EMS/Trauma Committee Meeting

Wednesday, February 5, 2020

California Hospital Association

1215 K Street, Suite 800

Boardroom

Sacramento, CA, 95814

(800) 882-3610 Access Code: 1953936#

Meeting Book - EMS/Trauma Committee Meeting

EMS/Trauma Committee Meeting Agenda - February 5, 2020

11:00 AM I. CALL TO ORDER/INTRODUCTIONS

11:05 AM II. CHA MEMBER SESSION STRATEGY DEVELOPMENT
Grellmann/Bartleson

A. Member Session/Strategy Development — Page 3
Grellmann/Bartleson

B. Behavioral Health Issues in Emergency Departments — Page 37
Bartleson/Lowe

12:00 PM III. LUNCH

12:15 PM IV. BUSINESS

A. EMS For Children — Page 44
Bartleson/Venezio

B. CDPH, OSHPD, CHA Task Force on EMS Surge — Page 47
Bartleson

V. INFORMATION

A. Membership

1. 2020 Roster — Page 50

2. Member Map — Page 54

3. Member Breakdown — Page 55

4. Committee Guidelines — Page 56

5. Committee Goals & Objectives 2019-20 — Page 60

B. October 16, 2019 Meeting Minutes — Page 62

Deemed approved by email.

2:00 VI. ADJOURNMENT

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 5, 2020

TO: EMS/Trauma Committee Members

FROM: Dietmar Grellmann, SVP, Policy
BJ Bartleson, MS, RN, NEA-BC, Vice President, Nursing and Clinical Services

SUBJECT: Member Session/Strategy Development

SUMMARY

To align our committee more directly with CHA 2020 policy and advocacy priorities, we would like to review the 2020 CHA priorities, and the mission of the CHA EMS/T committee to develop a specific detailed strategy that includes results-oriented activities and deliverables. In review, CHA seeks to develop consensus and establish public policy and advocacy priorities to serve hospitals and health systems. The present CHA EMS/T Committee mission is to advise CHA on key policy and advocacy issues specific to emergency services. To move to our 2020 goal, we would like to expand upon our present mission to include specific aligned actions that produce deliverables.

The attached power point outlines the 2020 public policy priorities as identified from specific region CEO's along with top priority issues identified by CHA Policy and Advocacy leadership. In summary, the policy issues are:

- Seismic
- Behavioral Health
- Affordability
    - Coverage for all
    - Equitable Access
    - Improve Value

DISCUSSION

1. Reviewing the CEO survey priority, and CHA priority, and our overall issues with behavioral health patients in our ED's, do you feel this is a top place for us to focus?
2. What are your priority issues in your ED and how do they align with CHA's priorities?
3. If we focus on behavioral health, what strategic imperatives might we drill down on, for example, the cost of ED overcrowding and lack of behavioral health reimbursement, 5150 holds and releases, etc.
4. Would we be able to quantify ED overcrowding in a meaningful way to improve access and affordability priorities?

ACTION REQUESTED

- Information sharing and feedback on the discussion questions.

Attachments: Member Policy Priorities
2020 Advocacy Priorities – Summary Report of Member Survey Results
2020 Environmental Scan

BJB:br

What We Heard From You

Importance of Current Priorities Issues – Top Five Highlighted

Statewide Summary	Hospital Council	HASC	HASD&IC
1. Behavioral Health	1. Behavioral Health	1. Behavioral Health	1. Behavioral Health
2. Medi-Cal Reimbursement	2. Medi-Cal Reimbursement	2. Medi-Cal Reimbursement	2. Medi-Cal Reimbursement
3. Medicare Reimbursement	3. Access to Care	3. Medicare Reimbursement	3. Medicare Reimbursement
4. Quality and Patient Safety	4. Quality and Patient Safety	4. Governmental Regulations	4. Access to Care
5. Access to Care	5. Workforce Shortages	5. Quality and Patient Safety	5. Quality and Patient Safety
6. Governmental Regulations	6. Medicare Reimbursement	6. Access to Care	6. Commercially Insured Reimbursement
7. Workforce Shortages	7. Governmental Regulations	7. Commercially Insured Reimbursement	7. Workforce Shortages
8. Commercially Insured Reimbursement	8. Cybersecurity	8. Workforce Shortages	8. Governmental Regulations
9. Cybersecurity	9. Population and Community Health Improvement	9. Other Reimbursement Issues	9. Emergency Department Crowding
10. Emergency Department Crowding	10. Health Outcome Disparities	10. Cybersecurity	10. Cybersecurity

CHA 2020 Advocacy Outlook

What's coming at us in 2020?

Policy

- Surprise medical billing/out-of-network billing
- Affordability (cost containment)
  - Healthy California for All Commission
  - Rate-setting
  - Consolidation
- Independent contractor fix

Politics

- 2020 presidential election
- State elections
- Ballot initiatives

CHA 2020 Advocacy Outlook

Why 2020 will be a landmark year…

- Affordability framework
- Governor's agenda taking shape
- Opportunity to reposition the field

CHA 2020 Advocacy Outlook

What are we for in 2020?

Policy

- Seismic
- Behavioral health
- Affordability
  - Coverage for all
  - Equitable access
  - Improving value

Members were asked for their top concern in each priority policy area and suggestions for revising or strengthening the Associations' focus on each issue. Member comments have been grouped by themes and are summarized below.

1. **Expand Access to Care – TOP CONCERNS**
   A. Equitable Access to Behavioral Health services in the community (particularly for homeless, underserved and low-income populations)
   B. Insufficient Provider Supply (both primary care and specialists)
   C. Inadequate funding for and reimbursement of mental health services to offset cost of care (and an inadequacy of Medi-Cal network and funding)
   D. Need for alternate sites of services (to reduce emergency department overutilization and improve post-acute care access)

   Expand Access to Care – SUGGESTIONS
   A. Keep and expand coverage – including Affordable Care Act, Covered California, Medicare Advantage Medi-Cal expansion
   B. Workforce development initiatives to increase provider supply
   C. Improve community collaborations of care including Long-term care, Skilled Nursing Facilities, Home Health services

2. **Improving Behavioral Health – TOP CONCERNS**
   A. Need for Behavioral Health services (access, capacity, locations) in the community
   B. Need for improved collaborations with community resources
   C. Insufficient behavioral health provider supply
   D. Inadequate funding, reimbursement, adequate insurance coverage

   Improving Behavioral Health – SUGGESTIONS
   A. Fair and equitable funding and reimbursement to cover costs and fund increased capacity initiatives
   B. Improve county-hospital-interagency dynamics and collaborations
   C. Increase inpatient psychiatric bed capacity and access to other community psych services

3. **Addressing Emergency Department Crowding – TOP CONCERNS**
   A. Address high frequency emergency department utilizers (homeless, mentally ill, pain management)
   B. Need for alternate sites of services (primary care, urgent care, social services, sobering centers)

   Addressing Emergency Department Issues – SUGGESTIONS
   A. Address Local Emergency Services Authority's (LEMSA) aggressive behavior such as fees and fines
   B. Address high frequency emergency department utilizers (homeless, mentally ill, pain management)
   C. Provide alternate sites of services in the community and allow paramedics to direct patients according to need (e.g. sobering center)

4. **Addressing Local Emergency Medical Services Agency Transport Policies – TOP CONCERNS**
   A. Poor Emergency Medical Services (EMS) policies/dynamics/control of quality/fees
   B. Lack of alternate sites of services in the community

Addressing Emergency Department Fees and Fines – TOP CONCERNS

A. EMS/County shifting (clogging) the burden of care from the County to the Hospital (e.g.: homelessness) which in turn clogs the emergency department, and then imposing fines on the hospital for missed metrics (e.g.: off load, patient throughput)
B. No value "add" to increased fines ("add to the bureaucracy")
C. Not an issue

5. **Enhancing Quality and Patient Safety – TOP CONCERNS**
   A. Rules/Regulations/Unfunded Mandates
   B. Too many metrics and required reporting from too many outside organizations that have conflicting, overlapping, unreliable metrics and standards

Enhancing Quality and Patient Safety – SUGGESTIONS

A. Develop a common platform, streamlining for quality reporting
B. Improve intra-agency collaborations and efficiencies in reporting, metrics determination and standards

6. **Tackling Workforce Shortages – TOP CONCERNS**
   A. Nursing shortage – need for increased quality nursing with improved training and compensation
   B. Salary competition for nurses (by the deep-pockets of the larger urban centers)
   C. Insufficient training programs and insufficient affordable housing

7. **Supporting Labor Relationship & Negotiations – TOP CONCERNS**
   A. Aggressive union tactics
   B. Unions influence/power with legislators
   C. Union activity adds no real value but drives up costs to the hospital
   D. Union fines and fees

Tackling Workforce Shortage and Supporting Labor Relationship & Negotiation – SUGGESTIONS

A. Educate legislators on the aggressive union lobby activities
B. Highly focused advocacy that takes on big labor unions on union-led initiatives/legislation that would hurt the hospitals
C. Regional collaborations and hospital planning to address nursing costs and affordability

8. **Supporting Population and Community Health Improvement – TOP CONCERNS**
   A. Adequate resources that support expanded access to services – behavioral health, services for homeless, primary care, substance abuse
   B. Need for improved funding for social services and collaborations with local government and other community agencies that address social determinants of health

9. **Addressing Health Outcome Disparity – TOP CONCERNS**
   A. Adequate resources that support expanded access to services – behavioral health, services for homeless, primary care, substance abuse disorder
   B. Need for improved funding for social services and collaborations with local government and other community agencies that address social determinants of health (e.g. housing, food security)

Supporting Population and Community Health and Health Outcomes Disparity – SUGGESTIONS

A. Align community collaboration strategies, share models and best practices, focus all hospitals on the same efforts for real leveraged impact
B. Strengthen public social services availability in the community; improve collaborations with the County and community agencies

10. Improving Health Information Exchange Across All Entities – TOP CONCERNS

A. Lack of standard platform (and too many disparate platforms)
B. Inability for portability/interoperability and meaningful data sharing
C. Costs

Improving Health Information Exchange Across All Entities – SUGGESTIONS

A. Support Emergency Department Information Exchange (EDIE) and CareLink
B. Support standardized platforms (if not just one platform used by all)

11. Improving Cybersecurity – TOP CONCERNS

A. Cyberattack; data breach

Improving Cybersecurity - SUGGESTIONS

A. Improve communications across hospitals regarding threats and best-practice solutions
B. Improve staff training/education

12. Increased Emphasis on Disaster Preparedness – TOP CONCERNS

A. Inadequate funding/unfunded mandate
B. Intra-agency collaboration, communication, education and training e.g.: incident command
C. Ability to respond as a provider community to major disaster like earthquake, fire, active shooter or health/disease outbreak (e.g.: due to the homeless populations in Los Angeles and San Francisco)

Increased Emphasis on Disaster Preparedness – SUGGESTIONS

A. Provide increased funding (through EMS) and support for intra-agency collaborations, training and education opportunities.

13. Addressing Medicare Reimbursement Issues – TOP CONCERNS

A. Reimbursement rate cuts (and rates not keeping pace with cost inflations)
B. Cost shifting
C. Changes to wage index
D. Volume increases and population growth

14. Addressing Medi-Cal Reimbursement Issues – TOP CONCERNS

A. Reimbursement rate cuts and denials
B. Cost shifting
C. Underfunding of care in non-inpatient settings such as outpatient, emergency department, mental health, skilled nursing facilities, population health initiatives

15. **Addressing Commercial Reimbursement Issues – TOP CONCERNS**
    A. Commercial Insurance "gaming" including cuts, denials, delays/stalled payments
    B. Inadequate reimbursement overall
    C. Surprise billing/rate setting
    D. Legislation/legislators that favor insurance companies over hospitals

16. **Addressing Other Reimbursement Issues – TOP CONCERNS**
    A. Insurance "gaming" including cuts, denials, delays/stalled payments
    B. Inadequate reimbursement overall

All Reimbursement Issues – SUGGESTIONS
    A. Build consensus and action around healthcare financing reform
    B. Payer transparency in negotiations
    C. Simplify, standardize the processes across all payers

17. **Local Government Regulations – TOP CONCERNS**
    A. CDPH and OSHPD
    B. County/State EMSA dynamics (lack of real value, collaboration)
    C. Lack of social services availability and funding, particularly mental health services and services for homeless like adequate housing and food security

18. **State Government Regulations – TOP CONCERNS**
    A. CDPH and OSHPD
    B. Nurse staffing ratios
    C. Inadequacy and deterioration of Medi-Cal and Medicare reimbursement and funding
    D. Unfunded mandates like seismic upgrades requirements

19. **Federal Government Regulations – TOP CONCERNS**
    A. Inadequacy and deterioration of Centers for Medicare and Medicaid Services reimbursement and funding
    B. Out-dated rules and regulations
    C. Outdated Stark Law

All Government Regulations - SUGGESTIONS
    A. Fight to lessen unfair and burdensome government regulations and constraints
    B. Improve government relations and collaborations, and increase education to legislators on issues faced by hospitals
    C. Develop aligned vision and incentives

American Hospital Association™

Advancing Health in America

2020 Environmental SCAN

The AHA's 2020 Environmental Scan is sponsored by:

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Welcome to the 2020 Environmental Scan

They say that change is the only constant in life. That certainly holds true today. Fresh technologies, new players in the market, increased emphasis on population health and social determinants of health, the advance of consumer-friendly care delivery models … all of these factors and more promise a significant and lasting transformation of health care.

For those in health care, we *welcome* this change. Because as we have always done, hospitals and health systems are leading this transformation, helping to shape and direct the future.

As a field, we have a remarkable track record for adaptability, seamlessly integrating decades of major breakthroughs in technology, biology and science — evolving treatments for cancer come to mind — into improved patient care.

In health care, change brings with it the opportunity to continue improving. It means better care for our patients. Change is what hospitals have been doing for far longer than any of us have been around. We know that there will always be changes we need to make to prepare for the future. That's what we're doing today.

RICK POLLACK

President and CEO
American Hospital Association

To help you, each year, we publish the AHA Environmental Scan. This year's scan offers an overview of the trends, statistics and economic forecasts likely to affect patients and providers at every level of care.

We track, interpret and share developments to make your job easier. With that in mind, we have identified several key topic areas that will likely impact health care in 2020 and beyond.

• **Access.** The cornerstone of healthy communities is having access to the right care at the right time in the right setting. Many factors affect this: availability of government programs such as Medicare, Medicaid and the Children's Health Insurance Program, private insurance coverage and a strong and resilient workforce.

• **Health.** The health care system continues to evolve beyond the walls of the hospital as hospitals and health systems seek to manage and prevent chronic disease and improve the well-being of patients. This includes addressing the social determinants of health such as housing, food insecurity and violence in partnership with community organizations, providing access to behavioral health resources and working to stem the tide of tragic drug overdose.

• **Innovation.** Innovative strategies are becoming the norm. Eighty-six percent of health systems have at least one executive dedicated to exploring partnerships, investments and other tactics to position for the future. Top priorities for innovation initiatives and investments will include IT/data analytics, patient/consumer engagement and use of artificial intelligence to improve care delivery.

• **Affordability and value.** Affordable health care is one of the biggest concerns facing families, employers and government. Hospitals and health systems are doing their part to make care more affordable. They are leading the charge toward value-based care with new models that provide better coordinated care at a lower cost. They are using the best technology and data to improve patient outcomes.

• **Individual as partner.** Today's consumers want health care when and where they want it. The availability of virtual care, patient-friendly online portals and alternative places of care such as retail clinics will be more important than ever.

This scan offers facts, predictions and statistics to think about and plan for, but nothing to fear. We've embraced change in the past and grown from it, and we will again.

As always, the AHA will stay on top of it as part of our commitment to helping America's hospitals and health systems as they care for their communities … saving lives, performing miracles and keeping people healthy.

ACCESS

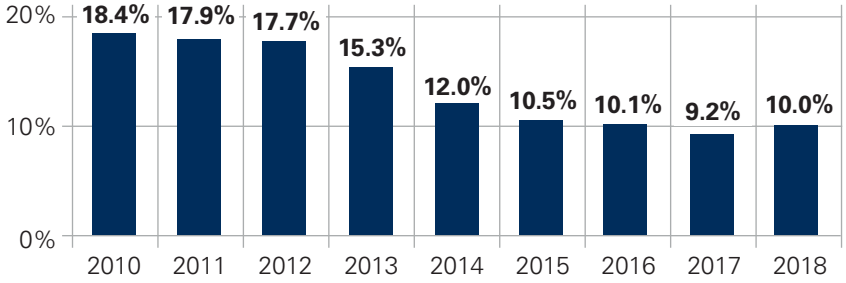
Access to affordable, equitable health, behavioral and social services

Hospitals, health systems and health care organizations recognize that access to care for individuals is the cornerstone for developing healthy communities across the nation. Insurance coverage and a strong workforce are key elements that influence access to health care.

COVERAGE

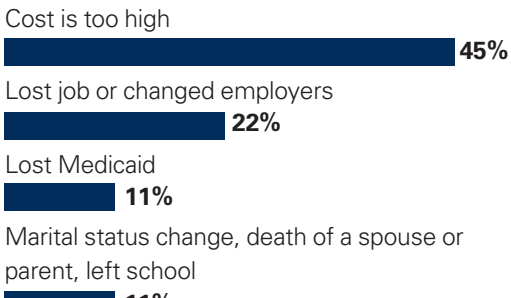
The Uninsured

UNINSURED RATE: YOUNGER THAN 65



"Health Insurance Coverage in the United States, 2013-2018" and "Income, Poverty, and Health Insurance Coverage in the United States: 2010-2012," www.census.gov/topics/health/health-insurance/library.html, U.S Census Bureau.

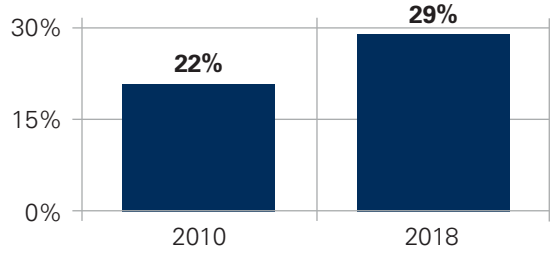
TOP REASONS FOR BEING UNINSURED AMONG NONELDERLY ADULTS



Source: "Key Facts about the Uninsured Population," Kaiser Family Foundation, kkf.org, Dec. 7, 2018.

The Underinsured

UNDERINSURED RATE: ADULTS AGES 19-64



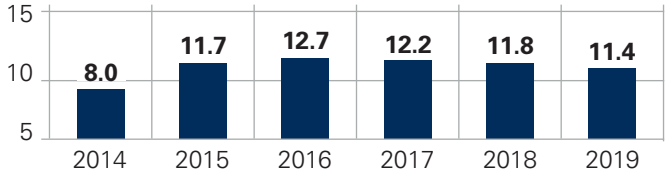
- In 2018, high out-of-pocket costs and deductibles contributed to underinsurance.
- The greatest growth in the number of underinsured adults occurred among those with employer plans.
- Continuously insured adults, including the underinsured, are more likely to get preventive care and cancer screenings.

Collins, Sara R. et al. "Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured," The Commonwealth Fund, Feb. 7, 2019.

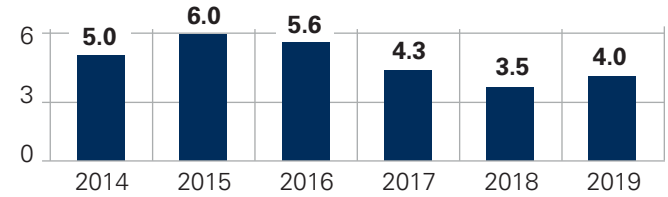
The Affordable Care Act (ACA)

The ACA individual marketplace

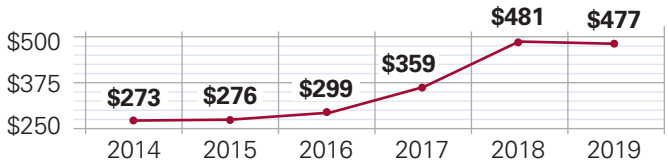
MARKETPLACE ENROLLMENT (in millions)



AVERAGE NUMBER OF PARTICIPATING INSURERS PER STATE

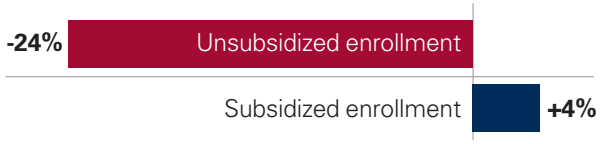


MARKETPLACE AVERAGE BENCHMARK PREMIUM



Note: Average calculated using second -lowest cost silver plans per market.
"Marketplace Enrollment, 2014-2019, Marketplace Average benchmark premiums, Number of Issuers Participating in the Individual Health Insurance Marketplaces" Kaiser Family Foundation, kkf.org. Accessed July 29, 2019.

IMPACT OF SUBSIDIES ON ENROLLMENT (between 2017 and 2018)



"Trends in Subsidized and Unsubsidized Enrollment," Centers for Medicare & Medicaid Services, Aug. 12, 2019.

The ACA linked to reduced disparities

- Gaps in insurance coverage among racial and ethnic groups decreased after implementation of the ACA coverage expansions. These effects were greatest in states that expanded Medicaid.*
- Under the ACA, women with ovarian cancer were more likely to be diagnosed at an early stage and receive treatment within 30 days of diagnosis.†

* Chaudry, Ajay et al. "Issue Brief: Did the Affordable Care Act Reduce Racial and Ethnic Disparities in Health Insurance Coverage?" The Commonwealth Fund, August 2019.
† Smith, Anna Jo and Nickels, Amanda. "Impact of the Affordable Care Act on early-stage diagnosis and treatment for women with ovarian cancer," *Journal of Clinical Oncology*, vol. 37, no. 18, June 5, 2019. Reprinted with permission. © 2019 American Society of Clinical Oncology. All rights reserved.

AFRICAN AMERICAN CANCER PATIENTS

+6% Increase in African American patients beginning treatment within a month of receiving diagnoses of advanced cancers in Medicaid expansion states post-expansion.

Doerr, Anne. "Yale study finds link between Medicaid expansion and equity in cancer care," *YaleNews*, June 2, 2019.

Medicare

As measured by expenditures, Medicare is the largest health care insurance program in the U.S.

2017 ENROLLMENT

	No. of people	% of U.S. population
Medicare Part A	**58 million**	**18.0%**
Medicare Part B	**53 million**	**16.0%**
Medicare Part D	**44 million**	**13.5%**

Klees, Barbara S. and Wolfe, Christian J. "Brief Summaries of Medicare & Medicaid," Office of the Actuary, CMS, Department of Health & Human Services, Oct. 15, 2018.

Impact of a potential Medicare public option

- By 2025, 6.3 million people would gain coverage, as opposed to 9.1 million people gaining coverage through additional support of the ACA.
- A reduction of $836 billion to hospitals over a 10-year period.
- A significant disruption to the employer-sponsored insurance market, which provides coverage to more than 150 million Americans.

Koenig, Lane et al. "The Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals," KNG Health Consulting, LLC, March 12, 2019, and supplemental report August 6, 2019.

Medicaid and the Children's Health Insurance Program (CHIP)

ENROLLMENT

- More than 72 million people, or 22% of the U.S. population.
- Medicaid expansion adult enrollment: nearly 17 million people.
- 47% of Medicaid and CHIP recipients are younger than 21.
- 11% of Medicaid recipients are 65 years or older.

"Who enrolls in Medicaid and CHIP," Medicaid.gov, July 28, 2019.

MEDICAID PAYS:

- $1 in $6 in the health care system.
- $1 in $3 to safety net hospitals and health centers.
- $1 in $2 for long-term care.
- For nearly half of all births in a typical state.

"Medicaid in the United States," fact sheet, Kaiser Family Foundation, November 2018.
Rudowitz, Robin, et al. "10 things to Know about Medicaid: Setting the Facts Straight," Kaiser Family Foundation, March 6, 2019.

WORKFORCE

Workforce shortages

PHYSICIAN SHORTAGE PROJECTIONS BY 2032

Primary care physicians	**21,100-55,200**
Non-primary care specialties	**24,800-65,800**
Surgical specialties	**14,300-23,400**

"2019 Update: The Complexities of Physician Supply and Demand: Projections from 2017 to 2032," prepared for the Association of American Medical Colleges; submitted by IHS Markit Ltd., April 2019.

HEALTH CARE WORKFORCE SHORTAGE PROJECTIONS BY 2025

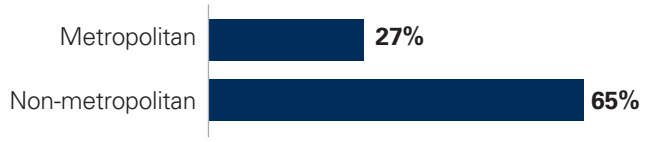
Home health aides	**446,300**
Nursing assistants	**95,000**
Medical and lab technologists/technicians	**98,700**
Nurse practitioners	**29,400**

Stevenson, Matthew. "Demand for Healthcare Workers Will Outpace Supply by 2025: An Analysis of the US Healthcare Labor Market," Mercer HPA, May 2018.

PSYCHIATRIST SHORTAGES BY 2030

Behavioral Health Workforce Projections, 2016-2030," HRSA National Center for Health Workforce Analysis, 2018.

PERCENTAGE OF COUNTIES WITHOUT A PSYCHIATRIST



Andrilla, C. Holly A. et al. "Geographic Variation in the Supply of Selected Behavioral Health Providers," *American Journal of Preventive Medicine*, vol. 54, no. 6, supplement 3 (June 2018): S199-S207.

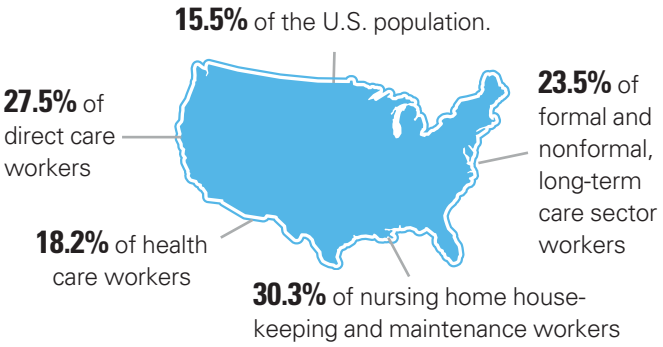
NURSING EDUCATION CAPACITY

75K Number of qualified applicants turned away from baccalaureate and graduate nursing programs by U.S. nursing schools in 2018 due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors and budget constraints.

"Fact Sheet: Nursing Faculty Shortage," American Association of Colleges of Nursing, aacnnursing.org, April 2019.

Workforce and immigration

IN 2017, IMMIGRANTS* ACCOUNTED FOR:



*Immigrants are defined as those born outside the U.S. and are naturalized citizens, legal noncitizens and unauthorized immigrants.
Zallman, Leah et al. "Care For America's Elderly And Disabled People Relies On Immigrant Labor," *Health Affairs*, vol. 38, no. 6 (June 2019).

Drivers of workforce changes

- Generational shifts
- Technology
- Consumerism
- Open talent models (e.g. gig, virtual and contract)
- Diversity*

Radin, Jennifer et al. "The future of work: How can health systems and health plans prepare and transform their workforce?" *Deloitte Insights*, Deloitte Center for Health Solutions, March 7, 2019. © 2019 Deloitte Development LLC.

*"The Imperative for Strategic Workforce Planning and Development: Challenges and Opportunities," American Hospital Association, 2017.

Artificial intelligence (AI) and the workforce

PERCENTAGE OF TASKS THAT COULD BE AUTOMATED IN HEALTH CARE

Implications:

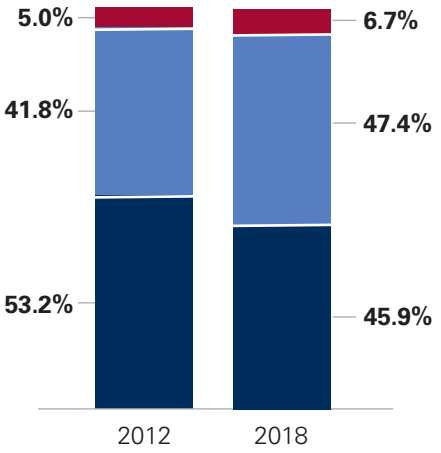
- Improved efficiency, productivity and performance.
- Expanded job responsibilities.
- Practicing at the top of license.
- "Soft" skills will matter more.
- Workforce will acquire new digital skills to be able to collaborate with AI teams.

"AI and the Health Care Workforce," Market Insights, AHA Center for Health Innovation, Sept. 23, 2019.

Learn More at AHA.ORG

Learn more about the AHA's workforce agenda: **aha.org/workforce**

Distribution of physicians by employment status

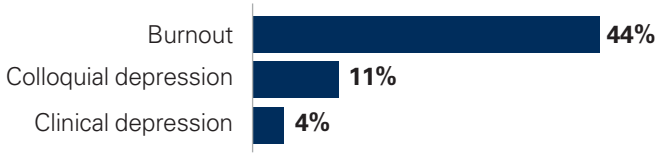


- 2018 marked the first year in which there were fewer physician owners than employees.

Kane, Carol. Policy Research Perspectives — "Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees," AMA Economic and Health Policy Research, American Medical Association, May 2019.

Clinician burnout

PHYSICIAN BURNOUT AND DEPRESSION



Kane, Leslie. "Medscape National Physician Burnout, Depression & Suicide Report 2019," Medscape, Jan. 16, 2019.

NURSE BURNOUT

"Wake Up to the Facts About Fatigue eBook," Kronos, 2018.

PHYSICIAN BURNOUT COST*

Focusing on physician turnover and reduced clinical hours, the annual cost of burnout on a national scale:

$4.6 billion, or $7,600 per employed physician

NURSE BURNOUT COST†

Annual cost of nurse burnout to the average hospital:

$5.2 – $8.1 million

* Han, Shasha et al. "Estimating the Attributable Cost of Physician Burnout in the United States," *Annals of Internal Medicine*, vol. 170, no. 11 (2019): 784-790.
† "2016 National Healthcare Retention & RN Staffing Report," NSI Nursing Solutions Inc., March 2016.

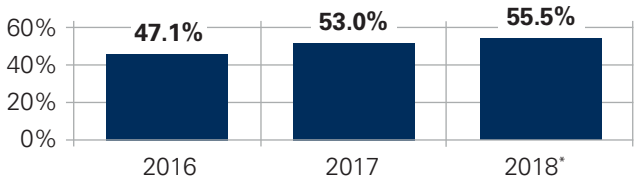
Nonmedical tasks take time

- Primary care physicians spend more than one-half of their workday, nearly 6 hours, interacting with the EHR during and after clinic hours.*
- During the time spent interacting with the EHR, 44% is focused on administrative tasks like order entry and billing and coding, and 24% is focused on inbox management.*
- An ED physician makes 4,000 mouse clicks over the course of a shift.†

* Arndt, Brian G. et al. "Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations," *Annals of Family Medicine*, vol. 15 no. 5 (Sept./Oct. 2017): 419-426.
† Fry, Erika and Schulte, Fred. "Death by a Thousand Clicks: Where Electronic Health Records Went Wrong," *Fortune*, March 18, 2019.

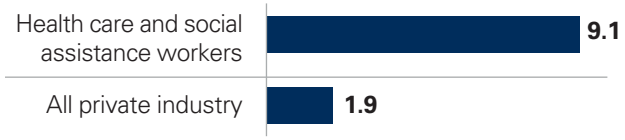
Workplace violence

HOSPITALS THAT HAVE FORMAL WORKPLACE VIOLENCE PREVENTION PROGRAMS



AHA Annual Survey of Hospitals data, American Hospital Association, 2017 - 2019
* 2018 data is preliminary.

RATE OF INTENTIONAL INJURIES BY OTHERS, PER 10,000 WORKERS IN 2017



"Injuries, Illnesses, and Fatalities," Department of Labor, Bureau of Labor Statistics, www.bls.gov/web/osh/cd_r8.htm. Accessed Aug. 7, 2019.

VIOLENCE IN THE EMERGENCY DEPARTMENT (ED)

- Nearly half of emergency physicians stated they have been physically assaulted at work.
- 71% personally witnessed others being assaulted during their shifts.
- 96% of female emergency physicians and 80% of male emergency physicians reported that a patient or visitor made inappropriate or unwanted advances toward them.

"ACEP Emergency Department Violence Poll Research Results," Marketing General Inc. and the American College of Emergency Physicians, September 2018.

Learn More at **AHA.ORG**

Learn more about the AHA's Hospitals Against Violence initiative: **aha.org/workplace-violence**

American Hospital Association™
Advancing Health in America

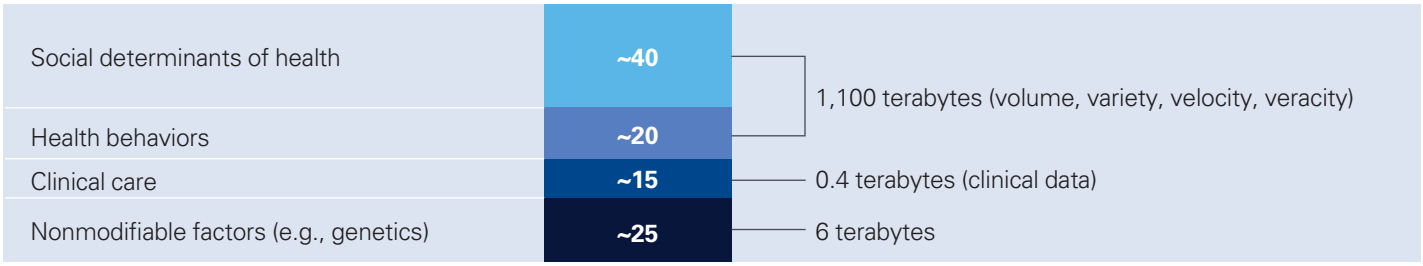
HEALTH

Focus on holistic well-being in partnership with community resources

The health care system is evolving outside the walls of the hospital and into the community in an effort to manage and prevent chronic disease and improve the well-being of patients.

Social determinants of health

SOCIETAL ISSUES HAVE A MAJOR IMPACT ON CONSUMER HEALTH



Note: This graphic has been adjusted from the original version.
Singhal, Shubham and Carlton, Stephanie. "The era of exponential improvement in healthcare?" McKinsey & Company, May 2019.

HOUSING*

- 11% of households spend more than half their income on housing costs.
- Severe housing-cost burden is associated with an increase in food insecurity, child poverty and people in fair or poor health.

FOOD INSECURITY†

- 11.8% of households were food insecure in 2017.
- 40 million people lived in food-insecure households.

* Givens, Marjory et al. "2019 County Health Rankings Key Findings Report," Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, March 2019.
† "Food Security Status of U.S. Households in 2017," Department of Agriculture, Economic Research Service, www.ers.usda.gov, Sept. 5, 2018.

SOCIAL DETERMINANTS AND YOUTH VIOLENCE

Many risk factors of youth violence are the result of chronic stress from living in impoverished neighborhoods or poor housing, food insecurity, racism and other instability.

- Each day, 14 young people become victims of homicide and 1,300 are treated in EDs for nonfatal, assault-related injuries.

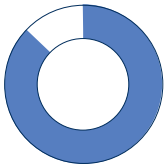
$21 BILLION Estimated cost of youth violence annually

1 in 5 high school students reported being bullied at school

"Preventing Youth Violence — Fast Facts," Centers for Disease Control and Prevention, cdc.gov, Feb. 26, 2019.

Hospitals and social determinants

SCREENING FOR SOCIAL DETERMINANTS



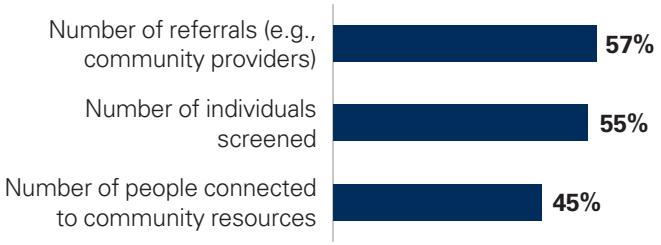
88% of hospitals screen for social needs.

UNMET SOCIAL NEEDS ARE ASSOCIATED WITH:

- Nearly twice the rate of depression.
- 60% higher prevalence of diabetes.
- More than double the rate of ED visits.
- More than double the rate of missed medical appointments.

TOP 3 GOALS UNDERLYING HOSPITALS' STRATEGY ON HEALTH-RELATED SOCIAL NEEDS

TOP 3 TYPES OF SOCIAL NEEDS METRICS TRACKED BY HOSPITALS



Lee, Josh and Korba, Casey. "Social determinants of health: How are hospitals and health systems investing in and addressing social needs?" Deloitte Center for Health Solutions, 2017. © 2017 Deloitte Development LLC.

Behavioral health

NATIONAL LANDSCAPE

1 in 5 Americans affected by behavioral health disorders

- 70% of adults with behavioral health disorders also have physical health conditions.
- Costs are 75% higher for people with both behavioral and physical conditions.
- Fewer than half of adults with any mental health disorder receive treatment.

"Behavioral Health Care is High-Value Care," American Hospital Association, May 2019.

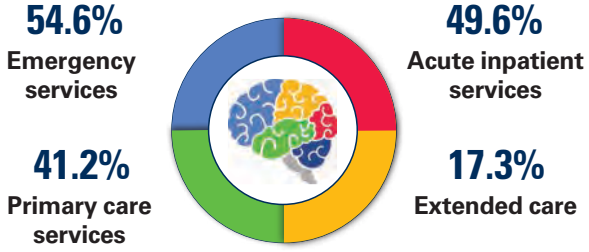
HOSPITALS, HEALTH ORGANIZATIONS AND BEHAVIORAL HEALTH

- Nearly 30% of patients who visited a hospital ED had at least one behavioral health diagnosis.

2,538 Number of community mental health centers in operation across the country in 2017

"Behavioral Health Integration: Treating the Whole Person," American Hospital Association Center for Health Innovation, 2019.

PERCENTAGE OF HOSPITALS REPORTING INTEGRATION OF ROUTINE BEHAVIORAL HEALTH SERVICES INTO THE FOLLOWING AREAS:



AHA Annual Survey of Hospitals data, American Hospital Association, 2019. Data is preliminary.

Major depression

DEPRESSION AND TREATMENT IN THE U.S.

People in the U.S. reporting at least one major depressive episode in 2017:

	No. of people	% of the respective population	% not receiving treatment
Adults	**17.3 million**	**7.1%**	**35.0%**
Adolescents (ages 12 to 17)	**3.2 million**	**13.3%**	**60.1%**

- The prevalence of adults with a major depressive episode was highest among individuals ages 18 to 25.
- The prevalence of a major depressive episode was 13.2% higher among adolescent females compared with males.

"Major Depression," National Institute of Mental Health, www.nimh.nih.gov, February 2019.

Suicide

IN 2017:

- More than 47,000 Americans died by suicide.
- The most common method of suicide — firearm (51%).
- Tenth-leading cause of death in the U.S.
- Second-leading cause of death among individuals ages 10-34.
- There were twice as many suicides as there were homicides.
- 4.3% of adults 18 and older had thoughts about suicide.

Suicide Statistics, National Institute of Mental Health, www.nimh.nih.gov, April 2019.

Veterans' behavioral health

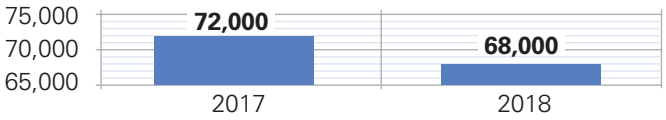
- About 20 former and current veterans die by suicide each day.
- The suicide rate is 22% higher than the general population.
- The Department of Veterans Affairs (VA) is using algorithms to identify potential veterans at risk.
- Since the VA adopted this technology in 2017, 250 fewer veterans have died by suicide than would have been expected based on the previous rate.

Ravindranath, Mohana. "How the VA uses algorithms to predict suicide," *Politico*, June 25, 2019.

Reversing the tide of drug misuse

DRUG OVERDOSES

Preliminary data from the CDC indicates that overdose deaths declined 5.1% in 2018, the first drop in the U.S. since 1990.

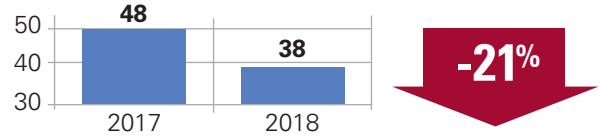


- Deaths from heroin and prescription painkillers are decreasing.

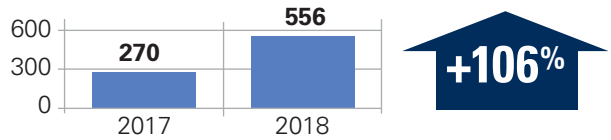
Finnegan, Joanne. "Decline in opioid prescriptions translates to drop in drug overdose deaths for the first time in decades," FierceHealthcare.com, July 18, 2019.

Opioids and naloxone

HIGH-DOSE OPIOID PRESCRIPTIONS (in millions)

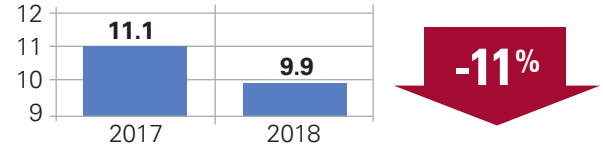


NALOXONE PRESCRIPTIONS INCREASE (in thousands)



Guy, Gery Jr. et al. "Vital Signs: Pharmacy-Based Naloxone Dispensing — United States, 2012–2018," Morbidity and Mortality Weekly Report, (2019) 68:679–686.

MISUSE OF PRESCRIPTION PAIN RELIEVERS BY U.S. RESIDENTS 12 OR OLDER (in millions)



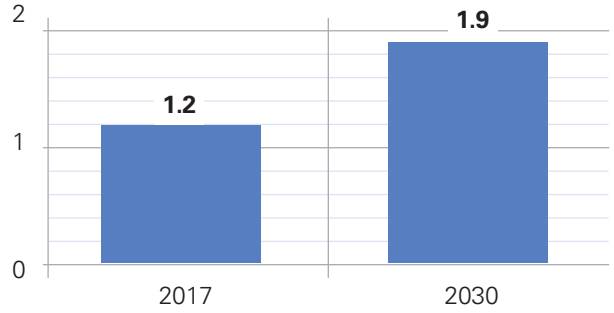
"Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health," Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, HHS Publication No. PEP19-5068, 2019.

Aging population

AMERICANS 65 AND OLDER

	No. of people	% of population
2018	**52 million**	**16%**
2060	**95 million**	**23%**

AMERICANS 65 AND OLDER REQUIRING NURSING HOME CARE (in millions)



Mather, Mark. et al. "Fact Sheet: Aging in the United States," Population Reference Bureau, July 15, 2019.

LONELINESS

Older adults ages 50 to 80:

- Chronic loneliness can impact memory, physical well-being, mental health and life expectancy.

Solway, Erica et al. "Loneliness and health," University of Michigan Institute for Healthcare Policy and Innovation's National Poll on Healthy Aging, March 2019.

ALZHEIMER'S DISEASE

- The sixth-leading cause of death in the U.S.
- 5.8 million Americans are living with the disease.
- By 2050, it is projected that 14 million Americans will have the disease.
- Every 65 seconds someone in the U.S. develops the disease.

$290 BILLION In 2019, Alzheimer's and other dementia will cost the nation $290 billion. By 2050, these costs could rise to **$1.1 trillion**.

"2019 Alzheimer's Disease Facts and Figures Infographic" Alzheimer's Association, alz.org, 2019.

Learn More at **AHA.ORG**

Learn more about the AHA's efforts to create age-friendly health systems: **aha.org/agefriendly**

INNOVATION

Seamless care propelled by teams, technology, innovation and data

The health care field is transforming. The digital health evolution, consumerism, clinical advancements, new entrants and unique partnerships are accelerating this transformation. Hospitals and health systems are taking a leadership role in preparing for the future by investing in innovative technologies, practices and cultures with the goals of improving outcomes, addressing affordability and reducing friction for individuals.

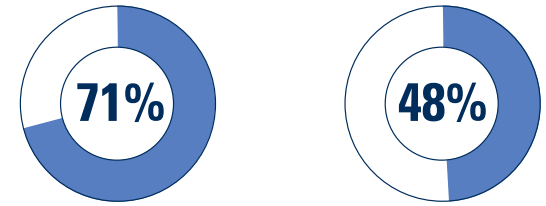
Health system innovation

TOP PRIORITIES FOR INNOVATION INITIATIVES AND INVESTMENTS

Innovation infrastructure

86% of health systems have one or more executives responsible for innovation strategy and oversight.

HEALTH SYSTEMS THAT HAVE A DEFINED DEPARTMENT DEDICATED TO INNOVATION



Forces driving health system innovation

- Prioritizing consumerism.
- Disruption from new entrants.
- Improving quality of care.
- Increasing value-based contracting.
- Decreasing operating margins.

INNOVATION INVESTMENT

14% of health systems have a formal investment or ventures arm.

MOST COMMON HEALTH SYSTEM INNOVATION PARTNERSHIPS

SPEED OF IMPLEMENTING AND SCALING INNOVATION

- 38% of health systems report the ability to scale quickly.
- 88% of health systems with a formal process for scaling innovation report the ability to scale quickly.

"Trends for Scaling Innovation in Health Care," Center for Connected Medicine and the Health Management Academy, June 2019.

Health IT

Based on a survey of health care IT leaders

TOP HEALTH CARE IT SECTORS TO EXPERIENCE GROWTH IN THE NEXT YEAR

TOP CHALLENGES TO HEALTH CARE IT INNOVATION IN THE NEXT YEAR

Roberts, Bryan. "2019 Healthcare Prognosis," Venrock, April 12, 2019.

Digital Health Forecast

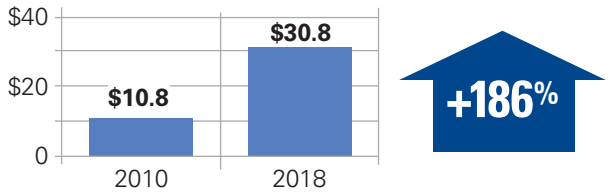
Health care IT leaders predict that digital health innovators will work to demonstrate real-world applications.

Examples:

- Broader adoption of AI and machine learning in population health to improve identification of those at risk and delivery of personalized services.
- Virtual reality/augmented reality as a routine treatment for pain control.
- Wearables and implantable health devices to enable detection of chronic conditions and monitor treatments.
- Broader use of voice recognition and intelligent assistants to reduce clinician burden.
- Increased use and impact of digital therapeutics.

"2019 Healthcare Trends Forecast: The Beginning of a Consumer-Driven Reformation," Healthcare Information and Management Systems Society (HIMSS), 2019.

HEALTH TECH AND DIGITAL HEALTH INVESTMENTS (in billions)

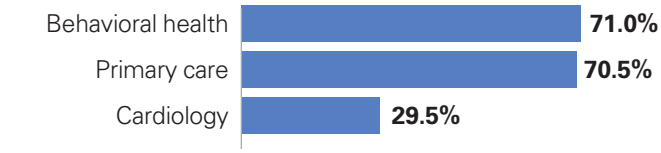


Singhal, Shubham and Carlton, Stephanie. "The era of exponential improvement in healthcare?" McKinsey & Company, May 2019.

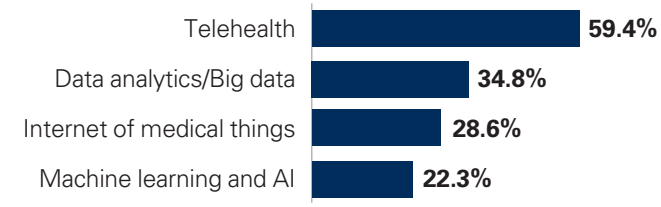
Disruptive innovation

Based on a survey of health care leaders

SERVICE LINES MOST RIPE FOR DISRUPTION FROM TECHNOLOGY

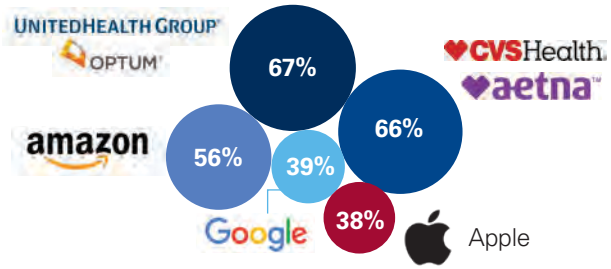


TECHNOLOGY THAT WILL HAVE THE BIGGEST IMPACT ON HEALTH CARE IN 2020



Survey to Health Care Leaders and Strategists, AHA Society for Health Care Strategy & Market Development, June 2019.

ORGANIZATIONS POSING STRONG COMPETITION TO HOSPITALS AND HEALTH SYSTEMS

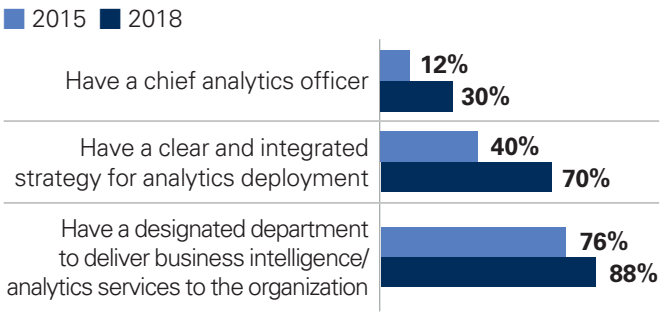


Crnkovich, Paul et al. "2019 State of Consumerism in Healthcare: The Bar is Rising," Kaufman Hall, 2019.

Health analytics

- Health systems with a higher number of value-based care arrangements are more likely to have a mature approach to analytics.

HEALTH SYSTEMS' INVESTMENT IN ANALYTICS



Hagan, Alison et al. "Shifting into high gear: Health systems have a growing strategic focus on analytics today for the future," *Deloitte Insights*, Deloitte Center for Health Solutions, 2019. © 2019 Deloitte Development LLC.

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THE DYNAMICS OF HEALTHCARE ARE SHIFTING

OUR LEADERS KEEP HOSPITALS HEALTHY.

A leadership opening can be an opportunity to re-engineer processes and re-energize your team. B.E. Smith is a strategic partner uniquely equipped to engage and secure the right talent across the continuum from managers to executives.

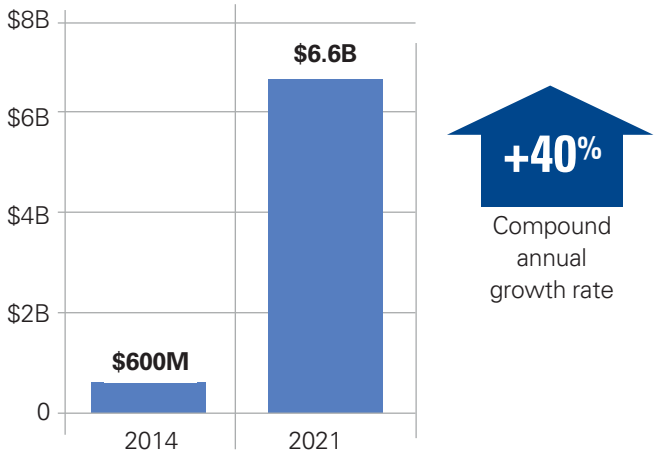
We work in collaboration with our clients and our candidates to ensure we are placing and supporting the right people, in the right place, at the right time. They consistently improve clinical, financial, and operational performance; reduce disruption; and enhance the patient experience.

GET TO KNOW

B.E. SMITH®
an AMN Healthcare company

Artificial Intelligence (AI)

HEALTH AI MARKET SIZE



Collier, Matt, Fu, Richard and Yin, Lucy. "Artificial Intelligence: Healthcare's New Nervous System," Accenture, June 2017.

10 AI applications with the greatest near-term impact in health care

- Robot-assisted surgery
- Virtual nursing assistants
- Administrative workflow assistance
- Fraud detection
- Dosage error reduction
- Connected machines
- Clinical trial participant identifier
- Preliminary diagnosis
- Automated image diagnosis
- Cybersecurity

$150 BILLION possible resulting savings by 2026

Collier, Matt, Fu, Richard and Yin, Lucy. "Artificial Intelligence: Healthcare's New Nervous System," Accenture, June 2017.

Personal genetic data

- By the start of 2019, more than 26 million consumers added their DNA to four leading commercial ancestry and health databases.
- As many people purchased consumer DNA tests in 2018 as in all previous years combined.
- If the pace continues, these companies could have the genetic makeup of more than 100 million people by the start of 2021.

Regalado, Antonio. "More than 26 million people have taken an at-home ancestry test," MIT Technology Review, Feb. 11, 2019.

Internet of Things (IoT)

AVERAGE NUMBER OF INTERNET-CONNECTED DEVICES PER PERSON IN THE U.S.

Cisco "Complete Visual Networking Index (VNI) Forecast, 2017-2022."

Opportunities and challenges of IoT

Opportunities:

Telehealth and remote monitoring, smart sensors, medical device integration, health care building facilities that optimize clinical processes and operational systems, voice assistants, robotics, smart pills and treatments of diseases.†

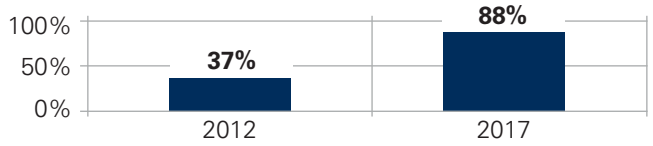
Challenges:

Data storage capability, cyberrisk, the need to update hospital infrastructure and human error.‡

† "IoT in Healthcare: Are We Witnessing a New Revolution?" Sciforce, Medium.com, Mar. 7, 2019.
‡ Matthews, Kayla. "5 Challenges Facing Health Care IoT in 2019," iotforall.com, Dec. 27, 2018.

Interoperability

PERCENTAGE OF HOSPITALS THAT SEND RECORDS TO AMBULATORY CARE PROVIDERS OUTSIDE THEIR SYSTEMS



BARRIERS TO INTEROPERABILITY

Other providers do not have an EHR or lack capability to receive information	63%
Experience challenges sending/receiving data across different vendor platforms	57%
Difficult to match or identify the correct patient between systems	37%
Additional costs to send/receive data with organizations outside system	35%
Had to develop customized interfaces to exchange information electronically	28%

"Sharing Data, Saving Lives: The Hospital Agenda for Interoperability," American Hospital Association, January 2019.

Learn More at AHA.ORG

Learn more about the AHA Center for Health Innovation: **aha.org/center**

American Hospital Association™
Advancing Health in America

AFFORDABILITY AND VALUE

The best care that adds value to lives

Affordable health care is one of the biggest concerns facing families, employers and government. Health care transformation and value-based care models focusing on populations can improve the quality of care at a lower cost.

COST TO STAKEHOLDERS

U.S. national health expenditures

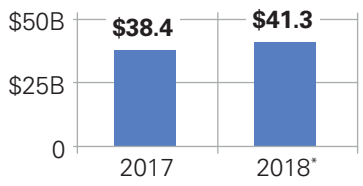
Year	% growth	Amount	% of GDP
2017	**3.9%**	**$3.5 trillion**	**17.9%**
2018*	**4.4%**	**$3.6 trillion**	**17.8%**
2019*	**4.8%**	**$3.8 trillion**	**17.8%**
2020-2027*	**5.7% average**	**$6.0 trillion by 2027**	**19.4% by 2027**

*Projection

National Health Expenditures Projections 2018-2027 — Tables, Office of the Actuaries Actuary, CMS, cms.gov, Feb. 20, 2019.

Financial impact for hospitals

HOSPITALS' COST TO PROVIDE UNCOMPENSATED CARE (in billions)



AHA Annual Survey of Hospitals data, American Hospital Association, 2018 and 2019.
* 2018 data is preliminary.

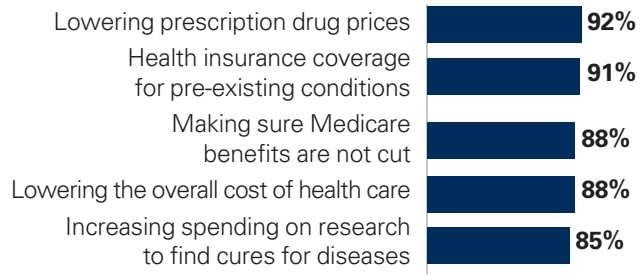
$76.6 BILLION

Combined Medicare and Medicaid underpayments to hospitals in 2018*

Patient perspective

69% Reducing health care costs should be a top national priority.

TOP HEALTH CARE PRIORITIES



Blendon, Robert J. et al. "The Upcoming U.S. Health Care Cost Debate — The Public's Views," *New England Journal of Medicine*, vol. 380 no. 26 (2019): 2487-2492.

OUT-OF-POCKET COSTS

- Out-of-pocket costs increased by 12% for inpatient, outpatient and ED care from 2017 to 2018*
- Medical fundraisers account for 1 in 3 campaigns for the crowdsourcing website GoFundMe.†

* "Out-of-Pocket Costs Rising Even as Patients Transition to Lower Cost Settings of Care," TransUnion Healthcare, June 25, 2019.
† Zdechlik, Mark. "Patients Are Turning To GoFundMe To Fill Health Insurance Gaps," National Public Radio, npr.org, Dec. 27, 2018.

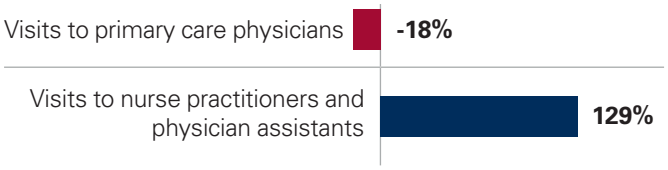
Employer-sponsored plans

INDIVIDUALS ENROLLED IN EMPLOYER-SPONSORED PLANS

- Half of Americans say they or an immediate family member have put off going to the doctor, not filled a prescription or delayed other medical care because of cost.*
- Four in 10 had difficulty paying a medical bill or insurance premium within the past year.†
- Four in 10 enrolled in a high-deductible plan do not have enough savings to cover the deductible.†
- One in 5 say health care costs have used up all or most of their savings.†

* Martin, Rachel. "Employees Start To Feel The Squeeze Of High-Deductible Health Plans," National Public Radio, npr.org, May 3, 2019.
† Levey, Noam N. "Health insurance deductibles soar, leaving Americans with unaffordable bills," *Los Angeles Times*, May 2, 2019.

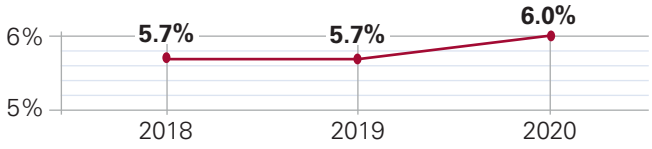
TRENDS AMONG CONSUMERS WITH EMPLOYER-SPONSORED INSURANCE FROM 2012 TO 2016



Frost, Amanda and Hargraves, John. "HCCI Brief: Trends in Primary Care Visits," Health Care Cost Institute, October 2018.

Medical cost trend

THE MEDICAL COSTS IN THE EMPLOYER INSURANCE MARKET PROJECTED TO INCREASE

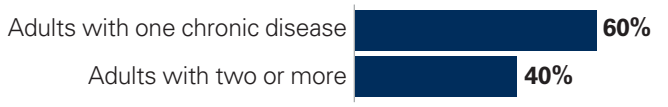


Drivers of medical cost trend

Retail drugs

Between 2020 and 2027, retail drug spending under private health insurance is projected to increase 3-6% a year.

Chronic disease

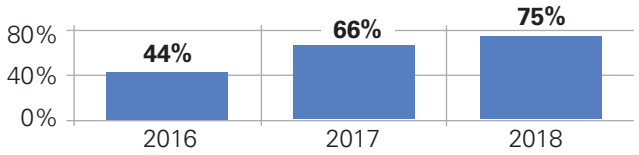


- For employers, per capita spending on an individual with a complex chronic disease is 8 times that of a healthy individual.

"Medical cost trend: Behind the numbers 2020," PWC Health Research Institute, June 2019.

Mental health services

PERCENTAGE OF EMPLOYERS OFFERING MENTAL HEALTH DISEASE-MANAGEMENT PROGRAMS



- Costs will go up in the short term. In the long term, addressing mental health is a significant deflator of medical cost trend.

"Medical cost trend: Behind the numbers 2020," PWC Health Research Institute, June 2019.

Employees bear the cost

- Average deductibles for employer-sponsored plans tripled between 2008 and 2018.*
- Average annual rate of cost sharing outpaced growth in wages from 2006 to 2016.*

- 84% of employers offered a High-Deductible Health Plan (HDHP) in 2019.*
- Enrollment in HDHPs reached 47% of the commercially insured, pre-Medicare population in 2018, representing a 3.3% increase from 2017.†

*"Medical cost trend: Behind the numbers 2020," PWC Health Research Institute, June 2019.
†Daly, Rich. "High-Deductible Plans Surge: CDC," Healthcare Financial Management Association, Aug. 28, 2018.

Prescription drugs

PRICES FOR MORE THAN 3,400 DRUGS INCREASED IN THE FIRST SIX MONTHS OF 2019

- An increase of 17% in the number of drug price increases.
- Average increase is 10.5% — five times the rate of inflation.

Picchi, Aimee. "Drug prices in 2019 are surging, with hikes at 5 times inflation," CBS News, cbsnews.com, July 1, 2019.

HOSPITAL PRESCRIPTION DRUG SPENDING

- Average total drug spending per hospital admission increased by 18.5% from 2015 to 2017.

"Recent Trends in Hospital Drug Spending and Manufacturer Shortages," NORC at the University of Chicago, Jan. 15, 2019.

MEDICARE AND MEDICAID DRUG SPENDING

From 2013 to 2017, prescription drug spending grew at an annual rate of 10.6% in Medicare Part D, 10.0% in Part B and 14.8% in Medicaid.

"CMS Updates Drug Dashboards with Prescription Drug Pricing and Spending Data," cms.gov, March 14, 2019.

PRESCRIPTION SPECIALTY DRUG COSTS IN 2017

$78,781 The average annual cost of prescription specialty drugs

vs.

$60,336 The median U.S. household income

7.0% Increase in cost vs. 2016

vs.

2.1% General rate of inflation

Schondelmeyer, Stephen W. and Purvis, Leigh. "Trends in Retail Prices of Specialty Prescription Drugs Widely Used by Older Americans: 2017 Year-End Update," AARP Public Policy Institute, June 2019.

Drug shortages

- Cost hospitals $359 million a year in additional labor costs.
- More than half of hospitals reported they had managed at least 20 shortages during a six-month period.

Vizient, Inc. Survey, "Drug shortages and labor costs, Measuring the hidden costs of drug shortages on U.S. hospitals," Vizient, Inc., June 2019.

Learn More at AHA.ORG

Learn more about AHA's The Value Initiative at **aha.org/value-initiative**

Advanced illness and palliative care

- Advanced illness accounts for 4% of the Medicare population and 25% of its costs.*
- 12 million U.S. adults and 400,000 children are living with serious illness.†
- 72% of hospitals with 50+ beds have a palliative care program.†

PALLIATIVE CARE IMPACT

$3.5 BILLION per year savings if hospitals nationwide implement high-quality palliative programs

66% reduction in symptom distress reported by palliative care patients

* Stuart, Brad et al. "A Large-Scale Advanced Illness Intervention Informs Medicare's New Serious Illness Payment Model," *Health Affairs*, vol. 38, no. 6 (2019): 950-956.
† "Changing how we think about palliative care," American Hospital Association, aha.org/palcare. Accessed Aug. 9, 2019.

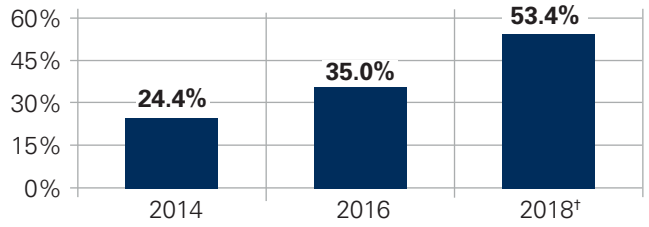
Learn More at AHA.ORG

Learn more about the AHA partnership with the Center to Advance Palliative Care: **aha.org/palcare**

CARE MODELS

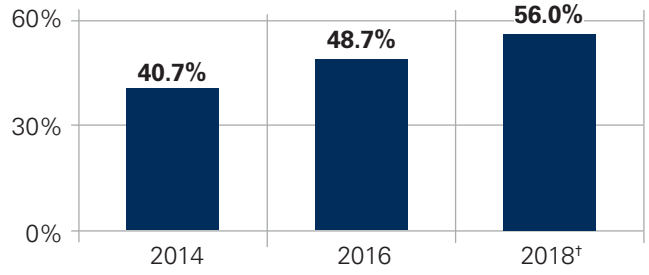
Trends in delivery models

HOSPITALS PARTICIPATING IN AN ACCOUNTABLE CARE ORGANIZATION (ACO)*

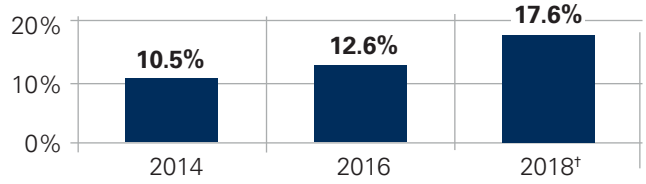


NOTE: 2018 survey question is not directly comparable to prior years.

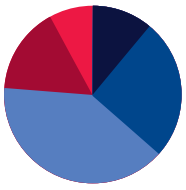
HOSPITALS WITH CONTRACTS WITH COMMERCIAL PAYERS TIED TO QUALITY/SAFETY PERFORMANCE*



HOSPITALS WITH SOME PERCENTAGE OF NET PATIENT REVENUE PAID ON A SHARED RISK BASIS*



HEALTH CARE LEADERS THINK VALUE-BASED RELATIONSHIPS THAT CONTAIN BOTH UPSIDE AND DOWNSIDE RISK WILL OCCUR‡



Less than 1 year	9.7%
1-2 years	26.7%
3-5 years	39.8%
5 or more years	17.5%
Never	6.3%

- Obstacles to shared-risk, value-based contracts: limitations in data sharing, no agreement on outcomes measures and a lack of incentives for payers and providers to work together

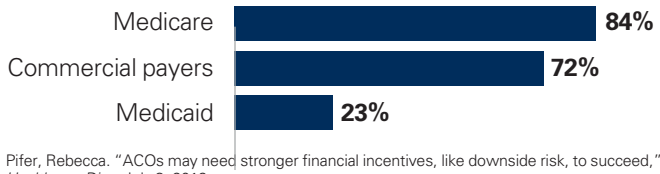
* AHA Annual Survey of Hospitals data, American Hospital Association 2015-2019.
† 2018 data is preliminary.
‡ "White Paper: The 9th Annual Industry Pulse Survey," Change Healthcare and the HealthCare Executive Group, March 18, 2019.

ACOs

ACOs BY THE NUMBERS

- The number of ACOs has multiplied 5 times since 2012.
- At the end of the first quarter of 2018, there were more than 1,000 ACOs across the U.S., covering 33 million lives and representing almost 1,500 commercial and public payment arrangements.
- 33% of ACOs had at least one contract with downside risk.

IN 2018, ACOs CONTRACTED WITH:



Pifer, Rebecca. "ACOs may need stronger financial incentives, like downside risk, to succeed," *Healthcare Dive*, July 3, 2019.

$740 MILLION Net savings generated by Medicare ACOs in 2018.

Verma, Seema. "Interest In 'Pathways To Success Grows: 2018 ACO Results Show Trends Supporting Program Redesign Continue," *HealthAffairs* blog, Sept. 30, 2019.

Top ACO priorities

TOP 5 PRIORITIES OF INTEGRATED SYSTEM/ HOSPITAL-LED ACOs

Reduce avoidable emergency department visits and inpatient admissions	57%
Manage post-acute care spending and quality	50%
Prevent readmissions through better care transitions	42%
Actively manage high-need, high-cost patients	37%
Reduce avoidable/unnecessary care	29%

TOP 5 CHALLENGES OF INTEGRATED SYSTEM/ HOSPITAL-LED ACOs

Difficulty aligning physician compensation with value-based contracts	63%
Ability to design and implement care delivery changes	57%
Quality of data provided by payers	36%
Lack of data analytic capability and tools	33%
Prospect of/participation in mandatory downside risk	22%

Edwards, Kerstin, et al. "The 2018 ACO Survey: Unique Paths to Success," Leavitt Partners, March 2019.

VALUE AND PERFORMANCE IMPROVEMENT

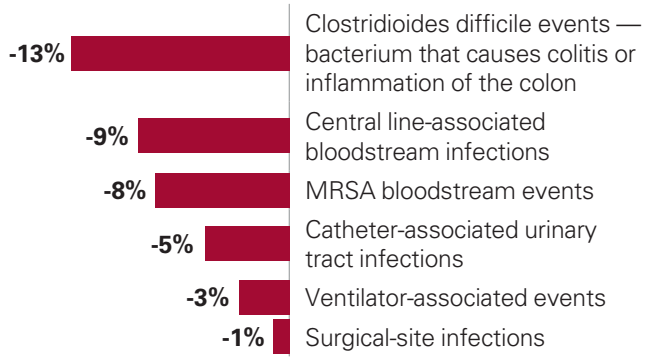
Performance improvement practices yield positive outcomes

HOSPITAL-ACQUIRED CONDITIONS: PROGRESS BETWEEN 2014 AND 2017

- 13% decrease in conditions
- 20,500 lives saved
- $7.7 billion saved in health care costs

"AHRQ National Scorecard on Hospital-Acquired Conditions," Agency for Healthcare Research and Quality, Rockville, Md. https://www.ahrq.gov/professionals/quality-patient-safety/pfp/index.html, January 2019.

PERCENTAGE DECREASE IN HOSPITAL-ACQUIRED INFECTIONS BETWEEN 2016 AND 2017 IN ACUTE CARE HOSPITALS



"2017 National and State Healthcare-Associated Infections Progress Report," Centers for Disease Control and Prevention, cdc.gov. Accessed July 28, 2019.

Top 5 patient safety concerns

- Diagnostic stewardship and test result management using EHRs
- Antimicrobial stewardship in physician practices and aging services
- Burnout and its impact on patient safety
- Patient safety concerns involving mobile health
- Reducing discomfort with behavioral health

"2019 Top 10 Patient Safety Concerns — Executive Brief," ECRI Institute, https://www.ecri.org/landing-top-10-patient-safety-concerns-2019. Accessed March 12, 2019.

Learn More at **AHA.ORG**

Learn more about how the AHA accelerates performance improvement and advances patient safety: **aha.org/center/performance-improvement**

American Hospital Association™ Advancing Health in America

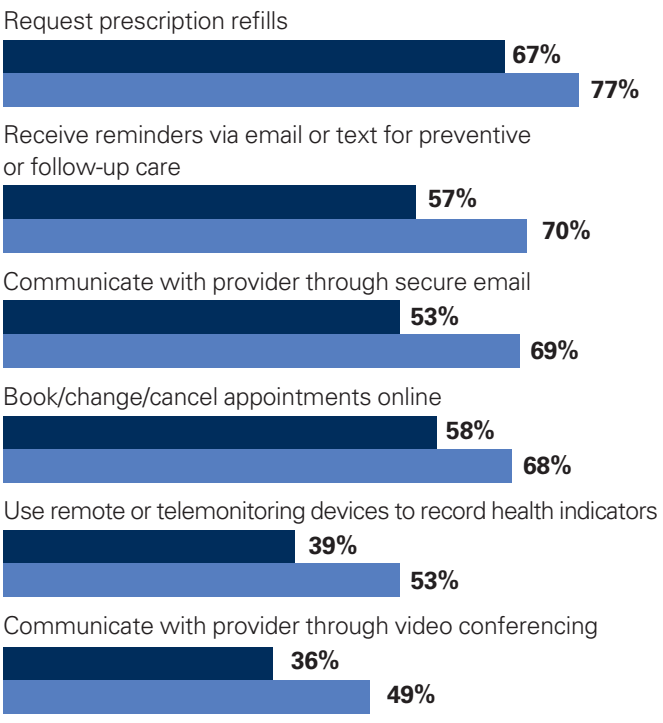
INDIVIDUAL AS PARTNER

Recognize the diversity of individuals and serve as partners in their health

Health care providers are fostering true patient engagement, recognizing that individuals are increasingly viewing health care through a consumer lens and connecting in ways that make sense in today's digital world.

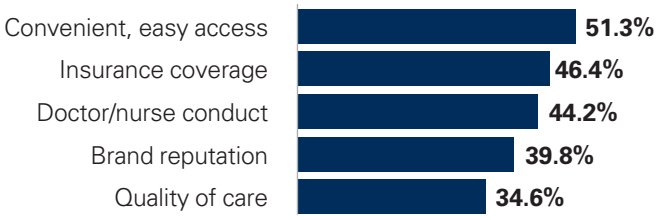
The consumer perspective

THE FOLLOWING ELECTRONIC CAPABILITIES INCREASE THE LIKELIHOOD OF AN INDIVIDUAL CHOOSING A PROVIDER:



Safavi, Kaveh and Kalis, Brian. "Today's Consumers Reveal the Future of Healthcare: The Accenture 2019 Digital Health Consumer Survey," Accenture, Feb. 12, 2019.

MOST IMPORTANT HEALTH CARE FACTORS INFLUENCING CONSUMERS' DECISION-MAKING

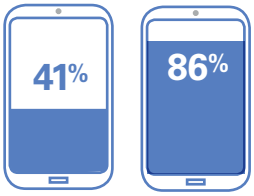


"2019 Healthcare Consumer Trends Report," NRC Health, Jan. 6, 2019.

Virtual care

Interest in virtual care is higher among consumers with more complex needs.*

EMPLOYERS OFFERING TELEHEALTH SERVICES†



61% of employers set employee cost-sharing lower for telemedicine visits than in-person visits in 2019.

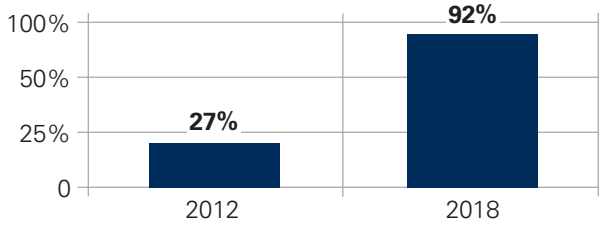
CONSUMERS WITH EMPLOYER COVERAGE ARE WILLING TO USE TELEHEALTH FOR:†

Ongoing assessment of a physical condition or ailment	**62%**
Initial assessment of a physical condition or ailment	**43%**
Mental/behavioral health services	**27%**
Emergency situations, such as urgent care	**25%**

* Safavi, Kaveh and Kalis, Brian. "Today's Consumers Reveal the Future of Healthcare: The Accenture 2019 Digital Health Consumer Survey," Accenture, Feb. 12, 2019.
† "Medical cost trend: Behind the numbers 2020," PWC Health Research Institute, June 2019.

Online Access

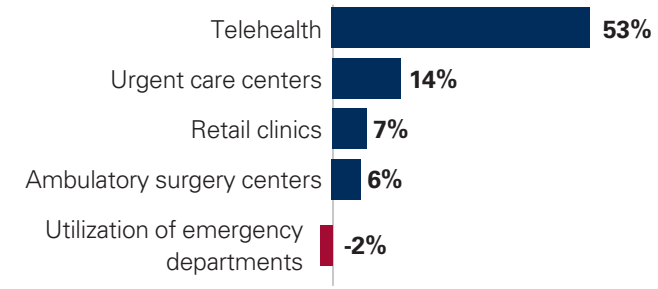
PERCENTAGE OF HOSPITALS THAT PROVIDE PATIENTS WITH THE ABILITY TO VIEW HEALTH INFORMATION ONLINE



AHA Annual Survey Information Technology Supplement, American Hospital Association, 2018.

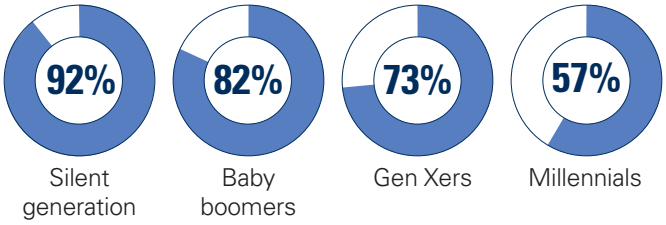
Alternative places of health care services: Consumer trends

UTILIZATION GROWTH RATES FROM 2016 TO 2017 ACCORDING TO PRIVATELY INSURED HEALTH CARE CLAIMS DATA



"FH Healthcare Indicators® and FH Medical Price Index® 2019: An Annual View of Place of Service Trends and Medical Pricing," White Paper, FAIR Health®, Inc., April 2019.

Who has a primary care physician?



MacCracken, Linda and Meklaus, Gerry. "Digital Health: When Primary Care is not Always Primary," Accenture, Sept. 19, 2018.

LGBTQ disparities

- 16% of people who identify as lesbian, gay, bisexual, trans, queer/questioning (LGBTQ) report being personally discriminated against when going to a doctor or health clinic because they are part of the LGBTQ community.*
- 18% of people who identify as LGBTQ say they have avoided medical care, even when in need, citing fear of discrimination.*
- High school students who identify as LGB are almost 5 times as likely to attempt suicide compared with their heterosexual peers.†
- Adults ages 50 to 95 who identify as LGBT reported greater rates of disability, depression and loneliness and increased likeliness to smoke and binge-drink compared with heterosexuals of similar ages.‡

* "Discrimination in America: Experiences and View of LGBTQ Americans," National Public Radio, Robert Wood Johnson Foundation and Harvard T.H. Chan School of Public Health, November 2017.
† LGBTQ, National Alliance on Mental Health, www.nami.org/find-support/lgbtq, Accessed Sept. 12, 2019.
‡ Seegert, Liz, "National study finds LGBT seniors face tougher old age," Association of Health Care Journalists, July 18, 2018.

Learn More at AHA.ORG

Learn more about the AHA's Institute for Diversity and Health Equity: **diversityconnection.org**

IMPACT AND LANDSCAPE OF HOSPITALS AND HEALTH SYSTEMS

Hospitals and health systems serve patients and communities as critical access points of health care services across the country.

Health care and the economy

11% of all jobs in the overall U.S. economy at the end of 2018 were in the health care sector.*

1 in 7 new jobs in the overall U.S. economy at the end of 2018 were in the health care sector.*

2.8 MILLION Number of jobs added to the health care sector between 2006 and 2016, a rate of growth almost 7 times faster than the rest of the economy†

Projections

- Employment of health care occupations is projected to grow 18% from 2016 to 2026, much faster than the average for all occupations, adding about 2.4 million new jobs.†
- Job growth in the home health field is projected to grow 54% from 2016 to 2026.‡

* Commins, John. "Healthcare Job Growth Outpaced Nearly Every Other Sector in 2018," *HealthLeaders*, Jan. 4, 2019.
† Salsberg, Edward and Martiniano, Robert. "Health Care Jobs Projected To Continue To Grow Far Faster Than Jobs In The General Economy," *Health Affairs*, May 9, 2018.
‡ "Occupational Outlook Handbook," Department of Labor, Bureau of Labor Statistics. Accessed Aug. 13, 2019.

American Hospital Association™
Advancing Health in America

Hospital prices

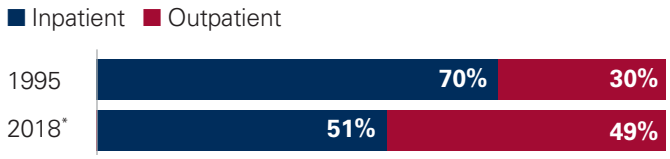
HOSPITAL PRICE GROWTH REMAINS LOW

In August 2019, annual health insurance inflation hit a five-year peak of 18.6%, while hospital prices increased just 2.1%.

Bureau of Labor Statistics Consumer Price Index data, 2019.

Community hospitals

INPATIENT/OUTPATIENT REVENUES FOR COMMUNITY HOSPITALS

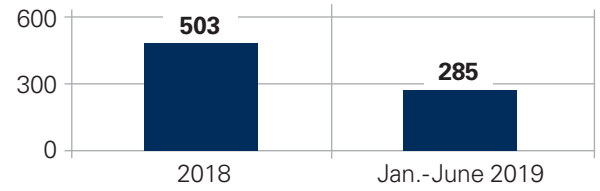


AHA Annual Survey of Hospitals data, American Hospital Association, 1996-2019.
*2018 data is preliminary.

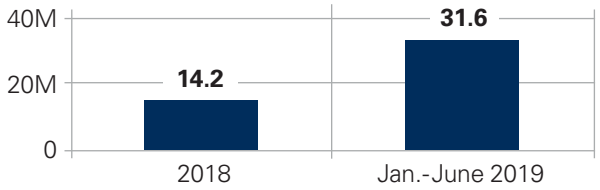
Cybersecurity

Health care cyber incidents

NUMBER OF U.S. HEALTH CARE DATA BREACHES



NUMBER OF PATIENT RECORDS AFFECTED
(in millions)



FROM JANUARY THROUGH JUNE 2019:

- External hacking was responsible for 88% of breached records.
- 72% of incidents occurred in the provider setting.
- Incidents involving business associates/third parties affected 74% of total patient records.

"Protenus 2019 Mid-Year Breach Barometer, Breached Patient Records in First Half of 2019 Double the Total for All of 2018," Protenus, Inc. in collaboration with DataBreaches.net, July 2019.

Learn More at AHA.ORG

Learn more about AHA cybersecurity and risk resources and services: **aha.org/cyberrisk**

The rural landscape

Rural hospitals at risk

- According to a study of hospital closure impacts, rural closures were associated with a 5.9% increase in inpatient mortality.*

AS OF SEPTEMBER 2019†

- 118 rural hospitals have closed since January 2010.
- 17 hospitals closed in 2019 alone, outpacing previous years.

* Gujral, Kritee, et al. "Impact of Rural and Urban Hospital Closures on Inpatient Mortality," Working Paper Series, National Bureau of Economic Research, July 22, 2019.
† The Cecil G. Sheps Center for Health Services Research, University of North Carolina, shepscenter.unc.edu. Accessed Oct. 10, 2019.

Rural health care workforce shortages

- While almost 20% of the U.S. population lives in rural areas, less than 10% of physicians practice in these communities.*

66% of primary care physician shortages in the U.S. in 2018 were located in rural or partially rural areas.†

62% of mental health professional shortages in the U.S. in 2018 were located in rural or partially rural areas.†

-23% Decrease in the supply of physicians in rural areas by 2030 while remaining steady in urban areas†

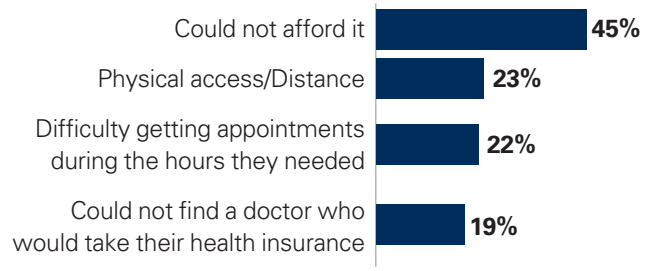
- In 2017, more than 50% of rural physicians were at least 50 years old and more than 25% were at least 60 years old.†

* Joynt E. Karen, et al. "Rural Hospital Participation and Performance in Value-Based Purchasing and Other Delivery System Reform Initiatives," ASPE Office of Health Policy, October 19, 2016.
† Skinner, Lucy, et al., "Implications of an Aging Rural Physician Workforce," *New England Journal of Medicine*, 2019; 381:299-301.

Health care access in rural America

- 42% of rural adults without health insurance reported they did not get care when they needed it, while 24% of those with health insurance did not get care when they needed it.

REASONS FOR NOT GETTING CARE



"Life in Rural America, Part II," National Public Radio, Robert Wood Johnson Foundation and Harvard T.H. Chan School of Public Health, May 1, 2019.

Learn More at AHA.ORG

Learn more about AHA rural health resources: **aha.org/rural**

AHA Agenda for Innovation and Transformation

The AHA continually examines the environment to develop strategies that both address the issues of today and proactively prepare our field for the future. The AHA's Agenda for Innovation and Transformation advances the areas of public policy, field engagement and innovation to enhance our support, value and leadership for members. Maryjane Wurth is responsible for AHA's overall strategic direction and is the lead executive for the AHA Center for Health Innovation.

Q&A

MARYJANE WURTH

Executive Vice President and Chief Operating Officer of the American Hospital Association

QUESTION: Hospitals and health systems are investing in innovation to address access, affordability and outcomes. What role does the AHA play in assisting and encouraging innovative culture, processes and solutions throughout the hospital field?

WURTH: Over a year ago, we launched the AHA Center for Health Innovation to help members drive high-impact innovation and transformation within their organizations and communities. The Center provides market intelligence, key insights, targeted education and actionable data and tools that support the unique situations of our members. One goal is to help hospitals and health systems build innovation capacity within their institutions.

Additionally, the AHA is uniquely positioned to provide a national perspective on forward-looking ideas and solutions, helping members learn from each other as well as traditional and nontraditional stakeholders. Examples include the AHA's work with more than 1,600 hospitals in the Hospital Improvement Innovation Network, efforts to address affordability through The Value Initiative, creation of a data collaborative with state hospital associations, exploration of new delivery models and development of resources to support population health management.

We're taking the work of spreading ideas and best practices to the next level. We are developing a process to scale transformation throughout the field through the Center's new virtual entity called the Design Studio, created in partnership with members, that focuses on advancing the next-generation health care system.

QUESTION: Can you tell us more about the AHA Design Studio? How is it different from hospital and health system innovation centers?

WURTH: The purpose of the Design Studio is to accelerate and lead transformation, addressing complex challenges in the field with unique member collaborations. The Design Studio will not duplicate what hospitals and systems are doing in their labs. The goal is to harness hospitals' and health systems' collaborative energy to discover novel solutions that would be much more challenging, or perhaps impossible, to develop alone.

The work in the Design Studio is based on a human-centered design approach. As the virtual studio 'rooms' progress, the design teams may take different paths and employ unique approaches. The Design Studio will emphasize issues that matter to our members and will rely on their input, engagement and enthusiasm. Our initial areas of focus, supported by the AHA's Board of Trustees, are behavioral health, EHR data usability and risk approaches.

A key outcome of the Design Studio will be the spread of curated learnings to all members throughout the design process. Other outcomes could include transformational partnerships, products, resources or tools or other outcomes we have yet to imagine. Our journey may take surprising turns. All together, the Design Studio ideas, solutions and results will drive value to address affordability and better health for patients, families and communities.

Innovation

2019 AHA CHAIR-ELECT

Melinda L. Estes, M.D.
President and CEO, Saint Luke's Health System

"Innovation is not just a buzz word — it is a shift in mindset and culture that allows for both continual improvement and transformative ideas to develop from all stakeholders within hospitals and health systems. The digital health evolution plays an important role; however, both high-tech and high-touch solutions are needed to solve our most difficult challenges. A starting point for innovation is to truly listen to and understand the needs of our patients and communities."

Next-gen leaders

2019 AHA CHAIR

Brian Gragnolati
President and CEO, Atlantic Health System

"I am optimistic about health care's future because emerging leaders in our field have the passion for improving the health of patients and populations and have an inspirational vision for a reimagined health system. They understand that health care is a team sport, and teams are more diverse and multigenerational than ever before. High-functioning teams that are empowered can express empathy, embrace change, solve problems and improve the health care experience for all."

Affordability

2019 AHA IMMEDIATE PAST CHAIR

Nancy Howell Agee
President and CEO, Carilion Clinic

"Affordability is one of the most important factors influencing Americans' ability to access care. The AHA recognizes that addressing the out-of-pocket costs for our patients needs to be a key focus of our efforts. From redesigning delivery and payment systems, to implementing operational solutions and investing in innovation, the hospital field is making changes to increase value, improve outcomes and reduce costs. And we are working to influence other stakeholders to do the same."

How to use the 2020 AHA Environmental Scan

- **Share with your board and staff at meetings and retreats.** Ask: What two or three pieces of information concern or surprise you the most? What are the implications for our patients and our community? If we were reinventing the health care system from scratch, what kind of system would we create to respond to these issues?
- **Use the information to tell your story to the community you serve.** Identify vehicles for these communications, such as presentations, reports, op-eds and material you share with legislators and funders. Post relevant information to your website and link to the entire Environmental Scan at **aha.org/environmentalscan**.
- **Talk with your strategy team** about the implications on your strategic plan, partnerships and business development strategy. Identify possible disruptions to your organization's business model. Use the scan data and themes in a SWOT analysis (strengths, weaknesses, opportunities and threats).
- **Talk with your chief innovation officer and chief financial officer** about the implications for your investment in innovation.
- **Perform competitive analyses and gather intelligence** to understand what existing or potential competitors might be planning around these trends.

Learn More at **AHA.ORG**

Continue exploring AHA's market intelligence, strategy and data resources on a regular basis to bring fresh issues and data to your teams. Resources include:

- AHA Data: **ahadata.com**
- AHA Market Scan e-newsletter: **aha.org/marketscan**
- AHA Market Insight reports: **aha.org/marketinsights**
- Futurescan 2020-2025, a publication exploring key issues that are transforming the field: **shsmd.org/futurescan**
- Learn about additional AHA tools and resources to help you Scan and Plan throughout the year: **aha.org/scanandplan**

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4 PILLARS TO BUILD LEADERSHIP STRENGTH

Organizations must simultaneously pursue strategies in these four areas to build strong leadership. Discover what insights are influencing the healthcare workforce.

RETENTION

40% HAVE A FORMAL SYSTEM FOR IDENTIFYING HIGH-PERFORMING LEADERS

45% HAVE STRATEGIES TO RETAIN TOP PERFORMERS

PREFERRED METHOD OF RECRUITING

37% REFERRALS

22% WEBSITE

INFLUENTIAL FACTORS TO RETAINING TOP TALENT

27% SUCCESSION PLANNING

27% BENEFITS / COMPENSATION

ENGAGEMENT

WAYS ENGAGEMENT IS MEASURED

72% EFFECT ON PATIENT SATISFACTION

54% OPERATIONAL MEASURES

46% FINANCES

RECRUITMENT

44% PLAN TO INCREASE RECRUITMENT OF PASSIVE CANDIDATES

43% SAY DIVERSITY IS A PRIMARY RECRUITMENT FOCUS

LEADERSHIP DEVELOPMENT

CURRENT PROGRAMS

64% FORMAL LEADERSHIP INSTITUTE

64% MENTORING

60% ORGANIZATIONAL PLANNING

B.E. SMITH: MATCHING LEADERS WITH ORGANIZATIONS

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 5, 2020

TO: EMS/Trauma Committee Members

FROM: BJ Bartleson, MS, RN, NEA-BC, Vice President, Nursing and Clinical Services
Sheree Lowe, Vice President Behavioral Health

SUBJECT: Behavioral Health Issues in Emergency Departments

SUMMARY

To further explore emergency services work related to CHA's overall priorities, CHA's Behavioral Health Agenda 2020, clearly aligns with significant problems affecting our emergency departments along the input, throughput, output flow points. The matrix below characterizes some of the specific issues.

Problem/Solution Matrix for Mental Health/SU/Homelessness in EDs

INPUT (Individuals are coming to EDs)	
Problem	Solutions
1. Too many individuals utilizing crowded EDs for behavioral health emergencies (i.e., they do not have a physical medical condition that requires emergency "medical" treatment).	a. Increase the availability of alternative destinations to obtain emergency mental health and/or substance use disorder treatment (e.g., crisis stabilization centers, urgent care centers with behavioral health capacity, behavioral health urgent care clinics) or obtain help with housing (e.g., homeless shelters). b. Require commercial health plans to participate in developing and/or covering alternative destinations. c. Increase the availability of community-based crisis intervention and stabilization teams. d. Identify solutions by analyzing data about the individuals with behavioral health emergencies who are currently seek care in EDs (e.g., volume, geography, whether on 5150 hold or walk-in, whether co-morbid physical health needs require emergency treatment, proportion who are homeless) e. Support alternative destination regulatory or legislative change

THROUGHPUT (What happens while individuals are at EDs)	
Problem	Solutions
1. Individuals brought to EDs on 5150 holds stay longer than necessary	a. Incentivize counties to send LPS designated individuals to the EDs more quickly to evaluate and/or clear involuntary 5150 holds. b. Expand availability of services to which individuals can be transferred, including crisis residential, inpatient hospitalization, housing assistance, and residential treatment and rehabilitation programs. c. Explore opportunities for changes in 5150 hold and release options.
2. EDs lack staff with capacity and expertise in mental health and substance use disorders	a. EDs can pair emergency physicians with others who have training in mental health and substance use disorders. This can include models in collaboration with the county behavioral health system to embed county staff or subcontract providers in the ED (e.g., Adventist Health/Rideout hospital in Yuba City). Also, note that the FY 2019-20 includes $20 million GF one-time for ED behavioral health peer navigators). b. Hospitals can develop trauma centers with psychiatric expertise (e.g., UCSF Department of Psychiatry at Zuckerberg San Francisco General Hospital and Trauma Center) c. Hospitals can establish crisis stabilization services, which exist in a few locations in California but the models vary (e.g., Providence St. Joseph, John George in Alameda County, Dignity Health/Sacramento County)
OUTPUT (What happens during and following discharge)	
Problem	Solutions
1. People return to EDs for non-“medical” treatment needs.	a. Increase the number and type of alternative destinations to obtain emergency mental health and/or substance use disorder treatment (e.g., post-acute psychiatric care, inpatient psychiatric beds) or obtain help with housing (e.g., homeless shelters).

	b. Improve care coordination and behavioral health programs embedded in EDs (e.g., California's new BRIDGE program for Medication Assisted Treatment of opioid disorders) c. Expand the availability of partial hospitalization and intensive outpatient programs for individuals who leave the EDs and individuals who are discharged from a hospital admission. d. Explore models and success that may have emerged from California's Whole Person Care Pilots and Health Homes programs.
	Updated January 30,2020

Reimbursement of mental health patients in GACH hospitals is complicated and hampered with numerous systemic issues, such as parity amongst all payers, actual services and access gaps, timely access, denials, longer LOS, sicker mental health and medical health comorbidities, etc.

The Draft Behavioral Health Finance Issue Log further breaks down the issues related to GACH ED applications. (see Attachment)

DISCUSSION

1. What problems are you having with mental health reimbursement in your ED?
2. Can you add any additional issues or potential solutions to the matrix above?
3. Do you work closely with your reimbursement staff to understand costs associated with ED overcrowding from BH, SU or homeless population?
4. Would your reimbursement staff be willing to work with us as we put together our strategy?
5. How does billing work for behavioral health patients in your facilities?
6. How could the system be designed to incentivize mental health plans to respond timelier?
7. What other issues are you aware of that can inform our conversation?

ACTION REQUESTED

- Information sharing and feedback on the discussion questions.

Attachment: Draft Behavioral Health Finance Issue Log

BJB:br

1/14/2020 **BEHAVIORAL HEALTH FINANCE (ISSUE LOG)**

No.	ISSUE	DESCRIPTION	Mapping to Opportunities	SHORT vs. LONG TERM (Select one)	PRIORITY (Select One)	IMPACTED PROVIDERS						
						GACH ED	GACH IN	GACH OUT	APH IN	APH OUT	CDRH IN	CDRH OUT
1	MH Parity Enforcement											
	· DMHC (HMO and PPO's only)	Established process (consumer complaint hotline) does not work for our hospitals. Our members don't like using the process; expedited review is to cumbersome, hospitals experience costly delays, and continued stay denials.	See #5 on Opportunities				X	X	X	X	X	X
	· CDI (PPO's only)	Established process (consumer complaint hotline) does not work for our hospitals. Our members don't like using the process; expedited review is to cumbersome, hospitals experience costly delays, and continued stay denials.	See #5 on Opportunities									
	· DHCS (MHP and MCPs only)	Ombudsman option does not adequately address the hospital's concerns. Medi-Cal Managed Care and Mental Health office of the Ombudsman. <Possible MH issues: CMC and LTC Ombudsman>	See #5 on Opportunities									
2	Ligature Costs	Regulations issued by CMS and accrediting organizations standards developed by The Joint Commission (TJC), and DNV GL Healthcare Accreditation.	Influence the interpretation by accrediting organizations (TJC past successes, DNV unknown)			X	X	X	X	X	X	X
		TJC, DNV, and/or CMS, standards are not consistently interpreted and applied.	Influence the interpretation by CDPH on behalf of CMS									
3	Appeals (not effective; hospital disadvantaged)						X		X			
	Two levels of Treatment Authorization Request (TAR) appeals:	Appeal process is antiquated, data is inaccessible to the provider community, and needs to be reformed.										
	1) To County MHP	Lack of consistent application across the 58 different counties	See Opportunities #6 CalAIM reference to BH Regional Contracting (Proposal 3.10)									
	2) To DHCS	Lack of willingness on provider to pursue a 2nd level appeal due to risks of additional costs and administrative burden. Additionally, DHCS does not share data on the denial appeals or outcome of 2nd level denial appeals. · Acute – 18-57% - Avg. 35% · Admin – 5-63% - Avg. 28% (no appeal option) Total days disallowed 30-55% - Avg. 49%	1) Legislative fix for the cost burden; 2) Issue guidance that allows for administrative denial appeals									
	3) No appeal option for administrative denials	Examples: IMD, County of Residence, 190-day cap for Medicare, lack of physician's signature, etc.										
4	Cross-County Inpatient Denials	Many patients are forced to cross county lines to receive patient IP care. Issue: MEDS database does not always accurately reflect the county of residence, which leads to higher levels of administrative denials.	1) Investment into MEDS modernization ($$) that would be reliable 2) Dispute resolution process for county of residence issue				X	X	X	X	X	X
	· Administrative with no opportunity to appeal	Providers can't always figure out the county of residence within the 14-day of rendering the care (TAR requirement).	See #6 on Opportunities; specifically the CalAIM ref. for improving beneficiary contact info.									
	190-Day Medicare Cap											

No.	ISSUE	DESCRIPTION	Mapping to Opportunities	SHORT vs. LONG TERM (Select one)	PRIORITY (Select One)	IMPACTED PROVIDERS						
						GACH ED	GACH IN	GACH OUT	APH IN	APH OUT	CDRH IN	CDRH OUT
6	· Medi-Cal issue due to admin denial (no appeal rights)	Medicare limits reimbursement to Acute Psych Hospitals and the database that our hospitals access to verify the eligible number of Medicare days remaining is not always accurate. If hospital receives notice following discharge that the patient exhausted their 190-day cap, the hospital is disadvantaged in pursuing reimbursement through Medi-Cal. Examples include: 1) automatic denial for failure to obtain authorization for the stay, 2) TAR submission deadline of 14-days post discharge is not met.	Seek Medi-Cal exemption from the 14-day TAR limitation for Medicare denials. This should mirror the physical health side, once evidence of the Medicare cap is met, Medi-Cal becomes the primary payor.						X			
7	IMD (age 21-64)	Federal law prohibition for counties to seek federal matching funds exists today, for mental health services provided to beneficiaries receiving services in an IMD setting (ages 21-64 years old). Counties should be paying providers from their short Doyle account (county realignment funds). DHCS issued informational notice (18-008) reminding counties of their obligations; however, counties continue to choose not to pay.	1) IMD waiver for federal funding; see Opportunities #6, CalAIM proposal 2.5 2) Legislative changes to increase enforcement options for DHCS or litigation options to compel the counties to pay providers.						X		X	
8	Medi-Cal Contracts											
	· Annual renewal	Medi-Cal plans (MHPs) are limiting provider contracts to 12 months. This isn't consistent with other Medi-Cal managed care plans or industry/commericial standards. ***NEED TO CHECK 1915(B) WAIVER (STCs) OR UNDERSTAND IF THERE ARE LEGAL HURDLES--CALAIM BH REGIONAL CONTRACTING PROPOSAL***	1) CalAIM Proposal 3.10; BH Regional Contracting (this proposal is between counties and State) The opportunity here is to tag our provider level request along with the broader BH Regional Contracting proposal.									
	· Unilateral	MHPs are unilaterly making changes to the provider/MHP contract. This is a one-side arrangement--there isn't an opportunity for the providers to negotiate the terms of the contract. LA County: Does not negotiate rates. San Bernardino: Hospitals were notified the reimbursement the hospital receives includes the professional fees. Other example: Concurrent review process amendments	Potential opportunity to have DHCS require MHPs to include reference to the H&S Code noting the Provider's Bill of Rights ***(NEED TO RESEARCH LEGAL APPLICABILITY)***				X		X			
	· Volume of Medi-Cal contracts (58)	Every hospital within the state is required to have multiple contracts with MHPs, that unfortunately are also required to be renewed annually.	1) CalAIM Proposal 3.10; BH Regional Contracting (this proposal is between counties and State) The opportunity here is to tag our provider level request along with the broader BH Regional Contracting proposal.									
	· Inpatient not measured for network adequacy	Inpatient services is not considered in the current network adequacy determinations and attestations signed by the Counties.	***Legal review needed: Statutory authority requires them?***									
9	Admin Day Stays – MHPs not complying & DHCS lack of enforcement						X	X	X	X		
	Admin Complexity	Hospitals required to have multiple contracts and										

No.	ISSUE	DESCRIPTION	Mapping to Opportunities	SHORT vs. LONG TERM (Select one)	PRIORITY (Select One)	IMPACTED PROVIDERS						
						GACH ED	GACH IN	GACH OUT	APH IN	APH OUT	CDRH IN	CDRH OUT
10	· Mild/Moderate/Severe MI	Hospitals do not have access to the MOU's established between the MHP and MCPs. Hospitals were not consulted in the establishment of these requirements--especially the Emergency Departments (where all the mild/moderates appear).	1) CalAIM Proposal 2.6; Discuss full integration of physical health, behavioral health, and oral health 2) CalAIM Proposal 3.8.1; Medical Necessity Criteria for SMHS or SUDS				X		X			
	· Different UR/UM for 58 counties	Every hospital within the state is required to have multiple contracts with MHPs--this ties back to the administrative complexity.	1) CalAIM Proposal 3.9; Administrative Integration of SMHS. Specifically, the Assessment tool that is universally applied to all <21 year olds and >21 year olds.									
11	Voluntary Inpatient Detox – Definition of Medical Necessity & Billing Process	Challenge with VID is that they have to be exhibiting the symptoms (trembling, sick, detox), to meet the Medical Necessity criteria. Example: Lab values and self-attestation should suffice. Hospitals are not billing this today, because symptoms are being treated with an accompanying medical/physical injury. Administrative processes and reimbursement is more advantegous for hospitals on the physical health side (it's easier!)	1) CalAIM Proposal 3.18; Proposed revisions to the medical necessity criteria for behavioral health services			X	X		X		X	
12	Infrastructure Inadequacies	DHCS did not require county MHPs to determine network adequacy for Inpatient services. This is contrary to the Medicaid Managed Care Final Rule and what DHCS has implemented on the physical health side.	MH Parity Enforcement 2020-21 Gov Budget focus on MH Parity			X	X	X	X	X	X	X
	· Commercial Plan Shortfalls	1) Benefit package is less than the Medicaid benefits package (we need to research examples and explore policy position) 2) no requirement for crisis services 3)	MH Parity Enforcement 2020-21 Gov Budget focus on MH Parity (need to research MH parity commreical to Medicaid)									
	· Homeless issue	Plcement challenges are exacerbated when someone has a mental illness.	Enhanced care management benefit and in lieu of servicesd beenfits.									
	· Nowhere to discharge	In some communitiies, the necessary array of dishcarge treatment options are not available. Board and care facilities are closing at an unsustainable pace. Disharge options for people woth complex needs are not available.	In lieu of services. Alsp, the in lieu of services framework allows for regions that do not currently have a sufficient infrastructure to provide the full array of services to build network capacity.									
	· Challenges with county of residence DHCS not accepting responsibility (also oversight issue)	two counties are disputing which county is responsble for the beneficiary and there is not a way to engage DHCS to settle the dispute. Providers report not having access to the MEDS database and that the database to which they have access (Automated Eligibility Verification System (AEVS)) is not updated.	Providers should not be in the middle of this fight. Payment responsibility for treatment provided should be the responsbility of the county identified in the database on the date that the provider accessed the database.									
	· Transportation	Dispute occurs with involuntary hold transport and the inconsistent interpretation by counties, providers, and transportation entitties of the hold status during transport and reimbursement for ambulance transport. Applicable to all payors.	LPS audit due Spring 2020. Governor's commitment during his budget comments to update the LPS Act. Proposed development of Behavioral Health Task Force under CHHSA in Governor's budget.									
	· Shortened lengths of stays, discharged to inadequate community infrastructure results in failure – readmission	All payors are reducing the number of covered acute inpatient days, resulting in earlier discharges which may not be in the best interest of the consumer and may result in readmissions.	DHCS behavioral health payment reform proposal.									

No.	ISSUE	DESCRIPTION	Mapping to Opportunities	SHORT vs. LONG TERM (Select one)	PRIORITY (Select One)	IMPACTED PROVIDERS						
						GACH ED	GACH IN	GACH OUT	APH IN	APH OUT	CDRH IN	CDRH OUT
13	Systematic barriers to providing whole person care: 1) Treatment standards (i.e. treat more emergent condition only) within the hospital 2) Licensing limitations for GACH	1) Co-Occurring MH/SUDs/Physical Health illnesses--For patients that are experiencing co-occuring illnesses (i.e. depression, physical health), that appear at a hospital are treated for the more serious illness (physicial health) and no treatment is focused on the co-occuring illness (mental health). 2) Licensing limitations for GACH because they are not licensed to provide psychiatric treatment, there is no mechanism for authorization to treat.	Research this within the WPC pilots			X	X		X		X	
14	Involuntary Hold Management · County delays with responses = hospital problems					X	X	X				
15	State Law Interpretation · 5150					X	X	X	X	X	X	X

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 5, 2020

TO: EMS/Trauma Committee Members

FROM: BJ Bartleson, MS, RN, NEA-BC, Vice President, Nursing and Clinical Services
Heather Venezio, RN, MS, CEN, TCRN, ED/Trauma Director, NorthBay Medical Center

SUBJECT: EMS For Children

SUMMARY

In preparation for the National Peds Ready Role Out Campaign in June (June 2020-September 2020), and with the newly finalized California EMS -C regulations, we are asking hospitals to review the regulations and work closely with the LEMSA, to identify their level and submit data as required by the EMSC regulations that went into effect on July 1, 2019. The detail definitions are listed below and can be found on the NEMSIS website at https://nemsis.org/media/nemsis_v3/release3.4.0/DataDictionary/PDFHTML/DEMEMS/index.html

§ 100450.223. Data Management Requirements.

(1) Baseline data from pediatric ambulance transports, including, but not limited to:
(A) Arrival time/date to the emergency department. **(eTime.11)**
(B) Date of birth. **(ePatient.17)**
(C) Mode of arrival. **(eDisposition.17)**
(D) Gender. **(ePatient.13)**
(E) Primary impression. **(eSituation.11)**
(2) Basic outcomes for EMS quality improvement activities, including but not limited to:
(A) Admitting hospital name if applicable. **(eDisposition.01)**
(B) Discharge or transfer diagnosis. **(eOutcome.13)**
(C) Time and date of discharge or transfer from the Emergency Department. **(eOutcome.16)**
(D) Disposition from the Emergency Department. **(eOutcome.01)**
(E) External cause of injury. **(eInjury.01)**
(F) Injury location. **(eScene.09)**
(G) Residence zip code. **(ePatient.09)**

The overall goal of the emergency medical services for children (EMSC) program is to ensure that acutely ill and injured children have access to high quality, coordinated, and comprehensive emergency and critical care services appropriate for children's special needs.

The EMS Authority, using a grant from the Maternal and Child Health Bureau, U.S. Department of Health and Human Services, and with the assistance of subcommittees of experts in various aspects of pediatric care, has developed guidelines, standards, and key products that make up a comprehensive model for EMSC services. The EMSC Model provides a continuum of care, beginning with the detection of an illness or injury to emergency department care and rehabilitation.

In addition to the California EMS-C regulations, the EMS-C Technical Advisory Committee is reminding facilities of the National Pediatric Readiness Assessment Survey campaign that will begin in June 2020. This 2020 assessment window period will allow your hospitals to take the survey assessment and receive your readiness score and a gap analysis report. The "Pediatric Readiness Score is based on a scale of 0-100 and reflects assessment of administration and coordination, MD, RN's and other ED staff; QI/PI in the Emergency Department, pediatric patient safety, policies, procedures and protocols, and equipment, supplies and medications.

DISCUSSION

1. Are you aware of the EMS-C regulations and have you officially designated your facility through your LEMSA? Why or Why not?
2. How are you involved in the National Pediatric Readiness Survey?
3. Is your staff aware of the Ca EMS-C educational events and do they participate?
4. What, if any issues need to be addressed with pediatric emergency preparedness?

ACTION REQUESTED

- Information sharing and feedback on the discussion questions.

Attachment: ENA Infographic – ED Readiness for Children

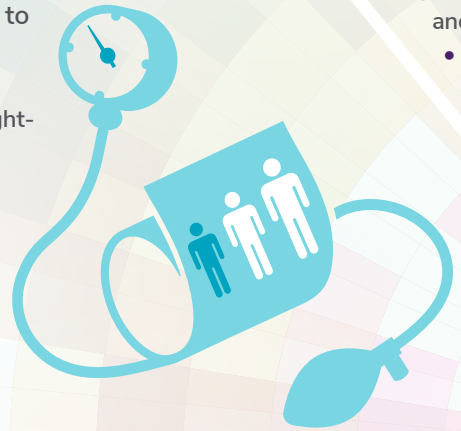
BJB:br

Improve Your ED's Readiness to Care for Children*

Equipment, Supplies, and Medications

Stock ED with appropriate-sized, easily accessible pediatric supplies and equipment for pediatric patients from newborn to adult ranges:

- Organize items logically
- Use a color-coded, weight-based, storage system
- Keep a fully stocked pediatric resuscitation cart readily accessible at all times



Competency in Pediatric Care

Ensure members of the healthcare team have the skills and knowledge to treat children of all ages and developmental stages:

- Periodically evaluate pediatric-specific competencies, including triage, medication administration, procedures, disaster preparedness, and handoff communication
- Use observation, written tests, and/ or chart reviews
- Pediatric board certification and pediatric emergency nursing certification is strongly encouraged.

Quality and Performance Improvement (QI/PI)

Implement a QI/PI plan that includes monitoring of outcomes-based pediatric-specific indicators.

- Integrate multidisciplinary QI/PI activities with:
  - prehospital agencies
  - inpatient pediatrics
  - trauma/injury prevention programs
  - pediatric critical care
- Use the Plan, Do, Study, Act method:
  - systematically review, identify, and mitigate variances in pediatric emergency care

Administration and Coordination for Care of Children

Identify Pediatric Emergency Care Coordinators (PECCs) to coordinate delivery and evaluation of pediatric care in the ED: An emergency physician and emergency nurse with demonstrated clinical competence and expertise in pediatric emergency care

Support Services for the ED

Ancillary services should have skills, equipment, and capability to provide care to pediatric patients:

- Radiology departments
  - develop protocols based on age and size of patients to reduce radiation exposure
- Clinical laboratories
  - facilitate testing for all ages of patients
  - ensure availability of microtechnology for small and limited samples
  - have transfer protocols for pediatric patients who exceed laboratory capabilities

Pediatric Patient and Medication Safety

Establish a culture of safety and educate staff in pediatric-specific safety considerations:

- weigh all patients in kilograms, ideally with scales locked in kilograms
- take full set of vital signs
- use weight-based dosing
- provide for cultural sensitivity, interpreter services, and family-centered care
- implement patient identification policies
- monitor/evaluate patient safety events

Policies, Procedures and Protocols

Develop and implement age-specific policies, procedures, and protocols that also address children with special health care needs through:

- Local collaboration with regional pediatric centers
- Use of standard, evidence-based guidelines found on the EMSC Innovation and Improvement Center website: https://emscimprovement.center/

Educate staff on policies and monitor compliance.

* Based on the 2018 AAP/ACEP/ENA Joint Policy Statement, "Pediatric Readiness in the Emergency Department"

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 5, 2020

TO: EMS/Trauma Committee Members

FROM: BJ Bartleson, MS, RN, NEA-BC, Vice President, Nursing and Clinical Services

SUBJECT: CDPH, OSHPD, CHA Task Force on EMS Surge

SUMMARY

Heidi Steinecker, Deputy Director for CDPH's Center for Health Care Quality (CHCQ) has suggested an interagency task force be formed to review the regulatory barriers between Title 22 and Title 24 that cause barriers and access issues during emergency department surge periods. This task force will develop a pilot program to take a deep dive into themes and patterns, and root causes of issues that prevent streamlined access and add to ED overcrowding. Many of these issues are caused by conflicts between two sets of regulatory rules that cause hospitals to develop program flexes and or band aids to prioritize patient care activities. Deputy Director Steinecker has established a Performance Improvement Management Office (PIM) within the Center for Health Care Quality to pay particular attention to both internal and external issues that need reengineering and performance improvement to improve stakeholder satisfaction, and, ultimately, patient quality of care and access.

This task force represents alignment with Governor Newsom's administrative priorities to focus on access for those with diseases of despair, such as homelessness, behavioral health and substance use disorder issues. In addition, California Health and Human Services Agency Secretary Ghaly has asked departments to adopt a culture of collaboration and innovation through new interagency approaches to solve intractable problems. He characterizes this as an unceasing pursuit of innovation, applied thoughtfully to catalyze improvement efforts.

DISCUSSION

1. What type of CDPH Title 22 program flexes do you have in your ED presently that deal with space or facilities issues that may have overlap with Title 24?
2. How do they contribute to ED impaction?
3. How might they be readdressed?
4. Are there other agencies that need to be involved, such as the Fire Marshall?
5. Would your facility be willing to participate?

ACTION REQUESTED

- Information sharing and feedback on the discussion questions.

Attachments: CHHSA Guiding Principles
CHHSA Strategic Priorities

BJB:br

California Health & Human Services Agency

Guiding Principles

Person Centered, Data Driven

Adopt a Culture of Collaboration & Innovation

When possible, program design should be developed across departments, including those outside the Agency, implemented in a collaborative manner, and supported by our entire Agency. We will courageously try new approaches to solve our most intractable problems. The unceasing pursuit of innovation, applied thoughtfully, will catalyze our improvement efforts.

Focus on Outcomes & Value Generation

We must ensure that the delivery of our programs and services are centered on the needs of the people we serve. We therefore focus our attention and energy on work which will directly improve the lives of the people.

Use Data to Drive Action

While we have built good systems to amass data, we find ourselves data rich but information poor. We must better leverage our data to understand the conditions in our community, the impact of our current programs, and the opportunities to improve our service delivery. Actionable data can help us advance social and economic mobility and improve the health and well-being of children, families, and individuals across California.

Put the Person back in Person-Centered

Somehow many “person-centered” programs stopped being about people and became focused on satisfying a specific funding source or administrative process. We must engage the people and their communities so that programs are structured to meet the diverse and unique needs of each community and constituent.

See the Whole Person

Regardless of which department is leading on a given issue, we should always be thinking about what each person needs comprehensively to thrive, and integrating opportunities to meet those needs – both within government and with our community partners.

Strategic Priorities

Person Centered, Data Driven

Together we must work with counties, cities, and communities, as well as our public, private, faith, and educational partners to make California a healthy, vibrant, inclusive place to live, play, work, and learn.

Build a Healthy California for All

- ✓ Create a system in which every Californian, regardless of origin or income, has access to high quality, affordable health care coverage;
- ✓ Ensure all Californians have meaningful access to care by modernizing the health workforce and expanding care delivery capacity;
- ✓ Reduce the rate of growth of health care costs in California, move toward single-payer principles and other strategies that emerge out of the Healthy California for All Commission; and
- ✓ Promote a whole person orientation to care, including inclusive cultural, linguistic and accessibility competencies.

Integrate Health and Human Services

- ✓ Enhance the accessibility and quality of California's mental health and substance use disorder systems as manifest by increasing the availability of community-based outpatient prevention and treatment service capacity and stabilizing and expanding the overall number of community-based placements, locked and unlocked, for individuals who require residential support on their road to greater independence;
- ✓ Integrate clinical, financial, and system structures among physical health, mental health, substance use disorder services, social services and developmental services to facilitate seamless care delivery; and
- ✓ Address upstream social determinants, including early childhood trauma, that drive disease and worsen health and economic disparities.

Improve the Lives of California's Most Vulnerable

- ✓ Reduce homelessness, especially chronic homelessness, by focusing on building up permanent supportive housing and the support services needed by those we house, including employment support as a path out of poverty;
- ✓ Expand diversion and re-entry services so that anyone released from an incarcerated setting has a service access plan and the main behavioral health treatment setting for those with serious mental illness stops being our jails by default;
- ✓ Improve outcomes for children living in extreme poverty and in foster care, including a focus on addressing adverse childhood experiences; and
- ✓ Address the needs of persons with disabilities and our growing aging population including issues such as care, support, housing and transportation for our most vulnerable populations.

EMS/TRAUMA COMMITTEE
2020 ROSTER

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EMS/T Committee Hospital Representation

BY COUNTY and HOSPITAL TYPE

As of January 2020

HOSPITAL/HEALTH SYSTEM TYPES	
Free-Standing Facility	4
Hospital System	13
Small/Rural Facility	1
University/Teaching Facility	4
TOTAL COMMITTEE REPRESENTATION	17

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

CHA Member/ED Breakdown
1/30/2020

ED TYPE BY MEMBER:

Pamela Allen, RN, MSN, CEN	Redlands Community Hospital
Rose Colangelo, RN, MSN, CEN	Scripps Memorial Hospital La Jolla
Annette Austin	Sharp Memorial Hospital
Carla Spencer, MSN, RN, CCRN	Salinas Valley Memorial Healthcare System
Cheryl Heaney, RN, DNP	St. Joseph's Medical Center
Christopher Childress, BSN, RN, CEN	Hoag Memorial Hospital Presbyterian
Claude Stang, RN, BSN, MA, CEN	Cedars-Sinai Medical Center
Connie Cunningham, RN, MSN	Loma Linda University Health
Fred Hawkins	Ridgecrest Regional Hospital
Jacqueline Saucier, PhD, MBA, MSN	Palomar Medical Center Poway
Jason Zepeda	Hoag Hospital Irvine
Joyce Eden	Saint Agnes Medical Center
Karen Sharp, RN, MSN	Saddleback Medical Center
Marlena Montgomery, MBA, MSN, RN, CEN	Sharp Memorial Hospital
Melanie Gawlik, RN, MSN	Scripps Memorial Hospital La Jolla
Neal Cline, RN, JD, CFRN	Enloe Medical Center - Esplanade Campus
Rupy Sandhu	UC Davis Medical Center

EX-OFFICIO COMMITTEE MEMBER:

Carl Scheuerman, FACHE	Office of Statewide Planning and Development
Chi Perlroth, MD, FACEP	CAL ACEP
David Duncan, MD	California EMS Authority
Elizabeth Winward	California EMS Authority
Heather Venezio, RN, MS, CEN TCRN	TMAC
James Pierson	Medic Ambulance
John Montalbano	California Department of Public Health
Kristin Weivoda	California EMS Authority - Yolo County
Lawrence Stock, MD, FACEP	Antelope Valley Hospital
Ron Smith, LVN, EMT1A	California Department of Public Health
Ross Fay	California Association of Air Medical Services
Susan Smith, RN	CalENA
Tricia Blocher	California Department of Public Health

CHA/REGIONAL STAFF

BJ Bartleson, MS, RN, NEA-BC	California Hospital Association
Mary Massey	California Hospital Association
Keven Porter, RN, BSN, MS	Hospital Association of Southern California
Caryn Sumek	Hospital Association of San Diego and Imperial Counties
Barbara Roth	California Hospital Association

STATE REPRESENTATION

Northern California	**6**
Southern California	**11**

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:

1. 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;
2. to provide CHA member EMS/Trauma providers with a statewide structure dealing with the issues important to their interests;
3. to create a representative form of leadership which is based on participation of all its members;
4. to provide direct input to the CHA Board of Trustees; and
5. 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, 2019-2020

CHA EMS/T Committee Mission

The mission of the CHA EMS/Trauma Committee is to represent CHA members that provide emergency medical and or trauma services in the state of California, and serve in an advisory capacity to CHA Board of Trustees regarding EMS/Trauma member needs, policy and advocacy to promote an optimally health society.

Goals and Objectives 2019- 2020

1. Develop policy, tools, information and strategies to support emergency department and trauma services of the future that enhance quality patient care.
   a. Connect local and regional best practices to produce statewide strategies.
   b. Explore new technologies and applications to streamline and improve emergency and trauma care practices.
   c. Continue to monitor APOT and work collaboratively with prehospital providers on performance improvement and reengineering efforts, including updated tools for members.

2. Develop data performance measures for statewide assessment of services.
   a. Use performance measures, technology and new modalities to assess ED crowding and strategize solutions across systems of care.
   b. Develop both provider and consumer education vehicles to improve ED crowding.
   c. Develop public policy and advocacy strategies to address ED crowding, particularly alternate destination policies for behavioral health patients.

3. Implement a successful annual ED conference that assists members to become agents of change during health care reform.
   a. Use state and national experts that emphasize a collaborative, multi-stakeholder level of involvement.
   b. Focus on member evidence based practices that are affecting change.

4. Represent Trauma issues on the EMSA trauma regulatory review task force.
   a. Appoint CHA EMS/T member to head the trauma subcommittee workgroup and present issues at the EMSA trauma task force.
   b. Assist with funding and solutions to maximize trauma care and provisions across the state.
   c. Select CHA EMS/T member to represent EMSC issues and report to the committee

5. Understand HIE systems and how they will benefit transitions of care for patients between systems of care.
   a. Work closely with HIE networks to understand connections and linkages to improved care transitions.
   b. Work with EMSA on HIE prehospital pilot work.

6. Closely monitor federal and state legislation and health care reform changes and their effect on emergency services and systems of care.
   a. Continue to monitor changes in the financial landscape that have a direct effect on emergency department visits.
   b. Monitor statutory and regulatory changes affecting hospital emergency /trauma services.

CHA EMS/TRAUMA COMMITTEE
MEETING MINUTES
June 5, 2019 / 10:00 a.m. – 4 p.m.

California Hospital Association, Sacramento

Members Present: **Pam Allen, Christopher Childress, Rose Colangelo, Daman Mott, Chi Perlroth, Jackie Saucier, Dan Smiley, Ron Smith, Susan Smith, Heather Venezio, Jason Zepeda**

Members on Phone: **Connie Cunningham, Marlena Montgomery, Rupy Sandhu, Karen Sharp, Carla Spencer**

Staff: **BJ Bartleson, Gail Blanchard-Saiger, Megan Howard, Alyssa Keefe, Sheree Lowe, Scott Masten, Keven Porter, Barb Roth, Maria Sperber, Judith Yates, Justin Ziombra**

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order at 10:09 am.
Committee recommended to update the Guidelines to reflect changes in meeting timing.

- *ACTION: CHA send survey to the committee for feedback and recommendations about changes in meetings.*
- *ACTION: CHA to seek new members across the state.*

II. REVIEW OF PREVIOUS MEETING MINUTES

Draft minutes from March 6, 2019 meeting provided for review and approval.

- *ACTION: Please review and advise approval or comments.*

Minutes approved as submitted.

III. BUSINESS

A. Data Analytics and AB 774, Reyes, D-Inland Empire (Bartleson/Masten/Ziombra)
The goal is to widen the discussion on ED delays, particularly in the media, about what is happening in the ED. HQI puts together a report: http://www.hqinstitute.org/numbers. Additional measures are needed, such as activity in emergency care and the community, that can be observed and measured across the state. The last 4 reporting periods show that California is consistently above the national average in all ED measures. Risk adjustment is a challenge. Slightly less than half of those visiting the ED in CA are unique patients (trackable)– based upon discharge data tracked within a year and across years. Mr. Zepeda reported that he is also looking at revisits to the ED without admission. In addition, Mr. Masten is looking at frequent visitors (more than 5 visits).

Affecting the length of stay metric is the problem of patients that do not have discharge plans – waiting for discharge to SNF, etc. or they are homeless with no place to go. This is a

symptom of a larger community-related problem. Also, the problem within the hospitals about "decision to admit" data.

Many hospitals report every day to their LEMSA 4 data points– 1) number of patients medically boarded, 2) total census, 3) psychiatric boarding, and, 4) ICU boarding. The definitions being used are important as all groups need to use the same definitions. Reddinet can be used for this purpose. The state requires an all-state bed count.

EDIE – Collective Medical Technologies – gathers data more frequently than what OSPHD releases. Gabe Waters will be at the next meeting to advise which hospitals are participating in their system.

CHA HQI is currently working on historical information from OSHPD. They are also working on getting direct submissions from hospitals to OSHPD to get real-time data. This would require hospitals to submit Mercal data to HQI at the time it is submitted to OSHPD. There would be no additional cost to hospitals as the data is already collected, just needing a couple of additional computer clicks to share the data with HQI.

Dr. Perlroth advised that AB 744 bill, which Cal ACEP sponsored, can be used to identify which EDs are doing it well and create best practices. The current focus on behavioral health and addiction related patient needs makes collecting this information timely. More inpatient units are not necessarily the answer to the problem. If funds are invested to collect all this information for OSPHD, what will be the ROI – will it be valid and reliable? The committee members questioned the resources hospitals will use to collect additional OSHPD information and will the data collection be done in a timely manner with a definitive return on investment. Mr. Masten suggested that making AB 744 optional might be more palatable in getting hospitals to participate, perhaps using it as leverage with the legislature to get additional funding. CHA may offer this to CalACEP as an amendment.

Mr. Ziombra reported that the social determinant (Z) codes are ones for which the coders do not need a provider to assign. These codes are being used very inconsistently by hospitals.

Ms. Sandhu reported that they have seen a significant increase in pediatric psychiatric visits. The patients can be in the ED for weeks because they have no place to go. Ms. Sharp advised that Saddleback is working with the school districts which are obligated by law to assist. The school districts get funding to help with getting children back to school and getting the student to the right facility. This

- *ACTION: CHA will consider recommending amendments to AB 744 on voluntary versus mandatory hospital participation*

B. Ambulance Patient Offload Time (APOT) and Ambulance Interfacility Transfer Issues (Bartleson/Masten/Ziombra)
Mr. Smiley reported that EMSA is adding data people. Collaboration and consistency are critical to make sure everyone is on the same page as far as data collection. Data is currently being submitted on a spreadsheet to EMSA. In the future, data will be mined from the EMSA system to allow access to more real-time data. EMSA is aware of the methodology issue and the need to research benchmarks, then go to LEMSAs to investigate.

According to statute, EMSA can set the methodology. They will determine the elements to ensure the methodology.

Ms. Bartleson suggested that CHA do a webinar on transfer of care with Ms. Allen, Ms. Colangelo and Ms. Montgomery offering to assist. The webinar could also include representation from EMSA. It would offer best practices from our partners to make sure transfer of care is consistent. It is important to illustrate successful programs that the hospitals are already using so that the information is valuable for ED staff.

- *ACTION: CHA Webinar on transfer of care (Ms. Allen, Ms. Colangelo, Ms. Montgomery and EMSA).*

C. Alternate Destination Regulations and AB 1544 (Bartleson)
The Gipson bill (AB 1544) is almost the exact same bill as the one last year from the California Professional Firefighters, with just a few minor changes. CHA is offering definitions of sobering center and mental health facilities.

Mr. Smiley said he is looking for approval of the alternate destination regulations at the September meeting in San Diego and to have them in place by the end of this year. The provisions in AB 1544 were narrowly modeled after work done with OSHPD, CDPH and DHCS, but additional changes would increase resources and organizational bureaucracy with potential disruption to EMSA and the local EMS system.

There are certain alternate destination voluntary facilities that would not be considered part of the current definition of a mental health facility or a sobering center. The current language states “medical facility” specifically, without definition. A non-licensed mental health facility might be a stretch for some of the alternate destinations, however, there is an ability for a sobering center to be designated as a health clinic by the county.

Pursuant to the wildfire in Paradise last year, during which the entire hospital except the ED was destroyed, Paradise has requested to maintain the remaining structure as a free-standing ED. Residents are still going there to get prescriptions refilled. However, it is illegal in CA to have a free-standing ED. According to Dr. Perlroth, ED physicians (CalACEP) say the facility must fill a need not currently being filled by a full-standing nearby hospital. The request in Feather River may meet the criteria for this. According to Title 22, however, to run a comprehensive ED, the eight basic services of a hospital must also be present.

- *ACTION: Information only.*

D. Ligature Risk Guidance (Bartleson/Keefe/Howard/Lowe)
CMS is not obligated to review submitted comments and no deadline was provided as to when the regulations will be final. For now, surveyors are to observe current guidelines. CHA conducted a member call on May 29 with the goal to get comments and questions submitted early and is currently working on a draft comment letter. CMS will conduct a call on June 20 at 11 am PT.

The biggest concern for ED is the lack of a clear definition of locked vs. unlocked areas. Hospitals have expended resources to train staff to comply and are asking CMS to limit the scope to just locked psychiatric units within med/surg hospitals and psychiatric hospitals. CMS sets the standard but TJC can raise that standard. Hospitals are pleased that CMS

realizes that the 60-day timeframe for compliance is unrealistic and have a Ligature Regulation Extension Request (LRER). A standard surveyor tool, accessible to hospitals, is also desirable.

Many hospitals are seeking beds/gurneys that are ligature free. Ms. Saucier has a source and will send the information to CHA.

Most members report that outside contractors, i.e. fillers of vending machines, do not get training as they are not involved in patient care. Non-clinical staff workers also do not get training. Everyone involved in patient care gets trained upon hire and updated yearly. Basic and additional training is given depending upon where in the hospital the employee works.

- *ACTION: Get information from Ms. Saucier regarding ligature free beds/gurneys.*

E. LEMSA Destination Fees and Responsibilities (Bartleson)
EMSA is a state entity employing approximately 100 people. ESMA writes regulations, guidelines and statutes, and governs EMS licensure, monitors EMTs and EMS systems coordination, such as management and communications, performs data collection, education and disaster medical response.

By statute each county, if they choose, can establish a local EMS agency. Each CA county has a LEMSA, albeit, some are single agency, and some are multi-county agencies. Some multi-county agencies have contract or joint powers agreement, and some are corporations. Each must follow EMSA statues and regulations. Once a county designates a LEMSA, they have independent statutory authority and the county (Board of Supervisors) is no longer involved. The LEMSA has several responsibilities. Staffing and costs of a LEMSA is estimated at about $65 per capita. There are about 6 million emergency responses in the states which get transported to 306 medical facilities EDs, with about 80,000 EMS personnel and 3000-4000 ambulances.

LEMSAs are designated. Some counties fund the LEMSA from the county tax base or MADDY funds. Some are funded through stipends or matching funds that the county and the state EMSA will put up. Some LEMSAs need to support their system by seeking destination fees. A LEMSA should be able to provide a rationale for a designation fee or group of fees. The fee structure should be transparent and readily available.

F. SB 1152 Homeless Update (Bartleson/Blanchard-Saiger)
CalOSHA requires all hospitals to have workplace violence prevention plans and report back. The issue for CHA is the increase in violent and aggressive behavior as a result of the SB 1152.

Ms. Blanchard-Saiger is seeking concerns and questions from the committee on how things are going and what issues hospitals are facing. One concern is the clothing being supplied to the homeless. There is nothing specific is in the law or CMS requirements on this issue. Some hospitals accept donations for this purpose, some are provided new clothing from foundations. Hospitals accepting donated clothing are not laundering the same as hospital linens.

- *ACTION: Ms. Bartleson to check with Ms. Wheeler on the issue of clothing for homeless on discharge.*

G. AFL 19-05 Emergency Services Regulations – Title 22 (Bartleson)
Information only.

H. EMSA Trauma Regulations Review Workgroup (Bartleson/Venezio)
The first meeting of this workgroup was held in May and will meet three more times. The group is working in sections, with the first section under review part of Title 22 defining the trauma regulations. The goal is to standardize the regulations, so they reflect the contemporary work set forth by ACS, however, there must be more structure than just ACS.

Mr. Smiley reported that they do not want to do a complete rewrite, only change those things that need be changed. A key issue is whether EMSA will require every hospital to have an ACS minimum. Consensus is yes, with the outlier of pediatrics. There is a reimbursement issue related to the centers that have different pediatric levels. Hospitals have gradually adopted ACS.

Saddleback is looking at becoming a trauma center. Committee member suggested that Christy Preston in LA has a great tool for this process.

- *ACTION: Information only.*

I. 2019 Emergency Services Regulations (Bartleson)
AB 1544 – CHA and stakeholders are seeking common ground with more conversations scheduled for this week. California Professional Firefighters are open to CHA's definition of a sobering center.

AB 774 – Per previous discussion, CHA may consider offering an amendment about making the data reporting voluntary rather than mandatory. It is agreed that everyone wants the information that the data would provide; the problem is how to gather and report it. Dr. Perlroth will go back to CalACEP about this option.

AB 27 (Rodriguez) – Raises the urgency of assault of ED providers.

SB 438 – Mr. Smiley reported that, as written, this bill will create downstream problems within the EMS system, such as: impact to the consumer for unreimbursable bills, absence of medical quality and patient safety, and lack of transparency.

- *ACTION: Information only.*

J. Human Trafficking (Bartleson/Colangelo)
Dignity Health has implemented a program for human trafficking. Sharp is creating a San Diego ED collaborative and will be conducting a webinar on August 13 with ACNL on starting a program.

The problem is spreading to suburban areas and the sense is that they are not ready for it. This problem is intensely resource heavy with a need for staff level training and safe places ready to accept the victims. There are various agencies in the county than can assist, but there is a need for a program in place to connect them.

- *ACTION: Ms. Colangelo to share information to the committee.*

K. ED Annual Forum (Bartleson)
In an effort to get more participation from ED people, CHA suggests partnering with ENA, CalACEP and others to create a broader perspective. Ms. Smith with ENA is interested.

An innovation document from San Diego that Kevin Moondahl and Jim Dunford prepared describing transitions of care and best practices – may be a method to bring participants together for the conference

- *ACTION: Information only.*

L. Bridge Program (Bartleson/Perlroth)
Dr. Moulin started the ED Bridge Program. Many hospital systems and health centers are creating programs. All sites got some portion of some federal funding. Due to this success, more funding is becoming available in August 2019. Substance Use Navigators (often a social worker or case manager) or Peer Navigators are crucial to the success of the program.

- *ACTION: Information only.*

M. EMSA (Smiley)
EMS-Children's (EMSC) established new regulations which become effective July 1.

EMSA is accepting input on legislation and bills regarding community paramedicine and dispatch bills that could be disruptive to the EMS system. They are working on HIE for EMS. DHS is pushing out an additional $50 mil for interoperability issues and HIE.

Dr. Backer is retiring at end of June.

EMSA continues to work on disaster medical response. Power outages as mitigation for wildfires is a substantial issue with need for discussion regarding the public health.

Ms. Bartleson with check in with CHA colleagues Ms. Martin and Ms. Massey to continue this discussion.

IV. ROUNDTABLE

- *ACTION: Next meeting, Mr. Zepeda will share their data metrics.*

V. NEXT MEETING

Tuesday, December 10, 2019. 10 am – 12 pm. ZOOM Meeting

- *ACTION: Committee recommended changing the next meeting date to October after legislation.*

VI. ADJOURNMENT

Having no further business, the meeting adjourned at 3:41 p.m.