CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

May 20, 2019

Esam El-Morshedy
Emergency Medical Services Authority
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BY ELECTRONIC CORRESPONDENCE

RE: Paramedic, Notice of Proposed Rulemaking, Title 22, Division 9. Prehospital Emergency Medical Services, Chapter 4.

Dear Mr. El-Morshedy:

California's hospital emergency departments (EDs) are committed to providing the right care, at the right time, for all our patients. An important component of providing that care is the state's use of alternate destinations for patients who would be more appropriately served in a setting other than hospital EDs. In furtherance of those efforts, the California Hospital Association (CHA) — on behalf of our more than 400 member hospitals and health systems —respectfully offers the following comments for consideration on the Emergency Medical Services Authority's (EMSA) proposed regulatory text for California Health and Safety Code sections 1797.116,1797.172, and 1797.194. In the attached public comment document, we have outlined specific comments related to collaboration on base station status as well as the definition of "sobering center."

In general, CHA salutes EMSA's pursuit of clarity and specificity about paramedic transport of non-emergency patients. ED overcrowding continues at a disturbing pace — hospital emergency departments across the state report more than 16 million visits annually. EMSA, local emergency medical services (EMS) agencies. and CHA all recognize the detrimental effect that emergency department overcrowding is having on the delivery of care, despite increased capacity and system-wide performance improvement measures. California hospital EDs do not have the non-emergent specialty care resources to properly care for behavioral health patients who require the services of licensed psychiatric facilities, nor the environment to adequately care for non-emergency patients such as those requiring sobering services.

California EMS systems have proven effective and highly successful in allowing prehospital personnel to triage complex patients to general acute care hospital (GACH) specialty centers designed to meet their specific needs. Triaging any patient requires understanding both complex and non-emergent needs, as well as the ability to recognize non-emergency needs; these skills are already part of paramedics' recognized scope of practice. Though existing regulations do not require patient transport — in fact, they specifically recognize non-transport as an option — there is confusion about paramedics' assessment and transport of patients to alternative destinations. In addition to confusion about

paramedic scope of practice, the legitimacy of alternate destinations is in question. These proposed regulatory changes will provide clarity on paramedic training and describe important licensing/accreditation considerations for safe transport to alternate destinations. These clarifications will help to avoid confusion and allay public concerns when paramedics assess and determine that a patient is in a "non-emergency" condition and can be transported to an alternate destination.

As this process moves forward, CHA offers two items for consideration. First, hospitals would like collaboration and mutual agreement on how medical control and base station status will be established and controlled throughout a local EMS agency (LEMSA) for alternate destinations. Hospitals and LEMSAs are stretched thin, performing unfunded duties required for EMS system innovation and change. While CHA and our hospital EMS providers support alternate destination as a means to get the patient to the right place, at the right time, the first time, some hospitals have expressed concerns about responsibilities for base station status. Oversight for education and performance improvement related to alternate destination specialty of care should be solidly placed in the hands of the alternate destination providers. Obviously, this may fluctuate across LEMSAs depending on LEMSA and provider resources. Alternate destination providers are the experts in care delivered at their site and should be directing delivery of appropriate patients, providing education and monitoring quality assurance processes.

Secondly, CHA asks that "sobering centers" be defined to capture the 13 present sobering center facilities operating across the state. Due to the contemporary status of these entities, CHA has worked closely with the newly formed National Sobering Center Collaborative (NSCC) to develop and implement criteria to educate decision makers and the public on the efficiency and effectiveness of these centers. While the state's longest-running sobering center in San Francisco is an federally qualified health center (FQHC), other highly effective centers are operating across the state without FQHC status. With the NSCC's assistance, we offer in the attached document a salient definition incorporating centers that meet safety and quality measures, particularly those that have been participating in the Office of Statewide Health Planning and Development Workforce Pilot Project #17 and others that are willing to pursue upcoming accreditation standards to be developed by the NSCC.

CHA agrees with EMSA and LEMSAs in that certain patients — including behavioral health and inebriated patients — could be more successfully treated in alternate destination sites. This would both alleviate hospital ED overcrowding and reduce EMS ambulance patient offload times. CHA stands ready and willing to work with EMSA and LEMSAs statewide to innovate and accelerate improved EMS care that puts patients first. We are committed to delivering the right care, at the right time, by the right provider, the first time we interact with a patient.

Sincerely,

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