

## Emergency Medical Services Program Policies – Procedures – Protocols

### ***Ambulance Service Performance Standards (1005.00)***

#### **I. Introduction**

The Kern County Ambulance Performance Standards (hereinafter referred to as Standards) establish minimum standards for ambulance service performance. These Standards are applicable to all contracted ground ambulance providers in Kern 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 Ground 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 ambulance providers. Definitions of terms in these Standards are in accordance with Ordinance definitions.

#### **II. Administrative**

- A. The ambulance provider shall maintain sufficient ambulances, operational procedures, and personnel with valid certification, licensure and accreditation within the ambulance service operating area to meet these standards and achieve compliance with all other Program policies, procedures, protocols and regulations.
- B. The ambulance provider shall respond to all calls for emergency and medically necessary non-emergency ambulance service, including the use of Program authorized mutual aid.
- C. When transportation is indicated for moving a patient from a medical facility, an ambulance shall be used under the circumstances listed below. The ambulance provider is responsible for obtaining all usual and customary documentation from the sending physician for interfacility ambulance service requests.

1. An interfacility transfer of a patient from one general acute care hospital to another general acute care hospital for in-patient admission or for administration of a diagnostic test of an in-patient.
2. Transport of a patient to a hospital emergency department.
3. Any patient requiring oxygen administration. Medical passengers that possess a self-administered oxygen device are excluded.
4. Any person with medication infusion through vascular access, gastro-intestinal port, or nasogastric tube that is not self administered.
5. Any person in orthopedic traction or skeletal immobilization device requiring either regular medical monitoring, or regular extremity perfusion/neurological assessment, or potential for device complication intervention during transport.
6. Any patient requiring airway suctioning or airway/ventilation monitoring.
7. Any person that requires medical monitoring by a qualified attendant during transport. Monitoring includes but is not limited to periodic assessment of vital signs.
8. Any person that requires basic life support (BLS) or advanced life support (ALS) medical intervention during transport.
9. An ambulance provider shall not require the use of an ambulance for transport of a medical passenger, and an ambulance provider is not required to transport a medical passenger. Use of an ambulance is not required to transfer a medical passenger that has been discharged from an acute care hospital and needs transport to a rehabilitation facility. However, any person that meets the definition of a patient or meets any of the above criteria shall be transported by ambulance.

D. The ambulance provider shall perform each medically necessary interfacility transport of a patient to the medical facility specified by the transferring physician. However, the ambulance provider may refuse a long-distance interfacility transfer to a destination outside of Kern County, under the following two circumstances:

1. The ambulance provider will not be reimbursed for the services performed (no payor available); or
2. The transferring physician fails to demonstrate that no general acute care or specialty hospital in Kern County is capable of accepting and providing appropriate care of the patient at the time the transfer is required.

The Program, through the Duty Officer, shall resolve disputes that cannot be resolved among involved parties.

- E. The ambulance provider shall maintain supervisory or management personnel, available on twenty-four (24) hour basis. Said personnel shall be authorized to make operational decisions, direct ambulance provider personnel, and commit ambulance provider resources for use.
- F. The ambulance provider shall maintain a quality improvement program, approved by the Program and Medical Director. The quality improvement program will include provisions for prehospital personnel continuing education, service operational procedures and standards, monitoring compliance with Program requirements, and continuous operational efficiency monitoring. The ambulance provider's quality improvement plan will function in accordance with the requirements of a Program led, Countywide quality improvement plan as specified by the Program. The ambulance provider shall participate in the Program's quality improvement program.
- G. The ambulance provider shall ensure that each patient is transported in compliance with the Ambulance Destination Decision Policies and Procedures.
- H. The ambulance provider will ensure that management, supervisory, dispatch, and field personnel maintain competency with multi-casualty and mass casualty incident medical operations, the incident command system, and the Kern County Med-Alert System, in accordance with Program requirements. The provider's internal plans, policies and operating procedures shall comply with the California Standardized Emergency Management System (SEMS) and National Incident Management System (NIMS).
- I. The ambulance provider shall not provide or advertise for a service that the ambulance provider is not authorized to provide. The ambulance provider, if providing public advertising, shall provide such advertising consistent with applicable law in accordance with the intent of 9-1-1 system for public use in an emergency and Program policy. Advertising any telephone number in lieu of 9-1-1 for prehospital emergency calls is prohibited.
- J. Any incentive program that provides additional monetary gain for field personnel (e.g. bonuses or stipends in addition to normal pay) which is directly or indirectly related to the application of medical procedures to patients is prohibited.
- K. Any program or practice that promotes an inappropriate incentive or kickback for any medical procedure or mode of transport is prohibited.
- L. Medical procedures and mode of transport shall be as determined by the Medical Director and Program policies and procedures.

### III. Personnel

- A. The ambulance provider shall ensure that personnel comply with Program policies, procedures, protocols, rules, and regulations while on duty.
- B. Each ambulance, when available for service, shall be staffed by appropriately licensed and certified personnel as specified below:
  - 1. BLS Ambulance – One EMT driver and one EMT attendant.
  - 2. ALS Ambulance – One EMT driver and one paramedic attendant, or one paramedic driver and one paramedic attendant.
  - 3. Critical Care Transport Ambulance (CCT) – Minimum of one (1) EMT driver, (1) Paramedic attendant, and one (1) specialty attendant. The specialty attendant may be a registered nurse, physician, nurse practitioner or physician assistant.
- C. Each ambulance provider shall have emergency medical dispatcher (EMD) service available at all times. This requirement may be satisfied with a contract for service from another locally EMD-accredited dispatch center, provided that said other dispatch center is responsible for accepting service request calls for the ambulance provider.
- D. The Program can authorize deviation from this section during any "State of emergency" or "local emergency" as defined in the California Government Code.
- E. The ambulance provider shall maintain files on all certified and/or licensed EMD, EMT, Paramedic and Registered Nurse and other clinical personnel employed on full time or part time basis. Each file shall contain all information on the following, required by law:
  - 1. Employee name, home address, and mailing address;
  - 2. Employee contact information including home telephone number, cellular phone number, and email as available;
  - 3. A valid copy of the employee's driver's license and/or other positive identification; and
  - 4. A valid copy of the employee's certification and/or license, including ambulance driver's certificate and medical examiner's certificate and copies of local accreditation if applicable.
- F. Ambulance providers shall report in writing to the Program whenever any of the following actions listed below are taken. Notification and supporting documentation shall be submitted within 30 days of the action.

1. An EMT, EMD, RN, or Paramedic is terminated or suspended for disciplinary cause or reason.
  2. An EMT, EMD, RN, or Paramedic resigns following notice of an impending internal investigation.
  3. An EMT, EMD, RN, or Paramedic is removed from duties for disciplinary cause or reason following the completion of an internal investigation.
  4. For the purpose of this section, "disciplinary cause or reason" means any action that is substantially related to the qualifications, functions, and duties of an EMT, RN, EMD, or Paramedic.
- G. Ambulance provider shall report to the Program whenever changes occur in management personnel of the ambulance company. Verbal notification shall be provided within 48 hours of the action, written notification shall be provided within 1 week. If the change is the result of disciplinary action or prompted by an impending internal investigation related to public health and safety or related to medical billing, such information shall be provided to the Program, to the extent allowed by law.

#### **IV. Facilities**

- A. The ambulance provider shall have and maintain a base facility or facilities of operations and administration with appropriate land use approval.
- B. The ambulance provider employing personnel on scheduled shifts greater than twelve (12) hours duration shall provide crews quarters with food preparation, restroom, bathing and sleeping facilities, heating, and cooling.
- C. The ambulance provider shall provide for a continuously available and staffed dispatch facility for receipt of calls, dispatch of ambulances and ambulance status maintenance. Facility shall have heating, cooling and restroom facilities, and the availability of auxiliary power (batteries, gas or diesel generator, and appropriate procedures) that will maintain adequate power to dispatch facility lights, phones and radio equipment to operate for a minimum of 72 hours. The dispatch center shall also have reasonable security measures in place to prevent unauthorized access to the dispatch center or equipment. Security may be in the form of locked entry, surveillance video, or a dispatch facility security plan.

#### **V. Vehicles**

- A. All in-service ambulances shall be equipped with the safety and emergency equipment required for ambulances by the Program, the California Vehicle Code, and the California Code of Regulations. The Program may conduct unannounced ambulance inspections as well as observational ride-a-longs at

- any time. The Program may remove an ambulance from service for non-compliance to Program requirements.
- B. The ambulance provider shall have a photocopy or the original valid registration, valid insurance identification, and valid ambulance identification card or ambulance inspection form indicating authorization from the California Highway Patrol present on each ambulance subject to call.
  - C. Each ALS ambulance shall have current Mobile Intensive Care Unit (MICU) authorization from the Program. The Program may issue temporary MICU authorization for instances of mechanical problems that warrant moving the supplies and equipment to another ambulance.
  - D. Each ambulance operated by the ambulance provider shall be of adequate size to conduct patient transport, at the discretion of the Program. The Program may refuse to authorize use of an ambulance that is not appropriately configured, supplied, or equipped. Ambulance vehicles will at all times be operated within the design limitations specified by the manufacturer to include gross vehicle weight restrictions.
  - E. Ambulance providers shall have a preventive mechanical maintenance program for ambulances, so as to ensure compliance with California Highway Patrol minimum standards.
  - F. The ambulance provider shall not allow ALS level services to be provided from a BLS ambulance unless staffed with a minimum of one paramedic attendant, and one EMT or paramedic driver. The ambulance provider may also request temporary authorization to operate a BLS ambulance as an ALS ambulance through the Program. Exceptions include paramedic back up response when it is not in the best interest of the patient to be moved from a BLS ambulance to an ALS ambulance, or multi-casualty incidents where insufficient resources make such action necessary for appropriate prehospital patient care and transport.
  - G. The ambulance provider may provide ALS or BLS services from an ambulance authorized as a MICU. BLS staffing on an MICU shall only be allowed if all advanced life support supplies and equipment, invasive in nature, are locked and completely inaccessible to the BLS crew, or removed from the ambulance entirely. Invasive advanced life support supplies and equipment shall include, manual defibrillator, all medications not in the EMT scope of practice including narcotics,, laryngoscope and blades, endotracheal tubes, nasogastric tubes and IV catheters . BLS staffing on an MICU shall not be allowed by the ambulance provider if the ambulance is externally identified with any wording indicating or relating to ALS service.

- H. Each ambulance shall have complete telecommunication capability with the Kern County Medical Radio System and shall have the technological ability to communicate on frequencies specified by the Program.
- I. The ambulance provider shall ensure that all ambulances subject to call or service are mechanically sound and safe to operate at all times.
- J. Ambulance personnel certified or licensed as an EMT or Paramedic shall wear insignia or labels that clearly identifies his/her level of certification/licensure/Accreditation to the public and other first responder personnel.

## **VI. Dispatch-Communications**

- A. The ambulance provider shall maintain dispatch procedures consistent with the Program EMS Dispatch Policies and Procedures.
- B. Each ambulance shall be capable of establishing and maintaining radio contact with ambulance provider's dispatch.
- C. Each ambulance provider will be responsible to maintain communications means to receive calls for service.
- D. The ambulance provider shall have access to a dispatch facility with sufficient telecommunication equipment for communications on Kern County Medical Radio System through the repeater network.
- E. The ambulance provider shall continuously staff the dispatch facility with dispatch personnel and maintain the ability to receive calls for service on a 24-hour basis.
- F. The ambulance provider shall use an Emergency Medical Dispatch (EMD) service that is authorized and accredited by the Program for receiving all pre-hospital calls for service. All calls shall be managed in accordance with the Program EMS Dispatch Policies and Procedures.
- G. The ambulance provider shall maintain a dispatch log, for all ambulance calls. At a minimum, the following information will be included in the log:
  - 1. Date: The date of the call.
  - 2. Call Time: The initial time that the call is answered by dispatcher and sufficient information is obtained to start response defined as a) determination of call location and b) an appropriate EMD code is determined in accordance with the County's EMS Policies and Procedures.

3. Call Location: The specific call location, including map coordinates if available.
4. Call Back Number: The telephone number used by the caller.
5. Reporting Party: The name of the caller, agency or organization.
6. Call Type or Chief Complaint: Identification of the type of call or chief complaint.
7. Unit Level Sent: The level (ALS, BLS, or SCT) and identification of the ambulance sent.
8. Response Priority Code: Response priority code used to the call location.
9. Enroute to Scene Time: The time the assigned ambulance begins response to the call location.
10. Response Upgrade or Downgrade Time: The time a responding ambulance response priority is upgraded or downgraded. The time of this event may be recorded in a notes field. However, the time shall be denoted and reported to the Program for purposes of determining response-time compliance, upon request.
11. Arrived at Scene Time: The time the assigned ambulance arrives at the requested call location or the scene, wheels stopped. If call location is not specific (i.e., vicinity of Highway 178 at Southlake) the Arrived at Scene Time shall be that moment when ambulance arrives to the originally dispatched location.
12. Start of Transport Time: The time the ambulance begins patient transport.
13. Transport Destination: The destination of the ambulance.
14. Transport Mode: Response mode used in transport to destination.
15. Destination Arrival Time: The time the ambulance arrives at the destination.
16. Available for Response Time: The time the ambulance is available for service or subject to dispatch for a subsequent call.
17. Relevant Dispatch and Response Details: The ambulance provider shall have the ability to keep information on all call cancellations prior to or during response; patient not transported; delay during response; and back up ambulance response information. This information may be recorded in a notes field, and it shall be reported to the Program, upon request.

- H. The ambulance provider shall provide access, upon reasonable request by the Program, to recorded telephone calls and two-way radio communication on the primary, or any other radio frequency routinely used for ambulance dispatch.



- I. The ambulance provider shall maintain audio recordings of the primary telephone and radio communications related to ambulance dispatch for a minimum of six (6) calendar months. Dispatch logs shall be maintained by the ambulance provider for a minimum of one (1) calendar year. If recording equipment breaks down due to mechanical failure or other reasons, the Program will allow a reasonable time for ambulance provider to have equipment repaired.
- J. The ambulance provider dispatch personnel shall inform the caller at call time if a request for service cannot be provided or will be delayed. The ambulance provider shall notify ECC at call time if the ambulance is responding from outside the boundaries of the EOA. However, when one ambulance provider is contracted to provide service to both EOA 4 and 5, it is not necessary to notify ECC that ambulance units are responding across the common EOA border. Further, for authorized single-ambulance communities, the ambulance provider shall notify ECC at call time if the ambulance is responding from outside the nearest community.
- K. The ambulance provider shall not refuse to respond to any emergency call, any medically necessary interfacility transfer call, any paid special event stand-by, or any public safety agency stand-by, in accordance with Ambulance Ordinance definitions. The Program shall resolve disputes that cannot be resolved among involved parties.
- L. The ambulance provider dispatch shall contact ECC and request back up ambulance response of the next closest ambulance resource if the provider has exhausted all immediately available resources. During Med-Alert incidents ambulance provider dispatch shall contact Program staff for coordination of ambulance transport.

## **VII. Non-transporting EMS Vehicle (Fly Car) Utilization**

- A. Kern County EMS Program approved ambulance providers may utilize ALS fly cars in conjunction with BLS Ambulances for the provision of Advance Life Support responses.
- B. The ambulance provider must submit a plan to the Program detailing the deployment of fly cars and ambulances into the system.
- C. At all times, the ambulance provider must maintain a 10% ALS ambulance to BLS ambulance ratio per EOA. (One ALS ambulance for every 10 BLS ambulances on duty)
- D. Tele911 shall be available and utilized according to policy, by all crew members.
- E. When utilizing the fly car system, the ambulance provider must dispatch one ALS fly car and one BLS ambulance to any ALS level call, as specified in the current Emergency Medical Dispatch Response Configuration.

- F. The response time clock stops upon the arrival of either the ALS fly car or the BLS ambulance.
- G. In the event the BLS ambulance arrive on scene first and determines that the patient does not need ALS care, they shall cancel the incoming ALS fly car.
- H. In the event the paramedic determines that the patient requires BLS transport, they will follow the ALS to BLS handoff policy, clear the scene and place themselves available.
- I. In the event the patient requires ALS transport, the paramedic will take all required ALS first responder equipment into the BLS ambulance and follow current transport policies and procedures. The second EMT will drive the fly car to the hospital following the ambulance. In the event that the paramedic determines a lights and siren (Code 3) transport is required, the fly car will follow without lights and siren (Code 2) to the hospital.
- J. Once at the hospital the paramedic will provide a patient handoff to a hospital nurse, remove any ALS equipment from the patient and place themselves available. The EMT crew will remain with the patient until placed in a hospital bed.

#### **VIII. Ambulance / Fly Car Resource Availability and Deployment**

- A. Ambulances and fly cars shall be dispatched according to the current Emergency Medical Dispatch Response Configuration. ALS service shall be indicated for the following calls: All Priority 5, 6, and 7 calls for interfacility transfer where the transferring physician requests ALS service, and All Priority 8 special event stand-by calls where the event sponsor requests ALS service.
- B. This shall not prohibit the ambulance provider from providing all ALS ambulance service for every call. A BLS ambulance may be dispatched to a designated ALS response, as specified in the current EMD Response Configuration, when all the ambulance provider's normally available ALS resources have been exhausted and the BLS unit(s) is the only remaining available ambulance(s).
- C. The ambulance provider shall dispatch an ambulance / fly car that will provide the shortest possible response time to the call location for Priority 1, 2, C3AF, C3B, and 3 calls, as specified in the current EMD Response Configuration.
- D. For Priority 1, 2, C3AF, C3B and 3 calls where ALS service is indicated by the current EMD Response Configuration, and the ambulance provider cannot place an ALS resource on scene within the required response time, and it is

immediately known that an adjacent mutual aid ALS resource can, the closest ALS resource shall be dispatched. In such instances, ECC shall also be notified.

See table on Page 14 for an explanation of the varying levels of priority codes.

- E. BLS ambulance use is authorized for pre-scheduled transport where BLS care is appropriate for the continuum of patient care, as determined by the transferring physician and consistent with Program approved policies, procedures, and protocols.
- F. BLS ambulance use is authorized for prearranged special event stand-by, if that is the level of care being requested by the event sponsor.

#### **IX. Ambulance / Fly Car Stand-By Services**

- A. Upon request of a public safety agency, the ambulance provider shall furnish stand-by coverage at significant emergency incidents involving a potential danger to the personnel of the requesting agency or the general public. In accordance with NIMS, once assigned to the standby, permission to release the unit(s) for other duties must be granted by the Incident Commander. The Incident Commander may release the unit(s) for response to another emergency if the resources are not currently in use at the stand-by scene, and the ambulance provider is able to re-deploy another ambulance / fly car in a time frame specified by the Incident Commander.
- B. Upon request of the Program, the ambulance provider shall furnish a mutually agreeable number of units to participate in as many as three scheduled functional training exercises each year.
- C. Other community-service-oriented entities may request stand-by coverage from the ambulance provider. The ambulance provider is encouraged to provide such non-dedicated stand-by coverage to events, when possible.
- D. If the ambulance provider is requested to provide such services with dedicated resources, then the ambulance provider may charge for the services at the rate established by the Board of Supervisors. Each dedicated event may have a two-hour minimum, plus an hour for set-up and an hour for cleanup. Ambulance provider is responsible for securing all billing information and obtaining payment from the event sponsors.
- E. For paid stand-by events, the ambulance provider may negotiate the beginning and ending times of each stand-by and the level of coverage with the requesting party. Once the time of the stand-by is established, the ambulance provider will place the agreed upon resources (ALS ambulance, BLS ambulance/fly car etc.) on scene no later than the agreed upon time. The ambulance provider will report compliance with this standard to the Program monthly.

- F. The ambulance provider assigned to an EOA may subcontract with other Kern County ambulance providers to provide special event standby service in the EOA, upon formal approval of the Board of Supervisors in accordance with Section 8.12.060 of the Ordinance.
- G. Ambulance providers will cooperate with the Program and Medical Director in establishing additional standards of coverage for special events and mass gatherings. If additional standards, delineating minimum levels of coverage for events of certain types and sizes are developed, they may be incorporated into this standard. (See Special Event Policy 1012.00)

**X. Response-Time Performance**

- A. The Program does not limit the ambulance provider's flexibility in providing and improving EMS services. Performance that meets or exceeds the response time requirements is the result of the ambulance provider's expertise and methods, and therefore is solely the ambulance provider's responsibility. An error or failure in any one portion of the ambulance provider's operation does not excuse required performance requirements in other areas of its operation. For instance, the failure of a vehicle does not excuse a failure to meet response time requirements or a staffing crisis does not excuse requirements for clinical credentials.
- B. The ambulance provider will use its best effort to minimize variations or fluctuations in response-time performances according to time of day, day of the week, or week of the month.
- C. For the purposes of these Standards, the term interfacility patient transfer will be limited to the following:
  - 1. Medically necessary transfer from a general acute care hospital to another general acute care hospital.
  - 2. Medically necessary transfer from a general acute care hospital to a specialty facility, non-acute care medical facility, or extended care facility.
  - 3. Medically necessary transfer from a general acute care hospital to lower levels of care or home.
  - 4. Medically necessary transfer from an acute care hospital to a prison infirmary, or a prison infirmary to a prison infirmary.
  - 5. Medically necessary transfer from a prison infirmary to an acute care hospital, if determined to be a Priority 6, 7, Response Code. However, if patient condition requires more immediate attention, a transfer from a

prison infirmary to an acute care hospital shall be deemed a pre-hospital call, and the response code shall be categorized as either Priority C3AF

6. For the purpose of accurate response time capture, the response time clock shall stop upon the unit arrival at the prison or military base gate/sally port.

D. Minimum Ambulance/Fly Car Response Time Standards:

1. Compliance is achieved when 90 percent or more of Priority 1 and 2 calls for each response time zone, in each Exclusive Operating Area (EOA) meets the specified response time criteria over a month. For example, to be in compliance, the ambulance provider would place an ambulance / fly car on the scene of each life-threatening emergency call within eight minutes and fifty-nine seconds not less than 90 percent of the time for all Priority 1, Metro Zone calls for that EOA in November.
2. The ambulance provider is required to meet the response times in the table below for each zone of the EOA. No zone shall be subject to substandard response time performance. The ambulance provider will take precautions to assure that no zone within the EOA is underserved. It is the responsibility of the ambulance provider to maintain a 90% response time compliance in all priorities listed. In the event that an ambulance provider's response times fall below 90% in any priority, the provider will provide written documentation outlining the cause of the response time issues as well as a plan to correct the issue.
3. The Program will evaluate response time performance, population density, and call volume, annually. If the Program determines that any area is underserved, or that changes in population or call volume warrant modification of the response zones, the Program may modify any or all of the zones. Ambulance providers shall be consulted prior to any changes in response time standards for any operating area

4. Required Maximum Response Times:

| Priority Code | Metro Zone | Urban Zone | Suburban Zone | Rural Zone | Wilderness Zone |
|---------------|------------|------------|---------------|------------|-----------------|
| 1             | 8 min      | 15 min     | 25 min        | 50 min     | 75 min          |
| 2             | 10 min.    | 15 min     | 25 min        | 50 min     | 75 min          |
| C3AF          | 15 min     | 25 min     | 30 min        | 50 min     | 75 min          |
| C3B           | 15 min     | 25 min     | 30 min        | 50 min     | 75 min          |
| 3             | 20 min     | 25 min     | 30 min        | 50 min     | 75 min          |
| 5             | 60 min     | 60 min     | 60 min        | 60 min     | 75 min          |

|   |      |      |      |      |      |
|---|------|------|------|------|------|
| 6 | 0:00 | 0:00 | 0:00 | 0:00 | 0:00 |
| 7 | 0:00 | 0:00 | 0:00 | 0:00 | 0:00 |
| 8 | 0:00 | 0:00 | 0:00 | 0:00 | 0:00 |
| 9 | N/A  | N/A  | N/A  | N/A  | N/A  |

For purposes of determining compliance with the listed response times, the call is not considered late until 60 seconds has elapsed beyond the listed response time. In other words, all maximum response times listed in the table above and referenced throughout this document include an additional 59 seconds of time before the call is deemed late. 0:00 indicates “On-time” performance with scheduled on scene time.

- Prehospital response priorities are defined according to priority-dispatch protocol approved by the Medical Director. For the purpose of response time calculations, responses shall be prioritized according to the table below.

| Response Priority Code | Response Time Definition  | EMD Response Level   | Minimum Time Compliance Standard                     | Time Zone (minutes)   | Response Mode          | Time Compliance Combination |
|------------------------|---|--|--|---|------------------------|-----------------------------|
| <b>1</b>               | <b>Life-Threatening Pre-hospital Emergencies</b> – All prehospital life-threatening emergency requests, as determined by the dispatcher in strict accordance with Program authorized EMD protocol.  | <ul style="list-style-type: none"> <li>As specified by the Program</li> </ul>  | Not less than ninety percent (90%) per month by EOA. | Closest ALS<br>Metro – 8<br>Urban – 15<br>Suburban – 25<br>Rural – 50<br>Wilderness – 75  | Hot, Code-3            | Priority 1                  |
| <b>2</b>               | <b>Time-sensitive Pre-hospital Emergencies</b> – All prehospital non-life-threatening emergency requests, including emergency standby requests, as determined by the dispatcher in strict accordance with Program authorized EMD protocol.                          | <ul style="list-style-type: none"> <li>As specified by the Program</li> </ul>  | Not less than ninety percent (90%) per month, by EOA | Closest ALS<br>Metro – 10<br>Urban – 15<br>Suburban – 25<br>Rural – 50<br>Wilderness – 75 | Hot, Code-3            | Priority 2                  |
| <b>C3AF</b>            | <b>Urgent Pre-hospital</b> – Emergency medical call where ambulance provider takes immediate steps to dispatch a response, as determined by the dispatcher in strict accordance with Program authorized EMD protocol. These include public safety standby requests. | <ul style="list-style-type: none"> <li>As specified by the Program</li> <li>Committed ALS/Fire</li> </ul>              |  | Closest ALS<br>Metro – 15<br>Urban – 25<br>Suburban – 30<br>Rural – 50<br>Wilderness – 75 | Cold, Committed Code-2 | Priority C3AF               |
| <b>C3A</b>             | <b>Time-sensitive Interfacility Emergencies</b> – medically necessary requests from an acute care hospital for a hot response for an emergency interfacility transfer   | <ul style="list-style-type: none"> <li>All acute care hospital emergency transfer requests for hot response</li> </ul> |  |   | Cold, Committed Code-2 | Priority C3A                |

|            |   |  |     |   |   |                  |
|------------|---|--|-----|---|---|------------------|
| <b>C3B</b> | <b>Urgent Pre-hospital</b> – Emergency medical call where ambulance provider takes immediate steps to dispatch a response, as determined by the dispatcher in strict accordance with Program authorized EMD protocol. These include public safety standby requests. | <ul style="list-style-type: none"> <li>As specified by the Program</li> <li>Committed BLS Only</li> </ul>            |     | Closest BLS<br>Metro – 15<br>Urban – 25<br>Suburban – 30<br>Rural – 50<br>Wilderness – 75 | Cold, Committed Code-2  | Priority C3B     |
| <b>3</b>   | <b>Urgent Pre-hospital</b> – Emergency medical call where ambulance provider takes immediate steps to dispatch a response, as determined by the dispatcher in strict accordance with Program authorized EMD protocol. These include public safety standby requests. | <ul style="list-style-type: none"> <li>As specified by the Program</li> </ul>  |     | Metro – 20<br>Urban – 25<br>Suburban – 30<br>Rural – 50<br>Wilderness – 75                | Cold, Code-2  | Priority 3, 4    |
| <b>5</b>   | <b>Urgent Interfacility</b> - medically necessary requests from an acute care hospital for an emergency interfacility transfer, based on patient acuity/condition.  | <ul style="list-style-type: none"> <li>All acute care hospital urgent transfer requests for cold response</li> </ul> |     | Metro – 60<br>Urban – 60<br>Suburban – 60<br>Rural – 60<br>Wilderness – 75                | Cold, Code-2  | Priority 5       |
| <b>6</b>   | <b>Scheduled Transfer or Long Distance Transfer</b> – All prescheduled patient transfer requests, including long distance transfer requests, as requested by caller.  | 4-hour advanced notification to ambulance provider is required   |     | On-Time, as mutually agreed   | Cold, Code-2  | Priority 6, 7, 8 |
| <b>7</b>   | <b>Unscheduled Transfer</b> – All non-emergency patient transfers, as requested by the caller. These may include transfer directly off- the-floor to SNF, home, etc.  | Non-emergency transfers <u>not</u> scheduled 4 hours in advance  |     | On-Time, as mutually agreed   | Cold, Code-2  | Priority 6, 7, 8 |
| <b>8</b>   | <b>Special Event Stand-by</b> – paid special event stand-by requests  | 24-hour advanced notification to ambulance provider is required  |     | On-Time, as mutually agreed   | Cold, Code-2  | Priority 6, 7, 8 |
| <b>9</b>   | <b>Miscellaneous</b> - ambulance responses that are requests for service outside Kern County.   | N/A  | N/A | N/A   | N/A   | N/A              |
| <b>10</b>  | <b>Any response to “Stage”</b>  | N/A  | N/A | N/A   | Cold, Code 2 unless scene is declared safe and a request is made to upgrade |                  |

- In the event that the ambulance provider anticipates that the maximum response time will be exceeded for prehospital Priority 1, 2, C3AF, C3B or 3 responses, ECC shall be notified per EMS Dispatch Policies and Procedures.
- In the event the ambulance provider anticipates that the maximum response time will be exceeded for Priority 5, 6, or 7 responses, the caller shall be notified and shall be given a reasonable estimate of the time that the unit will arrive (ETA). In the event that the provider and the caller cannot reach a mutually agreed upon pick up time, the Program duty officer shall be contacted for approval of an alternate Kern County transport provider to complete the transport. In the event that the EOA assigned provider cannot complete the call in a mutually agreed upon

time, and an alternate Kern County provider is used, the call will be reported in the monthly compliance data as a turned call.

8. Priority 5 calls are defined as an urgent interfacility transfer. A Priority 5 call is a medically necessary transport request from an acute care hospital for an emergency interfacility transfer. Medical necessity is to be determined by the ambulance provider in consultation with a hospital representative or the transferring physician. The difference between a Priority 5 call and a Priority 6 or 7 call is the urgency of the request based on patient acuity/condition. For example, conditions such as long bone fractures, chest pains, or conditions requiring frequent reassessment during transport would be appropriately placed in the Priority 5 category. Transfers solely for diagnostics such as a CT, MRI or other specialty services alone are not an indicator; the patient's condition/acuity will be the determining factor.

#### E. Response-Time Measurement:

1. Response time for Priority 1, 2, C3AF, C3B, 3, and 5 calls will be calculated from call time to arrive at scene time or cancellation time of the first transport-capable ambulance. Authorized first responders may make cancellations in compliance with Program requirements.
2. For Priority 5 requests, call time will begin upon the transferring facility/physician supplying the ambulance provider dispatch with all normal and customary documentation needed by the ambulance provider for accepting care for the patient. Compliance will be determined by comparing call time to arrive at scene time (at the transferring facility). An ambulance provider is compliant with a Priority 5 response in the Metro zone if the difference in the times is less than 61 minutes.
3. For Priority 6, 7, and 8 requests, the ambulance provider is compliant so long as the assigned unit's arrived at scene time is not later than the scheduled pickup time. For time compliance reporting purposes, an elapsed time of greater than 00:00:00 is a late response.
4. Arrived at scene means the time the assigned ambulance / fly car arrives at the requested call location or scene, wheels stopped, and ambulance dispatch is notified. In situations where the ambulance / fly car has responded to a location other than the scene (e.g., staging areas for hazardous scenes), arrived at scene shall be the time the ambulance / fly car arrives at the designated staging location. All responses to stage will be Priority C3AF. In the event that an ambulance has staged for greater than 30 minutes and law enforcement has not dispatched a unit to the call, the ambulance shall clear the scene and re-respond when called by law enforcement.



5. Arrived at scene time is to be reported to the ambulance provider dispatcher by a manual action of the ambulance / fly car crew. This requirement is typically satisfied by voice radio transmission or the use of a manually activated digital status-reporting device. Arrival times automatically captured solely by automated vehicle locator (AVL) positioning reporting shall not be used.
  - a. In the cases where employees fail to or are constrained from making direct contact with their dispatcher allowing for a real time capture of arrived at scene times, the ambulance provider may use other means to record the arrival time. Such other means are only valid if the ambulance provider can document the actual arrived at scene time. This may include first responders, AVL systems, ePCR entry, or vehicle tracking programs, i.e. the Road Safety Program.
  - b. If no alternative means of verification is available, the next radio or status transmission by the crew will be used to determine on-scene time.
6. Response Upgrades, Downgrades, Cancellations, and Reassignments:
  - a. When an assignment is upgraded to a higher priority prior to the arrival on scene of the first ambulance / fly car, the ambulance provider's compliance with response time standards will be calculated based on the shorter of:
    - 1) Time elapsed from call receipt to time of upgrade plus the higher priority response-time standard, or
    - 2) The lower priority response-time standard.
  - b. If an assignment is downgraded to a lower priority prior to the arrival on scene of the first ambulance / fly car, the ambulance provider's compliance with response time standards will be calculated based on:
    - 1) Lower priority response-time standard, if the unit is downgraded before it would have been judged late/non-compliant under the higher priority performance standard, or
    - 2) Higher response-time standard, if the unit is downgraded after the unit would have been judged late/non-compliant under the higher priority response standard.

- c. If an ambulance / fly car is cancelled enroute prior to an ambulance / fly car arriving on scene, and no ambulance is required at the scene location, the response time will end at the moment of cancellation. At the moment of cancellation, if the elapsed response time exceeds the response time requirement for the assigned priority of the call, the ambulance will be determined to be late/non-compliant. At the moment of cancellation, if the elapsed response time does not exceed the response time requirement for the assigned priority, the response will be deemed to be on-time/compliant.
- d. If an ambulance / fly car is reassigned en-route (e.g., to respond to a higher priority request at a different location), the ambulance provider's compliance to the original call will be calculated based on the response-time standard applicable to the priority assigned by ambulance provider dispatch from initial call time.
- e. If an ambulance / fly car is reassigned en-route (e.g., to respond to a higher priority request at a different location), the ambulance provider's compliance to the new call will be calculated based on the response time standard applicable to the priority assigned by ambulance provider dispatch at initial call time for the new incident.
- f. The ambulance provider will not be held responsible for response time compliance for any assignment originating outside of the ambulance provider's EOA(s). Responses to requests for service outside of the assigned ambulance provider's EOA(s) must be reported monthly to the Program, but these responses will not be counted in the total number of responses used to determine compliance. However, the ambulance provider of the assigned EOA where the incident occurred shall report the call on their required response time reports to the Program as "service requested, failed to respond". If the responding ambulance provider that is providing mutual aid into the EOA arrives at the scene on time, the ambulance provider assigned to the EOA may count the call as compliant with the response time performance standard.
- g. If a segment of an EOA has been sub-contracted to another ambulance provider, the original EOA provider assigned to the area shall be responsible for response time compliance and reporting.

7. For incidents requiring more than one ambulance / fly car, the first ambulance / fly car assigned to an incident shall be the only resource required to meet the response time standards. The ambulance provider shall make the best effort to place additional ambulances on-scene expeditiously.

F. Response Time Exceptions Requests:

1. The ambulance provider shall use best efforts to maintain mechanisms for reserve service capacity and to increase response service capability should temporary system overload persist. However, it is understood that from time-to-time unusual factors beyond the ambulance provider's reasonable control affect the achievement of the specified response time standards. These unusual factors include, but are not limited to local declared disasters, declared disasters in another county or state where provider's ambulances are sent for authorized mutual aid, Med-Alert, severe weather, or off-road responses where no discernable road is available. Authorized categories for minimum response time standards exceptions are as follows:
  - a. Local declared disaster involving mass casualties, or a Med-Alert.
  - b. A Program authorized Ambulance Strike Team medical mutual aid deployment inside or outside of Kern County.
  - c. If it can be demonstrated that providing Program-authorized emergency mutual aid into another ambulance provider's EOA caused a shortage of resources that is directly attributable for a late response within the responding ambulance provider's EOA, the Program is authorized to grant an exception for the late response.
  - d. Certain weather or roadway conditions that prohibit safe emergency vehicle operation to meet response time standard, or the specified call location is inaccessible by conventional ground ambulance, as authorized by Program.

G. Response time Exemption Requests:

1. Period of unusually high demand, as described below.
  - a. To request an exemption for a period of unusually high demand, the ambulance provider must demonstrate that, at

the moment the call was received, the number of emergency calls dispatched and being worked simultaneously exceeds the Overload Score. The Overload Score is derived using the following formula:

Overload Score = The Mean of (the highest number of the entire population of Priority 1, 2, 3, 4, and 5 calls dispatched for that hour over the past 10 weeks) and (the highest number of the entire population of Priority 1, 2, 3, 4, and 5 calls dispatched for that hour over the past 11 through 20 weeks); Rounded up to the nearest whole number.

2. Extended offload times at Hospitals as follows:

- a. To request an exemption for increased APOT, the ambulance provider must demonstrate that at the moment the call was received, 20% of their on duty fleet, in a specific EOA, is delayed receiving a bed for greater than 1 hour.
3. Equipment failures, traffic congestion, ambulance failures, inability to staff units, computer errors, and other causes will not be grounds for granting an exception to compliance with the response standards.
4. If the ambulance provider believes that any response or group of responses should be excluded from the calculation of the response time standards, the ambulance provider may request a review by the Program. Ambulance provider shall submit detailed documentation that supports the request, including but not limited to, a cover letter describing in detail the request, a screen shot showing system overload, overload score, and any other supporting documentation as requested by the Program. The exemption request must be made in writing and included with the monthly report. No Exemption requests will be accepted, by the Program, after the monthly data has been submitted. The Program will review the request and issue a final determination.

H. Aggregate Monthly Response Time Measurement:

1. All ambulance responses over each month will be separated by priority code and response time zone per EOA, and then analyzed by the Program. Priority 1 and 2 calls will be analyzed for compliance with the minimum 90 percent standard. Monthly response times may be reported with decimals, but no rounding factor will be used in determining compliance.

Example: For the month of March there were 357 Priority 1, Metro Zone (8:59 minutes) responses in the EOA. Twenty-one responses were over

8:59 minutes, 336 responses were at 8:59 minutes or under. The compliance rate is 94 percent.

2. Aggregate monthly response time performance will be applied to Priority 1 and 2 calls within each response time zone in each EOA. Any priority 1 or 2 call, by zone, resulting in less than the 90 percent response time performance is non-compliant with the Standards. All other response priorities will be analyzed each month. Ambulance providers are responsible to maintain response time compliance with all priorities listed in this document.

- I. The Program may audit reported response time data at any time by examination of dispatch logs and/or CAD data, a sampling of response time monitoring, or other methods.

#### J. Non-Compliance Vs. Breach

1. Non-compliance occurs when an ambulance provider fails to meet the 90% response time standard within a response time zone, within an EOA, in any month up to 3 consecutive months.
2. Breach of Contract occurs when an ambulance provider fails to meet the 90% response time standard within a response time zone, within an EOA, in a 4th consecutive month.

#### K. Performance Standards

##### 1. Quality Measure Compliance

- a. The ambulance provider shall comply with all current, state-mandated CORE measures and no more than 3 additional measures from the Kern County EQUIP to be updated annually and issued concurrently with the CORE measure release.
2. Non-compliance occurs when an ambulance provider fails to meet each individual quality measure metric as documented in the ePCR at 90% within an EOA, in any month up to 3 consecutive months.
3. Breach of Contract occurs when an ambulance provider fails to meet each individual quality measure metric as documented in the ePCR at 90% within an EOA, in a 4th consecutive month.

#### L. Penalties

1. Response Non-Compliance

If an ambulance provider fails to meet the 90% compliance standard for Priority 1 or 2 calls within any response time zone, in any month, within an EOA, up to 3 consecutive months, the provider will be charged a \$1000 fine each month.

2. Response Breach

If an ambulance provider fails to meet the 90% compliance standard for Priority 1 or 2 calls within any response time zone, in an EOA, in a 4th consecutive month, the provider will be charged a \$5000 fine each month thereafter until compliance is met.

3. Quality Measure Non-Compliance

If an ambulance provider fails to meet the 90% compliance standard for each individual quality measure in any month within an EOA, up to 3 consecutive months, the provider will be charged a \$1000.

4. Quality Measure Breach

If an ambulance provider fails to meet the 90% compliance standard for each individual quality measure in any month within an EOA, in a 4<sup>th</sup> consecutive month, the provider will be charged a \$5000 fine each month until compliance is met.

All quality Measure data shall be collected via FirstWatch and evaluated by EMS staff monthly.

## **XI. Records and Reports**

In order to maintain data collection and quality improvement control in the EMS system, it is necessary for all ambulance providers to submit to the Program specific documentation. Additional reports shall be submitted, as may be required by the Program, for purposes of quality improvement studies and investigation follow-up. For ambulance rate change requests, the ambulance provider shall submit reports and data described in Ambulance Rate Process.

A. Ambulance provider performance reports:

1. The ambulance provider shall provide monthly and annual reports in a format approved by the Program. The monthly reports will be submitted electronically.

2. Required monthly reports are listed below. All monthly reports shall be submitted to the Program before the 20th of the current month for the previous month.
  - a. **Call Volume** - Call volume of responses by priority code, by zone, by level of response (ALS, BLS) per EOA. For EOA 6, 8, and 11, this information shall also be provided by community.
  - b. **Response Time** - Response time performance by priority code by zone by level of response (ALS, BLS) per EOA. For EOA 6, 8, and 11, this information shall also be provided by community.
  - c. **Late Calls** - A list of all calls not meeting response-time performance criteria shall be included. For EOA 6, 8, and 11, this information shall also be provided by community. Late calls in which the ambulance provider is seeking an exception shall be identified, and the documentation to support the request submitted.
  - d. **Out of EOA Responses** - Each response to incidents outside the assigned EOA(s) and within the County shall be listed.
  - e. **Mutual Aid Responses** - Each response to Program-authorized mutual aid within and outside Kern County.
  - f. **Turned Calls** - All “service requested, failed to respond” calls shall be listed.
  - g. **Exemption Request** - The number of responses dispatched, by hour, by day, by EOA. This data will facilitate use of the Overload Score formula, and said report is only required if the ambulance provider is seeking a response time exemption.
  - h. **EMD Activity and QA Report** – The number of calls processed using the EMD protocol, categorized by EMD code. Report shall include the cases reviewed for quality assurance and the findings. The information contained in this report shall be provided in accordance with the standards set forth in the EMS Dispatch Policies and Procedures.
  - i. **Continuing Education** - Listing of continuing education provided for the employees, sequenced by date. Information to be provided shall include the topic and hours of credit.
  - j. **Community Service and Public Education** - Listing of community service and public education activities provided. Participation in meetings sponsored by the EMS Program would also be listed here.
  - k. **Customer Service Tracking Database** – report shall contain the information required by Section XI, below.

- I. **Call Data** – A comprehensive listing of each call for service the ambulance provider received during the month shall be provided in a standard electronic text file, comma delimited, format. The fields listed below shall be provided in the following order:
  - i. **Trip Date:** The date of the response. Data in this field must be in the following format MM/DD/YYYY.
  - ii. **Time of Call (TOC):** The time call is received. Data in this field must be in the following format HH:MM:SS.
  - iii. **Scheduled Pick-up Time:** The time the ambulance is scheduled to arrive at the patient pick-up location. Data in this field must be in the following format HH:MM: SS. This data field is only applicable to Priority 6, 7, and 8 calls, and the purpose of reporting this data is to determine compliance with the “On-time, as mutually agreed” measurement.
  - iv. **On Scene/Cancelled:** The time of scene arrival or cancellation during response. Data in this field must be in the following format HH:MM: SS.
  - v. **Elapsed:** The elapsed time duration from time of call to the on-scene or cancelled time. Data in this field must be in the following format HH:MM:SS. The ambulance provider may choose to omit this field if the data submitted for all time fields allows the elapsed time to be calculated automatically by the Program.
  - vi. **Unit ID:** Identification of the unit responded.
  - vii. **Unit Type:** Clinical capability of responding ambulance / fly car. ALS means the emergency vehicle is equipped with required ALS gear and staffed with at least one paramedic. BLS means ambulance is staffed with two EMT’s, and/or unit does not have the required ALS equipment. Data in this field must be in the following format: “ALS” or “BLS”.
  - viii. **Location:** The location of the incident which may be an address, intersection, roadway description, facility name or GPS coordinates.
  - ix. **Key Map:** Consisting of three separate components: the map key, map section, and quarter section. Data in this field must be in the following format XXX-XX-X. Quarter section designation shall be provided, when feasible. The three-digit Key Map number shall always be separated from the two-digit Section number with a dash.



- x. **Zone:** The response time zone the call is located in. The data in this field shall be spelled out as follows: METRO, URBAN, SUBURBAN, RURAL, WILDERNESS, or OTHER. OTHER shall only be used for responses into other counties or EOAs; OTHER shall never be used for a response location inside an ambulance provider's assigned EOA(s).
- xi. **Priority:** The response priority code. This code shall be listed as 1, 2, C3AF, C3B, 3, 4, 5, 6, 7, 8, or 9. If call priority is upgraded or downgraded, list the final priority code, and denote in the Comments field that call was upgraded/downgraded, as applicable.
- xii. **EOA:** The number of the exclusive operating area for which the scene/location is in. Data in this field shall be listed as a number of 1 through 11. There is no EOA 10. The ambulance provider may choose to omit this field if the data submitted for the Key Map field allows the EOA number to be determined automatically by the Program.
- xiii. **EMD:** The emergency medical dispatch code of the response. Data in this field consists of three separate components: the card number (always numeric), acuity level (always a letter), and descriptor (a number, sometimes combined with a letter). Data in this field must be in the following format XX-X-X. The three data elements may be separated with a dash, or combined as one code.
- xiv. **Community:** List the name of the community for which the scene/location is in. This data field is only applicable to EOA 6, 8, and 11. The data in this field shall be indicated as follows: KERNVILLE, LAKE ISABELLA, ARVIN, LAMONT, TEHACHAPI, FRAZIER PARK, CAL CITY, BORON, MOJAVE, or ROSAMOND, as applicable.
- xv. **Comments:** This field is available for provider to include notes or other optional information applicable to the call. Notes might include information such as "overload exemption request", "wait and return", "public safety standby", "priority upgrade from #", priority downgrade from #", etc. The comment field is an optional field.

The correct and complete electronic submission of the monthly Call Data report will enable the Program to generate monthly reports "a" through "e" automatically. It is not necessary for an ambulance provider to submit monthly reports "a" through "e" if the Program is capable of automatically generating the information from the Call Data report.

3. Required annual reports are listed below. All annual reports shall be submitted to the Program by April 15 of the current year for the previous year.
  - a. Copy of license issued by California Highway Patrol to operate an ambulance service
  - b. Copy of authorization issued by California Highway Patrol for each emergency response vehicle
  - c. Valid certificates of insurance in accordance with contract requirements
  - d. Listing of EMS Program licensed or accredited employees (EMD, EMT, Paramedic or RN)
  - e. Preventive mechanical maintenance program affirmation statement.

## **XII. Customer Service Performance**

- A. The ambulance provider shall provide a customer service program that addresses interactions with patients and families, oversight agencies, hospitals, emergency department physicians and nurses, other healthcare facilities, fire service agencies, law enforcement agencies, public officials, and media representatives. The ambulance provider shall make same-day initial contact with the customer. Investigation and follow-up of findings shall happen concurrently and outcomes shall be looped to the initial customer source, unless there is a legal patient-confidentiality restriction. The ambulance provider shall allow the Program to audit the customer service program, upon request.
- B. All verbal complaints that were not resolved within one business day, and all written complaints, shall be entered into a tracking database and reviewed weekly by the ambulance provider for completion and follow-through. The database shall track incident by source, types, and outcomes. Type of complaints shall be categorized as either clinical, billing, or customer service. The ambulance provider's quality improvement function through a monthly committee of field and managerial personnel shall analyze outcomes and trends.
- C. The tracking database, listing incidents by source, types, and outcomes, shall be submitted to the Program on a monthly basis.
- D. The Program may refer complaints of a significant or chronic nature to the EMCAB for review and recommendations.
- E. The Medical Director may review all complaints of a clinical nature.

### **XIII. Annual Achievement Benchmarks**

- A. By April 15th of each year, each ambulance provider will prepare and submit to the Program a report of contract compliance and achievement for the preceding year (January 1 through December 31). This report will be in a format acceptable to the Program, and the report will indicate the extent of compliance with all performance provisions of the ordinance, contract, and these standards. Additional achievements may also be required or submitted.

At a minimum the report must contain:

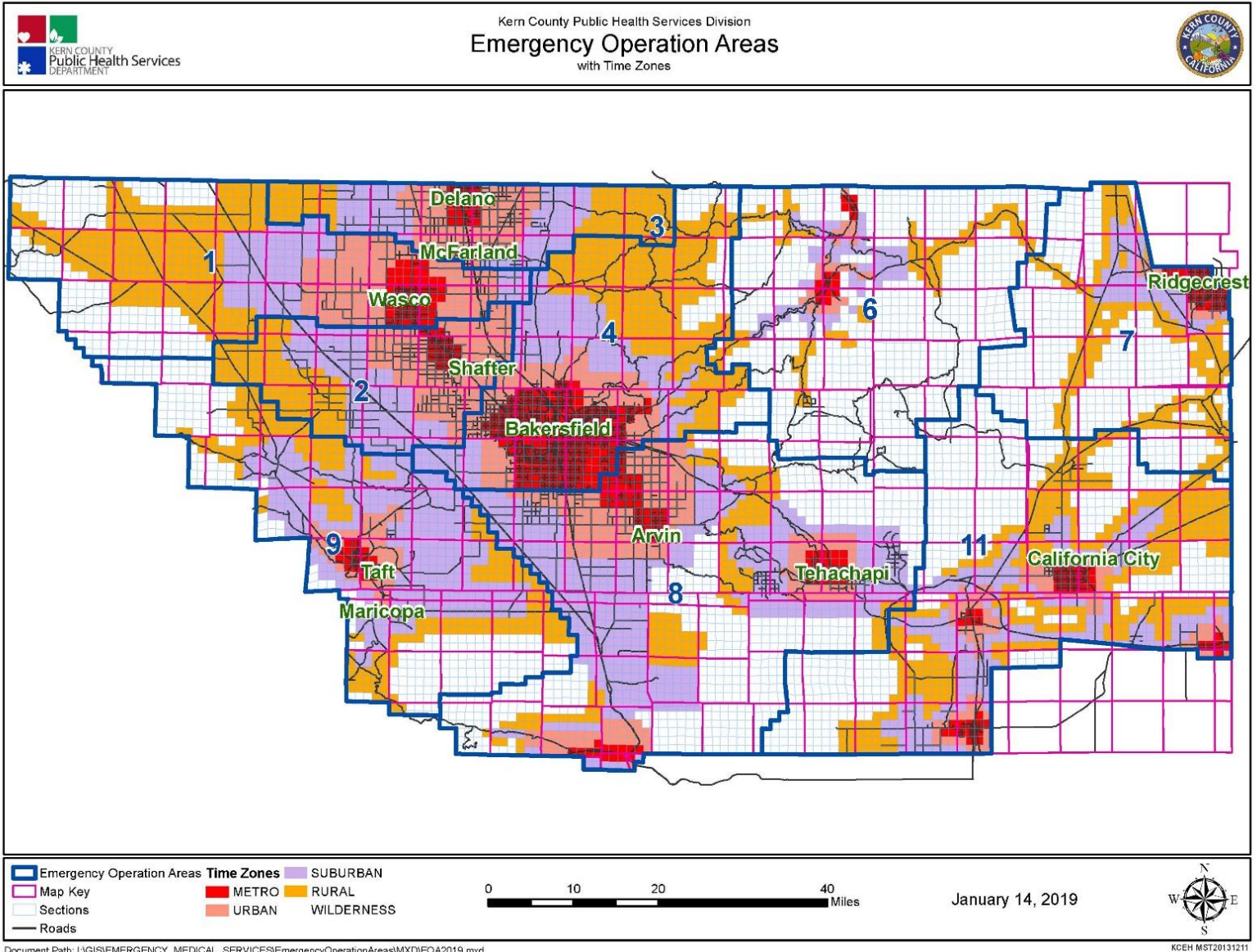
1. Call volume of responses by priority code by time zone per EOA
  2. Volume of transports by response priority code by time zone per EOA
  3. Volume of ALS ambulance transports by response mode by time zone per EOA
  4. Volume of BLS ambulance transports by response mode by time zone per EOA.
  5. Response time compliance by month, by priority, by community, and per EOA.
  6. Volume of “service requested, failed to respond” calls
  7. Volume of mutual aid given and received by ambulance provider.
  8. Emergency Medical Dispatch performance measures (EMD Activity and associated QA Reports).
  9. Customer service inquiry and complaint tracking database, listing incidents by source, types, and outcomes.
  10. Listing of community service and public education events conducted by month, including multiagency drills/exercises.
  11. Listing of Continuing education activities.
  12. Any other information the Program may need or request for use in preparing the Annual Report of Benchmark Achievement.
- B. At least once each year, the Program may require each ambulance provider to mail a quality and customer service questionnaire to designated patients served during a period of up to one month. The Program in consultation with the Medical Director and EMCAB will design and approve the content of the questionnaire and identify the types of designated patients to be surveyed. The ambulance provider must provide and send the questionnaire, when so requested by the Program. The questionnaire may be mailed and included within the ambulance provider’s billing process, at the ambulance provider’s

discretion. Questionnaires will be returned directly to the Program for processing.

- C. After receipt of each provider's annual report of contract compliance and achievement, the Program will prepare an Annual Report of Benchmark Achievement for each provider and the EMS system as a whole. The report will contain the following sections:
1. Contract Compliance - The ambulance provider's extent of contract compliance, any notices of exceptions or instances of non-compliance and provider's performance in curing those deficiencies.
  2. Ordinance Compliance - The ambulance provider's extent of compliance with ordinance requirements, any notices of exceptions or instances of non-compliance and provider's performance in curing those deficiencies.
  3. Customer Service Performance – Demonstrating the ambulance provider's efforts and acumen at providing customer service. The components of this section will include:
    - a. Inquiry and Complaint Tracking Database - listing incidents by source, types, and outcomes.
    - b. Customer Survey – If the Program required a customer service survey be conducted, the results of the survey shall be included. Service will be rated based on a statistical evaluation of customer responses. The rating system shall coincide with questions from the survey.
  4. Ambulance Performance Standards Compliance - The ambulance provider's extent of compliance with performance standards, including response time compliance, any notices of exceptions or instances of non-compliance and provider's performance in curing those deficiencies. Also, consideration will be given to an ambulance provider's active participation in Program projects, committees, task forces, etc., and multiagency training exercises.
  5. Clinical Performance - Prepared by the Medical Director determining each ambulance provider's extent of compliance with the clinical performance requirements in the following categories:
    - a. Maintaining all required clinical equipment in good working order
    - b. Adherence to clinical protocols
    - c. Quality Improvement Processes
    - d. Qualifications of clinical personnel (including certifications and continuing education)
    - e. EMD QA compliance

- f. Participation in County clinical processes
  - g. Active participation in Program projects, committees, task forces, etc.
  - h. Ratings will be issued based on compliance or non-compliance.
- D. The Program will compile the extent of compliance and will evaluate each ambulance provider's performance. The draft evaluation will be shared with each ambulance provider for review and comment prior to finalizing the report. The evaluation shall be submitted to the Board of Supervisors for consideration.
- E. If the Board of Supervisors determines that the ambulance provider has fulfilled the performance standards and achievement benchmarks, a year shall be added automatically to the term of the ambulance service performance contract, and the term of the contract shall be renewed and extended. In the event that the ambulance provider fails to fulfill the performance standards and achievement benchmarks the Board of Supervisors may, in its sole discretion, notify the ambulance provider that the performance contract is non-renewed and no additional time shall be automatically applied to extend the term of the contract.
- F. In the case of significant non-compliance, the Board of Supervisors may, in its sole discretion, declare the ambulance provider in breach of the contract and pursue the remedies and actions specified in the contract, and other actions allowed by law.

# XIV. Time Zone Maps



Key to Abbreviations:

ALS – Advanced Life Support  
BLS – Basic Life Support  
ECC – Emergency Communications Center  
EMCAB – Emergency Medical Care Advisory Board  
EMD – Emergency Medical Dispatcher  
EMT – Emergency Medical Technician  
  
EOA – Exclusive Operating Area  
MICN - Mobile Intensive Care Nurse  
MICU – Mobile Intensive Care Unit  
NIMS – National Incident Management System  
RN – Registered Nurse  
SEMS – Standard Emergency Management System  
CCT – Critical Care Transport  
9-1-1 – telephone number used to access EMS system

**Versions:**

December 5, 2006 – Board of Supervisors approval (Ver. 1.0)  
June 19, 2007 – Board of Supervisors approval (Ver. 2.0); update to incorporate provider and public comments, add definition for Priority 5, refine reporting requirements, and revise overload score formula scheduled to consider proposed revisions  
August 8th, 2018 – EMCAB Approval – October 9, 2018 – Board of Supervisors approval – Update to delete 100 call rule, incorporate fines for compliance violations in priority 1 and 2 responses.  
January 14, 2019 – Corrected formatting issues – replaced county EOA Map.  
  
October 13<sup>th</sup>, 2022 – Addition of C3AF and C3B response codes, Addition of non-transport emergency response vehicles (fly car), Addition of quality measure compliance, removed BLS limitation and compliance, removed Priority 4's,  
January 24, 2023 – Addition of code 2 response to all calls to stage.  
  
February 9<sup>th</sup>, 2023 – Approved by EMCAB to begin March 1<sup>st</sup>, 2023.