SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5010
Effective Date: xxxxxxx
Supersedes: January 3, 2022

RECEIVING HOSPITAL STANDARDS – EMSAC June 2022

I. PURPOSE

A. Establish minimum standards for all San Francisco EMS approved receiving hospitals.
B. Integrate receiving hospitals into the EMS system as stakeholders in the planning, design, and delivery of Emergency Medical Services.
C. Provide a mechanism for receiving hospitals to communicate with the EMS Agency and other system participants.

II. AUTHORITY

A. Code of Federal Regulations, Title 45, Section 164.512 (b) (l) (i)
B. California Health and Safety Code, Division 2.5, Sections 1797.67, 1797.204, 1797.222, 1797.250, 1797.252, 1798, 1798.150, and 1799.205.
C. California Code of Regulations, Title 22, Sections 100172, 100175, 70411-70419, and 70451 – 70459.
D. Joint Commission on Accreditation of Health Care Organizations, Emergency Department Standards

III. POLICY

A. General Requirements
1. All receiving hospitals must have a written agreement with the San Francisco EMS Agency to be recognized as an approved destination for ambulances transporting prehospital patients.
2. All receiving hospitals shall meet all Federal, State, and local requirements to be recognized as a Comprehensive Emergency Department, Basic Emergency Department, or Standby Emergency Department.
3. Receiving Hospitals shall be accredited by the Joint Commission on Accreditation of Health Care Organizations.
4. Medical Control of Advanced Life Support personnel shall be the sole responsibility of the Base Hospital.
5. Receiving hospitals shall comply with all EMS Agency Policies and develop internal policies compelling hospital personnel to comply with EMS Agency policies when their work relates to the EMS system.
6. Receiving Hospitals that are not designated Specialty Receiving Centers, e.g. STAR Receiving Centers, Stroke Centers, Trauma Centers or

Pediatric Critical Care Centers, shall have in place rapid transfer protocols, policies or procedures so that patients who need theses specialty receiving centers can access them rapidly.

7. Receiving Hospitals shall pay all required and associated fees within 30 days of being invoiced by the EMS Agency.

B. Personnel

1. Medical Director
    a) The ED Medical Director shall be a physician certified or qualified by training and experience for examination by the American Board of Emergency Medicine.
2. ED Physicians with direct patient care responsibilities
    a) Must be Board Eligible, Board Prepared, or Board Certified in Emergency Medicine, Internal Medicine, Surgery, or Family Practice and maintain current recognition in the following curricula:
        (1) Advanced Cardiac Life Support (or equivalent)
        (2) Pediatric Advanced Life Support (or equivalent)
        (3) Current certification in Emergency Medicine may be held in lieu of III, B, 2, a, 1 – 2.
3. Direct Supervision of Nursing and Medical Support Personnel
    a) A Registered Nurse qualified by training and experience in emergency room nursing care shall be responsible for nursing care within the ED at all times.
4. Nursing
    a) All regularly scheduled nurses in the ED shall maintain recognition in the following curricula:
        (1) Basic Life Support, Health Care Provider
        (2) Advanced Cardiac Life Support (or equivalent)
        (3) Pediatric Advanced Life Support (or equivalent)
    b) Nurses newly hired or assigned to the ED shall have current recognition in the above curricula within 6 months of hire or assignment.
5. At least one person trained to operate all EMS communications equipment shall be on duty at all times.
6. Each facility shall designate a person or person(s) to represent the hospital at EMS System Advisory Committee meetings, Trauma System Audit Committee meetings, act as a liaison to the EMS System, and disseminate information regarding EMS within the facility.

C. EMS Specific Training

1. All regularly scheduled full time employees, to include physicians, nurses, and support staff with patient care or ambulance interface duties, shall complete training in the following areas:
    a) EMS Agency Policies
    b) EMS Agency Exception Reporting

c) Diversion, EMS Agency and internal hospital policy
d) Operation of all communication and diversion monitoring equipment
e) San Francisco Department of Public Health Emergency Operations Plan
f) Internal disaster plans

2. All receiving hospitals will work cooperatively with the EMS Agency and the Base Hospital to provide Continuing Education for prehospital and ED personnel.

IV. SPECIFIC SERVICES AND EQUIPMENT REQUIREMENTS

A. Data Collection and Sharing
1. Record keeping
a) The Emergency Department shall maintain a medical record for each patient in accordance with Joint Commission standards.
(1) The record will include the Prehospital Care Report, if applicable;
(2) The records shall be immediately available to ED staff.
b) The Emergency Department shall maintain a register that includes all data elements defined by Joint Commission, Title 22, and will also include the name and unit number of the transporting ambulance, when applicable.
2. Hospitals will collect and report such information as determined necessary by the EMS Medical Director for the purposes of public health surveillance and injury prevention activities.
3. Hospitals shall comply with the data reporting components of the EMS Agency Quality Improvement plan.

B. Referrals and Resources
1. In addition to the required referrals listed in State law, receiving hospitals shall maintain names, addresses, and telephone numbers for the following:
a) Sexual assault victim referral
b) Elder, dependent adult, or child abuse
c) Battered intimate partner or spouse referral
d) Detoxification unit
e) Drug and Alcohol abuse counseling and support services
f) Psychiatric services
g) Hyperbaric chamber
h) Physician referral
i) Outpatient medical services
j) Resources for the homeless
k) Other city and county designated specialty care centers
l) Regional poison control center

2. All receiving hospitals shall maintain access to the current EMS Agency Policy Manual in the Emergency Department.
3. Contact information for the following shall be available in the ED:
    a) EMS Agency Duty Officer
    b) Department of Emergency Management Division of Emergency Communications (DEC) supervisor
    c) Ambulance providers supervisor and/or communications center
    d) Department of Public Health Emergency Preparedness and Response (PHEPR)
4. All hospitals shall have transfer agreements with EMSA designated specialty receiving centers (if such services are not available internally) including, but not limited to the following facilities:
    a) Trauma Center
    b) Pediatric Critical Care Center
    c) Burn Center
    d) Stroke Center
    e) STAR Center

C. Pediatric Services
1. All receiving hospitals shall have the capability to resuscitate and provide immediate, short-term post resuscitation care for pediatric patients (< 14 years of age) in the Emergency Department.
2. Appropriately sized and specialized equipment and pharmacological agents necessary to resuscitate and care for pediatric patients in accordance with current recommendations by the National Emergency Medical Services for Children Resource Alliance shall be immediately available in the Emergency Department.

V. STANDARDS COMPLIANCE

A. Each receiving hospital will complete a self-assessment at least once every 3 years to ensure compliance with EMS Agency requirements.
1. The self assessment may be performed concurrent with Joint Commission review.
2. Results of the self-assessment must be sent to the EMS Agency.

B. Receiving hospitals shall permit announced and unannounced visits by EMS Agency staff for the purposes of monitoring compliance.

C. Suspension/Revocation
1. The EMS Medical Director may suspend or revoke approval of any given receiving hospital for cause.
2. The EMS Agency shall notify the hospital administration in writing of its intent to deny, revoke, or suspend approval and give the hospital sixty (60) days to submit a corrective action plan.
3. The EMS Agency shall respond to the corrective action plan within thirty (30) days.

a) If the EMS Agency requests any modifications to the Corrective Action Plan, the hospital shall have thirty (30) days to respond to those requests.

4. The EMS Agency will monitor the hospital's compliance with the Corrective Action Plan and take action as indicated.
5. If, in the opinion of the EMS Medical Director, non-compliance or failures on the part of a hospital constitute an immediate and substantial hazard to the health, safety, or welfare of the public, the EMS Agency may immediately suspend approval of that hospital.
    a) The hospital may appeal such a decision to the Director of Public Health.
    b) The EMS Agency may continue a suspension pursuant to this section until the noted deficiencies are corrected.

VI. PATIENT OFFLOAD DELAY MITIGATION

1. For Receiving Facilities meeting Quality Assurance criteria of Policy 4000.1, Section IX, the Receiving Facility shall select a corrective option listed below and submit selection in writing to the EMS Agency within 30 days of issuance of the Hospital Report.
2. Option 1 – Traditional Pathway: Receiving Facility acknowledges that changes can be made by the Receiving Facility AND will eventually meet the APOT-1 standard, with 5% improvement month on month.
3. Receiving Facility shall submit a corrective action plan to reduce APOT-1 delays within 30 days of corrective option selection.
    a. The EMS Agency shall review the corrective action plan within 10 business days.
    b. The plan shall include, but not limited to, the following topics:
        i. Current data and patient trends
        ii. Patient surge measures implemented such as HICS (Hospital Incident Command System), alternative treatment spaces, emergency staffing
        iii. Identification of communication pathways and plans
        iv. Objectives, measurements, and metrics for improvement
    c. Upon approval of the plan by the EMS Agency, the Receiving Facility shall have a minimum of 30 days to reduce APOT-1 times below 90th percentile of 30 minutes.
    d. **This section (VI, 3(d) i-iii) is RESERVED until January 1, 2023.** Upon subsequent release of the monthly Hospital Report, allowing a minimum of 30 days for corrective actions for mid-month submission, hospitals with continued APOT-1 times greater than 30 minutes shall be subject to the following

adverse actions. A Receiving Facility may choose **one** of the following, in consultation with EMSA:

i. Mandatory implementation of an EMS offload plan that allows EMS providers to directly place a stable, noncritical patient into a waiting room to ensure a 30-minute offload time based on criteria for an APOT Alert in Policy 4000.1.
    1. The temporary implementation will last for 30 calendar days.
ii. Temporary suspension of the hospital's prehospital specialty care designation pursuant to Policy 5000 if the specialty care destination has three (3) or more receiving centers in San Francisco (ie STAR, stroke).
    1. The temporary suspension will last for 14 calendar days
iii. The Receiving Facility may choose to cancel a percentage of nonemergent, patient choice, elective surgeries as an adverse action in lieu of two adverse action options above. If the Receiving Facility chose this adverse action, the Receiving Facility would notify EMSA. EMSA would consider this decision a substantial step in lieu of some of the other adverse actions.

e. Any actions taken against a Receiving Facility shall be posted to the EMS Agency website, including notice of any Receiving Facilities on a Corrective Action Plan.
f. If a Receiving Facility does not make progress after implementation of one of the above adverse actions, the Receiving Facility may be subject to additional adverse actions.

4. Option 2 – Root Cause Analysis and Adjudication: Receiving Facility acknowledges that all changes that can be implemented have been implemented, resources have been exhausted, and external factors do not allow the Receiving Facility to meet the APOT-1 standard.
5. Receiving Facility submit a corrective action plan to reduce APOT-1 delays within 30 days of corrective option selection.
    a. The EMS Agency shall review the corrective action plan within 10 business days.
    b. The plan shall include, but not limited to, the following topics:
        i. Prominent dashboards on homepage of public facing Receiving Facility websites
        ii. Data submission and analysis as determined by the EMS Agency
        iii. Quarterly reports to the San Francisco Health Commission and Board of Supervisors (San Francisco

Controllers Office, if applicable or determined by EMS Agency)

c. Upon approval of the plan by the EMS Agency, the Receiving Facility shall comply with the plan or may be subject to adverse actions as listed in Section VI, 3(d)(i-iii).

VII. DIVERSION MITIGATION

1. For Receiving Facilities meeting Quality Assurance criteria of Policy 5020, Section X,C, the Receiving Facility shall select a corrective option listed below and submit selection in writing to the EMS Agency within 30 days of issuance of the Hospital Report.
2. Option 1 – Traditional Pathway: Receiving Facility acknowledges that changes can be made by the Receiving Facility AND will eventually meet the diversion standard, with 5% improvement month on month.
3. Receiving Facility shall submit a corrective action plan to reduce ambulance diversion within 30 days of corrective option selection.
    a. The EMS Agency shall review the corrective action plan within 10 business days.
    b. The plan shall include, but not limited to, the following topics:
        i. Current data and patient trends
        ii. Patient surge measures implemented such as HICS, alternative treatment spaces, emergency staffing
        iii. Identification of communication pathways and plans
        iv. Objectives, measurements, and metrics for improvement
    c. Upon approval of the plan by the EMS Agency, the Receiving Facility shall have a minimum of 30 days to reduce ambulance diversion monthly percentage times below 30%.
    d. Upon subsequent release of the monthly Hospital Report, allowing a minimum of 30 days for corrective actions for mid-month submission, hospitals with continued >30% ambulance diversion shall be subject to the following adverse actions. A Receiving Facility may choose **one** of the following, in consultation with EMSA:
        i. Temporary allocation of a maximum of eight (8) hours of ambulance diversion in a 24-hour period (midnight to midnight), including the use of Trauma Override, if applicable.
            1. The temporary implementation will last for 30 calendar days.
        ii. Temporary suspension of the hospital's prehospital specialty care designation pursuant to Policy 5000 if

the specialty care destination has three (3) or more receiving centers in San Francisco (ie STAR, stroke).

1. The temporary suspension will last for 14 calendar days.

iii. The Receiving Facility may choose to cancel a percentage of nonemergent, patient choice, elective surgeries as an adverse action in lieu of two adverse action options above. If the Receiving Facility chose this adverse action, the Receiving Facility would notify EMSA. EMSA would consider this decision a substantial step in lieu of some of the other adverse actions.

e. Any actions taken against a Receiving Facility shall be posted to the EMS Agency website, including notice of any Receiving Facilities on a Corrective Action Plan.

f. If a Receiving Facility does not make progress after implementation of one of the above adverse actions, the Receiving Facility may be subject to additional adverse actions.

4. Option 2 – Root Cause Analysis and Adjudication: Receiving Facility acknowledges that all changes that can be implemented have been implemented, resources have been exhausted, and external factors do not allow the Receiving Facility to meet the diversion standard.

5. Receiving Facility submit a corrective action plan to reduce diversion within 30 days of corrective option selection.

a. The EMS Agency shall review the corrective action plan within 10 business days.

b. The plan shall include, but not limited to, the following topics:

i. Prominent dashboards on homepage of public facing Receiving Facility websites

ii. Data submission and analysis as determined by the EMS Agency

iii. Quarterly reports to the San Francisco Health Commission and Board of Supervisors (San Francisco Controllers Office, if applicable or determined by EMS Agency)

c. Upon approval of the plan by the EMS Agency, the Receiving Facility shall comply with the plan or may be subject to adverse actions as listed in Section VII, 3(d)(i-iii).

VIII. EXCEPTIONS AND IMPLEMENTATION

1. **Sections VI and VII are considered a pilot policy and will undergo formal outcomes review in June 2023, with formal reporting of**

outcomes at July 2023 EMSAC to determine if this will be adopted into full policy. If an outcomes review does not occur or obtain consensus for any changes, sections VI and VII shall become adopted in full.

2. For Receiving Facilities that meet criteria as listed in Section VI(1) and/or VII(1) AND are required to submit a correction action plan, the following is in effect from July 1, 2022 until January 1, 2023.
    a. If Receiving Facility, in which is out of compliance, reduces APOT 90th Percentile metric by 5% over previous month, the corrective action plan requirement and adverse action process is stayed.
    b. If Receiving Facility, reduces monthly ambulance diversion by 5% over previous month, the corrective action plan requirement and adverse action process is stayed.
    c. The EMS Agency shall take into consideration external factors that affect the entire San Francisco healthcare system in corrective action plan requirements over a monthly period such as a pandemic surge or increased levels of EMS patients.
    d. Upon completion of the listed implementation period, the above section VIII is removed from EMSA policy.