

McMillan Stabilization Pilot Project
6-Month Interim Report
Attachments

**ATTACHMENT A
McMillan Stabilization Pilot Project Committees**

Name	Representing	Committee				
		Oversight	Program Evaluation	Case Mgmt	Organiz Develop	Medical Advisory
Abbie Yant	St. Francis Memorial Hospital					●
Alex Barnes	SFDPH – McMillan Stabilization Pilot Project			●		
Alice Gleghorn	SFDPH – Community Behavioral Health Services	●	●			
Arielle Piastunovich	SFDPH – McMillan Stabilization Pilot Project	●			●	
Barbara Garcia	SFDPH – Deputy Director of Health	Chair			●	
Barry Zevin	SFDPH – Tom Waddell Health Center	●	Co-Chair		●	Chair
Blanche Korfmacher	SFDPH – Community Behavioral Health Services				●	
Bob Cabaj	SFDPH – Community Behavioral Health Services	●				
Carol Chapman	SFDPH – Community Behavioral Health Services Program	●				
Cathy Garza	Advisor to Mayor Gavin Newsom	●				
Charles Morimoto	Community Programs - Admin	●			●	●
David Ofman	SFDPH – Primary Care	●				
David Pating	Kaiser Permanente					●
Donna Childers	SFDPH – IS	●				
Edwin Batongbacal	SFDPH – Community Behavioral Health Services				●	
Glenn Ortiz-Schuldt	Emergency Communications Department	●				
James Tate	SFDPH – Community Behavioral Health Services	●	●		●	●
Jane Smith	SFFD	●				
Janet Goy	Community Awareness & Treatment Services (CATS)	●		●		●
Jeff Burton	SFDPH – IS	●				
Jim Stillwell	SFDPH – Community Behavioral Health Services	●				
Jim Westphal	SFDPH – SFGH		●			●
John Brown	SFDPH - EMS	●	●			●
John Mendelson	UCSF – St. Francis Memorial Hospital	●	Co-Chair			●
Jorge Partida	SFDPH – Community Behavioral Health Services					●
Jorge Solis	SFDPH – McMillan Stabilization Pilot Project	●		Chair	●	●

**ATTACHMENT A
McMillan Stabilization Pilot Project Committees**

Name	Representing	Committee				
		Oversight	Program Evaluation	Case Mgmnt	Organiz Develop	Medical Advisory
Keith Fowler	Baker Places	●				●
Kristin Kuzman	EMS Communications		●			●
Kym Valadez	Swords to Plowshares	●				
Laurie Nobilette	SFDPH – Tom Waddell Health Center					●
Liz Gray	Community Programs - Placement	●			●	
Madeline Daley	SFDPH – Tom Waddell Health Center				●	●
Marc Trotz	SFDPH – Housing and Urban Health	●				
Maria X Martinez	Community Programs - Admin	●			Chair	
Marian Pena	SFDPH – Tom Waddell Health Center				●	
Mark Pletcher	UCSF	●	●			●
Niels Tangherlini	SFFD – EMS	●	●	●		●
Peter Washburn	Kaiser Permanente					●
Phil Castiglione	SFDPH – Community Behavioral Health Services – Treatment Access Program					●
Ron Smith	Hospital Council of Northern and Central California	●				
Scott Campbell	Kaiser Permanente – ER Diversion Task Force Chair	●				
Sharon Kennedy	SFDPH – SFGH ED					●
Sonia Bailey	Baker Places	●				●
Tom Hagan	SFDPH – Community Behavioral Health Services – Treatment Access Program	●			●	
Willie Hall	Community Awareness & Treatment Services (CATS)	●		●		●
Wylie Liu	Community Programs - Admin	●			●	

ATTACHMENT B
Inclusion Criteria for Sobering Unit

1. Sources of entry:
 - a. Found on Street, and/or in other public venue
 - b. Found in Police Department custody
 - c. Screened and cleared by Hospital Emergency Department
 - d. MAP
 - e. Ambulance transports patient from shelter or a and b above

2. All of the following must be present:
 - a. Indication of alcohol intoxication (odor of alcoholic beverages on breath, bottle)
 - b. Glasgow coma score 13 or greater
 - c. Systolic blood pressure greater than 100 and less than 180
 - d. Pulse rate over 60 and under 110
 - e. Respiratory rate over 12 and under 24
 - f. Blood sugar level over 80 and below 200
 - g. No active bleeding noted
 - h. No red or purple bruising or hematoma above clavicles
 - i. No active seizure
 - j. No laceration that has not been treated
 - k. Ability to ambulate with assistance, and ability to provide basic information

3. The patient must be age 18 or over

4. The patient must consent voluntarily or have presumed consent (not oriented enough to consent)

5. The patient is not on the McMillan Drop-In Center “exclusion list”.

Any other patient must be dispositioned according to current standard EMS System protocol (SF EMS System, MAP Standard Operating Procedures, or Individual Hospital Emergency Department Standards)

**ATTACHMENT C
Nursing Protocols**

**San Francisco Department of Public Health
McMillan Stabilization Pilot Project**

**39 Fell St.
San Francisco, CA. 94112
Revised 11/12/03**

Nursing Protocols

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ATTACHMENT C Nursing Protocols

Protocol #1

Call 911 Protocol

All Nursing staff must call 911, when assessing a client who presents with:

1. Unresponsiveness
2. Cardiac Arrest
3. Chest Pain
4. Grand mal seizure lasting more than 2 minutes
5. Abdominal and/or chest wounds
6. Vomiting blood
7. Violent Behavior
8. Suicidal and/or homicidal
9. O₂sat less than 93%
10. Audible wheezing and respiratory distress
11. Respiration less than 8 or greater than 24 per minute

Protocol #2

Call Medical Back-Up Protocol

Call Medical Back-Up:

Mon-Fri 8:30am –5:30pm Consult with the Nurse Practitioner on duty or call the Medical Director of McMillan Project – Barry Zevin MD, at **(415) 205-0913**, if unavailable call the TWHC urgent care MD on duty **(415) 355 – 7450**

Mon-Fri 5:30pm – 8:30 am, Sun & Sat call SFGH ED attending In Charge (AIC) **(415) 206-8111** and ask for attending in charge.

All nursing staff must state “I am calling from the McMillan Stabilization Center” and be prepared to give the following information: client age, gender, and present presentation and reason for calling, current level of consciousness, orientation, ability to ambulate and take PO fluids, relevant medical history. Nursing staff should state that “according to our protocols, this patient requires urgent evaluation. Should this patient be sent by ambulance, MAP, or taxi?”

Indications to call the Medical Back Up include:

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1. Fever greater than 101.5
2. Abnormal blood pressure (see protocol for hypertension & hypotension)
3. Abnormal pulse (see protocol for tachycardia & bradycardia)
4. Finger stick blood glucose greater than 250 (see protocol for diabetes)
5. Abnormal breathing (see protocol for short of breath)
6. Lacerations (see protocol for wounds & injuries)
7. Other indications as in individuals protocols

Protocol # 3

T.B. Protocol

Subjective Information

- History of exposure to active T.B.
- Complains of cough, weight loss, history of +PPD (TB skin test)

Objective Information

- Persistent coughing
- +PPD
- Hemoptysis (coughing up blood)

Assessment

Homeless individuals are at risk of contracting TB and exposing others to TB if they have active pulmonary tuberculosis. Alcoholics and people with poor nutrition and immunosuppression (e.g. HIV infection) are susceptible to reactivation of latent T.B. (Latent T.B. means that TB germs are hiding somewhere in a persons body but are not active and causing disease or contagious.) All homeless people (and staff who work with homeless population) should have screening for TB at least once every 6 months.

Plan

1. See cough alert policy
2. Clients with persistent coughing require urgent evaluation, alert NP during work hours.
3. Clients with hemoptysis, fever (see fever protocol) or difficulty breathing require urgent evaluation; call medical back-up to get advice on transport method and location.

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Protocol # 4

Lice and scabies Protocol

Subjective information

- Itching in head, hairy areas of body,
- Itching or report of rash on neck, axilla, waist, hands, genital area, etc
- Any allergies

Objective information

- Live lice on body or in seams of clothing
- Nits and lice in hair
- Excoriations
- Can not stop scratching

Assessment

Lice infestation

Possible scabies infestation

Plan

1. If patient is severely intoxicated and cannot ambulate safely delay treatment until patient is sobered up
2. Treat clients as soon after admission as it is safe to do so:
 - Remove all clothing and bag for 48 hours
 - Have client shower and wash thoroughly, staff person to supervise
 - Treat all clients with lice in hair with 0.5% permethrin shampoo
 - Leave lotion for 10 minutes then wash thoroughly with soap and water
 - Wash all clothes with hot water and dry at least 30minutes in high heat dryer
 - Treatment should be repeated in 7-10 days
 - For clients with suspected scabies refer to NP for further evaluation during working hours
 - Client with body lice only require only shower and clean clothes
 - All bedding must be washed before reuse

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Protocol #5

Chest Pain Protocol

Subjective information

- Complains of chest pain must be taken seriously. Try to gather as much information as possible, get as much description of the pain from the client and carefully determine the nature of the pain and patient's history.

PQRST

P Pain

Provocative factors
Palliative factors

Q Quality

Squeezing, crushing, heaviness,
pressure, burning, etc

R Region/radiation

Substernal, epigastric, neck, jaw

S Severity

T Temporal characteristics

How long has it been present
How long does it usually last
Does it occur at the same time
each day

Past Medical History

Associated Symptoms

Medications

Vital Signs

Skin signs

- Encourage the client to describe the location, intensity, and character of the pain- what it feels like (sharp, dull, crushing).
- Ask the client to tell you what they were doing when the pain started.
- Ask the client about other symptoms ie: SOB, nausea, weakness and if the pain travel to other areas.
- Ask if the client has had this problem before or if this is the first time.
- Is he taking any medication for any heart problems.

Assessment and Plan

The client complaining of chest pain requires an emergency medical assessment and as a result 911 should be called. No client complaining of chest pain should be admitted to the McMillan project.

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Protocol #6

Fever Protocol

Subjective information

- Chills and sweats
- Any infected wounds, cough, sore throat, abdominal pain, vomiting or diarrhea, dysuria
- Taking antibiotics

Objective information

- Temperature greater than 100
- Elevated pulse
- Signs and symptoms of infection or abscess

Assessment

The most common cause of fever in this setting is infections. It may be as a result of a variety of other conditions, including drug reactions, tumors, dehydration, and alcohol withdrawal. This is never considered a normal finding.

Plan

1. Refer to ED any client with a temperature greater than 101.5, call medical back up for advice in regards of mode of transportation
2. Recheck temperature and blood pressure every 2 hours for temperature between 100-101.5
3. Any temperature with abnormal blood pressure needs to follow BP protocol. And refer client to the ED
4. Rehydrate client as per dehydration protocol

Protocol #7

Shortness of Breath Protocol

Subjective information

- Complains of shortness of breath
- Client in respiratory distress
- History of Asthma, COPD
- Medications
- Presence of chest pain or pressure

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Objective information

- Audible wheezing
- Gasping for breath
- O₂sat less than 93%
- Respiration greater than 24 or less than 8 per minute (respirations must be regular and not labored)
- Slow, shallow breathing, noisy respirations
- Signs and symptoms of opiate/barbiturate/sedative/hypnotic use

Assessment

Vital signs

Respiratory rates outside acceptable parameters may be due to intoxication or pre-existing pulmonary disease.

Plan

1. Call 911 if respirations are less than 8 or greater than 24 per minute or if client has O₂sat less than 93% or if patient has audible wheezing or gasping for breath
2. Monitor respirations and level of consciousness every ½ hour
3. Place client in side lying position
4. If client has a history of Asthma or COPD, and has inhalers prescribed by MD, follow inhalers protocol
5. Check peak flow

Protocol #8

Head injury protocol

Subjective information

- History of head injury
- When and how did it occur
- Was there loss of consciousness
- Headaches, nausea, vomiting, lethargy, visual disturbance, weakness of an extremity, problems with coordination

Objective information

- Head contusions or laceration
- Level of consciousness
- Orientation to person, place, time, and situation
- Pupils; equality, size and reactivity
- Abnormal gait
- Ability to move all four extremities

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- Glasgow coma scale

Glasgow Coma Scale:

Eye opening	Spontaneous	4
	Responds to verbal stimuli	3
	Responds to painful stimuli	2
	No response	1
Motor Response	Obeys simple commands	6
	Localizes painful stimuli	5
	Flexion withdrawal	4
	Abnormal flexion (decorticate)	3
	Abnormal extension (decerebrate)	2
	No response	1
Verbal Response	Oriented and converses	5
	Confused	4
	Disorganized, nonsensical	3
	Unintelligible	2
	No response	1

In the presence of head trauma, patients with a score of <13 should be sent to the ED via 911.

Assessment

Persons with recent head injury, especially with loss of consciousness, are at risk for neurological complications. Signs of impending neurological disaster are easily confused with signs of acute intoxication. These clients must be observed carefully.

Signs of initial intracranial event are tachycardia and normal or low blood pressure

Late signs are widening pulse pressure and bradycardia

Plan

1. If client presents with signs of recent head trauma, (red or purple bruises anywhere above the clavicles, lacerations, dried blood) they must be referred to the ED for further evaluation. Call 911 if unresponsive or if abnormal neurological signs (unequal pupils, paralyzed limbs, not sobering up as expected)
2. Monitor level of consciousness and orientation
3. Neuro checks on admission and every 1 hour thereafter—check both pupils for reactivity and /equal size, check for ability to respond to simple commands, check movements of 4 extremities.

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Nursing Protocols

Protocol #9

Wounds protocol

Subjective information

- Place and duration of wound/injury
- Pain
- Discharge from wound
- History of tetanus immunization

Objective information

- Fever
- Redness, warmth, tenderness, swollenness
- Purulent discharge, color and amount
- Active bleeding
- Postures

Assessment

Lacerations less than 6 hours old with separation of skin edges may need suturing. Lacerations older than 6 hours cannot be closed. In this population and with dirty wounds the ED cut-off is 6 hours for suturing. Any deep lacerations, especially on the hand may involve deeper structures such as nerves or tendons.

Because of the poor hygiene and immuno-suppression associated with chronic substance abuse, wound infections are more common and may need antibiotic treatment, as well as local care.

Plan

1. Lacerations less than 6 hours refer client to the ED. Any stab wound to the neck, chest or abdomen refer client to the ED. Call medical back up for advice on transport method and location
2. Clean and dress wounds according to procedure
3. Administer Td if patient has not had tetanus shot in greater than 10 years (check LCR to confirm patient history)
4. Any deep laceration of the hands that is red, hot, swollen, and purulent must be refer to the NP in the AM for further evaluation
5. Any wound accompanied by fever must be closely monitored until evaluated by the NP

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Protocol #10

Altered Mental Status Protocol

Subjective information

- Knowledge of patients baseline mental status
- Client unable to give any information
- Presents quite confused and disoriented
- Lethargic
- Stuporous
- unresponsive

Objective information

- Pupils [equality, size, and responsiveness],
- Ability to move 4 limbs,
- Ability to follow commands,
- Response to painful stimuli,
- Unresponsiveness,
- Oxygen saturation by pulse oximeter <93%
- Finger stick glucose
- Blood Alcohol Level (BAL) by breath analyzer

Assessment

Changes in mental status can be as a result of various situations/conditions including but not limited to stroke, hypoglycemia, hyperglycemia, medication toxicity, liver, kidney, and heart failure or head injury. Any of these conditions may coexist with intoxication of alcohol or any other substances. If the client is not able to give simple yes and no answers about himself, he may have dangerously altered mental status and must be referred to the ED for further evaluation. Blood alcohol level .08 is usual limit for intoxication, if less than this other causes of abnormal MS should be suspected.

Abnormalities of focused neurological exam can point to serious problems.

Plan

1. Refer to ED any client who is unable to give name and answer basic yes/no answer or is entirely unable to ambulate even with assistance. Call 911 if totally unresponsive, unable to follow simple commands, or severely disoriented.
2. Ask client about recent head injury, examine for contusions, abrasions
3. Follow head injury protocol
4. Perform Neuro check assessment (check both pupils for reactivity and equal size, check for ability to respond to simple commands, check movements of 4 extremities) on admission and every ½ hour thereafter if client presents with anything atypical from expected alcohol intoxication.

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5. Note level of orientation – if not oriented to person call medical back – up for advice on transport method and location
6. Monitor level of consciousness and progress in improvement
7. Refer to ED if client’s condition deteriorates or does not recover as expected.
8. If patient’s level of consciousness is not improved after 4 hours check BAL by breathalyzer (if rising client is using alcohol secretly – check for hidden bottles.
9. If after 6 hours client level of consciousness is not improved enough for him to take PO fluids (see dehydration protocol) and to be oriented to place, person, and time contact the medical back – up for transport method.
10. If BAL is less than .08 and client is not fully alert call medical back up.

Protocol #11

Abdominal pain / Nausea and Vomiting protocol

Subjective information

- Client complains of abdominal pain
- History of ulcers, constipation, gallbladder problems, recent abdominal trauma, pancreatitis
- Menstruating or pregnant
- No food for past 24 hours
- Past Medical History
- Medications

Objective information

- Abdominal guarding, bending forward, unable to get comfortable
- Client is pale and clammy
- Anxiety and agitation
- Client reports vomiting diarrhea, blood in emesis or stool
- Dehydration
- Vital Signs

Assessment

Abdominal pain can be caused by something simple as gas or indigestion, or may very well be a serious life threatening condition like internal bleeding. Careful assessment and observation must be done.

Plan

1. Call 911 if vomiting blood, passing black tarry stools (melena), or bright red bloody stools (hematochezia)
2. Call medical back-up for other observed bleeding
3. Gather history carefully
4. Evaluate vital signs if BP < 90 call 911.

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5. If patient complains of abdominal pain offer fluids and reassess in 30 min. If pain is persistent and not improving call medical back-up for advice on transport method and location
6. If nausea persists have the client take slow sips of water reassess in 30 min.
7. If patient vomits assess as for nausea and have client sip fluids and reassess in 30 min.
8. Any pregnant women with abdominal pain call medical back – up for advice on transport method and location

Protocol #12

Suicidal protocol

Subjective information

- Depressed mood; feels sad, poor appetite, sleep disturbance, weight loss, lack of interest in life, under treatment for depression and has stopped meds
- Recent loss of family member or significant other,
- No social support
- History of past suicide attempts
- Verbal expressions of suicide
- History of other mental illness; bipolar, schizophrenia,
- Recent HIV positive test

Objective information

- Appears sad, apathetic, tearful, won't eat, withdrawn
- Unable to verbally contract to not harm themselves
- Assess for plan for suicide

Assessment

Clients with alcoholism are a high-risk group for suicide. We must be alert to possible suicidal ideation and always assess for potential suicide victims, especially if any history is known.

Plan

1. If client is suicidal Call 911 for 5150 evaluation
2. If client is able to verbally contract to no harm to self, keep a close monitoring on this person. Inform NP and case management team during working hours.

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Protocol #13

Violent Behavior Protocol

Subjective and Objective information

- Physical threats, verbal abusiveness, disruptive behavior, extreme agitation, combative behavior

Assessment

Assaultive or dangerous behavior is not tolerated in this center, it does not matter if this is as a result of substance induced behavior or mental health disorder. Combative clients are a higher risk to harm themselves and others.

Plan

1. Call 911 for assistance
2. Protect yourself, co-workers, and other clients from potential injury. Seek help from available staff and do not attempt to prevent client from leaving MDIC
3. Give the police officers any history you may have about the client's medical history
4. Bring to attention of project director during working hours

Protocol #14

Diabetes Protocol

Subjective information

- Any past history of DM
- Past history of Hyper or Hypoglycemic episodes
- Current medications
- Compliance with FS and insulin

Objective information

- Vital signs per standing orders
- Signs and symptoms of hypoglycemia ie; weakness, sweating, rapid pulse, tremor, hunger, anxiety, confusion, disorientation, and deterioration of level of consciousness
- FS monitoring: if FS is greater than 250 or less than 60 client needs to go to the ED

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Assessment

Hypoglycemia and Hyperglycemia may be difficult to distinguish from intoxication and withdrawal syndromes. Identification of diabetes and prevention of hypoglycemia are the main objectives of care. Hypoglycemia in general is less well tolerated and more rapid in onset than hyperglycemia. Alcoholics tend to deplete their sugar stores and are more prone to hypoglycemia than non-alcoholics. Diabetics are also prone to dehydration due to excessive diuresis.

Plan

1. Perform fingerstick glucose on any client whose status is uncertain
2. If FS blood glucose is greater than 250 clients need to be referred to the ED, call medical back-up for advice on transport method and location
3. If FS blood glucose is less than 60 encourage fluids and nutritional snacks and call medical back-up for advice on transport method and location.
4. Observe all diabetics for signs and symptoms of hypoglycemia and dehydration
5. Encourage fluids and snacks
6. Encourage diabetics to use their medications and insulin as directed
7. All diabetics who are stuporous/obtunded shall be referred to the ED for evaluation (see change in mental status protocol)

Protocol # 15

Hypothermia Protocol

Subjective information

- Complains of feeling cold
- Exposure to cold, especially wet, weather
- Inadequate clothing
- Shivering

Objective information

- Temperature less than 97.5
- Shivering, lethargic
- Damp or inadequate clothing
- Body is cold to touch
- Diminished level of consciousness

Assessment

A subnormal temperature in this setting is most often as a result of exposure. Rarely it will be a sign of other disorders such as sepsis or hypothyroidism.

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Plan

1. Radiant heat, dry clothes, blankets, warm liquids (note; never force fluids on a client with diminished level of consciousness)
2. Call 911 if temperature is less than 95 client needs to be sent to the ED
3. Recheck temperature every 2 hours until 97.5 or greater

Protocol #16

Pregnancy Protocol

Subjective information

- Client states that she is or might be pregnant
- Client appears to be pregnant
- Client states that her period is late

Objective information

- Client has a positive pregnancy test
- Client has documentation of pregnancy
- Date of LMP

Assessment

The pregnant client using drugs and alcohol has a significant risk for adverse birth outcomes. Substance using women often avoid prenatal care because they feel ashamed of their use or are too involved in using to make care a priority.

Plan

1. Start by performing a urine pregnancy test,
2. If she is pregnant, client must be referred to the a prenatal care clinic ASAP
3. Take detail information about her drug use
4. Make sure client gets plenty of fluids and food
5. If history or physical examination suggests pregnancy greater than 24 weeks refer to ED. Call medical back-up for advice on transport method and location.

ATTACHMENT C Nursing Protocols

Protocol #17

Hypertension Protocol

Subjective information

- Headache, chest pain, confusion, irritability, past history of elevated blood pressure, current antihypertensive medications

Objective information

- Take blood pressure
- Systolic Blood Pressure (SBP) greater than 180
- Diastolic Blood Pressure (DBP) greater than 90

Assessment

Elevated blood pressure may be due to essential hypertension, stress, drug effect, chronic alcoholism, alcohol withdrawal, or various medical conditions. The constellation of headache, confusion, and/or chest pain with SBP>180 and DBP>110 may represent malignant hypertension, a medical emergency. Often hypertensive persons are asymptomatic.

Plan

1. Refer to ED any client with a blood pressure of Systolic Blood Pressure (SBP) >**180** or Diastolic Blood Pressure (DBP) >**110**. Call for medical back-up for advice on transport method and location
2. If SBP is 140-180 or DBP is 90-110, rehydration of 1 liter of fluids and recheck BP in 30 min
3. Recheck blood pressure every 2 hours
4. Refer to NP for evaluation during working hours
5. Assess for other signs of alcohol withdrawal (see alcohol withdrawal protocol)
6. Appropriate client teaching if able.

Protocol #18

Tachycardia Protocol

Subjective information

- Current cardiac or antihypertensive medications
- Complain of palpitations, anxiety, fatigue, chest pain, dizziness
- Past history of pulse abnormalities

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Objective information

- Pulse >130
- Regular or irregular
- Syncope
- Medication
- Evaluate blood pressure. Hypotension in the presence of tachycardia is indicative of hypovolemia.

Assessment

Elevated pulse or tachycardia may be due to stress, drug effect, exertion, dehydration, heart problem, alcohol withdrawal, or a host of other conditions. A pulse above 100 is almost never normal except as a temporary reaction to stress or exercise. A client with a history of tachycardia may have an abnormal normal pulse rate.

Plan

1. Any client with a pulse >130 must be referred to the ED. Call medical back-up for advice on transport method and location
2. Monitor pulse every 2 hours if initial pulse greater than 100
3. Evaluate for other signs of alcohol withdrawal (see alcohol withdrawal protocol)
4. If client taking medication encourage to adhere to regimen
5. Client with abnormal pulse rate must be referred to the NP for evaluation during working hours

Protocol # 19

Bradycardia Protocol

Subjective information

- Current cardiac and other medications (e.g. clonidine, atenolol, propranolol, etc...)
- Past history of pulse abnormalities
- Fatigue, dizziness

Objective information

- Pulse rate <60
- Regular or irregular

Assessment

Low pulse or bradycardia may be due to a drug effect, heart problem, fainting, or may be normal in athletic persons

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Plan

1. Any client with a pulse lower than 60 must be referred to the ED. Call medical back-up for advice on transport method and location
2. Monitor pulse every 2 hours
3. Check Blood Pressure
4. Hydrate client
5. Refer to NP for evaluation during working hours

Protocol # 20

Hypotension Protocol

Subjective information

- Dizziness, especially when standing or getting up quickly
- Any antihypertensive (blood pressure) medication

Objective information

- Systolic blood pressure less than 90
- Pulse rate
- Any bleeding

Assessment

A systolic blood pressure less than 90 is not a normal finding, however, in some individuals a reading of 90 can be normal. Hypotension is most often a result of dehydration in this setting, it may also be due to blood loss, drug effect, heart problems, or hypothermia.

Plan

1. Call 911 and refer any client to the ED if systolic blood pressure is less than 80 or less than 90 and unresponsive or unable to take PO fluids
2. If initial BP is less than 100 encourage PO fluids and evaluate clients for dehydration and rehydrate if possible. If SBP is 80-90 and client is arousable and able to take PO fluids than give oral rehydration of 1 liter or more and recheck in 30 min. If less than 90 after 30min call 911
3. Recheck BP ½ hour after admission and every 2 hours after for SBP less than 100
4. Client on meds must be encouraged to comply with their meds except hold anti-hypertensive medications until NP evaluation if client has SBP less than 100.

ATTACHMENT C Nursing Protocols

Protocol #21

Alcohol Withdrawal Protocol

Subjective Information

- Client complains of withdrawal, strong craving for alcohol, past history of seizures, number of hours since last drink
- History of severe withdrawal symptoms in past

Objective Information

- Tremors, visual hallucinations, seizures
- Clients with D.T.s (delirium tremens) the most serious and dangerous form of alcohol withdrawal will have agitation, disorientation, hallucinations, tachycardia, hypertension, and may have fever and diaphoresis

Assessment

Alcohol withdrawal is common in chronic alcoholics and may occur even while the patient is still drinking and still has detectable BAL. Severe alcohol withdrawal (DT's) is less common but considered a medical emergency.

Plan

1. Call 911 for emergency medical care for patients with agitation, tachycardia (see protocol), hypertension (see protocol)
2. Reorient and reassure clients with hallucinations and tremor and mild disorientation
3. Refer to NP during work hours

Protocol #22

Seizure Protocol

Subjective Information

- Obtain past history of seizures
- Feeling of imminent seizure or other prodrome
- History of taking anti-epileptic medications

Objective Information

- If client feels he or she is likely to have a seizure place him/her on a mat on the floor.
- Protect area and observe
- If seizure occurs observe the client and note time and type of seizure

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Assessment

Seizures are common in chronic alcoholics and may be due to alcohol use or withdrawal, brain scarring due to previous head trauma, or idiopathic epilepsy. Seizures are not dangerous in themselves but risk of injury is very high.

Plan

1. If seizure last longer than 2 minutes call 911 for emergency transport to the ED
2. If client sustain head trauma, lacerations, or other serious injury call 911
3. If client is not alert and oriented after 20 min call 911 for emergency transport
4. If seizure is less than 2 min and client is alert and oriented after 20 min encourage PO fluids and refer to NP during work hours

Protocol #23

Dehydration Protocol

Subjective Information

- Client complains of being thirsty
- Client has not consumed any non-alcoholic fluids for greater than 4 hours
- Exposure to hot conditions or dressed inappropriately

Objective Information

- Dry mucus membrane
- Low blood pressure (see hypotension protocol)
- Tachycardia (see tachycardia protocol)

Assessment

Alcohol in any form may cause dehydration due to a diuretic effect. Chronic alcoholics may not drink other fluids and become dehydrated.

Plan

1. All clients are offered and re-offered oral rehydration
2. Mix 1 packet oral rehydration powder with 1 liter of water
3. All clients who are alert enough should be encouraged to drink as much oral rehydration as possible.

ATTACHMENT D

Case Management and Transition Protocols

**City and County of San Francisco
Department of Public Health**

**South of Market Mental Health Services
In Collaboration with
McMillan Stabilization Pilot Project**

McMillan Stabilization Project Case Management Protocol

The MOST team is a service team of South of Market Mental health Clinic. The team's primary focus is to provide a comprehensive and integrated services to homeless mentally ill, substance abuse, and medically complex individuals, who are not accessing clinic based services, and are frequent users of the EMS and ED system.

Treatment include:

- Intensive case management
- Individual Therapy
- Medication Support Services
- Crisis intervention
- Linkage and transition to the necessary treatment provider

Goals include:

- Engage individuals in mental health, substance abuse, and medical services
- Stabilize symptoms
- Prevent high use of the EMS and ED systems
- Meet basic need, enhance quality of life and social functioning
- Housing referral
- Benefits assistance
- Linkage

Criteria for referrals are:

- Referrals will be centralized through the McMillan drop-in center collaboration
- Frequent user of the EMS and ED system
- Homeless
- Dually or multiple diagnosed
- Unable to access clinic base services

The staff client ratio will depend on the intensity of this new population, as well as the collaboration of other programs. But, it is safe to say that the MOST team will transition and link clients to the necessary treatment providers and to maintain an open door policy.

ATTACHMENT D
Case Management and Transition Protocols

McMillan Stabilization Pilot Project
Case Management Client Transition Protocol
----DRAFT----

As a general guideline, the goal is to transition or close case management team clients within 12-18 months of working with them. This guideline is general and clients can be transitioned both earlier and later than this timeline depending on what is deemed clinically necessary and appropriate.

Transition can mean any of the following.

- 1) Linkage to an appropriate placement or team;
- 2) Re-linkage to original or primary case management team if our services have been contracted short-term;
- 3) Discharge of client from treatment due to client's death or travel out of the service area;
- 4) Internal change of reporting units – from 38719A to 38719C.

Transition may occur for any of the following reasons:

- 1) Client dies;
- 2) Client moves out of service area;
- 3) Client is linked back to original primary care provider;
- 4) Client is linked with appropriate long term care wherein transition to new providers has been completed;
- 5) Client cannot be found for a period of 3 months;
- 6) Client refuses all services for a period of 6 months when repeated attempts have been made to engage him into service.

Factors that may influence extending transition may include the following:

- 1) Continued EMS and emergency room usage due to ongoing psychiatric, medical and /or substance abuse issues;
- 2) Slow movement in treatment phases, i.e., client is not engaging, client remains unstable and continues to have crises, client needs additional time for maintenance treatment;
- 3) Prior transition attempts that have been seen to cause regression wherein it has been ascertained that the client needs more time for smoother transition;
- 4) The risk of regression into homelessness, severe substance abuse, mental illness, medical decompensation and/or death is imminent if client does not continue to receive treatment.

ATTACHMENT E
San Francisco Chronicle Article – February 7, 2003

Funds for sobering center/S.F., hospitals paying to ease drunk load in ERs

Ilene Lelchuk, Chronicle Staff Writer

Frustrated with chronic homeless alcoholics who sleep it off in San Francisco's emergency room beds, private hospitals will donate \$400,000 so the city can create a safe place for drunks to sober up, hospital and city officials announced Thursday.

The San Francisco Health Department, which runs the city's largest emergency room at San Francisco General Hospital, will pay another \$400,000 to start the new program in a Tenderloin clinic this spring.

The one-year pilot program is the result of a study by a City Hall task force that found that the number of hours that overcrowded emergency rooms must divert ambulances to other hospitals has grown tenfold in five years.

Nearly a third of the ambulances arriving at city hospitals were transporting chronic public alcoholics to the emergency room, the study found. And while an average patient spent about 3.5 hours in an emergency room, an intoxicated patient stayed six hours.

"One out of five of our patients on a Friday, Saturday or Sunday is a public inebriate," said Cheryl Fama, president of St. Francis Hospital, which donated \$50,000 to the sobering center.

Chinese Hospital, Kaiser Permanente, St. Luke's Hospital, UCSF and Catholic Health Care West also donated funds to the sobering center.

Supervisor Gavin Newsom, one of the city officials who requested the task force study, called the situation a health care crisis during a press conference Thursday.

"It's reducing the likelihood that you or your family can access emergency health care," said Newsom, who is running for mayor this fall.

The sobering center will be located in the existing 28-bed McMillan Center, the city's only walk-in clinic where homeless inebriates can sleep it off on a green mat, grab a snack and see a social worker.

For the pilot program, McMillan will add medical staff and be available to ambulances 24 hours a day so paramedics can drop off inebriates who have no other medical emergency. No date has been set for the opening.

The sobering center is one of the only new initiatives being funded this year by the Health Department, which is struggling to cut \$70 million -- including programs for the homeless and mentally ill -- to help the city erase a potential \$350 million deficit.

Mitch Katz, the city's public health chief, estimates that the city's \$400,000 investment in a sobering center will save San Francisco General Hospital \$200,000 by freeing up emergency room beds now taken up for hours by chronic inebriates so the hospital can serve more patients who move through the system more quickly.

ATTACHMENT E
San Francisco Chronicle Article – February 7, 2003

The sobering center is a small start to solving two major health care dilemmas hitting most urban areas: how to help chronic public drunks and how to unclog emergency rooms.

Newsom said the city is studying other ways to improve the city's emergency system, including creating a 311 phone number that the public can call for non-emergencies. To deal with public inebriates, he also is looking at programs where other cities have asked liquor stores and markets to restrict alcohol sales in heavily impacted neighborhoods.

ATTACHMENT F
San Francisco Chronicle Article – July 30, 2003

S.F. starts detoxification center for public alcoholics

Rachel Gordon, Chronicle Staff Writer

At 8 a.m. Thursday, San Francisco will start dealing with chronic street drunks a bit differently, with the goal of getting them out of pricey hospital emergency rooms and into a "sobering" center where they can tap into the system of long-term help.

The goal is ambitious and may not be met right away, given that there are an estimated 1,000 habitual alcoholics in the city who live on the streets and scarce resources to care for them. But, say city officials and hospital administrators who helped bankroll and organize the program, it's a start.

"We really do believe that this program will save lives," said Barbara Garcia, San Francisco's deputy director of public health.

The program will start out slowly. At first, emergency room staff in San Francisco hospitals can call the city and request that a patient ready for discharge whose chief problem is acute alcoholism be transported by van --with the patient's consent -- to the sobering center instead of just being let out on the street.

Once at the center, the patient could then meet with a case manager to see about going into a detox program and determine what other services are needed. Medical and mental health practitioners also will be on hand.

In the second phase of the program, set to start in September, paramedics will decide whether to take people to a hospital or directly to the sobering center.

A City Hall task force, chaired by Dr. Scott Campbell, an emergency room physician at Kaiser Permanente, issued a report earlier this year that found nearly a third of the ambulances arriving at hospitals in the city were carrying chronic, public alcoholics who used the emergency rooms to essentially sober up. Some people made multiple trips to the hospital in a day.

The new program, Campbell said, will start to "address the medical, social and psychological challenges of breaking the cycle of public inebriation."

Supervisor Gavin Newsom, who helped kick-start the program, said the annual cost of \$1.8 million in city funding needed to operate the around-the-clock program will be money well spent.

"Now we have a place we can send people to be triaged and get help without sending them through an acute care environment," he said.

San Francisco's private hospitals -- Kaiser Permanente, St. Francis, UCSF, Catholic Health Care West, St. Luke's and Chinese -- donated a combined \$422, 000 to help launch the initiative. If it works as intended, their emergency rooms will be freed up for other patients.

Dr. Barry Zevin, a public health doctor who works extensively with homeless people and who will oversee medical care at the sobering center, estimated that 1,000 homeless people fit into

ATTACHMENT F
San Francisco Chronicle Article – July 30, 2003

the category of chronic public inebriants. Garcia said the Department of Public Health has identified 160 individuals who are stuck in the revolving door between the streets and the emergency rooms.

The new program will be run out of the existing McMillian Center, a drop-in center for street alcoholics near Market and Van Ness streets. It has 28 beds, and Garcia said clients there will be given priority to get into residential treatment programs.

Currently, there are 25 medically supervised detox beds in the city, with usually one to three becoming available for a new patient every day. Public health officials say they easily could use another 25 beds to meet the demand.

The poster boy for the group has been Paul Sanchez, who has been picked up more than 100 times for being drunk in public, taking up the time of cops, ambulance crews, prosecutors and emergency room doctors and nurses. His case has highlighted the shortfalls of the system of care and frustrations and difficulties of getting people the help they need.

But Sanchez may become the poster boy for a new cause: people who have broken from the cycle. Garcia said Tuesday that he has been on the mend for eight months now, living in a board and care home.

ATTACHMENT G
San Francisco Examiner Article – July 30, 2003

A sobering prospect

By Evelyn Rusli

In an effort to free up hospital beds and offer comprehensive care to chronic alcoholics, Supervisor Gavin Newsom and representatives from the public and private sectors on Tuesday announced the opening of the McMillan Stabilization Project.

Starting Thursday, hospital emergency rooms will be able to transfer non-life-threatening inebriation cases to the McMillan Center, according to Scott Campbell, leader of the Emergency Room Diversion Task Force that outlined the program.

In September, this program will move into phase two and paramedics will be able to directly transfer patients to the McMillan facility.

For the first time in the state, paramedics will not automatically take every incoming patient to the hospital. Instead, paramedics will be responsible for using a standardized criterion to assess whether an inebriation problem can be handled at an alternative location, according to Glenn Ortiz-Schuldt, the Deputy Director of the Emergency Communications Department.

The center, located on 1446 Market Street, will help decrease The City's rising emergency room diversion rate by taking the pressure off overcrowded emergency rooms. Emergency room diversion occurs when hospitals are so congested that incoming patients are directed to other hospitals. This patient switch-off stalls medical care and potentially leads to fatal consequences.

"Diversion were increasing tenfold since 1995 and it's doubling every 18 months," Newsom said. "That's a crisis."

To reduce The City's current 40 percent diversion rate, this \$1.5 million project will add an extra 28 beds to the 140 emergency room beds available in The City, Campbell said. Hospitalizing alcohol abuse patients under today's system translates into an added \$13 million-\$22 million expense for taxpayers, Newsom said.

"It is a staggering human and financial cost," Newsom said.

Besides improving patient care at hospitals and saving taxpayers money, the project provides comprehensive care for chronic alcohol abusers including individual case management, detoxification and other health services. The facility will help The City take an aggressive approach toward rehabilitating people suffering from alcohol abuse.

"We want to truly help these people turn their lives around," Newsom said.

Eventually, McMillan's services are expected to expand as the program continues to grow and develop.

A coalition of public and private groups, including the Department of Public Health, Community Awareness and Treatment, the Emergency Communications Department, and the Hospital Council of Northern and Central California worked together to jumpstart the program. Eight private hospitals also helped foot the bill for the project's startup costs.

ATTACHMENT H

San Francisco Health Commission Minutes – September 16, 2003

PRESENTATION OF A REPORT ON THE McMILLAN STABILIZATION CENTER

Barbara A. Garcia, Deputy Director of Health, Community Health Services, presented an update on the McMillan Stabilization Center. The Board of Supervisors appointed the Hospital Diversion Task Force to address hospital diversion and the medical burden of chronic public inebriates. One of the recommendations was to develop a pilot sobering unit project that includes medically safe triage protocols for inebriate transport to a sobering center and on-site case management and linkage. Project funders included DPH, the Hospital Council and other private sources. It was a truly collaborative effort with many DPH programs, the Fire and Emergency Communications Departments, the Hospital Council, CATS and Baker Places.

Dr. Barry Zevin continued the presentation with a description of the McMillan Stabilization Project:

- McMillan Drop-in Center (MDIC) - located at 39 Fell Street, provides drop in support for unsheltered homeless people. MDIC is operated by CATS.
- Sobering Unit - 20 stabilization beds at MDIC and staff assigned to ensure that intoxicated clients will safely sober up.
- McMillan Stabilization Pilot Project - Sobering Unit and associated primary care and behavioral health providers collaborating to facilitate long term stability for clients.
- When fully staffed, the project will operate 24/7, 365 days per year. Paramedics will triage inebriates on the street. MDIC nursing staff will be guided by protocol with specific inclusion and exclusion criteria. The project has a robust case management model. And throughout the entire department, services will be prioritized for project clients.

McMillan Stabilization Project Goals

1. To provide better care for chronic public inebriates and improve their health outcomes. This goal will be measured through discharge status and utilization of the treatment system.
2. To decrease the number of inappropriate ambulance trips that are transporting chronic public inebriates to the Emergency Department. This goal will be measured by seeing if there has been appropriate triage and transportation of destination for the client on the street and if there has been a decrease in the total number of hours of ED diversion.
3. To decrease the number of inappropriate chronic public inebriates seen in the emergency room. This goal will be measured by determining if there has been a decrease in inappropriate ED use and the number of pick ups by the MAP VAN after clearance at participating hospitals.

It is anticipated that the program will serve 500 unduplicated clients per years and will have 5,000 to 10,000 encounters per year with these clients. The project had an ambitious timeline and Dr. Zevin said they planning committees (Project Oversight Committee and Medical Advisory Committee) have met the timeline goals.

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San Francisco Health Commission Minutes – September 16, 2003

Dr. Katz said one expected outcome is an improvement in the payor mix at the SFGH emergency department, which is important because these savings have already been allocated to fund the program.

Public Comments

- Scott Campbell, M.D., Chairman of the San Francisco Ambulance Diversion Task Force and emergency room physician at Kaiser San Francisco, said that this pilot project is a new model of public/private partnership for alternative transportation for a very complex group of patients. This has not been done before in California. The data shows that the number of ambulance transports a city generates directly correlates with how busy emergency departments are, so anything that can be done to decrease the number of transports will be beneficial.
- Abbie Yant, St. Francis Memorial Hospital and member of the Ambulance Diversion Task Force, said a number of decisions, including the Police Department decision to not transport inebriates to jails, culminated in the crisis of emergency room overcrowding. This project addresses a disenfranchised population in a way that meets their needs. They do not need to be in an emergency room, but instead in an environment like the stabilization center.
- Ron Smith, Hospital Council, said this was a wonderful public/private partnership that can be used as a model. The program has already had successful results.
- Glenn Ortiz-Schuldt, Emergency Communications Department, said ECD is excited about this new partnership. Currently ECD fields 6-8 calls per day from emergency rooms that are referred to the MAP van for patients to be transported to the stabilization center. On October 1, paramedics will for the first time transport from the scene directly to the sobering center. ECD will be tracking this data and can provide various reports to DPH upon request.

Commissioners' Comments

- Commissioner Monfredini asked about the staffing pattern. Dr. Zevin said the center has LVNs, medical assistants, nurse practitioners, caseworkers, social workers and sometimes physicians. Commissioner Monfredini asked if IVs could be used at the center. Dr. Zevin replied that if a patient requires an IV, he would be transported to a hospital. Commissioner Monfredini asked if the MAP van has the capacity to accommodate increased numbers. Barbara Garcia replied that the MAP van staffing has been reworked to now provide more than just transportation. There will be gaps, and the pilot project evaluation will identify these gaps. Dr. Campbell added that Seattle and Portland have been using MAP vans very safely and effectively.
- Commissioner Chow asked how the Department assures that the right mix of staff will be at the center. Dr. Zevin said that he visited both Seattle and Portland, talking to medical directors and reviewing their protocols. This information, was discussed through the Medical Advisory Committee, which developed the specific protocols for McMillan. Quality assurance will be performed throughout. The protocols are available on the DPH Intranet site.
- Commissioner Penn asked if the MAP van staff is trained on the same protocols. Dr. Zevin said MAP staff is not trained medical personnel, but trained on working with this population. They use their own protocol to determine where the person

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should be transported. Once a person is taken to McMillan, McMillan staff will reevaluate the patient and may determine that the person does need to go to a hospital. This is the same evaluation as that done by trained paramedics on the street. This will be fully analyzed as part of the pilot project evaluation.

Commissioner Penn asked if the pilot project evaluation would allow the Department to see if it is impacting the 20% of the patients who use 80% of the ambulances services. Barbara Garcia said they already have a cohort of 140 and can immediately look at their utilization. Furthermore, the new computer systems will allow the Department to look at service usage throughout the Department. Dr. Campbell added that many physicians are awaiting the data that will come out of McMillan and will provide another level of review.

- Commissioner Umekubo commended everyone for developing the public/private solution for this complex problem. With regard to funding, will the Hospital Council continue to fund a portion of the project, and how will funding be sustained. Ms. Garcia said the hope is that the private partners will continue to fund the project, there is funding from San Francisco General Hospital and funding will continue to be a high priority for DPH. Mr. Smith stated that the Hospital Council will evaluate the data and if the program is successful would look favorably at providing additional funding.
- Commissioner Chow asked when staff would be ready to report evaluation findings. Ms. Garcia said they could provide updates every six months. She noted, however, that there is no money attached to the evaluation piece but a number of people are interested in undertaking the evaluation. Commissioner Chow asked for an update on the October 1st implementation in November, in terms of volume of people being served. Project evaluation updates should go through the Community Health Network Joint Conference Committee.
- Commissioner Monfredini asked for the San Francisco General Hospital Joint Conference Committee to be kept apprised as well, specifically regarding the impact on SFGH ED diversion.
- Commissioner Guy asked how DPH would use the evaluation to identify both successes and areas that need modification. Funding for the evaluation is critical and needs to be identified. Ms. Garcia said that evaluation is a priority and there is a commitment from staff to undertake the evaluation.
- Commissioner Sanchez said there might be some evaluation funding available through state sources.
- Commissioner Parker is excited about the McMillan center, which has been badly needed for a long time. Crisis often leads to creativity, and this is one example. The money DPH will save in the emergency department will outweigh what is spent on this program, so DPH should continue to fight to maintain this service. This program will have a positive impact across the board, from diversion rates to homeless deaths, to quality of life.
- Commissioner Chow commented that the real message is that this program focuses the problems of public inebriates. This emphasis got lost in discussions about revenue losses at private hospitals and SFGH. This program emphasizes addressing the needs of this complex population.

ATTACHMENT I

McMillan Stabilization Pilot Project – EMS Proposal

1. Background/Significance:

Chronic public inebriates place a considerable resource burden on the entire emergency system, within and beyond the Department of Public Health. 1 in 4 ambulance transports in San Francisco during a recent informal patient count were found to be inebriate related. Chronic public inebriates significantly represent low acuity calls and transports. A recommendation from the Board of Supervisor's Hospital Diversion Task Force is to establish a sobering unit at the McMillan Drop-In Center to reduce emergency visits and improve health outcomes for chronic public inebriates. Similar programs in other cities have resulted in reduced emergency visits and improved health outcomes for chronic public inebriates. It is estimated this pilot project will free up 25 to 40 visits per day at local hospitals.

The Department of Public Health is proposing a pilot project to create a medically supervised stabilization center where an inebriated client can regain his/her sobriety over a number of hours. The client will also have access to medical, nursing, behavioral health, case management and housing services to assist in his/her short and long-term stabilization process. Under this pilot project, the public inebriate who would otherwise be transported by an ambulance to a hospital emergency room throughout the City will instead be identified and triaged by paramedics and transported to the McMillan Drop-In Center. Those with indications of significant withdrawal or significant acute medical illness or injury will continue to be transported to the hospital.

The proposed McMillan Stabilization Pilot Project will be operated through a partnership between the Department of Public Health's Tom Waddell Health Center, and Chemical Awareness Treatment Services (CATS), a non-profit agency. The Stabilization Center will be co-located at CATS' McMillan Drop-In Center. CATS and the McMillan Drop-In Center were selected as the partner agency because: (1) the location is central in the City and is a block from the Tom Waddell Clinic; (2) the site is open 24 hours per day, seven days per week; (3) the program has a substance abuse focus; and (4) the target population of the McMillan Drop-In Center is similar to the population the pilot project is addressing.

This pilot project will improve the quality of care in the EMS system by insuring that patients who are chronically inebriated are transported to the most appropriate sites and improving the availability of EMS and Emergency Department resources for more acute patients.

2. Objectives

The overall goals of the pilot project are:

- a) To provide better care for chronic public inebriates and improve their health outcomes;
- b) To decrease the number of ambulance trips that are transporting chronic public inebriates to the Emergency Department; and
- c) To decrease the number of inappropriate chronic public inebriates seen in the Emergency Room.

The hypothesis is that the McMillan Stabilization Pilot Project will decrease the number of ambulance transports of the target patient population (chronic inebriates) over time and increase their successful exit from a cycle of intoxication and

**ATTACHMENT I
McMillan Stabilization Pilot Project – EMS Proposal**

Emergency Department use. A corollary of this hypothesis is that this can be done without increasing ambulance time on task.

The Medical Advisory Committee, a committee created to design the pilot project, has discussed detailed objectives for each of the above goals. A set of draft medical, case management, administrative and evaluation strategies is currently being reviewed.

3. Design/Methods

The project design aims to create a safe place for acutely inebriated persons to safely stabilize and to establish a multidisciplinary team to provide comprehensive services to identified frequent users and at risk individuals. A policy is in place to ensure that these individuals are prioritized to receive needed services. The project design will inform the data that will be collected. Some of the broad short-term and long-term outcome measurements the project is interested in examining are:

- a) Change in the number of ambulance trips transporting chronic public inebriates to the City-wide Emergency Departments.
- b) Change in the target population utilization of acute services (number of Emergency Department visits).
- c) Change in the health outcomes of the target population.

Some of the outcome measures and their source of data include:

Outcome Measures	Data Source
a. Hospital Diversion Rates	EMS Section
b. Ambulance transports of repeat users, e.g., more than 4 EMS calls per month [Pending additional resources]	AIS (SFFD Billing Service)
c. Ambulance time on task [Pending additional resources]	AIS (SFFD Billing Service)
d. MAP van transport rates	MAP Program
e. Emergency Department (ED) visit rate of patients with uncomplicated inebriation, as defined by study parameters; decrease in ED patients “left without being seen”	Receiving Hospitals
f. “Rescue” ambulance calls, complications, and death rates at McMillan	McMillan Stabilization Project
g. Health outcomes of frequent utilizers (housing, primary care, psychiatric care, substance abuse treatment, hospitalization)	McMillan Stabilization Project
h. Service utilization by frequent utilizers, e.g., visits to the ED and McMillan, visits within SFDPH funded behavioral health and medical services. [Pending additional resources]	DPH data bases
i. Survey of EMS providers (dispatchers, paramedics, ED’s and McMillan Stabilization Project staff) to determine if job satisfaction and ability to treat chronic inebriates effectively is increasing	Oversight Committee
j. Survey of stakeholders [Pending additional resources]	Oversight Committee

Some of the system design changes that will enable the Stabilization Center to function are:

1. Stabilization Center communication links:

ATTACHMENT I
McMillan Stabilization Pilot Project – EMS Proposal

- a. Stabilization Center to Emergency Communications Department, Ambulances and Hospitals: HART system, ECD to develop policy
- b. Stabilization Center to MAP vans: Cell phone (or radio system), McMillan Drop-In Center to develop policy
2. EMS System Standard Triage Criteria for Chronic Inebriates
 - a. Standardized triage criteria for “inclusion”, Paramedics, ED Triage Nurses, MAP van personnel and Sobering Unit triage personnel to use: See Attachment 1.
 - b. Exclusion Criteria: See Attachment 1
3. Training
 - a. The McMillan Stabilization Project will provide EMS System providers training materials for use in education of their personnel on the causes of chronic inebriation, co-morbid conditions, and treatment options available for these patients in addition to the Pilot Program policies and procedures.
 - b. The McMillan Stabilization Project will train its staff on communications with the EMS System providers, the ECD, use of the HART system and pilot program policies and procedures.
 - c. The McMillan Stabilization Project will provide EMS system providers, MAP van personnel, and receiving hospitals regular feedback on their conformance with pilot program policies and procedures.
4. Ambulance transport from the Stabilization Center:
 - a. Ambulances that arrive at the Stabilization Center and have deteriorated en route to the extent that they no longer meet the inclusion criteria will be transported by the same ambulance to their original destination hospital (as if the Stabilization Center was not in use)
 - b. The Stabilization Center staff will contact 911 for patients who deteriorate while under the Stabilization Center’s care. The ambulance will then take the patient to the following destinations:
 - i. If the patient meets trauma center criteria or has a head injury with the anticipated need for neurosurgical care (as determined by the McMillan Stabilization Project staff): **SFGH**
 - ii. If the patient meets unstable patient criteria per EMS Section Destination Policy (s/p cardiac arrest, impending airway compromise): **Closest Receiving Hospital**
 - iii. If the patient has a medical condition that does not meet criteria i. Or ii. Above: **Closest open Receiving Hospital or Patient/Health Plan preference**
 - iv. Non-ambulance transport of patients can be accomplished by non-EMS resources, such as MAP van
 - c. For patients who may not fit in the above triage categories, Medical Control can be consulted during regular working hours by contacting the Tom Waddell Clinic Medical Officer by calling the project medical director at 205-0913 (if the project medical director is unavailable the back up is the physician on duty in the Tom Waddell Health Center urgent care 355-7450) After regular working hours (8:00AM – 6:00PM), the Attending In Charge at SFGH can be contacted by calling the Emergency Department at 206 8111.

**ATTACHMENT I
McMillan Stabilization Pilot Project – EMS Proposal**

5. Evaluation

The following statistical methods will be used to evaluate the data:

Methodology	Data Source
a. Aggregate and by hospital Emergency Department ambulance diversion rates: <ul style="list-style-type: none"> • Before and after intervention; add seasonal factors. • Statistical Test: chi-square test to compare proportions 	EMS Section
b. Service utilization by repeat users pre-post intervention: Percent of all transports made by frequent EMS users (more than 4 requests for ambulance service/year), median number of transports, ED visits, and hospitalizations per year by frequent EMS users. <ul style="list-style-type: none"> • Statistical test: chi-square test to compare proportions, and Kruskal-Wallis non-parametric test of equality to compare medians 	SFFD AIS billing service (and private ambulance provider billing services) to collect transport data, McMillan to collect ED and hospitalization data.
c. Monthly rate of ambulance calls to 39 Fell (“Rescue” calls) and deaths pre and post intervention <ul style="list-style-type: none"> • Statistical Test: chi-square test to compare rates 	ECD, CAD and McMillan Stabilization Project
d. Surveys of providers and general public: attitudes towards target patient population pre and post intervention. <ul style="list-style-type: none"> • Descriptive statistics 	Survey conducted by Medical Advisory Committee
e. Health Outcomes Measures: Housing and other health measures of McMillan Stabilization Project clients pre- and post-intervention <ul style="list-style-type: none"> • Statistical Tests: chi-square test and multiple regression 	McMillan Stabilization Project and other DPH programs and databases

Sentinel Events: These events require the Stabilization Center staff, Emergency Communications Department Staff or ambulance provider to notify the Medical Oversight Committee and the EMS Section, utilizing the EMS Unusual Occurrence form:

- Ambulance call to 39 Fell for patient in the Sobering Unit beds
- Patient death in the Sobering Unit
- Dispatch of a MAP van to a request for 911 ambulance service
- Patient death in a MAP van while transporting a chronic inebriate

Reporting: The Medical Oversight committee will generate an interim report on the Stabilization Center project at 6 months and a final report at 12 months to the EMS Section. The report will follow the format and timelines of the EMS Section Pilot Programs Policy 1080. The reports will also be made available to the EMS System Providers.

ATTACHMENT I
McMillan Stabilization Pilot Project – EMS Proposal

6. References

Some useful references for the protocols are:

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ATTACHMENT I
McMillan Stabilization Pilot Project – EMS Proposal

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Attachment 1:

Inclusion Criteria for Sobering Unit Pilot Program (DRAFT)

1. One of the following sources of entry:
 - a. Found on Street, and/or in other public venue
 - b. Found in Police Department custody, or
 - c. Screened and cleared by Hospital Emergency Department, or
 - d. MAP, or
 - e. Ambulance transports patient from shelter or a. and b. above.
2. All of the following must be present:
 - a. Indication of alcohol intoxication (odor of alcoholic beverages on breath, bottle)
 - b. Glasgow coma score 13 or greater
 - c. Systolic blood pressure greater than 100 and less than 180
 - d. Pulse rate over 60 and under 110
 - e. Respiratory rate over 12 and under 24
 - f. Blood sugar level over 80 and below 200
 - g. No active bleeding noted
 - h. No red or purple bruising or hematoma above clavicles
 - i. No active seizure
 - j. No laceration that has not been treated
 - k. Ability to ambulate with assistance, and ability to provide basic information
3. The patient must be age 18 or over.
4. The patient must consent voluntarily or have presumed consent (not oriented enough to consent)
5. The patient is not on the McMillan Drop-In Center “exclusion list”.

Any other patient must be dispositioned according to current standard EMS System protocol (SF EMS System, MAP Standard Operating Procedures, or Individual Hospital Emergency Department Standards)

McMillan Stabilization Pilot Project - 6 Month Data Report Aug 03 to Jan 04 - Attachment J

Category	#	% of Total
Total Unduplicated Clients (UDC)	1,261	~
Total Encounters	2,696	~
Aug-03	418	~
Sep-03	403	~
Oct-03	573	~
Nov-03	539	~
Dec-03	344	~
Jan-04	419	~
Average Encounters per Month	449	~
Avg # of Encounters per UDC	2.1	~

Total "High Ambulance Users" UDC * (% of Total UDC)	42	3%
"High Ambulance Users" Encounters (% of Total Encounters)	353	13%
Avg "High Ambulance Users" Encounters per UDC	8.4	~

Total "NON-High Ambulance Users" UDC (% of Total UDC)	1,222	97%
"NON-High Ambulance Users" Encounters (% of Total Encounters)	2,343	87%
Avg "NON-High Ambulance Users" Encounters per UDC	1.9	~

* 42 McMillan clients were 35% of the 120 Total "High Ambulance Users" identified by EMS in a Dec 03 report to DPH.

Encounters Per UDC	# UDC	% of Total UDC
# Clients with 1 Encounter Over Time Period	861	68.3%
2 Encounters	177	14.0%
3 Encounters	80	6.3%
4 Encounters	40	3.2%
5 Encounters	19	1.5%
6 Encounters	20	1.6%
7 Encounters	10	0.8%
8 Encounters	15	1.2%
9 Encounters	4	0.3%
10 Encounters	6	0.5%
11 to 20	19	1.5%
21 to 30	6	0.5%
31 to 58 (max)	4	0.3%
Total Encounters	1,261	100%

Average Length of Stay	# Encounters	% of Total Encounters
# Encounters when client released same day	1,509	56.0%
Released day after	1,155	42.8%
Other	32	1.2%
Total Encounters	2,696	100%

Admitted to McMillan Via	# Encounters **	% of Total Encounters
Unknown	202	7%
ER via MAP	485	18%
MAP Van	1,034	38%
Walk-in	576	21%
EMS	146	5%
Police	182	7%
Other	71	3%
Total Encounters	2,696	100%

McMillan Stabilization Pilot Project - 6 Month Data Report Aug 03 to Jan 04 - Attachment J

Category	#	% of Total
Total Unduplicated Clients (UDC)	1,261	~
Total Encounters	2,696	~

Health Outcomes	# Encounters **	% of Total Encounters	% of Known
Improved	1,085	40%	63%
Maintained	586	22%	34%
Worsened	50	2%	3%
Undetermined - Outcome NOT entered into record	974	36%	~
Total Encounters	2,696	100%	100%

** # Encounters = % determined within sample of 534 Encounters x Total Encounters

Discharge Outcomes	# Encounters **	% of Total Encounters	% of Known
Transferred to more appropriate level	106	4%	22%
Self-Discharged	364	13%	74%
5150	5	0%	1%
Escorted Out	15	1%	3%
Discharged to SFPD	-	0%	0%
Undetermined - Outcome NOT entered into record	2,206	82%	~
Total Encounters	2,696	100%	100%

** # Encounters = % determined within sample of 534 Encounters x Total Encounters

Case Management Services	# UDC	% of Total UDC
Clients Assessed/Linked by Case Management Team	329	26%
Clients Case-Managed by Team	21	1%

Discharged to Intensive Services	# Encounters	% of Total Encounters
Detox - Medical ***	45	2%
Detox - Social	107	4%
Emergent - SFDPH Psych Emerg (PES)	3	0%
Emergent - Westside Crisis	-	0%
Emergent - EDs	131	5%
Via MAP Van & % of 131 ED Discharges	49	37%
Via Ambulance & % of 131 ED Discharges	55	42%
Via Undetermined & % of 131 ED Discharges	27	21%
Sent to SFGH ED & % of 131 ED Discharges	114	87%
St. Francis & % of 131 ED Discharges	9	7%
CPMC Davies & % of 131 ED Discharges	-	0%
CPMC Pacific Campus & % of 131 ED Discharges	2	2%
UCSF & % of 131 ED Discharges	1	1%
Kaiser & % of 131 ED Discharges	2	2%
VA & % of 131 ED Discharges	1	1%
St. Lukes & % of 131 ED Discharges	1	1%
Chinese Hospital & % of 131 ED Discharges	-	0%
Other & % of 131 ED Discharges	1	1%
Total Encounters	286	11%

*** 37 clients added to the database's # of 8 to reflect the total 45 clients per Baker Places who were accepted into medical detox.

McMillan Stabilization Pilot Project - 6 Month Data Report Aug 03 to Jan 04 - Attachment J

Category	#	% of Total
Total Unduplicated Clients (UDC)	1,261	~
Total Encounters	2,696	~

Gender	# UDC	% of Total UDC	% of Known
Male	1,005	80%	83%
Female	201	16%	17%
Transgender	2	0%	0%
Undetermined - Gender NOT entered into record	53	4%	~
Total UDC	1,261	100%	100%

Living Situation Upon Admission	# UDC	% of Total UDC	% of Known
Homeless	1,062	84%	99%
Not Homeless	11	1%	1%
Undetermined - Living Situation NOT entered into record	188	15%	~
Total UDC	1,261	100%	100%

Ethnicity / Race	# UDC	% of Total UDC	% of Known
Caucasian	245	19%	42%
African American	221	18%	38%
Latino	83	7%	14%
Asian or Pacific Islander	5	0%	1%
Filipino	5	0%	1%
American Indian or Native Alaskan	13	1%	2%
Other	11	1%	2%
Undetermined - Ethnicity NOT entered into record	678	54%	~
Total UDC	1,261	100%	100%

Preferred Language	# UDC	% of Total UDC
English	1,053	84%
Spanish	46	4%
Other/Undetermined Preferred Language	162	13%
Total UDC	1,261	100%

ATTACHMENT K
Report from the SFFD Inebriate Survey
Mark Pletcher and Niels Tangherlini

Introduction/Methods

In order to estimate the scope of the public inebriation problem in San Francisco, and to pilot the triage criteria paramedics will use to decide which patients require ED care, the San Francisco Fire Department undertook a month-long survey of all patients transported by SFFD paramedics during July 2003 in whom alcohol inebriation appeared to be a primary factor. For each such patient, paramedics recorded demographic characteristics, location from which the patient was transported, chief complaint, vital signs, Glasgow coma scale score, finger-stick blood glucose level, presence or absence of a number of subjective and objective exclusion criteria, whether or not such a patient officially met criteria for triage to the McMillan Sobering Center, and whether or not they thought such triage was appropriate or not (see Appendix I for the SFFD Inebriate Survey data collection form). They then brought all such patients to a San Francisco ED per long-standing protocol.

Results

Description of the patients included in the study

The 172 patients San Francisco paramedics identified during July 2003 as probably inebriated were middle-aged (45 ± 12 years old) and mostly male (88%). Nearly half (44%) were identified by paramedics as being frequent users of the San Francisco Emergency Medical Services (EMS) system. Most were located outside, on the street, before being transported (80%); the rest were located in their own residence (7%), a hotel lobby (4%), a park (2%), a store/restaurant/bar (2%), a bus or bus station (2%), or another location (3%). Alcohol was specifically mentioned in about a third of chief complaints about or from such patients (34%). Other common complaint themes were trouble ambulating (18%), altered level of consciousness (14%) and pain (14%) (see Table 1). The number of patients transported varied between 1 and 17 per day, and tapered off over the course of the month (see Figure 1).

Triage criteria findings

Based on vital signs or other subjective and objective findings, 90 (52%) would have been officially eligible to be transported to the McMillan Sobering Center, and 82 (48%) would have officially required transport to a San Francisco ED. Over half of disqualified inebriated patients were disqualified from McMillan care because they were unable to ambulate (46/82, 56%), and 8 more (10%) because they couldn't give their name (see Table 2). Other common reasons for disqualification were suicidal ideation (11%) and abdominal pain (9%). A minority of disqualified patients were disqualified because of vital sign abnormalities, the most common being systolic blood pressure < 100 mmHg (10%), and blood glucose < 80 mg/dl (5%) or > 250 mg/dl (2%) (see Table 3).

Paramedic application of triage criteria

In comparing the information paramedics reported (vital signs, and subjective and objective exclusion criteria met) with their response to "Would this patient meet official triage criteria for transport to the McMillan Sobering Center?", we found that 20% of the time paramedics misapplied the triage criteria. That includes 37% (30/82) of the patients who should be sent to the ED, and 7% (6/90) of those who were cleared for transport to McMillan. Half of the mistriaged patients requiring ED care were triaged to the ED because they couldn't walk or say

their name (n=15), 17% for vital sign abnormalities (n=5), and 13% for chest or abdominal pain (n=4) (see Table 4).

Paramedic opinions regarding appropriateness of the triage criteria

Paramedics disagreed with official triage criteria in 64 patients (37%). When triage criteria recommended ED care, paramedics disagreed most of the time (56/82, 68%). Paramedics were less likely to disagree with the triage rules when patients met criteria for triage to McMillan (8/90, 9%) (see Table 4). If paramedics were completely correct in their judgment, the triage criteria were only moderately sensitive for finding patients who might require ED care (24/32, 75%) and even less specific for finding patients who don't (79/135, 59%).

Transport disposition

Table 5 shows where patients were transported. The column labeled with "Triage: McMillan" indicates the number of transports to EDs that theoretically would not have occurred had McMillan been fully functional during July 2003.

Conclusions

Patients transported by paramedics in whom alcohol intoxication appears to be a primary factor reflect the population of homeless alcoholics in San Francisco and the United States. We captured 172 transports in 31 days (approximately 5.5 visits/day), but this almost certainly represents an undercount given the non-mandatory nature of the survey, and the tapering we observed in the latter half of the month. If the rate of transports in the first half of the month is applied to the whole month, then we might expect about 215 transports in 31 days, or 6.9 transports/day, with only about half of those eligible for McMillan.

The primary reason for failing McMillan criteria was an inability to walk or to say one's name. Coupling this finding with the opinions of paramedics about the appropriateness of triage criteria suggests that our criteria may be too stringent. It is a stretch to make this conclusion, however, without validating the triage criteria against a better gold standard such as emergency department follow-up.

Paramedics incorrectly applied triage criteria in more than a third of transports, mostly when triage criteria suggested ED transport, and mostly when patients could not ambulate or say their name.

Recommendations

- 1) Establishment of the McMillan Stabilization Project Database as planned (implementation by Donna Childers underway), and enforcement of 100% compliance with data collection at McMillan, in order to ensure we find out about all adverse events and capture other vital data for monitoring progress at McMillan
- 2) Feedback of this information to paramedics in order to improve compliance with the triage criteria and decrease "turn-away" events at McMillan
- 3) Randomly sample EMS transports to get a better estimate of the number of relevant transports per day
- 4) Review ED records for the 172 patients in this survey in order to provide a "gold standard" for determining which patients truly require ED care. This will allow evidence-based improvement of the triage criteria.

Table 1. Characteristics of apparently intoxicated patients transported by San Francisco paramedics in July 2003

Characteristic	Triage: ED N=82*	Triage: McMillan N=90*	p-value†
<i>Patient characteristics</i>			
Age, mean years +/- SD	47 ± 11	43 ± 12	0.038
Sex, % male	89%	87%	0.64
Frequent caller per paramedic, %	44%	43%	0.94
<i>911 call characteristics</i>			
Call code, %			0.69
2	32%	35%	
3	68%	65%	
Location of patient when ambulance arrived, %			1.0
Street	80%	81%	
Shelter	0%	0%	
Residence	7%	7%	
Other (hotel lobby, park, restaurant, etc)	12%	11%	
Unknown	0%	1%	
<i>Chief complaint - includes a reference to:</i>			
Alcohol, %	26%	42%	0.022
Trouble ambulating or fall, %	24%	12%	0.038
Altered level of consciousness, %	18%	10%	0.12
Pain, %	18%	10%	0.12
No chief complaint noted, %	10%	17%	0.18

Figure 1. Number of transports by date

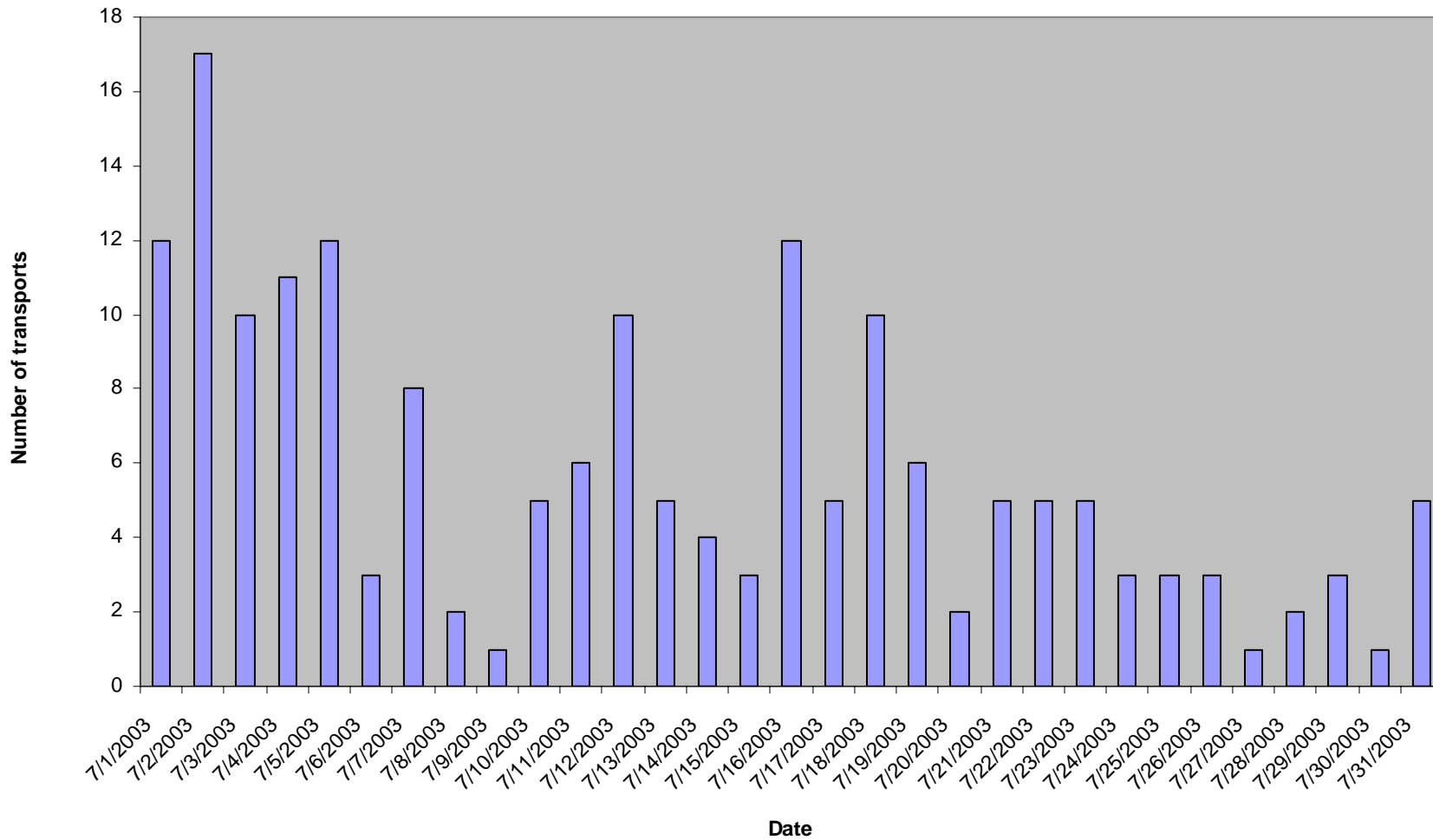


Table 2. Percent of apparently intoxicated patients not meeting specific requirements for transport to a non-emergency setting

Characteristic	All apparently intoxicated patients N=172
Can't give name, n (%)	8 (5%)
Unable to ambulate, n (%)	46 (27%)
Sign of recent head trauma, n (%)	9 (5%)
Laceration that could be sutured, n (%)	3 (2%)
Acute fracture, n (%)	3 (2%)
Seizure, n (%)	1 (1%)
Syncope, n (%)	0
Audible wheeze or gasping, n (%)	0
Shortness of breath, n (%)	0
Chest pain, n (%)	4 (2%)
Abdominal pain, n (%)	7 (4%)
Gastrointestinal bleeding, n (%)	1 (1%)
Suicidal ideation, n (%)	9 (5%)
Pregnant >20 weeks, n (%)	0

Table 3. Vital signs and objective measurements taken from apparently intoxicated patients transported by San Francisco paramedics in July 2003

Characteristic	All apparently intoxicated patients N=172*
Systolic blood pressure, mmHG, mean \pm SD, (range)	124 \pm 16, (72 - 178)
Missing measurements (n)	9 missing
- >180, n (%)	0
- <100, n (%)	8 (5%)
Diastolic blood pressure, mmHG, mean \pm SD, (range)	79 \pm 11, (50 - 100)
Missing measurements (n)	120 missing
- >110, n (%)	- 0
Pulse, beats/minute, mean \pm SD, (range)	89 \pm 14, (14 - 130)
Missing measurements (n)	3 missing
- >130, n (%)	- 0
- <60, n (%)	- 2 (1%)
Respiratory rate, breaths/minute, mean \pm SD, (range)	17 \pm 2, (12 - 30)
Missing measurements (n)	6 missing
- >24, n (%)	- 1 (1%)
- <12, n (%)	- 0
Oxygen saturation, %, mean \pm SD, (range)	97 \pm 2, (86 - 100)
Missing measurements (n)	63 missing
- <92%, n (%)	- 1 (1%)

Glasgow coma scale, points, mean \pm SD, (range)	14 \pm 1, (7 - 15)
Missing measurements (n)	7 missing
- <10, n (%)	- 2 (1%)
Blood glucose, mg/dl, mean \pm SD, (range)	115 \pm 36, (69 - 315)
Missing measurements (n)	49 missing
- >250, n (%)	- 2 (1%)
- <80, n (%)	- 4 (2%)

* - Many patients are missing 1 or more vital sign measurements; these observations are not included in results

SD – Standard deviation

Table 4. Paramedic accuracy in applying triage criteria and opinions about true need for ED care, and a description of mis-triaged patients

Subgroups	Count, %
Among patients requiring ED transport by official guidelines, (n=82)	
- n (%) triaged incorrectly to McMillan by paramedics	30 (37%)
- n (%) that paramedics thought didn't really need ED care	56 (68%)
- n (%) triaged to the ED just because they couldn't walk or give their name	31 (38%)
- n (%) triaged to the ED for vital sign abnormalities	18 (21%)
- n (%) triaged to the ED for chest or abdominal pain	10 (12%)
Among patients cleared for McMillan by official guidelines, (n=90)	
- % triaged incorrectly to the ED by paramedics	6 (7%)
- % that paramedics thought actually needed ED care	8 (9%)
Among patients mistakenly triaged to McMillan (n=30*)	
- n (%) required the ED just because they couldn't walk or give their name	15 (50%)
- n (%) required the ED for vital sign abnormalities	5 (17%)
- n (%) required the ED for chest or abdominal pain	4 (13%)
Among patients mistakenly triaged to the ED (n=6†)	
- n (%) no apparent reason for mistake	3 (50%)
- n (%) patient physically violent	1 (17%)
- n (%) vital sign criteria misapplied	1 (17%)
- n (%) unwitnessed seizure noted	1 (17%)

* - Note that 30 + 46 do not add up to 82. For 6 patients, we are missing data on paramedic assessment.

† - Note that 86 + 6 do not add up to 90. For 2 patients, we are missing data on paramedic assessment

Table 5. Disposition of apparently intoxicated patients transported by San Francisco paramedics in July 2003

Characteristic	Triage: ED		Triage: McMillan		p-value†
	N=78*		N=82*		
	n	(%)	n	(%)	
CHH	0		0		0.011
CPC	1	(1%)	0		
Davies Medical Center	6	(8%)	2	(2%)	
Kaiser San Francisco	2	(3%)	1	(1%)	
PMC	2	(3%)	7	(9%)	
Saint Francis Medical Center	25	(32%)	16	(20%)	
Saint Luke's Medical Center	9	(12%)	12	(15%)	
Saint Mary's Medical Center	4	(5%)	2	(2%)	
San Francisco General Hospital	19	(24%)	16	(20%)	
University of California, San Francisco	3	(4%)	1	(1%)	
Veteran's Administration Medical Center	2	(3%)	0		
PDT	2	(3%)	9	(11%)	
AMA	0		0		
MAP	2	(3%)	13	(16%)	
PD	1	(1%)	3	(4%)	

* - 4 patients triaged to the ED, and 8 patients triaged to McMillan had missing data on actual ambulance destination.

† - p-value by X² test

McMillan – The McMillan Stabilization Center (a “sobering center”); ED – Emergency department

Appendix I. SFFD INEBRIATE SURVEY

Unit#: _____ Date: _____ Case#: _____ SFFD ID#: _____

1. Does ETOH appear to be a primary factor in this event? Yes No

2. Age: _____ Gender: Male Female Frequent Caller? Yes No

3. Where was the patient picked up? Street Shelter Residence Other _____

4. Chief Compliant:: _____ Code of Call: 2 3

5. BP: _____ Pulse: _____ Resp: _____ GCS: _____ O2 Sat: _____ D.Stick: _____

6. Check any subjective exclusion criteria that apply to the patient:

- Chest Pain Abdominal Pain
 SOB Suicidal Ideation

7. Check any objective Exclusion criteria that apply to this patient:

- | | | |
|--|---|---|
| <input type="checkbox"/> SBP>180<100 | <input type="checkbox"/> Resp Rate>24<12 | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Diastolic>110 | <input type="checkbox"/> GCS<10 | <input type="checkbox"/> GI bleed |
| <input type="checkbox"/> Pulse>130<60 | <input type="checkbox"/> Can't give name | <input type="checkbox"/> D.Stick>250<80 |
| <input type="checkbox"/> Syncope | <input type="checkbox"/> Sign of recent head trauma | <input type="checkbox"/> Sutureable lac. |
| <input type="checkbox"/> Audible wheeze or gasping | <input type="checkbox"/> Unable to ambulate | <input type="checkbox"/> Acute fracture |
| <input type="checkbox"/> O2 Sat<92% | | <input type="checkbox"/> >20 wks pregnant |

8. Destination:

- | | | | |
|------------------------------|------------------------------|-------------------------------|------------------------------|
| <input type="checkbox"/> CHH | <input type="checkbox"/> PMC | <input type="checkbox"/> SFGH | <input type="checkbox"/> AMA |
| <input type="checkbox"/> CPC | <input type="checkbox"/> STF | <input type="checkbox"/> UCSF | <input type="checkbox"/> MAP |
| <input type="checkbox"/> DMC | <input type="checkbox"/> STL | <input type="checkbox"/> VAH | <input type="checkbox"/> PD |
| <input type="checkbox"/> KSF | <input type="checkbox"/> STM | <input type="checkbox"/> PDT | |

9. Would this patient meet official criteria for transport to McMillan Sobering Center?

- Yes No

10. Do you think transport to McMillan Sobering Center would be appropriate for this patient?

- Yes No

11. Please include your comments regarding the official triage criteria (listed above) and how you feel EMS could best serve this patient's needs (use the back of needed):