Emergency Medical Services/Trauma Committee Meeting

Wednesday, August 29, 2018

California Hospital Association - Boardroom

1215 K Street, Ste 800

Sacramento, CA, 95814

Conference Call Option:

(800) 882-3610 Access Code: 1953936#

Meeting Book - Emergency Medical Services/Trauma Committee Meeting

AGENDA - August 29, 2018

EMS/TRAUMA COMMITTEE
2018 ROSTER

Officers

Chair
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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

FROM: BJ Bartleson, RN, MSN, NEA-BC, VP Nursing & Clinical Services

SUBJECT: New Committee Members

SUMMARY

Christopher Childress, BSN, RN, CEN is the Director, Emergency Department at Hoag Memorial Hospital Presbyterian in Newport Beach. He replaced Carla Schneider when she retired earlier this year and has joined the EMS/T Committee.

Aaron Wolff, is presently the Coordinator, Trauma/Prehospital Care at Dignity Health in San Francisco and is a new member of the CHA EMS/Trauma Committee.

Daman Mott, MSN, RN, Associate Chief Nursing Officer at John Muir Medical Center in Concord has also joined the CHA EMS/Trauma Committee as a new member.

ACTION REQUESTED

- Information Only

Attachments: Daman Mott Resume

BJB:br

DAMAN M. MOTT, MSN, RN
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Mobile 707-592-8808
E-mail: daman.mott@johnmuirhealth.com

John Muir Health Concord Medical Center ***DEC 2017 to Present***
Associate Chief Nursing Officer

John Muir Medical Center Walnut Creek ***OCT 2016 to Present***
Director Medical Surgical Services

24/7 administrative and clinical oversight for 440 full time equivalents and 580 Personnel, and nine cost centers. Largest operational span of control for a director in the John Muir System

- Manned Walnut Creek Command Center during recent catastrophic fires
- 5 of 7 units at 100% percent on culture of safety survey
- Spearheaded RN-CNA Collaborative group
- Championed revamp of C.diff testing parameters resulting in reduction of HAI
- Successful JC stroke survey for 5B stroke unit
- Successful CARF survey for 4B Acute Rehab Unit
- Successful HIMSS Survey
- Navigated massive reorganization and transformation with minimal impact to staff through rigorous fiscal oversight
- Implemented daily leader rounding on units and created “Leader Sign” Led debriefs on unit during incredibly difficult loss of a staff member
- Guest Speaker at Volunteer Grad Night…praised by foundation and volunteer leadership and guests
- Implemented quality wall, public display of our results and improvements
- On track to meet or exceed nearly every quality metric tracked over 2016
- Inaugural guest speaker at unit council “meet a leader day”
- Initiated leadership involvement at the unit level for patient complaint resolution
- Collaborates with case management on complex case management of long term patients
- Led successful hand hygiene campaign for all 7 units

- 100% compliance with 2016 performance evaluations
    - Clinical liaison for 5A pharmacy construction and 4W rehab project

CHA Member/ED Breakdown
August, 2018

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 L. Murrell, MD	Kaiser Permanente South Sacramento Medical Center	Emergency/Trauma
Karen Sharp, RN, MSN	Saddleback Memorial Medical Center - San Clemente	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
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	**7**
Southern California	**10**

EMS/T Committee Hospital Representation

BY COUNTY and HOSPITAL TYPE

As of August 20, 2018

HOSPITAL/HEALTH SYSTEM TYPES	
Free-Standing Facility	4
Hospital System	13
Small/Rural Facility	1
University/Teaching Facility	5
TOTAL COMMITTEE REPRESENTATION	17

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

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

CHA Emergency Services/Trauma Committee Goals and Objectives, 2017-2019

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 2017- 2019

1. Develop guidance, 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 with toolkits or web connections.
   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.

2. Successfully launch the Emergency Care Systems Initiative to resolve California's overburdened emergency care system with a roadmap for change.
   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 Forum 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 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.

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.

CHA EMS/TRAUMA COMMITTEE
MEETING MINUTES
June 27, 2018 / 10:00 a.m. – 2:00 p.m.

1215 K Street, Suite 800
Sacramento, CA

Members Present: Bruce Barton, Rose Colangelo, Fred Hawkins, Cheryl Heaney-Ordez, Marlena Montgomery, Chi Perlroth, James Pierson, Ron Smith, Heather Venezio, Jason Zepeda

Members Attending by Call: Jackie Saucier, Karen Sharp, Carla Spencer, Claude Stang

Guests: Chris Childress, Scott Masten, Steve Pons, Gabe Waters, Aaron Wolff

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

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order at 10:01 am. Ms. Allen recognized the contributions of former Chair Carla Schneider who retired at the end of May. She also introduced Karen Sharp, Saddleback Medical Center and Carla Spencer, Salinas Valley Memorial Healthcare as the newest members of the EMS/Trauma Committee. Christopher Childress, Hoag Memorial Hospital Presbyterian attended the meeting as a guest.

II. REVIEW OF PREVIOUS MEETING MINUTES

The minutes of the March 7, 2017, EMS/Trauma Committee meeting were reviewed.

IT WAS MOVED, SECONDED AND CARRIED:

- *Minutes approved as submitted.*

III. NEW BUSINESS

A. Behavioral Health Action (Lowe)

Formerly known as Leading the Way, the Behavioral Health Action coalition is planning to start a dialogue with government officials from the Governor's office all the way down to local offices. The coalition will not take positions on bills or discuss legislation. One goal for this year is to bring gubernatorial candidates together for a debate regarding behavioral health. The subject of how hospitals are accomplishing 1:1 health holds was discussed.

Upcoming seminars - Managing Patients with Behavioral health Needs in Acute and ED Settings:
July 11 - Pasadena
July 26 –Sacramento

- *ACTION: Ms. Bartleson and Ms. Lowe to discuss risk analysis for behavioral health holds.*
- *ACTION: Provide registration information regarding seminars to committee.*

B. HQI – Emergency Department Discharge Data (Masten/Pon)
HQI receives the same information hospitals provide to OSHPD, but is able to review and integrate the data much more quickly than OSHPD. Mr. Masten is seeking feedback from CHA members regarding what type of information and breakdown of the information the hospitals will want to see.

➢ *ACTION: Information only.*

C. Emergency Rooms Not Prepared for Disaster (Hummel)
At the local level there is a lot of good work going on around the state. Ms. Hummel advised that the Emergency Management Advisory committee has found it challenging to get ED physicians involved.

Ms. Perlroth agreed that it is difficult to find physicians who have an interest in emergency planning (EMSA or LEMSA work). The disaster preparedness meetings have few physicians and rarely have discussions that include the physician's needs. Perhaps a subcommittee or workgroup for clinician planning could be created to provide information to the emergency preparedness group. This needs to come from hospital leadership as part of contracted training.

➢ *ACTION: Ms. Hummel will send Ms. Bartleson a presentation with information developed for training.*

IV. OLD BUSINESS

A. ED SAFE-T (Wolff)
The ED SAFE-T program helps identify saturation points to address crisis and overload in the emergency department. The program can improve flow and document the obstructions.

Ms. Bartleson emphasized that if CHA could get standardized data, like the information provided with this tool, it would be incredibly helpful when there is a need to testify regarding legislation.

➢ *ACTION: Information only.*

B. EMSA – EMS-C, Stroke and STEMI (Bartleson)

➢ *ACTION: Information only.*

C. APOT (Barton)
There is continued discussion amongst the LEMSAs regarding their support of the O'Donnell bill. The source of the problem is due to the fact that data is collected in different ways.

➢ *ACTION: Information only.*

D. Community Paramedicine (Bartleson/Cline/Pierson)
Ms. Bartleson expressed appreciation for everyone's assistance with promotion of AB 1795. The bill got to appropriations but did not pass.

➢ *ACTION: Information only.*

E. Collective Medical Technologies (Waters)
The EDIE system, currently in operation in multiple states, provides valuable, timely information about patients. Working in conjunction with the networks, this program analyzes information to quickly identify risks.

➢ *ACTION: Information only.*

F. Emergency Services Forum
Dr. Kivela will be the keynote speaker. Ms. Bartleson is seeking more speakers and best practices. CHA is also looking for collaboratives with pre-hospital people. Information regarding the forum is provided in meeting handouts and in the meeting book.

V. LEGISLATION

A. 2018 Bills (Bartleson)

➢ *ACTION: Information only.*

VI. REPORTS

A. EMSA (Smiley)

B. ENA (Susan Smith)

C. TMAC (Venezio)
The TMAC Conference will be July 12 at the Santa Clara Valley Medical Center. Dr. Michael McGonigal will be speaking.

TMAC will be partnering with ENA. LEMSA involvement is still a struggle for TMAC.

D. CDPH (Ron Smith)

E. Ground Ambulance

F. Air Ambulance

G. Cal ACEP (Perlroth)

H. EMS-C (Venezio)

VII. NEXT MEETING

August 29, 2018

Ms. Bartleson advised that the December committee meeting is currently scheduled for week after the Emergency Services Forum in Riverside. She offered the option of moving the meeting to the Tuesday evening before the forum. The committee agreed that the change in date and location for the December meeting is a good idea. The committee will be advised once logistics for the December meeting have been finalized.

➢ *ACTION: Update date/time/location for December 2018 committee meeting.*

VIII. ADJOURNMENT

Having no further business, the meeting adjourned at 2:03 p.m.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

FROM: David Perrott, MD, DDS, Senior Vice President & Chief Medical Officer

SUBJECT: Clarification of Ligature Risk Policy

SUMMARY

At our June 27, 2018, CHA EMS/T meeting a discussion occurred regarding the confusion surrounding the staffing requirements for psychiatric patients requiring medical care in a non-psychiatric setting (Medical inpatient units, ED, ICU, etc.) In general, all the new requirements are still under review as stated below.

The Centers for Medicare & Medicaid Services (CMS) announced in the attached memo that its interpretive guidance for helping to reduce suicide and self-harm in health care facilities will include The Joint Commission's ligature risk recommendations. CMS states in the memo that, until it releases its guidance, state survey agencies and accrediting organizations "may use their judgment as to the identification of ligature and other safety risk deficiencies, the level of citation for those deficiencies, as well as the approval of the facility's corrective action and mitigation plans to minimize risk to patient safety and remedy the identified deficiencies."

The American Society for Health Care Engineering, a professional membership group of the American Hospital Association, has created several tools and resources to help hospitals address ligature risk and patient safety.

CHA will be hosting a webinar, "Ligature Risks — Regulatory Update and Compliance Expectations for all Hospitals Webinar". Learn about CMS, TJC recommendations and ways to comply, on October 2, 2018 from 10:00-11:30 am. You can register CHA Ligature Risks Webinar.

ACTION REQUESTED

- Information Only.

DISCUSSION QUESTIONS

1) What types of mitigation planning and difficulties are you facing?
2) Have any citations been given for breaches?

Attachments: CMS QSO 18-21
TJC – Ligature Risks – Assessing and Mitigating Risk for Suicide and Self-Harm
ASHE – Patient Safety Tools and Resources
CHA – Ligature Risks Webinar Information
SAFER Room Checklist

BJB:br

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

QSO: 18-21-All Hospitals

DATE: **July 20, 2018**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group (*former Survey and Certification Group*)

SUBJECT: CMS Clarification of Psychiatric Environmental Risks

Memorandum Summary

- **Proposed Psychiatric Task Force: The Proposed Psychiatric Task Force** to address the environmental risks associated with the care of psychiatric inpatients is not the most appropriate vehicle to foster the changes that are required.
- **Ligature Risks Compromise Psychiatric Patients' Right to Receive Care in a Safe Setting:** The care and safety of psychiatric patients and the staff that provide that care are our primary concerns. CMS is incorporating the outcomes of the TJC Suicide Panel (in which CMS participated) into comprehensive ligature risk interpretive guidance to provide improved direction and clarity for state survey agencies (SAs) and accrediting organizations (AOs).
- **Interim Guidance:** Until CMS' comprehensive ligature risk interpretive guidance is released, the SAs and AOs may use their judgment as to the identification of ligature and other safety risk deficiencies, the level of citation for those deficiencies, as well as the approval of the facility's corrective action and mitigation plans to minimize risk to patient safety and remedy the identified deficiencies.

Background

The proposed CMS Psychiatric Care Task Force to address environmental risks related to the inpatient care of patients experiencing a psychiatric illness, will not be convened as planned. We will continue to seek your input, but have determined that a workgroup would not be the most appropriate vehicle to foster the required changes. The successful efforts by the TJC Suicide Panel to clarify and refine the issues involving ligature and safety risks are being incorporated into the revisions of the Interpretive Guidance. CMS felt that to repeat the work of TJC Suicide Panel (in which CMS participated) would not provide any substantive additional gains and would not be a productive use of the time and expertise of the participants.
The goal of revising the Interpretive Guidance is to incorporate and clarify standards, ligature risks, and safety issues that will assist providers/AOs in complying with the Conditions of Participation for Medicare (CoPs). Expectations regarding ligature risks and safety issues for patients receiving care and treatment for psychiatric disorders are included in the Hospital CoPs for Patient's Rights to Care in a Safe Setting.

We will continue with revisions to both the Interpretive Guidance for Psychiatric hospitals (Appendix AA) as well as the Interpretive Guidance for Hospitals (Appendix A), which will incorporate the standards that were recommended via the collaborative work of the TJC Suicide Panel Special Report: Suicide Prevention in Health Care Settings.

The December 8, 2017 QSO Memo: 18-06-Hospitals: *Clarification of Ligature Risk Policy* (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-06.pdf), and the proposed training materials will augment the Guidance so that there is clear direction for the care and treatment of this vulnerable patient population.

Contact: If you have any questions regarding this memorandum, please send inquiries to the hospital e-mailbox at hospitalscg@cms.hhs.gov .

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

cc: Survey and Certification Regional Office Management

Ligature Risks - Assessing and Mitigating Risk For Suicide and Self-Harm

What are the Joint Commission expectations for identifying and managing ligature risks in the hospital setting?

For inpatient psychiatric hospitals, inpatient psychiatric units in general acute care hospitals, and non-behavioral health units DESIGNATED for the treatment of psychiatric patients (i.e. special rooms/safe rooms in Emergency Departments or Medical Units):

The requirements found in the Environment of Care (EC) chapter of the accreditation manual at EC.02.06.01 require hospitals to establish and maintain a safe, functional environment. Element of Performance # 1 states "Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided". Therefore, ligature and self-harm risks must be identified and eliminated. While risks are in the process of being eliminated, policies and procedures must be developed and implemented to mitigate the harm posed by such risks. Mitigation plans must include, at a minimum the following: :

- Ensuring that leadership and staff are aware of the current environmental risks
- Identifying patients' risk for suicide or self-harm, then implement appropriate interventions based upon risk.
- Ongoing assessments and reassessments of at-risk behavior as defined by the organization.
- Ensuring the proper training of staff to properly identify patients' level of risk and implement appropriate interventions
- Incorporating suicide risk and self-harm reduction strategies into the overall Quality Assessment/Performance Improvement (QAPI) program - see LD.01.03.01 EP 21.
- If equipment poses a risk but is necessary for the safe treatment of psychiatric patients (i.e. medical beds with side rails on a geriatric unit), the organization must consider these risks in patients' overall suicide/self-harm risk assessments, then implement appropriate interventions to diminish those risks

In non-behavioral health units (i.e. Emergency Rooms or Medical Inpatient Units) that are NOT DESIGNATED specifically for the treatment of psychiatric patients; however, where psychiatric patients may temporarily reside, ligature/self-harm environmental risks must also be identified.

All physical risks not required for the treatment of the patient that can be removed, must be removed. Furthermore, an appropriate level of effective surveillance must be implemented if self-harm risks remain in the environment. Organizational policies and procedures must adequately guide staff in the assessment of patients' risk for suicide/self-harm and the implementation of interventions based upon the patients' individual needs.

For non-inpatient programs surveyed under the Hospital Accreditation manual, an environmental risk assessment should be completed. Based upon the results of that assessment, taking into account the individuals they serve, the organization determines if any modifications to the environment should be made. Policies and procedures should also be developed and implemented to address the immediate action to be taken by staff when a patient is assessed to be at risk for suicide.

Additional Resources for assessing suicide risk:
Sentinel Event Alert # 56
Facility Guidelines Institute: Design Guide for the Built Environment of Behavioral Health Facilities
Suicide Risk Booster - available to accredited organizations via their Secure Extranet Site

Was this response helpful?

Comments (Optional - For internal use only)

Rate This Question

Thank you for your feedback!

< Back to Manuals

Scripps

SAFER ROOM CHECKLIST FOR SUICIDAL IDEATION PATIENTS

PATIENT NAME _____

DATE OF BIRTH (DOB) _____

MEDICAL RECORD NUMBER(MRN) _____

ACCT. NO/CSN _____

To ensure safety when patients are identified as high risk with Behavioral Health Issues:

1. ***Notify Charge Nurse of Suicidal Risk patient and request a constant observer.***
2. ***Use this documentation key: N/R: not removed, medical necessity***
   N/A: not applicable for this room
   ✔: removed
3. ***Initial at the bottom of the column.***
4. ***Constant Observer is required to remain in room to provide 1:1 observation.***
5. ***Form is signed off every shift and on transfers to verify safe room check is completed.***
6. ***Form remains in patient's chart during stay, submit to the Charge Nurse after room equipment/supplies are returned to room after patient discharge.***
7. ***All objects that pose a risk for self harm that can be removed without adversely affecting the ability to deliver medical care should be removed.***
8. ***Remove all belongings prior to entering patient room***

	Date/time	Date/time	Date/time	Date/time	Date/time	Date/time	Replaced after pt. D/C Date and Time
Clothes/Belts/Shoe/Shoelaces							
Medications							
Contraband ie. lighter, matches, etc.							
Razors							
IV pumps/poles							
Monitor cords/module box (brains)							
Otoscope/Ophthalmoscope with cords							
Suction canister/tubing							
Oxygen tubing/regulator							
Air lines/tubing/regulator							
Blood pressure cuff and tubing							
Bedside supply cabinet (if mobile)							
Chairs/stools							
Over bed tables/Mayo stands							
Loose Linen/Linen Hamper							
Trash Cans							
Telephone /cords							
Plastic Bags/Ambu bag							
Thermometer							
Linen Carts							
TV/Nurse Call Cord							
Wireless on Wheels (WOW)							
Hangers							
Sharps (Pointed objects/pens/pencils)							
Personal Electronic Devices							
Other ie. Lift Device/Intermittent Pneumatic Device							
Initials							

Involuntary patients cannot sign out AMA nor leave until MD or court Judge releases them.

Sign off with each hand off to the next shift to verify safer room check was completed.

RN/CO Signature: _____ Printed Name or Corp. ID: _____ Date/Time: _____ Shift: _____
RN/CO Signature: _____ Printed Name or Corp. ID: _____ Date/Time: _____ Shift: _____
RN/CO Signature: _____ Printed Name or Corp. ID: _____ Date/Time: _____ Shift: _____
RN/CO Signature: _____ Printed Name or Corp. ID: _____ Date/Time: _____ Shift: _____
RN/CO Signature: _____ Printed Name or Corp. ID: _____ Date/Time: _____ Shift: _____
RN/CO Signature: _____ Printed Name or Corp. ID: _____ Date/Time: _____ Shift: _____
RN/CO Signature: _____ Printed Name or Corp. ID: _____ Date/Time: _____ Shift: _____

Date/time Patient discharged/transferred _____

NOT A PART OF THE MEDICAL RECORD

Patient Safety Tools and Resources: Preventing Self Harm and Ligature Risks

Hospitals and health systems are working to address the environmental risks associated with the care of patients at risk for suicide and self-harm. The Centers for Medicare & Medicaid Services (CMS) is currently creating comprehensive interpretive guidance, which will incorporate Joint Commission patient safety recommendations. To help hospitals and other health care facilities understand and implement these recommendations, ASHE is developing tools and resources for members.

Key Resources:

- ASHE Patient Safety and Ligature Identification Checklist
  – ASHE members can use this tool to create ligature-resistant environments when 1:1 continuous observation is not practical.
- ASHE Virtual Rounding Tools
  - Virtual Rounding Tool: General Acute Care Patient Room
  - Virtual Rounding Tool: General Acute Patient Care Bathroom
- ASHE Advocacy Alert
  - August 2018:
  - CMS to use Joint Commission guidance on preventing self-harm
- Joint Commission expert panel recommendations
- CMS Survey & Certification memos
  - August 2018:
  - CMS Clarification of Psychiatric Environmental Risks
  - December 2017:
  - Clarification of Ligature Risk Policy

Three-step ligature risk guidance for general acute care or emergency departments

ASHE recommends a three-step approach to managing ligature risks and preventing patient self-harm in general acute care or emergency departments. These steps do not apply for psychiatric units.

Step 1: Identify

Identify patients who are currently at risk for intential harm to themselves or others. Steps 2 and 3 only need to be taken with patients who are identified as a risk.

Step 2: Observe

Provide 1:1 monitoring of at-risk patients with continuous visual observation. The person observing the patient needs to be able to intervene immediately. Video observation is not appropriate since the video monitoring process cannot provide immediate intervention.

Some states require privacy in certain situations, such as when the patient is using the bathroom. In these instances, since 1:1 observation is not possible, the bathroom used by the patient must be ligature resistant. Converting a bathroom to a ligature-resistant environment can affect fire and life safety regulations and ADA compliance issues. Health care organizations should conduct a careful review of the rules and regulations that apply to their specific facilities.

Step 3: Remove

In any cases where 1:1 continuous observation is not feasible, hospitals must remove or clinically mitigate all environmental risks. Loose items should be removed from the patient area. Fixtures installed in the room do not need to be removed; however, patient access to certain areas may need to be restricted to prevent patients from reaching items that they could use for self-harm.

The American Society for Health Care Engineering of the American Hospital Association
155 N. Wacker Drive, Suite 400. Chicago, IL 60606
Phone: 312-422-3800 |
Fax: 312-422-4571 |
Email:
ashe@aha.org

CALIFORNIA HOSPITAL ASSOCIATION
Leadership in Health Policy and Advocacy

Ligature Risks — Regulatory Update and Compliance Expectations for all Hospitals Webinar

Learn about CMS, TJC recommendations, ways to comply

Register Now
October 2, 2018
10:00 – 11:30 a.m., Pacific Time

Overview | Agenda | Faculty | CEs | Tuition

Suicide is on the rise and the leading cause of death in the nation. In California, the rate increased nearly 15 percent from 1999 – 2016.* The Centers for Medicare & Medicaid Services (CMS) has taken notice too, expanding the types of health care facilities and hospital areas that must comply with the Medicare Conditions of Participation (CoPs) regarding ligature risk or self-harm.

While CMS' *Interpretive Guidelines* regarding ligature compliance are still in development, they have made their intentions for compliance clear in a recently released memo. Surveyors and health care providers are to follow recommendations developed by a Joint Commission multi-stakeholder Suicide Panel. CMS representatives were panel participants and plan to incorporate the panel's recommendations into the next release of the *Interpretive Guidelines*.

Join us for this important webinar and hear The Joint Commission panel participants explain the steps that all hospitals should take to maintain compliance with Medicare CoPs. Hospital representatives will share practical ways to maintain CoP compliance and safely care for at-risk patients.

**Source: Centers for Disease Control, https://www.cdc.gov/vitalsigns/suicide*

Recommended for:

Behavioral health care directors and managers, chief nursing officers and managers, chief risk officers and risk managers, compliance officers and ED directors and managers.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

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

SUBJECT: EMS Commission Administrative Appointee

SUMMARY

CHA has been asked to make a recommendation for the upcoming Governor appointed EMS commission hospital administrator position. Susan Webb, RN, has served this role for the past three years and has retired.

The EMS commission reviews and approves regulations, standards, and guidelines to be developed by the authority to implement its emergency medical services responsibilities. The commission is an 18 member commission representing multiple different associations and agencies within the emergency services and pre-hospital sector. CHA picks three candidates and submits them to the Governor for his approval and appointment.

The term is three years with quarterly face to face meetings in alternate sites across the state. The candidate should have executive and emergency services experience and interest.

ACTION REQUESTED

- CHA needs 3 CEO/COO candidate suggestions.

DISCUSSION QUESTIONS

1. How can this role influence decision making at the EMSA/LEMSA level?
2. Does anyone have experience as an EMS Commissioner?
3. How do we solicit CEO's?

Attachments: Commission on Emergency Medical Services
Commisssion on EMS Appointments
Commission on EMS Bylaws

BJB:br

COMMISSION ON EMERGENCY MEDICAL SERVICES

Purpose: Supports the role of Emergency Medical Service Agencies to ensure that patients have adequate access to quality emergency medical services, and to ensure the long term stability of these services.

Authority: Health and Safety Code §§ 1799 et seq.

Appointing Power: Governor – 12
Senate Committee on Rules – 3
Assembly Speakers - 3

Number: Eighteen (18)

Special Considerations:

Qualifications: Governor: (Health. & Saf. Code § 1799.2(d, e, h, j-q).)

1) One (1) county health officer appointed from a list of three (3) names submitted by the California Conference of Local Health Officers.
2) One (1) registered nurse, who is currently, or has been previously, authorized as a mobile intensive care nurse and who is knowledgeable in state emergency medical services programs and issues, appointed from a list of three (3) names submitted by the Emergency Nurses Association.
3) One (1) management member of an entity providing fire protection and prevention services appointed from a list of three (3) names submitted by the California Fire Chiefs Association.
4) One (1) hospital administrator of a base hospital who is appointed from a list of three (3) names submitted by the California Association of Hospitals and Health Systems.
5) One (1) full-time peace officer, who is either an EMT-II or a paramedic, who is appointed from a list of three (3) names submitted by the California Peace Officers Association.
6) Two (2) public members who have experience in local EMS policy issues, at least one (1) of whom resides in a rural area as defined by the authority.
7) One (1) administrator from a local EMS agency appointed from a list of four (4) names submitted by the Emergency Medical Services Administrator's Association of California.
8) One (1) medical director of a local EMS agency who is an active member of the Emergency Medical Directors Association of California.

COMMISSION ON EMERGENCY MEDICAL SERVICES
(continued)

Qualifications: (continued)

9) One (1) who is an active member of the California State Firemen's Association.
10) One (1) who is employed by the Department of Forestry and Fire Protection (CAL-FIRE) appointed from a list of three (3) names submitted by the California Professional Firefighters.
11) One (1) who is employed by a city, county, or special district that provides fire protection appointed from a list of three (3) names submitted by the California Professional Firefighters.

Senate Committee on Rules:
(Health. & Saf. Code, § 1799.2(a, c, f).)

1) One (1) full-time physician and surgeon, whose primary practice is emergency medicine, appointed from a list of three (3) names submitted by the California Chapter of the American College of Emergency Physicians.
2) One (1) physician and surgeon from a list of three (3) names submitted by the California Medical Association.
3) One (1) full-time paramedic or EMT-II, who is not employed as a full-time peace officer, appointed from a list of three (3) names submitted by the California Rescue and Paramedic Association.

Speaker of the Assembly:
(Health. & Saf. Code, § 1799.2(b, g, i).)

1) One (1) physician and surgeon, who is a trauma surgeon, appointed from a list of three (3) names submitted by the California Chapter of the American College of Surgeons.
2) One (1) prehospital emergency medical service provider from the private sector, appointed from a list of three (3) names submitted by the California Ambulance Association.
3) One (1) physician and surgeon who is board prepared or board certified in the specialty of emergency medicine by the American Board of Emergency Medicine and who is knowledgeable in state emergency medical services programs and issues.

Term: Three (3) years staggered, commencing January 1 of the year of appointment. (Health. & Saf. Code, § 1799.4(a)(b.6).)

Term Limits: Cannot serve for more than two (2) consecutive full terms. (Health. & Saf. Code, § 1799.4(a).)

At the discretion of the appointing power or body, a member of the commission may be reappointed or may continue to serve if he or

COMMISSION ON EMERGENCY MEDICAL SERVICES
(continued)

Term Limits: (continued)	she no longer continues to function in the capacity which originally qualified him or her for appointment. However, when Section 1799.2 requires that an appropriate organization submit names to the appointing power or body, a person shall not be reappointed pursuant to this section unless his or her name is submitted by that appropriate organization. (Health. & Saf. Code, § 1799.3.)
Grace Period:	Shall continue to serve until a successor has been qualified. (Gov. Code, § 1302.)
Compensation:	None, but shall be reimbursed for actual and necessary traveling expenses. (Health. & Saf. Code, § 1799.6.)
Meeting Frequency:	Shall meet at least quarterly on the call of the director, the chair, or three (3) members of the commission. (Health. & Saf. Code, § 1799.8.)
Bond:	Not stated in statute.
Oath:	Government Code §§ 1360-1363.
Duties:	Shall advise the authority on the development of an emergency medical data collection system. (Health. & Saf. Code, § 1799.51.) Shall advise the director with regard to communications, medical equipment, training personnel, facilities, and other components of an emergency medical services system. (Health. & Saf. Code, § 1799.53.) Shall review and comment upon the emergency medical services portion of the State Health Facilities and Service Plan developed pursuant to Section 127155. (Health. & Saf. Code, § 1799.54.) Based upon evaluations of the EMS systems in the state and their coordination, the commission shall make recommendations for further development and future directions of the emergency medical services in the state. (Health. & Saf. Code, § 1799.55.)
Website:	http://www.emsa.ca.gov/commission/membership.asp

Emergency Medical Services, Commission on

10901 Gold Center Drive, Suite 400

Rancho Cordova, CA 95670

	Appt. Date	End Date
John Daniel Burch (Emerg Med Servs Admin Assoc)	Jan 9 2017	Dec 31 2019
Turlock		
Mark Allen Hartwig (Fire Prot/Fire Chief Assoc)	Jan 8 2018	Dec 31 2020
Rancho Cucamonga		
Nancy Gordon (Public)	Feb 9 2017	Dec 31 2019
Scotts Valley		
Richard Owen Johnson (Local Health Ofcr)	Jan 8 2016	Dec 31 2018
Mammoth Lakes		
Steven Barrow (Public/Rural)	Jan 8 2016	Dec 31 2018
Antelope		
Steve Drewniany (Peace Offcr Assoc)	Jan 8 2016	Dec 31 2018
Gilroy		
Susan Marie Webb (Assoc Hosp Admin & Health Systems)	Jan 8 2016	Dec 31 2018
Foresthill		
Carole Ann Snyder (Emerg Nurse Assoc)	Jan 8 2018	Dec 31 2020
West Covina		
Lewis Stone (Firemen's Assn)	Jan 25 2010	Dec 31 2010
Burbank		
Eric Michael Rudnick M.D. (Emerg Med Dir Assoc)	Jan 8 2016	Dec 31 2018
Red Bluff		
Brent Morgan Stangeland (CPF/Cal-Fire/Prof Firefighters)	Jan 8 2018	Dec 31 2020
Sacramento		
David Edward Rose (City/Co/Spec Dist/Prof Firefighters)	Jan 8 2016	Dec 31 2018
Livermore		

CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY

Commission on EMS Appointments

Seats on the Commission on EMS are allocated to specific interest groups via state law in Health & Safety Code Section 1799.2 (a-q). Appointments are made on a staggered schedule established in statute in 1980 and each term is for three years. A commissioner may only serve two consecutive full terms. A commissioner may continue to serve in an expired appointment until a new appointment is made.

Members Appointed by the Governor

Member	Representing	Appointed	Expires
Carole Snyder	California Emergency Nurses Association	5/11/16	12/31/20
Dan Burch	EMS Administrators' Association of California	1/9/17	12/31/19
Steven Drewniany, Deputy Chief, EMT-P	California Peace Officers' Association	5/25/12 1/8/16	12/31/18
Nancy Gordon	Public Member	02/9/17	12/31/19
Mark Hartwig, Fire Chief, EMT-P	California Fire Chiefs Association	12/19/12 1/8/18	12/31/20
Richard O. Johnson, MD, MPH	California Conference of Local Health Officers	4/30/13 1/5/16	12/31/18
David Rose, Captain, EMT-P	City/County or Special District Fire Protection/ California Professional Firefighters	12/28/10 1/8/16	12/31/18
Eric Rudnick, MD, FACEP, FAAEM	EMS Medical Directors Association of California	3/23/10 1/8/16	12/31/18
Susan Webb, RN, BSN	California Hospital Association	1/8/16	12/31/18
Lewis Stone	California State Firefighters' Association	11/11/03 1/25/10	12/31/10
Steve Barrow	Public Member – Rural Communities	1/8/16	12/31/18

Member	Representing	Appointed	Expires
James Hinsdale, MD	California Medical Association	3/7/16	1/1/19
Atilla Uner, MD	California Chapter, California American College of Emergency Physicians	8/10/16	1/1/19
Jane Smith, MA, NREMT-P	California Rescue and Paramedic Association	6/25/08 2/23/11	1/1/14

Members Appointed by the Speaker of the Assembly

Member	Representing	Appointed	Expires
Jaison Chand, EMT-P, RN, BSN	California Ambulance Association	3/1/11	1/1/18
James Dunford, MD	Emergency Medicine Physician	2/22/16	1/1/19
Daniel Margulies, MD	California Chapter, American College of Surgeons	2/17/17	1/1/20

Commission on EMS Bylaws

June 2016

The Commission on Emergency Medical Services (EMS) for the State of California was created in the Health and Welfare Agency effective January 1, 1981. The statutory base for the Commission is found in Chapter 1260, Section 1799 of the Health and Safety Code and its role as an appeal body for local EMS agency systems plans is found in Section 1797.105. The following constitutes the Rules of Procedure of the Commission:

PURPOSE AND REGULAR DUTIES

I. Regular Duties

Section 1799.50 through 1799.56 specifies:

The Commission shall review and approve regulations, standards, and guidelines to be developed by the authority to implement its emergency medical services responsibilities.

The Commission shall advise the Authority on the development of an emergency medical data collection system.

The Commission shall advise the Director concerning the assessment of emergency facilities and services.

The Commission shall advise the Director with regard to communications, medical equipment, training personnel, facilities and other components of an emergency medical services system.

Based upon evaluations of the EMS systems in the state and their coordination, the Commission shall make recommendations for further development and future directions of emergency medical services in the State.

The Commission shall review and comment upon the emergency medical services portion of the State Health Facilities and Service Plan developed pursuant to Section 437.7.

II. Appeal Functions

Section 1797.105 specifies that the EMS Authority shall receive plans for the implementation of EMS from local EMS agencies. Local EMS agencies may implement a local plan developed pursuant to Section 1797.250, unless the authority determines such plan does not effectively meet the needs of residents and is not consistent with coordinating activities in the geographical area served, or the plan is not concordant

and consistent with applicable guidelines and/or regulations established by the authority.

Section 1797.105 (c) and (d) specify that a local EMS agency may appeal a determination of the Authority to the Commission. The Authority will start the appeal process and notify the Commission at the next scheduled meeting, if an appeal is submitted to the Authority before the Commission meeting.

The Commission adopts Chapter 13 of the California Code of Regulations, Title 22, Division 9 for the appeal of the denial of a local EMS agency plan.

MEMBERSHIP

I. Membership Qualification and Appointment

Section 1799.2 specifies the Commission shall consist of 18 members appointed as follows:

a. One full-time physician and surgeon, whose primary practice is emergency medicine, appointed by the Senate Rules Committee from a list of three names submitted by the California Chapter of the American College of Emergency Physicians.

b. One physician and surgeon, who is a trauma surgeon, appointed by the Speaker of the Assembly from a list of three names submitted by the California Chapter of the American College of Surgeons.

c. One physician and surgeon appointed by the Senate Rules Committee from a list of three names submitted by the California Medical Association.

d. One county health officer appointed by the Governor from a list of three names submitted by the California Conference of Local Health Officers.

e. One registered nurse, who is currently or has been previously authorized as a mobile intensive care nurse and who is knowledgeable in state emergency medical services programs and issues, appointed by the Governor from a list of three names submitted by the Emergency Nurses Association.

f. One full-time paramedic or EMT-II, who is not employed as a full-time peace officer, appointed by the Senate Rules Committee from a list of three names submitted by the California Rescue and Paramedic Association.

g. One prehospital emergency medical service provider from the private sector, appointed by the Speaker of the Assembly from a list of three names submitted by the California Ambulance Association.

h. One management member of an entity providing fire protection and prevention services appointed by the Governor from a list of three names submitted by the California Fire Chiefs Association.

i. One physician and surgeon who is board eligible or board certified in the specialty of emergency medicine by the American Board of Emergency Medicine and who is knowledgeable in state emergency medical services programs and issues, appointed by the Speaker of the Assembly.

j. One hospital administrator of a base station hospital who is appointed by the Governor from a list of three names submitted by the California Association of Hospitals and Health Systems.

k. One full-time peace officer who is either an EMT-ll or paramedic, who is appointed by the Governor from a list of three names submitted by the California Peace Officers Association.

l. Two public members who have experience in local EMS policy issues, at least one of whom resides in a rural area as defined by the Authority, and who are appointed by the Governor.

m. One administrator from a local EMS agency appointed by the Governor from a list of four names submitted by the Emergency Medical Services Administrators Association of California.

n. One medical director of a local EMS agency who is an active member of the EMS Medical Directors Association of California, and who is appointed by the Governor.

o. One person appointed by the Governor, who is an active member of the California State Firefighters Association

p. One person who is employed by the Department of Forestry and Fire Protection (CAL-FIRE) appointed by the Governor from a list of three names submitted by the California Professional Firefighters.

q. One person who is employed by a city, county, or special district that provides fire protection appointed by the Governor from a list of three names submitted by the California Professional Firefighters.

II. **Membership Terms**

Section 1799.4 of the Health and Safety Code describes the membership terms. Except as otherwise provided in Section 1799.4, the terms of the members of the commission shall be three calendar years, commencing

January 1 of the year of appointment. No member shall serve more than two consecutive full terms.

III. Membership Compensation

Section 1799.6 specifies the members of the Commission shall receive no compensation for their services, but shall be reimbursed for their actual necessary travel and other expenses incurred in the discharge of their duties. All necessary expenses must be approved by the EMS Authority in accordance with State rules of reimbursement.

IV. Membership Vacancies

A position on the Commission of Emergency Medical Services shall be considered vacant and the appointing authority is to be informed if the Commissioner dies, resigns, or moves his/her permanent place of residence out of the State of California. Should a Commissioner conduct himself/herself in a manner grossly inappropriate to the position or absent himself/herself from two consecutive regular noticed meetings of the full Commission without prior notification of a justifiable reason or without permission of the Chairperson, then the Commission shall describe the facts and circumstances in its minutes or by special resolution and shall submit said minutes or special resolution to the Commissioner's appointment authority for appropriate action.

OFFICERS

I. Officers

The officers of the Commission on EMS shall consist of a Chairperson, Vice-chairperson and Secretary. The Chairperson and Vice-chairperson shall be elected by the Commission annually from its members at the first regular meeting of the calendar year. No member shall serve as Chairperson for more than two consecutive one-year terms. The Director of the EMS Authority shall hold the office of Secretary and may participate in Commission and committee meetings but has no vote. The officers shall serve for the calendar year of election.

II. Officer Vacancies

In the event of an officer or Administrative Committee member vacancy prior to the end of the calendar year, the Chairperson shall open nominations and hold an election to fill the vacancy at the next scheduled meeting following the vacancy. Election to a vacant office seat shall require a majority vote by the membership.

III. Duties of Chairperson and Vice-Chairperson

The Chairperson shall preside at the Commission meetings; the Vice-chairperson shall function in the Chairperson's absence.

The Chairperson and Vice-chairperson shall be entitled to vote, make and second motions, and may serve on committees.

The Chairperson shall create committees as recommended by the Commission. The charge of the committee and its duration shall be designated at the time of its creation. The Chairperson may create ad hoc committees as deemed appropriate to study and recommend action on specific topics.

The Chairperson shall make all committee appointments and shall appoint the chairperson for each committee.

The Chairperson, upon the advice of the Administrative Committee, prepares the agenda for upcoming Commission meetings. The Director or any members of the Commission may add items to that agenda.

The Chairperson will assign business to the committees with the advice of the Administrative Committee.

The Chairperson or his/her designee may represent the Commission at legislative hearings, in public meetings, in press interviews and other public situations within the limits of established Commission policy or subject to confirmation at the subsequent regular Commission meeting.

The Chairperson shall annually appoint a committee to address System Platform Principles adopted by the EMS Commission. This committee shall submit their recommendations to the Commission.

IV. Duties of the Secretary

The Secretary shall cause to be recorded minutes which accurately reflect business conducted at Commission meetings. Approved minutes are public record. The Secretary will be responsible for providing notification of meetings to Commission members and others as specified below and for making materials available for inspection as specified.

In the absence of the Chairperson and Vice-chairperson, the Secretary shall convene the meeting of the Commission whose first act of business will be the election of a temporary chairperson from among its members.

ADMINISTRATIVE COMMITTEE

I. Administrative Committee Membership

The Administrative Committee shall consist of the Chairperson, Vice-chairperson, Secretary, immediate Past Chairperson of the Commission on EMS and two other members of the Commission elected annually at the first regular meeting of the calendar year. The members of the Administrative Committee shall serve for the calendar year following election.

II. Duties of the Administrative Committee

The Administrative Committee is advisory to the Chairperson and the Commission on administrative matters. Their deliberations will include, but not be restricted to, prioritizing agenda items, organizing reports, advising the chair on committee appointments and business assignments and assisting in development of interim positions of the Commission on urgent matters where Commission policy is unclear and an emergency meeting of the Commission seems unwarranted. The Administrative Committee may recommend the format in which agenda items are to be presented to the Commission.

MEETINGS

I. Regular Meetings

Section 1799.8 specifies that the Commission shall meet at least quarterly on the call of the Director, Chairperson, or three or more members of the Commission.

The Commission meeting dates will be set at the last meeting of the year for the next calendar year. All meetings of the Commission will be open with the exception of private or executive sessions permitted pursuant to the Government Code. Notice of all regular meetings of the Commission and an agenda of such meetings enumerating the items to be considered at the meeting shall be mailed to each commissioner at least ten days before the day on which the regular meeting of the Commission is scheduled. The agenda shall include the items of business to be transacted. No action item shall be added to the agenda unless a statement is included setting forth the emergency condition as provided below.

II. Notification of Meetings

Notice of Commission meetings, including the agenda, date and place of the meeting and the name, address, and telephone number to receive inquiries prior to this meeting shall be given at least ten days in advance

of such meeting to any person who requests such notice in writing. A person may request and be provided notice for all meetings of the Commission or may limit his request to notice for a specific meeting or meetings. Any mailing list maintained pursuant to this rule will be subject to annual correction as provided in Government Code Section 14911.

III. Special Meetings

A special meeting of the Commission may be called at any time by the Chairperson or a majority of the members of the Commission pursuant to Section 11125.4 of the California Government Code.

IV. Emergency Meetings

Emergency meetings of the Commission may be called at any time by the Chairperson, the Director of the EMS Authority, or by a majority of the Commission, when such a meeting is necessary to discuss an emergency condition as defined below. In the event such an emergency meeting is called, notice stating the agenda item(s) will be sent to those members entitled to vote and to those non-members who have requested such notice by such means as the Secretary deems appropriate.

V. Emergency Condition

An emergency condition shall be defined as:

a. Any condition requiring any action by the Commission because of a disaster involving mobilization of State disaster medical resources or other activities requiring the Commission's input to statewide mobilization.

b. Any other condition, which in the opinion of the Director, Chairperson, or a majority of the Commission could seriously affect the health and safety of the people of California if not acted upon by the Commission.

VI. Public Inspection of Material

Documents which are public records and which are distributed prior to commencement of a public meeting shall be made available at the Office of the Director for public inspection upon request prior to commencement of such meeting. If said material is distributed during a public meeting, it shall be made available for public inspection immediately or as soon as is practicable. The Authority, at the discretion of the Director, may charge a fee for a copy of any public records.

VII. Quorum

A majority of the appointed membership of the Commission or subcommittees shall constitute a quorum.

VIII. Voting

Each member entitled to vote shall be entitled to cast one vote for each matter submitted to a vote of the members.

If a quorum is present, all questions shall be decided by a majority of those members present. Voting may not take place without a quorum present.

No member shall be permitted to vote by proxy.

IX. Conflict of Interest

Commissioners must disqualify themselves from making or participating in the making of any decision when the Commissioner has a financial interest (as defined in Section 87103) which it is reasonably feasible may be affected materially by the decision. No Commissioner, however, shall be required to disqualify himself with respect to any matter which could not legally be acted upon without his/her participation. If such is the case (i.e., tie-breaking vote), the Commissioner should declare in the minutes a potential conflict of interest and then discharge his duty as a Commissioner in casting a vote.

X. Guests

Guests at Commission meetings may be allowed to participate in the discussion at the discretion of the Chairperson of the Commission. Guests addressing the Commission should identify themselves by name and organization prior to speaking on an issue.

COMMITTEES

I. Committees of the Commission

Committees of the Commission will meet as the business of the committee and budget dictate. Committee meetings may be called by the Chairperson of the Commission or of the committee. All committees are advisory to the full Commission and any action of the committees shall be referred to the commission for affirmation.

Minutes of committee meetings are the responsibility of the chairperson of that committee or his/her designee. Committee minutes become public record when adopted by the full Commission.

II. Consent Calendar

Any member of the Commission may pull any item from the consent calendar. All consent items must be accompanied by a description of the issue including the committee's recommendation. Except in emergency conditions, this description must be available for public inspection prior to the meeting of the Commission. Guests may address the Commission with regard to any item on the consent calendar.

All recommendations receiving a unanimous vote by a committee shall be referred to the Commission on a consent calendar.

CODE OF PARLIAMENTARY PROCEDURE

Robert’s Rules of Order shall prevail in all instances not covered by the above rules.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

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

SUBJECT: SB 432 (Pan) – Changes to Notification Requirements to Emergency Pre-Hospital Medical Care Personnel of Exposure to a Reportable Communicable Disease

SUMMARY

Effective January 1, 2018, SB 432 (Pan) revises the notification procedures for situations when prehospital emergency medical care personnel may have been exposed to a reportable communicable disease or condition that could result in transmission. The changes require additional reporting by the facility to the County Health Officer, and is time sensitive based on the urgency reporting requirements of 17CCR§2500(h)(i) attached.

Two health system policies are attached for reference and discussion purposes.

ACTION REQUESTED

- Information Only.

DISCUSSION QUESTIONS

1) How does this affect your current reporting processes?

Attachments: SB 432
AFL 18-06
Reportable Diseases
Pre-Hospital Exposure Process
Pre-Hospital Emergency Response Personnel Exposure Reporting
Exposure – Disease - Pre-Hospital Personnel – Reportable

BJB:br

Senate Bill No. 432

CHAPTER 426

An act to amend Section 1797.188 of the Health and Safety Code, relating to emergency medical services.

[Approved by Governor October 2, 2017. Filed with Secretary of State October 2, 2017.]

LEGISLATIVE COUNSEL'S DIGEST

SB 432, Pan. Emergency medical services.

Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, establishes the Emergency Medical Services Authority. The authority is responsible for the coordination and integration of all statewide activities concerning emergency medical services. The act requires all health facilities to notify prehospital emergency medical care personnel who have provided emergency medical or rescue services and have been exposed to a person afflicted with a reportable disease or condition that they have been exposed and should contact the county health officer under specified conditions. The act also requires a county health officer to immediately notify prehospital emergency medical care personnel that they have been exposed to a reportable disease or condition that the county health officer determines can be transmitted through oral contact or bodily secretions.

This bill would require the health facility infection control officer to give that notice immediately to a designated officer, as defined, upon determining, among other things, that the person to whom the prehospital emergency medical care personnel provided emergency medical or rescue services is diagnosed as being afflicted with a reportable communicable disease or condition, as specified, and to give notice to the county health officer with the name and telephone number of the prehospital emergency medical care personnel. The bill would then require the designated officer to notify the prehospital emergency medical care personnel of the exposure immediately or as otherwise specified. The bill would alternatively require the health facility infection control officer, if the names and telephone numbers of the prehospital emergency care personnel have not been provided to the facility, as specified, to notify the designated officer, as defined, of the employer of the prehospital emergency care personnel and the county health officer, and would require the designated officer to notify the prehospital emergency care personnel, if specified criteria are met. The bill would require a county health officer to notify prehospital emergency care personnel immediately if, in addition to existing requirements, the disease or condition has an urgency reporting requirement or the exposure may have included direct contact, as specified, with an infected person's blood.

Under certain circumstances, the bill would require specified information about the act's provisions to be posted on the Internet Web sites of those entities and provided during training to personnel, as specified. The bill would require a health facility infection control officer, as defined, and designated officer, as defined, to be available 24 hours per day, as specified.

The people of the State of California do enact as follows:

SECTION 1. Section 1797.188 of the Health and Safety Code is amended to read:

1797.188. (a) As used in this section:

(1) "Prehospital emergency medical care person or personnel" means any of the following: an authorized registered nurse or mobile intensive care nurse, emergency medical technician-I, emergency medical technician-II, emergency medical technician-paramedic, lifeguard, firefighter, or peace officer, as defined or described by Sections 1797.56, 1797.80, 1797.82, 1797.84, 1797.182, and 1797.183, respectively, or a physician and surgeon who provides prehospital emergency medical care or rescue services.

(2) "Reportable communicable disease or condition" or "a communicable disease or condition listed as reportable" means those diseases prescribed by Subchapter 1 (commencing with Section 2500) of Chapter 4 of Title 17 of the California Code of Regulations, as may be amended from time to time.

(3) "Exposed" means at risk for contracting the disease, as defined by regulations of the state department.

(4) "Health facility" means a health facility, as defined in Section 1250, including a publicly operated facility.

(5) "Health facility infection control officer" means the official or officer who has been designated by the health facility to communicate with a designated officer, or his or her designee.

(6) "Designated officer" means the official or officer of an employer of a prehospital emergency medical care person or personnel who has been designated by the state's public health officer or the employer.

(7) "Urgency reporting requirement" means a disease required to be reported immediately by telephone or reported by telephone within one working day pursuant to subdivisions (h) and (i) of Section 2500 of Title 17 of the California Code of Regulations.

(b) In addition to the communicable disease testing and notification procedures applicable under Chapter 3.5 (commencing with Section 120260) of Part 1 of Division 105, all prehospital emergency medical care personnel, whether volunteers, partly paid, or fully paid, who have provided emergency medical or rescue services and have been exposed to a person afflicted with a communicable disease or condition listed as reportable, which can, as determined by the county health officer, be transmitted through physical or oral contact or secretions of the body, including blood, shall be notified that

they have been exposed to the disease or condition in accordance with the following:

(1) If the prehospital emergency medical care person, who has rendered emergency medical or rescue services and believes that he or she may have been exposed to a person afflicted with a reportable communicable disease or condition in a manner that could result in transmission of a reportable communicable disease or condition, and provides the health facility infection control officer with his or her name and telephone number at the time the patient is transferred from that prehospital emergency medical care person to the admitting health facility; or the party transporting the person afflicted with the reportable communicable disease or condition provides that health facility with the name and telephone number of the prehospital emergency medical care person who provided the emergency medical or rescue services and believes he or she may have been exposed to a person afflicted with a reportable communicable disease or condition in a manner that could result in transmission of a communicable disease or condition, the health facility infection control officer, upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services is diagnosed as being afflicted with a reportable communicable disease or condition, and that the reportable communicable disease or condition may have been transmitted during the provision of emergency medical or rescue services, shall immediately notify the designated officer of the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the health facility infection control officer shall notify the designated officer consistent with Section 2500 of Title 17 of the California Code of Regulations. The health facility infection control officer shall also report the name and telephone number of the prehospital emergency medical care person to the county health officer. The designated officer shall immediately notify the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the designated officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations.

(2) If the prehospital emergency medical care person who has rendered emergency medical or rescue services and has been exposed to a person afflicted with a reportable communicable disease or condition, but has not provided the health facility infection control officer with his or her name

and telephone number pursuant to paragraph (1), the health facility infection control officer, upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services is diagnosed as being afflicted with a reportable communicable disease or condition that may have been transmitted during provision of emergency medical or rescue services, shall immediately notify the designated officer of the employer of the prehospital emergency medical care person and the county health officer if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the health facility infection control officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations. The designated officer shall immediately notify the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the designated officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations.

(c) The county health officer shall immediately notify the prehospital emergency medical care person who has provided emergency medical or rescue services and has been exposed to a person afflicted with a communicable disease or condition listed as reportable, which can, as determined by the county health officer, be transmitted through oral contact or secretions of the body, including blood, if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition, upon receiving the report from a health facility pursuant to paragraph (1) of subdivision (b). Otherwise, the county health officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations. The county health officer shall not disclose the name of the patient or other identifying characteristics to the prehospital emergency medical care person.

(d) An employer of a prehospital emergency medical care person or personnel that maintains an Internet Web site shall post the title and telephone number of the designated officer in a conspicuous location on its Internet Web site accessible from the home page. A health facility that maintains an Internet Web site shall post the title and telephone number of

the health facility infection control officer in a conspicuous location on its Internet Web site accessible from the home page.

(e) (1) The health facility infection control officer, or his or her designee, shall be available either onsite or on call 24 hours per day.

(2) The designated officer, or his or her designee, shall be available either onsite or on call 24 hours per day.

(f) An employer of a health facility infection control officer and an employer of a prehospital emergency medical care person or personnel shall inform those employees of this law as part of the Cal-OSHA Injury and Illness Prevention Program training required by paragraph (7) of subdivision (a) of Section 3203 of Title 8 of the California Code of Regulations.

(g) Nothing in this section shall be construed to authorize the further disclosure of confidential medical information by the health facility, the designated officer, or any prehospital emergency medical care personnel described in this section except as otherwise authorized by law.

(h) In the event of the demise of the person afflicted with the reportable communicable disease or condition, the health facility or county health officer shall notify the funeral director, charged with removing the decedent from the health facility, of the reportable communicable disease or condition prior to the release of the decedent from the health facility to the funeral director.

(i) Notwithstanding Section 1798.206, a violation of this section is not a misdemeanor.

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

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

EDMUND G. BROWN JR.
Governor

January 8, 2018

AFL 18-06

TO: Health Facilities

SUBJECT: Senate Bill (SB) 432: Changes to notification requirements to emergency prehospital medical care personnel of exposure to a reportable communicable disease

AUTHORITY: Health and Safety Code (HSC) section 1797.188

All Facilities Letter (AFL) Summary

This AFL notifies all health facilities of the chaptering of SB 432 that revises notification procedures to prehospital emergency medical care personnel when they may have been exposed to a reportable communicable disease or condition.

Effective January 1, 2018, SB 432 revises the notification procedures for situations when prehospital emergency medical care personnel may have been exposed to a reportable communicable disease or condition that could result in transmission. SB 432 requires health facilities to notify the designated officer of the prehospital emergency medical care personnel, as well as the county health officer, upon determining that the person provided care by the prehospital emergency medical care personnel has been diagnosed with a reportable communicable disease or condition that may have been transmitted during the provision of care.

The health facility must notify the designated officer immediately if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. If the reportable communicable disease does not meet these criteria, the health facility infection control officer must notify the designated officer consistent with Title 17 of the California Code of Regulations section 2500.

Upon receipt of notification, the designated health officer must immediately notify the prehospital emergency medical care personnel, if the reportable communicable disease or condition has an urgency reporting requirement, or if the conditions of the exposure are met. Otherwise, the designated officer must notify the prehospital emergency medical care personnel consistent with Title 17 of the California Code of Regulations section 2500. If the health facility does not have contact information for the prehospital emergency medical care personnel they must inform the county health officer and the designated officer at their place of employment.

Health facilities and the employer of a prehospital emergency medical care person must inform their employees of these requirements as part of the California Occupational Safety and Health Administration (Cal-OSHA) Injury and Illness Prevention Program training.

In addition, employers of prehospital emergency medical care personnel and health facilities that maintain internet web sites must post in a clearly visible and accessible location on the home page of the internet web site, the title and telephone number for the designated officer, or health facility infection control officer, respectively.

The California Department Public Health's failure to expressly notify facilities of statutory or regulatory requirements does not relieve facilities of their responsibility for following all laws and regulations. Facilities should refer to the full text of all applicable sections of the HSC and the California Code of Regulations to ensure compliance.

If you have any questions, please contact your respective Licensing and Certification District Office.

Sincerely,

Original signed by Jean Iacino

Jean Iacino
Deputy Director

Center for Health Care Quality, MS 0512 . P.O. Box 997377 . Sacramento, CA 95899-7377
(916) 324-6630 . (916) 324-4820 FAX
Department Website (cdph.ca.gov)

Page Last Updated : January 8, 2018

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆! = Report immediately by telephone (designated by a ♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations).
✆ = Report by telephone within one working day of identification (designated by a + in regulations).
FAX ✆✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
WEEK = All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

Disease Name	Urgency	Disease Name	Urgency
Amebiasis	FAX ✆✉	Listeriosis	FAX ✆✉
Anaplasmosis	WEEK	Lyme Disease	WEEK
Anthrax, human or animal	✆!	Malaria	FAX ✆✉
Babesiosis	FAX ✆✉	Measles (Rubeola)	✆!
Botulism (Infant, Foodborne, wound, Other)	✆!	Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ✆✉
Brucellosis, animal (except infections due to *Brucella canis*)	WEEK	Meningococcal Infections	✆!
Brucellosis, human	✆!	Mumps	WEEK
Campylobacteriosis	FAX ✆✉	Novel Virus Infection with Pandemic Potential	✆!
Chancroid	WEEK	Paralytic Shellfish Poisoning	✆!

Disease Name	Urgency	Disease Name	Urgency
Chickenpox (Varicella) (outbreaks,hospitalizations and deaths)	FAX ✆✉	Pertussis (Whooping Cough)	FAX ✆✉
Chikungunya Virus Infection	FAX ✆✉	Plague, human or animal	✆!
Chlamydia trachomatis infections, including lymphogranuloma venereum (LGV)	WEEK	Poliovirus Infection	FAX ✆✉
Cholera	✆!	Psittacosis	FAX ✆✉
Ciguatera Fish Poisoning	✆!	Q Fever	FAX ✆✉
Coccidioidomycosis	WEEK	Rabies, human or animal	✆!
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)	WEEK	Relapsing Fever	FAX ✆✉
Cryptosporidiosis	FAX ✆✉	Respiratory Syncytial Virus (only report a death in a patient less than less than five years of age)	WEEK
Cyclosporiasis	WEEK	Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like illnesses	WEEK
Cysticercosis or taeniasis	WEEK	Rocky Mountain Spotted Fever	WEEK
Dengue Virus Infection	✆!	Rubella (German Measles)	WEEK
Diphtheria	✆!	Rubella Syndrome, Congenital	WEEK
Domoic Acid Poisoning (Amnesic Shellfish Poisoning)	✆!	Salmonellosis (Other than Typhoid Fever)	FAX ✆✉
Ehrlichiosis	WEEK	Scombroid Fish Poisoning	✆!
Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ✆✉	Shiga toxin (detected in feces)	✆!
Escherichia coli: shiga toxin producing (STEC) including *E. coli* O157	✆!	Shigellosis	FAX ✆✉
Flavivirus infection of undetermined species	✆!	Smallpox(Variola)	✆!
Foodborne Disease	†FAX ✆✉	Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)	FAX ✆✉
Giardiasis	WEEK	Syphilis	FAX ✆✉
Gonococcal Infections	WEEK	Tetanus	WEEK
Haemophilus influenzae, invasive disease, all serotypes (report an incident less than 5 years of age)	FAX ✆✉	Trichinosis	FAX ✆✉
Hantavirus Infections	FAX ✆✉	Tuberculosis	FAX ✆✉
Hemolytic Uremic Syndrome	✆!	Tularemia, animal	WEEK
Hepatitis A, acute infection	FAX ✆✉	Tularemia, human	✆!
Hepatitis B (specify acute case or chronic)	WEEK	Typhoid Fever, Cases and Carriers	FAX ✆✉
Hepatitis C (specify acute case or chronic)	WEEK	*Vibrio* Infections	FAX ✆✉

Disease Name	Urgency	Disease Name	Urgency
Hepatitis D (Delta) (specify acute case or chronic)	WEEK	Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)	✆!
Hepatitis E, acute infection	WEEK	West Nile Virus (WNV) Infection	FAX ✆✉
Human Immunodeficiency Virus (HIV) infection, stage 3 (AIDS)	WEEK	Yellow Fever	✆!
Human Immunodeficiency Virus (HIV), acute infection	✆	Yersiniosis	FAX ✆✉
Influenza, deaths in laboratory-confirmed cases for age 0-64 years	WEEK	Zika Virus Infection	✆!
Influenza, novel strains (human)	✆!	OCCURRENCE of ANY UNUSUAL DISEASE	✆!
Legionellosis	WEEK	OUTBREAKS of ANY DISEASE (Including diseases not listed in **§2500**). Specify if institutional and/or open community.	✆!
Leprosy (Hansen Disease)	WEEK		
Leptospirosis	WEEK		

HIV REPORTING BY HEALTH CARE PROVIDERS §2641.30-2643.20

Human Immunodeficiency Virus (HIV) infection at all stages is reportable by traceable mail, person-to-person transfer, or electronically within seven calendar days. For complete HIV-specific reporting requirements, see Title 17, CCR, §2641.30-2643.20 and the California Department of Public Health's HIV Surveillance and Case Reporting Resource page (https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_case_surveillance_resources.aspx)

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness

(§2800-2812) Pesticide-related illness or injury (known or suspected cases)**

Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).

*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org. CDPH 110a (07/2016)

EXPOSURE IN THE PRE-HOSPITAL WORKER

INSTRUCTION SHEET: WHAT THE RN's NEED TO DO

THE EXPOSED WORKER **DOES NOT** HAVE TO SIGN INTO THE ED AS A PATIENT. THE PRE-HOSPITAL WORKER USUALLY GOES TO THE AGENCY WORK COMP CARRIER. THAT BEING SAID, WE ARE ALWAYS HAPPY TO HAVE THE WORKER SEEN IN OUR ED.

IF THE WORKER HAS BEEN EXPOSED TO A POTENTIALLY INFECTIOUS FLUID, THE SOURCE PATIENT **WILL BE DRAWN REGARDLESS OF WHETHER OR NOT THE WORKER IS SEEN IN OUR ED.**

FOLLOW THESE DIRECTIONS IN ORDER:

MICN –

1. HAVE THE EXPOSED WORKER COMPLETE **FORM A**, COMMUNICABLE DISEASE EXPOSURE.
2. PLACE THE **PINK COPY** IN LINDA'S BOX.
3. CALL THE CHARGE RN AND INTRODUCE THE EXPOSED WORKER
4. GIVE THE **WHITE & YELLOW COPIES** TO THE CHARGE RN.
5. THE CHARGE RN OR DESIGNEE WILL COMPLETE THE EXPOSURE PROCESS.

CHARGE RN –

6. AT THIS POINT, THE CHARGE RN TAKES RESPONSIBILITY FOR THE EXPOSURE PROCESS. THE CHARGE RN MAY DELEGATE THE REMAINDER OF THE PROCESS TO ANOTHER RN.

7. CALL LINDA ROSENBERG AT (858) 395-4447 AND LEAVE A MESSAGE STATING THAT THERE IS AN EXPOSURE; LEAVE YOUR NAME AND CONTACT NUMBER.

8. **FORM B; CONSENT**: ATTEMPT TO OBTAIN CONSENT FOR THE HIV TEST FROM THE SOURCE PATIENT. IF THE PATIENT IS UNABLE TO SIGN, IT IS CONSIDERED IMPLIED CONSENT. IF THE SOURCE PATIENT REFUSES TO SIGN THE CONSENT, BLOOD IN THE LAB MAY BE UTILIZED, OR SHOULD ADDITIONAL BLOOD NEED TO BE DRAWN FOR ANOTHER TEST, THAT BLOOD CAN BE USED FOR THE HIV TEST AS WELL.

9. **FORM C; DRAWING THE SOURCE PATIENT:** COMPLETE THE HIGHLIGHTED AREAS, FAX REQUEST TO LAB. CALL LAB TO NOTIFY THEM OF A SAT REQUEST.

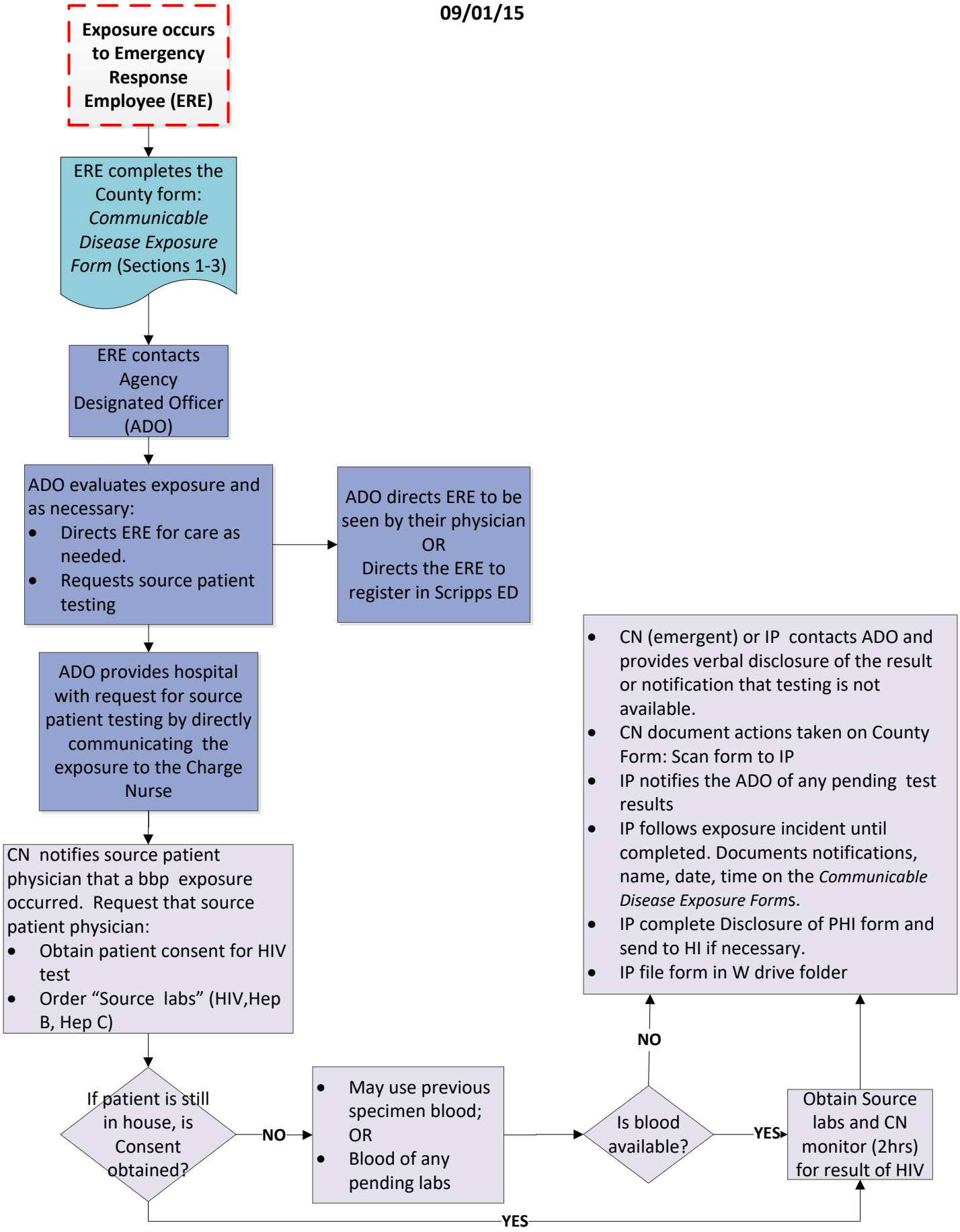
10. **ASSURE THE SOURCE PATIENT IS DRAWN.**

11. **FORM D; IF THE EXPOSED WORKER IS SEEN IN THE ED:** UTILIZE THE "NON-SHARP BFE PACKET POWER PLAN ON CERNER. THE ED MD WILL PROVIDE MEDICAL CARE FOR BODY FLUID EXPOSURE ACCORDING TO THE CDC AND/OR HIV PEP LINE RECOMMENDATIONS (888-448-4911).

12. COMPLETELY DOCUMENT WHAT WAS DONE ON **FORM A**; PLACE THE **WHITE** COPY IN LINDA'S BOX AND GIVE THE **YELLOW** COPY TO THE EXPOSED WORKER.

Exposure Pre-Hospital Personnel Response

09/01/15



Exposure Report Steps

1. Direct Emergency Response Employee (ERE) to complete sections 1-3 of the *Communicable Disease Exposure Form* and notify their Agency Designated Officer (ADO) of the exposure. (The charge nurse has a current listing of agency ADO contacts)
2. The ADO after evaluating the reported ERE exposure, if necessary, must provide the hospital with a request for source patient testing. Note: this is a decision of the agency, the charge nurse cannot determine if the ERE exposure was significant, the only thing the charge nurse can provide to the ADO is the CDC exposure recommendations as a resource for making their determination. (See below)
3. Charge nurse must speak with the ADO and record on the *Communicable Disease Exposure Form* section 5, the determination made by the ADO as to whether source patient testing is required or not. Charge nurse document on section 5; ADO name, date and time of communication. Example: "*ADO Sally Smith reports significant exposure of ERE and requests testing of source patient" date, time*. Signature of charge nurse.
4. Provide notification of ERE exposure to the source patient's physician who will proceed with obtaining tests per flow diagram on reverse side.
5. The ADO will direct their employee for care, either sending them to their physician of choice or directing them to register in the emergency department to see a physician.

Bloodborne Pathogen Exposures

HIGH Risk Exposure:
When blood, tissue or other potentially infectious fluids come in contact with:

- Percutaneous injury (needlestick or cut with a sharp object)
- Mucous membrane or non-intact skin (chapped, abraded, or afflicted with dermatitis

POTENTIALLY Infectious Body Fluids	**NOT Infectious Body Fluids**
• Cerebral spinal fluid (CSF) • Synovial fluid • Pleural fluid • Peritoneal fluid • Pericardial fluid • Amniotic fluid • Semen* • Vaginal fluid*	• Feces • Nasal secretions • Saliva • Sputum • Sweat • Tears • Urine • Vomitus

**Semen and vaginal secretions have been implicated in sexual transmission of HIV but have not been implicated in occupational transmission to healthcare workers.*

Human Bites:
Despite the fact that saliva is listed as a non-infectious agent for bloodborne pathogens, human bites are still listed as a possible transmission risk. It can be considered a low risk unless visible blood is identified in the saliva. Literature does document that HIV transmission has been reported, but not after occupational exposure.

Chicago Journals. Infection Control and Hospital Epidemiology, Vol.34, No.9 (Sept 2013)
http://www.cdc.gov/nhsn/PDFs/HPS-manual/exposure/3-HPS-Exposure-options.pdf **05/20/15**

Current Status: *Active*	**PolicyStat ID:**
Origination:	*03/1996*
Effective:	*11/2015*
Last Approved:	*11/2015*
Last Revised:	*11/2015*
Next Review:	*10/2018*
Owner:	
Policy Area:	*Emergency Services*
References:	*policy & procedure, Reportable Injuries & Diseases*
Applicability:	*xxxxxx,xxxxxxxx,xxxxxxxxxxx*

Exposure, Disease - Pre-Hospital Personnel (Reportable)

I. PURPOSE:

To supplement agency policies regarding work related injuries and illness by including a procedure for preventative medical treatment of agency employees who are suspected to have been exposed to a contagious disease.

II. DEFINITIONS:

A. EMT - Emergency Medical Technician

B. EMT-P - Emergency Medical Technician Paramedic

C. Agency - Employer

D. EMS – Emergency Medical Services

E. Ryan White Care Act - legislation, extended for four years in October 2009 under the name of the "Ryan White HIV/AIDS Treatment Extension Act of 2009", that provides funding for indigent care related to HIV/AIDS and requires sharing of information, as detailed in the law, with first responders who are exposed to communicable diseases while performing their duties as first responders.

III. BACKGROUND:

Pursuant to section 1797.186 of the California Health and Safety Code and the Ryan White Comprehensive AIDS Resources Emergency (Care) Act (Pub.L. 101-381). Agency is required to provide preventative medical treatment to paramedics (EMT-Ps), EMTs, lifeguards, fire fighters, and police officers who are exposed to contagious diseases while performing first aid or cardiopulmonary resuscitation services. Workers Compensation requires documentation of medical treatment.

IV. TEXT:

A. An exposure may be considered to occur in any of the following examples:

1. Mouth-to-mouth resuscitation
2. Blood or body fluid splash onto mucous membranes or open skin lesions.

3. Skin puncture with needles or other sharp instruments
4. Exposure to a significant communicable disease transmitted via airborne or droplet route.

B. The first EMT or EMT-P responder or transport personnel will notify the physician on duty and complete the "Reportable Disease Exposure" form which includes:

1. Emergency Medical Services (EMS) personnel's name, agency and phone number
2. Communicable disease exposed to, if known
3. How potential exposure occurred

V. PROCEDURE

PROCEDURE	RESPONSIBILITY
The following procedure is to be implemented in the case of exposure to a source person with a reportable disease which can be transmitted through oral contact or body secretions, including blood.	
A. First responder/Emergency Medical Technologist (EMT) and/or Paramedic(s) should notify their immediate supervisor. The supervisor will then direct them to the appropriate medical authorities. If the employee is directed to a Sharp Emergency Department the following procedure should be followed:	
1. Have the employee check in at triage and provide admission information.	1. EDRN/ Admitting
2. Document how exposure occurred with an initial patient assessment.	2. EDRN/Treating Provider
B. It is expected that treating providers will provide medical care for body fluid exposure according to CDC and/or HIV PEP line recommendations (888-448-4911).Recommendations regarding prophylaxis should be documented in the medical record.	B. Treating Provider
C. The Reportable Disease Exposure form, date of exposure and name of Emergency Medical Services (EMS) personnel will be documented and sent to the Pre-hospital EMS office. The designated agency representative will be contacted with follow-up by the Pre-hospital Manager or designee.	C. Pre-hospital Manager, Injury Prevention
D. For body fluid exposures, the source person is asked to sign the Consent for the Human Immunodeficiency Virus (HIV) Blood Test form authorizing the HIV blood test (form #720.15). The source patient may refuse the HIV test. If the source patient refuses the HIV test, blood in the lab may be utilized, or should additional blood need to be drawn for another test, that blood can be used for the HIV test as well.	D. Treating Provider, EDRN, MICN
E. The Authorization for Use or Disclosure of Protected Health Information form will be signed by the EMS personnel so that results may be given to those health care practitioners directly responsible for care and treatment, to include:	E. Prehospital Personnel

1. Those caring for pre-hospital workers who have been listed on the Authorization for Use or Disclosure of Protected Health Information form by the exposed person. 2. The designated Ryan White Officer identified on a list provided to the pre-hospital office by County Emergency Medical Services, and entered on the disclosure form prior to signing by the exposed party.	
F. For blood or body fluid exposures, obtain a provider order for collection of appropriate lab samples from the source patient.	Treating Provider
G. The agency will be billed for the source patient's lab work.	Lab/Billing
H. If the source patient has a known reportable communicable disease, the Infection Control Practitioner will notify the California Department of Public Health of the identity and diagnosis of the patient, the date of transport and the name and identifying data of the Emergency Medical Services (EMS) personnel exposed. Either the Pre-hospital Manager or the Infection Control Practitioner will notify the appointed officer of the agency as required by the Ryan White Care Act.	Infection Control Practitioner, Pre-hospital Manager

VI. REFERENCE:

A. California Occupational Safety and Health Act, Worker's Compensation California Health and Safety Code, Section 1797.186 Public Resources Code, Section 506 & 5163

B. CDC, Recommendations & Reports: Updated U.S. Public Health Services Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post Exposure Prophylaxis, MMWR2005; 54 (No. 44-9).

C. Ryan White Care Act, Pub.L.101-381.

ORIGINATOR:

Emergency Services

LEGAL REFERENCES:

County Policy #701, Health & Safety Code Sections 1797 & 1798

VII. CROSS-REFERENCE:

A. County EMS Reportable Disease Exposure Form, located in the Radio Room

VIII. ATTACHMENTS:

IX. APPROVALS:

A. Policy & Procedure Steering Cmte-6/20/96

B. General Nursing Policy & Procedure Cmte 01/24/03

C. Base Hospital Nurse Coordinators 01/03; 12/05, 03/09, 02/10; 01/13

D.

REPLACES:

A. originally dtd 4/87; Revised/Reviewed: 8/95

HISTORY:

System ; originally dtd 3/96
Revised/Reviewed:

Attachments:

No Attachments

Applicability

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

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

SUBJECT: Physician Education on Disaster Training

SUMMARY

At the last CHA EMS/T Committee meeting, an article was presented describing survey findings suggesting 93% of urban and suburban hospitals are not prepared for natural disaster or man-made events like mass shooting. While there was minimal detail behind how hospitals weren't prepared, 90% of 250 physicians polled said there was a shortage or absence of critical medications in their emergency departments.

CHA EMS/T members discussed the need to have physicians fully engaged in disaster training exercises and physicians present at the meeting discussed the difficulty of engagement due to lack of direct implications on physician practice.

Cheri Hummel, CHA VP for Disaster and Facilities Planning, shared a power point (attached) that could be customized by individual hospitals or physician groups for training purposes.

ACTION REQUESTED

- Information Only.

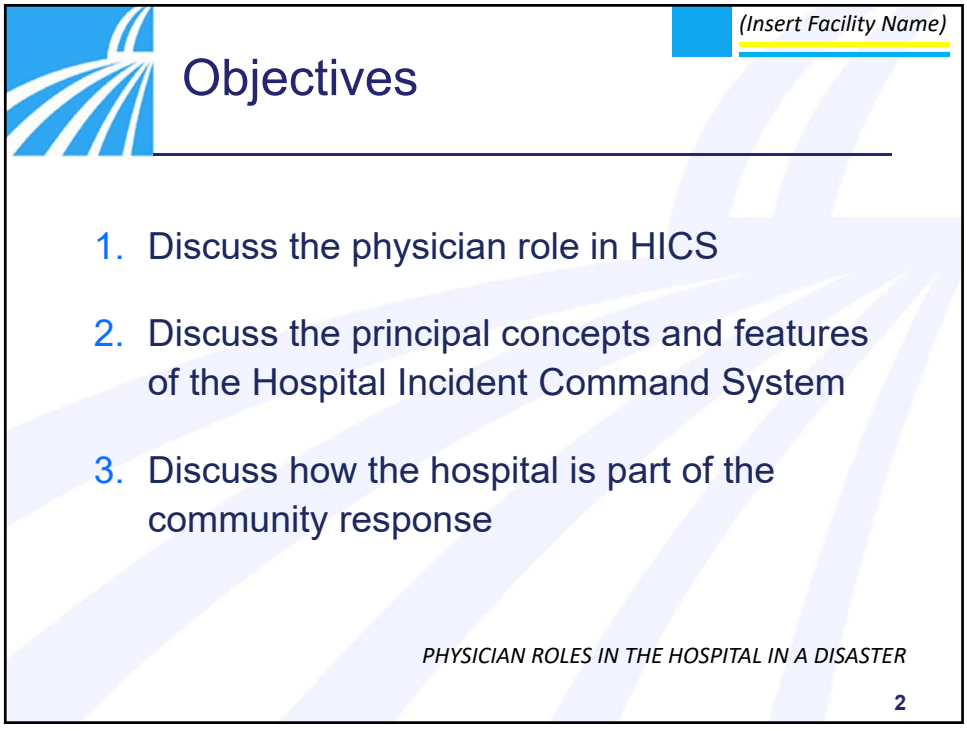
DISCUSSION QUESTIONS

1. Are there ways to incentivize physicians in their contracts to undertake training?
2. Are there other ways to incentivize physicians to take the lead in training?

Attachments: Physician Roles at the Hospitals in a Disaster

BJB:br


PHYSICIAN ROLES AT THE HOSPITAL IN A DISASTER
This material has been developed for training purposes. No part of this course or its materials shall be copied or utilized for monetary gain
CALIFORNIA HOSPITAL ASSOCIATION


(Insert Facility Name)
Objectives
1. Discuss the physician role in HICS
2. Discuss the principal concepts and features of the Hospital Incident Command System
3. Discuss how the hospital is part of the community response
PHYSICIAN ROLES IN THE HOSPITAL IN A DISASTER
2

(Insert Facility Name)

Planning

WHAT DO WE NEED TO PLAN FOR:

- What are the risks we face daily?
- What is on our Hazard Vulnerability Assessment list?

PHYSICIAN ROLES IN THE HOSPITAL IN A DISASTER

3

(Insert Facility Name)

The Responsibility is…

WHO IS RESPONSIBLE FOR EMERGENCY PREPAREDNESS AT *(Insert Facility)*:

- Emergency Management Committee
- Environment of Care Committee
- *(Insert specific methodology used)*
- CMS requires all staff, physicians and contractors be trained annually

4

(Insert Facility Name)

Emergency Response

HOW IS AN EMERGENCY RESPONSE DIFFERENT FROM DAY-TO-DAY?

- Emergency Operations Plan
- Emergency Codes
- Hospital Incident Command System

5

(Insert Facility Name)

HICS

HOSPITAL INCIDENT COMMAND SYSTEM:

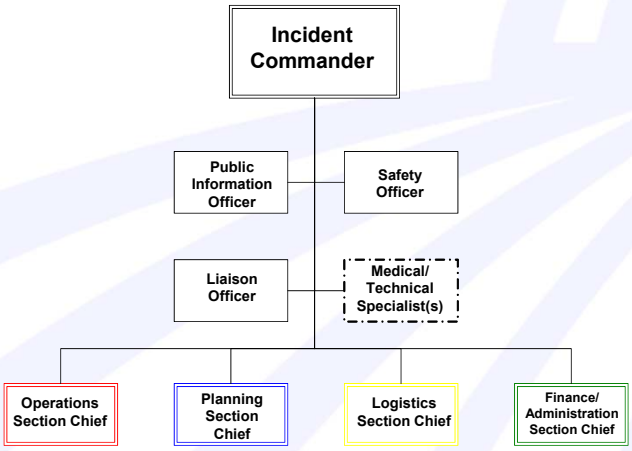
Helps improve hospital response and coordination between hospitals and other responders using:

- Defined responsibilities
- Clear reporting channels
- A common nomenclature

HICS does not replace or supplant daily hospital operations

6

BASIC INCIDENT COMMAND STRUCTURE



Modular Organization:
Functional Sections Activated as Needed

(Insert Facility Name)

HICS is Scalable

FLEXIBLE

The system is **scalable** so that ***more*** or ***fewer*** positions--depending on the emergency--may be implemented

PHYSICIAN ROLES IN THE HOSPITAL IN A DISASTER

8

(Insert Facility Name)

Activation of the Emergency Operations Plan

ACTIVATING THE PLAN:

The hospital Emergency Operations Plan is activated by: *(Insert method such as; administrator on call authorizing the hospital's emergency codes)*

PHYSICIAN ROLES IN THE HOSPITAL IN A DISASTER

9

(Insert Facility Name)

Activation of the Emergency Operations Plan

HOW DO YOU KNOW THE PLAN IS ACTIVATED?:

The hospital communicates that the plan is activated by:

- Overhead Page
- Email/Alerts
- Pager System

PHYSICIAN ROLES IN THE HOSPITAL IN A DISASTER

10

(Insert Facility Name)

HICS - Hospital Incident Command System

MANAGEMENT ROLES IN AN ACTIVATION :

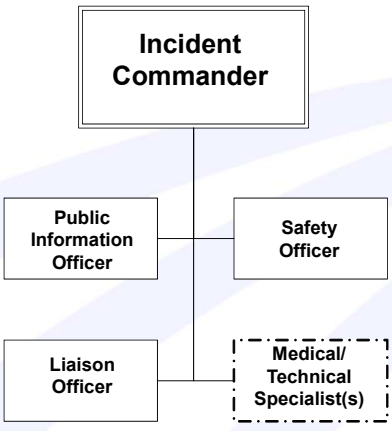
Command and

General Staff

PHYSICIAN ROLES IN THE HOSPITAL IN A DISASTER

11

COMMAND



- **Chemical**
- **Clinic Administration**
- **Communicable Disease**
- **Hospital Administration**
- **Legal Affairs**
- **Medical Ethicist**
- **Medical Staff**
- **Pediatric Care**
- **Radiological**
- **Risk Management**

COMMAND STAFF:

Incident Commander: Gives overall strategic direction for the hospital

Public Information Officer: Communicates with internal and external stakeholders including: staff, patients, visitors, and media

Safety Officer: Ensures safety of staff, patients and visitors

Liaison Officer: Hospital Command Center contact for supporting agencies and organizations

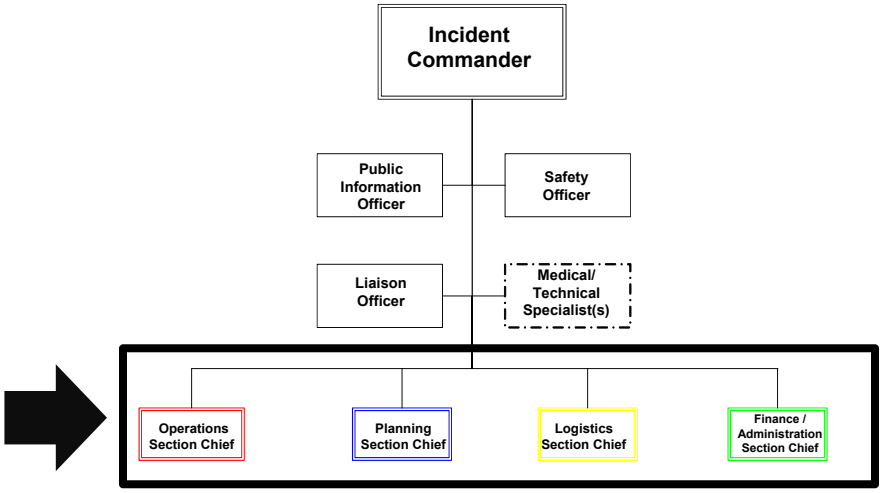
Medical Technical Specialist(s): Subject matter experts that advise the Incident Commander and/or assigned section

MEDICAL/TECHNICAL SPECIALIST

Examples Include:

- Biological
- Infectious Disease
- Chemical
- Radiological
- Legal Affairs
- Risk Management

GENERAL STAFF: SECTIONS



(Insert Facility Name)

HICS Sections

SECTIONS INCLUDE:

- Operations
- Planning
- Logistics
- Finance/ Administration

PHYSICIAN ROLES IN THE HOSPITAL IN A DISASTER

16

(Insert Facility Name)

Operations Section

OPERATIONS SECTION MISSION:

- Manage tactical operations
- Direct all tactical resources
- Carry out the mission and Incident Action Plan

PHYSICIAN ROLES IN THE HOSPITAL IN A DISASTER

17

(Insert Facility Name)

Operations

Some of the Operations Section Branches you may be assigned to:

- Medical Care Branch
- Patient Family Assistance Branch
- HazMat Branch

PHYSICIAN ROLES IN THE HOSPITAL IN A DISASTER

18

MEDICAL CARE BRANCH DIRECTOR

Supervises:

- Inpatient Unit Leader (all inpatient units)
- Outpatient Unit Leader (all outpatient services)
- Casualty Care Unit Leader (Treatment Areas including: Immediate, Delayed, Minor, and Expectant/Deceased)
- Behavioral/Mental Health Unit Leader
- Clinical Support Unit Leader (Lab, Diagnostic Imaging, Pharmacy, Morgue, Blood Bank)
- Patient Registration Unit Leader

(Insert Facility Name)

Other Sections

Logistics: Organizes and maintains the physical environment – providing human resources, material, and services to support the incident.

Planning: Collects, evaluates, and disseminates information and develops the Incident Action Plan

Finance/Administration: Monitors financial assets, accounting, and claims

(Insert Facility Name)

How Do I Get My Assignment

- Depending on the facility's Emergency Operations Plan, you can respond to the Labor Pool for assignment
- If you are not on staff and show up to help, the Medical Staff Office may handle the credentialing process *(insert facility process for credentialing)* (consider pre-registration as a medical volunteer)

(Insert Facility Name)

After Action Reporting

YOUR PART IN IMPROVING THE HOSPITAL'S RESPONSE: Hotwash and Debriefs

(Insert Facility Name)

Incident Response Guides

- Active Shooter
- Chemical Incident
- Earthquake
- Evacuation, Shelter-in-Place, and Hospital Abandonment
- Explosive Incident
- Hostage or Barricade
- Infectious Disease

(Insert Facility Name)

Incident Response Guide

- Mass Casualty Incident
- Missing Person
- Radiation Incident
- Severe Weather
- Staff Shortage
- Utility Failure
- Wildland Fire

(Insert Facility Name)

Documentation

How is documentation different in an emergency response:

- HICS Forms
- START Triage Tags
- How does the EMR Change in a Surge or IT Failure?
- Do we still follow HIPAA?

(Insert Facility Name)

Community Response

We are part of the national system:

- Individual Hospital
- Hospital System
- Community/County
- State
- Federal
- International

What if I Don't Get A HICS Assignment?

(Insert Facility Name)

How do I handle current/new patients?

- Assist in clearing the ED for new patients
- Review/evaluate inpatients for early discharge
- Assist in transfer of appropriate patients to other service areas or other facilities

What if I Don't Get A HICS Assignment?

(Insert Facility Name)

How do I handle current/new patients?

- Review cancelling elective surgery and procedures if necessary
- Prepare for patients transferred from an outside affected area such as another county or state
- Accept assignment to a treatment area
- Open up extra clinic appointments and/or staff Alternate Care Areas to "unload" the ED

What if I Don't Get A HICS Assignment?

Triage of Resources:

- Surgeons/Anesthesiologists: OR Availability and Priorities
- Radiologists: Imaging Priorities
- Pathologists: Lab Priorities
- Intensivists: Critical Care Priorities

Personal Plans

- Family/Pet Plans
- Department Plans

(Insert Facility Name)

What Can I Do Pre-Disaster

Educate Your Patients:

- Review and Evaluate DNR/POLST
- Extra Medications
- Disaster Supplies/Family and Reunification Plans
- Home Health and Special/Functional Needs Patients
- CERT Programs/First Aid

(Insert Facility Name)

What Can I Do Pre-Disaster

Personal/Departmental Preparedness:

- Office/Car Disaster Supplies
- Personal/Staff Disaster Supplies/Family, Pet and Reunification Plans
- Develop Departmental Disaster Plans
- Educate Your Staff
- Participate/Organize Disaster Exercises

What Can I Do Pre-Disaster

Society/Specialty Guidelines and Courses such as:

- National Disaster Life Support Foundation
- Disaster Management and Emergency Preparedness Course (DMEP; American College of Surgeons)
- American College of Emergency Physicians
- Society of Critical Care Medicine
- American Academy of Pediatrics
- American College of OB/GYN

33

(Insert Facility Name)

What Can I Do Pre-Disaster

- Consider Crisis Standards of Care
- Consider Improvisations in Austere Environments

34

(Insert Facility Name)

Crisis Standards of Care

A Systems Framework for Catastrophic Disaster Response; Institute of Medicine; 2012.

http://iom.nationalacademies.org/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx

California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies at www.bepreparedcalifornia.ca.gov

35

QUESTIONS

THANK YOU

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

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

SUBJECT: LEMSA Designation Fees

SUMMARY

Several hospitals have reported increases in LEMSA fees for programs such as Stroke and STEMI. CHA performed a Brief Report in 2013 (attached) that revealed a large disparity and inconsistency among LEMSA fees, services and terms of agreement. LEMSAs may charge certification fees per Health and Safety Code Chapter 4. Article 1. Local EMS Agency, 1797.212 that states, "The local EMS agency may establish a schedule of fees for certification *in an amount sufficient to cover the reasonable cost of administering the certification".* However, a local EMS agency shall not collect fees for the certification of EMT-P.

ACTION REQUESTED

- Information Only.

DISCUSSION QUESTIONS

1) Are you aware of the fees your facilities pay to the LEMSA and what they are for?
2) If you are, do you feel these fees are reasonable and necessary and covering appropriate costs?

Attachments: California Emergency Services Authority and Local EMS Agency Governance, Fees and Terms of Agreement, A Brief Report, March 2013

BJB:br

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

California Emergency Medical Services Authority and Local EMS Agency Governance, Fees and Terms of Agreement

A Brief Report
March 2013

Introduction

California hospitals are among the most highly regulated organizations and face increasing financial pressure from multiple county, state and federal agencies. Program service fees, regulatory penalties and continued increases in unfunded mandates threaten hospitals' ability to operate effectively in a rapidly changing environment. California's local emergency services agencies (LEMSAs) contract with individual hospitals to provide emergency services. LEMSAs may charge fees and wager terms of performance. A review of these fees and terms shows that there is notable variability among local jurisdictions. As a result of these differences, we conducted a preliminary review of available information.

Our review included interviewing staff from The Emergency Medical Services Authority (The EMS Authority) and individual LEMSAs. In particular, discussions were held with Dr. Howard Backer, director of the EMS Authority, Dan Smiley, the EMS Authority deputy director, and Cathy Chidester, director of the Emergency Management Services Administrators Association of California (EMSACC). All three individuals reaffirmed that no comprehensive document or readily available information exists at the state or local level to explain the disparity in LEMSA fees and terms or how they evolved.

Information gathering also included an analysis of Health and Safety Code Division 2.5 Sections 1797-1799, along with miscellaneous statutes referencing the EMS Authority. A fee schedule depicting the various LEMSA fees for trauma, stroke, STEMI, base hospital and pre-hospital receiving center designations was obtained from the EMS Authority Trauma Director Bonnie Sinz. Numerous discussions with hospital personnel from across the state were held. Each California Association of Hospitals and Health Systems (CAHHS) Regional Association vice president was contacted and gave relevant information on their respective LEMSA fees, policies and procedures. Every CAHHS regional vice president has collegial working relationships with their respective LEMSA directors and contributed to the body of work. Finally, relevant websites were reviewed and served as the primary reference documents for this report.

Through this analysis we obtained the previously referenced fee schedule outlining the major emergency services program designation fees. The schedule served as a sentinel alerting us to the extreme fee variability. We also uncovered other variable fees that occur inconsistently and less notably across jurisdictions, such as mobile intensive care nurse training and EMT training fees.

Policy and procedural terms such as ambulance offload delay metrics were more difficult to obtain, as each LEMSA has its own administrative infrastructure. There is no centralized means of information access for all the LEMSAs. A comparison of policies, procedures and hospital agreements required by each LEMSA does not exist. Various policies and procedures are listed on the LEMSA websites, but there is no consistency between each website. While a definitive fee schedule was obtained for the major programs, the various terms of agreement between the 32 LEMSAs was beyond the scope of this analysis.

Following is an overview of the governance of California Emergency Services Systems, along with a compilation of information obtained during our review.

Governance

The California Emergency Services Authority (The EMS Authority)

California pre-hospital emergency services are managed by the statewide EMS Authority and the local emergency service agencies commonly referred to as LEMSAs. Day-to-day emergency services management is the responsibility of the LEMSAs. The EMS Authority:

- Provides statewide coordination and leadership for the planning, development and implementation of the local emergency services systems (EMS) and sets standards for the training and scope of practice of EMS personnel.
- Promotes disaster medical preparedness and manages the state's medical response to major disasters.
- Works to promote quality EMS services statewide through the regional agencies,
- Works with local, state, federal, public and private agencies on emergency and disaster services

California did not have a centralized state agency prior to 1980. Emergency services were governed by the local county administrators, and while there was much disagreement on many issues, there was agreement that a more unified approach to emergency and disaster medical services was needed. In 1980 the Emergency Services System and Pre-hospital Emergency Care Personnel Act (SB 125) was passed, creating the Emergency Medical Services Authority as one of 13 departments within California's Health and Human Services Agency, adding division 2.5 to the California Health and Safety Code (Sections 1797-1799). The EMS Authority is headed by a director who is appointed by the Governor, upon nomination by the Secretary of California Health and Human Services. The director must be a physician and surgeon licensed in California.

The Commission on Emergency Medical Services was established through the Emergency Services Act to ensure that stakeholders have a voice in decisions affecting the EMS system in California. The duties of the Commission include approving regulations and guidelines developed by the EMS Authority and providing advice to the EMS Authority on the assessment of emergency facilities and services, communications, medical equipment, training personnel,

and components of an emergency medical services system. The Commission may also hear an appeal by a LEMSA regarding a local emergency services plan.

Local Emergency Services Agency (LEMSA)

California has 32 LEMSAs providing emergency medical services for the state's 58 counties. Seven regional EMS systems comprised of 33 counties and 25 single-county agencies provide the services. Regional systems are comprised of small, rural, less populated counties, and single-county systems exist in the larger and more urban counties. Yolo County has contracted with Sierra Sacramento Valley LEMSA for many years, and has now decided to establish its own single-county LEMSA. Yolo is working closely with neighboring Solano County LEMSA to set up the required functions and expects to be operational by July 2013.

The primary program responsibility and a large amount of autonomy are vested with the LEMSAs. Each program functions as a decentralized unit separate and unique from each other with oversight provided by the EMS Authority. LEMSAs — per Health and Safety Code Division 2.5 statutes — have authority over medical direction and management of standards established by the EMS Authority.

Each county may develop an emergency medical services program or LEMSA through a county contract. There can also be a joint powers agency created for administration of emergency medical services by agreement between counties or cities. The localized nature of each LEMSA within the county public health framework and the corresponding financial stream is more than likely the driver of the wide disparity in LEMSA fees and terms.

California counties perform greatly expanded services not only mandated by the state, but assumed under laws giving counties the option of providing additional services appropriate to local circumstances. More than 55 percent of county revenues come from state and federal sources. As agents of state government, with the same functions designated to all of them — in this case emergency services — counties are subject to extensive state administrative supervision and regulation. At the same time there is still an element of local autonomy and decentralization due to the variability in county size, geography and population demographics. While the Legislature may pass special laws for particular counties, state law also grants broad discretionary powers, allowing counties to adapt their internal structure, operations and programs to local conditions. As Howard Backer, MD, the EMSA Authority director stated, "The primary program responsibility and a large amount of autonomy is vested in the LEMSAs. The state has the role of coordination, oversight, regulation, licensing, evaluation and other responsibilities specified in statute. The struggle between consistency and autonomy is constant."

Every LEMSA has a full or part-time licensed physician and surgeon as medical director, who has emergency medicine experience and is designated by the county or by the joint powers agreement to provide medical control and assure medical accountability throughout the planning, implementation and evaluation of the EMS system. The LEMSA medical directors have an association called the Emergency Medical Directors Association of California, Inc. (EMDAC),

which offers leadership and expert opinion in the medical oversight, direction and coordination of emergency medical services in California.

Each LEMSA also has an administrator hired by the county. The administrators are members of the Emergency Medical Services Administrators Association of California (EMSAAC), a group that acts in an advisory capacity to the EMS Authority and the Commission on Emergency Medical Services in establishing goals, priorities, standards and quality assurance for Emergency Medical Services Systems. (See Exhibit #1 – California EMSA LEMSA County Map.)

LEMSAs contract with and designate hospitals or other entities to provide medical direction of pre-hospital emergency medical care personnel within their area of jurisdiction as either base hospitals, pre-hospital receiving centers or alternative base stations, respectively. This includes specialty designation status such as adult and pediatric trauma centers stroke, STEMI, and emergency services for children. Triage and transfer protocols, as well as critical care capabilities, are other types of designation status.

LEMSAs cannot impose penalties on hospitals per se. All LEMSAs have contractual and/or agreed upon administrative policies and procedures with hospitals that receive ambulance patients in their county. LEMSAs can hold hospitals accountable for those agreed upon standards as well as federal and state law, and/or redirect patients to other receiving hospitals if it is determined that patient care and safety are at risk.

LEMSA Fees

In review of fees charged to hospitals for designation of trauma, stroke, STEMI, base hospital and pre-hospital receiving center (see Exhibit #2 – LEMSA Fee Schedule), the dramatic variation in charges is evident. A majority of the annual fees are specified, and several LEMSAs have prorated charges based on patient volume, specific trauma level designation, or per ambulance patient fee. Seven LEMSAs charge no fees to hospitals for any status designation, and one LEMSA charges fees in all five categories. The majority of LEMSAs have charges in at least three of the five categories, varying from $2,000 to $250,000 annually. The trauma fee varies from no fee to as high as $250,000 annually. San Francisco County had no allotted value on this fee schedule. Responding to that omission, Lann Wilder, emergency management coordinator at San Francisco General stated, “San Francisco General Hospital does not have a contract with San Francisco LEMSA for being a receiving hospital, but we do meet the standards in emergency management system policy for receiving emergency patients as well as receiving specialty trauma, stroke, STEMI and base hospital standards. We pay the county one lump sum annually, and for FY 2012-2013, it was $13,310.”

According to Health and Safety Code 1798.164, LEMSAs may charge trauma fees, as follows: “(a) A local emergency medical services agency may charge a fee to an applicant seeking initial or continuing designation as a trauma facility in an amount sufficient to cover the costs directly related to the designation of trauma facilities pursuant to Section 1798.165, however, there is no other regulatory reference to LEMSA charges for other services. EMSA staff describe the

application of the newer program fees, such as stroke and STEMI, or other fees, such as provider education, being added to hospital fees to cover LEMSA costs."

Attendance at a Hospital Council of Northern and Central California Emergency Services Task Force Meeting on March 8, 2013, included a discussion on mobile intensive care nurse fees (MICN) charged by the Sacramento LEMSA to hospitals. The Sacramento LEMSA is proposing a MICN fee rate increase and additional fees for EMT/paramedic training, continuing education, and advanced life services provider provisions. Scott Seamons, Hospital Council RVP, was able to obtain a recent draft county memo (see Exhibit #3) with proposed Sacramento County LEMSA MICN fee changes along with additional proposed fees. The coincidental discovery of these fees raised the question of whether other fees exist with the individual LEMSAs, and why.

In the minutes of the task force's previous meeting, members raised questions and expressed concerns about why hospitals should be paying the county for services it doesn't provide. In the Hospital Council of Northern and Central California Emergency Services meeting minutes of Jan. 11, 2013, under the MICN Fee discussion, the following was reported:

"The two Emergency Services Task Force members who create (MICN) curriculum and facilitate all the (MICN) training (which includes all the work with no approval process from the county) remarked that being charged "money for nothing" is not okay. While the fee is a way to generate cash flow for the county, there should at least be something in place that benefits the hospitals for paying the fees. There is not. Hospitals also pay with staff time to attend the classes, nurse training time is involved, etc. Additionally, EMS receives $50,000 of HPP grant funds from the hospitals every year along with the fees – grant money that the hospitals could use to expand or update their disaster preparedness resources."

LEMSAs may charge certification fees per Health and Safety Code Chapter 4. Article 1, Local EMS Agency, 1797.212 states, "The local EMS agency may establish a schedule of fees for certification in an amount sufficient to cover the reasonable cost of administering the certification. However, a local EMS agency shall not collect fees for the certification or EMT-P." In this scenario it is unclear why the county charges hospitals administrative fees when, in fact, the hospitals are doing a majority, if not all, of the administrative functions.

Clearly the broad variation in major program fees across county LEMSAs and the high probability that other county LEMSAs, as in Sacramento County, have obscure miscellaneous fees, elevates the need for continued investigation to understand what those costs are, why they have been assessed, and why there is such broad variation.

LEMSA Terms

CHA has been working with the EMS Authority on a stakeholder collaborative to solve the problem of patient ambulance offload delays in hospital emergency departments. When investigating this issue across LEMSAs throughout the state, we found the same level of disparity with policies and procedures or terms of agreement as we did with LEMSA fees. For

instance, some LEMSAs, such as Riverside LEMSA, have offload delay metrics in their base station administrative policies, while others, such as the Central California LEMSA, do not.

Hospitals enter into agreements with their respective LEMSA through contracts, policies and procedures. Terms in the contracts and policy and procedures vary by LEMSA, as evidenced by the regulatory requirements listed in Health and Safety Code Division 2.5 Chapter 6, Facilities, Article 1 Base Hospitals. Hospitals contract to become base stations to provide medical direction of pre-hospital emergency care provided for the area defined by the LEMSA with policies and procedures established by the local EMS agency and approved by the LEMSA medical director. According to Health and Safety Code (1798.102), the base hospital shall supervise pre-hospital treatment, triage and transport advanced life support or limited advanced life support and monitor personnel program compliance by direct medical supervision (1798.102). The agreements, while collaborative in nature, are driven by the LEMSA in conjunction with the public health needs and resources of the respective county or counties.

Identification of individual LEMSA base hospital agreements was beyond the scope of this report. Each LEMSA has numerous contracts, policies and procedures amongst over 300 hospitals. Reliable review of the information would entail extensive hours of contract review, assessment, evaluation and compilation of findings, in addition to review and analysis of state and county laws and.

Conclusion

While California is a diverse and highly populated state, with counties exercising a great deal of governance autonomy to meet local jurisdictional needs, the disparity and inconsistency among LEMSA fees, services, and terms of agreement needs continued focus and review. Hospitals endure ongoing costs of unfunded mandates and fees and, in this case, those fees may be extremely inconsistent and unnecessary. The EMS Authority manages LEMSA services and, in that regard, should be reviewing fees and terms from each LEMSA comparatively as to how they affect the individual LEMSA, and the state as a whole.

References

1. http://emsa.ca.gov/
2. California Emergency Medical Services Law, Health and Safety Code Division 2.5
3. http://emsaac.org/

CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY

Local EMS Agency Administrators

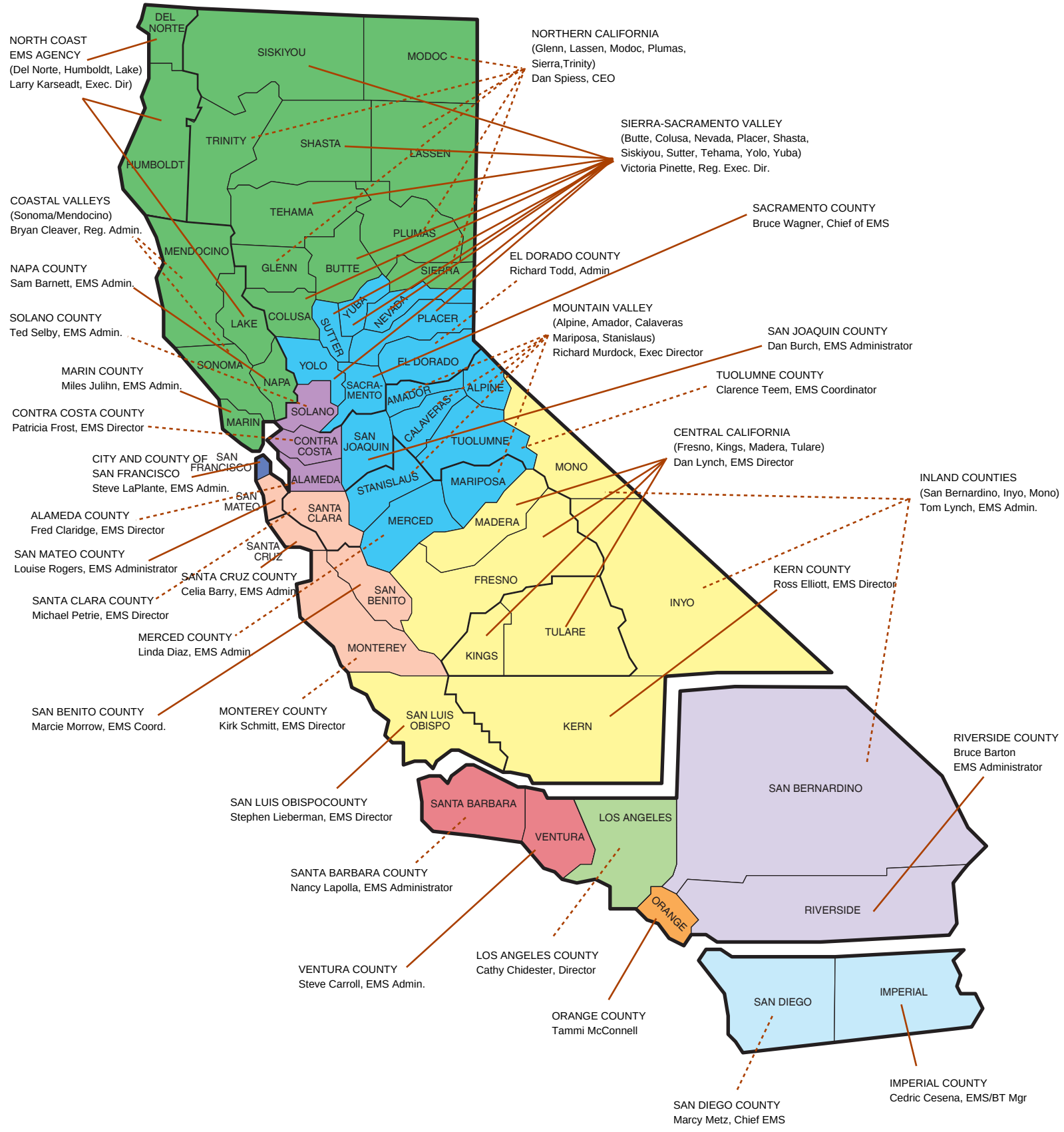


EXHIBIT #2

LEMSA Fee Schedule

Annual Fees charged to	STEMI	Stroke	Trauma	BH	PRC	Comments	
Alameda	$0	$0	$0	$0	$0	Charge ambulance provides a small amount permit fees	
Central California	$0	$0	$0	$0	$0		
Coastal Valleys	$10,000 - $20,000 (formula based on workload defined by patient volume)	$0	$25,000 (Lvl IV); $132,000 (Lvl II)	$40,000	$8,000	Mendocino County hospitals have a $4.75 per pt transport fee in place of annual lump sums for BH and PRC	
Contra Costa	$5,000	$5,000	$250,000	$0	$0		
El Dorado	$0	$0	see note	$0	$0	Trauma Centers must be ACS certified. If EMS agency must go to review anything, they charge $97/hour for medical director + $48/hour for administrator	
ICEMA	$17,400	$19,000	$25,000	$5,000	$0		
Imperial	$0	$0	$0	$0	$0		
Kern	$0	$0	$134,000	$6,000	$0	Base Hospital operating permit: $6,113; Base Hospital operating permit (rural): $3,140; Receiving Hospital operating permit: $1,806; Trauma Center: $134,000	
Los Angeles	$0	$0	$83,880	$0	$0		
Marin	$0	$0	$0	$12,165	$0		
Merced	$0	$0	$0	$0	$0		
Monterey	$0	$0	TBA	$0	$0		
Mountain Valley	$32,000	$0	$75,000	$0	$0		
Napa	$15,000	$5,000	$28,000	$21,787	$0		
North Coast	$15,000	$0	$5,000 - III $2,500 - IV	$2,000	$0	*Base Hospital Closure or Downgrade = $2,000 (we don't charge any sort of annual fee for base, only if they want to shut down)	Initial AIS Provider Fee = $500 (we don't charge any sort of annual fee, only an initial fee)
Northern California	$0	$0	$40,000 Level II (currently have no Trauma Center)	$0	$0	All hospitals pay a fee of $800 + $2.15 per patient arriving by ambulances. All ambulance services pay a fee of $250 + $0.50 per patient contact unless they have annual call volume > 50 calls, then no fee.	Each county pays the Region a contract fee with a base of $10,000 + a variable based on patient contract
Orange	Survey fee ($22,339) every 3 years	$0	$0	$0	$0		

EXHIBIT #2

LEMSA Fee Schedule

Annual Fees charged to	STEMI	Stroke	Trauma	BH	PRC	Comments	
Riverside	$0	$0	$0	$0	$0		
Sacramento	$0	$0	See note	$0	$0	Annual Trauma fees only. UC Davis (Lvl I adult, Lvl I peds) - $101,000; Kaiser (Lvl II adults) $52,000; Sutter Roseville (Lvl II out of county) $4,064	
San Benito	$0	$0	$0	$0	$0		
San Diego	$0	$0	$40,000	$25,000	$0		
San Francisco				$13,000 *		* Per SF General, total FY 2012-13 annual fees = $13,310	
San Joaquin	$25,000	$0	Level II: $150,000/yr Level III: $75,000/yr	$0	$0		
San Luis Obispo	$0	$0	Designation: $85,000; Annual: $45,000	$0	$0	Annual maintenance fee may vary as it is calculated on actual cost with an estimate of staff time/benefits, etc. at 20 hrs/week (1/3 STEMI and 2/3 Trauma)	
San Mateo		$0	$0	$0	$0		
Santa Barbara	$15,000 initial, $10,000 annually thereafter	$0	Level II designation; $125,000 annually		$0		
Santa Clara	$10,000	$10,000	$125,000	$10,000	$10,000		
Santa Cruz	$15,000	$0	$0	$0	$0		
Sierra-Sacramento Valley	Designation $20,000; annual monitoring $10,000	$0	Level I & II $20,000; Level III $10,000	$0		Level IV no fee & no annual fee for any	
Solano	$10,000	$0	$50,000	$0	$0		
Tuolumne	$0	$0	$0	$0	$0		
Ventura	$0	$0	$75,000	$0	$0		

COUNTY OF SACRAMENTO
INTERNAL SERVICES AGENCY
DEPARTMENT OF FINANCE
AUDITOR-CONTROLLER

Inter-Departmental Correspondence

February 13, 2013

To: Sherri Z. Heller
Director of Health and Human Services

DRAFT

From: Julie Valverde
Director of Finance

Subject: **REVIEW OF ESTIMATED COSTS ASSOCIATED WITH PROPOSED EMS FEES**

Per your department's request, we have reviewed the full cost recovery amounts included in the last column of the attached schedule. Our review was limited to reviewing the methodology used in calculating the amount necessary for full cost recovery. We have not reviewed the time estimates or counts used in the calculation.

Based on our review, we concur with the methodology used in calculating the full cost amounts.

If you have any questions regarding this matter, please call Pat Marion at 874-7573.

Attachment

cc: Pat Marion, Department of Finance

PROPOSED NEW FEES

FEE	DESCRIPTION OF FEE	NEW FEE (annual)	FULL COST RECOVERY FEE
MICN Certification	This fee is assessed for certification as a Mobile Intensive Care Nurse.	$ 35 (2 yr)	$ 53 (2 yr)
MICN Training Program	This fee is assessed for approval as a Sacramento County Mobile Intensive Care Nurse Training Program. The amount of this fee will cover the direct cost to the program for providing this service.	$ 782	$ 782
EMT -1 Training Program	This fee is assessed for approval as a Sacramento County EMT -1 Training Program. The amount of this fee will cover the direct cost to the program for providing this service.	$ 1,340	$ 1,340
Paramedic Training Program	This fee is assessed for approval as a Sacramento County Paramedic Training Program. The amount of this fee will cover the direct cost to the program for providing this service.	$ 7,294	$ 7,294
Continuous Education (CE) Provider	This fee is assessed for approval as a Sacramento County Continuous Education Provider. The amount of this fee will cover the direct cost to the program for providing this service.	$ 377	$ 377
ALS Service Provider (non-public)	This fee is assessed for approval as a Sacramento County Advanced Life Support Service Provider. The amount of this fee will cover the direct cost to the program for providing this service.	$ 14,936	$ 14,936

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

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

SUBJECT: CDPH Requested Input on Pre-Regulatory Development

SUMMARY

The California Department of Public Health issued seven All Facilities Letters (AFLs) addressing upcoming changes to its regulations for general acute care hospitals. In each, the department seeks stakeholder input to inform its regulation development process. The letters are:

- AFL 18-30, which applies to hospital administration regulations
- AFL 18-31, which applies to hospital employee/personnel records requirements
- AFL 18-32, which applies to hospital license, supplemental service approval and special permit regulations
- AFL 18-33, which applies to hospital medical records regulations
- AFL 18-34, which applies to hospital medical service regulations
- AFL 18-35, which applies to hospital records and reporting regulations
- AFL 18-36, which applies to small and rural hospital regulations

Instructions for submitting comments, which are due Aug. 31, are included in each letter. Questions should be submitted to CHCQRegulationsUnit@cdph.ca.gov.

ACTION REQUESTED

- Provide CHA feedback on any areas you feel need to be addressed.

DISCUSSION QUESTIONS

- Are there any areas which you have concerns are comments?

Attachments: Title 22 Regulations
AFLs (18-30, 18-31, 18-32, 18-33, 18-34, 18-35, 18-36)

BJB:br

§ 70101. Inspection of Hospitals.
22 CA ADC § 70101
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70101

§ 70101. Inspection of Hospitals.

(a) The Department shall inspect and license hospitals.

(b) Any officer, employee or agent of the Department may, upon presentation of proper identification, enter and inspect any building or premises at any reasonable time to secure compliance with, or to prevent a violation of, any provision of these regulations.

(c) All hospitals for which a license has been issued shall be inspected periodically by a representative or representatives appointed by the Department. Inspections shall be conducted as frequently as necessary, but not less than once every two years, to assure that quality care is being provided. During the inspection, the representative or representatives of the Department shall offer such advice and assistance to the hospital as is appropriate. For hospitals of 100 licensed bed capacity or more, the inspection team shall include at least a physician, registered nurse and persons experienced in hospital administration and sanitary inspections.

(d) The Department may provide consulting services upon request to any hospital to assist in the identification or correction of deficiencies or the upgrading of the quality of care provided by the hospital.

(e) The Department shall notify the hospital of all deficiencies of compliance with these regulations and the hospital shall agree with the Department upon a plan of corrections which shall give the hospital a reasonable time to correct such deficiencies. If at the end of the allotted time, as revealed by repeat inspection, the hospital has failed to correct the deficiencies, the Director may take action to revoke or suspend the license.

(f) Reports on the results of each inspection of a hospital shall be prepared by the inspector or inspection team and shall be kept on file in the Department along with the plan of correction and hospital comments. The inspection report may include a recommendation for reinspection. All inspection reports, lists of deficiencies and plans of correction shall be open to public inspection without regard to which body performs the inspection.

(g) The Department shall have the authority to contract for outside personnel to perform inspections of hospitals as the need arises. The Department, when feasible, shall contract with nonprofit, professional organizations which have demonstrated the ability to carry out the provisions of this section. Such organizations shall include, but not be limited to, the California Medical Association Committee on Medical Staff Surveys and participants in the Consolidated Hospital Survey Program.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70101, 22 CA ADC § 70101

END OF DOCUMENT

§ 70103. License Required.
22 CA ADC § 70103
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70103

§ 70103. License Required.

(a) No person, firm, partnership, association, corporation, political subdivision of the state or other governmental agency shall establish, operate or maintain a hospital, or hold out, represent, or advertise by any means that it operates a hospital, without first obtaining a license from the Department.

(b) The provisions of this article do not apply to any facility conducted by and for the adherents of any well-recognized church or religious denomination for the purpose of providing facilities for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of the religion of such church or denomination.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70103, 22 CA ADC § 70103

END OF DOCUMENT

§ 70105. Application Required.
22 CA ADC § 70105
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70105

§ 70105. Application Required.

(a) A verified application shall be forwarded to the Department whenever any of the following circumstances occur:

(1) Construction of a new or replacement facility or addition to an existing facility.

(2) Increase or decrease of licensed bed capacity.

(3) Added service or change from one service to another.

(4) Change of ownership.

(5) Change of name of hospital.

(6) Change of license category.

(7) Change of location of the hospital.

(8) Change of bed classification.

HISTORY

1. Amendment filed 11-12-76 as an emergency; effective upon filing (Register 76, No. 46).

2. Certificate of Compliance filed 3-8-77 (Register 77, No. 11).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70105, 22 CA ADC § 70105

END OF DOCUMENT

§ 70107. Content of Application.
22 CA ADC § 70107
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70107

§ 70107. Content of Application.

(a) Any person, firm, partnership, association, corporation, political subdivision of the state, state agency or other governmental agency desiring to obtain a license shall file with the Department an application on forms furnished by the Department. The application shall contain the following information:

(1) Name of applicant and, if an individual, verification that the applicant has attained the age of 18 years.

(2) Type of facility to be operated and types of services for which approval is requested.

(3) Location of the hospital.

(4) Name of person in charge of the hospital.

(5) If the applicant is an individual, satisfactory evidence that the applicant is of reputable and responsible character.

(6) If applicant is a firm, association, organization, partnership, business trust, corporation or company, satisfactory evidence that the members or shareholders thereof and the person in charge of the hospital for which application for license is made are of reputable and responsible character.

(7) If the applicant is a political subdivision of the State or other governmental agency, satisfactory evidence that the person in charge of the hospital for which application for license is made is of reputable and responsible character.

(8) If the applicant is a partnership, the name and principal business address of each partner.

(9) If the applicant is a corporation, the name and principal business address of each officer and director of the corporation; and for nonpublic corporations, the name and business address of each stockholder owning 10 percent or more of the stock and any corporate member who has responsibility in the operation of the hospital.

(10) Copy of the current organizational chart.

(11) Certificate of Need or a Certificate of Exemption from the Department if required by Chapter 1, Division 7 of this title.

(12) Such other information or documents as may be required by the Department for the proper administration and enforcement of the licensing law and requirements.

HISTORY

1. Amendment filed 11-12-76 as an emergency; effective upon filing (Register 76, No. 46).

2. Certificate of Compliance filed 3-8-77 (Register 77, No. 11).

3. Amendment of subsection (a)(11) filed 5-25-77; effective thirtieth day thereafter (Register 77, No. 22).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70107, 22 CA ADC § 70107

END OF DOCUMENT

§ 70109. Architectural Plans.
22 CA ADC § 70109
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70109

§ 70109. Architectural Plans.

Applications submitted for proposed construction of new hospitals or additions to licensed hospitals shall include architectural plans and specifications. Information contained in such applications shall be on file in the Department and available to interested individuals and community agencies.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70109, 22 CA ADC § 70109

END OF DOCUMENT

§ 70110. Fee.
22 CA ADC § 70110
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70110

§ 70110. Fee.

(a) Each application for a license shall be accompanied by the prescribed fee as authorized by Health and Safety Code, section 1266.

(b) No fee shall be refunded to the applicant if the application is withdrawn or if the application is denied by the Department.

(c) An additional fee of $25.00 shall be paid for processing any change of name. However, no additional fee shall be charged for any change of name, which is processed upon a renewal application or upon an application filed because of a change of ownership.

(d) Fees for licenses which cover periods in excess of 12 months shall be prorated on the basis of the number of months to be licensed divided by 12 months.

(e) Fees shall be waived for any facility conducted, maintained or operated by this state or any state department, authority, bureau, commission or officer or by the Regents of the University of California or by a local hospital district, city or county.

Note: Authority cited: Sections 1266, 1275 and 131200. Health and Safety Code. Reference: Sections 1266, 131050, 131051 and 131052, Health and Safety Code.

HISTORY

1. New section filed 1-30-80; effective thirtieth day thereafter (Register 80, No. 5).

2. Change without regulatory effect amending subsection (a), repealing subsections (b) and (c), relettering subsections and amending Note filed 1-9-2013 pursuant to section 100, title 1, California Code of Regulations (Register 2013, No. 2).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70110, 22 CA ADC § 70110

END OF DOCUMENT

§ 70115. Safety, Zoning and Building Clearance.
22 CA ADC § 70115
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70115

§ 70115. Safety, Zoning and Building Clearance.

(a) Architectural plans shall not be approved and a license shall not be originally issued to any hospital which does not conform to: the regulations in this chapter; state requirements on seismic safety, fire and life safety and environmental impact; and local fire safety, zoning and building ordinances. Evidence of such compliance shall be presented in writing to the Department.

(b) It shall be the responsibility of the licensee to maintain the hospital in a safe structural condition. If the Department determines that an evaluation of the structural condition of a hospital building is necessary, the licensee may be required to submit a report by a licensed structural engineer which shall establish a basis for eliminating or correcting the structural conditions which are found to be hazardous to occupants.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70115, 22 CA ADC § 70115

END OF DOCUMENT

§ 70117. Issuance, Expiration and Renewal.
22 CA ADC § 70117
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70117

§ 70117. Issuance, Expiration and Renewal.

(a) Upon verification of compliance with the licensing requirements, the Department shall issue the applicant a license.

(b) If the applicant is not in compliance with the laws or regulations, the Department shall deny the applicant a license and shall immediately notify the applicant in writing. Within 20 days of receipt of the Department's notice, the applicant may present his written petition for a hearing to the Department. The Department shall set the matter for hearing within 30 days after receipt of the petition in proper form. The proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Each initial license shall expire at midnight, one year from the date of issue. A renewal license:

(1) May be issued for a period not to exceed two years if the holder of the license has been found not to have been in violation of any statutory requirements, regulations or standards during the preceding license period.

(2) Shall reflect the number of beds that meet construction and operational requirements and shall not include beds formerly located in patient accommodation space which has been permanently converted.

(3) Shall not be issued if the hospital is liable for and has not paid the special fees required by Section 90417, Chapter 1, Division 7, of this Title.

(d) The Department shall mail an application form for renewal of license to the licensee at least 45 days prior to expiration of a license. Application for renewal, accompanied by the necessary fees, shall be filed with the Department annually and not less than ten days prior to the expiration date. Failure to make a timely renewal application shall result in expiration of the license.

HISTORY

1. Amendment of subsection (c) filed 11-12-76 as an emergency; effective upon filing (Register 76, No. 46).

2. Certificate of Compliance filed 3-8-77 (Register 77, No. 11).

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70117, 22 CA ADC § 70117

END OF DOCUMENT

§ 70119. Provisional Licensing of Distinct Parts.
22 CA ADC § 70119
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70119

§ 70119. Provisional Licensing of Distinct Parts.

(a) The initial license, issued by the Department to an applicant when the hospital includes a distinct part which will function as a skilled nursing or intermediate care service, shall include a separate provisional authorization for the distinct part. The provisional authorization for the distinct part service shall terminate six months from the date of issuance. The Department shall give the distinct part, and supporting elements of the hospital, a full and complete inspection within 30 days prior to termination of the provisional authorization. A regular authorization will be included in the license if the hospital and distinct part meet all applicable requirements for licensure. If the hospital does not meet the requirements for licensure but has made substantial progress toward meeting such requirements, as determined by the Department, the initial provisional license shall be renewed for six months. If the Department determines that there has not been substantial progress toward meeting licensure requirements at the time of the first full inspection provided by this section, or if the Department determines upon its inspection made within 30 days of the termination of a renewed provisional license that there is lack of full compliance with such requirements, no further license shall be issued.

(b) An applicant who has been denied provisional licensing may contest such denial by filing a statement of issues, as provided in Section 11504 of the Government Code: The proceedings to review such denial shall be conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500), Part 1, Division 3, Title 2, of the Government Code.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70119, 22 CA ADC § 70119

END OF DOCUMENT

§ 70121. Separate Licenses.
22 CA ADC § 70121
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70121

§ 70121. Separate Licenses.

Separate licenses shall be required for hospitals which are maintained on separate premises even though they are under the same management. This does not apply to outpatient departments or clinics of hospitals designated as such which are maintained and operated on separate premises. Separate licenses shall not be required for separate buildings on the same grounds or adjacent grounds.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70121, 22 CA ADC § 70121

END OF DOCUMENT

§ 70123. Posting.
22 CA ADC § 70123
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70123

§ 70123. Posting.

The license, or a true copy thereof, shall be posted conspicuously in a prominent location within the licensed premises and accessible to public view.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70123, 22 CA ADC § 70123

END OF DOCUMENT

§ 70125. Transferability.
22 CA ADC § 70125
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70125

§ 70125. Transferability.

Licenses are not transferable. The licensee shall notify the Department in writing at least 30 days prior to the effective date of any change of ownership. A new application for license shall be submitted by the prospective new owner.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70125, 22 CA ADC § 70125

END OF DOCUMENT

§ 70127. Report of Changes.
22 CA ADC § 70127
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70127

§ 70127. Report of Changes.

(a) The licensee shall notify the Department in writing any time a change of stockholder owning ten percent or more of the non-public corporate stock occurs. Such notice shall include the name and principal mailing address of the new stockholder.

(b) Each licensee shall notify the Department in writing within ten days prior to any change of the mailing address of the licensee. Such notice shall include the new mailing address of the licensee.

(c) Any change in the principal officer shall be reported in writing within ten days by the licensee to the Department. Such notice shall include the name and principal business address of such officer.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70127, 22 CA ADC § 70127

END OF DOCUMENT

§ 70129. Program Flexibility.
22 CA ADC § 70129
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70129

§ 70129. Program Flexibility.

(a) All hospitals shall maintain continuous compliance with the licensing requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects provided such exceptions are carried out with the provisions for safe and adequate care and with the prior written approval of the Department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the Department.

(b) Hospitals which by reason of remoteness are unable to comply with provisions of the regulations for basic services and perinatal or pediatric services, shall submit a written request to the Department for exception. In reviewing such request, special attention may be required regarding qualifications of medical staff and personnel.

(c) Special exceptions may be granted under this section for hospitals required to provide services and accommodations for persons who may have dangerous propensities necessitating special precautions, personnel with special qualifications, locked accommodations, special protection for windows, type and location of lighting and plumbing fixtures, signal systems, control switches, beds and other furnishings. This applies to psychiatric units and detention facilities where added protection is necessary for patients, staff members and members of the public.

(d) Any approval of the Department granted under this section or a true copy thereof, shall be posted immediately adjacent to the facility's license that is required to be posted by Section 70123.

HISTORY

1. Editorial correction of subsection (b) (Register 95, No. 44).

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70129, 22 CA ADC § 70129

END OF DOCUMENT

§ 70131. Voluntary Suspension of License or Licensed Beds.
22 CA ADC § 70131
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70131

§ 70131. Voluntary Suspension of License or Licensed Beds.

(a) Upon written request, a licensee may request that his license or licensed beds be put in suspense. The Department may approve the request for a period not to exceed 12 months.

(b) Any license or portion thereof which ha been temporarily suspended by the Department pursuant to this section shall remain subject to all renewal requirements of an active license, includingthe payment of license renewal fees, during the period of temporary suspension.

(c) Any license suspended pursuant to this section may be reinstated by the Department within 12 months of the date of suspension upon receipt of an application and evidence showing compliance with licensing operational requirements in effect at the time of reinstatement. If the license is not reinstated within the 12 month period, the license shall expire automatically and shall not be subject to reinstatement.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70131, 22 CA ADC § 70131

END OF DOCUMENT

§ 70133. Voluntary Cancellation of License.
22 CA ADC § 70133
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70133

§ 70133. Voluntary Cancellation of License.

(a) The licensee shall notify the Department in writing as soon as possible and in all cases at least 30 days prior to the desired effective date of cancellation of the license.

(b) Any license voluntarily cancelled pursuant to this section may be reinstated by the Department within 12 months of the date of voluntary cancellation upon receipt of an application along with evidence showing compliance with operational and construction licensing requirements.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70133, 22 CA ADC § 70133

END OF DOCUMENT

§ 70135. Revocation or Involuntary Suspension of License.
22 CA ADC § 70135
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70135

§ 70135. Revocation or Involuntary Suspension of License.

(a) Pursuant to provisions of Chapter 5 (commencing with Section 11500), Part 1, Division 3, of Title 2, Government Code, the Department may suspend or revoke any license issued under the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, upon any of the following grounds.

(1) Violation by the licensee of any of the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the regulations promulgated by the Department.

(2) Aiding, abetting or permitting the violation of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the regulations promulgated by the Department.

(3) Conduct inimical to the public health, morals, welfare or safety of the people of the State of California in the maintenance and operation of the premises or services for which a license is issued.

(b) The license of any hospital against which special fees are required by Section 90417, Chapter 1, Division 7, of this Title shall be revoked, after notice of hearing, if it is determined by the Department that the fees required were not paid within the time prescribed.

(c) The Director may temporarily suspend any license prior to any hearing when, in his opinion, such action is necessary to protect the public welfare.

(1) The Director shall notify the licensee of the temporary suspension and the effective date thereof and at the same time shall serve such licen -see with an accusation.

(2) Upon receipt of a notice of defense by the licensee, the Director shall set the matter for hearing within 15 days. The hearing shall be held as soon as possible but no later than 30 days after receipt of such notice.

(3) The temporary suspension shall remain in effect until such time as the hearing is completed and the Director has made a final determination.

(4) If the Director fails to make a final determination within 60 days after the original hearing has been completed, the temporary suspension shall be deemed vacated.

(5) If the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the regulations promulgated by the Director are violated by a licensee which is a group, corporation or other association, the Director may suspend the license of such organization or may suspend the license as to any individual person within such organization who is responsible for such violation.

(d) The withdrawal of an application for a license shall not deprive the Department of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground, unless the Department consents in writing to such withdrawal.

(e) The suspension, expiration or forfeiture of a license issued by the Department shall not deprive the Department of its authority to institute or continue a proceeding against the license upon any ground provided by law or to enter an order suspending or revoking a license or otherwise taking disciplinary action against the licensee on any such ground.

Note: Authority cited: Section 208(a), Health and Safety Code. Reference: Section 1296, Health and Safety Code.

HISTORY

1. Amendment filed 11-12-76 as an emergency; effective upon filing (Register 76, No. 46).

2. Certificate of Compliance filed 3-8-77 (Register 77, No. 11).

3. Amendment of subsection (c)(2) filed 7-25-79; effective thirtieth day thereafter (Register 79, No. 30).

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70135, 22 CA ADC § 70135

END OF DOCUMENT

§ 70136. Conviction of Crime: Standards for Evaluating Rehabilitation.
22 CA ADC § 70136
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70136

§ 70136. Conviction of Crime: Standards for Evaluating Rehabilitation.

When considering the denial, suspension or revocation of a license based on the conviction of a crime in accordance with Section 1265.1 or 1294 of the Health and Safety Code, the following criteria shall be considered in evaluating rehabilitation:

(1) The nature and the seriousness of the crime(s) under consideration.

(2) Evidence of conduct subsequent to the crime which suggests responsible or irresponsible character.

(3) The time which has elapsed since commission of the crime(s) or conduct referred to in subdivision (1) or (2).

(4) The extent to which the applicant has complied with any terms of parole, probation, restitution, or any other sanction lawfully imposed against the applicant.

(5) Any rehabilitation evidence submitted by the applicant.

Note: Authority cited: Sections 208(a), 1265.2 and 1275, Health and Safety Code. Reference: Sections 1265.1, 1265.2 and 1294, Health and Safety Code.

HISTORY

1. New section filed 9-13-84; effective thirtieth day thereafter (Register 84, No. 37).

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70136, 22 CA ADC § 70136

END OF DOCUMENT

§ 70137. Bonds.
22 CA ADC § 70137
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 2. License (Refs & Annos)

22 CCR § 70137

§ 70137. Bonds.

(a) Each licensee shall file or have on file with the Department a bond issued by a surety company admitted to do business in this State if the licensee is handling or will handle money in the amount of $25 or more per patient or $500 or more for all patients in any month.

(1) The amount of the bond shall be according to the following schedule:

Amount Handled	Bond Required
$750 or less	$1,000
$751 to $1,500	$2,000
$1,501 to $2,500	$3,000

(2) Every further increment of $1,000 or fraction thereof shall require an additional $1,000 on the bond.

(b) Each application for an original license or renewal of license shall be accompanied by an affidavit on a form provided by the Department. The affidavit shall state whether the licensee handles or will handle money of patients and the maximum amount of money to be handled for any patient and for all patients in any month.

(c) No licensee shall either handle money of a patient or handle amounts greater than those stated in the affidavit submitted by him without first notifying the Department and filing a new or revised bond if required.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70137, 22 CA ADC § 70137

END OF DOCUMENT

§ 70201. Medical Service Definition.
22 CA ADC § 70201
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 3. Basic Services (Refs & Annos)

22 CCR § 70201

§ 70201. Medical Service Definition.

Medical service means those preventive, diagnostic and therapeutic measures performed by or at the request of members of the organized medical staff.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70201, 22 CA ADC § 70201

END OF DOCUMENT

§ 70203. Medical Service General Requirements.
22 CA ADC § 70203
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 3. Basic Services (Refs & Annos)

22 CCR § 70203

§ 70203. Medical Service General Requirements.

(a) A committee of the medical staff shall be assigned responsibility for:

(1) Recommending to the governing body the delineation of medical privileges.

(2) Developing, maintaining and implementing written policies and procedures in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.

(3) Developing and instituting, in conjunction with members of the medial staff and other hospital services, a continuing cardiopulmonary resuscitation training program.

(4) Determining what emergency equipment and supplies should be available in all areas of the hospital.

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

(c) The following shall be available to all patients in the hospital:

(1) Electrocardiographic testing.

(2) Pulmonary function testing.

(3) Intermittent positive pressure breathing apparatus.

(4) Cardiac monitoring capability.

(5) Suction.

(d) 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.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70203, 22 CA ADC § 70203

END OF DOCUMENT

§ 70205. Medical Service Staff.
22 CA ADC § 70205
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 3. Basic Services (Refs & Annos)

22 CCR § 70205

§ 70205. Medical Service Staff.

A physician shall have overall responsibility for the medical service. This physician shall be certified or eligible for certification in internal medicine by the American Board of Internal Medicine. If such an internist is not available, a physician, with training and experience in internal medicine, shall be responsible for the service.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70205, 22 CA ADC § 70205

END OF DOCUMENT

§ 70207. Medical Service Equipment and Supplies.
22 CA ADC § 70207
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 3. Basic Services (Refs & Annos)

22 CCR § 70207

§ 70207. Medical Service Equipment and Supplies.

There shall be adequate equipment and supplies maintained related to the nature of the needs and the services offered.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70207, 22 CA ADC § 70207

END OF DOCUMENT

§ 70209. Medical Service Space.
22 CA ADC § 70209
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 3. Basic Services (Refs & Annos)

22 CCR § 70209

§ 70209. Medical Service Space.

There shall be adequate space maintained to meet the needs of the service.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70209, 22 CA ADC § 70209

END OF DOCUMENT

§ 70301. Supplemental Service Approval Required.
22 CA ADC § 70301
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 4. Supplemental Service Approval (Refs & Annos)

22 CCR § 70301

§ 70301. Supplemental Service Approval Required.

(a) Any licensee desiring to establish or conduct, or who holds out, represents or advertises by any means the provision of a supplemental service, shall obtain prior approval from the Department or a special permit if required by Section 70351.

(b) The provisions of this Article shall apply only to any supplemental service for which a special permit is not required.

(c) Any licensee who offers a supplemental service for which approval is now required under these regulations is authorized to continue furnishing such service without obtaining approval until the Department inspects and evaluates the quality of the service and determines whether such service meets the requirements for the service contained in these regulations. If the Department determines that the service meets such requirements, it shall notify the licensee in writing. If the Department determines that the service does not meet the requirements, it shall so notify the licensee of all deficiencies of compliance with these regulations and the hospital shall agree with the Department upon a plan of corrections which shall give the hospital a reasonable time to correct such deficiencies. If at the end of the allotted time, as revealed by repeat inspection, the hospital has failed to correct the deficiencies, the licensee shall cease and desist all holding out, advertising or otherwise representing that it furnishes such recognized service.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70301, 22 CA ADC § 70301

END OF DOCUMENT

§ 70303. Application.
22 CA ADC § 70303
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 4. Supplemental Service Approval (Refs & Annos)

22 CCR § 70303

§ 70303. Application.

Any licensee desiring approval for a supplemental service shall file with the Department an application on forms furnished by the Department.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70303, 22 CA ADC § 70303

END OF DOCUMENT

§ 70305. Issuance, Expiration and Renewal.
22 CA ADC § 70305
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 4. Supplemental Service Approval (Refs & Annos)

22 CCR § 70305

§ 70305. Issuance, Expiration and Renewal.

(a) The Department shall list on the hospital license each supplemental service for which approval is granted.

(b) If the applicant is not in compliance with the laws and regulations, the Department shall deny the applicant approval and shall immediately notify the applicant in writing. Within 20 days of receipt of the Department's notice, the applicant may present his written petition for a hearing to the Department. The Department shall set the matter for hearing within 30 days after receipt of the petition in proper form. The proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Each supplemental service approval shall expire on the date of expiration of the hospital license. A renewal of the approval may be issued for a period not to exceed two years if the holder of the approval has been found not to have been in violation of any statutory requirements, regulations or standards during the preceding approval period.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70305, 22 CA ADC § 70305

END OF DOCUMENT

§ 70307. Program Flexibility.
22 CA ADC § 70307
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 4. Supplemental Service Approval (Refs & Annos)

22 CCR § 70307

§ 70307. Program Flexibility.

(a) All hospitals shall maintain continuous compliance with the supplemental service requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects provided such exceptions are carried out with the prior written approval of the Department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the Department.

(b) Any approval granted by the Department pursuant to this section, or a true copy thereof, shall be posted immediately adjacent to the facility's license required to be posted by Section 70123.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70307, 22 CA ADC § 70307

END OF DOCUMENT

§ 70309. Revocation or Involuntary Suspension of Approval.
22 CA ADC § 70309
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 4. Supplemental Service Approval (Refs & Annos)

22 CCR § 70309

§ 70309. Revocation or Involuntary Suspension of Approval.

(a) Pursuant to provisions of Chapter 5 (commencing with Section 11500) Part I, Division 3, Government Code, the Department may suspend or revoke the approval of a supplemental service issued under the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, upon any of the following grounds:

(1) Violation by the licensee of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or of the supplemental service regulations promulgated by the Department.

(2) Aiding, abetting or permitting the violation of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or of any supplemental service regulations promulgated by the Department.

(3) Conduct inimical to the public health, morals, welfare or safety of the people of the State of California in the maintenance and operation of a supplemental service.

(b) The Director may temporarily suspend any supplemental service approval prior to any hearing when, in his opinion, such action is necessary to protect the public welfare.

(1) The Director shall notify the licensee of the temporary suspension and the effective date thereof and at the same time shall serve such licensee with an accusation.

(2) Upon receipt of a notice of contest by the licensee, the Director shall set the matter for hearing within 30 days after receipt of such notice.

(3) The temporary suspension shall remain in effect until such time as the hearing is completed and the Director has made a final determination.

(4) If the Director fails to make a final determination within 60 days after the original hearing has been completed, the temporary suspension shall be deemed vacated.

(5) If the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the supplemental service regulations promulgated by the Director are violated by a licensee which is a group, corporation or other association, the Director may suspend the approval of such organization or may suspend the approval as to any individual person within such organization who is responsible for such violation.

(c) The withdrawal of an application for approval shall not deprive the Department of its authority to institute or continue a proceeding against the applicant for the denial of the approval upon any group provided by law or to enter an order denying the approval upon any such ground, unless the Department consents in writing to such withdrawal.

(d) The suspension, expiration or forfeiture of an approval issued by the Department shall not deprive the Department of its authority to institute or continue a proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking approval or otherwise taking disciplinary action against the licensee on any such ground.

(e) A licensee whose approval has been revoked or suspended may petition the Department for reinstatement or reduction of penalty after a period of not less than one year has elapsed from the effective date of the decision or from the date of the denial of a similar petition.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70309, 22 CA ADC § 70309

END OF DOCUMENT

§ 70351. Special Permit Required.
22 CA ADC § 70351
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 5. Special Permit (Refs & Annos)

22 CCR § 70351

§ 70351. Special Permit Required.

(a) Any licensee desiring to establish or conduct, or who holds out, represents or advertises by any means, the performance of a special service shall obtain a special permit from the Department.

(b) The following supplemental services are also special services for which a special permit is required:

(1) Basic emergency medical service.

(2) Burn center.

(3) Cardiovascular surgery service.

(4) Chronic dialysis unit.

(5) Comprehensive emergency medical service.

(6) Intensive care newborn nursery service.

(7) Psychiatric unit.

(8) Radiation therapy service.

(9) Renal transplant center.

HISTORY

1. Amendment filed 11-12-76 as an emergency; effective upon filing (Register 76, No. 46).

2. Certificate of Compliance filed 3-8-77 (Register 77, No. 11).

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70351, 22 CA ADC § 70351

END OF DOCUMENT

§ 70353. Application.
22 CA ADC § 70353
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 5. Special Permit (Refs & Annos)

22 CCR § 70353

§ 70353. Application.

Any licensee desiring to obtain a special permit shall file with the Department an application on forms furnished by the Department. Such other information or documents as may be required for the proper administration and enforcement of the licensing law and requirements shall be submitted with the application.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70353, 22 CA ADC § 70353

END OF DOCUMENT

§ 70357. Issuance, Expiration and Renewal.
22 CA ADC § 70357
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 5. Special Permit (Refs & Annos)

22 CCR § 70357

§ 70357. Issuance, Expiration and Renewal.

(a) Upon verification of compliance with the supplemental service requirements for any service which is a special service, the Department shall issue a special permit except that no special permit shall be issued for new special services for which there is no valid, subsisting, and unexpired Certificate of Need or Certificate of Exemption.

HISTORY

1. Amendment filed 11-12-76 as an emergency; effective upon filing (Register 76, No. 46).

2. Certificate of Compliance filed 3-8-77 (Register 77, No. 11).

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70357, 22 CA ADC § 70357

END OF DOCUMENT

§ 70359. Posting.
22 CA ADC § 70359
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 5. Special Permit (Refs & Annos)

22 CCR § 70359

§ 70359. Posting.

The special permit, or a true copy thereof, shall be posted conspicuously in a prominent location within the licensed premises and accessible to public view.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70359, 22 CA ADC § 70359

END OF DOCUMENT

§ 70361. Transferability.
22 CA ADC § 70361
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 5. Special Permit (Refs & Annos)

22 CCR § 70361

§ 70361. Transferability.

Special permits are not transferable. The licensee shall notify the Department in writing at least 30 days prior to the effective date of any change of ownership. A new application for special permit shall be submitted by the prospective new owner.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70361, 22 CA ADC § 70361

END OF DOCUMENT

§ 70363. Program Flexibility.
22 CA ADC § 70363
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 5. Special Permit (Refs & Annos)

22 CCR § 70363

§ 70363. Program Flexibility.

(a) All hospitals shall maintain continuous compliance with the special permit requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects provided such exceptions are carried out with the prior written approval of the Department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the Department.

(b) Any approval granted by the Department pursuant to this section, or a true copy thereof, shall be posted immediately adjacent to the facility's license required to be posted by Section 70123.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70363, 22 CA ADC § 70363

END OF DOCUMENT

§ 70365. Voluntary Suspension of Special Permit.
22 CA ADC § 70365
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 5. Special Permit (Refs & Annos)

22 CCR § 70365

§ 70365. Voluntary Suspension of Special Permit.

(a) Upon written request and good cause, a licensee may request that a special permit be put in suspense. The Department may approve the request for a period not to exceed 12 months.

(b) Any special permit which has been temporarily suspended by the Department pursuant to this section shall remain subject to all renewal requirements of an active special permit, including the payment of renewal fees, during the period of temporary suspension.

(c) Any special permit suspended pursuant to this section may be reinstated by the Department within 12 months of the date of suspension upon receipt of an application and evidence showing compliance with supplemental service requirements in effect at the time of reinstatement. If the special permit is not reinstated within the 12-month period, the special permit shall expire automatically.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70365, 22 CA ADC § 70365

END OF DOCUMENT

§ 70367. Voluntary Cancellation of Special Permit.
22 CA ADC § 70367
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 5. Special Permit (Refs & Annos)

22 CCR § 70367

§ 70367. Voluntary Cancellation of Special Permit.

(a) The licensee shall notify the Department in writing as soon as possible and in all cases at least 30 days prior to the effective date of cancellation of a special permit.

(b) Any special permit cancelled pursuant to this section may be reinstated by the Department on receipt of an application along with evidence showing compliance with supplemental service requirements.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70367, 22 CA ADC § 70367

END OF DOCUMENT

§ 70369. Revocation or Involuntary Suspension of Special Permit.
22 CA ADC § 70369
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 5. Special Permit (Refs & Annos)

22 CCR § 70369

§ 70369. Revocation or Involuntary Suspension of Special Permit.

(a) Pursuant to provisions of Chapter 5 (commencing with Section 11500), Part I, Division 3, Title 2, Government Code, the Department may suspend or revoke any special permit issued under the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, upon any of the following grounds:

(1) Violation by the licensee of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or of the supplemental service regulations promulgated by the Department.

(2) Aiding, abetting or permitting the violation of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or supplemental service regulations promulgated by the Department.

(3) Conduct inimical to the public health, morals, welfare or safety of the people of the State of California in the maintenance and operation of a supplemental service.

(b) The Director may temporarily suspend any special permit prior to any hearing when, in his opinion, such action is necessary to protect the public welfare.

(1) The Director shall notify the licensee of the temporary suspension and the effective date thereof and at the same time shall serve such licensee with an accusation.

(2) Upon receipt of a notice of contest by the licensee, the Director shall set the matter for hearing within 30 days after receipt of such notice.

(3) The temporary suspension shall remain in effect until such time as the hearing is completed and the Director has made a final determination.

(4) If the Director fails to make a final determination within 60 days after the original hearing has been completed, the temporary suspension shall be deemed vacated.

(5) If the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the regulations promulgated by the Director are violated by a licensee which is a group, corporation or other association, the Director may suspend the special permit of such organization or may suspend the special permit as to any individual person within such organization who is responsible for such violation.

(c) The withdrawal of an application for a special permit shall not deprive the Department of its authority to institute or continue a proceeding against the applicant for the denial of the special permit upon any group provided by law or to enter an order denying the special permit upon any such ground, unless the Department consents in writing to such withdrawal.

(d) The suspension, expiration or forfeiture of a special permit issued by the Department shall not deprive the Department of its authority to institute or continue a proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking a special permit or otherwise taking disciplinary action against the licensee on any such ground.

(e) A person whose special permit has been revoked or suspended may petition the Department for reinstatement or reduction of penalty after a period of not less than one year has elapsed from the effective date of the decision or from the date of the denial of a similar petition.

This database is current through 7/20/18 Register 2018, No. 29

22 CCR § 70369, 22 CA ADC § 70369

END OF DOCUMENT

§ 70701. Governing Body.
22 CA ADC § 70701
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70701

§ 70701. Governing Body.

(a) The governing body shall:

(1) Adopt written bylaws in accordance with legal requirements and its community responsibility which shall include but not be limited to provision for:

(A) Identification of the purposes of the hospital and the means of fulfilling them.

(B) Appointment and reappointment of members of the medical staff.

(C) Appointment and reappointment of one or more dentists, podiatrists, and/or clinical psychologists to the medical staff respectively, when dental, podiatric, and/or clinical psychological services are provided.

(D) Formal organization of the medical staff with appropriate officers and bylaws.

(E) Membership on the medical staff which shall be restricted to physicians, dentists, podiatrists, and clinical psychologists competent in their respective fields, worthy in character and in professional ethics. No hospital shall discriminate with respect to employment, staff privileges or the provision of professional services against a licensed clinical psychologist within the scope of his/her licensure, or against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O. or D.P.M. degree. Wherever staffing requirements for a service mandate that the physician responsible for the service be certified or eligible for certification by an appropriate American medical board, such position may be filled by an osteopathic physician who is certified or eligible for certification by the equivalent appropriate American Osteopathic Board.

(F) Self-government by the medical staff with respect to the professional work performed in the hospital, periodic meetings of the medical staff to review and analyze at regular intervals their clinical experience and requirement that the medical records of the patients shall be the basis for such review and analysis.

(G) Preparation and maintenance of a complete and accurate medical record for each patient.

(2) Appoint an administrator whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body.

(3) The Department shall be notified in writing whenever a change of administrator occurs.

(4) Provide appropriate physical resources and personnel required to meet the needs of the patients and shall participate in planning to meet the health needs of the community.

(5) Take all reasonable steps to conform to all applicable federal, state and local laws and regulations, including those relating to licensure, fire inspection and other safety measures.

(6) Provide for the control and use of the physical and financial resources of the hospital.

(7) Require that the medical staff establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical staff be required to demonstrate their ability to perform surgical and/or other procedures competently and to the satisfaction of an appropriate committee or committees of the staff, at the time of original application for appointment to the staff and at least every two years thereafter.

(8) Assure that medical staff by-laws, rules and regulations are subject to governing body approval, which approval shall not be withheld unreasonably.

(9) These by-laws shall include an effective formal means for the medical staff, as a liaison, to participate in the development of all hospital policy.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

HISTORY

1. Amendment filed 2-8-83; designated effective 3-2-83 (Register 83, No. 7).

2. Editorial correction of subsection (a)(7) filed 8-31-83; effective thirtieth day thereafter (Register 83, No. 36).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70701, 22 CA ADC § 70701

END OF DOCUMENT

§ 70703. Organized Medical Staff.
22 CA ADC § 70703
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70703

§ 70703. Organized Medical Staff.

(a) Each hospital shall have an organized medical staff responsible to the governing body for the adequacy and quality of the care rendered to patients.

(1) The medical staff shall be composed of physicians and, where dental or podiatric services are provided, dentists or podiatrists.

(2) As required by section 1316.5 of the Health and Safety Code:

(A) Where clinical psychological services are provided by clinical psychologists, in a health facility owned and operated by the state, the facility shall establish rules and medical staff bylaws that include provisions for medical staff membership and clinical privileges for clinical psychologists within the scope of their licensure as psychologists.

(B) Where clinical psychological services are provided by clinical psychologists, in a health facility not owned or operated by this state, the facility may enable the appointment of clinical psychologists to the medical staff.

(b) The medical staff, by vote of the members and with the approval of the governing body, shall adopt written by-laws which provide formal procedures for the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeals mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate. The medical staff shall abide by and establish a means of enforcement of its by-laws. Medical staff by-laws, rules and regulations shall not deny or restrict within the scope of their licensure, the voting right of staff members or assign staff members to any special class or category of staff membership, based upon whether such staff members hold an M.D., D.O., D.P.M., or D.D.S. degree or clinical psychology license.

(c) The medical staff shall meet regularly. Minutes of each meeting shall be retained and filed at the hospital.

(d) The medical staff by-laws, rules, and regulations shall include, but shall not be limited to, provision for the performance of the following functions: executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting the medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services. These functions may be performed by individual committees, or when appropriate, all functions or more than one function may be performed by a single committee. Reports of activities and recommendations relating to these functions shall be made to the executive committee and the governing body as frequently as necessary and at least quarterly.

(e) The medical staff shall provide in its by-laws, rules and regulations for appropriate practices and procedures to be observed in the various departments of the hospital. In this connection the practice of division of fees, under any guise whatsoever, shall be prohibited and any such division of fees shall be cause for exclusion from the staff.

(f) The medical staff shall provide for availability of staff physicians or psychologists for emergencies among the in-hospital population in the event that the attending physician or psychologist or his or her alternate is not available.

(g) The medical staff shall participate in a continuing program of professional education. The results of retrospective medical care evaluation shall be used to determine the continuing education needs. Evidence of participation in such programs shall be available.

(h) The medical staff shall develop criteria under which consultation will be required. These criteria shall not preclude the requirement for consultations on any patient when the director of the service, chairman of a department or the chief of staff determines a patient will benefit from such consultation.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1315, 1316, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

HISTORY

1. Amendment filed 2-8-83; designated effective 3-2-83 (Register 83, No. 7).

2. Amendment of subsection (d) filed 10-3-88; operative 11-2-88 (Register 88, No. 41).

3. Amendment filed 6-15-89 as an emergency; operative 6-15-89 (Register 89, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-13-89.

4. Certificate of Compliance as to 6-15-89 order transmitted to OAL on 10-13-89 and disapproved by OAL on 11-13-89 (Register 89, No 46).

5. Amendment refiled 11-16-89 as an emergency; operative 11-16-89 (Register 89, No. 46). A Certificate of Compliance must be transmitted to OAL within 120 days or the section will be reinstated as it existed prior to the emergency on 3-16-90.

6. Certificate of Compliance as to 11-16-89 order transmitted to OAL 3-15-90 and filed 4-16-90 (Register 90, No. 17).

7. Amendment of section and Note filed 3-3-2010; operative 4-2-2010 (Register 2010, No. 10).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70703, 22 CA ADC § 70703

END OF DOCUMENT

§ 70705. Medical Staff, Residents, Interns and Students.
22 CA ADC § 70705
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70705

§ 70705. Medical Staff, Residents, Interns and Students.

(a) The hospital shall not permit any physician, dentist, podiatrist, or clinical psychologist or any medical, dental, podiatric or clinical psychology resident, intern or student to perform any service for which a license, certificate of registration or other form of approval is required unless such person is licensed, registered, approved or is exempted therefrom under the provisions of the State Medical Practice Act, the State Dental Practice Act, the State Podiatric Practice Act, or the State Psychology Licensing Law and, further, unless such services are performed under the direct supervision of licensed practitioner whenever so required by law.

(b) If patient care is provided by residents, interns and medical students, such care shall be in accordance with the provisions of a program approved by and in conformity with: the Council on Education of the American Medical Association, the American Osteopathic Association Board of Trustees through the Committee on postdoctoral training and the Bureau of Professional Education, the American Dental Association, the American Podiatry Association, or the Education and Training Board of the American Psychological Association and/or the residency training programs of the respective specialty boards.

(c) Except in an emergency, all other patient care by interns, house officers, residents or persons with equivalent titles, not provided as specified in subdivision (b) of this section, must be provided by a practitioner with a current license to practice in California.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

HISTORY

1. Amendment filed 2-8-83; designated effective 3-2-83 (Register 83, No. 7).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70705, 22 CA ADC § 70705

END OF DOCUMENT

§ 70706. Interdisciplinary Practice and Responsibility for Patient Care.
22 CA ADC § 70706
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70706

§ 70706. Interdisciplinary Practice and Responsibility for Patient Care.

(a) In any facility where registered nurses will perform functions requiring standardized procedures pursuant to Section 2725 of the Business and Professions Code, or in which licensed or certified healing arts professionals who are not members of the medical staff will be granted privileges pursuant to Section 70706.1 there shall be a Committee on Interdisciplinary Practice established by and accountable to the Governing Body, for establishing policies and procedures for interdisciplinary medical practice.

(b) The Committee on Interdisciplinary Practice shall include, as a minimum, the director of nursing, the administrator or designee, and an equal number of physicians appointed by the Executive Committee of the medical staff, and registered nurses appointed by the director of nursing. When the hospital has a psychiatric unit and one or more clinical psychologists on its medical staff, one or more clinical psychologists shall be appointed to the Committee on Interdisciplinary Practice by the Executive Committee of the medical staff. Licensed or certified health professionals other than registered nurses who are performing or will perform functions as in (a) above shall be included in the Committee.

(c) The Committee on Interdisciplinary Practice shall establish written policies and procedures for the conduct of its business. Policies and procedures shall include but not be limited to:

(1) Provision for securing recommendations from members of the medical staff in the medical specialty, or clinical field of practice under review, and from persons in the appropriate nonmedical category who practice in the clinical field or specialty under review.

(2) Method for the approval of standardized procedures in accordance with Sections 2725 of the Business and Professions Code in which affirmative approval of the administrator or designee and a majority of the physician members and a majority of the registered nurse members would be required and that prior to such approval, consultation shall be obtained from facility staff in the medical and nursing specialties under review.

(3) Providing for maintaining clear lines of responsibility of the nursing service for nursing care of patients and of the medical staff for medical services in the facility.

(4) Intended line of approval for each recommendation of the Committee.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

HISTORY

1. New section filed 3-13-80; effective thirtieth day thereafter (Register 80, No. 11).

2. Amendment of subsections (b) and (c)(2) and Note filed 3-3-2010; operative 4-2-2010 (Register 2010, No. 10).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70706, 22 CA ADC § 70706

END OF DOCUMENT

§ 70706.1. Granting of Nonphysician Privileges.
22 CA ADC § 70706.1
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70706.1

§ 70706.1. Granting of Nonphysician Privileges.

(a) Registered Nurses. The Committee on Interdisciplinary Practice shall be responsible for recommending policies and procedures for the granting of expanded role privileges to registered nurses, whether or not employed by the facility, to provide for the assessment, planning, and direction of the diagnostic and therapeutic care of a patient in a licensed health facility. These policies and procedures will be administered by the Committee on Interdisciplinary Practice which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges.

(b) Physician's Assistant. A physician's assistant who practices in a licensed facility shall be supervised by a physician approved by the Division of Allied Health Professions of the Medical Board of California who is a member of the active medical staff of that facility. Physician's assistants shall apply to and be approved by the Executive Committee of the medical staff of the facility in which the physician's assistant wishes to practice.

Note: Authority cited: Section 1275 and 131200, Health and Safety Code. Reference: Sections 1276, 131050, 131051 and 131052, Health and Safety Code.

HISTORY

1. New section filed 3-13-80; effective thirtieth day thereafter (Register 80, No. 11).

2. Change without regulatory effect amending subsection (b) and amending Note filed 3-12-2013 pursuant to section 100, title 1, California Code of Regulations (Register 2013, No. 11).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70706.1, 22 CA ADC § 70706.1

END OF DOCUMENT

§ 70706.2. Standardized Procedures.
22 CA ADC § 70706.2
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70706.2

§ 70706.2. Standardized Procedures.

(a) The Committee on Interdisciplinary Practice shall be responsible for:

(1) Identifying functions and/or procedures which require the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the facility, and initiating the preparation of such standardized procedures in accordance with this section.

(2) The review and approval of all such standardized procedures covering practice by registered nurses in the facility.

(3) Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee on Interdisciplinary Practice or by delegation to the director of nursing.

(b) Each standardized procedure shall:

(1) Be in writing and show date or dates of approval including approval by the Committee on Interdisciplinary Practice.

(2) Specify the standardized procedure functions which registered nurses are authorized to perform and under what circumstances.

(3) State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure.

(4) Specify any experience, training or special education requirements for performance of the functions.

(5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the functions.

(6) Provide for a method of maintaining a written record of those persons authorized to perform the functions.

(7) Specify the nature and scope of review and/or supervision required for the performance of the standardized procedure functions; for example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated.

(8) Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition.

(9) State any limitations on settings or departments within the facility where the standardized procedure functions may be performed.

(10) Specify any special requirements for procedures relating to patient recordkeeping.

(11) Provide fo periodic review of the standardized procedure.

(c) If nurses have been approved to perform procedures pursuant to a standardized procedure, the names of the nurses so approved shall be on file in the office of the director of nursing.

Note: Authority cited: Section 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

HISTORY

1. New section filed 3-13-80; effective thirtieth day thereafter (Register 80, No. 11).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70706.2, 22 CA ADC § 70706.2

END OF DOCUMENT

§ 70719. Personnel Policies.
22 CA ADC § 70719
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70719

§ 70719. Personnel Policies.

(a) Each hospital shall adopt written personnel policies concerning qualifications, responsibilities and conditions of employment for each type of personnel, which shall be available to all personnel. Such policies shall include but not be limited to:

(1) Wage scales, hours of work and all employee benefits.

(2) A plan for orientation of all personnel to policies and objectives of the hospital and for on-the-job training where necessary.

(3) A plan for at least an annual evaluation of employee performance.

(b) Personnel policies shall require that employees and other persons working in or for the hospital familiarize themselves with these and such other regulations as are applicable to their duties.

(c) Hospitals shall furnish written evidence of a plan for growth and development of the hospital staff through:

(1) Designation of a staff member qualified by training and experience who shall be responsible for staff education.

(2) Reference material relevant to the services provided by the hospital which shall be readily accessible to the staff.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70719, 22 CA ADC § 70719

END OF DOCUMENT

§ 70721. Employees.
22 CA ADC § 70721
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70721

§ 70721. Employees.

(a) The hospital shall recruit qualified personnel and provide initial orientation of new employees, a continuing in-service training program and competent supervision designed to improve patient care and employee efficiency.

(b) If language or communication barriers exist between hospital staff and a significant number of patients, arrangements shall be made for interpreters or for the use of other mechanisms to insure adequate communications between patients and personnel.

(c) The hospital shall designate a member of the staff as a patient discharge planning coordinator.

(d) All employees of the hospital having patient contact, including students, interns and residents, shall wear an identification tag bearing their name and vocational classification.

(e) Appropriate employees shall be given training in methods of hospital infection control and cardiopulmonary resuscitation.

(f) Uniform rules shall be established for each classification of employees concerning the conditions of employment. A written statement of all such rules shall be provided each employee upon commencing employment.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70721, 22 CA ADC § 70721

END OF DOCUMENT

§ 70723. Employee Health Examinations and Health Records.
22 CA ADC § 70723
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70723

§ 70723. Employee Health Examinations and Health Records.

(a) Personnel evidencing signs or symptoms indicating the presence of an infectious disease shall be medically screened prior to having patient contact. Those employees determined to have infectious potential as defined by the Infection Control Committee shall be denied or removed from patient contact until it has been determined that the individual is no longer infectious.

(b) A health examination, performed by a person lawfully authorized to perform such an examination, shall be required as a requisite for employment and must be performed within one week after employment. Written examination reports, signed by the person performing the examination, shall verify that employees are able to perform assigned duties.

(1) Initial examination for tuberculosis shall include a test for tuberculosis infection that is recommended by the federal Centers for Disease Control and Prevention (CDC) and licensed by the federal Food and Drug Administration (FDA). If the result is positive, a chest X-ray shall be obtained. If a person has a previously documented positive tuberculosis test result, a test for tuberculosis infection need not be done but a baseline chest X-ray shall be obtained.

(2) Policies and Procedures that address the identification, employment utilization and medical referral of persons with positive tuberculosis tests including those who have converted from negative to positive shall be written and implemented.

(3) An annual tuberculosis test shall be performed on those individuals with a previously documented negative tuberculosis test. If an individual with a previously documented negative tuberculosis test has a subsequent positive tuberculosis test result, a chest X-ray shall be obtained.

(4) Less frequent testing for tuberculosis, but never less than every four years, may be adopted as hospital policy when documented in writing as approved by the Infection Control Committee, the medical staff and the health officer of the health jurisdiction in which the facility is located.

(c) Employee health records shall be maintained by the hospital and shall include the records of all required health examinations. Such records shall be kept a minimum of three years following termination of employment.

(d) Personnel shall be made aware of recommended vaccinations for preventable diseases that can be prevented by vaccination.

Note: Authority cited: Sections 1275, 121357 and 131200, Health and Safety Code. Reference: Sections 1250, 1276, 121362, 131050, 131051 and 131052, Health and Safety Code.

HISTORY

1. Amendment of subsection (b) filed 3-13-80; effective thirtieth day thereafter (Register 80, No. 11).

2. Amendment filed 6-15-89 as an emergency; operative 6-15-89 (Register 89, No. 25). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 10-13-89.

3. Certificate of Compliance as to 6-15-89 order transmitted to OAL on 10-13-89 and disapproved by OAL on 11-13-89 (Register 89, No. 46).

4. Amendment refiled 11-16-89 as an emergency; operative 11-16-89 (Register 89, No. 46). A Certificate of Compliance must be transmitted to OAL within 120 days or the section will be reinstated as it existed prior to the emergency on 3-16-90.

5. Certificate of Compliance as to 11-16-89 order including amendment of subsections (a), (b) and (d) transmitted to OAL 3-15-90 and filed 4-16-90 (Register 90, No. 17).

6. Amendment of subsections (b)(1)-(3) and amendment of Note filed 5-30-2013; operative 5-30-2013 pursuant to Government Code section 11343.4(b)(3) (Register 2013, No. 22).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70723, 22 CA ADC § 70723

END OF DOCUMENT

§ 70725. Employee Personnel Records.
22 CA ADC § 70725
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70725

§ 70725. Employee Personnel Records.

All hospitals shall maintain personnel records of all employees. Such records shall be retained for at least three years following termination of employment. The record shall include the employee's full name, Social Security number, the license or registration number, if any, brief resume of experience, employment classification, date of beginning employment and date of termination of employment. Records of hours and dates worked by all employees during at least the most recent six-month period shall be kept on file at the place of employment.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70725, 22 CA ADC § 70725

END OF DOCUMENT

§ 70727. Job Descriptions.
22 CA ADC § 70727
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70727

§ 70727. Job Descriptions.

Job descriptions detailing the functions of each classification of employee shall be written and shall be available to all personnel.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70727, 22 CA ADC § 70727

END OF DOCUMENT

§ 70729. Advertising.
22 CA ADC § 70729
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70729

§ 70729. Advertising.

No hospital shall make or disseminate any false or misleading statement or advertise by any manner or means any false claims regarding services provided by the hospital.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70729, 22 CA ADC § 70729

END OF DOCUMENT

§ 70733. Records and Reports.
22 CA ADC § 70733
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70733

§ 70733. Records and Reports.

(a) Each hospital shall maintain copies of the following applicable documents on file in the administrative offices of the hospital:

(1) Articles of incorporation or partnership agreement.

(2) Bylaws or rules and regulations of the governing body.

(3) Bylaws and rules and regulations of the medical staff.

(4) Minutes of the meetings of the governing body and the medical staff.

(5) Reports of inspections by local, state and federal agents.

(6) All contracts, leases and other agreements required by these regulations.

(7) Patient admission roster.

(8) Reports of unusual occurrences for the preceding two years.

(9) Personnel records.

(10) Policy manuals.

(11) Procedure manuals

(12) Minutes and reports of the hospital Infection Control Committee.

(13) Any other records deemed necessary for the direct enforcement of these regulations by the Department.

(b) The records and reports mentioned or referred to above shall be made available for inspection by any duly authorized officer, employee or agent of the Department.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70733, 22 CA ADC § 70733

END OF DOCUMENT

§ 70735. Annual Reports.
22 CA ADC § 70735
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70735

§ 70735. Annual Reports.

All hospitals shall submit annual reports to the Department on forms supplied by the Department and by the date specified on the form.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70735, 22 CA ADC § 70735

END OF DOCUMENT

§ 70736. Sterilization Reporting Requirements.
22 CA ADC § 70736
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70736

§ 70736. Sterilization Reporting Requirements.

(a) All hospitals performing tubal ligations, vasectomies, and hysterectomies shall submit to the Department a quarterly report containing the following information:

(1) The total number of such sterilizations performed, including diagnoses and types of procedures employed.

(2) The number and type of such sterilizations performed by each physician on the medical staff preserving the anonymity of the physicians and patient.

(3) Demographic and medical data as required by the Department.

Note: Authority cited: Sections 208, 1275, 1276, Health and Safety Code. Reference: Sections 1250 et seq. , Health and Safety Code.

HISTORY

1. New section filed 5-27-77; effective thirtieth day thereafter (Register 77, No. 22).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70736, 22 CA ADC § 70736

END OF DOCUMENT

§ 70737. Reporting.
22 CA ADC § 70737
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70737

§ 70737. Reporting.

(a) Reportable Disease or Unusual Occurrences. All cases of reportable diseases shall be reported to the local health officer in accordance with Section 2500, Article 1, Subchapter 4, Chapter 4, Title 17, California Administrative Code. Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors shall be reported as soon as reasonably practical, either by telephone or by telegraph, to the local health officer and to the Department. The hospital shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require.

(b) Testing for Phenylketonuria. Hospitals to which maternity patients or infants 30 days of age or under may be admitted shall comply with the requirements governing testing for phenylketonuria (PKU) contained in Section 6500 of Title 17, California Administrative Code.

(c) Rhesus (Rh) Hemolytic Disease of the Newborn. Hospitals to which maternity patients may be admitted shall comply with the requirements for the determination and reporting of the rhesus (Rh) blood type of maternity patients and the reporting of rhesus (Rh) hemolytic disease of the newborn contained in Section 6510 of Title 17, California Administrative Code.

(d) Child Placement. Hospitals shall report to the Department on forms supplied by them, within 48 hours, the name and address of any person other than a parent or relative by blood or marriage, or the name and address of the organization or institution into whose custody a child is given on discharge from the hospital. The release of children for adoption shall be in conformity with the state law regulating adoption procedure.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70737, 22 CA ADC § 70737

END OF DOCUMENT

§ 70738. Infant Security.
22 CA ADC § 70738
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70738

§ 70738. Infant Security.

Written policies and procedures shall be adopted and implemented to accurately identify infants and to protect infants from removal from the facility by unauthorized persons. The policies and procedures shall be reviewed and updated by the facility every two years.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

HISTORY

1. New section filed 1-24-90 as an emergency; operative 1-24-90 (Register 90, No. 5). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5-24-90.

2. Certificate of Compliance as to 1-24-90 order transmitted to OAL 5-24-90 and filed 6-21-90 (Register 90, No. 33).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70738, 22 CA ADC § 70738

END OF DOCUMENT

§ 70741. Disaster and Mass Casualty Program.
22 CA ADC § 70741
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70741

§ 70741. Disaster and Mass Casualty Program.

(a) A written disaster and mass casualty program shall be developed and maintained in consultation with representatives of the medical staff, nursing staff, administration and fire and safety experts. The program shall be in conformity with the California Emergency Plan of October 10, 1972 developed by the State Office of Emergency Services and the California Emergency Medical Mutual Aid Plan of March 1974 developed by the Office of Emergency Services, Department of Health. The program shall be approved by the medical staff and administration. A copy of the program shall be available on the premises for review by the Department.

(b) The program shall cover disasters occurring in the community and widespread disasters. It shall provide for at least the following:

(1) Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials.

(2) An efficient system of notifying and assigning personnel.

(3) Unified medical command.

(4) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.

(5) Prompt transfer of casualties, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definite care.

(6) A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved.

(7) Procedures for the prompt discharge or transfer of patients already in the hospital at the time of the disaster who can be moved without jeopardy.

(8) Maintaining security in order to keep relatives and curious persons out of the triage area.

(9) Establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will be made to provide organized dissemination of information.

(c) The program shall be brought up-to-date, at least annually, and all personnel shall be instructed in its requirements. There shall be evidence in the personnel files, e.g., orientation checklist or elsewhere, indicating that all new employees have been oriented to the program and procedures within a reasonable time after commencement of their employment.

(d) The disaster plan shall be rehearsed at least twice a year. There shall be a written report and evaluation of all drills. The actual evacuation of patients to safe areas during the drill is optional.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70741, 22 CA ADC § 70741

END OF DOCUMENT

§ 70743. Fire and Internal Disasters.
22 CA ADC § 70743
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70743

§ 70743. Fire and Internal Disasters.

(a) A written fire and internal disaster program, incorporating evacuation procedures, shall be developed with the assistance of fire, safety and other appropriate experts. A copy of the program shall be available on the premises for review by the Department.

(b) The written program shall include at least the following:

(1) Plans for the assignment of personnel to specific tasks and responsibilities.

(2) Instructions relating to the use of alarm systems and signals.

(3) Information concerning methods of fire containment.

(4) Systems for notification of appropriate persons.

(5) Information concerning the location of fire fighting equipment.

(6) Specification of evacuation routes and procedures.

(7) Other provisions as the local situation dictates.

(c) Fire and internal disaster drills shall be held at least quarterly for each shift of hospital personnel and under varied conditions. The actual evacuation of patients to safe areas during a drill is optional.

(d) The evacuation plan shall be posted throughout the facility and shall include at least the following:

(1) Evacuation routes.

(2) Location of fire alarm boxes.

(3) Location of fire extinguishers.

This database is current through 7/27/18 Register 2018, No. 30

22 CCR § 70743, 22 CA ADC § 70743

END OF DOCUMENT

§ 70745. Fire Safety.
22 CA ADC § 70745
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70745

§ 70745. Fire Safety.

All hospitals shall be maintained in conformity with the regulations adopted by the State Fire Marshal for the prevention of fire and for the protection of life and property against fire and panic. All hospitals shall secure and maintain a clearance relative to fire safety from the State Fire Marshal.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70745, 22 CA ADC § 70745

END OF DOCUMENT

§ 70746. Disruption of Services.
22 CA ADC § 70746
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70746

§ 70746. Disruption of Services.

(a) Each hospital shall develop a written plan to be used when a discontinuance or disruption of services occurs.

(b) The administrator shall be responsible for informing the Department, via telephone, immediately upon being notified of the intent of the discontinuance or disruption of services or upon the threat of a walkout of a substantial number of employees, or earthquake, fire, power outage or other calamity that causes damage to the facility or threatens the safety or welfare of patients or clients.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70746, 22 CA ADC § 70746

END OF DOCUMENT

§ 70747. Medical Records Service.
22 CA ADC § 70747
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70747

§ 70747. Medical Records Service.

(a) The hospital shall maintain a medical record service which shall be conveniently located and adequate in size and equipment to facilitate the accurate processing, checking, indexing and filing of all medical records.

(b) The medical records service shall be under the supervision of a registered health information administrator or registered health information technician. The registered health information administrator or registered health information technician shall be assisted by such qualified personnel as are necessary for the conduct of the service.

Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Sections 1276, 131050, 131051 and 131052, Health and Safety Code.

HISTORY

1. Change without regulatory effect amending subsection (b) and adding new Note filed 3-12-2013 pursuant to section 100, title 1, California Code of Regulations (Register 2013, No. 11).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70747, 22 CA ADC § 70747

END OF DOCUMENT

§ 70749. Patient Health Record Content.
22 CA ADC § 70749
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70749

§ 70749. Patient Health Record Content.

(a) Each inpatient medical record shall consist of at least the following items:

(1) Identification sheets which include but are not limited to the following:

(A) Name.

(B) Address on admission.

(C) Identification number (if applicable).

1. Social Security.

2. Medicare.

3. Medi-Cal.

(D) Age.

(E) Sex.

(F) Martial status.

(G) Religion.

(H) Date of admission.

(I) Date of discharge.

(J) Name, address and telephone number of person or agency responsible for patient.

(K) Name of patient's admitting licensed health care practitioner acting within the scope of his or her professional licensure.

(L) Initial diagnostic impression.

(M) Discharge or final diagnosis.

(2) History and physical examination.

(3) Consultation reports.

(4) Order sheet including medication, treatment and diet orders.

(5) Progress notes including current or working diagnosis.

(6) Nurses' notes which shall include but not be limited to the following:

(A) Concise and accurate record of nursing care administered.

(B) Record of pertinent observations including psychosocial and physical manifestations as well as incidents and unusual occurrences, and relevant nursing interpretation of such observations.

(C) Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration.

(D) Record of type of restraint and time of application and removal. The time of application and removal shall not be required for soft tie restraints used for support and protection of the patient.

(7) Vital sign sheet.

(8) Reports of all laboratory tests performed.

(9) Reports of all X-ray examinations performed.

(10) Consent forms, when applicable.

(11) Anesthesia record including preoperative diagnosis, if anesthesia has been administered.

(12) Operative report including preoperative and postoperative diagnoses, description of findings, technique used, tissue removed or altered, if surgery was performed.

(13) Pathology report, if tissue or body fluid was removed.

(14) Labor record, if applicable.

(15) Delivery record, if applicable.

(16) A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, his condition on discharge and the recommendations and arrangements for future care.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

HISTORY

1. Amendment filed 3-13-80; effective thirtieth day thereafter (Register 80, No. 11).

2. Amendment of subsection (a)(1)(K) and (a)(12)-(13) and Note filed 3-3-2010; operative 4-2-2010 (Register 2010, No. 10).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70749, 22 CA ADC § 70749

END OF DOCUMENT

§ 70751. Medical Record Availability.
22 CA ADC § 70751
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70751

§ 70751. Medical Record Availability.

(a) Records shall be kept on all patients admitted or accepted for treatment. All required patient health records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon the request of:

(1) The admitting licensed healthcare practitioner acting within the scope of his or her professional licensure.

(2) The nonphysician granted privileges pursuant to Section 70706.1.

(3) The hospital or its medical staff or any authorized officer, agent or employee of either.

(4) Authorized representatives of the Department.

(5) Any other person authorized by law to make such a request.

(b) The medical record, including X-ray films, is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. The hospital shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

(c) Patient records including X-ray films or reproduction thereof shall be preserved safely for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.

(d) If a hospital ceases operation, the Department shall be informed within 48 hours of the arrangements made for safe preservation of patient records as above required.

(e) If ownership of a licensed hospital changes, both the previous licensee and the new licensee shall, prior to the change of ownership, provide the Department with written documentation that:

(1) The new licensee will have custody of the patients' records upon transfer of the hospital and that the records are available to both the new and former licensee and other authorized persons; or

(2) Arrangements have been made for the safe preservation of patient records, as above required, and that the records are available to both the new and former licensees and other authorized persons.

(f) Medical records shall be filed in an easily accessible manner in the hospital or in an approved medical record storage facility off the hospital premises.

(g) Medical records shall be completed promptly and authenticated or signed by a licensed healthcare practitioner acting within the scope of his or her professional licensure within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a signature by a licensed healthcare practitioner acting within the scope of his or her professional licensure, only when that licensed healthcare practitioner acting within the scope of his or her professional licensure, has placed a signed statement in the hospital administrative offices to the effect that he/she is the only person who:

(1) Has possession of the stamp or key.

(2) Will use the stamp or key.

(h) Medical records shall be indexed according to patient, disease, operation and licensed healthcare practitioner acting within the scope of his or her professional licensure.

(i) By July 1, 1976 a unit medical record system shall be established and implemented with inpatient, outpatient and emergency room records combined.

(j) The medical record shall be closed and a new record initiated when a patient is transferred to a different level of care within a hospital which has a distinct part skilled nursing or intermediate care service.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

HISTORY

1. Amendment of subsection (a) filed 3-13-80; effective thirtieth day thereafter (Register 80, No. 11).

2. Amendment of subsections (a)(1), (g) and (h) and Note filed 3-3-2010; operative 4-2-2010 (Register 2010, No. 10).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70751, 22 CA ADC § 70751

END OF DOCUMENT

§ 70753. Transfer Summary.
22 CA ADC § 70753
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70753

§ 70753. Transfer Summary.

A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the distinct part skilled nursing or intermediate care service unit of the hospital. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, medications, treatments, dietary requirement, rehabilitation potential, known allergies and treatment plan and shall be signed by the licensed healthcare practitioner acting within the scope of his or her professional licensure.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

HISTORY

1. Amendment of section and new Note filed 3-3-2010; operative 4-2-2010 (Register 2010, No. 10).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70753, 22 CA ADC § 70753

END OF DOCUMENT

§ 70754. Special Hospital Transfer Agreement.
22 CA ADC § 70754
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70754

§ 70754. Special Hospital Transfer Agreement.

A special hospital shall have an effective written agreement with a general acute care hospital in the same geographic area for the provision of surgical and anesthesia services and any other service which may be required and which the special hospital does not provide.

Note: Authority cited: Section 208 and 1250, Health and Safety Code. Reference: ACR 67, Chapter 83, Statutes of 1977.

HISTORY

1. New section filed 7-28-78; effective thirtieth day thereafter (Register 78, No. 30).

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70754, 22 CA ADC § 70754

END OF DOCUMENT

§ 70759. Exercise Stress Testing.
22 CA ADC § 70759
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70759

§ 70759. Exercise Stress Testing.

Where exercise stress testing is performed, there shall be appropriate monitoring and resuscitative equipment and persons trained in cardiopulmonary resuscitative techniques physically present.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70759, 22 CA ADC § 70759

END OF DOCUMENT

§ 70761. Medical Library.
22 CA ADC § 70761
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70761

§ 70761. Medical Library.

(a) Each hospital shall maintain a medical library consistent with the needs of the hospital.

(b) The medical library shall be located in a convenient location, and its contents shall be organized, easily accessible and available through authorized personnel at all times.

(c) The library shall contain modern textbooks in basic sciences and other current textbooks, journals and magazines pertinent to the clinical services maintained in the hospital.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70761, 22 CA ADC § 70761

END OF DOCUMENT

§ 70763. Medical Photography.
22 CA ADC § 70763
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70763

§ 70763. Medical Photography.

The hospital shall have a policy regarding the obtaining of consent for medical photography.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70763, 22 CA ADC § 70763

END OF DOCUMENT

§ 70765. Conference Room.
22 CA ADC § 70765
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 7. Administration (Refs & Annos)

22 CCR § 70765

§ 70765. Conference Room.

Suitable space for conferences shall be provided in the hospital.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70765, 22 CA ADC § 70765

END OF DOCUMENT

§ 70901. Applicability of Article 9.
22 CA ADC § 70901
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 9. Regulations Specific to Small and Rural Hospitals (Refs & Annos)

22 CCR § 70901

§ 70901. Applicability of Article 9.

Regulations found in Article 9 are applicable to all small and rural hospitals as defined in Health and Safety Code Section 442.2(c).

Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.

HISTORY

1. New section filed 2-26-90 as an emergency; operative 2-26-90 (Register 90, No. 9). A Certificate of Compliance is not required to be transmitted and this emergency regulation remains in force and effect pursuant to Health and Safety Code Sections 442.3(b) and 442.6(e). Issuing agency: Office of Statewide Health Planning and Development.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70901, 22 CA ADC § 70901

END OF DOCUMENT

§ 70903. Enforcement of Article 9.
22 CA ADC § 70903
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 9. Regulations Specific to Small and Rural Hospitals (Refs & Annos)

22 CCR § 70903

§ 70903. Enforcement of Article 9.

Each regulation in Article 9 provides an alternative for a specific regulation or regulations found elsewhere in Chapter 1. Preceding or included in each section in Article 9 is the number of the section it will modify or replace.

Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.

HISTORY

1. New section filed 2-26-90 as an emergency; operative 2-26-90 (Register 90, No. 9). A Certificate of Compliance is not required to be transmitted and this emergency regulation remains in force and effect pursuant to Health and Safety Code Sections 442.3(b) and 442.6(e). Issuing agency: Office of Statewide Health Planning and Development.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70903, 22 CA ADC § 70903

END OF DOCUMENT

§ 70905. Surgical Service General Requirements.
22 CA ADC § 70905
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 9. Regulations Specific to Small and Rural Hospitals (Refs & Annos)

22 CCR § 70905

§ 70905. Surgical Service General Requirements.

Section 70223 shall apply as written with the following exception: Hospitals with a licensed bed capacity of 25 or more but less than 50 shall only be required to maintain one operating room.

Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.

HISTORY

1. New section filed 2-26-90 as an emergency: operative 2-26-90 (Register 90, No. 9). A Certificate of Compliance is not required to be transmitted and this emergency regulation remains in force and effect pursuant to Health and Safety Code Sections 442.3(b) and 442.6(e). Issuing agency: Office of Statewide Health Planning and Development.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70905, 22 CA ADC § 70905

END OF DOCUMENT

§ 70907. Dietetic Service Staff.
22 CA ADC § 70907
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 9. Regulations Specific to Small and Rural Hospitals (Refs & Annos)

22 CCR § 70907

§ 70907. Dietetic Service Staff.

Section 70275 shall be replaced by the following:

(a) A registered dietitian shall be employed on a full-time, part-time or consulting basis for approval of all menus and participation in development or revision of dietetic policies and procedures and in planning and conducting in-service education programs.

(b) Sufficient dietetic service personnel shall be employed, oriented, trained and their working hours scheduled to provide for the nutritional needs of the patients and to maintain the dietetic service areas. If dietetic service employees are assigned duties in other service areas, those duties shall not interfere with the sanitation, safety or time required for dietetic work assignments.

(c) A record shall be maintained of the number of persons by job title employed full or part-time in dietetic services and the number of hours each works weekly.

(d) Hygiene of Dietetic Service Staff.

(1) Dietetic service personnel shall be trained in basic food sanitation techniques, shall be clean, wear clean clothing, including a cap and/or a hair net and shall be excluded from duty when affected by skin infection or communicable diseases. Beards and mustaches which are not closely cropped and neatly trimmed shall be covered.

(2) Employee's street clothing stored in the kitchen area shall be in a closed area.

(3) Kitchen sinks shall not be used for handwashing. Separate handwashing facilities with soap, running water and individual towels shall be provided.

(4) Persons other than dietetic personnel shall not be allowed in the kitchen area unless required to do so in the performance of their duties.

Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.

HISTORY

1. New section filed 2-26-90 as an emergency; operative 2-26-90 (Register 90, No. 9). A Certificate of Compliance is not required to be transmitted and this emergency regulation remains in force and effect pursuant to Health and Safety Code Sections 442.3(b) and 442.6(e). Issuing agency: Office of Statewide Health Planning and Development.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70907, 22 CA ADC § 70907

END OF DOCUMENT

§ 70909. Intensive Care Service Space.
22 CA ADC § 70909
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 9. Regulations Specific to Small and Rural Hospitals (Refs & Annos)

22 CCR § 70909

§ 70909. Intensive Care Service Space.

Section 70499 shall apply as written with the following exceptions: an intensive care unit may consist of less than four (4) but shall not consist of less than two (2) patient beds; an isolation room is not required.

Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.

HISTORY

1. New section filed 2-26-90 as an emergency; operative 2-26-90 (Register 90, No. 9). A Certificate of Compliance is not required to be transmitted and this emergency regulation remains in force and effect pursuant to Health and Safety Code Sections 442.3(b) and 442.6(e). Issuing agency: Office of Statewide Health Planning and Development.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70909, 22 CA ADC § 70909

END OF DOCUMENT

§ 70913. Perinatal Unit Space.
22 CA ADC § 70913
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 9. Regulations Specific to Small and Rural Hospitals (Refs & Annos)

22 CCR § 70913

§ 70913. Perinatal Unit Space.

Section 70553 shall apply as written with the following exception: The operating room may serve as the delivery room in hospitals having a licensed bed capacity of 50 or less.

Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.

HISTORY

1. New section filed 2-26-90 as an emergency; operative 2-26-90 (Register 90, No. 9). A Certificate of Compliance is not required to be transmitted and this emergency regulation remains in force and effect pursuant to Health and Safety Code Sections 442.3(b) and 442.6(e). Issuing agency: Office of Statewide Health Planning and Development.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70913, 22 CA ADC § 70913

END OF DOCUMENT

§ 70915. Physical Therapy Service General Requirements.
22 CA ADC § 70915
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 9. Regulations Specific to Small and Rural Hospitals (Refs & Annos)

22 CCR § 70915

§ 70915. Physical Therapy Service General Requirements.

Section 70557 shall apply as written with the following exception: Procedures for outpatient treatment, home visits and referrals to appropriate community agencies need only be established if such resources are available.

Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.

HISTORY

1. New section filed 2-26-90 as an emergency; operative 2-26-90 (Register 90, No. 9). A Certificate of Compliance is not required to be transmitted and this emergency regulation remains in force and effect pursuant to Health and Safety Code Sections 442.3(b) and 442.6(e). Issuing agency: Office of Statewide Health Planning and Development.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70915, 22 CA ADC § 70915

END OF DOCUMENT

§ 70917. Physical Therapy Service Equipment and Supplies.
22 CA ADC § 70917
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 9. Regulations Specific to Small and Rural Hospitals (Refs & Annos)

22 CCR § 70917

§ 70917. Physical Therapy Service Equipment and Supplies.

Section 70561 shall apply as written with the following exception: Adjustable tables shall not be required if a suitable alternative is available.

Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.

HISTORY

1. New section filed 2-26-90 as an emergency; operative 2-26-90 (Register 90, No. 9). A Certificate of Compliance is not required to be transmitted and this emergency regulation remains in force and effect pursuant to Health and Safety Code Sections 442.3(b) and 442.6(e). Issuing agency: Office of Statewide Health Planning and Development.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70917, 22 CA ADC § 70917

END OF DOCUMENT

§ 70919. Physical Therapy Service Space.
22 CA ADC § 70919
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 9. Regulations Specific to Small and Rural Hospitals (Refs & Annos)

22 CCR § 70919

§ 70919. Physical Therapy Service Space.

Section 70563 shall not apply.

Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.

HISTORY

1. New section filed 2-26-90 as an emergency; operative 2-26-90 (Register 90, No. 9). A Certificate of Compliance is not required to be transmitted and this emergency regulation remains in force and effect pursuant to Health and Safety Code Sections 442.3(b) and 442.6(e). Issuing agency: Office of Statewide Health Planning and Development.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70919, 22 CA ADC § 70919

END OF DOCUMENT

§ 70921. Standby Emergency Medical Services, Physician on Call, Space.
22 CA ADC § 70921
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 9. Regulations Specific to Small and Rural Hospitals (Refs & Annos)

22 CCR § 70921

§ 70921. Standby Emergency Medical Services, Physician on Call, Space.

Section 70657 shall apply as written with the following exceptions: The reception area may be a multi-purpose area and the observation room need not be dedicated solely for that purpose.

Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.

HISTORY

1. New section filed 2-26-90 as an emergency; operative 2-26-90 (Register 90, No. 9). A Certificate of Compliance is not required to be transmitted and this emergency regulation remains in force and effect pursuant to Health and Safety Code Sections 442.3(b) and 442.6(e). Issuing agency: Office of Statewide Health Planning and Development.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70921, 22 CA ADC § 70921

END OF DOCUMENT

§ 70923. Conference Room.
22 CA ADC § 70923
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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 9. Regulations Specific to Small and Rural Hospitals (Refs & Annos)

22 CCR § 70923

§ 70923. Conference Room.

Section 70765 shall be modified as follows: A hospital shall either provide suitable space for conferences within the facility or shall otherwise provide access to suitable space for conferences.

Note: Authority cited: Sections 442.3 and 442.6, Health and Safety Code. Reference: Section 442.3, Health and Safety Code.

HISTORY

1. New section filed 2-26-90 as an emergency; operative 2-26-90 (Register 90, No. 9). A Certificate of Compliance is not required to be transmitted and this emergency regulation remains in force and effect pursuant to Health and Safety Code Sections 442.3(b) and 442.6(e). Issuing agency: Office of Statewide Health Planning and Development.

This database is current through 7/6/18 Register 2018, No. 27

22 CCR § 70923, 22 CA ADC § 70923

END OF DOCUMENT

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

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

EDMUND G. BROWN JR.
Governor

July 27, 2018

AFL 18-30

TO: General Acute Care Hospitals (GACHs)

SUBJECT: Request for Stakeholder Input in Amending GACH Administration Regulations

All Facilities Letter (AFL) Summary

The California Department of Public Health's Center for Health Care Quality (CHCQ) is seeking input from interested stakeholders in amending GACH administration regulations under California Code of Regulations, Title 22, sections 70701 through 70706.2, 70729, 70731, and 70757 through 70765.

CHCQ is seeking input from interested stakeholders as part of the regulation development process to ensure proposed regulations are consistent with other laws and regulations, modern hospital practices, and other relevant standards. CHCQ has begun the process of revising regulations governing GACHs under California Code of Regulations, Title 22. These GACH regulations include the following sections:

- section 70701 Governing Body
- section 70703 Organized Medical Staff
- section 70705 Medical Staff, Residents, Interns and Students
- section 70706 Interdisciplinary Practice and Responsibility for Patient Care
- section 70706.1 Granting of Nonphysician Privileges
- section 70706.2 Standardized Procedures
- section 70729 Advertising
- section 70754 Special Hospital Transfer Agreement
- section 70757 First Aid and Referrals
- section 70759 Exercise Stress Testing
- section 70761 Medical Library
- section 70763 Medical Photography
- section 70765 Conference Room

Instructions for Submitting Written Comments

Please submit your written comments by **August 31, 2018** using the Written Comments for GACH Administration Regulations Survey. Stakeholders may submit supporting documentation as attachments at the end of this survey. Please include your name, title, the name of organization you represent, and AFL number to any attachment(s).

Please submit your questions by email to CHCQRegulationsUnit@cdph.ca.gov.

Sincerely,

Original signed by Scott Vivona

Scott Vivona
Assistant Deputy Director

Attachment: Written Comments for GACH Administration Regulations Survey

Center for Health Care Quality, MS 0512 . P.O. Box 997377 . Sacramento, CA 95899-7377
(916) 324-6630 . (916) 324-4820 FAX
Department Website (cdph.ca.gov)

Page Last Updated : July 27, 2018

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

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

EDMUND G. BROWN JR.
Governor

July 27, 2018

AFL 18-31

TO: General Acute Care Hospitals (GACHs)

SUBJECT: Request for Stakeholder Input in Amending GACH Employee/Personnel Records and Requirements Regulations

All Facilities Letter (AFL) Summary

The California Department of Public Health's Center for Health Care Quality (CHCQ) is seeking input from interested stakeholders in amending GACH employee/personnel records and requirements regulations under California Code of Regulations, Title 22, sections 70719 through 70727.

CHCQ is seeking input from interested stakeholders as part of the regulation development process to ensure proposed regulations are consistent with other laws and regulations, modern hospital practices, and other relevant standards. CHCQ has begun the process of revising regulations governing GACHs under California Code of Regulations, Title 22. These GACH regulations include the following sections:

- section 70719 Personnel Policies
- section 70721 Employees
- section 70723 Employee Health Examinations and Health Records
- section 70725 Employee Personnel Records
- section 70727 Job Descriptions

Instructions for Submitting Written Comments

Please submit your written comments by **August 31, 2018** using the Written Comments for GACH Employee/Personnel Records and Requirements Regulations Survey. Stakeholders may submit supporting documentation as attachments at the end of this survey. Please include your name, title, the name of organization you represent, and AFL number to any attachment(s).

Please submit your questions by email to CHCQRegulationsUnit@cdph.ca.gov.

Sincerely,

Original signed by Scott Vivona

Scott Vivona
Assistant Deputy Director

Center for Health Care Quality, MS 0512 . P.O. Box 997377 . Sacramento, CA 95899-7377
(916) 324-6630 . (916) 324-4820 FAX
Department Website (cdph.ca.gov)

Page Last Updated : July 27, 2018

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

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

EDMUND G. BROWN JR.
Governor

July 27, 2018

AFL 18-32

TO: General Acute Care Hospitals (GACHs)

SUBJECT: Request for Stakeholder Input in Amending GACH License, Supplemental Service Approval, and Special Permit Regulations

All Facilities Letter (AFL) Summary

The California Department of Public Health's Center for Health Care Quality (CHCQ) is seeking input from interested stakeholders in amending GACH license, supplemental service approval, and special permit regulations under California Code of Regulations, Title 22, sections 70101 through 70137, 70301 through 70309, and 70351 through 70369.

CHCQ is seeking input from interested stakeholders as part of the regulation development process to ensure proposed regulations are consistent with other laws and regulations, modern hospital practices, and other relevant standards. CHCQ has begun the process of revising regulations governing GACHs under California Code of Regulations, Title 22. These GACH regulations include the following sections:

- section 70101 Inspection of Hospitals
- section 70103 License Required
- section 70105 Application Required
- section 70107 Content of Application
- section 70109 Architectural Plans
- section 70110 Fee
- section 70115 Safety, Zoning and Building Clearance
- section 70117 Issuance, Expiration and Renewal
- section 70119 Provisional Licensing of Distinct Parts
- section 70121 Separate Licenses
- section 70123 Posting
- section 70125 Transferability
- section 70127 Report of Changes
- section 70129 Program Flexibility
- section 70131 Voluntary Suspension of License or Licensed Beds
- section 70133 Voluntary Cancellation of License
- section 70135 Revocation or Involuntary Suspension of License
- section 70136 Conviction of Crime: Standards for Evaluating Rehabilitation
- section 70137 Bonds
- section 70301 Supplemental Service Approval Required
- section 70303 Application
- section 70305 Issuance, Expiration and Renewal

- section 70307 Program Flexibility
- section 70309 Revocation or Involuntary Suspension of Approval
- section 70351 Special Permit Required
- section 70353 Application
- section 70357 Issuance, Expiration and Renewal
- section 70359 Posting
- section 70361 Transferability
- section 70363 Program Flexibility
- section 70365 Voluntary Suspension of Special Permit
- section 70367 Voluntary Cancellation of Special Permit
- section 70369 Revocation or Involuntary Suspension of Special Permit

Instructions for Submitting Written Comments

Please submit your written comments by **August 31, 2018** using the Written Comments for License, Supplemental Service Approval, and Special Permit Regulations Survey. Stakeholders may submit supporting documentation as attachments at the end of this survey. Please include your name, title, the name of organization you represent, and AFL number to any attachment(s).

Please submit your questions by email to CHCQRegulationsUnit@cdph.ca.gov.

Sincerely,

Original signed by Scott Vivona

Scott Vivona
Assistant Deputy Director

Attachment: Written Comments for License, Supplemental Service Approval, and Special Permit Regulations Survey

Center for Health Care Quality, MS 0512 . P.O. Box 997377 . Sacramento, CA 95899-7377
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Director and State Public Health Officer

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

EDMUND G. BROWN JR.
Governor

July 27, 2018

AFL 18-33

TO: General Acute Care Hospitals (GACHs)

SUBJECT: Request for Stakeholder Input in Amending GACH Medical Records Regulations

All Facilities Letter (AFL) Summary

The California Department of Public Health's Center for Health Care Quality (CHCQ) is seeking input from interested stakeholders in amending GACH medical records regulations under California Code of Regulations, Title 22, sections 70747 through 70753.

CHCQ is seeking input from interested stakeholders as part of the regulation development process to ensure proposed regulations are consistent with other laws and regulations, modern hospital practices, and other relevant standards. CHCQ has begun the process of revising regulations governing GACHs under California Code of Regulations, Title 22. These GACH regulations include the following sections:

- section 70747 Medical Records Service
- section 70749 Patient Health Record Content
- section 70751 Medical Record Availability
- section 70753 Transfer Summary

Instructions for Submitting Written Comments

Please submit your written comments by **August 31, 2018** using the Written Comments for GACH Medical Records Regulations Survey. Stakeholders may submit supporting documentation as attachments at the end of this survey. Please include your name, title, the name of organization you represent, and AFL number to any attachment(s).

Please submit your questions by email to CHCQRegulationsUnit@cdph.ca.gov.

Sincerely,

Original signed by Scott Vivona

Scott Vivona
Assistant Deputy Director

Attachment: Written Comments for GACH Medical Records Regulations Survey

Center for Health Care Quality, MS 0512 . P.O. Box 997377 . Sacramento, CA 95899-7377
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Department Website (cdph.ca.gov)

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Director and State Public Health Officer

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

EDMUND G. BROWN JR.
Governor

July 27, 2018

AFL 18-34

TO: General Acute Care Hospitals (GACHs)

SUBJECT: Request for Stakeholder Input in Amending GACH Medical Service Regulations

All Facilities Letter (AFL) Summary

The California Department of Public Health's Center for Health Care Quality (CHCQ) is seeking input from interested stakeholders in amending GACH medical service regulations under California Code of Regulations, Title 22, sections 70201 through 70209.

CHCQ is seeking input from interested stakeholders as part of the regulation development process to ensure proposed regulations are consistent with other laws and regulations, modern hospital practices, and other relevant standards. CHCQ has begun the process of revising regulations governing GACHs under California Code of Regulations, Title 22. These GACH regulations include the following sections:

- section 70201 Medical Service Definition
- section 70203 Medical Service General Requirements
- section 70205 Medical Service Staff
- section 70207 Medical Service Equipment and Supplies
- section 70209 Medical Service Space

Instructions for Submitting Written Comments

Please submit your written comments by **August 31, 2018** using the Written Comments for GACH Medical Service Regulations Survey. Stakeholders may submit supporting documentation as attachments at the end of this survey. Please include your name, title, the name of organization you represent, and AFL number to any attachment(s).

Please submit your questions by email to CHCQRegulationsUnit@cdph.ca.gov.

Sincerely,

Original signed by Scott Vivona

Scott Vivona
Assistant Deputy Director

Attachment: Written Comments for GACH Medical Service Regulations Survey

Center for Health Care Quality, MS 0512 . P.O. Box 997377 . Sacramento, CA 95899-7377
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Page Last Updated : July 27, 2018

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Director and State Public Health Officer

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

EDMUND G. BROWN JR.
Governor

July 27, 2018

AFL 18-35

TO: General Acute Care Hospitals (GACHs)

SUBJECT: Request for Stakeholder Input in Amending GACH Records and Reporting Regulations

All Facilities Letter (AFL) Summary

The California Department of Public Health's Center for Health Care Quality (CHCQ) is seeking input from interested stakeholders in amending GACH records and reporting regulations under California Code of Regulations, Title 22, sections 70733 through 70738, and 70741 through 70746.

CHCQ is seeking input from interested stakeholders as part of the regulation development process to ensure proposed regulations are consistent with other laws and regulations, modern hospital practices, and other relevant standards. CHCQ has begun the process of revising regulations governing GACHs under California Code of Regulations, Title 22. These GACH regulations include the following sections:

- section 70733 Records and Reports
- section 70735 Annual Reports
- section 70736 Sterilization Reporting Requirements
- section 70737 Reporting
- section 70738 Infant Security
- section 70741 Disaster and Mass Casualty Program
- section 70743 Fire and Internal Disasters
- section 70745 Fire Safety
- section 70746 Disruption of Services

Instructions for Submitting Written Comments

Please submit your written comments by **August 31, 2018** using the Written Comments for GACH Records and Reporting Regulations Survey. Stakeholders may submit supporting documentation as attachments at the end of this survey. Please include your name, title, the name of organization you represent, and AFL number to any attachment(s).

Please submit your questions by email to CHCQRegulationsUnit@cdph.ca.gov.

Sincerely,

Original signed by Scott Vivona

Scott Vivona
Assistant Deputy Director

Attachment: Written Comments for GACH Records and Reporting Regulations Survey

Center for Health Care Quality, MS 0512 . P.O. Box 997377 . Sacramento, CA 95899-7377
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Director and State Public Health Officer

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California Department of Public Health

EDMUND G. BROWN JR.
Governor

July 27, 2018

AFL 18-36

TO: General Acute Care Hospitals (GACHs)

SUBJECT: Request for Stakeholder Input in Amending GACH Regulations Specific to Small and Rural Hospitals

All Facilities Letter (AFL) Summary

The California Department of Public Health's Center for Health Care Quality (CHCQ) is seeking input from interested stakeholders in amending GACH regulations specific to small and rural hospitals under California Code of Regulations, Title 22, sections 70901 through 70923.

CHCQ is seeking input from interested stakeholders as part of the regulation development process to ensure proposed regulations are consistent with other laws and regulations, modern hospital practices, and other relevant standards. CHCQ has begun the process of revising regulations governing GACHs under California Code of Regulations, Title 22. These GACH regulations include the following sections:

- section 70901 Applicability of Article 9
- section 70903 Enforcement of Article 9
- section 70905 Surgical Service General Requirements
- section 70907 Dietetic Service Staff
- section 70911 Perinatal Unit Staff
- section 70913 Perinatal Unit Space
- section 70915 Physical Therapy Service General Requirements
- section 70917 Physical Therapy Service Equipment and Supplies
- section 70919 Physical Therapy Service Space
- section 70921 Standby Emergency Medical Services, Physician on Call, Space
- section 70923 Conference Room

Instructions for Submitting Written Comments

Please submit your written comments by **August 31, 2018** using the Written Comments for Regulations Specific to Small and Rural Hospitals Survey. Stakeholders may submit supporting documentation as attachments at the end of this survey. Please include your name, title, the name of organization you represent, and AFL number to any attachment(s).

Please submit your questions by email to CHCQRegulationsUnit@cdph.ca.gov.

Sincerely,

Original signed by Scott Vivona

Scott Vivona
Assistant Deputy Director

Attachment: Written Comments for Regulations Specific to Small and Rural Hospitals Survey

Center for Health Care Quality, MS 0512 . P.O. Box 997377 . Sacramento, CA 95899-7377
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Page Last Updated : July 27, 2018

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

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

SUBJECT: Time in ED – Impact on Reputation

SUMMARY

A study of 1,000 hospitals across the nation found no correlation with ED wait times and whether patients would recommend the hospital to another family member or friend. Another study looked across multiple ED time metrics also showed no correlation.

ACTION REQUESTED

- Information and suggestions on how we use data for decision making.

DISCUSSION QUESTIONS

1) What are your experiences with ED wait times and satisfaction or recommendation of your hospital?
2) What variables could be influencing the lack of correlation?
3) Is there any way our data analytics team can help us with these kind of studies?

Attachments: Time in Emergency Department NOT Correlated with Patient Satisfaction

BJB:br

Time in Emergency Department NOT Correlated with Patient Satisfaction

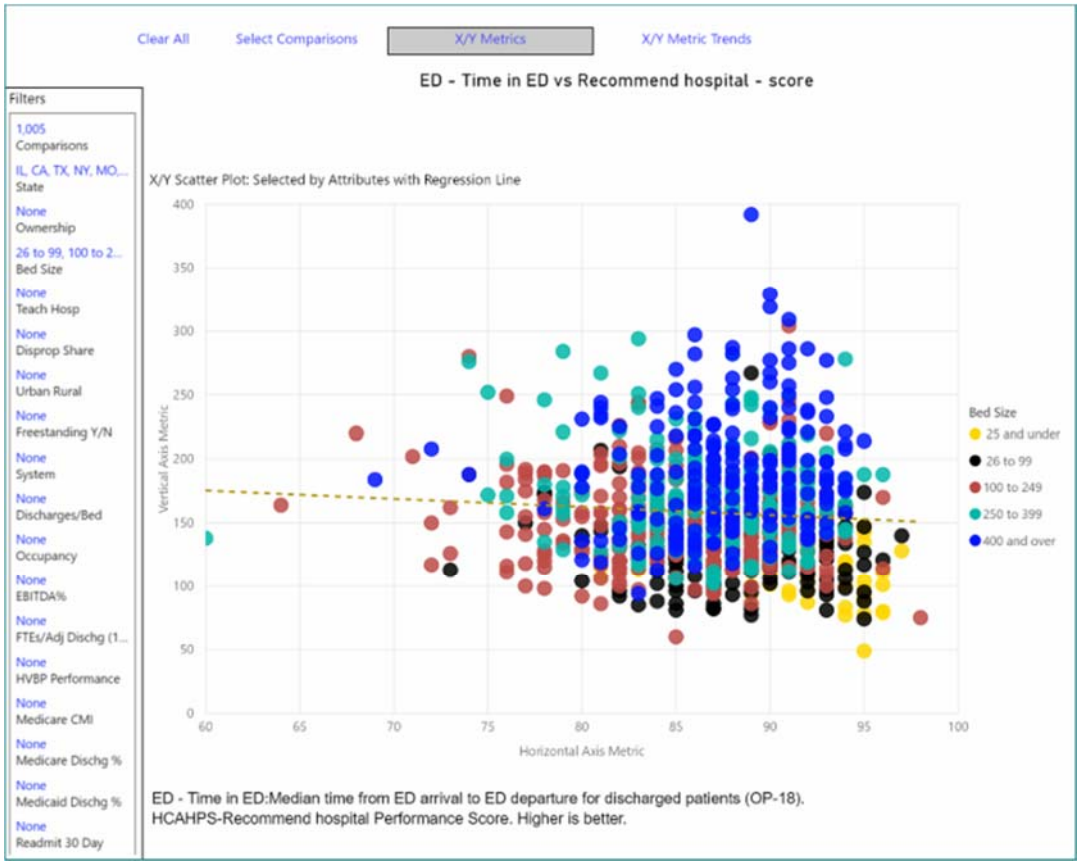
BOSTON, MA – August 6, 2018 – Conventional Wisdom says that time in the ED is a very important patient satisfier…we've all seen the billboards and apps that display ED wait times.

Remarkable as this might seem, and looking at 1,000 hospitals across the US, when it comes to the time a patient spends in the ED, there is NO correlation with whether patients would recommend the hospital to another family member or friend.

And, it's not just the total time in the ED, it's across the spectrum of ED times monitored in the industry: Franklin:BI studied data collected by 3,700 hospitals, including unpublished data from CMS. Metrics evaluated include:

- **Patients who left without being seen**
- **Time to diagnostic evaluation**
- **Time to ECG**
- **Time to fibrinolysis**
- **Time to pain management**
- **Time to transfer for AMI**
- **Time - arrival to admission**
- **Time - decision to admission**
- **Time in ED**
- **Time to discharge**

The regression line below shows no correlation for **Time in ED** compared to "**Would you recommend?**". The lack of correlation is very similar to all other Time metrics studied.



Want to see more about your own market or see other quality, safety and satisfaction metrics for peers or competitors? Click Here.

We all need to be better strategists; know more...understand more about comparative costs and quality, competitors, markets, changing decision makers, caregivers, and payment mechanisms, -- **Analytics are at the core**.

We can help you accelerate into analytics...and **help** your whole organization. If you are in the business of health care, we can show you how quickly you can build your own intelligence. Click here.

About Franklin Trust Ratings, LLC
Franklin Trust Ratings is a health care business intelligence company that supports better, faster, smarter decision making.

Franklin:BI lets you understand the competitive or comparative performance landscape of providers in the blink of an eye. Operations, Clinical Quality and Safety and Mix, Market Share and Winners/Losers, Provider panels, Ambulatory strategies. One place, always current, always available, Lightning fast!

CA AB 263

AUTHOR: Rodriguez [D]
TITLE: Emergency Medical Services Workers: Working Conditions
FISCAL COMMITTEE: no
URGENCY CLAUSE: no
INTRODUCED: 01/31/2017
LAST AMEND: 06/21/2017
DISPOSITION: Pending
LOCATION: Senate Rules Committee
SUMMARY:

Relates to the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act. Requires an employer that provides emergency medical services as part of an emergency medical services system or plan to authorize and permit its employees to take prescribed rest periods. Requires a specified report concerning violent incidents involving EMS providers. Specifies application of these provisions to employers that are air carriers.

STATUS:

09/01/2017 From SENATE Committee on APPROPRIATIONS: Do pass to Committee on RULES. (5-2)

INDEX: 35, 57
ISSUES: BJ, GBS*
LOBBYIST: CD, KAS*
POSITION: F, X

CA AB 451

AUTHOR: Arambula [D]
TITLE: Health Facilities: Emergency Services and Care
FISCAL COMMITTEE: yes
URGENCY CLAUSE: no
INTRODUCED: 02/13/2017
LAST AMEND: 07/05/2017
DISPOSITION: Pending
LOCATION: Senate Appropriations Committee
SUMMARY:

Specifies that a psychiatric unit within a genera acute care hospital, a psychiatric health facility, or an acute psychiatric hospital is required to provide emergency services to care to treat a person with a psychiatric emergency medical condition who has been accepted by the facility if the facility has appropriate facilities and qualified personnel. Makes conforming changed to related provisions.

STATUS:

09/01/2017 In SENATE Committee on APPROPRIATIONS: Held in committee.

INDEX: 35, 77
ISSUES: BJ, SL*
LOBBYIST: AH*, CD
POSITION: N/A, X

CA AB 735

AUTHOR: Maienschein [R]
TITLE: Swimming Pools: Public Safety
FISCAL COMMITTEE: yes
URGENCY CLAUSE: no
INTRODUCED: 02/15/2017
LAST AMEND: 05/26/2017

DISPOSITION: Pending
LOCATION: Senate Appropriations Committee
SUMMARY:

Requires public swimming pools that are required to provide lifeguard services and that charge a direct fee to provide an Automated External Defibrillator during pool operations. Requires the State Department of Education, in consultation with the State Department of Public Health, to issue best practices guidelines related to pool safety at K-12 schools.

STATUS:

09/01/2017 In SENATE Committee on APPROPRIATIONS: Held in committee.

INDEX: 35
ISSUES: BJ
LOBBYIST: CD
POSITION: F

CA AB 1116

AUTHOR: Grayson [D]
TITLE: Peer Support and Crisis Referral Services Pilot Program
FISCAL COMMITTEE: yes
URGENCY CLAUSE: no
INTRODUCED: 02/17/2017
LAST AMEND: 08/09/2018
DISPOSITION: Pending
FILE: 217
LOCATION: Senate Third Reading File
SUMMARY:

Creates the Peer Support and Crisis Referral Services Pilot Program. Defines peer support team as a team composed of the emergency services personnel and other fields 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 or the Commission on Correctional Peace Officer Standards and Training.

STATUS:

08/13/2018 In SENATE. Read second time. To third reading.

INDEX: 31, 35
ISSUES: BJ, CLH, LR*
LOBBYIST: CD, KAS*
POSITION: F

CA AB 1795

AUTHOR: Gipson [D]
TITLE: Emergency Medical Services: Behavioral Health Facility
FISCAL COMMITTEE: yes
URGENCY CLAUSE: no
INTRODUCED: 01/09/2018
LAST AMEND: 04/19/2018
DISPOSITION: Pending
LOCATION: Assembly Appropriations Committee
SUMMARY:

Authorizes a local emergency medical services agency to submit, as part of its emergency medical services plan, a plan to transport specified patients who meet triage criteria to a behavioral health facility or a sobering center. Authorizes a city or county to designate, and contract with, a sobering center to

receive patients and establishes sobering center standards.

STATUS:

05/25/2018	In ASSEMBLY Committee on APPROPRIATIONS: Held in committee.

INDEX:	35
ISSUES:	BJ*, DP
LOBBYIST:	CD
POSITION:	S, X

CA AB 2118

AUTHOR:	Cooley [D]
TITLE:	MediCal: Emergency Medical Transportation Services
FISCAL COMMITTEE:	no
URGENCY CLAUSE:	no
INTRODUCED:	02/08/2018
LAST AMEND:	06/18/2018
DISPOSITION:	Pending
COMMITTEE:	Senate Appropriations Committee
HEARING:	08/16/2018

SUMMARY:

Amends existing law relating to the MediCal Emergency Medical Transportation Reimbursement Act. Makes technical, nonsubstantive changes to the provisions, as specified.

STATUS:

08/06/2018	In SENATE Committee on APPROPRIATIONS: To Suspense File.

INDEX:	35, 65
ISSUES:	AO*, BJ, DP, RY
LOBBYIST:	BG*, CD
POSITION:	F

CA AB 2262

AUTHOR:	Wood [D]
TITLE:	Coast Life Support District Act: Urgent Medical Care
FISCAL COMMITTEE:	no
URGENCY CLAUSE:	no
INTRODUCED:	02/13/2018
LAST AMEND:	04/16/2018
DISPOSITION:	Pending
FILE:	81
LOCATION:	Senate Third Reading File

SUMMARY:

Updates Coast Life Support District Act's reference to the Cortese-knox Local Government Reorganization Act of 1985 to instead reference the Cortese-knox-hertzberg Local Government Reorganization Act of 2000, and would, if the board of directors of the Coast Life Support District desires to exercise the power to provide urgent medical care services, require the board to first receive the approval of the local agency formation commission.

STATUS:

07/02/2018	In SENATE. Read second time. To Consent Calendar.
07/02/2018	In SENATE. From Consent Calendar. To third reading.

INDEX:	33, 35
ISSUES:	BJ*, DP, PW
LOBBYIST:	BG, CD*
POSITION:	S, X

CA AB 2280

AUTHOR: Chen [R]
TITLE: Emergency Medical Services: Patient Offload Time
FISCAL COMMITTEE: no
URGENCY CLAUSE: no
INTRODUCED: 02/13/2018
LAST AMEND: 03/15/2018
DISPOSITION: Pending
LOCATION: Assembly Health Committee
SUMMARY:

Amends existing law relating to nonstandard patient offload time. Requires the Emergency Medical Services Authority to annually report on the information received by the local EMS agencies regarding nonstandard patient offload times. Requires the report to include any local EMS associated costs attributed to the nonstandard patient offload times.

STATUS:

03/15/2018	To ASSEMBLY Committee on HEALTH.
03/15/2018	From ASSEMBLY Committee on HEALTH with author's amendments.
03/15/2018	In ASSEMBLY. Read second time and amended. Re-referred to Committee on HEALTH.

INDEX: 35, 65
ISSUES: AK, BJ*, DP
LOBBYIST: BG, CD*
POSITION: O, X

CA AB 2961

AUTHOR: O'Donnell [D]
TITLE: Emergency Medical Services
FISCAL COMMITTEE: no
URGENCY CLAUSE: no
INTRODUCED: 02/16/2018
LAST AMEND: 07/03/2018
DISPOSITION: Pending
COMMITTEE: Senate Appropriations Committee
HEARING: 08/16/2018
SUMMARY:

Requires a local Emergency Medical Services agency to submit quarterly data to the Emergency Medical Services Authority that is sufficient for the Authority to calculate ambulance patient offload time by local EMS agency jurisdiction and by each facility in a local EMS agency jurisdiction. Requires the Authority to calculate ambulance patient offload time and report it twice per year to the Commission on Emergency Medical Services.

STATUS:

08/06/2018	In SENATE Committee on APPROPRIATIONS: To Suspense File.

INDEX: 35
ISSUES: BJ
LOBBYIST: CD
POSITION: O, X

CA SB 398

AUTHOR: Monning [D]
TITLE: Acquired Brain Trauma
FISCAL COMMITTEE: yes

URGENCY CLAUSE:	no
INTRODUCED:	02/15/2017
LAST AMEND:	03/23/2018
DISPOSITION:	Pending
COMMITTEE:	Assembly Appropriations Committee
HEARING:	08/16/2018

SUMMARY:

Relates to a program of services for persons with acquired traumatic brain injury. Makes that program operative until a specified date. Requires the Department of Rehabilitation to pursue all sources of funding and by authorizing the department to require that service providers meet specified program and operational certification standards in order to receive ongoing funding.

STATUS:

06/27/2018	In ASSEMBLY Committee on APPROPRIATIONS: To Suspense File.
INDEX:	35, 65
ISSUES:	AK*, AO, DBR
LOBBYIST:	BG*, CD
POSITION:	F

CA SB 792

AUTHOR:	Wilk [R]
TITLE:	Homeless Coordinating and Financing Council
FISCAL COMMITTEE:	yes
URGENCY CLAUSE:	no
INTRODUCED:	02/17/2017
LAST AMEND:	07/03/2018
DISPOSITION:	Pending
COMMITTEE:	Assembly Appropriations Committee
HEARING:	08/16/2018

SUMMARY:

Requires the Homeless Coordinating and Financing Council to develop and implement a statewide strategic plan for addressing homelessness in the state. Requires the Council to implement 2 strategic plans to assist federal Housing and Urban Development Continuum of Care lead agencies in either or both better implementing Housing and Urban Development recommended activities and meeting Housing and Urban Development requirements.

STATUS:

08/08/2018	In ASSEMBLY Committee on APPROPRIATIONS: To Suspense File.
INDEX:	109, 35
ISSUES:	AM*, BJ
LOBBYIST:	BG*, KAS
POSITION:	F

CA SB 944

AUTHOR:	Hertzberg [D]
TITLE:	Community Paramedicine Act
FISCAL COMMITTEE:	no
URGENCY CLAUSE:	no
INTRODUCED:	01/29/2018
LAST AMEND:	05/25/2018
DISPOSITION:	Pending
COMMITTEE:	Assembly Appropriations Committee
HEARING:	08/16/2018

SUMMARY:

Amends the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act. Establishes the Community Paramedicine Act. Authorizes local EMS agencies to develop a community paramedicine program and provide specified community paramedic services. Requires local EMS agencies to integrate the proposed program into the local emergency medical services plan, enter into certain agreements, and provide specified training. Establishes an Oversight Committee.

STATUS:

08/08/2018	In ASSEMBLY Committee on APPROPRIATIONS: To Suspense File.

INDEX:	35
ISSUES:	BJ*, DP
LOBBYIST:	CD
POSITION:	O, X

CA SB 1372

AUTHOR:	Pan [D]
TITLE:	Sugar-Sweetened Beverages: Study
FISCAL COMMITTEE:	no
URGENCY CLAUSE:	no
INTRODUCED:	02/16/2018
LAST AMEND:	03/22/2018
DISPOSITION:	Pending
LOCATION:	Senate Rules Committee

SUMMARY:

Requires the California Department of Tax and Fee Administration to conduct a study and to submit a report to the Legislature, and to appropriate policy and fiscal committees, on how sugar-sweetened beverage taxes affect residents where those taxes are locally imposed within the state.

STATUS:

03/22/2018	From SENATE Committee on RULES with author's amendments.
03/22/2018	In SENATE. Read second time and amended. Re-referred to Committee on RULES.

INDEX:	35, 65
ISSUES:	AK*, AO, BJ
LOBBYIST:	BG*, CD
POSITION:	F

File name: CHAP/VETO2017

CA AB 340

AUTHOR:	Arambula [D]
TITLE:	Early and Periodic Screening: Trauma Screening
FISCAL COMMITTEE:	yes
URGENCY CLAUSE:	no
INTRODUCED:	02/07/2017
ENACTED:	10/12/2017
DISPOSITION:	Enacted
LOCATION:	Chaptered
CHAPTER:	2017-700

SUMMARY:

Amends existing law providing that EPSDT services include necessary services to correct or ameliorate defects, physical conditions, and mental illnesses, whether or not the services are covered under the state plan. Requires the

department to convene an advisory working group to update, amend, or develop tools and protocols for screening children for trauma, as defined, within the EPSDT benefit. Requires the department to identify an existing working group to periodically review protocols.

STATUS:

10/12/2017	Chaptered by Secretary of State. Chapter No. 2017-700
INDEX:	35, 65
ISSUES:	AK*, DBR, SL
LOBBYIST:	AH, BG*
POSITION:	F

CA AB 545

AUTHOR:	Bigelow [R]
TITLE:	Joint Powers Agreements: County of El Dorado
FISCAL COMMITTEE:	no
URGENCY CLAUSE:	no
INTRODUCED:	02/13/2017
ENACTED:	07/24/2017
DISPOSITION:	Enacted
LOCATION:	Chaptered
CHAPTER:	2017-124

SUMMARY:

Authorizes a private, nonprofit hospital in the County of El Dorado to enter into a joint powers agreement with a public agency. Prohibits nonprofit hospitals and public agencies participating in the agreement from reducing or eliminating any emergency services without a public hearing.

STATUS:

07/24/2017	Chaptered by Secretary of State. Chapter No. 2017-124
INDEX:	15, 35
ISSUES:	AM, PW*
LOBBYIST:	CD*, KAS
POSITION:	F

CA SB 432

AUTHOR:	Pan [D]
TITLE:	Emergency Medical Services
FISCAL COMMITTEE:	yes
URGENCY CLAUSE:	no
INTRODUCED:	02/15/2017
ENACTED:	10/02/2017
DISPOSITION:	Enacted
LOCATION:	Chaptered
CHAPTER:	2017-426

SUMMARY:

Requires a health facility infection control officer to give a certain notice immediately to a designated officer upon determining that the person to whom prehospital emergency medical care personnel provided emergency medical or rescue services is diagnosed as being afflicted with a specified disease or condition and to give notice to the county health officer with the name and telephone number of the personnel.

STATUS:

10/02/2017	Signed by GOVERNOR.
10/02/2017	Chaptered by Secretary of State. Chapter No. 2017-426
INDEX:	35
ISSUES:	BJ*, LR, SL

	LOBBYIST:	CD
	POSITION:	S, X

CA SB 687

AUTHOR:	Skinner [D]
TITLE:	Health Facilities: Emergency Services: Attorney General
FISCAL COMMITTEE:	yes
URGENCY CLAUSE:	no
INTRODUCED:	02/17/2017
VETOED:	10/14/2017
DISPOSITION:	Vetoed
LOCATION:	Vetoed

SUMMARY:

Applies existing notice and consent requirements to a nonprofit corporation that operates or controls a health facility plans to sell, transfer, lease or otherwise dispose of the assets resulting from the reduction or elimination of emergency medical services provided at a licensed emergency center after the consent of the Attorney General. Prohibits the Department of Public Health from licensing a stand-alone emergency room or freestanding emergency center that is not part of a general acute care hospital.

STATUS:

10/14/2017	Vetoed by GOVERNOR.
INDEX:	24, 35
ISSUES:	AM*, LR, SL
LOBBYIST:	CD, KAS*
POSITION:	O, X

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

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

SUBJECT: Behavioral Health Symposium and ED Forum Update

SUMMARY

We are finalizing our speakers and ED Forum event that will take place on Wednesday, December 12, 2018, at Riverside Convention Center. We have received two abstracts that we will use during the afternoon breakouts. We have an opportunity to make the afternoon breakouts smaller abstract presentations versus hour long sessions, similar to scientific meetings if the group has more and thinks there are more willing participants. We could also start to specialize breakout sessions per EMS stakeholder if there is interest from pre-hospital folks, for example LEMSA's, EMSA, CDPH, CAA, etc.

ACTION REQUESTED

- Can each member contact and work with an additional sponsor to attend our meeting in December?
- How would the group like to work the breakout sessions? Would more groups like to do speaking presentations, or would more hospitals like to present operational activities?
- Please let us know if you plan to come the committee meeting and dinner the night of December 11th - we will have a brief committee meeting from 5-7 pm and a committee/ speaker dinner from 7-9 pm.

DISCUSSION QUESTIONS

1) Is there anything missing on our conference day?
2) Would you like us to encourage shorter presentations and or more interactive sessions?
3) Do you want a lunch speaker or a break and time with your colleagues?
4) Are there other suggestions to increase our participation- we are growing and I would like to continue and evaluate potential new opportunities in the future.

Attachments: Save the Date
Sponsor Application
Call for Abstracts
Event Flow

BJB:br

Save the Date for 2018

December 10 - 11
December 12

Behavioral Health Care Symposium
Emergency Services Forum

Here's what attendees had to say about last year's program:

"I learned so much about how technology can influence behavioral health practices"

"Enjoyed the keynote speaker because she reminded me of the awesome responsibility that we have as a leader and how we encourage, motivate, and challenge our staff."

"I learned so much about improving transition of care in the ER and how to control overcrowding in the ER."

The annual **Behavioral Health Care Symposium** and **Emergency Services Forum** will provide you with three days of need-to-know content that will inspire and motivate you to create change in your facility.

Hotel
The Mission Inn Hotel & Spa has discounted sleeping rooms available starting at $185 for single or double occupancy. For reservations, call (800) 843-7755 and mention the California Hospital Association to receive the discounted rate. Discount deadline is **November 15**.

Additional sleeping rooms are available nearby at the Marriott Riverside at the Convention Center. Rooms are available for $145, single or double occupancy. For reservations, call (800) 228-9290 and mention the California Hospital Association to receive the discounted rate. Discount deadline is **November 15**.

Event Site
Educational sessions will be held at the remodeled Riverside Convention Center, just a short walk away from the Mission Inn.

Sponsors
For sponsor opportunities, contact Lisa Hartzell at lhartzell@calhospital.org or (916) 552-7502.

More information will be posted on the CHA website in the coming months.

Visit the website at www.calhospital.org/education.

CALIFORNIA HOSPITAL ASSOCIATION

Sponsorship Options

Emergency Services Forum
December 12, 2018, Riverside Convention Center

Why sponsor? In the exhibit area, participants will be able to interact with decision makers of hospital emergency departments.

What's the display space like? Sponsors will have a tabletop display in the exhibit area.

Who are our attendees? Emergency department leaders including emergency department physicians, chief nursing officers, emergency department supervisors, hospital administrators, EMS personnel and public health officials.

How many attend? Approximately 200+ participants each year.

Select Your Level of Participation

Benefits	Platinum Sponsor $3,500	Gold Sponsor $2,500	Silver Sponsor $1,500
Exclusive promotion of keynote or luncheon	√		
Exhibit table with electricity in exhibit area	√	√	√
Complimentary registrations to the educational program	2	1	1
Company logo on Emergency Services Forum website	√	√	√
Color ad in rotating PowerPoint slides and signage shown in the exhibit area	1	1	1
Acknowledgement at the beginning of the program	√	√	√
Attendee list	√	√	√

Additional Fees

$345 (Wed. only) Registration for *each additional* representative

Where and When

December 12, 2018
Riverside Convention Center
3637 Fifth Street
Riverside, CA 92501

Contact

Lisa Hartzell
Director, Education Operations
(916) 552-7502
lhartzell@calhospital.org
www.calhospital.org/promotional-opportunities

CHA reserves the right to decline exhibitor applications.

Exhibit Rules

Emergency Services Forum
December 12, 2018, Riverside Convention Center

Space Assignments
Assignment of tables will be made by the California Hospital Association (CHA) based on the following criteria: exhibitor level, order in which reservations are received, number of tables purchased, suitability and availability of locations.

Space and Services Included in Fee
Space charge is included in exhibitor fee. Items provided are: draped 6-foot table, 2 chairs, table-tent card with company name. Exhibitors are also listed in the conference program with a description of up to 75 words.

Exhibit Refund Policy
Exhibit fees are NON-REFUNDABLE.

Preliminary Exhibit Dates and Hours
(Date/Times are approximate and subject to change)

Location: Riverside Convention Center

Wednesday, December 12
Set-up: 6:00 a.m. – 7:00 a.m.
Viewing: 7:00 a.m. – 4:30 p.m.
Dismantling: 4:30 p.m.

Exhibit Set-up and Clean-up
Set-up of exhibits must be completed and ready for inspection by **7:00 a.m. on Wednesday, December 12**. No set-up work will be permitted after this time without specific permission from CHA. Exhibitors are prohibited from dismantling their exhibits until the designated tear-down time of **4:30 p.m. on Wednesday, December 12**. It is the responsibility of the exhibitor to remove all materials from the exhibit area on Tuesday.

Admittance to the Forum
Exhibit hall admittance is limited to symposium attendees and company representatives who have contracted and paid for exhibit space.

Eligible Exhibits
CHA reserves the right to refuse rental of display space, exhibit, or any part of an exhibit to any company.

Exhibitor Raffle
Exhibitors will have an opportunity to give prizes to the attendees. Each exhibitor is limited to two raffle prizes minimum value of $100 is recommended.

How the Prize Drawing Works!
An exhibit tour card with a list of each participating vendor will be made available within the exhibit area. To enter and win a prize, the attendee must receive a sticker (CHA will provide stickers) from all vendors. Once they have visited each vendor they can enter the completed card in the raffle prize basket. The raffle will take place at the last break. A CHA representative will ask you to come up and draw the winner of your prize. The attendee must be present to win and CHA will provide the winner's contact information to the donating exhibitor.

Fire and Safety
All flammable materials must be flame proofed before being placed in the exhibit area. All materials and installations are subject to the fire and safety regulations in force by state and/or city fire authorities. Exhibitors must provide certification of flame proofing if requested by show management or the fire department. Volatile or flammable fluids, substances or materials of any nature are prohibited in any booth.

Social Functions
Social functions sponsored by exhibitors must not be scheduled during exhibit hours or during the CHA education program. Any function not approved by CHA that would compete for attendees' time, either during the hours of the exhibition or hours of educational sessions, general sessions or programs is prohibited.

Security
Exhibitors are responsible for any valuables at their booth. Security guards will be present at all times.

Exhibitor Checklist

Emergency Services Forum
December 12, 2018, Riverside Convention Center

CALIFORNIA HOSPITAL ASSOCIATION

Please provide the following by **November 15, 2018**

- Exhibit fees—make checks payable to CHA/CAHHS or provide Visa, MasterCard or American Express number with expiration date.
- Company logo in high resolution .jpeg file format.
- Artwork for a full color advertisement rotating in exhibit area.
  Dimension of ad: 13"w x 10"h. Ad submitted as a .jpeg file.
- A short description of your organization (75 words or less).
- A description of your tabletop, dimensions, and product(s) being displayed.
- A description of items you may wish to contribute for the Exhibit show raffle prize drawing.
  **minimum value of $100 is recommended*

All materials can be submitted via email: lhartzell@calhospital.org • Fax: 916-552-7506
Mail: CHA, Education Department, 1215 K Street, Suite 800, Sacramento, CA 95814

Hotel & Exhibit Information

- The Mission Inn Hotel & Spa has discounted sleeping rooms available starting at $185 for single or double occupancy. For reservations, call (800) 843-7755 and mention the California Hospital Association to receive the discounted rate. Discount deadline is **November 15**.
- Additional sleeping rooms are available nearby at the Marriott Riverside at the Convention Center for $145, single or double occupancy. For reservations, call (800) 228-9290 and mention the California Hospital Association to receive the discounted rate. Discount deadline is **November 15**.
- Exhibit area includes one draped, 6 ft table, (2) chairs and a name tent listing your company's name. Please contact Lisa Hartzell at (916) 552-7502 or lhartzell@calhospital.org if you would like electricity at your tabletop and have not already signed up for it.
  NOTE: This is a table top exhibit. Each exhibitor will have roughly 8ft of space to display (this includes the 6ft table), so please plan accordingly.
- Shipping information: Packages must arrive **no sooner than Thursday, December 6, 2018.**
  Ship to: **Riverside Convention Center**
  Event Name/Date: Emergency Services Forum; Dec. 12, 2018
  ATTN: Pamela Sturrock
  3637 Fifth Street,
  Riverside, CA 92501

  *Please include your company name on the shipping label so the Convention Center knows to look out for your package.

Exhibit Schedule on **Wednesday, December 12**

- **Set-up:** 6:00 a.m. – 7:00 a.m.
- **Viewing:** 7:00 a.m. – 4:30 p.m.
- **Dismantling:** 4:30 p.m.

Application

CALIFORNIA HOSPITAL ASSOCIATION

Emergency Services Forum
December 12, 2018, Mission Inn Hotel & Spa and Riverside Convention Center

Submit Completed Application

Fax: (916) 552-7506
E-mail: lhartzell@calhospital.org
Mail: California Hospital Association
Education Department
1215 K Street, Suite 800, Sacramento, CA 95814
Questions: Lisa Hartzell, (916) 552-7502

Select Your Level

☐ Platinum Sponsor ($3,500)

☐ Silver Sponsor ($1,500)

☐ Gold Sponsor ($2,500)

☐ Additional Registration ($345)(Wed. only)

Amount to be Billed: $

Billing Information

☐ VISA ☐ MC ☐ AMEX

Name on Card:

Card Number:

Expiration Date: Security Code:

Billing Address:

City: State: Zip:

Authorizing Signature:

**Make checks payable to "CAHHS/CHA"*

Company Information

Please list your company name as you wish it to appear in marketing materials.

Company:

Contact Name/Title:

Address:

Telephone:

E-mail:

Company web address:

Please provide a brief description about your company. This description will be used in marketing materials. Please adhere to 75 words. CHA reserves the right to alter your description for marketing purposes.

Please list special request consideration in table assignments (e.g., companies you do not wish to be located next to). List specific company names, not products or services. CHA cannot guarantee requests will be met but will make every effort to accommodate them.

Attending Representatives

Please list exactly as you wish it to appear in conference program.

Representative #1:

Title:

Telephone:

E-mail *(required)*:

Representative #2:

Title:

Telephone:

E-mail *(required)*:

Representative #3 *(Gold/Platinum Exhibitors Only)*:

Title:

Telephone:

E-mail *(required)*:

Representative #4 *(Platinum Exhibitors Only)*:

Title:

Telephone:

E-mail *(required)*:

Authorization

Exhibitor assumes responsibility and agrees to indemnify and defend the California Hospital Association and the Riverside Convention Center and their respective employees and agents against any claims or expenses arising out of the use of the exhibition premises. The Exhibitor understands that neither the California Hospital Association nor the Riverside Convention Center maintains insurance covering the Exhibitor's property, and it is the sole responsibility of the exhibitor to obtain such insurance Our company shall be bound by the terms and conditions in the Exhibitor Rules information material.

Authorized Signature: Date

2018 Behavioral Health Care Symposium and Emergency Services Forum

Theme: Agents of Change - Challenging the Status Quo

Updated 7/23/18 RT

Mission Inn and Riverside Convention Center

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

Time	Sunday, Dec 9 Session Event	Time	Day 1—Monday, Dec 10 Session Event	Time	Day 2—Tuesday, Dec 11 Session/Event	Time	Day 3—Wednesday, Dec 12 Session/Event
7:00		7:00		7:00	Continental Breakfast	7:00	Continental Breakfast
7:15		7:15		7:15		7:15	
7:30		7:30		7:30		7:30	
7:45		7:45		7:45		7:45	
8:00		8:00		8:00	Opening Comments — Sheree Lowe BJ Bartleson	8:00	Brief Intro and Keynote Session
8:15		8:15		8:15	Keynote Session	8:15	Dr. Kivela- Pres. Nat. Assoc. of Physicians
8:30		8:30		8:30	Allison Massari	8:30	Leadership of Emergency Services Into the Futur
8:45		8:45		8:45		8:45	
9:00		9:00	Opening Comments, Chair, S. Lowe	9:00		9:00	Break
9:15		9:15	Carmela	9:15		9:15	Roneet - fireside chat -
9:30		9:30		9:30	General Session	9:30	Dusen, KevinMackey, Amy Moulin, Dr. Paul Moore
9:45		9:45		9:45		9:45	
10:00		10:00		10:00		10:00	
10:15		10:15		10:15		10:15	Break
10:30		10:30		10:30	Break	10:30	Breakout Session Roneet
10:45		10:45	Break	10:45		10:45	Breakout Session Aaron Wolfe dignity health
11:00		11:00	General Session	11:00	General Session	11:00	
11:15		11:15		11:15		11:15	
11:30	Executive Committee Meeting	11:30		11:30		11:30	
11:45		11:45		11:45		11:45	
12:00pm		12:00pm	Hosted Luncheon	12:00pm	Hosted Luncheon	12:00pm	Hosted Luncheon
12:15		12:15	Announce Board & Chair	12:15		12:15	
12:30		12:30		12:30		12:30	
12:45		12:45		12:45		12:45	
1:00	CBH Board Meeting	1:00		1:00		1:00	Breakout SF sobering center
1:15	Mission Inn	1:15	General Session	1:15	Passing Break	1:15	Breakout Session Kevin Mackey
1:30		1:30		1:30	General Session	1:30	AliceMoughamian, Simon Pang
1:45		1:45		1:45		1:45	Megan Kennel, Clement Yeh
2:00		2:00		2:00		2:00	Food Break--Giveaway
2:15		2:15		2:15		2:15	
2:30		2:30	General Session	2:30		2:30	Breakout Session Practice Makes Perfect: Interdisciplin
2:45		2:45		2:45	Food Break and Giveaway	2:45	Breakout session Rose- Sepsis
3:00		3:00		3:00		3:00	Jolie Hultner
3:15		3:15		3:15	Closing Session	3:15	
3:30		3:30	Break	3:30		3:30	General Session
3:45		3:45		3:45		3:45	
4:00		4:00	General Session	4:00		4:00	Dr. Moore- Partnership Health Payer
4:15		4:15		4:15		4:15	
4:30		4:30		4:30		4:30	
4:45		4:45		4:45		4:45	
5:00		5:00	Reception	5:00		5:00	
5:15		5:15		5:15		5:15	
5:30		5:30		5:30		5:30	
5:45		5:45		5:45		5:45	
6:00	Reception	6:00		6:00		6:00	
6:15		6:15		6:15		6:15	
6:30		6:30		6:30		6:30	
6:45		6:45		6:45		6:45	
7:00		7:00		7:00		7:00	

CHA is now accepting submissions for presentations and best practices posters for the 2018 CHA Emergency Services Forum (ESF). The forum is a unique opportunity for your organization to showcase and share its emergency preparedness knowledge and expertise with a cross-section of peers. Submissions must be received by **October 1, 2018.**

The ESF is expected to draw more than 250 hospital emergency department leaders including ED physicians, CNOs, ED supervisors, hospital administrators, EMS personnel and public health officials. Mark your calendar — the ESF will be held December 12 in Riverside. We hope you'll plan to join us!

Presentations

Presenters who wish to be considered for both general and breakout sessions should submit an abstract for review. Presentations must be emergency department-focused. Suggested topics include, but are not limited to:

- Care Coordination for ED super users
- Health care collaboration to improve community care access
- Whole Person Care pilots and their impact on ED's-HIE use to improve ED care
- Innovations in ED practice and treatment
- Responding to crisis events
- Managing violence in ED environments
- Prehospital partnerships that work
- Developing transitional/bridge services for homeless
- ED practices to spot and manage opioid addicted patients
- EDIE best practices
- ED quality and improvement using data and stories

Click here **to submit your presentation entry form**.

Best Practices Poster Showcase

The Best Practices Poster Showcase is a way for members to share innovative ideas and model programs that can be replicated by other hospitals. Poster displays will be showcased at the event. Hospital representatives should be available during exhibit and poster viewing sessions to discuss their best practices with attendees.

Click here **to submit your best practices poster entry form**.

Need More Information?

Call the CHA Education Department at (916) 552-7637.

CALIFORNIA HOSPITAL ASSOCIATION

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

FROM: Sheree Lowe, Vice President Behavioral Health

SUBJECT: Behavioral Health Action Update

SUMMARY

The Behavioral Health Action Coalition is moving full speed ahead on all fronts related to next steps for candidate engagement for the November elections. As you recall long with the National Alliance on Mental Illness California, CHA has built a powerful coalition of more than 50 statewide organizations, including health care providers as well as representatives from law enforcement, education, labor, the court system, local governments and business. The coalition's objectives are to:

- Give voice to the problems and potential solutions for improving behavioral health in California
- Educate elected officials and other key decision makers
- Create new and innovative ways to treat and support Californians in need

https://www.behavioralhealthaction.org/

ACTION REQUESTED

- Information Only.

DISCUSSION QUESTIONS

1) How does emergency services fit into the Behavioral Health Action Initiative?
2) Are their opportunities for emergency services assist with education and issue discussion on areas of crossover such as 5150, ligature risk, workplace violence, etc?

Attachments: Behavioral Health Action and Common Agenda
CHA and NAMI Article

BJB:br

BEHAVIORAL HEALTH ACTION

May 2018

Our Purpose

To join in a powerful and diverse coalition leading California to improve behavioral health through collaboration of services and care, without stigma, for all Californians.

Our Objectives

To Elevate – it is the mission of this coalition to lift the issue of behavioral health to the top of the list of federal, state and local priorities. We will work together to create opportunities to give voice to the problems, needs and potential solutions for improving behavioral health in California.

To Educate – this coalition will play a leading role in educating and influencing elected officials and other key decision makers, the many professionals who witness California's behavioral health challenges every day, and the public about issues, challenges and needed improvements.

To Innovate – a key role of this coalition is to be an incubator for new ideas…to think differently about ways to address behavioral health needs, remove legal and regulatory barriers to improvement, create new and innovative ways to prevent, treat and support Californians in need.

Our Path Forward

Focus on the "intersectionality" of the many interests represented.

Develop, collect and share best practices to inform all those involved.

Identify implementable change for service gaps, models of care, and funding streams to support.

Create a plan to improve access and effective treatment for the behavioral health care needs of Californians.

Execute the innovative ideas, by communicating, advocating, and educating change makers throughout California.

Our Focused Common Agenda

As a coalition, our goal is to create a movement within California for more coordinated and integrated care services for individuals with behavioral health needs and to reduce stigma and disparities in behavioral health resources and care that exist in our communities. Many existing systems touch the lives of those with behavioral health needs – health care, social services, law enforcement, criminal justice, education, and more. The needs are great. The existing systems are complex. The gaps in service and the resulting opportunities are equally enormous.

There are many opportunities for investment, innovation, and change to the behavioral health system. This coalition, involving some of the best experts in the state, believes that, of all the actions that could be undertaken, the following focused agenda provides commonly agreed upon initial and immediate action steps for California:

1) **Prevention and Early Intervention of Behavioral Health Needs**
   a. Awareness: Education of the public about behavioral health to destigmatize behavioral health needs and promote behavioral health. Shift focus from responding to acute crises to preventing crisis through wellness and prevention.
   b. Availability: Adequate prevention and early intervention resources and services for those needing help at first on-set of a behavioral health challenge.
   c. Access: Coordinated effort among all to remove barriers to accessing care.

   Recommended Action – Make it a top state priority to define, evaluate, invest in and deploy best practices for preventing behavioral health crises, and intervening with individuals and families, especially children, early. Best practices should include changing the way people think about mental illness and substance use disorder through social media and other new tools, removing payment barriers to parity and to people accessing care when they need it, and creating an integrated model for addressing behavioral health in California.

2) **Crisis Prevention and Response**
   a. Educate: Reduce stigma in the general population, including those providing care and assistance to individuals with behavioral health needs and change the culture through training and education.
   b. Engage: Achieve best outcomes by eradicating the silos in the behavioral health system through greater collaboration and engagement of every touch point along the continuum of care.
   c. Evolve: Humanize rather than criminalize those in crisis by providing the right care at the right time and in the right setting. Those dealing with a behavioral health crisis should be able to access directly the appropriate care or service provider.

   Recommended Action – Identify and invest in the consistent deployment and spread of best practices in crisis care models including crisis stabilization units, crisis residential programs, and peer respite programs. Invest in and continue to fund the Investment in Mental Health Wellness Act of 2013 to support these efforts.

3) **Workforce Development and Improvement**

a. Determine: Recognize and invest in the behavioral health workforce shortage in California, with a focus on diversity. Identify gaps and determine the need for existing and new types of behavioral health providers of care, service and support. Invest where needed, with emphasis on expanding the diversity of the workforce.
b. Develop: Develop new types of providers for behavioral health services to leverage new and different types of treatment, care and support.
c. Distribute: Integrate behavioral health care with primary care and ensure that the workforce resources, especially human resources, are sufficient to meet demand and well-distributed throughout communities. Integration of behavioral health within traditional care and service settings will allow those experiencing early symptoms to get the care they need, when they need it, but only if there is widespread geographic distribution of professionals who are knowledgeable in behavioral health.

Recommended Action – Address critical shortages of behavioral health professionals by recognizing and facilitating reimbursement for existing behavioral health workers and expanding the workforce by developing additional qualified paraprofessionals, including psychiatric rehabilitation practitioners, peer counselors, community health workers, promatoras, cultural brokers, and others.

Advocating for better access to behavioral health should be an election-year imperative

By Carmela Coyle and Jessica Cruz

Our nation's behavioral health system faces great challenges—from shortages of mental health professionals and inpatient beds to a lack of early intervention and prevention programs.

While more Americans have access to behavioral health coverage, thanks in large part to the expansion of Medicaid under the Affordable Care Act, most still lack access to care. According to Mental Health America, 56% of adults in the U.S. with a mental illness do not receive treatment.

Behavioral health, in many respects, is the great unaddressed issue of our time.

The California Hospital Association and the National Alliance on Mental Illness California, in partnership with other behavioral health advocacy groups, are attempting to change this trajectory in the Golden State. Recently, a coalition of more than 50 nontraditional partners launched a new advocacy organization called Behavioral Health Action.

The goal of Behavioral Health Action is to generate public awareness and political dialogue aimed at creative and meaningful solutions. The time has long passed for discussion of how best to help those who face behavioral health challenges that can be disabling and even deadly. It is time for action.

For too long, our society has been reluctant to confront behavioral health problems. The stigma and misunderstandings are still too great. That must end. It is time to bring these issues out of the shadows.

Whether it is substance use disorder or mental illness, behavioral health matters. It affects all of us—our family members, friends and neighbors. It affects the criminal justice system, the workplace, the classroom and the healthcare system. Virtually everyone has a personal story—whether it's about themselves, a family member or a close friend—involving behavioral health and the struggle to deal with it.

Carmela Coyle, left, is CEO of the California Hospital Association. Jessica Cruz is CEO of the National Alliance on Mental Illness California.

Many of the homeless individuals who fill our streets suffer from mental illness. And there has been a marked rise in our country's suicide rate, thrown into the spotlight most recently by the high-profile deaths of celebrity chef Anthony Bourdain and designer Kate Spade.

Behavioral Health Action has brought together an unusual alliance of not only hospitals and healthcare providers, but also groups representing the criminal justice system, labor, local government, not-for-profit organizations and business.

Many of these groups are not traditional allies, but their members have all been touched in some manner by behavioral health and they can speak with collective authority about the need to pursue solutions.

With a united voice, Behavioral Health Action will work to cut through the clutter of competing priorities and pursue common goals that include, but are not limited to crisis prevention and response, workforce development, and prevention and early intervention.

And, in this election year, Behavioral Health Action intends to play a leading role in engaging California's gubernatorial candidates and those seeking other elective offices in a serious dialogue on the need to make behavioral health a top political priority. A recent statewide poll commissioned by Behavioral Health Action found that 92% of likely voters want California's elected leaders to address the unmet needs of our state's behavioral health system. This public sentiment is not unique to California. In poll after poll conducted in recent years by various mental health advocacy organizations, the American public consistently ranks access to behavioral healthcare as a top national priority.

Behavioral Health Action intends to be a powerful catalyst in not only raising the profile of the unmet behavioral health needs in the nation's largest state, but also in mapping out concrete solutions that may ultimately benefit all Americans. Our nation's quality of life, its economy and its prosperity hang in the balance. ●

Interested in submitting a Guest Expert op-ed? View guidelines at **modernhealthcare.com/op-ed.** Send drafts to Assistant Managing Editor David May at dmay@modernhealthcare.com.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

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

SUBJECT: Ambulance Patient Offload Times and Delays (APOT, APOD)

SUMMARY

Ambulance patient offload times and delays continue to be of concern to the prehospital environment. While at the time of this writing AB 2961 is on suspense, it will more than likely move and be signed by the Governor. The bill will mandate that LEMSAs collect and report APOT times, specifying hospitals. We continue to work with EMSA/LEMSAs on improving the data collection processes, however, there are still numerous issues between LEMSAs, prehospital providers and hospitals.

In light of this continued focus on APOT data collection and lack of clarity around collection and reporting, we need to determine next steps to assure as much validity and reliability can be built into the system. We could also work with potential vendors and HIE technology to improve systems and interoperability between stakeholders.

ACTION REQUESTED

- Direction for next steps on APOT/APOD

DISCUSSION QUESTIONS

1. At our last meeting we discussed the idea of adding an APOT 2.0 toolkit to incorporate the latest methodology, technology updates and best practice activity from the field. Attached is Pam Allen's excellent presentation last year on "Using Technology to Decrease APOD", which could be beneficial information to hospital and ED members looking to improve data collection- is this something the members would like us to pursue?

Attachments: Pam Allen, 2018 ED Forum Presentation: APOD 3.0 Using Technology to Improve Offload Delay
Amendments
CHA – Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department

BJB:br

APOD 3.0: Using Technology to Improve Offload Delay

Pamela Allen
Redlands Hospital

CALIFORNIA HOSPITAL ASSOCIATION

Using Technology to Improve Offload Delay

Pam Allen, MSN, RN, CEN

Who's Been There?

RCH Licensed Beds

- 195 General Acute
- 24 Perinatal
- 17 NICU
- 12 ICU stroke designated beds
- 59 Telemetry stroke designated beds
- 16 Skilled Nursing
- 18 Acute Psychiatric
- 21 Emergency Department beds
- 18 Observation beds

RCH- About Us

American Heart Association
American Stroke Association
CERTIFICATION
Meets standards for
Primary Stroke Center

- Primary Stroke Center
- Spine Joint Institute
- Outpatient Behavioral Medicine Program
  - Partial Hospital Care Program
  - Intensive Outpatient Care Program
- Family Clinics
- Home Health and Hospice

SPINE & JOINT INSTITUTE
REDLANDS COMMUNITY HOSPITAL

Emergency Services-About Us

- 21 Licensed Beds
- 7 Bed Fast Track
- Hallway- chairs and gurney's
- RME- 4 cubicles
- Base Station
- Internal waiting room with 4 recliners
- Remodel/Expansion- Fall 2017
  - 36 beds
  - Triple the size
- Volume: 2013: 44,000 2017: 54,000

ED Overcrowding and Ambulance Patient Off-Load Delays (APOD)

- National Study between 2006-2012
  - Hand off increased from 20 to 45 minutes
- Consequences
  - Ambulance Diversion
  - Prolonged wait times
  - Patient delay and suffering

Myriad of Issues

- Decreased ED and inpatient bed capacity
- Mandated nurse-to-patient ratio
- Increased patient acuity
- Increased volume of mental health patients
- Delays in throughput
- Shortage of primary care clinics/providers
- Millions of newly insured
- Insufficient physician reimbursement for Medi-Cal patients

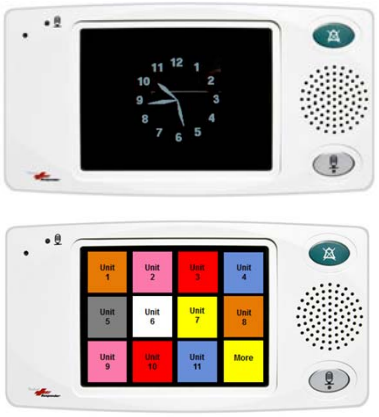
Redirection Pilot Program

- Prior: No ED saturation or diversion
- Bed Delays
  - ICEMA- 25 minutes, REMSA- 30 minutes
- Trial- May 1, 2015
  - Authorizes temporary redirection of ambulances if a patient remains on an ambulance gurney more than 90 minutes
- APOD Task Force
- APOD- Behavioral Health Committee

RCH Implementation

- Install central monitor with an ambulance call light system
- Centrally located
  - Main Nursing station
  - 40 inch screen
- Increased provider and RN staffing to match patient arrival

Process



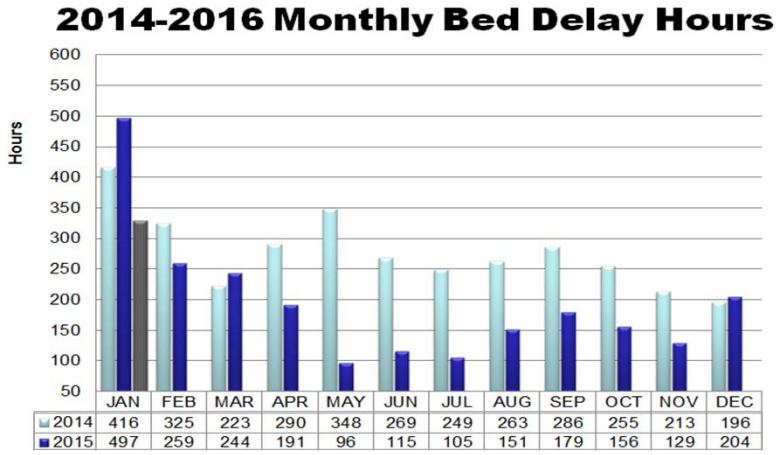
- MICN assigns crew number
- Crew arrives and presses number
- Box highlights

Process

Call's Section on 40 inch Monitor

- 0-20 minutes= **green** color
- 21-65 minutes= **yellow** color
- 66-90 minutes= **orange** color
- > 90 minutes= **red**= Redirect

Results

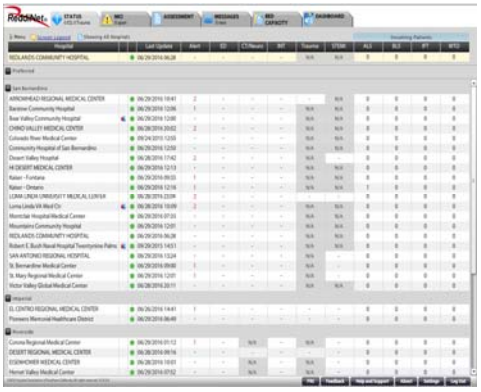


	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
2014	416	325	223	290	348	269	249	263	286	255	213	196
2015	497	259	244	191	96	115	105	151	179	156	129	204

Reddinett Utilization

ReddiNet® A HASC SERVICE

- Go Live June 22, 2015
- Notification for redirection by e-mail alerts
- Hospital calls ambulance provider when handoff occurs.
- Hospitals on Redirection are noted in Reddinett



AB -1223 Emergency Medical Services: Ambulance Transport

AB -1223 Emergency Medical Services: Ambulance Transport

- Approved September 30, 2015
- Authorizes local EMS agencies to adopt P&P and reporting of ambulance patient offload times
- Establish criteria for reporting of and quality assurance follow-up of a nonstandard patient offload times

First Watch

- Prior - Telephone call to Ambulance provider that handoff occurred.
- Implemented March 1, 2016
- Allows visualization of ambulances enroute, present at site and length of stay
- Screens are posted at:
  - Charge Nurse computer
  - Central monitor with Ambulance call light system
- Charge Nurse greets paramedics and completes TOC following handoff
- Ability to see data and pull reports

First Watch

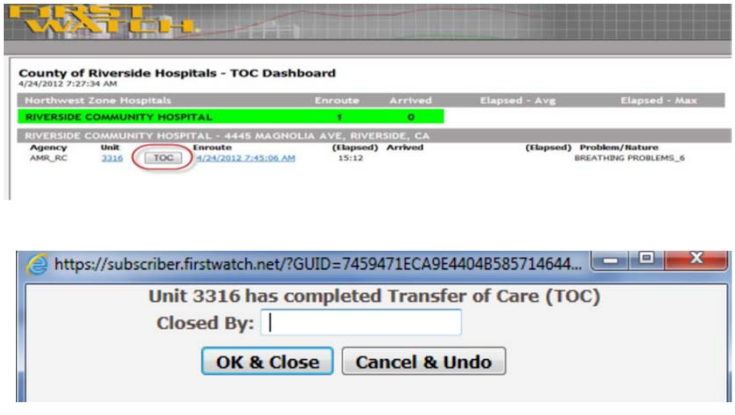
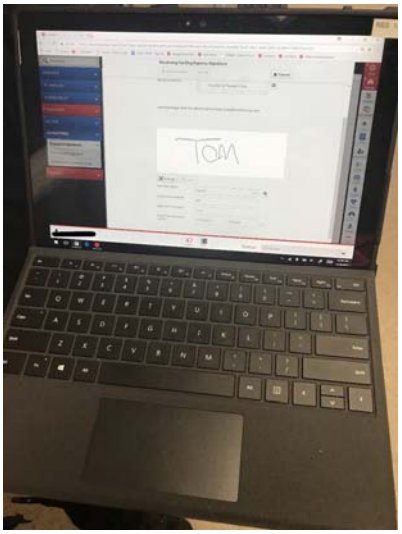
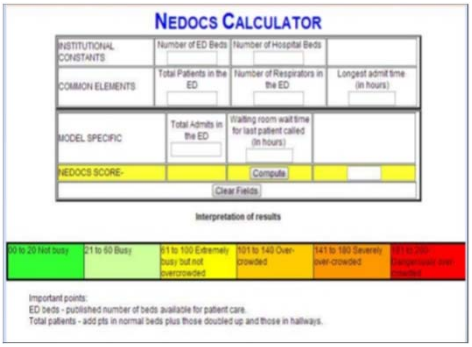


Image Trend Elite-
Sign, Clock & Lock



ED Overcrowding Surge Plan

- NEDOCS
- CEDOCS
- Storm Watch
- AB 911
  - ER Overcrowding



Storm Watch

- Management of patient flow during periods of high demand for service
- Four response levels: Green, Yellow, Orange, and Red
- Each Level is defined and has an ED and Hospital action plan

Redlands Community ED Hospital Surge Capacity Plan

Color/Level	Description	ED Intervention	Hospital Intervention
Level 1 Green	APOD < 25 minutes MSE < 45 minutes	1.Standard operations in effect 2.Board Rounds: 0730,1930- ED Charge Nurse (ED CN) and MD 1030- ED CN, Case Manager, MD 1530- ED CN, House Supervisor & MD	Standard operations in effect Turn around time from admit order written to inpatient bed less than 2 hours.
Level 2 Yellow	1. APOD > 25 minutes-90 minutes 2. MSE 45-90 minutes 3. Charge RN is taking overflow patients 4. All monitored beds are occupied 5 Holds: a. 4 Tele/OBS/MS &/or b. 1-2 ICU	1. ED CN call Storm Watch Level 2 2. ED CN conducts board rounds to assess status of patients and to triage monitored patients. 3. ED CN determines cause for decreased throughput a. In-patient holds: ED CN talks to House Supervisor for bed assignments b. Holds transferred immediately and bedside report given (exception: no physical bed available) c. Assess psych patients for possible movement to the Obs Unit. 4. Radiology supervisor to call ED US to acknowledge 5. Lab supervisor to call ED US to acknowledge 6. Cardiopulmonary: Contact Cardiologist to complete stress tests and discharge patients.	1. Bed meeting will be held within 45 minutes from activation to include House Supervisor, Charge Nurses, ED Case Manager. a. In-patient Charge Nurses will bring most current bed status, pending discharges with identified obstacles and/or discharge times. b. Staffing Coordinator and department assistants to call staff to work. 2. Radiology to inform their services of Storm Watch and to expedite testing 3. Hospitalist offices (BMG & TH) will be contacted to facilitate admission and discharge orders. In addition, to assist in triaging in patient telemetry status for downgrades. 4. STAT clean placed on all empty rooms

Redlands Community ED Hospital Surge Capacity Plan

Color/Level	Description	ED Intervention	Hospital Intervention
Level 3 Orange	1. 3 ambulances with 2 waiting over 90 minutes 2. MSE > 90 minutes 3. ED CN has patients 4. Break nurse has assignment 5. All monitored beds occupied 6. Holds: a. 8 Tele/OBS /MS &/or b. 3 -4 ICU patients 7. Closing areas to maintain staffing	1. ED CN call Storm Watch Level 3 2. ED CN, ED physician and HS to conduct hourly board rounds until condition resolved 3. ED Director and VP of Patient Care Services/ designee to be called after hours by House Supervisor 4. ED Director to notify ED Medical Director 5. ED Leadership and office staff will be available to assist in flow.	1. Bed meeting will be held within 45 minutes from activation to include staffing coordinator, Nurse Managers, House Supervisor, Case Manager representive, EVS Director. Charge nurses to remain on unit and handoff to Nurse Managers who will bring most current bed status to meeting. 2. No outside transfers will be accepted as direct admits unless already accepted. 3. Department leadership will be available on units to assist with patient flow 4. Case management will assist units to expediate patient needs for discharge or transfer. 5. Hospitalist will review in house patients for possible discharge and expedite admission orders. 6. No flexing of staff until released by House Supervisor. 7. Consider ICU beds in PACU and/or use of PACU staff to assist with ICU patients 8. Nurse Educators will be utilized
Level 4 Red	1. 3 ambulances with APOD of > than 120 minutes 2. MSE > 120 minutes 3. Unable to maintain staffing ratios 4. The ED is at maximun capacity 5. Holds: a. > 8 Tele/Obs /MS &/or b. > 4 ICU patients	1. ED CN call Storm Watch Level 4 2. ED CN, ED physician and HS maintain hourly board rounds until condition resolved. 3. ED Nursing and Physician Leadership at hospital.	1. "Level 4/ Condition Red" Centralized Command Center is activated by House Supervisor to include VP of Patient Care Services or designee, staffing coordinator, Nurse Directors, Director of Case Management, House Supervisor, EVS Director, Hospitalist representive and ancillary department representatives. All should be prepared with current department status and number of staff on hand. 2. All Nursing Leadership at hospital. 3. All hospital meetings cancelled. 4. Consider canceling elective surgeries 5. Administrative nurses will act as additional nursing resources as delegated by the House Supervisor. 6. Closed nursing units opened if staffing allows. 7. Emergency discharge lounge/area to be identified for discharge patients awaiting rides. 8. Primary Care Physicians and Surgeons to be contacted to assist Hospitalists with patient flow.

Questions & Comments?


Agents of change
Emergency Services Forum
Thank you
Pamela Allen
paa2@redlandshospital.org
CALIFORNIA HOSPITAL ASSOCIATION

AMENDMENTS

SECTION 1.
The Legislature finds and declares the following:

(a) In 2015, the Legislature directed the Emergency Medical Services Authority (EMSA) to develop a methodology to measure and report ambulance patient offload time.

(b) Ambulance patient offload time is the interval between the arrival via ambulance of a patient at an emergency department and the time the patient is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for the care of the patient.

(c) Patients who are experiencing an emergency and are transported to the hospital must get rapid, efficient transfer and attention at an emergency care facility. Ensuring immediate transfer of patient care at emergency rooms will not only benefit the patient under direct care, but also ensure that emergency medical services (EMS) professionals can reenter the field to help others in need.

(d) Significant delays in ambulance patient offload time unacceptably prevent a patient from receiving appropriate and immediate care, and pose a public safety risk by having fewer qualified EMS personnel available to respond to other emergencies.

(e) Chapter 379 of the Statutes of 2015 required the EMSA to create a common definition of ambulance patient offload time and charged the EMSA with establishing a standard way of measuring the problem across the state, while allowing for the collection of data needed to measure ambulance patient offload time and address issues.

(f) While the EMSA has established the methodology, reporting by local EMS agencies has been intermittent. Some local EMS agencies reported ambulance patient offload time quarterly during 2017, some local EMS agencies reported incomplete data, and more than a dozen local EMS agencies have not reported any data.

(g) Chapter 377 of the Statutes of 2015 directs EMS providers to utilize an electronic patient care record system to track patient care records and to submit that data to local EMS agencies. An electronic system allows for better data collection, better data sharing between agencies, and better coordination between the EMS system and emergency departments.

(h) Electronic patient care records include data tracking for each emergency response call that includes transferring a patient to an emergency department. Currently, ~~that~~ *electronic patient care record* data is not shared *consistently or completely* with EMSA.

(i) It is imperative that local EMS agencies report this data to EMSA to inform EMSA and EMS system stakeholders in considering or adopting reasonable policy solutions to reduce or eliminate ambulance patient offload time.

SEC. 2.
Section 1797.123 is added to the Health and Safety Code, immediately following Section 1797.122, to read:

1797.123.
(a) Upon receipt of data reported by a local EMS agency to the authority pursuant to Section 1797.228, the authority shall calculate average ambulance patient offload time by local EMS agency jurisdiction and by each facility in a local EMS agency jurisdiction.

(b) The authority shall report twice per year to the Commission on Emergency Medical Services the average ambulance patient offload time by local EMS agency jurisdiction and by each facility in a local EMS agency jurisdiction.

(c) On or before December 1, 2020, the authority *in collaboration with the LEMSAs* shall submit a report to the Legislature on the average ambulance patient offload time and recommendations to reduce or eliminate ambulance patient offload time. The report shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 3.
Section 1797.228 is added to the Health and Safety Code, immediately following Section 1797.227, to read:

1797.228.
(a) On or before July 1, 2019, a local EMS agency shall transmit ambulance patient offload time data to the authority, consistent with the policies and procedures developed pursuant to Section 1797.225. ~~or by utilizing electronic health record system data reported by emergency medical care providers pursuant to Section 1797.227.~~

~~(b) If an local EMS agency elects to *shall* submit *all patient health record* data *to the authority* from the electronic patient care records under an electronic health record system, reported pursuant to Section 1797.227., the data must be sufficient for the authority to calculate and report ambulance patient offload time, as defined in subdivision (b) of Section 1797.120, by local EMS agency jurisdiction and by each facility in a local EMS agency jurisdiction.~~

(1) T~~t~~he data must be sufficient for the authority to calculate and report ambulance patient offload time, as defined in subdivision (b) of Section 1797.120, by local EMS agency jurisdiction and by each facility in a local EMS agency jurisdiction.

~~(b) Before submitting data to the authority, the local EMS agency shall ensure that personally identifying patient data is not included in the submission.~~

~~(d) A local EMS agency shall submit quarterly data to the authority no later than 15 days after the end of the quarter.~~

SEC. 4.
If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

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

SUBJECT: Community Paramedicine Update

SUMMARY

CHA co-sponsored AB 1795 (Gipson) which was held in appropriations. CPF sponsored SB 944 (Hertzberg) which had tremendous opposition by numerous stakeholders including CNA, EMSAAC, EMDAC, and others. Both CHA and EMSA had strong oppose unless amended positions. As of today the bill was not lifted from suspense.

The mid-year report continues to show safe and effective delivery of care under these programs (see attached)

In addition to SB (944), the EMSAAC and EMDAC associations put out a joint position statement on medical control and alternate destination statutory interpretation, (attached). CHA has also been in contact with OSHPD relative to renewing the community paramedicine pilot projects. EMSA has sent a one year renewal request to OSHPD.

ACTION REQUESTED

- Information Only.

DISCUSSION QUESTIONS

1. What are your thoughts on next steps for community paramedicine?

Attachments: Community Paramedicine Pilot Program: Summary and Two Year Evaluation
Update of Evaluation of California's Community Paramedicine Pilot Program
Research Highlight: Key Findings From Two-Year Evaluation of Health Workforce Pilot Project #173 – Community Paramedicine
EMSAAC EMDAC Position Statement on Medical Control
Morales Letter re Destination

BJB:br

Community Paramedicine Pilot Program

Summary and Two Year Evaluation

University of California, San Francisco
Philip R. Lee Institute for Health Policy Studies and
Healthforce Center
Janet Coffman, MPP, PhD
Lead Evaluator

California Emergency Medical Services Authority
Howard Backer, MD, MPH, FACEP
PI for HWPP #173

Lou Meyer
Project Manager

Working Definition of Community Paramedicine

A locally determined community-based, collaborative model of care that leverages the skills of paramedics and EMS systems to address care gaps identified through a community-specific health care needs assessment.

- New models of community-based health care that bridge primary care and emergency care
- Utilizes paramedics outside their traditional emergency response and transport roles

Why Paramedics?

- Trusted and accepted by the public
- In most communities--inner city and rural
- Work in home and community-based settings
- Licensed personnel that operate under medical control as part of a system of care
- Trained to make health status assessments, recognize and manage life-threatening conditions outside of the hospital
- Always available (24 / 7 / 365)

Community Paramedicine Concepts

- Post hospital discharge short-term follow-up
- Frequent EMS user case management
- Directly Observed Therapy for tuberculosis: public health department collaboration
- Hospice support
- Alternate destination to mental health crisis center
- Alternate destination to sobering center
- Alternate destination to urgent care center (Cancelled)

Methods

- Evaluation period 24 to 28 months except for alternate destination to sobering center (depending on project start time between June 2015-October 2015)
- Outcomes assessed across three domains
  - Safety
  - Effectiveness
  - Potential savings accrued by other parts of the health care system

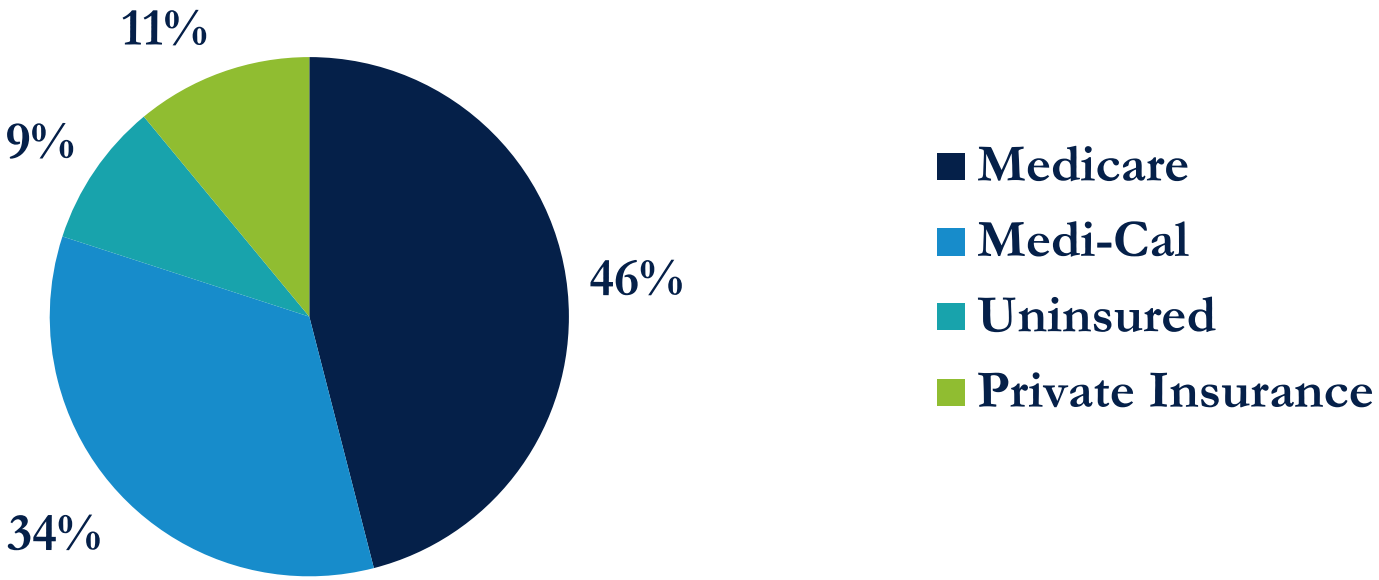
Cumulative Patients Enrolled by Concept through September 2017*

Concept	# Enrolled
Post-Discharge Short-term Follow-Up	1,401
Frequent EMS Users	103
Directly Observed Therapy for Tuberculosis	42
Hospice	270
Alternate Destination – Mental Health	251
Alternate Destination –Sobering Center	400
Alternate Destination – Urgent Care	48§
All Projects	2,515

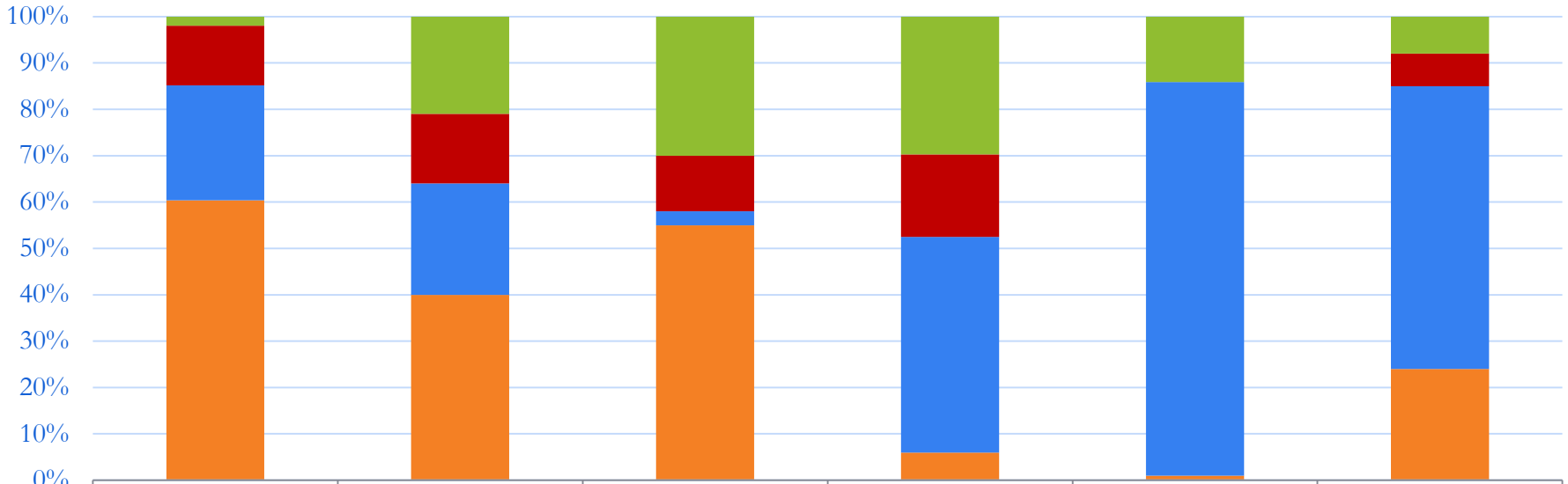
* 24 to 28 months for individual projects, depending on start date except for alternate destination to sobering center

§ Pilot projects for alternate destination urgent care cancelled

Enrolled Patients' Payer Types – Through September 2017



Community Paramedicine Patient Payer Mix



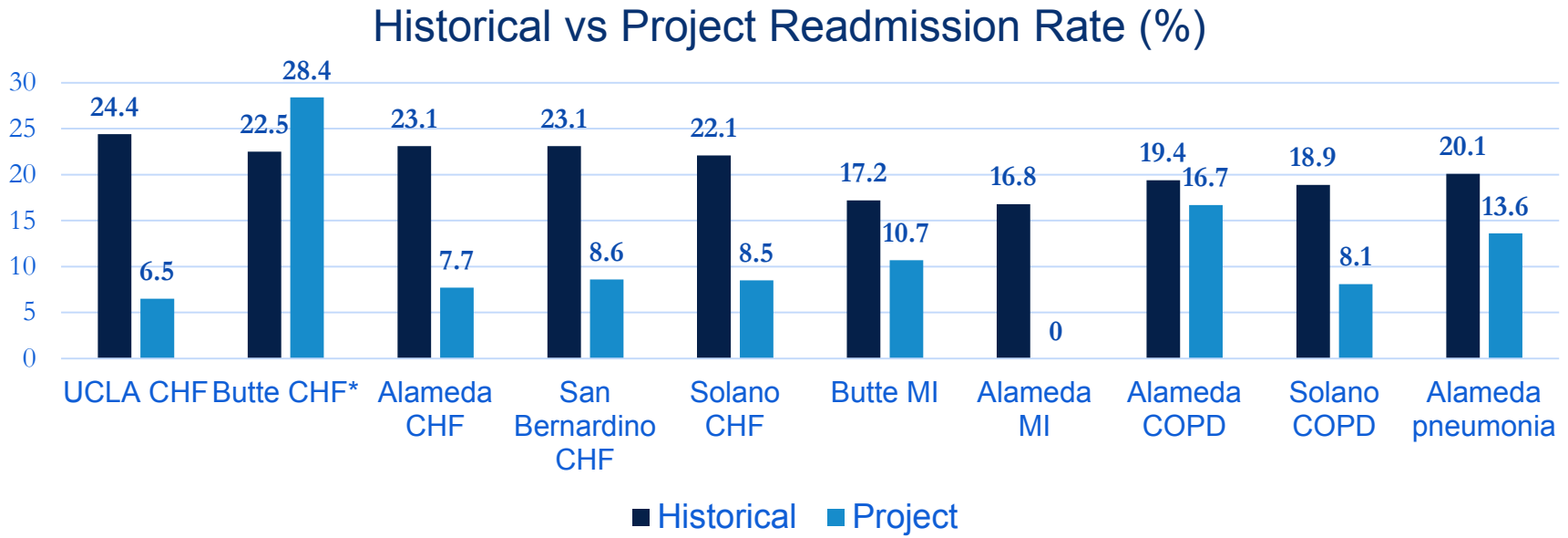
	Post discharge	Frequent 911	Hospice	TB	Alt Dest Mental Health	Alt Dest Sobering
Uninsured	2%	21%	30%	30%	14%	8%
Commercial	13%	15%	12%	18%	0%	7%
Medi-Cal	25%	24%	3%	47%	84%	61%
Medicare	61%	40%	55%	6%	1%	24%

Medicare Medi-Cal Commercial Uninsured

Post-Discharge Short-term Follow-Up

- Decreased hospital readmissions within 30 days for at least one diagnosis at all sites
- CPs identified 229 patients (16%) who misunderstood how to take their medications or had duplicate medications and were at risk for adverse effects.
- All five post-discharge projects achieved potential cost savings for payers, primarily Medicare and Medi-Cal.

Project Impact on 30 Day Hospital Readmission Rate

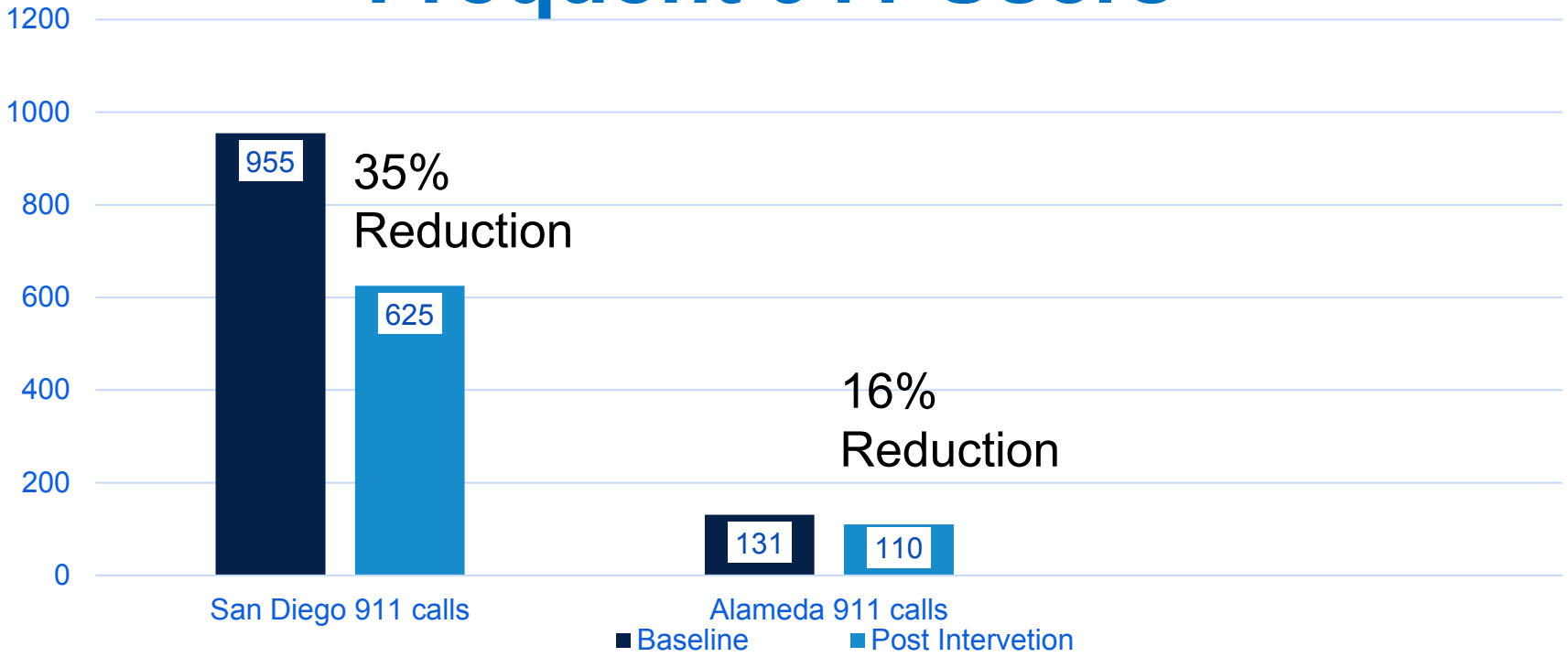


*All projects except Butte CHF and Alameda COPD showed statistically significant reduction in the readmission rate for enrolled patients relative to the partner hospitals' historical readmission rates (p value < 0.05). Alameda COPD had no statistically significant difference. Butte CHF had a higher readmission rate than the historical rate.

Frequent EMS Users

- Reductions in numbers of 911 calls, ambulance transports, and ED visits among enrolled patients.
- Assisted patients in obtaining housing and other non-emergency services that met the physical, psychological, and social needs that led to their frequent EMS use
- EMS collaboration with many other community organizations

Reduction in Emergency Services: Frequent 911 Users



Note: 24 months of operation for San Diego, 28 months for Alameda

Directly Observed Therapy for Tuberculosis

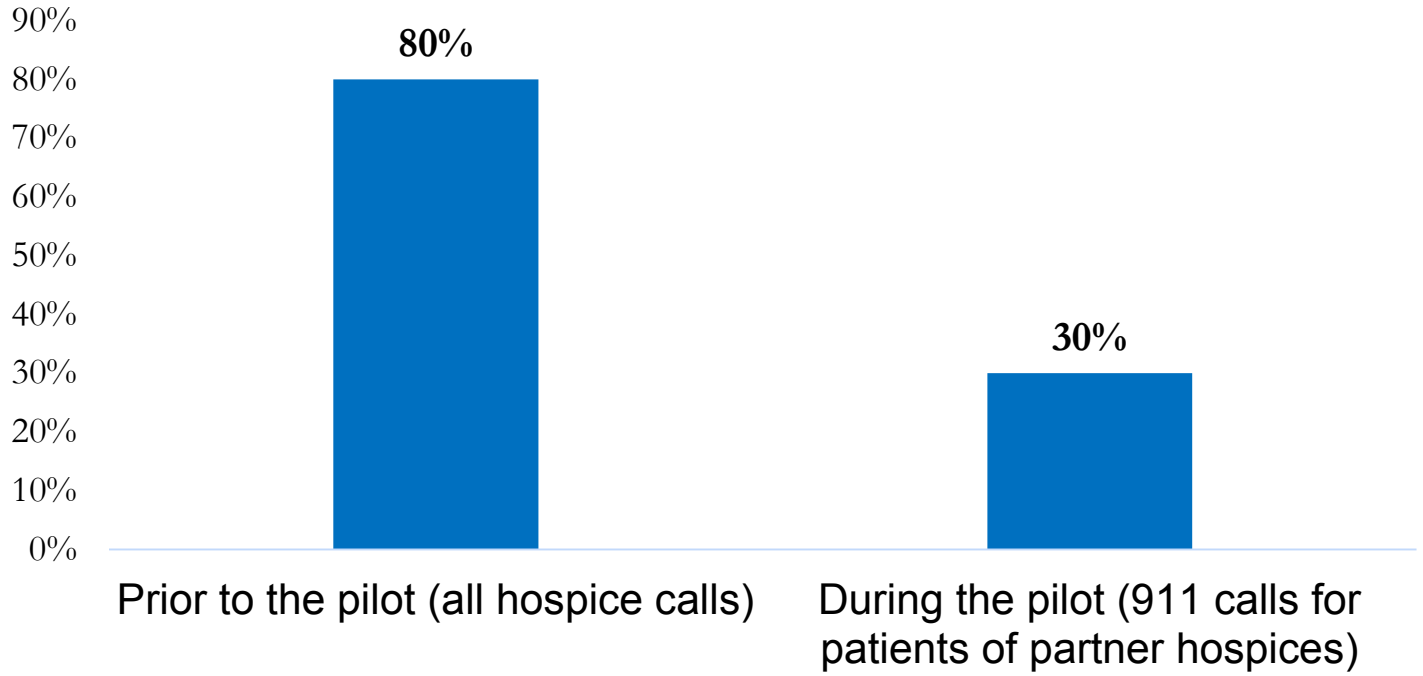
- Dispensed appropriate doses of tuberculosis (TB) medications and monitored side effects and symptoms that could necessitate a change in treatment regimen
- CPs achieved better compliance (99.9%) than community health workers (93.3%) and provided care to patients that CHW could not reach
- Demonstrates capability for collaborative work with public health

Hospice Support

- Provided hospice patients and their families with psychosocial support and administered medications in consultation with a hospice nurse, until nurse could arrive
- In accordance with patient wishes, reduced rates of ambulance transports to an ED
- Potential savings for Medicare and other payers by reducing unnecessary ambulance transports, ED visits, and hospitalizations

Percent of 911 Calls for Hospice Patients Resulting in Transport to ED

(26 months data; N=270 hospice patient calls to 911)

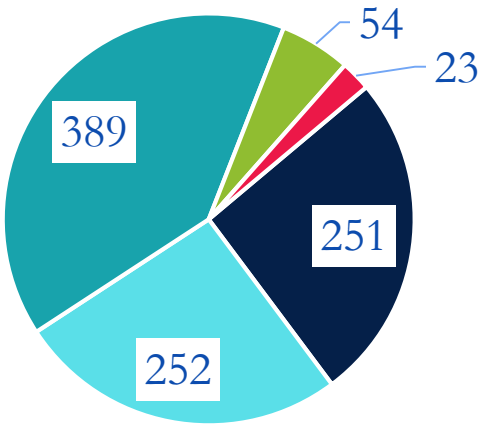


Alternate Destination – Mental Health

- Performed medical screening of patients to determine whether they could be safely transported directly to a mental health crisis center
- 96% of patients enrolled were evaluated at the mental health crisis center without the delay of a preliminary ED visit.
- Over study period (24 months), 4% of patients required subsequent transfer to the ED (9 patients)
- Potential savings for payers, primarily Medi-Cal, due to reduced ED visits and subsequent transfer to mental health center
- Strongly supported by law enforcement because reduces the amount of time required for mental health calls

Alternate Destination—Mental Health

Number of Enrolled, Eligible, and Ineligible Patients
N=969 patients evaluated over 24 months



- Enrolled-transported
- Eligible-not enrolled due to lack of capacity or insurance type
- Ineligible-Intoxicated, medical
- Ineligible-Prior disruptive behavior
- Did not consent

Alternate Destination-Sobering

- Performed medical screening of patients to determine whether they could be safely transported directly to a sobering center
- Enrolled and transported 400 patients in first 8 months.
- Ten patients (2.5%) were transferred to an ED within six hours of admission to the sobering center due to medical complaints
  - 9/10 complaints developed after admission to sobering center
  - 7 subsequently treated and released, 2 transferred for psych eval, 1 left ED without being seen
- Potential savings for payers, primarily Medi-Cal, due to reduced ED visits

Alternate Destination – Urgent Care

- Insufficient data to make firm conclusions about this model
- No patients experienced an adverse outcome, although two patients were transferred to an ED following admission to an urgent care center
- Nine patients were rerouted to an ED because the urgent care center declined to accept
- Projects closed: Multiple barriers to this model in California, although successful in other states

Potential Cost Savings

Accrue Primarily to Hospitals and Payers

Post Discharge	**UCLA** $403,284 $2,619/pt	**Butte** $196,781 $246/pt	**Alameda** $110,718 $1,045/pt	**San Bernardino** $417,687 /$2,120/pt	**Solano** $224,964 $1,551/pt
Frequent EMS Users	**Alameda** $28,392 ($860/patient)			**San Diego** $551,760 ($14,912/patient)	
Hospice				**Ventura** $203,715 ($755/patient)	
Alt Destination Behavioral Health				**Stanislaus** $266,200 ($1,061/patient)	
Alt Destination Sobering Center				**San Francisco** $133,699 ($332/patient)	

Conclusion

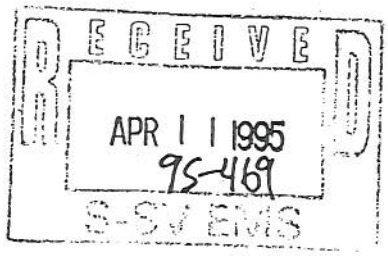
- Specially trained paramedics can provide services beyond their traditional and current statutory scope of practice in California
- Projects have improved patients' well-being
- No adverse outcomes for patients
- No other health professionals displaced
- In most cases, yielded savings for health plans and hospitals

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

PETE WILSON, Governor

EMERGENCY MEDICAL SERVICES AUTHORITY
1930 9TH STREET, SUITE 100
SACRAMENTO, CA 95814-7043
(916) 322-4336
FAX (916) 324-2875

DATE: April 5, 1995



TO: EMS Medical Directors
EMS Administrators
Other Interested Parties

FROM: Joseph Morales, MD, MPA
Director

SUBJECT: **Policy Regarding Patient Destination**

ISSUE:

May a local EMS agency develop policies to allow transport of 9-1-1 patients to facilities other than acute care hospitals with emergency departments?

BACKGROUND:

Solano County is seeking to alter their EMS system to include the option of making decisions to transport patients who contact their 9-1-1 system to facilities other than hospitals with emergency departments. The county EMS agency recently inquired of the Authority whether current statute and regulations permit them to make these decisions regarding alternate destinations for patients.

PERTINENT ISSUES:

1. **Who may make decisions regarding medical care, patient destination policies, and quality improvement?**

The local EMS agency medical director may establish policies and procedures that guide patient care and destination as outlined in HSC 1797.220. This section, last amended in 1988, is the latest statute related to patient destination. The Legislature has given authority to make patient care decisions to the local EMS agency medical director.

2. **Must all patients who contact the 9-1-1 system be transported?**

No. There is no requirement in Division 2.5 or regulations that all persons who enter the 9-1-1 system must be transported. Each system has the authority to develop protocols and policies to address the situation where a patient either does not need transport or refuses transport.

3. **Must all 9-1-1 patients who are transported be transported to an acute care hospital with an emergency facility?**

No. We believe that the references to "transport to a general acute care hospital" found in 1797.52 and 1797.218 are permissive and non-specific. Because of the overriding need to allow flexibility for EMS medical directors, HSC 1797.220 prevails. HSC 1798.101 addresses problems of rural areas where, for "geographic or other extenuating circumstances, as determined by the authority," arrangements may be made for patients to be taken to other appropriate non-hospital facilities. Yet, we find that there is nothing in statute which restricts the destination of patients in other than rural areas to hospitals. Presumably, as in the rural areas, the local agency medical director would determine whether these alternate facilities have the capability to receive patients, and would determine which patients are appropriate for those alternate facilities.

4. **Is there precedent for transporting 9-1-1 patients to alternate facilities?**

Yes. For several years, selected 9-1-1 patients in the inner-city areas of Los Angeles County have been transported to urgent care centers attached to Comprehensive Health Centers. The EMS personnel function under protocols and are capable of deciding which patients are appropriate for transport to the urgent care centers. The urgent care centers are under contract with the local agency to receive appropriate 9-1-1 patients.

5. **May EMT-Paramedics transport patients to these alternate facilities and may they initiate "ALS" treatment on the patients?**

Yes. We find no restriction in statute or regulation regarding which category of EMS personnel may transport patients to these alternate sites. This is a decision which is best made locally. In addition, it is reasonable that all patients should receive the level of care appropriate to their condition, as determined by the EMS personnel attending to them or by local protocol. These are medical decisions which are within the authority of the local agency medical director to make.

6. **What types of alternate facilities are involved?**

It would be the decision of the local EMS agency regarding which specific sites are willing and capable of receiving appropriate 9-1-1 patients.

7. **How would the facilities be selected and integrated?**

We envision that a facility wishing to receive patients would apply to the local EMS agency, and the agency would determine their capability to receive patients. The agency may enter into an agreement with the facility to receive patients and maintain appropriate data and QI

information.

SUMMARY:

The local EMS agency and the local EMS agency medical director have the authority to formulate policies and procedures which will ensure quality medical care for their patients. These policies may include decisions regarding transportation to alternate non-hospital sites for care.

....\ptdest.45

Update of Evaluation of California's Community Paramedicine Pilot Program

by Janet M. Coffman, PhD, MPP, Lisel Blash, MA, and Ginachukwu Amah, Healthforce Center and Philip R. Lee Institute for Health Policy Studies at UCSF

July 12, 2018

Abstract / Overview

Community paramedicine, also known as mobile integrated health (MIH-CP) is an innovative model of care that seeks to improve the effectiveness and efficiency of health care delivery by using specially trained paramedics in partnership with other health care providers to address the needs of local health care systems. In November 2014, the California Office of Statewide Health Planning and Development (OSHPD) approved an application from the California Emergency Medical Services Authority to establish a Health Workforce Pilot Project that has encompassed 17 projects in 13 communities across California that are have tested seven different community paramedicine concepts. Eleven projects are currently enrolling patients. An additional project plans to begin enrolling patients as soon as it receives approval from its Institutional Review Board (IRB). Five of the initial projects have closed due to various challenges.

The Philip R. Lee Institute for Health Policy Studies and Healthforce Center at the University of California, San Francisco, are conducting an independent evaluation of these projects. This report presents findings through March 31, 2018, for projects currently enrolling patients and the projects that have closed. The evaluators conclude that Californians benefit from these innovative models of health care that leverage an existing workforce that operates at all times under medical control — either directly or by protocols developed by physicians experienced in emergency care. The projects have improved coordination among providers of medical, behavioral health, and social services and reduced preventable ambulance transports, emergency department visits, and hospital readmissions. They have not resulted in any adverse outcomes for patients. This report presents a summary of major findings from the evaluation for policymakers. All data submitted by project sites are reported to OSHPD on a quarterly basis.

Acknowledgements

The authors thank the pilot sites, project participants, the California Emergency Medical Services Authority, and the California Office of Statewide Health Planning and Development for their assistance in carrying out this evaluation. They also thank the California Health Care Foundation for funding the evaluation.

Contents

The mission of Healthforce Center is to equip health care organizations with the workforce knowledge and leadership skills to effect positive change.

Healthforce Center at UCSF 3333 California Street, Suite 410 San Francisco, CA 94143

Executive Summary

Community paramedicine, also known as mobile integrated health (MIH-CP) is an innovative model of care that seeks to improve the effectiveness and efficiency of health care delivery by using specially trained paramedics in partnership with other health care providers to address the needs of local health care systems.

On November 14, 2014, the California Office of Statewide Health Planning and Development (OSHPD) approved an application from the California Emergency Medical Services Authority to establish a Health Workforce Pilot Project (HWPP) to test multiple community paramedicine concepts. OSHPD has since renewed the HWPP for one-year periods in 2015, 2016, and 2017. The community paramedicine HWPP has encompassed 17 projects in 13 communities across California that have tested seven different community paramedicine concepts. Eleven projects are currently enrolling patients, including eight projects launched in 2015, one launched in 2017, and two launched in 2018. An additional project plans to begin enrolling patients as soon as it receives approval from its Institutional Review Board (IRB). Five of the initial projects have closed due to various challenges.

The HWPP regulations require organizations that sponsor pilot projects to retain an independent evaluator to assess trainee performance, patient acceptance, and cost effectiveness. The Philip R. Lee Institute for Health Policy Studies and Healthforce Center at the University of California, San Francisco, are conducting the evaluation funded by the California Health Care Foundation.

This report presents a summary of major findings from the evaluation for policymakers. All data submitted by project sites are reported to OSHPD on a quarterly basis. The report presents findings from the time the initial group of pilot projects began enrolling patients (June 2015 to October 2015) through March 2018, for nine of the eleven community paramedicine projects that are currently enrolling patients and the five projects that have closed. The tenth and eleventh projects that are currently enrolling patients, Santa Clara County EMS's alternate destination - mental health project and its alternate destination - sobering center project, are not included because they did not begin enrolling patients until June 2018.

The seven community paramedicine concepts that sites are testing are described below:

1. **Post-Discharge, Short-term Follow-Up:** Provide short-term, home-based follow-up care to people recently discharged from a hospital due to a chronic condition (e.g., heart failure) to reduce their risk of readmission and improve their ability to manage their condition.

2. **Frequent EMS Users:** Provide case management services to people who are frequent 911 callers and frequent visitors to emergency departments (EDs) to identify needs that could be met more effectively outside of an ED and assist patients in accessing primary care and obtaining services to address non-medical needs, such as food, housing, and substance use disorder treatment.

3. **Directly Observed Therapy for Tuberculosis:** In collaboration with a public health agency, provide directly observed therapy (DOT) to people with tuberculosis (i.e., dispense medications and observe patients taking them) to assure effective treatment of tuberculosis and prevent its spread.

4. **Hospice:** In response to 911 calls made by or on behalf of hospice patients, collaborate with hospice agency nurses, patients, and family members to treat patients in their homes according to their wishes instead of transporting them to an ED.

5. **Alternate Destination – Mental Health:** In response to 911 calls, offer people who have mental health needs, but no acute medical needs, transport directly to a mental health crisis center instead of to an ED with subsequent transfer to a mental health facility.

6. **Alternate Destination – Urgent Care:** In response to 911 calls, offer people with low-acuity medical conditions transport to an urgent care center for evaluation by a physician, instead of to an ED.

7. **Alternate Destination – Sobering Center:** In response to 911 calls, offer people who are acutely intoxicated but do not have an acute medical or mental health needs transport directly to a Sobering Center for monitoring instead of to an ED.

Key findings are as follows.

General Project Status

- The pilot projects enrolled 3,142 persons through March 31, 2018.
- Thirteen pilot projects were launched from June through October of 2015.
- San Francisco's alternate destination – sobering center project, began enrolling patients in February 2017.
- Two new projects, Santa Clara County EMS's alternate destination - mental health project and Santa Clara's alternate destination - sobering center project, began enrolling patients in June 2018.
- Fresno's alternate destination - mental health project plans to begin enrolling patients as soon as it receives approval from its Institutional Review Board (IRB).
- Five projects, the UCLA Center for Pre-Hospital Care's post-discharge project, San Diego's frequent EMS user project, and all three alternate destination – urgent care project, have closed. The post-discharge project and the frequent EMS user project closed due to lack of local resources. The alternate destination – urgent care projects closed due to low enrollment.
- OSHPD has approved six additional projects that are currently on hold pending action on community paramedicine legislation that the State Legislature is considering.

Post-Discharge

- From June 2015 through March 2018, the five post-discharge projects have enrolled 1,571 patients. Butte's project has the largest enrollment (903 patients) and Alameda had the smallest (119 patients).
- Four post-discharge projects (Alameda, San Bernardino-Rialto, Solano, and UCLA) have provided at least one home visit to every patient since they were launched in 2015. From July 2015 through October 2017, Butte's project provided a telephone call to every patient and provided a home visit to only a subset of patients. Effective November 2017, Butte changed its protocol to provide at least one home visit to every patient.
- The post-discharge projects are improving patient safety by performing home visits within a few days of a patient's hospital discharge to ensure that patients understand their discharge instructions, are taking medications as prescribed, have sufficient refills to manage their conditions, have scheduled follow-up visits with their physicians, and are adhering to any dietary restrictions pertinent to management of their condition.
- All five post-discharge projects have all-cause 30-day readmission rates for persons with one or more of the chronic conditions they target that are below the partner hospital's historical readmission rate. Butte's heart failure patients were the only group whose all-cause 30-day readmission rate was higher than the historical

rate. In response to these findings, Butte changed its protocol in November 2017 to provide at least one home visit to every patient but its readmission rate for patients with heart failure has not decreased.

- The five post-discharge projects avoided potential costs of approximately $1.4 million, the majority of which (61%) would accrue to Medicare. Participating hospitals also reduced their risk of incurring Medicare penalties for excessive readmissions.

Frequent EMS User

- The two frequent emergency medical services (EMS) user projects have enrolled 114 persons from July 2015 through March 2018.
- San Diego's frequent EMS user project has not enrolled new clients since December 2016, because the community paramedics working on the project were reassigned to traditional 911 response crews. The pilot project manager, who had maintained the program at reduced capacity since 2016, was reassigned effective January 2018, in effect ending the program.
- The frequent EMS user projects have achieved large reductions in the number of times enrolled patients called 911 and were transported to an ED.
- Frequent EMS user projects linked patients to organizations that provide primary care, mental health services, substance abuse treatment, food, housing assistance, transportation assistance and other services that can address their needs more effectively than the EMS system.
- The two frequent EMS user projects avoided potential costs of approximately $582,000 by reducing 911 calls, ambulance transports, and ED visits. San Diego's project also potentially reduced the amount of uncompensated care provided by ambulance services and hospitals because 43% of the patients enrolled in the project were uninsured.

Directly Observed Therapy for Tuberculosis

- The tuberculosis (TB) project enrolled 44 persons from June 2015 through March 2018.
- Most persons are enrolled for multiple months because treatment for TB typically spans six to nine months.
- Community paramedics dispensed appropriate doses of TB medications and their TB patients did not experience side effects any more frequently than typically associated with TB treatment.
- Twelve patients were admitted to a hospital in the period during which the project has been in operation, but only one patient was hospitalized for TB. This patient needed intravenous medication to treat TB meningitis, which had been diagnosed prior to enrollment in the program.
- People with TB who received directly observed therapy from community paramedics were more likely to receive all doses of TB medication prescribed by the TB clinic physician than people who received directly observed therapy from the TB clinic's staff, probably because community paramedics were available 24 hours per day, 7 days per week.

Hospice

- The hospice project enrolled 325 persons between August 2015 and March 2018.
- The hospice project reduced the likelihood that patients who preferred treatment at home were transported to an ED, which could result in loss of hospice benefits. Patients were not denied transport to an ED where it was indicated and consistent with the patient's preference.
- Among hospice patients enrolled in the pilot project, the percentage of 911 calls that resulted in transport to an ED decreased from 80% to 28%.
- The hospice project avoided potential costs of $255,021 by reducing ambulance transports and ED visits.

Alternate Destination – Mental Health

- The alternate destination – mental health project enrolled 310 persons between September 2015 and March 2018.
- Twenty-eight percent of persons screened by the community paramedics were transported to the mental health crisis center. Additional patients could have been transported to the crisis center if the county had more inpatient psychiatric beds or if the crisis center accepted persons with private health insurance or Medicare. Some persons the community paramedics screened were not eligible for transport to the mental health crisis center because they had a medical need, were intoxicated, or were violent.
- In addition to responding to 911 calls regarding mental health emergencies, the community paramedics screen "walk-in" clients who come to the mental health crisis center on their own or who are brought by friends or family to determine whether they have any medical conditions that might necessitate transport to an ED instead of direct admission to the crisis center.
- Only 3% of patients enrolled in the project (n = 9) were transferred from the mental health crisis center to an ED within six hours of admission. None of the transfers involved a life-threatening condition and none of the patients transferred to an ED were admitted for inpatient medical care.
- The project also enhanced public safety because law enforcement officers called to the scene could transfer responsibility for the patient to paramedics and return to law enforcement duties instead of transporting the patient to an ED and waiting with the patient for evaluation.
- The project avoided potential costs of $331,100 by reducing the number of 911 calls that resulted in an ED visit and subsequent transport of a patient from an ED to an inpatient psychiatric facility.

Alternate Destination – Urgent Care

- The three alternate destination – urgent care projects enrolled 48 persons from September 2015 through November 2017.
- One of the alternate destination – urgent care projects closed in May 2017 and the other two projects closed in November 2017.

- Enrollment in the alternate destination – urgent care projects was substantially lower than anticipated because fewer 911 calls than expected met the strict inclusion criteria and many calls for eligible patients occurred at times of the day during which urgent care centers are closed. In addition, clinicians at urgent care centers were reluctant to treat some conditions, such as a dislocated shoulder, that could be treated safety and effectively in that setting.

- Most patients enrolled had a laceration or an isolated closed extremity injury.

- Since the alternate destination – urgent care projects began enrolling patients, two patients (4%) were transferred from an urgent care center to an ED within six hours of arrival at the urgent care center. Nine patients (19%) were transported to an urgent care center and then rerouted to an ED because clinicians at the urgent care center declined to treat the patient.

Alternate Destination – Sobering Center

- The alternate destination - sobering center project enrolled 730 persons from February 2017 through March 2018. Ninety-four patients (13%) were repeat visitors to the sobering center.

- 97.6% of patients enrolled in the alternate destination – sobering project were treated safely and effectively at the sobering center. Only 17 patients (2.3%) were transferred to an ED within six hours of admission to the sobering center and only one (0.1%) was rerouted from the sobering center to an ED because registered nurses at the sobering center declined to accept the patient. None of these patients were admitted to a hospital for inpatient medical care.

- In addition, community paramedics participating in the project provide feedback to paramedics on 911 crews on how to screen acutely intoxicated persons to determine if they are candidates for transfer to the sobering center. They are also collaborating with homeless outreach workers to encourage people who use the sobering center frequently to seek treatment for chronic alcoholism, housing, and other services.

- During its first 14 months of operation, the project avoided potential costs of $248,087 by replacing ED visits with visits to the sobering center. The majority of potential savings accrued to Medi-Cal because the majority of patients enrolled in the project are Medi-Cal beneficiaries.

Conclusion

The community paramedicine pilot projects have demonstrated that specially trained paramedics can provide services beyond their traditional and current statutory scope of practice in California. No adverse outcome is attributable to any of these pilot projects. The projects are enhancing patients' well-being by improving the coordination of medical, behavioral health, and social services, and reducing ambulance transports, ED visits, and hospital readmissions. The majority of potential savings associated with these pilot projects accrued to Medicare and hospitals serving Medicare patients because Medicare beneficiaries accounted for the largest share of persons enrolled in the pilot projects. Potential savings also accrued to the Medi-Cal program and providers that serve Medi-Cal beneficiaries.

These pilot projects integrate with existing health care resources and utilize the unique skills of paramedics and their availability 24 hours per day, seven days per week. The pilot projects have not displaced any other health professionals. Instead, they have demonstrated that community paramedics can collaborate with physicians, nurses, behavioral health professionals, and social services workers to fill gaps in the health and social services

safety net. The community paramedics operate at all times under medical control, either directly or by protocols developed by physicians experienced in EMS and emergency care.

Research conducted to date indicates that community paramedicine programs are improving the effectiveness and efficiency of the health care system. Findings from this research also suggest that the benefits of community paramedicine programs grow as they mature, solidify partnerships, and find their optimal structure and niche within a community. The evaluation of HWPP #173 yields consistent findings for six of the seven community paramedicine concepts tested. All of the post-discharge, frequent 911 users, DOT for TB, hospice, and alternate destination – mental health projects have been in operation for at least two and a half years and have improved patients' well-being and, in most cases, have potentially increased health care value by yielding potential savings for payers and other parts of the health care system. Findings regarding outcomes of a project testing the sixth concept, alternate destination – sobering center, suggest that this project is also benefitting patients and the health care system over the course of its first 14 months. The seventh concept, alternate destination – urgent care, shows potential but further research involving a larger volume of patients transported to urgent care centers with wider ranges of services and expanded hours is needed to draw definitive conclusions.

If California implements community paramedicine on a broader scale, the current EMS system design is well suited to utilize the results of these pilot programs to optimize the design and implementation of proposed programs and to assure effectiveness and patient safety. The two-tiered system enables cities and counties to design and administer community paramedicine programs to meet local needs while both local and state oversight and regulation ensure patient safety.

Introduction

Community paramedicine (CP), also known as mobile integrated health (MIH-CP) is an innovative model of care that seeks to improve the effectiveness and efficiency of health care delivery by using specially trained paramedics in partnership with other health care providers to address identified patient needs in local health care systems. Community paramedics receive additional training beyond that required for licensure and provide care outside of their traditional role, which in California is restricted to responding to 911 calls, treating patients at the scene of an emergency, transporting patients to EDs, and inter-facility transfers.[i] They are supervised by physicians and nurses who work for the emergency medical services (EMS) agencies that employ them and by staff of the health care and community service agencies with which their EMS agencies partner. According to a survey conducted by the National Association of Emergency Medical Technicians, by 2017 there are 129 MIH-CP programs in 34 states and the District of Columbia.[ii]

On December 19, 2013, the California Emergency Medical Services Authority (EMSA) submitted an application to the California Office of Statewide Health Planning and Development (OSHPD) for a Health Workforce Pilot Project (HWPP) to evaluate community paramedicine. In 1972, California established the HWPP program (HSC §§ 128125-128195), which was originally called the Health Manpower Pilot Projects program, to enable health care organizations to test and evaluate innovative models of care that utilize health professionals in new roles. A HWPP is necessary to establish community paramedicine initiatives in California because the sections of the Health and Safety Code that govern paramedic scope of practice (HSC §§ 1797.52, 1797.218) limit the settings where paramedics can provide services and the settings to which they can transport patients. OSHPD approved HWPP #173 on November 14, 2014, for one year and renewed approval for additional one-year periods in 2015, 2016, and 2017.

The HWPP regulations require organizations that sponsor pilot projects to retain an independent evaluator to assess trainee performance, patient acceptance, and cost effectiveness. A team of evaluators at the Philip R. Lee Institute for Health Policy Studies and Healthforce Center at the University of California, San Francisco, serves as the independent evaluator for HWPP #173. The California Health Care Foundation funds the evaluation.

This report presents a summary of major findings from the evaluation for policymakers. All data submitted by the project sites are reported to OSHPD on a quarterly basis.

Overview of California Community Paramedicine Pilot Projects

The community paramedicine HWPP has encompassed 17 projects in 13 communities across California. Eleven projects are currently enrolling patients. An additional project plans to begin enrolling patients as soon as it receives approval from its Institutional Review Board (IRB). Five of the original projects have closed. A map that displays the locations of projects that are currently enrolling patients and the new project that is awaiting IRB approval can be found in Appendix A.

This report addresses nine of the eleven projects that are currently enrolling patients and projects that have closed. It covers the months from the launch dates for each of the pilot projects, which range from June 2015 to February 2017, through March 2018. Two projects that are currently enrolling patients, Santa Clara County EMS's alternate destination - mental health project and its alternate destination - sobering center project, are not included because they did not begin enrolling patients until June 2018.

These projects are testing seven different concepts for the practice of community paramedicine.

The seven concepts are:

1. **Post-Discharge, Short-term Follow-Up:** Provide short-term, home-based follow-up care to people recently discharged from a hospital due to a chronic condition (e.g., heart failure) to reduce their risk of readmission and improve their ability to manage their condition. These services are provided by paramedics who completed the full community paramedic training described below. Four projects provide at least one home visit to all patients; one initially provided a telephone call to all patients and a home visits to patients at high risk of readmission but began providing a home visit to every patient in November 2017.

2. **Frequent EMS Users:** Provide case management services to people who are frequent 911 callers and frequent visitors to EDs to identify needs that could be met more effectively outside of an ED and assist patients in accessing primary care and non-medical needs, such as food, housing, and substance use disorder treatment. Services are provided by paramedics who completed the full community paramedic training.

3. **Directly Observed Therapy for Tuberculosis:** In collaboration with a public health agency, provide directly observed therapy (DOT) to people with tuberculosis (i.e., dispense medications and observe patients taking them) to assure effective treatment of tuberculosis and prevent its spread. Services are provided by paramedic supervisors who completed the full community paramedic training.

4. **Hospice:** In response to 911 calls made by or on behalf of hospice patients, collaborate with hospice agency nurses, patients, and family members to treat patients in their homes according to their wishes, instead of transporting them to an ED. Services are provided by paramedic supervisors who completed the full community paramedic training.

5. **Alternate Destination – Mental Health:** In response to 911 calls, offer people who have mental health needs, but no emergent medical needs, transport directly to a mental health crisis center instead of to an ED with subsequent transfer to a mental health facility. Services are provided by paramedics who completed the full community paramedic training.

6. **Alternate Destination – Urgent Care:** In response to 911 calls, offer people with low-acuity medical conditions transport to an urgent care center for evaluation by a physician, instead of to an ED. Services were provided by paramedics on 911 response crews who were trained how to use a protocol to determine if patient would be eligible for transport to an urgent care center and how to follow procedures for enrolling patients who agree to be transported to an urgent care center. These paramedics were supervised by paramedics who completed the full community paramedic training.

7. **Alternate Destination – Sobering Center:** In response to 911 calls, offer people who are acutely intoxicated but do not have an acute medical or mental health problem transport directly to a Sobering Center for monitoring instead of to an ED. Services were provided by paramedics who were trained to use a protocol to identify eligible patients for transport to an sobering center and to follow procedures for enrolling patients who agree to be transported to a sobering center. These paramedics are mentored by other paramedics who completed the full community paramedic training and who also perform quality assurance reviews of transports to the sobering center.

All sites obtained approval from an institutional review board (IRB) and enrolled patients following consent procedures stipulated by the IRB.

OSHPD has approved six additional projects in five communities across the state to test four existing CP concepts: post-discharge, frequent EMS users, alternate destination – mental health, and alternate destination – sobering center. These projects are on hold pending action on community paramedicine legislation that the State Legislature is considering.

Training of Community Paramedics

Paramedics were eligible for training to perform new roles as community paramedics if they had at least four years of experience, volunteered to participate in the pilot, and were sponsored by their local EMS authority. The State of California Community Paramedic Educational Taskforce developed a core curriculum that OSHPD reviewed and approved. The curriculum was adapted from the Paramedic Foundation's National Community Paramedic Curriculum to better align with the standards and requirements of practice in California. The curriculum included 48 hours of didactic, classroom-based instruction and 48 hours of clinical, hands-on training, for a total of 96 hours of instruction. Community paramedic trainees were additionally required to complete 56 hours of study outside the classroom, which included required readings and other assignments.

The site supervisors from Alternate Destination – Urgent Care projects and paramedics recruited to coordinate the Alternate Destination – Sobering project were required to complete the core curriculum. At these pilot sites all other paramedics in the system received training focused on (1) screening patients according to a protocol to determine if they would be eligible to enroll in the pilot, and (2) the procedures for enrolling patients who agree to be transported to an urgent care center or a sobering center. This approach was pursued because these concepts focus on clinical decision-making in the field regarding where to transport a patient. This is routine practice for paramedics, who must identify which patients to take to specialty care centers, such as stroke and trauma centers, that may not be the closest ED.

The first cohort of community paramedics consisted of 79 paramedics who were enrolled in the core curriculum and site-specific coursework during the first quarter of 2015. Two of the 79 paramedics were unable to complete the training for nonacademic reasons. All of the 77 paramedics who completed the core curriculum passed a written final examination, a simulated patient scenario examination, and an oral examination by the pilot site's medical director. Since then, three sites (Solano, Stanislaus, and Ventura) have trained 12 additional community paramedics to expand their programs or replace paramedics who have left their agencies or been promoted to other positions. San Francisco trained 10 community paramedics prior to the launch of its pilot project in February 2017. Fresno has trained 11 community paramedics and Santa Clara has trained 10.

Patient Safety

Multiple procedures to ensure patient safety are incorporated into all levels of the pilot projects. Every project has a project manager, a medical director who is an emergency medicine physician, and a quality assurance officer who is most often a registered nurse with specialty in emergency medicine. Community paramedics have real-time access to physicians and registered nurses for consultation. Each project conducts a retrospective review of all patient encounters. In addition, each project has a local steering committee that approves protocols and reviews data on project outcomes. A statewide steering committee has oversight over all the projects and reviews quarterly reports from the sites. Sites are also required to report unusual occurrences to EMSA's project manager. The independent evaluator reviews data provided by sites for the evaluation and raises any concerns about patient safety that emerge from the data reported. Finally, OSHPD staff review the protocols and performance of the pilot sites and raise any patient safety issues they identify.

Funding

Funding for the pilot sites was provided primarily through in-kind services or funds from fire departments or approved operating budgets of private providers of EMS services. Two sites – Orange County's Alternate Destination – Urgent Care project and Solano's Post-discharge project received grants from health care systems that participated in their pilot projects.

Methods

Information presented in this report was obtained from multiple sources. Each of the pilot sites used a standardized, online data collection tool to report data to the independent evaluator on a quarterly basis. Metrics for which data were collected included numbers of people enrolled, characteristics of enrollees, and outcomes of community paramedic services, including patient safety outcomes. Sites also reported information about people who were eligible for their projects but not enrolled.

Estimates of potential savings for payers were derived from data that each site reported on the cost of ambulance transports, and from existing sources of data on the cost of ED visits and inpatient hospital admissions. Appendix C contains details about the methods the evaluator team used to estimate potential savings. It is important to note that the evaluation was not designed to be a cost effectiveness analysis that compares the costs and effects of community paramedics to other alternatives. With the exception of the directly observed therapy for tuberculosis concept, the services that community paramedics provide under the pilots differ from services furnished by other health care providers in their communities. Thus, the evaluation team concluded that an analysis of potential savings associated with the projects would be more informative.

The team collected data on the cost of operating the community paramedicine pilot projects. These data were reported in the initial public report and are not included in this update to the public report for two reasons. First, standardizing cost data across sites proved difficult due to differences in how projects were staffed (e.g., full-time community paramedics vs. paramedics who both provide community paramedicine services and respond to 911 calls), the generosity of employee benefits (e.g., pension vs. 401K plan), and allocation of costs for vehicles, and medical supplies. Second, the community paramedicine pilot projects are not authorized to bill for the services they provided. All costs for paramedic salaries, benefits, vehicles, and medical supplies are borne by the agencies that operate the pilot projects. Thus, at present payers do not bear any of the costs associated with these projects, although that could change in the future if private payers choose to pay for community paramedicine services or legislation is enacted that authorizes Medi-Cal or Medicare to pay for these services.

Evaluation team members conducted site visits at all project sites, where they interviewed EMS agency leaders, project managers, community paramedics, and representatives of hospitals and other partner agencies. The purpose of the site visits was to obtain a better understanding of how the projects operated and to hear the perspectives of multiple stakeholders. The site visits were augmented with conference calls with EMSA's project manager and the site-level project managers. The evaluation team also reviewed minutes of local steering committee meetings and reports that site-level project managers submitted to EMSA's project manager.

This evaluation focuses solely on the community paramedicine pilot projects and does not take into account other changes in health care delivery that may have affected the outcomes observed. This caveat is particularly important for the post-discharge projects. Since Medicare began imposing penalties on hospitals with "excessive" 30-day readmission rates in federal fiscal year 2013,[1] hospitals have deployed multiple strategies to reduce readmissions. These strategies include utilizing registered nurses to provide intensive discharge planning, patient education, and telephone support to patients following hospital discharge.[iii] Recent research by the Medicare Payment Advisory Commission (MedPAC) suggests that hospitals nationwide are not responding the Medicare penalties by treating patients in EDs or admitting them for observation instead of readmitting them to for inpatient care, because increases in observation stays and ED visits have been smaller than the decrease in readmissions and have not differed between patients who were recently admitted and patients who were not recently admitted.[iv]

[1] Medicare penalizes hospitals that have 30-day readmission rates that exceed the national average adjusted for characteristics of patients who were readmitted and characteristics of the entire population of patients that a hospital serves. Hospitals that exceed this benchmark receive a 3% penalty across all Medicare admissions regardless of whether they resulted in a readmission within 30 days. C. Boccuit and G. Casillas. Aiming at Fewer Hospital U-Turns: The Medicare Hospital Readmissions Reduction Program. Menlo Park, CA: Kaiser Family Foundation, 2017. http://files.kff.org/attachment/Issue-Brief-Fewer-Hospital-U-turns-The-Medicare-Hospital-Readmission-Reduction-Program.

To the extent that hospitals participating in the post-discharge pilot projects utilize other strategies to reduce readmissions, it is possible that the findings of the evaluation are due to those strategies and not the post-discharge community paramedicine pilot projects.

Results

The results section begins with a summary of major findings related to all seven community paramedicine concepts. The summary is followed by a discussion of major findings regarding key metrics relevant to individual community paramedicine concepts.

Highlights

- Collectively, the community paramedicine pilot projects enrolled 3,142 people from June 2015 through March 2018.
- The post-discharge projects enrolled the largest number of persons and the tuberculosis project had the smallest enrollment.
- Two new projects opened in 2018.
  - Santa Clara's alternate destination – mental health center project
  - Santa Clara's alternate destination – sobering center project
- One additional project plans to begin enrolling patients as soon as it obtains IRB approval.
- Five projects have closed.
- The majority of patients enrolled in the projects were Medicare or Medi-Cal beneficiaries.

General Project Status

Table 1 lists the lead agencies for each pilot project operated under the auspices of HWPP #173, the concept tested, the date on which the project began enrolling patients, and the total number of patients enrolled from the time each project began through March 31, 2018. The longest running projects, Alameda's post-discharge project and Ventura's tuberculosis project, began enrolling patients in June 2015. The newest project included in this report, San Francisco's alternate destination – sobering center project, began enrolling patients in February 2017.[2] Santa Clara's alternate destination – mental health project and its alternate destination – sobering center project began enrolling patients in June 2018. Fresno's alternate destination – mental health project plans to begin enrolling patients as soon as IRB approval is obtained. Five projects have closed due to various challenges.

Collectively, the projects enrolled 3,142 people from June 2015 through March 2018. The number of people enrolled per project ranged from a low of two for the City of Carlsbad's Alternate Destination – Urgent Care project to a high of 903 for Butte County's Post-discharge --project.

[2] An additional project, Santa Clara County's Alternate Destination – Mental Health and Sobering Center project, is not included in this report because it did not begin enrolling patients until June 2018.

Table 1. Pilot Sites, Community Paramedicine Concepts, and Enrollment through First Quarter 2018

Community Paramedicine Concept	Lead Agency	Date Implemented	Total Patients Enrolled
Post-Discharge	Alameda City EMS	June 1, 2015	119
Post-Discharge	Butte County EMS	July 1, 2015	903
Post-Discharge	San Bernardino County and Rialto Fire Depts.	August 13, 2015	217
Post-Discharge	UCLA Center for Prehospital Care*	September 1, 2015	154
Post-Discharge	Medic Ambulance Solano	September 15, 2015	178
All Post-Discharge Projects			**1,571**
Frequent EMS User	Alameda City EMS	July 1, 2015	68
Frequent EMS User	City of San Diego****	October 12, 2015	46
All Frequent EMS User Projects			**114**
Tuberculosis	Ventura County EMS	June 1, 2015	**44**
Hospice	Ventura County EMS	August 1, 2015	**325**
Alternate Destination – Mental Health	Mountain Valley – Stanislaus EMS	September 25, 2015	**310**
Alternate Destination – Urgent Care	UCLA Center for Prehospital Care**	September 8, 2015	12
Alternate Destination – Urgent Care	Orange County Fire Chiefs***	September 14, 2015	34
Alternate Destination – Urgent Care	Carlsbad Fire Dept***	October 9, 2015	2
All Alternate Destination – Urgent Care Projects			**48**
Alternate Destination – Sobering	San Francisco Fire Dept.	February 1, 2017	**730**
All Projects			**3.142**

* Ceased enrolling patients on August 31, 2017.
** Ceased enrolling patients on May 31, 2017.
*** Ceased enrolling patients on November 13, 2017.
****Ceased enrolling new patients December 2016.

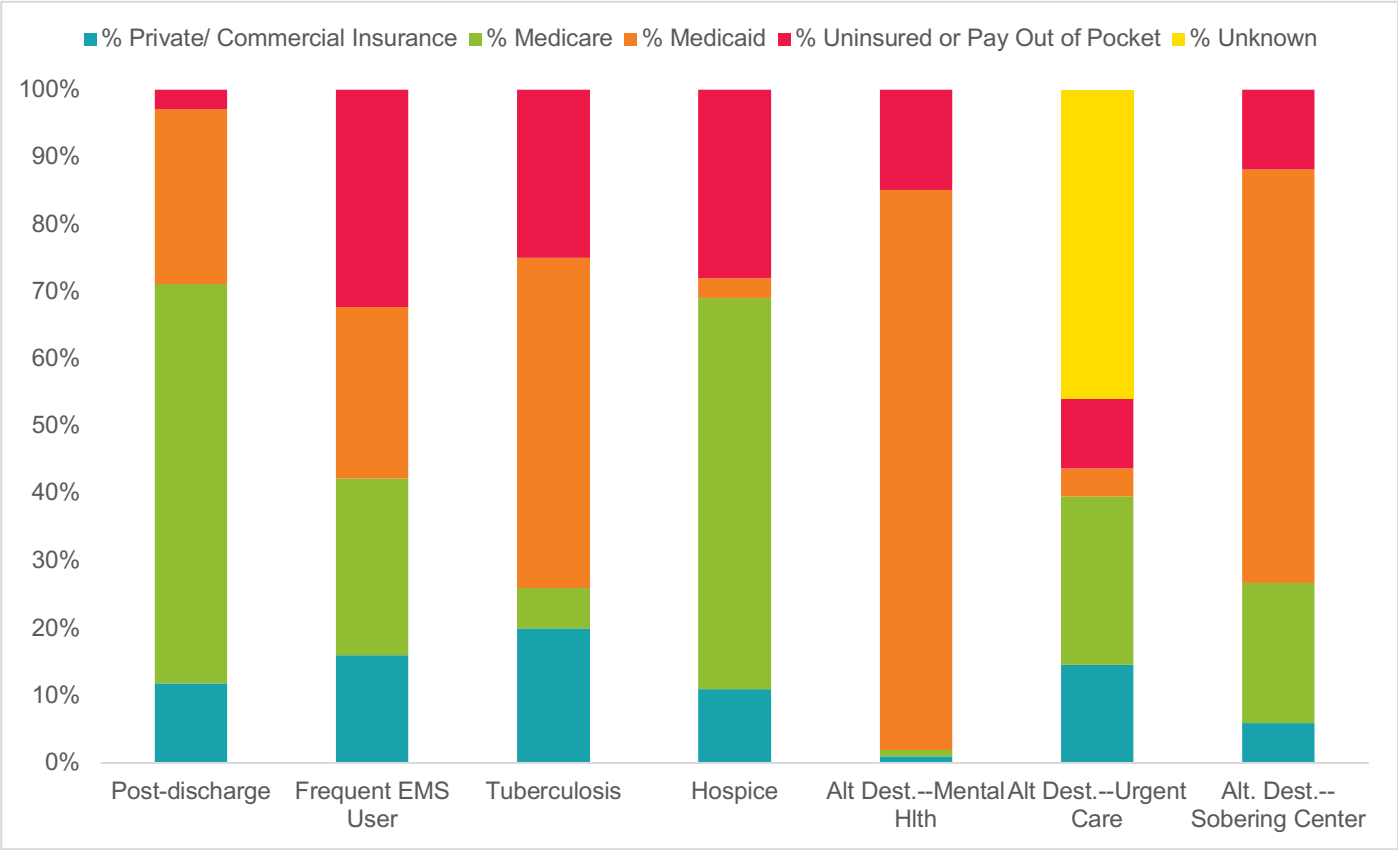
Consistent with findings from the original evaluation report, the distribution of patients by health insurance status varied substantially across the 14 projects, in large part due to differences in the characteristics of the patients served. Medicare beneficiaries accounted for the largest percentage of patients enrolled by four of the five post-discharge projects (Alameda, Butte, Solano, UCLA – Glendale), one of the frequent EMS user projects

(Alameda), and the hospice project. For one of the post-discharge projects (San Bernardino), Medi-Cal beneficiaries constituted the largest share of enrollees and Medicare beneficiaries accounted for the second largest share. Medi-Cal beneficiaries and uninsured persons comprised the majority of patients enrolled in Ventura's tuberculosis project, San Diego's frequent EMS user project, Stanislaus' alternate destination – mental health project, and San Francisco's alternate destination – sobering center project. Many of the people who these projects serve have mental illness, substance use disorders, or other conditions that limit their access to employer-sponsored health insurance. Persons who are dually eligible for Medicare and Medi-Cal are classified as Medicare beneficiaries because Medicare is responsible for paying the majority of costs associated with their hospitalizations, ED visits, and office visits. Table 2 displays these findings in tabular form and Figure 1 displays them graphically.

Table 2. Health Insurance Status of Enrolled Patients (n =3,142)

Community Paramedicine Concept	Lead Agency	% Private/ Commercial Insurance	% Medicare	% Medi-Cal	% Uninsured or Pay Out of Pocket	% Unknown	Total Persons Enrolled
Post-Discharge	Alameda City EMS	16%	50%	26%	8%	0%	119
Post-Discharge	Butte County EMS	14%	67%	19%	0%	0%	903
Post-Discharge	San Bernardino County and Rialto Fire Depts.	9%	40%	44%	7%	0%	217
Post-Discharge	UCLA Center for Prehospital Care	7%	81%	11%	1%	0%	154
Post-Discharge	Medic Ambulance Solano	8%	47%	42%	2%	0%	178
Frequent EMS User	Alameda City EMS	17%	60%	19%	3%	0%	68
Frequent EMS User	City of San Diego	16%	14%	28%	43%	0%	46
Tuberculosis	Ventura County EMS	20%	6%	49%	25%	0%	44
Hospice	Ventura County EMS	11%	58%	3%	28%	0%	325
Alternate Destination – Mental Health	Mountain Valley – Stanislaus EMS	1%	1%	84%	15%	0%	310
Alternate Destination – Urgent Care	UCLA Center for Prehospital Care	0%	8%	0%	0%	92%	12
Alternate Destination – Urgent Care	Orange County Fire Chiefs	15%	32%	6%	15%	32%	34
Alternate Destination – Urgent Care	Carlsbad Fire Dept.	100%	0%	0%	0%	0%	2
Alternate Destination – Sobering	San Francisco Fire Dept.	6%	21%	62%	12%	0%	730

Figure 1. Enrollees by Insurance Status (n = 3,142)



Post-Discharge

Highlights

- The post-discharge projects enrolled 1,571 persons from June 2015 through March 2018.
- One of the post-discharge projects closed in August 2016 because the partner fire department was unwilling to continue funding the project.
- All of the post-discharge projects reduced the rate of 30-day admission for any cause for at least one of the diagnoses targeted.
- The four post-discharge projects that provided at least one home visit to all patients outperformed the project that initially relied primarily on telephone calls.
- Community paramedics identified 266 patients who needed instruction on how to use their medications correctly.
- The post-discharge projects potentially avoided $1.4 million in costs by reducing hospital readmissions; most potential savings would have accrued to Medicare and Medi-Cal.

Description

The goal of the five post-discharge projects is to reduce hospital readmissions for people discharged from a hospital for treatment of a chronic condition. A major impetus for the post-discharge projects is the Medicare Readmission Reduction Program, under which Medicare reduces payments to hospitals if they have rates of readmission that are deemed excessive. The projects aim to give patients the tools to manage their conditions more effectively so that they can avoid readmission. In collaboration with its partner hospital, each project identified one or more chronic conditions to address. Once a project enrolls a patient, a telephone call or home visit with a community paramedic is scheduled. During the call or visit, the community paramedic assesses the patient and reviews the patient's discharge instructions per the site's protocols. Some projects also provide home safety inspections during home visits.

The post-discharge projects worked with their partner hospitals to determine which conditions to target. UCLA – Glendale and San Bernardino - Rialto only enroll people with heart failure. Butte enrolls people with heart failure or myocardial infarction, and Solano enrolls people with heart failure or chronic obstructive pulmonary disease. Alameda enrolls people with heart failure, acute myocardial infarction, chronic obstructive pulmonary disease, diabetes, pneumonia, or sepsis.

The post-discharge projects provide short-term assistance during the immediate post-hospital period and do not replace home health care or any other services available to patients. The sites' protocols call for community paramedics to complete phone calls or visits within the first few days of hospital discharge. Some partner hospitals focus on enrolling uninsured persons and Medi-Cal beneficiaries who do not have insurance coverage for home health. In other cases, community paramedics serve a stop-gap role by providing calls or home visits while patients wait to obtain home health services. Interviewees at partner hospitals consistently indicated that home health agencies in their communities often cannot schedule a home visit until one week after a patient is discharged from the hospital despite the fact that people are at the greatest risk of readmission during the first week after discharge. When community paramedics learn that a patient is receiving home health services, they coordinate with home health agency staff.

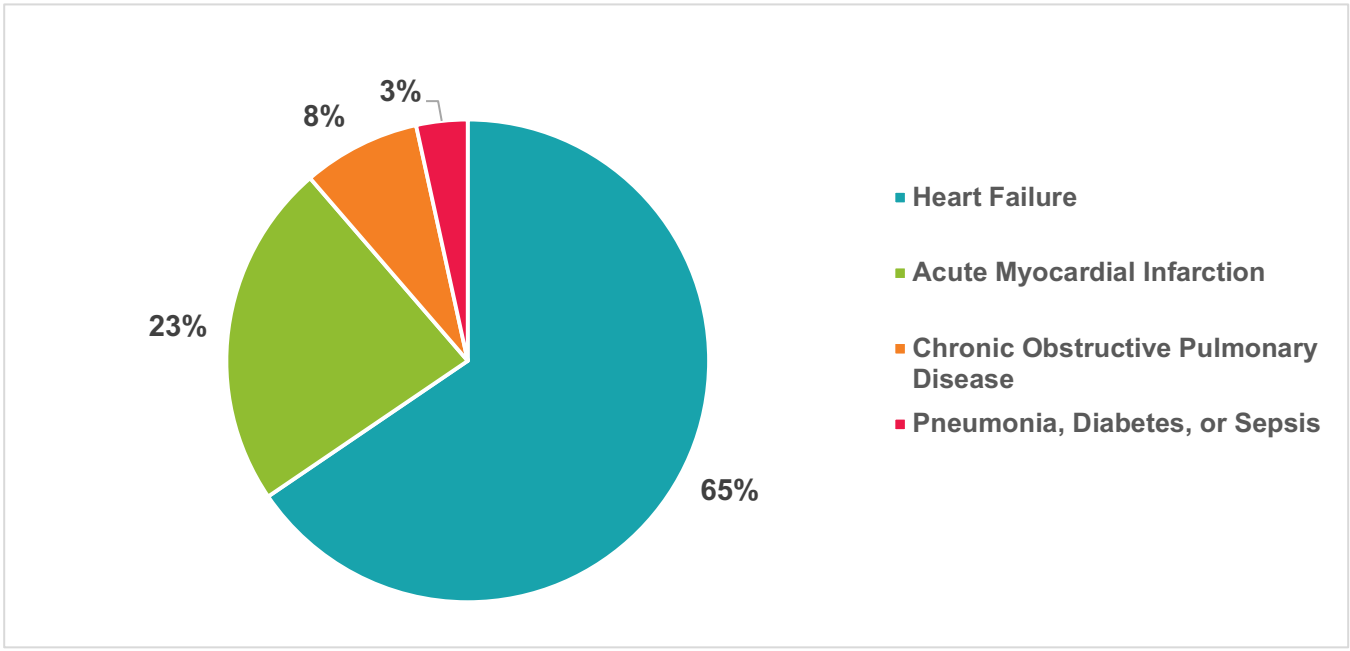
Two projects have full-time community paramedics (Alameda's project and the now closed UCLA-Glendale project) and three projects have part-time paramedics (Butte, San Bernardino-Rialto, and Solano). Since launching their projects, Alameda, San Bernardino-Rialto, and Solano (and formerly UCLA) have provided at least one home visit to all patients. Initially, Butte's protocol called for paramedics perform an initial assessment by telephone for all patients and use an algorithm to determine whether the patient needs additional assistance. If a

Butte community paramedic determined that a patient would benefit from a home visit, the community paramedic requested the patient's permission to do so. Butte's protocol changed effective November 2017. Its community paramedics now provide at least one home visit to all patients. This change was made in response to findings from the evaluation that Butte's project was less effective in reducing readmissions among patients with heart failure than the post-discharge projects that provided patients with at least one home visit.

Findings

The post-discharge projects enrolled 1,571 patients between June 2015 and March 2018. Butte had the largest enrollment (903 patients) and Alameda had the smallest (119 patients). Across the five projects, 65% of patients enrolled had heart failure, 23% had acute myocardial infarction, 8% had chronic obstructive pulmonary disorder, and 3% had pneumonia, diabetes, or sepsis. (Figure 2)

Figure 2. Post-Discharge Project Enrollees by Condition (n = 1,571)



Safety

The evaluation team found no evidence of any harm to patients enrolled in the post-discharge projects. On the contrary, there is substantial evidence that the projects reduced the risk of harm. The most compelling evidence of reduced harm concerns prescription medications. Community paramedics performed medication reconciliation for all patients, which involved examining all prescription drugs in a patient's possession and reconciling them with the instructions given to the patient when he or she was discharged from the hospital. The community paramedics identified 266 instances in which a patient needed additional instructions about how to take their medications as directed. Some patients had multiple prescriptions for the same medication and assumed they were supposed to take all of them. Other patients were discharged from the hospital with only a 30-day supply of medication and did not understand that they needed to obtain refills to control their condition. If a patient had a personal physician, the community paramedic worked with the patient to contact the physician to obtain refills. If a patient did not have a physician, the community paramedic helped the patient find one.

Effectiveness

The post-discharge pilot projects achieved their primary goal of reducing inpatient readmissions within 30 days of discharge. Table 3 shows the historical 30-day readmission rates at the projects' partner hospitals and the 30-day readmission rates for patients enrolled in the post-discharge projects who had heart failure, myocardial infarction, congestive heart failure, or pneumonia. Patients with diabetes or sepsis are not included because historical data on readmission rates for persons with these diseases were not available. Figure 3 displays the data in a graphical format.

Table 3. Readmissions within 30 Days for Post-Discharge Project Enrollees versus Partner Hospitals' 30-Day Readmission Rates, 2012–2015 (Cumulative; n = 1,571)

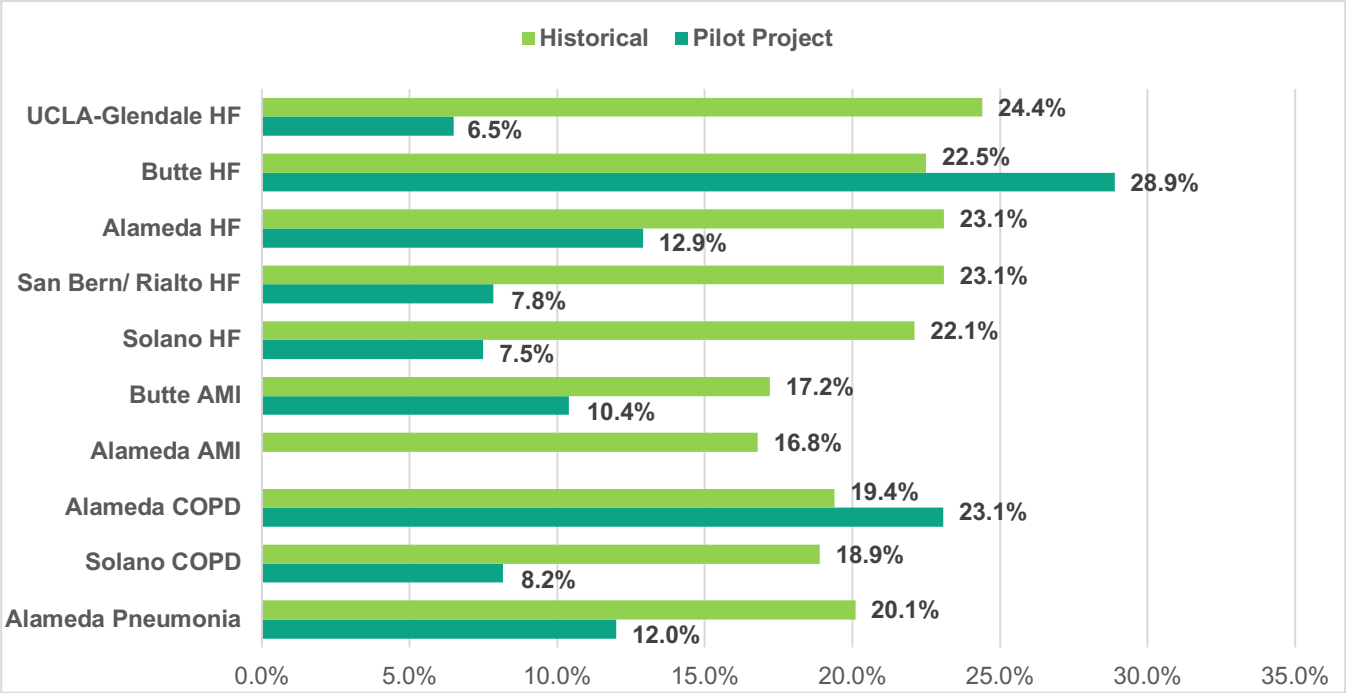
Diagnosis	Sponsoring Agency	Number of Patients Enrolled	Number Readmitted	Historical 30-day Readmission Rate*	% Enrollees Readmitted*
Heart Failure	UCLA	154	10	24.4%	6.5%**
	Butte	547	158	22.5%	28.9%***
	Alameda	31	4	23.1%	12.9%**
	San Bernardino and Rialto	217	17	23.1%	7.8%**
	Solano	80	6	22.1%	7.5%**
Acute Myocardial Infarction	Butte	356	37	17.2%	10.4%**
	Alameda	8	0	16.8%	0.0%**
Chronic Obstructive Pulmonary Disease	Alameda	26	6	19.4%	23.1%
	Solano	98	8	18.9%	8.2%**
Pneumonia	Alameda	25	3	20.1%	12.0%**

* Includes readmissions for any reason.
** 30-day readmission rate for enrolled patients was *lower* than the historical 30-day readmission rate.
*** 30-day readmission rate for enrolled patients was *higher* than the historical 30-day readmission rate.

Patients enrolled by all sites had lower rates of 30-day readmission than historical rates for their partner hospitals except Butte's heart failure patients and Alameda's chronic obstructive pulmonary disease patients. A notable difference from the original evaluation report is that the 30-day readmission rate for persons with chronic obstructive pulmonary disease who are enrolled in Alameda's post-discharge project is that there is no longer a statistically significant difference between the 30-day readmission rate for enrollees and the partner hospital's historical average. Butte's heart failure patients were the only group whose 30-day readmission rate has not been consistently at or below the partner hospital's historical rate.

To date, the change in Butte's protocol to require at least one home visit for every patient has not reduced its readmission rate for heart failure patients. Prior to the change in Butte's protocol, the project's 30-day all-cause readmission rate for persons with heart failure was 28.4%; following the change the 30-day all-cause readmission rate for persons with heart failure was 31.2%.

Figure 3. Readmissions within 30 Days for Post-Discharge Project Enrollees versus Partner Hospitals' 30-Day Readmission Rates, 2012–2015 (Cumulative; n = 1,571 Patients)



Another important indicator of the effectiveness of post-discharge projects is referral of patients to providers of other services to improve the patients' well-being. Through March 2018, community paramedics made at least 199 referrals to a wide range of service providers, using manuals of local resources that they prepared as part of their training. These services included primary care physicians, specialist physicians, pharmacists, mental health services, public health departments, home health providers, drug and alcohol treatment programs, senior home safety programs, food assistance agencies, housing assistance providers, transportation assistance agencies, and domestic violence resources. At least one community paramedic helped a patient enroll in Covered California to obtain health insurance. If community paramedics perceived the need as urgent and were concerned that a patient might not follow through on their own, they assisted the patient in obtaining these services.

Potential Savings

All of the post-discharge projects have potentially avoided costs for insurers by reducing 30-day all cause readmissions among the patients they enrolled. Estimates of potential savings are based on differences between rates of readmission among enrolled patients and historical readmission rates obtained from Medicare Hospital Compare and on estimates of the cost of admissions for targeted diagnoses derived from OSHPD's public hospital inpatient discharge dataset. The evaluators estimate that the five post-discharge projects avoided potential costs of approximately $1.4 million through March 31, 2018. The amount of potential costs avoided ranged from a low of $88,114 for Alameda's project to a high of $475,299 for San Bernardino and Rialto's project.

Differences in potential savings across sites reflect differences in the total number of 30-day readmissions avoided and the cost of readmissions. Butte's project realized potential savings despite having a 30-day readmission rate for heart failure that is higher than the partner hospital's historical rate, because it reduced 30-day readmissions for acute myocardial infarction, a diagnosis with a much higher average cost per admission than heart failure ($26,621 vs. $14,403). Potential savings generated by Alameda's project may have been greater than the estimate reported because savings associated with reductions in admissions for diabetes and sepsis could not be estimated, since Medicare Hospital Compare does not report data on historical rates of readmission for these conditions.

The majority of potential savings associated with the post-discharge projects would have accrued to Medicare because 61% of patients enrolled are Medicare beneficiaries. Potential savings would also have accrued to Medi-Cal because 25% of enrollees are Medi-Cal beneficiaries. Partner hospitals also may have benefitted if reductions in readmissions were sufficient to avert a Medicare penalty for excessive readmissions.

Table 4. Potential Savings for Post-discharge Projects

	UCLA - Glendale	Butte	Alameda*	San Bernardino and Rialto	Solano
Total Enrollment	154	903	119	217	178
Difference in Readmission Rates (percentage points)	-17.9	+1.2	-6.2	-15.3	-12.5
Number of Readmissions Avoided	Heart failure = 28	Heart failure = -35 AMI = 24	Heart failure = 3 AMI = 1 COPD = -1 Pneumonia = 2	Heart failure = 33	Heart failure = 12 COPD = 11
Average Cost of Readmission	Heart failure = $14,403	Heart failure = $14,403 AMI = $26,621	Heart failure = $14,403 AMI = $26,621 COPD = $11,562 Pneumonia = $14,923	Heart failure = $14,403	Heart failure = $14,403 COPD = $11,562
Total Potential Savings from Readmissions Avoided	**$403,284**	**$134,799**	**$88,114**	**$475,299**	**$300,018**
Potential Savings per Enrollee	**$2,619**	**$149**	**$740**	**$2,190**	**$1,685**

* Savings estimate does not include 31 Alameda patients who had diabetes or sepsis because Medicare Hospital Compare does not report historical 30-day readmission rates for these conditions.

An important limitation of this analysis is that it does not taken into account repeat visits to an ED within 30 days of hospital discharge or use of observation status. If the community paramedicine projects were associated with an increase in repeat ED visits or use of observation status, potential net savings associated with the post-discharge projects would be lower. Effects on ED visits within 30 days were not discussed due to a lack of readily available data on repeat ED visits to partner hospitals by persons who were eligible for the program but not enrolled. Medicare Compare, the source of historical data on 30-day readmission rates at partner hospitals does not report rates of ED visits within 30 days of discharge.

The evaluation team did not compare 30-day ED revisit rates for participants to 30-day ED revisit rate reported in studies conducted in other hospitals, because the hospitals included in such studies may have patient populations that differ from those of participating hospitals in ways that could affect our conclusions. We did not attempt to assess the number of patients placed on observation status, because these patients can be difficult to track due to inconsistencies in availability of data on patients placed on observation status and the methods used to identify them.[v] Furthermore, recent research by the Medicare Payment Advisory Commission (MedPAC) finds that nationwide increases in observation stays and ED visits have been smaller than the decrease in readmissions.[iv] If the hospitals that participated in the post-discharge projects are similar to hospitals nationwide, observation stays and ED visits are not fully offsetting the reductions in readmissions that we observed.

Conclusion

The post-discharge projects have demonstrated capability to reduce hospital readmissions within 30 days among persons with the chronic conditions they target. The projects also increased the likelihood that patients will take medications for these conditions as directed, by reconciling their prescriptions, reviewing the instructions for taking the medications, and assisting patients with medication refills, if needed. Moreover, community paramedics have referred patients to providers of other services that can improve their ability to manage their conditions and their overall well-being. The projects potentially avoided costs, primarily for the Medicare and Medi-Cal programs.

Frequent EMS User

Highlights

- The two frequent EMS user projects enrolled 114 persons between July 2015 and March 2018.
- The San Diego project has not enrolled any new patients since December 2016 because its community paramedics were reassigned to traditional 911 response crews. Effective January 2018, the project manager was also reassigned, ending the project.
- The projects potentially avoided costs of $582,000 by, reducing ambulance transports and ED visits. A substantial share of potential savings accrued to ambulance transport agencies and hospitals because a large percentage of patients were uninsured.

Description

The two frequent EMS user projects enroll people who call 911 and/or who have ED visits frequently and whose use of emergency services is not routinely warranted by their medical condition. The goal of these projects is to reduce frequent EMS users' dependence on EMS agencies and EDs for care. Community paramedics assess patients' physical, psychological, and social needs and provide individualized case management to link them with nonemergency services. Patients remain enrolled in the projects until community paramedics believe that the patients no longer need the project's services. Criteria for determining that a patient no longer needs services emphasize reaching important individual milestones, such as obtaining housing or maintaining sobriety.

Findings

The two Frequent EMS User projects enrolled 114 patients from July 2015 through March 2018. The two projects enroll different populations of frequent EMS users. San Diego's project primarily enrolled persons with 20 or more ED visits per year. Alameda's project, which serves a city whose population is much smaller than San Diego's (79,227 vs. 1,391,676),[vi] is open to all persons referred by staff of the EMS agency or the partner hospital. San Diego's enrollees were younger than Alameda's enrollees and were more likely to be uninsured or enrolled in Medi-Cal.

Safety

The evaluation team found no evidence of any harm to patients enrolled in the frequent EMS user projects. On the contrary, there is substantial evidence that patients benefitted from the projects. The community paramedics visited patients multiple times to assess their physical, psychological, and social needs and assist them in obtaining nonemergency services to meet their needs, as discussed below in the section on effectiveness.

Effectiveness

The frequent EMS user projects achieved large reductions in the number of 911 calls and ED visits among enrolled patients. Reductions in 911 calls were highly correlated with reductions in ED visits, because most 911 calls for frequent EMS users result in transport to an ED. Data on 911 calls were examined to estimate the projects' impact for persons enrolled in both frequent EMS user projects for whom data were available for at least

12 months prior to enrollment and for at least 12 months following enrollment. Data on 911 calls and ED use during the month of enrollment were not analyzed to allow time for the intervention to affect patients' utilization.

Among persons enrolled in San Diego's frequent EMS user project during the time at which the community paramedics were on duty (November 2015 through December 2016) and for whom data are available for 12 months prior to enrollment and 12 months following enrollment (n =37) the total number of 911 calls decreased from 955 to 625, a decrease of 35%. The average number of 911 calls per person decreased from 26 per year to 17 per year and some enrollees had much larger decreases in 911 calls. Among persons enrolled in Alameda's frequent EMS user project for whom data are available for 12 months prior to enrollment and 12 months following enrollment (n = 37) the total number of 911 calls decreased from 134 to 111, a decrease of 17%. In Alameda, the average number of 911 calls per person decreased from four calls per year to three calls per year. The difference in impact between the two projects reflects differences between the persons enrolled. San Diego's clients had substantially more 911 calls prior to enrollment than Alameda's clients and, thus, there was greater room for improvement.

The frequent EMS user projects also succeeded in linking patients to services that address the needs that led them to make frequent ED visits. During their first visits with patients, community paramedics in Alameda and San Diego reported making 60 referrals to medical care providers, mental health providers, drug and alcohol treatment programs, food assistance programs, housing assistance programs, transportation assistance programs, domestic violence resources, and other social services. They may have made additional referrals during subsequent visits because some patients were not interested in referrals initially. In addition, community paramedics transported patients to these types of providers on 50 occasions to ensure that they obtained services. In some cases, community paramedics collaborated with staff of multiple service providers to go beyond routine care to meet patients' complex needs.[vii]

Providing assistance with housing is an important component of frequent EMS user projects because many frequent EMS users are homeless. Among the 46 patients enrolled in San Diego's frequent EMS user project, 33 patients (72%) were homeless. Community paramedics are uniquely positioned to assist homeless persons because they are often familiar with the patient already. They are also mobile and can be dispatched or consulted when one of their enrolled patients contacts 911, and they are familiar with the sites at which homeless persons congregate and can meet patients at any location.

San Diego's project encountered challenges that constrained its ability to meet patients' needs. In December 2016, the community paramedics working on San Diego's project were reassigned to traditional 911 response crews. The project manager and an emergency medicine fellow operated the program to the best of their ability but they were not able to manage clients as intensively as the community paramedics had. The project manager was reassigned effective January of 2018, ending the program.

Potential Savings

Among persons enrolled in San Diego's project during the months in which community paramedics were on duty (November 2015 through December 2016) and for whom 12 months of data on 911 calls pre- and post-enrollment were available, the project reduced the number of 911 calls and ED visits by 330, avoiding potential costs of $551,760. (See Table 5.) A substantial percentage of potential savings from the reduction in ED visits would have accrued to ambulance transport providers and hospitals because 43% of San Diego's enrollees were uninsured. From July 2015 through March 2018, Alameda's frequent EMS user project avoided potential costs of $31,096. The majority of potential savings by Alameda's project would have accrued to Medicare because the majority of its patients are Medicare beneficiaries.

Table 5. Potential Savings Associated with Frequent EMS User Projects

Variable	Amount	
	Alameda	**San Diego**
Total Enrollment	68	46
Number of Enrollees with 12 Months of Data on 911 Calls Pre and Post Enrollment	37	37
Number of Transports and ED Visits Avoided	23	330
Average Cost of Ambulance Transport	$603	$923
Average Cost of ED Visit	$749	$749
Potential savings from Ambulance Transports Avoided (patients with 12 months pre-post data)	$13,869	$304,590
Potential savings from ED Visits Avoided (patients with 12 months pre-post data)	$17,227	$247,170
Total Potential Savings (patients with 12 months pre-post data)	**$31,096**	**$551,760**
Potential Savings per Patient Enrolled (patients with 12 months pre-post data)	**$840**	**$14,912**

Conclusion

The frequent 911 user projects have achieved substantial reductions in 911 calls, transports, and ED visits among the patients they have enrolled, often by linking patients with primary care, behavioral health, food, housing, and social services. These reductions in 911 calls, transports, and ED visits have potentially avoided costs for public health insurance programs (i.e., Medicare and Medi-Cal) and health care providers.

Directly Observed Therapy for Tuberculosis

Highlights

- The directly observed therapy for tuberculosis project has enrolled 44 persons between June 2015 and March 2018.
- The community paramedics dispensed all but two (0.05%) doses of TB medications prescribed by the TB clinic's physician.
- One patient was hospitalized twice for intravenous treatment of TB meningitis that was diagnosed prior to enrollment in the pilot project. Eleven other patients were hospitalized for reasons unrelated to their TB.

Description

Tuberculosis (TB) is a highly contagious disease treated with special antibiotic medications. A physician with expertise in TB treatment determines the number of medications and frequency of dosing. People with TB must take their medication as directed, because stopping treatment too soon or missing doses of medication could lead to development of a drug-resistant strain of TB, which poses a major public health risk to a community.[viii] To ensure that people with TB take their medication as directed, TB treatment clinics often provide directly observed therapy (DOT). Under DOT, a health care worker gives a patient medication, observes the patient taking the medication, and monitors the patient for side effects.

In Ventura County, public health officials asked the county's EMS provider to collaborate with the TB clinic to provide DOT, because the TB clinic does not have sufficient staff to provide DOT to all TB patients in the county. Ventura covers a large geographic area and it is not feasible for some patients to travel to the TB clinic for DOT. The TB clinic utilizes community health workers (CHWs) to administer DOT at remote locations, but the CHWs only work Mondays through Fridays and thus do not provide DOT on weekends. In addition, the CHWs are based in Oxnard, where the TB clinic is located, and have to drive as long as 60 minutes to reach some patients. In contrast, the community paramedics are available 24 hours per day seven days per week and are stationed throughout the county, so they usually can reach patients within 15 minutes.

Findings

Ventura's TB project enrolled 44 patients through March 2018. Because the management of tuberculosis often spans six to nine months,[vi] the community paramedics usually carry a caseload of patients whom they treat for multiple months. Over the course of the pilot project, the community paramedics' caseload averaged seven patients per month.

TB clinic leaders indicated that there were conscious decisions to assign patients to either community paramedics or CHWs based on the likelihood that patients would comply with treatment. They often assigned patients to community paramedics who resist treatment or who were verbally abusive or sexually inappropriate because paramedics have more experience and training than the CHWs in managing persons with challenging behavior. They were also more likely to be assigned homeless persons and other patients who are difficult to locate.

Safety

The evaluation team found no evidence that the TB project harmed patients. Community paramedics dispensed appropriate doses of TB medications, and their TB patients did not experience any greater frequency of side effects or symptoms beyond those typically associated with taking TB medications.

Twelve patients enrolled in the pilot project have been hospitalized. One patient was hospitalized twice for TB meningitis, which had been diagnosed prior to enrollment in the program. The other eleven patients were hospitalized one time for a reason other than their TB diagnosis; one hospitalization was for a scheduled surgical procedure.

Effectiveness

People with TB who received DOT from community paramedics were more likely to receive all doses of TB medication prescribed by the TB clinic physician than people who received DOT from the TB clinic's CHWs. Since the project was launched in June 2015, the community paramedics were unable to dispense only two (0.05%) DOT treatments prescribed by the TB clinic physician (Table 6). In contrast, the CHWs were unable to dispense 851 (7.0%) prescribed DOT treatments. This difference is due primarily to the availability of community paramedics on nights and weekends. Availability on weekends ensures that patients have DOT seven days per week if needed, and availability in evenings improves compliance among patients who travel outside of Ventura County for work during business hours. Taking all recommended doses of TB medications as prescribed increases the likelihood that a patient will be cured and will not spread TB to others. It also decreases the risk that the patient could develop a drug-resistant strain of TB that would be much harder to treat and to control in the community.

Community paramedics also helped patients address health care needs other than TB. For example, some TB patients also have diabetes, which is associated with worse outcomes of TB treatment, especially if it is not well controlled. One TB patient treated by community paramedics had severely impaired vision and had difficulty filling syringes with the prescribed amount of insulin. The community paramedics found a local pharmacy that would prefill syringes for the patient to ensure that he would receive the correct dose.

Table 6. Instances of Non-Completion of Directly Observed Therapy among Patients Treated by Community Paramedics (Cumulative)

	Community Paramedic Patients	TB Clinic Patients
Number of Times Community Paramedic Could Not Complete Scheduled DOT	2 (0.05%)	851 (7.0%)
Reasons Why Patient Did Not Complete Treatment	One patient went out of town without making prior arrangements for the DOT. The other was not home at the scheduled time and did not respond to phone calls in a timely manner.	Most missed doses occur on holidays and weekends when the TB clinic was closed and CHWs were not available to treat patients outside the clinic.

Potential Savings

There was a small increase in adherence to the prescribed TB medication schedule when community paramedics administered DOT instead of CHWs, but we cannot estimate the effect of increased adherence in this range in the United States. If the project substantially increased adherence among hard-to-reach patients, the project may have increased the number of patients in Ventura treated successfully for TB and, thus, reduced medical and public health expenditures associated with public health investigation to identify, test, and treat close contacts of people who did not complete treatment. The project also reduced the need for CHWs to travel long distances to provide DOT, increasing their availability to complete other tasks.

Conclusion

Community paramedics can safely administer DOT for TB and monitor patients for side effects, under the direction of a physician who specializes in treatment of TB and in collaboration with public health nurses. Due to their unique schedule and mobility, they can achieve a very high rate of adherence to TB treatment, augmenting the resources of the public health clinic and reducing the risk that patients will develop a drug-resistant strain of TB and transmit it to other persons. They can also assist with patients' other social and medical needs that might create barriers to TB treatment.

Hospice

Highlights

- The hospice project enrolled 325 persons between August 2015 and March 2018.
- Community paramedics collaborate successfully with nurses on the staffs of partner hospices to provide care consistent with patients' wishes.
- The percentage of patients of partner hospices transported to an ED after a 911 call decreased from 80% prior to the pilot project to 28% during the pilot project.
- The project has potentially avoided costs of $255,021 by reducing ambulance transports and ED visits.

Description

The goal of hospice care is to provide medical, psychological, and spiritual support to persons dying from a terminal illness in a patient's home, a residential care facility, a nursing home, or an inpatient hospice facility. Hospice staff members tell hospice patients, their family members, and other caregivers to contact the hospice instead of 911 if they believe there is a medical need or if they become concerned about the patient's comfort. Despite this instruction, some hospice patients and their families call 911 instead of the hospice.

The standard response to a 911 call made on behalf of a hospice patient is to transport the patient to an ED, which may be upsetting and uncomfortable for hospice patients. In addition, clinicians in EDs may perform medical interventions that the hospice patient would prefer not to receive and may admit the hospice patient for inpatient care. Moreover, insurers may revoke hospice benefits if the patient receives treatment or hospitalization for their terminal illness that is incompatible with the hospice approach of comfort care.

Ventura County's hospice project seeks to prevent transports that are not consistent with hospice patients' wishes. This is especially important for hospice patients who reside in a residential care or skilled nursing facility. In those facilities, staff may call 911 without discussing the decision with the patient or family members.

In Ventura, if a 911 dispatcher or a first responder on scene determines that a person is under the care of a hospice agency participating in the pilot project, the dispatcher or first responder requests that a community paramedic come to the patient's home, which may be in a private residence, residential care, or skilled nursing facility. The community paramedics are supervisors who can respond to hospice calls while other paramedics respond to different 911 calls.

Once on scene, the community paramedic assesses the patient, talks with family members and caregivers, and contacts a registered nurse employed by the hospice agency. The hospice nurse directs the community paramedic regarding what care to provide. Depending on the circumstances, the hospice nurse may ask the community paramedic to wait with the patient, family members and/or caregivers until the nurse can arrive on scene. The hospice nurse may also ask the community paramedic to administer pain medications to the patient that the hospice has provided in a "comfort care" pack. ***No hospice patient who requests transport to an ED is denied transportation.***

Findings

Ventura's hospice pilot project responded to 325 calls made on behalf of patients of participating hospice agencies. Hospice patients, family members, or staff of residential or skilled nursing facilities in which hospice patients resided initiated most 911 calls, but hospice nurses made some 911 calls during visits with patients. The reasons for 911 calls to which Ventura's community paramedics responded varied and included altered level of consciousness, cardiac arrest, constipation, fall, seizure, shortness of breath, syncope, and family concern about hospice care.

Safety

The evaluation found no evidence that the hospice project harmed patients. After an assessment to determine that the patient could remain at home under hospice care, the community paramedics' work consisted primarily of providing emotional support to hospice patients and their families and administering medications in patients' "comfort care" packs as directed by a hospice nurse until the hospice nurse could arrive and further evaluate the patient.

The hospice project reduced harm by honoring patients' wishes and reducing the likelihood that they would experience an undesired and uncomfortable trip to the ED and potentially lose hospice benefits. Community paramedics worked with patients, families, and hospice nurses to avoid ED transports, unless a patient requested transport or had a medical need that could not be met in the patient's home, such as a fracture. No patient was denied ED care when it was indicated and consistent with his or her wishes.

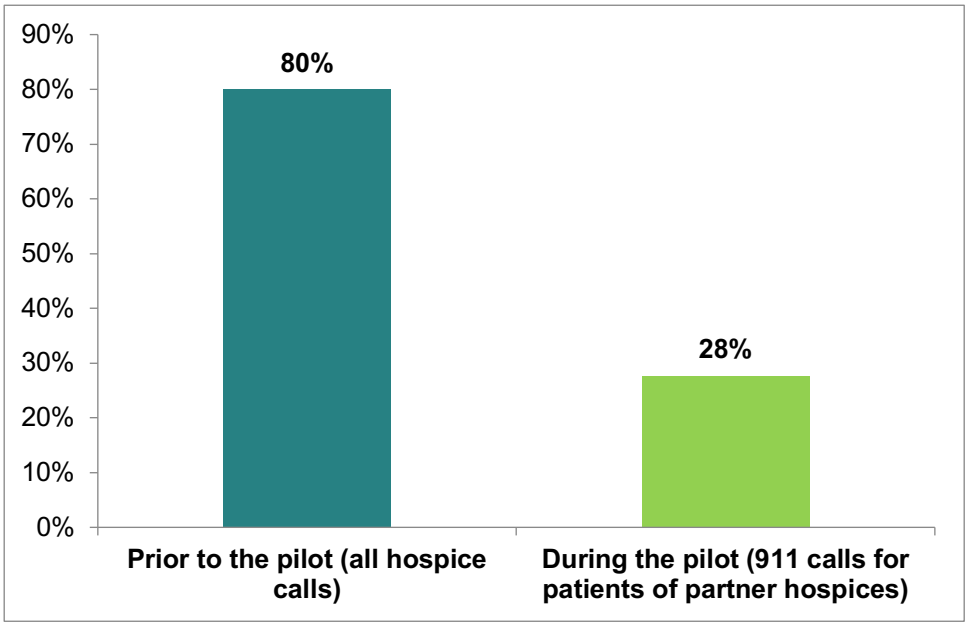
Effectiveness

The project achieved its goal of honoring patients' wishes to remain in their homes by integrating EMS and hospice protocols. Figure 4 shows the impact of the pilot project on the percentage of 911 calls for hospice patients that resulted in transport of the patient to an ED. Prior to the launch of the pilot project, 80% of 911 calls for hospice patients resulted in the transport of a patient to an ED.[3] Among patients of partner hospices, the percentage of patients transported decreased to 28% after the pilot project was implemented. Although data on hospice revocation rates prior to the pilot project are not available, it is very likely that the large reduction in ED transports also led to a reduction in the percentage of patients of partner hospices whose benefits were revoked.

Community paramedics also alerted hospices and family members to patients' unmet needs for additional assistance. For example, the project's very first hospice call involved a patient who had fallen during the night while walking to the bathroom. With the patient's permission, the community paramedic who responded to the call contacted a family member who arranged for the patient to have a caregiver at night as well as during the day to assist her with toileting and other needs.[ix]

[3] The 80% rate of transport to an ED prior to the launch of the pilot project differs from the rate that AMR Ventura reported in its proposal to participate in the pilot project (42%). The 42% rate was based on a manual search of electronic records for 911 calls on which a specific box had been checked. The 80% estimate is derived from an electronic search of AMR Ventura's records to identify all records in which the term "hospice transport" appeared. The evaluation uses the latter rate because it reflects the results of a more thorough search of AMR Ventura's records.

Figure 4. Percentage of 911 Calls for Hospice Patients That Result in Transport to an ED (Cumulative)



Potential Savings

As indicated in Table 7, the hospice project avoided potential costs of $255,021 ($785 per patient enrolled). These estimates are based on reductions in ambulance transports to an ED and ED visits. Potential savings could be higher than these estimates because some hospice patients who were transported to an ED were probably admitted to a hospital for inpatient care. However, cost avoidance associated with inpatient admissions could not be estimated because the pilot project was unable to obtain data from hospitals in Ventura County on the number of enrolled hospice patients who were transported to their EDs who were subsequently admitted to their hospitals.

Table 7. Potential Savings Associated with the Hospice Community Paramedicine Project

Variable	Amount
Total Number of Patients Enrolled	325
Total Number of ED Visits Avoided (# if baseline rate persisted - # ED visits during pilot project)	169
Average Cost of ED Transport Avoided	$520
Average Cost of ED Visit Avoided	$989
Potential Savings from ED Transports Avoided	$87,880
Potential Savings from ED Visits Avoided	$167,141
Total Potential Savings	**$255,021**
Potential Savings per Patient Enrolled	**$785**

Conclusion

The hospice project demonstrates that community paramedics can partner with hospice nurses to safely reduce the number of hospice patients unnecessarily transported to an ED. Reducing ED transports increases the health care system's ability to honor the wishes of hospice patients, reduces the risk that they will lose their hospice benefits, and potentially reduces health care costs.

Alternate Destination – Mental Health

Highlights

- The alternate destination – mental health project enrolled 310 persons between September 2015 and March 2018.
- The project has enabled persons with mental health needs to obtain mental health services more quickly.
- In addition to 911 calls involving patients with mental health needs, the community paramedics have begun performing medical screening examinations for "walk-in" clients who come to the mental health crisis center for treatment.
- 97% of patients transported to the mental health crisis center were treated safely and effectively and no patients experienced adverse outcomes. Nine persons (3%) were transferred to an ED within six hours of transport to the mental health crisis center. Most transfers occurred during the first months of operation.
- The project has potentially avoided $331,100 in costs by reducing ED visits for medical clearance and subsequent ambulance transports to a mental health facility. Additional costs potentially could have been avoided if the county's inpatient mental health facility had more inpatient beds.

Description

Many EDs in California are overcrowded. Some of the people they serve can be treated safely and effectively in other settings, including some who arrive at EDs via ambulance. Alternate destination pilot projects focus on transporting such patients to settings in which they can obtain appropriate care more efficiently. In California, the need for alternatives is particularly critical for people with mental health needs. Since 1995, the number of beds in inpatient psychiatric facilities in California has decreased by nearly 30%.[x] Patients with mental health needs routinely spend hours in an ED waiting for medical clearance. In some cases, they spend days in an ED waiting for a bed to become available in an inpatient psychiatric facility, without getting definitive mental health care.[xi] Nationwide, the mean length of ED visits is longer for psychiatric patients than medical patients (194 minutes vs. 138 minutes), and psychiatric patients are more likely to have stays in an ED lasting greater than 24 hours[xii]

The community paramedics participating in the Stanislaus County pilot project provide medical clearance for people with mental health needs and arrange for them to be transported directly to a county-operated mental health crisis center. Community paramedics are dispatched in response to 911 calls that a dispatcher believes involve a mental health problem, or when another paramedic or a law enforcement officer identifies a patient as having mental health needs. The community paramedics respond to these calls as needed in addition to responding to traditional 911 calls.

Once on scene, a community paramedic assesses the patient to determine whether he or she has any medical needs or is intoxicated due to alcohol or drug consumption. If the patient has no emergent medical needs, is not intoxicated, and is not violent, the community paramedic contacts the mental health crisis center to determine whether the county inpatient psychiatric facility located next door to the crisis center has beds available. If the inpatient psychiatric facility has the capacity to accept the patient through the crisis center, the community paramedic gives the patient the option to be transported by ambulance to the mental health crisis center instead of an ED. The only exceptions are patients who the crisis center staff decline to admit because their behavior was disruptive during past visits to the crisis center; such patients are always transported to an ED.

After a patient arrives at the crisis center, mental health professionals on the crisis center staff evaluate the patient further to determine what mental health services he or she needs. Eligibility for the pilot project is limited to adults who are uninsured or enrolled in Medi-Cal because the county inpatient psychiatric facility does not accept

patients with other types of health insurance. A private psychiatric facility is available to persons in Stanislaus County who have Medicare or commercial health insurance.

In recent months, the mental health crisis center staff have asked community paramedics to provide medical screening to "walk in" clients (i.e., persons not transported by ambulance). In the past, the crisis center had relatively few walk-in clients and these clients were sent to a nearby ED for medical clearance. As the volume of walk-in clients has increased, the mental health crisis center staff has requested that the community paramedics come to the crisis center to screen clients. This has enabled clients to obtain medical screening more quickly and begin mental health treatment more quickly, if they do not have any acute medical needs.

Findings

Stanislaus's alternate destination – mental health project enrolled 310 persons from September 2015 through March 2018. Many patients enrolled in recent months were "walk in" clients who come to the mental health crisis center for care. The crisis center's protocol requires screening these patients for medical needs prior to admission to the crisis center.

Safety

The evaluation team found no evidence of patient harm caused by the alternate destination – mental health project. The community paramedics accurately screened patients to determine which of them could be safely transported directly to the mental health crisis center. Only nine of patients enrolled in the project (3%) were transferred to an ED within six hours of arrival at the crisis center.

Table 8 lists the reasons why the nine patients were transferred to an ED. None of the transfers to an ED involved life-threatening conditions and none of the patients transferred were admitted for inpatient medical care. Seven of these nine patients were subsequently transferred to an inpatient psychiatric facility. The other two patients were discharged from an ED without transfer. Eight of the nine transfers occurred during the first six months in which the project was in operation. The sharp decrease in transfers reflects the efforts of the project's medical director to develop protocols and screening methods that maximized the likelihood that the mental health crisis center would accept patients.

Table 8. Reasons for Transfer to an ED within Six Hours of Admission to Mental Health Crisis Center (9 of 310 Patients)

Reason for Transfer to an ED	Number of Patients
Agitation	2
Blood pressure above the mental health crisis center's threshold	2
Urinary incontinence	2
Patient had sleep apnea, and the county inpatient psychiatric facility did not have a continuous positive airway pressure (CPAP) machine	1
Change in patient condition	1
No capacity at psychiatric hospital	**1**
Total	**9**

The alternate destination – behavioral health project has also improved public safety. Law enforcement officers interviewed by the evaluation team stated that having community paramedics available enhanced their ability to respond effectively to persons with mental health needs because community paramedics are better prepared to address mental health needs and can arrange ambulance transports for mental health patients. This allows law enforcement officers to return to other law enforcement duties instead of transporting patients to an ED in their squad cars and waiting in the ED to transfer responsibility for the patient to a clinician.

Effectiveness

The pilot project substantially reduced the rate at which 911 calls involving patients with mental health needs resulted in a transport to an ED for medical screening. After the pilot project was implemented, 28% of mental health patients (n = 310) were transported to the mental health crisis center instead of an ED. An additional 27% (n = 300) met the eligibility criteria and could have been transported to the crisis center if additional beds were available in the county's inpatient psychiatric facility or if the crisis center accepted patients who have a form of health insurance other than Medi-Cal. The community paramedics also determined that 429 people (38% of people assessed) were not eligible for transport to the mental health crisis center because they had a medical need, had vital signs outside parameters for admission to the crisis center, were intoxicated, violent, agitated, or over age 65 years. Five percent (n = 56) met the medical criteria for admission to the mental health crisis center but were not admitted due to a history of disruptive behavior during previous admissions to the crisis center. Only two percent of eligible patients (n = 25) did not consent to be transported to the mental health crisis center.

The pilot project also reduced the time to treatment by a mental health professional, which improved patients' well-being. A mental health professional assessed people transported directly to the mental health crisis center within minutes of arrival. In contrast, people initially transported to an ED had a much longer wait for a medical screening evaluation before they were transported to an inpatient psychiatric facility to be assessed by a mental health professional.

Potential Savings

As indicated in Table 9, the alternate destination – mental health project potentially avoided an estimated $331,100 in costs ($1,068 per patient) because transporting a mental health patient to the crisis center avoids an ED visit and a secondary transport of a patient from an ED to an inpatient mental health facility. Most of these potential savings would have accrued to the Medi-Cal program because 84% of patients enrolled in the project were Medi-Cal beneficiaries.

Table 9. Potential Savings Associated with the Alternate Destination – Mental Health Project

Variable	Amount
Total Number of Patients Enrolled	310
Total Number of ED Visits Avoided	301
Average Cost of ED Transport Avoided	$554
Average Cost of ED Visit Avoided	$546
Potential Savings from ED Transports Avoided	$166,754
Potential Savings from ED Visits Avoided	$164,346
Total Potential Savings	**$331,100**
Potential Savings per Patient Enrolled	**$1,068**

Conclusion

The alternate destination – mental health project demonstrates that community paramedics can perform medical screening examinations for persons with mental health needs and determine which of them can be transported directly to a mental health crisis center. Transporting these persons directly to a crisis center enables them to obtain mental health services more quickly, which is likely to improve their well-being. The project also potentially avoids health care costs by reducing the numbers of persons transported to and assessed in an ED. Most of these potential savings would accrue to Medi-Cal because most persons participating in this project are Medi-Cal beneficiaries.

Alternate Destination – Urgent Care

Highlights

- The three alternate destination – urgent care projects enrolled 48 patients between September 2015 and November 2017.
- All three of the alternate destination – urgent care projects closed in 2017 due to low enrollment.
- Most patients enrolled had a laceration or an isolated closed extremity injury.
- Patients did not experience any adverse outcomes. Two patients (4%) were transferred to an ED within six hours of admission to an urgent care center; nine (19%) were rerouted to an ED because the urgent care center declined to treat the patient.
- The projects potentially avoided costs of $3,640 because insurers pay urgent care centers less than EDs for treatment of eligible conditions.

Description

Three pilot projects offered patients who have minor injuries or minor medical conditions the option of transportation to an urgent care center, instead of to an ED for evaluation by a physician. Urgent care centers are walk-in clinics that treat persons with illnesses or injuries that can be evaluated and treated safely without the full range of resources available in an ED. California does not license urgent care centers as a distinct category of health care provider; they operate under the licenses of hospitals or of the physicians who operate them.[xiii] This means that there are no requirements regarding operating hours, equipment, or the types of medical services provided.

All three alternate destination – urgent care projects enrolled patients who had any of the following five conditions: isolated closed extremity injury, laceration with controlled bleeding, soft tissue injury, isolated fever or cough, and other minor injury. One site, Carlsbad, also enrolled patients who had generalized weakness. Patients were screened by paramedics on 911 response crews who were trained to use a protocol that was developed by emergency physicians to determine whether transporting a patient to an urgent care center was an appropriate option. The protocols excluded patients with medical conditions that were emergent, complex, or inappropriate for transport to an urgent care center.

If paramedics concluded that a patient could be treated safely at an urgent care center, the paramedics offered transport to an urgent care center approved by the jurisdiction's local emergency medical services agency (LEMSA). Urgent care centers approved by the LEMSAs were required to provide respiratory therapy treatments, x-rays, and point of care laboratory testing for blood and urine and to have an automated external defibrillator. ***Patients who declined to be transported to an urgent care center were transported to an ED.*** After transporting a patient to an urgent care center, paramedics were available to reroute the patient to an ED if a clinician at the urgent care center determined that the urgent care center could not treat the patient safely and appropriately. ***It is important to note that these projects did not involve evaluation and release of patients by paramedics. All patients were transported to a facility where they were evaluated by a physician.***

Findings

Forty-eight persons were enrolled in the three alternate destination – urgent care projects through November 2017. Orange County's project had the largest enrollment (34 patients) and Carlsbad's project had the smallest enrollment (2 patients). UCLA's alternate destination – urgent care project closed in May 2017 and Carlsbad and Orange County's projects closed in November 2017. All closures of alternate destination – urgent care projects were due to low enrollment.

There are multiple reasons why enrollment in the alternate destination – urgent care projects was substantially lower than anticipated. All three sites had fewer patients than expected who met all of the criteria for inclusion in the pilot project. In addition, many 911 calls occurred at times of the day during which urgent care centers were closed. In the case of Carlsbad's project, enrollment was limited to non-elderly adults who have insurance coverage through a single health plan.

Most of the patients for whom information on type of injury or illness was reported had a laceration or an isolated closed extremity injury, such as a dislocation, sprain, or fracture (Table 10).

Table 10. Number of Enrollees in Alternate Destination – Urgent Care Projects by Condition (Cumulative)

Lead Agency	Total Enrollees	Closed Extremity	Laceration	Soft Tissue	Fever or Cough	Other Minor Injury	Generalized Weakness
UCLA – Glendale and Santa Monica	12	5	0	0	0	7	0
Orange	34	17	15	0	1	1	0
Carlsbad	2	0	0	0	0	0	2
Total	**48**	**22**	**15**	**0**	**1**	**8**	**2**

Safety

The alternate destination – urgent care projects did not harm patients. Among the 48 patients enrolled in the alternate destination – urgent care projects, two patients (4%) were subsequently transferred to an ED within six hours of arrival at an urgent care center. In addition, nine patients (19%) were transported to an urgent care center but then rerouted to an ED because clinicians at the urgent care center declined to treat the patient. None of these patients had life-threatening conditions and there were no adverse outcomes. The reasons for transport from an urgent care center to an ED are listed in the table below. Additional detail about the two secondary transfers can be found in the initial public report on the community paramedicine pilot projects.[xiv]

Table 11. Reasons for Transfer or Rerouting to an ED within Six Hours of Admission to an Urgent Care Center (11 of 48 Patients)

Reason for Transfer to an ED	Number of Patients
Secondary Transfers	
Patient experienced shortness of breath and heart rate slowed after transport to an urgent care center for treatment of nausea without abdominal pain	1
Patient required surgery for injury	1
Rerouted Transfers (aka Continuous Transfers)	
Patient requested opioid pain medication	3
Diagnostic equipment broken or unavailable	2
Urgent care physician believed shoulder injury needed further evaluation	2
Urgent care center physician believed patient needed to be examined by an orthopedist	2
Total	**11**

Effectiveness

While paramedics participating in the pilot projects were able to triage patients according to protocol effectively, it was challenging for the paramedics and project leaders to determine which patients the urgent care centers would accept. Urgent care centers sometimes rejected patients who have conditions that can be safely treated outside an ED, such as a dislocated shoulder. Interviews with project managers and paramedics suggest that urgent care centers may be hesitant to accept patients transported by an ambulance since that is a new practice for them. In addition, the range of services offered by urgent care centers varies substantially. For example, some urgent care centers do not have the capacity to administer intravenous fluids, which limits their ability to treat persons with dehydration and other conditions that can be treated safely outside of an ED.

Potential Savings

Table 12 displays estimates of the potential savings associated with two of the three alternate destination –urgent care projects. Data for the third site are not included because it had only enrolled two patients before it closed in November 2017. These projects potentially avoided costs of $3,640. The estimates of potential savings are based on estimates of the difference between the amounts insurers pay for treatment of the same condition in an ED and an urgent care center. Costs for ambulance transports were not reduced because no transports were avoided.

Table 12. Potential Savings Associated with the Alternate Destination – Urgent Care Projects

Variable	Amount	
	UCLA – Glendale and Santa Monica	**Orange**
Total Enrollment	12	34
Total Patients Treated in an Urgent Care Center and Released	6	29
Estimated Difference Between the Cost of an ED Visit and an Urgent Care Visit	$104	$104
Total Potential Savings	**$624**	**$3,016**
Potential Savings per Patient Enrolled	**$52**	**$89**

Conclusion

More data are needed to draw firm conclusions about the alternate destination – urgent care concept. Paramedics participating in the alternate destination – urgent care projects have demonstrated capacity to evaluate patients according to triage protocols to determine whether they are candidates for treatment at an urgent care center. No patients experienced adverse outcomes. However, only 48 patients were enrolled across the three sites over 26 months, in large part because many people with eligible conditions called 911 at times at which urgent care centers were not open. The only concept for which fewer people were enrolled – Directly Observed Therapy for Tuberculosis – is being tested at only one site and involves people who have a rare condition. In addition, two of the 48 patients enrolled were transferred to an ED following admission to an urgent care center and nine were rerouted to an ED because the urgent care center declined to accept the patient. These findings suggest that for alternate destination – urgent care projects to offer a viable alternative to EDs, screening protocols will need to be more closely aligned with the capabilities of urgent care centers and the illnesses and injuries they are willing to treat. The savings generated were modest due to the low enrollment and the design of the project, which only changed the location to which patients were transported and did not reduce the number of transports.

Alternate Destination – Sobering Center

Highlights

- The alternate destination – sobering center project enrolled 730 patients from February 2017 through March 2018.
- 97.6% of patients (n = 712) were treated safely and effectively at the sobering center. Only 2.3% (n = 17) were transferred to an ED within six hours of admission. Only one patient (0.1%) was rerouted to an ED because the sobering center's registered nurses did not accept the patient.
- Persons treated in the sobering center have better access to social workers who can help them obtain detoxification, supportive housing, and other services.
- The projects potentially avoided costs of $241,157 because the cost of treating intoxicated persons in the sobering center is less than the cost of treating them in an ED.

Description

Acutely intoxicated persons are another population for whom alternatives to routine transport to an ED are needed. Nationwide an estimated 9.7% of ED visits are due to inebriation.[xv] In busy EDs, clinicians have little time to assist intoxicated patients unless they also have an acute medical need. They may not counsel patients about their drinking or give them information about detoxification programs, case management, or other resources.

Cities around the US have established sobering centers to care for these patients.[xvi] Sobering centers are less expensive to operate than EDs and their staff are able to focus on the needs of intoxicated persons.[xvii] In February 2017, the City and County of San Francisco began a pilot project under which paramedics transport eligible persons directly to its sobering center. The sobering center has cared for over 50,000 persons since it opened in 2003. It serves people who are acutely intoxicated but do not have other urgent health care needs. The sobering center is open 24 hours per day, 7 days per week and staffed by registered nurses who monitor patients throughout their stay. The registered nurses follow standardized procedures for treatment of a variety of medical and mental health conditions. There are also social workers on the sobering center's staff who help patients obtain treatment for alcohol use disorders and mental health conditions, housing, Medi-Cal, Supplemental Social Security, and General Assistance. Most patients stay for 4 to 12 hours. Approximately 33% of patients are treated at the sobering center multiple times per year and approximately 90% of patients are homeless at the time that services are provided.[xviii]

San Francisco has trained all paramedics on 911 response crews to screen intoxicated patients to determine if they are eligible to enroll in the pilot project. Patients are deemed eligible for transport to the sobering center if they are have acute alcohol intoxication but do not have any acute medical or mental health needs. If a patient meets all eligibility criteria, the paramedics offer the patient a choice of transport to the sobering center or an ED. Patients who do not meet all eligibility criteria are transported directly to an ED, as are patients who express a preference for transport to an ED.

Ten experienced paramedics have completed the full community paramedic training. The community paramedics work with 911 response crews and the sobering center's staff to perform quality assurance reviews for patients transported to the sobering center. They provide training and are available to paramedics by telephone or in person for consultation if paramedics in the field are unsure whether a patient is eligible for transport to the sobering center. In addition, the community paramedics collaborate with San Francisco's Homeless Outreach Team (HOT) outreach workers to engage sobering center patients who are high utilizers of county health care services.

Findings

The alternate destination – sobering project enrolled 730 patients during its first 13 months of operation (February 1, 2017 through March 31, 2018). Ninety-four of the 730 patients (13%) enrolled in the project have visited the sobering center more than once.

Safety

The community paramedics and the staff of the sobering center review the records of all patients transported to the sobering center by ambulance. Cases that involve a secondary transport of a patient to an ED are also reviewed by a committee that consists of the sobering center's deputy director, the sobering center nurse coordinator, the San Francisco Emergency Medical Services Agency's Medical Director, and the San Francisco Fire Department's Medical Director.

The most common risk to sobering center patients is an unforeseen need for medical detoxification, which is difficult to predict initially among people with chronic alcohol consumption. A patient may also have taken another drug that paramedics cannot detect when they examine the patient in the field. Clients are monitored via comprehensive nursing protocols that assess potential effects of other drugs, including the impact of sedating medications on orientation and respiratory status.

Among the 730 patients enrolled in the alternate destination – sobering project, 17 patients 2.3%) were transferred to an ED within six hours of admission to the sobering center. These secondary transfers were due to falls, abdominal pain, agitation, alcohol withdrawal, chest pain, confusion, hallucinations seizure, suicidal ideation, tachypnea (i.e., rapid shallow breathing), and a client request for oxygen despite not having symptoms of respiratory distress. (Table 13) In 16 cases, the transfer to the ED could not have been avoided because the need for transfer was not evident when the paramedics assessed the patient in the field. When the community paramedics reviewed records for the patient with tachypnea, they concluded that the patient's respiration rate in the field had been outside the range for admission to the sobering center and that the paramedics on the 911 crew that transported the patient to the sobering center had not relayed this information to the registered nurse on duty. The community paramedics coached the 911 response crew and their supervisor on how to use a patient's respiration rate in the field to determine if a patient is eligible for transport to the sobering center. One additional patient (0.1%) was rerouted from the sobering center to an ED due to hypothermia and bradycardia. When this patient arrived at the sobering center, his temperature was below the threshold for admission to the sobering center based on nursing protocols. The registered nurses directed the paramedics to reroute the patient to an ED because he could not be rewarmed within 15 minutes. Among the 18 patients transferred or rerouted to an ED, 11 were treated in an ED and released. Four patients were medically cleared in the ED and transferred to a psychiatric ED. Two left an ED's waiting room without being seen. The disposition of one patient is unknown.

Effectiveness

The alternate destination – sobering center project has reduced the number of intoxicated persons transported to an ED. Interviews with project leaders indicate that one of the greatest benefits of treating these clients in the sobering center is that the sobering center social workers have greater ability to connect clients with medical detoxification, social work, case management services, and permanent housing. EDs have social workers but they are not able to focus exclusively on intoxicated patients. In addition, the sobering center is equipped to provide withdrawal management for patients if a bed is available in a medical detoxification center, which helps patients cope with withdrawal and increases their willingness to complete detoxification.

Table 13. Reasons for Transfer to an ED within Six Hours of Admission to Sobering Center or Rerouting from the Sobering Center (18 of 730 Patients)

Reason for Transfer to an ED	Number of Patients
Secondary Transfers	
Fall	5
Confusion/Hallucinations	3
Alcohol withdrawal	2
Suspected suicide attempt/suicidal intentions	2
Agitation with chest pain	1
Chest/abdominal pain	1
Client requested oxygen despite lack of respiratory distress	1
Seizures/history of seizures	1
Tachypnea/Increasing temperature	1
Rerouted Transfers (aka Continuous Transfers)	
Hypothermic/bradycardia	1
Total*	**18**

*Some patients are listed in multiple categories.

Another strength of the alternate destination – sobering center project is the use of paramedics in two complementary roles. Paramedics on 911 response crews can contact community paramedics for guidance if they are uncertain whether a patient meets the criteria for transport to the sobering center. Community paramedics review transports of patients to the sobering center and give 911 crews feedback on their use of the protocol for screening patients.

In addition, the community paramedics' partnership with the HOT outreach workers extends the project beyond transport to the sobering center to encompass outreach to high utilizers to encourage them to seek treatment for their alcohol use disorder. According to the project's leaders, this outreach is important because San Francisco has substantial services for homeless people with alcohol use disorders, but people often do not know how to access these services or will not seek help on their own. Pairing community paramedics with homeless outreach workers leverages the strengths of both groups of workers. Community paramedics contribute medical knowledge, ability to access medical records, and relationships with ambulance crews. Homeless outreach workers, many of whom are formerly homeless and or in recovery from substance us disorders, can form closer relationships with clients due to their lived experience.

Potential Savings

Table 14 displays estimates of potential savings associated with the alternate destination – sobering center project. For this project, savings were due to the difference in the cost of caring for intoxicated persons in the sobering center versus in an ED. For patients who were treated in the sobering center and released, savings were estimated by multiplying the number of patients by the difference between the cost of treating them in an ED or in the sobering center ($385). These savings were offset by the cost of a sobering center visit for the nine patients who were transferred to an ED and the cost of a second ambulance transport. During its first fourteen months of

operation, the project generated $241,157 in potential savings ($330 per person) due to the reduction in ED visits. Actual savings realized by insurers may have differed because the data used to estimate costs are not used for billing purposes.[xvi] The majority of potential savings accrued to Medi-Cal because sobering center staff estimate that 62% of the patients enrolled in the project are Medi-Cal beneficiaries. Costs for ambulance transports were not reduced because no transports were avoided.

Table 14. Potential Savings Associated with the Alternate Destination – Sobering Center Project

Variable	Amount
Total Number of Patients Enrolled	730
Total Number of ED Visits Avoided	712
Average Cost of Ambulance Transport	$1,675
Average Cost of ED Visit	$649
Average Cost of Sobering Center Visit	$264
Potential Savings Associated with Sobering Center Visits	$274,120
Number of Secondary Transfers to ED	17
Potential Cost Associated with Sobering Center Visit for Secondary Transfers to an ED	$4,488
Potential Cost Associated with Secondary Transfers to an ED	$28,475
Total Potential Savings (Net of Cost)	**$241,157**
Potential Savings per Patient Enrolled	**$330**

Conclusion

Preliminary findings suggest that paramedics participating in the alternate destination – sobering center project can accurately screen intoxicated patients to identify those who can be treated safely and effectively in a sobering center. To date the project has resulted in the transport of 713 fewer persons to an ED. Only two patients (0.1% of all patients enrolled) were transported to the sobering center who did not meet the eligibility criteria (i.e., the patient rerouted from the sobering center to the ED and the patient accepted by the sobering center who had tachypnea). Only 17 patients (2. 3%) were transferred to an ED subsequent to admission to the sobering center. There were no adverse outcomes from secondary transfers to an ED. The project potentially reduced costs because providing care to intoxicated persons in the sobering center is less expensive than caring for them in an ED. In addition, the community paramedics participating in the project provide valuable feedback to paramedics on 911 response crews and are collaborating effectively with homeless outreach workers to encourage people with chronic alcoholism to seek treatment.

Summary and Conclusion

The community paramedicine pilot projects have demonstrated that specially trained paramedics can provide services beyond their traditional and current statutory scope of practice in California. No adverse outcome is attributable to any of these pilot projects. These projects are enhancing patients' well-being, improving the integration and efficiency of health services in the community, and reducing ambulance transports, ED visits, and hospital readmissions. The majority of potential savings associated with these pilots would accrue to Medicare and Medi-Cal and to hospitals serving Medicare and Medi-Cal patients.

Specifically, the sites testing the seven concepts have demonstrated the following.

Post-Discharge

- All five post-discharge projects decreased hospital readmissions within 30 days of discharge for at least one of the diagnoses targeted. Butte's heart failure patients were the only group of patients whose 30-day readmission rate exceeded the partner hospital's historical all-cause readmission rate. The difference may have been due to differences in protocols. Prior to November 2017, Butte's project did not provide home visits to all patients, whereas all patients enrolled in the other four post-discharge projects received at least one home visit. In November 2017, Butte changed its protocol to provide every patient with at least one home visit.
- The projects improved patients' knowledge of their medications and their ability to take medications as prescribed by their physicians.
- The projects avoided potential costs for payers (primarily Medicare and Medi-Cal) and hospitals due to reductions in readmissions within 30 days of discharge. Participating hospitals also reduced their risk of incurring Medicare penalties for excessive readmissions.

Frequent EMS User

- These projects achieved substantial reductions in the number of 911 calls, ambulance transports, and ED visits among enrolled patients.
- Community paramedics assisted patients in obtaining housing and other nonemergency services that address the physical, psychological, and social needs that led to their frequent EMS use.
- Both projects avoided potential costs for payers by reducing 911 calls, ambulance transports, and ED visits. San Diego's project also potentially decreased the amount of uncompensated care furnished by ambulance providers and hospitals because 43% of the patients it enrolled were uninsured.

Directly Observed Therapy for Tuberculosis

- Community paramedics dispensed appropriate doses of TB medications and monitored side effects and symptoms that could necessitate a change in treatment regimen.
- Persons with TB who received directly observed therapy (DOT) from community paramedics were more likely to receive all doses of TB medication prescribed by the TB clinic physician than patients who received DOT from the TB clinic's community health workers. Receiving all doses prescribed by the TB clinic physician increased the likelihood that a patient will be treated successfully and will not spread TB to others or develop a drug-resistant strain of TB that would be much harder to treat and to control in the community.

Hospice

- Community paramedics assessed hospice patients, provided psychosocial support, and administered medications from the hospice patients' "comfort care" packs when necessary, in consultation with a hospice nurse.
- The hospice project enhanced ability to honor patients' wishes to receive hospice services at home by markedly reducing rates of ambulance transports to an ED and ED visits.
- The reduction in unnecessary transports and ED visits potentially avoided costs for Medicare and other insurers. Expenditures for inpatient care were also potentially reduced because some ED visits for hospice patients result in an inpatient admission.

Alternate Destination – Mental Health

- Twenty-eight percent of persons screened by the community paramedics were transported to the mental health crisis center rather than an ED and an additional 27% could have been transported to the crisis center if the county had more inpatient psychiatric beds or if the crisis center accepted people with private insurance or Medicare. (Forty-three percent of persons the community paramedics screened were not eligible for transport to the mental health crisis center because they had a medical need, were intoxicated, or were violent.)
- Ninety-seven percent of patients who participated in the project (301 of 310 patients) were treated safely and effectively at the mental health crisis center without the delay of a preliminary emergency department visit for medical screening. Only 3% of patients (n = 9) required subsequent transfer to the ED, and none experienced adverse outcomes.
- The project also improved public safety because community paramedics could take responsibility for a person with mental health needs, which allowed law enforcement officers to return to law enforcement duties instead of transporting the person to an ED and waiting to transfer responsibility for the person to clinicians in the ED.
- The project avoided potential costs for payers, primarily Medi-Cal, by reducing ED visits and transfers of patients from EDs to psychiatric facilities. For uninsured persons, the amount of uncompensated care provided by ambulance providers and hospitals also decreased.

Alternate Destination – Urgent Care

- Conclusions cannot be drawn about the impact of the alternate destination – urgent care projects due to low enrollment.
- Among patients who were enrolled, paramedics were able to screen patients according to protocol and identify those for whom transport to an urgent care center was an appropriate option.
- No patients experienced an adverse outcome, although two patients (4%) were transferred to an ED following admission to an urgent care center, and nine patients (19%) were rerouted to an ED because the urgent care center declined to accept the patient.
- To operate safely and efficiently, these projects need to closely match field screening protocols with the capabilities of urgent care centers and the illnesses and injuries they are willing to treat.
- The projects potentially yielded modest savings for payers because they pay less for treatment provided in urgent care centers than in EDs for the same illnesses and injuries.

Alternate Destination – Sobering Center

- 97.6% percent of patients enrolled in the alternate destination – sobering project (712 of 730) were treated safely and effectively at the sobering center. Only 17 patients (2.3%) were transferred to an ED within six hours of admission to the sobering center and only one (0.1%) was rerouted from the sobering center to an ED because the sobering center registered nurses declined to accept the patient. None of these patients were admitted to a hospital for inpatient medical care.

- In addition, community paramedics participating in the project provided feedback to paramedics on 911 crews on how to screen intoxicated persons to determine if they are candidates for transfer to the sobering center. They also partnered effectively with homeless outreach workers to encourage people who use the sobering center frequently to seek treatment for chronic alcoholism, housing, and other services.

- During its first 14 months of operation, the project avoided potential costs of $241,157 by substituting sobering center visits for ED visits. The majority of potential savings accrued to Medi-Cal because the majority of patients enrolled in the project were Medi-Cal beneficiaries.

Conclusion

The California community paramedicine pilot projects were designed to integrate with existing health care resources and utilize the unique skills of paramedics and their round-the-clock availability. Findings from the evaluation indicate that Californians benefit from these innovative models of health care that leverage an existing workforce that operates at all times under medical control — either directly or by protocols developed by physicians experienced in EMS and emergency care. No other health professionals were displaced. Instead, these pilot projects have demonstrated that community paramedics can partner with physicians, nurses, behavioral health professionals, and social services workers to fill gaps in the health and social services safety net. No adverse patient outcome is attributable to any of these pilot projects.

At least 34 states are operating community paramedicine programs,[ii] and research conducted to date indicates that they are improving the efficiency and effectiveness of the health care system[xix-xxiv] These findings suggest that the benefits of community paramedicine programs grow as they mature, solidify partnerships, and find their optimal structure and niche. The evaluation of HWPP #173 yields consistent findings for six of the seven community paramedicine concepts tested. All of the post-discharge, frequent 911 users, DOT for TB, hospice, alternate destination – mental health projects have been in operation for at least two and a half years and have improved patients' well-being and, in most cases, have yielded savings for payers and other parts of the health care system. Findings for a project testing a sixth concept, alternate destination – sobering center, indicate that this project has also benefitted patients and the health care system during its first 14 months in operation. The seventh concept, alternate destination – urgent care, shows potential but projects that tested this concept did not enroll sufficient numbers of persons to draw conclusions about effectiveness. These projects were closed in 2017. Further research involving a larger volume of patients transported to urgent care centers with wider ranges of services and expanded hours would be needed to determine whether this concept is effective.

If community paramedicine is implemented on a broader scale, the current EMS system design is well suited to utilize the results of these pilot programs to optimize the design and implementation of proposed programs and to assure effectiveness and patient safety. The two-tiered system enables cities and counties to design and administer community paramedicine programs to meet local needs while both local and state oversight and regulation ensure patient safety.

Appendix A. Map of California Community Paramedicine Pilot Projects Currently Enrolling Patients and Projects Expected to Begin Enrolling Patients in 2018

Appendix B. Methods for Estimating Savings

This appendix describes the methods used to estimate savings associated with each of the seven community paramedicine concepts that are being tested as part of HWPP #173. Estimates of savings associated with the seven community paramedicine concepts reflect savings that accrue to parts of the health care system other than EMS transport providers, such as health insurers and hospitals. None of the projects realized savings for the EMS transport provider because they operate on fee-for-service basis and are reimbursed only for transport. These agencies had to provide in-kind contributions of supplies and labor to operate the pilot projects.

Different methods were used to estimate the savings associated with each concept due to the differences in the services provided and the types of outcomes each concept seeks to improve. For concepts that strive to reduce unnecessary ambulance transports, ED visits, and hospitalizations, the analysis focused on estimating the impact of these reductions on health insurers' expenditures because insurers typically pay for these services. Effects on hospitals' ability to manage "full risk" contracts with health insurers and avoid Medicare readmission penalties for excessive readmissions were addressed but could not be estimated quantitatively.

Post-Discharge

To generate estimates of savings, the differences between (1) the rates of readmission within 30 days of discharge among persons enrolled in the post-discharge projects, and (2) historical 30-day readmission rates for partner hospitals were calculated. Historical readmission rates were obtained from Medicare Hospital Compare.[xxv] a system for reporting and publicly releasing data on the quality of care provided by Medicare-certified hospitals. Medicare Compare collects data on readmissions for persons with four of the six conditions targeted by the post-discharge projects: heart failure, acute myocardial infarction, chronic obstructive pulmonary disease, and pneumonia. A dataset containing data on readmission rates of partner hospitals between July 2012 and June 2015 was downloaded from Data.Medicare.gov.[xxvi] These data were used to assess the projects' impact on 30-day readmission rates because all partner hospitals used similar methods to report the data to Medicare and because there was minimal overlap between the time period for which Hospital Compare data were collected and the implementation of the post-discharge projects.

The difference in the rate of readmission was multiplied by the number of people enrolled in each pilot project to generate an estimate of the number of readmissions avoided for each of the targeted diagnoses. The number of readmissions avoided was multiplied by an estimate of the average cost of admissions for patients with diagnoses targeted by the projects. Estimates of the cost of admissions for targeted diagnoses were derived from OSHPD's public hospital inpatient discharge dataset. Costs per admission were calculated by multiplying the hospital's average charges for a diagnosis by the hospital's cost-to-charge ratio. This is a widely used method for estimating the cost of inpatient care. Using this method, costs per admission varied substantially across diagnoses targeted by the pilot projects, ranging from $11,562 for chronic obstructive pulmonary disease to $26,621 for acute myocardial infarction. For each project, the average cost per readmission was calculated as a weighted average of the costs of admissions of persons with targeted diagnoses with weights assigned based on the proportion of total readmissions that occurred among persons with each targeted diagnosis.

Frequent EMS User

Savings were estimated by multiplying the numbers of ambulance transports and ED visits avoided by (1) the average cost per transport to an ED, and (2) the mean Medicare reimbursement for ED visits. Based on interviews with manager of San Diego's frequent 911 user projects, we assumed that every 911 call prevented resulted in avoidance of an ambulance transport and an ED visit.

For San Diego's project, the number of ambulance transports and ED visits avoided was estimated by comparing the number of 911 calls made by enrolled patients during the 12 months prior to their enrollment to the number of

911 calls made during the 12 months following enrollment. Calls made during the month of enrollment were excluded in recognition that the month of enrollment is a time of transition for patients. Data on 911 calls pre- and post-enrollment were available for 35 of the 46 enrollees from November 2015 through June 2017. The reduction in 911 calls over the 12 months post-enrollment was divided by 12 to estimate the numbers of 911 calls, ambulance transports, and ED visits avoided per month.

Estimates of the cost of ambulance transports avoided were obtained from the sites. Data for ED cost estimates were obtained from the University of California Research Exchange (UC ReX) and reflect visits to EDs at University of California medical centers in 2015. Hospitals bill insurers for ED visits at one of five levels based on the amount of equipment and supplies needed to care for a patient. Level 1 is the lowest level and level 5 is the highest. For the frequent EMS user projects, we used the national average Medicare reimbursement rate for all five levels of ED visits because information was not available to enable us to determine the most common reasons why frequent EMS users visit EDs or the severity and complexity of their needs. Medicare reimbursement rates were used because Medicare is the payer whose reimbursement is widely considered to be closest to the cost of care. The analysis was not limited to ED visits for any particular diagnoses because diagnosis is not a criterion for enrolling in the Frequent EMS User projects. We could not use the cost-to-charge ratio method used to estimate the cost of inpatient readmissions avoided, because OSHPD does not collect complete data on charges for ED visits.

Tuberculosis

A quantitative analysis of savings associated with the project that provides directly observed therapy (DOT) for tuberculosis (TB) was not conducted due to challenges associated with estimating the impact of the project. As discussed in the main body of the report, the project found that community paramedics missed a smaller percentage of prescribed DOT treatments than community health workers (0.06% vs. 6.7%). However, we found no research that addressed the impact of a difference in adherence in a US population that compared groups of people with adherence rates of over 90%. In the absence of such research, we concluded that the most we could do would be to make directional statements about the potential impact of the increase in adherence on public health expenditures associated with investigation of close contacts of persons with TB and treating people infected by a noncompliant patient. We also make a directional statement about the impact of the use of community paramedics on the TB clinic's use of community health workers.

Hospice

Savings for the Hospice project were estimated by multiplying the number of transports and ED visits avoided by (1) the average cost per ambulance transport to an ED and (2) the average Medicare reimbursement for an ED visit for a high-acuity patient. The estimate of costs per transport reflects data reported by the pilot site for June 2015 through September of 2016. The estimates represented actual "cash collected" by the agency from insurers and other payers. The number of transports avoided equals the difference between the number of transports that would have occurred if the percentage of hospice 911 calls that resulted in a transport to an ED remained at the level observed prior to the pilot project (80%) and the number of transports that occurred among hospice patients enrolled in the pilot project.

As indicated above in the description of the estimates of savings for the Frequent EMS User projects, data for ED cost estimates were obtained from the University of California Research Exchange (UC ReX) and reflect visits to EDs at University of California medical centers in 2015. To estimate the cost of ED visits that do not result in a hospital admission, we applied national average Medicare reimbursement rates for all care provided to patients. For the hospice project, the median reimbursement for level 4 and 5 visits was used because terminally ill patients are likely to have acute needs. Mean reimbursement for level 4 and 5 visits across all diagnoses were used in lieu

of the costs related to specific diagnoses because information was not available to determine the diagnoses for which hospice patients were transported to an ED.

Alternate Destination – Mental Health

Savings for the Alternate Destination – Mental Health project were estimated by multiplying the numbers of ambulance transports and ED visits avoided by (1) the average cost per transport and (2) the average Medicare reimbursement for an ED visit for persons who only have behavioral health diagnoses. Because patients enrolled in the project are transported directly to the mental health crisis center, an ED visit is avoided every time a patient is enrolled as well as a secondary transport from an ED to a behavioral health facility.

The estimate of the average cost per ambulance transport was based on information provided by Stanislaus' EMS provider.

As indicated above in the description of the estimates of savings for the Frequent EMS User projects, data for estimates of the cost of ED visits were obtained from the University of California Research Exchange (UC ReX) and reflect visits to EDs at University of California medical centers in 2015. To estimate the cost of ED visits that do not result in a hospital admission, we applied national average Medicare reimbursement rates for all care provided to patients for which the only diagnoses reported are mental health diagnoses. These diagnoses were chosen because the alternate destination – mental health project serves persons who only have acute mental health needs.

Alternate Destination – Urgent Care

Savings for the Alternate Destination – Urgent Care project were calculated based on an estimate from the literature of the difference in the cost of treating minor illnesses and injuries in an ED versus an urgent care center. Estimates published in the literature suggest that insurers pay urgent care centers 45% of what they pay hospitals for ED visits for the same minor illnesses and injuries.[xxvii] The difference between reimbursement for ED visits and urgent care center visits was multiplied by the number of persons enrolled in the alternate destination – medical care projects to obtain an estimate of total savings.

No estimate of savings associated with reduction in ambulance transports is included because, unlike other community paramedicine concepts that reduce ED visits, the Alternate Destination – Urgent Care projects did not reduce ambulance transports. Transport costs do not change because all enrolled patients are transported to an urgent care center.

As indicated above in the description of the estimates of savings for the Frequent EMS User projects, data for estimates of ED costs were obtained from the University of California Research Exchange (UC ReX) and reflect visits to EDs at University of California medical centers in 2015. To estimate the cost of ED visits that do not result in a hospital admission, we applied national average Medicare reimbursement rates for level 1 and level 2 ED visits. These levels were used because these projects enrolled people with minor illnesses or injuries. This rate was multiplied to estimate the average cost of treating people with minor illnesses or injuries in an urgent care center.

Alternate Destination – Sobering Center

Savings for the Alternate Destination – Sobering Center project were estimated by multiplying the numbers of ambulance transports and ED visits avoided per month by the cost of treating an intoxicated person with no co-morbidities in an ED. Costs for ambulance transports were included in the calculation only for patients who were secondarily transferred from the sobering center to an ED. The cost of initial transport to the sobering center was

not included because the San Francisco Fire Department would have incurred the cost of an ambulance transport regardless of whether a patient was transported to an ED or the sobering center.

The estimate of the average cost of treating an intoxicated person with no co-morbidities in an ED was based on an estimate generated by the San Francisco Department of Public Health.[xv] This estimate represents average total costs for a patient to be served at Zuckerberg San Francisco General Hospital, the county's public hospital, by dividing total operational and facility expenses by the number of patients served. These costs are not used for billing purposes and, thus, may not reflect what the hospital charges insurers for treating these patients.

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RESEARCH HIGHLIGHT

Healthforce Center at UCSF

Key Findings from Two-year Evaluation of Health Workforce Pilot Project #173 – Community Paramedicine

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Introduction

Community paramedicine, also known as mobile integrated health (MIH-CP) is an innovative model of care that seeks to improve the effectiveness and efficiency of health care delivery by using specially trained paramedics in partnership with other health care providers to address the needs of local health care systems. In November 2014, the California Office of Statewide Health Planning and Development (OSHPD) approved an application from the California Emergency Medical Services Authority (EMSA) to establish a Health Workforce Pilot Project (HWPP) that has encompassed projects testing seven different community paramedicine concepts. Ten projects are currently enrolling patients and several new projects will begin enrolling patients in 2018.

EMS agencies that operate pilot projects provide these services in addition to 911 response services. Agencies are not permitted to divert resources from 911 response to provide community paramedicine services. Consistent with requirements for all services EMS agencies provide, community paramedicine pilot projects are also required to serve all eligible persons regardless of their race/ethnicity, gender, age, or type of health insurance.

The HWPP regulations require organizations that sponsor pilot projects to retain an independent evaluator to assess trainee performance, patient acceptance, and cost effectiveness. The Philip R. Lee Institute for Health Policy Studies and Healthforce Center (formerly the Center for the Health Professions) at the University of California, San Francisco, are conducting the evaluation funded by the California Health Care Foundation. This document provides an overview of the evaluation and summarizes major findings. The latest full report on the evaluation is available here.

Evaluation Methodology

The primary objectives of the evaluation are to assess the safety and effectiveness of the pilot projects and to estimate their potential to yield savings for health plans and health systems.

Safety and Effectiveness

- The evaluation contains extensive information about the safety and effectiveness of the pilot projects.
- Every project has a project manager, a medical director who is an emergency medicine physician, and a quality assurance officer who is most often a registered nurse whose specialty is emergency nursing.
- The pilot projects review records for 100% of the patients they enroll to monitor patient safety.
- Sites are required to report unusual occurrences to EMSA's project manager.
- The independent evaluator reviews data provided by sites for the evaluation and shares any concerns about patient safety that emerge from the data to EMSA and OSHPD.

Cost Analysis

- The independent evaluator conducted an analysis of incremental costs incurred by participating EMS providers. Costs that EMS providers would incur regardless of whether they were participating in the pilot project, such as dispatching ambulances for 911 calls, were not included.
- Estimating costs for labor and vehicles across the pilot projects is difficult due to differences in how projects are staffed, generosity of employee benefits, and the manner in which each site allocates costs for vehicles, supplies, etc., to the pilot project activities.
- The evaluation was designed to estimate the potential of the pilot projects to yield savings for health plans and health systems. It was not designed to assess the cost effectiveness of the pilot projects. Mature programs in other states have been able to demonstrate cost effectiveness.

Dissemination and Use of the Evaluation

- All data received from the sites are included in the quarterly reports that the evaluator submits to OSHPD. Only the evaluator, not EMSA, receives data from the project sites.
- A report summarizing findings from the evaluation for the first year in which the pilot projects were in operation was released in January 2017. An update that presents findings from the first two years of the pilot projects was released in February 2018 and is available here.
- Findings from the quarterly reports and the annual reports on the evaluation are shared with EMSA which has used the findings to make decisions regarding the pilot projects.
    - EMSA discontinued the alternate destination – urgent care projects because the evaluation found that enrollment was low.
    - EMSA required Butte's post-discharge project to change its protocol to provide a home visit to every patient enrolled because the other four post-discharge projects that provided a home visit to every patient had better outcomes.

General Findings

Safety

- None of the pilot projects have resulted in any adverse outcomes for patients.

Collaboration with Other Health Professionals

- In all projects, paramedics collaborate with registered nurses, mental health professionals, social services providers, and other health professionals. They do not replace any other health care personnel.

Enrollment

- There are multiple reasons why the numbers of patients enrolled by pilot projects have been lower than the numbers that sites projected in their applications. These reasons include
    - Limitations of data that were available to pilot sites to estimate the number of people who would be eligible to enroll in the pilot projects.
    - All patients are offered the option to accept or decline enrollment. Some eligible people have chosen not to enroll.
- Some sites have had staffing challenges that have prevented them from serving all eligible patients.
- Each of the pilot projects was implemented in response to local needs and serves people with specific health care needs within specific parts of the health care system. Projects were designed at the local level by the local EMS authority, emergency (911) response partners, and health care delivery system partners to meet the needs of specific groups of people in their communities. Due to large differences in the demographic characteristics of people in different regions of California, the demographic characteristics of persons served by the pilot projects should not be expected to reflect the demographic characteristics of California's overall population.

Concept Specific Findings

Alternate Destination – Mental Health Crisis Center

- Stanislaus' alternate destination – mental health project enrolled 251 persons between September 2015 and September 2017.

- Persons enrolled in Stanislaus' pilot project receive care from a mental health professional more quickly than persons with mental health needs who were not enrolled in the pilot project because they do not have to first go to an ED for a medical evaluation and then be transported to a mental health crisis center.

- Stanislaus' pilot project only enrolls Medi-Cal beneficiaries and uninsured persons because the mental health crisis center that participates in the pilot project is operated by Stanislaus County and only accepts Medi-Cal beneficiaries and uninsured persons.

- The rate at which patients transported to Stanislaus' mental health crisis center are transported to an ED within six hours of admission is low.
    - Only 4% of the patients transported to Stanislaus' mental health crisis center (9 of 251 patients) had a secondary transport to an ED.
    - None of these patients were admitted to a hospital for inpatient medical care.
    - The savings associated with transporting 242 patients directly to the mental health crisis center without first transporting them to an ED for medical clearance exceeds the costs associated with secondary transports to an ED for 9 patients.

Alternate Destination – Sobering Center

- San Francisco's alternate destination – sobering center project enrolled 400 persons between February 2017 and September 2017.
- Registered nurses (RNs) on the San Francisco sobering center's staff monitor acutely intoxicated patients closely. They focus exclusively on their needs and are not diverted to care for patients with other health care needs.
- The evaluation is collecting data on the number of people transported to San Francisco's sobering center who are turned away by RNs on the sobering center's staff.
    - From February 2017 through September 2017, the staff refused to admit only 1 of the 400 patients transported to the sobering center.
    - The patient was rerouted to an ED because his body temperature was below minimum specified in the sobering center's protocol.
    - The screening protocol that the paramedics follow was subsequently revised to require them to take patients' temperatures in the field and to transport acutely intoxicated patients directly to an ED if their temperature is below the minimum specified in the sobering center's protocol.
- The rate at which patients transported to San Francisco's sobering center are transported to an ED within six hours of admission is low.
    - Only 2% of the patients transported to San Francisco's sobering center (9 of 400 patients) had a secondary transport to an ED.
    - None of these patients were admitted to a hospital for inpatient medical care.
    - The savings associated with transporting 391 patients directly to the sobering center instead of first transporting them to an ED for medical clearance exceed the costs associated with secondary transports to an ED for 9 patients.
- The intensity of case management and supportive services available to acutely intoxicated persons treated at the sobering center is greater than the intensity of services provided by EDs in San Francisco.

Post-Discharge

- The five post-discharge projects enrolled 1,401 people between June 2015 and September 2017.
- The one post-discharge project for which patients have a higher rate of hospital readmission within 30 days of discharge than the hospital's historical rate originally did not offer home visits to all patients. EMSA has required this project (Butte) to revise its protocol to visit every patient in his or her home at least once unless the patient declines effective November 2017.
- Persons enrolled in the four post-discharge projects that provide a home visit to every patient (Alameda, San Bernardino, Solano, and UCLA – Glendale) have 30-day readmission rates that are lower than their partner hospitals' historical readmission rates except for persons enrolled in Alameda's project who have chronic obstructive pulmonary disease.
- The quarterly reports that the evaluator provides to OSHPD and the public reports on the evaluation include data on revisits to an ED within 30 days of hospital discharge and note differences between the site that originally did not offer home visits (Butte) to all patients and the four sites that did.
- The rates of ED revisits reported in the quarterly reports to OSHPD are for all ED revisits regardless of whether those revisits resulted in readmission to an inpatient ward.
- The post-discharge project that originally did not offer home visits to all patients (Butte) has a higher rate of ED visits that did not result in a hospital readmission than the four post-discharge projects that have always provided a home visit to every patient.
- The public report on the evaluation does not compare the impact of the post-discharge projects on repeat visits to the ED and placement of patients on observation status because the project lacks a source of readily available historical data on repeat ED visits and use of observation status at hospitals participating in the pilot projects. Comparisons that rely on data from other hospitals may not reflect the actual experience of participating hospitals.

Frequent EMS Users

- The two Frequent EMS user projects enrolled 103 persons between July 2015 and September 2017.
- Alameda and San Diego's frequent EMS user projects utilize community paramedics on a full-time basis. When these paramedics are working as community paramedics they are not scheduled to respond to 911 calls. They only respond if a 911 call involves one of their clients.
- The Frequent EMS user projects link clients to organizations that provide a wide range of services including medical care, mental health services, drug and alcohol treatment, food assistance, housing assistance, transportation assistance, and domestic violence resources.
- San Diego's project has encountered challenges that have constrained its ability to meet patients' needs. In December 2016, the community paramedics working on San Diego's project were reassigned to traditional 911 response crews. Their employer was experiencing difficulties meeting contractual obligations for 911 response and determined that all paramedics needed to be assigned to 911 response crews. According to San Diego management, these difficulties were not due to the community paramedicine pilot project, and they intend to provide the resources to restart the project as soon as possible.

Hospice

- Ventura County's hospice project enrolled 270 people between August 2015 and September 2017.
- Since this is a pilot project, Ventura County's EMS agency only partners with a small number of hospices with which it has close relationships.
- The community paramedics support hospice nurses by responding rapidly to 911 calls. If a hospice nurse is not already on scene, the community paramedic who responds to the call contacts a hospice nurse who provides guidance on how to care for the patient.
- The hospice project has reduced the percentage of hospice patients transported to an ED from 80% to 30%.
- For Ventura's hospice project, the evaluation used a higher baseline rate of transports of hospice patients who called 911 than the rate Ventura reported in its application to participate in the pilot project. Subsequent to submission of the application, Ventura conducted a more thorough electronic search of its records of 911 calls. That analysis identified additional 911 calls that involved transport of hospice patients to an ED.

Directly Observed Therapy for Tuberculosis

- Ventura County's directly observed therapy for tuberculosis project enrolled 42 people between June 2015 and September 2017.
- The community paramedics who participate in Ventura's directly observed therapy for tuberculosis project receive direction from the county's tuberculosis control physician and nurse manager.
- The community paramedics who participate in Ventura's directly observed therapy for tuberculosis project have not displaced any community health workers. Ventura County has not terminated nor has it reduced the hours of any community health workers employed by the tuberculosis control program. Paramedics complement community health workers, enabling Ventura County to provide directly observed therapy to more people with tuberculosis.
- The community paramedics dispensed 99.9% of doses prescribed by the tuberculosis control physician due to their availability after hours and weekends and their ability to serve people in all parts of the county.

Alternate Destination – Urgent Care Center

- The three alternate destination – urgent care projects enrolled 48 people between September 2015 and September 2017.
- EMSA cancelled the alternate destination – urgent care projects due to the low enrollment which made it impossible to conclusively evaluate the safety and effectiveness of the concept and to estimate the potential for this approach to yield savings for health plans and health systems.

Acknowledgements

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Emergency Medical Services Administrators and Emergency Medical Directors Associations of California

JOINT POSITION STATEMENT

Medical Control and Alternate Destination and Release from Scene

The Emergency Medical Services Administrators Association of California (EMSAAC) and the Emergency Medical Directors Association of California (EMDAC) believe:

- Patients access the emergency medical services (EMS) system for many reasons. Not all patients accessing the EMS system want or require transport to an emergency department.
- Current EMS Authority interpretation of statute compel all ambulance transportation to an emergency department regardless of patient need.
- Daily paramedics and emergency medical technicians safely make complex triage decisions in accordance with local EMS medical control policies.
- The vast majority of emergency departments do not have the specialty care resources to properly care for behavioral health patients that require the services of licensed psychiatric facilities.
- Sobriety programs in San Francisco and other communities nationwide have demonstrated that intoxicated persons may be safely managed in a non-acute care setting with proper supervision during the sobering process.
- In California, emergency departments are often overcrowded due in part to the number of behavioral health patients awaiting transfer to a licensed psychiatric facility and with intoxicated persons whose needs could be safely met in a sobering center.
- Ambulance patient destination decisions are and historically have been fully within the medical control authority of the local EMS agency medical director.

Concept:

Develop a process that is consistent with the Emergency Medical Services Authority (EMSA), *"California Statewide Guidelines to Inform Local EMS Policies and Protocols for EMS Response without Patient Transport"* to authorize the assessment and referral of specified patients by paramedics and emergency medical technicians to a County behavioral health designated psychiatric crisis center (PCC) or an authorized sobering center (SC).

Problem Statement:

The medical direction of emergency medical services (EMS) systems has proven effective in developing policies allowing prehospital care personnel to triage complex patients to a variety of specialty care centers designed to meet the specific needs of a wide category of patients. It is a recognized EMS system best practice to triage patients to the facility with the specialized staff and equipment to care for the specific patient's need. However, in California two categories of patients are excluded from receiving the benefits of this best practice – patients in need of psychological services and patients in need of sobering center services.

In 2016, according to data from the Office of Statewide Health Planning (OSHPD) there were more than 14 million hospital emergency department visits in California[1]. EMSA, local EMS agencies, and the California Hospital Association all recognize the impact emergency department (ED) overcrowding is having on the delivery of medical services to acutely ill and injured patients throughout the state[2].

[1] https://www.oshpd.ca.gov/HID/ED-AS-Data.html#Encounters
[2] https://emsa.ca.gov/wp-content/uploads/sites/47/2017/07/Toolkit-Reduce-Amb-Patient.pdf

The impact of ED overcrowding is exacerbated when behavioral patients and alcohol-intoxicated individuals whose needs would be best addressed in a PCC or SC are transported instead to an ED. Behavioral health patients and intoxicated individuals often require one-on-one staffing in the ED environment and occupy limited bed and treatment space needed for acutely ill and injured patients. This results in EDs being doubly taxed by the need to care for individuals whose needs would be best met by a PCC or SC. Patients experiencing a psychiatric emergency and/or placed on an involuntary hold and inebriated individuals may be held in the ED from several hours to several days waiting to sober or to be transferred to a PCC. These patients require specialized care and referrals that are not available in the ED. Their very presence adds to the ED overcrowding; decreases the number of ED beds available; which, in turn, delays the off-loading patients and increases the amount of time ambulances and their personnel are held at the hospital.

The EMS Authority has the position that advanced life support (ALS) ambulances operating in the 911 system are required to transport to the ED of an acute care hospital. EMSA has cited various statutes, Health and Safety Code Sections (H&SC) 1797.52 and 1797.218, to support its position that ALS ambulances are required to transport every patient to the ED of an acute care hospital regardless of the level of care required. This interpretation of statute is a significant departure from EMSA's previous position that: "We [EMSA] believe that the reference to 'transport to a general acute care hospital' found in 1797.52 and 1797.218 are permissive and nonspecific. Because of the overriding need to allow flexibility of EMS medical directors, HSC 1797.220 prevails."[3]

More recently, EMSA has opined that this statute may also apply to basic life support (BLS) ambulances. The EMSA may not be aware of the common, long-standing practice of BLS ambulance companies contracting to transport patients for Department of Mental Health, insurers, and law enforcement to psychiatric facilities.

Coinciding with EMSA's reinterpretation of H&SC 1797.52 and 1797.218, it has been EMSA's push for the use of community paramedic pilot projects as a vehicle for local EMS Agency (LEMSA) oversight and approval of alternate destinations such as transport to a PCC or sobering center. Even though many local EMS agencies had already authorized the use of alternative destinations (e.g., behavioral health crisis centers, sobering centers) since the 1990s, EMSA pressured these local EMS agencies into participating in the community paramedicine pilot projects. EMSA seems to have switched its position without warning or preamble that local EMS agencies did not have the authority to authorize ALS and BLS ambulances to transport patients to alternative destinations outside of EMSA's new community paramedic pilot projects. Though EMSA seemed to have good intentions, this change severely disrupted established safe and effective local medical control policies that had been meeting patient and community needs for many years.

As more fully discussed below, It is the position of the Emergency Medical Services Administrators of California (EMSAAC) and the Emergency Medical Directors Association of California (EMDAC) that the local EMS agency medical director has clear and unambiguous authority under Health and Safety Code Section 1797.220 and 1798 to develop and enact policies to allow for the transport of patients and individuals not requiring evaluation at an acute care emergency department to a psychiatric crisis center or sobering center. Such policies are inherently a triage decision and are not a violation of H&SC 1797.52 or 797.218, which pertain only to ***when*** a demonstrated need for transport to an ED exists. Nor are such policies a deviation from the recognized scope of practice of paramedics and emergency medical technicians.

[3] Letter from Joseph Morales, M.D., Director to local EMS agencies dated April 5, 1995

Recent experience with legislation attempting to address alternate destination using the community paramedicine model have been disappointing, highlighting the difficulty of working through the legislative process with its myriad of special interest groups that do not understand the history of EMS systems in California and the role of the LEMSA medical director in ensuring medical control. Senate Bill 944/Hertzberg, the only existing legislative vehicle for keeping community paramedicine projects operating, placed local EMS agencies in an untenable situation. It is unclear if any LEMSA would even consider enacting a community paramedicine program if the legislation passes as written.

Assess and Refer Program (ARP):

A recent document promulgated by the EMSA, *"California Statewide Guidelines to Inform Local EMS Policies and Protocols for EMS Response without Patient Transport"* describes a best practice process for local EMS agencies to establish a standardized approach for "Assess and Refer Protocols" (ARP). It is the intent of local EMS agencies throughout the state to develop and refine their existing policies that allow prehospital care personnel to respond to an incident and perform an assessment and refer the individual to a facility that will best meet the needs of the individual. EMTs and paramedics frequently perform assessments on individuals and release low acuity patients or non-ill/non-injured individuals at scene; or, by use of triage protocols, determine that a patient requires specialized transport to an appropriate hospital (i.e., STEMI, trauma, stroke).

A standardized ARP policy/procedure would be implemented under the existing medical control and CQI models established in each local EMS system which allows prehospital care personnel to respond to calls for service, perform an assessment, and when appropriate not transport the individual. The prehospital patient assessment determines if an acute medical problem exists that requires transport to an emergency department or whether the individual's condition meets criteria to be referred to a destination that will meet their specific needs, which could be a behavioral health crisis center or a sobering center. Essentially, once it is determined that the individual does not require care at an emergency department, local EMS destination policies will guide ambulance personnel to transport the patient to the most appropriate facility that will meet his/her needs. The presumption of a medical emergency no longer applies based on an objective patient assessment performed according to the medical control standards of the local EMS agency.

The goal of ARP is to get the individual to the right place the first time and the emergency department is not always the right place.

Existing Authority

Local EMS agencies are required to exercise "medical control" over their local EMS systems. HS&C 1797.220. They do so under the "direction and management" of a local medical director. HS&C 1798(a). As the California Supreme Court has made clear, the medical control LEMSAs exercise must be construed "in fairly expansive terms, encompassing matters directly related to regulating the quality of emergency medical services …." *County of San Bernardino v. City of San Bernardino*, 938 P.2d 876, 887 (Cal. 1997). Local EMS agencies, moreover, *must* "formulate medically related policies and procedures to govern EMS providers." *Valley Med. Transport, Inc. v. Apple Valley Fire Protec. Dist.*, 952 P.2d 664, 668 (Cal. 1998).

Consistent with this statutory responsibility, local EMS agencies have the authority to implement an Assess and Refer programs. EMSA frequently uses 1797.52 (definition of ALS), 1797.114 (EMS Transport Guidelines) and 1797.218 (LEMSA Approval of ALS program) as evidence that an ALS ambulance is required to transport to an acute care hospital. Two of these sections refer to "advanced life support" and the "scene of an emergency"; however, the responses we are discussing do not involve ALS care and once properly assessed, the scene is no longer presumed to be an emergency. HS&C 1797.114, in particular, makes clear that paramedics and EMTs must transport a patient to a medical facility "if the emergency health care needs of the patient dictate

this course of action." As this language recognizes the need for emergency responders to make qualitative judgments about patient needs and medical conditions, such personnel frequently release individuals at scene after an assessment.

The decision-making that would be required under an ARP would be very similar, except the ambulance is not leaving the individual at scene; they are transporting the individual to a non-acute care facility to receive *appropriate* care. This concept is consistent with the EMSA's discussions with EMDAC regarding the establishment of standardized treat and refer guidelines. Objectively, prehospital personnel transporting a patient to a designated facility is conservatively safer than releasing the patient from scene.

The regulations provided in Health and Safety Code, Division 2.5, do not specify any restriction on the use of BLS ambulance transport as it relates to this subject. Thus, local EMS agencies, may under the authority of H&SC 1797.220, develop policies utilizing BLS ambulance transport to any appropriate medical, psychiatric, or other care facility. Indeed, BLS ambulances and even critical care transport (in some cases), transport to dialysis centers, clinics, jails, etc.

Health and Safety Code Sections:

1797.52. (Advanced Life Support) "Advanced life support" means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital. (Amended by Stats. 1984, Ch. 1391, Sec. 4.) [Underline added]

1797.88. (Hospital) "Hospital" means an acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2, with a permit for basic emergency service or an out-of-state acute care hospital which substantially meets the requirements of Chapter 2 (commencing with Section 1250) of Division 2, as determined by the local EMS agency which is utilizing the hospital in the emergency medical services system, and is licensed in the state in which it is located. (Amended by Stats. 1986, Ch. 1162, Sec. 1. Effective September 26, 1986.)

1797.114. (EMS Transport Guidelines) The rules and regulations of the authority established pursuant to Section 1797.107 shall include a requirement that a local EMS agency local plan developed pursuant to this division shall require that in providing emergency medical transportation services to any patient, the patient shall be transported to the closest appropriate medical facility, if the emergency health care needs of the patient dictate this course of action. Emergency health care need shall be determined by the prehospital emergency medical care personnel under the direction of a base hospital physician and surgeon or in conformance with the regulations of the authority adopted pursuant to Section 1797.107. (Added by Stats. 1998, Ch. 979, Sec. 4. Effective January 1, 1999.) [Underline added]

1797.218 (Local EMS Agency Approval of ALS & Limited ALS Programs) Any local EMS agency may authorize an advanced life support or limited advanced life support program which provides services utilizing EMT-II or EMT-P, or both, for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care hospital, during interfacility transfer, while in the emergency department of a general acute care hospital until care responsibility is assumed by the regular staff of that hospital, and during training within the facilities of a participating general acute care hospital. (Amended by Stats. 1983, Ch. 1246, Sec. 34.) [Underline added]

Proposed ARP Guidelines

In order to promote consistency between local EMS agencies the following is a list of items each medical director should address in establishing an Assess and Refer Plan that include PCC and/or SC:

- Paramedic education hours and curriculum
- Agreements or MOUs between the LEMSA and recognized sobering centers and psychiatric centers addressing:
    - Facility requirements
        - Medical staff
        - Program coordinator
        - Medical training (CPR) and equipment (AED)
        - Quality Improvement including case review and patient disposition
- LEMSA consultation with the County's Public Health Officer or Director of Department of Behavioral Health before entering an agreement or MOU
- Prehospital triage protocols
- Prehospital transfer of care protocol
- Prehospital, sobering center, and psychiatric center documentation
- Tracking and reporting data including patient disposition and outcome

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 29, 2018

TO: EMS/Trauma Committee Members

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

SUBJECT: EMS Stroke, STEMI, EMS-C Update

SUMMARY

EMSA has had public comment periods open for EMS-C, STEMI and Stroke. The STEMI second 15 day public comment period runs through August 29, 2018. Attached are comments given to EMSA over the course of the comment periods.

ACTION REQUESTED

- Information Only.

DISCUSSION QUESTIONS

1) How will these get implemented in the field?
2) Will your local EMSA agency request destination fees?
3) Do you have any other issues that need to be addressed?

Attachments: EMS-C – CHA Letter and Comments – 4-30-18
EMS Stroke – CHA Letter and Comments – 5-21-18
EMS STEMI – CHA Letter and Comments – 5-21-18
EMS Stroke – CHA Letter and Comments – 7-25-18
EMS Stroke – Second 15 Day Comment Period – Due September 1, 2018

BJB:br

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

April 30, 2018

Corrine Fishman
Legislative and Regulatory Affairs
Emergency Medical Services Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670

RE: Comments on Proposed Emergency Medical Services for Children Regulations
Chapter 14, Division 9, Title 22, California Code of Regulation, 45-day Public Comment Period
March 16, 2018, through April 30, 2018

Dear Ms. Fishman:

On behalf of more than 400 member hospitals and health systems, the California Hospital Association (CHA) respectfully offers the following comments on the California Emergency Medical Services Authority's (EMSA's) proposed regulatory text for California Health and Safety Code section 1799.202 – 1799.207.

CHA appreciates EMSA's pursuit of high-quality pediatric emergency care standards. CHA submitted extensive comments on Emergency Medical Services for Children (EMS-C) regulations in 2012. Further, CHA incorporates EMS-C goals into our CHA EMS/Trauma Committee, and our members have actively participated in EMSA's EMS-C Committee. CHA and its members embraced the Pediatric Readiness Project and supported its growth and maturation.

CHA has nine comments on the regulations, most of which are non-substantive and offered as opportunities to sharpen understanding of the regulatory intent. Of concern to CHA is the need to align the pediatric age limit, use pediatric advanced life support as a competency for the pediatric emergency care coordinator, include hospital authorization in data request information, and broaden the disclosure language to include all pertinent state and federal laws.

Specific recommendations are listed below and in the attached public comment grid.

Article 1. Definitions

1. § 100450.208. Pediatric Patient – "Pediatric patient" is defined in this proposal as a person who is less than or equal to 14 years of age." However, Title 22, section 70537(d) states that "Patients beyond the age of 13 shall not be admitted to or cared for in spaces approved for pediatric beds unless approved by the pediatrician in unusual circumstances and the reason documented in the patient's medical record." Because this discrepancy will cause undue burden on hospitals with patients who are 14 years of age, but are in pediatric spaces, CHA recommends changing the age **from 14 to 13** to mirror Title 22 regulations.

2. § 100450.209. Pediatric Receiving Center (PedRC) – "Pediatric Receiving Center" (PedRC) is defined in this proposal as a "licensed general acute care hospital that, at minimum, has a permit for basic or comprehensive services and has been formally designated by the local EMS agency for its role in an EMS system." CHA recommends clarifying this definition by adding "…or comprehensive services ***that has been formally designated as one of four types of PedRCs*** by the local EMS agency for its role in an EMS system."

3. § 100450.211 Pediatric Receiving Center – Level II – "Level II pediatric receiving center" is defined in this proposal as a "California Children's Services (CCS)-approved pediatric community hospital." A level II pediatric community hospital may be designated as a PedRC by the local EMS agency if the hospital has full, provisional, or CCS approval readily available." CHA recommends a minor edit to add PedRC II as follows: "Level II pediatric receiving center means a CCS-approved pediatric community hospital. A level II pediatric community hospital may be designated as a **PedRC II** by the local EMS agency if the hospital has a full, provisional, or CCS approval readily available."

Article 2. Local EMS Agency EMSC Program Requirements.

1. § 100450.211 (3) Line 204, "Care rendered to pediatric patients outside the hospital readily available upon request." – CHA requests clarification of this statement — does this refer to EMS-C prehospital care, hospital emergency care outside the hospital, or both? An example would be helpful.

Article 3. Pediatric Receiving Centers

1. § 100450.225 (1)(C), Line 419, line 440 (B) – CHA recommends **adding Pediatric Acute Care Life Support (PALS)** to both the physician and nurse PECC personnel requirements
2. § 100450.225, Line 482-485, - (D) – CHA recommends that this section be clarified to confirm that **nurse practitioners or physician assistants may be used in place of or in addition to the registered nurse or medical doctor requirement under (3) (B) and (3)(C), but are not required.**

Article 4. Data Management, Quality Improvement and Evaluations

1. §100450.227, line 573-574 – "(1) The EMSC program shall include the collection of both prehospital and hospital patient care data, as determined by the local EMS agency." **CHA recommends additional language that includes hospital PedRC in determining hospital data requests by the local EMS agency.**
2. §100450.227, line 583-612 – Since subsections a. A1. A2. and b language above these lines establish the general data requirement to comply with the most current California EMS Information System (CEMSIS) and require hospital participation, details in line 583-612 are unnecessary and prescriptive and potentially limiting. **CHA recommends deleting these lines.**
3. §100450.228, line 626-627 – CHA recommends **broadening this statement** to be consistent and compliant with all federal and state laws by adding to the beginning of line 626,

> "Consistent and compliant with all federal and state laws protecting and governing patient safety, quality, and confidentiality including but not limited to…"

CHA appreciates the opportunity to comment on this critical document that will assure statewide consistency in policy and program elements and improve pediatric patient care. Children have unique needs, and it is therefore vital that EMS providers and emergency departments provide high-quality care in a coordinated, collaborative approach. If you have any questions, please contact me at bjbartleson@calhospital.org or (916) 552-7537.

Sincerely,

BJ Bartleson
Vice President, Nursing & Clinical Services

Comments on Proposed Emergency Medical Services for Children (EMSC) Regulations
Chapter 14, Division 9, Title 22, California Code of Regulations
45-day Public Comment Period
March 16, 2018 Through April 30, 2018

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
ARTICLE 1. DEFINITIONS **1.§100450.208.page2, line 74 – Pediatric Patient**	CHA	There is an age discrepancy between the proposed EMS-C regulations of "less than or equal to 14", and Title 22, "pediatric patient "definition, which states, "Patients beyond the age of 13 shall not be admitted to or cared for in spaces approved for pediatric beds unless approved by the pediatrician in unusual circumstance and the reason documented in the patient's medical record." This will cause undue burden on hospitals, and **CHA requests the age be changed to 13 to match Title 22 regulations.**	
2.§100450.209, page 3, line 80-81	CHA	This PedRC description is not clear. Is it a separate category, or a minimum standard for all four categories? CHA recommends changing the sentence to read **"means a licensed general acute care hospital with at minimum, a permit for basic or comprehensive emergency services that has been formally designated as one of four types of PedRCs by the local EMS agency for its role in an EMS system."**	

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
3.§100450.211, page 3, line101	CHA	Minor edit, **Add "II" after PedRC**	
ARTICLE 2. LOCAL EMS AGENCY EMS-C PROGRAM REQUIREMENTS **1.§100450.219, page 5 line 204-205**	CHA	"care rendered to pediatric patients outside the hospital" is an unclear statement, **please clarify with an example**	
ARTICLE 3. PEDIATRIC RECEIVING CENTERS **1.§100450.225. page, 10, line 419 (C), line 440 (B)**	CHA	**Add PALS to both the physician and nurse PECC personnel requirements in line 414 and line 440.**	
2.§100450.225, page 11-line 482-485	CHA	Suggest clarifying this statement. The assumption is minimum staffing for each PedRC is a NP or PA. **Recommend: NP/PAs be used in place of the RN or MD requirement under (3)(B) and (3)(C) or in addition to.**	
ARTICLE 4. DATA MANAGEMENT, QUALITY IMPROVEMENT AND EVALUATION **1. §100450.227, page 13 line 573-574**	CHA	"The EMSC program shall include the collection of both prehospital and hospital patient care data, as determined by the local EMS agency". **Recommend: "as determined by the local EMS agency and agreed upon by the PedRC"**	
2. §100450.227, Line 583-612	CHA	Since subsections a. A1.A2 and b. language above these lines establish the general data requirement to be compliant/consistent with the most	

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		current CEMSIS and requires hospital participation, details in line 583-612 are unnecessary and prescriptive, and potentially limiting. CHA recommends deleting these lines.	
2.100450.228, page 14, line 626-627	CHA	Broaden confidentiality and disclosure language. **To beginning of line 626, add "Consistent and compliant with all federal and state laws protecting and governing patient safety, quality, and confidentiality including but not limited to"**	

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

May 21, 2018

Corrine Fishman
Legislative and Regulatory Affairs
California Emergency Medical Services Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670-6073
Corrine.fishman@emsa.ca.gov

BY ELECTRONIC CORRESPONDENCE

RE: Stroke Critical Care System, Notice of Proposed Rulemaking, Title 22, Division 9, Prehospital Emergency Medical Services, Chapter 7.2

Dear Ms. Fishman:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) respectfully offers the following comments for consideration on the proposed regulatory text for the Emergency Medical Service Authority (EMSA), California Health and Safety Code sections 1797.102, 1797.103, 1797.105, 1797.176, and 1798.150.

CHA appreciates EMSA's pursuit of a highly functional stroke critical care system. Establishing these standards related to local optional acute Stroke Critical Care Systems throughout the State for the local EMS agencies (LEMSAs) to adopt will improve the care of patients suffering from life-threatening acute strokes. The regulations should provide statewide consistency and fairness, increase transparency of local and state government, and align with national standards for stroke critical care. This will assure Californians that there is a comprehensive systemic approach for care of the stroke victim that is evidence based, continuously evaluated, well-coordinated, and, driven by the most efficient and effective use of resources.

CHA offered substantive changes to the infrastructure of the document during the first public comment period, January 2017. While we acknowledge this is an unacceptable request, we encourage EMSA to continue to pursue the ability to format regulations based on the use of national standards to accommodate today's rapid changes in science and technology. CHA proposed using national stroke certification standards, principally, the American Heart Association/American Stroke Association (AHA/ASA) Standards, that represent the leading scientific, evidence based standards of practice and are updated every two years. By utilizing AHA/ASA standards as the certifying body, versus the proposed written regulations, hospitals will be held to current evidence based practice, as well as effectively complying with new changes in practice and technology that cannot be accommodated efficiently through the present state regulatory review process. Using existing AHA/ASA standards of Stroke certification, the EMSA state regulations are kept current without tedious, lengthy, regulatory review,

approval and change. AHA/ASA standards of stroke practice are reviewed every two years which coincides with the presently proposed stroke critical care hospital policy and procedure review period. Many other states have adopted this methodology and CHA suggests that California do the same.

In lieu of the inability to adopt such standards, CHA offers the following comments (outlined in the attached Public Comment Table and below).

I. Article 1.Definitions-
   a. Use of the word "diagnose" and "diagnostic" in lines 37 and 113 to affirm all components of care provided.
   b. Adding the word "prevention" as an inclusive component of the critical care system as implied in the request in line 223.
   c. Add the word "emergency" before "critical care," in line 136, as hospitals may have multiple medical directors for emergency and or critical care duties. This implies they need to be responsible for both areas.
   d. Add the in line 181, "when clinically warranted" as a clarification statement to confirm optimal time frames and diagnosis are critical based against national standards

II. Article 3. Prehospital Stroke Critical Care System Requirements
   a. Add to line 285, "shall be used in conjunction with transfer to the most appropriate stroke center" to hasten the need for consultation and transfer.
   b. Change the term "facility" in line 292 to "hospital" for clarity.

III. Article 4. Hospital Stroke Care Requirements and Evaluations
   a. Add the wording, "based on national standards" at the end of the sentence on line 329 to reinforce use of national standards.
   b. Change wording in line 341-342 to meet national standards. "A neurointerventionalist meeting national standards, or a neurosurgeon, neurologist or radiologist who has completed neurovascular fellowship supervised by ACGME, or other appropriate body".
   c. Change lines 393-394 per (b) above.
   d. In line 405, there is lack of clarity on the term "expanded advanced imaging".
   e. Add to line 438 "in consultation with the Thrombectomy Capable Stroke Center" at the end of the sentence to assure appropriate communication takes place between local EMS and hospitals.
   f. Add "minimal reporting standards based on national requirements" to line 438 to reconfirm use of national standards.
   g. Add "in consultation with the Acute Stroke Ready Center" to line 617 to confirm appropriate communication exchange.
   h. Add to the end of the sentence in line 631 "in consultation with the EMS receiving hospital" to assure appropriate communication exchange.

In summary, CHA appreciates the opportunity to comment on this document to set the stage for the achievement and acceleration of exceptional quality stroke care across the state.

Sincerely,

BJ Bartleson, RN, MS, NEA-BC
VP Nursing and Clinical Services
California Hospital Association
(916)552-7537
bjbartleson@calhospital.org

Comments on Proposed Stroke Critical Care System Regulations
Chapter 7.2, Division 9, Title 22, California Code of Regulations
45-day Public Comment Period
April 6, 2018 through May 21, 2018

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Article 1 §100270.203, page 1, line 36-38 Comprehensive Stroke Center	CHA	Line 37 add "diagnose" after "receive," and, add "all " before the word "stroke" in line 38.	
§100270.212, page 3, line 113	CHA	Add the word "diagnostic" after the word "triage."	
§100270.213, page 3, line 126	CHA	Add the word "prevention" after "deliver" and before "treatment" as it is implied as part of the critical care system plan in line 223.	
§100270.214, page 4, line 136	CHA	Add the word "emergency" before "critical care system." Hospitals may have multiple medical director experts. Emergency in addition to critical care adds clarity to the role	
§100270.219, page 5, line 182	CHA	Add "when clinically warranted" to confirm optimal timeframes and diagnosis are critical relative to national standards of care.	
Article 3, §100270.222, page 7 line 284-285	CHA	Add "shall be used in conjunction with transfer to the most appropriate stroke center"	
§100270.222, page 7 line 292	CHA	Change "stroke center of care facility" to "hospital stroke center of care"	
Article 4. §100270.223, page 8, line 329	CHA	Add the wording "based on national standards" at the end of the sentence	

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
§100270.223, page 8, line 341-342	CHA	Change wording to meet national standards: "A neurointerventionalist meeting national standards, or a neurosurgeon, neurologist or radiologist who has completed a neurovascular fellowship supervised by ACGME, or other appropriate body."	
§100270.223, page 10, line 393-394	CHA	Suggest change as indicated in line 341-342 above	
§100270.223, page 10, line 405	CHA	Lack of clarity on the term "expanded advanced imaging"	
§100270.223, page 11, line 438	CHA	Add "in consultation with the Thrombectomy –Cable Stroke Center", at the end of the sentence.	
§100270.225, page 13	CHA	Suggest adding minimal reporting standards based on national requirements.	
§100270.226, page 15, line 617	CHA	Add "in consultations with the Acute Stroke Ready Center"	
§100270.227, page 15 line 630-631	CHA	Add the following to the end of the sentence "in conjunction with the EMS receiving hospital"	

EMERGENCY MEDICAL SERVICES AUTHORITY
10901 GOLD CENTER DR STE 400
RANCHO CORDOVA, CA 95670-6073
(916) 322-4336 FAX (916) 324-2875

DATE: August 17, 2018

FROM: Jennifer Lim, Deputy Director of Legislative, Regulatory & External Affairs

SUBJECT: SECOND 15-DAY PUBLIC COMMENT ON PROPOSED CHAPTER 7.2 STROKE CRITICAL CARE SYSTEM.

The Emergency Medical Services Authority (EMSA) is proposing to add Chapter 7.2 to Division 9, Title 22, of the California Code of Regulations. This chapter will establish standardized best practices for a Stroke Critical Care System.

The public is invited to submit written comments on modifications to the proposed regulations during the second 15-day public comment period from August 17, 2018, through September 1, 2018. Comments can be submitted to Esam El-Morshedy by email at esam.el-morshedy@emsa.ca.gov or by fax at (916) 322-8765. Comments can also be sent to our mailing address at:

EMS Authority
Attn: Stroke Regulations
10901 Gold Center Drive, Ste. 400
Rancho Cordova, CA 95670.

EMSA must receive written comments on the proposed changes by 5:00 pm on September 1, 2018. Please note comments should be limited to only the most recent modifications made to the originally proposed language. Comments directly concerning the proposed modifications to the text of the regulations will be considered and responded to in the Final Statement of Reasons.

The modified proposed regulation text, as well as the Notice of Proposed Regulations, Initial Statement of Reasons and other regulatory documents are available for review on EMSA's website at https://emsa.ca.gov/public_comment/

If you are unable to access the website and would like a copy of the proposed Chapter 7.2 regulations mailed, faxed or emailed to you, or if you have any questions, please contact Esam El-Morshedy by calling (916) 431-3656, or by email at esam.el-morshedy@emsa.ca.gov. If Esam El-Morshedy is unavailable, you may contact Jennifer Lim at jennifer.lim@emsa.ca.gov or by phone at (916) 431-3700.

The Emergency Medical Services Authority has illustrated changes to the original text in the following manner:

- Additions to the original text from 45-day comment period are shown underlined
- Deletions to the original text from 45-day comment period are shown in ~~strikeout~~

The Emergency Medical Services Authority has illustrated changes to the modified text from the 15-day comment period in the following manner:

- Additions to the modified text are shown in double underline.
- Deletions to the modified text are shown in ~~double strikeout~~.

California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 7.2 Stroke Critical Care System

ARTICLE 1. DEFINITIONS

§ 100270.200. Acute Stroke Ready Hospital

"Acute stroke-ready hospitals" or "Satellite stroke centers" means a hospital able to provide the minimum level of critical care services for stroke patients in the emergency department, and are paired with one or more hospitals with a higher level of stroke services.

Note: Authority cited: Sections 1797.94, 1797.103, 1797.107, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100270.201. Board-certified

"Board-certified" means a physician who has fulfilled all the Accreditation Council for Graduate Medical Education (ACGME) requirements in a specialty field of practice, and has been awarded a certification by an American Board of Medical Specialties (ABMS) approved program.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100270.202. Board-eligible

"Board-eligible" means a physician who has applied to a specialty board examination and has completed the requirements and ~~received permission~~ is approved to take the examination by ABMS. Board certification must be obtained within the allowed time by ABMS from the first appointment.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100270.203. Comprehensive Stroke Center

"Comprehensive stroke center" means a hospital with specific abilities to receive, diagnose and treat ~~the most complex~~ all stroke cases and provide the highest level of care for stroke patients.

Note: Authority cited: Sections 1797.94, 1797.103, 1797.107, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100270.204. Clinical Stroke Team

"Clinical stroke team" means a team of healthcare professionals who provide care for the stroke patient and may include, but is not limited to, neurologists, neuro-interventionalists, neurosurgeons, anesthesiologists, emergency medicine physicians, registered nurses, advanced practice nurses, physician assistants, pharmacists, and technologists.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100270.205. Emergency Medical Services Authority

"Emergency medical services authority" or "EMS Authority" means the department in California that is responsible for the coordination and the integration of all state activities concerning emergency medical services (EMS).

Note: Authority cited: Sections 1797.107 and 1797.54, Health and Safety Code. Reference: Sections 1797.100, and 1797.103, Health and Safety Code.

§ 100270.206. Local Emergency Medical Services Agency

"Local emergency medical services agency" or "local EMS agency" means the agency, department, or office having primary responsibility for administration of emergency medical services in a county and which is designated pursuant Health and Safety Code section 1797.200.

Note: Authority cited: Sections 1797.94, 1797.107, 1797.176, and 1797.200, Health and Safety Code. Reference: Section1797.94, Health and Safety Code.

§ 100270.207. Primary Stroke Center

"Primary stroke center" means a hospital that ~~stabilizes and~~ treats acute stroke patients, ~~providing initial acute care,~~ and identify patients who may benefit from transfer to ~~one or more~~ a higher level of care~~. Centers~~ when clinically warranted.

Note: Authority cited: Sections 1797.94, 1797.103, 1797.107, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100270.208. Protocol
"Protocol" means a predetermined, written medical care guideline, which may include standing orders.

Note: Authority cited: Sections 1797.107, 1797.176, 1797.220, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100270.209. Quality Improvement
"Quality improvement" or "QI" means methods of evaluation that are composed of a structure, process, and outcome evaluations which focus on improvement efforts to identify causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process and recognize excellence in performance and delivery of care.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.174, 1797.176 and 1798.150 Health and Safety Code. Reference: Sections 1797.174, 1797.202, 1797.204, 1797.220 and 1798.175, Health and Safety Code.

§ 100270.210. Stroke
"Stroke" means a condition of impaired blood flow to a patient's brain resulting in brain dysfunction, most commonly through vascular occlusion or hemorrhage.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100270.211. Stroke Call Roster
"Stroke call roster" means a schedule of licensed health professionals available twenty-four (24) hours a day, seven (7) days a week for the care of stroke patients.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.220, Health and Safety Code.

§ 100270.212. Stroke Care
"Stroke care" means emergency transport, triage, <u>diagnostic,</u> acute intervention and other acute care services for stroke patients that potentially require immediate medical or surgical intervention treatment, and may include education, primary prevention, acute intervention, acute and subacute management, prevention of complications, secondary stroke prevention, and rehabilitative services.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

100270.213. Stroke Critical Care System
"Stroke critical care system" means a subspecialty care component of the EMS system developed by a local EMS agency. This critical care system links prehospital and

hospital care to deliver optimal treatment to the population of stroke patients ~~who potentially require immediate medical or surgical intervention~~.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

§ 100270.214. Stroke Medical Director

"Stroke medical director" means a board-certified physician ~~designated by the hospital who is~~ in neurology or neurosurgery or another board with sufficient experience and expertise dealing with cerebrovascular disease as determined by the hospital credentialing committee ~~and~~ that is responsible for the stroke service, performance improvement, and patient safety programs related to a stroke critical care system.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

§ 100270.215. Stroke Program Manager~~/Coordinator~~

"Stroke program manager~~/coordinator~~" means a registered nurse or qualified individual designated by the hospital with the responsibility for monitoring and evaluating the care of stroke patients and the coordination of performance improvement and patient safety programs for the stroke center in conjunction with the stroke medical director**.**

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

§ 100270.216. Stroke Program

"Stroke program" means an organizational component of the hospital specializing in the care of stroke patients.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

§ 100270.217. Stroke Team

"Stroke team" means the clinical ~~stroke team~~personnel, support personnel, and administrative staff that function together as part of the hospital's stroke team.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

§ 100270.218. Telehealth

"Telehealth" means the mode of delivering health care services and public health via

information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code. California Business and Professions Code Sec. 2290.5

§ 100270.219. Thrombectomy-Capable Stroke Center

"Thrombectomy-capable stroke center" means a primary stroke center with the ability to perform mechanical thrombectomy for the ischemic stroke patient when clinically warranted.

ARTICLE 2. LOCAL EMS AGENCY STROKE CRITICAL CARE SYSTEM REQUIREMENTS

§ 100270.220. Stroke Critical Care System Plan ~~Approval.~~

(a) The local EMS agency may develop and implement a stroke critical care system.

(b) The local EMS agency implementing a~~A s~~Stroke ~~c~~Critical ~~c~~Care ~~s~~System Plan ~~that starts after the effective date of these regulations~~ shall have ~~the~~ a ~~S~~stroke ~~C~~critical ~~C~~care ~~S~~system ~~Plan~~ approved by the EMS Authority prior to implementation.

(c) The Stroke Critical Care System Plan submitted to the EMS Authority shall include, at a minimum, all of the following components:

(1) The names and titles of the local EMS agency personnel who have a role in a stroke critical care system.

(2) ~~Verification of agreements with hospitals for designation~~The list of stroke designated facilities with ~~a list of stroke hospital contracts~~ the agreements ~~with~~ expiration dates.

(3) A description or a copy of the local EMS agency's stroke patient identification and destination policies.

(4) A description or a copy of the method of field communication to the receiving hospital-specific to stroke patients, designed to expedite time-sensitive treatment on arrival.

(5) A description or a copy of the policy that facilitates the inter-facility transfer of stroke patients.

(6) A description of the method of data collection from the EMS providers

and designated stroke hospitals to the local EMS agency and the EMS Authority.

(7) A ~~copy~~ policy or description of ~~all written agreements for coordination of stroke transport across LEMSA lines, with neighboring local EMS agencies to provide stroke care~~how the LEMSA integrates a receiving center in a neighboring jurisdiction.

(8) A description of the integration of stroke into an existing quality improvement committee or a description of any stroke-specific quality improvement committee.

(9) A description of programs to conduct or promote public education specific to stroke.

(d) The EMS Authority shall, within 30 days of receiving a request for approval, notify the requesting local EMS agency in writing of approval or disapproval of its Stroke Critical Care System Plan. If the Stroke Critical Care System Plan is disapproved, the response shall include the reason(s) for the disapproval and any required corrective action items.

(e) The local EMS agency shall provide an amended plan to the EMS Authority within 60 days of receipt of the disapproval letter.

(f) The local EMS agency currently operating a stroke critical care system implemented before the effective date of these regulations, shall submit to the EMS Authority a Stroke Critical Care System Plan as an addendum to its next annual EMS plan update, or within 180 days of the effective date of these regulations, whichever comes first.

(g) Any stroke center designated by the local EMS agency before implementation of these regulations may continue to operate. Before re-designation by the local EMS agency at the next regular interval, stroke centers shall be re-evaluated to meet the criteria established in these regulations.

(h) No health care facility shall advertise in any manner or otherwise hold itself out to be affiliated with a stroke critical care system or a stroke center unless they have been designated by the local EMS agency, in accordance with this Chapter.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.173, 1797.176, 1797.220, 1797.250, 1798.150, 1798.170, and 1798.172, Health and Safety Code. Reference: Sections 1797.105, 1797.176, and 1797.220, Health and Safety Code.

§ 100270.221. Stroke Critical Care System Plan Updates

(a) The local EMS agency shall submit an annual update of its Stroke Critical Care System Plan, as part of its annual EMS plan submittal, which shall include, at a minimum, all the following:

(1) Any changes in a stroke critical care system since submission of the prior annual plan update or the Stroke Critical Care System Plan addendum.

(2) The status of the Stroke Critical Care System Plan goals and objectives.

(3) Stroke critical care system performance improvement activities.

(4) The progress on addressing action items and recommendations provided by the EMS Authority within the Stroke Critical Care System Plan or status report approval letter, if applicable.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.250, 1797.254, 1798.150, and 1798.172, Health and Safety Code. Reference: Sections 1797.176, 1797.220, 1797.222, and 1798.170, Health and Safety Code.

ARTICLE 3. PREHOSPITAL STROKE CRITICAL CARE SYSTEM REQUIREMENTS

§ 100270.222. EMS Personnel and Early Recognition

(a) The local EMS agency shall ~~ensure that prehospital stroke assessment and treatment training is available~~ establish prehospital care protocols related to the early recognition, assessment, treatment, and transport of stroke patients for prehospital emergency medical care personnel as determined by the local EMS agency.

~~(b) The local EMS agency shall require the use of a validated prehospital stroke-screening algorithm for early recognition and assessment.~~

(b) The local EMS agency shall require the use of a validated prehospital stroke-screening algorithm for early recognition and assessment.

~~(c)(b)~~(c) The local EMS agency's protocols for the use of online medical direction shall be used ~~in conjunction with transfer~~ to determine the most appropriate stroke center ~~utilized for suspicious~~ to transport a patient in cases of confusing or complex findings.

~~(d)(c)~~(d) The prehospital treatment policies for stroke-specific basic life support (BLS), advanced life support (ALS), and limited advanced life support (LALS) shall be developed according to the scope of practice and local accreditation.

~~(e)(d)~~(e) Notification of ~~P~~prehospital findings of suspected stroke patients~~, as defined by the local EMS agency,~~ ~~will~~ shall be communicated in advance of the arrival to ~~a hospital~~ the stroke centers ~~of care facility in advance of arrival,~~ according to the local EMS agency's Stroke Critical Care System Plan.

Note: Authority cited: Sections 1797.92, 1797.103, 1797.107, 1797.176, 1797.189(a)(2), 1797.206, 1797.214, and 1798.150, Health and Safety Code. Reference: Sections 1797.176, 1797.220, 1798.150, and 1798.170, Health and Safety Code.

ARTICLE 4. HOSPITAL STROKE CARE REQUIREMENTS AND EVALUATIONS

§ 100270.223. Comprehensive Stroke Care Centers

(a) Hospitals designated as a comprehensive stroke center by the local EMS agency shall meet the following minimum criteria:

(1) Satisfy all the requirements of a thrombectomy-capable and primary stroke center as provided in this chapter.

(2) Neuro-endovascular diagnostic and therapeutic procedures available twenty-four (24) hours a day, seven (7) days a week.

(3) Advanced imaging, available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, which shall include but not be limited to:

~~(A) Computed tomography (CT) angiography.~~

~~(B) Magnetic resonance imaging (MRI).~~

(A) All imaging requirements for thrombectomy-capable centers.

~~(C)(A)~~(B) Diffusion-weighted magnetic resonance imaging (MRI) and computed tomography (CT) perfusion imaging.

~~(B)~~(4) Transcranial Doppler (TCD) shall be available in a timeframe that is clinically appropriate.

~~(4)~~(5) Intensive care unit (ICU) beds with licensed independent practitioners with the expertise and experience to provide neuro-critical care twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five days (365) days per year.

~~(5) Written policies and procedures for comprehensive stroke services that are reviewed at least every two (2) years, revised as needed, and implemented.~~

~~(6)(5)~~(6) Data-driven, continuous quality improvement process~~,~~ including collection and monitoring of standardized ~~comprehensive stroke center~~ performance measures.

~~(7)(6)~~(7) A stroke patient research program.

~~(8)(7)~~(8) Satisfy all the following staff qualifications:

(A) A neurosurgical team capable of assessing and treating complex stroke and stroke- like syndromes.

~~(B) A neuro-radiologist with a current Certificate of Added Qualifications in Neuroradiology on staff.~~

~~(C) A physician with neuro-interventional angiographic training and skills on staff as deemed by the hospital's credentialing process.~~

~~(D)~~(B) A qualified neuro-radiologist, board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

~~(E)~~(C) A qualified vascular neurologist, board-certified by either the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, or with appropriate education and experience as defined by the hospital credentials committee.

~~(F)~~(D) If teleradiology is used in image interpretation, all staffing and staff qualification requirements ~~provided~~ contained in this section shall remain in effect and shall be documented by the hospital.

(E) Written call schedule for attending neurointerventionalist, neurologist, neurosurgeon providing availability twenty-four (24) hours a day seven (7) days a week.

~~(8)~~(9) Provide comprehensive rehabilitation services either on-site or by written transfer agreement with another health care facility licensed to provide such services.

~~(9)~~(10) Written transfer agreements with primary stroke centers in the region to accept the transfer of patients with complex strokes when clinically warranted.

~~(10)~~(11) A comprehensive stroke center shall at a minimum, provide guidance and continuing stroke-specific medical education to hospitals designated as a primary stroke center with which they have transfer agreements.

(b) Additional requirements may be ~~required at the discretion of~~ stipulated by the local EMS agency medical director.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.204, 1797.220, 1798.150, and 1798.172, Health and Safety Code. Reference: Sections 1797.204, 1797.220, and1797.222, Health and Safety Code.

§ 100270.224. Thrombectomy-Capable Stroke Centers

(a) Hospitals designated as a thrombectomy-capable stroke center by the local

EMS agency shall meet the following minimum criteria:

(1) Satisfy all the requirements of a primary stroke center as provided in this chapter.

(2) The ability to perform mechanical thrombectomy for the treatment of ischemic stroke twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year.

(3) Dedicated neuro-intensive care unit beds to care for acute ischemic stroke patients twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year.

(4) Satisfy all the following staff qualifications:

~~(A) A neurosurgical team capable of assessing and treating complex stroke and stroke-like syndromes, if provide neurosurgical services.~~

~~(B) A neuro-radiologist with a current Certificate of Added Qualifications in Neuroradiology on staff.~~

~~(C)~~(A) A physician with neuro-interventional angiographic training and skills on staff as deemed by the hospital's credentialing process.

~~(D)~~(B) A qualified neuro-radiologist, board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

~~(E)~~(C) A qualified vascular neurologist, board-certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

~~(F)~~(D) If teleradiology is used in image interpretation, all staffing and staff qualification requirements ~~provided~~ contained in this section shall remain in effect and shall be documented by the hospital.

(5) The ability to perform ~~expanded~~ advanced imaging twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, which shall include, but not be limited to, the following:

(A) Computed tomography angiography (CTA).

~~(B) Magnetic resonance imaging (MRI).~~

~~(C)~~(B) Diffusion-weighted ~~magnetic resonance imaging~~ MRI ~~and/~~or CT Perfusion.

~~(D) Computed tomography (CT) of the head.~~

~~(E)~~(C) Catheter angiography.

~~(F)~~(D) Magnetic resonance angiography (MRA).

(E) And the following modalities available when clinically necessary:

~~(G)(E)~~(i) Carotid duplex ultrasound.

~~(H) Transcranial ultrasonography.~~

~~(I)(F)~~(ii) Transesophageal echocardiography (TEE).

~~(G)~~(iii) Transthoracic Echocardiography (TTE).

(6) A process to collect and review data regarding adverse patient outcomes following mechanical thrombectomy.

~~(7) The ability to submit data for thirteen standardized performance measures:~~

~~(A) Eight (8) stroke (STK) measures.~~

~~(B) Five comprehensive stroke (CSTK) measures for the ischemic stroke population.~~

~~(8)~~(7) Written transfer agreement with at least one comprehensive stroke center.

(b) Additional requirements may be ~~required at the discretion of~~ stipulated by the local EMS agency medical director.

§ 100270.225. Primary Stroke Centers

(a) Hospitals designated by the local EMS agency as a primary stroke center shall meet all the following minimum criteria:

(1) Adequate staff, equipment, and training to perform rapid evaluation, triage, and treatment for the stroke patient in the emergency department.

(2) Standardized stroke care protocol/order set.

(3) Stroke diagnosis and treatment capacity twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year.

(4) ~~A~~ Data-driven, continuous quality improvement ~~system,~~process including ~~data~~ collection and monitoring of standardized performance measures.

(5) Continuing education in stroke care provided for staff physicians, staff nurses, staff allied health personnel, and EMS personnel.

(6) Public education on stroke and illness prevention.

(7) A~~n acute~~clinical stroke team, available to see in person or via telehealth, a patient identified as a potential acute stroke patient within 15 minutes following the patient's arrival at the hospital's emergency department or within 15 minutes following a diagnosis of a patient's potential acute stroke.

(A) At a minimum, a~~n acute care~~clinical stroke team shall consist of:

~~1.~~ (i) A neurologist, neurosurgeon, interventional neuro-radiologist, or emergency physician who is board certified or board eligible in neurology, neurosurgery, endovascular neurosurgical radiology, or other board-certified physician with sufficient experience and expertise in managing patients with acute cerebral vascular disease as determined by the hospital credentials committee.

~~2.~~ (ii) A registered nurse, physician assistant or nurse practitioner ~~who has demonstrated competency, as determined by the physician director described in above, in~~ capable of caring for acute stroke patients that has been designated by the hospital as a stroke program manager.

(8) Written policies and procedures for stroke services which shall include written protocols and standardized orders for the emergency care of stroke patients. These policies and procedures shall be reviewed at least every ~~two (2)~~ three (3) years, revised as needed, and implemented.

(9) Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures.

(10) Neuro-imaging services capability that is available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days per year, such that imaging shall be initiated within twenty-five (25) minutes following emergency department arrival.

(11) CT scanning or equivalent neuro-imaging shall be initiated within twenty-five (25) minutes following emergency department arrival.

~~(11)~~(12) ~~Neuro~~ Other imaging ~~services~~ shall be available within ~~this~~ a clinically appropriate timeframe and shall, at a minimum, include:

~~(A) Computerized tomography (CT) scanning.~~

~~(B)~~(A) ~~Magnetic resonance imaging (~~MRI~~)~~.

~~(C)~~(B) ~~Computed tomography angiography (~~CTA~~)~~ and / or Magnetic resonance angiography (MRA).

~~(D)~~(C) TEE or ~~Transthoracic echocardiography (~~TTE~~)~~.

~~(C)~~~~(E)~~(13) Interpretation of the imaging.

~~(12)~~(A) If teleradiology is used in image interpretation, all staffing and staff qualification requirements contained in this section shall remain in effect and shall be documented by the hospital.

~~(13)~~(B) Neuro-imaging studies shall be reviewed by a physician with appropriate expertise, such as a board-certified radiologist, board-certified neurologist, a board-certified neurosurgeon, or residents who interpret such studies as part of their training in ACGME-approved radiology, neurology, or neurosurgery training program within forty- five (45) minutes of emergency department arrival.

~~(A)~~(i) For the purpose of this subsection, a qualified radiologist shall be board certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

~~(B)~~(ii) For the purpose of this subsection, a qualified neurologist shall be board certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

~~(C)~~(iii) For the purpose of this subsection, a qualified neurosurgeon shall be board certified by the American Board of Neurological Surgery.

(14) Laboratory services capability that is available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, such that services may be performed within forty-five (45) minutes following emergency department arrival.

(15) Neurosurgical services ~~that are~~ shall be available, including operating room availability, either directly or under an agreement with a thrombectomy-capable, comprehensive or other primary stroke center with neurosurgical services, within two (2) hours following the ~~admission~~ arrival of acute stroke patients to the primary stroke center.

(16) Acute care rehabilitation services.

(17) Transfer arrangements with one or more higher level of care centers when clinically warranted or for neurosurgical emergencies.

(18) There shall be a ~~physician~~ stroke medical director of a primary stroke center, who may also serve as a physician member of a stroke team, who is board-certified in

neurology or neurosurgery or another board-certified physician with sufficient experience and expertise dealing with cerebral vascular disease as determined by the hospital credentials committee.

(b) Additional requirements may be stipulated by ~~required at the discretion of~~ the local EMS agency medical director.

Note: Authority cited: Sections 1797.102, 1797.103, 1797.107, 1797.176, 1797.204 1797.220, 1797.250, 1797.254, 1798.150, and 1798.172, Health and Safety Code. Reference: Sections 1797.104, 1797.176, and 1797.204, 1797.220, 1797.222, 1798.170, Health and Safety Code.

§ 100270.226. Acute Stroke Ready Hospitals

(a) Hospitals designated by the local EMS agency as an acute stroke ready hospital shall meet all the following minimum criteria:

(1) A~~n acute~~ clinical stroke team available to see, in person or via telehealth, a patient identified as a potential acute stroke patient within ~~thirty (30)~~ twenty (20) minutes following the patient's arrival at the hospital's emergency department.

(2) Written policies and procedures for emergency department stroke services that are reviewed, revised as needed, and implemented at least every three (3) years.

(3) Emergency department policies and procedures shall include written protocols and standardized orders for the emergency care of stroke patients.

(4) Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures.

(5) Neuro-imaging services capability that is available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, such that imaging shall be performed and reviewed by a physician within sixty (60) minutes following emergency department arrival.

(6) Neuro-imaging services shall, at a minimum, include~~:~~ CT or MRI, or both.

~~(A) Computerized tomography (CT).~~

~~(B) Magnetic resonance imaging (MRI).~~

~~(C)~~(7) Interpretation of the imaging.

~~(7)~~(A) If teleradiology is used in image interpretation, all staffing and staff qualification requirements contained in this ~~sub~~section shall remain in effect and shall be documented by the hospital.

~~(8)~~(B) Neuro-imaging studies shall be reviewed by a physician with appropriate expertise, such as a board-certified radiologist, board-certified neurologist, a board-certified neurosurgeon, or residents who interpret such studies as part of their training in ACGME-approved radiology, neurology, or neurosurgery training program within forty-five (45) minutes of emergency department arrival.

~~(A)~~(i) For the purpose of this subsection, a qualified radiologist shall be board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

~~(B)~~(ii) For the purpose of this subsection, a qualified neurologist shall be board-certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

~~(C)~~(iii) For the purpose of this subsection, a qualified neurosurgeon shall be board-certified by the American Board of Neurological Surgery.

~~(b)~~(8) Laboratory services shall, at a minimum, include blood testing, electrocardiography and x-ray services, and be available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, and able to be completed and reviewed by physician within sixty (60) minutes following emergency department arrival.

~~(c)~~(9) Neurosurgical services ~~that are~~ shall be available, including operating room availability, either directly or under an agreement with a thrombecotomy-capable, primary or comprehensive stroke center, within three (3) hours following the ~~admission~~ arrival of acute stroke patients to an acute stroke-ready hospital.

~~(d)~~(10) Provide IV thrombolytic treatment and have ~~T~~transfer arrangements with one or more thrombectomy-capable, primary or comprehensive stroke center(s) that facilitate the transfer of patients with strokes to the stroke center(s) for care when clinically warranted.

~~(e)~~(11) There shall be a medical director of an acute stroke-ready hospital, who may also serve as a member of a stroke team, who is a physician or advanced practice nurse who maintains at least ~~six (6)~~ four (4) hours per year of educational time in cerebrovascular disease;

~~(f)~~(12) ~~Acute care~~ Clinical stroke team for an acute stroke-ready hospital at a minimum shall consist of a nurse and a physician with training and expertise in acute stroke care.

~~(g)~~(b) Additional requirements may be ~~included at the discretion of~~ stipulated by the local EMS agency medical director.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.204, 1797.220, 1798.150, and 1798.172, Health and Safety Code. Reference: Sections 1797.204, 1797.220, and1797.222, Health and Safety Code.

§ 100270.227. EMS Receiving Hospitals (Non-designated for Stroke Critical Care Services)

(a) An EMS receiving hospital that is not designated for stroke critical care services shall do the following, at a minimum and in cooperation with stroke receiving centers and the local EMS agency in their jurisdictions:

(1) Participate in the local EMS agency's quality improvement system, including data submission as determined by the local EMS agency medical director.

(2) Participate in the inter-facility transfer agreements to ensure access to a stroke critical care system for a potential stroke patient.

Note: Authority cited: Sections 1797.88, 1797.103, 1797.107, 1797.176, 1797.220, 1798.100, 1798.150, and 1798.172, Health and Safety Code. Reference: Sections 1797.176, 1797.220, and1798.150, 1798.170, Health and Safety Code.

ARTICLE 5. DATA MANAGEMENT, QUALITY IMPROVEMENT AND EVALUATION

§ 100270.228. Data Management Requirements

(a) The local EMS agency shall implement a standardized data collection and reporting process for stroke critical care systems.

(b) The system shall include the collection of both prehospital and hospital patient care data, as determined by the local EMS agency.

(c) The prehospital stroke patient care elements shall be compliant with the most current version of the California EMS Information Systems (CEMSIS) database and the National EMS Information System (NEMSIS) database.

(d) The hospital stroke patient care elements shall be ~~compliant~~ consistent with the U.S. Centers for Disease Control and Prevention, Paul Coverdell National Acute Stroke Program Resource Guide, dated October 24, 2016.

(e) All hospitals that receive stroke patients via EMS shall participate in the local EMS agency data collection process in accordance with local EMS agency policies and procedures.

(f) ~~Stroke~~ The prehospital care record and the hospital data elements shall be collected and submitted by the local EMS agency, and subsequently to the EMS Authority, on no less than a quarterly basis.

Note: Authority cited: Sections. 1797.102, 1797.103, 1797.107, 1797.176, 1797.204, 1797.220, 1797.227, 1798.150, and 1798.172. Health and Safety Code. Reference: Section 1797.220, 1797.222, 1797.204.

§ 100270.229. Quality Improvement and Evaluation Process

(a) Each stroke critical care system shall have a quality improvement process ~~to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. This process~~that shall include, at a minimum:

(1) Evaluation of program structure, process, and outcome.

~~(1)~~(2) ~~A detailed a Audit~~ Review of ~~all~~ Stroke-related deaths, major complications, and transfers.

~~(2)~~(3) A multidisciplinary Stroke Quality Improvement Committee, including both prehospital and hospital members.

~~(3)~~(4) Participation in the ~~P~~QI process by all designated Stroke centers~~, other hospitals that treat stroke patients~~ and prehospital providers involved in the stroke critical care system.

~~(4)~~(5) Evaluation of ~~both local and~~ regional ~~components of the~~ integration of stroke ~~system~~patient movement.

~~(3)~~(5)(6) Participation in the stroke data management system.

~~(4)~~(6)(7) Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality, and a disclosure-protected review of selected stroke cases.

~~(b) The local EMS agency shall be responsible for the following:~~

~~(1) The on-going performance evaluation of a local or regional stroke critical care system.~~

~~(2) The development of a quality improvement process.~~

~~(3) Ensuring that designated stroke centers, other hospitals that treat stroke patients and prehospital providers involved in a Stroke critical care system participate in the quality improvement process.~~

~~(c)~~(b) The local EMS agency shall be responsible for on-going performance evaluation~~s~~

~~of all levels of stroke centers~~ and quality improvement of the stroke critical care system.

Note: Authority cited: Sections 1797.102, 1797.103, 1797.107, 1797.176, 1797.204, 1797.220, 1797.250, 1797.254, 1798.150, and 1798.172. Health and Safety Code. Reference: Section 1797.104, 1797.176, 1797.204, 1797.220, 1797.222, 1798.170 Health and Safety Code.

Comments on Proposed Stroke Critical Care System Regulations
Chapter 7.2, Division 9, Title 22, California Code of Regulations
15-day Public Comment Period
July 10, 2018, through July 25, 2018

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Los Angeles County EMS Agency	There is no Stroke Technical Advisory Committee designated within the regulations. A TAC is designated for other specialty programs within the regulations- Trauma and STEMI.	Comment acknowledged The TAC committee is a volunteer base advisory committee to the EMSA Director on the specialty Care systems and does not have to be in regulations.
	Los Angeles County EMS Agency	Recommend reorganizing and starting with ASRH and build up. With the CSC requirements first, it requires a lot of back and forth to determine requirements.	Comment acknowledged No change. This type of organizational change would make the current proposed regulations difficult to read and review and, upon adoption, can be made as a non-substantive change without regulatory effect.
100270.200. Page 1 Line 17	Karrie Groves Trauma, STEMI, Stroke, Policy and Procedures, and CQI Program Coordinator Marin County EMS	Both TJC and AHA use "most complex strokes" in their definitions. Recommend leaving the language as is.	Comment acknowledged No change
100270.203. Page 1 Lines 43-45	Los Angeles County EMS Agency	Clarification – the revised definition excludes thrombectomy-capable while destination decisions in EMS are the same for thrombectomy-capable and comprehensive. There is no definitive testing to determine if this is a bleed or thrombectomy candidate unless there is a mobile stroke unit. If LA County combines	Comment acknowledged The Hospital designation and Patient destination policy are at the local control. As long as they meet the criteria for that level. Functionally they

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		thrombectomy capable and comprehensive for destination, calling both comprehensive, does this constitutes a violation of this regulation	may have a similar destination for both of these classifications.
100270.204. Page 2 Line 50	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Clinical Stroke Team is defined however it is not used within the document. Consider defining "Acute Stroke Team" as well as "acute ***care*** stroke team" as they both differ from the define "Stroke Team" as mentioned above.	Comment acknowledged Change accepted EMSA replaced the language with Clinical Stroke team which is defined.
100270.206. Page 2 Line 70	Dr. Eric Rudnick, LEMSA Med Director Nor-Cal EMS	Please add that the LEMSA designates who a stroke center. Mentioned else where should be in the general introduction document.	Comment acknowledged No Change
100270.207. Page 2 Line 80	Karrie Groves Trauma, STEMI, Stroke, Policy and Procedures, and CQI Program Coordinator Marin County EMS	No where in any formal definition of PSC is the ability to transfer patients ever mentioned. It is understood. Recommend using definitions from AHA/TJC or CDC.	Comment acknowledged No change
100270.213. Page 3 Line 133	Sutter Medical Center Sacramento Loni Howard	Linking prehospital with in-hopsital. Need to clearly delineate which data the agency is looking at. Is it reasonable to request data on ALL stroke patients? How will this data be utilized to improve systems of care?	Comment acknowledged No change It is explained in Data section of the regulations.
100270.214. Page 4 Line 142	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider removing "required board-certification". As long as the director has sufficient knowledge of cerebral vascular disease as defined by the organization, physicians need not be board-certified.	Comment acknowledged No change The Medical Director should be board-certified.
100270.214. Page 4	Karrie Groves	Run on sentence. Recommend rewriting.	Comment acknowledged No change

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Line 143	Trauma, STEMI, Stroke, Policy and Procedures, and CQI Program Coordinator Marin County EMS		
100270.215. Page 4 Line 153	Dan Sitar, REMSA/Loreen Gutierrez, ICEMA	General comment: Stroke Program coordinator/manager is defined in ss100270.215, but is not mentioned or required of any level of stroke center in the regs. Please add a line to all levels of stroke center that requires each has a stroke program manager (except non-designated facilities). Also, recommendation to drop "coordinator" portion of the title and leave it as, "Stroke Program Manager." This is consistent with STEMI and Trauma regs.	Comment acknowledged Accept the change Stroke program manager added to the Primary Stroke center requirement which is required in other higher level of care centers.
100270.217. Page 4 Line 171	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider defining "Acute Stroke Team" as well as "acute ***care*** stroke team" as they both differ from the define "Stroke Team".	Comment acknowledged EMSA replaced the language with Clinical Stroke team which is defined.
100270.219. Page 5 Line 191	Karrie Groves Trauma, STEMI, Stroke, Policy and Procedures, and CQI Program Coordinator Marin County EMS	Replace "means" with "is"; remove "when clinically warranted." It is understood.	Comment acknowledged No change It is consistent with other definition language.
100270.220. Page 5 Lines 229-230	Los Angeles County EMS Agency	Strike entire section Rationale: Operationally this does not occur. Patients are directed to the closest appropriate hospital regardless of which LEMSA they are located in. If necessary for transfer "back', this is a hospital issue, not LEMSA.	Comment acknowledged EMSA has rewritten the language to make consistent with other critical care systems regulations.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.220. Page 6 Line 245	Dr. Eric Rudnick, LEMSA Med Director Nor-Cal EMS	The 60 day period of time should be 90 days, May take time to make a correction with a hospital.	Comment acknowledged No change EMSA has determined this to be a reasonable timeframe.
100270.220. Page 6 Line 258-260	Sutter Medical Center Sacramento Lanette Wathen	No health care facility shall advertise in any manner or otherwise hold itself out to be affiliated with a stroke critical care system or **a stroke center unless they have been designated by the local EMS agency**, in accordance with this Chapter. <u>Comment</u>: Needs clarification. The way the bolded statement is written suggests that a hospital certified by The Joint Commission, or similar certification body, would not be able to advertise this certification unless designated by EMS. If this is accurate, hospitals achieve certification by meeting rigorous requirements put forth by those certifying bodies and the ability to advertise this certification should not be dictated by EMS designation.	Comment acknowledged No change The designation has to be by LEMSA even if certified by another party.
100270.126. Page 7 Line 297	Brajesh Agrawal, M.D., Medical Director, Stroke Program, Seton Medical Center, Daly City, California	Line 297, Addition: "The local EMS agency shall ensure validated prehospital stroke severity scales as screening tools in the field by American Heart Association/American Stroke Association e.g. BEFAST, GFAST, RACE, LAMS, FAST-ED etc. as established prehospital care protocols. These protocols shall be used in conjunction with transfer to the most appropriate stroke center."	Comment acknowledged EMSA has rewritten the language to improve clarity

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		Comment: Pre-hospital Stroke severity scales in the field is evidence based and recommended by AHA/ASA to transfer patients to appropriate stroke centers. Local EMS agencies should be able to decide which scales to choose from above. For example, the Santa Clara County have recently chosen G-FAST as the stroke severity screening tool for pre-hospital assessment.	
100270.222. Page 7 Lines 297-298	Los Angeles ounty EMS Agency	Reinstate Rationale: Research has demonstrated that validated stroke scales are reliable to predict stroke occurrence. Why would it not be required that an EMS stroke system use a proven stroke scale?	Comment acknowledged EMSA has rewritten the language to improve clarity
100270.222. Page 7 Line 297-298	Southern California Kaiser Regional Stroke Program	Suggest including this line. "The local EMS agency shall require the use of a validated prehospital stroke screening algorithm for early recognition and assessment. Rationale: We feel it's important to include the use of a validated tool in the EMS setting.	Comment acknowledged EMSA has rewritten the language to improve clarity
100270.222. Page 7 Lines 297-298	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director	We continue to feel that it is important that any screening algorithm, if used, needs to be validated. We suggest adding the following "Any required prehospital stroke screening tool or algorithm shall be validated prior to use."	Comment acknowledged EMSA has rewritten the language to improve clarity

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Hospital and Health Plan Quality Kaiser Permanente, Northern California		
100270.222. Page 7 Lines 300-302	Los Angeles County EMS Agency	Change: "The local EMS agency's protocols for the use of on-line medical direction shall be ~~used in conjunction with transfer to the most appropriate stroke center~~ utilized for suspicious or complex findings <u>and</u> ~~used~~ in conjunction with ~~transfer~~ <u>transportation</u> to the most appropriate stroke center." Rationale: Current wording is confusing and LEMSA medical director is not responsible for directing transfers. Goal is not to transfer patient but have initial transport to the appropriate stroke center.	Comment acknowledged EMSA has rewritten the language to improve clarity
100270.222. Page 7 Lines 300-302	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	These lines are unclear, and we suggest they be deleted. Online medical direction is rarely used and should not be in a regulation with a "shall" directive.	Comment acknowledged No change
100217.222. Page 7	Los Angeles County EMS Agency	Delete section Rationale: This is the standard of care	Comment acknowledged No change

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Lines 304-306		and not included in any other specialty center regulations. This is not needed.	It is necessary for the Specialty Cares to be clear on their scope of work.
100270.222. Page 7 Lines 308-310	Los Angeles County EMS Agency	Change: "..to a ~~hospital~~ designated stroke center ~~of care~~ in advance…" Rationale: Center is the word used for all designated stroke centers. Wording as is, is very unclear. Addition of the word hospital was unnecessary.	Comment acknowledged No change
All Stroke Center Designations criteria selections	Dan Sitar, REMSA/Loreen Gutierrez, ICEMA	General comment: Reverse the order in which the stroke center level designation criteria appear, i.e., Non-designated, ASRH, Primary, Thrombectomy, Comprehensive. In this way it reads easier and is clearer.	Comment acknowledged No change
100270.223. Page 7 Line 318	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	Format inconsistent throughout (e.g. intent was to build upon the Acute Stroke Ready to the most complex, Comprehensive). Repetition inconsistent in some areas and lacking in others. Recommend reformat with ASR 1st, followed by PSC, TCS, CSC and adding the relevant changes ONLY to each section.	Comment acknowledged No change
100270.223. Page 8 Lines 326-327	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director	"Availability" 24/7 is necessary but not sufficient for public health. We feel the state should include a focus on the performance of the stroke critical care system. We suggest adding a performance requirement such as "Neuro-endovascular diagnostic and therapeutic procedures are available twenty-four	Comment acknowledged No change

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Hospital and Health Plan Quality Kaiser Permanente, Northern California	hours a day, seven days a week, within timeframes determined by National Standards and the local EMS agency to optimize favorable patient outcome."	
100270.223. Page 8 Line 329-337	Southern California Kaiser Regional Stroke Program	CSC level hospitals appear to have less advanced imaging services than that of the thrombectomy capable level hospitals. Although line 323-324 allows one to infer the greater requirements, we suggest more clarity in the wording.	Comment acknowledged The CSC requirement is Thrombectomy capable requirement plus what it is written in that section.
100270.223. Page 8 Line 333	Karrie Groves Trauma, STEMI, Stroke, Policy and Procedures, and CQI Program Coordinator Marin County EMS	CSC must have the availability to perform MRI/MRA, CTA, DSA and TCD. Recommend leaving all of these in.	Comment acknowledged The CSC requirement is Thrombectomy capable requirement plus what it is written in that section.
100270.223. Page 8 Line 333-339	Sutter Medical Center Sacramento Lanette Wathen	Advanced imaging available should include **A)** Computed tomography (CT) **B)** Computed tomography angiography (CTA) **C)** Magnetic resonance imaging (MRI), including diffusion-weighted MRI as this is what is required by The Joint Commission. Question the availability of Transcranial Doppler (TCD) 24/7(Joint Commission does not specify a timeframe but rather 'when indicated by patient need' for these imaging studies).	Comment acknowledged The CSC requirement is Thrombectomy capable requirement plus what it is written in that section.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.223. Page 8 Line 337	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	We suggest the following addition "and CT perfusion imaging", the standard imaging modality used in the DAWN and DEFUSE-3 trials.	Comment acknowledged Accept the changes
100270.223. Page 8 Line 339	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	We suggest the regulations be consistent with the Joint Commission requirement, requiring Transcranial Doppler in a timeframe that is clinically appropriate. We suggest the following language "Transcranial Doppler (TCD) shall be available in a timeframe that is clinically appropriate". An alternative would be to change the header for Transcranial Doppler to the following: (4) Transcranial Doppler (TCD). It will be its own number, without the 24/7 requirement, which is not based on clinical need. This will require renumbering the remaining items in this section.	Comment acknowledged Accept the changes
100270.223. Page 8 Line 352	Dr. Eric Rudnick, LEMSA Med Director Nor-Cal EMS	Consider removing research component.	Comment acknowledged No change Program research is a requirement of the Joint Commission.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.223. Page 8 Line 352	Southern California Kaiser Regional Stroke Program	Suggest changing the wording to read, "Participation in Stroke Patient Research". Rationale: a formal stroke research program may not be available to all stroke hospitals.	Comment acknowledged No change
100270.223. Page 8 Lines 365-366	Los Angeles County EMS Agency	Delete entire statement Rationale: This is a TSC requirement and they have to meet TSC requirements, as stated on Line 323 (Lines 423-424 under TSC)	Comment acknowledged Accept the change
100270.223. Page 8 Lines 368-370	Los Angeles County EMS Agency	Delete entire statement Rationale: This is a TSC requirement and they have to meet TSC requirements, as stated on Line 323 (Lines 426-428 under TSC)	Comment acknowledged Accept the change
100270.223. Page 8 Line 368-370	Sutter Health Neuroscience Institute, Michelle Manifield	Recommend adding "or appropriate education and experience as defined by the organization" to correlate with Joint Commission clarifications on the definition for vascular neurologist.	Comment acknowledged EMSA has rewritten the language to improve clarity
100270.223. Pages 8-9 Lines 372-373	Los Angeles County EMS Agency	Delete entire statement Rationale: This is a TSC requirement and they have to meet TSC requirements, as stated on Line 323 (Lines 430-431 under TSC)	Comment acknowledged No change The diagnostic tools and techniques required in CSC is not the same as Thrombolytic capable centers.
100270.223. Page 9 Line 388ff	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California	Some general reporting requirements that serve to validate the performance of the Comprehensive Stroke Center (CSC) should be required. We suggest the following addition: (11) A Comprehensive Stroke Center shall report to the local	Comment acknowledged No change This is already permitted within the QI section.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	EMS Agency performance times related to Comprehensive Stroke Center specific interventions. This will include arrival time to reperfusion by thrombectomy and arrival time to neurosurgical intervention. The local EMS Agency shall establish standards for performance for these measures."	
100270.223. Page 9 Line 388ff	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	LEMSA should be permitted to accept The Joint Commission certification as a Comprehensive Stroke Center in lieu of specifics. We suggest adding the following: "The local EMS Agency may accept certification by The Joint Commission, or equivalent national standard, as meeting the criteria for a Comprehensive Stroke Center in these regulations."	Comment acknowledged No change The designation is under local control. LEMSA may accept Joint Commission or commission certification.
100270.223. Page 9 Line 390	Nicholas Clay EMS Director Santa Barbara County Public Health Department	(b) Additional requirements may be ~~required at the discretion of~~ stipulated by the local EMS agency medical director, such cost recovery fees or more stringent guidelines. Rationale: The fact that this type of language exist in the Trauma Statute [10255 (e)] but is absent in these two regulations is significant. While there is no language that prohibits the LEMSA from charging fees, this omission is used by hospitals to oppose the charging of cost recovery fees by a LEMSA. The cost of running these	Comment acknowledged No change The cost and fees are at the local control. As currently written this provision does not place limitations on cost recovery by the LEMSA.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		programs is onerous and for LEMSA's who are entirely funded by a cost recovery model, not having the State Statute backed language specifically addressing fee collection is challenge.	
100270.224. Page 9 Lines 404-406	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	"Ability" 24/7 is necessary but not sufficient for public health. We feel that the state should include a focus on the performance of the TCSC in the stroke critical care system. We suggest adding a performance requirement such as "The ability to perform mechanical thrombectomy for the treatment of ischemic stroke twenty-four hours a day, seven days a week, three hundred and sixty-five days a year, within timeframes determined by national standards and the local EMS agency to optimize favorable patient outcome."	Comment acknowledged No change Performance metrics determined in QI sections.
100270.224. Page 9 Lines 414-415	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	Neurosurgery is not required at TCSC by any national standard. Requiring neurosurgery at the TCSC makes it virtually identical to a CSC. We suggest deleting or adding language regarding a transfer agreement when neurosurgical intervention is required. Since a transfer agreement requirement is already in the requirement for the PSC, and since TCSC must meet PSC requirements, it may be unnecessary here, thus suggest deleting the two lines entirely.	Comment acknowledged Change accepted
100270.224. Page 9 Line 415	Karrie Groves	"…, if providing neurosurgical services."	Comment acknowledged

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Trauma, STEMI, Stroke, Policy and Procedures, and CQI Program Coordinator Marin County EMS		Not all the Thrombectomy Capable center has neurosurgical services
100270.224. Page 10 Lines 420-421	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	TCSC must have an adequately trained and credentialed neurointerventionalist. This is the point of the TCSC and CSC! The requirements for neurointerventionalists in the current version of the regulations are inadequate to ensure quality care for these complex patients. In addition, the current regulations require board certification for neurologists, neurosurgeons, radiologists and neuroradiologists, but no competency requirements for neurointerventionalists. This represents a significant risk to quality care for these patients. We suggest adding "A qualified neurointerventionalist, who is board-certified by the American Board of Neurological Surgery or the American Osteopathic Board of Surgery with Primary Certification in Neurological Surgery, the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, or the American Board of Radiology or the American Osteopathic Board of Radiology, and who has successfully completed an endovascular fellowship supervised by the ACGME, the Committee for Advanced Subspecialty Training, or the United Council for Neurologic Subspecialties, or equivalent oversight body."	Comment acknowledged No change The Neuro-interventional angiographic training approved by the Hospital credentialing process covers that.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.224. Page 10 Line 423	Brajesh Agrawal, M.D., Medical Director, Stroke Program, Seton Medical Center, Daly City, California	Line 423 (C) "A qualified ~~neuro-~~radiologist <u>with sufficient experience and expertise in reporting neuroimaging studies as determined by the hospital credentialing committee</u>, board certified by American board of radiology or the american osteopathic board of radiology." Comment: Board certified radiologist with experience in stroke care should be considered as equivalent to neuroradiologists.	Comment acknowledged No change At the Thrombectomy capable level should be Board certified Neuroradiologist.
100270.224. Page 10 Line 426	Brajesh Agrawal, M.D., Medical Director, Stroke Program, Seton Medical Center, Daly City, California	Line 426 (D) "A qualified ~~vascular~~ neurologist <u>with sufficient experience and expertise in managing patients with acute cerebral vascular diseases as determined by the hospital credentialing committee</u>, board certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry." Comment: Board certified neurologist with experience in stroke care should be considered as equivalent to vascular neurologists.	Comment acknowledged No change At the Thrombectomy capable level should be board certified vascular Neurologist
100270.224. Page 10 Line 426	Sutter Health Neuroscience Institute, Michelle Manifield	Recommend adding "or appropriate education and experience as defined by the organization" to correlate with Joint Commission clarifications on the definition for vascular neurologist.	Comment acknowledged No change

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.224. Page 10 Line 449-455	Sutter Roseville Medical Center Jennifer Bingham	Question the availability of carotid duplex ultrasound, TEE, and Transthoracic echocardiography 24 hours a day. (Joint Commission does not specify a timeframe but rather 'when indicated by patient need' for these imaging studies.)	Comment acknowledged No changes Should be available at the Thrombectomy capable level of care.
100270.224. Page 10 Lines 449-455	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	We suggest deleting these lines as there is no documented clinical need, nor a Joint Commission requirement, for 24/7 carotid dopplers, Transesophageal echocardiography (TEE) and Transthoracic Echocardiography (TTE). We suggest creating a new number "(6) Carotid duplex ultrasound, TEE, and TTE in a timeframe clinically indicated." This will require renumbering the remaining items in this section. And, if this requirement is added to the PSC requirements, it may be entirely deleted here.	Comment acknowledged Accept the change EMSA has rewritten this subsection to improve clarity.
100270.224. Page 11 Line 467ff	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	Some general reporting requirements that serve to validate the performance of the TCSC should be required. We suggest adding number "(8) A Thrombectomy-Capable Stroke Center shall report to the local EMS Agency performance times related to Thrombectomy-Capable Stroke Center-specific interventions, including arrival time to reperfusion by thrombectomy. The local EMS Agency shall establish standards for performance of these measures."	Comment acknowledged No change This is supported in the QI section.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.224. Page 11 Line 467ff	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	LEMSA should be permitted to accept The Joint Commission certification as a TCSC in lieu of specifics. We suggest adding "The local EMS Agency may accept certification by The Joint Commission, or equivalent national standard, as meeting the criteria for Thrombectomy-Capable Stroke Center in these regulations."	Comment acknowledged No change The designation is under local control. LEMSA may choose to accept Joint Commission certification.
100270.224. Page 11 Line 468	Nicholas Clay EMS Director Santa Barbara County Public Health Department	(b) Additional requirements may be ~~required at the discretion of~~ stipulated by the local EMS agency medical director, such cost recovery fees or more stringent guidelines. Rationale: The fact that this type of language exist in the Trauma Statute [10255 (e)] but is absent in these two regulations is significant. While there is no language that prohibits the LEMSA from charging fees, this omission is used by hospitals to oppose the charging of cost recovery fees by a LEMSA. The cost of running these programs is onerous and for LEMSA's who are entirely funded by a cost recovery model, not having the State Statute backed language specifically addressing fee collection is challenge.	Comment acknowledged No change The cost and fees are at the local control. As currently written this provision does not place limitations on cost recovery by the LEMSA.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.225. Page 11 Line 491, 496	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Please clarify acute stroke team versus acute care stroke team – are they to be used interchangeably?	Comment acknowledged Change accepted EMSA replaced the language with Clinical Stroke team which is defined.
100270.225. Page 11 Lines 504-506	Los Angeles County EMS Agency	Delete entire statement Rationale: Physician director is not responsible for determining competency, the facility is	Comment acknowledged Change accepted
100270.225. Page 12 Line 510	Southern California Kaiser Regional Stroke Program	Suggest removing "These policies and procedures shall be reviewed at least every two (2) years, revised as needed and implemented." And replace with "These policies and procedures shall be reviewed according to hospital policy and revised as needed and implemented." Rationale: some of our hospitals may have moved to a 3-year cycle for policy revisions.	Comment acknowledged No change
100270.225. Page 12 Line 516-531	Alison Roomsburg, BSN, RN, SCRN Neuroscience & Sepsis Programs Adventist Health	All of the neuro-imaging services mentioned in this section should be available at a Primary Stroke Center. However, not all of them are required to be performed within 25 minutes of patient arrival. Recommendation: Split this into 2 categories: 1) Neuro-imaging that must be available and initiated within 25 minutes of patient arrival to ED - CT Head 2) Neuro-imaging that must be available and completed in a reasonable time frame:	Comment acknowledged Accept the change; EMSA rewrote the language for more clarity.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		- CTA - MRI - MRA - TEE or TTE	
100270.225. Page 12 Lines 518 and 526	Los Angeles County EMS Agency	Please verify. Rationale: 24/7/365 initiation of MRI within 25 minutes is not the standard. It is only a standard for backup if the facility cannot perform CT for some reason and not a standing expectation for PSCs	Comment acknowledged EMSA rewrote the language for more clarity.
100270.225. Page 12 Lines 518 and 528- 531	Los Angeles County EMS Agency	Please verify Rationale: CTA/MRA and TEE/TTE are to be available <u>but not</u> 24/7/365. Only CT and interpretation of said CT are required 24/7. If want to keep, then an additional statement should be added that they are "Available if clinically indicated" and Line 533 is moved up	Comment acknowledged EMSA rewrote the language for more clarity.
100270.225. Page 12 Line 516, 520, 100270.224. Page 11 Line 433, 100270.223. Page 8 Line 329	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	For clarity, consistent language for PSC/TCS/CSC, change "initiated within 25 minute following ED arrival to "performed and read within 45 minutes of ED arrival". 519 PSC 433 TCS 329 CSC	Comment acknowledged EMSA rewrote the language for more clarity.
100270.225. Page 12 Line 520, 100270.224. Page 11	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	For clarity, reword tests with turn-around-time requirements to consistently state "Neuro-imaging services available within this timeframe shall, at a minimum, include:"	Comment acknowledged EMSA rewrote the language for more clarity.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Line 437, 100270.223. Page 8 Line 329		520 PSC- CT, MRI, CTA, MRA, 437 TSC- CT, MRI, CTA, MRA, Diffusion-weighted MRI &/or CT Perfusion, 329 CSC- Same as TSC: CT, MRI, CTA, MRA, Diffusion-weighted MRI &/or CT Perfusion,	
100270.225. Page 12 Line 521	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider adding " Twenty-five (25) minutes versus "available within this time frame for clarity or remove	Comment acknowledged EMSA rewrote the language for more clarity.
100270.225. Page 12 Line 526	Sutter Roseville Medical Center Jennifer Bingham	Imaging within 25 minutes of arrival is specific to CT Brain non-contrast in certification standards and clinical practice guidelines. MRI <u>within 25 minutes of arrival</u> is not a Joint Commission certification requirement.	Comment acknowledged Accept the change; EMSA rewrote the language for more clarity.
100270.225. Page 12 Line 528	Sutter Roseville Medical Center Jennifer Bingham	Imaging within 25 minutes of arrival is specific to CT Brain non-contrast in certification standards and clinical practice guidelines. MRA <u>within 25 minutes of arrival</u> is not a certification standard.	Comment acknowledged Accept the change; EMSA rewrote the language for more clarity.
100270.225. Page 12 Line 531	Sutter Roseville Medical Center Jennifer Bingham	TEE or Transthoracic echocardiography initiated <u>within 25 minutes of arrival</u> is not a certification standard.	Comment acknowledged Accept the change; EMSA rewrote the language for more clarity.
100270.225. Page 12 Line 531	Los Angeles County EMS Agency	Move to separate area Rationale: This is not a neuro-imaging service. Additionally, it is not required to be initiated within 25 minutes. It is not a time critical exam.	Comment acknowledged EMSA rewrote the language for more clarity.
100270.225. Page 12 Line 531	Jay Goldman, MD, FACEP Director of EMS and Ambulance	TTE and TEE are not neuroimaging modalities and thus do not belong under (11). In addition, there is no documented clinical need, nor a Joint Commission	Comment acknowledged EMSA rewrote the language for more clarity.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	requirement for 24/7 TEE and TTE. We suggest inserting a new number (12) "TEE and/or TTE in a timeframe clinically indicated." This will require renumbering the remaining items in this section.	
100270.255. Page 12 Line 531-533	Dan Sitar, REMSA/Loreen Gutierrez, ICEMA	Under ss100270.255, paragraph 11D, lines 531-533 indicate that TTE/TEE and MRA are available to be performed and *interpreted* within 25 minutes. This is an inappropriate time frame for most centers to achieve these particular imaging studies and have them read. CT and plain MRI are ok to stay at 25 mins for *performance* of the imaging, but interpretation standard is within 45 minutes (per AHA guidelines). The remainder of the imaging should not be tied to a specific time frame. Suggest, "promptly available" is better availability for TTE/TEE and MRA.	Comment acknowledged EMSA rewrote the language for more clarity.
100270.225. Page 12 Line 533	Sutter Medical Center Sacramento Lanette Wathen	Interpretation of imaging is not required within 25 minutes following emergency department arrival is not a certification requirement.	Comment acknowledged EMSA rewrote the language for more clarity.
100270.225. Page 12 Line 533	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair, and Stroke Program Coordinator Eisenhower Medical Center	Delete as this is addressed in 539 and it also currently appears as if it falls under the 25 minute time frame	Comment acknowledged EMSA rewrote the language for more clarity.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.225. Page 12 Line 539-543	Sutter Roseville Medical Center Jennifer Bingham	Neuro-imaging studies results within 45 minutes is a standard specific to CT Brain results.	Comment acknowledged EMSA rewrote the language for more clarity.
100270.225. Page 12 Line 542	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	Delete "within line 542 forty- five (45) minutes of emergency department arrival" Note: included in recommendation above line # 516	Comment acknowledged EMSA rewrote the language for more clarity.
100270.225. Page 13 Line 556	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider adding "resulted" within 45 minutes as this is the standard expectation	Comment acknowledged EMSA rewrote the language for more clarity.
100270.225. Page 13 Line 560	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider changing expectation to "within 2 hours of being ***deemed clinically warranted***" versus "following the admission…."	Comment acknowledged EMSA rewrote the language for more clarity.
100270.225. Page 13 Line 561	Los Angeles County EMS Agency	Change: "…or under an agreement with a comprehensive or other ~~primary~~ stroke center with neurosurgical services…" Rationale: A TSC may also have neurosurgical capabilities. So primary needs to be deleted or thrombectomy-capable added.	Comment acknowledged EMSA rewrote the language for more clarity.
100270.225. Page 13 Line 562	Alison Roomsburg, BSN, RN, SCRN Neuroscience & Sepsis Programs Adventist Health	Recommend changing "…following the **admission** of…" to "following the **arrival** of…". The goal being to transfer the patient out for higher level of care within 2 hours from the time they **arrived** to the initial hospital.	Comment acknowledged Accept the change; EMSA rewrote the language for more clarity.
100270.225. Page 13 Line 568	Los Angeles County EMS Agency	The addition of "neurosurgical emergencies" seems to be in direct conflict with Line 361-362 and the ability to	Comment acknowledged No change

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		transfer to another PSC with neurosurgical services.	
100270.225. Page 13 Line 570	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider removing "physician director" and change to align with the defined terminology of "Stroke Medical Director"	Comment acknowledged Accept the change
100270.225. Page 13 Line 574ff	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	Some general reporting requirements that serve to validate the performance of the PSC should be required. We suggest adding "(19) A PSC shall report to the local EMS Agency performance times related to PSC-specific interventions. The local EMS Agency shall establish standards for performance for these measures."	Comment acknowledged No change This is covered in Section 100270.229; the LEMSA is responsible for performance evaluation and QI.
100270.225. Page 13 Line 576	Nicholas Clay EMS Director Santa Barbara County Public Health Department	(b) Additional requirements may be ~~required at the discretion of~~ stipulated by the local EMS agency medical director, such cost recovery fees or more stringent guidelines. Rationale: The fact that this type of language exist in the Trauma Statute [10255 (e)] but is absent in these two regulations is significant. While there is no language that prohibits the LEMSA from charging fees, this omission is used by hospitals to oppose the charging of cost recovery fees by a LEMSA. The cost of running these programs is onerous and for LEMSA's who are entirely funded by a cost recovery	Comment acknowledged No change The cost and fees are at the local control. As currently written this provision does not place limitations on cost recovery by the LEMSA.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		model, not having the State Statute backed language specifically addressing fee collection is challenge.	
100270.226. Page 13 Line 589	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider adding "a member" of the acute stroke team is available…… Consider 15 minutes versus 20 minutes per the BAC & TJC recommendations	Comment acknowledged No change
100270.226. Page 13 Line 600, 100270.225. Page 12 Line 518, 100270.224. Page 11 Line 484, 100270.223. Page 8 Line 349	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	For clarity, consistent language, Change ASR, PSC, TSC, PSC to all state "Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures. 600 ASR 484, 513 PSC 456 TSC 349 CSC	Comment acknowledged Change accepted
100270.226. Page 14 Line 602, 100270.225. Page 12 Line 516, 100270.224. Page 10 Line 433,	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	For clarity, create category with statement " Other neuro-imaging studies to be available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, which shall include but not be limited to:" PSC – TEE or TTE TSC - TEE, TTE, Catheter Angiogram, Carotid Duplex Ultrasound	Comment acknowledged EMSA rewrote the language for more clarity.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.223. Page 8 Line 329		PSC - TEE, TTE, Catheter Angiogram, Carotid Duplex Ultrasound, Transcranial Doppler 329 CSC 433 TSC 516 PSC 602 ASR Note: no turn-around-time for these studies as they are not typically part of the hyper acute phase	
100270.226. Page 14 Line 602	Dan Sitar, REMSA/Loreen Gutierrez, ICEMA	Under ss100270.266, paragraph 5, line 602, turn-around times for head CT imaging is 45 minutes for standard of care regardless of stroke designation. This is an AHA/ASA, and TJC guideline. Please change under ASRH designation criteria to 45 minutes.	Comment acknowledged Accept the change; EMSA rewrote the language for more clarity.
100270.226. Page 14 Line 604	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	For clarity, consistent language, change "imaging shall be performed and reviewed by a physician" to "performed and read within 60 minutes of ED arrival".	Comment acknowledged No change Unnecessary change
100270.226. Page 14 Line 609, 611	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider adding "and/or" as both would not typically be clinically indicated	Comment acknowledged No change Unnecessary changes
100270.226. Page 14 Line 613	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	Delete (C) Interpretation of the imaging. Note: included in recommendation above Line # 604	Comment acknowledged EMSA rewrote the language for more clarity.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.226. Page 14 Line 615, 100270.225. Page 12 Line 535, 100270.224. Page 10 Line 430, 100270.223. Page 8 Line 372	California Hospital Association Stroke Program Coordinator Eisenhower Medical Center	For clarity, consistent language, Change ASR, PSC, TSC, PSC tele-radiology to all state "If tele-radiology is used, staffing and staff qualification requirements provided in this section shall remain in effect and shall be documented by the hospital." 615 ASR 535 PSC 430 TSC 372 CSC	Comment acknowledged Change accepted
100270.226. Page 14 Line 635	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider changing "60" minutes to "45" minutes as this is the standard expectation for BAC & TJC	Comment acknowledged No change The 45 minutes is after Order not ED arrival
100270.226. Page 14 Line 641	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider changing expectation to "being deemed clinically warranted" versus "following the admission…."	Comment acknowledged EMSA rewrote the language for more clarity.
100270.226. Page 14 Line 643	Alison Roomsburg, BSN, RN, SCRN Neuroscience & Sepsis Programs Adventist Health	Recommend changing "…following the **admission** of…" to "following the **arrival** of…". The goal being to transfer the patient out for higher level of care within 2 hours from the time they **arrived** to the initial hospital.	Comment acknowledged Accept the change
100270.226. Page 14 Line 646	Los Angeles County EMS Agency	Change: "Provide IV thrombolytic treatment <u>and have</u> transfer arrangements…" Rationale: Current wording is incomplete	Comment acknowledged Accept the change; EMSA rewrote the language for more clarity

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.226. Page 15 Line 649, 100270.225. Page 13 Line 570	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	Stroke Medical Director to replace 649 "director", 570 "physician director"	Comment acknowledged Accept the change; EMSA rewrote the language for more clarity
100270.226. Page 15 Line 650	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Inconsistent language-consider Stroke medical director versus director. Consider "4" hours versus 6 hours of education as this aligns with BAC & TJC	Comment acknowledged Accept the change; EMSA rewrote the language for more clarity
100270.226. Page 13 Line 657	Nicholas Clay EMS Director Santa Barbara County Public Health Department	(g) Additional requirements may be ~~required at the discretion of~~ stipulated by the local EMS agency medical director, such cost recovery fees or more stringent guidelines. Rationale: The fact that this type of language exist in the Trauma Statute [10255 (e)] but is absent in these two regulations is significant. While there is no language that prohibits the LEMSA from charging fees, this omission is used by hospitals to oppose the charging of cost recovery fees by a LEMSA. The cost of running these programs is onerous and for LEMSA's who are entirely funded by a cost recovery model, not having the State Statute backed language specifically addressing fee collection is challenge. Rationale:	Comment acknowledged No change The cost and fees are at the local control. As currently written this provision does not place limitations on cost recovery by the LEMSA.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.227. Page 15 Lines 664-678	Los Angeles County EMS Agency	Delete section Rationale: What is the goal for the non-designated stroke centers? Just because a hospital does not participate at the EMS level in the care of stroke patients, it does not mean they are not capable of caring for stroke patients.	Comment acknowledged No change The goal is to give the LEMSA the authority to integrate them into the system if desired.
100270.228. Page 16 Line 693	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	We suggest some basic measures be specified here, either in addition to those in each section above (CSC, TCSC, PSC) or in place of those above. We suggest adding "Comprehensive, Thrombectomy Capable, and Primary Stroke Centers shall collect performance data related to their respective special requirements, including time from arrival to neurosurgical intervention, arrival to thrombectomy, arrival to reperfusion, arrival to thrombolysis, and arrival to transfer to higher level of care."	Comment acknowledged No change. Using the Coverdell data set in participating in the QI process automatically introduces those measures.
100270.228. Page 16 Lines 694-696	Los Angeles County EMS Agency	If the LEMSA is responsible for submitting the data to EMSA, why does the hospital have to be consistent with the CDCP Paul Coverdell National Acute Stroke Program Resource Guide? What is meant by consistent? There are a multitude of data elements in this registry that are not pre-hospital and would not affect EMS treatment decisions and these are pre-hospital regulations. Additionally, with a dated reference, any update to the Coverdell Resource Guide would not be required without updating the regulations	Comment acknowledged No change The purpose of regulations is to create standardization in the system, these elements are using for the QI purpose and will use at the state and national level comparison. If the Guideline changes, yes, we need to update our regulations.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100270.228. Page 16 Line 698	Los Angeles County EMS Agency	Change: ""All hospitals the receive stroke patients <u>via EMS</u> shall…" Rationale: This is an EMS system, and needs to clearly state EMS versus walk-ins. The EMS Agency has no control over walk-in patients	Comment acknowledged Change accepted
100270.229. Page 16 Line 710	Los Angeles County EMS Agency	Change: "Each stroke critical care ~~system~~ <u>facility</u> shall…" Rationale: Per the regulations the term 'system' is LEMSA level and 'facility' is hospital level. The LEMSA cannot audit all Stroke-related deaths, major complications, and transfers as required on Line 718	Comment acknowledged EMSA changed "Audit" to "Review". The purpose of the regulations is to create QI for the Stroke system which organizes by LEMSAs in coordination with the facilities
100270.229. Page 16 Lines 723-727	Los Angeles County EMS Agency	What do these two statements mean? They are vague and unclear and as such would be impossible to evaluate.	Comment acknowledged No change

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

May 21, 2018

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BY ELECTRONIC CORRESPONDENCE

RE: STEMI Critical Care System, Notice of Proposed Rulemaking, Title 22, Division 9, Prehospital Emergency Medical Services, Chapter 7.1, ST Elevation Myocardial Infarction Critical Care System

Dear Corrine:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) respectfully offers the following comments for consideration on the proposed regulatory text for the Emergency Medical Services Authority (EMSA), California Health and Safety Code sections 1797,103 and 1797.176.

CHA appreciates EMSA's pursuit of a highly functional ST Elevation Myocardial Infarction (STEMI) critical care system. Establishing standards related to local acute STEMI critical care systems will improve the care of patients suffering from life-threatening myocardial infarction. The regulations should provide statewide consistency and fairness, increase transparency of local and state government, and align with national standards for STEMI critical care. This will assure Californians that there is a comprehensive, systemic approach for STEMI care that is evidence-based, continuously evaluated, well-coordinated and driven by the most efficient and effective use of resources.

CHA previously submitted numerous remarks to streamline, clarify and specify hospital STEMI requirements so that they may be applied consistently statewide. Many of those comments were adopted in this draft, which CHA appreciates. However, CHA continues toemphasize the need to modernize these and future regulations according to nationally based standards of care. The present regulatory process is tedious and unable to accommodate today's rapid changes in science and technology. In our previous comments, CHA proposed that state regulatory standards of care be based on current national standards — in this case, national STEMI certification standards. The American Heart Association's (AHA) Mission Lifeline Standards represent leading scientific evidence-based standards of practice and are updated every two years, which coincides with the proposed stroke critical care hospital policy and procedure review period. National standards are mentioned in §100270.131 Data Management, relative to National EMS Information System and the National Cardiovascular Data Registry. As written in the present draft, local emergency medical services agencies and hospitals would be required to comply with the most current version. CHA suggests that this type of infrastructure be

applied to the rest of the STEMI regulations, which would mirror the methodology adopted in other states and prevent resource intensive reviews.

The comments outlined on the attached comment form (Comments for Draft STEMI Regulations) reflect changes we propose to this draft. A summary of our comments is below.

I. Article 1. Definitions

a. §100270.111 PCI – Suggest adding a more detailed definition of Percutaneous Coronary Intervention. The present definition is narrow and does not include diagnoses. The proposed definition is based on American College of Cardiology (ACC) and includes both diagnostic and treatment characteristics.
b. §100270.115 & §100270.118, STEMI Medical Director and STEMI Program Manager – Suggest adding the word "emergency" before critical care. Hospitals may have specialists in either emergency STEMI or critical care STEMI. It needs to be clear this is an emergency critical care position.
c. §100270.119 STEMI Receiving Center – Change to "a licensed GACH with a special permit for a cardiac catheterization laboratory and cardiovascular surgery by the California Department of Public health and that meets the minimum hospital STEMI care requirements, pursuant to Section §100270.127."
d. §100270.127 STEMI Receiving Center - Add "any changes deemed necessary by the local emergency medical services agency should be made in consultation with the affected Stemi Receiving Center"
e. §100270.129 STEMI Referring Center – Change "referring" to "receiving."
f. §100270.129 Data Management – add "American College of Cardiology" before "National Cardiovascular Data Registry."

CHA appreciates the opportunity to comment on this critical document that will not only modernize the development of California's STEMI Critical Care System, but set the stage for the achievement and acceleration of exceptional quality STEMI care across the state.

Sincerely,

BJ Bartleson, RN, MS, NEA-BC
Vice President, Nursing and Clinical Services
California Hospital Association
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Comments on Proposed ST Elevation Myocardial infarction **(STEMI) Critical Care System Regulations**
Chapter 7.1, Division 9, Title 22, California Code of Regulations
45-day Public Comment Period
April 6, 2018 through May 21, 2018

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
§100270.111 Percutaneous Coronary Intervention (PCI), Page 3, line 92	CHA, BJ Bartleson	Change wording to read, "Percutaneous Coronary Intervention or PCI means a broad group of percutaneous techniques utilized in the dilation of coronary, heart or arterial obstructions to diagnose and treat patients with STEMI"	
§100.270.115 STEMI Medical Director, page 4, line 128	CHA	Add the word "emergency" before "critical care"	
§100270.118 , STEMI Program Manager, page 4 line 152	CHA	Add the word "emergency" before "critical care system"	
§100270.119 STEMI Receiving Center (SRC), page 4, line 157	CHA	Change to, "A licensed GACH with a special permit for a cardiac catheritization laboratory and cardiovascular surgery by the California Department of Public Health and that meets the minimum hospital STEMI care requirements pursuant to Section §100270.127"	
§100270.127 STEMI Receiving Center (SRC), page 9 , line 364	CHA	Change to: "Additional requirements may be included at the discretion of the local EMS agency medical director in consultation with the SRC"	
§100270.129. STEMI Referring	CHA	Change "referring" to "receiving"	

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Hospital, page 10, line 396			
§100270.129 Data Management, page 11, line 428	CHA	Add: "American College of Cardiology" before National Cardiovascular Data Registry	

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

July 25, 2018

Esam El-Morshedy
Legislative and Regulatory Affairs
California Emergency Medical Services Authority
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BY ELECTRONIC CORRESPONDENCE

RE: Stroke Critical Care System, Notice of Proposed Rulemaking, Title 22, Division 9, Prehospital Emergency Medical Services, Chapter 7.2

Dear Mr. El-Morshedy:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) respectfully offers the following comments for consideration on the proposed regulatory text for the Emergency Medical Service Authority (EMSA), California Health and Safety Code sections.

CHA appreciates EMSA's pursuit of a highly functional stroke critical care system. Establishing these standards related to local optional acute Stroke Critical Care Systems throughout the State for the local EMS agencies (LEMSAs) to adopt will improve the care of patients suffering from life-threatening acute strokes. The regulations should provide statewide consistency and fairness, increase transparency of local and state government, and align with national standards for stroke critical care. This will assure Californians that there is a comprehensive systemic approach for care of the stroke victim that is evidence based, continuously evaluated, well-coordinated, and, driven by the most efficient and effective use of resources.

CHA and our members offer, mostly non-substantive changes, with several recommendations to improve the reader flow and consistency of the document. Additional comments for clarity on times with wording and clarifying statements.

In summary, CHA appreciates the opportunity to comment on this document to set the stage for the achievement and acceleration of exceptional quality stroke care across the state.

Sincerely,

BJ Bartleson, RN, MS, NEA-BC

VP Nursing and Clinical Services
California Hospital Association
(916)552-7537
bjbartleson@calhospital.org

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
50	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Clinical Stroke Team is defined however it is not used within the document. Consider defining "Acute Stroke Team" as well as "acute *care* stroke team" as they both differ from the define "Stroke Team" as mentioned above	
142	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider removing "required board-certification". As long as the director has sufficient knowledge of cerebral vascular disease as defined by the organization, physicians need not be board-certified	
171	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider defining "Acute Stroke Team" as well as "acute *care* stroke team" as they both differ from the define "Stroke Team"	
318	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	Format inconsistent throughout (e.g. intent was to build upon the Acute Stroke Ready to the most complex, Comprehensive). Repetition inconsistent in some areas and lacking in others. Recommend reformat with ASR 1st, followed by PSC, TCS, CSC and adding the relevant changes ONLY to each section.	
491, 496	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Please clarify acute stroke team versus acute care stroke team – are they to be used interchangeably?	
516, 520,433, 329	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	For clarity, consistent language for PSC/TCS/CSC, change "initiated within 25 minute following ED arrival to "performed and read within 45 minutes of ED arrival". 519 PSC 433 TCS 329 CSC	

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
520, 437, 329	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	For clarity, reword tests with turn-around-time requirements to consistently state "Neuro-imaging services available within this timeframe shall, at a minimum, include:" 520 PSC- CT, MRI, CTA, MRA, 437 TSC- CT, MRI, CTA, MRA, Diffusion-weighted MRI &/or CT Perfusion, 329 CSC- Same as TSC: CT, MRI, CTA, MRA, Diffusion-weighted MRI &/or CT Perfusion,	
521	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider adding " Twenty-five (25) minutes versus "available within this time frame for clarity or remove	
524, 526, 528	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider adding "and/or" as not all elements may be indicated. As it reads now it appears all are expected at a minimum and subject to completion within 25 minutes following ED arrival	
533	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair, and Stroke Program Coordinator Eisenhower Medical Center	Delete as this is addressed in 539 and it also currently appears as if it falls under the 25 minute time frame	
542	California Hospital Association and Stroke Program Coordinator Eisenhower Medical Center	Delete "within line 542 forty- five (45) minutes of emergency department arrival" Note: included in recommendation above line # 516	
556	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider adding "resulted" within 45 minutes as this is the standard expectation	
560	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider changing expectation to "within 2 hours of being *deemed clinically warranted*" versus "following the admission…."	
570	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider removing "physician director" and change to align with the defined terminology of "Stroke Medical Director"	

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
589	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider adding "a member" of the acute stroke team is available…… Consider 15 minutes versus 20 minutes per the BAC & TJC recommendations	
600, 518,484, 349	California Hospital Association and, Stroke Program Coordinator Eisenhower Medical Center	For clarity, consistent language, Change ASR, PSC, TSC, PSC to all state "Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures. 600 ASR 484, 513 PSC 456 TSC 349 CSC	
602, 516, 433, 329	California Hospital Association, and Stroke Program Coordinator Eisenhower Medical Center	For clarity, create category with statement " Other neuro-imaging studies to be available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, which shall include but not be limited to:" PSC – TEE or TTE TSC - TEE, TTE, Catheter Angiogram, Carotid Duplex Ultrasound PSC - TEE, TTE, Catheter Angiogram, Carotid Duplex Ultrasound, Transcranial Doppler 329 CSC 433 TSC 516 PSC 602 ASR Note: no turn-around-time for these studies as they are not typically part of the hyper acute phase	
604	California Hospital Association and, Stroke Program Coordinator Eisenhower Medical Center	For clarity, consistent language, change "imaging shall be performed and reviewed by a physician" to "performed and read within 60 minutes of ED arrival".	
609, 611	California Hospital Association and Inland Empire Stroke Coordinators	Consider adding "and/or" as both would not typically be clinically indicated	

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Association –Chair		
613	California Hospital Association, and Stroke Program Coordinator Eisenhower Medical Center	Delete (C) Interpretation of the imaging. Note: included in recommendation above Line # 604	
615, 535, 430, 372	California Hospital Association Stroke Program Coordinator Eisenhower Medical Center	For clarity, consistent language, Change ASR, PSC, TSC, PSC tele-radiology to all state "If tele-radiology is used, staffing and staff qualification requirements provided in this section shall remain in effect and shall be documented by the hospital." 615 ASR 535 PSC 430 TSC 372 CSC	
635	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider changing "60" minutes to "45" minutes as this is the standard expectation for BAC & TJC	
641	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Consider changing expectation to "being deemed clinically warranted" versus "following the admission…."	
649, 570	California Hospital Association and, Stroke Program Coordinator Eisenhower Medical Center	Stroke Medical Director to replace 649 "director", 570 "physician director"	
650	California Hospital Association and Inland Empire Stroke Coordinators Association –Chair	Inconsistent language-consider Stroke medical director versus director. Consider "4" hours versus 6 hours of education as this aligns with BAC & TJC	

FENTANYL†

SAFETY RECOMMENDATIONS FOR FIRST RESPONDERS

† For the purposes of this document, fentanyl, related substances, and synthetic opioids (herein after referred to as fentanyl†) includes fentanyl analogues (e.g., acetylfentanyl, acrylfentanyl, carfentanil, furanylfentanyl), novel synthetic opioids (e.g., U-47700), and other drugs that may be laced with these substances.

- **The abuse of drugs containing fentanyl† is killing Americans. Misinformation and inconsistent recommendations regarding fentanyl† have resulted in confusion in the first responder community.**
- You as a first responder (law enforcement, fire, rescue, and emergency medical services (EMS) personnel) are increasingly likely to encounter fentanyl† in your daily activities (e.g., responding to overdose calls, conducting traffic stops, arrests, and searches).
- This document provides scientific, evidence-based recommendations to protect yourself from exposure.

WHAT YOU NEED TO KNOW

- Fentanyl† can be present in a variety of forms (e.g., powder, tablets, capsules, solutions, and rocks).
- Inhalation of airborne powder is MOST LIKELY to lead to harmful effects, but is less likely to occur than skin contact.
- Incidental skin contact may occur during daily activities but is not expected to lead to harmful effects if the contaminated skin is promptly washed off with water.
- Personal Protective Equipment (PPE) is effective in protecting you from exposure.
- Slow breathing or no breathing, drowsiness or unresponsiveness, and constricted or pinpoint pupils are the specific signs consistent with fentanyl† intoxication.
- Naloxone is an effective medication that rapidly reverses the effects of fentanyl†.

Actions to take . . .

To protect yourself from exposure

- Wear **gloves** when the presence of fentanyl† is suspected.
- **AVOID actions that may cause powder to become airborne.**
- Use a properly-fitted, NIOSH-approved **respirator ("mask")**, wear **eye protection**, and minimize skin contact when responding to a situation where small amounts of suspected fentanyl† are visible and may become airborne.
- Follow your department guidelines if the scene involves large amounts of suspected fentanyl† (e.g., distribution/storage facility, pill milling operation, clandestine lab, gross contamination, spill or release).

When exposure occurs

- Prevent further contamination and notify other first responders and dispatch.
- Do not touch your eyes, mouth, nose or any skin after touching any potentially contaminated surface.
- Wash skin thoroughly with cool water, and soap if available. **Do NOT use hand sanitizers as they may enhance absorption.**
- Wash your hands thoroughly after the incident and before eating, drinking, smoking, or using the restroom.
- If you suspect your clothing, shoes, and PPE may be contaminated, follow your department guidelines for decontamination.

If you or other first responders exhibit

- Slow Breathing or No Breathing
- Drowsiness or Unresponsiveness
- Constricted or Pinpoint Pupils

- Move away from the source of exposure and call EMS.
- Administer naloxone according to your department protocols. Multiple doses may be required.
- If naloxone is not available, rescue breathing can be a lifesaving measure until EMS arrives. Use standard basic life support safety precautions (e.g., pocket mask, gloves) to address the exposure risk.
- If needed, initiate CPR until EMS arrives.

Collaborative Support From:

- American College of Emergency Physicians
- American College of Medical Toxicologists
- American Industrial Hygiene Association
- Association of State and Territorial Health Officials
- Association of State Criminal Investigative Agencies
- Fraternal Order of Police
- International Association of Chiefs of Police
- International Association of Fire Chiefs
- International Association of Fire Fighters
- Major Cities Chiefs Association
- Major County Sheriffs of America
- National Alliance of State Drug Enforcement Agencies
- National Association of Counties
- National Association of County and City Health Officials
- National Association of Emergency Medical Technicians
- National Association of EMS Physicians
- National Association of State EMS Officials
- National Governor's Association
- National HIDTA Directors Association
- National Narcotic Officers' Associations' Coalition
- National Sheriffs' Association
- National Volunteer Fire Council
- Police Executive Research Forum
- Police Foundation

https://www.whitehouse.gov/ondcp/key-issues/fentanyl

A Baby Was Treated With A Nap And A Bottle Of Formula. The Bill Was $18,000.

*By Jenny Gold and Sarah Kliff, Vox*July 9, 2018

Jang Yeo Im plays with her son, Park Jeong Whan, in their family's bedroom. (Jun Michael Park for Vox)

On the first morning of Jang Yeo Im's vacation to San Francisco in 2016, her 8-month-old son, Park Jeong Whan, fell off the bed in the family's hotel room and hit his head.

There was no blood, but the baby was inconsolable. Jang and her husband worried he might have an injury they couldn't see, so they called 911, and an ambulance took the family — tourists from South Korea — to Zuckerberg San Francisco General Hospital (SFGH).

The doctors at the hospital quickly determined that baby Jeong Whan was fine — just a little bruising on his nose and forehead. He took a short nap in his mother's arms, drank some infant formula and was discharged a few hours later with a clean bill of health. The family continued their vacation, and the incident was quickly forgotten.

Two years later, the bill finally arrived at their home: They owed the hospital $18,836 for a visit lasting three hours and 22 minutes, the bulk of which was for a mysterious fee for $15,666 labeled "trauma activation," also known as "a trauma response fee."

A photo of Park Jeong Whan at Zuckerberg San Francisco General Hospital after his admission shows bruise marks on the forehead and nose from his fall. (Jun Michael Park for Vox)

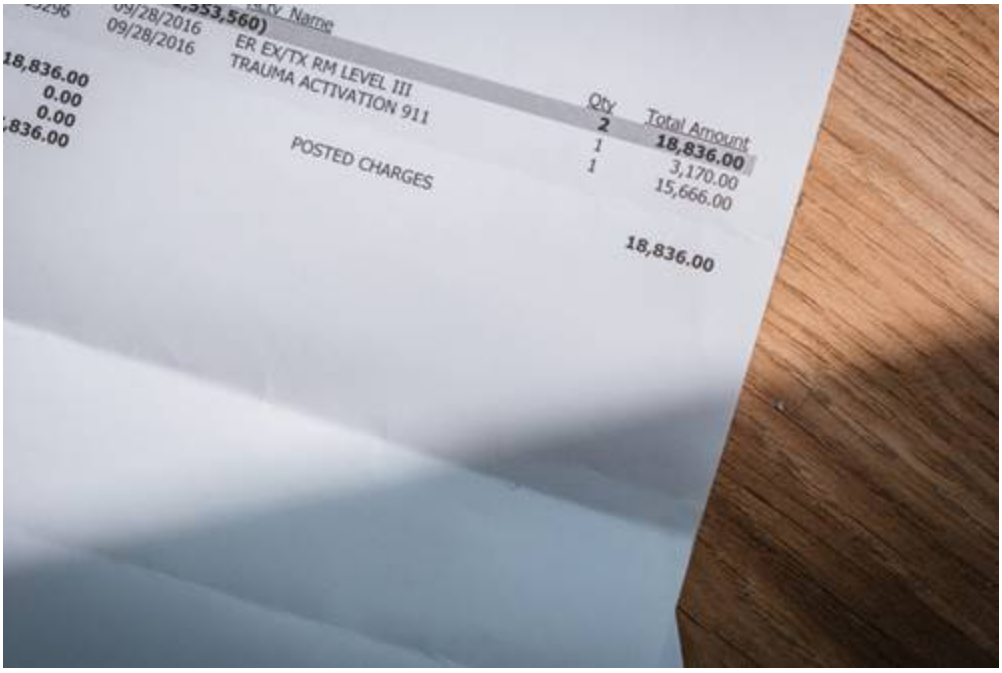
“It’s a huge amount of money for my family,” said Jang, whose family had travel insurance that would cover only $5,000. “If my baby got special treatment, OK. That would be OK. But he didn’t. So why should I have to pay the bill? They did nothing for my son.”

American hospital bills are today littered with multiplying fees, many of which don’t even exist in other countries: fees for blood draws, fees for checking the blood oxygen level with a skin probe, fees for putting on a cast, minute-by-minute fees for lying in the recovery room.

But perhaps the pinnacle is the “trauma fee,” in part because it often runs more than $10,000 and in part because it seems to be applied so arbitrarily.

A trauma fee is the price a trauma center charges when it activates and assembles a team of medical professionals that can meet a patient with potentially serious injuries in the ER. It is billed on top of the hospital’s emergency room physician charge and procedures, equipment and facility fees.

Emergency room bills collected by Vox and Kaiser Health News show that trauma fees are expensive and vary widely from one hospital to another.



The medical bill for $18,836 from Zuckerberg San Francisco General Hospital. (Jun Michael Park for Vox)

Charges ranged from $1,112 at a hospital in Missouri to $50,659 at a hospital in California, according to Medliminal, a company that helps insurers and employers around the country identify medical billing errors.

“It’s like the Wild West. Any trauma center can decide what their activation fee is,” says Dr. Renee Hsia, director of health policy studies in the emergency medicine department at the University of California-San Francisco.

Hsia is also an emergency medicine doctor at Zuckerberg San Francisco General Hospital, but was not involved in the care of the patients discussed in the story — and spoke about the fees generally.

Comprehensive data from the Health Care Cost Institute shows that the average price that health insurers paid hospitals for trauma response (which is often lower than what the hospital charges) was $3,968 in 2016. But hospitals in the lowest 10 percent of prices received an average of $725 — while hospitals in the most expensive 10 percent were paid $13,525.

Data from Amino, a health cost transparency company, shows the same trend. On average, Medicare pays just $957.50 for the fee.

According to Medicare guidelines, the fee can be charged only when the patient receives at least 30 minutes of critical care provided by a trauma team — but hospitals do not appear to be following that rule when billing non-Medicare patients.

At the turn of the century such fees didn’t even exist.

But today many insurers willingly pay them, albeit at negotiated rates for hospitals in their networks. Six insurers and industry groups declined to discuss the fees, and a spokeswoman

for America's Health Insurance Plans, the industry trade group, said, "We have not seen any concerning trends surrounding trauma center fees."

Trauma centers argue that these fees are necessary to train and maintain a full roster of trauma doctors, from surgeons to anesthesiologists, on-call and able to respond to medical emergencies at all times.

SFGH spokesman Brent Andrew defended the hospital's fee of over $15,000 even though the baby didn't require those services.

"We are the trauma center for a very large, very densely populated area. We deal with so many traumas in this city — car accidents, mass shootings, multiple vehicle collisions," said Andrew. "It's expensive to prepare for that."

At What Cost Trauma?

Experts who've studied trauma fees say that at some hospitals there's little rationale behind how hospitals calculate the charge and when the fee is billed. But, of course, those decisions have tremendous financial implications.

After Alexa Sulvetta, a 30-year-old nurse, broke her ankle while rock climbing at a San Francisco gym in January, she faced an out-of-pocket bill of $31,250 bill.

An ambulance also brought Sulvetta to Zuckerberg San Francisco General Hospital, where, she recalled, "my foot was twisted sideways. I had been given morphine in the ambulance."

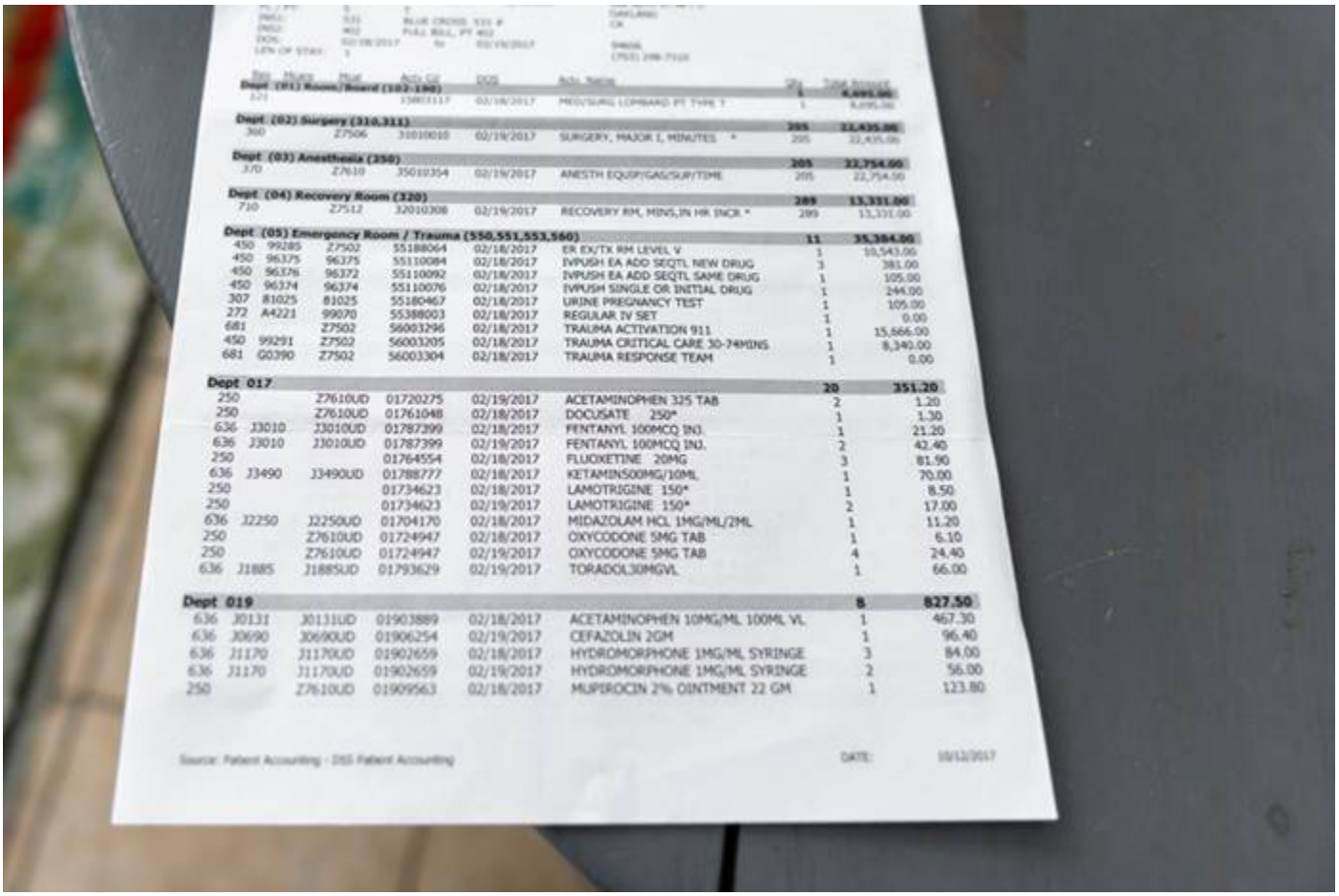
Sulvetta was evaluated by an emergency medicine doctor and sent for emergency surgery. She was discharged the next day.

Alexa Sulvetta and her husband, Ben Verley, at their home in Oakland, Calif. (Heidi de Marco/California Healthline)

SFGH also charged Sulvetta a $15,666 trauma response fee, a hefty chunk of her $113,338 bill. Her insurance decided that the hospital fees for the one-day stay were too high, and — after negotiations — agreed to pay only a charge it deemed reasonable. The hospital then went after Sulvetta for $31,250.

“My husband and I were starting to think about buying a house, but we keep putting that off because we might need to use our life savings to pay this bill,” she said.

SFGH spokesman Andrew, meanwhile, said that the hospital is justified in pursuing the bill. “It’s fairly typical for us to pursue patients when there are unpaid balances,” he said. “This is not an uncommon thing.”



Dept (01) Room/Board (102-190)							1	6,695.00
Dept (02) Surgery (310,311)							205	22,435.00
360		Z7506	31010010	02/19/2017	SURGERY, MAJOR I, MINUTES *		205	22,435.00
Dept (03) Anesthesia (250)							205	22,754.00
370		Z7610	35010354	02/19/2017	ANESTH EQUIP/GAS/SUP/TIME		205	22,754.00
Dept (04) Recovery Room (320)							289	13,331.00
710		Z7512	32010308	02/19/2017	RECOVERY RM, MINS,1N HR INCR *		289	13,331.00
Dept (05) Emergency Room / Trauma (550,551,553,560)							11	35,384.00
450	99285	Z7502	55188064	02/18/2017	ER EX/TX RM LEVEL V		1	10,543.00
450	96375	96375	55110084	02/18/2017	IVPUSH EA ADD SEQTL NEW DRUG		3	381.00
450	96376	96372	55110092	02/18/2017	IVPUSH EA ADD SEQTL SAME DRUG		1	105.00
450	96374	96374	55110076	02/18/2017	IVPUSH SINGLE OR INITIAL DRUG		1	244.00
307	81025	81025	55180467	02/18/2017	URINE PREGNANCY TEST		1	105.00
272	A4221	99070	55388003	02/18/2017	REGULAR IV SET		1	0.00
681		Z7502	56003296	02/18/2017	TRAUMA ACTIVATION 911		1	15,666.00
450	99291	Z7502	56003205	02/18/2017	TRAUMA CRITICAL CARE 30-74MINS		1	8,340.00
681	G0390	Z7502	56003304	02/18/2017	TRAUMA RESPONSE TEAM		1	0.00
Dept 017							20	351.20
250		Z7610UD	01720275	02/19/2017	ACETAMINOPHEN 325 TAB		2	1.20
250		Z7610UD	01761048	02/18/2017	DOCUSATE 250*		1	1.30
636	J3010	J3010UD	01787399	02/18/2017	FENTANYL 100MCQ INJ.		1	21.20
636	J3010	J3010UD	01787399	02/19/2017	FENTANYL 100MCQ INJ.		2	42.40
250			01764554	02/18/2017	FLUOXETINE 20MG		3	81.90
636	J3490	J3490UD	01788777	02/18/2017	KETAMINS00MG/10ML		1	70.00
250			01734623	02/18/2017	LAMOTRIGINE 150*		1	8.50
250			01734623	02/19/2017	LAMOTRIGINE 150*		2	17.00
636	J2250	J2250UD	01704170	02/18/2017	MIDAZOLAM HCL 1MG/ML/2ML		1	11.20
250		Z7610UD	01724947	02/18/2017	OXYCODONE 5MG TAB		1	6.10
250		Z7610UD	01724947	02/19/2017	OXYCODONE 5MG TAB		4	24.40
636	J1885	J1885UD	01793629	02/19/2017	TORADOL30MGVL		1	66.00
Dept 019							8	827.50
636	J0131	J0131UD	01903889	02/18/2017	ACETAMINOPHEN 10MG/ML 100ML VL		1	467.30
636	J0690	J0690UD	01906254	02/19/2017	CEFAZOLIN 2GM		1	96.40
636	J1170	J1170UD	01902659	02/18/2017	HYDROMORPHONE 1MG/ML SYRINGE		3	84.00
636	J1170	J1170UD	01902659	02/19/2017	HYDROMORPHONE 1MG/ML SYRINGE		2	56.00
250		Z7610UD	01909563	02/18/2017	MUPIROCIN 2% OINTMENT 22 GM		1	123.80

Alexa Sulvetta’s hospital bill includes a trauma activation fee. (Heidi de Marco/California Healthline)

‘I Feel Like I Created A Monster’

Trauma response fees were first approved by the National Uniform Billing Committee in January 2002, following a push by a national consulting firm specializing in trauma care. The high costs of staffing a trauma team available at all hours, the firm argued, threatened to shut down trauma centers across the country.

Trauma centers require special certification to provide emergency care for patients suffering very serious injuries above and beyond a regular emergency department.

“We were keeping an ongoing list of trauma centers that were closing all over the country,” said Connie Potter, who was executive director of the firm that succeeded in getting the fee approved. She now consults with hospital trauma centers on how to bill appropriately.

Trauma teams are activated by medics in the field, who radio the hospital to announce they are arriving with a trauma patient. The physician or nurse who receives the call then decides whether a full or partial trauma team is needed, which results in different fees. Potter said that person can also activate the trauma team based on the consultation with the EMTs.

But reports from the field are often fragmentary and there is much discretion in when to alert the trauma team.

An alert means paging a wide range of medical staff to stand at the ready, which may include a trauma surgeon, who may not be in the hospital.

Potter said if the patient arrives and does not require at least 30 minutes of critical care, the trauma center is supposed to downgrade the fee to a regular emergency room visit and bill at a lower rate, but many do not do so.

Hospitals were supposed to come up with the fee for this service by looking at the actual costs of activating the trauma team, and then dividing it over the amount that their patients are likely to pay. Hospitals that see a lot of uninsured and Medicaid patients might charge more to patients with private insurance to make up for possible losses.

But soon, Potter said, some hospitals began abusing the fee by charging an exorbitant amount that seemed to be based on the whims of executives rather than actual costs.

“To a degree, I feel like I created a monster,” Potter said. “Some hospitals are turning this into a cash cow on the backs of patients.”

The $15,666 is San Francisco General’s low-level trauma response fee. The high-level response fee in which the trauma surgeon is called into action is $30,206. The hospital would not provide a breakdown of how these fees are calculated.

Unfortunately, outside of Medicare and state hospitals, regulators have little sway over how much is charged. And at public hospitals, such fees may be a way to balance government budgets. At SFGH, the $30,206 higher-level trauma response fee, which increased by about $2,000 last year, was approved by the San Francisco Board of Supervisors.

An Ibuprofen, Two Medical Staples — And A $26,998 Bill

Some patients question whether their particular cases ought to include a trauma fee at all — and experts think they’re right to do so.

Sam Hausen, 28, was charged a $22,550 trauma response fee for his visit to Queen of the Valley Medical Center in Napa, Calif., in January.

An ambulance brought him to the Level 3 trauma center after a minor motorcycle accident, when he took a turn too quickly and fell from his bike. Records show that he was alert with normal vital signs during the 4-mile ambulance ride, and that the ambulance staff alerted the hospital that the incoming patient had traumatic injuries.

He was at the hospital for only about half an hour for a minor cut on his head, and he didn't even need X-rays, CAT scans or a blood test.

Sam Hausen was charged a $22,550 trauma response fee for his visit to Queen of the Valley Medical Center in Napa, Calif., after a motorcycle accident. (Heidi de Marco/California Healthline)

"The only things I got were ibuprofen, two staples and a saline injection. Those were the only services rendered. I was conscious and lucid for the whole thing," said Hausen.

But because the ambulance medics called for a trauma team, the total for the visit came to $26,998 — and the vast majority of that was the $22,550 trauma response fee.

Queen of the Valley Medical Center defended the charge. "Trauma team activation does not mean every patient will consult with and/or be cared for by a trauma surgeon," spokeswoman Vanessa deGier said over email. "The activation engages a team of medical professionals. Which professional assesses and cares for a trauma patient depends on the needs and injury/illness of the patient."

Guidelines for trauma activation are written broadly on purpose, in order to make sure they don't miss any emergencies that could otherwise kill patients, said Dr. Daniel Margulies, a trauma surgeon at Cedars-Sinai in Los Angeles and chair of the American College of Surgeons committee on trauma center verification and review. Internal injuries, for example, can be difficult to diagnose at the scene of an accident.

"If you had someone who needed a trauma team and didn't get called, they could die," he said.

Medics err on the side of caution when calling in trauma patients to avoid missing a true emergency. To that end, the American College of Surgeons says it is acceptable to "overtriage," summoning the trauma team for 25-35 percent of patients who don't end up needing it.

But that logic leaves health consumers like Jang, Sulvetta and Hausen with tens of thousands in potential debt for care they didn't ask for or need, care that is ordered out of an abundance of caution — a judgment call by an ambulance worker, a triage nurse or a physician — based on scant information received over a phone.

Jeong Whan had fallen 3 feet from a hotel bed onto a carpeted floor when his nervous parents summoned an ambulance. By the time the EMTs arrived, Jeong Whan was "crawling on the bed, not appearing to be in any distress," according to the ambulance records. The EMTs called SFGH and, after a consultation with a physician, transported Jeong Whan as a trauma patient, likely because of the baby's young age.

At the hospital, Jeong Whan was evaluated briefly by a triage nurse and sent to an emergency department resuscitation bay.

Jang recalls being greeted by nine or 10 providers at the hospital, but the baby's medical records from the visit do not mention a trauma team being present, according to Teresa Brown of Medliminal, who reviewed the case.

The baby appeared to have no signs of major injury, and no critical care was required. Five minutes later, the family was transferred to an exam room for observation before being released a few hours later. Brown said she would dispute the $15,666 trauma response fee because the family does not appear to have received 30 minutes of critical care from a trauma team.

Jang currently has a patient advocate working on her behalf to try to negotiate the bill with the hospital. She said she fears that the pending medical debt could prevent her from getting a visa to visit New York and Chicago, which she hopes to do in the next few years.

She said her experience with the U.S. health care system and its fees has been shocking. "I like the USA. There are many things to see when traveling," she said. "But the health care system in USA was very bad."

This story was produced in collaboration with Vox, which is collecting emergency room bills as part of a year-long project focused on American health care prices.

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By Renee Y. Hsia, Nandita Sarkar, and Yu-Chu Shen

Is Inpatient Volume Or Emergency Department Crowding A Greater Driver Of Ambulance Diversion?

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NO. 7 (2018): 1115–1122

ABSTRACT **Inpatient volume has long been believed to be a contributing factor to ambulance diversion, which can lead to delayed treatment and poorer outcomes. We examined the extent to which both daily inpatient and emergency department (ED) volumes at specified hospitals, and diversion levels (that is, the number of hours ambulances were diverted on a given day) at their nearest neighboring hospitals, were associated with diversion levels in the period 2005–12. We found that a 10 percent increase in patient volume was associated with a sevenfold greater increase in diversion hours when the volume increase occurred among inpatients (5 percent) versus ED visitors (0.7 percent). When the next-closest ED experienced mild, moderate, or severe diversion, the study hospital's diversion hours increased by 8 percent, 23 percent, and 44 percent, respectively. These findings suggest that efforts focused on managing inpatient volume and flow might reduce diversion more effectively than interventions focused only on ED dynamics.**

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When an emergency department (ED) does not have the capacity to take on more patients, it must close its doors to incoming ambulances. This phenomenon, known as diversion, means that ambulances must drive to the next available ED, which increases the time required to reach the ED. This potentially delays ambulance turnaround[1] and treatment of patients,[2] increases both short- and long-term patient mortality rates by up to 10 percent,[3,4] and results in lost hospital revenues[5] and in higher patient medical costs from increased need for more-intensive treatment that otherwise would have been unnecessary.[6] Inpatient volume has long been anecdotally cited by physicians as a main contributing factor to crowding in the ED and the subsequent triggering of diversion.[7–11] Identifying whether inpatient volume is associated with diversion could prove critically important to formulating more effective interventions to decrease diversion, since many current interventions focus on ED dynamics rather than overall hospital systems and resources.[12,13]

Previous studies that examined the relationship between patient volume and ED diversion used average or annual volumes instead of daily volumes[14] or limited sample sizes[15–17] or were based on simulations[18]—design features that limit their ability to accurately quantify the association between diversion and patient volume. While some of the literature describes the relationship between inpatient boarding and ambulance diversion,[19–21] most studies that cite the contribution of inpatient boarding, volume, or both to diversion are based on cross-sectional surveys or anecdotal reports.[7,8,22–25] Quantifying the empirical relationship between diversion and both daily inpatient and ED volumes is critical to identifying where bottlenecks occur—specifically, whether diversion is more sensitive to input factors such as demand for ED care, or to output factors such as lack of available staffed

inpatient beds.[24] Furthermore, it is important to know whether the volume-diversion relationships are magnified in "high-occupancy" hospitals with fewer available beds—which is possible given that high occupancy has been associated with crowding and increased lengths of stay for ED patients[26]—and how these relationships change if there is another hospital with an ED within a ten-minute drive.

The primary goal of our work was to determine whether inpatient volume is a bigger driver of ambulance diversion than ED volume is. To this end, we used a combination of large data sets containing information about daily inpatient and ED volumes and diversion hours in California to longitudinally investigate how diversion hours fluctuate with a hospital's inpatient and ED volumes and with the level of crowding experienced by a hospital's next-closest ("nearby") ED, as measured by diversion level (that is, the number of hours in which ambulances were diverted on a given day); and whether the relationships between both inpatient and ED volumes and diversion hours differ by a hospital's occupancy rate and by whether there was another ED within a ten-minute drive (in "close proximity"). We hypothesized that there was a strong positive association between the number of diversion hours a hospital experienced and both its own patient volumes and nearby-ED diversion level. We expected the association to be stronger for hospitals with high occupancy rates but weaker for hospitals with a close-proximity ED.

Study Data And Methods

DATA We extracted daily diversion data from ambulance diversion logs maintained by all seventeen local emergency medical services agencies (LEMSAs) in California that did not ban ambulance diversion during the study period (2005–12). We excluded the following counties from the analysis because they banned diversion: Inyo (as of January 2009), Imperial (as of August 2009), and Riverside (as of March 2008). Some LEMSAs were not able to provide daily diversion data, including those in rural areas. Roughly 88 percent of the population in California lived in areas in our analytical sample.

We constructed daily volume information using patient-level data and hospital occupancy information from the Hospital Annual Utilization Data obtained from the California Office of Statewide Health Planning and Development.[27] The nonpublic inpatient and ED discharge data and vital statistics contained information on all inpatient admissions and ED visits from every nonfederal, general, acute care hospital in California in the period 2005–12.

Daily inpatient volume included all inpatients at each hospital in the data source, regardless of source of admission (direct inpatient admission or admission from the ED), because once a patient is under inpatient care, they effectively reduce the resources available during the inpatient stay (which could include days with no diversion). Often, an ED may reach capacity because it boards inpatients when inpatient beds are unavailable or transfer to other facilities is delayed.[21,28] Daily ED volume included all patients either discharged from an ED after treatment (that is, "treat-and-release patients") or admitted to a hospital from an ED.

STUDY DESIGN Our empirical analysis included two sets of key independent variables. The first was daily patient volume, which allowed us to examine the correlations (and sizes of the effect) between the number of diversion hours experienced and a hospital's inpatient and ED volume. The second was diversion levels experienced by a hospital's nearby ED, which allowed us to analyze how a hospital's diversion hours were affected by diversion levels at nearby hospitals ("spillover effects"). We identified nearby EDs using automated Google Maps queries[29] based on longitude and latitude information from each hospital's physical address or heliport.[30] As was done in previous literature,[4,6] we classified nearby EDs' diversion levels into four categories based on the total hours of diversion experienced on a given day: zero hours, less than six hours (mild), six to less than twelve hours (moderate), and twelve hours or more (severe).

We used unique hospital identification numbers to link the above information with additional hospital characteristics obtained from the American Hospital Association Annual Survey and the Healthcare Cost Report Information System, including ownership type, teaching status, system membership, total number of beds, occupancy rates, and market competition (defined by the Herfindahl-Hirschman Index, which is commonly used to measure market concentration in the hospital industry).

The University of California San Francisco Institutional Review Board approved this study.

STATISTICAL ANALYSIS We used hospital days as our unit of analysis and compared daily patient volumes on days when hospitals did and did not experience diversion. We used a multivariate fixed-effects linear regression model, which took into account the nested days within each hospital and the unobserved heterogeneity across hospitals, to explore the relationship between patient volumes and diversion. For our main results, we estimated two models. The first explored the "extensive margin," with the sample containing all hospital days and the dependent variable in-

dicating whether or not a hospital had any diversion hours on a given day (a binary indicator). The second model explored the intensity of the relationship between volume and diversion, with the sample containing only hospital days with nonzero positive diversion hours and the dependent variable being log-transformed daily diversion hours.

Our first model included hospital fixed effects to remove baseline differences, such as those in the underlying patient population and across hospitals. This approach is equivalent to the case-crossover design, in which a hospital serves as its own control in comparisons of fluctuations in diversion hours due to changes in patient volume. The model also included time-varying hospital characteristics—indicators for year, month, and day of the week—to capture macro trends (that is, normal fluctuations in diversion hours over time not related to patient volume). In the second model, for ease of interpretation, we log-transformed the dependent variable (daily diversion hours) so that coefficients for inpatient and ED volumes could be interpreted as percentage changes. Our five key variables of interest included log-transformed inpatient and ED volumes and three indicators for nearby-ED diversion level, with "no diversion" as the reference group. We performed all analyses using Stata, version 14.

The first model had advantages over traditional hierarchical models for our analysis because it removed unobserved time-invariant differences across hospitals; doing so was critical to our estimation—that is, the hospital fixed effects approach allowed us to rule out the possibility that the relationship we observed between patient volume and diversion was due to managerial style or care culture in a given hospital. Hierarchical models, in contrast, would assume that hospital-level variation followed a random-effects model and would not be able to remove the unobserved differences across hospitals, such as underlying managerial style or general health of the patient population.[31]

We estimated two additional interaction models, stratified by whether the hospital was high occupancy and whether there was a close-proximity ED, to explore how the association between key independent variables and diversion hours varied between these classifications. We classified a hospital as "high occupancy" if it had a mean annual occupancy rate greater than 65 percent (the median in our sample) and "low occupancy" otherwise. We defined close-proximity EDs, as previously stated, as those within a ten-minute drive. The reference hospitals for the first and second interaction models were low-occupancy hospitals and hospitals without another ED within its proximity (that is, within a ten-minute drive), respectively. We added interaction terms between the indicators for each stratification (occupancy and proximity of next-closest ED) and the five key independent variables included in our main model.

LIMITATIONS Our study had several limitations. First, hospitals self-reported the occupancy rates used in our study, and there could be discrepancies between numbers of staffed versus licensed beds. Because data from the Office of Statewide Health Planning and Development report licensed beds rather than staffed beds, occupancy rates in our study could be underestimates.

Second, there could be some measurement error or reporting bias in self-reported diversion data. However, the potential errors are likely minimal, as we obtained the diversion data directly from EMS online reporting systems, and in all counties, hospitals on diversion notify a base hospital (a hospital designated by the local EMS agency to provide medical direction and supervision to prehospital personnel), and the time and date of each diversion episode is automatically logged into the system. In addition, we found a high degree of concurrence when we compared aggregated daily data to yearly levels of diversion using several years of our diversion data and the data reported to the state (not shown).

Third, we did not investigate the underlying reasons for each diversion episode. In California, local EMS agencies provide guidance to hospitals regarding diversion policies.[32,33] Most local EMS agencies have similar reasons for diversion (for example, ED saturation, internal disruptions such as when a fire or bomb threat causes a facility to shut down, or unavailability of critical equipment). However, in general, there are no specific thresholds for the number of inpatients or ED patients that will trigger diversion. The unobserved variation in specific reasons triggering diversion may make our estimates less precise.

Fourth, while fixed effects remove unobserved time-invariant differences across EDs, there may be unobserved time-varying hospital characteristics associated with hospital overcrowding and diversion that were not captured in the data. However, our results were robust when we used hierarchical models.

Fifth, we included all inpatients and ED patients, who have a wide range of conditions with varying levels of acuity, and patient case-mix (that is, the severity of illness across patients) may vary from hospital to hospital. However, our fixed-effects models ensured that we identified the estimated relationship between patient vol-

ume and diversion using hospitals as their own case controls, so our results were not driven by differences in the underlying patient population across hospitals.

Lastly, because some LEMSAs were not able to provide daily diversion data, our data contained information only about urban areas in California, and although 12 percent of the US population resides in California, our results might not be generalizable to the rest of the country—especially not to rural areas.

Study Results

Our sample contained information on 248,128 hospital days, representing 208 hospitals in California that reported having a diversion on at least one day in the period 2005–12. Hospitals reported diversions on 81,802 days, or 33 percent of all hospital days. We generated daily patient volumes from 5,875,979 inpatient stays and 18,784,196 "treat-and-release" patients. The average hospital treated approximately 133 inpatients and 81 ED patients per day (exhibit 1). Forty-six percent of the hospitals encompassed by our data were small, with fewer than 200 beds.

EXHIBIT 1

Descriptive hospital characteristics, based on hospital-day sample

	Mean	Percent	SD
Daily patient volume per hospital			
Inpatient	133.21		87.40
Emergency department	81.27		41.60
Control variables included in multivariate models			
Ownership type			
For profit		20.06	
Non-profit		62.00	
Government owned		17.94	
Teaching status			
Teaching hospital		13.70	
Non-teaching hospital		86.30	
Hospital size (number of beds)			
<100		12.26	
100–199		33.82	
200–299		30.33	
≥300		23.59	
Part of a system		72.59	
Case-mix index	1.46		0.21
Occupancy rate	0.64		0.15
Herfindahl-Hirschman Index	0.16		0.15
Mean wage index	1.32		0.18
Mean share of Medicare	0.26		0.14

SOURCES Authors' analysis of data from the California Office of Statewide Health Planning and Development, American Hospital Association Annual Survey, Healthcare Provider Cost Reporting Information System, and daily ambulance diversion logs of all seventeen local emergency medical services agencies (LEMSAs) in California that did not ban ambulance diversion during the study period. **NOTES** $N = 248{,}128$ hospital days. SD is standard deviation.

Twenty percent were for profit, 18 percent were government owned, and 14 percent were teaching hospitals.

Average daily inpatient volumes across the entire sample were consistently higher on days with diversion (mean: 161 patients) compared to days without (mean: 105) during the study period (exhibit 2). Similarly, daily ED volumes were higher on days with diversion (mean: 87) compared to days without (mean: 70). The only exception was between January and September of 2012, when average daily ED volumes were similar on days with and without diversion. We compared trends for inpatient and ED volume, each with and without diversion, using the nonparametric Kolmogorov-Smirnov test for equality of distribution, and we found that the trends for inpatient and ED volume did not follow the same distribution ($p < 0.0001$). In other words, daily patient volume trends in days with and days without diversion were significantly different from each other.

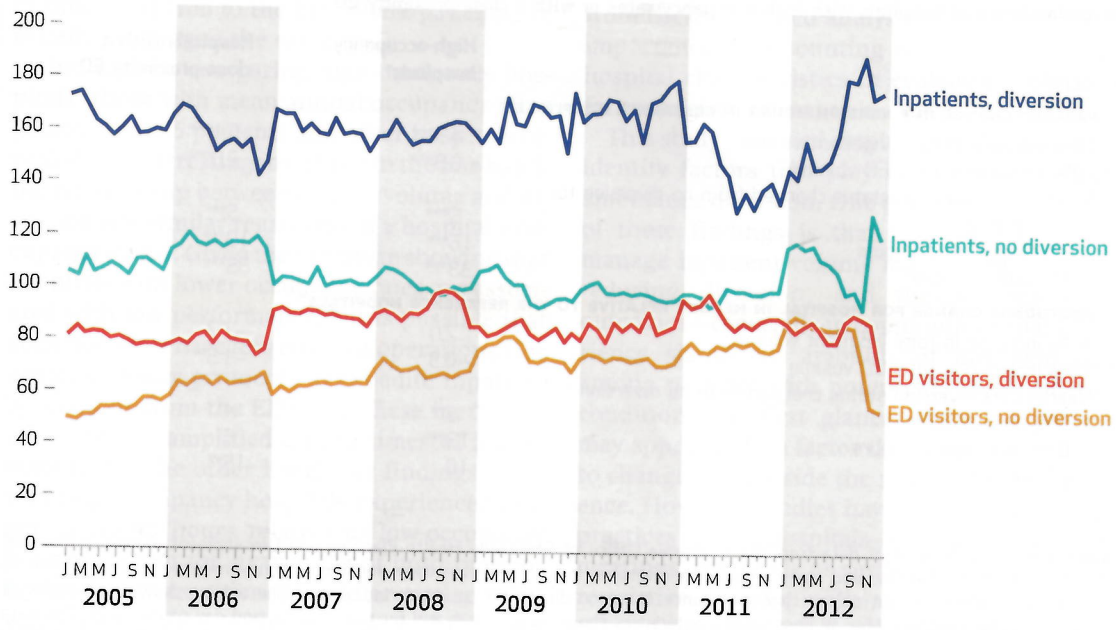
MAIN RESULTS The first column of exhibit 3 shows the results of the "extensive margin," where we examined whether a hospital goes on diversion at all. For every 10 percent increase in inpatient or ED volume, the probability of diversion occurring on a given day increased by 0.9 percentage point (95% confidence interval: 0.2, 1.6) and 1.0 percentage point (95% CI: 0.7, 1.4), respectively. (Full results are available in online appendix exhibit A1.)[34] To put this into perspective, diversion occurred in 33 percent of hospital days, so a 1.0-percentage-point increase is equivalent to a 3 percent increase in the probability of having a diversion. The probability that a hospital experienced any diversion also increased proportionally with the amount of diversion experienced by its nearby ED, rising 10 percentage points (95% CI: 8, 12) when the nearby ED experienced mild diversion, 19 percentage points (95% CI: 15, 22) when the diversion was moderate, and 21 percentage points (95% CI: 17, 25) when it was severe.

If a diversion occurred, a 10 percent increase in inpatient volume was associated with a 5 percent increase in diversion hours (95% CI: 3.8, 6.3), while a 10 percent increase in ED volume was associated with a 0.7 percent increase (95% CI: 0.2, 1.2). When the nearby ED experienced moderate or severe diversion, the hospital experienced a 23 percent (95% CI: 18, 27) and 44 percent (95% CI: 37, 51) increase in diversion hours, respectively. However, when the nearby ED experienced only mild diversion, compared to days with no diversion, there was only an 8 percent (95% CI: 5, 11) increase. (Full results are in appendix exhibit A2.)[34]

RESULTS FROM INTERACTION MODELS Exhibit 4

EXHIBIT 2

Numbers of inpatients and emergency department (ED) visitors, by hospitals' ambulance diversion status, 2005–12



SOURCE Authors' analysis of data from the California Office of Statewide Health Planning and Development and from daily ambulance diversion logs of all seventeen local emergency medical services agencies (LEMSAs) in California that did not ban ambulance diversion during the study period.

shows the results of our examination of the intensity of the relationship between patient volume and diversion along two dimensions. First, when we stratified the analysis by hospital occupancy rate, the relationships between patient volume (both inpatient and ED) and diversion were statistically similar between high- and low-occupancy hospitals. However, high-occupancy hospitals experienced longer diversion hours compared to low-occupancy hospitals when a nearby ED was also on diversion. Specifically, compared to days when a nearby ED experienced no diversion, during days when it experienced mild or moderate diversion, high-occupancy hospitals had an additional 6 percent (95% CI: 0, 11) and 13 percent (95% CI: 4, 21) increase in

EXHIBIT 3

Effects of changes in inpatient and emergency department (ED) volume and ambulance diversion status of nearby ED on hospital ambulance diversion hours

	Percentage-point change in probability that a hospital is on ambulance diversion on a given day[a]	Percent change in diversion hours[b]
10% increase in inpatient volume	0.9**	5.0***
10% increase in ED volume	1.0***	0.7***
Nearby ED's diversion status changed from no diversion to diversion of:		
Less than 6 hours	10***	8***
6 to less than 12 hours	19***	23***
12 hours or more	21***	44***

SOURCE Authors' analysis of data from the California Office of Statewide Health Planning and Development and from daily ambulance diversion logs of all seventeen local emergency medical services agencies (LEMSAs) in California that did not ban ambulance diversion during the study period. **NOTES** The exhibit shows the results of regressions that controlled for all hospital characteristics shown in exhibit 1 and for year, month, and day of the week. The data are only for the 33 percent of all hospital days when hospitals experienced ambulance diversion (that is, 81,802 of 248,128 hospital days). Full results are in appendix exhibits A1 and A2 (see note 34 in text). [a]Dependent variable: whether a hospital day has nonzero positive diversion hours. The sample is all 248,128 hospital days. [b]Dependent variable: diversion hours, log-transformed. The sample is 81,802 hospital days with positive diversion hours. **$p < 0.05$ ***$p < 0.01$

EXHIBIT 4

Effects of inpatient and emergency department (ED) volume and ambulance diversion status of nearby ED on ambulance diversion hours at hospitals with high occupancy rates or with a close-proximity ED

	High-occupancy hospitals[a]	Hospitals with a close-proximity ED
PERCENT CHANGE IN DIVERSION HOURS IN REFERENCE HOSPITALS[b]		
10% increase in total inpatient volume	4.3***	6.1***
10% increase in total ED volume	0.8***	2.0***
Nearby ED's diversion status changed from no diversion to:		
Less than 6 hours	5***	5***
6 to less than 12 hours	16***	19***
12 hours or more	38***	35***
ADDITIONAL CHANGE FOR HOSPITAL IN HEADER RELATIVE TO THE REFERENCE HOSPITALS[b]		
10% increase in total inpatient volume	2.0	−1.7
10% increase in total ED volume	−0.3	−1.5***
Nearby ED's diversion status changed from no diversion to:		
Less than 6 hours	6**	4
6 to less than 12 hours	13***	6
12 hours or more	10	15**

SOURCE Authors' analysis of data from the California Office of Statewide Health Planning and Development, American Hospital Association Annual Survey, and daily ambulance diversion logs of all seventeen local emergency medical services agencies (LEMSAs) in California that did not ban ambulance diversion during the study period. **NOTES** The exhibit shows the results of regressions that controlled for all hospital characteristics shown in exhibit 1 and for year, month, and day of the week. The data are for the 81,802 days when hospitals experienced ambulance diversion. Full results are in appendix exhibit A2 (see note 34 in text). A "nearby" ED is one in a hospital that is nearest geographically to the hospital in question. A "close-proximity" ED is one within a ten-minute drive of the hospital in question. [a]Hospitals with a mean annual occupancy rate higher than 65 percent (the median in our sample). [b]Reference hospitals for the first column are low-occupancy hospitals; reference hospitals for the second column are hospitals that did not have an ED within a ten-minute drive. $^{**}p < 0.05$ $^{***}p < 0.01$

diversion hours, respectively.

Second, when we stratified the analysis by the presence of a close-proximity ED, we found that the presence of such an ED can relieve a hospital's diversion burden when its own ED volume is high. Specifically, a 10 percent increase in ED volume was associated with a 2.0 percent increase in diversion hours among hospitals without a close-proximity ED but just 0.5 percent $(2.0 - 1.5 = 0.5)$ among hospitals with such an ED—the 1.5 percentage point difference is statistically significant ($p < 0.05$; 95% CI: −2.7, −0.4). However, when the nearby ED experienced a severe diversion, hospitals with a close-proximity ED had substantially higher diversion hours relative to hospitals without a close-proximity ED: Diversion hours for hospitals with a close-proximity ED rose by an additional 15 percent (95% CI: 2, 27), relative to hospitals without one.

Discussion

Our findings indicate that both inpatient and ED volumes are associated with higher probability of an ED going on diversion. If a hospital experiences a diversion, our findings also show that a 10 percent increase in patient volume is associated with a sevenfold increase in diversion hours when inpatient volume increases, compared to when ED volume increases (5.0 percent versus 0.7 percent). Additionally, nearby-ED diversion may increase a hospital's diversion hours by 8–44 percent.

Theoretically, our findings of associations between both inpatient and ED volume and diversion could be interpreted in two ways. Either increased inpatient volume could cause a backlog of patients in the ED awaiting inpatient admission, who are then boarded in the ED, which leads in turn to ED crowding and subsequent diversion, or ED crowding could be a cause of increases in both inpatient volume (through increased admissions) and diversion. The previous literature shows that boarding of nonemergency inpatients is a key contributor to ED crowding and that managing inpatient flow can decrease boarding in the ED—which suggests that the former relationship is more likely to be the case than the latter.[35–37]

Why would inpatient and ED volumes have a similar effect on diversion status in a binary fashion but have such different associations when evaluated conditional on diversion (meaning that inpatient volumes played the much larger role in influencing the amount of diversion)? Given that ED diversion is temporary and can be easily switched on and off, it is likely that high inpatient and ED volumes can prompt administrators to go on diversion temporarily but that

inpatient volumes have a more lasting effect on the duration of a diversion—since it is difficult to create more inpatient capacity in a short amount of time compared to the ED, where patients are usually discharged the same day.

Our analysis comparing high-occupancy hospitals (those with mean annual occupancy rates greater than 65 percent) and other hospitals revealed two interesting insights. On the one hand, the relationship between patient volume and diversion was similar regardless of a hospital's occupancy status. Given the literature showing that hospitals with lower occupancy rates are associated with low performance,[38] it is possible that such hospitals have less efficient operations (for example, fewer protocols to expedite inpatient admissions from the ED), and these inefficiencies could be amplified during times of higher volume. On the other hand, our findings show that high-occupancy hospitals experienced longer diversion hours relative to low-occupancy hospitals when the nearby ED of both types of hospitals also experienced mild or moderate diversion (less than twelve hours), and that two EDs within close proximity can influence each other's diversion status. Although having a close-proximity ED can relieve a hospital's burden when its own ED is on diversion, all else being equal, when the nearby ED experiences a prolonged diversion, it significantly increases the diversion hours (by another 15 percent) of its close-proximity ED. These findings could either illustrate that there is a domino effect or be a result of preemptive or defensive diversion.[39] They could also simply reflect the fact that all EDs within a certain proximity are likely affected by similar factors (for example, the time of day, referral practices, and flu season). Our findings from these stratified analyses shed light on the importance of accounting for community and hospital characteristics in evaluating solutions for managing patient volume.

This study provided empirical evidence to help identify factors that play a significant role in ambulance diversion. One potential implication of these findings is that initiatives to better manage inpatient volume may be important in reducing diversion, and thereby improving outcomes—especially in communities that experience significant amounts of diversion and among patients with potentially time-sensitive conditions. At first glance, inpatient volume may appear to be a factor that would be difficult to change and outside the scope of policy influence. However, studies have shown that certain practices within hospitals (such as bed control meetings, bed crisis or surge models, and more restrictive diversion policies) could result in decreased time on diversion[33,40] but have not been widely adopted.[41] Other possibilities include better use of licensed beds: The literature shows that a significant proportion of these beds are often not staffed (these are sometimes known as "phantom beds"), which decreases the number of beds that can actually be used.[42] Taken together with other literature, our findings suggest that addressing systemwide hospital factors to better manage inpatient volume could have a larger effect on reducing time on diversion, compared with initiatives focused solely on the ED. ■

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By Jonathan Yun, Kathryn Oehlman, and Michael Johansen

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DATAWATCH

Per Visit Emergency Department Expenditures By Insurance Type, 1996–2015

Between 1996 and 2015, mean annual increases in per visit emergency department (ED) expenditures were significantly greater for private insurance than Medicare, Medicaid, and no insurance, with no corresponding difference in ED charges. Expenditures as a proportion of charges decreased for all insurers over time. Private insurance had the highest expenditure-to-charge ratio in each year.

Emergency department (ED) spending in the United States has increased at a faster rate than overall health care spending over the past twenty years.[1,2] However, it is unknown whether these increases differ among visits paid for by public and private insurers. Previous research has shown a widening gap between rates paid for inpatient care by private and public payers.[3] With ED expenditures accounting for an increasing proportion of health care spending,[2,4] determining whether growth in payment rates for ED services is also greater for private and public payers could inform policy debates about rising health care spending more broadly.

Using data for the period 1996–2015 from the Medical Expenditure Panel Survey (MEPS), we

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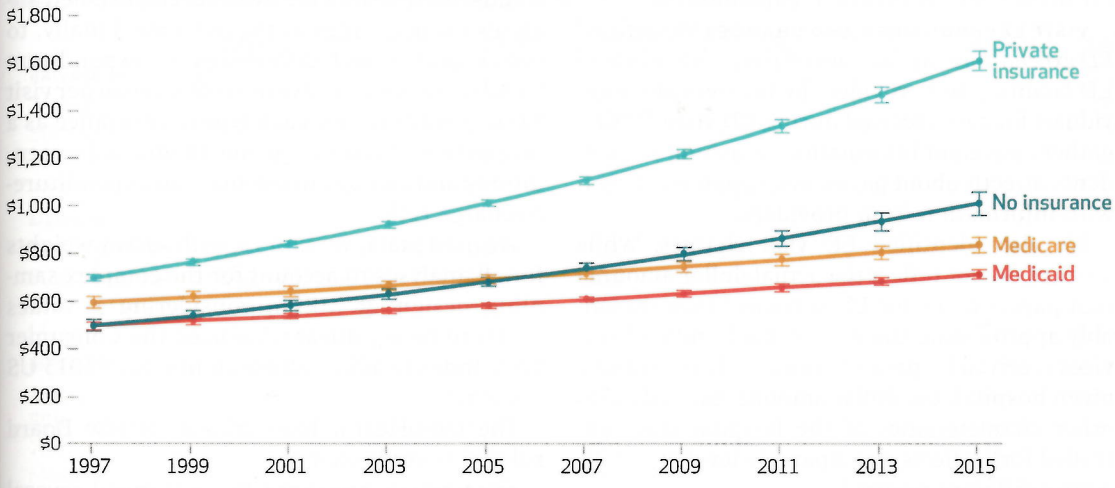
EXHIBIT 1

Mean per visit emergency department (ED) expenditures, by type of insurance, 1997–2015



SOURCE Authors' analysis of data for 1997–2015 from the Medical Expenditure Panel Survey. **NOTES** There were 114,736 ED visits. A generalized linear model with a gamma distribution and a log link function followed by postprediction average marginal effects was used to predict expenditures. The mean annual increase in per visit ED spending or slope was $50.59 for private insurance (95% percent confidence interval: 45.59, 55.59), $17.66 for Medicare (95% CI: 11.89, 23.43), $9.51 for Medicaid (95% CI: 7.14, 11.88), and $26.86 for no insurance (95% CI: 20.77, 32.94) ($p < 0.001$, for all). The model controlled for sociodemographic variables (age, age squared, sex, race/ethnicity, poverty category, and region [Northeast, Midwest, South, and West]) and several visit-level variables (as detailed in the text) to approximate an average ED visit. Visits assigned to "other insurance" were included in the model, but expenditures for them are not reported here. Appendix A gives a detailed description of how visits were assigned to types of insurance (see note 9 in text). The error bars represent 95% confidence intervals, each of which is symmetrical about its mean expenditure. All expenditures were calculated using survey weights and adjusted to 2015 US dollars using the Consumer Price Index (see note 10 in text). Estimates that support the exhibit and standard errors are in appendix exhibit C1 (see note 9 in text).

found that mean annual per visit ED spending rose during the period for all insurance types (exhibit 1). Private insurance began the period with the highest annual expenditures at $699 and also experienced the greatest mean annual increase at $50.59. Mean annual increases for no insurance, Medicare, and Medicaid were, respectively, $26.86, $17.66, and $9.51 ($p < 0.001$ for all).

We also found that unadjusted mean annual increases in per visit ED charges (that is, billing amounts submitted to payers) were greater for Medicare than private insurance and similar for Medicaid and private insurance. Mean annual per visit expenditures expressed as a proportion of mean per visit charges decreased for all insurance types, with private insurance having the highest expenditure-to-charge ratio every year.

Study Data And Methods

We analyzed ED visit[5] and full-year consolidated data[6] files from MEPS.[1,2] Sponsored by the Agency for Healthcare Research and Quality, the survey gathers sociodemographic and medical care utilization data from a nationally representative sample of noninstitutionalized civilian US adults. MEPS interviews two overlapping panels of 15,000 households five times over two years.

VISIT INCLUSION We analyzed ED visits that did not result in hospitalizations in the period 1996–2015. We excluded ED visits with hospitalizations because MEPS counts facility expenditures for these visits as inpatient expenditures.[7]

VISIT EXPENDITURES AND CHARGES We defined *ED expenditures* as the sum of payments made to ED facilities and providers by insurers and individuals for care received during ED visits. MEPS gathers payment information by asking respondents directly about payments, supplementing it with information from providers.[8]

We also identified ED visit charges. While charges do not reflect the actual dollar amounts that payers make for ED services,[7] they reasonably approximate the cost of the bundle of services received by patients since, at least within a given hospital, the dollar amount charged (with other characteristics of the hospital stay controlled for) reflects a comparable level of service across different payers.[3]

INSURANCE TYPE Each ED visit was matched to a payer (private insurance, Medicare, Medicaid, no insurance, and "other insurance") using the type of insurance with the greatest reported payment, the respondent's reported coverage type, and several other criteria. (See online appendix A for more details about how visits were assigned to payers.)[9]

VISIT-LEVEL VARIABLES We identified magnetic resonance imaging (MRI) or computed tomography (CT) scans, ultrasounds, surgical procedures, labs, x-rays, and electrocardiograms performed in the ED to control for visit intensity. We also identified ED visits that led to hospital admissions, as explained above.

STATISTICAL ANALYSIS We calculated summary statistics for per visit expenditures and determined the proportion of visits paid by each type of insurance for two-year periods from 1996 through 2015. For example, the interval beginning in 2014 included both 2014 and 2015 expenditures. Other outcomes were calculated per year. To determine whether differences existed in per visit ED expenditures over time across payers, we modeled expenditures using two different generalized linear models. Both models had a gamma distribution with a log link function and included a two-factor interaction term between insurance type and survey year. The first model did not adjust for sociodemographic or visit-level variables. The second model controlled for sociodemographic variables (age, age squared, sex, race/ethnicity, poverty category, and region [Northeast, Midwest, South, and West]) and several visit-level variables (MRI/CT scans, ultrasounds, surgical procedures, labs, x-rays, and electrocardiograms).

After running each model, we used postprediction average marginal effects to calculate the annual growth in per visit ED expenditures for different payers.

To contextualize the modeled expenditure trends, we repeated the two abovementioned analyses using charges as the outcome. Finally, to better understand differences in expenditure trends across payers, we measured mean per visit ED expenditures for each type of insurance as a proportion of charges, using unadjusted expenditures and charges to calculate an expenditure-to-charge ratio.

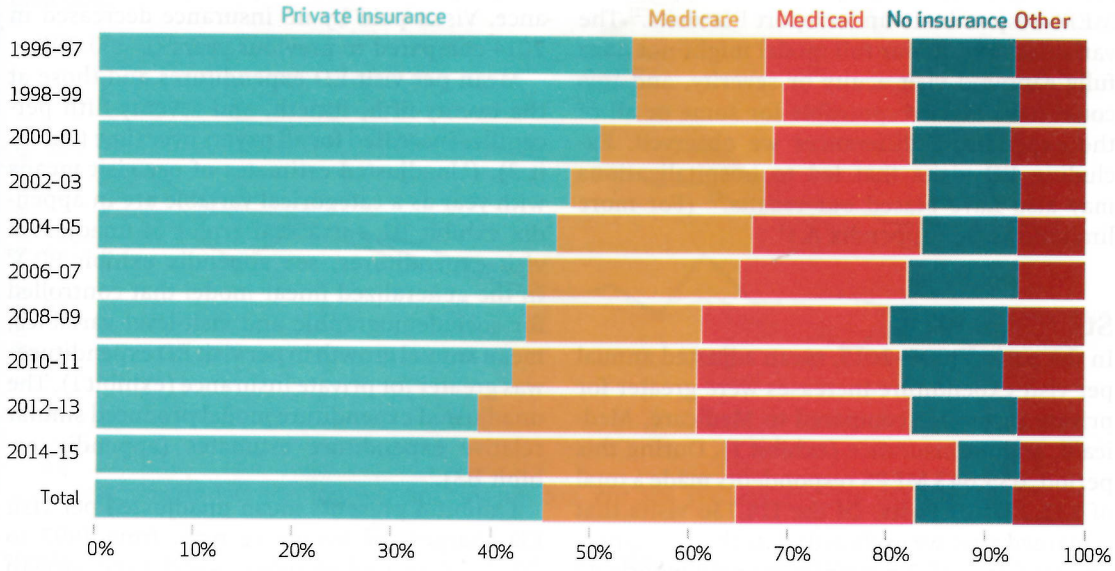
We used Stata, version 13, with survey weights for all analyses to account for the complex sampling design of MEPS, considering p values <0.01 to be significant. We used the Consumer Price Index to adjust all expenditures to 2015 US dollars.[10]

The OhioHealth Institutional Review Board ruled this study exempt.

SENSITIVITY ANALYSES We performed several sensitivity analyses to determine whether expenditures and charges changed with different assignments of visits to payers, the transformation of expenditure outliers, exclusion of data gathered from years with different survey methodologies, adjustment for different combinations of sociodemographic variables, and inclusion of visits that resulted in hospitalizations (for more methodological details, see appendix A).[9]

EXHIBIT 2

Percentages of emergency department (ED) visits, by type of insurance, 1996–2015



SOURCE Authors' analysis of data for 1996–2015 from the Medical Expenditure Panel Survey (in two-year survey waves). **NOTES** There were 114,736 ED visits. All percentages were calculated after survey weights were applied to make the study sample representative of the noninstitutionalized US population. Each ED visit was assigned to a type of insurance through a multistep process that used the type with the greatest reported payment, a respondent's reported type, and several other criteria. Appendix A gives a detailed description of how visits were assigned to types of insurance (see note 9 in text).

EXHIBIT 3

Emergency department (ED) expenditures per visit, by insurance type, 1996–2015

	1996–97	1998–99	2000–01	2002–03	2004–05	2006–07	2008–09	2010–11	2012–13	2014–15
PRIVATE INSURANCE										
25th percentile	$187	$198	$197	$256	$ 273	$ 333	$ 338	$ 351	$ 381	$ 382
50th percentile	387	390	419	505	575	662	724	780	829	911
75th percentile	707	727	765	966	1,157	1,256	1,419	1,511	1,650	1,859
Mean	682	673	713	872	1,099	1,174	1,295	1,370	1,400	1,676
MEDICARE										
25th percentile	$165	$198	$184	$176	$ 198	$ 237	$ 251	$ 250	$ 267	$ 275
50th percentile	332	412	400	388	458	474	490	527	532	549
75th percentile	644	723	760	766	808	825	965	952	1,026	912
Mean	702	604	757	728	722	817	1,221	1,041	993	892
MEDICAID										
25th percentile	$ 98	$ 97	$102	$106	$ 125	$ 119	$ 141	$ 149	$ 153	$ 143
50th percentile	184	179	199	193	228	242	266	281	295	286
75th percentile	377	332	378	369	480	477	547	544	546	527
Mean	348	319	375	391	456	465	543	516	557	504
NO INSURANCE										
25th percentile	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 13	$ 16	$ 23	$ 22
50th percentile	213	174	227	205	155	166	295	280	237	261
75th percentile	472	482	551	599	578	658	841	893	920	772
Mean	413	480	523	564	639	602	802	1,032	920	723

SOURCE Authors' analysis of data for 1996–2015 from the Medical Expenditure Panel Survey (in two-year survey waves). **NOTES** There were 114,736 ED visits. Expenditures for visits assigned to "other insurance" are not reported here. Survey weights were applied to make the frequency of visits at each expenditure level representative of those for the noninstitutionalized US population. Expenditures were adjusted to 2015 US dollars using the Consumer Price Index (see note 10 in text). Appendix A gives a detailed description of how visits were assigned to types of insurance (see note 9 in text).

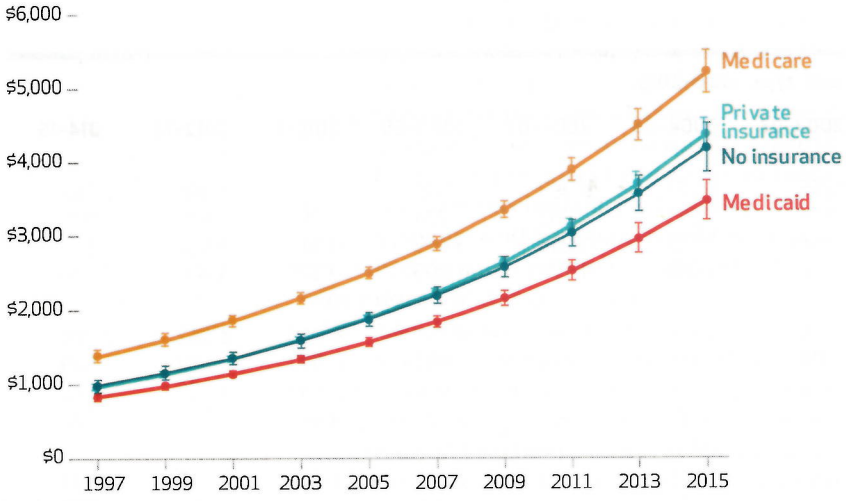
LIMITATIONS Our study had several limitations. Notably, there may have been differential reporting of ED visits by insurance type, since MEPS respondents underreport ED visits.[11] The variables used in our full model might not have fully captured visit acuity or severity, and this could have been responsible for some or all of the expenditure differences we observed. Excluding ED visits that led to hospitalizations may also have biased our results.[12] (For more limitations, see appendix A.)[9]

Study Results

In the period 1996–2015, mean adjusted annual per visit expenditure increases were greater for private insurance compared to Medicare, Medicaid, and no insurance (exhibit 1). During this period, 655,643 MEPS respondents made a total of 122,227 ED visits. Of the 114,736 visits that remained after we excluded visits that led to hospitalizations, 45.3 percent were paid by private insurance, 19.5 percent by Medicare, 18.0 percent by Medicaid, 10.0 percent by no insurance, and 7.2 percent by other insurance (exhibit 2).

EXHIBIT 4

Mean unadjusted per visit emergency department (ED) charges, by type of insurance, 1997–2015



SOURCE Authors' analysis of data for 1997–2015 from the Medical Expenditure Panel Survey (two-year survey waves). **NOTES** There were 114,736 ED visits. A generalized linear model with a gamma distribution and a log link function followed by postprediction average marginal effects was used to predict charges. The model included a two-factor interaction term between type (private insurance, Medicare, Medicaid, and no insurance) and survey year. The mean annual increase in per visit ED charges or slope was $183.35 for private (95% confidence interval: 170.65, 196.97), $231.25 for Medicare (95% CI: 209.93, 252.57), $161.97 for Medicaid (95% CI: 143.05, 180.89), and $176.94 for no insurance (95% CI: 156.05, 197.83) ($p < 0.001$ for all). Visits assigned to "other insurance" were included in the model, but charges for them are not reported here. Appendix A gives a detailed description of how visits were assigned to types of insurance (see note 9 in text). The error bars represent 95% confidence intervals, each of which is symmetrical about its mean charge. All charges were calculated using survey weights and adjusted to 2015 US dollars using the Consumer Price Index (see note 10 in text). Estimates that support the exhibit and standard errors are in appendix exhibit C2 (see note 9 in text).

The proportion of visits paid by public insurance increased during the study period, compared to the proportion of visits paid by private insurance. Visits paid by no insurance decreased in 2014 compared to previous years ($p < 0.001$).

Mean per visit ED expenditures and those at the twenty-fifth, fiftieth, and seventy-fifth percentiles increased for all payers over time (exhibit 3). (Unadjusted estimates of per visit means with year as a categorical variable are in appendix exhibit B1; for a scatterplot of unadjusted visit expenditures, see appendix exhibit B2.)[9] In the generalized linear model that controlled for sociodemographic and visit-level variables, mean annual growth in per visit ED expenditures was greater for private insurance (exhibit 1). The unadjusted expenditure model produced similar relative expenditure estimates (appendix exhibit B3).[9]

Exhibit 4 presents mean unadjusted per visit ED charges, by insurance type, from 1997 to 2015. All insurance types experienced growth during the period, with Medicare exceeding private insurance in annual mean increase: $231.25 versus $183.35 (exhibit 4 shows estimates with year as a continuous variable). For unadjusted estimates of per visit charges with year as a categorical variable, see appendix exhibit B1; for a scatterplot of unadjusted visit charges, see appendix exhibit B4).[9] Annual increases in mean charges were similar among private insurance, Medicaid ($161.97), and no insurance ($176.94) ($p > 0.043$ for all pairwise comparisons). We obtained similar charge relationships in an adjusted analysis (appendix exhibit B5).[9]

Mean unadjusted per visit ED expenditure-to-charge ratios decreased for all payers from 1996 to 2015; exhibit 5 shows per visit mean unadjusted ratios with year as a categorical variable. Private insurance had the highest ratio during all of the years in the study period. Its mean ratio decreased from 0.75 (95% CI: 0.73, 0.76) in 1996 to 0.47 (95% CI: 0.45, 0.48) in 2015. Medicare's ratio was 0.54 in 1996 (95% CI: 0.52, 0.57) and 0.24 (95% CI: 0.23, 0.26) in 2015. Medicaid's ratio decreased from 0.47 (95% CI: 0.45, 0.50) to 0.25 (95% CI: 0.23, 0.27), and the ratio for no insurance fell from 0.47 (95% CI: 0.42, 0.53) to 0.29 (95% CI: 0.24, 0.34) in 2015.

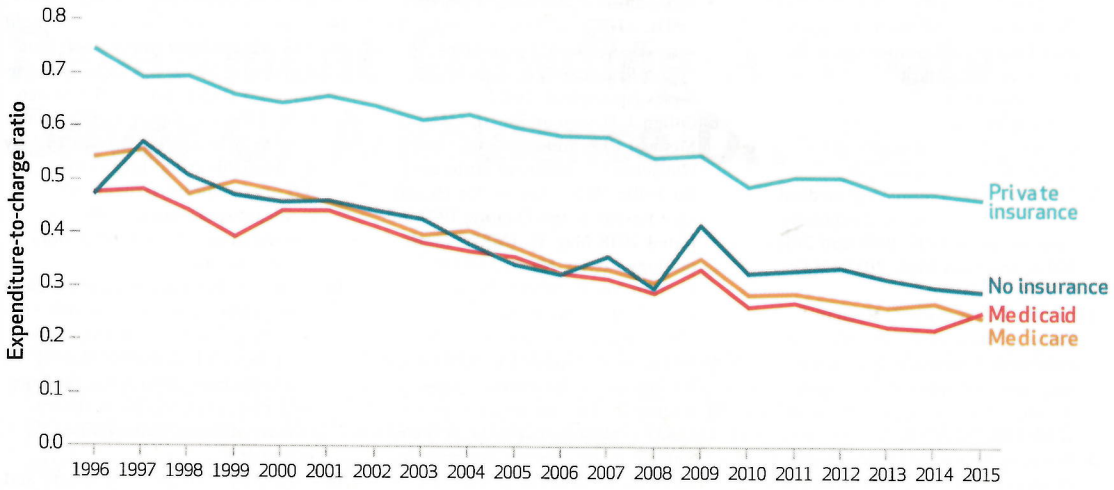
There were no notable differences in rates of mean expenditure increase among payers between our main analysis and sensitivity analyses.

Discussion

Over the past two decades, mean per visit ED expenditures have increased at a faster rate for private insurance than for Medicare and Medicaid. Mean per visit ED charges increased at a

EXHIBIT 5

Mean annual unadjusted per visit emergency department (ED) expenditure-to-charge ratios, by type of insurance, 1996–2015



SOURCE Authors' analysis of data for 1996–2015 from the Medical Expenditure Panel Survey. **NOTES** There were 114,736 ED visits. Survey weights were applied to expenditures and charges to make their means representative of those for the noninstitutionalized US population before we calculated each ratio. All expenditures were adjusted to 2015 US dollars using the Consumer Price Index (see note 10 in text).

similar rate for Medicaid and private insurance, and at a faster rate for Medicare. Unadjusted and adjusted trend relationships among insurance types were similar for both expenditures and charges. Additionally, numerous sensitivity analyses did not change our primary analysis findings.

We also found that expenditure-to-charge ratios for private insurance, Medicare, and Medicaid all decreased over time. Our data demonstrate, however, that private insurance had the smallest proportional decline in this ratio between 1996 and 2015. Consequently, despite observing that unadjusted mean annual increases in per visit charges were smaller for private insurance than for Medicare, and similar to the increases for Medicaid and no insurance, adjusted and unadjusted analyses showed that private insurance had the greatest mean annual increase in per visit expenditures.

Our results are consistent with previous MEPS-based studies of inpatient care, which have identified higher expenditure increases for visits associated with private insurance,[3,13] and with previous comparisons of Medicaid and private insurance.[14] They suggest that neither sociodemographic variables nor the intensity of ED services explains why mean expenditure increases over time are greater for private insurance than for Medicare and Medicaid. Instead, our findings may demonstrate private insurance's comparatively weaker bargaining position with hospitals, which are increasingly consolidated.[15,16] The findings may also show that Medicare's large patient pools and regulatory power allow it greater payment-setting ability,[16,17] and that Medicaid's regulatory power may result in underpayment for ED care, threatening the financial viability of many EDs.[18]

Most of our data were collected prior to 2014, when various provisions of the Affordable Care Act were fully implemented. Policy makers who seek to understand health spending should consider how implementation of the ACA has affected the ED expenditure growth trends we observe in our results and how future versions of the law may continue to have an impact. ■

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9 To access the appendix, click on the Details tab of the article online.

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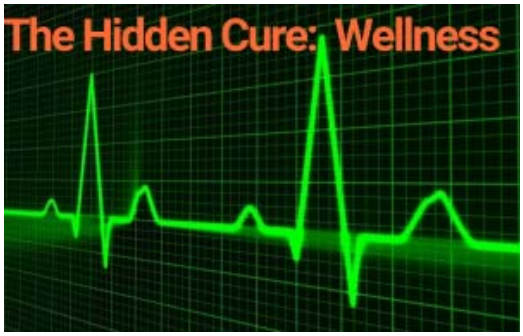
How California hopes to halt the revolving door to the ER

calmatters.org/articles/how-california-hopes-to-halt-the-revolving-door-to-the-er/

By David Gorn

August 14, 2018



The state budget that kicked in last month devotes more than $100 billion to Medi-Cal, California's health system for the poor. The bulk of that money will be spent on a tiny fraction of patients. And although they're in need of help, they're not the sickest people.

> Just 10 percent of state-supported patients use up almost two thirds of the Medi-Cal budget;
>
> Only 5 percent of patients account for more than half of Medi-Cal spending;
>
> One percent of Medi-Cal's current 13.2 million enrollees, or 132,000 people, will use up more than a quarter of the money.

Officials are trying to change this super-user pattern—identified in a 2015 report that still reflects state and even national trends—with an ambitious intervention.

Some super-users have life-threatening illnesses, such as children with rare cancers or people receiving major organ transplants. But most of them struggle with addiction or mental health problems and rack up high numbers of emergency-room visits and hospital admissions. So in late 2016, the state launched a five-year, $3 billion effort to identify and treat them, coordinate their care and direct them to recovery and prevention programs.

WhatMatters: Your daily guide to California policy & politics.

Through 25 pilot projects across California, with varying approaches from county to county, officials hope to reach more than 300,000 chronic users and save hundreds of millions of dollars. About a third of all Californians receive care through Medi-Cal, and the projects, funded with half state and half federal dollars, stem from a larger state move to reduce chronic conditions and save money.

Initial results from participating counties are expected to be released this fall.

Studying super-users is relatively new, and the private sector is also exploring ways to improve their care and cut costs. According to Nadereh Pourat, director of research at UCLA's Center for Health Policy Research, no other state has this kind of project. But they will, she said, once savings can be realized and documented in California.

A single hospital stay can cost $10,000, Pourat said. "If you can avoid one hospital visit a week, you could reduce costs by 2 percent or 3 percent, and that's significant savings."

Melissa Tober-Beers runs the pilot program in Orange County. "This isn't official, and it's not cumulative," she said, "but…at one hospital, they said they saved $2 million so far." She pauses to let the number sink in. "And that's just one hospital."

Seven hospitals in Orange County are participating. The county works with the hospitals and dozens of clinics, health insurers, homeless shelters, advocacy groups and other organizations to identify super-users and get their physical, mental and substance-abuse problems under control.

At a recuperation facility run by the nonprofit Illumination Foundation—blocky and nondescript on the outside, tidy and homelike on the inside—about three dozen homeless residents are recovering from hospital procedures. About half of them are part of the pilot program, said Summer Thomason, who runs the center.

Summer Thomason runs a recuperation center in Orange County. Photo by David Gorn/CALmatters

“We had one person here—we called him Million Dollar Murray. He was in the ER or hospital 142 times in one year” with psychotic episodes and various physical maladies, Thomason said.

Inappropriate use of the ER falls into two main categories, said Jacey Cooper, an assistant deputy director at the state Department of Health Care Services, which oversees Medi-Cal and the pilot programs. Some patients don’t need emergency care and use the ER like they’re visiting a friend. Some have a genuine emergency, often because they’ve delayed care of a problem or illness until it reached a crisis. At that point, it’s difficult to treat—and more expensive.

Many such patients are homeless, Cooper said. “They have no circle of support; they often have mental health issues or substance use problems.”

Cooper said some counties in the pilot program reach people as they’re released from jail, assigning them a care manager because they’re at high risk for homelessness, drug abuse and frequent use of the health system. And some place a health professional in the ER to find and coordinate care for high users. It can be easy to identify them there, because personnel may greet them by name, she said.

That was the case for Robin Miller, 41, a former Illumination Foundation resident who now lives in Riverside. “I was in the ER all the time,” Miller says.

She’s sitting in the dining area of her small apartment, her perky Australian terrier-mix dog in her lap. She’s been sober for nine months—and counting. But in 2015 and 2016, she went to the ER regularly for episodes of severe depression, and for nerve pain so bad she couldn’t walk, which she attributed to drinking. She went several times after falls, which she said were due to lost consciousness after drug use.

“And one time I went to the ER just because I didn’t want to sleep on the street,” she says, laughing now. “I don’t remember what I told them was wrong with me. But I just wanted a bed to sleep in.”

Treatment of her physical and psychological problems, along with help obtaining county and state services after she transferred to an Illumination Foundation center, have helped turn her life around. She used to teach at community colleges and hopes to get back to the classroom soon.

“When I first got out of the hospital, I could barely walk,” she said. “Now I take my medication, I see a therapist, I go to AA meetings….I’ve started writing again.

“I’m walking pretty well, and that’s going to get better. And I wake up every morning grateful to be alive. Food tastes better. Everything around me, it all feels new.”

This is the fourth article in a series on state efforts to foster healthy living as a way to reduce chronic illness.