Attachment A

COUNTY OF LOS ANGELES
BOARD OF SUPERVISORS

KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET
LOS ANGELES, CALIFORNIA 90012

January 18, 2018

The Honorable Edmund G. Brown, Jr.
Governor, State of California
State Capitol
Sacramento, CA 95814

Dear Governor Brown:

We are writing to respectfully urge you to support AB 1795 by Assembly Member Mike Gipson, which would allow local Emergency Medical Services agencies to submit a plan to the California Emergency Medical Services Authority to allow for the transport of patients to a community care facility based on a determination that there is no need for emergency medical treatment. This important bill is sponsored by Los Angeles County and co-sponsored by the California Hospital Association.

Current law requires paramedics responding to emergency 911 calls to transport all patients who show signs of a non-emergent mental health condition and/or inebriation to an acute care emergency department (ED), even though there might be more appropriate levels of care. While mental health urgent care and sobering centers can accept walk-ins and referrals made from law enforcement, hospitals, and other health care providers, paramedic ambulances are not allowed to transport patients to these alternative community care facilities.

This measure would help reduce the transport of patients who could be better served in a community care facility to EDs, which often results in overcrowding and strains on medical staff and financial resources, and may prevent EDs from treating patients in critical need in a timely manner or at the appropriate level of care. Mental health urgent care and sobering centers can offer inebriated patients or those experiencing a non-emergent mental health condition with more timely access to specialized care, and to connect them with supportive services.

We respectfully urge you to sign AB 1795 measure when it reaches your desk. Thank you for your consideration of this important matter.

Sincerely,

SHEILA KUEHL
Chair of the Board
Supervisor, Third District

HILDA L. SOLIS
Supervisor, First District

MARK RIDLEY-THOMAS
Supervisor, Second District

JANICE HAHN
Supervisor, Fourth District

KATHRYN BARGER
Supervisor, Fifth District

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CALIFORNIA AMBULANCE ASSOCIATION

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The Honorable Mike A. Gipson, Assembly Member
Capitol Office, Room 3173
Sacramento, CA 94249

February 5, 2018

AB 1795 (Gipson) – SUPPORT, IF AMENDED

Dear Assembly Member Gipson:

The California Ambulance Association (CAA) represents providers of emergency and non-emergency medically necessary transportation services throughout the State of California. Since its founding in 1948, the objectives of the CAA have been to promote better patient care, develop the highest level of ambulance services, cooperate with organizations providing medical care to the citizens of California, seek to improve standards for personnel and equipment, and encourage the highest standards of ethics and conduct. It is with these values in mind that we support AB 1795, if amended. Several of our members' companies are directly involved in the delivery of community paramedic services though the pilot projects.

The concept of transporting a patient by ambulance to a psychiatric facility or sobering center that is best capable of meeting his/her medical needs, the first time, instead of always transporting to an acute care hospital emergency department is an important principle. Under strict and appropriate protocols, with destination decisions made by highly trained and skilled paramedics, in a program overseen with proper medical control by the local EMS medical director, the concept proposed by AB 1795 is worthy and sound. Medical care can be improved and simultaneously provided at less cost with the implementation of this bill, as confirmed by OSHPD's studies. However, the concept and implementation is not viable nor sustainable unless the bill addresses and specifically authorizes reimbursement for the paramedic and ambulance services being provided.

The CAA supports the programs to be authorized by this proposed law, but we can only support this bill if it is amended to include provisions for reimbursement of the services. Under existing law and regulations, ambulances must transport patients to acute care hospitals to qualify for payment for ambulance service. Transports to alternate destinations such as psychiatric facilities or sobering centers are typically not eligible for reimbursement. These transports being conducted as part of the pilot programs are generally conducted for free. This is not sustainable.

Therefore, the CAA supports AB 1795 contingent upon its amendment to address compensation for the services provided. In order to make the concept of alternate destinations viable and sustainable for the long-term, it must be made clear in this bill that ambulance transports to psychiatric facilities or sobering centers will be paid by State programs (i.e. Medi-Cal, workers compensation, prison contracts, etc.) and all insurance plans and managed care plans at the same rate paid for ambulance transport to an acute care hospital.

Sincerely,

Ross Elliott,
Executive Director

cc: Chris Micheli, Aprea & Micheli

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CALIFORNIA ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

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January 24, 2018

The Honorable Mike Gipson
California State Assembly
State Capitol Building, Room 3173
Sacramento, CA 95814

RE: AB 1795 (Gipson) – Oppose Unless Amended – Introduced January 9, 2018

Dear Assembly Member Gipson:

The California Chapter of the American College of Emergency Physicians (California ACEP), representing emergency physicians treating California's patients in more than 14.5 million emergency department visits annually, **must respectfully oppose your AB 1795, unless it is amended.**

The Health Workforce Pilot Projects Program was enacted by the Legislature to test, demonstrate, and evaluate new or expanded roles for healthcare professionals, or new healthcare delivery alternatives, before changes in licensing laws are made by the Legislature. Specifically, Health and Safety Code Section 128125 states, "The Legislature also finds that large sums of public and private funds are being spent to finance health workforce innovation projects, and that the activities of some of these projects exceed the limitations of state law. These projects may jeopardize the public safety and the careers of persons who are trained in them. It is the intent of the Legislature to establish the accountability of health workforce innovation projects to the requirements of the public health, safety, and welfare, and the career viability of persons trained in these programs."

In 2014 EMSA submitted Health Workforce Pilot Project Application #173 to the Office of Statewide Health Planning and Development (OSPHD) in order to test expansion of scope of practice for EMTs in a variety of settings. The application, which sought to test 13 different pilots, was approved and programs began implementation in late 2015. AB 1795 seeks to permanently expand EMT scope of practice to authorize the transport of patients directly to a mental health urgent care center or to a sobering center, rather than to an emergency department (ED) as currently required by law. As currently drafted, we must oppose the bill unless it is amended to protect patient safety.

Scope Expansion Authorization Must Replicate Pilots Shown to be Safe for Patients

We have significant concern about EMTs' ability to safely triage patients in the field and appropriately determine their medical condition. A 2013 study in *JAMA* found a nearly 90% overlap between symptoms of emergencies and non-emergencies.[1] As reported in *Annals of Emergency Medicine* in 2014[2] "Nearly all

[1] Raven MC, Lowe RA, Maselli J, Hsia RY. Comparison of presenting complaint vs discharge diagnosis for identifying "nonemergency" emergency department visits. JAMA 2013 309(11):1145-53.
[2] Morganti KG, Alpert A, Margolis G, Wasserman J, Kellermann AL. Should payment policy be changed to allow a wider range of EMS transport options? Annals of Emergency Medicine 2014 May; 63(5):615-626.e5.

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the studies published to date have found significant rates of under triage by EMS Personnel…" These investigators identified 13 research studies examining the ability of paramedics and EMTs to determine the need for transport to an ED. Included among these studies was one describing a cohort of under triaged patients, whom EMS professionals felt did not require transport to EDs for care, who subsequently required admission to the hospital (18%), including a subset requiring admission to the Intensive Care Unit (6%). The safety-net for this high level of severe under-triage is the ED.

This under-triage concern is exacerbated in patients with mental illness. Patients with mental illness have a higher rate of other chronic conditions than the rest of the population.

- Patients treated for schizophrenia or bipolar disorder were 3x more likely to have 3 or more chronic medical conditions than the rest of the population[3]
- More than half of Medicaid enrollees with mental health conditions also had diabetes, cardiovascular disease, or pulmonary disease.[4]
- According to Medicare and Medicaid data, 75% of patients with mental health conditions also had a heart condition, 42% had a musculoskeletal disorder, and 36% had diabetes.[4] (CMS)

A recent pilot in Stanislaus County indicates the potential for safe transport of patients to an Acute Psychiatric Hospital rather than an ED. That pilot appears to protect patient safety because of the 140 hours of additional training required of the Community Paramedics, the protocols as revised during study, the agreements entered into with law enforcement, the agreements entered into with the destination, and a variety of other components. None of these components are required by AB 1795. Instead, AB 1795 allows each LEMSA to establish their own protocols, training, processes, and destinations. This bill authorizes 58 different, untested, permanent pilot programs.

In contrast, the concept of diverting patients away from the ED to a sobering center has only been added to Health Workforce Pilot Project #173 in February 2017. There has been little data collected to date, yet a preliminary review of the data indicates they are not collecting the number of people turned away by the center and sent to the ED – an important data point for determining the ability of EMTs to safely screen patients in the field.

Destinations must be Defined and Licensed

A critical component of ensuring a patient can safely be transported to an alternate destination, is to ensure that the destination itself is safe. However, there is no definition in California law for a sobering center. There are no staffing standards, no facility regulations, and no licensing or inspection requirements. Patient safety cannot be assured without standards. A recent series of articles in the OC Register has exposed high death rates at regulated, non-medical (no

[3] Druss, B. G., & Reisinger Walker, E. (2011). Mental disorders and medical comorbidity. Robert Wood Johnson Foundation.
[4] (2014). *Physical and Mental Health Condition Prevalence and Comorbidity Among Fee-for-Service Medicare-Medicaid Enrollees.* Centers for Medicare and Medicaid Services.

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physician) rehab facilities: https://www.ocregister.com/2017/12/17/detox-can-end-in-death-at-some-non-medical-southern-california-rehabs/, https://www.ocregister.com/2017/05/21/how-some-southern-california-drug-rehab-centers-exploit-addiction/. AB 1795 must contain licensing and regulatory standards for sobering centers.

Patients with mental illness who participated in Health Workforce Pilot Project #173 were transported to an Acute Psychiatric Hospital, as defined in Health and Safety Code Section 1250(b). AB 1795 instead allows EMTs to transport patients to a mental health urgent care center. Again, there is no definition of "mental health urgent care center" in law. AB 1795 should not allow transport of patients to a destination which is unregulated and unlicensed. Similarly, there is no data to indicate whether patients can safely be transported by EMTs to "mental health urgent care centers." The Health Workforce Pilot Projects Program was enacted by the Legislature to test the safety of scope expansion before it was embarked upon statewide, yet the concept in AB 1795 has not been tested. This bill should be amended to specify that patients will only be transported to Acute Psychiatric Hospitals, as tested in the Stanislaus County Pilot.

EMTALA Non-Discrimination Protections Must be Included

As required by Health and Safety Code Section 1317, EDs may not discriminate against patients in the provision of care: "In no event shall the provision of emergency services and care be based upon, or affected by, the person's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any other characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient."

A similar protection must be included in AB 1795 to ensure that the decision of who to transport to an alternate destination is not based on discriminatory reasons. The decision to transport a patient to a sobering center or psychiatric hospital should be based exclusively on the patient's medical condition, not on race, insurance status, economic status, or any other protected class.

Bill Should Require Data Collection and Contain A Two-Year Sunset

While it is critical that whatever is authorized by AB 1795 replicate the components piloted in Stanislaus County, no other program can be exactly the same. The individuals, both patients and paramedics, distances to facilities, availability of bed space, etc., will all vary by jurisdiction. LEMSAs should be required to collect and report the data to evaluate safety of all programs.

For example, the project must assess the following for those patients transported to an alternate destination:

1. How many patients could be seen in a timely fashion at an alternate destination?
2. How many patients were referred to an ED or other specialty from the alternate destination?
3. How many patients were referred emergently by 911 ambulances?

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4. How many patients deteriorated and required further health care 3 days, 7 days, and 30 days post intervention?
5. Was the overall care provided, including all follow-up and complications, non-inferior (in terms of safety and patient outcomes) compared to standard care that begins with EMS transport to EDs?

Additionally, the implementing LEMSAs should assess the impact on other patients currently being treated by EMS that are not in the intervention group. Because it may take more time per call for the patients in the intervention group, the paramedics and ambulances may have less availability to respond to emergencies. The proposal has no evaluation mechanism to assess unintended, adverse consequences on patients requiring EMS services whose care is delayed due to increased duties and additional time per call required of community paramedics.

This data should be reported to the Legislature and AB 1795 should sunset in two years to allow for evaluation of these reports.

For these reasons, California ACEP must oppose AB 1795 unless it is amended to address our concerns. If you have any questions, please contact our office at (916) 325-5455.

Respectfully,

ELENA LOPEZ-GUSMAN
Executive Director