CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

September 24, 2019

Esam El-Morshedy
Emergency Medical Services Authority
Attn: Paramedic Regulations
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670-6073

By email to:
Esam.el-morshedy@emsa.ca.gov

RE: Fourth 15-day Public Comment on Proposed Revisions to Chapter 4 Emergency Medical Services for Paramedics

Dear Mr. El-Morshedy:

California's hospital emergency departments (EDs) are committed to providing the right care, at the right time, at the right place, for all our patients. An important component of providing that care is the state's use of alternate destinations for patients who would be more appropriately served in a setting other than hospital EDs. In furtherance of those efforts, the California Hospital Association (CHA) — on behalf of our more than 400 member hospitals and health systems —respectfully offers the following comments for consideration on the Emergency Medical Services Authority's (EMSA) proposed regulations regarding standards, policies, and procedures for paramedic training, scope of practice, licensure, and discipline.

We understand that EMSA has removed the alternate destination language from the proposed text to give the new EMSA Director the opportunity to work with stakeholders and collaborate on a path forward. We want to assure EMSA of our commitment and dedication to all forms of community paramedicine, and most importantly, alternate destinations. Alternate destination protocols are necessary because, as you know, ED overcrowding continues at a disturbing pace — hospital emergency departments across the state report more than 16 million visits annually. EMSA, local emergency medical services agencies (LEMSAs) and CHA all recognize the detrimental effect that emergency department overcrowding is having on the delivery of care, despite increased capacity and system-wide performance improvement measures. California hospital EDs do not have the non-emergent specialty care resources to properly care for behavioral health patients who require the services of psychiatric facilities. California hospital EDs also do not have the capacity to care for non-emergent patients such as those requiring only sobering services. Pilot projects operated under the auspices of the California Office of Statewide Health Planning and Development have demonstrated that these patients can be successfully treated in alternate destination sites. It is imperative that the definitions/criteria adopted for participating sobering centers and mental health facilities protect quality and patient safety, and are broad enough to ensure access to the wide variety of facilities able to provide safe care.

CHA offers four specific comments, as specified in the attached comment grid and discussed below.

1) **Article 3. Program Requirements For Paramedic Training Programs, §100149, page 11, line 39**. The text of (j)(3)(C) should be revised from "are accredited by a Centers for Medicare & Medicaid Services with deeming authority" to "are certified by the Centers for Medicare &

Medicaid Services." This is just a technical correction. There are two ways a hospital may be certified to participate in the Medicare and Medicaid (Medi-Cal) programs: either by being certified directly by the Centers for Medicare & Medicaid Services (CMS), or by being accredited by an organization that has been granted deeming authority by CMS. The EMSA regulations should be clear that either method of being certified by CMS is acceptable.

2) **Article 7. System Requirements, §100170, page 40, line 8.** We propose adding language to this provision to support hospitals that are concerned with the growing responsibilities of base station oversight stemming from newly added pilot alternate destination sites, and those that may be added in the future. These responsibilities include additional quality assurance activities, data collection, and educational requirements. We therefore request that there be collaborative decision making when developing additional alternate destination base station policies and procedures between the LEMSA and the GACH base station providers. Our proposed language is specified in the attached comment grid.

3) **Article 7. System Requirements, §100170, page 40 line 45.** As stated in paragraph 2 above, CHA and its members request that the regulations ensure collaboration on base station alternate destination policy and procedures. We therefore offer the language specified in the attached comment grid.

4) **Article 7. System Requirements, §100170, page 41, line 28**. CHA requests that the sobering center definition be revised in any future rulemaking to include the 13 sobering center facilities currently operating across the state. CHA has worked closely with the newly-formed National Sobering Center Collaborative (NSCC) to develop criteria to ensure access to and the quality of these centers. While the state's longest-running sobering center in San Francisco is a federally qualified health center (FQHC), other highly effective centers are operating across the state without FQHC status. CHA's proposed definition assures that non-FQHC sobering centers meet safety and quality measures, including those centers that are participating in the Office of Statewide Health Planning and Development Workforce Pilot Project #17 and others that are willing to pursue upcoming accreditation standards to be developed by the NSCC. Our proposed language is specified in the attached comment grid.

As EMSA is aware, alternate destination policies will both alleviate hospital ED overcrowding and reduce EMS ambulance patient offload times. CHA stands ready and willing to work with EMSA and LEMSAs and other stakeholders to innovate and accelerate improved EMS care that puts patients first. We are committed to delivering the right care, at the right time, by the right provider, the first time we interact with a patient.

Sincerely,

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Comments on the Proposed Paramedic Regulations
Chapter 4, Division 9, Title 22, California Code of Regulations
Fourth 15-day Public Comment Period
September 13 - September 28, 2019

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Article 3. Program Requirements for Paramedic Training Programs, §100149. Page 11, line 39	California Hospital Association	Change (j)(3)(C) from "are accredited by a Centers for Medicare and Medicaid Services with deeming authority" to **"are certified by the Centers for Medicare & Medicaid Services."** There are two ways a hospital may be certified to participate in the Medicare and Medicaid (Medi-Cal) programs: either by being certified directly by the Centers for Medicare & Medicaid Services (CMS), or by being accredited by an organization that has been granted deeming authority by CMS. The EMSA regulations should be clear that either method of being certified by CMS is acceptable.	
Article 7. System Requirements, § 100170. Page 40, line 8	California Hospital Association	Change (a)(2) from "Local medical control policies and procedures as they pertain to the paramedic base hospitals, alternative base stations, paramedic service providers, paramedic personnel, patient destination, and the LEMSA" to "**Local medical control policies and procedures as they pertain to the paramedic base hospitals, alternative base stations, paramedic service providers, paramedic personnel, patient destination, and the LEMSA as mutually agreed upon by the LEMSA, alternate destination and general acute care hospital (GACH) providers**." Hospitals want more involvement in policies driving GACH base station activities.	
Article 7. System Requirements, § 100170. Page 40, line 45	California Hospital Association	Change (a)(7)(A) from "Policies, procedures, and protocols for medical control and quality of care" to "**Policies, procedures and protocols for medical control, base station and quality of care, as**	

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		mutually agreed upon by LEMSA, alternate destination and GACH providers." As above, hospitals want more involvement in policies driving GACH Base Station activities	
Article 7 System Requirements, § 100170. Page 41, line 28		Change (a)(7)(F) 3. from "Authorized Sobering Centers that are either a federally qualified health center or a clinic as described in Section 1211 of the Health and Safety Code" to **"Authorized sobering centers that are non-correctional facilities that provide a safe, supportive environment for intoxicated individuals to become sober that meet one of the following requirements: (a) the facility is a federally qualified health center, including a clinic described in subdivision (b) or (d) Section 1206; (b) the facility is certified by the Department of Health Care Services, Substance Use Disorder Compliance Division, to provide outpatient, non-residential detoxification services; (c) the facility has been accredited as a sobering center under the standards developed by the National Sobering Center collaborative; or (d) the facility is a hospital-based outpatient department. Facilities granted approval for operation by OSHPD before November 28, 2017, under the Health Workforce Pilot Project #173, or otherwise providing sobering center services as of December 31, 2019, are authorized to continue operation until twelve months after the National Sobering Collaborative accreditation becomes available**. This language will be broad enough to encompass all 13 active sobering centers plus those who could	

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		additionally be accredited through the National Sobering Center Collaborative.	