Draft Policy Public Comments Received: 12/31 - 01/31/2025

S-883 Emergency Medical Dispatch Enhanced Care Access		
DATE	**NAME**	**PUBLIC COMMENT**
1/31/2025	Christopher Kahn	It is encouraging that the LEMSA is working to develop policies in this realm. There are some changes that would improve the usefulness and feasibility of this policy. First, as noted above, there is likely to be significant disagreement as to the regulatory reach of this policy, specifically on which programs and which agencies are or are not subject to it. Working with the regional stakeholders to clarify this as much as possible is likely to improve the acceptance and workability of this policy. III (definitions). The EMD medical director should be board certified/eligible in emergency medical services specifically, not just emergency medicine generally. General emergency medicine training makes no reference or inclusion regarding EMS dispatch methodologies. If the LEMSA wishes to include a “grandfathering” clause for a period of transition that may be appropriate. The ECAP center program manager does not need to be a nurse, nor is the “five years of recent emergency department experience” the relevant experience.

1/31/2025	Christopher Kahn (Cont.)	Nurses (like emergency medicine generalist physicians) do not receive any training in dispatch methodologies and do not have unique qualifications making them automatically suited for this role. The program manager should be an EMS clinician with relevant field EMS experience, which could include a nurse, physician, PA, NP, paramedic, and perhaps other clinicians if they have demonstrable experience providing EMS care in the field to best inform their ECAP practice. ECAP navigators, similar to ECAP center program managers, should not be defined as "typically" a nurse with five years of recent ED experience for the same reasons noted above. A seasoned paramedic or other field provider will have a much better understanding of field conditions – including urgent health care navigation – than a nurse who has only worked in the ED but not in the field as an EMS clinician. IV.C. While this may appropriate for now, there are times when dispatching emergency resources simply because they are demanded is an inappropriate response. We encourage the LEMSA to be even more forward-looking and to consider modifying or removing this requirement.
1/31/2025	Christopher Kahn (Cont.)	There is no California law or regulation entitling all 911 callers to receive an emergency ambulance response. V.A.5. What is the purpose of these questionnaires? Are there specific items the LEMSA would like asked? VI (QA/QI components). The numbering is incorrect in this section. VI.B.10 (likely meant to be numbered as VI.B.5). It may not be possible to determine with 100% reliance/accuracy whether patients who are referred to a clinic, urgent care, or other destination arrive at that destination without a requirement for those facilities to report back to the ECAP. Patients who are managed with responses such as calling in a medication refill will almost certainly not cause the pharmacy to either notify the ECAP that the prescription was successfully filled or to respond to the ECAP if asked whether the prescription was filled. Further, determining whether "all medical needs were met" is not a question that can be honestly answered by anybody other than the care provider and the patient, making it impossible for any ECAP to meet this requirement, particularly without some reasonable limitation on the definition of "all medical needs".

1/31/2025	Christopher Kahn (Cont.)	It would be astonishing to require an ECAP to ensure that a patient's overdue screening colonoscopy was scheduled, performed, and that any biopsy results were appropriately addressed when the patient's call was related to a stubbed toe, yet that would fall squarely in this overly broad definition. VII (procedures). VII.A.2 describes a 12-month probationary period, but VII.B describes a 6-month probationary period. This is inconsistent. VII.A.3. This requirement, if taken literally, is both exceedingly restrictive/unworkable and contrary to patient safety protection. For example, if a determinant was found by the ECAP to include an unacceptably high number of patients requiring secondary transport to an emergency department, the ECAP would not be allowed to stop including those patients in their program until that change was approved by the LEMSA medical director. Is it the intent of the LEMSA to specifically approve every combination of determinant (including suffixes), caller party, time of day, health network, and all other factors that might be considered in whether a patient could qualify for inclusion in an ECAP? Does the LEMSA have an evidence base informing these decisions that could be made available to all agencies considering development and implementation of an ECAP? This would be the most efficient and successful approach to implementation of an ECAP.