County of Kern
Emergency Medical Services

Rotor-wing Air Ambulance Service Performance Standards

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Introduction:

The Kern County Rotor-Wing Air Ambulance Performance Standards (hereinafter referred to as Standards) establish minimum standards for air ambulance service performance. These Standards are applicable to all contracted rotor-wing air ambulance providers (hereinafter referred to as Provider) in Kern County (hereinafter referred to as County).

These Standards are directly referenced in the Kern County Ordinance Code Chapter 8.12., entitled Ambulances (hereinafter referred to as Ordinance) and each Agreement for Provision of Rotor-Wing Air Ambulance Service (hereinafter referred to as Agreement) executed by the County.

Both the Ordinance and Agreement contain basic performance provisions. The Standards further define performance requirements for air ambulance Providers. Definitions of terms in these Standards are in accordance with Ordinance definitions and the definitions listed in Appendix 2.

These standards are not applicable to fixed-wing air ambulance providers. Any qualified fixed-wing air ambulance provider can be used within Kern County.

These Standards may be adjusted by the Kern County EMS Department (hereinafter “Department”) through the course of the Agreement consistent with the modifications in EMS operational and medical standards that are developed by the Department, in coordination with the Provider. The Provider shall be notified with sixty (60) days advance notice of the effective date of the change and shall define any Agreement impact within thirty (30) days of initiation.

1. Administrative:

1.1 Each rotor-wing air ambulance Provider shall continuously maintain all services in accordance with the proposal submitted by the Provider to the Department and the request for proposal process issued by the Department.

1.2 Provider shall maintain continuous compliance with Kern County EMS Department – Rotor-Wing Air Ambulance Standards.

1.3 Provider shall adhere to all applicable EMS policies of the Department and shall comply with all federal, State, and local laws, rules and regulations.

1.4 At a minimum, the Provider must provide rotor-wing air ambulance service. The Department shall be pre-notified of any planned change in the type of aircraft assigned to the County. The Department may approve or deny the planned change.

1.5 Provider must provide 24-hour, 365-day per year coverage for all emergency air ambulance requests for service for the term of the Agreement. The Provider must meet or exceed the required response times each calendar month, as specified in the Provider’s response time commitments approved by the Department.

1.6 A service delivery plan (SDP) shall be developed and maintained by the Provider. The SDP shall be submitted to the Department for approval and adhered to by the Provider.
Changes to the SDP shall be forwarded to the Department for review and approval before implementation of the changes. All resources to be used in this franchise for air ambulance service shall be included in this SDP. The SDP must have clearly identified back up/mutual aid air ambulances, particularly for those areas that might be best served by a Provider from outside the County.

1.7 The Provider must be a single legal entity properly licensed to do business in the State of California. If the Provider relies on the prior experience or factors of production of a partner, shareholder, or constituent governmental agency for the purposes of meeting the requirements of these Standards; then each partner, shareholder, or constituent governmental agency must individually be prepared to guarantee that all of the contractual requirements will be met and be jointly and severally liable for any breach of contract, tort, rule violation, infraction, or penalty imposed.

1.8 The Department shall be pre-notified of any planned change in corporate or company structure, including any partnership or contractor change. The Department may approve or deny the change.

1.9 Provider shall be properly licensed by the State of California and hold all appropriate licenses and certificates required by the Federal Aviation Administration. This includes a valid FAA Part 135 Air Carrier Certificate held by the Provider or under contract.

1.10 The Provider shall pay all taxes lawfully imposed upon it with respect to this proposal or any product delivered with respect to the Agreement. The Department makes no representation whatsoever as to the exemption from liability to any tax imposed by any governmental entity on the Provider.

1.11 The Provider shall be in compliance with all applicable standards, orders or requirements issued under Section 306 of the Clear Air Act (41 USC 1857(h)), Section 508 of the Clean Water Act (33 USC, 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR, Part 15) which prohibits the use under nonexempt federal contracts, grants, and loans of facilities included on the EPA List of Violating Facilities. The Provider shall report violations to the applicable federal agency and the US EPA Assistant Administrator for enforcement.

1.12 The Provider shall maintain a drug-free workplace as set forth by the federal Drug-Free Workplace Act of 1988 or as last revised.

1.13 The Provider shall obtain an accreditation for rotor-wing ambulance service, as established by CAMTS, within one (1) year of the effective date of the Agreement and maintain it throughout the term of the Agreement.

2. Availability:

2.1 The Provider shall respond to all requests for service within the Provider exclusive operating area on a seven (7) day per week, twenty four (24) hour per day basis, in accordance with Department policy.
2.2 All of the following transports originating in the Kern County EOA shall be referred to the Provider of the EOA, and the Provider shall provide all responses and air transports as follows:

2.2.1 Made in response to requests for immediate air ambulance service, within its assigned EOA, transmitted through the Kern County Emergency Communications Center (hereinafter referred to as ECC);

2.2.2 Any other request for service requiring an air ambulance response, as defined by the Department's policies and procedures.

2.2.3 The Provider shall not self-dispatch an air ambulance response to any 911 on scene incident, or respond into the area of any such incident, unless requested to respond by an authorized agency in accordance with Department requirements.

2.2.4 All air interfacility rotor-wing transports requiring the services of a rotor-wing air ambulance, including interfacility transports originating in Kern County. Certain exceptions to this provision may be made when aviation, clinical, weather or other circumstances dictate that another service is more appropriate for the safe care and conveyance of the patient.

2.3 Should the Provider be unable to provide any of the above services when requested, it shall fall to the Provider to immediately obtain alternate air ambulance services to meet the service request. In the event that the two EOA’s are assigned to different Providers, the Providers shall maintain a functional automatic mutual aid system to help to meet this requirement. In any case in which a mutual aid Provider is used, the EOA Provider shall notify and coordinate with ECC. Any mutual aid arrangements or plans shall be pre-approved by the Department. The Department may approve or deny a mutual aid plan.

2.4 Provider shall respond to all emergency calls regardless of the potential payment capability of the patient and shall be prohibited from making any assessment of potential payment capability of the patient at the scene.

2.5 Provider shall participate with the Department and provide the necessary expertise in the development and designation of EMS landing sites within the Department jurisdiction.

2.6 Provider shall maintain operational control of the aircraft used in the service of the Agreement, and shall control all aviation and related flight operations of the aircraft at all times. The Provider, and its pilots assigned, shall be in command of the aircraft at all times. No flight will commence until and unless the Provider’s pilot and the director of operations are satisfied, at their sole discretion, that the pilot is fit; the aircraft mechanically sound and properly loaded; and the weather, landing zone, airstrip, airport and any other conditions necessary for a safe flight are deemed acceptable.

2.7 The Provider, and its pilots, at their sole discretion, may unilaterally make any changes prior to or while in flight to accommodate changes in weather, air traffic, FAA directive, mechanical problems, or other matters affecting safety in flight. Under no circumstances shall any other person or passenger overrule the pilot regarding the aviation operations of any flight. The Provider shall operate all flights under the flight time limitations and rest
requirements of FAR Part 135, and the hospital emergency medical evacuation services rules of the FARs shall apply to all pilots.

3. Dispatch and Communications:

3.1 The Provider shall assure that personnel and equipment are activated immediately upon direction of the authorized EMS dispatch center even if it appears that the scene is not in the assigned EOA described herein. Incidents of possible dispatch error should be dealt with after the emergency situation is mitigated. A report shall be forwarded by the Provider to the Department relative to any suspected “dispatch errors.”

3.2 The Provider shall maintain and operate a dispatch center and flight following service in substantial compliance with CAMTS Standards for such services. This requirement can be met by directly providing the dispatch center and flight following service or contracting for the dispatch center or flight following service.

3.3 In addition, the Provider shall provide the following in the operation of the dispatch and flight following service:

3.3.1 All telephone lines and radio frequencies, used for emergency or business communications, in and out of the center will be recorded and kept for a minimum of one (1) year from the date of the incident.

3.3.2 Emergency back-up power will be available.

3.3.3 The Department shall have full and free access to the tapes, logs, data, etc., at reasonable times without prior notice and shall have the authority to audit tapes, logs, data, etc.

3.3.4 Provide all required periodic reports pursuant to the Agreement and as required/requested by the Department.

3.4 The Provider shall obtain, install, and maintain in Provider’s helicopters all such radio and telecommunications equipment as is necessary for the effective and efficient dispatch of helicopters and for effective and efficient communication with public safety agencies, the EMS dispatch center (ECC), first response agencies, ground ambulance units, and base and receiving hospitals.

3.5 The Provider shall cooperate, train with, participate in quality control procedures and communicate with ECC to assure a smooth delivery of dispatch services.

4. Response Time:

4.1 The Provider shall record or cause to be recorded, the times at each of the stages of a response (time of call -TOC, dispatch time - DSP, enroute time - ER, scene arrival time - OS, enroute hospital time - ERH, arrival at hospital time - OSH, leaving hospital time – AOR, and arrival back at base time - ABB) as defined herein, and by map grid for each
and every request for service, whether emergency or non-emergency, transfer, or dry run. This includes response stand-by requested by ECC.

4.2 Prehospital response time commitments shall be measured from the receipt time of the request to respond from ECC until the air ambulance reports it is “at the scene.” For the purpose of response time calculation, “at the scene” shall be defined as within ¼ nautical mile and not more than 1000 feet above ground level (AGL) from the actual scene or designated landing area. Stand-by time is not included in response time calculation.

4.3 The Provider shall assure that an air ambulance is on the scene of all prehospital emergency calls 90 percent of the time, as measured each calendar month, within the exclusive operating area response time grids as shown in Appendix 1. All prehospital responses in all grids will be measured to determine EOA performance compliance on a monthly basis.

4.4 For purposes of determining compliance, the call is not considered late until 60 seconds has elapsed beyond the response time for the location of the response. In other words, all maximum response times referenced throughout this document include an additional 59 seconds of time before the call is deemed late.

4.5 100-Response Rule:

4.5.1 For the purposes of determining compliance with response time requirements of each EOA each month, the following method will be used. For every month in which 100 or more prehospital responses originate within the EOA, 90 percent compliance is required for the month. However, for any month within which fewer than 100 responses originate within the EOA, compliance will be calculated using the last 100 sequential responses. Interfacility transfer response times will be measured separate from prehospital response times using the same method.

For example, if EOA “A” produces 105 prehospital responses, the Provider is required to meet the prehospital response time standard for the month. If EOA “A” produces only 30 interfacility transfer responses, compliance will be determined using the last 100 sequential interfacility transfer responses.

4.6 Interfacility response time commitments shall be measured as follows:

4.6.1 For emergency interfacility transfers where an immediate response is requested response time is measured from call time to facility arrival time. The time standard is based upon location of the facility within the exclusive operating area response time grids as shown in Appendix 1. The Provider shall assure that an air ambulance is at the facility based on the response time grid a minimum of ninety percent of the time for each month.

4.6.2 For interfacility transfers where an immediate response is not requested, the response time is measured from call time to facility arrival time. The time standard is no more than two hours for a minimum of ninety percent of the responses for each month.
4.6.3 For prescheduled interfacility transfers, response time is measured from the requested pick-up time (at least 2 hours in advance) to facility arrival time. The time standard is to be on-time for a minimum of ninety percent of the responses for each month.

4.6.4 Response time compliance will be measured for all interfacility transfers on a monthly basis, separate from the prehospital responses.

4.6.5 Nothing in Section 4.6 shall be construed as requiring the Provider to accept interfacility transfers in which patient care would be better served by an alternate provider or more appropriate means of transport (i.e.: ground ambulance transport or fixed-wing air ambulance). In all such cases, the Provider shall assist the transferring facility, as required, in locating and arranging transport with, such an alternate provider.

4.7 Response time analysis and exemption requests will be managed by the Department in the following process:

4.7.1 Calls referred to another agency will be included as part of the response-time requirements for calculating compliance.

4.7.2 Canceled/Aborted Responses, Multiple Aircraft Units and Mechanical Failures. From time to time, special circumstances may cause changes in call classification. Response-time calculations for determination of compliance and penalties will be as follows:

4.7.2.1 If a call is canceled or aborted prior to the air ambulance unit arrival on the scene, the Provider compliance and penalties will be calculated based on the elapsed time from receipt of call to the time the call was canceled. However, if the Provider makes a request for mutual aid air ambulance response as stipulated in these standards, the Provider may not cancel the mutual aid responder if the responding provider is closer to the call.

4.7.2.2 For each response in which the Provider’s management or field staff fails to report the at-scene time, the response shall be counted as a late response in doing the response-time percentage calculations for that month. At-scene times shall be established from vehicle data or radio transmissions identifying the at-scene time.

4.7.2.3 Mechanical failures, scheduled aircraft maintenance and crew scheduling issues will not be considered as grounds to excuse late responses.

4.7.3 The Department may grant exclusions to response-time performance requirements stated herein, on a case-by-case basis, for calls where weather conditions, multi-casualty incidents, or other situations beyond the Provider’s control cause unavoidable delay. All such calls will be individually examined by the Department as to system status and staffing levels, appropriate backup air ambulance capability, dispatch and in-service times, and other influencing factors.
(e.g., weather conditions), and if the circumstances warrant, the Department may authorize the exclusion of such calls when calculating performance compliance.

4.7.4 Exclusion means that a late call, which has received approval for an appeal will not count as an on-time response - rather it is excluded from the database for the purpose of fractal performance calculation.

4.7.5 In order to be eligible for an exclusion, the Provider shall notify the Department within fourteen calendar days of the occurrence. Equipment failure, dispatcher or personnel error, or lack of a nearby air ambulance does not constitute grounds for an exclusion to response time performance requirements.

4.7.6 The Provider may apply to the Department for an exclusion to response-time compliance calculations in the following situations:

4.7.6.1 Response canceled prior to the unit’s arrival at the scene (must provide evidence that call was canceled within required response time).

4.7.6.2 Severe weather that slows travel and/or is cause for an aborted flight due to safety considerations.

4.7.6.3 Data or voice recording or transmission errors when accurate information cannot be verified.

4.7.6.4 Inaccurate location given by the reporting party. If inaccurate response information is the result of an error by the Provider’s personnel, exclusion will not be allowed.

4.7.6.5 Locally declared disaster. The Provider may apply for an exclusion to response time standards during times of declared emergencies, locally or in a neighboring county, as defined by the emergency operations procedures of the jurisdictions involved (e.g. city or County).

4.7.6.6 Multi-Casualty Incident (2 or more patients at the same location). Appeals for incidents while there is a multi-casualty incident occurring elsewhere within the Provider’s area of operation will be considered for exemption. The Provider is eligible if one or more of the Provider’s air ambulance units are simultaneously committed to a multi-casualty incident and the Provider is staffed to the Service Delivery Plan including sufficient backup air ambulance coverage. If the appeal meets the above conditions, the Provider is eligible for a one-for-one exemption for each response during the multi-casualty incident.

4.7.6.7 The Provider will not be held responsible for response-time performance on an emergency response to a location outside the assigned EOA. However, the Provider shall use its best efforts in responding to mutual-aid calls. Responses to emergencies located outside the assigned EOA will not be counted in the number of total calls used to determine monthly compliance.
4.8 When response stand-by is initiated by ECC, the Provider shall insure that flight preparation measures are completed by the crewmembers. This includes checking weather, donning uniforms, preparing equipment in preparation for the flight. The intent of response stand-by is to lessen lift-off time when a response request is issued for a particular incident. Crewmembers are not required to be on-board the aircraft when response stand-by is in place; but should be response ready until a response request is issued or the response stand-by is canceled by ECC.

4.9 During any period of time that the Provider has no units available for service or is unable to respond to requests for service due to foul weather, mechanical failure, etc., the Provider shall make reasonable efforts to obtain “backup”, “standby” or “mutual aid” services from authorized air ambulance providers in adjacent areas to provide coverage for the Provider’s assigned area. The Department and ECC shall be kept informed of such alternate service arrangements. In each instance when the Provider has no units available upon request, the Provider shall submit a report to the Department which at a minimum shall include how long the services were not available, status of all its units at the time of the insufficiency, the number of calls that could not be responded to within the contracted response time and the elapsed delay of response time for each missed call.

4.10 In each instance of helicopter mechanical failure while on an emergency call which results in a cancelled or aborted mission and/or the inability to continue the response to, or transport of the patient, Provider shall submit a report, which at a minimum shall include how long it took for another EMS helicopter or ground ambulance to respond to the same call, the identity of the responding unit, and the reason or suspected reason(s) for said failure and/or malfunction.

4.11 Failure to meet the response time performance standards of the EOA in any month will result in a notice of non-compliance from the Department. Failure to meet the response time requirements for any three (3) consecutive months or for four (4) months in any Agreement year will be grounds for Agreement termination and the reassignment of the EOA by the Department.

5. **Patient Treatment Protocols:**

5.1 The Provider shall provide advanced life support (ALS) level service for all requests for air ambulance service within the EOA. ALS level service shall be satisfied with one paramedic and one flight nurse as staffing on the aircraft at all times. Additional medical personnel to this minimum staffing requirement can be used as indicated.

5.2 Paramedic personnel shall comply with Kern County Paramedic Treatment Protocols at all times.

5.3 The Provider may develop and implement patient treatment protocols for flight nurses that are Provider Medical Director and Department pre-approved; and within a Registered Nurse scope of practice. The Department may disapprove any patient treatment protocol and may require immediate modification at any time.

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5.4 The Provider shall obtain Department pre-approval of any new industry medical device to be placed on-board the aircraft. At minimum, the Provider shall consult the Department to determine if the new medical device requires Department review and approval.

6. Patient Transport Destination:

6.1 The Provider will ensure continued compliance with Ambulance Destination Decision Policies and Procedures as the primary means to determine air ambulance patient transport destination. Air ambulance medical personnel shall consider current hospital emergency department status, and case-specific hospitals, in determination of transport destination.

6.2 During Med-Alert operations, the Department staff will direct air ambulance transport destination. Air ambulance medical personnel shall make contact with Department staff to determine the air transport destination.

6.3 The provider should communicate the air transport destination to ECC, the designated EMS Aircraft Dispatch Center for Kern County.

6.4 In the case of interfacility transfer, the selection of an appropriate receiving facility shall be determined by the transferring physician at the sending hospital, and the Provider shall ensure that the transportation of said patient shall be to the receiving facility so designated.

6.5 Should safety or any other considerations require an alteration of a patient destination as provided for in Sections 6.2 or 6.4, the Provider shall submit a report to the Department within 48 hours describing the circumstances that required any such alteration, to include a detailed explanation of the factors which precipitated such alternate patient destination.

6.6 In each instance where the mode of patient transport changes due to aircraft mechanical failure and/or malfunction, the Provider will assure that the EMS personnel on the helicopter which failed/malfunctioned submit prehospital report forms regarding the medical care the patient received while in their care.

7. Mutual Aid:

7.1 The Provider shall have written mutual aid agreements with all providers in adjacent service areas, and shall submit those agreements to the Department for review and approval prior to implementation. The Department may approve or deny a mutual aid agreement. Any changes to mutual aid agreements shall be submitted to the Department for review and approval prior to implementation.

7.2 In most cases, ECC will manage mutual aid deployment for prehospital emergency rotor-wing air ambulance responses when the primary Provider for EOA “A” or EOA “B” is unavailable. The Department maintains an authorized mutual aid rotor-wing air ambulance provider list through ECC.
7.3 Should the Provider be unable to effect a mutual aid agreement with an adjacent provider after a good faith effort, the Provider shall notify the Department.

7.4 The Department may make certain exceptions to the exclusivity of the EOA’s when it is, in the sole judgment of the Department, in the best interest of public welfare or patient care. Examples include but are not limited to allowing a neo-natal interfacility team to use its own contracted air provider and allowing a provider using aircraft with unique capabilities such as high payload or altitude operations.

8. **Personnel:**

8.1 When responding to a call, the air ambulance shall be staffed with a minimum of one (1) pilot and two (2) medical personnel. The two (2) medical personnel shall, at a minimum, be one EMT-P and one flight nurse that is at a minimum a registered nurse. Should a Provider offer staffing with two nurses or a nurse and physician, physician assistant or nurse practitioner, one of the medical staff members must be accredited as a paramedic within the County.

8.2 For special and unique circumstances, the Provider may request a temporary exemption from the minimum staffing requirements through the Department on a case-by-case basis. The Department may approve or deny the request.

8.3 Medical crew minimum requirements for mutual aid providers must meet the local requirements in the location where the aircraft is normally based and must be substantially similar in composition to the Department requirements. Mutual aid providers must be approved by the Department if they are intended to substitute for Provider units to meet these performance requirements.

8.4 All employees of the Provider engaged in patient care shall meet and comply with the applicable training/continuing education requirements as established by the State of California, the Department, and the Provider for their level of certification/licensure.

8.5 The Provider shall not permit any employee to perform any services when there is reasonable cause to believe that they may be under the influence of any alcoholic beverage, medication, narcotic, or other substance that might impair physical or mental performance.

8.6 The Provider shall ensure that the crew person attending the patient(s) complete medical reports as required and submit the reports to the receiving hospital and the Department according to Department policies and procedures.

8.7 The Provider and its subcontractors shall not discriminate unlawfully against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical handicap, mental disability, sexual preference, medical condition, marital status, age or sex.
8.8 The Provider and its subcontractors shall further comply with the Civil Rights Act of 1964 (and any amendments thereto and the rules and regulations thereunder) and Section 504 of Title V of the Vocational Rehabilitation Act of 1973 as amended.

8.9 The Provider shall also comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 1200 et seq.), the regulations promulgated thereunder (California Administrative Code, Title 2, Section 7285.0 et seq.), the provisions of Article 9.5, Chapter 1, Part 1, Division 3, Title 2 of the Government Code (Government Code, Sections 11135 - 11139.5) and the regulations or standards adopted by the State of California to carry out such articles.

8.10 All material, equipment, or labor shall meet the required standards of OSHA 1970 and CA-OSHA 1973 as last revised. The Provider shall warrant that the described material, equipment or labor meets all appropriate OSHA safety and health requirements. Further, the Provider warrants that the said material or equipment will not produce or discharge in any manner or form, directly or indirectly, chemicals or toxic substance that could pose a hazard to the health or safety of anyone who may use the material or equipment or come into contact with the material or equipment.

8.11 No shifts greater than forty-eight (48) hours are permitted unless under a written policy approved by the Department. The Provider shall have a policy and monitoring system in place to prohibit clinical staff from working greater than forty-eight (48) hour shifts when combining shifts with shifts from second employment. Additionally, the Provider shall have policies and safeguards to assure that the clinical crew members meet applicable legal requirements, CAMTS standards and the ability to function without being unduly affected by fatigue.

9. Equipment and Supplies:

9.1 Each air ambulance unit shall carry equipment and supplies as needed to appropriately provide patient care within the authorized scope of practice and Department requirements. The Provider shall also carry equipment and supplies as needed to appropriately provide patient care within the Department approved patient care guidelines/procedures for the Provider’s licensed staff. Vehicles, equipment, and supplies shall be maintained in clean, sanitary, and safe mechanical condition at all times.

9.2 The EMS Medical Director or his agents may at any time, without prior notice, inspect the Provider’s air ambulance units in order to verify compliance with these Standards. An inspection may be postponed if it is shown that the inspection would unduly delay the air ambulance unit from responding to an emergency call. Any deficiencies resulting from an inspection shall be immediately corrected by the Provider. Repeated deficiencies upon two or more inspections will be grounds for a breach of the Agreement.

9.3 The Provider shall develop and maintain a maintenance plan in compliance with the manufacturers recommended maintenance schedules, maintain a record of the preventative maintenance, repairs and replacement of equipment and shall make such plan and records available to the Department upon request.
10. Reports:

10.1 The Provider shall maintain financial records in an auditable form and content and according to generally accepted accounting practices including all costs, expenses, and revenues. The Provider shall make these financial records available for review by the Department no later than ninety days after the end of the Provider’s fiscal year. All such financial records will be considered proprietary information by the Department and will not be made available to the public except as required under the Public Records Act.

10.2 The Provider shall maintain an active list of employees including their current addresses, phone numbers, qualifications, certificates, and licenses with expiration dates. Such list will be available for review by the Department.

10.3 All Provider records, except recorded radio and telephone communications, shall be preserved by the Provider for at least three years from the termination of the Agreement. Recorded radio and telephone communications shall be maintained for a minimum of one year from the date of the incident.

10.4 The Provider shall, upon a request by the Department, prepare and submit written reports on any incident arising out of services provided.

10.5 The Provider shall submit monthly operations reports to the Department by the 20th of the month, for the previous month, in a format specified by the Department.

10.6 The Provider shall provide additional information and reports as the Department may request from time to time to monitor performance.

10.7 The Provider shall submit patient care records in accordance with Department specifications, process, and format.

10.8 The Provider shall have measures continuously in place to ensure that data, once entered into the CAD system, remains secure and not subject to tampering. This includes the equipment and procedures to be employed so that the Department will have access to data for purposes of verifying Agreement compliance. Access policies must include at least the following:

10.8.1 Department staff access to onsite monitoring, audit and data review of EMS dispatch functions and data of the EOA.

10.8.2 Random sample audit requests by the Department staff of EOA call information.

10.8.3 Restricted release of information that is the subject of current law or fire investigation.

10.9 The Provider shall agree to not seek economic gain from data received from the 9-1-1/PSAP in any manner without approval from the Department except as otherwise needed to collect traditional transport revenue from 9-1-1 calls and interfacility transfers.
10.10 The Provider shall complete all forms and data reports required by the Department, including field-assessment forms and standardized data requests and shall cooperate and participate in field research as requested including special medical and trauma studies. Patient Care Reports (PCRs) shall be delivered to the emergency department (ED) at the time of patient delivery at least ninety percent of the time during any three-month audited time period. Electronic data bases shall be developed by the Provider and be able to track individual patients from dispatch through billing and collection phases. Data collection and reporting methods shall also allow for data aggregation. Data collection requirements shall be completed and submitted electronically on a periodic basis and with a format specified by the Department.

10.11 Response-time summaries by response time requirement and zone, including the listing of all response-time exceptions, shall be reported monthly. These reports must include compliance with response-time standards in a format established by the Department including the ability to sort by city, and other geographic zones, incidents of mechanical failures, listing of calls referred to other agencies, mutual-aid response times, call downgrades and other reports used to determine Agreement compliance.

10.12 The Provider shall comply with all applicable federal, State and local laws, rules and regulations that are in effect at the inception of the Agreement and that become effective during the term of the Agreement, including without limitations the Health Insurance Portability and Accountability Act (42 USC sections 1320d et. Seq.).

11. Aircraft and Maintenance:

11.1 The Provider shall develop and maintain a maintenance plan in compliance with the manufacturers recommended maintenance schedules, maintain a record of the preventative maintenance, repairs and replacement of helicopters and shall make such plan and records available to the Department upon request.

11.2 Upon the effective date of the Agreement, and annually thereafter, the Provider shall submit to the Department an inventory of all air ambulances utilized by the Provider in the EOA.

11.3 All aircraft used shall be in compliance with all FAA requirements. All medical equipment and medical care should be provided in accordance with CAMTS standards.

11.4 The Provider shall notify the Department of any anticipated change in the type of aircraft assigned to the EOA. The Department may approve or deny the proposed change.

12. Safety:

12.1 The Provider shall continuously provide a safety and risk management program that shall at a minimum include each of the following:

   12.1.1 A safety manual that insures compliance with OSHA requirements.
12.1.2 An orientation program that instructs all new employees in safety practices and will prepare the employees to avoid risk; protect them from danger; and preserve them from loss.

12.1.3 A training program for all managers and supervisors to insure that they can properly instruct the employees in safety programs and to properly investigate all safety incidents.

12.1.4 Assignment of a person, with formal training on risk and loss issues, that is responsible for the safety and risk program.

12.2 The Provider shall maintain a safety and risk program that starts in the employment application phase which includes an employment physical exam and a physical capacities evaluation that is fair, nondiscriminatory, and commensurate with job requirements.

12.3 The Provider shall ensure continued compliance of all pilots with any and all FAA licensing requirements.

12.4 The Provider shall maintain a continuing education program for all employees on safety and health issues that is scheduled no less than bi-annually.

12.5 The Provider shall maintain a system of conducting background and credentials checks on all employees of the local operation.

13. Quality Improvement:

13.1 The Provider shall have at least one EMT-P or flight nurse designated as a training officer who shall perform the necessary orientations for all new EMT-P(s) and flight nurses employed by the Provider.

13.2 The Provider shall have at least one EMT-P or flight nurse, designated to function as a liaison between the Provider and the Department to participate in a quality improvement process per Department policies, assist in the investigation of unusual occurrences as identified by the Provider or the Department and, to the degree possible, attend liaison meetings as requested by the Department.

13.3 The Provider shall provide regular training to first responder agencies, ground ambulance companies, and other allied agencies in flight safety, landing zone coordination, communications, and flight operations.

13.4 The Provider shall maintain a continuous quality improvement (CQI) plan meeting the standards of the quality improvement in the health-care and air ambulance industry. The plan shall describe:

13.4.1 A management philosophy and approach focused on achieving an environment of continuous improvement and innovation.

13.4.2 Continuous learning and development of staff and management.
13.4.3 Service to all internal and external EMS contractors and customers.

13.4.4 Commitment to participate in and contribute to the Department CQI process.

13.4.5 Commitment to cooperate with system research.

13.4.6 The plan shall include internal mechanisms such as interface with the Provider medical director, CQI manager, CQI committee structure and process; prospective training and education efforts, concurrent and retrospective review, personnel development, problem identification, needs assessment, education/compliance remediation, problem resolution and the documentation and tracking of implementation strategies and outcomes.

13.5 The Provider CQI program shall interface with the Department, hospitals, first responders, dispatch centers, ambulance providers, fire departments and law enforcement.

13.6 The Provider CQI program shall also include a section on client/patient rights which includes all of the following:

13.6.1 Fast, effective medical treatment and transportation to a facility of their choice (unless this is in conflict with medical policies of the Department), regardless of ability to pay.

13.6.2 Full information regarding the immediate treatment needed with the right to refuse any treatment or service.

13.6.3 Full explanations of bills about which the patient or responsible party has questions.

13.6.4 Confidential treatment of medical records.

13.6.5 Billing insurance or third-party payer as part of the service to the patient.

13.6.6 Retention of patient records and patient access to their records.

13.7 The Provider, at least annually, shall conduct a survey of customers and health care facilities regarding their satisfaction of the Provider's interfacility and transfer services. Survey results will be forwarded to the Department.

13.8 The Provider shall conduct on an annual basis no less than six public education and/or demonstrations within the exclusive operating area assigned to the Provider. The Provider shall report all community education activities on the monthly operations report.

13.9 It is the intent of the Department to ensure open communication, as well as active coordination and cooperation between all EMS system participants. The Provider shall ensure that any unresolved incidents or sensitive issues involving other EMS system participants are brought to the attention of the Department.
14. **Medical Control:**

14.1 The Provider shall continuously maintain a Provider Medical Director who, at a minimum is a California licensed Medical Doctor or Doctor of Osteopathy with appropriate specialty training and experience to oversee the clinical and operational aspects of the air ambulance service.

14.2 The Provider Medical Director shall be responsible for oversight of the clinical aspects of the program; and for development and maintenance of flight nurse treatment protocols, subject to Department approval.

14.3 The Provider Medical Director shall not be construed to manage the responsibilities or authority of the Department Medical Director. The Department Medical Director shall retain all authority within the jurisdiction.

15. **Billing and Rates:**

15.1 For non-emergency, elective transports the Provider may financially pre-qualify patients prior to accepting a transport. All other patient transports shall not be financially pre-qualified by the Provider.

15.2 The Provider shall maintain billing in accordance with the rotor-wing air ambulance rates approved by the Department at all times.

15.3 Provider rates may only be changed in accordance with the Agreement. Only the Department authorized rates may be charged for any patient transport. Provider rates may be adjusted through the Ambulance Rate Process through the Department.

15.4 The Provider billing system shall provide each of the following:

15.4.1 Generate and electronically bill Medicare and MediCal statements.

15.4.2 HIPAA-compliant at the time of Agreement execution and afterward.

15.4.3 Handle third-party payers, private-pay patients, special contracts, DRG transports, and other special arrangements.

15.4.4 Provide itemized statements which shall list all procedures and supplies employed, unless included in base rate.

15.4.5 Respond to patient and third-party payer inquiries regarding submission of insurance claims, dates and types of payments made, itemized charges, and other inquiries.

15.4.6 Provide daily, monthly and annual reports which furnish clear audit trails, including details of payments and adjustments.
15.4.7 Provide for reconciling on a regular basis between "run" and other production data and patient data. An audit trail shall exist linking reported transports and calls to billed transports and calls, with exceptions noted.

15.4.8 Support monitoring of employee accuracy and completeness in gathering data for required operations.

15.4.9 Facilitate updates of account type, addresses, and other pertinent patient and third party payer data.

15.4.10 Include procedures and reports to process accounts requiring special attention. These procedures shall cover at least the following:

- Assignment of follow up based on accounts receivable aging reports
- Reminder mailings
- Telephone collection methods
- Policy regarding use of collection agents
- Policy regarding write-off of accounts receivable
- Identifying and pursuing alternative third party payments and other reimbursements.
- Policies for hardship cases and write-offs.

15.4.11 The Provider shall exclude on-scene collection. On-scene collections are prohibited.

15.4.12 Billing and collection data shall track to dispatch data by use of a record identifier.
Attachment 1 – Response Times Maps

Rotor-Wing Air Ambulance EOA “A”
Attachment 2 – Definitions

2.1 AAMS - Association of Air Medical Services

2.2 Authorizing EMS Agency - Means the LEMSA which approves utilization of specific EMS aircraft within its area of jurisdiction.

2.3 Advanced Life Support Ambulance (ALS Ambulance) – Means a ground ambulance staffed and equipped to provide advanced life support consistent with Section 1797.52 of the Health and Safety Code and current pre-hospital care guidelines approved by the Department.

2.4 Available on Radio/Request (AOR) - Means the moment the unit is available on radio/pager to respond to direction from Provider’s dispatch center and flight following service.

2.5 Back-up - Shall normally be a unit which is activated for a request for service when the primary unit is unavailable.

2.6 Base Hospital - Means a hospital responsible for directing the prehospital care system assigned to it by the Department in accordance with Section 1797.58 of the Health and Safety Code.

2.7 Basic Life Support Ambulance (BLS Ambulance) - Means a ground ambulance staffed and equipped to provide basic life support consistent with Section 1797.60 of the Health and Safety Code and current prehospital care guidelines as approved by the Department.

2.8 Call Received/Time of Call (TOC) - Means the moment the Provider’s dispatch center receives a request for service from the authorized Kern County EMS Aircraft Dispatch Center and has enough information to respond appropriately i.e. location, map page numbers, Latitude and Longitude coordinates, etc.

2.9 CAMTS - Commission on Accreditation of Medical Transport Services.

2.10 Designated EMS Aircraft Dispatch Center - Shall mean the authorized Kern County EMS Dispatch Center.

2.11 Dispatched (DSP) - Means the moment the pilot has obtained adequate information (e.g. weather, fuel status, etc.) to allow him/her to accept the flight.

2.12 Emergency - Means the functions involved in responding to a request for an ambulance to transport or assist persons in apparent sudden need of medical attention in accordance with the “Emergency Medical Dispatch Priority Card System” approved by the
Department, and, relative to inter-facility transports, shall mean a transport to a facility with specialty care capabilities not available at the transferring facility.

2.13 **EMS Aircraft** - Shall mean a rotor-wing type aircraft.

2.14 **Enroute (ER)** - The moment the helicopter and crew are physically enroute to the incident as evidenced by initiating flight.

2.15 **ETA** - Means the estimated time of arrival.

2.16 **FAA** - Means the Federal Aviation Administration.

2.17 **Facility** - Means an acute care hospital licensed by the State of California under Chapter 2 (commencing with Section 1250) of Division 2, California Health and Safety Code, with a stand-by, basic or comprehensive emergency service permit.

2.18 **FAR** - Federal Aviation Regulations.

2.19 **From Scene/Enroute Hospital (ERH)** - Means the moment the helicopter lifts off from the scene enroute to a health care facility or rendezvous point, such that the helicopter has attained an altitude that allows for radio transmission.

2.20 **Helicopter** - Shall mean a rotor-wing type aircraft meeting the qualifications of an air ambulance.

2.21 **LEMSA** - Local Emergency Medical Services Agency

2.22 **Map Grid/Quadrant** – Means an area on a map approved by the Department, which has been given an alpha or numeric designation by the COUNTY and has been categorized metropolitan, urban, suburban, rural or wilderness, such that quantitative and chronological analysis of response activity to that area can be made both by the Provider and the Department.

2.23 **Mutual Aid** - Means a response to a request for service in an area not customarily served by the responder.

2.24 **On Scene Hospital/Arrive Dest (OSH)** - Means the moment the unit arrives at a health care facility or a point where it can rendezvous with another unit.

2.25 **On Scene/At Scene (OS)** - Means the moment the pilot reports that the EMS aircraft is within one-quarter (1/4) nautical miles and no greater than 1000 feet above ground level of the EMS incident or designated emergency landing site.

2.26 **Zone/Area** - a distinct geographic area of service defined with maps and narrative and established in consideration of historical service information, geographic, demographics, and the locations of air ambulance base of operations such that response times might be minimized.