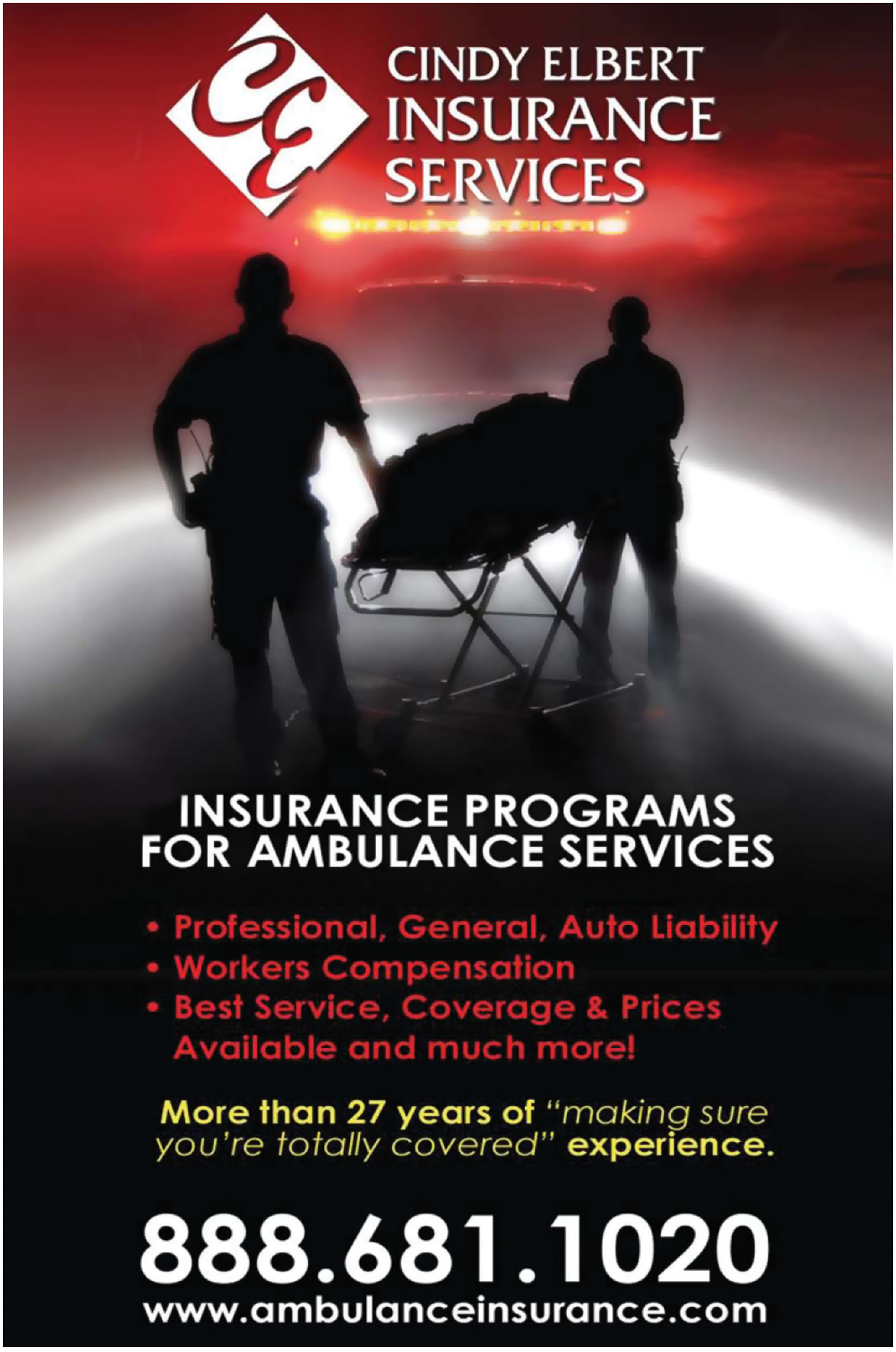
CAA Elections | HIPAA Protection | CAAPAC | Medi-Cal Rates

Siren

Fall 2014

A Publication of the California Ambulance Association

Convention Preview | Wall Times | Highway Safety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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 private enterprise emergency and non-emergency ambulance services.
- Promote high quality, efficient and medically appropriate patient care.
- Advocate the value that pre-hospital care provides in achieving positive patient outcomes.
- Promote effective and fiscally responsible EMS systems and establish standards for system design.

CAA *Leadership*

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

Chair's *Message*

Helen Pierson | *Chair of the Board*

The Passing of the Gavel

Our 66th Annual Convention & Reimbursement Conference promises to be informative, interesting and entertaining. This year's program will feature two tracks of outstanding speakers and topics, including state specific issues that will protect and help our ambulance services grow. Our Annual Ray Lim Memorial Golf Tournament will be held at Torrey Pines Golf Course. Our Keynote Speaker will be Mr. Darren Kavinoky, who is the creator and host of the television show, Deadly Sins on the Investigation Discovery Channel. I would like to thank all those individuals who were involved in organizing this year's event, especially our Executive Director June Iljana, Administrative Director Kim Ingersoll and our association's Education Committee.

At our convention this year, our association will be voting in a new Chair. After two years, it is my turn to pass the gavel. It truly has been an honor for me to serve as your Chair. It has been a pleasure working with a Board that is hardworking, determined and are truly ambassadors of our industry. I would like to send a special thank you to Mr. Dana Solomon, Mrs. Brenda Staffan and Mr. Fred Sundquist. Their guidance, leadership and experience assisted me greatly.

We have had many success stories this year. Our Stars of Life event was highly attended with the largest number of "Stars" being awarded that we have had in recent years. We were thrilled to have our very own Assemblyman Freddie Rodriguez, EMT for 30 years, as our keynote speaker and to have him acknowledge that he was an alumni of the Stars of Life event and that he appreciated the great work that we all do for the State of California. Our "Hands Only CPR at the Capitol" event had positive feedback and was greatly appreciated by all of our legislative representatives and their staff.

Within our association there are many people that are consistently working hard behind the scenes to get things done for our industry as a whole. I would like to thank two of these people. Mr. Jaison Chand of City Ambulance of Eureka, Inc., who is our representative on the State EMS Commission, is truly an unsung hero and works tirelessly for our association and we are very fortunate to have him representing us. The other person I would like to personally thank is John Surface of Hall Ambulance, our CAAPAC Chair, who motivates us all and is a constant reminder that we all need to be politically active if we want our message to be heard at the Capitol. John's presence has opened the door with many of our legislators.

We are extremely fortunate to have an association where members want to become involved. This involvement and enthusiasm needs to continue. New faces bring new ideas and keep our association invigorated. Being united as an industry is important to gain the respect of the legislature. We all know there is still work to be done. Our attempts for an increase in Medi-Cal reimbursement have been met with many challenges, but with persistence and working together we will achieve success.

It has been a wonderful two years serving as your Chair. It has been my honor. ✱

Executive Director's *Report*

June Iljana | *Executive Director*

Wall times: studying the problem is not enough

So many of the challenges ambulance service providers face are the outgrowth of larger healthcare system issues that are not addressed. So it is with Wall Times, now dubbed Ambulance Patient Offload Delays (APOD), which place a huge financial and readiness burden on providers as crews wait in the emergency department for an hour or more until hospital staff take over care of the patient.

Last year the State Emergency Medical Services Authority, the California Hospital Association and the State EMS Administrators Association created a joint working group to try and address this problem. The California Ambulance Association along with numerous other stakeholder groups have been participating in the process.

Three workgroups were tasked with 1) defining the problem by surveying jurisdictions regarding delays and determining metrics for what constitutes a delay, 2) examining current legal and regulatory factors, and 3) investigating and collecting best practices.

Surveys of LEMSAs and hospitals had disparate results, however it was clear that, although providers in many areas of the state rarely experience delays at the emergency department, those that do have significant delays serve more than 70% of the state population.

We also learned through surveying the hospitals that there are multiple factors contributing to delays including staffing limits, boarding patients due to lack of mental health facilities, and - most frequently cited - issues with moving patients to a ward expeditously. As one administrator put it, ED overcrowding is often a whole hospital function.

In August, the collaborative released its work product, "Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department." We have posted it on our webiste at http://www.the-caa.org/mem_patient-transfer-delays.asp. The document basically recaps what was learned from the LEMSA and hospital surveys. The essence of the document is, I suppose, sharing with hospitals and LEMSAs what strategies have been implemented in hospitals where delays are not a problem and encouraging their implementation in areas where it is.

What it comes down to is that ambulance services are being forced to bear the resource burden of hospitals that can't manage their patient load in a timely manner. In other words, ambulance staff are supplementing hospital staff as a form of cost-shifting from the hospital to the ambulance service provider - costs which then have to be shifted to the patient.

While I applaud the efforts of all participants in this process, it is essential for the hospitals to now take this information and put it to use. If your service is impacted by offload delays, I encourage you to print the toolkit, gather your data regarding hours your crews have spent at the ED, and schedule a meeting with the hospital and the LEMSA Adminstrator and make sure this is addressed. There are too many areas in which ambulance services are not able to recoup costs. Let's nail this one. ✱

Chris Micheli

2014 Legislative Year Wrap-Up

Chris Micheli | CAA Legislative Advocate

The Legislature adjourned in the early morning hours on August 30 and Governor Jerry Brown has until September 30 to sign or veto legislation sent to him. CAA is still battling on a few remaining pieces of legislation that reached the Governor's Desk. Prior to that point, the CAA worked against a number of bills that were either amended or defeated during the session, including SB 935 (Leno) – the proposed minimum wage increase, and SB 1021 (Wolk) – the school district parcel tax increase.

Although we were not successful in obtaining a Medi-Cal rate hike this year, we achieved several other victories and have potential avenues we are exploring with the Department of Health Care Services (DHCS) on how to increase Medi-Cal provider rates. CAA staff met with senior officials at the DHCS and is working during the fall exploring potential options. Moreover, we will continue to work with the large Medi-Cal provider coalition led by the California Medical Association in efforts to increase provider rates through the budget process.

In terms of legislation, it was a mixed bag this year. Held on the Senate Appropriations Committee's Suspense File in August were two bills we supported: AB 1621 (Lowenthal) and AB 1759 (Pan). AB 1621 would have established a statewide standard for EMS data systems. We were able to achieve a number of amendments to the bill that caused our position to change from oppose to support. We also worked on amendments to AB 1759, which would have required DHCS to contract annually for a third party assessment of Medi-Cal provider rates. As a result of our amendments, we were able to actively support the bill.

We also worked diligently against two bills that are pending on the Governor's Desk: The opposition coalition on AB 1522 (Gonzalez) was able to secure amendments to temper our concerns and the Cal Chamber removed its "Job Killer" tag. The coalition remains opposed to the bill and is seeking a gubernatorial veto. AB 1522 mandates all employees, whether part-time or full-time, to be provided with 3 days of paid sick leave annually. Existing PTO policies will satisfy this requirement so long as an equivalent amount of time is provided. The Governor signed this bill into law on September 10, 2014.

We have also been actively opposing AB 1897 (Hernandez) and its new civil liability for the use of contracted workers that are not subject to a business' control would establish a terrible precedent in California law. It would also create a disincentive to use contracted workers. We are working diligently to ensure that this bill gets vetoed by the Governor.

Other bills of interest that we worked on during the Legislative Session include: SB 1211 (Padilla), SB 1438 (Pavley), and AB 2577 (Cooley). SB 1211 would establish the Next Generation 911 system. SB 1438 would require EMT - I training for certain narcotics. We sent a letter to the Governor requesting his signature on SB 1211. AB 2577 expands the GEMT supplemental reimbursement. We expect these bills to be signed by the Governor.

In the final weeks of session, we had to deal with another problematic bill: SB 556 (Padilla), which was taken over in August by Senator Padilla from Senator Corbett who had carried the measure last year. We had opposed SB 556 last year and stopped it on the Assembly Floor. This bill represents the classic case of providing a solution for a problem that does not actually exist. This bill requires public safety and EMS personnel contracting with a public agency to have specified disclosures on their uniforms and vehicles in order to ensure that the public "is not confused," as the proponents claim. We

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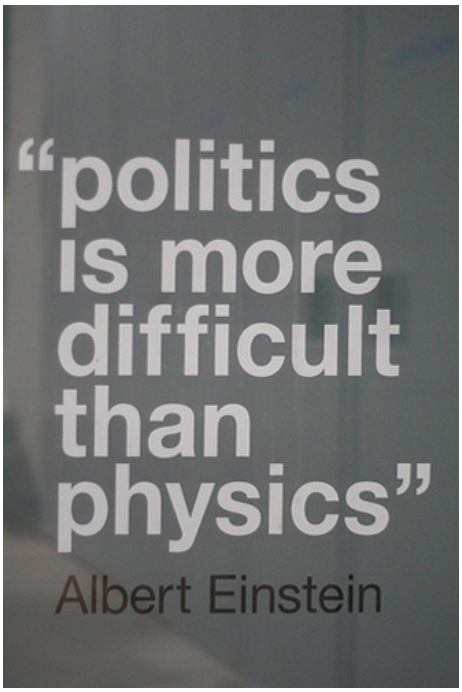

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have sent a letter requesting the Governor's veto of this unnecessary bill and argue that nothing has changed since his veto two years ago of Assemblywoman Lowenthal's similar bill.

Finally, we were also involved in two resolutions this Session: ACR 84 (Rodriguez) that declared the week of May 22 as EMS Week, and AJR 48 (Rodriguez) which asked Congress to support the National EMS Memorial. We are pleased to be working with Assemblyman Rodriguez on a number of legislative measures as he is a former EMT. We look forward to continuing to work with him for years to come.

The new Legislature will convene for the 2014 - 2016 Legislative Session at noon on Monday, December 1.

CAA Political Action Committee

John Surface | Hall Ambulance Service, Inc.
CAAPAC Chair

It's that time of year again when the California Ambulance Association Political Action Committee (CAAPAC) needs your support.

2014 has been a lean year so far for CAAPAC and, as the summer ends, it's important that everyone consider contributing.

Why give to CAAPAC? CAAPAC's mission is to help educate your legislators in Sacramento on the value of the true Safety Net providers in California and help advocate for you on the issues that threaten your companies.

In the last two years CAAPAC has helped your advocacy team be noticed. The California Ambulance Association is routinely called upon to support or oppose important pieces of legislation. The fact that legislators are looking for our support shows we are making progress. But CAA members remain under attack.

Recently, a new, very real, threat has emerged in the expansion of the Ground Emergency Medical Transportation program. This program is predicted to bring half of a billion dollars into California for supplemental Medi-Cal payments to cities and special districts that provide ambulance service. This program does nothing to help private providers narrow the gap between cost and reimbursement while overpaying cities and districts for the same service.

CAAPAC must help the CAA find a solution. But to do this, CAAPAC needs your full support. We need your financial contributions today as your advocacy team has several opportunities to educate and advocate in the near future.

Many CAA members are missing from the list of supporters for CAAPAC. Please help us reach our goals of 100% participation of CAA members and $100,000 of total support. This is more than double last year's total. But now is the time for all CAA members to step up and help CAAPAC advocate for you.

To learn more about how you as a CAA member can help advocate and educate our policy makers, you can contact John Surface at 661-322-8741 or *surfacej@hallamb.*

California Must Increase Ambulance Medi-Cal Reimbursement Rates

June Iljana and Chris Micheli

This article was printed in part in the Sacramento Business Journal and was provided to CAA members for submission to their local newspapers.

Emergency ambulance service is essential for all Californians. It is the first component of the health care safety net and the public expects our state's 911 system to quickly respond in a medical emergency. Unfortunately, California's ambulance system is at risk due to extremely low reimbursement levels by the state Medicaid program, Medi-Cal.

While all Medi-Cal providers are underpaid in California, ambulance companies are unique because they must treat all patients within a contracted period of time. Ambulance services play a vital role in providing quality health care and are a critical component of the emergency medical service system in California. Unlike other health care providers, ambulance providers cannot pick and choose their patients, as ambulance providers respond to, treat and transport all emergency patients without regard to a patient's ability to pay.

Ambulance service in California is paid for by a combination of private insurance companies (18%), the federal government via Medicare (35%), the state government via Medi-Cal (21%), as well as directly by individuals via co-payments, deductible payments and payment by the uninsured (18%), and by facilities transferring their patients (8.5%). Some jurisdictions have as high as 40% Medi-Cal patients. And that percentage will continue to grow due to the expansion of Medi-Cal to include another two million individuals in this state.

In California, the estimated total annual expenditures for ground ambulance services are approximately $2 billion. With 21% of patients being Medi-Cal beneficiaries, Medi-Cal's share of the cost for ambulance service should be about $400 million. However, expenditures by Medi-Cal for ambulance service are just $44 million – that figure represents a mere .15% of all Medi-Cal expenditures annually in the State of California.

Ambulance services experience significant levels of uncompensated care, including charity care, provided to the uninsured and below-cost reimbursement from Medi-Cal, Medicare and other government insurers. Ambulance services in our state provide about double the amount of uncompensated care compared to other healthcare provider groups, such as hospitals and physicians. Statewide, public and private providers annually deliver:

- Over $320 million in charity care to the uninsured
- Over $165 million in uncompensated care to Medi-Cal beneficiaries
- Over $20 million in uncompensated care to Medicare beneficiaries

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Medi-Cal pays ambulance providers less than a quarter of what it actually costs a provider to treat and transport a patient in California. A Government Accounting Office (GAO) analysis of ambulance expenditures found that the average cost of providing ambulance service on a per transport basis was $592, including the cost of readiness which encompasses the costs associated with maintaining the capability to respond to an emergency quickly.

The current Medi-Cal base reimbursement rate is less than $120 and the average reimbursement including additional charges is $150. On average, ambulance providers lose approximately $439 per Medi-Cal patient they serve. Currently, no state or federal funding is provided to offset uncompensated care and charity care for ambulance services.

To make matters worse, while the costs to provide essential ambulance services have significantly increased during the past decade, including escalating wages and benefits, increasing insurance costs, and newly mandated equipment, including vehicles and supplies, Medi-Cal reimbursement rates have not kept pace with these increased costs and have, in fact, declined. Medi-Cal rates for ambulance providers were further reduced by 10 percent beginning in September 2013. The last Medi-Cal rate increase for 911 providers was in 1991. California pays the third lowest Medicaid ambulance reimbursement rate of any state in the nation.

Ambulance rates are subject to local government regulation, meaning each county approves the maximum rate an ambulance provider may charge based on a financial evaluation that takes into account all payer types and how much they pay. In general, the less government pays for service to Medi-Cal and Medicare beneficiaries, the higher the rates will be for individuals and commercial insurers. Increasingly, private insurers are not paying the full billed charges, pushing back on the cost-shifting that occurs, and refusing to carry the additional burden of Medi-Cal underpayment that should be borne by the State.

Medicare reimburses ambulance services an average of $426 per transport, which is still a loss of $163 per transport, but this amount is almost 300% of the rate paid by Medi-Cal. Current California law requires ground ambulance services provided to state prison inmates to be reimbursed at the maximum rate of 120 percent of the Medicare Ambulance Fee Schedule (Penal Code Sec. 5023.5). In addition, current law requires ground ambulance services provided under the state workers' compensation program to be reimbursed at the maximum rate of 120 percent of the Medicare Ambulance Fee Schedule (8 Cal. Code Regs. Sec. 9789.70).

Emergency medical services are a critical safety net service relied upon by the entire population of the State of California. Private ambulance companies are providing 75% of all transports in this state. Ninety percent of Medi-Cal ground ambulance transports are for emergencies. Severe below-cost Medi-Cal payment rates threaten to collapse the entire 911 emergency medical system safety net in California. The State needs to address this continued funding shortfall and ensure California's EMS providers are appropriately compensated for the critical care that they provide to our local communities.

June Iljana is the Executive Director of the California Ambulance Association (CAA) and can be reached at jiljana@the-caa.org. Chris Micheli is a lobbyist with Aprea & Micheli, Inc., serves as the Legislative Advocate for the CAA, and can be reached at cmicheli@apreamicheli.com.

2014 CAA Membership Elections

CAA active members have received their official ballots for the 2014-2015 California Ambulance Association elections. Active members are eligible to vote for candidates seeking election as Officers of the Association, Directors of the Board and members of the Ethics & Professionalism Committee.

On the following pages are candidate statements from nominees for election to serve the CAA during its 2014-2015 operating year. Candidates were formally ratified by the Board of Directors. In accordance with the bylaws, elections are conducted by mail. Results will be announced during the Annual Meeting of the Membership that will be held on October 9, 2014 at the Bahia Resort Hotel, San Diego, CA, with any ties being broken by the Active membership in attendance at the Annual Membership Meeting. This gives every active member the opportunity to exercise their right to vote whether or not they are present at the Annual Membership Meeting.

In addition, this year's ballot includes an opportunity for members to vote on a proposed change to the CAA Bylaws. This change would allow the Chair of the Board of Directors of the California Ambulance Association to appoint an associate member, commercial member, non-emergency member, or public agency member to serve in a non-voting seat on the Board for a two-year term. Information pertaining to this bylaw amendment is at right, however you should review the full revision which was provided to you by mail with your official ballot. ✱

Proposed Bylaw Amendment – September 9, 2014

Please note that new language is denoted by italics and deleted language is denoted by strikethrough. This is an abbreviated version of the amendments necessary to make this change. Please review the full amendment in the official ballot which was mailed to you.

ARTICLE III – MEMBERSHIP – Section 4

Section 1 - Number and Qualifications of Directors. The Board of Directors shall consist of seven (7) Active Members in good standing to be elected as provided in these Bylaws. The Sergeant-at-Arms shall serve without voting power at all Board Meetings. *In addition, the Chair may appoint one (1) individual from either the Associate, Non-Emergency, Commercial or Public Agency Membership categories to a non-voting position on the Board of Directors.*

Section 3 – Election and Term of Office. The members of the Board of Directors shall be elected at the Annual Meeting of the Corporation for two year terms. *The appointed position shall be appointed by the Chair for a two-year term.*

If a vacancy occurs, the Board of Directors shall elect an Active Member in good standing to complete the unexpired term. *If a vacancy occurs with the appointed position, the Chair may or may not appoint another individual to complete the unexpired term.*

2014-2015 Slate of Candidates

Richard Angotti
St. Joseph's Ambulance Service
San Rafael, CA

Candidate for Chair
(One-Year Term)

It has been my distinct pleasure to have served on the CAA Board of Directors for the last five years. I feel the time is right to now serve you as the Chair of the Board of Directors. I have valued my time serving on the Board as well as my three years as Chair of the Ethics and Professionalism Committee.

Throughout these years I have always put the best interest of the membership first in my discussions and voting as a board member.

As an ambulance service owner and having grown up in the ambulance business, I have worked and navigated every aspect of the business.

I am a graduate of Gonzaga University School of Business as well as Daniel Freeman Hospital Paramedic School.

Having 911 paramedic experience in Oakland, San Francisco and Marin County has given me a true insight on ambulance field operations.

Our industry has changed and is changing with a lot of challenges now and in the future. As an association we need to be prepared and ready to meet every challenge. I look forward to helping the association and its goals in conjunction with the abundance of talent we have in our membership. As always, thank you for being a member of the CAA.

Eb Muncy
Desert Ambulance Service
Barstow, CA

Candidate for Vice Chair
(One-Year Term)
Candidate for Director
(Two-Year Term)

*Note: Must be elected to the Board of Directors to qualify as Vice Chair.

I am the owner of Desert Ambulance Service. I am a second generation owner. In 1994 my wife, Nellie, and I purchased the business from my father. We operate the business as a small "mom and pop" operation.

I have worked in the ambulance industry for more than 40 years. I have done every job to run an ambulance company from working as an EMT, vehicle maintenance, to dispatching, to billing, to accounts receivable and payable, to management.

I graduated in 1997 from Western State University, College of Law with a degree in Juris Doctor. In 1988 I passed the California State Bar. I practice law, with emphasis on Business Law (transaction and litigation), Real Estate Law, Trust and Conservatorship. I am a member of the Labor Law Section of the State Bar.

I served on the Barstow City Council from 1994 through 2000. I served as Mayor Pro-Tem, Chairman to the Barstow Redevelopment Agency, and Vice Chairman of the Mojave Air Quality Management District.

I am currently on the Board of Directors of the CAA. I currently hold the position of Secretary/Treasurer. Previously I served on the Ethics and Professional Committee and as Chairman of the Legislative Committee.

I am seeking the positions of Board of Director and Vice-Chairperson. I hope that you will support me in this endeavor.

CAA *Elections*

Alan McNany
American Legion Post #108 Ambulance
Sutter Creek, CA

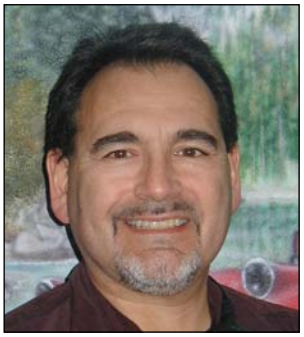
Candidate for Secretary/ Treasurer
(One-Year Term)

I have been in the EMS industry for over 25 years and I am very enthusiastic when it comes to EMS. With a strong desire to provide the citizens of our State the best care possible, we in the EMS profession must continue to provide the best education to our fellow workers, provide state of the art equipment and continue to push for better reimbursement.

I have been a part of the CAA for over 12 years and have served as Chair on the Ethics & Professional Committee, Sergeant at Arms, Secretary Treasurer and Vice Chair.

I have seen the CAA progress like never before. Right now, the CAA is stronger than it ever has been and has a voice that is heard on the State level. I attribute this to our Executive Director, management team and my fellow Board Members. I am excited about the CAA and proud to be part of the leadership team.

As part of the leadership team of the CAA, we must continue to grow and be recognized as the leader in ground ambulance transportation, seek reimbursements to cover our costs and protect existing EOA's.



Edward Guzman
Sierra Ambulance Service, Inc.
Oakhust, CA

Candidate for Director
(Two-Year Term)

It has been my honor to serve the CAA as a director for the last two years. I have been an active CAA member since 1998. I am the general manager and executive director of Sierra Ambulance Service. Sierra is a 501c3 non-profit organization serving eastern Madera County. I have been with Sierra since 1991 and have been the manager since 1997.

Prior to my experience here in Oakhurst at Sierra Ambulance, I worked in San Diego City and County, first for Medevac Ambulance and later for Hartson. I have been a private ambulance guy since my first EMT job with Rand Brooks and Professional Ambulance in 1977. I am a proud product of L.A. Unified, East Los Angeles College and Cal State Fresno. I returned to school and earned an MBA in 2002. I have been a licensed paramedic since 1981.

I have had the privilege of working with and being mentored by many wonderful EMS professionals throughout the years. I have enjoyed being a part of the CAA leadership team. They are a talented and committed group. As all of you know, we face great challenges ahead as we balance quality service with declining reimbursements and increasing costs of operation. I look forward to working with our board of directors and the entire CAA membership in confronting these obstacles. I believe our organization has the talent, the drive and the commitment to meet and overcome these challenges.

Michael S. Williams
Sierra Medical Services Alliance
Reno, NV

Candidate for Director
(Two-Year Term)

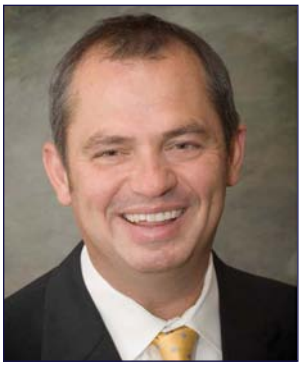
I bring 43 years of EMS experience at all levels from "ambulance driver" to the Florida State Director of EMS. My company, SEMSA, currently operates two ambulance services in Merced County and one in Lassen County, California. Prior to SEMSA, I was the Vice President of Operations for REMSA in Reno, Nevada. My experience includes leadership of hospital based, for-profit, not-for-profit, private and government based ambulance services in California, Nevada, Georgia, Idaho, Texas, Arizona, and Michigan. I have also served as a national EMS consultant, educator and speaker/ lecturer. I have many years of experience on professional boards including as a Director of the AAA.

From my experience, California EMS providers face even more significant issues than other providers in the country. These include a fractured system of government oversight from LEMSA to LEMSA, a State EMS Authority that may want to do the right thing but is ineffective as the LEMSA's go their own direction, and a State government that demands readiness and response from ambulance providers yet only reimburses a fraction of the actual cost per transport. On the larger national stage, the development and application of what is popularly known as "community paramedicine"

CAA Elections

has already been established. CMS has publically stated that with the Affordable Care Act, EMS reimbursement will be based more on not transporting a patient than the past practice of reimbursing only for transport. These are all issues the CAA must address as a successful leader of the entire California EMS industry.

Finally, the CAA must not only be the champion of the state's ambulance services but also, provide EMS education to the State as a whole while promoting our employees, services, and programs.



Todd Valeri
American Ambulance
Fresno, CA

Candidate for Ethics & Professionalism Committee (Two-Year Term)

I am asking for your support to serve on the CAA Ethics and Professionalism Committee. I believe my experience, education and proven leadership abilities would be beneficial to the committee. My current role as President of American Ambulance in Fresno and Kings Counties has given me unique insight into the challenges faced by large and small ambulance companies alike.

I am responsible for leading and directing a diverse workforce of nearly 600 employees serving large urban population centers to small rural communities. We provide the full continuum of ground ambulance services, a multicounty communications center for both ambulance and fire suppression services, as well as a successful air ambulance program.

I have 32 years of EMS experience, an MBA from CSU-Fresno and am a Nationally Accredited and California State Licensed Paramedic. I would be honored to have your support to be on the CAA Ethics and Professionalism Committee.

Stacey L. Zill

How Employers Can Avoid Hefty HIPAA Violations

Stacey L. Zill | Michelman & Robinson, LLP

According to the U.S. Department of Health & Human Services, the fraudulent use and sale of protected health information (PHI) is on the rise. The vast majority of Health Insurance Portability and Accounting Act (HIPAA) violations in 2013 were attributed, in part, to workplace theft and mishandling of PHI. Employers can avoid many of the violations arising out of employee misconduct by instituting proper training protocols. While HIPAA itself provides for no private right of action, individuals are increasingly using its privacy standards as the basis for actions under state laws, including claims for invasion of privacy, negligence, negligent supervision and hiring, and intentional infliction of emotional distress. These actions are, in essence, creating a private right to recover monetary damages where a person's PHI has not been properly protected as required by HIPPA. As a health care employer, do you have proper protocols in place that are consistent with the protections afforded by HIPPA, and sufficient to avoid employee theft or mishandling of PHI?

The Consequences of Employee Theft & Negligence

Theft of PHI is often committed by employees. Theft can be in the form of the intentional taking of the private information, or result from the inadvertent or negligent mishandling of PHI. The result, however, is the same; i.e., employer exposure to HIPPA violations and costly civil litigation brought by the person whose PHI was mishandled.

To illustrate, in *Abigail E. Hinchy v. Walgreen Co.*, Walgreens was recently ordered to pay $1.44 million after a pharmacist looked up the records of her husband's ex-girlfriend, and shared the information with her husband.[1] The patient sued, claiming Walgreens was negligent in supervising the pharmacist. While the pharmacist acted willfully, this kind of situation highlights the necessity for continuous employee training. Simply reading and signing an employee handbook is not enough; employees must be vigilantly reminded that workplace HIPAA offenses carry severe penalties, both personally (in the form of immediate termination), and massive fines and corrective action plans for the employer. Further, security measures, risk assessments and compliance audits should be regularly updated to mitigate the risk of this kind of breach.

What happens when a hospital employee takes work home with her and accidentally leaves 192 billing records on a Boston subway? For Massachusetts General, it meant entering into a resolution agreement with the Department of Health and Human Services that included a $1 million fine, a three-year corrective action plan, and the implementation of a comprehensive HIPAA training program, requiring written certification that all staff received and understood HIPPA policies.

While computer-related breaches make up the majority of HIPAA violations, employers need to ensure that employees exercise the utmost care when handling physical documents as well. Proper policies and training are necessary. Does the employer have policies about the creating, disposing or handling of documents containing PHI? Likewise, does the employer have policies addressing the protection and handling of PHI in electronic form? Has the employee been properly educated on the consequences associated with mishandling PHI? Asking the hard questions is a first step to avoid being another Walgreens or Massachusetts General.

Implementing Computer Procedures

Storing all PHI on secure, encrypted networks with firewalls is the bare minimum that should be done to protect PHI. An employer, however, should implement additional security procedures to maintain

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control over employees' access and use of PHI. This is especially true since PHI can be found in hard copy documents and on easily transportable computers. In fact, many of the most egregious HIPAA violations in 2013 were a result of stolen laptops. Because of their mobile nature, health care employers should rethink using laptops or tablets for this kind of sensitive patient data. To the extent these devices must be used, backup storage, including cloud storage databases, is highly recommended for security purposes, and health care employers should use clearance IDs and a complex password protection system to ensure privacy is maintained.

Social Media and HIPAA

By changing the way we communicate, social media sites like Facebook, LinkedIn and Twitter have increased the likelihood that HIPAA will be violated by those who possess sensitive, personal medical data. Because employers are generally liable for the acts of their employees during the scope of their employment, and many professionals access social networking sites several times throughout the work day, health care employers have good reason to be concerned. As a result, health care employers may want to consider extending their existing policies -- relating to HIPAA compliance and patient confidentiality -- to explicitly cover all social media websites. Employees may become more sensitive to the privacy issues stemming from the use of social media if provided with examples of how seemingly small, innocuous statements can violate HIPAA.

In *Jane Doe v. Simon P. Green et al.*, for example, a paramedic got into "hot water" after posting details about a rape victim on his MySpace page.[2] Although she did not mention the patient by name, she described the victim and detailed the victim's statements about the perpetrator. As a result of this conduct, other people began doing their own personal recognizance of the victim. The Police found that Green's posting had compromised the investigation, while the trial court found that the victim had suffered serious emotional distress. As a result, Green's employer, AMR Emergency Services, was found to have negligently hired, trained and supervised Green, and was forced to pay a hefty fine.

Similarly, several doctors have faced severe consequences including being fired and subsequently reprimanded by state medical boards for posting patient and procedure information—again without disclosing the patients' names— on medical blogs, Facebook and Twitter.[3] Oftentimes, the disclosure of clinical data is enough to constitute a HIPAA violation. These illustrations underscore the importance of being careful when participating in social media. If employees were better educated about the potential HIPPA pitfalls, violations may be avoided.

Requirements for Employees and Business Partners

Ignorance is not an excuse when it comes to PHI and HIPAA violations. The HIPAA Security Rule establishes requirements for companies to take proactive steps and continuously monitor for HIPAA compliance. A PHI policy and security plan should be created that includes workforce training, safeguards, and sanctions for policy violations. Thereafter, employees with exposure to PHI information should be educated on the company PHI policies, and then be required to sign an agreement that they participated in the training, understand the policies, and will abide by the policies.

Moreover, a step frequently overlooked by medical employers is to require outside vendors / business partners that handle, process or transmit PHI to read, fully understand and sign contracts with sections devoted to their duty of strict confidentiality under HIPAA. Further, health care employers may want to consider requiring that their business partners (e.g., billing and medical device companies) to have in place HIPPA compliant protection systems, or risk being held to have violated HIPPA based on the mishandling of PHI by business partners. Mishaps do occur. For example, last year a transcription company stored data on a non-secure site and left a firewall open, causing thousands of private medical records to appear in the Google index.

Reinforcing the Severity of Penalties

Health care employers are under tremendous pressure to track the storage and handling of PHI. The penalties for failing to train and supervise employees who handle sensitive personal and medical data are severe, and include large fines, and potential criminal liability.

Moreover, employees are not immune from being penalized for their mishandling of PHI and, as a result, educating employees that they have "skin in the game" and can be

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Feature *Article*

Planning for Mobile Integrated Health Care:

What do the people with the checkbook think is important?

Chris R. Carlson, PhD |
The Carlson Group

In the effort to redefine EMS delivery, organizations (both public and private) are rushing to hang out their shingle as 'Community Paramedicine' or 'Mobile Integrated Health Care' (MIHC) Providers.

The fact remains, that aside from a few pilot projects, there has been no compensation mechanism provided or identified for these services. One thing remains clear in the age of value driven care; there will be no compensation unless clear value can be demonstrated. So what are the people who will define what 'value' is talking about and what is the emerging conventional wisdom that defines the era of integrated care?

The background data for this summary effort consisted of literature reviews, (industry periodicals and white-papers) and interviews or correspondence with leaders in large integrated delivery systems and payers.

What emerges in the common theme that any potential value-added service will be measured in the context the 'triad of value' driving the current health care economy: increased access, increased quality and decreased cost. There is a tendency for EMS organizations seeking to find their way in the era of redefined health care to initially look to their ability to extend clinical care and by so doing, define their value-added potential in terms of managing population risk primarily through post acute care and navigating system access.

Before the days of readmission penalties and 3-day payment moratoriums, improvement in outcome initiatives focused on patient care within the four walls of the hospital. However, the advent of financial incentives/penalties with an increased focus on the quality of care has enhanced the need to ensure appropriate care, medication verification, and patient compliance through the entire care episode including out-of-facility care. Providers and payers are increasingly recognizing the critical need to have formal patient navigation, referral and monitoring PARTNERSHIPS in place. The key word that is evolving is "Partnerships."

Payers and acute providers are being cautioned to look for 'true' partnerships in their integrated care and population management strategies as a replacement for the historical method of simple patient discharge that was driven by maximizing bed capacity and patient flow. This has, in many instances, made medical transportation a function of the patience of a floor nurse rather than the focus on a quality of care initiative.

A consistent expectation of these groups has already formed that these 'partnerships' be based on clearly defined and aligned levels of care and outcome performance metrics. The results of a MIHC program will be required to provide detailed data that integrates into, and becomes part of an evidenced-based care plan.

The role that post-acute care providers and system navigators play is emerging as the central focus of current triad improvement strategies (Increased Access, Increased Quality and Reduced Cost). Reimbursement incentives are likely to expand the importance of this theme. As such, 'Integrated Health Care Partners' will likely have mandates for partner organizations to be "an extension of the primary healthcare organization's brand." Provider organizations are being cautioned, "partners that enhance the patient experience are essential to maintaining high patient satisfaction ratings, positive community reputation (brand) and strong physician relationships all of which are critical in new reimbursement models."

A further review of the literature reveals specific, identifiable themes related to the evolution of integrated care systems. Effective and sustainable MIHC efforts

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will recognize these issues and have direct strategies for dealing with them:

1. Integrated Health Care Partners (e.g. MIHC) must have contemporary technology that enables real-time data exchange. ACOs and other system providers routinely ask for specific patient data in the current environment. Shortly, ALL acute care providers and payer systems will expect and demand patient progress and outcome information from their partners providing Integrated Health services. The exchange of this information will be required to take place electronically, in real time and with standard integration interfaces and data formats to improve timeliness and accuracy of data as opposed to telephone, fax or manual data entry.

2. Efficient Provision of Services. Integrated Healthcare Partners must demonstrate effective, consistent and compassionate care plan enforcement capabilities. Understanding of the plan of care and the ability to network directly with ancillary care providers on a real time basis, based on a specific clinical need will be expected. Aside from clinical perspectives, there is a growing concern that Integrated Healthcare Partners be aligned with the financial goals of the at-risk provider or payer. Data in the post-acute world confirm that partners who demonstrate consistent execution against metrics based on care plans and monitoring of patient outcomes are more likely to be aligned with the financial goals of the health system. Modern technologies that can enforce guidelines and facilitate creative, collaborative care approaches are critical foundations for the emerging MIHC partnership.

3. Expect data to evaluate performance. Not only should the exchanged data enable real-time visibility into the care that the at-risk organizations' patients are receiving, but the Integrated Health Partner should be able to independently and in concert with the acute care provider, evaluate this data to determine the reasons for readmissions or other non-optimal clinical outcomes in order to improve interventions. Reviewing trends and identifying causes of readmissions, or an inability to reach therapy goals, on a regular basis is a critical component of the MIHC collaboration. Working together to address patient needs and appropriate points of care lead to better overall patient care and reduced cost.

4. Partners should have critical expertise and should expect to expand and change roles. An effective model of an integrated healthcare network will likely require multiple post-acute providers to access different areas of expertise needed for hospital populations that are most at risk for readmission. These needs are likely to change over time. It is here that the potential value-add for navigation of chronic system users catches traction. Metrics and a description of chronic disease management strategies that provide guidance to clinicians and educators to prevent unnecessary readmissions, reassure acute care providers that the MIHC provider is well prepared to care for specific populations. For example, a EMS agency that provides medication compliance and Oxygen therapy training will be more valuable and effective than an agency that just provide compliance monitoring or step-down patient destination referrals.

5. Partner organizations must have similar goals and philosophies. Providers and payers are consistently cautioned about the critical importance of similar goals, mission, philosophy and culture. No matter how successful each individual organization is in the community, a culture clash in a partnership will not work in enhancing the patient experience, improving quality or reducing cost. For example, a hospital that is extremely cost conscious will not work well with an integrated provider that is not. A hospital district that has debt service on a new freestanding Emergency Department will have difficulty in initiatives that reduce fee-for-service volumes. Both partner organizations must have the same expectations from the start of the partnership because the reputation, quality of care and lives of patients are at stake.

These 5-issues comprise a summary of the thought exposure of literature and networking that is becoming the

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MIHC Continued from page 15

contemporary wisdom of the people that will be determining the value that integrated care (both mobile and not) adds to the delivery system. It is in this wisdom that the future of reimbursement for a redefined EMS lays. A few questions are worth going over as part of an EMS agency's strategic plan as it relates to the MIHC transition:

- Do I have the technology that will allow me to integrate with my partners?
- Can I invest in the needed technology, both short and long term?
- Do I have the ability to apply business analytics to both my data and the integrated data from my integrated partner?
- Do I have the management knowledge to interpret the data in such a way to identify and then execute on opportunities or needs in the continuum of care?
- Do I have workforce knowledge with the capabilities to interpret a plan of care and provide knowledgeable plan compliance techniques and reporting?
- Do I have, or can I get, certified Navigators to assist in identifying appropriate payers, payer options and appropriate resources for care?
- Do I have the ability to obtain Point-of-Service Payment?
- Is my organization sufficiently integrated into the health care system to allow for immediate, electronic communication and integrated referrals along the continuum of care?
- Does my organization have the flexibility to expand our knowledge base to an expert level in specific disease states or conditions based on my community and partner needs?

Organizations seeking to have sustainable and REIMBURSIBLE Mobile Integrated Health Care initiatives must then also build the systems that support the collaborative process. In addition to data integration, organizational integration must also occur with systems and structures that include all organizations and care givers along the entire continuum of care.

The current literature in healthcare leadership suggests that as healthcare continues the transition to value-based reimbursement models, integrated care is the future of patient care. Integrated delivery (including mobile) along the entire continuum of care will require collaboration models that benefit both organizations – financially and clinically.

By taking steps now to ensure you are preparing your organization to partner with the forward-thinking acute-care providers and other at-risk organizations, EMS leaders can strengthen their financial strategy and obtain greater probability of success in preparing for the new world of health care.

Dr. Carlson has been recognized as a leader and innovator in medical transportation and healthcare for over 30 years. He currently serves as CEO of The Carlson Group, a pre-eminent consulting firm in the health care, airline, medical transportation, EMS and public safety sectors. He can be reached at chris@carlsonmed.com or 619.390.3373.

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penalized for their HIPPA violations. As a result, developing solid security and privacy procedures is a start, but employees also need to be made aware of the severe consequences of a breach. HIPAA states that knowingly obtaining or criminally disclosing PHI can result in a $50,000 fine and up to a one-year prison sentence. If the theft is done with "intent to sell, transfer or use for commercial advantage, personal gain or malicious harm," offenders can face up to a $250,000 fine and 10 years in prison. Civil violations start at $50,000 and cap at $1.5 million a year. Further, while there is no private right of action under HIPAA, California's Confidentiality of Medical Information Act does provide a private cause of action, including compensatory and punitive damages. Through a thorough, aggressive and ongoing training program, health care employers can demonstrate to employees how the smallest, ostensibly harmless example could establish a breach, thereby mitigating the likelihood of a violation occurring that could result in a lawsuit or massive fine.

Stacey L. Zill, Esq. is a litigation attorney at Michelman & Robinson, LLP who represent health care clients. Ms. Zill is a member of the Health Care Department; she can be reached at 818.783.5530 or by email at szill@mrllp.com. This article is not be relied upon as legal advice. Consult counsel for advice in specific situations.

1 *Abigail E. Hinchy v. Walgreen Co. et al.*, case number 49D06-1108-CT029165, in the State of Indiana Superior Court, County of Marion.

2 *Jane Doe v. Simon P. Green*, Case No. 0704-04734, Circuit Court for the State of Oregon, Multnomah County.

3 Christopher Danzig, April 29, 2011, ER Doctor Forgets Patient Info is Private, Gets Fired for Facebook Overshare. Above the Law.

Feature *Article*

The Road Map to a Safer California

Laurie Reiss | Strategic Highway Safety Plan

Over 24 million licensed drivers travel over 175 thousand miles of roadway each year in California resulting in nearly 3,000 deaths and over 10,000 serious injuries. While the traffic safety picture has improved in the state, those large numbers leave no doubt about the need for a road map that can reduce the human and economic costs of traffic crashes. The National Highway Traffic Safety Administration (NHTSA) estimates these crashes are costing the state over $22 billion each year.

To reduce the toll on the State's roadways, California is updating its Strategic Highway Safety Plan (SHSP), a data-driven, statewide, comprehensive safety plan that provides a framework for reducing deaths and serious injuries on all public roads. The plan is designed to involve a broad range of stakeholders including engineers, enforcement, education, and emergency medical services – the 4Es of safety. Included in those 4Es are transportation planners, maintenance personnel, injury prevention specialists, public health professionals, highway safety advocates, and others at the state, regional, and local levels.

The goal of the SHSP is to reduce crashes and the resulting fatalities and serious injuries by sharing resources and targeting efforts to the areas of greatest need. This undertaking requires leaders, pathfinders, problem solvers, and visionaries; and California is reaching out to state, regional, and local agencies, institutions, private sector organizations, and concerned citizens to help solve the roadway safety problem.

As part of the SHSP update process, California is asking stakeholders to lend their voices, ideas, and concerns to identifying the most effective ways to improve traffic safety on all public roads.

A series of interactive webinars will be held in late October to provide briefings on the primary California traffic safety issues and accept comments and ideas from all interested stakeholders. Mark your calendar to attend one or more of the SHSP webinars on:

October 28, 2014

10:00 am to 12:00 pm Tribal Safety

2:00 pm to 4:00 pm Special Populations (Young Drivers, Older Drivers, Commercial)

October 29, 2014

10:00 am to 12:00 pm Driver Behavior (Impaired Driving, Seat Belts, Speeding, Distracted Driving)

2:00 pm to 4:00 pm Infrastructure & Operations (Roadway Departures, Intersections, Work Zones)

October 30, 2014

10:00 am to 12:00 pm Vulnerable Road Users (Pedestrians, Bicyclists, Motorcyclists)

2:00 to 4:00 pm Emergency Medical Services (EMS)

Two Safety Summits will provide a day-long interactive forum on the state of traffic safety in California. Details on dates and times will be on the SHSP web site in the near future.

More information including how to register for the Webinars and Summits, and a form to provide comments will be available on the SHSP website at http://www.dot.ca.gov/hq/traffops/shsp/.

Association *Events*

The California Ambulance Association cordially invites California's EMS leaders and professionals to join us at the Annual Convention & Reimbursement Conference on October 8-10, 2014 at the Bahia Resort Hotel in San Diego, California. Below is a brief look at the presentations. For a more thorough overview, plus schedule and registration form, visit www.the-caa.org.

Wednesday, October 8, 2014

Opening day features the Annual Raymond Lim Memorial Golf Tournament at the famous Torrey Pines Golf Course, followed by a Welcome Dinner with Special Guest, A.J. Heightman, Editor-in-Chief of JEMS.

Thursday, October 9, 2014

CAA Marketplace: Throughout the day, attendees will visit vendor exhibits to learn more about products and services related to the ambulance industry and participate in a **treasure hunt** to win prizes!

Welcome & General Session with speaker Darren Kavinoky, the creator and host of the hit TV show "Deadly Sins ." He is a certified interventionist, attorney, and "misbehavior" expert.

Business Issues from the State Capitol with Jennifer Barrera, California Chamber of Commerce. Jennifer will discuss major issues facing California's ambulance companies as employers.

Billing Audits and Compliance with Damaris Medina, Esq., Michelman & Robinson, LLP. The escalating pressure on government and commercial payers to decrease costs means providers must become "audit-ready."

The Future of EMS in California: An Economics-Based Perspective: Michael Petrie – Santa Clara County EMS. Mike will examine the history, current state, and future trends of EMS in California, based primarily upon financial and economic drivers.

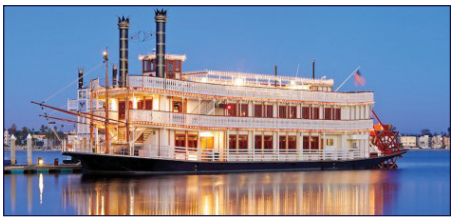
Getting Paid and Keeping Your Money with Andrew Selesnick, Esq., Michelman & Robinson LLP. Compensation for ambulance services is under attack by payers. Ambulance service providers need to know how to ensure they are properly being reimbursed.

Thursday's Lunch & General Membership Meeting will feature CAA Election Results, Federal Lawsuit Update, Legislative Update, and a State of the Association report.

Lessons Learned from the Reno Air Show Disaster with Michael Williams of SEMSA. Disasters or mass casualty incidents are all relative. Hear about tips to make your disaster "all in a day's work."

Medicare Update and Post-ACA Issues with Brian Werfel of Werfel & Werfel, AAA Medicare Consultant. In two sessions Brian will get you up to date on changes affecting Medicare, trends in the federal government's attempts to curb fraud plus impacts to reimbursement after implementation of the Affordable Care Act.

Driver Modification: Using Data to Create a Drive Safe Culture with James Pierson – Medic Ambulance Service, Inc. Jimmy will discuss how data and driver modification programs can change culture, behavior and corporate compliance and save hundreds of thousands of dollars.



The Chair's Reception and Awards Banquet Thursday evening will be held aboard the *William D. Evans Sternwheeler*.

Friday, October 10th

CAAPAC Raffle & Marketplace Treasure Hunt Prizes will be Awarded midway through the day.

Surviving the Perfect Storm - Understanding CA Leave Laws with Stephanie Hawkins of the California Employers Association. Stephanie will cover the 19 different types of leave in California and provide you with a CA Leave Law Cheat Sheet.

Medicare Update with Kathy Montoya of Noridian Healthcare Solutions. Kathy will provide an industry-specific overview for ambulance companies billing Medicare.

Quality Measures in Leadership with Troy Hagen of Care Ambulance Service, Inc. Troy will discuss the challenges and opportunities of establishing effective quality measures for EMS supervisors and all employees to achieve optimal performance.

Medi-Cal Update with Mari Gonzalez of Xerox State Healthcare, the Medi-Cal Fiscal Intermediary. Mari will discuss top billing errors and issues ambulance companies may be facing with their Medi-Cal Claims. Q&A included.

Immense thanks to our sponsors for their valued support of the CAA:

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CAA 66th Annual Convention, Oct. 8-10, 2014 — REGISTRATION FORM

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FULL REGISTRATION

Full registration features admission to all events on Thursday, October 9th & Friday, October 10th including seminars, all refreshments, CAA Marketplace, Opening Lunch, Chair's Reception and Chair's Banquet. ***Full registration does not include the golf tournament or the Welcome Reception & Dinner.***

CAA Members	Non-Members
REGISTRATION	
On or Before September 29, 2014:	**On or Before September 29, 2014:**
Qty. _____@ $465 each = $_____ Total **A-1**	Qty. _____@ $930 each = $_____ Total **A-1**
After September 29, 2014:	**After September 29, 2014:**
Qty. _____@ $515 each = $_____ Total **A-2**	Qty. _____@ $1,030 each = $_____ Total **A-2**

GUEST TICKETS

Welcome Reception & Dinner (10/8/14):	**Welcome Reception & Dinner (10/8/14):**
Qty. _____@ $65 each = $_____ Total **M-1**	Qty. _____@ $125 each = $_____ Total **M-1**
Opening Lunch (10/9/14):	**Opening Lunch (10/9/14):**
Qty. _____@ $40 each = $_____ Total **M-2**	Qty. _____@ $80 each = $_____ Total **M-2**
Chair's Reception/Banquet (10/9/14):	**Chair's Reception/Banquet (10/9/14):**
Qty. _____@ $80 each = $_____ Total **M-3**	Qty. _____@ $160 each = $_____ Total **M-3**

GOLF TOURNAMENT (separate fee required)

Golf registration includes: green fees, box lunch, 1/2 cart, refreshments, tee prize, Welcome Reception and Dinner.

Raymond Lim Memorial Golf Tournament (10/8/14):	**Raymond Lim Memorial Golf Tournament (10/8/14):**
Qty. _____@ $295 each = $_____ Total **S-1**	Qty. _____@ $395 each = $_____ Total **S-1**

TOTAL REGISTRATION FEES = $_____

Please print or type all attendee names (even if they're only attending social functions) as they should appear on each name badge. Indicate the type of registration for each person (A-1, A-2, etc.) and the social activities each person will attend (S-1, S-2, etc.):

Attendee Name **E-mail** **Type (A-1, S-1, etc)**

_____

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66TH Annual Convention

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— October 8-10, 2014 —
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San Diego, CA

See page 18 for a preview and registration form.