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

S-TBD Ambulance Patient Offload Mitigation Practices		
DATE	**NAME**	**PUBLIC COMMENT**
1/8/2024	Mary Murphy	V5 subsection c : If the patient's needs are unable to be met by ED medical personnel after a 30-minute APOT , EMS personnel may continue Standing Order treatments, as needed Can you give me an example of a patient need that couldn't be met by the ED personnel?
1/8/2024	Mary Murphy	why does receiving ALS medications preclude a patient from going to the waiting room? for example a patient was experiencing nausea and received Zofran which resolved the nausea and now feels improved. Why cant that patient sit in the waiting room ?

1/8/2024	Mary Murphy	EMS Offload Monitoring Team is passing along the expense of offload delays to the agencies again and throughout the latter part of this policy it seems to be a huge part of the counties APOT plan also is there a county criteria to: Identify personnel who may be released to accept other emergency calls
1/11/2024	Jennifer Cochran	Section C-2-g ; it seems reasonable to allow for the patient to be offloaded to a waiting area if accompanied by law enforcement or PERT. Section C-2-j ; this seems a bit restrictive Section C-2-k ; "ongoing monitoring" are you implying cardiac monitoring, or just observing the patient? Section D-2 ; "on-site supervisor" - does the supervisor have to be on site? Often this would be a BC and they have response duties in their district, proposing a safety concern. Rather than deploy a "team" it seems reasonable to allow unit to unit assistance within each agency. Supervisors will be notified and coordinate this process. The plan would be communicated to the ED. Cots, chairs, wheelchairs should be the responsibility of the ED, not the transporting agencies.

1/20/2024	Nate Pearson	Please remove reference to "non-standard" offload time - see comments from S-610 Section IV Policy C. 1. (e) Complete a transfer of care within 30 minutes of patient arrival in ED (This language should apply to both hospitals and EMS staff. Under C.2.(e) it is attributed to EMS crews when they do not control this timeline, it is the hospitals responsibility to receive care within 30 minutes. EMS crews are not delay the transfer so the time obligation should be placed on both. C.5.(b) - suggest change to "request assistance with patient offload delays" Offload delays are not always throughput related. This may be related to staffing or other complications. Section V A.5.(a) - suggest change "not authorized by the State of California AND the County of San Diego". OR would imply that if the treatment is in the CA scope but not the SD protocol it would be approved once in the hospital for EMS personnel to monitor. Section 6 C.2(j) - Remove or modify to accommodate comfort care (ie -zofran) for offload to waiting area. D.2 - Revise language to remove "supervisor". For Fire based EMS systems this would indicate an Engine/Truck Captain (the standard FD field level supervisor), this is not realistic and will not help. There are currently patient consolidation practices in place throughout the county that transfer and consolidate patients to the same or higher level of care within an agency on offload delay. Consider "EMS agencies anticipating utilization of an EMS Offload Monitoring Team shall determine and document in the ePCR an on-site team leader, that is equally qualified or higher as the most advanced level of care being provided, (e.g. senior paramedic from the provider agency) to:.....

1/27/2024	Jon Jordan	It would be helpful if there were an option for a unit-to-unit transfer during APOD. The proposed policy has the EMS offload Monitoring Team Option but no option for one ambulance to transfer to another ambulance. This option would allow one ambulance to remain on an APOD and allow the other ambulances the ability to return to service. This could be used if an agency has multiple ambulances on APOD at the same hospital.
1/27/2024	Jon Jordan	For the EMS Offload Monitoring Team Option, allowing the supervisor to be off-site might be more reasonable. It may be challenging for EMS agencies to deploy an on-site supervisor every time. Allowing off-site supervision will still ensure the monitoring team communicates with a supervisor but is not as limiting as requiring them to be on-site.
2/3/2024	Brian Covell	" S-TBD APOT Pg.5/VI. APOD Mitigation/C. Offload to Waiting/2. Criteria/b. Possible typo in age line - if under vs over 18 years of age. Pg.6/D. EMS Offload/2.e. [supervisor to] Ensure patient and crew accountability, in conjunction with ED medical personnel - Unclear what this means, possible incomplete/fragmented item? Pg.7/D./5.a (addition?) EMS personnel shall provide a verbal patient report and if available, a written EMS report to ED medical personnel with TOC. This is to address issues with incomplete info sharing when care transferred from primary to secondary EMS personnel and then to ED personnel. Or maybe it could be related to the above D.2.e. line? TY! "

2/4/2024	Christopher Kahn	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 S-610 IV. C. and that definition does not match the definition here. It may be preferable to delete the definition here and rely on the other policy section instead. Finally, the APOT Standard definition does not match the definition in the proposed revision to S-610, and should be revised to match that definition (subject to the caveat above on correcting the erroneous language on “assuming responsibility for care”).

2/4/2024	Christopher Kahn (Cont.)	There are other definition mismatches as well. IV There are mismatches between the proposed policy steps here and the proposed revisions in S-610. The policy as proposed here is generally preferable, as it allows slightly more flexibility in who must call/notify whom at what time, but as noted in the comments made on S-610 the goal should be awareness rather than absolute adherence to a list of phone calls and mandatory language that will produce "alarm fatigue" and decrease the effectiveness of this policy. IV. C. 1 Please add "and" after each part, and add a section "e", reading, "Complete transfer of care within 30 minutes." This matches the requirement in the next item for EMS personnel to complete transfer of care within 30 minutes. V. A. 1. b While the intent is laudable – ensuring that patients moved off of EMS gurneys are not later moved back onto the EMS gurney to wait further – there are other transfer of care elements defined in S-610 that also need to be completed. V. A. 5. a This does not rule out these medications/procedures being performed on the EMS gurney. It merely states that EMS personnel do not have responsibility for those medications/procedures (which is already clearly stated in federal law). This clarification is definitely appreciated, but does not address a critical patient-centered issue: If medications/procedures are administered but the hospital will not accept transfer of care, then who is monitoring the patient? While EMS personnel cannot be expected to be aware of all possible adverse effects of items outside of their scope, what happens to a patient who receives such a treatment but is not transferred to ED personnel who then has some kind of adverse effect?

2/4/2024	Christopher Kahn (Cont.)	Who will provide treatment for this adverse effect if needed, particularly if the treatment requires a base hospital order? Base hospitals almost uniformly will not 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. If EMS personnel do not have responsibility (and/or standing order authority) for treatment, ED personnel decline to provide treatment or accept transfer of care, and base hospital personnel decline to provide assistance, how does the patient get the treatment they need? This is unfortunately not a hypothetical scenario. Today, in our region, patients are left stranded, in multiple cases literally screaming in pain for hours, with the EMS provider prohibited by policy from providing patient care. This will continue to happen even if this policy is implemented as drafted, as repeat doses of analgesia often require a base hospital order that will be unobtainable (referencing V. A. 5. c in this proposed policy). In other LEMSAs, patients have died whileawaiting ambulance offload. While idealistic, it is not realistic to expect that ED personnel will have the capacity to provide needed treatment to all patients awaiting offload. It unfortunately may be necessary to allow EMS personnel to provide BHO treatments as well (similar to the allowances under P-405) during periods of APOD; while it should not be their responsibility, the EMS team also should not be forced to let their patients suffer due to significant failures of our health care system. If the EMS team is required to provide additional treatments, each of these should be reported under proposed policy S-610 F. 2, “occurrence of APOD with the patient decompensating or worsening in condition”, and those reports should be publicly available redacted of protected health information but NOT redacted of the location (i.e., specific hospital) where the incident(s) occurred.

2/4/2024	Christopher Kahn (Cont.)	V. A. 5. c SO treatments do not allow for ongoing administration of analgesics beyond a few doses, administration of push-dose epinephrine for hypotension, and many other important interventions. What should EMS personnel do when a patient requires an intervention that is not standing order but the ED does not provide that intervention? Does the base hospital have a role in this situation? If so, what should EMS personnel do if they are not able to reach that base hospital? Please refer to the comment above on V. A. 5. a for more detail. Also, this is another example of asking hospitals to investigate themselves for potential QA issues, which is a clear conflict of interest. VI. C. 1 (and VI. C. 2. a) Why is this limited to instances of APOD (APOT over 30 minutes)? This should be an option for all patients who do not have their care immediately transferred to the ED. Requiring an EMS crew to wait 28 minutes but not 30 minutes for the same stable patient is arbitrary and will still contribute to system stress and decreased EMS unit availability. VI. C. 1-2 If ED personnel decline an attempted transfer of care for patients who “shall” be offloaded into waiting areas, what steps should EMS providers take? They will either be violating ED personnel direction by offloading the patient or violating LEMSA policy by not offloading the patient. Additionally, the current language suggests that EMS providers and ED personnel must *independently* confirm that all the criteria in VI. C. 2 are met, which in turn means that when ED personnel are too busy to provide their independent confirmation then this option is not available – just when it is most needed. VI. C. 2. d. 4 Since it is acceptable to offload patients with limited mobility that can safely sit in a wheelchair, as noted in the following item, how does the LEMSA propose to check an exertional pulse oximetry measurement on such patients as required in this item

2/4/2024	Christopher Kahn (Cont.)	(normally done by ambulating the patient)? VI. C. 2. e Who determines if hospital staff are “available”, and how is this determination made? VI. D Does this proposed policy violate California Code of Regulations §100146, “Scope of Practice of Paramedic”? Their scope only allows them to provide patient care in a hospital in the following circumstances: 1) As part of his/her training or continuing education under the direct supervision of a physician, registered nurse, or physician assistant; and 2) While working in a small and rural hospital pursuant to HSC 1797.195. Monitoring patients in an urban/suburban ED – for that matter, even providing treatment to patients on EMS gurneys during periods of APOD as described in Section V of this proposed policy – does not appear to fall within either of those two circumstances allowed by regulation. California Code of Regulations 100063, “Scope of Practice of Emergency Medical Technician”, contains similar limitations that may conflict with this proposed policy. VI. D Why is the EMS provider agency required to authorize placement of cots, chairs, and/or wheelchairs (item 2.g) when the equipment is provided by the receiving ED (item 4)? If the equipment is provided by the receiving ED (item 4), why does item 4.a refer to agency-owned equipment? Further, if the patient can be offloaded to ED-owned equipment, why can’t transfer of care be completed at that time? As a feasibility note, hospitals have generally been reluctant to store agency-owned equipment on their premises, having previously reported concerns on lack of storage space and potential for liability should the equipment be lost, broken, or misused. VI. D If a patient decides to change their mind during APOD and leave against medical advice, how should EMS personnel manage this?

2/4/2024	Christopher Kahn (Cont.)	They will not be able to contact a base hospital for advice, as base hospitals decline any responsibility for providing orders or medical direction for patients already at receiving facilities. However, Policy S-412 mandates that EMS personnel contact the base hospital for almost all AMAs. The EDs will almost certainly state they never “assumed responsibility” for the patient (contrary to federal law) and will likely refuse to be involved in an AMA discussion. However, hospitals have previously – despite not having accepted transfer of care of the involved patient – reported EMS providers in this exact position to the LEMSA for “substandard care” and “patient abandonment”, with those personnel having subsequently been admonished by the LEMSA at the Prehospital Audit Committee. It is reasonable to project that EMS personnel with a patient wishing to leave AMA during APOD will not be supported by ED personnel, base hospitals, or LEMSA policy as currently extant and proposed. One potential solution would be to require that EMS personnel notify ED personnel of patients wishing to leave AMA, but then clearly state that it is the sole responsibility of ED personnel – again, consistent with federal law – to evaluate the patient, make any determinations of decision-making capacity that are relevant, explain the risks to the patient, provide a plan for follow-up care including prescriptions and referrals if appropriate and accepted by the patient, and ensure that any requirements related to safe discharge of the patient are met. This would be the case even if the patient chooses to leave while EMS personnel are notifying ED staff, as there should be no expectation or requirement that EMS personnel restrain a patient who wishes to leave AMA solely to provide time for ED personnel to fulfill their obligations to the patient.