Draft Policy Public Comments Received: 03/04 - 03/12/2024

S-610 Transfer of Care Guidelines		
DATE	**NAME**	**PUBLIC COMMENT**
3/5/2024	Don Sullivan	IV. c This section should have something to the effect: This is a transfer off EMS gurney and onto a ED facility bad, gurney, chair. this is not when patients are registered or triaged. All too often (this is a two way street) when a pt hits the wall and is registered, both parties assume this to be a turn over.
3/5/2024	Jess Specht	What does "formal transfer of care" mean? (letter B). Also, what is an ambulance crew to do if hospital refuses to sign PCR? This has happened. We need to ensure the ambulance crew has an ability to navigate ER personnel unwilling to assist in the transfer of care, up to and including refusing to sign for a patient. We cannot allow the hospitals to hold units hostage by refusing a "formal transfer" and/or refusing to sign the PCR.

3/8/2024	Nate Pearson	Section IV - -subsection B. - This places the responsibility on EMS personnel but does not compel the receiving facility to accept the TOC. suggest "A transfer of care that includes: - a verbal report acknowledged by receiving facility personnel and -placement of the patient on a receiving facility bed, chair or other appropriate location shall occur for each patient." -Subsection D - This section appears to authorize the continued treatment of EMS patients after arrival at the ER. While continuing medications/treatments that are in place prior to arrival is standard stating that "EMS personnel and receiving facility medical personnel shall ensure there is no interruption or delay in patient care" could be read to assume that EMS personnel must continue treating the patient upon arrival if no bed is available. This is a continuance of EMS personnel augmenting ER staffing. If treatment is needed upon arrival it becomes the receiving facility's responsibility. Suggest dropping "EMS personnel" to read "Receiving facility medical personnel shall ensure there is no interruption or delay in patient care while waiting for a formal transfer of care. Treatments in place upon arrival may continue until transfer of care is complete. All patient care by EMS personnel shall be documented according to CoSD EMS policies." Also, "formal transfer of care" is referenced several times but never defined. Please provide criteria for completing "transfer of care".

3/11/2024	Jeffrey M Clyons	This looks like the whole policy is basically gone? There is nothing here to assist EMS in transfer of care in a timely manner. There is just a standard that may be tracked and then what? Hospitals can be told they are not meeting the standard and then what? I guess the real question with getting only a totally redacted policy after all the discussion is what happened? What changed? What is the plan for the future? Is there one? Are we just letting the hospitals do what they want and EMS field providers just deal with it? Thank you
3/12/2024	Becky Newell	I am concerned that in the absence of a defined policy, individual agencies may adopt their own guidelines on how to best handle APOT, which would cause increased confusion and stress on ambulance crews and hospital staff alike. This could result in patient care that is not equitable based on system status, destination/geography, time of day, etc.

Draft Policy Public Comments Received: 01/05 - 02/04/2024

S-610 Transfer of Care Guidelines		
DATE	**NAME**	**PUBLIC COMMENT**
1/8/2024	Mary Murphy	EMS personnel and ED medical personnel shall ensure there is no interruption or delay in patient care while waiting for a formal transfer of care. This is way too broad as there are any sutilies as to what happens on the Gurney
1/8/2024	Mary Murphy	I'm confused, the policy says : The EMS Authority will report APOT time exceedance to CoSD EMS. Is that the state EMS Authority ?

1/20/2024	Nate Pearson	Section III. Suggest change: Remove "Non-Standard Patient Offload Time", replace with "Ambulance Patient Offload Delay" is any future instance or use. The "non-standard language is not used again throughout the policy and is not included in the legislation. Non standard is also vague and possibly confusing, there is no need for two terms for the same definition. Transfer of Care - suggest the following definition: "The transition of patient care responsibility from EMS personnel to receiving hospital ED medical personnel completed when patient has been moved from the EMS gurney, report of care has been provided and a transfer of care signature has been provided." This is supported by the legislation: 1797.120.5 (a (2)"The signature shall be collected when physical transfer of the patient occurs and the report is given to hospital staff and shall note ambulance arrival time at the hospital." Section V Procedures: A. 5. Change time for notification to EMS office to 90 minutes. 120 is 4x the legislated standard and even greater than the current diversion policy. 90 is progress towards a reduced tolerance for excessive patient offload delays. B. 6(new) - Invoke 1797.120.7 If, during the preceding month, an ED experiences APOT in excess of the approved standard LEMSA shall: (a)alert San Diego County EMS provider agencies of the hospital experiencing offload delay. (b)confirm execution of APOD reduction plan established with EMSA. 1797.120.7 For reference: (1) Report the ambulance patient offload time exceedance to the relevant local EMS agency and the commission via electronic means. (2) Direct the local EMS agency to alert all EMS providers in the jurisdiction.

1/20/2024	Nate Pearson (Cont.)	(3) Direct the licensed general acute care hospital with an emergency department to implement the ambulance patient offload time reduction protocol developed pursuant to Section 1797.120.6. (4 Host, at minimum, bi-weekly calls with the relevant hospital administration, including emergency department leadership, EMS providers, local EMS agency, and hospital employees to update and discuss implementation of the protocol and the outcomes.

2/4/2024	Christopher Kahn	Although not included in this policy, the related S-610A policy is now obsolete and should be retired. III. In some of these definitions (APOT, APOT Standard, and APOD) there is reference to the time interval between the arrival of an ambulance and the time the ED assumes responsibility for care. Federal law has clearly established that the ED assumes responsibility for care when the ambulance arrives at the hospital. It is unfortunate that California has adopted language which contradicts this, as this places the LEMSA in the unenviable position of using definitions that either do not comport with state law or do not comport with federal law. Please consider changing these definitions to use the more accurate language “when the ED accepts transfer of care”. It is of critical importance that our LEMSA’s policies do not conflict with federal law. If this is not felt to be possible, please add a clarifying paragraph at the beginning of the definition section along the lines of: “While the definitions below are written to match state-provided language when relevant, County of San Diego EMS recognizes that federal law considers the receiving ED to have assumed responsibility for the patient once they arrive at the hospital.” Similarly, please change the definition of transfer of care, as it is more specifically defined in IV. C. and that definition does not match the definition here. It may be preferable to delete the definition here and rely on the later policy section instead. . IV. B While the separate mitigation policy being proposed (“S-XXX”) addresses this, the language here is aspirational but unachievable. Patients awaiting transfer of care for prolonged periods are inevitably having their care delayed and potentially interrupted.

2/4/2024	Christopher Kahn (Cont.)	Even with the mitigation measures proposed in S-XXX, there will be decrements, delays, and interruptions in patient care. Either the language here should be changed from “shall ensure there is no” to “shall minimize any” to recognize this reality, or the LEMSA should be prepared to address multiple daily violations of this policy. IV. E. 1 It is unreasonable to expect hospitals to “validate” APOT data when they do not have the data needed to perform such validation. Hospital-based “ambulance arrival time” is inaccurate and based on ED registration time, which can be delayed by dozens of minutes when the ED is overwhelmed. Hospitals do not have access to what the standard requires: “the time the ambulance stops/arrives at the location outside the hospital ED where the patient will be unloaded from the ambulance.” The LEMSA and EMS provider agencies have these data, validated by automated GPS tracking and reporting. Including hospitals here as validating entities – particularly without the inclusion of EMS provider agencies in the same capacity – creates both a conflict of interest and decreased data quality. Concerns about the only other relevant data point – transfer of care or clock stop time – should be adjudicated by the LEMSA rather than “validated” by hospitals. . If there is disagreement between hospitals and EMS provider agencies on specific transfer of care time instances, and the LEMSA is not able to determine with confidence that a time other than the already-reported time is accurate, the reported time should be used. If there is no reported time, then the current default of using a clear/available time is a reasonable failsafe measure.

2/4/2024	Christopher Kahn (Cont.)	IV. E. 3 Please clarify that ALL metrics, not just the ones that the LEMSA may choose to measure, will be publicly available through the online dashboard. These metrics should not be reported in purely anonymized or aggregated fashion, as the public has a vital interest in knowing which hospitals do not offload ambulance patients in a timely fashion. There is a similar strong public interest in knowing which hospitals are closed for internal disaster or have been placed on County ambulance diversion due to capacity constraints, and these data should be publicly available in real time, perhaps on the same website. IV. F While commented on previously, it is important to note that as the official "existing EMS QA/QI process" is driven by the base hospitals, this is requiring that base hospitals choose to report themselves after choosing how to investigate themselves, leading to perceptions both of conflict of interest and bias in reporting. This is not only unfair to satellite hospitals should those perceptions prove true to any degree, but more importantly the mere existence of those perceptions is detrimental to our community's trust in the QA/QI process. QA/QI of APOT/APOD should be performed by neutral LEMSA personnel. An additional item of reporting on the publicly available website should be how many times the EMS duty officer needed to intervene to alleviate an instance of APOD. If there are particular intervention methods that prove useful and would be items that can be performed by EMS provider agency personnel (whether field- or supervisory-level), those techniques should be shared with the EMS provider agencies to facilitate faster resolution of APOD and decrease the number of times the EMS duty officer needs to be

2/4/2024	Christopher Kahn (Cont.)	contacted. V While several items in this list of EMS Personnel Responsibilities state that EMS personnel “shall” do something, there is nothing stating that ED personnel “shall” actually engage in the conversations, evaluations, and interventions listed here. It is difficult to mandate that dialogue occur while only mandating that one of the parties to that dialogue participate in it. It is also likely that the mandated dialogue will be of little to no value, as ED charge nurses (as one example) will likely tire of being told by each individual crew that has waited past the APOT standard that the standard has been exceeded, to be followed shortly by a call from the EMS supervisor for each crew that is waiting. This may have the unintended effect of delaying ambulance patient offload if the ED charge nurse is prevented from taking other actions to mitigate the delay because he or she is taking several calls with the same mandated language. One possible change here would be to require that EMS personnel ensure that the ED staff are aware of the delay and the urgent need to release ambulance resources – and, for that matter, non-ambulance EMS resources such as suppression apparatus personnel and other personnel not based on ambulances – without requiring affirmative contact by every crew and their supervisor for every instance of delay. The duty officers may also tire of being called for each and every instance of delay, particularly given their long periods of being on duty and their significant other job responsibilities. V. A. 5. It would be helpful to ensure that EMS provider agencies have input into the online form development, since they will be the ones using it almost every day.

2/4/2024	Christopher Kahn (Cont.)	Follow-up should include feedback to the reporting agency with public reporting on the number of reports received and the kinds of issues noted in those reports at the APOT information web page referred to earlier. At a minimum, as the four items noted in the preceding section (F) of the policy are important enough to be specifically called out for evaluation, these four items should be reported publicly. Further, to facilitate reporting per IV.F.3, the LEMSA may wish to develop a standard form/handout (including a QR code linking to the appropriate section of the LEMSA's web site) that patients can use if they wish to file complaints related to APOD, which will relieve the EMS provider agencies of the need to develop these handouts independently and redundantly. Filing those complaints should be possible via an online form, telephone call, postal mail address, or in-person report, with the methods for exercising those options made available to all EMS patients. An additional item of reporting on the publicly available website should be how many times the EMS duty officer needed to intervene to alleviate an instance of APOD. If there are particular intervention methods that prove useful and would be items that can be performed by EMS provider agency personnel (whether field- or supervisory-level), those techniques should be shared with the EMS provider agencies to facilitate faster resolution of APOD and decrease the number of times the EMS duty officer needs to be contacted.

2/4/2024	Christopher Kahn (Cont.)	V. B. 1. We strongly encourage that the reminder to hospitals that their responsibility for the care of the patient begins when the ambulance arrives on the hospital grounds NOT be deleted. This is consistent with federal law (see 42 USC 1395dd et seq and 42 CFR 489.20 et seq, particularly 42 CFR 489.24(b)) and should remain an integral part of the policy. Further, consistent with the mandatory language found throughout the EMS Personnel Responsibilities section, the items in V. B should also use mandatory language such as “shall” for fairness and consistency, including replacing the “should” in item V. B. 1 with “shall”.

Draft Policy Public Comments Received: 11/20 - 12/20/2023

S-610 Transfer of Care Guidelines		
DATE	**NAME**	**PUBLIC COMMENT**
12/11/2023	Mary Murphy	Do all PCR charts not list the incident times secondary to CAD so why is there a note that after TOC the chart shall note ambulance arrival time at the hospital? If APOD should not exceed 30 minutes why is extended APOD defined as over 1 hour. Surely it should be 31 minutes? And why are units being kept out of service for 2 hours prior to CoSD EMS Duty Officer being notified ? If 7 units arrive at the ER in that 2 hour window, shouldn't we act quicker to resolve the issues ? As this is a major service reduction to the community.

12/18/2023	Brett McClain	Dear Director Collins: Sharp HealthCare (“Sharp”) appreciates the opportunity to submit comments on San Diego County Emergency Medical Services Office’s (CoSD EMS) proposed changes to the Transfer of Care Guidelines (policy S-610). We submit these comments to express our support for the proposed changes and provide recommendations to further improve the policy. First, Sharp appreciates CoSD EMS’s adoption of the 30-minute, 90% transfer of care (TOC) standard rather than a more restrictive requirement. While San Diego County hospitals have improved ambulance patient offload times (APOT) over recent years, the 90% standard is a stretch goal, as no hospital in the County has achieved that rate consistently. Sharp appreciates the recognition that pairing a 90% standard with an APOT of less than 30 minutes would be unachievable at this time. Sharp also appreciates the inclusion of the Emergency Medical Services Authority (EMSA) definitions into the policy for clarity and consistency. Negative TOC Times Sharp appreciates CoSD EMS’s inclusion of EMSA’s Criteria for Quality Assurance Follow-up within the policy. However, the triggering criteria for review does not include criteria for evaluating negative TOC times, which occur when an ambulance reports that a patient has been transferred to the emergency department in less than zero minutes.

12/18/2023	Brett McClain (Cont.)	These negative TOC times account for up to 5% of all ALS ambulance transports and could be the difference between a hospital emergency department meeting or missing the 90% standard. Sharp requests that, “Occurrence of negative TOC times by an ambulance provider” be added to section F’s list of criteria for quality assurance or quality improvement actions. Negative TOC times are made in error and should be managed alongside all other variances outlined in the policy. The above addition aligns with the triggers outlined in section F and analysis by CoSD EMS would lead to additional data and opportunities for TOC improvement. Local Data Validation for the EMSA Audit Tool Health & Safety Code 1797.120.5 requires EMSA to develop and implement an audit tool to “improve the data accuracy of transfer of care with validation from hospitals and local EMS agencies” by December 31, 2024. CoSD EMS’s proposed policy does not articulate how CoSD EMS will work with local hospitals to validate the TOC data for the EMSA audit tool. This audit tool is essential to ensure the TOC policy is implemented accurately and appropriately, but the accuracy of the audit tool will rely upon the collaboration between the local EMS agency and hospitals on local data validation. Sharp urges CoSD EMS add a section to the TOC policy outlining a local validation process that allows hospitals to review and reconcile any errors in the TOC data, using the approved audit tool, before being submitted to EMSA.

12/18/2023	Brett McClain (Cont.)	Establishing this local policy will support EMSA's successful go-live of the audit tool by December 31, 2024 Additional TOC Calculation Considerations In developing the local data validation policy for the EMSA audit tool, Sharp requests CoSD EMS consider two items for data accuracy. There are instances when BLS ambulance transport data has been included in CoSD EMS's TOC calculations. BLS data can impact the calculations – when a BLS unit is dispatched to a 911 call, or an ALS unit is downgraded to BLS for transport – as they are unable to capture TOC times accurately with a signature on the electronic PCR. To accurately calculate TOC times, we request CoSD establish a process to remove the BLS data prior to calculating a hospital's TOC and allow hospitals to review the data prior to finalizing the TOC calculations. In addition, Sharp is concerned about how TOC times are impacted when an ambulance does not collect a signature on the PCR. Currently, if an ambulance does not collect a signature on the PCR, the TOC time stamp defaults to the "cleared destination" time, which is after TOC has been completed. Transports without signature on the PCR can account for up to 6% of transports from some agencies. Hospitals' TOC times should not be negatively impacted because an ambulance does not collect a signature on the PCR. Sharp urges CoSD to remove the data from transports that do not collect a signature on the CPR for TOC calculations. Sharp urges CoSD EMS to adopt the two additions to the proposed TOC Guidelines, which will make both the policy and EMS system more effective in ensuring patients receive timely care. Thank you for the opportunity to provide comments; we appreciate your consideration of these comments.

12/18/2023	Brett McClain (Cont.)	If you have any questions or need further information about our comments, please reach out to Marlena Montgomery (marlena.montgomery@sharp.com). Sincerely, /s/ Brett McClain Executive Vice President & Chief Operating Officer Sharp HealthCare
12/19/2023	Don Sullivan	The CoSD EMS Duty Officer will be notified for an APOD exceeding 120 minutes that cannot be resolved at the EMS/ED medical personnel supervisory level be resolved at the EMS/ED medical personnel supervisory level. AS CURRENTLY WRITTEN 120 MINUTES IS AN EXTRAORDINARY AMOUNT OF TIME FOR AN ALS UNIT TO WAIT TO INFORM DUTY OFFICER OFAPOD. 60 MINUTES SHOULD BE THE MAX

12/20/2023	Christopher Kahn	III. Technically, you can never have a patient on APOD if the standard includes a 90% fractile. While the APOT Standard needs to be defined as it is in accordance with the updated law, the APOD definition must simply refer to 30 minutes. If considered necessary, one could use redundant language such as “30 minutes as defined in the APOT standard”, but this could lead to confusion and should be avoided. Unless the intent of the LEMSA is NOT to have 30 minutes be the expectation (not mandated standard) for ALL patients, please reword the APOD definition from “beyond the APOT standard” to “beyond 30 minutes from the time of ambulance arrival at the emergency department.” IV.B.1: Do we need to define “assume responsibility” (and perhaps add that to the definitions in III)? This revision deletes this from the current policy (V.B.1). This is an item of disagreement between EMS provider agencies and receiving facilities. EMTALA (see 42 USC 1395dd et seq and 42 CFR 489.20 et seq, particularly 42 CFR 489.24(b)) states they have responsibility for providing “an appropriate medical screening examination” and “any necessary stabilizing treatment” the moment the ambulance is within 250 yards of the main buildings of the hospital. In previous APOD-related discussions with hospitals, they have made it clear that they do not consider themselves to have responsibility for patient care until they have specifically stated so.

12/20/2023	Christopher Kahn (Cont.)	As this item specifies both “assumes responsibility” AND that the patient has been physically placed in an ED “gurney, bed, chair, or other acceptable location”, this may not be a critical item, but it does raise the question of whether a patient could be placed in such a location in the ED with a written report left for ED staff should they refuse to accept a verbal report. The issue of when receiving facilities “assume responsibility” for the patient does have one aspect that immediately impacts patient-centered care, however. Revision of this policy provides an opportunity to clarify who can provide medical care for patients during periods of APOD. Base hospitals almost uniformly refuse to provide orders allowing care for patients once they have arrived at a receiving facility, as they do not want to direct care at other facilities. Receiving hospitals often refuse to provide care to patients during APOD as they do not want to be perceived as having accepted responsibility for them; some hospitals will not even triage patients on EMS gurneys – perhaps for hours – until they are placed in a treatment location for the express purpose of avoiding the perception of having accepted patient care responsibility. The 10/19/2022 “treatment on the EMS gurney community consensus guidance” memo (https://www.sandiegocounty.gov/content/dam/sdc/ems/Policies_Protocols/memos-and-updates/CoSD%20EMS%20Treatment%20on%20Gurney%20Guidance%20Memo%2010%2019%2022.pdf) valiantly attempted to address this gap, but it does not allow for treatments other than standing orders at any time, nor ANY treatment after 30 minutes.

12/20/2023	Christopher Kahn (Cont.)	The result is that patients have been left stranded, in multiple cases literally screaming in pain for hours, with the EMS provider prohibited by policy from providing patient care. Their only option is to suffer along with the patient whose needs are being ignored by all the other medical personnel present. The memo was well-intended, in that EMS personnel should not be expected to function as hospital employee extenders and should instead be allowed to return to service. Unfortunately, the result has not been that hospitals have offloaded EMS patients more quickly; it has been that EMS patients have been forced to suffer despite the availability of appropriate treatments all around them. IV.B.3.a: Please clarify that this is the “verbal report”. This turnover of care time is not dependent on transfer of the written report. Additionally, the time of ambulance arrival at the ED is not currently displayed to ED personnel on most ePCR platforms, and would require the expense of reprogramming software to display something that receiving personnel likely have no interest in actually reviewing. As it is being captured in a consistent fashion and does not impact whether the signature at transfer of care is given or withheld, it does not seem necessary to undergo the time and expense of this software change. IV.D.2: It is welcome news that hospital-specific APOT information will be publicly available. We should make sure that all diversion/bypass data are ALSO publicly available, as this is directly related, relevant, and of public interest.

12/20/2023	Christopher Kahn (Cont.)	Both APOT information and diversion/bypass data should be available in real time and not just in retrospective aggregate contexts. IV.F: As the official “existing EMS QA/QI process” is 100% driven by the base hospitals, this is requiring that base hospitals choose to report themselves after choosing how to investigate themselves, leading to perceptions both of conflict of interest and bias in reporting. This is not only unfair to satellite hospitals should those perceptions prove true at any level, but more importantly the mere existence of those perceptions is detrimental to our community’s trust in the QA/QI process. QA/QI of APOT/APOD should be performed by neutral LEMSA personnel. IV.F.4: Please remove “e.g.,” from the parenthetical, as this is the defined standard rather than an example of a standard. Alternatively, remove the parenthetical entirely as the standard is already defined earlier in the policy. IV.G: It would be helpful to ensure that EMS provider agencies have input into the online form development, since they will be the ones using it almost every day. Regarding “follow up as necessary”, it would be preferable to consider follow up as ALWAYS necessary on every report with public reporting on the number of reports received and the kinds of issues noted in those reports at the APOT information web page referred to earlier. At a minimum, as the four items noted in the preceding section of the policy are important enough to be specifically called out for evaluation, these four items should be reported publicly.

12/20/2023	Christopher Kahn (Cont.)	Further, to facilitate reporting per IV.F.3, the LEMSA may wish to develop a standard form/handout (including a QR code linking to the appropriate section of the LEMSA's web site) that patients can use if they wish to file complaints related to APOD, which will relieve the EMS provider agencies of the need to develop these handouts independently and redundantly. Filing those complaints should be possible via an online form, telephone call, postal mail address, or in-person report, with the methods for exercising those options made available to all EMS patients. An additional item of reporting on the publicly available website should be how many times the EMS duty officer needed to intervene to alleviate an instance of APOD. If there are particular intervention methods that prove useful and would be items that can be performed by EMS provider agency personnel (whether field- or supervisory-level), those techniques should be shared with the EMS provider agencies to facilitate faster resolution of APOD and decrease the number of times the EMS duty officer needs to be contacted.

12/20/2023	Jessamyn Specht	In section B, number 1 it states "...the emergency department assumes responsibility for the care of patient" only occurs after the listed criteria is met. However, the patient is the responsibility of the hospital upon arrival of the patient on the hospital's property, as defined in 42 CFR § 489.24(b). At such point in time, the patient has become a hospital patient. The criteria for this policy does NOT need to be met for the patient to become the hospital's responsibility. EMS transport providers have a shared goal of ensuring quality patient care is delivered but the patient is the hospital's responsibility as soon as the patient arrives on the hospital property regardless of whether a signature, turnover, etc is provided. B. EMS personnel are required to complete a transfer of care. Transfer of care is complete when: 1. The patient is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for care of the patient. It
12/20/2023	Lynne Seabloom	The language requiring a verbal report and receiving staff signature are problematice when ED staff refuse to accept report and refuse to sign the record, holding EMS staff hostage caring for the hospital's patient. There should be some exception language if ED staff refuse to receive patients. Also it will be helpful to include that stable patients should not require constant EMS monitoring as they will not receive it once turnover occurs. Finally, federal law supercedes state and county regulations, and per EMTALA, the patient is the hospitals once EMS arrives.