**Assembly Bill No. 3115**

---

Passed the Assembly August 31, 2018

_____

*Chief Clerk of the Assembly*

---

Passed the Senate August 31, 2018

_____

*Secretary of the Senate*

---

This bill was received by the Governor this _____ day of _____, 2018, at _____ o'clock ___M.

_____

*Private Secretary of the Governor*

CHAPTER _____

An act to amend Section 1799.2 of, to amend, repeal, and add Section 1797.272 of, to add Section 1797.259 to, and to add and repeal Chapter 13 (commencing with Section 1800) of Division 2.5 of, the Health and Safety Code, relating to community paramedicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 3115, Gipson. Community Paramedicine or Triage to Alternate Destination Act.

(1) Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems. The existing act establishes the Emergency Medical Services Authority, which is responsible for the coordination and integration of EMS systems. Among other duties, existing law requires the authority is required to develop planning and implementation guidelines for EMS systems, provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of EMS systems, and receive plans for the implementation of EMS and trauma care systems from local EMS agencies. Existing law makes violation of the act or regulations adopted pursuant to the act punishable as a misdemeanor.

This bill would establish within the act until January 1, 2025, the Community Paramedicine or Triage to Alternate Destination Act of 2018. The bill would authorize a local EMS agency to develop a community paramedicine or triage to alternate destination program, as defined, to provide specified community paramedicine services. The bill would require the authority to develop regulations to establish minimum standards for a program, and would further require the Commission on Emergency Medical Services to review and approve those regulations. The bill would require the authority to review a local EMS agency's proposed program and approve, approve with conditions, or deny the proposed program no later than 6 months after it is submitted by the local EMS agency. The bill would require a local EMS agency that opts to develop a program to perform specified duties that include, among others,

integrating the proposed program into the local EMS agency's EMS plan. The bill would require the Emergency Medical Services Authority to contract with an independent 3rd party to prepare a report on community paramedicine or triage to alternate destination programs on or before June 1, 2023, as specified.

The bill would prohibit a person or organization from providing community paramedicine or triage to alternate destination services or representing, advertising, or otherwise implying that it is authorized to provide those services unless it is expressly authorized by a local EMS agency to provide those services as part of a program approved by the authority. The bill would also prohibit a community paramedic from providing community paramedicine services if he or she has not been certified and accredited to perform those services and is working as an employee of an authorized community paramedicine provider. Because a violation of the act described above is punishable as a misdemeanor, and this bill would create new requirements within the act, the bill would expand an existing crime, thereby imposing a state-mandated local program.

(2) Existing law authorizes a county to establish an emergency medical care committee and requires the committee, at least annually, to review the operations of ambulance services operating within the county, emergency medical care offered within the county, and first aid practices in the county. Existing law requires the county board of supervisors to prescribe the membership, and appoint the members, of the committee.

This bill would require the committee to include additional members, as specified, and to advise a local EMS agency within the county on the development of its community paramedicine or triage to alternate destination program if the local EMS agency develops that program. The bill would specifically require the mayor of a city and county, rather than the county board of supervisors, to appoint the membership.

The bill would repeal these provisions on January 1, 2025.

(3) Existing law establishes the Commission on Emergency Medical Services with 18 members. The commission, among other things, reviews and approves regulations, standards, and guidelines developed by the authority.

This bill would increase the membership of the commission to 20 members and modify the entities that submit names for

appointment to the commission by the Governor, the Senate Committee on Rules, and the Speaker of the Assembly.

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

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

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

SECTION 1. Section 1797.259 is added to the Health and Safety Code, to read:

1797.259. A local EMS agency that elects to implement a community paramedicine or triage to alternate destination program on or after the effective date of the regulations adopted pursuant to Section 1830 shall develop and submit a plan for that program to the authority according to the requirements of Chapter 13 (commencing with Section 1800) prior to implementation of that program.

SEC. 2. Section 1797.272 of the Health and Safety Code is amended to read:

1797.272. (a) The county board of supervisors, or in the case of a city and county, the mayor, shall prescribe the membership, and appoint the members, of the emergency medical care committee. If two or more adjacent counties establish a single committee, the county boards of supervisors shall jointly prescribe the membership, and appoint the members of the committee. If a city and county establishes a single committee with one or more adjacent counties, the county board of supervisors for each county and the mayor of the city and county shall jointly prescribe the membership, and appoint the members of the committee.

(b) If a local EMS agency within the county elects to develop a community paramedicine or triage to alternate destination program pursuant to Section 1840, the county board of supervisors, or in the case of a city and county, the mayor, shall establish an emergency medical care committee, or if an emergency medical care committee is already established, ensure that the membership includes, all of the following members to advise the local EMS

agency on the development of the community paramedicine or triage to alternate destination program:

(1) One emergency medicine physician and surgeon who is board certified or board eligible practicing at an emergency department within the local EMS agency's jurisdiction.

(2) One registered nurse practicing within the local EMS agency's jurisdiction.

(3) One licensed paramedic practicing in the local EMS agency's jurisdiction. Whenever possible, the paramedic shall be employed by a public agency.

(4) One acute care hospital representative with an emergency department operating within the local EMS agency's jurisdiction.

(5) If a local EMS agency elects to implement a triage to alternate destination program to a sobering center, one individual with expertise in substance use disorder detoxification and recovery.

(6) Additional advisory members in the fields of public health, social work, hospice, or mental health practicing in the local EMS agency's jurisdiction with expertise commensurate with the program specialty or specialties described in Section 1815 proposed to be adopted by the local EMS agency.

(c) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 3. Section 1797.272 is added to the Health and Safety Code, to read:

1797.272. (a) The county board of supervisors shall prescribe the membership, and appoint the members, of the emergency medical care committee. If two or more adjacent counties establish a single committee, the county boards of supervisors shall jointly prescribe the membership, and appoint the members of the committee.

(b) This section shall become operative on January 1, 2025.

SEC. 4. Section 1799.2 of the Health and Safety Code is amended to read:

1799.2. The commission shall consist of 20 members appointed as follows:

(a) One full-time physician and surgeon, whose primary practice is emergency medicine, appointed by the Senate Committee on Rules from a list of three names submitted by the California Chapter of the American College of Emergency Physicians.

(b) One physician and surgeon, who is a trauma surgeon, appointed by the Speaker of the Assembly from a list of three names submitted by the California Chapter of the American College of Surgeons.

(c) One physician and surgeon appointed by the Senate Committee on Rules from a list of three names submitted by the California Medical Association.

(d) One county health officer appointed by the Governor from a list of three names submitted by the California Conference of Local Health Officers.

(e) One registered nurse, who is currently, or has been previously, authorized as a mobile intensive care nurse and who is knowledgeable in state emergency medical services programs and issues, appointed by the Governor in consultation with the Emergency Nurses Association and the California Labor Federation.

(f) One full-time paramedic or EMT-II, who is not employed as a full-time peace officer, appointed by the Senate Committee on Rules from a list of three names submitted by the California Labor Federation.

(g) One prehospital emergency medical service provider from the private sector, appointed by the Speaker of the Assembly from a list of three names submitted by the California Ambulance Association.

(h) One management member of an entity providing fire protection and prevention services appointed by the Governor from a list of three names submitted by the California Fire Chiefs Association.

(i) One physician and surgeon who is board prepared or board certified in the specialty of emergency medicine by the American Board of Emergency Medicine and who is knowledgeable in state emergency medical services programs and issues appointed by the Speaker of the Assembly from a list of three names submitted by the California Chapter of the American College of Emergency Physicians.

(j) One hospital administrator of a base hospital who is appointed by the Governor from a list of three names submitted by the California Hospital Association.

(k) One full-time peace officer, who is either an EMT-II or a paramedic, who is appointed by the Governor from a list of three names submitted by the California Peace Officers Association.

(*l*) Two public members who have experience in local EMS policy issues, at least one of whom resides in a rural area as defined by the authority, and who are appointed by the Governor.

(m) One administrator from a local EMS agency appointed by the Governor from a list of four names submitted by the Emergency Medical Services Administrator's Association of California.

(n) One medical director of a local EMS agency who is an active member of the Emergency Medical Directors Association of California and who is appointed by the Governor.

(o) One person appointed by the Governor, who is an active member of the California State Firemen's Association.

(p) One person who is employed by the Department of Forestry and Fire Protection (CAL-FIRE) appointed by the Governor from a list of three names submitted by the California Professional Firefighters.

(q) One person who is employed by a city, county, or special district that provides fire protection appointed by the Governor from a list of three names submitted by the California Professional Firefighters.

(r) One physician and surgeon specializing in comprehensive care of individuals with co-occurring mental health or psychosocial and substance use disorders appointed by the Governor in consultation with the California Psychiatric Association and the California Society of Addiction Medicine.

(s) One licensed clinical social worker appointed by the Governor in consultation with the California State Council of the Service Employees International Union and the California Chapter of the National Association of Social Workers.

SEC. 5. Chapter 13 (commencing with Section 1800) is added to Division 2.5 of the Health and Safety Code, to read:

## Chapter 13. Community Paramedicine Or Triage to Alternate Destination

### Article 1. General Provisions

1800. This chapter shall be known, and may be cited, as the Community Paramedicine or Triage to Alternate Destination Act of 2018.

1801. (a) It is the intent of the Legislature to establish state standards that govern the implementation of community paramedicine or triage to alternate destination programs by local EMS agencies in California.

(b) It is the intent of the Legislature that a community paramedicine or triage to alternate destination program developed by a local EMS agency be submitted to the Emergency Medical Services Authority for review and approval.

(c) It is the intent of the Legislature to improve the health of individuals in their communities by authorizing licensed paramedics, working under expert medical oversight, to deliver community paramedicine or triage to alternate destination services in California utilizing existing providers, promoting continuity of care, and maximizing existing efficiencies within the first response and emergency medical services system.

(d) It is the intent of the Legislature that a community paramedicine or triage to alternate destination program developed by a local EMS agency and approved by the Emergency Medical Services Authority do all of the following:

(1) Improve coordination among providers of medical services, behavioral health services, and social services.

(2) Preserve and protect the underlying 911 emergency medical services delivery system.

(3) Preserve, protect, and deliver the highest level of patient care to every Californian.

(e) It is the intent of the Legislature that an alternate destination facility participating as part of an approved program always be staffed by a health care professional with a higher scope of practice, such as, at minimum, a registered nurse.

(f) It is the intent of the Legislature that the delivery of community paramedicine or triage to alternate destination services is a public good to be delivered in a manner that promotes

continuity of care and continuity of providers and is consistent with, coordinated with, and complementary to, the existing first response and emergency medical response system in place in a local EMS agency's jurisdiction.

(g) It is the intent of the Legislature that a community paramedicine or triage to alternate destination program be designed to improve community health and be implemented in a fashion that respects the current emergency medical system and its providers. In furtherance of the public interest and good, agencies that provide first response services are well positioned to deliver care under a community paramedicine or triage to alternate destination program.

(h) It is the intent of the Legislature that the development of any community paramedicine or triage to alternate destination program reflects input from all practitioners of appropriate medical authorities, including, but not limited to, medical directors, physicians, nurses, mental health professionals, first responder paramedics, hospitals, and other entities within the emergency medical response system.

(i) It is the intent of the Legislature that local EMS agencies be authorized to develop a community paramedicine or triage to alternate destination program to improve patient care and community health. A community paramedicine or triage to alternate destination program should not be used to replace any other health care worker, reduce personnel costs, harm working conditions of emergency medical and health care workers, or otherwise compromise the emergency medical response or health care system. The highest priority of any community paramedicine or triage to alternate destination program should be improving patient care and providing further efficiencies in the emergency medical system.

## Article 2. Definitions

1810. Unless otherwise indicated in this chapter, the definitions contained in this article govern the provisions of this chapter.

1811. "Alternate destination facility" means a treatment location that is an authorized mental health facility or an authorized sobering center, but not a general acute care hospital, as defined in subdivision (a) of Section 1250 or 1797.88.

1812. "Authorized mental health facility" means a designated facility, as defined in subdivision (n) of Section 5008 of the Welfare and Institutions Code, that has at least one registered nurse staffed onsite at the facility at all times.

1813. "Authorized sobering center" means a facility that is staffed at all times with at least one registered nurse and is a federally qualified health center, including a clinic described in Section 1211.

1814. "Community paramedic" means a paramedic licensed under this division who has completed the curriculum for community paramedic training adopted pursuant to paragraph (1) of subdivision (d) of Section 1830, has received certification in one or more of the community paramedicine program specialties described in Section 1815, and is certified and accredited to provide community paramedic services by a local EMS agency as part of an approved community paramedicine program.

1815. "Community paramedicine program" means a program developed by a local EMS agency and approved by the Emergency Medical Services Authority to provide community paramedicine services consisting of one or more of the program specialties described in this section under the direction of medical protocols developed by the local EMS agency that are consistent with the minimum medical protocols established by the authority. Community paramedicine services may consist of the following program specialties:

(a) Providing short-term postdischarge followup for persons recently discharged from a hospital due to a serious health condition, including collaboration with and by providing referral to home health services when eligible.

(b) Providing directly observed therapy to persons with tuberculosis.

(c) Providing case management services to frequent emergency medical services users in collaboration with and by providing referral to existing appropriate community resources.

1816. "Community paramedicine provider" means an advanced life support provider authorized by a local EMS agency to provide advanced life support who has entered into a contract to deliver community paramedicine services as described in Section 1815 as part of an approved community paramedicine program developed by a local EMS agency.

1817. "Public agency" means a city, county, city and county, special district, or other political subdivision of the state that provides first response services, including emergency medical care.

1818. "Triage paramedic" means a paramedic licensed under this division who has completed the curriculum for triage paramedic services adopted pursuant to paragraph (2) of subdivision (d) of Section 1830, has been accredited by a local EMS agency in one or more of the triage paramedic specialties described in Section 1819 as part of an approved triage to alternate destination program.

1819. (a) "Triage to alternate destination program" means a program developed by a local EMS agency and approved by the Emergency Medical Services Authority to provide triage paramedic assessments consisting of one or more specialties described in this section operating under triage and assessment protocols developed by the local EMS agency that are consistent with the minimum triage and assessment protocols established by the authority. Triage paramedic assessments may consist of the following program specialties:

(1) Providing care and comfort services to hospice patients in their homes in response to 911 calls by providing for the patient's and the family's immediate care needs, including grief support in collaboration with the patient's hospice agency until the hospice nurse arrives to treat the patient.

(2) Providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination facility.

(b) Nothing in this section shall be construed to prevent or eliminate any authorities to provide continuous transport of a patient to a participating hospital for priority evaluation by a physician, nurse practitioner, or physician assistant followed by a transport to an alternate destination facility.

1820. "Triage to alternate destination provider" means an advanced life support provider authorized by a local EMS agency to provide advanced life support triage paramedic assessments as part of an approved triage to alternate destination program specialty, as described in Section 1819.

Article 3. State Administration

1830. (a) The Emergency Medical Services Authority shall develop regulations that establish minimum standards for the development of a community paramedicine or triage to alternate destination program.

(b) The Commission on Emergency Medical Services shall review and approve the regulations described in this section in accordance with Section 1799.50.

(c) The regulations described in this section shall be based upon, and informed by, the Community Paramedicine Pilot Program under the Office of Statewide Health Planning and Development Health Workforce Pilot Project No. 173 and the protocols and operation of the pilot projects approved under the project.

(d) The regulations that establish minimum standards for the development of a community paramedicine or triage to alternate destination program shall consist of all of the following:

(1) Minimum standards and curriculum for each program specialty described in Section 1815. The authority, in developing the minimum standards and curriculum, shall provide for community paramedics to be trained in one or more of the program specialties described in Section 1815 and approved by the local EMS agency pursuant to Section 1840.

(2) Minimum standards and curriculum for each program specialty described in Section 1819. The authority, in developing the minimum standards and curriculum shall provide for triage paramedics to be trained in one or more of the program specialties described in Section 1819 and approved by the local EMS agency pursuant to Section 1840.

(3) A process for verifying on a paramedic’s license the successful completion of the training described in paragraph (1) or (2).

(4) Minimum standards for approval, review, withdrawal, and revocation of a community paramedicine or triage to alternate destination program in accordance with Section 1797.105. Those standards shall also include, but not be limited to, both of the following:

(A) A requirement that facilities participating in the program accommodate privately or commercially insured, Medi-Cal, Medicare, and uninsured patients.

(B) Immediate termination of participation in the program by the alternate destination facility or the community paramedicine or triage to alternate destination provider, if it fails to operate in accordance with subdivision (b) of Section 1317.

(5) Minimum standards for collecting and submitting data to the authority to ensure patient safety that include consideration of both quality assurance and quality improvement. These standards shall include, but not be limited to, all of the following:

(A) Intervals for community paramedicine or triage to alternate destination providers, participating health facilities, and local EMS agencies to submit community paramedicine services data.

(B) Relevant program use data and the online posting of program analyses.

(C) Exchange of electronic patient health information between community paramedicine or triage to alternate destination providers and health providers and facilities. The authority may grant a one-time temporary waiver, not to exceed five years, of this requirement for alternate destination facilities that are unable to immediately comply with the electronic patient health information requirement.

(D) Emergency medical response system feedback, including feedback from the emergency medical care committee described in subdivision (b) of Section 1797.272.

(E) If the community paramedicine or triage to alternate destination program utilizes an alternate destination facility, consideration of ambulance patient offload times for the alternate destination facility, the number of patients that are turned away, diverted, or required to be subsequently transferred to an emergency department, and identification of the reasons for turning away, diverting, or transferring the patient.

(F) An assessment of each community paramedicine or triage to alternate destination program's medical protocols or other processes.

(G) An assessment of the impact that implementation of a community paramedicine or triage to alternate destination program has on the delivery of emergency medical services, including the impact on response times in the local EMS agency's jurisdiction.

1831. For regulations adopted pursuant to Section 1830 relating to a triage to alternate destination program, the Emergency Medical Services Authority shall ensure the following:

(a) Local EMS agencies participating in providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination facility shall ensure that any patient who meets the triage criteria for transport to an alternate destination facility, but who requests to be transported to an emergency department of a general acute care hospital, shall be transported to the emergency department of a general acute care hospital.

(b) Local EMS agencies participating in providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination facility shall require that a patient who is transported to an alternate destination facility and, upon assessment, is found to no longer meet the criteria for admission to an alternate destination facility, be immediately transported to the emergency department of a general acute care hospital.

(c) For transport to a behavioral health facility, training and accreditation shall include topics relevant to the needs of the patient population, including, but not limited to:

(1) A requirement that a participating EMT-P complete instruction on all of the following:

(A) Mental health crisis intervention, provided by a licensed physician and surgeon with experience in the emergency department of a general acute care hospital.

(B) Assessment and treatment of intoxicated patients.

(C) Local EMS agency policies for the triage, treatment, transport, and transfer of care, of patients to a behavioral health facility.

(2) A requirement that the local EMS agency verify that the participating EMT-P has completed training in all of the following topics meeting the standards of the United States Department of Transportation National Highway Traffic Safety Administration National Emergency Medical Services Education Standards:

(A) Psychiatric disorders.

(B) Neuropharmacology.

(C) Alcohol and substance abuse.

(D) Patient consent.

(E) Patient documentation.

(F) Medical quality improvement.

(d) For transport to a sobering center, a training component that requires a participating EMT-P to complete instruction on all of the following:

(1) The impact of alcohol intoxication on the local public health and emergency medical services system.

(2) Alcohol and substance use disorders.

(3) Triage and transport parameters.

(4) Health risks and interventions in stabilizing acutely intoxicated patients.

(5) Common conditions with presentations similar to intoxication.

(6) Disease process, behavioral emergencies, and injury patterns common to those with chronic alcohol use disorders.

1832. (a) The Emergency Medical Services Authority shall consult with a committee of advisory members in the fields of public health, social work, hospice, or mental health with expertise commensurate with the program specialty or specialties described in Section 1815 and physicians and surgeons whose primary practice is emergency medicine, including, but not limited to, local EMS medical directors with two each named by the EMS Medical Directors Association of California and the California Chapter of the American College of Emergency Physicians, and adopt minimum medical protocols for each community paramedicine program specialty described in Section 1815 and minimum triage and assessment protocols for triage to alternate destination program specialties described in Section 1815 minimum triage and assessment protocols for triage to alternate destination program specialties described in Section 1819.

(b) The protocols described in this section shall be based upon, and informed by, the Community Paramedicine Pilot Program under the Office of Statewide Health Planning and Development's Health Workforce Pilot Project No. 173, and further refinements provided by local EMS agencies during the course and operation of the pilot projects.

1833. (a) The Emergency Medical Services Authority shall submit an annual report on the community paramedicine or triage to alternate destination programs operating in California to the relevant policy committees of the Legislature in accordance with Section 9795 of the Government Code, and shall post the annual report on its Internet Web site. The authority shall submit and post

its first report six months after the authority adopts the regulations described in Section 1830, and every January 1 thereafter for the next five years.

(b) The report required in subdivision (a) shall include all of the following:

(1) An assessment of each program specialty, including an assessment of patient outcomes in the aggregate and an assessment of any adverse patient events resulting from services provided under approved plans pursuant to this chapter.

(2) An assessment of the impact that the program specialties have had on the emergency medical system.

(3) An update on the implementation of program specialties operating in local EMS agency jurisdictions.

(4) Policy recommendations for improvement of administration of local plans and for the improvement of patient outcomes.

(c) All data collected by the authority shall be posted on its Internet Web site in a downloadable format with due regard for the confidentiality of information that would identify individual patients.

1834. (a) The Emergency Medical Services Authority shall identify and contract with an independent third-party evaluator to develop the report required pursuant to subdivision (b).

(b) (1) No later than June 1, 2023, the Emergency Medical Services Authority shall submit a review report on the community paramedicine or triage to alternate destination programs operating in California to the relevant policy committees of the Legislature, in accordance with Section 9795 of the Government Code, and shall post the annual report on its Internet Web site.

(2) The report required in paragraph (1) shall include all of the following:

(A) A detailed assessment of each community paramedicine or triage to alternate destination program operating in local EMS agency jurisdictions.

(B) An assessment of patient outcomes in the aggregate resulting from services provided under approved plans under the program.

(C) An assessment of workforce impact due to implementation of the program.

(D) An assessment of the impact of the program on the emergency medical services system.

(E) An assessment of how the currently operating program specialties achieve the legislative intent stated in Section 1801.

(F) An assessment of community paramedic and triage training.

(c) The report in subdivision (b) may include recommendations for changes to, or the elimination of, community paramedicine or triage to alternate destination program specialties that do not achieve the community health and patient goals expressed in Section 1801.

1835. (a) The Emergency Medical Services Authority shall review a local EMS agency's proposed community paramedicine or triage to alternate destination program following procedures consistent with Section 1797.105 and review the program's protocols as described in subdivision (b) of Section 1797.172, to ensure the proposed program is consistent with the authority's regulations and the provisions of this chapter.

(b) The authority may impose conditions as part of the approval of a community paramedicine or triage to alternate destination program that the local EMS agency is required to incorporate into its program to achieve consistency with the authority's regulations and the provisions of this chapter.

(c) The authority shall approve, approve with conditions, or deny the proposed community paramedicine or triage to alternate destination program no later than six months after it is submitted by the local EMS agency.

1836. (a) A community paramedicine pilot program approved under the Office of Statewide Health Planning and Development's Health Workforce Pilot Project No. 173 before January 1, 2019, is authorized to operate until one year after the regulations described in Section 1830 become effective.

(b) The Office of Statewide Planning and Development shall continue to review, and where appropriate, approve Health Workforce Pilot Project No. 173 applications until one year after the regulations described in Section 1830 become effective.

## Article 4. Local Administration

1840. A local EMS agency may develop a community paramedicine or triage to alternate destination program that is consistent with the Emergency Medical Services Authority's regulations and the provisions of this chapter and submit evidence

of compliance with the requirements of Section 1841 to the authority for approval pursuant to Section 1835.

1841. A local EMS agency that opts to develop a community paramedicine or triage to alternate destination program shall do all of the following:

(a) Integrate the proposed community paramedicine or triage to alternate destination program into the local EMS agency's emergency medical services plan described in Article 2 (commencing with Section 1797.250) of Chapter 4.

(b) Consistent with this article, develop a process to select community paramedicine providers, to provide services as described in Section 1815, at a periodic interval established by the local EMS agency.

(c) Facilitate any necessary agreements with one or more community paramedicine or triage to alternate destination providers for the delivery of community paramedicine or triage to alternate destination services within the local EMS agency's jurisdiction that are consistent with the proposed community paramedicine or triage to alternate destination program. The local EMS agency shall provide medical control and oversight of the program.

(d) Any contract to provide the program specialties described in subdivisions (a) to (c), inclusive, of Section 1815 shall not be included as part of an existing or proposed contract for the delivery of emergency medical services as part of an exclusive operating area awarded pursuant to Section 1797.224 or the provision of, or administration of, emergency medical services authorized pursuant to Section 1797.201.

(e) If the community paramedicine program proposes to provide the program specialties described in subdivisions (a) to (c), inclusive, of Section 1815, the local EMS agency shall coordinate and review and approve any written agreements for the provision of those specialties to ensure compliance with the requirements of this chapter and according to the following:

(1) A local EMS agency shall provide a right of refusal for the public agency or agencies within the jurisdiction of the proposed program area to provide the proposed program specialties. If the public agency or agencies agree to provide the proposed program specialties, the local EMS agency shall review and approve written agreements with those public agencies.

(2) A local EMS agency shall review and approve agreements with community paramedicine providers that partner with a public agency or agencies to deliver those program specialties described in subdivisions (a) to (c), inclusive, of Section 1815.

(3) If no public agency chooses to provide the proposed program specialties pursuant to paragraph (1) or (2), the local EMS agency shall develop a process to select community paramedicine providers to deliver the specialties described in subdivisions (a) to (c), inclusive, of Section 1815.

(f) For triage to alternate destination program specialties described in Section 1819, the local EMS agency shall continue the use of existing providers operating within the local EMS agency's jurisdiction pursuant to Section 1797.201 or 1797.224 and shall do all of the following:

(1) At the discretion of the local medical director, develop additional triage and assessment protocols commensurate with the need of the local programs authorized under this act.

(2) Require the triage and assessment protocols and decision of the triage paramedic to transport to an alternate destination facility to not be based upon, or affected by, the patient's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any other characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

(3) Certify and provide documentation and periodic updates to the Emergency Medical Service Authority showing that the alternate destination facility authorized to receive patients has adequate licensed medical and professional staff, facilities, and equipment that comply with the requirements of the Emergency Medical Services Authority's regulations and the provisions of this chapter which shall include the following:

(A) Qualified staff to care for the degree and severity of a patient's injuries and needs.

(B) Standardized medical and nursing procedures for nursing staff.

(C) The equipment and services available at an alternate destination facility necessary to care for patients requiring medical

services, including, but not limited to, an automatic external defibrillator and at least one bed or mat per individual patient.

(D) The time of day and any limitations that may apply for an alternate destination facility to treat patients requiring medical services.

(4) Secure an agreement with the alternate destination facility that requires the facility to notify the local EMS agency within 24 hours if there are changes in the status of the facility with respect to the protocols and the facility's ability to care for patients.

(5) Secure an agreement with the alternate destination facility attesting that the facility will operate in accordance with Section 1317 and providing that failure to operate in accordance with Section 1317 will result in the immediate termination of use of the facility as part of the triage to alternate destination facility.

(g) A local EMS agency shall establish the following training pursuant to the requirements established by the authority and the program specialty that is being proposed by the local EMS agency:

(1) Establish a process to verify training and accreditation of community paramedics in each of the proposed community paramedicine program's specialties described in subdivisions (a) to (c), inclusive, of Section 1815.

(2) Establish a process for training and accreditation of triage paramedics in each of the proposed triage to alternate destination program's specialties described in Section 1819.

(h) Facilitate funding discussions between a community paramedicine or triage to alternate destination provider and public or private health system participants to support the implementation of the local EMS agency's community paramedicine or triage to alternate destination program.

## Article 5. Miscellaneous

1850. A community paramedicine pilot program approved under the Office of Statewide Health Planning and Development's Health Workforce Pilot Project No. 173 before January 1, 2019, to deliver community paramedicine services as described in Section 1815, is authorized to continue the use of existing providers and shall be exempt from subdivisions (d) and (e) of Section 1841 until such time as the provider elects to reduce or eliminate one or more of those community paramedicine services approved under the

pilot program or fails to comply with the program standards as required by this chapter.

1851. A person or organization shall not provide community paramedicine or triage to alternate destination services or represent, advertise, or otherwise imply that it is authorized to provide community paramedicine or triage to alternate destination services unless it is expressly authorized by a local EMS agency to provide those services as part of a community paramedicine or triage to alternate destination program approved by the Emergency Medical Services Authority in accordance with Section 1835.

1852. A community paramedic shall provide community paramedicine services only if he or she has been certified and accredited to perform those services by a local EMS agency and is working as an employee of an authorized community paramedicine provider.

1853. A triage paramedic shall provide triage to alternate destination services only if he or she has been accredited to perform those services by a local EMS agency and is working as an employee of an authorized triage to alternate destination provider.

1854. The disciplinary procedures for a community paramedic shall be consistent with subdivision (d) of Section 1797.194.

1855. Entering into an agreement to be a community paramedicine or triage to alternate destination provider pursuant to this chapter shall not alter or otherwise invalidate an agency's authority to provide or administer emergency medical services pursuant to Section 1797.201 or 1797.224.

1856. The liability provisions described in Chapter 9 (commencing with Section 1799.100) apply to this chapter.

1857. This chapter shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because 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 XIII B of the California Constitution.

Approved _____, 2018

_____

*Governor*