AGENDA
EMERGENCY MEDICAL CARE ADVISORY BOARD (EMCAB)
REGULAR MEETING

THURSDAY – AUGUST 9th, 2018

4:00 P.M.

Location: Kern County Public Health Services Department

San Joaquin Room – 1st Floor

1800 Mount Vernon Avenue - Bakersfield, California 93306

(661) 321-3000

I. Call to Order

II. Flag Salute

III. Roll Call

IV. Consent Agenda (CA): Consideration of the consent agenda.

All items listed with a "CA" are considered by Division staff to be routine and non-controversial. Consent items may be considered first and approved in one motion if no member of the Board or audience wishes to comment or discuss an item. If comment or discussion is desired, the item will be removed from consent and heard in its listed sequence with an opportunity for any member of the public to address the Board concerning the item before action is taken.

V. (CA) **Approval of Minutes:** EMCAB Meeting May 10th, 2018– approve

VI. Subcommittee Reports: None

VII. Public Comments:

This portion of the meeting is reserved for persons desiring to address the Board on any matter not on this Agenda and over which the Board has jurisdiction. Members of the public will also have the opportunity to comment as agenda items are discussed.

VIII. Public Requests:

a. Accreditation Policy – Paula Isbell – Kern Medical

IX. Unfinished Business: Continued to November 8th

~~a. State Regulations on Naloxone Release-receive and file~~
~~b. Opioid Overdose Data-receive and file~~

X. New Business:

a. Impact of ALS to BLS Handoff Protocol-receive and file
b. Ambulance Performance Standards-approve
c. ALJ/EMSA Commission Decision-receive and file

XI. Director's Report: Hear presentation

XII. Miscellaneous Documents for Information:

A. (CA) EMS Fund Annual Report – receive and file

XIII. Board Member Announcements or Reports:

On their own initiative, Board members may make a brief announcement or a brief report on their own activities. They may ask a question for clarification, make a referral to staff, or take action to have staff place a matter of business on a future agenda. (Government Code Section 54954.2 [a.])

XIV. Announcements:

A. Next regularly scheduled meeting: Thursday, November 8th, 2018, 4:00 p.m., at the Kern County Public Health Services Department, Bakersfield, California.

B. The deadline for submitting public requests on the next EMCAB meeting agenda is Thursday, October 25th, 2018, 5:00 p.m., to the Kern County EMS Division Senior Emergency Medical Services Coordinator.

XV. Adjournment

Disabled individuals who need special assistance to attend or participate in a meeting of the Kern County Emergency Medical Care Advisory Board (EMCAB) may request assistance at the Kern County Public Health Services Department located at 1800 Mount Vernon Avenue, Bakersfield, 93306 or by calling (661) 321-3000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting materials available in alternative formats. Requests for assistance should be made at least three (3) working days in advance whenever possible.

EMERGENCY MEDICAL CARE ADVISORY BOARD
Membership Roster

Name and Address	***Representing***
Mike Maggard, Supervisor Third District 1115 Truxtun Avenue Bakersfield, CA 93301 (661) 868-3670 Alternate Mick Gleason, Supervisor First District 1115 Truxtun Avenue Bakersfield, CA 93301 (661) 868-3651	Board of Supervisors
Donny Youngblood, Sheriff Kern County Sheriff's Department 1350 Norris Road Bakersfield, CA 93308 (661) 391-7500 Alternate Vacant	Police Chief's Association
Brian Marshall, Chief Kern County Fire Department 5642 Victor Street Bakersfield, CA 93308 (661) 391-7011 Alternate Vacant	Fire Chief's Association
James Miller 14113 Wellington Court Bakersfield, CA 93314 (817) 832-2263 Alternate Vacant	Urban Consumer

Name and Address	***Representing***
Vacant	Rural Consumer
Alternate Vacant	
Randy Miller Mayor, City of Taft 209 E. Kern Street Taft, CA 93268	City Selection Committee
Alternate Cathy Prout Mayor, City of Shafter 435 Maple Street Shafter, CA 93263 (661) 746-6409	
Paul Paris City of Wasco 746 8th Street Wasco, CA 93280 (661) 758-7214	Kern Mayors and City Managers Group
Alternate Vacant	
Vacant	Kern County Medical Society
Alternate Vacant	
Bruce Peters, Chief Executive Officer Mercy and Mercy Southwest Hospitals 2215 Truxtun Avenue P.O. Box 119 Bakersfield, CA 93302 (661) 632-5000	Kern County Hospital Administrators
Alternate Jared Leavitt, Chief Operating Officer Kern Medical Center 1700 Mount Vernon Avenue Bakersfield, CA 93306 (661) 326-2000	

Name and Address	***Representing***
John Surface Hall Ambulance Inc. 1001 21st Street Bakersfield, CA 93301 (661) 322-8741	Kern County Ambulance Association
Alternate Aaron Moses Delano Ambulance Service P.O. Box 280 Delano, CA 93216 (661) 725-3499	
Kristopher Lyon, M.D. 1800 Mount Vernon Avenue, 2rd floor Bakersfield, CA 93306 (661) 321-3000	EMS Medical Director
Support Staff	
Jeff Fariss, Senior EMS Coordinator 1800 Mount Vernon Avenue, 2nd floor Bakersfield, CA 93306 (661) 321-3000	EMS Division
Karen Barnes, Chief Deputy 1115 Truxtun Avenue, 4th Floor Bakersfield, CA 93301 (661) 868-3800	County Counsel
Amanda Ruiz 1115 Truxtun Avenue, 5th Floor Bakersfield, CA 93301 (661) 868-3164	County Administrative Office

V. Approval of Minutes

May 10, 2018

MINUTES
EMERGENCY MEDICAL CARE ADVISORY BOARD (EMCAB)
REGULAR MEETING

THURSDAY – May 10, 2018

4:00 P.M.

Location: Kern County Public Health Services Department

San Joaquin Room – 1st Floor

1800 Mount Vernon Avenue - Bakersfield, California 93306

(661) 321-3000

I. Call to Order

II. Flag Salute
LED BY: Miller

III. Roll Call: Maggard, Marshall, Miller, Prout, Peters, Surface, Lyon

IV. Consent Agenda (CA): Consideration of the consent agenda.

All items listed with a "CA" are considered by Division staff to be routine and non-controversial. Consent items may be considered first and approved in one motion if no member of the Board or audience wishes to comment or discuss an item. If comment or discussion is desired, the item will be removed from consent and heard in its listed sequence with an opportunity for any member of the public to address the Board concerning the item before action is taken.

V. (CA) **Approval of Minutes:** EMCAB Meeting February 8, 2018 **–** approve
Marshall-Peters: All ayes

VI. Subcommittee Reports: None

VII. Public Comments:

This portion of the meeting is reserved for persons desiring to address the Board on any matter not on this Agenda and over which the Board has jurisdiction. Members of the public will also have the opportunity to comment as agenda items are discussed.
NO ONE HEARD

VIII. Public Requests: None

IX. Unfinished Business: None

X. New Business:

A. Resuscitation Academy **–** receive and file
Miller-Peters: All ayes

B. Napa Fires – receive and file
Prout-Lyon: All ayes

C. Annual ALS Provider Performance Reports – receive and file
Marshall-Lyon: All ayes

D. Annual EMS System Activity Report – receive and file
Lyon-Marshall: All ayes

XI. Director's Report: Hear presentation – receive and file
Peters-Lyon: All ayes

XII. Miscellaneous Documents for Information:

A. (CA) EMS Fund Report – receive and file
Marshall-Peters: All ayes

XIII. Board Member Announcements or Reports:

On their own initiative, Board members may make a brief announcement or a brief report on their own activities. They may ask a question for clarification, make a referral to staff, or take action to have staff place a matter of business on a future agenda. (Government Code Section 54954.2 [a.])

XIV. Announcements:

A. Next regularly scheduled meeting: Thursday, August 9, 2018, 4:00 p.m., at the Kern County Public Health Services Department, Bakersfield, California.

B. The deadline for submitting public requests on the next EMCAB meeting agenda is Thursday, July 26, 2018, 5:00 p.m., to the Kern County EMS Division Senior Emergency Medical Services Coordinator.

XV. Adjournment
Lyon

Disabled individuals who need special assistance to attend or participate in a meeting of the Kern County Emergency Medical Care Advisory Board (EMCAB) may request assistance at the Kern County Public Health Services Department located at 1800 Mount Vernon Avenue, Bakersfield, 93306 or by calling (661) 321-3000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting materials available in alternative formats. Requests for assistance should be made at least three (3) working days in advance whenever possible.

VIII.Public Request

A. Accreditation Policy

Accreditation of EMS Personnel (1010.00)

I. Intent

It is the intent of the Emergency Medical Services Division (Division) to provide a method for medical oversight of all personnel operating within the organized Kern County emergency medical services (EMS) system; under the direction of the Medical Director. The Division further intends to create a method for quality assurance oversight. Medical Control shall be maintained through compliance with these policies and applicable policies listed in sections below.

II. Authority

This policy is administered under the authority of Health and Safety Code Sections 1797.107, 1797.172, 1797.173, 1798, and California Code of Regulations, Title 22, Division 9, Chapter 4, Sections 100147 and 100153, and PC11105.3.

California Code of Regulations, Division 9, Chapter 1.5, 2, 4. EMSA Publication #130.

III. General Provisions

EMS personnel shall not provide care within the Kern County EMS system without obtaining local accreditation

A. Individuals seeking accreditation shall apply to the Division either in-person or through the online portal.
B. All local Kern County Accreditations require a Live Scan to be completed using the Kern County form.

IV. Public Safety First Aid Optional Skill Accreditation

A. Individuals who possess a current first aid certification from an approved training provider may be accredited in Kern County upon successful completion of the accreditation requirements.
B. Individuals must maintain compliance with *Public Safety First Aid Optional Skills Policies and Procedures.*
C. Individuals wishing to apply for an initial Kern County Public Safety First Aid Optional Skills Accreditation shall:
    1. Provide evidence of completion of an approved Public Safety First Aid training program.
    2. Submit a completed and signed “All Purpose Certification/Accreditation Form.”
    3. Be employed by a public safety agency which has been approved by the Division to provide optional skills. Employment verification shall be provided by the public safety agency.

4. Provide proof of successful training in all optional skills items mandated by the Division
5. Provide proof of successful training in all optional skill items mandated by the public safety agency and approved by the Division.
6. Provide proof of CPR and AED training.
7. Provide a Live Scan using Division approved form.
8. Provide proof of successful completion of any training mandated by the Division, if applicable.
9. Provide a copy of government issued photo identification (current state driver's license or identification, federally issued passport, or similar)
10. Pay the fee established in Ordinance, if applicable.

D. Accreditation shall be continuous unless the Public Safety First Aid provider separates from employer, First Aid certification lapses or the employer no longer participates in the PSFA.
E. Local accreditation expiration dates shall coincide with First Aid certification expiration dates.
F. The Public Safety First Aid Optional Skill provider shall apply for re-accreditation to the Division prior to the expiration of current accreditation
G. Individuals wishing to apply for reaccreditation of the Kern County Public Safety First Aid Optional Skill accreditation shall:
   1. Meet the standards listed above,
   2. Provide proof of successful completion of training and demonstration of skills competency for each approved optional scope of practice items mandated by the Division or the employer and approved by the Division

V.Emergency Medical Technician (EMT) California State Certification

Initial Certification – 1st time California EMT:

A. Application complete and signed
B. Proof of current NREMT
C. Live Scan results received and reviewed

Renewal or lapse less than 6 months:

A. Application complete and signed
B. California EMT Certification with expiration date of less than 6 months
C. Continued Education (24 Hours Approved CE)
D. Skills Competency Form

Reinstatement – lapse greater than 6 months but less than 12 months:

A. Application complete and signed
B. California EMT Certification with expiration date of greater than 6 months but less than 12 months.
C. Continued Education (36 Hours of Approved CE)

D. Skills Competency Form

Reinstatement – lapse greater than 12 months:

A. Application complete and signed
B. Continued Education (48 hours of Approved CE)
C. Skills Competency Form
D. Proof of current NREMT or current California paramedic license
E. Live Scan results received and reviewed

VI. Emergency Medical Technician (EMT) Accreditation

A. Individuals who possess a current EMT certification from the State of California may be accredited in Kern County upon successful completion of the accreditation requirements.
B. Individuals must maintain compliance with EMT Provider Policies and Procedures (5001.00) and Emergency Medical Technician Protocols and Procedures (5002.00).
C. Individuals wishing to apply for an initial Kern County EMT Accreditation shall:
    1. Possess a current and valid EMT certification issued by a local EMS agency on behalf of the State of California. Certifications issued by certifying entities other than a local EMS agency shall obtain written verification from the certifying entity of willingness to provide certification oversight throughout remainder of certification cycle.
    2. Submit a completed and signed “All Purpose Certification/Accreditation Form.”
    3. Be employed by a Division approved Emergency Medical Technician Provider. Employment verification shall be provided by the provider.
    4. Proof of successful training in all Optional Scope of Practice items mandated by the Division.
    5. Proof of successful training in all Optional Scope of Practice items mandated by the employer and approved by the Division.
    6. Provide a Live Scan, if not certified by the Division.
    7. Provide proof of CPR and AED training.
    8. Provide proof of successful completion of any training mandated by the Division, if applicable.
    9. Provide a copy of government issued photo identification (current state driver’s license or identification, federally issued passport, or similar)
    10. Pay the fee established in Ordinance, if applicable.
D. Accreditation shall be continuous unless EMT separates from employer or EMT certification lapses.
E. Local accreditation expiration dates shall coincide with EMT state certification expiration dates.
F. The EMT shall apply for re-accreditation by the Division prior to the expiration of current accreditation

G. Individuals wishing to apply for reaccreditation of the Kern County EMT accreditation shall:
    1. Meet the standards listed above,
    2. Provide proof of successful completion of training and demonstration of skills competency for each approved optional scope of practice items mandated by the Division or the employer and approved by the Division.

VII. Paramedic Accreditation

A. Individuals who possess a current and valid paramedic license issued by the State of California may be accredited in Kern County upon successful completion of the accreditation requirements. Accreditation shall allow the paramedic to work within the Kern County scope of practice without a paramedic partner while employed by an approved Kern County provider.
B. Individuals must maintain compliance with all Division policies, procedures, and protocols.
C. Individuals wishing to apply for an initial Paramedic Accreditation shall:
    1. Present a valid paramedic license issued by the State of California.
    2. Submit a completed and signed "All Purpose Certification/Accreditation Form.
    3. Provide a Live Scan using Division approved form.
    4. Be employed by a Division approved paramedic service provider. Employment verification shall be provided by the provider.
    5. Successfully complete a supervised pre-accreditation field evaluation by a recognized Kern County Preceptor consisting of a minimum ten (10) advanced life support contacts.
    6. Provide verification of orientation to Kern County EMS policies, procedures, and protocols.
    7. Provide proof of BLS healthcare provider CPR.
    8. Provide proof of successful completion of training for all Division authorized Optional Scope of Practice items.
    9. Successfully pass the Kern County accreditation test with a score of 80% or better.
    10. Provide a copy of government issued photo identification (current state driver's license or identification, federally issued passport, or similar)
    11. Pay the fee established in Ordinance, if applicable.
H. Accreditation shall be continuous unless paramedic separates from employer or paramedic certification lapses.
I. Local accreditation renewal dates shall coincide with paramedic license expiration dates.
J. If the individual fails to complete all requirements for accreditation outlined in this policy within thirty (30) days of application, the Division will notify the individual and the employer of the denial of accreditation. Provisional extension of up to ninety (90) days may be authorized for good cause by the Division as mutually

agreeable to the individual. Individuals shall not apply for accreditation more than three (3) times per calendar year.

K. The paramedic shall apply for renewal of accreditation by the Division prior to the expiration of current accreditation.
L. Individuals wishing to apply for reaccreditation of the Kern County paramedic accreditation shall:
    1. Meet standards 1, 2, 3, 6, and 9 listed above,
    2. Provide proof of successful completion of training and demonstration of skills competency for each approved optional scope of practice items mandated by the Division or the employer and approved by the Division.
    3. Provide proof of successful completion of any Division mandated training (i.e., paramedic update training)
    4. Provide copy of the State of California EMT Paramedic Renewal Application, STATEMENT OF CONTINUING EDUCATION, and all additional copies requested by the State for renewal with the Authority.
    5. Provide proof of Advanced Cardiac Life Support Training.
    6. Provide proof of Pre-Hospital Trauma Life Support Training.
    7. Provide proof of Pediatric Advanced Life Support Training.
    8. One skills verification form for each year of the accreditation cycle, not to be closer than six (6) months apart.
    9. Successfully pass the Kern County accreditation test with a score of 80% or better.
    10. If paramedic accreditation is expired, pay the fee established in Ordinance.

VIII. Paramedic Preceptor Accreditation

A. The purpose of this policy is to outline the procedure for a Kern County accredited paramedic to be considered for paramedic preceptor.
B. The procedure is the same for all paramedics regardless of whether the paramedic preceptor will be a preceptor of paramedic students or initial accreditations for paramedics in Kern County.
C. The paramedic preceptor shall be responsible for the training, supervision and evaluation of personnel in Kern County who are preparing for accreditation and paramedic interns. The paramedic preceptor is responsible for ensuring appropriate patient care is provided to every patient encounter in accordance with County Paramedic Protocols, all local policies, and procedures, as well as all appropriate local, and/or State rules and regulations.
D. In order to be eligible for accreditation as a paramedic preceptor a candidate shall:
    1. Present a valid paramedic license issued by the State of California to the County EMS Division.
    2. Be a Kern County accredited paramedic for at least two years, and have a minimum of 300 patient contacts.
    3. The paramedic's license and accreditation must be in good standing with the County EMS Division and the State of California Emergency Medical Services Authority. A paramedic is considered in good standing if:

a. License status with the State of California Emergency Medical Services Authority is either “Active” or “Approved” only.
b. The following statuses with the State of California Emergency Medical Services Authority are <u>not</u> considered in good standing: “Active-PROBATION”, “Active-PROVISIONAL”, “Active-RESTRICTED”,
c. No disciplinary action taken against the paramedic’s accreditation by the County EMS Division within the last two (2) years.
d. No mandated remedial training within the last year.

4. Attend a preceptor training class approved by the County EMS Division from one of the paramedic training programs below:
   a. Bakersfield College Paramedic Training Program.
   b. University of Antelope Valley Paramedic Training Program.
5. Successfully complete a written exam on local optional scope of practice and local operational procedures with a passing score of 90 percent.
   a. If the candidate fails the exam on the first attempt, the candidate will have the option to retake the exam after one (1) week of the initial attempt.
   b. If the candidate fails the second attempt, the candidate shall wait a period of three (3) months to re-attempt the process for paramedic preceptor accreditation. This means paramedic license and accreditation will be reviewed to determine if the candidate is in good standing as outlined above. The candidate shall attend a second preceptor training class as outlined above, and the candidate shall submit a second letter of recommendation from his or her employer as outlined below.
   c. The employer of the preceptor candidate will be notified by the Division upon each failed attempt at passing the exam.
6. Present a letter of recommendation from the candidate’s employer, who must be an approved ALS provider.

E. Upon successful completion of the above requirements, the paramedic shall be placed on an approved list of paramedic preceptors for the County.
F. A candidate who fails to complete the process within two (2) attempts shall wait a period of one (1) year prior to being eligible for consideration of paramedic preceptor accreditation. The candidate shall repeat all procedures for consideration as outlined in this policy.
G. Paramedic preceptor status shall be continuous upon each Kern County accreditation renewal, provided:
   1. The candidate continues to pass the written exam on local optional scope and local operational procedures with a passing score of 90 percent.
   2. The candidate attends all required update classes as mandated by the preceptor training class that was attended.
H. Failure to maintain the requirements set forth in this policy and/or failure to remain in good standing with the EMS Division or the State of California Emergency Medical Services Authority will result in immediate removal from the approved preceptor list.

I. Paramedics that have had their paramedic preceptor status revoked will not be eligible to attempt paramedic preceptor accreditation for a period of two (2) years.

IX.Emergency Medical Dispatcher Accreditation

A. Individuals who possess a valid NAED card in the current version of the protocol, or course completion record for the basic EMD training program may be accredited in Kern County upon successful completion of the accreditation requirements.
B. Individuals must maintain compliance with the EMD Policies and Procedures (2001.00).
C. Individuals wishing to apply for an initial Kern County EMD Accreditation shall:
    1. Possess a current and valid EMD certification issued by National Academies of Emergency Dispatch (NAED)
    2. Submit a completed and signed “All Purpose Certification/Accreditation Form.”
    3. Provide a Live Scan using Division approved form.
    4. Proof of completion record verifying 8 hours of protocol training in local EMD policies, procedures, and protocols by EMD authorized instructor dated with issue date of not more than one year.
    5. Copy of the applicant’s government issued photo identification (may be current state driver’s license or identification, federally issued passport, or similar photo identification).
    6. Skills verification documentation that demonstrates EMD competency signed by EMD preceptor.
    7. Valid CPR card
    8. Pay the fee established in Ordinance, if applicable.
D. Local accreditation expiration dates shall coincide with NAED certification expiration dates.
E. The EMD shall apply for reaccreditation by the Division prior to the expiration of current accreditation.
F. Individuals wishing to apply for reaccreditation of the Kern County EMD accreditation shall meet the standards 1, 2, 3, 5, 7 and 8.

X.Mobile Intensive Care Nurse Accreditation

A. Individuals who possess a current and valid registered nursing license issued by the State of California may be certified in Kern County upon successful completion of the certification requirements. Certification shall allow the registered nurse to work as an MICN in Kern County.
B. Individuals must maintain compliance with all Division policies, procedures, and protocols.

C. Individuals wishing to apply for an initial MICN certification shall:
    1. Present a valid registered nurse license issued by the State of California.
    2. Submit a completed and signed “All Purpose Certification/Accreditation Form.”
    3. Provide a Live Scan using Division approved form.
    4. Successfully complete the Mobile Intensive Care Nurse Certification program with an 80% or better.
    5. Successfully complete a supervised pre-certification field evaluation by a recognized Kern County MICN consisting of a minimum of four (4) ALS level communication cases under the supervision of a certified MICN, and completion of 16 hours of paramedic ambulance ride time.
    6. Provide proof of ACLS (Advance Cardiac Life Support)
    7. Provide a copy of government issued photo identification (current state driver’s license or identification, federally issued passport, or similar).
    8. Pay the fee established in Ordinance, if applicable
D. Local certification shall be good for two years from date of completion of certification process.
E. The Mobile Intensive Care Nurse shall apply for recertification to the Division prior to the expiration of current certification dates.
F. Individuals wishing to apply for recertification of the Kern County Mobile Intensive Care Nurse shall:
    1. Meet the standards listed above,
    2. Provide proof of successful completion of the Mobile Intensive Care Nurse Recertification program with 80% or higher.

Appendix A- Procedure for Mandatory Passing of Local Exam for Accrediting and Re-accrediting Paramedics

All New and re-accrediting paramedics in Kern County will be required to pass an exam on local policies, procedures, and protocols. The pass rate is 80% to obtain/retain accreditation. If at any point in the process the paramedic accreditation expires, the paramedic will not be allowed to report to duty. Reinstatement of accreditation from expiration or failure to pass the exam after three (3) attempts will be subject to accreditation fee as established in Ordinance. The procedure for paramedic testing is outlined below.

A. The paramedic will have three (3) attempts at passing the exam. There is no time restriction or waiting period between exam attempts with the exception of remediation.

B. If the paramedic fails the first two (2) attempts, the paramedic shall be referred to his/her employer for remedial education.
    1. The Division will fill out a form citing which local policies, procedures, or protocols were missed on the exam(s).
    2. The paramedic will present the form to the employer for assignment of training.
    3. Remedial training may be conducted by a Pre-Hospital Continuing Education Provider Program or Division approved preceptor at the discretion of the employer.
    4. Training will be focused on the policies, procedures, protocols listed on the Division form.
    5. There is no minimum requirement for the number of training hours. Satisfaction of completion of remedial training will be at the discretion of the employer.
    6. The paramedic must have the form signed by the trainer to be eligible for the third attempt at the exam.
C. The paramedic shall present a signed remedial education form to the Division to attempt the exam a third time.
D. If the paramedic fails the third attempt at the exam, his or her accreditation will be suspended or not renewed.
E. Reinstatement of accreditation will require completion of a Division sponsored policy, procedure, protocol class. Course completion will require passing of an exam.
F. If the paramedic fails to complete the course, the paramedic will not be eligible for accreditation for one (1) year following the date of the fourth and final exam.
G. Reinstatement after the one (1) year time frame will require the paramedic to complete the accreditation process (including ten ALS contacts).

Appendix B- Paramedic Skills Verification Procedure

A. The policy establishes the policies and procedures for the Paramedic Skills Verification program.
B. These policies shall apply to all Kern County paramedics and all Kern County ALS providers.
C. The Division reserves the right to change or update these policies and procedures as deemed necessary in accordance with Health and Safety Code, California Code of Regulations Title 22, and Kern County Ordinance.
D. All Paramedics shall be certified in CPR, PALS, ACLS, and PHTLS.
    1. Paramedics shall present copies of their cards at time of re-accreditation.
    2. An instructor in PALS, ACLS, and PHTLS may verify a skill during the course if a manipulative station is part of the normal course material.
E. The following skills require verification:
    1. Cricothyrotomy
    2. Thoracic Decompression
    3. Endotracheal Intubation (if applicable)
        a. Adult
    4. Intraosseous needle placement
F. Skills that are successfully completed in the field may be used as verification.
G. The following information must be provided for verification:
    1. Run Number
    2. Date of Procedure
    3. Indications
    4. Complications
    5. Attempt
H. The Paramedic must turn in the skills verification sheets at the time of re-accreditation.
I. Two verifications will be required to be presented at reaccreditation:
    1. One verification must be completed within twelve months of accreditation
    2. One verification must be completed greater than twelve months after accreditation
    3. Verifications must be more than six months apart
J. Skills may be verified through a refresher course that provides hands-on manipulation. The refresher course must include the following:
    1. Review of indications and contraindications
    2. Paramedic must be able to physically identify landmarks
    3. Paramedic must be able to practice the procedure and have positive feedback indicating success
    4. A Division approved device shall be used.

Appendix C- Items needed for accreditation:

- ☐ All purpose application
- ☐ Completed Live Scan Form
- ☐ Driver's license or other form of government issued ID
- ☐ Copy of your expiring county card (EMT, Paramedic, MICN, EMD, PSFA)
- ☐ Copy of your state card (EMT, Paramedic, RN) or NAEMD,NREMT
- ☐ Copy of your CPR
- ☐ Copy of other required certifications (ACLS, PALS, PHTLS)
- ☐ Copy of CE's (page 2 of the paramedic state application or required amount of original CE's for EMT's)
- ☐ Required Fee's (We accept cash, money orders, cashier checks, Visa or MasterCard; please make money order or cashier's check payable to "Kern County EMS")
- ☐ Proof of all county training required by the Division.

X. New Business

A. Impact of ALS to BLS Handoff Protocol

KERN COUNTY
Public Health Services
DEPARTMENT

MATTHEW CONSTANTINE
DIRECTOR

1800 MT. VERNON AVENUE BAKERSFIELD, CALIFORNIA, 93306-3302 661-321-3000 WWW.KERNPUBLICHEALTH.COM

Impact of ALS to BLS Handoff on Bakersfield Metro Response Times

In 2017, the EMS Division recognized that response time standards were not being met in several metropolitan zones throughout Kern County. Not only did this affect the ambulance provider's ability to meet their contractual duties to EMS, but it also created a potential public health concern for the communities they serve. In response, the EMS Division initiated quality improvement efforts to develop long-term solutions for this issue.

One area of improvement that EMS identified was the metro priority 1 response times for EOA-4 and EOA-5. These areas service the majority of metro Bakersfield.

Ambulance patient offload times (APOT) and increased call volumes were acknowledged by the EMS Division as possible contributing factors to extended response times, particularly in these metro zones. In order to mitigate compliance issues within these metro areas, EMS created the ALS to BLS Handoff protocol and Direct to Triage policy. The theory behind these changes was to allow Advanced Life Support (ALS) units to transfer care of lower acuity patients to either Basic Life Support (BLS) ambulances or to the hospital triage nurse. This would allow ALS units to bypass the emergency department thus freeing up an ALS unit to respond more quickly to higher acuity patients.

The ALS to BLS Handoff protocol was adopted November 1, 2017 for use mainly in metro areas. As of May 31st, 2018, this protocol has been used 374 times by ALS crews. The impact of this protocol is very apparent, as response times immediately dropped in the metro EOAs and are now below the standard set forth in the Ambulance Performance Standards.

The Direct to Triage policy was adopted April 1, 2018 and data on its use is not yet available.

Since the ALS to BLS Handoff protocol was instituted in November 2017, all Bakersfield metro priority 1 response times have been at or below the 08:59 standard (See Figure 1 below). Between November 2017 and May 2018, response times in EOA-4 decreased by 01:28 minutes and response times in EOA-5 decreased by 00:50 seconds.

Response times in EOA-4 have seen the most improvement. Before the adoption of this protocol, this EOA was non-compliant with response times for priority 1 metro. After November 2017, response times in this EOA dropped and have remained consistent.

KERN COUNTY
Public Health Services
DEPARTMENT

MATTHEW CONSTANTINE
DIRECTOR

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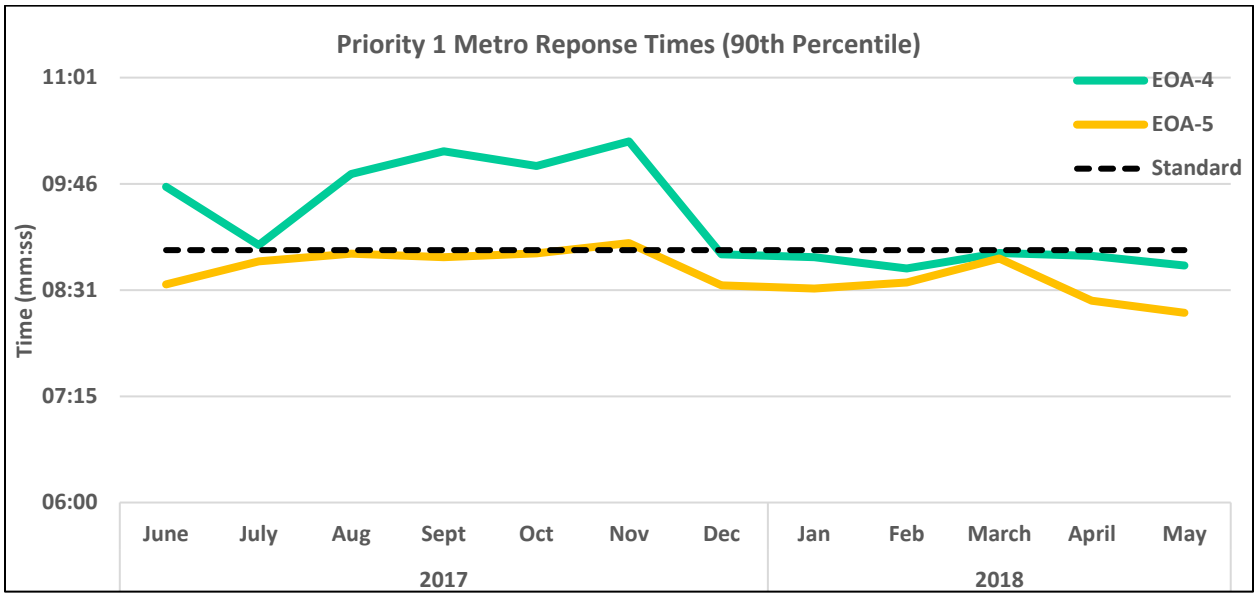

Figure 1. Response Times (90th percentile) for Metro Bakersfield. The ALS to BLS Handoff was adopted in November 2017 and Direct to Triage in April 2018. Since these policies were adopted, metro priority 1 response times are below the standard of 08:59.

X. New Business

B. Ambulance Performance Standards

KERN COUNTY
Public Health Services
DEPARTMENT

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EMS Division Staff Report for EMCAB-August 9th, 2018

Ambulance Performance Standards

Background

The Kern County Ambulance Performance Standards establish minimum standards for ambulance services across the county. These Standards are applicable to all contracted ground ambulance providers.

These Standards are directly referenced in the Kern County Ordinance Code Chapter 8.12., entitled Ambulances and each Agreement for Provision of Ground Ambulance Service executed by the County.

Both the Ordinance and Agreement contain basic performance provisions, however the Standards define performance requirements specific to ambulance providers.

The Dilemma

Originally written in 2006, the Ambulance Performance Standards have been the yard stick used to measure ambulance service compliance throughout the county for the past 12 years. During that time there have been significant changes to our system that are not reflected in this document. Examples include; numerous changes to the Emergency Medical Dispatch policies, increased use of Basic Life Support ambulances, increases in population leading to a higher call volume, and the negative effect of the 100 call rule.

The EMS Division Plan of Action

In response to these and other changes to our system, EMS has spent many hours revising the Ambulance Performance Standards to better reflect the needs of our system and of the citizens of Kern County. Those changes include pointing the standards to the most current versions of policies such as the Emergency Medical Dispatch Policy, implementing fines for failure to comply with the Ambulance Performance Standards, and focusing on real time response by removing the 100 call rule.

I believe that the changes to the Ambulance Performance Standards present a significant improvement to our EMS system, a real time view of response compliance, a method to hold our ambulance providers accountable, and a clear path into the future.

Therefore IT IS RECOMMENDED, the Board approve the updated Ambulance Performance Standards.

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 acreditation ~~and license~~ within the ambulance service operating area to meet these standards and achieve compliance with all other ~~Department~~Division 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 ~~Department~~Division authorized mutual aid. ~~The ambulance provider shall not refuse to transport any patient~~.

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.

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, ~~except~~ 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 ~~can~~ demonstrate that ~~there is~~ no general acute care or specialty hospital in Kern County ~~that~~ is capable of accepting and providing appropriate care of the patient at the time the transfer is required.

The ~~Department~~Division, through the on-call Coordinator, 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 ~~Department~~Division and Medical Director. The program will include provisions for prehospital personnel continuing education, service operational procedures and standards, monitoring compliance with ~~Department~~Division requirements, and continuous operational efficiency monitoring. The ambulance provider's quality improvement plan will function in accordance with the requirements of a ~~Department~~Division led, Countywide quality improvement plan as specified by the ~~Department~~Division. The ambulance provider shall participate in the ~~Department~~Division'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 ~~Department~~Division 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 ~~Department~~Division 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 ~~Department~~Division policies and procedures.

III. Personnel

A. The ambulance provider shall ensure that personnel comply with ~~Department~~Division 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~~-1~~ driver and one EMT~~-1~~ attendant.

2. ALS Ambulance – One EMT~~-1~~ driver and one paramedic attendant, or one paramedic driver and one paramedic attendant.

3. Critical~~Specialty~~ Care Transport Ambulance (CS~~S~~CT) – Minimum of one (1) EMT~~-1~~ driver, (1) Paramedic attendant, and one (1) specialty attendant. The specialty attendant may be a registered nurse, physician, nurse practitioner ,or physician assistant~~, or respiratory therapist that is directly related to the continuum of the patient's care~~.

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 ~~Department~~Division 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 ~~emergency medical dispatch (~~EMD~~)~~, EMT~~-1~~, ~~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, ~~pager,~~ 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 ~~Department~~Division~~'s Medical Director~~ 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~~-1~~, EMD, RN, or ~~EMT-~~Paramedic is terminated or suspended for disciplinary cause or reason.

2. An EMT~~-1~~, EMD, RN, or ~~EMT-~~Paramedic resigns following notice of an impending internal investigation.

3. An EMT~~-1~~, EMD, RN, or ~~EMT-~~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 ~~only~~ any action that is substantially related to the qualifications, functions, and duties of an EMT~~-1~~, RN, EMD, or ~~EMT-~~Paramedic.

G. Ambulance provider shall report~~ in writing~~ to the ~~Department~~Division whenever changes occur in management personnel of the ambulance company. Verbal n~~N~~otification shall be provided~~submitted~~ within 48 hours~~30 days~~ 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 ~~Department~~Division, 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 ~~Department~~Division, the California Vehicle Code, and the California Code of Regulations. The ~~Department~~Division may conduct unannounced ambulance inspections as well as observational ride alongs at any time. The ~~Department~~Division may remove an ambulance from service for non-compliance to ~~Department~~Division requirements.

B. The ambulance provider shall have a photocopy or the original ~~of~~ 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 ~~Department~~Division. The ~~Department~~Division 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 ~~Department~~Division. The ~~Department~~Division 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 ~~-1~~ or paramedic driver. The ambulance provider may also request temporary authorization to operate a BLS ambulance as an ALS ambulance through the ~~Department~~Division. 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 ~~ECG monitor~~, manual defibrillator, all medications not in the EMT scope of practice including narcotics, ~~all medical needles~~, laryngoscope and blades, endotracheal tubes~~,~~ ~~and~~ 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 ~~Department~~Division.

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 ~~1~~ or ~~EMT-~~Paramedic shall ~~routinely~~ 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 ~~Department~~Division 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 ~~Department~~Division for

receiving all pre-hospital calls for service. All calls shall be managed in accordance with the ~~Department~~Division 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 ~~Department~~Division 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 reported to the ~~Department~~Division, upon request.

H. The ambulance provider shall provide access, upon reasonable request by the ~~Department~~Division, 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 ~~Department~~Division 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 ~~Department~~Division 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 ~~Department~~Division staff for coordination of ambulance transport.

VII. Ambulance Resource Availability and Deployment

~~A. An ALS ambulance shall be dispatched to all calls where ALS service is presumptively indicated~~Ambulances shall be dispatched according to the current Emergency Medical Dispatch Response Configuration. ALS service shall be ~~presumptively~~ indicated for the following calls:

- ~~All Priority 1 calls,~~
- ~~All Priority 2 calls,~~
- ~~All Priority 3 calls where an ALS response is indicated by EMS Dispatch Policies and Procedures,~~

A. All Priority 4, 5, 6, 7, and 8 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.

~~See table on Page 13 for an explanation of the varying levels of priority codes.~~

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, ~~used on the above listed Priority 1, 2, and 3 calls~~ when all of the ambulance provider's normally available ALS ambulance resources have been exhausted and the BLS unit(s) is the only remaining available ambulance(s).

The use of a BLS ambulance on designated ALS responses, as specified in the current EMD Response Configuration, ~~the above listed Priority 1, 2, and 3 calls~~ more frequently than three percent per month per Priority Code per EOA is considered excessive use. The ambulance provider is non-compliant with this standard when BLS ambulances are excessively used three consecutive months in the same Priority Code, or four months in any consecutive 12-month period for the same Priority Code.

For example, there were 168 ~~Priority 2~~ALS designated responses in the EOA in the month, with four of the calls being answered by a BLS ambulance. Four is 2.4 percent of 168, and the limit of 3 percent has not been exceeded. The number of times a BLS ambulance was actually used for the month in

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the EOA was less than three percent of the ~~Priority 2~~ALS call volume. Therefore, the ambulance provider did not excessively use BLS resources.

B. The ambulance provider shall dispatch an ~~ALS ambulance (or BLS ambulance as allowed above)~~ ambulance that will provide the shortest possible response time to the call location for Priority 1, ~~and~~ 2 and 3 calls, ~~level~~ as specified in the current EMD Response Configuration. In an instance where an ambulance provider dispatches a BLS ambulance because of proximity to the call location, and the ambulance provider dispatches an ALS ambulance simultaneously, the use of the BLS ambulance will be exempt from the calculation of excessive use if the on-scene time of ALS ambulance is reported and used for determining response time compliance for the incident. If the on-scene time of the BLS ambulance is reported and used for determining response time compliance, the call will be included in the calculation of excessive use.

C. For Priority 1, 2, and 3 calls where ALS service is ~~presumptively~~ indicated ~~as described above~~by the current EMD Response Configuration, and the ambulance provider cannot place an ALS ambulance on scene within the required response time, and it is immediately known that an adjacent mutual aid ambulance provider can, the closest ALS ambulance shall be dispatched. In such instances, ECC shall also be notified.

See table on Page 13 for an explanation of the varying levels of priority codes.

D. BLS ambulance use is authorized whenever indicated by the current EMD Response Configuration.

~~D.~~E. BLS ambulance use is authorized for a prescheduled transport where BLS care is appropriate for the continuum of patient care, as determined by the transferring physician and consistent with ~~Department~~Division approved policies, procedures, and protocols.

~~E.~~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.

G. ~~F.~~ There may arise unforeseen unusual circumstances that reasonably justify BLS ambulance use. When it is determined by the ~~Department~~Division that such a circumstance occurred, individual BLS responses would be exempted from the calculation of excessive use.

H. A BLS ambulance may be dispatched simultaneously with an ALS first responder to an emergency call when ALS is specified in the current EMD Response Configuration. The use of the BLS ambulance will be exempt from the calculation of excessive use if the on-scene time of the ALS first

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responder is reported and used for determining response time compliance for the incident.

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~~I~~C. BLS ambulance use on calls where ALS service is ~~presumptively~~ indicated in the current EMD Response Configuration shall be subject to review by the ~~Department~~Division.

VIII. Ambulance 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 ambulance(s) for response to another emergency if the ambulance is not currently in use at the stand-by scene, and the ambulance provider is able to re-deploy another ambulance in a time frame specified by the Incident Commander.

B. Upon request of the ~~Department~~Division, the ambulance provider shall furnish a mutually agreeable number of units to participate in as many as three scheduled functional~~multi-agency~~ 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 a dedicated ambulance, 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 clean-up. 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, etc.) on scene no later than the agreed upon time. The ambulance provider will report compliance with this standard to the ~~Department~~Division ~~at least~~ monthly., ~~and the provider shall maintain a minimum of 90 percent compliance with this standard. If the provider fails to meet the 90 percent standard in any month the Department may find that the provider is out of compliance with this standard in that EOA.~~

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 ~~Department~~Division 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.

IX. Response-Time Performance

A. The ~~Department~~Division 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, or 8 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 1, 2, or 3, as appropriate.

~~5.~~6. For the purpose of accurate response time capture, the response time clock shall stop upon the ambulances arrival at the prison or military base gate/sally port.

D. Minimum Ambulance Response Time Standards:

1. Compliance is achieved when 90 percent or more of Priority 1 and 2 calls for each response time ~~priority by~~ 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 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 falls 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.

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3. The ~~Department~~Division will evaluate response time performance, population density, and call volume, annually. If the ~~Department~~Division determines that any area is underserved, or that changes in population or call volume warrant modification of the response zones, the ~~Department~~Division 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

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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
3	20 min	25 min	30 min	50 min	75 min
4	15 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

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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.

5. 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. ~~For determining contractual response time compliance, some of the Response Priority Codes will be combined to reduce the number of categories. Priority 1 will be a stand-alone reporting category. Priority 2 will be a stand-alone reporting category. Priority 3 and 4 will be a combined reporting category. Priority 5 will be a stand-alone reporting category. Priority 6, 7, and 8, will be a combined reporting category. For purposes of determining contract compliance, there are a total of five reporting categories.~~

Response Priority Code	Response Time Definition	EMD Response Level	Minimum Time Compliance Standard	Time Zone (minutes)	Response Mode	Time Compliance Combination
1	**Life-Threatening Pre-hospital Emergencies** – All prehospital life-threatening emergency requests, as determined by the dispatcher in strict accordance with ~~Department~~Division authorized EMD protocol.	• All Echo calls • All Delta calls	Not less than ninety percent (90%) per month by EOA.	Closest ALS Metro – 8 Urban – 15 Suburban – 25 Rural – 50 Wilderness – 75	Hot, Code-3	Priority 1
2	**Time-sensitive Pre-hospital Emergencies** – All prehospital non-life-threatening emergency requests, including emergency standby requests, as determined by the dispatcher in strict accordance with ~~Department~~Division authorized EMD protocol.	• All Charlie calls • All Bravo and Alpha calls where hot response is authorized.	Not less than ninety percent (90%) per month, by EOA	Closest ALS Metro – 10 Urban – 15 Suburban – 25 Rural – 50 Wilderness – 75	Hot, Code-3	Priority 2
3	**Urgent Pre-hospital** – Emergency medical call where ambulance provider takes immediate steps to dispatch a response, as determined by the dispatcher in strict accordance with ~~Department~~Division authorized EMD protocol. These include public safety standby requests.	• All Alpha and Bravo calls where cold response is authorized • All Omega calls	~~Not less than ninety percent (90%) per month, by EOA~~	Metro – 20 Urban – 25 Suburban – 30 Rural – 50 Wilderness – 75	Cold, Code-2	Priority 3, 4
4	**Time-sensitive Interfacility Emergencies** – medically necessary requests from an acute care hospital for a hot response for an emergency interfacility transfer	• All acute care hospital emergency transfer requests for hot response	~~Not less than ninety percent (90%) per month, by EOA~~	Metro – 15 Urban – 25 Suburban – 30 Rural – 50 Wilderness – 75	Hot, Code-3	Priority 3, 4
5	**Urgent Interfacility -** medically necessary requests from an acute care hospital for an emergency interfacility transfer, based on patient acuity/condition.	• All acute care hospital urgent transfer requests for cold response	~~Not less than ninety percent (90%) per month, by EOA~~	Metro – 60 Urban – 60 Suburban – 60 Rural – 60 Wilderness – 75	Cold, Code-2	Priority 5
6	**Scheduled Transfer or Long Distance Transfer** – All prescheduled patient transfer requests, including long distance transfer requests, as requested by caller.	4-hour advanced notification to ambulance provider is required	~~Not less than ninety percent (90%) per month, by EOA~~	On-Time, as mutually agreed	Cold, Code-2	Priority, 6, 7, 8
7	**Unscheduled Transfer** – 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 **not** scheduled 4 hours in advance	~~Not less than ninety percent (90%) per month, by EOA~~	On-Time, as mutually agreed	Cold, Code-2	Priority 6, 7, 8
8	**Special Event Stand-by** – paid special event stand-by requests	24-hour advanced notification to ambulance provider is required	~~Not less than ninety percent (90%) per month, by EOA~~	On-Time, as mutually agreed	Cold, Code-2	Priority 6, 7, 8
9	**Miscellaneous** - ambulance responses that are requests for service outside Kern County.	N/A	N/A	N/A	N/A	N/A

~~6.~~4. In the event that the ambulance provider anticipates that the maximum response time will be exceeded for prehospital Priority 1, 2, or 3 responses, ECC shall be notified per EMS Dispatch Policies and Procedures.

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~~7.~~5. In the event the ambulance provider anticipates that the maximum response time will be exceeded for Priority 4, 5, 6, 7 or 8 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 Division on call coordinator 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 a CT, MRI or other specialty services alone are not an indicator; the patient's condition/acuity will be the determining factor.

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E. Response-Time Measurement:

1. Response time for Priority 1, 2, 3, 4, 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 ~~Department~~Division 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 arrived 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 arrives at the requested call location or scene, wheels stopped, and ambulance dispatch is notified. In situations where the ambulance 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 arrives at the designated staging location. For Priority 1 or 2 responses, the response time standard to staging area shall not be relaxed unless the public safety agency has instructed the ambulance provider to stage for law enforcement or fire, to ensure the scene is safe. If staging for such a purpose, the required response time shall be the same as a Priority 3 response. The response mode shall be in accordance with EMS Dispatch Policies and Procedures.

5. Arrived at scene time is to be reported to the ambulance provider dispatcher by a manual action of the ambulance 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, 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, 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 is cancelled enroute prior to an ambulance 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 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 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.

7. 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 ~~Department~~Division, 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 ~~Department~~Division 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.

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.

8. For incidents requiring more than one ambulance, the first ambulance 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.

E. ~~F.~~ Response Time Exceptions ~~and Exemption~~ 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 disenable road is available,~~or periods of unusually high demand for ambulance services~~. Authorized categories for minimum response time standards exceptions are as follows:

   a. Local declared disaster involving mass casualties, or a Med-Alert.

   b. A ~~Department~~Division-authorized Ambulance Strike Team medical mutual aid deployment inside or outside of Kern County.

   c. If it can be demonstrated that providing ~~Department~~Division-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

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ambulance provider's EOA, the ~~Department~~Division is authorized to grant an exception for the late response.

d. Certain weather or roadway conditions that prohibit safe ambulance operation to meet response time standard, or the specified call location is inaccessible by conventional ground ambulance, as authorized by ~~Department~~Division.

F. Response time Exemption Requests:

~~e~~a. Period of unusually high demand, as described below.

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.

b. Extended offload times at ~~hopstitals~~ Hospitals as follows:

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.

2. 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.

2. ~~3.~~ 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 ~~Department~~Division. Ambulance provider shall submit detailed documentation that supports the request, including but~~y~~ not limited to~~e~~, 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 Division.~~, a s~~. The ~~exclusion~~ exemption request must be made in writing and included with the monthly report. No Exemption requests will be accepted, by

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the Division, after the monthly data has been submitted. The ~~Department~~Division will review the request and issue a final determination.

~~4. Requests for exemptions to time standards shall only be considered if the ambulance provider's performance falls below the required 90 percent threshold.~~

G. ~~G.~~ 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 Division. Priority 1 and 2 calls will be analyzed for compliance with the minimum 90 percent standard. ~~The number of calls within standard for a specific priority code (or combined priority codes, as noted) and response time zone divided by the total number of calls for that priority code and response time zone to determine the aggregate percentage compliance within each EOA.~~ 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 ~~each priority code and~~ within each response time zone in each EOA. Any priority 1 or 2 call ~~code~~, 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.

H. ~~H.~~ The ~~Department~~Division 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.

I. Non-Compliance Vs. Breach

a. 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~~.~~ u~~U~~p to 3 consecutive months.

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b. 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.

J. Penalties

Non-Compliance

a. 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.

Breach

b. 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.

~~I. 100-Response Rule:~~

~~1. For the purposes of determining compliance with response time requirements within the each zone of each EOA each month, the following method will be used. For every month in which 100 or more responses of any priority originate within the zone, 90 percent compliance is required for the month. However, for any month within which fewer than 100 of any priority responses originate within the EOA zone, compliance will be calculated using the last 100 sequential responses for that priority.~~

~~For example, if the Metro Zone produces 105 Priority 1 responses and 89 Priority 2 responses during May, the ambulance provider will be required to meet 90 percent compliance in May for Priority 1, while Priority 2 will be subject to the 100-response rule. The requirement for 90 percent response time compliance is not applicable to a zone until that zone accumulates 100 responses.~~

X. Records and Reports

A. 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 ~~Department~~Division specific documentation.

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B. Additional reports shall be submitted, as may be required by the ~~Department~~Division, for purposes of quality improvement studies and investigation follow-up.

C. For ambulance rate change requests, the ambulance provider shall submit reports and data described in Ambulance Rate Process.

D. Ambulance provider performance reports:

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

1. Required monthly reports are listed below. All monthly reports shall be submitted to the ~~Department~~Division before the 20th of the current month for the previous month.

   a. **Call Volume** - Call volume of responses by priority code, by~~by time~~ zone, by type of ambulance (ALS, BLS) per~~by~~ 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 type of ambulance (ALS, BLS) per~~by~~ 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 ~~Department~~Division-authorized mutual aid within and outside Kern County.

   f. **Turned Calls** - All "service requested, failed to respond" calls shall be listed.

   g. **Ex~~e~~emption 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 ~~exception~~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 ~~Department~~Division would also be listed here.

k. **Customer Service Tracking Database** – report shall contain the information required by Section XI, below.

l. **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:

1. **Trip Date:** The date of the response. Data in this field must be in the following format MM/DD/YYYY.

2. **Time of Call (TOC):** The time call is received. Data in this field must be in the following format HH:MM:SS.

3. **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.

4. **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.

5. **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 chose to omit this field if the data submitted for all time fields allows the elapsed time to be calculated automatically by the ~~Department~~Division.

6. **Unit ID:** Identification of the unit responded.

7. **Unit Type:** Clinical capability of responding ambulance. ALS means the ambulance is equipped with required ALS gear and staffed with at least one paramedic. BLS means ambulance is staffed with only an EMT ~~-1~~ crew, or unit does not have the required ALS equipment. Data in this field must be in the following format: "ALS" or "BLS".

8. **Location:** The location of the incident which may be an address, intersection, roadway description ~~,or~~ facility name or GPS coordinates.~~-~~

9. **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.

10. **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).

11. **Priority:** The response priority code. This code shall be listed as a single digit of 1 through 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.

12. **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 chose to omit this field if the data submitted for the Key Map field allows the EOA number to be determined automatically by the ~~Department~~Division.

13. **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.

14. **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~~spelled out~~ ~~–~~as follows: KERNVILLE, LAKE ISABELLA, ARVIN, LAMONT, TEHACHAPI, FRAZIER PARK, CAL CITY, BORON, MOJAVE, or ROSAMOND, as applicable.

15. **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 ~~Department~~Division 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 ~~Department~~Division is capable of automatically generating the information from the Call Data report.

2. Required annual reports are listed below. All annual reports shall be submitted to the ~~Department~~Division 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 ~~Department~~Division licensed or accredited employees (EMD, EMT~~-1~~, ~~EMT-~~Paramedic or RN)

   e. Preventive mechanical maintenance program affirmation statement.

XI. 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~~Division~~ 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 ~~Department~~Division 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 ~~Department~~Division on a monthly basis.

D. The ~~Department~~Division 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.

XII. Annual Achievement Benchmarks

A. By April 15th of each year, each ambulance provider will prepare and submit to the ~~Department~~Division 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 ~~Department~~Division, 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.~~3. Volume of transports by response priority code by time zone per EOA

~~3.~~4. Volume of ALS ambulance transports by response mode by time zone per EOA

~~4.~~5. Volume of BLS ambulance transports by response mode by time zone per EOA.

~~5.~~6. Response time compliance by month, by priority, by community, and per~~by~~ EOA.

~~6.~~7. Volume of "service requested, failed to respond" calls

8. ~~7.~~ Volume of mutual aid given and received by ambulance provider.
9.
10. ~~8.~~ Emergency Medical Dispatch performance measures (EMD Activity and associated QA Reports).
11.
12. ~~9.~~ Customer service inquiry and complaint tracking database, listing incidents by source, types, and outcomes.
13.
14. ~~10.~~ Listing of community service and public education events conducted by month, including multi-agency drills/exercises.
15.
16. ~~11.~~ Listing of Continuing education activities.
17.
18. ~~12.~~ Any other information the ~~Department~~Division may need or request for use in preparing the Annual Report of Benchmark Achievement.

B. At least once each year, the ~~Department~~Division 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 ~~Department~~Division 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 ~~Department~~Division. 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 ~~Department~~Division for processing.

C. After receipt of each provider's annual report of contract compliance and achievement, the ~~Department~~Division 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:

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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 ~~Department~~Division 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 ~~Department~~Division projects, committees, task forces, etc., and multi-agency 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 ~~Department~~Division projects, committees, task forces, etc.

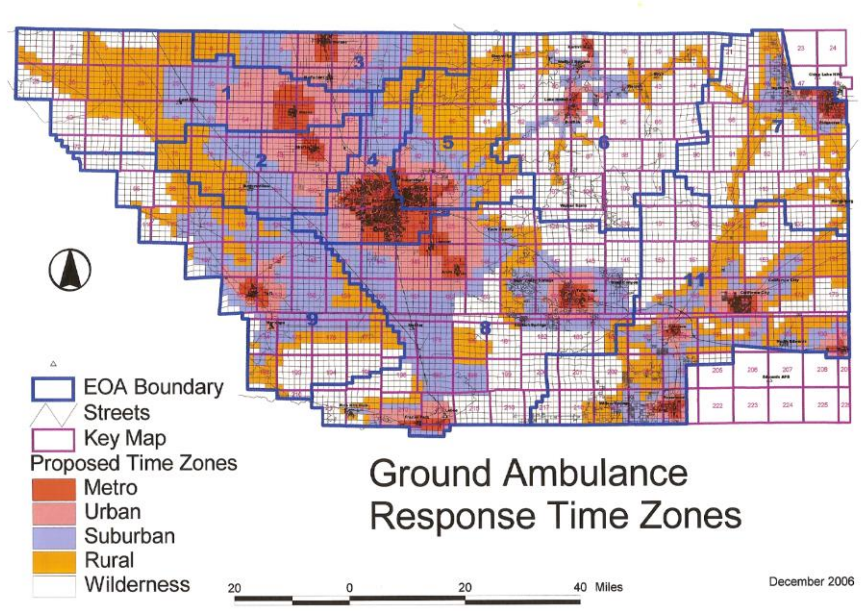
h. Ratings will be issued based on compliance or non-compliance.

D. The ~~Department~~Division 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.

XIII. 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 ~~-1~~ – Emergency Medical Technician ~~- 1~~
~~EMT-P - Emergency Medical Technician - Paramedic~~
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
~~SCT~~CCT – Critical~~Specialty~~ 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
September 11, 2018 -

X. New Business

C. ALJ/EMSA Commission Decision

KERN COUNTY
Public Health Services
DEPARTMENT

MATTHEW CONSTANTINE
DIRECTOR

1800 MT. VERNON AVENUE BAKERSFIELD, CALIFORNIA, 93306-3302 661-321-3000 WWW.KERNPUBLICHEALTH.COM

EMS Division Staff Report for EMCAB-August 9th, 2018

ALJ/Commission Decision

Background

Health and Safety Code 1797.254 states, "Local EMS agency shall annually submit an emergency medical services plan for the EMS area to the authority, according to EMS systems, standards, and guidelines established by the authority." Such a plan was filed with the California Emergency Medical Services Authority in 2012. This EMS plan was denied by the authority who indicated that the transportation section was at issue due to EMSAs disapproval of our EOA structure. The EMS Director at the time believed that the EMS plan was valid and appealed the states denial. This marked the first time that a Local Emergency Medical Services Agency filed an appeal of an EMSA decision.

The Dilemma

The Emergency Medical Services Authority had no official due process procedure in place so the appeal had be put on hold in order for the state to create a due process system. In March of 2018 the appeal was finally heard in this room by an Administrative Law Judge. After three days of testimony and the filing of amicus briefs by both attorneys the judge took the case. On May 18th, 2018, Administrative Law Judge Samuel D. Reyes, issued his proposed decision. In the proposed decision Judge Reyes upheld Kern County's Exclusive Operating Areas 2, 3, 4, 5, 6, 8, and 9 however he agreed with the state for EOAs 1, 7, and 11. On June 20th, 2018, the State of California Commission on EMS adopted the proposed decision by Judge Reyes.

The EMS Division Plan of Action

Due to Judge Reyes' decision and the adoption of said decision by the EMS Commission, Kern County EMS will undertake the task of conducting a competitive bid process with intention of awarding Exclusive Operating Areas 1, 7 and 11 to the most qualified bidder(s). This process is expected to be lengthy and take one to two years to complete.

Therefore IT IS RECOMMENDED, the Board receive and file this report.

XII. Misc. Documents for Information

A. EMS Annual Fund Report

EMS DIVISION
KERN COUNTY PUBLIC HEALTH SERVICES DEPARTMENT
MADDY EMS FUND

FISCAL YEAR 2017-18 ACTIVITY

	MADDY Deposits + Interest	RICHIE'S Deposits + Interest	Admin 10% of Each Fund	Richie's Fund (15%) Distribution	Total Physician Claims Submitted In Quarter	Physicians 58% both funds Balance	Physician Payments in Quarter	Percent Paid to Physcians	Hospitals 25% of Both Fund Balance	Hospital Payments in Quarter	Other EMS 17% MADDY Balance	Other EMS 17% RICHIE"S Balance
JULY 2017	118,701.99	98,291.41	21,699.34	14,743.71		105,319.29			45,137.59		18,161.40	12,532.16
AUGUST 2017	114,632.46	99,978.06	21,461.06	14,996.71		106,814.06			44,538.19		17,538.77	12,747.20
SEPTEMBER 2017	106,637.60	98,603.56	20,524.12	14,790.53		100,529.62			42,481.63		16,315.55	12,571.95
Total for Quarter 1	339,972.05	296,873.03	63,684.52	44,530.95	308,087.23	312,662.97	154,060.13	50%	132,157.41	214,539.67	52,015.72	37,851.31
OCTOBER 2017	101,984.83	89,617.37	19,160.23	13,442.61		93,492.73			39,749.84		15,603.68	11,426.21
NOVEMBER 2017	108,455.80	99,181.01	20,763.68	14,877.15		100,474.31			42,999.00		16,593.74	12,645.58
DECEMBER 2017	95,501.33	89,200.21	18,470.15	13,380.03		89,368.31			38,212.84		14,611.70	11,373.03
Total for Quarter 2	305,941.96	277,998.59	58,394.06	41,699.79	314,098.63	283,335.35	157,067.12	50%	120,961.68	198,106.29	46,809.12	35,444.82
JANUARY 2018	97,490.78	84,912.04	18,240.28	12,736.81		88,053.13			37,856.43		14,916.09	10,826.29
FEBRUARY 2018	113,984.85	106,944.02	22,092.89	16,041.60		106,551.86			45,698.60		17,439.68	13,635.36
MARCH 2018	113,606.77	103,015.69	21,662.25	15,452.35		105,022.33			44,876.97		17,381.84	13,134.50
Total for Quarter 3	325,082.40	294,871.75	61,995.42	44,230.76	365,025.46	299,627.32	182,531.83	50%	128,432.00	210,258.91	49,737.61	37,596.15
APRIL 2018	126,067.00	113,879.12	23,994.61	17,081.87		116,029.34			49,717.41		19,288.25	14,519.59
MAY 2018	104,580.50	99,328.36	20,390.89	14,899.25		42,154.68			42,154.68		16,000.82	12,664.37
JUNE 2018	132,216.61	112,633.92	24,485.05	16,895.09		50,867.60			50,867.60		20,229.14	14,360.82
Total for Quarter 4	362,864.11	325,841.40	68,870.55	48,876.21	319,122.06	209,051.62	-	0%	142,739.69	233,160.68	55,518.21	41,544.78
YEAR-END SUP.		-	-								-	
YEAR TO DATE	1,333,860.52	1,195,584.77	252,944.55	179,337.71	1,306,333.38	1,104,677.26	493,659.08	38%	524,290.78	856,065.55	204,080.66	152,437.06