Sonoma County EMS Workgroup
Meeting Minutes

April 16, 2018 – 9:30-11:00 AM
Sonoma County Water Agency Redwood Conference Rooms
404 Aviation Blvd, Santa Rosa CA 95403

Project Goal: To create a safe, effective system that delivers high-quality field care medicine that is responsive to the community needs of Sonoma County as supported by qualified, committed and accountable EMS caregivers.

Goal for this meeting: To complete the broad stakeholder input on what works/doesn't work in today's EMS system, look to the future and to begin the focus group process to address the identified topics

Meeting Minutes

EMS Project Facilitator Chris Thomas opened the meeting with introductions around the room.

Chris updated the group on the progress of the request for extension of the current EOA Agreement between Sonoma County and American Medical Response. The County has developed a draft extension letter, and posted it as a Google Doc reachable through the EMS Workgroup website. Our request is for a one-year extension to the current EOA agreement. We are presenting this letter to the Sonoma County Board of Supervisors on 5/8/18 to inform them of the extension, and to update the Board on activities from the stakeholders' workgroup.

Kurt Henke, (Cal Chiefs, Sonoma County Fire Chiefs' Association) commented on the extension request letter 2nd page. Kurt states he felt the reference "more importantly" with respect to system redesign efforts associated with the fires is a "poison pill" based on his impression of the EMSA statements made during phone call with DHS, CVEMSA and stakeholders. Kurt felt restating that actual process time is the issue to stress, and as a side result [of the fires] we have identified other issues and feel this is the time to address and correct those issues. There was no further feedback on the request letter at the time. At the end of the meeting, Chris asked stakeholders to

provide any further feedback on the letter by the end of the week so that the letter can be finalized to go to the Board of Supervisors.

Chris also shared that CVEMSA is preparing and disseminating position papers on particular topics relevant to the ordinance and RFP.

Kurt stated that he appreciated sending out policy memos but please send out 3-5 days prior meetings. Chris mentioned the position papers were sent out this morning, but will not be discussed in this meeting. Chris explained that these papers are on general LEMSA positions rather than specific meeting discussion, and will be sent out as they are completed.

Chris moved on to complete the discussion of what works in current system, what doesn't work in current system – picking up from 4-2-18 meeting and including specific focus on declared emergencies then moving to opportunities and threats which might occur in next 5 and 10 years.

What isn't working

Chris started the discussion by stating he has heard mentions of issues related to scope of practice and ambulance posting and not enough rural focus.

There was a general discussion on feedback to the system participants being needed to support education, and loop closure on patient outcomes so care providers can know how care they provided to patients made a difference in patient outcomes. ImageTrend (ePCR program) is helping with this in the case of specialty care systems like Trauma and STEMI. Ultimately, having an inherent process that provides outcome information for all calls and being part of the health information exchange is important for EMS providers to understand and learn from patient outcomes. Other system stakeholders needing patient outcome information are patient "medical homes" (such as Federally Qualified Healthcare Center or FQHC) organizations, essentially, anyone providing patient care anywhere in the system. Sharing information across systems for the purposes of education is not a process built into the current healthcare system. We should be looking at the continuum of care to learn from what happened with the patients we care for and what we can our providers do as EMTs and Paramedics differently to make the outcome better. There was a discussion on Health Information

Exchanges (HIEs), and bringing EMS into those system of patient information exchanges. The health system needs to see all field providers from ALS to BLS 1st responder as clinicians deserving of outcome information on the patients they care for.

EMS Responders also need to have access to previous discharge instructions for patients cared for previously by the healthcare system, so the information can inform patient care decisions if relevant.

Support was expressed for seamless, routine access to information (medical history, medications, and allergies) available to responders even if they were not the clinicians on a previous patient contact. Beyond a basic infrastructure need, is there a missing link in information sources to the infrastructure? Hospitals have Electronic Health Records, and these systems need integration with pre-hospital electronic medical records through direct linkage or HIE integration. It is expensive, but it can happen.

Mike Williams (The Abaris Group) stated an opinion that response times don't mean anything, outcomes of patients are what is most important. Suggested RFP consider sanctions and incentives to make this happen.

Bryan Cleaver (CVEMSA Administrator) expressed that there is need to form a focus group to carve out the process. Bryan shared awareness of a current project in the works to support EMS/HIE integration with a 90-10 match from Medi-Cal to put forward to help with this process.

Kurt Henke stated response times are based on fines, with private providers sanctioned for not meeting response times. Kurt stated fines represented money unavailable to improve the system. Kurt suggested instead of fines money should go back into the system to benefit the system. Kurt stated providers that are fined will choose to pay the fines instead of changing the process that resulted in the performance. Kurt stated fines don't do anything to benefit rural providers.

Jeff Schach, (City of Petaluma Fire Department) raised concern about EMS response zones. What if the provider serving a response zone is challenged by another entity wanting to operate in that zone? The ordinance needs to help those already established, and protect current provider from new challenges.

Steve Akre (Sonoma Valley Fire-Rescue Authority) and Kevin Smith (UEMSW) raised concerns about levels of resources available to both stock back-up ambulances and enough ambulances to outfit available staff. Overall system capacity is not sufficient to provide adequate service consistently.

Discussion was had on the Move-up and Cover practices and the use of outside the EOA providers to cover EOA calls. For rural areas, coming in to cover EOA can leave them without ambulances and greatly extend even further response times that are already long. It was also noted that another problem occurs when the EOA provider covers outside provider zones or responses; during that period they are relived from accountability for internal zone compliance with response times are then not accessed for penalties.

No one has complete financial pictures. Studies are limited to vendor assessments of EOA zone, there is no study for funding outside of the EOA and county-wide.

Specifically with respect to the October Fires

Chris then asked that the group consider the question of what does (and does not) work through the lens of the fires. Steve Herzberg (BBFPD, EMCC Dist 5 Rep) felt too few cross trained fire/ALS ambulances were available to go into the fire zones; non-fire units could not be sent in due to lack of PPE/ training. Dean Anderson (AMR) noted some ambulance crews were lost because some were pulled off to fight fires. Others objected to those assertions; Steve Akre felt no SVFRA units were down due to staffing, and Kevin Smith stated he knew of many cases where AMR crews were in mandatory evacuation areas were fires were burning around the crews. Dean Anderson (AMR) pointed out Fire was unavailable at times for first-response medical due to the need to do suppression and rescue and AMR crews evacuated many people. Chris reminded everyone that each of us may not have the full picture and that the point was simply to identify areas that worked or didn't work at this stage not to try to quantify or further detail any specific cases.

James Salvante (CVEMSA) pointed out the difference in perspective and belief about the events that occurred was itself an issue. Viewpoints expressed were based largely on what individuals experienced at the time. James stated during the initial stages of

the fires, even at the Medical Health Branch in the EOA, achieving and maintaining situational awareness was a problem and exercising command and control was not something we could do. Lack of situational awareness and lack of resources resulted in a lot of resources waiting for directions, and not getting direction. Suggestion, in SF, if communications goes silent, units operate on their own.

One identified problem was not being able to use out-of-county mutual aid for 911 calls. Suggestion about compliance with SEMS and NIMS something to put in ordinance.

A mention was made about the concept of “Leaders Intent” wherein system partners exercise concepts they have trained on as part of a coordinated system when forced to do so independent of command and control if cut off from direct communication with leadership.

Communications with Hospitals for evacuation was raised. Suggestion made regarding training and joint discussion with healthcare coalition on disaster and evacuations. Possible inclusion of outside agencies for mutual aid and redundancy.

System Capacity was raised again, looking at the need for “surge” capacity for equipment, vehicles, perhaps ALS caches.

Overall communication between County EOC, EMS and out to field needs better coordination.

<u>What Worked:</u>

State Parks opened for free camping for evacuated folks. Established in advance, so you can know how many campsites are available and set up medical support for those numbers. State Parks pointed out that if we needed to evacuate all of our hospitals a 101 closure could play havoc for that process, and the assistance the Parks could provide would be very helpful to the County. There is a need to look at and plan for this resource in advance. In addition, we should be cognizant of the other demands it may place on resources (e.g. having to respond to the parks once folks move there during response and recovery).

Positive comments on Training i.e. MCI, disaster funding, and we do these regularly. We should incorporate outside counties to help do mutual aid so they know what infrastructure is in county and provide redundancy.

Community Service; all the providers, without exception, did everything they could to provide excellent care to the community regardless of patch on the sleeve.

Future trends:

A lot of uncertainty: funding model used in CA for incentivizing EOAs may not be sustainable; what's next?

Governance: Where/how will we decide where the borders of zones are; will our process need to completely change based on pending court decisions, and how will that impact our system construction?

Scope of practice changes such as community paramedic implementation. Will there be funding from Medicare and Medi-Cal?

Homelessness and Behavioral Health issues. Increasing problems with impact to our system partners and no solutions at hand

Projection of population growth in Sonoma County. Demand for services increasing as well.

Alternatives destinations or alternative response to 911 calls. Using secondary nurse triage, but only with collaboration of whole system.

Bystander involvement. AED deployment and responders; is there something else we need to think about? Should we be training bystanders to do other types of pre-arrival emergency assistance? An example is PulsePoint for CPR and AED, we work to notify trained lay people to help. Are there other ways in which we can train the community to become more independent rather than wait for others to provide initial care in an emergency?

There may be more CERT training for natural disasters as a consequence of the October Fires. Does the system need to consider or interface with these?

In the future we may have more and longer post disaster recovery periods associated with potentially more frequent and/or severe natural disasters. What should be looked at to ensure that the system can handle these?

Another topic was a Paradigm shift allowing more latitude in sending assistance to begin with. Resources are harder to support and maybe we can't serve everybody with emergent response as we have been doing. More people are aging, increasing the load on services. Now we serve anyone who calls, but it may be other options will be considered in the future. Consider how to educate folks on alternatives to emergency care as the primary way to get assistance, and shift the paradigm to look at other resources and alternatives.

Point raised about sending the right resource to the patient, as well as referring the patient to the right services. Not all works well when using the same hammer, and every problem is not the same nail. A over emphasis on response times is equivalent to the same hammer used for different nails. A system built solely for response time compliance may poorly serve those individuals who need a service other than a fast response and can't get it because the system has spent itself on the effort of maintaining low times at the expense of other system components.

Chris concluded the discussion by turning the group over to Mike Williams for focus group formation. Chris explained he'd be in the group, but Mike would be the guide to get the work to the next stage. Mike is charged to help the group work out what goes in ordinance how in gets there and methods of working on the issues raised.

Mike passed around a project charter document and a list of nominees for a smaller group. Mike expressed the intent is for the stakeholders to work through the representatives specified for the functional area they align with in the system to represent the viewpoints and concerns as we work through the process. All would be welcome to attend meetings, but discussion and voting on topic would be via a representational process.

Several stakeholders had objections to reducing the size of the group and/or limiting input to a representational process at the current time.

Assignments for the next meeting

Mike stated the intent of suggesting a smaller group was to save some time and have effective process, but we will work in large group if that is the desire of the participants. Participants were asked to review documents between now and next meeting. We will discuss at the next meeting.

Announcements and any other thoughts before adjournment

Deadline for comments on extension letter this week by 4/20/18.

Project Website:

https://www.coastalvalleysems.org/about-us/committees/sonoma-county-ems-systems-workgroup.html