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**Versions:**
December 22, 2004 – Initial list of standards
March 17, 2005 – Initial rough draft
April 28, 2005 – revised draft
August 17, 2005 – revised draft
March 15, 2006 – revised draft
March 31, 2006 – revised draft
September 21, 2006 – Initial refined working draft
September 28, 2006 – Revised working draft
October 3, 2006 – Revised working draft
October 5, 2006 – Revised working draft
October 6, 2006 – 1st public draft
October 24, 2006 – 2nd public draft
October 30, 2006 – 3rd public draft
November 3, 2006 – 4th public draft (for EMCAB of Nov 9)
**November 10, 2006 – 5th public draft**
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 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 and license within the ambulance service operating area to meet these standards and achieve compliance with all other Department 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 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. 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. The ambulance provider is responsible for obtaining all medical justification and customary documentation from the sending physician for non-emergent interfacility ambulance service requests. When transportation is indicated for moving a patient from a medical facility, an ambulance shall be used under the following circumstances:

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, gastrointestinal port, or nasogastric tube.

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 long-distance interfacility transport of a patient to the medical facility specified by the transferring physician. However, the ambulance provider may refuse an-a long-distance interfacility transfer to a destination outside of Kern County, except under the following two circumstances:

1. The ambulance provider will be reimbursed for the services performed; or

2. The transferring physician can demonstrate that there is no physician associated with a general acute care 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, 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 and Medical Director. The program will include provisions for prehospital personnel continuing education, service operational procedures and standards, monitoring compliance with Department requirements, and continuous operational efficiency monitoring. The ambulance provider’s quality improvement plan will function in accordance with the requirements of a Department led, Countywide quality improvement plan as specified by the Department. The ambulance provider shall participate in the Department’s quality improvement program.

G. The ambulance provider shall ensure that each patient is transported to the closest most appropriate hospital in compliance with the Ambulance Destination Decision Policies and Procedures. An ambulance shall transport emergency patients to the most accessible emergency medical facility equipped, staffed, and prepared to administer care appropriate to the needs of the patient, according to Department requirements.

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 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 policy. Advertising any telephone number in lieu of 9-1-1 for prehospital emergency calls is prohibited.

J. Any incentive programs which provide additional monetary gain for field personnel (e.g. bonuses or stipends in addition to normal pay) which are directly or indirectly related to the application of medical procedures to patients shall not be permitted.

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 policies and procedures.

III. Personnel

A. The ambulance provider shall ensure that personnel comply with Department
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. Specialty Care Transport Ambulance (SCT) – 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,
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 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’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-P is terminated or suspended for disciplinary cause or reason.

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

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

G. Ambulance provider shall report in writing to the Department whenever changes occur in management personnel of the ambulance company. Notification shall be submitted within 30 days of the action. 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, 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, the California Vehicle Code, and the California Code of Regulations. The Department may conduct
unannounced ambulance inspections at any time. The Department may remove an ambulance from service for non-compliance to Department requirements.

B. The ambulance provider shall have a photocopy or 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. The Department may issue temporary MICU authorization for instances of mechanical problems that warrant moving the supplies and equipment to another ambulance.

D. The Department may inspect any ambulance at any time. Each ambulance shall be stocked with all supplies and equipment as specified by the Department, the California Vehicle Code, and the California Code of Regulations. The Department may remove an ambulance from service for non-compliance to Department requirements.

E. Each ambulance operated by the ambulance provider shall be of adequate size to conduct patient transport, at the discretion of the Department. The Department 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.

F. Ambulance providers shall have a preventive mechanical maintenance program for ambulances, so as to ensure compliance with California Highway Patrol minimum standards.

G. 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. 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.

H. 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 including narcotics, all medical needles, laryngoscope and blades, endotracheal tubes and nasogastric tubes. 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.
I. 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.

J. The ambulance provider shall ensure that all ambulances subject to call or service are mechanically sound and safe to operate at all times.

K. Each ambulance will be subject to unannounced inspection by the Department. The Department may remove an ambulance from service for non-compliance to Department requirements.

L. Ambulance personnel certified or licensed as EMT-1 or EMT-P shall routinely wear insignia or labels that clearly identifies his/her level of certification/licensure to the public and other first responder personnel.

VI. Dispatch-Communications

A. The ambulance provider shall maintain dispatch procedures consistent with Department 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 for receiving all pre-hospital calls for service. Said All calls shall be managed in accordance with the Department 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 EMD 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 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.

12. Start of Transport Time: The time the ambulance begins patient transport.


14. Transport Priority Code: Transport priority code used to destination.

15. Destination Arrival Time: The time the ambulance arrives at the destination.

16. Available for Response Time: The time the ambulance is available for service or subject to dispatch for a subsequent call.

17. Relevant Dispatch and Response Details: The ambulance provider shall have the ability to keep information on all call cancellations prior to or during response; patient not transported; delay during response; and back up ambulance response information. This information may be recorded in a notes field, and it shall be reported to the Department, upon request.

H. The ambulance provider shall provide access, upon reasonable request by Department, 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 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 or 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. 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 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 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. 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,
   - 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 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 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 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 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 the EOA was less than three percent of the Priority 2 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) that will provide the shortest possible response time to the call location for Priority 1 calls. 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, 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.

D. 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 approved policies, procedures, and protocols.

E. BLS ambulance use is authorized for prearranged special event stand-by, if that is the level of care being requested by the event sponsor.

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

G. BLS ambulance use on calls where ALS service is presumptively indicated shall be subject to review by the Department.

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, the ambulance provider shall furnish a mutually agreeable number of units to participate in as many as three scheduled 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 at least monthly and shall maintain a minimum of 90% compliance with this standard. If the provider fails to meet the 90% standard in any EOA in any month the Department may find that the provider is out of compliance with this standard.

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 Department 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 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 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.

D. Minimum Ambulance Response Time Standards:

1. Compliance is achieved when 90% of calls for each priority by zone, in each Exclusive Operating Area (EOA) meets the specified response time criteria over a calendar month period. For example, to be in compliance for Priority 1 responses for Metro Zone, 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% of the time for all Priority 1, Metro Zone calls for that EOA in the calendar month of November.

2. The ambulance provider is required to meet the Maximum 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 chronically underserved.
3. The Department will evaluate response time performance, population density, and call volume, annually. If the Department determines that any area is chronically underserved, or that changes in population or call volume warrant modification of the response zones, the Department may modify any or all of the zones. Ambulance providers shall be consulted prior to any changes in response time standards for any operating area.

4. Maximum Required Response Times:

<table>
<thead>
<tr>
<th>Priority Code</th>
<th>Metro Zone</th>
<th>Urban Zone</th>
<th>Suburban Zone</th>
<th>Rural Zone</th>
<th>Wilderness Zone</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>8 min</td>
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<td>50 min</td>
<td>75 min</td>
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</table>

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 throughout these standards 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.
<table>
<thead>
<tr>
<th>Response Priority Code</th>
<th>Response Time Definition</th>
<th>EMD Response Level</th>
<th>Minimum Time Compliance Standard</th>
<th>Time Zone (minutes)</th>
<th>Response Mode</th>
<th>Time Compliance Combination</th>
</tr>
</thead>
</table>
| 1                     | Life-Threatening Pre-hospital Emergencies – All prehospital life-threatening emergency requests, as determined by the dispatcher in strict accordance with Department 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 authorized EMD protocol. | • All Charlie calls  
• All Bravo and Alpha calls where hot response is authorized.  
• All Omega calls                                                                                     | Not less than ninety percent (90%) per month, by EOA | 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 authorized EMD protocol. | • All Alpha and Bravo calls where cold response is authorized.  
• All Omega calls                                                                                     | Not less than ninety percent (90%) per month, by EOA | Metro – 15 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 | • All acute care hospital urgent transfer requests for cold response | Not less than ninety percent (90%) per month, by EOA | Metro – 45 Urban – 60 Suburban – 60 Rural – 60 Wilderness – 60 | Cold, Code-2 | Priority 5                  |
| 6                     | Scheduled Transfer – All prescheduled interfacility patient 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 interfacility patient transfers, as requested by the caller. | 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                     | Long Distance Transfer, or Special Event Stand-by – long-distance interfacility patient transport requests or paid special event stand-by requests | 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             |
| 9                     | Miscellaneous Transports - ambulance responses that are requests by for service outside Kern County. | N/A                                                                                                   | N/A                             | N/A                | N/A          | N/A                         |

6. 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.
7. In the event that 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).

E. Response-Time Measurement:

1. Response time 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 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 if the difference in the times is less than 46 minutes.

3. For Priority 6, 7, and 8 requests for interfacility transfer, the call time is the same as the arrived at scene time. The ambulance provider is compliant so long as the transporting unit is on scene by or prior to the scheduled call time.

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 ECC 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 dispatched, 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, 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 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 as if that segment is within the original contractor’s EOA.

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.

F. Response Time Exceptions and Exemption Requests:

1. The ambulance provider shall use best efforts to maintain mechanisms for reserve production-response capacity and to increase production-response 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 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-authorized Ambulance Strike Team medical mutual aid deployment inside or outside of Kern County.

   c. If it can be demonstrated that providing Department-authorized emergency mutual aid into another ambulance provider’s EOA caused a shortage of resources that is directly attributable for a late response within the responding ambulance provider’s EOA, the Department 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.
Period of unusually high demand, applicable to EOAs 1, 3, 4, 5, 7 and 9 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 sum of the following formula:

\[ \text{Overload Score} = (1.5 \times [1 \text{ Standard Deviation}]) + \text{The Mean} \]
rounded to the nearest whole call
for the entire population of Priority 1, 2, 3, 4, and 5 calls dispatched for that hour for the past 20 weeks.

In no case shall the Overload Score be less than 1.

2. Equipment failures, traffic congestion, ambulance failures, inability to staff units, and other causes will not be grounds for granting an exception to compliance with the response standards.

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 such a review by the Department. Ambulance provider shall submit detailed documentation that supports the request. The exclusion request must be made in writing and included with the monthly report. The Department 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. 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 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: From March 1st through March 31st for the month of March there were 357 Priority 1, 2, 3, 4, and 5 calls dispatched for that hour for the past 20 weeks. The compliance rate is 94 percent.

2. Aggregate monthly response time performance will be applied to each priority code and response time zone in each EOA. Any priority code, by zone, resulting
in less than the 90% percent response time performance is non-compliant with the Standards.

H. The Department 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. 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 calendar 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 a single month May, the ambulance provider will be required to meet 90% percent compliance for the month 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 specific documentation.

B. Additional reports shall be submitted, as may be required by the Department, 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:

1. The ambulance provider shall provide monthly and annual reports in a format approved by the Department. The reports will be submitted electronically. These will include the following reports:

a. Monthly Response Standard Reports: Monthly operations reports providing response volume, transport volume, and response time performance by priority code by zone for the previous month. A list of all calls not meeting response-time performance criteria shall be included. Late calls in which the ambulance provider is seeking an exception shall be identified, and the documentation to support the request submitted. Additionally, all “service requested, failed to
respond” calls shall be listed. Each response to incidents outside the assigned EOA(s) shall be listed. Each response to Department-authorized mutual aid within and outside Kern County shall be listed.

i For EOAs 1, 3, 4, 5, 7 and 9, the report shall include the number of responses, by hour, by day, by EOA for the preceding 30 days, to facilitate use of the Overload Score formula.

ii For authorized single-ambulance communities, all response time information required for the EOA shall be submitted for each community.

b. All monthly reports shall be submitted to the Department before the 15th of the current month for the previous month.

c. Monthly Resource Use Reports: Monthly reports showing the number of BLS ambulance responses to Priority 1 calls, Priority 2 calls, Priority 3 calls where staging is indicated, and those Priority 4 calls where the transferring physician requests ALS service per EOA. The report shall include the number of ALS responses, by hour, by day, for the preceding 30 days, to facilitate use of the ALS Overload Score formula.

d. Other Monthly Reports:

1) Monthly Operation Report providing a monthly total complete report of unit-hour utilization, incidence of first responder “ride-ins,” EMD Activity and QA Report, continuing medical education provided, public education and information activities provided, investigations and inquiries by source types, outcomes, and resolution, and a list of customer complaints received during the preceding month.

2) Monthly Clinical Performance Report that will include, at a minimum, a summary of cardiac-arrest resuscitation attempts, percentage of successful resuscitations, endotracheal intubation success rates, and such other data as may be required by the Medical Director or Department designee.

3) Gurney Off-Load Time - the time the patient is moved off the ambulance gurney at the transport destination and care is transferred to receiving staff. Gurney off-load time shall be reported by the total number of minutes per month at each of the acute care hospitals in Kern County that have an emergency department authorized to receive ambulance patients. The total number of transports to each facility for the month shall also be reported.
XI. Customer Service Performance

A. When an ambulance provider receives a complaint from the general public, patients, patients’ families, healthcare facilities, or providers and public safety agencies regarding his/her organization or employee, the ambulance provider will log each and every complaint. All complaints whether received in writing or received by telephone will be included, provided that the plaintiff gives their name and contact information. The ambulance provider shall provide a customer service program that addresses interactions with patients and families, oversight agencies, hospitals, emergency department physicians and nurses, other healthcare facilities, fire service agencies, law enforcement agencies, public officials, and media representatives. The ambulance provider shall make same-day initial contact with the customer. Investigation and follow-up of findings shall happen concurrently and outcomes shall be looped to the initial customer source, unless there is a legal patient-confidentiality restriction. The ambulance provider shall allow the Department to audit the customer service program, upon request.

B. The complaint log shall contain at a minimum, 1) the nature of the complaint, 2) a determination of whether the complaint was resolved or not, 3) the time, in days, it took to resolve the complaint, and 4) the Run Number if applicable to a specific call. All inquiries and 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. The ambulance provider’s quality improvement function through a monthly committee of field and managerial personnel shall analyze outcomes and trends.

C. Ambulance provider will initiate an internal complaint resolution process in an attempt to address the issue. The tracking database, listing incidents by source, types, and outcomes, shall be submitted to the Department on a monthly basis.

D. The Department 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.

F. When an ambulance provider receives an accolade or commendation from the general public, patients, patients’ families, healthcare facilities, or providers and public safety agencies regarding his/her organization or employee, the ambulance provider will log all praises. All praises whether received in writing or received by telephone will be included, provided that the person gives their name and contact information.

G. The praise log shall contain at a minimum, 1) the nature of the appreciation, and 2) the Run Number if applicable to a specific call.

H. Both logs will be submitted to the Department on a monthly basis, in an electronic format approved by the Department.
XII. Annual Achievement Benchmarks

A. By April 15th of each contract year, each ambulance provider will prepare and submit to the Department a report of contract compliance and achievement. This report will be in a format acceptable to the Department, and the report will indicate the extent of compliance with all performance provisions of the contract and these standards. Additional achievements may also be required or submitted.

At a minimum the report must contain:

1. Call volume of responses by priority code by time zone per EOA
2. Volume of transports by priority code by time zone per EOA
3. Volume of ALS transports by priority code by time zone per EOA
4. Volume of BLS transports by priority code by time zone per EOA.
5. Response time compliance by month, by priority, by community, and by EOA.
6. Volume of “service requested, failed to respond” calls
7. Volume of mutual aid given and received by ambulance provider.
8. Volume of standbys and special events by month.
10. Customer service inquiry and complaint tracking database, listing incidents by source, types, and outcomes.
11. Listing of community service and public education events conducted by month, including multi-agency drills/exercises.
12. Listing of Continuing education activities.
13. Any other information the Department may need or request for use in preparing the Annual Report of Benchmark Achievement.

B. At least once each year, the Department may require each ambulance provider to mail a quality and customer service questionnaire to every patient served during a period of up to one month. The Department in consultation with the Medical Director and EMCAB will design and approve the content of the questionnaire. The ambulance provider must provide and send the questionnaire, when so requested by the Department. 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 for processing.
C. After receipt of each provider’s annual report of contract compliance and achievement, the Department will prepare an Annual Report of Benchmark Achievement for each provider and the EMS system as a whole. The report will contain the following sections:

1. Contract Compliance - The ambulance provider’s extent of contract compliance, any notices of exceptions or instances of non-compliance and provider’s performance in curing those deficiencies.

2. Ordinance Compliance - The ambulance provider’s extent of compliance with ordinance requirements, any notices of exceptions or instances of non-compliance and provider’s performance in curing those deficiencies.

3. Customer Service Performance – Demonstrating the ambulance provider’s efforts and acumen at providing customer service. The components of this section will include:
   a. Inquiry and Complaints Tracking Database - listing incidents by source, types, and outcomes.
   b. Customer Survey – If the Department 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 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. Provision of adequate clinical equipment.
   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 projects, committees, task forces, etc.
h. Ratings will be issued based on compliance or non-compliance.

D. The Department will compile the extent of compliance and will evaluate each ambulance provider’s performance. 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

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