June 23, 2016

1215 K Street, Suite 800

Sacramento, CA 95814

Conference Call Option:

(800) 882-3610 Access Code: 1953936#

# Emergency/Medical Services/Trauma Committee

10:00 **I. CALL TO ORDER/INTRODUCTIONS**
Bradley / Schneider

A. Membership

1. Roster

*CHA EMS/T Roster* Page 6

2. Member Updates

Neal Cline

Jason Zepeda

3. Member Map

*EMS/T County Representation* Page 9

4. CHA Member Breakdown

*EMS/T Member ED Breakdown* Page 10

5. CHA EMS/T Guidelines for Committee

*EMS/T Guidelines* Page 11

6. CHA EMS/T Goals and Objectives 2016-2017

*EMS/T Goals and Objectives* Page 15

10:20 **II. REVIEW OF PREVIOUS MEETING MINUTES** *Recommendation: Approval*
Bradley / Schneider

*A. Draft Minutes - March 9, 2016* Page 16

**III. NEW BUSINESS**

10:25 A. All Access Transfer Center
Kinniburg

1. *All Access Transfer Center Memo* Page 22

2. *Transfer Center Services - 911 for Hospitals* Page 23

10:45 B. Screening, Brief Intervention, and Referral to Treatment (SBIRT)
Padwa

1. *SBIRT Memo* Page 44

2. *SBIRT Issue Brief* Page 45

11:05 C. Every ED Instantly at Your Fingertips (EDIE)
Waters

1. *EDIE Memo* Page 52

2. *EDIE Information* Page 53

3. *Sample EDIE Report* Page 58

11:50 D. American College of Surgeons Trauma Consultation Visit Report
Sinz

1. *ACS Trauma Consultation Visit Memo* Page 59

12:00 E. Maddy Funds
Bartleson

1. *Maddy Funds Memo* Page 60

12:10 F. Lunch

1:00 G. NIH Grant Proposal: NIA ROI Evaluating the Impact of Hospital Occupancy on Older Patient Outcome: A Mixed Method Study
Bartleson

1. *NIH Grant Proposal.docx* Page 61

1:10 H. Legislative Review
Bartleson

1. *Legislative Memo* Page 62

2. *Legislative Bills - Emergency Services* Page 63

## IV. OLD BUSINESS

1:20 A. CBH/EMS Work Group Update
Rogers

1:30 B. Community Paramedics
Bartleson

1. *Community Paramedics Memo* Page 68

2. *Community Paramedicine Implementation: Quarter 1 2016* Page 69

3. *Health Workforce Pilot Projects Program HWPP# 173 - Community Paramedicine* Page 112

1:35 C. ED Crowding Task Force
Bartleson

1. *CHA Board Memo* Page 131

2. *Redefining the Successful ED - Discussion Guide* Page 134

3. *Redefining the Successful ED - Recommendations* Page 140

1:40 D. ED Forum 2016 Planning
Bartleson

1. *ED Forum 2016 Planning Memo* Page 144

2. *Event Flow* Page 146

3. *The Patient Protection and Affordable Care Act's Effect on Emergency Medicine: A Synthesis of the Data* Page 147

1:50 E. APOT Update
Bartleson

1. *APOT Update Memo* Page 158

2. *APOT Task Force Summary for CHA 6-2-16.pdf* Page 159

3. *Ambulance Patient Offload Time* Page 160

4. *Ambulance Patient Offload Time - Extended Delay* Page 162

## V. INFORMATION ONLY

A. Articles

1. *Why Patients Still Need EMTALA.pdf* Page 165

2. *Emergency Department Encounters by Expected Payer* Page 170

3. *California Among 10 States with Worst Emergency Response Times* Page 171

4. *Press Release - REACH - CALSTAR Merger Announced* Page 183

5. *Ambulances, in Place of "Caged Car" to Carry People in Mental Crisis* Page 185

B. Brochure

1. *Coverage Does Not Equal Access* Page 189

## VI. NEXT MEETING

A. August 30, December 14, 2016

2:00 **VII. ADJOURNMENT**
Bradley / Schneider

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

# EMS/TRAUMA COMMITTEE
# 2016 MEMBER ROSTER

*CO-CHAIRS*

**DARLENE BRADLEY, RN, PhD, MSN**
Director, Emergency Trauma Services
University of California, Irvine
333 City Blvd., West, Suite 640
Route 128-01
Orange, CA 92868-3201
(714) 456-5248
*dbradley@uci.edu*

**CARLA SCHNEIDER, MSN, MICN, CEN**
Emergency Department Director
Hoag Memorial Presbyterian Hospital
One Hoag Drive
P.O. Box 6100
Newport Beach, CA 92658-6100
(949) 764-5926
(949) 764-8599 *(cell)*
*carla.schneider@hoaghospital.org*

*MEMBERS*

**NANCY BLAKE, PhD, RN**
Director, Patient Care/Critical Care Services
Children's Hospital Los Angeles
4650 Sunset Blvd., #74
Los Angeles, CA 90027
(323) 361-2164
*nblake@chla.usc.edu*

**NEAL CLINE, RN, JD, CFRN** Sr.
Flight Nurse Enloe FlightCare
Assistant Chief, Butte County EMS
STEMI Manager,
PreHospital Clinical Coordinator
Community Paramedic Manager
Enloe Medical Center
1531 Esplanade
Chico, CA 95926
(530) 332-7933
*neal.cline@enloe.org*

**CONNIE CUNNINGHAM, RN**
Executive Director
Pre-Hospital, Emergency & Trauma Services
Loma Linda University Medical Center and
Children's Hospital
11234 Anderson, Room A122A
Loma Linda, CA 92354
(909) 558-7875
*ccunningham@llu.edu*

**KARLA EARNEST, RN**
Pediatric Trauma Program Manager
Lucile Packard Children's Hospital at Stanford
300 Pasteur Drive - Room HG021, MC 5239
Stanford, CA 94305 (650) 724-
4942
*kearnest@stanfordchildrens.org*

**ROSS FAY, MBA**
(***Ex Officio*** – CALSTAR)
Regional Director
CALSTAR (California Shock Trauma Air Rescue)
177 John Glenn Drive
Concord, CA 94520
(925) 798-7670
*rfay@calstar.org*

**ALLISON KERR, RN, MSN**
Vice President, Neuroscience Service Line |
Psychiatry & Behavioral Sciences and
Operations
Stanford Health Care
300 Pasteur Drive, MC 5230
Stanford, CA 94305
(650) 736-9084
*akerr@stanfordmed.org*

*Last revised 02/23/16*

**FRANK MAAS, RN** Director,
Emergency Center Children's Hospital
of Orange County
455 South Main
Orange, CA 92868
(714) 512-3694
*fmaas@choc.org*

**ERIC MORIKAWA, CHIEF**
***(Ex Officio** - CDPH)*
Field Operations Branch, Region II
California Department of Public Health
Licensing and Certification Program
P.O. Box 997377, MS 3001
Sacramento, CA 95899-7377
(916) 440-7363
*eric.morikawa@cdph.ca.gov*

**KAREN MURRELL, MD** Assistant
Physician in Chief Department of
Emergency Services Kaiser
Permanente South Sacramento
6600 Bruceville Road
Sacramento, CA 95823
(916) 688-6536
*karen.I.murrell@kp.org*

**FARID NASR, MD (*Ex
Officio – EMS*)** California
EMS Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670
(916) 322-4336 Ext. 400
*farid.nasr@emsa.ca.gov*

**CHI PERLROTH, MD, FACEP**
***(Ex Officio** - Cal ACEP)*
Emergency Room Physician
1601 Ygnacio Valley Road
Walnut Creek, CA 94598
(213) 810-4785
*chiyonglee@hotmail.com*

**JAMES PIERSON *(Ex Officio)***
Vice President of Operations
Medic Ambulance Service
506 Couch Street
Vallejo, CA 94590
(707) 644-1761
*jpierson@medicambulance.net*

**KIMBERLEE ROBERTS, MPH**
Director, Clinical Services
Scripps Memorial Hospital La Jolla
*9888 Genesee Ave IJ 101*
*La Jolla, CA 92037 (858)626-7118*
*roberts.kimberlee@scrippshealth.org*

**BONNIE SINZ, RN BS (*Ex Officio*)**
***(Ex Officio** - EMS)*
State Trauma System Coordinator
California EMS Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670
(916) 431-3649 (W)
(916) 713-8185 (C)
*bonnie.sinz@emsa.ca.gov*

**RON SMITH, LVN/EMT1A**
**(*Ex Officio - CDPH)***
**Alternate for Eric Morikawa**
Disaster Response Coordinator,
Terrorism Liaison Officer
Emergency Preparedness & Disaster Response
Section
California Department of Public Health
Licensing & Certification Program
1615 Capitol Avenue,
Sacramento, CA 95814
(916) 552-8642
*ron.smith@cdph.ca.gov*

*Last revised 02/23/16*

**LAWRENCE STOCK, MD, FACEP**
*(**Ex Officio** - Cal ACEP)*
**Alternate for Vivian Reyes, MD**
Vice Chair, Department of Emergency Medicine
Antelope Valley Hospital
1600 W Avenue J
Lancaster, CA 93534
(310) 849-0709 (cell)
*drlarrystock@gmail.com*

**HEATHER VENEZIO, RN**
*(CAL ENA Representative)*
Trauma Program Director
North Bay Medical Center
1200 B. Gale Wilson Blvd.
Fairfield, CA 94533
(707) 646-4019
*hvenezio@northbay.org*

**CHRIS WALKER MS, RN, NP, CNS, CCRN, CEN**
Director of Emergency Services
Sharp Memorial Hospital
7901 Frost Street
San Diego CA 92123
(858) 939-3099
*walkssd@gmail.com*

**AARON WOLFF, RN**
Director, Performance Excellence
Dignity Health
185 Berry Street, Suite 300
San Francisco, CA 94107
(530) 949-0519 (M)
(530) 242-5413 (F)
*aaron.wolff@dignityhealth.org*

**JASON ZEPEDA**
Program Manager, Performance Improvement
Hoag Memorial Presbyterian Hospital
One Hoag Drive
P.O. Box 6100
Newport Beach, CA 92658-6100
(949) 764-1944
*Jason.Zepeda@Hoag.org*

*REGIONAL ASSOCIATION REPRESENTATIVES*

**JAIME GARCIA**
Regional Vice President, Greater LA Area
Hospital Association of Southern California
515 S. Figueroa Street, Suite 1300
Los Angeles, CA 90071
(213) 538-0702
*jgarcia@hasc.org*

**DAVID SERRANO SEWELL**
Regional Vice President
235 Montgomery Street, Suite 1158
San Francisco, CA 94104
(415) 616-9990
*dserranosewell@hospitalcouncil.org*

**JUDITH YATES**
Senior Vice President
Hospital Association of San Diego &
Imperial County
5575 Ruffin Rd., Suite 225
San Diego, CA 92123 (858) 614-1557
*jyates@hasdic.org*

*CHA STAFF*

**BJ BARTLESON, RN**
Vice President, Nursing & Clinical Services
California Hospital Association
1215 K Street, Suite 800
Sacramento, CA 95814 (916) 552-7537
*bjbartleson@calhospital.org*

**RONDA FRICKE**
Administrative Assistant
California Hospital Association
1215 K Street, Suite 800
Sacramento, CA 95814 (916) 552-7616
*rfricke@calhospital.org*

*Last revised 02/23/16*

# EMS/T Committee Hospital Representation

## BY COUNTY and HOSPITAL TYPE

As of June 23, 2016

| HOSPITAL/HEALTH SYSTEM TYPES | |
|---|---|
| Free-Standing Facility | 3 |
| Hospital System | 6 |
| Small/Rural Facility | 0 |
| University/Teaching Facility | 3 |
| TOTAL COMMITTEE REPRESENTATION | 12 |


*Denotes number of hospitals/health systems represented within that county.*

CHA Member/ED Breakdown

Jun-16

**HOSPITAL COMMITTEE MEMBER:**

| | |
|---|---|
| Nancy Blake | Children's Hospital Los Angeles |
| Frank Maas | Children's Hospital of Orange County |
| Aaron Wolff | Dignity Health |
| Darlene Bradley | UC Irvine |
| Connie Cunningham | Loma Linda University Med Center |
| Karla Earnest | Lucile Packard Children's Hospital |
| Kimberlee Roberts | Scripps Memorial Hospital La Jolla |
| Carla Schneider | Hoag Memorial Presbyterian Hospital |
| Chris Walker | Sharp Memorial Hospital |
| Karen Murrell | Kaiser Permanente South Sacramento |
| Neal Cline | Enloe Medical Center |
| Jesse Zepeda | Hoag Memorial Presbyterian Hospital |

**ED TYPE BY MEMBER:**

| | | |
|---|---|---|
| Nancy Blake | Children's Hospital Los Angeles | Pediatric/Trauma |
| Frank Maas | Children's Hospital of Orange County | Pediatric/Trauma |
| Karla Earnest | Lucile Packard Children's Hospital | Pediatric/General |
| Kimberlee Roberts | Scripps Memorial Hospital La Jolla | General |
| Aaron Wolff | Dignity Health | Trauma/General |
| Neal Cline | Enloe Medical Center | Trauma/General |
| Jesse Zepeda | Hoag Memorial Presbyterian Hospital | Trauma/General |
| Connie Cunningham | Loma Linda University Med Center | Trauma/General |
| Allison Kerr | Stanford Health Care | General |
| Chris Walker | Sharp Memorial Hospital | General |
| Karen Murrell | Kaiser Permanente South Sacramento | General |
| Darlene Bradley | UC Irvine | General |
| Carla Schneider | Hoag Memorial Presbyterian Hospital | Trauma/General |

**EX-OFFICIO COMMITTEE MEMBER:**

| | |
|---|---|
| Vivian Reyes | CAL ACEP |
| Heather Venezio | CAL ENA |
| Eric Morikawa | California Department of Public Health |
| Farid Nasr | California EMS Authority |
| Ross Fay | CALSTAR |
| . Jaime Garcia | HASC |
| Jim Pierson | Medic Ambulance |
| Ron Smith | California Department of Public Health |
| Lawrence Stock | Antelope Valley Hospital |
| Chi Perlroth | CAL ACEP |
| Bonnie Sinz | EMSA |

**CHA/REGIONAL STAFF**

| | |
|---|---|
| BJ Bartleson | California Hospital Association |
| Cheri Hummel | California Hospital Association |
| Judith Yates | HASD&IC |
| David Serrano Sewell | HCNCC |
| | |

**STATE REPRESENTATION**

| | |
|---|---|
| Northern California | **4** |
| Southern California | **8** |
| | |

# GUIDELINES FOR THE CALIFORNIA HOSPITAL ASSOCIATION'S EMS/TRAUMA COMMITTEE

*Updated 09/23/15*

## I. NAME

The name of this committee shall be the CHA EMS/Trauma Committee.

## II. MISSION

The EMS/Trauma Committee represents CHA members that provide emergency medical and/or trauma services in the State of California, and serves in an advisory capacity to the CHA Board of Trustees regarding EMS/Trauma member needs, policies and legislation.

Recognizing the diverse organizations and providers that work in emergency systems across the state, the mission of the committee also includes representation from diverse multidisciplinary health care organizations and associations that include professional associations, regulatory agencies, emergency services organizations, prehospital providers and others, that promote quality emergency services in the state of California. This multidisciplinary group will act as a collaborative source of emergency services expertise, providing a venue for the coordination of emergency and trauma services to advocate for the highest standards of emergency trauma care services across the state.

The purposes of the Committee shall be:

- to serve as a forum for all CHA members and associated groups interested in EMS/Trauma to receive and exchange information, adopt policies and positions, guide management, adopt strategies and serve as the primary public policy arm of CHA for emergency medical services and trauma issues;

- to provide CHA member EMS/Trauma providers with a statewide structure dealing with the issues important to their interests;

- to create a representative form of leadership which is based on participation of all its members;

- to provide direct input to the CHA Board of Trustees; and

- to provide a unified voice on behalf of CHA members, taking into account the multiple diverse organizations that interact with hospital emergency/trauma services

## III. COMMITTEE

The committee shall consist of a maximum of 22 representatives from California hospital /health system organizations, and organizations with related interests.

A. MEMBERSHIP

1. Membership on the CHA EMS/Trauma Committee shall be based upon membership in CHA, and reserved for those members.

2. The Committee shall consist of various representatives from large hospital systems, public institutions, private facilities, free-standing facilities, small and rural facilities, university/teaching facilities, specialty facilities and a representative from a professional group specializing in EMS/Trauma issues.

3. Membership by EMS related organizations will be considered Ex-officio members. Ex-officio members will be determined by committee input and CHA determination.

4. Appointment of members to the Committee will follow the CHA Guidelines for Committee Membership.

B. TERMS OF THE COMMITTEE MEMBERS

1. As members leave the Committee, vacancies shall be filled. It is understood that a member forfeits his/her seat if they no longer serve in the capacity, or represent a facility that is not a CHA member.

2. Committee members with specialized skills, knowledge, or professional associations may serve on the committee as ex-officio members. Ex-officio members are not subject to the above terms. These determinations shall be made by CHA.

3. Provider representatives who transition from one position to another are welcome to attend committee meetings during their transition; however, this should not exceed two consecutive meetings.

4. Provider representatives who misrepresent their organization's position are subject to review and dismissal from the committee.

C. COMMITTEE MEETINGS

1. Meetings of the Committee shall be held quarterly.

2. Provider representatives may send an appropriate substitute to the meetings when they are unable to attend. To maintain continuity for Committee meetings, this should be used sparingly, not to exceed two consecutive meetings.

3. Three consecutive unexcused absences by a Committee member may initiate a review by the Chair and CHA staff for determination of the Committee member's continued service on the Committee.

4. Special meetings may be scheduled by the Chair, majority vote or CHA staff.

5. Membership is based on one's ability to be physically present at quarterly meetings and conference call only as needed for emergency situations.

D. VOTING

1. Voting rights shall be limited to members of the Committee, and each member present shall have one vote. Voting by proxy is not acceptable.

2. All matters requiring a vote of the Committee must be passed by a majority of a quorum of the Committee members only at a duly called meeting or telephone conference call.

E. QUORUM

Except as set forth herein, a quorum shall consist of the majority of the Committee membership in attendance.

F. MINUTES

Minutes of the Committee shall be recorded at each meeting, disseminated to the membership, and approved as disseminated or as corrected at the next meeting of the Committee.

## IV. OFFICERS

The officers of the Committee shall be the committee chair, co-chair, and CHA staff.

Except as provided herein, the chair and co-chair shall be elected by the Committee for a two-year term.

The chair officers vacate their Committee positions upon election, and their seats shall be filled through the nominating and election process. The past-chairs will be invited by the Committee to serve as ex-officio members.

Should a chair or co-chair vacate his/her position prior to the end of the term, a nominating committee will convene to select a replacement, and assume a two-year term of office.

## V. COMMITTEES

For special and specific purposes, the chair or CHA staff may appoint a committee or ad hoc on task force. Membership may be expanded to non-members of the Committee.

## VI. GENERAL PROVISIONS

The strategic plan defining the goals, objectives, and work plans shall be developed annually by the CHA staff and approved by the Committee. Quarterly updates and progress reports shall be completed by the Committee and CHA staff.

Staff leadership at the state level shall be provided by CHA with local staff leadership provided by HCNCC, HASD&IC, and HASC. The primary office and public policy development and advocacy staff of the Committee shall be located within the CHA office.

The Committee staff shall be an employee of CHA.

## VII. AMENDMENTS

These Guidelines may be amended by a majority vote of the members of the Committee at any regular meeting of the Committee.

## VIII. LEGAL LIMITATIONS

Any portion of these Guidelines which may be in conflict with any state or federal statutes or regulations shall be declared null and void as of the date of such determination.

Any portion of these Guidelines which are in conflict with the Bylaws and policies of CHA shall be considered null and void as of the date of the determination.

Information provided in meetings is not to be sold or misused.

## IX. CONFIDENTIALITY FOR MEMBERS

Many items discussed are confidential in nature, and confidentiality must be maintained. All Committee communications are considered privileged and confidential, except as noted.

## X. CONFLICT OF INTEREST

Any member of the Committee who shall address the Committee in other than a volunteer relationship excluding CHA staff and who shall engage with the Committee in a business activity of any nature, as a result of which such party shall profit pecuniarily either directly or indirectly, shall fully disclose any such financial benefit expected to CHA staff for approval prior to contracting with the Committee and shall further refrain, if a member of the Committee, from any vote in which such issue is involved.

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

CHA Emergency Services /Trauma Committee Goals and Objectives, 2016-2017

**SUMMARY**

Goals and Objectives have been drafted for review and approval of the committee.

1) Develop guidance, tools, information and strategies to support emergency department and trauma services of the future that enhance quality patient care.

    a. Implement subject matter task forces where members can utilize their expertise to explore, plan and suggest strategies for the larger EMS/T committee

2) Advise the CHA Board on ED crowding surge issues and the changing LEMSA regulatory environment affecting hospital/health systems and EMS/Trauma care systems.

    a. Develop an issue brief that describes the present environment, issues and strategic recommendations.

3) Plan and implement a successful 2015 Behavioral Health/EMS Summit where one full day is dedicated to pure EMS/T issues and one day is combined EMS/behavioral health topics.

    a. Discuss conference planning activities at the 6/24/2015 committee meeting
    b. Assess other statewide ED conferences and identify topics of interest to stimulate high conference participation
    c. Bring interested members together as a planning team

**ACTION ITEM**

Discuss and advise.

Should you have any questions, please feel free to contact me at (916) 552-7537 or via email at bjbartleson@calhospital.org.

1215 K Street, Suite 800, Sacramento, CA 95814 · *Telephone:* 916.443.7401 · *Facsimile:* 916.552.7596 · www.calhospital.org
*Corporate Members:* Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

**EMS/TRAUMA COMMITTEE**
**MEETING MINUTES**
*March 9, 2016 / 10:00 a.m. – 2:00 p.m.*

Hospital Council
1215 K Street, Suite 730
Sacramento, CA

**Members Present:** Frank Maas, Nancy Blake, Darlene Bradley, Connie Cunningham, Ross Fay, Farid Nasr, James Pierson, Carla Schneider, Ron Smith, Chris Walker, Aaron Wolff, Jaime Garcia, Judith Yates, Vivian Reyes, Jan Remm

**Members Absent:** Karla Earnest, Allison Kerr, Eric Morikawa, Karen Murrell, CHI Perlroth, Kimberlee Roberts, Bonnie Sinz, Lawrence Stock, Heather Venezio, David Serrano-Sewell

**Guests:** Dana Stradling, Neal Cline

**CHA Staff:** BJ Bartleson, Ronda Fricke, Sheree Lowe

## I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order at 10:00 a.m. Introductions were made and Ms. Bartleson discussed new co-chairpersons for the committee. Ms. Bartleson stated unless there were any objections she would appoint Mses. Darlene Bradley and Carla Schneider co-chairpersons. Ms. Bartleson thanked Mr. Maas for his years of service.

Ms. Schneider recommended Mr. Jason Zepeda as a new committee member adding he wants to make a difference in hospital policy. Ms. Bartleson felt he would be an asset to the committee.

Mr. Maas asked for a motion to approve Mr. Zepeda as a new member. Ms. Blake made a motion and Mr. Walker seconded. There was no opposition. Mr. Zepeda will be added to the committee.

- *ACTION: Ms. Fricke to send Mr. Zepeda committee information.*

## II. REVIEW OF PREVIOUS MEETING MINUTES

The minutes of the September 23, 2015, EMS/Trauma Committee meeting were reviewed as submitted.

***IT WAS MOVED, SECONDED AND CARRIED:***

- *To approve the minutes of the September 23, 2015, EMS/Trauma Committee meeting. Passed as written.*

Ms. Schneider asked if there was an update on data collection from the ED Behavioral Health Holding workgroup and how it would be measured. Ms. Bartleson stated the monkey survey has been sent out along with a copy of the definitions.

Mr. Cline mentioned that All Access Transfer Center already measures data and their push is how long it takes to move adolescent patients. He suggested contacting them rather than recreating the data.

Ms. Yates asked what do they attribute their successful outreach to mental health facilities too? Mr. Fay noted that All Access Transfer Center is a part of the CALSTAR organization and that they have a large referral network that allows them to access destination beds more efficiently. He added the service plays to the requirement of the client and that data is an added benefit (the software can track up to 700 data points, i.e. demographics, needs, etc.) Mr. Fay suggested Ms. Schneider reach out to him and he can put her in contact with the right person.

- *ACTION: Ms. Bartleson will arrange a conference call with Mr. Fay, Ms. Schneider and All Access Transfer Center*

## III. NEW BUSINESS

A. ACS Statewide Trauma Visit

Mses. Bartleson, Yates and Mr. Maas will be participating in the upcoming site visit. Ms. Yates noted that EMSA has been working to create a statewide system but it has been challenging. She also noted that EMSA is moving forward with a statewide trauma plan and is hoping that ACS trauma consultation feedback can be used to strengthen the statewide trauma plan. The committee discussed the lack of consistency among the counties. There was discussion about hospitals dropping out of the ACS certification program due to the costs in meeting the guidelines. Ms. Yates asked what do we want to do and how do we move the needle with the committee's experience?

Ms. Bartleson asked if there was additional feedback on items they would like her to advocate for. Ms. Yates brought up the issue of consistency of trauma systems and statewide data collection as well as the need for additional money.

- *ACTION: ACS trauma consultation attendees will report back at the next EMS/T committee meeting.*

B. Trauma Regulation Review

Ms. Bartleson directed the members to page 38 of the meeting book noting trauma core functions and essential services of the trauma system integrated with the public health model is a good example of future healthcare delivery.

Ms. Bartleson discussed the trauma regulations and asked what needs to be changed, if anything? Do they serve our needs? Do we need to advocate change

on any of the items? Ms. Bartleson asked the committee to think about recreating a subcommittee to review the regulations and that it would be approximately a year and a half project.

The following members volunteered to be a part of the committee: Mses. Roberts, Blake, Bradley and Messrs. Wolff and Maas.

*ACTION: Ms. Bartleson will convene the trauma subcommittee.*

C. Stroke Programs

Ms. Bartleson introduced Ms. Dana Stradling, UC Irvine Stroke Manager who gave a presentation on stroke programs. She started by saying most hospitals want to keep their stroke patients and care for them. She reviewed what a stroke system of care is and why stroke systems are necessary. Ms. Stradling discussed the Comprehensive Stroke Designation and why they are important and what it entails to become a designated stroke center. Ms. Stradling discussed the importance of getting the patient to the right facility as quick as possible and how that affects their treatment.

*ACTION: Informational only.*

D. STEMI Programs

Ms. Bartleson introduced Mr. Neal Cline, Sr. Flight Nurse, STEMI Manager, Community Paramedic Manager providing some background of his experience. Mr. Cline provided a presentation on STEMI. Mr. Cline concluded there was a need for more education, technology and money to enhance program effectiveness. It was also noted that it's tough to meet the needs of each region.

*ACTION: Informational only.*

E. Hospitals and Their Responsibilities as Airport Managers

Mr. Fay showed a video of drones that was set to classical music.

Mr. Fay discussed the responsibility of the hospital to make sure there is an FAA Form 5010 registered with the FAA and that the information is correct. (online at: http://www.faa.gov/airports/airport_safety/airportdata_5010/) He noted that according to the FFA, whoever is responsible for the hospital helipad is considered an Airport Manager. The Airport Manager should be the person who grants permission for a request to fly a drone in their airspace however there is still a lot of unknowns. The Feds would like to create a law that if a drone is flying in uncontrolled airspace, the operator doesn't need permission to operate based on the rule that they are a remote control airplane. Ms. Bradley asked if drones can land on helipads without permission and Mr. Fay replied probably not. Ms. Cunningham noted they had a recent situation where a drone interfered with a helicopter that was transporting a patient. Mr. Fay referred the committee to

knowbeforeyoufly.org as a good resource. Ms. Bartleson mentioned that AB 1680 includes drones and definition for penalties for someone interring with medical personnel.

*ACTON: Informational only.*

F. Legislative Review and Ballot Initiatives

Ms. Bartleson briefly mentioned the ballot initiatives and EMS/T legislation included in the meeting book and suggested members review at their convenience.

*ACTION: Members should review the ballot initiatives and legislation included in the meeting book.*

OLD BUSINESS

A. FSED

Ms. Bartleson informed the group that FSED legislation is still on the back burner because of its controversy. Mr. Cline added that the FSED in Downeyville recently closed.

*ACTION: Informational only.*

B. AOPD Update

Ms. Bartleson introduced Ms. Jan Remm. Ms. Remm discussed AB 1223 related to ambulance patient offload time methodology, reporting and criteria. There was some discussion on the definitions relating to ambulance patient offload time. There was also discussion on reporting and what it will look like. Ms. Remm didn't think it would be unusual but thinks the challenge will come with capturing times.

Ms. Bartleson discussed the 20 minute ambulance / patient offload time adding that 20 minutes won't be workable in most areas right now. Mses. Remm and Bartleson have been pushing for EMSA to develop reasonable metrics. Ms. Yates added that the group is spinning their wheels on a larger problem and this won't resolve the real issue. She noted there needs to be a footnote that it's a symptom of a larger problem.

*ACTION: Informational only.*

C. ONC HIE

Ms. Bartleson mentioned that EMSA would be receiving a $2.75 million grant over the next two years to advance health information exchange (HEI) statewide during a disaster and regionally in daily emergency medical services. (EMS) The grant will be used to help develop the Patient Unified Lookup System that will establish connections between two community health information organizations (HIO) via a secure web portal should a disaster occur.

*ACTION: Informational only.*

D. CURES 2.0 Advisory Workgroup

Ms. Bartleson reminder the members that the mandatory sign up must be completed by July 1, 2016 and asked that they push to make sure the physicians are registered. She also mentioned that if anyone was having issues registering, please reach out to her directly.

*ACTION: Informational only.*

E. Behavioral Health AB 1300

Ms. Sheree Lowe gave an overview of AB 1300 noting the language is due to be finalized today. She informed the members that the language of this bill hasn't been touched since the 1960s and delivery was much different then. She added that sections 5150, 5151 and 5152 were involved.

Ms. Lowe also touched on several of the provisions including, the ability for ED room physicians to write holds, the liability protection for emergency transportation vendors, provisions include some Federal HIPPA language into the state bill and telehealth technology to be used during assessment. There was some discussion on telehealth.

Ms. Lowe also gave an update on AB 2043, Psychiatric Bed Registry. She noted this bill is sponsored by the Steinberg Institute and will not be part of Legislative Day because there is still work being done to try and make changes to the current bills.

Ms. Lowe also updated the members with her name change and advised she will continue to receive emails for Sheree Kruckenberg for the time being.

*ACTION: Informational only.*

F. ED Post Conference Review

Ms. Bartleson directed the members to page 245 in the meeting book that shows feedback from the ED Conference. Ms. Bartleson expressed there would be more flexibility when picking topics for this year's conference. She asked the members

to think about topics that would be helpful to them and provide those to her. She added that the conference will be in December and that dates will follow soon.

*ACTION: Ms. Fricke will send conference dates to the committee.*

## IV. INFORMATION ONLY

Ms. Bartleson briefly referenced the documents under this section.

## V. NEXT MEETING

June 23, August 30, December 14, 2016.

*ACTION: Ms. Fricke will send updated meeting planners to the committee.*

## VI. ADJOURNMENT

Having no further business, the meeting adjourned 2:04 p.m.

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

June 23, 2016

TO: Emergency Medical Services / Trauma Committee

SUBJECT: All Access Transfer Center

**Objective**
To learn about the services the All Access Transfer Center offers.

**Background**
With a single call from the hospital staff or the patient's physician, the All-Access Transfer Center will manage the entire transfer process either inbound to your facility or outbound to an appropriate receiving facility. Lynne Smith-Kinniburgh, CFC, Transfer Center Manager, will discuss the Center functions and operations.

**Conclusion**
Informational Only

BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing & Clinical Services

# TRANSFER CENTER SERVICES

## "911 FOR HOSPITALS"

**Presented by:** Lynne Kinniburgh & Debbie Pardee

**Updated:** 01/12/16

ALL ACCESS Transfer Center

# 911 for Hospitals

**With a single call from the hospital staff or the patient's physician, the All-Access Transfer Center will manage the entire transfer process either inbound to your facility or outbound to an appropriate receiving facility.**

- **YOU** place the call
- **WE** find the doctor
- **WE** find the bed
- **WE** arrange & manage the transportation
- **WE** report back to you

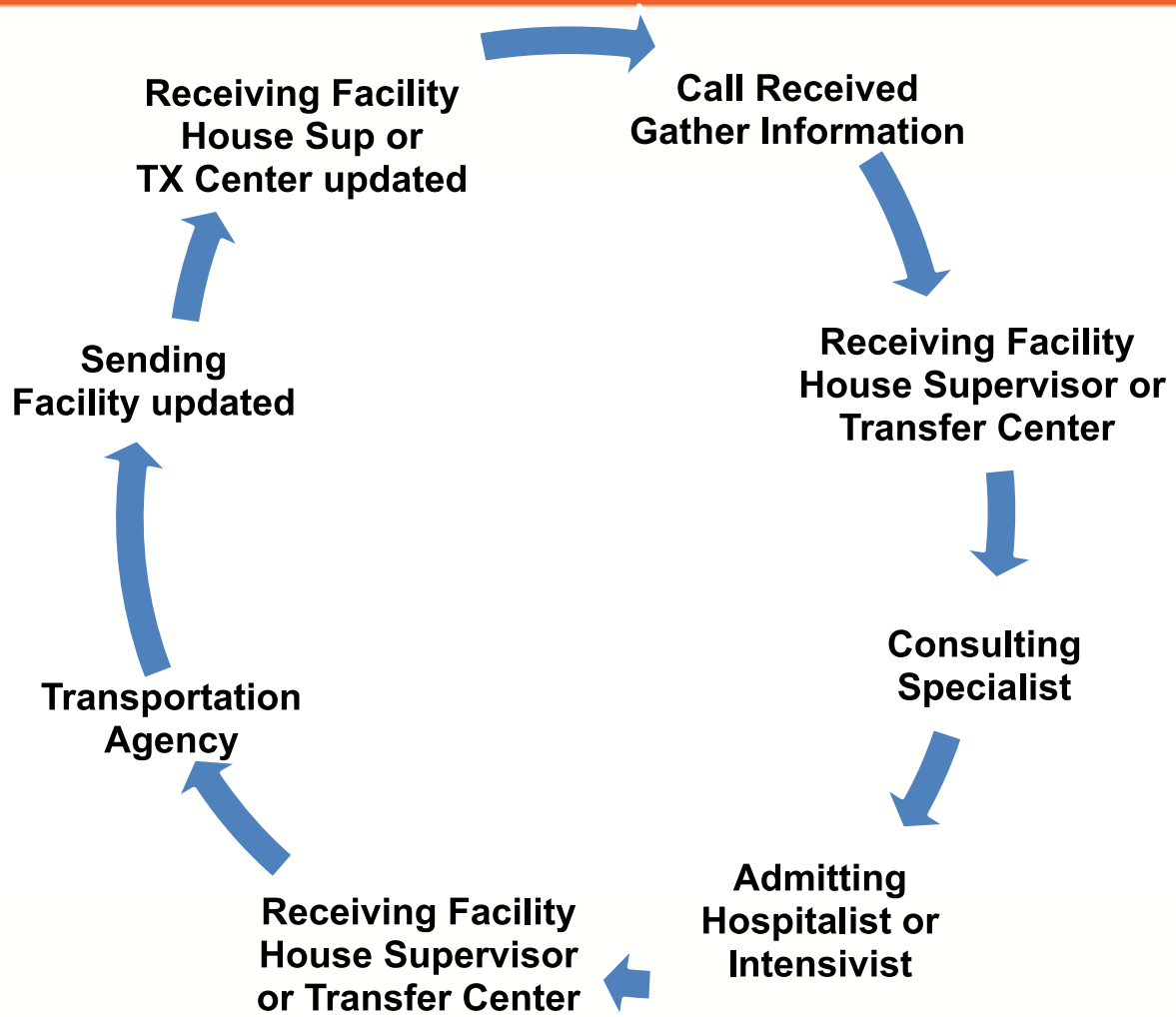
ALL ACCESS Transfer Center

# All-Access Transfer Center (A-ATC)

- **Full Service Patient Transfer & Referral Center**
  - **“We don’t just say it, we deliver it!”**
  - **Everything you would expect from a full service transfer center plus:**
    - **Critical & non-critical patient placement**
    - **Discharge follow-up to reduce re-admissions**
    - **Patient diversion and In & Out of network monitoring**
    - **Acute care placement for mental health patients**

ALL ACCESS Transfer Center

# Transfer Evolution




ALL ACCESS Transfer Center

# The “6 R’s” of A-ATC

**The Transfer Center will assist you with all the necessary steps to facilitate a smooth transfer process using the “6 R’s”**

- **Right Receiving Facility**
- **Right Consulting MD**
- **Right Admitting MD**
- **Right Transportation Vendor**
- **Right Bed Type**
- **Right Time Frame**

ALL ACCESS Transfer Center

# Median Transfer Metrics
# Request to Patient Acceptance

- **Trauma referrals**
  - **< 8 minutes**
- **STEMI referrals**
  - **< 11 minutes**
- **Consult requests no possibility of transport**
  - **<30 minutes**
- **Interfacility request – critical patient**
  - **<30 minutes**
- **Interfacility request - stable patient**
  - **<45 minutes**

***Dependent on Bed and Physician Availability***

ALL ACCESS Transfer Center

# Median Transfer Timeline
# Request to Mental Health Patient Placement

- **Pediatric (0-12 years of age)**
  - **1 hour 30 minutes**
- **Adolescent (13-17 years of age)**
  - **1 hour 45 minutes**
- **Adult (18+ years of age)**
  - **2 hour 45 minutes**

***Dependent on Bed, Physician & Transportation Availability***

*Does not include special classifications*

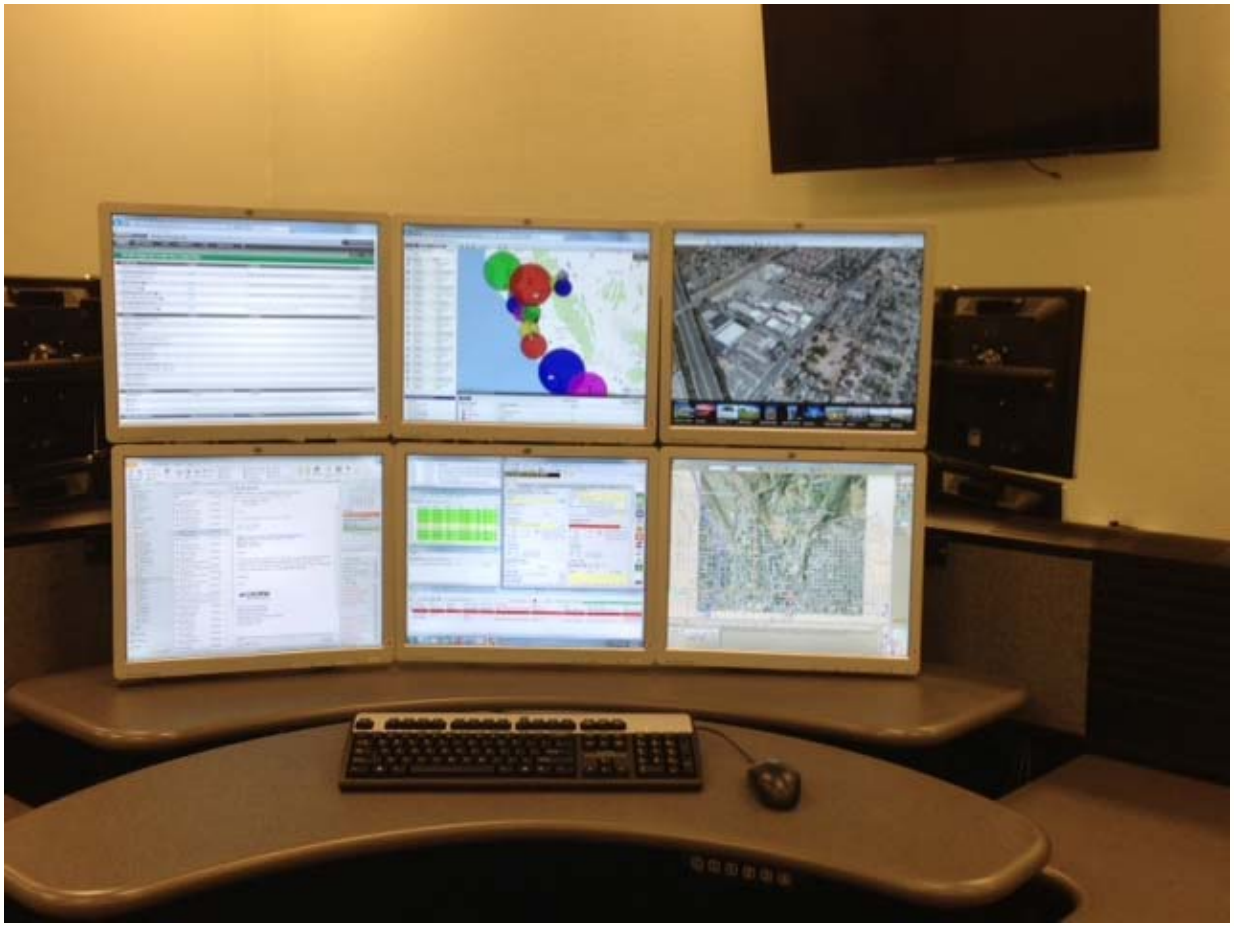
ALL ACCESS Transfer Center

# A-ATC's Guiding Principles

- **Always do what is best for the patient**
- **Streamline transfer processes**
  - **ED to ED for critical patients**
  - **ED to patient care unit or stable patients to prevent over-crowding in ED**
- **Establish working relationships with admitting and administration to ensure patients remain within a particular hospital system**
- **Coordinate with admitting and consulting specialist**
- **Reduce the need for diversion management**

ALL ACCESS Transfer Center

# Extensive Database & Secure Technology



ALL ACCESS Transfer Center

# A-ATC Unique Attributes

- **Custom vanity phone number assigned for all your admissions**
- **EMTALA compliance**
  - **A-ATC services are based on the physician's declaration of medical necessity to ensure proper and efficient patient placement**
- **Operates 24/7 in a Tier 3 data center**
  - **Redundant back-up systems with guaranteed <20 seconds downtime annually**
- **Metrics and data collection**
  - **Over 1300 data points available from the A-ATC data base**
- **Physician Medical Director**
  - **David Duncan, MD, provides physician oversight, robust CQI, and staff development for the transfer center**

ALL ACCESS Transfer Center

# A-ATC Benefit Overview

## CASE MANAGEMENT

>> Available 24/7

>> Management of both emergent and non-emergent patients

>> Guarantees utilization of the closest, most appropriate ground or air resource for the patient

## HOSPITAL ADMINISTRATION

>> Operating Labor Expense Savings

>> Revenue Protection

>> Enhanced Patient Repatriation

>> Accurate Quantifiable Data

>> Assurance of Legal/Regulatory Compliance

## EMERGENCY DEPARTMENT

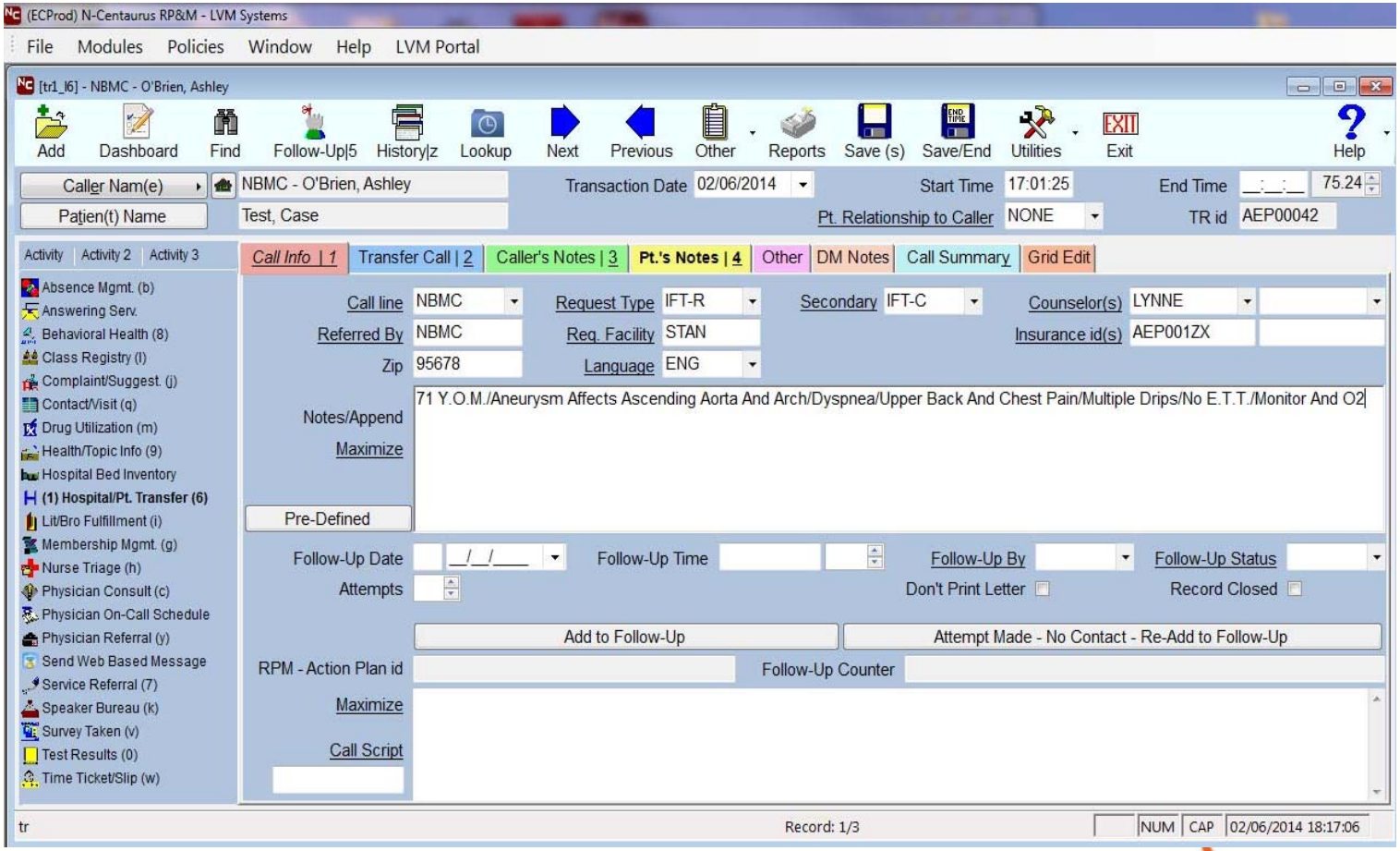
>> Reduces staff stress and pressure

>> Saves time on administrative tasks, allowing focus to remain on patient care

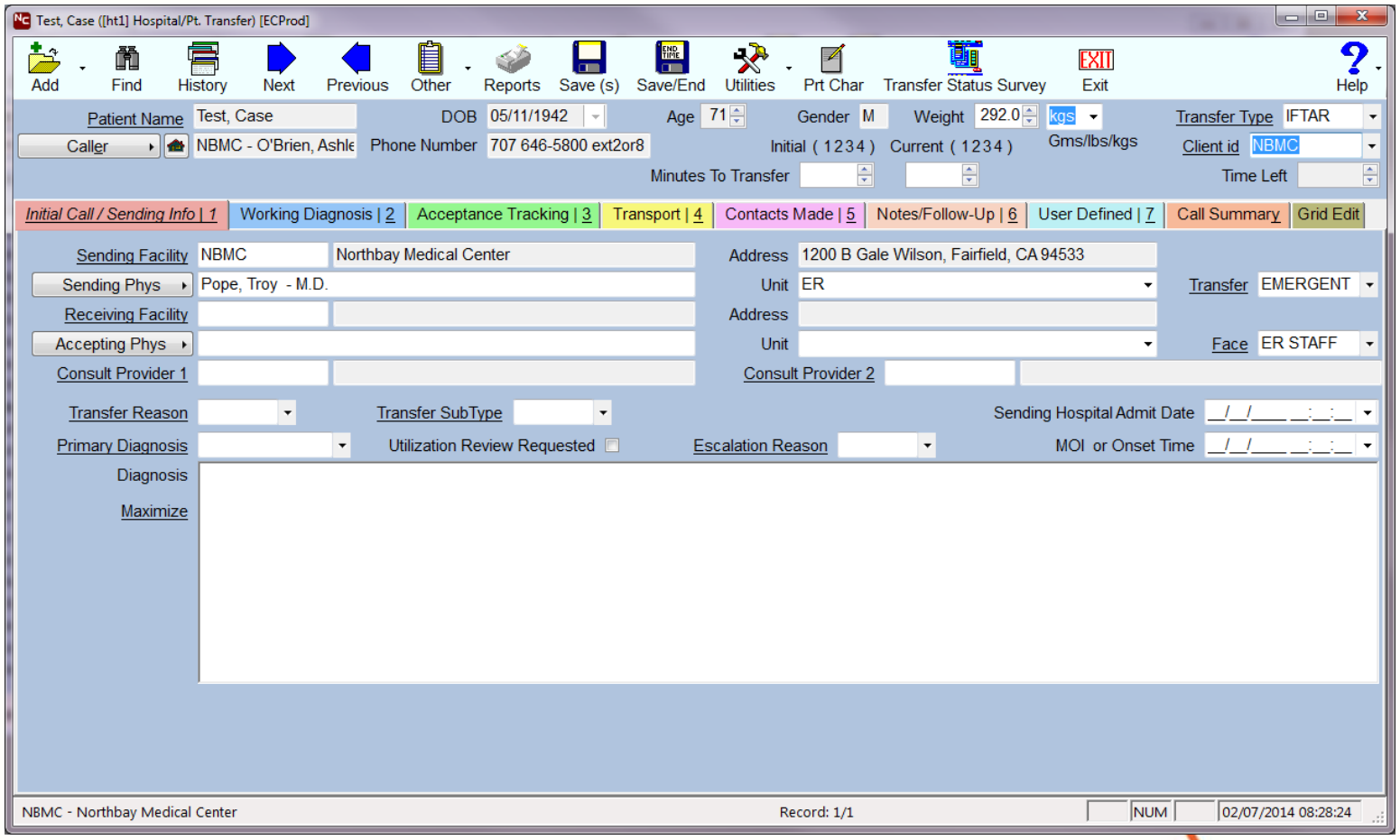
>> Improves throughput and reduces department congestion by transferring patients efficiently out of the Emergency Department, and when appropriate, sending incoming patients directly to an in-patient unit

ALL ACCESS Transfer Center

# A-ATC Call Intake



# Start the Transfer Process

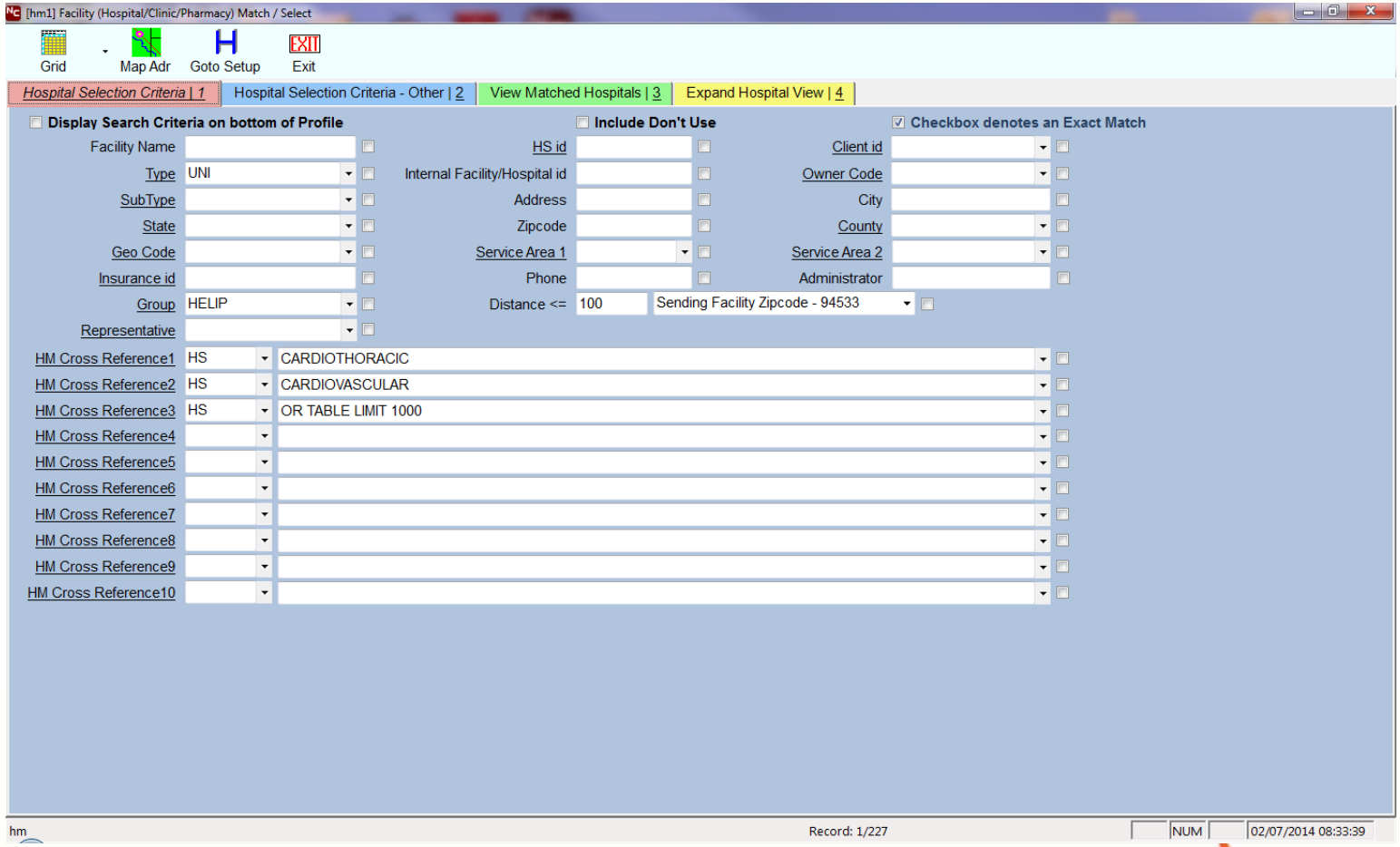


# Identify the Search Criteria

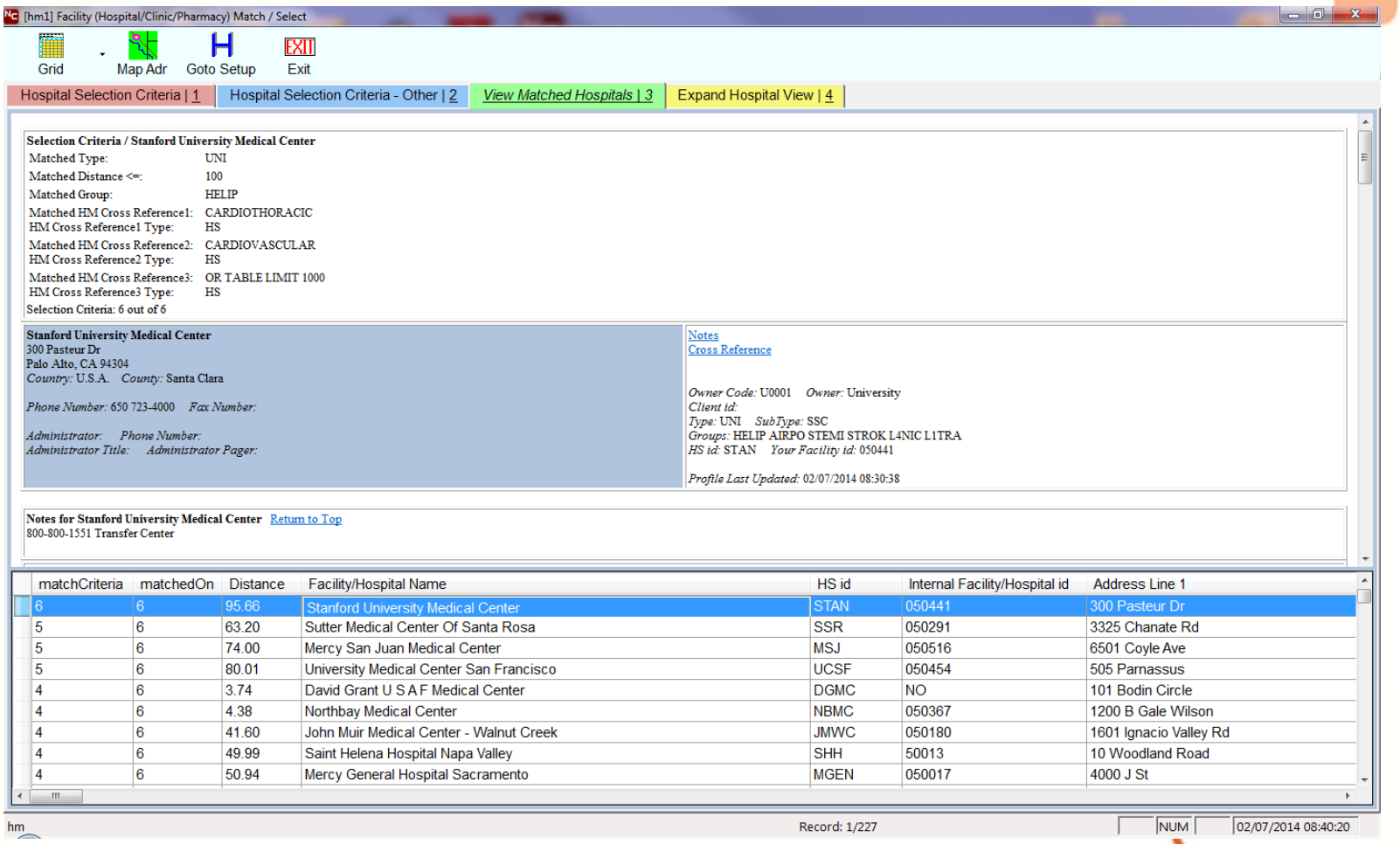
- **Helipad to Helipad or Ground arrangements**
- **University level of care**
- **Physician specialty**
- **OR Table that will take the patients weight**
  - **search the data base**

ALL ACCESS Transfer Center

# Search the Data Base

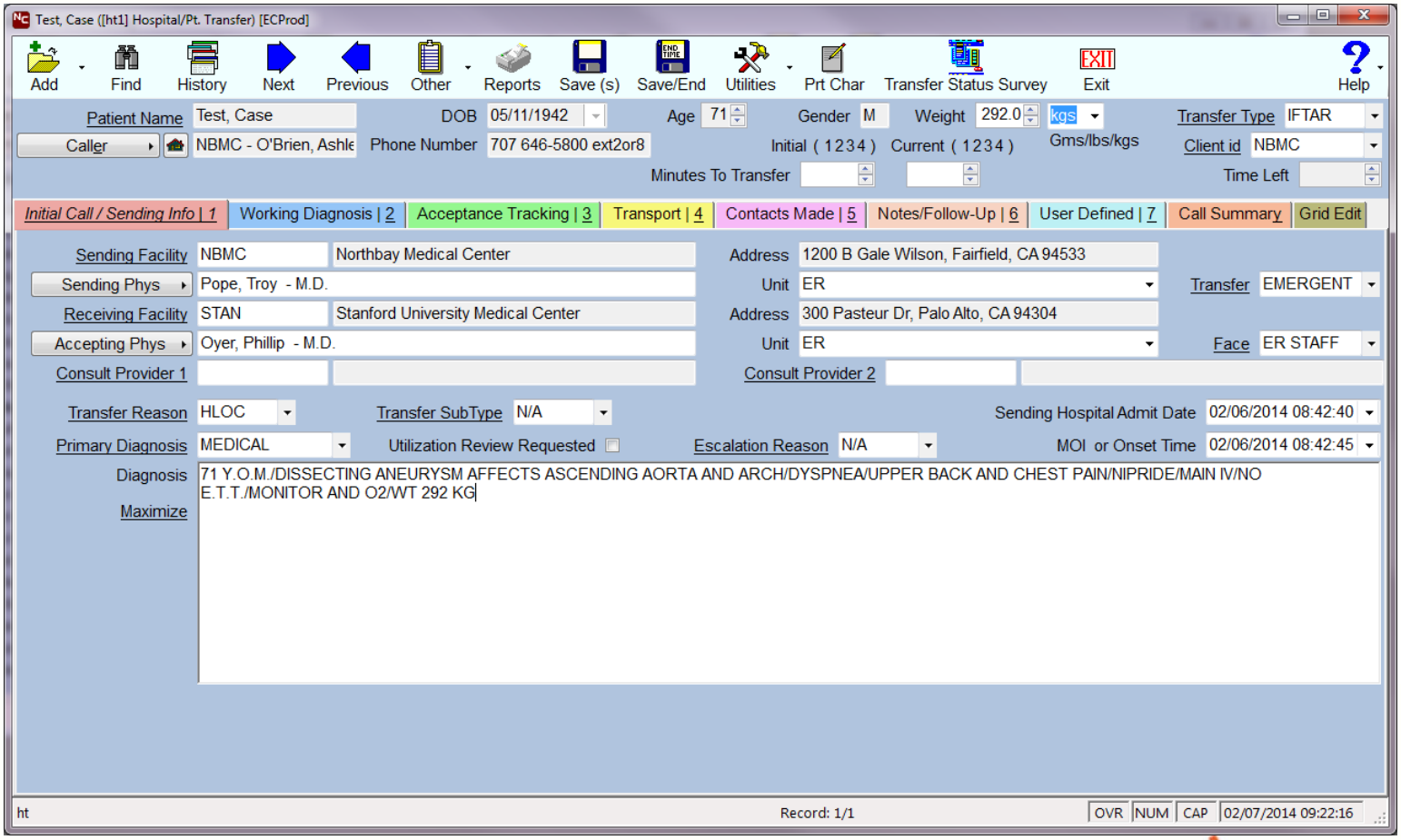


# Search Results



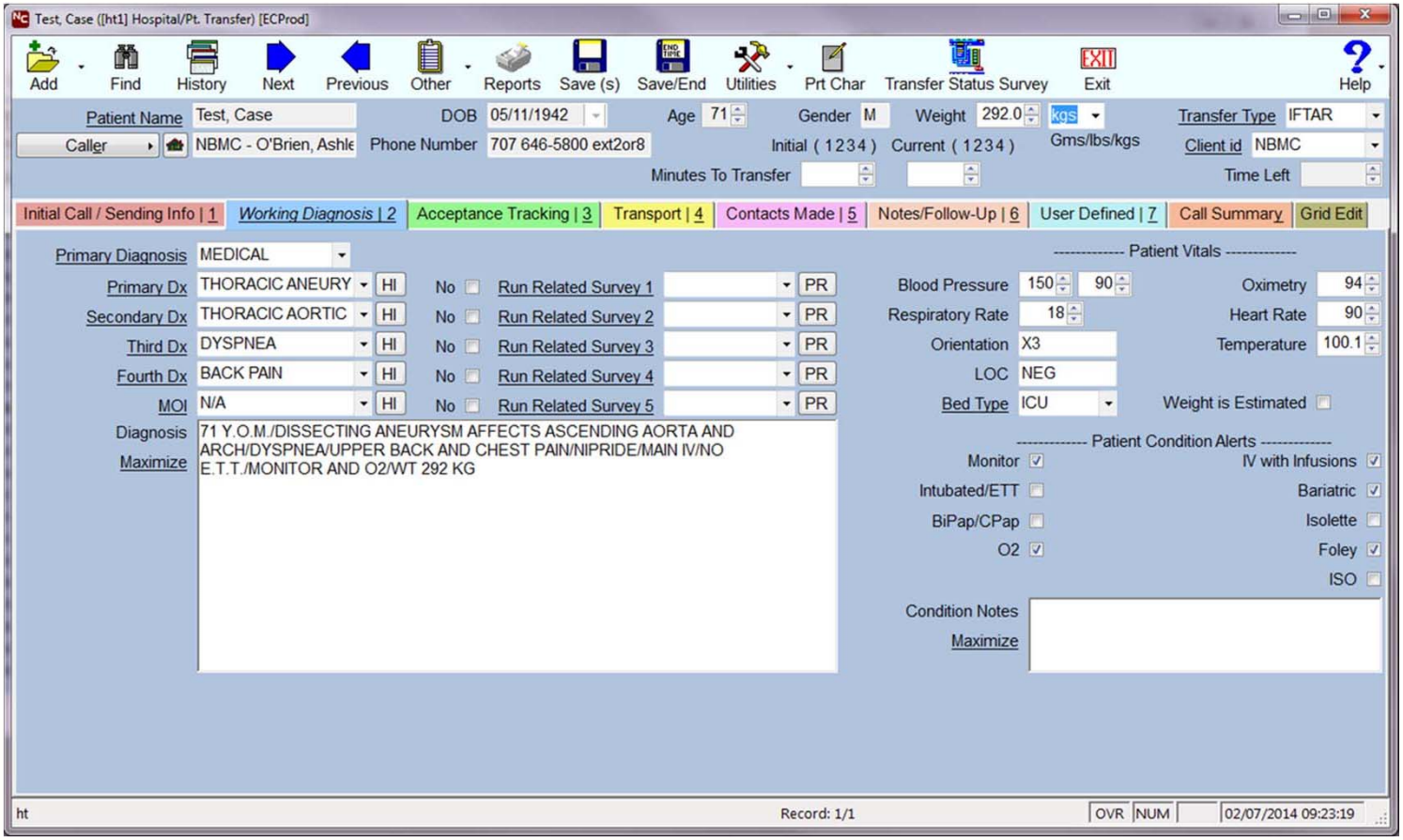

ALL ACCESS Transfer Center

# Initial Call Information

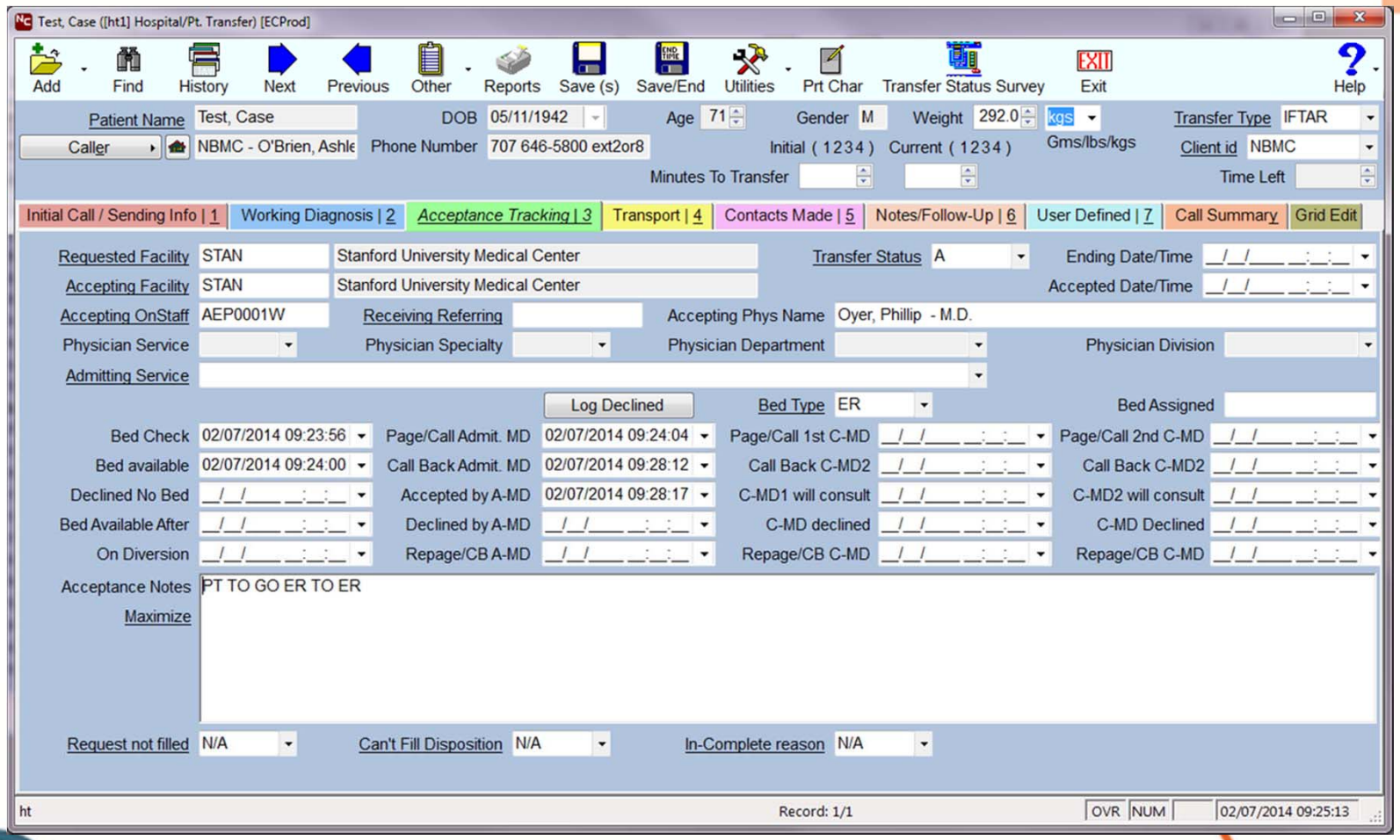



ALL ACCESS Transfer Center

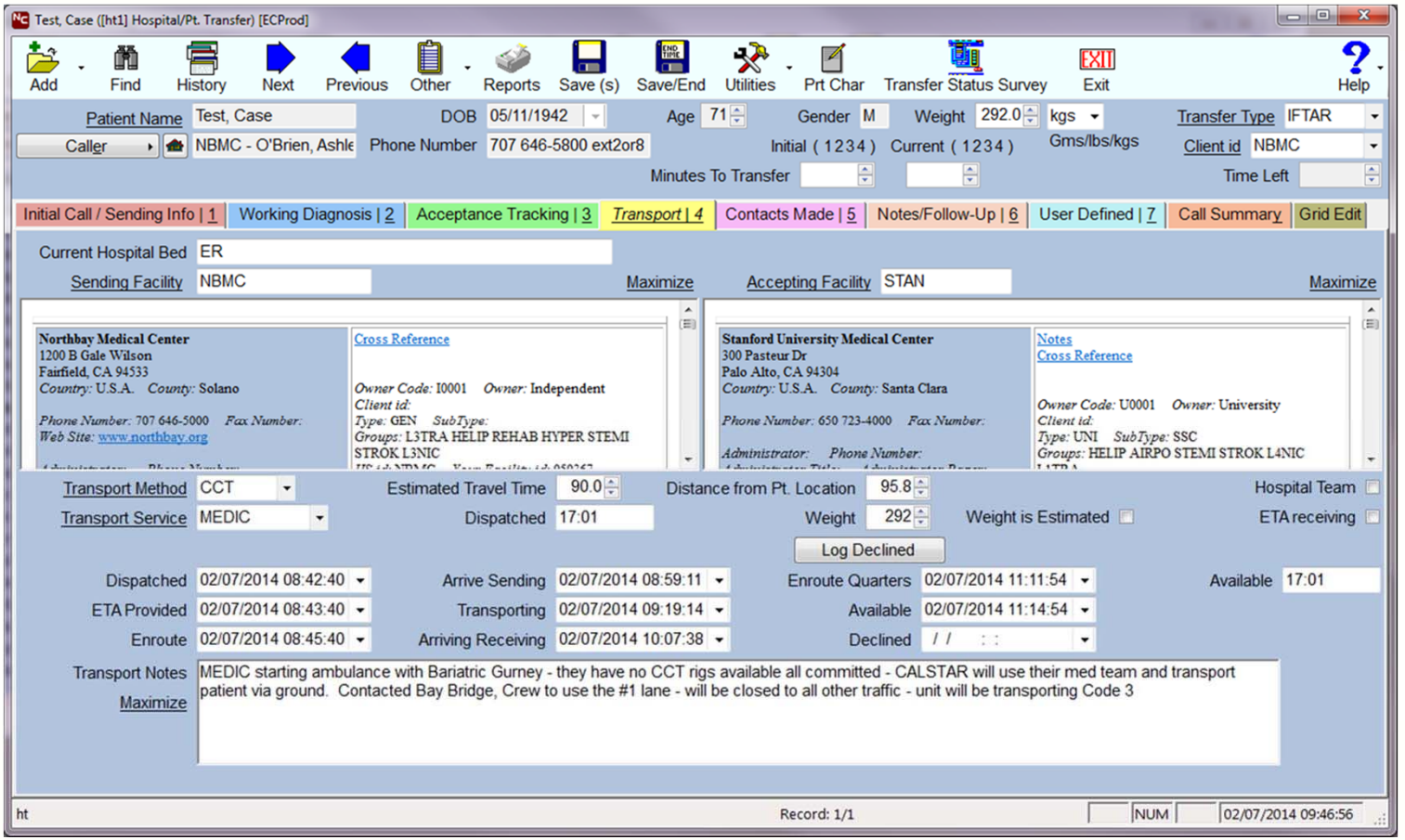
# Diagnosis


Test, Case ([ht1] Hospital/Pt. Transfer) [ECProd]
Add
Find
History
Next
Previous
Other
Reports
Save (s)
Save/End
Utilities
Prt Char
Transfer Status Survey
Exit
Help
Patient Name
Test, Case
DOB
05/11/1942
Age
71
Gender
M
Weight
292.0
kgs
Gms/lbs/kgs
Transfer Type
IFTAR
Caller
NBMC - O'Brien, Ashle
Phone Number
707 646-5800 ext2or8
Initial ( 1234 )
Current ( 1234 )
Client id
NBMC
Minutes To Transfer
Time Left
Initial Call / Sending Info | 1
Working Diagnosis | 2
Acceptance Tracking | 3
Transport | 4
Contacts Made | 5
Notes/Follow-Up | 6
User Defined | 7
Call Summary
Grid Edit
Primary Diagnosis
MEDICAL
Primary Dx
THORACIC ANEURY
Secondary Dx
THORACIC AORTIC
Third Dx
DYSPNEA
Fourth Dx
BACK PAIN
MOI
N/A
HI
No
Run Related Survey 1
Run Related Survey 2
Run Related Survey 3
Run Related Survey 4
Run Related Survey 5
PR
Diagnosis
Maximize
71 Y.O.M./DISSECTING ANEURYSM AFFECTS ASCENDING AORTA AND ARCH/DYSPNEA/UPPER BACK AND CHEST PAIN/NIPRIDE/MAIN IV/NO E.T.T./MONITOR AND O2/WT 292 KG
Patient Vitals
Blood Pressure
150
90
Respiratory Rate
18
Orientation
X3
LOC
NEG
Bed Type
ICU
Oximetry
94
Heart Rate
90
Temperature
100.1
Weight is Estimated
Patient Condition Alerts
Monitor
Intubated/ETT
BiPap/CPap
O2
IV with Infusions
Bariatric
Isolette
Foley
ISO
Condition Notes
Maximize
ht
Record: 1/1
OVR
NUM
02/07/2014 09:23:19

# Accepting


Test, Case ([ht1] Hospital/Pt. Transfer) [ECProd]
Add
Find
History
Next
Previous
Other
Reports
Save (s)
Save/End
Utilities
Prt Char
Transfer Status Survey
Exit
Help
Patient Name
Test, Case
DOB
05/11/1942
Age
71
Gender
M
Weight
292.0
kgs
Gms/lbs/kgs
Transfer Type
IFTAR
Caller
NBMC - O'Brien, Ashle
Phone Number
707 646-5800 ext2or8
Initial ( 1234 )
Current ( 1234 )
Client id
NBMC
Minutes To Transfer
Time Left
Initial Call / Sending Info | 1
Working Diagnosis | 2
Acceptance Tracking | 3
Transport | 4
Contacts Made | 5
Notes/Follow-Up | 6
User Defined | 7
Call Summary
Grid Edit
Requested Facility
STAN
Stanford University Medical Center
Transfer Status
A
Ending Date/Time
Accepting Facility
STAN
Stanford University Medical Center
Accepted Date/Time
Accepting OnStaff
AEP0001W
Receiving Referring
Accepting Phys Name
Oyer, Phillip - M.D.
Physician Service
Physician Specialty
Physician Department
Physician Division
Admitting Service
Log Declined
Bed Type
ER
Bed Assigned
Bed Check
02/07/2014 09:23:56
Page/Call Admit. MD
02/07/2014 09:24:04
Page/Call 1st C-MD
Page/Call 2nd C-MD
Bed available
02/07/2014 09:24:00
Call Back Admit. MD
02/07/2014 09:28:12
Call Back C-MD2
Call Back C-MD2
Declined No Bed
Accepted by A-MD
02/07/2014 09:28:17
C-MD1 will consult
C-MD2 will consult
Bed Available After
Declined by A-MD
C-MD declined
C-MD Declined
On Diversion
Repage/CB A-MD
Repage/CB C-MD
Repage/CB C-MD
Acceptance Notes
PT TO GO ER TO ER
Maximize
Request not filled
N/A
Can't Fill Disposition
N/A
In-Complete reason
N/A
ht
Record: 1/1
OVR
NUM
02/07/2014 09:25:13

# Transport




ALL ACCESS Transfer Center

# All-Access Transfer Center

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

June 23, 2016

TO: Emergency Medical Services / Trauma Committee

SUBJECT: Screening Brief Intervention and Referral to Treatment (SBIRT)

**Objective**
To learn the benefits of SBIRT.

**Background**
Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidenced-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs. Howard Padwa, PhD from UCLA Integrated Substance Abuse Programs will be presenting the work.

**Conclusion**
Informational Only

BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing & Clinical Services

1215 K Street, Suite 800, Sacramento, CA 95814 · *Telephone:* 916.443.7401 · *Facsimile:* 916.552.7596 · www.calhospital.org
*Corporate Members:* Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

# SBIRT: Screening, Brief Intervention, and Referral to Treatment

## *Opportunities for Implementation and Points for Consideration*

### *SBIRT: Basics*

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidenced-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs[1, 2]. Typically, this practice is conducted in medical settings, including community health centers, and has proved successful in hospitals, specialty medical practices such as HIV/STD clinics, emergency departments, and workplace wellness programs such as Employee Assistance Programs. SBIRT can be easily used in primary care settings and enables healthcare professionals to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work, or family issues. SBIRT aims to prevent the unhealthy consequences of alcohol and drug use among those whose use may not have reached the diagnostic level of a substance use disorder, and to help those with the disease of addiction enter and stay with treatment.

Charged with developing a strategy to substantially improve healthcare quality over 10 years, the Institute of Medicine's Committee on the Quality of Health Care in America in 2001 called for community-based screening for health risk behaviors — including substance use — with appropriate assessment and referral activities[3] in its report, *Crossing the Quality Chasm: A New Health System or the 21st Century*. In that landmark report, the Institute of Medicine specifically cited the SBIRT model as a promising practice.

### *SBIRT: Benefits*

Substance misuse and abuse often result in poor health outcomes and substantial healthcare costs related to illness, hospitalizations, motor vehicle injuries, and premature deaths. An Office of National Drug Control Policy study estimated that in 2011 substance use accrued a societal cost of $193 billion[4]. Research has demonstrated SBIRT's numerous benefits. Specifically, SBIRT successfully reduces:

- Healthcare costs[5];
- Severity of drug and alcohol use; and
- Risk of trauma (distressing events that may have long lasting, harmful effect on a person's physical and emotional health and wellbeing) and the percentage of at-risk patients who go without specialized substance use treatment[6].

A 2010 study examined SBIRT's cost - benefit from an employer's perspective. The study considered the costs of absenteeism and impaired presenteeism due to problem drinking. The results indicated that when absenteeism and impaired presenteeism costs, the net value of SBIRT adoption was $771 per employee[7].

#### *SBIRT reduces healthcare costs*

- Multiple studies have shown that investing in SBIRT can result in healthcare cost savings that range from $3.81 to $5.60 for each $1.00 spent[8].

- People who received screening and brief intervention in an emergency department, hospital or primary care office experienced 20% fewer emergency department visits, 33% fewer nonfatal injuries, 37% fewer hospitalizations, 46% fewer arrests and 50% fewer motor vehicle crashes[9].

***SBIRT decreases severity of drug and alcohol use***

- In 2002, researchers analyzed more than 360 controlled trials on alcohol use treatments and found that screening and brief intervention was *the single most effective treatment method* of the more than 40 treatment approaches studied, particularly among groups of people not actively seeking treatment. Additional studies and reports have produced similar results showing that substance use screening and intervention help people recognize and change unhealthy patterns of use[10].
- Studies have found that patients identified through screening as having unhealthy patterns of drug or alcohol use are more likely to respond to brief intervention than those who drink heavily[11]. The latter group is more likely to meet diagnostic criteria for a substance use disorders that needs more intensive treatment.

***SBIRT reduces risk of physical trauma and the percentage of patients who go without specialized substance use treatment***

- Studies on brief intervention in trauma centers and emergency departments have documented positive effects such as reductions in alcohol consumption,[12] successful referral to and participation in alcohol treatment programs,[13] and reduction in repeat injuries and injury hospitalizations[14, 15].

Given SBIRT's demonstrated cost and health savings, federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA), Veterans Administration, Department of Defense and the White House Office of National Drug Control Policy, as well as managed care providers and major medical associations, have recommended SBIRT's routine use. Not only does SAMHSA recommend SBIRT, but the agency also continues to support SBIRT's expanded use by funding grants across the country to further implement the practice in healthcare settings.

## *SBIRT: Core Components*

### *Screening*

Screening is a quick, simple method of identifying patients who use substances at at-risk or hazardous levels and who may already have substance use-related disorders. The screening instrument provides specific information and feedback to the patient related to his or her substance use. The typical screening process involves the use of a brief 1-3 question screen such as the National Institute on Alcohol Abuse and Alcoholism's single question screen or National Institute on Drug Abuse's quick screen. If a person screens positive on one of these instruments, s/he is then given a longer alcohol or drug use evaluation, using a standardized risk assessment tool such as AUDIT or ASSIST. The screening and risk assessment instruments are easily administered and provide patient-reported information about substance use that any healthcare professional can easily score.

### *Brief Intervention*

Brief Intervention is a time-limited, patient-centered strategy that focuses on changing a patient's behavior by increasing insight and awareness regarding substance use. Depending on severity of use and risk for adverse consequences, a 5-10 minute discussion or a longer 20-30 minute discussion provides the patient with

personalized feedback showing concern over drug and/or alcohol use. The topics discussed can include how substances can interact with medications, cause or exacerbate health problems, and/or interfere with personal responsibilities[16].

Brief intervention is designed to motivate patients to change their behavior and prevent the progression of substance use. During the intervention, patients are:

- Given information about their substance use based on their risk assessment scores.
- Advised in clear, respectful terms to decrease or abstain from substance use.
- Encouraged to set goals to decrease substance use and to identify specific steps to reach those goals.
- Taught behavior change skills that will reduce substance use and limit negative consequences.
- Provided with a referral for further care, if needed.

Brief interventions are typically provided to patients with less severe alcohol or substance use problems who do not need a referral to additional treatment and services. In addition to behavioral health professionals, medical personnel (e.g., doctors, nurses, physician assistants, nurse practitioners) can conduct these interventions and need only minimal training. In the case of patients with addictions, more intensive interventions may be needed. Much of the discussion in intensive intervention is similar to that of the brief intervention; however, the intensive sessions tend to be longer (20-30 minute) and can include multiple sessions, a referral to an addiction specialty program, and the addition of a specific pharmacological therapy. While medical personnel who have received additional training may conduct intensive interventions, behavioral health professionals often conduct these longer counseling sessions.

***Referral to Treatment***

In some cases, a more advanced treatment option is necessary and the patient is referred to a higher level of care. This care is often provided at specialized addiction treatment programs. The referral to treatment process consists of helping patients access specialized treatment, selecting treatment facilities, and facilitating the navigation of any barriers such as cost of treatment or lack of transportation that would hinder them from receiving treatment in a specialty setting. In order for this process to occur smoothly, primary care providers must initially establish and cultivate relationships with specialty providers, and then share pertinent patient information with the referral provider. Handling the referral process properly and ensuring that the patient receives the necessary care coordination and follow-up support services is critical to the treatment process and to facilitating and maintaining recovery.

## *SBIRT: Opportunities and Points for Consideration*

The passage of the Patient Protection and Affordable Care Act in 2010 availed several opportunities for service delivery and payment reform in healthcare, including recognition of the importance of screening and intervention in primary care to reduce disease, disability and premature mortality.

As of October 14, 2011, Medicare covers screening and behavioral counseling related to alcohol misuse in the primary care setting, which the U.S. Preventive Services Task Force recommended with a grade of B. In its

Decision Memo for Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse, the Centers for Medicare and Medicaid Services (CMS) conclude that these services are "reasonable and necessary for the prevention or early detection of illness or disability"[17]. Medicare entitles beneficiaries to yearly alcohol screenings by a primary care provider and up to four behavioral counseling interventions[18].

Additionally, in December 2011, the U.S. Department of Health and Human Services (HHS) issued its first round of guidance on how states and health plans are to implement the Essential Health Benefits (EHBs) provisions of the Affordable Care Act. The Essential Health Benefits are a set of healthcare service categories that must be covered by all insurance policies participating in state health insurance exchanges and all state Medicaid plans beginning in 2014. As required by the Affordable Care Act, the EHB package must include mental health and substance use disorder services at parity with other medical/surgical care, prevention services, and rehabilitative services. However, rather than designing one standard benefit package for all health plans in the nation to follow, HHS proposed to allow states to define their own essential health benefits. States would have 10 options for selecting a "benchmark" plan in which its covered benefits would be the basis of that state's EHB package. While the package must include mental health and substance use disorder services, each state will determine the extent of coverage. The development of the EHB package is a prime opportunity to promote the inclusion of SBIRT across multiple healthcare settings. However, inclusion of these services may be dependent upon action at the state level. Stakeholders should pay close attention to further guidance released by HHS, as well as opportunities within their own state to influence the process.

Even with reimbursement codes available, it is important to note that some states may still have difficulty covering screening and brief intervention services when they are provided by non-physician professionals. According to a SAMHSA learning collaborative run by the National Network to Eliminate Disparities, Federally Qualified Health Centers (FQHCs) in Tennessee and Colorado received reimbursement from insurance carriers only when SBIRT services were conducted by primary care physicians and not when provided by psychologists or social workers. As it turned out, this caveat was included in the criteria for payment in these states. Once identified, both states were able to change their payment methodologies to correct this problem. In Colorado, health educators are now able to receive payment for delivering screening and brief intervention.

### *Utilizing SBIRT Reimbursement Codes*

SBIRT is an effective method to identify, intervene and help treat individuals with substance use problems. Its use across healthcare settings, including emergency rooms, community clinics and trauma centers, is paramount. Hence, SBIRT coding and billing policies are a crucial component to widespread use of this practice. However, coding and reimbursement are dependent upon the payer type; reimbursement is available through commercial insurance Current Procedural Terminology (CPT) codes, Medicare G codes, and Medicaid Healthcare Common Procedure Coding System (HCPCS) codes[19].

While Medicare currently pays for screening and brief intervention as a preventive service in the primary care setting, some states are working to "activate" Medicaid codes for SBIRT reimbursement. According to the most recent information from SAMHSA, 16 states have approved SBIRT codes in their respective Medicaid plans; of these, five states have activated codes that allow providers to bill and receive payment for the services, four have activated SBIRT codes to allow for reimbursement of non-physician professionals, including Alaska, Tennessee, Colorado, and Virginia, and two states — Indiana and Oklahoma — have activated SBIRT codes to allow for reimbursement of physicians only.

SAMHSA has funded a number of state SBIRT initiatives and has found that SBIRT programs can be implemented successfully in primary care settings[20]. However, sustainability can pose a problem once a grant-funded project ends. Addressing SBIRT reimbursement barriers not only expands the use of SBIRT, but also assists in the sustainability of providing these services in the primary care setting.

More information on SBIRT billing codes may be found through the Institute for Research, Education &Training Institute in Addictions, CMS and the SAMHSA-HRSA Center for Integrated Health Solutions.

### *Addressing Workflow Issues*

In addition to reimbursement issues, SBIRT proponents encounter other barriers to broad implementation and sustainability of this evidence-based practice. In Maryland, efforts to integrate SBIRT into community health centers demonstrate the importance of resolving workflow hurdles and providers' time constraints in the primary care setting. Through an Open Society Institute-funded pilot project in 2010, four community health centers in Baltimore engaged in a workflow redesign process that resulted in successful institutionalization of SBIRT practices in their centers. Through this process, key lessons learned were that administrative and physician champions are essential to early adoption and that recognizing the role of technology was critical. As a result, the Baltimore SBIRT pilot supported sites in incorporating SBIRT screening into their electronic health records. This produced a dramatic improvement in delivery of brief interventions and facilitated ease in documentation and data collection.

One common barrier to implementing SBIRT in primary care settings is the additional time the practice will add to already short visits. As indicated above, the Baltimore SBIRT project overcome this hurdle by employing multi-disciplinary change team to identify not only the best screening and risk assessment tools for that practice setting, but also which existing clinical and administrative staff would conduct specific SBIRT functions. This led to the creation of several different SBIRT delivery models across seven community health centers in 14 separate locations across the state of Maryland. In some models, medical assistants complete the screening and risk assessment tools with patients; then, the primary care provider reviews the information and conducts the brief intervention. In other health centers, the primary care provider conducts only part of the brief intervention for each patient and refers to internal behavioral health professionals for completion. The success of the Maryland health center project led Baltimore Substance Abuse Systems, Inc., the lead funder of substance abuse treatment for the city, to fund SBIRT projects in six high schools and one emergency department. These efforts are currently underway. The keys to Maryland's successful implementation have included collaboration with health staff to tailor SBIRT to existing infrastructure and resources, ongoing training, data collection for quality monitoring and process revision based on results.

Visit SAMHSA-HRSA Center for Integrated Health Solutions for resources that address workflow issues.

### *Maintaining Confidentiality*

As SBIRT's use advances, patient privacy must be carefully considered as data collected through the screening process by healthcare organizations other than addiction specialty programs are not covered by 42 CFR. Providers must ensure that all applicable safeguards are in place to protect patient data.

## SBIRT: Adapting to the Health Home Model

Under the Affordable Care Act, states have the option to establish a "health home" to better meet the healthcare needs of individuals with chronic conditions. As stipulated by the federal government, these health homes must provide comprehensive, evidence-based care and provide mental health and substance use prevention and treatment services. CMS has released guidance on the development of health homes, (available on SAMHSA's health homes webpage). Hence, as states move forward with implementing health home initiatives, an opportunity exists to significantly expand the use of SBIRT services to provide more comprehensive care to the individuals that are served through these models. The state of New York in its Health Home State Plan Amendment (SPA) and in proposals to transform their Medicaid system have proposed a significant expansion of the use of SBIRT. It is the state's hope that this expansion will lead to early interventions before more severe and costly consequences occur from alcohol and drug misuse. The state of Missouri has also taken a similar approach in the development of its Health Home SPA by identifying the use of SBIRT as a critical component of addressing the health needs of Missouri's low-income populations and those living with chronic medical and behavioral health conditions. Stakeholders must educate state Medicaid directors on the benefits of incorporating SBIRT services into health home models and allowing psychologists and licensed social workers to bill for these services. As mentioned, Alaska, Tennessee, Colorado, and Virginia have successfully worked with state Medicaid programs to activate SBIRT billing codes to allow reimbursement for non-physician professionals.

Stakeholders interested in receiving technical assistance and consultation around the Health Home SPA can contact the Substance Abuse and Mental Health Services Administration.

## SBIRT: Implications

The cost of healthcare in the U.S. has been steadily growing and providers, policy makers and consumers are eager to identify high quality, cost-effective strategies to coordinate the care of individuals and manage chronic illnesses[21]. SBIRT is an evidence-based practice that has been clinically shown to identify, reduce and prevent substance misuse and the disease of addiction and ultimately reduce healthcare costs. While implementation barriers still exist, recent developments under the Affordable Care Act have created valuable opportunities for the expansion of SBIRT utilization across various healthcare settings. As states begin to explore opportunities through the Health Homes SPA, stakeholders must recognize SBIRT's value and the need to implement the practice to comprehensively address consumers' health needs. Through the use of evidence-based practices such as SBIRT, individuals will receive quality care that will lead to improved population health outcomes.

## SBIRT: Additional Resources

SAMHSA-HRSA Center for Integrated Health Solutions

Substance Abuse and Mental Health Services Administration

Centers for Medicaid and Medicare Services

National Institute on Alcohol Abuse and Alcoholism

The Big Initiative

Foundations of SBIRT

1. Bien, T. H., Miller, W. R., & Tonigan, J. S. (1993). Brief intervention for alcohol problems: A review. Addiction, 88, 315–335
2. Madras BK, Compton WM, Avula D et al. Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and six months later. Drug and Alcohol Dependence 2009; 280-295.
3. Institute of Medicine, Committee on Quality of Health Care in America (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC, 2001.
4. National Drug Intelligence Center (2011) The Economic Impact of Illicit Drug Use on American Society. Washington D.C.: United States Department of Justice.
5. Quanbeck A, Lang K, Enami K, & Brown RL. (2010). A cost-benefit analysis of Wisconsin's screening, brief intervention, and referral to treatment program: adding the employer's perspective. State Medical Society of Wisconsin, Feb; 109(1):9-14
6. Gentilello, L.M., Ebel, B.E., Wickizer, T.M., Salkever, D.S. & Rivara, F.P. (2005). Alcohol intervention for trauma patients treated in emergency department and hospitals: a cost benefit analysis. Annals of Surgery, 241 (4), 541-550
7. Quanbeck A (2010)
8. Fleming, M. F., Mundt, M. P., French, M. T., Manwell, L. B., Stauffacher, E. A., & Barry, K. L. (2000). Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. Medical Care, 38(1), 7–18.
9. ibid
10. Miller, W.R., & Wilbourne, P.L. (2002). Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. Addiction, 97, 265–277
11. Fleming M (2000)
12. Gentilello, L. M. (2007). Alcohol and injury: American College of Surgeons Committee on Trauma requirements for trauma center intervention. *Journal of Trauma, 62,* S44–S45
13. Gentilello, L. M., Rivara, F. P., Donovan, D. M., Jurkovich, G. J., Daranciang, E., Dunn, C. W., et al. (1999). Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Annals of Surgery*, *230,* 473–483
14. ibid
15. Soderstrom, C. A., DiClemente, C. C., Dischinger, P. C., Hebel, J. R., McDuff, D. R., Auman, K. M., et al. (2007). A controlled trial of brief intervention versus brief advice for at-risk drinking trauma center patients. *Journal of Trauma, 62*, 1102–1112.
16. Institute for Research, Education and Training in Addictions (undated) SBIRT, Screening, Brief Intervention, and Referral to Treatment. www.ireta.org/sbirt/1_multipart_xF8FF_4_sbirt.pdf
17. Centers for Medicare and Medicaid Services. (2011). Decision memo for screening and behavioral counseling interventions in primary care to reduce alcohol misuse. www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=249
18. Centers for Medicare and Medicaid Services. (2011). Medicare Claims Processing Manual: Chapter 18 - Preventive and Screening Services. Available at: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//clm104c18.pdf
19. Ensuring Solutions to Alcohol Problems (2008). The Promise of the New Reimbursement Codes. The George Washington University Medical Center. Available at: www.ensuringsolutions.org/moreresources/moreresources_show.htm?doc_id=672933
20. Substance Abuse and Mental Health Services Administration (2011). Screening, Brief Intervention and Referral to Treatment (SBIRT) in Behavioral Healthcare. Available at: www.samhsa.gov/prevention/sbirt/SBIRTwhitepaper.pdf
21. Kaiser Family Foundation. (2011). **Health Care Spending in the United States and Selected OECD Countries. Available at:** www.kff.org/insurance/snapshot/oecd042111.cfm

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

June 23, 2016

TO: Emergency Medical Services / Trauma Committee

SUBJECT: Every ED Instantly at your Fingertips (EDIE)

**Objective**
To learn about the EDIE program offered by Collective Medical Technologies (CMT).

**Background**
Collective Medical Technologies' (CMT) EDIE connects Emergency Departments, and consolidates and standardizes patient-centered care coordination information across them. All to deliver the right information to the right place, the instant it is needed to impact better patient outcomes. Gabe Waters from CMT will be presenting this information.

**Conclusion**
Informational Only

BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing & Clinical Services

# Get to Know EDIE®

## *Every ED at Your Fingertips*

The treatment workflow of an Emergency Department (ED) is unique. Time and space are scarce resources to be spent on treating emergencies and saving lives.

Too often, patients seek care at the ED for chronic, non-emergent conditions that could be more appropriately treated in a different care venue. ED clinicians and case managers spend valuable time trying to dig up information about these patients' histories and are often not able to get an accurate view of what has really brought the patient to the ED. The lack of historical context aside, often if care coordination information exists for a patient outside of a hospital's own EHR, that information can't be surfaced where and when it is needed most.

Collective Medical Technologies' (CMT) EDIE connects Emergency Departments, and consolidates and standardizes patient-centered care coordination information across them. All to deliver the right information to the right place, the instant it is needed to impact better patient outcomes.

# Key Benefits

EDs on EDIE join a growing network of providers instantly collaborating on a shared patient perspective contributed to by all EDs visited by a patient. This creates a dynamic care coordination environment that ensures that wherever a patient goes, treating providers are operating from the same playbook every time, resulting in the following:

### Saved ED Resources

EDIE instantly empowers clinicians with the context they need without their having to search, request records, or wade through piles of information. EDIE helps clinicians avoid unnecessary or duplicative work-ups, and kick-starts the care coordination process the instant a patient registers.

### Connected Care

EDIE unites EDs in a new way: by curating and disseminating data across all EDs visited by a patient, giving clinicians the information they need when they need it to impact change, and by providing a common venue and easy-to-use platform where patient information may be added, helping to ensure the care coordination message is delivered wherever a patient goes. This enables hospitals to identify risk within moments of patient registration, divert medically-unnecessary patient volume to more appropriate care settings, and reduce costs through better allocated ED resources.

### Improved Outcomes

EDIE delivers a broader picture of a patient's care history and needs to all points of care. A consistent message delivered wherever the patient goes opens up a dialog with they go, and helps to ensure that patients get to the care they need in the appropriate venue, ultimately resulting in improved patient outcomes.

# EDIE Features

EDIE establishes a live data feed with all participating hospitals in order to create a comprehensive ED visit history for a patient, and to alert EDs when a patient with a significant history registers at their facility in the form of an EDIE Notification. Encounter information contributed by all EDs visited by a patient is just part of the puzzle. The EDIE Web Application provides a venue where care coordination information for a patient can be added to help complete the picture. What this combination creates is a powerfully interconnected network and care coordination environment unlike anything else.

## *EDIE Notifications*

What EDIE does is simple: when a patient registers at an EDIE-participating ED, the hospital's EHR immediately sends their information to EDIE. EDIE determines if the patient meets the ED's unique risk criteria, and if the patient's history meets any one of the ED's risk criteria, EDIE immediately sends an EDIE Notification. These are ***smart notifications*** that present:

- A consolidated view of the patient's ED visit history contributed by all EDs visited,
- Any known care providers for the patient,
- Security event information,
- Care history information,
- Prescription Drug Monitoring Program information (when allowed by state law), and
- Any existing care coordination information for the patient.

EDIE consolidates all of this into a format that can be read in 60-seconds or less, and delivers it to the ED within moments of patient registration, ***without anyone ever having to ask for it***.

## *EDIE Web Application*

Within this powerful application, users have access to a wide range of features specifically built to enhance and support the care coordination process. Information added within the web app attaches to the patient, not the facility, ensuring that wherever the patient goes, their care coordination message goes with them. This extends the work of a case manager or social worker beyond their own facility, and ensures that their work is seen by the right clinician at the right time, without clinician or case manager action. The web application houses many features, including the following:

- Patient-Centered Care Guidelines Publisher
- Care History Tracker
- Security Event Reporting Mechanism
- Known Care Providers
- Patient Notes & Correspondences Tracker

To see any of these features in action, contact us today at sales@collectivemedicaltech.com.

## Flexible EHR Integration Options

One of the many compelling features of EDIE is that hospital IT personnel can implement the system quickly and easily. Once the initial integration is complete, your IT team likely won't need to touch it again. CMT monitors each hospital's data feed 24/7/365 to ensure everything is working as expected, and with EDIE there is never an update to install or hardware to maintain.

No matter the integration option selected by your organization, CMT will provide easy to follow specifications and technical support to ensure that the integration process goes as smoothly and as quickly as possible.

- **Basic Integration**: A hospital can go-live with EDIE with a Basic Integration in an average of 12 hours[1] of time from IT personnel to establish an ADT connection, with basic mapping information. Once the ADT connection to EDIE is live, CMT will set-up EDIE Notifications to send to a fax machine or network printer in your hospital's ED.
- **Bidirectional Integration**: Hospitals often prefer to consume EDIE Notifications within the clinical workflow of their EHR. With CMT assistance, hospital IT personnel can set up a Bidirectional Integration in an average of 40 hours[2] of time. This option enables an icon to display in the EHR's ED Track Board when a patient registers that triggers an EDIE Notification. ED clinicians can then click on the icon to view the EDIE Notification within the EHR.
- **Full Integration**: Where hospitals want to author care guidelines and input additional patient details into EDIE through their EHR directly, CMT will assist hospital IT personnel in implementing a Full Integration. This option will enable case managers and ED clinicians to consume and contribute care coordination information within the clinical workflow of their EHR, with the contributed information pushing into EDIE automatically, cutting down on duplicate documentation.

[1] CMT has established Basic Integrations with over 150 hospital EHR systems, including Epic, Cerner, NextGen, Meditech, GE, CPSI, and Healthland.
[2] CMT has established Bidirectional Integrations with hospitals and hospital systems on Epic and Cerner. We will be happy to work with customers to develop integrations with other EHR platforms at no cost to the customer.

# The EDIE Network

EDIE is already live in hospitals from Washington to California, and is expanding rapidly across the country. The growing network provides a dynamically connected care coordination community collaborating on patients across cities, counties, and state lines.; This not only ensures that providers get the information they need when they need it, regardless of where it originated, but also ensures that patients get the consistent care they need wherever they go. The EDIE network includes:

## 150+ Hospitals

Contributing all hospital visits to EDIE, and that number is growing. CMT is in discussions with hospitals across the country who are interested in collaborating across geographic area regardless of hospital affiliation, EHR system or state lines.

## 62,000+ Active Care Guidelines

That communicate a patient's unique care history and care recommendations from past providers to any ED they visit, ensuring consistent care coordination wherever they go. This in turn helps get patients routed to the care they need in the right venue.

## 250+ Clinics & Other Providers

Also contributing information to help complete the patient puzzle through CMT's PreManage application. Since EDIE and PreManage are built on the same platform, hospitals, clinics, specialists, ACOs and even health plans can all contribute and consume patient information, ensuring that everyone across the care continuum are operating from the same playbook, regardless of affiliation or technology platform.

## The Results: Spotlight on Washington

As part of the Washington State "ER is for Emergencies" initiative to reduce unnecessary ED visits by Medicaid patients, EDIE was adopted in 92 hospitals across Washington State. Not only did implementing EDIE connect hospitals state-wide on a common care coordination platform—increasing data exchange and collaboration on shared patients—but the results of this wide-spread adoption speak for themselves.

In its most recent report to the Washington State Legislature, the Washington State Health Care Authority reporting that for the previous fiscal year, the state experienced[3]:

- *10% Reduction in Rate of ED Visits by Medicaid Patients*
- *24% Reduction Rate of ED Visits Resulting in Scheduled Narcotic Prescriptions*
- *14% Reduction Rate of ED Visits for Low Acuity Diagnoses*
- ***$33.6 Million in Savings for the Washington State Medicaid Program***

[3] Source: Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation, Report to the Legislature, Washington State Health Care Authority (March 20, 2014).

# How is EDIE Legal under HIPAA?

Hospitals must be careful that their use and disclosure of "protected health information" (PHI) for their patients complies with the applicable rules of HIPAA and the more recent HITECH Act, as well as state regulations. The regulations that implement the HIPAA and HITECH legislation (i.e., the HIPAA "Privacy Rule") provide two clear paths which enable hospitals to share PHI through EDIE:

1. ***Disclosure for Health Care Treatment***: The HIPAA Privacy Rule enables hospitals to share PHI for "treatment", "payment", or "operations" purposes related to patient care, including their own treatment of a patient or another provider's treatment of a patient. See, 45 CFR 164.402(a)(1); 45 CFR 164.506(c)(2).
2. ***Disclosure for Health Care Operations & Case Management:*** The HIPAA Privacy Rule also allows hospitals to share PHI with hospitals and other health care organizations for health care operations purposes, which include "population-based activities relating to improving health or reducing health care costs…, case management and care coordination." See, 45 CFR 164.506(c)(4); 45 CFR164.501.

The HIPAA Privacy Rule recognizes the critical need that healthcare providers have to share information and coordinate care for patients in a diverse healthcare ecosystem and clearly establishes that clinicians and case managers at hospitals that participate in the EDIE network are both able to share and receive information about patients who visit their hospital for care coordination and case management purposes. CMT's customer contracts clearly articulate that hospitals retain full ownership rights over their PHI, and that CMT and any participants in the network can only use or share PHI for treatment, payment, or operations (TPO) purposes for patients with whom the participant has a TPO relationship.

# How to get EDIE

Implementing EDIE is surprisingly painless and fast. CMT has worked with customers for years to streamline the onboarding process to minimize the drain on scarce IT and clinical resources. Legal and compliance review, IT work, and staff training and on-boarding can all be put in motion quickly, so that your organization can get up and running with EDIE as efficiently as possible. Here are the basics:

## *Decision Making*

Start by evaluating EDIE from a clinical and IT/security perspective. Connect with existing EDIE users and hear about their experiences. Subscribing to EDIE is low risk: fees are low and hospitals can terminate service at any time for any reason.

## *Legal*

Because EDIE involves sharing of patient information to a network of other hospitals and healthcare organizations, participating hospitals sign a contract that includes industry standard privacy, security, and operational protections for all of the other members of the network. CMT also enters into a Business Associate Agreement with each hospital to provide additional assurances regarding privacy and security of PHI.

## *IT Process*

After a hospital selects its preferred EHR integration option, CMT will send integration instructions and technical specifications, and set up a call to get started. CMT will interface with any EHR platform at no additional cost, and will work to make the process as easy and painless for hospital IT personnel as possible.

## *Training & On-Boarding*

While the IT integration is in process, CMT will work with hospital clinical and case management staff to set up EDIE Notifications, risk criteria, and to identify users for the EDIE Web Application, and train users on the app. Training typically takes about an hour, and post go-live, your dedicated CMT Client Relations Manager will be there for on-going support and training.

# What's Next?

We'd love to give you a demo of the system and get your organization started with EDIE.

Contact us today at:

sales@collectivemedicaltech.com

## About Us

EDIE is developed by Collective Medical Technologies® (CMT), a Salt Lake City, Utah-based company.

Based on the simple notion that gaps in communication lead to gaps in patient care, CMT develops tools to close these gaps in communication across care venues. In the hands of our healthcare clients, these tools are helping to enable real change, conserve valuable healthcare resources, and ultimately improve patient outcomes.

The result is a comprehensive, highly-accurate, and broadly-integrated care coordination environment unlike any other platform.

For more information about who we are and what we do, contact us today or visit www.collectivemedicaltech.com.

**Collective Medical Technologies, Inc.**

2795 Cottonwood Pkwy., Suite 320
Salt Lake City, Utah 84121

info@collectivemedicaltech.com
www.collectivemedicaltech.com

# EDIE ALERT 04/13/2015 14:18 PM Mouse, Mickey ( DOB: 01/04/1952 )

This patient has registered at the Ford Medical Center Emergency Department. You are being notified because this patient has recommended Care Guidelines. For more information visit: Please login to EDIE and search for this patient by name.

## Care Providers

| Provider | Type | Phone | Fax | Service Dates |
|---|---|---|---|---|
| John K SMITH MD | | (801) 856-8575 | (855) 343-7671 | Current |

## ED Care Guidelines from Ford Medical Center

Last Updated: Wed Feb 17 10:35:40 MDT 2015

**Care Recommendation:**

**Pain contract and scheduled substance prescribing:** Patient had a controlled substance agreement with Dr. Smith but Dr. Jamison. **Dr. Jamison prescribes regular 1 mg Clonazepam, 1 mg Lorazepam, and hydrocodone as needed.** Please do not use controlled substances in the ER unless there are new objective findings.

**Additional Information:**

1. No opiates in the ED for chronic pain or opiate withdrawal. No opiate or benzodiazepine prescriptions at discharge.
2. Strongly encourage or assist Pt in making a PCP appointment prior to d/c.

These are guidelines and the provider should exercise clinical judgment when providing care.

## Care Histories

**Behavioral**

03/4/2015 Ford Medical Center

- **AXIS I:** Bipolar disorder, type I, hypomanic.
- History of PTSD
- **AXIS II:** Borderline personality features.

**Radiation History**

- 15 CT scans on record from 2007 through 2/6/15, as well as numerous radiology exams.

## Security Events

| Date | Location | Type | Specifics |
|---|---|---|---|
| 11/03/2014 | Ford Medical Center | Verbal | • Patient was verbally abusive towards care providers, staff or patient. |

| Security Events (18 Mo.) | Count |
|---|---|
| Verbal | 1 |
| **Total** | **1** |

## Washington PDMP Report

***Rx Details (6 Mo.)***

| Fill Date | Drug Description | Qty. | Prescriber | CS | MED |
|---|---|---|---|---|---|
| 2015-02-18 | HYDROCODONE-ACETAMINOPHEN 7.5-325 | 30 | John Smith, MD | 3 | 60.0 |
| 2015-01-31 | HYDROCODONE-ACETAMINOPHEN 7.5-325 | 30 | John Smith, MD | 3 | 60.0 |
| 2015-01-10 | HYDROCODONE-ACETAMINOPHEN 7.5-325 | 15 | John Smith, MD | 3 | 60.0 |
| 2014-12-18 | HYDROCODONE-ACETAMINOPHEN 7.5-325 | 30 | John Smith, MD | 3 | 60.0 |
| 2014-11-29 | HYDROCODONE-ACETAMINOPHEN 5.0-250 | 30 | John Smith, MD | 3 | 60.0 |
| 2014-10-31 | HYDROCODONE-ACETAMINOPHEN 5.0-250 | 30 | John Smith, MD | 3 | 60.0 |
| 2014-10-02 | HYDROCODONE-ACETAMINOPHEN 5.0-250 | 30 | John Smith, MD | 3 | 60.0 |

| Rx Summary (12 Mo.) | Count |
|---|---|
| CS II-V Rx | 0 |
| CS-II Rx | 0 |
| Quantity Dispensed | 480 |
| Unique Prescribers | 2 |
| Unique Pharmacies | 1 |
| Benzos | 1 |
| Opioids | 20 |
| Long Acting Opioids | 2 |

## Recent Inpatient Summary

| Visit Date | Location | Type | Diagnoses |
|---|---|---|---|
| 03/24/2015 | Ford Medical Center | Inpatient | - Fever, unspecified |
| 02/21/2015 | Ford Medical Center | Surgery | - Malignant neoplasm of liver, secondary |

| Visit Date | Location | Type | Diagnoses |
|---|---|---|---|
| 04/13/2015 | Ford Medical Center | Emergency | - Headache<br>- Cough |
| 03/30/2015 | Murray Medical Center | Emergency | - Fever, unspecified |
| 03/18/2015 | Ford Medical Center | Emergency | - Long-term (current) use of other medications |
| 03/03/2015 | Providence Centralia Hospital | Emergency | - Other chronic bronchitis<br>- Fever, unspecified |

| E.D. Visit Count (1 Yr.) | Visits |
|---|---|
| Providence Centralia Hospital | 4 |
| Ford Medical Center | 37 |
| Murray Medical Center | 6 |
| Total | **47** |

Note: Visits indicate total known visits.

Note: Visits indicate total known visits.

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

June 23, 2016

TO: Emergency Medical Services / Trauma Committee

SUBJECT: American College of Surgeons Trauma Consultation Visit Report

**Objective**
To educate CHA EMS/T members on the ACS Trauma Systems Evaluation consultation visit that occurred March 22-25, 2016.

**Background**
EMSA funded a statewide trauma systems consultation visit by the American College of Surgeons to evaluate the state's trauma system infrastructure and support the state and local trauma planning and development initiatives. Bonnie Sinz, RN, BSN EMSA State Trauma Coordinator will present the information and findings.

**Conclusion**
Informational Only

BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing & Clinical Services

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

June 23, 2016

TO: Emergency Medical Services / Trauma Committee

SUBJECT: Maddy Funds

**Objective**
To inform the CHA EMS/T Committee on the status of the Maddy Emergency Services Trauma Fund.

**Background**
SB 867 (Senator Richard Roth, D-Riverside) would indefinitely extend the operative date of the Maddy Emergency Services Fund and authorize each county to establish an emergency services fund for reimbursement of costs related to emergency medical services. SB 867 passed the Assembly Public Safety Committee on June 14, 2016. SB 867 will be voted on by the full Assembly.

**Conclusion**
Informational Only

BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing & Clinical Services

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

May 26, 2016

TO: CHA EMS/T Committee

FROM: BJ Bartleson, VP Nursing and Clinical Services

SUBJECT: NIH Grant Proposal, NIA RO1, Evaluating the Impact of Hospital Occupancy on Older Patient Outcomes: A Mixed Method Study

**SUMMARY**

HQI has asked to support and discuss potential interest in participating in an upcoming NIH grant on ED crowding and high hospital occupancy and it's effect on older patient outcomes. The grant will be funded in 2017. Hospital commitment presently is non-binding.

**ADDITIONAL INFORMATION**

- Hospitals will be directly reimbursed: nurse to conduct observations in hospital units and EDs 4x year
- Hospitals will be directly reimbursed: data pulls for approximately 200 patients (averaged between size of hospital) of required data points to assign an Apache risk score
- Hospitals will get: final report that describes operational characteristics and best practices in conditions of "surge" or overcrowding in inpatient and ED
- Hospitals and HQI are positioned with funding from NIH
- HQI serves as clinical operations advisor to interpret findings.
- HQI will help to recruit 50 hospitals to volunteer for the study
- HQI with associations will solicit general and non-binding interest in the study by May 27, 2016

**ACTION REQUIRED**

- Review information and discuss
- Discuss with your hospitals and if interested let me know

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

June 23, 2016

TO: Emergency Medical Services / Trauma Committee

SUBJECT: Legislative Review

**Objective**
To provide an update on the Legislative Bills.

**Background**

**Conclusion**
Informational Only

BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing & Clinical Services

**File name: CAHHS**

**California**

## 1. CA AB 510

| Introduced | Passed 1st Committee | Passed 1st Chamber | Passed 2nd Committee | Passed 2nd Chamber | Enacted |
|---|---|---|---|---|---|
| | | | | | |

**Author:** Rodriguez (D)
**Title:** Wireless 911 Calls: Emergency Telephone User Surcharge
**Fiscal Committee:** yes
**Urgency Clause:** yes
**Introduced:** 02/23/2015
**Last Amend:** 07/15/2015
**Disposition:** Pending - Carryover
**Location:** Senate Energy, Utilities and Communications Committee
**Summary:** Requires the 911 Emergency Communications Branch to work with the Department of the California Highway Patrol to continue the work of the Routing on Empirical Data Project using specified technology and procedures. Provides that the intrastate telephone service surcharge used to provide revenues sufficient to fund 911 emergency telephone system costs is changed to a flat monthly rate.
**Status:** 07/15/2015 From SENATE Committee on ENERGY, UTILITIES AND COMMUNICATIONS with author's amendments.
07/15/2015 In SENATE. Read second time and amended. Re-referred to Committee on ENERGY, UTILITIES AND COMMUNICATIONS.
**INDEX:** 35
**ISSUES:** BJ*, CLH, DP
**LOBBYIST:** CD
**POSITION:** F

## 2. CA AB 1386

| Introduced | Passed 1st Committee | Passed 1st Chamber | Passed 2nd Committee | Passed 2nd Chamber | Enacted |
|---|---|---|---|---|---|
| | | | | | |

**Author:** Low (D)
**Title:** Emergency Medical Care: Epinephrine Auto-Injectors
**Fiscal Committee:** yes
**Urgency Clause:** no
**Introduced:** 02/27/2015
**Last Amend:** 06/13/2016
**Disposition:** Pending
**Committee:** Senate Judiciary Committee
**Hearing:** 06/21/2016 1:30 pm, Room 112
**Summary:** Permits a defined authorized entity to use an epinephrine auto-injector to render emergency care to another person in accordance with these provisions. Authorizes a pharmacy to furnish such auto-injectors to an authorized entity. Requires an operations plan. Requires specified reports on incidents related to the administration of such auto-injectors. Provides a definition. Provides the entity is not liable for civil damages resulting from any act or omission in connection with the use of such auto-injector.
**Status:** 06/13/2016 From SENATE Committee on JUDICIARY with author's amendments.
06/13/2016 In SENATE. Read second time and amended. Re-referred to Committee on JUDICIARY.
**INDEX:** 35
**ISSUES:** BJ*, DP
**LOBBYIST:** CD
**POSITION:** F

## 3. CA AB 1564

| Introduced | Passed 1st Committee | Passed 1st Chamber | Passed 2nd Committee | Passed 2nd Chamber | Enacted |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |

**Author:** Williams (D)
**Title:** Emergency Services: Wireless 911 Calls: Routing
**Fiscal Committee:** yes
**Urgency Clause:** no
**Introduced:** 01/04/2016
**Last Amend:** 03/17/2016
**Disposition:** Pending
**Committee:** Senate Energy, Utilities and Communications Committee
**Hearing:** 06/21/2016 9:00 am, Room 3191
**Summary:** Requires that a provider of commercial mobile radio services provide access for end users of that service to the local emergency telephone systems described in the Warren-911-Emergency Assistance Act, that 911 be the primary access number for those services, and that user validation not be required. Prohibits a provider from charging any airtime, access, or similar usage charge for any 911 call placed from a commercial mobile radio service telecommunications device.
**Status:** 05/19/2016 To SENATE Committee on ENERGY, UTILITIES AND COMMUNICATIONS.
**INDEX:** 35
**ISSUES:** BJ*, CLH, DP
**LOBBYIST:** CD
**POSITION:** F

## 4. CA AB 1680

| Introduced | Passed 1st Committee | Passed 1st Chamber | Passed 2nd Committee | Passed 2nd Chamber | Enacted |
|---|---|---|---|---|---|
| | | | | | |

**Author:** Rodriguez (D)
**Title:** Crimes: Emergency Personnel
**Fiscal Committee:** yes
**Urgency Clause:** no
**Introduced:** 01/19/2016
**Last Amend:** 05/05/2016
**Disposition:** Pending
**Committee:** Senate Public Safety Committee
**Hearing:** 06/21/2016 9:00 am, John L. Burton Hearing Room (4203)
**Summary:** Includes, for purposes of existing law regarding impeding police officers, firefighters, emergency medical, or other emergency personnel or military personnel in the performance of their duties during an emergency, the operation or use of an unmanned aerial vehicle, remote piloted aircraft, or drone, regardless of the operator's location, in the definition of a person.
**Status:** 05/19/2016 To SENATE Committee on PUBLIC SAFETY.
**INDEX:** 35
**ISSUES:** BJ*, DP, GBS
**LOBBYIST:** CD, KAS*
**POSITION:** S, X

## 5. CA AB 1931

| Introduced | Passed 1st Committee | Passed 1st Chamber | Passed 2nd Committee | Passed 2nd Chamber | Enacted |
|---|---|---|---|---|---|
| | | | | | |

**Author:** Rodriguez (D)
**Title:** Emergency Medical Services: Paramedics: Discipline
**Fiscal Committee:** yes
**Urgency Clause:** no
**Introduced:** 02/12/2016
**Last** 04/25/2016

**Amend:**
**Disposition:** Pending
**Committee:** Senate Appropriations Committee
**Hearing:** 06/27/2016 10:00 am, John L. Burton Hearing Room (4203)
**Summary:** Requires the development and adoption of guidelines for disciplinary orders, temporary suspensions, and conditions of probation for EMT-P license holders. Integrates and conforms procedures for investigating misconduct of specified EMT license and certificate holders. Requires notification of an EMT's employer upon a decision to further investigate, discipline or upon a temporary suspension of an EMT's license.
**Status:** 06/08/2016 From SENATE Committee on HEALTH: Do pass to Committee on APPROPRIATIONS. (7-0)
**INDEX:** 35, 57
**ISSUES:** BJ*, DP, GBS, SL
**LOBBYIST:** CD*, KAS
**POSITION:** F

## 6. CA AB 1959

| Introduced | Passed 1st Committee | Passed 1st Chamber | Passed 2nd Committee | Passed 2nd Chamber | Enacted |
|---|---|---|---|---|---|
| | | | | | |

**Author:** Rodriguez (D)
**Title:** Assault on an Emergency Medical Technician
**Fiscal Committee:** yes
**Urgency Clause:** no
**Introduced:** 02/12/2016
**Disposition:** Pending
**Location:** Assembly Appropriations Committee
**Summary:** Makes provisions of existing law applicable to an assault on an emergency medical technician when the person knows or reasonably should know that the person is an emergency medical technician engaged in the performance of his or her duties.
**Status:** 05/27/2016 In ASSEMBLY Committee on APPROPRIATIONS: Held in committee.
**INDEX:** 35
**ISSUES:** BJ*, DP, GBS, SL
**LOBBYIST:** CD
**POSITION:** F, X

## 7. CA AB 2260

| Introduced | Passed 1st Committee | Passed 1st Chamber | Passed 2nd Committee | Passed 2nd Chamber | Enacted |
|---|---|---|---|---|---|
| | | | | | |

**Author:** Wood (D)
**Title:** Emergency Medical Services
**Fiscal Committee:** yes
**Urgency Clause:** no
**Introduced:** 02/18/2016
**Last Amend:** 05/27/2016
**Disposition:** Pending
**Committee:** Senate Health Committee
**Hearing:** 06/22/2016 1:30 pm, John L. Burton Hearing Room (4203)
**Summary:** Requires the Emergency Medical Services Authority to determine a single set of data elements and formatting for air ambulance providers to submit to local EMS agencies, after consulting with such providers and agencies. Authorities the Authority to stakeholders annually to modify the elements and formatting the data. Prohibits the Authority from mandating that such provider use a specific health record system to collect and share data with a local agency. Relates to air ambulance electronic health records.
**Status:** 06/09/2016 To SENATE Committee on HEALTH.
**INDEX:** 35
**ISSUES:** BJ*, DP, SL
**LOBBYIST:** CD

**POSITION:** F

## 8. CA AB 2425

| Introduced | Passed 1st Committee | Passed 1st Chamber | Passed 2nd Committee | Passed 2nd Chamber | Enacted |
|---|---|---|---|---|---|
| | | | | | |

**Author:** Brown (D)
**Title:** Public Health: Unintentional Injuries
**Fiscal Committee:** yes
**Urgency Clause:** no
**Introduced:** 02/19/2016
**Last Amend:** 05/31/2016
**Disposition:** Pending
**Committee:** Senate Health Committee
**Hearing:** 06/29/2016 1:30 pm, John L. Burton Hearing Room (4203)
**Summary:** Relates to public health and incident site reports. Requires the State Department of Public Health to develop a State data collection plan and uniform standards and protocols for the purposes of collecting statewide information on unintentional injury incidents incurred by individuals within a specified age group.
**Status:** 06/09/2016 To SENATE Committee on HEALTH.
**INDEX:** 35, 95
**ISSUES:** BJ*, DP
**LOBBYIST:** AH, CD*
**POSITION:** F

## 9. CA AB 2453

| Introduced | Passed 1st Committee | Passed 1st Chamber | Passed 2nd Committee | Passed 2nd Chamber | Enacted |
|---|---|---|---|---|---|
| | | | | | |

**Author:** Rodriguez (D)
**Title:** Emergency Services: State 911 Advisory Board
**Fiscal Committee:** yes
**Urgency Clause:** no
**Introduced:** 02/19/2016
**Last Amend:** 04/28/2016
**Disposition:** Pending
**File:** A-18
**Location:** Assembly Inactive File
**Summary:** Increases the membership of the State 911 Advisory Board. Prohibits a representative of the State Emergency Medical Services, or with a background in the telecommunications industry from being a member of the Board under certain circumstances. Prohibits a Board member from participating in a claim, contract, controversy, determination, plan, study or other matter considered by the Board. Prohibits a member from being employed within a listed profession after leaving the Board for a specified time period.
**Status:** 05/05/2016 In ASSEMBLY. From Consent Calendar. To third reading.
05/05/2016 In ASSEMBLY. From third reading. To Inactive File.
**INDEX:** 35
**ISSUES:** BJ*, CLH, DP
**LOBBYIST:** CD
**POSITION:** F

## 10. CA SB 867

| Introduced | Passed 1st Committee | Passed 1st Chamber | Passed 2nd Committee | Passed 2nd Chamber | Enacted |
|---|---|---|---|---|---|
| | | | | | |

**Author:** Roth (D)
**Title:** Emergency Medical Services

**Fiscal Committee:** no
**Urgency Clause:** no
**Introduced:** 01/11/2016
**Last Amend:** 04/12/2016
**Disposition:** Pending
**File:** 53
**Location:** Assembly Third Reading File
**Summary:** Extends the operative date of the provides of existing law the established the Maddy Emergency Medical Services Fund and authorizes each county to establish an emergency medical services fund for reimbursement of costs related to emergency medical services.
**Status:** 06/16/2016 In ASSEMBLY. Read second time. To third reading.
**INDEX:** 35
**ISSUES:** BJ*, DP
**LOBBYIST:** CD
**POSITION:** S, X

## 11. CA SB 1404

| Introduced | Passed 1st Committee | Passed 1st Chamber | Passed 2nd Committee | Passed 2nd Chamber | Enacted |
|---|---|---|---|---|---|
| | | | | | |

**Author:** Leno (D)
**Title:** Victims of Violent Crimes: Trauma Recovery Centers
**Fiscal Committee:** yes
**Urgency Clause:** no
**Introduced:** 02/19/2016
**Last Amend:** 05/31/2016
**Disposition:** Pending
**Committee:** Assembly Public Safety Committee
**Hearing:** 06/21/2016 9:00 am, State Capitol, Room 126
**Summary:** Recognizes the Trauma Recovery Center at San Francisco General Hospital, University of California, San Francisco, as the State Pilot Trauma Recovery Center. Requires the use of an evidence-based Integrated Trauma Recovery Services model when grants to trauma recovery centers are provided. Requires the creation of a committee to advise on matters pertaining to the administration of funds designated for use at trauma recovery centers and criteria for grants. Provides for interagency agreements.
**Status:** 06/09/2016 To ASSEMBLY Committees on PUBLIC SAFETY and HEALTH.
**INDEX:** 35
**ISSUES:** BJ*, DP, SL
**LOBBYIST:** CD
**POSITION:** F, X

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

June 23, 2016

TO: Emergency Medical Services / Trauma Committee

SUBJECT: Community Paramedics

**Objective**
Update the CHA EMS/T Committee on the OSHPD Community Paramedicine Pilot Project.

**Background**
Attached is the first quarter, 2016 OSPHD/UCSF Community Paramedicine report for review.

**Conclusion**
Informational Only

BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing & Clinical Services

1215 K Street, Suite 800, Sacramento, CA 95814 · *Telephone:* 916.443.7401 · *Facsimile:* 916.552.7596 · www.calhospital.org
*Corporate Members:* Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

UCSF
University of California
San Francisco

# Community Paramedicine Implementation:
## *Quarter 1 2016*

Janet Coffman, MPP, PhD (presenter)
Cynthia Wides, MA

Philip R. Lee Institute for Health Policy Studies
University of California, San Francisco

# Outline

- Background
- Findings applicable to all community paramedicine (CP) concepts
- Findings for specific CP concepts

# Background

OSHPD approved the Community Paramedicine pilot projects on November 14, 2014, and renewed approval for an additional year on November 14, 2015.

Five concepts:

- Post-Discharge
- Frequent 911 Callers
- Tuberculosis
- Hospice
- Alternate Destination –behavioral health and medical care

# Pilot Project Implementation Dates

| Project # | Lead Agency | Concept | Month Implemented |
|---|---|---|---|
| CP001 | UCLA Center for Pre-Hospital Care | Alternate Destination | Sept.8, 2015 |
| CP002 | UCLA Center for Pre-Hospital Care | Post-Discharge | Sept. 1, 2015 |
| CP003 | Orange County Fire Chiefs | Alternate Destination | Sept. 14, 2015 |
| CP004 | Butte County EMS | Post-Discharge | July 1, 2015 |
| CP005 | Ventura County EMS | Tuberculosis | June 1, 2015 |
| CP006 | Ventura County EMS | Hospice | Aug. 1, 2015 |
| CP007A | Alameda City EMS | Frequent 911 Callers | July 1, 2015 |
| CP007B | Alameda City EMS | Post-Discharge | June 1, 2015 |
| CP008 | San Bernardino County Fire Dept. | Post-Discharge | Aug. 13, 2015 |
| CP009 | Carlsbad Fire Department | Alternate Destination | Oct. 9, 2015 |
| CP010 | San Diego County | Frequent 911 Callers | Oct. 12, 2015 |
| CP012 | Mountain Valley EMS AMR Stanislaus | Alternate Destination | Sept. 25, 2015 |
| CP013 | Medic Ambulance Solano | Post-Discharge | Sept. 15, 2015 |

# CP Pilot Project – Evaluation Plan

The evaluation is a three phase process.

- Phase I focused on “baseline” data collection and reporting, reflecting care given prior to the pilot program.
- Phase II focused on training of the CPs.
- Phase III covers the implementation period.

Data reported in this presentation will pertain exclusively to the first quarter of 2016.

UCSF
University of California
San Francisco

# Findings Applicable to All Concepts

6/2/2016

# Data Across All Projects

Data pertaining to all sites include:

- Cumulative enrollment
- Cumulative eligible but not enrolled (ENE)
  - Did not consent
  - All other reasons
- Demographic Characteristics
- Payer Type

# Enrollment by Project

| | | Enrolled for the First Time | | | Total Enrolled | | | Cumulative Enrolled* |
|---|---|---|---|---|---|---|---|---|
| **Project No.** | Concept | Jan. | Feb. | March | Jan. | Feb. | March | |
| **CP001** | Alternate Destination | < 5 | < 5 | < 5 | < 5 | < 5 | < 5 | **11** |
| **CP003** | Alternate Destination | 3 | 4 | 0 | 3 | 4 | 0 | **17** |
| **CP009** | Alternate Destination | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **CP012** | Alternate Destination | 16 | 18 | 10 | 16 | 18 | 10 | **104** |
| **CP007A** | Frequent 911 Callers | 2 | 4 | 0 | 15 | 18 | 16 | **32** |
| **CP010** | Frequent 911 Callers | 4 | 5 | 7 | 16 | 21 | 28 | **29** |
| **CP002** | Post-Discharge | 14 | 14 | 17 | 24 | 28 | 31 | **100** |
| **CP004** | Post-Discharge | 34 | 57 | 35 | 50 | 74 | 63 | **344** |
| **CP007B** | Post-Discharge | 8 | 4 | 4 | 13 | 13 | 10 | **43** |
| **CP008** | Post-Discharge | 6 | 10 | 13 | 6 | 10 | 13 | **84** |
| **CP013** | Post-Discharge | 2 | 7 | 9 | 6 | 8 | 16 | **35** |
| **CP006** | Hospice | 17 | 9 | 8 | 17 | 9 | 8 | **87** |
| **CP005** | Tuberculosis | 2 | 1 | 2 | 7 | 6 | 6 | **20** |
| **All Projects** | | **108** | **133** | **105** | **173** | **209** | **201** | **906** |

# Eligible but not Enrolled by Project

| Project No. | Concept | Eligible but not enrolled | | Total Q1/2016 | Cumulative ENE* |
|---|---|---|---|---|---|
| | | Refused consent | All other reasons | | |
| CP003 | Alternate Destination | 4 | 35 | 39 | 41 |
| CP009 | Alternate Destination | 17 | 1 | 18 | 648 |
| CP012 | Alternate Destination | 6 | 51 | 57 | 56 |
| CP007A | Frequent 911 Callers | 5 | 84 | 89 | 269 |
| CP010 | Frequent 911 Callers | 19 | 417 | 436 | 50 |
| CP002 | Post-Discharge | 82 | 59 | 141 | 63 |
| CP004 | Post-Discharge | 16 | 2 | 18 | 74 |
| CP007B | Post-Discharge | 23 | 14 | 37 | 70 |
| CP008 | Post-Discharge | 45 | 260 | 305 | 93 |
| CP013 | Post-Discharge | 37 | 0 | 37 | 233 |
| CP006 | Hospice | 0 | 22 | 22 | 736 |
| CP005 | Tuberculosis | 0 | 70 | 70 | 183 |
| **All Projects** | | **254** | **1015** | **1269** | **2516** |

# Cumulative Patients by Concept

| Concept | Cumulative # Enrolled | Cumulative # Eligible but Not Enrolled |
|---|---|---|
| Post-Discharge | 606 | 533 |
| Alternate Destination | 132 | 745 |
| Hospice | 87 | 736 |
| Frequent 911 Callers | 61 | 319 |
| Tuberculosis | 20 | 183 |
| **All Projects** | **906** | **2516** |

# Reasons Why Eligible Patients Not Enrolled

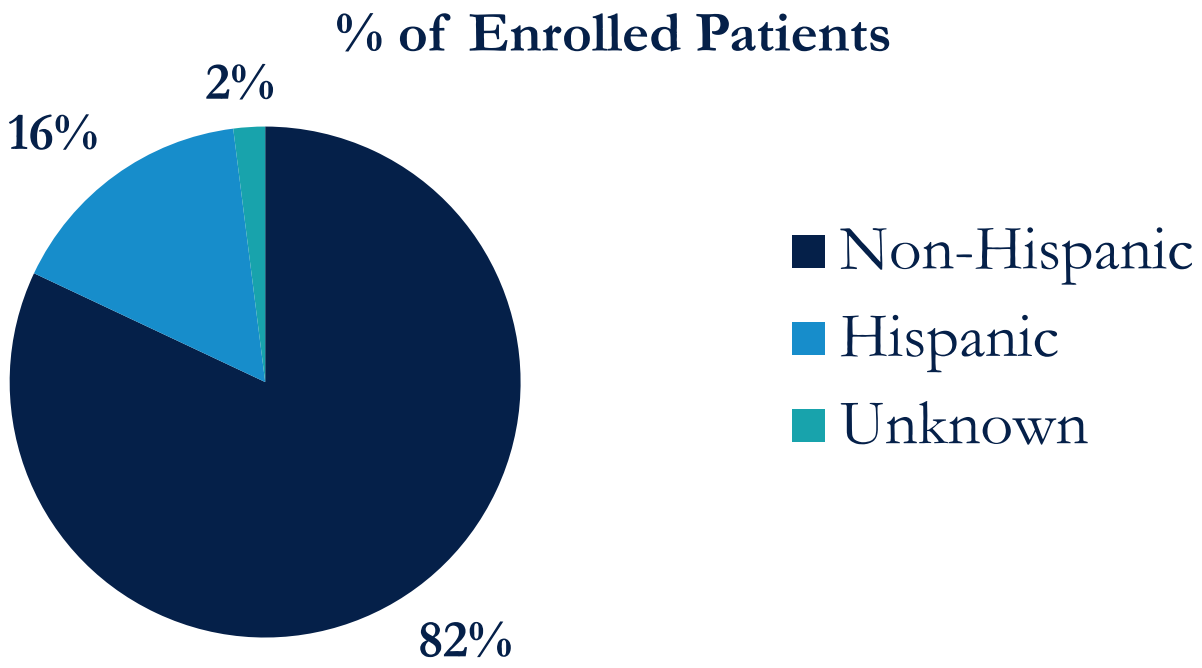
- Post-Discharge – CP was unavailable to enroll patient at time of discharge.
- Alternate Destination – 911 call occurred outside of UCC hours or county behavioral health facility was full.
- Hospice – Patient's hospice provider is not a partner in the pilot project.
- Frequent 911 – The patient could not be located after discharge from the ED.
- Tuberculosis – TB patients receives all DOT treatments from TB clinic community health workers.

# Enrolled Patients' Demographics – Q1 2016

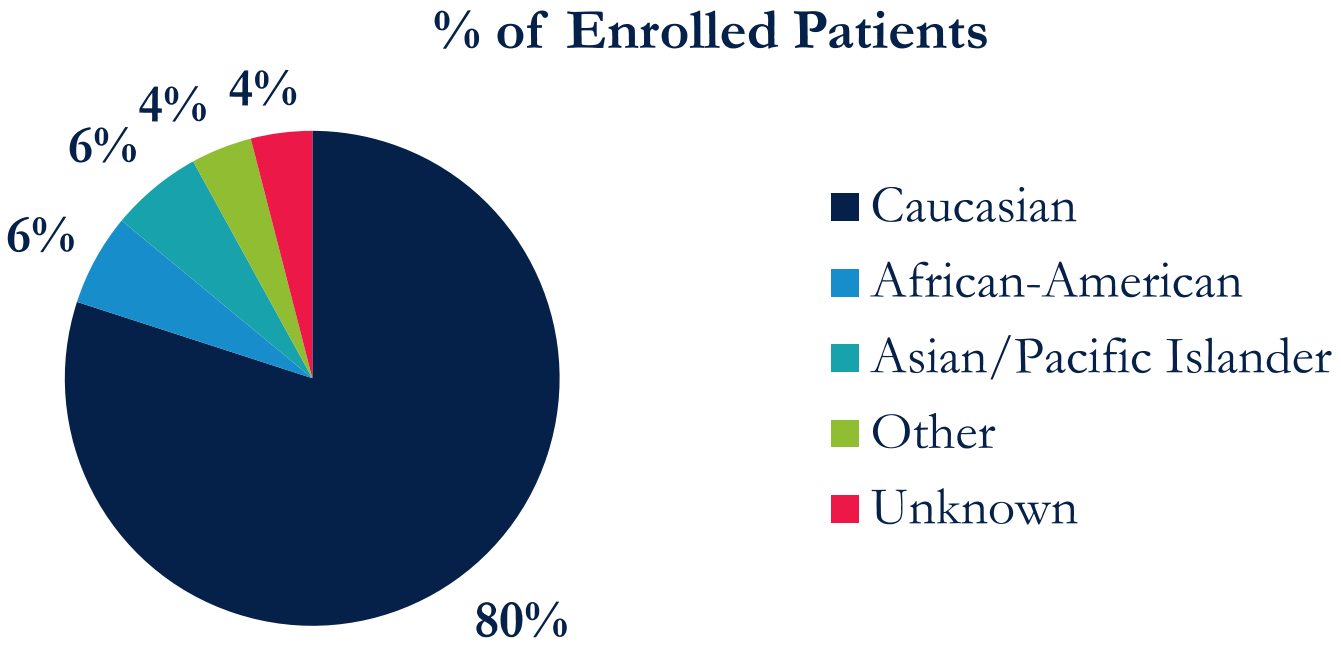
Across all projects:

- The majority of patients were male.
- Patients' average age ranged from 28 years in Stanislaus' Behavioral Health pilot to 87 years in Ventura's Hospice pilot.

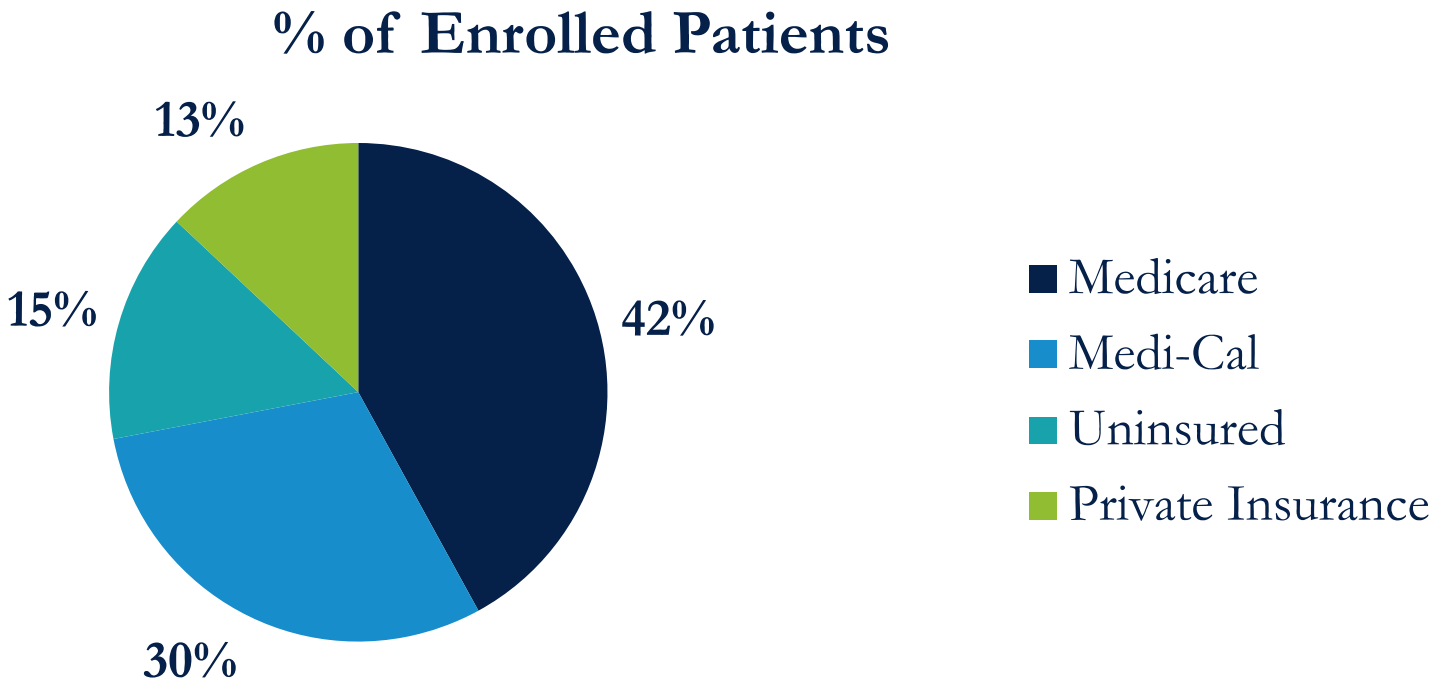
# Enrolled Patients' Demographics – Q1 2016



# Enrolled Patients' Demographics – Q1 2016



# Enrolled Patients' Payer Types – Q1 2016



# Enrolled Patients' Payer Types – Q1 2016

For some projects, the majority of patients were enrolled in Medi-Cal.

- Stanislaus had 80+% Medi-Cal patients in each month
- The majority of Ventura's TB patients were enrolled in Medi-Cal in each month.
- In January and February, Solano had 50% or more patients covered by Medi-Cal as did San Bernardino in January.

UCSF
University of California
San Francisco

# Findings for Specific CP Concepts

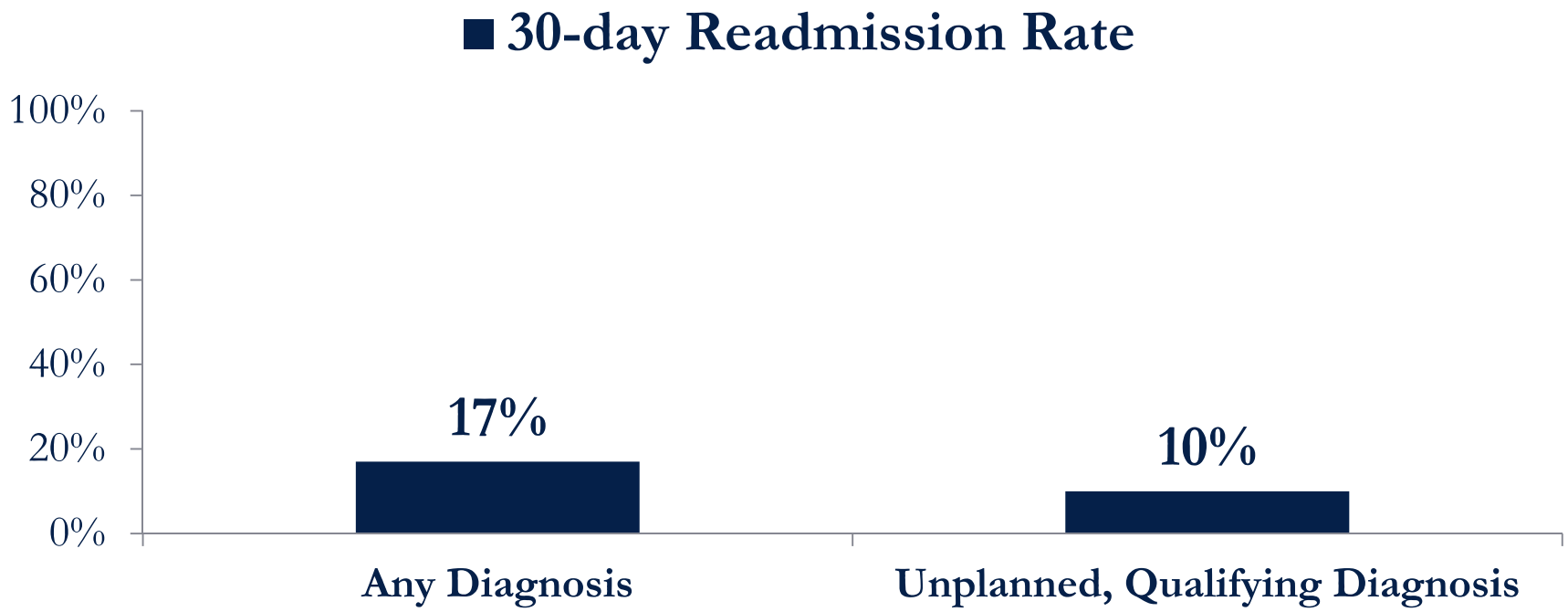
6/2/2016

UCSF
University of California
San Francisco

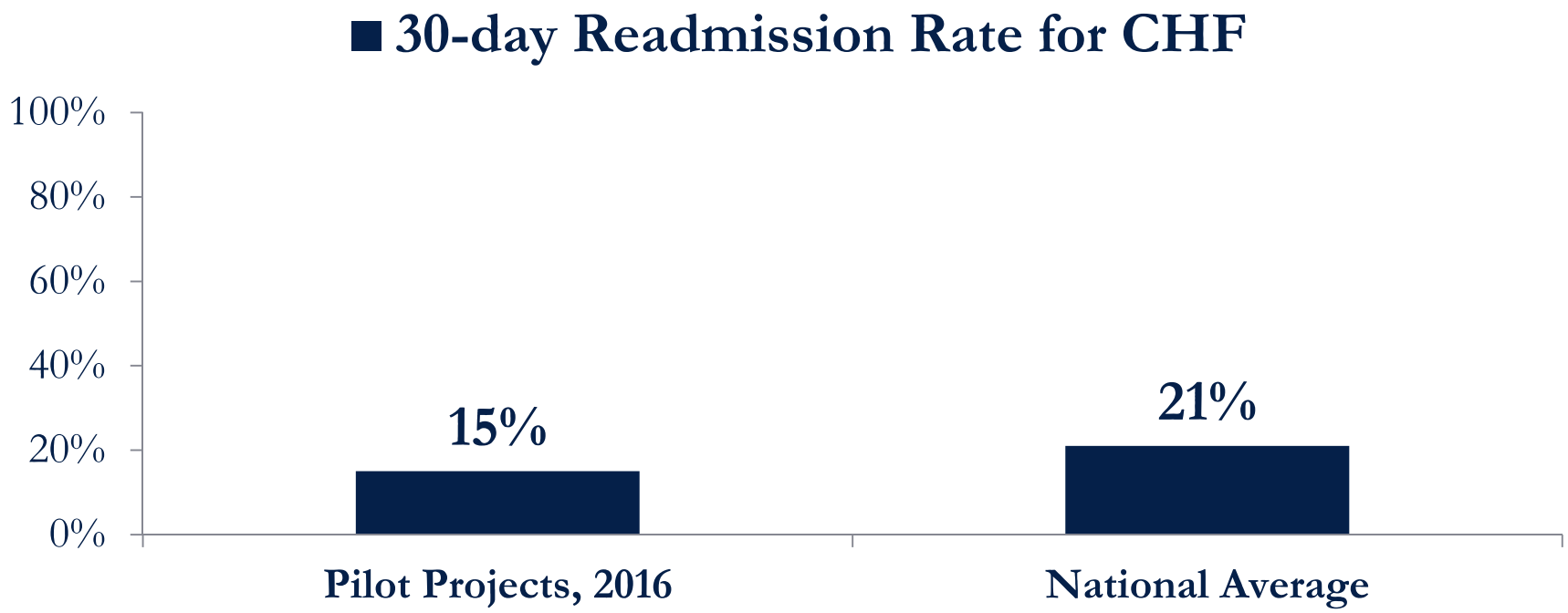
# Post-Discharge

6/2/2016

# Post-Discharge – Readmission Rate



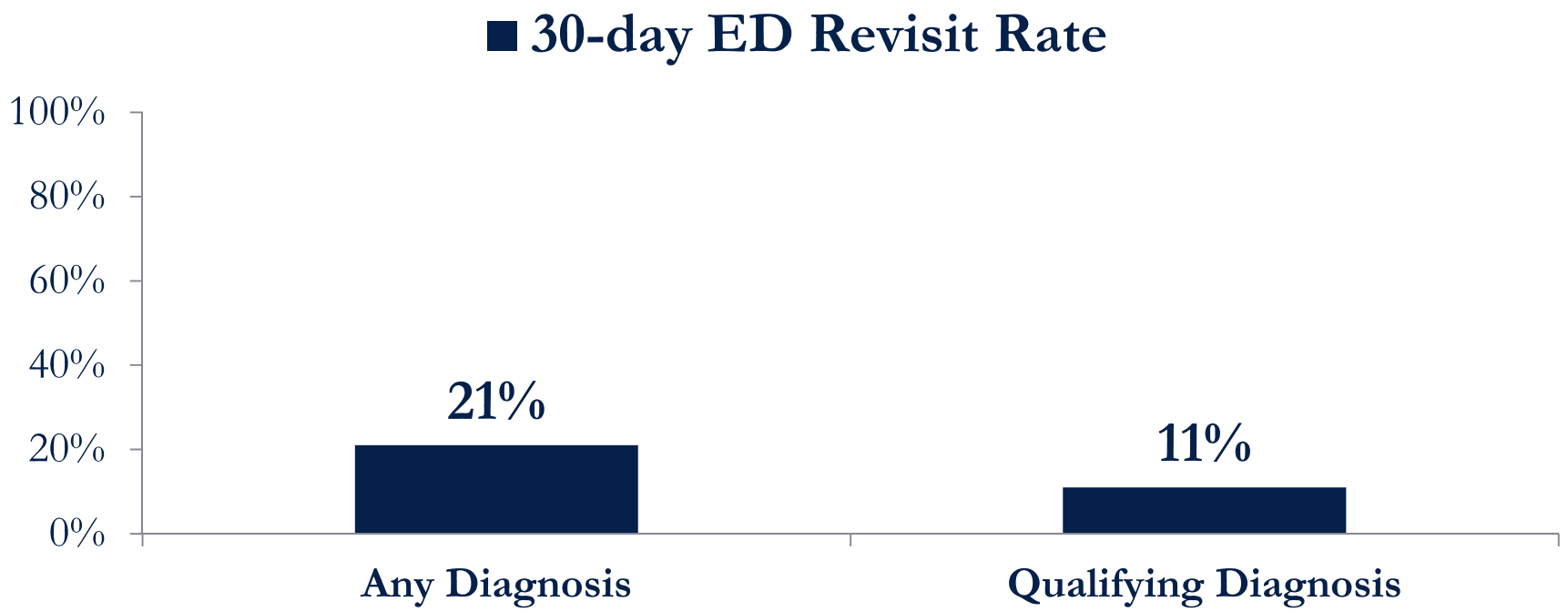
# Post-Discharge – Readmission Rate, CHF



# Post-Discharge – Readmission Rate

- Readmission rates varied across the five post-discharge projects
- Projects that conduct at least one home visit with each patient have lower readmission rates

# Post-Discharge – ED Visit Rate



# Post-Discharge – ED Visit Rate, CHF

- 13% of post-discharge patients with CHF had ≥ 1 ED visit within 30 days of discharge
- The national average ED revisit rate for CHF is 8%
- Not clear whether the national average includes
  - All ED visits regardless of whether they result in an admission
  - Only ED visits during which the patient was treated and released

# Post-Discharge Medication Reconciliation

- All post-discharge sites reported devoting substantial time to medication reconciliation
- Many patients had 10+ prescriptions
- One site found at least one contraindication for each patient

UCSF
University of California
San Francisco

# Frequent 911 Callers

6/2/2016

# Frequent 911 Callers – ED Visits

- Differences between the patients targeted by Alameda and San Diego make comparisons difficult.
  - San Diego focuses primarily on patients with 20+ ED visits in the previous year
  - Alameda enrolls all who are referred to the program
- San Diego's patients have more ED visits than Alameda's but the program has achieved substantial reductions in EMS and ED use
- For one patient, the number of 911 calls was reduced from 40 per month to 5 per month (88% decrease)

# Frequent 911 Callers – Referrals

- Alameda - 4 patients
  - Domestic violence resources, food assistance, housing assistance, transportation assistance, fall prevention program/ senior home safety equipment installation services

- San Diego – 6 patients
  - 211-San Diego County Services Referral Agency, alcohol recovery, homeless assistance program, mental health services, veteran's services

# Frequent 911 Callers – Patient Progress

Graduations from the project since implementation:

- Alameda - 14 patients
- San Diego – zero patients

Patients moved into permanent housing since implementation:

- Alameda - zero patients
- San Diego – 3 patients

UCSF
University of California
San Francisco

# DOT for Tuberculosis

6/2/2016

# Direct Observed Therapy - Tuberculosis

CPs augment TB clinic work force:

- 20 TB patients to date (some completed, some still in treatment)
- Call patients who miss a scheduled appointment until they are found and treated.
- CPs have more medical training than community health workers employed by TB clinic.
- Better cooperation from challenging patients.

# Direct Observed Therapy - Tuberculosis

## Contact Investigations

- CPs assist the staff of Ventura's TB clinic with contact investigations to identify persons to whom TB patients may have transmitted the disease
- Five contact investigations have been undertaken since implementation; none in Q1 2016.

UCSF
University of California
San Francisco

# Hospice

6/2/2016

# Hospice – Transports to an ED

| Month | Total Enrolled | Number of Transports | Number Removed from Hospice | Percent Transported |
|---|---|---|---|---|
| Jan | 17 | 5 | 2 | 29% |
| Feb | 9 | 3 | 2 | 33% |
| March | 8 | 2 | 1 | 25% |
| Total– Q12016 | 34 | 10 | 5 | 29% |

# Hospice – Arrival of Hospice Agency

| Month | Number Enrolled | # Hospice Agency's presence needed | Hospice Agency arrived < 30 minutes | Hospice Agency arrived ≥ 30 minutes |
|---|---|---|---|---|
| Jan | 17 | 9 | 4 | **5** |
| Feb | 9 | 3 | 0 | **3** |
| March | 8 | 4 | 1 | **3** |
| Total– Q12016 | **34** | **16** | **5** | **11** |

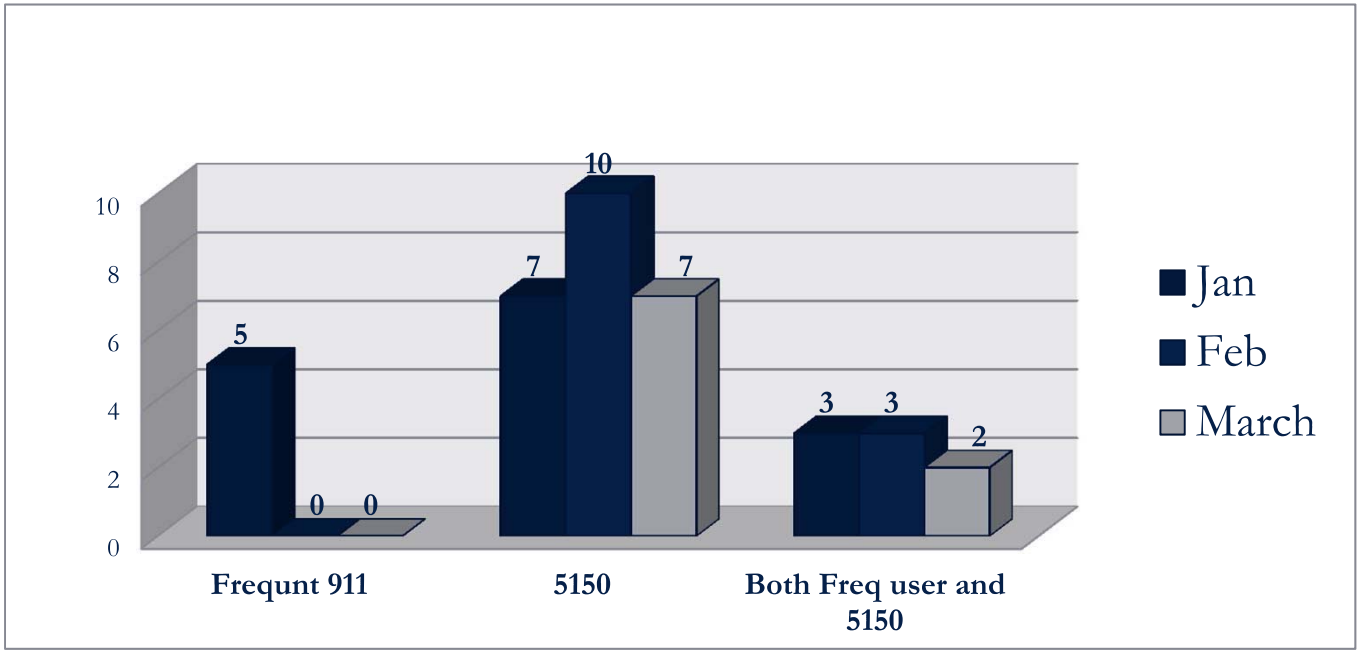
UCSF
University of California
San Francisco

# Alternate Destination – Behavioral Health

6/2/2016

# Alternate Destination – Behavioral Health

Frequent 911 users and 5150 patients taken to county behavioral health center instead of emergency department in 2016



# Alternate Destination – Behavioral Health

| Month | No. Patients Enrolled | No. Patients transferred ED within 6 hours | Reasons for transfer to the ED |
|---|---|---|---|
| **Jan** | 16 | 1 | Incontinence |
| **Feb** | 18 | 1 | Patient required CPAP for sleeping which is not available at facility |
| **March** | 10 | 2 | Agitation that behavioral health facility could not manage |

# Alternate Destination – Behavioral Health

- Buy in from Police Department and Sheriff's Department leaders
- Officers and deputies who have used the service are enthusiastic
  - Able to transfer custody of many persons with behavioral health needs to CPs
  - Reduces the number of times they need to drive people to EDs
  - Enables them to respond more quickly to other 911 calls

# Alternate Destination – Behavioral Health

- The capacity of the county's inpatient behavioral health facility limits the number of patients enrolled
- County facility also not equipped to handle dual diagnosis patients (mental illness plus substance use disorder)
  - Using breathalyzers to screen patients for intoxication
- EMS and county behavioral health physicians collaborated to identify a threshold for blood pressure that was acceptable to both

UCSF
University of California
San Francisco

# Alternate Destination – Medical Care

6/2/2016

# Alternate Destination – Medical Care

| Project No. | Month | No. Patients Enrolled | Treated at UCC and Discharged | ED Transfers within 6 hours | Continuous transfers | Reasons for transfer to the ED |
|---|---|---|---|---|---|---|
| **CP002** | Jan-March | 11 | 5 | 6 | 4 | **3 requested for opioid medication; 2 issues with diagnostic equipment; 1 chest pain.** |
| **CP003** | Jan | 3 | 2 | 1 | 1 | **Shoulder pain that may have been a dislocation** |
| | Feb | 4 | 3 | 1 | 1 | **UCC believed that additional resources needed to assess the patient** |
| | March | 0 | 0 | 0 | 0 | |
| **CP009** | Jan | 0 | 0 | 0 | 0 | |
| | Feb | 0 | 0 | 0 | 0 | |
| | March | 0 | 0 | 0 | 0 | |
| **Total – Jan. - March.** | | **18** | **10** | **8** | **6** | |

# Alternate Destination – Medical Care

- Barriers to enrollment
  - Limited hours during which UCCs are open
  - Limited services offered by UCCs
  - Enrollment limited to non-elderly Kaiser enrollees (Carlsbad)
  - Did not train all paramedics initially (Orange)

Through its singular focus on health,
UCSF is leading revolutions in health.

UCSF
University of California
San Francisco

**Many thanks to the pilot sites, project participants, the California Emergency Medical Services Authority (EMSA) and the California Healthcare Foundation (CHCF).**

OSHPD

# Health Workforce Pilot Projects Program
# HWPP #173-Community Paramedicine

# AGENDA

- Welcome and Introductions
- Overview of the HWPP Program
  - HWPP#173 Update
    - Project Milestones
    - Site Visit Summary
  - Independent Evaluator Site Visit Report and Site Implementation Phase Data Summation
  - Questions and Answers
  - Public Comment
  - Follow Up and Adjournment

# HEALTHCARE WORKFORCE PILOT PROJECTS

Pursuant to Health and Safety Code 128125-128195 OSHPD is authorized to administer HWPP. These projects test, demonstrate and evaluate new and expanded skills sets and alternative methods of delivering health care.

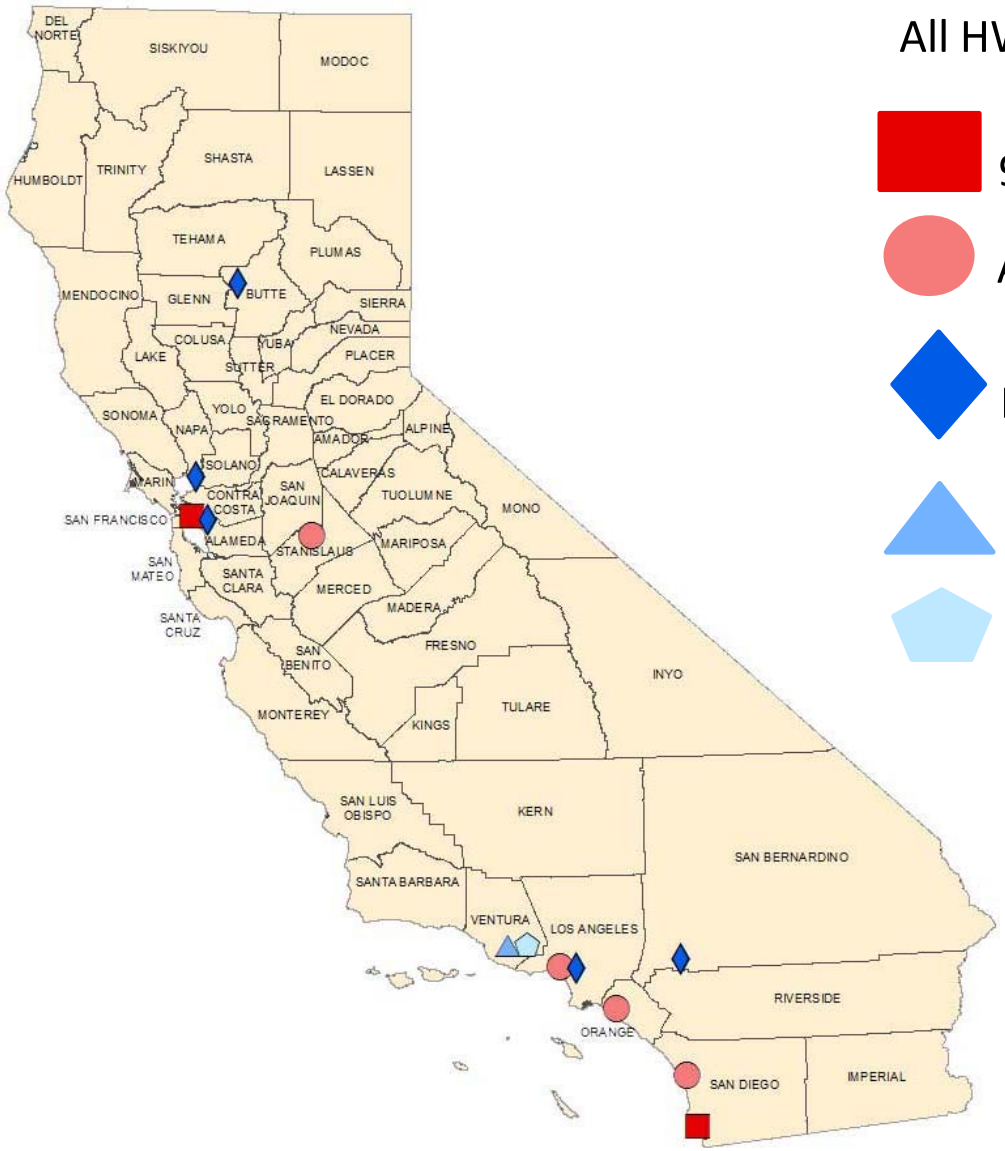
# ROLES AND RESPONSIBILITIES

## Advisory Committee/Council of Advisors Role and Responsibilities

- Provide oversight and make recommendations to OSHPD on various aspects of the project
  - Attend meetings and site visits
  - Advisement on training, competencies and collection of data, protocols, project reports and ongoing assurance of patient safety
  - Advisement on project issues, should they arise

# SITE VISIT AUTHORIZATION

- Health Workforce Pilot Project Site Visits are conducted per California Code of Regulations, Volume 31, Title 22, Division 7, Chapter 6, Article 7, Section 92603 to:
- A) Determine that adequate patient safeguards are being utilized
- B) Validate that the project is complying with the approved or amended application
- C) Interview project participants and recipients of care




All HWPP #173 Sites

911 Frequent Users

Alternate Destination

Post-Discharge Follow-Up

Direct Observed Treatment of Tuberculosis

Hospice Patient Support

# EVALUATIVE SITE VISITS

- The HWPP #173 application was approved on November 14, 2014. Subsequently, Community Paramedics were trained and IRBs were acquired at all 12 sites.
- All sites were in full implementation as of October 2015.
- Evaluation team (including OSHPD HWPP staff and Advisory members) have conducted implementation phase site visits at all 12 sites. Collecting information via in-person interviews of project site personnel, partners and reported patient survey information.


Alternate Destination

# FINDINGS BY CONCEPT

Alternate Destination (4 sites)

Sites reported:

- Strengthened community partnerships and support
- Cost savings to the health care delivery system
- Need for more trained CPs for larger population centers
- Low patient enrollment

Evaluation team noted:

- Additional training for CPs on fractures and how to consent patients is needed

# Post Discharge Follow-Up

# FINDINGS BY CONCEPT CONT'D

Post Discharge follow-up (5 sites)

Sites reported:

- CPs medication reconciliation may have prevented patients from experiencing harmful medication interactions/overdoses
- Cost savings to health care delivery system based on reduction in readmissions

Evaluation team noted:

- Home visits uncover more than a traditional office visit
- CPs demonstrate increased job satisfaction


Direct Observed TB

# FINDINGS BY CONCEPT CONT'D

Direct Observed Therapy for Tuberculosis (1 site)

Site reported:

- Patients are more compliant with CPs
- Public Health Nurse appreciates the support and time to address other activities

Evaluation team noted:

- Concept appears to have little impact on existing operations
- CPs are identifying additional patients to be diagnosed and treated

# 911 Frequent Users

# FINDINGS BY CONCEPT CONT'D

911 Frequent Users (2 Sites)

Sites reported:

- CPs are addressing the full spectrum of patients needs
- Sustainability of the concept is an issue as CPs are working overtime

Evaluation team noted:

- CPs are building trusting relationships with the patients they serve
- The concept is building local coordination of serivces


# Hospice Patient Support

# FINDINGS BY CONCEPT CONT'D

Hospice patient support (1 Site)

Site reported:

- Patients are getting interventions they request rather than transport to the ER

Evaluation team noted

- There were some logistical challenges related to coordination with the 18 different hospice care providers in the area

# NEXT….

- Project current approval expires November 2016 unless an extension is requested and granted
- Until then, HWPP will continue to receive monthly reports and distribute them to the A/C
- Continued monitoring of the project through site visits

OSHPD

Office of Statewide Health Planning and Development

Healthcare Workforce Development Division
400 R Street, Suite 330, Sacramento, CA 95811
(916) 326-3700 | http://oshpd.ca.gov/hwdd

**Office of Statewide Health Planning and Development**
Robert P. David, Director

**State of California**
Edmund G. Brown Jr., Governor

**California Health and Human Services Agency**
Diana S. Dooley, Secretary

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

July 14, 2016

TO: CHA Board of Trustees

FROM: BJ Bartleson, VP Nursing and Clinical Services
Chair, ED Crowding Task Force

SUBJECT: Emergency Department Crowding Task Force Report

## A .SUMMARY

A recommendation was made at the November, 2015, CHA/Regional Associations Retreat for a task force of representative association members to develop a draft charge for the escalating problem of emergency department (ED) crowding. The charge would lead to the development of a statewide playbook of high impact solutions for crowded emergency ED's.

The group determined that since multiple complex factors affect ED utilization, a thorough understanding of successful ED operations, from our members and key stakeholders, was essential to assess before developing tools and solutions. To gain a thorough understanding of our members and stakeholders across the state, the ED Crowding Task Force proposed the development and dissemination of the **"Redefining the Successful ED, Discussion Guide"** to facilitate discussion on multiple issues precipitating ED crowding. The information collected from various stakeholder discussions will be summarized and used to inform CHA and the regional asoociations on necessary policy, advocacy and ED crowding resolution activity.

The **"Redefining the Successful EDDiscussion Guide"** is attached for your review. The "Discussion Guide" is the tool that would be used with stakeholders to generate discussion on successful ED's of the future. It consists of introductory comments, discussion guide talking points, questions to facilitate discussion, and an inventory of potential discussion participants

Since that time, the ED Crowding Task Force has written an additional paper entitled, **"Redefining the Successful ED, Recommendations",** that was presented at the CHA/Regional Retreat in May. This paper was the result of research on the Washington State Hospital Association's (WSHA) statewide collaborative, "ER is for Emergencies" http://www.wsha.org/quality-safety/projects/er-is-for-emergencies/ .The task force felt the WSHA's system wide approach might serve as a model for how to organize our efforts. WSHA initiated a statewide partnership of doctors, hospitals and state Medicaid representatives to improve ED utilization, quality of care and cost savings. Their initiative consisted of research that defined visits and overall use patterns of emergency services, defining avoidable ED visits,

tracking frequent visitors and determining " seven best practices" solutions based on data and quality improvement measures. They decreased their overall ED visits by 9%, dropped frequent visitor ED visits by 10%, decreased rate of scheduled drug prescribing by 24% and decreased low acuity visits by 14%.

The "**Redefining the Successful ED, Recommendations"** paper is attached for your review. The "Recommendations" paper proposes that CHA and the Regional Associations develop a similar initiative in California to clearly define successful ED's and problems, address member consensus issues, develop a statewide forum, and a coordinated strategic approach with a centralized location of information.

**B. DISCUSSION**

Discussion today is intended to guide CHA and the Regional Associations in representing members in the many arenas in which ED crowding arises. To date, CHA and the regional associations have focused primarily on ED crowding and ambulance patient offload delays (APOD) which is a symptom of a much larger more complex community wide dilemma that includes a myriad of issues from lack of behavioral health capacity, homeless, avoidable ED visits, lack of primary care, etc.

Hospitals can only control what happens within their walls and we know that ED volumes are climbing at record rates. CHA and the Regionals have numerous tools and solutions occurring to tackle symptoms of ED crowding. We are proposing to take the lead, as WSHA did, to understand the root cause of the problem and align policies and strategies that not only affect local and individual stakeholders, but improve health care costs, assure access to care, manage resource utilization, and address possible delivery and payment model reform, all while ensuring quality of care and patient/provider satisfaction. Emergency Services of the future must be redefined and organized in a manner that addresses complexity through collaboration, innovation and discovery.

C. **DISCUSSION QUESTIONS**

1. Keeping in mind your definition of a successful ED, do you believe the ED crowding task force , with it's emerging recommendations , is moving in the right direction?
2. Has the task force identified an appropriate pathway by which to explore emergency services landscape, identify federal, and state barriers, and successful models for change?
3. What modifications or changes would you recommend to the task force?

**D. ED CROWDING TASK FORCE MEMBERS**

BJ Bartleson, RN, MS, NEA-BC, Chair
Anne McLeod
Dave Perrott, MD, DDS

Dimitrios Alexios, FACHE
Judith Yates
Debby Rogers, RN, FAEN
Jan Remm
Brian Jensen

# CHA/Regional Hospital Associations

# Emergency Department Crowding

# Redefining the Successful ED

## *Discussion Guide*

*April 2016*

## Introduction

California Hospital emergency departments (ED) play a pivotal role in the health care delivery system. They provide the only guaranteed source of health care for the uninsured and supply around-the-clock health care access to anyone. They also act as the state's safety net for individual and mass-casualty emergencies.

Recently, the evolving role of EDs and ACA insurance coverage expansion has stressed ED capacity issues in many areas across the state. With a 14% statewide ED visit increase since 2009, EDs are reaching capacity more frequently and symptoms of ED crowding, such as ambulance patient offload delays, longer wait times, and ED bypass are ramping up threatening patient safety and quality of care. While California hospitals have increased ED bed stations by 12%, the continued uptick in volume is straining routine surge mitigation strategies.

EDs specialize in individual and community wide surge activity to accommodate busy activity periods such as flu season or multi-trauma events. They manage the internal surge with resource reallocation and external surge with communitywide diversion and surge plans distributing patients equally to all area hospitals. These common hospital strategies are being challenged not only by volume increases but by the special needs of patients who turn to the ED for care. The rate of non-urgent or non-admits to EDs increased 17%, many of whom are newly insured Medi-Cal patients unable to access primary care in the community. An increased number of patients with unmet behavioral health needs in EDs are also driving crowding issues due to the decline of behavioral health resources in the community. In addition, many EDs remain crowded because there are very limited inpatient psychiatric services available to serve this population in need. Many of these issues are complex, multifaceted and beyond the hospitals ability to control.

Another confounding factor is the 911 Emergency Medical Service (EMS) systems. Despite tremendous diversity in how EMS is provided across the nation and state, little has changed since the 1970s when growing pressure to reduce highway motor vehicular deaths and injuries prompted Congress to fund improvements in the EMS systems across the country. This included federal and state laws to protect the public by assuming that all 911 callers have a true medical emergency.

Our present EMS systems continue to focus on emergency stabilization and rapid transport to the hospital ED despite the evidence that a significant proportion of 911 calls are for non-emergent medical conditions

that do not require immediate care and transport. Hospital EDs are often neither the most appropriate nor the most cost effective destination for patients who are seeking routine primary care or 'urgent' care that would otherwise be provided in a physician's office or other non-emergent setting.

For local governments, the growing mismatch between the capacity of existing EMS systems and the demand from constituents for non-emergent but "unscheduled" medical care represents a failure in service delivery resulting in crowded emergency departments and inefficient use of prehospital EMS resources. EMS resources, particularly ambulances, are increasingly unavailable for emergencies while they transport non-emergent patients to the hospital.

CHA is interested in exploring this topic with hospital members and community stakeholders to determine what a successful ED looks like under the new paradigm of health care reform and how to bring multiple stakeholders together to understand and solve multifaceted issues affecting ED crowding to promote high quality emergency care services.

CHA has developed this Discussion Guide to use as a springboard for dialogue to determine what efficient and effective EDs look like, how success is measured, and how to engage the community stakeholders and hospitals in developing solutions that support health care reform's Triple Aim objectives.

Steps to inform CHA/Regional Hospital Associations are as follows:

1. CHA/Regional Hospital Associations will distribute the Discussion Guide to stakeholders listed in the Discussion Guide Inventory List of Participants to understand what the successful ED and EMS system of the future should look like under health care reform.

2. Discussion Topic Talking Points have been outlined under subject categories to stimulate thinking on ED issues during stakeholder discussions.

3. Questions are listed after the Discussion Guide Talking Points to guide the discussion sessions.

4. Discussion dialogue and recommendations will be summarized and used to inform CHA on necessary policy, advocacy and ED crowding resolution activity.

## Discussion Topic Talking Points

**Emergency Department Data:**

ED use in California has increased substantially (14%) since 2009. This is due to an increased rate of ED visits that do not require admission to the hospital, which rose from 9.9 million in 2009 to 11.6 million in 2014, a 17% overall increase. The number of ER admissions (ER visits resulting in inpatient admissions) has remained stable (OSHPD EMS Data).

**ED Crowding:**

ED crowding "refers to extreme excess of patients in the treatment areas, exceeding ED capacity and frequently necessitating medical care be provided in ED hallways and other makeshift examination areas". (S. Trzeciak, E. Rivers, Emergency Department Overcrowding in the United States: An Emerging Threat to Patient Safety and Public Health", 2003, Emergency Med. J: 20-402-405). ED crowding has been identified as a major public health issue by the Institute of Medicine in 2006 (IOM, 2006). ED crowding is generally defined as greater demand for ED resources than the supply of those resources (Asplin et al., 2003).

A significant contributor to ED crowding is the care of patients in need of a psychiatric inpatient admission. The likelihood of boarding for longer than 6 hours was 5 times higher in patients with psychiatric conditions than for non-psychiatric patients. Patients with psychiatric conditions boarded for 2.8 hours longer than patients with medical or surgical conditions (Nolan, Fee, Cooper, Rankin, & Blegen, 2015).

Manifestations of ED overcrowding include: (1) boarding (2) increased risk of medical errors (3) ambulance diversion (4) threat to disaster preparedness and (5) eroding reliability of the emergency care system. (S.Trzeciak, Rivers)

Research and expert opinion connect emergency department crowding, ambulance diversion, patient offload delay and ED patient boarding with obstructions in hospital throughput. (GAO, 2011)

Drivers of crowded EDs are multifaceted and include such things as lack of access to timely primary care, additional Medi-Cal insured under ACA (who lack access to community care), lack of appropriate behavioral health care, frequent ED users or "super utilizers", homeless, financial and legal obligations by hospitals to treat all patients who arrive at the ED, ED operational inefficiencies, overall hospital inefficiencies, financial incentives and disincentives, insufficient discharge capabilities, etc.

In the current healthcare delivery system, EDs are the only institutional providers required by Federal law to evaluate anyone seeking care. The Emergency Medical Treatment and Active Labor Act require that all hospital EDs medically screen all patients seeking care in the ED including evaluation and stabilization of patients suffering with behavioral conditions.

**Evolving Role of the Emergency Department:**

While the core role of EDs is to evaluate and stabilize seriously ill and injured patients, the vast majority are non-urgent patients. Trends noted: (1) EDs have become an important source of inpatient admissions. (2) EDs are being used with increased frequency to conduct complex diagnostic workups of patients with worrisome symptoms. (3) Despite efforts to strengthen primary care, the principal reason patients visit EDs for non-emergent outpatient care is lack of timely options elsewhere. (4) Office based physicians appear to be making growing use of EDs to perform complex workups and expedite non-elective admissions. (5) ED physicians are serving as the primary decision makers for up to half of all hospital admissions… (Rand Research Report, 2013)

**Financial Factors:**

According to a US Senate report issued in 2011, many hospital EDs are expanding capacity to accommodate the increased demand as well as to increase revenues from resulting inpatient admissions and procedures. Far from perceiving EDs as money losers, most hospital have little financial incentive to discourage ED use by privately insured and Medicare patients, including non-urgent health problems, which could complicate efforts to shift some non-urgent visits to more appropriate community settings. (US Senate Report, 2011, Non-Urgent Use of Hospital Emergency Departments, Can it Provide Better Care at Lower Costs?)

**Medi-Cal Expansion Factors:**

In calendar year 2014, the first year of the Medi-Cal expansion, hospital EDs treated one million more Medi-Cal patients than the prior year. Much of this ED volume is driven by lack of access to primary care physicians as a result of extremely low reimbursement rates for doctors.

**Quality and Patient Safety:**

ED overcrowding threatens patient safety and has been linked to delays in diagnosis and treatment, decreased quality of care and poor patient outcomes. (Lewin, 2002, Derlet, 2000, 2001, 2002)

According to the Joint Commission, over one half of all "sentinel event" cases of morbidity and mortality secondary to delays in treatment occur in hospital EDs, and ED crowding has been cited as a contributing factor in 31% of these cases". (JC 2000)

**Behavioral Health Factors:**

Behavioral health conditions, a leading cause of disability and suicide, carries huge social, economic, and personal costs. Despite the awareness that mental illness poses a formidable burden for individuals, families, government payers, policy makers, and healthcare providers, the public health impact remains severely under recognized and services remain underfunded.

When behavioral health services and supports are unavailable or poorly coordinated, patients with unmet needs turn to the ED for care. California's behavioral healthcare delivery system, decentralized, under resourced, and disorganized, has recklessly collided with emergency medicine. Decades of cuts to local and state-funded behavioral health programs have led to an increased dependence on hospital EDs without corresponding resources. The ED has become the only safety net provider for many patients with unmet behavioral health care needs in California leading to patients boarding for long hours, even days, in EDs awaiting transfer for psychiatric services.

The growing number of patients seeking psychiatric care in hospital EDs in California is well documented and estimated to comprise between 6% and 9% of all ED visits. Research has shown a disproportionate increase in behavioral health related ED visits, in comparison to ED visits in general. Between 2005 and 2011, the number of documented behavioral health related ED visits increased by 47%, compared to a 14% increase in overall ED usage. Past studies have also shown average boarding times ranging from 6.8 hours to 34 hours for patients awaiting admission for a psychiatric condition.

Many proposed solutions to this issue have focused solely on increasing available inpatient psychiatric hospital beds rather than considering alternative emergency care delivery models that could provide prompt access to treatment and reduce the need for many hospitalizations.

This system of delivering behavioral healthcare in the ED leads to inappropriate and inadequate patient care, issues with patient and staff safety, and overall decreased ED capacity. There is a great need to reduce this reliance on EDs and identify more appropriate treatment options.

**Pre-Hospital Environment:**

The current EMS system, as designed, is to assume that all callers have a true medical emergency, need ambulance services and immediate transport to the closest, most appropriate medical facility.

This coupled with other factors such as lack of primary care resources and inadequate basic health education lead many individuals to access care for chronic disease, pain, or other non-urgent conditions through the EMS system. According to Gardett et al. it is "estimated that as many as 56% of ED visits could be avoided with a potential savings of $38 billion."

There are also legislative barriers which implore transportation of 911callers seeking medical care to hospital EDs. California Emergency Medical Services Law, Health and Safety Code Section 1797.218 states "Any local EMS agency may authorize an advanced life support or limited advanced life support program which provides services utilizing EMT-II or EMT-P, or both, for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care hospital…"

## Questions

1. What should successful emergency departments look like under health care reform?
2. What performance measures illustrate a successful ED?
3. What are the obstacles to ED success in achieving that level of performance?
4. What are the opportunities to improve ED success?
5. How do we position EDs for success today and in the future?
6. What policy and advocacy issues need to be addressed to facilitate EDs meeting the triple aim goals?
7. What role do hospitals want to play with public health and the community to the fundamental issues of building community-based services?

## Discussion Group Inventory List of Participants

1. Hospital Associations
   California Hospital Association
   CHA Emergency Services/Trauma Group
   Hospital Council of Northern and Central California
   Hospital Association of Southern California
   Hospital Association of San Diego and Imperial Counties

2. Regulatory Agencies and Groups
   Emergency Services Authority- EMSA
   Emergency Medical Services Administrator Association – EMSAAC
   Emergency Medical Directors Association – EMDAC
   California Department of Public Health – CDPH
   Joint Commission

3. Professional Associations
   Emergency Nurses Association
   ACNL Association of California Nurse Leaders
   Cal ACEP

4. Hospitals
   Hospital System(s)
   Public Hospital(s) Representation
   Trauma Hospital(s) Representation
   Community Hospital(s) Representation
   Rural Hospital(s) Representation
   Critical Access Hospital(s) Representation

5. Other
   Skilled Nursing Facilities
   Law Enforcement
   Department of Behavioral Health
   Payers (Managed Care, Medi-Cal, Blue Cross, Anthem, Kaiser, etc.)

# CHA/Regional Hospital Associations

# Emergency Department Crowding

# Redefining the Successful ED

## *Recommendations*

*May 2016*

## Introduction

In November 2015, CHA and the Regional Associations created the Emergency Department Crowding (EDC) Task Force to develop a collaborative statewide approach for the escalating problems of emergency department (ED) crowding. The EDC task force determined that since multiple factors affect emergency department utilization, a thorough understanding of successful emergency department operations and ED crowding, from our members and key stakeholders, was essential. The "Emergency Department Crowding, Redefining the Successful ED Discussion Guide" was developed and contains key information on emergency departments and emergency department crowding. The discussion guide is formatted with an introduction and talking points to be used to stimulate discussion and consensus with members and stakeholders on successful emergency services under health care reform. The discussion guide is under review by the CHA and Regional Boards. It has been reviewed at HASC, and HASDIC and both boards are in agreement to move forward with this collaborative approach. Review by the Hospital Council Board and the CHA Board is forthcoming.

Since the development of the EDC Task Force and the vetting of the discussion guide, continued intensification of ED crowding issues, and multiple staff, member and stakeholder concerns have led the EDC Task Force to reconsider its approach. While the EDC Task Force agrees that member/stakeholder consensus is important, and the discussion guide implementation should move forward, we have identified other critical issues demanding a more robust strategy for tackling ED crowding.

The issues revolve around two broad themes. First, the definition of ED crowding is not clearly defined and most often based on the stakeholder perspective. Multiple stakeholders across numerous diverse settings (prehospital providers, EMSA, LEMSA's, ED physician providers, public health, payers, and hospitals) describe crowding in a compartmentalized approach which leads to ineffective band aide solutions and divisiveness. While there is a 60% increase in Medi-Cal ED non-admission visits across the state, we don't know specific characteristics of those visits that would be essential in developing appropriate policy, strategies and solutions. We also don't have a clear, agreed upon definition of "avoidable visit."

Secondly, in addition to an ineffectual definition of ED crowding, we do not have consensus across the membership and various stakeholders on what constitutes successful emergency services. This includes a myriad of issues such as effects of ED cost and quality, the availability of ED services (closure of hospital ED), alternative payment models and delivery models (CAH maintaining a hospital to receive IPPS for SNF), alignment of physicians and hospitals, population health management and the impacts of lack of ED services in vulnerable communities. Never before has the need for diverse interdependent stakeholder consensus been greater. The need for collaborative partnerships is now pervasive as multiple health care providers and organizations become increasingly accountable for cost effective results that may not be under their direct control. Successful emergency services public policy demands collaboration through partnerships with parties closest to the issue to produce solutions that go beyond any one group's limited vision of what is possible.

Objectively defining the ED crowding problem and bringing partners together for consensus solutions are the two broad overarching themes driving the ED Task Force's request to reconsider a new approach. The specific issues are outlined below.

## Issues

- Statewide ED crowding data is needed to develop an objective understanding of the problem and ensure that policy is empirically grounded rather than based on perception, and solutions are directly aligned with identified assessment criteria. Specifics include:
    - Lack of a definition of avoidable and potentially avoidable visits; type and characteristic of the visits (time visited, age, ICD-9, etc.)
    - Lack of quality data on ED care
    - Lack of standardized metrics to assess successful ED utilization
    - Lack of cost data
    - Lack of standardized ambulance patient offload delay metrics
- Lack of member and other key stakeholder (ambulance providers, firefighters) consensus on shifting of non-urgent patients to more appropriate settings.
- Lack of a statewide forum for the stakeholder groups to collaborate and develop consensus on goals and objectives that meet the triple aim to improve emergency services quality and patient safety and decrease costs across the state.
- Lack of a coordinated approach to solutions and strategies based on a regular and systematic collection and analysis of data.
- No centralized location of statewide emergency department crowding activity, tools and solutions including new delivery and payment models, and aligned incentives throughout the health care system to ensure access to ED care.
- Antiquated regulations that prohibit shifting of non-urgent patients to more appropriate settings.

## Discussion

Numerous ED crowding solutions are occurring regionally and statewide despite lack of an objective understanding of the problem as identified above. Community Paramedicine Pilots, hospital

reengineering, APOD tracking, safe pain prescribing guidelines, frequent ED use tracking (EDIE), AB 1300, and alternate care delivery models are just a few of the best practices occurring. Intensive efforts at the regional level are occurring due to local pressure from the prehospital community. In addition, at the request of the CHA Board, there is a taskforce consisting of regional and CHA representatives addressing the issue of Free Standing Emergency Departments. This workgroup is focusing on several emergency services models that would address access and expansion of emergency services in different settings. There is, however, no coordinated approach to emergency department crowding solutions, and as stated before, no clear definition and consensus on what constitutes emergency department crowding and how to solve it.

The EDC Task Force was exposed to the work occurring at the Washington State Hospital Association (WSHA) and felt it might serve as a model for how to organize our efforts.

WSHA initiated a statewide partnership of doctors, hospitals and state Medicaid representative in 2012 to improve ED utilization, quality of care and savings. Their initiative, consisting of research that defined overall use patterns of emergency services, defining potentially avoidable ED visits, along with their "seven best practices "solutions, decreased their overall ED visits by 9%, dropped frequent user ED visits by 10%, decreased rate of scheduled drug prescribing by 24% and decreased low acuity visits by 14.2%. They made an estimated savings of approximately $33 million to their state budget. The best practices include, tracking frequent ED visits, implementing patient education, extensive case management, prompt primary care visits, use of narcotic pain prescribing guidelines and Prescription Drug Maintenance Program (PDMP), as well as a robust tracking program of all interventions and outcomes. They have a robust website available to all stakeholders explaining their initiative findings, solutions and ongoing work.

The EDC Task Force reviewed the WSHA Initiative and proposes that CHA and the Regional Associations develop a similar initiative in California to clearly define the problem, address member consensus issues, develop a statewide forum, and a coordinated strategic approach with a centralized location of information.

## Conclusion

The EDC Task Force reviewed all current regional and statewide efforts and determined that the current CHA/Regional model of various taskforces working on this complex issue is not one that will produce a quality policy position. CHA and the Regionals must take the lead, as did Washington State, to understand the root cause of the problem and align policies and strategies that not only affect local and individual stakeholders, but improve health care costs, assure access to care, manage resource utilization, and address possible delivery and payment model reforms, all while ensuring quality care and patient satisfaction. Most importantly, emergency services of the future must be redefined and organized in a manner that addresses complexity through collaboration, innovation and discovery.

## Recommendations

- Coordinate all CHA and Regional Association ED crowding efforts inside the associations and externally with a multi-stakeholder process.
- Use the WSHA model as a template to begin discussions and data analysis.
- Develop a position paper for discussion at the regional association October meetings.

- Present the position paper to the December CHA BOT meeting.

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

June 23, 2016

TO: Emergency Medical Services / Trauma Committee

SUBJECT: ED Forum 2016 Planning

**Objective**
To obtain feedback on recommendations for the planning to date for the Emergency Services Forum, December 7th, 2016.

**Background**
To date the following speakers and topics have been retained for the Emergency Services Forum.

- Dr. Laura Medford-Davis, MD - author of "The Patient Protection and Affordable Care Act's Effect on Emergency Medicine: A Synthesis of the Data- Annals of Emergency Medicine, 2015 – RWJ study
- Carol Wagner, RN, MBA WSHA, and, Hon. Nathaniel Schlicher, MD, JD, FACEP, WSHA's "ED is for Emergencies"
- APOT Panel - Jan Remm, LEMSA, CEO, Legislator
- Dr. Zahn - Emerging Medical Diseases
- Gail Blanchard-Saiger, Esq. - Workplace Violence Prevention, Cal OSHA Regulations

Investigating the following speakers:

- Brendan Carr, MD, MA,MS – Associate Dean of Healthcare Delivery Innovation at Thomas Jefferson University, on Emergency Services Innovation Within the Community
- Sandra Morgan, PhD, RN ,Director - Global Center for Women & Justice, Human Trafficking
- Ricardo Martinez, MD, - last year's keynote in now working for Adeptus and willing to return, if requested.

Last year we added speakers for lunch from the San Bernardino mass shooting. In discussions, the idea of bringing Orlando healthcare providers to the table emerged.

**ACTION REQUIRED:**
Discussion on present speaker line up and recommendations for further speaker/topic suggestions, particularly related to the Orlando mass shooting.

BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing & Clinical Services

**Behavioral Health Care Symposium and Emergency Services Forum**

Created by Liz, 6.2.16

Mission Inn and Riverside Convention Center

Behavioral Content Only | Overlap Day Behavioral and ED Content | Emergency Services Forum (ED content Only)

| Time | Sunday, Dec 4<br>Session Event | Time | Day 1—Monday, Dec 5<br>Session Event | Time | Day 2—Tuesday, Dec 6<br>Session/Event | Time | Day 3—Wednesday, Dec 7<br>Session/Event |
|---|---|---|---|---|---|---|---|
| 7:00 | | 7:00 | | 7:00 | Continental Breakfast | 7:00 | Continental Breakfast |
| 7:15 | | 7:15 | | 7:15 | | 7:15 | |
| 7:30 | | 7:30 | | 7:30 | | 7:30 | |
| 7:45 | | 7:45 | | 7:45 | | 7:45 | |
| 8:00 | | 8:00 | | 8:00 | Opening Comments — Sheree Kruckenberg, BJ Bartleson | 8:00 | Opening Comments — BJ Bartleson |
| 8:15 | | 8:15 | | 8:15 | General Session | 8:15 | Keynote Session |
| 8:30 | | 8:30 | | 8:30 | | 8:30 | |
| 8:45 | | 8:45 | | 8:45 | | 8:45 | |
| 9:00 | | 9:00 | | 9:00 | | 9:00 | |
| 9:15 | | 9:15 | | 9:15 | General Session | 9:15 | General Session |
| 9:30 | | 9:30 | Opening Comments, Chair, S. Kruckenberg | 9:30 | | 9:30 | Longer for panel option… can be made shorter. |
| 9:45 | | 9:45 | Keynote Session | 9:45 | | 9:45 | |
| 10:00 | | 10:00 | | 10:00 | | 10:00 | |
| 10:15 | | 10:15 | | 10:15 | Break | 10:15 | |
| 10:30 | | 10:30 | | 10:30 | | 10:30 | Break |
| 10:45 | | 10:45 | Break | 10:45 | General Session | 10:45 | |
| 11:00 | | 11:00 | Panel Presentation and Discussion | 11:00 | | 11:00 | General Session |
| 11:15 | | 11:15 | | 11:15 | | 11:15 | |
| 11:30 | | 11:30 | | 11:30 | | 11:30 | |
| 11:45 | | 11:45 | | 11:45 | | 11:45 | |
| 12:00pm | | 12:00pm | Hosted Luncheon | 12:00pm | Hosted Luncheon | 12:00pm | Hosted Luncheon |
| 12:15 | | 12:15 | | 12:15 | | 12:15 | |
| 12:30 | | 12:30 | | 12:30 | | 12:30 | |
| 12:45 | | 12:45 | | 12:45 | | 12:45 | Legislative Update? |
| 1:00 | CBH Board Meeting | 1:00 | Simanek Award | 1:00 | Luncheon speaker? | 1:00 | BJ Bartleson |
| 1:15 | | 1:15 | General Session | 1:15 | Passing Break | 1:15 | Passing Break |
| 1:30 | | 1:30 | | 1:30 | Breakout Session / Breakout Session | 1:30 | Breakout Session / Breakout Session |
| 1:45 | | 1:45 | | 1:45 | | 1:45 | |
| 2:00 | | 2:00 | | 2:00 | | 2:00 | |
| 2:15 | | 2:15 | | 2:15 | | 2:15 | |
| 2:30 | | 2:30 | Breakout Session / Breakout Session | 2:30 | | 2:30 | |
| 2:45 | | 2:45 | | 2:45 | Food Break and Giveaway | 2:45 | Food Break |
| 3:00 | | 3:00 | | 3:00 | | 3:00 | Closing Session |
| 3:15 | | 3:15 | | 3:15 | Closing Session | 3:15 | |
| 3:30 | | 3:30 | Break | 3:30 | | 3:30 | |
| 3:45 | | 3:45 | | 3:45 | | 3:45 | |
| 4:00 | | 4:00 | General Session | 4:00 | | 4:00 | |
| 4:15 | | 4:15 | | 4:15 | | 4:15 | |
| 4:30 | | 4:30 | | 4:30 | | 4:30 | |
| 4:45 | | 4:45 | | 4:45 | | 4:45 | |
| 5:00 | | 5:00 | Reception | 5:00 | | 5:00 | |
| 5:15 | | 5:15 | | 5:15 | | 5:15 | |
| 5:30 | | 5:30 | | 5:30 | | 5:30 | |
| 5:45 | | 5:45 | | 5:45 | | 5:45 | |
| 6:00 | Reception | 6:00 | | 6:00 | | 6:00 | |
| 6:15 | | 6:15 | | 6:15 | | 6:15 | |
| 6:30 | | 6:30 | | 6:30 | | 6:30 | |
| 6:45 | | 6:45 | | 6:45 | | 6:45 | |
| 7:00 | | 7:00 | | 7:00 | | 7:00 | |

# The Patient Protection and Affordable Care Act's Effect on Emergency Medicine: A Synthesis of the Data

Laura N. Medford-Davis, MD*; Vidya Eswaran, BS; Rohan M. Shah, BS; Cedric Dark, MD, MPH

*Corresponding Author. E-mail: Lmedfo@mail.med.upenn.edu, Twitter: @MedfordDavis.

This review synthesizes the existing literature to provide evidence-based predictions for the future of emergency care in the United States as a result of the Patient Protection and Affordable Care Act, with a focus on emergency department (ED) visit volume, acuity, and reimbursement. Patient behavior will likely be quite different for patients gaining Medicaid than for those gaining private insurance through the Marketplaces. Despite the threat of the individual mandate, not all uninsured patients will enroll, and those who choose to enroll will likely be a different population from those who remain uninsured. New Medicaid enrollees will be a sicker population and will likely increase their number of ED visits substantially. Their acuity will be higher at first but will then revert to the traditionally high number of low-acuity visits made by Medicaid patients. Most patients enrolling through the Marketplace are choosing high-deductible health plans, and they will initially avoid the ED because of high out-of-pocket costs but may present later and sicker after self-rationing their care. Most patients gaining health coverage through the Affordable Care Act will be shifting from uninsured to either Medicaid or private insurance, both of which reimburse more than self-pay, so ED collections should increase. Because of the differences between Medicaid and Marketplace plans, there will be a difference in ED volume, acuity, and financial outcomes, depending on states' current demographics, whether states expand Medicaid, and how aggressively states advertise new options for coverage in Medicaid or state health insurance Marketplaces. [Ann Emerg Med. 2015;66:496-506.]

Please see page 497 for the Editor's Capsule Summary of this article.

A **podcast** for this article is available at www.annemergmed.com.

0196-0644/$-see front matter

http://dx.doi.org/10.1016/j.annemergmed.2015.04.007

## INTRODUCTION

### Background

The practice of medicine has been under enormous external pressure as health insurers, governments, and the general public have become more conscious of cost, health outcomes, and the experience of care. In this climate, the emergency department (ED) has been scrutinized for providing expensive and unnecessary care.[1]

Statistics indicate that 129.8 million visits were made to US EDs in 2010,[2] and there has been an increase in the per-capita rate of ED visits every year since 1997 (with 2010 being the exception).[3] Emergency physicians account for only 4% of the total physician workforce, yet of the 354 million annual acute unscheduled care visits, emergency physicians treat a disproportionate share.[4] Approximately half of acute unscheduled care visits for patients with Medicaid/Children's Health Insurance Program and more than 60% of acute unscheduled care visits for the uninsured are provided by emergency physicians.[4] An increasing use of EDs for acute unscheduled care has occurred despite a 12.7% decline in the number of hospital-based EDs between 1991 and 2011.[5] With the expansion of health insurance coverage as a result of the Patient Protection and Affordable Care Act of 2010, many expect that the strain on our nation's EDs will continue to increase.[6]

Regardless of its ability to affect health care quality, freedom of choice, affordability, or access to care, the Affordable Care Act will have far-reaching influence on the practice of emergency medicine. Some elements of the law will affect the demand for emergency care and others will change expectations for the ED's role in coordinating care.[7] A poll of emergency physician opinions in 2014 found that after implementation of the Affordable Care Act, 46% perceived increases in their visit volume, 86% expected ED visits to continue to increase, and 51% expected reimbursement to decrease.[8] Despite these perceptions, administrative data from EDs in Maryland and the District of Columbia offer contradictory findings of a 3.7% decrease in ED visits.[9]

Many peer-reviewed studies have been published demonstrating the relationship between changes in health care legislation and resulting trends in emergency care. This review synthesizes the existing literature to

**Editor's Capsule Summary**

*What is already known on this topic*

The Patient Protection and Affordable Care Act may change how patients access the health care system. Organizations may attempt to steer less ill patients away from expensive emergency department (ED) care.

*What question this study addressed*

This systematic review predicted what the future would be for EDs in the Affordable Care Act era.

*What this study adds to our knowledge*

The insurance profile of patients treated in EDs may change, with variable effects on reimbursement to physicians and hospitals, depending on geography and other circumstances.

*How this is relevant to clinical practice*

This will help ED and hospital administrators prepare to best meet the needs of the population as payer models evolve under the Affordable Care Act.

provide evidence-based predictions for the future of emergency care in the United States as a result of the Affordable Care Act.

## MATERIALS AND METHODS

We searched the PubMed, EMBASE, PsycINFO, and Ovid Healthstar databases for all articles combining the free-text terms "Affordable Care Act" and "emergency medicine." Additionally, we searched for variations including "emergency room," "emergency department," "ED," "ER," and "emergency physician." Additionally, we searched the CINAHL database, using its predefined Boolean phrases.

Our search uncovered 198 unique sources. From these sources, the first and senior authors (LNM-D and CD) reviewed titles and abstracts to exclude any article not directly related to the federal health reform law or the practice of emergency medicine. The full text of the remaining 40 articles was reviewed for inclusion in our synthesis, leading to the exclusion of an additional 16 that did not focus on the Affordable Care Act's effect on the ED specifically. References of selected articles were also explored for relevance, and 15 more articles were added to our review (Figure 1).

After review, the selected literature was grouped into the Affordable Care Act's anticipated effects on the following categories: ED volume, acuity of emergency care, and reimbursement for emergency care.

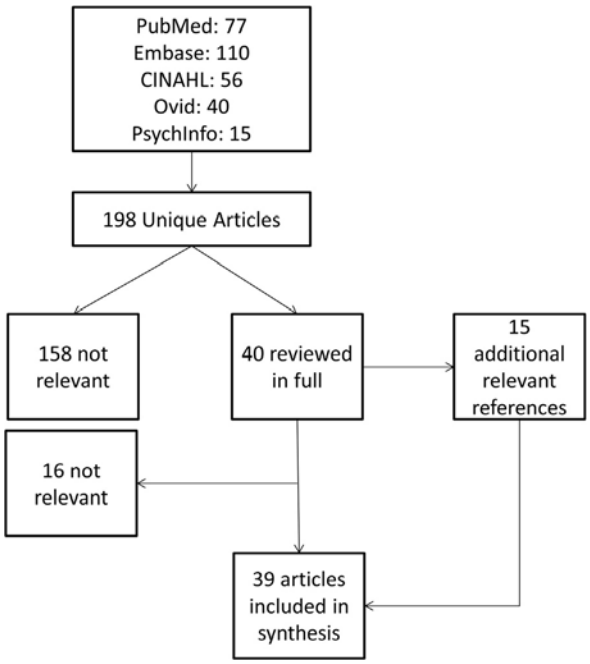



**Figure 1.** Literature review flowchart.

## RESULTS

Given the steady increase in ED visits in the past decade,[3] contrasted with the expectation by policymakers that the Affordable Care Act will replace ED utilization with primary care visits,[10] the net effect of the Affordable Care Act on ED volumes is the subject of much speculation. In 2010, 71% of emergency physicians expected a surge in visits.[11] This percentage increased to 86% of emergency physicians expecting surges in 2014.[8] Forty-six percent thought they had already observed increasing ED visits in the first 4 months of 2014, coinciding with the first full-scale efforts to implement the Affordable Care Act.[8]

Policymakers designed the Affordable Care Act to provide increased access to primary care providers, with the assumption that this would cause substitution of emergency care with primary care. Although increased rates of insurance coverage are designed to improve access to primary care, fewer than half of Americans with a primary care provider have access to that physician after hours (nights and weekends) when a significant number of acute care visits are made.[12] When patients call to make appointments, true availability of primary care for new privately insured patients is only 84.7% and decreases to 57.9% for Medicaid patients.[13]

Appointment availability was lowest and wait times were longest in Massachusetts,[13] a state that implemented Affordable Care Act–like reforms. This research suggests that patients may face a limited supply of primary care providers after national health care expansion.[14] National surveys find that patients who report difficulty accessing their primary care provider use the ED more often[15-17] and that the percentage of patients reporting such barriers has doubled from 6.3% to 12.5% during the past decade.[16] Sixty-four percent of ED patients with a primary care provider and 78% of those without a primary care provider reported an issue with access to care rather than perceived acuity of their condition as the cause of their most recent ED visit.[1] Research from Massachusetts combined with the trends in primary care provider access suggest that significant barriers to accessing primary care will remain a problem for patients after Affordable Care Act implementation. This could lead to greater ED utilization.

Many researchers suggest that true Affordable Care Act results cannot be studied until at least a full year "washout period" after implementation,[18,19] so current trends may not accurately portray long-term changes. However, early evidence from Colorado, comparing the first 2 quarters of 2014 to pre–Affordable Care Act implementation, shows that states choosing to expand Medicaid have experienced a 5.6% increase in total ED visits compared with just 1.8% in nonexpansion states.[20] Previous research suggests that this increase may be temporary. People who lose or gain insurance coverage report using significantly more ED care within the first year after their coverage change.[21,22] Patients obtaining Medicaid coverage visit the ED approximately 21% more frequently than those obtaining private insurance,[21] which may explain some of the early findings in states expanding Medicaid.[20]

A recent analysis of the Low Income Health Program in California that expanded Medicaid early (in July 2011) showed a large spike in Medicaid visits in the first year, which leveled off after 18 months.[23] People in the program who had no previous health care coverage or visits, whom the authors characterized as having high "pent-up demand," were responsible for the majority of the increase in ED visits.[23] Similarly, in Massachusetts' Affordable Care Act–like health reform, patients who were uninsured before gaining Marketplace-type insurance increased their ED visits by 12%, whereas patients who had public insurance before gaining a private plan decreased their ED visits by 18%.[24] Additionally, the results of a nongovernmental program in Virginia that provided free primary care (but not full Medicaid) to the people who would be eligible for Affordable Care Act Medicaid expansion found that with continuous primary care provider access, ED visits continued to decrease each year for 3 years.[25] At least in the near future, it appears the Affordable Care Act will substantially increase ED visits, particularly for individuals who have been uninsured previously or who gain Medicaid, but visit rates may stabilize to the slow growth rate observed before the Affordable Care Act within 1 to 2 years. Figure 2 presents a prediction of the anticipated effects of the Affordable Care Act on ED visit rates according to available data.

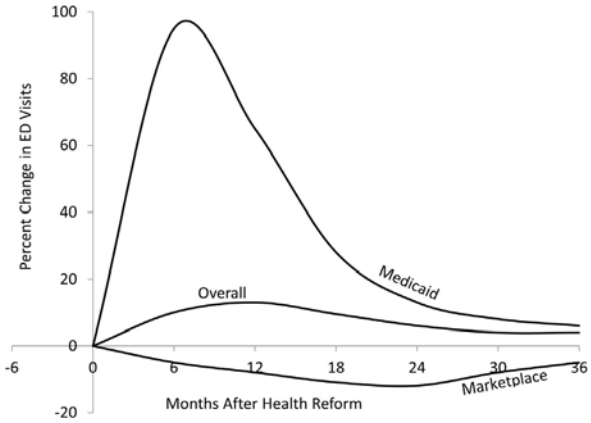



**Figure 2.** Anticipated change in ED visits above baseline annual growth after national health reform.

State insurance expansion experiments can be used to extrapolate the results of the Affordable Care Act. Massachusetts implemented a health care reform similar to the Affordable Care Act in 2006. The state had a much lower uninsured rate before their health reform than the national average before the Affordable Care Act (10.9% versus 18.4%) and is therefore not fully representative of expected national effects but does provide some suggestions about the effects of this type of insurance coverage change. Two surveys found that patients in Massachusetts reported more clinic-based and preventive care after reform.[19,26] Although policymakers hope this trend will lead to decreased ED use, true behavior is subject to complex incentives.

One survey found a nonsignificant 2% decrease in ED use at 2 years postreform (2008 versus 2003 to 2005).[19] Another survey found a significant 3.8% decrease in the number of people making any annual ED visit, a 1.9% decrease in people visiting the ED more than 3 times annually, and a 3.8% reduction in people making nonemergency visits to the ED.[26] However, this decline did not begin until 2010, when health reform had already been in place for 4 years.[26] Thus, the Affordable Care Act may ultimately slow the growth in ED use very slightly from the pre–Affordable Care Act baseline after an initial bump in utilization.

To supplement self-reports, Massachusetts has also produced several studies of administrative ED visit data. The study by Miller[27] found that, compared with that of neighboring states that had not expanded health coverage, ED use in Massachusetts decreased by more than 5%.[27] These reductions were mostly in primary care–treatable conditions during weekday hours when outpatient clinics were open. These results are consistent with patients' reports and suggest that health reform is having the desired effect of replacing nonemergency ED use with clinic use when available.

However, Chen et al[28] found no difference in ED visits between Massachusetts and 2 neighboring states. Two studies compared changes in ED utilization for counties in Massachusetts that had small or large changes in insurance coverage after reform. Two different methods to estimate a county's change in insurance coverage led to 2 opposite results: Smulowitz et al[29] found a 2.2% increase in ED visits, whereas Miller[27] found a 6% to 8% decrease in ED visits in counties where the most people gained insurance. In addition, a study of changes in insurance coverage in California found that both total and low-acuity ED visits decreased when insurance rates increased.[30] The majority of the evidence from Massachusetts and the evidence from California suggest that increased insurance coverage is associated with a small decrease in ED visits.

In 2008, Oregon expanded Medicaid to a select number of eligible adults by a lottery system, creating a randomized natural experiment that provides the most robust prediction of how Medicaid expansion will affect ED visits. Analyses of self-reported health care use in the year after expansion found no change in ED visits for patients gaining Medicaid.[31,32] However, a subsequent analysis by the same authors, using administrative ED visit data, found that patients obtaining Medicaid actually made 41% more ED visits than those who remained uninsured.[33] Their direct comparison of survey and interview reports of ED use to actual ED use provides a warning against the overreliance on reported rather than actual behavior. These results from Oregon suggest that among the Medicaid population, ED visits could increase substantially.

Similarly, a public insurance expansion in Wisconsin that automatically enrolled low-income adults without children, the group most likely to benefit from Affordable Care Act Medicaid expansion, found a 46% increase in ED visits after expansion despite a 55% increase in preventive visits and a 13.5% increase in acute care visits to clinics.[34] When Tennessee reversed course, taking Medicaid coverage away from 171,000 adults in 2005, weekly ED visits decreased by 2.6% in the state, further corroborating that patients with Medicaid use the ED more frequently than the uninsured.[35]

However, a study matching 10 states that chose to expand their Medicaid eligibility between 2000 and 2009 to control states that did not expand it found that people obtaining Medicaid did not decrease their ED utilization any more than Medicaid enrollees in matched nonexpansion states.[36] New Medicaid enrollment increases ED utilization within states expanding eligibility, but this increase may not be significant when compared to temporal trends in states not expanding it.

The Affordable Care Act includes a provision that took effect in September 2010 that allows young adults aged 18 to 25 years to remain insured by their parents' private health insurance plans. Previous analysis of young adults who lost their parents' health insurance in 7 states revealed that they were 40% less likely to visit the ED when uninsured.[37] These data suggest that young adults will increase ED visit rates as a result of the Affordable Care Act. However, a later analysis of the same data set after the Affordable Care Act took effect did not find any difference in ED visits by individuals younger than 25 years after they remained insured.[18] Two separate analyses of ED administrative data actually reported decreases in ED visits by young adults in the first 15 months after the Affordable Care Act of 2.1% and 1.6 visits per 1,000 young adults.[38,39]

Abraham[40] combined the estimated changes in ED visits observed in several previous studies with a large data set of pre–Affordable Care Act ED utilization to make overall estimates about the Affordable Care Act's potential effect. The study's estimates ranged from a 9% decrease to a 12% increase in ED utilization. The specifics of the different studies reviewed indicate that this wide range is due to the difference between the types of coverage expansion (Table 1). A general increase in health care coverage, as was observed in Massachusetts, is associated with stable or slight decreases in ED use. An increase in private health coverage leads to decreased ED use for young adults, whereas an increase in Medicaid coverage alone appears to significantly increase ED use. Young adults are likely a much healthier population with fewer health care needs than those gaining Medicaid. Visit rates may also depend on whether patients were uninsured or insured before gaining policy-related insurance. All of these changes may stabilize over time to the baseline slow growth rate observed pre–Affordable Care Act.

It has been debated whether expanded insurance coverage will decrease the severity of illness of patients presenting to the ED (ie, acuity). When patients are treated and managed in the outpatient setting, the provision of

**Table 1.** Changes in ED volume by type of coverage expansion.

| Reference | Percentage Change | State | Data Source | Subjects* |
|---|---|---|---|---|
| **Overall health reform** | | | | |
| Long, 2012[26] | ↓3.8 | MA | 2006–2010 Massachusetts-based telephone survey | 15.5K patients 18–64, with oversampling of uninsured and adults in low-income areas |
| Miller, 2012b[27] | ↓5–8 | MA | State hospital data and census data | Change in insurance coverage by county |
| Chen 2011, Miller 2012a[19,28] | Zero | MA | Chen—2004–2009 state hospital data, NH and VT are controls; Miller—2003–2008 National Health Interview Survey, 8 control states | Chen—2.2M ED visits in MA by patients <65<br>Miller—21.6K respondents 18–64 |
| Abraham 2014[40] | ↓9–↑12 | USA | 2008–2010 Medical Expenditure Panel Survey; compares use by the uninsured eligible for ACA with those already insured | 184.7M nondisabled persons 18–64 |
| Smulowitz 2014[29] | ↑1.2–2.2 | MA | 2004–2009 state hospital data; insured rates in each county estimated by percentage of hospital visits covered by insurance in the area | 2M annual outpatient ED visits, 850K inpatient admissions, and 150K observation stays |
| **Medicaid expansion states** | | | | |
| CHA 2014a[20] | ↑5.6 | USA | 2013–2014 hospital data, 15 states | 465 hospitals |
| **Medicaid nonexpansion states** | | | | |
| CHA 2014a[20] | ↑1.8 | USA | 2013–2014 hospital data, 15 states | 465 hospitals |
| **Young adult population** | | | | |
| Anderson 2012[37] | ↑40 | USA | 2005–2007 ED administrative data in 5 states | 1.7M ED visits by patients 18–19 |
| Chua 2014[18] | Zero | USA | 2002–2011 Medical Expenditure Panel Survey | 56.5K adults 19–34 |
| Antwi 2015[39] | ↓1.4 | USA | 2007–2011 Healthcare Utilization Project Nationwide Emergency Department Sample, 30 states | 77M ED visits by patients 19–29 |
| Hernandez-Boussard 2014[38] | ↓2.1 | CA, FL, NY | 2009–2011 HCUP SEDD and SID and census data | 10.2M ED visits by patients 19–31 |
| **Marketplace population** | | | | |
| Lee 2015[24] | ↓4 | MA | 2004–2008 Public health insurance enrollment data and statewide ED visit claims | 353K adults >17 |
| Wharam 2013[47] | ↓4.6–11.7 | MA | 2001–2008 claims data | 16.3K people <65 whose employers switched them from HMOs to HDHPs |
| **Medicaid population** | | | | |
| Lo 2014[23] | ↑300 | CA | 2013–2014 state claims data | 182K LIHP new enrollees who would be eligible for Medicaid after expansion |
| DeLeire 2013[34] | ↑46 | WI | 2008–2009 state claims data | 9.6K new Medicaid enrollees |
| Taubman 2014[33] | ↑41 | OR | 2007–2009 survey data, Medicaid enrollment data, and ED administrative data from 12 Portland hospitals | 25K Medicaid lottery winners 19–64 |
| Heavrin 2011[35] | ↑2.6 | TN | 2004–2006 HCUP SEDD and SID, Medicaid enrollment data, and census data | 4.6M ED visits by adults >17 |
| Baicker 2011, Finkelstein 2012[31,32] | Zero | OR | 2008–2009 mail surveys | 23.7K Medicaid lottery winners 19–64 who responded to mailed surveys |

*K*, Thousand; *M*, million; *ACA*, Patient Protection and Affordable Care Act; *CHA*, Colorado Hospital Association; *HCUP*, Healthcare Cost and Utilization Project; *SEDD*, State Emergency Department Database; *SID*, State Inpatient Database; *HMO*, health maintenance organization; *HDHP*, high-deductible health plan; *LHIP*, low-income health program.
*Age is provided in years.

timely primary care may prevent acute exacerbations of chronic illness and late presentations of acute illness by the uninsured. Indeed, since Affordable Care Act implementation, the percentage of people reporting that they have delayed health care needs because of cost, which can lead to more urgent untreated conditions, has declined 17.5%, the first decline in a decade.[41] Conversely, the Affordable Care Act could increase the ED acuity of the patients who continue to visit the ED because of the relative decrease in low-acuity conditions' being shifted to the primary care setting. In an opinion poll of emergency physicians by the American College of Emergency Physicians, more than half of respondents believed the Affordable Care Act would make no difference in visit acuity.[8]

Most published evidence indicates that mortality rates have decreased in Massachusetts and in several other states after voluntary Medicaid expansions, which might suggest lower severity of illness at the population level or improved access to lifesaving care.[42,43] When Tennessee decreased Medicaid enrollment in 2005 (a reform opposite of the Affordable Care Act), ED visit mix shifted from Medicaid

**Table 2.** Changes in ED acuity by acuity measure and type of coverage expansion.

| Reference | Percentage Change | State | Data Source | Subjects* |
|---|---|---|---|---|
| **Low-acuity visits** | | | | |
| **Exchange population** | | | | |
| Wharam 2013[47] | ↓8.7 low-acuity visits† | MA | 2001–2008 claims data | 16.3K people <65 whose employers switched them from HMOs to HDHPs |
| **Medicaid population** | | | | |
| Taubman 2014[33] | ↑43 ED discharges | OR | 2007–2009 survey data, Medicaid enrollment data, and ED administrative data from 12 Portland hospitals | 25K Medicaid lottery winners 19–64 |
| DeLeire 2013[34] | ↑38.7 low-acuity visits† | WI | 2008–2009 claims data | 9.6K new Medicaid enrollees |
| Gandhi 2014[44] | ↓1–4 low-acuity visits† | USA | 2000–2009 National Hospital Ambulatory Medical Care Survey and current population survey | 185K ED visits by Medicaid enrollees compared to uninsured <65 |
| **High-acuity visits** | | | | |
| **Exchange population** | | | | |
| Wharam 2013[47] | ↓31.9 high-acuity visits† | MA | 2001–2008 claims data | 16.3K people <65 |
| **Medicaid population** | | | | |
| Lo 2014[23] | ↑0.3–15.2 admissions | CA | 2013–2014 state claims data for LIHP; result stratified by insurance status before LIHP enrollment | 182K new LIHP enrollees who would be eligible for Medicaid after expansion |
| Colorado Hospital Association 2014a[20] | ↑9–13 number of concurrent diagnoses | CO | 2013–2014 hospital data | Medicaid inpatients from 153 hospitals |
| Heavrin 2011[35] | ↓0.6 ED admits | TN | 2004–2006 HCUP-SEDD and SID, Medicaid enrollment data, and census data | 4.6M ED visits by adults >17 |
| **Mortality** | | | | |
| **Medicaid population** | | | | |
| Sommers 2012[42] | ↓6.1 mortality | NY, ME, AZ | 1997–2007 Centers for Disease Control and Prevention Compressed Mortality File and census data | 68K deaths of adults 20–64 |

*Age is provided in years.
†Low acuity is defined as treatable in the primary care setting.

to uninsured, and acuity, as defined by hospitalizations, increased slightly for the uninsured.[35] There was also a slight increase (0.6%) in total ED visits leading to hospitalization (Table 2).[35]

Reviewing a national database of ED visits, Gandhi et al[44] found that adult Medicaid enrollees made the most nonemergency visits (538.2/1,000 people) and that their rate of nonemergency visits has been increasing in the past decade, whereas nonemergency visits for the uninsured (202.5/1,000) and privately insured (106.1/1,000) were much less frequent and have remained constant. Wisconsin's 46% increase in ED visits for patients attaining Medicaid was primarily due to a 38.7% increase in low-acuity visits.[34] In Oregon, despite the 41% increase in ED visits by patients attaining Medicaid there was no increase in hospitalizations.[33] These data suggest that Medicaid patients will make more low-acuity ED visits.

On the other hand, reports on the first 2 quarters of Medicaid enrollees accessing care in Medicaid expansion states revealed a 10% increase in case acuity and a 9.2% to 13.2% increase in the number of concurrent diagnoses per visit, suggesting that regardless of whether visits themselves are emergency or not, the new Medicaid enrollees so far are a relatively sicker population.[20] Cook County in Chicago expanded Medicaid to the Affordable Care Act–eligible population 1 year early. Reports indicate that new enrollees had high rates of obesity, diabetes, and hypertension, and a quarter of them had been admitted to the hospital in the year before enrollment.[45] Eighty-five percent of the Cook County enrollees could not afford their medications in the year before enrolling, suggesting they may have sequelae of untreated chronic disease.[45] Similarly, people enrolled through the early Medicaid expansion in California had high rates of hospital admissions, particularly if they had gone without health care in the year before expansion, although with time their admission rate returned to baseline.[23] People choosing to take advantage of newly available Medicaid coverage under the Affordable Care Act may represent a sicker population who will make higher-acuity ED visits because of multiple and previously untreated medical conditions.

Behavior may be different for the patients gaining private health insurance through Affordable Care Act Marketplaces, particularly because 85% have chosen

high-deductible health plans.[46] There are not yet many data about patients transitioning from uninsured to a high-deductible health plan, but a study of patients switching from a health maintenance organization to a high-deductible health plan may offer some insight. Patients with lower socioeconomic status (many of the people eligible for Marketplace subsidies) decreased their high-severity ED visits by 24.5% in the first year and an additional 7.4% the second year.[47] In contrast, patients with high socioeconomic status (those earning >400% of the federal poverty level) and high-deductible health plans decreased their overall ED visits by 14.8% but made no change in high-severity visits.[47] In the same study, patients of low socioeconomic status also initially decreased their hospitalization rates by 23% the first year.[47] However, in the second year, hospitalizations increased back to baseline levels, suggesting that these patients simply delayed presenting for high-acuity conditions.[47] 2014 Data from Hospital Corporation of America (HCA), a national hospital chain, showed that Marketplace patients had higher acuity as measured by the ratio of ED visits to admissions than traditional employer-based private insurance or the uninsured (2.86:1 versus 3.39:1 versus 9.58:1).[48] Like the early enrollees in Medicaid, those taking earliest advantage of Marketplace plans may also be a relatively sicker population with recently untreated health needs.

Overall, the data suggest that Medicaid patients make many low-acuity ED visits, but that the initial Affordable Care Act Medicaid enrollees represent a sicker and higher-acuity population. Many patients who gain coverage through high-deductible health plans might delay needed care despite gaining health insurance which, although initially decreasing the proportion of high-acuity visits in early years of implementation, could lead to higher-acuity ED visits.

ED reimbursement is an important issue to both the emergency physician and the hospital administrator. A few analyses of anticipated profit changes caused by the Affordable Care Act, as well as outcomes from state-level reforms, are promising, but decreased Medicaid Disproportionate Share Hospital funding that also comes with the Affordable Care Act may offset these gains. Indeed, more than half of emergency physicians fear reduced reimbursement under the Affordable Care Act.[8]

Wilson and Cutler[49] estimated that hospital ED profit margins (facility fees) would be higher with the Affordable Care Act than without it (7.3% versus 11.7%, respectively) in 2023. In addition, an analysis by Galarraga and Pines[50] similarly estimated that physician reimbursements (professional fees) for newly insured Medicaid patients will increase by 17%; for newly privately insured patients, by 39%.

Current ED reimbursement trends reveal that 15% to 18% of ED visits are self-pay,[4,49] and only 10.4% of uninsured patients ever make any payment on their hospital bills.[48] The majority of hospital ED profits come from admissions (21.8% profit margin compared with 3.2% for discharges) and the privately insured (profit margin 39.6%).[49] Although EDs lose money on Medicaid visits (negative 35.9% profit margin), EDs lose substantially more on self-pay visits (negative 54.4% margin), so converting the currently uninsured into Medicaid or privately insured patients should be beneficial to ED profit margins for both the hospital and the physician.[49]

However, profitability varies by visit acuity. Henneman et al[51] found that commercial insurance pays 1,256% more for level 5 visits than level 1 ($1,281 versus $102), whereas Medicaid pays just 246% more for the highest-acuity visits ($273 versus $111). As a result, Medicaid visits with levels of service 1 to 3 are profitable for EDs, and only levels 4 and 5 Medicaid visits lose money.[51] For ED level of service 1 visits, Medicaid and commercial insurance are actually approximately equally profitable (margin $67 versus $68 per visit).[51]

We can again turn to other state-level health insurance changes for clues about what to expect from the Affordable Care Act. The uninsured will likely make up a smaller percentage of ED visits as a result of the act. When Tennessee decreased Medicaid eligibility, Medicaid ED visits declined by 6.2% (3,319 visits per week), whereas uninsured ED visits increased by 5.3% (2,203 visits per week).[35] By doing the opposite, as the Affordable Care Act does, Massachusetts increased Medicaid and private insurance coverage while decreasing ED visits by the uninsured from 9.5% to 5.7%.[29]

Early analyses of the Affordable Care Act reveal that the payer mix for emergency ED visits by young adults has experienced a 3.1% to 5.0% increase in private insurance and a 1.7% to 2.9% decrease in self-pay patients.[39,52] Arkansas hospitals, where the state has aggressively pursued Affordable Care Act health reform, reported a 24% reduction in uninsured ED visits in the first 3 months of the Affordable Care Act.[53] Tenet, a national hospital chain, reported a 33% reduction in uninsured visits in states that expanded Medicaid compared with an increase in uninsured visits in nonexpansion states.[53]

A report of more than 400 hospitals in 30 states found that in expansion states Medicaid charges had increased 29% and uninsured charges had decreased 25%, with total charity care decreasing by 30% as a result.[54] These changes to charges match the volume-based changes to payer mix and were not observed in nonexpansion states.[54] Early

expansion of Medicaid in Chicago led to a 10% decrease in charity care by the end of the first year.[53] Financial outcomes from the Affordable Care Act thus far reveal favorable changes in payer mixes, particularly for EDs in states choosing to expand Medicaid.

Unfortunately, although there may be an increase in revenue because of a shift of patients from uninsured to private insurance and Medicaid, much of the increased revenue will be needed to offset costs for the remaining uninsured populations, which will include undocumented immigrants, legal immigrants living in the United States for fewer than 5 years, adults not earning enough income (<100% federal poverty level) to qualify for subsidies in health insurance Marketplaces in states not expanding Medicaid, and those eligible for Medicaid or Marketplace subsidies but choosing not to enroll.

Before the Affordable Care Act, hospitals providing uncompensated charity care received funding from Medicaid and Medicare Disproportionate Share Hospital programs. Because the act expected to decrease the uncompensated care pool by insuring a much larger percentage of the population, the law mandated large cuts to Disproportionate Share Hospital payments (Table 3).

After 2 delays, $1.8 billion (16%) will be cut from total federal Medicaid Disproportionate Share Hospital payouts in 2017, $4.7 billion per year (41%) in 2018 to 2020, and up to $5 billion per year through 2023.[55] The cuts will be relatively larger or smaller for each state, depending on the uninsured rate in the state and the way the state chooses to distribute its Disproportionate Share Hospital funds to hospitals.[56] States with high pre–Affordable Care Act uninsured rates who do not expand Medicaid, such as Texas, Louisiana, and Florida, are expected to lose the most in Disproportionate Share Hospital payments[57] while losing new Medicaid reimbursements for the currently uninsured because the payment calculations are based on historical uninsured rates that lag a few years behind, so initial payments would continue to give robust payments to expansion states despite decreases in their uninsured rates. The double loss to nonexpansion states should be somewhat offset by the delayed start date, which will shorten the lag to incorporate the higher uninsured rates post–Affordable Care Act in these states.

We expect EDs and emergency physicians to experience increased reimbursements from the Affordable Care Act because of the shift of patients from uninsured to Medicaid or private insurance. However, cuts to federal Disproportionate Share Hospital payments will adversely affect hospital revenue, particularly in states not expanding Medicaid, in which EDs will realize fewer benefits from the Affordable Care Act and face larger Disproportionate Share Hospital losses.

**Table 3.** Reductions from Disproportionate Share Hospital funding by year.*

| Year | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|
| Medicaid, $ | 1.8 | 4.7 | 4.7 | 4.7 | 4.8 | 5.0 | 5.0 | 4.4 |

*In billions of dollars. Reductions are from the annual pre-ACA allotment (which was stable but inflation adjusted), independent of the amount reduced in the previous year, for a total of $34.7 billion in reductions from 2017 to 2024. Source: Medicaid Program, State Disproportionate Share Hospital Allotment Reductions, Final Rule, September 9, 2013.

## DISCUSSION

Early into Affordable Care Act expansion, publicly reported preliminary trends show increases in ED volumes, possible increases in patient acuity for Medicaid and Marketplace patients, and decreases in uncompensated care for states expanding Medicaid.[20,45,48,54] However, it is still early in the act's rollout, and as late as January 2015 states have continued to change their individual approach to expansion and Marketplace creation.[58] Thus, it is too early to determine the long-term effects on EDs and emergency physicians. Most current evidence comes from previous state-level reforms and shows a mixed picture, depending on the type of insurance gained, insurance status before reform, and the length of time since implementation.

The actual experiences for EDs and emergency physicians will differ greatly, depending on whether the state in which they practice chooses to expand Medicaid or aggressively promote Affordable Care Act Marketplace enrollment, because patient behavior may be quite different for new Medicaid versus Marketplace patients. Of uninsured adults, 12.9 million will be eligible for Marketplace plans and just 8.6 million will be eligible for Medicaid.[59] There will also be a difference in outcomes according to states' current uninsured rates, pre–Affordable Care Act Medicaid eligibility levels, income levels, and numbers of undocumented immigrants who will remain ineligible for coverage expansions. Over time, there may be reductions in mortality as a result of expanded insurance coverage.[42,43]

Although the individual mandate was intended to lead to nearly universal enrollment, predictions estimate that the Affordable Care Act will cover only approximately half of the uninsured population.[49,60] Individuals who choose to enroll will likely be a different population from those who remain uninsured. People taking advantage of early expanded Medicaid enrollment tended to be relatively sicker, with high rates of chronic illness and numerous barriers to care.[45] The relatively sicker[20,45] new Medicaid

enrollee may initially have higher-acuity visits even though traditionally Medicaid patients make the greatest proportion of low-acuity visits of all payer types.[44]

The classic RAND Health Insurance Experiment suggests that care use is highly dependent on the amount of cost sharing, so patients gaining Medicaid who have no copayments may use a high number of services, whereas patients enrolling in high-deductible health plans through the Affordable Care Act Marketplaces may decrease their use of services.[61] Low-income patients with high-deductible health plans may initially avoid the ED because of deductibles but may present later as a sicker population after self-rationing of their care.[47] Conversely, they may also have high unmet health needs similar to those enrolling in Medicaid if they were uninsured previously, leading to frequent ED visits after enrollment.[48]

Oregon and Wisconsin both experienced large increases in ED visits after expanding Medicaid,[33,34] whereas Massachusetts's expansion of private insurance with a more modest Medicaid expansion appears to have had a much smaller absolute effect on ED visits.[19] However, Massachusetts Medicaid enrollees who were uninsured before enrollment increased their ED visits.[24] Thus, the overall declining ED visit rates in Massachusetts may reflect their lower-than-average uninsured rates before health care reform and may not hold true nationwide.

Another consideration is whether the shift toward Medicaid Managed Care will change patient behavior and ED outcomes. More Medicaid patients are shifting to managed care plans from traditional fee-for-service plans, but Medicaid Managed Care is implemented differently in each state[62] and is likely to have a mixed effect on emergency care, depending on how it is implemented. Although Oregon initially reported increased ED visits after Medicaid expansion,[33] updates show a 21% decrease in ED visits for Medicaid patients enrolled in Oregon's particular brand of managed care.[63] It is not yet known whether other states' versions of managed care will have similar or opposite effects on ED utilization.

Medicaid reimburses much less than private insurance but more than the average self-pay patient.[49] As long as the majority of people gaining Medicaid were previously uninsured, total ED reimbursement should increase. If patients gaining Medicaid do make more low-acuity visits as experienced in Oregon and Wisconsin, however, those visits will be as profitable as commercial low-acuity visits.[33,34,51] It is yet to be determined whether coverage through the Marketplace with private insurance, traditionally the highest payer for ED services, will have similar reimbursement to standard employer-based private insurance products. It is also possible that crowd-out of some patients from private insurance to Medicaid will occur as well. In fact, some companies such as Walmart, Target, and Home Depot that previously offered private insurance plans chose to discontinue their plans and allow their employees to choose Medicaid or Marketplace plans instead.[64] HCA has reported that 56% of their patients insured by Marketplace plans in 2014 were previously insured versus 44% converting from uninsured to Marketplace.[48] However, the percentage of previously insured individuals converting to Marketplace plans from Medicaid versus employer-sponsored plans was not reported and will be most relevant to whether reimbursement for their care will increase or decrease. These reimbursement trends need to be monitored by providers of emergency care.

High-deductible health plans could make a patient's first few ED visits effectively self-pay if patients have no yet met their deductible. Emergency physicians are therefore concerned that these changes will not be reimbursed. In 2014, only 33.7% of HCA patients with Marketplace plans made any payment on their bills, and payments averaged only $390 for those who paid, but this is still more than the 10.4% of uninsured patients who made any payment.[48] In addition to being high deductible, many Marketplace plans also offer limited networks, which could similarly decrease providers' reimbursement if they are out of network. Some providers have found themselves in a different network than the hospital where they are contracted. These changes could require a more robust mechanism on the part of emergency physician groups to procure compensation from patients seeking care before satisfying their deductibles, which will increase the administrative burden and costs for the ED.

However, in accordance with the literature the newly insured patients should bring an overall desirable reimbursement mix.[49,50] If this proves true, emergency physician groups may want to actively recruit them. Potential mechanisms could include efforts to improve wait times and the overall patient experience[65] and to direct outreach to in-network patients.

For emergency physicians trying to determine their role in the changing face of health care, research will be required to monitor how the Affordable Care Act is actually implemented and what changes health reform actually brings. Interesting analyses will include the difference between Medicaid expansion and nonexpansion states and between states operating federal versus state Marketplaces. According to the drastic change in estimates from Oregon between actual ED claims data and patient-reported data,[33] large administrative data sets will likely yield more accurate information about use, acuity, and reimbursement, whereas patient-centered survey methods will be useful to determine the motivations behind observed behavioral

changes. Other Affordable Care Act reforms such as bundled payments, mental health parity, and Accountable Care Organizations may have significant effects on EDs, but data are currently lacking on their influence. Many other payment and care delivery models have been funded by the Affordable Care Act and are currently being demonstrated across the country, but it remains to be seen whether and how each of these distinct models will affect emergency care.

*The authors acknowledge Seth Trueger, MD, MPH, and Brandon Maughan, MD, for their assistance preparing the article.*

*Supervising editor:* Daniel A. Handel, MD, MBA

*Author affiliations:* From the Department of Emergency Medicine, University of Pennsylvania Perelman School of Medicine, and the Robert Wood Johnson Foundation, Philadelphia, PA (Medford-Davis); the Section of Emergency Medicine (Dark), Baylor College of Medicine (Eswaran, Shah), Houston, TX; and the Harris Health System, Houston, TX (Dark).

*Funding and support:* By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The authors have stated that no such relationships exist.

*Publication dates:* Received for publication November 26, 2014. Revision received March 22, 2015. Accepted for publication April 2, 2015.

## REFERENCES

1. PricewaterhouseCoopers Health Research Institute. The price of excess: identifying waste in healthcare spending. 2008. Available at: http://www.pwc.com/us/en/healthcare/publications/the-price-of-excess.jhtml. Accessed February 3, 2015.
2. CDC NCHS. *National Hospital Ambulatory Medical Care Survey: 2010 Emergency Department Summary*; 2010. http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2010_ed_web_tables.pdf. Accessed October 1, 2014.
3. Henry J. Kaiser Family Foundation. Hospital emergency room visits per 1,000 population. Available at: http://kff.org/other/state-indicator/emergency-room-visits/#notes. Accessed October 1, 2014.
4. Pitts SR, Carrier ER, Rich EC, et al. Where Americans get acute care: increasingly, it's not at their doctor's office. *Health Aff (Millwood)*. 2010;29:1620-1629.
5. American Hospital Association. Trendwatch Chartbook 2013. 2013. Appendix 1, Table 3.3. Available at: http://www.aha.org/research/reports/tw/chartbook/index.shtml. Accessed October 1, 2014.
6. Gardner A, Schneider SM; Future of Emergency Medicine Summit II Participants. The future of emergency medicine: update 2011. *Ann Emerg Med*. 2013;61:624-630.
7. McClelland M, Asplin B, Epstein SK, et al. The Affordable Care Act and emergency care. *Am J Public Health*. 2014;104:e8-e10.
8. ACEP. 2014 ACEP polling survey results. April 2014; 1–20. Available at: http://newsroom.acep.org/ACEP-Emergency-Visits-Up-Since-Implementation-of-ACA. Accessed October 1, 2014.
9. Simon RM. Hard data contradicts ACEP survey of emergency physicians. *Future of Healthcare, MEP News*. 2014; 2014. Available at: http://www.mephealth.com/the-shift/the-shift/future-of-healthcare/national-narrative-er-volumes-likely-wrong/. Accessed November 20, 2014.
10. US House of Representatives Committee on Ways and Means. Hearing on the president's fiscal year 2012 budget proposal with US Department of Health and Human Services Secretary Kathleen Sebelius. Available at: http://waysandmeans.house.gov/news/documentsingle.aspx?DocumentID=230472. Accessed October 11, 2014.
11. ACEP. More than two-thirds of emergency physicians expect ER visits to increase despite national health care reform. May 17, 2010. Available at: http://www.acep.org/content.aspx?id=48442. Accessed October 1, 2014.
12. O'Malley AS. After-hours access to primary care practices linked with lower emergency department use and less unmet medical need. *Health Aff (Millwood)*. 2013;32:175-183.
13. Rhodes KV, Kenney GM, Friedman AB, et al. Primary care access for new patients on the eve of health care reform. *JAMA Intern Med*. 2014;174:861-869.
14. Henry J. Kaiser Family Foundation. *Massachusetts Health Care Reform: Six Years Later*. Menlo Park, CA: 2012. 8311. Available at: http://kff.org/health-costs/issue-brief/massachusetts-health-care-reform-six-years-later/. Accessed November 20, 2014.
15. Mortensen K. Access to primary and specialty care and emergency department utilization of Medicaid enrollees needing specialty care. *J Health Care Poor Underserved*. 2014;25:801-813.
16. Cheung PT, Wiler JL, Ginde AA. Changes in barriers to primary care and emergency department utilization. *Arch Intern Med*. 2011;171:1397-1399.
17. Rust G, Ye J, Baltrus P, et al. Practical barriers to timely primary care access: impact on adult use of emergency department services. *Arch Intern Med*. 2008;168:1705-1710.
18. Chua KP, Sommers BD. Changes in health and medical spending among young adults under health reform. *JAMA*. 2014;311:2437-2439.
19. Miller S. The effect of the Massachusetts reform on health care utilization. *Inquiry*. 2012;49:317-326.
20. Colorado Hospital Association, Center for Health Information and Data Analytics. Impact of Medicaid expansion on hospitals: updated for second-quarter 2014. September 2014. Available at: http://www.cha.com/Documents/CHA-Study/FINAL-CHA-Medicaid-Expansion-Study-Q2-Sept-2014.aspx. Accessed October 12, 2014.
21. Ginde AA, Lowe RA, Wiler JL. Health insurance status change and emergency department use among US adults. *Arch Intern Med*. 2012;172:642-647.
22. Lau JS, Adams SH, Boscardin WJ, et al. Young adults' health care utilization and expenditures prior to the Affordable Care Act. *J Adolesc Health*. 2014;54:663-671.
23. Lo N, Roby DH, Padilla J, et al. *Increased Service Use Following Medicaid Expansion Is Mostly Temporary: Evidence From California's Low Income Health Program*. Los Angeles, CA: UCLA Center for Health Policy Research; 2014.
24. Lee J, Ding R, Zeger SL, et al. Impact of subsidized health insurance coverage on emergency department utilization by low-income adults in Massachusetts. *Med Care*. 2015;53:38-44.
25. Bradley CJ, Gandhi SO, Neumark D, et al. Lessons for coverage expansion: a Virginia primary care program for the uninsured reduced utilization and cut costs. *Health Aff (Millwood)*. 2012;31:350-359.
26. Long SK, Stockley K, Dahlen H. Massachusetts health reforms: uninsurance remains low, self-reported health status improves as state prepares to tackle costs. *Health Aff (Millwood)*. 2012;31:444-451.
27. Miller S. The effect of insurance on emergency room visits: an analysis of the 2006 Massachusetts health reform. *J Public Econ*. 2012;96:893-908.
28. Chen C, Scheffler G, Chandra A. Massachusetts' health care reform and emergency department utilization. *N Engl J Med*. 2011;365:e25.

29. Smulowitz PB, O'Malley J, Yang X, et al. Increased use of the emergency department after health care reform in Massachusetts. *Ann Emerg Med*. 2014;64:107-115, 115.e101-103.
30. Baker LC, Hsia RY. The association between community-level insurance coverage and emergency department use. *Med Care*. 2014;52:535-540.
31. Baicker K, Finkelstein A. The effects of Medicaid coverage—learning from the Oregon experiment. *N Engl J Med*. 2011;365:683-685.
32. Finkelstein A, Taubman S, Wright B, et al. The Oregon health insurance experiment: evidence from the first year. *Q J Econ*. 2012;127:1057-1106.
33. Taubman SL, Allen HL, Wright BJ, et al. Medicaid increases emergency-department use: evidence from Oregon's Health Insurance Experiment. *Science*. 2014;343:263-268.
34. DeLeire T, Dague L, Leininger L, et al. Wisconsin experience indicates that expanding public insurance to low-income childless adults has health care impacts. *Health Aff (Millwood)*. 2013;32:1037-1045.
35. Heavrin BS, Fu R, Han JH, et al. An evaluation of statewide emergency department utilization following Tennessee Medicaid disenrollment. *Acad Emerg Med*. 2011;18:1121-1128.
36. Ndumele CD, Mor V, Allen S, et al. Effect of expansions in state Medicaid eligibility on access to care and the use of emergency department services for adult Medicaid enrollees. *JAMA Intern Med*. 2014;174:920-926.
37. Anderson M, Dobkin C, Gross T. The effect of health insurance coverage on the use of medical services. *AEJ Policy Volume*. 2012;4:1-27.
38. Hernandez-Boussard T, Burns CS, Wang NE, et al. The Affordable Care Act reduces emergency department use by young adults: evidence from three states. *Health Aff (Millwood)*. 2014;33:1648-1654.
39. Antwi YA, Moriya AS, Simon K, et al. Changes in emergency department use among young adults after the Patient Protection and Affordable Care Act's dependent coverage provision. *Ann Emerg Med*. 2015;65:664-672.
40. Abraham JM. How might the Affordable Care Act's coverage expansion provisions influence demand for medical care? *Milbank Q*. 2014;92:63-87.
41. Commonwealth Fund. The rise in health care coverage and affordability since health reform took effect. January 2015. Available at: http://www.commonwealthfund.org/publications/issue-briefs/2015/jan/biennial-health-insurance-survey. Accessed February 8, 2015.
42. Sommers BD, Baicker K, Epstein AM. Mortality and access to care among adults after state Medicaid expansions. *N Engl J Med*. 2012;367:1025-1034.
43. Sommers BD, Long SK, Baicker K. Changes in mortality after Massachusetts health care reform: a quasi-experimental study. *Ann Intern Med*. 2014;160:585-593.
44. Gandhi SO, Grant LP, Sabik LM. Trends in nonemergent use of emergency departments by health insurance status. *Med Care Res Rev*. 2014;71:496-521.
45. Frost P. Cook County releases 1st snapshot of new Medicaid patients. *Chicago Tribune*. 2014. Available at: http://articles.chicagotribune.com/2014-06-02/business/ct-medicaid-illinois-snapshot-0602-biz-20140602_1_cook-county-health-countycare-health-law. Accessed November 2, 2014.
46. Department of Health and Human Services. *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period*. Washington, DC: 2014. Available at: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf. Accessed October 1, 2014.
47. Wharam JF, Zhang F, Landon BE, et al. Low-socioeconomic-status enrollees in high-deductible plans reduced high-severity emergency care. *Health Aff (Millwood)*. 2013;32:1398-1406.
48. Hospital Corporation of America Reporting, Benchmarking & Analytics. Analysis of HCA data relevant to aspects of the Affordable Care Act. January 2015. Available at: http://hcahealthcare.com/util/documents/hca-data-aca.pdf. Accessed February 7, 2015.
49. Wilson M, Cutler D. Emergency department profits are likely to continue as the Affordable Care Act expands coverage. *Health Aff (Millwood)*. 2014;33:792-799.
50. Galarraga JE, Pines JM. Anticipated changes in reimbursements for US outpatient emergency department encounters after health reform. *Ann Emerg Med*. 2014;63:412-417.e412.
51. Henneman PL, Nathanson BH, Li H, et al. Is outpatient emergency department care profitable? hourly contribution margins by insurance for patients discharged from an emergency department. *Ann Emerg Med*. 2014;63:404-411.e401.
52. Mulcahy A, Harris K, Finegold K, et al. Insurance coverage of emergency care for young adults under health reform. *N Engl J Med*. 2013;368:2105-2112.
53. Kardish C. Uncompensated care dropping fast in Medicaid expansion states. *Governing*. 2014. Available at: http://www.governing.com/topics/health-human-services/gov-uncompensated-care-dropping-fast.html. Accessed October 1, 2014.
54. Colorado Hospital Association, Center for Health Information and Data Analytics. Impact of Medicaid expansion on hospital volumes. June 2014. Available at: http://www.cha.com/Documents/Press-Releases/CHA-Medicaid-Expansion-Study-June-2014.aspx. Accessed October 12, 2014.
55. Neuhausen K, Davis AC, Needleman J, et al. Disproportionate-share hospital payment reductions may threaten the financial stability of safety-net hospitals. *Health Aff (Millwood)*. 2014;33:988-996.
56. Centers for Medicare & Medicaid Services. Fact sheets: Medicaid state Disproportionate Share Hospital allotment reductions final rule. 2013. Available at: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2013-Fact-sheets-items/2013-09-13.html. Accessed February 7, 2015.
57. Graves JA. Medicaid expansion opt-outs and uncompensated care. *N Engl J Med*. 2012;367:2365-2367.
58. The Advisory Board Company. Where the states stand on Medicaid expansion. 2015. Available at: http://www.advisory.com/daily-briefing/resources/primers/medicaidmap. Accessed February 6, 2015.
59. Henry J. Kaiser Family Foundation. How will the uninsured fare under the Affordable Care Act? April 7, 2014. Available at: http://kff.org/health-reform/fact-sheet/how-will-the-uninsured-fare-under-the-affordable-care-act/. Accessed October 4, 2014.
60. Insurance coverage provisions of the Affordable Care Act—CBO's April 2014 baseline. 2014. 43900. Available at: http://www.cbo.gov/publication/43900. Accessed October 12, 2014.
61. Brook RH, Ware JE, Rogers WH, et al. The effect of coinsurance on the health of adults: results from the RAND Health Insurance Experiment. *Reports*. 1984:1-123. Available at: http://www.rand.org/pubs/reports/R3055.html. Accessed October 1, 2014.
62. Sparer M. Medicaid managed care: costs, access, and quality of care. *Robert Wood Johnson Foundation Research Synthesis Report*. September 2012.
63. Oregon Health Authority. Mid-year health system transformation report shows continued progress into 2014 [press release]. January 14, 2015.
64. Banjo S, Wilde Mathews A, Francis T. Wal-Mart to end health insurance for some part-time employees. *Wall Street Journal*. October 7, 2014. Available at: http://online.wsj.com/articles/wal-mart-to-end-health-insurance-for-some-part-time-employees-1412694790. Accessed November 1, 2014.
65. Becker NV, Friedman AB. ED, heal thyself. *Am J Emerg Med*. 2014;32:175-177.

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

June 23, 2016

TO: Emergency Medical Services / Trauma Committee

SUBJECT: APOT Update

**Objective**
To inform the CHA EMS/T Committee members on the work of the statewide task force developing APOT guidelines in response to SB 1223. Jan Remm, RVP from the Hospital Association of Southern California will present a summary and update. Attached are the summary and two draft APOT core measures.

**Background**
Ambulance Patient Offload Delays have been a high priority for CHA members for several years. The CHA EMS/T Committee co-led a collaborative with EMSA and developed the Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department. http://www.calhospital.org/wall-time-toolkit. Last year AB 1223 was passed requiring EMSA and respective LEMSA's to develop APOT standard methodology. Ms. Remm has been the hospital representative on the collaborative workgroup defining the metrics. Attached are the summary and two core measures.

**Conclusion**
Informational Only

BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing & Clinical Services

HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA

**H • A • S • C**
Inland Area Office
3993 Jurupa Avenue, Suite 105
Riverside, CA 92506-2229
(951) 222-2284

**Jan Remm,** *Vice President*

**Key Points: AB 1223 Task Force**

- AB 1223 was passed in 2015 and took effect in 2016. This bill mandates the State EMSA to develop standard methodology for calculation of, and reporting by a local EMS agency of ambulance patient offload time. It also allows for local EMS agencies to adopt these policies and procedures for calculating APOT.
- The EMSA has developed a stakeholder group to develop these standardized reporting methodologies.
- Initially, the conversations were geared to establish a statewide standard offload time. This was stopped because that is not what AB 1223 calls for. However, the LEMSAs on the call are sharing that in their circles, some LEMSAs may use the reporting methodology to define "non-standard" as anything outside of the standard reporting methodology time known as APOT 1.
- There are two measures:
    - APOT 1 – is compliance at the 90$^{th}$ percentile for an Ambulance Patient Offload Time at the Hospital Emergency Department.
    - APOT 2 – non-standard time: reporting of offload times at intervals of 60 minutes, 120 minutes, and 180 minutes at the Hospital Emergency Department.
- The other stakeholders on the call have made it known that the goal would be to utilize the data to study areas where there is exceptionally good practices at work as well are to drive improvements in underperforming areas. There may also be a push to utilize the data to drive fines at some point.
- There are also discussions about the need to validate data at the local level. This will be important to ensure that data is accurate. We all need to be poised to study and validate the data locally and urge LEMSA Directors to validate with hospitals in a side by side comparison, rig by rig, patient by patient analysis.
    - There remains question about how the data will be collected. In some areas it may be electronic through CAD data, electronic medical records data, or use of First Watch. In other areas it may be manually collected. The important aspect to agree upon locally is how the data will be collected. I encourage everyone to engage with their LEMSA to begin dialogue about how this will occur in each area.
- The APOT data will be publically reported on the State EMSA site.
- There was a robust discussion about how data will be graphically depicted at the last stakeholder meeting. Reports will likely look similar to reports already produced by some LEMSAs. There was agreement regarding some examples of reports already in place.

# AMBULANCE PATIENT OFFLOAD TIME

| | | |
|---|---|---|
| **MEASURE SET** | Ambulance Patient Offload Time | |
| **SET MEASURE ID #** | APOT-1 | |
| **PERFORMANCE MEASURE NAME** | Ambulance Patient Offload Time for Emergency Patients | |
| **Description** | What is the 90th percentile for on Ambulance Patient Offload Time at the Hospital Emergency Department? | |
| **Type of Measure** | Process | |
| **Reporting Value and Units** | Time (Minutes and Seconds) | |
| **Continuous Variable Statement (Population)** | Time (in minutes) from time ambulance arrives at the hospital until the patient is transferred to hospital emergency department care. | |
| **Inclusion Criteria** | **Criteria** | **Data Elements** |
| | • All events for which eResponse.05 "type of service requested" has value 2205001 "911 response (Scene),";<br>• All events in eDisposition.21 was Transport to Hospital-Emergency Department was made and has value of 4221003;<br>• eTimes.11 "Patient Arrived at Destination Date/Time" values are logical and present<br><br>AND<br><br>• All events for which eResponse.05 "type of service requested" has value 2205001 "911 response (Scene),";<br>• eTimes.11 "Patient Arrived at Destination Date/Time" values are logical and present | • Type of Service Requested (eResponse.05)<br>• Type of Destination (eDisposition.21)<br>• Patient Arrived at Destination Date/Time (eTimes.11)<br>• Destination Patient Transfer of Care Date/Time (eTimes.12) |
| **Exclusion Criteria** | **Criteria** | **Data Elements** |
| | None | |
| **Indicator Formula Numeric Expression** | The formula is the 90th Percentile of the given numbers or distribution in their ascending order. | |
| **Example of Final Reporting Value (number and units)** | 19 minutes, 34 seconds (19:34) | |

| | |
|---|---|
| **Sampling** | No |
| **Aggregation** | Yes |
| **Minimum Data Values** | Not Applicable |
| **Data Collection Approach** | ☐ Retrospective data sources for required data elements include administrative data and pre-hospital care records.<br>☐ Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency. |
| **Suggested Display Format & Frequency** | Process control or run chart by month |
| **Suggested Statistical Measures** | 90th Percentile Measurement. Aggregate measure of central tendency and quantile (fractile) measurement to determine the span of frequency distributions. |
| **Trending Analysis** | Yes |
| **Benchmark Analysis** | (TBD) |
| **Reporting Notes** | Report aggregate values by:<br><br>1) LEMSA (using total denominator),<br>2) Broken out by individual hospital<br><br>Report the 90 percentile time calculated and the denominator (number of transports)<br><br>Report Quarterly, within 2 months of the end of the quarter:<br>• June 1 for period of January 1 through March 31;<br>• September 1 for period of April 1 through June 30;<br>• December 1 for period of July 1 through September 30;<br>• March 1 for period of October 1 through December 31<br>Statute allows the LEMSA to set their standard target time; however, the workgroup recommends a target time of 20 minutes, which EMSA will use for the data display. |

# AMBULANCE PATIENT OFFLOAD TIME—EXTENDED DELAY

| | | |
|---|---|---|
| **MEASURE SET** | Extended Ambulance Patient Offload Time | |
| **SET MEASURE ID #** | APOT-2 | |
| **PERFORMANCE MEASURE NAME** | Duration of Ambulance Patient Offload Time for Emergency Patients | |
| **Description** | 2.1: What percentage of patients transported by EMS personnel experience a transfer between 20-60 minutes of arrival at the Hospital Emergency Department?<br><br>2.2: What percentage of patients transported by EMS personnel experience a transfer of care between 61-120 minutes after arrival at the Hospital Emergency Department?<br><br>2.3: What percentage of patients transported by EMS personnel experience a transfer of care between 121-180 minutes after arrival at the Hospital Emergency Department?<br><br>2.4: What percent of patients transported by EMS personnel experience a transfer of care more than 180 minutes after arrival in the Hospital Emergency Department. | |
| **Type of Measure** | | |
| **Reporting Value and Units** | (%) Percentage | |
| **Denominator Statement (population)** | Number of patients who were transported to a hospital emergency department by EMS Personnel. | |
| **Denominator Inclusion Criteria** | **Criteria** | **Data Elements** |
| | • All events for which eResponse.05 “type of service requested” has value 2205001 “911 response (Scene),”;<br>• All events in eDisposition.21 was Transport to Hospital-Emergency Department was made and has value of 4221003;<br>• eTimes.11 “Patient Arrived at Destination Date/Time” values are logical and present | • Type of Service Requested (eResponse.05)<br>• Type of Destination (eDisposition.21)<br>• Patient Arrived at Destination Date/Time (eTimes.11) |
| **Exclusion Criteria** | **Criteria** | **Data Elements** |
| | None | |

| | | |
|---|---|---|
| **Numerator Statement (sub-population)** | 2.1: Number of patients who were transported to a hospital emergency department by EMS Personnel and had their care transferred within 60 minutes after their arrival to the Emergency Department.<br><br>2.2: Number of patients who were transported to a hospital emergency department by EMS Personnel and had their care transferred 61-120 minutes after their arrival to the Emergency Department.<br><br>2.3: Number of patients who were transported to a hospital emergency department by EMS Personnel and had their care transferred 121-180 minutes after their arrival to the Emergency Department.<br><br>2.4: What percent of patients transported by EMS personnel experience a transfer of care more than 180 minutes after arrival in the Hospital Emergency Department. | |
| **Numerator Inclusion Criteria** | **Criteria** | **Data Elements** |
| | • All events for which eResponse.05 "type of service requested" has value 2205001 "911 response (Scene),";<br>• All events in eDisposition.21 was Transport to Hospital-Emergency Department was made and has value of 4221003;<br>• eTimes.11 "Patient Arrived at Destination Date/Time" values are logical and present<br><br>AND<br><br>• eTimes.12 "Destination Patient Transfer of Care Date/Time" values are logical and present<br><br>Transferred to hospital care must include:<br><br>• Hospital Emergency Department Triage completed<br>• Patient is moved from the Pre-hospital EMS equipment to the hospital Emergency Department Equipment. | • Type of Service Requested (eResponse.05)<br>• Type of Destination (eDisposition.21)<br>• Patient Arrived at Destination Date/Time (eTimes.11)<br>• Destination Patient Transfer of Care Date/Time (eTimes.12) |
| **Exclusion Criteria** | **Criteria** | **Data Elements** |
| | None | |

| | | |
|---|---|---|
| **Indicator Formula Numeric Expression** | The formula is to divide (/) the numerator (N) by the denominator (D) and then multiply (x) by 100 to obtain the (%) value the indicator is to report. Therefore the indicator expressed numerically is N/D =% | |
| **Example of Final Reporting Value (number and units)** | 15% | |
| **Sampling** | No | |
| **Aggregation** | Yes | |
| **Minimum Data Values** | Not Applicable | |
| **Data Collection Approach** | • Retrospective data sources for required data elements include administrative data and pre-hospital care records.<br>• Variation may exist in the assignment of coding; therefore, coding practices may require evaluation to ensure consistency. | |
| **Suggested Display Format &Frequency** | Process control or run chart by month | |
| **Suggested Statistical Measures** | Mean (x); Mode (m) | |
| **Trending Analysis** | Yes | |
| **Reporting Notes** | Report aggregate values by:<br>1) LEMSA (using total denominator),<br>2) Broken out by individual hospital<br><br>Report the % calculated and the denominator used to calculate (number of runs)<br><br>Report Quarterly, within 2 months of the end of the quarter:<br>• June 1 for period of January 1 through March 31;<br>• September 1 for period of April 1 through June 30;<br>• December 1 for period of July 1 through September 30;<br>• March 1 for period of October 1 through December 31 | |

# Why patients still need EMTALA

By Harris Meyer | March 26, 2016

In September 2012, a man arrived in the emergency department at Bon Secours St. Francis Health System in Greenville, S.C., after being shot in the leg during a robbery. A few months later, in February 2013, another man came to the same St. Francis ED after being shot in the abdomen at a club. In both cases, the hospital didn't provide stabilizing treatment because the on-call specialist declined to come in and evaluate the patients. It transferred the patients to another hospital.

This past December, Bon Secours St. Francis agreed to pay a $100,000 civil penalty to settle allegations that it violated the federal Emergency Medical Treatment and Active Labor Act (EMTALA) by improperly transferring the two gunshot victims, even though it had the capacity to treat them. The benefits of the transfer did not outweigh the risks and unnecessarily placed their health at further risk, according to HHS' Office of Inspector General.

Spurred by the federal investigation, the hospital's administrators, physicians and staff launched an initiative to improve the ED's trauma processes and internal communication. Everyone was instructed on hospital and physician responsibilities under EMTALA. The hospital formed a multidisciplinary trauma committee to regularly review emergency and transfer cases, improve processes for treating patients quickly, and strengthen collaboration between ED staff and specialty surgeons.

**Key provisions of EMTALA**

**Hospitals must:**

**Screen any individual** who shows up in the emergency room to identify any medical condition, including active labor, requiring immediate treatment, regardless of ability to pay

**Provide stabilizing treatment** to the full extent of the hospital's capabilities

**Provide an appropriate transfer** to another hospital if it cannot stabilize the patient after securing acceptance from a receiving hospital

**Accept appropriate transfers** from referring hospitals if the receiving hospital has the capability and capacity to treat the patient

**Penalties for hospitals and physicians:**

**Up to a $50,000 civil fine** per incident ($25,000 for hospitals under 100 beds)

**Exclusion from the Medicare and Medicaid** programs

**Potential liability** in civil lawsuits

"Our physicians have taken full ownership of this process and agreed that when a physician is on call, they call back to the ED within 15 minutes and they have boots on the ground at the patient's bedside within an hour," said Dr. Saria Saccocio, the hospital's chief medical officer.

All of that happened because of a law signed 30 years ago by President Ronald Reagan. Congress passed EMTALA, known as the patient anti-dumping law, in response to national outrage over a surge in community hospitals transferring unstable emergency patients—including women in labor—to public hospitals and academic medical hospitals, largely for financial reasons.

It was the first federal legislation establishing an affirmative right to healthcare, albeit a limited one.

Experts say the law remains essential in ensuring that people receive basic treatment for emergencies, since tens of millions of Americans remain uninsured or underinsured despite the coverage expansions under theAffordable Care Act.

EMTALA requires Medicare-participating hospitals to screen patients for emergency medical conditions and provide stabilizing treatment, regardless of their ability to pay. Hospitals with specialized capabilities must accept appropriate transfers to provide stabilizing treatment. The law does not require providers to continue treating patients once they are stable, nor does it generally apply after someone is admitted as an inpatient.

Hospitals found in violation of the law potentially face a $50,000 civil fine per incident, and can be barred from the Medicare and Medicaid programs. The law also gives dumped patients or their families the right to sue the provider.

**MH TAKEAWAYS**The unfunded mandate signed into law by President Ronald Reagan sharply reduced cases of hospitals refusing to treat ED patients without insurance. Experts blame poor communication and inadequate training for most of the remaining incidents.

EMTALA—whose basic requirements are posted on the walls of every hospital ED—is widely credited with sharply reducing the number of cases of hospitals dumping or avoiding uninsured or underinsured patients. “It was the first universal healthcare law,” said retired Democratic congressman Pete Stark of California, one of the authors of the bipartisan legislation. “It's done what it was meant to do—making emergency rooms open to everyone without cost.”

“When I started practicing in 1976, I witnessed substantial economic discrimination against patients,” said Dr. Robert Bitterman, an emergency physician and attorney who advises hospitals facing EMTALA investigations. “EMTALA largely changed the very bad behavior that was going on in the 1970s and 1980s. It still happens occasionally, but this isn't common anymore.”

Despite the law's positive impact, there continue to be hundreds of complaints each year about allegedly inappropriate transfers that potentially endanger the lives of patients facing medical emergencies.

About 200 complaints a year are found to have merit. While that represents a tiny fraction of the more than 136 million annual emergency department visits in the U.S., there's broad agreement that the law continues to play an important role.

Sidebar: 'It was ridiculous, putting her and the baby at risk like that'
“If the law went away and there were no penalties, given human nature and financial pressures, the attitude would be, 'Who cares if the patient is unstable, get 'em out of here,' ” said Dr. Mark Langdorf, a professor of clinical emergency medicine at the University of California at Irvine who co-authored a new study on EMTALA enforcement.

The law's failure to finance its mandate is still widely resented by hospital leaders and physicians. “Hospitals are required by law to provide services, regardless of ability to pay,” said Chip Kahn, CEO of the Federation of American Hospitals, who helped draft the law as a staffer for then-Sen. David Durenberger of Minnesota. “But at the end of the day, those services have to be funded.”

Experts say there are a variety of reasons why violations of the law continue to occur. Factors include pressure on hospitals to improve their finances, poor staff training, flawed systems and processes, communication mishaps, growing challenges in getting specialty physicians to be on-call to the ED,

and a lack of inpatient beds and community resources for serving mentally ill patients.

“Part of it is failure to follow policies and procedures, part is lack of education of medical and nursing staff,” Bitterman said. “Some hospitals just want money and are reluctant to change their ways.”

“Hospitals take seriously their EMTALA responsibility and other responsibilities to their patients,” said Tom Nickels, executive vice president of the American Hospital Association. “Unfortunate and isolated cases result from a breakdown in communication. ... There always will be opportunities to improve communications, processes and care.”


The impetus for EMTALA was an epidemic of patient transfers that were widely seen as inappropriate and dangerous for patients, including pregnant women in labor being turned away from emergency rooms. Studies showed that in the early 1980s, there were about 250,000 transfers a year from private hospitals to public or Veterans Health Administration hospitals.

Nearly 90% were for economic reasons, with 24% of these patients unstable at the time of transfer. Their mortality rate was triple that of other patients. In Chicago during the 1980s, 89% of transferred patients were black or Hispanic, according to a study published in the New England Journal of Medicine.

Public anger peaked after CBS' “60 Minutes” in 1985 broadcast tapes of phone conversations between a referring physician at a Dallas-area private hospital and officials at public Parkland Memorial Hospital, which was being asked to accept an unstable female patient. Parkland balked.

“Don't give me all that crap. She does not have any insurance, the hospital does not want to take care of her, OK?” the doctor attempting to make the transfer said. “This is a private, capitalistic, money-making hospital. They're on my back to have her transferred.”

Enforcement, which started slowly, gained momentum after Congress amended the law in 1989 to require facilities with specialized services to accept transfer patients. Over the years, the law became a basic feature of hospital and physician practice.

“EMTALA is completely embedded in the way hospitals operate,” Kahn said. “When a person is

sufficiently in need of care, the first question is, 'What services do we need to provide to make you stable?' Finances are second."

Indeed, Republican politicians who normally oppose government mandates have pointed to EMTALA when downplaying the need for federal health insurance expansion. Long before Obamacare, the law served as a safety net to ensure that people didn't die in the street. "I mean, people have access to healthcare in America," President George W. Bush said in 2007. "After all, you just go to an emergency room."

But EMTALA is no guarantee of appropriate emergency care. From 2002 to 2015, the CMS conducted 6,035 investigations of EMTALA complaints against hospitals and physicians—an average of 431 a year, according to a new study in the Western Journal of Emergency Medicine. The CMS found violations in 2,436 of the complaint cases it surveyed in conjunction with state agencies—an average of 174 a year.

To keep their Medicare certification, hospitals found in violation must submit a corrective plan, which the CMS reviews and approves. The agency then forwards those cases to the OIG for possible civil monetary penalties.

Of the cases referred to the OIG from 2002 to 2015, 192 resulted in settlements, including eight by physicians, according to the study. The most common citations were for failure to screen (75%) and stabilize (42.7%) for emergency conditions. Patients were turned away from hospitals for financial reasons in 15.6% of cases.

David Wright, a CMS deputy regional administrator who has handled EMTALA cases for more than 20 years, said most violations involve hospitals refusing to accept appropriate transfers from facilities that lack the capability to screen and stabilize the patient's emergency condition. "It's either an individual action or it's something driven by resource constraints hospitals face," he said.

Many EMTALA violators do not receive fines and those cases are not publicly reported by the OIG, said Sandra Sands, a senior attorney with the OIG who has been handling EMTALA cases since 1989. "The cases we report on the Internet are among the worst cases, but they aren't the only bad cases," she said. "We don't have the resources to pursue every case."

Settlements in 2014 and 2015 included two cases where the patients died, according to the OIG. A settlement in December by Lake City Medical Center in Florida, an HCA facility, involved a patient who a hospital staffer determined did not need immediate medical attention. Police were called to escort the patient out of the ED even though she had vomited and complained of arm pain. She was taken to another hospital where she was placed on a ventilator in the ICU and diagnosed with bacterial meningitis.

Lake City Medical Center self-reported the case. Corrective action included staff termination, EMTALA education for all ED and registration staff, and training for the hospital's senior managers and nursing supervisors, according to a hospital spokeswoman.

In October 2014, the DCH Medical Center in Tuscaloosa, Ala., paid $40,000 to settle a case involving a gunshot victim, for whom the emergency physician called the on-call general surgeon to help. According to the OIG, the surgeon said he was busy performing previously scheduled elective procedures. No other surgeon was available.

After waiting two hours, the patient died without having received an evaluation or stabilizing treatment. The hospital declined to comment on the case, saying there is pending civil litigation.

A number of cases reported by the OIG involved patients with psychiatric emergencies. Between 2011 and 2014, the OIG reported fining five hospitals for such violations, including a $180,000 settlement in 2012 with Duke University Health System, Durham, N.C., for allegedly failing to accept five transfers of patients with unstable psychiatric emergency conditions.

Dr. Marc Futernick, president of the California chapter of the American College of Emergency Physicians, said lack of EMTALA enforcement in psychiatric emergency cases is a big problem. His ED often holds psychiatric patients for many days because psychiatric units at many Los Angeles-area hospitals conduct financial screening and won't accept patients for stabilization who are uninsured or on Medi-Cal. “You can't send these hospitals a patient without insurance,” he said.

A growing issue in recent years has been the refusal of many physicians to accept emergency on-call duty, particularly in specialties such as trauma surgery, orthopedics, ophthalmology, neurosurgery and hand surgery. Hospitals are required to have appropriate specialists available to screen and stabilize ED patients. But Bitterman said specialists increasingly avoid call panels because many emergency patients are uninsured or underinsured, ED calls disrupt their private practice schedule, and they don't want to be summoned in the middle of the night.

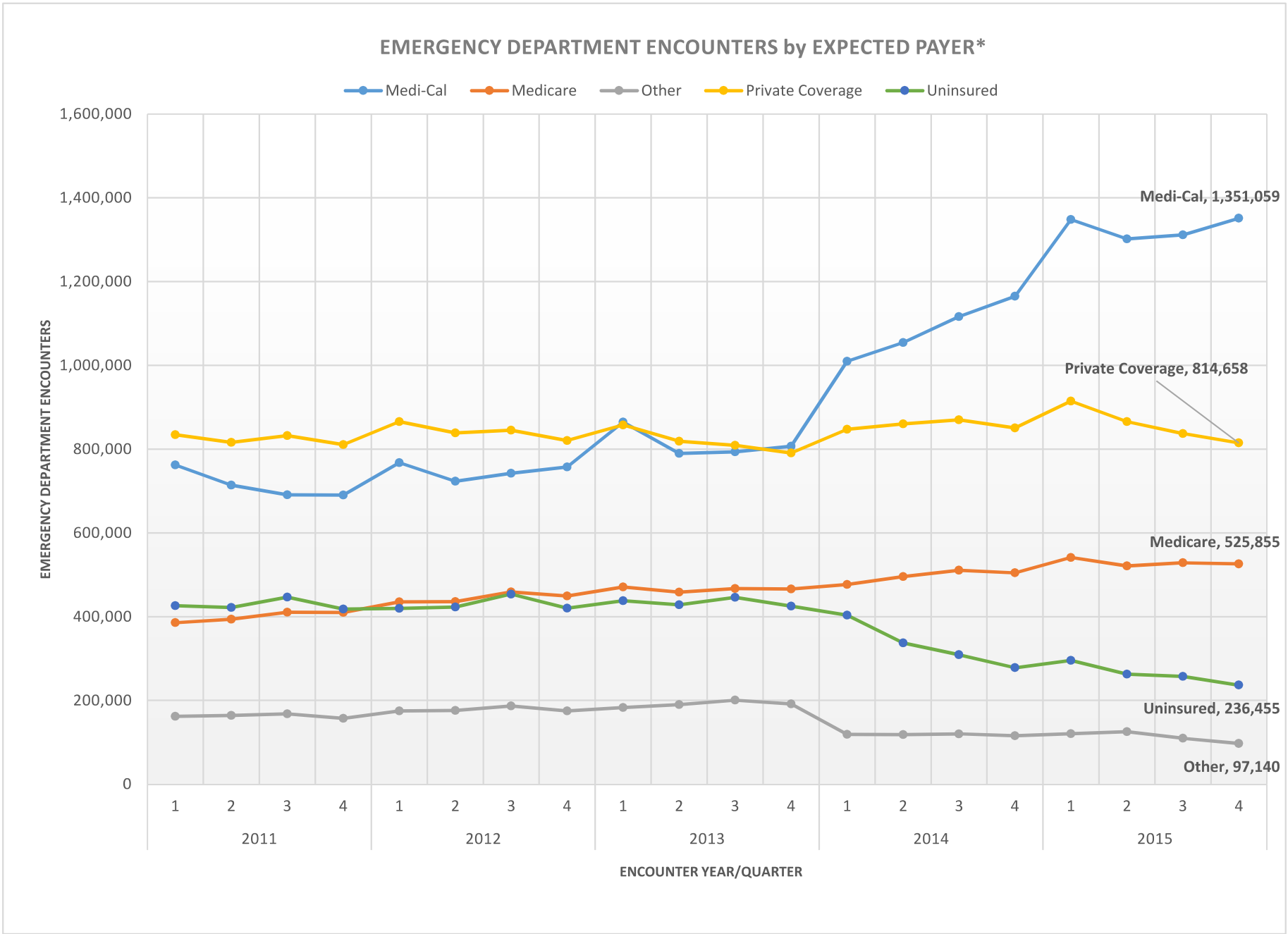
Despite these failures, even critics acknowledge EMTALA has changed hospital and medical culture for the better. A case settled by Santa Rosa (Calif.) Memorial Hospital for $50,000 in December illustrates how the law has heightened awareness and spurred hospitals to correct serious problems in how they handle patients in emergencies.

In September 2011, Santa Rosa, a part of St. Joseph Health System, allegedly failed to respond when notified several times that a homeless man who had just been treated for alcohol withdrawal and discharged was lying on the edge of the hospital parking lot, according to the OIG. The man, identified in news reports as Michael Torres, was later found dead of acute bacterial pneumonia.

The hospital conducted a full review of the case and offered to share the information with Torres' family. In a letter to the community, the hospital's then-CEO, Kevin Klockenga, admitted his organization “did not act as expeditiously as we could have to obtain ambulance assistance.” The hospital subsequently retrained staff to improve policies and processes for getting needed assistance to people in distress on the hospital's grounds, conducted mock drills, and consulted with local social-service agencies to better address the needs of homeless people.

Klockenga wrote to the family to “express our heartfelt sorrow over the death of Mr. Torres and vow to improve our own processes, as well as take a leadership role in improving care for the homeless in our community.”

“People's lives are being saved” by the law, said the OIG's Sands. “When a hospital calls and says, 'I need you to take care of this patient,' hospitals say 'yes' because they realize that otherwise, they would be violating federal law. The statute makes a very big difference every single day.”




Source: Emergency Department Data, 2011-2015
Office of Statewide Health Planning and Development
April, 2016

***Excludes ED patients that were admitted to the hospital**

# California among 10 states with worst emergency response times

**By Tessa Boyce, Graphiq**
**The Mercury News**

Posted:Thu Jun 16 05:51:26 MDT 2016

In a health emergency, timing is crucial. Minutes ticking by can literally mean life or death. Recently, HBO's John Oliver critiqued the lackadaisical 911 response in the U.S., stating, "Ubers can find you better than ambulances can. Depending on where you live, [911 dispatchers] may also be underfunded, understaffed and full of outdated technology - which is fine, if you're describing a Radio Shack."

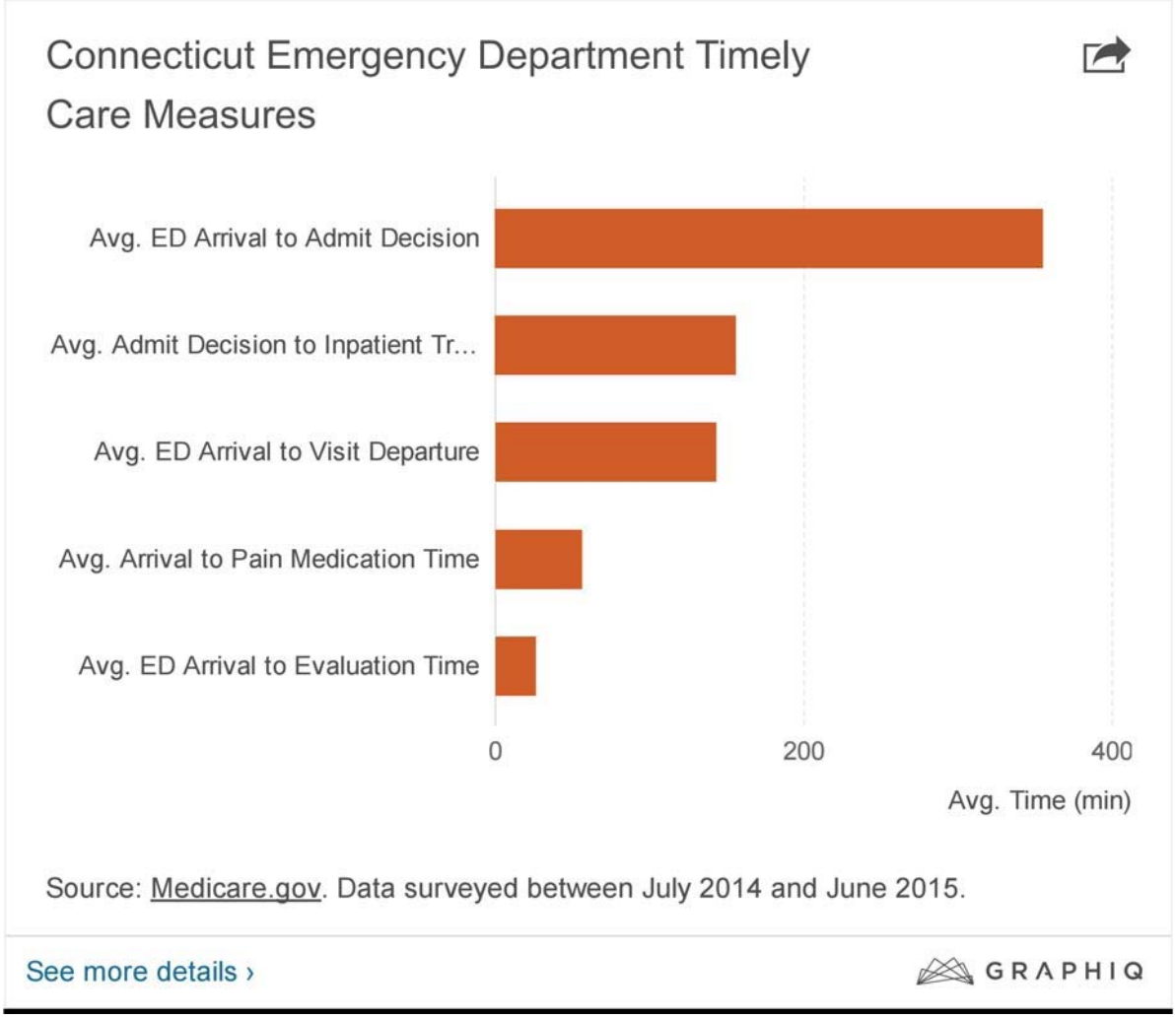
But what happens at the next step, when we arrive at the hospital in an ambulance or on our own? Many people still face a painfully long wait before they are seen by a physician or properly diagnosed. HealthGrove, a health data site that's part of Graphiq, wanted to find out which states have the slowest emergency department response. Using data collected from a Medicare survey of more than 4,000 hospitals, HealthGrove found the 10 states with the slowest emergency response times based their **Timeliness Score**. The Timeliness Score is a comprehensive score out of 100, based on the following metrics:
Patient's total arrival to departure time at the hospital
Average time patient spends in the emergency department before they are seen by a healthcare professional
Average time patient spends in the emergency department, after the doctor decides to admit them as an inpatient, before leaving the emergency department for their inpatient room
Average time patient spends in the emergency department, before they are admitted to the hospital as an inpatient
Average time patients who come to the emergency department with broken bones wait before receiving pain medication
Percentage of patients who leave the ER without being seen
Percentage of patients with stroke symptoms who receive brain scan results within 45 minutes of arrival

The hospital with the patient's longest arrival to departure time is also highlighted in each state. Many hospitals with a slow emergency response are teaching hospitals associated with state universities, but there are a few private hospitals where patients

find themselves spending two to three hours in waiting room purgatory.

While highly populated states like New York or California exhibit long emergency wait times on average, hospitals in small states with dense populations have the slowest response times of all. In one state, patients with broken bones have to wait an average of an hour and ten minutes before receiving pain medication. In an emergency, we cannot be too picky with our hospitals, but in many cases a long wait can aggravate the problem.

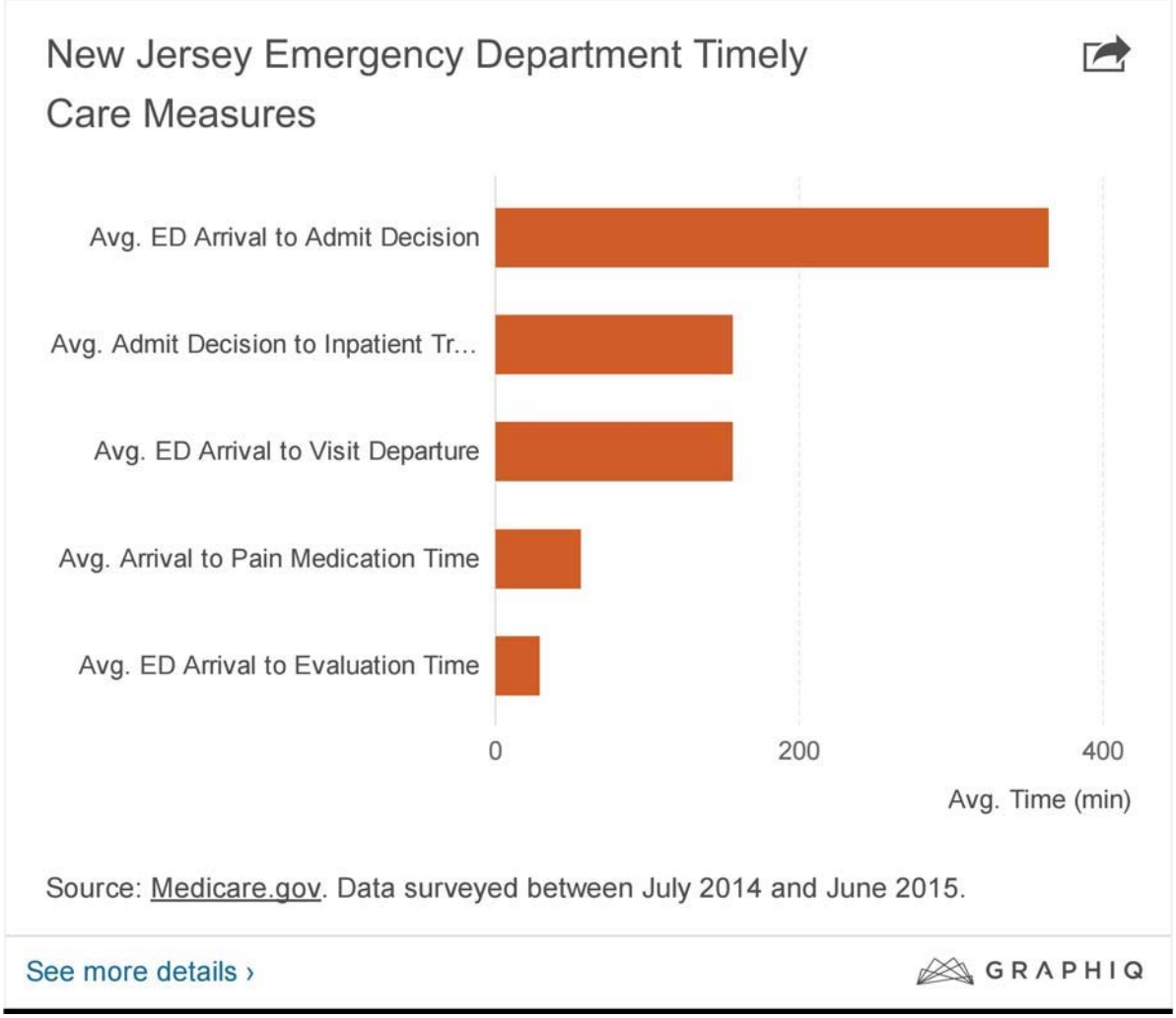
## #10. Connecticut




**Timeliness Score:** 48.06

**Hospital With Slowest Response Time:** Waterbury Hospital

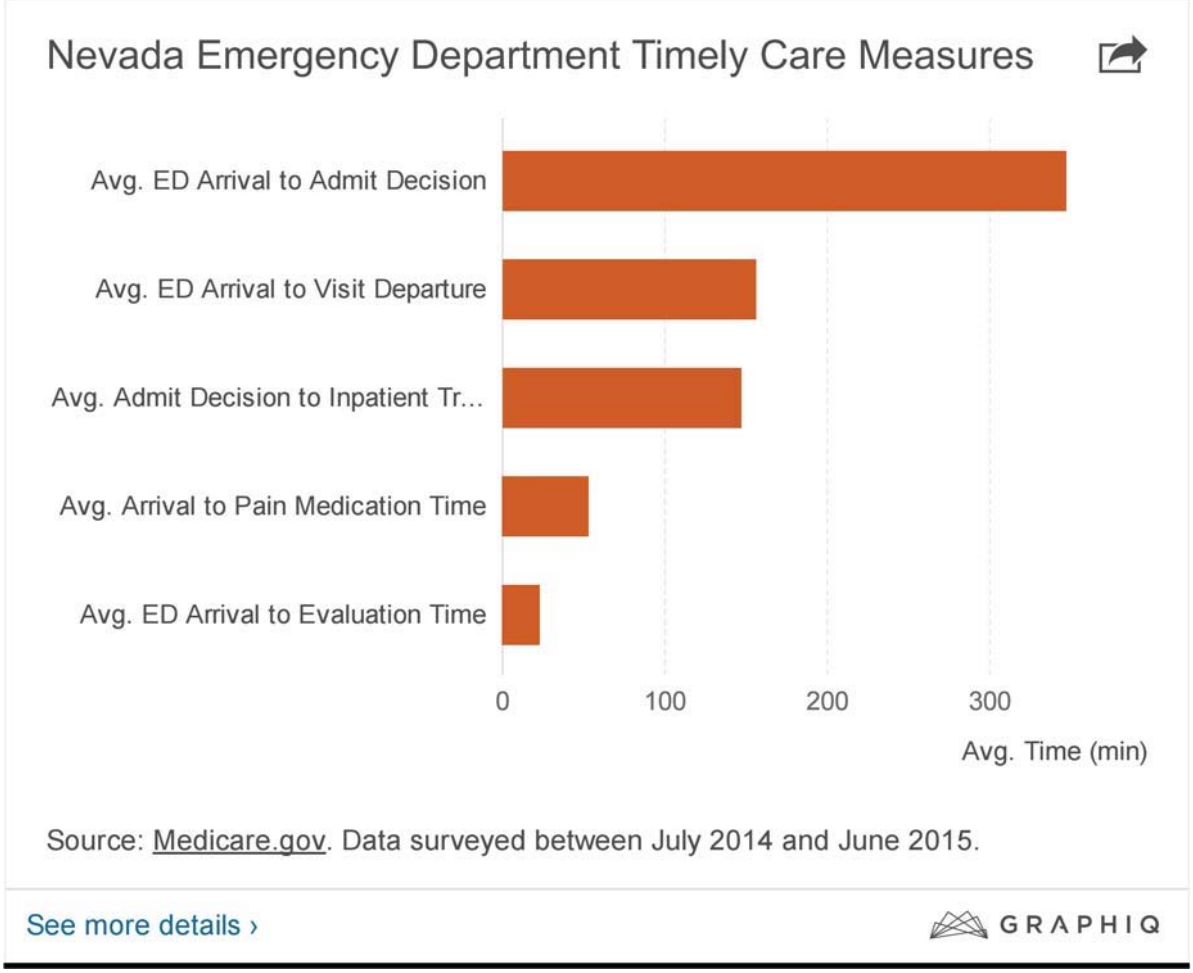
## #9. New Jersey




**Timeliness Score:** 42.92

**Hospital With Slowest Response Time:** University Hospital

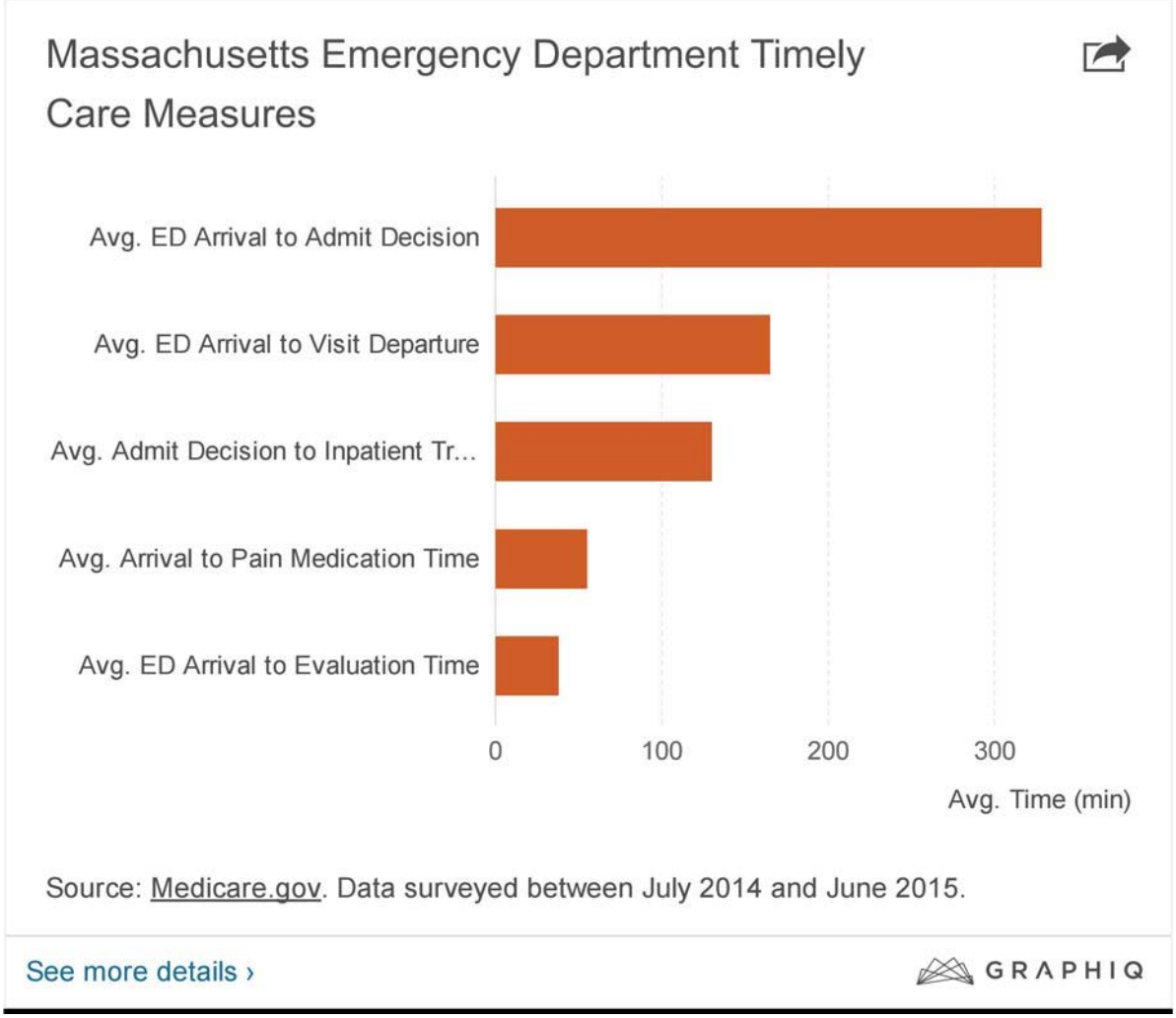
## #8. Nevada




**Timeliness Score:** 42.2

**Hospital With Slowest Response Time:** Spring Valley Hospital

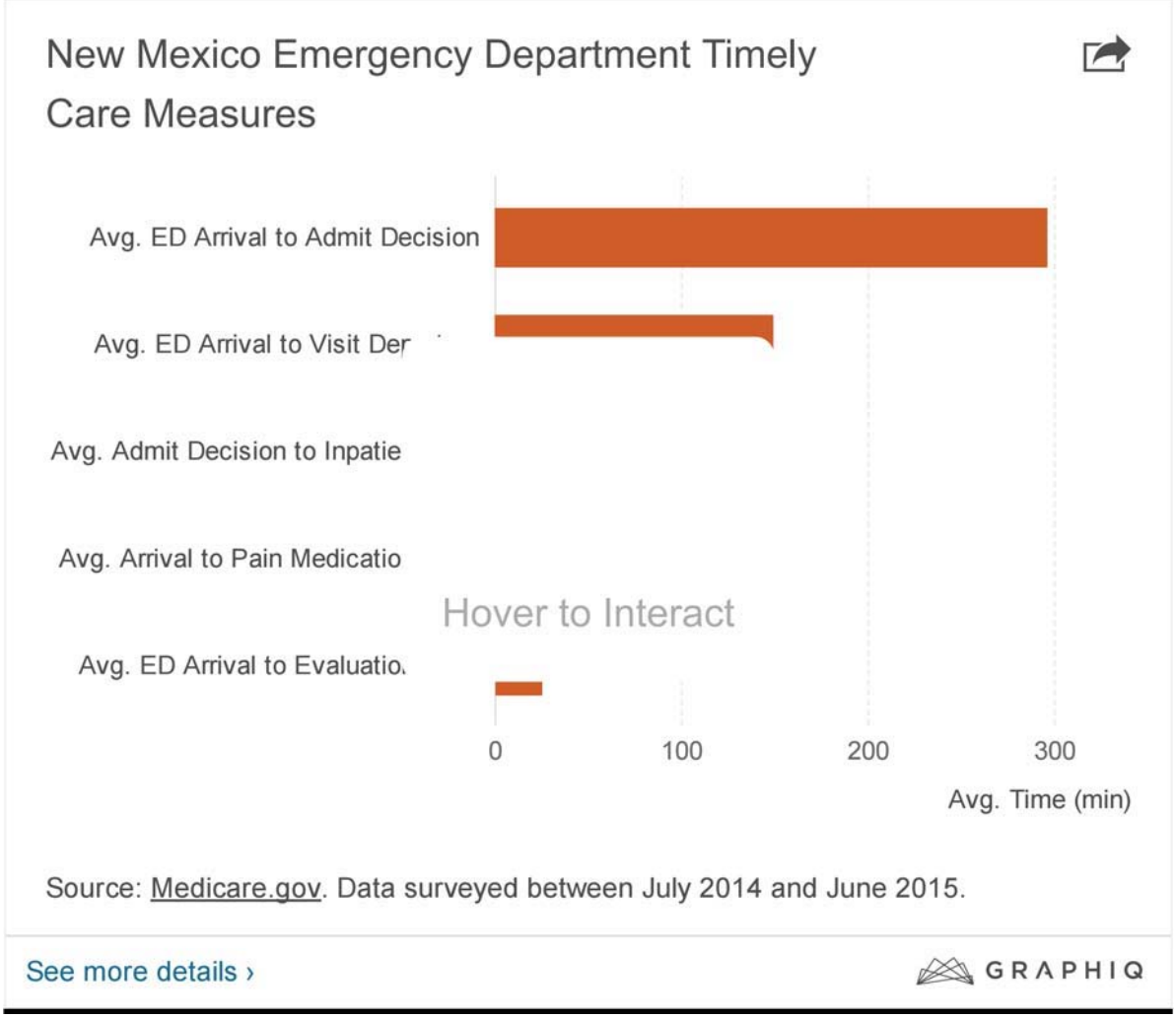
## #7. Massachusetts




**Timeliness Score:** 42.19

**Hospital With Slowest Response Time:** Baystate Medical Center

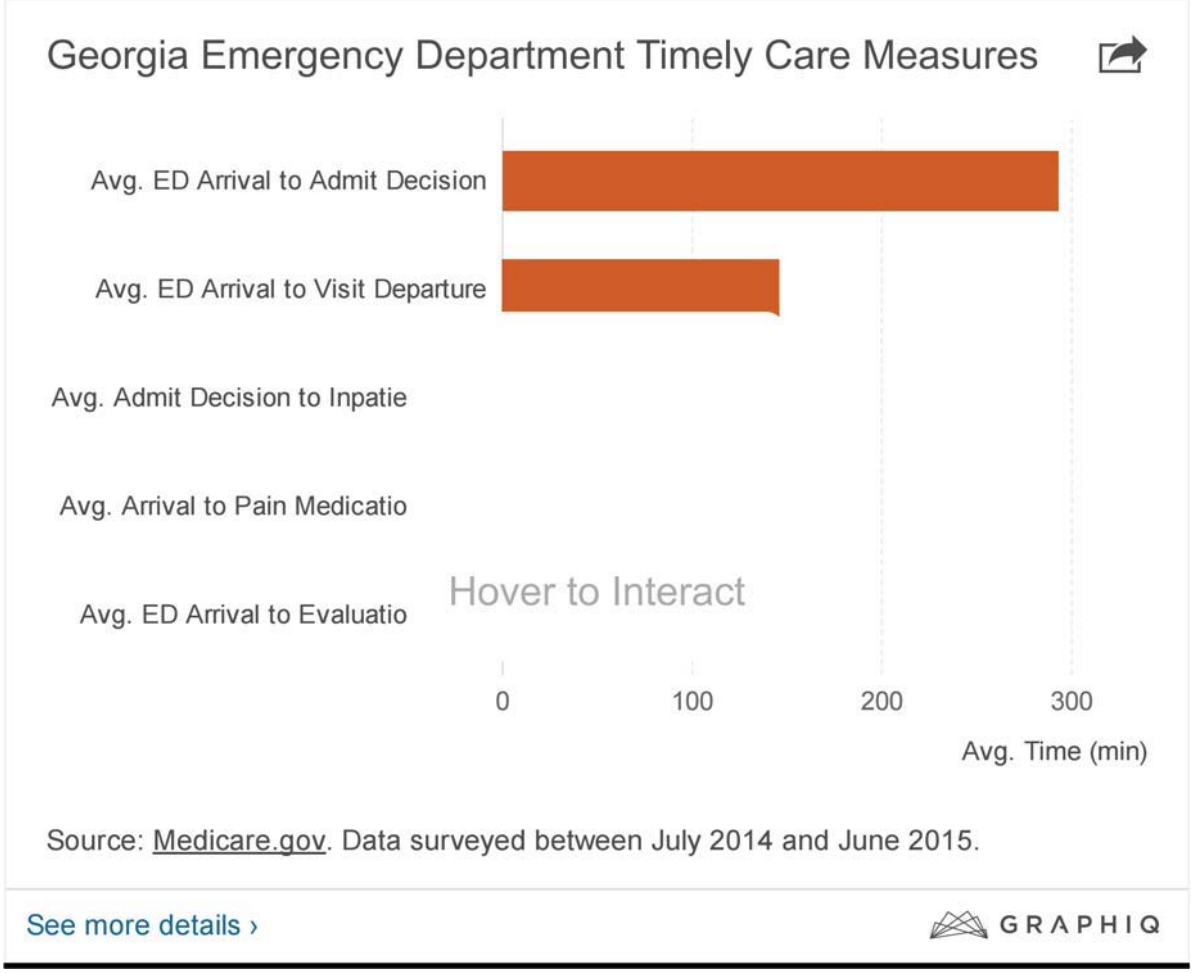
## #6. New Mexico




**Timeliness Score:** 41.99

**Hospital With Slowest Response Time:** UNM Hospital

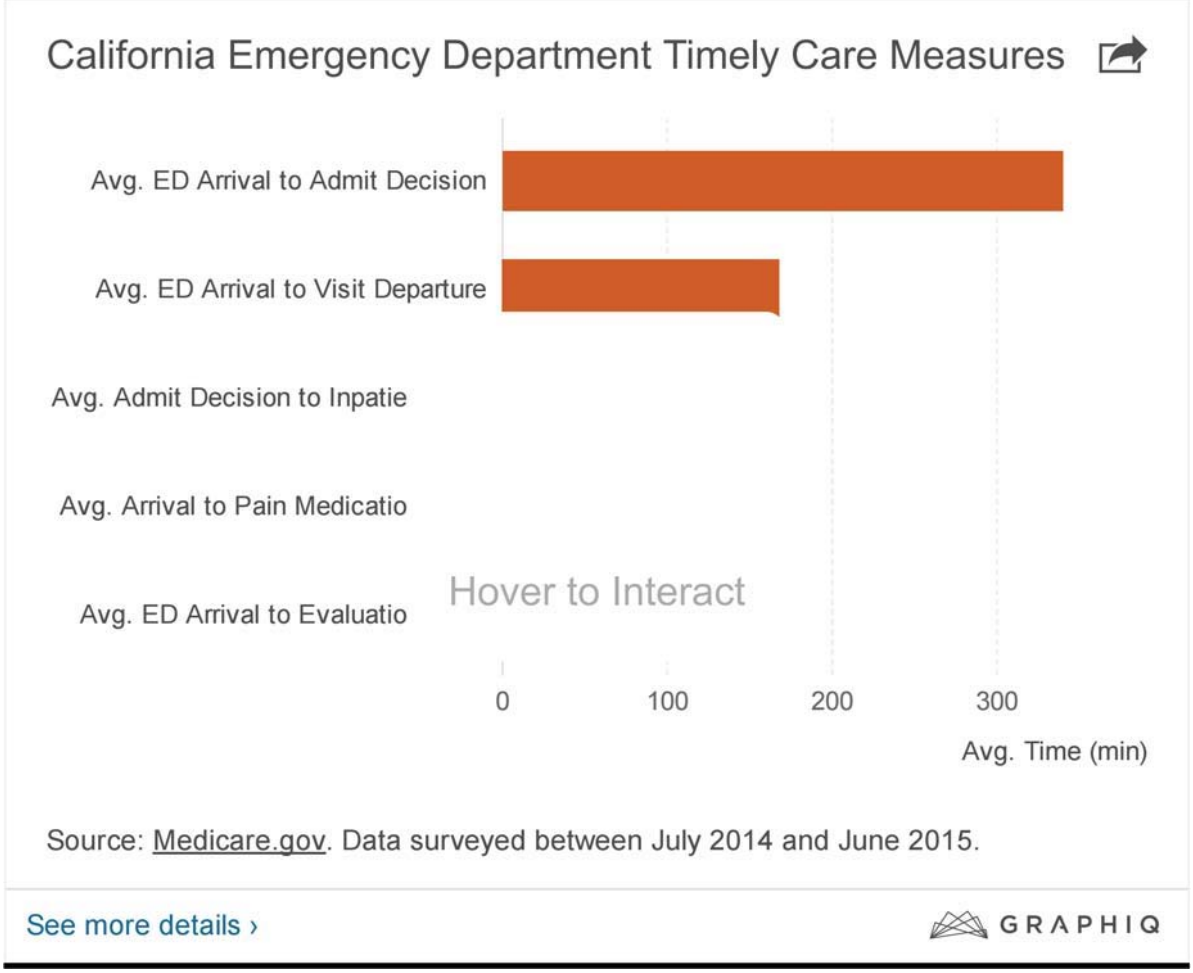
## #5. Georgia




**Timeliness Score:** 40.33

**Hospital With Slowest Response Time:** Grady Memorial Hospital

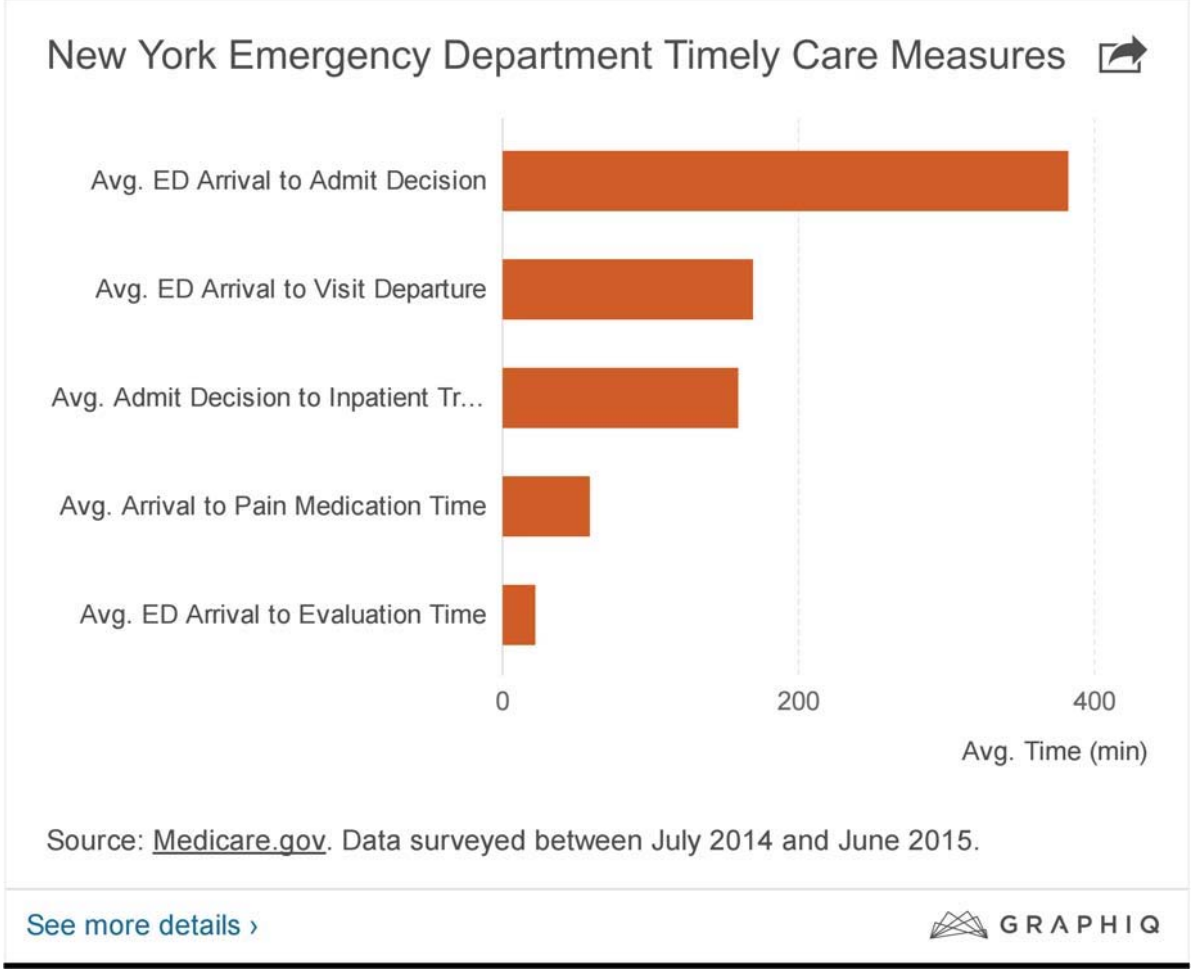
## #4. California




**Timeliness Score:** 37.44

**Hospital With Slowest Response Time:** LAC+USC Medical Center

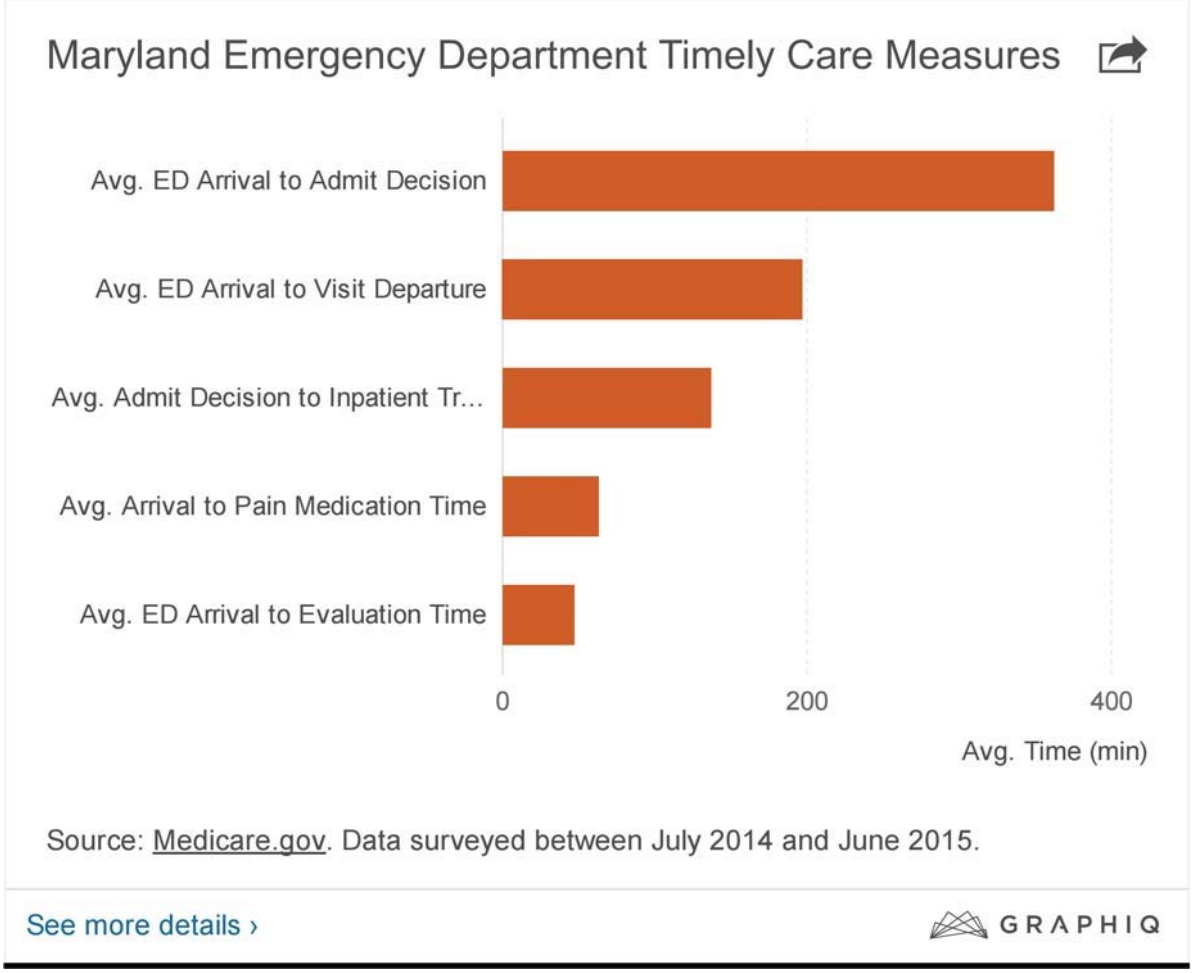
## #3. New York




**Timeliness Score:** 35.2

**Hospital With Slowest Response Time:** St. Francis Hospital, Roslyn, NY Center

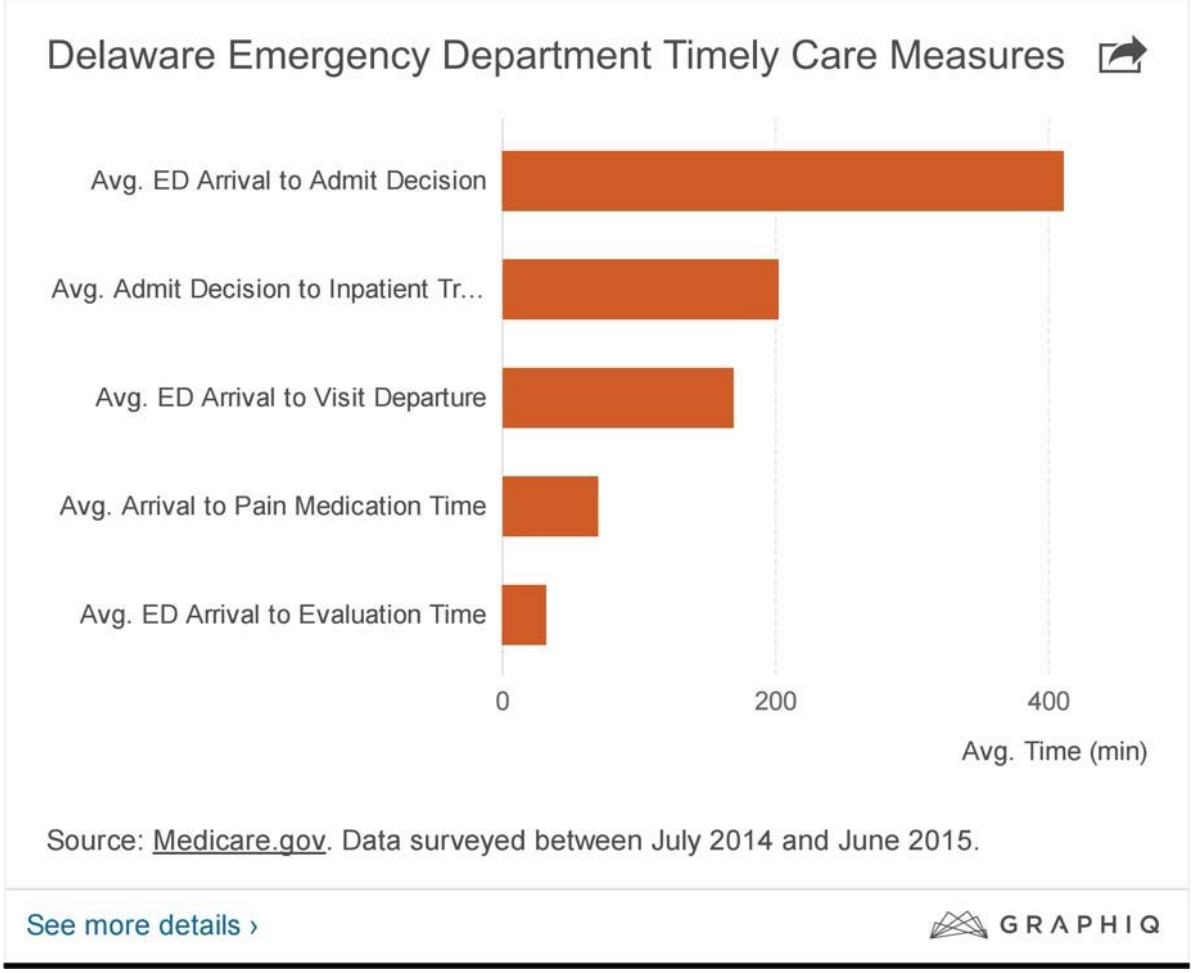
## #2. Maryland




**Timeliness Score:** 5.89

**Hospital With Slowest Response Time:** The Johns Hopkins Hospital

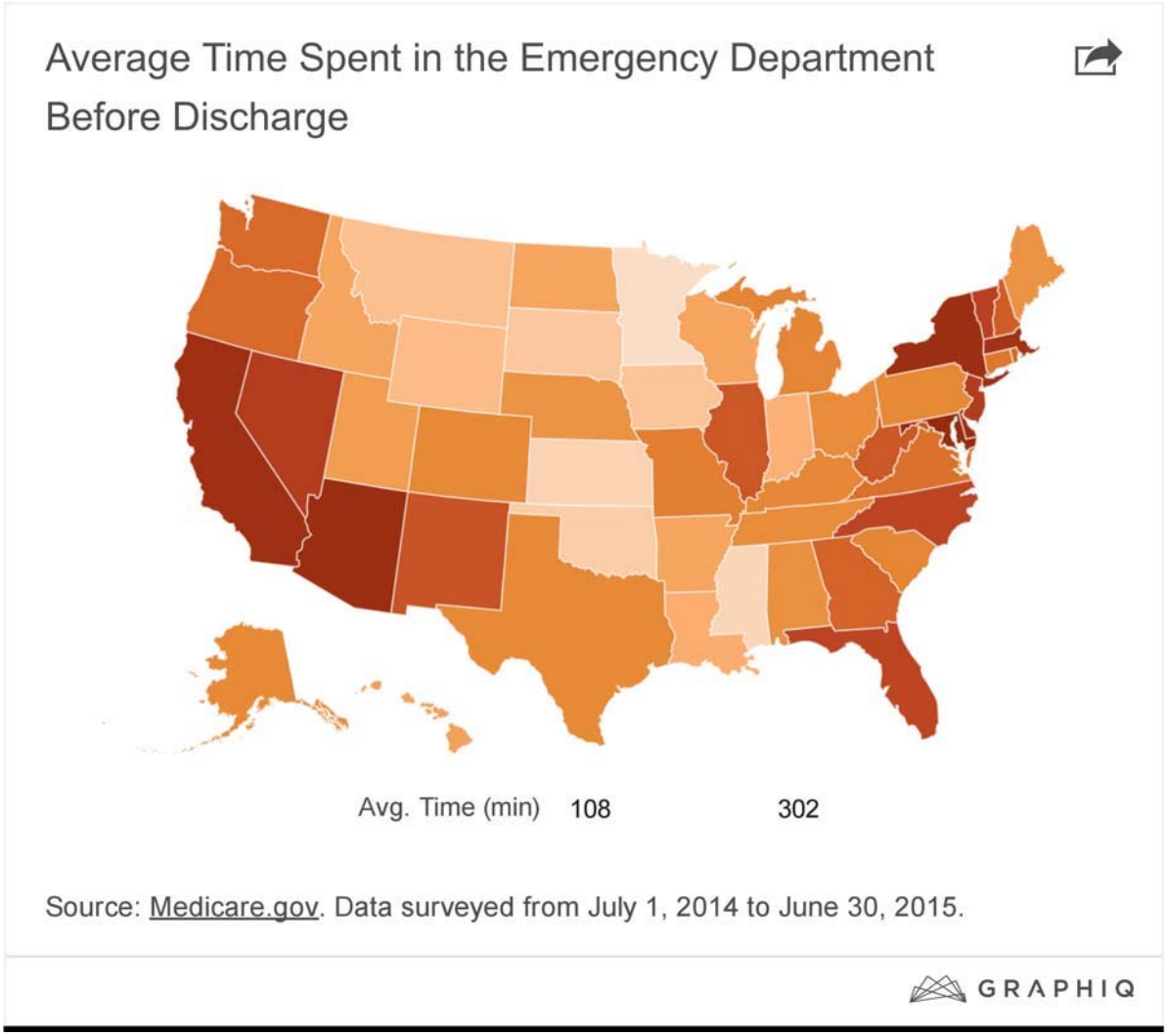
## #1. Delaware




**Timeliness Score:** 0

**Hospital With Slowest Response Time:** Bayhealth, Kent General Hospital

## Emergency Department Response by State




Research Your Hospital's Response Time and Reviews on HealthGrove

Close Window Send To Printer

Media Contacts:

Anna Blair
REACH, VP Business Relations & Development
(707) 508-6204

Lynn Malmstrom
CALSTAR, CEO
(916) 921-4072

**FOR IMMEDIATE RELEASE**

## REACH, CALSTAR Announce Air Medical Services Merger
## Bases in Northern, Central California form Largest Statewide Network

**SANTA ROSA, CA – June 16, 2016** - REACH Air Medical Services LLC ("REACH") and CALIFORNIA SHOCK TRAUMA AIR RESCUE ("CALSTAR"), two of the preeminent air medical ambulance providers in Northern and Central California for three decades, are entering into an agreement that will place CALSTAR within the same corporate holding company as REACH ("REACH Medical Holdings LLC").

In a joint announcement today, Sean Russell, REACH President, and Lynn Malmstrom, CALSTAR CEO, said the air medical operation of CALSTAR will become a limited liability company (LLC) as part of the terms of the agreement, and will operate under the current CALSTAR brand as CALSTAR Air Medical Services LLC. The parties intend to better serve the community through their united efforts.

The new company will be one of the three firms under REACH Medical Holdings, LLC, a holding corporation (the "Company") which is part of Air Medical Group Holdings, Inc. (AMGH), one of the largest air medical firms in the United States. Cal-Ore Life Flight, which merged with REACH in 2011, also is a part of the holding company.

CALSTAR Air Medical Services LLC will continue to operate with its own unique brand and flight nurse staffing model. REACH and CALSTAR officials foresee no base closures with the goal being to focus on integration, support and maintaining the services that have made both organizations successful. No other decisions have been made related to services.

Financial terms are not being disclosed at this time. The proceeds of this transaction will go to and fund a new not-for-profit foundation to benefit the public. The mission and activities of this new foundation are still to be determined and will be shared at a later date as they become available.

"Our companies have been competitors for 30 years, built upon similar foundations of high quality services, patient care and loyalty to our communities, to our patients and to our members who rely upon us for safe, reliable air medical transport," Russell said.

Media Contacts:

Anna Blair
REACH, VP Business Relations & Development
(707) 508-6204

Lynn Malmstrom
CALSTAR, CEO
(916) 921-4072

Malmstrom said a team comprised of staff from each company will be appointed to help guide the integration process. “We want to ensure that the resources of both programs are reviewed and utilized in a manner that is reflective of the best practices from our 30-year commitments to community and patient care, to industry-leading employee training and to the safe operations of one of the most modern rotor and fixed-wing fleets in air medical care.”

CALSTAR’s current members will become members of the AirMedCare Network, extending their membership benefits with no out-of-pocket expenses related to transport across 32 states and more than 251 aircraft locations that are part of AMGH.

Malmstrom and two others on his senior executive team – Tad Henderson (COO) and Mark Vincenzini (CFO) – will assist with the integration, but their respective roles will cease within the next 12 months as part of the agreement. Both Russell and Malmstrom told employees today that the goal is to maintain current operations and that no other decisions affecting base locations, staffing and fleet have been made.

- End -

**Background on REACH and CALSTAR:**

REACH (www.reachair.com) has been headquartered in Santa Rosa, CA, since its founding in 1987. The company, including Cal-Ore Life Flight, has more than 40 rotor and fixed-wing aircraft at more than 30 bases in California, Oregon, Nevada, Wyoming, Montana and Colorado and has bases affiliated with hospitals in Texas, and also assists customers in ground transport programs. Combined with Cal-Ore, the company has approximately 600 employees. In October 2015, REACH was named Program of the Year by the Association of Air Medical Services (AAMS), one of the air medical transport industry’s highest honors. REACH also is accredited by the Commission on Accreditation of Medical Transport Services (CAMTS).

CALSTAR (www.calstar.org) was founded in 1984 with headquarters in Hayward, CA and now is headquartered in McClellan, CA. CALSTAR has approximately 225 employees, and 14 rotor and fixed-wing aircraft at nine bases of operation.

# Ambulances, in place of 'caged police car,' to carry people in mental health crisis

Under the new approach, an ambulance, not police, would carry a person who needs mental health care, to a local hospital or the new Unity Center for Behavioral Health. The police could transfer an involuntary mental health hold to the ambulance service, and wouldn't have to go to the hospital at all. (Mike Zacchino|Oregonian\OregonLive)

By Maxine Bernstein | The Oregonian/OregonLive

on May 28, 2016 at 7:00 AM

## DEPARTMENT OF JUSTICE INQUIRY

• U.S. Justice Dept. lawyers to Portland police: Drop 'us vs. them' mentality in police training

All Stories

Police throughout the metro area expect this fall to start routinely calling for an ambulance to carry people suffering a mental health crisis to the hospital instead of handcuffing them in the back of a patrol car for the ride.

The state has adopted new rules that allow for ambulance services to apply to provide secure transport for people suffering behavioral health problems.

"This really is not criminal behavior. So why do you put someone who needs help frankly in a caged police car? It's not the appropriate response for somebody who really needs medical help," said Portland police Capt. Mike Marshman. "These folks being handcuffed in a car can traumatize them even more."

A group of hospital officials and emergency department doctors, police and ambulance company executives have met once a month for more than a year to develop the new approach.

The police are at the table, Marshman said, because of a 2012 federal investigation that found Portland police engaged in a pattern of excessive force against people with mental illness.

The new plan is modeled after a system in Alameda, California, where state law allows police to transfer custody of people on mental health holds to an ambulance service. The medical crew then screens the people at the scene to determine if they need care at a regular hospital or a psychiatric emergency unit.

Here, people would either be taken to an ER or the new Unity Center for Behavioral Health in Northeast Portland, a psychiatric emergency department scheduled to open in January.

**Who pays?**

If a person has insurance and goes voluntarily by ambulance to the hospital for mental health help, that's considered a medical necessity and insurance should pay the bill, said Amber Shoebridge, a Legacy Health spokeswoman.

But co-pays and deductibles vary, Shoebridge said.

The cost for an ambulance ride, which is controlled by county contracts, is about $1,000 per patient in the Portland metro area, said Randy Lauer, AMR's general manager.

AMR, for example, recoups about 30 percent of that, he said. When police call an ambulance for an involuntary mental health hold, the patient rarely can afford the cost, he said, and the company has backed away from billing the city of Portland.

"We end up writing that cost off," Lauer said.

Portland police alone estimate they typically drive about 1,000 people to hospitals on involuntary mental health holds throughout the year. That compares to about 2,000 general mental health transfers to hospitals that ambulances in Multnomah County already do.

Officers usually must wait at hospital emergency rooms, sometimes for hours, until a doctor can do an evaluation and decide whether to maintain the mental health hold or release the patient.

Under the new approach, ambulances not only would take people to the hospital, but police wouldn't have to follow along as they do now on the occasions when both officers and ambulances are called to a mental health emergency.

American Medical Response Inc. would transport people in Multnomah and Clackamas counties; Metro West would cover such transports in Washington County. Overall, 132 licensed ambulance services in Oregon would be eligible to apply.

"It's what everybody wants. We don't want to handcuff a behavioral health patient on what could be the worst day of their life," said Rick Ralson, Legacy Health's project manager for Behavioral Health Services.

Police are working out some of the logistical issues, such as sending officers' reports electronically to an ambulance company to submit to a hospital.

AMR and MetroWest ambulance companies are training their paramedics and emergency medical technicians to handle the decisions in the field.

"It's kind of a natural shift," said Randy Lauer, AMR's general manager. "Paramedics look at people as someone either suffering from a traumatic crisis or medical problem that they need help with. It's just a different approach."

The company's paramedics and emergency medical technicians now are trained to deal with "combative, out of control" patients using cloth Velcro to tie their arms and legs to a stretcher, in addition to a shoulder harness, he said.

The National Alliance on Mental Illness, along with Disability Rights Oregon, welcome the change, but pushed for clear standards for ambulance providers, enhanced crisis intervention training for ambulance workers and annual training on when to use restraints.

Kevin Fitts, executive director of the Oregon Mental Health Consumers Association, said he's

"generally in favor of less police contact for folks in crisis and less coercion and force in providing services."

"I am hopeful this is a better solution, but I am mildly fearful of the old cliche of the men in the white van with butterfly nets chasing down the individual in an extreme state," he said.

Under the new practice, Marshman envisions police showing up to a mental health call to provide safety at the scene. If no crime has been committed, officers would step out of the way and allow medics to step in instead.

It's similar to how police respond to heroin overdose calls, he said.

"A high percentage of the time, we stand around and do nothing. We watch AMR and fire do medical treatment and then transport. That's how I envision a majority of these mental health calls resolving themselves," Marshman said. "We'd be there solely for scene safety. It just makes sense."

Police and ambulances should be the last resort, said Jason Renaud, a volunteer with the Mental Health Association of Portland.

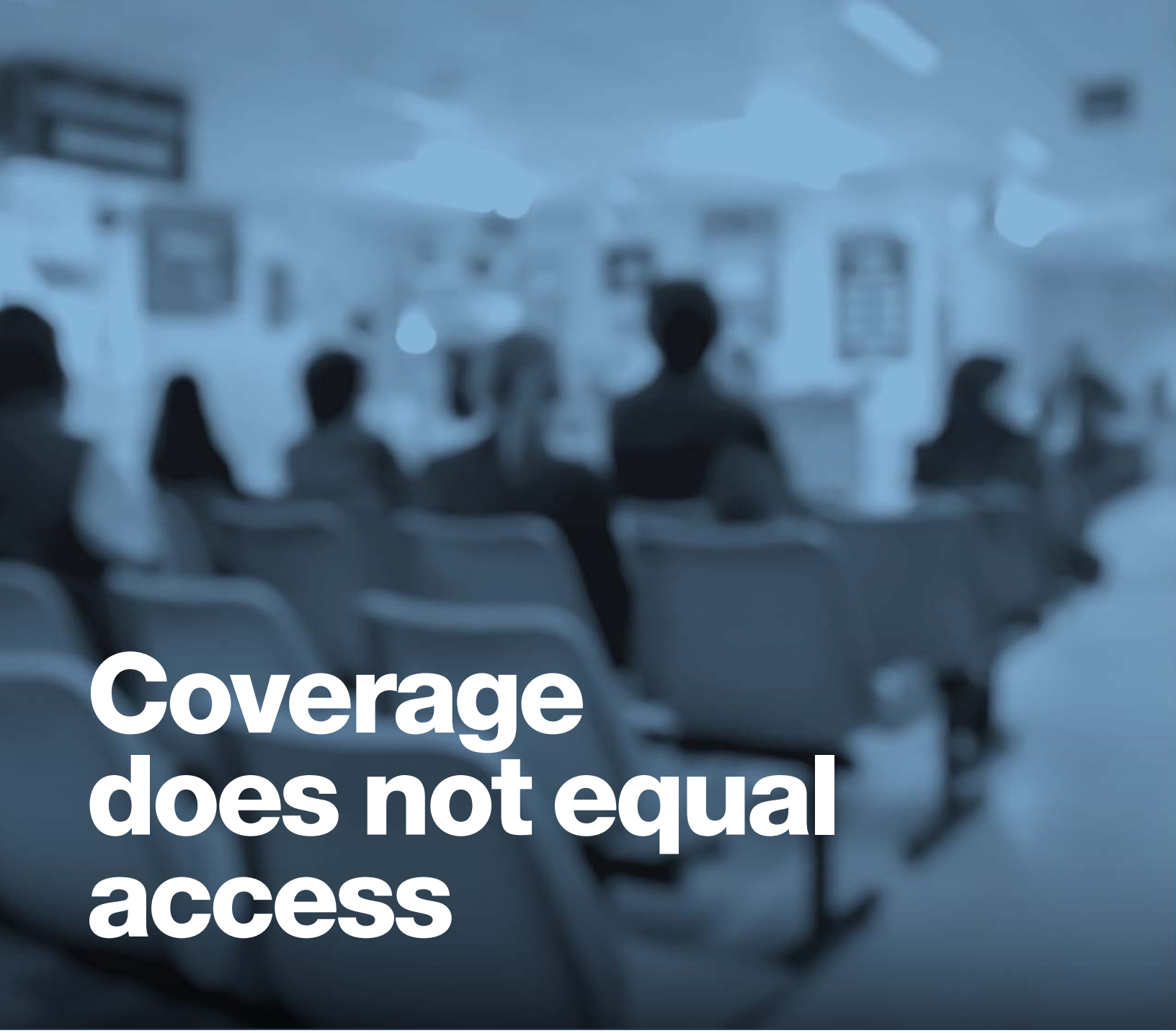
He suggested less expensive alternatives, perhaps a mental health consumer in recovery could provide a transport service or even Uber.

Portland Fire & Rescue Bureau's Interim Chief Ken Burns, previously its deputy chief of emergency medical services, said he'd be open to such changes down the road.

"People are starting to ask more questions. Let's try to get people to the right place for the right reason in the right way," Burns said.

If people aren't a danger to themselves, ambulances might not be the most appropriate way to drive them to a hospital, Burns acknowledged. "Maybe we need to arrange for alternative transportation, a friend or perhaps a taxi," he said.

-- Maxine Bernstein



# Coverage does not equal access

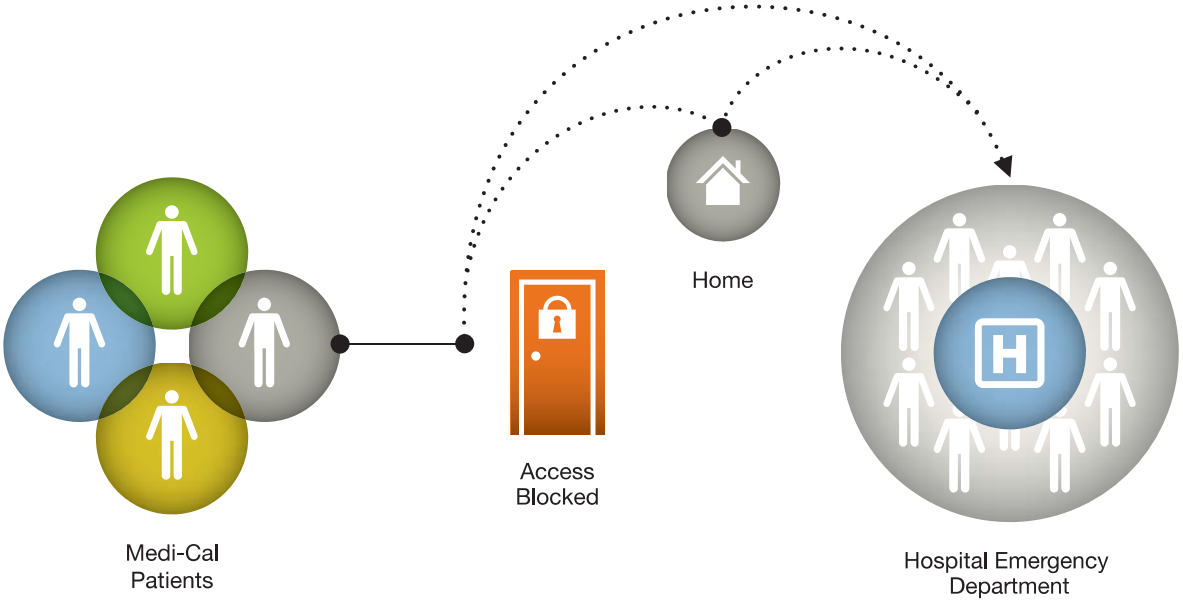
California leads the nation in expanding health care coverage. Now let's create access.

CALIFORNIA HOSPITAL ASSOCIATION

# The Problem:

## Poor access, compromised health

**Having health care coverage is not the same as having access to care.** California led the nation by expanding Medi-Cal to cover more than 13 million people. However, many providers are unwilling to treat Medi-Cal patients due to low reimbursement rates. When patients can't get seen by a doctor, they often turn to hospital emergency departments (EDs) as a last resort.




**5 Million**
ED visits by Medi-Cal patients last year

**Hospital emergency departments are overwhelmed by patients who cannot get the care they need.**

**And, some patients stay in hospitals longer than necessary due to the lack of available providers willing to accept low Medi-Cal reimbursement.**

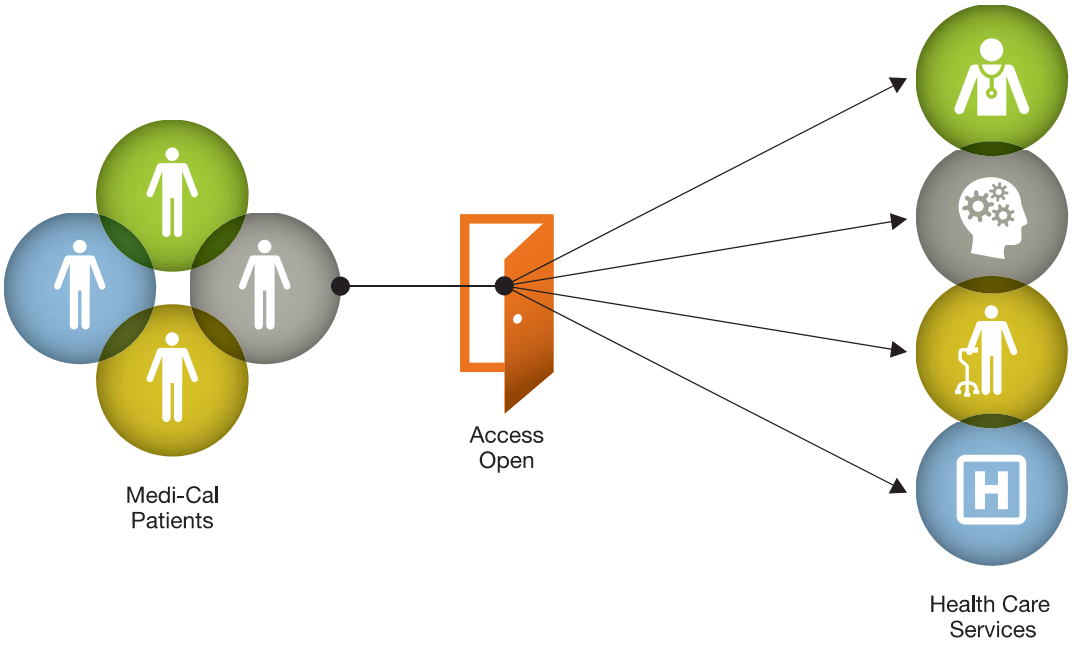
- **13+ Million**
  Total Medi-Cal population — one in three Californians has Medi-Cal coverage
- **47th**
  California's rank among states in terms of Medi-Cal reimbursement
- **40%**
  Percentage of all ED visits that are by Medi-Cal patients
- **1 Million**
  Number of patients with behavioral health needs that visited an ED last year
- **1,000+**
  Number of patients with behavioral health needs held in EDs every day

# The Solution:

## Open the door to access

**Medi-Cal should work for patients.** Help improve health care for millions by ensuring that patients have access to primary care, behavioral health, post-acute and rehabilitative services. Patients recover quicker when they receive timely and appropriate care. And, the proper level of treatment is often less costly.

Preserving EDs for those truly needing emergent care ensures life-saving treatment is there when needed.




**Medi-Cal patients deserve** the right care, at the right time, at the right place

**Caring for patients in the appropriate setting can lower costs and improve patient well-being.**

- **Access** Medi-Cal patients should have access to quality care when and where they need it.
- **Funding** Improved funding will increase access to preventive and primary care, which is far less costly than treating patients in an ED.
- **Appropriate** Expanding rehabilitative and post-acute services would allow patients to receive care in an alternative setting.
- **Update** The involuntary detainment standards that hold patients with behavioral health needs in an ED must be updated so these patients can be released and treated in a specialized setting. The ED is not the place to treat these patients.
- **Flexibility** Physicians are retiring at record rates. California needs greater flexibility to treat patients in appropriate, cost-effective settings.

## California Hospital Association

The statewide leader representing the interests of California's hospitals and health systems. Proudly representing:

**400+** hospitals and health systems | **95%** of California hospital beds

### Did You Know?

- California hospitals employ more than 500,000 individuals
- California hospitals provide more than $15 billion in uncompensated health care services each year
- On an annual basis, Californians make 52 million visits to hospitals
- Californians make 14 million visits to the ED each year
- 500,000 babies are born each year in California hospitals

CALIFORNIA HOSPITAL ASSOCIATION

*Leadership in Health Policy and Advocacy*

1215 K Street, Suite 800
Sacramento, CA 95814
(916) 443-7401
www.calhospital.org

**Regional Association Partners:**

Hospital Council of Northern and Central California
Hospital Association of Southern California
Hospital Association of San Diego and Imperial Counties