Draft Policy Public Comments Received: 08/07 - 08/21/2025

S-883 Emergency Medical Dispatch Enhanced Care Access		
DATE	**NAME**	**PUBLIC COMMENT**
8/20/2025	Nate Pearson	As a general comment, this policy serves as a sub-program of an approved dispatch plan (S-882), the language should reflect the same tone as S-882 which is more collaborative and provides for local agencies to meet the needs in their communities with oversight provided by their Dispatch Medical Directors. Continuing the approach that agencies should take an active role in QM participation in concert with SD Co EMS staff makes for a more nimble and patient centered system while still providing for a wholistic system. By placing the responsibility for authorization and approval entirely with the SD Co Medical Director, the county may now absorb some liability for outcomes under local ECAP programs. Requiring authorization and approval by the SD Co EMS MD of changes to the system also slows down process improvement when practices that do not benefit the patients are identified.

	Nate Pearson (cont.)	Under S-882 (Section VII.B.) - "Dispatch Centers implementing Tiered Dispatch may tailor these response models and criteria to local jurisdiction and population needs. Elements to be included for San Diego County EMS Office review includes:...5. Alternate Call Routing programs". The language used here to indicate that a collaboration between Dispatch Medical Directors and SD Co EMS staff to provide transparency while maintaining local authority to manage these non-emergent patients should be brought in to S-883. Please see below for specific comments and suggestions. III. Definitions (last line) change "prehospital health care system" to "prehospital Emergency Medical System". 1797.94 and 1797.200 do not provide authority over all prehospital "health care". The LEMSA is intended to administer the EMS system. Under the heading "EMERGENCY MEDICAL DISPATCH (EMD) CENTER " many of these definitions already exist in S-882. Repeating them here provides an opportunity for them to become out of sync in the future. Recommend removing redundant definitions that exist in other policy (e.g. - S-882 has Dispatch Center Medical Director, S-883 has EMD Medical Director the definitions are substantially similar but not identical leaving confusion on which is to be used).

	Nate Pearson (cont.)	Definitions (cont.) ENHANCED CARE ACCESS PROGRAM (ECAP) CENTER ECAP Navigator - "ECAP Navigator qualifications must be approved by the CoSD EMS Medical Director and shall include clinical licensure and relevant emergency care experience as defined by CoSD EMS." This is unclear if each employee's qualification must be approved by the CoSD MD. Hiring and qualifications are at the discretion of the hiring agency. If there is a minimum qualification recommendation, please provide it here but this level of authorization should remain at the Dispatch Medical Director as this program is their responsibility. Section IV Policy-Section A. Agencies implementing Alternate Care Routing have already received approval via S-882. Please change this policy to from "Dispatch Medical Director approval is required prior to implementation of an ECAP." Should read " CoSD Medical Director shall be notified of program for review and collaboration utilizing template S-883A." VI. "QA/QI COMPONENTS" Section A.1.e - "Providing CoSD EMS access to EMD and ECAP recordings"; This information is for internal QM usage and review. Carte blanche access is unnecessary and unreasonable. Rephrase to state "CoSD EMS may request audio recordings for case review as part of QA/QI

	Nate Pearson (cont.)	process" Section B. "Quality Improvement" 4. "Providing outcome data to CoSD EMS" - outcome data is not currently available for patients that remain in the EMS system. Requiring outcome data for non-emergency patients that are not in the EMS system, other than patient surveyed information" is unrealistic. 6. "Verification that referred patients received clinically appropriate patient care." - See above. In our current EMS system we cannot even provide this verification for patients that AMA with more serious conditions. Expecting follow-up verification, other that patient's stated plan at time of disconnect, is not possible. VII. PROCEDURE Section A. “Proposal Submission Process” 2. - "Approved proposals are subject to a minimum 12-month probationary period." – This is unreasonable and unnecessary. Program operations should remain at the discretion of the local Dispatch Medical Director. Holding full approval authority at the CoSD MD level brings program operation and liability back to the County. If more frequent check-ins are desired include that in the QA/QI plan for greater frequency during the first 12 months of operation. 3. “Substantive changes to provisionally approved proposals must be resubmitted for CoSD EMS Medical Director approval.”

	Nate Pearson (cont.)	Requiring CoSD MD approval for changes may delay changes that are locally identified to improve patient outcomes and safety. This authority must remain with the local Dispatch Medical Directors. Section B. “Probationary Requirements:” – Please remove probation as a component of this policy Section C. “Approved Program Requirements” 5. “Submission of program staffing changes within 10 business days.” – This should only be for defined positions such as Program Manager or Medical Director. All employees do not need to be verified with CoSD EMS. 6. “Submission of all substantive ECAP changes for CoSD EMS Medical Director approval.” - Holding full approval authority at the CoSD MD level bring program operation and liability back to the County. This should be phrased “Submission of all substantive ECAP changes for CoSD EMS Medical Director review.” Thank you for reviewing these comments. Please reach out for clarification.

8/22/2025	Christopher Kahn	General question: What is the overlap between this new S-883 policy(specifically for “transportation to medical care locations other than emergency departments”) and the provisional TAD-1000 series of policies/protocols? Will all ECAP centers need to restrict ECAP activities to agencies approved under the TAD framework (of which, of course, there are currently none)? Please clarify CoSD EMS’ intent on which agencies, dispatch centers, and EMS providers are (and are not) covered under both S-883 and the provisional TAD-1000 series. IV.C. While this may appropriate for now, there are times when dispatching emergency resources simply because they are demanded is an inappropriate response. We encourage the LEMSA to be even more forward-looking and to consider modifying or removing this requirement. There is no California law or regulation entitling all 911 callers to receive an emergency ambulance response. V.A.5. What is the purpose of these questionnaires? Are there specific items the LEMSA would like asked?

	Christopher Kahn (cont.)	VI.A.1.d This remains unworkable. It is simply not possible to "confirm that every person referred to resources outside of the 911 system successfully accessed clinically appropriate patient care." First, what is "clinically appropriate" is subjective. Second, most patients may choose to refuse care at any time, making it virtually certain that not all patients will ultimately access care. Third, It is highly unlikely that receiving facilities will provide feedback to the ECAP center regarding what care all patients referred to them received, particularly for lower acuity care such as medication refills. Again, I strongly urge that this language be changed to reflect the aspiration that it is rather than a requirement that can never be met. This also applies to VI.B.6.

Draft Policy Public Comments Received: 03/14 - 04/14/2025

S-883 Emergency Medical Dispatch Enhanced Care Access		
DATE	**NAME**	**PUBLIC COMMENT**
4/10/2025	Jon Jordan	Section III. Are there cases for ECPA Centers outside of San Diego that have different requirements for program managers and navigators? If a center is already operating outside of San Diego as a center, would their current approval from their home county be valid in San Diego County? Section IV: The LEMSA could approve a new center located in San Diego County, but for an ECAP outside of San Diego County, would the LEMSA approve using that existing center in San Diego County? Not necessarily approving the implementation of the center since it is already operating? Section VI. B. 5. Recommended adding language to state "Process to make every effort to attempt to confirm..." There may be times when the patient refuses to participate in the follow-up process. Section VII.C. Does this apply to existing ECAPs or only if a local government is looking to develop a new ECAP with a private vendor?

4/11/2025	Nate Pearson	IV.A.2 - Possible Typo - "QM/QI" this term is not defined. Should it be "QA/QI"? VII.B(first paragraph) - consider breaking this list of requirements during the probationary period into a subsectioned list for ease of reference and reading. Define "probationary" and "approved" and list requirement under each. VII.B.(second paragraph) - "Probationary programs that do not meet the CoSD EMS Office Medical Director established standards, will not receive approval." Where are the "established standards" defined? How will an agency know what standard they are trying to meet. This is unclear and subjective. VII.B.1 & 2 - switch order, this currentl implies that the first course of action would be to revoke or suspend and program approval prior to suggesting modifications. VII.B.2 - "Request modifications to ECAP protocols, including approved determinant codes". Determinant codes and protocols may be established by national standards that cannot be modified locally. Additionally, response levels/utilization of established determinant levels are the purview of the ECAP medical director. Rephrase to state "Suggest modifications of approved plan to improve outcomes or patient safety". Move this item to VII.B.1. Thank you.

Draft Policy Public Comments Received: 12/31/2024 - 01/31/2025

S-883 Emergency Medical Dispatch Enhanced Care Access		
DATE	**NAME**	**PUBLIC COMMENT**
1/31/2025	Christopher Kahn	It is encouraging that the LEMSA is working to develop policies in this realm. There are some changes that would improve the usefulness and feasibility of this policy. First, as noted above, there is likely to be significant disagreement as to the regulatory reach of this policy, specifically on which programs and which agencies are or are not subject to it. Working with the regional stakeholders to clarify this as much as possible is likely to improve the acceptance and workability of this policy. III (definitions). The EMD medical director should be board certified/eligible in emergency medical services specifically, not just emergency medicine generally. General emergency medicine training makes no reference or inclusion regarding EMS dispatch methodologies. If the LEMSA wishes to include a “grandfathering” clause for a period of transition that may be appropriate. The ECAP center program manager does not need to be a nurse, nor is the “five years of recent emergency department experience” the relevant experience.

1/31/2025	Christopher Kahn (Cont.)	Nurses (like emergency medicine generalist physicians) do not receive any training in dispatch methodologies and do not have unique qualifications making them automatically suited for this role. The program manager should be an EMS clinician with relevant field EMS experience, which could include a nurse, physician, PA, NP, paramedic, and perhaps other clinicians if they have demonstrable experience providing EMS care in the field to best inform their ECAP practice. ECAP navigators, similar to ECAP center program managers, should not be defined as "typically" a nurse with five years of recent ED experience for the same reasons noted above. A seasoned paramedic or other field provider will have a much better understanding of field conditions – including urgent health care navigation – than a nurse who has only worked in the ED but not in the field as an EMS clinician. IV.C. While this may appropriate for now, there are times when dispatching emergency resources simply because they are demanded is an inappropriate response. We encourage the LEMSA to be even more forward-looking and to consider modifying or removing this requirement.
1/31/2025	Christopher Kahn (Cont.)	There is no California law or regulation entitling all 911 callers to receive an emergency ambulance response. V.A.5. What is the purpose of these questionnaires? Are there specific items the LEMSA would like asked? VI (QA/QI components). The numbering is incorrect in this section. VI.B.10 (likely meant to be numbered as VI.B.5). It may not be possible to determine with 100% reliance/accuracy whether patients who are referred to a clinic, urgent care, or other destination arrive at that destination without a requirement for those facilities to report back to the ECAP. Patients who are managed with responses such as calling in a medication refill will almost certainly not cause the pharmacy to either notify the ECAP that the prescription was successfully filled or to respond to the ECAP if asked whether the prescription was filled. Further, determining whether "all medical needs were met" is not a question that can be honestly answered by anybody other than the care provider and the patient, making it impossible for any ECAP to meet this requirement, particularly without some reasonable limitation on the definition of "all medical needs".

1/31/2025	Christopher Kahn (Cont.)	It would be astonishing to require an ECAP to ensure that a patient's overdue screening colonoscopy was scheduled, performed, and that any biopsy results were appropriately addressed when the patient's call was related to a stubbed toe, yet that would fall squarely in this overly broad definition. VII (procedures). VII.A.2 describes a 12-month probationary period, but VII.B describes a 6-month probationary period. This is inconsistent. VII.A.3. This requirement, if taken literally, is both exceedingly restrictive/unworkable and contrary to patient safety protection. For example, if a determinant was found by the ECAP to include an unacceptably high number of patients requiring secondary transport to an emergency department, the ECAP would not be allowed to stop including those patients in their program until that change was approved by the LEMSA medical director. Is it the intent of the LEMSA to specifically approve every combination of determinant (including suffixes), caller party, time of day, health network, and all other factors that might be considered in whether a patient could qualify for inclusion in an ECAP? Does the LEMSA have an evidence base informing these decisions that could be made available to all agencies considering development and implementation of an ECAP? This would be the most efficient and successful approach to implementation of an ECAP.