SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5010
Effective Date: January 3, 2022
Supersedes: September 1, 2009

RECEIVING HOSPITAL STANDARDS

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. STEMI 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.

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 JCAHO 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 JCAHO, 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 a current copy of the 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 JCAHO 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 Tier 2 or Tier 3 criteria of Policy 4000.1, Section IX, the Receiving Facility shall submit a corrective action plan to reduce APOT-1 delays within 30 days of issuance of the Hospital Report.
    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. 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:
        i. Temporary suspension of the hospital's Receiving Facility status for a total of 24 hours over a month-long period.
            1. Upon review of monthly data and the Receiving Facility's corrective action plan, the EMS Agency will select the most likely times in which

a facility has severe APOT delays totaling no more than 6 hours in a 24-hour period.

2. Upon selection of the 6-hour period, the hospital will be placed on Internal Disaster.
3. Prior to placement on Internal Disaster, the hospital will be unable to receive specialty care patients for a period of 6 hours proceeding temporary Internal Disaster status should three (3) or more Specialty Centers be available. This period does not apply overall total of 24-hours of temporary suspension.
4. The temporary suspension includes all prehospital and all inbound inter-facility transfers. This does not include inter-facility transfers out of a hospital to reduce patient census or for specialty care at other facilities.
5. This process will repeat on a monthly basis if the Receiving Facility fails to comply with Tier 2 or Tier 3 APOT-1 standards.
6. If greater than 2 incidents of 24-hour suspension periods occur in 6-month period, the EMS Agency will revoke the hospital's Receiving Facility status.

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 steps follow Section VI, 1, d(i) above.

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

VII. DIVERSION MITIGATION

1. For Receiving Facilities meeting Tier 2 or Tier 3 criteria of Policy 5020, Section X,C, the Receiving Facility shall submit a corrective action plan to reduce ambulance diversion within 30 days of issuance of the Hospital Report.
    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:
    i. 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).
    ii. 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.
    iii. If a Receiving Facility is a single specialty care center (ie Trauma, Burns), institution of bypass plans for the specialty service.
    iv. The above options shall remain in effect until the Receiving Facility meets monthly diversion below 30%.
v. Any actions taken a Receiving Facility shall be posted to the EMS Agency website, including notice of any Receiving Facilities on a Corrective Action Plan.

VIII. IMPLEMENTATION PERIOD

1. For the purposes of the implementation period, Tier 2 and Tier 3 criteria shall be temporarily combined for Policy 4000.1 (Patient Offload) as follows:
    a. 90th percentile APOT-1 time over 35 minutes for two (2) consecutive months
2. For the purposes of the implementation period, Tier 2 and Tier 3 criteria shall be temporarily combined for Policy 5020 (Hospital Diversion) as follows:
    a. Monthly diversion percentage greater than 50% for two (2) consecutive months
3. The implementation period with combine Tiers listed above shall commence January 1, 2022 until July 1, 2022.

4. Upon completion of the implementation period, Section VIII language shall be removed from the policy, and previous Tier 2 and Tier 3 measures listed in Policy 4000.1 and 5020 shall go into effect.
5. On January 1, 2022, a temporary, limited participant subcommittee shall be formed to address the root causes of diversion and APOT consisting of the following:
    a. 3 members from EMSA
        i. Nominated by EMSA Director and EMSA Medical Director
    b. 3 members from San Francisco EMS Providers
        i. Nominated by each of the three (3) 911 EMS Provider organizations
    c. 3 members from San Francisco Receiving Hospitals
        i. Nominated by the Hospital Council of Northern California
    d. 1 member from DEC
        i. Nominated by DEC Deputy Director
    e. 1 member from the public
        i. Nominated by the EMSA Director and EMSA Medical Director
6. The subcommittee shall produce and submit its recommendations to the EMS Agency Medical Director for review by June 30, 2022.