PPE Shortages + COVID-19 Patient Management

Siren

Spring 2020

A Publication of the California Ambulance Association

CAA Conference and *Stars of Life* Update

CALIFORNIA AMBULANCE ASSOCIATION

CAA *Vision*

Assure delivery of excellent pre-hospital care to the people of California by promoting recognized industry best practices.

CAA *Mission*

Serve as the voice and resource on behalf of emergency and non-emergency ambulance services to promote effective and fiscally responsible EMS systems and standards.

CAA *Leadership*

California Ambulance Association
2520 Venture Oaks Way, Suite 150
Sacramento, CA 95833
(877) 276-1410 (toll free)
(916) 924-7323 (fax)
www.the-caa.org

SPRING 2020

Siren

A PUBLICATION OF THE CALIFORNIA AMBULANCE ASSOCIATION

Table *of Contents*

Editorial *Information*

Circulation among California's private ambulance providers, elected officials and EMSA administrators.

President's *Message*

Todd Valeri | President

Every day brings a new challenge. In my 38 years in EMS, this has always been the case. I have thrived on the often unpredictable, sometimes chaotic, nature of our industry, which could be said of most people who choose EMS as their career. As we gain experience, most of us learn to anticipate changes in the operating environment and adapt to meet the needs of the communities we serve; that is, until we faced the challenges brought about by the COVID-19 pandemic.

Early on when I began tracking the developing crisis in China, I had a certain degree of skepticism about it making its way to California in a significant way. Afterall, we had been warned in the past about SARS, MIRS and H1N1; yet neither seemed to have a big societal impact. In early March, it became clear that COVID-19 was becoming an international problem, but not to crisis levels. The number of cases and deaths were quickly escalating in Italy, cases began increasing across the globe, and it became clear the United States would not be spared.

During the week of March 8th, rumors began circulating in my community that the City of Fresno may be issuing a shelter in place order within a matter of days, although many still weren't convinced it would happen. On Saturday, March 14th, five days before the City of Fresno actually issued it's shelter in place order, I happened to look at my EMS system tracking app and noticed we were triple posted at all of our Metro posts. These unexpectedly high system levels remained throughout that weekend. By Monday morning, I realized we were facing a new operating environment and needed to respond quickly.

Every Monday morning at 9 am, I meet with our C-suite team to discuss the past week's results, activities for the week to come, and check-in on strategic objectives. The meeting on Monday, March 16th, took on a different tone. All of us in the room had anecdotally noticed our high levels throughout the weekend, but were shocked to see the dramatic drop in transports. Given that all ambulance services operate in a fee-for-service environment, whether private, public or non-profit, we knew we had to create a plan to address a significant drop in revenue, if this was our new norm. The outcome of that meeting was a high level framework that included scaling our operation to the new demand, and creating stability for our workforce, supply chain, and cashflow.

Scaling Operations

With an initial reduction of 20% of our transport volume, we knew there needed to be a corresponding decrease in unit hours from our demand-based coverage units without impacting geographic coverage or

Continued on page 2

President's *Message*

Continued from page 1

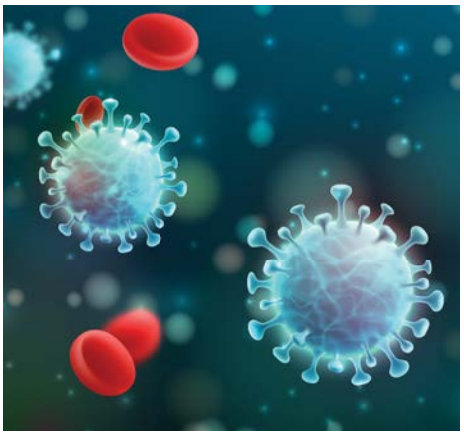
response performance. We also realized that whatever we did to reduce unit hours, we also needed the ability to rapidly ramp up capacity should we see a sudden surge in calls. Our plan included eliminating all overtime and using sunk-cost administrative personnel to cover unfilled shifts in the field and dispatch, encouraging vacations, and authorizing personal leaves of absence. Unfortunately, we also had to suspend an EMT orientation class and laid off three administrative employees. Everything we did can be quickly undone to allow us to meet increased demand for service. The net result was a 12% payroll reduction, which put us in a sustainable position without any response time or service compromise.

Workforce Stability

Even though we needed to rescale our operation, we also had to inspire confidence and protect a worried and at-risk workforce if we were to have a foundation for long term success. If at any point our employees lost confidence in leadership, things could quickly spiral out of control. We used a three-fold approach: communicate, communicate, communicate.... That started with a simple, but clear, message to the workforce from me, as the owner of the company, that no matter what, we would have their backs. This was followed by regular messaging regarding our COVID response from our Operations team and Medical Director. Since the outbreak, we have seen a dramatic decrease in the number of sick callouts. I attribute this both to our amazing dedicated employees and to our clear communication with the workforce, emphasizing a culture of safety, and letting people know how much people in the communities we serve depend on us.

Supply Chain Stability

Given the national shortage of supplies, it seems like everyone in the country now knows the term PPE. It also seems like everyone in the country wants to have PPE, which further complicates the supply chain. When we first realized getting PPE could be a challenge, we conservatively forecasted our burn rate to determine how long our inventory would last. The initial coverage was XX days, with no clear source for many items. That meant we had to both decrease our burn rate and find new sources.



We learned quickly that as the number of COVID-19 cases rose, so did the shortage of PPE. Our Operations and Support Services departments collaborated on tracking strategies designed to decrease our PPE burn rate, while ensuring the safety of our employees. PPE bags are now assigned to crews at log on with a predetermined amount of PPE. Usage rates are logged and the Operations staff compares the data to call types that occurred during the shift. Our Inventory Coordinator now sends daily "PPE Status" e-mails to Operations and Support Services leadership with updated inventory information, and the departments meet weekly to evaluate our current processes in a continually changing environment.

How do you increase PPE supply when everyone on the planet is vying for the same product? Our current cadre of large scale vendors has always been a reliable source, but we've also found success in securing PPE with smaller, secondary "gray" market distributors. Keeping up with new CDC guidelines has given us the flexibility to purchase alternative PPE, such as KN-95 masks, to supplement the surge in demand on the N-95 supply chain. Sharing information with other EMS organizations increased our number of purchasing opportunities. Our local EMS Agency has also been instrumental at a state level in helping us increase our inventory of PPE.

Managing Our Cashflow

Ambulance service is a high volume, low margin industry. Any prolonged cash flow interruption can be a challenge for even well capitalized organizations, whether private or public sector. We quickly did both an external and internal assessment to identify weak links. We immediately reached out to most of our large volume payers to confirm there wouldn't be claims processing interruptions. It was subsequently determined that insurance claims processing is an essential business, which allowed us to take that off the list of concerns.

Like most offices, the primary goal is to keep staff safe and working to maintain cash flow. We expanded work hours, eliminated physical meetings, implemented a work from home option for staff and followed CDC guidelines to develop a social distancing policy. To ensure communication, we have created a daily check in and check out of staff via e-mail. Finally, seeing transport levels were down, staff were reassigned to follow up work, researching unpaid tickets and contacting insurances to resolve disputed payments.

New Focus

Over 38 years, although every day brings a new challenge, I thought I had seen most of what could come our way. COVID-19 showed me there is no limit to the challenges we can face. We need to reflect on every aspect of this situation. Our new focus will be to reimagine our business continuity planning to include dramatic swings in volume, such that we hadn't previously experienced. If we don't use every moment of this crisis to find lessons and learn what we can, I think it will be disrespectful to so many who have died and the millions who continue to suffer physically, mentally and financially. ✱

Legislative & Agency Relations *Committee*

Myron Smith, Chair
Legislative & Agency Relations Committee

The CAA continues to monitor and actively engage our legislature with the help of our legislative advocacy firm, Arc Strategies. Many of the legislature's focus has shifted to COVID-19 related bills and responses. Arc Strategies has been meeting with members of the CAA Legislative Committee on a weekly basis.

Most of the Assembly and Senate have discontinued in person meetings for the immediate future. The Assembly has indicated they may move back into session as early as May 4th. The Senate originally set a return date of May 4th as well, however, we are hearing that this date may be pushed further based on COVID-19 curve data throughout California. We are clearly not out of the woods and will likely not return to business as usual for several weeks, perhaps even months from now.

There have been several bills of interest to our CAA members authored by Assembly Member Tasha Boerner-Horvath and Assembly Member Freddie Rodriguez. Both Assembly Members have indicated that they are considering holding those bills this year in an effort to address COVID-19 related budget and policy priorities, and will likely reintroduce those bills during the next legislative session.

To that end, despite the fact that potential legislation negatively affecting the emergency medical transport industry may be shelved this year, the current COVID-19 pandemic affects CAA members in many ways. Specifically, the CAA anticipates that ambulances will be needed to transport patients – both COVID-19 and non-COVID-19 – to and from hospitals as well as alternate destinations considering that the current authority allow for providing acute care services at licensed and non-licensed settings. Our advocates are working to ensure that all transports to and from alternative destinations are viewed as emergency medical transports by insurance companies at least until 90 days after the crisis period ends. There have been a few bills that attempted to change the statute to allow for alternative destinations prior to the pandemic, but have failed passage. We will continue to work diligently to prevent having patients' bills sent to collections during these financially uncertain times when they are transported to an alternative facility.

From a budget perspective, the following actions have been taken that have impacted California's ability to respond to the crisis:

- The Legislature passed SB 89 (Committee on Budget and Fiscal Review), Chapter 2, Statutes of 2020, on March 16, 2020, which appropriates up to $1 billion

Continued on page 4

Legislative & Agency Relations *Committee*

Continued from page 3

for any purpose related to the March 4, 2020 proclamation of a state of emergency related to the coronavirus. SB 89 established a process whereby the Administration must notify the Joint Legislative Budget Committee (JLBC) 72 hours prior to the use of any of the funds. To date, the Administration has notified the JLBC regarding the use of approximately $650 million from this appropriation (these funding requests are described in more detail later in the agenda).

- The Governor transferred $1.3 billion to the Disaster Response Emergency Operations Account (DREOA), bringing its balance to $1.4 billion. The DREOA is the source of funds that the Administration uses to quickly respond to emergencies. This account is within the Special Fund for Economic Emergencies.

- Through the Executive Order in which the Governor announced the DREOA transfer, he stipulated that he would utilize these funds and any other legally available state funds to help address the COVID-19 emergency. Making it clear that, if needed, he will use emergency powers to spend above the current balance of the DREOA.

The Federal Government has passed three COVID-19 funding packages:

- Phase I, the Coronavirus Preparedness and Response Supplemental Appropriations Act was enacted into law March 6, 2020 and provided $8.3 billion in emergency funding to treat and prevent the spread of COVID-19 through ensuring vaccines developed to fight the coronavirus are affordable, that impacted small businesses can qualify for Small Business Administration Economic Injury Disaster Loans and that Medicare recipients can consult with their providers by telephone or teleconference, if necessary or desired.

- Phase II, the Families First Coronavirus Response Act, became law March 18, 2020. This act provided for a $100 billion package that includes provisions for paid sick leave, free coronavirus testing, expanded food assistance, additional unemployment benefits, and requirements that employers provide additional protection for healthcare workers.

- Phase III, The Coronavirus Aid, Relief, and Economic Security Act (CARES) provides an estimated $2 trillion stimulus package to battle the harmful effects of the COVID-19 pandemic. Some of the major components of the CARES Act include:

  - Creates a $150 billion Coronavirus Relief Fund for state, local and tribal governments.

  - $30 billion for an Education Stabilization Fund for states, school districts and institutions of higher education for costs related to the coronavirus.

  - $45 billion for the Disaster Relief Fund for the immediate needs of state, local, tribal and territorial governments to protect citizens and help them respond and recover from the overwhelming effects of COVID-19.

  - $4.3 billion, thorough the Centers for Disease Control and Prevention, to support federal, state and local public health agencies to prevent, prepare for, and respond to the coronavirus.

  - $25 billion for transit systems.

  - Expanding unemployment insurance from three to four months, and provides temporary unemployment compensation of $600 per week, which is in addition to and the same time as regular state and federal UI benefits.

  - A $500 billion lending fund for businesses, cities and states.

  - $1,200 direct payments to many Americans and $500 for each dependent child. ✱

Steve Grau, Chair
Membership Development & Services Committee

Better Together

Geography has made us neighbors. History has made us friends. Economics has made us partners. And necessity has made us allies. Those whom God has so joined together, let no man (or pandemic) put asunder.

— John F. Kennedy

During the last three months, while the raging pandemic has adversely impacted our families, organizations, cities, states, our country, and the world, one bright ray of positivity has been our ability to put our differences as competitors aside and to band together as comrades in the fight against the rapidly changing crisis.

A newly formed IFT (Inter-facility transport) committee, comprised of the leading California ambulance providers (AlphaOne Ambulance, American Ambulance, AmWest Ambulance, Falcon Critical Care Transport, LineLine Ambulance, MaxCare Ambulance, Medic Ambulance Service, NORCAL Ambulance, and Royal Ambulance, has set a professive plan to work together to support CAA's vision – *"To serve as the voice and resource on behalf of emergency and non-emergency ambulance services."*

By sharing best practices, improving team safety, regulatory compliance, patient experience, and reimbursement changes, we aim to promote and improve healthcare outcomes in pre and post-hospital care.

While our state and federal government work on flattening the curve, we've been meeting weekly to stay ahead of our own "curve." Exchanging ideas on how to combat PPE shortage, decontamination best practices, and sorting through a slew of new regulations have proven to be integral to our ability to lead our organization and the industry.

Drawing inspiration from John F. Kennedy's wise words, today we ask ourselves not what our association can do for us, but what we can do for our association, each other, and the communities we serve.

If you are a member, thank you. If you've been waiting for the right time to join, now is that time. If you are an EMS stakeholder, let's work together on building bridges and making an impact on healthcare where we are all recognized not just in this dire time of need but as equal partners and an integral part of the healthcare ecosystem. ✱

Steve Melander, Chair
Content Committee

Preparing for the Second Wave

Danielle Campagne | MD
Mark Reece | MPH
Steve Melander | BS, EMTP

At the time of publication, we are all knee deep in the COVID-19 crisis. As the fight against COVID-19 continues, it's important to reflect on effective strategies used to overcome challenges, as well as prepare for a potential return of the virus.

Wait ... a *"return?"* Aren't we still fighting the first one? Well, yes. But some health experts remain concerned that a second wave will hit us in the fall of 2020. With a multitude of logistical implications and variables surrounding a potential return of coronavirus, we'll attempt to answer a few particularly relevant questions regarding the *second wave*.

> Disclaimer: by 'first' and 'second' wave, we are referring to the first major collective impact of COVID that we are currently amidst, followed by an independently defined impact that could occur in the fall.

First off, what are the odds of a second wave?

DC I think that the second wave will come. It is not an "if" but a "when" and hopefully not as bad as the first. A recent study in Lancet[1] discusses how China modeled the potential adverse effects of premature relaxation of interventions like social distancing, masking, etc. All of these relaxing of rules led to an increase in transmissibility of COVID-19.

MR With no current tangible intervention to interrupt the virulence progression of the virus, increased incidence rates in the fall seem highly likely.

SM A second wave is imminent. Current optimistic projections are that an effective vaccine is 18-24 months out. In the meantime, the strategy is to slow the spread and prevent the oversaturation of the healthcare system. The hope is that we will see small waves, not tidal waves.

What will a second wave look like?

DC It is hard to predict what this will look like. I think it will depend on how slow or fast social distancing is released.

MR On the community/social side, some countries are going to be amidst their own 'second wave' while others are still recovering from the first. Similar travel/work restrictions are reasonable to expect.

SM It is very difficult to tell. If our current mitigation strategies

Continued on page 7

Continued from page 6

continue to be effective we will be able to weather subsequent waves. What I think we will see is incremental growth over a period of time with pockets of outbreaks in high-risk populations living in close quarters like we are currently experiencing in our skilled nursing facilities.

PPE is already scarcely low across the board ... what type of impact will a second wave have on this?

DC I think this first wave taught the medical field what their PPE needs are. I think with the increased production of PPE and the flattening of the California curve, this gave our health care time to ramp up and prepare. I believe we will be ready when the second wave hits.

MR A great deal of attention has been brought to the global status of PPE. Any pandemic will place a strain on inventory, but hopefully improved preparedness leads to enhanced availability.

SM We will continue to have challenges meeting the supply demands until manufacturers can catch up. If you have not already implemented strict inventory control, do it now. Continue to be aggressive in your procurement of supplies and employ limited reuse policies according to CDC guidelines. Providers need to prepare ahead of time and try to secure a 60-90 day supply of PPE (based on their current and projected burn rates). I'm not suggesting hoarding, I'm suggesting adequate reserves on hand to weather supply chain disruptions.

What have we learned from this first wave and how can we apply that to be better prepared for a potential second wave?

DC The baseline needs of PPE for our workforce is now known. The daily needs to keep the crews safe is known. This added knowledge will help make EMS systems and the health care system as a whole more prepared. Also our baseline infection prevention efforts – handwashing, wiping down surfaces, etc. are now a part of our everyday routine. So improved infection prevention will help us be better prepared for wave two.

MR Having policies and test kits in our back pocket from the first go-around will be instrumental. It's like watching film after a game-here's what worked, what didn't work, and what we'll do to get better. There are processes, whether large scale government orders or local company directives, that have been effective and serve as a great starting point for when the response to another wave is needed.

SM EMS providers are always looking for ways to be more efficient and operate more economically. We have stopped stockpiling resources and have depended on our vendors to be able to provide exactly what we need when we need it. Additionally, as an industry, we have allowed our infection control procedures to become lax. We must place a strong emphasis on proper training, PPE donning and doffing, and decontamination processes.

What type of impact will the second wave have on EMS, particularly call-volume and staffing?

DC I think this completely depends on your city. Some cities have seen a drastic decrease in call volume with the first wave. This may happen during the second wave too. A lot likely depends on how effective social distancing is in your community. If the second wave comes, social distancing and effective public health initiatives will be needed to squash it again.

MR If a second wave occurs simultaneously with flu season it presents challenges but doesn't change the game plan ... use every resource available to ensure operability. It's a unique situation where it behooves providers to be prepared for both a significant influx in volume, and also a continued drought.

SM Unsurprisingly, a second wave will compound our normal flu season that already results in highly impacted emergency departments with no beds, long wait times, etc. Traditionally, our winter season has provided the most challenges with a larger volume of flu, respiratory patients. Now is the time to work with your local facilities to develop best practices for patient flow to reduce wall time. Regarding staffing, we must continue to keep the pipeline full with new trainees, and continue to provide the best training, equipment, and infection control practices for our employees. Our employees who are on the front lines need to feel safe and supported by their employer. The primary focus must be on provider safety at all times. ✱

References:

1. Yuanyuan L, Shunqing X, Beware of the second wave of COVID-19. Lancet, April 8, 2020.

Donna Hankins, Chair
Payer Issues Committee

When Life Hands You Lemons

One of the consequences of the California Stay at home order is a reduction in the number of calls for California Ambulance providers since Mid March 2020. One response will be to analyze "where did the call volume drop?" in order to visualize which payer group is being affected by the drop in calls. Providers can study trauma (car accidents, falls) versus medical, examine calls from locations types, or check calls by priority (emergency versus scheduled) to see who is calling less due to the change in our social order. Regardless of the analysis, call volume is down and all departments have to make changes in the system to adjust.

A reduction in calls allows each Billing Office to turn the challenge into an opportunity or as the old saying goes "turn lemons into lemonade." This reduction of call volume provides an ability to slow down, implement technology enhancements, and examine processes to ensure smart, more efficient actions to obtain full payment from claims.

Implement New Technology

Technology provides multiple tools that exchange time (to setup and learn) for long term benefits of process improvement. Plan during the call volume decrease to dedicate work to improving technology so when call volume returns, the processes performed are better documented and more efficient:

- Implement a password manager program (RoboForm, LastPass or 1Password) and setup your insurance passwords and websites;
- Assign structured time to document key processes (in case someone needs to step in for another employee) and implement online document access for using OneNote or Evernote (creates virtual binders to store the processes online);
- Clean the inbox, update software contacts with insurance leads, and implement additional e-mail features (calendar and notes);
- Review and update billing system data (locations, insurances, diagnosis codes);
- Attend webinars, online training classes on a weekly basis to improve computer skills, compliance knowledge, or medical billing education.

Identify Hurdles to Payments

Everyone agrees claim processing done properly reduces the reimbursement timeline. By slowing down and grouping payers into categories, claim issues can be identified and process improved. Below are suggestions by payer group of "prebill" (review of claim before first bill) or followup (review of denied, underpaid and unpaid claims) actions.

Continued on page 9

Payer Issues *Committee*

Continued from page 8

Medicare: While, CMS has relaxed some billing rules (beneficiary signatures can be verbal for presumed/positive COVID-19 patients for example), Medicare will always be the payer most likely to audit an ambulance claim. A lower call volume means extra time to review Medicare calls to ensure documentation is complete and shows medical necessity.

This is a time to review policy, validate steps to develop billing comments (following the directive "tell a story") and ensure appeals are timely and valid. One payment delay is "denied for duplicate" (same patient, same day). Before filing an appeal, review both calls to ensure both have complete documentation showing medical necessity. When Medicare (Noridian) reviews a denial for a duplicate, they are validating if both claims (the paid and the denied claim) meet medical necessity as well as the appeal that the patient was transported twice in one day.

Medicare Advantage claims: The slowdown in call volume is a chance to identify the Third Party Administrator (TPA) or Independent Physician Association (IPA) before mailing the claim and documenting the setup for future calls. Use this slowdown to collect information about each Medicare Advantage plan and create additional documentation of success. Finally, slow down receipts posting to verify reimbursement is correct and confirm payments: did the Medicare Advantage plans update the 2020 allowed amounts and remove the 2% sequestration on May 1, 2020 as directed by CMS?

Medi-Cal and Medi-Cal Managed Care: Now is an opportunity to identify patterns and problems with Medi-Cal claims. In prebill, practice checking eligibility every time for Medi-Cal eligibility (Medi-Cal has a system to move patients from FFS to a Medi-Cal Managed plan insurance within 30 days). Stop and examine underpayments and denials before rebilling or appealing to see if an issue exists that needs more than a case by case appeal. Medi-Cal managed care plans create requirements for 1500s and electronic claims that are a hybrid of commercial and Medi-Cal rules. Identifying denial patterns may lead to a solution by modifying software or a large scale appeal to the insurance (rather than claim by claim processing).

This is also the time to dedicate GEMT/QAF payments, checking for payments and contacting any Medi-Cal Managed Plan who has not paid the GEMT add on (for retroactive calls) or is not paying the GEMT add on (for prospective calls). Start with the general support and work up the ladder to request a large scale review of the GEMT program if you are not being paid correctly.

Commercial Insurances: I have always been an advocate of "send it to collections" if a commercial insurance has a pattern of underpayments, no payment or invalid responses from the insurances. In this moment, however, patients might be easier to reach and more eager to help you with problem insurances to avoid medical bill debts. Before sending a claim to collections check to see if one of these scenarios apply:

- Insurance Denied wanting information from patient. Make a call and send a letter to patient explaining if the patient contacts the insurance with information, the insurance will process the claim. This happens specifically on trauma calls where auto or liability insurance might be a factor.
- Insurance underpaid the claim. Use this situation as an opportunity to call the patient and have the patient file a complaint with the insurance for the insurance's processing of the claim as "in network" (if not contracted). Keep in contact with the patient in case the insurance pays the patient direct.
- Insurance paid the patient direct. Make a call to make sure the patient knows the check they received is for ambulance services and coordinate reimbursement.

Private Pay: If the patient does not have insurance, find out if the patient is working to apply for Medi-Cal. Also consider a hardship policy for uninsured patients to collect something from the patient while being considerate of the economic downturn many individuals are facing.

Finally, as you are billing, make sure to document COVID-19 related transports. You do not necessarily need to bill with COVID-19 diagnosis codes (especially if the clearing house does not recognize those codes) but you do want to know if COVID was involved in the patient's situation because insurances might waive deductibles or copays (and you might be obligated to take payment at in network pricing). Work with your software vendor to create a tracking mechanism for COVID – 19 related transports. ✱

CAA 72ND Annual Convention
CALIFORNIA AMBULANCE ASSOCIATION
HARVEYS LAKE TAHOE
September 22-25, 2020

2020 Annual Convention Update

The California Ambulance Association's Annual Convention & Reimbursement Conference will be held September 22-25, 2020 at Harvey's in Lake Tahoe and WE ARE STILL A GO! We have an action-packed lineup with the highest quality speakers focusing on a variety of Leadership, Operational and Reimbursement topics that are impacting our industry.

Connie Podesta is this year's Day 1 Keynote Speaker. She is a game-changing, idea-generating ball of fire whose rare blend of humor, substance, style and personality have made her one of the most memorable, in-demand speakers in the world today. In 25 years, she has presented to over two million people and 1000 organizations. Connie is a Hall of Fame speaker, Award-winning author of seven books, Former Radio/TV personality, and Comedienne.

Additionally, we have industry experts like Doug Wolfberg J.D., Ed Norwood, Danielle Campagne M.D., Jeff Jarvis M.D., Donna Hankins, and many more key leaders of our industry. We will be having several panels related to the COVID-19 responses in review of how our CAA members impacted lives and communities during this pandemic. Together we can share our valuable information with our EMS community to ensure future readiness, and preparedness. In honor of the CAA's great friends and colleagues, Raymond Lim and Jim McNeal, Jr., this year's golf tournament will be held September 22nd at the beautiful Edgewood Golf Course. Set along the south shore of beautiful Lake Tahoe, Edgewood Tahoe is arguably one of the most scenic golf courses in the world.

We will be releasing our 2020 California Ambulance Association Service Excellence (CAASE) awards in May. The CAASE awards showcase the best practices of the ambulance business in the state. The California Ambulance Association recognizes excellence in the ambulance industry specific to California operations. The CAASE awards provides California ambulance operators the opportunity to be recognized for excellence, resourcefulness, and ground-breaking ideas. This is a golden opportunity to tout your company's accomplishments! Sharing your knowledge and ideas with your colleagues is the ideal way to demonstrate your company's commitment to excellence. ✱

Member *News*

2020 *Stars of Life* Update

The CAA's Annual Stars of Life Celebration is the most exciting state event that recognizes and honors the dedicated professionals in the ambulance services industry. The program also features meetings with Members of the Legislature at the State Capitol where your ambulance company will deliver important information to your Assembly Members and Senators. This year's event was scheduled for May 12th and 13th, however due to the COVID-19 pandemic we have had to postpone the event. We are in discussion currently with our event Chair, John Surface of Hall Ambulance, the Board of Directors and Sheraton Hotel staff. We are hoping to set a new date in mid-August; however it will be dependent on the current governmental allowances. We will continue to update via our website and member alert e-mails. *

Protecting Our Patient Care Providers – Bringing Creative Solutions to the PPE Shortage

Jim Karras, EMT
AmbuServe Ambulance

On Wednesday, March 11, 2020, our lives changed. The World Health Organization (WHO) declared a global pandemic of the coronavirus (COVID-19). California led the Nation in heading the call for action and by March 19th Governor Newsom signed the statewide Stay at Home Order.

However, prior to that, healthcare providers across California already were beginning to understand we were facing some daunting challenges. On March 3rd, Governor Newsom took action to assist with a growing concern of shortages in personal protective gear being available to all essential workers. On that day, he issued a directive to release from the State's disaster stockpile millions of N95 masks to multiple county health departments across the state to address the increased reports of shortages.

In Los Angeles County, we received several shipments of personal protective gear which included N95 masks, surgical masks, and some isolation gowns from the Los Angeles Department of Health Services Emergency Medical Services Agency. However, we soon realized that we would need more eye protection and isolation gowns then we could acquire on the open market as quickly products like hand sanitizer and other isolation equipment vanished from the marketplace and the state's cache had to be delivered to multiple communities in many counties.

In mid-March, a task-group at AmbuServe was formed consisting of Joseph ("Joey") Diaz, Communications Center Manager, Luis Perez, Fleet Manager and Robert Cambreros, Regulatory Affairs Supervisor to assess what we could do internally to manufacture isolation gowns and face shields in house. Within one week, three 3D printers were purchased and put into service. Plastics materials and other materials were sourced from existing partners through vendor relationships in place by our fleet department personnel.

We already had many machines in fleet that could be re-purposed for these new manufacturing duties. They include, a CNC machine and a Vinyl Cutter. The fleet department, under the direction of Joey, developed the first wood patterns used to cut the plastic we obtained to make the isolation gowns. Using heat guns, the seams of the gowns were created and each gown was placed into plastic bags also made in-house, sealed and boxed.

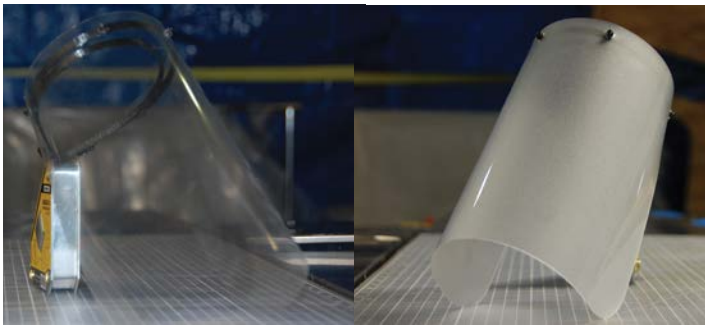
The final design of the face shields followed suit and soon thereafter, the three 3D printers were placed into service around-the-clock churning out the parts needed to assemble the face shields we needed. The face shields

Continued on page 13

Feature *Article*

Continued from page 12

are made using thin plastic sheets molded in a semi-round shape with snaps attached at the top for the plastic molded (3D printed) head brace to be attached upon assembly by the crewmembers prior to donning. An elastic band attached to the head brace is used to secure the face shield in place on the care provider's head. Each face shield is packaged in a plastic sleeve and sealed.



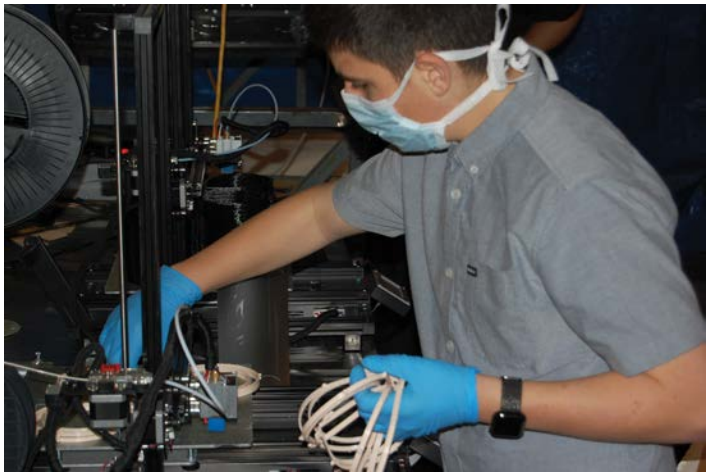
Ambulance staff have volunteered to assist the fleet department in keeping the manufacturing process running around the clock. EMTs and Paramedics have learned how to work at each of our manufacturing line work stations and we have increased our daily output of finished products threefold.

To ensure our ambulance staff has the needed personal protective gear needed for each call, the isolation gowns and face shields are bundled and used as a kit for each call. So far, we have received all requested shipments of N95 and surgical masks required to maintain our current need.

To date, we have manufactured over 2,000 isolation gowns and 200 face shields and are now on track to make 100 face shields each day.

The creativity, collaboration and ingenuity of our team has been remarkable and truly amazing.

While we all hope we can put this equipment to other uses as soon as possible, our entire team has become much more appreciative of this new technology. We also are thankful for the many shining stars from within our ranks that rose to the challenge with solid solutions. ✱



Feature *Article*

QUICK TAKE: COVID-19 EMS Patient Management: Myth vs. Reality Webinar

Communication, PPE, and decontamination strategies highlighted the 4th FirstWatch and Paramedic Chiefs of Canada COVID-19 webinar

Rob Lawrence | Rob Lawrence Consulting

(Reprinted from Rob Lawrence's EMS One-stop column published March 17, 2020)

On March 13, FirstWatch and Paramedic Chiefs of Canada delivered the fourth webinar in their ongoing series. The topic was COVID-19 EMS Patient Management: Myth vs. Reality. What was delivered from the outset was the shape of things to come – not the COVID-19 outcome, but the cooperation and partnerships required to work as one prehospital, public safety and public health team.

Also signing on to this latest webinar was the Academy of International Mobile Healthcare Integration (AIMHI), National Association of Emergency Medical Technicians (NAEMT), the California Ambulance Association (CAA) and the International Academies of Emergency Dispatch (IAED). The webinar itself was chaired by NAEMT President, Matt Zavadsky. Through COVID-19, the alphabet soup of associations is spelling UNITY and this is no bad thing.

COVID-19 LESSONS FROM SOLANO COUNTY QUARANTINE

The COVID situation is currently changing on a global scale almost minute by minute and dominates the world news. In the Webinar, Jimmy Pierson, president/COO Medic Ambulance (also vice president, California Ambulance Association), Solano County California; Dr. Bela Matyas, Solano County Public Health director; and Ted Selby, Solano County EMS administrator,

gave an account of the management of their COVID-19 confirmed and persons under investigation (PUI) patients at Travis AFB in Northern California.

Solano County and Medic Ambulance became deeply involved in the COVID-19 related planning and handling of patients after the federal decision was taken to quarantine returning personnel at Travis Air Force Base (AFB), which is in Solano County. Repatriated citizens arrived at Travis AFB in three distinct waves.

First to arrive were the U.S. State employees arriving directly from Wuhan, China. Second were evacuees from the cruise ship Diamond Princess, who arrived from Japan. And finally, 800 transfers arrived from the cruise ship Grand Princess, which landed its passengers in the Port of Oakland. All were to spend a period of quarantine at Travis AFB with those with confirmed COVID-19 and PUIs being transferred to local hospitals for observation and treatment.

During the planning, preparation and execution phase of the repatriation, the Solano team had the opportunity to roll out their MCI plans and learn lessons as the situation evolved. They also had the opportunity to consult with Riverside County, California, which was receiving repatriated citizens at a DoD facility there also. During the Travis repatriation(at the time of writing), more than 40 patients have been transported to area hospitals for further treatment.

TAKE-AWAYS FROM THE COVID-19 EMS PATIENT MANAGEMENT WEBINAR

1. Communications and Leadership

An all-informed organization. Technical and clinical issues aside, the clearest lesson – and one that is playing out across the EMS

Continued on page 15

Continued from page 14

and public safety community right now – is the need for strong leadership combined with clear communication. Pierson was very clear that an all-informed communication style is needed. That is not limited to email and social media communication, but also includes the ongoing need to ensure that everyone possible available attends the organization's conference calls to hear the news and situational updates directly from leadership.

Dr. Matyas stressed the importance of over-communication and having hundreds of people on calls. This approach was met with positivity by all staff and, in turn, assisted with the maintenance of morale and without a doubt confident in the leader.

For those staff placed in quarantine, communications with employees and their loved ones are of paramount importance, with a minimum of daily personal calls to ensure they too were briefed and up to date in the latest situation.

Maintaining a wide communication net. Ted Selby reinforced the communications message. To operate in a multi-jurisdictional environment, particularly when planning was occurring around the repatriation of citizens and patients from cruise ships, it was vital to have all the key decision makers on the calls and ensure no one was overlooked.

Selby stressed that there is also a requirement for all involved to have an exceptionally clear understanding of the mission at hand. Selby also stressed the need to keep neighboring jurisdictions informed as transporting through those areas or using local healthcare facilities may be required as the operation unfolds.

2. CDC COVID-19 PPE Guidelines

Pierson said that the PPE levels that Medic used were right out of the CDC guidelines "with N95 mask, (with the local addition of a) face shield, gown, boot protection and hair protection, and that's it." Though Medic is a California regional authorized infectious disease transport provider equipped with ISOPOD units, Tyvek suits, and PAPR units, they were not needed. Pierson observed that while they had earlier seen other agencies deploy PPE to the full extent, the Medic team had confidence in their techniques and procedures, and robust decontamination protocols.

3. Vehicle Preparation and Decontamination

Pierson noted that they resisted the urge to recreate the "Ebola era" ambulance, with the patient compartment covered, top to bottom in plastic. They did make every effort to segregate the cab area from the patient compartment, if necessary where an open space existed, with a plastic sheet. Additionally, crews placed a disposable style blanket on top of the gurney to add a level of protection and offer a further barrier.

To provide comprehensive vehicle decontamination, Medic took the practice from its AIMHI partner at the Richmond Ambulance Authority and purchased an electrostatic sprayer. These devices work by spraying an electrostatically charged mist onto surfaces and objects. The electrostatic spray uses a specialized solution that is combined with air and atomized by an electrode which then sprays positively charged particles that can aggressively adhere to surfaces and objects. Because the particles in the spray are positively charged, they cling to and coat any surface they're aimed at. These devices work by RAA Biochemical cleaner. ✱

About the Author

Rob Lawrence has been a leader in civilian and military EMS for over a quarter of a century. Currently, he is the principal of Robert Lawrence Consulting. He previously served as the chief operating officer of Paramedics Plus in Alameda County, California. Before that, Rob was the COO of the Richmond Ambulance Authority, which won both state and national EMS Agency of the Year awards during his 10-year tenure.

Before coming to the U.S. from the U.K. in 2008, Rob served as the COO for the East of England Ambulance Service in Suffolk County, England, and as the executive director of operations and service development for East Anglian Ambulance NHS Trust. Rob is a graduate of the UK's Royal Military Academy Sandhurst and served worldwide in the Royal Army Medical Corps with a 22-year military career encompassing many prehospital and evacuation leadership roles,

Rob is a former board member of the American Ambulance Association and currently serves as chair of its Communications Committee and a member of the media rapid response task force, providing industry media response to national industry-related news inquiries.

Rob has also recently accepted the position of Interim Executive Director for the California Ambulance Association. Thank you, Rob!

CAA Membership is a Business Essential

The business environment, the healthcare sector and the EMS industry are evolving at an ever-increasing pace. At the CAA we are dedicated to providing members with the essential tools, information, resources, and solutions to help your organization grow and prosper. And, the CAA's collective efforts on statewide legislative and regulatory issues are not possible without strong membership support and engagement.

Take your place in California's statewide ambulance leadership

Membership not only saves you money on CAA events and resources, but also keeps you up to date on trends, innovations, and regulatory changes through:

- Leadership on statewide legislative and regulatory issues
- Targeted conferences & educational programs
- Member-only updates and alerts
- Member-only discounts & access to expert resources
- Opportunities to exchange ideas with your colleagues statewide

CALIFORNIA AMBULANCE ASSOCIATION

Join the California Ambulance Association

Go to *www.the-caa.org/membership* for a membership application.

Subscribe to the *Siren*

The official magazine of the California Ambulance Association

CAA members receive the *Siren* as a member benefit.

1 year: $90* 2 years: $150*

Call (877) 276-1410 to subscribe.

*California residents, add 8.5% sales tax

The California Ambulance Association is now welcoming non-members to subscribe to the *Siren* magazine. Published quarterly, the *Siren* is a comprehensive source of information on issues that are important to the ambulance industry. Contents include feature articles, association educational and networking events, legislative updates and analysis, member news and much more.

CALIFORNIA AMBULANCE ASSOCIATION

CAA Newsletter Advertising Policies & Agreement to Advertise

CAA Headquarters
2520 Venture Oaks Way, Suite 150, Sacramento, CA 95833
(916) 239-4095 - phone • (916) 924-7323 - fax
www.the-caa.org • info@the-caa.org

Unless otherwise stated, ads for this publication will be printed in full-color.

AD SIZES AND RATES

Ad Size (WxH)		1x Rate	4x Rate
2 Page Spread	(16" W x 9⅛" H)	$1,000	$900
Full Page	(8½"W x 11" H)	$750	$675
2/3 Page	(5" W x 10" H)	$450	$405
½ Page Horizontal	(7¼" W x 4½" H)	$400	$360
½ Page Vertical	(3½" W x 9¼" H)	$400	$360
¼ page	(3½" W x 4¼" H)	$200	$180
Business Card	(3½" W x 2¼" H)	$150	$135

PLEASE NOTE: if the artwork you provide does not conform to the above specifications, we reserve the right to alter the ad to fit these dimensions.

ARTWORK SPECIFICATIONS

Please submit ads digitally where possible (PC format, not Mac) either on CD, zip disk, floppy disk, or via E-mail. Such electronic submissions should be in EPS, TIF, or PDF format, including all fonts where applicable, and should be compatible with Adobe Photoshop, Illustrator, PageMaker, InDesign, or Acrobat. We will also accept camera-ready (printed) full-sized images suitable for scanning, at either 133 or 150 line screen. Please see above for specific ad sizes and dimensions. Artwork should be e-mailed to "Advertising c/o **CAA**" at *info@the-caa.org* or mailed to:

Advertising c/o **CAA**
2520 Venture Oaks Way
Suite 150
Sacramento, CA 95833

I will be submitting my ad:
☐ **Camera-ready by mail**
☐ **Digitally on disc** ☐ **Via E-mail**
☐ **I need assistance designing a new ad (we will discuss design rates separately)**

PAYMENT TERMS

Advertisers are billed after their ad appears. A frequency discount is given to those who agree in writing (ie. this signed contract) to advertise in every issue of the calendar year, or in an equal number of consecutive issues. If the written agreement is not fulfilled, the advertiser is liable for the one-time rate charges. Advertisers who submit an ad contract but fail to submit artwork by the publication deadline will be invoiced.

CONDITIONS

1. Advertisers and advertising agencies are liable for all content (including text, representations, and illustrations) of advertisements and are responsible, without limitation, for any and all claims made thereof against *the Siren,* the association, its officers, agents, or vendors.
2. No advertiser is guaranteed placement, but every attempt will be made to provide the desired position.
3. Publisher reserves the right to revise, reject or omit any advertisement at any time without notice.
4. CAA accepts no liability for its failure, for any cause, to insert advertisement.
5. Publisher reserves the right to publish materials from a previous advertisement if new materials are not received by material deadline.
6. The word "advertisement" will appear on any ad that resembles editorial material.
7. Drawings, artwork and articles for reproduction are accepted only at the advertiser's risk and should be clearly marked to facilitate return.
8. No verbal agreement altering the rates and/or terms of this rate card shall be recognized.
9. All advertisements, layout and designs produced for the advertiser by CAA's Graphic Staff will remain the property of CAA.
10. All requests for advertising must be in writing, in the form of this signed contract, for the protection of both the advertiser and CAA.
11. Once an order for advertising is placed, it cannot be withdrawn or cancelled in whole or in part.
12. By signing this contract, advertiser agrees to pay in full for reserved space, even if the ad is not run due to lateness or absence of materials.

PLACING YOUR AD

To place an ad, complete the form below and mail or fax to: CAA, 2520 Venture Oaks Way, Suite 150, Sacramento, CA 95833 • (916) 924-7323 - fax. ***Do not e-mail.*** CAA will not run your ad without this contract.

Name of Company/Organization Being Advertised: _____
Billing Contact: _____ Billing Address: _____
Phone: _____ Fax: _____ E-mail: _____

Agency or Advertising Representative (if different from above): _____
Phone: _____ Fax: _____ E-mail: _____

Person to Contact with Artwork-specific Questions (if different from above): _____
Phone: _____ Fax: _____ E-mail: _____

I agree to place a _____ size ad in the following issue(s), and to be billed at a rate of $_____ per issue: (note: The multiple-issue rate can apply to *any* consecutive series of issues starting at any point in the year. If you choose the multi-issue rate, please number your first issue "#1" below, and the other issues as they occur chronologically. See condition #5, above.)

	_____Summer	_____Fall	_____Winter	_____Spring
Material Deadlines:	**July 17, 2020**	**October 16, 2020**	**February 19, 2021**	**April 30, 2020**

METHOD OF PAYMENT

Total $_____ **Please check one:**
☐ Send me an Invoice ☐ Enclosed is check #_____ (Payable to CAA) ☐ Charge my Credit Card ○ MC ○ Visa ○ AmEx
Last 4 digits of card: _____ Billing Address: _____
Print Cardholder's Name: _____ Signature: _____

(rev. 5/20)

Full Credit Card# _____ Exp: _____ CVV#: _____

Return completed form and payment by mail or fax to: **California Ambulance Association, 2520 Venture Oaks Way, Suite 150 • Sacramento, CA 95833 • (916) 924-7323 – fax**

For more information, contact us at: (916) 239-4095 – phone • (877) 276-1410 – toll free • *www.the-caa.org*

CALIFORNIA AMBULANCE ASSOCIATION
2520 VENTURE OAKS WAY, SUITE 150
SACRAMENTO, CA 95833 • *www.the-caa.org*
877.276.1410 (toll free) • 916.924.7323 (fax)