

Attachment # 3



EMERGENCY MEDICAL CARE COMMITTEE

Regular Meeting

Friday, April 26, 2013 – 9:00 a.m.

Location: Hall of Administration: Commission Hearing Room
333 W. Santa Ana Blvd, Santa Ana, CA 92701

MINUTES

MEMBERSHIP / ATTENDANCE

MEMBERS	CATEGORY REPRESENTED	HCA STAFF	REPRESENTING
<input type="checkbox"/> Chan Le Nguyen, MD	- Board of Supervisors, First District	Holly Veale	Medical Services
<input checked="" type="checkbox"/> Patrick Powers	- Board of Supervisors, Second District	Lydia Mikhail	Division Manager
<input checked="" type="checkbox"/> Nick Anas, MD	- Board of Supervisors, Third District	Sam Stratton, MD	EMS Medical Director
<input checked="" type="checkbox"/> Jon Gilwee	- Board of Supervisors, Fourth District	Mike Delaby, RN	EMS Facilities Coordinator
<input type="checkbox"/> vacant	- Board of Supervisors, Fifth District	Eileen Endo	Office Specialist
<input checked="" type="checkbox"/> Monica Ruzich	- American Red Cross, OC Chapter		
<input type="checkbox"/> Julie Wanstreet, RN	- Orange Coast Emergency Nurses Assn.	Others Present	
<input checked="" type="checkbox"/> Kenneth McFarland	- Hospital Association of So. Calif.	Bill Weston	Care Ambulance
<input checked="" type="checkbox"/> Michelle Tom, MD	- Society of OC Emergency Physicians	Michael Dimas	Medix Ambulance
<input checked="" type="checkbox"/> Philip Davis	- Ambulance Association of OC	John Detviler	Medix Ambulance
<input checked="" type="checkbox"/> Brad Reese	- League of California Cities	Walter Garcia	Medix Ambulance
<input checked="" type="checkbox"/> Margie Harrier	- OC Business Council	Julie Puentes	Hosp Assoc of So Cal
<input type="checkbox"/> vacant	- OC City Managers Association	Stephen Wontrobski	public
<input checked="" type="checkbox"/> Wolfgang Knabe	- OC Fire Chiefs Association		
<input checked="" type="checkbox"/> Bryan Hoynak, MD	- OC Medical Association		
<input type="checkbox"/> Chief Paul Henisey	- OC Police Chiefs/Sheriffs Assn.		
<input type="checkbox"/> vacant	- OC Senior Citizens Advisory Council		

1. CALL TO ORDER

Meeting called to order by Jon Gilwee, Chair

2. INTRODUCTIONS / ANNOUNCEMENTS

3. APPROVAL OF MINUTES

MSC Approval of minutes from February 22, 2013 meeting

4. OCEMS REPORT / CORRESPONDENCE

- Medical Director Update
- OC-MEDS Update
March/April 2013 Progress Report was provided to members.
- Disaster Preparations
Updated on Bio-detection Device System (BDS) exercise last week.
- Hospital Diversion
Compared to 2011/12 data, ER diversion increased by 1300 hours, remained high in January 2013 but normalized during Feb/March 2013.
- EMCC Correspondence
Attachments provided to members as well as a related letter received on 4/26/13.

5. **OLD BUSINESS**

A. **Ground Ambulance Services Basic Life Support (BLS) Rates Adjustment and Advanced Life Support (ALS) Rate**

Information presented and included the 4/5/13 Notification to City Managers, Fire Chiefs and Ambulance providers for the 2013/14 Annual rate adjustment and 6/28/13 date for EMCC discussion and action. Included calculation for proposed rate adjustment based on the methodology used for the 2012/13 Board approved rates.

6. **NEW BUSINESS**

A. **Public Hearing Notice: Closure of Emergency Services: Anaheim General Hospital**

Opportunity for public comment, no speakers.

B. **Mandatory Field Observations for Mobile Intensive Care Nurses**

Information, survey results and recommendation to have subcommittees further discuss issue provided by Dr. Stratton.

C. Pre-public comment: Policy #700.00: Paramedic Service Provider Criteria

Information and Discussion: Notification to public and EMS system of the impending release of the policy that defines the criteria for being a 9-1-1 Advanced Life Support (ALS) provider in Orange County. Primarily, OCEMS is intending to incorporate national standards for ALS response and performance and to place the policy up for public comment. Chair Gilwee asked for release date and was advised 1-2 weeks. Member Powers commented on the relevancy of specific requirements such as the letter of commitment.

D. **Interfacility Transport Advanced Life Support (IFT-ALS) Pilot Interim Report**

Information and Discussion: Dr. Stratton reported that the white paper was released three days ago by OCEMS and opened the item for further discussion.

Phil Davis – Acknowledged representative status for Ambulance Association Orange County (AAOC) and owner of Emergency Ambulance and provided oral comment regarding usage of paramedic and Registered Nurse transports and affirmed that patient care is a priority. Dr. Stratton commented that OCEMS is not replacing Registered Nurses with paramedics and the Critical Care Transport-Nurse (CCT-RN) model is not expected to change. Acknowledged that the AAOC has been on record against the pilot program and OCEMS continues to explore issues described in white paper. and will release final data evaluation at June EMCC meeting.

Chief Knabe- Oral comment (1) seeking clarification that the IFT –ALS transports do not fall under the definition of 9-1-1 service. Dr. Stratton responded that those transports are designed to function parallel to the 9-1-1 system and the response criteria is described in white paper. Oral comment (2) regarding availability of public paramedic through extensive mutual aid agreements. Oral comment (3) clarifying that the EMCC is advisory to the OC Board of Supervisors. Dr. Stratton affirmed that the authority for medical matters is outlined in the Health & Safety Code and rests with the Medical Director. Oral comment (4) questioned if other alternatives were considered to decrease the extended response times for RN transports models. Dr. Stratton replied that OCEMS is open to

other proposals or suggestions and that the pilot IFT-ALS model is currently being used by other systems such as Los Angeles and Riverside. Further, anticipated demands from hospitals affected by healthcare reform impacts and hospital feedback related to delayed transport responses was a determining factor in implementing this pilot. Oral comment (5) questioned whether the delayed responses are due to nursing availability or financial issues. Dr. Stratton responded that OC Health Care Agency cannot definitively determine as medical authority over CCT-RN service has not been exercised nor has any data supporting assertions of non-delay been presented. Oral comment (5) seeking clarification on the appropriateness of the aforementioned attorney letter. Dr. Stratton replied that the document he was referring to is in the Agenda packet.

Patrick Powers – Oral comment regarding alternative solutions such as the recent passage of the Critical Care Paramedic regulation standards.

Monica Ruzich – Oral comment seeking clarification of the oversight of CCT RN transports and suggested that the committee move that these types of transports be considered to come under EMS. Response from Dr. Stratton acknowledged that these transports are high risk and fairly unregulated and that OCEMS is considering inclusion of these transports under the control of the EMS Medical Director.

John Gilwee – Oral comment asking if it is the attending physician who decides the level of patient transport. Dr. Stratton confirmed that federal and state law define that the decision for the level of IFT is under the transferring physician.

Dr. Hoynak - Oral comment regarding affordable care act implications and suggested that the financial responsibility for an IFT should fall under the Accountable Care Organization and the medical control remain under the EMS Medical Director.

7. **EMCC ADVISORY SUBCOMMITTEE AND ADVISORY GROUP REPORTS**

8. **MEMBER COMMENTS**

No comments.

9. **PUBLIC FORUM** (non-agenized)

Steven Wontrobski– Oral comment regarding IFT Pilot program

Baryic Hunter– Oral comment regarding IFT Pilot program

Bill Weston – Oral comment regarding IFT Pilot program

Kathy Moran - Oral comment regarding IFT Pilot program

10. **NEXT MEETING** - June 28, 2013, 9:00 a.m.
Commission Hearing Room - 333 W. Santa Ana Blvd, Santa Ana 92701

11. **ADJOURNMENT**

Attachment # 4

Newport Beach Fire Department to Launch ePCR by End of July – Creates Their Own Custom ePCR Template

The Newport Beach Fire Department (NBFD) is nearing the final stages of full implementation of the OC-MEDS ePCR. Led by Firefighter/Paramedic Adam Novak, NBFD anticipates that they will successfully transition to 100% utilization of ePCRs by the end of July 2013. NBFD appointed Firefighter/Paramedic Novak as their full-time “ePCR Coordinator” in April 2013. Since then, he has successfully managed the difficult tasks of template design, curriculum development, staff training, and hardware selection. OCEMS had the chance to ask FF/PM Novak a few questions:

OCEMS: *How easy (or difficult) was it to use the layout editor to create your own template?*

Novak: *The layout editor is a powerful tool for customizing the ePCR template. When I redesigned our template, I removed many of the data elements that NBFD did not need. The great thing about the layout editor is that I can now add things back in and/or modify the template on a trial and error basis. The Layout Editor allows me to constantly tweak things to make the ePCR more efficient for the end users.*

OCEMS: *What was your rationale for choosing a consumer tablet versus a more rugged commercial tablet?*

Novak: *The bottom line was that we wanted to pair Field Bridge with the best device possible for our end users while considering long term budgetary constraints. We have been using the Samsung ATIV 700T for 6 months and it has been a great device so far. Not only does it cost half as much as the more ruggedized devices, but its light, fast, and has a large high definition display.*

OCEMS: *Any “pearls of wisdom” regarding ePCR training for staff?*

Novak: *I have been assigned to a 40 hour work week with the sole purpose of training staff and implementing the ePCR for the Newport Beach Fire Department. Teaching one’s peers is amongst the toughest environments for an instructor. So, if I could give some simple advice it would be to have a lot of patience and keep a positive attitude. The transition to ePCR is one of the biggest changes in the fire service in recent history. It is very important to let your staff know that it is completely acceptable to struggle with the new technology and that it will get better over time and with practice. With that said, it is extremely important for the Fire Department to support its end users. To help accomplish this, we’ve used our city intranet to post educational resources about the ePCR including PowerPoints, user guides, and training videos.*

OCEMS: *About when do you anticipate that your department will be 100% “live” on ePCR?*

Novak: *75% of Newport Beach Fire Department has been trained and we will be 100% “live” by the end of July. Although we are not 100% live on ePCR when it comes to personnel, we continue to have 100% “live” days where all of our patient care reports are electronic.*



Firefighter/Paramedic Adam Novak

Who’s “Going Live”?

eBHR and Base Hospital Communications Equipment



Base Hospital Coordinator Kathy Kelly tests new Base Console at Western Medical Center – Santa Ana

Base Hospital Communications Consoles Replacement Project A Success

Orange County Communications (OCC), in collaboration with OCEMS, has successfully completed the Base Hospital Communications Console Replacement Project. The project fully replaced aging communications consoles used by Mobile Intensive Care Nurses (MICN) at each Base Hospital. The new consoles include modern radio communication components with computerized touch screen controls. In addition to new communications capabilities, the project will soon include new Electronic Base Hospital Report (eBHR) software that will allow each base hospital to be interoperable with the OC-MEDS ePCR software used by paramedics in the field.

ePCR Hardware

OCEMS Distributes Over 140 UASI Grant Funded Tablets To Fire Departments

In collaboration with the Anaheim/Santa Ana Urban Area Security Initiative (UASI) and most Orange County Fire Departments, Orange County EMS (OCEMS) has successfully purchased and distributed over 140 computer tablets to public EMS providers to stimulate the final implementation of ePCR systems countywide. This equipment was purchased in support of the OC-MEDS project with UASI FY 2011 Grant Funds. OCEMS is planning to work with the remaining Fire Departments to facilitate the selection and procurement of devices after July 1, 2013.

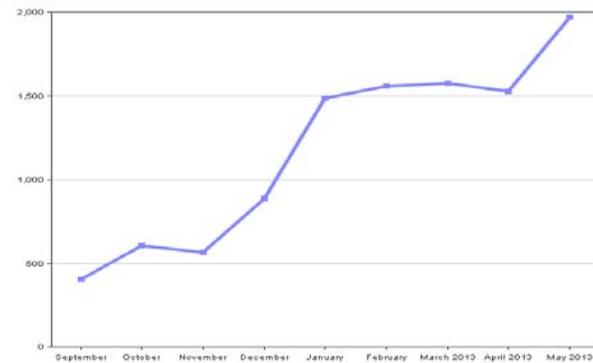


ePCR Utilization

OC-MEDS ePCR Usage By Fire Departments On Track To Meet 25% Goal by Fall 2013

Last Spring, OCEMS set a goal of 25% ePCR utilization by fire departments by Fall 2013. The objective was to measure the countywide monthly average EMS call volume (n = 14,000) and compare it to the number of ePCRs that were completed and posted by fire department personnel. We are on track to meet that goal with **the May 2013 totals coming in at 14%**. OCEMS is committed to the success of the ePCR project and will continue to work with fire departments to encourage agency implementation of the ePCR with a target monthly average of at least **25% by Fall 2013 and 75% by Winter 2013.**

Number of Records by Date



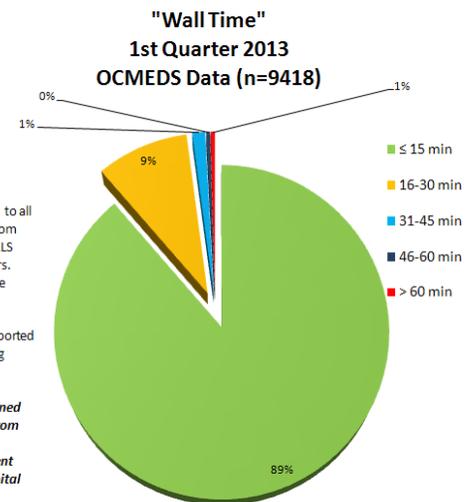
Incident Date	Count
September 2012	407
October 2012	605
November 2012	566
December 2012	806
January 2013	1,489
February 2013	1,560
March 2013	1,579
April 2013	1,827
May 2013	1,973

CQI and Data Reports

Report Writer Beginning To Generate Meaningful Data

OCEMS has been working with EMS provider agencies for several years to implement the OC-MEDS project. We are finally in the position to be able to generate some meaningful data that can help us all better manage the delivery of prehospital patient care for the citizens that we serve.

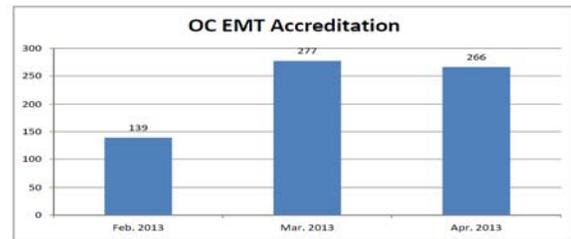
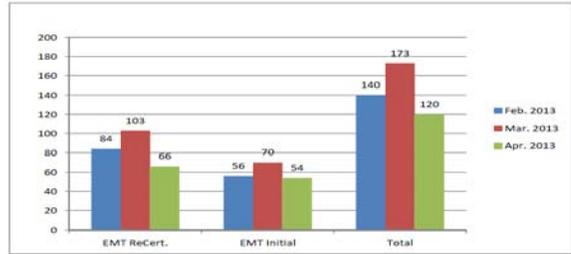
The issue of Emergency Department (ED) "Wall Times" has been a perpetual discussion topic for several years among EMS Systems throughout the nation. It has been a regular topic in Orange County too, with the perception that "Wall Times" may be getting longer. Using data submitted to OC-MEDS from both public and private EMS Providers, we can now begin to evaluate "Wall Times" to better determine their impacts and shape future policies if needed.



Online EMT Certification System A Success

The online EMT Certification system, a component of the Orange County Medical Emergency Data System (OC-MEDS) project, has been fully operational since December 17, 2012 and is being used by nearly all EMT applicants served by OCEMS. The system is operational 24 hours per day / 7 days per week and may be accessed at: <https://www.oc-meds.org/licensure/public/orangecounty/>.

The system is already generating valuable information about the certification of EMTs in Orange County, and example of which is viewable in the exhibit.





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Integrity
Service*

COUNTY OF ORANGE HEALTH CARE AGENCY

HEALTH DISASTER MANAGEMENT EMERGENCY MEDICAL SERVICES

MARK REFOWITZ
DIRECTOR

HOLLY A. VEALE
ACTING DEPUTY AGENCY DIRECTOR
MEDICAL SERVICES

LYDIA MIKHAIL, MBA
INTERIM DIVISION MANAGER
HEALTH DISASTER MANAGEMENT

TAMMI McCONNELL RN, MSN
EMS PROGRAM MANAGER

405 W FIFTH STREET, SUITE 301A
SANTA ANA, CALIFORNIA 92701

TELEPHONE: 714- 834-3500
FAX: 714- 834-3125

June 4, 2013

Mr. Richard A. Levine
Silver, Hadden, Silver, Wexler, and Levine
1428 Second Street
Santa Monica, California

SUBJECT: INTERFACILITY TRANSPORT-ADVANCED LIFE SUPPORT

Greetings Mr. Levine:

This letter is in reply to your letter of May 20, 2013.

Attached is a March 25, 2013 letter your client received that addresses the comments contained in your May 20 letter. In addition, the following points further address claims made in your May 20 letter:

1. Contrary to your assertions regarding a contract for Lynch Ambulance to provide interfacility transfers, be advised that no such contract exists.
2. Your comment that neither the EMS Agency nor EMCC has responded to your March 2013 letter is baseless in construct as the March 2013 letter was not addressed or sent to the EMS Agency and the EMCC was simply copied with that communication.

With best regards,

Samuel J. Stratton, MD, MPH
Orange County EMS Medical Director

Attachment: March 25 letter to Dave Rose of OCPFA

CC: EMCC
Deputy Director, HCA Medical Services
Division Manager, HCA HDM

SJS/ss/#1686



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COUNTY OF ORANGE HEALTH CARE AGENCY

HEALTH DISASTER MANAGEMENT EMERGENCY MEDICAL SERVICES

MARK REFOWITZ
DIRECTOR

HOLLY A. VEALE
ACTING DEPUTY AGENCY DIRECTOR
MEDICAL SERVICES

LYDIA MIKHAIL, MBA
INTERIM DIVISION MANAGER
HEALTH DISASTER MANAGEMENT

TAMMI McCONNELL RN, MSN
EMS PROGRAM MANAGER

405 W FIFTH STREET, SUITE 301A
SANTA ANA, CALIFORNIA 92701

TELEPHONE: 714- 834-3500
FAX: 714- 834-3125

March 25, 2013

Dave Rose, President
Orange County Professional Firefighters Association
1900 East Warner Avenue, Suite G
Santa Ana, California 92705-5549

SUBJECT: OCFPA MARCH 18 LETTER

Greetings Mr. Rose:

Thank you for your letter of March 18; the OCFPA interest in the pilot addressing the safety, feasibility, and efficacy of the Interfacility Transport-Advanced Life Support (IFT-ALS) project is appreciated. Following are replies to your letter of March 18.

With respect to the statement in the letter that approval of the pilot project is required by the EMCC, as outlined by the State EMS Guidelines - review of Orange County EMS (OCEMS) policy and bylaws reveals there is not an obligation on the part of EMCC to approve such a limited pilot project. Contrary to the statement made in the OCPFA letter, there is no obligation for EMCC approval for the IFT-ALS pilot project within State EMS Guidelines (see California Health and Safety Code, Div. 2.5, Chpt. 4, Article 3).

Lynch Ambulance was selected to participate in the pilot because they are one of the two Orange County ambulance providers that have the capability for electronic data submission that is required to conduct the IFT-ALS program. As a matter of fact, participation in the pilot project is open to any eligible public or private ambulance provider.

It is stated in the OCPFA letter that Lynch Ambulance is not an ambulance provider within the County of Orange. It is assumed that this is a typographical error as Lynch Ambulance has been a fully licensed Orange County ambulance provider for the past 25 years.

OCPFA reference to a conflict of interest or potential Brown Act violation by the EMCC or its members is baseless. The EMCC was only made aware of the intent to conduct a pilot. As you stated, the pilot program was not reviewed or approved by the EMCC. Thus, any implication that the EMCC violated the law on something it did not review or approve is groundless.

Similarly, your statement that the IFT-ALS program will increase costs to the community and offer reduced care has no current factual basis. Analysis based on national Medicare billing rates shows that ambulance costs will decrease for the community and health care payers. With respect to the assertion of reduced care, the pilot is specifically designed to assess the quality of care for transports accomplished through the proposed IFT-ALS program.

Because the pilot project is limited in scope and time, participation in the IFT-ALS pilot project is not based on a contractual agreement. OCEMS or Lynch Ambulance can discontinue either's participation in the pilot at any time without risk of contract violation.

OCEMS is aware of the opposition to the IFT-ALS concept by the Ambulance Association of Orange County as described in the OCPFA letter. In recognition of the concerns of the Ambulance Association, the IFT-ALS program has been designed such that it will not interfere with the 911 system. IFT-ALS providers are required to defer medical aid emergencies to the 911 system. Interfacility 911 level transports will continue to be managed by the 911 emergency response system. In this way, the 911 exclusive operating contracts held by some members of the Ambulance Association will not be threatened.

With respect to the OCPFA letter reference to Saddleback College, an opposition position to the IFT-ALS program has not been received by or expressed to OCEMS by Saddleback College.

Finally, OCEMS will continue to be vigilant in maintaining high quality EMS care for the people of Orange County. This is evidenced by OCEMS conducting a limited pilot study of the safety, feasibility, and efficacy of the IFT-ALS concept prior to making a final decision regarding the implementation of such a community service. Once pilot study data (approximately 1-2 months) is analyzed, results will be made available for review and discussion at all OCEMS and Orange County Emergency Medical Care Committee (including subcommittee) meetings.

With best regards,



Samuel J. Stratton, MD, MPH, FACEP
Medical Director, Orange County Emergency Medical Services

CC: Orange County Board of Supervisors
Director, Health Care Agency
Deputy Director HCA Medical Services
President, Saddleback College

SILVER, HADDEN, SILVER, WEXLER & LEVINE

A PROFESSIONAL LAW CORPORATION

STEPHEN H. SILVER
WILLIAM J. HADDEN
SUSAN SILVER
ROBERT M. WEXLER
RICHARD A. LEVINE
KEN YUWILER
ELIZABETH SILVER TOURGEMAN
HOWARD A. LIBERMAN
JACOB A. KALINSKI

1428 SECOND STREET
SANTA MONICA, CALIFORNIA 90401
MAILING ADDRESS
POST OFFICE BOX 2161
SANTA MONICA, CALIFORNIA 90407-2161
TELEPHONE (310) 393-1486
TELEPHONE (323) 870-0900
FACSIMILE (310) 395-5801

WORKERS' COMPENSATION
OF COUNSEL
STEVEN E. KAYE

May 20, 2013

Emergency Medical Care Committee
Attn: Dr. Samuel Stratton, M.D., Medical Director
John Gilwee, Chairman
Michelle Tom, Co-Chair
Hall of Administration,
333 W. Santa Ana Blvd.
Santa Ana, CA. 92701

Via Certified Mail

Re: Interfacility Transport-Advanced Life Support Project;
Lynch Ambulance Company, Conflict of Interest

Dear Medical Director and Board Members:

As you aware, this office represents the interest of the Orange County Professional Firefighters Association, IAFF Local 3631 (OCPFA) and this letter is written on their behalf.

In accordance with our March 19, 2013 correspondence served by Certified U.S. Mail on your Committee, a complaint was lodged respecting the March 19, 2013 implementation of the Critical Care Transport pilot program wherein interfacility transfers from one hospital to another would be serviced by Lynch Ambulance Company, a private paramedic service. It was and is our understanding that the award of such a contract to Lynch was unilaterally authorized by Emergency Medical Director Stratton, without a competitive request for proposal process, and in the absence of an open and public legislative proceeding pursuant to the Brown Act.

Moreover, of significant concern raised in our correspondence was the actual or apparent conflict of interest by Emergency Medical Care Committee member and Training and Development Chair Patrick Powers in the decision by the Orange County Emergency Medical Services Agency to award the pilot program to Lynch Ambulance Company of which the OCPFA understands that Mr. Powers is the Director of EMS Development and/or Vice President of Lynch Ambulance and/or Company employee.

SILVER, HADDEN, SILVER, WEXLER & LEVINE

Emergency Medical Care Committee
Attn: Dr. Samuel Stratton, M.D., Medical Director
John Gilwee, Chairman
Michelle Tom, Co-Chair
Page 2

Unfortunately, neither the Emergency Medical Services Agency nor the Emergency Medical Care Committee to date has responded in any manner to our March 2013 letter. It is my understanding that during the recent April 26, 2013 EMCC meeting, the Committee sought to justify its failure to refer the conflict of interest concern to the appropriate investigative agency since the Committee was uncertain as to the authenticity of our correspondence. May this serve as a formal request on behalf of the OCPFA for referral of this matter to an appropriate independent investigative agency for a full and complete investigation.

Very truly yours,



RICHARD A. LEVINE

cc: Dave Rose President OCPFA
Baryic Hunter, Board Member OCPFA

Attachment # 6



IMPACT EVALUATION REPORT
Closure of Anaheim General Hospital
April 2013

PURPOSE

The purpose of this Impact Evaluation Report (IER) is to provide an assessment of potential impacts on the community, availability of emergency care at surrounding hospitals, and effects on emergency medical services (EMS) providers following the closure of Anaheim General Hospital on March 26, 2013.

The report contains statutory authorities related to hospital closures, immediate historical background, city demographics; AGH and surrounding hospital capabilities including Emergency Department (ED) volumes; 9-1-1 paramedic services; ambulance transports; public comments and incorporates impact analysis statements within appropriate sections.

AUTHORITY/ED CLOSURE REQUIREMENTS

California state law outlines requirements on general acute care hospitals and the local emergency services agency related to service downgrades and closures of emergency departments. Hospitals must notify the California Department of Public Health (CDPH), the local government in charge of health care services, health plans under contract with the hospital and the public. The notification must be made as soon as possible but not later than 90 days prior to the proposed reduction or elimination of emergency services (Attachment 1).

Pursuant to the Health and Safety Code, Division 2, Chapter 2, Articles 1 and 5, §1255, §1300 (<http://law.onecle.com/california/health/1255.html> & <http://law.onecle.com/california/health/1300.html>), correlating OCEMS policy #615.00 and general public policy, an impact evaluation is conducted by the local governmental body and forwarded to the California Department of Public Health (CDPH) within 60 days of a notice of hospital service downgrade and/or closure of an emergency department. CDPH considers the report findings and makes a final hospital licensure determination.

BACKGROUND

On March 26, 2013, Anaheim General Hospital (AGH) reported to Orange County Emergency Medical Services (OCEMS) that AGH had notified the California Department of Public Health (CDPH) of AGH's intent to voluntarily suspend their Acute Care Hospital license for the main campus (AGH) and the Buena Park campus. Shortly thereafter, all hospital services were discontinued.

OCEMS actions and points of awareness that occurred just prior to the final closure that affected the immediate service area and are included for context:

- 3/18/13 EMS system directive applied to divert all ambulance transports from AGH related to inability to sustain emergency communication functions
- 3/21/13 Verbal confirmation of hospital's intent to suspend license following corporate approval
- 3/25/13 Formal notice to AGH employees of intent to close hospital
- 3/26/13 Notice of OCEMS investigation and revocation of paramedic receiving center designation
System notification of revocation paramedic receiving center designation
By end of business day, AGH reported loss of on-call medical coverage
Emergency signage covered and AGH staff activated plan to divert all walk-in patients to alternate ED's

Following the hospital closure, a public hearing opportunity was noticed and held at the regularly scheduled Emergency Medical Care Committee (EMCC) on Friday, April 26, 2013 in the Commission Hearing Room at 333 Santa Ana Boulevard, Santa Ana, CA 92705. There were no speakers requesting to be heard on the matter.

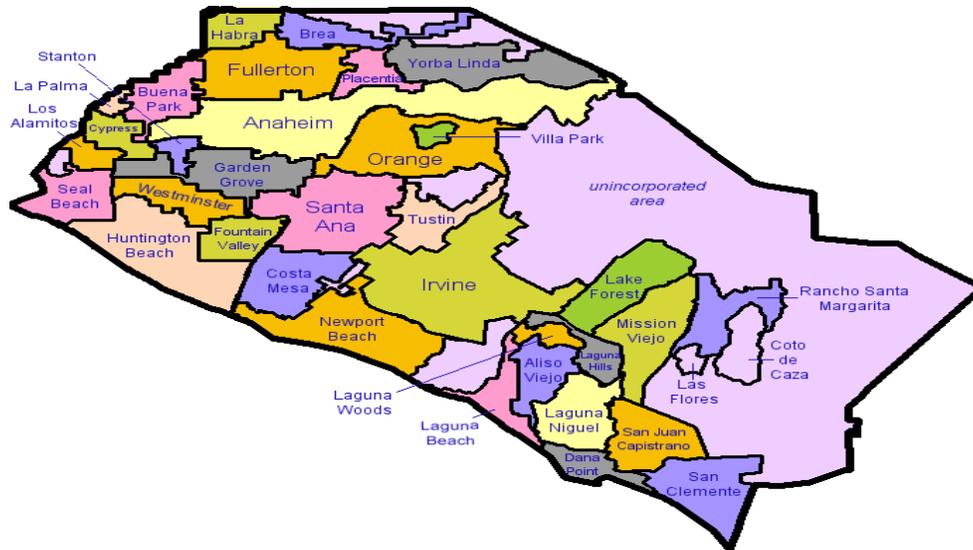
April 2013, prepared by Orange County Emergency Medical Services, Page 1



IMPACT EVALUATION REPORT Closure of Anaheim General Hospital April 2013

SUMMARY OF FINDINGS City of Anaheim – Anaheim General Hospital

Anaheim General Hospital (AGH) is owned and operated by Pacific Health Corporation and is located in the northwest portion of the County in the City of Anaheim. Bordering cities include Buena Park, Fullerton, Garden Grove, Orange, Stanton, Placentia, Yorba Linda. The city is 55 square miles and has a population of 343,793 residents with a median age of 32.4 years. The predominant ethnicity is Hispanic (52.5%) (<http://www.anaheim.net/images/articles/236/AtaGlanceFinalDraft.pdf>).



AGH was a small community hospital and not designated as a specialty receiving center for Cardiac, Stroke or Trauma nor did the facility provide obstetric services. The hospital was licensed for 106 acute care beds and had 6 Emergency Department (ED) treatment beds. In first quarter 2013, the average daily inpatient census was 20.

In March 2013, an OCEMS designation site survey was conducted. AGH administration reported that between 2010 and 2012, ED visits totaled 22,372 (17,749 adult and 4,623 pediatric). The mode of arrival was overwhelmingly by walk-in/private auto and triage categories ranged from Non-Urgent (57%), Urgent (41%) and Emergent (2%). In first quarter 2013, the average daily ED census was 30 and the 2012 ED Payer Mix was about 70% compensated and 30% uncompensated care.

There were 156 interfacility transfers out of AGH's ED for higher level of care and/or insurance purposes in 2012. Mode of transport based on service level ranged from CCT ambulance (55%); BLS ambulance (53%) and less than 2% were sent via 9-1-1 paramedic transport. Patient destinations were primarily UC Irvine Medical Center, Fountain Valley Regional Medical Center, Children's Hospital Orange County and Kaiser-Anaheim.

The 9-1-1 emergency medical service response in the AGH area is provided by the Anaheim Fire Department and Orange County Fire Authority. Those agencies reported that a total of 723 patients were transported in 2012 to AGH. That same year, Basic Life Support (BLS) transport volume to AGH, unrelated to a 9-1-1 EMS comprised 13% of their total ED volume or 1,117 patients. Based on limited transport volume and the proximity of alternative facilities, displacement impacts to EMS transported patients previously serviced by AGH appear minimal. Patients presenting to other ED's may experience longer wait times which may cause increased utilization of 9-1-1 by those seeking shorter wait times.



IMPACT EVALUATION REPORT Closure of Anaheim General Hospital April 2013

Orange County Emergency Medical Services System

The Orange County EMS system is comprised of 25 acute care hospitals that are all designated as OCEMS Emergency Receiving Centers. Of those, one has the distinction of a Comprehensive Children's Receiving Center and the others have varying levels of specialty designations such as Trauma, Cardiovascular and Stroke Neurology (Attachment 2).

Data obtained from the Orange County Medical Emergency Data System (OC-MEDS), the Office of Statewide Health Planning and Development (OSHPD), 9-1-1 paramedic service providers and transporters for 2011 denote the following in approximation:

- OC Emergency ED visits: 810,000
 - Anaheim General Hospital: 6,305
- OC Emergency 9-1-1 paramedic responses: 168,000
- OC Emergency 9-1-1 paramedic transports: 54,000
 - Anaheim General Hospital: 112 (2012: 723)

Overall, AGH treated less than 1 percent of the total number of patients seen in OC ED's. There are three Emergency Receiving Centers (ERC) within a five-mile radius of AGH that have 53 ED treatment beds and three additional ERC's within a ten-mile radius that have 52 ED treatment beds. All combined, the ERC's within these ranges have the capabilities to provide for emergency and specialty care and are within minimal transport distance.

A compilation of the nearest Emergency Receiving Centers' (ERC) proximity to AGH, hospital capabilities, OCEMS designation status and 2011 ED visits are illustrated within Attachment 3.

CONCLUSION

The downgrade or closure of any emergency service has an impact. Of most concern is the communities' loss of an acute care hospital within walking distance of an already underserved sector in Orange County. Although alternative hospitals are in close proximity, any decrease in service to this vulnerable population has undeterminable impacts to individuals and assumed impacts of increased emergency department wait times at alternative hospitals.

While it is possible, it is not anticipated that the closure of AGH will have detrimental impacts to individual patients in the northwest region of the county. Since its closure, the EMS system has not experienced significant increases in diversion hours from the three nearest Emergency Receiving Center's nor has the OCEMS office received any provider or public complaints related to the closure. Fortunately, the emergency and specialty capabilities within those surrounding hospitals are expected to be able to absorb and meet the demands of additional patients.



IMPACT EVALUATION REPORT

Closure of Anaheim General Hospital

April 2013

Attachment 1

Health & Safety Code Division 2, Chapter 2, Article 5, §1255.1: 1300

1255.1. (a) Any hospital that provides emergency medical services under Section 1255 shall, as soon as possible, but not later than 90 days prior to a planned reduction or elimination of the level of emergency medical services, provide notice of the intended change to the state department, the local government entity in charge of the provision of health services, and all health care service plans or other entities under contract with the hospital to provide services to enrollees of the plan or other entity

(b) In addition to the notice required by subdivision (a), the hospital shall, within the time limits specified in subdivision (a), provide public notice of the intended change in a manner that is likely to reach a significant number of residents of the community serviced by that facility.

(c) A hospital shall not be subject to this section or Section 1255.2 if the state department does either of the following: (1) Determines that the use of resources to keep the emergency center open substantially threatens the stability of the hospital as a whole. (2) Cites the emergency center for unsafe staffing practices.

1300. (a) Any licensee or holder of a special permit may, with the approval of the state department, surrender his or her license or special permit for suspension or cancellation by the state department. Any license or special permit suspended or canceled pursuant to this section may be reinstated by the state department on receipt of an application showing compliance with the requirements of Section 1265.

(b) Before approving a downgrade or closure of emergency services pursuant to subdivision (a), the state department shall receive a copy of the impact evaluation of the county to determine impacts, including, but not limited to, an impact evaluation of the downgrade or closure upon the community, including community access to emergency care, and how that downgrade or closure will affect emergency services provided by other entities. Development of the impact evaluation shall incorporate at least one public hearing. The county in which the proposed downgrade or closure will occur shall ensure the completion of the impact evaluation, and shall notify the state department of results of an impact evaluation within three days of the completion of that evaluation. The county may designate the local emergency medical services agency as the appropriate agency to conduct the impact evaluation. The impact evaluation and hearing shall be completed within 60 days of the county receiving notification of intent to downgrade or close emergency services. The county or designated local emergency medical services agency shall ensure that all hospital and prehospital health care providers in the geographic area impacted by the service closure or change are consulted with, and that local emergency service agencies and planning or zoning authorities are notified, prior to completing an impact evaluation as required by this section. This subdivision shall be implemented on and after the date that the county in which the proposed downgrade or closure will occur, or its designated local emergency medical services agency, has developed a policy specifying the criteria it will consider in conducting an impact evaluation, as required by subdivision (c).

(c) The Emergency Medical Services Authority shall develop guidelines for development of impact evaluation policies. On or before June 30, 1999, each county or its designated local emergency medical services agency shall develop a policy specifying the criteria it will consider in conducting an impact evaluation pursuant to subdivision (b). Each county or its designated local emergency medical services agency shall submit its impact evaluation policy to the state department and the Emergency Medical Services Authority within three days of completion of the policy. The Emergency Medical Services Authority shall provide technical assistance upon request to a county or its designated local emergency medical services agency.



IMPACT EVALUATION REPORT
Closure of Anaheim General Hospital
April 2013

Attachment 3

West Anaheim Medical Center



- Approximately 1 mile from AGH
- 23 ED beds; Licensed for 219 acute care hospital beds
- OCEMS designated receiving centers: Emergency and Cardiovascular
- **2011 ED visits: 29,885**

La Palma Intercommunity Hospital



- Approximately 4 miles from AGH
- 10 ED beds; Licensed for 200 acute care hospital beds
- OCEMS designated receiving center: Emergency
- **2011 ED visits: 14,614**

Los Alamitos Medical Center



- Approximately 4 miles from AGH
- 20 ED beds; Licensed for 167 acute care hospital beds
- OCEMS designated receiving centers: Emergency, Cardiovascular and Stroke Neurology
- **2011 ED visits: 29,875**

Anaheim General Hospital
6 ED beds; 106 acute care hospital beds
Emergency Receiving Center
2011 ED Visits 6,305
9-1-1 Paramedic Transports in 2012
723

Anaheim Regional Medical Center



- Approximately 6 miles from AGH
- 21 ED beds; Licensed for 223 acute care hospital beds
- OCEMS designated receiving centers: Emergency and Cardiovascular
- **2011 ED visits: 42,164**

Western Medical Center Anaheim



- Approximately 8 miles from AGH
- 11 ED beds; Licensed for 188 acute care hospital beds
- OCEMS designated receiving center: Emergency and Cardiovascular
- **2011 ED visits: 17,246**

UC Irvine Medical Center



- Approximately 9 miles from AGH
- 20 ED beds; Licensed for 415 acute care hospital beds
- OCEMS designated receiving centers: Emergency, Cardiovascular, Stroke Neurology & Trauma
- **2011 ED visits: 39,820**

**PROPOSED FY 2013-14 RATES FOR
 ORANGE COUNTY AMBULANCE PROVIDERS
 CALCULATED RATE ADJUSTMENT**

TYPE OF CHARGE	BASIS FOR CHARGE	CURRENT RATES	PROPOSED RATES	% CHANGE ↑2%
Emergency BLS (Basic Life Support) Base Rate	Applicable for urgent or Code III response at the request of a public safety employee.	\$717.07	\$731.41	↑14.34
Mileage	Per patient mile or fraction thereof.	\$16.54	\$16.87	↑0.33
Oxygen (includes mask or cannula)	Applicable when administered.	\$81.12	\$82.74	↑1.62
Standby	Per 15 minutes after the first 15 minutes and any fraction thereof.	\$40.03	\$40.83	↑0.80
Expendable Medical Supplies	Maximum per response or fair market value, whichever is least.	\$32.02	\$32.66	↑0.64
OCFA ONLY: Emergency ALS (Advanced Life Support) Base Rate	Applicable for patients who have received ALS assessment by paramedics and who are transported via BLS or ALS	\$379.75	\$387.35	↑7.60

Consumer Price Index – “All Items” Los Angeles – Riverside – Orange County

<http://www.bls.gov/data/>

2011 Annual: 231.928

2012 Annual: 236.648

2.03511% rounded to nearest tenth = ↑ 2%

Ambulance Rate History
Prepared for Emergency Medical Care Committee
June 28, 2013

AUTHORITY

As specified in Division 9, Title 4, of the Codified Ordinances of the County of Orange (Ambulance Ordinance 3517), the Board of Supervisors establishes the maximum Basic Life Support (BLS) emergency ground ambulance rates applicable within the County's unincorporated area and cities that have agreed with the Ordinance for the provision of licensing and regulation of ambulance services. Ordinance 3517 also establishes the authority to adjust the maximum Advanced Life Support (ALS) Paramedic Assessment and Transport rate applicable for Orange County Fire Authority's (OCFA) jurisdictional areas, with the exception of three cities that establish their own ALS rate.

Orange County Emergency Medical Services (OCEMS) policy #720.314: Ground Emergency Ambulance Service Rates Adjustment identifies the process for annually rate adjustments. In the past two years, the Board has considered alternatives but not formally directed program to change the current process or methodology. **Annual adjustments are based on the percentage change in the annual "all items" Consumer Price Index (CPI) for the Los Angeles, Riverside & Orange County area and multiplied by a factor of 1.5.** Data is obtained from the US Dept of Labor Bureau of Labor Statistics (www.bls.gov) to determine the percentage from the prior year and applied to current rate. The proposed rate adjustment, presented to the Emergency Medical Care Committee (EMCC) for review and comment, is forwarded to the Board for approval. For the last two years the Board of Supervisors has approved an increase without the factor.

ORDINANCE HISTORY

The current Ambulance Ordinance 3517 primarily regulates the operation of ambulances within the unincorporated areas of Orange County and those member cities of OCFA. However, most non-member cities have adopted or minimally edited 3517 and integrated the same language into their city codes. Decades ago, there were two ambulance Ordinances 3022 & 3138. Ordinance 3022 established that ambulance licensees were not permitted to charge more or less than the rates set by the County for ambulance and convalescent services.

In the early 1980's, Ordinance 3517 was drafted at the direction of the Board by the Health Care Agency (HCA) and the Orange County Fire Department in conjunction with County Counsel based on the following principles:

- De-regulation of Non-Emergency Ambulance Services
 - The Ordinance accomplished this by requiring specific response areas in regard to emergency situations only. All other forms of ambulance transportation were not restricted & allowed for ambulance providers to solicit non-emergency business in any of the areas governed by the Ordinance.
- Setting Maximum Rates for Ambulance Responses
 - The partial de-regulation of ambulance services eliminated the [then] current pricing structure for emergency and non-emergency transfer responses. The resultant policy was designed to encourage competition among providers without County intervention by establishing only a maximum rate for public safety dispatched transports.
- Development of an Objective Competitive Mechanism Whereby Contracts for Emergency Response Areas may be Awarded
 - This was achieved through language in the Ordinance requiring a Request for Proposals (RFP) bid system.

Ambulance Rate History
Prepared for Emergency Medical Care Committee
June 28, 2013

Section 4-9-13 of the Ordinance specifies that no ambulance licensee shall charge more than those rates approved by the Board for emergency ambulance services. Since one of the guiding principles in drafting the Ordinance was to deregulate to the extent feasible, the Ordinance was written to set a maximum allowable rate for emergency transportation only, allowing competitive prices for the minimum rates. A national index was used to establish the rate. Of note, the Ordinance does not make reference to whether emergency ambulance service is BLS, ALS or both services.

On 4/30/85 the Board passed and adopted Ordinance 3517 (repealing 3022 & 3138) and currently remains in effect. **In short, the intent of Ordinance 3517 was to establish general operating procedures and standards for medical transportation services operating within the unincorporated areas of the County in both emergency and other situations; provide a fair & impartial means of allowing responsible private operators to provide such services in the public interest; provide a means for the designation of emergency response areas; and establish maximum rates for public safety dispatched transports.**

RATE SETTING METHODOLOGIES

6/16/87: Board approved a rate increase for ambulance providers after an application was submitted & evaluated through HCA.

8/8/89: Board approved a rate increase for ambulance providers after an application was submitted & evaluated through HCA. The Board was advised that using a national index to measure the cost of overhead & labor did not fairly represent the cost to the ambulance companies. At that time HCA stated that it would begin utilizing the medical & transportation Consumer Price Index (CPI) values gathered from the greater Los Angeles area as well as other appropriate factors. The resultant rates: base rate \$150; emergency response \$40; Night Call \$30; Mileage \$8; Oxygen \$30; Standby \$22; Supplies \$10.

1989-2001: Relatively small adjustments with an important distinction in that the emergency response charge was combined with the base rate in 1991 & the night call was combined in 1994.

2000: Ambulance Association of Orange County (AAOC) reported that the service quality was affected by uncollectible bills & fixed Medicare, Medical & Indigent rates that did not cover costs; diminished revenues & increased costs. AAOC requested OCEMS to approve a one-time rate increase to bring the maximum rate into the median range of California counties and to develop a process to ensure that rate adjustments were fair. This proposal (a 43% increase over the then current base rate of \$220) was approved by the BOS on 6/19/01 and in order to ensure that emergency ambulance service continued to be financially viable & to prevent large increase requests in the future, OCEMS policy/Ambulance Rules & Regulations were revised to provide for an annual review & possible rate adjustment by the Board.

7/16/02: Board approved an annual adjustment of base rate based on the median rates in effect for San Bernardino, LA Counties & the City of San Diego.

6/24/03; 4/27/04; 5/24/05: Board approved an annual rate adjustment utilizing the 2002 methodology.

2005: OCEMS convened a committee to review methodologies that could be employed for establishing future rate adjustments. The committee was put on hold to await a General Accounting Office (GAO) report on ambulance service costs that was anticipated by the end of 2005. The report was not issued until 2007.

6/26/06: Board approved an annual adjustment of base rate based on the 2002 methodology.

Ambulance Rate History
Prepared for Emergency Medical Care Committee
June 28, 2013

In 2007, OCEMS evaluated the GAO report released in May 2007 that examined providers' costs of ground ambulance transports (from 2004) & factors that contributed to cost differences; average Medicare ambulance payments expected under the national fee schedule in 2010; how these payments related to providers' costs per transport; and changes that occurred in Medicare beneficiaries' use of ambulance transports from 2001-2004. The GAO estimated costs were based on a national survey of 215 ambulance providers that did not share costs with non-ambulance services. Providers that shared costs with other institutions or services and could not report their ambulance service costs separately, such as fire departments, were excluded because their reported costs appeared unreliable.

The study, with one recommendation, had limited findings; indicated that transport costs were highly variable & dependent on several factors including volume of transports, service area (urban vs. rural) and local tax revenues, etc. Nationally, the average cost per transport was reported to be \$415 (95% confidence interval \$381-\$450). The urban costs were lower at \$370 (95% CI \$326-\$414) due to efficiencies of scale & volume. The sole recommendation: continue to monitor utilization of ambulance transports.

Accordingly, OCEMS surveyed all of the Local EMS agencies throughout California for their rates & rate setting procedures. Responses varied but most counties tied rates to one of the Consumer Price Indices (CPI). The majority utilized the US Dept of Labor CPI to make adjustments; some based increases on the Medical Care Index & others a combination of the Medical Care and Transportation Indices. Along with this information, the Board was presented with seven options to consider for determining the rate and process.

On 10/16/07, the Board approved an annual methodology for setting maximum ambulance rates: The annual change in the LA-Riverside-Orange County "all items" CPI multiplied by 150%. The multiplier was added to compensate for the cost-shifting of un/under-funded patients. Following this, rate adjustments were sporadically applied in order to explore alternate methodologies or not made due to unstable economic factors.

Advanced Life Support Fee

In 1998, the Board authorized OCFA to issue a Request for Proposal (RFP) for ambulance services in the unincorporated areas, including the collection of Advanced Life Support (ALS) charges and reimbursement for paramedic accompanied patients. The fee was established as a means to reimburse OCFA for its ALS services and was based on partial recovery of the incremental costs of the OCFA paramedic program and included a factor for collection and processing costs incurred by ambulance companies. The fee remains applicable to all of the OCFA jurisdictional areas, with the exception of San Clemente, Buena Park and Westminster which establish their own ALS rates.

In 2004, the Board approved an OCFA ALS rate adjustment equal to the BLS rate for emergency transports and directed the Health Care Agency to return annually to adjust the fee by the same percentage as the BLS rate, provided that the resulting rate did not exceed the actual costs of OCFA ALS service.

June 28, 2013

This year's proposed rate increase is computed based on the methodology utilized by the Board when rates were last adjusted on July 24, 2012. The proposed adjustment (increase) has been provided and effects the maximum allowable 9-1-1 emergency ground ambulance rate for BLS services chargeable to a patient transported at the request of a public safety employee and the OCFA maximum ALS fee by the same percentage. The recommendation from the EMCC will be included in the proposal to the Board.



ORANGE COUNTY FIRE AUTHORITY PRE-HOSPITAL CARE BUSINESS MODEL

Advance Life Support (ALS) Rate
Orange County Emergency Medical Care Committee
Presented By:
Bill Lockhart, Battalion Chief Emergency Medical Services
Jim Ruane, Finance Manager/Auditor

DELIVERING QUALITY
EMERGENCY MEDICAL
SERVICE THROUGH A
PUBLIC/PRIVATE
PARTNERSHIP




ALS/BLS RATE SETTING BACKGROUND:

- The Orange County Board of Supervisors sets the maximum Advanced Life Support (ALS) , Basic Life Support (BLS) and medical supplies billing rates
 - County Staff is proposing a 2.0% increase based on the existing Ambulance Rate setting policy, however Board of Supervisors may approve a different amount.
- The OCFA Board of Directors sets the OCFA ALS paramedic and BLS Medical Supply reimbursement rates by:
 - The same annual percentage increase of ALS/BLS maximum billable rates that are approved by the BoS, and
 - Cost of service (marginal cost only)
 - Current cost recovery is only approximately 60% of the OCFA's marginal cost



ALS/BLS RATE SETTING BACKGROUND:

Current & Proposed Rates—Billed by Private Ambulance 9-1-1 Provider:

Approval Authority	Maximum Rate*	CURRENT	PROPOSED w/ 2.0% INCREASE	\$ CHANGE	NOTES
County	Basic Life Support (BLS) Billing Rate	\$717.07	\$731.41	\$14.34	Pending Approval by BOS
OCFA	OCFA Medical Supply Reimbursement Rate	\$30.05	\$30.65	\$0.60	OCFA Board Approved
	Ambulance Revenue	\$687.02	\$700.76	\$13.74 (*)	
County	Advanced Life Support (ALS) Billing Rate	\$1,096.82	\$1,118.76	\$21.94	Pending Approval by BOS
OCFA	(ALS Increment- Reference)	<u>379.75</u>	<u>387.35</u>	<u>7.60</u>	OCFA Board Approved
	OCFA ALS Paramedic Reimbursement Rate	<\$269.00>	<\$274.38>	<\$5.38>	
	OCFA Medical Supply Reimbursement Rate	<\$30.05>	<\$30.65>	<\$0.60>	
	Ambulance Revenue	\$797.77	\$813.73	\$15.96(*)	

*Does not include mileage or oxygen and is subject to Medicare/Medical caps.



ADDITIONAL SUPPORTING DETAIL

- Proposed Advanced Life Support rate was developed by OCFA staff based on FY 2013/14 approved S&EB, S&S, and equipment and vehicle replacement costs. Consistent with the OCFA Board approved fee study methodology
 - Cost recovery includes only the marginal costs of providing the service
- Rate calculations were reviewed by Lance Soll & Lunghard (LSL), an independent firm of certified public accountants
 - LSL determined that the proposed rates were a reasonable representation of OCFA's marginal costs. In addition, OCFA's actual costs exceed the amounts to be reimbursed under the proposed rates - LSL determined that the rates have been limited to the maximum 2.0% BLS billing rate permitted by the County
- OCFA staff also compared the proposed ALS rate to the rates of surrounding Counties. The proposed ALS appears to be reasonable in comparison to those jurisdictions.



EMCC COMMITTEE RECOMMENDATIONS:

- Authorize staff to increase OCFA's Advanced Life Support (ALS) rate by the same percentage increase, currently proposed at (2.0%), approved by the Board of Supervisors.

OCFA Maximum Billing Rate	CURRENT	PROPOSED	\$ CHANGE	% CHANGE
ALS (incremental)	\$379.75	\$387.35	\$7.60	2.0%

QUESTIONS

SUMMARY OF ORANGE COUNTY RATE ADJUSTMENT FOR EMERGENCY TRANSPORTATION SERVICES

	1977 ¹	1980	1983	1987	1989	1991	1992	1993	1994	1995	1998 ⁴	2001	2002	2003	2004	2005	2006	2007	2011	2012	2013 ⁵
BLS Base Rate		\$75.00	\$96.00	\$110.00	\$150.00	\$201.50	\$217.50	\$225.30	\$242.75	\$263.20	\$314.00	\$450.00	\$466.00	\$480.00	\$531.75	\$581.50	\$601.50	\$671.75	\$698.22	\$717.07	\$731.41
Percent change - EBR			28.00%	14.58%	36.36%	34.33%	7.94%	3.59%	7.75%	8.42%	19.30%	43.31%	3.56%	3.00%	10.78%	9.36%	3.44%	4.96%	3.94%	2.70%	2.00%
Emergency Response ²		\$15.00	\$19.00	\$22.00	\$40.00																
Percent change -ER			26.67%	15.79%	81.82%																
Night Call ³		\$15.00	\$19.00	\$22.00	\$30.00	\$35.25	\$38.50	\$39.90	\$40.90												
Percent change - NC			26.67%	15.79%	36.36%	17.50%	9.22%	3.64%	2.51%												
Expendable Medical Supplies		\$20.00	\$20.00	\$30.00	\$10.00	\$11.50	\$12.50	\$13.00	\$13.30	\$13.30		\$20.10	\$20.75	\$21.25	\$23.50	\$25.75	\$26.75	\$28.25	\$31.18	\$32.02	\$32.66
Percent change - EMS			0.00%	50.00%	-66.67%	15.00%	8.70%	4.00%	2.31%	0.00%		51.13%	3.23%	2.41%	10.59%	9.57%	3.88%	5.61%	10.37%	2.69%	2.00%
Oxygen		\$15.00	\$19.00	\$22.00	\$30.00	\$35.25	\$38.50	\$39.90	\$40.90	\$40.90		\$57.00	\$60.50	\$60.75	\$63.00	\$65.50	\$68.25	\$71.75	\$78.99	\$81.12	\$82.74
Percent change - Oxygen			26.67%	15.79%	36.36%	17.50%	9.22%	3.64%	2.51%	0.00%		39.36%	6.14%	0.41%	3.70%	3.97%	4.20%	5.13%	10.09%	2.70%	2.00%
Mileage		\$5.00	\$6.00	\$7.50	\$8.00	\$8.50	\$9.50	\$9.80	\$10.05	\$10.05		\$12.40	\$12.25	\$12.25	\$13.00	\$13.25	\$13.75	\$14.75	\$16.11	\$16.54	\$16.87
Percent change - Milage			20.00%	25.00%	6.67%	6.25%	11.76%	3.16%	2.55%	0.00%		23.38%	-1.21%	0.00%	6.12%	1.92%	3.77%	7.27%	7.27%	9.22%	2.67%
Standby		\$15.00	\$19.00	\$22.00	\$22.00	\$25.25	\$27.50	\$28.50	\$29.20	\$29.20		\$32.25	\$30.75	\$30.75	\$31.00	\$31.00	\$33.50	\$35.25	\$38.98	\$40.03	\$40.83
Percent change - Standby			26.67%	15.79%	0.00%	14.77%	8.91%	3.64%	2.46%	0.00%		10.45%	-4.65%	0.00%	0.81%	0.00%	8.06%	5.22%	10.58%	2.69%	2.00%
(Advanced Life Support Established 1998)																					
****ALS Base Rate												\$185.00	\$185.00	\$185.00	\$282.00	\$308.25	\$319.00	\$338.00	\$369.77	\$379.75	\$387.35
Percent change - ALS Base Rate													0.00%	0.00%	52.43%	9.31%	3.49%	5.96%	9.40%	2.70%	2.00%
OCFA ALS Reimbursement Rate																\$218.60	\$226.00	\$240.00	\$252.00	\$269.00	\$274.38
Percent change - ALS Rate																	3.39%	6.19%	5.00%	6.75%	2.00%
ALS Supplies																\$24.47	\$25.31	\$26.82	\$29.26	\$30.05	\$30.65
Percent change - ALS Supplies																	3.43%	5.97%	9.10%	2.70%	2.00%
ALS Administration Rate																\$92.75	\$98.00				
Percent change - ALS Admin Rate																		5.66%			
Notes:																					
¹ Data not available for 1977 although system established																					
² Emergency Response combined with BLS Base Rate from 1991 and subsequent adjustments																					
³ Night call charges eliminated for 1995 and subsequent rate adjustments																					
⁴ BLS base rate for 1998 derived from Board ASR for FY 2001, other rate categories not available																					
⁵ Proposed rate increase for 2013																					

Interfacility Transport – Advanced Life Support

Orange County Emergency Medical Services Phase II Interim Report to
The County Paramedic Advisory Committee
May 8, 2013

Introduction: This report is for Phase II of the Orange County IFT-ALS pilot project. After an initial 100 cases reviewed for the pilot project, adjustments were made in dispatch such that focus was placed on calls most appropriate for the IFT-ALS program. Additionally, IFT-ALS personnel developed experience and understanding of the Orange County health care system.

Objectives: Describe IFT-ALS performance using predetermined performance criteria to assess safety, feasibility, and efficacy.

Methods: Prospective observational evaluation of IFT-ALS staffed unit transports. Included in the pilot study phase II analysis were consecutive IFT-ALS field encounters that met ALS criteria; excluded were consecutive IFT-ALS calls that did not meet ALS criteria or that were turned over to a 911 provider by dispatch personnel or after initial field assessment. IFT-ALS personnel are trained in standardized standing orders and system standards for management of non-base contact ALS transports. Standard medical dispatch protocols are used for IFT-ALS dispatches. The IFT-ALS dispatch center refers 911-level calls directly to the 911 system. Outcome measures for feasibility and safety of the proposed program were determined prior to initiation of the pilot with measured elements defined (see attached protocol). The primary outcome measure of interest is transport from sending to arrival facility without medical deterioration during transport as determined by quantitative measures of serial vital signs and level of consciousness (GCS). Data for the study was entered from OCMEDS into a study database that did not contain personal identifiers. Data analysis is descriptive and by frequency with precision analysis of measures of central tendency.

Results: Results are provided in Table 1. Of the first 121 consecutive transports, two were excluded from dispatch to scene time analysis because ambulances for these responses were pre-deployed and standby for a scheduled transport. For measure of the outcome measure of interest: stable arrivals to receiving facility, three transports were excluded due to lack of arrival vital signs. There was 100% compliance with data input into the OCMEDS system, allowing for identification of all potential cases. Four cases fell out for appropriate dispatch as more appropriate for 911 evaluations and transports. Two of the dispatch fall outs were emergency department to emergency department transfers for which the IFT-ALS program was requested. Data for each study measure showed performance within the thresholds set for the pilot.

Conclusion: Interim data analysis shows performance within thresholds and parameters set prior to initiation of the pilot project.



DATE: February 8, 2013

Protocol for Pilot Study of Interfacility-ALS (IFT-ALS) Proposal

Introduction:

The IFT-ALS program is being considered as a service for transport of advanced life support (ALS) level patients between health facilities and home healthcare settings. The IFT-ALS program is designed as an off-line (standing orders and protocols) ALS transport system with rapid response capability. The program does not replace or substitute for Critical Care Nurse transport capable services.

Pilot Goal:

Demonstrate feasibility and safety of an IFT-ALS program in Orange County.

Pilot Study Methods:

The pilot will be a prospective observation of IFT-ALS staffed transport units. IFT-ALS staff will function under defined standing orders and procedures developed by Orange County Emergency Medical Services (OCEMS). Study data will be retrieved from OCMEDS (OCEMS Medical Data System).

Included in the pilot study will be all of the first 100 IFT-ALS level transports that occur after initiation of the pilot. After interim review of the first 100 cases, a second period of evaluation of the second 100 cases may be done.

Excluded will be any BLS level transports performed by IFT-ALS crews.

Outcome measures will include:

Feasibility:

1. Attainment of complete data through the OCMEDS system with threshold = 95%.
2. Dispatch appropriate for IFT-ALS transports with threshold = 95%
3. Proper use of standing orders/procedures as demonstrated by application of appropriate standing orders when used, lack of exclusion of standing order/procedure steps, and proper dosing of medications with fallout rate < 2%
4. Assessment of patient outcomes with determination of whether patient arrived at receiving facility without deterioration during transport (as measured by vital signs and level of consciousness); assessed qualitatively.
5. Dispatch to arrival at facility response times with average time of 30 min.

Safety:

1. Frequency of traffic accidents related to IFT-ALS transports, none expected.
2. Frequency of IFT-ALS work related injuries (e.g. needle sticks) related to IFT-ALS transports, 1-2 expected.
3. Assessment of vaccination rate of IFT-ALS providers with current influenza vaccine, 100% threshold.
4. Frequency of respiratory or cardiac arrest of patients during IFT-ALS transport, 2 expected.
5. Frequency of medication errors (failure to provide, administration of wrong medication) during IFT-ALS transports, threshold 0%.

Statistical analysis:

Analysis of data will be by descriptive and frequency analysis, with measure of precision for data using measures of central tendency or proportions.

Interfacility Transport – Advanced Life Support

Orange County Emergency Medical Services Phase II Interim Report to
The County Paramedic Advisory Committee
May 8, 2013

Introduction: This report is for Phase II of the Orange County IFT-ALS pilot project. After an initial 100 cases reviewed for the pilot project, adjustments were made in dispatch such that focus was placed on calls most appropriate for the IFT-ALS program. Additionally, IFT-ALS personnel developed experience and understanding of the Orange County health care system.

Objectives: Describe IFT-ALS performance using predetermined performance criteria to assess safety, feasibility, and efficacy.

Methods: Prospective observational evaluation of IFT-ALS staffed unit transports. Included in the pilot study phase II analysis were consecutive IFT-ALS field encounters that met ALS criteria; excluded were consecutive IFT-ALS calls that did not meet ALS criteria or that were turned over to a 911 provider by dispatch personnel or after initial field assessment. IFT-ALS personnel are trained in standardized standing orders and system standards for management of non-base contact ALS transports. Standard medical dispatch protocols are used for IFT-ALS dispatches. The IFT-ALS dispatch center refers 911-level calls directly to the 911 system. Outcome measures for feasibility and safety of the proposed program were determined prior to initiation of the pilot with measured elements defined (see attached protocol). The primary outcome measure of interest is transport from sending to arrival facility without medical deterioration during transport as determined by quantitative measures of serial vital signs and level of consciousness (GCS). Data for the study was entered from OCMEDS into a study database that did not contain personal identifiers. Data analysis is descriptive and by frequency with precision analysis of measures of central tendency.

Results: Results are provided in Table 1. Of the first 121 consecutive transports, two were excluded from dispatch to scene time analysis because ambulances for these responses were pre-deployed and standby for a scheduled transport. For measure of the outcome measure of interest: stable arrivals to receiving facility, three transports were excluded due to lack of arrival vital signs. There was 100% compliance with data input into the OCMEDS system, allowing for identification of all potential cases. Four cases fell out for appropriate dispatch as more appropriate for 911 evaluations and transports. Two of the dispatch fall outs were emergency department to emergency department transfers for which the IFT-ALS program was requested. Data for each study measure showed performance within the thresholds set for the pilot.

Conclusion: Interim data analysis shows performance within thresholds and parameters set prior to initiation of the pilot project.



DATE: February 8, 2013

Protocol for Pilot Study of Interfacility-ALS (IFT-ALS) Proposal

Introduction:

The IFT-ALS program is being considered as a service for transport of advanced life support (ALS) level patients between health facilities and home healthcare settings. The IFT-ALS program is designed as an off-line (standing orders and protocols) ALS transport system with rapid response capability. The program does not replace or substitute for Critical Care Nurse transport capable services.

Pilot Goal:

Demonstrate feasibility and safety of an IFT-ALS program in Orange County.

Pilot Study Methods:

The pilot will be a prospective observation of IFT-ALS staffed transport units. IFT-ALS staff will function under defined standing orders and procedures developed by Orange County Emergency Medical Services (OCEMS). Study data will be retrieved from OCMEDS (OCEMS Medical Data System).

Included in the pilot study will be all of the first 100 IFT-ALS level transports that occur after initiation of the pilot. After interim review of the first 100 cases, a second period of evaluation of the second 100 cases may be done.

Excluded will be any BLS level transports performed by IFT-ALS crews.

Outcome measures will include:

Feasibility:

1. Attainment of complete data through the OCMEDS system with threshold = 95%.
2. Dispatch appropriate for IFT-ALS transports with threshold = 95%
3. Proper use of standing orders/procedures as demonstrated by application of appropriate standing orders when used, lack of exclusion of standing order/procedure steps, and proper dosing of medications with fallout rate < 2%
4. Assessment of patient outcomes with determination of whether patient arrived at receiving facility without deterioration during transport (as measured by vital signs and level of consciousness); assessed qualitatively.
5. Dispatch to arrival at facility response times with average time of 30 min.

Safety:

1. Frequency of traffic accidents related to IFT-ALS transports, none expected.
2. Frequency of IFT-ALS work related injuries (e.g. needle sticks) related to IFT-ALS transports, 1-2 expected.
3. Assessment of vaccination rate of IFT-ALS providers with current influenza vaccine, 100% threshold.
4. Frequency of respiratory or cardiac arrest of patients during IFT-ALS transport, 2 expected.
5. Frequency of medication errors (failure to provide, administration of wrong medication) during IFT-ALS transports, threshold 0%.

Statistical analysis:

Analysis of data will be by descriptive and frequency analysis, with measure of precision for data using measures of central tendency or proportions.

Expected Results:

It is expected that the first 100 IFT-ALS transports will demonstrate the feasibility and safety of the program. In the case that results are equivocal, a second set of 100 transports will be evaluated. If a second set of 100 transports are evaluated, outcome measures may be adjusted for that group.

A second evaluation may be done to determine feasible and safe staffing for IFT-ALS transport units. This initial pilot is being done with 2 IFT-ALS personnel staffing each IFT-ALS unit. Further evaluation may show that a staffing pattern utilizing 1 IFT-ALS and 1 Accredited EMT is equally feasible and safe.

TABLE 1: IFT-ALS Pilot Feasibility and Outcome Analysis

Interim Analysis # 2:
Total Calls Analyzed= 121

Age Data: Median Age = 71.5 (25% Q: 60; 75% Q: 85)

Feasibility:

<u>Measure</u>	<u>Threshold</u>	<u>Score</u>	<u>Comments:</u>
1. OCMEDS System input:	95%	100%	
Data Error Rate:		2.5%	3/121 records with missing data
2. Appropriate Dispatch:	95%	97%	Fallouts: 4 1. Two ED to ED acute MI patients for heart cath. 2. Two SNF to ED with systolic BP < 90.
Referral Rate to 911 System:		17 per 121 (14%) ALS dispatched (Table 3)	
3. Proper Use of Standing Orders:	<2% fallout	0.8% fallouts	(one with chest pain, NTG indicated)

Outcome Measures:

4. Stable Arrival to Receiving Facility ¹ :		100%	1. Three excluded due to missing arrival vital signs.
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Note:
1. Defined as arrival vital signs unchanged or improved.

5. Dispatch to Arrival at Scene:	Avg = 30 minutes	24.7 +/- 17.0 minutes ²
		< 25 min = 65% ²
		< 30 min = 76% ²
		< 35 min = 85% ²

Note:
2. Two standby (0 min response time) excluded.

Descriptive Data:

6. Types of Transports		7. ALS Field Procedures:
SNF to ED:	39	Cardiac Monitor: 113 (93.4% of total)
ED to ED:	26	IV TKO NS/SL: 3 (2.5% of total)
AL to ED:	15	12-lead ECG: 5 (4.1% of total)
ECF to ED:	13	CPAP 1 (0.8% of total)
ED to Hospital (Direct Admit):	11	
Other:		ALS Medications:
Hospital to ED:	5	Normal Saline Infusion: 10 (8.3% of total)
Rehab to ED:	4	D50 Dextrose: 2 (1.6% of total)
ED to SNF:	3	Albuterol: 1 (0.8% of total)
MD Office to ED:	1	Ondansetron: 1 (0.8% of total)
Clinic to ED:	1	Prehung BiCarb: 1 (0.8% of total)
Clinic to Hospital:	1	
B & C to ED:	1	
Home Health to ED:	1	

TABLE 2: IFT-ALS Pilot Safety Analysis

Interim Analysis: Phase 2

121 transports

<u>Safety Measure:</u>	<u>Threshold</u>	<u>Performance</u>
Frequency of traffic accidents:	0	0
Frequency of work injury:	0	0
Influenza vaccination of ALS staff:	100%	100%
Frequency of Cardiac/Resp Arrest during transport:	2	0
Medication errors:	0	0
ACLS certification current ALS providers:	100%	100%
PALS/PEPP certification current:	100%	100%

TABLE 3: DISPATCH REFERRAL TO 911 SYSTEM

Interim Analysis: Phase 2
Per 121 ALS Calls:

<u>Type of Site</u>	<u>Case Description</u>
Medical Office	Acute MI
Medical Office	Chest Pain
B & C	Respiratory Failure
B & C	Weak, unable to stand, vomiting bile
SNF	Respiratory Failure
SNF	Low BP
SNF	Low BP
SNF	Respiratory Distress
SNF	Syncope/High BP
SNF	Low BP
SNF	Respiratory Failure
SNF	Respiratory Failure
SNF	Respiratory Distress
SNF	Abdominal Pain
SNF	ALOC
SNF	Weakness/Low BP
Private Residence	Medical Emergency/Not IFT

Definitions:

B & C: Board and Care – Licensed facility providing on-going boarding and personal care services.

SNF: Skilled Nursing Facility – Licensed facility providing on-going nursing services.

Attachment # 7



EMERGENCY MEDICAL CARE COMMITTEE

SUMMARY REPORT APPLICATIONS FOR ORANGE COUNTY EMS FACILITY DESIGNATIONS JUNE 28, 2013

The following hospitals have applied to Orange County Emergency Medical Services (OCEMS) for Emergency Receiving Center (ERC), Base Hospital (BH), Cardiovascular Receiving Center (CVRC), and/or Stroke Neurology Receiving Center (SNRC) designation or re-designation. This report summarizes an OCEMS review of the applications noting deficiencies, conditions and recommendations. Today, it is presented to the Emergency Medical Care Committee for endorsement of their designation or re-designation.

General Findings: Two hospitals are presented for initial designation and seven hospitals are presented for re-designation. Facility evaluations and findings were based on designation questionnaire responses, facility trends on OCEMS monitored data, public and private data reporting sources and site surveys processes. Endorsement considerations of designation are for a full three-year term or otherwise specified by committee.

NEW FACILITY DESIGNATIONS

Children’s Hospital Orange County	(Review Period 2013)
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Comprehensive Children’s Emergency Receiving Center (CCERC)

Criteria Deficiencies: No deficiencies noted. Application and site survey in full compliance with OCEMS Policy 680.00 CCERC criteria.

Endorsement Consideration: One year (April 2013 – March 2014)

Hoag Hospital Irvine	(Review Period 2013)
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Cardiovascular Receiving Center (CVRC)

Criteria Deficiencies: No deficiencies noted. Application and site survey in full compliance with OCEMS Policy 630.00 CVRC criteria.

Endorsement Consideration: One year (July 2013 – June 2014)

FACILITIES – CONTINUING DESIGNATIONS

Kaiser Permanente Anaheim	(Review Period 2010-2012)
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Emergency Receiving Center (ERC)

Criteria Deficiencies: Prior deficiencies corrected. Six conditions assigned in September 2012 have been satisfied. Facility in full compliance with OCEMS Policy 600.00 ERC criteria.

Endorsement Consideration: Full three year designation (July 2013 – June 2016)



Huntington Beach Hospital

(Review Period 2010-2012)

Emergency Receiving Center (ERC)
Base Hospital (BH)

Criteria Deficiencies:

Deficiency 1: Deficiency in response to unannounced ReddiNet/HEAR tests (ERC).

Deficiency 2: Deficiency in demonstrating staff competency and training for care of pediatric patient populations (ERC).

Conditions:

Condition 1: Hospital will submit a corrective action plan within 60 days from notification and demonstrate compliance to unannounced emergency medical communications network tests per OCEMS Policy 600.00 VIII. B. 4 and OCEMS Policy 853.00 within 120 days from notification by OCEMS.

Condition 2: Hospital will submit a corrective action plan within 60 days from notification and implement annual pediatric education and competency specific to staff needs as identified through hospital quality improvement programs or an annual education and competency validation process for care of pediatric patients of all ages specific to illness and injury triage and pediatric assessment. Education for staff shall be provided and completed within the first year of current designation.

Endorsement Consideration: Two years (July 2013 – June 2015)

Coastal Communities Hospital

(Review Period 2010-2012)

Emergency Receiving Center (ERC)

Criteria Deficiencies:

Deficiency 1: Deficiency in response to unannounced ReddiNet/HEAR tests (ERC).

Deficiency 2: Deficiency in demonstrating staff competency and training for pediatric patient populations (ERC).

Conditions:

Condition 1: Hospital will submit a corrective action plan within 60 days from notification and demonstrate compliance to unannounced emergency medical communications network tests per OCEMS Policy 600.00 VIII. B. 4 and OCEMS Policy 853.00 within 120 days from notification by OCEMS.

Condition 2: Hospital will submit a corrective action plan within 60 days from notification and implement annual pediatric education and competency specific to staff needs as identified through hospital quality improvement programs or an annual education and competency validation process for care of pediatric patients of all ages specific to illness and injury triage and pediatric assessment. Education for staff shall be provided and completed within the first year of current designation.

Endorsement Consideration: Two years (July 2013 – June 2015)

Hoag Hospital Irvine

(Review Period 2010-2012)

Emergency Receiving Center (ERC)

Criteria Deficiencies:

Deficiency 1: Deficiency in response to unannounced ReddiNet/HEAR tests (ERC).

Conditions:

Condition 1: Hospital will submit a corrective action plan within 60 days from notification and demonstrate compliance to unannounced emergency medical communications network tests per OCEMS Policy 600.00 VIII. B. 4 and OCEMS Policy 853.00 within 120 days from notification by OCEMS.

Endorsement Consideration: Three years (July 2013 – June 2016)



Anaheim Regional Medical Center

(Review Period 2010-2012)

Emergency Receiving Center (ERC)

Paramedic Resource Center

Cardiovascular Receiving Center (CVRC)

Criteria Deficiencies:

Deficiency 1: Deficiency in response to unannounced ReddiNet/HEAR tests (ERC).

Deficiency 2: Excessive emergency department diversion hours with upward trend (ERC).

Diversion Trends: 2010 = 1.64%
 2011 = 3.41%
 2012 = 6.35%
 2013 = 10.41% (1st Quarter)

Conditions:

Condition 1: Hospital will submit a corrective action plan within 60 days from notification and demonstrate compliance to unannounced emergency medical communications network tests per OCEMS Policy 600.00 VIII. B. 4 and OCEMS Policy 853.00 within 120 days from notification by OCEMS.

Condition 2: Hospital will minimize the duration and occurrence of diversion with a maximum annual average diversion rate of six percent within the first year of the current designation. Hospital will submit a corrective action plan demonstrating active initiatives to mitigation diversion hours within 60 days from notification by OCEMS.

Endorsement Consideration: Two years (July 2013 – June 2015)

Western Medical Center Anaheim

(Review Period 2010-2012)

Emergency Receiving Center (ERC)

Cardiovascular Receiving Center (CVRC)

Criteria Deficiencies:

Deficiency 1: Deficiency in response to unannounced ReddiNet/HEAR tests (ERC).

Deficiency 2: Deficiency in demonstrating staff competency and training for pediatric patient populations (ERC).

Deficiency 3: Emergency department accepting ambulance traffic when the hospital is on diversion and closed for emergency department saturation. Deficiency includes accepting admitted patients through the emergency department when the emergency department is closed for emergency department saturation (ERC).

Deficiency 4: Excessive emergency department diversion hours with upward trend (ERC).

Diversion Trends: 2010 = 5.48 %
 2011 = 7.99 %
 2012 = 7.19 %
 2013 = 7.60 % (1st Quarter)

Deficiency 5: Excessive Cardiovascular Receiving Center diversion hours with upward trend (CVRC).

Diversion Trends: 2010 = 0.90 %
 2011 = 1.44 %
 2012 = 2.33 %
 2013 = 1.59 % (1st Quarter)

Deficiency 6: Deficiency in demonstrating cardiovascular lab staff competency and training for low frequency/high risk invasive cardiovascular procedures (CVRC).

Deficiency 7: Deficiency in demonstrating staff competency and training for invasive procedure (vascular closure devices) performed by radiology technologist and nursing staff (CVRC).



Conditions:

- Condition 1:** Hospital will submit a corrective action plan within 60 days from notification and demonstrate compliance to unannounced emergency medical communications network tests per OCEMS Policy 600.00 VIII. B. 4 and OCEMS Policy 853.00 within 120 days from notification by OCEMS.
- Condition 2:** Hospital will submit a corrective action plan within 60 days from notification and implement annual pediatric education and competency specific to staff needs as identified through hospital quality improvement programs or an annual education and competency validation process for care of pediatric patients of all ages specific to illness and injury triage and pediatric assessment. Education for staff shall be provided and completed within the first year of current designation.
- Condition 3:** Hospital will provide a statement of adherence to OCEMS Policy 310.96 and submit a corrective action plan within 60 days from notification to ensure compliance with the requirements of OCEMS Policy 310.96 "Guidelines for PRC request for diversion status". Hospital shall notify OCEMS verbally and in writing any time the hospital is not in compliance with OCEMS Policy 310.96.
- Condition 4:** Hospital will minimize the duration and occurrence of diversion with a maximum annual average diversion rate of six percent within the first year of the current designation. Hospital will submit a corrective action plan demonstrating active initiatives to mitigation diversion hours within 60 days of from notification from OCEMS.
- Condition 5:** Hospital will minimize the duration and occurrence of cardiovascular catheterization laboratory diversion. Hospital will submit a corrective action plan demonstrating active initiatives to mitigation diversion hours within 60 days of from notification from OCEMS.
- Condition 6:** Hospital shall submit within 60 days of notification a statement describing annual cardiovascular catheterization laboratory education and competency verification specific to staff needs as identified through hospital quality improvement programs or an annual education and competency validation process for low frequency/high risk invasive cardiovascular procedures. Education for staff shall be provided and completed within the first year of current designation.
- Condition 7:** Hospital shall submit within 60 days of notification a statement identifying the formalized hospital approval process for allowing radiology technologist and registered nursing staff to perform vascular closure device procedures. Hospital shall submit within 60 days of notification demonstration of annual cardiovascular catheterization laboratory education, competency specific training and validation for all radiology technologist and nursing staff performing vascular closure device procedures.

Endorsement Consideration: One year (July 2013 – June 2014)

Saddleback Memorial Medical Center (Laguna Hills & San Clemente)	(Review Period 2010-2012)
<u>Emergency Receiving Center (ERC) – Laguna Hills & San Clemente</u>	
<u>Cardiovascular Receiving Center (CVRC) – Laguna Hills</u>	
<u>Stroke Neurology Receiving Center (SNRC) – Laguna Hills</u>	

Criteria Deficiencies:

Deficiency 1: Deficiency in response to unannounced ReddiNet/HEAR tests (ERC).

Conditions:

- Condition 1:** Hospital will submit a corrective action plan within 60 days from notification and demonstrate compliance to unannounced emergency medical communications network tests per OCEMS Policy 600.00 VIII. B. 4 and OCEMS Policy 853.00 within 120 days from notification by OCEMS.

Endorsement Consideration: Three years (July 2013 – June 2016)



City of Anaheim

ANAHEIM FIRE DEPARTMENT

June 26, 2013

Sam Stratton, MD
Medical Director
OCEMS Agency
PO Box 355
Santa Ana, Ca. 92802

Dear Dr. Stratton,

Anaheim Fire & Rescue (AF&R) is officially advising Orange County Emergency Medical Services of our plan to place a paramedic engine in service to better serve our community. AF&R will be adding the additional Advanced Life Support (ALS) engine to Fire Station 8 at 0800 hours on June 28, 2013, utilizing the designation of Anaheim Engine 8.

ANAHEIM FIRE & RESCUE JUSTIFICATION

AF&R currently staffs paramedic units in all fire stations within our city. To enhance current coverage and improve response times, our operational plan is to have every emergency response unit capable of providing ALS level service to our community. We began this migration in 2011 when Truck 1 and Truck 2 were transitioned from Basic Life Support (BLS) to ALS units. Anaheim Engine 8 will be staffed with a minimum of two State-licensed and Orange County accredited paramedics. Justifications for this enhancement to our EMS delivery system include:

- Increasing the capacity of our ALS delivery system resulting in more effective and efficient patient care
- Adding the additional ALS unit will increase ALS unit availability in our city
- Increasing fire unit availability to meet the required Effective Response Force (ERF) needed to respond to fire calls, as identified in National Fire Protection Standard (NFPA) 1710 - Standard for the organization and deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments
- In 2011, due to budget reductions, a BLS unit was removed from service at Station 8. The Anaheim City Council has approved funding to put this unit back into service with enhance ALS capabilities for the community.

- The closure of Kaiser Permanente Hospital – Lakeview facility, and relocation to a new facility now located further west and outside of Station 8’s first in-service area, has increased ALS transport and follow-up times for all three canyon fire stations.
- AF&R has seen an increase in call volumes for Station 5 and Station 9, which boarder the Station 8 service area.

EMS call volumes have been increasing each year, with a definite increase in ALS calls noted. The City of Anaheim experiences an unusual phenomenon in the number of residents, workers and visitors who are within our city boundaries on any given day or time. Our normal population is approximately 350,000, but because of our unique composition of large convention center facilities, amusement parks, hotels and sports venues, our population can double or even triple on a given day to over a million people. We also have within our city several venues that are considered at higher risk for possible terrorist activities, and the addition of additional paramedic units would enhance our current ALS response capabilities to such an event.

WORKLOAD ANALYSIS

Our EMS calls are generally between 84-85% of all 911 calls generated to Anaheim Fire Department. In 2012 AF&R saw an increase of 8.5 % in overall fire department responses, going from 28,752 in 2011 to 31,084 in 2012

Call volumes for areas contiguous to Station 8 have been increasing annually.

	2011 TOTAL EMS CALLS	2012 TOTAL EMS CALLS	2011 AVERAGE EMS CALLS/DAY	2012 AVERAGE EMS CALLS/DAY
Anaheim Engine 5	1,730	1775 3% increase from '11	4.74	4.86
Anaheim Truck 8	1276	1179	3.50	3.23
Anaheim Engine 9	1097	1225 12% increase from '11	3.01	3.36

GEOGRAPHICAL LOCATIONS/BOUNDARIES

Anaheim Paramedic units assigned to Station 8 (Engine 8 and Truck 8) would service the northeastern parts of our city which are at the Anaheim/Placentia/Yorba Linda/Orange borders.

Engine 8 general boundaries:

- North: Orangethorpe Avenue
- East: Imperial Highway
- West: Tustin Avenue
- South: Lincoln / Nohl Ranch

PROPOSED IMPLEMENTATION TIME FRAME

June 28, 2013, at 0800 is the date for the activation of ALS Anaheim Engine 8

DRUGS/FORMULARY/SUPPLIES/INVENTORIES/TELECOMMUNICATIONS

AF&R agrees to continue to maintain the mandated drug and IV solution inventory, along with basic and ALS medical equipment and supplies, as specified by policies from the OCEMS Agency. We will continue with our commitment to utilize and maintain medical telecommunications as specified by OCEMS Agency.

BOARD OF SUPERVISORS RESOLUTION 79-240

AF&R has one unit for every 20,000 population which exceeds the established one unit for every 64,000 population created by the Board of Supervisors. Additionally, AF&R has one unit for every three square miles.

ALS TRAINING

AF&R agrees to continue to meet the training needs and OCEMS Agency staffing requirements at all times with a minimum of two paramedics (EMT-Ps) per ALS unit.

NOTICE OF RIGHTS, REMEDIES, AND PRIVILEGES RETAINED: The City of Anaheim, pursuant to Section 1797.201 of the California Health & Safety Code (Division 2.5, Chapter 4, Article 1), retains all rights, remedies, and privileges regarding the provision, administration, and operational control of all prehospital emergency medical services within its jurisdiction including, but not limited to: 1) the continued receipt and processing of "requests for emergency medical assistance," including all 9-1-1 calls by a "live-caller," the dispatching of prehospital emergency ambulances, apparatus, and personnel, and all functions related to operating a Public Safety Answering Point including Emergency Medical Dispatch; 2) the continued provision of "prehospital transport services," including emergency ambulance response and patient transport services; 3) the continued provision of "prehospital non-transport services," including Advanced Life Support provided by Firefighter Mobile Intensive Care Paramedics, Basic Life Support provided by Firefighter Emergency Medical Technicians, and First Responder / First Aid level care provided by Law Enforcement Officers, Lifeguards, and Water Safety Instructors. This correspondence, and any action/transaction that is the subject matter of this correspondence, shall not constitute an agreement for the provision of prehospital emergency medical services pursuant to Section 1797.201, and shall not constitute a waiver, modification, reduction, or acquiescence of any rights, remedies, or privileges retained pursuant to Section 1797.201, and shall not in any way affect the rights, remedies, or privileges retained by the City of Anaheim pursuant to Section 1797.201, or

pursuant to any other applicable statute or legal authority, to provide, administer, and/or maintain operational control over all prehospital emergency medical services within its jurisdiction.

Sincerely,

A handwritten signature in black ink that reads "Randy R. Bruegman". The signature is written in a cursive, slightly slanted style.

Randy R. Bruegman
FIRE CHIEF

CC: DC Pat Russell
DC Rusty Coffelt
Joelle Samsel, RN
Kristin Thompson, RN
Mary Massey, RN – ARMC BHC
Shelly Brukman, RN – UCI BHC

**CITY OF COSTA MESA
OFFICE OF THE FIRE DEPARTMENT**

TO: TAMMI MCCONNELL, PROGRAM MANAGER OCHCA
FROM: FRED SEGUIN, ACTING DEPUTY CHIEF
DATE: JUNE 3, 2013
SUBJECT: CHANGE IN DELIVERY OF PARAMEDIC SERVICE

Costa Mesa Fire Department (CMFD) would like to notify Orange County Health Care Agency (OCHCA) of our intention in moving forward with the reorganization of CMFD and the way our paramedics get to the scene of an incident. Currently, our delivery model is a four-person firefighter paramedic engine company and with the restructuring of CMFD, our intention is to take the paramedics off the engine companies and place them on two person paramedic units. CMFD is currently preparing a Council Agenda Report to be placed on the June 18th City Council Meeting to purchase and build six ambulances. We have leased from the Orange County Fire Authority two ambulances, which will allow us to begin phase 1 of the restructure tentatively set for June 16, 2013 at 07:30. By leasing the ambulances, we will be able to take two paramedic engine companies out of service and replace them with two (3) person BLS companies and place two ambulance paramedic units in service. The paramedic unit will be used to transport paramedics to an incident; follow up to the hospital if necessary and we will still use our current ambulance transport provided (Care) to transport the patient to the hospital. At this time, it is not our intention to use the paramedic unit as a transportation component unless it is in the patient's best care due to extended ETA from an ambulance provider. We will also contact OCHCA to have the units certified by the county as we transition with our reorganization. Below is the new deployment model tentatively set for June 16, 2013:

Fire Station 1- MME81 (Paramedic Engine Company)
Fire Station 2- ME82 (BLS Engine) & **MM82 (Paramedic Unit)**
Fire Station 3- MQ83 (BLS Truck Company) & **MM83 (Paramedic Unit)**
Fire Station 4- MME84 (Paramedic Engine Company)
Fire Station 5- MME85 (Paramedic Engine Company)
Fire Station 6- MT86 (BLS Truck Company)