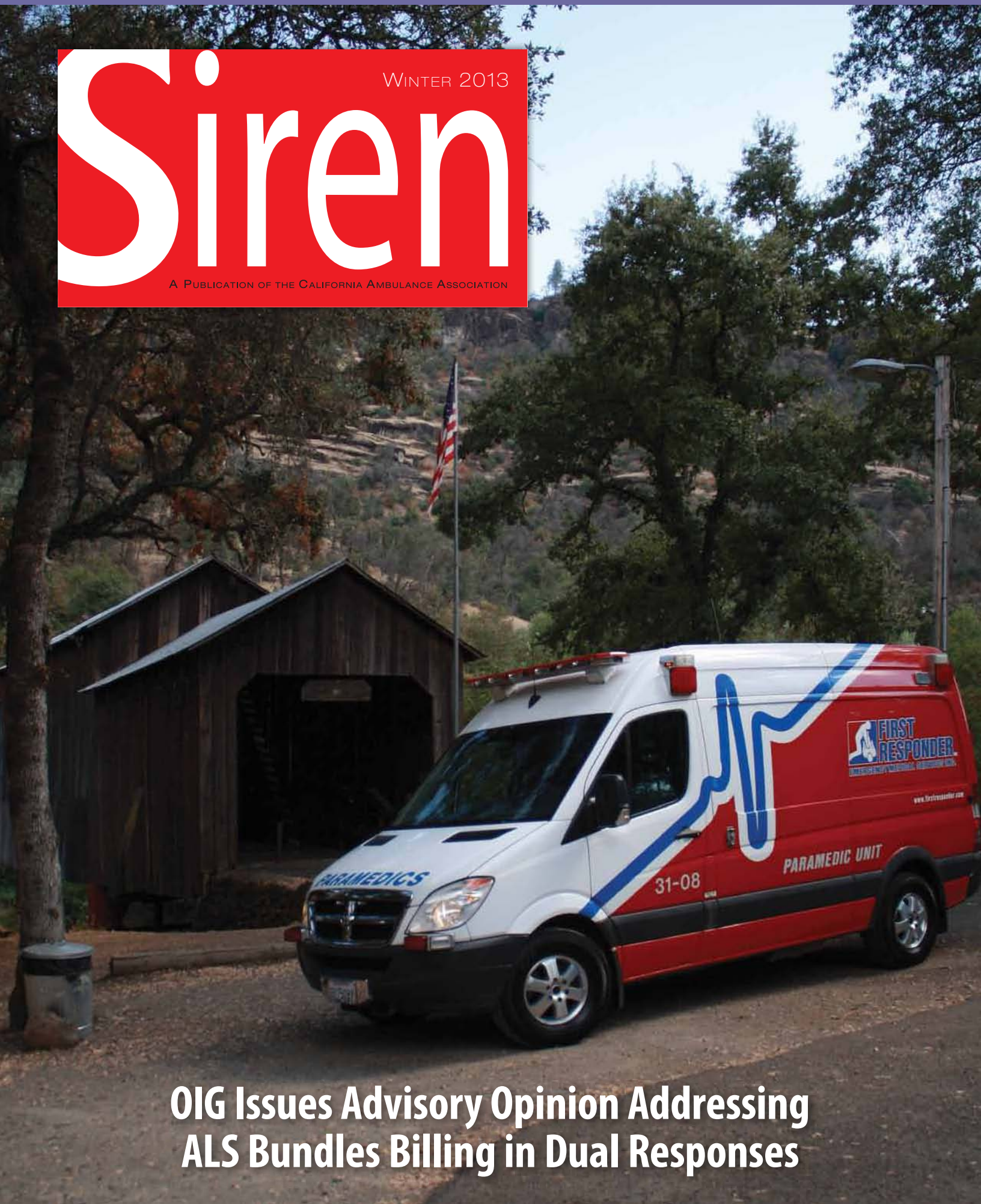
2012 California Workers' Compensation Reform Package Enacted

Winter 2013

Siren

A Publication of the California Ambulance Association



OIG Issues Advisory Opinion Addressing ALS Bundles Billing in Dual Responses

CALIFORNIA AMBULANCE ASSOCIATION

CAA *Vision*

Assure delivery of excellent pre-hospital care to the people of California by promoting recognized industry best practices.

CAA *Mission*

- Serve as the voice and resource on behalf of private enterprise emergency and non-emergency ambulance services.
- Promote high quality, efficient and medically appropriate patient care.
- Advocate the value that pre-hospital care provides in achieving positive patient outcomes.
- Promote effective and fiscally responsible EMS systems and establish standards for system design.

CAA *Leadership*

California Ambulance Association
2520 Venture Oaks Way, Suite 150
Sacramento, CA 95833
(877) 276-1410 (toll free)
(916) 924-7323 (fax)
www.the-caa.org

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Chair's *Message*

Helen Pierson | *Chair of the Board*

Kicking Off 2013 With the CAA

First let me start by wishing you all a Happy New Year. I hope your holidays were full of cheer and good times.

The year is off to a great start for those in the ambulance business. Congress extended the temporary Medicare ambulance relief of 2% urban, 3% rural and super rural increases for another year. I'd like to thank the CAA members who assisted this effort by writing to their members of Congress, urging for this extension. It is likely that the CAA will be asking you to do the same thing at the end of this year so your assistance with that effort will be much appreciated.

The CAA Board of Directors, committees and staff are all working hard to make CAA's 2013 successful and exciting.

The ***Stars of Life & Legislative Summit*** will be taking place in Sacramento from April 22 – 24, 2013. We are also planning another ***Health Care Reform Summit for April 22***nd. Health Care Reform will be an ongoing theme for CAA's education this year and I encourage you all to attend these events when possible so you can stay informed on all of the changes that are sure to come.

The ***2013 Annual Convention & Reimbursement Conference*** will be taking place at the end of September in Anaheim. The dates and exact location will be announced soon and when they are, I hope you'll mark your calendar and keep your schedule free so you're able to attend.

As 2012 came to a close we said farewell to Executive Director Brenda Staffan, who has served the Association for the past four years. Brenda left to take on a groundbreaking community paramedicine demonstration project for the Regional Emergency Medical Services Authority in Reno. During her tenure at CAA, Brenda has been a strong voice on behalf of private-sector ambulance service providers in California. Her achievements in analyzing the impacts of healthcare reform on EMS and in addressing inequities in reimbursement for government-funded ambulance services have provided a solid policy base for our efforts going forward.

In February, the Board selected June Iljana to take over the Executive Director role, which involves overseeing day-to-day operations of the Association and leading CAA's policy activities, including efforts to advance sustainable system design. June previously served as Deputy Director for EMS Policy, Legislation and External Affairs for the California Emergency Medical Services Authority where she worked with EMS providers and local EMS agencies on system design, EMS data and personnel standards.

June Iljana | *Incoming Executive Director*

By now, you should have received your 2013 membership renewal. If you have already renewed your membership, I thank you. If you have not, I encourage you to do so. If you are on the fence regarding your CAA membership this year, I encourage you to reach out to me or CAA staff to express your concerns. The CAA is always looking for feedback from members. Remember, united we stand, divided we fall.

Happy New Year! I wish you all the best for 2013.

Impact of Health Care Reform on California's EMS System

Brenda Staffan
Outgoing Executive Director

One of the CAA's most important strategic initiatives is to assess the impact of health care reform on CAA members as well as the communities and patients they serve. Now that uncertainty regarding implementation of the Patient Protection and Affordable Care Act (PPACA) has been resolved, it is important to begin to prepare the statewide EMS system for the upcoming challenges and opportunities. On behalf of the CAA, I had the opportunity to provide two briefings regarding the impact of health care reform on the California EMS system. The first briefing was in August to staff at the EMS Authority. The second was a presentation at the September meeting of the California EMS Commission. Because patient care revenues provide major support of nearly every aspect of the statewide EMS system, our assessment focuses first on the direct financial impact of the PPACA on ambulance service revenues.

Coverage Expansion Causes Shifting Payer Mix

When implementation begins in 2014, insurance coverage expansion will result in more patients being covered by Medi-Cal, more patients seeking coverage through *Covered California* and fewer uninsured. However, many experts predict that insurance coverage will continue to shift as businesses that currently provide insurance to their employees make adjustments which may include increasing co-pays and deductibles and even dropping coverage altogether. Many EMS patients that are currently uninsured will gain coverage through Medi-Cal which provides the lowest source of provider reimbursement. On average, uninsured patients pay more out-of-pocket than current Medi-Cal rates and commercial insurers are finding more ways to stop the cost shift. Therefore, coverage expansion in California could create the unintended consequence of less overall patient care revenues as more patients gain their coverage through the Medi-Cal program.

Near Universal Coverage Leads to Sustained Charity Care

The coverage expansion will create *near-universal* coverage of the uninsured. Of the 7 million California residents currently uninsured, state policy makers estimate that 1 to 2 million people will remain uninsured. The CAA estimates that the statewide EMS system currently delivers nearly $300 million in charity care to the uninsured. Through rate regulation, counties retain responsibility for indigent care (Lomita decision) and often design EMS systems to shift this cost of care to commercial insurers (charges to commercial insurers are 5-8 times higher than Medi-Cal) and insured patients (via higher out-of-pocket co-pays/deductibles). The PPACA and Medi-Cal expansion reduces, but does not eliminate, treatment and transport of the uninsured. Unlike hospital, emergency ambulance providers do not receive offsets for their charity care and rarely receive subsidies from local government.

Patient Access to Care Threatened by Flawed Definition Applied to EMS

With the recent implementation of a flawed access to care standard to ambulance services, state policy makers have failed to recognize that emergency medical services are different from every other type of health care. The potential impacts to patients served by the statewide EMS system include: lowered quality of care, decreased access to care, reduced supply of care and barriers to access to care.

Broader Reforms Eventually Reach EMS

The PPACA features a broad array of new regulations that will be rolled out over the next several years. While EMS often stays off the radar screen, many of these reforms will eventually apply to providers and systems. New health information technology requirements will be expanded to include EMS; value-based purchasing (also known as pay-for-performance) may eventually apply to EMS providers; comparative effectiveness research may eventually impact EMS system design; and some types of ambulance services could eventually be included in bundled services or accountable care organizations. These are all concepts that should be on the radar screen of California's EMS regulators and stakeholders.

Opportunities for Innovation & System Redesign

Not all of the challenges posed by health care reform can be addressed solely by resolving severe Medi-Cal under-funding. The CAA

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Executive Director's *Update*

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recommends that each EMS system establish a baseline assessment of current EMS system revenues and then implement a system to monitor the impact of changing revenue on quality, access and supply. In addition to continued work on Medi-Cal funding issues by state and local EMS administrators as well as ambulance providers, there may be a need to consider redesigning aspects of local EMS systems. There also will be opportunities to better integrate emergency medical services into the overall health care delivery system. One example is the upcoming policy brief on Community Paramedicine by the California Health Care Foundation. Hopefully, this project will lead to opportunities for California-based pilot projects which to date have been short-lived or stymied for a variety of reasons.

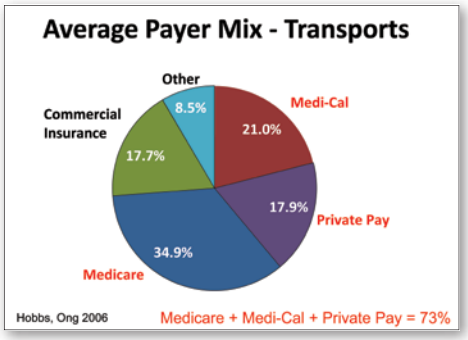
Recommendations

As the California legislature prepares for its 2013 legislative session and a potential special health care session, providers, patients and communities will begin to be impacted unless the funding gaps in the statewide EMS system are addressed. The CAA recommends the following legislative and regulatory proposals:

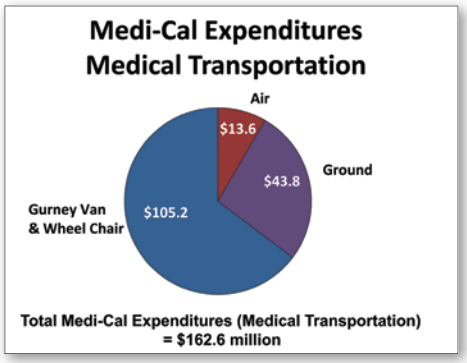
- Pass legislation to establish supplemental Medi-Cal payments for ground ambulance services.
- Establish county-based models to fund sustained charity care (via intergovernmental transfers).
- Establish an access to care definition specifically for emergency medical services.
- Continue implementation of uniform coding system for Medi-Cal (HCPCS codes).

It is essential that every stakeholder in the statewide EMS system support these EMS-specific reforms. It is also time for the EMS community to focus new effort on how the statewide system can contribute to the triple aim: improved health outcomes, improved care for patients, and reduced cost. Our country and the national health care system are turning the corner and we must as well. ✱

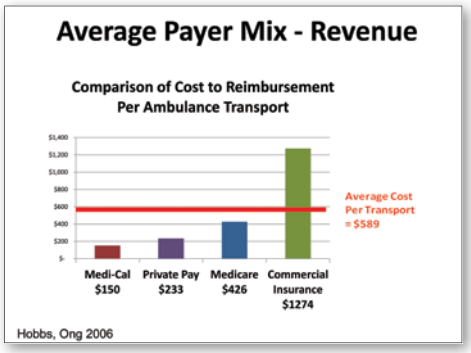
As I complete my work as Executive Director of the CAA, I want to say thank you to our members. The CAA's officers, board members and committee chairs are an outstanding group of leaders. Through their stewardship and hard work, the CAA has advanced its legislative and regulatory policy initiatives and provided enhanced value to its members. I am truly grateful to have had the opportunity to work with this fine organization.



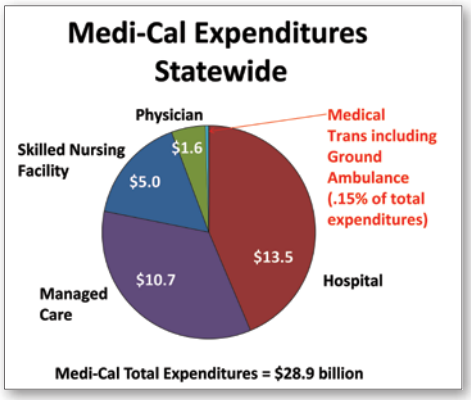
Combined, Medicare and Medi-Cal comprise an average of 73% of total transports and both programs reimburse providers below the national average cost of service.



Medi-Cal reimbursement covers just one quarter the cost of service and commercial insurance rates are 5-8 times higher than Medi-Cal rates to cover the shortfall.



The Medi-Cal Medical Transportation budget category includes non-medical gurney van and wheel chair services, ground ambulance services and air ambulance services.



The Medi-Cal Medical Transportation budget category is .15% of total statewide Medi-Cal expenditures.

2012 End-of-Session Wrap-Up

Chris Micheli | *CAA Legislative Advocate*

With the recently-concluded 2012 Legislative Session under our belt, we look back on several issues with which CAA was heavily involved, as well as look forward to the 2013 Legislative Session. Before reviewing the key bills of interest to CAA this past session, we look at the 2012-13 State Budget and where California's finances stand at this time.

The **2012-13 State Budget** that was adopted attempted to do three things:

- It addressed a $16 billion problem
- It assumes passage of Prop. 30 (Governor's tax increase proposal)
- It includes trigger cuts of almost $6 billion if Prop. 30 fails

How is the **State's General Fund** spent?

- K-12 Education: 41%
- Health and Human Services: 29%
- Corrections: 10%
- Higher Education: 10%
- Other: 10%

In an unexpected surprise, California received over $5 billion in additional revenues due to estimated tax payments received in January. It is not yet clear whether this amount is a one-time or potential ongoing sum of General Fund monies. Nonetheless, the Governor's budget still relies upon the 10% Medi-Cal provider rate reductions for a total amount of "savings" of $488 million.

In addition, there were a number of **key bills of interest** to the CAA membership. The following is a summary of the major bills with which CAA was engaged during the 2012 Legislative Session:

AB 1387 (Solorio)
Emergency Medical Services
CAA Position: Oppose, unless amended
Outcome: Failed passage
This bill would have modified the EMS Act to authorize a city or fire district to increase its geographic size under specified conditions and would have prohibited a LEMSA from creating an EOA for certain pre-hospital EMS.

AB 1275 (Torres)
PRA Exemption for Emergency 911 Calls
CAA Position: Oppose
Outcome: Failed passage
This bill would have prohibited a state or local agency from disclosing any portion of a 911 emergency telephone call providing medical or personal identifying information.

AB 1486 (Lara)
CEQA Exemption for LA Regional Interoperable Communications System
CAA Position: Support
Outcome: Signed into law by the Governor; Chapter 690
This bill creates an exemption from CEQA until 1/1/17 for design, construction, and operation of structures and equipment for the LA Regional Interoperable Communications System.

AB 1657 (Wieckowski)
$1 Traffic Offense Surcharge for Spinal Cord Injury Research
CAA Position: Watch
Outcome: Vetoed by the Governor
This bill would have imposed an additional penalty of $1 for every conviction of state or local traffic laws (except parking) and dedicate those funds to spinal cord injury research.

AB 1944 (Gatto)
EMT – P Discipline
CAA Position: Oppose
Outcome: Failed passage
This bill would have revised procedures and requirements for discipline of EMT-Ps before the Authority may deny, suspend or revoke a license; would have allowed only an employer with physician oversight to conduct an investigation; and, would have allowed the medical director of a LEMSA to refer information to the Authority and employer in certain circumstances.

AB 2281 (Torres)
State 911 Advisory Board
CAA Position: Watch
Outcome: Failed passage
This bill would have added two members to the 911 Advisory Board selected by the Legislature.

AB 2389 (Lowenthal)
Contractor Disclosure Requirements
CAA Position: Oppose
Outcome: Vetoed by the Governor
This bill would have prohibited a contractor that provides services that require entering the residence from utilizing a uniform that bears the name or logo of the contracting entity, unless certain requirements are met (conspicuously state the contractor's name and logo), and would have prohibited a contractor that provides health or safety services from using a vehicle that bears the name or logo of the contracting entity, unless the vehicle also conspicuously states the contractor's name and logo.

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Legislative *Update*

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AB 2394 (Nielsen)
EMS Commission Composition
CAA Position: Oppose
Outcome: Failed passage
This bill would have revised the membership of the EMS Commission to replace a physician and surgeon representative with an air ambulance representative.

AB 2545 (Logue)
Medi-Cal Nonemergency Medical Transportation
CAA Position: Watch
Outcome: Failed passage
This bill would have required nonemergency medical transportation services provided to Medi-Cal beneficiaries by managed care organizations to be subject to the same personnel, equipment and inspection requirements provided by fee-for-service enrolled providers.

SB 336 (Lieu)
Emergency Room Crowding
CAA Position: Support
Outcome: Vetoed by the Governor
This bill requires every licensed general acute care hospital with an emergency department to determine the range of crowding scores for the ED every four hours to assess the crowding condition of its ED, and then development and implement a full-capacity protocol by 1/1/14.

SB 359 (Hernandez)
Medi-Cal Reimbursement Rates
CAA Position: Support/Sponsor
Outcome: Amended into different subject matter
This bill would have required the Department of Health Care Services by 7/1/12 to adopt regulations establishing a higher Medi-Cal reimbursement rate for ground ambulance services using one of two specified methodologies.

SB 1365 (McLeod)
EMS Immunity
CAA Position: Support
Outcome: Signed into law by the Governor, Chapter 69
This bill extends liability limits applicable to firefighters, police officers, and EMTs to emergency medical services rendered during an emergency air or ground ambulance transport at the scene of an emergency or during an emergency air or ground ambulance transport.

SB 1378 (Hancock)
EMS Personnel
CAA Position: Oppose
Outcome: Failed passage
This bill would have required the medical director of a LEMSA to evaluate the good character and rehabilitation of an applicant for a certificate who has a prior criminal conviction before denying a certificate.

SB 1436 (Lowenthal)
Automated External Defibrillators
CAA Position: Support
Outcome: Signed into law by the Governor, Chapter 71
This bill makes permanent the immunity from civil damages for use in connection with AEDs.

SB 1528 (Steinberg)
Medical Damages
CAA Position: Oppose
Outcome: Failed passage
This bill would have provided that an injured person whose health care is provided through a capitated health care service plan shall be entitled to recover as damages the reasonable and necessary value of those medical services.

Also of interest to CAA members was the adoption of the workers' compensation reform bill – SB 863 (de Leon). With current employer costs having risen from $15 billion to $19 billion in just the past two years, it was very important to have this reform legislation. This bill is estimated to save employers about $1 billion. It also contains a substantial increase in permanent disability benefits for disabled workers.

Finally, in looking forward to the **2013 Session**, there are a number of changes in store for the CAA and its membership. For example, the new term limits law took effect and will bring over 35 new legislators to the State Capitol for the start of the new 2-year session. Moreover, that measure allows a legislator to serve a maximum of 12 years (down from the prior limit of 14 years), but can do so in one house of the Legislature. Most political observers believe their change will result in greater stability in the State Assembly, where there has been large-scale turnover of legislators every two years for almost two decades. We also expect Assembly Members to now chair committees for much longer time periods and develop greater expertise as a result. This should improve the legislative process and decision-making.

Member News

2012 Annual Convention & Reimbursement Conference Wrap-Up

The California Ambulance Association held their 64th Annual Convention & Reimbursement Conference in Anaheim at Disney's Paradise Pier® Hotel from September 25-28, 2012. Things got started with a golf tournament on September 25th at the beautiful Tustin Ranch Golf Club. Sponsors of the golf tournament included DerManouel Insurance Group, San Luis Ambulance, King American Ambulance, THOMCO, SEMSA and Schaefer Ambulance.

On Wednesday, September 26th, the CAA Committees and Board of Directors met to discuss important issues regarding the CAA and the ambulance industry as a whole. These meetings are open to all members and the CAA encourages participation. On Wednesday night, the CAA hosted the Welcome Reception & Golf Awards Dinner at Disney's Grand Californian® Hotel & Spa with special guest speaker Assemblymember Ricardo Lara. Assemblymember Lara was instrumental in organizing the ambulance donation project that was featured in the last issue of the *Siren*.

The CAA Marketplace opened Thursday morning and convention attendees were able to browse the booths and talk to the vendors about their products and services. Educational sessions also got underway Thursday morning, beginning with a speaker from the Disney Institute. Conference attendees called this session a "nice way to start" and stated that the speaker offered "great insight." Other Thursday sessions covered topics such as Health Care Reform, High Performance Billing Operations and Complying with California's Meal and Rest Period Requirements. The always informative Mike Scarano, Esq. presented a session entitled "ACA Update: Bundling, Demonstration Projects & Enforcement." That evening, convention attendees gathered for the Annual Chair's Banquet & Awards featuring comedian and political satirist, Will Durst. The board members and committee chairs were honored for their hard work and dedication and at the end of the evening, Outgoing Chair, Bob Barry passed the gavel to Incoming Chair, Helen Pierson.

Friday's sessions included a Medicare Claims Update and one on Medicare Revalidations & PECOS from Kathy Montoya from Palmetto GBA. Dr. Jerry Allison, MD discussed Opportunities for CA EMS Systems regarding Community Paramedicine. The convention adjourned at noon and many of the convention attendees could be found getting an early start on their weekend over at the amusement parks.

The CAA would like to thank all of the sponsors, vendors, speakers, attendees and guests for joining us for this fun, educational and informative event. We hope to see you at the next convention! ✻

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Comments or questions about membership applications should be directed to: Kim Ingersoll: *kingersoll@the-caa.org.*

Partnership Donates Ambulances to Underserved Nayarit, Mexico

OIG Issues Advisory Opinion Addressing ALS Bundles Billing in Dual Responses

Mike Scarano | *Foley & Lardner LLP*

The Office of Inspector General of the Department of Health and Human Services ("OIG") has issued an advisory opinion addressing the important issue of what constitutes a reasonable allocation of payment when a BLS transport provider jointly responds with an ALS non-transport agency and submits a "bundled bill" to Medicare. Such arrangements have become increasingly common, especially between private BLS ambulance providers and fire department ALS first responders.

The opinion, No. 12-12 (issued September 6, 2012), responded to an inquiry regarding a proposed arrangement between a nonprofit BLS transport provider and a nonprofit ALS intercept provider. The BLS transport provider holds the BLS "primary service area responder designation" for 911 calls from the state EMS agency and the ALS provider holds the same designation for ALS services. As a result, the BLS provider is required by law to call the ALS provider in the event the patient requires the ALS level of care. When called, the ALS provider performs paramedic intercept services, resulting in what CMS refers to as a "BLS/ALS Joint Response."

To compensate the ALS provider for its services when Medicare or Medicaid patients are involved, the parties proposed to enter into a written "Bundled Billing Agreement" providing for the BLS transport provider to submit claims to those programs at the ALS rate for transports where the ALS supplier performed ALS services. Upon receipt of payment from Medicare or Medicaid, the BLS provider would pay the ALS supplier the difference between the BLS supplier's customary BLS reimbursement and the amount paid for the ALS bundled bill by Medicare or Medicaid ("the BLS-ALS Differential"). The BLS provider would also collect any applicable copayments and pay the ALS provider the difference between the portion of the copayment attributable to BLS services and the total copayment received. Since those payment amounts likely would equate to less than what the ALS supplier could collect if it charged patients directly, the ALS supplier might also be paid an additional amount negotiated under the terms of the Bundled Billing Agreement, to be adjusted as necessary based on the parties' annual review of call volume. The parties represented that there would not be any remuneration of any kind from the ALS supplier to the BLS supplier for referring business under the proposed arrangement.

Although such joint response and bundled billing arrangements are common throughout the country, this was the first advisory opinion addressing the issue of what constitutes a reasonable allocation of compensation between the ALS and BLS providers. The OIG approved the arrangement, based in part on a provision in the Medicare Benefit Policy Manual which specifically addresses this type of joint response. With respect to billing for BLS/ALS joint responses, the Manual states:

"In situations where a BLS entity provides the transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment, paramedic intercept services, etc.), the BLS supplier may bill Medicare at the ALS rate provided that a written agreement between the BLS and ALS entities exist prior to submitting the Medicare claim ... Medicare does not regulate the compensation between the BLS entity and the ALS entity."

Although the last sentence suggests that the government would not scrutinize the payments between ALS and BLS providers in joint response/bundled billing arrangements, the OIG chose to do so here. The OIG stated that while the two providers "may not divide the payment in such a way as to compensate either party for referring or generating federal health care program business, nothing in the facts of the proposed arrangement suggests that this would occur here." The OIG reasoned that the ALS intercept provider was not in a position to refer or influence the referrals of federal health care program business or any other business to the BLS provider. Further, the OIG noted that the BLS provider, under state law, was required to call the ALS provider for paramedic services whenever ALS services were necessary. Although the OIG acknowledged that this made the BLS provider a source of referrals to the ALS provider, the proposed payment arrangement (i.e., payment to the BLS provider of the BLS rate and to the ALS provider of the BLS-ALS Differential) did not constitute remuneration.

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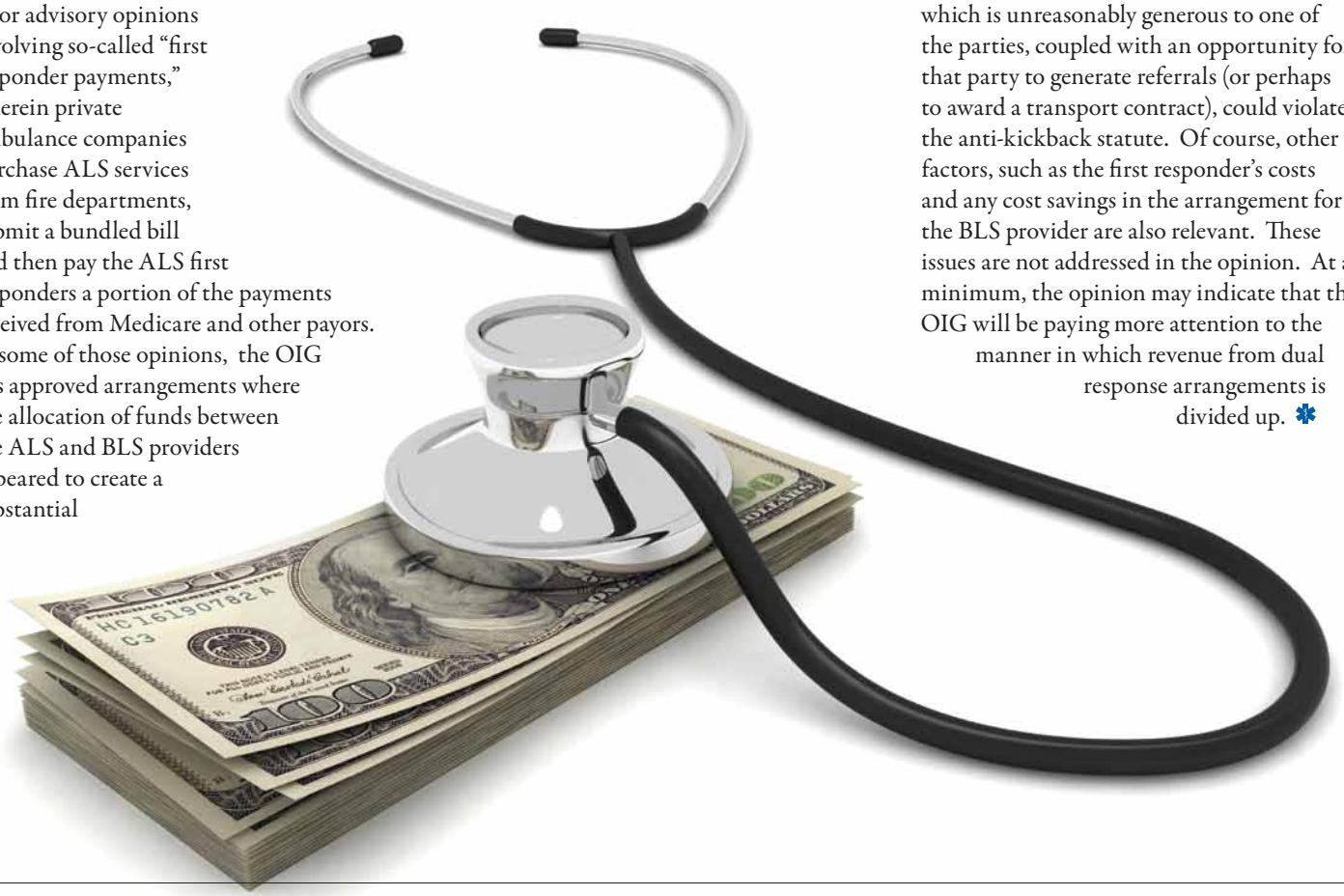
However, the OIG added a very significant caveat: in a footnote, the OIG states that "we might have reached a different result if ... the BLS [provider's] payments under the bundled billing agreement were not limited to the BLS rate of payment." In other words, the OIG suggests that if the BLS provider had been paid in excess of the BLS rate, that excess might have been viewed by the OIG as remuneration for its referrals to the ALS provider.

Although not specifically addressed by the OIG, the Opinion may also have implications for the converse situation where the ALS responder, rather than the BLS transport provider, is paid in excess of the amount approved by the OIG in this Opinion (i.e., the BLS-ALS Differential), if the ALS provider is in a position to make referrals to the BLS transport provider. This issue has been raised, but not specifically addressed, in prior advisory opinions involving so-called "first responder payments," wherein private ambulance companies purchase ALS services from fire departments, submit a bundled bill and then pay the ALS first responders a portion of the payments received from Medicare and other payors. In some of those opinions, the OIG has approved arrangements where the allocation of funds between the ALS and BLS providers appeared to create a substantial danger that referrals – or perhaps the award of the transport contract itself – were being rewarded or encouraged.

For example, in Advisory Opinion 06-06 (May 1, 2006), the OIG reviewed a proposal by a city to issue an RFP for a BLS transport provider to perform joint ALS/BLS responses with the city, which would provide the ALS first response. The transport provider would submit a bundled bill to Medicare and would compensate the city for its ALS services. In the RFP, the city proposed to state that the minimum amount bidders could propose as compensation for the city's ALS services would be the BLS-ALS differential. The OIG approved the arrangement even though the amount payable to the city for its ALS services would necessarily exceed the BLS-ALS differential.

In another advisory opinion, number 04-10 (August 4, 2010), the OIG also reviewed a joint response/bundled billing arrangement in which a city that operated an ALS first responder proposed to award its BLS ambulance contract to the private company that would pay the highest amount for ALS first response, even if that amount was far in excess of the BLS-ALS Differential. Again, the OIG approved the arrangement. Many observers felt that these two opinions were an invitation to public agencies with ALS first responder capability to gouge BLS transport agencies by requiring them to pay an exorbitant portion of the bundled fee to the ALS agency.

The footnote in new Advisory Opinion 12-12 may implicitly cut back on these earlier opinions by suggesting that the BLS-ALS differential represents a fair and reasonable payment to an ALS first responder or ALS intercept provider, and that an allocation which is unreasonably generous to one of the parties, coupled with an opportunity for that party to generate referrals (or perhaps to award a transport contract), could violate the anti-kickback statute. Of course, other factors, such as the first responder's costs and any cost savings in the arrangement for the BLS provider are also relevant. These issues are not addressed in the opinion. At a minimum, the opinion may indicate that the OIG will be paying more attention to the manner in which revenue from dual response arrangements is divided up. ✱



Feature *Article*

2012 California Workers' Compensation Reform Package Enacted

Chris Micheli | *CAA Legislative Advocate, Aprea & Micheli, Inc.*

As California's ambulance companies are well aware, workers' compensation costs have been on the rise the past few years. These increased costs are being paid by employers, while injured workers are not seeing benefit increases. Most agree that delays and frictional costs in the workers' compensation system are to blame. Both employers and workers want to ensure that injured workers receive timely medical care and appropriate benefits to ensure prompt return to work.

As a result, organized labor and employer representatives spent many months in 2012 negotiating numerous changes to California's workers' compensation laws, which were eventually dropped into SB 863 (de Leon). This reform package began after completion of almost three years of research that was conducted by the Commission on Health and Safety and Workers' Compensation. Moreover, the Department of Industrial Relations held a series of statewide hearings to receive recommendations from interested parties to improve the comp system.

Those negotiations took place with involvement of key members of the Brown Administration, as well as major businesses including Disney, Safeway, and Grimmway Farms. Workers were represented by the California Labor Federation. The last reforms to California's workers' compensation system were enacted in 2004 under the Schwarzenegger Administration. Although comp costs were substantially reduced after they peaked in 2003, insurance costs have steadily risen over the past half a dozen years.

Shortly after the statewide listening tour was completed by the DIR staff, labor and employer groups negotiated over three major principles:

- Empirical data showed that injured workers require increased permanent disability benefits;
- Delays and system costs hurt everyone;
- Benefit increases have to be offset by more than equivalent savings in the system.

The resulting changes contained in SB 863 center on four major areas:

- Improved Medical Treatment
- Increased Permanent Disability Benefits
- Decreased Friction and Inefficiencies in the System
- Stabilized Insurance Market

Some of the major reforms include: independent medical review, modeled after the health insurance process, to help minimize delays in medical treatment with quick turnarounds and evidence-based treatment guidelines. Medical access assistants are created to assist injured workers. An estimated benefit increase of over $700 million will be provided during a phase-in of two years. Several adjustment factors for future earning capacity are eliminated. The bill also contains significant changes to the lien process, including imposition of a filing fee and independent bill review process for adjudication of billing disputes. New fee schedules are also established for certain services and equipment.

There is some disappointment that the Workers' Compensation Insurance Rating Bureau would only recommend a 1% decrease in the planned 12.6% advisory pure premium rate increase that will take effect January 1, 2013. Nonetheless, all major employer groups, including CGA, were in support of the package because it reflected a negotiated compromise to provide a substantial increase in PD benefits, as well as eliminate waste and inefficiencies that result in unnecessary employer costs.

The following is a summary of the major provisions of SB 863:

- Eliminates the Workers' Compensation Appeals Board's authority to adjudicate medical treatment disputes that are directed to the Independent Medical Review system.
- Establishes the IMR process, patterned after a similar process used for resolving health insurance disputes in order to resolve medical treatment issues. This process is binding on all parties absent certain circumstances.
- Allows employees to appeal utilization review decisions under specified circumstances.
- Establishes an Independent Bill Review process to take medical billing disagreements out of the jurisdiction of the WCAB adjudication system.
- Repeals the requirement that a second opinion be obtained in cases of spinal surgery.
- Establishes a prohibition for any interested party in the WC system

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Feature *Article*

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to have a financial interest in another entity to which it is referring a party for services or for which it is paying or receiving compensation.

- Increases PD benefits by approximately $740 million per year, to be phased-in over a two-year period and adjust the formula for calculating the benefit amount.
- Eliminates certain "add-ons" to primary injuries that do not include these injuries when calculating the level of permanent disability, and eliminates the diminished future earnings capacity from the PD determination.
- Establishes a return-to-work program administered by the Department of Industrial Relations that will be funded by an annual appropriation of $120 million for the purpose of making supplemental payments to workers whose PD benefits are disproportionately low in comparison to their earnings loss.
- Makes numerous changes to the Medical Provider Networks, including required periodic audits by the Administrative Director, and establishing an expedited process to resolve any disputes about whether the injured workers is required to be treated within the MPN.
- Makes several modifications to the Supplemental Job Displacement Benefit rules.
- Makes a number of changes to the filing of liens, including a prohibition against filing of liens where awards were subject to the IMR and IBR dispute resolution processes; establishing a $150 filing fee; adopting time limits within which liens must be filed.
- Adopts a fee schedule for ambulatory surgery centers. ✱

Feature *Article*

Health Care Reform Implementation in California

Chris Micheli | *CAA Legislative Advocate, Aprea & Micheli, Inc.*

On December 3, 2012, a new California legislature got sworn in for the 2013-14 Legislative Session, with new members, a super-majority of Democrats, and an effort to implement health reform and improve health care in general. Both Senate President Pro Tem Darrell Steinberg and Assembly Speaker John A. Perez mentioned health issues in their opening remarks after being formally re-elected to their leadership posts in early December.

Senator Steinberg directly addressed some of the commentary about the California Legislature's new 2/3 "supermajority" for the Democratic Party. "We get the overreach warning," he said, but also expressed concern about "the danger of being so cautious ... that we fail to take advantage of opportunities." On the budget, he expressed relief that "we don't have to cut more," and that the possibility of future surplus means that "even if we can't reinvest this year, we have to [think] about public investments in the future."

Along with building a budget reserve and paying off debt, Senate Leader Steinberg expressed that a final third of any surplus should go to restore key services that had been lost. The main cut that he highlighted for restoration was the elimination of dental coverage in 2009 for 3 millions adults in Medi-Cal, a cut made in bleaker budget days. Steinberg recalled going to a free dental clinic at Cal Expo last summer, and seeing "endless lines of people" (mostly working families) requiring root canals and dental surgery, who had put off basic dental care for years.

In the Assembly, Speaker Perez also discussed the improving budget condition, but also listed accomplishments such as the establishment of the Health Benefits Exchange for families and small businesses. The Speaker discussed health care when laying out future plans: "Certainly much of the early focus of this legislature will be on the special session on health care that the Governor will call in January. While there is great diversity and debate over its tenants, the Affordable Care Act is the law of the land," and "our duties as legislators is to implement its provisions in the most efficient and effective manner for the people of California."

The Speaker cited expanding coverage, as well as the long-term work of bringing health care costs down. "Californians are counting on us that we ensure access to affordable health care ... not just for the health of our population, but also for the health of our finances."

As cited by Speaker Perez, it is expected that Governor Brown will call a special legislative session in January to continue the work of implementing federal health care reform in California. New benefits of the Affordable Care Act come online on January 1, 2014, and the goal is to start signing Californians up for these new coverage options in October 2013 – ten short months away.

The special legislative session on health reform implementation is expected to consider the new rules for insurers (including banning denials for pre-existing conditions), and the expansion of Medi-Cal. Much more work is needed at the Department of Health Care Services, Department of Managed Health Care, Department of Insurance, and the new health benefits exchange, now called Covered California. ✱

Is Your Ambulance Clean?

Jimmy Pierson | *Medic Ambulance Service, Inc.*

Here is a shocking statistic: According to the United States Centers for Disease Control and Prevention (CDC) Nosocomial Infections (or Healthcare Associated Infections – "HAIs") defined as "... infections which are a result of treatment in a hospital or a healthcare service unit, but secondary to the patient's original condition" are the 4th leading cause of death in the United States. The CDC estimates that nosocomial infections sicken 1.7 million patients and are responsible for 99,000 associated deaths each year in US hospitals alone. HAIs KILL almost 100,000 people and make around 1.7 MILLION patients sick and/or sicker PER YEAR in the US. Why is this information important to us in the ambulance industry? We need to be asking ourselves what are we doing to prevent these bacteria/infections in our ambulances? Does your company have Standard Operating Guidelines (SOG) for how to properly disinfect and clean your ambulances and equipment. Do your guidelines speak to pre and post call cleanings? We review some national studies regarding this topic.

STUDY 1 – Eau Claire Fire Department, Eau Claire, Wisconsin

Eau Claire Fire Rescue does not have guidelines in place for cleaning of the ambulance and EMS equipment between transports of patients. A study was conducted to determine the level of contamination on EMS equipment and ambulance, to develop a decontamination guideline for Eau Claire Fire Rescue personnel so as to prevent cross-contamination of patients. The action research approach was used to answer the following questions:

1. What level and type of decontamination is found on Eau Claire Fire Rescue EMS equipment and ambulances?
2. What type of a cleaning process is needed to decontaminate the EMS equipment and ambulances?
3. How long is it between cleaning processes before contamination is found again?

The procedures that were used for this study were swab testing of ambulances and EMS equipment to determine levels of contamination prior to and after two different methods of cleaning were utilized. The research found that Eau Claire Fire Rescue ambulances and EMS equipment were contaminated with several types of bacteria prior to, and after cleaning, with both cleaning methods. The research found that manual cleaning of ambulances was just as effective as using a commercially available cleaning system. The recommendation for this research was to develop a Standard Operating Guideline for the cleaning of Eau Claire Fire Rescue ambulances and EMS equipment. For full article please go to: *www.usfa.fema.gov/pdf/efop/efo44611.pdf*

STUDY 2 – 7 in 10 Ambulances Positive for Staph Isolates

Drug-resistant strains of infectious bacteria are hitching a ride into hospitals through an under-appreciated path – the ambulance – according to a sample of 71 Chicago-area emergency response vehicles. The researchers, led by James Rago of the Lewis University Department of Biology in Romeoville and members of the Orland Fire Protection District in Illinois, obtained samples from 26 sites in 71 ambulances from 34 Chicago area municipalities. They found at least one isolate of Staphyloccocus aureus in 69% of all ambulances, and 77% showed resistance to at least one antibiotic, and one third were resistant to two or more. Ampicillin resistant strains were most common, found in 74% of all isolates, although 70% showed resistance to erythromycin.... Rago said that the study should prompt paramedic service personnel to pay more "meticulous attention to proper ambulance cleaning by the pre-hospital emergency care community." In a news release, Rago said the study's results indicate that first responders in general "are doing a good job of protecting their patients. The research is significant because improper cleaning of these surfaces could be a cause for concern due to the frequency with which emergency medical technicians may touch infected surfaces during patient care, the prevalence of open wounds among burn victims, and the fact that these patients go directly to the hospital where they come in contact with patients with compromised immune systems who are vulnerable to infections." How often should ambulances be cleaned? "The more, the better, within reason of course," Rago said. For full article please go to: *www.healthleadersmedia.com/content/QUA-278359/7-in-10-Ambulances-Positive-for-Staph-Isolates*

Below are some terms you should know:

STERILIZATION: This is a term used to describe the total and complete removal of all forms of microbial life including bacteria, viruses, fungi, and other organisms in all phases of their lifecycle.

HIGH-LEVEL DISINFECTION: This is a term used to describe a very broad-

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spectrum disinfection process that destroys almost all microbial life but may not completely remove all possible bacteria, viruses, or spores. It is usually accomplished by a prolonged soak in a liquid chemical sterilant but not for the contact time needed for terminal sterilization. This process is used for "semi-critical devices" that come into contact with mucous membranes but for which sterilization is not completely attainable or would damage the equipment. Examples of semi-critical devices in the EMS field include laryngoscope blades, Magill Forceps, etc.

DISINFECTION: This term is used to describe a process in which an environmental surface is first cleaned and then processed in a manner that kills a defined amount of known microbial organisms. There are two further loose classifications of disinfection practices below the above: "Intermediate" which is used for patient care equipment and surfaces such as EKG monitors, Ambulance cots, BP cuffs, stethoscopes, and other like equipment. "Low" level disinfection would be appropriate for environmental surfaces such as walls, floors, and countertops.

SANITIZATION: This process is defined as a chemical substance or process that kills 99.9% of a specific bacterial sample within 30 seconds but when compared to a normal use concentration a disinfecting agent will kill a broader spectrum of microbial life.

ANTISEPTIC AGENT: This is a term used to describe a process that kills microbial life on living tissue, such as antiseptic soap or alcohol hand sanitizer.

CLEANING (OR PRE-CLEANING): This is a process used with a detergent and a cloth or other friction-causing device that removes dirt and other gross contaminants from a surface. By removing the gross contaminants, you remove the food that microbes eat, the dirt particles that they hide in, and the biofilms that they create and thrive in. Most disinfectants and sanitizers require a pre-cleaning process in order to be effective.

CONTACT TIME: The length of time that a surface must remain saturated with a sanitizer or disinfectant in order to kill the specified number and type of microbes desired.

As you can read in the above articles and information it doesn't take a huge organizational change to ensure the equipment and ambulances used to treat our patients is clean and disinfected. It doesn't take investing thousands of dollars into bacteria killing machines. What it takes is a commitment from your organization to ensure your company has the proper processes in place. Some ways to implement these processes include:

- Create Standard Operating Guidelines (SOG): These guidelines should dictate to your employees, when, what, how to, and with what to clean their ambulance and EMS Equipment.
- Create a culture of cleanliness: Have crews wash and mop their ambulance and equipment at the beginning and end of every shift.
- Create Clean Days: Use logistics staff and supervisory staff to re-educate field personnel on the importance of cleaning and review technique of field personnel.
- Make cleaning supplies readily available: Ensure field personnel have proper cleaning work stations and fixed deployment stations and ensure field personnel have extra cleaning products with them in their ambulance (i.e., wash towels, EPA-approved cleaning materials, etc.). Both of these are requirements for the Commission on the Accreditation of Ambulance Services (CAAS).

There is no way to completely eliminate these dangerous and infectious bacteria, however we have an obligation to our patients and citizens to ensure the ambulance and EMS equipment we treat with are clean and do not cause harm. Overall, EMS has done a good job at keeping this at bay, but we need to ensure we are doing enough.

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Member *Profile*

FIRST RESPONDER™
EMERGENCY MEDICAL SERVICES, INC.

In the Winter 2011 issue of *the Siren*, R. Michael Scarano, Jr., Esq. described in some detail the appellate court decision that answered the long-outstanding question of whether the existing providers in Butte County (First Responder Emergency Medical Services, Inc. ["First Responder"] and Enloe Ambulance [a department of Enloe Medical Center, "Enloe Ambulance"]) would be allowed to continue their historical ambulance operations in exclusive operating areas ("EOAs") granted under the grandfather provisions of Section 1797.224 of the State EMS Act. Butte County's ambulance services were finally put out to bid in the beginning of 2012; proposals were submitted on July 18, 2012; a recommendation to approve the joint proposal of First Responder and Enloe Ambulance was made in September of 2012; and First Responder is delighted to report that the JPA approved the recommendation on November 9, 2012.

HOW WE GOT HERE

First Responder's operations started in 1988, when Byron Parsons and Marcus Whitaker purchased Chico Ambulance from Chico Community Hospital and began operations as a partnership named Chico Paramedic Rescue. The beginnings were humble, two high mileage ambulances and five employees, Byron Parsons, Marcus Whitaker, Louwane Dagler and two part-time paramedics.

Byron and Marcus had an operating philosophy in mind as they started Chico Paramedic Rescue: "Give excellent patient and community care; take excellent care of each other; and become profitable enough to continue the first two goals." Expanding on this philosophy, Byron explains: "Patients and their families benefit greatly from taking that little extra bit of time to explain what's happening and why. In times of crisis everyone involved is under some stress and it is our responsibility as professionals in the field to see that everyone's needs are assessed and addressed. If time on scene is an issue then a follow-up phone call to family members or a friendly stop at the fire station can make a huge difference in everyone's experience. To this day, First Responder tries to go the extra mile."

Byron and Marcus survived the early growing pains, and incorporated the business in January, 1991 as First Responder. After Marcus' death in 1991, Byron and Louwane Parsons continued the company's operation as a small family owned business which it continues to be to this day. In 1997, First Responder expanded its operations to Paradise by acquiring Paradise Ambulance from Don Howard. In 2002, First Responder expanded its operations to Oroville by acquiring Oroville Ambulance from Oroville Hospital.

Today, First Responder operates throughout Butte County with approximately 36 Paramedics, 35 EMTs, 3 Emergency Medical Dispatchers ("EMDs") and 16 ambulances.

In 1998, Byron decided to step out of his comfort zone and explore non-emergency medical transport operations in and around Sacramento. Byron and his partners formed a second corporation, First Responder EMS – Sacramento, Inc. ("First Responder – Sacramento"), to serve Sacramento, Yolo and Placer Counties with 24-hour coverage of CCT Nurse ambulance transport, neonatal and pediatric intensive care ambulance transport (in partnership with UC Davis Medical Center), ALS ambulance transport, BLS ambulance transport, gurney van service, and wheelchair van services. First Responder – Sacramento currently has approximately 171 employees (including

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37 Paramedics and 104 EMTs), 14 RNs, 6 EMDs and 31 ambulances.

Through Chico Creek Aviation, which owns a twin-engine Piper Navajo, N539M, First Responder is also able to provide a fixed-wing air ambulance transport.

WHAT WE HAVE LEARNED

Let's just stipulate that family operated ambulance companies share certain characteristics. They tend to be deeply involved in their communities hence they are somewhat less focused on the bottom line and more focused on people. Managers are involved in every aspect of the day-to-day operations – hence it is never a problem going directly to anyone in the command chain with a problem or issue, up to and including the CEO. Relationships develop over time that permeate the corporate gestalt. From associations with base hospitals and SNFs, standbys at football games, involvement with police and fire on tactical training exercises, and high school assemblies such as Every Fifteen Minutes, to integration with public health on a variety of issues such as the H1N1 virus and mental health responses, our roots in the community have grown deep. We're rural, less bureaucratized, known in the community and we love it. We're locally owned and operated and proud to be able to continue that tradition. (If you're curious, please take the time to watch our video on the face page of our BCEMS website at *www.buttecountyems.org.)*

Butte County is an Island

Still a few peculiarities about Butte County put First Responder in a good position to make a bid. As outlined above, one of the facts that cannot be ignored is that we were well aware that the bid process was coming. We had years to put systems and equipment in place to compete with the best of them. On top of that, Butte County is an island. We are surrounded by 6 counties, 4 of which have only two ambulances available for the entire County. The remaining two Counties, Yuba and Sutter have approximately 10 combined. Not only are there few mutual aid resources available, the geographical distances mean that it would take at least 45 minutes for another provider to arrive. This is why First Responder preferred a system with above average redundancies. It is also why we use stations and don't down staff at night to save a few extra dollars.

Because we are an Island, we have always been compelled to go above and beyond, not only looking at our own service area, but also responding to the needs of our neighbors. Butte County was one of the first three counties in California with a paramedic program. As a result, First Responder has been at the forefront of discussions regarding the appropriate scope of practice for paramedics; generally pushing for an expansion of scope along the lines of community paramedicine models being instituted in numerous areas through the United States. We have participated in numerous test and pilot programs regarding our scope as well as drug efficacy trials and beta testing new equipment. When 12-Lead EKGs became available, First Responder partnered with Enloe Ambulance not only to install this new equipment throughout our fleets, but also to obtain grants so that 12-Leads would be available in surrounding counties. To quote Bob Wentz of Oroville Hospital: "We have always been blessed with a very excellent ambulance service."

An example of the benefits of our decision to develop a system with above-average redundancies can be pulled from our 2012 fire season. Our LEMSA needed to make contingency plans for evacuations in Plumas County. They called us and we had 6 ambulances and crews available for a strike team to evacuate Seneca Hospital. The call came in around 2:00 p.m. on Tuesday. We had resources committed by 5:00 p.m. The redundancies in our system, by design, allowed us to make these resources available with absolutely no impact to our system needs in Butte County.

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*Patient Centered **Prehospital** Care.*

Yes, we are an ambulance company performing thousands of emergency medical transports a month and we've already shared our philosophy for always treating the patient first, but we view our business in a larger sense. How can we gently nudge paramedic services to keep people out of the hospital? Let us give you one example. Healthcare reform now ties hospital reimbursement to specific performance measures. Currently, CMS will not pay hospitals when patients with certain diagnoses are readmitted within 30 days of discharge. In collaboration with SSVEMSA, the State EMSA, and Enloe Medical Center, BCEMS has plans to launch the *Avoidable Hospital Readmission Management Pilot Project*. Our plan will schedule BCEMS field supervisors and paramedics to make post-discharge visits to patients with a Core Measure diagnosis to determine if we can deter unnecessary readmissions due to non-compliance with discharge instructions.

Other examples abound. Participation in Tactical strike teams for MCIs or terrorist incidents; coordination with fire for massive wildfires, community paramedicine all demonstrate the depth of our involvement in local issues. The pilot project described above shows the need to expand ambulance services from just emergency transports to other areas of prehospital care to which paramedicine is particularly suited. Mental health patients provide another excellent example. Devising a way to keep these patients out of the emergency department benefits the system as a whole. In our view, the paramedic portion of the ideal emergency medical system will be proactive as well as reactive. Maybe we are shaped by our location in rural Butte County, but First Responder will always go the extra yard and never believe our service begins or ends at the hospital door.

Vehicles and Equipment

First Responder has exemplified professionalism in every corner of our success. Equipment is no exception. From the beginning, our strategy has been to bring to our employees the absolute best in every piece of equipment. Well before the competitive process, the best of the best deployed into our system. In 2007, 12 lead EKG's began their tenure. The ecofriendly Sprinter Ambulances, along with global positioning hardware and software was deployed in 2008. The full suite of Zoll products was introduced in 2008. Recently, in 2012, we have brought to the table, the next generation of 12 lead EKG's, Zoll's X Series with WiFi telemetry. We have not

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even begun to mention Road Safety, ePro Scheduler/Manager, Rescuenet Link and Insight from Zoll. These expensive pieces of equipment fit together like a puzzle to do one thing, provide a high degree of professionalism so we can center our focus on the patient. For First Responder this was one of the easiest areas in which to compete.

LOOKING AHEAD

There are days when we look back and recall the days when family owned business meant we knew not only the names of each of our employees, but also those of their wives, children and families. Notwithstanding all the outside forces pushing First Responder into a more corporate world of policies and procedures, internal rules and regulations, First Responder will always maintain those aspects of its operations that make the ambulance business in a rural county special. Although the ties may seem, from time to time, attenuated, we still have some attributes that some companies lack. We are deeply local and value the 25 years we have spent developing a nationally competitive EMS system. We are deeply thankful for the help of countless others in the community and elsewhere who contributed to its development. We remain committed to providing our employees with the best possible environment in which to practice paramedicine. Finally, we look forward to the challenges that lie ahead; and plan to continue to be at the forefront of providing practical solutions to the challenges, solutions that work in all the counties we serve.

A Final Anecdote

Every ambulance company has stories. We'd like to leave you with the story we chose to tell at the end of our bid proposal:

A REMINDER

We wish to close our proposal with the following story. It is a reminder to all of us of why we do what we do. In 2002, Janis Anderson was dying of untreatable liver cancer. Frail, hooked up to IVs, bedridden, with days to live, her husband made a series of phone calls to various agencies that eventually led to First Responder. Brian simply wanted to give his wife one last gift. Assistant Chief Denise Kratzer immediately approved the idea and arranged a time to send an ambulance with its collapsible gurney to the Anderson's home. Ms. Kratzer's quote in the paper says it all: 'She said this was being done as a service with no fee involved. This wasn't business. This was about people helping each other.'

At the appointed time, the ambulance team arrived, gently moved Janis onto a gurney and with Brian at her side, carefully rolled her outside into the sunshine. The crew left the couple alone and after a short time, took her back to her bed. To this day, Mr. Anderson sends flowers to the crew in appreciation for their efforts. The public appreciates our service, we appreciate the opportunity to serve, the flowers weren't necessary, but once a year we are blessed with a reminder of why we all wanted to serve the public as EMS professionals."

Byron Parsons is the CEO of First Responder, First Responder – Sacramento, and PHP as well as a Managing Director of BCEMS. He is Chairman of the Ethics & Professionalism Committee of the CAA. His direct line is (530)879-5510.

To learn more about First Responder Emergency Medical Services, Inc., visit *http://firstresponder.com* or call (530) 891-4357.

CALIFORNIA AMBULANCE ASSOCIATION
2520 VENTURE OAKS WAY, SUITE 150
SACRAMENTO, CA 95833 • *www.the-caa.org*
877.276.1410 (toll free) • 916.924.7323 (fax)

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