EMERGENCY MEDICAL CARE COMMITTEE
CONTRA COSTA COUNTY

Wednesday, March 12, 2014
4:00 – 5:30 p.m.
Contra Costa County Schools Insurance Group Conference Room
550 Ellinwood Way, Pleasant Hill, CA 94523

Agenda

4:00 p.m. 1. Introduction of Members and Guests

4:05 2. Approval of Minutes from December 18, 2013

4:06 3. Cardiac Arrest Recognition
Pam Dodson, Contra Costa EMS

4:07 4. Comments from the Public
Members of the public may speak up to 3 minutes each on matters either on or not on this agenda.

4:10 5. Chair’s Report

4:13 6. Members’ Reports

4:16 7. Fire Chiefs’ Report
- Fire Service Study, Chief Carman
- East Contra Costa Fire Department, Chief Henderson

4:21 8. Annual QI Report
Craig Stroup, Mia Fairbanks, Joseph Barger - Contra Costa EMS

4:30 9. Update on Doctors Medical Center
Dawn Gideon, President and CEO - Doctors Medical Center, San Pablo

4:45 10. Ambulance Ordinance Revision Update
Bruce Kenagy - Contra Costa EMS

4:50 11. Hospital Offload Times
Pat Frost, EMS Director - Contra Costa EMS

5:00 12. EMS Director’s Report
Pat Frost, EMS Director – Contra Costa EMS

5:15 13. EMS Medical Director’s Report
Joseph Barger, MD, EMS Medical Director – Contra Costa EMS


5:30 15. Adjournment

Reasonable accommodations can be made for persons with disabilities planning to attend the EMCC Meeting by contacting EMS Staff at least 24 hours in advance at (925) 646-4690.

Any disclosable public records related to an item on a regular meeting agenda and distributed by the County to a majority of members of the Emergency Medical Care Committee less than 96 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Suite 126, Martinez during normal business hours.
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March 1, 2014

In This Issue...

NASEMSO NEWS
1. NASEMSO Congratulates Dr. Robert Bass on Receiving 2014 JEMS Lifetime Achievement Award
2. Final Draft Model Interstate Compact for EMS Personnel Licensure for State Adoption Now Available
3. NASEMSO Offers Compilation of Blast Injury Training Resources
4. NASEMSO Poster Competition Slated for 2014 Annual Meeting

FOR THE STATES
5. New Document Focuses on Local Health Departments Working With the NIOSH HHE Program

AIR MEDICAL
6. FAA Final Rule Addresses Helicopter Operations for Air Ambulance, Commercial, and Part 91
7. NTSB Issues Two Safety Alerts Focusing on Improving Helicopter Safety

COMMUNICATIONS
8. DHS S&T Releases Key Findings Related to Wireless Emergency Alerts

DOMESTIC PREPAREDNESS
9. FEMA Releases Resource Typing Library Tool
10. FEMA Seeks Applicants for National Advisory Committee
12. CMS Extends Deadline for Comments
14. SAMHSA Behavioral Health Disaster Response Mobile App
15. NTSB Offers Training Related to Transportation Accidents

EDUCATION AGENDA
16. NASEMSO Offers New Resources to Assist Implementation Efforts
17. New Standards Interpretations Adopted by CoAEMSP Board of Directors
18. CAAHEP Standards Under Revision
19. CoAEMSP and NAEMSE Offer “Evaluating Student Competency Workshop”--March 7-8 in New Orleans
**HITS**

20. NIOSH Invites Comments on Center for Motor Vehicle Safety Strategic Plan

**FEDERAL PARTNERS**

21. ECCC Launches EMS Collaboration Community on IdeaScale
22. AHRQ Study Finds Use of Contact Precautions in Emergency Departments Varies
23. 2014 GAO Report Highlights Drug Shortages
24. IOM Committee on DHS Workforce Resilience Releases Follow-up Report
25. Etomidate Injection Recall Announced by Manufacturer
26. Philips Respironics Initiates Recalls Trilogy Ventilator
27. FY 2013 Fire Prevention and Safety Grants Application Period Now Open

**INDUSTRY NEWS**

28. ACEP Reports Nation Receives a D+ in Emergency Care
29. National Organizations Promote Guidelines for Geriatric Emergency Departments

**UPCOMING EVENTS**

***STATEWIDE EMS CONFERENCES***

***National Conferences and Special Meetings***

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1. **NASEMSO Congratulates Dr. Robert Bass on Receiving 2014 JEMS Lifetime Achievement Award**
   
   The James O. Page Charitable Foundation and JEMS, the Journal of Emergency Medical Services, named Dr. Robert Bass, as the 2014 recipient of a Lifetime Achievement Award for Outstanding Service in Emergency Medical Services. The Lifetime Achievement Award honors an individual who has made an extraordinary contribution to the advancement of EMS over the course of a career. Dr. Bass was honored for his tireless work as an advocate for the needs of EMS professionals and development of EMS and trauma systems excellence. A NASEMSO past president, as well as past president for the National Association of EMS Physicians (NAEMSP), and former chair of the American College of Emergency Physicians EMS Committee, Bass was the only non-federal member serving on the Federal Interagency Committee on EMS (FICEMS). He recently retired as the executive director of the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and has been involved in EMS issues on many levels for more than three decades. Dr. Bass received the Award at the EMS Today Conference in Washington, D.C., on February 6, 2014. Congratulations, Bob!!

2. **Final Draft Model Interstate Compact for EMS Personnel Licensure for State Adoption Now Available**
   
   Over the past several months, NASEMSO engaged a National Advisory Panel with representatives of 23 national organizations, industry stakeholders, and guidance from the Council of State Governments and Vedder Price to develop a model interstate compact for states’ legislative use to solve the problem associated with day-to-day emergency deployment of EMS personnel across state boundaries. The final draft has been delivered to the Department of Homeland Security and rollout has commenced throughout the EMS community. [For more information...](#)
3. NASEMSO Offers Compilation of Blast Injury Training Resources

The National Association of State EMS Officials (NASEMSO) Education and Professional Standards Council, Medical Directors Council, and Domestic Preparedness Committee has prepared a compilation of EMS training resources on bombings and blast injuries available free of charge through the Terrorism Injuries: Information, Dissemination and Exchange (TIIDE) partnership, the Firefighters Support Foundation, the International Association of Arson Investigators, and others. Several of these resources can be immediately used to support just in time blast injury and public health preparedness training efforts to prepare EMS responders at the state, regional, and local levels. NASEMSO will be utilizing this model to assist state EMS offices with future training needs. For more information...

4. NASEMSO Poster Competition Slated for 2014 Annual Meeting

Interested persons are reminded that NASEMSO is conducting a poster competition in conjunction with the NASEMSO Annual Meeting in Cleveland, OH October 6-10, 2014. The goal of the NASEMSO-sponsored poster competition is to foster and develop system research and performance assessment and improvement skills in State offices of EMS and trauma. Download the Call for Posters here for complete details. Deadline for abstracts is Aug. 31, 2014. Questions should be directed to Terry Mullins, terry.mullins@azdhs.gov.

5. New Document Focuses on Local Health Departments Working With the NIOSH HHE Program

Local health departments often are asked by the public, a local employer, or a local government official to look into a health problem in someone’s workplace. Some have the resources to do this, others do not. A new NIOSH brochure for local health departments describes the NIOSH Health Hazard Evaluation Program and how local health departments can use its services to help meet their public health mission. The brochure can be downloaded at http://www.cdc.gov/niosh/docs/2014-113/.

6. FAA Final Rule Addresses Helicopter Operations for Air Ambulance, Commercial, and Part 91

The U.S. Department of Transportation’s Federal Aviation Administration (FAA) has issued a final rule that requires helicopter operators, including air ambulances, to have stricter flight rules and procedures, improved communications, training, and additional on-board safety equipment. The rule represents the most significant improvements to helicopter safety in decades and responds to government’s and industry’s concern over continued risk in helicopter operations. All U.S. helicopter operators, including air ambulances, are required to use stricter flying procedures in bad weather. This will provide a greater margin of safety by reducing the probability of collisions with terrain, obstacles or other aircraft. Within 60 days, all operators will be required to use enhanced procedures for flying in challenging weather, at night, and when landing in remote locations. Within three years, helicopter air ambulances must use the latest on-board technology and equipment to avoid terrain and obstacles, and within four years, they must be equipped with flight data monitoring systems. Under the new rule, all Part 135 helicopter operators are required to:

- Equip their helicopters with radio altimeters.
- Have occupants wear life preservers and equip helicopters with a 406 MHz Emergency Locator Transmitter (ELT) when a helicopter is operated beyond power-off glide distance from the shore.
- Use higher weather minimums when identifying an alternate airport in a flight plan.
- Require that pilots are tested to handle flat-light, whiteout, and brownout conditions and demonstrate competency in recovery from an inadvertent encounter with instrument meteorological conditions.

In addition, under the new rule, all air ambulance operators are required to:

- Equip with Helicopter Terrain Awareness and Warning Systems (HTAWS).
- Equip with a flight data monitoring system within four years.
Establish operations control centers if they are certificate holders with 10 or more helicopter air ambulances.
Institute pre-flight risk-analysis programs.
Ensure their pilots in command hold an instrument rating.
Ensure pilots identify and document the highest obstacle along the planned route before departure.
Comply with Visual Flight Rules (VFR) weather minimums, Instrument Flight Rules (IFR) operations at airports/heliports without weather reporting, procedures for VFR approaches, and VFR flight planning.
Conduct the flight using Part 135 weather requirements and flight crew time limitation and rest requirements when medical personnel are on board.
Conduct safety briefings or training for medical personnel.

This rule is effective April 22, 2014. For more information...

7. NTSB Issues Two Safety Alerts Focusing on Improving Helicopter Safety
The National Transportation Safety Board recently issued two Safety Alerts highlighting the importance of proper maintenance and simulator training as critical ways to improve helicopter safety. This year, helicopter safety was added to the NTSB's Most Wanted List of Safety Improvements. In the past decade, over 1,500 accidents have occurred involving helicopters used as air ambulances, for search and rescue missions, commercial helicopter operations such as tour flights, and instructional operations. During that same time, the NTSB issued over 200 safety recommendations on issues related to helicopter investigations. The two Safety Alerts are: • Safety Through Helicopter Simulators • Helicopter Safety Starts in the Hangar. Accompanying the safety alerts are two videos, produced in conjunction with Helicopter Association International. Featured in the videos are NTSB investigators sharing their perspectives about the lessons learned from helicopter accident investigations.

The two helicopter Safety Alerts and the two videos, are available at:
http://www.ntsb.gov/safety/safety_alerts.html

8. DHS S&T Releases Key Findings Related to Wireless Emergency Alerts
The Department of Homeland Security’s (DHS) Science and Technology Directorate (S&T) has announced the release of a report entitled: Wireless Emergency Alerts (WEA) Mobile Penetration Strategy. Launched in 2012, WEA provides a national capability to deliver alert messages directly to the public via mobile devices in a specific affected geographic region. The Mobile Penetration Strategy is directed toward decision makers throughout all levels of government, commercial mobile service providers (CMSPs) and mobile wireless device manufacturers.

The report characterizes WEA coverage across the nation, identifies barriers to adoption, and suggests options for improving coverage. It provides recommendations for each group on how to improve the utilization of WEA nationwide, maximize public awareness and user acceptance. During the development of the Mobile Penetration Strategy, researchers solicited information from a wide range of commercial and government sources to estimate WEA penetration and coverage geographically, demographically, by wireless carrier coverage, and by mobile device populations. Researchers also conducted interviews with officials in the public and private sectors throughout the country. Research conducted by the National Defense Research Institute found that: most state emergency managers plan to use WEA; CMSPs can provide WEA to almost all of the United States; and that demographic and other factors affect WEA use. The WEA Mobile Penetration Strategy can be downloaded from www.firstresponder.gov at http://go.usa.gov/BRn4.
9. FEMA Releases Resource Typing Library Tool

The Resource Typing Library Tool (RTLT) is an online catalogue of national resource typing definitions and job titles/position qualifications. The Federal Emergency Management Agency (FEMA) National Integration Center (NIC) provides the RTLT to support the implementation of the National Preparedness System. Nationally typed resources support a common language for the mobilization of resources (equipment, teams, units, and personnel) prior to, during, and after major incidents. Resource users at all levels use these definitions to identify and inventory resources for capability estimation, planning, and for mobilization during mutual aid efforts. Nationally typed resources represent the minimum criteria for the associated component and capability. Definitions and job titles/position qualifications are easily searchable and discoverable through the RTLT. They can be downloaded in PDF format or directly used by third party software applications using the available Web Services application-programming interface (API). FEMA is hosting a series of webinars to introduce the RTLT and the latest version of the Incident Response Inventory System (IRIS). All webinars will be open to the whole community, which includes—individuals (including those with disabilities and others with access and functional needs), businesses and nonprofits, faith-based and community groups, schools, and all levels of government. These webinars will provide an overview on how to navigate the RTLT and its use in inventorying critical resources. Each webinar will cover the same information. Advance registration is required due to space limitations. The (webinar) agenda will cover topics such as:

- Overview of National Preparedness Efforts
- How RTLT and IRIS support Resource Management
- Introduction to the Resource Typing Library Tool and the Incident Resource Inventory System
- Demonstration of RTLT and IRIS

Registration is on a first come, first serve basis. To register, please visit [http://www.fema.gov/resource-management](http://www.fema.gov/resource-management). Special note: several of the EMS and medical resource types were revised in 2013. The RTLT contains an older (2009) version of the documents and it is anticipated the 2013 revisions will be available in the near future.

10. FEMA Seeks Applicants for National Advisory Committee

On February 18th, the Department of Homeland Security’s Federal Emergency Management Agency (FEMA) announced that it was requesting individuals who are interested in serving on the National Advisory Council (NAC) to apply for appointment. The NAC is an advisory council established to ensure effective and ongoing coordination of federal preparedness, protection, response, recovery, and mitigation for natural disasters, acts of terrorism, and other man-made disasters. The NAC advises the FEMA Administrator on all aspects of emergency management while incorporating the whole community’s input through appointed council members. The NAC consists of up to 35 members, experts and leaders in their respective fields, appointed for a three-year term by the FEMA Administrator and are composed of federal, state, tribal, local, private sector, and non-profit leaders and subject matter experts in a wide range of disciplines. The NAC will have one position open for applications and nominations in each of the following disciplines:

- Emergency Management
- Emergency Response
- Non-Elected Local Government Officials
- Elected Tribal Government Officials
- Non-Elected Tribal Government Officials
- Health Scientist
- Communications
- Infrastructure Protection
- Standards Settings and Accrediting
Individuals interested in serving on the NAC are invited to apply for appointment by submitting a Cover Letter and a Resume or Curriculum Vitae (CV) to the Office of the National Advisory Council by Friday, March 14, 2014, 11:59 p.m. EST. For more information...

Snow thaw and the potential for heavy spring rains heighten the flood risk throughout the nation in the coming months. Floods are one of the most common hazards in the United States, however not all floods are alike. Some floods develop slowly, while others such as flash floods, can develop in just a few minutes and without visible signs of rain. Additionally, floods can be local, impacting a neighborhood or community, or very large, affecting entire river basins and multiple states. Having an evacuation plan in place before a flood occurs can help avoid confusion and prevent injuries and property damage. A thorough evacuation plan should include:

- Conditions that will activate the plan
- Chain of command
- Emergency functions and who will perform them
- Specific evacuation procedures, including routes and exits
- Procedures for accounting for personnel, customers and visitors
- Equipment for personnel
- Review the plan with workers

Several online resources are available to assist agencies and individuals with flood preparedness:

- Occupational Safety and Health Administration
- Centers for Disease Control and Prevention
- Federal Emergency Management Agency
- American Red Cross

12. CMS Extends Deadline for Comments
On December 27th, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to "establish national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to ensure that they adequately plan for both natural and man-made disasters, and coordinate with federal, state, tribal, regional, and local emergency preparedness systems. It would also ensure that these providers and suppliers are adequately prepared to meet the needs of patients, residents, clients, and participants during disasters and emergency situations." CMS recently announced that it has extended the deadline for comments to March 31st (previously due February 25th). For more information...

The importance of global health security has never been clearer. New microbes are emerging and spreading, drug resistance is rising, and laboratories around the world could intentionally or unintentionally release dangerous microbes. Globalization of travel and trade increase the chance and speed of these risks spreading. To address these challenges, CDC is joining with other U.S. government agencies and global partners to advance a Global Health Security Agenda. The aim of this agenda is to accelerate progress toward a safe world and to promote global health security as an international priority to Prevent and reduce the likelihood of outbreaks – natural, accidental, or intentional; Detect threats early to save lives and; Respond rapidly and effectively using multi-sectorial, international coordination and communication.
14. SAMHSA Behavioral Health Disaster Response Mobile App
A free new behavioral health app from the Substance Abuse and Mental Health Services Administration (SAMHSA) offers first responders immediate access to field resources for aiding disaster survivors. Has the ability to search for and map behavioral health service providers in the impacted area, review emergency preparedness materials, and send resources to colleagues. For more information...

15. NTSB Offers Training Related to Transportation Accidents
The National Transportation Safety Board (NTSB) is offering two investigative courses and one focused on family assistance at the NTSB’s Training Center in Ashburn, Va., next month. Cognitive Interviewing (March 19-20) provides the foundational knowledge and skills needed to conduct interviews of participants in, and witnesses to, transportation incidents or accidents. Learn more at http://go.usa.gov/BJBP. The Transportation Disaster Response: Family Assistance course (March 25-27) was developed for commercial transportation officials, representatives of federal agencies, staff of non-governmental relief organizations and emergency managers and is instrumental in understanding how any organization involved in the accident response can most effectively support the family assistance efforts. Learn more at http://go.usa.gov/BJBG. Aircraft Accident Investigation (March 31-April 11) provides participants with a comprehensive overview of the procedures and methods used and the skills required to investigate an aircraft accident. Examples from recent NTSB investigations will be used to demonstrate particular aspects of the investigative process. Learn more at http://go.usa.gov/BJKW. Information about the NTSB Training Center, course registration information and a complete listing of all public courses offered is available at http://go.usa.gov/gfEA.

16. NASEMSO Offers New Resources to Assist Implementation Efforts
To assist state EMS officials, EMS program administrators, and others explain background and implementation progress related to the EMS Education Agenda for the Future, NASEMSO’s Implementation Team has posted a Powerpoint presentation, “2014: A New Day in EMS Education The Progress Continues” on the NASEMSO web site. It has been provided in a ppt format so that users can modify the approach to meet state and local needs. The presentation can be downloaded here. Visitors to NASEMSO’s Education Agenda web site should notice that the web site has been reorganized to provide greater access to several resources intended to support implementation efforts, hopefully making them easier to find and use.

17. New Standards Interpretations Adopted by CoAEMSP Board of Directors
During its recent meeting, the CoAEMSP Board of Directors adopted several new Interpretations for the CAAHEP Standards and Guidelines. The CoAEMSP Interpretations are NOT part of the Standards and Guidelines document and are subject to change by CoAEMSP. Questions regarding the Interpretations can be directed to the CoAEMSP Executive Office. The new Interpretations include:
- Sponsorship with regards to students in other states (Distance Education)
- Medical Director Qualifications with regards to students in other states (Distance Education)
- Hospital/Clinical/Field/Internship Affiliations
- Curriculum - Tracking
- Faculty Responsibilities
- Safeguards
Access the new interpretations here.

18. CAAHEP Standards Under Revision
The Committee on Accreditation of Educational Programs for the EMS Professions (CoAEMSP) is responsible for
developing and periodically revising the CAAHEP Standards and Guidelines in order to maintain: a) compliance with CAAHEP policy, including the Standards Template; and b) congruence between the educational preparation of students and the accepted state of practice for the discipline. CAAHEP requires the CoAEMSP to review Standards and Guidelines at least once every five (5) years and provide the CAAHEP Board of Directors with a written report on the outcome of review. The current Standards were last approved by CAAHEP in 2005. In 2010, with the anticipated change in the profession for programs to become accredited by January 1, 2013, CoAEMSP requested and CAAHEP granted an extension for reviewing the Standards. In 2014, with the huge influx of programs successfully brought into the accreditation system, the CoAEMSP has embarked on the revision of the CAAHEP Standards and Guidelines. On February 8, 2014, the CoAEMSP Board of Directors approved the first draft of the proposed Standards and Guidelines. The draft is being reviewed by the CAAHEP Standards Committee for its formal review and comment. Once the draft is finalized between the CAAHEP Standards Committee and the CoAEMSP Board of Directors, the draft will be disseminated to all the 14 sponsoring organizations and communities of interest. Solicitations will be made via e-newsletters, social media announcements, the coaemsp.org website, CoAEMSP workshops, sponsoring organizations communiqués, etc. The revision process is expected to take 18-24 months.

19. CoAEMSP and NAEMSE Offer “Evaluating Student Competency Workshop”—March 7-8 in New Orleans
This 2-day workshop is designed to assist instructors in appropriately evaluating students in all domains as well as complying with CAAHEP accreditation Standards related to student evaluation. This workshop has an online pre-course component that is approximately 4 hours in length. The following will be addressed:

- Principles of Student Evaluation
- Constructing an Evaluation Strategy / Case Studies
- Written Evaluation Tools
- Item Analysis of Written Exams
- Cut Score Determination
- Developing a Portfolio Competency
- Affective Evaluation
- Simulations & Scenario Oral Evaluation

For more information...

20. NIOSH Invites Comments on Center for Motor Vehicle Safety Strategic Plan
The National Institute for Occupational Safety and Health (NIOSH) invites public comment on the draft Research and Guidance Strategic Plan 2014-2018 for the NIOSH Center for Motor Vehicle Safety. Fatality data show that across all industries, motor vehicle-related incidents are consistently the leading cause of work-related fatalities, and are the first or second leading cause in every major industry sector. The Center is the focal point for research and prevention activities within the Institute to reduce work-related motor vehicle crashes and resulting injuries. Comments on the draft strategic plan must be received no later than March 8, 2014. The request for comments is available here. For more information, contact Stephanie Pratt atSPratt@cdc.gov

21. ECCC Launches EMS Collaboration Community on IdeaScale
The HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) has created a public forum for stakeholders to discuss and share individual ideas about public health and medical emergency preparedness, response, and recovery. Taking the concept a step further, ASPR’s Emergency Care Coordination Center (ECCC) in conjunction with the Office of the National Coordinator for Health Information Technology (ONC) is pleased to announce a campaign related to Emergency Medical Services (EMS) and Health Information Technology (HIT).
ECCC hopes to connect the emergency care, EMS, and HIT communities so they can share and discuss pilot projects, concepts, and initiatives related to health information exchange. This forum also allows others to benefit from those experiences and the resulting knowledge base to avoid or overcome barriers. Support your ideas and vote of others at http://www.phegov.ideascale.com, Health Information Technology and EMS.

22. AHRQ Study Finds Use of Contact Precautions in Emergency Departments Varies
In a survey of 301 emergency departments (EDs) in 49 states, AHRQ-funded researchers found that policies on the use of contact precautions to prevent the spread of antimicrobial resistant organisms and *Clostridium difficile* varied greatly, according to a study published online February 3 in *Infection Control and Hospital Epidemiology*. The researchers found that, while most EDs require their staff to use contact precautions (wearing a gown and gloves) when treating patients suspected of having an infection caused by a specific organism, less than half of EDs require such contact precautions when treating patients with symptoms often caused by those organisms. For example, 79 percent of EDs required isolation (including contact precautions) when treating patients with suspected *methicillin-resistant Staphylococcus aureus* (MRSA), but only 49 percent required contact precautions for all patients with purulent skin infections, which are predominantly caused by community-acquired MRSA. The authors also found that most EDs had not participated in quality improvement projects related to decreasing the spread of these organisms. The authors suggest, based on the variations they observed, that ED organizations and leaders enact policies on the use of contact precautions in the ED. Select to access an abstract of the study’s findings.

23. 2014 GAO Report Highlights Drug Shortages
From prolonged duration of a disease, to permanent injury, to death, drug shortages have led to harmful patient outcomes. FDA—an agency within the Department of Health and Human Services (HHS)—works to prevent, alleviate, and resolve shortages. In 2011, Government Accountability Office (GAO) recommended that FDA should enhance its ability to respond to shortages. In 2012, the Food and Drug Administration Safety and Innovation Act (FDASIA) gave FDA new authorities to address drug shortages. FDASIA also mandated GAO to study drug shortages. In the report on which it is based, GAO focuses on (1) trends in recent drug shortages and describes what is known about their effect on patients and providers; (2) the causes of drug shortages; and (3) the progress FDA has made in addressing drug shortages. GAO analyzed data from FDA and the University of Utah Drug Information Service, which is generally regarded as the most comprehensive source of drug shortage information for the time period we reviewed. GAO interviewed officials from FDA, organizations representing providers, and drug manufacturers. GAO also reviewed the literature, relevant statutes, regulations, and documents. DRUG SHORTAGES: Threat to Public Health Persists Despite Actions to Help Maintain Product Availability GAO-14-339T is now available at http://www.gao.gov/products/GAO-14-339T.

In related news, an related hearing by the House Energy & Commerce Subcommittee on Health broadcast on C-SPAN with presentations by the GAO and FDA is available here.

24. IOM Committee on DHS Workforce Resilience Releases Follow-up Report
The more than 200,000 men and women who make up the U.S. Department of Homeland Security (DHS) are entrusted with ensuring that the United States is safe, secure, and resilient against terrorism and other hazards. DHS, in turn, is responsible for protecting the health, safety, and resilience of its employees as well as guaranteeing effective management of the medical needs of those under DHS care or custody. The DHS Office of Health Affairs (OHA) asked the Institute of Medicine (IOM) to recommend ways to better integrate occupational health functions and operational medicine throughout DHS with the necessary centralized oversight authority. Building off the foundational recommendations from a 2013 IOM report, this report concludes that although DHS has worked
diligently to overcome overarching management problems, its fragmented health protection system remains a barrier to promoting a healthy, safe, and resilient workforce. In order to ensure mission readiness and to provide DHS employees with occupational health support, strategic alignment through committed leadership, organizational and functional alignment, and management of health and safety information are needed. For more information...

25. Etomidate Injection Recall Announced by Manufacturer
Agila Specialties notified medical care organizations of a nationwide recall to the hospital/user level of 10 lots of Etomidate Injection 2 mg/mL – 10 mL and 20 mL. All of the products bear a Pfizer label. Product was distributed Nationwide to distributors, retailers, hospitals, pharmacies, and/or clinics. The product was recalled due to the potential for small black particles, identified as paper shipper labels, to be present in individual vials; the potential for missing lot number and/or expiry date on the outer carton, and the potential for illegible/missing lot number and expiry on individual vials. Intravenous administration of particles may lead to impairment of microcirculation, phlebitis, infection, embolism and subsequent infarction. For more information...

26. Philips Respironics Initiates Recalls Trilogy Ventilator
On February 11, 2014, Philips Respironics initiated a voluntary recall to address a potentially defective component on the Trilogy Ventilator power management board, which could affect the function of the device. If this issue is not corrected it is possible that the ventilator may fail to deliver mechanical breaths and that the alarm functionality may be reduced to indicate ventilatory failure, resulting in serious adverse health consequences or death. There have been no reports of death or serious injury related to this potential problem. The Philips Respironics Trilogy Ventilator is intended to provide continuous or intermittent ventilatory support for the care of individuals who require mechanical ventilation. The devices are intended to be used in home, institution/hospital, and portable applications such as wheelchairs and gurneys. For more information...

27. FY 2013 Fire Prevention and Safety Grants Application Period Now Open
Starting Tuesday, February 18, 2014, organizations may begin online grant applications for Fiscal Year (FY) 2013 Fire Prevention and Safety (FP&S) Grant funding. The deadline for all FP&S Grant applications is Friday, March 21, 2014, at 5 p.m. Eastern Time (ET). Key Changes in the FY 2013 Fire Prevention and Safety funding opportunity:

- The grantee cost sharing is now 5% for all eligible applicants for both FP&S and Research and Development (R&D) activities regardless of population size or applicant type.
- Applications and awards are limited to a maximum federal share of $1.5 million dollars, regardless of applicant type.
- The evaluation criteria under the Research and Development activity have been modified and now clarifies the evaluation process for the Research and Development applications.

The FY 2013 Fire Prevention and Safety Grants Funding Opportunity Announcement (FOA) explains the purpose of the grant program, activities eligible for support, eligibility criteria, award criteria, application instructions, and Federal requirements for grantees.

28. ACEP Reports Nation Receives a D+ in Emergency Care
Emergency physicians have sounded a warning that the continuing failure of state and national policies is endangering emergency patients, citing as proof a worse grade of D+ in the latest edition of a state-by-state report card on support for emergency care (Report Card). The Report Card forecasts an expanding role for emergency departments under the Affordable Care Act and describes the harmful effects of the competing pressures of shrinking resources and increasing demands. The Report Card measures conditions and policies under which
emergency care is being delivered, not the quality of care provided by hospitals and emergency providers. “America’s Emergency Care Environment: A State-by-State Report Card” — has 136 measures in five categories:

- Access to Emergency Care (30 percent of the grade): the nation received a D-
- Quality and Patient Safety (20 percent): the nation received a C
- Medical Liability Environment (20 percent): the nation received a C-
- Public Health and Injury Prevention (15 percent): the nation received a C
- Disaster Preparedness (15 percent): the nation received a C-

The District of Columbia ranked first in the nation with a B-, surpassing Massachusetts, which held the top spot in the 2009 Report Card. Wyoming ranked dead last, receiving an F overall. The top ranked states were the District of Columbia (1st, B-), Massachusetts (2nd, B-), Maine (3rd, B-), Nebraska (4th, B-) and Colorado (5th, C+). The bottom ranked states were Wyoming (51st, F), Arkansas (50th, D-), New Mexico (49th, D), Montana (48th, D) and Kentucky (47th, D).

29. National Organizations Promote Guidelines for Geriatric Emergency Departments

The American College of Emergency Physicians, the American Geriatrics Society, Emergency Nurses Association, and the Society for Academic Emergency Medicine announce the availability of a Geriatric Emergency Department Guidelines document, a product of two years of consensus-based work. The purpose of Geriatric Emergency Department Guidelines is to provide a standardized set of guidelines that can effectively improve the care of the geriatric population and which is feasible to implement in the ED. The guidelines create a template for staffing, equipment, education, policies and procedures, follow-up care, and performance improvement measures and encourages EMS training. For more information...

UPCOMING EVENTS

***STATEWIDE EMS CONFERENCES***

Twenty-Eighth Annual Conference on the Prevention of Child Abuse. March 3-4, 2014  Omni Colonnade Hotel San Antonio, Texas. For more information...

13th Annual Update in Acute and Emergency Care Pediatrics Conference. Knoxville, TN on March 28-29, 2014. For more information...


***National Conferences and Special Meetings***

<table>
<thead>
<tr>
<th>NAEMSE Instructor Course Level 1</th>
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<tbody>
<tr>
<td>March 14-16, 2014</td>
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<td>April 4-6, 2014</td>
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<td>April 25-27, 2014</td>
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<th>NAEMSE Instructor Course Level 2</th>
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National Association of State EMS Officials
NASEMSO Washington Update 2014

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 7-8, 2014</td>
<td>Orland Park, IL</td>
</tr>
<tr>
<td>March 21-22, 2014</td>
<td>Loudon, VA</td>
</tr>
<tr>
<td>May 2-4, 2014</td>
<td>Sacramento, CA</td>
</tr>
<tr>
<td>May 16-17, 2014</td>
<td>Macon, GA</td>
</tr>
</tbody>
</table>

NASEMSO Mid-Year Meeting, March 3-5, 2014. Rosen Center, Orlando, FL.  For more information...

ENA Leadership Conference. March 5-9, 2014. Phoenix, AZ.  For more information...

AAMS Spring Conference. March 11, 2014. Washington, DC.  For more information...


2014 Preparedness Summit. April 1-4, 2014 in Atlanta GA.

National Public Health Week. April 7-13, 2014.  For more information...

Fire-Rescue Med. April 29-May 3, 2014. Arlington, VA.  For more information...

ACEP Leadership and Advocacy Conference. May 18-21, 2014. Washington, DC.  For more information...

National EMS Week. May 18-24, 2014. This year’s theme is "EMS: Dedicated. For Life."  For more information...

Pinnacle EMS Leadership and Management Conference. July 21-25, 2014. Scottsdale, AZ.  For more information...

ITS America World Congress. September 7-11, 2014. Detroit Marriott at the Renaissance Center. Detroit, MI.  For more information...

NAEMSE Symposium. September 16-21, 2014. Peppermill Resort Hotel. Reno, NV.  For more information...


NASEMSO Annual Meeting. October 6-10, 2014. Westin Cleveland and Cleveland Public Auditorium, Cleveland, OH.  For more information...

ENA Annual Meeting. October 7-11, 2014. Indiana Convention Center. Indianapolis, IN.  For more information...

ACEP Annual Meeting. October 27-October 30, 2014. Chicago, IL.  For more information...

EMS Expo. November 9-13, 2014. Nashville, TN.  For more information...

See more EMS Events on NASEMSO’s web site at http://www.nasemso.org/Resources/Calendar/index.asp
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DATE: February 26, 2014

TO: All California Local EMS Agencies

FROM: Howard Backer, M.D., MPH, FACEP
       Director

SUBJECT: Local EMS Agency HIPAA Responsibilities

The purpose of this memorandum is to provide statewide guidance to all Local EMS Agencies (LEMSA) regarding protected health information under the Health Insurance Portability and Accountability Act (HIPAA). Both LEMSAs and EMSA have the authority to collect and disclose personal health information (PHI) for the oversight of a health care system.

Health and Safety Code State and local requirements
LEMSA functions, as outlined in California Health and Safety Code, Division 2.5, Sections 1797 et seq., include EMS interagency coordination and medical control, public health surveillance activities, EMS data and quality of care, regulation and enforcement, trauma registry reporting, and other activities related to the oversight of the prehospital health care system in California. It is the opinion of the EMS Authority that these functions are primarily for the benefit of the counties they serve not the covered entities who are obligated by statute to provide the necessary patient data. LEMSAs are required to collect information from both EMS providers and hospitals to comply with their statutory requirements.

The California Health and Safety statutes allow for this oversight activity, and the LEMSAs also act as an extension of the State EMS Authority in those regional system oversight responsibilities. The further transmission of the information into a database by the State of California for the purpose of statewide system oversight activities is consistent with the directives of Division 2.5. Pursuant to the H&S Code, the EMS Authority (EMSA) is required to develop planning and implementation guidelines for local emergency medical services (EMS) systems which address data collection and evaluation (H&S Code § 1797.103(f)).

In addition, EMSA is required to use regional and local information to assess EMS systems in order to determine the need for additional EMS; coordinate EMS; and evaluate the effectiveness of EMS (H&S Code § 1797.102). EMSA is required to report to the Legislature on the effectiveness of the EMS systems, including systems impact evaluations on death and disability (H&S Code § 1797.121). In order to comply with the above requirements, EMSA must collect and analyze LEMS data.
Health Insurance Portability and Accountability Act (HIPAA)
Pursuant to Title 45, Code of Federal Regulations (CFR), § 164.512(d), a covered entity has
the authority to collect and disclose personal health information (PHI) for the oversight of a
health care system.

45 CFR § 164.512(d)
"A covered entity may disclose protected health information to a health oversight agency for
oversight activities authorized by law...including...oversight of (i) The health care
system;...(iii) Entities subject to government regulatory programs for which health information
is necessary for determining compliance with program standards..."

Covered entity is defined as a health plan, a health care clearinghouse, or a health care
provider who transmits any health information in electronic form in connection with a
transaction covered by 45 CFR, Subchapter C (CFR § 160.103).
Oversight agency is defined as an entity who is authorized by law to oversee a health care
system (45 CFR § 164.501).

Since LEMSAs and EMSA are responsible for the oversight of EMS systems as part of a two-
tiered regulatory system, which is a part of California’s health care system, both LEMSAs and
EMSA are considered health oversight agencies.

Local EMS Agencies (LEMSAs) and EMSA are not a covered entity under HIPAA because of
their oversight responsibilities, consistent with other similar programs. The citation
referencing the exemption from business associate status for an oversight organization can
be found in HIPAA 45 CFR 164.512 (d) of the Health Insurance Portability and Accountability
Act of 1996, (“HIPAA”), 42 USC 1320d et seq. Therefore, “Business Associate”, or “Trading
Partner” agreements are not required since LEMSAs and EMSA are not “Covered Entities”
when carrying out the role of a health oversight agency, as defined in HIPAA privacy
regulation 45 CFR 160.103.

A business associate is defined as “one that performs certain functions or activities on behalf
of or provides services to a covered entity, that involve the use of protected health
information” (45 CFR § 160.103). The HIPAA privacy rule lists most of the services a
business associate would perform for the covered entity as: claims processing or
administration, utilization review, quality assurance, billing, management, legal services,
accounting, consulting, data aggregation, accreditation, and financial services. Under normal
circumstances, the LEMSAs do not perform these activities.

California Civil Code
The Confidentiality of Medical Information Act (CMIA) permits disclosure of medical
information when specifically authorized by law (Civil Code § 56.10(c)(14)). Since HIPAA
expressly authorizes the disclosure of protected health information to health oversight
agencies, that disclosure is specifically authorized by law and meets this exception in the
CMIA.
Summary
In utilizing the available information cited above, it is clear that EMS Authority and LEMSA oversight activities do not give rise to a business associate relationship, and patient health care information may be disclosed by a covered entity to a LEMSA functioning as a trading partner under HIPAA regulations. However, if other activities occur separately from these oversight responsibilities, a business associate agreement may be appropriate.

EMS data received from the LEMSAs will be maintained by an entity that EMSA contracts with for operation and maintenance of its State level data system. This entity is one of the LEMSAs in the State and they are prohibited from accessing or using the EMS data except to the extent necessary to maintain the database on behalf of EMSA. The further transmission of the information into a database by the State of California for the purpose of statewide system oversight is consistent with the directives of H&S Code, Division 2.5, § 1797 et seq.

The EMS Authority has consulted with the California Office of Health Information Integrity (CalOHII) in providing this statewide guidance. We recommend that all LEMSAs proceed accordingly and consult their respective counsels for further direction if necessary.

If you have any questions, please contact Tom McGinnis, EMS Systems Division Chief at (916) 431-3695.
Monthly Average 911 Code 3 (EMS Only) Response Times

10/01/2012 - 1/31/2014
Average Monthly Call Volume (Fire + Ambulance): 40 Calls

Average Monthly Call Volume (Fire + Ambulance): 40 Calls

Average Response Time (Minutes)

Fire Station Closures
1/15/2013
Stations 4, 11, 12 and 16

Fire Station Closures
7/08/2013
Station #87 (Pittsburg)

CCCFPD: Response time: from time call is assigned to fire unit to the time fire unit reports arrival on scene
AMR: Response time: from time call received by AMR dispatch to the time unit reports arrival on scene
 CCCFPD: Response time : from time call is assigned to fire unit to the time fire unit reports arrival on scene
AMR: Response time: from time call received by AMR dispatch to the time unit reports arrival on scene
Monthly Average 911 Code 3 (EMS Only) Response Times

10/01/2012 - 1/31/2014
Average Monthly Call Volume (Fire + Ambulance): 232 Calls

Average Response Time (Minutes)

CCC-FPD: Response time: from time call is assigned to fire unit to the time fire unit reports arrival on scene
AMR: Response time: from time call received by AMR dispatch to the time unit reports arrival on scene

Fire Station Closures
1/15/2013
Stations 4, 11, 12 and 16

Fire Station Closures
7/08/2013
Station #87 (Pittsburg)
Pittsburg - AMR
Pittsburg - CCCFPD

CCCFPD: Response time: from time call is assigned to fire unit to the time fire unit reports arrival on scene
AMR: Response time: from time call received by AMR dispatch to the time unit reports arrival on scene

Monthly Average 911 Code 3 (EMS Only) Response Times
10/01/2012 - 1/31/2014
Average Monthly Call Volume (Fire + Ambulance): 410 Calls

Average Response Time (Minutes)

Fire Station Closures
1/15/2013
Stations 4, 11, 12 and 16

Fire Station Closures
7/08/2013
Station #87 (Pittsburg)

Average Monthly Call Volume (Fire + Ambulance): 410 Calls
Monthly Average 911 Code 3 (EMS Only) Response Times
10/01/2012 - 1/31/2014
Average Monthly Call Volume (Fire + Ambulance): 546 Calls

- Walnut Creek - AMR
- Walnut Creek - CCFPD

Average Response Time (Minutes)

CCCFFP: Response time: from time call is assigned to fire unit to the time fire unit reports arrival on scene
AMR: Response time: from time call received by AMR dispatch to the time unit reports arrival on scene

Fire Station Closures
- 1/15/2013
  - Stations 4, 11, 12 and 16
- 7/08/2013
  - Station #87 (Pittsburg)
HEALTH INFORMATION EXCHANGE POISED TO TRANSFORM PRE-HOSPITAL CARE IN CALIFORNIA

Grant to Emergency Medical Services Authority Advances Effective Use of HIE Technology

The handoff of patients from ambulances to emergency departments (ED) is one of the most critical and information-dependent moments in the healthcare system. Advances in health information exchange (HIE) technology are bringing new opportunities to vastly improve communication and transfer of patient data from the field to ED prior to arrival. This allows activation of hospital teams to initiate time-sensitive interventions for stroke, heart attacks, and trauma.

To promote effective use of HIE among California’s emergency medical services agencies, the California Health and Human Services (CHHS) Agency awarded a grant to the state Emergency Medical Services Authority (EMSA). Funded by the State HIE Cooperative Agreement, part of the federal HITECH Act, EMSA undertook a three-part project that included a two-day statewide summit; an assessment of the current state of HIE in emergency medical services; and three demonstration projects.

“In pre-hospital emergency care, as in all phases of medical treatment, patient safety, quality of care, and cost-efficacy of care are enhanced by access to patient health information,” said EMSA Director Howard Backer, MD, MPH.

Emergency response had always been part the State’s strategic plan for HIE, according to Christine Schmoockel, chief information officer for the California Office of Health Information Integrity (CalOHII), which administers the Cooperative Agreement grant. “We are delighted with the success of EMSA’s activities and the model they have set for EMS nationally.”

STATEWIDE SUMMIT FEATURED LESSONS LEARNED AND BEST PRACTICES

More than 200 EMS stakeholders and representatives from local, state, and federal government attended a summit hosted by EMSA November 19-20, 2013 in Los Angeles called, “Planting the HIE Seed Today...To Grow an EMS Solution for the Future.”

“The EMS Authority believes that the real-time exchange of patient health information between providers in the field and healthcare facilities and their practitioners is an essential component of the patient care continuum,” said Tom McGinnis, EMS Systems Division chief. “The Summit helped us communicate current information and explore possibilities for future HIE development in California.”

Among attendees was Lee Stevens, director, State Health Information Exchange Policy for the federal Office of the National Coordinator for HIT (ONC).

“In a state where emergency medical services must be prepared at all times for the unexpected, HIE is a critical thread running through the support system,” he said. “The EMS Summit in Los Angeles instilled an additional sense of purpose for the work we’ve done over the past four years [at the federal level] to enable HIE across the country, and especially in partnership with the State of California. The enthusiasm and mission-oriented focus of the California EMS and fire officials, HIE experts, and healthcare partners should be a great comfort to all Californians.”
Chris Muir, the ONC program manager who oversaw the California Cooperative Agreement grant, said, “The EMS Summit in Los Angeles illustrates the progressive approach of California EMS and fire officials and the dedication to improving emergency services as new technologies become available. Interoperable HIE enabled by the State and its partners, when made available to emergency services providers, can dramatically improve a patient transition during a small or large-scale event. This is a significant step forward in saving lives.”

November’s Summit featured speakers from agencies around California that have been leaders in adopting health information technology in the pre-hospital setting. The following highlights three successful efforts.

Los Angeles Fire Department ePCR deployment

The Los Angeles Fire Department (LAFD) is one of the largest fire-based ambulance providers in the nation, transporting about 600 patients each day. But in 2010 they were still documenting their patient care using paper forms. LAFD Assistant Chief Gregory Reynar noted that paper records have many disadvantages – they get wet in the rain, handwriting can be illegible, and paperwork can get lost in the rush of an emergent situation or while traveling through administrative processes.

In 2010 the department gained approval to initiate its electronic Patient Care Record (ePCR) program and distribute portable electronic devices to all its field personnel. The impetus, Reynar said, was to better document data captured in the field for quality improvement analysis and also to support an ambulance billing upgrade project.

Before getting approval from city leaders, the department spent months looking at the options for hardware and software used to create electronic patient care records, considering a number of vendors before choosing Sansio, which also serves the New York Fire Department. The actual field rollout took about six months. In the three years since, the department has reduced the speed of reimbursement from about 30-45 days to 5-7 business days. “Reimbursement revenue from ambulance transports arrives here in the city much faster since program implementation,” Reynar says.

Maintaining information about patient care electronically benefits the department’s efforts to better analyze the quality of care it provides. Reynar described his staff previously spending hours organizing stacks of paper to carry out QI projects; now they have a cloud-based database for much easier access to the standardized data fields in their ePCR. “Today my QI folks are more analysts,” he said. “They are a mouse click away from the data and being able to begin their work.”

The department found that program training was crucial for a successful implementation. The LAFD held orientation meetings for hospital partners and provided a four-hour training class to firefighters and paramedics tasked with using the new system.
The equipment distributed during the original 2011 rollout is being upgraded in 2014 to a tablet style device that uses Windows 8 and is capable of 4G cellular access rather than the 3g of the original devices. The program upgrade will also be compliant with the latest NEMSIS version 3 requirements. NEMSIS stands for the National Emergency Medical Services Information System. NEMSIS is the national repository that will be used to potentially store EMS data from every state in the nation.

During initial rollout, sharing the information with other providers required additional work, as the County of Los Angeles is not yet connected to a regional health information exchange. Most important was how ambulance crews would transmit patient information to the emergency department destination. Because LAFD transports to dozens of hospitals, its leaders coordinated with the Hospital Association of Southern California and the Los Angeles County EMS Agency to work out a way of transmitting the information that would satisfy concerns about privacy and security of the patient information.

With the new system, participating hospitals can access information in the LAFD electronic record in close-to-real time as the paramedics are typing it in during on-scene care and transit.

The LAFD is looking forward to continued regional cooperation and a future that may allow for the exchange of health information among all patient care providers. “The LAFD continually strives to improve our patient care and ePCR programs such as the one implemented in the City of Los Angeles could be the seed for a future HIE,” Reynar said.

Orange County EMS Agency

Over a number of years, Orange County’s EMS agency has endeavored to work with a wide variety of stakeholders to create a web-based hub known as the OC-MEDS that functions as either a central database or an electronic medical record system. Laurent Repass, a paramedic and the agency’s EMS coordinator, described a long, ongoing effort by a wide range of health care organizations in Orange County to develop a comprehensive information exchange system in their large, densely populated geographic area.

“In many respects it functions like an HIE, but not to the true extent of an HIE,” Repass said. The system went live toward the end of 2013, transitioning the participating emergency response agencies from a paper-based to an electronic system. One of our greatest challenges, he said, was finding a solution that meets the needs of the EMS system as well as the business needs and record-keeping requirements of each agency. Some bill for services and others don’t, he noted.

The effort began in 2006 with the formation of a task force, which developed a five-step action plan. Over the years, the group pulled together various grant-funding sources and in 2010 chose a software vendor, ImageTrend.

A major advantage was the adoption on a national level of NEMSIS 3 as being HL-7 compliant, meaning its technical standard is compatible with the way electronic documents are shared by hospitals and physician offices.

One of the major goals of the project has been to eliminate passing a paper record when a patient is transferred from an EMS provider to the hospital. “One of the greatest challenges has been how we do that transfer in the electronic world,” Repass said. Each hospital is given access
to the system through a secure web portal where they have access to the EMS patient care record.

Eventually, he said, multiple agencies could share the records by working with a health information exchange organization. “It’s possible that during any 911 call that one patient may be touched by three or four different EMS providers before being delivered to the hospital. How do you transfer the record effectively?”

Sharing information among the many players in Orange County is part of the long-term plan for the agency’s project, Repass said. “This is the first step in a really long journey to get there,” he said.

**Hall Ambulance, Bakersfield**

Hall Ambulance, the dominant emergency provider in the Bakersfield area, has had electronic patient care recordkeeping for about 15 years. In fact, the private ambulance company jumped into the electronic world before its county was prepared to accept electronic data from emergency responses.

While the system has allowed Hall Ambulance to track its own work internally, its leaders are looking forward to improvements in exchanging patient information that will allow emergency responders in Bakersfield to look up information on patients’ previous care and have their own care notes transmitted into a community or hospital record system to provide a longitudinal look at patients’ health.

“We want to get our data from the bedside to the hospital and then get feedback to our paramedics,” said John Surface, manager of Hall’s ambulance division. “We’re probably a year or two in development to get there.”

An early lesson for Hall, said Surface, was that saving money is the wrong reason to invest in electronic patient records. “It’s about managing the customer experience and your quality improvement program.”

The Bakersfield system, maintained by Zoll, is able to send patient information into a county emergency agency database once every four hours. At the hospital, patient information collected during the response and transport is printed out and left at the patient’s hospital ED bedside and another copy is faxed to the hospital’s medical records department.

Soon, Surface said, that information will be sent directly into the hospital’s information system. Also, paramedics will be able to look up information about past responses and transports for a given patient; that access has been delayed until Hall can ensure that it would not violate any patient confidentiality laws.

Because many patients with chronic illnesses are transported by ambulance repeatedly, paramedics could benefit from having information about past treatment, allergies, and medications, and potentially transport to the same hospital the patient has been to before. “If I can look and see we’ve taken [patient Doe] 11 times, and I can check his allergies and meds, it will improve the field treatment plan and the ER treatment plan,” Surface said.

**BECAUSE MANY PATIENTS WITH CHRONIC ILLNESSES ARE TRANSPORTED BY AMBULANCE REPEATEDLY, PARAMEDICS COULD BENEFIT FROM HAVING INFORMATION ABOUT PAST TREATMENT, ALLERGIES, AND MEDICATIONS.**
EIGHTY PERCENT OF EMS PROVIDERS SAW AN INCREASE IN DATA ACCURACY AFTER CONVERTING TO AN ELECTRONIC SYSTEM.

SURVEY FINDS HIE READINESS WIDESPREAD

All 33 of the state’s local EMS agencies reported that their EMS providers are making the transition from paper to electronic patient care records, according to a survey commissioned by EMSA. However, most providers are still in the early stages of being able to electronically transmit data to the hospital that is receiving the patient.

The Health Information Exchange Readiness Assessment/Survey rated each agency and its emergency response providers on a wide range of health IT capabilities. Using a seven-stage model of health IT readiness, the survey found that most agencies and their providers are in early stages, with 78.8 percent reporting the use of an electronic patient care record (ePCR).

Twenty-three different ePCR software vendors are used by providers. Most common are MEDS (14), Zoll (13), and ImageTrend (8). Most indicated that the vendor maintains the information collected, with a small number (10 percent) keeping it in a data cloud.

About two-thirds of the agencies (62.5 percent) said that patient care data is transmitted electronically to the hospital. The rest said it is not sent electronically, and the most common alternative method is sending by fax or by hand. Of the agencies that are not currently transmitting to the hospital electronically, the vast majority said they intend to, but cited barriers such as cost or concern about privacy.

Most agencies (87 percent) reported that they have not currently integrated the pre-hospital patient information into the hospital’s EHR system, though several said they are working to do so.

The survey also asked about providers’ implementation issues and found that about two-thirds had a positive experience. Some 80 percent saw an increase in data accuracy after converting to an electronic system. Most were not able to document whether patient outcomes had improved because they do not receive information back from hospitals about the health status of the patients they transport.

Describe what level your agency is at based on the 7 levels of EMS ePCR and HIE Adoption Model (more than one option may apply)
STATE HIE COOPERATIVE GRANT-SUPPORTED EMS DEMONSTRATION PROJECTS

Contra Costa County Emergency Medical Services

Contra Costa County’s EMS, part of Contra Costa Health Services, is using the state EMS/HIE demonstration grant to do three things:

- Examine workflows to save steps and make them more efficient
- Determine how to connect the pre-hospital system with the Epic electronic health record in the county’s hospitals
- Pilot test a dashboard for the county’s hospitals that provides color-coded, real-time information about patients being treated and transported by emergency responders

“These are all collaborations and processes,” said Pat Frost, director of the agency. “We’re hoping to be an incubator for HIE activity.”

The workflow analysis, carried out by a consultant, involved a detailed examination of all the EMS agency’s programs. It found more than 13 individual information systems in use. By examining its own internal workflow, the agency is better prepared for the more complex task of sharing information with other parties and working, Frost said.

“We found that this was mission critical to do before you get your feet wet in the HIE environment,” Frost said. “HIE with multiple parties is extremely complex and the devil is in the details. We learned we had a lot of unnecessary steps and we were not using data systems to their greatest efficiency.” For example, the analysis found that the trauma program could be reduced from 20 to nine steps; the STEMI (heart attack) program from 13 steps to four.

Another grant-supported project, the First Watch Solutions Hospital Offload Dashboard, tracks the time from when an ambulance arrives to the scene to when it leaves, and tracks the number of units parked at each hospital. There are color-coded warnings to let emergency department staff know where the emergency response resources are and what patients might be on their way. “We presented this to our emergency departments and they were very enthusiastic about using it, but later we found people were not actually using it,” said Frost. “You can create all sorts of tools but if the tools aren’t part of people’s workflow they won’t be successful.”

As part of the demonstration project, the agency reassessed the tool and decided to redeploy it with additional training and education. They found that the ED staff did not have time to go to a monitor and pull up the dashboard. In the new deployment, a monitor will be placed in an easily viewable location, visible at all times, without requiring the extra step of opening it on the computer.

Meanwhile, the agency’s Epic project is designed to prepare the pre-hospital system to send information to area hospitals, which should all be using the same Epic software platform by 2016. Frost said her agency is interested in obtaining outcome information for patients transported to local hospitals so it can do quality analysis on patient care protocols, particularly those for trauma, cardiac arrest, stroke, STEMI, and patient safety.

Frost said the agency is also working with the county’s hospital system to explore the use of a continuity-of-care document (CCD) to enable data for transported patients to be pulled and pushed, which could serve as a method for future real-time data exchange. It could be similar to the secure CCD that is sent to primary care physicians for patients seen by Contra Costa Regional Medical Center’s emergency department.
The EMS agency is also pursuing discussions about how Contra Costa hospitals and other health care providers will interact outside of the shared Epic platform, potentially through HealthShare Bay Area, the region’s health information organization. The pre-hospital care system needs to be involved with regional conversations about coordinated, population-based healthcare, Frost notes.

“People need to know the value-added EMS can bring to continuity of care and chronic conditions. We can really make a contribution,” Frost said. “EMS services tend not to be considered part of the healthcare system. People think we are just transportation, but we really are healthcare providers.”

**Monterey County Emergency Medical Services Agency**

Monterey’s EMS agency received funding to explore linking pre-hospital care with hospital systems. According to Agency Director Kirk Schmitt, emergency departments reported that they need pre-hospital information within an hour of arrival or it is of no value to treatment. “Doing this electronically we are hoping to overcome that one-hour limit,” he said.

Monterey County has four hospitals and a major ambulance provider, AMR, which handles more than 90 percent of transports. The company’s electronic patient care record is used by emergency crews who enter the information, hit the print button, and hand off the printed sheet to the hospital emergency department. The hospitals typically scan that printed report into their systems in a PDF format that is difficult to search for specific pieces of data.

The Monterey agency has been working for two years on a project to map out and align the potential information exchange between the AMR system, the four hospitals, and the area’s other transporters. “If we made all these in alignment we would have a flow of information going into the hospital, but also back to the pre-hospital providers about patient outcomes,” Schmitt said.

The CalOHII grant, he said, was “icing on the cake” of that project, allowing the agency to make a bridge between the AMR system and the hospitals. The funding allowed the Monterey agency to hire a database developer to carry out mapping between the AMR ePCR system and hospital records so the information from one record can end up in the correct data fields of the other. The grant, received in August, allowed the work to take place during the fall and pilot tests were carried out later in the year to ensure there were no broken links in the connections.

The emergency agency learned through this project that it needed to have health IT expertise on its staff and hired an IT specialist to oversee the work.
It is time-consuming but doable to build interfaces between the systems, one hospital at a time, Schmitt said. “It’s not that it’s hard, but it is more complicated than somebody who doesn’t have IT expertise might envision,” he said. “There are a lot of moving pieces in there. We just assumed there were standards and definitions and being HL7 compliant would allow for easy mapping, but apparently it doesn’t.”

The EMS agency took on responsibility for pulling together the project because of its regional system coordination role. Schmitt said the biggest issue so far has been that even while field providers and hospital emergency department staff were very supportive of being able to look at one another’s electronic records, it was important to engage the ultimate decision-makers in their organizations to get the work done. “You have to elevate it beyond the field level to the management level (including CIOs) and get them engaged early before you make any decisions,” he said.

The project’s goal is to have all four hospitals connect to the ambulance company’s ePCR system by second quarter 2014.

**Inland Counties Emergency Medical Agency**

California’s Inland Empire, which includes San Bernardino, Inyo, and Yolo counties, is home to both a dynamic HIO that is helping hospitals and physician offices share patient information, as well as an EMS agency that was an early adopter of electronic recordkeeping for emergency responders. The combination of those efforts could give the region one of the first opportunities in the state to understand the complete continuum of care, from the time an ambulance rolls up to a medical response scene all the way through to the patient’s discharge back home.

“If we can take the patient from first contact in the field to discharge from the hospital and beyond, we can measure what we’re doing,” said Ron Holk, RN, EMS nurse specialist for the Inland Counties Emergency Medical Agency (ICEMA). “A big missing part for our quality-improvement efforts is knowing what happens to patients at the hospital.”

The Inland Counties agency switched to an electronic process for field paramedics about a decade ago. While the agency has a well-developed pre-hospital electronic patient record and some sharing capabilities, it was able to use the grant funding to enhance the system and expand its use. Specifically, the agency wanted to provide the base hospital that is advising paramedics with the capability to expand on standing orders in a way that remains in the patient record rather than being strictly verbal. Having the complete picture of pre-hospital orders and care provides quality improvement staff at the agency with crucial information when they analyze patient care practices, Holk explained.
A BIG MISSING PART FOR QUALITY-IMPROVEMENT EFFORTS IS KNOWING WHAT HAPPENS TO PATIENTS AT THE HOSPITAL.

With the grant support the agency is also working to expand access to its ePCR system to four other EMS agencies in northern California: Northern California EMA, Sierra-Sacramento Valley, North Coast EMS, and Tuolumne County EMS.

ICEMA is also working on integrating its database with that of the Inland Empire Health Information Exchange, a local health information organization. “Once we connect they can pull up any patient record at any time and get a complete medical history,” Holk said. “The hospital can get information on what happened in the field all the times that patient has been transported, even if it was to another hospital.”

Linking emergency response to the rest of the care continuum has the potential to improve the quality of care, Holk said. “You end up reducing the possibility of errors because you can follow the progression of the disease process,” he said.

The California Emergency Medical Services Authority

The mission of EMSA is to ensure quality patient care by administering an effective, statewide system of coordinated emergency medical care, injury prevention, and disaster medical response. For more information see www.emsa.ca.gov

The California Office of Health Information Integrity (CalOHII) focuses on advancing electronic health information exchange so that patient information is available when and where it is needed for care, while ensuring that the data is protected and exchanged under strict medical privacy and confidentiality standards and procedures.

twitter.com/CAeHealth
By Dr. Joseph Barger and Patricia Frost

Your Feb. 5 editorial discussed the tax measure proposed to rescue Doctors Medical Center in San Pablo. This hospital plays a critical role in saving lives, and we believe this editorial significantly understated the potential impact of its closure on patients and the health care system in the West Contra Costa County area.

The editorial stated that without the emergency room, “residents will be forced to drive farther when they need lifesaving help,” but additionally said that “most of the hospital’s services can be provided elsewhere.”

This is an over-simplification of a complex issue — the closure would mean much more than this.

Losing Doctors Medical Center would mean more patients would be sent to other already-overloaded emergency departments throughout our county and other counties, more stress would be placed on the emergency ambulance system, and, most important, care could be delayed in critical emergencies for people needing immediate and often specialized interventions.

Doctors Medical Center is more than an emergency department. It is the lone provider of advanced cardiac care for heart attack victims in western Contra Costa. Minutes do count — timely interventions in heart attack, stroke and numerous other types of serious illnesses will be delayed, with the potential result of lost lives or increased disability when one of those illnesses strikes.

Compounding this is that the West County community is as a whole is at higher risk than many for heart attack and stroke. Access to emergency care in California is already highly compromised — a recent report ranked California 42nd in the nation in that regard.

The East Bay is one of those areas already struggling to provide access, and that will worsen markedly if Doctors Medical Center closes.

Moving 35,000 or more annual visits to other emergency departments is much more than an inconvenience — it will impact the timeliness of care for all patients in all those departments.

Last year, ambulances from Contra Costa’s 911 system transported more than 8,000 patients to Doctors San Pablo. If Doctors’ emergency department is closed, 911 will still be called and ambulances will still take patients to emergency departments. But those emergency departments will be several miles farther away, and that means it will take longer to get people the lifesaving care they need.

While paramedics can provide some critical interventions en route, other patients require definitive care available only at hospitals.

It’s clear that all of those ambulances cannot simply go to Kaiser Richmond, the lone remaining emergency department in the West County area.

Kaiser’s emergency department is already very busy, is half the size of Doctors’ emergency facility, and already receives more than 5,000 patients by ambulance annually from the 911 system.

Once an ambulance has left the West County region, local ambulance supply is diminished until that ambulance returns or another is moved there to replace it.

The problem is further exacerbated by delays for ambulances at hospitals when emergency rooms are bursting at the seams — full beds mean that transfer of the patient from the ambulance journey to the emergency department bed will be delayed.

Ambulances are scarce resources, and the response system has the potential to be significantly strained by the closure.

The impacts of the closure of Doctors Medical Center San Pablo won’t simply be measured in time, gasoline, or wear on tires.

It will challenge provision of emergency medical services and the ability of surviving hospitals to care for all patients, and will be measured in lives lost or impaired.

Joseph Barger, MD, is medical director of Contra Costa Emergency Medical Services. Patricia Frost, RN, is director of Contra Costa Emergency Medical Services.
California continues to rank among the top 10 states for Public Health and Injury Prevention and has improved in three of the other four categories. However, this large and diverse state suffers from poor overall Access to Emergency Care, with an inadequate supply of medical facilities and low rates of health insurance coverage.

**Strengths.** California is a national leader in Public Health and Injury Prevention. It has extremely low rates of adult smoking (13.7%) and obesity (23.8%). California’s infant mortality rate (4.7 per 1,000 live births) is among the lowest in the nation, and the infant mortality disparity ratio is better than average. California has implemented strong child safety seat and seat belt legislation, primary enforcement of distracted driving laws, and requires motorcycle helmet use for all riders. These state policies, in concert with the provision of outstanding trauma care in a large state where 97.7% of the population lives within 60 minutes of a Level I or II trauma center, contribute to a low overall rate of traffic fatalities (5.3 per 100,000 people).

California continues to support a favorable Medical Liability Environment and has been rewarded with lower-than-average medical liability insurance premiums, which will help recruit physicians to the state and improve access to emergency care. The state encourages physician apologies by preventing them from being admitted as evidence in a trial. California has enacted a $250,000 cap on non-economic damages in medical liability cases, which helps to control health care costs by keeping medical liability insurance premiums affordable.

California has also improved in Disaster Preparedness since the 2009 Report Card. It is one of only 11 states that has a state budget line item for disaster preparedness funding specific to health care surge. In 2011, it conducted more than nine emergency drills per hospital involving hospital personnel, equipment, or facilities. California has been accredited by the Emergency Management Accreditation Program.

**Challenges.** California continues to struggle with provider and facility shortages in Access to Emergency Care. Overcrowding and lack of access to needed medical facilities are critical problems for the state. California has the lowest number of emergency departments (ED) per capita (0.7 per 1 million people) and lacks adequate numbers of staffed inpatient beds (223.8 per 100,000 people) and psychiatric care beds (18.3 per 100,000 people). The state also has extremely low rates of orthopedists and hand surgeon specialists (8.5 per 100,000 people) and registered nurses (664.0 per 100,000 people), and has a shortage of physicians accepting Medicare fee-for-service patients.

All these factors contribute to high ED wait times, which average 334 minutes (or 5.6 hours) from ED arrival to ED departure for admitted patients.

Financial barriers to care persist in California, impeding access to care. The state has one of the highest rates of adults with no health insurance (22.7%) and a high rate of children with no health insurance (10.8%). It also has moderately high rates of underinsurance for adults (8.2%) and children (18.9%).

While California has regionalized much of its emergency medical services (EMS), there are some key aspects of the Quality and Patient Safety Environment that the state could support, including funding for quality improvement of the EMS system and the development of state field triage protocols. California lacks a statewide trauma registry and a uniform system for providing pre-arrival instructions.

**Recommendations.** California must work to address a number of issues in Access to Emergency Care, including a gap in medical facilities, financial barriers to care, and long wait times in the emergency department. It should invest in ensuring that its citizens can afford doctor visits. Without a concentrated effort to increase the health care workforce and support adequate facilities, the problem of overcrowding will worsen.

Despite its improved Disaster Preparedness grade, California should consider developing additional statewide systems and procedures to ensure that all citizens are protected in the event of a disaster. California does not have a statewide patient tracking system or a real-time or near real-time syndromic surveillance system. While this kind of surveillance system has been installed in some counties, the state could work to ensure that all counties have access to this technology.

California could also improve its overall emergency care system by enhancing its Medical Liability Environment, including pretrial screening panels or case certification, which would help discourage frivolous lawsuits. Additional liability protection for care mandated by the Emergency Medical Treatment and Labor Act (EMTALA) would help ensure fairness regarding the liability burden placed on emergency care providers and help encourage specialists to be on call for high-risk patients.
### ACCESS TO EMERGENCY CARE

<table>
<thead>
<tr>
<th>Access to Emergency Care</th>
<th>Yes</th>
<th>No</th>
<th>Partially</th>
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<th>Not Applicable</th>
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<td>Board-certified emergency physicians per 100,000 pop.</td>
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<td>Emergency physicians per 100,000 pop.</td>
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<td>Neurosurgeons per 100,000 pop.</td>
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<tr>
<td>Orthopedists and hand surgeon specialists per 100,000 pop.</td>
<td>8.5</td>
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<td>Plastic surgeons per 100,000 pop.</td>
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<td>ENT specialists per 100,000 pop.</td>
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<td>Registered nurses per 100,000 pop.</td>
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<td>Additional primary care FTEs needed per 100,000 pop.</td>
<td>1.7</td>
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<td>Additional mental health FTEs needed per 100,000 pop.</td>
<td>0.4</td>
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<td>% of children able to see provider</td>
<td>93.1</td>
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<td>Level I or II trauma centers per 1M pop.</td>
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<td>% of population within 60 minutes of Level I or II trauma center</td>
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<td>Accredited chest pain centers per 1M pop.</td>
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<td>% of population with an unmet need for substance abuse treatment</td>
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<td>Pediatric specialty centers per 1M pop.</td>
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<td>Physicians accepting Medicare per 100 beneficiaries</td>
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<td>Medicaid fee levels for office visits as a % of the national average</td>
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<td>% change in Medicaid fees for office visits (2007 to 2012)</td>
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<td>% of adults with no health insurance</td>
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<td>% of adults uninsured</td>
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<tr>
<td>% of children with no health insurance</td>
<td>10.8</td>
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<tr>
<td>% of children uninsured</td>
<td>18.9</td>
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<td>% of adults with Medicaid</td>
<td>12.9</td>
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<tr>
<td>Emergency departments per 1M pop.</td>
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<td>Hospital closures in 2011</td>
<td>0</td>
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<td>Staffed inpatient beds per 100,000 pop.</td>
<td>223.8</td>
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<td>Hospital occupancy rate per 100 staffed beds</td>
<td>69.8</td>
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<tr>
<td>Psychiatric care beds per 100,000 pop.</td>
<td>18.3</td>
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<tr>
<td>Median minutes from ED arrival to ED departure for admitted patients</td>
<td>334</td>
<td></td>
<td></td>
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<tr>
<td>State collects data on diversion</td>
<td>Yes</td>
<td></td>
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### MEDICAL LIABILITY ENVIRONMENT

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<thead>
<tr>
<th>Medical Liability Environment</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Lawyers per 10,000 pop.</td>
<td>17.7</td>
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<tr>
<td>Lawyers per physician</td>
<td>0.6</td>
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<td>Lawyers per emergency physician</td>
<td>13.7</td>
<td></td>
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<tr>
<td>ATRA judicial helloholes (range 2 to 6)</td>
<td>2</td>
<td></td>
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<td>Malpractice award payments/100,000 pop.</td>
<td>2.1</td>
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<td>Average malpractice award payments</td>
<td>$143,192</td>
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<td>Databank reports per 1,000 physicians</td>
<td>27.7</td>
<td></td>
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<tr>
<td>Provider apology is inadmissible as evidence</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Patient compensation fund</td>
<td>No</td>
<td></td>
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<tr>
<td>Number of insurers writing medical liability policies per 1,000 physicians</td>
<td>1.1</td>
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<tr>
<td>Average medical liability insurance premium for primary care physicians</td>
<td>5.9</td>
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<tr>
<td>Average medical liability insurance premium for specialists</td>
<td>9.834</td>
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<tr>
<td>Presence of pretrial screening panels</td>
<td>No</td>
<td></td>
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<td>Pretal screening panel's findings admissible as evidence</td>
<td>N/A</td>
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<tr>
<td>Periodic payments</td>
<td>Upon request</td>
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<tr>
<td>Medical liability cap on non-economic damages</td>
<td>$250,000</td>
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<td>Additional liability protection for EMALA-mandated emergency care</td>
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<td></td>
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<tr>
<td>Joint and several liability abolished</td>
<td>Partially</td>
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### QUALITY & PATIENT SAFETY ENVIRONMENT

<table>
<thead>
<tr>
<th>Quality &amp; Patient Safety Environment</th>
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<th>No</th>
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<tr>
<td>Collateral source rule, provides for awards to be offset</td>
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<td>State provides for case certification</td>
<td>No</td>
<td></td>
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<tr>
<td>Expert witness must be of the same specialty as the defendant</td>
<td>No</td>
<td></td>
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<tr>
<td>Expert witness must be licensed to practice medicine in the state</td>
<td>No</td>
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<tr>
<td>Funding for quality improvement within the EMS system</td>
<td>No</td>
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<td>Funded state EMS medical director</td>
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<td>Emergency medicine residents per 1M pop.</td>
<td>14.1</td>
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<td>Adverse event reporting required</td>
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<td></td>
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<td>% of counties with E-911 capability</td>
<td>100</td>
<td></td>
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<td>Uniform system for providing pre-arrival information</td>
<td>Yes</td>
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<td>CDC guidelines are basis for state field triage protocols</td>
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<td>State has or is working on a stroke system of care</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Triage and destination policy in place for stroke patients</td>
<td>Yes</td>
<td></td>
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<tr>
<td>State has or is working on a PCI network or a STEMI system of care</td>
<td>No</td>
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<tr>
<td>Triage and destination policy in place for STEMI patients</td>
<td>Yes</td>
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<td>Statewide trauma registry</td>
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<tr>
<td>Triage and destination policy in place for trauma patients</td>
<td>Yes</td>
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<td>Prescription drug monitoring program (range 0-4)</td>
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<td>% of hospitals with computerized practitioner order entry</td>
<td>81.9</td>
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<tr>
<td>% of hospitals with electronic medical records</td>
<td>94.6</td>
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<td>% of patients with AMI given PCI within 90 minutes of arrival</td>
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<td>Median time to transfer to another facility for acute coronary intervention</td>
<td>64</td>
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<td>% of patients with AMI who received aspirin within 24 hours</td>
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<td>% of hospitals collecting data on race/ethnicity and primary language</td>
<td>44.4</td>
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<td>% of hospitals having or planning to develop a diversity strategy</td>
<td>35.3</td>
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### PUBLIC HEALTH & INJURY PREVENTION

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<tr>
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<tr>
<td>Traffic fatalities per 100,000 pop.</td>
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<td>Bicyclist fatalities per 100,000 cyclists</td>
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<td>Pedestrian fatalities per 100,000 pedestrians</td>
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<td>% of traffic fatalities alcohol related</td>
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<td>Front occupant restraint use (%)</td>
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<td>Helmet use required for all motorcycle riders</td>
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<td>Child safety seat/seat belt legislation (range 0-10)</td>
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<td>Distracted driving legislation (range 0-4)</td>
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<td>Graduated drivers' license legislation (range 0-5)</td>
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<td>% of children immunized, aged 19-35 months</td>
<td>80.4</td>
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<tr>
<td>% of adults aged 65+ who received flu vaccine in past year</td>
<td>57.2</td>
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<td></td>
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<tr>
<td>% of adults aged 65+ who ever received pneumococcal vaccine</td>
<td>68.1</td>
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<td>Fat injury-related fatalities per 1M workers</td>
<td>19.0</td>
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<td>Homicides and suicides (non-motor vehicle) per 100,000 pop.</td>
<td>16.1</td>
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<tr>
<td>Unintentional fall-related fatalities per 100,000 pop.</td>
<td>5.6</td>
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<tr>
<td>Unintentional fire/burn-related fatality injuries per 100,000 pop.</td>
<td>0.4</td>
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</tbody>
</table>

### DISASTER PREPAREDNESS

<table>
<thead>
<tr>
<th>Disaster Preparedness</th>
<th>Yes</th>
<th>No</th>
<th>Partially</th>
<th>N/A</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per capita federal disaster preparedness funds</td>
<td>$6.98</td>
<td></td>
<td></td>
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<tr>
<td>State budget line item for health care surge</td>
<td>Yes</td>
<td></td>
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<tr>
<td>ESF-8 plan shared with all EMS and essential hospital personnel</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Emergency physician input into the state planning process</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Public health and emergency physician input during an ESF-8 response</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Drills, exercises conducted with hospital personnel, equipment, facilities per hospital</td>
<td>9.5</td>
<td></td>
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<tr>
<td>Accredited by the Emergency Management Accreditation Program</td>
<td>No</td>
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<tr>
<td>Special needs patients in medical response plan</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Patients on medication for chronic conditions in medical response plan</td>
<td>No</td>
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<tr>
<td>Medical response plan for supplying dialysis</td>
<td>No</td>
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<tr>
<td>Mental health patients in medical response plan</td>
<td>No</td>
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<tr>
<td>Medical response plan for supplying psychotropic medication</td>
<td>No</td>
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<tr>
<td>Mutual aid agreements with behavioral health providers</td>
<td>State-level</td>
<td></td>
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<tr>
<td>Long-term care and nursing home facilities must have written disaster plan</td>
<td>Yes</td>
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<tr>
<td>State able to report number of exercises with long-term care or nursing home facilities</td>
<td>Yes</td>
<td></td>
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<tr>
<td>“Just-in-time” training systems in place</td>
<td>County- or city-wide</td>
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<tr>
<td>Statewide medical communication system with one layer of redundancy</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Statewide patient tracking system</td>
<td>No</td>
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<tr>
<td>Statewide real-time or near-real-time syndromic surveillance system</td>
<td>No</td>
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<tr>
<td>Real-time surveillance system in place for common ED presentations</td>
<td>No</td>
<td></td>
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<tr>
<td>Bed surge capacity per 1M pop.</td>
<td>358.8</td>
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<tr>
<td>ICU beds per 1M pop.</td>
<td>236.5</td>
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<tr>
<td>Burn unit beds per 1M pop.</td>
<td>5.3</td>
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<tr>
<td>Verified burn centers per 1M pop.</td>
<td>0.2</td>
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<tr>
<td>Physicians in ESAR-VHP per 1M pop.</td>
<td>43.7</td>
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<tr>
<td>Nurses in ESAR-VHP per 1M pop.</td>
<td>180.0</td>
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<tr>
<td>Behavioral health professionals in ESAR-VHP per 1M pop.</td>
<td>8.3</td>
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<tr>
<td>Strike teams or medical assistance teams</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Disaster training required for essential hospital, EMS personnel</td>
<td>NR</td>
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<tr>
<td>Liability protections for healthcare workers during a disaster (range 0-4)</td>
<td>4</td>
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<tr>
<td>% of RNs received disaster training</td>
<td>43.7</td>
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</table>