specifies the criteria the County will use in conducting an impact evaluation of the effect of a downgrade or closure of any emergency services in County hospitals. Impact evaluation criteria include service area, Base Hospital designation, trauma care, specialty services, and patient volume. Public hearings are required. This policy was put in place to delineate the process should such an impact evaluation ever be needed.

Recently a hospital in Humboldt County abruptly ceased emergency department services without notice or process. Throughout California, hospitals are shutting down or scaling back emergency services because of decreased reimbursement, downgrading of service charges, inability to recruit physicians, shortages of nurses, and lack of specialty beds.

Solutions

Santa Cruz County hospitals are meeting to promote good communication and develop contingency plans to provide hospital ED access when faced with pressures of increased patient demand and limited physician and nurse resources. The Prehospital Advisory Committee will review the EMS Program policy on hospital diversion. The Emergency Medical Care Commission and the Health Services Agency are tracking legislative efforts to improve trauma and EMS care and setting advocacy priorities.

Broader solutions to the problems of Emergency Department access must include better access to outpatient care for patients, advocacy for legislation to improve coverage for the under-insured and uninsured, increased hospital specialty bed capacities, increased numbers of critical care nurses and increased specialty physician coverage, better reimbursement, and public education about the appropriate use of the emergency department.

BEFORE THE BOARD OF SUPERVISORS
OF THE COUNTY OF SANTA CRUZ, CALIFORNIA

RESOLUTION No.

On the motion of Supervisor
Duly seconded of Supervisor
The following resolution is adopted

RESOLUTION SUPPORTING THE PASSAGE OF SENATE BILL 254, ASSEMBLY BILL 686 AND ASSEMBLY BILL 687

WHEREAS, Emergency Departments serve as the safety net for health care, providing universal access to emergency, acute, chronic, and episodic medical care for all persons; and

WHEREAS, emergency medical care continues to be the health service in greatest demand by the public; and

WHEREAS, the emergency care system has been damaged by the increase in high acuity patients, primary care patients with no routine source of care, nursing shortages, ancillary care staff shortages, low reimbursement rates, the impact of uninsured patients, and the challenges of recruiting physicians for staff and specialty on-call positions; and

WHEREAS, Senate Bill 254 would appropriate State General Fund dollars to provide reimbursement for initial stabilizing medical services, implement a critical emergency service provider program, and establish the Critical Emergency Service Facility Fund; and

WHEREAS, Assembly Bill 686 would establish a Trauma Care Fund in the State Treasury to allocate General Fund dollars to local EMS agencies that operate eligible trauma care systems; and

WHEREAS, Assembly Bill 687 would create the EMS and Trauma Care Fund to pay for uncompensated care provided by trauma facilities.

NOW, THEREFORE, BE IT RESOLVED that the Santa Cruz County Board of Supervisors support SB 254, AB 686, and AB 687 to decrease the impact of uninsured patients on the emergency care system and increase support for on-call specialty physicians.

PASSED AND ADOPTED, by the Board of Supervisors of the County of Santa Cruz, State of California, this 24th day of April, 20001 by the following vote:

AYES: SUPERVISORS
NOES: SUPERVISORS
ABSTAIN: SUPERVISORS

_____
Chair of the Board

ATTEST: _____
Clerk of the Board

APPROVED AS TO FORM: _____
County Counsel

CC: CAO
Auditor-Controller
County Counsel
HSA Administration

BILL NUMBER: AB 687 INTRODUCED 0246
BILL TEXT

INTRODUCED BY Assembly Members Thomson and Hertzberg

FEBRUARY 22, 2001

An act to add Article 5 (commencing with Section 1798.190) to Chapter 2.6 of Division 2.5 of the Health and Safety Code, and to amend Section 1464 of the Penal Code, relating to the State Penalty Fund.

LEGISLATIVE COUNSEL'S DIGEST

AB 687, as introduced, Thomson. State penalty funds.

Existing law permits each county to establish an emergency medical services program in accordance with various requirements.

Existing law establishes the State Penalty Fund, the moneys in which are distributed on a monthly basis to various state funds, including the Driver Training Penalty Assessment Fund.

This bill would create the Emergency Medical Services and Trauma Care Fund to pay for uncompensated care provided by trauma facilities. This bill would further provide that the Driver Training Penalty Assessment Fund would no longer receive a percentage of the money in the State Penalty Fund each month, and that instead the Emergency Medical Services and Trauma Care Fund would receive the percentage of money that the Driver Training Penalty Fund receives each month.

The bill would prohibit any county from receiving moneys from the fund unless the county has an emergency medical services program.

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

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

SECTION 1. Article 5 (commencing with Section 1798.190) is added to Chapter 2.6 of Division 2.5 of the Health and Safety Code, to read:

Article 5. Emergency Medical Services and Trauma Care Fund

1798.190. (a) There is hereby created in the State Treasury the Emergency Medical Services and Trauma Care Fund, the moneys in which may, upon appropriation by the Legislature, be expended for the purposes of funding uncompensated care.

(b) No moneys may be received from the Emergency Medical Services and Trauma Care Fund by a county unless the county has an emergency medical services program established pursuant to Section 1797.200.

SEC. 2. Section 1464 of the Penal Code is amended to read:

1464. (a) Subject to Chapter 12 (commencing with Section 76000) of Title 8 of the Government Code, there shall be levied a state penalty, in an amount equal to ten dollars ($10) for every ten dollars ($10) or fraction thereof, upon every fine, penalty, or forfeiture imposed and collected by the courts for criminal offenses, including all offenses, except parking offenses as defined in subdivision (i) of Section 1463, involving a violation of a section of the Vehicle Code or any local ordinance adopted pursuant to the Vehicle Code. Any bail schedule adopted pursuant to Section 1269b may include the necessary amount to pay the state penalties established by this section and Chapter 12 (commencing with Section 6) of Title 8 of the Government Code for all matters where a

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personal appearance is not mandatory and the bail is posted primarily to guarantee payment of the fine.

(b) Where multiple offenses are involved, the state penalty shall be based upon the total fine or bail for each case. When a fine is suspended, in whole or in part, the state penalty shall be reduced in proportion to the suspension.

(c) When any deposited bail is made for an offense to which this section applies, and for which a court appearance is not mandatory, the person making the deposit shall also deposit a sufficient amount to include the state penalty prescribed by this section for forfeited bail. If bail is returned, the state penalty paid thereon pursuant to this section shall also be returned.

(d) In any case where a person convicted of any offense, to which this section applies, is in prison until the fine is satisfied, the judge may waive all or any part of the state penalty, the payment of which would work a hardship on the person convicted or his or her immediate family.

(e) After a determination by the court of the amount due, the clerk of the court shall collect the penalty and transmit it to the county treasury. The portion thereof attributable to Chapter 12 (commencing with Section 76000) of Title 8 of the Government Code shall be deposited in the appropriate county fund and 70 percent of the balance shall then be transmitted to the State Treasury, to be deposited in the State Penalty Fund, which is hereby created, and 30 percent to remain on deposit in the county general fund. The transmission to the State Treasury shall be carried out in the same manner as fines collected for the state by a county.

(f) The moneys so deposited in the State Penalty Fund shall be distributed as follows:

(1) Once a month there shall be transferred into the Fish and Game Preservation Fund an amount equal to 0.33 percent of the state penalty funds deposited in the State Penalty Fund during the preceding month, except that the total amount shall not be less than the state penalty levied on fines or forfeitures for violation of state laws relating to the protection or propagation of fish and game. These moneys shall be used for the education or training of department employees which fulfills a need consistent with the objectives of the Department of Fish and Game.

(2) Once a month there shall be transferred into the Restitution Fund an amount equal to 32.02 percent of the state penalty funds deposited in the State Penalty Fund during the preceding month. Those funds shall be made available in accordance with Section 13967 of the Government Code.

(3) Once a month there shall be transferred into the Peace Officers' Training Fund an amount equal to 23.99 percent of the state penalty funds deposited in the State Penalty Fund during the preceding month.

(4) Once a month there shall be transferred into the Driver Training Penalty Assessment Fund, Emergency *Medical Services and* Trauma *Care Fund* an amount equal to 25.70 percent of the state penalty funds deposited in the State Penalty Fund during the preceding month.

(5) Once a month there shall be transferred into the Corrections Training Fund an amount equal to 7.88 percent of the state penalty funds deposited in the State Penalty Fund during the preceding month. Money in the Corrections Training Fund is not continuously appropriated and shall be appropriated in the Budget Act.

(6) Once a month there shall be transferred into the Local Public Prosecutors and Public Defenders Training Fund established pursuant to Section 11503 an amount equal to 0.78 percent of the state penalty funds deposited in the State Penalty Fund during the preceding month. The amount so transferred shall not exceed the sum of eight hundred fifty thousand dollars ($850,000) in any fiscal year. The remainder in excess of eight hundred fifty thousand dollars ($850,000) shall be transferred to the Restitution Fund.

(7) Once a month there shall be transferred into the Victim-Witness Assistance Fund an amount equal to 8.64 percent of the state penalty funds deposited in the State Penalty Fund during the

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preceding month.

(8) (A) Once a month there shall be transferred into the Traumatic Brain Injury Fund, created pursuant to Section 4358 of the Welfare and Institutions Code, an amount equal to 0.66 percent of the state penalty funds deposited into the State Penalty Fund during the preceding month. However, the amount of funds transferred into the Traumatic Brain Injury Fund for the 1996-97 fiscal year shall not exceed the amount of five hundred thousand dollars ($500,000). Thereafter, funds shall be transferred pursuant to the requirements of this section. Notwithstanding any other provision of law, the funds transferred into the Traumatic Brain Injury Fund for the 1997-98, 1998-99, and 1999-2000 fiscal years, may be expended by the State Department of Mental Health, in the current fiscal year or a subsequent fiscal year, to provide additional funding to the existing projects funded by the Traumatic Brain Injury Fund, to support new projects, or to do both.

0248

(B) Any moneys deposited in the State Penalty Fund attributable to the assessments made pursuant to subdivision (i) of Section 27315 of the Vehicle Code on or after the date that Chapter 6.6 (commencing with Section 5564) of Part 1 of Division 5 of the Welfare and Institutions Code is repealed shall be utilized in accordance with paragraphs (1) to (8), inclusive, of this subdivision.

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BILL NUMBER: AB 686 INTRODUCED
BILL TEXT

0249

INTRODUCED BY Assembly Members Hertzberg and Thomson

FEBRUARY 22, 2001

An act to amend Section 1798.162 of, and to add Chapter 2.75 (commencing with Section 1797.99) to Division 2.5 of, the Health and Safety Code, relating to emergency medical services, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 686, as introduced, Hertzberg. Emergency medical services: trauma centers: funding.

Existing law authorizes each county to develop an emergency medical services (EMS) program. Existing law authorizes a local EMS agency to implement a trauma care system only if the system conforms with regulations adopted by the state Emergency Medical Services Authority, and a plan developed by the trauma care system and submitted to the authority in accordance with those regulations. Existing law also permits the Santa Clara County Emergency Medical Services Agency to implement a trauma care system prior to the adoption of the authority's regulations, in accordance with specified conditions.

This bill would establish the Trauma Care Fund in the State Treasury, and would appropriate an unspecified sum from the General Fund to the fund, to be allocated by the authority to local EMS agencies that operate eligible trauma care systems. The bill would require each local EMS agency receiving funds pursuant to the bill, on March 1, 2002, and on each March 1 thereafter, to file a report with the authority regarding the distribution of funds pursuant to the bill.

This bill would eliminate the above provisions relating to the Santa Clara County Emergency Medical Services Authority. The bill would instead provide that a local emergency services agency that implements a trauma care system pursuant to the regulations and plan described above shall be eligible to receive funding in accordance with the funding provisions established in the bill. The bill would provide that it is not to be construed to require any local emergency medical services agency to include a designated trauma care system within its boundaries.

Vote: 2/3. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares as follows:

(a) Trauma centers save lives by providing immediate coordination of highly specialized care for the most life-threatening injuries.

(b) Trauma centers save lives, and also save money, because access to trauma care can mean the difference between full recovery from a traumatic injury and serious disability necessitating expensive long-term care.

(c) Trauma centers do their job most effectively as part of a system that includes a local plan with a means of immediately identifying trauma cases and transporting those patients to the nearest trauma center.

(d) Trauma care is an essential public service.

(e) It is the intent of the Legislature in enacting this act to

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promote access to trauma care by ensuring the availability of services through EMS agency designated trauma centers, and by establishing an adequately funded statewide trauma system that is based on local planning and administration. 0250

SEC. 2. Chapter 2.75 (commencing with Section 1797.99) is added to Division 2.5 of the Health and Safety Code, to read:

CHAPTER 2.75. TRAUMA CARE FUND

1797.99. (a) (1) The Trauma Care Fund is hereby created in the State Treasury, from which moneys shall be allocated by the authority to local emergency medical services (EMS) agencies that implement a trauma care system meeting the requirements of Section 1798.162. Moneys in the Trauma Care Fund shall be distributed to agencies with designated trauma centers located in their service areas.

(2) The sum of ____ dollars ($) is hereby appropriated from the General Fund to the Trauma Care Fund for the purposes set forth in this chapter.

(b) (1) Local EMS agencies shall disburse funds received from the Trauma Care Fund to EMS agency-designated trauma centers. Both public and private hospitals designated as trauma centers shall be eligible for funding.

(2) ____ percent of funds shall be distributed to trauma centers to assist in maintaining trauma center viability. The remaining funds shall be distributed to trauma centers for reimbursement for uninsured patients meeting criteria defined by local EMS agencies pursuant to subdivision (a) of Section 1798.160 for whom data has been appropriately submitted to the local EMS agency's trauma registry.

(c) Local EMS agencies may reserve a maximum of one percent of their allocation pursuant to this section to assist in developing and maintaining a trauma plan.

(d) On March 1, 2002, and on each March 1 thereafter, each local EMS agency receiving funds pursuant to this section shall file a report with the authority regarding the agency's distribution of funds pursuant to this section.

SEC. 3. Section 1798.162 of the Health and Safety Code is amended to read:

1798.162. (a) A local emergency medical services agency may implement a trauma care system only if the system meets the minimum standards set forth in the regulations for implementation established by the authority and the plan required by Section 1797.257 has been submitted to, and approved by, the authority. Prior to submitting the plan for the trauma care system to the authority, a local emergency medical services agency shall hold a public hearing and shall give adequate notice of the public hearing to all hospitals and other interested parties in the area proposed to be included in the system. This subdivision does not preclude a local EMS agency from adopting trauma care system standards which are more stringent than those established by the regulations.

(b) Notwithstanding subdivision (a) or any other provision of this article, the Santa Clara County Emergency Medical Services Agency may implement a trauma care system prior to the adoption of regulations by the authority pursuant to Section 1798.161. If the Santa Clara County Emergency Medical Services Agency implements a trauma care system pursuant to this subdivision prior to the adoption of those regulations by the authority, the agency shall prepare and submit to the authority a trauma care system plan which conforms to any regulations subsequently adopted by the authority. ***A local emergency services agency that implements a trauma care system pursuant to subdivision (a) shall be eligible to receive funding in accordance with Chapter 2.75 (commencing with Section 1797.99).***

(c) ***Nothing in this section shall be construed to require the service area of any local emergency medical services agency to include a designated trauma center within its boundaries.***

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0251

BILL NUMBER: SB 254 AMENDED 0252
BILL TEXT

AMENDED IN SENATE MARCH 28, 2001

INTRODUCED BY Senator Dunn *Senators Dunn and* Speier
(Coauthors: Senators Escutia, *Figueroa,* Johannessen, *Romero, Sher,* and *Vincent)*
(Coauthors: *Assembly Members Alquist, Bates, Koretz, Robert Pacheco, Richman, Runner,* and Strom-Martin)

FEBRUARY 15, 2001

An act to amend Sections 1797.98a, 1797.9833, 1797.100, 1797.101, 1797.107, 1797.108, 1797.200, 1797.254, and 1798.161 of, to add Sections 1275.9, 1367.13, 1797.87, 1797.115, and 1797.251 to, and to repeal Section 1798.166 of, the Health and Safety Code, to add Section 10126.7 to the Insurance Code, and to amend Section 14106.6 of, and to add Section 14106.65 to, the Welfare and Institutions Code, relating to emergency services, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 254, as amended, Dum. Emergency medical services.

Existing law provides for the licensure and regulation of health facilities, including the provision of emergency medical services and care by those facilities.

This bill would require the State Department of Health Services, upon consultation with the Emergency Medical Services Authority and local EMS agencies, to revise regulations concerning the categorization and licensure of emergency departments on or before July 1, 2002.

Existing law regulates health care service plans and certain insurers that cover hospital, medical, and surgical expenses, and providers, in the reimbursement of claims of providers. Existing law sets forth requirements with respect to the reimbursement of claims for services rendered to a patient who is provided specified emergency services and care.

This bill would set forth additional requirements with respect to the reimbursement for initial stabilizing medical services, as defined, provided in response to medical emergencies.

By changing the definition of a crime relative to health care service plans, the bill would impose a state-mandated local program.

Under existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, the authority is responsible for the coordination and integration of state activities concerning emergency medical services and personnel.

This bill would require the authority to implement a critical emergency service provider program. The program would require a local EMS agency to designate within a county a minimum of one *sufficient number. of* emergency department *departments* or designated trauma center *centers* as a critical emergency service facility *facilities*. The bill would establish the Critical Emergency Service *Services* Facility Fund, the moneys from which, upon appropriation, would be expended by the authority for purposes of administering and funding the program in each county.

The bill would require the authority and the department to adopt, by December 31, 2002, certain regulations related to ensuring minimum

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standards for a system of coordinated emergency medical care.

Existing law authorizes each county to designate an emergency medical services agency (local EMS agency) for the establishment and administration of an emergency medical services program in the county, and authorizes the establishment by a county of a Maddy Emergency Medical Services (EMS) Fund for this purpose. The source of moneys in the fund are penalty assessments each county levies upon fines, penalties, and forfeitures imposed and collected by the courts for criminal offenses. A county establishing a fund under this provision is required to report certain information related to the fund to the Legislature through the authority.

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This bill would require every county to designate a local EMS agency and establish a fund under these provisions.

Existing law provides. for specified percentage distributions of the money in a Maddy EMS Fund to certain physicians and surgeons, to hospitals providing disproportionate trauma and emergency medical services, and for other emergency medical services purposes as determined by each county.

This bill would delete the distributions to the hospitals and revise the distribution formula upon the implementation and funding of the critical emergency services program provided under this bill.

Existing law sets forth requirements of local EMS agencies, including the submission of an annual emergency medical services plan.

The bill would require the local EMS agency to evaluate and periodically inspect hospitals within its jurisdiction pursuant to regulations established by the authority. The bill would add to the requirements of a local EMS agency with regard to the submission of the annual emergency medical services plan.

By increasing the duties of counties and local EMS agencies, this bill would impose a state-mandated local program.

Existing law provides for the Medi-Cal program, which is administered by the department, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

This bill would specify that initial stabilizing medical services in response to medical emergencies are a covered benefit under the Medi-Cal program.

Existing law requires the director to establish and update annually a rate schedule of reimbursement under the Medi-Cal program for paramedic services based on reasonable cost standards of the department.

This bill would instead require the director to establish and update annually separate specified schedules of reimbursement for (1) advanced life support and basic life support ambulance transportation services and (2) advanced life support and basic life support initial stabilizing medical services.

The bill would require *the Emergency* Medical *Services* Authority *to conduct an evaluation of this bill and report* to *certain committees of the Legislature by April 1, 2004.*

The bill would appropriate $200,000,000 from the General Fund to the authority for purposes of the critical emergency services program required under the bill. The bill would appropriate $100,000,000 from the General Fund to the authority to distribute to counties as provided under the bill.

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, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

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

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be made pursuant to the statutory provisions noted above.
Vote: 2/3. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

0254

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

SECTION 1. (a) This act shall be known and may be cited as the Essential Trauma and Emergency Care Act.

(b) The Legislature finds and declares all of the following:

(1) Access to trauma and emergency care is hindered by a decrease in the availability of trauma and emergency care services statewide, hospital diversions, a lack of on-call medical specialists, and an inability to provide advanced life support services by first responder agencies which could result in lower institutional costs.

(2) Eighty percent of licensed emergency departments reported losing money during the 1998-99 fiscal year. Losses for those hospitals exceeded $315 million statewide.

(3) Losses to physicians providing emergency and on-call specialty services exceeded $100 million during the 1998-99 fiscal year.

(4) Trauma and emergency care is an essential public service.

SEC. 2. Section 1275.9 is added to the Health and Safety Code, to read:

1275.9. The department, upon consultation with the Emergency Medical Services Authority and local EMS agencies, shall revise regulations concerning the categorization and licensure of emergency departments on or before July 1, 2002. These regulations shall ensure a minimum level of service for critical emergency services, including on-call physician services, provided by an *a* critical emergency service facility, as defined in Section 1797.87.

SEC. 3. Section 1367.13 is added to the Health and Safety Code, to read:

1367.13. (a) Every health care service plan issued, amended, or renewed on or after January 1, 2002, shall contain a provision requiring that reimbursement be provided for initial stabilizing medical services provided to subscribers and enrollees in response to medical emergencies.

(b) For purposes of this section, "initial stabilizing medical services" means that component of emergency medical services that is provided by the EMT-Is, EMT-IIs, and EMT-Ps who first arrive on the scene of the medical emergency and provide any emergency medical services needed to stabilize the medical emergency, other than transport services.

(c) The reimbursement for initial stabilizing medical services pursuant to this section shall be provided to the EMS provider of the services. This reimbursement shall be in addition to any reimbursement that might be provided to the providers of transportation services.

SEC. 4. Section 1797.87 is added to the Health and Safety Code, to read:

1797.87. "Critical emergency service facility" means an emergency department that may include a designated trauma center, designated by a local EMS agency as provided in subdivision (a) of Section 1797.251, that is necessary to meet the needs of the community by maintaining the availability of trauma and emergency services.

SEC. 5. Section 1797.98a of the Health and Safety Code is amended to read:

1797.98a. (a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical *Services* (EMS) Fund.

(b) Each county shall establish an emergency medical services fund. The money in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its emergency medical services fund administered by the state. Costs of administering the fund shall be reimbursed by the

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fund, up to 10 percent of the amount of the fund. All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section.

(c) The fund shall be utilized to reimburse physicians and surgeons ___nd hospit n l n except as provided in paragraph (2), *and hospitals* for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county ___, as follows.

___(1) After . *After* costs of administration, 58 percent of the balance of the money in the fund shall be distributed to physicians and surgeons for emergency services provided by all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic or comprehensive emergency services up to the time the patient is stabilized, 25 percent of the balance of the fund shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services, and 17 percent of the balance of the fund shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers.

___(2) Upon the implementation and funding of t h e critical emergency services program for purposes of Section 1 7 9 7 251 the fund shall be distributed pursuant to this paragraph rather than paragraph (1). After costs of administration, 80 percent of the balance of the money in the fund shall be distributed to physicians and surgeons, as described in paragraph (1), and the remaining balance of the fund shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers.

(d) The continuing source of the money in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 of the Government Code.

(e) A General Fund augmentation may supplement any continuing source of money.

SEC. 6. Section 1797.9833 of the Health and Safety Code is amended to read:

1797.98b. (a) On January 1, each county shall report to the Legislature on the implementation and status of the *Maddy* Emergency Medical Services Fund. The report shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the *Maddy* Emergency Medical Services Fund.

(2) The fund balance and the amount of moneys disbursed under the program to physicians and for other emergency medical services purposes.

(3) The pattern and distribution of claims and the percentage of claims paid to those submitted.

(4) The amount of moneys available to be disbursed to physicians, the dollar amount of the total allowable claims submitted, and the percentage at which ___such these claims were reimbursed.

(5) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(b) (1) Each county, upon request, shall make available to any member of the public the report required under subdivision (a).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and hospitals that have received reimbursement from the *Maddy* Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual basis.

SEC. 7. Section 1797.100 of the Health and Safety Code is amended to read:

1797.100. There is in ___the state government in the California Health and Human Services Agency, the Emergency Medical Services Authority.

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SEC. 8. Section 1797.101 of the Health and Safety Code is amended to read:

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1797.101. The Emergency Medical Services Authority shall be headed by the Director of the Emergency Medical Services Authority who shall be appointed by the Governor upon nomination by the Secretary of the California Health and Human Services Agency. The director shall be a physician and surgeon licensed in California pursuant to the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and who has substantial experience in the practice of emergency medicine.

SEC. 9. Section 1797.107 of the Health and Safety Code is amended to read:

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

(b) The authority and the department shall, jointly, adopt regulations to ensure minimum standards for a system of coordinated care by emergency departments, trauma centers, emergency transport services, and nontransport advanced life support services by December 31, 2002.

SEC. 10. Section 1797.108 of the Health and Safety Code is amended to read:

1797.108. (a) Subject to the availability of funds appropriated therefor, the authority may contract with local EMS agencies to provide funding assistance to those agencies for planning, organizing, implementing, and maintaining regional emergency medical services systems.

(b) In addition, the authority may provide special funding to multicounty EMS agencies that serve rural areas with extensive tourism, as determined by the authority, to reduce the burden on the rural EMS agency of providing the increased emergency medical services required due to that tourism.

(c) (1) Each local or multicounty EMS agency receiving funding pursuant to this section shall make a quarterly report to the authority on the functioning of the local EMS system. The authority may continue to transfer appropriated funds to the local EMS agency upon satisfactory operation.

(2) Any single or multicounty EMS agency receiving funds for critical emergency services shall report quarterly to the authority the disbursement of funds utilizing a simplified form developed by the authority.

(d) Subject to the availability of funds appropriated therefor, the authority shall annually contract with single or multicounty EMS agencies to provide funding assistance to those agencies that designate critical emergency service facilities pursuant to subdivision (a) of Section 1797.251.

SEC. 11. Section 1797.115 is added to the Health and Safety Code, to read:

1797.115. (a) The Critical Emergency Services Facility Fund is hereby created in the State Treasury. The moneys in the fund, upon appropriation by the Legislature, shall be expended by the authority to implement a critical emergency service program in accordance with Section 1797.251.

(b) The total amount of funding for services authorized by this section shall not exceed two hundred million dollars ($200,000,000) annually.

(c) The authority shall allocate funds from the fund to each local EMS agency for designated critical emergency service facilities according to the following formula:

(1) Forty percent of the fund shall be distributed evenly among all counties with a designated critical emergency service facility.

(2) Sixty percent of the fund shall be distributed according to

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population statistics as published by the Department of Finance

local EMS agency that has an approved plan for coordinated emergency and trauma *care, including designated critical* emergency *service facilities. Distribution shall be based on a statewide assessment by the authority of need after the authority reviews and approves local EMS agency designations and plans. The authority shall establish an advisory body comprised of representatives from hospital,* physician, nurse, *and paramedic associations to* review *local EMS agency plans.* 0257

(d) **A local EMS agency may not use more than 10 percent of funds allocated to the agency for purposes of this section for the administration of its critical emergency service program.**

(e) **(1) A hospital, if designated as** an **a critical emergency service facility, may receive funding for the provision of emergency and trauma services from the local EMS agency. These funds may be used only for the continuation of critical emergency services and trauma care and** may **include reimbursements for on-call physician specialists.**

(2) The authority shall establish a funding formula to ensure that emergency care services at a designated hospital are maintained. Factors to be considered in developing the funding formula shall include but not be limited to all of the following:

(A) Geographic isolation.

(B) Number of 911 transports.

(C) Number of paramedic contacts per month.

(D) Number of trauma patients received per month.

(E) Specialty emergency services provided by the hospital.

(F) Number of county indigent visits per month.

(3)

(2) A hospital receiving funding under this section shall demonstrate efficiency in operations to ensure the provision of emergency services to the public based upon minimum standards as established by regulation.

(4)

(3) **In order to receive funding under this section, a hospital shall report to both the local EMS agency and the authority the number of patients served and the cost of providing services.**

SEC. 12. Section 1797.200 of the Health and Safety Code is amended to read:

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

SEC. 13. Section 1797.251 is added to the Health and Safety Code, to read:

1797.251. (a) A local EMS agency shall designate a minimum of one *sufficient* **number** *of* **hospital emergency** department *departments,* **or designated trauma** center as a critical emergency service facility *centers as critical emergency service facilities* **necessary to meet the needs of the community. Any acute care hospital shall be eligible to receive designation as a critical emergency service facility.**

(b) ***A local EMS agency shall establish a public process to designate hospitals as critical emergency service facilities. Local EMS agencies shall consult*** **with** ***local interest*** **groups,** ***including groups that represent consumers, hospitals, physicians,*** **nurses,** ***and paramedics. Factors to be considered in the designation of a hospital as*** **a** ***critical*** **emergency** ***service facility shall include, but not be limited to, all of the following:***

(1) Geographic isolation.

(2) **Number** ***of county indigent, uninsured, and Medi-Cal visits*** **per** ***month.***

(3) Specialty emergency services provided by the hospital.
(4) Number of emergency department visits *per* month.
(5) Number of 911 transports.

0258

(c) A local EMS agency shall evaluate *survey and study* the capabilities of hospitals within its jurisdiction to meet emergency services and care needs and periodically review the hospital's capability based upon regulations established by the authority.

(c)

(d) A local EMS agency shall periodically evaluate the service demand of the community and the ability of providers of emergency services and care to meet the demand.

SEC. 14. Section 1797.254 of the Health and Safety Code is amended to read:

1797.254. (a) Local EMS agencies shall annually submit, no later than January 31 of each year, an emergency medical services plan for the EMS area to the authority, according to EMS Systems, Standards, and Guidelines established by the authority.

(b) The plan shall include, but not be limited to, all of the following:

(1) A designation of a minimum of one hospital emergency department or designated trauma center as a critical emergency service facility *with the reasons* for *each* designation *and the criteria used in making each designation*

(2) A process for the coordination of the emergency care and trauma system.

(3) A process for the distribution of funds to designated facilities, including a percentage allocation to each facility.

(4) Information requested from and submitted by hospitals, physicians, ambulance services, and first responders concerning the prior fiscal year that shall include, but not be limited to, the number of patients receiving emergency services and care and the cost of providing the care.

(c) The requirements of subdivision (b) shall become operative January 1, 2003.

SEC. 15. Section 1798.161 of the Health and Safety Code is amended to read:

1798.161. (a) The authority shall adopt regulations specifying minimum standards for the implementation of trauma care systems. These regulations shall provide specific requirements for the care of trauma cases and shall ensure that the trauma care system is fully coordinated with all elements of the existing emergency medical services system. The regulations shall be adopted as provided in Section 1799.50, and shall include, but not be limited to, all of the following:

(I) Prehospital care management guidelines for triage and transportation of trauma cases.

(2) Flow patterns of trauma cases and geographic boundaries regarding trauma and nontrauma cases.

(3) The number and type of trauma cases necessary to assure that trauma facilities will provide quality care to trauma cases referred to them.

(4) The resources and equipment needed by trauma facilities to treat trauma cases.

(5) The availability and qualifications of the health care personnel, including physicians and surgeons, treating trauma cases within a trauma facility.

(6) Data collection regarding system operation and patient outcome.

(7) Periodic performance evaluation of the trauma system and its components.

(b) The authority may grant an exception to a portion of the regulations adopted pursuant to subdivision (a) upon substantiation of need by a local EMS agency that, as defined in the regulations, compliance with that requirement would not be in the best interests of the persons served within the affected local EMS area.

SEC. 16. Section 1798.166 of the Health and Safety Code is repealed.

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SEC. 17. Section 10126.7 is added to the Insurance Code, to read:

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10126.7. (a) Every policy of disability insurance issued, amended, or renewed on or after January 1, 2002, that covers hospital, medical, or surgical benefits shall contain a provision requiring that reimbursement be provided for initial stabilizing medical services provided to any insured or other person covered in response to medical emergencies.

(b) For purposes of this section, "initial stabilizing medical services" means that component of emergency medical services that is provided by the EMT-Is, EMT-IIs, and EMT-Ps who first arrive on the scene of the medical emergency and provide any emergency medical services needed to stabilize the medical emergency, other than transport services.

(c) The reimbursement for initial stabilizing medical services pursuant to this section shall be provided to the EMS provider of the services. This reimbursement shall be in addition to any reimbursement that might be provided to the providers of transportation services.

SEC. 18. Section 14106.6 of the Welfare and Institutions Code is amended to read:

14106.6. (a) The director shall establish and update annually a separate schedule of reimbursement for advanced life support and basic life support ambulance transportation services that are based upon reasonable cost standards of the department and that are not less than 60 percent of the rate applicable to the medicare median allowable charge for the current year for all California providers of advanced life support and basic life support ambulance transportation services.

(b) Notwithstanding any other provision of law, and to the extent federal financial participation is available, any city, county, or special district providing paramedic services as set forth in subdivision (r) of Section 14132, shall reimburse the Health Care Deposit Fund for the state costs of paying the medical claims. Funds allocated to the county from the County Health Services Fund pursuant to former Part 4.5 (commencing with Section 16700) of Division 9 of the Welfare and Institutions Code, as that part read before January 1, 2000, may be utilized by the county or city to make the reimbursement. Nothing in this chapter shall be construed to require a city, county, or special district providing, or contracting for, paramedic services as part of a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code, to seek Medi-Cal reimbursement for services rendered to eligible Medi-Cal recipients.

(c) This section shall be implemented only to the extent federal financial participation is available.

SEC. 19. Section 14106.65 is added to the Welfare and Institutions Code, to read:

14106.65. (a) Reimbursement shall be made pursuant to this chapter for initial stabilizing medical services in response to medical emergencies. The director shall establish and annually update a separate schedule of reimbursement rates for advanced life support and basic life support initial stabilizing medical services.

(b) The director shall seek the appropriate federal waivers or approval to apply federal funds to the reimbursement of initial stabilizing medical services in response to medical emergencies. Until these federal funds may be applied to reimburse these services, the director shall reduce the reimbursement rates provided under this section by 50 percent.

(c) For purposes of this section, "initial stabilizing medical services" means that component of emergency medical services that is provided by the EMT-Is, EMT-IIs, and EMT-Ps who first arrive on the scene of the medical emergency and provide any emergency medical services needed to stabilize the medical emergency, other than transport services.

(d) The reimbursement for initial stabilizing medical services pursuant to this section shall be provided to the EMS provider of the services. This reimbursement shall be in addition to any

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reimbursement that might be provided to the providers of transportation services.

SEC. 20

0260

(e) Nothing **in** ***this section shall expand or broaden the scope of practice for paramedics as prescribed by statute or regulation.***

SEC. 20. The Emergency Medical Services Authority shall conduct an evaluation of this act to assess its effectiveness **in** ***improving and*** **providing** ***support*** **to California's** ***emergency medical and trauma*** *system.* ***The authority shall consider access to emergency*** *room care* ***and services, average waiting*** *times* ***for emergency services, access to*** *oncall* ***physicians,*** **frequency** ***in which emergency departments*** **practice** ***diversion, the number of emergency department*** **closures,** ***geographic access to emergency services, and the financial stability of emergency medical and trauma service providers. The authority shall report the evaluation to the chairpersons of the Assembly*** **Committee** ***on Budget, the Assembly Health Committee, the Senate Health*** **and Human** ***Services Committee, and the*** **Senate Committee on** ***Budget and Fiscal Review by April 1, 2004.***

SEC. 21. **(a) The sum of two hundred million dollars** ($200,000,000) **is hereby appropriated from the General Fund to the Emergency Medical Services Authority to provide funds to single and multicounty EMS agencies that designate critical emergency service facilities pursuant to Section 1797.251 of the Health and Safety Code for services provided by the designated critical emergency facility and the implementation of Section 1797.251 of the Health and Safety Code.**

(b) The sum of one hundred million dollars ($100,000,000) **is hereby appropriated from the General Fund to the Emergency Medical Services Authority. The authority shall distribute the funds to each county that has established a Maddy Emergency Medical Services (EMS) Fund based on the number of county indigent emergency department visits reported during the prior fiscal year.**

SEC 21

SEC. 22. **No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution for certain costs that may be incurred by a local agency or school district because in that regard this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIIIB of the California Constitution.**

However, notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), **reimbursement shall be made from the State Mandates Claims Fund.**

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BILL NUMBER: SB 254 INTRODUCED
BILL TEXT

0261

INTRODUCED BY Senator Dunn

FEBRUARY 15, 2001

An act to amend Sections 1797.98a, 1797.98b, 1797.100, 1797.101, 1797.107, 1797.108, 1797.200, 1797.254, and 1798.161 of, to add Sections 1275.9, 1367.13, 1797.87, 1797.115, and 1797.251 to, and to repeal Section 1798.166 of, the Health and Safety Code, to add Section 10126.7 to the Insurance Code, and to amend Section 14106.6 of, and to add Section 14106.65 to, the Welfare and Institutions Code, relating to emergency services, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 254, as introduced, Dunn. Emergency medical services.

Existing law provides for the licensure and regulation of health facilities, including the provision of emergency medical services and care by those facilities.

This bill would require the State Department of Health Services, upon consultation with the Emergency Medical Services Authority and local EMS agencies, to revise regulations concerning the categorization and licensure of emergency departments on or before July 1, 2002.

Existing law regulates health care service plans and certain insurers that cover hospital, medical, and surgical expenses, and providers, in the reimbursement of claims of providers. Existing law sets forth requirements with respect to the reimbursement of claims for services rendered to a patient who is provided specified emergency services and care.

This bill would set forth additional requirements with respect to the reimbursement for initial stabilizing medical services, as defined, provided in response to medical emergencies.

By changing the definition of a crime relative to health care service plans, the bill would impose a state-mandated local program.

Under existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, the authority is responsible for the coordination and integration of state activities concerning emergency medical services and personnel.

This bill would require the authority to implement a critical emergency service provider program. The program would require a local EMS agency to designate within a county a minimum of one emergency department or designated trauma center as a critical emergency service facility. The bill would establish the Critical Emergency Service Facility Fund, the moneys from which, upon appropriation, would be expended by the authority for purposes of administering and funding the program in each county.

The bill would require the authority and the department to adopt, by December 31, 2002, certain regulations related to ensuring minimum standards for a system of coordinated emergency medical care.

Existing law authorizes each county to designate an emergency medical services agency (local EMS agency) for the establishment and administration of an emergency medical services program in the county, and authorizes the establishment by a county of a Maddy Emergency Medical Services (EMS) Fund for this purpose. The source of moneys in the fund are penalty assessments each county levies upon fines, penalties, and forfeitures imposed and collected by the courts for criminal offenses. A county establishing a fund under this provision is required to report certain information related to

the fund to the Legislature through the authority.

This bill would require every county to designate a local EMS agency and establish a fund under these provisions. 0262

Existing law provides for specified percentage distributions of the money in a Maddy EMS fund to certain physicians and surgeons, to hospitals providing disproportionate trauma and emergency medical services, and for other emergency medical services purposes as determined by each county.

This bill would delete the distributions to the hospitals and revise the distribution formula upon the implementation and funding of the critical emergency services program provided under this bill.

Existing law sets forth requirements of local EMS agencies, including the submission of an annual emergency medical services plan.

The bill would require the local EMS agency to evaluate and periodically inspect hospitals within its jurisdiction pursuant to regulations established by the authority. The bill would add to the requirements of a local EMS agency with regard to the submission of the annual emergency medical services plan.

By increasing the duties of counties and local EMS agencies, this bill would impose a state-mandated local program.

Existing law provides for the Medi-Cal program, which is administered by the department, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

This bill would specify that initial stabilizing medical services in response to medical emergencies are a covered benefit under the Medi-Cal program.

Existing law requires the director to establish and update annually a rate schedule of reimbursement under the Medi-Cal program for paramedic services based on reasonable cost standards of the department.

This bill would instead require the director to establish and update annually separate specified schedules of reimbursement for (1) advanced life support and basic life support ambulance transportation services and (2) advanced life support and basic life support initial stabilizing medical services.

The bill would appropriate $200,000,000 from the General Fund to the authority for purposes of the critical emergency services program required under the bill. The bill would appropriate $100,000,000 from the General Fund to the authority to distribute to counties as provided under the bill.

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, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

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: 2/3. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. (a) This act shall be known and may be cited as the Essential Trauma and Emergency Care Act.

(b) The Legislature finds and declares all of the following:

(1) Access to trauma and emergency care is hindered by a decrease in the availability of trauma and emergency care services statewide,

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hospital diversions, a lack of on-call medical specialists, and an inability to provide advanced life support services by first responder agencies which could result in lower institutional costs.

(2) Eighty percent of licensed emergency departments reported losing money during the 1998-99 fiscal year. Losses for those hospitals exceeded $315 million statewide. 0263

(3) Losses to physicians providing emergency and on-call specialty services exceeded $100 million during the 1998-99 fiscal year.

(4) Trauma and emergency care is an essential public service.

SEC. 2. Section 1275.9 is added to the Health and Safety Code, to read:

1275.9. The department, upon consultation with the Emergency Medical Services Authority and local EMS agencies, shall revise regulations concerning the categorization and licensure of emergency departments on or before July 1, 2002. These regulations shall ensure a minimum level of service for critical emergency services, including on-call physician services, provided by an critical emergency service facility, as defined in Section 1797.87.

SEC. 3. Section 1367.13 is added to the Health and Safety Code, to read:

1367.13. (a) Every health care service plan issued, amended, or renewed on or after January 1, 2002, shall contain a provision requiring that reimbursement be provided for initial stabilizing medical services provided to subscribers and enrollees in response to medical emergencies.

(b) For purposes of this section, "initial stabilizing medical services" means that component of emergency medical services that is provided by the EMT-Is, EMT-IIs, and EMT-Ps who first arrive on the scene of the medical emergency and provide any emergency medical services needed to stabilize the medical emergency, other than transport services.

(c) The reimbursement for initial stabilizing medical services pursuant to this section shall be provided to the EMS provider of the services. This reimbursement shall be in addition to any reimbursement that might be provided to the providers of transportation services.

SEC. 4. Section 1797.87 is added to the Health and Safety Code, to read:

1797.87. "Critical emergency service facility" means an emergency department that may include a designated trauma center, designated by a local EMS agency as provided in subdivision (a) of Section 1797.251, that is necessary to meet the needs of the community by maintaining the availability of trauma and emergency services.

SEC. 5. Section 1797.98a of the Health and Safety Code is amended to read:

1797.98a. (a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical Services (EMS) Fund.

(b) Each county may *shall* establish an emergency medical services fund upon adoption of a resolution by the board of supervisors. The money in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its emergency medical services fund administered by the state. Costs of administering the fund shall be reimbursed by the fund, up to 10 percent of the amount of the fund. All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section. The

(c) The fund shall be utilized to reimburse physicians and surgeons , and hospitals *except as provided in paragraph (2),* for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county. Fifty-eight percent of the balance of the money in the fund after , *as follows:*

(1) After costs of administration *58 percent of the balance of the money in the fund* shall be distributed to

physicians and surgeons for emergency services provided by all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic or comprehensive emergency services up to the time the patient is stabilized, 25 percent of the balance of the fund after costs of administration shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services, and 17 percent of the balance of the fund after costs of administration shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers.

(c) The

(2) Upon the implementation and funding of the critical emergency services program for purposes of Section 1797.251, the fund shall be distributed pursuant to this paragraph rather than paragraph (1). After *costs of administration, 80 percent of the balance of the money in the fund shall be distributed to physicians and* surgeons, *as described in paragraph (1), and* the *remaining balance of the fund shall be distributed for* other *emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers.*

(d) The continuing source of the money in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 of the Government Code.

(e) A General Fund augmentation may *supplement any continuing* source *of money.*

SEC. 6. Section 1797.98b of the Health and Safety Code is amended to read:

1797.98b. (a) Each *On January 1,* each county establishing a fund, on January 1, 1989, and on each January 1 thereafter, shall report to the Legislature on the implementation and status of the Emergency Medical Services Fund. The report shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Emergency Medical Services Fund.

(2) The fund balance and the amount of moneys disbursed under the program to physicians and for other emergency medical services purposes.

(3) The pattern and distribution of claims and the percentage of claims paid to those submitted.

(4) The amount of moneys available to be disbursed to physicians, the dollar amount of the total allowable claims submitted, and the percentage at which such claims were reimbursed.

(5) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(b) (1) Each county, upon request, shall make available to any member of the public the report required under subdivision (a).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and hospitals that have received reimbursement from the Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual basis.

SEC. 7. Section 1797.100 of the Health and Safety Code is amended to read:

1797.100. There is in the state government in the *California* Health and Welfare *Human Services* Agency, the Emergency Medical Services Authority.

SEC. 8. Section 1797.101 of the Health and Safety Code is amended to read:

1797.101. The Emergency Medical Services Authority shall be headed by the Director of the Emergency Medical Services Authority who shall be appointed by the Governor upon nomination by the Secretary of the *California* Health and Welfare *Human* Services Agency. The director shall be a

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physician and surgeon licensed in California pursuant to the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and who has substantial experience in the practice of emergency medicine.

SEC. 9. Section 1797.107 of the Health and Safety Code is amended to read:

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

(b) The authority and the department shall, jointly, adopt *regulations* to *ensure minimum standards for* a *system of coordinated care by* emergency *departments, trauma centers, emergency transport* services, *and nontransport* advanced *life support services by December 31, 2002.*

SEC. 10. Section 1797.108 of the Health and Safety Code is amended to read:

1797.108. *(a)* Subject to the availability of funds appropriated therefor, the authority may contract with local EMS agencies to provide funding assistance to those agencies for planning, organizing, implementing, and maintaining regional emergency medical services systems.

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(b) In addition, the authority may provide special funding to multicounty EMS agencies which *that* serve rural areas with extensive tourism, as determined by the authority, to reduce the burden on the rural EMS agency of providing the increased emergency medical services required due to that tourism.

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(c) (1) Each local or multicounty EMS agency receiving funding pursuant to this section shall make a quarterly report to the authority on the functioning of the local EMS system. The authority may continue to transfer appropriated funds to the local EMS agency upon satisfactory operation.

(2) Any single *or multicounty EMS agency receiving funds for critical emergency* services *shall report quarterly to the authority the disbursement of funds utilizing a simplified form developed by the authority.*

(d) Subject to the availability of funds appropriated therefor, the authority shall annually contract with single *or multicounty EMS agencies to provide funding assistance to* those *agencies that designate critical emergency service facilities pursuant to subdivision (a) of Section 1797.251.*

SEC. 11. Section 1797.115 is added to the Health and Safety Code, to read:

1797.115. (a) The Critical Emergency Services Facility Fund is hereby created in the State Treasury. The moneys in the fund, upon appropriation by the Legislature, shall be expended by the authority to implement a critical emergency service program in accordance with Section 1797.251.

(b) The total amount of funding for services authorized by this section shall not exceed two hundred million dollars ($200,000,000) annually.

(c) The authority shall allocate funds from the fund to each local EMS agency for designated critical emergency service facilities according to the following formula:

(1) Forty percent of the fund shall be distributed evenly among all counties with a designated critical emergency service facility.

(2) Sixty percent of the fund shall be distributed according to population statistics as published by the Department of Finance.

(d) A local EMS agency may not use more than 10 percent of funds allocated to the agency for purposes of this section for the

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administration of its critical emergency service program.

(e) (1) A hospital, if designated as an critical emergency service facility, may receive funding for the provision of emergency and trauma services from the local EMS agency. These funds may be used only for the continuation of critical emergency services and trauma care and may include reimbursements for on-call physician specialists. 0266

(2) The authority shall establish a funding formula to ensure that emergency care services at a designated hospital are maintained. Factors to be considered in developing the funding formula shall include, but not be limited to, all of the following:

(A) Geographic isolation.

(B) Number of 911 transports.

(C) Number of paramedic contacts per month.

(D) Number of trauma patients received per month.

(E) Specialty emergency services provided by the hospital.

(F) Number of county indigent visits per month.

(3) A hospital receiving funding under this section shall demonstrate efficiency in operations to ensure the provision of emergency services to the public based upon minimum standards as established by regulation.

(4) In order to receive funding under this section, a hospital shall report to both the local EMS agency and the authority the number of patients served and the cost of providing services.

SEC. 12. Section 1797.200 of the Health and Safety Code is amended to read:

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

SEC. 13. Section 1797.251 is added to the Health and Safety Code, to read:

1797.251. (a) A local EMS agency shall designate a minimum of one hospital emergency department or designated trauma center as a critical emergency service facility necessary to meet the needs of the community. Any acute care hospital shall be eligible to receive designation as a critical emergency service facility.

(b) A local EMS agency shall evaluate the capabilities of hospitals within its jurisdiction to meet emergency services and care needs and periodically review the hospital's capability based upon regulations established by the authority.

(c) A local EMS agency shall periodically evaluate the service demand of the community and the ability of providers of emergency services and care to meet the demand.

SEC. 14. Section 1797.254 of the Health and Safety Code is amended to read:

1797.254. *(a)* Local EMS agencies shall annually submit *no* later than January 31 *of each* year, an emergency medical services plan for the EMS area to the authority, according to EMS Systems, Standards, and Guidelines established by the authority.

(b) The plan shall *include,* but *not be limited to, all of the following:*

(1) A designation of a minimum of one hospital emergency department or designated trauma *center as a critical emergency service facility.*

(2) A process for the coordination of the *emergency care and trauma system.*

(3) Information requested from and submitted by hospitals, physicians, ambulance services, and first *responders concerning the prior fiscal year that shall include, but not be limited to,* the

number of patients receiving emergency services and care *and the cost of providing the care.*

(c) The requirements *of subdivision (b) shall* become operative *January 1, 2003.*

SEC. 15. Section 1798.161 of the Health and Safety Code is amended to read:

1798.161. (a) The authority shall submit **draft** *adopt* regulations specifying minimum standards for the implementation of trauma care systems to the commission on or before July 1 1984, and shall adopt the regulations on or before July 1, 1985. These regulations shall provide specific requirements for the care of trauma cases and shall ensure that the trauma care system is fully coordinated with all elements of the existing emergency medical services system. The regulations shall be adopted as provided in Section 1799.50, and shall include, but not be limited to, all of the following:

(I) Prehospital care management guidelines for triage and transportation of trauma cases.

(2) Flow patterns of trauma cases and geographic boundaries regarding trauma and nontrauma cases.

(3) The number and type of trauma cases necessary to assure that trauma facilities will provide quality care to trauma cases referred to them.

(4) The resources and equipment needed by trauma facilities to treat trauma cases.

(5) The availability and qualifications of the health care personnel, including physicians and surgeons, treating trauma cases within a trauma facility.

(6) Data collection regarding system operation and patient outcome.

(7) Periodic performance evaluation of the trauma system and its components.

(b) The authority may grant an exception to a portion of the regulations adopted pursuant to subdivision (a) upon substantiation of need by a local EMS agency that, as defined in the regulations, compliance with that requirement would not be in the best interests of the persons served within the affected local EMS area.

SEC. 16. Section 1798.166 of the Health and Safety Code is repealed.

1798.166. A local emergency medical services agency which elects to implement a trauma care system on or after January 1, 1984, shall develop and submit a plan to the authority according to the regulations established prior to the implementation.

SEC. 17. Section 10126.7 is added to the Insurance Code, to read:

10126.7. (a) Every policy of disability insurance issued, amended, or renewed on or after January 1, 2002, that covers hospital, medical, or surgical benefits shall contain a provision requiring that reimbursement be provided for initial stabilizing medical services provided to any insured or other person covered in response to medical emergencies.

(b) For purposes of this section, "initial stabilizing medical services" means that component of emergency medical services that is provided by the EMT-Is, EMT-IIs, and EMT-Ps who first arrive on the scene of the medical emergency and provide any emergency medical services needed to stabilize the medical emergency, other than transport services.

(c) The reimbursement for initial stabilizing medical services pursuant to this section shall be provided to the EMS provider of the services. This reimbursement shall be in addition to any reimbursement that might be provided to the providers of transportation services.

SEC. 18. Section 14106.6 of the Welfare and Institutions Code is amended to read:

14106.6. *(a)* The director shall establish and update annually a rate *separate* schedule of reimbursement for paramedic services which provides reimbursement *advanced life support and basic* life

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support ambulance transportation services that are based upon reasonable cost standards of the department *and that are not less than 60 percent of the rate applicable to the medicare median allowable charge for* the *current year for all California providers of advanced life support and basic life support ambulance transportation services .*

Notwithstanding

(b) Notwithstanding any other provision of law, and to the extent federal financial participation is available, any city, county, or special district providing paramedic services as set forth in subdivision (s) *(r)* of Section 14132, shall reimburse the Health Care Deposit Fund for the state costs of paying such *the* medical claims. Funds allocated to the county from the County Health Services Fund pursuant to *former* Part 4.5 (commencing with Section 16700) of Division 9 of the Welfare and Institutions Code *, as that part read before* January 1, 2000, may be utilized by the county or city to make such the reimbursement. Nothing in this chapter shall be construed to require a city, county, or special district providing, or contracting for, paramedic services as part of a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code, to seek Medi-Cal reimbursement for services rendered to eligible Medi-Cal recipients.

This

(cl This section shall be in effect *implemented* only to the extent federal financial participation is available.

SEC. 19. Section 14106.65 is added to the Welfare and Institutions Code, to read:

14106.65. (a) Reimbursement shall be made pursuant to this chapter for initial stabilizing medical services in response to medical emergencies. The director shall establish and annually update a separate schedule of reimbursement rates for advanced life support and basic life support initial stabilizing medical services.

(b) The director shall seek the appropriate federal waivers or approval to apply federal funds to the reimbursement of initial stabilizing medical services in response to medical emergencies. Until these federal funds may be applied to reimburse these services, the director shall reduce the reimbursement rates provided under this section by 50 percent.

(c) For purposes of this section, "initial stabilizing medical services" means that component of emergency medical services that is provided by the EMT-Is, EMT-IIs, and EMT-Ps who first arrive on the scene of the medical emergency and provide any emergency medical services needed to stabilize the medical emergency, other than. transport services.

(d) The reimbursement for initial stabilizing medical services pursuant to this section shall be provided to the EMS provider of the services. This reimbursement shall be in addition to any reimbursement that might be provided to the providers of transportation services.

SEC. 20. (a) The sum of two hundred million dollars ($200,000,000) is hereby appropriated from the General Fund to the Emergency Medical Services Authority to provide funds to single and multicounty EMS agencies that designate critical emergency service facilities pursuant to Section 1797.251 of the Health and Safety Code for services provided by the designated critical emergency facility and the implementation of Section 1797.251 of the Health and Safety Code.

(b) The sum of one hundred million dollars ($100,000,000) is hereby appropriated from the General Fund to the Emergency Medical Services Authority. The authority shall distribute the funds to each county that has established a Maddy Emergency Medical Services (EMS) Fund based on the number of county indigent emergency department visits reported during the prior fiscal year.

SEC. 21. No reimbursement is required by this act pursuant to

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Section 6 of Article XIIIB of the California Constitution for certain costs that may be incurred by a local agency or school district because in that regard this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIIIB of the California Constitution.

However, notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.