EMS/Trauma Committee Meeting

Wednesday, March 6, 2019

10 am - 12 pm

ZOOM Meeting - https://calhospital.zoom.us/j/9165527616

Conference Line: 720-707-2699

Meeting ID: 916 552 7616

Meeting Book - EMS/Trauma Committee Meeting

EMS/Trauma Committee Meeting Agenda - March 6, 2019

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 6, 2019

TO: CHA EMS/Trauma Committee Members

FROM: BJ Bartleson, RN, MS, NEA-BC, Vice President Nursing and Clinical Services
Scott Masten, Senior Biostatistician, Hospital Quality Institute
Brandon Sherman, Data Specialist, Hospital Quality Institute

SUBJECT: Ed Data Reporting, Public Policy Institute of California, "Emergency Department Use in California"

SUMMARY

"The Emergency Department Use in California, Demographics, Trends, and the Impact of the ACA" is an example of how data can assist with understand ED utilization and issues across the state. Of note is the finding that while our ED visits have increased, the analyses from this article imply that ACA coverage expansion did not increase ED use in California, and may have reduced it. HQI staff have the ability to track some of this information and need to understand what data points would be most useful.

Previously, we discussed the ED Benchmarking Alliance and the San Diego EMOC which is able to provide micro level data on things like staffing and length of stay of psychiatric patients.

DISCUSSION QUESTIONS

1. Did you find the PPIC report helpful?
2. What data measures are of most interest to you?

Attachments: PPIC Report – Emergency Department Use in California

BJB:br

PPIC PUBLIC POLICY INSTITUTE OF CALIFORNIA

25 YEARS

FEBRUARY 2019

Shannon McConville,
Caroline Danielson,
Renee Hsia

Emergency Department Use in California

Demographics, Trends, and the Impact of the ACA

SUMMARY

CONTENTS

Technical appendices to this report are available on the PPIC website.

Hospital emergency departments (EDs) have a vital role in our health care system. As the only guaranteed access point to medical care for all Californians, they are often characterized as the safety net of the safety net. But they are also a relatively expensive setting to provide health services. A substantial uptick in ED use over the past several years has raised questions about the impact of the Affordable Care Act (ACA). In particular, the large expansion of the Medi-Cal program under the ACA has raised concerns that the dramatic declines in uninsured residents in such a short timeframe may be spurring increases in ED use.

In this report, we look at trends in ED use from 2005 to 2016, with a particular focus on rates of ED use since ACA insurance expansions were fully implemented in 2014. We find no evidence that the ACA was responsible for increased ED use—indeed, our analysis suggests that ED visit rates for non-elderly adults would have been higher in the absence of the coverage expansions.

Our key findings include:

- **Large reductions in the number of uninsured Californians** as a result of the 2014 ACA expansion of major insurance coverage options did not increase ED use among adults under age 65, and may in fact have reduced ED use among middle-age adults ages 35–54.
- **Among non-elderly adults, women age 19–34 have the highest rates of ED use** (42 visits per 100 population in 2016), at least partly due to pregnancy-related visits.
- **The vast majority (about 90%) of all ED visits made by adults under age 65 are outpatient visits**—patients are treated and released the same day. Only about 10 percent of ED visits result in admission to the hospital.
- **ED outpatient use has increased substantially across all demographic groups and for all reasons.** Non-elderly adults experienced the largest uptick, increasing by 38 percent between 2005 and 2016.

While our findings on the impact of the ACA are encouraging, the growing use of EDs for complex needs requires closer consideration of how EDs fit into our evolving health care system. Medi-Cal has a key role to play in monitoring and managing ED use. This is both because one in three Californians has health insurance through the Medi-Cal program and because Medi-Cal enrollees have higher visit rates compared to those with private coverage and the uninsured.

More broadly, as state policymakers contemplate further insurance expansions with an eye toward universal coverage, it will be essential to continue monitoring patterns of health care use and to carefully evaluate efforts aimed at curbing ED use.

Introduction

Hospital emergency departments (EDs) are a critical component of our health care system, offering the only guaranteed source of health care available 24 hours a day, 365 days a year. They are required by federal law to treat all people in need of medical care regardless of whether they have insurance coverage or are able to pay for that care.[1] But emergency departments are also relatively expensive health care providers, particularly for conditions that could be treated in other outpatient settings such as doctor offices or urgent care clinics. The high cost, coupled with the fact that ED use for certain conditions is considered an indicator of poor access to outpatient care, have long made EDs a focus for policymakers and practitioners alike (Sommers & Simon 2017a).

The Affordable Care Act (ACA)—the largest health care reform in more than 50 years—has brought renewed attention to ED use. With the ACA, state and federal policymakers aimed to both improve access to health coverage and care, with an eye toward managing health care costs. In theory, insurance coverage can support both aims, but only if cost-effective care is coordinated and health care resources are allocated to maximize value. Given the sizable amount of public funds that go toward health care expenditures, it is crucial that health care dollars be deployed in the most efficient way possible. ED use can serve as a bellwether for these goals—and a comprehensive examination of patterns of ED use offers an important assessment of the success of ACA reforms.

There is no doubt that ACA coverage expansion in California succeeded in substantially increasing access to insurance coverage. Since 2014—when major coverage expansions went into effect—California's uninsured rate has declined more than 10 percentage points, which translates into 4 million fewer uninsured Californians. Much of the coverage gain has been driven by expanded eligibility and enrollment in Medi-Cal, the state's Medicaid program; Medi-Cal enrollment has grown by more than 50 percent and the program now provides health insurance coverage to about one-third of the state's population. While the coverage expansion is clearly a success, the large growth in such a short time span raises concerns about the ability of the health care system to meet the needs of newly insured patients.

As we move into the fifth year of ACA implementation, rigorous examination of the effects of coverage expansions becomes vitally important. We start by looking at trends in ED use from 2005 through 2016 across various subgroups. We then offer a detailed analysis of the effect the ACA coverage expansions may have had on ED use over the past few years.

[1] The Emergency Medical Treatment and Active Labor Act (EMTALA), a federal law passed in 1986, requires hospitals that participate in the Medicare program—essentially all hospitals—to provide screening, stabilization, and all necessary medical care regardless of insurance coverage or the ability to pay. Although there is debate about what EMTALA requires and it has been subject to clarifying legislation, it is considered a fundamental component of the US health care system that promises access to emergency medical care (Rosenbaum 2013).

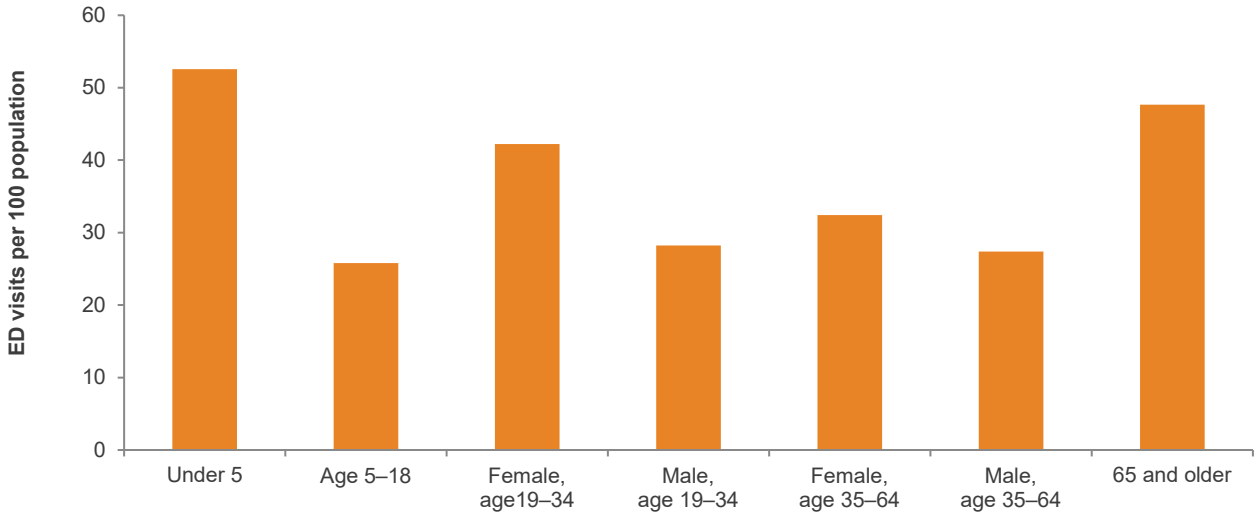
ED Use Has Been Increasing

People visit the ED for everything from serious injuries or heart attacks requiring immediate, lifesaving care to relatively minor conditions that could be handled in other outpatient settings such as a doctor's office or clinic. Figure 1 shows that very young and older Californians have higher rates of ED use than the ages in between. High visit rates for young children are driven largely by infants and toddlers and reflect parental concern for very young children. Higher visit rates among adults over age 65 are also to be expected: as people age, their health deteriorates.

Young women (age 19–34) have the highest per capita visit rate among non-elderly adults (about 42 visits per 100). Pregnancy is a major reason for this: about one in seven ED outpatient visits by women age 19–34 are related to pregnancy complications. Older women (age 35–64) have a considerably lower ED visit rate—about 32 per 100—but this is higher than the rates for non-elderly adult men; all male adult age groups have visit rates of about 28 per 100 population.

FIGURE 1

Young children, seniors, and women age 19–34 have the highest ED visit rates



SOURCE: Author calculations from emergency department and inpatient discharge records from the California Office of Statewide Health Planning and Development (OSHPD) department. National Institute of Health, SEER population estimates.

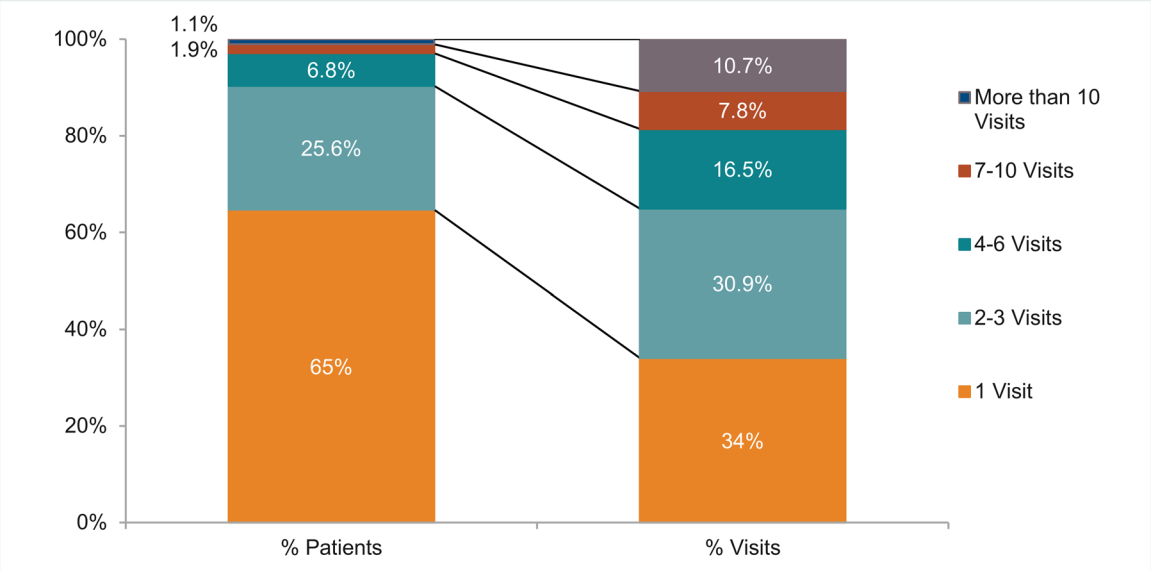
NOTE: Includes all ED visits made in calendar year 2016. Population denominators are from SEER.

It is important to note that ED visit rates do not account for people who make multiple visits in any given time period (see text box). So these rates should not be taken to mean that one in every three adult males visited the ED in 2016.

Frequent ED users account for a disproportionate share of ED visits

Our examination of ED visits does not take into account that some people visit the ED more than once in any given time period—possibly many times—while others never do. Frequent ED users—referred to as "frequent flyers"—are often the focus of provider and policy interventions designed to better manage health care utilization and resources.

In California, nearly two-thirds of ED patients in 2016 made only one ED visit and accounted for about one-third of total ED visits. One in ten patients made four or more visits and were responsible for about one-third of all ED visits. Heavy ED users—those who make more than 10 visits in a year—made up only 1 percent of ED patients but accounted for nearly 11 percent of all ED visits.



SOURCE: Author calculations of OSHPD discharge data for 2016.

NOTES: Patient-level counts are based on linking ED visits across patients using a unique record linkage number (RLN). About 10 percent of all ED visits for adults over age 18 do not have an RLN and are excluded.

Interventions designed to reduce frequent ED use have yielded mixed results, suggesting that there is not a one-size-fits-all strategy that can address this issue. Most frequent ED users are insured (and those covered by public insurance such as Medicaid and Medicare are overrepresented). Frequent flyers are also heavy users of other sources of health care, including outpatient, primary care, and other ambulatory encounters (Billings and Raven 2013). This group also has a high prevalence of chronic illnesses and high rates of hospital admission, which suggests poor health status (McConville et al. 2018; Zuckerman and Shen 2004). Mental health conditions, in particular, are much more prevalent among frequent ED users and mental health severity is associated with increased ED visits (Niedzwiecki et al. 2018).

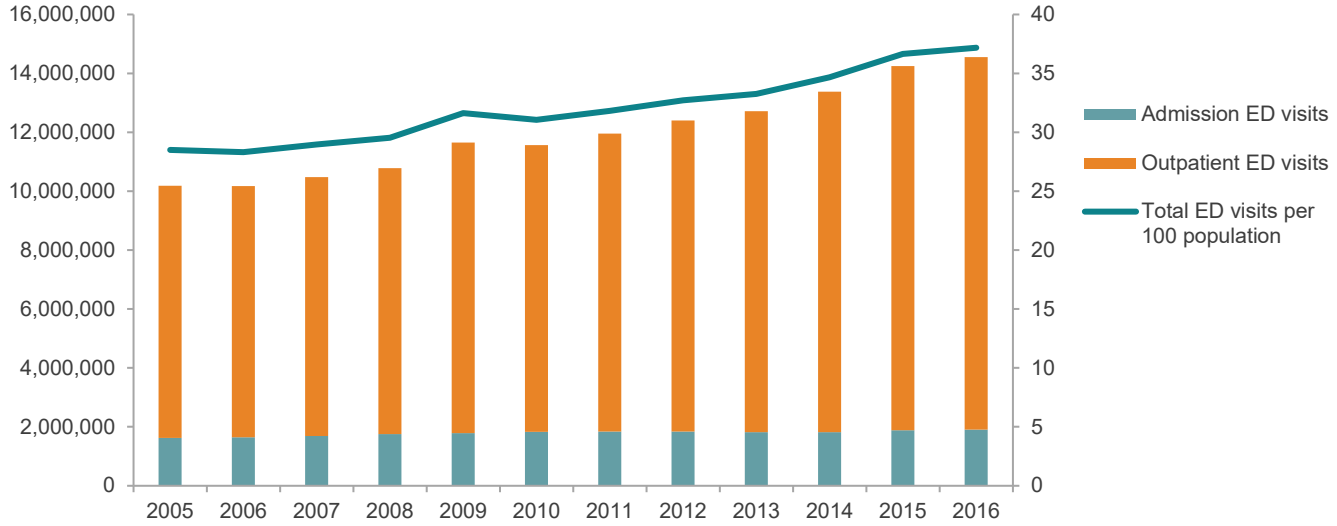
The role of hospital EDs has evolved considerably over the past half century—their ability to provide lifesaving medical care and diagnose complex conditions has expanded dramatically. This increased capacity contributed to the growth in demand, as did changes in clinical practices that led to primary care physicians serving greater numbers of patients and focusing on preventive care and managing chronic conditions (Kellermann et al. 2013). Office-based physicians increasingly rely on EDs to evaluate complex patients with potentially serious problems,

rather than managing these patients themselves (Morganti et al. 2013). A recent study found that one-quarter of all ED visits nationwide were referrals by an outpatient provider (Raven and Steiner 2018).[2]

In California, ED use has increased considerably, both in terms of the total number of ED visits and on a per capita basis (Figure 2). In 2005, California EDs recorded just over 10 million visits. Just 10 years later, the number of ED visits had grown to more than 14.5 million—an increase of more than 40 percent. When we adjust for population growth over this time period, we still observe a sizable increase from about 28 ED visits per 100 population in 2005 to more than 37 ED visits per 100 people in 2016—a 31 percent increase. Looking just at the first two years after the major health insurance expansions took effect, we see a 7 percent increase (from nearly 35 visits per 100 in 2014 to a little over 37 visits per 100 in 2016).

FIGURE 2

Total ED visits and per capita ED visits have been growing over the past decade



SOURCE: Author calculations from OSHPD hospital discharge data.

NOTE: Denominators for the per-capita measures are from SEER population data.

These upward trends are not unique to California. Across the country, ED use has been increasing since at least the 1990s, with the largest uptick in use leading up to the passage of the ACA recorded among adults ages 19 to 64 (Burt and McCaig 2001; Tang et al. 2010). In 2015, national estimates of per capita ED use reached an all-time high of about 46 visits per 100 population (Sun et al. 2018). And while California's per capita usage is lower than the national rate, the recent statewide increase seems to be outpacing the national trend.

Outpatient ED Visits Account for Most of the Increase

The vast majority (89%) of ED visits result in patients being treated and released the same day (referred to as outpatient ED visits in this report). Figure 3 breaks down ED visits made by male and female patients age 19–64, showing the shares of visits that resulted in a hospital admission—and for those discharged directly from the ED, the primary diagnoses for the visit. Men have higher shares of inpatient admissions than women (13.3% vs. 9.7%). Men also have higher shares of visits for injuries (20.2% vs. 13.8%) and chronic conditions (12.4% vs. 10.3%),

[2] This study was not able to distinguish between referrals made by primary care physicians during office visits or clinic visits versus recommendations from other sources such as nurse advice lines.

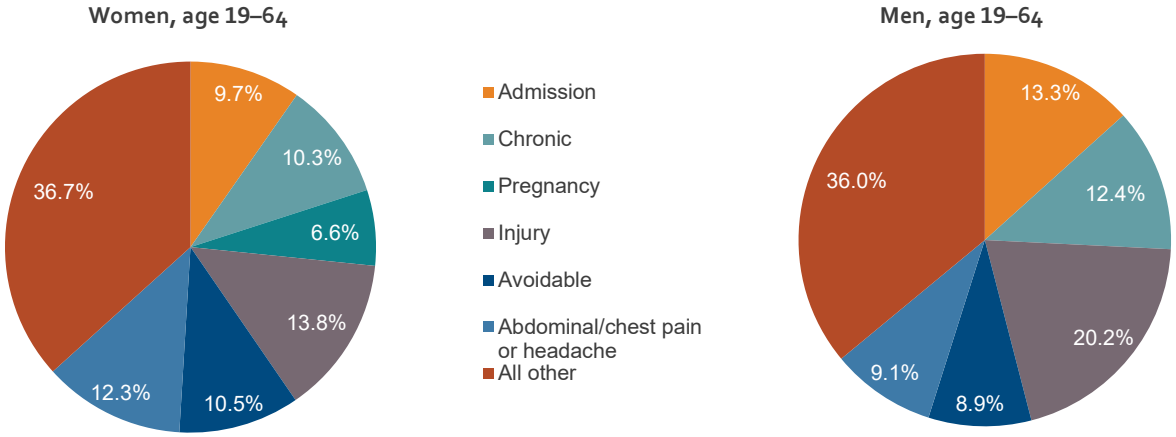
which include treatment for diseases such as cancer and diabetes.[3] Nearly 40 percent of ED visits for chronic conditions involve behavioral health issues, including mental illness, substance use, and alcohol-related problems. Women make higher shares of ED visits for abdominal pain, chest pain, or headaches (12.3% vs. 9.1%) and nearly 7 percent of ED visits made by women are for pregnancy-related conditions.

Avoidable ED visits are a focus of policymakers and practitioners looking for ways to control costs and manage hospital resources. In the late 2000s, for example, initiatives to address avoidable ED visits among Medi-Cal beneficiaries were a focus of quality improvements implemented by the Department of Health Care Services in partnership with Medi-Cal managed care plans (California Department of Health Care Services 2012). To identify avoidable visits, we use new emergency department prevention quality indicators (PQIs) developed and validated by the Agency for Healthcare Research and Quality (Davies et al. 2017).[4]

Overall, we find that only one in ten ED visits among adults were potentially preventable—meaning that they could have been avoided with access to high-quality community-based care. Women have a slightly higher share of avoidable visits (10.5%) than men (8.9%). Among visits classified as avoidable, nearly 30 percent were for treatment of upper respiratory infections, followed by cellulitis (18%), back pain (13%), and dental issues (11%).

FIGURE 3

Avoidable visits make up a relatively small share of ED visits made by non-elderly men and women



SOURCE: Author calculations from OSHPD emergency department and inpatient discharge records.

NOTES: Figure includes all ED visits made by adults age 19–64 between January 2014 and September 2015. Diagnostic categories for outpatient ED visits are based on the primary diagnosis. We restrict our analysis of diagnoses to this time period because of the change from ICD-9 to ICD-10 codes and the sources we use to categorize ED visits into broader categories rely on and/or have only be validated using ICD-9 codes. Avoidable visits are classified according to new AHRQ ED prevention quality indicators (Davies et al. 2017). Pain-related conditions include abdominal pain, chest pain, or headaches (not classified as chronic), pregnancy-related conditions, and injury-related visits are based on ICD-9 codes matched to Clinical Classifications Software (CCS) and chronic conditions are based on the Chronic Condition Indicator (CCI) developed and maintained by the Healthcare Cost and Utilization Project (HCUP) sponsored by AHRQ.

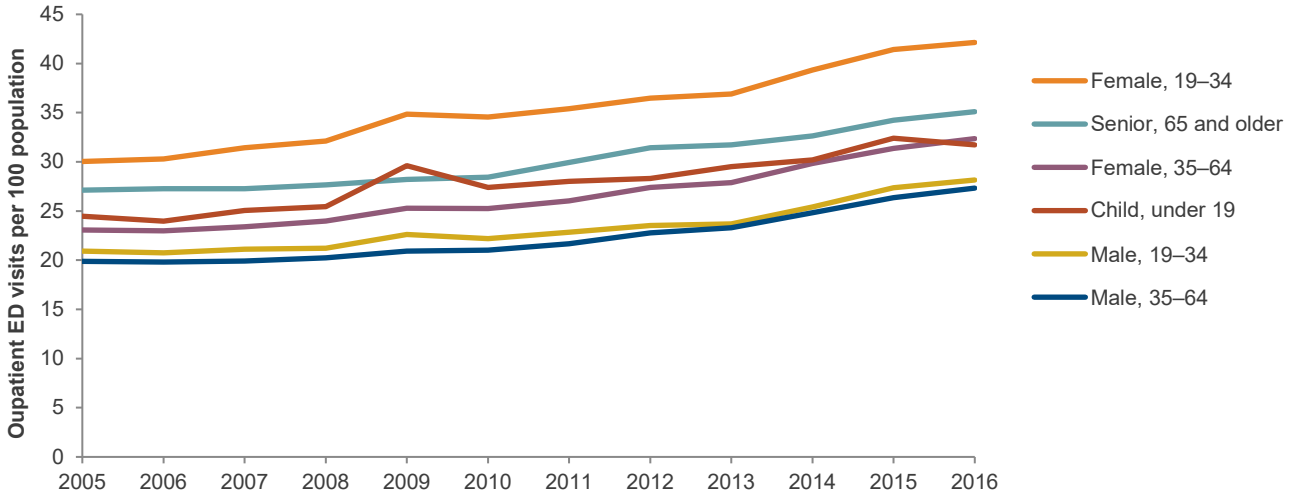
[3] There is a slight overlap between diagnosis codes used for avoidable visits and chronic conditions. In addition, some visits for headaches, including migraine and cluster headaches, are in the chronic conditions category. We create mutually exclusive categories to classify conditions using the following hierarchy – first we classify avoidable visits, then chronic conditions not considered avoidable, then pain-related conditions not considered avoidable or chronic.

[4] Much of the current research on avoidable visits either relies on an algorithm developed more than 20 years ago or focuses on avoidable hospitalizations in an inpatient setting rather than avoidable visits in an ED setting (Davies et. al. 2017; Durand et. al. 2011). An algorithm developed by physicians and researchers at NYU assigns probabilities that an ED visit falls into one of four severity categories based on ICD-9 diagnostic codes (Billings et al., 2000). The ambulatory care sensitive conditions (ACSC) classification system identifies hospitalizations that could have been avoided with access to community-based health care. ACSC rates are used to assess differences in health care resources across communities and intended to inform policies to improve health care access.

Most of the recent increase in overall ED use has been driven by outpatient ED visits. Controlling for population growth, overall per capita outpatient ED visits grew nearly 35 percent over this time period, compared to a 7 percent increase in per capita ED visits that resulted in a hospital admission. In 2016, non-elderly adults made about 32 outpatient ED visits per 100 people, up from 23 visits in 2005—an increase of 38 percent (Figure 4). Young women (age 19–34), a group with an already high use rate, had the largest increase (40%). However, there were also large increases among non-elderly men (35%), while rates among seniors and children increased 29 percent.

FIGURE 4

Outpatient ED visits rates have increased across all age groups



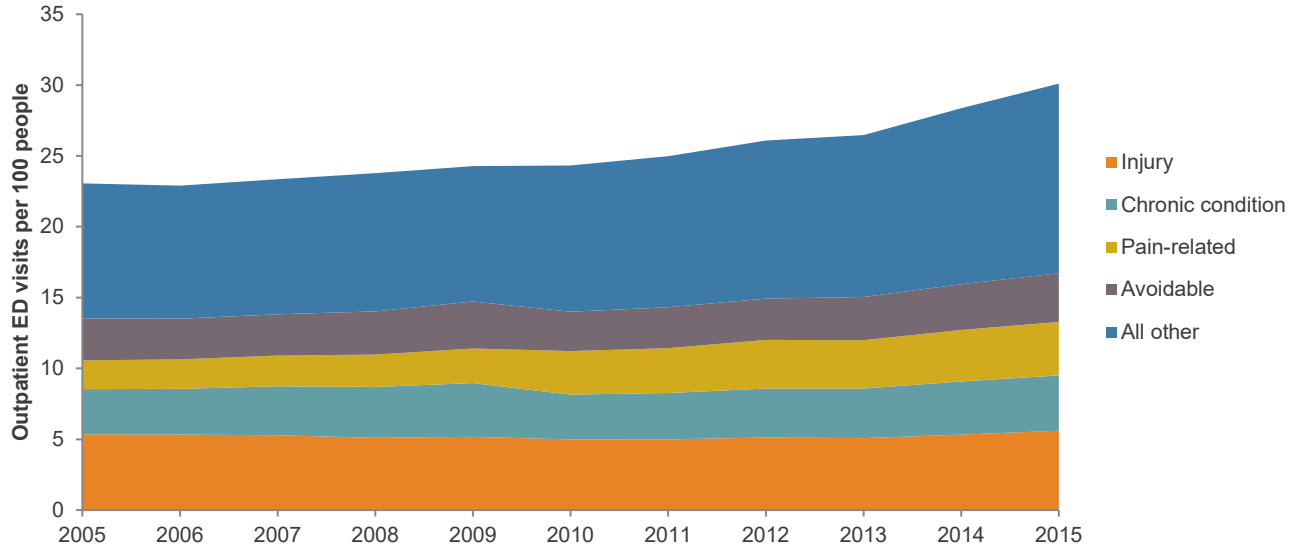
SOURCE: Author calculations from OSHPD discharge data and SEER population estimates.

NOTE: Figure includes only outpatient ED visits in the numerator and uses the appropriate population denominator for the age/sex group. See Technical Appendix B for more details.

When we break down outpatient ED visits by primary diagnosis, we find increases across all types (Figure 5). The smallest increase was for rates of injury-related ED visits: this type of visit—which accounted for the largest share of categorized outpatient ED use—increased by about 7 percent between 2005 and 2015. ED visit rates for chronic conditions grew more—by 22 percent—from about 3.2 visits per 100 population in 2005 to 3.9 in 2015. There was a slightly smaller uptick in avoidable visits, which increased about 18 percent. The largest increase—more than 80 percent—was in visits for which the primary diagnosis was related to abdominal pain, chest pain, or headaches.

FIGURE 5

Trends in ED visits for particular conditions vary over time



SOURCE: Author calculations from OSHPD discharge data.

NOTES: Figure includes all outpatient ED visits made by adults age 19–64. Diagnoses are based on the ICD-9 codes recorded as the primary diagnosis for the ED visit. These codes are categorized into more meaningful categories using the Clinical Classification Software algorithm from AHRQ. Injury and pain-related health conditions rely on CCS categories; those in the pain-related category include abdominal pain, chest pain, and headaches. Back pain is also a common primary diagnosis, but most ED outpatient visits for back pain are included in the avoidable category. ED visits categorized as avoidable are based on the ED PQI diagnoses. Due to the change from ICD-9 codes to ICD-10 codes in October 2015, we only include through quarter 3 of 2015 in all analyses of diagnoses or types of ED visits.

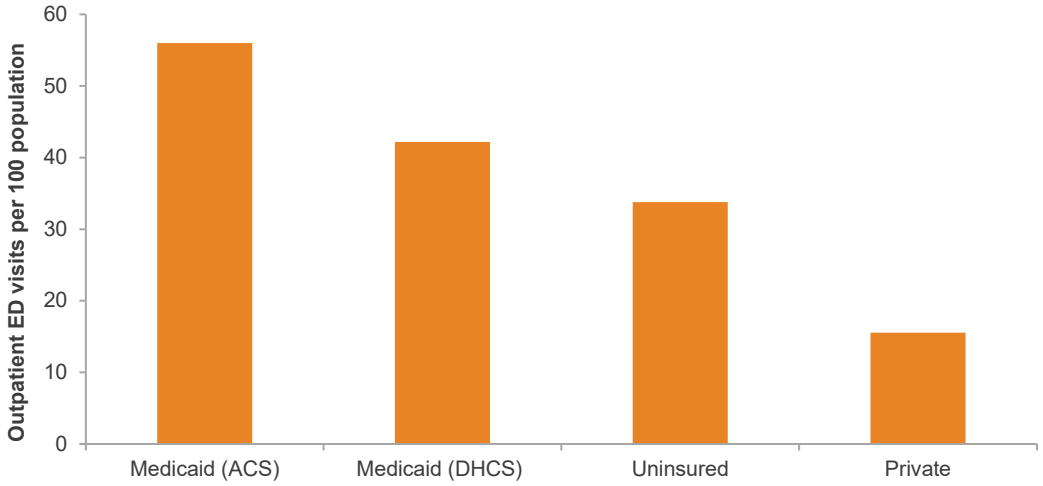
ED Use Varies across Sources of Insurance Coverage

Next, we look at the relationship between health insurance coverage and ED use. There are well-documented differences in ED usage patterns across insurance coverage groups. Historically, Medicare and Medicaid beneficiaries have had the highest ED visit rates in both California and the nation; ED rates are lower among the uninsured and lowest among the privately insured (Hsia 2018; Sun et al. 2018).

Figure 6 shows per capita outpatient ED visit rates for California adults in 2016. Because survey data tend to underestimate those with public coverage, we used two measures for the Medi-Cal visit rate, each with a different population denominator (Boudreaux 2015). According to both measures, non-elderly adult Medi-Cal beneficiaries have much higher per capita ED rates (55 or 42 visits per 100) than either the privately insured (16 visits per 100) or the uninsured (34 visits per 100). This is consistent with previous state and national measures.

FIGURE 6

Per capita ED use among adults age 19–64 is highest among those covered by Medi-Cal



SOURCE: Author calculations from OSHPD discharge data, 2016 American Community Survey, and DHCS Medi-Cal Certified Eligibles – Recent Trends.

NOTES: The population denominators for the Medicaid (ACS), uninsured, and private visit rates are estimates for the 19-to-64-year-old population from the ACS. The population denominator used for the Medicaid (DHCS) visit rate is based on counts of Medi-Cal certified eligibles from the California Department of Health Care Services for July 2016.

There are several reasons for observed differences in ED use across coverage groups. The most obvious is related to differences in the out-of-pocket costs for an ED visit. Generally, Medicaid beneficiaries do not have any out-of-pocket costs for ED use.[5] This is quite different than most private insurance, which often requires fairly sizable patient co-pays to discourage ED use in favor of other outpatient settings. And while the uninsured may not be able to pay, the fact that they are often billed for the care they receive creates barriers.

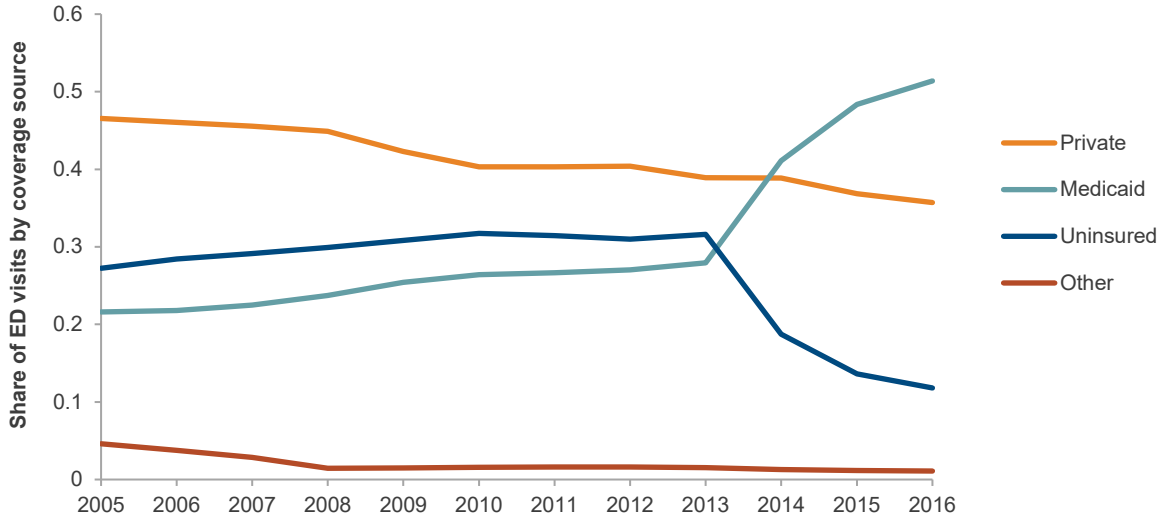
Other research exploring ED use among Medicaid beneficiaries finds that patients who use the ED more have higher physical health burdens and use more outpatient care as well (Billings and Raven 2013). Qualitative work suggests that Medicaid beneficiaries access the ED rather than outpatient care because they lack transportation, have limited access to urgent appointments with a primary care provider, and because it is more convenient. (Capp et al. 2016; Cheung et al. 2012).

As we might expect, the composition of ED visits by coverage source shifted after 2013, when many low-income adults gained access to Medi-Cal (Figure 7). The share of outpatient ED visits among adults 19 to 64 who are covered by Medi-Cal increased from 26 percent in 2013 to 47 percent by 2016. There were commensurate declines in the share of uninsured ED visits—from 29 percent in 2013 to 11 percent in 2016. The proportion of visits covered by private insurance also declined by about 3 percent between 2013 and 2016. It is not clear why we observe the small decline in ED use among the privately insured, but it is important to note that we do not have information on the type of private coverage, and patients' out-of-pocket costs for ED care vary considerably across private insurance carriers.

[5] In recent years, more states have established co-payments for ED visits by Medicaid enrollees; these co-pays are quite low—typically in the $5 range. Evidence is mixed on whether co-pays have any impact on ED usage among Medicaid recipients (Sabik and Gandhi 2016; Mortensen 2010).

FIGURE 7

After the ACA coverage expansion, outpatient ED visits with Medi-Cal increased while uninsured visits declined



SOURCE: Author calculations of OSHPD discharge data.

NOTES: Figure includes outpatient ED visits for adults age 19–64. "Other coverage" includes Medicare visits, which for the non-elderly population is a proxy for disability. Coverage is based on expected payer source recorded on the discharge abstract.

Clearly, the ACA changed the payer mix for outpatient ED visits; the share covered by Medi-Cal increased about 20 percentage points, while the share for uninsured visits declined by 18 percentage points. While we do not have information on how many ED patients may have enrolled as a result of an ED visit, we do know that Medi-Cal now pays for almost half of all ED visits among non-elderly adults. Beyond the shifts in coverage sources for ED visits, it is also important to investigate whether the ACA caused changes in trends in ED use.

Presumptive eligibility for Medi-Cal

Presumptive eligibility (PE) allows certain health care providers to give temporary Medicaid coverage to individuals likely to qualify for the program based on their income and household size. The ACA expanded the scope of presumptive eligibility from children and pregnant women to all individuals who are income-eligible for Medicaid. It also made hospital presumptive eligibility a requirement (previously, it was a state option).

California implemented the Hospital Presumptive Eligibility (HPE) program on January 1, 2014, providing immediate access to temporary Medi-Cal coverage for uninsured patients who visit the ED and meet eligibility criteria. A hospital employee can determine that an uninsured patient is eligible for Medi-Cal. Nearly all hospitals in the state are qualified HPE providers.

Moreover, Medicaid coverage is retroactive, meaning that the Medi-Cal program will pay for health care services provided up to three months *before* enrollment of any individual who would have been eligible during that period. Presumptive eligibility and retroactive Medicaid coverage are intended as safeguards to low-income, vulnerable populations and the health care providers that serve them (Musumeci and Rudowitz 2017).

How Did ACA Coverage Expansions Affect ED Use?

In this final section, we investigate how the Affordable Care Act—the largest expansion in insurance coverage in the last 50 years—affected ED use in California. As we have seen, the relationship between health insurance coverage and emergency department use is complex and multifaceted. On the one hand, insurance coverage typically reduces the out-of-pocket costs of patients seeking care at the ED, which could lead to an increase in ED visits. On the other hand, insurance coverage should expand access to other outpatient health services and could reduce ED use, especially if those gaining coverage are being connected to a primary care provider through managed care plans—and most Medi-Cal patients are in managed care plans (Sommers et al. 2017).

As a result, it is not immediately clear how the ACA coverage expansions might be affecting ED visits, particularly in the relatively short time since the ACA was implemented. Existing research provides mixed evidence. Studies that examine state-based coverage expansions that pre-date the ACA have come to different conclusions. The Oregon Health Insurance Experiment—a randomized, controlled study of Medicaid expansion—found that ED visits increased significantly among individuals who gained Medicaid coverage compared to a control group made up of people who remained uninsured after signing up for a lottery to receive Medicaid (Taubman 2016; Finkelstein 2017). However, other studies that used quasi-experimental research designs have found significant declines in ED visits attributable to increased coverage. A study of ED use in Massachusetts found strong evidence that outpatient ED visits significantly declined as the result of major state-level reforms (Miller 2012).

The few studies that focus on how the ACA Medicaid expansion in 2014 impacted ED use nationally have also generated conflicting results. Pines et al. (2016) find no significant change in ED use across hospitals in states that expanded Medicaid compared to those that did not, while Sommers et al. (2017b) report significant reductions in ED use among patients who gained ACA coverage in select states. In contrast, Nikpay et al. (2017) find significantly higher per capita ED rates comparing Medicaid expansion states to states that chose not to expand their Medicaid programs.

These differences suggest that the effect of coverage expansions on ED use is determined by many factors, including the population groups most affected by the expansion, the types of coverage and health plans in which people enroll, and the health care resources available across geographic areas (Sommers and Simon 2017a). Thus, a thorough analysis of what has happened across California in the post-ACA environment is needed to help policymakers and practitioners understand the impact of coverage expansion.[6]

[6] A recent study provides a detailed examination of the impacts of the ACA for California including an analysis of ED use (Duggan et al. 2019). This study uses similar data to ours, but employs different methods and finds ED use increased as a result of the ACA. Specifically, the study employs a regression discontinuity research design focused on adults aged (64/65) for its main analysis of the effects of the ACA. For more discussion of how their analysis relates to ours, see Technical Appendix E.

Data and methods

Our analysis relies on hospital discharge records submitted to the California Office of Health Planning and Development. Licensed hospitals in the state are required to submit information on all hospital encounters, including ED visits. We combine this information with population counts from the National Institutes of Health SEER program to develop our per capita ED visit rates. We rely on Census Bureau data for county-level uninsured rates and household income estimates and Bureau of Labor Statistics data for employment levels (see Technical Appendix B).

To estimate the effect of the ACA coverage expansion on ED use, we apply an analytic method that uses the variation across county uninsured rates to isolate the effect of insurance coverage on ED use. While the ACA coverage expansion went into effect at the same time across the state, counties with high uninsured rates in the years prior to the coverage expansion had the potential to experience larger changes in coverage. We identify counties with higher-than-average (75th percentile) uninsured rates in the pre-ACA period and those with relatively low pre-ACA uninsured rates (25th percentile). We use a difference-in-differences approach to compare the post-reform changes in per capita ED visit rates across these two county groups. For more information, refer to Technical Appendix C.

Isolating the Impact of the ACA on ED Use

As we have seen, ED use had been increasing well before the ACA. To disentangle the role that the ACA coverage expansions may have played from longstanding trends in ED use, we focus on a comparative county analysis, using a strategy developed by Miller (2012) in her examination of coverage expansions in Massachusetts.[7]

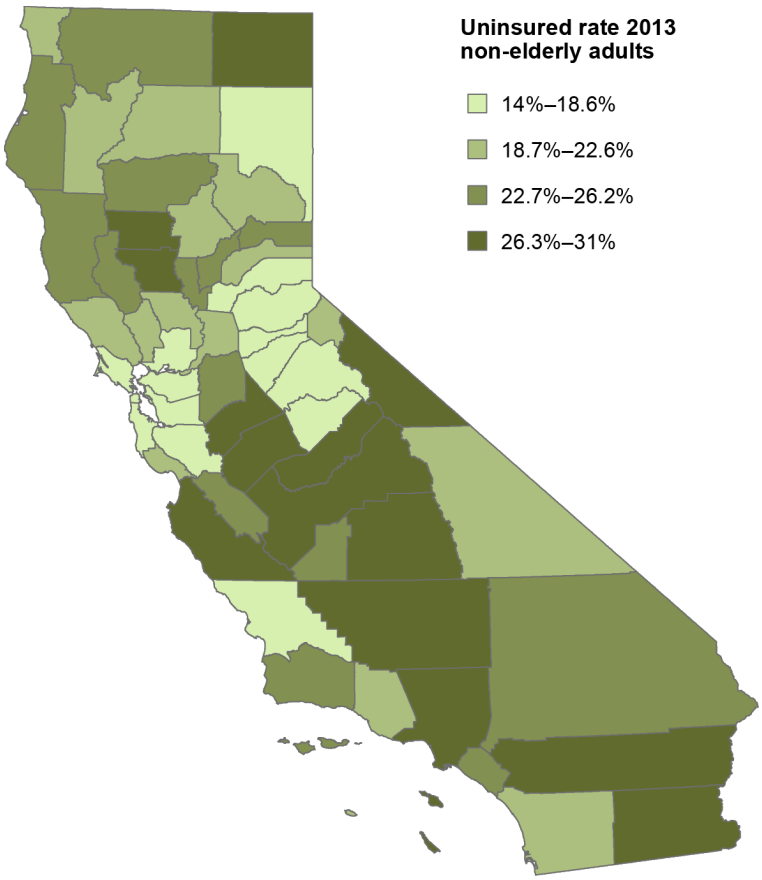
In the years leading up to ACA implementation, there were large differences in uninsured rates across California's counties. In 2013, the year before major ACA coverage expansions, more than 25 percent of adults age 18 to 64 lacked health insurance coverage in some counties—mainly in the central and southern parts of the state. In other counties, fewer than 15 percent of adults were uninsured (Figure 8).[8]

[7] While we use the analytic approach developed by Miller (2012) for the main results presented in this report, we also considered an alternative analytic strategy to examine how the ACA affected ED use. In Technical Appendix E, we consider whether the elderly could be a reasonable pre-ACA control group in place of counties with low uninsured rates.

[8] We use the pre-ACA uninsured rate rather than the actual observed drop in the uninsured rate that resulted from the coverage expansion. This minimizes the possible effect of counties with larger observed declines in their uninsured rate taking different actions to increase coverage and those efforts could be related to changes in ED use. However, counties with higher uninsured rates did in fact experience larger declines compared to counties that had lower pre-ACA rates.

FIGURE 8

Pre-ACA uninsured rates varied considerably across California counties



SOURCE: US Census Bureau, Small Area Health Insurance Estimates.

NOTES: Uninsured rates are for adults age 18–64. Rate categories are based on quartiles. Counties with the darkest shading had uninsured rates for adults age 19–64 in the top quartile—75th percentile or above. They are: Colusa, Fresno, Glenn, Imperial, Kern, Los Angeles, Madera, Merced, Modoc, Mono, Monterey, Riverside, Stanislaus, and Tulare.

We leverage these large differences in pre-ACA uninsured rates to estimate the relationship between changes in per capita ED use and increased insurance coverage that resulted from the ACA. We do so by comparing the trends in ED use in the group of 15 counties with the highest pre-ACA uninsured rates (75th percentile and higher) to a similar number of counties that had much lower uninsured rates (25th percentile and below) before the ACA expansion. (We also identified counties in the middle of the uninsured distribution—between the 25th and 75th percentile.) This allows us to separate out the effects of the dramatic increase in insurance coverage from the pre-existing growth in ED visit rates.

The statewide drop in the uninsured rate among non-elderly adults between 2013 and 2016 was about 13.5 percentage points. Looking at our two groups of counties, we observe a much larger decline (16.1 percentage points) in uninsured rates for the first group (counties with the highest pre-ACA uninsured rates) than for the second group (counties with lowest pre-ACA uninsured rates), which saw a 9.9 percentage point reduction in their uninsured rate.[9]

[9] Differences in uninsured rates across counties—in both the pre- and post-ACA periods—may be related to the distribution of undocumented immigrants across the state. Undocumented immigrants were largely excluded from the ACA coverage expansions and are not eligible for comprehensive Medi-Cal coverage except in limited cases. While California expanded full Medi-Cal coverage to undocumented immigrant children in 2016, undocumented adults can only receive emergency services, also referred to as "limited scope" Medi-Cal, if they meet other eligibility requirements. We do not explicitly adjust for undocumented immigrants in our

In our analysis, we take a number of steps to further ensure that we are isolating the effect of the ACA coverage expansions from other pre-existing and trending factors. First, we include county indicators to account for underlying differences across counties that do not vary over time. Second, we include annual measures of county-level demographics, economic conditions, and health care resources—such as per capita counts of ED beds, community clinic providers, and clinic visits—that may have changed within counties over our study period and could be contributing to the trends we see in ED use. Third, we restrict our analytic time period to 2011 (three years before ACA coverage expansions) through 2016 (three years after) because there were differential ED-use trends across counties during the Great Recession (see Technical Appendix C for more details). Finally, we control for county implementation of Low-Income Health Programs (LIHPs) during our pre-ACA period. LIHPs acted as a "pre-expansion" of Medi-Cal to low-income uninsured adults in preparation for the full expansion that began in January 2014. All but five California counties implemented LIHPs.

ACA Coverage Expansion Reduced Outpatient ED Use among Middle-aged Adults

Our statewide analysis of all 58 counties provides evidence of significant reductions in outpatient ED visits among adults age 19–64 attributable to the ACA coverage expansion that started in 2014. In other words, the increase in ED visit rates that we observe would have been even larger in the absence of the ACA. Statewide, ED use increased, on average, by about 4 visits per 100 people from 2011–13 to 2014–16. However, it would have increased significantly more (by nearly 3 additional visits) in counties with the highest pre-ACA uninsured rate if there had not been a large increase in coverage. Narrowing our analysis to the 35 largest counties in the state—those with at least 100,000 residents—we find no significant effect of increased insurance coverage on ED use. Thus, we conclude that the ACA coverage expansions were not responsible for the growth in ED use observed since 2014.

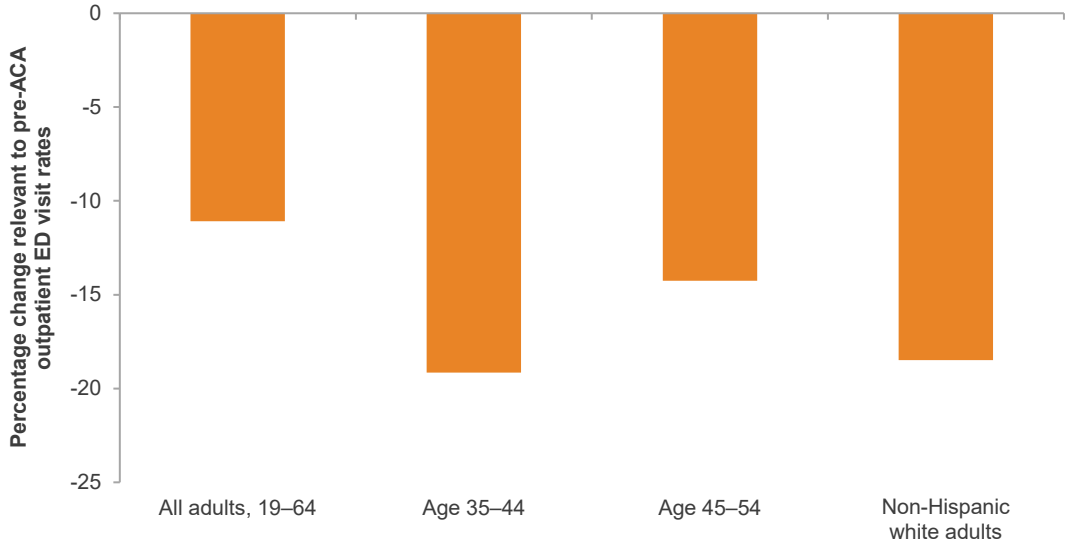
To further probe how the ACA impacted ED visit rates, we examined changes in per capita ED use across a number of patient subgroups—age, sex, and race/ethnicity—across all 58 counties. We find evidence that declines in per capita ED use attributable to the ACA were concentrated among middle-aged adults—more specifically, those age 35–54. Men and women in this age range saw similar declines, but we see evidence that non-Hispanic whites saw declines while other racial/ethnic groups did not.

Figure 9 shows the estimated percent change in per capita ED use caused by ACA coverage expansions for all adults as well as for subgroups with statistically significant reductions in ED visits. These reductions range from an 11 percent decline in per capita ED use among all non-elderly adults to a nearly 20 percent decline for adults age 35–44 and non-Hispanic white adults.

models, but the inclusion of county fixed effects account for baseline differences across counties in undocumented residents and we do not have reason to believe that the distribution of undocumented immigrants across the state changed during our analytic time period.

FIGURE 9

The ACA brought about declines in outpatient ED visits for some adult groups



SOURCE: Author calculations from data described in Technical Appendix B and "top quartile" model coefficients shown in technical appendix Tables D2–D5.

NOTE: Model coefficients shown are all significant at the 0.05 level or better; to obtain the percentages shown in the figure, coefficients are divided by the 2011–13 average per capita ED visits in each subgroup. See Technical Appendix C for details.

Looking at primary diagnoses, we do not see a change in ED visits due to the ACA for chronic conditions or visits classified as avoidable. We do find a small decline in injury-related visits—this is somewhat puzzling given the expectation that chronic or avoidable visits that could be treated in other outpatient settings would be more impacted by coverage expansions.

Finally, we conducted analyses using only the largest 35 counties (100,000 people or more) in the state rather than all 58 counties. Nearly two in five of California's counties (23 of 58) have very small populations—these 23 counties are home to only about 1.5 million (about 4%) of the state population—and this poses challenges for accurately estimating our key variable of interest, pre-ACA uninsured rates. For this reason, and because statewide outcomes are driven by what happens in the larger counties, we ran all of our models on the subset of large counties. In these results, we find no statistically significant effects from 2014 through 2016 (see technical appendix Table E1). In other words, the ACA coverage expansions had no detectable effect on ED use in larger counties.[10]

In sum, our analyses imply that the ACA coverage expansions did not increase ED use in California; indeed, they may have reduced it.

[10] We also ran models that included only the 16 largest counties—those with half a million people or more. We discuss this analysis in the technical appendices but do not include it in the main results presented in the report because the 16-county analysis becomes a regional comparison between Bay Area counties—which had flat trends in ED use compared to the state as a whole—and large counties in the southern and central regions of the state. These results probably reflect specific regional differences rather than the broader effects of the ACA on ED use throughout the state. That said, our findings of reductions in ED use are different when we narrow the analysis to a small number of counties.

Conclusion

The ACA's expansion of health insurance to millions of Californians raised reasonable concerns about increased coverage—in particular, the dramatic growth in Medi-Cal enrollment—driving increases in ED use. We find no evidence that this is the case. In fact, in our analysis of all 58 counties, our results suggest that, without the large reductions in uninsured rates in the wake of the ACA, ED visit rates would have been even higher, particularly for adults age 35–54.

Nonetheless, the growing reliance on emergency departments for complex needs is cause for concern, given the large share of ED visits that are publicly funded through Medi-Cal. Efforts to curtail ED use often focus on increasing the cost of accessing ED care to discourage avoidable ED visits. However, the existing, limited evidence on how effective copays are in reducing ED use among Medicaid beneficiaries does not offer clear policy prescriptions.

Medi-Cal managed care plans will need to play a key role in stemming the upward trend in ED visits. More than 85 percent of Medi-Cal participants are enrolled in managed care. Medi-Cal initiatives including Whole Person Care pilots and health homes that focus on case management and integration of physical and behavioral health are designed to lower ED use by frequent users. Rigorous evaluations of these pilot programs will be important in helping tailor policies aimed at curbing ED use.

One important note of caution: reductions in ED visit rates should not be interpreted as being linearly associated with cost reductions. The actual costs of providing health care are complex—and the increasing reliance on managed care, risk-sharing arrangements, and delegation have further complicated our ability to understand—let alone control—costs. That said, ensuring the most efficient and effective allocation of health care spending and resources will be important to finding sustainable solutions to growing health care costs.

Moving forward, it will be crucial to monitor the evolving patterns of health care use as Californians who gained coverage become incorporated into the health care delivery system. Recent steps toward developing an all-payer claims database could go a long way in helping policymakers, providers, and the public alike better understand and improve our health care system. As state policymakers focus on further expansions of health insurance in an effort to reach universal coverage, reliable information on coverage, costs and health care use become even more essential.

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 6, 2019

TO: CHA EMS/Trauma Committee Members

FROM: BJ Bartleson, RN, MS, NEA-BC, Vice President Nursing and Clinical Services
Gail Blanchard-Saiger, Vice President & Counsel, Labor and Employment

SUBJECT: SB 1152 Homeless Bill and Violence

SUMMARY

CHA is collecting issues that hospitals are grappling with regarding implementation and the upcoming July tracking deadline for the homeless bill. We sent a SurveyMonkey to you outlining seven areas of the bill with the results attached for your review.

CHA is also interested in understanding workplace violence as it relates to homelessness.

CHA is also collecting best practices in an attempt to develop and distribute tools and strategies for members.

DISCUSSION QUESTIONS

1) What is the biggest barrier for you at this point?
2) How are you coordinating care and adequate placement for homeless patients?
3) How are you planning to implement the July 1st requirements?
4) Are you noticing an increase in work place violence due to homelessness?

Attachments: Survey Results

BJB:br

SB 1152 - questions Feb 2019				
	1	2	3	4
How are homeless patients identified in your facility? Is there variation in the process based upon workflow?	Registration will ask the 3 questions and then place "zzzzz" in the zip code field in the EMR. This generates the homeless process and documentation. No variation in process.	generally by registration or nursing at the bedside, sometimes ambulance gives a heads up	through admitting process. They are asked when gather information after the MSE	Registration asks patients for their address, (defined by SB 1152) they make notation in EMR. Nursing staff will also make notations as they get to know the patient when providing care. Variation occurs more by patient, rather than workflow.
Describe your program in the ED for providing specific meals based upon MD orders and ensuring ED has enough food 24/7.	We stock pre-made wraps that equal a meal in calories. They are stocked by Nutrition Services everyday. We also pulled baseline data, so we would know about how many we need/day.	We have breakfast, lunch and dinner available through food and nutrition, and extra meals in our refrigerators for after hours, with kosher options.	We have sandwiches in the ED 24/7. If patient has a specific meal order placed, then we can order though food and nutrition services for delivery to the ED.	We have par levels for food in the ED 24/7 based on previous needs/use
The new law requires the offering of weather appropriate clothing - how does your ED handle storage of clothing? What if patients return for clothes?	We have a storage room outside the ER that we keep the clothes in. It is stocked by materials management. Patient stickers are placed on cards for tracking. We do not take returned clothes. We took donations for coats and they will be laundered by our linen company	We have purchased lockers for clothing and are starting to include the volunteers in the process around maintaining clothes. If patients return for clothes, we will use our discretion.	we have an area the houses clothing. we currently have used clothing but will be switching to new clothing once the CMS rule comes out that we have to show proof of laundered clothing. We try and get coats, but sweats seem to be the best for this time of year and can be modified in the warmer months. If they return for clothes (which has happened), we give them more clothing.	We have not seen any trends of people returning just for clothes. we keep our clothing in closed containers by size and type

SB 1152 - questions Feb 2C			
	5	6	7
How are homeless patients identified in your facility? Is there variation in the process based upon workflow?	On registration we trained our access staff to ask patients if they have a "permanent address". If they do not we created a flag in the Emergency Department and a banner in EPIC if the patient is admitted to make sure that staff are aware and can provide the necessary resources; offer the appropriate paperwork if not insured during the visit and on discharge. We use EPIC	Per registration and patient interview	RN Screening in ED and upon admission. Patient registration field as well.
Describe your program in the ED for providing specific meals based upon MD orders and ensuring ED has enough food 24/7.	We created bagged lunches for the emergency department for patients. We have a par level of 10 and food services checks stock 3 times a day. We have back up in our kitchen that our Operational Supervisor has access to if we require more. We monitor our par levels to increase them if needed if we are running out frequently.	Always have par stock of sandwiches, juices, milk etc in the ED patient refrigerator	Sandwiches/snack/juice available as a sack lunch to go. Par managed by food and nutrition services. No MD order necessary. Required to offer at discharge.
The new law requires the offering of weather appropriate clothing - how does your ED handle storage of clothing? What if patients return for clothes?	We have a cabinet in the Emergency Department that we have one person responsible for with the ability to order monthly based on our PAR levels. We can order sweats; ponchos; shoes. We do have some staff that do bring in clothes but limit it based on our needs based on our par levels. We don't change our process and if patients return we provide them the required clothing even if they return 3 times a day but require new clothing based on their current clothes being soiled.	We have a room with clothing. If patients return for clothes, they get them	We have purchased a cache of clothing- pants/sweatshirts/rain ponchos/sandals. If they return and check in to ED we are required to assess for weather appropriate clothing, if they are in appropriate clothing (or we know they have it) we are not required to give it.

	1	2	3	4
How are you screening homeless patients for vaccines and infectious disease?	All based on chief complaints in ER, then referral to health Department for the ones not related to chief complaint.	Providers do this upon initial assessment.	ask them in triage. Safety Net Connect also has some information from other facilities on care given elsewhere in the county (OC). Hopeful to get EDIE soon	Physicians are screening based on presenting conditions, just as they would any other patient.
Describe your process for screening and offering homeless patients affordable health insurance.	Information given at discharge of where and who they can call. If during business hours, med assist screens.	Registration begins this process and introduces Social Work or Case Mgmt as necessary.	Not an ED function, Case manager will provide education either in ED or if after hours, the next day.	When registration inquires about coverage, if patient does not have coverage, they begin the process with the patient at that time. Often times the patient doesn't have required documents, or outside resources are not open (after hours) so we follow up with them by our community navigators to complete the process either during their stay or post discharge
Describe your process for offering homeless patients warm hand-offs and placement coordination.	Lack of resources in county for shelters. We are still working through this. If at night they usually stay in the ER waiting room because shelters close during the night.	We have an excellent relationship with Saban Clinic. we promote warm handoffs as much as possible. We will provide transportation should that be needed to complete the process.	challenging after hours but will call the individuals at the homeless shelter (they rarely answer the phone) and at least attempt to perform warm handoff.	We are really struggling with this as the shelters are not helpful with complying with what we are required to do by law

	5	6	7
How are you screening homeless patients for vaccines and infectious disease?	Based on Public health outbreaks we provide vaccinations if there are active outbreaks such as the Hep A. All other times we will ask about vaccinations and trust what the patient states. We do offer flu if patient willing to take a flu shot. We provide Tetanus for lacerations.	Per patient interview/ assessment	We are adding infectious disease referral to all d/c instructions. An infectious disease screening happens within the MD medical screening exam (MSE), but it is difficult to capture in the EMR. We offer ALL patients vaccinations based on their presenting condition. Currently the only vaccine that meets this criteria is tetanus.
Describe your process for screening and offering homeless patients affordable health insurance.	Access staff will follow up with all patients flagged as homeless to offer affordable health insurance. A financial specialist will complete and submit the paperwork.	Upon discharge per registration or social work. Not a solid process.	The Registration staff screens all homeless patients prior to d/c.
Describe your process for offering homeless patients warm hand-offs and placement coordination.	Resources are offered to homeless patient and documented in patient's chart if resources for placement accepted. We have loaded area specific for the North and South and have worked with certain places for placement. If the patient is agreeable we can communicate to the receiving facility. We have standard work for staff to refer to and we created a share point place that is reference place for staff to find all the resources that are needed. We have case management available with social work at different times at our different sites and will assist if patient's requesting placement but the resource page that was created is for the RNs to use to make sure we are compliant in meeting the homeless population needs. We created documentation in EPIC to document the care and resources provided and we can run reports to review compliance.	Per social worker assessment and intervention with local open shelters.	Outpatients are receiving the SD 211 pamphlet. The inpatients will have case management call the shelters, document attempt and release with shelter packet info.

	1	2	3	4
Are follow up medical and behavioral health information sent to the placement location for homeless patients? Please elaborate.	No	No...we provide to the patient and/or verbally on the telephone to the accepting agency.	when able ye. We have a social worker part time though a granted position (Whole Person Care) that will follow up using the phone or the safety net connect system to inform.	We have not been able to get shelters to accept patients, so no information has been sent

	5	6	7
Are follow up medical and behavioral health information sent to the placement location for homeless patients? Please elaborate.	If the patient accepts placement for behavioral health and we find a location we work with our Psychiatric Liaison Team that will arrange placement and give a warm hand off if patient is agreeable.	No	Getting homeless placed in a shelter in real time is rare, but we would send follow up information. All patients receive a follow up for medical or BH based on their need. No different than a non homeless patient.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 6, 2019

TO: CHA EMS/Trauma Committee Members

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

SUBJECT: AFL 19-05 Emergency Services Regulations

SUMMARY

Per the attached All Facilities Letter (AFL), CDPH would like to discuss and hear our ideas for updating the GACH emergency services regulations. The regulations and questions they will be asking at the meeting are also attached. While the stakeholder meeting will be held before this committee meeting, CHA would like to take your input, since CDPH has not given us a due date for submittal as this is not an official public comment period but a "pre-public" comment period.

DISCUSSION QUESTIONS

1) Do these regulations address the standards practice in your ED?
2) Do you have suggestions or comments regarding additions or deletions to the present regulatory language?

Attachments: AFL 19-05
Questions for Stakeholder Engagement
Title 22 Emergency Medical Service

BJB:br

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

February 8, 2019 AFL 19-05

TO: General Acute Care Hospitals

SUBJECT: Notice of Stakeholder Meeting for General Acute Care Hospital Emergency Services Regulations

All Facilities Letter (AFL) Summary

This AFL notifies facilities that the California Department of Public Health (CDPH), Center for Health Care Quality (CHCQ) is holding a stakeholder meeting on March 1, 2019, to discuss general acute care hospital (GACH) emergency services regulations.

CDPH is holding a stakeholder meeting to discuss updating the GACH emergency services regulations. The meeting will be held at:

Date	March 1, 2019
Time	2:00 PM to 3:30 PM
Location	1500 Capitol Avenue Training Room A Sacramento, CA 95814

CDPH would like to discuss and hear your ideas for updating the GACH emergency services regulations. Please come to the meeting prepared to share your comments and suggestions after reviewing the "Questions for Stakeholder Engagement – Emergency Medical Services" (PDF).

There is limited seating, so if you are attending in-person, please reserve your seat by February 22, 2019, by emailing CHCQRegulationsUnit@cdph.ca.gov. If you are attending via WebEx, please register with the WebEx Registration link. When choosing an audio connection, select "I will call in."

Please check the Regulation Stakeholder Meetings webpage for updates and opportunities to comment. If you have any questions about this AFL, please email CHCQRegulationsUnit@cdph.ca.gov.

Sincerely,

Original signed by Heidi W. Steinecker

Heidi W. Steinecker
Deputy Director

Attachments:
Questions for Stakeholder Meeting – GACH Emergency Services (PDF)
Existing Title 22 Basic Emergency Services Regulations (PDF)

Questions for Stakeholder Engagement

Emergency Medical Services

To be held February 4, 2019

1. How do emergency departments ensure that there are appropriate specialists available to meet the needs of the patient population?

2. What kinds of medical imaging services (X-ray, CT, etc.) are available for emergency patients in:
    - Standby emergency departments?
    - Basic emergency departments?
    - Comprehensive emergency departments?

3. Are medical imaging services available to the emergency department 24 hours per day, 7 days per week?

4. During 2011 stakeholder engagement, one organization requested that the regulations require a triage area. Should this be a licensing requirement?

5. Do emergency departments have special emergency preparedness requirements in addition to the hospital-wide emergency preparedness requirements?

6. How does the emergency department manage psychiatric patients when no beds are available in an inpatient psychiatric unit or acute psychiatric hospital?
    a. How do emergency departments ensure the safety of suicidal patients?
    b. What training is appropriate for emergency department staff who care for psychiatric patients?

7. During 2011 commentary, one organization commented that the requirement for "…blood storage facilities in or adjacent to the emergency service" is obsolete. How does the emergency department ensure that blood and blood products are readily available?

8. How does the emergency department ensure that it has reliable and rapid communication with essential support services (blood bank, lab, imaging, police, fire, etc.)?

9. What is the process for ensuring that medication information is accurately communicated when a patient is transferred to an inpatient unit?

10. How does the emergency department ensure the safety of obese patients?

11. Does the emergency department have equipment that is appropriate for children, including newborns?

12. What special considerations, if any, should apply to small and rural emergency departments?

13. Do you have any additional suggestions or comments regarding emergency department licensing regulations?

Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 1. General Acute Care Hospitals
Article 6. Supplemental Services

Basic, Comprehensive, and Standby Emergency Medical Services

§ 70411. Basic Emergency Medical Service, Physician on Duty, Definition.
Basic emergency medical service, physician on duty, means the provision of emergency medical care in a specifically designated area of the hospital which is staffed and equipped at all times to provide prompt care for any patient presenting with urgent medical problems.

§ 70413. Basic Emergency Medical Service, Physician on Duty, General Requirements.

(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the administration and medical staff where such is appropriate.
(b) The responsibility and the accountability of the emergency medical service to the medical staff and administration shall be defined.
(c) The emergency medical service shall be so located in the hospital as to have ready access to all necessary services.
(d) A communications system employing telephone, radiotelephone or similar means shall be in use to establish and maintain contact with the police department, rescue squads and other emergency services of the community.
(e) The emergency medical service shall have a defined emergency and mass casualty plan in concert with the parent hospital's capabilities and the capabilities of the community serviced.
(f) The hospital shall require continuing education of all emergency medical service personnel.
(g) Medical records shall be maintained on all patients presenting themselves for emergency medical care. These shall become part of the patient's hospital medical record. Past hospital records shall be available to the emergency medical service.
(h) An emergency room log shall be maintained and shall contain at least the following information related to the patient: name, date, time and means of

arrival, age, sex, record number, nature of complaint, disposition and time of departure. The name of those dead on arrival shall be entered in the log.

(i) All medications furnished to patients through the emergency service shall be provided by a pharmacists or an individual lawfully authorized to prescribe. Such medications shall be properly labeled and all required records shall be maintained in accordance with state and federal laws.

(j) Each Basic Emergency Medical Service shall be identified to the public by an exterior sign, clearly visible from public thoroughfares. The wording of such signs shall state: BASIC EMERGENCY MEDICAL SERVICE, PHYSICIAN ON DUTY.

(k) Standardized emergency nursing procedures shall be developed by an appropriate committee of the medical staff.

(l) A list of referral services shall be available in the basic emergency service. This list shall include the name, address and telephone number of the following:
   (1) Police department.
   (2) Antivenin service.
   (3) Burn center.
   (4) Drug abuse center.
   (5) Poison control information center.
   (6) Suicide prevention center.
   (7) Director of the State Department of Health or his designee.
   (8) Local health department.
   (9) Clergy.
   (10) Emergency psychiatric service.
   (11) Chronic dialysis service.
   (12) Renal transplant center.
   (13) Intensive care newborn nursery.
   (14) Emergency maternity service.
   (15) Radiation accident management service.
   (16) Ambulance transport and rescue service.
   (17) County coroner or medical examiner.

(m) The hospital shall have the following service capabilities:
   (1) Intensive care service with adequate monitoring and therapeutic equipment.
   (2) Laboratory service with the capability of performing blood gas analysis and electrolyte determinations.
   (3) Radiological service shall be capable of providing the necessary support for the emergency service.
   (4) Surgical services shall be immediately available for life-threatening situations.
   (5) Postanesthesia recovery service.

(6) The hospital shall have readily available the services of a blood bank containing common types of blood and blood derivatives. Blood storage facilities shall be in or adjacent to the emergency service.

(n) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.

§ 70415. Basic Emergency Medical Service, Physician on Duty, Staff.

(a) A physician trained and experienced in emergency medical services shall have overall responsibility for the service. He or his designee shall be responsible for:
(1) Implementation of established policies and procedures.
(2) Providing physician staffing for the emergency services 24 hours a day who are experienced in emergency medical care.
(3) Development of a roster of specialty physicians available for consultation at all times.

(b) All physicians, dentists and podiatrists providing services in the emergency room shall be members of the organized medical staff.

(c) A registered nurse trained and experienced in emergency nursing care shall be on duty at all times.

(d) A registered nurse trained and experienced in emergency nursing care shall be on duty at all times.

(e) There shall be sufficient other licensed nurses and skilled personnel as required to support the services offered.

§ 70417. Basic Emergency Medical Service, Physician on Duty, Equipment and Supplies.

All equipment and supplies necessary for life support shall be available, including but not limited to, airway control and ventilation equipment, suction devices, cardiac monitor defibrillator, pacemaker capability, apparatus to establish central venous pressure monitoring, intravenous fluids and administration devices.

§ 70419. Basic Emergency Medical Service, Physician on Duty, Space.

(a) The following space provisions and designations shall be provided:
(1) Treatment room.
(2) Cast room.
(3) Nursing station.
(4) Medication room.
(5) Public toilets.
(6) Observation room.
(7) Staff support rooms including toilets, showers and lounge.

(8) Waiting room.
(9) Reception area.

(b) Observation beds in the emergency medical service shall not be counted in the total licensed bed capacity of the hospital.

§ 70451. Comprehensive Emergency Medical Service Definition.

Comprehensive Emergency medical service means the provision of diagnostic and therapeutic services for unforeseen physical and mental disorders which, if not promptly treated, would lead to marked suffering, disability or death. The scope of services is comprehensive with in-house capabilities for managing all medical situations on a definitive and continuing basis.

§ 70453. Comprehensive Emergency Medical Service General Requirements.

(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the administration and medical staff where such is appropriate.

(b) The responsibility and the accountability of the emergency medical service to the medical staff and administration shall be defined.

(c) The emergency medical service shall be so located in the hospital as to have ready access to all necessary services.

(d) A communications system employing telephone, radiotelephone or similar means shall be in use to establish and maintain contact with the police department, rescue squads and other emergency services of the community.

(e) The emergency medical service shall have a defined emergency and mass casualty plan in concert with the hospital's capabilities and the capabilities of the community served.

(f) The hospital shall require continuing education of all emergency medical service personnel.

(g) Medical records shall be maintained on all patients presenting themselves for emergency medical care. These shall become part of the patient's hospital record. Past hospital records shall be available to the emergency medical service.

(h) An emergency room log shall be maintained and shall contain at least the following information relating to the patient: name, date, time and means of arrival, age, sex, record number, nature of complaint, disposition and time of departure. The name of those dead on arrival shall also be entered in the log.

(i) All medications furnished to patients through the emergency service shall be provided by a pharmacist or an individual lawfully authorized to prescribe. Such medications shall be properly labeled and all required records shall be maintained in accordance with state and federal laws.

(j) Each comprehensive emergency medical service shall be identified to the public by an exterior sign, clearly visible from public thoroughfares. The wording of such signs shall state: COMPREHENSIVE EMERGENCY MEDICAL SERVICE PHYSICIAN ON DUTY.

(k) Standardized emergency nursing procedures shall be developed by an appropriate committee of the medical staff.

(l) A list of referral services shall be available in the emergency center. This list shall include the name, address and telephone number of the following:
(1) Police department.
(2) Antivenin service.
(3) Drug abuse center.
(4) Poison control information center.
(5) Suicide prevention center.
(6) Director of State Department of Health or his designee.
(7) Local health department.
(8) Clergy.
(9) County coroner or medical examiner.

(m) The hospital shall have the following additional services which shall be continuously staffed in a manner that permits the performance of all required functions:
(1) Chronic dialysis service.
(2) Burn center.
(3) Respiratory care service.
(4) Intensive care newborn nursery.
(5) Coronary care service.
(6) Intensive care service.
(7) Pediatric service.
(8) Psychiatric unit.
(9) Cardiovascular surgery service.
(10) Postanesthesia recovery unit.

(n) The radiological service shall be capable of performing contrast studies including angiography in addition to its usual capabilities.

(o) The clinical laboratory shall be capable of performing blood gas analysis, pH, serum electrolytes and other procedures appropriate for emergency medical care.

(p) Surgical services shall be immediately available for life-threatening situations.

(q) The hospital shall have readily available the service of a blood bank containing common types of blood and blood derivatives. Blood storage facilities shall be in or adjacent to the emergency service.
(r) There shall be affiliation of the emergency medical service with a medical school.
(s) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.

§ 70455. Comprehensive Emergency Medical Service Staff

(a) A full-time physician trained and experienced in emergency medical service shall have overall responsibility for the service. The physician or her or his designee shall be responsible for:
  (1) Implementation of established policies and procedures.
  (2) Providing continuous staffing with physicians trained and experienced in emergency medical service. Such physicians shall be assigned to and be located in the emergency service area 24 hours a day.
  (3) Providing experienced physicians in specialty categories to be available in-house 24 hours a day. Such specialities include but are not limited to medicine, surgery, anesthesiology, orthopedics, neurosurgery, pediatrics and obstetrics-gynecology.
  (4) Maintenance of a roster of specialty physicians immediately available for consultation and/or assistance.
  (5) Assurance of continuing education for all emergency service staff including physicians, nurses and other personnel.
(b) All physicians, dentists and podiatrists providing services in the emergency room shall be members of the organized medical staff.
(c) A registered nurse qualified by education and/or training shall be responsible for nursing care within the service.
(d) All registered nurses shall have training and experience in emergency lifesaving and life support procedures.
(e) A registered nurse trained and experienced in emergency nursing care shall be on duty at all times.
(f) There shall be sufficient licensed nurses and other skilled personnel on duty as required to support the services.

§ 70457. Comprehensive Emergency Medical Service Equipment and Supplies.

All equipment and supplies necessary for life support shall be available, including but not limited to: airway control and ventilation equipment, suction devices, cardiac

monitor, defibrillators, pacemaker capability, apparatus to establish central nervous system monitoring and administration devices.

§ 70459. Comprehensive Emergency Medical Service Space.

(a) The following space provisions and designations shall be provided:
(1) Treatment rooms.
(2) Cast rooms.
(3) Operating room fully equipped.
(4) Intensive care in or adjoining the emergency medical service area.
(5) Nursing station.
(6) Medication room.
(7) Clean and dirty utility room.
(8) X-ray spaces.
(9) Laboratory facilities.
(10) Staff support rooms including toilets, showers, lounge and sleeping area.
(11) Public toilets.
(12) Observation room.
(13) Police and press room.
(14) Waiting room.
(15) Reception area.

(b) Observation beds in the emergency medical service shall not be counted in the total licensed bed capacity of the hospital.

§ 70649. Standby Emergency Medical Service, Physician on Call, Definition.
Standby emergency medical service, physician on call, means the provision of emergency medical care in a specifically designated area of the hospital which is equipped and maintained at all times to receive patients with urgent medical problems and capable of providing physician service within a reasonable time.

§ 70651. Standby Emergency Medical Service, Physician on Call, General Requirements.

(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the administration and medical staff where such is appropriate.
(b) The responsibility and the accountability of the emergency medical service to the medical staff and administration shall be defined.
(c) There shall be a roster of names of physicians and their telephone numbers who are available to provide emergency service.
(d) A communication system employing telephones, radiotelephone or similar means shall be in use to establish and maintain contact with the police department, rescue squads and other emergency services of the community.
(e) The emergency medical service shall have a defined emergency and mass casualty plan in concert with the hospital's capabilities and the capabilities of the community served.
(f) The hospital shall require continuing education of all emergency medical service personnel.
(g) Medical records shall be maintained on all patients presenting themselves for emergency medical care. These shal become part of the patient's hospital medical record. Past hospital records shall be available to the emergency medical service.
(h) An emergency room log shall be maintained and shall contain at least the following information relating to the patient: name, date, time and means of arrival, age, sex, record number, nature of complaint, disposition and time of departure. The name of those dead on arrival shall also be entered in the log.
(i) Each standby emergency medical service shall be identified to the public by an exterior sign, clearly visible from public thoroughfares. The wording of such signs shall state STANDBY EMERGENCY MEDICAL SERVICE, PHYSICIAN ON CALL.
(j) Standardized emergency nursing procedures shall be developed by an appropriate committee of the medical staff.

(k) A list of referral services shall be available in the emergency service. This list shall include the name, address and telephone number of the following:
(1) Police department.
(2) Blood bank.
(3) Antivenin service.
(4) Burn center.
(5) Drug abuse center.
(6) Poison control information center.
(7) Suicide prevention center.
(8) Director of the State Department of Health or his designee.
(9) Local health department.
(10) Clergy.
(11) Emergency psychiatric service.
(12) Chronic hemodialysis service.
(13) Renal transplant center.
(14) Intensive care newborn nursery.
(15) Emergency maternity service.
(16) Radiation accident management service.
(17) Ambulance transport and rescue services.
(18) County coroner or medical examiner.

(l) Periodically, and appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.

§ 70653. Standby Emergency Medical Service, Physician on Call, Staff.

(a) A physician shall have overall responsibility for the service. He or his designee shall be responsible for:
(1) Implementation of established policies and procedures.
(2) Development of a system for assuring physician coverage on call 24 hours a day to the emergency medical service.
(3) Assurance that physician coverage is available within a reasonable length of time, relative to the patient's illness or injury.
(4) Development of a roster of specialty physicians available for consultation at all times.
(5) Assurance of continuing education for the medical and nursing staff.

(b) All physicians, dentists and podiatrists providing services in the emergency room shall be members of the organized medical staff.

(c) A registered nurse shall be immediately available within the hospital at all times to provide emergency nursing care.

(d) There shall be sufficient other personnel to support the services offered.

§ 70655. Standby Emergency Medical Service, Physician on Call, Equipment and Supplies.

All equipment and supplies necessary for life support shall be available. Equipment shall include, but need not be limited to, airway control and ventilation equipment, suction devices, cardiac monitor defibrillator, intravenous fluids and administering devices and including blood expanders.

§ 70657. Standby Emergency Medical Service, Physician on Call, Space.

(a) The following space provisions and designations shall be met:
    (1) Designated emergency room area.
    (2) Reception area.
    (3) Observation room.
(b) Observation beds in the emergency medical service shall not be counted in the total licensed bed capacity of the hospital.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 6, 2019

TO: CHA EMS/Trauma Committee Members

FROM: BJ Bartleson, RN, MS, NEA-BC
Alex Hawthorne, Legislative Advocate

SUBJECT: AB 70 Spot Bill, Suicide Prevention

SUMMARY

A new bill has been proposed that would require hospitals to give any patient who has been determined to be injured from self-harm, a "suicide prevention safety plan" – see attached amendments and safety plan example. We are trying to prevent burdensome regulations by showing this is unnecessary as it is already our standard of care and treatment for patients.

DISCUSSION QUESTIONS

1) Do you feel this is necessary?
2) What do you do presently when a patient is in the ED with injury from self-harm?
3) What other care and treatment standards can we offer the sponsor related to preventing this burdensome request?
4) Are their standards of care for suicidal, self-harm patients, that we could use to describe this work is already being done?

Attachments: Amendments
Safety Plan Example

BJB:br

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1259.3 is added to the Health and Safety Code, to read:

1259.3. (a) Every general acute care hospital shall provide a suicide prevention safety plan to any patient that is an at-risk patient.

(b) For the purposes of this section, the following terms have the following meanings:

(1) "At-risk patient" means any patient that the general acute care hospital has determined to be injured due to self harm.

(2) "Suicide prevention safety plan" means a prioritized written list of coping strategies and sources of support that patients can use during or preceding suicidal crises. The intent of a suicide prevention safety plan is to provide a predetermined list of potential coping strategies as well as a list of individuals or agencies that patients can contact in order to help them lower their imminent risk of suicidal behavior.

(c) Notwithstanding any other law, including Section 1290, failure to comply with this section shall not constitute a criminal offense.

(d) This section shall become operative on January 1, 2021.

- 0 -

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 6, 2019

TO: CHA EMS/Trauma Committee Members

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

SUBJECT: 2019 Legislation to Date

SUMMARY

As the 2019-2020 legislative session begins, CHA is reviewing and categorizing bills, many of which are "spot" or placeholder bills with yet undetermined language. Attached is the EMSA Legislative List. Bills of high interest to CHA are:

AB 1544 (Gipson) - Community Paramedicine
AB 329 (Rodriguez) - Hospital Assault and Battery
AB 890 (Wood) – Nurse Practitioner Full Practice Authority
SB 227 (Leyva) – Nurse staffing ratio penalties

DISCUSSION QUESTIONS

1. Are there issues from the field on other legislation not listed?
2. Do any of you know of physicians who would be willing to testify for NP full practice authority or Community Paramedicine?

Attachments: EMSA Legislative Report

BJB:br

EMSA Legislative Report

Monday, February 25, 2019

Analyze

AB 26 (Rodriguez D) Emergency ambulance employees.
Introduced: 12/3/2018
Status: 1/17/2019-Referred to Com. on L. & E.
Location: 1/17/2019-A. L. & E.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would require an emergency ambulance provider to provide each emergency ambulance employee, who drives or rides in the ambulance, with body armor and safety equipment to wear during the employee's work shift. The bill would also require the emergency ambulance employer to provide training to the emergency ambulance employee on the proper fitting and use of the body armor and safety equipment. The bill would not apply to the state or a political subdivision thereof.

AB 27 (Rodriguez D) Emergency Ambulance Employee Safety and Preparedness Act.
Introduced: 12/3/2018
Status: 1/17/2019-Referred to Com. on L. & E.
Location: 1/17/2019-A. L. & E.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would require every current emergency ambulance employee, on or before July 1, 2020, and every new employee hired on or after January 1, 2020, within 6 months of being hired, to attend a 6-hour training on violence prevention that includes, among other things, understanding types of anger, proven and effective verbal deescalation skills, and hands-on demonstrations, workshops, and role-playing scenarios. The bill would require an emergency ambulance employee, following the completion of the 6-hour violence prevention training, to receive a one-hour refresher course each calendar year thereafter.

AB 453 (Chau D) Emergency medical services: EMT-P training.
Introduced: 2/11/2019
Status: 2/21/2019-Referred to Com. on HEALTH.
Location: 2/21/2019-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Under current law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, the Emergency Medical Services Authority is responsible for establishing minimum standards and promulgating regulations for the training and scope of practice for emergency medical technician-paramedics (EMT-P).This bill would require EMT-P standards established pursuant to the above provision to include a training component that would require a minimum of 2 hours of dementia-specific training for EMT-P licensure and recertification.

AB 921 (Arambula D) Emergency medical services: training standards.
Introduced: 2/20/2019
Status: 2/21/2019-From printer. May be heard in committee March 23.
Location: 2/20/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current law establishes the Emergency Medical Services Authority to oversee emergency medical services in the state and requires the authority to develop minimum training and scope of practice standards for EMT-I, EMT-II, and EMT-P personnel. Current law states that these requirements do not preclude the adoption of additional training standards for EMT-II and EMT-P personnel by local emergency medical services agencies.This bill would make technical, nonsubstantive changes to these provisions.

AB 1211 (Reyes D) Firefighters.
Introduced: 2/21/2019
Status: 2/22/2019-From printer. May be heard in committee March 24.
Location: 2/21/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would declare the intent of the Legislature to enact legislation that would provide a career pathway to individuals with previous criminal convictions who have demonstrated rehabilitation and desire to work as firefighters. The bill would provide Legislative findings in support of the measure.

AB 1231 (Boerner Horvath D) Emergency services.
Introduced: 2/21/2019
Status: 2/22/2019-From printer. May be heard in committee March 24.
Location: 2/21/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would require response time requirements in any contract for ground emergency medical transportation entered into, amended, or renewed, by a state or local entity on and after January 1, 2020, to be consistent with performance standards established by the International Academies of Emergency Dispatch. By increasing the duties of local entities, this bill would create a state-mandated local program.

AB 1280 (Grayson D) Peer Support and Crisis Referral Services Pilot Program.
Introduced: 2/21/2019
Status: 2/22/2019-From printer. May be heard in committee March 24.
Location: 2/21/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: This bill would, until January 1, 2025, create the Firefighter Peer Support and Crisis Referral Services Pilot Program. The bill would, for purposes of the act, define a “peer support team” as a team composed of emergency service personnel, as defined, hospital staff, clergy, and educators who have been appointed to the team by a Peer Support Labor-Management Committee, as defined, and who have completed a peer support training course developed and delivered by the California Firefighter Joint Apprenticeship Committee, as specified. The bill would provide that a communication made by emergency service personnel or a peer support team member while the peer support team member provides peer support services, as defined, is confidential and shall not be disclosed in a civil, administrative, or arbitration proceeding. The bill would authorize the disclosure of that communication under limited circumstances, including, among others,

when disclosure is reasonably believed to be necessary to prevent death, substantial bodily harm, or commission of a crime, or when disclosure is reasonably believed to be required pursuant to the peer support policy, as specified. The bill would also provide that, except for an action for medical malpractice, a peer support team member providing peer support services as a member of a peer support team is not liable for damages, as specified, relating to an act, error, or omission in performing peer support services, unless the act, error, or omission constitutes gross negligence or intentional misconduct. The bill would further provide that a communication made by emergency service personnel to a crisis hotline or crisis referral service, as defined, is confidential and shall not be disclosed in a civil, administrative, or arbitration proceeding, except as specified.

AB 1437 (Chen R) Community redevelopment: paramedic tax funds.
Introduced: 2/22/2019
Status: 2/22/2019-Introduced. To print.
Location: 2/22/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: The Community Redevelopment Law authorized the establishment of redevelopment agencies in communities to address the effects of blight, as defined. Current law dissolved redevelopment agencies as of February 1, 2012, and provides for the designation of successor agencies to, among other things, wind down the affairs of the dissolved redevelopment agencies and make payments due for enforceable obligations. This bill would state the intent of the Legislature to enact legislation that would revert tax revenues collected to fund paramedics that are currently being used for redevelopment.

AB 1455 (Cooper D) Emergency medical services.
Introduced: 2/22/2019
Status: 2/22/2019-Introduced. To print.
Location: 2/22/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: The Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act establishes the Emergency Medical Services Authority. The act requires the authority, among other things, to develop planning and implementation guidelines for emergency medical services systems and to review plans for the implementation of emergency medical services and trauma care systems from local EMS agencies.This bill would make technical, nonsubstantive changes to the establishment of the Emergency Medical Services Authority.

AB 1544 (Gipson D) Community Paramedicine or Triage to Alternate Destination Act.
Introduced: 2/22/2019
Status: 2/22/2019-Introduced. To print.
Location: 2/22/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would establish within the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act until January 1, 2030, the Community Paramedicine or Triage to Alternate Destination Act of 2019. The bill would authorize a local EMS agency to develop a community paramedicine or triage to alternate destination program, as defined, to provide specified community paramedicine services.

The bill would require the authority to develop regulations to establish minimum standards for a program, and would further require the Commission on Emergency Medical Services to review and approve those regulations.

AB 1708 (Rodriguez D) Emergency response: trauma kits.
Introduced: 2/22/2019
Status: 2/22/2019-Introduced. To print.
Location: 2/22/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would define “trauma kit” to mean a first aid response kit that contains specified items, including, among other things, at least 2 tourniquets. The bill would require a person or entity that supplies a trauma kit to provide the person or entity that acquires the trauma kit with all information governing the use, installation, operation, training, and maintenance of the trauma kit.

Track

AB 139 (Quirk-Silva D) Emergency and Transitional Housing Act of 2019.
Introduced: 12/11/2018
Status: 1/24/2019-Referred to Com. on H. & C.D.
Location: 1/24/2019-A. H. & C.D.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: The The Planning and Zoning Law requires, after the legislative body of the city or county has adopted all or part of a general plan, the planning agency to investigate and make recommendations to the legislative body of the city or county regarding reasonable and practical means to implement the general plan or element and to provide by April 1 of each year an annual report to the legislative body, the Office of Planning and Research, and the Department of Housing and Community Development that includes specified information pertaining to the implementation of the general plan, including, among other things, a listing of sites rezoned to accommodate that portion of the city’s or county’s share of the regional housing need for each income level that could not be accommodated on specified sites. This bill would additionally require the report to include the number of emergency shelter beds currently available within the jurisdiction and the number of shelter beds that the jurisdiction has contracted for that are located within another jurisdiction, as specified.

AB 141 (Cooper D) Cannabis: informational, educational, or training events.
Introduced: 12/12/2018
Status: 1/24/2019-Referred to Com. on B. & P.
Location: 1/24/2019-A. B.&P.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would authorize retailers, cultivators, and manufacturers that are licensed under MAUCRSA to participate in, and not be required to obtain a temporary cannabis event license or other temporary license for, a cannabis informational, educational, or training event held for state and local government officials and their employees, including, but not limited to, legislators, city council members, law enforcement organizations, emergency medical services staff, firefighters, child protective services, and social workers; employees of health care facilities; and employees of public and private schools, if specified

conditions are met.

AB 329 (Rodriguez D) Hospitals: assaults and batteries.
Introduced: 1/31/2019
Status: 2/11/2019-Referred to Com. on PUB. S.
Location: 2/11/2019-A. PUB. S.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Calendar: 3/12/2019 9 a.m. - State Capitol, Room 126 ASSEMBLY PUBLIC SAFETY, JONES-SAWYER, Chair

Summary: Would make an assault committed against a physician, nurse, or other healthcare worker of a healthcare facility engaged in providing services within the facility punishable by imprisonment in a county jail not exceeding one year, by a fine not exceeding $2,000, or by both that fine and imprisonment. By expanding the scope of a crime, this bill would impose a state-mandated local program.

AB 362 (Eggman D) Controlled substances: overdose prevention program.
Introduced: 2/4/2019
Status: 2/15/2019-Referred to Coms. on HEALTH and PUB. S.
Location: 2/15/2019-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Calendar: 3/19/2019 1:30 p.m. - State Capitol, Room 4202 ASSEMBLY HEALTH, WOOD, Chair

Summary: Would, until January 1, 2026, authorize the City and County of San Francisco to approve entities to operate overdose prevention programs that satisfy specified requirements, including, among other things, the provision of a hygienic space supervised by healthcare professionals, as defined, where adults who use drugs can consume preobtained drugs, sterile consumption supplies, and access to referrals to substance use disorder treatment. The bill would require the City and County of San Francisco, prior to authorizing an overdose prevention program in its jurisdiction, to provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting.

AB 367 (Flora R) Presence at care facilities: conviction of crimes.
Introduced: 2/4/2019
Status: 2/15/2019-Referred to Com. on HUM. S.
Location: 2/15/2019-A. HUM. S.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Current law prohibits the State Department of Social Services from authorizing individuals who have been convicted of certain crimes from working or otherwise being present at a community care facility, a residential care facility for persons with a chronic, life-threatening illness, a residential care facility for the elderly, or a child daycare facility. This bill would enumerate additional crimes that prohibit the department from authorizing an individual from working or otherwise being present at these facilities, including, among other crimes, the willful and unlawful use of personal identifying information.

AB 389 (Arambula D) Substance use disorder treatment: peer navigators.
Introduced: 2/5/2019
Status: 2/15/2019-Referred to Com. on HEALTH.
Location: 2/15/2019-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require the State Department of Health Care Services to either establish a pilot program or expand an existing pilot program for purposes of measuring the efficacy and cost avoidance of utilizing trained substance use disorder peer navigators and behavioral health peer navigators in the emergency department of an acute care hospital, as described, if Funds for this purpose are appropriated in the annual Budget Act. The bill would provide that an acute care hospital may be eligible to receive funding under the pilot program to fund peer navigator positions.

AB 451 (Arambula D) Health care facilities: treatment of psychiatric emergency medical conditions.
Introduced: 2/11/2019
Status: 2/21/2019-Referred to Com. on HEALTH.
Location: 2/21/2019-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a psychiatric unit within a general acute care hospital, a psychiatric health facility, or an acute psychiatric hospital that has accepted a person for the purpose of determining the existence of a psychiatric medical emergency condition, to provide emergency services and care to treat that person, regardless of whether the facility operates an emergency department, if the facility has appropriate facilities and qualified personnel. These requirements would not apply to a state psychiatric hospital. By creating a new crime, this bill would impose a state-mandated local program.

AB 651 (Grayson D) Air ambulance services.
Introduced: 2/15/2019
Status: 2/19/2019-From printer. May be heard in committee March 21.
Location: 2/15/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee, insured, or subscriber, as applicable, receives covered services from a noncontracting air ambulance provider, the enrollee, insured, or subscriber shall pay no more than the same cost sharing that the enrollee, insured, or subscriber would pay for the same covered services received from a contracting air ambulance provider, referred to as the in-network cost-sharing amount.

AB 732 (Bonta D) County jails: pregnant inmates.
Introduced: 2/19/2019
Status: 2/20/2019-From printer. May be heard in committee March 22.
Location: 2/19/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Would require an inmate of a county jail who is identified as possibly pregnant during an intake health examination to be scheduled for laboratory work to verify pregnancy within 3 business days of arrival at the jail. The bill would require an inmate who is confirmed to be pregnant to be scheduled for an obstetrics examination within 7 days. The bill would require pregnant inmates to be scheduled for prenatal care visits, as specified. The bill would require pregnant inmates to be provided specified prenatal services and a referral to a medical social worker.

AB 1014 (O'Donnell D) Health facilities: notices.
Introduced: 2/21/2019
Status: 2/22/2019-From printer. May be heard in committee March 24.
Location: 2/21/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current law requires a hospital that provides emergency medical services to, as soon as possible, but not later than 90 days prior to a planned reduction or elimination of the level of emergency medical services, provide notice of the intended change to the department, other specified entities, and the public. Current law requires a health facility implementing a downgrade or change to make reasonable efforts to ensure that the community it serves is informed of the downgrade or closure. Current law also requires a health facility to provide public notice, as specified, not less than 30 days prior to closing the facility, eliminating a supplemental service, as defined, or relocating the provision of supplemental services to a different campus. This bill would require a hospital that provides emergency medical services or a health facility to provide notice, as specified, at least 180 days before making the changes described above.

AB 1134 (Limón D) Traffic violator school: fees.
Introduced: 2/21/2019
Status: 2/22/2019-From printer. May be heard in committee March 24.
Location: 2/21/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would require the clerk to permit a defendant who is ordered or permitted to attend traffic violator school, and who demonstrates to the court an inability to pay the total required fee immediately, to pay the fee in installments. The bill would make the defendant eligible to attend traffic violator school upon payment of the first installment.

AB 1168 (Mullin D) Emergency services: text to 911.
Introduced: 2/21/2019
Status: 2/22/2019-From printer. May be heard in committee March 24.
Location: 2/21/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current law, the Warren-911-Emergency Assistance Act, provides that each local public agency within its respective jurisdiction establish a basic system that automatically connects a person dialing 911 to an established public safety answering point through normal telephone service facilities, or to be part of such a system. This bill would require each public safety answering point to deploy a text to 911 service, no later than January 1, 2021, that is capable of accepting either Short Message Service messages or Real-Time Text messages.

AB 1299 (Flora R) Office of Emergency Services.
Introduced: 2/22/2019
Status: 2/22/2019-Introduced. To print.
Location: 2/22/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: The California Emergency Services Act establishes the Office of Emergency Services within the Governor's office under the supervision of the Director of Emergency Services and makes the office responsible for the state's emergency and disaster response services for natural, technological, or manmade disasters and emergencies. The act requires the Office of Emergency Services, in consultation with relevant local and state agencies, to develop and adopt a state fire service and rescue emergency mutual aid plan that meets specified criteria. This bill would make a nonsubstantive change to those criteria provisions.

AB 1336 (Smith D) Child health and safety fund.
Introduced: 2/22/2019
Status: 2/25/2019-Read first time.
Location: 2/22/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current law establishes the "Have a Heart, Be a Star, Help Our Kids" specialized license plate program. Current law establishes fees for those specialized license plates and requires those and other fees, less specified expenses, to be deposited in the Child Health and Safety Fund. A specified amount of moneys in the fund are available, upon appropriation, for programs that address specified child health and safety concerns, including, among others, vehicular safety and drowning prevention. This bill would include in that list of specified child health and safety concerns, among other concerns, pedestrian safety, sleep suffocation, and sports-related concussions.

AB 1595 (Maienschein D) Interscholastic athletic programs: automated external defibrillator.
Introduced: 2/22/2019
Status: 2/22/2019-Introduced. To print.
Location: 2/22/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: If a school district or charter school elects to offer any interscholastic athletic program, current law requires the school district or charter school to acquire at least one automated external defibrillator (AED) for each school within the school district or the charter school.This bill would instead require a school district or charter school offering an interscholastic athletic program to acquire at least one AED for each school within the school district or the charter school that participates in the interscholastic athletic program.

AB 1601 (Ramos D) Office of Emergency Services: behavioral health response.
Introduced: 2/22/2019
Status: 2/22/2019-Introduced. To print.
Location: 2/22/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered

1st House	2nd House	Conc.			

Summary: Would establish a behavioral health deputy director within the Office of Emergency Services to ensure individuals have access to necessary mental and behavioral health services and supports in the aftermath of a natural disaster or declaration of a state of emergency and would require the deputy director to collaborate with the Director of Health Care Services to coordinate the delivery of trauma-related support to individuals affected by a natural disaster or state of emergency.

AB 1611 (Chiu D) Emergency hospital services: costs.
Introduced: 2/22/2019
Status: 2/22/2019-Introduced. To print.
Location: 2/22/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would require a health care service plan contract or insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee or insured receives covered services from a noncontracting hospital, the enrollee or insured is prohibited from paying more than the same cost sharing that the enrollee or insured would pay for the same covered services received from a contracting hospital. The bill would require a health care service plan or insurer to pay a noncontracting hospital for emergency services rendered to an enrollee or insured pursuant to a specified formula, would require a noncontracting hospital to bill, collect, and make refunds in a specified manner, and would provide a dispute resolution procedure if any party is dissatisfied with payment.

AB 1699 (Levine D) Telecommunications: public safety customer accounts: states of emergency.
Introduced: 2/22/2019
Status: 2/22/2019-Introduced. To print.
Location: 2/22/2019-A. PRINT

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Would prohibit a telecommunications service provider from throttling or otherwise failing to provide adequate or necessary telecommunications service to its public safety customer accounts during a state of emergency.

SB 58 (Wiener D) Alcoholic beverages: hours of sale.
Introduced: 12/17/2018
Status: 2/20/2019-Set for hearing March 12.
Location: 1/16/2019-S. G.O.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Calendar: 3/12/2019 9:30 a.m. - John L. Burton Hearing Room
(4203) SENATE GOVERNMENTAL ORGANIZATION, DODD, Chair

Summary: Would, beginning January 1, 2022, and before January 2, 2027, require the Department of Alcoholic Beverage Control to conduct a pilot program that would authorize the department to issue an additional hours license to an on-sale licensee located in a qualified city which would authorize, with or without conditions, the selling, giving, or purchasing of alcoholic beverages at the licensed premises between the hours

of 2 a.m. and 4 a.m., upon completion of specified requirements by the qualified city in which the licensee is located. The bill would impose specified fees related to the license to be deposited in the Alcohol Beverage Control Fund.

SB 160 (Jackson D) Emergency services: cultural competence.
Introduced: 1/24/2019
Status: 2/6/2019-Referred to Com. on G.O.
Location: 2/6/2019-S. G.O.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Current law defines the terms “political subdivision” and “emergency plans” for purposes of emergency services provided by local governments. Current law requires a county, upon the next update to its emergency plan, to integrate access and functional needs into its emergency plan, as specified. This bill would require a county to integrate cultural competence, as defined, into its emergency plan, upon the next update to its emergency plan, as specified. By increasing the duties of local officials, this bill would impose a state-mandated local program.

SB 261 (Wilk R) Office of Emergency Services.
Introduced: 2/12/2019
Status: 2/21/2019-Referred to Com. on RLS.
Location: 2/12/2019-S. RLS.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: The California Emergency Services Act, among other things, establishes the Office of Emergency Services for the purpose of mitigating the effects of natural, manmade, or war-caused emergencies and makes findings and declarations relating to ensuring that preparation within the state will be adequate to deal with those emergencies.This bill would make nonsubstantive changes to these provisions.

Total Measures: 32

CHA EMS/TRAUMA COMMITTEE
MEETING MINUTES
December 11, 2018 / 5:00 p.m. – 7:00 p.m.

Mission Inn, 3649 Mission Inn Avenue
Riverside, CA

Members Present: **Christopher Childress, Rose Colangelo, Connie Cunningham, James Pierson, Jackie Saucier, Karen Sharp, Ron Smith, Susan Smith, Carla Spencer, Jason Zepeda**

Members Attending by Call: **Neal Cline, Jason Zepeda**

Staff: BJ Bartleson, Sheree Lowe, Keven Porter, Barb Roth, Judith Yates

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order at 5:00 pm.

2019 Goals and Objectives Update (Bartleson)

CHA and the Regional Hospital Associations have established new priorities for 2019. Emergency services was lower on the Regional Priority Ranking, so we will revise the existing Committee Goals and Objectives.

- *ACTION: Emergency services data and story collection will be included as an updated goal for 2019.*

Ambulance patient offload delay (APOD) may also be an issue next year.

- *ACTION: Ms. Bartleson, Ms. Colangelo, Ms. Allen and Mr. Barton will work on APOD book two as a means to continue the conversation and awareness of APOT/Delays and how to make improvements.*

Trauma issues and ED Health Information Exchange will remain as goals through 2019.

With attendance at the ED Forum not increasing significantly in the past couple of years, it was suggested that the date and time of the forum be changed to separate it from the Behavioral Health Symposium.

- *ACTION: Evaluate changes to date/location for ED Forum in 2019.*

The lack of pediatric psych beds and adequate ED behavioral health workforce are important information to collect as emphasized by the demand currently experienced on a daily basis by members. Ms. Lowe indicated that this information is critical to obtain to educate the legislature.

Committee recognized Jimmy Pierson who was named EMT of the Year at the EMSA meeting.

2019 Committee Schedule Change:
In recognition of the time and budget constraints, CHA leadership decided to change committee meetings to two meetings per year instead of four. One meeting will be in-person and one virtual, with the potential for additional virtual meetings as needed. Presented with the proposed schedule of four meetings in 2019, the EMS/Trauma Committee decided to have the in-person meeting on June 12, to allow for better input regarding legislation, and leave the other dates on the calendar as potential calls. HASC and/or hospitals may be able to host other nearby committee members for the virtual calls to allow better group participation.

- *ACTION: Committee meetings for 2019, in-person on June 12. Increase length of meeting (i.e.: 10 am – 4 pm).*
- *ACTION: Leave other dates/time on calendar for meetings as needed.*

II. REVIEW OF PREVIOUS MEETING MINUTES

The minutes of the August 29, 2018, EMS/Trauma Committee meeting were reviewed for approval.

IT WAS MOVED, SECONDED AND CARRIED:

- *Minutes approved as submitted.*

III. NEW BUSINESS

A. Medical Transportation Liabilities (Hawkins)
Fred Hawkins was unable to attend due to unforeseen circumstances.

- *ACTION: Add to next meeting agenda.*

B. Emergency Department Benchmarking Alliance (Bartleson)
Dr. Lev conducts this survey annually in San Diego and has been doing so for 10-12 years . The ED Benchmarking Alliance Standard Survey questions plus additional San Diego specific questions are used to describe emergency services among 19 hospitals.

- *ACTION: As Scripps is one of the hospitals participating in the survey, Ms. Colangelo offered to see if she can obtain a complete list of the participating hospitals from Dr. Augustine.*
- *ACTION: Ms. Bartleson to send the report to the committee.*

IV. OLD BUSINESS

A. Emergency Department Registration Process (Bartleson/Colangelo/Sandhu)
Ms. Colangelo has information on Scripps' registration process to provide to the committee. Other committee members reported they are also reviewing their registration process. Ms. Spencer is investigating the kiosk system at Salinas Valley and will report back to the committee on what she finds out about this process. Teletriage was discussed and interest was expressed to have someone present information about this at a future meeting. Perhaps a contact at EPIC might know someone.

- *ACTION: Ms. Colangelo to provide information from Scripps' process to the committee.*
- *ACTION: Mr. Zepeda has a couple of articles to send to Ms. Bartleson for review.*

B. Designation Fees (Bartleson)
Local Emergency Medical Agencies, which are set up differently from each other throughout the state, have designation fees for Stroke, STEMI, etc. Some are making significant increases to these fees. A few committee members reported experiencing this in their area. CHA wants to understand where these fees are increasing and the reasons for the increases.

- *ACTION: Committee members to advise Ms. Bartleson if they are experiencing an increase in designation fees.*
- *ACTION: Ms. Smith will provide additional information.*

C. Roundtable Topics for Discussion

Community Paramedicine (Pierson)
Existing programs were extended one year. Nine additional programs were approved, but only 3-4 are active. A few programs were discontinued.

EDIE (Bartleson)
There are now 128 hospitals on EDIE. Some hospitals with whole person care projects are using it.

CURES and Opioid Issues (Bartleson)
Ms. Lowe – The ED Bridge Project was recently initiated, offering up financial and technical assistance for opioid and substance abuse disorder treatment in the ED.

- *ACTION: Add Dr. Hannah Schneider to agenda to talk about this program.*

SB 1152 Homeless Discharge (Bartleson)
Hospitals will need a policy and documentation beginning January 1, 2019. In July 2019, hospitals will need a log, assessment and policy on community partners.

- *ACTION: Information only.*

V. NEXT MEETING

Wednesday, March 6, 2019. 10 am – 12 pm. Virtual Meeting.

VI. ADJOURNMENT

Having no further business, the meeting adjourned at 6:56 p.m.

EMS/TRAUMA COMMITTEE
2019 ROSTER

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EMS/T Committee Hospital Representation

BY COUNTY and HOSPITAL TYPE

As of March, 2019

HOSPITAL/HEALTH SYSTEM TYPES	
Free-Standing Facility	4
Hospital System	12
Small/Rural Facility	1
University/Teaching Facility	4
TOTAL COMMITTEE REPRESENTATION	16

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

CHA Member/ED Breakdown
March, 2019

ED TYPE BY MEMBER:

Pam Allen, RN, MSN, CEN	Redlands Community Hospital	Emergency Services
Aaron Wolff	Dignity Health	Emergency Services
Carla Spencer, MSN, RN, CFRN	Salinas Valley Memorial Healthcare System	Emergency Services
Cheryl Heaney, DNP, RN	St. Joseph's Medical Center	Emergency Services
Christopher Childress, BSN, RN, CEN	Hoag Memorial Hospital Presbyterian	Emergency Services
Claude Stang, RN, BSN, MA, CEN	Cedars-Sinai Medical Center	Emergency/Trauma
Connie Cunningham, RN, MSN	Loma Linda University Health	Emergency/Trauma
Daman Mott	John Muir Medical Center	Emergency Services
Fred Hawkins	Ridgecrest Regional Hospital	Emergency/Trauma
Jackie Saucier, PhD, MBA, MSN	Palomar Medical Center Poway	Emergency Services
Jason Zepeda	Hoag Memorial Hospital Presbyterian	Emergency Services
Karen Sharp, RN, MSN	Saddleback Medical Center	Emergency Services
Marlena Montgomery, MBA, MSN, RN, CEN	Sharp Memorial Hospital	Emergency/Trauma
Neal Cline, RN, JD, CFRN	Enloe Medical Center - Esplanade Campus	Emergency/Trauma
Rose Colangelo, RN, MSN, CEN	Scripps Memorial Hospital La Jolla	Emergency/Trauma
Rupy Sandhu	UC Davis Medical Center	Emergency/Trauma

EX-OFFICIO COMMITTEE MEMBER:

Bruce Barton	Riverside County EMS Agency
Chi Perlroth, MD, FACEP	CAL ACEP
Daniel Smiley	California EMS Authority
Eric Morikawa	California Department of Public Health
Heather Venezio, RN, MS, CEN TCRN	TMAC
James Pierson	Medic Ambulance
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

CHA/REGIONAL STAFF

BJ Bartleson, MS, RN, NEA-BC	California Hospital Association
David Serrano Sewell	Hospital Council of Northern and Central California
Judith R. Yates, BSN, MPH	Hospital Association of San Diego and Imperial Counties
Keven Porter, RN, BSN, MS	Hospital Association of Southern California
Barbara Roth	California Hospital Association

STATE REPRESENTATION

Northern California	**6**
Southern California	**10**

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.