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Mayor

Department of Emergency Management
Emergency Medical Services Agency
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Mary Ellen Carroll
Executive Director

Date: August 1, 2023

To: Elizabeth Basnett, Acting Director, EMS Authority
Hernando Garzon, MD, Acting Medical Director, EMS Authority
Tom McGinnis, Chief, EMS Division, EMS Authority

From: Andrew Holcomb, EMS Director

Re: Community Paramedicine and Triage to Alt. Destination EMS Plan – Executive Summary

The San Francisco EMS Agency (SFEMSA) is hereby submitting and attaching plan documents required under the Community Paramedicine or Triage to Alternate Destination Act of 2020, specifically California Health and Safety Code (HSC) §§ 1835, 1840-1843 and California Code of Regulations (CCR), Title 22, § 100190.

Since Chapter 5 regulation implementation went into effect on November 1, 2022, SFEMSA and partners have worked nonstop, dedicating hundreds of hours into this submission. While SFEMSA is submitting the plan and attachments, I feel immense gratitude and want to acknowledge the partners who made this submission possible including the Office of the Mayor, San Francisco Fire Department, San Francisco Department of Public Health, San Francisco City Attorney's Office, San Francisco Veterans Affairs Medical Center, American Medical Response, and King American Ambulance.

Under HSC § 1842, the existing San Francisco Fire Department EMS-6 Community Paramedic pilot program is being submitted as the City and County of San Francisco's Community Paramedicine Provider including a Community Paramedicine training program.

Under HSC § 1843, all three 911 Exclusive Operating Area EMS Providers including the San Francisco Fire Department, American Medical Response, and King American Ambulance are being submitted as Triage to Alternate Destination Providers. The Triage to Alternate Destination training program will be administered by SFEMSA.

Under HSC § 1813, the San Francisco Department of Public Health Sobering Center is being submitted as a Triage to Alternate Destination Facility as an authorized sobering center.

Under HSC § 1819(3), The San Francisco Veterans Affairs Medical Center is being submitted as a Triage to Alternate Destination Facility for patients who identify as veterans.

Recognizing a 30-day review period by the EMS Authority under 22 CCR § 100190, SFEMSA asks the EMS Authority to expedite review of this Community Paramedic and Triage to Alternate Destination submission, prioritizing Triage to Alternate Destination training program curriculum review. With nearly six hundred Accredited Paramedics to complete a 4-hour course and issue Accreditations, San Francisco continues to be racing toward the October 31, 2023 deadline. SFESMA is pausing any training until the EMS Authority reviews the Triage to Alternate Destination training curriculum to avoid having to complete any re-training.

With the addition of Community Paramedicine and Triage to Alternate Destination program implementation, SFEMSA remains dedicated to our mission of oversight through directing, planning, monitoring, and evaluating San Francisco's EMS System. For any questions, concerns, or requests for additional information regarding our submission, please do not hesitate to contact me directly.



Andrew Holcomb
EMS Director, EMS Agency
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628-217-6014

Cc: Dr. John Brown, EMS Agency Medical Director
Rob Smuts, DEM Deputy Director
Mary Ellen Carroll, DEM Executive Director
Christina Fletes-Romo, Deputy City Attorney

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SECTION I - Policies



May 3, 2023

San Francisco EMS Agency
333 Valencia St, Suite 210
San Francisco, CA 94103

Dear Dr. John Brown and EMS Director Andrew Holcomb,

With the passing of State Assembly Bill 1544, known as the Community Paramedicine or Triage to Alternate Destination Act of 2020, the statutory requirements in California Health and Safety Code, Division 2.5, Chapter 4, Article 3, Section 1797.273 require establishment of an emergency medical care committee to advise the local EMS agency on the development of the program and other matters relating to emergency medical services. Where a committee is already established, the membership should be updated to reflect the requirements of the new law.

The long-standing Emergency Medical Services Advisory Committee (EMSAC), established under EMS Agency Policy 1010 – Advisory Committees, already exists for the purposes of advising the local EMS Agency on all matters relating to emergency medical services. The EMSAC membership must therefore be updated to ensure it meets the minimum membership requirements for Community Paramedicine and Triage to Alternate Destination services within the City and County of San Francisco.

I hereby direct the Department of Emergency Management to ensure the members of the EMSAC meet the requirements of Section 1797.273(b).

Sincerely,

A handwritten signature in blue ink, reading "London N. Breed".

London N. Breed
Mayor, City and County of San Francisco

cc: Andres Power, Policy Director, Office of Mayor London N. Breed
Mary Ellen Carroll, Executive Director, Department of Emergency Management
Robert Smuts, Deputy Director, Department of Emergency Management
Kate Kimberlin, Deputy City Attorney

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 1010
Effective Date: October 1, 2023
Supersedes: April 1, 2023

ADVISORY COMMITTEES

I. PURPOSE

To define the roles, structure, membership, and procedural standards for advisory committees to the EMS Agency Medical Director.

II. POLICY

- A. Advisory committees, composed of EMS system constituents, shall convene to review EMS system issues relevant to their scope of responsibility and recommend actions to the EMS Agency Medical Director concerning matters of policy, procedure, and protocol.
- B. The EMS Agency Medical Director, as mandated by state statute, provides medical control and assures medical accountability throughout the planning, implementation and evaluation of the EMS System. The EMS Agency Medical Director retains the final decision through his/her medical authority for the EMS system.

III. OPEN PUBLIC MEETINGS

- A. All committee and sub-committee meetings are open to members of the public. Meeting agendas, minutes, and other documents pertaining to these committees, except quality improvement documents, are public records and subject to public review. The EMS Agency shall distribute and post on its website an annual meeting schedule.
- B. The quality improvement portions of the EMS Advisory Committee and its sub-committees are closed meetings because of confidential patient information reviewed during case discussions.

IV. PARLIAMENTARY AUTHORITY / QUORUM

- A. Proceedings of the advisory committee and subcommittees are conducted under the "Robert's Rules of Order" when they do not conflict with this policy. This policy shall take precedence if any procedures are in conflict with "Robert's Rules of Order."
- B. A quorum is required to call the meeting to order and to transact committee business. A committee must maintain a quorum to continue a meeting. Specific quorum requirements are listed in Section VII.

V. COMMITTEE MEMBERSHIP

- A. Representative organizations are listed the appendices to this policy. Committee members are nominated by their representative organization and appointed by the EMS Agency Medical Director to a two-year term. Members may be re-appointed to their position with concurrence of the EMS Agency Medical Director and their organization.
- B. Members who do not attend three meetings within a year may be replaced in their position by the EMS Agency Medical Director.

VI. COMMITTEE OFFICERS

- A. Each committee shall elect a Chair and Vice-Chair. The Chair of each committee shall call and preside over all meetings of that committee. The Chair shall develop the committee agenda in consultation with the EMS Agency Medical Director. The Vice-Chair shall assume the duties of the Chair in their absence.
- B. Committee Chairs and Vice-Chairs serve a one-year term from July 1 – June 30. At the last meeting of each committee before July 1st, the members shall elect a Chair and Vice-Chair. Chair and Vice Chair terms are effective at the first meeting of that committee after July 1st. The committee may vote to extend their term once (for a total of two years of consecutive service) if the current officers who wish to continue. Past officers are eligible for service again after three years from the end of their last term.
- C. This provision does not apply to the Trauma System Audit Sub-Committee, which has the Trauma Medical Director at San Francisco General Hospital as the standing Chair.
- D. The EMS Agency will provide professional and clerical support to the advisory committees created by this policy.

VII. STANDING ADVISORY COMMITTEE AND SUBCOMMITTEES

- A. **Emergency Medical Services Committee (EMSAC):** The standing advisory committee that is a multi-disciplinary forum for reviewing and making recommendations related to the following:
 - Prehospital clinical policies and treatment protocol issues involving First Responder, Basic Life Support, Advanced Life Support, interfacility transport, and/or critical care transport personnel in the San Francisco EMS system;
 - General system management and operational policies including communications, system performance, destination, ambulance diversion, and development of strategies to optimize the EMS System;
 - Disaster medical emergency management, including mitigation, preparedness, response and recovery, and

- Approval of prehospital pilot and research projects.

Meetings: Held five times per year in even numbered months or more frequently by request of the Committee Chair, vote of the committee, or the request of the EMS Agency Medical Director or his/her designee.

Location: As set by agenda

EMS Agency Staff: Medical Director, EMS Administrator, EMS Agency Specialists

Quorum: Consists of:

- 33% + one of the representatives from the prehospital EMS organizations listed under Appendix A.
- 33% + one of the hospital organizations listed under Appendix B.

Membership: Consists of the EMS Agency Medical Director (ex-officio) and one primary representative and one alternate representative from:

- Ambulance Provider Companies listed in Appendix A
- San Francisco Receiving Hospitals listed in Appendix B
- San Francisco Emergency Physicians' Association
- City College of San Francisco - Paramedic Training Program
- CityEMT – EMT Training Program
- San Francisco Department of Public Health
- San Francisco General Hospital Base Hospital Medical Director
- San Francisco Fire Department EMS Medical Director
- San Francisco Emergency Communications Department Medical Director
- Paramedic field representatives currently accredited in San Francisco and working for a permitted ambulance company appointed by the EMS Agency Medical Director
- EMT field representatives currently certified in San Francisco and working on a permitted ambulance company appointed by the EMS Agency Medical Director
- Members of the public, not affiliated with a regulated provider organization, and appointed by the EMS Agency Medical Director
- Membership shall be in compliance with Appendix D (1797.273) for Community Paramedicine and Triage to Alternate Destination programs. Should above membership not meet or exceed Appendix D requirements, EMS Agency Medical Director shall appoint additional representation.

- B. **Trauma System Audit Subcommittee (TSAC):** A standing subcommittee of the EMS Advisory Committee that advises on trauma system policy. Its goals are the evaluation and administration of the trauma system with oversight responsibility for system vulnerabilities, the development of policy and/or approaches to related issues such as

major trauma and burn-related prehospital care, injury surveillance, trauma transfers, repatriation, and long-term outcomes.

Meetings: Meets two times per year, coincident with dates of the EMS Advisory Committee, or by request of the subcommittee Chair or the EMS Agency Medical Director.

Location: As set by agenda

EMS Agency Staff: EMS Medical Director, EMS Administrator and Trauma Coordinator

Quorum: Consists of:

- 33% + one of the hospital organizations listed under TSAC Membership
- 33% + one of the prehospital EMS organizations listed under Membership
- One representative from SFGH Trauma Center
- One representative from St. Francis Bothin Burn Center

Membership: Hereby consists of:

- EMS Agency Medical Director (ex-officio)
- Zuckberg San Francisco General Hospital Trauma Medical Director (ex-officio)
- Zuckerberg San Francisco General Hospital Trauma Program Manager (ex-officio)
- St. Francis Bothin Burn Center Medical Director (ex-officio)
- St. Francis Bothin Burn Center Manager (ex-officio)
- One representative from a minimum of five of the San Francisco Receiving Hospitals listed in Appendix B (including San Francisco General Hospital and St. Francis Memorial Hospital)
- One representative from each approved ALS ambulance provider
- One member of the public not affiliated with a regulated stakeholder organization, appointed by the EMS Agency Medical Director

- C. **STAR Subcommittee:** A standing subcommittee of the EMS Advisory Committee that advises on STEMI and post-cardiac arrest prehospital care. The subcommittee's goals are the evaluation of STEMI and cardiac arrest policies and protocols for the EMS system with the responsibility for addressing system vulnerabilities. It assists the EMS Medical Director by evaluating topics and data about related issues such as clinical research on prehospital STEMI and cardiac arrest care, clinical outcomes, community education, interfacility transfers, repatriation, and long-term outcomes.

Meetings: Four times per year by request of the subcommittee Chair or the EMS Agency Medical Director.

Location: As set by agenda.

EMS Agency Staff: EMS Medical Director, EMS Administrator and STAR program coordinator.

Quorum: Consists of:

- 33% + one of the hospital organizations listed under STAR Committee Membership
- 33% + one of the prehospital EMS organizations listed under Membership

Membership: Hereby consists of:

- EMS Agency Medical Director (ex-officio)
- Two representatives from each approved of the STAR designated hospitals; one from hospital administration, and one clinical expert (preferably an interventional cardiologist) who are knowledgeable about the cases reviewed at each institution's STEMI committee
- One representative from a non-STAR designated hospital
- At least one representative from a permitted ALS ambulance provider

Stroke Subcommittee: A standing subcommittee of the EMS Advisory Committee that advises on Stroke prehospital care. The subcommittee's goals are the evaluation of Stroke policies and protocols for the EMS system with the responsibility for addressing system vulnerabilities. It assists the EMS Medical Director by evaluating topics and data about related issues such as clinical research on prehospital Stroke care, clinical outcomes, community education, interfacility transfers, repatriation, and long-term outcomes.

Meetings: Four times per year by request of the subcommittee Chair or the EMS Agency Medical Director.

Location: As set by agenda.

EMS Agency Staff: EMS Medical Director, EMS Administrator and Stroke program coordinator.

Quorum: Consists of:

- 33% + one of the hospital organizations listed under Stroke Committee Membership
- 33% + one of the prehospital EMS organizations listed under Membership

Membership: Hereby consists of:

- EMS Agency Medical Director (ex-officio)
- Two representatives from each approved of the Stroke designated hospitals; one from hospital administration, and one clinical expert who are knowledgeable about the cases reviewed at each institution's Stroke committee
- At least one representative from a permitted ALS ambulance provider

EMS For Children Subcommittee: A standing subcommittee of the EMS Advisory Committee that advises on pediatric prehospital care. The subcommittee's goals are the evaluation of pediatric policies and protocols for the EMS system with the responsibility for addressing system vulnerabilities. It assists the EMS Medical Director by evaluating topics and data about related issues such as clinical research on prehospital pediatric care, clinical outcomes, community education, interfacility transfers, repatriation, and long-term outcomes.

Meetings: Two times per year by request of the subcommittee Chair or the EMS Agency Medical Director.

Location: As set by agenda.

EMS Agency Staff: EMS Medical Director, EMS Administrator.

Quorum: Consists of:

- Medical Directors from four Pediatric Receiving Centers (including both Critical Medical Peds centers).
- Medical Director and QI staff from one 911 EMS Provider

Membership: Hereby consists of:

- EMS Agency Medical Director (ex-officio)
- Two representatives from each approved of the pediatric designated hospitals; one from hospital administration, and one clinical expert who are knowledgeable about the cases reviewed at each institution's pediatric committee
- At least one representative from a permitted ALS ambulance provider

- D. **Quality Improvement (QI) Subcommittee:** A standing subcommittee of the EMS Advisory Committee that advises on system quality improvement issues. The subcommittee's goal is to report and evaluate the EMS system and recommend any necessary changes. It assists the EMS Medical Director by evaluating topics and data about issues such as response capabilities, system structure, clinical performance, clinical outcomes, and professional training.

Meetings: Three times per year by request of the subcommittee Chair or the EMS Agency Medical Director

Location: As set by agenda

EMS Agency Staff: EMS Medical Director, EMS Quality Manager

Quorum: Consists of at least one representative from each of the following:

- Department of Emergency Communication

- Prehospital providers, and
- Emergency department supervisors.

Membership: Consists of:

- EMS Agency Medical Director (ex-officio)
- DEC Medical Director
- DEC Quality Management staff
- One representative from a designated EMS receiving hospital
- One representative from each approved ALS ambulance

VIII. AUTHORITY

California Health and Safety Code, Section 1797 et seq. and 1798 et seq;
California Government Code, Section 54950 et seq.;
California Code of Regulations, Title 22, Division 9;
City and County of San Francisco Administrative Code, Section 67.1 et seq.

APPENDIX A: SAN FRANCISCO AMBULANCE PROVIDERS

1. San Francisco Fire Department
2. American Medical Response
3. King American Ambulance
4. Pro-Transport 1
5. Bayshore Ambulance
6. St. Joseph's Ambulance
7. Falck Northern California
8. NorCal Ambulance

APPENDIX B: SAN FRANCISCO RECEIVING HOSPITALS

1. Zuckerberg San Francisco General Hospital Trauma Center & Base Hospital
2. California Pacific Medical Center – Pacific, Davies, California and St Luke's Campuses
3. Kaiser Permanente Medical Center
4. St. Mary's Medical Center
5. St. Francis Memorial Hospital
6. University of California, San Francisco Medical Center, Parnassus Campus
7. University of California, San Francisco, Mission Bay Campus
8. Veterans Administration Medical Center
9. Chinese Hospital
10. Seton Medical Center (San Mateo)
11. South Kaiser (San Mateo)

APPENDIX C: STAR DESIGNATED RECEIVING HOSPITALS

1. Zuckerberg San Francisco General Hospital
2. California Pacific Medical Center – Pacific Campus

3. Kaiser Permanente Medical Center
4. St. Mary's Medical Center
5. University of California, San Francisco Medical Center, Parnassus Campus

APPENDIX D: COMMUNITY PARAMEDICINE AND TRIAGE TO ALTERNATE DESTINATION

(Required under 1797.273)

1. One emergency medicine physician and surgeon who is board certified or board eligible practicing at an emergency department within the jurisdiction of the local EMS agency.
2. One registered nurse practicing within the jurisdiction of the local EMS agency.
3. One licensed paramedic practicing within the jurisdiction of the local EMS agency.
4. One acute care hospital representative with an emergency department that operates within the jurisdiction of the local EMS agency.
5. Additional advisory members in the fields of public health, social work, hospice, substance use disorder detoxification and recovery, or mental health practicing within the jurisdiction of the local EMS agency with expertise in specialties such as Community Paramedicine and Triage to Alternate Destination.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 2050
Effective Date: October 1, 2023
Supersedes: February 1, 2015

PARAMEDIC ACCREDITATION

I. PURPOSE

To establish procedures for a California licensed Paramedic to become accredited in the City and County of San Francisco under the following Accreditation sub-types:

- A. Advanced Life Support (ALS) Local Accreditation
- B. Community Paramedicine
- C. Triage to Alternate Destination

II. POLICY

- A. Applicants for initial or re-accreditation as a Paramedic in the City and County of San Francisco for all Paramedic Accreditation types must apply to the San Francisco EMS Agency. Applicants must meet all minimum requirements identified in this policy.
- B. No person shall use the ALS Paramedic scope of practice in San Francisco unless they are currently an ALS Local Accredited Paramedic or have completed the requirements to be an ALS Local Accreditation Candidate. No person shall use Community Paramedicine Scope of Practice or Triage to Alternate Destination protocols without obtaining the Accreditation subtypes.
- C. Paramedic applicants with background issues listed under Health & Safety Code, Section 1798.200 in the categories of actions constituting a threat to public safety may be precluded from obtaining a Paramedic accreditation. The Paramedic applicant may be required to submit additional information or participate in an in-person interview for determination of the applicability of Health & Safety Code, Section 1798.200. Denial of accreditation shall be subject to provisions of this policy and *Policy 2070 Certificate / License Discipline Process for Prehospital Personnel*. The EMS Agency Medical Director retains the final decision through his/her medical authority whether to grant or revoke a Paramedic accreditation in San Francisco.

III. GENERAL REQUIREMENTS FOR ALL ALS LOCAL ACCREDITATION PARAMEDIC APPLICANTS

- A. Submit a completed San Francisco EMS Agency Paramedic Accreditation application along with the required fee. Go to the EMS Agency office or sf.gov/ems
- B. Provide a photocopy of the following:

1. Current picture identification (State driver's license or ID card, valid Passport, valid US military ID card or other government-issued ID).
 2. Current California Paramedic license.
 3. Current Basic Life Support (Healthcare Provider Level) CPR Card from the American Heart Association, American Red Cross or American Safety & Health Institute.
 4. Submit proof or application for Triage to Alternate Destination Accreditation
- C. Payment of any associated fees

IV. INITIAL ACCREDITATION - ALS LOCAL ACCREDITATION

- A. Submission of all general requirements listed in Section III.
- B. Submit photocopies of current certification cards or proof of course completion for the following:
1. Advanced Cardiac Life Support (ACLS).
 2. Pediatric Advanced Life Support (PALS) or Pediatric Education for Prehospital Professionals (PEPP).
 3. Prehospital Trauma Life Support (PHTLS) or Basic Trauma Life Support (BTLS).
 4. Incident Command System Training (ICS) 100, 200 and IS 700a, Introduction to National Incident Management System.
 5. Hazmat First Responder Awareness course (FRA) per 29 CFR 1910-120.
- C. Provide verification of successful completion of a San Francisco EMS system orientation given by the employer. The verification form should include any San Francisco EMS approved Optional Scope of Practice protocols
- D. The EMS Agency shall process the accreditation application within 15 days of receiving it. The accreditation applicant may perform the basic Paramedic scope of practice with a second accredited Paramedic until receipt of local accreditation.
- E. The initial accreditation term shall be from the date issued until the applicant's license expires. Upon renewal, accreditation will be concurrent with California Paramedic License.

V. RE-ACCREDITATION - ALS LOCAL ACCREDITATION

- A. Accreditation for practice shall be continuous as long as licensure is maintained and the following requirements are met:
1. Submission of all general requirements listed in Section III.

2. Verification of employment as a Paramedic from a permitted San Francisco ambulance provider.
3. Verification from the employer of completion of training on EMS Agency policy and protocols and updates or any other trainings required by the EMS Agency Medical Director that have been issued in the previous 12 months.
4. Submit photocopies of current certification cards for the following:
 - a) Advanced Cardiac Life Support (ACLS)
 - b) Pediatric Advanced Life Support (PALS) or Pediatric Education for Prehospital Professionals (PEPP).

VI. LICENSE OR ACCREDITATION LAPSES - ALS LOCAL ACCREDITATION

- A. Accreditation lapse less than 30 days:
 1. Meet the requirements for Re-accreditation in Section V.
- B. Accreditation lapse greater than 30 days, but less than 1 year:
 1. Meet the requirements for Re-accreditation in Section V, and
 2. Submit written request from employer that the individual to be re-accredited.
- C. Accreditation lapse between 1 and 2 years:
 1. Meet the requirements for Re-accreditation in Section V;
 2. Submit a written request from an employer for re-accredited; and
 3. Successfully pass a supervised skills competency examination provided by the ALS ambulance provider.
- D. Accreditation lapse 2 or more years:
 1. Follow Section IV Initial Accreditation.

VII. TRANSFER OF SAN FRANCISCO PARAMEDIC ACCREDITATION - ALS LOCAL ACCREDITATION

- A. A Paramedic seeking to transfer employment between San Francisco based ALS providers remains an accredited Paramedic when:
 1. Employed and working in the field as a Paramedic for the new employer within 90 days of the date last worked in the field as a Paramedic from the last employer; and
 2. The accreditation period is current.
- B. The new employer must submit written notification to the EMS Agency at least 2 business days in advance of the Paramedic's new employment start date. The notification must include:

1. Name of the Paramedic and his/her current San Francisco EMT-P accreditation number;
2. Name of the previous employer and date last worked in the field with that employer.
3. Termination date with previous employer.
4. Name of new employer and date of hire.
5. Start date in the field with the new employer.

C. The Paramedic must submit a completed, signed EMS Agency Transfer application to the EMS Agency at least 2 business days in advance of the assignment to the field as a Paramedic with the new San Francisco based ALS Provider. Include from the new employer verification of completed training on San Francisco EMS Agency policy and protocols, including updates or revisions issued within the previous 12 months.

D. Any Paramedic seeking to transfer employment between San Francisco based ALS providers who does not meet the requirements in the section will be considered an Initial Accreditation applicant.

VIII. GENERAL REQUIREMENTS FOR TRIAGE TO ALTERNATE DESTINATION ACCREDITATION APPLICANTS

- A. A Triage to Alternate Destination Paramedic shall only utilize triage to alternate destination skills when accredited by the San Francisco EMS Agency as a Triage to Alternate Destination Paramedic and employed by an approved San Francisco Triage to Alternate Destination Service Provider.
- B. An initial Triage to Alternate Destination Paramedic accreditation shall expire on the last day of the month, two (2) years from the effective date of the initial accreditation or consistent with the expiration date of already existing ALS Local Accreditation.
- C. Triage to Alternate Destination accreditation requires renewal every two (2) years or by date as listed on accreditation card.
- D. California Paramedic License must be active and unrestricted
- E. Payment of any associated fees

IX. INITIAL ACCREDITATION – TRIAGE TO ALTERNATE DESTINATION

- A. Submission of all general requirements listed in Section III.
- B. Completed Triage to Alternate Destination Application
- C. Triage to Alternate Destination course completion certificate from a San Francisco EMS Agency-approved course

X. RENEWAL ACCREDITATION – TRIAGE TO ALTERNATE DESTINATION

- A. Submission of all general requirements listed in Section III.
- B. Completed Triage to Alternate Destination Application
- C. Completion of four (4) hours Triage to Alternate Destination-related Continuing Education (CEs) approved by the San Francisco EMS Agency.

XI. REINSTATEMENT OF ACCREDITATION - TRIAGE TO ALTERNATE DESTINATION

- A. Submission of all general requirements listed in Section III
- B. Completed Triage to Alternate Destination Application
- C. If expired twelve (12) months or less, completion of four (4) hours of Triage to Alternated Destination-related CE's approved by the San Francisco EMS Agency
- D. If expired twelve (12) months or more, San Francisco EMS Agency-approved Triage to Alternate Destination course completion certificate within one (1) year of reinstatement application submission date.

XII. GENERAL REQUIREMENTS FOR COMMUNITY PARAMEDIC ACCREDITATION APPLICANTS

- A. A Community Paramedic shall only utilize Community Paramedicine skills when accredited by the San Francisco EMS Agency as a Community Paramedic and employed by an approved San Francisco Community Paramedic service provider.
- B. An Initial Community Paramedic Accreditation shall expire on the last day of the month, two (2) years from the effective date of the initial accreditation or consistent with the expiration date of the already existing ALS Local Accreditation.
- C. Community Paramedic accreditation requires renewal every two (2) years or by date as listed on accreditation card.
- D. California Paramedic license must be active and unrestricted
- E. Payment of any associated fees

XIII. INITIAL ACCREDITATION – COMMUNITY PARAMEDIC

- A. Submission of all general requirements listed in Section III
- B. Completed Community Paramedic Application
- C. Community Paramedic course completion certificate from a San Francisco EMS Agency-approved course
- D. IBSC Community Paramedic certificate within the last two (2) years of the date of application submission.

XIV. RENEWAL ACCREDITATION – COMMUNITY PARAMEDIC

- A. Submission of all general requirements listed in Section III
- B. Completed Community Paramedic Application

- C. Completion of eight (8) hours Community Paramedicine-related CEs approved by the San Francisco EMS Agency
- D. Proof of continued active, unrestricted IBSC Community Paramedic certificate

XV. REINSTATEMENT OF ACCREDITATION – COMMUNITY PARAMEDIC

- A. Submission of all general requirements as listed in Section III
- B. Completed Community Paramedic Application
- C. If expired twelve (12) months or less, completion of eight (8) hours community paramedicine-related CEs approved by the San Francisco EMS Agency and proof of active, unrestricted IBSC Community Paramedic certificate
- D. If expired twelve (12) months or more, San Francisco EMS Agency-approved Community Paramedic course completion certificate and proof of passing IBSC Community Paramedic examination within the last two (2) years from the submission date of the reinstatement application

AUTHORITY

California Health and Safety Code, Sections 1797.172 et seq., 1797.214, 1797.185 et seq., and 1801-1857.

California Code of Regulations, Sections Title 22, Division 9, Article 1, Section 100142; and Article 6, Sections 100165 & 100166., Article 8, Section 100171; and Article 9, Section 100172.
California Code of Regulations, Title 22, Division 9, Chapter 5

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5000
Effective Date: October 1, 2023
Supersedes: July 11, 2022

DESTINATION POLICY

I. PURPOSE

- A. To identify the approved ambulance-transport destinations for the San Francisco EMS System.
- B. To delineate clinical criteria when patients should be transported to a general or specialty care hospitals or other alternate destinations.

II. DEFINITION

Decision Maker: Generic term used in this policy to refer to whoever is making the transport destination decision for the EMS patient. This may include the patient, family, or medical personnel managing the patient's care. For patients with psychiatric illness, this may also include the custodian placing the 5150 involuntary hold.

III. POLICY

- A. The Emergency Medical Services (EMS) Agency designates hospitals approved to receive ambulances according to [Policy 5010 – Receiving Hospital](#). The EMS Agency Medical Director may approve Specialty Care Facilities or alternate destinations that support the mission of the EMS System to receive ambulance patients as either temporary or permanent additions to the EMS System.
- B. Ambulances may only transport patients to the approved destinations listed in this policy. Prearranged inter-facility transports, as defined in [Policy 5030 – Interfacility Transfers](#) are exempt from this policy.
- C. When a patient is in need of specialty treatment (e.g. OB/GYN, STEMI, etc), the ambulance crew may bring the patient directly to that hospital's specialty care department if directed to do so by hospital staff.

IV. DESTINATION DECISION

- A. Hospital destination decisions for EMS patients shall be prioritized based on the following:
 - 1. Patient medical need;
 - 2. Hospital diversion status and/or EMS Alert status (see section V);
 - 3. Patient preference;
 - 4. Family or private physician preference (if patient unable to provide information);

5. Patients without a preference who require no specialty care shall be transported to the closest open general medical designated hospital.
- B. All patients who are in law enforcement custody (defined as “under arrest,” “detained,” or “incarcerated”) must be taken to Zuckerberg San Francisco General Hospital for evaluation.
- C. Patients with medical needs meeting any of the Clinical Field Triage Criteria listed in Section IV below will be transported to the most appropriate specialty care facility. Specialty care designations includes:
 1. Pediatric Medical
 2. Pediatric Critical Medical
 3. STAR (STEMI and/or Post Arrest with ROSC)
 4. Replantation (Microvascular Surgery)
 5. Burns
 6. Obstetrics
 7. Stroke
 8. Trauma
 9. LVAD
 10. Post-Sexual Assault
 11. Sobering
- D. Destinations other than those listed in this policy require approval from the Base Hospital Physician prior to transport except in instances as noted in Policy 4030 - Intercounty and Bridge Response.
- E. In the event of a Multi-Casualty Incident (MCI), destinations will be determined in accordance with [Policy 8000 – Multi-Casualty Incident](#).

V. EMS ALERT

- A. **EMS Alert:** Automatic ambulance routing function to supplement Hospital Diversion. EMS Alert looks at a ratio of current EMS volume and ED size to provide a fluid, point-in-time reflection of each hospital’s EMS impact.
 1. EMS Alert ratio is calculated as follows:
 - a) 60-Minute EMS Volume (Numerator): The sum of the units en route + units at-hospital + units cleared in the past 60 minutes.
 - b) ED Surge Cap (Denominator): Determined by the “30% or 6 Rule” which is 30% of a hospital’s licensed ED bed count or 6, whichever is lowest.
 - c) Receiving Facilities that have changes to their licensed ED bed count shall notify the EMS Agency within 30 days.

- B. EMS Alert status shall be followed by EMS Personnel, consistent with Diversion Policy 5020. EMSA shall add a dashboard to the monthly Hospital Report for EMS Provider compliance with EMS Alert.
- C. Ambulances are not permitted to transport to a Receiving Facility while on EMS Alert except (ref. Destination Decision above section IV, A):
1. Patients who meet any criteria which would allow bypass of diversion (e.g. Trauma, stroke, STEMI, in-custody)
 2. Extenuating circumstances where a patient has specific clinical needs that require care at a certain facility (e.g. recent transport or <48 hour surgical patient requesting transport to the hospital that performed the procedure). These situations required approval from the Dispatch Rescue Captain or King American/AMR On-duty Supervisor prior to transport. EMS Alert bypass requires documentation of the extenuating circumstances within the Patient Care Record (PCR) and the name of the supervisor who approved the bypass.
 - a) Examples include, but not limited to:
 - Recent organ transplant patient going to the hospital that performed the procedure
 - Patient <48-hours post-surgery requesting transport to the hospital that performed the procedure
 - Patient recently discharged (<2-hours) from an ED returning to the hospital where they were initially seen
 - Patient with an EMS6 care plan in which EMS6 feels another hospital is not appropriate
 - Patient with cancer receiving specialized care such as chemotherapy
- D. EMS Alert Suspension: diversion suspension has no effect on EMS Alert. EMS Alert is suspended when the sum of hospitals on Diversion, Trauma Override, or EMS Alert is equal to or greater than 5. When EMS Alert is suspended, hospitals might receive 1 additional ambulance transport above their designated ratio each time EMS Alert is suspended.
- E. In order to obtain EMS Alert and Hospital Diversion status, review of ReddiNet via mobile data terminal shall be the primary tool by EMS personnel. Calling DEC shall be a secondary option, such as in cases of equipment failure, to minimize radio traffic and routing errors.

VI. CLINICAL FIELD TRIAGE CRITERIA

- A. **Critical Airway:** Patients in whom EMS personnel cannot obtain adequate airway control should be transported to the closest Receiving Hospital regardless of diversion status. For patients under age 18, the preference is for a critical pediatric medical hospital

(CPMC Van Ness or UCSF Mission Bay) if ETA is equal to or less than any other receiving facility.

- B. **Adult Critical Medical:** Patients with one (1) or more of the following conditions should be transported to the closest Receiving Hospital:
1. Airway obstruction or respiratory insufficiency with inadequate ventilation;
 2. Hypotension with shock;
 3. Status epilepticus;
 4. Acute deteriorating level of consciousness without trauma.
- C. **Adult Medical:** Patients who do not meet any of the following: critical airway, critical medical adult or specialty criteria, may be transported to any Receiving Hospital or Standby Receiving Hospital.
- D. **Pediatric Critical Medical:**
1. Pediatric definition of <18 years old applies only to this policy for selection of a hospital destination. It does NOT apply to any patient treatment policies or protocols.
 2. Patients under age 18 with 1 or more of the following conditions should be transported to the closest Pediatric Critical Medical receiving hospital):
 - a) Cardiopulmonary arrest or post-arrest;
 - b) Hypotension with shock;
 - c) Status epilepticus;
 - d) Acute deteriorating level of consciousness without trauma
- E. **Pediatric Medical:** Pediatric definition of <18 years old applies only to this policy for selection of a hospital destination. It does NOT apply to any patient treatment policies or protocols. Patients under age 18 years not meeting the criteria for Critical Medical Pediatric may be transported to any Receiving Hospital listed as “pediatric medical.”
- F. **ST Elevation Myocardial Infarction / Post Arrest with ROSC (STAR):** Patients are considered to be STEMI patient if they meet the STEMI criteria as defined in [Protocol 2.06 – Chest Pain/Acute Coronary Syndrome](#). Patients experiencing a STEMI shall be transported to a designated **ST** Elevation Myocardial Infarction / Post **A**rrest with **R**OSC (**STAR**) Center according to the following hierarchy:
1. Cardiopulmonary arrest - Patients who are age 18 or over and are in cardiac arrest or those who are post-arrest with return of spontaneous circulation in the field;
 2. Patients who are unstable and would experience a significant delay in their care by transport to a preferred STAR Center shall be transported to the closest, designated STAR Center;
 3. Patient preference for transport to a specific Receiving Hospital that is designated as a STAR Center;

4. Family or private physician preference (if patient unable to provide information) for transport to a specific Receiving Hospital that is designated as a STAR Center;
 5. Patients without a preference shall be transported to the closest Receiving Hospital that is designated as a STAR Center.
- G. **Stroke:** Patients who are age 18 or over and are experiencing the symptoms of acute stroke (last seen normal 24 hours or less prior to 911 call) and exhibiting an “abnormal” result on the Cincinnati Prehospital Stroke Scale (see [Protocol 2.14 – Stroke](#)) shall be transported to a designated Stroke Center according to the following hierarchy:
1. Patients who are unstable and would experience a significant delay in their care by transport to a preferred Stroke Center shall be transported to the closest designated Stroke Center;
 2. Patient preference for transport to a specific Receiving Hospital that is designated as a Stroke Center;
 3. Family or private physician preference (if patient unable to provide information) for transport to a specific Receiving Hospital that is designated as a Stroke Center;
 4. Patients without a preference shall be transported to the closest Receiving Hospital that is designated as a Stroke Center.
- H. **Replantation:** If the patient has any of the following amputations or devascularization injuries, they may be taken to the Replantation (Microsurgical) Facility of their choice or to the closest Replantation Center if the patient has no preference:
1. Isolated amputation or partial amputation distal to the ankle or wrist;
 2. Extensive facial, lip, or ear avulsion;
 3. Penile amputation;
 4. If the patient meets trauma triage criteria, transport to a Trauma Center;
 5. Simple avulsion lacerations of the distal phalanx will be transported to any open Receiving Hospital or the closest open Receiving Hospital if the patient has no preference.
- I. **Burns:** Patients with the following criteria shall be transported to the Saint Francis Hospital Burn Center:
1. Partial thickness burns > 10% of the total body surface area (TBSA);
 2. Burns involving the face, eyes, ears, hands, feet, perineum or major joints;
 3. Full thickness or 3rd degree burns in any age group;
 4. Serious electrical burns;
 5. Serious chemical burns;
 6. Inhalation injuries (including burns sustained in a closed space for purposes of facial burns);
 7. Pediatric burn patients who do not meet trauma triage criteria shall be transported to Saint Francis Memorial Hospital;

8. Transport to Zuckerberg San Francisco General Hospital Trauma Center if the burned patient meets trauma triage criteria.
- J. **Obstetrics:** Pregnant patients who are over 20 weeks gestation (by patient history) with any condition that does not fall under other specialty center should be transported to the Obstetrics Specialty Care Facility of their choice or the closest open Obstetrics Specialty Care Facility if the patient has no preference.
- K. **Psychiatric** (see 5000.2 Flowchart):
The psychiatric criteria listed below apply to patients with signs and symptoms of a psychiatric illness and / or who are on a 5150 involuntary hold:
 1. All patients with signs and symptoms of a psychiatric illness who are under law enforcement custody (defined as “under arrest,” “detained,” or “incarcerated”) must go to Zuckerberg San Francisco General Hospital.
 2. For (not incarcerated, detained or under arrest) patients with signs and symptoms of a psychiatric illness, the destination is based on the following:
 - a) Patient age;
 - b) Patient medical need;
 - c) Hospital diversion status;
 - d) For involuntary patients, the patient decision maker placing the hold will identify hospital destination.
 - e) Patient preference;
 - f) Family/guardian or private physician preference;
 - g) If no preference, hospital location (“geographically closest”).
 3. Patients with signs and symptoms of a psychiatric illness less than 18 years old must go to medically appropriate pediatric designated Receiving Hospital.
 4. Patients with signs and symptoms of a psychiatric illness AND WITH suspected or active medical complaints must go to medically appropriate Receiving Hospital. This includes:
 - a) Patients who are severely agitated or combative and whose combativeness prevents an assessment (vital signs or examination) and / or requires field sedation with midazolam.
 - b) Patients with any medication overdose or who show signs of potential toxicity from drugs or alcohol.
 5. Patients with signs and symptoms of a psychiatric illness **may** go to directly Psychiatric Emergency Services (PES) at Zuckerberg San Francisco General (ZSFG) if it is open (not on divert) and are medically appropriate by meeting **ALL** of the following criteria:
 - a) Age 18 – 65 years.

- b) Glasgow Coma Score of 13 or greater;
 - c) Pulse rate between 55 - 120;
 - d) Systolic blood pressure between 90 - 190;
 - e) Diastolic blood pressure between 60 - 110;
 - f) Respiratory rate between 12 - 24;
 - g) Temperature between 96.5 and 100.5°F (or 35 to 38°C);
 - h) Oxygen saturation greater than 94%;
 - i) Blood glucose level between 60 – 250;
 - j) No active bleeding;
 - k) No bruising or hematoma above clavicles;
 - l) No active seizure; and
 - m) No lacerations that have not been treated.
- L. **Trauma:** Emergent patients meeting the criteria described in [Policy 5001 – Trauma Triage Criteria](#) will be transported to a Trauma Center. For non-emergent patients who meet Trauma Triage Criteria, Base Hospital contact is required prior to transport to establish appropriateness of Trauma designation and to receive approval to transport to Zuckerberg San Francisco General Hospital.
- M. **LVAD:** Any patient with a left ventricular assist device (LVAD) should be transported to the LVAD Center that implanted the device (UCSF or CPMC Van Ness). You are authorized to BYPASS the closest San Francisco LVAD Center to get the patient to the LVAD Center that implanted their device no matter the patient's condition. If the LVAD Center that implanted the device is not in San Francisco, take the patient to the closest San Francisco based LVAD Center.
- N. **Post-Sexual Assault:** Any patient who self-identifies as a victim of sexual assault or abuse within the 72 hours prior to their activation of 911 services AND does not have an overriding medical complaint or meet any special care criteria listed in this policy should go to Zuckerberg San Francisco General Hospital. This also applies to pediatric patients who are identified as being victims of sexual assault or abuse.
- O. **Alternate Destination (Sobering Services):** Intoxicated patients with no acute medical condition(s) or co-existing medical complaints may go to an approved sobering service, if the patient meets the following criteria:
- 1. Be at least 18 years or older;
 - 2. Voluntarily consents or has presumed consent (when not oriented enough to give verbal consent) to go to an approved sobering service;
 - 3. If going to the San Francisco Sobering Center, must not be on their "Exclusion List."
 - 4. Be medically appropriate by meeting **ALL of the following criteria:**
 - a) Indication of alcohol intoxication (odor of alcoholic beverages on breath, bottle found on person);

- b) Glasgow Coma Score of 13 or greater;
- c) Pulse rate between 55 - 120;
- d) Systolic blood pressure between 90 - 190;
- e) Diastolic blood pressure between 60 - 110;
- f) Respiratory rate between 12 - 24;
- g) Temperature between 96.5 and 100.5°F (35 and 38°C);
- h) Oxygen saturation greater than 94%;
- i) Blood glucose level between 60 – 250;
- j) No active bleeding;
- k) No bruising or hematoma above clavicles ;
- l) No active seizure; and
- m) No lacerations that have not been treated.

If ALS transport by a Paramedic to Sobering Services, Paramedic shall hold Triage to Alternate Destination Accreditation under Policy 2050.

- P. **Alternate Destination (Veteran's Hospital (VA) Standby Facility):** Patients who identify as VA members, request transport to the San Francisco VA Medical Center, and do not meet the following:

- 1. Critical airway
- 2. Critical medical adult or specialty criteria

If ALS transport by a Paramedic to San Francisco VA Medical Center, Paramedic shall hold Triage to Alternate Destination Accreditation under Policy 2050.

Q. **Additional Alternative Destination Information**

- a. If a patient meets above criteria, but requests transport to an emergency department, the patient shall be transported to a Receiving Facility.
- b. If a patient is transported to an Alternate Destination and is found to no longer meet criteria, patient shall be immediately transported to a Receiving Facility.
- c. Alternate Destinations shall send with each patient copies of all medical records related to the patient's transfer.
- d. Transportation to an Alternate Destination shall not be based on or affected by a patient's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services or any other characteristic as defined as California Civil Code, Division 1, Section 51 except to the extent a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

VII. AUTHORITY

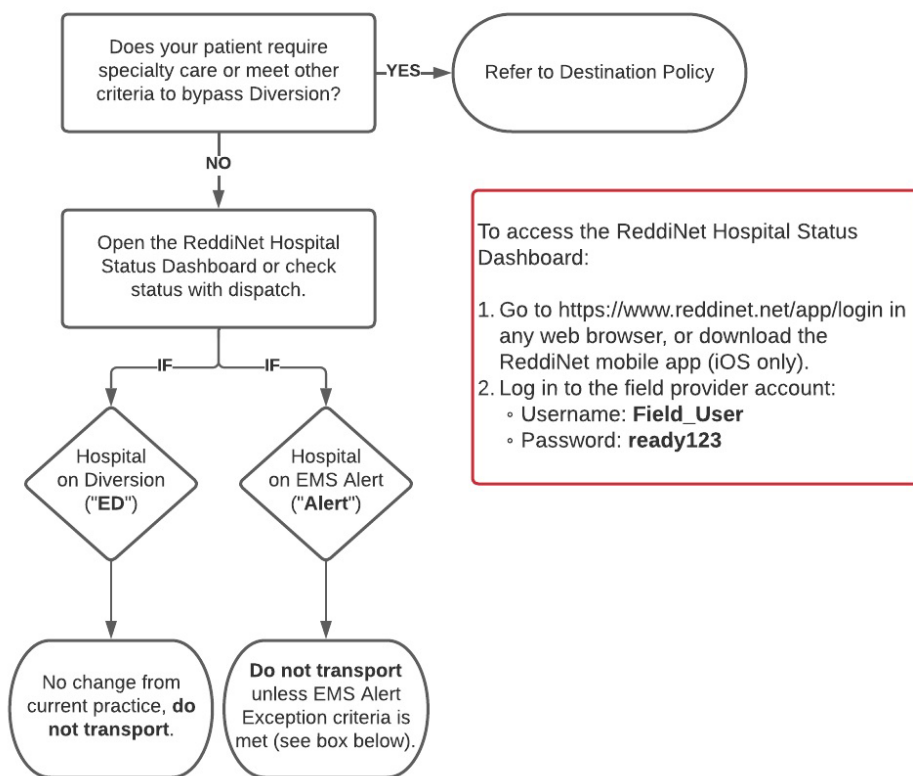
California Health and Safety Code, Division 2.5, Sections 1798, 1798.163, and 1801-1857
California Code of Regulations, Title 22, Division 9, Chapter 5

Appendix A

“EMS Alert” Guide Sheet

EMS Alert is a parallel system to Diversion. It provides a fluid, point-in-time reflection of each hospital’s EMS impact based on current EMS activity in relation to a hospital’s capacity. Background information, technical details, and FAQ can all be found in the EMS Alert section of the Policy & Protocol App, as well as on the EMS Agency webpage.

Instructions for using EMS Alert are below and are based on current guidance from the EMS Agency Medical Director. The EMS Memo with this information can also be found on the Policy & Protocol App and webpage.



EMS Alert Exception

Paramedics shall contact the Radio RC (SFFD ambulance) or King/AMR Supervisor (Private ambulance) if the patient meets the specialty cases outlined below. These personnel can only approve a patient going to an ED on EMS Alert in these specific cases.

- Recent organ transplant patient going to the hospital that performed the procedure
- Patient <48-hours post-surgery requesting transport to the hospital that performed the procedure
- Patient recently discharged (<2-hours) from an ED returning to the hospital where they were initially seen
- Patient with an EMS6 care plan, in which EMS6 feels another hospital is not appropriate
- Patients with cancer receiving specialized care such as chemotherapy

In the event that a provider cannot contact a supervisor after 2 attempts, EMS Alert bypass may be initiated. For other clinical scenarios not listed above, in which a Paramedic feels a patient should bypass, Base Hospital contact is required. This should be treated the same as Base Hospital destination consultation while a hospital is on Diversion. Bypass of EMS Alert requires documentation of extenuating circumstances and supervisor/physician name.

CITY AND COUNTY OF SAN FRANCISCO

COMMUNITY PARAMEDICINE (CP) & TRIAGE TO ALTERNATE DESTINATION (TAD) PROGRAMS

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PROGRAM STANDARDS – APPLICABLE TO BOTH TRIAGE TO ALTERNATE DESTINATION (TAD) AND COMMUNITY PARAMEDICINE (CP)

1. PURPOSE

- 1.1. Community Paramedicine (CP) and Triage to Alternate Destination (TAD) programs are community focused extensions of traditional emergency response transportation and recognized as an emerging model of care to meet an unmet need within the community.
- 1.2. Authorized CP and TAD Paramedics, working under medical oversight, will deliver CP and TAD services to improve coordination among providers of medical service, behavioral health services, and social services; preserve and protect the underlying 911 EMS system; provide high quality patient care; and empower health systems to provide care more effectively and efficiently.

(Community Paramedicine or Triage to Alternate Destination Act of 2020; California Health and Safety Code, Division 2.5, Chapter 13; California Code of Regulations (CCR), Title 22, Division 9, Chapter 5)

2. MEDICAL DIRECTION

- 2.1. A CP and TAD Paramedic shall utilize the paramedic scope of practice, approved EMS Agency local optional scope and trial study scope as described in EMS Agency policy and protocols. This includes utilizing general paramedic scope and other approved scopes while transporting to alternate destinations, providing care to discharged patients, providing vaccinations, and through other conditions as identified in CP and TAD programs.

3. DOCUMENTATION AND CONTINUOUS QUALITY IMPROVEMENT

- 3.1. CP and TAD Paramedics shall complete and submit electronic patient care records in accordance with 22 CCR § 100171, and document destination facility with standardized facility codes per the California Emergency Medical Services Information System (CEMSIS).
- 3.2. A CP and TAD program shall have a written Continuous Quality Improvement (CQI) plan approved by the EMS Agency. The CQI plan shall complement the EMS Provider's existing CQI plan. CQI plans shall include provisions for continuing education including types of activities, frequency, and required hours.
- 3.3. CP and TAD programs shall exchange electronic patient health information between CP/TAD providers and facilities unless a waiver is obtained under 22 CCR § 100185(c).

4. LOCAL IMPLEMENTATION

- 4.1. CP and TAD programs shall be reviewed, submitted, and implemented within the EMS Agency's EMS Plan under Ca. Health and Safety Code § 1797.250.
- 4.2. EMS Agency shall provide medical control and oversight for CP and TAD programs.
- 4.3. The EMS Agency with CP and TAD Providers shall facilitate agreements to ensure delivery of CP and TAD services.
- 4.4. The EMS Agency shall annually review CP and TAD training programs, providers, and facilities to ensure compliance with all requirements.
- 4.5. The EMS Agency shall notify the EMS Authority of any complaints or unusual occurrences for approved CP and TAD programs within seventy-two (72) hours with supporting documentation. The local process for reporting an unusual occurrence is detailed in [EMSA Policy 6020 – Incident Reporting](#).
- 4.6. CP and TAD Providers, Training Programs, TAD Facilities and Accreditation Applicants must pay all associated fees.

5. CP AND TAD PROVIDER/FACILITY OVERSIGHT

- 5.1. CP and TAD Provider/Facility's failure to comply with the provisions of statute, regulation, and/or any additional EMS Agency requirements may result in denial, probation, suspension, or revocation of approval by the EMS Agency.
- 5.2. The process for noncompliance is listed in 22 CCR § 100184.

6. TRAINING PROGRAM REVIEW AND APPROVAL

- 6.1. CP and TAD training programs shall submit a written request for training program approval to the EMS Agency
- 6.2. The EMS Agency shall receive and review the following documentation prior to program approval:
 - 5.2.1. A statement verifying that the course content meets the requirements contained in the current version of the United States Department of Transportation (U.S. DOT) National EMS Education Standards as required by Section 1831(c)(2) of the Health and Safety Code.
 - 5.2.2. An outline of course objectives and curriculum
 - 5.2.3. Performance objectives for each skill.
 - 5.2.4. The names and qualifications of the training program director, program medical director, and instructors.
 - 5.2.5. If the training program includes supervised clinical training, then provisions for supervised clinical training including student evaluation criteria and standardized forms for evaluating CP students; and monitoring of preceptors by the training program shall be included.
 - 5.2.6. If the training program includes supervised field internship, then provisions for supervised field internship including CP student evaluation criteria and standardized forms for evaluating students; and monitoring of preceptors by the training program shall be included.
 - 5.2.7. The proposed location(s) and date(s) for courses.
 - 5.2.8. Written contract or agreements between the training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.
 - 5.2.9. Written contracts or agreements between the training program and a provider agency(ies) for student placement for field internship training.
 - 5.2.10. Samples of written and skills examinations administered by the training program.
 - 5.2.11. Evidence that training program facilities, equipment, examination securities, and student record keeping are compliant with the provisions of statute, regulation, and EMS Agency requirements.
- 6.3. The EMS Agency shall approve and establish the effective date of program approval in writing upon the program satisfactory meeting and documenting compliance with all program requirements.
- 6.4. Notification of program approval or deficiencies with the application shall be made in writing by the EMS Agency to the requesting training program within ninety (90) days of receiving the training program's request for approval.
- 6.5. Training program approval shall be valid for four (4) years ending on the last day of the month in which it was issued and may be renewed every four (4) years
- 6.6. The EMS Agency shall notify the EMS Authority in writing of the training program approval, including the name and contact information of the program director, medical director, and effective date of the program.
- 6.7. Training Program shall provide any documents and materials on an annual basis to support EMS Agency EMS Plan submission to maintain continuity of CP and TAD programs.

7. TRAINING PROGRAM REQUIREMENTS

- 7.1. Program Medical Director
 - 7.1.1. Each training program shall have a program medical director who is a board certified or board eligible emergency medical physician currently licensed in the State of California, who has experience in emergency medicine and has education or experience in methods of instruction. Duties of the program medical director shall include, but not be limited to the following:
 - 7.1.2. Review and approve educational content, standards, and curriculum; including training objectives and local protocols and policies for the clinical and field instruction, to certify its ongoing appropriateness and medical accuracy.
 - 7.1.3. Review and approve the quality of medical instruction, supervision, and evaluation of the students in all areas of the program.

- 7.1.4. Approval of hospital clinical and field internship experience provisions.
- 7.1.5. Approval of instructor(s).
- 7.1.6. The program medical director will certify that guest educators invited by primary instructors to provide instruction or facilitation have the appropriate expertise to deliver the proposed educational content.

7.2. Program Director

- 7.2.1. Each training program shall have a program director who shall meet the following requirements:
 - 7.2.1.1. Has knowledge or experience in local EMS protocol and policy,
 - 7.2.1.2. Is a board certified or board eligible California licensed emergency medicine physician, registered nurse, paramedic, or an individual who holds a baccalaureate degree in a related health field or in education, and
 - 7.2.1.3. Has education and experience in methods, materials, and evaluation of instruction including:
 - 7.2.1.4. A minimum of one (1) year experience in an administrative or management level position, and
 - 7.2.1.5. A minimum of three (3) years academic or clinical experience in prehospital care education
- 7.2.2. Duties of the program director shall include, but not be limited to the following:
 - 7.2.2.1. Administration, organization, and supervision of the educational program.
 - 7.2.2.2. In coordination with the program medical director, approve the instructor(s), teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate the development of curriculum, including instructional objectives, and all methods of evaluation.
 - 7.2.2.3. Ensure training program compliance with this chapter and other related laws.
 - 7.2.2.4. Ensure that all course completion records include a signature verification.
 - 7.2.2.5. Ensure the preceptor(s) are trained according to the subject matter being taught.

7.3. Instructors

- 7.3.1. Each training program shall have instructor(s), who are responsible for areas including, but not limited to, curriculum development, course coordination, and instruction and shall:
 - 7.3.1.1. Be a physician, registered nurse, physician assistant, nurse practitioner, paramedic, who is currently certified or licensed in the State of California,
 - 7.3.1.2. Have six (6) years' experience in an allied health field or community paramedicine, or four (4) years of experience in an allied health field and an associate degree or two (2) years of experience in an allied health field and a baccalaureate degree, and
 - 7.3.1.3. Be knowledgeable in the course content of the U.S. DOT National Emergency Medical Services Education Standards, and
 - 7.3.1.4. Be able to demonstrate expertise and a minimum of two (2) years of experience within the past five (5) years in the subject matter being taught by that individual, and
 - 7.3.1.5. Be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.
 - 7.3.1.6. An instructor may also be the program medical director or program director.

8. MINIMUM TRAINING AND CURRICULUM REQUIREMENTS

- 8.1. TAD program shall meet or exceed minimum training and curriculum requirements as listed in 22 CCR §§ 100189(e)(2), 100189(f), and 100189(h).
- 8.2. CP program shall meet or exceed minimum training and curriculum requirements as listed in 22 CCR §§ 100189(e)(1), 100189(g-h).

9. TRAINING PROGRAM OVERSIGHT

- 9.1. A CP or TAD program's failure to comply with the provisions of statute, regulation, and/or any additional EMS Agency requirements may result in denial, probation, suspension, or revocation of approval by the EMS Agency.
- 9.2. The EMS Agency may conduct onsite visits, inspect, investigate, and discipline approved training

programs for any violations or for failure to fulfill any additional requirements.

9.3. The requirements of training program noncompliance notification and actions are as follows:

9.3.1. The EMS Agency shall provide written notification of noncompliance state and/or local standards and requirements to the training program provider. The notification shall be in writing by certified mail.

9.3.2. Within fifteen (15) days from receipt of the noncompliance notification, the training program shall submit in writing to the EMS Agency one of the following:

9.3.2.1. Evidence of compliance with the provisions of state and/or local standards and requirements, as applicable, or a plan to comply with the provisions of state and/or local standards and requirements, as applicable, within sixty (60) days from the day of receipt of the notification of noncompliance.

9.3.2.2. Within fifteen (15) days from receipt of the training program's response, or within thirty (30) days from the mailing date of the noncompliance notification, if no response is received from the training program, the EMS Agency shall issue a decision letter by certified mail to the EMS Authority and the training program. The letter shall identify the EMS Agency's decision to take one or more of the following actions:

- Accept the evidence of compliance provided.
- Accept the plan for meeting compliance provided.
- Place the training program on probation.
- Suspend or revoke the training program approval.

9.3.2.3 The decision letter shall also include, but need not be limited to, the following information:

- Date of the EMS Agency's decision,
- Specific provisions found noncompliant by the EMS Agency
- The probation or suspension effective and ending date
- The terms and conditions of the probation or suspension
- The revocation effective date

9.3.2.4 The EMS Agency shall establish the probation, suspension, or revocation effective dates.

TRIAGE TO ALTERNATE DESTINATION (TAD) – PROGRAM-SPECIFIC STANDARDS

10. DEFINITIONS AND SCOPE

- 10.1. Alternate Destination Facility is defined as a treatment location that is an:
 - 10.1.1. Authorized mental health facility (Health and Safety Code § 1812)
 - 10.1.2. Authorized sobering center (Health and Safety Code § 1813)
- 10.2. A TAD program also includes providing transport services for patients who identify as veterans and desire transport to a local veterans administration emergency department for treatment.
- 10.3. Approved alternate destinations are located within [EMSA Policy 5000 – Destination Policy](#).
- 10.4. Advanced Life Support (Paramedics) shall not transport patients to any destinations not approved as a Receiving Facility, Standby Facility, or Alternate Destination.
- 10.5. TAD Provider
 - 10.5.1. Advanced Life Support provider authorized by the EMS Agency to provide Advanced Life Support triage paramedic assessments as part of an approved triage to alternate destination program specialty.
- 10.6. TAD Program
 - 10.6.1. Program developed by the EMS Agency and approved by the EMS Authority (State) to provide triage paramedic assessments.
- 10.7. TAD Paramedic
- 10.8. Paramedic who has completed the curriculum for triage paramedic services and receives local TAD Accreditation.

11. TAD DESTINATION REVIEW AND APPROVAL REQUIREMENTS

- 11.1. Must be an Alternate Destination as defined in Section 8 above.
- 11.2. Notify the EMS Agency review via written request for facility review.
- 11.3. Pay any associated fees.
- 11.4. Review and approval by the EMS Agency including site visit.
- 11.5. Facility must maintain all requirements including, but not limited to:
 - 11.5.1. Qualified staff to care for the degree of a patient's injuries and needs
 - 11.5.2. Standardized medical and nursing procedures for nursing staff
 - 11.5.3. Necessary equipment and services at the Alternate Destination facility to care for patients including, but not limited to an automatic external defibrillator and at least one bed or mat per individual patient
 - 11.5.4. Facility shall maintain a ReddiNet account, post status, respond to emergency polls and assessments within 5 minutes. Facility shall notify the EMS Agency within 24 hours or less if there are changes in the status of the facility with respect to protocols and the facility's ability to care for patients.
 - 11.5.5. Facility shall maintain an agreement with the EMS Agency to ensure compliance with provisions in statute, regulations, and local policies including operation in accordance with Ca. Health and Safety Code § 1317. Failure to operate under § 1317 will result in immediate termination of the facility as part of the TAD facility.
 - 11.5.6. Facilities participating as an alternate destination shall accommodate privately or commercially insured, Medi-Cal, Medicare, and uninsured patients.

12. TAD ACCREDITATION

- 12.1. The process and requirements for local TAD Accreditation is located within [EMSA Policy 2050 – Paramedic Accreditation](#).
- 12.2. A TAD paramedic shall only utilize TAD skills when accredited by the San Francisco EMS Agency as a TAD paramedic within San Francisco City and County and when employed by an EMS Agency-approved TAD Provider.
- 12.3. A TAD accreditation is deemed effective when recorded in the Central Registry public look-up database.

12.4. The San Francisco EMS Agency shall review the submitted eligibility criteria for TAD Accreditation and notify the applicant in writing within thirty (30) business days from the date of submission that:\

12.4.1. The submission is incomplete or illegible and required corrective action or

12.4.2. The accreditation request has been approved and the accreditation data entered in the Central Registry public look-up database.

12.4.3. The accreditation request has been denied; including the reason and notification of the applicant's right to appeal.

12.5. The process for Accreditation action and appeal for a TAD Accreditation is the same process as ALS Local Accreditation and as listed in [EMSA Policy 2070 – Certificate/License Process for Prehospital Personnel](#) and is consistent with Ca. Health and Safety Code § 1797.194.

13. TAD DATA SUBMISSION

13.1. TAD Provider shall submit the minimum data requirements on required intervals as listed in 22 CCR § 100185.

14. TAD EQUIPMENT REQUIREMENTS

14.1. TAD Provider shall ensure all vehicles utilized for TAD transports meet or exceed [EMSA Policy 4001 – Vehicle Equipment & Supply List](#) and [4001.a – Minimum Equipment Requirements for First Response and Ambulances](#).

14.2. TAD transports, with a patient, shall be completed via Medical Response Vehicle - ALS/BLS transport unit and be issued an ambulance permit.

COMMUNITY PARAMEDICINE (CP) – PROGRAM-SPECIFIC STANDARDS

15. PURPOSE

- 15.1. The San Francisco EMS Agency (EMSA), in collaboration with the San Francisco Fire Department (SFFD) will utilize the Community Paramedicine Program to provide case management services to frequent emergency medical services users in collaboration with, and by providing referral to, existing appropriate community resources.
- 15.2. The CP programs of the San Francisco Fire Department promote health and social equity among those with unmet medical, mental health and social needs. Frequent users of the EMS system are defined locally as individuals who activate 911 four or more times in a month, 10 times in a year and/or vulnerable populations including persons experiencing behavioral crises, substance use disorders, and/or unsheltered homelessness.

16. PRINCIPLES

- 16.1. EMS Provider Agency (SFFD) must be approved by the EMS Agency to provide CP services described in Ca. Health and Safety Code § 1815 and must be authorized to provide the CP program specialty pertaining to the provision case management services to frequent EMS users.

17. STAFFING

- 17.1. Community Paramedic Unit
 - 17.1.1. A minimum of one (1) CP who has completed the curriculum for CP training, received certification in the 'frequent users' program specialty, and has been Accredited to provide CP services.
 - 17.1.2. CP may operate on their own or within Mobile-Integrated-Health teams (listed below) alongside other providers. They may be assigned to operate ALS First Response vehicles which are authorized under [EMSA Policy 4001 – Vehicle Equipment & Supply List](#).
- 17.2. Community Paramedic Teams
 - 17.2.1. CPs will be organized in teams in order to meet specific CP program goals.
 - 17.2.2. In order to satisfy CP program goals, CPs may be paired with additional providers while engaging individuals. The CP Provider will have agreements with the agencies supplying these non EMS-providers that specifies each non EMS-providers' roles and responsibilities during patient engagements. The management/supervision of the non-EMS staff and their licensure credentials fall under their respective agencies.
- 17.3. Advanced Provider
 - 17.3.1. Individuals such as Nurse Practitioners, Physician Assistants, Physicians, Licensed Clinical Social Workers, Clinical Psychologists, Marriage and Family Counselors.
- 17.4. Peer Support Staff
 - 17.4.1. Individuals designated from other City agencies or community-based organizations to provide peer support staff.
- 17.5. CP Provider shall provide the EMS Agency with a list of all regular staff working on a CP unit and ensure list is updated.
- 17.6. CP Provider shall retain copies of current and valid credentials for all personnel performing services under this program.

18. CP SCOPE OF PRACTICE

- 18.1. CPs may perform case management of EMS frequent users as defined above.
- 18.2. CPs may engage patients in emergency and non-emergency encounters (definitions below).
- 18.3. CPs may perform biopsychosocial assessments of individuals they encounter and provide case management services, in collaboration with, and by providing referral to, existing appropriate community resources.
- 18.4. CPs may provide referrals to proactive and comprehensive healthcare and social services that meet the specific needs of each patient.
- 18.5. Only CPs working a CP-specific shift may perform the roles stipulated in this subsection.

19. EXCEPTIONAL SITUATIONS

19.1. Critical Patients and On-views

19.1.1. If a CP identifies someone as a patient, per policy 4040, the CP shall:

19.1.1.1. Notify the dispatch communication center,

19.1.1.2. Provide appropriate patient care as a First Responder, which may include any indicated ALS interventions following appropriate EMS Agency protocols.

19.2. Client Deterioration During Transport

19.2.1. If during a non-emergency transport by a CP unit the client begins to deteriorate after transport has begun, the encounter will become emergency encounter and personnel shall:

19.2.1.1. Provide appropriate care that may include any indicated BLS and ALS interventions following appropriate EMS protocols.

19.2.1.2. Request additional resources from the dispatch communication center as needed.

19.2.1.3. Provide appropriate care while waiting for an ambulance arrival and transfer care to the transport paramedic or EMT.

20. STANDARD OF CARE

20.1. Client Engagement Protocols

20.1.1. Referral Sources

20.1.1.1. Teams receive requests for client engagement from a variety of sources ("referrals").

20.1.2. 911 System

20.1.2.1. The Department of Emergency Management's (DEM) Division of Emergency Communications (DEC) may dispatch specific CP teams based on triage criteria.

20.1.3. Radio

20.1.3.1. Referring emergency services personnel may request a team's support by radio through DEC ("special call").

20.1.4. Phone

20.1.4.1. In some circumstances, referring parties may contact teams by phone. This referral pathway is not to replace emergent calls for service that should be routed through 911.

20.1.5. Email

20.1.5.1. In some circumstances, parties may refer clients to teams via email. These referrals are exclusively for non-emergent requests.

20.1.6. Self-assign

20.1.6.1. Teams may attach themselves to 911 incidents in progress if believed, based on dispatch notes or radio traffic, that patient or providers on scene may benefit from an additional CP resource.

20.1.7. On-view

20.1.7.1. If teams encounter an individual who may benefit from their services, they will notify DEC via radio and request a new incident be generated and appropriate resources be dispatched. All communications will comply with regulations pertaining to patient confidentiality and privacy.

20.2. CP providers will attempt to respond to requests for service in accordance with response patterns determined by AMPDS and approved by the EMS Agency Medical Director. This requirement pertains to all emergent, urgent, immediate, and/or unscheduled requests for service received by any means.

20.3. Emergency Encounters

20.3.1. The following section outlines emergency encounter guidelines for members of the CP Division. An emergency encounter is defined as an unscheduled interaction when the 911 emergency care system has been activated by an individual or on that individual's behalf due to a known or suspected medical, mental health or other emergency.

20.3.2. CPs will engage clients during a 911 incident when:

20.3.2.1. Dispatched by the DEC,

20.3.2.2. Special called by a 911 provider,

20.3.2.3. Self-assigned,

- 20.3.2.4. An on-view incident has occurred, and CP has evaluated the individual to be a patient in accordance with [EMSA Policy 4040 – Procedure and Documentation for Non-Transported Patients](#).
- 20.3.3. Only an on-duty SFFD-designated CP accredited by EMS Agency, may perform their duties within the CP scope of practice.
- 20.3.4. If the CP is the first provider on the scene of an emergency encounter, they will perform an assessment in accordance with [EMSA Policy 4041 – Scene Management, Physician on Scene and Mass Gatherings](#).
- 20.3.5. The CP may assist the transporting unit by providing patient care within their scope of practice.
- 20.3.6. If the patient receives an assessment not resulting in an ambulance transport (either a Patient Declines Transport - PDT or Against Medical Advice - AMA disposition), the CP may engage the individual and perform an assessment of unmet, non-emergent medical, behavioral, social or substance addiction needs via a biopsychosocial assessment.
- 20.3.7. CPs will offer referrals to appropriate services.
- 20.3.8. CPs may arrange for non-emergent transport of the client. Non-emergent transport could include public transportation, taxi or other ride service, other city agency transport, or CP non-emergency transport.
- 20.3.9. Non-emergent transportation will only be provided once the individual or client disengages from the emergency care system using current [EMSA Policy 4040 – Procedure and Documentation for Non-Transported Patients](#).
- 20.3.10. If the individual remains in the community, CPs will make a reasonable attempt to ensure their safety under [EMSA Policy 4040 – Procedure and Documentation for Non-Transported Patients](#).
- 20.3.11. CPs may contact the base hospital and/or senior base physician for consultation by radio, telephone, or telemedicine at any time during the encounter regarding the care of the patient if necessary under [EMSA Policy 3020 – Field to Hospital Communications](#).
- 20.4. Non-Emergency Encounters
 - 20.4.1. A non-emergency encounter is defined as an encounter in which the 911 emergency care system has not been activated and in which there is no known or suspected medical, mental health or other emergency.
 - 20.4.2. During non-emergency encounters, CPs will engage individuals who have been referred to us. CPs will perform a scene size up and global assessment of the individual ([EMSA Policy 1.01 -Patient Assessment – Primary Survey](#)).
- 20.5. If at any point the individual meets the definition of a patient as defined by [EMSA Policy 4040 – Procedure and Documentation for Non-Transported Patients](#), the engagement will become an emergency encounter (refer to section 18.3 Emergency Encounters).
- 20.6. CPs will engage the individual and perform an assessment of unmet non-emergent medical, behavioral, social, or substance addiction needs (biopsychosocial assessment).
- 20.7. If the individual accepts placement at a non-emergency resource, the CP will arrange transportation to the resource destination. Non-emergent transport could include public transportation, taxi, other ride service, other city agency transport, or CP non-emergency transport.
- 20.8. CPs will explain the referral, care coordination, and wraparound services that are offered.
- 20.9. If the individual remains in the community, CPs will make a reasonable attempt to ensure their safety.
- 20.10. CPs will contact the medical direction team by radio, telephone, or telemedicine if consultation regarding the care of the client is needed.

21. CP COMPETENCY STANDARDS

- 21.1. All CPs shall meet the following requirements to maintain their local EMS Agency approval to function with their advanced CP scope of practice:
- 21.2. Completion of annual in-service CP policy and skills competency education which, at the minimum, shall meet the above Continuing Education requirements for CP reaccreditation.

- 21.3. Compliance with Paramedic and CP policy and skills competency standards is required to maintain standing as an active CP. Any variance requires approval of the EMS Agency. Skill list may be expanded at the discretion of the local EMS Agency Medical Director.

22. CP ACCREDITATION

- 22.1. The process and requirements for local CP Accreditation is located within [EMSA Policy 2050 – Paramedic Accreditation](#).
- 22.2. A CP paramedic shall only utilize CP skills when accredited by the San Francisco EMS Agency as a CP paramedic within San Francisco City and County and when employed by an EMS Agency-approved CP Provider.
- 22.3. A CP accreditation is deemed effective when recorded in the Central Registry public look-up database.
- 22.4. The San Francisco EMS Agency shall review the submitted eligibility criteria for CP Accreditation and notify the applicant in writing within thirty (30) business days from the date of submission that:
- 22.4.1. The submission is incomplete or illegible and required corrective action or
- 22.4.2. The accreditation request has been approved and the accreditation data entered in the Central Registry public look-up database.
- 22.4.3. The accreditation request has been denied; including the reason and notification of the applicant's right to appeal.
- 22.5. The process for Accreditation action and appeal for a CP Accreditation is the same process as ALS Local Accreditation and as listed in [EMSA Policy 2070 – Certificate/License Process for Prehospital Personnel](#) and is consistent with Ca. Health and Safety Code § 1797.194.

23. CP DATA SUBMISSION

- 23.1. CP Provider shall submit the minimum data requirements on required intervals as listed in 22 CCR § 100185.

24. CP EQUIPMENT REQUIREMENTS

- 24.1. CP Provider shall ensure all vehicles utilized for CP transports meet or exceed [EMSA Policy 4001 – Vehicle Equipment & Supply List](#) and [4001.a – Minimum Equipment Requirements](#) for ALS Foot/Bike.
- 24.2. CP Provider shall ensure equipment for local optional scope or trials, such as Buprenorphine, is added in addition to ALS Foot/Bike requirements.
- 24.2.1. CP Provider shall provide a checklist of additional list of equipment carried to meet local optional scope or trials.

SECTION II – Quality Improvement



London Breed
Mayor

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Mary Ellen Carroll
Executive Director

Date: August 1, 2023

To: Elizabeth Basnett, Acting Director, EMS Authority
Hernando Garzon, MD, Acting Medical Director, EMS Authority
Tom McGinnis, Chief, EMS Division, EMS Authority

From: Andrew Holcomb, EMS Director

Re: Community Paramedicine and Triage to Alt. Destination - Quality Improvement

The San Francisco EMS Agency (SFEMSA), as the Local EMS Agency (LEMSA), will continue to include Community Paramedicine (CP) and Triage to Alternate Destination (TAD) in EMS System Quality Improvement (QI). SFEMSA, in recent months, has revised, developed, and approved local policies for the implementation CP and TAD programs to include QI requirements. In addition, CP and TAD agreements contain language within the document to ensure providers and facilities meet QI standards under California Code of Regulations (CCR), Title 22, Division 9, Chapter 5. Already existing efforts include:

- Continuance of key CP and TAD representatives in our EMSC (locally known as EMSAC). Current CP and TAD Provider representatives include San Francisco Fire Department (SFFD - CP and TAD Provider), King American Ambulance (TAD Provider), and American Medical Response (TAD Provider). Additionally, SF VA Medical Center has been an ongoing member as a TAD Facility.
- SFFD CP QI Plan was submitted in most recent 2023 EMS Plan submission and is included in the CP and TAD plan submission as a reference.
- TAD Provider QI Plans will be managed through existing 911 Provider QI Plans as both SF VA Medical Center and Sobering Center have been in the San Francisco EMS System for well over 5 years.
- SFEMSA policies have existing QI framework which includes emerging specialties such as CP and TAD.

Through CP and TAD Program implementation, additional QI efforts will include:

- Addition of representatives to our EMSC to including CP-specific representative from the San Francisco Fire Department and TAD-specific representative from the Sobering Center.
- Assignment of SFEMSA Deputy Director, Quality Improvement, Elaina Gunn to manage CP and TAD Quality Improvement efforts through the QI Subcommittee that meets quarterly
- Annual review of QI Plans for CP and TAD Providers.
- Collection and submission of required data metrics, on a provided EMS Authority template, under 22 CCR § 100185(d).

Cc: Dr. John Brown, EMS Agency Medical Director
Elaina Gunn, EMS Deputy Director, Quality Improvement



San Francisco Fire Department Continuous Quality Improvement EMS Division

Last revised: May 18, 2023

Introduction

The San Francisco Fire Department, EMS Division, has developed and implemented this plan in cooperation with the San Francisco Emergency Medical Services Agencies' Policies and Protocols, as well as the Rules and Regulations of the San Francisco Fire Department. This plan and the oversight process involved are designed to oversee the prehospital medical care provided to the citizens and public of the City and County of San Francisco.

Any activity related to EMS within the Fire Department is overseen for quality and improvement including, but are not limited to:

- Organizational Structure
- Personnel (Facilitated through the San Francisco Department Division of Training by managing licensing and certifications of all members)
- Clinical Quality Improvement and Patient Outcomes
- Documentation
- Research and Development
- Retraining/ Re-education (Facilitated with the San Francisco Fire Department Office of Continuous Quality Improvement and the San Francisco Fire Department Division of Training)
- Risk Management
- Data Collection and Reporting
- Public Education and Prevention (Facilitated in cooperation with the San Francisco Fire Department Fire Prevention, CORE Committee, PIO, and various other programs)
- Transportation and Facilitates (Facilitated in cooperation with the San Francisco Fire Department Division of Support Services and Bureau of Equipment)

Organizational Structure

Continuous Quality Improvement within the San Francisco Fire Department is overseen by the Medical Director of the San Francisco Fire Department and Rescue Captain(s), who report directly to the San Francisco Fire Department Assistant Deputy Chief of Emergency Medical Services. Community Paramedicine's CQI is overseen by the Medical Director of Community Paramedicine, the Department Medical Director and Rescue Captain(s) within Community paramedicine who then report to the Section Chiefs of Community Paramedicine who then reports to the Assistant Deputy Chief of Community Paramedicine. Both Assistant Deputy Chiefs report to the Deputy Chief of EMS and Community Medicine.

Rescue Captains at the SFFD Airport Division review calls, as needed, and report to the Assistant Deputy Chief of the Airport Division who reports to the Deputy Chief of Operations. Of note, since the Airport resides in San Mateo County, they are overseen by San Mateo County

EMS Agency and follows their policies and protocols and participate in their CQI activities, as needed.

Continued Quality Improvement

The continued quality improvement process will recognize individual and system-wide clinical and operational incidents and trends. The process will determine whether these trends are individual trends, systematic clinical trends, or operational trends and address the trends accordingly through retraining and reeducation.

The trends will be determined through random and focused audits, in conjunction with the California Core Measures and the San Francisco Emergency Medical Services Agency / San Francisco Fire Department initiatives as agreed upon.

Training and Education

Training and Education includes informal discussions with members, as well as formal Remediation and Performance Improvement Plans or coachings. Minor concerns may be administered with informal discussions in the form of coaching sessions and/or “tailboard” trainings performed by San Francisco Fire Department Rescue Captains. More formal training and reeducation will be administered in the form of a Remediation or Performance Improvement Plan, which will be directed by the EMS chain of command and San Francisco Fire Department’s Medical Director(s). The Remediation or Performance Improvement Plan will be generated and administered by The San Francisco Fire Department Office of Continuous Quality Improvement or the San Francisco Fire Department Division of Training. A coaching or performance improvement plan is separate from any applicable discipline and is considered training only.

We hope to expand training and education by increasing the number of presentations, both live and recorded. These presentations will be uploaded to the Department training module (Vector Solutions) for providers to review. In addition, we hope to have focused lectures on relevant, high-yield, recent incidents where crews can join the lecture in person or by virtual platform (e.g. Microsoft Teams) and contribute and learn about pathophysiology, hospital treatment and outcome, along with feedback from the presenting provider. The Medical Director, as well as CQI and Training staff, EMS Fellows and Emergency Medicine residents needing to fulfill an EMS teaching requirement may participate in these lectures.

Additionally, rapid review lectures of advanced skills and low frequency/high risk topics will be done and occasionally recorded for distribution online.

Finally, in-person, in-service training will be conducted every 6 months to mimic the protocol update schedule of the EMS Agency. The training will cover both the protocol updates and review advanced skills and other high-yield topics.

Risk Management

Risk Management is paramount in providing a safe workplace for the members of the prehospital care system and the public we serve.

The five risk management steps are:

- Identify the risk
- Quantify the risk potential
- Prioritizing the risk
- Implementing controls and mitigations strategies
- Evaluating and revising the process

Frequency evaluation of the risk:

- **Very often:** A near-certainty to occur;
- **Often:** May occur regularly or periodically;
- **Not often:** Rare, or unlikely to occur;
- **Almost never:** Zero or near-zero probability.

Severity evaluation of the risk:

- **Catastrophic:** Death or permanently disabling injury or loss of work facility;
- **Serious consequences:** Severe debilitating injury or interruption of operations;
- **Moderate impact:** Significant injury or illness requiring more than first aid;
- **Minor impact:** No injury, lost work time or interruption of work.

After an event occurs, immediate steps will be taken to minimize impact to our patient population and to our organization to mitigate similar incidents. In cooperation with the San Francisco Fire Department Administration, the San Francisco EMS Administration, the San Francisco Fire Department Office of Continuous Quality Improvement, and the San Francisco Fire Department Investigative Services Bureau, these steps should include:

- Immediate investigation ordered
- Take statements
- Gather reports
- Consult with legal council
- Evaluation of the risks with all appropriate information gathered
- Take appropriate actions to mitigate and prevent recurrence

Focused audits occur twice per year on a rolling schedule, or as needed as concerns arise with the following schedule:

| | |
|-------------------|-------------------------|
| January: | Trauma |
| February: | STEMI / Stroke |
| March: | Critical Adult Medical |
| April: | Pediatric |
| May: | Cardiac Arrest |
| June: | Other including AMA/PDT |
| July: | Trauma |
| August: | STEMI / Stroke |
| September: | Critical Adult Medical |
| October: | Pediatric |
| November: | Cardiac Arrest |
| December: | Other including AMA/PDT |

The results of these audits will ensure compliance or need for improvement. After the Risk Management Plan has identified issues which arise, Research and Development may be implemented to study systematic issues, and/or suggest operational and administrative changes for system changes and focused clinical improvements.

Research and Development

The San Francisco Fire Department supports the development and execution of evidence-based data. These data directly contribute to improving clinical patient care. More and more, treatment decisions are based on these type of data. Part of the Department's CQI data monitoring is to examine trends that support the continued use of care modalities based on current clinical findings versus suggesting the need for additional retrospective or prospective studies that could suggest different practice methodologies. The San Francisco Fire Department's clinical research stance is to utilize data as a primary indicator of areas of interest, a guide to the safety and efficacy of research efforts and as a means of supporting or refuting hypotheses related to care.

At the direction of the San Francisco Fire Department Administration, the San Francisco Fire EMS Administration, The Medical Director, as well as the San Francisco Fire Department Office of Continuous Quality Improvement, focused research will address such trends.

Data Collection and Reporting

Data is collected and stored for Continuous Quality Improvement from identified trends, both systemic, and individual. In cooperation with the San Francisco Emergency Medical Services Agency, all reportable incidents, either systemic or individual, shall be analyzed and reported

necessary as an Exception Report or Sentinel Event, as directed by the San Francisco Emergency Medical Services Agency's Policies and Protocols.

Should a referral be made for quality improvement to any outside entity, such as another 911 provider or the EMS Agency, that referral shall be forwarded to the San Francisco Fire Department Quality Improvement Staff in a timely matter. The Department will then review the case and take any necessary action. If referred by the EMS Agency, the Department will inform the agency of the results of our investigation and plan for improvement. The EMS Agency will not pursue cases until internal review has been done and reported back to the agency except in extenuating circumstances.

Audits

Audits are categorized by time frequency and incident scope and summarized in the figures below. The time frame is categorized as spot (one time or limited frequency) or continuous. Incident scope may be Department-wide (all incidents to which the San Francisco Fire Department responds) or focused on specific providers, locations, or situations. Audits will be done by CQI staff and reviewed by supervising staff and the Medical Director when appropriate.

| <i>Time Frequency</i> | <i>Target Scope</i> |
|--|--|
| Spot: Performed at one time or on a limited frequency | Focused: limited to specific provider(s), locations, or situation |
| Continuous: Monitored at all times | System: all available SFFD incidents are audited |

Spot audits are conducted when a case is referred to CQI by another person, whether it is a patient, hospital provider, EMS provider, supervisor, or outside agency, for review for any reason. The call will be reviewed comprehensively by CQI staff, with special attention to the reason for the referral.

In an effort to broaden the scope and breadth of spot audits and CQI, a Peer Review spot audit process has been in process since April 2021. Paramedics are selected on a volunteer basis to review and provide feedback for incidents using a provided rubric on an online management system with redacted provider and patient information. The rubric will be created by CQI staff and reviewed by the Medical Director. Calls of any type are eligible for review, especially cardiac arrest, STEMIs, stroke, pediatric calls, trauma and others.

Focused QI will be done when potential issues are identified with high-risk situations, locations or providers, and especially providers who are on a Remediation or Performance Improvement Plan entailing CQI monitoring.

Continuous QI will be done for the following incidents:

- Advanced airway management, especially video and direct laryngoscopy
- Critical calls
- Field deliveries
- AMA/PDT refusals
- Cardiac arrests
- Advanced Skills Review
- Retriages/repatriation after initial patient transport
- Repeat incidents/calls meeting certain criteria
- Major trauma
- Any skill related to a new policy, protocol or pilot project, as needed

Additionally, reports are routinely done for Ambulance Patient Offload Times (APOT), Narcan administration, and California Core Measures. Time intervals including dispatch intervals, treatment/transport intervals, and hospital intervals will also be tracked.

California Core Measures include:

- Transport of trauma patients to a trauma center
- Aspirin for STEMI or suspected cardiac chest pain
- Advanced hospital notification for STEMI patients
- Treatment administered for hypoglycemia
- Prehospital screening for suspected stroke patients
- Advanced hospital notification for suspected stroke
- Glucose testing for suspect stroke patients
- Respiratory assessment for pediatric patients
- Request for service that include lights and siren response
- Request for service that included lights and siren transport

Community Paramedicine Quality Improvement and Oversight Plan

Introduction

The mission of the Community Paramedic Division is to provide rapid, high-quality trauma informed care to San Francisco's most vulnerable residents through the EMS-6, Street Crisis Response Team (SCRT), and Street Overdose Response Team (SORT) programs.

All aforementioned CQI plans from the Emergency Medical Services division also apply to the medical aspects of community paramedicine, including medical care rendered to clients and AMA/PDT refusals.

The purpose of the Community Paramedicine CQI Division is to ensure compliance with all state, local, and Department policies and protocols, and to ensure we are providing the highest quality care for our clients while also reducing unnecessary 911 responses in San Francisco.

Organizational Structure

Continuous Quality Improvement within the San Francisco Fire Department Community Paramedicine Section is overseen by the Medical Director of the San Francisco Fire Department, the Medical Director of Community Paramedicine and Community Paramedic Section Chiefs, who report directly to the San Francisco Fire Department Section Chief of Community Paramedicine, who in-turn reports to the San Francisco Fire Department Deputy Chief of Emergency Medical Services and Community Paramedicine. The Community Paramedicine CQI Captain and Data Analyst will perform the majority of CQI activities, with support from the EMS Continuous Quality Improvement staff as needed.

Clinical Quality Improvement and Patient Outcomes

Community Paramedicine CQI will identify and review high-risk events, areas of potential improvement, perform prospective, concurrent and retrospective data analysis to identify trends, develop and adopt best practices, evaluate outcomes and provider competency, provide clinical supervision and feedback specifically regarding Community Paramedicine domains of the biopsychosocial assessment and the social determinants of health. We will promote excellence and pride within the Community Paramedicine Division by providing timely relevant feedback and training opportunities to enhance skill set.

Pilot projects and/or new initiatives, such as 5150 holds and buprenorphine, will follow their specific QI plan submitted with their initial application.

Data Collection and Reporting

All Community Paramedicine teams will have weekly review of encounter reports and patient care reports.

A monthly report will be created for both teams and CQI staff will measuring the following performance indicators/data points:

- Monthly call volume, volume of calls responded to
- Call source (911 call, special call, onview, other)
- Response time
- On scene time
- Disposition of clients without medical complaints
- Disposition of clients with medical complaints
- Most common medical complaints
- Use of chemical and physical restraints
- Workplace violence incidents
- 5150's generated along with their indication
- ESO, encounter log and Avatar are reconciliation
- COVID testing
- Buprenorphine administration, as detailed in the LOSOP's CQI plan
- Base hospital contacts and senior base physician contacts
- *Rate of alternate destination diversion, resulting in ED transport (i.e. Dore is full, so patient goes to a standard ED instead)*
- *Track amount of behavioral health calls, special calls by police and PDTs and AMAs after implementation of SCRT.*

In addition, there is regular tracking of the following variables: number of patients who have medical complications, re-triages from the original destination or repeat 911 activations within 24 and 72 hours for either police or medical care. Any transport within 24 hours of a community paramedic contact will be spot audited and reviewed.

Review and compliance assurance with San Francisco Emergency Medical Services Agency Policy 4040 and transfer of care policies will be performed on a regular basis. Audit of disposition of calls, with particular attention to those left in the community and/or with a disposition of AMA refusals will be performed and feedback will be provided to Community Paramedicine certified paramedics.

We aim to track community satisfaction from the SCRT, SORT and EMS-6 program, by surveying SFFD providers, ancillary providers, hospital personnel, ambulance providers, police, hospital providers and clients/patients.

Our review process is designed to assess biopsychosocial parameters and patient outcomes and provide feedback to community paramedics in a standardized fashion. Our CQI also aims to provide learning opportunities by identifying available trainings, disseminating that information broadly and providing time on duty for training and CE's.

Spot audits are done weekly at various meetings, including our EMS 6 case conferences, Key Performance Indicator meetings, 5150 meetings, suboxone meetings and CP CQI meetings.

Focused QI will be done when clients experience any adverse events, re-triages, enter the "red" category during a case conference illustrating decompensation, or when a case is referred to QI staff.

Community Needs Assessment & Impetus for SFFD Community Paramedicine Program Development

San Francisco's 911 system serves as a safety net and access point for many people who need access to primary care, behavioral health care, and social services. Coordinating resources in the healthcare system to provide "The right care, for the right patient, at the right time" has been a major challenge for health care over the last decade. Within San Francisco's EMS system, this mismatch has manifested as overuse of emergency medical services for non-emergency care and saturation of EMS and ED resources, resulting in increased risk to the public if emergency services are overwhelmed and unable to adequately respond to incidents.

Background and History

San Francisco has a long history of progressive public health programming. Whether leading the nation in response to the AIDS epidemic of the 1980's or the COVID-19 pandemic, San Francisco health providers have consistently been pioneers in confronting some of the most prominent public health challenges of our time. Community paramedicine's novel and impactful approaches to caring for our community members continues this strong tradition.

In October 2004, the Homeless Outreach and Medical Emergency team (HOME) was launched. A collaborative effort between San Francisco's Fire Department and Department of Public Health to engage vulnerable high users of multiple health systems, the HOME team would be a precursor to what we now define as community paramedicine.

The HOME team's work and published research demonstrated the need to address frequent utilization of 911 and emergency medical systems both on a cost and health care basis.

The recession of the late 2000's led to the HOME team's defunding and demobilization in 2009. The need to address frequent utilizers of EMS did not dissipate, however. In 2016, the next iteration of the HOME team was launched: EMS-6 ("EMS six"). In San Francisco's community of care providers, EMS-6 has become a term synonymous with both community paramedicine and impactful care. EMS-6 began operations in 2016 as a frequent utilizer program and was

officially accepted as a California EMSA community paramedicine pilot program in 2017. EMS-6 has become integral to the City's network of providers as the team continues its work among the high frequency client target population.

In 2020, recognizing the need to re-imagine the public safety response for individuals experiencing mental health crisis, the Street Crisis Response Team was mobilized. Responding in lieu of police to support individuals experiencing a behavioral or mental health crisis, SCRT teams have proven the safety and efficacy of this new care model by safely providing real-time connections to definitive mental health services with coordinated follow-up care.

Summer of 2021 saw the launch of the Street Overdose Response Team. As drug overdose deaths rapidly increased on a national and local level, San Francisco again showed a willingness to engage a challenging population health issue that contains significant socioeconomic and racial inequalities. SORT is actively engaging underserved and high-risk populations, providing medication assisted treatment, harm reduction, and shelter directly to those who need it most.

HUMS, EMS High-Users and Super-Users

High Users of Multiple Systems (HUMS) are defined as people who utilize SF city services with the highest frequency. Approximately 250-500 HUMS clients are in active case management by SFDPH. During FY2010-11, 511 clients—representing approximately 1% of emergent/urgent users, accounted for 25% of the costs. The annual cost per client in this group averaged \$50,000. The top 5% of clients incur over \$30 million per year.

Similarly, a small group of EMS patients account for a disproportionately high portion of EMS encounters. These “high-users” are defined as having more than four and fewer than fifteen (4-15) EMS encounters in a single month. A smaller subset of these patients, termed “Super-Users”, utilizes EMS more than 15 times per month (>15). In 2015, SFFD identified 312 high users who were responsible for 8,217 transports or 14.3% of the total 57,597 SFFD transport volume that year.

Many of identified HUMS clients struggle with chronic medical, behavioral health, and substance addiction conditions in addition to housing insecurity. The city's at-risk population is continuing to grow with 9,975 individuals experiencing partial or

full-year homelessness identified in FY14-15. Among this group, rates of substance addiction (59%), psychiatric conditions (53%), and chronic medical conditions (48%) are much higher than the general population, with 30% of individuals reporting tri-morbid conditions.

EMS high-users engage the 911 system for a multitude of reasons. In order to determine an optimal deployment to engage system high-users and improve the likelihood of successful EMS-6 intervention, Computer Aided Dispatch (CAD) records were analyzed. The 2014 CAD records of cases in which patients were released to SF Homeless Outreach Team (HOT) or Mobile Assistance Patrol (MAP) are described below. The locations of calls have been highly concentrated in the South of Market, Tenderloin and Mission District. The map below (Figure 1) shows call density by neighborhood. Based on the location of these calls, the EMS-6 team has been dynamically deployed with a focus on the downtown corridor.

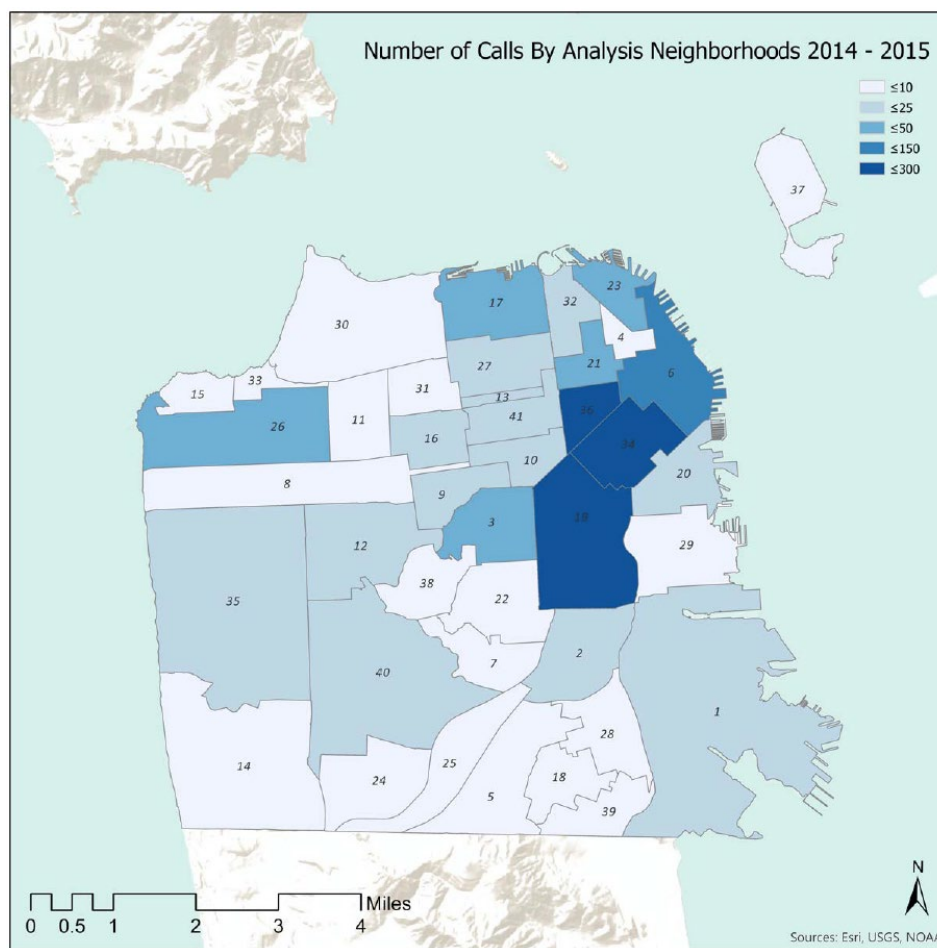


Figure 1

Current support systems remain stressed by a growing at-risk population and continued shortage of resources. Too often the emergent and non-emergent care is not effectively coordinated, leading to waste and missed opportunities for improved health. The lack of vertical integration between the EMS system and larger medical system creates a barrier for patients for whom the EMS system has been activated and options for non-emergency care or referral are limited. This project will utilize a community paramedicine outreach model to integrate care and directly address this challenge.

Community Paramedicine: Building Linkages to Definitive Care

The community paramedic programs of the San Francisco Fire Department promote health and social equity among those with unmet medical, mental health and social needs. These populations disproportionately included people of color, people experiencing homelessness, and people with substance and mental health disorders. Our teams assist in providing immediate stabilization of medical and behavioral health emergencies, as well as helping our community to navigate an often-confusing array of services for those not experienced in obtaining care. This means helping to connect people to case management, housing, primary and mental health care, withdrawal management services, pre-hospital treatment plans, and virtually any other service that can assist our populations in need.

Sobering Center Data for TAD:
Submit quarterly to Andrew
Holcomb and Elaina Gunn

| | |
|---------|------------------------------------|
| Green: | Data already collected by Sobering |
| Orange: | Data will come from EMS side |

Citation: 100185(e)

| | Q1 2023 | Q2 2023 to date | Sobering FYIs |
|---|---------|-----------------|---|
| Total number of patients evaluated who were transported by EMS. | 68 | 56 | |
| Total number of these patients who were treated and released | 68 | 56 | |
| Total number of these patients who were transferred to an acute care Emergency Department. | 3 | 1 | |
| Total number of these patients admitted to another care facility. | 0 | 0 | |
| Total number of these patients who experienced an adverse resulting from services provided under this program | 0 | 0 | Sobering to review this further. Pull UOs |

Citation: 100185(f)

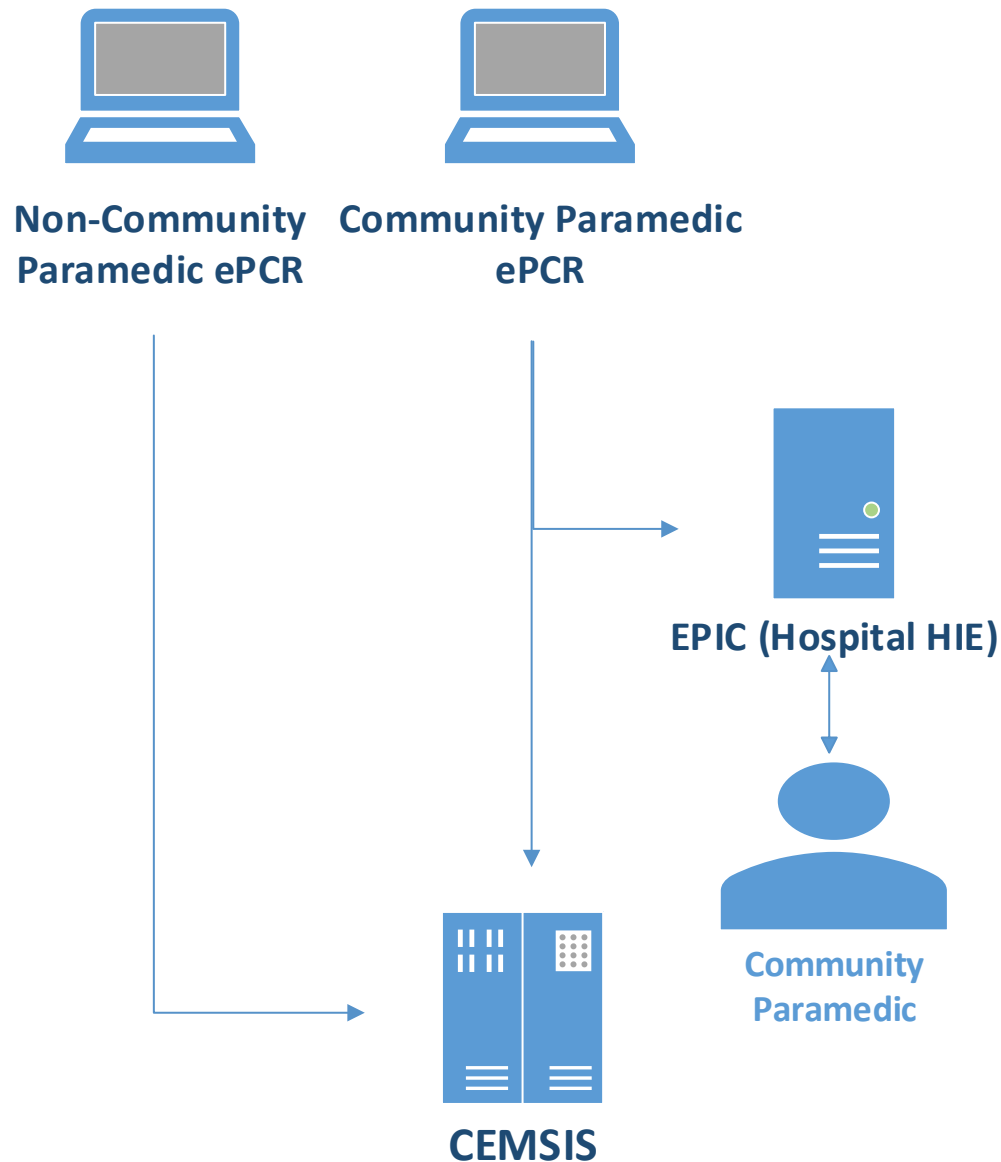
| | Q1 2023 | Q2 2023 to date | Sobering FYIs |
|---|----------|-----------------|---------------|
| Quarterly Ambulance Patient Offload Times for every alternate destination facility. | TAD team | TAD Team | n/a |

| | | | |
|---|---|---|---|
| Quarterly total EMS transports to every alternate destination facility. | 68 | 56 | n/a |
| Quarterly total number of patients turned away or diverted from every alternate destination facility. | SC developed new process to collect | SC developed new process to collect this | Sobering has implemented a documentation encounter which will pull into the data flowsheet; captures turned away and diverted patients. |
| Quarterly total number of patients who require subsequent transfer to an Emergency Department from an alternate care facility. | 3 | 1 | |
| A summary of the primary reasons for turning away, diverting, or transferring patients to Emergency Departments from alternate care facilities. | SC developed new process to collect and track | SC developed new process to collect and track | Implemented data pull down menu for reasons for decline (Reasons turn away - on ROS list, does not meet vitals parameters, unmet medical need, does not meet behavioral criteria, GCS < 13, not intoxicated on alcohol, other |
| A summary of feedback about the program from the Emergency Medical Care Committee. | TAD team | TAD Team | |
| Community Paramedicine Program summary of outcomes (noted in subsection (c) above | TAD Team | TAD Team | |

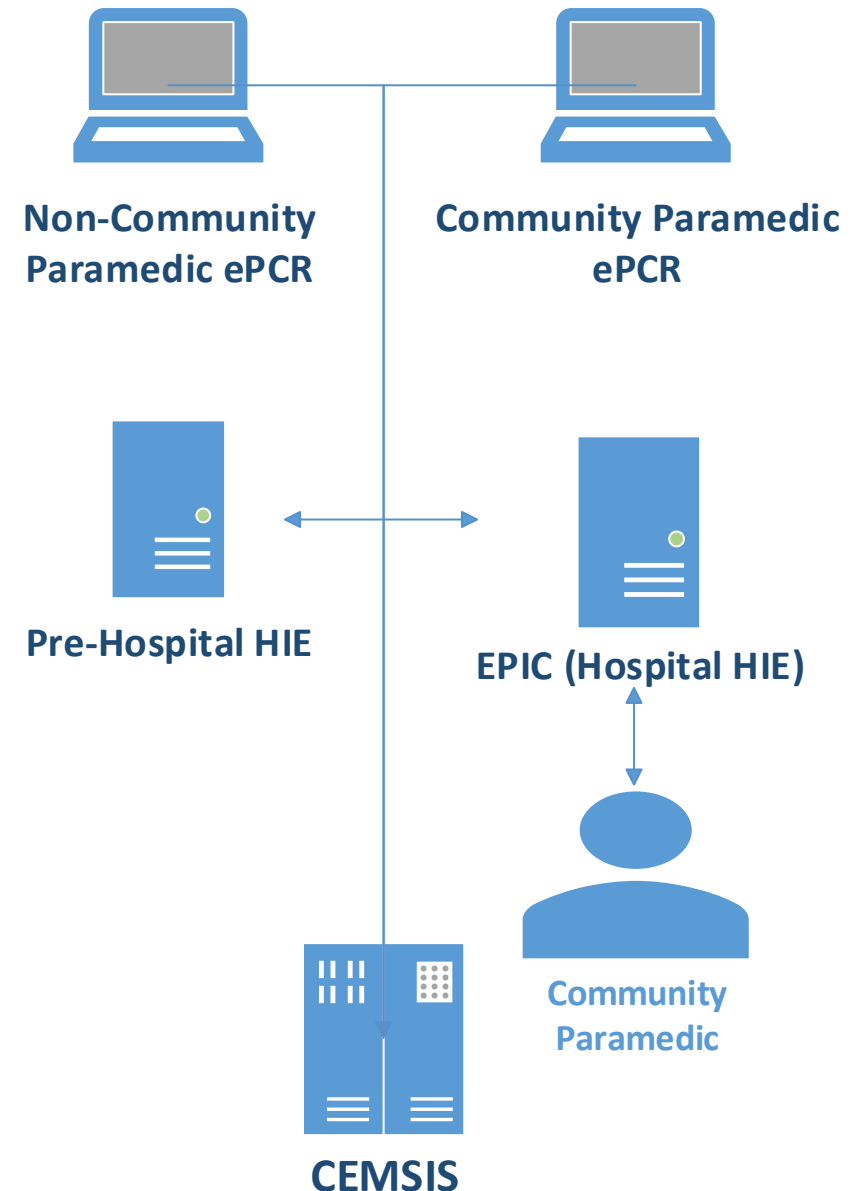
| | | | |
|---|--|---|---|
| Alternate Destination Facility summary of patient outcomes (noted in subsection (d) above). | Already collecting | Already collecting | |
| A once annual summary of all alternate destination facilities that certifies each facility maintains adequate licensed medical and professional staff, facilities, and equipment pursuant to the authority's regulations and the provisions of this chapter, which shall include all the following: | Identification of qualified staff to care for the degree of a patient's injuries and needs. | Staff roster vs. staffing pattern? | Sobering to maintain a binder that has all of this information listed, that can be easily accessible. Staff roster with license number. |
| | Identification of qualified staff to care for the degree of a patient's injuries and needs. | SC standardized protocols | n/a |
| | Certification that the necessary equipment and services are available at the alternate destination facility to care for patients, including, but not limited to, an automatic external defibrillator and at least one bed or mat per individual patient. | Generate list of standard equipment available at SC | Updated annually in a binder to include # treatment spaces, # beds, # AEDs with serial number, etc |

Current & Future SFFD Information Prehospital Information Structure

Current Information Model



Future Information Model (< 5 years)





Department of Emergency Management
Emergency Medical Services Agency
333 Valencia St., Suite 210, San Francisco, CA 94103
Phone: (628) 217-6000 Fax: (628) 217-6001



London Breed
Mayor

Mary Ellen Carroll
Executive Director

Date: August 1, 2023

To: Elizabeth Basnett, Acting Director, EMS Authority
Hernando Garzon, MD, Acting Medical Director, EMS Authority
Tom McGinnis, Chief, EMS Division, EMS Authority

From: Andrew Holcomb, EMS Director

Re: California Code of Regulations, Title 22, § 100185(c) – Waiver Request

To the extent that additional data transmission or health information exchange requirements are needed or identified by the EMS Authority, the San Francisco EMS Agency (SFEMSA) is hereby requesting a 5-year, one-time waiver under the provisions of California Code of Regulations (CCR), Title 22, § 100185(c).

Under 22 CCR § 100185 and newly developed local SFEMSA policy (ref. Section 13), Community Paramedics (CP) and Triage to Alternate Destination (TAD) Paramedics will be required to document an electronic Patient Care Report (ePCR) record and use CEMSIS standardized destination facilities. All of San Francisco's 911 Providers are expected to be TAD Providers and have been transporting to both anticipated TAD facilities under 22 CCR §§ 1813 and 1819(3) for well over 5 years (San Francisco VA Medical Center and Dept. of Public Health Sobering Center).

Under existing SFEMSA Policy 6050 Documentation of Prehospital Care, ePCRs must be completed by the end of shift or within 24 hours. In many cases, ePCRs are completed prior to departing the facility. Additionally, a copy of the ePCR must be provided to the receiving facility (paper or electronic). In practice, 911 Providers provide access to ePCR platforms based on facility destination so staff may download and obtain the ePCR records using current platforms including ESO, Zoll, and AMR Meds (soon to be ImageTrend). In short, prehospital data is being shared in a timely manner. SFEMSA will work with CP and TAD Providers to ensure (1) copies given are solely electronic records (2) confirm all Receiving and TAD facilities have access to Provider ePCR platforms and records as part of transfer of care. The San Francisco Fire Department Community Paramedics have access to Epic records from Department of Public Health.

To meet any additional requirements not approved in our plan above, SFEMSA will need additional support to address data integration, sharing, procurement, privacy/security review, and agreements. SFEMSA 911 Providers have 3 different ePCR systems alone and hospital facilities are on different Electronic Health Record (EHR) systems. Even if readily deployable solutions and technology exist, additional implementation requirements will likely take years of considerable effort to obtain buy-in and investment with key stakeholders. Furthermore, budget and additional position requests will be needed, which in a best-case scenario takes 2-3 years to obtain the funding. In the immediate term, SFEMSA FY23-24 budget includes General Fund revenue of one-time \$200,000 and annual \$100,000 to support ongoing CP costs. Additionally, SFEMSA plans to apply for the CP and TAD Grant through the CARESTAR Foundation, which may result in additional funding to support meeting this requirement. San Francisco plans to use current and expected funding allocations to meet any additional requirements in the short term.

Cc: Dr. John Brown, EMS Agency Medical Director
Christina Fletes-Romo, Deputy City Attorney

SECTION III – TAD Training Program



London Breed
Mayor

**Department of Emergency Management
Emergency Medical Services Agency**
333 Valencia St., Suite 210, San Francisco, CA 94103
Phone: (628) 217-6000 Fax: (628) 217-6001



Mary Ellen Carroll
Executive Director

Date: August 1, 2023

To: Elizabeth Basnett, Acting Director, EMS Authority
Hernando Garzon, MD, Acting Medical Director, EMS Authority
Tom McGinnis, Chief, EMS Division, EMS Authority

From: Andrew Holcomb, EMS Director

Re: Triage to Alternate Destination Training Program Overview

The San Francisco EMS Agency (SFEMSA), as the Local EMS Agency (LEMSA), will host the Triage to Alternate Destination (TAD) Training Program at the county LEMSAs level. As San Francisco has three TAD Providers, a policy decision was made to have all Paramedics be issued a TAD Accreditation, which reflects almost six hundred personnel. Initial and Renewal TAD Accreditation requires completion of TAD curriculum through a TAD Training Program and biannual 4 hours of Continuing Education.

To streamline this process, SFEMSA will host the training within our Learning Management System (LMS) to ensure ease of access to high quality training. The LMS was highly successful during local optional scope training to support vaccination training efforts during COVID-19 pandemic.

Dr. John Brown, EMS Agency Medical Director, will serve as the TAD Training Program Director with Ron Pike, EMS Specialist, as curriculum development and administration support of the program. Training curriculum and objectives are included with this submission. Items such as resumes, exams, and certificates are maintained on file. To ensure integrity of curriculum, these items are available upon request.



Cc: Dr. John Brown, EMS Agency Medical Director
Kayleigh Hillcoat, EMS Deputy Director, Operations
Ron Pike, EMS Specialist, Training

TAD Course Objectives

- Describe Triage to Alternate Destination in SF
- Understand Alcohol Abuse and assessing the intoxicated patient
- Understand the different TAD locations within SF County
- Understand the transport requirements for TAD locations in SF County

Triage to Alternate Destination (TAD)

Created by:
San Francisco EMS Agency
San Francisco Fire Department
San Francisco Sobering Center



1

Course Objectives

- Describe Triage to Alternate Destination in SF
- Understand Alcohol Abuse and assessing the intoxicated patient
- Understand the different TAD locations within SF County
- Understand the transport requirements for TAD locations in SF County

2

What is Triage to Alternate Destination

- Was part of the California EMS Authority Community Paramedicine pilot program
- Allows for the transport of a small subset of patients to other facilities that are not acute care Emergency Departments such as Urgent Care, Sobering Centers and VA hospitals (newly added)
- San Francisco EMS providers were a part of this State pilot program allowing for transport to the Sobering Center if the patient met specific criteria
- After passage of AB1544 TAD is now under Div. 9 Ch. 5 of the State EMS Regulations

3

TAD in San Francisco

- 400 persons were transported to the sobering center in the first eight (8) months of the program, reducing the burden on the local emergency departments
- 98% of the patients transported to the sobering center were treated safely and effectively with only ten (10) patients needing transfer to the ED
- In the first eight (8) months of the program there was potentially \$132,700 in savings; about \$332 per patient
- The San Francisco VA hospital ED initially was considered a stand-by facility but has now been re-classified as an alternate destination
- San Francisco has two (2) alternate destination sites available to EMS providers: Sobering Center and VA hospital



4



San Francisco TAD Accreditation

All San Francisco paramedics will be required to take the TAD training as well as obtain the TAD endorsement from the San Francisco EMS Agency

All San Francisco paramedics will be required to maintain the TAD endorsement at time of renewal and complete at least four (4) hours of TAD related CEs every two (2) years

5

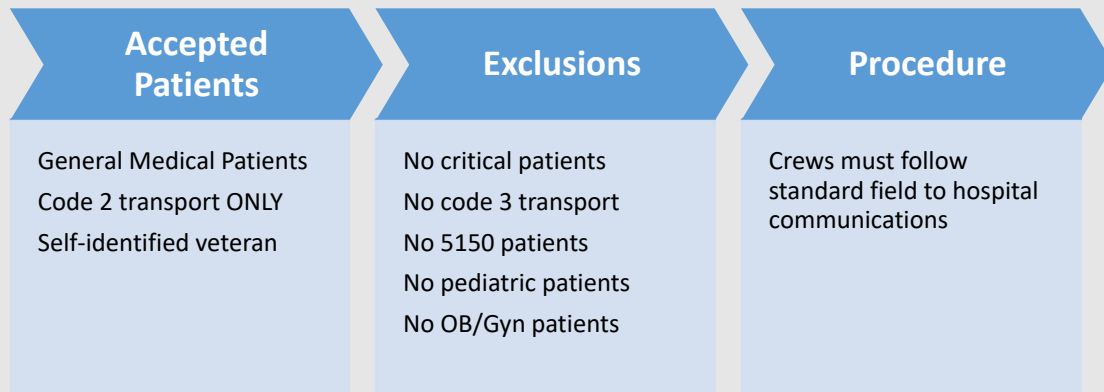
About San Francisco VA Hospital

- The San Francisco VA was established in 1934
- Has been affiliated with UCSF for nearly 60 years
- Designated an ambulance receiving facility in 1996
- Initially considered a stand-by emergency department but has been re-classified to alternate destination with the implementation AB 1544



6

San Francisco VA Transport Requirements



7



- The Sobering Center opened its doors in 2003 and has cared for well over 50,000 patients
- Staffed 24/7 with nurses who monitor patients throughout their stay and social workers who assist with housing and obtaining ongoing treatment
- Most patients will stay for four (4) to twelve (12) hours
- In February 2017 as part of the Community Paramedic and Triage to Alternate Destination pilot programs the Sobering Center became a site in which EMS crews were able to transport intoxicated patients who met a specific criteria

8

Sobering Center



9

Alcohol Abuse



10

Assessing the Intoxicated Patient

Assessing the “Intoxicated” Patient

MELODY GLENN MD

11

Evaluating Capacity

THE COMBATIVE, UNCOOPERATIVE, ARRESTED,
AND THREATENING TRAUMA PATIENT: A LEGAL,
ETHICAL, AND MEDICAL MINEFIELD!

CHRISTOPHER COLWELL, MD

12

Sobering Center Transport Criteria

- Currently found under Policy 5000 (O; Sobering Services)
- Intoxicated patients with no acute medical conditions or co-existing medical complaints may go to an approved sobering center, if they meet the following criteria:
 - At least 18 years or older
 - Voluntarily consents or has presumed consent (when not oriented enough to give verbal consent) to go to approved sobering center
 - Must not be on the "Exclusion List"
 - Be medically appropriate by meeting ALL the following criteria:
 - Indication of alcohol intoxication (odor of alcoholic beverages on breath, bottle found on person)
 - Glasgow Coma Score of 13 or greater
 - Pulse between 55 – 120
 - Systolic blood pressure between 90 – 190
 - Diastolic blood pressure between 60 - 110
 - Respiratory rate between 12 – 24
 - Temperature between 96.5 and 100.5°F (35 and 38°C)
 - Oxygen saturation greater than 94%
 - Blood Glucose level between 60 – 250
 - No active bleeding
 - No active seizure
 - No lacerations that have not been treated
 - Contact Sobering Center prior to transport to ensure beds are available
- When in doubt contact Base Hospital or transport to ED

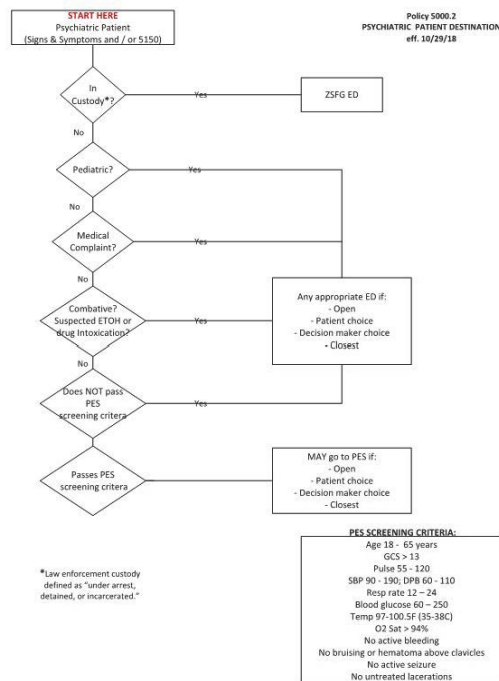
13

Mental Health

- Currently there is no alternate destination for psychiatric patients in San Francisco, but PES is utilized through transport to Zuckerberg San Francisco General Hospital
- *When transporting to PES consider a prehospital COVID test*
- Patients may also be transported to other facilities based on Policy 5000 if they are not incarcerated or detained or under arrest if the destination is based on the following:
 - Patient Age
 - Patient medical need
 - Hospital Diversion Status
 - For involuntary patients, the decision maker placing the hold will identify the hospital
 - Patient preference
 - Family/guardian or private physician preference
 - If no preference, hospital location
- ALL patients who are incarcerated, detained or under arrest must be transported to ZSFGH.

14

PES – Flowchart



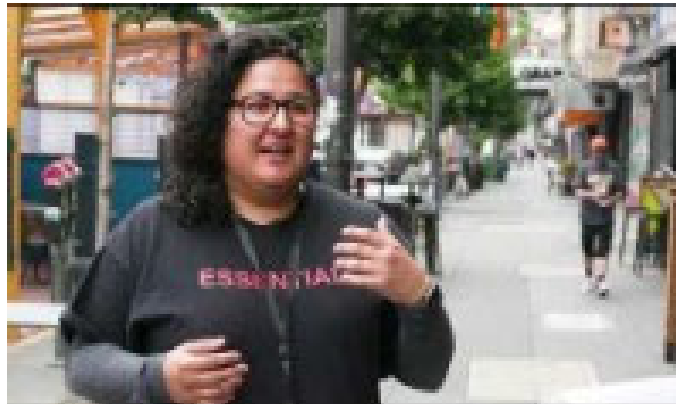
15

Mental Health

- Patients with signs and symptoms of psychiatric illness and under 18 years old must go to medically appropriate pediatric designated receiving hospital
- Patients with signs and symptoms of a psychiatric illness and suspected medical complaint must go to medically appropriate receiving hospital, this includes:
 - Patients who are severely agitated or combative and whose combativeness prevents assessment (vital signs or examination) and/or requires field sedation
 - Patients with any medication overdose or who show signs of potential toxicity from drugs or alcohol
- When responding to 911 psychiatric incidents and there are no medical complaints or agitation a request can be made for SFFD Street Crisis Response Team (SCRT) to assist

16

Mental Health - SCRT



17

SCRT Update

As of March 4, 2023 the behavioral health clinicians have been moved to the follow up team

Even with the change, SCRT remains a critical asset and is a recommended resource when responding to mental health emergencies

18

Mental Health - Suicide Risk Factors

| Individual Risk Factors: | Relationship Risk Factors: | Community Risk Factors: |
|--|--|--|
| <ul style="list-style-type: none"> • Previous suicide attempt • History of depression and other mental illnesses • Serious illness such as chronic pain • Criminal/legal problems • Job/financial problems or loss • Impulsive or aggressive tendencies • Substance use • Current or prior history of adverse childhood experiences • Sense of hopelessness • Violence victimization and/or perpetration | <ul style="list-style-type: none"> • Bullying • Family/loved one's history of suicide • Loss of relationship • High conflict or violent relationship • Social Isolation | <ul style="list-style-type: none"> • Lack of access to healthcare • Suicide cluster in the community • Stress of acculturation • Community violence • Historical trauma • Discrimination |

19

Key Take Aways

All San Francisco paramedics will be required to obtain TAD endorsement and maintain TAD endorsement while working in San Francisco

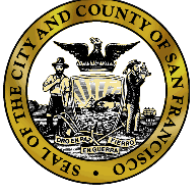
San Francisco VA Hospital is considered a TAD location and patients must meet specific criteria

Not every intoxicated patient is a candidate for transport to the sobering center

Patients must meet ALL criteria listed in Policy 5000 Sobering Services in order to be transported to Sobering Center

20

SECTION IV – CP Training Program



London Breed
Mayor

Department of Emergency Management
1011 Turk Street, San Francisco, CA 94102

Division of Emergency Services
Emergency Medical Services Agency
333 Valencia St., Ste. 210, San Francisco, CA. 94102
Phone: (415) 558-3800 Fax: (415) 558-3643



Mary Ellen Carroll
Executive Director

APPLICATION FOR EMS TRAINING PROGRAMS

Application Date: 7/25/2023

Circle Application Type and EMS Training Programs Applying For:

Initial Application Renewal Application
Paramedic Program EMT Program ☒ Community Paramedic Continuing Education

Program Information:

Program Name: SF Fire Department Community Paramedicine Training Program
Address: 1415 Evans Ave. San Francisco, CA 94124
Telephone #: 415-555-3200 Fax #: 415-558-3407

Program Type:

☐ Hospital ☒ EMS Provider ☐ Public Education ☐ Other: _____

Program Director

Director Name: Joseph Graterol
Telephone #: 628-222-0305
Email Address: joseph.graterol@ucsf.edu

Program Clinical Director

Clinical Director Name: Joseph Graterol
Telephone #: 628-222-0305
Email Address: joseph.graterol@ucsf.edu

Additional Contact Person: Daniel Nazzareta
Contact Telephone #: 628-222-0232
Contact Email Address: daniel.nazzareta@sfgov.org

Renewal Applicants Only:

Has there been a change in personnel for the positions of Program Director or Clinical Director during the past 4 year approval period? If yes, please provide the date that change was effective: _____

Please submit the following with this application:

- Resumes for both the Program Director and Clinical Director
- Verification of Program Director's educational qualifications (22 CCR 100170)
- Course documents for all classes offered: objectives; CE Units offered per course; material covered in course (Initial and Renewal Applicants)
- Course rosters and completed evaluations for last 6 CE Classes offered (Renewal Applicants)
- EMS Training Program Fee (see attached Fee Schedule, item (c) (1) or (2))

I certify that the above is true and correct and the personnel listed as Program Director and Program Clinical Director meet the minimum requirements as described in 22 CCR 100170. The EMS Agency may require a site review and an audit of any or all records pertinent to the program prior to approval.

DocuSigned by:
Joseph Graterol 7/25/2023
Program Director Signature

DocuSigned by:
Joseph Graterol 7/25/2023
Program Clinical Director Signature



London Breed
Mayor

Department of Emergency Management
Emergency Medical Services Agency
333 Valencia St., Suite 210, San Francisco, CA 94103
Phone: (628) 217-6000 Fax: (628) 217-6001



Mary Ellen Carroll
Executive Director

Date: July 28, 2023

To: Dr. Joseph Graterol, SFFD, Medical Director, Community Paramedicine
Assistant Deputy Chief Simon Pang, SFFD, Community Paramedicine
Captain Daniel Nazzareta, SFFD, Community Paramedicine

From: Dr. John Brown, EMS Agency Medical Director
Ron Pike, EMS Specialist, Training

Re: Community Paramedicine Training Program – Preliminary Approval

The San Francisco EMS Agency (SFEMSA) reviewed San Francisco Fire Department's (SFFD) Community Paramedic (CP) Training Program as required under the Community Paramedicine or Triage to Alternate Destination Act of 2020 (AB1544).

Based on extensive submissions and collaboration, SFEMSA determined SFFD meets or exceeds all requirements for a CP Training Program under, Title 22, Ca. Code of Regulations (CCR) §§ 100187 – 100189.

Under 22 CCR § 100190, SFEMSA must submit San Francisco's overall CP Program, in which CP Training Program elements are included, to the EMS Authority for review and approval. Therefore, SFEMSA can give preliminary approval for SFFD's CP Training Program. Final approval is contingent on overall CP Program approval by the EMS Authority with Dr. Joseph Graterol as CP Program Director/Program Clinical Director and Captain Daniel Nazzareta as CP Program Instructor.

Once finalized, SFFD's CP Training Program will receive approval for four (4) years. SFEMSA will follow-up with additional information upon full program review by the EMS Authority.

Congratulations on this major milestone and for continuing to provide these educational and training opportunities to San Francisco.

DocuSigned by:

John Brown

Dr. John Brown
EMS Agency Medical Director
john.brown@sfdph.org
628-217-6013

DocuSigned by:

Ron Pike

Ron Pike
EMS Specialist, Training
ronald.pikejr@sfgov.org
628-217-6017

Cc: Chief Jeanine Nicholson, SFFD
Deputy Chief Sandy Tong, SFFD, EMS and Community Paramedicine
Section Chief Michael Mason, SFFD, Community Paramedicine
Section Chief April Sloan, SFFD, Community Paramedicine
Dr. Jeremy Lacocque, SFFD, Medical Director
Andrew Holcomb, EMS Director
Kayleigh Hillcoat, EMS Deputy Director, Operations

SAN FRANCISCO



FIRE DEPARTMENT

COMMUNITY PARAMEDICINE DIVISION

7/20/2023

To Whom it May Concern:

I, Dr. Joseph Graterol, serving as both the San Francisco Fire Department's Community Paramedicine Division Medical Director, and as the proposed Program Director for our training program application, certify that our community paramedicine course content, to the best of my knowledge, meets the requirements contained in the current version of the United States Department of Transportation (U.S. DOT) National Education Standards.

Sincerely,

A handwritten signature in blue ink, appearing to read "Joseph Graterol", with a stylized flourish.

Joseph Graterol, MD

| AB1544 Curriculum: Subject Matter | Source Material |
|--|---|
| 1. Foundations of Community Paramedicine | |
| A. Overview of the US and California Healthcare Systems and Reimbursement | 1A. Introduction into Community Paramedicine |
| B. Overview of Public Health | 5A. Population Health Through an EMS Lens |
| C. Effect of the ACA on development of Community Paramedicine Nationally and in California | 1C. Community Paramedic Overview |
| D. Roles of the Community Paramedic | 1D. Triage To Alternate Destination Program |
| E. Community Paramedic Scope of Practice | 1E. Community Paramedicine Program Overview and Scope |
| F. Legal and Ethical Issues | 1F. Ethics |
| G. Chronic Disease Management (Pathophysiology, CHF, Asthma, HTN, COPD, Peds, Dementia, Medications, I | 1G. Chronic Diseases |
| H. Sub-Acute Disease Management (as above) | 1G. Chronic Diseases |
| I. Personal Safety and Wellness | 1I. Personal Safety |
| J. ISBC | 1J. IBSC Written Materials |
| K. Research in Evidence-Based Practice | 1K. Epidemiology through an EMS Lens |
| 2. Cultural Humility, Equity and Access within Community Paramedicine and Healthcare | |
| A. Social Determinants of Health | 2A Community_Needs_Assessment |
| B. Bio-Medical Ethics | 1F. Ethics |
| C. Equity vs. Equality | 2C. Tools for Dismantling Inequities |
| D. Disparities in Healthcare Access and Healthcare Outcomes by Age, Race, Gender, Ethnicity, Language, Abili | 2C. Tools for Dismantling Inequities |
| E. Implicit Bias in Healthcare | 2E. Bias in the workplace |
| F. Cultural Humility as a Framework for Community Paramedicine, Pubic Health Practice | 2A Community_Needs_Assessment |
| G. Roles of the Culturally Effective Community Paramedic | 2A Community_Needs_Assessment |
| H. Trauma Informed Care | 2C. Tools for Dismantling Inequities |
| 3. Inter-Disciplinary Collaboration and Systems of Care Navigation | |
| A. Healthcare Coordination | 3C. Principles of Individual Outreach |
| B. Systems of Care Navigation | 4I. Web of Resources |
| C. Outreach and Advocacy for Target and At-Risk Populations | 3C. Principles of Individual Outreach |
| D. Client Referral | 3D. Patient Assessment |
| E. Documentation Across Disciplines | 3E. Professional and Secure Communications |
| F. Overview of the Subject Areas of: | |
| i. Nutrition | 3Fi. Nutrition for CP |
| ii. Palliative Care | 3Fii. Hospice And Pallative Care |
| iii. Hospice Care | 3Fiii. Hospice And Pallative Care |
| iv. End of Life Care | 3Fiv. Hospice And Pallative Care |
| v. Home Health vs. Home Care | 3Fvi. Wounds |
| vi. Mental Health Care | 3vi. Intro to Phychiatric Emergencies |
| vii. Substance Use Care | 3Fvii. Intro into Phychiatric Emergencies |
| 4. Client-Centered Care | |
| A. Client approach and Biopsychosocial Assessment, including embedding Cultural Humility Practices in Client | 4A. Principles of Individual Outreach |
| B. Motivational Interviewing | 4B. Relationship based communications |
| C. Interventional Techniques | 4B. Relationship based communications |
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SECTION V – Agreements

**City and County of San Francisco
San Francisco Department of Emergency Management
Emergency Medical Services Agency
333 Valencia St, Suite 210
San Francisco, California 94103**

**Agreement between the City and County of San Francisco,
acting by and through its Department of Emergency Management
and**

Department of Public Health Alcohol Sobering Center, Triage to Alternate Destination Facility

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This Memorandum of Understanding (“MOU”) is made on July 1, 2023 in the City and County of San Francisco, State of California, by and between the San Francisco Department of Public Health (“DPH”) and the San Francisco Department of Emergency Management (“DEM”).

Recitals

WHEREAS, DEM is the designated local Emergency Medical Services Agency (“LEMSA”) for the City, under California Health and Safety Code Section 1797.200; and

WHEREAS, California Health and Safety Code Sections 1797.204, 1797.220, and 1797.222, authorize and require LEMSAs to plan, implement, and evaluate the Emergency Medical Services (“EMS”) system, including destination and transport policies; and

WHEREAS, the Community Paramedicine or Triage to Alternate Destination Act of 2020 (“Act”), passed under Assembly Bill 1544, effective January 1, 2021, requires all pilot Community Paramedic and Triage to Alternate Destination Providers, Programs, and Facilities to cease operations on October 31, 2023, or meet statutory and regulatory requirements under the Act.

WHEREAS, California Health and Safety Code Sections 1841 and 1843 require a LEMSAs that elects to develop Triage to Alternate Destination program (“Program”) to provide medical control and oversight, facilitate agreements with Providers and Facilities for the delivery of Services, and integrate the Program into the LEMSAs emergency medical Services plan under California Health and Safety Code Section 1797.250; and

Now, **THEREFORE**, the Parties agree as follows:

Article 1 Definitions

The following definitions apply to this MOU:

1.1. **“Advanced Life Support” or “ALS”** means special Services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.

1.2. **“Alternate Destination Facility”** means a transport location that is an authorized mental health facility or sobering center as defined in California Health and Safety Code Sections 1812-1813.

1.3. **“City”** means the City and County of San Francisco, a municipal corporation, acting by and through both its Department of Emergency Management.

1.4. **“Confidential Information”** means confidential City information including, but not limited to, personally-identifiable information (“PII”), protected health information (“PHI”), or individual financial information (collectively, “Proprietary or Confidential Information”) that is subject to local, state or federal laws restricting the use and disclosure of such information, including, but not limited to, Article 1, Section 1 of the California Constitution; the California Information Practices Act (Civil Code § 1798 et seq.); the California Confidentiality of Medical Information Act (Civil Code § 56 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §§ 6801(b) and 6805(b)(2)); the privacy and information security aspects of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act (45 CFR Part 160 and Subparts A, C, and E of part 164); and San Francisco Administrative Code Chapter 12M (Chapter 12M).

1.5. **“Hospital”** means an acute care hospital licensed in California with at least a permit for basic emergency service.

1.6. **“Local EMS Agency (LEMSA)”** means the San Francisco EMS Agency having primary responsibility for administration of emergency medical Services in the City and County of San Francisco as designated by California Health and Safety Code Section 1797.200.

1.7. **“LEMSA Medical Director”** means the San Francisco Director of Health, or his or her designee, responsible for the duties set forth in California Health and Safety Code Section 1797.202.

1.8. **“Medical Control”** means the medical direction and management of the EMS system pursuant to California Health and Safety Code Sections 1798 and 1841(b)

1.9. **“Services”** means all Services performed by Facility under this MOU.

1.10. **“Sobering Center”** means a noncorrectional facility that is staff at all times with at least one registered nurse, that provides a safe, supportive environment for intoxicated individuals to become sober, that is identified as an alternate destination in a plan developed pursuant to California Health and Safety Code Section 1843 and meets all requirements in Section 1813(1-3).

1.11. **“Triage Paramedic”** means a paramedic licensed under this division who has completed the curriculum for triage paramedic Services and has been accredited by LEMSAs in one or more of the triage paramedic specialties as part of an approved triage to alternate destination program.

1.12. **“Triage to Alternate Destination Program” or “Program”** means a program developed by LEMSAs and approved by the EMS Authority to provide triage paramedic assessments consisting of one or more specialties operating under protocols developed by LEMSAs. Triage to alternate destination programs include: providing care and comfort Services to hospice patients in their homes; providing patients with ALS triage, assessment by a triage paramedic, and transportation to an alternate destination facility, and providing transport Services for patients who identify as veterans and desire transport to a local veterans administration emergency department for treatment, when appropriate.

1.13. **“Triage to Alternate Destination Facility” or “Facility”** means an ALS Facility authorized by LEMSAs to provide advanced life support triage paramedic assessments as part of an approved triage to alternate destination program specialty, as described in California Health and Safety Code Section 1819.

Article 2 Term of the MOU

2.1 Initial Term.

The term of this MOU shall commence on July 1, 2023 and expire 9 years later on June 30, 3032, unless earlier terminated as otherwise provided herein. In no event may the term exceed ten years.

Article 3 Fees

3.1 Fees.

As authorized by Cal. Code Regs. Tit. 22, Section 100193, and to the extent LEMSAs is authorized by local ordinance for collection of fees, Facility agrees to pay fees authorized by LEMSAs. Fees may be added or adjusted each year. Annually, LEMSAs will publish a memorandum updating fees to be paid.

3.2 Audit

Facility agrees to maintain and make available to the City, upon reasonable advance written notice and during regular business hours, accurate records, including but not limited to patient care, staffing, operations, training records, and all other records relating to Facility Services performed under this MOU. Facility will permit City to audit such books and records related to all matters covered by this MOU.

3.3 MOU Amendments.

3.3.1 Formal Amendment. This MOU may be amended only by a formal modification executed and approved in the same manner as the original MOU.

3.3.2 No-Cost MOU: This is a no-cost MOU. In no event may the City compensate Facility under this MOU.

Article 4 Services

4.1 Services

Alternate Destination Facility must provide the general Services detailed in:

4.1.1 Appendix A (Triage to Alternate Destination Facility Statement of Work)

4.2 Qualified Personnel.

Facility shall ensure all Facility personnel are actively certified, licensed, and/or accredited in accordance with state and local policies and regulations in order to provide medical care as part of the Program Services.

4.3 Subcontracting

Facility may subcontract Services under this MOU only with written approval of the City.

4.4 Independent Contractor.

For the purposes of this Article 4, "Facility shall be deemed to include not only Facility, but also any agent or employee of Facility. Facility acknowledges and agrees that at all times, Facility or any agent or employee of Facility shall be deemed at all times to be an independent contractor wholly responsible for the manner in which it performs the Services under this MOU. Facility, its agents, and employees will not represent or hold themselves out to be employees of the City at any time. Facility or any agent or employee of Facility shall not have employee status with City, nor be entitled to participate in any plans, arrangements, or distributions by City pertaining to or in connection with any retirement, health or other benefits that City may offer its employees. Facility or any agent or employee of Facility is liable for the acts and omissions of itself, its employees and its agents. Facility shall be responsible for all obligations and payments, whether imposed by federal, state or local law, including, but not limited to, FICA, income tax withholdings, unemployment compensation, insurance, and other similar responsibilities related to Facility's Services. Nothing in this MOU shall be construed as creating an employment or agency relationship between City and Facility.

4.5 Assignment

Neither this MOU, nor any duties or obligations hereunder, may be assigned unless first approved by City by written instrument executed and approved in the same manner as this MOU

4.6 Activities at Facility's Expense.

Any act that Facility performs under this MOU shall be performed at Facility's expense.

4.7 Warranty.

“Facility warrants to City that the Services will be performed with the degree of skill and care that is required by current, good and sound professional procedures and practices, and in conformance with generally all state, federal and local laws, regulations, requirements, and accepted professional standards prevailing at the time the Services are performed, so that all Services are performed as contemplated in this MOU as detailed in the Appendices.

Article 5 Insurance and Indemnity (Reserved for SFDPH)

Article 6 Liability of the Parties

6.1 Liability for Incidental and Consequential Damages.

IN NO EVENT EITHER PARTY BE LIABLE, REGARDLESS OF WHETHER ANY CLAIM IS BASED ON CONTRACT OR TORT, FOR ANY SPECIAL, CONSEQUENTIAL, INDIRECT OR INCIDENTAL DAMAGES, INCLUDING, BUT NOT LIMITED TO, LOST PROFITS, ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT OR THE SERVICES PERFORMED IN CONNECTION WITH THIS AGREEMENT

Article 7 Payment of Taxes (Reserved)

Article 8 Termination and Default

8.1 Termination for Convenience

Either party may terminate this agreement for convenience by giving the other party ninety (90) days’ prior written notice of termination. The notice shall specify the date on which termination shall become effective. Any pre-paid fees are nonrefundable

Article 9 Rights In Deliverables (Reserved)

Article 10 Additional Requirements Incorporated by Reference

10.1 Alcohol and Drug-Free Workplace.

City reserves the right to deny access to, or require Facility to remove from performance of Services under this MOU personnel of any Facility who City has reasonable grounds to believe has engaged in alcohol abuse or illegal drug activity which in any way impairs City's ability to protect the health and well-being of City employees and the general public. Illegal drug activity means possessing, furnishing, selling, offering, purchasing, using or being under the influence of illegal drugs or other controlled substances for which the individual lacks a valid prescription Alcohol abuse means possessing, furnishing, selling, offering, or using alcoholic beverages, or being under the influence of alcohol. For clarity, for purposes of this MOU “controlled substance” includes cannabis and derivative products.

10.2 Nondiscrimination Requirements.

In the performance of this MOU, Facility agrees that it will not discriminate against any individual because of race, color, religion, sex, age, ancestry, national origin, sexual orientation, handicap, veteran’s status, medical condition (as defined in Section 12926 of the State of California Government Code), marital status, or citizenship because of habit, local custom, or otherwise.

Article 11 General Provisions

11.1 Notices to the Parties.

Unless otherwise indicated in this MOU, all written communications sent by the Parties may be by U.S. mail or e-mail, and shall be addressed as follows:

| | |
|--------------|--|
| To City: | Andrew Holcomb, MS, EMS Director, San Francisco EMS Agency Department of Emergency Management City and County of San Francisco 333 Valencia St, Suite 210, San Francisco, CA 94103 628-217-6014 andrew.holcomb@sfgov.org |
| To Facility: | SFDPH ALCOHOL SOBERING CENTER ALTERNATE DESTINATION FACILITY 465 GROVE STREET, SAN FRANCISCO, CA 94102 415-609-4368 MEDICAL DIRECTOR: DEVORA KELLER (DEVORA.KELLER@SFDPH.ORG) NURSE MANAGER: ALICE MOUGHAMIAN (ALICE.MOUGHAMIAN@SFDPH.ORG) |

Any notice of default must be sent by registered mail or other trackable overnight delivery. Either Party may change the address to which notice is to be sent by giving written notice thereof to the other Party. If email notification is used, the sender must specify a receipt notice.

11.2 Compliance with Americans with Disabilities Act.

Facility shall provide the Services in a manner that complies with the Americans with Disabilities Act (ADA), including but not limited to Title II's program access requirements, and all other applicable federal, state and local disability rights legislation.

11.3 Sunshine Ordinance.

Facility acknowledges that this MOU, all records related to its formation and Facility's performance of Services are subject to the California Public Records Act, (California Government Code §6250 et. seq.), and the San Francisco Sunshine Ordinance, (San Francisco Administrative Code Chapter 67). Such records are subject to public inspection and copying unless exempt from disclosure under federal, state or local law.

11.4 MOU Made in California; Venue.

The formation, interpretation and performance of this MOU shall be governed by the laws of the State of California. Venue for all litigation relative to the formation, interpretation and performance of this MOU shall be in San Francisco.

11.5 Construction.

All paragraph captions are for reference only and shall not be considered in construing this MOU.

11.6 Entire Agreement.

This contract sets forth the entire agreement between the parties, and supersedes all other oral or written provisions. This MOU may be modified only as provided in Section 11.5, "Modification of this Agreement."

11.7 Compliance with Laws.

Facility shall keep itself fully informed of the City's Charter, codes, ordinances and duly adopted rules and regulations of the City and of all state, and federal laws in any manner applicable to Facility's performance of this MOU, and must at all times comply with such local codes, ordinances, and regulations and all applicable laws as they may be amended from time to time.

11.8 Severability.

Should the application of any provision of this MOU to any particular facts or circumstances be found by a court of competent jurisdiction to be invalid or unenforceable, then (a) the validity of other provisions of this MOU shall not be affected or impaired thereby, and (b) such provision shall be enforced to the maximum extent possible so as to effect the intent of the parties and shall be reformed without further action by the parties to the extent necessary to make such provision valid and enforceable.

11.9 Cooperative Drafting.

This MOU has been drafted through a cooperative effort of City and Contractor, and both Parties have had an opportunity to have the MOU reviewed and revised by legal counsel. No Party shall be considered the drafter of this MOU, and no presumption or rule that an ambiguity shall be construed against the Party drafting the clause shall apply to the interpretation or enforcement of this MOU.

11.10 Third Party Beneficiaries.

No third parties are intended by the parties hereto to be third party beneficiaries under this MOU, and no action to enforce the terms of this MOU may be brought against either party by any person who is not a party hereto.

Article 12 Data and Security

12.1 City Data

12.1.1 Data Breach; Loss of City Data. In the event of any breach of City Data that compromises or is suspected to compromise the security, confidentiality, or integrity of City Data or the physical, technical, administrative, or organizational safeguards put in place by Facility that relate to the protection of the security, confidentiality, or integrity of City Data, Facility shall notify the City immediately following discovery, but no later than twenty-four (24) hours, of becoming aware of such occurrence or suspected occurrence and shall thereafter cooperate with the City in accordance with the City's directives.

12.1.2 Data Privacy and Information Security Program. Without limiting Contractor's obligation of confidentiality as further described herein, Contractor shall establish and maintain a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to: (i) ensure the security and confidentiality of the City Data; (ii) protect against any anticipated threats or hazards to the security or integrity of the City Data; (iii) protect against unauthorized disclosure, access to, or use of the City Data; (iv) ensure the proper disposal of City Data; and, (v) ensure that all of Contractor's employees, agents, and subcontractors, if any, comply with all of the foregoing.

12.1.3 Data Transmission. Contractor shall ensure that all electronic transmission or exchange of City Data will be encrypted using current industry standards. Contractor shall also ensure

that all data exchanged shall be used expressly and solely for the purposes stated in the MOU. City Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Contractor not involved in administration of this MOU, unless otherwise permitted in this MOU. The Facility shall ensure that no City Data of any kind shall be copied, modified, destroyed, deleted, transmitted, exchanged or otherwise passed to other vendors or interested parties except on a case-by-case basis as specifically agreed to in writing by City.

12.2 Business Associate Agreement.

The City represents that it is a Covered Entity as defined in the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and is required to comply with the HIPAA Privacy Rule governing the access, transmission, and storage of health information and the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act").

In accordance with applicable laws, the parties acknowledge that Facility will:

1. ☐ Do **at least one** or more of the following:
 - A. Create, receive, maintain, or transmit PHI for or on behalf of CITY (including storage of PHI, digital or hard copy, even if Facility does not view the PHI or only does so on a random or infrequent basis); or
 - B. Receive PHI, or access to PHI, from CITY or another Business Associate of City, as part of providing a service to or for CITY, including legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial; or
 - C. Transmit PHI data for CITY and require access on a regular basis to such PHI. (Such as health information exchanges (HIEs), e-prescribing gateways, or electronic health record vendors)

FOR PURPOSES OF THIS MOU, FACILITY IS A BUSINESS ASSOCIATE OF CITY, AS DEFINED UNDER HIPAA. FACILITY MUST COMPLY WITH AND COMPLETE THE FOLLOWING ATTACHED DOCUMENTS, INCORPORATED TO THIS MOU AS THOUGH FULLY SET FORTH HEREIN:

- A. **Appendix E Business Associate Agreement (BAA) (04-12-2018)**
 1. Attestation 1 PRIVACY (06-07-2017)
 2. Attestation 2 DATA SECURITY (06-07-2017)
2. ☒ **NOT do any of the activities listed above in subsection 1;**
LEMSA (DEM) and Facility are both Covered Entities. No BAA is required for the purposes of this MOU.

12.3 Protected Health Information.

Facility and all agents and employees shall comply with all federal and state laws regarding the transmission, storage and protection of all private health information disclosed to Facility by City in the performance of this MOU. Facility agrees that any failure of Contractor to comply with the requirements of federal and/or state and/or local privacy laws shall be a material breach of the Contract. In the event

that City pays a regulatory fine, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible use or disclosure of protected health information given to Facility or its subcontractors or agents by City, Facility shall indemnify City for the amount of such fine or penalties or damages, including costs of notification. In such an event, in addition to any other remedies available to it under equity or law, the City may terminate the Contract.

Article 13 MacBride And Signature

13.1 MacBride Principles -Northern Ireland.

The provisions of San Francisco Administrative Code §12F are incorporated herein by this reference and made part of this MOU. By signing this MOU, Facility confirms that Facility has read and understood that the City urges companies doing business in Northern Ireland to resolve employment inequities and to abide by the MacBride Principles, and urges San Francisco companies to do business with corporations that abide by the MacBride Principles.

IN WITNESS WHEREOF, the parties hereto have executed this MOU on the day first mentioned above.

RECOMMENDED

Mary Ellen Carroll
Executive Director
Department of Emergency Management

DocuSigned by:
Mary Ellen Carroll 6/23/2023
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Facility
SFDPH Alcohol Sobering Center

DocuSigned by:
Greg Wagner 6/20/2023
28527524752949F...

Grant Colfax, MD
Director of Health
Department of Public Health

APPROVED

John F. Brown, M.D.
Medical Director
San Francisco LEMS

DocuSigned by:
John Brown 6/23/2023
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Appendices

A: Statement of Work–Triage to Alternate Destination Facility

Appendix A – Triage to Alternate Destination Facility

STATEMENT OF WORK

I. Triage to Alternate Destination Facility and Program Approval Process

1. Pursuant to California Health and Safety Code Section 1851, no person or organization shall provide alternate destination Services unless authorized by LEMSA and approved by the State EMS Authority in accordance with California Health and Safety Code Section 1835. Any Facility seeking to obtain a Certificate of Participation must:

a. **Application:** Apply to LEMSA, by submitting all necessary information and paying all applicable fees, and

b. **Program Review:** Participate in a Program review to integrate Facility into the San Francisco Emergency Medical Services Plan, under California Health and Safety Code Sections 1797.250 and 1797.252 to ensure compliance with local and state regulatory standards such as California Health and Safety Code Sections 1800 – 1857 and Cal. Code Regs. Tit. 22, Sections 100181 - 100193.

II. General Requirements For Facility

1. Approved Facility shall perform as follows:

a. Verify that all Facility personnel used for alternate destination Services are licensed medical and professional staff.

b. Certify and provide documentation to LEMSA and the EMS Authority showing that Facility is authorized to receive patients and maintains adequate licensed medical and professional staff, facilities, and equipment that comply with the requirements of LEMSA and the EMS Authority. This includes, but not limited to, identification of qualified staff to care for the degree of a patient's injuries and needs; certification of standardized medical and nursing procedures for nursing staff; and certification that the necessary equipment and services are available at Facility to care for patients, including, but not limited to, an automatic external defibrillator and at least one bed or mat per individual patient.

c. Notify LEMSA within 24 hours if there are changes in the status of Facility with respect to protocols and the Facility's ability to care for patients.

d. Operate in accordance with California Health and Safety Code Section 1317. Failure to operate in accordance with California Health and Safety Code Section 1317 may result in immediate termination of this MOU.

e. Ensure competency and compliance of Facility personnel through exams, training, and continuing education with LEMSA local medical control and oversight.

f. Ensure Facility training programs, curriculum, administration, record-keeping, faculty and instructors meet or exceed compliance with Cal. Code Regs. Tit. 22, §§ 100187 – 100189.

g. Follow all state regulations and LEMSA Policies (all LEMSA policies can be found at sf.gov/ems).

h. Participate in an annual review by the LEMSA. LEMSA or the EMS Authority may take potential adverse actions, such as denial, probation, suspension, or revocation of Facility for failure to

comply with applicable policies and regulations. The process for such action is listed in California Health and Safety Code Section 1835 and Cal. Code Regs. Tit. 22, § 100184.

2. Emergency Medical Services (“EMS”) System Committees:

Facility must participate (attend a minimum of 75% of Committee meetings annually) in the following EMS System Committees which will be convened on a periodic basis, but not greater than a six-month interval, by the LEMSA:

- a. Emergency Medical Services Advisory Committee (“EMSAC”)
- b. Quality Improvement Committee
- c. Other Committees determined by the LEMSA

3. Performance Standards – Facility Shall:

a. Comply with all state laws and regulations regarding the provision of EMS and Triage to Alternate Destination Services.

b. Comply with all provisions, including fee provisions, of San Francisco Health Code, Articles 3 (Hospitals) and 14 (Ambulances and Routine Medical Transport Vehicles), including any and all amendments thereto, if any, whether enacted before or during the term of this MOU and any extensions.

c. Comply with all LEMSA EMS Policies, Procedures and Protocols, and Directives as approved and amended.

d. Comply with the Emergency Medical Treatment and Labor Act (“EMTALA”) (42 U.S.C § 1395dd) and the regulations promulgated thereunder for any receipt or transfer of a patient.

e. Facility shall ensure that a patient who is transported to Facility and, upon assessment, is found to no longer meet the criteria for admission to an Facility, be immediately transported to the emergency department of a general acute care hospital.

f. Facility shall send with each patient at the time of transfer or, in the case of an emergency, as promptly as possible, copies of all medical records related to the patient’s transfer. The requirements in California Health and Safety Code Section 1831 do not apply if the Facility has entered into a written transfer agreement with a local hospital that provides for the transfer of medical records.

g. Facility shall accommodate privately or commercially insured, Medi-Cal, Medicare, and uninsured patients.

4. Documentation, Data Submission, and Quality Improvement:

a. Facility shall comply with Cal. Code Regs. Tit. 22, Sections 100185 and 100171 related to the provision of Services.

b. In compliance with Cal. Code Regs. Tit. 22, Section 100185, Facility shall exchange patient health information (HIE) between community paramedicine or triage to alternate destination Providers and health providers and Facilities. Should Facility be unable to establish an (HIE), a plan to establish such exchange shall be submitted to LEMSA to request a waiver from the EMS Authority.

c. Facility shall submit quarterly summaries of patient outcomes to the LEMSA as listed in Cal. Code Regs. Tit. 22, Section 100185.

5. Incident Reporting

a. Facility shall file (by email exceptionreport@sfgov.org) an Exception Report form (form is located at <https://sf.gov/emsa>) consistent with LEMSA Policy No. 6020 within time frame reporting requirements set forth in LEMSA Policy No. 6020.

**City and County of San Francisco
San Francisco Department of Emergency Management
Emergency Medical Services Agency
333 Valencia St, Suite 210
San Francisco, California 94103**

**Agreement between the City and County of San Francisco,
acting by and through its Department of Emergency Management
and**

San Francisco Veteran Affairs Health Care System, Triage to Alternate Destination Facility

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This Memorandum of Understanding (“MOU”) is made on July 1, 2023 in the City and County of San Francisco, State of California, by and between San Francisco Veteran Affairs Health Care System and the City and County of San Francisco (“City”), acting by and through its Department of Emergency Management (“DEM”).

Recitals

WHEREAS, DEM is the designated local Emergency Medical Services Agency (“LEMSA”) for the City, under California Health and Safety Code Section 1797.200; and

WHEREAS, California Health and Safety Code Sections 1797.204, 1797.220, and 1797.222, authorize and require LEMSA to plan, implement, and evaluate the Emergency Medical Services (“EMS”) system, including destination and transport policies; and

WHEREAS, the Community Paramedicine or Triage to Alternate Destination Act of 2020 (“Act”), passed under Assembly Bill 1544, effective January 1, 2021, requires all pilot Community Paramedic and Triage to Alternate Destination Providers, Programs, and Facilities to cease operations on October 31, 2023, or meet statutory and regulatory requirements under the Act.

WHEREAS, California Health and Safety Code Sections 1841 and 1843 require a LEMSA that elects to develop Triage to Alternate Destination program (“Program”) to provide medical control and oversight, facilitate agreements with Providers and Facilities for the delivery of Services, and integrate the Program into the LEMSA emergency medical Services plan under California Health and Safety Code Section 1797.250; and

Now, **THEREFORE**, the Parties agree as follows:

Article 1 Definitions

The following definitions apply to this MOU:

1.1. **“Advanced Life Support” or “ALS”** means special Services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.

1.2. **“Alternate Destination Facility”** means a transport location that is an authorized mental health facility or sobering center as defined in California Health and Safety Code Section Sections 1812-1813.

1.3. **“City”** means the City and County of San Francisco, a municipal corporation, acting by and through both its Department of Emergency Management.

1.4. **“Confidential Information”** means confidential City information including, but not limited to, personally-identifiable information (“PII”), protected health information (“PHI”), or individual financial information (collectively, "Proprietary or Confidential Information") that is subject to local, state or federal laws restricting the use and disclosure of such information, including, but not limited to, Article 1, Section 1 of the California Constitution; the California Information Practices Act (Civil Code § 1798 et seq.); the California Confidentiality of Medical Information Act (Civil Code § 56 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §§ 6801(b) and 6805(b)(2)); the privacy and information security aspects of the Administrative Simplification provisions of the federal Health Insurance Portability and

Accountability Act (45 CFR Part 160 and Subparts A, C, and E of part 164); and San Francisco Administrative Code Chapter 12M (Chapter 12M).

1.5. **“Hospital”** means an acute care hospital licensed in California with at least a permit for basic emergency service.

1.6. **“Local EMS Agency (LEMSA)”** means the San Francisco EMS Agency having primary responsibility for administration of emergency medical Services in the City and County of San Francisco as designated by California Health and Safety Code Section 1797.200.

1.7. **“LEMSA Medical Director”** means the San Francisco Director of Health, or his or her designee, responsible for the duties set forth in California Health and Safety Code Section 1797.202.

1.8. **“Medical Control”** means the medical direction and management of the EMS system pursuant to California Health and Safety Code Sections 1798 and 1841(b)

1.9. **“Services”** means all Services performed by Facility under this MOU.

1.10. **“Sobering Center”** means a noncorrectional facility that is staff at all times with at least one registered nurse, that provides a safe, supportive environment for intoxicated individuals to become sober, that is identified as an alternate destination in a plan developed pursuant to California Health and Safety Code Section 1843 and meets all requirements in Section 1813(1-3).

1.11. **“Triage Paramedic”** means a paramedic licensed under this division who has completed the curriculum for triage paramedic Services and has been accredited by LEMSA in one or more of the triage paramedic specialties as part of an approved triage to alternate destination program.

1.12. **“Triage to Alternate Destination Program” or “Program”** means a program developed by LEMSA and approved by the EMS Authority to provide triage paramedic assessments consisting of one or more specialties operating under protocols developed by LEMSA. Triage to alternate destination programs include: providing care and comfort Services to hospice patients in their homes; providing patients with ALS triage, assessment by a triage paramedic, and transportation to an alternate destination facility, and providing transport Services for patients who identify as veterans and desire transport to a local veterans administration emergency department for treatment, when appropriate.

1.13. **“Triage to Alternate Destination Facility” or “Facility”** means an ALS Facility authorized by LEMSA to provide advanced life support triage paramedic assessments as part of an approved triage to alternate destination program specialty, as described in California Health and Safety Code Section 1819.

Article 2 Term of the MOU

2.1 Initial Term.

The term of this MOU shall commence on July 1, 2023 and expire 9 years later on June 30, 2032, unless earlier terminated as otherwise provided herein. In no event may the term exceed ten years.

Article 3 Fees

3.1 Fees.

As authorized by Cal. Code Regs. Tit. 22, Section 100193, and to the extent LEMSA is authorized by local ordinance for collection of fees, Facility agrees to pay fees authorized by LEMSA. Fees may be added or adjusted each year. Annually, LEMSA will publish a memorandum updating fees to be paid.

3.2 Audit

Facility agrees to maintain and make available to the City, upon reasonable advance written notice and during regular business hours, accurate records, including but not limited to patient care, staffing, operations, training records, and all other records relating to Facility Services performed under this MOU. Facility will permit City to audit such books and records related to all matters covered by this MOU.

3.3 MOU Amendments.

3.3.1 Formal Amendment. This MOU may be amended only by a formal modification executed and approved in the same manner as the original MOU.

3.3.2 No-Cost MOU: This is a no-cost MOU. In no event may the City compensate Facility under this MOU.

Article 4 Services

4.1 Services

Alternate Destination Facility must provide the general Services detailed in:

4.1.1 Appendix A (Triage to Alternate Destination Facility Statement of Work)

4.2 Qualified Personnel.

Facility shall ensure all Facility personnel are actively certified, licensed, and/or accredited in accordance with state and local policies and regulations in order to provide medical care as part of the Program Services.

4.3 Subcontracting

Facility may subcontract Services under this MOU only with written approval of the City.

4.4 Independent Contractor.

For the purposes of this Article 4, "Facility shall be deemed to include not only Facility, but also any agent or employee of Facility. Facility acknowledges and agrees that at all times, Facility or any agent or employee of Facility shall be deemed at all times to be an independent contractor wholly responsible for the manner in which it performs the Services under this MOU. Facility, its agents, and employees will not represent or hold themselves out to be employees of the City at any time. Facility or any agent or employee of Facility shall not have employee status with City, nor be entitled to participate in any plans, arrangements, or distributions by City pertaining to or in connection with any retirement, health or other benefits that City may offer its employees. Facility or any agent or employee of Facility is liable for the acts and omissions of itself, its employees and its agents. Facility shall be responsible for all obligations and payments, whether imposed by federal, state or local law, including, but not limited to, FICA, income tax withholdings, unemployment compensation, insurance, and other similar responsibilities related to Facility's Services. Nothing in this MOU shall be construed as creating an employment or agency relationship between City and Facility.

4.5 Assignment

Neither this MOU, nor any duties or obligations hereunder, may be assigned unless first approved by City by written instrument executed and approved in the same manner as this MOU

4.6 Activities at Facility's Expense.

Any act that Facility performs under this MOU shall be performed at Facility's expense.

4.7 Warranty.

"Facility warrants to City that the Services will be performed with the degree of skill and care that is required by current, good and sound professional procedures and practices, and in conformance with generally all state, federal and local laws, regulations, requirements, and accepted professional standards prevailing at the time the Services are performed, so that all Services are performed as contemplated in this MOU as detailed in the Appendices.

Article 5 Insurance and Indemnity

5.1 Insurance.

5.1.1 Required Coverages. Without in any way limiting Facility's liability pursuant to the "Indemnification" section of this MOU, Facility must maintain in force, during the full term of the MOU, insurance in the following amounts and coverages:

(a) Workers' Compensation, in statutory amounts, with Employers' Liability Limits not less than \$1,000,000 each accident, injury, or illness; and

(b) Commercial General Liability Insurance with limits not less than \$10,000,000 each occurrence for Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations; policy must include Abuse and Molestation coverage,-and

(c) Commercial Automobile Liability Insurance with limits not less than \$10,000,000 each accident, "Combined Single Limit" for Bodily Injury and Property Damage, including Owned, Non-Owned and Hired auto coverage, as applicable.

(d) Professional liability insurance, applicable to Facility's profession, with limits not less than \$5,000,000 each claim with respect to negligent acts, errors or omissions in connection with the Services.

(e) Technology Errors and Omissions Liability coverage (RESERVED).

(f) Cyber and Privacy Insurance with limits of not less than \$10,000,000 per claim. Such insurance shall include coverage for liability arising from theft, dissemination, and/or use of confidential information, including but not limited to, bank and credit card account information or personal information, such as name, address, social security numbers, protected health information or other personally identifying information, stored or transmitted in any form.

(g) Facility shall be permitted to use umbrella, excess coverage and/or a program of self-insurance to meet the required limits for insurance in this section.

5.1.2 Additional Insured Endorsements

(a) Commercial General Liability and Commercial Automobile Liability Insurance policies must be endorsed to name as additional insured the City and County of San Francisco, its Officers, Agents, and Employees.

5.1.3 All policies shall be endorsed to provide thirty (30) days' advance written notice to the City of cancellation or intended non-renewal. Notices shall be sent to the City address set forth in Section 11.1, entitled "Notices to the Parties."

5.1.4 The Workers' Compensation policy(ies) shall be endorsed with a waiver of subrogation in favor of the City for all work performed by the Facility, its employees, agents and subcontractors.

5.1.5 **Primary Insurance Endorsements.** Commercial General Liability and Automobile Liability policies are primary insurance to any other insurance available to the Additional Insureds, with respect to any claims arising out of this MOU, and that insurance applies separately to each insured against whom claim is made or suit is brought.

5.2 General Indemnification.

Facility shall indemnify and hold harmless City and its officers, agents and employees from, and, if requested, shall defend them from and against any and all claims, demands, losses, damages, costs, expenses, and liability (legal, contractual, or otherwise), including infringement and/or intellectual property claims ("Claims"), arising from Facility's performance of this MOU, except to the extent that such indemnity is void or otherwise unenforceable under applicable law, and except where such loss, damage, injury, liability or claim is the result of the active negligence or willful misconduct of City and is not contributed to by any act of, or by any omission to perform some duty imposed by law or agreement on Facility, its subcontractors, or either's agent or employee. Contractor shall also indemnify, defend and hold City harmless from all Claims for breach of federal and/or state law regarding the privacy of health information, electronic records or related topics.

Article 6 Liability of the Parties

6.1 Liability for Incidental and Consequential Damages.

IN NO EVENT EITHER PARTY BE LIABLE, REGARDLESS OF WHETHER ANY CLAIM IS BASED ON CONTRACT OR TORT, FOR ANY SPECIAL, CONSEQUENTIAL, INDIRECT OR INCIDENTAL DAMAGES, INCLUDING, BUT NOT LIMITED TO, LOST PROFITS, ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT OR THE SERVICES PERFORMED IN CONNECTION WITH THIS AGREEMENT

Article 7 Payment of Taxes (Reserved)

Article 8 Termination and Default

8.1 Termination for Convenience

Either party may terminate this agreement for convenience by giving the other party ninety (90) days' prior written notice of termination. The notice shall specify the date on which termination shall become effective. Any pre-paid fees are nonrefundable

Article 9 Rights In Deliverables (Reserved)

Article 10 Additional Requirements Incorporated by Reference

10.1 Alcohol and Drug-Free Workplace.

City reserves the right to deny access to, or require Facility to remove from performance of Services under this MOU personnel of any Facility who City has reasonable grounds to believe has engaged in alcohol abuse or illegal drug activity which in any way impairs City's ability to protect the health and well-being of City employees and the general public. Illegal drug activity means possessing, furnishing,

selling, offering, purchasing, using or being under the influence of illegal drugs or other controlled substances for which the individual lacks a valid prescription Alcohol abuse means possessing, furnishing, selling, offering, or using alcoholic beverages, or being under the influence of alcohol. For clarity, for purposes of this MOU “controlled substance” includes cannabis and derivative products.

10.2 Nondiscrimination Requirements.

In the performance of this MOU, Facility agrees that it will not discriminate against any individual because of race, color, religion, sex, age, ancestry, national origin, sexual orientation, handicap, veteran’s status, medical condition (as defined in Section 12926 of the State of California Government Code), marital status, or citizenship because of habit, local custom, or otherwise.

Article 11 General Provisions

11.1 Notices to the Parties.

Unless otherwise indicated in this MOU, all written communications sent by the Parties may be by U.S. mail or e-mail, and shall be addressed as follows:

| | |
|--------------|--|
| To City: | Andrew Holcomb, MS, EMS Director, San Francisco EMS Agency Department of Emergency Management City and County of San Francisco 333 Valencia St, Suite 210, San Francisco, CA 94103 628-217-6014 andrew.holcomb@sfgov.org |
| To Facility: | JONATHAN GARBER, MD, CHIEF MEDICAL- EMERGENCY San Francisco Veterans Affairs Medical Center 4150 CLEMENT STREET (111A3), SAN FRANCISCO, CA, 94121 415-680-0241 JONATHAN.GARBER@VA.GOV |

Any notice of default must be sent by registered mail or other trackable overnight delivery. Either Party may change the address to which notice is to be sent by giving written notice thereof to the other Party. If email notification is used, the sender must specify a receipt notice.

11.2 Compliance with Americans with Disabilities Act.

Facility shall provide the Services in a manner that complies with the Americans with Disabilities Act (ADA), including but not limited to Title II's program access requirements, and all other applicable federal, state and local disability rights legislation.

11.3 Sunshine Ordinance.

Facility acknowledges that this MOU, all records related to its formation and Facility’s performance of Services are subject to the California Public Records Act, (California Government Code §6250 et. seq.), and the San Francisco Sunshine Ordinance, (San Francisco Administrative Code Chapter 67). Such records are subject to public inspection and copying unless exempt from disclosure under federal, state or local law.

11.4 MOU Made in California; Venue.

The formation, interpretation and performance of this MOU shall be governed by the laws of the State of California. Venue for all litigation relative to the formation, interpretation and performance of this MOU shall be in San Francisco.

11.5 Construction.

All paragraph captions are for reference only and shall not be considered in construing this MOU.

11.6 Entire Agreement.

This contract sets forth the entire agreement between the parties, and supersedes all other oral or written provisions. This MOU may be modified only as provided in Section 11.5, "Modification of this Agreement."

11.7 Compliance with Laws.

Facility shall keep itself fully informed of the City's Charter, codes, ordinances and duly adopted rules and regulations of the City and of all state, and federal laws in any manner applicable to Facility's performance of this MOU, and must at all times comply with such local codes, ordinances, and regulations and all applicable laws as they may be amended from time to time.

11.8 Severability.

Should the application of any provision of this MOU to any particular facts or circumstances be found by a court of competent jurisdiction to be invalid or unenforceable, then (a) the validity of other provisions of this MOU shall not be affected or impaired thereby, and (b) such provision shall be enforced to the maximum extent possible so as to effect the intent of the parties and shall be reformed without further action by the parties to the extent necessary to make such provision valid and enforceable.

11.9 Cooperative Drafting.

This MOU has been drafted through a cooperative effort of City and Contractor, and both Parties have had an opportunity to have the MOU reviewed and revised by legal counsel. No Party shall be considered the drafter of this MOU, and no presumption or rule that an ambiguity shall be construed against the Party drafting the clause shall apply to the interpretation or enforcement of this MOU.

11.10 Third Party Beneficiaries.

No third parties are intended by the parties hereto to be third party beneficiaries under this MOU, and no action to enforce the terms of this MOU may be brought against either party by any person who is not a party hereto.

Article 12 Data and Security

12.1 City Data

12.1.1 Data Breach; Loss of City Data. In the event of any breach of City Data that compromises or is suspected to compromise the security, confidentiality, or integrity of City Data or the physical, technical, administrative, or organizational safeguards put in place by Facility that relate to the protection of the security, confidentiality, or integrity of City Data, Facility shall notify the City immediately following discovery, but no later than twenty-four (24) hours, of becoming aware of such occurrence or suspected occurrence and shall thereafter cooperate with the City in accordance with the City's directives.

12.1.2 Data Privacy and Information Security Program. Without limiting Contractor's obligation of confidentiality as further described herein, Contractor shall establish and maintain a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to: (i) ensure the security and confidentiality of the City Data; (ii) protect against any anticipated threats or hazards to the security or integrity of the City Data; (iii) protect against unauthorized disclosure, access to, or use of the City Data; (iv) ensure the proper disposal of City Data; and, (v) ensure that all of Contractor's employees, agents, and subcontractors, if any, comply with all of the foregoing.

12.1.3 Data Transmission. Contractor shall ensure that all electronic transmission or exchange of City Data will be encrypted using current industry standards. Contractor shall also ensure that all data exchanged shall be used expressly and solely for the purposes stated in the MOU. City Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Contractor not involved in administration of this MOU, unless otherwise permitted in this MOU. The Facility shall ensure that no City Data of any kind shall be copied, modified, destroyed, deleted, transmitted, exchanged or otherwise passed to other vendors or interested parties except on a case-by-case basis as specifically agreed to in writing by City.

12.2 Business Associate Agreement.

The City represents that it is a Covered Entity as defined in the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and is required to comply with the HIPAA Privacy Rule governing the access, transmission, and storage of health information and the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act").

In accordance with applicable laws, the parties acknowledge that Facility will:

1. ☐ Do **at least one** or more of the following:
 - A. Create, receive, maintain, or transmit PHI for or on behalf of CITY (including storage of PHI, digital or hard copy, even if Facility does not view the PHI or only does so on a random or infrequent basis); or
 - B. Receive PHI, or access to PHI, from CITY or another Business Associate of City, as part of providing a service to or for CITY, including legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial; or
 - C. Transmit PHI data for CITY and require access on a regular basis to such PHI. (Such as health information exchanges (HIEs), e-prescribing gateways, or electronic health record vendors)

FOR PURPOSES OF THIS MOU, FACILITY IS A BUSINESS ASSOCIATE OF CITY, AS DEFINED UNDER HIPAA. FACILITY MUST COMPLY WITH AND COMPLETE THE FOLLOWING ATTACHED DOCUMENTS, INCORPORATED TO THIS MOU AS THOUGH FULLY SET FORTH HEREIN:

- A. **Appendix E Business Associate Agreement (BAA) (04-12-2018)**
 1. Attestation 1 PRIVACY (06-07-2017)
 2. Attestation 2 DATA SECURITY (06-07-2017)

2. ☒ **NOT** do any of the activities listed above in subsection 1;
 LEMSA (DEM) and Facility are both Covered Entities. No BAA is required for the purposes of this MOU.

12.3 Protected Health Information.

Facility and all agents and employees shall comply with all federal and state laws regarding the transmission, storage and protection of all private health information disclosed to Facility by City in the performance of this MOU. Facility agrees that any failure of Contactor to comply with the requirements of federal and/or state and/or local privacy laws shall be a material breach of the Contract. In the event that City pays a regulatory fine, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible use or disclosure of protected health information given to Facility or its subcontractors or agents by City, Facility shall indemnify City for the amount of such fine or penalties or damages, including costs of notification. In such an event, in addition to any other remedies available to it under equity or law, the City may terminate the Contract.

Article 13 MacBride And Signature

13.1 MacBride Principles -Northern Ireland.

The provisions of San Francisco Administrative Code §12F are incorporated herein by this reference and made part of this MOU. By signing this MOU, Facility confirms that Facility has read and understood that the City urges companies doing business in Northern Ireland to resolve employment inequities and to abide by the MacBride Principles, and urges San Francisco companies to do business with corporations that abide by the MacBride Principles.


IN WITNESS WHEREOF, the parties hereto have executed this MOU on the day first mentioned above.

RECOMMENDED

Mary Ellen Carroll
 Executive Director
 Department of Emergency Management

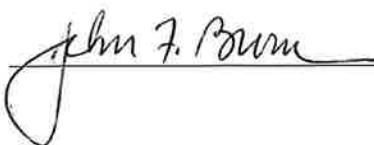


Facility
 San Francisco Veteran Affairs Health Care
 System


 Jia F. Li, MBA, FACHE
 Health Care System Director
 San Francisco VA Health Care System

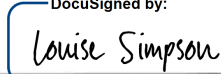
APPROVED

John F. Brown, M.D.
 Medical Director
 San Francisco LEMSA



APPROVED AS TO FORM

David Chiu
City Attorney

DocuSigned by:

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Louise S. Simpson
Deputy City Attorney

7/20/2023

Appendices

A: Statement of Work—Triage to Alternate Destination Facility

Appendix A – Triage to Alternate Destination Facility

STATEMENT OF WORK

I. Triage to Alternate Destination Facility and Program Approval Process

1. Pursuant to California Health and Safety Code Section 1851, no person or organization shall provide alternate destination Services unless authorized by LEMSA and approved by the State EMS Authority in accordance with California Health and Safety Code Section 1835. Any Facility seeking to obtain a Certificate of Participation must:

- a. **Application:** Apply to LEMSA, by submitting all necessary information and paying all applicable fees, and
- b. **Program Review:** Participate in a Program review to integrate Facility into the San Francisco Emergency Medical Services Plan, under California Health and Safety Code Sections 1797.250 and 1797.252 to ensure compliance with local and state regulatory standards such as California Health and Safety Code Sections 1800 – 1857 and Cal. Code Regs. Tit. 22, Sections 100181 - 100193.

II. General Requirements For Facility

1. Approved Facility shall perform as follows:

- a. Verify that all Facility personnel used for alternate destination Services are licensed medical and professional staff.
- b. Certify and provide documentation to LEMSA and the EMS Authority showing that Facility is authorized to receive patients and maintains adequate licensed medical and professional staff, facilities, and equipment that comply with the requirements of LEMSA and the EMS Authority. This includes, but not limited to, identification of qualified staff to care for the degree of a patient's injuries and needs; certification of standardized medical and nursing procedures for nursing staff; and certification that the necessary equipment and services are available at Facility to care for patients, including, but not limited to, an automatic external defibrillator and at least one bed or mat per individual patient.
- c. Notify LEMSA within 24 hours if there are changes in the status of Facility with respect to protocols and the Facility's ability to care for patients.
- d. Operate in accordance with California Health and Safety Code Section 1317. Failure to operate in accordance with California Health and Safety Code Section 1317 may result in immediate termination of this MOU.
- e. Ensure competency and compliance of Facility personnel through exams, training, and continuing education with LEMSA local medical control and oversight.
- f. Ensure Facility training programs, curriculum, administration, record-keeping, faculty and instructors meet or exceed compliance with Cal. Code Regs. Tit. 22, §§ 100187 – 100189.
- g. Follow all state regulations and LEMSA Policies (all LEMSA policies can be found at sf.gov/emsa).
- h. Participate in an annual review by the LEMSA. LEMSA or the EMS Authority may take potential adverse actions, such as denial, probation, suspension, or revocation of Facility for failure to

comply with applicable policies and regulations. The process for such action is listed in California Health and Safety Code Section 1835 and Cal. Code Regs. Tit. 22, § 100184.

2. Emergency Medical Services (“EMS”) System Committees:

Facility must participate (attend a minimum of 75% of Committee meetings annually) in the following EMS System Committees which will be convened on a periodic basis, but not greater than a six-month interval, by the LEMSA:

- a. Emergency Medical Services Advisory Committee (“EMSAC”)
- b. Quality Improvement Committee
- c. Other Committees determined by the LEMSA

3. Performance Standards – Facility Shall:

a. Comply with all state laws and regulations regarding the provision of EMS and Triage to Alternate Destination Services.

b. Comply with all provisions, including fee provisions, of San Francisco Health Code, Articles 3 (Hospitals) and 14 (Ambulances and Routine Medical Transport Vehicles), including any and all amendments thereto, if any, whether enacted before or during the term of this MOU and any extensions.

c. Comply with all LEMSA EMS Policies, Procedures and Protocols, and Directives as approved and amended.

d. Comply with the Emergency Medical Treatment and Labor Act (“EMTALA”) (42 U.S.C § 1395dd) and the regulations promulgated thereunder for any receipt or transfer of a patient.

e. Facility shall ensure that a patient who is transported to Facility and, upon assessment, is found to no longer meet the criteria for admission to an Facility, be immediately transported to the emergency department of a general acute care hospital.

f. Facility shall send with each patient at the time of transfer or, in the case of an emergency, as promptly as possible, copies of all medical records related to the patient’s transfer. The requirements in California Health and Safety Code Section 1831 do not apply if the Facility has entered into a written transfer agreement with a local hospital that provides for the transfer of medical records.

g. Facility shall accommodate privately or commercially insured, Medi-Cal, Medicare, and uninsured patients.

4. Documentation, Data Submission, and Quality Improvement:

a. Facility shall comply with Cal. Code Regs. Tit. 22, Sections 100185 and 100171 related to the provision of Services.

b. In compliance with Cal. Code Regs. Tit. 22, Section 100185, Facility shall exchange patient health information (HIE) between community paramedicine or triage to alternate destination Providers and health providers and Facilities. Should Facility be unable to establish an (HIE), a plan to establish such exchange shall be submitted to LEMSA to request a waiver from the EMS Authority.

c. Facility shall submit quarterly summaries of patient outcomes to the LEMSA as listed in Cal. Code Regs. Tit. 22, Section 100185.

5. Incident Reporting

a. Facility shall file (by email exceptionreport@sfgov.org) an Exception Report form (form is located at <https://sf.gov/emsa>) consistent with LEMSA Policy No. 6020 within time frame reporting requirements set forth in LEMSA Policy No. 6020.

**City and County of San Francisco
San Francisco Department of Emergency Management
Emergency Medical Services Agency
333 Valencia St, Suite 210
San Francisco, California 94103**

**Agreement between the City and County of San Francisco,
acting by and through its Department of Emergency Management
and**

**San Francisco Fire Department (“SFFD”), EMS Division, Community Paramedicine and Triage to
Alternate Destination Provider**

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This Memorandum of Understanding (“MOU”) is made on July 21, 2023 in the City and County of San Francisco, State of California, by and between the City and County of San Francisco, acting by and through its San Francisco Fire Department (“SFFD”), and the City and County of San Francisco, acting by and through its Department of Emergency Management (“DEM”).

Recitals

WHEREAS, the San Francisco Department of Emergency Management is the designated local Emergency Medical Services Agency (“LEMSA”) for the City and County of San Francisco, under California Health and Safety Code Section 1797.200; and

WHEREAS, California Health and Safety Code §§ 1797.204, 1797.220, and 1797.222, authorize and require LEMSAs to plan, implement, and evaluate the EMS system, including destination and transport policies; and

WHEREAS, the passage of the Community Paramedicine or Triage to Alternate Destination Act of 2020 was passed under Assembly Bill 1544, effective January 1, 2021, requiring all pilot Community Paramedic and Triage to Alternate Destination providers, programs, and facilities to cease operations on October 31, 2023 or meet statutory and regulatory requirements under the Community Paramedicine or Triage to Alternate Destination Act of 2020.

WHEREAS, California Health and Safety Code Section 1841, requires a LEMSAs, that elects to develop Community Paramedicine and/or Triage to Alternate Destination programs, to provide medical control and oversight, facilitate agreements with Community Paramedicine and/or Triage to Alternate Destination Providers for the delivery of Community Paramedicine and/or Triage to Alternate Destination Services, and integrate Community Paramedicine and/or Triage to Alternate Destination Programs in the LEMSAs emergency medical services plan under California Health and Safety Code Section 1797.250; and

WHEREAS, California Health and Safety Code Section 1842, authorizes and requires LEMSAs to provide a first right of refusal to the public agency, SFFD, within the jurisdiction of the proposed program area to provide the proposed program specialties for Community Paramedicine; and

WHEREAS, California Health and Safety Code Section 1843, authorizes and requires LEMSAs to utilize existing Advanced Life Support providers, including public agencies, within the jurisdiction of the proposed program area to provide the proposed program specialties for Triage to Alternate Destination; and

WHEREAS, California Health and Safety Code Section 1843 provides that an ALS provider who is authorized to provide emergency medical transport services pursuant to Section 1797.224 may enter into agreements with public agency ALS providers to deliver triage to alternate destination program specialties without impairing or altering an existing right to provide emergency medical transportation services pursuant to Section 1797.224; and

WHEREAS, entering into an agreement to be a Community Paramedicine and/or Triage to Alternate Destination Provider shall not alter, impair, or otherwise supersede California Health and Safety Code 1797.201 or 1797.224, or any existing rights thereunder; and

WHEREAS, Parties wish to make SFFD a recognized and approved Community Paramedicine and/or Triage to Alternate Destination Provider and Training Program permitted by LEMSAs; and

Now, **THEREFORE**, the Parties agree as follows:

Article 1 Definitions

The following definitions apply to this MOU:

1.1. **“Advanced Life Support”** means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.

1.2. **“Alternate Destination Facility”** means a transport location that is an authorized mental health facility or sobering center as defined in California Health and Safety Code Sections 1812-1813.

1.3. **“Community Paramedic”** means a paramedic licensed under California Health and Safety Code who has completed the curriculum for community paramedic training pursuant to Section 1830, has received certification in one or more of the community paramedicine program specialties described in Section 1815, and is accredited to provide community paramedic services by a LEMSA as part of an approved community paramedicine program.

1.4. **“Community Paramedicine Program”** means a program developed by a LEMSA and approved by the state Emergency Medical Services Authority (“Authority”) to provide community paramedicine services consisting of one or more of the program specialties described in Section 1815 as providing case management services to frequent emergency medical services users in collaboration with, and by providing referral to, existing appropriate community resources, under the direction of medical protocols developed by the LEMSA that are consistent with the minimum medical protocols established by the Authority.

1.5. **“Confidential Information”** means confidential City information including, but not limited to, personally-identifiable information (“PII”), protected health information (“PHI”), or individual financial information (collectively, “Proprietary or Confidential Information”) that is subject to local, state or federal laws restricting the use and disclosure of such information, including, but not limited to, Article 1, Section 1 of the California Constitution; the California Information Practices Act (Civil Code § 1798 et seq.); the California Confidentiality of Medical Information Act (Civil Code § 56 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §§ 6801(b) and 6805(b)(2)); the privacy and information security aspects of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act (45 CFR Part 160 and Subparts A, C, and E of part 164); and San Francisco Administrative Code Chapter 12M (Chapter 12M).

1.6. **“Hospital”** means an acute care hospital licensed in California with at least a permit for basic emergency service.

1.7. **“Local EMS Agency (LEMSA)”** means the San Francisco EMS Agency having primary responsibility for administration of emergency medical services in the City and County of San Francisco as designated by California Health and Safety Code, Division 2.5, Section 1797.200.

1.8. **“LEMSA Medical Director”** means the San Francisco Director of Health, or his or her designee, responsible for the duties set forth in California Health and Safety Code, Division 2.5, Section 1797.202.

1.9. **“Provider”** means SFFD.

1.10. **“Medical Control”** means the medical direction and management of the EMS system pursuant to California Health and Safety Code, Division 2.5, Sections 1798 and 1841(b).

1.11. **“Triage Paramedic”** means a paramedic licensed under this division who has completed the curriculum for triage paramedic services and has been accredited by LEMSA in one or more of the triage paramedic specialties as part of an approved triage to alternate destination program.

1.12. **“Triage to Alternate Destination Program”** means a program developed by LEMSA and approved by the EMS Authority to provide triage paramedic assessments consisting of one or more specialties operating under protocols developed by LEMSA. Triage to alternate destination programs include: providing care and comfort services to hospice patients in their homes; providing patients with ALS triage, assessment by a triage paramedic, and transportation to an alternate destination facility; and providing transport services for patients who identify as veterans and desire transport to a local veterans administration emergency department for treatment, when appropriate.

1.13. **“Triage to Alternate Destination Provider”** means SFFD, which is an ALS provider authorized by LEMSA to provide advanced life support triage paramedic assessments as part of an approved triage to alternate destination program specialty.

Article 2 Term of the MOU

2.1 Initial Term.

The term of this MOU shall commence on July 21, 2023 and expire 9 years later on July 20, 2032, unless earlier terminated as otherwise provided herein.

2.2 Audit

SFFD agrees to maintain and make available to DEM, upon reasonable advance written notice and during regular business hours, all records related to the services provided by SFFD under this MOU, as required by applicable laws and regulations.

2.3 MOU Amendments.

2.3.1 **Formal Amendment.** This MOU may be amended only by a formal modification executed and approved in the same manner as the original MOU.

2.3.2 **No-Cost MOU:** This is a no-cost MOU.

Article 3 Services

3.1 Services

SFFD must provide the general services detailed in:

3.1.1 Appendix A (Community Paramedic Provider Statement of Work)

3.1.2 Appendix B (Triage to Alternate Destination Provider Statement of Work)

3.2 Qualified Personnel.

Community Paramedicine and/or Triage to Alternate Destination Provider shall ensure all Community Paramedicine and/or Triage to Alternate Destination Provider personnel are actively certified, licensed, and/or accredited in accordance with state and local policies and regulations in order to provide medical care as part of Community Paramedicine and/or Triage to Alternate Destination services.

3.3 Subcontracting

Community Paramedicine and/or Triage to Alternate Destination Provider may subcontract services under this MOU only with written approval of the LEMSA.

3.4 Reserved (Independent Contractor).

3.5 Assignment

The Services to be performed by Community Paramedicine and/or Triage to Alternate Destination Provider are personal in character. Neither this MOU, nor any duties or obligations hereunder, may be assigned unless first approved by LEMSA by written instrument executed and approved in the same manner as this MOU

3.6 Reserved (Activities at Community Paramedicine and/or Triage to Alternate Destination Provider's Expense).

3.7 Warranty.

Community Paramedicine and/or Triage to Alternate Destination Provider warrants that the Services will be performed with the degree of skill and care that is required by current, good and sound professional procedures and practices, and in conformance with generally all state, federal and local laws, regulations, requirements, and accepted professional standards prevailing at the time the Services are performed, so that all Services are performed as contemplated in this MOU as detailed in the Appendices.

Article 4 Reserved (Insurance and Indemnity).

Article 5 Reserved (Payment of Taxes).

Article 6 Termination and Default

6.1 Termination for Convenience

Either party may terminate this agreement for convenience by giving the other party ninety (90) days' prior written notice of termination. The notice shall specify the date on which termination shall become effective.

Article 7 Reserved (Rights In Deliverables)

Article 8 Additional Requirements Incorporated by Reference

8.1 Alcohol and Drug-Free Workplace.

SFFD agrees to maintain and enforce a policy that prohibits SFFD employees from performing any services under this MOU under the influence of any alcoholic beverage, illegal drug, or narcotic.

8.2 Nondiscrimination Requirements.

In the performance of this MOU, Community Paramedicine and/or Triage to Alternate Destination agrees that it will not discriminate against any individual because of race, color, religion, sex, age, ancestry, national origin, sexual orientation, handicap, veteran's status, medical condition (as defined in Section 12926 of the State of California Government Code), marital status, or citizenship because of habit, local custom, or otherwise.

Article 9 General Provisions

9.1 Notices to the Parties.

Unless otherwise indicated in this MOU, all written communications sent by the Parties may be by U.S. mail or e-mail, and shall be addressed as follows:

| | |
|--|--|
| To City: | Andrew Holcomb, MS, EMS Director, San Francisco EMS Agency Department of Emergency Management City and County of San Francisco 333 Valencia St, Suite 210, San Francisco, CA 94103 628-217-6014 andrew.holcomb@sfgov.org |
| To Community Paramedicine and/or Triage to Alternate Destination Provider: | Jeanine Nicholson, Chief of Department 698 2nd Street San Francisco, CA, 94107 415 558 3200 jeanine.nicholson@sfgov.org |

Any notice of default must be sent by registered mail or other trackable overnight delivery. Either Party may change the address to which notice is to be sent by giving written notice thereof to the other Party. If email notification is used, the sender must specify a receipt notice.

9.2 Compliance with Americans with Disabilities Act.

Community Paramedicine and/or Triage to Alternate Destination shall provide the Services in a manner that complies with the Americans with Disabilities Act (ADA), including but not limited to Title II's program access requirements, and all other applicable federal, state, and local disability rights legislation.

9.3 Sunshine Ordinance.

Community Paramedicine and/or Triage to Alternate Destination acknowledges that this MOU and all records related to its formation, Community Paramedicine and/or Triage to Alternate Destination's performance of Services, and City's payment are subject to the California Public Records Act, (California Government Code §6250 et. seq.), and the San Francisco Sunshine Ordinance, (San Francisco Administrative Code Chapter 67). Such records are subject to public inspection and copying unless exempt from disclosure under federal, state or local law.

9.4 MOU Made in California; Venue.

The formation, interpretation and performance of this MOU shall be governed by the laws of the State of California. Venue for all litigation relative to the formation, interpretation and performance of this MOU shall be in San Francisco.

9.5 Construction.

All paragraph captions are for reference only and shall not be considered in construing this MOU.

9.6 Entire Agreement.

This contract sets forth the entire agreement between the parties, and supersedes all other oral or written provisions. This MOU may be modified only as provided in Section 11.5, "Modification of this Agreement."

9.7 Compliance with Laws.

Community Paramedicine and/or Triage to Alternate Destination Provider shall keep itself fully informed of the City's Charter, codes, ordinances and duly adopted rules and regulations of the City and of all state, and federal laws in any manner applicable to Community Paramedicine and/or Triage to Alternate Destination Provider's performance of this MOU, and must at all times comply with such local codes, ordinances, and regulations and all applicable laws as they may be amended from time to time.

9.8 Severability.

Should the application of any provision of this MOU to any particular facts or circumstances be found by a court of competent jurisdiction to be invalid or unenforceable, then (a) the validity of other provisions of this MOU shall not be affected or impaired thereby, and (b) such provision shall be enforced to the maximum extent possible so as to effect the intent of the parties and shall be reformed without further action by the parties to the extent necessary to make such provision valid and enforceable.

9.9 Cooperative Drafting.

This MOU has been drafted through a cooperative effort, and both Parties have had an opportunity to have the MOU reviewed and revised by legal counsel. No Party shall be considered the drafter of this MOU, and no presumption or rule that an ambiguity shall be construed against the Party drafting the clause shall apply to the interpretation or enforcement of this MOU.

9.10 Third Party Beneficiaries.

No third parties are intended by the parties hereto to be third party beneficiaries under this MOU, and no action to enforce the terms of this MOU may be brought against either party by any person who is not a party hereto.

Article 10 Data and Security.

10.1 Reserved (City Data).

10.2 Covered Entities.

The Parties acknowledge that they are each a Covered Entity as defined in the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and are required to comply with the HIPAA Privacy Rule governing the access, transmission, and storage of health information and the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"). The Parties agree that any access, transmission, and storage of information under this Agreement shall comply with applicable laws and regulations.

Article 11 Signature

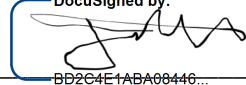
IN WITNESS WHEREOF, the parties hereto have executed this MOU on the day first mentioned above.

RECOMMENDED

Mary Ellen Carroll
Executive Director
Department of Emergency Management


DocuSigned by:
 7/28/2023
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Community Paramedicine and/or Triage to
Alternate Destination Provider
San Francisco Fire Department

DocuSigned by:
 7/27/2023
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Jeanine R. Nicholson
Chief of Department

APPROVED

John F. Brown, M.D.
Medical Director
San Francisco LEMS

DocuSigned by:
 7/28/2023
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Appendices

- A: Statement of Work–Community Paramedicine Provider
- B: Statement of Work–Triage to Alternate Destination Provider

Appendix A – Community Paramedicine Provider

STATEMENT OF WORK

I. Community Paramedicine Provider and Program Approval Process

1. Pursuant to California Health and Safety Code Section 1851 no person or organization shall provide community paramedicine services unless authorized by a LEMSA and approved by the EMS Authority in accordance with California Health and Safety Code Section 1835. Any Community Paramedic Provider seeking to obtain a Certificate of Participation must:

- a. **Application:** Apply to the LEMSA, by submitting all necessary information and paying all applicable fees, and
- b. **Program Review:** Participate in a program review required by the LEMSA to integrate a Community Paramedicine Program into the San Francisco Emergency Medical Services Plan under § 1797.250 and 1797.252 to ensure compliance with local and state regulatory standards such as California Health and Safety Code Sections 1800 – 1857 and Cal. Code Regs. Tit. 22, Sections 100181 - 100193.

II. General Requirements for Community Paramedicine Providers

1. Approved Community Paramedicine Providers shall perform as follows:

- a. Verify and maintain that all Community Paramedics used for community paramedic services are licensed and accredited by the LEMSA and working as an employee of an authorized Community Paramedicine Provider.
- b. Ensure competency and compliance of Community Paramedic personnel through exams, training, and continuing education with local medical control and oversight of Community Paramedicine.
- c. Ensure Community Paramedic training programs, curriculum, administration, record-keeping, faculty and instructors meet or exceed compliance with Cal. Code Regs. Tit. 22, Sections 100187 – 100189.
- d. Participate in an annual review by the LEMSA.
- e. Follow all state regulations and LEMSA Policies (all LEMSA policies can be found at sf.gov/emsa)
- f. Any discipline involving a Community Paramedic shall be consistent with established procedures under California Health and Safety Code § 1797.194 and LEMSA policies.
- g. LEMSA or State EMS Authority may take potential adverse actions, such as denial, probation, suspension, or revocation of Community Paramedicine Providers or Training Programs for failure to comply with applicable policies and regulations. The process for such action is listed in Health and Safety Code Section 1835 and Cal. Code Regs. Tit. 22, Section 100184.

2. Emergency Medical Services (“EMS”) System Committees:

All Community Paramedic Providers must participate (attend a minimum of 75% of Committee meetings annually) in the following EMS System Committees which will be convened on a periodic basis, but not greater than a six-month interval, by the LEMSA:

- a. Emergency Medical Services Advisory Committee (“EMSAC”)

- b. Quality Improvement Committee
- c. Other Committees determined by the LEMSA

3. Performance Standards – Community Paramedicine Provider Shall:

- a. Comply with all state laws and regulations regarding the provision of EMS and Community Paramedicine.
- b. Comply with all provisions, including fee provisions, of San Francisco Health Code, Articles 3 (Hospitals) and 14 (Ambulances and Routine Medical Transport Vehicles), including any and all amendments thereto, if any, whether enacted before or during the term of this MOU and any extensions.
- c. Comply with all LEMSA EMS Policies, Procedures and Protocols, and Directives as approved and amended.
- d. Comply with the Emergency Medical Treatment and Labor Act (“EMTALA”) (42 U.S.C § 1395dd) and the regulations promulgated thereunder for any receipt or transfer of a patient.

4. Documentation, Data Submission, and Quality Improvement:

- a. Community Paramedicine Provider shall comply with Cal. Code Regs. Tit. 22, Section 100185 and 100171 related to the provision of community paramedicine services.
- b. In compliance with Cal. Code Regs. Tit. 22, Section 100185, Community Paramedicine Provider shall exchange patient health information (HIE) between community paramedicine or triage to alternate destination providers and health providers and facilities. Should Community Paramedicine Provider be unable to establish an (HIE), a plan to establish such exchange shall be submitted to LEMSA to request a waiver from the Authority.
- c. Community Paramedicine Provider shall submit quarterly summaries of patient outcomes to the LEMSA as listed in Cal. Code Regs. Tit. 22, Section 100185.
- d. Community Paramedicine Provider shall submit a Quality Improvement Plan appendix and annual updates to existing LEMSA ALS Provider Quality Improvement Plan

5. Incident Reporting

- a. Community Paramedicine Provider shall file (by email exceptionreport@sfgov.org) an Exception Report form (form is located at <https://sf.gov/ems>) consistent with LEMSA Policy No. 6020 within time frame reporting requirements set forth in LEMSA Policy No. 6020.

6. Funding

- a. LEMSA shall facilitate funding discussions between Community Paramedic Provider and public or private health system participants to support the implementation of the LEMSA’s Community Paramedicine programs.

Appendix B – Triage to Alternate Destination Provider

STATEMENT OF WORK

I. Triage to Alternate Destination Provider and Program Approval Process

1. Pursuant to California Health and Safety Code Section 1851 no person or organization shall provide alternate destination services unless authorized by a LEMSA and approved by the Authority in accordance with California Health and Safety Code Section 1835. Any Triage to Alternate Destination Provider seeking to obtain a Certificate of Participation must:

- a. **Application:** Apply to the LEMSA, by submitting all necessary information and paying all applicable fees, and
- b. **Program Review:** Participate in a program review required by the LEMSA to integrate a Triage to Alternate Destination Program into the San Francisco Emergency Medical Services Plan under Sections 1797.250 and 1797.252 to ensure compliance with local and state regulatory standards such as California Health and Safety Code Sections 1800 – 1857 and Cal. Code Regs. Tit. 22, Sections 100181 - 100193.

II. General Requirements for Triage to Alternate Destination Providers

2. Approved Triage to Alternate Destination Provider shall perform as follows:

- a. Verify and maintain that all Triage Paramedics used for alternate destination services are licensed and accredited by the LEMSA and working as an employee of an authorized Triage to Alternate Destination Providers.
- b. Ensure competency and compliance of Triage to Alternate Destination personnel through exams, training, and continuing education with local medical control and oversight of Triage to Alternate Destination.
- c. Ensure Triage to Alternate Destination training programs, curriculum, administration, record-keeping, faculty and instructors meet or exceed compliance with Cal. Code Regs. Tit. 22, Sections 100187 – 100189.
- d. Follow all state regulations and LEMSA Policies (all LEMSA policies can be found at sf.gov/ems)
- e. Participate in an annual review by the LEMSA.
- f. Any discipline involving a Triage to Alternate Destination Paramedic shall be consistent with established procedures under California Health and Safety Code Section 1797.194 and LEMSA policies.
- g. The LEMSA or State EMS Authority may take potential adverse actions, such as denial, probation, suspension, or revocation of Triage to Alternate Destination Providers or Training Programs for failure to comply with applicable policies and regulations. The process for such action is listed in Health and Safety Code Section 1835 and Cal. Code Regs. Tit. 22, Section 100184.

3. Emergency Medical Services (“EMS”) System Committees:

All Triage to Alternate Destination Providers must participate (attend a minimum of 75% of Committee

meetings annually) in the following EMS System Committees which will be convened on a periodic basis, but not greater than a six-month interval, by the LEMSA:

- a. Emergency Medical Services Advisory Committee (“EMSAC”)
- b. Quality Improvement Committee
- c. Other Committees determined by the LEMSA

4. Performance Standards – Triage to Alternate Destination Provider Shall:

- a. Comply with all state laws and regulations regarding the provision of EMS and Triage to Alternate Destination.
- b. Comply with all provisions, including fee provisions if applicable, of San Francisco Health Code, Articles 3 (Hospitals) and 14 (Ambulances and Routine Medical Transport Vehicles), including any and all amendments thereto, if any, whether enacted before or during the term of this MOU and any extensions.
- c. Comply with all LEMSA EMS Policies, Procedures and Protocols, and Directives as approved and amended.
- d. Comply with the Emergency Medical Treatment and Labor Act (“EMTALA”) (42 U.S.C § 1395dd) and the regulations promulgated thereunder for any receipt or transfer of a patient.

5. Documentation, Data Submission, and Quality Improvement:

- a. Triage to Alternate Destination Provider shall comply with Cal. Code Regs. Tit. 22, Sections 100185 and 100171 related to the provision of triage to alternate destination services.
- b. In compliance with Cal. Code Regs. Tit. 22, Section 100185, Triage to Alternate Destination Provider shall exchange patient health information (HIE) between community paramedicine or triage to alternate destination providers and health providers and facilities. Should Triage to Alternate Destination Provider be unable to establish an (HIE), a plan to establish such exchange shall be submitted to LEMSA to request a waiver from the Authority.
- c. Triage to Alternate Destination Provider shall submit quarterly summaries of patient outcomes to the LEMSA as listed in Cal. Code Regs. Tit. 22, Section 100185.
- d. Triage to Alternate Destination Provider shall submit a Quality Improvement Plan appendix and annual updates to existing LEMSA ALS Provider Quality Improvement Plan

6. Incident Reporting

- a. Triage to Alternate Destination Provider shall file (by email exceptionreport@sfgov.org) an Exception Report form (form is located at <https://sf.gov/ems>) consistent with LEMSA Policy No. 6020 within time frame reporting requirements set forth in LEMSA Policy No. 6020.

7. Funding

- a. LEMSA shall facilitate funding discussions between Triage to Alternate Destination Provider and public or private health system participants to support the implementation of the LEMSA’s Triage to Alternate Destination programs

**City and County of San Francisco
San Francisco Department of Emergency Management
Emergency Medical Services Agency
333 Valencia St, Suite 210
San Francisco, California 94103**

**Agreement between the City and County of San Francisco,
acting by and through its Department of Emergency Management
and**

**Allied Medical Services of California, D.B.A. King-American Ambulance Company,
Triage to Alternate Destination Provider**

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This Memorandum of Understanding (“MOU”) is made August 1, 2023 in the City and County of San Francisco, State of California, by and between Allied Medical Services of California D.B.A. King-American Ambulance Company (“Provider”) and the City and County of San Francisco (“City”), acting by and through its Department of Emergency Management (“DEM”).

Recitals

WHEREAS, DEM is the designated local Emergency Medical Services Agency (“LEMSA”) for the City, under California Health and Safety Code Section 1797.200; and

WHEREAS, California Health and Safety Code Sections 1797.204, 1797.220, and 1797.222, authorize and require LEMSAs to plan, implement, and evaluate the Emergency Medical Services (“EMS”) system, including destination and transport policies; and

WHEREAS, the Community Paramedicine or Triage to Alternate Destination Act of 2020 (“Act”), passed under Assembly Bill 1544, effective January 1, 2021, requires all pilot Community Paramedic and Triage to Alternate Destination Providers, Programs, and Facilities to cease operations on October 31, 2023, or meet statutory and regulatory requirements under the Act.

WHEREAS, California Health and Safety Code Section 1841, requires a LEMSAs, that elects to develop a Triage to Alternate Destination program (“Program”), to provide medical control and oversight, facilitate agreements with Providers and Facilities for the delivery of Services, and integrate the Program into the LEMSAs emergency medical Services plan under California Health and Safety Code Section 1797.250; and

WHEREAS, California Health and Safety Code Section 1843 authorizes and requires LEMSAs to utilize existing Advanced Life Support providers, within the jurisdiction of the proposed program area to provide the proposed program specialties for Triage to Alternate Destination; and

WHEREAS, entering into an agreement to be a Provider shall not alter or otherwise supersede California Health and Safety Code Sections 1797.201 or 1797.224; and

Now, **THEREFORE**, the Parties agree as follows:

Article 1 Definitions

The following definitions apply to this MOU:

1.1. **“Advanced Life Support” or “ALS”** means special Services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.

1.2. **“Alternate Destination Facility” or “Facility”** means a transport location that is an authorized mental health facility or sobering center as defined in California Health and Safety Code Section Sections 1812-1813.

1.3. **“City”** means the City and County of San Francisco, a municipal corporation, acting by and through both its Department of Emergency Management.

1.4. **“Confidential Information”** means confidential City information including, but not limited to, personally-identifiable information (“PII”), protected health information (“PHI”), or individual

financial information (collectively, "Proprietary or Confidential Information") that is subject to local, state or federal laws restricting the use and disclosure of such information, including, but not limited to, Article 1, Section 1 of the California Constitution; the California Information Practices Act (Civil Code § 1798 et seq.); the California Confidentiality of Medical Information Act (Civil Code § 56 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §§ 6801(b) and 6805(b)(2)); the privacy and information security aspects of the Administrative Simplification provisions of the federal Health Insurance Portability and Accountability Act (45 CFR Part 160 and Subparts A, C, and E of part 164); and San Francisco Administrative Code Chapter 12M (Chapter 12M).

1.5. **"Hospital"** means an acute care hospital licensed in California with at least a permit for basic emergency service.

1.6. **"Local EMS Agency (LEMSA)"** means the San Francisco EMS Agency having primary responsibility for administration of emergency medical Services in the City and County of San Francisco as designated by California Health and Safety Code Section 1797.200.

1.7. **"LEMSA Medical Director"** means the San Francisco Director of Health, or his or her designee, responsible for the duties set forth in California Health and Safety Code Section 1797.202.

1.8. **"Medical Control"** means the medical direction and management of the EMS system pursuant to California Health and Safety Code Sections 1798 and 1841(b)

1.9. **"Services"** means all Services performed by Provider under this MOU.

1.10. **"Triage Paramedic"** means a paramedic licensed under this division who has completed the curriculum for triage paramedic Services and has been accredited by LEMSAs in one or more of the triage paramedic specialties as part of an approved triage to alternate destination program.

1.11. **"Triage to Alternate Destination Program" or "Program"** means a program developed by LEMSAs and approved by the EMS Authority to provide triage paramedic assessments consisting of one or more specialties operating under protocols developed by LEMSAs. Triage to alternate destination programs include: providing care and comfort Services to hospice patients in their homes; providing patients with ALS triage, assessment by a triage paramedic, and transportation to an alternate destination facility, and providing transport Services for patients who identify as veterans and desire transport to a local veterans administration emergency department for treatment, when appropriate.

1.12. **"Triage to Alternate Destination Provider" or "Provider"** means an ALS provider authorized by LEMSAs to provide advanced life support triage paramedic assessments as part of an approved triage to alternate destination program specialty, as described in California Health and Safety Code Section 1819.

Article 2 Term of the MOU

2.1 Initial Term.

The term of this MOU shall commence on August 1, 2023 and expire 9 years later on July 31, 2032, unless earlier terminated as otherwise provided herein. In no event may the term exceed ten years

Article 3 Fees

3.1 Fees.

As authorized by Cal. Code Regs. Tit. 22, Section 100193, and to the extent LEMSA is authorized by local ordinance for collection of fees, Provider agrees to pay fees authorized by LEMSA. Fees may be added or adjusted each year. Annually, LEMSA will publish a memorandum updating fees to be paid.

3.2 Audit

Provider agrees to maintain and make available to the City, upon reasonable advance written notice and during regular business hours, accurate records, including but not limited to patient care, staffing, operations, training records, and all other records relating to Provider Services performed under this MOU. Provider will permit City to audit such books and records related to all matters covered by this MOU.

3.3 MOU Amendments.

3.3.1 Formal Amendment. This MOU may be amended only by a formal modification executed and approved in the same manner as the original MOU.

3.3.2 No-Cost MOU: This is a no-cost MOU. In no event may the City compensate Provider under this MOU.

Article 4 Services

4.1 Services

Alternate Destination Facility must provide the general Services detailed in:

4.1.1 Appendix B (Triage to Alternate Destination Provider Statement of Work)

4.2 Qualified Personnel.

Provider shall ensure all Provider personnel are actively certified, licensed, and/or accredited in accordance with state and local policies and regulations in order to provide medical care as part of the Program Services.

4.3 Subcontracting

Provider may subcontract Services under this MOU only with written approval of the City.

4.4 Independent Contractor.

For the purposes of this Article 4, "Provider shall be deemed to include not only Provider, but also any agent or employee of Provider. Provider acknowledges and agrees that at all times, Provider or any agent or employee of Provider shall be deemed at all times to be an independent contractor wholly responsible for the manner in which it performs the Services under this MOU. Provider, its agents, and employees will not represent or hold themselves out to be employees of the City at any time. Provider or any agent or employee of Provider shall not have employee status with City, nor be entitled to participate in any plans, arrangements, or distributions by City pertaining to or in connection with any retirement, health or other benefits that City may offer its employees. Provider or any agent or employee of Provider is liable for the acts and omissions of itself, its employees and its agents. Provider shall be responsible for all obligations and payments, whether imposed by federal, state or local law, including, but not limited to, FICA, income tax withholdings, unemployment compensation, insurance, and other similar responsibilities related to Provider's Services. Nothing in this MOU shall be construed as creating an employment or agency relationship between City and Provider.

4.5 Assignment

Neither this MOU, nor any duties or obligations hereunder, may be assigned unless first approved by City by written instrument executed and approved in the same manner as this MOU

4.6 Activities at Provider's Expense.

Any act that Provider performs under this MOU shall be performed at Provider's expense.

4.7 Warranty.

"Provider warrants to City that the Services will be performed with the degree of skill and care that is required by current, good and sound professional procedures and practices, and in conformance with generally all state, federal and local laws, regulations, requirements, and accepted professional standards prevailing at the time the Services are performed, so that all Services are performed as contemplated in this MOU as detailed in the Appendices.

Article 5 Insurance and Indemnity

5.1 Insurance.

5.1.1 Required Coverages. Without in any way limiting Provider's liability pursuant to the "Indemnification" section of this MOU, Provider must maintain in force, during the full term of the MOU, insurance in the following amounts and coverages:

- (a) Workers' Compensation, in statutory amounts, with Employers' Liability Limits not less than \$1,000,000 each accident, injury, or illness; and
- (b) Commercial General Liability Insurance with limits not less than \$4,000,000 each occurrence, \$6,000,000 in the aggregate, for Bodily Injury and Property Damage, including Contractual Liability, Personal Injury, Products and Completed Operations; and
- (c) Commercial Automobile Liability Insurance with limits not less than \$4,000,000 each accident, "Combined Single Limit" for Bodily Injury and Property Damage, including Owned, Non-Owned and Hired auto coverage, as applicable.
- (d) Professional liability insurance, applicable to Provider's profession, with limits not less than \$5,000,000 each claim with respect to negligent acts, errors or omissions in connection with the Services. Policy will include Abuse and Molestation coverage.
- (e) Technology Errors and Omissions Liability coverage (RESERVED).
- (f) Cyber and Privacy Insurance with limits of not less than \$5,000,000 per claim. Such insurance shall include coverage for liability arising from theft, dissemination, and/or use of confidential information, including but not limited to, bank and credit card account information or personal information, such as name, address, social security numbers, protected health information or other personally identifying information, stored or transmitted in any form.
- (g) Provider shall be permitted to use umbrella, excess coverage and/or a program of self-insurance to meet the required limits for insurance in this section.

5.1.2 Additional Insured Endorsements

- (a) Commercial General Liability and Commercial Automobile Liability Insurance policies must be endorsed to name as additional insured the City and County of San Francisco, its Officers, Agents, and Employees.

5.1.3 All policies shall be endorsed to provide thirty (30) days' advance written notice to the City of cancellation or intended non-renewal. Notices shall be sent to the City address set forth in Section 11.1, entitled "Notices to the Parties."

5.1.4 The Workers' Compensation policy(ies) shall be endorsed with a waiver of subrogation in favor of the City for all work performed by the Provider, its employees, agents and subcontractors.

5.1.5 **Primary Insurance Endorsements.** Commercial General Liability and Automobile Liability policies are primary insurance to any other insurance available to the Additional Insureds, with respect to any claims arising out of this MOU, and that insurance applies separately to each insured against whom claim is made or suit is brought.

5.2 **General Indemnification.**

Provider shall indemnify and hold harmless City and its officers, agents and employees from, and, if requested, shall defend them from and against any and all claims, demands, losses, damages, costs, expenses, and liability (legal, contractual, or otherwise), including infringement and/or intellectual property claims ("Claims"), arising from Provider's performance of this MOU, except to the extent that such indemnity is void or otherwise unenforceable under applicable law, and except where such loss, damage, injury, liability or claim is the result of the active negligence or willful misconduct of City and is not contributed to by any act of, or by any omission to perform some duty imposed by law or agreement on Provider, its subcontractors, or either's agent or employee. Contractor shall also indemnify, defend and hold City harmless from all Claims for breach of federal and/or state law regarding the privacy of health information, electronic records or related topics.

Article 6 Liability of the Parties

6.1 **Liability for Incidental and Consequential Damages.**

IN NO EVENT EITHER PARTY BE LIABLE, REGARDLESS OF WHETHER ANY CLAIM IS BASED ON CONTRACT OR TORT, FOR ANY SPECIAL, CONSEQUENTIAL, INDIRECT OR INCIDENTAL DAMAGES, INCLUDING, BUT NOT LIMITED TO, LOST PROFITS, ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT OR THE SERVICES PERFORMED IN CONNECTION WITH THIS AGREEMENT

Article 7 Payment of Taxes (Reserved)

Article 8 Termination and Default

8.1 **Termination for Convenience**

Either party may terminate this agreement for convenience by giving the other party ninety (90) days' prior written notice of termination. The notice shall specify the date on which termination shall become effective. Any pre-paid fees are nonrefundable

Article 9 Rights In Deliverables (Reserved)

Article 10 Additional Requirements Incorporated by Reference

10.1 **Alcohol and Drug-Free Workplace.**

City reserves the right to deny access to, or require Provider to remove from performance of Services under this MOU personnel of any Provider who City has reasonable grounds to believe has engaged in alcohol abuse or illegal drug activity which in any way impairs City's ability to protect the health and well-being of City employees and the general public. Illegal drug activity means possessing, furnishing,

selling, offering, purchasing, using or being under the influence of illegal drugs or other controlled substances for which the individual lacks a valid prescription Alcohol abuse means possessing, furnishing, selling, offering, or using alcoholic beverages, or being under the influence of alcohol. For clarity, for purposes of this MOU “controlled substance” includes cannabis and derivative products.

10.2 Nondiscrimination Requirements.

In the performance of this MOU, Provider agrees that it will not discriminate against any individual because of race, color, religion, sex, age, ancestry, national origin, sexual orientation, handicap, veteran’s status, medical condition (as defined in Section 12926 of the State of California Government Code), marital status, or citizenship because of habit, local custom, or otherwise.

Article 11 General Provisions

11.1 Notices to the Parties.

Unless otherwise indicated in this MOU, all written communications sent by the Parties may be by U.S. mail or e-mail, and shall be addressed as follows:

| | |
|--------------|--|
| To City: | Andrew Holcomb, MS, EMS Director, San Francisco EMS Agency Department of Emergency Management City and County of San Francisco 333 Valencia St, Suite 210, San Francisco, CA 94103 628-217-6014 andrew.holcomb@sfgov.org |
| To Provider: | ALLIED MEDICAL SERVICES OF CALIFORNIA D.B.A. KING-AMERICAN AMBULANCE COMPANY 2570 BUSH STREET SAN FRANCISCO, CA 94115 ATTN: JOSH NULTEMEIER TITLE: OPERATIONS MANAGER/CHIEF PARAMEDIC EMAIL: JOSH@KINGAMERICAN.COM |

Any notice of default must be sent by registered mail or other trackable overnight delivery. Either Party may change the address to which notice is to be sent by giving written notice thereof to the other Party. If email notification is used, the sender must specify a receipt notice.

11.2 Compliance with Americans with Disabilities Act.

Provider shall provide the Services in a manner that complies with the Americans with Disabilities Act (ADA), including but not limited to Title II’s program access requirements, and all other applicable federal, state and local disability rights legislation.

11.3 Sunshine Ordinance.

Provider acknowledges that this MOU, all records related to its formation, and Provider’s performance of Services are subject to the California Public Records Act, (California Government Code §6250 et. seq.), and the San Francisco Sunshine Ordinance, (San Francisco Administrative Code Chapter 67). Such records are subject to public inspection and copying unless exempt from disclosure under federal, state or local law.

11.4 MOU Made in California; Venue.

The formation, interpretation and performance of this MOU shall be governed by the laws of the State of California. Venue for all litigation relative to the formation, interpretation and performance of this MOU shall be in San Francisco.

11.5 Construction.

All paragraph captions are for reference only and shall not be considered in construing this MOU.

11.6 Entire Agreement.

This contract sets forth the entire agreement between the parties, and supersedes all other oral or written provisions. This MOU may be modified only as provided in Section 11.5, "Modification of this Agreement."

11.7 Compliance with Laws.

Provider shall keep itself fully informed of the City's Charter, codes, ordinances and duly adopted rules and regulations of the City and of all state, and federal laws in any manner applicable to Provider's performance of this MOU, and must at all times comply with such local codes, ordinances, and regulations and all applicable laws as they may be amended from time to time.

11.8 Severability.

Should the application of any provision of this MOU to any particular facts or circumstances be found by a court of competent jurisdiction to be invalid or unenforceable, then (a) the validity of other provisions of this MOU shall not be affected or impaired thereby, and (b) such provision shall be enforced to the maximum extent possible so as to effect the intent of the parties and shall be reformed without further action by the parties to the extent necessary to make such provision valid and enforceable.

11.9 Cooperative Drafting.

This MOU has been drafted through a cooperative effort of City and Contractor, and both Parties have had an opportunity to have the MOU reviewed and revised by legal counsel. No Party shall be considered the drafter of this MOU, and no presumption or rule that an ambiguity shall be construed against the Party drafting the clause shall apply to the interpretation or enforcement of this MOU.

11.10 Third Party Beneficiaries.

No third parties are intended by the parties hereto to be third party beneficiaries under this MOU, and no action to enforce the terms of this MOU may be brought against either party by any person who is not a party hereto.

Article 12 Data and Security

12.1 City Data

12.1.1 Data Breach; Loss of City Data. In the event of any breach of City Data that compromises or is suspected to compromise the security, confidentiality, or integrity of City Data or the physical, technical, administrative, or organizational safeguards put in place by Provider that relate to the protection of the security, confidentiality, or integrity of City Data, Provider shall notify the City immediately following discovery, but no later than twenty-four (24) hours, of becoming aware of such

occurrence or suspected occurrence and shall thereafter cooperate with the City in accordance with the City's directives.

12.1.2 Data Privacy and Information Security Program. Without limiting Contractor's obligation of confidentiality as further described herein, Contractor shall establish and maintain a data privacy and information security program, including physical, technical, administrative, and organizational safeguards, that is designed to: (i) ensure the security and confidentiality of the City Data; (ii) protect against any anticipated threats or hazards to the security or integrity of the City Data; (iii) protect against unauthorized disclosure, access to, or use of the City Data; (iv) ensure the proper disposal of City Data; and, (v) ensure that all of Contractor's employees, agents, and subcontractors, if any, comply with all of the foregoing.

12.1.3 Data Transmission. Contractor shall ensure that all electronic transmission or exchange of City Data will be encrypted using current industry standards. Contractor shall also ensure that all data exchanged shall be used expressly and solely for the purposes stated in the MOU. City Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Contractor not involved in administration of this MOU, unless otherwise permitted in this MOU. The Provider shall ensure that no City Data of any kind shall be copied, modified, destroyed, deleted, transmitted, exchanged or otherwise passed to other vendors or interested parties except on a case-by-case basis as specifically agreed to in writing by City.

12.2 Business Associate Agreement.

The City represents that it is a Covered Entity as defined in the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and is required to comply with the HIPAA Privacy Rule governing the access, transmission, and storage of health information and the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act").

In accordance with applicable laws, the parties acknowledge that Provider will:

1. ☐ Do **at least one** or more of the following:
 - A. Create, receive, maintain, or transmit PHI for or on behalf of CITY (including storage of PHI, digital or hard copy, even if Provider does not view the PHI or only does so on a random or infrequent basis); or
 - B. Receive PHI, or access to PHI, from CITY or another Business Associate of City, as part of providing a service to or for CITY, including legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial; or
 - C. Transmit PHI data for CITY and require access on a regular basis to such PHI. (Such as health information exchanges (HIEs), e-prescribing gateways, or electronic health record vendors)

FOR PURPOSES OF THIS MOU, PROVIDER IS A BUSINESS ASSOCIATE OF CITY, AS DEFINED UNDER HIPAA. PROVIDER MUST COMPLY WITH AND COMPLETE THE FOLLOWING ATTACHED DOCUMENTS, INCORPORATED TO THIS MOU AS THOUGH FULLY SET FORTH HEREIN:

A. Appendix E Business Associate Agreement (BAA) (04-12-2018)

1. Attestation 1 PRIVACY (06-07-2017)
2. Attestation 2 DATA SECURITY (06-07-2017)

2. ☒ **NOT do any of the activities listed above in subsection 1;**
LEMSA (DEM) and Provider are both Covered Entities. No BAA is required for the purposes of this MOU.

12.3 Protected Health Information.

Provider and all agents and employees shall comply with all federal and state laws regarding the transmission, storage and protection of all private health information disclosed to Provider by City in the performance of this MOU. Provider agrees that any failure of Contactor to comply with the requirements of federal and/or state and/or local privacy laws shall be a material breach of the Contract. In the event that City pays a regulatory fine, and/or is assessed civil penalties or damages through private rights of action, based on an impermissible use or disclosure of protected health information given to Provider or its subcontractors or agents by City, Provider shall indemnify City for the amount of such fine or penalties or damages, including costs of notification. In such an event, in addition to any other remedies available to it under equity or law, the City may terminate the Contract.

Article 13 MacBride And Signature**13.1 MacBride Principles -Northern Ireland.**

The provisions of San Francisco Administrative Code §12F are incorporated herein by this reference and made part of this MOU. By signing this MOU, Provider confirms that Provider has read and understood that the City urges companies doing business in Northern Ireland to resolve employment inequities and to abide by the MacBride Principles, and urges San Francisco companies to do business with corporations that abide by the MacBride Principles.

IN WITNESS WHEREOF, the parties hereto have executed this MOU on the day first mentioned above.

RECOMMENDED

Mary Ellen Carroll
Executive Director
Department of Emergency Management

DocuSigned by:

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7/18/2023

APPROVED

John F. Brown, M.D.
Medical Director
San Francisco LEMSAs


DocuSigned by:

DD821142FB724F0...

7/18/2023

Provider

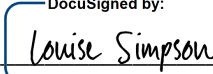
Allied Medical Services of California
D.B.A. King-American Ambulance Company

DocuSigned by:

F1DC87A81887450...
Josh Nultemeier
Operations Manager/Chief Paramedic

7/18/2023

APPROVED AS TO FORM

David Chiu
City Attorney

DocuSigned by: 7/20/2023


Louise S. Simpson
Deputy City Attorney

Appendices

B: Statement of Work–Triage to Alternate Destination Provider

Appendix B – Triage to Alternate Destination Provider

STATEMENT OF WORK

I. Triage to Alternate Destination Provider and Program Approval Process

1. Pursuant to California Health and Safety Code Section 1851, no person or organization shall provide alternate destination Services unless authorized by, LEMSA and approved by the State EMS Authority, in accordance with California Health and Safety Code Section 1835. Any Triage Provider seeking to obtain a Certificate of Participation must:

- a. **Application:** Apply to the LEMSA, by submitting all necessary information and paying all applicable fees, and
- b. **Program Review:** Participate in a Program review to integrate Provider into the San Francisco Emergency Medical Services Plan, under California Health and Safety Code Sections 1797.250 and 1797.252 to ensure compliance with local and state regulatory standards such as California Health and Safety Code Sections 1800 – 1857 and Cal. Code Regs. Tit. 22, Sections 100181 - 100193.

II. General Requirements For Provider

2. Approved Provider shall perform as follows:

- a. Verify that all Triage Paramedics used for alternate destination Services are licensed and accredited by the LEMSA and working as an employee of Provider.
- b. Ensure competency and compliance of Provider personnel through exams, training, and continuing education with LEMSA local medical control and oversight.
- c. Ensure Provider training programs, curriculum, administration, record-keeping, faculty and instructors meet or exceed compliance with Cal. Code Regs. Tit. 22, Sections 100187 – 100189.
- d. Follow all state regulations and LEMSA Policies (all LEMSA policies can be found at sf.gov/emsa)
- e. Participate in an annual review by the LEMSA. The LEMSA or State EMS Authority may take potential adverse actions, such as denial, probation, suspension, or revocation of Triage to Alternate Destination Providers or Training Programs for failure to comply with applicable policies and regulations. The process for such action is listed in Health and Safety Code Section 1835 and Cal. Code Regs. Tit. 22, Section 100184. Any discipline involving a Triage to Alternate Destination Paramedic shall be consistent with established procedures under California Health and Safety Code Section 1797.194 and LEMSA policies.

3. Emergency Medical Services (“EMS”) System Committees:

Provider must participate (attend a minimum of 75% of Committee meetings annually) in the following EMS System Committees which will be convened on a periodic basis, but not greater than a six-month interval, by the LEMSA:

- a. Emergency Medical Services Advisory Committee (“EMSAC”)
- b. Quality Improvement Committee
- c. Other Committees determined by the LEMSA

4. Performance Standards –Provider Shall:

a. Comply with all state laws and regulations regarding the provision of EMS and Triage to Alternate Destination Services.

b. Comply with all provisions, including fee provisions, of San Francisco Health Code, Articles 3 (Hospitals) and 14 (Ambulances and Routine Medical Transport Vehicles), including any and all amendments thereto, if any, whether enacted before or during the term of this MOU and any extensions.

c. Comply with all LEMSA EMS Policies, Procedures and Protocols, and Directives as approved and amended.

d. Comply with the Emergency Medical Treatment and Labor Act (“EMTALA”) (42 U.S.C § 1395dd) and the regulations promulgated thereunder for any receipt or transfer of a patient.

5. Documentation, Data Submission, and Quality Improvement:

a. Provider shall comply with Cal. Code Regs. Tit. 22, Sections 100185 and 100171 related to the provision of Services.

b. In compliance with Cal. Code Regs. Tit. 22, Section 100185, Provider shall exchange patient health information (HIE) between community paramedicine or triage to alternate destination Providers and health providers and Facilities. Should Provider be unable to establish an (HIE), a plan to establish such exchange shall be submitted to LEMSA to request a waiver from the Authority.

c. Provider shall submit quarterly summaries of patient outcomes to the LEMSA as listed in Cal. Code Regs. Tit. 22, Section 100185.

d. Provider shall submit a Quality Improvement Plan appendix and annual updates to existing LEMSA ALS Provider Quality Improvement Plan

6. Incident Reporting

a. Provider shall file (by email exceptionreport@sfgov.org) an Exception Report form (form is located at <https://sf.gov/ems>) consistent with LEMSA Policy No. 6020 within time frame reporting requirements set forth in LEMSA Policy No. 6020.

7. Funding

a. LEMSA shall facilitate funding discussions between Provider and public or private health system participants to support the implementation of the LEMSA’s Program.

SECTION V – Agreements
(Placeholder for AMR TAD Agreement)



**Department of Emergency Management
Emergency Medical Services Agency**
333 Valencia St., Suite 210, San Francisco, CA 94103
Phone: (628) 217-6000 Fax: (628) 217-6001



London Breed
Mayor

Mary Ellen Carroll
Executive Director

Date: September 1, 2023

To: Elizabeth Basnett, Acting Director, EMS Authority
Hernando Garzon, MD, Acting Medical Director, EMS Authority
Tom McGinnis, Chief, EMS Division, EMS Authority

From: Andrew Holcomb, EMS Director

Re: Community Paramedicine and Triage to Alt. Destination EMS Plan – Additional Submissions

Based on feedback from the EMS Authority on August 31, 2023 related to San Francisco EMS Agency's (SFEMSA) submission of plan documents required under the Community Paramedicine or Triage to Alternate Destination Act of 2020, specifically California Health and Safety Code (HSC) §§ 1835, 1840-1843 and California Code of Regulations (CCR), Title 22, § 100190, please see the following attachments:

- §§ 100192(b), 100192(f), and 100192(j) – Memo dated August 31, 2023 to San Francisco EMS Agency EMS Certifications and Enforcement Unit
- § 100193 – Memo outlining Community Paramedicine Provider and Accreditation fees. For fiscal year 2023-2024, San Francisco does not charge for Triage to Alternate Destination Provider, Facility or Accreditation fees.
- § 100189(e)(1) – Statement signed September 1, 2023 by San Francisco Fire Department's Community Paramedicine Medical Director and Program Director
- § 100189(h)(1, 3) – Highlighted change in SFEMSA Policy Section 13. SFEMSA will revise and release as an immediate policy release to go into effect October 1, 2023.

Please contact me directly with any additional questions or concerns.

Andrew Holcomb
EMS Director, EMS Agency
andrew.holcomb@sfgov.org
628-217-6014

Cc: Dr. John Brown, EMS Agency Medical Director
Rob Smuts, DEM Deputy Director
Mary Ellen Carroll, DEM Executive Director
Christina Fletes-Romo, Deputy City Attorney



City and County of San Francisco
London Breed, Mayor

Department of Emergency Management
Emergency Medical Services Agency

Date: August 31, 2023

To: Kayleigh Hillcoat, EMS Deputy Director, Operations
Camilla Arcia, Office Manager
Ronald Pike, EMS Specialist
Somersby Jenkins, EMS Certifications Specialist

From: Andrew Holcomb, EMS Director 

Subject: **Community Paramedicine and Triage to Alternate Destination Accreditation Requirements**

As you are assigned to the EMS Certifications and Enforcement Unit for our Local EMS Agency, you are required to complete the following under the provisions of our Community Paramedicine and Triage to Alternate Destination programs:

- Update the Central Registry within five (5) business days of an application being approved for Community Paramedicine and/or Triage to Alternate Destination Accreditation
- Notate date of application approval and renewal in our internal local certifications database for both Community Paramedicine and Triage to Alternate Destination Accreditation

Additionally, Deputy Director Hillcoat is responsible for completing the EMS Authority form with EMS Certifications Unit assistance. Under California Health and Safety Code, Title 22, Division 9, Chapter 5, Section 100192(j), the form shall be submitted to the EMS Authority on the following intervals:

- January 30, April 30, July 30, October 30

At minimum, please ensure the form is completed and submitted to the EMS Authority 15 days ahead of the deadline.

EMS Agency Certification

| | Community Paramedic | Triage Paramedic |
|---|---------------------|------------------|
| Total certified and accredited | | |
| Number newly certified this year | | |
| Number recertified this year | | |
| Total accredited on July 1 of reporting year | | |
| Number of certification reviews resulting in: | | |
| • Formal investigations | | |
| • Probation | | |
| • Suspensions | | |
| • Revocations | | |
| • Denials | | |
| • No action taken | | |

If you have any questions, please contact your supervisor. Thank you for your diligence and support to ensure compliance with state regulations.

San Francisco EMS Agency
333 Valencia, Suite 210 • San Francisco, CA 94103
Phone (628) 217-6000 • sf.gov/emsa




City and County of San Francisco
London N. Breed, Mayor

Department of Emergency Management
Emergency Medical Services Agency

Date: August 1, 2023

To: San Francisco County EMS Providers
Receiving Hospitals and Specialty Centers
EMS Training Programs
Event Medical Planners and Promoters

From: Andrew Holcomb 
EMS Director
Department of Emergency Management (DEM)

Re: Fee Schedule for Fiscal Year 2023 - 2024

The San Francisco EMS Agency fees for Fiscal Year 2023-2024 (FY24) have been approved. Attached is a Fee Schedule for your reference outlining the description of services and the new fees that begin with FY24. The FY24 fee schedule includes several new fees. The new fees will be reflected on future invoices, EMT and Paramedic Applications, and will be posted on the EMS Agency Website. Annual invoicing will begin in early September 2023.

For future fiscal years (July 1 – June 30), a fee increase is continued to be anticipated for all fee types.

Please contact the EMS Agency if you have any additional questions.

Cc: Mary Ellen Carroll, DEM Executive Director
Rob Smuts, DEM Deputy Director
Will Lee, DEM Deputy Director
John Brown, EMS Agency Medical Director

Emergency Medical Services Agency

Fee Schedule for Fiscal Year 2023-2024

The new fees noted in this section are effective for FY24.

| Description of Services | FY 22-23 Fees | FY 23-24 Fees |
|--|---------------|---------------|
| Initial Application for Certificate of Operation | 12,800.00 | 13,517.00 |
| Annual Ambulance Renewal | 6,400.00 | 6,758.00 |
| Annual Ambulance Permit | 2,048.00 | 2,163.00 |
| Initial Training Program Application for EMT-P | 2,272.00 | 2,399.00 |
| Initial Training Program Application for EMT | 1,517.00 | 1,602.00 |
| Initial Training Program Application for CE | 762.00 | 805.00 |
| Renewal Training Program Application for EMT-P | 1,139.00 | 1,203.00 |
| Renewal Training Program Application for EMT | 832.00 | 879.00 |
| Renewal Training Program Application for CE | 461.00 | 487.00 |
| Initial EMT Certificate | 183.00 | 193.00 |
| Renewal EMT Certificate | 135.00 | 143.00 |
| Initial and Lapsed EMT-P Accreditation | 40.00 | 42.00 |
| Initial and Lapsed Critical Care Paramedic Endorsement | N/A | 42.00 |
| Initial and Lapsed Community Paramedic Accreditation | N/A | 42.00 |
| Lost/Duplicate Card Fee | N/A | 25.00 |
| Professional Verification Form Completion Fee | N/A | 25.00 |
| Receiving Hospital | 19,523.00 | 20,616.00 |
| STEMI Heart Attack Center | 23,861.00 | 25,197.00 |
| Stroke Center | 23,861.00 | 25,197.00 |
| Trauma Center | N/A | 25,197.00 |
| Pediatric Center | N/A | 25,197.00 |
| Initial Community Paramedicine Provider | N/A | 200,000.00 |
| Renewal Community Paramedicine Provider | N/A | 100,000.00 |
| Event Medical Plan Review Fee 1 to 999 Persons | N/A | 50.00 |
| Event Medical Plan Review Fee 1,000 to 4,999 Persons | N/A | 150.00 |
| Event Medical Plan Review Fee 5,000 to 9,999 Persons | N/A | 500.00 |
| Event Medical Plan Review Fee 10,000 Persons or More | N/A | 1,000.00 |

Statement of Education Standards Compliance

Community Paramedicine Training

The San Francisco Fire Department utilizes United States Department of Transportation National Education Standards (U.S. DOT) which includes learning and performance objectives.

The San Francisco Fire Department utilizes approved curriculum that meets the minimum training and curriculum standards set forth in Chapter 5, section 100189:

| Foundations of Community Paramedicine | Yes/No |
|--|--------|
| Subjects and theories to be learned <ul style="list-style-type: none"> • Overview of the US and California Healthcare systems and reimbursement • Overview of Public Health • Effect of the Affordable Care Act of development of Community Paramedicine nationally and in California • Roles of the Community Paramedic • Community Paramedic Scope of Practice • Legal and Ethical issues in client- and community-centered care • Chronic disease management • Subacute Disease Management • Personal Safety and Wellness • International Board of Specialty Certification • Research in evidence-based practice | Yes |
| Knowledge and Abilities Acquired Should Include <ul style="list-style-type: none"> • Understanding the relationship of the system of care as a Community Paramedic within Public Health • Advocating for the client and the health care team through an equity lens • Maintaining a health workplace stressor balance | Yes |
| Cultural Humility, Equity and Access within Community Paramedicine and Healthcare | |
| Subjects and theories to be learned <ul style="list-style-type: none"> • Social determinants of health • Biomedical ethics • Equity versus equality • Implicit bias in healthcare • Disparities in healthcare access and health outcomes by age, race, gender, ethnicity, language, ability status, socioeconomic status, mental health, and community, • Cultural humility as a framework for public health and Community Paramedic practice • Roles of the culturally effective Community Paramedic • Trauma-informed care | Yes |
| Knowledge and Abilities Acquired Should Include <ul style="list-style-type: none"> • Examination of potential biases toward clients and/or communities. • Application of evidence-based tools and models for practicing cultural humility in client-centered care. • Connect with culturally diverse/aware community partners. • Application of culturally effective Community Paramedic as a community advocate. | Yes |

| | |
|--|-----|
| <ul style="list-style-type: none"> • Access qualified interpreter services for language access and communication with clients and community. | |
| Interdisciplinary Collaboration and Systems of Care Navigation | |
| <p>Subjects and theories to be learned</p> <ul style="list-style-type: none"> • Healthcare coordination • Systems of care navigation • Outreach and advocacy for target and at-risk populations • Client referral • Documentation across disciplines • Overview of the subject areas of nutrition, palliative care, hospice care, end of life care, home health vs. home care, mental health care, and substance use care. | Yes |
| <p>Knowledge and Abilities Acquired Should Include</p> <ul style="list-style-type: none"> • Collegial communications with interdisciplinary team members • Appreciative inquiry with care team members • Interdependent relationships with team members • Appropriate referrals and system navigation | Yes |
| Client-centered Care | |
| <p>Subjects and theories to be learned</p> <ul style="list-style-type: none"> • Client approach and the biophysical assessment, including embedding cultural humility practices in client case management • Motivational Interviewing • Interventional Techniques • Crisis Intervention • Client assessment, referral, and education • Creating a care plan • Implementing a care plan • Resources for client case management • Service coordination and client counseling • Documentation and follow up | Yes |
| <p>Knowledge and Abilities Acquired Should Include</p> <ul style="list-style-type: none"> • Core proficiency in health assessment, referral, health education, service coordination, and client-centered counseling. • Create resource map and examine webs of resources • Create outreach strategies to connect client/community to resources | Yes |
| Community and Public Health | |
| <p>Subjects and theories to be learned</p> <ul style="list-style-type: none"> • Population based care • Health equity across populations • Epidemiology • Public Health Mission • Community health/needs assessment • Public Health disaster response • Prevention • Isolation and Quarantine • Public education • Interagency Communications | Yes |
| <p>Knowledge and Abilities Acquired Should Include</p> <ul style="list-style-type: none"> • Engages in public health planning and implementation • Develops resources that aid in public health responses • Coordinates and manages mass events | Yes |

In addition, the San Francisco Fire Department verifies utilization of:

- A minimum of two (2) formative examinations and one (1) final comprehensive competency-based examinations
- Education standards are met and is focused on the knowledge and skills needed to successfully complete the International Board of Specialty Certification (IBSC) examination.
- LEMSA approved Community Paramedicine course completion certificate.
- Documentation of successful student clinical and field internship performance, if applicable.

The San Francisco Fire Department attests to utilizing an appropriate training program facility and equipment.

The San Francisco Fire Department attests to utilizing examination securities and complies with student record keeping requirements (CE Provider).

Signed: _____ Dated: 9/1/2023

DocuSigned by:
Joseph Graterol
249F486EDDD044D...

Name and Title: Dr Joseph Graterol, San Francisco Fire Department Community Paramedicine Division Medical Director, Training Program Director, and Training Program Clinical Director

- 7.1.4. Approval of hospital clinical and field internship experience provisions.
- 7.1.5. Approval of instructor(s).
- 7.1.6. The program medical director will certify that guest educators invited by primary instructors to provide instruction or facilitation have the appropriate expertise to deliver the proposed educational content.
- 7.2. Program Director
 - 7.2.1. Each training program shall have a program director who shall meet the following requirements:
 - 7.2.1.1. Has knowledge or experience in local EMS protocol and policy,
 - 7.2.1.2. Is a board certified or board eligible California licensed emergency medicine physician, registered nurse, paramedic, or an individual who holds a baccalaureate degree in a related health field or in education, and
 - 7.2.1.3. Has education and experience in methods, materials, and evaluation of instruction including:
 - 7.2.1.4. A minimum of one (1) year experience in an administrative or management level position, and
 - 7.2.1.5. A minimum of three (3) years academic or clinical experience in prehospital care education
 - 7.2.2. Duties of the program director shall include, but not be limited to the following:
 - 7.2.2.1. Administration, organization, and supervision of the educational program.
 - 7.2.2.2. In coordination with the program medical director, approve the instructor(s), teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate the development of curriculum, including instructional objectives, and all methods of evaluation.
 - 7.2.2.3. Ensure training program compliance with this chapter and other related laws.
 - 7.2.2.4. Ensure that all course completion records include a signature verification.
 - 7.2.2.5. Ensure the preceptor(s) are trained according to the subject matter being taught.
- 7.3. Instructors
 - 7.3.1. Each training program shall have instructor(s), who are responsible for areas including, but not limited to, curriculum development, course coordination, and instruction and shall:
 - 7.3.1.1. Be a physician, registered nurse, physician assistant, nurse practitioner, paramedic, who is currently certified or licensed in the State of California,
 - 7.3.1.2. Have six (6) years' experience in an allied health field or community paramedicine, or four (4) years of experience in an allied health field and an associate degree or two (2) years of experience in an allied health field and a baccalaureate degree, and
 - 7.3.1.3. Be knowledgeable in the course content of the U.S. DOT National Emergency Medical Services Education Standards, and
 - 7.3.1.4. Be able to demonstrate expertise and a minimum of two (2) years of experience within the past five (5) years in the subject matter being taught by that individual, and
 - 7.3.1.5. Be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.
 - 7.3.1.6. An instructor may also be the program medical director or program director.

8. MINIMUM TRAINING AND CURRICULUM REQUIREMENTS

- 8.1. TAD program shall meet or exceed minimum training and curriculum requirements as listed in 22 CCR §§ 100189(e)(2), 100189(f), and 100189(h).
- 8.2. CP program shall meet or exceed minimum training and curriculum requirements as listed in 22 CCR §§ 100189(e)(1), 100189(g-h).

8.3. Required Testing

- 8.3.1. ISBC community paramedic exam approved paramedic training programs shall include a minimum of two (2) formative examinations and one (1) final comprehensive competency-based examinations to test the knowledge and skills specified in this chapter.
- 8.3.2. Triage paramedic approved programs shall include a minimum of one (1) final

comprehensive competency-based examination to test the knowledge and skills specified in this chapter.

8.3.3. Documentation of successful student clinical and field internship performance, if applicable.

9. TRAINING PROGRAM OVERSIGHT

- 9.1. A CP or TAD program's failure to comply with the provisions of statute, regulation, and/or any additional EMS Agency requirements may result in denial, probation, suspension, or revocation of approval by the EMS Agency.
- 9.2. The EMS Agency may conduct onsite visits, inspect, investigate, and discipline approved training programs for any violations or for failure to fulfill any additional requirements.
- 9.3. The requirements of training program noncompliance notification and actions are as follows:
 - 9.3.1. The EMS Agency shall provide written notification of noncompliance state and/or local standards and requirements to the training program provider. The notification shall be in writing by certified mail.
 - 9.3.2. Within fifteen (15) days from receipt of the noncompliance notification, the training program shall submit in writing to the EMS Agency one of the following:
 - 9.3.2.1. Evidence of compliance with the provisions of state and/or local standards and requirements, as applicable, or a plan to comply with the provisions of state and/or local standards and requirements, as applicable, within sixty (60) days from the day of receipt of the notification of noncompliance.
 - 9.3.2.2. Within fifteen (15) days from receipt of the training program's response, or within thirty (30) days from the mailing date of the noncompliance notification, if no response is received from the training program, the EMS Agency shall issue a decision letter by certified mail to the EMS Authority and the training program. The letter shall identify the EMS Agency's decision to take one or more of the following actions:
 - Accept the evidence of compliance provided.
 - Accept the plan for meeting compliance provided.
 - Place the training program on probation.
 - Suspend or revoke the training program approval.
 - 9.3.2.3 The decision letter shall also include, but need not be limited to, the following information:
 - Date of the EMS Agency's decision,
 - Specific provisions found noncompliant by the EMS Agency
 - The probation or suspension effective and ending date
 - The terms and conditions of the probation or suspension
 - The revocation effective date
 - 9.3.2.4 The EMS Agency shall establish the probation, suspension, or revocation effective dates.