Emergency Medical Services/Trauma Committee

California Hospital Association

Dec 07, 2014 at 04:00 PM - 06:00 PM

Crown Plaza Redondo Beach and Marina

300 N Harbor Drive

Redondo Beach, California 90277

Conference Call Option:

(800) 882-3610 Access Code: 1953936#

Meeting Book - EMS/Trauma Committee Meeting

AGENDA

Meeting Facilitator: BJ Bartleson

4:00	**I. CALL TO ORDER/INTRODUCTIONS**	Maas
	A. Membership	
	i. Roster - Page 4	
	ii. Member Map - Page 8	
	B. Review of committee mission and objectives	
	i. Guidelines - Page 9	
	C. Content Champions/Thought Leaders/Workgroups	
	i. How do we tap into ED Leaders?	
4:15	**II. REVIEW OF MEETING MINUTES**	ALL
	A. Draft Minutes of the September 10, 2014 Meeting - Page 13	
4:20	**III. OLD BUSINESS**	Bartleson
	A. ED Overcrowding	
	i. Next Steps	
	B. Community Paramedicine Partnership	
	i. Health Workforce Pilot Project #173 - Page 18	
	C. Walltime Update	
	i. Walltime/BHS Presentation - Page 26	
	ii. Behavioral Health Resources for ED's - Page 78	
4:45	**IV. NEW BUSINESS**	
	A. AHRQ	Fair
	i. AHRQIX Health Care Innovations Exchange - Page 108	
	B. EMSA HIE & Proposed Legislation	Ogar/Bartleson
	i. HIE in EMS Summit - Page 124	
	ii. HIE for Quality Improvement - Page 139	
	C. Ebola	Bartleson
	i. Identify, Isolate, Inform: ED' s and Ebola - Page 172	
	ii. Ebola Treatment Centers - DHHS 12/2/14 - Page 173	

	iii. Recommended Policy and Procedures for EMS, re: EVD patients - Page 178	
	D. FSED	Bartleson
	E. PES	Bartleson
	i. PES White Paper - Page 215	
	F. ED Cal Noc Outcomes	Rogers
	G. Goals for 2015	Bartleson
5:30	**V. ROUNDTABLE DISCUSSION**	ALL
5:45	**VI. NEXT MEETING**	ALL
	A. Thursday, March 20, 2015 - Sacramento	
	i. 2015 Meeting Schedule - Page 222	
6:00	**VII. ADJOURNMENT**	ALL

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

EMS/T COMMITTEE
2014 MEMBER ROSTER

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EMS/T Committee Representation

BY COUNTY

As of November 26, 2014

HOSPITAL / HEALTH SYSTEM MEMBERS	
Free-Standing Facility	3
Large Hospital System	10
Private Facility	0
Small and Rural Facility	0
Specialty Facility	0
University / Teaching Facility	4
ADMINISTRATIVE REPRESENTATIVES	
Professional Group Specializing in EMS/T	2
Public Institution	3
State Trade Association	2
REGIONAL REPRESENTATIVES	
Regional Representatives	3
OTHER	
Ambulance Services	3
CHA Staff	1
TOTAL COMMITTEE REPRESENTATION	**31**

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

GUIDELINES FOR THE

CALIFORNIA HOSPITAL ASSOCIATION'S
EMS/TRAUMA COMMITTEE
Updated 2/27/06

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. The purposes of the Committee shall be:

- to serve as a forum for all CHA members interested in EMS/Trauma to receive and exchange information, adopt policies and positions, guide management, adopt strategies and serve as the primary public policy arm of CHA for emergency medical services and trauma issues;
- to provide CHA member EMS/Trauma providers with a statewide structure dealing with the issues important to their interests;
- to create a representative form of leadership which is based on participation of all its members;
- to provide direct input to the CHA Board of Trustees; and
- to provide a unified voice on behalf of CHA members offering EMS/Trauma services.

III. COMMITTEE

The committee shall consist of a maximum of 22 representatives from California 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. 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.

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.

EMS/TRAUMA COMMITTEE MEETING
MINUTES
September 10, 2014 / 10:30 am to 2:30 pm
California Hospital Association

Members Present:	Jo Coffaro (Phone), Karla Earnest (Phone), Ross Fay, Frank Maas, Mark Mayes, Daman Mott, Kimberly Murphy, Farid Nasr, Vivian Reyes (Phone), Janet Rimicci (Phone), Kimberlee Roberts, Heather Venezio, Judith Yates, Terri Gill, Jonathan Jones
Members Absent:	Stuart Buttlaire, Connie Cunningham (phone) , Stacey Hanover (phone), Eric Morikawa, James Pierson, Cheri Hummel, Frederick Dennis, Aaron Wolff (phone), Nancy Blake, Gerald Bracht, , Andrew Greene, Darin Huard, Sharon Rudnick,
Guests:	Julie Hamilton (Emergency Medical Services Authority)
CHA Staff:	BJ Bartleson, Amber Morton, Debby Rogers, Lois Richardson, Rhonda Filipp, Cheri Hummel (absent), Sheree Kruckenberg, David Perrott (absent)

I. CALL TO ORDER/INTRODUCTIONS

A. The meeting was called to order at 10:26 a.m. Introductions were made. Member updates were reviewed.
   a. Roster
   b. Member Updates

B. Review of Committee Mission & Objectives

C. Content Champions/Thought Leaders/Workgroup

II. REVIEW OF MINUTES OF PREVIOUS MEETING

A. Minutes

IT WAS MOVED, SECONDED AND CARRIED:

- *To approve the minutes of June 11, 2014 EMS/T.*

III. OLD BUSINESS

A. Member Map:

Special attention was brought to the current membership map. There is a need to fill-in the gaps in membership, especially ED directors and managers located in Central California. The request was made for members to reach out to colleagues and contacts who may be interested in being active members.

IV. NEW BUSINESS

A. Trauma Quality Improvement Program (TQIP) Presentation – Jonathan Jones

Mr. Jones presented on TQIP from the perspective of the Trauma Center. The discussion following the presentation established that TQIP is a valuable asset in measuring hospital quality across the state, but there are some barriers to all hospitals using it. These barriers include a questionable return on investing in TQIP and hospital unease of the use of recorded data both for appropriate confidentiality status and regulations.

It was discussed that a good first step in seeking increased TQIP usage would be to define basic concepts such as: what is a trauma patient? In addition, the data provided by Ms. Jones' system could be used to promote the idea of trauma guiding principles of care in California.

Action: Ms. Bartleson to send state trauma plan to Rural Hospital Committee.

B. HIE

1. Barriers and Core Measures: - Julie Hamilton Emergency Medical Services Authority (EMSA)

Hospitals are overwhelmed with too many patients throughout California. In the Los Angeles region (including Orange County, Riverside, San Bernardino, San Diego and Ventura) the hospitals are participating in a bidirectional patient program. This includes initiating a Disaster Portal that allows providers to login during a disaster and track bed availability, patient movement and help families find victims. Ms. Hamilton is encouraged by the sample location as they have 56% of the state's population, 38 million people, and a diverse population type. Contra Costa County with Kaiser Program currently running.

Barriers have included hospitals with reservations about HIPA compliance and patient privacy violations by sharing data. Ms. Hamilton indicated that this issue would be covered in the EMSA's November Conference (November 17-19, 2014). November 17th is to be a "boot camp" of HIE and what is happening in California.

V. LUNCH

VI. NEW BUSINESS CONTINUED

A. Strategy for National EMS Culture of Safety - Rhonda Filipp

Ms. Filipp presented on the NHTSA, HRSA, EMSC and ACEP's Strategy for National EMS Culture of Safety (details of which can be found in the September 10, 2014 meeting pack on page 244).

The conversation following the presentation brought up concerns about the protection of patient information provided downstream in the patient profile. Mr. Mott stated EMS services need to be included in the solution. Ms. Yates asked how the workplace safety component was being addressed within this system. Ms. Bartleson indicated that it was an overall culture change that would affect the workplace environment.

Mr. Jones advocated for including definitions of EMS activities to ease communication and reporting to the various stakeholders.

B. 2015 Meeting Schedule

The following meeting dates were purposed for 2015. It was asked that all members review and verify the dates are acceptable.

WEDNESDAY, MARCH 25, 2015 10:30 AM – 2:30 PM	SACRAMENTO, CHA OFFICES BOARD ROOM 1215 K Street, Suite 800
WEDNESDAY, JUNE 24, 2015 10:30 AM – 2:30 PM	SACRAMENTO, CHA OFFICES BOARD ROOM 1215 K Street, Suite 800
WEDNESDAY, SEPTEMBER 23, 2015 10:30 AM – 2:30 PM	SACRAMENTO, CHA OFFICES BOARD ROOM 1215 K Street, Suite 800
SUNDAY, DECEMBER 6-8, 2015 10:30 AM – 2:30 PM	**Joint Meeting – EMST/Center for Behavioral Health** Location TBD

C. HIE Legal Parameters – Lois Richardson

Ms. Richardson explained the complications with answering the question: Can hospitals release identifiable information for quality improvement to LEMSA and others?

CMIA has two new pertinent sections: 5610C4 and 5610C14. Civil 5610C4 is meant to allow the sharing of patient information with insurers and providers, but not technically to be used by hospitals for cross provider quality improvement. It is a loop hole in the law that is not necessarily valid. 5610C14 allows that patient information may be disclosed where otherwise authorized or required by law.

HIPAA augments this issue. The original intent of HIPAA was to provide a floor for information sharing not to prevent sharing completely. That said, the legal experts vary on where HIPAA allows or rather stops the legal sharing of patient information for quality evaluation.

Action: Discuss draft bill language to outline sharing rules and common determinative language. CHA to present information at the EMSA Nov. 2014 HIE Conference.

VII. Old Business

A. Community Paramedicine – BJ Bartleson

Ms. Bartleson reviewed that CHA has submitted comments to OSHPD regarding their community paramedicine program. It is currently believed that all 12 pilots in the purposed program will be moving forward.

B. Walltime Toolkit – BJ Bartleson

Ms. Bartleson distributed versions of the toolkit to those members present and thanked them for their help in creating this valuable tool.

Action: CHA will present the toolkit in a session at the Behavioral Health Symposium in December (2014).

VIII. Standing Items

A. Joint Commission Throughput EP

CEO's have stated that the number one issue is throughput. The group discussed creating a common language and toolkit guide similar to the Walltime Toolkit just released.

IX. New Business continued – Sheree Kruckenberg

A. Psychiatric Emergency Services

There are new statues aimed at modernizing 5150. This will only reflect pre-72 hour assessment, confirmation through the law enforcement and determination. Statute VII C will encourage implementation of independent psychology departments. These facilities would not take an ER patient that had physical issues but would be open 24-7, bound by EMTALA, offer to assess everyone, can bill everyone, have law enforce drop off and be located on or near hospital. CHA has offered comments on the statues to hospitals and LEMSA's.

B. SB 82 Grants

Money is available to support the founding of psychiatric wings. In the documents attached to the September meeting packet is a list of hospitals who have received the fund and information on the funds intent as well as application process. Ms. Kruckenberg encouraged each member to see if their hospital has been granted funds and become involved in the process as soon as possible.

X. REGULATORY UPDATES – Farid Nasr

A. STEMI

STEMI, stroke regulations are being revised. Mr. Nasr hopes to do another public comment request in the end of October and open to the OAL by end of this year.

B. State Trauma Plan

Mr. Nasr noted that comments are being reviewed for the State Trauma Plan. It is anticipated that the plan will be put out for another public comment period in the end September/early October and will be submit for final review in December.

XI. ROUND TABLE DISCUSSION

XII. NEXT MEETING

Sunday, December 7, 2014 – Redondo Beach

XIII. ADJOURNMENT

Having no further business, the meeting adjourned at 2:25 p.m.

BJB:am

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November 14, 2014

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RE: Health Workforce Pilot Project (HWPP) #173 – Community Paramedicine Approval with Modifications

Dear Dr. Backer:

I am pleased to announce the approval of the Emergency Medical Services Authority (EMSA) application, HWPP #173 Community Paramedicine with modifications. This project will test, demonstrate, and evaluate the practice of Community Paramedicine in the following areas:

- Transport patients with specified conditions to alternate locations other than an acute care emergency department;
- Address the needs of frequent 9-1-1 callers or frequent visitors to emergency departments;
- Provide short-term home follow-up care for persons recently discharged from a hospital and at increased risk of a return visit to the emergency department or readmission to the hospital; and
- Provide short-term home support for persons with diabetes, asthma, congestive heart failure, or multiple chronic conditions.

The Emergency Medical Services Authority, as the project sponsor, is approved to proceed with all of the concepts and pilot sites proposed in its application for HWPP #173 provided that all of the modifications specified in the OSHPD staff recommendation memorandum dated October 13, 2014 (attached for reference) are implemented. Those recommendations are as follows:

Patient Safety

- The sponsor shall work with the HWPP Program and HWPP #173 project evaluator to determine the scope and timeline for data submission and reports during the initial six months of the Phase III: Intervention Period.
- The sponsor shall require all sites to include in their patient eligibility protocols and consent forms that patients who cannot consent due to inebriation, mental incapacity, legal incapacity, or no responsiveness will be treated in accordance with current

regulations and local protocols governing EMT-Paramedics. These patients would not be included in the pilot project unless consent is lawfully given.

- The sponsor shall provide triage protocols for each site to the HWPP Program and HWPP Program Advisory Committee for review and feedback, and strengthen those protocols if requested by the HWPP Program.

Representation

- The sponsor shall include a paramedic and a member of the general public who is not a licensed healthcare provider on each site's Community Paramedic Steering Committee.

Consent Forms

- The sponsor shall require all sites to incorporate the following heading on all consent forms "Informed Consent" as identified in the program regulations.
- The sponsor shall require all sites to develop an Informed Consent form specific to languages of the population proposed to be served.

Training

- The sponsor shall ensure that core standards for training address multiple disciplinary team coordination.
- The sponsor shall require additional training for project participants, where warranted (i.e., if after the review and expansion of additional data collection elements, the HWPP Program deems additional training necessary to ensure patient safety).

Pilot Project Evaluation

- The sponsor shall conduct an overall evaluation of the pilot project and an evaluation at the site level.

Data Collection and Analysis

- The sponsor shall work with the HWPP Program to more explicitly define "patient safety" as it relates to the submission of data during the Phase III: Intervention Period.
- The sponsor shall work with the HWPP Program in collaboration with the HWPP Advisory Committee to identify and expand the data elements collected during the Phase III: Intervention Period to include patient outcomes. The expansion of patient outcomes will be specific to each site and may include items such as:
    - When was the patient discharged?
    - Where was the patient discharged (i.e. home or hospitalized)?
    - Did the patient need additional treatment?
- The sponsor shall collaborate with the HWPP Program in determining the frequency of data submission to HWPP.

Additionally, all of the following five provisions must be met:

- In addition to the requirements specified in the OSHPD staff recommendation memorandum dated October 13, 2014, the sponsor shall ensure that all project sites modify the Informed Consent form to read as follows:

  "Patients who cannot consent due to inebriation, mental incapacity, legal incapacity, or no responsiveness will be treated in accordance with current regulations and local protocols governing EMT-Paramedics. An exception to this requirement will be allowed for study sites where the main objective is to evaluate alternative destinations for

patients with mental health issues that potentially prevent them from having adequate capacity to consent, and where paramedics participating in the Behavioral Health Pilot Project have completed a specified Psychiatric Emergency Response Team Training Course in Behavioral Health issues in addition to the completion of the Community Paramedicine Core Training. In these cases, efforts should still be made to obtain informed patient consent for the study, but inability for psychiatric reasons will not prevent the patient from participating. Patients in these mental health projects with other reasons for incapacity, such as unresponsiveness, and patients in all other projects cannot be included in the pilot projects unless consent is lawfully given."

- The sponsor shall work with the project sites to develop further consistency with the medical criteria, protocols and training for similar concepts that are being tested.
- The sponsor shall ensure that all alternate destination concepts (CP 001, CP 003, CP 009 and CP 012) send additional personnel to both the statewide and local training.
- The sponsor shall require all sites to pursue local Institutional Review Board (IRB) approval.
- OSHPD will ensure that data safety monitoring is included in the responsibility of the HWPP #173 Advisory Committee, through site visits and data submission reports.

As was stated in the staff recommendation, the HWPP Program will:

- Monitor the approved project through reporting and site visit evaluations as well as collaborate with the HWPP Program Advisory Committee,
- Request the sponsor's oversight advisory committee assist the HWPP Program with monitoring and development of guidelines to tighten protocols pursuant to any findings, and
- Request the sponsor to submit a copy of each site's Institutional Review Board (IRB) approved report for each site seeking IRB approval. The IRB approval should be obtained prior to the implementation of the employment/utilization phase.

Any findings related to an endangerment to participating patients will be addressed as follows:

- Sponsor shall provide immediate notification to the HWPP Program regarding any and all patient safety concerns and adverse consequences, and
- Sponsor shall advise the HWPP Program of any resolution or proposed resolution to the safety concerns and adverse consequences.

Notwithstanding any proposed resolutions to safety concerns and adverse consequences, the HWPP Program will:

- Consider any proposed solution brought by the sponsor, the site's Community Paramedicine Steering Committee, and the HWPP Program Advisory Committee,
- Consider the degree of endangerment by reviewing all data collected, reports written and any other relevant information which may provide insight into the activity,
- Review program regulations and project protocols to determine if the project was operating in compliance with the stated guidelines,
- Consider suspending project activities at the specified site and the trainee(s) involved,
- Consider the termination of that portion of the pilot project if it deems there has been no satisfactory resolution,

- Consider the termination of the pilot project if there were system-wide concerns relating to any endangerment activity without resolution, and make available its findings to the general public.

We appreciate your willingness to modify aspects of your project as a result of the review and comment phase of the application process. This approval is granted pursuant to Health and Safety Code Section 128125 of the governing administration of the HWPP Program.

This approval is effective immediately and will expire on November 14, 2015. You will be asked to submit reports and data that describe the progress in meeting objectives. If an extension of time is needed, you will be required to provide this Office with information to justify the request by September 15, 2015.

OSHPD will monitor HWPP #173 through written reports and site visit evaluations. In addition, we expect the Advisory Committee to assist the Office with the monitoring and development of guidelines to strengthen protocols, if possible, pursuant to their findings.

Ms. Kristen M. Widdifield will serve as the Program Administrator and you may contact her with any questions at (916) 326-3718 or Kristen.Widdifield@oshpd.ca.gov.

Very truly yours,

ROBERT P. DAVID
Director

cc: Lupe Alonzo-Diaz, Deputy Director, Healthcare Workforce Development Division

Memorandum **State of California**

OSHPD "Access to Safe, Quality Healthcare Environments that Meet California's Diverse and Dynamic Needs"

To: Robert P. David
Director

Date: October 13, 2014

Via: Stephanie Clendenin
Chief Deputy Director

From: Lupe Alonzo-Diaz
Deputy Director
Healthcare Workforce Development Division

Subject: Recommendation Regarding Health Workforce Pilot Project (HWPP) #173
Community Paramedicine Proposal

On December 28, 2013, the California Emergency Medical Services Authority (EMSA) submitted an application for the HWPP Program's consideration for status as a pilot project. EMSA proposes a pilot project regarding the practice of Community Paramedicine (CP) in the following areas:

- Transport patients with specified conditions to alternate locations other than an acute care emergency department,
- Address the needs of frequent 9-1-1 callers or frequent visitors to emergency departments,
- Provide short-term home follow-up care for persons recently discharged from a hospital and at increased risk of a return visit to the emergency department or readmission to the hospital, and
- Provide short-term home support for persons with diabetes, asthma, congestive heart failure, or multiple chronic conditions.

The HWPP Program has completed a review process for application HWPP #173 in accordance with California Health and Safety Code Section 128175. This included:

- A review of the application to ensure that it met statutory and regulatory criteria,
- Seeking input from relevant healing arts licensing boards and professional organizations,
- Posting the application for public comment before and during the public meeting and public hearing,
- Holding a public meeting on April 9, 2014 to permit the HWPP #173 sponsor to present and receive public input on the application, and
- Holding a public hearing on July 30, 2014 by a disinterested state government official as is required for projects sponsored by a state agency.

I recommend approval of the HWPP #173 application for pilot project status with the following modifications and provisions. This recommendation is based on the HWPP

Program's review and consideration of the information presented via the review process.

The required modifications and provisions are as follows:

Patient Safety

- The sponsor shall work with the HWPP Program and HWPP #173 project evaluator to determine the scope and timeline for data submission and reports during the initial six months of the Phase III: Intervention Period.
- The sponsor shall require all sites to include in their patient eligibility protocols and consent forms that patients who cannot consent due to inebriation, mental incapacity, legal incapacity, or no responsiveness will be treated in accordance with current regulations and local protocols governing EMT-Paramedics. These patients would not be included in the pilot project unless consent is lawfully given.
- The sponsor shall provide triage protocols for each site to the HWPP Program and HWPP Program Advisory Committee for review and feedback, and strengthen those protocols if requested by the HWPP Program.

Representation

- The sponsor shall include a paramedic and a member of the general public who is not a licensed healthcare provider on each site's Community Paramedic Steering Committee.

Consent Forms

- The sponsor shall require all sites to incorporate the following heading on all consent forms "Informed Consent" as identified in the program regulations.
- The sponsor shall require all sites to develop an Informed Consent form specific to languages of the population proposed to be served.

Training

- The sponsor shall ensure that core standards for training address multiple disciplinary team coordination.
- The sponsor shall require additional training for project participants, where warranted (i.e., if after the review and expansion of additional data collection elements, the HWPP Program deems additional training necessary to ensure patient safety).

Pilot Project Evaluation

- The sponsor shall conduct an overall evaluation of the pilot project and an evaluation at the site level.

Data Collection and Analysis

- The sponsor shall work with the HWPP Program to more explicitly define "patient safety" as it relates to the submission of data during the Phase III: Intervention Period.

- The sponsor shall work with the HWPP Program in collaboration with the HWPP Advisory Committee to identify and expand the data elements collected during the Phase III: Intervention Period to include patient outcomes. The expansion of patient outcomes will be specific to each site and may include items such as:
    - When was the patient discharged?
    - Where was the patient discharged (i.e. home or hospitalized)?
    - Did the patient need additional treatment?
- The sponsor shall collaborate with the HWPP Program in determining the frequency of data submission to HWPP.

HWPP Program Monitoring
If the project is approved, the HWPP Program will:

- Monitor the approved project through reporting and site visit evaluations as well as collaborate with the HWPP Program Advisory Committee,
- Request the sponsor's oversight advisory committee assist the HWPP Program with monitoring and development of guidelines to tighten protocols pursuant to any findings, and
- Request the sponsor to submit a copy of each site's Institutional Review Board (IRB) approved report for each site seeking IRB approval. The IRB approval should be obtained prior to the implementation of the employment/utilization phase.

Any findings related to an endangerment to participating patients will be addressed as follows:

- Sponsor shall provide immediate notification to the HWPP Program regarding any and all patient safety concerns and adverse consequences, and
- Sponsor shall advise the HWPP Program of any resolution or proposed resolution to the safety concerns and adverse consequences.

Notwithstanding any proposed resolutions to safety concerns and adverse consequences, the HWPP Program will:

- Consider any proposed solution brought by the sponsor, the site's Community Paramedicine Steering Committee, and the HWPP Advisory Committee,
- Consider the degree of endangerment by reviewing all data collected, reports written and any other relevant information which may provide insight into the activity,
- Review program regulations and project protocols to determine if the project was operating in compliance with the stated guidelines,
- Consider suspending project activities at the specified site and the trainee(s) involved,
- Consider the termination of that portion of the pilot project if it deems there has been no satisfactory resolution,

- Consider the termination of the pilot project if there were system-wide concerns relating to any endangerment activity without resolution, and
- Make available its findings to the general public.

CHA Toolkit to Reduce Ambulance Patient Offload Delays

Advancing Behavioral Health In Your Hospital

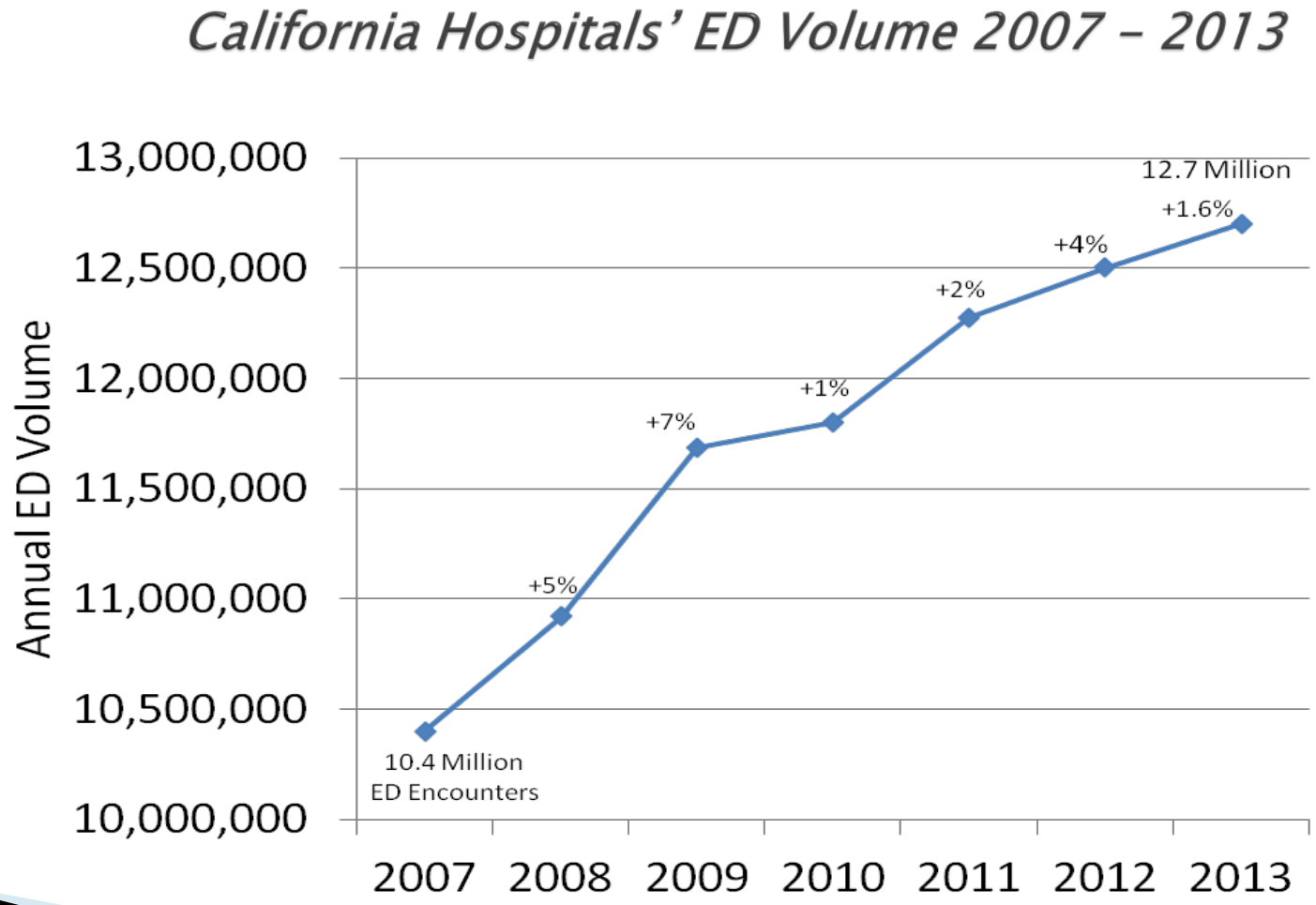
California Hospital Association's
9th Annual
Behavioral Health Care Symposium
December 8 – 9, 2014
Crowne Plaza Redondo Beach and Marina
Redondo Beach

BJ Bartleson, RN, MS, NEA-BC
Vice President, Nursing & Clinical Services
California Hospital Association
Sacramento, California

Objectives

- *Understand what EMS ambulance patient offload time is and the various ways it's described (Walltime)*
- *Learn the impacts of offload delays from the perspective of the state and local EMS agencies, hospitals, patients and the community*
- *Familiarize yourself with the CHA Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department*
- *Be able to assess, and intervene, with local Walltime issues using suggested CQI framework, metrics, and mitigation strategies*
- *Understand federal/state and accreditation laws; regulations and performance standards regarding offload delays*
- *Hear current best practices and success stories*

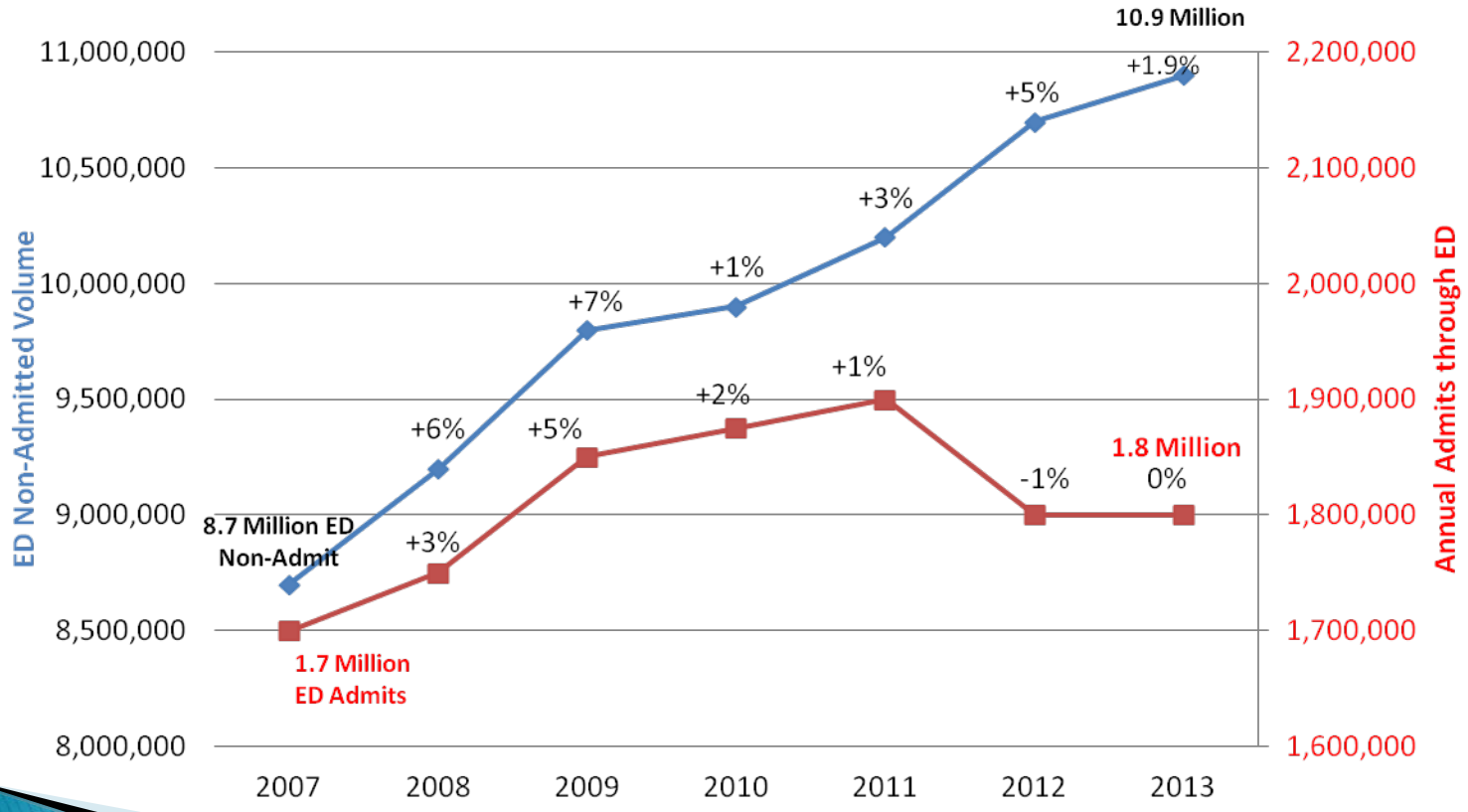
California Hospitals' ED Volume Growth Slowing



Source: OSHPD EMS Utilization Trends

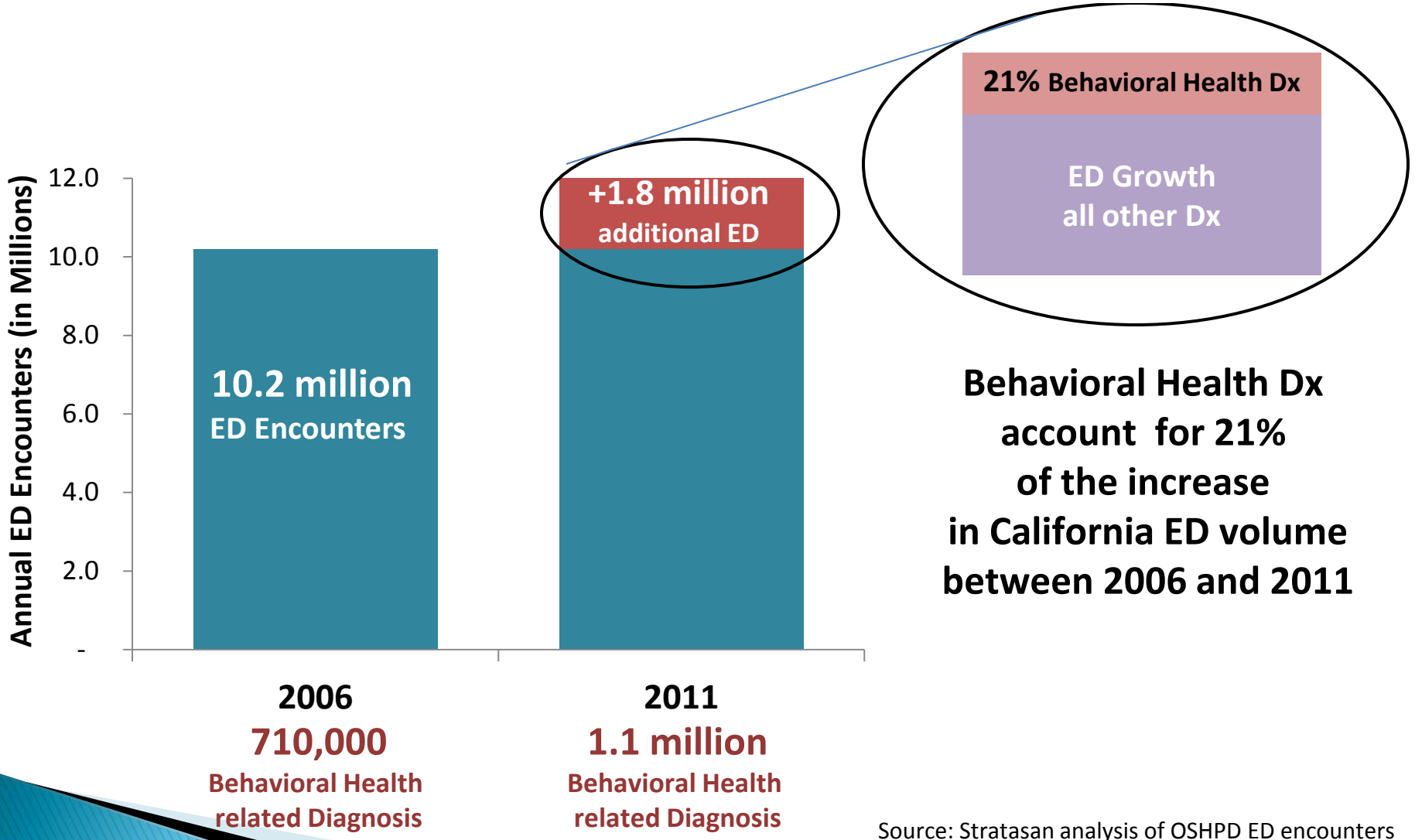
Non-Admit Volume Increase Slowing but Still Greater than Admits

California Hospital ED Volume Non-Admit versus Admit, 2007 – 2013



Source: OSHPD EMS Utilization Trends

Behavioral Health related Dx significant component of ED Growth in California



Behavioral Health Dx account for 21% of the increase in California ED volume between 2006 and 2011

Source: Stratasan analysis of OSHPD ED encounters

EMS Ambulance Patient Offload Time

AKA…

- Ambulance wall time
- Ambulance wait times
- EMS patient parking
- Capture of emergency medical services
- Patient handover delays
- Patient offload delays

"The interval between arrival of an ambulance patient at the ED until the EMS and ED personnel transfer the patient to an ED stretcher and the ED staff assume the responsibility for care for the patient."

National Association of EMS Physicians position statement, 2011

ACEP Clinical Policy

American College of Emergency Physicians

Boarding of Admitted and Intensive Care Patients in the Emergency Department, April 2011

- ED crowding is a direct result of diminished bed and resource capacity created by boarding.
- A proxy for ED crowding is the time patients remain in the ED after the decision to admit.
- Boarding of admitted patients in the ED contributes to lower quality of care and reduced patient satisfaction.
- The problem is multifactorial with causes that span the entire health care delivery system.

EMS and Community Impacts

- Fewer units in community may result in longer response times
- Inability to meet contractual response obligations
- Costs shifted from hospital to EMS systems
- Readiness cost of paramedics and ALS units absorbed by EMS system

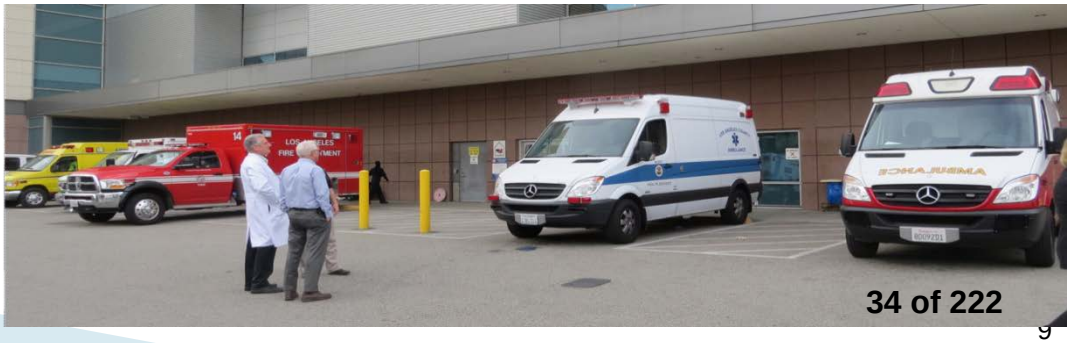
Patient Impacts of Offload Delay

ED Overcrowding demonstrated impacts:

- Delay to definitive care
- Poor pain control
- Delayed time to antibiotics
- Prolonged hospital stay

Ultimately, there is a reasonable concern that ambulance offload delay will compromise patient safety."

Cooney DR, et al, National Association of EMS Physicians position statement.
Prehosp Emerg Care.
2011 Oct-Dec;15(4):555-61



California Walltime Collaborative

California Hospital Association
Emergency Medical Services Authority
Local Emergency Medical Services Administrators
EMS, hospitals, health systems, professional organizations

1. Develop metrics and measure uniformly
2. Develop best practices to address problem
3. Dialogue with hospitals and medical systems
4. Encourage quality improvement and best practices
5. Observe impact of new Joint Commission metrics on hospital throughput

CHA-EMSA Wall Time Collaborative

Triple Aim

Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department

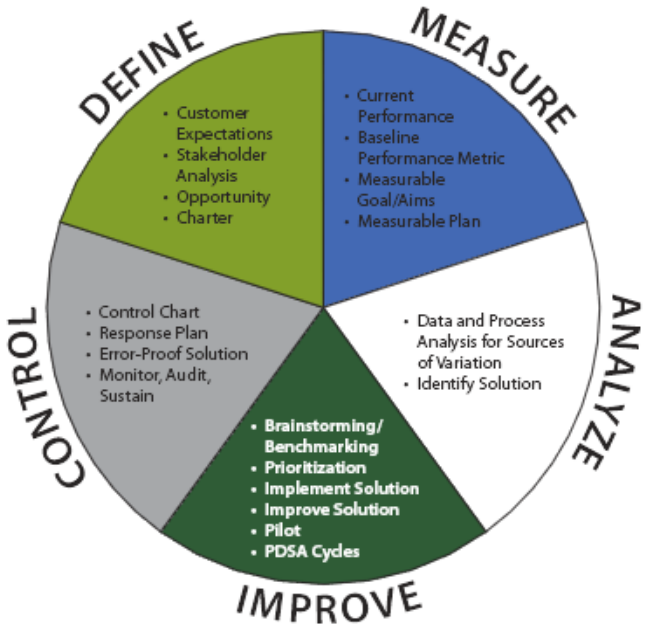
Building Strategies for California Hospitals and Local Emergency Services Agencies

Web link: http://www.calhospital.org/cha-news-article/cha-releases-toolkit-reduce-ambulance-patient-offload-delays

Quality Improvement Approach

- Develop a collaborative structure for learning and action
- Combine subject matter experts
- Define, measure, analyze, improve and control
- Reflect and share lessons learned and best practices
- www.hqinstitute.org

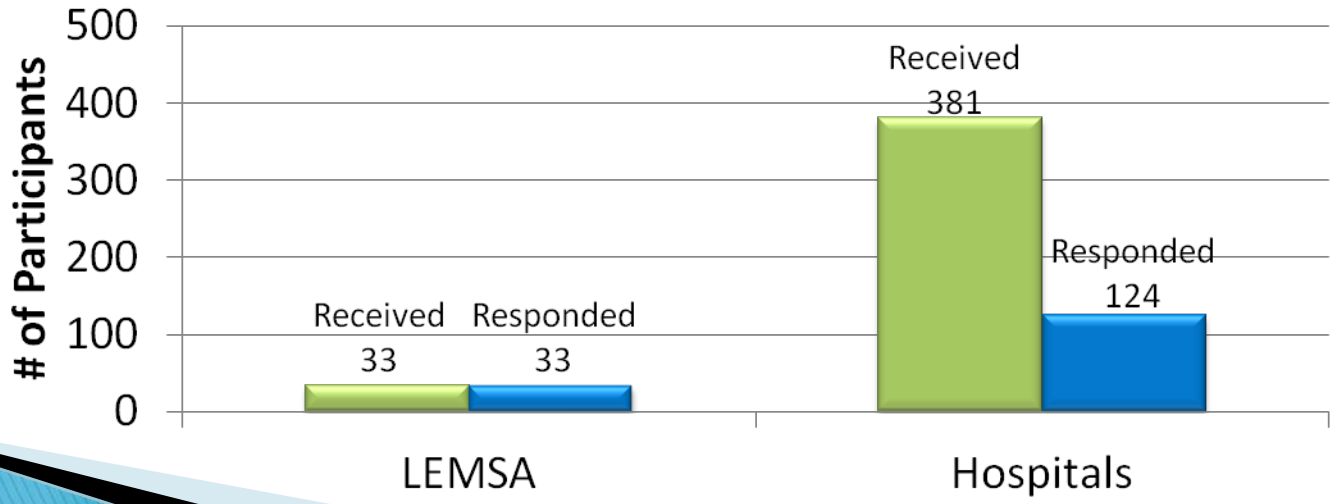
Hospital Quality Institute
Leadership in quality and patient safety



Best Practice Workgroup
Survey Response Levels

Hospital Survey
- Sent to 381 hospitals; 124 responses received
- 32.5% response rate

LEMSA Survey
- Sent to 33 Local EMS agencies; all responded

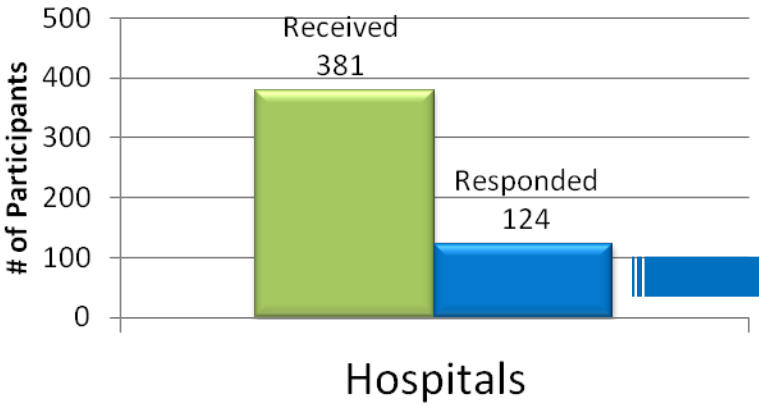


Results

EMS Offload Delay Issue is Polarized

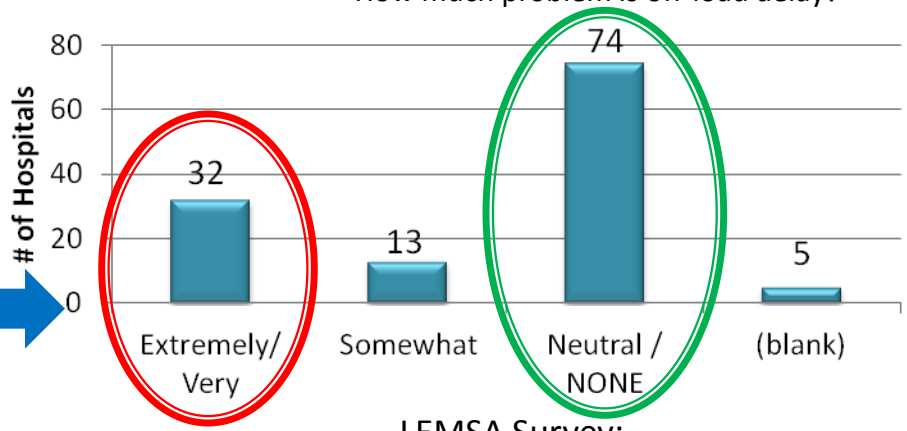
Respondents in both surveys either had extreme delay problems or none

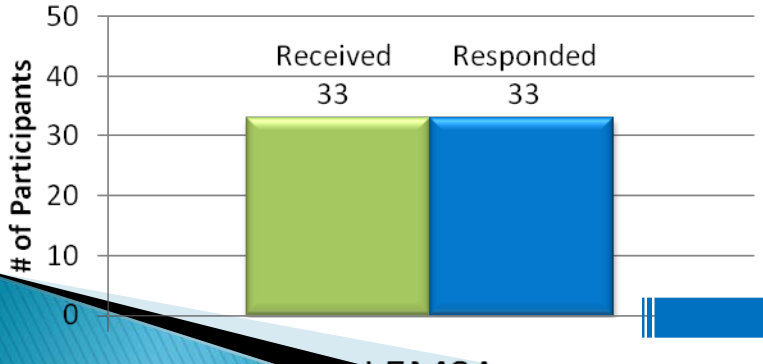
- Majority of responders (~60%) did NOT have an issue



Hospital Survey:

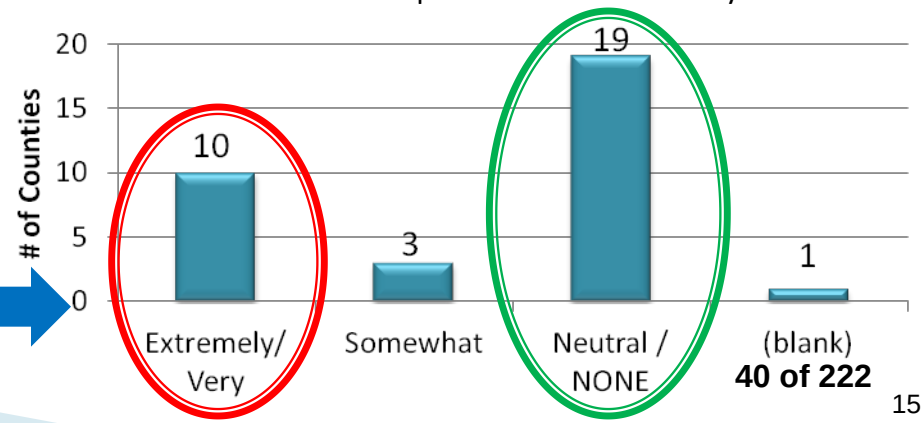
How much problem is off-load delay?





LEMSA Survey:

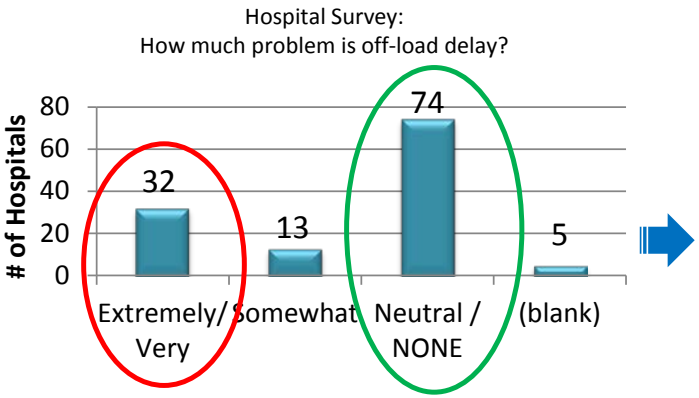
How much problem is off-load delay?

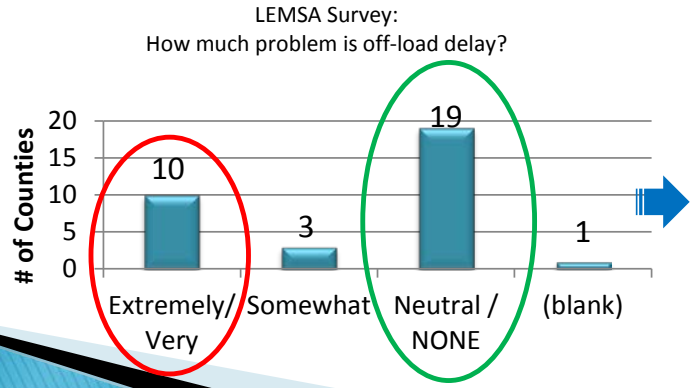


40 of 222

Consensus on Offload Delays

Both LEMSAs and hospitals showed consensus on issues with offload delays except for Coastal Valley and Mountain Valley counties where hospitals reported offload delays “not significant” and LEMSA reported “very significant”.

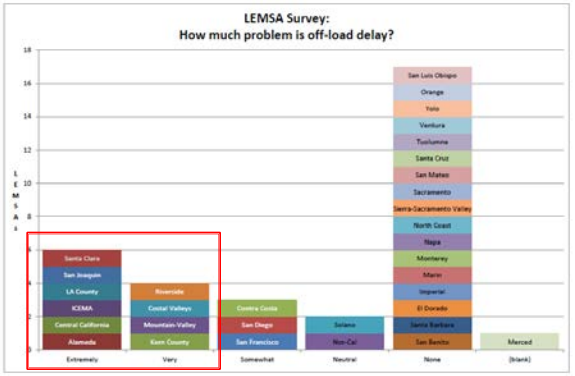




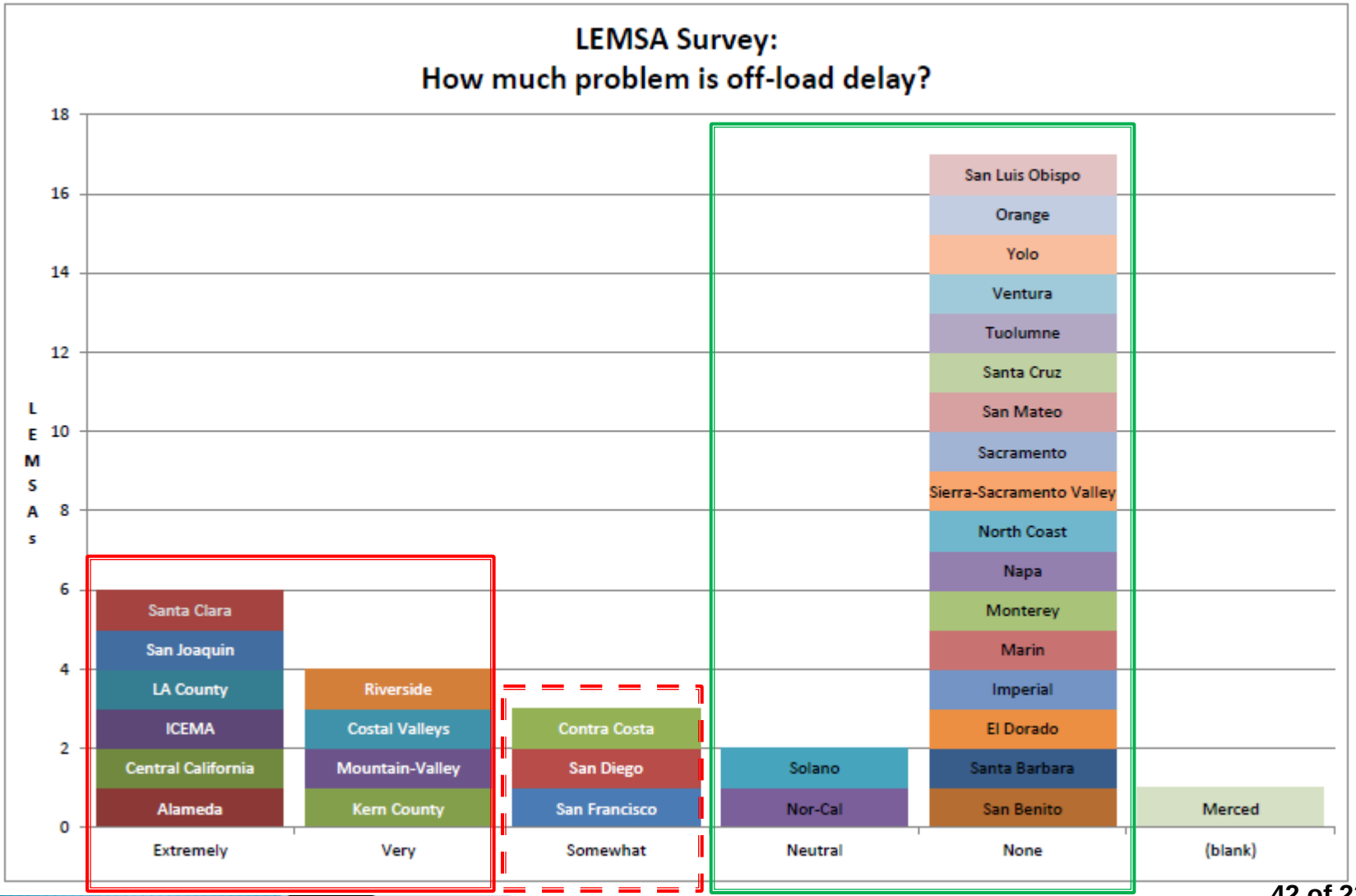
Hospital Respondents Grouped by LEMSA Region

Respondents by Region That Report "Very Significant" or "Extremely Significant" Impacts of Offload Delays	Count	Percent
Los Angeles	10	31.3%
ICEMA	5	15.6%
Riverside	5	15.6%
Alameda	2	6.3%
Kern	2	6.3%
Central California	1	3.1%
Contra Costa	1	3.1%
Merced	1	3.1%
Orange	1	3.1%
Sacramento	1	3.1%
San Joaquin	1	3.1%
Santa Clara	1	3.1%
Sierra-Sacramento Valley	1	3.1%
Coastal Valley	0	0.0%
Imperial	0	0.0%
Marin	0	0.0%
Monterey	0	0.0%
Mountain Valley	0	0.0%
North Coast	0	0.0%
Northern California	0	0.0%
San Diego	0	0.0%
San Francisco	0	0.0%
San Mateo	0	0.0%
Santa Barbara	0	0.0%
Solano	0	0.0%
Tuolumne	0	0.0%
Ventura	0	0.0%
Yolo	0	0.0%
Total	32	100.0%

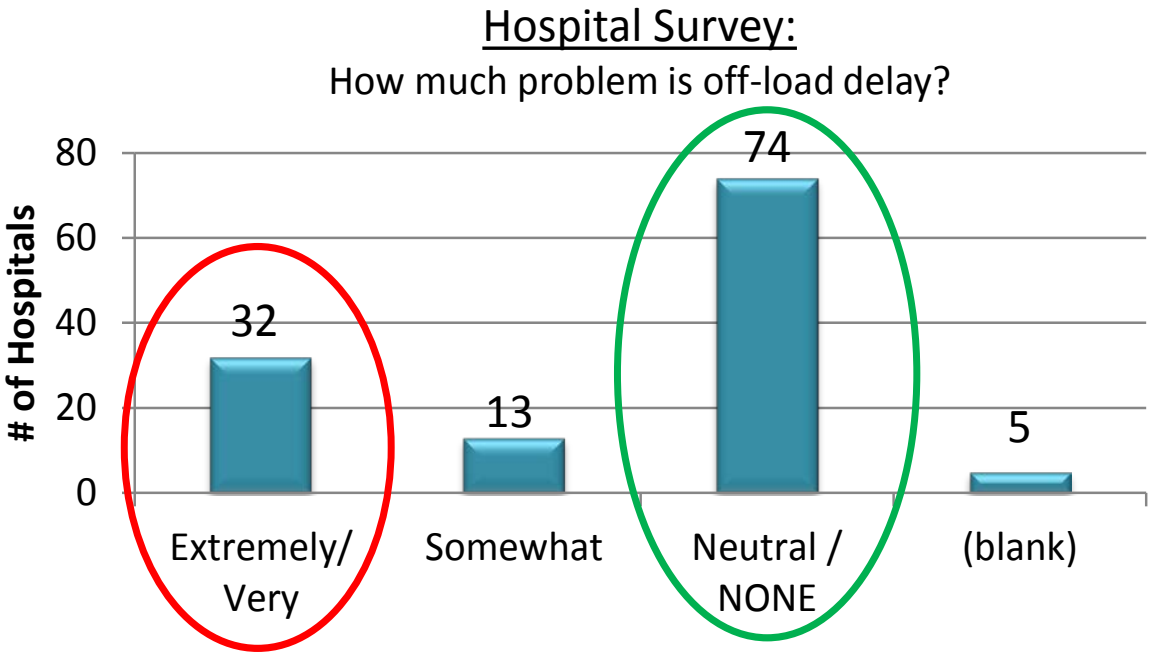
Respondents by LEMSA That Report "Neutral" or "Not Significant" Impact of Offload Delays	Count	Percent
Los Angeles	15	20.3%
San Diego	7	9.5%
Sierra-Sacramento Valley	6	8.1%
Orange	5	6.8%
Kern	4	5.4%
Coastal Valley	3	4.1%
ICEMA	3	4.1%
Santa Barbara	3	4.1%
Solano	3	4.1%
Ventura	3	4.1%
Contra Costa	2	2.7%
Monterey	2	2.7%
Mountain Valley	2	2.7%
Riverside	2	2.7%
San Mateo	2	2.7%
Yolo	2	2.7%
Alameda	1	1.4%
Central California	1	1.4%
Imperial	1	1.4%
North Coast	1	1.4%
Northern California	1	1.4%
Sacramento	1	1.4%
San Francisco	1	1.4%
San Joaquin	1	1.4%
Santa Clara	1	1.4%
Tuolumne	1	1.4%
Marin	0	0.0%
Merced	0	0.0%
Total	74	100.0%



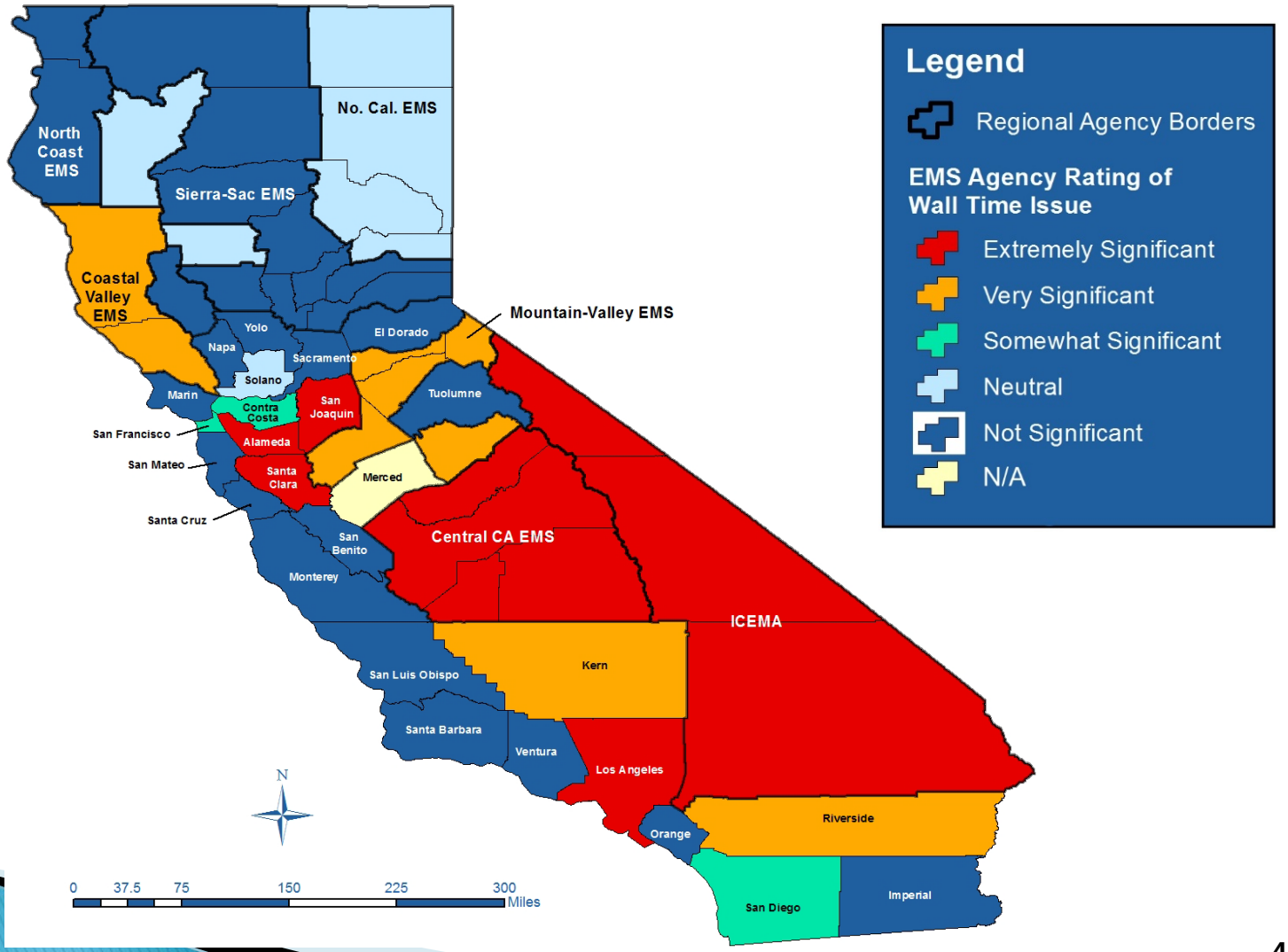
LEMSA Survey Results



Hospital Survey Response Results



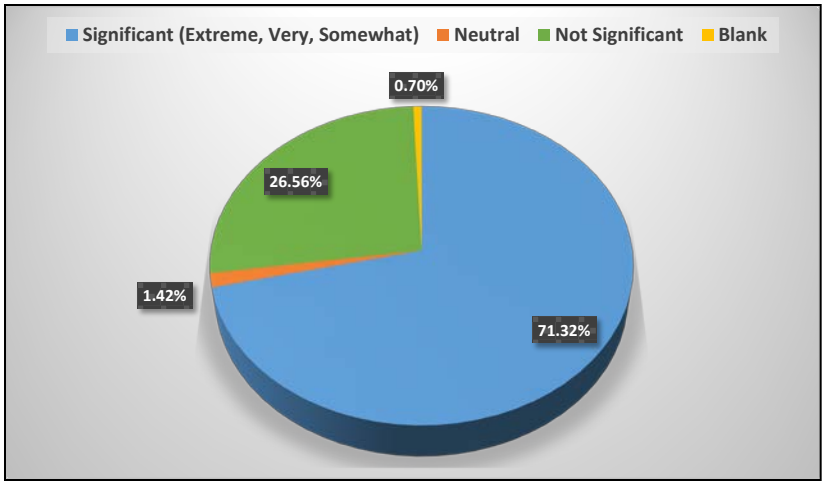
Map of EMS Agency Rating of Wall Time Issue



LEMSA Survey Observations: Population is a major factor

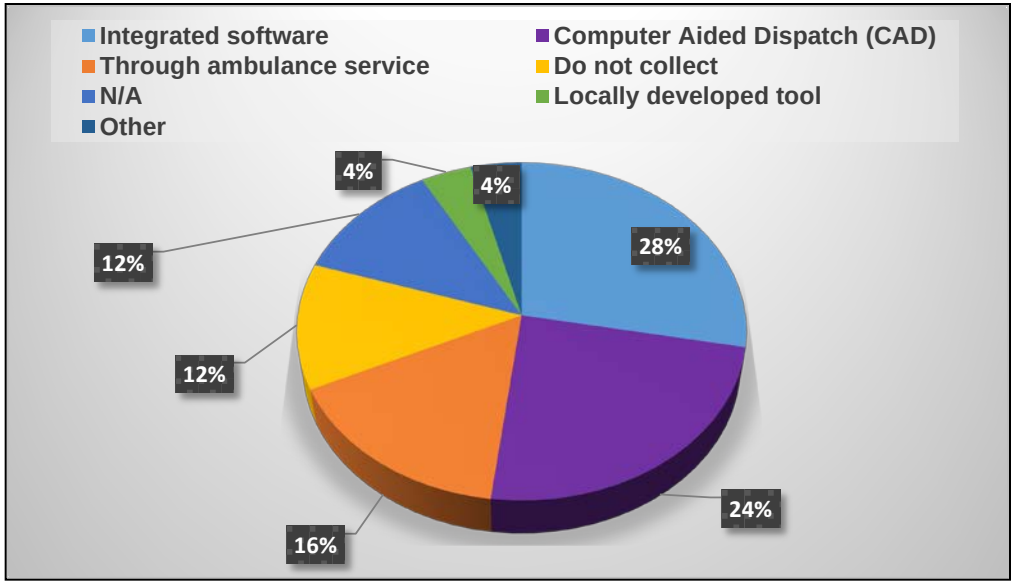
- Agencies with **"extremely significant"** offload delay issues correlate strongly to **large populations**
  - *6 agencies account for a total population of 17.5M*
- Agencies with **"not significant"** problems have significantly **smaller populations**
  - *17 agencies account for a total population of 9.8M*

Offload Delay Severity as Percentage of CA Population (2010) in LEMSA Boundary		
Response	**Sum of Population**	**Response Count**
Extremely significant	17,540,255	6
Very significant	3,734,661	4
Somewhat significant	4,949,573	3
Neutral	523,080	2
Not significant	9,766,713	17
Left Blank	255,793	1
Grand Total	36,770,075	33



LEMSA Data Collection Methods

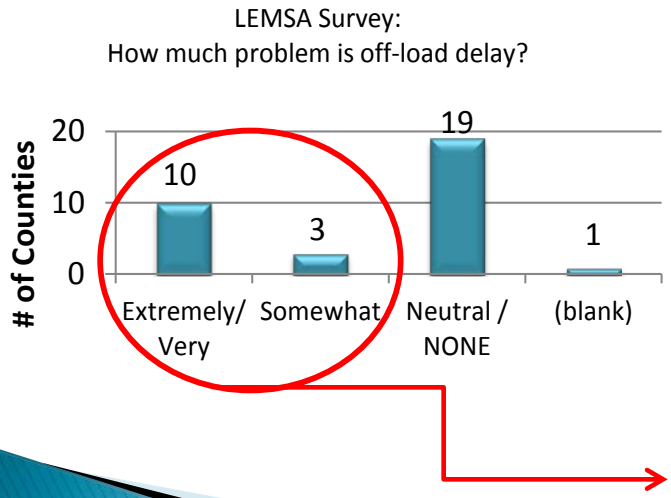
How is offload time interval data collected?	Count
Integrated software	7
Computer Aided Dispatch (CAD)	6
Through ambulance service	4
Do not collect	3
N/A	3
Locally developed tool	1
Other	1
Total	25
Left Blank	8
Grand Total	33



LEMSA Survey Observations:
Collection and Reporting of Data

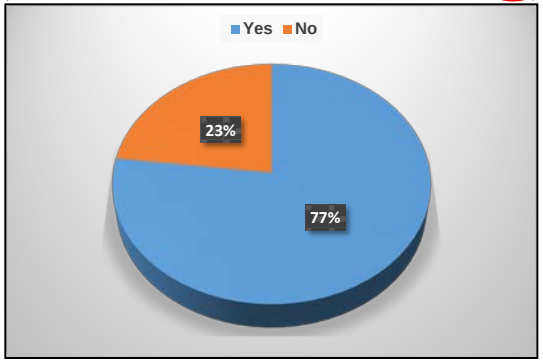
Further detail on those LEMSA agencies that reported a significant problem ("extremely", "very", "somewhat")

- A majority (77%) do collect EMS offload time interval data
- Only a little over half (54%) actually report the data



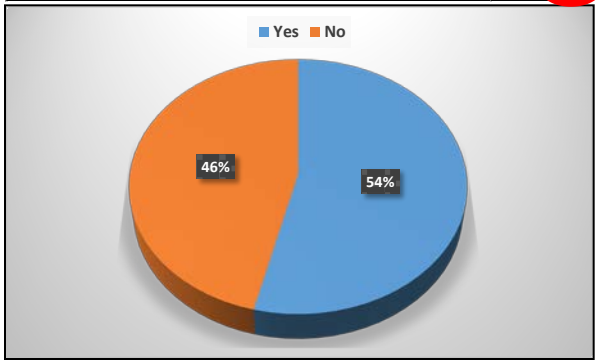
Collect offload time interval data?

If you reported a significant problem ("extremely", "very", "somewhat") from Question #9, do you collect EMS offload time interval data in your jurisdiction?	Count
Yes	10
No	3
Total	13



Report offload bed delay data?

If you have a "somewhat" significant to "extremely" significant problem with offload delays (Question #9), does your agency produce an EMS offload bed delay report (Question #7)?	Count
Yes	7
No	6
Total	13

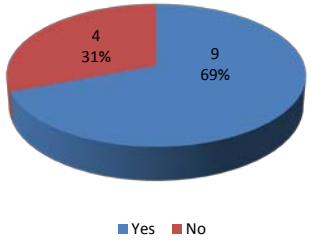


Closer look at LEMSAs with significant offload delay issues

Summary of the 13 LEMSAs that reported issue as "extremely", "very", or "somewhat"

Implementation?

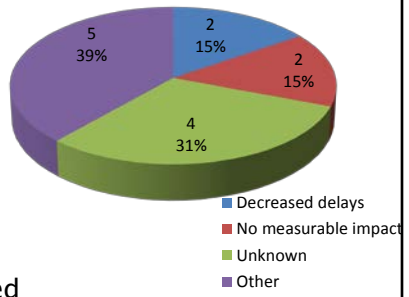
Have you implemented policies or procedures to improve or manage delays?	Count
Yes	9
No	4
Total	13



- Over two-thirds (69%) of LEMSAs have implemented procedures

Impact?

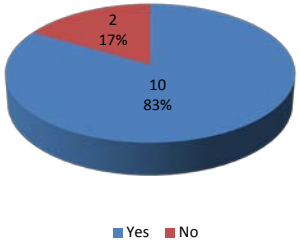
Have your policies had an impact on delays?	Count
Decreased delays	2
No measurable impact	2
Unknown	4
Other	5
Total	13



- Impact measures are scattered
- "Other" included QI activities with hospitals have resulted in fewer delays, capacity that was created was quickly over run by other hospital processes, Field Supervisors and Duty Officers getting involved helps

Addressing Efforts?

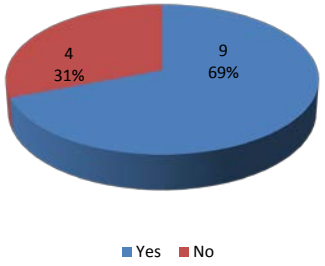
Current or planned efforts to address delay?	Count
Yes	10
No	2
Total	12
Left Blank	1
Grand Total	13



- The majority of LEMSAs are trying to address the issue

Improvements?

Are you aware of a hospital or health system that has taken action and improved its EMS offload delays?	Count
Yes	9
No	4
Total	13



- Two-thirds of LEMSAs (69%) are aware of other organizations that improved EMS delays
- Sharing of information from those without delays could be key in achieving some resolution → Toolkit

Majority of LEMSAs are implementing and addressing efforts but impact is scattered. One-third are not aware of other hospitals or health systems that have taken action to improve issue. Information sharing and collaboration is key

Hospital Offload Mitigation Strategies: Summary

- ED Intake was the strategy that had the highest frequency of being implemented
- Conversely, the topic with the least frequency of being implemented was ED output

Mitigation Strategy Implemented Topics	Count
ED Intake	460
ED Throughput	250
ED Output	105
ED Overall	317
Hospital Inpatient	240
Hospital Overall	240

Total Number of Hospital Mitigation Strategies

Of the **74 hospitals** who said the impact of EMS offload delay was either **neutral/not significant** the implemented category was selected the most frequently.

Of the **32 hospitals** who said the impact of EMS offload delay was either **extremely or very significant**, the number of implemented strategies was selected far less frequently than those who do not consider offload delay a problem (946 vs. 453).

Mitigation Strategies Stratified by Those Who Said EMS Offload Delay Was Either Neutral or Not Significant	Implemented	Considering	Not tried	Tried; ineffective	Unknown
Management of ED throughput metrics	67	1	2	1	0
Bedside registration	58	7	2	1	0
Orders from triage	57	3	4	1	1
Effective ordering of lab and imaging	56	6	3	1	3
ED management "rounding"	56	6	7	1	1
"Direct to bed" policy	55	8	2	1	1
Performance improvement system; for example, LEAN, Six Sigma, PDSA	54	4	3	2	5
Accelerated intake processes	53	3	10	0	2
Hospital throughput dashboards	53	10	2	2	5
Innovating staffing utilization	51	10	5	1	4
Charge ED physician-nurse concept (shift leaders)	51	4	12	0	3
Hospital program	44	3	12	0	10
Hospital Code Alert for ED overcrowding	39	7	13	5	3
Accelerated inpatient intake practices	34	14	17	2	0
Bed turnover process	34	6	18	1	7
Standardized discharge process	30	13	11	1	13
Medical staff management of rounding practices and discharges	29	14	15	3	8
Mid-level or physician provider at triage	25	13	17	7	2
Greeter/patient liaison	25	6	30	2	1
Universal telemetry (all hospital beds)	19	6	37	0	2
Use pharmacist in ED	16	12	40	1	0
Use of Cynical Decision Unit (CDU)	12	6	45	2	3
Discharge czar/accelerator	11	13	41	2	1
Standardized ICU step down bed management	11	5	39	1	9
Rapid Admission Unit (RAU)	5	9	47	0	5
Discharge instructions upon arrival	1	4	61	1	1
Total	946	193	495	39	90

Mitigation Strategies Stratified by Those Who Said EMS Offload Delay Was Either Extremely or Very Significant	Implemented	Considering	Not tried	Tried; ineffective	Unknown
Management of ED throughput metrics	28	1	1	0	1
Hospital throughput dashboards	27	2	3	0	0
Bedside registration	26	4	1	1	0
Effective ordering of lab and imaging	26	5	0	1	0
Innovating staffing utilization	25	5	0	1	0
ED management "rounding"	25	6	1	0	0
Accelerated intake processes	24	4	0	2	0
Orders from triage	24	4	0	2	0
"Direct to bed" policy	23	6	1	1	0
Performance improvement system; for example, LEAN, Six Sigma, PDSA	23	6	1	0	1
Charge ED physician-nurse concept (shift leaders)	22	9	0	0	1
Standardized discharge process	20	4	2	3	1
Medical staff management of rounding practices and discharges	19	6	4	1	1
Mid-level or physician provider at triage	18	10	2	2	0
Accelerated inpatient intake practices	17	6	6	2	0
Hospital program	17	4	3	4	2
Hospital Code Alert for ED overcrowding	16	6	5	4	0
Bed turnover process	16	6	7	1	1
Greeter/patient liaison	15	7	4	3	0
Discharge czar/accelerator	10	6	14	1	0
Use pharmacist in ED	10	2	16	2	1
Standardized ICU step down bed management	7	6	16	0	1
Use of Cynical Decision Unit (CDU)	5	5	14	1	4
Universal telemetry (all hospital beds)	5	5	21	0	0
Rapid Admission Unit (RAU)	4	3	20	3	0
Discharge instructions upon arrival	3	3	24	0	1
Total	453	131	166	35	15

Implementation is key.

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EMS Offload Mitigation Factors

For hospitals with Neutral + Not Significant EMS offload delays, what factors would you attribute to this? Check all that apply.	Count	Percent
Optimized ED intake process	37	23%
Successful hospital process improvement measures	34	21%
Hospital and local EMS agency collaborate and have ongoing patient improvement measures	23	14%
No historical problem on this subject	27	17%
Other (please specify)	30	19%
Physical plant redesign	9	6%
Total	160	100%
Hospital Count	74	-

Other Response for – What Factors do you Attribute to No Offload Delay?

Hospital administration awareness/Entire hospital involved/Inpatient bed control/New processes/Float RN assigned to hall patients	11	37%
EMS arrivals get a bed immediately even if it means using wheelchairs, triage and hallway beds	7	23%
Working with providers	5	17%
Other: Impacts our psych ED/Pediatric specific/High wall time because of walk-ins, BLS & ALS patients	3	10%
Work with EMS agency	2	7%
Identified what other hospitals have done to reduce offload times	1	3%
Built a bigger ED	1	3%
Total	30	100%

Hospital Offload Mitigation Strategies in the ED

Summary of ALL hospitals that participated in the survey

ED Intake?

ED Intake:	Implemented	Considering	Tried; Ineffective	Not Tried	Unknown	Total	Blank	Grand Total
Bedside registration	98	13	2	4	-	117	7	124
Orders from triage	92	10	3	7	1	113	11	124
Accelerated intake processes	91	8	2	11	2	114	10	124
"Direct to bed" policy	89	17	3	4	1	114	10	124
Mid-level or physician provider at triage	47	29	11	23	3	113	11	124
Greeter/patient liaison	43	16	6	41	1	107	17	124
Other (please specify)	-	-	-	-	-	-	-	7
Total	460	93	27	90	8	-	-	-

- Top 3 efforts to address delay via ED intake were bed side registration, orders from triage, and accelerated intake processes

ED Throughput?

ED Throughput:	Implemented	Considering	Tried; Ineffective	Not Tried	Unknown	Total	Blank	Grand Total
Effective ordering of lab and imaging	97	12	2	3	4	118	6	124
Innovating staffing utilization	89	17	2	7	4	119	5	124
Hospital Code Alert for ED overcrowding	64	16	9	23	3	115	9	124
Other (please specify)	-	-	-	-	-	-	-	17
Total	250	45	13	33	11	-	-	-

- Top 3 efforts to address delay via ED throughput were effective ordering of lab and imaging, innovating staffing utilization, and hospital code alert for ED overcrowding

ED Output?

ED Output:	Implemented	Considering	Tried; Ineffective	Not Tried	Unknown	Total	Blank	Grand Total
Accelerated inpatient intake practices	59	26	4	26	-	115	9	124
Discharge czar/accelerator	24	20	3	68	1	116	8	124
Use of Clinical Decision Unit (CDU)	19	13	3	70	9	114	10	124
Discharge instructions upon arrival	3	9	1	98	3	114	10	124
Other (please specify)	-	-	-	-	-	-	-	9
Total	105	68	11	262	13	-	-	-

- Majority of hospitals have not tried many of these strategies
- Those that have, accelerated inpatient intake practices, was the top strategy.

ED Overall?

ED Overall:	Implemented	Considering	Tried; Ineffective	Not Tried	Unknown	Total	Blank	Grand Total
Management of ED throughput metrics	110	3	1	4	1	119	5	124
ED management "rounding"	93	15	2	8	1	119	5	124
Charge ED physician-nurse concept (shift leaders)	84	14	1	15	4	118	6	124
Use pharmacist in ED	30	17	3	65	2	117	7	124
Other (please specify)	-	-	-	-	-	-	-	7
Total	317	49	7	92	8	-	-	-

- Top 3 efforts in the ED overall were management of ED throughput metrics, charge ED physician-nurse concept, and using pharmacists in the ED

Majority of hospitals are relying on ED intake mitigation strategies to reduce offload delay issues

Other Responses: ED Intake

EMS patients taken to room immediately	3	30%
Triage RN serves as greeter	2	20%
Bedside registration	1	10%
BLS goes to triage	1	10%
Eliminated triage process	1	10%
Zero allowance for diversion by EMS agency and hospital	1	10%
Other: EMS agency and hospital have a discrepancy with the data	1	10%
Total	10	100%

Other Responses: ED Throughput

Collaborate with inpatient managers and staff	5	23%
Bed meetings twice a day	1	5%
Float staff	1	5%
Peak time staffing	1	5%
ED designated lab staff	1	5%
Radiology priority	1	5%
Use medical students and residents for admitting and discharge	1	5%
"Live Process"	1	5%
Push/Pull	1	5%
Super track area	1	5%
Use protocols for lab and rad	1	5%
Revising Hospital Code Alert	1	5%
Data analysis of saturation	1	5%
Implementing CALDOCS	1	5%
Using electronic alerts	1	5%
Using Lean	1	5%
Other Comments: some physicians wait until one set of test results come back before ordering others/Limited in-house participation	2	9%
Total	22	100%

Other Responses: ED Output and ED Overall

ED Out put: Other Responses	Count	Percent of Total
Intake process is being revised/Process improvement project/Using Lean process	3	38%
Patient case manager in ED/RN navigators/Admission RN	1	13%
Use CDU protocol in ED (but do not have a formal CDU)	1	13%
Once a bed is identified, floor has 30 min to retrieve patient, if not, department manager is called	1	13%
Other: Hospitalists are a bottle neck/EMR has slowed us down	2	25%
Total	8	100%

Q14. ED Overall: Other Responses	Count	Percent of Total
Using pharmacy techs/Pharmacy on trauma team	3	43%
Used to use pharmacy, but eliminated due to downsizing	1	14%
Only one physician on duty per shift	1	14%
Use ED charge RN on duty	1	14%
Implemented team care approach to physician and RN collaboration	1	14%
Total	7	100%

Hospital Offload Mitigation Strategies: Hospital Inpatient Bed Availability

Hospital Inpatient Bed Availability:	Implemented	Considering	Tried; Ineffective	Not Tried	Unknown	Total	Blank	Grand Total
Hospital program	69	10	4	16	17	116	8	124
Standardized discharge process	57	21	4	17	16	115	9	124
Rapid Admission Unit (RAU)	10	14	3	79	6	112	12	124
Bed turnover process	58	14	2	29	9	112	12	124
Universal telemetry (all hospital beds)	26	12	-	69	5	112	12	124
Standardized ICU step down bed management	20	14	2	62	14	112	12	124
Other (please specify)	-	-	-	-	-	-	-	6
Total	240	85	15	272	67	-	-	-

Other Response to Hospital Inpatient Bed Availability

Hospital Inpatient Bed Availability: Other Responses	Count	Percent of Total
Developing and implementing processes	3	38%
Bed meeting at 8:45A and 9P daily and can be called as needed	1	13%
Surge capacity policy that includes NEDOCS	1	13%
Staff meeting every 6 hours	1	13%
Use hospitalists	1	13%
Changing housekeeping staffing to match discharges	1	13%
Total	8	100%

Hospital Offload Mitigation Strategies: Hospital Overall

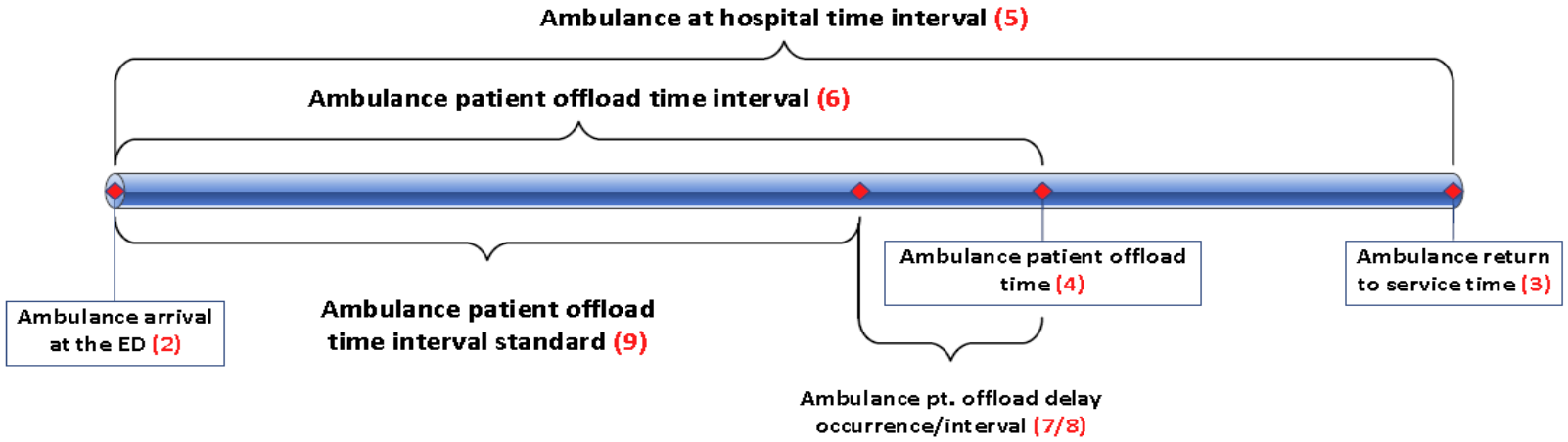
Hospital Overall:	Implemented	Considering	Tried; Ineffective	Not Tried	Unknown	Total	Blank	Grand Total
Performance improvement system; for example, LEAN, Six Sigma, PDSA	90	12	2	5	6	115	9	124
Hospital throughput dashboards	89	17	2	7	6	121	3	124
Medical staff management of rounding practices and discharges	61	20	4	23	9	117	7	124
Other (please specify)	-	-	-	-	-	-	-	9
Total	240	49	8	35	21	-	-	-

Other Responses to Hospital Strategies Overall

Hospital Overall: Other Responses	Count	Percent of Total
Management staffing for admits and discharges/Medical staff/Hospitalists	3	25%
Whole hospital perspective	3	25%
Implemented an 11A discharge policy/Created a council to review physician rounding practices	2	17%
Optimized housekeeping staff	1	8%
Attempted Lean, but difficult with physical plant and lack of physician buy-in	1	8%
Created ED dashboard	1	8%
Other: Not hard wired for medical staff yet	1	8%
Total	12	100%

Metrics

Ambulance Patient Offload Delay
Draft Definitions and Nomenclature for Metric Development
February 2014



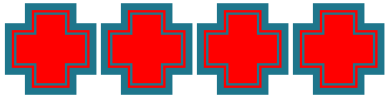
1. **Ambulance transport** – is defined as the transport of a patient from the prehospital EMS system by emergency ambulance to an approved EMS receiving hospital
2. **Ambulance arrival at the ED** - is defined as the time ambulance stops (actual wheel stop) at the location outside the hospital ED where the patient is unloaded from the ambulance.
3. **Ambulance return to service time** – is defined as the time the ambulance is response ready after transporting a patient to a hospital ED.
4. **Ambulance patient offload time** – is defined as the time the patient is physically removed from the ambulance gurney to hospital equipment.
5. **Ambulance at hospital time interval** – defined as the period of time between ambulance arrival at the hospital ED and ambulance return to service time.
6. **Ambulance patient offload time interval** (commonly referred to as ambulance wait time or wall time) – is defined as the period of time between ambulance arrival at the ED and ambulance patient offload time.
7. **Ambulance patent offload delay interval** – is the resulting period of time produced when the ambulance patient offload time interval exceeds the established ambulance patient offload time interval standard. That is to say it is the time accumulated when a patient remains on the ambulance gurney in excess of the offload time interval standard.
8. **Ambulance patient offload delay occurrence –** the occurrence of an ambulance patient remaining on the ambulance gurney beyond the ambulance patient offload time interval standard.
9. **Ambulance patient offload time interval standard** – is the established system performance standard for the period of time between ambulance arrival at the ED and ambulance patient offload time.

Reference: CHA/EMSA Wall Time Collabo… …trics Workgroup

EMS Transports Represent 15% of Hospital ED volume and 40% of Acute Admits

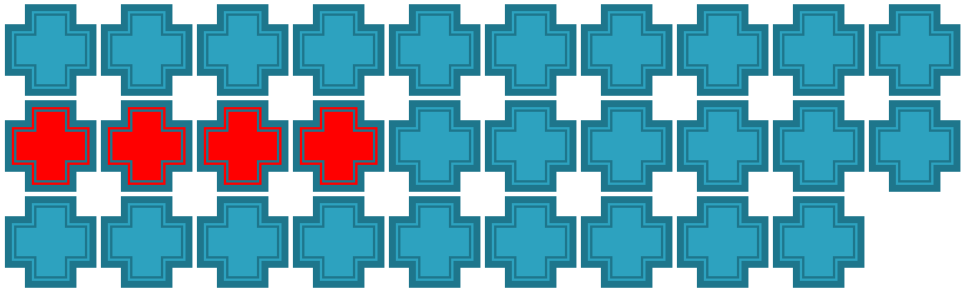
Illustration based on volume from two contiguous counties in Southern California

EMS Transport Volume

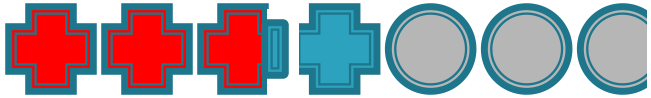


~ 200,000 EMS transports

As Component of all ED Volume



As Component of Acute Admits



Each symbol represents 50,000 patients

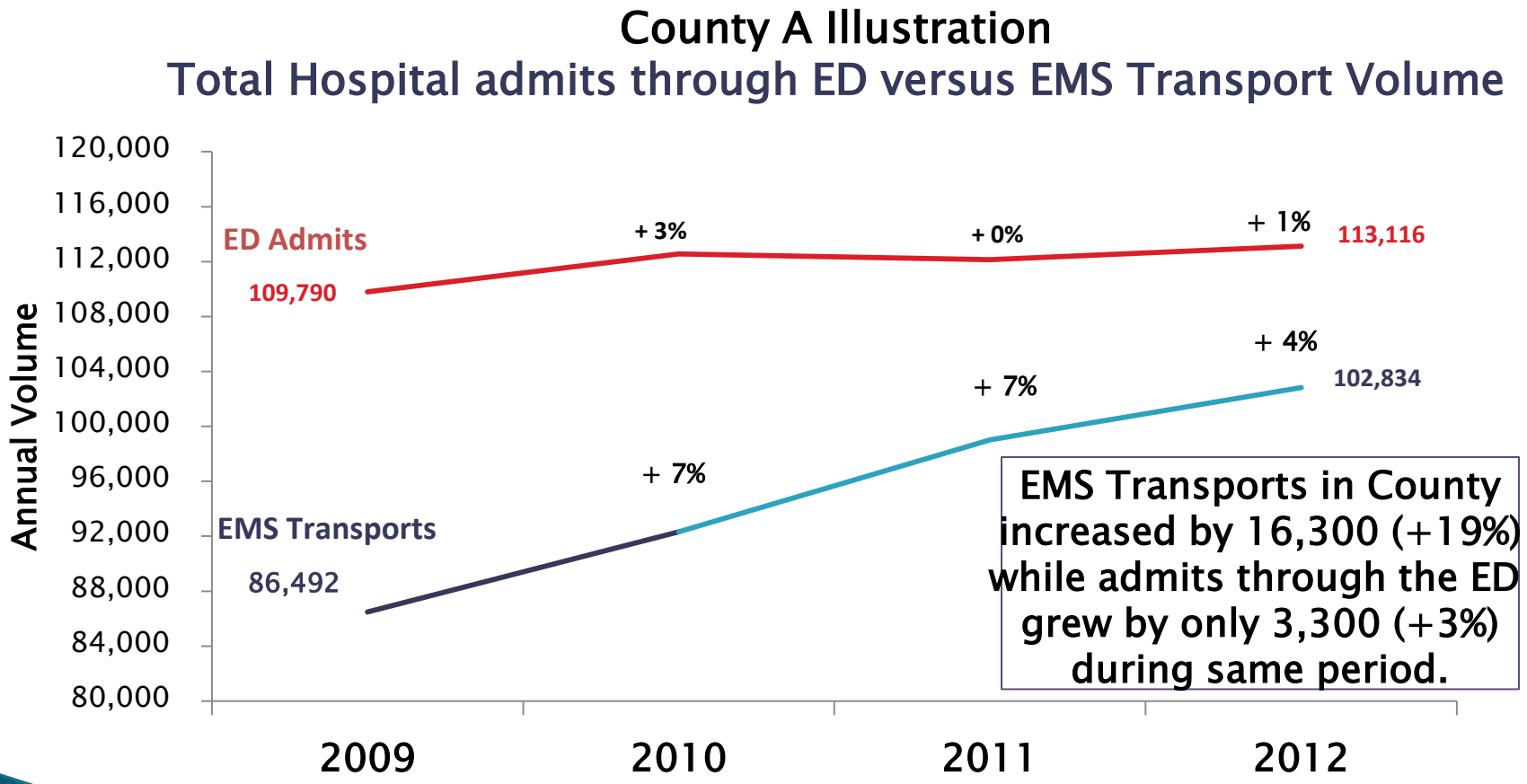
= EMS transport

= non-transport ED

= non-ED acute admit

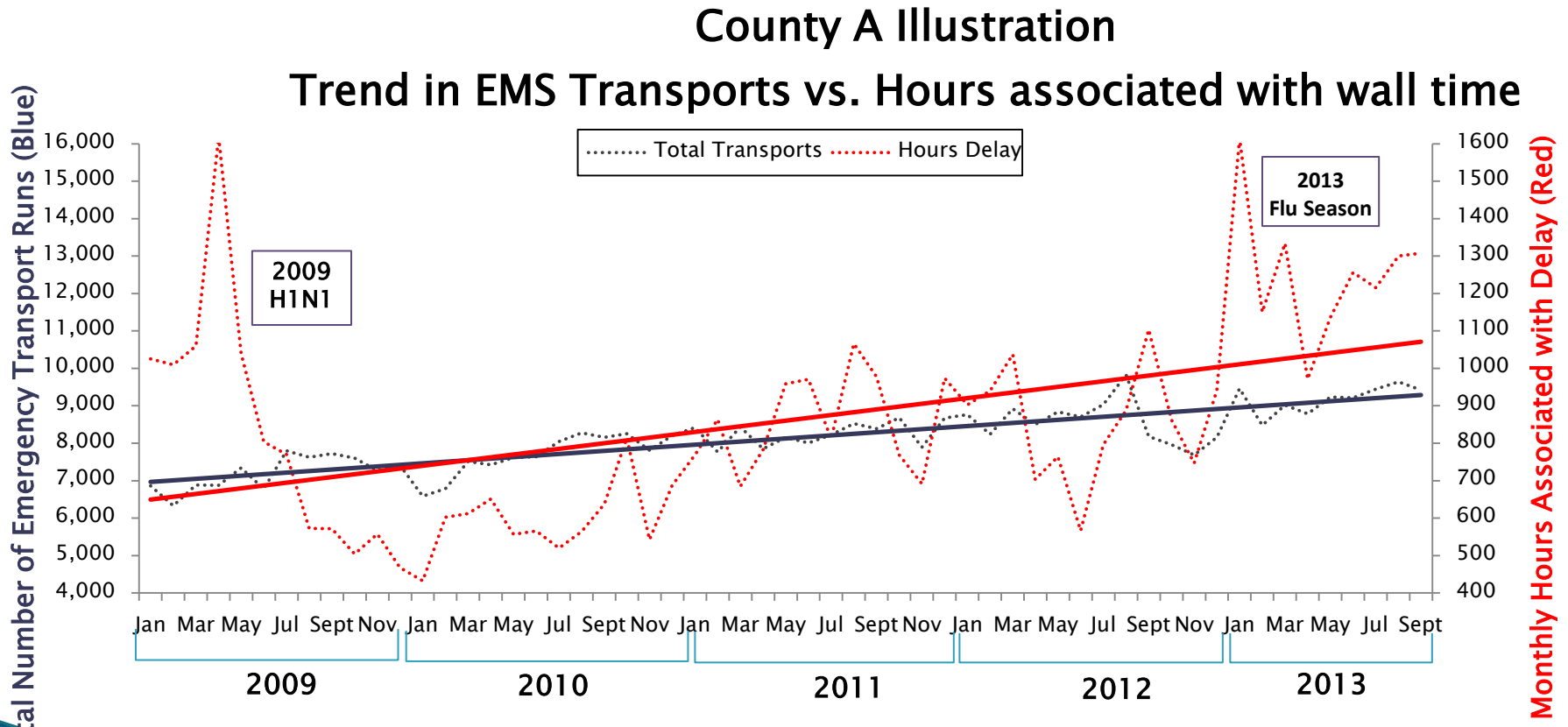
Source: Based on analysis of county [illegible]lished transport data and OSHPD Encounters data for 2011.

Observed growth in EMS transports greater than growth in Hospital admits through ED



Source: Based on analysis of county published transport data and OSHPD.

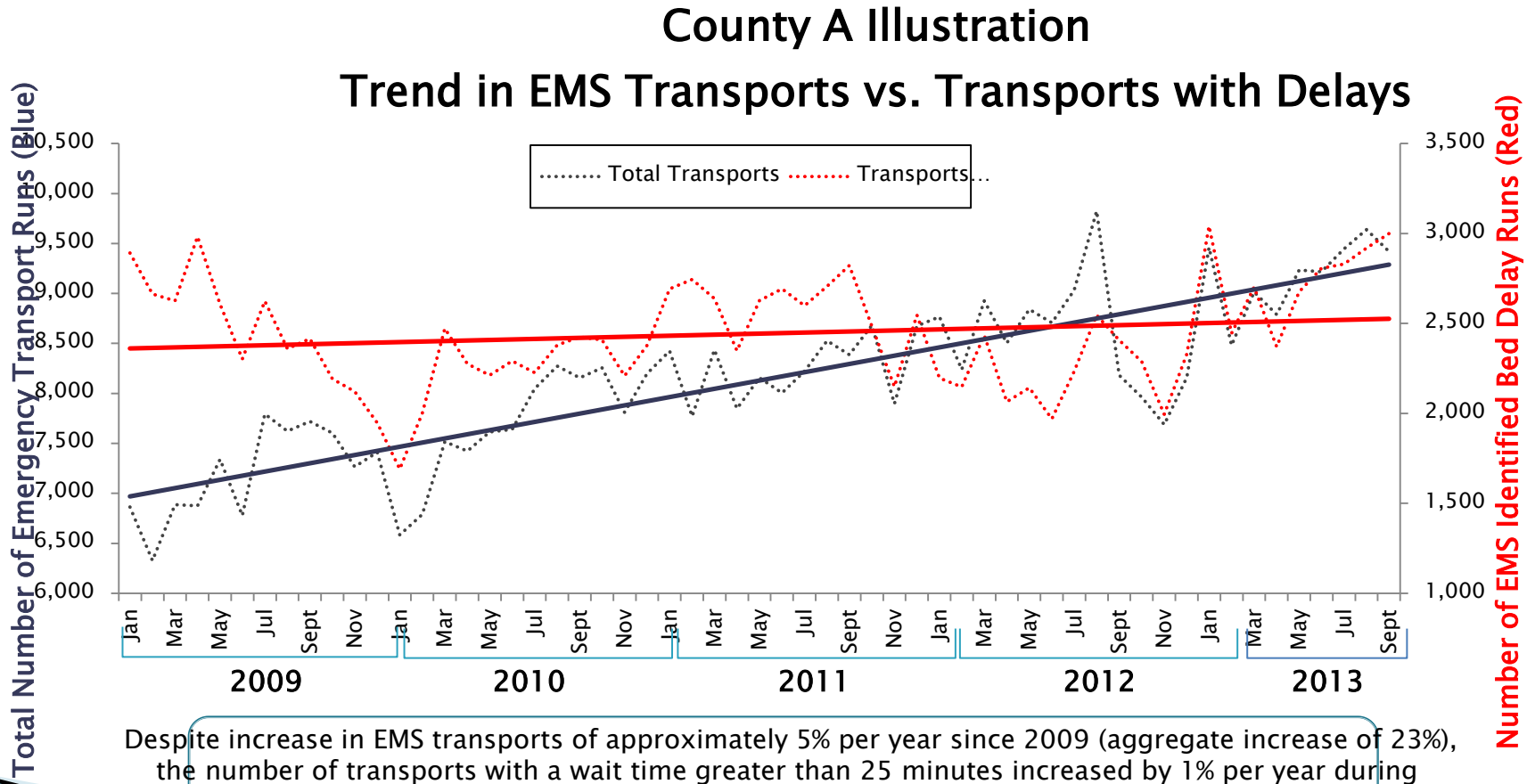
Hours associated with ambulance "wall time" has grown, driven by both increased transport volume and wait times



While EMS transport have increased by 23% since 2009, the yearly hours associated with wall time delays has increased by 38%. This is driven by an increase in the average "delay time" from 20 minutes to 26 minutes (delays are measured as time over the initial 25 minute delay threshold).

Source: Based on data in monthly reports publ[illegible] county.

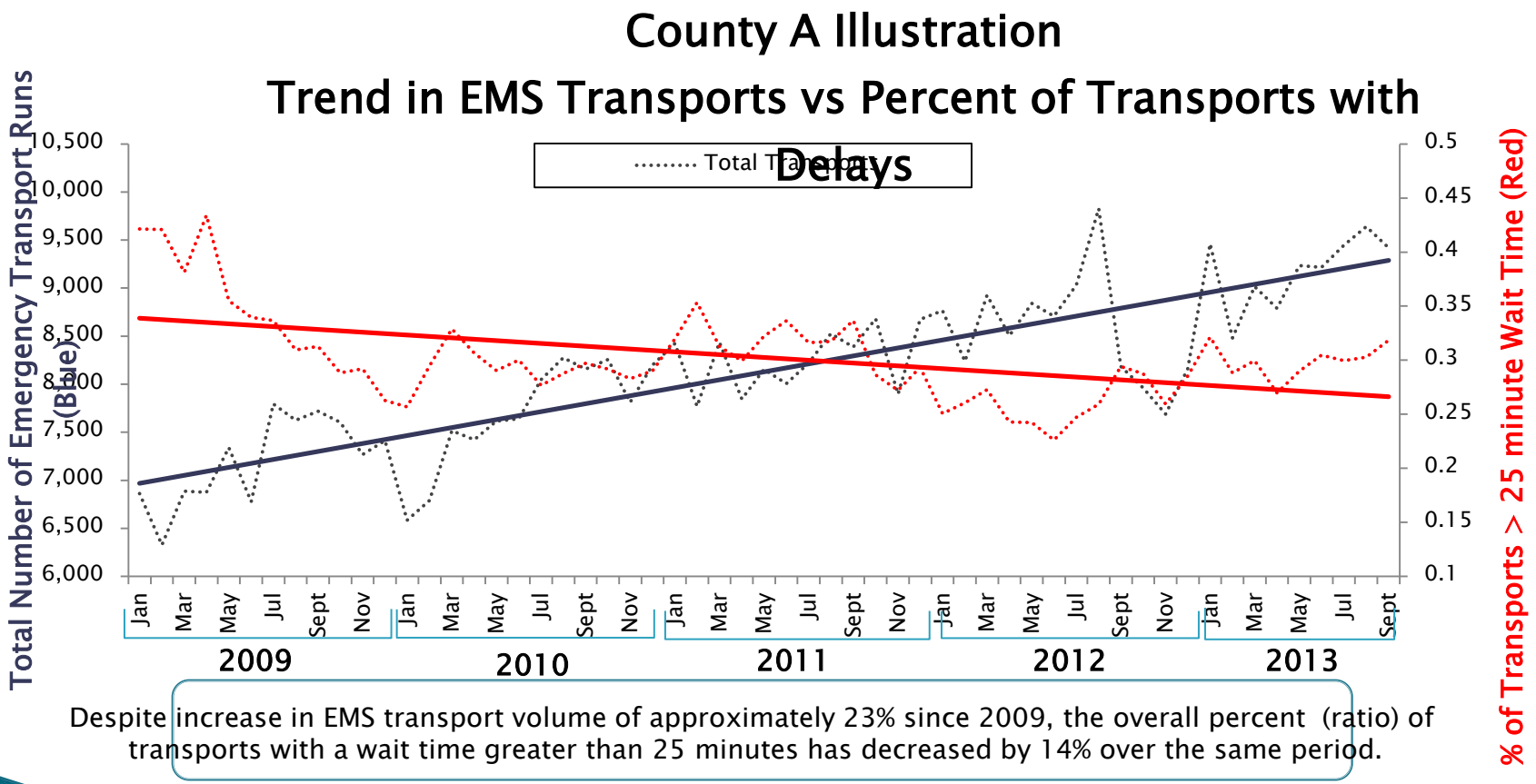
As transports have increased, hospitals have managed to keep the number ambulance delays from escalating



Despite increase in EMS transports of approximately 5% per year since 2009 (aggregate increase of 23%), the number of transports with a wait time greater than 25 minutes increased by 1% per year during the same period. In 2013, however, the number of bed delays has increased by 18% over 2012 levels.

Source: Based on data in monthly reports published by county.

When delays are viewed as a ratio of overall transports, Delays have actually improved



Despite increase in EMS transport volume of approximately 23% since 2009, the overall percent (ratio) of transports with a wait time greater than 25 minutes has decreased by 14% over the same period.

Source: Based on data in monthly reportes published by county.

Use of Emergency Services in counties is a multi-faceted issue that does not lend itself to a "one size fits all" solution

	County	ED Visits per 1,000 residents	% of ED Visits Medi-Cal or Uninsured	MD Licenses per 100,000 residents	FQHC per 100,000 residents < 150% FPL	EMS Stations per 100,000 residents	% of Population < 150% FPL	% of Population > age 65
High ED Rate	Imperial	**516**	57%	76	10	22	39%	11%
	Contra Costa	**398**	38%	287	3	25	18%	13%
	Kern	**381**	64%	129	9	19	38%	9%
	San Bernardino	370	50%	182	1	21	33%	10%
	Fresno	361	51%	199	6	20	42%	11%
Mid	Sacramento	359	50%	311	3	20	30%	12%
	Alameda	353	42%	305	11	22	21%	12%
	California Avg.	**333**	**45%**	**272**	**7**	**20**	**28%**	**12%**
	San Francisco	333	38%	747	9	20	23%	14%
	Riverside	323	45%	128	3	18	30%	12%
Lower ED Rate	Los Angeles	318	47%	285	6	18	31%	11%
	San Diego	293	40%	311	10	20	25%	12%
	San Mateo	**280**	28%	374	4	17	15%	14%
	Orange	**278**	31%	306	3	22	22%	12%
	Santa Clara	**261**	36%	405	7	15	18%	12%

= Unfavorable relative to characteristic driving ED volume

= Favorable relative to characteristic drving ED volume

Sources: OSHPD, Ca[illegible] Department of Finance and US Census Bureau. All data represents 2012.

Legal Considerations

- Paramedic scope of practice
- EMTALA
- Definition of “triage” and “medical screening”
- How does CMS/CDPH address EMS delays in transfer ?
- What are the JC standards on ED and hospital throughput?

Can EMS Legally Practice in a Hospital?

CA Health and Safety Code, Division 2.5, and CCR Title 22, Chapter 4, Section 100145

- Allows paramedics to practice at the scene of an emergency, during transport *and* "while in the ED of an acute care hospital until responsibility is assumed by hospital staff"
- Does not provide for routine or extended continuation of care for patients transported by EMS personnel once the hospital is responsible for the care of the patient

Legal/Regulatory Issues

Emergency Medical Treatment and Labor Act (EMTALA)

- A hospital is responsible for the care of a patient when the patient or ambulance arrives on "hospital grounds"
- Requires initial assessment and triage of the patient without delay
- EMTALA does not specifically define the transfer of responsibility or the 'formal acceptance' of the patient from EMS to ED staff

Legal/Regulatory Issues

Center for Medicare and Medicaid Services (CMS) S&C-06-21, July 2006

"Parking" patients in hospitals and refusing to release EMS equipment or personnel jeopardizes patient health and impacts the ability of EMS personnel to provide emergency services to the rest of the community.

Delaying ambulance ED offload may result in a violation of the Emergency Medical Treatment and Labor Act (EMTALA) and raises serious concerns for patient care and the provision of emergency services in a community. Additionally, this practice may also result in violation of the Conditions of Participation for Hospitals….

Legal/Regulatory Issues

Center for Medicare and Medicaid Services (CMS) S&C-07-20, April 2007

Clarifies that S&C 06-21 does not mean that "a hospital will not necessarily have violated EMTALA if it does not, in every instance, immediately assume from the EMS provider all responsibility for the individual, regardless of any other circumstances in the ED…. In some circumstances it could be reasonable for the hospital to ask the EMS provider to stay with the individual until such time as there were ED staff available to provide care to that individual."

Joint Commission

Joint Commission accreditation standard for ED Patient Flow (LD.04.03.11)

- Went into effect January 2, 2014
- Nine elements of performance (EP)
- Recommended that "boarding time frames not exceed four hours in the interest of patient safety and quality of care"
- The individuals who manage patient flow processes review measurement results to determine that goals were achieved
- Leaders take action to improve patient flow processes when goals are not achieved

ED Crowding, Wall Time and Output Activities

- ED crowding caused by boarding of admitted patients a patient safety concern. Least controlled aspect for ED staff
- The JC new 2014 Elements of Performance for leaders outside the ED to be accountable to take actions
- Where are the barriers?
  Informed consent in nursing homes, placement issues, behavioral health placements, primary care, provider availability

Best Practices

- Santa Clara
- San Diego
- Los Angeles

ED Patient Throughput Scoring Tools and Patient Management Metrics

- Do you have an ED Crowding Scoring Tool?
- Do you collect and utilize data to improve patient flow management?
- CHA Webinar on the California Community ED Overcrowding Scoring Tool, CEDOCS and DEDOCS, Dignity Health's Customized Management of Patient Flow
- CHA Educational Programs Tab- program recordings: www.calhospital.org
- www.jointcommission.org/accreditation/patient.flow.resources
- CHA's Toolkit to Reduce Ambulance Patient Offload Delay in the Emergency Department and CHA's Behavioral Health Toolkit

Questions

CHA EMERGENCY DEPARTMENT TOOLKITS

BEHAVIORAL HEALTH RESOURCES FOR ED'S

and

TOOLKIT TO REDUCE AMBULANCE PATIENT OFFLOAD DELAYS

BJ Bartleson, RN, MS, NEA-BC
Vice President, Nursing & Clinical Services
California Hospital Association
Sacramento, California

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

Objectives

- Learn about a comprehensive behavioral health resource toolkit for hospital emergency departments
- Support staff in their identification of solutions and strategies to treat behavioral health crises and improved emergency department patient throughput
- Develop a just-in-time web-based tool that reflects current behavioral health trends and practices
- Be familiar with a toolkit to reduce ambulance patient offload delays
- Understand “walltime” delays and hospital mitigating strategies

CALIFORNIA HOSPITAL ASSOCIATION

Leadership in Health Policy and Advocacy

Home | Legislation & Advocacy | Hospital Topics | Centers & Committees | Newsroom | Education | Publications | About CHA

BACK

This item appears in:

EMS / Trauma Committee Documents

Emergency Department Toolkit

Behavioral Health Resources for the Emergency Department

NOVEMBER 22, 2013 | BJ BARTLESON | SHEREE KRUCKENBERG

Special resource toolkit developed by CHA's EMS/Trauma Committee and the Center for Behavioral Health. Designed to help staff provide support to patients in the ED with psychosis and/or substance abuse disorders, this toolkit provides access to articles, policies, management techniques, assessment tools and more.Click the topic tabs below to access resources and information.

Assessment Tools | CHA Manuals/Resources | Family Resources | Laws/Regulations | Patient Throughput | Psych Patient Management | Suicide Prevention

Behavioral Health Assessment Template

Sample Excel form to assess the extent to which numerous items are implemented.

Key Elements for Conducting a One-Hour Face-to-Face Assessment

APNA pre-recorded initial session designed as a resource for RNs who are conducting the CMS-mandated one-hour face-to-face assessment of patients in restraint or seclusion. There is an archive access fee to APNA non-members.

> Assessment Guide for Key Elements in the One-Hour Face-to-Face Assessment
> This APNA interactive session builds upon the information found in "Key Elements for Conducting a One-Hour Face-to-Face Assessment." Podcast includes guided self-study examples and self-directed quizzes and answers, PowerPoint slides, a study guide, and case studies. Both sessions are approved for continuing education credit. There is an online access fee.

Medical Clearance Criteria/Exclusion Policy

Policy on Patient Assessment, from St. Joseph's Behavioral Health Center.

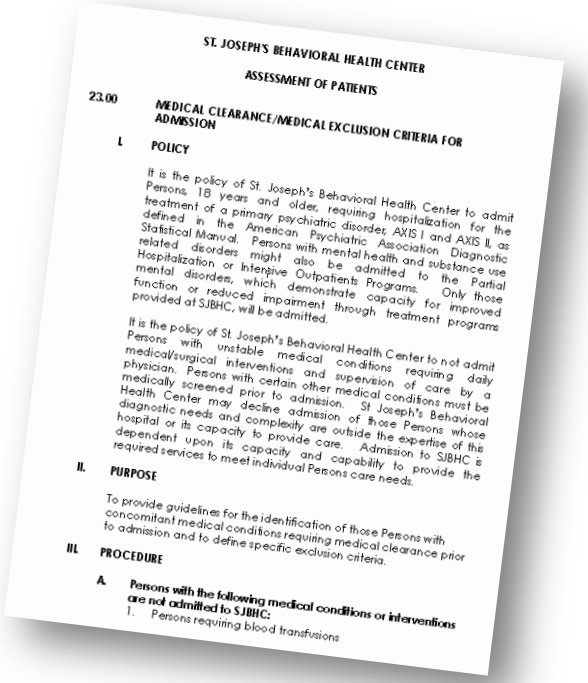
BJ Bartleson
Vice President
Nursing & Clinical Services

Sheree Kruckenberg
Vice President, Behavioral Health

Assessment Tools

ASSESSMENT TEMPLATES & GUIDES

- Behavioral Health Assessment
- One Hour Face-to-Face Assessment Guide
- Medical Clearance Criteria
- Medical Clearance Exclusion Policy
- RN Admission Review



ST. JOSEPH'S BEHAVIORAL HEALTH CENTER

ASSESSMENT OF PATIENTS

23.00 MEDICAL CLEARANCE/MEDICAL EXCLUSION CRITERIA FOR ADMISSION

I. POLICY

It is the policy of St. Joseph's Behavioral Health Center to admit Persons, 18 years and older, requiring hospitalization for the treatment of a primary psychiatric disorder, AXIS I and AXIS II, as defined in the American Psychiatric Association Diagnostic Statistical Manual. Persons with mental health and substance use related disorders might also be admitted to the Partial Hospitalization or Intensive Outpatients Programs. Only those mental disorders, which demonstrate capacity for improved function or reduced impairment through treatment programs provided at SJBHC, will be admitted.

It is the policy of St. Joseph's Behavioral Health Center to not admit Persons with unstable medical conditions requiring daily medical/surgical interventions and supervision of care by a physician. Persons with certain other medical conditions must be medically screened prior to admission. St Joseph's Behavioral Health Center may decline admission of those Persons whose diagnostic needs and complexity are outside the expertise of the hospital or its capacity to provide care. Admission to SJBHC is dependent upon its capacity and capability to provide the required services to meet individual Persons care needs.

II. PURPOSE

To provide guidelines for the identification of those Persons with concomitant medical conditions requiring medical clearance prior to admission and to define specific exclusion criteria.

III. PROCEDURE

A. Persons with the following medical conditions or interventions are not admitted to SJBHC:

1. Persons requiring blood transfusions

CHA Manuals & Resources

- EMTALA
- Consent Manual
- Principles of Consent and Advance Directives
- Mental Health Law
- HIPAA/HITECH
  - Final Rule and California Law Webinar DVD

Family Resources

Support groups

Al-Anon, alateen, etc.

Web Sites

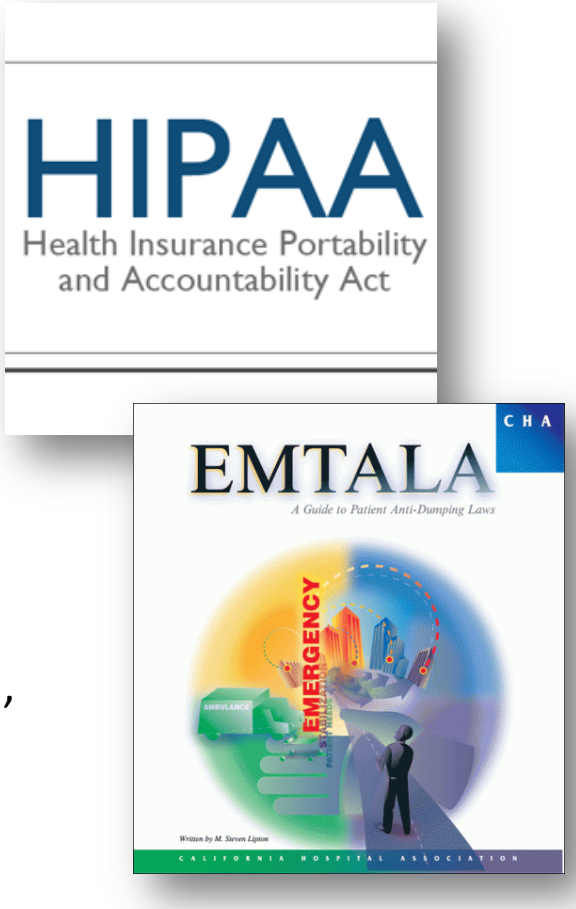
chadd.org, nimh.nih.gov, etc.

Medical Community

Laws and Regulations

STATE LAW

- Health Information Privacy Manual
- Assembly and Senate bills
- California Department of Public Health
- Lanterman-Petris-Short (LPS) Act
  5150 Involuntary Commitment

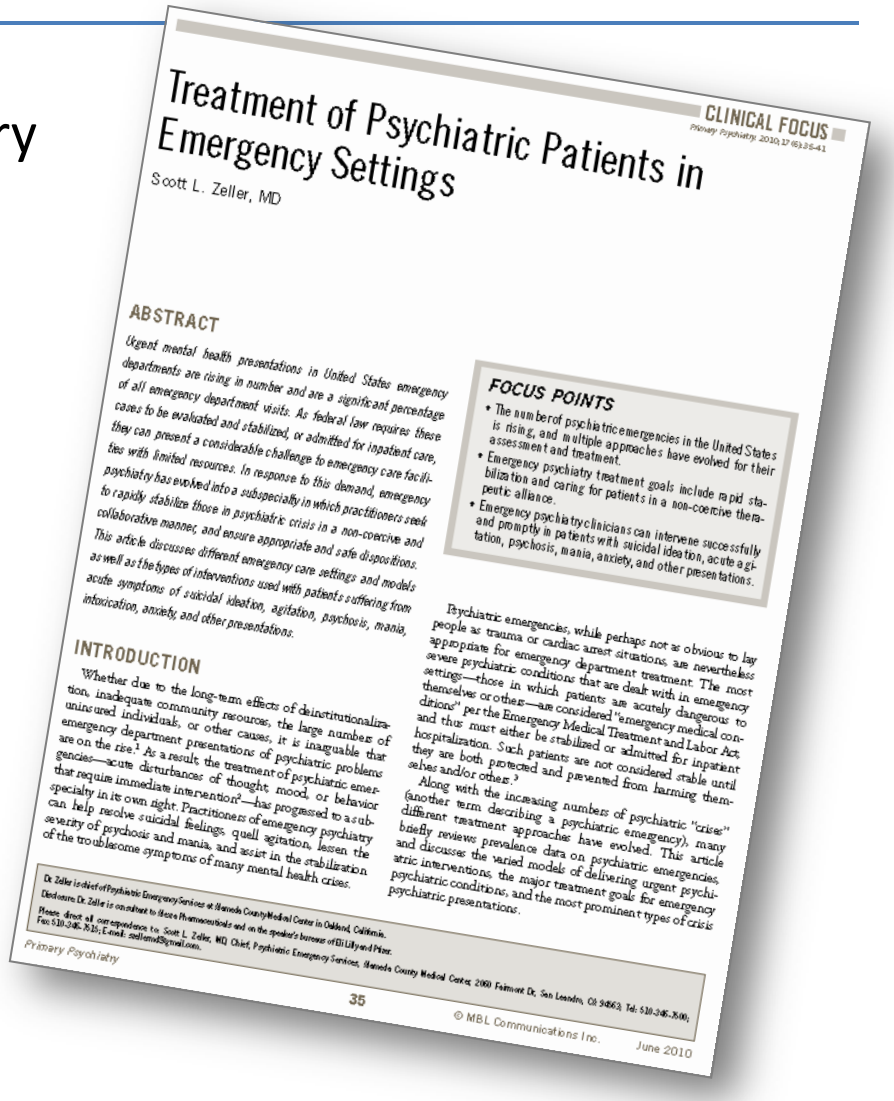


FEDERAL LAW

- HIPPA
  - Patient privacy rights, use/disclosure of PHI, and breaches
- EMTALA
  - Patient anti-dumping laws

Patient Throughput

- Trends in Emergency psychiatry
- Improving flow and reducing agitation
- Performance improvement
- Adapting and implementing new strategies
- Reducing ED “boarding” of psychiatric patients
- Decreasing lengths of stay



CLINICAL FOCUS

Treatment of Psychiatric Patients in Emergency Settings

Scott L. Zeller, MD

ABSTRACT

Urgent mental health presentations in United States emergency departments are rising in number and are a significant percentage of all emergency department visits. As federal law requires these cases to be evaluated and stabilized, or admitted for inpatient care, they can present a considerable challenge to emergency care facilities with limited resources. In response to this demand, emergency psychiatry has evolved into a subspecialty in which practitioners seek to rapidly stabilize those in psychiatric crisis in a non-coercive and collaborative manner, and ensure appropriate and safe dispositions. This article discusses different emergency care settings and models as well as the types of interventions used with patients suffering from acute symptoms of suicidal ideation, agitation, psychosis, mania, intoxication, anxiety, and other presentations.

FOCUS POINTS

- The number of psychiatric emergencies in the United States is rising, and multiple approaches have evolved for their assessment and treatment.
- Emergency psychiatry treatment goals include rapid stabilization and caring for patients in a non-coercive therapeutic alliance.
- Emergency psychiatry clinicians can intervene successfully and promptly in patients with suicidal ideation, acute agitation, psychosis, mania, anxiety, and other presentations.

INTRODUCTION

Whether due to the long-term effects of deinstitutionalization, inadequate community resources, the large numbers of uninsured individuals, or other causes, it is inarguable that emergency department presentations of psychiatric problems are on the rise.[1] As a result, the treatment of psychiatric emergencies—acute disturbances of thought, mood, or behavior that require immediate intervention[2]—has progressed to a subspecialty in its own right. Practitioners of emergency psychiatry can help resolve suicidal feelings, quell agitation, lessen the severity of psychosis and mania, and assist in the stabilization of the troublesome symptoms of many mental health crises.

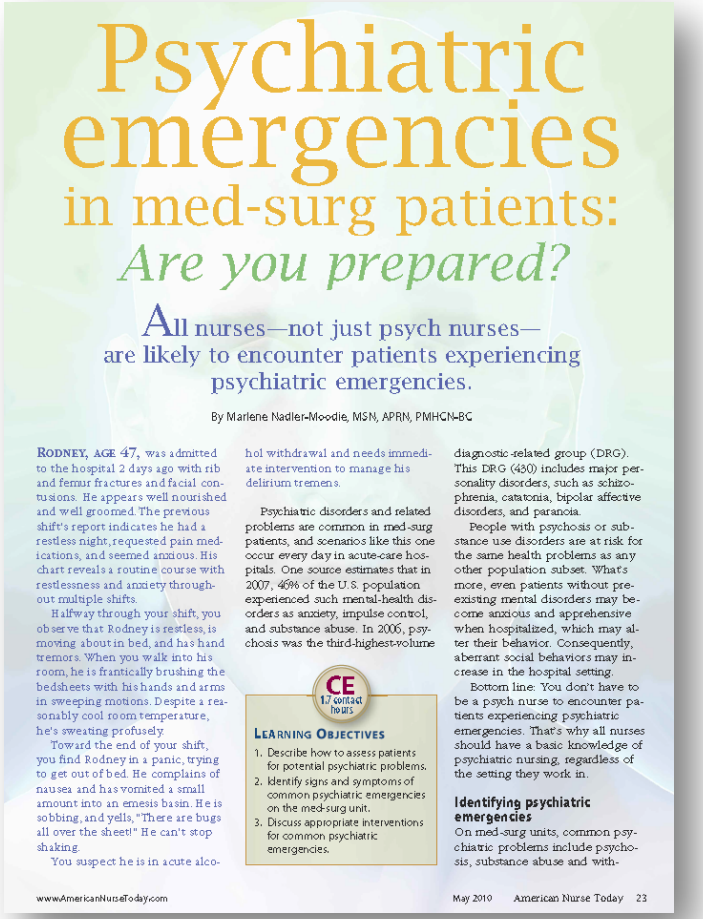
Psychiatric emergencies, while perhaps not as obvious to lay people as trauma or cardiac arrest situations, are nevertheless appropriate for emergency department treatment. The most severe psychiatric conditions that are dealt with in emergency settings—those in which patients are acutely dangerous to themselves or others—are considered "emergency medical conditions" per the Emergency Medical Treatment and Labor Act, and thus must either be stabilized or admitted for inpatient hospitalization. Such patients are not considered stable until they are both protected and prevented from harming themselves and/or others.[3]

Along with the increasing numbers of psychiatric "crises" (another term describing a psychiatric emergency), many different treatment approaches have evolved. This article briefly reviews prevalence data on psychiatric emergencies, and discusses the varied models of delivering urgent psychiatric interventions, the major treatment goals for emergency psychiatric conditions, and the most prominent types of crisis psychiatric presentations.

Dr. Zeller is chief of Psychiatric Emergency Services at Alameda County Medical Center in Oakland, California.
Disclosure: Dr. Zeller is on a retainer to Abbott Pharmaceuticals and on the speaker's bureaus of Eli Lilly and Pfizer.
Please direct all correspondence to: Scott L. Zeller, MD, Chief, Psychiatric Emergency Services, Alameda County Medical Center, 2060 Fairmont Dr, San Leandro, CA 94603; Tel: 510-346-8500; Fax: 510-346-8510; E-mail: szellermd@gmail.com.

Psych Patient Management

- Psychiatric emergencies in Med/Surg
- Psychiatric crash cart
- Rapid response team
- Interagency guideline on opioid dosing
- Managing drug-seeking patients
- Ethical, legal, professional challenges



Psychiatric emergencies in med-surg patients: *Are you prepared?*

All nurses—not just psych nurses—are likely to encounter patients experiencing psychiatric emergencies.

By Marlene Nadler-Moodie, MSN, APRN, PMHCN-BC

RODNEY, AGE 47, was admitted to the hospital 2 days ago with rib and femur fractures and facial contusions. He appears well nourished and well groomed. The previous shift's report indicates he had a restless night, requested pain medications, and seemed anxious. His chart reveals a routine course with restlessness and anxiety throughout multiple shifts.

Halfway through your shift, you observe that Rodney is restless, is moving about in bed, and has hand tremors. When you walk into his room, he is frantically brushing the bedsheets with his hands and arms in sweeping motions. Despite a reasonably cool room temperature, he's sweating profusely.

Toward the end of your shift, you find Rodney in a panic, trying to get out of bed. He complains of nausea and has vomited a small amount into an emesis basin. He is sobbing, and yells, "There are bugs all over the sheet!" He can't stop shaking.

You suspect he is in acute alcohol withdrawal and needs immediate intervention to manage his delirium tremens.

Psychiatric disorders and related problems are common in med-surg patients, and scenarios like this one occur every day in acute-care hospitals. One source estimates that in 2007, 46% of the U.S. population experienced such mental-health disorders as anxiety, impulse control, and substance abuse. In 2006, psychosis was the third-highest-volume diagnostic-related group (DRG). This DRG (430) includes major personality disorders, such as schizophrenia, catatonia, bipolar affective disorders, and paranoia.

People with psychosis or substance use disorders are at risk for the same health problems as any other population subset. What's more, even patients without preexisting mental disorders may become anxious and apprehensive when hospitalized, which may alter their behavior. Consequently, aberrant social behaviors may increase in the hospital setting.

Bottom line: You don't have to be a psych nurse to encounter patients experiencing psychiatric emergencies. That's why all nurses should have a basic knowledge of psychiatric nursing, regardless of the setting they work in.

CE 1.7 contact hours

LEARNING OBJECTIVES

1. Describe how to assess patients for potential psychiatric problems.
2. Identify signs and symptoms of common psychiatric emergencies on the med-surg unit.
3. Discuss appropriate interventions for common psychiatric emergencies.

Identifying psychiatric emergencies

On med-surg units, common psychiatric problems include psychosis, substance abuse and with-

www.AmericanNurseToday.com May 2010 American Nurse Today 23

Suicide Prevention

PRESENTATIONS AND WEBINARS

- Managing suicidal patients in the ED
- Suicide risk assessments
- Prevention and research

PUBLICATIONS

- Recognition, treatment and prevention
- Research and references

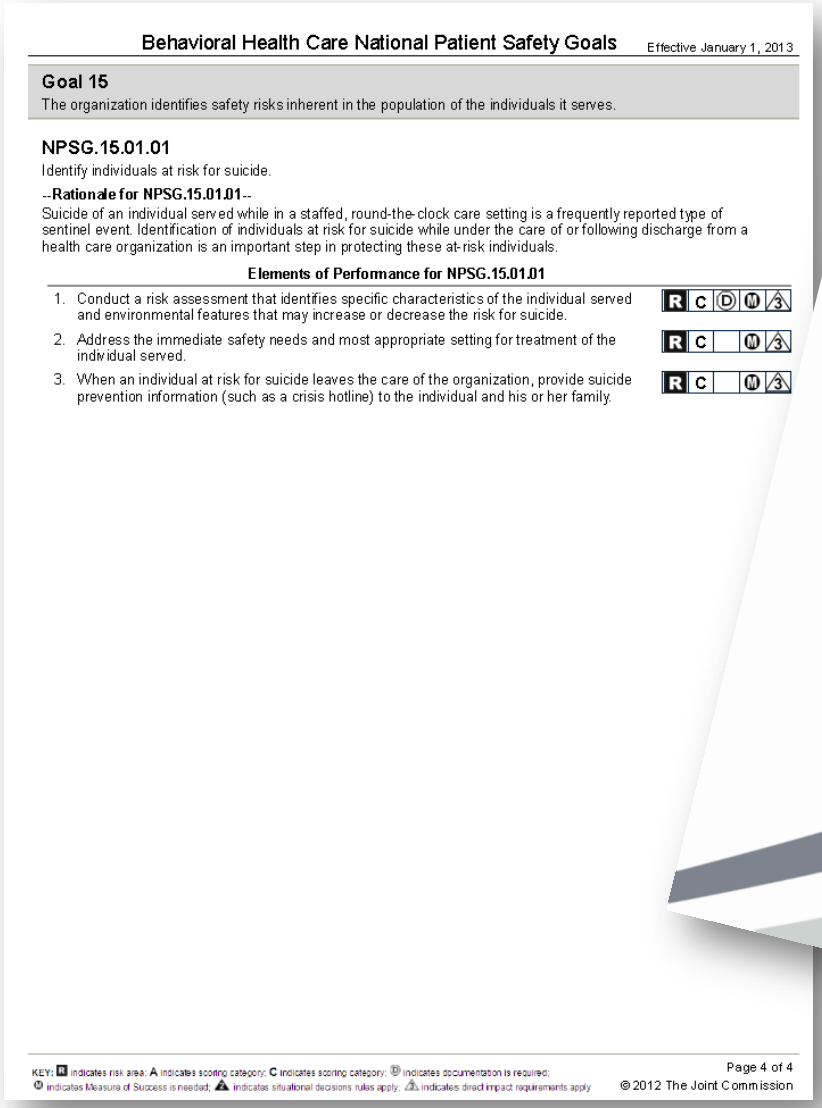
TOOLS AND GUIDES

- FAQs, posters, brochures, guides

WEBSITES

- National suicide prevention resources

Suicide Prevention Publications



Behavioral Health Care National Patient Safety Goals Effective January 1, 2013

Goal 15

The organization identifies safety risks inherent in the population of the individuals it serves.

NPSG.15.01.01

Identify individuals at risk for suicide.

--Rationale for NPSG.15.01.01--

Suicide of an individual served while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

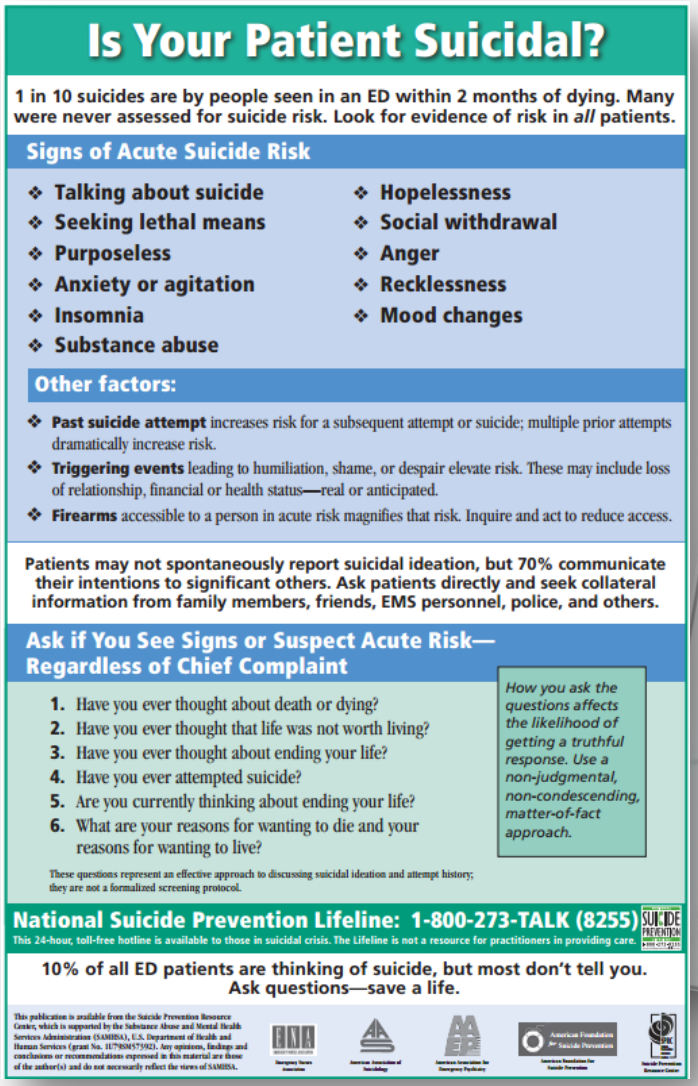
Elements of Performance for NPSG.15.01.01

1. Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide. R C D M 3
2. Address the immediate safety needs and most appropriate setting for treatment of the individual served. R C M 3
3. When an individual at risk for suicide leaves the care of the organization, provide suicide prevention information (such as a crisis hotline) to the individual and his or her family. R C M 3

KEY: R indicates risk area; A indicates scoring category; C indicates scoring category; D indicates documentation is required; M indicates Measure of Success is needed; ▲ indicates situational decisions rules apply; ⚠ indicates direct impact requirements apply

Page 4 of 4

Suicide Prevention Tools and Guides



Is Your Patient Suicidal?

1 in 10 suicides are by people seen in an ED within 2 months of dying. Many were never assessed for suicide risk. Look for evidence of risk in *all* patients.

Signs of Acute Suicide Risk

- **Talking about suicide**
- **Seeking lethal means**
- **Purposeless**
- **Anxiety or agitation**
- **Insomnia**
- **Substance abuse**
- **Hopelessness**
- **Social withdrawal**
- **Anger**
- **Recklessness**
- **Mood changes**

Other factors:

- **Past suicide attempt** increases risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk.
- **Triggering events** leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status—real or anticipated.
- **Firearms** accessible to a person in acute risk magnifies that risk. Inquire and act to reduce access.

Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others. Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.

Ask if You See Signs or Suspect Acute Risk—Regardless of Chief Complaint

1. Have you ever thought about death or dying?
2. Have you ever thought that life was not worth living?
3. Have you ever thought about ending your life?
4. Have you ever attempted suicide?
5. Are you currently thinking about ending your life?
6. What are your reasons for wanting to die and your reasons for wanting to live?

How you ask the questions affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter-of-fact approach.

These questions represent an effective approach to discussing suicidal ideation and attempt history; they are not a formalized screening protocol.

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

This 24-hour, toll-free hotline is available to those in suicidal crisis. The Lifeline is not a resource for practitioners in providing care.

10% of all ED patients are thinking of suicide, but most don't tell you. Ask questions—save a life.

This publication is available from the Suicide Prevention Resource Center, which is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (grant No. 1U79SM57592). Any opinions, findings and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of SAMHSA.

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1 IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2 IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

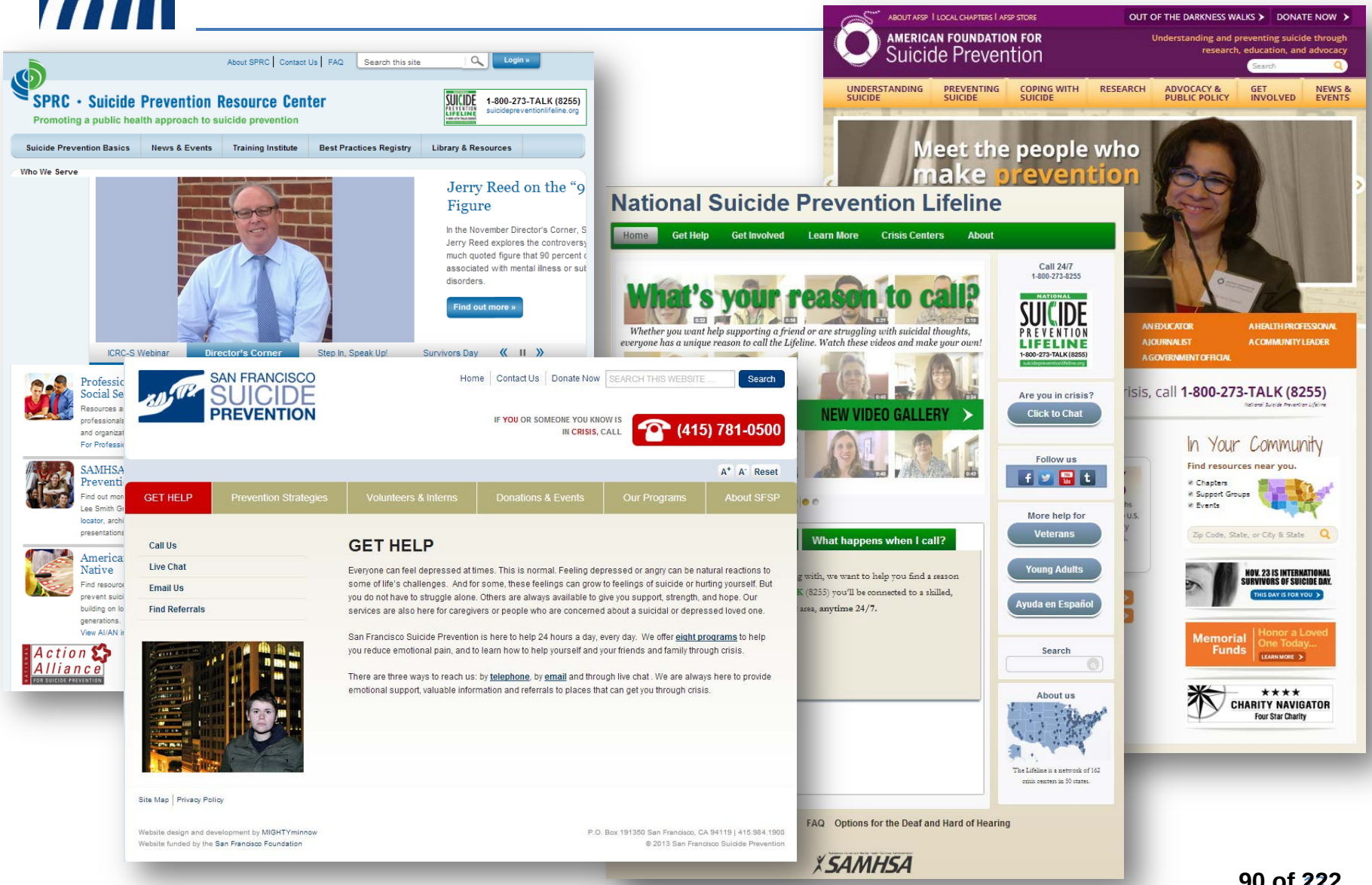
3 CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4 DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5 DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Suicide Prevention Websites



CALIFORNIA HOSPITAL ASSOCIATION

Leadership in Health Policy and Advocacy

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BACK

This item appears in:

EMS / Trauma Committee Documents

Emergency Department Toolkit

Behavioral Health Resources for the Emergency Department

NOVEMBER 22, 2013 | BJ BARTLESON | SHEREE KRUCKENBERG

Special resource toolkit developed by CHA's EMS/Trauma Committee and the Center for Behavioral Health. Designed to help staff provide support to patients in the ED with psychosis and/or substance abuse disorders, this toolkit provides access to articles, policies, management techniques, assessment tools and more.Click the topic tabs below to access resources and information.

BJ Bartleson
Vice President Nursing & Clinical Services

Sheree Kruckenberg
Vice President, Behavioral Health

http://www.calhospital.org/general-information/emergency-department-toolkit

ED Walltime

ED Walltime Toolkit

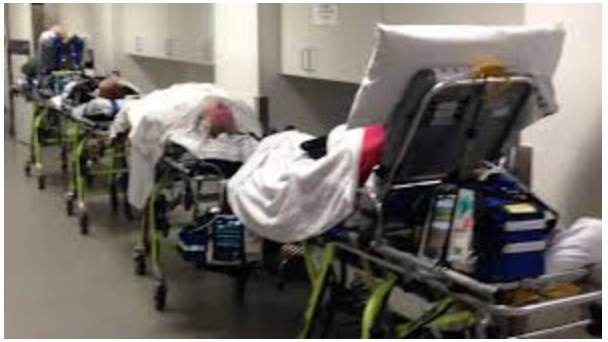
Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department

Building Strategies for California Hospitals and Local Emergency Services Agencies

Web link: http://www.calhospital.org/cha-news-article/cha-releases-toolkit-reduce-ambulance-patient-offload-delays

EMS Ambulance Patient Offload Time

AKA…



- Ambulance wall time
- Ambulance wait times
- EMS patient parking
- Capture of emergency medical services
- Patient handover delays
- Patient offload delays

"The interval between arrival of an ambulance patient at the ED until the EMS and ED personnel transfer the patient to an ED stretcher and the ED staff assume the responsibility for care for the patient."

National Association of EMS Physicians position statement, 2011

California Walltime Collaborative

California Hospital Association
Emergency Medical Services Authority
Local Emergency Medical Services Administrators
EMS, hospitals, health systems, professional organizations

1. Develop metrics and measure uniformly
2. Develop best practices to address problem
3. Dialogue with hospitals and medical systems
4. Encourage quality improvement and best practices
5. Observe impact of new Joint Commission metrics on hospital throughput

CHA-EMSA Wall Time Collaborative

Triple Aim

Toolkit

- Distribution
- Local process improvement activities

Stakeholder Reconvening

Toolkit Wall Time Collaborative

Workgroups

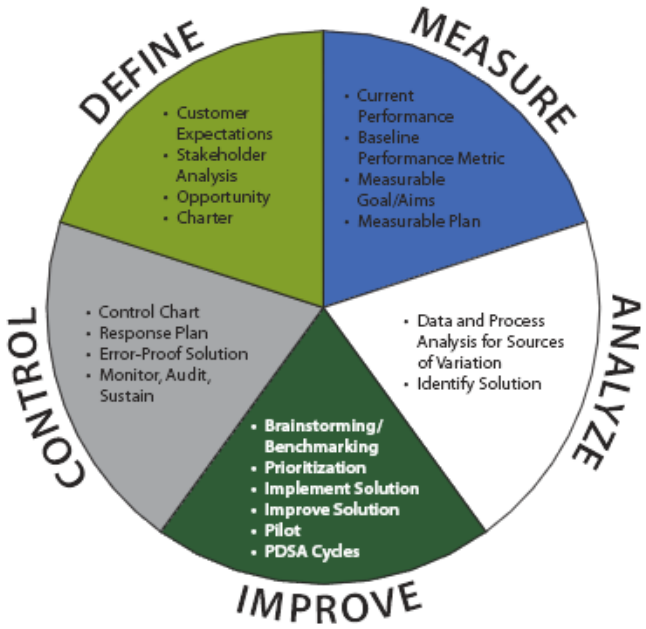
- Legal/Regulatory
- Best Practices
- Metrics

Initial Stakeholder Meeting

Quality Improvement Approach

- Develop a collaborative structure for learning and action
- Combine subject matter experts
- Define, measure, analyze, improve and control
- Reflect and share lessons learned and best practices
- www.hqinstitute.org

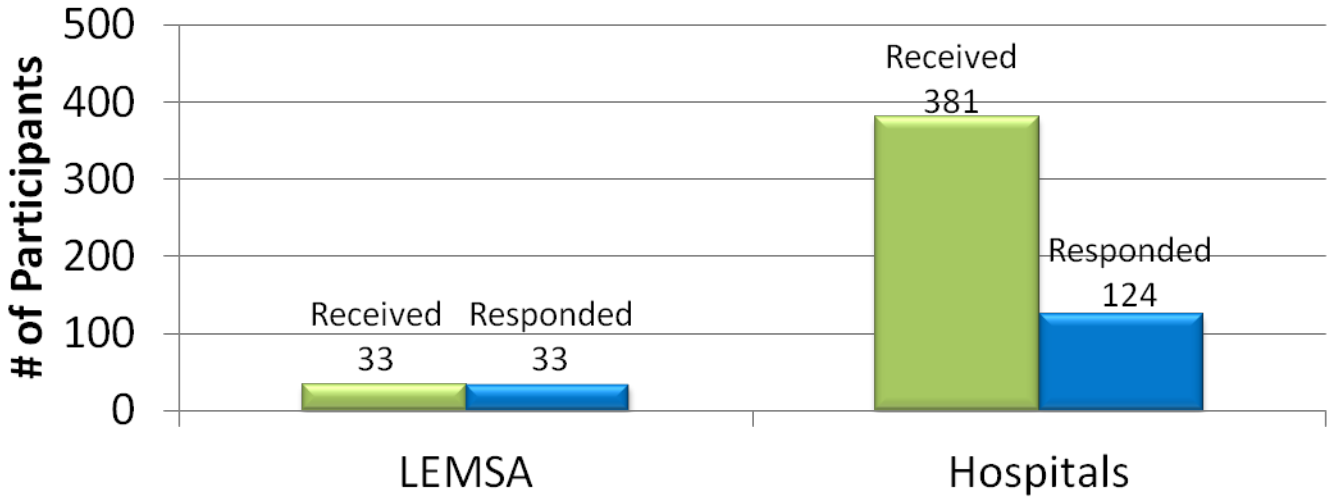
Hospital Quality Institute
Leadership in quality and patient safety



Best Practice Workgroup
Survey Response Levels

Hospital Survey
- Sent to 381 hospitals; 124 responses received
- 32.5% response rate

LEMSA Survey
- Sent to 33 Local EMS agencies; all responded

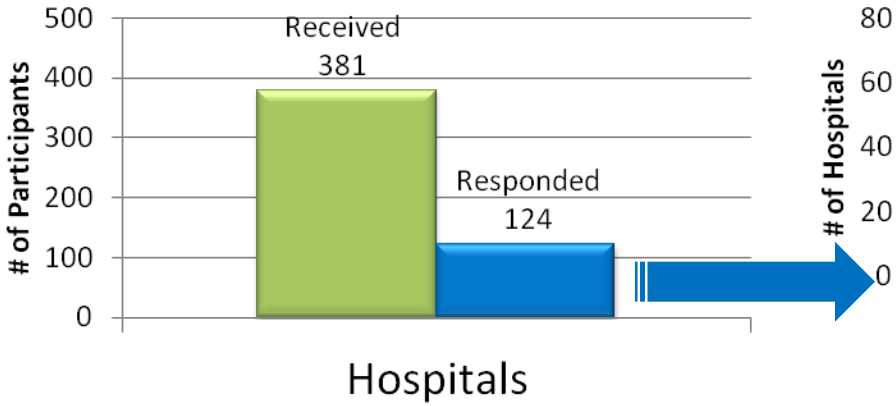


Results

EMS Offload Delay Issue is Polarized

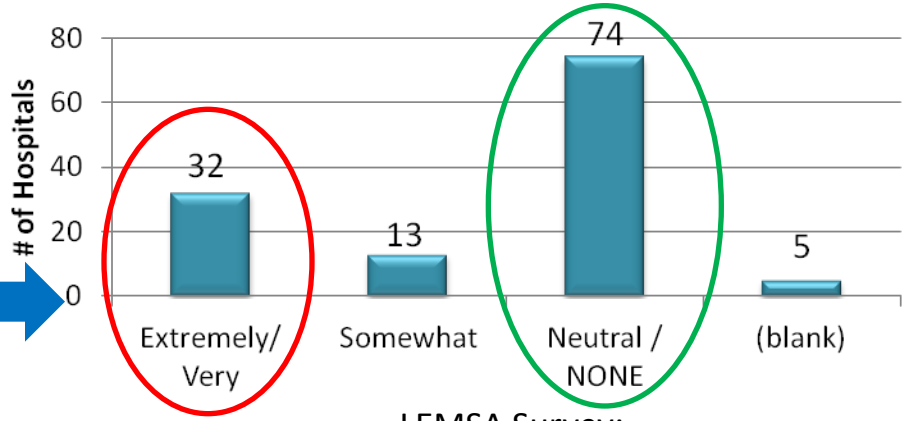
Respondents in both surveys either had extreme delay problems or none

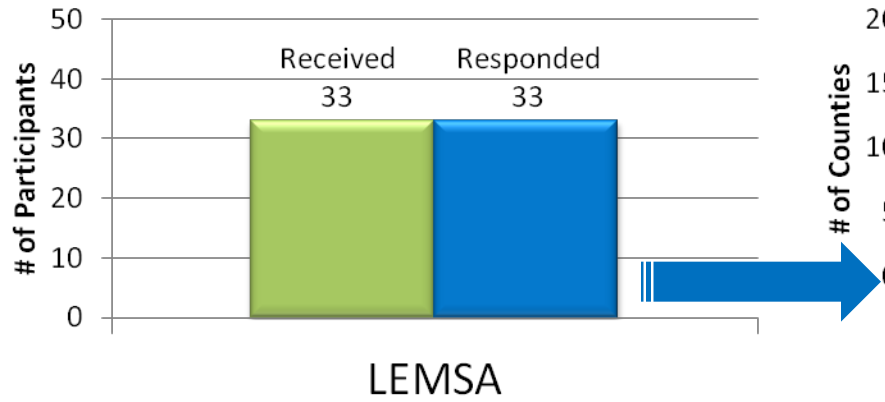
- Majority of responders (~60%) did NOT have an issue



Hospital Survey:

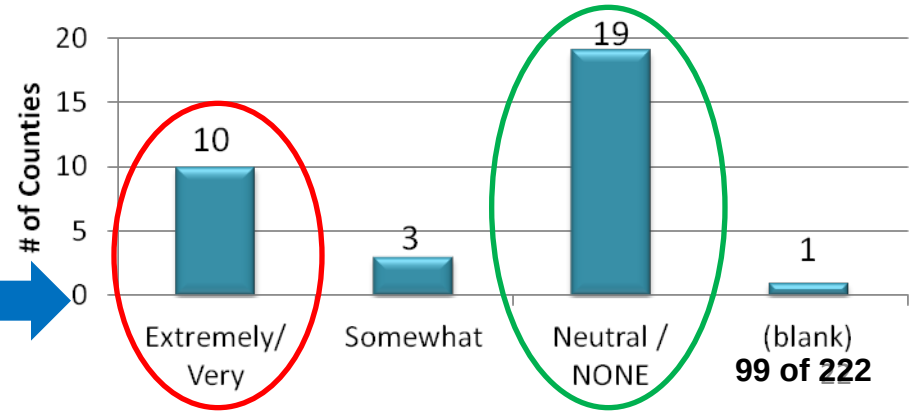
How much problem is off-load delay?





LEMSA Survey:

How much problem is off-load delay?



Hospital Offload Mitigation Strategies: Summary

- ED Intake was the strategy that had the highest frequency of being implemented
- Conversely, the topic with the least frequency of being implemented was ED output

Mitigation Strategy Implemented Topics	Count
ED Intake	460
ED Throughput	250
ED Output	105
ED Overall	317
Hospital Inpatient	240
Hospital Overall	240

Total Number of Hospital Mitigation Strategies

Of the **74 hospitals** who said the impact of EMS offload delay was either **neutral/not significant** the implemented category was selected the most frequently.

Of the **32 hospitals** who said the impact of EMS offload delay was either **extremely or very significant**, the number of implemented strategies was selected far less frequently than those who do not consider offload delay a problem (946 vs. 453).

Mitigation Strategies Stratified by Those Who Said EMS Offload Delay Was Either Neutral or Not Significant	Implemented	Considering	Not tried	Tried; ineffective	Unknown
Management of ED throughput metrics	67	1	2	1	0
Bedside registration	58	7	2	1	0
Orders from triage	57	3	4	1	1
Effective ordering of lab and imaging	56	6	3	1	3
ED management "rounding"	56	6	7	1	1
"Direct to bed" policy	55	8	2	1	1
Performance improvement system; for example, LEAN, Six Sigma, PDSA	54	4	3	2	5
Accelerated intake processes	53	3	10	0	2
Hospital throughput dashboards	53	10	2	2	5
Innovating staffing utilization	51	10	5	1	4
Charge ED physician-nurse concept (shift leaders)	51	4	12	0	3
Hospital program	44	3	12	0	10
Hospital Code Alert for ED overcrowding	39	7	13	5	3
Accelerated inpatient intake practices	34	14	17	2	0
Bed turnover process	34	6	18	1	7
Standardized discharge process	30	13	11	1	13
Medical staff management of rounding practices and discharges	29	14	15	3	8
Mid-level or physician provider at triage	25	13	17	7	2
Greeter/patient liaison	25	6	30	2	1
Universal telemetry (all hospital beds)	19	6	37	0	2
Use pharmacist in ED	16	12	40	1	0
Use of Cynical Decision Unit (CDU)	12	6	45	2	3
Discharge czar/accelerator	11	13	41	2	1
Standardized ICU step down bed management	11	5	39	1	9
Rapid Admission Unit (RAU)	5	9	47	0	5
Discharge instructions upon arrival	1	4	61	1	1
Total	946	193	495	39	90

Mitigation Strategies Stratified by Those Who Said EMS Offload Delay Was Either Extremely or Very Significant	Implemented	Considering	Not tried	Tried; ineffective	Unknown
Management of ED throughput metrics	28	1	1	0	1
Hospital throughput dashboards	27	2	3	0	0
Bedside registration	26	4	1	1	0
Effective ordering of lab and imaging	26	5	0	1	0
Innovating staffing utilization	25	5	0	1	0
ED management "rounding"	25	6	1	0	0
Accelerated intake processes	24	4	0	2	0
Orders from triage	24	4	0	2	0
"Direct to bed" policy	23	6	1	1	0
Performance improvement system; for example, LEAN, Six Sigma, PDSA	23	6	1	0	1
Charge ED physician-nurse concept (shift leaders)	22	9	0	0	1
Standardized discharge process	20	4	2	3	1
Medical staff management of rounding practices and discharges	19	6	4	1	1
Mid-level or physician provider at triage	18	10	2	2	0
Accelerated inpatient intake practices	17	6	6	2	0
Hospital program	17	4	3	4	2
Hospital Code Alert for ED overcrowding	16	6	5	4	0
Bed turnover process	16	6	7	1	1
Greeter/patient liaison	15	7	4	3	0
Discharge czar/accelerator	10	6	14	1	0
Use pharmacist in ED	10	2	16	2	1
Standardized ICU step down bed management	7	6	16	0	1
Use of Cynical Decision Unit (CDU)	5	5	14	1	4
Universal telemetry (all hospital beds)	5	5	21	0	0
Rapid Admission Unit (RAU)	4	3	20	3	0
Discharge instructions upon arrival	1	3	24	0	1
Total	453	131	166	35	15

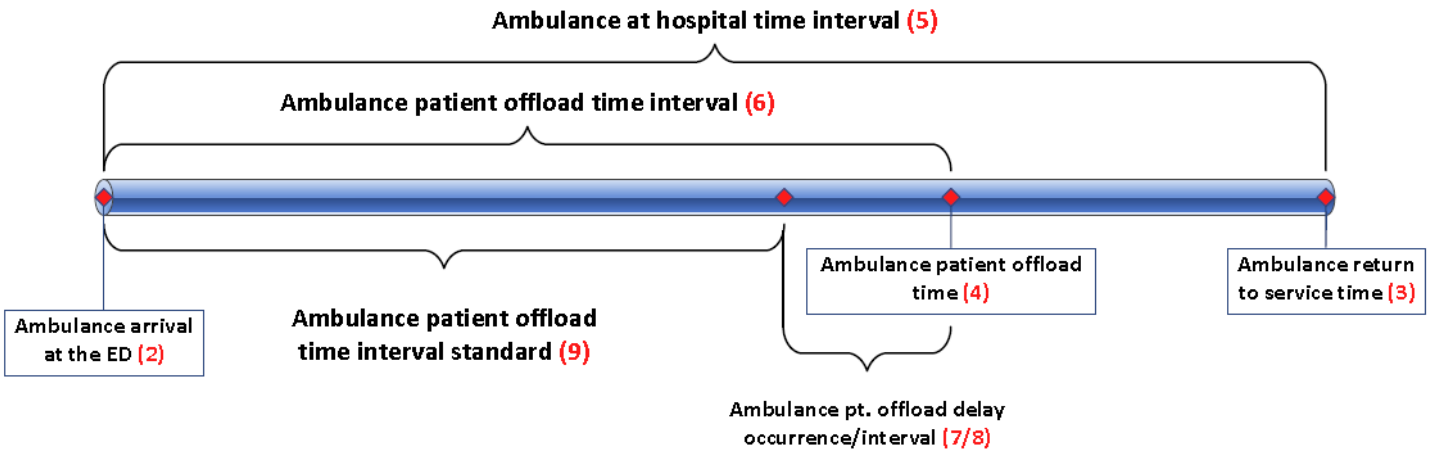
Implementation is key.

EMS Offload Mitigation Factors

For hospitals with Neutral + Not Significant EMS offload delays, what factors would you attribute to this? Check all that apply.	Count	Percent
Optimized ED intake process	37	23%
Successful hospital process improvement measures	34	21%
Hospital and local EMS agency collaborate and have ongoing patient improvement measures	23	14%
No historical problem on this subject	27	17%
Other (please specify)	30	19%
Physical plant redesign	9	6%
Total	160	100%
Hospital Count	74	-

Metrics

Ambulance Patient Offload Delay
Definitions and Nomenclature for Metric Development
February 2014

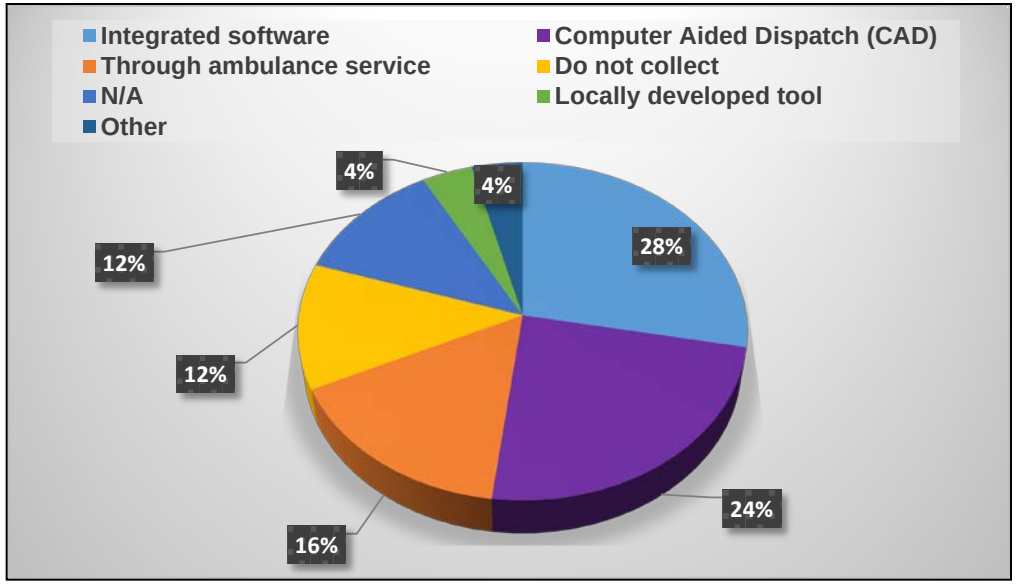


1. **Ambulance transport** – is defined as the transport of a patient from the prehospital EMS system by emergency ambulance to an approved EMS receiving hospital
2. **Ambulance arrival at the ED** - is defined as the time ambulance stops (actual wheel stop) at the location outside the hospital ED where the patient is unloaded from the ambulance.
3. **Ambulance return to service time** – is defined as the time the ambulance is response ready after transporting a patient to a hospital ED.
4. **Ambulance patient offload time** – is defined as the time the patient is physically removed from the ambulance gurney to hospital equipment.
5. **Ambulance at hospital time interval** – defined as the period of time between ambulance arrival at the hospital ED and ambulance return to service time.
6. **Ambulance patient offload time interval** (commonly referred to as ambulance wait time or wall time) – is defined as the period of time between ambulance arrival at the ED and ambulance patient offload time.
7. **Ambulance patent offload delay interval** – is the resulting period of time produced when the ambulance patient offload time interval exceeds the established ambulance patient offload time interval standard. That is to say it is the time accumulated when a patient remains on the ambulance gurney in excess of the offload time interval standard.
8. **Ambulance patient offload delay occurrence –** the occurrence of an ambulance patient remaining on the ambulance gurney beyond the ambulance patient offload time interval standard.
9. **Ambulance patient offload time interval standard** – is the established system performance standard for the period of time between ambulance arrival at the ED and ambulance patient offload time.

Reference: CHA/EMSA Wall Time Collaborative - Metrics Workgroup

LEMSA Data Collection Methods

How is offload time interval data collected?	Count
Integrated software	7
Computer Aided Dispatch (CAD)	6
Through ambulance service	4
Do not collect	3
N/A	3
Locally developed tool	1
Other	1
Total	25
Left Blank	8
Grand Total	33



Legal Considerations

- Paramedic scope of practice
- EMTALA
- Definition of “triage” and “medical screening”
- How does CMS/CDPH address EMS delays in transfer ?
- What are the JC standards on ED and hospital throughput?

Solutions

- Hospital throughput initiatives
  - CHA's Toolkits to Reduce Ambulance Patient Offload Delays in the Emergency Department
  - Intake measures most commonly deployed
  - Output measures least implemented - Focus on causes for, for ie. decreased inpatient capacity & lack of post acute placement issues
  - ED Behavioral Health Tool kit , CHA Behavioral Health Symposium

QUESTIONS

AHRQ Health Care Innovations Exchange

Presentation for the California Hospital Association EMS/Trauma Committee

December 7, 2014

Shannon Fair, RN, MPH
Westat

The AHRQ Health Care Innovations Exchange provides a resource that supports decision making on the potential adoption and implementation of health care innovations and tools.

Primary goals:

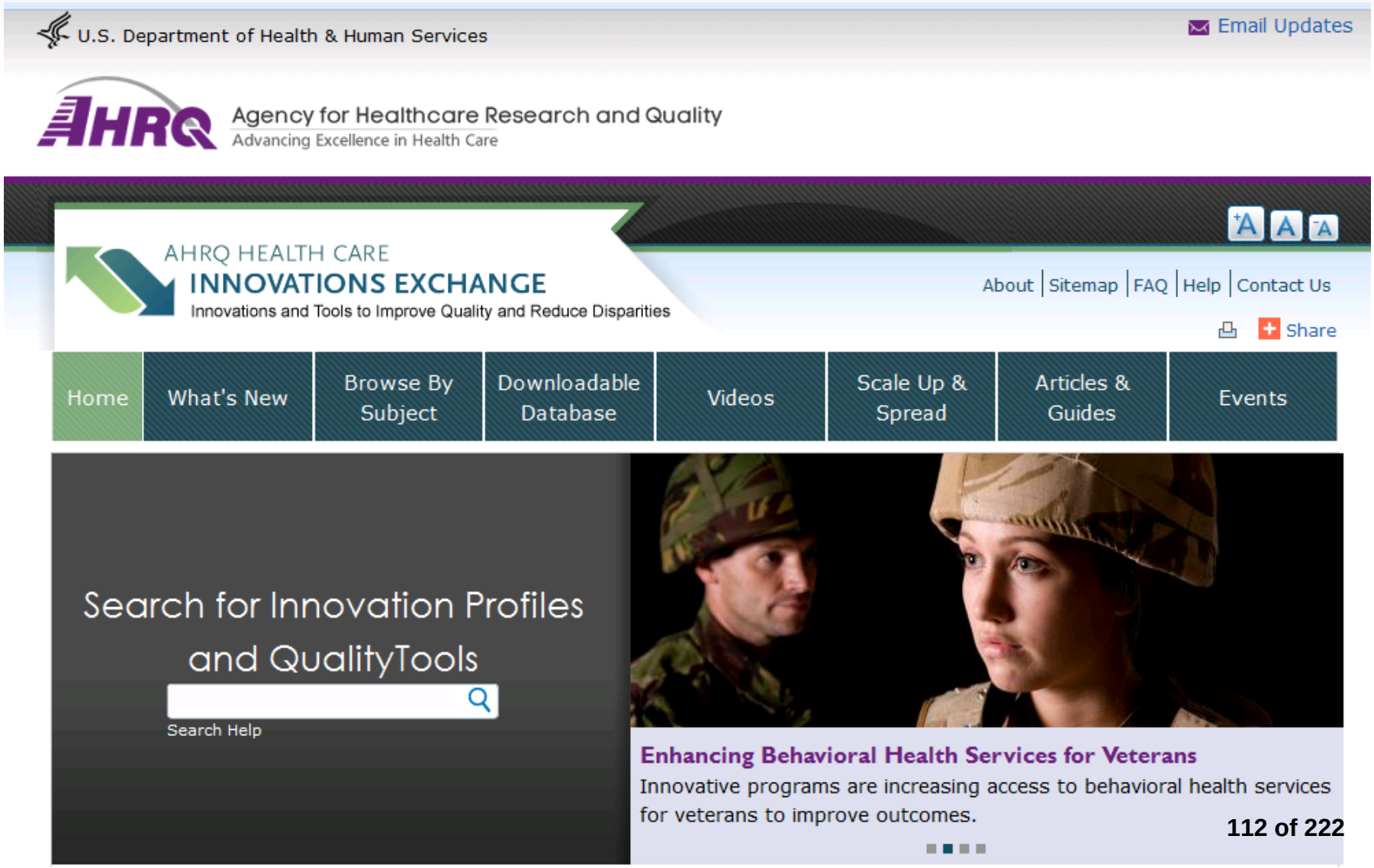
- To accelerate the diffusion and uptake of novel methods of care delivery and policies to improve quality and reduce disparities in health care
- To facilitate the exchange of information, by providing:
  - usable information on health care innovations and quality improvement tools at www.innovations.ahrq.gov
  - learning and networking opportunities

Searchable database of service delivery and policy innovations and tools

- Includes successes and attempts
- Wide variety of sources including unpublished materials
- Vetted for effectiveness and applicability to patient care delivery
- Categorized for ease of use: extensive browse and search functions
- Innovators' stories and lessons learned
- Expert commentaries and perspectives

- Ranks among the higher scoring Federal Web sites measured by the American Customer Satisfaction Index (ACSI) Survey
- Attracts more than 50,000 users monthly
- Reaches more than 43,000 subscribers
- Expert Panel – 13 nationally known experts in health care delivery and innovation strategy provide strategic guidance on key issues
- Editorial Board – 6 nationally known editors and authors provide guidance on selection of content and strategies to enhance adoption and implementation of innovation

www.innovations.ahrq.gov



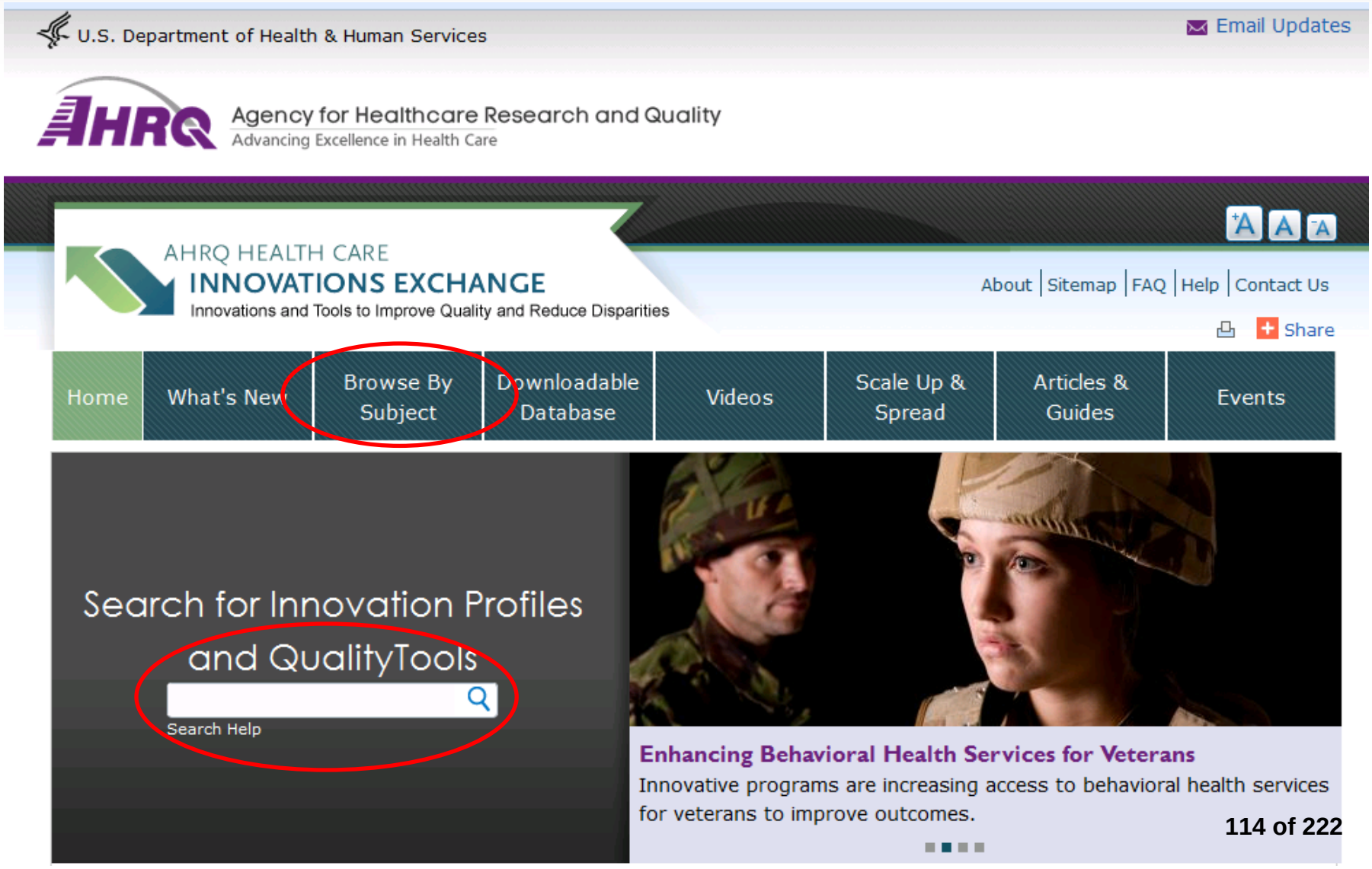
Currently 880+ Innovation Profiles

- Focus on service delivery and policy innovations
- Intent to improve health care quality and reduce disparities

Currently 1,550 QualityTools

- Practical tools for assessing, measuring, promoting and improving health care quality
- Checklists, manuals, reports, and others

Ways to Find Relevant Content



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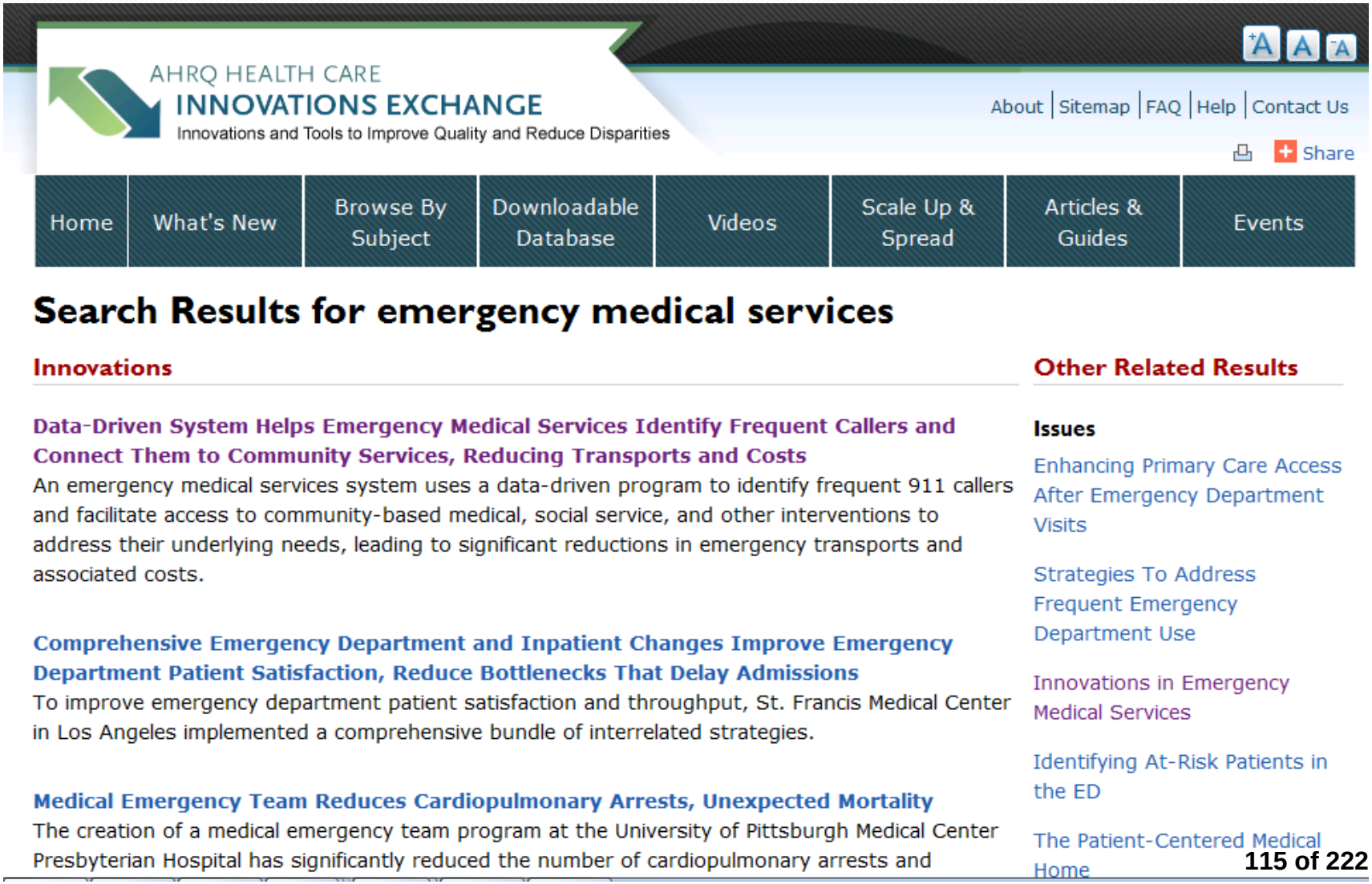

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Innovations and Tools to Improve Quality and Reduce Disparities

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Search Results for emergency medical services

Innovations

Data-Driven System Helps Emergency Medical Services Identify Frequent Callers and Connect Them to Community Services, Reducing Transports and Costs
An emergency medical services system uses a data-driven program to identify frequent 911 callers and facilitate access to community-based medical, social service, and other interventions to address their underlying needs, leading to significant reductions in emergency transports and associated costs.

Comprehensive Emergency Department and Inpatient Changes Improve Emergency Department Patient Satisfaction, Reduce Bottlenecks That Delay Admissions
To improve emergency department patient satisfaction and throughput, St. Francis Medical Center in Los Angeles implemented a comprehensive bundle of interrelated strategies.

Medical Emergency Team Reduces Cardiopulmonary Arrests, Unexpected Mortality
The creation of a medical emergency team program at the University of Pittsburgh Medical Center Presbyterian Hospital has significantly reduced the number of cardiopulmonary arrests and

Other Related Results

Issues

Enhancing Primary Care Access After Emergency Department Visits

Strategies To Address Frequent Emergency Department Use

Innovations in Emergency Medical Services

Identifying At-Risk Patients in the ED

The Patient-Centered Medical Home

Browse by Subject Options

Browse by Subject

Find Innovations and QualityTools by subject.

Disease Or Clinical Category

- Allergy and immunologic care (84)
- Cardiovascular care (252)
- Dental health care (35)
- Diet and nutrition (213)
- Endocrinologic/metabolic care (210)
- Gastroenterologic care (33)
- Gynecologic/obstetric care (150)
- Hematologic/oncologic care (243)
- HIV/aids care (96)
- Infectious disease care (248)
- Mental health care (268)
- Musculoskeletal care (191)
- Nephrologic care (28)
- Neurologic care (108)
- Ophthalmologic care (20)
- Otolaryngologic care (16)
- Pediatric care (166)
- Respiratory/pulmonary care (158)
- Skin and soft-tissue care (42)
- Substance abuse (180)
- Surgical care (41)
- Urologic care (6)

Find diseases by A–Z: A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

IOM Domains Of Quality

- Effectiveness (1,642)
- Efficiency (376)
- Equity (495)
- Not within an IOM domain (18)
- Patient-centeredness (1,351)
- Safety (600)
- Timeliness (223)

Organizational Processes Affected By The Innovation

- Active care processes: diagnosis and treatment (1,836)
- After care processes (447)
- Care management processes (911)
- Patient-focused processes/psychosocial care (1,597)
- Population health processes (731)
- Pre-care processes (215)
- Preventive care processes (1,010)

Patient Population

- Prevention and wellness (660)
- Quality improvement strategies (617)

Setting Of Care

- Ambulatory setting (727)
- Ancillary service setting (30)
- Battlefield/military field hospital (4)
- Emergency setting (113)
- Health plans and managed care organizations (191)

Browse by Subject Options

Medical record keeping (146)
Organizational culture change (115)
Pay for performance/incentives (60)
Personal health records (31)
Physical environment modification (92)
Policies and procedures (415)
Public communication (78)
Quality measurement, benchmarking, data feedback (151)
Referrals (219)
Staff scheduling (30)
Staffing (555)
Team building (263)
Technology—HIT (259)
Technology—other (104)
Training, knowledge management (529)
Workflow redesign (166)

Patient Care Process

Race and ethnicity (237)
Vulnerable populations (1,415)

Quality Improvement Goals And Mechanisms

Avoidable hospitalizations (142)
Confidentiality/hipaa compliance (30)
Cultural competence (199)
Length of stay reduction/management (40)
Medical home (61)
Patient satisfaction (97)
Rapid response teams (18)

QualityTool Topic

Benchmarking/comparative data (104)
Disease/condition-related (680)
Guideline-related (123)
Other (75)
Patient/medication safety (314)

Hospital inpatient —services/departments (109)
Mobile (e.g., health vans) (14)
Residential facilities (104)
Safety net provider (65)
Telehealth (179)

Stage Of Care

Acute care (458)
acute on chronic care (i.e., an acute condition resulting from underlying chronic disease) (17)
Chronic care (603)
Emergency care (137)
End-of-life care (62)
Intensive care (55)
Long-term care (110)
Preventive care (936)
Primary care (587)
Rehabilitation care (88)
Urgent care (26)

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Recent Publication Issue - Emergency Medical Services

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Innovations in Emergency Medical Services | *Wednesday, June 4, 2014*

Inappropriate calls to emergency medical services (EMS) providers and unnecessary use of the emergency department (ED) occur frequently. Handling nonemergency calls raises the costs of providing EMS and ED services, diverts valuable resources away from true emergencies, and can result in delayed care, ED crowding, and poor patient outcomes.

The **featured Innovations** describe two programs that implemented innovative strategies to reduce the use of EMS by frequent 911 callers, leading to major cost savings and increased capacity in area EDs. The third featured profile describes a State policy that banned ambulance diversions to other nearby EDs, resulting in reduced ED length of stay and ambulance turnaround time.

Also in This Issue:

Innovations ▸

- Multifaceted Program Helps Pediatricians Screen for Maternal Depression and Assess Infant Crying and Toilet Training, Enhancing Their Ability To Prevent, Identify, and Address Cases of Potential Child Abuse
- Regular Meetings of Patients and Staff Reduce Violent Episodes by 85 Percent on Inpatient Psychiatric Unit
- Community-Driven Clinic for

Examples of Innovations - Emergency Medical Services

- Data-Driven System Helps Emergency Medical Services Identify Frequent Callers and Connect Them to Community Services, Reducing Transports and Costs:

  https://innovations.ahrq.gov/profiles/data-driven-system-helps-emergency-medical-services-identify-frequent-callers-and-connect

- Statewide Ban on Ambulance Diversions Reduces Ambulance Turnaround Time and Emergency Department Length of Stay for Patients Admitted to the Hospital:

  https://innovations.ahrq.gov/profiles/statewide-ban-ambulance-diversions-reduces-ambulance-turnaround-time-and-emergency

- Trained Paramedics Provide Ongoing Support to Frequent 911 Callers, Reducing Use of Ambulance and Emergency Department Services:

  https://innovations.ahrq.gov/profiles/trained-paramedics-provide-ongoing-support-frequent-911-callers-reducing-use-ambulance-and

Examples of QualityTools - Emergency Medical Services

- Community Paramedic Evaluation Tool: https://innovations.ahrq.gov/qualitytools/community-paramedic-evaluation-tool
- Mission: Lifeline Tools and Resources: https://innovations.ahrq.gov/qualitytools/mission-lifeline-tools-and-resources
- Prehospital Medical Information System: https://innovations.ahrq.gov/qualitytools/prehospital-medical-information-system

Other Relevant Recent Publication Issues

- Identifying At-Risk Patients in the ED: https://innovations.ahrq.gov/issues/2013/11/20/identifying-risk-patients-ed
- Strategies To Address Frequent Emergency Department Use: https://innovations.ahrq.gov/issues/2013/10/23/strategies-address-frequent-emergency-department-use
- Alternative Care Settings To Reduce Hospital Use: https://innovations.ahrq.gov/issues/2013/03/13/alternative-care-settings-reduce-hospital-use
- Enhancing Primary Care Access After Emergency Department Visits: https://innovations.ahrq.gov/issues/2012/08/29/enhancing-primary-care-access-after-emergency-department-visits

How to Engage

- Search / Browse the site for strategies to address specific quality improvement challenges
- Provide feedback through the Comments feature
- Subscribe to email updates
- Follow us on Twitter: #AHRQIX
- Visit the Innovations Exchange LinkedIn page
  - Forum for discussion and collaboration with like-minded peers
  - Free and open to anyone who has a LinkedIn account
  - https://www.linkedin.com/groups/AHRQ-Health-Care-Innovations-Exchange-7436684?home=&gid=7436684

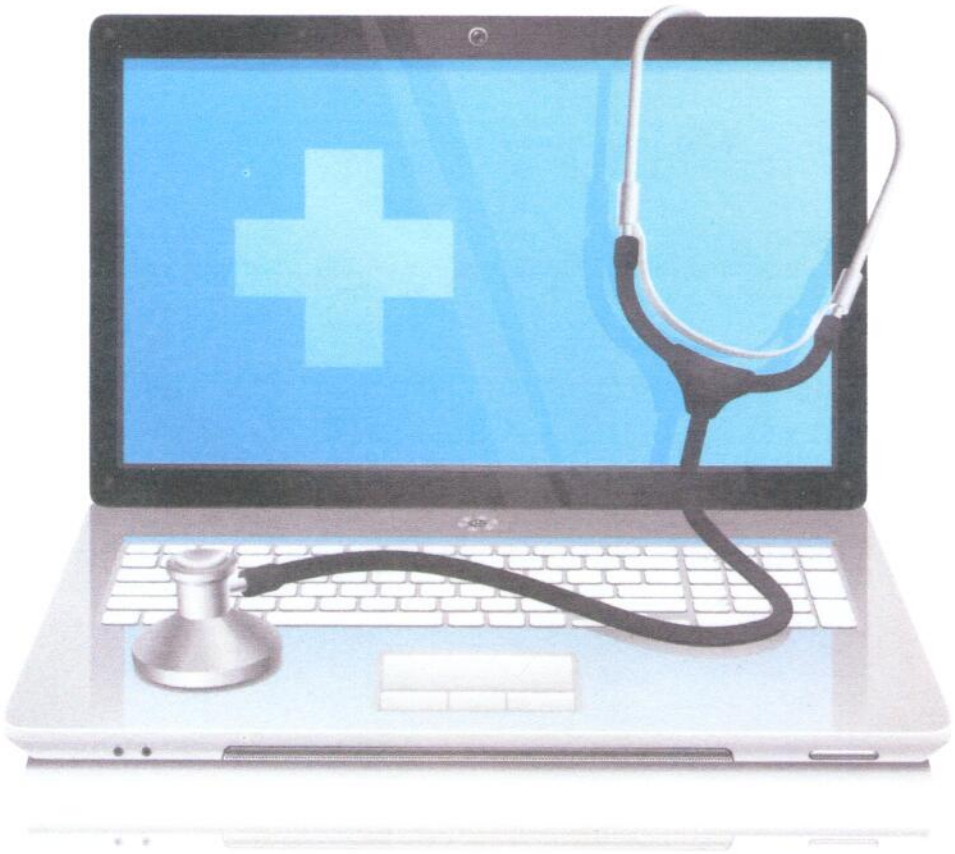
Questions?

HIE in EMS Summit 2014

"INTEGRATING NATIONAL, STATE AND REGIONAL PERSPECTIVES"

November 17, 2014 - November 19, 2014

Los Angeles, California



Program Guide

EMS HIE

CALIFORNIA EMERGENCY MEDICAL SERVICES HEALTH INFORMATION EXCHANGE

EMERGENCY MEDICAL SERVICES AUTHORITY • CALIFORNIA • EMSA

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY
EDMUND G. BROWN JR., *Governor*

EMERGENCY MEDICAL SERVICES AUTHORITY
10901 GOLD CENTER DRIVE, SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875

November 18, 2014

On behalf of the California Emergency Medical Services Authority (EMSA), it is with great pleasure that I welcome you to Los Angeles for the 2014 EMS Health Information Exchange (HIE) Summit. This promises to be an exciting and informative event. We hope that over the next two days you will share your knowledge as well as learn with your EMS partners.

This year's theme – HIE in EMS: Integrating National State, and Regional Perspectives – focuses on collaboration at all levels in order to gain a common vision as we continue to move towards HIE.

We have a very full agenda for the Summit with an impressive faculty to discuss many topics, including: national visions for HIE, state perspectives on HIE privacy and security, and updates from county EMS agencies on local projects.

We are especially honored to have as distinguished keynote speaker, Dr. Richard Hunt, Director for Medical Preparedness, National Security Council Staff, The White House, and Senior Medical Advisor at National Healthcare Preparedness Programs, ASPR, U.S. Department of Health and Human Services.

Now that our medical system is finally entering the digital information age, it is incumbent on all of us to steer the development toward a model that works for all parts and providers within the system, including EMS. It must also support our day-to-day needs, multi-casualty events, and large scale disasters. As EMS professionals, we have the knowledge and the experience to ensure that patient care is seen as an emergency care continuum that begins in the community and moves to the hospital and that information follows the patient through all phases of care.

Thank you for attending and for adding your expertise to this Summit. We hope your time here is enjoyable, informative, and rewarding.

Howard Backer, MDM MPH, FACEP
Director
California Emergency Medical Services Authority

ACKNOWLEDGEMENTS

California Emergency Medical Services Authority Staff

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Leticia Marin, Senior Legal Typist

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Reba Anderson, Associate Governmental Program Analyst

Public Affairs Office

Jennifer Lim, Deputy Director

Adam Willoughby, Associate Health Program Analyst

A Special Thanks To:

College of Continuing Education at
California State University, Sacramento

AGENDA: PRECONFERENCE HIE BOOTCAMP

Monday, November 17, 2014 — 10:00 a.m. - 4:00 p.m.
Grand Ballroom

* All times are subject to change

9:00 a.m.- 10:00 a.m.	Check-In/Continental Breakfast
10:00 a.m.- 10:15 a.m.	Welcome/Housekeeping Dan Smiley, *EMSA Chief Deputy Director*
10:15 a.m.- 11:00 a.m.	HIE 101: Foundation and Current State of HIE Dr. Robert Cothren, *California Association of Health Information Exchanges*
11:00 a.m.- 11:45 a.m.	HIE 102: Governance and Stakeholder Engagement Dr. Richard Swafford, *Inland Empire Health Information Exchange*
11:45 a.m.- 12:45 p.m.	Lunch — Grand Ballroom Foyer
12:45 p.m.- 1:30 p.m.	HIE 103: Privacy and Security Cassie McTaggart, *CalOHII*
1:30 p.m.- 2:15 p.m.	HIE 104: Technology – A Deeper Dive David Minch, *HealthShare Bay Area*
2:15 p.m.- 3:00 p.m.	Break
3:00 p.m.- 3:45 p.m.	HIE Considerations in Designing EMS System Infrastructure Dan Smiley, *EMSA Chief Deputy Director*
3:45 p.m.- 4:00 p.m.	End of Day/Evaluations/CE Quiz Dan Smiley, *EMSA Chief Deputy Director*

Please visit the following link or scan the QR code to access presentation materials.

http://www.emsa.ca.gov/2014_HIE_inEMS_Summit

AGENDA: SUMMIT DAY 1

Tuesday, November 18, 2014 — 10:00 a.m. - 5:00 p.m.
Grand Ballroom

* All times are subject to change

9:00 a.m. - 10:00 a.m.	Check-In/On-site Registration/Continental Breakfast Vendor Exhibits
10:00 a.m. - 10:10 a.m.	Opening/Welcome/Housekeeping Dan Smiley, *EMSA Chief Deputy Director*
10:10 a.m. - 10:20 a.m.	Accepting the Challenge for HIE Dr. Howard Backer, *EMSA Director*
10:20 a.m. - 11:05 a.m.	Integrating the National Vision for Health Information and EMS Dr. Richard Hunt, *Keynote Speaker*
11:05 a.m. - 11:25 a.m.	Break and Vendor Exhibits
11:25 a.m. - 12:05 p.m.	National Interoperability Roadmap Bryan Sivak, *CTO, HHS*
12:05 p.m. - 1:10 p.m.	Lunch — Grand Ballroom Foyer Vendor Exhibits
1:10 p.m. - 1:55 p.m.	Moving NEMSIS Into HIE Environments Dr. N. Clay Mann, *University of Utah, NEMSIS*
1:55 p.m. - 2:45 p.m.	The California Report: HIE Architecture and PULSE Scott Afzal, *Audacious Inquiry*
2:45 p.m. - 3:25 p.m.	NHTSA Vision for EMS and Health Information Exchange Susan McHenry, *National Highway Traffic Safety Administration*
3:25 p.m. - 3:45 p.m.	Break and Vendor Exhibits
3:45 p.m. - 4:30 p.m.	HIE in EMS: Why is it Important? Nick Nudell, *PrioriHealth Partners*
4:30 p.m - 5:00 p.m.	End of Day/Evaluations/CE Quiz Dan Smiley, *EMSA Chief Deputy Director*
5:00 p.m. - 6:00 p.m.	Evening Reception

AGENDA: SUMMIT DAY 2

Wednesday, November 19, 2014 — 9:00 a.m. - 4:00 p.m.
Grand Ballroom

* All times are subject to change

8:00 a.m. - 9:00 a.m.	Check-In/Continental Breakfast Vendor Exhibits
9:00 a.m. - 9:10 a.m.	Opening/Welcome Dan Smiley, *EMSA Chief Deputy Director*
9:10 a.m. - 9:40 a.m.	Health Information Integrity, Security, Privacy Pam Lane, *CalOHII*
9:40 a.m. - 10:10 a.m.	Interconnecting Hospitals with EMS BJ Bartleson & Lois Richardson, *California Hospital Association*
10:10 a.m. - 10:30 a.m.	Break and Vendor Exhibits
10:30 a.m. - 11:15 a.m.	Maintaining the Momentum Lee Stevens, *ONC*
11:15 a.m. - 11:35 a.m.	LEMSA HIE Updates Kirk Schmitt, *Monterey County* Tom Lynch, *ICEMA*
11:35 a.m. - 12:10 p.m.	San Diego HIE – EMS Integration 2.0 Dan Chavez, *San Diego Health Connect*
12:10 p.m. - 1:15 p.m.	LUNCH — Grand Ballroom Foyer Vendor Exhibits
1:15 p.m. - 1:50 p.m.	CAHIE: Health Information Organization's Role in EMS Information Exchange David Minch, *HealthShare Bay Area* Dr. Robert Cothren, *California Association of Health Information Exchanges*
1:50 p.m. - 2:20 p.m.	Designing a System with Paul Budilo Laurent Repass, *Orange County EMS*
2:20 p.m. - 2:40 p.m.	Break
2:40 p.m. - 3:25 p.m.	EMS, HIEs, and Health System Resilience Kevin Horahan, *Assistant Secretary for Preparedness and Response (ASPR)*
3:25 p.m. - 4:00 p.m.	HIE and NEXT STEPS Dan Smiley, *EMSA Chief Deputy Director*

SPEAKER BIOGRAPHIES

Biographies not listed were not available at the time of printing.

Scott Afzal

Scott Afzal is a Partner at Audacious Inquiry, a health information policy and technology company. Scott also serves as the Program Director of Maryland's statewide health information exchange, called CRISP. His responsibilities include managing the roll-out of CRISP's HIE network and leading the development of new service offerings. He has also managed the implementation of large scale master data management platforms, focused on patient and provider identity management. Scott is a noted speaker on health information exchange, having presented at regional and national health IT conferences. Prior to joining Audacious Inquiry, he served as a Business and Systems Integration Consultant with Accenture, Inc out of their New York City office. Scott holds a BSBA in Business Management from Bucknell University.

BJ Bartleson

BJ Bartleson provides leadership in developing, communicating and implementing CHA policy related to nursing, emergency services, trauma and medication safety. She is recognized statewide and nationally as a nurse leader with more than 30 years of experience as an administrator, educator, researcher, clinician, manager and expert in multiple areas of acute patient care management and nursing practice.

BJ received her Bachelor of Science degree with distinction at the University of Virginia School of Nursing in 1978, and her Master's degree in Nursing Administration at the University of California, San Francisco, in 1990. She served as the 2010 Association of California Nurse Leaders president and was on the board of the American Organization of Nurse Executives for more than 10 years. She has also served on the CHA Board of Trustees and the American Hospital Association Regional Policy Board.

Daniel J. Chavez

Daniel J. Chavez joined San Diego Beacon HIE as Executive Director in March 2013 with more than 30 years of health care information technology experience. He has an extensive track record of cultivating startups, business development and product marketing. Previously, he served as Vice President of Marketing and Business Development for Independa, a San Diego-based innovator that provides solutions to help the elderly remain independent. In his previous positions, Mr. Chavez was Executive Vice President at Payformance Corporation, Senior Vice President and General Manager of the medical division of Immersion Corporation, and Senior Vice President at Availity. His prior experience includes IBM, GTE, SAIC, Stellcom Technologies and CSC. He holds a BA from San Jose State University and an MBA from Stanford University.

Dr. Robert "Rim" Cothren

Dr. Cothren is a leader in developing policies, processes, and technologies that promote widespread, secure sharing of health information to deliver coordinated care and improve community health. As acting Executive Director for the California Association of Health Information Exchanges, Dr. Cothren leads California's stakeholders in realizing statewide HIE. As acting CTO for the National Association for Trusted Exchange, he promotes interstate sharing of health information. Dr. Cothren has participated in nationwide HIE since the inception of NHIN, has over 20 years of experience in health technology, and currently teaches health informatics as part of the University of California Davis Extension.

SPEAKER BIOGRAPHIES (continued)

Kevin Horahan

Kevin is a Senior Policy Analyst with the U.S. Department of Health and Human Services in the Office of the Assistant Secretary for Preparedness and Response (ASPR), Office of Policy and Planning, Division of Health System Policy. In this role, he provides expertise to support the Division's mission to build a strong, sustainable, resilient health care system through strategic policy initiatives. Included in Kevin's portfolio are emergency medical services and emergency care (through ASPR's Emergency Care Coordination Center), health information technology/telehealth, and other issues related to disaster/ public health preparedness and response.

Prior to joining ASPR, Kevin worked on health regulatory issues at the Labor department, as a policy analyst for the National Conference of State Legislators, and in the disease management and clinical outcomes department of a university hospital. He received his B.S. from the Bloustein School of Planning and Public Policy at Rutgers University, a Master of Public Health from the George Washington University School of Public Health and Health Services, and a law degree and certificate in law and public policy from the Catholic University of America's Columbus School of Law. He also maintains both National Registry and Maryland paramedic credentials and practices in Montgomery County, Maryland.

Pamela Lane

Pamela Lane, MS, RHIA, CPHIMS is California Health & Human Services' Deputy Secretary for Health Information and Director, Office of Health Information Integrity. Pam advocates for the advancement of the seamless availability of health information to achieve efficiencies and improve quality of care for all Californians.

Pam is a former US Navy Corpsman and has more than 31 years of experience in health information management both in hospital operations and in the vendor environment. She has served as director of clinical information and administrative information areas for a number of health care facilities, and as a best practice consultant in workflow process redesign and revenue cycle management. In addition, she has experience as information security officer and compliance officer for both private and government health care sectors.

Pam received a degree in communications from the University of Dayton in Ohio and later received her master's degree from Boston University.

Tom Lynch

Prior to joining the Inland Empire EMS Agency in August 2012, Tom was an EMS director for San Luis Obispo, Monterey, Santa Clara, and Alameda counties. He was also a Prehospital Coordinator for the City and County of San Francisco EMS Agency when he first came to California. Tom began his EMS career with the New York City EMS as an EMT in the South Bronx. He went on to be a member of the third NYC EMS paramedic class before being assigned to the first paramedic ambulance in the Harlem community.

Tom was with the EMS system in the City and County of Denver for 12 years where he served in multiple roles as a Denver General paramedic, EMS educator and administrator. In Denver, Tom started a prehospital program and a hospital based, fixed wing inter-facility flight service where he functioned as both a flight coordinator and paramedic.

Tom has a special interest in disaster management and has served as the Medical Health Operational Area Coordinator in several counties and as the Region I Regional Disaster Medical Health Coordinator during the Northridge earthquake. He has also authored a number of articles in EMS journals and served as a Board of Governors member of a community hospital for 11 years.

N. Clay Mann

Dr. Mann is a tenured Professor in the Department of Pediatrics at the University of Utah School of Medicine and Director for Research at the Intermountain Injury Control Research Center. Dr. Mann received his Ph.D. from the University of Texas in Preventive Medicine. He has published over 100 peer-reviewed articles dealing with traumatic injuries to children, trauma system evaluation, cardiac and trauma resuscitation and the role of emergency medical services in health care. Currently, Dr. Mann serves as the Principal Investigator for the NEMSIS Technical Assistance Center.

Susan McHenry

Susan McHenry, MS, is an EMS Specialist with the U.S. Department of Transportation/ National Highway Traffic Safety Administration, Office of Emergency Medical Services (March, 1996 to Present). She is the former Director, Office of Emergency Medical Services, Virginia Department of Health (1976 - 1996). Susan received her Master of Science Degree in Urban and Regional Planning from Florida State University. Among her major responsibilities in the NHTSA Office of EMS is the project coordination and direction of the National EMS Information System (NEMSIS) and the NEMSIS Technical Assistance Center.

SPEAKER BIOGRAPHIES (continued)

Cassandra McTaggart

Cassie McTaggart was appointed Chief of the Health Information Policy & Standards Division at the California Department of Health Information Integrity (CalOHII) in May 2012 bringing over 14 years of public service and leadership. She has facilitated projects across government, overseeing multi-million dollar budgets, contracts and procurement, strategic planning, compliance review, implementation of court mandates, and promulgation of regulations. Cassie has lead teams in a number of state agencies including the Department of Public Health, the Department of Consumer Affairs, and the Department of Corrections and Rehabilitation, giving her a broad understanding of the inner workings of government.

Cassie is also the California representative for the National Association for Trusted Exchange (NATE), formerly the Western States Consortium (WSC), and represents California on the California Association of Health Information Exchanges (CAHIE) Board. Cassie brings this vast and varied government experience, a bachelor's degree from the University of California at Davis, and great personal commitment to the mission of building and nurturing a robust infrastructure for the secure transmission of electronic health information.

David A. Minch

Mr. Minch, BS, FHIMSS, is the President and COO of HealthShare Bay Area. Previous engagements include 14 years with John Muir Health, an IDN in the San Francisco East Bay, in various management roles; Manager of Business Engineering for Kaiser's Northern California Region; President of Coast Micro, Inc., a small software development company in the SF East Bay; and Vice President of Amherst Associates' Computer Services Division. He received a Bachelor of Science degree from the University of California, Irvine, and entered the health care industry in 1976 after spending seven years in insurance data processing; and has accumulated nearly forty years of health care computing and strategic planning experience.

In addition to his current responsibilities for building and operating a Health Information Exchange in the SF Bay Area, Mr. Minch co-chairs the Policy Steering Team of the California Office of Health Information Integrity (CalOHII), is President and Board Chair of the California Association of HIEs, is a Co-Founder of the California e-Health Collaborative, and is a Director on the Board of MDISS (Medical Device Innovation, Safety, and Security consortium). Mr. Minch presently leads the California participation in the national EHR-HIE Interoperability Workgroup and was a member of the National HIE Governance Forum under NeHC.

Mr. Minch participates in several HIMSS national committees and is a past Chair of the National HIMSS HIE Committee, which he helped to found in 2007, and is the past National HIE Roundtable Chair. He is also the Programs Chair on the HIMSS Northern California Chapter Board. Mr. Minch has spent several years as a National HIMSS Educational Program Reviewer, and speaks frequently at HIMSS, HFMA, and other national and regional forums.

Laurent Repass

Laurent Repass is a Nationally Registered Paramedic with over 20 years of EMS operations and management experience in California. For the past 9 years, Laurent has served as an EMS Coordinator and Program Manager for the Orange County Emergency Medical Services Agency and has led the County's efforts to plan, implement, and manage the Orange County Medical Emergency Data System, or OC-MEDS. OC-MEDS is the countywide integrated electronic prehospital care report (ePCR) system used by all Orange County EMS providers. Laurent is an advocate for evidence based EMS Quality Improvement and firmly believes that the future of EMS rests with integration into the health care continuum through technological advancement and health information exchange.

Lois Richardson

Lois Richardson, Esq., is vice president of privacy and legal publications/ education at the California Hospital Association (CHA), where she has worked in a variety of legal positions for 23 years. Ms. Richardson is responsible for all health privacy-related issues at CHA and for the development, writing and editing of CHA's legal publications. Her noteworthy publications include the California Health Information Privacy Manual, which addresses both state and federal laws regarding the use and disclosure of health information; the Consent Manual – A Reference for Consent and Related Healthcare Law; the California Hospital Survey Manual; the Cal/OSHA Safe Patient Handling Regulation Guidebook; the California Mental Health Law Manual; and Minors and Healthcare Law. Additionally, she has served as the executive director for the California Society for Healthcare Attorneys since 2000. Prior to working at CHA, Ms. Richardson worked at the University of California, Davis Medical Center, where she specialized in contract negotiations between the hospital/ faculty physician group and payers.

Ms. Richardson has a B.S. in Business Administration (finance) from the University of California, Berkeley and a J. D. from the University of California, Hastings College of the Law.

SPEAKER BIOGRAPHIES (continued)

Kirk Schmitt

Kirk Schmitt brings a wide array of expertise and experience from his 20+ years in Emergency Medical Services. Currently, he is the EMS Agency Director for Monterey County which provides oversight and responsibility for the regulation and authorization of county EMS Agencies, authorization of county EMS Training Programs, certification of EMS Providers, designation of Trauma Care Facilities and leading the effort to integrate pre-hospital patient care data with hospital inpatient data. Previously, Kirk was the State of Iowa EMS Bureau Chief, with similar roles and responsibilities and led the development/implementation of new Scope of Practice provider levels for the state of Iowa. His 20+ years in EMS has culminated in the leadership roles he now occupies, those many roles include EMS field supervision for both ground and air services, clinical education and coordination, certification development, implementation, testing and renewal, dispatch center management, trauma system development, disaster planning, ambulance contract/license management, quality assurance, data system development/monitoring, and safety program development and implementation. Kirk was a nationally registered paramedic, has a M.S. in Health Administration and a B.S. in Business Administration.

Bryan Sivak

Bryan Sivak joined HHS as the Chief Technology Officer in July 2011. In this role, he is responsible for helping HHS leadership harness the power of data, technology, and innovation to improve the health and welfare of the nation.

Previously, Bryan served as the Chief Innovation Officer to Maryland Governor Martin O'Malley, where he has led Maryland's efforts to embed concepts of innovation into the DNA of state government. He has distinguished himself in this role as someone who can work creatively across a large government organization to identify and implement the best opportunities for improving the way the government works.

Prior to his time with Governor O'Malley, Bryan served as Chief Technology Officer for the District of Columbia, where he created a technology infrastructure that enhanced communication between the District's residents and their government, and implemented organizational reforms that improved efficiency, program controls, and customer service. Bryan previously worked in the private sector, co-founding InQuira, Inc., a multi-national software company, in 2002, and Electric Knowledge LLC, which provided one of the world's first Natural Language Search engines available on the web in 1998.

Lee Stevens

Lee Stevens, serving in the Office of the National Coordinator, is Director of the Office of State and Interoperability Policy. In this role, Lee leads the office that oversees state policies and regulatory efforts to improve interoperable health information exchange, governance and patient matching. Lee leads outreach and coordination with governors, state and local officials and national associations invested in Health IT.

Lee previously served as Director of the State Health Information Exchange (HIE) Policy Office and as the State HIE Program Manager for the Eastern and Southern regions of the U.S., including Puerto Rico and the Virgin Islands. In this role, Lee was responsible for state and territorial development of HIE plans, technical assistance and long-term planning activities related to enabling exchange.

Prior to the passage of the HITECH Act, Lee served in the Immediate Office of the Secretary as the Intergovernmental Affairs Specialist on issues related to Health IT, the State Children's Health Insurance Program (S-CHIP), Medicaid and other CMS issues.

Before coming to the Department of Health and Human Services, Lee served as the Federal Policy Director for the Southern Governors' Association where he managed the Gulf Coast Health Information Technology (HIT) Task Force. The Gulf Coast HIT Task Force was created to establish a dialogue on health information exchange between states impacted by Hurricanes Katrina and Rita.

Lee has also served as the Washington, D.C. based health and human services advisor for North Carolina Governor Jim Hunt and previously as a senior legislative assistant on health issues for former U.S. Congressman Charlie Rose.

SPEAKER BIOGRAPHIES (continued)

Dr. Richard Swafford

Dr. Swafford has over 25 years of experience in the information technology (IT) industry with specialized experience in education and health care information technology (HIT). His proven leadership in not only the day-to-day activities of an IT organization but the ongoing strategic planning efforts associated with a variety of industries, is represented by his ability to leverage the most positive attributes from his staff while maintaining a level of professionalism that creates confidence in customers and end users. His holistic approach to technology implementation and management is evident in the various successes experienced throughout his career.

As Executive Director for the Inland Empire Health Information Exchange (IEHIE), Dr. Swafford has worked with a collaborative governance team to select and contract with Orion Health (HIE vendor) and in January 2012, launch the initial pilot project consisting of 6 Hospitals – 2250 beds, 7 medical groups – 800 physicians and a health plan – 600,000 lives. The IEHIE is a self-sustaining HIE that supports San Bernardino and Riverside Counties with 4.2 million patients.

Prior to joining IEHIE, Dr. Swafford supported the California Health Information Partnership and Services Organization (CalHIPSO), the California State Regional Extension Center (REC) as the Chief Technology Officer (CTO). His involvement in the development and deployment of the REC service delivery model, vendor contract negotiation (Group Purchasing Contracts) and management of service partners led to the successful roll-out of the REC for the State of California.

As the Chief Information Officer (CIO) of the Community Clinics Health Network (CCHN), Dr. Swafford was responsible for the Technical Services Organization (TSO). This department focused on technical solutions for its members in the form of consulting, planning, hosting, application and system support, training and product selection/implementation.

Dr. Swafford is presently a member of the faculty for a number of large Universities in Southern California. His education has allowed him to explore a variety of topics primarily related to the overlap that exists between various disciplines and he has been asked to develop curriculum and documentation around these areas of expertise. Dr. Swafford's dissertation (Technology Management: Guiding Organizational Direction Now and in the Future: A Technologist's Guide) focused on the application of technology in the overall strategic direction of an organization and how shifts in generational demographics will impact the management of technology.

HIE for Quality Improvement

Lois Richardson, JD
BJ Bartleson, MS, RN

California Hospital Association

Why won't hospitals share information with us?

- Hospitals understand the importance of CQI
- Hospitals get many data request demands from multiple external organizations, often times it is not used
- Hospitals need to safely exchange data under state and federal regulations

EMS Core Measures

- EMS Core Measures may be a place to start

  Car-3- out of hospital cardiac arrests survival to emergency department discharge

  Car-4- out of hospital cardiac arrests survival to hospital discharge

- Stroke and Stemi programs- San Mateo

Perennial Question

Can a California hospital provide individually-identifiable patient medical information for the purpose of quality improvement to:

1. EMS providers, such as ambulance companies, and/or
2. LEMSAs or State EMSA

Without obtaining the written authorization of each patient (or legal representative)?

Considerations in Determining Legality of Disclosure

Important factors: RECIPIENT of information (that is, who is it being disclosed to?) and PURPOSE of disclosure (why is it being disclosed?)

Purpose: Quality Improvement

Quality assessment and improvement, outcomes evaluation, development of clinical guidelines, reviewing competence of health care professionals, and evaluating practitioner performance is considered by HIPAA to be “health care operations.”

Quality Improvement Disclosures

- We are not talking about disclosures for purposes of:
  - Diagnosis/treatment of the patient
  - Billing
  - Research (think IRB, patient informed consent)
  - Other purposes

State and Federal Health Information Privacy Laws

California hospitals must comply with all:

- HIPAA
- Confidentiality of Medical Information Act (CMIA)
- Lanterman-Petris-Short Act (LPS)
- Other laws not relevant here

HIPAA Preemption Rules

- Federal government intended to create a floor of privacy protection when enacting HIPAA
- HIPAA purposely and expressly did not pre-empt state laws that were more protective of the patient's privacy
- Therefore, providers must determine that a particular disclosure is permissible under both HIPAA and the applicable state law

Big Picture Structure of Privacy Laws

- HIPAA, CMIA, and LPS have the same basic structure: a health care provider cannot disclose health information about a patient unless:
  - The law contains an exception that *requires* or *permits* the disclosure, or
  - The patient authorizes the disclosure

Disclosures to EMS Providers: HIPAA

HIPAA permits a hospital to disclose PHI to another health care provider for the purposes of the recipient's health care operations IF:

- Each provider has or had a relationship with the patient and the medical information pertains to such relationship
- "Minimum necessary" standard applies – so what info can you disclose?

Disclosures to EMS Providers: State Law

Patients that are brought to hospital EDs may be covered by either LPS or CMIA

LPS

LPS applies to information and records obtained in the course of providing services to patients evaluated or treated under Div. 5 of W&I:

- Section 5150 et seq. (danger to self/others) - mental health disorder, inebriation
- Certified, judicially committed, court-ordered evaluation and treatment
- But not H&S 1799.111

LPS (cont'd)

LPS also applies to information and records obtained in the course of providing services to patients receiving voluntary or involuntary MH services in a:

- State mental hospital
- County psychiatric ward, facility, hospital
- UC psychiatric hospital, unit, clinic (Langley Porter, "Neuropsychiatric Institute, UCLA")

LPS (cont'd)

- SNF with a special treatment program service unit for patients with chronic psychiatric impairments
- Community program funded by Bronzan-McCorquodale Act (W&I 5600-5778)
- Community program specified in W&I 4000-4390 or W&I 6000-6008
- Also, recipients of state developmental disability services (i.e., Regional Centers)

CMIA

- CMIA is the general health information privacy law that applies to most patients brought to EDs by EMS providers
- If a patient isn't covered by LPS, he/she is covered by CMIA
- LPS is an express exception to CMIA
- Are you coding your pts as CMIA v LPS?

Disclosures Under LPS

- No exception to the general prohibition that would allow disclosures to EMS providers for purposes of quality improvement (exceptions are listed in Welfare & Institutions Code Sections 5328-5328.9)
- Even though these disclosures are permitted by HIPAA, they are prohibited by LPS

Disclosures Under CMIA

- No clear express authority (list of exceptions at Civil Code 56.10(c).
- Two closest possibilities: 56.10(c)(4) or 56.10(c)(14)

Civil Code Section 56.10(c)(4)

The information may be disclosed to … contractors, or persons or organizations insuring, responsible for, or defending professional liability that a provider may incur, if the … contractors, or persons are engaged in reviewing the competence or qualifications of health care professionals or in reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges.

Civil Code Section 56.10(c)(4)

- This provision generally interpreted to allow a hospital to disclose info to *its own* insurers, self-insurance personnel, and risk management consultants, med mal attorneys, etc.
- Also: does performance improvement = quality of care?

Civil Code Section 56.10(c)(4)

- Is this provision broad enough for a hospital to provide info to a “person or organization responsible for professional liability that a provider [the ambulance company] may incur?
- EMSA memo of 2/26/14 did not cite this provision as authorizing disclosure
- Open legal question. If no, then a disclosure = a breach

Civil Code Section 56.10(c)(14)

- "The information may be disclosed when the disclosure is otherwise specifically authorized by law…"
- Is the effect of this provision to authorize a disclosure under the CMIA if that disclosure is specifically authorized by HIPAA?

Civil Code Section 56.10(c)(14)

- Remember: Federal government intended to create a floor of privacy protection when enacting HIPAA
- HIPAA purposely and expressly did not pre-empt state laws that were more protective of the patient's privacy
- Can this CMIA provision actually pull in HIPAA provisions so as to make information MORE "disclosable?"

Civil Code Section 56.10(c)(14)

- Answer: we don’t know.
- Privacy experts do not agree
- Cal/OHI and Cal/OHII lawyers over the years have had inconsistent opinions (both by the same lawyer on different topics (EMS v. clergy), and by different lawyers on the same topic)
- A judge would not have to defer to Cal/OHII lawyer’s opinion

Bottom Line

Hospital disclosure to EMS provider:

- Allowed by HIPAA, but only give information about that EMS provider's patients (do you code which ambulance company brings the patient?)
- Not allowed by LPS. Delete any information related to these patients (probably easiest to delete all MH pts)
- Risky under CMIA – we just don't know

Moving On … Disclosures to LEMSAs and EMSA

HIPAA permits a provider to disclose information to a health oversight agency for *oversight activities authorized by law*, [different from quality improvement] including: audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

(i) The health care system; …

(iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; …

- Under California law, what oversight authority do LEMSAs and EMSA have over hospitals? What information is "minimally necessary" to disclose for purposes of this oversight? Base station hospital? Trauma designation?

Disclosures to LEMSAs and EMSA

LPS has no exception that allows a hospital to disclose information for the purpose of health quality improvement to LEMSAs or EMSA. In the context of health oversight, LPS authorizes information to be given only to:

1. Authorized licensing personnel of the State Department of Health Services (now CDPH) who are licensed or registered health professionals;

2. Authorized representatives of the State Department of Social Services for inspection and licensure of health facilities; and

3. Professional licensing boards when the Director of Mental Health believes there's been a violation of a law subject to the jurisdiction of that board.

Disclosures to LEMSAs and EMSA Under CMIA

- No clear express authority (list of exceptions at Civil Code 56.10(c).
- Two closest possibilities: 56.10(c)(5) or 56.10(c)(14)

Civil Code Section 56.10(c)(5)

"The information in the possession of a provider of health care or health care service plan may be reviewed by a private or public body responsible for licensing or accrediting the provider of health care or health care service plan. *However, no patient-identifying medical information may be removed from the premises except as expressly permitted or required elsewhere by law*, nor shall that information be further disclosed by the recipient in a way that would violate this part."

Civil Code Section 56.10(c)(14)

- "The information may be disclosed when the disclosure is otherwise specifically authorized by law…"

- Same question as before

Bottom Line

Hospital disclosure to LEMSA or EMSA:

- HIPAA: Not clear what PHI may be disclosed, if any
- Not allowed by LPS. Delete any information related to these patients.
- Questionable/risky under CMIA

Future Action

EMS providers, LEMSAs, EMSA, and hospitals should work together to determine precisely what data is appropriate to share for purposes of quality improvement ("minimum necessary")

- Determine who will pay for data collection, analysis
- Consider authorizing legislation

Thank You

- Questions?
- Contact information:
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Identify, Isolate, Inform: Emergency Department Evaluation and Management of Patients with Possible Ebola Virus Disease

1 Identify exposure history:
Has patient lived in or traveled to a country with widespread Ebola transmission or had contact with an individual with confirmed Ebola Virus Disease within the previous 21 days?

NO → Continue with usual triage and assessment

YES

2 Identify signs and symptoms:
Fever (subjective or ≥100.4°F or 38.0°C) or Ebola-compatible symptoms: headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain, or hemorrhage

NO →
- **A.** Continue with usual triage and assessment
- **B.** Notify relevant health department
- **C.** Monitor for fever and symptoms for 21 days after last exposure in consultation with the relevant health department

YES

3 Isolate and determine personal protective equipment (PPE) needed
Place patient in private room or separate enclosed area with private bathroom or covered, bedside commode. Only essential personnel with designated roles should evaluate patient and provide care to minimize transmission risk. The use of PPE should be determined based on the patient's clinical status:
- Is the patient exhibiting obvious bleeding, vomiting , copious diarrhea or a clinical condition that warrants invasive or aerosol-generating procedures (e.g., intubation, suctioning, active resuscitation)?

YES

4 Inform
- **A.** IMMEDIATELY notify the hospital infection control program and other appropriate staff
- **B.** IMMEDIATELY report to the health department

NO →
For clinically stable patients, healthcare worker should at a minimum wear:
- **A.** Face shield & surgical face mask
- **B.** Impermeable gown
- **C.** 2 pairs of gloves

If patient's condition changes, reevaluate PPE

YES →
- **A.** Use PPE designated for the care of hospitalized patients **http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html**
- **B.** If the patient requires active resuscitation, this should be done in a pre-designated area using pre-designated equipment.

5 Further evaluation and management
- **A.** Complete history and physical examination; decision to test for Ebola should be made in consultation with relevant health department
- **B.** Perform routine interventions (e.g. placement of peripheral IV, phlebotomy for diagnosis) as indicated by clinical status
- **C.** Evaluate patient with dedicated equipment (e.g. stethoscope)

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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News

FOR IMMEDIATE RELEASE
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Contact: CDC Press Office
404-639-3286

35 U.S. hospitals designated as Ebola treatment centers

CDC trains and assesses Ebola hospital readiness in collaborative effort

An increasing number of U.S. hospitals are now equipped to treat patients with Ebola, giving nationwide health system Ebola readiness efforts a boost. According to the Centers for Disease Control and Prevention (CDC), state health officials have identified and designated 35 hospitals with Ebola treatment centers, with more expected in the coming weeks.

Hospitals with Ebola treatment centers have been designated by state health officials to serve as treatment facilities for Ebola patients based on a collaborative decision with local health authorities and the hospital administration.

Ebola treatment centers are staffed, equipped and have been assessed to have current capabilities, training and resources to provide the complex treatment necessary to care for a person with Ebola while minimizing risk to health care workers.

"We continue our efforts to strengthen domestic preparedness and hospital readiness. I am pleased to announce that 35 hospitals have been designated by state health officials as Ebola treatment centers that are prepared, trained, and ready to provide care for a patient with Ebola," said Health and Human Services Secretary Sylvia M. Burwell.

More than 80 percent of returning travelers from Ebola-stricken countries live within 200 miles of an Ebola treatment center. During their active monitoring, state or local public health authorities communicate every day with potentially exposed individuals to check for symptoms and fever for the 21 day incubation period of the Ebola virus.

"As long as Ebola is spreading in West Africa, we must prepare for the possibility of additional cases in the United States," said CDC Director Tom Frieden, M.D., M.P.H. "We are implementing and constantly strengthening multiple levels of protection, including increasing the number of hospitals that have the training and capabilities to manage the complex care of an Ebola patient. These hospitals have worked hard to rigorously assess their capabilities and train their staff."

The additional facilities supplement the three national bio containment facilities at Emory University Hospital, Nebraska Medical Center, and the National Institutes of Health (NIH), which will continue to play a major role in our overall national treatment strategy, particularly for patients who are medically evacuated from overseas. Facilities will continue to be added in the next several weeks to further broaden geographic reach.

CDC also released guidance for states and hospitals to use as they identify and designate an Ebola treatment center. The guidance covers the range of capabilities hospitals need in order to provide comprehensive care for patients with Ebola. HHS, through the CDC and the Office of the Assistant Secretary of Preparedness and Response (ASPR), also provided technical assistance to health departments and hospitals.

Each hospital with an Ebola treatment center has been assessed on-site by a CDC Rapid Ebola Preparedness (REP) team. The CDC REP team is staffed with experts in all aspects of caring for a patient with Ebola, including staff training, infection control, personal protective equipment (PPE) use, and details such as handling and management of the trash from the patient's room. As of December 1st, CDC has conducted REP team assessments in over 50 hospitals in 15 states and Washington, D.C.

Because of the active monitoring program of returning travelers from countries where Ebola is present, federal health officials have a clear sense of where travelers from affected countries in West Africa are going and where Ebola treatment centers are most likely to be needed. The priority areas are jurisdictions served by the five international airports screening returning travelers for Ebola, cities with high proportion of returning travelers from West Africa, and cities with large populations of individuals from West Africa.

The 35 hospitals with Ebola treatment centers to date are:

- Kaiser Oakland Medical Center; Oakland, California
- Kaiser South Sacramento Medical Center; Sacramento, California
- University of California Davis Medical Center; Sacramento, California
- University of California San Francisco Medical Center; San Francisco, California
- Emory University Hospital; Atlanta, Georgia
- Ann & Robert H. Lurie Children's Hospital of Chicago; Chicago, Illinois
- Northwestern Memorial Hospital; Chicago, Illinois
- Rush University Medical Center; Chicago, Illinois
- University of Chicago Medical Center; Chicago, Illinois
- Johns Hopkins Hospital; Baltimore, Maryland
- University of Maryland Medical Center; Baltimore, Maryland
- National Institutes of Health Clinical Center; Bethesda, Maryland
- Allina Health's Unity Hospital; Fridley, Minnesota
- Children's Hospitals and Clinics of Minnesota – Saint Paul Campus, Saint Paul, Minnesota
- Mayo Clinic Hospital – Rochester, Saint Marys Campus; Rochester, Minnesota
- University of Minnesota Medical Center, West Bank Campus; Minneapolis, Minnesota

- Nebraska Medical Center; Omaha, Nebraska
- North Shore-LIJ Health System/Glen Cove Hospital; Glen Cove, New York
- Montefiore Health System; New York City, New York
- New York-Presbyterian/Allen Hospital; New York City, New York
- NYC Health and Hospitals Corporation/HHC Bellevue Hospital Center; New York City, New York
- Robert Wood Johnson University Hospital; New Brunswick, New Jersey
- The Mount Sinai Hospital; New York City, New York
- Children's Hospital of Philadelphia; Philadelphia, Pennsylvania
- Hospital of the University of Pennsylvania; Philadelphia, Pennsylvania
- University of Texas Medical Branch at Galveston; Galveston, Texas
- Methodist Hospital System in collaboration with Parkland Hospital System and the University of Texas Southwestern Medical Center; Richardson, Texas
- University of Virginia Medical Center; Charlottesville, Virginia
- Virginia Commonwealth University Medical Center; Richmond, Virginia
- Children's Hospital of Wisconsin, Milwaukee; Milwaukee, Wisconsin
- Froedtert & the Medical College of Wisconsin – Froedtert Hospital, Milwaukee; Milwaukee, Wisconsin
- UW Health – University of Wisconsin Hospital, Madison, and the American Family Children's Hospital, Madison; Madison, Wisconsin
- MedStar Washington Hospital Center; Washington, DC
- Children's National Medical Center; Washington DC
- George Washington University Hospital; Washington DC

Active Monitoring program

CDC has worked with state and local health officials to implement an active monitoring program for travelers returning from affected countries in West Africa. Each traveler, on entry to the U.S., is provided with a CARE (Check and Report Ebola) kit including a thermometer, temperature log, contact information with the State health department, and wallet card with important information. Since inception of the program, more than 3,000 travelers have been monitored more than 30,000 times by state or local health departments to check daily for fever or other symptoms. In each case since implementation of the program, travelers who have experienced fever or other Ebola compatible symptoms have been connected with the health department through this process and safely transported to a facility that was ready to care for them using appropriate infection control.

Assessment hospitals -- careful bridge to hospitals with Ebola treatment centers

In addition to designated hospitals to treat Ebola patients, CDC has been working with state and local public health officials to identify Ebola assessment hospitals. Assessment hospitals are hospitals identified by state health officials, in collaboration with local health authorities and the hospital administration, as the point of referral for those individuals being actively monitored and who develop symptoms compatible with Ebola such as fever.

These hospitals have the capability to: evaluate and care for someone who is having the first symptoms of Ebola for up to 96 hours; initiate and coordinate testing for Ebola and for other diseases alternative diagnoses; and either rule out Ebola or transfer the individual to an Ebola treatment center, as needed.

An assessment hospital would only care for a patient who might have Ebola during the time before a confirmed diagnosis is made until it then transfers the patient to an Ebola treatment center.

While no states had such plans in September, 15 states that have the majority of the travelers now have plans in place to evaluate persons under investigation and for providing care for up to 96 hours while testing can be arranged. CDC also released guidance for states and hospitals to use as they identify Ebola assessment hospitals.

Keeping Americans safe

The designated hospitals add to U.S. Ebola readiness efforts. However, all health care workers at hospitals and other health care facilities should be trained and able to recognize symptoms, safely isolate a potential Ebola patient, and contact public health authorities for guidance on next steps for safely managing the patient. Since July, HHS, with leadership from CDC, has conducted and continue to conduct extensive outreach to the health care community, including hospitals, clinicians, healthcare unions, and medical and nursing provider associations.

CDC has educated nearly 150,000 healthcare workers via webinars, and trained more than 525,000 via online clinical resources, to assure that healthcare workers are trained and able to recognize and safely isolate a potential Ebola patient in the unlikely event that such a patient presents unexpectedly. CDC continues to conduct infection control training.

In addition, CDC Ebola Response Teams (CERT), made up of experts in epidemiology, infection control, laboratory, and communications stand ready to deploy to any hospital in the United States with probable Ebola cases.

CDC is now supporting 42 state and local laboratories throughout the county to perform rapid Ebola testing. Four months ago only CDC and the US Armed Forces laboratory could test for Ebola. These additional laboratories capable of diagnosing Ebola cut the time needed to rule out a person for Ebola or confirm a case and speed the patient's transport and treatment in a specialized Ebola treatment center.

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Note: All HHS press releases, fact sheets and other news materials are available at *http://www.hhs.gov/news*.

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INTERIM

Recommended Policy and Procedures for Emergency Medical Services (EMS) Personnel for the Contact, Management, and Transport of Potential Ebola Virus Disease (EVD) Patients

Objective and Methods

The objective of this document is to provide guidance for development of local policies and protocols for the effective management of patients with Ebola Virus Disease (EVD or Ebola) and the safety of Emergency Medical Services (EMS) personnel. This information is intended for: Managers of 9-1-1 Public Safety Answering Points (PSAPs), local emergency medical services agencies (LEMSAs), EMS Systems, law enforcement agencies and fire service agencies, as well as individual emergency medical services providers (including emergency medical technicians [EMTs], paramedics, and medical first responders).

This interim document of recommended policies, procedures and protocols was developed by a collaboration of the California Emergency Medical Services Authority (EMSA), representatives from the Emergency Medical Director's Association of California (EMDAC: Gregory Gilbert, Ken Miller, Karl Sporer), and representatives from the Emergency Medical Services Administrator's Association of California (EMSAAC: Clarence Teem, David Magnino, Richard Murdock). The broader membership of EMDAC and EMSAAC provided additional input. This document draws on guidance issued by the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), and Department of Industrial Relations (DIR) and CalOSHA, and local EMS jurisdictions in California.

This document suggests practices derived from numerous sources and are presented here for use by local jurisdictions, private providers, and Public Safety Answering Point personnel to develop local protocols for screening suspect cases, providing treatment, and transporting potential or positive Ebola Virus Disease patients. Information and protocols for this issue are subject to frequent changes based on national and state guidance. Please monitor EMSA's website at www.emsa.ca.gov for updates. Other pertinent guidelines can be found at Centers for Disease Control and Prevention (CDC) and California Department of Public Health (CDPH) websites.

EMSA is currently recommending that each LEMSA:

- Establish local procedures and protocols under medical guidance for prehospital care personnel using these recommendations to inform their local policies.
- In cooperation with the Local Health Department, establish destination policies from the prehospital care setting and during interfacility transport for patients suspected or confirmed to have Ebola Virus Disease that require evaluation or treatment.
- Identify EMS providers who will be able to provide transportation for patients with suspect or confirmed Ebola Virus Disease using identified ambulance units and trained staff, i.e., Infectious Disease Ambulance Response Teams (IDART).

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Case Definition

Ebola Virus Disease (EVD or Ebola) is a rare and deadly viral illness. Ebola is a hemorrhagic fever virus contracted through direct contact with the secretions (blood, saliva, semen, sweat, diarrhea) of infected patients or contact with infected bats or infected non-human primates. Ebola carriers are only infectious after the onset of symptoms (see symptomology below). Onset of symptoms can occur up 21 days after contracting the virus, usually within 10-12 days. More virus is shed as infection progresses and victims evolve from "dry" symptomology (no discharge of secretions, diarrhea, vomiting) to "wet" symptomology (diarrhea, vomiting, profuse sweating, bleeding).

Epidemiological Factors

Based on the CDC Case Definition for Ebola (dated November 16, 2014), a person under investigation (PUI) for Ebola disease is a person who has both consistent signs or symptoms and risk factors as follows:

1. Elevated body temperature or subjective fever or symptoms, including severe headache, fatigue, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage

   AND

2. An epidemiologic risk factor within 21 days before onset of symptoms

Epidemiologic risk factors are as follows:

1. High risk includes any of the following:
   - Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids of a person with Ebola while the person was symptomatic,
   - Exposure to the blood or body fluids (including but not limited to feces, saliva, sweat, urine, vomit, and semen) of a person with Ebola while the person was symptomatic without appropriate personal protective equipment (PPE) (http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html),
   - Processing blood or body fluids of a person with Ebola while the person was symptomatic without appropriate PPE or standard biosafety precautions,
   - Direct contact with a dead body without appropriate PPE in a country with widespread Ebola virus transmission (http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html),
   - Having lived in the immediate household and provided direct care to a person with Ebola while the person was symptomatic
2. Some risk includes any of the following:
   - In countries with widespread Ebola virus transmission (http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-

map.html): direct contact while using appropriate PPE with a person with Ebola while the person was symptomatic

- Close contact in households, health care facilities, or community settings with a person with Ebola while the person was symptomatic
  - Close contact is defined as being for a prolonged period of time while not wearing appropriate PPE within approximately 3 feet (1 meter) of a person with Ebola while the person was symptomatic

3. Low (but not zero) risk includes any of the following:
   - Having been in a country with widespread Ebola virus transmission (http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html) within the past 21 days and having had no known exposures
   - Having brief direct contact (e.g., shaking hands) while not wearing appropriate PPE, with a person with Ebola while the person was in the early stage of disease
   - Brief proximity, such as being in the same room for a brief period of time, with a person with Ebola while the person was symptomatic
   - In countries without widespread Ebola virus transmission: direct contact while using appropriate PPE with a person with Ebola while the person was symptomatic
   - Traveled on an aircraft with a person with Ebola while the person was symptomatic.
4. No identifiable risk includes:
   - Contact with an asymptomatic person who had contact with a person with Ebola
   - Contact with a person with Ebola before the person developed symptoms
   - Having been more than 21 days previously in a country with widespread Ebola virus transmission (http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html)
   - Having been in a country without widespread Ebola virus transmission and not having any other exposures as defined above

A confirmed case of Ebola is a person under investigation with laboratory-confirmed diagnostic evidence of Ebola Virus Disease.

EMS and Public Safety Answering Point (PSAP) Screening

Policy and Protocol Issue:
The decision to initiate PSAP screening of callers requesting medical assistance through 9-1-1 should be made in collaboration with the LEMSA and local health department leadership. The EMS work group recommends this practice to identify patient encounters that may require first responders to don Personal Protective Equipment (PPE) prior to contact. The method chosen for patient screening for Ebola symptoms and epidemiological factors is at the discretion of the local jurisdiction, e.g. local Emergency Medical Services Agency Medical Director. This does not preclude first responders and paramedics from obtaining a travel and symptom history before entering the residence.

Travel History Screening

For jurisdictions using PSAP screening cards, PSAP dispatchers will query patients reporting infectious disease symptoms about recent travel or contact with returning travelers from the countries of Sierra Leone, Guinea, Liberia, or Mali. If the caller indicates travel from one of the above countries with an active Ebola outbreak within the last 21 days, the patient is currently considered to be at risk for Ebola (Low Risk if there is no known exposures according to the CDC; See **Case Definition**). In the pre-hospital setting, the use of specific terminology is recommended for use by all PSAPs and EMS providers for consistent and precise communication, for example: "**Public Health Monitored Patient**" (a patient at risk of infection, either known to public health and being monitored; see www.cdph.ca.gov for further information on patients monitored by public health) or "**EMS Screened, Possible Ebola Patient**" (a patient previously unknown to and not being monitored by local public health, who is determined by PSAP or EMS questioning to meet the screening criteria of a person with potential Ebola).

It is recommended, whether or not doing PSAP screening, that EMS personnel conduct travel screening queries upon arrival at the patient's location. Screening of patients with infectious disease symptoms should be conducted while maintaining a physical distance of at least three feet from the patient. This distance should be increased if the patient is actively vomiting or coughing. It is recommended that only one EMS responder approach the patient to conduct screening. The screening may also be done by interview with family members, if appropriate. The patient is asked about travel from any of the countries of Sierra Leone, Guinea, Liberia, or Mali within the previous 21 days or close contact with anyone else who has traveled from Sierra Leone, Guinea, Liberia, or Mali within the last 21 days, who is ill (note no risk if not ill). If the patient's history is positive for travel and/or contact as defined above, the EMS responder should remove themselves from the vicinity of the patient and don appropriate Personal Protective Equipment (PPE). If the patient screens positive as a possible Ebola case, subsequent notification must be clear to EMS and hospital personnel that they are transporting a "**Public Health Monitored Patient**" or an "**EMS Screened, Possible Ebola Patient**."

Local protocols for EMS screening must include precise screening criteria to avoid false positives from patients beyond the 21 day window of potential contact, travel to countries other than those currently at risk, and compatible symptoms. Patients are not considered contagious unless there is both a specific travel and/or close contact history AND symptoms. While risk is currently limited to exposure in four West African countries, other countries might be added to the list. Check for updates of countries with current outbreaks on the CDC website (http://www.cdc.gov/vhf/ebola/index.html).

To avoid false positive designation of possible Ebola Virus Disease, some jurisdictions have a protocol for EMS personnel to contact local public health from the field to provide consultation for more details screening. If public health can exclude risk that requires serologic testing, this avoids the necessity for EMS and the destination facility to don full PPE and isolate the patient for suspected EVD.

Travelers Being Actively Monitored by Public Health

With screening currently being done at points of entry to the U.S. on all international travelers from the high-risk countries of West Africa there should be few, if any, patients who are unknown to local health departments and identified by patient screening in the community. As local health departments are notified of returning travelers with known or potential contact with Ebola patients they should notify EMS agencies that there are contacts within the jurisdiction that are being actively monitored. This does not need to include person information but should at least communicate risk and general location to allow local EMS agencies to work with the health department to develop transportation and destination plans for these returned travelers, in case they become ill. Understanding the need to protect privacy, we do not recommend that personal identifying information be provided to EMS provider agencies or PSAP.

In addition to regular monitoring based on the level of risk of Ebola Virus Disease, the local health department will provide written instructions to these returned travelers to notify the LHD immediately if fever or other symptoms of Ebola develop. This notification should trigger a pre-determined plan for transportation to an evaluation facility.

Far less desirable alternative is the plan for a monitored person at risk of infection to notify 911 and report their symptoms and risk status. A plausible scenario is that the patient or their family may be frightened by the implication of any symptoms and call 911 rather than the health officer.

Transporting these patients in a private vehicle by a household member to a pre-arranged facility at a pre-arranged time has been proposed. This could avoid an extra transport when medical intervention is not required; however, it poses problems related to a potential traffic accident, possible increased exposure to the household member, and decontamination of the vehicle.

Notification and Communication Protocols for the Management of Potential Cases of Ebola

LEMSAs must work with their acute care hospitals and their local health department to develop protocols and procedures for rapid notification. Redundancy may be desirable.

If a patient requiring transport is determined to be a "**Public Health Monitored Patient**" or "**EMS Screened, Possible Ebola Patient**," this should be communicated to the EMS responder's Supervisor and receiving hospital upon determination and prior to patient transport. Additional notifications from that point will follow local jurisdiction protocols, but should include local EMS Administrator, local EMS Medical Director, and local Health Officer. Notification should include the clinical presentation of the patient, pertinent travel history and any other information relevant to both the management of the patient, transport destination, and efforts to minimize broader exposure to healthcare providers and the public.

To avoid some false positive epidemiological screening, some jurisdictions have a protocol to contact the health department from the field to help conduct additional screening. Early notification of local public health is essential to assist in further epidemiological evaluation of patient on arrival to hospital. Local public health should be available 24/7. If unable to reach local public health, a state infectious disease duty officer can consult. Contact with EMS base hospital can be used to assure early notification of the local health department.

Similarly, protocols should be established for hospitals and ambulatory care centers to notify the LEMSA as well as public health of the receipt of patients with known or suspected Ebola virus who self-present to the facility. EMS agencies must be kept informed of the patient's subsequent evaluation, since they must prepare for possible inter-facility transport.

Caution is warranted for radio traffic concerning a "**Public Health Monitored Patient**" or an "**EMS Screened, Possible Ebola Patient**." Telephone communications may provide better discretion for communications. It is the opinion of EMSA that the principles that govern any type of information in a dispatch applies to, and is the same for, any patient who has any injury or other suspected communicable disease. All information could be considered private health information and must be protected in the transmission from the PSAP to the responder (by whatever method) from outside interception. A code word can be assigned for a particular response, but if that code word is broadcast over an open frequency along with other personal health information (PHI), then a breach of PHI has occurred.

Patient Encounter

Depending on the information provided, EMS responders may repeat the travel history, before physically contacting the patient.

CDC has developed an algorithm for initial approach to patients with previously undetermined risk for the Emergency Department that is also applicable to the pre-hospital environment. http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html (See Appendix A)

Response to patients with suspicion of Ebola Virus Disease (positive travel history and clinical presentation) may require modification of typical resource allocation to minimize risk to responders. Patient management considerations begin with the strategy of limiting personnel and equipment exposure to the possible Ebola Virus Disease patient. The number of EMS personnel involved in patient contact should be kept to the minimum necessary for treatment and transport, but if the patient is a "**Public Health Monitored Patient**" or an "**EMS Screened, Possible Ebola Patient**," additional manpower may be required. This is a local jurisdictional consideration to be made with consultation between the LEMSA and providers.

If the patient is a Public Health Monitored Patient who notifies public health of symptoms, the local health department should contact the local EMS agency and implement existing transport protocols. The recommendation is that this patient transport should not be initiated through the 911 system. Early symptoms should not present as a medical emergency requiring rapid action. There should be time to initiate pre-identified transport unit and destination, even it that requires several hours.

If 911 has been notified by a known monitored patient or if the patient has been identified by dispatch with a positive screening history for risk of Ebola Virus Disease, consider the following procedures.

- When there are fire agency first responders, they may remain outside to serve as Incident Command, scene control, communications, providing minimum necessary equipment to avoid unnecessary contamination and monitoring donning of PPE. They would then follow the transport unit to the hospital to provide oversight for doffing and management of contaminated waste. Alternatively, they may be the ones to do patient evaluation and transport, if they have an appropriate, prepared transport vehicle.
- If the patient is able to ambulate and walk to the ambulance, only one provider could enter the residence; this is preferred over exposing additional EMS personnel.
- If the patient needs a gurney, two providers go in with the patient, and two remain outside to serve the functions above--if there are sufficient personnel.
- The "two in" personnel don enhanced contact precautions PPE for patient contact, including interviewing the patient and refining history.
- The "two out" personnel remain outside of the door/room and make no physical contact with the patient or the immediate surroundings (6 feet or more and no body fluids).
- Only essential equipment should be passed to those with patient contact.

Clinical Care

Most early symptomatic patients will be clinically stable. Whenever clinically appropriate, limit prehospital care to Basic Life Support (BLS) to avoid procedures in an uncontrolled environment and to limit the use of sharps while in PPE. However, airway interventions and fluid resuscitation should be performed if necessary to stabilize a patient with respiratory distress or signs of circulatory insufficiency.

- Field evaluation protocol may be altered if transporting an early symptomatic patient to limited exposure of equipment and personnel. For example, it may be sufficient to note the temperature and pulse and unnecessary to perform a blood pressure and auscultate the lungs.
- Limit activities, especially during transport that can increase the risk of exposure to infectious material.
- No procedures should be attempted in a moving ambulance.
- Limit the use of needles and other sharps as much as possible.
- Handle all needles and sharps with extreme care and dispose in puncture-proof, sealed containers.
- In the case of a cardiac or respiratory arrest, EMS treatment protocols need to consider the risk to providers as well as the clinical situation and likelihood of resuscitation (for example, there are other conditions that may not warrant CPR, such as blunt trauma arrest). Any tendency to forgo CPR must be balanced by the fact that not all patients will be proven to have Ebola. EMS personnel must be in maximal PPE if providing ventilatory support, since resuscitation procedures can produce aerosolization of contaminated droplet particles. Questions concerning the initiation of resuscitation efforts should be directed to the base hospital or to the EMS Medical Director.
- An ethical debate on providing CPR in this situation can be read at http://www.thehastingscenter.org/Bioethicsforum/Post.aspx?id=7135&blogid=140
- EMS personnel should make base hospital contact or use ALS-no-contact as required by local EMS policy. The intent is to be operationally independent regarding responder safety and incident management.

Contingencies

- Against Medical Advice (AMA)
    - If a patient with a suspicious travel history with or without symptoms refuses care and transport notify local health department
        - The local health officer may provide a standing order for base hospital to order transport against the patient's will for evaluation; however, this would need to involve law enforcement.
        - California law does allow a health officer delegation of authority to first responders (California Health & Safety Code §101080.2 – see Appendix B)

- Deceased patient
    - Evaluate signs of life
        - Use ECG monitor cables to remotely observe ECG rhythm then leave the monitor cables with the patient
    - Notify local law enforcement and public health
    - Doff PPE at a location removed from the patient's immediate location and leave it at the scene
- Multiple household members exposed but asymptomatic
    - To the extent possible keep asymptomatic exposed persons in the residence/location in which they were encountered so that they may be evaluated by public health.
    - Household members should not accompany the patient in the ambulance, but if an asymptomatic exposed contact of the patient must accompany the patient to the hospital, transport them with the patient in the patient compartment of the ambulance, with PPE.
    - Public health will determine the need for quarantine and for management of potentially contaminated items in the residence.

Considerations for EMS Transportation Including Development and Use of Specialized Transportation Resources

Policy and Protocol Issue:
At this time, there are no specific statewide standards for identification of specialized transport units for patients with possible or confirmed Ebola infection. General criteria that are discussed below include preparation of the interior of the ambulance to minimize contamination, recommended PPE for highest level protection of EMS personnel, additional training of personnel specific to worker safety, clinical care protocols, and communications protocols. (See Appendix C - IDART) Also refer to: Considerations for safe EMS transport of patients infected with Ebola Virus (Lowe JJ, et al. Prehospital Emergency Care 2014) (from Nebraska biocontainment unit)

Designated units should be used to transport patients confirmed to have Ebola and are preferred for patients known to be high or moderate risk and being monitored by public health. If possible, designated units should be considered for 9-1-1 response and transport of patients with undefined risk but possible Ebola infection. Some providers have considered using older ambulances or reserve units as designated IDART units.

It is the responsibility of the LEMSA to determine the integration of these resources into the medical transport system and consideration of any contractual plans for response to local calls. As specialized treatment centers are identified around the state, designated transport units can be coordinated regionally and statewide using mutual aid concepts.

An example of specialized infectious disease ambulance response teams can be found in Appendix C - Infectious Disease Ambulance Response Teams (IDART).

If a non-specialized unit responds to a patient with high index of suspicion for Ebola infection, they may call in a specialized transport unit, if the clinical situation allows. Patients with early symptoms should be able to wait for an appropriate transport unit to arrive.

All ambulances transporting symptomatic "**EMS Screened, Possible Ebola Patients**" should be prepared prior to transport. It is recommended that the ambulance be outfitted with 6 mil polyethylene plastic sheeting to protect the patient compartment and to isolate the back from the front cabin. It is recommended that all units carry pre-cut and numbered sheeting and tape to rapidly shield the patient compartment of an ambulance. The sheeting should also isolate the patient compartment from the driver compartment. While not proven, this technique has been widely adopted as a form of vehicle protection, analogous to PPE. For pre-designated units, it is beneficial to remove any unnecessary equipment from the patient care compartment of the ambulance prior to installing plastic sheeting. Equipment that may be needed can be sealed in plastic bags and if not used, removed without contamination or need to disinfect.

Even if the patient compartment is isolated, the driver should use PPE, but may not need patient care level PPE. Driver must be familiar with transport unit ventilation to assure that air is not recirculated from the patient compartment to the driver compartment.

If a "**Public Health Monitored Patient**" or an "**EMS Screened, Possible Ebola Patient**" is transported in a non-plastic sheeted ambulance, decontamination becomes much more difficult. (See **Decontamination of Ambulance Vehicles** for further information)

After patient transport, the response site becomes the responsibility of local Public Health, Environmental Health, and law enforcement. If there are asymptomatic persons in the same household as the symptomatic patient, to the extent possible, keep them in the house/apartment to await Public Health. Family members may be discouraged or denied transport in the patient compartment of the ambulance. If family member insists on accompanying the patient, provide a gown and surgical mask for them to reduce exposure in the patient compartment of the ambulance.

Personal Protective Equipment

Policy and Protocol Issue: PPE for EMS
PPE and procedures for their use must be consistent with California Division of Occupational Safety and Health (Cal/OSHA) regulations and CDPH recommendations. Applicable Cal/OSHA regulations include the Bloodborne Pathogens standard (8 CCR § 5193), the Aerosol Transmissible Disease standard (8 CCR § 5199), the Personal Protective Equipment standard (8 CCR § 3380-3385) and the Injury and Illness Prevention Program (8 CCR § 3202). At this time, recommendations for EMS that comply with Cal/OSHA regulations are currently under development and will be included as soon as possible. This may involve two levels of PPE depending on the level of risk posed by the patient. It is anticipated that recommendations will also be needed for PPE procedures appropriate to ambulance personnel who are not providing direct patient care, such as the driver of the unit. While these recommendations are being developed, CDC guidelines for EMS personnel apply as the minimum standard; however, providers may exceed those guidelines.

Recommended PPE

If evaluating a person not being monitored and with unknown infectious risk there should be no risk to EMS personnel who enter a house and approach within 3-6 feet of a patient with symptoms only of fever, malaise, headache in order to complete epidemiological screening. Similarly, if EMS personnel may encounter a potentially but otherwise unknown patient for an unrelated condition (i.e., an auto accident). To guard against unnecessary exposure, personnel may use the specific screening criteria for recent travel to the countries with an active outbreak of Ebola virus in the last 21 days. If the answer to this inquiry is no, then no further questioning is warranted. However, a

"Yes" response to the travel question should be followed up with questioning specific to confirm the area of travel. Based on the response, protection as recommended above may be appropriate.

If any patient provides a negative travel history, or a positive travel history without suggestive clinical symptoms, and no other likely exposure, then standard precautions for the clinical presentation should be employed.

If the patient is being monitored by public health or meets the screening criteria above, they should be presumed to be actively infectious with the Ebola virus and the appropriate level PPE should be utilized.

CDC has established the following recommendations for PPE use by health care workers treating Ebola patients that should also apply to the pre-hospital environment. http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html

Protection is designed to eliminate any and all skin and mucous membrane exposure to droplets. Any combination of the below to achieve this requirement can be recommended. Specific products used will depend on supply availability.

- Level C OSHA HAZMAT splash protection
- Full body suit or single-use (disposable) fluid-resistant or impermeable gown that extends to at least mid-calf or coverall without integrated hood. Coveralls with or without integrated socks are acceptable.
- Single-use (disposable), fluid-resistant or impermeable apron that covers the torso to the level of the mid-calf, if Ebola patients have vomiting or diarrhea. An apron provides additional protection against exposure of the front of the body to body fluids or excrement.
- Double Gloves, outer gloves should have extended cuffs
- Boots and boot covers (booties)
- Hooded Face shield or similar, covers front and sides of face
- N95 filtering face piece fluid resistant respirator (minimum requirement) or PAPR/SCBA respirator.

Any respiratory procedures or management of an "**EMS Screened, Possible Ebola Patient**" actively vomiting or having diarrhea while in the ambulance warrant maximal protection. For prolonged transports of confirmed or symptomatic high-risk patients, a PAPR (purified air powered respirator) may be recommended for safety as well as comfort for long transports.

Recommendations have also been issued by the Interagency Board for Equipment Standardization and Interoperability (IAB), which is recognized by CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) as a source for additional information on nationally-recognized standards on appropriate PPE for protecting first responder personnel. IAB guidelines outline determination of patient risk and appropriate levels of PPE, in addition to clear descriptions of types of PPE that fit the requirements for protection.

https://iab.gov/Uploads/IAB Ebola PPE Recommendations_10 24 14.pdf

Final California requirements will be determined by CalOSHA guidelines. Guidelines for hospitals are available at:
http://www.dir.ca.gov/dosh/EbolaVirusInformation.htm

EMS providers should consult these guidelines as an indication of forthcoming EMS specific guidelines. In these guidelines for hospital staff, PAPRs are required for staff working in the room with the patient due to the risk of procedures such as airway procedures that will generate aerosolized droplets. They are also required for those cleaning the rooms and for transporting the patient.

Donning and Doffing of PPE

The following principles apply to EMS personnel as well as to hospital personnel caring for Ebola infected patients.

1. Prior to working with Ebola patients, all healthcare workers involved in the care of Ebola patients must have received repeated training and have demonstrated competency in performing all Ebola-related infection control practices and procedures, and specifically in donning/doffing proper PPE.
2. While working in PPE, healthcare workers caring for Ebola patients should have no skin exposed.
3. Each step of PPE donning/doffing procedure must be supervised by a trained observer to ensure proper completion of established PPE protocols. This may be as simple as having one provider put on PPE and manage the patient while the other provider does not engage in patient care but serves in the role of trained observer and driver.
    - EMS personnel wearing PPE who have cared for the patient must remain in the back of the ambulance and not be the driver.
    - EMS agencies may consider sending additional resources (for example, a dedicated driver for the EMS unit who may not need to wear maximum PPE if the patient compartment is isolated from the cab). This driver should not provide any patient care or handling.
    - With prior agreement, hospitals may provide a monitor for EMS personnel for doffing PPE
    - Some EMS providers plan to have a supervisor monitor PPE use and assist with doffing. EMS may also request fire agency support.
    - DIR/CalOSHA guidelines require that employees assisting in removing contaminated or potentially contaminated PPE must also use their own PPE, including a respirator.
    - A sample procedure can be found in Appendix D.

Recommended PPE should be used by EMS personnel as follows:

- PPE should be put on before entering the scene and continued to be worn until personnel are no longer in contact with the patient. PPE should be carefully put on under observation as specified in the CDC's "Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)".

PPE should be carefully removed while under observation, in an area designated by the receiving hospital, and following proper procedures as specified in the CDC's guidance. Particular attention should be devoted to doffing as the PPE should be considered contaminated.

Several agencies have developed instructive videos. The following is a link to a video series from CDC that allows you to select specific PPE equipment that will be used and watch a video on how to don/doff that equipment.
http://www.cdc.gov/vhf/ebola/hcp/ppe-training/index.html

Two videos produced by the University of Nebraska show proper donning and doffing:

- Donning: http://www.youtube.com/watch?v=T5knZceQ1xA
- Doffing: http://www.youtube.com/watch?v=ls69Tib1PjU.

If a breach of PPE occurs during patient care the crew member will exit patient care. The crew member will doff PPE and wash with soap and water and/or disinfect the exposed area with 0.5% bleach. It is important to remain calm and to NOT remove PPE hastily due to the anxiety and stressful situation. This situation may create a secondary contamination opportunity.

The crew member will be monitored in coordination with the local health department.

Appropriate procedures for disposal of contaminated material should be developed.
(See **Hospital Patient Hand-Off** on page 20)

Considerations for Patient Destination Determination and Inter-facility Transportation of EMS and/or Hospital Screened Positive Patients

Policy and Protocol Issue: Destination hospital
A system of receiving hospitals for suspect or identified cases is under development in California. Currently, five U.C. medical campuses are identified, but additional health system and local hospitals with capability to treat patents with Ebola infection are expected. Other hospitals will fall under two categories: All licensed acute care hospitals should be capable of screening and isolating suspect patients arriving by EMS or walk-in. Ebola Evaluation Hospitals may be designated to admit patients pending confirmation. Local EMS Systems should coordinate with local public health to develop policies and protocols to address destination issues for patients being monitored by public health and for patients identified by screening through ambulatory clinics or 911. There are currently no standards for the various levels of facility described, analogous to other specialty centers; CDC and some local jurisdictions have developed check lists for treatment facilities.

Facility Destination

Local public health and LEMSA should assure hospital capability locally or regionally to screen and evaluate suspect Ebola infected patients. The current recommendation of EMDAC, EMSA, and CDPH is that all acute care hospitals in California should be "Ebola Ready", to at least screen and transfer patients, but it is clear that many small hospitals do not have the capacity or capability to admit suspect Ebola patients, and even an admission to the emergency department could paralyze the hospital. Two other levels of capability are evolving:

1. Evaluation centers should be capable of evaluating possible Ebola infected patients and isolate them as an in-patient during the confirmation process that may be 1-3 days. The reality is that some facilities have inadequate staff and space to isolate and manage a suspect Ebola infection as an inpatient. Local or regional Ebola Evaluation Hospitals may be designated by LEMSA and local public health as the initial destination.
2. Treatment facilities are being identified at the national, state and local levels. EMS must be involved in local decisions to identify specialized treatment facilities and to bypass other facilities. State and local EMS, public health, and emergency management will collaborate to develop a system of transportation statewide to these facilities based on established regions, patient movement patterns, existing EMS plans and transport arrangements. In California, there are currently five identified U.C. treatment centers (UC Davis, UC Irvine, UC Los Angeles, UC San Diego, and UC San Francisco).

Field Destination Determination

Local EMS Agencies (LEMSAs) are responsible for the planning and coordination of EMS systems to ensure that response and care appropriate to the patient's clinical

needs are provided. LEMSAs should coordinate with local health department to develop policies, procedure and protocols for the destination determination of patients at known risk who are being monitored by public health and of previously unknown patients who screen positive by EMS or ambulatory clinics who then call EMS. Pre-planning should be done for patients being monitored by public health to identify an EMS provider agency that will transport and a likely destination. This will allow orderly decision-making and avoid the necessity to search for a suitable transport unit and receiving facility.

It may be acceptable for EMS to bypass a hospital, if the facility is unequipped to receive and evaluate a suspect Ebola patient; if they do not have the proper PPE available; if they lack the physical space to isolate the patient or there are no waste disposal protocols in place. If a refusal occurs, the LEMSA and local health department should investigate and determine what steps the hospital needs to take to accept these patients for further screening or determine alternate destination protocols. In rural areas, a regional hospital may need to act as the evaluation center.

Even in rural areas, EMS cannot be stranded without a facility to transport a patient, and EMTALA requires a facility to accept an emergency patient from EMS and perform a screening exam. If unable to treat the patient, they may then transfer to a higher level of care.

As protocols are developed with identified treatment centers, transfers of patients with known risk and compatible symptoms who are in geographic proximity may be accepted prior to confirmation of infection to avoid two hospitals and two transfer EMS units being exposed to the patient. These destination decisions must be made with engagement of local public health that will determine the level of infection risk. The identified destination hospital may vary, depending on:

- The capability and capacity of the hospital to manage suspected/possible Ebola patients;
- The risk level of the individual and the specific symptoms that develop;
- The health system to which the individual belongs and whether that system has identified hospitals within the system that will manage suspected and/or confirmed Ebola patients; and/or
- Available local resources.

Ultimately, Destination decisions and transportation planning must be made in consultation between the local and state public health, the local EMS agency, the MHOAC and RDMHS, and the sending and receiving facilities.

Inter-Facility Transfers

Patients being monitored by public health should have a pre-determined transfer plan that may be initiated without a call to 911. It is expected that each LEMSA will be aware of their resources for transportation of patients infected with Ebola.

Transfers to one of the identified UC treatment centers are coordinated by prior arrangement through CDPH after an assessment by local public health in consultation with CDPH. However, it is the responsibility of the LEMSA, not public health, to coordinate the transport.

- The LEMSA should collaborate with the local health department to predetermine modes of transport to identified hospitals.
    - The LEMSA will pre-identify Infectious Disease Ambulance Response Team (IDART) and/or ambulance crews and first responders that can appropriately and safely transport suspected and confirmed suspect or confirmed Ebola patients, including transportation from a home or clinic to an evaluation hospital, or from a local hospital facility to an identified Ebola treatment hospital.
- If a decision is made to transport the person being monitored or a suspected/confirmed Ebola case, this is an Unusual Event as defined in the Public Health and Medical Emergency Operations Manual (EOM) and the appropriate jurisdictional partners should be notified.
    - The LHD will contact the LEMSA to arrange appropriate transportation of the individual to the determined facility.
    - Either the LEMSA or local health department should notify/activate the Medical and Health Operational Area Coordinator (MHOAC), in keeping with the Standardized Emergency Management System (SEMS), Emergency Function 8 procedures and the EOM.
        - The MHOAC may notify the Regional Disaster Medical and Health Specialist (RDMHS) and other necessary jurisdictional partners of the pending transfer, if needed.
        - The RDMHS may coordinate and notify regional medical and public health individuals and entities to assist with or facilitate the transport across jurisdictions in the region to the identified facility.

Other EMTALA transfer guidelines apply, for example, the transferring physician must communicate with a physician at the receiving facility to accept the patient. Health systems with their own treatment center may coordinate their transportation internally, but must notify local public health prior to transfer. The LEMSA should also be notified of the patient status and transfer.

Protocol Issue: Transport from remote jurisdictions without treatment facilities

- Due to the limited time that providers can remain comfortable wearing full PPE, ground transport is limited to 2-3 hours duration.
- Usual air helicopter services are not capable of transporting Ebola patients. California National Guard can transport in larger rotary aircraft, but will only do so if the patient is contained in a portable isolation unit.
- If resource request is made, Federal DHHS can arrange for a contracted air provider (Phoenix Air) to transport these patients, but this will be very costly (about $125,000). For the initial domestic transports, this cost has been borne by CDC. (Phoenix Air has done all of the international and domestic transports of confirmed Ebola patients. They recently added a second special transport aircraft.)
- Another alternative may be transfer of the patient between ambulances while in route to allow new crew to take over care.

Since ambulances can use lights and sirens to minimize transport time in heavy traffic, escort by law enforcement should not be necessary.

Hospital Patient Handoff

Hospitals must develop a specific protocol for the receipt from the field by EMS of patients with highly infectious diseases, in this case, Ebola. The objective is to develop and maintain a “field of isolation” that would minimize broader contamination of the facility, including caregivers, other patients and the public.

Agreement and protocols should be developed between hospitals and transport providers for the doffing and disposal of contaminated PPE following transport.

- Stay with the patient in the ambulance until the hospital staff is prepared to receive the patient
- Anticipate patient handoff to hospital staff occurring at the ambulance and not inside the hospital
- Patient handoff may be at a location other than the emergency department, for example, an isolation room in the hospital
- Drop-off location may not be the regular ambulance bay
- Coordinate patient handoff with any procedures the hospital may have in place
- EMS Personnel will doff PPE at the hospital, using the hospital location of choice. This may be in a well-lit location outside of the hospital. Do not doff in a poorly lit location or an exposed location in poor or wet weather.
- Doffing must be done with a trained monitor who is wearing PPE. This should be pre-arranged for appropriate training. Monitor may be any of the following:

  - Hospital infection control doffing monitor
  - EMS provider agency specially-trained supervisor or other staff
  - Fire or HAZMAT personnel
- Hospital practices may vary, so anticipate case-by-case adaptation
- Procedure for handoff of a “wet” patient (a patient that is vomiting, having diarrhea or other active fluid shedding) may differ, including placing the patient on plastic sheeting (see below)

Post-Incident Personnel Monitoring

- The use of appropriate PPE constitutes a protected exposure that the CDC classifies as “Low (but not zero) risk”
- Personnel will be identified to local health department and a protocol determined for their follow-up.
- This may entail recording body temperature once or twice daily. Specific strategies will be determined by the nature of the incident and patient care operations
- The two-out personnel who did not make patient contact and the fire apparatus would not be considered exposed and would be able to engage in post-incident duties.
- Behavioral Health Services should be provided to manage exposure and potential exposure concerns by EMS.

Infectious Waste

Policy and Protocol Issue: Infectious waste

- Biohazard waste consisting of EMS PPE and plastic sheeting from ambulance should be bagged in hazardous medical waste bags according to protocol.
- The hospital should accept this waste for disposal, since private companies like ambulance providers who are not licensed by DOT cannot transport this waste without a special license.
- If the hospital refuses to manage biohazard waste, the EMS crew may need to call local HAZMAT to respond to the hospital to manage their PPE equipment.
- For small amounts of waste, government agencies may be exempt from these licensing provisions, but moving it creates many other problems.
- All non-disposable equipment used on the patient will be left at the hospital with the patient, or if not accepted by the hospital, in the ambulance after patient handoff.

CDPH protocol for waste management is available at:
http://www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/2013/Ebola%20medical%20waste%20management-CDPH%20interim%20guidance-28%20Oct%202014.pdf

Decontamination of Ambulance Vehicles

Policy and Protocol Issue: Cleaning EMS transport vehicles after transporting a patient with suspected or confirmed Ebola

Ambulance decontamination (see **Decontamination** below)
Several options have been discussed for decontamination of the ambulance, but other options may be identified.

1. The ambulance is removed to a location where it is taken out of service and quarantined until public health determines that 1) the patient is not a risk and does not require testing, or 2) the tests for Ebola Virus are negative.
2. Contracted environmental services respond to the hospital to decontaminate the ambulance.
3. The ambulance is removed to a location where specially trained workers or contract services decontaminate the unit and return it to service.
4. The hospital provides trained environmental staff to decontaminate on site and allow the ambulance back in service (unlikely, unless rural area with very limited resources for EMS).

After transport of a suspect case, the ambulance should be placed out of service until a test comes back negative/positive. If positive, a professional decontamination company should be contracted.

Whoever employs the workers that perform the decontamination is responsible for their safety according to CalOSHA standards. CalOSHA has determined that hospital cleaning crews should use PAPRs.
(http://www.dir.ca.gov/dosh/EbolaVirusInformation.htm)

Nebraska Biocontainment Unit guidelines for ambulance decontamination can be found in: Lowe JJ, et al. Prehospital Emergency Care 2014

CDC Guidance for Decontamination

Personnel performing cleaning and disinfection should wear recommended PPE (described above) and consider use of additional barriers (e.g., rubber boots or shoe and leg coverings) if needed. Face protection (facemask with goggles or face shield) should be worn since tasks such as liquid waste disposal can generate splashes.

Patient-care surfaces (including stretchers, railings, medical equipment control panels, and adjacent flooring, walls and work surfaces) are likely to become contaminated and should be cleaned and disinfected after transport.

A blood spill or spill of other body fluid or substance (e.g., feces or vomit) should be managed through removal of bulk spill matter, cleaning the site, and then disinfecting the site. For large spills, a chemical disinfectant with sufficient potency is needed to overcome the tendency of proteins in blood and other body substances to neutralize the disinfectant's active ingredient.

An EPA-registered hospital disinfectant with label claims for viruses that share some technical similarities to Ebola (such as, norovirus, rotavirus, adenovirus, poliovirus) and instructions for cleaning and decontaminating surfaces or objects soiled with blood or body fluids should be used according to those instructions. After the bulk waste is wiped up, the surface should be disinfected as described above.

Contaminated reusable patient care equipment should be placed in biohazard bags and labeled for cleaning and disinfection according to agency policies. Reusable equipment should be cleaned and disinfected according to manufacturer's instructions by trained personnel wearing correct PPE. Avoid contamination of reusable porous surfaces that cannot be made single use.

Use only a mattress and pillow with plastic or other covering that are impermeable to fluids. To reduce exposure among staff to potentially contaminated textiles (cloth products) while laundering, discard all linens, non-fluid-impermeable pillows or mattresses as appropriate.

DOT regulations (see below) prevent an ambulance from being used to transport infectious waste, but a contaminated ambulance and equipment that can be decontaminated are not considered infectious waste.

> The Ebola virus is a Category A infectious substance regulated by the U.S. Department of Transportation's (DOT) Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 171-180). Any item transported for disposal that is contaminated or suspected of being contaminated with a Category A infectious substance must be packaged and transported in accordance with the HMR. This includes medical equipment, sharps, linens, and used health care products (such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets, used Personal Protection Equipment [e.g., gowns, masks, gloves, goggles, face shields, respirators, booties] or byproducts of cleaning) contaminated or suspected of being contaminated with a Category A infectious substance. (http://www.nclonline.com/products/view/MICRO_CHEM_PLUS_)

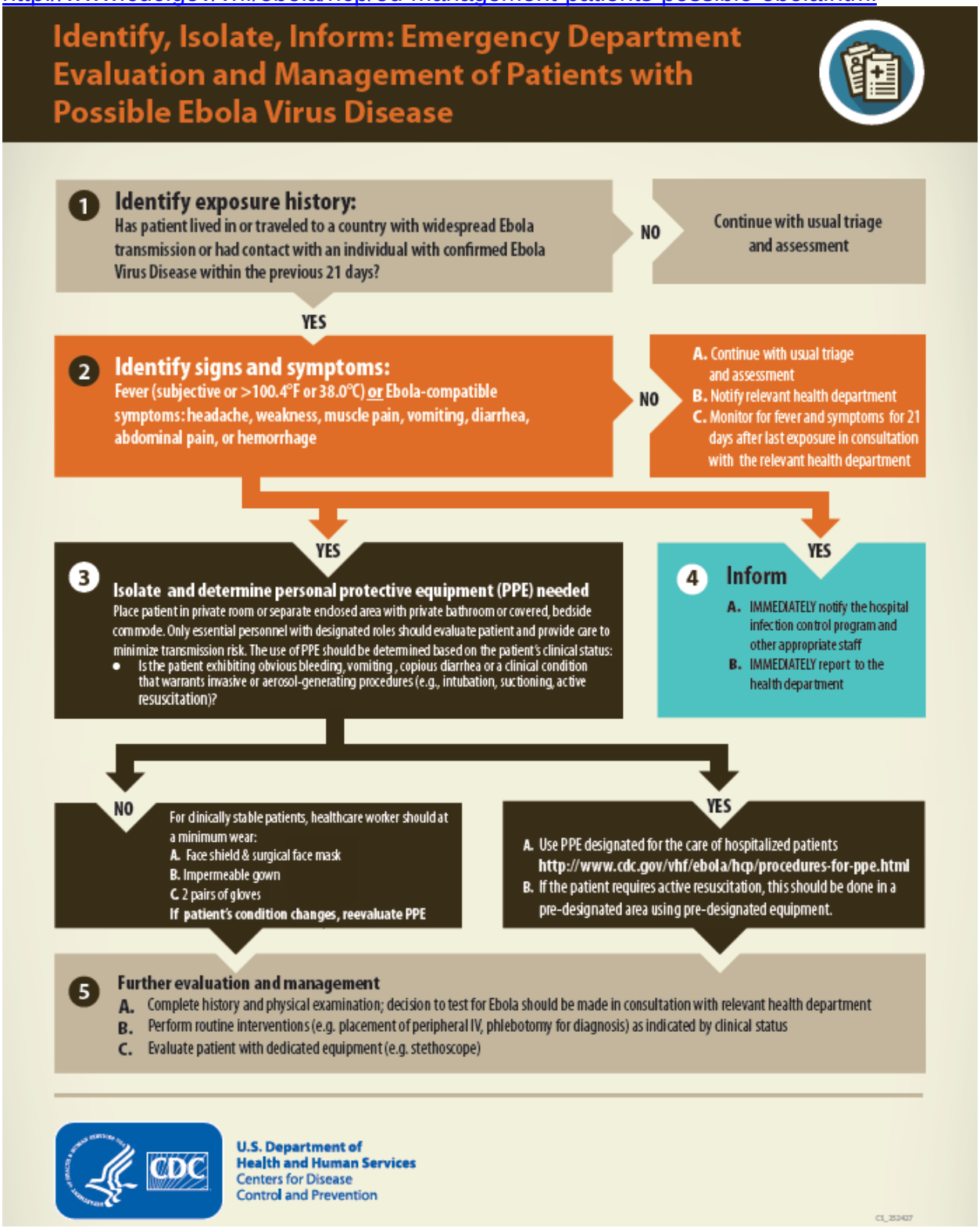
Military Protocol: Decontamination of Vehicles & Equipment Used for Transportation of Potential Ebola Virus Disease (EVD) Patients or Related Equipment: Technical Information Paper 13-031-0914
http://disasterlit.nlm.nih.gov/record/9182

Legal References

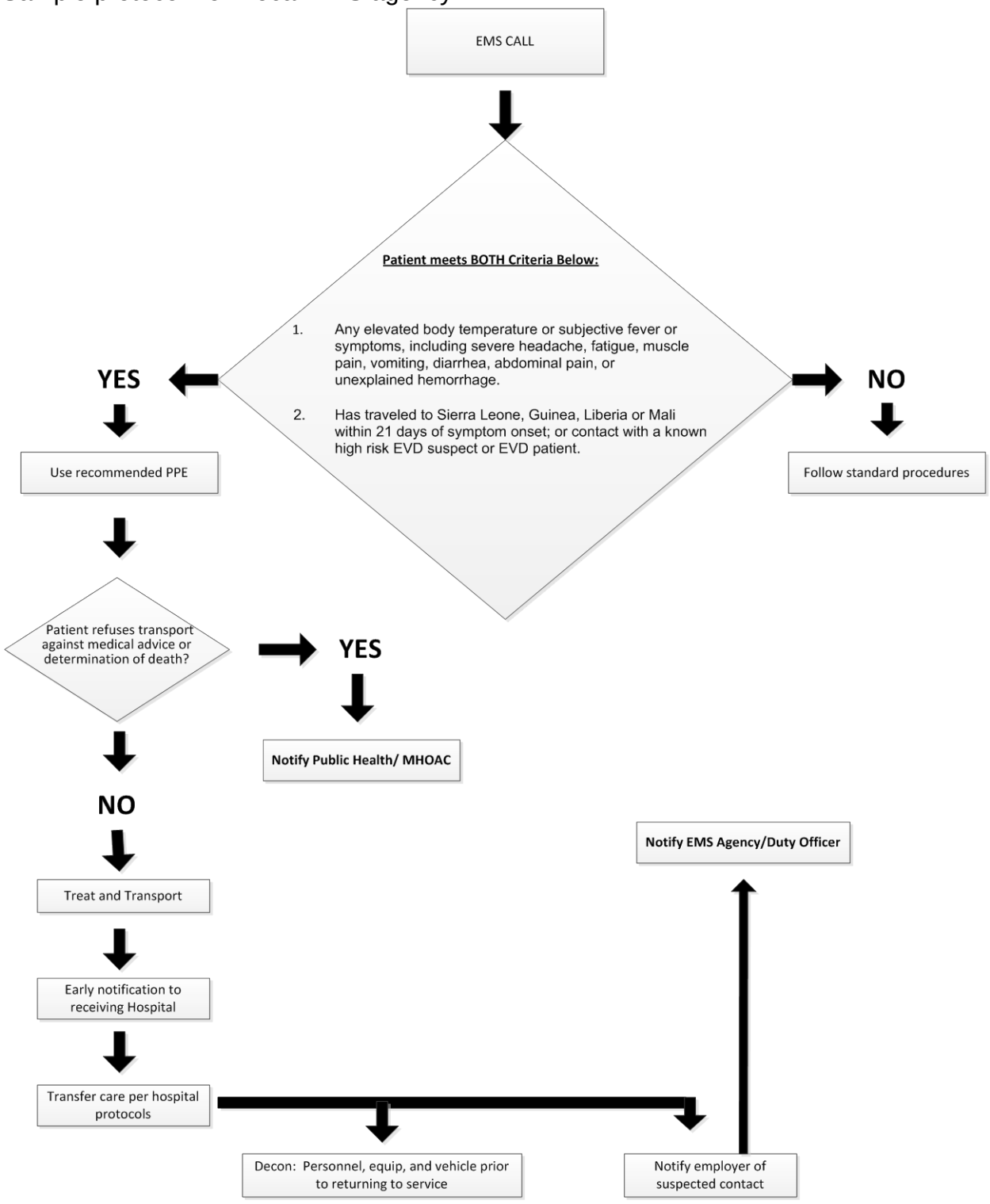
See Appendix E regarding Title 17, California Code of Regulations (CCR) Reportable Diseases and Conditions and Appendix F State of California Emergency Medical Services Law, Health & Safety Code Division 2.5.

Appendix A: Algorithm for Identify, Isolate, Inform

This is also applicable to the pre-hospital environment
http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html



Sample protocol from local EMS agency



Appendix B: California Health & Safety Code §101080.2

Section 101080.2. (Added by Stats. 2006, Ch. 874, Sec. 4)

(a) The local health officer may issue, and first responders may execute, an order authorizing first responders to immediately isolate exposed individuals that may have been exposed to biological, chemical, toxic, or radiological agents that may spread to others. An order issued pursuant to this section shall not be in effect for a period longer than two hours and shall only be issued if the means are both necessary and the least restrictive possible to prevent human exposure.

(b) Before any implementation of the authority in subdivision (a), the local health officer shall establish a related memorandum of understanding with first responders in his or her jurisdiction that shall require consultation with the Office of Emergency Services operational area coordinator, consistent with the standardized emergency management system established pursuant to Section 8607 of the Government Code, and shall include where and how exposed subjects will be held pending decontamination in the local jurisdiction. That memorandum of understanding shall be made available to the public.

(c) A violation of an order issued by the local health officer and executed by a first responder pursuant to subdivision (a) is a misdemeanor, punishable by a fine of up to one thousand dollars ($1000), or by imprisonment in the county jail for a period of up to 90 days, or by both.

Appendix C: Infectious Disease Ambulance Response Teams (IDART)

Jurisdictions who have the resources to field specialized Infectious Disease Ambulance Response Teams (IDART) may wish to consider some of the principles below (Note: The use of the term “Strike Team” is discouraged for these resources as Ambulance Strike Teams already exist and are used for completely different circumstances). This concept could be applied to units providing elective interfacility transports for confirmed or known high risk patients.

Goal: An IDART Program is intended to provide a strategic ambulance asset, supported by appropriate medical oversight, to the pre-hospital and medical community facing the challenges of managing emerging infectious diseases.

Objectives:

1. To provide reliable specialized emergency medical transportation resource for patients with suspected and confirmed cases of known and emerging infectious diseases.
2. Assure the highest level of competency in EMS personnel responsible for the medical transportation of suspect or confirmed disease that warrants activation of IDART.
3. Reduce risk by minimizing the exposure of first responders and non-IDART ambulance personnel needed to suspected or confirmed incidents of infectious disease.
4. The IDART program would be flexible, with deployments based upon reasonable estimates of threat to the system.
5. IDART personnel would be recruited to serve on a dedicated team of prehospital professionals with specialized training and competencies to qualify them to effectively manage high risk infectious disease medical transportation.

Concept of Operations: Use of IDARTS is <u>not intended to minimize efforts to adequately train and equip health care providers to safely manage patients suspected of having serious infectious disease.</u> However, the expectation that all providers in all medical settings can achieve a uniform level of technical expertise in the management of patients with a potentially highly infectious disease is unrealistic.

The IDART approach provides a small but highly trained team of EMS providers (paramedics and EMTs) skilled in PPE, isolation and safe medical transport of at risk patients. The asset would be accessible 24/7, 365 to respond to all settings for patients with suspect or confirmed conditions.

An IDART unit could be utilized in the following ways:

1. If during a 9-1-1 call the dispatcher learns of a possible suspect case e.g. caller reports risk factors of Ebola the unit would be deployed. Fire First Responders might not be deployed to reduce potential for exposure and risk, however this approach could vary from jurisdiction to jurisdiction.
2. If during a 9-1-1 call the dispatcher learns from an ambulatory health care setting of a suspect case the unit would be deployed. Fire First Responders might not be deployed to reduce potential for exposure and risk (See 1, above).
3. If a determination is made on scene of a possible suspect case through initial screening by either first responders or first on scene emergency ambulance personnel, the IDART unit could be subsequently deployed. In the absence of clinical demands to the contrary, the number of personnel remaining in contact with the patient while the IDART responds should be minimized.
4. Air to ground and ground to air transfers of suspect patients
5. Response to a hospital facility for planned or urgent inter-facility transfer of patients to evaluation or treatment center.
6. IDART response times may be greater in some cases however control of the environment to reduce spread of the disease and protection of the workforce in are the highest priorities when responding to these events.

IDART personnel will develop proficiency through competency based training. This could include:

1. Overview of Emerging Infectious Disease, Mechanisms of transmission and principles for exposure risk
2. Appropriate medical management of the patient during transport including mechanisms to limit patient contact to reduce exposure and potential for inoculation
3. Instruction and competency testing in all levels of PPE both standard and extensive PPE including PAPR’s and respirators
4. Extensive competency in (donning and doffing with buddy) at all times
5. Isolation procedures including draping of the inside of the ambulance
6. Hospital early alert and notification procedures
7. Procedures for patient handoff for each receiving in county receiving facility
8. Procedures for decontamination of ambulance, equipment and personnel post transportation
9. Procedures for disposal, sterilization and cleaning of contaminated materials and provider clothing
10. Protocols for reporting of accidental breach of PPE, exposure or inoculation

Appendix D: Sample Donning/Doffing Procedure (from LEMSA)

Donning

- Dress in hooded over-garment
- Put on N-95 or P-100 respirator
- Pull hood over head, neck and face to cover all skin areas (tape if necessary)
- Put on full-face shield
- Double glove with both sets of glove cuffs extending over the over-garment sleeves
    - Tape them if necessary to prevent skin from becoming exposed
- Have another person check that all skin areas are covered and the double gloves are tightly over the sleeves of the over-garment with several inches of overlap
- Under observation extend and flex neck, extend arms, flex at the waist, stoop and squat to be certain the PPE is properly fitted and that no skin becomes exposed

Doffing

- Critical moment in patient care provider safety and must be followed exactly under direct supervision and reading of the step-by-step procedure
- Doffing may occur either by the individual in the PPE or by another personnel in PPE cutting the over-garment (see below)
- As each PPE component is removed place them in a red biohazard bag
    - Wash outer gloves in 0.5% bleach/EPA registered disinfectant rated for non-enveloped viruses /alcohol based hand rub with at least 60% alcohol
    - Remove outer gloves by inserting fingers under cuff and inverting
        - Use the cutting procedure below if tape was used
    - Wash inner gloves in 0.5% bleach/EPA registered disinfectant rated for non-enveloped viruses/alcohol based hand rub with at least 60% alcohol
    - Remove face shield
    - Wash inner gloves in 0.5% bleach/EPA registered disinfectant rated for non-enveloped viruses /alcohol based hand rub with at least 60% alcohol
    - Open front zipper of over-garment
        - Defer if cutting procedure below is used
    - Wash inner gloves in 0.5% bleach/EPA registered disinfectant rated for non-enveloped viruses /alcohol based hand rub with at least 60% alcohol
    - Remove over-garment
        - If cutting procedure is used:
            - Have person in PPE stand with feet apart and arms extended outward

    - From behind, a second person in PPE uses clean scissors to cut down the back, down each leg and out along each arm
    - Allow over-garment to fall forward and off of individual
- Remove respirator
- Wash inner gloves in 0.5% bleach/EPA registered disinfectant rated for non-enveloped viruses /alcohol based hand rub with at least 60% alcohol
- Remove inner gloves
- Wash hands

Link to a video series from CDC that allows you to select specific PPE equipment and watch a video on how to don/doff that equipment.
http://www.cdc.gov/vhf/ebola/hcp/ppe-training/index.html

Appendix E: Title 17, California Code of Regulations (CCR) Reportable Diseases and Conditions

- **§ 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.

- **§ 2500(h)(i)** Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses) must be reported immediately by telephone.

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

Appendix F: State of California Emergency Medical Services Law

Health & Safety Code Division 2.5

HS 1979.188: Notification of Exposure: Hospital

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 disease or condition" or "a 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 Administrative Code, 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.

(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 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, shall be notified that they have been exposed to the disease and should contact the county health officer if all the following are satisfied:

(1) 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 disease or condition, provides the health facility 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 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.

(2) The health facility reports the name and telephone number of the prehospital emergency medical care person to the county health 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 disease or condition.

(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 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, upon receiving the report from a health facility pursuant to paragraph (1) of subdivision (b). The county health officer shall not disclose the name of the patient or other identifying characteristics to the prehospital emergency medical care person.

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

In the event of the demise of the person afflicted with the reportable 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 disease prior to the release of the decedent from the health facility to the funeral director.

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

HS 1797.189: Notification of Exposure: Coroner

1797.189. (a) As used in this section:

(1) "Chief medical examiner-coroner" means the chief medical examiner or the coroner as referred to in subdivision (m) of Section 24000, Section 24010, subdivisions (k), (m), and (n) of Section 24300, subdivisions (k), (m), and (n) of Section 24304, and Sections 27460 to 27530, inclusive, of the Government Code, and Section 102850.

(2) "Prehospital emergency medical care person or personnel" means any of the following: 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.

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

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

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

(b) Any 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 disease or condition listed as reportable, that can, as determined by the county health officer, be transmitted through oral contact or secretions of the body, including blood, shall be notified that they have been exposed to the disease and should contact the county health officer if all of the following conditions are met:

(1) 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 disease or condition, provides the chief medical examiner-coroner with his or her name and telephone number at the time the patient is transferred from that prehospital medical care person to the chief medical examiner-coroner; or the party transporting the person afflicted with the reportable disease or condition provides that chief medical examiner-coroner with the name and telephone number of the prehospital emergency medical care person who provided the emergency medical or rescue services.

(2) The chief medical examiner-coroner reports the name and telephone number of the prehospital emergency medical care person to the county health 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 disease or condition.

(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 disease or condition listed as reportable, that can, as determined by the county health officer, be transmitted through oral contact or secretions of the body, including blood, upon receiving the report from a health facility pursuant to paragraph (1) of subdivision (b). The county health officer shall not disclose the name of the patient or other identifying characteristics to the prehospital emergency medical care person.

Nothing in this section shall be construed to authorize the further disclosure of confidential medical information by the chief medical examiner-coroner or any of the prehospital emergency medical care personnel described in this section except as otherwise authorized by law.

The chief medical examiner-coroner, or the county health officer shall notify the funeral director, charged with removing or receiving

the decedent afflicted with a reportable disease or condition from the chief medical examiner-coroner, of the reportable disease prior to the release of the decedent from the chief medical examiner-coroner to the funeral director.

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

HS 1797.220: Local Medical Control Policies, Procedures

(including patient destination policies and patient care guidelines)

1797.220. The local EMS agency, using state minimum standards, shall establish policies and procedures approved by the medical director of the local EMS agency to assure medical control of the EMS system. The policies and procedures approved by the medical director may require basic life support emergency medical transportation services to meet any medical control requirements including dispatch, patient destination policies, patient care guidelines, and quality assurance requirements.

HS 1798.150: Guidelines for Critical Care Facilities

1798.150. The authority may establish, in cooperation with affected medical organizations, guidelines for hospital facilities according to critical care capabilities.

HS 1798.170: Development of Triage and Transfer Protocol

1798.170. A local EMS agency may develop triage and transfer protocols to facilitate prompt delivery of patients to appropriate designated facilities within and without its area of jurisdiction. Considerations in designating a facility shall include, but shall not be limited to, the following:

(a) A general acute care hospital's consistent ability to provide on-call physicians and services for all emergency patients regardless of ability to pay.

(b) The sufficiency of hospital procedures to ensure that all patients who come to the emergency department are examined and evaluated to determine whether or not an emergency condition exists.

(c) The hospital's compliance with local EMS protocols, guidelines, and transfer agreement requirements.

HS 1798.172: Patient Transfer Agreement Guidelines

1798.172. (a) The local EMS agency shall establish guidelines and standards for completion and operation of formal transfer agreements between hospitals with varying levels of care in the area of jurisdiction of the local EMS agency consistent with Sections 1317 to

1317.9a, inclusive, and Chapter 5 (commencing with Section 1798). Each local EMS agency shall solicit and consider public comment in drafting guidelines and standards. These guidelines shall include provision for suggested written agreements for the type of patient, initial patient care treatments, requirements of interhospital care, and associated logistics for transfer, evaluation, and monitoring of the patient.

(b) Notwithstanding subdivision (a), and in addition to Section 1317, a general acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2 shall not transfer a person for nonmedical reasons to another health facility unless that other facility receiving the person agrees in advance of the transfer to accept the transfer.

The PES – Crisis Stabilization and Evaluation for All
Regional Dedicated Psychiatric Emergency Services (PES)
Dedicated Psychiatric/Substance Use Disorder Emergency Department

Too often, individuals with urgent mental health needs have no alternative but to go to medical emergency rooms (ER) at hospitals, where there can be few staff trained in mental health, the environment is not conducive to healing, and there may be little alternatives for disposition but psychiatric hospitalization.

The vast majority of individuals in mental health crisis who arrive at a hospital emergency department are placed on an involuntary LPS 5150 police detainment order and brought to a hospital by law enforcement or emergency transportation vehicles. The method by which an individual is placed on an LPS 5150 detainment and subsequently transported varies by county. There is also wide variation on whether a law enforcement officer physically stays with the individual detained on an LPS 5150 once they arrive at a hospital emergency department.

Unfortunately, there are no local or statewide mechanisms to track the number of LPS 5150 detainment orders written, nor is there a way to determine how many of the LPS 5150s are evaluated under LPS 5151and upheld for detainment. This also holds true for determining the number of individuals who ultimately are involuntarily committed on an LPS 5152, 72-hour hold. It is estimated that a minimum of 300,000 individuals are on 5150 detainment in hospital emergency departments annually. It is also estimated that at least 210,000 (70%) of these 300,000 individuals did not meet the criteria for inpatient admission under the LPS 5152, 72-hour involuntary hold criteria.

A Psychiatric Emergency Services (PES) unit is a far better alternative for people in crisis. A PES can be located on a hospital campus or in the community, but even when on the hospital grounds, the PES interior is far more calming and welcoming than a medical ER. PES layouts typically have décor, lighting, sound/music, and open spaces designed with the goal of encouraging healing and recovery, which make them quite different from a hectic, antiseptic medical ER with its noisy machinery and frightening equipment.

PES programs are designed to provide accessible, professional, cost-effective services to individuals in psychiatric and/or substance abuse crisis, and strive to stabilize consumers on site and avoid psychiatric hospitalization whenever possible. A PES provides emergency/urgent walk-in and police-initiated evaluation and crisis phone service 24 hours a day, 7 days a week.

A PES provides complete evaluation and treatment for all who present, regardless of level of acuity or insurance status. PES programs do not have "exclusion" or "no-admit" lists which prevent certain patients from entering their facility. Rather, a PES will work with everyone in need, following "Zeller's Six Goals of Emergency Psychiatric Care":

- Exclude medical etiologies of symptoms
- Rapidly stabilize the acute crisis
- Avoid coercion

- Treat in the least restrictive setting
- Form a therapeutic alliance
- Formulate an appropriate disposition and aftercare plan

As studies have estimated as many as 20-30% of psychiatric emergencies may be due to, or are combined with, serious medical concerns, it is important that all crisis patients receive an appropriate medical screening. Next, all efforts are made to stabilize or reduce the symptoms that are causing a person distress – be they suicidal thoughts, auditory hallucinations, severe paranoia, mania, or other difficult conditions. Whenever possible, all evaluation and treatment is done free of coercion, with staff forming a therapeutic, collaborative partnership with each consumer. Treatment is done in the least restrictive setting, so restraints and/or seclusion are to be avoided, and consumers should be returned to their home or freedom in the community as soon as possible. All who leave the PES should have a solid aftercare plan including follow-up appointments, medication information, and strategies to help the person avoid crises in the future.

A typical dedicated PES department meets all these goals, and is staffed with psychiatric physicians and mental health professionals around the clock who can provide:

- Screening for all emergency medical conditions and provide basic primary medical care (e.g., oral alcohol withdrawal, asthma, diabetes management, pain, continuation of outpatient medications)
- medication management
- laboratory testing services
- psychiatric evaluation/assessment for voluntary and involuntary treatment
- treatment with observation and stabilization capability on site
- crisis intervention and crisis stabilization
- screening for inpatient psychiatric hospitalization
- linkage with resources and mental health and substance abuse treatment referral information

A PES can dramatically improve access to care and quality of care while decreasing costs to the health care delivery system. Today, in communities without a PES, patients are taken to traditional hospital emergency rooms and often languish with no psychiatric assistance or intervention for hours, sometimes days, awaiting the arrival of an individual trained to provide a psychiatric assessment or an available inpatient psychiatric bed. This, in and of itself, undermines the formation of a positive therapeutic alliance for the patient, delays treatment for the patient, ties up staff time and an ER bed in an already overburdened medical emergency department. Unfortunately, for safety reasons, too often patients are placed in restraints, with a sitter, or both, if considered a danger to themselves or others.

A 2009 survey of Medical Directors of medical emergency departments in hospitals across the U.S. called for Regional Dedicated Psychiatric Emergency Programs as a potential solution to the major national problems of psychiatric patients boarding for long hours in emergency departments. Indeed, a recent study showed that a PES in a system decreased boarding times

over 80% compared to overall California boarding times, and led to stabilization and discharge without needing inpatient admission over 75% of the time.

The ability of a PES to avoid hospitalization for the vast majority of patients is due to being able to treat patients for up to 23 hours and 59 minutes (thus sometimes referred to as "23-hour treatment facilities"). This permits time for treatment, observation and "healing time," which is often sufficient to stabilize patients' symptoms so they can return home or to another less-restrictive level of care. This follows a simple truth, that most patients in psychiatric crisis do not need hospitalization, though they do need urgent intervention and care.

The goals of healthcare reform include improved access to care, improved quality of care, improved timeliness of care, along with less hospital admissions and reduced costs. Adding a PES to appropriate systems helps to meet all these goals.

To standardize definitions, the key concept that differentiates a true PES from what are more often called crisis stabilization units, crisis clinics, etc., is that a true PES is a program separately housed from a medical hospital ED (i.e., not considered to be just a wing of a larger ED) that can take ambulance/police deliveries independently from the field. This makes it different from the typical Crisis Stabilization Unit, which usually evaluates and treats patients who have already been initially received and medically screened in a medical ED, then transfers over when considered medically stable. However, both programs do what is basically called "Crisis Stabilization," and there are so many variations in design that difference in these programs can be minimal.

The concept of a PES being a "dedicated emergency department" comes from EMTALA law:

> "A dedicated emergency department is defined as meeting one of the following criteria regardless of whether it is located on or off the main hospital campus: The entity: (1) is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or (2) is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions (EMC) on an urgent basis without requiring a previously scheduled appointment; or (3) during the preceding calendar year, (i.e., the year immediately preceding the calendar year in which a determination under this section is being made), based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment. This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric units of hospitals) where patients are routinely evaluated and treated for emergency medical conditions."

A PES is not a "medical emergency department," nor a "community clubhouse model," but a blend of both, which is community-based and uses the Recovery Model concept.

In California, there are at least 10 PES departments operating in seven counties. There may be other comparable facilities or programs as well. The current PES departments are:

1. Alameda Health System, Oakland
2. Contra Costa County Regional Medical Center
3. Los Angeles County (Harbor-UCLA Medical Center, LAC+USC Medical Center and Olive View Medical Center)
4. Marin County
5. San Francisco General Hospital
6. San Mateo County
7. Valley Hospital (Santa Clara County)
8. One under construction in Ventura County

There is a need for at least an additional ten PES units; see attached map.

Psychiatric Emergency Services (PES) vs. Crisis Stabilization Unit (CSU)

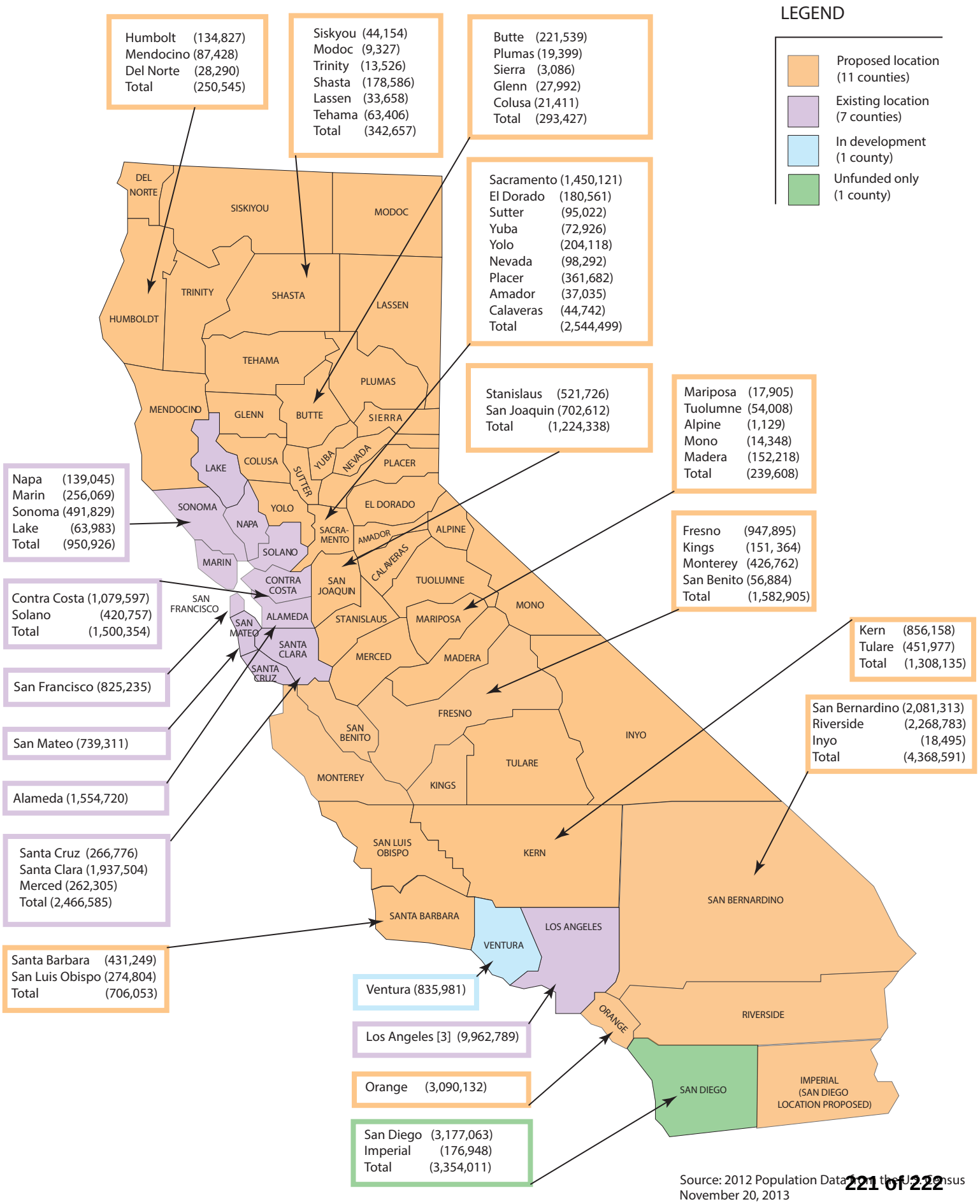
Psychiatric Emergency Department	Proposed Blended Model Emergency Treatment Services	Crisis Stabilization Unit
Operates as an active Treatment Model and services are available 24/7 and no one is restricted from using the service as it falls under EMTALA rules as patients are seen as having an "Emergency Medical Condition"	Open 24/7	Provides Triage and limited treatment, assessment for starting or discontinuing a hold and referral services. A psychiatrist is the lead clinician either in person or via telepsychiatry – may not be available 24/7
Open with physician available 24/7	Medical staff available 24/7 including telepsychiatry services	Not open 24/7 or have physician present
Capacity to screen for all "Emergency Medical Conditions"	Capacity to screen for all "Emergency Medical Conditions"	Does not have capacity to screen for all "Emergency Medical Conditions"
Has contracts for payment with plans	Contracts for payment with plans	Does not typically contract with plans
Qualifies under EMTALA	EMTALA qualification to be determined	Does not qualify as EMTALA provider
Required to assess all who present	Required to treat all individuals, regardless of payment or legal status (voluntary and involuntary)	Can be selective about patients served
Can bill Medicare ($117 per hour up to 20)		Cannot bill Medicare
Can bill under Medi-Cal Waiver ($90+ hr.)		Can bill under Medi-Cal Waiver ($90+hr.)
Do not maintain "Do not admit lists"		May maintain a "Do not drop off list"
Law enforcement drop-offs allowed	Drop-off by EMS, law enforcement, family, friend, or self	No 5150 law enforcement drop offs
Typically located on hospital grounds	May be located on hospital grounds or in the community	May be located on hospital grounds or in the community

Regulations:

Residential Treatment: Welfare & Institutions Code §5671

Crisis Stabilization: Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, §1810.210

Proposed and Existing Psychiatric Emergency Services (PES) and Service Areas in California (with population)



Source: 2012 Population Data from the U.S. Census
November 20, 2013

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

DATE: November 24, 2014

TO: Emergency Medical Services/Trauma Committee Members

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

SUBJECT: 2015 Meeting Schedule

The following is the meeting schedule for 2015 EMS/T Committee in-person meetings:

WEDNESDAY, MARCH 25, 2015 10:30 AM – 2:30 PM	SACRAMENTO, CHA OFFICES BOARD ROOM 1215 K Street, Suite 800
WEDNESDAY, JUNE 24, 2015 10:30 AM – 2:30 PM	SACRAMENTO, CHA OFFICES BOARD ROOM 1215 K STREET, SUITE 800
WEDNESDAY, SEPTEMBER 23, 2015 10:30 AM – 2:30 PM	SACRAMENTO, CHA OFFICES BOARD ROOM 1215 K Street, Suite 800
SUNDAY, DECEMBER 6, 2015 TBD	Joint Meeting – EMST/Center for Behavioral Health Location TBD

Thank you, and if you have any questions, please feel free to call me directly at **(916) 552-7537.**

BJB:mb
Rev 112414